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MEDICARE PROVIDER-SPONSORED ORGANIZATIONS

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED FIFTH CONGRESS

FIRST SESSION

APRIL 24, 1997

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MEDICARE PROVIDER-SPONSORED ORGANIZATIONS

THURSDAY, APRIL 24, 1997

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

The subcommittee met, pursuant to notice, at 1:40 p.m., in room 1100, Longworth House Office Building, Hon. Bill Thomas (chairman of the subcommittee) presiding.

[The advisories announcing the hearing follow:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
April 17, 1997
No. HL-11

CONTACT: (202) 225-3943

Thomas Announces Hearing on Medicare Provider-Sponsored Organizations

Congressman Bill Thomas (R-CA), Chairman, Subcommittee on Health of the Committee on Ways and Means, today announced that the Subcommittee will hold a hearing on Medicare provider sponsored organizations. **The hearing will take place on Thursday, April 24, 1997, in room 1310 Longworth House Office Building, beginning at 1:00 p.m.**

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

BACKGROUND:

Provider-sponsored organizations were a key component included in the Balanced Budget Act of 1995 (which was vetoed by the President) to increase the array of private plan choices available to Medicare beneficiaries. President Clinton also included a PSO initiative in his Fiscal Year 1998 budget proposal. Under current law, the only types of managed-care organizations qualified to participate in Medicare are Federally-qualified health maintenance organizations (HMOs) and State-approved competitive medical plans. HMOs and competitive medical plans are required by Medicare law, among other things, to be licensed under the laws of a State as a condition of participating in Medicare, and many states require PSOs to meet the same licensing and operating requirements as HMOs.

PSOs generally are cooperative ventures of hospitals and groups of physicians that eliminate the health insurer or managed-care plan as an intermediary and offer health services and insurance coverage directly to patients.

While there is now a growing consensus that PSOs should be allowed as a new option for Medicare beneficiaries, the conditions under which PSOs will be allowed to participate in the Medicare program have been subject to considerable debate.

Under the Balanced Budget Act of 1995, PSOs were defined broadly as public or private entities established or organized by health care providers or groups of affiliated providers. The Balanced Budget Act generally required affiliated providers to assume full financial risk on a prospective basis for all Medicare benefits, and allowed PSOs to meet Federal solvency and capital standards developed under a negotiated rulemaking process. PSOs could seek temporary waivers of State laws, other than for solvency, under certain circumstances.

(MORE)

The President's PSO proposal would require PSOs to be affiliated with hospitals, require PSOs to assume substantial financial risk only under certain circumstances, and preempt State solvency laws that differ from Federal PSO solvency standards. The President's proposal would require State licensure of PSOs where State standards are substantially equivalent or, after 1999, more stringent than the Federal Government's PSO licensing requirements. Both the Balanced Budget Act and the President's proposal would reduce for PSOs the minimum number of enrollees necessary to participate in the Medicare program and waive the requirement under certain circumstances that PSOs have 50-percent non-Medicare and non-Medicaid enrollees. Several separate bills also have been introduced in the 105th Congress by Members of both parties in the House and Senate to make PSOs available under the Medicare program.

In announcing the hearing, Chairman Thomas stated: "Expanding choice by allowing beneficiaries to enroll in provider-sponsored organizations and other private health plans was a key point of the Republican Medicare restructuring plan in the 104th Congress. I am pleased that the President has now joined us in the growing consensus to give seniors more choice. Because the health care market is constantly changing, however, we need to examine more closely the proper role of the Federal government and standards of participation for PSOs in the Medicare program. I believe doctors and hospitals ought to have the right incentives to join together to offer their own health plans to Medicare beneficiaries."

FOCUS OF THE HEARING:

The hearing will focus on the role that PSOs may play in offering expanded private coverage options to Medicare beneficiaries and the standards of participation under which PSOs are most likely to optimize benefits to beneficiaries.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Any person or organization wishing to submit a written statement for the printed record of the hearing should submit at least six (6) copies of their statement and a 3.5-inch diskette in WordPerfect or ASCII format, with their address and date of hearing noted, by the close of business, Thursday, May 8, 1997, to A.L. Singleton, Chief of Staff, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. If those filing written statements wish to have their statements distributed to the press and interested public at the hearing, they may deliver 200 additional copies for this purpose to the Subcommittee on Health office, room 1136 Longworth House Office Building, at least one hour before the hearing begins.

FORMATTING REQUIREMENTS:

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

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages including attachments. **At the same time written statements are submitted to the Committee, witnesses are now requested to submit their statements on a 3.5-inch diskette in WordPerfect or ASCII format.**

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

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

4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

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

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

(MORE)

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202-225-1721 or 202-225-1904 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

*****

*****NOTICE — CHANGE IN ROOM AND TIME*****

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
April 23, 1997
No. HL-11-Revised

CONTACT: (202) 225-3943

Room and Time Change for Subcommittee Hearing on Thursday, April 24, 1997, on Medicare Provider-Sponsored Organizations

Congressman Bill Thomas, (R-CA), Chairman of the Subcommittee on Health, Committee on Ways and Means, today announced that the Subcommittee hearing on Medicare provider-sponsored organizations previously scheduled for Thursday, April 24, 1997, at 1:00 p.m., in 1310 Longworth House Office Building, **will be held instead in the main Committee hearing room, 1100 Longworth House Office Building beginning at 1:30 p.m.**

All other details for the hearing remain the same. (See Subcommittee press release No. HL-11, dated April 17, 1997.)

****

Chairman THOMAS. The subcommittee will come to order.

Today's hearing is the 12th subcommittee hearing this year, and this particular hearing will focus on Medicare provider-sponsored organizations. PSOs were among the private health plan options at the heart of the Republican's plan during the 104th Congress to reform the Medicare program. While the Balanced Budget Act, which contained those physician-sponsored organizations, was vetoed by President Clinton, I am pleased to see that in the President's proposal he has embraced PSOs as well.

I do strongly believe that doctors and hospitals should be encouraged to join together and offer private health plans directly to Medicare beneficiaries. Health plans owned and controlled by doctors and hospitals can provide a unique opportunity for providers to furnish high-quality health care plans at affordable costs, particularly in rural America.

At the same time, however, we obviously need to assure beneficiaries and taxpayers that these health plans are not only the highest quality, but also are financially sound. It's easier to say that than to figure out a structure under current knowledge to do it at a very high comfort level.

While we should reduce obstacles that may deny doctors and hospitals the opportunity to compete in the Medicare marketplace, we obviously can't lower the bar so far that Medicare beneficiaries and the Medicare Trust Fund are exposed to excessive financial risks and disruptions in crucial health services.

Reasonable people can differ. There are a number of reasonable bills in. What we want to do is to try to find as high a commonly-accepted approach as we possibly can. I believe, over the last several years, everyone has gained a better understanding of whether or not what they initially assumed to be true was true or not. That's why I look forward to today's testimony. I know it will help guide us in creating a policy which balances these competing goals.

The gentleman from California.

Mr. STARK. Thank you, Mr. Chairman. I thank you for holding this hearing.

I guess I could sum it up by saying that PSOs make me nervous. It escapes me as to why we should take a rather loosely defined group of providers and give them special exemption from the laws that seem to be working throughout the country.

The New York Times documented abuses in a major national hospital system's fee-for-service type operation, and I don't know how we prevent those under capitated PSOs. I worry about rural areas, where suddenly all of the resources may come under one provider group and not refer out cases that may be beyond the competence of, say, primary care or family physicians.

Then the question is, why did we consider overriding State law? PSOs are happening. I don't know that they need special regulations. I don't know that the regulations are more onerous when applied to professionals of higher skill.

I have trouble deciding whether one doctor in a chain of hospitals makes it a physician PSO, or one hospital and a group of physicians makes it a hospital PSO. But we do have regulations that seem to be working. I guess I have to be shown that there is something intrinsic in just saying you can take a group—I mean, it

would be a lot easier for any managed care group to say "I want to become a PSO." How do they do it? Do you get one doctor on the group, or do you get 10 or 20 percent? I don't know how that would work.

I would like to ask that we include in the record a letter from a group of 11 health care and consumer groups who are concerned about this, and make that complete my statement.

Chairman THOMAS. Without objection.

Mr. STARK. I thank the Chairman.

[The following was subsequently received:]

April 23, 1997

The Honorable Fortney "Pete" Stark
Ranking Democratic Member
Subcommittee on Health, Committee on Ways and Means
239 Cannon HOB
Washington, DC 20515

Dear Representative Stark:

The Health Subcommittee of the Ways and Means Committee is considering proposals relating to the regulation of provider-sponsored organizations (PSOs) under Medicare. Our organizations are greatly concerned that these proposals, including H.R. 475 and the Administration's budget, would afford PSOs special treatment that would erode existing consumer and quality protections, as well as limit the effect of future state improvements.

Currently, Medicare risk contractors must meet state licensure requirements. The proposals before the Committee would end that requirement for PSOs. As you know, many states have passed or are considering legislation to protect consumers enrolled in managed care plans. Examples of such provisions include expanding information and disclosure, due process rights for providers and enrollees, the elimination of marketing abuses, access to specialists and specialty care centers, external quality assurance programs and consumer representation. We believe that state standards that afford greater protections should apply to Medicare beneficiaries -- senior citizens and persons with disabilities who may be most vulnerable to managed care abuses. The interests of consumers would not be advanced by the creation of PSOs that provide less protection or lower quality care than would otherwise be required under state law.

Additionally, we are concerned about provisions in the PSO proposals that seek to restrict greatly the care which PSO enrollees can obtain from non-participating providers. For many Medicare beneficiaries, including those with chronic health care conditions, the ability to obtain out-of-network care is an important quality and continuity issue.

Many of the proponents of PSOs have argued that consumers are better served by local, provider-operated delivery systems. However, there is little evidence that turning hospital administrators and physicians into managed

care plan administrations results in major differences in quality or access to care. In fact, a study of six large PSOs in California found hospital utilization rates 40 percent below those of other California HMOs and about half the rate of national Medicare and commercial plans. Therefore, we believe that there is little justification in exempting PSOs from state standards designed to improve quality and access.

Finally, in addition to these problems that affect all PSOs, we are concerned that the proposals could have the result of encouraging the growth of PSOs operated by large, multi-state provider organizations. Those concerns are exemplified by the current practices of hospital chains such as Columbia/HCA, the nation's largest for-profit hospital chain and the country's ninth largest private employer, which is currently under federal investigation for questionable Medicare billing practices. Columbia/HCA could obtain PSO status directly under some proposals or indirectly through its local provider entities under others, allowing it to operate free from many important consumer protections.

For these reasons, we hope that the Subcommittee will reject proposals to override state licensure requirements for PSOs enrolling Medicare beneficiaries. We appreciate your attention to our views.

Sincerely,

AIDS Action Council
Center for Disability and Health
Citizen Action
Consumer Federation of America
Consumers Union
National Association of Social Workers
National Council of Senior Citizens
National Health Law Program
National Senior Citizens Law Center
Neighbor to Neighbor
United Church of Christ, Office of Church in Society

Chairman THOMAS. Just let me briefly respond, that all of your questions are questions that I find interesting. Obviously, we're going to have to find answers to them.

Just from a quick personal experience in the community of Ridgecrest, that has one hospital and 34 doctors, through a HCFA waiver we've been able to create a PSO. The key there was bringing in a third party to deal with many of the financial arrangements between the doctors and the hospital. This is evolving.

I think all of the gentleman's questions need to be responded to and hopefully answered at a level that will give the gentleman some comfort, but certainly responded to.

Does the gentlewoman from Connecticut want to make a statement?

Mrs. JOHNSON. Thank you, Mr. Chairman.

I would just like to take a moment to mark this hearing as a significant event. In the 104th Congress, a group of Republicans spent many, many hours on a very significant Medicare reform bill that addressed many of the underlying problems in our health care system, both for seniors and nonseniors. As you will recall, we changed the way medical education was funded, to provide long-term strength to our medical centers, and we also wrote the first PSO law, to try to assure that the managed care market would embody a competition focused on quality.

We do have to answer all the questions that my colleague, Mr. Stark, posed. But there is some reason to believe that provider-sponsored organizations will help the competitive market focus on and be accountable for quality, all actors in it.

This is a hearing and a discussion and a consideration that we should have been able to have in the last Congress. As one elected official in this Nation who felt particularly strongly about the deception of reducing the Medicare debate to cutting spending, as many did, including our President, I would just have to say that today is a very important occasion, because it is a time now in which we're beginning to talk about the real structural reforms necessary to enable Medicare to offer better benefits, a more modern benefit package, to our seniors, and at the same time constrain the rate of growth of costs. Not only will we do that in our market, but we will strengthen the under-65 market if we do this right.

I congratulate the chairman on holding this hearing, and I congratulate the administration for, now that the political debate is over, supporting a discussion that is extremely important to seniors in America, because it's the only avenue through which they're going to get better benefits at reasonable cost, and also joining us in a difficult discussion that ought to be fruitful at the end of the course.

Thank you, Mr. Chairman.

Chairman THOMAS. I thank the gentlewoman.

Now, if we might hear from Kathleen Buto, the Associate Administrator for Policy, Health Care Financing Administration. Any written testimony you may have, Kathy, will be made a part of the record, and you can address us in any way you see fit.

I note that the testimony is dated April 24th, 1997. To underscore the gentlewoman from Connecticut, it would have been exciting had it been '95 or '96. But, better late than never.

Thank you very much.

STATEMENT OF KATHLEEN BUTO, ASSOCIATE ADMINISTRATOR FOR POLICY, HEALTH CARE FINANCING ADMINISTRATION

Ms. BUTO. Thank you, Mr. Chairman. I am very pleased to be here and have an opportunity to discuss the Administration's proposals.

I am going to specifically focus on the similarities and differences regarding PSOs in the President's 1998 budget proposals, the Balanced Budget Act of 1995, and a bipartisan bill introduced by Representatives Greenwood and Stenholm, which is very similar to a bill introduced by Senators Frist and Rockefeller. I will also present our experience to date with PSOs in the Medicare Choices demonstration program.

Let me start with areas of agreement. With the goal of increasing managed care choices, all three proposals would permit PSOs to contract directly with Medicare to enrolled beneficiaries. We believe the PSO option, coupled with revisions to managed care payment methodologies, will have an important and positive impact on increasing managed care enrollment for Medicare beneficiaries in areas where enrollment is low, including rural areas.

There is also agreement in all three bills, with a few exceptions, that PSOs should be required to meet the same standards as Medicare HMOs. Under the President's budget, PSOs would be held to all of the same standards related to quality, access, marketing, beneficiary liability, benefits, and appeals and grievances, as Medicare HMOs. This is also true of the Balanced Budget Act and the Greenwood-Stenholm bill.

There are differences, and let me focus on these. The proposals have different approaches in four areas: fiscal soundness and solvency, private enrollment requirements, State licensure requirements for PSOs, and the ability of the PSO to offer a point-of-service option. It is important that we have a forum such as this hearing to discuss these issues and the concerns of all stakeholders. In developing consensus on these issues, I believe that we would all agree that our primary focus should be what is best for the beneficiary.

Let me start first with fiscal soundness and solvency. Under all three proposals, PSOs would be subject to different fiscal soundness and solvency standards than HMOs because of differences between the delivery systems. Under the President's budget and the Balanced Budget Act, HCFA would develop these standards through regulation. The Greenwood-Stenholm bill; however, establishes detailed standards in statute. The Administration would prefer that these standards be developed in regulation so that we could receive extensive input and consultation with other parties on this complex issue.

The second issue is private enrollment requirements. The President's budget would maintain the 50–50 rule until a new quality measurement system is finalized, with additional waiver authority in the interim. This 50–50 rule applies to all managed care plans involving commercial enrollment. Under the Greenwood-Stenholm bill, PSOs would be deemed to meet the 50–50 rule if they had ex-

perience providing coordinated care and met special quality standards that we believe are substantially similar to our current statutory regulatory requirements for Medicare HMOs.

The Balanced Budget Act would repeal altogether the 50–50 rule for managed care plans, including PSOs. The Administration believes that the 50–50 rule should not be completely eliminated until it can be replaced by quality measurement systems.

The President's budget would maintain current law minimum commercial enrollment requirements, which neither the Balanced Budget Act nor the Greenwood-Stenholm bill would require. The PSOs have experience managing risk for commercial enrollees before they enroll Medicare beneficiaries.

The third issue involves licensure. The Administration wants to ensure that PSOs would not face unreasonable barriers to entering the managed care marketplace, while also ensuring that PSOs are financially sound entities. We do not believe that a broad preemption of State licensing is necessary and that preemption of State licensing requirements should be limited as much as possible.

Under the President's budget, PSOs would be required to obtain State licensure once the State certification and monitoring program for PSOs had been approved by the Secretary. To be approved, the State's program would have to be substantially similar to Federal standards. After the year 2000, however, the State could impose more stringent standards, but before the approval of the State's program licensing requirements would be preempted.

The Balanced Budget Act utilizes a different approach; however, I do not plan to address this in detail. Both the Balanced Budget Act and the Greenwood-Stenholm bill provide for an approach that essentially requires identical standards which the States hold to the Federal standards. However, we believe that substantially equivalent or similar criteria in the President's budget is more reasonable and more flexible.

Before the year 2002, in the Greenwood-Stenholm bill, PSOs would not need to be licensed by the States at all, and the State law would be preempted, regardless of the relationship of these laws to Federal standards. After 2002, PSOs would be required to have a license only if they are identical.

The last issue is the point-of-service option. Under the President's budget, we would prohibit PSOs from offering a point-of-service option. We believe that, essentially, if a PSO wants to offer such an option, it essentially becomes more like an insurance product and really does fall under the purview of the States and ought to be regulated as an insurance product, rather than have the special provisions that we have set forth for PSOs.

I see that my time is running short. Let me just conclude by mentioning our Medicare Choices demonstration sites. These sites total 17, and 11 sites are PSOs. We have already learned that there is capability in PSOs to conduct enrollment and to process claims. Many of the functions that we anticipated PSOs would be able to handle, PSOs are handling.

One of our Florida PSOs, which has been in operation the longest, has already enrolled 4,000 beneficiaries and enrolls more every day. We expect that these demonstrations will give us a good in-

sight as to how some of the provider-sponsored organizations operate.

I would just note that the Choices demo was designed to reach areas where we do not have managed care plans, and it appears that PSOs have really been the entities that have stepped up to the plate.

Let me just conclude by saying that, while there are differences, I am very confident that, working together, we can accomplish the important objective of bringing these organizations into the Medicare program.

Thank you.

[The prepared statement follows:]

INTRODUCTION

Mr. Chairman, I am pleased to be here today to discuss the Administration's proposals regarding provider-sponsored organizations (PSOs). In other hearings this year, we have spoken about PSOs as one part of our Medicare managed care proposals, but this is our first opportunity to focus more closely on this important, new, managed care option.

In my testimony, I have been asked to discuss general areas of agreement regarding PSOs in the President's fiscal year 1998 budget, the Balanced Budget Act (BBA) of 1995, and a bipartisan bill recently introduced in the House by Representatives Greenwood and Stenholm, the Medicare Provider Sponsored Organization Act of 1997. I should note that Senators Frist and Rockefeller also introduced a bill which is very similar to the Greenwood-Stenholm bill. I will highlight the different approaches that each of these bills take in four key areas related to fiscal soundness and solvency, private enrollment requirements, State licensure requirements, and the ability to offer a point-of-service (POS) option. Finally, I will present our experience to date with PSOs in the Medicare Choices demonstration.

AREAS OF GENERAL AGREEMENT

Currently, the Health Care Financing Administration (HCFA) can contract with Federally-qualified health maintenance organizations (HMOs) and competitive medical plans (CMPs) to enroll Medicare beneficiaries. The Administration believes that Medicare beneficiaries should have more managed care choices. Thus, the President's budget would expand managed care options to include preferred provider organizations (PPOs) and PSOs. On this point, there is general agreement between Congress and Administration with both the BBA and the Greenwood-Stenholm bill permitting beneficiaries to enroll in PSOs.

We believe that direct contracts with alternative managed care models such as PSOs are the key to expanding managed care, particularly in rural areas. Currently, there are twenty-five States that have Medicare HMOs serving rural areas. As of March 1996, sixty-eight Medicare HMOs (fifty eight risk plans and seventeen cost plans) served beneficiaries in rural areas; only 79,000 enrollees out of a possible 1 million beneficiaries in these rural regions enrolled in Medicare HMOs. Coupled with revisions to the managed care payment methodology under which rural areas would be paid either a minimum payment amount ($350 per month in 1998) or a blended payment rate, we believe that the establishment of a PSO option would have a positive impact on managed care enrollment in rural areas.

There is also agreement that, with a few exceptions, PSOs should be required to meet the same standards as Medicare HMOs. Under the President's budget and the BBA, PSOs would be held to all of the same standards related to quality, access, marketing, beneficiary liability, benefits, and appeals and grievances. Under the Greenwood-Stenholm bill, PSOs would meet all the same standards as HMOs.

DIFFERENT APPROACHES IN FOUR AREAS

Although there is general agreement on PSOs as a new managed care option for beneficiaries, the various bills have somewhat different approaches on four issues -- (1) fiscal soundness and solvency, (2) private enrollment requirements, (3) state licensure requirements for PSOs, and (4) the ability of the PSO to offer a point-of-service (POS) option. Hearings like this one today will allow us to listen to all viewpoints -- from the States, managed care plans, providers, and beneficiaries and their advocates -- and to debate the merits of the various approaches.

In developing a consensus on these issues, I believe we would all agree that our primary focus should be what is best for the Medicare beneficiary. We all want to provide beneficiaries with new managed care choices. However, to ensure continuity and quality of care for our beneficiaries, we also want to be certain that such choices are sufficiently capitalized and have adequate protections against insolvency. We want to be certain that these new entities have experience managing risk and are appropriately certified and monitored for compliance with Medicare's requirements.

Fiscal Soundness and Solvency Standards

Since all Medicare HMOs are licensed by the State, all Medicare HMOs also meet State standards for fiscal soundness and solvency, which in many instances are more stringent than Federal standards. For example, Medicare's regulations require only that plans have a positive net worth, while States may require that plans maintain a minimum net worth.

Medicare also requires that contracting HMOs must also have a plan for handling insolvency that allows for continuation of benefits (for inpatients until they are discharged and for all enrollees for the remainder of the contract period for which payment has been made) and arrangements to protect members from incurring liability for payment of any fees which are the legal obligation of the HMO. To satisfy these requirements, the HMO must demonstrate that it has arrangements in place to cover at least two months of health care expenses, in the event the HMO becomes insolvent. The arrangements to cover health care expenses could include insolvency insurance, "hold harmless" provisions in provider contracts, continuation of benefits provisions, letters of credit, restricted State reserves, guarantees from the financially sound parent corporation, and net worth.

Under the President's budget, PSOs would be subject to different fiscal soundness and solvency standards than HMOs because of differences between their delivery systems. Unlike most HMOs which provide services through contracts, PSOs would provide a substantial proportion of services directly through their own physicians and hospitals. These fiscal soundness and solvency standards for PSOs are not specified in the President's budget bill. Instead, these standards would be carefully developed through regulation so that we could consider input from all parties on this complicated, evolving issue. Likewise, the BBA also would have permitted PSOs to meet solvency standards that are different than those applied to HMOs. The BBA also specified that in developing solvency standards for PSOs, the Secretary would take into account alternative means of protecting against insolvency. The Greenwood-Stenholm bill takes a somewhat different approach. While special solvency standards would be developed for PSOs, the bill specifically establishes such standards. As noted above, because of the complexities associated with this issue, the Administration would prefer that fiscal soundness and solvency standards for PSOs be developed in regulation rather than statute.

Private Enrollment Requirements

Under current law, to ensure that HMOs enrolling Medicare beneficiaries have sufficient experience managing risk, Medicare HMOs must have a minimum commercial enrollment of 5000 members in urban areas and 1500 in rural areas. In addition, a Medicare HMO's Medicare and Medicaid enrollment cannot exceed 50 percent of its total enrollment. This requirement is often referred to as the 50/50 rule. The 50/50 rule is considered by many as a "proxy for quality."

The President's budget would maintain the 50/50 rule for all managed care plans until a new quality measurement system is finalized. However, the rule would be modified by excluding Medicaid enrollees from the calculation, thus an HMO's Medicare enrollment only (not Medicare and Medicaid) could not exceed its commercial enrollment. In addition, before the quality measurement system is implemented, the Secretary would have additional authority to waive the 50/50 rule for managed care plans serving rural areas, for plans with good track records and in other circumstances the Secretary deems appropriate. The President's plan would also maintain the minimum private enrollment requirements for all managed care plans. However, the President's plan would allow PSOs to meet the 50/50 rule and the minimum private enrollment requirement in a different way than HMOs. The PSO could "count" as commercial enrollees individuals for whom the PSO providers were at substantial financial risk. For example, if the physician group of a PSO had received capitated payments from an HMO for a number of the HMO's enrollees, those individuals would count towards meeting the 50/50 and minimum private enrollment requirement for the PSO.

Under the BBA, the 50/50 rule was repealed for all managed care plans, including PSOs. The Administration believes that the 50/50 rule should not be eliminated until it can be replaced with

a quality measurement system. Under the Greenwood-Stenholm bill, PSOs would be deemed to meet the 50/50 rule if they had experience providing coordinated care and if they met "higher" quality assurance standards. I would like to note that while the Greenwood-Stenholm bill considers the standards listed in the bill as more rigorous than current law standards for HMOs, the Administration believes that these standards are similar to current statutory, regulatory and administrative requirements for Medicare-contracting HMOs, with the exception of the requirement to provide comparative outcome data. HCFA now requires all Medicare HMOs to submit HEDIS performance measures, and we will disseminate this comparative information to beneficiaries in the future. We believe it is important that outcome data for all managed care plans, not just PSOs, be provided to our beneficiaries so they can make informed decisions. To that end, under our Choices demonstration, we will be developing and testing quality outcomes that use encounter data.

Both the BBA and the Greenwood-Stenholm bill would permit PSOs to meet lower minimum enrollment requirements compared to current law. Under these bills, the Secretary could not enter into a contract with a PSO unless the PSO had at least 1500 enrollees in urban areas and 500 enrollees in rural areas. These minimum membership requirements, however, would not apply for the first three years of the PSO's contract. The Administration has concerns that these enrollment requirements would not ensure that PSOs' providers had sufficient experience managing risk before the PSO began enrolling Medicare beneficiaries.

Licensure Requirement for PSOs

There are different perspectives regarding whether PSOs should be required to be licensed by the State. Some assert that State insurance departments (who license HMOs in addition to other insurers) may impose unnecessarily stringent requirements, particularly fiscal soundness and solvency requirements, that would effectively prohibit PSOs from entering the managed care market. Consequently, they argue that the Federal government's standards for PSOs should pre-empt the State's licensing requirements. Alternatively, State insurance officials, HMOs and others argue that since PSOs would accept the same degree of risk as HMOs, in the form of capitated payments for their enrollees, both should be subject to the same State-determined standards.

The Administration wants to ensure that PSOs would not face unreasonable barriers to entering the managed care market place, while also ensuring that they are financially sound entities with the ability to manage risk. We do not believe that a broad pre-emption of State licensing requirements is necessary and that pre-emption of State licensing requirements should be limited to the extent possible. This approach is similar to that taken under Title XIII of the Public Health Service Act, also know as the HMO Act. Under the HMO Act, federally qualified HMOs are required to be organized under the laws of the State. However, the HMO Act also exempts federally qualified HMOs from any law or regulation that would prohibit the health plan from doing business in the State as an HMO.

The President's budget would provide Federal pre-emption of State licensing requirements in limited circumstances. Prior to approval of a State's certification and monitoring program for PSOs, the Medicare program would not require PSOs to be State-licensed in order to obtain a Medicare contract. State licensing requirements would be preempted unless the State's requirements are identical to Federal contracting standards. However, after the State has a certification and monitoring program approved by the Secretary based on its standards being substantially similar to Federal standards, PSOs would be required to obtain a license from the State. After 2000, the State could impose more stringent standards, but these standards would have to be approved by the Secretary.

The BBA utilizes a somewhat different approach, but we believe that the overall goal is the same. Like the President's budget, the BBA wants to ensure that PSOs are treated fairly compared to other managed care plans and that no PSO faces unreasonable barriers to entering the market. Under the BBA, PSOs would be required to apply for a license from the State. However, PSOs could seek a waiver of the licensing requirement from the Secretary if the State

does not act on the licensing application within 90 days or the State denied the application and one of the following applied: the State's standards were not the same as for other entities in substantially the same business; the State applied solvency standards but did not have its program approved by the Secretary (to be approved, the State's solvency standards must be identical to Federal standards); or the PSO has been reviewed by the Secretary and determined to meet Federal standards, but the State has denied the license based on the PSO's failure to meet its solvency standards.

We believe that the "substantially similar" criteria used to evaluate State programs used in the President's budget is more reasonable than the "identical" standards criteria in the BBA and Greenwood-Stenholm bill, since minor differences between State and Federal standards should not result in exemption from State licensure.

The Greenwood-Stenholm bill offers yet a third approach on this issue and appears to permit broader pre-emption of State licensing laws than under either the President's budget or the BBA. Under the Greenwood-Stenholm bill, before 2002, PSOs would not need to be licensed by the States. After 2002, PSOs will be required to have a license only if the State's solvency standards are identical to Federal standards and non-solvency standards are substantially equivalent. PSOs could request waiver of the licensure requirement if the State took more than 90 days to act on licensing application or if the State imposed unreasonable barriers to entry.

Point of Service Option

Under the President's budget, PSOs would be prohibited from offering a point-of-service (POS) option. We believe that if the PSO wants to offer an insurance product and accept risk beyond its own providers it should be treated as a Medicare HMO and meet the corresponding State licensure and Medicare contracting requirements. Neither the BBA or the Greenwood-Stenholm bill would prohibit PSOs from offering a POS option.

EXPERIENCE WITH PSOs IN THE MEDICARE CHOICES DEMONSTRATION

As you know from our past appearances before this Committee, the objective of the Medicare Choices demonstration is to test a broad range of managed care delivery systems, such as PSOs, and to evaluate the suitability of such options for the Medicare program. As a result, the Medicare Choices demonstration will give HCFA a " head start" on developing solutions to a wide range of implementation issues with respect to PSOs.

Of the seventeen sites in the Medicare Choices demonstration, eleven are PSOs. Of the eleven PSOs, four have received final awards and we have completed negotiations and certified the sites, which have started, or are about to start, enrollment under the demonstration. The remaining seven PSOs are completing developmental activities in preparation for site awards. Following is information about the eleven PSO Choice participants, including a description of the provider network, whether or not the PSO has received or will receive licensure from the State, the current status of the award and enrollment to date.

- **Mount Carmel Health System** in Columbus, Ohio, is a PSO of physicians and three hospitals. The final demonstration award was made February 28, 1997. This PSO has an HMO license from the State. The PSO initiated enrollment March 1, 1997 and has enrolled 530 beneficiaries.

- **Florida Hospital Healthcare System** in Orlando, Florida, is a PSO associated with the Adventist Health System. The plan will offer a basic HMO benefit in three counties in the Orlando area. The final demonstration award was made December 26, 1996. This PSO received special permission from the State to operate without a license for purposes of the demonstration. The PSO initiated enrollment January 1, 1997 and enrolled over 4,000 beneficiaries during the first 3 months.

- **Memorial Sisters of Charity** in Houston, Texas, is a PSO sponsored by the Memorial Healthcare System and the Sisters of Charity of the Incarnate Word. The final demonstration award was made December 26, 1996. This PSO has an HMO license. The PSO initiated enrollment in mid-February 1997 and reports 547 enrollees to date.

- **Crozer-Keystone Health System** in Media, Pennsylvania, is a PSO based in Delaware County. The final demonstration award was made December 26, 1996. This PSO has a risk-bearing PPO license. The PSO initiated enrollment around March 1, 1997 and has over 405 Medicare enrollees to date.

- **Georgia Baptist Health Care System, Inc.**, in Atlanta, Georgia, is a PSO with its flagship hospital in inner-city Atlanta. This PSO would allow Medicare beneficiaries to select a specialist as a primary care physician. The plan will be available in the four counties encompassing Greater Atlanta. The plan has received a State PSO license but, the State has not yet completed its certification of the plan's delivery system. The PSO plans to initiate enrollment this summer.

- **Baptist/St. Vincent's Health System** in Jacksonville, Florida, is a PSO which will offer benefits to Medicare beneficiaries in Duval and Nassau Counties. The PSO, which assumed the lead on this demonstration site following the withdrawal of the original HMO applicant (Healthcare USA), plans to submit revised application documents this summer in order to initiate enrollment in early 1998. This PSO will probably need and receive permission from the State to operate without a license for purposes of the demonstration.

- **Mercy Health Corporation** in Bala Cynwyd, Pennsylvania, is a PSO proposing a managed care product, "Liberty ElderCare", for Medicare beneficiaries including those beneficiaries qualifying for Medicaid. The delivery system will provide full Medicare benefits, including supplemental services, in medically underserved areas of Philadelphia and Delaware Counties. The plan is currently discussing the structure of its dual-eligible benefit design with the State and is exploring licensing options, including a joint venture with Keystone East HMO. The issue of licensure is still to be determined for this PSO. The plan hopes to initiate enrollment late this year.

- **People's Health Network** in Kenner, Louisiana, is a PSO established by Tenet Healthcare in March 1994 as a management services organization whose members are the New Orleans area Tenet hospitals and their affiliated Independent Practice Associations (IPAs). This PSO has an HMO license from the State. The HCFA certification site visit is scheduled for this month, and the plan hopes to start enrollment this summer.

- **The Morgan Health Group, Inc.**, in Norcross, Georgia, is a PSO organized as a physician-led primary care management organization. Morgan will serve beneficiaries in the 16 counties currently served by the Morgan Health Group. The plan has applied for a PSO license from the State of Georgia and hopes to initiate enrollment this summer.

- **University of California at San Diego (UCSD) Healthcare Network** in San Diego, California, is a PSO originally organized to manage commercial HMO risk agreements with the UCS provider network. This PSO has a modified Knox-Keene license from the State which the State has stated is sufficient for the Medicare Choices demonstration. The HCFA site visit is scheduled for this month, and the plan hopes to start enrollment this summer.

- **St. Joseph's Health System** in Atlanta, Georgia, is a PSO of 18 hospitals led by St. Joseph's Hospital of Atlanta. The plan will offer a full range of Medicare services in a 36-county service area in northern Georgia. The plan has applied for

a PSO license from the State of Georgia and hopes to initiate enrollment this summer or next fall.

Because only one PSO has been in operation for more than 3 months, and most have not yet started to enroll beneficiaries, experience under the Medicare Choices Demonstration at this time is still quite limited. Nonetheless, we have made some observations.

First, the PSO is an attractive option for Medicare beneficiaries. While enrollment rates vary among plans, all seem to be attracting beneficiaries. Florida Hospital reported receiving 5,500 calls during its first week of operation and enrolling 400 beneficiaries in those first few days. Of the 4,000 Medicare enrollees to date, 60 percent are from the fee-for-service market while 40 percent are transferring from HMOs. In a survey of 120 of those enrollees, the primary reason for joining the Florida Hospital plan was the hospital's reputation followed by the quality of the physician network. Over 80 percent of the respondents rated the fact that the plan was operated by a local hospital and physicians as very important. Over 90 percent also considered as very important the fact that the plan was locally headquartered.

Second, PSOs have been able to develop administrative capabilities in order to qualify for a contract with Medicare. While most of the PSOs in the demonstration have had some experience in providing health care under a capitated payment arrangement, few of the plans had experience as primary contractors responsible for all administrative functions. Although the plans remain at various stages of development, several of the plans have been able, quite expeditiously, to design marketing plans, establish enrollment procedures, and develop claims processing operations.

CONCLUSION

Despite our different approaches regarding financial standards, minimum private enrollment requirements, State licensure requirements for PSOs and the ability to offer a point-of-service option, there appears to be widespread bipartisan agreement that Medicare beneficiaries have the option of enrolling in PSOs. In resolving these differences, our overall goal should be to craft PSO legislation that best serves our Medicare beneficiaries. I am confident that working together we will accomplish this important objective.

Chairman THOMAS. Thank you, Miss Buto.

In your testimony you talk about the 50–50 rule as a proxy for quality—and I think we're all familiar with the history of it. But I guess my argument would be that, as long as you maintained a solid front that this was our substitute for quality, and everybody honored the 50–50 rule as our substitute for quality, that argument at least had some merit by being consistent.

When we now start saying that in certain areas you're not going to have to follow the 50–50 rule, but in other areas you are, in essence, you're competing. Then, don't we really erode the argument for maintaining a 50–50 standard anywhere?

Ms. BUTO. Let me address that in two parts.

The different rule, I believe that you are referring to a situation in which we would allow PSOs to count, instead of commercial enrollees, individuals which are at risk, and meet the 50–50 rule, we would not repeal it. We would broaden it so that PSOs can count individuals for whom PSOs have borne the risk.

The reason for that is PSOs do not have licenses to actually be HMOs, so PSOs are unable to have individuals as enrollees now and to bear risk. We were looking for a way to recognize PSOs' experience in managing commercial enrollees for another HMO or for another plan.

Mr. JOHNSON of Texas. Will the gentleman yield?

Chairman THOMAS. If that was your rationale, then why couldn't you take somebody who was required to follow the 50–50 rule and look at a history, and if they had—pick a year—a three year, five year, ten year, twenty year history in dealing with that same universe of people, you could begin to feel that you had a belief that they also would——

Ms. BUTO. Our proposal would provide for exemptions from the 50–50 rule, even as we are moving to the quality measurement approach and would eliminate it all together. Our proposal would include provisions for plans with good track records to obtain an exemption, as well as plans in rural areas. Therefore, we do broaden the exception for these plans.

Chairman THOMAS. I understand. But some folks get to fly by definition and others have to bump along the ground with exceptions. It just seems to me that we have reached the point—and it's not necessarily a contentious one. It's one, I think, of a maturing understanding of what's going on, fully understanding why the 50–50 rule went in in the first place, and that hopefully, in later testimony, or shortly, we'll get some experiential assistance in dealing with risk adjustment and other factors that will help us get a comfort level in moving away from what are agreed arbitrary methods of attempting to substitute quality.

The gentleman from Texas.

Mr. JOHNSON of Texas. Thank you, Mr. Chairman.

I believe a couple of those organizations in your test unit have State HMO licenses anyway. Are they meeting the 50–50 rule?

Ms. BUTO. You're talking about the Choices demonstration sites?

Mr. JOHNSON of Texas. Yes.

Ms. BUTO. A number of these do. I think four of the eleven have HMO licenses.

Mr. JOHNSON of Texas. Are they meeting the 50–50 requirement?

Ms. BUTO. A number of the sites are not meeting the 50–50 requirement.

Mr. JOHNSON. But they're still functioning in good shape. That's what he's talking about.

I totally agree with you, Mr. Thomas.

Ms. BUTO. If I could just comment on that, I agree that what we basically want to do is to move away from a proxy measure to real measures of quality. I think we have plans in the legislation to issue a set of specific quality requirements next year in rulemaking that would actually lay out alternatives for replacing the 50–50 rule all together. I believe this is the direction we wish to pursue for all plans.

Mr. JOHNSON of Texas. Thank you, Mr. Chairman.

Chairman THOMAS. Certainly.

I appreciate, even if it's just a brief review, of the various models and the way in which I think you fairly treated the work product, BBA, yours, and the Greenwood-Stenholm bill.

The one thing I would focus on, though—I don't know whether it has intrinsic value—but the BBA proposal for approval of the PSOs was subjected to a very extensive discussion between the House and the Senate. Since folk would sit at the table with a priori beliefs about whether or not PSOs and HMOs were a distinction without a difference and, therefore, should have to meet the same solvency standards, or that because of the uniqueness of the structure, they may not have to, and if States traditionally play the role, to what extent would the Federal Government intervene, if at all, and if so, when, or, in fact, should it be primarily Federal versus State.

As the gentlewoman from Connecticut said, we spent hours and hours discussing this and came up with a proposal which was predisposed to stay with the States, unless an evidentiary level would bring it to the Federal level.

The President's plan, as I think you rightly describe it, is kind of the other way around. It presupposes a Federal involvement which creates a series of preemptions and decisions and standards by fixed dates. In my opinion, if these are going to be as successful as we want them to be, that is a fairly extensive additional administrative responsibility that's going to be placed on HCFA.

What level of assurance can you give us that, in creating the pattern that you did, different than the one we did, you were fully cognizant and willing to assume the additional administrative responsibilities and burdens that would be placed on HCFA if the President's plan was to go forward, notwithstanding whether it's the appropriate way to go or not?

Ms. BUTO. We have certainly considered that, and we have had a little experience—although I do not think it is entirely parallel—where the Federal Government had a role both with the Medigap standardization and with the HCFA rules involving, if you will, the setting of some Federal standards and having the States then come in and either meet these standards or show equivalence. Therefore, we have had some experience in this area.

We have certainly considered it. If a State already has identical standards, we would immediately defer to the State and require that the PSOs be licensed by the State. We have this provision be-

cause we recognize that many States are moving fairly quickly in this area. We consider this provision as a more limited preemption.

Our experience has been that States move very quickly to standardize and to meet the requirements, so that states can, in fact, go ahead and license new entities and new models of care.

Chairman THOMAS. Thank you.

One concern, before I move on to others, is the belief that I think is shared by all of us, that if we could get a structure in place that made sense, in terms of hospitals and doctors creating, in essence, a local HMO, it would provide a better and more affordable service for rural areas.

You folks in your proposal have grappled with the AAPCC adjustments for low payment counties, which pretty obviously has as one of its components the medical use aspect in the area. We all agree that the AAPCC is an imperfect instrument, and then we look around for something that won't do more damage, skewing it in one direction or another, and we wind up with the AAPCC.

You folks have now suggested moving to a level, which was the balanced budget act level, of $350. Our rural friends have moved to a different approach, with a different formula. But regardless of how you determine it, it's clear that the decision is to move relatively significant amounts of money very quickly into rural areas. I think there's no question that, over time, that will create—especially in combination with provider-sponsored organization enablement—an opportunity to provide what you say you want to provide in your testimony.

My concern is that if you bump a rural county in Iowa from $221 a month to $350 a month, notwithstanding your willingness to move rapidly at the Federal level, how can we give any assurance to those folk who believe they're going to be receiving something approximating $1,500 a year additional benefits by virtue of the increase that these dollars will actually flow through the system? How can we, with our data, in terms of adjusting the community rate within that structure dealing with non-Medicare enrollees and the other factors of determining costs, be focused on, at the same time we change two of those moving parts, increase the AAPCC significantly, provide for provider-sponsored organizations, and make the statement that people in rural areas are going to get more of this increased benefit?

Do you understand my question? I know you've looked at it, but I didn't see it anywhere in the testimony, of how we're actually going to deliver what we say and think we're going to deliver in rural areas, other than simply increasing the take-home pay of the physicians who are there.

Ms. BUTO. I understand what you are saying: more benefits, increased quality of care, and better access.

What has been very good about one of the aspects of the AAPCC is the requirement that extra benefits be provided, where the payments, under the Medicare law, exceed what it actually costs to deliver care in that area. That difference will increase. It will be larger in rural areas than it is now. Currently, people would argue that there is very little available at all, which will actually require plans to offer extra benefits or other kinds of enhancements to bene-

ficiaries who use the plan. This is something that we monitor and carefully consider.

A second point is that we are reconsidering the ACR to determine how to calculate the costs to deliver this package of services. However, ultimately, the increased payment to rural areas should go back to the beneficiaries in the form of additional benefits.

Chairman THOMAS. I prefaced all my remarks on in what way are you going to be able to do that. That's my concern. Saying it ought to go back and having a mechanism in which we can show that, in fact, it's flowing through, when we don't have sufficient data on the non-Medicare enrollees, and coupling it with the suggested problems with the 50–50, I'm just saying there is a lot of moving parts in there——

Ms. BUTO. There are.

Chairman THOMAS [continuing]. And I don't have a comfort level that we can, to the degree we would like to make a statement to people in the rural areas, say we have increased the amount and they will receive, in essence, a flow through of that increased amount. I just don't see it right now.

Ms. BUTO. I think the key really is, as you pointed out, getting better data and being able to actually track the use of the additional money. That is something that we very much want to do.

Chairman THOMAS. But nobody's talking about in 1998 a better data structure. We don't have a substitute quality measure for the 50–50 rule. You know, three years down the road we have built in increased structures there and I don't want to play catch up when we've taken quite a bit of money, in a very limited time, and pumped it into areas where I don't yet see a high chance of gaining our return on our investment in providing these folks with quality care at cheaper prices and in choice structures.

We're going to have to work on that——

Ms. BUTO. That is a good point.

Chairman THOMAS [continuing]. And saying it doesn't make it so.

Ms. BUTO. I agree.

Chairman THOMAS. I hate to put money in an area and hope the weeds grow. I would much rather make sure the ground is cultivated and the flowers grow.

Ms. BUTO. I agree.

Let me just make one point about Provider Sponsored Organizations that is slightly different in that regard. Since PSOs are provider based, many collect data. We have data on use by physicians of services and a basis for developing a way of reviewing an increase in access or services.

Chairman THOMAS. You don't have to sell us on PSOs. I like especially the idea in the rural area, where it is the doctor moving to the new structure, rather than the patient having to find a new doctor in the new structure. That, to me, is the beauty of the ability of the rural doctors and hospital in creating a PSO, to minimize the fear and concern of the patients. So all of that makes sense to me.

I just have not seen how we're going to require a different computation of the ACR based upon the way the world has changed. That, to me, is an important part of any understanding of how this is going to occur.

I guess it's just a criticism of the fact that if we're really this close, then I'm going to start looking at the items that we don't have nailed down, because it would be a shame to agree to put in a structure and then find out it isn't doing what we wanted, because we don't have the data, we didn't plan for it, and we didn't structure it in a way to make it happen.

The gentleman from California.

Mr. STARK. Thank you, Mr. Chairman.

Miss Buto, I guess I'm concerned as to why we find a need to have a different regulation and standard for PSOs than we already have in place. I don't think you can define a PSO. I want to start the other way and ask you to define for me an entity which provides medical care now that wouldn't qualify as a PSO?

It sounds to me that what you're doing here, with very little adjustment, is basically removing any and all regulations from what are loosely called managed care providers.

Ms. BUTO. Not any entity would qualify because——

Mr. STARK. Name an entity that would not.

Ms. BUTO. Well, you have to be able to provide both hospital and physician services in order to——

Mr. STARK. All right. PHOs, MSOs, IDSs all qualify, right?

Ms. BUTO. Well, again, one of the things—There is not just a definition. There is the issue of do PSOs meet the solvency requirements, will PSOs they meet the quality requirements, et cetera.

Mr. STARK. I read here that all you have to have is a hospital, or group of hospitals, and physicians. That's basically your definition. Yes, there are some loose constrictions here on financial stuff, but not much. You don't define financial soundness. I mean, you have one paragraph. "The entity meets requirements for fiscal soundness and provision against insolvency developed by the Secretary."

Ms. BUTO. You also have to have experience managing risk, although it is experience managing the risk under a capitation agreement with HMOs and other entities.

Mr. STARK. How does a new one have experience if you organize a new one? The AMA is in here salivating at the thought of having a bunch of doctors organize these things and they've had no experience managing risk. They're doctors.

What I'm suggesting to you is—let me come back. I don't think you can name an entity that is now contracting generally with the public to provide health care services that wouldn't qualify. Name one.

Ms. BUTO. Well, I am unable to, because we have not yet defined the solvency standards. Until you do——

Mr. STARK. Leave solvency aside. That's something for the "bean counters" to deal with. It may or may not have a lot to do with quality.

Suggest to me a kind of organization that doesn't qualify for a PSO and, therefore, has been deregulated.

Ms. BUTO. All right. A physician group practice that does not have direct arrangements with a hospital, or any arrangements with affiliated providers, would not meet the requirement.

Mr. STARK. They don't qualify under your plan, so you're saying a group of physicians can't do it unless they affiliate with a hospital. You say here, if they affiliate.

So you've got to have a doctor and a hospital, at a minimum, right?

Ms. BUTO. At a minimum——

Mr. STARK. Tell me a plan that doesn't have a doctor and one hospital, or one hospital and one doctor, that wouldn't qualify.

Ms. BUTO. Would meet the definition of who could be considered, but you have to also meet these other requirements of managing risk, solvency, having the other arrangements that are needed to provide care.

Mr. STARK. Come on. You can't define those.

Ms. BUTO. That is what the statutes do.

Mr. STARK. There's nobody who wouldn't qualify.

The States have been wrestling with this for some time, and some States have done a better job than others. Why not let them continue?

Ms. BUTO. I believe that we very much want the states to continue. That is why we have written the statute the way we have, with basically the States taking over as quickly as the states' standards can be found to be substantially equivalent to the Federal standards.

Mr. STARK. You don't have standards that are half as good as California's now. Why should California catch up with you? That's like a rush to the bottom.

Now, there may be some States that don't have standards. New York has very good standards. You're going to wait until you catch up to New York, or until New York catches up to you? I don't know.

Ms. BUTO. I do not think we want to be in that position. What we are trying to do is to establish some basic standards. Since Medicare is a national program, we want to make sure that entities meet basically the same standards.

Mr. STARK. I read this as you're removing the standards. I mean, heavens sake, why would you exempt all these people from State standards?

Ms. BUTO. Let me try to answer that by saying that the reason we put this in was, when we drafted the legislation last year, many of these entities were unable to obtain State licenses.

Mr. STARK. Ah. Why?

Ms. BUTO. For reasons that we thought were worth considering an alternative set of standards for, having to do with solvency, and differences in their delivery systems. They also directly deliver care, and reasonable standards could be applied to these organizations——

Mr. STARK. So you mean you're weakening the State standards?

Ms. BUTO [continuing]. These standards do not currently exist.

Mr. STARK. You found State standards that these guys couldn't qualify for, right?

Ms. BUTO. They were trying to obtain, in some cases, HMO licenses, that they believed——

Mr. STARK. And they couldn't.

Ms. BUTO. The witnesses who will testify after me will probably testify at greater length—that they believed that these were inappropriate for their kind of system. So it is a delivery system——

Mr. STARK. So what you want to do is replace State standards that you perceive as being too tough with no standards at all?

Ms. BUTO. We are wanting to recognize these entities as——

Mr. STARK. You don't know who they are.

Ms. BUTO [continuing]. As different entities from HMOs.

Mr. STARK. Hey, I can recognize them. I can recognize every schlock, shyster, in the delivery business, and you're going to qualify him with one bill which says we don't have any more State standards. Come on.

Ms. BUTO. No, we are not interested in that, either.

Mr. STARK. But you're creating that. Why don't you allow the States to continue to regulate them? You have in your own bill where you define—I mean, you turn over to the States—here, the term physician. I'm quoting from the Social Security Act. It is defined as "is authorized to practice medicine and surgery by the State in which he performs such function."

Are you going to relieve the State's authority to recognize a physician?

Ms. BUTO. No.

Mr. STARK. Okay. So you're relying on the States for that much.

Ms. BUTO. We currently rely on the States for the basic standards under the Medicare HMO program. We intend to do that with PSOs as well.

Mr. STARK. Then why don't you continue to do that under this program?

Ms. BUTO. I believe that the legislation definitely says we want to do that. We want their laws to govern——

Mr. STARK. Why don't you come back to us when you have a set of standards, when you can define for me what the financial standards are, what the quality standards are, how many doctors they have to have? When you can do that——

Mrs. JOHNSON [presiding]. If the gentleman will conclude.

Mr. STARK. My time has expired, but I would just close, Madam Chairman, by suggesting that this is an administration that is ill-prepared to regulate anything. They might as well allow those States who are doing a good job to continue.

I find this not worthy of HCFA. It is just throwing away what has been a pretty good regulation. I certainly hope this kind of stuff doesn't see the light of day.

Mrs. JOHNSON. I will yield my time to myself as the next questioner.

I certainly disagree with my colleague, Mr. Stark, in many ways, so in a sense I want to take the question he has raised from a completely different angle.

I was struck by your comment, Miss Buto, that you don't want to allow the point-of-service option to an HMO because it would make it an insurance product. I don't understand why we would not want seniors in America to have the option of the variety of insurance products, as long as those insurance products provided all Medicare benefits and, you know, met the standards of solvency and quality that States have chosen to impose on their own Medi-

care systems and that we have chosen to impose on Medicare risk contracts.

Why wouldn't we want them to have that option when the market has demonstrated over and over again that the options will be varied, will offer a far greater range of benefits than anything Medicare is going to be able to offer in the foreseeable future and so on and so forth? Why wouldn't we want seniors to have the option of an insurance product, as long as that product very simply provided all Medicare benefits and met the solvency standards that the State imposes for other HMOs in their territory, and the general qualification standards that we have set for HMO risk contracts?

Ms. BUTO. Let me say that we very much support point-of-service. As you know, Medicare risk plans now offer I believe a number of—there is something like 30 plans which currently offer a point-of-service option.

The reason is fundamentally tied to the way that we are proposing Provider Sponsored Organizations——

Mrs. JOHNSON. Let me get that clear. You say that already there are Medicare programs offering the point-of-service option?

Ms. BUTO. Medicare risk programs.

Mrs. JOHNSON. But the legislation that you're proposing will not allow HMOs that aren't Medicare risk contractors to offer the point-of-service option?

Ms. BUTO. No. I am sorry. Our legislation on PSOs does not allow the point-of-service option for PSOs.

Mrs. JOHNSON. Why?

Ms. BUTO. The reason is——

Mrs. JOHNSON. They're just another form of an HMO. They have a different delivery system.

Ms. BUTO. Let me describe for you one of the real rationales—and this is an issue where clearly there are differences of opinion—for the Provider Sponsored Organization being able to preempt State law, whether it is for a short time or having that option preempted for a longer time, as under the Greenwood-Stenholm bill. This rationale involves fundamentally the plant, the equipment, the sweat equity of these entities which guarantee that the care provided will be there, and that the solvency requirement should recognize that and should allow for other liquidity to cover the out-of-plan services.

Point-of-service is an option that says fundamentally that beneficiaries can go outside the plan under a variety of different arrangements——

Mrs. JOHNSON. Exactly, a variety of different arrangements, and presumably, someone who qualified for a POS option would have that reflected in the standards that they were required to meet in terms of solvency.

Ms. BUTO. The solvency question gets much more complicated, if they get into point-of-service, and out——

Mrs. JOHNSON. Of course. But that is one of the issues that a State licensure group would look at.

Are you going to be a narrow PSO that only serves within, or are you going to be a provider service organization that also offers an out-of-network option? Then you would have different solvency re-

quirements. But why would we, at the Federal level, say you can't offer this option if you can meet the regulatory standards to offer it?

Ms. BUTO. I am just saying that, from our standpoint, it undercuts the basic point of having the preemption for the PSOs to have really what are regulated insurance products as part of their entire business.

Mrs. JOHNSON. Why do we need to preempt?

Ms. BUTO. I am sorry. That really does seem to be an issue where the States really ought to be regulating these products, not the Federal Government through a preemption, limited though it might be, by statute.

I understand your point.

Mrs. JOHNSON. I don't think that this is an irreconcilable problem. My time has expired, but I do think this is a far longer discussion about how we work out Federal and State authority in this area.

My goal, in working those issues out, is to assure that seniors have the maximum insurance type products possible, in the freest market to develop options possible. Because I think that serves their interest. We have already seen that.

Those are the products that expanded the Medicare benefit program, not the Medicare HMOs, not the Federal Government. So in looking at this issue, I'm looking for maximum flexibility, because I think seniors will benefit under that.

Ms. BUTO. I understand your point. Thank you.

Mrs. JOHNSON. Mr. Kleczka.

Mr. KLECZKA. Thank you, Madam Chair.

I don't necessarily agree with the line of questioning of my good friend and colleague, Pete Stark, but I would like to re-ask his same question, just to clarify something in my mind.

Let's say I run Kaiser, and I have doctors, I have hospitals, I have experience, I have all the criteria for a PSO/PSN. However, do you know what I don't like? I don't like the regulation in the solvency standards of the State of California. Like my own home State of Wisconsin—we're going to hear from our Commissioner—they're tough. So I'm going to go shopping around for a regulator who is not as tough.

I see that a part of the BBA includes that the Department of HHS will come up with regulations for solvency and the like, so I'm going to bet that it's not going to be as tough as California and I'm going to become a PSN.

So Pete's question is, why can't Kaiser flop, call themselves something else, and go shopping for some decent regulations, or easier regulations?

Ms. BUTO. Kaiser could do that.

Mr. KLECZKA. That was his point.

Ms. BUTO. However, I believe that the way we have structured our proposal it would not be in their interest to change over to a PSO regulation and to meet PSO standards in reporting. As soon as we certify that the State of California has a program to certify PSOs, Kaiser could return to the State of California. I am not sure that changing to a PSO regulation makes sense. However, it is an issue, obviously, and one that we are concerned about.

The reason why——

Mr. KLECZKA. So the answer to Pete's question is that any organization that has those components, like a Kaiser, can become a PSN? They would have to decide whether or not it's in their interest or what they're looking for, but that's the point he tried to make and——

Ms. BUTO. That is right.

Mr. KLECZKA [continuing]. And I think he was correct.

Ms. BUTO. Our objective is to make sure that the standards we set are standards that meet all the solvency and quality requirements, which that we would want in any plan of——

Mr. KLECZKA. Okay. But we're betting on that because the bill does not set those forth. It says they're going to be developed, right? So I don't know how long, when, et cetera.

Let me let you know where I'm coming from. The question in my mind is not when we're going to get PSOs, but how. I have no opposition to the creation of these entities. However, we had the issue before this committee last session, and the question came about as to who was going to regulate, who's going to license these types of entities. I produced an amendment, at the behest of the Governor of my State, and the Commissioner, and lost miserably on a roll call vote before the committee, because those who are promoting this new entity don't want State regulation.

However, under the Medicare program now, we have HMOs doing business with us, right?

Ms. BUTO. Right.

Mr. KLECZKA. Who licenses those HMOs and who provides the regulation for the current HMOs in the Medicare program?

Ms. BUTO. Well, first of all, Medicare certifies HMOs, but they must be licensed by the State. HMOs must also meet Medicare's requirements, and we certify HMOs. But we require——

Mr. KLECZKA. Okay. But they are also licensed like any other insurer, by the State that they're organized in, right?

Ms. BUTO. That is correct.

Mr. KLECZKA. So that begs the question, why do we need a whole new set of Federal rules and regulations on solvency and regulation when we already depend on the States to give us that for the HMOs currently doing business with the same program that PSOs are going to do business with?

Ms. BUTO. The answer is that the current State regulation goes to the HMO licensing. PSOs have made a case, and we at least agree with PSOs that there is a good case to be made, that PSOs can provide directly these kinds of services under risk, under capitation agreement, and have different solvency requirements.

Mr. KLECZKA. Why would they be different than any other organization serving the medical needs of my constituents?

You see, what we're talking about here is consumer protection, okay?

Ms. BUTO. I understand that.

Mr. KLECZKA. Because once the PSN pledges the building and blows the building, that person has to go somewhere for that insurance coverage. That's the problem that I possibly foresee in the future. So the bottom line to my logic here is that, if it's good enough for the Medicare HMOs, it should be good enough for these groups.

Let me tell you, the proponents of the legislation are the first ones that I've ever experienced that are looking for Federal regulation. Every other business entity in the country and the world wants to stay as far away from Washington, DC, as possible, and wants the regulators closer to them—i.e., in the States. Then, all of a sudden, for this particular type of entity, the Federal Government is going to offer a better deal. I question that and I'm very concerned about that.

Ms. BUTO. The recently enacted "Health Insurance Portability and Accountability Act of 1996" provides that the Federal Government sets standards. Therefore, I do not believe this is entirely without precedence.

Mr. KLECZKA. Again, let me finish by saying, if it's good enough for the HMOs in the Medicare program, it should be good enough for these new entities.

Thank you, Madam Chair.

Mrs. JOHNSON. Thank you.

Mr. McCrery.

Mr. MCCRERY. Thank you, Madam Chair.

This is a most interesting discussion. Mr. Stark, Mr. Kleczka, and perhaps their Democratic colleagues, argue in favor of devolution of power to the States.

Mr. KLECZKA. Would the gentleman yield?

Mr. MCCRERY. Sure, I would be glad to.

Mr. KLECZKA. I have learned well over the last two years, that all the knowledge and power rests in the States, and we're trying to push everything to the States. Eventually we're going to push the fiscal liability, but the Governors don't know that yet. [Laughter.]

Mr. MCCRERY. But, besides the fact that this is great fun, we have raised a lot of good questions today. I want to commend the Administration for at least putting forth a proposal on this subject. It's a very important subject, I think one that deserves a lot more discussion.

Many of these questions, many of these same concerns, were raised last year and the year before, and although we did reduce our thinking to legislation, as you know, and the President chose to veto it, much of what we had in our legislation is reflected in your proposal. There are some differences.

I look forward to working with the administration and with my colleagues with different views, to work out a suitable proposal to allow the market to offer this different kind of delivery system to seniors.

Thank you, Miss Buto.

Ms. BUTO. Thank you.

Mrs. JOHNSON. Mr. Johnson I think is next.

Mr. JOHNSON of Texas. No questions.

Mrs. JOHNSON. Mr. Ensign, Mr. Christensen?

Okay. Thank you very much, Miss Buto. I know this is the beginning of a long and extensive conversation, but I do hope that this year it will come to fruition, as I think it's an important issue. Thank you.

Ms. BUTO. Thank you so much.

Mrs. JOHNSON. If the next panel will come forward, we have Gail Wilensky, Chair of the Physician Payment Review Commission, accompanied by David Colby, Deputy Director of the Commission; and Josephine Musser, Chair of the Special Committee on Health Insurance, and President of the National Association of Insurance Commissioners, and Commissioner of the Office of the Commissioner of Insurance, State of Wisconsin.

I would have to say this was an extremely important source of information as we discussed these issues two years ago, and very helpful as we wended our way through. I know you will be an important consultant as we move forward. Of course, Dr. Wilensky has long contributed to the work of this committee and of the Executive branch as well, and we welcome the panel.

Mr. KLECZKA. Madam Chair, if I might have a moment to also extend a welcome to the Commissioner of Insurance from the State of Wisconsin. Commissioner Musser is the one who got me in trouble on this issue last year, and I'm going to ask her, in her comments, to get me out of trouble now. I look forward to her testimony. It's good to see you here.

Ms. MUSSER. I'll try.

Mrs. JOHNSON. Dr. Wilensky.

STATEMENT OF HON. GAIL R. WILENSKY, PH.D., CHAIR, PHYSICIAN PAYMENT REVIEW COMMISSION; ACCOMPANIED BY DAVID C. COLBY, PH.D., DEPUTY DIRECTOR, PHYSICIAN PAYMENT REVIEW COMMISSION

Ms. WILENSKY. Thank you, Madam Chair. I appreciate the opportunity to present the views of the Physician Payment Review Commission on provider-sponsored organizations. This is an area that we have looked at and commented on in the last two reports, including the one that was issued about three weeks ago to you.

The view of the Commission is that PSOs represent both opportunities and challenges, and we have come to some recommendations with regard to how they may be treated.

The opportunities are that they present a way to increase the availability of private plan options in areas that have had some difficulties. Those are particularly some of the rural areas and some of the smaller urban areas, but, of course, they may make a difference in larger urban areas as well, and, in general, because they offer options that have not previously been available to seniors, and we applaud that.

There are some challenges, however, that the Commissioners have been concerned about. In particular, it is to make sure that the seniors are protected, protected both from potential plan failure and also protected in the sense of making sure that quality health care is provided in these plans, and finally, as a matter of equity, to make sure that there are not advantages created for certain kinds of plans relative to other kinds of plans.

When the Balanced Budget Act was passed in the last session of Congress, there was a waiver of the usual requirements of State licensure and some new Federal standards with regard to solvency. The staff of PPRC attempted to assess how much change has occurred in the last two years, and what effect that might have on the need for new regulations and legislation.

As best they could tell, there appears to be substantial growth and changes going on in the States, in terms of how they are attempting to deal with the PSOs. There also appear to be a number of PSOs that have come forward indicating that there perhaps may be fewer barriers and obstacles to the development of PSOs than appeared to be the case in 1995.

The basic position of PPRC is that it is important to apply the same standards to all plans, but that it is also important to have some flexibility in terms of the establishment and the enforcement of these standards. In addition, it is very important to find direct measurements for quality and to get rid of or replace the 50–50 rule, which has not been a good way to assure quality and has also stopped the development of some of the plans that could provide health care.

In terms of the main policy options, there are really three questions that you need to deal with. The first is, should the PSOs be subjected to the same standards. We believe the answer to that is yes. We think there is a general consensus when it comes to quality assurance. The big debate has been whether or not there should be the same standards when it comes to financial reserves, deposit requirements, and to the minimum enrollment.

The question that I think the Congress needs to answer for itself is, whether there is a way to really guarantee the provision of contractual obligations in the case of financial failure or bankruptcy? If there could be, that might allow a lot more leeway.

The second issue is to find direct measures so that you can replace the 50–50 rule, that would allow the development of a lot of plans that are specifically geared toward the Medicare population, although we don't expect that that would be all plans by any means.

Then the third is the issue that you were discussing at the end of the last witness, which is who ought to be enforcing and developing the standards, the State or the Federal Government.

As you know, historically it's been the States. Our position is that it ought to continue as it has been, perhaps relying on NAIC to set a model that would have some consistency, since there is legitimate concern that some States have not been nearly as well developed in terms of their standards and may, in fact, have created barriers.

I personally—and I'm speaking for myself and not the Commission—would suggest that you consider an intermediate option as well. That is the use of provisional certification and licensure, if one of two occurrences happen. The first is if you have a Medicare only plan once you've allowed that now to occur by replacing the 50–50 rule. It would seem to me reasonable to allow for a Federal certification in that case, or secondly, if a plan can show unreasonable barriers, which I assume the other witness will assure us won't occur. But if it could be shown, then to have a temporary or provisional licensure, while that problem is eliminated, seems to me to be a reasonable intermediate position. Again, I would like to stress that is my personal opinion and not the opinion of PPRC.

Thank you.

[The prepared statement follows:]

STATEMENT BEFORE
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

PROVIDER SPONSORED ORGANIZATIONS

GAIL R. WILENSKY, Ph.D.
PHYSICIAN PAYMENT REVIEW COMMISSION

April 24, 1997

Mr. Chairman and members of the Subcommittee, I appreciate the chance to present the Physician Payment Review Commission's views on provider-sponsored organizations (PSOs). As you know, the Commission over the past two years has studied PSOs and other issues relating to the expansion of beneficiaries' options in the Medicare program.

Although PSOs are difficult to define and even harder to describe systematically, they appear to be growing in importance in various markets around the country. As a result, there is considerable interest from both policymakers and the organizations themselves in establishing a larger role for PSOs in Medicare.

From the perspective of the Medicare program, PSOs present both an opportunity and a challenge. As such, it is important to highlight both sides of the story. The opportunity lies in the hope that PSOs might increase the availability of private health plan options for beneficiaries, especially those with no options today. Advocates contend that PSOs may be more likely to emerge in small urban markets and rural areas that may have a hospital and groups of physicians, but no history of managed-care involvement.

The opportunity also lies in the possibility that PSOs may offer beneficiaries different options than they have under either traditional fee-for-service Medicare or in the health maintenance organizations (HMOs) that serve as risk contractors today. Many providers believe that provider ownership of health plans could be a way to reassert the importance of the physician-patient relationship and enhance quality while maintaining the organizational efficiencies associated with managed care.

The challenge for Medicare comes in ensuring that beneficiaries are protected in the event that new plans fail. Some experts warn that the risk of failure may be higher for PSOs, either because they are new, small organizations or because they lack adequate managerial experience or capitalization.

The challenge also is posed by the desire to avoid creating an advantage for one type of plan over others. This means making sure that standards are neither higher nor lower for PSOs or any other specific type of health plan.

Both this year and last year, the Commission called for applying the same standards to all plans participating in Medicare. In making this recommendation, we also conclude that, given differences in plan design, some flexibility might be appropriate in both establishing and enforcing these standards.

Providers seeking to form PSOs or to expand their presence in Medicare, however, assert that some rules in place today create barriers to market entry. In their eyes, for example, Medicare's requirement of a state license becomes a barrier if state regulators expect a PSO to conform to standards designed for an insurer or an HMO. Medicare's enrollment composition rule, better known as the 50-50 rule, is an obstacle for plans that prefer not to compete in a saturated commercial market as a prerequisite for competing in the Medicare market. (The 50-50 rule requires that no more than 50 percent of a plan's enrollees be Medicare and Medicaid beneficiaries.)

In 1995, PSO advocates convinced the Congress that they were different enough from other types of plans to warrant special treatment. Because state regulators were generally unwilling to recognize these differences, the Balanced Budget Act would have waived the usual requirement of state licensure and substituted new federal standards in the critical area of ensuring solvency.

Since then, however, circumstances have further reinforced the Commission's position. We concluded that the context of 1997 differs from that of 1995 in several ways. States are starting to make the adjustments necessary to ensure that PSOs do not face unnecessary barriers to market entry. In addition, whether under old or revised regulatory structures, PSOs in many markets have been succeeding. Together, these trends seem to reduce the urgency of special treatment for PSOs in federal Medicare legislation. Whereas the 1995 proposals generally assumed that state regulations were a significant obstacle, it may be reasonable in 1997 to assume that states are moving in an appropriate direction.

Accordingly, the Commission this year reiterates its support of the general principle that all plans that contract with Medicare should be subject to the same standards, as well as its position that some flexibility may be necessary to accommodate differences in plan design. We have added a specific call to monitor plan participation in Medicare to ensure that the rules, however structured, do not prevent qualified organizations from entering the Medicare market.

The Commission also concludes that the 50-50 rule has outlived its usefulness. Although viewed as a rough proxy for quality, the rule is arguably no longer needed in a Medicare program where more direct measures of health plan quality and performance are being implemented. Concurrent with implementing an enhanced quality assurance system that incorporates health performance measures, the Commission recommends that the 50-50 rule be dropped. Plans instead should be required to participate in an audited system of consumer-oriented performance reporting, maintain an internal quality assurance program, and be subject to external quality review by an independent entity approved by the Department of Health and Human Services.

To understand the combination of factors leading to the Commission's recommendations, I will talk about several topics in the remainder of my testimony:

- the current risk program, including types of plans participating and their availability to beneficiaries in different parts of the country,
- the characteristics of PSOs, and
- the current status of state regulatory efforts to accommodate new organizational forms.

At the end of my statement, I will elaborate on the policy issues and options that must be addressed by Medicare. A more detailed discussion of PSOs is in our *Annual Report to Congress 1997*, which you received three weeks ago.

AVAILABILITY OF HEALTH PLANS TO MEDICARE BENEFICIARIES

Provider-sponsored organizations are viewed by policymakers as an element in a strategy of broadening the private plan options available to Medicare beneficiaries. This strategy is important because many beneficiaries today lack access to managed-care plans.

As of April 1, 1997, 276 plans participated in Medicare as risk contractors. Another 84 plans had some type of cost contract, and 18 plans were involved in demonstration projects. These numbers have risen dramatically over the past several years (Figure 1).

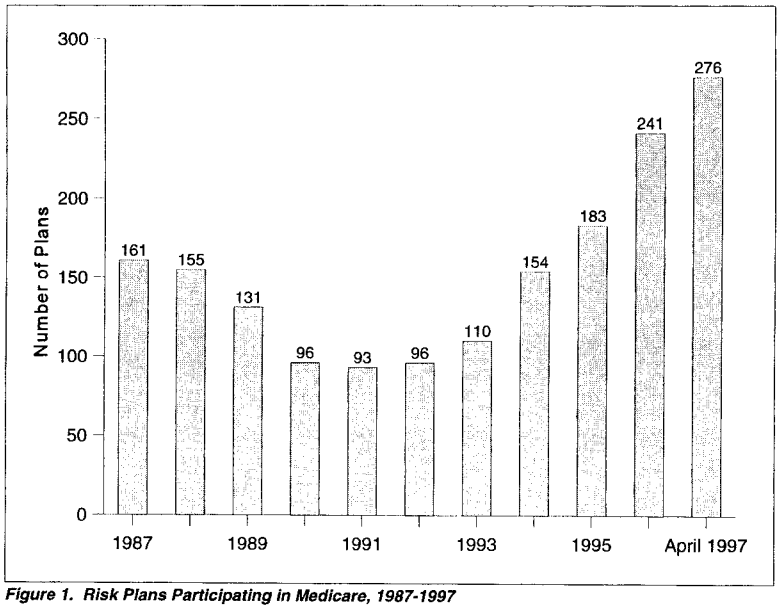


Figure 1. Risk Plans Participating in Medicare, 1987-1997

Even with the large and growing number of plans that participate in Medicare, two issues remain. One is that a large minority of beneficiaries have no plan available to them. The other is that Medicare's rules typically restrict participation to HMOs. Under the Medicare Choices demonstration, however, other types of plans, especially PSOs, are becoming involved.

Plan Availability

As of June 1996, 63 percent of Medicare beneficiaries had access to at least one risk plan. Each plan is required to define its service area as a set of contiguous counties and partial counties, where the latter are designated at the ZIP code level. Beneficiaries may enroll only in a plan designated as serving their ZIP code of residence.

Plan availability has increased rapidly. In just one year, 8 percent of all beneficiaries gained access to at least one risk plan, while the number with access to at least five plans rose from 14 percent to 25 percent.

Plan availability, however, is not uniform across the country. All residents of central urban areas, the cities at the core of the largest metropolitan areas, have at least one choice, while over half have five or more. By contrast, rural beneficiaries rarely have even a single plan available (Figure 2). In addition, residents of nearly half of all the metropolitan areas in the country have no plans. These include markets as diverse as Elmira, New York; Gary, Indiana; Madison, Wisconsin; Shreveport, Louisiana; and Tallahassee, Florida.

Types of Plans Participating in the Risk Program

In general, Medicare requires that a plan must employ or have contractual relationships with providers for at least half of all services that are delivered. As a result, plans such as preferred provider organizations that permit a majority of services to be delivered by nonnetwork providers do not qualify. The Medicare Choices demonstration project was

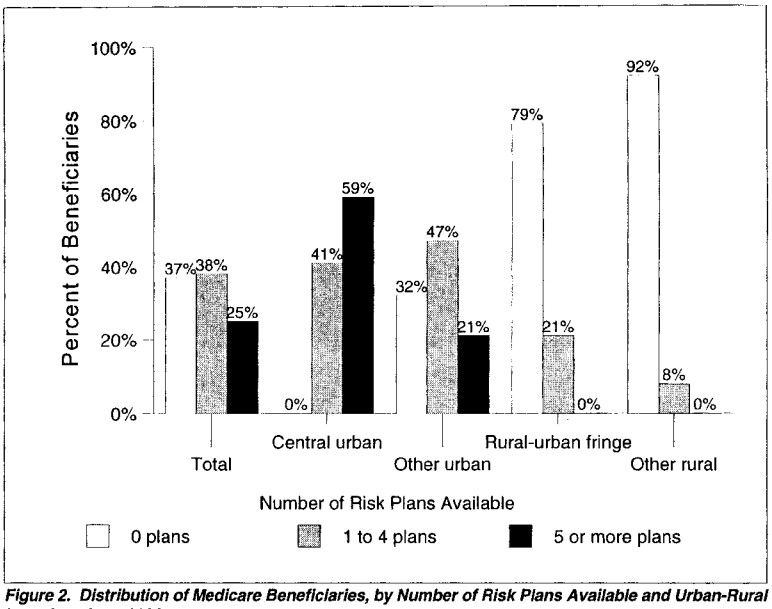


Figure 2. Distribution of Medicare Beneficiaries, by Number of Risk Plans Available and Urban-Rural Location, June 1996

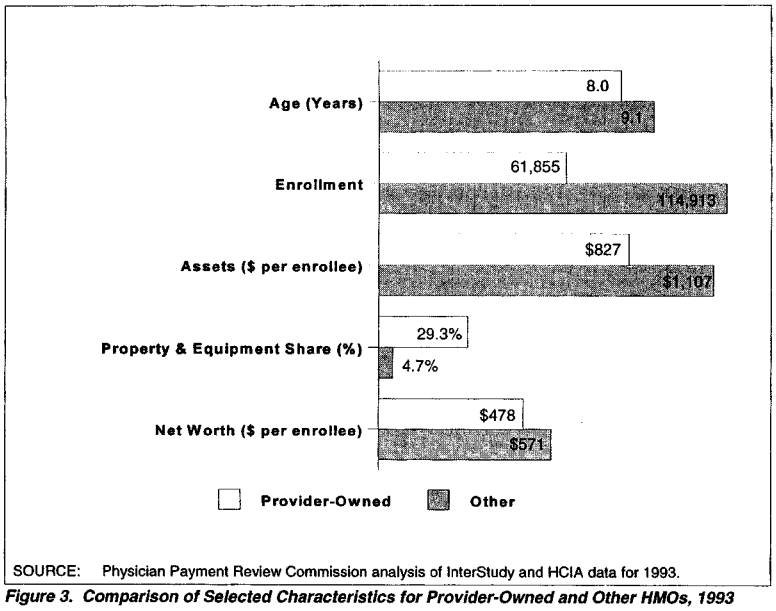
designed to offer flexibility, so that other types of health plans could participate in Medicare. At present, eight plans (located in Billings, Montana; Columbus, Ohio; Houston; Orlando; and Philadelphia) have been permitted to start enrolling beneficiaries. These plans include seven PSOs and one preferred provider organization. Although it is too early to have data, the demonstration is an important test of the attractiveness of these plans to beneficiaries.

DESCRIBING PROVIDER-SPONSORED ORGANIZATIONS

A PSO is not easily defined. The common thread is that PSOs are owned, governed, operated, managed, or supervised by physicians, hospitals, or other providers. But a PSO could be an HMO, a preferred provider organization, a physician-hospital organization (PHO), or any of various other models with accompanying three-letter acronyms (e.g., management service organizations and integrated delivery systems). At one extreme, a PSO could be a hospital that affiliates with several physician groups, but has little integration of clinical or managerial functions. Alternatively, it could be an integrated delivery system, where all revenues flow through the organization.

In the absence of a clear-cut definition, it is even more difficult to characterize PSOs. The Commission sought to use available data on various types of PSOs to describe them. These data, however, provide only an incomplete picture.

Generally, PSOs appear to be younger, smaller, less well integrated, and have fewer financial resources than other managed-care organizations. Looking first at physician-hospital organizations, or PHOs, about three-fourths of them have been in business for less than two years, whereas only 1 percent of HMOs are that new. A majority of PHOs had fewer than 25,000 enrollees, compared to only 5 percent of HMOs. Over half of PHOs have no full-time employees in finance, utilization management, information systems, marketing, or provider relations. Because PHOs, where the providers maintain ownership



SOURCE: Physician Payment Review Commission analysis of InterStudy and HCIA data for 1993.

Figure 3. Comparison of Selected Characteristics for Provider-Owned and Other HMOs, 1993

of their practices, tend to represent one of the least integrated models of PSOs, these data probably exaggerate somewhat the differences with other types of plans.

PSOs that obtain an HMO license represent a model closer to the other end of the spectrum. Not surprisingly, the differences between these PSOs and other HMOs are smaller, but they are in the same direction as the differences that I just described between PHOs and HMOs. In 1993, provider-owned HMOs were about a year younger, enrolled slightly more than half as many members, and held about 25 percent fewer assets than other HMOs (Figure 3). Notably, property and equipment accounts for almost 30 percent of the total assets of provider-owned HMOs, but for only 5 percent of total assets of non-provider-owned plans.

REGULATORY STRUCTURE

By tradition and by law, regulation of health insurers has been a state function. As HMOs began to gain popularity in the early 1970s, both federal and state governments set regulatory and oversight standards for them. When the Congress in 1982 established a role for HMOs as Medicare risk contractors, it specified different ways to set plan standards. Plans can either meet the standards of federal qualification as established in the Health Maintenance Organization Act of 1973 or a similar set of standards in the Social Security Act. In either case, state licensure is necessary.

As with HMOs, the first PSOs evolved largely outside the scope of existing state and federal regulatory frameworks. Concerns about PSOs accepting financial risk, however, prompted legislators and regulators to explore ways to modify existing rules to oversee these entities. If a PSO accepts risk for the cost of delivering health services (for example, through capitation payments), most states expect it to be licensed in some manner. Through this license requirement, states are in a position to protect consumers. Although specific rules vary, states typically compel plans to:

- maintain a quality assurance program,
- establish appeals and grievance procedures for consumers,
- maintain a minimum net worth,
- set aside financial reserves to pay bills in the case of plan failure,
- guarantee continued coverage of benefits in the event of insolvency, and
- include hold-harmless clauses in provider contracts to prevent providers from collecting additional payments from enrollees in case of insolvency.

While many states continue to deliberate, some states have developed specific laws or regulations to oversee PSOs. Most states, however, have applied existing laws, such as those governing indemnity insurance or HMOs, to PSOs.

States that have not established PSO-specific rules have used a number of different license categories, including such classifications as HMOs, limited HMOs, indemnity insurers, health service corporations, or preferred provider organizations. For example, New York has licensed a number of PSOs as HMOs. California has issued what it calls a limited HMO license to PSO that are in effect subcontractors to other HMOs. The limited HMO license waives requirements, such as marketing, that are not the PSO's responsibility. Other examples include Michigan, which has licensed PSOs under its alternative financing and delivery system statute, and Maine, which has used its preferred provider organization law.

According to a 1996 study, eight states had in place some type of law or regulation specifically addressing PSOs. Iowa, for example, established a licensure category for plans (called organized delivery systems) that were neither HMOs nor insurers. Such plans must meet standards that appear less restrictive than those applying to HMOs. By contrast, Minnesota has chosen a different approach. Effective later this year, it will require all plans (including HMOs, PSOs, and other models) to be licensed as integrated service networks. Although the rules for these entities are based generally on current HMO rules, they are designed to increase the flexibility for plans seeking to qualify.

The National Association of Insurance Commissioners (NAIC) is developing an approach similar to Minnesota's, where all existing model statutes for licensing health coverage products would be consolidated into a single model law that would apply to all entities assuming risk. Under this model, for example, a plan's financial reserve requirements would be linked to the amount of risk it assumes rather than to its identity as an HMO or PSO.

The Commission is encouraged by NAIC's effort to establish some guidance for the states (and potentially some consistency among them). Should the NAIC succeed in bringing interested parties to consensus on these issues, it will make the job of the Congress substantially easier.

POLICY ISSUES FOR INTRODUCING PSOs TO MEDICARE

Ultimately, the challenge for Medicare takes the form of such questions as whether PSOs should meet the same regulatory standards as other health plans and whether these standards should be set and enforced by federal or state governments.

Should PSOs Meet the Same Standards as Other Managed-Care Plans?

Some rules translate relatively easily from one setting to another. For example, there seems to be a consensus that PSOs should meet the same basic quality assurance standards as other plans. Similarly, most agree that PSO enrollees, like those in other

plans, should be protected from the consequences of plan failure through means such as hold-harmless contract provisions, which guarantee that the enrollee is not liable for the cost of services normally covered by the plan.

The application of other standards to different types of plans is not as straightforward. Specifically, PSOs contend that financial reserve and deposit requirements set by the states and minimum enrollment rules set by Medicare have the potential to become obstacles to PSOs's ability to contract with Medicare.

PSOs argue that, because they provide medical care directly and own a larger share of the resources needed to provide that care (e.g., hospitals), they have a lower risk of financial failure than HMOs that rely on contracts with providers. As a result, they believe that they should have lower financial solvency requirements. An alternative view is that PSOs may be inherently more prone to solvency problems than HMOs. Because they exhibit many of the characteristics of other small businesses, such as limited financial assets and experience, they may also experience the higher failure rates of small businesses in other industries. Many PSOs may lack the economies of scale needed to compete with national managed-care companies.

In addition, PSOs argue that states should relax limits they impose on the amount of plan-owned health care delivery assets that can be used to meet financial requirements. Others, however, note that delivery assets may not be fully liquid and their value may be diminished if the plan faces insolvency.

Finally, PSOs contend that, as owners and providers of care, they will continue coverage in cases of plan failure. If true, the need for cash reserves to pay for services when insolvency occurs is lessened. It remains unclear, however, whether providers can be held to these commitments in case of cash shortfalls. Contractual obligations may be of little use to beneficiaries if providers cannot be compelled to provide services.

Additional issues include the applicability of certain Medicare standards to PSOs. One such standard requires that plans cover at least 5,000 members (1,500 in rural areas). Legislative proposals in 1995 would have reduced the minimum enrollment requirement for PSOs. The lower standard would make it easier for these plans to get started, but might make them more vulnerable to the financial stress of high-cost cases.

As I described earlier, the Commission concurs in the ultimate elimination of Medicare's 50-50 rule. Although instituted to increase plans' accountability and to serve as a quality proxy, it presents obstacles to the development of plans specializing in the care of elderly or disabled beneficiaries and impedes Medicare participation or market expansion by health plans. The rule also deters Medicare risk plans from participating in Medicaid, and thus from being able to offer comprehensive prepaid care for dually eligible beneficiaries. In its place, plans would be required to participate in an enhanced quality assurance system.

Should Standards be Developed and Enforced by States or by Medicare?

As I described earlier, the Commission's major recommendation would require all types of plans participating in Medicare to meet the same standards intended to preserve access and quality and to protect consumers from the consequences of plan failure. Implementation of this goal can be accomplished in several different ways. One option would maintain the current requirement that all plans obtain state licenses. Another would rely exclusively on federal standards.

Currently, Medicare relies on the states to develop and enforce many key standards. To do so, it requires plans to obtain appropriate state licenses. At issue is whether it should continue this requirement. PSOs argue that it is difficult for them to get licenses in some states more accustomed to dealing with HMOs. Even so, Medicare may be reluctant to take over a role that historically has been granted to the states — especially if it means

establishing a process for setting and enforcing standards, for example, collecting financial reserves.

The Commission's reading of the evidence is that regulatory changes are moving in the right direction. As I described earlier, some states have in place rules designed with PSOs in mind. Others appear to have made informal accommodations. There clearly remain some states, however, where the regulatory environment has been less helpful. With the steps the NAIC is now taking to achieve consensus on its new model laws, it would become simpler for the Congress to urge states to adopt those models than to develop and promulgate separate federal standards.

A second approach could be to replace state standards with uniform federal standards that apply to all Medicare-contracting plans. Medicare would drop its requirement of a state license. Instead, HMOs, PSOs, and other types of plans would all be subject to new federal rules, although Medicare could contract with state agencies for enforcement. This approach would require a broader federal role than exists today, including some functions (e.g., collection of financial deposits) that are now performed by the states. It would also remove states' traditional role of protecting state residents.

An intermediate option that was used in the Balanced Budget Act of 1995 was to offer plans limited waivers from state regulation. But this approach is at best a stopgap measure that raises issues of which plans should be eligible for waivers, the circumstances under which they are eligible, and the length and renewability of waivers.

Regardless of how implemented, an important benefit of treating all plans equally in federal legislation is that it lessens the need for the Congress to become enmeshed in a series of technical and definitional issues. For example, it would not be necessary to define in legislation or regulations what organizations qualify as PSOs, what providers would be considered to be owners, or what portion of services must be delivered by the provider-owners.

Another benefit to applying the same standards across plans would be to ensure that Medicare beneficiaries enrolling in PSOs receive the same protection as those in other types of plans. Applying the rules that have generally worked in the past — especially with the modifications being developed by the states — should help to protect beneficiaries without imposing substantial barriers to market entry.

Chairman THOMAS [presiding]. Thank you, Gail. I'm sorry I wasn't here to welcome you. I have your testimony and I read it and appreciate it.

Next we'll turn to Josephine Musser, who has been a stalwart companion on this march to understanding. We appreciate your willingness to testify before us. Any written testimony you have will be made a part of the record, and you can address us in any way you see fit.

STATEMENT OF JOSEPHINE W. MUSSER, CHAIR, SPECIAL COMMITTEE ON HEALTH INSURANCE, AND PRESIDENT, NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS; AND COMMISSIONER OF INSURANCE, STATE OF WISCONSIN

Ms. MUSSER. Thank you, and good afternoon, Mr. Chairman, and members of the subcommittee.

I am Jo Musser, President of the National Association of Insurance Commissioners, and the Commissioner of Insurance for the State of Wisconsin. I am here today on behalf of the members of the NAIC Special Committee on Health Insurance, which is 42 member States.

As Chair of the committee, I want to thank you for the opportunity to speak, but I also would like to speak on behalf of my membership, to say how much we appreciate your leadership on health care issues, which are of great importance to the States.

The State insurance regulators play a key role in safeguarding consumers across the Nation. An important part of that role is encouraging competition. This maximizes choices for consumers. We do that by adapting to changing markets, changing markets in all lines of insurance. We are adapting to the evolving market in health care insurance and delivery systems which are presently emerging in the market.

To meet the needs of that market, the States have initiatives well underway for a framework design to oversee health insuring organizations by the function that they perform and not by the acronym they might use.

You are being asked to consider special treatment for risk-bearing provider organizations serving the Medicare managed care program. These proposals would deprive our most vulnerable population, the elderly and the disabled, of crucial consumer safeguards. Approving these proposals will also have a far-reaching impact on the entire insurance marketplace.

Protecting the consumers is the primary responsibility of State insurance regulators. We meet this responsibility with tools developed over years of experience. We approve organizations for licensure to engage in the business of insurance, including an application of time-tested financial requirements. We also continually monitor an organization's ongoing financial condition and market conduct through extensive examinations and financial analysis.

We have the authority to act quickly to supervise and rehabilitate any of these organizations they show signs of financial distress. We maintain sophisticated financial data bases for auditing and exchanging information within the State and among the States through the NAIC.

Having just enumerated some of the expertise of the State insurance departments, I would like to emphasize that the individual pieces of State insurance regulation form a comprehensive and integrated whole. The individual components are important regulatory tools, but their effectiveness is only achieved by their use with complementary and interdependent components.

As you can see, the State insurance regulation is a great deal more than merely verifying an organization's initial net worth. To provide the same level of consumer protection, the Federal Government would need to duplicate the States' existing regulatory framework. We feel it is a costly and unnecessary duplication, not to mention the total burden to the health care system.

The States are major purchasers of health benefits as well, and a competitive marketplace is advantageous to the States just as it is to the Federal Government and other large employers. The States strongly favor increasing consumer choices. A healthy and competitive marketplace, with its myriad of consumer choices, can be achieved through the integrated regulatory framework already established by the States. The regulatory oversight provided by the States is both vital and necessary, especially to community-based organizations, because a more highly competitive environment increases the risk and the magnitude of insolvency.

The States are keenly aware of and constantly adapting to the rapidly evolving health insurance market. State insurance regulators are comprehensively evaluating the range of issues which are presented by the diversity of organizations in today's marketplace. Organizations that are sponsored by providers participate in and make an important contribution to the health insurance market today. The current regulatory structures do not impose a barrier to the entry of different types of organizations operating in the marketplace. This is because the States have been responsive to the changing market needs.

This is borne out by the active presence of licensed organizations owned and controlled by providers in many States. In fact, it is reported by the PPRC and others that approximately 15 to 20 percent of the existing HMOs in this country are organizations sponsored by providers.

In my own State of Wisconsin, as you've heard a number of times, the majority of the HMOs, 18 of the 26, were originally organized and sponsored by physicians and hospitals. Wisconsin offers an example of the States adapting to the environment and the evolving marketplace. In the late 1980s, my department saw the bankruptcy of several independent practice associations, or IPA, physician networks. To help prevent these failures in the future, Wisconsin solvency standards were increased in 1987 to reflect the financing necessary for the level of risk that was being assumed by the organizations.

Health insuring organizations, with all shapes and varying forms of ownerships and affiliations, are licensed by the States because of the insurance function that they perform, not according to whether or not they are sponsored by providers. To better meet the needs of emerging health insuring organizations, the States, working through the NAIC, are developing a uniform model for health insuring organizations as part of the CLEAR effort, Consolidated

Licensure of Entities Assuming Risk. This effort seeks to protect consumers and promote a more competitive marketplace by ensuring that entities that perform the same or similar functions are subject to a level regulatory playing field, regardless of their acronym.

The Ohio Insurance Department, which has proposed uniform licensure to govern all health insuring organizations, offers an example of the CLEAR initiative. The States recognize that some of the organizations and arrangements in today's market may warrant flexibility in regulatory standards.

The NAIC's risk-based capital, or RBC, formula for managed care organizations is the most notable component of the CLEAR initiative. This recognizes the structural differences among organizations. The formula sets minimum capital requirements according to the level of risk being assumed by the organization and provides consumer assurances that services promised will be services delivered.

The States are an essential part of the overall framework that governs Medicare managed care. We are committed to protecting all the consumers, while adapting to the regulatory environment. The States can do this best by continuing to license health organizations, including provider-sponsored organizations.

Thank you.

[The prepared statement follows:]

TESTIMONY

OF THE

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS'

SPECIAL COMMITTEE ON HEALTH INSURANCE

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE COMMITTEE ON WAYS AND MEANS

OF THE UNITED STATES HOUSE OF REPRESENTATIVES

ON

MEDICARE PROVIDER-SPONSORED ORGANIZATIONS

Josephine W. Musser
President, NAIC
Commissioner of Insurance, State of Wisconsin

April 24, 1997

I. INTRODUCTION

Good morning Mr. Chairman and Members of the Subcommittee. My name is Josephine Musser. I am President of the National Association of Insurance Commissioners (NAIC) and Chair of the NAIC's (EX) Special Committee on Health Insurance. I am also Commissioner of Insurance for the State of Wisconsin. On behalf of the Special Committee on Health Insurance, I appreciate the opportunity to speak with you today about the regulation of provider-sponsored health insuring organizations participating in the Medicare managed care program.

The NAIC, founded in 1871, is the nation's oldest association of state public officials and is composed of the chief insurance regulators of the fifty states, the District of Columbia, and four U.S. territories. The NAIC's (EX) Special Committee on Health Insurance is composed of 42 of our members. The NAIC established this Special Committee over three years ago as a forum to discuss federal proposals related to health insurance reform and to provide technical advice on a nonpartisan basis to all who sought our expertise.

On behalf of the Special Committee, I want to thank you for inviting us to speak with you about the proposals to exempt from state regulation provider-sponsored health insuring organizations serving Medicare. I would like you to keep in mind three main points related to this issue. First, the states provide necessary and fundamental consumer protections. These include financial and market conduct examinations among other activities, that serve as the underlying framework for the current regulatory structure. Second, the states already have underway numerous initiatives to adapt to the evolving marketplace and to further promote market competition. And third, the state insurance regulators have strong concerns about proposals that would exempt from state regulation health insuring organizations that are sponsored by providers, thus establishing at a national level regulation based on acronym as opposed to function.

The states have traditionally regulated the business of insurance. This traditional role was affirmed by Congress in 1945 when Congress passed the McCarran-Ferguson Act.[1] We believe that all health insuring organizations, whether they are sponsored by providers or others, should continue to be regulated by the states. States welcome the expressions by Members of Congress in support of the states. In the case of insurance regulation, we urge Congress not to dilute the states' authority to regulate insurance by granting risk-bearing provider organizations special treatment in federal legislation.

State insurance regulation already contains the necessary flexibility to accommodate the presence of health insuring organizations that have structural differences. Health insuring organizations, with varying forms of ownership and affiliations, are licensed by the several states because of the insurance function they perform. Organizations subject to state insurance regulation include organizations that are sponsored by providers. The states have the expertise to evaluate them and the ability to address any structural differences that may legitimately warrant flexibility in regulatory standards for health insuring organizations.

States are keenly aware that the health insurance market is evolving rapidly. States have been comprehensively evaluating the range of issues presented by this evolving marketplace. This process has included attention to structural differences among health insuring organizations and attention to the arrangements the organizations enter into that may warrant flexibility in regulatory standards. The development of risk-based capital standards by the NAIC for health insuring organizations is the leading indicator that the states can accommodate structural differences where appropriate. These efforts will be discussed in more detail later in this testimony.

States are major purchasers of health benefits. A competitive marketplace is advantageous to the states just as it is advantageous to other purchasers like the federal government and other large employers. States support public policy strategies designed to increase competition in the health insurance market. In the health insurance market, efforts to promote competition must be balanced, however, by effective consumer protection.

Reliance on the states' expertise and established infrastructure is the best way to achieve effective consumer protection in the health insurance market. States have over 100 years of experience regulating an industry involving billions of dollars across all lines of insurance. States regulate insurance through a sophisticated infrastructure that involves technical and detailed financial examination and analysis, elaborate information databases, detailed organizational review, and the authority to act quickly when the need arises. Effective regulation requires this strong, labor-intensive oversight because of the nature of the risk being assumed by a health insuring organization and the certain harm to consumers in the event of an organization's failure.

States regulate health insuring organizations through a host of fundamental consumer protection activities. State insurance departments license organizations engaged in the business of insurance. The licensing standards include financial requirements that organizations must meet. The departments conduct extensive examinations of licensed organizations to review their financial condition and market conduct activities. State insurance departments supervise, rehabilitate, or liquidate financially distressed or insolvent organizations. The departments also regulate agents and others that serve insurance organizations.

State insurance regulation serves as the foundation for the current regulatory structure. Health insuring organizations that serve the Medicare managed care program must comply with state licensure standards. Federal standards build upon, rather than preempt, fundamental state requirements. States provide fundamental consumer protections through activities that extend beyond financial solvency and other licensing standards to market conduct standards as well as financial examination activities. These fundamental consumer protections are essential because of the public policy concerns inherent in the health insurance function. The fundamental consumer protections provided by the states complement the less comprehensive regulation conducted at the federal level. To provide these consumer protections itself, the federal government would need to replicate the states' insurance regulatory framework. To do so would result in significant and unnecessary costs to the federal government.

How to regulate provider-sponsored health insuring organizations that serve the Medicare managed care program is an important question for several reasons. First, many providers lack experience in assuming insurance risk. Second, the population served by the Medicare program, the elderly and disabled, tend to use more health care resources than other individuals. And third, some providers face complex incentives in today's competitive health care environment. For example, hospitals face added pressures in a managed care market. They must balance the challenge of managing care cost-efficiently with the challenge of filling their beds and increasing hospital market share.[2] These challenges may make it more difficult for

them to operate within the limited payment available under a managed care insurance arrangement. Each of these factors, coupled with the fact that the first few years of any health insuring organization's existence are precarious, argue for reliance on the states for effective regulatory oversight.

Organizations that are sponsored by providers participate in and make important contributions to the health insurance market. However, states believe strongly that all health insuring organizations that perform insurance functions should be subject to state regulatory standards. States have developed their regulatory standards through long-standing experience. Particularly in today's intensely competitive health insurance environment, where the risk and magnitude of insolvency can be significant, the regulatory oversight provided by the states is a necessary component to the regulatory structure for health insuring organizations participating in a federal program.

II. CHARACTERISTICS OF HEALTH INSURING ORGANIZATIONS

Types of Risk Assumed by Health Insuring Organizations

Health insuring organizations assume a variety of forms of risk, most notably insurance risk. In this section, we discuss some of the types of risk common to all health insuring organizations.

Health insuring organizations contract with individuals, employers, or other groups to receive a prepayment in exchange for covering the cost of an unknown, future level of health care services. In doing so, the health insuring organization assumes what is commonly known as insurance or actuarial risk. Under this arrangement, the individual, employer, or other group transfers to the health insuring organization some or all of their own risk of financial loss as a result of the use of health care services. Because the actual level of services that will be used in the future is unknown, the health insuring organization is at risk for financial loss if the amount of services used exceeds the amount of the prepayment (commonly known as a premium). The principal characteristics of a health insurance arrangement are not only the transfer of the risk of financial loss to the health insuring organization but the spreading of that risk of financial loss associated with the use of health care services by any one individual among a group of individuals insured by the organization. Organizations that assume insurance risk on behalf of an individual, employer, or other groups are engaged in the business of insurance and should remain subject to state insurance regulation.

In addition to insurance risk, all health insuring organizations must deal with several other forms of risk, including asset risk and general business risk. All health insuring organizations face asset risk, which is the risk that existing assets will decline in value and erode surplus as a result of that decline. Additionally, all health insuring organizations face general business risks, which are the range of risks associated with any type of business such as administrative expense overruns. To a large extent, the different risks health insuring organizations face are interrelated. For example, losses associated with insurance risk affect the ability of a health insuring organization to meet the many demands associated with general business risk (such as paying staff salaries, utility bills, or debt service).

Examples of Principal Types of Risk for Health Insuring Organizations

- *Insurance or Actuarial Risk*
- *Asset Risk*
- *General Business Risk*

Types of Health Insuring Organizations

In the health insurance context, there are a number of types of health insuring organizations that are regulated by state insurance departments. In this section, we review the types of health insuring organizations regulated by the states and the insurance functions these health insuring organizations perform.

State-regulated health insuring organizations include:

- traditional indemnity insurance carriers;
- Blue Cross and Blue Shield plans;
- health maintenance organizations; and
- limited health service organizations.

Under a traditional indemnity insurance contract, the health insuring organization assumes the risk of loss associated with a covered person's medical condition. The risk is assumed in exchange for a prepayment by an individual, employer, or other group. Through this indemnity contract, the insurer may promise to reimburse an individual who has already paid for the medical care received; this is the traditional approach for indemnity insurance carriers. Or, the insurer may promise to reimburse the provider for medical care received by an individual; this is the traditional approach for Blue Cross and Blue Shield plans. In other words, the traditional indemnity insurance carrier and the traditional Blue Cross and Blue Shield plan pays the individual or the provider for the medical services that are received. The traditional indemnity insurance carrier or traditional Blue Cross and Blue Shield plan does not actually deliver, or contract for the delivery of, those medical services.

Health maintenance organizations (HMOs) are health insuring organizations that manage care and serve both an insurance and delivery function. HMOs may be freestanding or may be subsidiaries of an indemnity insurance carrier or a Blue Cross and Blue Shield plan. In consideration for a prepayment by an individual, employer, or other group, HMOs deliver or arrange for the delivery of health care services. Like the traditional indemnity insurer and traditional Blue Cross and Blue Shield plan, the HMO is responsible for the cost of care. HMOs differ from traditional indemnity insurance carriers and traditional Blue Cross and Blue Shield plans in that, in addition to the cost of care, HMOs are responsible for delivering or arranging for the delivery

of that care as well. HMOs fulfill this responsibility by entering into contractual arrangements with providers or groups of providers, by providing the services directly, or through some combination of the two. For example, if an individual is in need of a tonsillectomy, the HMO is not only responsible for covering the cost of the physician, hospital, and other services related to the tonsillectomy. The HMO is also responsible for maintaining a network of available physicians, hospitals, and other health care resources to deliver the tonsillectomy.

Traditional indemnity insurance carriers may also offer services that do not involve insurance risk. These services may include third party administrators (TPA) or preferred provider organizations (PPOs) that do not bear insurance risk. TPAs perform administrative duties, such as claims processing. PPOs often contract with and market a network of individual physicians that provide medical services at a negotiated discounted rate. In other words, under these arrangements, the organization is not spreading the financial risk of loss among a group of persons. Instead, the TPA accepts a fee to perform specified administrative services, such as processing claims and marketing. Or in the case of a non-risk-bearing PPO, fixed payments are made for specific services delivered by providers rather than for an undetermined amount of services. Some HMOs also offer non-insurance risk TPA and PPO-type services where the HMOs "rent" the networks that they created and the renters of the network pay for health care services on a fee-for-service basis.

Limited Health Service Organizations (LHSOs) are organizations that deliver or arrange for the delivery of a limited range of health services on a prepaid basis. Examples of limited health services are dental care services, vision care services, mental health services, and pharmaceutical services.

All of the health insuring organizations we have been discussing — traditional indemnity insurance carrier, Blue Cross and Blue Shield plan, HMO, or LHSO — may or may not be sponsored by providers. As described in more detail later in this testimony, there are HMOs and other forms of health insuring organizations licensed in the states, including Wisconsin, that are owned or controlled by providers. Under the current structure, state standards apply to organizations that perform health insurance functions and Medicare requirements do not undercut these requirements.

To exempt organizations from state regulation based on their structure would create an unnecessarily divided regulatory structure. Further, we submit that such a split structure erodes the efficacy of state regulation of health insuring organizations. Any activities undertaken by the Medicare program will have a far-reaching impact on the health insurance market as a whole and the ability of the states to regulate that market effectively. Federal preemption of state regulation for organizations owned or controlled by providers will further erode an already unnecessarily fragmented health insurance market. If more pieces of the insurance market receive federal exemptions from state regulation, others that perform the same or similar functions will begin to seek actively those same exemptions and favored treatment from the federal government. It is absolutely imperative in this policy debate that the relationship between the regulation of health insuring organizations sponsored by providers and other health insuring organizations not be ignored.

Common Elements of Health Insuring Organizations

The activities of all health insuring organizations share the common elements of the insurance function. The extent to which an entity is provider-sponsored does not impact the analysis regarding its function (and hence, the regulatory structure to which it should be subject). In this section, we review the common elements of the arrangements entered into by health insuring organizations and distinguish these arrangements from those which generally do not involve insurance.

Whether they are provider-sponsored or not, health insuring organizations have certain key elements in common. Health insuring organizations contract with an individual, employer, or other group. The purpose of the contract is to cover payment for a range of health care services which may be required in the future. The amount of the services that will actually be utilized in the future is unknown. Health insuring organizations accept a prepayment from the individual, employer, or other group in exchange for assuming the financial risk associated with the cost of the health care services covered by the contract. Health insuring organizations pool all of the prepayments by the individual, employer, or other group of persons to cover the cost of health care services used. Health insuring organizations are at risk for financial loss if the cost of an individual's care is greater than anticipated and exceeds the prepayment made by or on behalf of the individual. All health insuring organizations are involved in arrangements that contain these elements.

Common Elements of Health Insuring Organizations

- ***Contracts with an individual, employer, or other group***
- ***Pays for or delivers a range of health care services***
- ***Pays for or delivers an amount of services that is unknown in advance***
- ***Accepts a prepayment for assuming the financial risk associated with health care services***
- ***Spreads the risk of loss among a group of persons by pooling the prepayments made by or on behalf of individual enrollees to cover the cost of services for all individuals in the group***
- ***Assumes the risk of suffering financial loss if the cost of an individual's care is greater than anticipated.***

General rules exist to help distinguish between arrangements that have the common elements of an insurance arrangement and those that do not. Health insurance arrangements are not directly tied to the actual use of specific services by an enrollee. In exchange for a prepayment, the health insuring organization agrees to pay for or deliver a range of services, regardless of the amount of services the enrollee actually uses. The health insuring organization is liable for expenses beyond the prepaid amount. If the enrollee uses fewer services than are covered by the prepayment, the health insuring organization keeps the remaining amount of the payment.

A common factor among arrangements that generally do not involve insurance risk is that the payment method is linked to the actual use of predetermined and identifiable services to a specific enrollee. No degree of uncertainty exists as to the future amount of services that will be utilized. Consequently, the organization receiving the payment does not rely on payments for a pool of enrollees to fund care for specific individuals. The payment of a fee that is received to perform a specific service is a factor that distinguishes an insurance arrangement from one that is not an insurance arrangement. No payment is received for services which are not used.

An arrangement involving a prepayment that is not tied directly to the actual use of specific services is insurance risk for two reasons. First, the health insuring organization bears the risk that the costs of any individual's use of services will exceed the amount of prepayment by that individual. Second, the health insuring organization pools the prepayments of all covered individuals. Consequently, the health insuring organization relies on the law of averages to ensure that any one individual's use of services will be balanced by the use (or lack of use) of other covered individuals.

Organizations that assume health insurance risk through the receipt of a prepayment for an undetermined amount of services are engaged in the business of insurance and thus give rise to the public policy concerns that insurance regulation is designed to address. Arrangements that involve the spreading of risk often rely upon complex, actuarial analysis involving the calculation of statistical risk for their financial success. In contrast, business risk arrangements, like those that involve the payment of a fee for a specific service, do not involve risk-spreading and do not inherently carry with them the same nature of risk as insurance risk. Additionally, prepayment for the future delivery of services in an insurance risk arrangement establishes a long-term commitment to the consumer. State insurance solvency and other standards provide fundamental protections to consumers against financial incentives, such as incentives for underutilization, inherent in certain health insurance arrangements. State standards also serve to strengthen the ability of participants in the health insurance market to fulfill their obligations to the consumer and other parties affected by the health insurance arrangement.

Provider organizations have argued that direct provision of services by providers transforms the financial risk of loss to a more general form of business risk rather than insurance risk. That is not the case. As long as pooling of financial risk of loss exists, insurance risk is present. Organizations that assume insurance risk are engaged in the business of insurance and that business is subject to regulation by the states as a matter of federal law under the McCarran-Ferguson Act. Direct provision of services by providers will rarely reduce the insurance risk to a de minimis level. Many question the assertion that providers are willing to take notable reductions in their own salaries if the organization experiences significant losses. Nevertheless, even if providers are willing to work on greatly reduced or nonexistent additional income, the health insuring organization still may be responsible for a wide range of expenses necessary to support the provision of health care services. In addition to the expenses of physician services, examples of additional expenses may include:

- Other Clinical Personnel (including nurses, nurse assistants, physical therapists, laboratory technicians, etc.)
- Administrative Staff (including business office managers, registration clerks, secretaries, etc.)
- General Administrative Expenses (including medical and paper supplies, patient registration, information systems, data and claims processing, etc.)
- General Facility Expenses (including electricity, lights, water, telephone, etc.)
- Laboratory services
- Debt Service (including for facility, equipment, etc.)
- Other Business Expenses (including legal and actuarial services, etc.)

Further, health insuring organizations must deal with the general business risks associated with having adequate cash flow (commonly known as liquidity). This is a particularly important issue for organizations that are owned or controlled by providers. These organizations may have inconsistent levels of cash flow available to meet expenses. Also, many of their assets are in buildings and equipment. Ownership of assets such as buildings and equipment contribute to an ability to control costs to some degree. However, this advantage in the ownership of these assets must be appropriately and objectively balanced with the fact that these assets are necessary to fulfill contractual obligations under the health insurance arrangement and are generally unavailable as liquid assets if the organization needs additional funds to pay claims or cover general business expenses.

Ownership or control of the health insuring organization and its assets by the providers who are directly providing the services may have a certain salutary effect on the level of risk being assumed. However, the ownership or control of the health insuring organization does not affect the type or magnitude of risk in an arrangement to a degree that negates the need for consumer protections most effectively performed at the state level. The type of risk being assumed by these organizations triggers the need for the application of fundamental state consumer protections.

State Regulation of Health Insuring Organizations

Because of the public policy concerns present when an organization is engaged in the business of health insurance, health insuring organizations require careful oversight. States have developed significant expertise in providing this oversight as the primary regulators of insurance, which was underscored by Congress in the McCarran-Ferguson Act. The most fundamental components of state regulation include the licensing process, financial standards and examinations as well as market conduct standards and examinations. The process for the licensing of a health insuring organization is a detailed process. State regulation of HMOs can be used as an example to illustrate the states' regulatory process for health insuring organizations.

The regulation of HMOs is an apt example of the state regulatory process because most health insuring organizations currently operating in the marketplace that are sponsored by providers are licensed as HMOs. In Wisconsin, for example, most of the HMOs presently operating were originally organized by sponsoring provider groups. The ownership status of these organizations has changed over time as the marketplace has consolidated. Wisconsin currently has sixteen (16) licensed HMOs that are provider-owned or controlled and two (2) indemnity insurers that are provider-owned or controlled.

A few examples may provide a sense of the various forms and structures of these provider-sponsored health insuring organizations. In Wisconsin, one of the licensed health insuring organizations is sponsored by a hospital and a clinic. Another licensed organization is wholly owned by an integrated delivery system. Yet another organization is owned one-third by an indemnity insurer, one-third by a hospital, and one-third by a clinic.

- Licensing

The first step in the regulatory process for an HMO is to submit to the state an application for a license (also called a certificate of authority). Organizations that perform the functions of an HMO without obtaining a license are subject to a state's

unauthorized insurer statute. The license application includes a variety of important materials such as the organization's articles of incorporation, bylaws, proposed detailed business plan, feasibility study, financial statements, and commitment of a viable provider network. The applicant must also meet minimum start-up capital requirements. Several insurance department staff members are usually necessary to review properly each individual application.

Once an application is received, the state will review the application to determine if all the information needed to perform a proper review is included. The state will also verify the information contained in the application. For example, the state will want to make certain that there is sufficient capital and surplus deposited in an acceptable financial institution.

The length of the application processing time is dependent upon a number of factors including the length of time it takes for an application to become complete, the number of applications under consideration at a particular time, and the number of staff available to review the applications. Usually, the initial submission of the application is incomplete. The average application processing time for complete applications by most states is within ninety (90) days.

The completeness of the application and the responsiveness of the applicant can greatly affect the length of the application process. The states have found that applicants that familiarize themselves with the application process prior to filling out an application receive final responses to their applications more quickly. State insurance departments recommend to applicants that they meet with the department prior to filling out an application to learn more about the application process, including the components of a successful application and the pitfalls to avoid. Departments also recommend that applicants maintain contact with the department while developing the application. Organizations that follow this approach tend to submit applications that are closer to completion, and consequently, tend to have applications that can be processed more quickly. Extended periods of time for application processing are often the result of inadequate information from the applicant or lack of timely response to department requests for information. For reference, the appendix of this testimony includes a list of state insurance department contacts for questions on individual state application processes. This list of state insurance department health contact persons can also be found on the NAIC's home page on the Internet at "www.naic.org".

- Financial Standards and Examinations

Every state regulates HMOs as does the District of Columbia, American Samoa, and Puerto Rico. More than half of the states have HMO laws based upon the NAIC's Health Maintenance Organization Model Act (the "HMO model"). The HMO model governs organizations that deliver or arrange for the delivery of basic health care services to enrollees on a prepaid basis. Under the HMO model, HMOs are subject to initial minimum net worth requirements of $1,500,000 and must maintain minimum net worth requirements of $1,000,000.[3] Contracts between the HMO and a contracting provider must contain a hold harmless provision that prevents the provider from holding the subscriber or enrollee liable if the HMO does not pay the provider.

In Wisconsin, the initial minimum net worth requirements are $1.125 million. This $1.125 million must consist of $750,000 of capital and $375,000 of initial surplus. The capital requirements must be met through cash contributions by the HMO's sponsors and stockholders and not through such mechanisms as lines of credit, letters of credit, or subscription agreements.

HMOs must also maintain financial solvency and stability for the protection of HMO enrollees and the health insurance market. Wisconsin HMOs must maintain a minimum net worth of $750,000 or three (3) percent of the previous twelve (12) months' premium, whichever is greater. They must also maintain a security deposit equal to one (1) percent of the premium written by the HMO in the prior year. Further, as with any other insurance company doing business in Wisconsin, the HMO must undergo an annual CPA audit. Typical reinsurance practices for Wisconsin HMOs are to maintain $50,000 to $75,000 per enrollee in reinsurance coverage. The Wisconsin Office of the Commissioner of Insurance examines the business plan submitted by the HMO to assess its approach and ensure that it is prudent.

In addition to the financial standards that a health insuring organization must meet, states perform financial examinations of health insuring organizations; this is one of the most important aspects of state insurance regulation. These financial examinations involve reviewing the books and records of the organization, becoming familiar with the company's management and operations, and conducting meetings with the organization. The examination includes a review of audit operations and controls, budgeting and budget monitoring processes, and financial planning and reporting processes. Certain aspects of the organization may be targeted by the state based upon the research leading up to the actual examination or the course of the examination itself. If there are indications of financial problems, the examination will be more comprehensive than otherwise.

One of the most important aspects of state regulation is the ability of the state to intervene in the event of financial problems. When the state becomes aware of a financial problem, it will conduct either informal or formal supervision activities which might include requesting a business plan for resolving problems or requiring a change in certain business practices to correct the problems. The state may also place the organization under its supervision until such time as the organization can perform appropriately the necessary functions without supervision. If all else fails, the state may liquidate the organization.

In analyzing a company's financial status, the organization's unique characteristics and structure is taken into account. When an organization's capital level falls below the minimum requirements, the state works with that organization to address its financial problems. For example, the state will analyze the cause of the organization's financial problems to discover whether the problem is related to bad management, inadequate pricing, imprudently rapid enrollment, or a combination of these and other reasons. Characteristics of the organization are highly relevant to this analysis. The state will work with the organization to facilitate the correction of financial problems. The state may also perform other functions such as helping the organization find an investor to infuse it with additional cash resources.

- Market Conduct Standards and Examinations

Further, the states establish market conduct standards which they monitor and enforce. Market conduct standards related, but not limited to, marketing, the issuing of policies, and claims handling must be met. For health insuring organizations, such as HMOs, standards related to quality assurance, grievance procedures, provider credentialing, and other areas are also relevant.

States perform market conduct examinations to determine compliance with state market conduct standards. In a market conduct examination, the state insurance department initiates and conducts an extensive examination of a health insuring organization, including visits to the organization's offices, to determine how the company is conducting its business within the state. These examinations focus on such areas as an organization's marketing and sales practices, and its payment of claims and involve the review of numerous records and files.

State regulation has not posed a barrier to entry into the health insurance market for organizations owned or controlled by providers. According to one source, approximately 15-20 percent of the existing HMOs in this country are estimated to be organizations sponsored by providers.[4] A recent NAIC survey of state insurance departments indicates that most of the states currently have licensed organizations that are owned or controlled by providers under their insurance laws. A number of states have applications pending or are in discussions with organizations that are owned or controlled by providers and that plan to file an application with the department. And, as will be discussed below, some states have organizations that were owned or controlled by providers upon initial licensure but have experienced change in ownership or control since that time. The vast majority of these organizations are licensed as HMOs.

The state of Texas reports that about one-half of the HMO licenses issued in the past two years have been to organizations sponsored by providers. Some examples of these organizations are hospital organizations, such as Texas Children's Hospital, Memorial Sisters of Charity, and Seton Health Systems, as well as physician organizations, such as Physicians Care HMO. In the Commonwealth of Pennsylvania, several HMOs owned or controlled by providers serve both the urban and rural markets. One of these organizations, Geisinger Health Plan of Pennsylvania, which is currently composed of a medical center and physician group practice, is said to be the largest rural HMO in the country. In the state of Louisiana, licensed HMOs that are owned or controlled by providers include one that is owned by a small group practice in New Orleans and another that is owned by a group of psychiatric hospitals. States with a large rural population also have licensed organizations that are owned or controlled by providers, including Kansas, North Dakota, and South Dakota.

Several states, including some that currently do not have licensed organizations that are owned or controlled by providers, reported that some licensed organizations may have been initially formed by providers but are no longer owned or controlled by providers due to mergers or management changes. Changes in ownership of an organization are not that unusual given the evolution and rapid consolidation in today's health insurance and delivery marketplace.

A few states have developed laws specific to health insuring organizations owned or controlled by providers. The states that have done so include Georgia, Iowa, Kentucky, New York, Oklahoma, and Texas. The standards established by these laws are almost identical to the state's HMO laws or not significantly different from the average state regulatory standards for HMOs. For example, the state of Georgia developed regulations for Provider-Sponsored Health Care Corporations (PSHCC) in 1996 under an existing state statute - the Health Care Plan statute. Under the new regulations, the PSHCCs are insurers subject to lower minimum initial and maintenance capital requirements than an HMO in Georgia. PSHCCs are subject to a minimum initial and maintenance capital requirement of one million dollars ($1,000,000). HMOs are subject to a minimum three million dollar ($3,000,000) capital requirement. Georgia's financial solvency requirements for PSHCCs are not substantially different from that of many other states' HMO solvency requirements. Similarly, the state of Kentucky created a category of insurer called Provider-Sponsored Integrated Delivery Network. The new statute imposes on this new category lower minimum capital and surplus requirements than on HMOs. HMOs in Kentucky are subject to an initial minimum net worth requirement of approximately $3,000,000. The Provider-Sponsored Integrated Delivery Networks are subject to an initial minimum net worth requirement of $1,500,000. The solvency standards for the Provider-Sponsored Integrated Delivery Network closely resemble the standards in the NAIC HMO model act.

A few other states have developed provider-specific legislation that is almost identical to the state's HMO law. The state of New York created a category called Integrated Delivery Systems (IDSs). The IDSs are insurers governed by the state's insurance laws and must meet the same requirements as an HMO. However, the insurance department may modify existing initial HMO financial solvency standards, on a case-by-case basis, for IDSs. Similarly, the state of Texas certifies Approved Nonprofit Health Corporations - a form of physician group. These organizations must meet the standards for an HMO license and be accredited.

Further, where states have differences in regulation between laws specific to health insuring organizations owned or controlled by providers and non-provider-specific laws, some states tend to be leaning toward eradicating those differences, including differences related to solvency and quality standards. For example, the Health Systems and Plans Committee of the state of Iowa's Health Regulation Task Force recommended that current differences between the provider-specific and non-provider-specific laws be eliminated.

Consolidated Licensure Initiatives

Distinctions among health insuring organizations are becoming increasingly blurred as more organizations move from operating as indemnity insurers or on a non-insurance risk basis into the managed care market. Interest in becoming a health insuring organization in the managed care market is certainly not limited to providers. Most, if not all, health insuring organizations are eager to gain a significant presence as a provider of managed care services in any given market. State insurance regulators recognize that the delivery of health services is evolving away from traditional fee-for-service insurance arrangements to managed care arrangements of many types.

Model Laws

Through the NAIC, states are studying thoroughly and addressing comprehensively the changes which are taking place in the health insurance market. The NAIC's Regulatory Framework (B) Task Force has begun a review of NAIC model laws. The task force will soon begin the actual development of a uniform model law for health insuring organizations as part of NAIC's Consolidated Licensure of Entities Assuming Risk (CLEAR) initiative.

Through this initiative, the members of the NAIC seek to promote a more competitive marketplace by ensuring that entities that perform the same or similar functions are subject to a level regulatory playing field. CLEAR also serves to clarify that the wide array of organizations performing managed care functions, including health maintenance organizations, preferred provider organizations, point of service plans, fee-for-service plans, Blue Cross and Blue Shield plans, commercial plans, and any other

plans which finance and deliver health care, fall within the scope of state regulation. The NAIC's CLEAR process will include a review of financial standards and reporting requirements as well as the incorporation of health plan accountability standards. These standards, most of which are now completed, relate to: network adequacy, quality, grievance procedures, utilization review, provider credentialing verification, and confidentiality. Issues related to data reporting and consumer disclosure are also being explored.

Ohio offers an example of a state effort to develop a comprehensive licensure scheme. The Ohio Insurance Department has been developing a regulatory structure that defines the business of insurance for managed care entities by focusing on how the organizations function. It recently developed a Managed Care Uniform Licensure Act for Health Insuring Corporations designed to achieve this end. The bill, currently under consideration by Ohio's General Assembly, repeals the laws which govern prepaid dental plan organizations, medical care corporations, health care corporations, dental care corporations, and health maintenance organizations, and creates one type of regulated entity called health insuring corporations (HICs). The HIC is defined broadly enough to encompass all entities that assume insurance risk.

The NAIC's efforts to address the changes in the health insurance market are the result of considerable research and open discussion. Particularly, within the last few years, state insurance regulators have studied closely the forms of organizations developing in the marketplace and the types of arrangements into which they are entering. State insurance regulators' proposals and recommendations are the product not only of their experience and expertise, but of this studied approach to marketplace changes.

Risk-Based Capital for Managed Care Organizations

At the NAIC, an important component of the CLEAR effort is the development of a Health Organizations Risk-Based Capital (HORBC) formula. The risk-based capital (RBC) approach is a flexible formula that sets minimum capital requirements according to the level of known risk being assumed by the health insuring organization. An RBC formula is a marked departure from the traditional fixed level approach that states have used to establish insurer's minimum capital and surplus requirements. RBC formulas have been in use for several years in state regulation of life and health, and property and casualty, insurers. RBC formulas are not only designed to set capital requirements but are a central part of a state's overall regulatory strategy. A state insurance regulator uses the RBC requirement to determine if regulatory action is called for. The NAIC's Risk-Based Capital for Insurers Model Act sets forth the points at which a state insurance commissioner is authorized and expected to take various levels of regulatory action.

An NAIC Working Group is developing an RBC formula for managed care organizations and continues to receive technical advice and assistance from the American Academy of Actuaries, the American Association of Health Plans, the Blue Cross/Blue Shield Association, the Health Insurance Association of America, the American Hospital Association and other interested parties, trade associations, academics and health care economists. The input from all interested parties is being used by the NAIC Working Group as guidance in developing the formula as a practical regulatory tool. The working group expects to have a completed formula available for testing this summer. As with the life and health and property and casualty formulas, the NAIC's RBC formula for managed care organizations will be a dynamic formula, continuously updated, assessed, reviewed and refined to ensure that it continues to reflect the true underlying risk of managed care arrangements in a constantly evolving marketplace.

Through the formula, state insurance regulators recognize that managed care organizations that assume insurance risk have unique characteristics. For example, some managed care organizations have substantial assets in real property, such as hospitals, that are used directly to provide services. Further, some payment methods used under managed care reduce risk to the health insurer by passing along risk to the provider directly providing services.

Managed Care Credits

The RBC formula for managed care organizations will include components that address these and other unique characteristics. These components include managed care credits that recognize the reduction in underwriting risk when using certain risk transfer mechanisms, such as fixed payments or contractual arrangements involving capitated payments made to providers. All else being equal, an organization that reduces its underwriting risk by using these risk-transfer mechanisms requires less capital. Staff model HMOs that employ salaried medical providers (or organizations with analogous characteristics) receive the most significant level of managed care credits because these organizations typically experience less uncertainty concerning the level of claims payments that will be made because the salaries of providers are not directly tied to utilization. Managed care credits are applied to these arrangements because they improve predictability of ultimate claims payments per dollar of revenue and therefore reduce risk, irrespective of whether these arrangements raise or lower the average cost of providing care.

Health Delivery Assets

The managed care context also presents other unique challenges for regulators developing a useful risk-based capital formula for managed care organizations. One challenge is to establish fair and reasonable capital standards for health care delivery assets. Managed care organizations often directly own land, buildings, and equipment used to deliver health services. Debate continues over the appropriate accounting treatment for these assets and the degree to which these assets should be considered admitted assets for statutory accounting purposes. Admitted assets are those assets which can be shown on the organization's balance sheet under statutory accounting purposes. The current RBC formula for managed care organizations assumes full admission for health care delivery real estate and other delivery assets. If that assumption does not bear out over time, then the RBC formula for managed care organizations will be adjusted to reflect the accounting treatment ultimately adopted for those assets.

There is also debate over the appropriate level of the risk factor for these types of assets. The risk factor is based on the potential drain on an organization's surplus from these types relative to other types of assets. On the one hand, direct control over health care delivery facilities can help to control medical costs and reduce underwriting risk. However, there is also a significant risk posed to the organization because of underutilization. Additionally, there is a liquidity risk, in that the health care delivery assets cannot be converted to cash to pay out-of-network medical claims or other financial claims on the managed care organization, such as interest expense or salaries. An appropriate risk factor must recognize risks such as underutilization or the inability of the managed care organization to convert those assets to dollars to pay outside claims as well as the salutary effect of those assets in controlling claims costs.

The current draft of the formula assigns health care delivery assets a ten percent risk factor. This is the same risk factor that is applied to company-occupied real estate, such as a home office building, in the existing life and health, and property and casualty, RBC formulas. The ten percent factor, as applied in the managed care formula, strikes a balance between the cost control advantages associated with these assets and the disadvantages posed by potential extremes in downside risk associated with these assets. While this risk factor is generally higher than the average risk factor applied for invested assets, such as bonds, it is considerably lower than the average factor generated by other equity-type assets which share many of the same downside risk characteristics as would a wholly-owned hospital or clinic. This issue will be followed closely during the testing of the formula to evaluate its impact on the industry and individual companies. Additionally, throughout the entire process of developing this formula, interested parties have been asked to provide any supporting documentation, economic studies, or rigorous statistical analyses that could empirically support alternative risk factors for these types of assets.

Other Unique Characteristics

Managed care organizations that assume insurance risk are also subject to unique types of risk not present in other health insuring organizations. For example, there is an additional type of credit risk faced by managed care organizations that differs from the credit risk faced by traditional indemnity insurers. Credit risk is the risk that third parties will not meet their financial obligations to the insuring organization. Managed care organizations are often parties to large-scale risk transfer agreements with intermediaries and subcontracting providers. There is a risk that these intermediaries will not fulfill their contractual obligations or that other receivables, such as health care receivables or reinsurance recoverables, will not be paid in full. These credit risks are common in managed care arrangements and are acknowledged in the current draft of the RBC formula for managed care organizations as are financial safeguards that mitigate these risks.

The NAIC's CLEAR effort is being undertaken through a deliberative evaluation of the changes occurring in the marketplace and the issues that are arising as a result of those changes. As described above, this approach includes flexible measurement tools for certain standards. All health insuring organizations engage in functions that involve a range of risks. State insurance regulation provides fundamental consumer protections for consumers and others that may be affected by the health insurance arrangement. The ownership or control of the organization does not alter to any substantive degree the extent to which those fundamental consumer protections are essential.

III. STATE INSURANCE REGULATION AND THE MEDICARE PROGRAM

State insurance regulation complements well the objectives of the Medicare program for a number of reasons. The state regulatory framework reassures the federal government that the organizations with which it contracts have met fundamental standards for engaging in insurance arrangements. It also assures the federal government that these organizations are receiving an adequate level of oversight for those functions. These fundamental standards are not limited to financial solvency standards. State insurance regulatory activities related to market conduct standards and financial examination activities are also essential components for effective consumer protection. Because of the activities of the states, the federal government saves considerable resources which it would otherwise have to spend in order to regulate effectively health insuring organizations.

Preemption of State Insurance Regulation

Under the current regulatory framework for Medicare, an HMO or competitive medical plan is required to obtain a state insurance license prior to serving Medicare managed care beneficiaries as a Medicare risk contractor. In most instances, the Medicare HMO is also required to serve commercial enrollees as well. However, in the 104th and 105th Congresses, proposals have surfaced which would remove some of the state regulatory foundation for these plans. For example, under H.R. 475, the "Provider Sponsored Organization Act of 1997," health insuring organizations that meet the definition of "qualified provider-sponsored organization" (PSO) would not be required to meet either of these requirements in certain circumstances.

H.R. 475 defines "qualified provider-sponsored organization" as a public or private entity that is a provider or a group of affiliated providers organized to deliver a spectrum of health care services (including basic hospital and physician services) under contract to purchasers of such services. It lists four ways in which an organization would be considered a group of affiliated providers. The specific language of H.R. 475 makes it difficult to understand what organizations actually would be considered a qualified PSO. The bill does not define the term provider. The definition of affiliation is also vague. Further, while qualified PSOs must provide a substantial portion of services directly, the definition of substantial portion is left to be defined by the Secretary.

The definition of qualified PSO in this bill has the same problems as other federal proposals that have attempted to define a provider-sponsored health insuring organization. The broad proposed definitions for qualified PSOs cannot help but encompass non-provider groups. This favored treatment at the federal level will result in more fragmentation of the health insurance market and undermine the state regulatory process. Further, we respectfully submit that the decision whether any particular organization is qualified to engage in the business of insurance and participate in the health insurance market, whether public or private, ought to remain with the states.

The bill recognizes that these organizations are involved in health insurance activities, and would otherwise be subject to state insurance laws by requiring that they obtain a state insurance license after January 1, 2002. Yet, the bill also establishes federal standards for these organizations, including solvency standards. Until January 1, 2002, the state may not license health insuring organizations that only provide health insurance services to the Medicare managed care program and are qualified PSOs. The bill gives the Secretary of the Department of Health and Human Services (HHS) ninety (90) days to process an application for certification as a qualified PSO after receipt of a completed application. This timeframe may be significantly less than the timeframe the Secretary currently takes to process the application of a Medicare risk contractor. According to one source, it takes approximately six (6) months to obtain approval as a Medicare risk plan once a complete application has been submitted.[5]

The bill ties the states' ability to perform its responsibilities after January 1, 2002 to the adoption of specific federal requirements, shifting significant responsibility away from the states. After January 1, 2002, a state may license these organizations if the State's solvency standards are identical to the federal standards and its other standards are substantially equivalent to federal standards. Further, the bill gives the Secretary of HHS the authority to waive state licensure requirements if the state does not act on the application within 90 days, or the state denies the application and the Secretary determines that

the state's standards impose unreasonable barriers to market entry. The bill also requires that the Secretary of HHS contract with the appropriate state agency to monitor the qualified PSO's performance.

While the bill draws upon the NAIC's HMO model for solvency requirements, its differences from the model are significant. For example, the bill requires that the HHS Secretary rely on financial resources that are not cash or cash-equivalents to meet the basic fiscal solvency requirements under the bill. The bill also requires changes in the statutory accounting treatment of health delivery assets. The adoption of these standards at the federal level will undermine effective solvency regulation at both the state and federal level.

In addition to providing for inadequate solvency standards, the bill also does not consider the differences in health insurance markets throughout the country. States have experienced different levels of managed care penetration, in part because of the different evolutionary stages of their health care markets. The level of managed care penetration impacts the kinds of standards that might be appropriate. Consequently, uniform regulatory standards across the country may hinder, instead of foster, the growth of managed care in the Medicare program or the commercial market. We respectfully request that this Subcommittee acknowledge the differences in heath insurance markets and recognize the expertise of the states in applying appropriate consumer protection standards for their jurisdictions.

Under this proposal the states will not have the ability to perform basic underlying licensure activities. Consequently, for the next few years the federal government will be exclusively responsible for enforcement of the bill's standards. Without the underlying licensure activities conducted by state insurance departments, the federal program will be burdened with an additional degree of monitoring and enforcement for these organizations. This burden may be particularly acute given the lack of experience of many providers in assuming insurance risk. The early years of a health insuring organization's development are the most critical and precarious. While the Medicare program has in place some standards and performs some oversight, the level of standards and oversight do not mirror the depth of state regulation.

Further, the Medicare program does not currently have in place the resources to duplicate the state regulatory framework or the breadth of state experience to protect consumers effectively. Absent significant investments in a regulatory framework by the federal government, consumers will not benefit from the necessary protections offered by state insurance regulation.

CONCLUSION

State insurance regulators determine whether and how to regulate an organization by analyzing what the organization does and not what the organization calls itself. In making such assessments, state insurance regulators focus on whether the organization engages in the business of insurance. To this end, the most essential element to consider is whether the organization has assumed insurance risk. The acronym or ownership of an organization should not impact the decision whether an organization serving the Medicare program should be treated as a health insuring organization under the existing regulatory structure. This principle applies to organizations that are provider-sponsored. Provider-sponsored organizations assume insurance risk and should be regulated by the states.

The states have the expertise and the tools to regulate appropriately the range of organizations operating in the marketplace. Current regulatory structures do not pose a barrier to the entry of different types of organizations operating in the health insurance marketplace. This statement is borne out by the active presence of licensed organizations owned and controlled by providers in the several states. The states also have well underway an initiative that acknowledges the dynamic nature of the marketplace. The RBC formula for managed care organizations is a notable element of this initiative. The formula recognizes structural differences among organizations operating in the health insurance market while retaining a consistent regulatory approach to the maximum extent possible. The RBC formula is very close to completion and will be continuously assessed and refined once implemented.

State insurance regulation offers essential elements of an effective regulatory framework for organizations serving the Medicare managed care program. We urge you not to hinder the ability of the states to use their expertise and apply the standards appropriate to their markets. Federal preemption of state insurance regulation will weaken protections for Medicare beneficiaries and further fragment the health insurance market.

We appreciate the opportunity to testify before you today concerning the regulation of provider-sponsored organizations. The NAIC looks forward to working with this Subcommittee and the 105th Congress on this and other issues of mutual concern.

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[1] 15 U.S.C. § 1011-1015.

[2] Sutton, Harry L., Jr. , F.S.A., Reinsurance in the Managed Care Environment, Society of Actuaries (1996).

[3] Specifically, the model requires that HMOs maintain a minimum net worth equal to the **greater** of $1,000,000; or two percent of annual premium revenues on the first $150,000,000 of premium and one percent of annual premium revenues in excess of $150,000,000; or an amount equal to the sum of three months uncovered health care expenditures; or an amount equal to the sum of eight percent of annual health care expenditures (except those paid on a capitated basis or managed hospital payment basis) and four percent of annual hospital expenditures paid on a managed hospital payment basis. NAIC Model Act Section 13 (model 430).

[4] Pat J. Butler, J.D., Dr. P.H. and Elizabeth Mitchell, Health Care Provider Networks: Regulatory Issues for State Policy Makers, National Academy for State Health Policy (February 1996) citing Physician Payment Review Commission 1995 Annual Report to Congress.

[5] Taylor, Roger S. and Craig Schub, *Medicare Risk Plans: The Health Plan's View*, Managed Health Care Handbook, Peter R. Kongstvedt, ed., 3d ed., 746 (Aspen 1996).

Chairman THOMAS. Thank you, Jo.

The "$64,000 question" from the time we've begun this process is, if there is a distinction, is it a distinction that makes a difference. I'm waiting for the "silver bullet." I just have to tell you, when you say the same or similar, you don't give me any comfort level, because that means there's a difference, and is the difference enough to create a different standard. That's what I'm hoping you're going to provide to us as you go through this study.

But I want to get some understandings, and I guess, Gail, you're the one who would be most likely to try to respond to this.

The American Hospital Association, in testimony before us a short time ago, in talking about PSOs versus HMOs and creating an argument that PSOs are better than HMOs, the points they made in terms of why they're better is, one, in their testimony, AHA said "They put clinical decisions in the hands of those most capable of balancing efficiency and patient care." Another quote: PSOs are more likely "to focus on improving the health of the entire community." A third quote, "Economic and patient care incentives for PSOs are all aligned."

Do you have any credible study or any evidence that you could provide this subcommittee that PSOs actually provide those advantages to enrollees or beneficiaries beyond traditional HMOs?

Ms. WILENSKY. I think it——

Chairman THOMAS. Outside of any pamphlet or brochure that might otherwise claim to be——

Ms. WILENSKY. I think basically it would be impossible to do so. In the first place, they're very new entities. To be able to assess the impact would mean they would have had to have been around for a while and then assessed.

But even beyond that, the fact is you have provider-sponsored HMOs. You know that. And Wisconsin is a very good example. Therefore, the notion that there is something that would distinguish the motivation just on that basis just makes no sense.

In terms of enrollment and the number of years that they have been going on, it is very clear that PSOs, in general, are just younger entities. So I think that anyone who seriously wanted to do a study would have to wait a while. But you can at least raise a question on that because of all of the provider-sponsored HMOs.

Chairman THOMAS. My argument would be let's get them up and running, with reasonable and appropriate structures, and let people vote with their feet. That's my preferred way to always resolve who's better.

On page 15 you talk about the various approaches, and that in the balanced budget amendment we took what you call a stopgap measure. It was taken simply because we didn't have adequate information, nor was anyone able to provide us with a relatively solid evidentiary position that we should leave it entirely to the States or that we should move it to the Federal level.

It seems to me, if we can get a model that we can use, all we need to do at the Federal level is say this is a pretty good model and, you know, the old business of Federal preemption, that if States don't follow up, we'll do it. But we didn't have that. So I thought what I came up with was, one, something that the House and the Senate could agree to, but I guess I would ask you again.

Can you give me any level of confidence that there would be no artificial barrier placed in front of any PSO in any State?

Ms. WILENSKY. No, I certainly can't, and the presumption is that in some States there will be obstacles or barriers of some kind, which is why I think having the safety valve of being able to appeal to the Federal Government is attractive.

Chairman THOMAS. Additionally in your statement, on page 2, you talk about the same standard should apply to all the plans participating in Medicare, and then you go on to say, however, you've got to understand the differences in plan design and some flexibility might be appropriate in establishing and enforcing these standards. So if you're going to have the same but maybe some flexibility, it's kind of like same or similar.

What types of different standards do you think should be applied to PSOs? What rationale can you provide for the need to handle it differently? I know that doctors argue that they have, in essence, professional sweat equity that they bring to the table. This takes us back two or three years ago, with all the discussions that we had.

I guess the question is, by your making this statement, do you believe there are differences that would require handling them differently?

Ms. WILENSKY. We think there are differences, if the seniors are protected, that are worth taking into account. The issue is not only the solvency requirement but what kind of assets you might want to use to count toward solvency.

With regard to the sweat equity issue, the question is, if you have an organization that declares bankruptcy or is otherwise financially insolvent, is there a way to assure the seniors that the individuals or the institution, if there's a hospital attached, will continue to provide services through the plan, even in the presence of a bankrupt organization. If there is a way to write a contractual obligation that did that, that was the kind of flexibility that we had in mind. If it's not possible, and if the arrangement is only with the organization, per se, then once it's bankrupt, the assurances don't mean anything and you haven't resolved the problem.

So it was really a matter of principle that we thought was important to put in place. How you would actually carry it out, as you're indicating, gets very tricky.

Chairman THOMAS. Obviously, we wouldn't be carrying on these hearings, nor would we have different approaches, if we had a yardstick for solvency that we could lay beside any different model to determine the level of coverage necessary.

I guess, asking the same question the other way around, Jo, do you have a comfort level that there is no State currently placing unnecessary barriers in front of the approval of PSOs that would warrant us not talking about a fallback that we had in the BBA, to allow for someone, if they made the case, to deal with some entity other than a State, if the State was blocking them?

Ms. MUSSER. I can't guarantee you, no, that every State will never pose any kind of what may be presented to you as an unreasonable barrier. I can tell you that, in looking at the States, how they calculate admitted assets, how they calculate risk-based capital or capital requirements, and their licensure process and how

long that takes, the other financial filing requirements, their auditing requirements, in the current setup, whether it's CISNs in Minnesota or ODSs in Iowa, or HMOs in Wisconsin, or PSOs in Georgia. There are many States who are well underway to accommodate provider-owned organizations.

My question, in part, is—and my HMOs are owned by physicians. They address a number of the points that were made by the hospital association, and now——

Chairman THOMAS. Jo, we're pinched for time. Everybody else has left to vote. I think some members want to hear your response to this, and an additional one. So the subcommittee will stand in recess until I get back.

Ms. MUSSER. Thank you.

[Recess.]

Chairman THOMAS. The subcommittee will reconvene.

When we last talked, just to let the subcommittee members know, I asked two unfair questions and they were answered appropriately. One to Dr. Wilensky, could she assure me there would be no need for a relief, a safety valve structure, in case States, for whatever reason, would not play the game fairly, in essence, and then the reverse question to Jo Musser, could she assure me—and she began her discussion by saying she can't guarantee.

To a certain extent, we're right back to where we started. I don't want to create a Federal approval structure unless someone tells me that's the only option. I don't have a comfort level that we just leave it to the States, because we don't know whether there is sufficient sophistication, willingness, cooperation, understanding, to deal with the approval of PSOs in unhindered fashion. That's why we wound up with the structure we had in the BBA, and until I get a comfort level otherwise, that's the structure that I'm going to look at.

What I would ask you, Dr. Musser, if you can't guarantee me that no State wouldn't, will you guarantee me that you're going to give me a work product in your stated time frame which begins to shed light on the experiences out there, to the best of our current experential knowledge, on some kind of a yardstick for the question of solvency risk.

Ms. MUSSER. Yes, sir, I can. We have been working on the fast track, to be sure, on our risk-based capital standard. It is moving along beautifully.

The risk-based capital standard is a calculation that determines the level of working capital necessary to start up a business like this, and it takes into account a variety of managed care credits, including equity arrangements, compensation arrangements, whether there are withholds or capitation or partials. It takes into account buildings and equipment, takes into account reinsurance agreements, and it is, again, by function, not acronym, so it doesn't apply to any specific entity, which we would argue against, but, rather, whatever the States chooses to call it.

It starts out with a risk level, and then, as an organization lays off risk through its structure—whether it's reinsurance or capitation, partial capitation or equity—it gives credit toward that capital requirement and reduces it through these various credits.

That formula, as I said, is on the fast track. I'm very, very pleased with its development. I told you that we would have it done by June, and if things continue to go as they are going, we will.

Chairman THOMAS. Thank you very much. That's of some comfort. Beginning or end of June? [Laughter.]

Ms. MUSSER. Well, our national meeting is actually June 6–13, so if things continue to go well, it will be presented there.

Chairman THOMAS. I appreciate that. Often in the movie industry they have a preview of coming attractions. If we might be able to take a look at it prior to any formal structure, just to begin to get some ideas—because our timetable may not be able to just await your arrival at the national meeting and the official send off.

Ms. MUSSER. I've been preparing a document that explains it in plain English, and it covers these various credits. We've got a draft document that I will give to you as soon as we can get it cleaned up.

Chairman THOMAS. Thank you very much.

Mr. Stark.

Mr. STARK. Well, I would like to thank the witnesses for their input.

What I'm hearing, Ms. Musser, from you, is that we should allow the State commissioners to continue to do what they seem to do very well.

I did understand that Glenn Pomeroy, who I suspect is the brother of our own Earl—it keeps running in the family. There's a lot of nepotism among these insurance commissioners, huh? He testified that, in his 39-State survey, 27 States have processed PSO applications in an average turnaround time of 90 days.

Now, nobody gets away with that kind of bragging without somebody criticizing him. But you're not doing so bad. It was Columbia Hospital who said it takes 18 to 24 months, and I can understand that. Maybe it ought to take 18 years for them. [Laughter.]

So what Glenn would suggest to us that it isn't so bad having the States continue to try and protect the consumers and keep these organizations solvent.

Gail, I guess what you're saying is that we might have some problems if we just remove the regulations, and admittedly, there are different kinds of entities, and we maybe ought to be more flexible in how we apply regulations, but we ought to try and have uniform regulations for all providers. Is that a fair——

Ms. WILENSKY. Yes, and to keep it basically at the State level, perhaps with an appeal, but to have the State remain the main line of defense.

Mr. STARK. In support of your testimony, I'm going to suggest something to my colleagues, and it may suggest to them that perhaps we ought to keep this uniform and not start making special exceptions for special groups.

I know, Dr. Wilensky, that you're familiar with physician reimbursement laws, are you not?

Ms. WILENSKY. Yes.

Mr. STARK. And I know you're aware of the angst that has caused among medical providers and in the industry, and that there have been more lawsuits and more investigations and more

exceptions and more ways to try to get around the referral and kickback laws, or conform with them in creative ways.

I'm suggesting that once we start having all different levels of providers of managed care, we're going to get into that same box again. We're going to create a whole cottage industry of lawyers trying to figure out how to shoehorn insurance companies and qualify them as PSOs and we're not going to have much time to do anything else.

Is that a fair analogy, just to suggest that what we have is working—okay, it needs improvement—and if there are going to be new types of providers, let's try and just keep one standard as we have now.

Ms. WILENSKY. I think the enforcement provisions of the State, in the best States, is much more extensive, as you had mentioned earlier, than what we're likely to get at the Federal level.

My personal opinion—again, it was not a PPRC recommendation—is that one of these entities could appeal to the Secretary. If the Secretary agrees in that there's a problem, provide provisional licensure or certification.

Mr. STARK. Yeah. That makes more sense to me, if the——

Ms. WILENSKY. But not write a separate law.

Mr. STARK. Thank you very much. I want to thank both you and Ms. Musser for enlightening us.

Chairman THOMAS. The gentlewoman from Connecticut.

Mrs. JOHNSON. Thank you.

Actually, that's pretty much the structure that was in the Balanced Budget Amendment in the Medicare reform of the 104th Congress. I think it does give us some pretty good guidance as we start this debate now.

I want to turn to a different aspect. The administration said there were four controversial areas, one of them being quality assurance. You know, the 50–50 rule is 15 years old. Surely, with all the technological advances that have taken place in that time, we can do better than that. I don't understand why, when the National Commission on Quality Assurance has developed the HEDIS system, and now has three years of reporting under their belt—this is a system that was specifically developed to look at quality across all kinds of plans, regardless of whether they were HMOs or managed cares or whatever. Now we have three years of data reported under this system.

Why can't we use that system and require that these plans be approved by either an NCQA approval process for quality, a quality assurance process, or something along that line? Why does the Federal Government rely on a 50–50 rule that is basically irrelevant instead of at least moving that far to an NCQA quality assurance standard based on HEDIS' experience?

Ms. WILENSKY. I think the answer is the Federal Government can and should. Kathy Buto mentioned that HCFA was planning to have regulations, I think, in 1998. It might be helpful to have a sense of the Congress or a directive to have those, indeed, issued in 1998. I think the 50–50 rule is a proxy that was excusable in the 1980s, but the work that has been done really ought to supersede 50–50.

Under HEDIS now, and under Medicare's requirement to report HEDIS information for Medicare managed care plans, which is now going into effect, there is just reporting but there is no mechanism in place to audit and take action based on the information that's reported. That's what HCFA needs to do as the next step, but I think it needs to do it now.

Mrs. JOHNSON. Why wouldn't it be reasonable to require that these plans meet the NCQA standard and then, by '98, HCFA have a specific standard from this data? I mean, even in an interim sense, their standard is more quality focused and does more about quality care in a network setting than 50–50 rules do.

Ms. WILENSKY. NCQA has two functions. One is an accreditation function, and the second is that it establishes a data system. So the issue for HCFA now is, when the information is reported in the HEDIS format, if there are measurements that are not met, what happens next. That's really the issue, the ongoing measurement, the ongoing quality assurance, and the steps that need to be development to remedy any failures.

Mrs. JOHNSON. But given those two different functions, why couldn't we use their certification program until the Federal Government evaluates the data and either alters or adjusts it for Medicare, or perhaps doesn't, depending on what they find?

Ms. WILENSKY. I think the less-than-perfect state of HEDIS is far better, in my mind, than the 50–50 rule, personally.

Mrs. JOHNSON. Thank you very much.

Thank you, Mr. Chairman.

Chairman THOMAS. The gentleman from Nebraska.

Mr. CHRISTENSEN. Thank you, Mr. Chairman.

Mrs. Musser, I wanted to find out from you what enforcement provisions you have in place for those PSOs that might be in noncompliance?

Ms. MUSSER. If I understand your question correctly, do you mean noncompliance with financial?

Mr. CHRISTENSEN. Yes.

Ms. MUSSER. I see. Okay.

In Wisconsin, we don't have PSOs. We have HMOs, which are the same structure as you're talking about. So first I will address Wisconsin.

We have financial reporting requirements; we have auditing requirements. Upon audit and financial analysis, and the submission of their quarterly and annual financial statements, if they're approaching a level of surplus or solvency that troubles us, as soon as we decide that it becomes troublesome, we go in and work with management. We can help them find additional sources of capital. We can recommend—in fact, strongly recommend that they change management, if that's the problem. We can have them sell off pieces of lines of their business, et cetera. We have a surplus level that is required, and if they fall below that level, we can put them into liquidation.

We in Wisconsin have very few liquidations because we get involved much earlier, and we try to preserve the integrity of the organization. Other States are very similar as it relates to how they regulate for solvency, in all lines of insurance. In fact, what I just told you applies to all lines of insurance.

Mr. CHRISTENSEN. I may have misunderstood you. Did you say you have no PSOs in Wisconsin?

Ms. MUSSER. We have no PSOs in Wisconsin. We have HMOs in Wisconsin, which are owned by doctors and hospitals.

Mr. CHRISTENSEN. How would you separate the two—if you wanted for lack of a better definition, I think you probably may have PSOs and HMOs. How would you describe the difference in Wisconsin?

Ms. MUSSER. Well, you know, it's confusing to me. I must be very honest with you. Eighteen of our 26 HMOs were founded and owned, initially started up by physicians, large specialty clinics owned by physicians, sometimes with hospitals. They, in fact, make the medical decisions, they make the utilization review decisions, they hire an outside firm to do claims management, a third party administrator. They have a licensed company, called an HMO in Wisconsin.

We do have reduced solvency requirements for HMOs than indemnity insurers. Ours are a million five for HMOs, or three percent of premium. If they choose to go into the point-of-service business, they have to come up to ten percent. So we do regulate by function now, and you could call them really whatever you want. We happen to call them HMOs.

Mr. CHRISTENSEN. So if you're putting a little T-bar chart together on the differences between an HMO and, say, a PSO, a quasi-PSO, in the State of Wisconsin, do you have anything on the right side of the chart?

Ms. MUSSER. No. I mean, there are no barriers for providers owning and operating risk-bearing entities in Wisconsin. They put together a million five, they file a business plan, we approve their licensure and their geographic service area, we have 26 HMOs covering virtually every part of the State, rural and urban. You could call them PSOs. Iowa would probably call them ODSs. Minnesota would call them CISNs. You know, it's just a matter of terminology or acronym, as I said earlier.

Depending on the function or the level of risk they take, we do have varying levels of capital requirement. The risk-based capital formula I think will improve on that dramatically. It's a very dynamic formula that really gets at many more of the different structures that we're seeing emerging now.

Mr. CHRISTENSEN. Thank you.

Chairman THOMAS. The gentleman from New York?

Mr. HOUGHTON. No questions.

Chairman THOMAS. I thank both of you. Gail, I'm sure you'll be back here fairly soon, continuing to do a good job.

Jo, when I next see you, I expect to have something in your hand for us. If I don't see you before then, good luck in bringing it about.

Ms. MUSSER. Thank you.

Ms. WILENSKY. Thank you, Mr. Chairman.

Chairman THOMAS. We would ask the next panel to come forward. John Brownlow, Vice President and Chief Operating Officer, Florida Hospital Healthcare System, Orlando, Florida, on behalf of the American Hospital Association; Mary Nell Lehnhard, Senior Vice President, Office of Policy and Representation, Blue Cross and

Blue Shield; and Dr. Richard Corlin, Speaker of the House of Delegates, American Medical Association.

I want to thank all of you for your willingness to testify. If you have a written statement, it will be made a part of the record. You may inform us, in the time you have, any way you see fit.

We will start with Mr. Brownlow and work to you folks on his left.

STATEMENT OF JOHN BROWNLOW, CHIEF OPERATING OFFICER AND VICE PRESIDENT FOR MANAGED CARE, FLORIDA HOSPITAL HEALTHCARE SYSTEM, ON BEHALF OF THE AMERICAN HOSPITAL ASSOCIATION

Mr. BROWNLOW. Thank you.

Mr. Chairman and members of the committee, my name is John Brownlow. I am Vice President and Chief Operating Officer of Florida Hospital Healthcare System, a provider-sponsored organization located in Orlando, Florida.

Our provider-sponsored organization is made up of 648 physicians, five hospitals, 13 walk-in medical centers, and 14 ancillary providers.

I am pleased to be here today on behalf of the American Hospital Association and its diverse members, 5,000 hospitals, health systems, networks, and other health care providers.

Before I begin with our experience, I would like to say we greatly appreciate the work of Chairman Thomas, in trying to make PSOs a Medicare option through his drafting of the original legislation reported out of this committee in 1995, and we commend Representatives Greenwood and Stenholm for introducing bipartisan PSO legislation in this Congress. AHA strongly supports this legislation.

I want to briefly share with you some of our firsthand experiences as a provider-sponsored organization that has entered into a Medicare risk contract with HCFA under the Medicare Choices demonstration project. We believe we have a valuable story to tell about the real life experience of a PSO.

The name of our health plan for seniors is called Florida Hospital Premier Care. We determined that it was important to include the name "Florida Hospital" in the health plan name, since Florida Hospital has been in the community for over 80 years and currently serves almost half of the traditional Medicare population in the greater Orlando market, which is comprised of about 140,000 Medicare beneficiaries. Currently, 30 percent of Medicare beneficiaries receive benefits from Medicare risk HMOs in our market. This is a level that has been relatively flat in recent years.

After receiving approval from HCFA on December 26th to be a PSO in the demonstration project, we ran the first announcement of our new plan in the newspaper on December 31, and again on New Year's Day. The response to our early marketing efforts has been tremendous. On the first day our newspaper ad ran, we received over 500 calls from interested Medicare beneficiaries. On January 2, the first business day after the New Year, our staff were overwhelmed from the 2,500 responses that were received.

FHHS's early marketing results have shown that 60 percent of our enrollees have come from traditional fee-for-service Medicare,

and 40 percent have left their Medicare HMO to join a health plan locally owned and operated.

I would like to point out some of the differences between our health plan versus a traditional and typical Medicare risk HMO, some of which HMOs have been in the market for over five years.

First, our roots are in the local community and we're there to stay. We're enrolling Medicare beneficiaries that have grown to trust the hospital and physicians in the community based on providing compassionate and quality health care. We know that by sponsoring and putting our name on the health plan, we are relying on a reputation that the hospital and physicians have spent decades developing.

Based upon a survey of our current members, over 80 percent of the individuals mentioned that the hospital's reputation in the community, and the fact that the plan was sponsored and owned by a local community hospital, was the basis for their decision.

Second, we bring health care decisions back to local providers. We believe that physician leadership is critical in any high-quality health care delivery system. That means having decisions made by local providers with the first-hand knowledge that a beneficiary needs.

Our affiliated physicians have freely given hundreds of hours each month over the last three years participating in the administration of the organization, developing the medical management process, policies and procedures, reviewing patient care, and providing input on how to make the managed care process better by putting the patient first.

Many of the primary care physicians that are in our network had never experienced or participated in a Medicare risk plan before because of all the "hassle" they experienced with commercial HMOs in the past. Not until they had a say and were engaged in the process of managing a PSO did they choose to participate in the Medicare risk plan.

Additionally, PSOs will help pull down health care costs by directly managing both the use of services and the cost of producing these services. PSOs will reduce administrative expenses that will both save Medicare dollars and increase the percentage of health care dollars going to patient care and member health improvements.

To ensure PSOs are a viable option for seniors, Medicare should enter into contracts only with PSOs that provide coordinated care, accept financial risk, and meet Medicare's risk contracting standards.

Thank you.

[The prepared statement follows:]

American Hospital Association

Liberty Place
Washington Office
325 Seventh Street, N.W.
Washington, DC 20004-2802
202-638-1100

Statement
of the
American Hospital Association
before the
Subcommittee on Health
of the
Committee on Ways and Means
of the
U.S. House of Representatives
on
Medicare Provider-Sponsored Organizations

April 24, 1997

Introduction

Mr. Chairman, I am John Brownlow, Chief Operating Officer and Vice President for Managed Care for the Florida Hospital Healthcare System, a provider-sponsored organization (PSO) with a Medicare risk contract. In December 1996, Florida Hospital Healthcare System received final approval for our Medicare Choices Demonstration Project from the Health Care Financing Administration (HCFA).

Our provider-sponsored organization grew out of a strong desire on the part of Orlando's Florida Hospital and its medical staff to develop a more integrated system of coordinated care. In 1994, the hospital and its physician leadership developed the necessary expertise and related administrative components of a PSO called Florida Hospital Healthcare System (FHHS). As a local plan offered by a community-based hospital, our mission is to improve the health of our members both now and for the future. As part of the local community, FHHS is attentive to the long-term interests of the community we serve. We have formed effective partnerships with local health care and community organizations to implement community health improvement initiatives, such as Orlando's Health Care Clinic for the Homeless.

FHHS has grown into a fully integrated delivery system capable of providing the full range of Medicare benefits for members for a flat monthly fee. The FHHS provider network for our Medicare full-risk business includes 615 physicians, as well as five hospitals, 13 walk-in medical centers, and 14 ancillary providers.

On behalf of the American Hospital Association (AHA) and its 5,000 hospitals, health systems, and other providers of care, I welcome this opportunity to testify on provider-sponsored organizations and their potential to increase Medicare beneficiaries' participation in managed care plans. We recognize and appreciate the leadership of Subcommittee Chairman Thomas in advancing PSOs as a Medicare option. The original Medicare PSO legislation was drafted by the Chairman and reported from this subcommittee in 1995. We also commend Reps. Jim Greenwood (R-PA) and Charles Stenholm (D-TX) for introducing H.R. 475, legislation we wholeheartedly endorse, that would make PSOs a long-term option available to Medicare beneficiaries.

Today, we would like to explain what PSOs are, outline the critical elements embodied in H.R. 475, and then show how many of these key elements have been worked out by FHHS. This will give you a real-world sense of how we are bringing a new kind of managed care to Medicare beneficiaries -- a kind we believe can overcome many of their current reservations about joining managed care plans. First, some background about PSOs in general.

PSOs come in many shapes. Integration among hospitals, physicians, and other caregivers is a prime characteristic of PSOs. The integration can take many forms, among them: consolidating administrative activities; jointly sharing payment risk; coordinating clinical care; and combining or merging corporate and governance structures. PSOs accomplish this integration through various organizational structures, and have the ability to accept financial risk-sharing for a broad spectrum of services in their contracts with health plans, including under capitated payment (a fixed, per-person, per-month payment). Consequently, PSOs can make a major contribution to the evolution in how managed care is practiced in this country. As community-based, integrated networks of providers that offer a spectrum of care in exchange for a fixed payment, PSOs can achieve both *cost* and *quality* goals:

- **PSOs achieve the cost efficiencies necessary to hold down health care costs** by **directly managing** both the **use** of services **and the cost of producing those services**. PSO direct contracting relationships have the potential to decrease the overall costs of health care by reducing one layer of billing and administrative processes injected by insurance companies and many HMOs. Such direct contracting preserves the largest percentage of health premiums or government health expenditures for direct patient care and community health improvement initiatives.

- **Since PSOs are provider-driven, not insurer-driven, they put clinical decisions in the hands of those most capable of balancing efficiency and patient care** -- local community-based health care providers.

- **PSOs address consumer concerns about stable relationships with providers.** Under some commercial managed care plans, panels of participating clinicians change frequently as the plans move from one provider group to another, seeking deeper discounts. PSOs are built on a more stable provider base -- often the very providers with whom consumers already have established relationships. Consumers don't have to change plans to follow their providers; their providers *are* the plan.

- **PSOs are good for local communities**. Rooted in communities, PSOs are attentive to the long-term interests of the communities they serve. They are more likely, for example, to focus on improving the health of the entire community.

Essential Elements of a Medicare PSO Option

More important, PSOs can provide both cost savings and quality to Medicare beneficiaries as well. PSOs carry benefits beyond those normally associated with a managed care plan -- such as the ability to choose physicians and hospitals, not just a plan and whichever providers come with it. We're the hospitals and doctors our seniors know. A survey of our early FHHS Medicare members underscores the importance of this PSO characteristic: our hospital's reputation and the physicians who make up our network were the first and second most important reasons members gave for enrolling.

Because PSOs help maintain the direct link between patients and providers that Medicare beneficiaries often cite as the most important aspect of their care (and also cite as a major reason for staying with traditional fee-for-service Medicare), we believe these benefits will motivate Medicare beneficiaries to choose PSOs. Again, FHHS' experience lends credibility to our belief: in a market where 30 percent of Medicare beneficiaries receive benefits from managed care plans -- a level that has been rather flat -- *our survey showed that 60 percent of our enrollees came from the fee-for-service ranks.*

Congress should make provider-sponsored organizations a permanent option for Medicare beneficiaries. Unless Congress acts, FHHS' direct managed care relationship with beneficiaries will end. More important, without legislation a significant opportunity to extend this more appealing, locally-based managed care option to beneficiaries across the country will be lost.

To ensure that PSOs are a viable option for seniors, however, HCFA should enter into Medicare contracts only with PSOs that provide coordinated care, accept financial risk-sharing, and meet

Medicare's risk contracting requirements. For example, the basic definition of a PSO is a public or private provider or group of affiliated providers organized to deliver a spectrum of health care services under contract to purchasers of such services. **Medicare-qualified PSOs, however, should be even more precisely defined, as they are in H.R. 475.** Important criteria, included in the bill, are as follows:

First, Medicare-qualified PSOs must provide the entire Medicare benefit package to seniors. In addition, they must deliver the *substantial portion* of those services -- significantly more than half -- directly through their own affiliated providers. Most of the remaining services must be delivered by providers who are under contract to the PSO. This allows health care providers to come together to form a delivery system through a variety of means, including common ownership, common control, or substantial shared financial risk, and also ensures sufficient integration to support true coordinated care and capitation.

FHHS believes there is a substantial benefit to providers and to health plan members when the economic and patient care incentives are all aligned. Through either direct ownership or shared substantial risk, providers affiliated with our PSO share a significant common economic interest through shared financial accountability and governance. FHHS physicians have incentives to monitor their own peers, look for under- and overutilization and questionable business practices, and resolve quality issues because of the impact these areas have on the success of the PSO. FHHS providers take total responsibility for patient satisfaction, financial success and quality outcomes.

Second, all Medicare health plan options should ensure that beneficiaries are protected from poor quality care, financial liability from poorly managed plans, and inappropriate plan behavior. To that end, H.R. 475 would require that all PSOs be subject to all federal Medicare requirements imposed on Medicare risk contractors regarding marketing practices, enrollment processes, enrollee rights to review of coverage decisions, appeal mechanisms that involve external reviewers, and disclosure of plan information.

At FHHS, we recognized that in order to become a Medicare Choices demonstration site we had to ensure certain core competencies. Although we knew we would be able to serve a significant number of Medicare members using the existing administrative components that the hospital and physicians already developed through FHHS, we needed to establish additional infrastructure for Medicare operations, compliance, enrollment/eligibility, sales and marketing. Therefore, in addition to our core competencies, we launched efforts to enhance our management information system, develop Medicare-specific policies and procedures, modify and augment existing policies and procedures, and increase staffing for sales, member services, medical management and claims management.

Third, H.R. 475 proposes to enhance quality assurance standards and make solvency standards more appropriate to PSOs. The revisions we support are, in many cases, applied only to PSOs, based on distinctive PSO characteristics; others apply to all Medicare risk contractors. These include the following:

- **Waive the 50/50 requirement in favor of direct measurement of quality and coordinated care experience.** The requirement that Medicare risk contractors have at least 50 percent commercial enrollment (the "50/50 rule") is a significant barrier to PSO Medicare contracting. It doesn't recognize the experience PSOs have gained as they contract to provide patient care services to managed care organizations because of their "down stream" care-giver position.

  FHHS, for example, offers provider network and administrative capabilities for a variety of insurance partners, including preferred provider organizations (PPOs), point-of-service plans (POSs), and health maintenance organizations (HMOs), for commercial, Medicare and Medicaid products. Key core operational areas and administrative services of FHHS include utilization management, quality management, contracting, provider relations, credentialing, medical management, claims management, financial management, information systems, sales and marketing, compliance, and member services.

Medicare-qualified PSOs would not enter the commercial market to sell health plan coverage. Rather, they would maintain their traditional direct relationships with Medicare by using their coordinated care experience gained under managed care contracts to provide coordinated care to beneficiaries under a Medicare health plan contract.

As in H.R. 475, we believe all Medicare risk contractors, including PSOs, should be able to have the 50/50 rule waived *if* they meet enhanced quality assurance requirements and can demonstrate experience in providing coordinated care (as a health plan or, more likely, under contract with health plans). Waiver of the rule would acknowledge that its original purpose as a proxy for quality measurement is no longer necessary, given today's improved quality measurement tools.

- **A federal certification process should be provided initially for PSOs, with involvement of state regulators appropriate to a Medicare-only plan.** It is inappropriate to initially require both federal certification *and* state licensure for PSOs when PSOs are directly enrolling only Medicare beneficiaries. Medicare already has its own rules on contractor capabilities and consumer protections, and the majority of these rules would apply to PSOs without change.

  From a government efficiency perspective, it does not make sense to initially require state licensure. The state's findings are not helpful to Medicare in judging whether PSOs meet federal requirements; Medicare must do its own evaluation, under its own rules, of the PSO. If the PSO is not directly enrolling individuals in the commercial market, a state licensure process is inappropriate and not needed on top of federal Medicare requirements.

  We support H.R. 475's reliance on an initial four-year period of federal rules and federal certification to enroll Medicare beneficiaries. During that time, Medicare could contract with state agencies to locally monitor on-going PSO performance. After the first four years, Medicare could allow state licensure in those states where their requirements are identical to the federal standards for solvency, and generally line up with federal requirements for quality.

  For the purpose of the FHHS demonstration, HCFA, with cooperation from Florida's Department of Insurance, waived the requirement to have 50% of our covered lives in commercial HMO business and to have a minimum of 5,000 total covered lives from commercial HMO business. Also waived was the requirement to have a state HMO license to operate in the State of Florida. The Florida Department of Insurance waived these items because it believed there was adequate oversight and regulation of FHHS' plan by HCFA. AHA agrees: it is appropriate to waive state licensure requirements for a federal program serving federal enrollees with services paid for by federal dollars, especially in the critical launch years. Although factors vary among states, the process of applying for a state HMO license can be so extended that it can be a barrier to PSO formation.

- **Adopt a PSO solvency standard that is responsible and specific.** In the 1995-96 Congressional debate about how to include a PSO option, the Congressional proposals included a process for the Secretary to develop solvency standards, without the inclusion of any specific statutory requirements. Unfortunately, the lack of a specific standard created the inaccurate impression that hospitals and physicians did not support appropriate solvency requirements, and raised significant concerns.

  Let me assure you at the outset that the American Hospital Association supports a rigorous and specific standard, like the one included in H.R. 475. We, like you, do not want to encourage undercapitalized PSOs to contract with Medicare. Specifically, we recommend that the current Medicare HMO/CMP requirements for financial soundness, insolvency plans, provider contracting, and continuity of care and coverage be applied to

PSOs as well. This ensures that both Medicare beneficiaries and the Medicare program will be protected under PSO contracts, as they are under HMO and CMP contracts.

Further, we recommend that the PSO financial soundness test be specified in the Medicare law. We believe the financial soundness test should be based on the net worth and reserve requirements found in the National Association of Insurance Commissioners' (NAIC) current model HMO act.

Basing the federal standard on NAIC's model, as H.R. 475 specifies, does require limited revisions to reflect accounting differences and payment variations between PSOs and HMOs, and to assure that the model act's recognition of health delivery assets in assessing net worth is maintained. This last issue is especially important to PSOs because it recognizes that their core business is the delivery of health care services -- not selling insurance. This recognition acknowledges that PSOs meet their coverage commitments through using their assets to produce the covered services directly, rather than selling investment assets to pay claims. The presence of a claims reserve requirement ensures the PSO has the capacity to pay for services they do not produce directly, such as out-of-area services.

We also recommend that alternative means of demonstrating financial soundness be recognized, such as letters of credit, financial guarantees, reinsurance or stop loss insurance, certification by an independent actuary, unrestricted fund balances, diversity of lines of business, and presence of non-risk related revenue. These alternatives include items found in many state statutes or regulations, and many of the alternatives are practices common within the insurance industry.

In order to obtain the necessary dollars to enhance FHHS infrastructure for Medicare operations, FHHS needed a capital partner willing to invest substantial financial resources. In addition, as part of the demonstration project approval process, HCFA required our PSO to meet certain solvency and capital requirements. HCFA required that two and a half months of estimated claims be covered either through the equity of a parent organization or through other mechanisms, and that we were capitalized sufficiently. HCFA recommended that our PSO borrow an additional $2 million beyond what we had already capitalized.

These requirements could be met in a variety of ways, including by subordinated debt, capital from physicians and the hospital together, or a greater proportion of capital from either physicians or the hospital. In FHHS' case, our parent corporation, Adventist Health System, Inc., with total assets in excess of $1.2 billion and equity in excess of $500 million, provided that support, including the $2 million of additional capital. Adventist Health System, Inc., made a significant investment in the PSO because its leaders understood the need to shift from focusing on hospital admissions and treating sickness and disease to the new focus of covered lives of plan members, with an emphasis on wellness and prevention.

- **Medicare should take advantage of the unique capabilities of PSO health care delivery systems to consistently implement high-level quality requirements that reflect the state-of-the art in quality management and also address problems with some current forms of managed care.** There are many problems with some current forms of managed care that health care providers see every day, such as the degree of intrusion in the doctor-patient relationship caused by health plan cost management techniques, the degree to which clinical management policies are not developed by practicing clinicians, and the degree to which cost considerations seem to override quality considerations. PSOs provide a way for hospitals and physicians to develop and implement their own approaches to addressing these problems.

  PSOs would develop and implement plans to move from utilization review done on a case-by-case basis as part of a precertification or claims review process, to the evaluation of patterns of care as part of an integrated quality assurance and utilization management

process. This will develop the mechanisms that are most effective in evaluating and altering inappropriate care patterns, while putting clinicians back in charge on a day-to-day, patient-by-patient basis.

At FHHS, our Medical Management Program is designed to monitor, evaluate and improve the quality of care delivered to patients. The program meets all standards for both the National Committee for Quality Assurance (NCQA) and the Joint Commission for the Accreditation of Health Care Organizations (JCAHO). A critical component of the system is the ability to manage the health care needs of a population in order to provide the best care in the best setting.

Quality assurance and utilization review allow FHHS to perform continuous quality improvement, evaluate continuity of care, and monitor the over- or underutilization of services. In addition, FHHS provides each member with health education, an important factor in keeping members healthy versus treating them once they are sick. As a PSO, FHHS is leading the transition to focus on wellness instead of sickness.

Through the quality and utilization management process, provider practice patterns are monitored and evaluated for both in- and outpatient services. If issues for improvement are confirmed, a corrective action plan is implemented which may include staff education and development, administrative changes, contract changes, intensified performance monitoring, peer review, limitation of privileges, sanctions, suspension or ultimately termination.

- **PSOs participating in Medicare should be eligible for full-risk and partial-risk payments.**

  ✓ Currently, Medicare full-risk plans are paid on the basis of 95 percent of the Adjusted Average Per Capita Cost, or the AAPCC. That system itself, however, is seriously deficient in several ways and in need of reform.

  There is wide variation in historic fee-for-service utilization patterns, and therefore a resulting wide variation in health plan payments -- *more than 300 percent among counties across the United States*. We believe these payments should be made more equitable across the United States in a way that will allow more communities to establish provider-sponsored networks.

  We advocate Medicare managed care payments that are uniform across the country, but then adjusted to reflect differences in the cost of delivering care due to the fact that some areas may care for less-healthy, more costly Medicare beneficiaries. The current AAPCC should be blended with a new payment rate that eliminates differences in historical patterns of use across counties. And, a payment floor should be quickly established to raise payments in the lowest-rate areas.

  Finally, we believe that payments for graduate medical education (GME) and for those hospitals treating a large volume of low-income individuals -- the disproportionate share hospitals (DSH) -- should be "carved out" from Medicare managed care payments. The carve out is needed because traditionally the Medicare program has paid hospitals directly for the special, additional costs associated with teaching and with treating large numbers of low-income individuals. Because these special payments often remain buried within a fixed, Medicare health plan payment, health plan organizations receiving the payment are not passing on the funding to those institutions actually incurring the added costs. Medicare payments for clinical education and for hospitals treating a disproportionately large share of low-income individuals should be paid directly to the organizations fulfilling those responsibilities.

- ✓ In addition to AAPCC payment changes, we support a "partial risk" payment option for all Medicare plans, including PSOs. Where Medicare and a plan agree to partial risk payment, the plan would be responsible for offering the full Medicare benefit package, but would be paid a mix of capitation and cost for all services. Under such arrangements, the Medicare program shifts much, but not all, of its risk to the plan. This creates a more viable option in communities that have little or no access to such managed care options now. This provision allows participation by smaller risk contractors such as those in rural areas who may not be able to absorb the wide swings in costs that often occur in smaller pools of beneficiaries. It would also enable the greater use of coordinated care for the disabled and chronically ill.

We believe partial risk payment is critically important to efforts to expand the availability of coordinated care options under Medicare. Partial risk methods, already in use in the private sector to a significant degree, would increase the tools available to modernize Medicare.

The President's PSO Proposal

The Medicare reforms recently proposed by the President are a positive step toward establishing PSOs as an option for Medicare beneficiaries. His plan recognizes that a federal process is needed and warranted for a federal program providing coverage and care to federal enrollees. It is a good starting point.

AHA is concerned, however, that the President's legislation is too vague with respect to requirements that PSOs have commercial contracts. If required to have commercial contracts, PSOs would need acquire state HMO licenses -- the key impediment to their development. AHA believes that strong quality standards, as proposed in H.R. 475, are a far more appropriate means to fulfill the original intent of the rule requiring that 50 percent of enrollees be from the commercial market.

AHA also believes that the approach to ensuring PSO solvency in H.R. 475 is superior to the President's proposal. His plan would leave development of solvency rules up to the Secretary of HHS. Although not in itself objectionable, this approach was of major concern to some when it was included as a part of the Medicare PSO legislation in the Balanced Budget Act of 1995. To alleviate those concerns, AHA supports specific, statutory solvency standards appropriate to provider-based organizations.

Conclusion

We commend Rep. Thomas, along with Rep. Greenwood and Rep. Stenholm, for advancing the debate on PSOs. H.R. 475 includes the essential elements needed to create an important new option for Medicare beneficiaries. The bill demonstrates that concerns raised last year by Members and interest groups were heard and have resulted in legislative improvements and refinements. And we would like to recognize the leadership of Subcommittee Chairman Thomas in making Medicare PSOs a viable option, through his drafting of the original Medicare PSO legislation reported out of this subcommittee in 1995.

Mr. Chairman, we appreciate this opportunity to share with you our views on provider-sponsored organizations. AHA and its members are focusing significant resources on moving health care delivery to a more efficient and effective integrated model. We believe PSOs are the right vehicle to accomplish this goal. Powerful market, regulatory, and demographic forces undergird our view. AHA and its members believe that extending provider-sponsored organizations to Medicare would bring benefits to beneficiaries, to providers, to communities, and, perhaps most significantly from this Committee's point of view, to the Medicare program itself. We believe the enthusiastic acceptance of the Florida FHHS plan demonstrates the real-world potential of PSOs.

The AHA is deeply concerned about the impending Medicare financing crisis. Action must be taken soon to make fundamental structural changes that will allow this nation to continue to meet the health care needs of the elderly. Broadening beneficiaries' choice of Medicare health plans,

including PSOs, is a vital part of this effort. Repairing the AAPCC's present variability and unpredictability should be another.

Overall, the Medicare program has been an outstanding success in bringing health care security to the elderly. In a nation where eroding access to health care coverage in the working population is already contributing to a steady rise in the uninsured, we cannot afford a future in which we lack the resources to keep the Medicare promise. We look forward to working with you to make provider-sponsored organizations a significant factor in a fiscally healthy Medicare program.

Chairman THOMAS. Thank you very much.

Miss Lehnhard.

STATEMENT OF MARY NELL LEHNHARD, SENIOR VICE PRESIDENT, OFFICE OF POLICY AND REPRESENTATION, BLUE CROSS AND BLUE SHIELD ASSOCIATION

Ms. LEHNHARD. Mr. Chairman, members of the committee, I am Mary Nell Lehnhard, Senior Vice President for the Blue Cross and Blue Shield Association, and I'm here today representing all the Blue Cross and Blue Shield plans.

I would say at the outset that we welcome competition from PSOs and we believe absolutely that they should be a choice for Medicare beneficiaries. We do not believe they should be exempt from State licensure. Under current Medicare law, any organization that accepts Medicare capitation and signs a Medicare risk contract must meet all Medicare standards and be licensed by the State as meeting all local consumer protection laws.

This rule applies to HMOs and PSOs. This rule assures that Medicare beneficiaries get the strongest possible set of protections, all State laws and all Federal Medicare rules. It is not necessary, nor is it good public policy, to waive this important requirement for PSOs to be in the program, and I would like to make four brief points.

First, PSOs can meet State standards. Many PSOs are already operating under State licensure laws, and many are in the process of approval. The NAIC risk-based capital will provide a more sophisticated way to set financial standards for these organizations.

In fact, according to AHP, 14 percent of Medicare risk plans already are PSOs. I would repeat that. Fourteen percent of Medicare risk plans are PSOs.

Secondly, timeliness is not a barrier. The NAIC has done a survey, that 75 percent of applications submitted by PSOs are processed in 90 days.

Third, waiving the consumer protection laws would be a tremendous disservice to beneficiaries and would result in a different and confusing set of standards based on what kind of products you have. Beneficiaries wouldn't know whether they're protected by State and Federal law, or just Federal law. Experience suggests that they would ask for essentially a truth in labeling to figure out how their plan is protected.

In addition—and this is extremely important—all beneficiaries in PSOs would lose very visible State protections. These State laws will frequently go beyond Medicare Federal rules, no matter how broad HHS tries to make these. I would point out that we focused on financial standards today, and financial standards are but one part of what the States have in place to protect consumers. There is a very broad range, over a thousand consumer protection laws on the books, that States have to protect consumers.

For example, Maryland has stringent laws regarding the collection and verification on the network physicians. They look at their training, their certification, their physical and mental status, and past malpractice. Seventeen States have rules like this that would be preempted by the Federal Government if this provision passes.

A majority of States have regulations governing brokers that sell HMO and PSO products. These requirements include disclosure of commissions and limits on compensations and other rules for brokers. Other States have special requirements to assure that the network primary care physician actually has experience in providing primary care.

Medicare beneficiaries will be very concerned that these laws apply to some products, HMOs, but not other products, PSOs.

The fourth point I would make is that Congress will be sending a very powerful message that could result in some communities literally losing their hospitals. The message would be one of encouragement, especially to small rural hospitals, to sign up to be a Medicare risk plan, the promise of a new income stream. The encouragement is the waiving of consumer and financial protections that State legislatures have determined to be necessary to protect beneficiaries.

For example, at the heart of the financial standards that hospital and physician PSOs want to waive are the current liquidity requirements. The NAIC investment guidelines in many States require HMOs and PSOs to have a minimum amount of their assets in liquid assets or cash assets. The PSO bills that have been introduced would allow PSOs to meet this liquidity test with their land and their buildings.

This means that a PSO, particularly in a rural area that has to send a majority of its complicated cases into the city, could not be required, either by the State or the Secretary, to have cash on hand to pay those claims that had to be paid on a fee-for-service basis. Their hands would be tied. You can't pay out-of-area claims with a hospital parking lot.

The result of inadequate cash means the community loses its PSO and it means the community loses its hospital. We believe the answer to encouraging PSOs to develop is not to waive important State standards that very visibly protect consumers, the PSO and the hospital. Rather, we believe Congress should first increase the AAPCC payment in rural areas. PSOs would immediately have well-capitalized partners knocking at their door, and they wouldn't have to assume unreasonable risk on their own.

Secondly—and we don't necessarily advise this—but Congress could waive the 50–50 rule. This is an absolute barrier to PSOs that only want to be in Medicare, signing up for Medicare risk contracts.

In summary, we don't oppose PSOs. We just believe that Congress should not waive the current Medicare requirements that assure the highest level of protections for beneficiaries.

[The prepared statement follows:]

BlueCross BlueShield Association
An Association of Independent
Blue Cross and Blue Shield Plans

Testimony

on

Provider Sponsored Organizations

before the

Subcommittee on Health
Ways and Means Committee
U.S. House of Representatives

presented by

Mary Nell Lehnhard
Senior Vice President

April 24, 1997

Mr. Chairman, I am Mary Nell Lehnhard, the Senior Vice President for the Office of Policy and Representation of the Blue Cross and Blue Shield Association (BCBSA). I am pleased to present to the Ways and Means Committee the views of the 59 Blue Cross and Blue Shield Plans on the important topic of Provider Sponsored Organizations (PSOs).

BCBSA supports public policies that promote fair and vigorous competition because we believe this will expand the availability of affordable health care for all Americans. A healthy, competitive marketplace will best meet consumer demands for access to high quality health care -- and we believe Provider Sponsored Organizations (PSOs) should be part of this marketplace.

BCBSA does not oppose the formation of PSOs. In fact, many Blue Cross and Blue Shield Plans partner with PSOs to create, deliver and manage innovative health plans.

However, we are opposed to proposals that would exempt PSOs that contract with Medicare from the current requirement that all Medicare risk plans meet both federal standards for HMOs <u>and</u> be licensed by the state as meeting all the consumer protection laws in that state. Contrary to provider assertions, existing state licensure requirements for HMOs do not prevent the development of health plans that are sponsored, controlled, and managed by providers. In fact, 14 percent of all licensed HMOs are provider controlled, i.e., PSOs.

Our testimony highlights our concerns that:

1) PSOs should be subject to current requirements that Medicare risk contractors meet <u>both</u> federal and state consumer protection rules.
2) Medicare beneficiaries should have the benefit of the protection of over 1000 state consumer protection laws that assure:
    - appropriate financial standards
    - adequate access to quality care
3) Unlicensed rural PSOs could jeopardize delivery systems in rural areas.

PSOs Should Meet Current Medicare Risk Contract Standards Regarding Federal <u>and</u> State Consumer Protections

Providers have asked Congress to exempt PSOs from current Medicare risk contractor standards requiring compliance with state consumer protection rules. Under these requirements, federal law provides a minimum set of consumer

protection standards with which all Medicare risk contractors must comply. This provides a national "floor" for consumer protection. Medicare law also requires Medicare risk contractors to be licensed by the state and comply with state consumer protection rules so that beneficiaries have the benefit of the strongest protection standards available.

We believe that an exemption of PSOs from state licensure standards is unnecessary and presents unacceptable risks for Medicare beneficiaries as well as the Medicare program itself.

Medicare simply is not the place to roadtest unlicensed health plans. Medicare beneficiaries enrolled in PSOs should have the same protections as their Medicare neighbors enrolled in state licensed HMOs.

States that experimented in the past with separate standards for Medicaid HMOs met with disastrous results. For instance, Florida waived commercial HMO license rules for Medicaid HMOs in the early 1990s and consequently faced widespread abuses, including the provision of poor and possibly life threatening care. Florida has since required these entities to comply with all commercial enrollee rules.

Moreover, recent research indicates most PSOs are just emerging and are inexperienced in managing health care risk assumption. A 1996 survey by Ernst and Young on Integrated Delivery and Financial Systems indicated 71 percent of PSOs were less than three years old. Twenty percent of PSOs reported losing money last year, but most troubling of all-- nearly 40 percent of survey participants did not track the amount of revenue received and 20 percent did not know whether they were profitable or not. The business of managing risk requires a complex set of skills and competencies; emerging PSOs need close monitoring at the local level.

Medicare Beneficiaries Should Have the Benefit of State Consumer Protection Rules

Recent research by consumer attorney Carol Jimenez documents over 1000 state laws that currently protect consumers in prepaid health plans. These laws address a myriad of issues but are generally designed to assure two objectives:

1) The health plan is financially sound and ethically operated.
2) The consumer has adequate access to quality care from the health plan.

If Congress exempts PSOs from state licensure, Medicare beneficiaries enrolled in PSOs will not have access to the same level of protections as their Medicare neighbors enrolled in a state licensed Medicare HMO.

1) Consumer Protection: Financial Standards

The driving force behind consumers' enrolling in a health plan is their desire for security regarding future health care expenses as well as obtaining needed health care.

Financial standards (e.g. minimum net worth, investment rules, etc.) are the primary mechanism by which states assure consumers that a health plan will be capable of paying for its enrollees' health care needs currently and in the future. In today's ultra-competitive health care market, such standards are necessary to assure that health plans have a financial cushion to protect against the implications of aggressively underpricing products to jump-start sales, loss of market share, unanticipated increases in utilization, or the enrollment of particularly high risk individuals.

PSOs claim they can be exempt from state requirements to hold minimum net worth standards in cash or cash equivalent assets because:

1. They have substantial assets (investments) in hospital plant and real estate; and
2. They employ the staff that provide care, and this staff's "sweat equity" -- the ability to work longer hours for no additional pay -- will provide a cushion if a higher than predicted number of subscribers fall ill.

These arguments fail to adequately address the underlying reasons for the application of minimum net worth and investment standards to risk-bearing entities. These rules assure the existence of a financial cushion that PSOs -- like other health plans -- need to cover both internal and external costs:

- Internal Network Costs: PSOs, like other entities, must cover expenses incurred in providing services. Even if physician owners were willing to work longer hours at no cost, PSOs would still incur the expenses of nurses, physical therapists, and others that are not owners. In the case of hospitals, there is little room to use "sweat equity." Seventy-five percent of hospital expenses are labor related, e.g., nurses, nurses' aides, cleaning and maintenance staff, etc. In addition, an unexpected level of patient illnesses would require cash payments for expensive pharmaceuticals, surgical kits and other hospital supplies.

- External Costs: PSOs must be able to pay for a subscriber's emergency care that is obtained from hospitals that are not part of the PSO and tertiary care such as open heart surgery or cancer treatment that the PSO's hospitals and physicians cannot provide.

In cases where a PSO fails to adequately estimate their patient care costs and lack a liquid -- that is, cash equivalent -- financial cushion, the PSO would be forced to borrow against or even sell its delivery assets. These buildings and equipment are the very items the PSO relies upon in order to deliver services.

Many states limit the investments that prepaid health plans can make in land, buildings or equipment because these assets, while valuable, cannot be readily converted into the cash needed to pay unexpected claims or to pay for out of network care.

State investment rules assure health plans can still pay claims even when plans incur unexpected underwriting losses. Otherwise, consumers could be left footing the bill when their health plan encounters cash flow problems or becomes insolvent. The same investment standards must be applied to all risk bearing entities -- insurers, HMOs, PSOs, or whatever other organizations evolve, in order to provide consistent protection for consumers.

2(a) Consumer Protection: State Standards for Access and Quality

According to consumer attorney Carol Jimenez, there is nothing "magical" about Provider Sponsored Organizations that would warrant exemption from consumer protection rules. She states that PSOs are virtually indistinguishable from HMOs from a consumer's perspective.

Jimenez also dismisses PSO arguments that providers are less likely than HMOs to let financial pressures influence patient care. In fact, in a PSO there are likely to be fewer layers to give a financial cushion for the provider rendering care. Consequently, she argues that these entities must be subject to the same standards that states impose on local HMOs. Exemption from licensing standards for PSOs would mean beneficiaries in these PSOs would have *separate and unequal protections* from their neighbors who are enrolled in state licensed Medicare HMOs.

An exemption from state law would mean PSOs would not need to comply with state law, including:

- **Quality Assurance Laws:**
  States require health plans to develop and implement quality assurance plans, undergo external monitoring, and implement procedures for verifying the credentials of physicians and other providers. Other laws address utilization review.

- **Marketing and Enrollment Laws:**
  State laws prevent false and misleading advertising and eliminate practices designed to deny enrollment or continued enrollment to persons based on their health status.

- **Data Collection:**
  State laws require HMOs to track enrollee grievances, malpractice claims and report to the state. Other items required include patient outcome data and utilization data.

- **Access and Benefit Laws:**
  State laws regulate specialty care referrals, minimum time or distance that members should travel to obtain primary or other care as well as mandated benefits.

- **Grievance Procedures:**
  All states require health plans to establish grievance procedures through which a member can appeal what he or she believes is an unjustified denial of coverage.

- **Conflicts of Interests**
  State laws require HMOs to disclose any potential conflicts of interest and maintain a fidelity bond for those administering HMO funds.

2(b) Consumer Protection: Examples of State Laws Exceeding Medicare

Each state's laws within the above categories vary from one another. Each state's approach to health plan regulation stems from the unique experience of their community with the health care delivery system. The common thread for all states is that they have enacted rules that provide additional protections for Medicare beneficiaries. These protections will be lost if PSOs are allowed an exemption from state licensure rules. A few specific examples of the types of laws that exceed Medicare at the state level:

- **Provider Credentialing**: In Maryland, HMOs must collect, review, and verify information concerning physicians' training, certification, hospital privileges, physical and mental status, evidence of any adverse action imposed by any

hospital or Board, verification of status though the federal National Practitioner Data Bank, and past malpractice. Maryland HMOs also must re-evaluate selection of physicians every two years, including updating initial criteria, assessment of performance based on complaints filed through the grievance system, malpractice claims, utilization, quality and risk data and physician practice patterns.

- **Grievance:** California has an extensive grievance system for enrollees. The grievance system includes a requirement for an expedited plan review of grievance for cases involving an imminent and serious threat to the health of the patient. Or, if the treating physician believes the effectiveness of the proposed treatment would be materially reduced if not provided at the earliest date, the health plan must conduct a grievance conference within five days of the complaint.

  In addition, the plan must organize an independent external panel to review the plan's coverage decisions regarding experimental or investigation therapies. The external panel must be composed of at least three physicians who are experts regarding the treatment of the beneficiary's condition as well as knowledgeable about the recommended therapy. The panelists are prohibited from having any relationship to the health plan.
- **Disclosure:** The state of New York has extensive disclosure requirements for beneficiaries. Health plans must release to beneficiaries the minimum qualifications for providers to be considered for participation in the network as well as specific written clinical review criteria and other clinical information used in utilization review for a specific disease or condition. The health plan must also disclose to enrollees their rights to "standing referrals" with regard to specialists, specialist centers, and continuity of care.

- **Beneficiary Participation:** Georgia requires that one-third of the members of the governing body of the health plan be public members. In addition, the health plan must establish a process though which enrollees may participate in matters of policy and operation.

- **Financial Rules:** Minnesota requires health plans to be non-profit. All net earnings of the HMO must be devoted to nonprofit purposes in providing comprehensive care. The HMO may not make payments directly or indirectly to any person as a dividend or rebate. Minnesota also requires any person receiving commissions for the sale of coverage or enrollment in a health plan to disclose in writing to the prospective purchaser the amount of the compensation prior to the sale of coverage.

- **Alternative Physician Opinions:** Florida requires health plans to allow beneficiaries to seek a second medical opinion from any physician of their selection, even if the selected physician is outside of the network. In addition, the HMO must pay the amount of such charges which are reasonable for the community and cannot require the subscriber to contribute more than forty percent of these charges. In addition, the professional judgment of a physician regarding the proper course of treatment cannot be subject to modification by the health plan or any of its directors or administrators unless the treatment is inconsistent with prevailing community medical standards.

Unlicensed Rural PSOs Could Jeopardize Rural Consumers' Access To Health Care.

PSO advocates argue that a PSO exemption from state law is necessary to expand access in rural areas. However, a recent report released by the Barents Group indicates that unlicensed PSOs could exacerbate current health care delivery problems in rural communities.

The report, "Are Unlicensed Plans Risky In Rural Communities?" concludes that the cumulative effects of the rural environment make financial standards even more critical for a rural PSO than for those in urban areas. Barents documents the unique challenges faced by rural health care delivery systems:

- **The prevalent use of out-of-area and out-of-network health care services by rural residents**

  A review of rural research studies demonstrates that rural residents frequently travel outside of their local community for health care services. In fact, 60 to 80 percent of rural residents have traveled outside of their local area for hospitalization at some point in time. Rural residents receive treatment from non-local hospitals for numerous reasons, including emergency and tertiary care. Out-of-area services require cash payments by rural PSOs. This is one of the primary reasons states impose financial standards on risk bearing entities. PSO advocates argue that PSOs do not need to comply with state financial standards because "sweat equity" will allow providers to work long hours without increasing costs. But "sweat equity" cannot be used to pay for out-of-network services.

  In addition, a high rate of out-of-area services severely constrains the ability of PSOs to manage the continuum of care — a managed care entity's most

important cost control tool. As a result, rural PSOs may face a more volatile cost structure than those in urban or suburban areas.

- **A shortage of providers**
  The shortage of health care providers in rural areas may make it difficult for PSOs to negotiate traditional risk-sharing arrangements with providers or influence provider practice patterns. Both risk-sharing arrangements and utilization review and management are critical methods through which managed care entities stabilize their costs.

- **The potential for adverse selection**
  Rural PSOs face an accentuated risk for adverse selection because they operate in areas with small populations and a high rate of serious injuries. The challenges of rural health care suggest that PSOs would have difficulty attracting enough enrollees to spread their risks and to cover fixed administrative costs. A small population base limits the potential profit to be earned by a PSO even if costs are controlled. Yet the PSO remains at risk for substantial loss stemming from even a few enrollees with expensive illnesses.

- **Limited access to capital**
  Rural PSOs will need substantial capital to initiate operations. Adequate capital is necessary to finance the claims payments systems, medical management programs and other systems essential for creating an effective rural managed care organization. More importantly, adequate initial capitalization is imperative to pay professionals who are qualified to administer claims and financial systems.

The collective historical experience of HMOs indicates that adequate capital is one of the principal indicators in determining success. Yet providers are now asking for special exemptions from capital requirements for PSOs. Specifically, PSOs would like to count hospital plant and equipment toward solvency standards. However, these assets -- while valuable -- cannot readily be converted to cash to pay for unexpected health costs and prevent cash flow crises. Exemptions from state licensure (i.e. solvency and liquidity requirements) could result in undercapitalized PSOs endangering health care delivery assets in rural communities.

The financial failure of -- or even significant cash flow problems with -- a rural PSO could have devastating effects on local rural providers. Local providers could be left with large unpaid bills and community hospitals -- which are already financially distressed -- could finally be forced to close their doors. The closure of a hospital

would exacerbate current access problems as well as have a profound impact on employment and the overall local economy.

In a rural area where the loss of even one provider causes serious problems, the financial stability of a PSO is a great concern. Policymakers must ensure that the standards developed for PSOs reflect the unique characteristics of health care delivery in rural areas, especially providing for adequate financial cushions.

Conclusion

BCBSA remains opposed to provider initiatives to exempt PSOs from current Medicare risk contractor that standards require compliance with state licensure and consumer protection rules. Under current Medicare rules, federal law provides a minimum set of consumer protection standards with which all Medicare risk contractors must comply. This provides a national "floor" for consumer protection. Medicare law also requires Medicare risk contractors to comply with state consumer protection rules so that beneficiaries have access to the strongest protection standards available. We believe Medicare beneficiaries deserve the protection of *both* federal and state consumer rules and that all Medicare risk contractors should compete on a level playing field.

In just a few short years, competition has reshaped and reformed the way health care is financed and delivered in the United States. Vigorous competition is causing an unprecedented number of new and innovative products to be developed and offered to consumers. It is also causing a growing number of provider organizations to enter into new types of partnerships with health plans -- and even to launch their own health plans to compete with products offered by established HMOs and insurers.

The Blue Cross and Blue Shield system welcomes these new plans, and believes that their entrance into the market will continue to spur the development of products that offer consumers more of what they want.

However, we believe that allowing Medicare to contract with unlicensed Provider Sponsored Organizations is unnecessary and presents unacceptable risks for both the Medicare beneficiaries they will enroll and the Medicare program itself. A PSO that offers a benefit package to its members in return for a captivation payment from Medicare is indistinguishable from an HMO, and should be subject to the same regulatory standards and oversight as health plan offered by licensed entity.

Chairman THOMAS. Thank you very much, Miss Lehnhard.

Dr. Corlin.

STATEMENT OF RICHARD F. CORLIN, M.D., SPEAKER, HOUSE OF DELEGATES, AMERICAN MEDICAL ASSOCIATION

Dr. CORLIN. Thank you, Mr. Chairman, and members of the committee.

I'm a gastroenterologist in Santa Montica, CA, and I'm Speaker of the House of Delegates of the American Medical Association.

The case for PSOs is compelling. Yet regulatory obstacles clearly do stand in the way. Last year, with strong congressional bipartisan support, we were successful in overcoming one of these obstacles. Despite massive opposition from the insurance companies, the FTC and the DOJ opted for expanded consumer choice and increased competition. Last August, they issued new antitrust guidelines for physician networks.

We are here today to seek your help in securing the remaining tools needed to promote the development of provider-sponsored organizations and provider-sponsored networks. Physicians continue to be troubled by the threat to patients when third parties intrude into medical decision making. Physicians know that by using recently developed techniques we can reduce costs and lead medicine into a new era of improved quality for our patients.

The importance of physician leadership in health plans is well documented. Recent studies have confirmed the high performance of health care systems which directly integrate physicians into medical and management decision making. Yet, fear of competition has caused HMOs and other insurance industry representatives to balk. In vehemently opposing PSO legislation, they're using the same arguments against us that were used against them to oppose the development of the Blue Cross/Blue Shield plans of the 1930s and '40s, and the 1973 HMO Act.

I might point out here that HMOs were well operational prior to 1973, but that Act facilitated their further development, just as this Act will facilitate further PSO development. How ironic it is now to, having gotten into the lifeboat, the Blues and the HMOs want to pull in the ladder so that nobody else can climb aboard.

The AMA is pleased that Congress acknowledged the importance of PSOs and PSNs by including provisions facilitating their development in the Balanced Budget Act of 1995. In addition, we note the strong bipartisan support this year for PSOs, including the introduction of H.R. 475 by Representatives Greenwood and Stenholm, the President's proposal, and the "blue dog" plan. We look forward to working with the Congress and the administration to realize the full potential of physician and other health care provider led networks.

The AMA believes that PSO legislation should have certain characteristics. First, just as did the HMO Act in 1973, this legislation should allow for as much flexibility as possible to stimulate innovation in the delivery of patient care. It should not favor any health care provider group over another in the ownership and management structure of a PSO. Balance must prevail so that medical ethics and patient welfare dominate over other concerns.

Second, PSO legislation should contain tough consumer protection standards. Some PSO opponents claim that we are asking for exemptions from provisions related to quality assurance, marketing and enrollment protection, data collection, access to care, grievances and conflicts of interest, when, in fact, nothing could be further from the truth. Indeed, we have been the ones championing tougher regulation in these areas.

Third, PSO legislation should address regulatory obstacles that interfere with the development of PSNs. These include certain of the anti fraud and abuse laws and self-referral laws which were designed for nonrisk sharing arrangements and are totally inappropriate here.

Fourth, since Medicare is a Federal program, PSOs should be subject to Federally developed standards which will recognize their unique differences. Many State regulators fail to account for the distinction between provider networks that deliver services directly and insurers that merely purchase health care services from others and then resell them.

By developing a Federal framework, Congress will continue its precedent of encouraging new ventures that stimulate competition and provide efficiencies.

The 1973 HMO Act created a Federal regulatory scheme for HMOs, preempting State laws that interfered with their formation and operation. Over the objection of insurance companies, HMOs argued successfully that they represented a different product which should be evaluated by different standards.

Finally, any legislation considered by the House should also include the creation of PSNs. PSNs could contract with PSOs or other eligible organizations to deliver needed health care services. Provider networks offer a tremendous evolution in health care delivery. The encouragement of PSOs subject to Federal regulation will benefit both the Medicare program and Medicare beneficiaries.

We thank you, Mr. Chairman, and would be pleased to answer any questions you or others may have.

[The prepared statement follows:]

STATEMENT

of the

AMERICAN MEDICAL ASSOCIATION

to the

Subcommittee on Health
Committee on Ways and Means
United States House of Representatives

RE: Medicare Provider Sponsored Organizations

April 24, 1997

My name is Richard F. Corlin, MD. I am a gastroenterologist in private practice in Santa Monica, California. I also serve as Speaker of the American Medical Association (AMA) House of Delegates. On behalf of the AMA, I appreciate the opportunity to testify before this Subcommittee concerning the need for promoting greater patient choice of health plans in the marketplace.

Toward this goal, we commend you, Mr. Chairman, for holding this hearing on the need for provider sponsored organizations (PSOs). We look forward to working with this Subcommittee to create the framework necessary to stimulate the formation of PSOs dedicated to the delivery of high quality, affordable patient care.

Fulfilling the Promise of Antitrust Relief for Physician Networks

The market for health care finance and delivery is undergoing substantial change. It would be optimal if this transformation resulted in a greater choice of health plans for patients, including those formed by physicians, hospitals, or other health care providers to compete with insurance companies. However, regulatory obstacles block the way.

Last year, we came to Congress seeking relief from one of those obstacles -- antitrust enforcement policies that chilled the development of physician-owned health care delivery networks and health plans. In response, House Judiciary Committee Chairman Henry Hyde introduced H.R. 2925, legislation that would allow physician networks the same antitrust treatment as joint ventures in other industries. The bill gained a formidable list of cosponsors -- over 150 in all. Ultimately, the Federal Trade Commission and the Department of Justice agreed that changes were needed, and despite massive opposition from the insurance companies, issued new enforcement guidelines similar in application to Chairman Hyde's legislation. According to those agencies, the goal of the guidelines is to "ensure a competitive marketplace in which consumers will have the benefit of high quality, cost-effective health care and a wide range of choices, including new provider-controlled networks that expand consumer choice and increase competition."

We are here today to seek your help in securing the remaining tools needed to promote the development of PSOs and Provider Service Networks (PSNs). In so doing, Congress can

improve health care quality by putting physicians and other qualified health care providers back in charge of medical decision-making.

The Case for PSOs

Many physician networks have been successful in reducing health care costs while maintaining or enhancing quality. For example, a recent study in the *New England Journal of Medicine*, by James C. Robinson and Lawrence P. Casalino, reported on the cost performance of six physician-owned medical groups in California that accepted global capitation arrangements (which means that the physicians accepted the risk that patients would need hospital services as well as physician services). It found that hospital use by these groups in 1994 ranged from 120 to 149 days per 1,000 non-Medicare members, and from 643 to 936 days per 1,000 Medicare members. In contrast, the mean number of 1993 hospital days per 1,000 non-Medicare members for commercial health maintenance organizations in California was 232 days, and for Medicare members was 1,337. This is especially significant because hospital use accounts for by far the highest percentage of health care expenditures, and the primary source of savings achieved by managed care health plans has been reductions in hospital usage.

Underlying these developments, and making them possible, are changes in the way that physicians are approaching medical care. First, allopathic medicine is undergoing a period of comprehensive reassessment to determine what health care services are in fact beneficial to

patients. Those found not to be effective are being discarded. Second, physicians are evaluating the best ways to coordinate the services of multiple providers used to treat an illness or injury. The object is to eliminate inefficient uses of resources and to improve the quality of the outcome of the treatment process.

This process of assessment and coordination is handled by groups of physicians who evaluate data about their performance, including cost and outcome, and then investigate the care giving sequence. They determine whether all services provided in the sequence were effective, and whether the services were provided in the most efficient way possible. Some have called this process "total quality improvement." This process is best handled by the physicians involved in providing the care. It is not possible for insurers or other intermediaries to engage in this process effectively, since they are not involved in the direct provision of medical care. They are too remote from actual health care delivery.

Insurance companies managed by non-physicians can, and have, reduced health care costs by placing restrictions on hospital stays by their beneficiaries. They enforce these limits with "preauthorization procedures," which require physicians to obtain approval for all hospitalizations from the insurance company. Insurers have done this by using non-physician personnel to enforce the limits during preauthorization procedures. These personnel usually communicate with physicians by telephone, fax or computer, and are often hundreds or thousands of miles away from where the care is being provided.

These limits do little to improve the quality of care provided and, more importantly, there is a limit on the extent to which these restrictions can reduce costs without compromising quality. Once hospital stays are reduced to the levels contained in the limits, there is little more that the insurer can do.

In order to achieve additional savings while actually improving quality, it is necessary for physicians to gather data about the exact services provided to treat an illness or injury, how the services were provided, the cost, and the outcome. By engaging in a critical review of the details of the process, they can determine the best services to treat an illness or injury, thereby improving quality, and the most efficient provision of these services, thereby reducing costs. This is a much different process than placing arbitrary limits on hospital stays or denying coverage for various kinds of treatment.

That is why PSOs and PSNs are so important to the future of health care in our country. They are health care delivery systems owned by physicians and other health care providers that are designed to maximize cost savings and quality by engaging in this process. Their development is essential to reach the next level of cost savings while enhancing quality of care.

In general, PSOs are defined as health care delivery systems owned and operated by physicians and/or other health care providers with the ability to provide a substantial part of

the Medicare benefit package pursuant to risk sharing arrangements. A PSN is a provider network that does not have the capacity to deliver a substantial portion of Medicare benefits, but which can contract with PSOs or other eligible organizations to deliver care pursuant to risk sharing arrangements.

Physicians and other providers are eager to develop PSOs and PSNs. We are concerned about third party intrusion into the patient-physician relationship and, ultimately, medical decision-making. We are troubled about judgments being made about the care of individual patients pursuant to restrictions imposed from remote sites by non-physicians. Physicians and other health care providers believe that we can not only reduce costs but lead medicine into a new era of improved quality if we can take back the reins.

The AMA is pleased that Congress acknowledged the importance of PSOs and PSNs by including provisions meant to facilitate their development in the Balanced Budget Act of 1995, which was subsequently vetoed by President Clinton.

In addition, we note the introduction of the "Medicare Provider-Sponsored Organization Act of 1997" (H.R. 475) by Representatives Greenwood and Stenholm. This legislation would allow PSOs to provide benefits to Medicare beneficiaries without unnecessary insurance middleman. The legislation would establish standards that qualified PSOs must meet in order to serve Medicare patients such as solvency requirements, licensing requirements, and

enhanced quality standards and consumer protections. We commend the sponsors of this legislation for moving the PSO debate forward this year in the House. We look forward to working with Representatives Greenwood and Stenholm to ensure that the full potential of physician and other health care provider-led networks is realized.

The AMA's Vision of PSOs

The AMA's plan to transform Medicare is based on expanding the choice of health plans available to Medicare beneficiaries, including PSOs and other eligible organizations that partner with PSNs. Congressional action is essential to fostering the formation of these entities. The AMA believes that PSO legislation should have certain characteristics.

First, the legislation should allow as much flexibility as possible to stimulate innovation in the delivery of patient care. Legislation should not favor any one PSO model type or any health care provider group over another in the ownership and management structure of a PSO. The market should determine what PSO models and ownership structures are the most successful.

With regard to flexibility, the AMA is concerned that H.R. 475 would favor the hospital-owned or physician\hospital organization (PHO) model to the exclusion of others. The AMA believes that physician networks and large group practices should also be able to lead the formation of PSOs. This is important to the public because it is ultimately physicians who

must engage in the process of evaluating medical care to improve its quality and reduce its cost. Again, we believe these decisions should be left to the market to determine.

Indeed, the importance of physician leadership is borne out by research. A recent study led by Stephen M. Shortell, a Professor of Health Services Management at Northwestern University, found that health care delivery systems which had significant "physician-system integration" performed better than those that did not. The author defined physician system integration as the degree to which physicians use the system, including being involved in the planning, management, and governance of the system. The study also found that the higher the degree of physician-system integration, the greater the delivery system's inpatient productivity. The study noted that "(i)t is simply not possible to achieve any measurable level of clinical integration for patients without a close relationship of physicians with an organized delivery system."

Second, PSO legislation should contain tough consumer protection standards. Such standards should include requirements that PSOs use continuous quality improvement methods, evaluate continuity of care, monitor the over- or under-provision of care, provide information to help beneficiaries choose plans and require coordination of utilization review with a PSO's quality program.

The AMA has long been committed to protection of the patient. The AMA has undertaken a number of unprecedented efforts in the area of quality assessment and physician performance. As you may be aware, the AMA last year approved the development of an accreditation program for physicians. Subsequently named the American Medical Accreditation Program (AMAP), the program is designed to establish national standards of physician performance.

Recently, AMAP took its first step toward implementation and announced that it is ready to approve self-assessment programs for inclusion in the AMAP program. As a result, AMAP has invited those entities with self-assessment programs to submit them for review. In addition, the AMA recently unveiled our perspective on a set of health plan characteristics that we believe to be essential to the operation of a quality managed health care plan. The document, entitled "Essential Characteristics of a Quality Health Plan," describes what makes for "good" managed care, including patient rights, continuous quality improvement, accreditation and respect for the patient-physician relationship. We look forward to working with the Congress on these quality improvement initiatives.

Third, PSO legislation should address regulatory obstacles that interfere with the development of PSNs. These include certain anti-fraud and abuse laws and self-referral laws. These laws were designed to regulate the conduct of physicians in independent practice under traditional fee-for-service medicine, and they were intended to prevent the provision of unnecessary care.

The laws make sense for the regulation of fee-for-service arrangements where the physician may have an incentive to provide unnecessary care. However, they have no purpose in the regulation of networks that are designed to reduce the provision of unnecessary care, especially when the networks are involved in risk sharing arrangements in which physicians have an incentive to reduce unnecessary care.

Another regulatory obstacle is pension regulations pursuant to Section 414(m) of the IRS Code. They may require that physicians who form certain kinds of networks aggregate their pensions and comply with the nondiscrimination provisions. Those provisions could have a material adverse effect on the retirement plans set up by individual physicians. This could discourage physicians from developing networks.

Fourth, solvency standards should reflect the unique characteristics of PSOs. In spite of the potential benefits of having physicians direct health plans, in 1994 only 6.4% of health maintenance organizations (HMOs) were owned by physicians, physician medical groups, physician hospital organizations (PHOs), and state medical societies combined. This is due in part to the chilling effect of state insurance and HMO regulations that fail to account for the distinctions between provider networks that deliver services directly and traditional HMOs and insurers that purchase health care services and resell them.

There are dramatic differences between provider organizations that assume risk and insurance companies. Provider organizations exist for the primary purpose of delivering health care services to patients. To the extent that they enter into risk sharing arrangements, they do so for the primary purpose of delivering health care. The assets of providers that enter risk sharing arrangements are concentrated in health care delivery. A way to better understand this concept is to consider the analogy of repair warranties issued by car manufacturers. These warranties involve the assumption of risk, and are a significant financial commitment. However, car manufacturers offer them for the primary purpose of selling cars, and the assets of car companies are concentrated in car manufacturing.

In contrast, the primary purpose of insurance companies is to profit by underwriting risk. Insurance companies do not deliver health care services. They buy them to the extent necessary to satisfy claims. Insurers seek to profit by investing the spread between premium income and claims in financial securities such as stocks, bonds, mortgages, and other investments. Their assets are concentrated in such liquid securities, not in health care delivery. However, the regulations of most states, including solvency standards, statutory accounting principles, and financial reporting requirements, are designed for insurance companies, not provider networks that assume risk. They typically require that insurers maintain a substantial amount of liquid assets and maintain a financial management system that identifies those liquid assets for insurance regulators. This suits the business of insurance well because insurers typically maintain a substantial amount of liquid assets in the ordinary

course of their business, and if they do not, then they are likely to be in danger of becoming insolvent.

State regulations do not fit the operations of health care providers. Health care providers normally do not maintain substantial liquid assets. However, that does not mean that they are in danger of becoming insolvent. Their assets are concentrated in health care delivery, and they have the capacity to deliver services for which they assume risk. That does not mean that provider networks can sustain substantial and unexpected catastrophic losses, but they can sustain themselves longer without liquid reserves because of their health care delivery assets.

Because of this, and because of the particular demands of the Medicare program for uniformity in administration and operation across the United States, PSOs should be subject to federally-developed solvency standards which recognize their unique differences. Solvency standards should recognize the value of assets used in health care delivery as well as ways of responsibly handling risk such as reinsurance, capitation, and fee withholds. PSOs are critical to the success of a reformed Medicare system based on free market competition; it is essential that they not be forced into inappropriate state regulatory structures that would compel them to become HMOs, thereby eliminating them as a separate option under Medicare.

By regulating PSOs at the federal level, Congress will follow its precedent of encouraging new ventures that stimulate competition and provide efficiencies. A notable example is the

Federal HMO Act of 1973 that was intended to, and did, facilitate the development of HMOs as a means of increasing access and lowering costs. At the time, HMOs faced legal barriers including state solvency requirements viewed as not recognizing their particular characteristics. To remedy the barriers, the Act created a federal regulatory scheme for HMOs that preempted state laws that interfered with their formation and operation. These provisions included grants and loan guarantees for the formation of new HMOs, solvency requirements different from those of other health plans, and a mandate that employers offer HMOs available in their geographic locations as a health benefit option to their employees. In comparison, the provisions to facilitate PSOs are modest in scope.

Finally, any legislative proposal considered by the House should also include the creation of PSNs. PSNs, owned and operated by physicians and other health care providers, could contract with PSOs to deliver health care services.

Physicians usually begin the process of managing care with a PSN, because the development of skills and capacity necessary to operate a PSO takes time and experience. These networks typically begin with simple arrangements that are easy to manage, such as discounted fee-for-service networks, and then enter into risk sharing arrangements that require greater managerial sophistication. If the network is successful and is able to manage greater and greater amounts of risk, meaning that larger amounts of services and patients are included in

these arrangements, the network could evolve into a provider-owned health plan such as a PSO. Therefore, PSN development is important to the creation of PSOs.

Setting the Record Straight

Fear of competition has caused the insurance industry to vehemently oppose any PSO legislation. Since most insurance companies are corporate profit-making entities, first and foremost, it is to their advantage to keep physicians, hospitals and others out of the market. Insurers argue that different solvency standards for provider networks will put patients at financial risk.

The reality is that HMOs and other insurance industry representatives are making the same arguments against the House provisions regulating provider networks that were advanced by others against them in the 1970s to oppose the federal HMO Act, and in the 1930s and 1940s to oppose the formation of the Blue Cross/Blue Shield plans in the various states. In these instances, Blue Cross plans, and most recently, HMOs argued successfully that they represented different products and should be evaluated by different standards. Now, having got into the lifeboat, these plans want to pull up the ladder so that no one else can get in!

In short, established insurers will maintain an unfair competitive advantage if provider networks are required to meet the same standards as insurance companies. Patients will

ultimately bear the unnecessary cost of excessive capital requirements. Physician and hospital networks are different than insurance companies and commercial HMOs that operate as third party payers. PSOs must and should be required to meet high standards that guarantee consumer protection and quality assurance. But they should not be treated as something they are not: insurance companies.

The insurers also argue that PSOs would lack consumer protections without state licensing. The reality is that pending legislation before the House and Senate would apply current Medicare consumer protections to PSOs, such as grievance and appeals processes and enrollment and marketing standards. Enhanced quality standards are also required by the legislation, including continuous quality improvement methods and evaluation of continuity of care.

Next, the insurance companies contend that there are no barriers to licensure of PSOs at the state level. This is simply not true. In addition to the cumbersome licensure process in some states, there are vastly different reserve requirements among them. Since Medicare is a federal program, PSOs should be subject to federally-developed standards, not a patchwork of various state laws. Congress saw the wisdom of federal oversight to stimulate innovation when it approved the 1973 federal HMO Act.

Finally, the insurers argue that state insurance regulation will better protect consumers. The truth is that insurance companies have a checkered history on patient protection. Several plans have either suffered unfavorable court rulings or have been forced to refund millions of dollars bilked from beneficiaries. Tax-favored plans in certain states have overcharged patients by failing to pass on discounted rates and have collected excessive patient co-payments.

Conclusion

The case for PSOs and PSNs is compelling. Yet, provider networks will be unable to present a meaningful alternative to insurance company plans, and, thereby, improve the competitive process, if they are not permitted to operate effectively. The encouragement of these networks subject to federal regulation will benefit both the Medicare Program and Medicare beneficiaries. Mr. Chairman, the AMA looks forward to working with you and the Subcommittee to ensure passage by the Congress of meaningful PSO and PSN legislation. We thank you for the opportunity to share our thoughts and concerns.

Chairman THOMAS. Thank you, Doctor.

Well, I guess maybe the first thing I could do is pose some questions that were posed in the testimony so that other folk can respond to them.

Miss Lehnhard, what is different now that was different when HMOs felt it necessary to have major changes in legislation, both at the State level and, in fact, at the Federal level, in the Health Maintenance Organization Act of 1973 that provided for an exemption at the Federal level for HMOs? Why isn't it fair to do for PSOs the same thing we did for HMOs, or more fairly, why is there no need to do for PSOs what we did for HMOs?

Ms. LEHNHARD. I would make three points about that. First of all, this is not an "us and them" issue. The '73 HMO Act helped PSOs just like it helped HMOs. The same laws that were barriers for HMOs were barriers for PSOs, so we were both helped by that.

Secondly, it was generally agreed that everyone went too far in '73. There were a lot of very visible HMO financial insolvencies and the States had to go back and put stronger standards for HMOs on the books. In fact, that was the genesis for the NAIC/HMO model act.

Third, I think the most important difference is that it did not set up a parallel Federal track of regulations. The HMOs still have to be licensed by the State. It merely got rid of some very absolute barriers to being structured.

Chairman THOMAS. Do you believe that PSOs and HMOs really aren't different, that it's a distinction without a difference, or is there a difference and can you discern one?

Ms. LEHNHARD. The differences that I see is an ownership issue. The PSOs are owned by physicians or a hospital, provider owned. They are both accepting risk when they accept a capitation payment; they promise to provide all the services under the contract for that capitation payment.

I believe the same in that regard, they should have to meet the same financial standards, the same consumer protection standards. I think the NAIC risk-based capital standards will refine those standards, and a key point is they will reduce some of the financial standards for HMOs that have reinsurance or have a lot of protections. It's going to be a calibration of the financial standards, not a total overhaul.

Chairman THOMAS. Dr. Corlin or Mr. Brownlow, if you want to jump in, this is one of my concerns and one of the reasons I'm so desperate for a yardstick that I can use to see if there really is a difference.

I'm somewhat concerned and haven't spent the time to work it out—and maybe you folks have, because of your particular focus—that if we set up a structure for approval, as Miss Lehnhard said, based upon ownership and control, rather than on function and risk assumption, which is the direction the NAIC is going with its model—I mean, time passes, relationships change.

If we have these PSOs out there that are based upon ownership and control, and an HMO wants to acquire one, or a PSO wants to acquire an HMO, do you have any concern about creating sufficiently different structures so that when there are mergers, combinations, failures, assumptions of responsibilities, that you don't

create a situation in which, if you have a Federal standard based upon ownership and control and there's an HMO based upon the risk assessment at the State level and there's a merger, you're either going to have to go back through the State—you know, this business of trying to mix apples and oranges when they may not be apples and oranges.

Dr. CORLIN. Yes, Mr. Thomas. We're very concerned about that. That's why we have proposed that this simply be as four-year start up, if you would, exemption, to allow the cash requirements to be built up as the plan is built up. We think that would answer the major part of the very legitimate concern you have.

But underneath that there's another issue. Almost half the insurance in the United States already is written under Federal regulation, ERISA, which are plans that totally exempt themselves from State legislation. It's a uniform Federal standard. And that's for State employees; it's for private employees and the State, not even for beneficiaries covered by a uniform Federal plan.

Secondly, the statement that there exists throughout all the States uniform standards is, very simply, fiction. And the fact that 90 days is sufficient to get a plan licensed is an absolute fiction.

We have attempted to get data and information. When you call State insurance commissioners, first of all, the cash requirements are vastly different from State to State. Secondly, when you say "I want to start a PSO, send me an application," the most common answer you get is, look in the regulations, the information is there. And the statement that data supplied is insufficient and applications are not complete is simply because nobody has told the applicants what they need to do to apply. There is no desire to submit an incomplete application. Nobody tells us what information is necessary.

Chairman THOMAS. I understand that problem, but HMOs faced it and apparently they've been able to overcome it with some degree of success. I think what you're telling me is the people that you're thinking about having run these operations don't want to deal with bureaucracies at the State level.

You know, you're giving me a number of arguments which, frankly, to me, are not dispository. They are simply, "Hey, you want to own the business, this is the price of doing business today," which is unfortunate and I would love to deal with that as well.

But let me ask the question another way. If you're asking for a greater Federal role because of all the problems that you at some length explained to us, would you be willing then to move the HMO regulation to the Federal level as well, notwithstanding whether the regulation of either PSOs or HMOs is a good thing at the Federal level. If you're doing it at the Federal level, why shouldn't HMOs be doing it at the Federal level?

Dr. CORLIN. Well, we're talking here about beneficiaries who are a Federal responsibility, at least with regard to the source of the payment for their care. Secondly, we are simply asking for some start-up help to allow these organizations to enter and compete effectively in a market which is already, for some organizations, well capitalized from other sources, and we want to be able to show that we can deliver health care which answers, in many cases, better

quality improvement, better quality assurances, and secondly, has its financial incentives in——

Chairman THOMAS. How can you show us that it's better quality assurance? I would love to see that. A number of assertions have been made that if we go for this structure and facilitate it at the Federal level, that what we're going to get is something better than what it would be if that same structure were required to have to be approved at the State level.

The argument that it's better and, therefore, we should be compelled to provide Federal assurance, is a compelling one. I just haven't seen the compelling evidence.

Dr. CORLIN. The uniformity of it I believe is an advantage, particularly during the start-up——

Chairman THOMAS. So do the HMOs. They would love to have uniformity in dealing with—in offering services. They currently have to bump along the ground through the States.

You see, we're looking for the compelling reason for changing the current system. If you'll recall in the BBA, we didn't know for sure whether the arguments had merit, so we said go to the States first. And when you showed us the States were unwilling to deal with you folks in a reasonable way, we would provide a Federal structure. Frankly, I haven't heard any answers right now that give me a comfort that what we provided in the BBA isn't the best thing out there.

Mr. BROWNLOW. Mr. Chairman, could I respond?

One of the things that PSOs ar trying to do is only participate in the Medicare population. One of the requirements that a State has is that you do have to have the 50–50 rule, a rule that would not apply under a PSO doing only Medicare beneficiary HMO coverage.

I think that's an important distinction. I think, as well, one of the things that we look for is some Federal certification that will be consistent from State to State. At this point, many States have not defined what a PSO is. They're not sure how to deal with it. They're not sure how to regulate it. They're not sure how to certify it.

So I think if the Federal Government would come up with certification that would be applied equally, State to State, these could get started and they could enroll the Medicare beneficiary population.

Chairman THOMAS. Mr. Brownlow, all those arguments were made with HMOs, and in talking to the people who actually do the work, I'm impressed with the sophistication of a number of them, by whatever name it's called, in terms of the structure.

One very quick question. On page 10 of your testimony, Doctor, you talked about the problem of getting doctors to go into a structure because of pension nondiscrimination rules.

Are you asking for a class exemption there? Is that the point you're making, or just that life is difficult when you——

Dr. CORLIN. We're not asking for a class exemption.

Chairman THOMAS. Okay. Thank you very much.

The gentleman from New York.

Mr. HOUGHTON. Just one quick question for Miss Lehnhard.

Dr. Corlin, reading from page 9 of your testimony, you say that PSO legislation should address regulatory obstacles, and these in-

clude anti fraud and abuse laws and self-referral laws, things like that, and that, in effect, these laws have no purpose in the regulation of networks but are designed to reduce the provision of unnecessary care.

How do you feel about that?

Dr. CORLIN. Well, the——

Mr. HOUGHTON. I'm was really asking Miss Lehnhard. I know how you feel about it.

Dr. CORLIN. I'm sorry.

Ms. LEHNHARD. I don't know what barriers they're talking about that have to do with—is it State fraud laws?

Mr. HOUGHTON. I think what Dr. Corlin was saying is that there are many laws, such as anti fraud and abuse laws and self-referral laws which should not be applied to the PSOs, that they would just be inappropriate.

Ms. LEHNHARD. I think that the HMOs would have had the same problem, since these are also networks of physicians. If the PSOs are flourishing in the States—I haven't heard of these problems. I'm sorry.

Mr. HOUGHTON. Would you like to make a comment, Doctor?

Dr. CORLIN. Yeah. The real issue here—and I'm sorry the point was missed in the previous response. The real issue is that those laws and provisions are extremely relevant in a fee-for-service reimbursement system. They are not relevant and, indeed, are often counterproductive in a capitated reimbursement system.

That's the reason for saying that we need the exemptions, not because it's a special organization but because it operates in a totally different type of reimbursement system from the one that the anti fraud and abuse and self-referral laws were designed to protect the public from abuses in—that was a terrible sentence, but——

Mr. HOUGHTON. I understand, and that's very helpful.

Yes, ma'am?

Ms. LEHNHARD. Sir, my response would be, I don't know of any State where PSOs have to be licensed as an insurance company, a fee-for-service plan. They all have the option of being licensed as a capitated plan, where these rules won't apply.

Mr. HOUGHTON. Thank you.

Mr. CHRISTENSEN [president]. Mr. Brownlow, we have about two and a half minutes before we have to go vote. I know that during your opening testimony you had about four or five points that you wanted to make, in terms of differences of PSOs, that you felt were important.

Is that in your written testimony?

Mr. BROWNLOW. Yes.

Mr. CHRISTENSEN. Okay. I'll take a look at that and maybe I can follow up with some written questions at the time and visit with you on that.

Mr. BROWNLOW. Some of the points are in there. I would make a couple more as well.

I think that a difference between a PSO and an HMO is, under the PSO, the Federal Government will be paying the providers directly. They won't be going through an HMO, with administrative and profit and overhead taken off the top before the downstream

risk finally gets to a PSO, to then be able to administrate the plan for the Medicare beneficiary.

I think, second, an HMO provides insurance. A PSO provides health delivery. As well, a PSO is reimbursed under multiple types of reimbursement. We've got point-of-service, we've got PPO, we've got HMO, and so forth. Typically, in an HMO, all of the reimbursement is in the form of a fixed premium paid by a subscriber, or the government in the case of Medicare.

Mr. CHRISTENSEN. I'm going to have to go run and vote. I want to thank you for coming all the way from Orlando. I'm sorry that we've gone so far into the day, but thank you for coming up. I appreciate it, Mrs. Lehnhard, Dr. Corlin. Thank you very much.

This meeting is adjourned.

[Whereupon, at 4:05 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

AAHSA

AMERICAN ASSOCIATION OF HOMES AND SERVICES FOR THE AGING
901 E STREET NW, SUITE 500, WASHINGTON, DC 20004-2037
202 • 783 • 2242 FAX 202 • 783 • 2255

STATEMENT OF

SHELDON L. GOLDBERG
PRESIDENT

AMERICAN ASSOCIATION OF HOMES AND SERVICES

FOR THE AGING

BEFORE THE

WAYS AND MEANS COMMITTEE

SUBCOMMITTEE ON HEALTH

US HOUSE OF REPRESENTATIVES

HEARING: April 24, 1997

ON

MEDICARE PROVIDER SPONSORED ORGANIZATIONS

Representing not-for-profit organizations dedicated to providing quality health care, housing and services to the nation's elderly
JAMES E. DEWHIRST, *CHAIR* SHELDON L. GOLDBERG, *PRESIDENT*
Regional Offices in Albany • Chicago • Denver • Orlando

INTRODUCTION

The American Association of Homes and Services for the Aging (AAHSA) appreciates the opportunity to submit written testimony on Medicare Provider Sponsored Organizations to the U.S. House of Representatives, Ways and Means Committee, Subcommittee on Health.

AAHSA is a national nonprofit organization representing over 5,000 not-for-profit providers of health care, housing, long-term care, and community services to more than a million individuals daily. More than half of AAHSA's membership is affiliated with religious organizations, while the remaining members are sponsored by private foundations, fraternal organizations, government agencies, unions, and community groups. Our members include not only nursing facilities, but also affordable elderly housing, continuing care retirement communities (CCRCs), and providers of assisted living, home health care, adult day care, respite care, meals on wheels and other services. Each of our members has long-standing relationships with the communities in which they operate; some even predate the Constitution.

For the past thirty-six years, the Association has been an advocate for the elderly and has striven in the public policy arena to create a long-term care delivery system that assures the provision of quality care to every individual our members serve in a manner and environment that enhances his or her quality of life. The Association's vision is of a world in which every community offers an integrated and coordinated continuum of high quality, affordable and innovative health care, housing and home and community-based services. We believe that such a continuum must include not only acute care but the whole spectrum of care and services, especially for those with chronic care needs. If our society can create such a system, it will be less confusing to the consumer and more cost-efficient than the current fragmented one we now see. Long-term care must play a central role in the development of the integrated future, and the provisions of H.R. 475 are but one component.

THE ROLE OF LONG-TERM CARE

As an Association whose members have a long-standing commitment to delivering care to some of our nation's most vulnerable citizens, we believe that any discussion of Provider Service Networks (PSNs) or Provider Sponsored Organizations (PSOs) for the Medicare population must recognize the importance of integrating acute and long-term care services. Currently, there is little consensus about what constitutes "integration" in the delivery system. One view conceives of integration as improving the transfers and referrals between acute and long-term care services. An alternate conceives of integration as dramatically changing how acute and long-term care services are provided, with multidisciplinary geriatric teams at the center of the care process. The nation's changing demographics and growing needs of our chronically ill population support the latter view. The complex needs of the chronically ill require

not only traditional primary and acute care services generally covered by managed care plans, but also institutional and community-based long-term care services. Currently, Medicare is the primary funding source for primary and acute care services, whereas Medicaid covers the majority of long-term care services.

At the time of enactment 30 years ago, Medicare was patterned on the health insurance models then widely used by private employers and insurers for the under age 65 population. The primary function was simply to pay the bills. Today, Medicare remains essentially a bill paying insurance program somewhat disconnected from the evolving role of the government as purchaser in the health care marketplace, the Medicare beneficiaries' growing need for long-term chronic care and consumer preferences concerning both location for and types of care and services. Managed care is rapidly gaining acceptance as an appropriate vehicle for serving the elderly and persons with disabilities. The need to restructure Medicare becomes compelling in light of the demographic and financial challenges in the next millennium.

THE ELDER EXPLOSION

The aging of the baby boom will mean an explosion in the number of elders. The Medicare populations has been growing steadily at about 2 percent per year for the last decade. This growth will accelerate in the next several decades, with forecasts of the proportion of the U.S. population 65 years of age and older increasing from about 12 percent of the population in 1990 to 20 percent in 2030; during the same period the proportion of people 85 years of age and over is expected to double, from 1.2 percent to 2.4 percent.

These demographic changes promise to generate an unprecedented increase in the demand for long-term care. Despite the recent good news by researchers at Duke University ("Chronic Disability Trends in Elderly United States Populations: 1982-1994") that the aging population is experiencing a decline in disability, the increased numbers of old-old and chronically ill persons necessitate a system with the capacity to serve the full continuum of needs. More elders will be aging in place in their homes or congregate housing settings, which will increase the need for home and community based services as well. The vision of an integrated delivery system is both a necessary antidote to the growing problems in the nation's health care system and a means for long-term care providers to ensure that "health" services to the chronically ill are not "over -medicalized," emphasize both quality of care and quality of life, and are provided in the most cost effective manner.

THE CHRONICALLY ILL

People with chronic diseases and disabilities represent the highest cost and fastest-growing service group in health care. The term "chronic care" often is used interchangeably with "long-term care" in reference to nursing homes and home care agencies. AAHSA believes that chronic care is a broader concept, encompassing a spectrum of integrated services -- medical, personal, social

and rehabilitative care, taking place in hospitals, nursing homes, other facilities, and in the home that assist people with chronic health conditions in living fuller lives. See the recent Robert Wood Johnson Report, Chronic Care in America: A 21st Century Challenge, 1996 (hereinafter, "RWJ").

Despite the recent growth of managed care and capitation under Medicare and Medicaid, few initiatives have addressed the needs of the chronically ill or functionally disabled beneficiaries who account for a substantial share of the spending. A relatively small portion of the Medicare population consumes a significant share of total program spending. Ten percent of Medicare beneficiaries account for 70% of program expenditures. A handful of efforts, many operated under federal demonstration waivers by members of this Association, have attempted to develop capitated managed care arrangements to serve the frail elderly and the disabled. These experiments have tested the theory that the integration of acute and long-term care services in a single managed care program could improve coordination of services and reduce costs. Examples include HCFA's demonstrations such as the Social Health Maintenance Organizations (S/HMOs) and the Program for All Inclusive Care for the Elderly (PACE). AAHSA supports the shift of the PACE demonstration sites into full provider status because the model has proven to be a cost-effective way to provide integrated care to frail elders. At the same time, states are currently exploring ways to incorporate long-term care into their Medicaid managed care programs.

The RWJ report identified individuals with two or more chronic illnesses as 5.7 times more expensive than individuals with only an acute condition. These higher per capita costs make chronically ill individuals especially vulnerable in a managed care environment. In addition, the chronically ill use a different configuration of services than the acutely ill, underscoring the need for appropriate care management for this population.

PSO DEFINITION

The Provider Sponsored Organization option as introduced in H.R. 475 would allow federally qualified PSOs to contract directly with Medicare and other payers to assume risk. PSOs would be groups of providers that are "affiliated," a bond much closer than many current relationships between health care providers. Affiliation relationships require greater integration of provider interests and activities, theoretically leading to better coordination of care among providers and greater efficiency than may be afforded through contractual relationships with HMOs or other "at risk" payers. PSOs would be predominantly care delivery organizations with more dollars going directly to patient care. There are many communities, especially in rural areas, where there are no Medicare managed care plans. In these areas PSOs are especially attractive vehicles for serving community needs.

The movement to wider consumer choice in Medicare, including PSOs, is likely to have a profound impact on the way long-term care services are financed

and delivered. Despite the existing demonstration projects, Medicare managed care plans have had little experience with the severely impaired elderly beneficiaries, a group that is likely to grow. Looking well into the future, we believe that integrated, high quality care demands meaningful participation by AAHSA members. They will be providing care and services financed by systems that coordinate care across time, place and provider. These systems will emphasize prevention, risk-sharing and appropriate utilization of services based on consumer and community demand for high quality health and well-being at lower overall cost. We see the beginnings of these systems now, as evidenced by the growth of managed care and Medicare beneficiaries' growing participation in HMOs. There is a greater use of cost-effective, post-acute services and fewer days spent in expensive, acute care hospitals by managed care enrollees. Managed care organizations already receive substantial cost savings from the use of subacute care services without a three day prior hospital stay and from the substitution of post-acute care for unnecessary hospital days. Unfortunately, the Medicare program currently cannot reap the same savings from these trends.

AAHSA members are united by a commitment to address the needs of the chronically ill. If Medicare were restructured to allow for a full range of primary, acute and long-term care services, acute care savings could be achieved by using more cost effective services across the continuum of care.

In particular, PSOs represent an opportunity for our members to demonstrate their expertise in managing a primarily elderly, chronically ill population and to reaffirm their commitment to community. Medicare qualified PSOs must offer the full range of Medicare primary, acute and skilled nursing services, and may offer additional benefits, including vision, hearing, pharmacy and domicilliary services. Long-term care providers must be included specifically among the providers represented within each Medicare PSO ownership or affiliation group. Long-term care providers have acknowledged experience in managing a primarily elderly, chronically ill population. If they are not specifically identified, Medicare PSOs may relegate long-term care providers to the role of contractual vendors, which risks perpetuating the current fragmented and inefficient system. It also could jeopardize successful Medicaid reform, because Medicare PSOs undoubtedly will be a model to which state Medicaid programs turn to effectuate cost savings in services to long-term and chronic care populations. Otherwise, PSOs could serve only to further entrench an acute care/disease treatment model of care, rather than spurring the transition to a preventive/chronic care model better suited to the changing needs of the nation and its elderly. In addition, to enhance their responsiveness to consumer demand, PSOs also should arrange to provide preventive community services such as nutrition, health screenings, home care, transportation, etc.

ENROLLMENT PROVISIONS

Waiver of the "50/50 rule": The current Medicare requirement is that no more than 50 percent of a health plan's members may be Medicare or Medicaid

enrollees. At least half the plan's enrollees must come from the "commercial" population. We believe that the "50/50 rule" should be waived for PSOs and any other Medicare plans that meet enhanced quality standards and have demonstrated experience in delivering coordinated care. This is especially important for rural and other PSOs, by recognizing provider experience in delivering coordinated care, albeit under contract with private payers, managed care organizations or Medicaid programs. If the "50/50 rule" were maintained, otherwise qualified PSOs could not be offered to Medicare beneficiaries because most PSOs, particularly those organized by providers with experience in managing care for a Medicare-eligible, chronic care population, are unlikely to enroll commercial populations. Waiving the 50/50 rule when enhanced quality requirements are met would retain all of the current beneficiary protections, including internal grievance procedures, beneficiary appeals processes and enrollment and marketing requirements, and would more directly address quality of care and experience issues. The additional quality standards of the legislation would provide better assurance of quality than the current enrollment requirement.

Reduced Minimum Enrollment: AAHSA supports the lower minimum plan enrollment provisions of H.R. 475. Changes are needed to reduce barriers to providing coordinated care to Medicare beneficiaries and to reflect that PSOs may be directly "enrolling" only Medicare beneficiaries. Minimums should not drop below proposed levels, however, because the absence of any floor could jeopardize a PSOs ability to spread risk and, thereby, threaten the provision of care.

SOLVENCY

Solvency standards are necessary to ensure the fiscal soundness of PSOs. H.R. 475 sets solid, quantifiable net worth and reserve requirements. Most importantly, H.R. 475 adjusts solvency and reserve requirements to reflect the value of capital assets and direct services provided by PSO operations. This adjustment is crucial in recognizing the health delivery assets specific to a PSO. It acknowledges that for a PSO, only a portion of the revenue is at full risk because the affiliated providers are producing their own services. The proposed PSO requirements still require demonstrated fiscal soundness, albeit through alternative net worth and reserve requirements or through reliance on a combination of factors which may include net worth and reserves (modeled on the National Association of Insurance Commissioners Model HMO Act-proposed).

QUALITY ASSURANCE / QUALITY OF CARE

H.R. 475 would require effective ongoing quality assurance systems. The new standards address many consumer concerns about managed care. They ensure that PSOs evaluate the continuity and coordination of care and monitor possible patterns of under- as well as over-utilization.

Long-Term Care and Quality

The primary function of a PSO must be to meet consumer and community demand for the delivery of quality health services under a system that coordinates care across time, place and provider. To ensure quality of care for vulnerable populations like the chronically ill, quality of care plan standards for PSOs should require a specific plan for delivering care to the chronically ill. This would ensure that chronically ill individuals in PSOs receive appropriate and necessary services.

The quality assurance provisions included in the PSO legislative proposals are concepts already supported and embodied by long-term care providers in managing the chronically ill and assuring the adequacy and provision of needed and appropriate services to the frail and elderly.

Outcomes vs. Process

The emphasis on quality measures based on health outcomes rather than process is crucial to evaluating the provision of care and continuous quality improvement. The measure of a provider's ability to meet patients' needs must be based on actual performance rather than on the provider's potential capacity to assure adequate services. However, health outcome measures for long-term care, where individuals are frequently being treated for multiple chronic conditions, have limited prognoses for healing or "cure," and are experiencing the natural declines in status associated with aging, must remain distinct from outcome measures generally applied to patients in acute or subacute care settings.

This shift in focus from process to outcomes is one that AAHSA has strongly supported within the long-term care arena. Because of their history in managing chronic care populations and progressive efforts over the past ten years to develop and use outcomes-based measures to assess the quality of long-term care, AAHSA's members and nursing facilities more generally bring unique experience and perspective to the implementation of this type of quality assurance system.

The focus on outcomes contained in the OBRA '87 nursing facility reform provisions has proven consistent with the increased concentration on outcomes as a quality measure across provider types and health care settings. In the rising tide of managed care, purchasers, payers and consumers increasingly want to know what they are getting for their dollars. For long-term care facilities, at least, this standard has been codified in the OBRA mandate that each resident must attain or maintain the highest practicable degree of physical, mental and psychosocial well-being.

In addition, no other provider type must serve as many masters as nursing facilities (SNFs and NFs). No other health care provider, including hospitals, physicians and home health agencies, is subject to the volume of regulation

and oversight by such a plethora of federal and state agencies. Currently, nursing facilities must comply with regulations promulgated by the Health Care Financing Administration (HCFA), the Food and Drug Administration (FDA), the Occupational Safety and Health Administration (OSHA), the Department of Justice (DOJ), the Environmental Protection Agency (EPA), the Department of Labor (DOL), the Office of Civil Rights (OCR), the Federal Communication Commission (FCC), and State Survey and Certification and Medicaid agencies. Nursing facilities are challenged daily to strike the balance that will allow them to achieve and maintain compliance with the requirements issued by these varied regulatory authorities, while simultaneously ensuring optimal well-being for residents ranging in extremes across age, acuity level, physical independence, and cognitive ability.

AAHSA supports the Congressional intent conveyed through these proposed requirements --that is, to promote state-of-the-art continuous quality improvement and to ensure that consumers of health care services have useful quality information for comparison and choice. We agree that providers must take action to improve quality, evaluate the effectiveness of their programs, and be publicly accountable for those results. Any standards promulgated to achieve this goal, however, must recognize the substantial advances already made by nursing facilities and must hold all provider types to both substantially similar outcomes and measures of those outcomes for substantially similar population-based needs.

UTILIZATION REVIEW (UR)

The PSO legislative proposal requires that, if a PSO uses case-by-case utilization review, it must base review on current medical practice standards, coordinate review with the quality assurance program, and transition to focusing on patterns of care. The utilization review provision reflects the commitment to move away from UR processes that overly intrude into the doctor-patient relationship by involving its local physicians in reviewing patterns of care.

Long-term care facilities are already moving in this direction. UR ceased to be a requirement, but remained optional, for Medicare/Medicaid SNFs/NFs effective October 1, 1990. The repeal was based on the premise that the OBRA-mandated Resident Assessment Instrument Minimum Data Set (RAI/MDS) would replace and enhance the UR function. AAHSA supports enhanced UR standards provided that they recognize the advances that long-term care providers already have made, and assure the use of geriatric and gerontologic best practices, not merely extension of concepts created by evaluation of younger and healthier populations.

Outcome measures for long term-care must be established and defined in the context of the populations being served. In recent years, large employers have imposed standards beyond state licensure minimums, including demands that HMOs be privately accredited by independent entities, such as the National Committee on Quality Assurance (NCQA). Accreditation standards are often

similar to licensure requirements, but may exceed the licensing standards established by states. Requiring PSOs to outline and implement specific procedures and mechanisms to ensure quality care compels better monitoring of utilization and quality. Once again, however, any accreditation or certification programs approved by the federal government for PSOs or other Medicare risk contractors must reflect the outcome goals and measures upon which a truly integrated and effective care delivery system should be based.

DUALLY ELIGIBLE POPULATIONS

H.R. 475 provides for at least 10 state demonstrations that will allow a State's Medicaid program to become an eligible organization (i.e., a Medicare-qualified PSO) to provide for the delivery of primary, acute, and LTC through an integrated delivery network that emphasizes non-institutional care. The term "dually eligible" refers to the group of Medicare beneficiaries who also qualify for Medicaid benefits. Approximately 13% of Medicare beneficiaries, nearly 6 million Americans age 65 or older, receive some assistance from Medicaid.

AAHSA strongly supports this demonstration provision because it permits integration of the Medicare and Medicaid funding streams for the dually eligible population and presumably would permit the rationalization of conflicting requirements of the two programs. It enlarges the role of LTC providers from the relatively narrow Medicare benefit, broadens the range of services that could be included and enhances the opportunity to integrate care. Unfortunately, the demonstrations would place the state Medicaid program in the role of the PSO and would not permit the providers to form the PSO directly. Absent oversight, there is a legitimate concern that state governments could, as an effective monopolist, improperly exercise market power to underpay providers for needed care and services. Such an outcome clearly threatens the quality of care provided to beneficiaries of both programs, particularly those with chronic conditions that require more coordinated case management.

Nevertheless, these demonstrations could identify methods for integrating medical and institutional care with a broad range of home and community based services. They also would highlight administrative requirements in both Medicare and Medicaid that would need revision if such integration is to be streamlined. Assuming adequate research design, evaluation and oversight, cost savings from such integration also might be identified. The demonstration provision for the dually eligible population will enhance the development of integrated care, particularly for the chronically ill.

MEDICAID HMOS

H.R. 475 broadens the Medicaid definition of HMOs so that states may include PSOs in the Medicaid program. Opening Medicaid markets to PSOs is critical for LTC providers because Medicare pays for a very limited share of LTC services compared to the Medicaid program. For example, NFs receive approximately 5% of their revenue from Medicare and over half from Medicaid. Also, a higher

proportion of Medicaid enrollees are in managed care than are Medicare beneficiaries, though not necessarily by choice, and they might be more receptive to this new form of managed care. Although, State Medicaid programs to date have targeted primarily the AFDC population, not the elderly, for managed care, several are exploring PSO-concepts for long-term care/managed care waivers.

AAHSA is concerned, however, because the Medicare and Medicaid programs have differing requirements and regulations concerning participating MCOs. These differences affect enrollment, quality improvement and administration, among other issues. These differences may mean that a dually eligible individual who belongs to a Medicaid HMO may not be able to use the same HMO for his or her Medicare benefits and may have to join another HMO if the managed care option is preferable under Medicare. There are other structural differences between the two programs that would not be eliminated merely by this definitional change for Medicaid and have other potentially adverse implications for truly integrated and coordinated care. Although states may circumvent certain federal Medicaid requirements through waivers that could benefit PSOs trying to operate in both programs, a waiver approach ultimately may prove too cumbersome for successful integration.

By permitting Medicaid contracting with Medicare PSOs, the legislation opens PSOs to both another funding stream and a new source of patients. It also creates a new provider category without the conflicting regulations that hinder other managed care organizations that try to participate in both Medicare and Medicaid. Particularly in this context, long-term care providers offer a wealth of experience and expertise in managing a dually eligible population.

CONCLUSION

AAHSA is committed to affording provider organizations, including PSOs, the opportunity to contract directly with the Medicare Program and other purchasers of health care and services. AAHSA strongly believes that such opportunities must extend to appropriately qualified groups of long-term care providers because they have the experience and ability to manage a predominantly aging chronic care population, precisely the group that does and increasingly will cost the most to serve. For the elderly, the advent of provider sponsored organizations will bring a less confusing system of care and services. PSOs comprised of not-for-profit providers of long-term care would bring stability and connections to the community based on their long-term commitments to providing care and services throughout the nation's history. In expanding choices for Medicare beneficiaries, AAHSA urges Congress to ensure that PSOs include not-for-profit long-term care providers in order to develop an effective and integrated delivery system for the special needs of vulnerable populations. To do less would ill serve the twin goals of enchanced quality and controlled costs.

555 13th Street, N.W. ✣ Suite 600 East ✣ Washington, D.C. 20005✣ (202) 824-1770 ✣ FAX (202) 824-1771

April 24, 1997

The Honorable William Thomas
Chairman
Ways & Means Health Subcommittee
United States House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

In the continuing discussions about how best to rescue Medicare from looming insolvency, there has been general recognition that the program must look to the private sector's example of cost containment through managed care. Much attention, including that of the Health Subcommittee at its April 24 hearing, has focused on provider-sponsored organizations.

The Association of Managed Healthcare Organizations believes that the Medicare program should offer the same range of plan choices available in the private sector, including PSOs and PPOs. If financial and consumer-protection standards are met, PSOs will offer a worthwhile addition to available risk-contract options.

In considering Medicare modernization, however, the Subcommittee should not confine its deliberations to fully risk-bearing entities. H.R. 475, sponsored by Representatives Greenwood and Stenholm, would permit the Secretary of HHS to enter into partial-risk contracts. AMHO supports this idea, and the accompanying concept of applying regulatory controls in proportion to the level of risk assumed by the contractor.

AMHO advocates a further step as well. Since the bulk of the beneficiary population remains in the fee-for-service component of the program, it makes sense to look beyond the risk-contract model to the concept of *managed fee-for-service*, as delivered by open-panel networks such as preferred provider organizations. These entities typically do not bear risk, and so have not been subject to state regulation and licensure requirements. Similarly, many of the concerns addressed through federal regulation of Medicare risk contractors would not apply. AMHO has proposed quality and consumer-protection standards, however, with which contracting non-risk PPOs would comply.

PPOs have gained wide acceptance among both patients and physicians, as attested by the 117.1 million Americans eligible to participate in PPOs through their employer-based or individual health coverage and the average 7300 doctors per network. This popularity is due in large

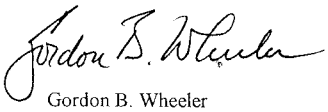
measure to a flexibility not found in existing Medicare risk contracts. Beneficiaries participating in a PPO retain the freedom to choose their own doctors. They are given financial incentives to seek care within the PPO network, but are not prohibited from -- or expected to bear the full cost of -- seeing a non-participating doctor. PPOs have the capacity to absorb large numbers of Medicare beneficiaries. Because both their provider networks and their geographic areas typically are larger than HMOs', PPOs can more readily absorb rapid enrollment.

PPOs can bring to Medicare the same management expertise and patient-friendly attitude that have made them a success in the private sector. For optimum effectiveness, they should not be forced into a regulatory framework that changes their very character. While some PPOs might be able and willing to seek licensure as full risk contractors, Medicare would be best served by allowing PPOs to take the lead in creating a managed fee-for-service program. In this environment, HCFA would retain the insurance risk (much as a self-insured employer does), delegating administration and utilization/quality management to a contracted PPO. PPOs would demonstrate their compliance with quality and consumer-protection standards, and might negotiate with HCFA a means to condition a portion of their administrative fee on the attainment of savings or other performance targets.

Within the fee-for-service portion of Medicare, a PPO option would offer beneficiaries a way to access the benefits of managed care (credentialed providers, a quality management program, perhaps additional coverages, such as wellness and prescription drug programs) without feeling locked into a limited choice of providers.

AMHO would be pleased to discuss this range of risk options in greater detail with you or your staff. Thank you for your attention to our views, and we ask that this letter be made part of the April 24 hearing record.

Sincerely,



Gordon B. Wheeler
President and Chief Operating Officer

cc: Charles N. Kahn, III

Statement of
James L. Scott
President, Premier Institute
Premier, Inc.
Before the Subcommittee on Health
Committee on Ways and Means
on Provider-Sponsored Organizations in Medicare

April 24, 1997

MR. CHAIRMAN, I am pleased to write you today on behalf of Premier, Inc. , the nation's largest healthcare alliance. Premier represents more than 240 owner hospitals and hospital systems that own or operate 700 healthcare institutions and have purchasing affiliations with another 1,100. Premier owners operate hospitals, HMOs and PPOs, skilled nursing facilities, rehabilitation facilities, home health agencies, and physician practices. Through participation in Premier, healthcare leaders can access cost reduction avenues, delivery system development and enhancement strategies, technology management, decision support tools, and a variety of opportunities for networking and knowledge transfer.

I very much appreciate this opportunity to share our views and recommendations on the need to expand participation in Medicare managed care options to include provider-sponsored organizations (PSOs). As the Medicare program faces its most serious crisis since its inception over 30 years ago, we are convinced that expanding beneficiary choice of private health plan options is an essential component of any strategy to preserve and strengthen the program for the 21st century.

Today's hearing brings into focus very significant advances that are occurring in the private sector to improve the quality and affordability of care through greater reliance on organized systems of care. As employers and other purchasers of health care services have put pressure on providers and insurers to limit premium increases and overall health care costs, new models for organizing and delivering care have emerged. We have seen the first generation of managed care plans -- group and staff model HMOs -- give way to HMOs with point-of-service options and preferred provider organizations (PPOs) promoting best clinical practices through utilization management. More recently, some employers have begun to contract directly with locally-based provider-sponsored organizations that are capable of providing a comprehensive array of health care services.

The purpose of this hearing is to learn more about how PSOs are serving patients in many communities and to consider how their advantages can be made available to the Medicare program and its beneficiaries. First, we want to extend our appreciation to Represenatives Jim Bunning, John Ensign, Phil English, Amo Houghton, and Nancy Johnson, for co-sponsoring H.R. 475, a bill that would make qualified PSOs eligible as a Medicare coverage option. This measure

Amo Houghton, and Nancy Johnson, for co-sponsoring H.R. 475, a bill that would make qualified PSOs eligible as a Medicare coverage option. This measure carefully sets forth the terms and conditions for PSO participation in Medicare -- holding them fully accountable while recognizing their unique structure.

What are PSOs?

Very simply, a PSO is an organized system of care serving patients in a local community. Typically, PSOs are sponsored by local hospitals, physicians and other licensed providers who are affiliated with each other through common ownership or control and share financial risk. These organizations are an attractive option to consumers who want to receive their health care from a network of local providers that have a long-term commitment to their communities. PSOs are more likely to focus on improving health throughout their communities while coordinating care across the continuum of services that may be required to diagnose and treat illnesses and injuries for its enrollees.

What really distinguishes PSOs from other forms of managed care is their provider base in contrast to an insurance or health plan model where the insurer or plan is not directly involved in the provision of care. Insurers or HMOs must contract with facilities and practitioners in order to deliver care to their enrolled members. PSOs are both the plan and the provider of care. As such they can more easily put patients first and maintain a proper balance between the need to achieve efficiencies and the obligation to ensure the highest quality and consumer protection standards.

While not all PSOs are structured in exactly the same way, they all share some common features including:

- Integration of all clinical services supported by clinical and financial information systems and by adherence to community standards of practice;
- Direct provision of a substantial portion of services by providers that share financial risk; and
- Flexibility in the design of medical management approaches that are adapted to local needs and coordinated with other community resources.

We believe PSOs can offer a patient-focused delivery system that is equally attractive to beneficiaries in urban areas with considerable managed care competition as well as in rural areas where coordinated care systems have not often been available.

PSOs and Medicare

It is widely recognized that organized systems of care have been responsible for reducing the cost of private health coverage to employers and workers. In contrast to the fragmented, episodic fee-for-service system, coordinated care systems can also improve the quality and outcomes of care. The Medicare program has moved much more slowly in making private managed care options available to beneficiaries. We believe there is now an opportunity, indeed a

mandate, to begin taking advantage of these private sector successes by expanding beneficiary choices to include PSOs and other integrated care systems that meet appropriate standards.

Enrollment of Medicare beneficiaries in qualified HMOs has been growing dramatically recently -- more than 25% per year -- and the Congressional Budget Office in January predicted that the percentage of beneficiaries in managed care plans would nearly double -- from 11.7% to 22.9% -- over the next 5 years. However, these figures remain quite low in comparison with the private sector where fully two-thirds of workers with health coverage are in managed care plans.

One reason that Medicare lags behind the private sector with regard to managed care participation is that the program has limited private plan options to traditional HMOs. We strongly supported provisions included in the Balanced Budget Act of 1995 that would have established federal standards and certification for PSOs in the Medicare program. However, in the final bill -- which was vetoed -- we believe the standards were too restrictive and that significant discretion was ceded to the states which would likely take very different approaches that could impede opportunities for PSOs.

Since that time, the Medicare program has launched a series of demonstrations designed to test the acceptability of a wider range of private plan options. As you may know, the Medicare Choices Demonstration involves 25 sites, 9 of which are PSOs. One of our members, the Florida Hospital Healthcare System in Orlando, has already begun enrolling Medicare beneficiaries under a capitation-based risk contract with Medicare. Within its first two months of operation, the plan enrolled more than 1500 beneficiaries. Significantly, the plan was qualified directly by HCFA and was not required to obtain a state HMO license.

We are greatly encouraged by the strong interest that beneficiaries have displayed in our Orlando PSO. We know that many of our members are capable of coordinating care for Medicare beneficiaries and are anxious to have this opportunity in their communities. Enactment of H.R. 475 would make PSOs more widely available and hold them accountable to appropriate financial, quality, and patient protection standards.

H.R. 475, The Medicare Provider-Sponsored Organization Act of 1997

The legislation introduced by Congressman Greenwood and Congressman Stenholm on January 21st, H.R. 475, includes a number of specific and important changes from the proposals that were offered during the Medicare debates in the last Congress. In our view, this legislation holds PSOs to even higher standards than are currently in place for HMOs that contract with Medicare. We think it is critically important to recognize that this measure is not an effort to lower Medicare standards or put beneficiaries at risk.

H.R. 475 sets forth the terms and conditions for PSO participation in the Medicare program. The measure builds on the requirements already in place under the current risk contractor program. A Medicare qualified PSO must have the capability to provide the full benefit package under capitation payment including the direct provision of substantially all the covered benefits by providers who are under common control and share substantial financial risk. Financial solvency must be demonstrated by meeting a series of specific measures based on the

current NAIC model HMO act. PSOs must also meet all current Medicare quality standards plus enhanced standards related to utilization review programs and physician participation in designing quality improvement programs.

We also believe that it's important to make sure that the enforcement and oversight of PSOs are carried out in an efficient and fair manner. Historically, state regulatory systems have not kept pace with the changing delivery system models in terms of the application of their licensure statutes. Thus, PSOs and other integrated delivery systems face in many states regulatory requirements designed for traditional health insurers or HMOs that must set aside reserves against claims and must contract with the providers that actually render services. As a result, H.R. 475 seeks to coordinate federal and state regulatory efforts by initially calling for federal certification of PSOs. After four years, state licensure would be required for PSOs in any state that adopted standards equivalent to the federal standards.

Finally, H.R. 475 includes a number of other provisions such as limited waivers of the enrollment composition rule (the so-called 50/50 rule), authorization for partial risk payment arrangements combining capitation with cost-based payments, uniform standards for the coverage of emergency services, and a limited preemption of state laws that prohibit the operation of managed care plans. These provisions help to ensure a level playing field for PSOs and a more consistent and appropriate set of standards through which they can be held accountable.

Conclusion

MR. CHAIRMAN, we believe PSOs show great promise as an option for Medicare beneficiaries by giving them access to community-based, patient focused, coordinated care. This translates into real value for those who rely on Medicare for their health coverage. PSOs will expand the range of beneficiary choices, they will put clinical decisions back into the hands of local practicing physicians, they will meet current consumer protection and quality assurance standards, and they will reduce the burden and frustration of the traditional fee-for-service claims system.

We believe that the enthusiasm with which Medicare beneficiaries have embraced the PSOs that are participating in the Medicare Choices demonstration is indicative of the reception they will receive if they become more widely available. It's important to remember that H.R. 475 represents a significant and much more comprehensive approach to establishing the conditions for and assuring the accountability of provider-sponsored organizations.

We urge this Committee to include this legislation in any Medicare reform legislation that may be recommended later this year. We look forward to working with you, MR. CHAIRMAN, and the other members of the Committee in moving this bill forward.

Thank you for this opportunity to present our views and recommendations on the critical opportunity to expand Medicare choices.