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S. HRG. 108–145

MEDICARE REFORM AND COMPETITION SEPARATING FACT FROM FICTION

HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING UNITED STATES SENATE

ONE HUNDRED EIGHTH CONGRESS

FIRST SESSION

WASHINGTON, DC

MAY 6, 2003

Serial No. 108–9

Printed for the use of the Special Committee on Aging

U.S. GOVERNMENT PRINTING OFFICE

88–256 PDF WASHINGTON : 2003

For sale by the Superintendent of Documents, U.S. Government Printing Office
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MEDICARE REFORM AND COMPETITION: SEPARATING FACT FROM FICTION

TUESDAY, MAY 6, 2003

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, DC.

The committee met, pursuant to notice, at 10:05 a.m., in room SD–628, Dirksen Senate Office Building, Hon. Larry E. Craig (chairman of the committee) presiding.

Present: Senators Craig, Carper, and Stabenow.

OPENING STATEMENT OF SENATOR LARRY E. CRAIG, CHAIRMAN

The CHAIRMAN. Good morning, and thank all of you for joining us. As Congress' Medicare discussion enters what may be its critical final weeks, we are here today to examine one of the central issues in that debate, namely proposals to offer seniors a new array of competing health plans offering prescription drugs and other benefits not currently available under Medicare.

These approaches, variations of which have been advanced by President Bush, Majority Leader Frist, and others on both sides of the aisle, would offer all of America's seniors the same kind of first-class, high-quality health coverage now enjoyed by the members of Congress and over 8 million other Federal employees.

Today's hearing assembles several of the nation's foremost experts on this issue, including the administrator of the Federal Employees Health Benefits Program (FEHB). There has been much confusion and indeed disinformation about the implications of adding a competitive dimension to Medicare. It is time to sit down and hear candidly from both sides, ask some hard questions, and get to the bottom of what this approach will mean in terms of access, quality, value, cost, and member satisfaction.

The Medicare Program in place today is a creaky, inflexible, and increasingly unmanageable system that micromanages the tiniest details of medical payment and procedure—including the pricing and regulation of more than 7,000 medical procedures and over 500 hospital procedures.

Of course, traditional Medicare can and should remain as an option for those seniors who want to keep it, but I believe that America's retirees also deserve access to the better benefits, the greater innovation, and the superior coordination of care that a competitive insurance environment offers. Members of Congress enjoy all of these advantages. Why not our parents? Why not our grandparents? That is our purpose today, to examine those issues and

build a record for the Finance Committee here in the Senate and others directly involved in this as we craft this legislation to review.

Before I do that, let me turn to a member of this committee, the Senator from Michigan.

Senator Stabenow.

STATEMENT OF SENATOR DEBBIE A. STABENOW

Senator STABENOW. Thank you, Mr. Chairman.

I am pleased to be here today. This is an extremely important topic, and I appreciate those who are joining us today.

I have a slightly different perspective, but I am very interested in listening to what our witnesses have to say today. I, at home in Michigan, do not hear people asking for more insurance companies to choose from; I hear them asking to have Medicare work in terms of prescription drug coverage, to be updated, but overwhelmingly, Medicare, which is the only part of our health care system that is universal, available to everyone at the age of retirement or for the disabled, has been a success in providing a guaranteed level of care—defined benefit; people know what they are getting; it is stable.

It is interesting, because as we debate the question of choice, we actually set up a number of years ago an option on choice—private sector HMOs through Medicare+Choice. I believe that those under Medicare have predominantly chosen to stay in traditional Medicare overwhelmingly.

Interestingly, my mother chose Medicare+Choice and went into a private sector HMO and had a very good experience except that the HMO, the insurance company, dropped Medicare. They dropped Medicare because of funding issues. So that choice was then no longer available to her.

So when I look at the issues of Medicare as we go along in this extremely important debate, I intend to raise another set of questions, and that is whether we think health care is important enough to really fund Medicare and to provide resources for our hospitals and doctors and home health care agencies and so on, and private choices—if people want to go into Medicare+Choice, fine. But what I see in Michigan is that overwhelmingly, people are saying we want traditional Medicare, and we just want it to be updated to cover prescription drugs, and we want it to work. I am all for doing away with some of that bureaucracy and paperwork so it is more efficient and less onerous in terms of the paperwork, but I come from a perspective of saying that Medicare has been a great American success story and has saved a lot of lives, and I am hopeful that we can continue to strengthen it in a way that will continue to do that.

Thank you.

The CHAIRMAN. Senator, thank you.

We certainly agree that probably one of the most important issues that we will tackle this session of Congress is this issue, not only for the current recipients but for the long-term effect it will have on our society in quality health care coverage—both that which is realistic in the modern-day health care system and affordable in relation to the overall costs.

So that is what we are about today, and now let me introduce our first panel.

The CHAIRMAN. Our first panel this morning will focus specifically on the Federal Employees Health Benefits Program and how it compares to Medicare. Starting us off this morning will be the person most directly responsible for direction of the Federal employees program, Abby Block, Senior Advisor for Employee and Family Support Policy at the Office of Personnel Management.

Also testifying—if he arrives—will be Walton Francis, expert consultant and author of "Checkbook's Guide to Health Insurance for Federal Employees."

Finally, we are joined—and he has arrived—on our first panel by Bob Moffit, Director of the Center for Health Policy Studies at The Heritage Foundation. Bob and his staff have studied and written extensively on the Federal employees' health program as a possible model for Medicare reform.

We look forward to your testimony, and Ms. Block, if you would start, please, we would appreciate it.

STATEMENT OF ABBY L. BLOCK, SENIOR ADVISOR FOR EMPLOYEE AND FAMILY SUPPORT POLICY, STRATEGIC HUMAN RESOURCES POLICY DIVISION, U.S. OFFICE OF PERSONNEL MANAGEMENT, WASHINGTON, DC

Ms. BLOCK. Thank you, Mr. Chairman.

May I request that I be allowed to submit my entire statement for the record, and I will make an abbreviated statement now?

The CHAIRMAN. Thank you very much. All of your testimonies will be made a part of our record.

Thank you.

Ms. BLOCK. I am pleased to be here today to discuss the Federal Employees Health Benefits Program. Our Health Benefits Program has been in operation for more than 40 years. It is an employer-based program and forms an important part of the compensation package offered by the Federal Government.

The Office of Personnel Management has developed widely recognized expertise in the complexities of arranging health care coverage for more than 100 private sector health plans with a covered population of about 8.5 million people. In 2002, the program accounted for $24 billion in annual premium revenue.

The program relies heavily on market competition and consumer choice to provide our members with comprehensive, affordable health care. In 2003, 188 discrete options are being offered by 133 different health plans.

An important and distinctive feature is nationwide availability. About 3 million enrollees are in fee-for-service/PPO-type plans, and one million in HMOs. There is an opportunity to enroll in the program, change health plans, or change enrollment status at least once a year during the 4-week annual open season that begins in November.

All of the FEHBP national plans except for the Blue Cross and Blue Shield Basic Option offer their members access to all of the covered providers in their community. But for those providers that have not agreed to participate in a preferred provider network, the member does not get the advantage of reduced out-of-pocket costs.

It is clear in our informational materials that the preferred provider benefit is an enhancement over the standard non-network benefit. In a typical network arrangement, the provider agrees to accept a rate of payment lower than billed charges in exchange for advantages such as more potential patients, expedited reimbursements, and other services provided by the plan.

Often, plans monitor the services provide in network to ensure that their providers are well-informed about current practice patterns and new developments in health care delivery. The plan in turn can pass on the benefits it derives from provider participation in the network to members in the form of lower out-of-pocket costs when they use a preferred provider. Those lower costs are offered as an incentive to members to choose in-network services when they are available.

However, since the Blue Cross/Blue Shield Basic Option provides no coverage for out-of-network services, we negotiated special provisions for that option to ensure that coverage would be available everywhere in the country.

While all participating plans offer a core set of benefits broadly outlined in statute, benefits vary among plans because there is no standard benefits package. Even where coverage is nearly identical, cost-sharing provisions may differ significantly among plans.

Benefits and rates are negotiated annually, but OPM does not issue a request for bids. Instead, we issue a call letter to participating carriers in the spring that provides them guidance for the upcoming negotiations. Plans remain in the program from year to year unless they choose to terminate their contracts, typically for business reasons.

Under current law, the window for new plans to enter the program is essentially limited to HMOs. Unlike the 1980's, when we were flooded with HMO applications, in the current market, we average about six new plans a year.

Rates are negotiated with the national plans primarily on their claims experience. About 93 percent of premium, or 93 cents out of every dollar, reflects benefit costs. The remaining 7 percent covers the plans' administrative costs.

For community-rated plans, rate negotiations are based on per-member, per-month community rate, and adjustments can be made to that rate based on demographic factors or utilization factors of our particular group.

Our oversight focuses on key areas of plan performance, including attention to quality, customer services, and financial accountability. All of our contracts include mechanisms through which premiums can be adjusted based on performance. In addition, all carriers are subject to audit by the independent OPM inspector general. As a result of our collaboration with the IG, the program recovers on average more than $100 million a year.

While the program has a statutory and regulatory framework, key aspects of plan design such as coverage or exclusion of certain services and benefit levels are in neither law nor regulation. Within broad parameters set by OPM, plans have the flexibility to determine both their benefits package and their delivery system.

Because policy guidance is developed by OPM and provided to the plans annually, prior to the start of negotiations, policy

changes can be made quickly in response to market factors. For example, this past year, we accepted a proposal from one of our plans for a consumer-driven option that reflects the development of new products in a fluid market.

The FEHB Program uses a hybrid approach that shares practices with both public sector and private employer health insurance programs. While we believe the program has been very successful over its long history, we are always looking for ways to ensure that it continues to reflect the current health care environment, meet the needs of its members, and service the government in its recruitment and retention efforts.

Our survey results are good. About 80 percent of those enrolled in our national plans are satisfied. Our work with the participating plans, however, on quality improvement is ongoing. We think that the FEHB Program is an excellent example of effective public-private partnership.

Thank you for inviting me to be here today. I am pleased to answer your questions.

The CHAIRMAN. Ms. Block, thank you very much.

[The prepared statement of Ms. Block follows:]

STATEMENT OF
ABBY L. BLOCK
SENIOR ADVISOR FOR EMPLOYEE AND FAMILY SUPPORT POLICY
OFFICE OF PERSONNEL MANAGEMENT

Before the

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

MAY 6, 2003

Mr. Chairman and Members of the Committee:

I am pleased to be here today to discuss the Federal Employees Health Benefits (FEHB) Program.

Our Health Benefits Program has been in operation for more than forty years. It is an employer-based program and forms an important part of the compensation package offered by the Government, enabling it to recruit and retain individuals who carry out the vital work of government. The operating philosophy of the Program is competition with a consumer focus, just as President Bush has highlighted in his framework for Medicare reform.

The Office of Personnel Management (OPM) has developed widely-recognized expertise in the complexities of arranging health care coverage with more than one hundred private sector health plans with a covered population of about eight and a half million people including 2.2 million employees, 1.9 million retirees, and members of their families. In 2002, the program accounted for $24 billion in annual premium revenue. The Director of OPM, Kay Coles James, has made the FEHB Program a central focus of OPM attention, especially in terms of maintaining competition while ensuring that Federal employees and retirees and their families receive high quality services. Her strategy has been to encourage innovation from the health plans, support tough negotiations by her contracting staff, collaborate with the OPM Inspector General in his efforts to detect and control fraud and cultivate a culture of accountability within the FEHB Program at all levels, and finally to focus on the demand side by working with the health plans to make sure their members have the information they need to make the right choices about healthy life styles and appropriate utilization of services.

FEHB Program Structure

The Program relies heavily on market competition and consumer choice to provide our members with comprehensive, affordable health care. In 2003, 188 discrete options are being offered by 133 health plans.

An important and distinctive feature is nationwide availability. No matter where one lives, all members may choose from among a dozen options offered by nationwide fee-for-

service/preferred provider organization (PPO) plans open to all. Some members may elect one of the six nationwide plans limited to members of sponsoring organizations, and many may choose a Health Maintenance Organization (HMO) in their geographic area. About 3 million Federal enrollees are in fee-for-service/PPO plans and 1 million in HMO's. There is an opportunity to enroll in the Program, change health plans, or change enrollment status at least once a year during the 4-week annual open season that begins in November. OPM and the participating plans provide information on benefits and rates, provider availability, and quality indicators during the annual open season so that members can determine which plan best suits their needs and the needs of their family and make their plan election.

All of the FEHB national plans, except for the Blue Cross and Blue Shield (BCBS) Basic Option, offer their members access to all of the covered providers in their community. But for those providers that have not agreed to participate in a preferred provider network, the member does not get the advantage of reduced out-of-pocket costs. Since the fee-for-service plans introduced preferred provider networks into the Program in the 1980s, we have always made clear in our informational materials that the preferred provider benefit is an enhancement over the standard non-network benefit offered by the pans. In a typical network arrangement, the provider agrees to accept a rate of payment lower than billed charges in exchange for advantages such as more potential patients, expedited reimbursements, and other services provided by the plan. Often plans monitor the services provided in-network to ensure that their providers are well informed about current practice patterns and new developments in health care delivery. The plan, in turn, can pass on the benefits it derives from provider participation in the network to members in the form of lower out-of-pocket costs when they use a preferred provider. Those lower costs are offered as an incentive to members to choose in-network services when they are available. We have never guaranteed in-network coverage except in the BCBS Basic Option. Since Basic is an Option in a nationwide plan and it provides no coverage for out-of-network services, we negotiated special provisions to ensure that coverage would be available everywhere in the country.

While all participating plans offer a core set of benefits broadly outlined in statute, benefits vary among plans because there is no standard benefits package. Even where coverage is nearly identical, cost-sharing provisions may differ significantly among plans.

The design of the FEHB Program permits OPM to focus on three key elements: policy design, contract negotiations, and contract administration including financial oversight.

Benefit and Rate Negotiations

While benefits and rates are negotiated annually, OPM does not issue a request for bids. Instead we issue a call letter to participating carriers in the spring that provides them guidance for the upcoming negotiations. The call letter is a strategic tool in setting the stage for negotiations and highlighting the interests of the Director. In 2002, OPM highlighted coverage for colorectal screenings in the context of competition for members among the plans. In 2003, OPM highlighted coverage for preventive services, and sound oversight by the plans of their pharmacy benefits managers. Plans remain in the Program from year to year unless they choose to terminate their contracts for business reasons, including failure to reach agreement with OPM on

benefits and rates for the coming year. Under current law, the window for new plans to enter the Program is limited to HMO's. Unlike the 1980s when we were flooded with HMO applications, in the current market, we average about 6 new plans a year.

Rates are negotiated with the national plans based primarily on their claims experience. About 93 percent of premium, or 93 cents out of every dollar, reflects benefit costs. The remaining 7 percent covers the plan's administrative costs.

For the community-rated plans, rate negotiations are based on a per member per month community rate. Adjustments may be negotiated to the base rate for a variety of reasons, including changes to their standard benefits package, the demographics of the Federal group, and the utilization of benefits by the Federal group.

We, along with all purchasers of health insurance, have experienced significant rate increases over the past few years. Our increase in 2003 with 11.1 percent, which was high, but well below the industry average. The increase for CalPERS, the second largest employer-based program in the country, was 25 percent. In 2002, our increase was 13.3 percent. In 2001 it was 10.5 percent.

Contract Administration and Financial Oversight

Our oversight focuses on key areas of plan performance, including attention to quality, customer service, and financial accountability. Measures and expectations regarding quality assurance, patient safety, prevention of fraud and abuse, and compliance with accounting standards are built into our contracts. Some measures, such as the results of the industry standard consumer satisfaction survey conducted annually, and the accreditation of health plans and providers by independent accrediting organizations, are reported to our members in both print and electronic format. Members use the information, often in conjunction with decision support tools that we provide on our web site, to choose their health plan during the annual open season.

We began recently to centralize plan performance data in a data repository that facilitates analysis by contracting staff. All of our contracts include mechanisms through which profits can be adjusted based on performance.

In addition to oversight by the contracting office, all carriers are subject to audit by the independent OPM Inspector General (IG). As a result of the close collaborative relationship between the contracting office and the IG, the Program recovers on average more than one hundred million dollars a year based on defective community rate findings and unallowable administrative expense or benefit cost findings. Director James views the OPM IG as a central partner in maintaining the creditability of the Program in the eyes of employees and retirees. She has supported successive increases in the IG's budget to expand his oversight capacity. This year, our call letter telegraphed specifically the Director's interest in working with the IG to review costs associated with the operation of pharmacy benefits managers in the Program.

Policy Design

We administer the FEHB Program in a way that mirrors other employer-based health insurance programs. We also are in compliance with all applicable Federal laws and meet all the standard Federal accountability requirements.

While the Program has a statutory and regulatory framework, key aspects of plan design, such as coverage or exclusion of certain services and benefit levels are in neither law nor regulation.

Within broad parameters set by OPM, plans have the flexibility to determine both their benefits package and their delivery system. Because policy guidance is developed by OPM and provided to the plans annually prior to the start of negotiations, policy changes can be made quickly in response to market factors. For example, this past year we accepted a proposal from one of our plans for a consumer-driven option that reflects the development of new products in a fluid market.

Because our policy is to encourage innovation and private sector initiatives, plans use business-based processes to achieve desired results. For example, when Blue Cross and Blue Shield introduced its basic option a couple of years ago, they had to make adjustments to their provider arrangements to ensure members access to a nationwide provider network since the plan does not cover out-of-network services. Other plans take a different approach and guarantee out-of-network benefits only in parts of the country where they cannot develop a strong provider network, such as rural areas.

While plans have considerable flexibility to deal with specific issues such as access to services, the FEHB Program, by statute, has a provision for Medically Underserved Areas that ensures that Members have access to health care providers. Our fee-for-service plans must pay for covered services provided by any licensed provider practicing within the scope of his or her license, even if that provider is not considered a covered plan provider.

Conclusion

The FEHB Program uses a hybrid approach that shares practices with both public sector and private employer health insurance programs. While we believe the Program has been very successful over its long history in offering Federal employees, retirees, and their families quality coverage for a reasonable price, we are always looking for ways to ensure that it continues to reflect the current health care environment, meets the needs of its members, and serves the Government in its recruitment and retention efforts. While our survey results are relatively good – about 80 percent of those enrolled in our national plans are satisfied – our work with the participating plans on quality improvement is ongoing.

We have benefited from close collaboration with the participating health plans and with other purchasers. We also work closely with the Center for Medicare and Medicaid Services (CMS), particularly on issues affecting the population we serve jointly, our Medicare-covered retirees.

We think that the FEHB Program is an excellent example of effective public-private partnerships.

Thank you for inviting me to be here today. I will be pleased to answer your questions.

The CHAIRMAN. Mr. Francis, we are pleased to see that you have arrived, frustrated, I trust, by the traffic of Washington. Let me again reintroduce you to the committee.

Walton Francis is an expert consultant and author of "Checkbook's Guide to Health Insurance for Federal Employees." I think I have seen your work on an annual basis.

Please proceed.

STATEMENT OF WALTON FRANCIS, FEDERAL EMPLOYEE HEALTH BENEFITS PROGRAM EXPERT CONSULTANT AND AUTHOR, FAIRFAX, VA

Mr. FRANCIS. I hope so, Senator. Thank you very much.

I want to report to all concerned that there is a disaster in the North Capitol Street tunnel. It is blocked and not moving and backed up for miles in every direction. So I apologize for my late arrival.

The CHAIRMAN. I am glad you finally found a way to avoid it or get around it.

Mr. FRANCIS. I would like with your permission to abbreviate my written testimony.

The CHAIRMAN. Yes. All of your written testimonies are part of the record.

Thank you.

Mr. FRANCIS. Thank you.

I decided not to talk about the FEHBP as such, but to talk about how it compares to Medicare from the point of view of both the enrollee and the sponsor, if you will, the U.S. Government in both cases. Although the programs are very different in some respects the FEHBP as a fringe benefit of employment, and Medicare as a guarantee to older Americans that they will not be impoverished by their health care costs—the programs nonetheless are the two largest Federal Government insurance programs in terms of lives covered and are very instructive in the lessons they teach.

It is also the case that there seems to be an increasing set of criticisms of the FEHBP, mostly dead wrong, some uninformed, some just using phony statistics or whatever, and I thought I would lay some of those to rest.

Let me just review very briefly the key point of my testimony. Retirement health care benefits are better in the FEHBP than in Medicare, substantially better. This is obvious to everybody who has looked at both programs, but it always warrants saying. I estimated for this hearing what Medicare would provide if it were a plan offered under the FEHBP as an option for retirees and how that would compare to what retirees actually get, and not surprisingly, I found that the out-of-pocket costs under Medicare are roughly twice as high on average as those under the FEHBP for that elderly population.

The components of this better coverage are obvious and well-known—catastrophic coverage, prescription drug coverage, and a minor benefit to which I will return, coverage when traveling abroad or living abroad, for that matter.

On access, 99 percent of physicians accept fee-for-service and PPO patients. That means that 99 percent of physicians accept FEHBP enrollees. Only 96 percent of doctors accept Medicare pa-

tients. So access is better—sure, 99 versus 96 is not a huge difference, but it suggests that in rural areas and other places where physician availability is quite constrained, FEHBP is superior.

Furthermore, FEHBP is everywhere. In every county in America, there are no fewer than 12 plans available to Federal retirees and employees. In most of the places where Federal employees reside in large numbers—not just Washington, DC, although that is obvious, but most of the larger cities around the country—there are from 15 to 20 plans available.

Over time, in sharp contrast to Medicare, the FEHBP painlessly adapts to changes in the health care marketplace. Both of these programs, by the way, started vintage 1960. It is not just that FEHBP has painlessly adopted prescription drug benefits—in fact, they were in the program from the get-go because nobody would voluntarily enroll in a program that did not have prescription drug benefits even back in 1960—but that those benefits and many others have adapted over time to reflect the realities of the health care market place. For example, 10 or 15 years ago, most of the fee-for-service plans paid roughly 75 percent of your prescription drug costs, whatever they were; that was the model. The model today is typically a six-tier system in which there are three price levels for mail-order drugs and three price levels for local pharmacy drugs, with generics being the cheapest, approved or formulary name brand drugs the medium-priced spread in terms of copayments, and you pay most of all if you take a non-formulary name brand drug.

The point of this is that had such a benefit been enacted in Medicare 15 years ago, it would have been that 25 percent option because that is what was common on those days. It would never have gotten changed. I estimate that the six-tier drug benefit system used in most of the plans in this program saves the program roughly $500 million a year. That is a very significant savings, based on academic research out there that demonstrates that those kinds of benefit structures save a lot of money by inducing frugal choices.

Enrollee satisfaction in this program is very high. There is no direct comparison with Medicare possible, but OPM, to its credit, was a pioneer in developing surveys of enrollee satisfaction to assist enrollees with information on how to better choose plans. They find that in these fee-for-service plans, 79 percent of participants rate the plans 8, 9, or 10 on a scale of 1 to 10.

On guaranteed benefits, this program is often criticized because the benefits are not written into law—my gosh, you cannot be sure you are going to get them or something. Well, that is absurd. They are guaranteed. They are guaranteed indirectly, and they are guaranteed in a way that gets the government out of micromanaging benefit-by-benefit details.

Let me stop there and conclude. This is a very successful program. It contains many lessons for Medicare reform, and I hope those can be incorporated as you deliberate this year.

Thank you.

The CHAIRMAN. Mr. Francis, thank you very much.

[The prepared statement of Mr. Francis follows:]

TESTIMONY OF WALTON FRANCIS

AUTHOR AND INDEPENDENT CONSULTANT

BEFORE THE SPECIAL COMMITTEE ON AGING

UNITED STATES SENATE

MAY 6, 2003

Mr. Chairman, and Members of the Committee:

I am delighted to testify before you today concerning the lessons of the FEHBP for Medicare modernization. In my dual careers and capacities as a consumer advocate and advisor on how to choose the best health insurance plan (Francis 2002a), and policy analyst advising on government policy options and reforms, I have long argued that the FEHBP is a superb model for Medicare reform.

A distinguished student of both programs opined several years ago that "the FEHBP has outperformed Medicare every which way--in containment of costs both to consumers and the government, in benefit and product innovation and modernization, and in consumer satisfaction" (Cain 1999). I agree. In my testimony I will try to provide data that will support these conclusions and also dispel misconceptions about the FEHBP.

Benefits. Medicare serves as a lifeline to the elderly of America. Its coverage of hospital and doctor costs is vital to the economic well being and survival of millions. Yet, Medicare is infamous for its obsolete, vintage 1960 design. It does not provide a catastrophic ceiling on costs even for those costs it covers. It does not cover prescription drugs (except in rare instances). It does not cover many preventive services. It does not cover dental services. And, by failing to cover health care costs incurred abroad (except in Canada and Mexico), it forces the elderly either to forgo retirement travel outside of North America or to obtain other coverage. Indeed, so deficient is Medicare coverage that some ninety percent of its enrollees purchase or have purchased for them some form of supplementary insurance.

None of these deficiencies affect the FEHBP. That program was also created vintage 1960, but it has painlessly evolved over time through the competitive, consumer-driven process that is its central feature. In preparing for this hearing, I rated the Medicare plan for its benefit coverage in 2003, compared to typical FEHBP plans. For a retired person without dual coverage I obtained the following results (these data include dental costs and exclude premiums):

Category	Medicare	FEHBP
Average Out of Pocket Cost	$2,640	$1,260
Likely Cost at Expense Level of $84,000	$12,580	$6,080
Ceiling on Combined Hospital, Doctor, and Drug costs	None	$5,000 plus or minus $1,000

These data demonstrate that **FEHBP retirement benefit coverage is far superior to Medicare's**.

There is another significant dimension of benefit superiority. In both programs the great majority of common hospital and physician procedures are covered routinely. However, at the margin Medicare coverage choices are dictated either by statutory law or by administrative law dictated through the Medicare coverage processes. In the FEHBP, in contrast, coverage choices at the margin are made by individual plans. This means that consumers can seek out plans that have better coverage for particular services of importance to them. Acupuncture, cardiac rehabilitation, expensive dental procedures, and other services are usually available, at a price, in some available plan. Medically proven procedures, such as pancreas-only transplants, are covered in all or almost all FEHBP plans

but are often covered by Medicare only after years of delay, if ever. And FEHBP plans are free to, and often do, cover services that they would not ordinarily cover at all if these are approved as part of a case management package tailored to a particular enrollee.

Provider Choice and Access. Medicare is, in a sense, one of the relatively few remaining pure fee-for-service (FFS) medical plans in America. Most private plans either limit provider choices substantially or, as is quite common, provide differential cost sharing depending on whether or not the provider is "preferred". Of course, Medicare is not really fee-for-service since it regulates prices and, indeed, makes it illegal for providers to negotiate higher prices with enrollees and still obtain any reimbursement (Hoff 1998). The FEHBP national plans almost all allow enrollees to go "out of plan" and pay only one fourth of a reasonable charge above that level. These plans' reimbursements are more favorable for "preferred" physicians, but some payment is available whether the physician has any arrangement of any kind with the insurance company. At worst, the patient pays the bill and then gets reimbursed directly from the insurance company. **Every Federal retiree can join health plans that reimburse him for most of his costs for virtually any physician who accepts private patients at all. More physicians are available through the FEHBP than through Medicare.**

The Medicare Payment Advisory Commission conducts surveys of physicians and in its most recent report found that physicians are significantly less willing to accept Medicare patients than private plan patients (MedPAC 2003). Specifically, in 2002 over 99 percent of physicians accepted private FFS and PPO patients, but only 96 percent accepted Medicare patients. This is a seemingly small difference but if it is your doctor, or the best specialist in town, who will not accept you, it can have a major effect on your health care. And until recently enacted payment increases, it appeared that the proportion of physicians unwilling to accept Medicare patients was about to rise substantially.

In this context, the FEHBP has a significant advantage over Medicare because of its multiplicity of plans. **Every Federal employee or retiree, no matter where he or she lives, anywhere in America or anywhere in the world, has no fewer than twelve plan options from which to choose in 2003.** (This includes both "high" and "standard" options offered by the same carrier, since these options always differ significantly in benefits and in premium.)

Federal retirees in areas covered by participating HMOs have additional plans from which to choose. Thus, while a retiree in North Dakota or Wyoming may "only" have twelve plan choices, a retiree in medium and large size cities in almost all states will typically have several more plan options. In the larger metropolitan areas, where the great majority of both Medicare and FEHBP retirees reside, there are often about 20 plan choices available to Federal retirees.

Benefit Innovation. The importance of plan choices, of course, goes far beyond serving patient needs for provider choice and benefit options. The fundamental model of the FEHBP, like most services in our economy, relies on competition in attracting consumers as the driving force for quality improvements and restraint of costs. For example, plans are free to add, drop, increase, or decrease deductibles. These are not trivial decisions. Deductibles have substantial effects on consumer acceptance, on premiums, and on health care utilization. Plans that strike the right balance do best over time. The fact that wide variations in deductibles persist over time suggests that there is more than one "right" model.

In fact, most plan benefits are quite stable. Deductibles are not frequently changed. But some benefits do change rapidly in most plans. Notable for experimentation and change are plan payments for prescription drugs. Ten or fifteen years ago, most plans either charged a nominal copayment or modest coinsurance percentage for all drugs. Enrollees were free to go to the drug store of their

choice. Mail order and formularies were almost nonexistent. In the last decade, with ever increasing spending on drugs--reflecting mainly new drugs with major new therapeutic benefits--plans have vigorously changed their approaches. Today, most plans have a six-tier benefit structure for drugs. There is one set of copayments for mail order, and another somewhat higher set for using preferred pharmacies. Generic drugs cost the enrollee the lowest copayment, preferred name brand drugs on the formulary somewhat more, and other name brand drugs the most. One can only imagine the political turmoil and potential for unnecessarily costly or constraining decisions were price controls and formularies to be proposed as features of a Medicare drug benefit. (Perhaps I had better say: just look at the last several years of political paralysis!) And it is inconceivable that such a benefit, once enacted into law under the standard Medicare approach, would receive the kind of nimble evolutionary adjustments used in the FEHBP as plans jockey for the best mix of generosity and cost control to attract customers.

Current FEHBP drug benefit structures place both the burden and the opportunity for decision making on the enrollee. They encourage frugality, but allow for medical necessity. They have evolved virtually without political controversy or legislative or bureaucratic fiat. And these approaches to benefit design been proven to keep down drug spending and save both the payer and the enrollees a great deal in premium costs (Joyce 2002). Based on RAND research, I estimate that the annual savings to the FEHBP from current tiered payment systems is somewhere around $500 million annually, about 2 or 3 percent of program-wide premium costs, shared by the government and enrollees (Francis 2002b). **Adoption and continuing reform of prescription drug and other benefits in the FEHBP has been politically and programmatically painless, while saving billions of dollars over time**.

Consumer Satisfaction. Consumer satisfaction is very difficult to measure fairly, and I am not aware of any studies that directly compare Medicare to the FEHBP using elderly persons as the sample universe. However, we have some important information. OPM has innovated in the use of quality information in the FEHBP program, and led the way to adoption of participant surveys. By providing this information to enrollees, OPM has significantly aided them in plan selection. These surveys focus mainly on specific dimensions of plan performance, such as getting needed care, how well doctors communicate, and claims processing, but also measure overall satisfaction. The most recent survey information shows that on a scale of 1 to 10, about 79 percent of FFS and PPO enrollees and 63 percent of HMO enrollees rate their plans 8 or higher.

We also have information from the annual Open Season, in which enrollees decide whether to stay in their plan or "vote with their feet" by moving to another plan. Each year, fewer than 10 percent of employees and fewer than 5 percent of retirees elect to switch plans. **The overall level of enrollee satisfaction with the FEHBP is clearly very high**.

A recent Commonwealth Fund Survey of Health Insurance did compare Medicare and private insurance generally (Davis 2002). It found, for example, that 85 percent of Medicare elderly rated their plan as good, very good, or excellent. In contrast, "only" 81 percent of those privately insured and of working age rated their plans as highly. However, these results really prove nothing. It is well known that plan satisfaction increases with age of respondent. Younger enrollees are more critical. This largely explains the differential between FFS and PPO ratings in the FEHBP, since the HMOs disproportionately attract younger enrollees. In the Commonwealth survey, I would interpret an 81 percent favorable rating by those aged 19 to 64, compared to 85 percent favorable among those aged 65 or more, as showing that **private health plans would actually be rated by consumers far higher than Medicare if available to each age group**. After all, both the experts and the elderly

agree that Medicare's benefit gaps are serious in comparison to private plans, so how could Medicare be more popular than private insurance if enrollees were given a chance to select better plans?

Guaranteed Benefits. The FEHBP and Medicare programs differ fundamentally in several ways, one of which is the difference between a "premium support" as opposed to "defined benefit" structure. One recent study argues that the Medicare approach is better because the benefits are "entitlements" that are "protected" because defined in law (Caplan 2000). This line of argument is fundamentally flawed in three ways.

First, statutorily defined benefits can be taken away whether or not defined as legal entitlements. The Medicare deductible used to be defined by law at $50 but is now $100. The Congress once enacted prescription drug benefits and then repealed them. Indeed, the Congress amends the Medicare statute every year. As the program steadily progresses toward bankruptcy, maintenance of current benefit levels hardly seems assured. Relatedly, the FEHBP is just as much an "entitlement" as Medicare. It is simply handled a different way. **The FEHBP premium level is "protected" by being defined in law and the "entitlement" formula that defines the premium level provides a substantially better than Medicare level of insurance benefits**. The entitlement says, in essence, that the government pays 75 percent of the average cost of plans that enrollees voluntarily choose. Indeed, unlike Medicare the FEHBP statute has never been amended to reduce enrollee benefits.

Second, FEHBP benefits are superior to those of Medicare for decades. The "defined benefit" turns out to be no more than a guarantee for a second rate product, and the allegedly weaker "premium support" guarantee has proven a superior guarantor by actual experience.

Third, both premiums and benefits can be guaranteed in statute without using the "enumerate every benefit in excruciating micro-managed detail" approach used by Medicare. Enrollees can be guaranteed by law an actuarially reasonable value of benefits, both overall and in broad categories such as hospital or drugs. Within such a constraint(s), plans can make the decisions as to which deductibles (if any) to use, where to set deductible levels, where to set copayment and coinsurance levels, whether or not to tier benefits, which treatments to accept as medically proven, where to set the catastrophic guarantee level, etc. In fact, this is essentially the way that OPM operates the FEHBP. The FEHBP statute could be amended to make the actuarial fairness and soundness tests explicit guarantees better than those of Medicare, without changing the program in any way. **The "premium support" model used by the FEHBP has proven to be both better and safer as an entitlement than the "defined benefit" Medicare model**.

Consumer Understanding. It has often been alleged that consumers, particularly elderly consumers, cannot handle the complications of a competitive plan system (for an extensive discussion, see MedPAC 1999). While by definition choice certainly is more complicated than no choice, there is no evidence that consumer choice poses any more of a problem for health insurance than for any other product or service. The elderly choose their own doctors, their own automobiles, their own foods, and their own living arrangements. Any or all of these are as or more complicated than health insurance.

How many consumers of any age understand the innate workings of automobiles--the technology used in engine, transmission, braking, and other systems? Yet, somehow, through magazine ratings, recommendations of friends, test drives, modest government oversight and regulation, and above all the pressures of a competitive market place, the elderly are able to select and use cars that are effective, durable, safe, comfortable, and economical.

Competitive choice among health plans is certainly facilitated by careful oversight and information dissemination. OPM has proven to be effective in these matters, and the private market has provided additional information that consumers and those family and friends who advise them can use effectively. See the latest *CHECKBOOK's Guide to Health Insurance Plans* (Francis 2002a, at www.retireehealthplans.org), and the OPM Web site at http://www.opm.gov/insure/health for thorough and user friendly displays of information.

Confusion in choosing among competing products has simply not been a problem for the millions of Federal annuitants who, over the years, have benefited from their plan selection decisions. **Should Medicare be reformed into a pro-consumer choice system, assuring adequate information will not be difficult if the OPM approach is emulated, and the private sector encouraged to supplement government information**.

Adverse Selection. Some argue that any form of multiple plan choice will necessarily lead to destructive risk selection and unpredictable exit and entrance of plans--the dreaded "death spiral." I have criticized the FEHBP for having no system of any kind for managing risk selection (Francis 2002b). In contrast, Medicare ceaselessly searches for improved methods of fine-tuning its risk management features. Reform of the absurd AAPCC (Adjusted Average Per Capita Cost) system was delayed for a decade or more because no one could devise a perfect system. The long delayed reform failed again to correct the fundamental problem that managed health care still does not in fact cost half again more in Miami than in Des Moines, or in Prince Georges County than in Fairfax County.

There is even a respectable argument that some risk selection is desirable. For example, if people with dental problems tend to join plans with better dental benefits, willingly paying the full marginal cost of their decision, what ethical or managerial principle is violated?

The FEHBP has survived for four decades with no management of risk selection other than the stability inherently produced by its insurance subsidy. A recent study concluded that the program has almost no measurable adverse risk selection (Florence and Thorpe 2003). Whatever circumstances may lead to the "death spiral", they do not obtain in a plan choice program like the FEHBP.

The Medicare+Choice Experience. Some claim that because Medicare+Choice has had a rocky start, and failed to reduce overall Medicare costs, consumer choice has been tried and has failed. However, under the reimbursement formula used in that program, relying on the fundamentally flawed AAPCC estimates of geographic variability in health costs, and tied to the yo-yo of annual changes in Medicare spending levels, Medicare+Choice never had a chance to perform properly (Gold 2003). A well designed defined contribution program using rolling averages or all-plan averages and minimal geographic adjustments (if any) would have functioned far better. In addition, a set of draconian and unreasonable mandates made participation expensive and burdensome for any FFS or PPO plan, and for most HMOs. One regulatory mandate, for language interpreter services paid by each plan, is illegal in at least three different ways. Incredibly, despite these problems Medicare+Choice still manages to attract about 150 plans and some 5 million enrollees, about 1 in 8 Medicare clients.

A program that made it financially infeasible for HMOs in most of the Midwest to participate, and that has even forced Kaiser plans to withdraw, is a fundamentally flawed program. **The FEHBP shows far better ways than Medicare+Choice to implement effective plan choice**.

Cost Control. When I last examined cost control in detail (Francis 1993) I found, to my surprise, that the FEHBP had actually controlled costs slightly better than Medicare. I have updated my analysis and now conclude that the two programs roughly tie.

Each program has good years and bad years, and these do not correspond in any simple way. By careful selection of base year, it is easy to "prove" that one program outperforms the other. And depending on whether the comparison covers one, three, five, or ten years, the answer is very different. To get around these problems, I prefer to use the method of multiple rolling averages covering 10 years. This shows long term performance without the noise that affects shorter comparisons. One needs multiple ten year comparisons because the latest one can be (and usually is) unduly influenced by a particular good or bad base year in one program or the other. The table below shows my latest results, all taken from publicly available budgetary data covering 28 years (I have appended the raw data at the end of this testimony).

Ending in Fiscal Year	Medicare 10 Year Record	FEHBP 10 Year Record	Difference	Cumulative Difference
1985	15%	12%	-2%	-2%
1986	13%	8%	-5%	-7%
1987	12%	10%	-2%	-9%
1988	11%	11%	0%	-8%
1989	10%	11%	1%	-7%
1990	10%	11%	1%	-6%
1991	9%	10%	1%	-5%
1992	8%	11%	2%	-3%
1993	8%	10%	2%	-2%
1994	8%	8%	0%	-1%
1995	8%	9%	1%	0%
1996	8%	10%	3%	3%
1997	8%	7%	-1%	2%
1998	8%	6%	-1%	1%
1999	7%	6%	0%	0%
2000	6%	6%	0%	1%
2001	6%	5%	-1%	0%
2002	5%	5%	0%	0%
2003 est	5%	6%	1%	1%

What these data show is that in recent years both programs have had a 10 year average cost increase of around 5 or 6 percent a year, and that even over the full set of comparisons the programs have only differed by more than a percentage point a few times. The cumulative difference over comparisons covering 28 years of data is a1 percent advantage for Medicare. The best way to interpret this trivial difference is that Medicare has kept costs down better than FEHBP by so little (if at all) that even after 28 years there is no measurable difference in overall performance.

I stopped my analysis in FY 2003, because the budgetary projections for 2004 are unreliable for both programs. But we have recently learned from the Medicare actuary that there is an unexpected increase of 12% in Medicare Part B costs for 2004. Had I been able to obtain later estimates for both programs, the FEHBP would likely have outperformed Medicare in the cumulative comparison. **In**

summary, the FEHBP and Medicare programs have virtually identical records over time on keeping cost increases down.

It should not really be surprising that the records are similar, since both programs operate in the context of the American health care system, with the same underlying structure of hospitals, doctors, costs, technological changes, and a myriad of other commonalities.

However, viewed another way, there is a surprise. The Medicare Administrator, he operates a system of price controls. As the Congress has so amply demonstrated in its recent flip flop attempts to set physician, hospital, and Medicare+Choice reimbursements at the "right" levels, determined in large part by the decibel level of the political outcry, price controls can be set arbitrarily within a fairly broad range. Thus, Medicare could outperform the FEHBP in reducing premium costs through cutbacks in provider prices and income, through benefit reductions, and through other government-mandated reductions. Health care resources, both human and bricks and mortar, are not in the short run perfectly mobile. Thus, the Medicare budget is set ultimately by what the political system tolerates, not by the market or any objective method.

One recent study claims that "Medicare can be counted on to control per enrollee spending growth over time, more than private insurers can" (Boccuti and Moon 2003). This study relies on a comparison of Medicare and private insurance payment data derived from National Health Accounts data provided by the agency that administers Medicare. The data purport to show that since the mid-1980s Medicare has consistently outperformed the private sector in controlling spending on comparable services (e.g., excluding prescription drugs because these are not covered by Medicare). Unfortunately, the paper fails to explain its methods and does not display the underlying data and how they are derived, massaged, and interpreted. I am skeptical that the National Health Account data really allow for analysis of this kind. Regardless, the conclusion of the paper is wrong, at least insofar as it applies to managed competition like the FEHBP. My data on comparative performance of the FEHBP and Medicare programs over the last 28 years demonstrate that **well-designed health insurance programs such as the FEHBP that rely on competing private plans that respond to consumer choices can and do perform as well as Medicare in controlling costs.**

Conclusion. I have attempted to address each of the major areas in which fundamentally different approaches to health insurance programs can be compared. On each dimension of performance, the FEHBP is arguably at least equal, and usually superior, to Medicare as currently constructed. This doesn't lead to any simple conclusion as how best to reform Medicare. The issues are many and complicated.--And it certainly does not mean that the FEHBP program is perfect--it has many important problems (Francis 2002b).

But there is one fundamental issue that should be prominent in deciding among reform options and alternatives. The Medicare program is overwhelmingly statist. Medicare uses political fiat and centralized bureaucratic process to try and regulate an infinitely complicated trillion dollar health care market. Every decision that Medicare makes is necessarily a compromise that is wrong, often deeply wrong, for large numbers of enrollees and providers. Medicare is like a government designed automobile (actually, we have had two of these: the jeep and the Humvee). Designed by committee, changed too late, final details set by legislative or bureaucratic fiat, based on the principal that "one size fits all" and the corollary ethical proposition that every one should get an identical benefit because anything else is "unfair", Medicare lurches along like Dumbo the elephant (Cain 1999). And like the jeep and the Humvee, it fits very few as well as the plan (or auto) they would choose for themselves, if offered a choice.

In contrast, the FEHBP uses the mildest forms of government direction and oversight to allow the forces of choice and competition to determine health plan costs, benefits, provider choice, administrative convenience, and a host of details. For example, every single FEHBP plan covers health care anywhere in the world (HMOs offer care anywhere outside the plan area for emergencies). Why is this? Because very few consumers would voluntarily enroll in a plan that didn't offer this feature, even if they had no travel plans. If this feature cost a great deal, some plans would decline to offer it to their members, seeking to attract the "stay at home" group. The fact that hundreds of health plans do not act this way demonstrates that the extra costs of this feature are small. Why then does Medicare not offer this benefit? The answer surely lies in bureaucratic inertia and perceived cost. Cost might indeed be high for Medicare due to its inflexible methods of reimbursement--very few providers around the world would ever agree to regulation by the United States government, even such seemingly benign regulation as obtaining a provider number. But that just begs the question. Why should Medicare feel obliged to regulate foreign providers by Medicare methods? Which leads us back to bureaucratic inertia, though paralysis might be a better word.

I don't mean to dwell on coverage abroad, which is a far less important issue than prescription drug coverage and many others. But a program run on the bureaucratic model necessarily fails to deal optimally with many problems both large and small. Indeed, we all know that the chief impediment to a Medicare drug benefit is that the Medicare program is a price control program run along lines not seen elsewhere in most of the American economy since World War II. Price controls are anathema not only to the pharmaceutical industry, but also to all of us who expect that cures for Alzheimer's disease (and many others) are likely only from a profit-driven industry free to charge "high prices" without government control.

The choice before the Congress ultimately is between these two models--consumer choice or detailed legislative and bureaucratic control. By good fortune we have as an example the successful performance of the consumer choice model in meeting the health insurance needs of 9 million employees and retirees. Surely we can use that model to aid in reforming the Medicare program.

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DATA ON MEDICARE AND FEHBP COST CONTROL OVER TIME

5/2/2003

	Medicare Benefits Paid					FEHBP Benefits Paid				
Fiscal Year	Part A	Part B	Total Cost per enrollee	Annual increase	Ten Year Average	Obligations (M)	end of year enroll-ment(K)	Total Cost per enrollee	Annual increase	Ten Year Average
1975	$434	$161	$595			$1,753	3147	$557		
1976	*$512*	*$203*	$715	20%		$2,239	3226	$694	25%	
1977	$589	$245	$834	17%		$2,600	3297	$789	14%	
1978	*$680*	*$288*	$968	16%		$2,808	3393	$828	5%	
1979	*$772*	*$331*	$1,103	14%		$3,150	3491	$902	9%	
1980	$863	$374	$1,237	12%		$3,674	3598	$1,021	13%	
1981	*$1,008*	*$446*	$1,454	18%		$4,653	3684	$1,263	24%	
1982	*$1,153*	*$518*	$1,671	15%		$4,980	3729	$1,335	6%	
1983	*$1,297*	*$590*	$1,887	13%		$5,525	3641	$1,517	14%	
1984	*$1,442*	*$662*	$2,104	11%		$6,583	3689	$1,784	18%	
1985	$1,587	$734	$2,321	10%	15%	$6,482	3768	$1,720	-4%	12%
1986	$1,591	$831	$2,422	4%	13%	$5,723	3847	$1,488	-14%	8%
1987	$1,592	$969	$2,561	6%	12%	$7,714	3909	$1,973	33%	10%
1988	$1,630	$1,070	$2,700	5%	11%	$9,016	4010	$2,248	14%	11%
1989	$1,765	$1,158	$2,923	8%	10%	$10,169	4050	$2,511	12%	11%
1990	$1,970	$1,282	$3,252	11%	10%	$10,922	4041	$2,703	8%	11%
1991	$2,009	$1,381	$3,390	4%	9%	$12,657	4077	$3,104	15%	10%
1992	$2,315	$1,445	$3,760	11%	8%	$14,024	4074	$3,442	11%	11%
1993	$2,546	$1,524	$4,070	8%	8%	$14,546	4077	$3,568	4%	10%
1994	$2,783	$1,658	$4,441	9%	8%	$15,218	4096	$3,715	4%	8%
1995	$3,063	$1,788	$4,851	9%	8%	$15,515	4053	$3,828	3%	9%
1996	*$3,289*	*$1,867*	$5,156	6%	8%	$16,148	4159	$3,883	1%	10%
1997	*$3,569*	*$2,054*	$5,623	9%	8%	$16,557	4133	$4,006	3%	7%
1998	$3,493	$2,066	$5,559	-1%	8%	$17,161	4120	$4,165	4%	6%
1999	$3,328	$2,146	$5,474	-2%	7%	$18,654	4123	$4,524	9%	6%
2000	$3,190	$2,370	$5,560	2%	6%	$19,662	4084	$4,814	6%	6%
2001	$3,408	$2,652	$6,060	9%	6%	$21,143	4075	$5,188	8%	5%
2002	$3,588	$2,777	$6,365	5%	5%	$22,820	4046	$5,640	9%	5%
2003 est	$3,667	$3,024	$6,691	5%	5%	$26,461	4057	$6,522	16%	6%

Notes: FY 2004 estimates excluded because of recent announcement that Medicare costs will far exceed budget estimate.
FEHBP amounts do not equal annual premium announcements because of reserve payments and Open Season shifts.
Sources: FEHBP data from U.S. Budget Appendix since FY 1982 and, for earlier years, OPM annual Insurance Report.
Medicare data before FY 1999 from Green Book; from 1999 forward from HHS Budget in Brief. Some years interpolated (italics).

The CHAIRMAN. Now let us turn to Bob Moffit, Director of the Center for Health Policy Studies at The Heritage Foundation.

Bob, welcome to the committee.

STATEMENT OF ROBERT E. MOFFIT, DIRECTOR, CENTER FOR HEALTH POLICY STUDIES, THE HERITAGE FOUNDATION, WASHINGTON, DC

Mr. MOFFIT. Thank you very much, Mr. Chairman and Senator Stabenow.

I am the Director of the Health Policy Studies Center at The Heritage Foundation, but the testimony I give today is my own and does not represent the views of The Heritage Foundation or its officers or its trustees.

First of all, I want to say how deeply appreciative I am for the opportunity to appear before this committee and talk about this issue. Let me also say that for me, this is not merely an academic exercise. I was a Federal employee. I was involved in the Federal employee system. I was a deputy assistant secretary at the Department of Health and Human Services during the Reagan Administration, and I also served as an assistant director at the Office of Personnel Management, the agency that Abby Block represents today. I am very familiar with that agency and worked there for several years.

But it was not until 1992 that my colleagues at The Heritage Foundation persuaded me—"persuaded" is the appropriate word, I suppose—to write about the Federal Employees Health Benefits Program and its potential for policy guidance for broader health care reform, including reform of the Medicare Program.

The central policy question facing the Congress and the Nation is whether the Medicare Program as it is today can absorb the demographic shock of the baby boom generation and continue to deliver high-quality medical care in an economically efficient fashion. That is the real nature of this debate. I do not think that it can.

Having said that, that does not mean—I repeat, it does not mean—that we should rely on a private sector model of health care delivery, nor does it mean that we should rely upon the Medicare Choice experience for delivery of medical services.

The best serviceable model is in fact a public-private partnership, and that means both elements, both the public sector and the private sector working together. As Abby Block has said to the committee, the best serviceable model we have of this kind of public-private partnership is the Federal Employees Health Benefits Program. It is a program with which we have 43 years of experience. It is characterized by choice, patient choice, market competition, and very solid consumer information and satisfaction.

As Mr. Francis has pointed out, every Federal employee, whether they are retirees or active employees, whether they live in urban areas or rural areas, has a choice of at least 12 plans nationally. Most of these plans are fee-for-service plans and PPO plans. They are not HMOs. You can enroll in an HMO; if you want to enroll in an HMO, that is your choice. Thirty percent of all enrollees do so.

There is no reason why Congress could not establish a similar structure of national plan choice for future Medicare enrollees. I

would suggest two things in transition to a new Medicare Program, two areas where Congress could actually improve on the program more effectively.

First, it could integrate private retiree health insurance into the new system, creating a seamless continuity of coverage and care. If individuals have had a good experience all of their working lives with a private plan, and they want to carry that private plan into retirement with them as their primary coverage and keep the doctors and specialists they already have, they should be able to do so and get a government contribution to offset the cost of that plan.

Another recommendation I would make is that Congress could also make sure that new consumer-driven options similar to what Abby Block has mentioned in the FEHBP are also easily accessible to retirees who want them, including medical savings accounts, health reimbursement accounts, or other forms of health accounts. Right now, Mr. Chairman, there are 1.5 million Americans with such options, and there are prospects for significant growth in that market, and people should be able to take advantage of that in their retirement.

As Mr. Francis has pointed out, the FEHB provides a benefits package which is clearly superior to Medicare in every conceivable way. It has a reasonable record of administrative cost—one percent for OPM in administrative costs and roughly 7 percent for the carriers. It allows and encourages innovation in health care delivery. It provides a regulatory system that focuses primarily on consumer protection rather than provider regulation. Under its statutory authority, OPM is to contract with health plans that are licensed in the States, that guarantee basic benefits, that charge rates that are reasonably and equitably reflecting the costs and the benefits.

The FEHB model provides for a regulatory environment that is light and flexible and does not demoralize doctors or other medical professionals.

Under Section 8902 of Title V of the U.S. Code, OPM is authorized to prescribe "reasonable minimum standards" for health care benefits for plans and carriers. The FEHB regulatory system provides a level playing field for competing health care plans. The FEHB model also gives enrollees the ability to act on solid information in selecting plans as well as doctors, hospitals, and medical treatments.

I think that for the baby boomer generation in particular, this is critically important. In the 21st century, information technology will accelerate and become an instrument for increasingly sophisticated personal decisionmaking. Right now, about 70 percent of all Americans in the work force during their prime years from their twenties to their fifties use computers and have access to the internet. According to the Department of Commerce, Americans who use computers and the internet when they are younger are likely to continue to do so as they age.

There is no reason why 21st century retirees, particularly the baby boom generation, should not be able to take advantage of rapidly advancing information technology for periodic health care comparisons and even more detailed comparative information on quality, on service, on outcomes, on the availability of evidence-based medicine among providers.

Mr. Chairman, the other important point here is that the FEHB model provides for a financially stable program. The FEHB trust fund is unified. Its administration is comparatively simple. The premium income and disbursements in the trust fund are easily tracked; the fund's income is routinely subjected to congressional action and oversight. If for any reason there is a need for a supplemental appropriation for the FEHB trust fund, Congress can and does provide it. In this respect, the FEHB trust fund model is superior as a mechanism for monitoring the solvency and ensuring the financial stability of a modernized Medicare system.

Mr. Chairman, that concludes my remark. My only point is that we have 43 years of experience with this program—43 years of experience. We know its strengths, we know its weaknesses, we know where it can be improved, and we know how to make it better. The important point is that with this record of success, we have a tremendous opportunity to build a superior health care system for the retirees now and in the future, particularly the baby boom generation that is going to retire in just 8 years.

Thank you.

[The prepared statement of Mr. Moffit follows:]

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Congressional Testimony

TESTIMONY BEFORE THE
SENATE SPECIAL COMMITTEE ON AGING
TESTIMONY

A ROAD MAP TO MEDICARE REFORM: BUILDING ON THE EXPERIENCE OF THE FEHBP

May 6, 2003

Robert E. Moffit, Ph.D.
Director, Center for Health Policy Studies
The Heritage Foundation

Mr. Chairman and Members of the Committee:

My name is Robert E. Moffit. I am the Director of the Center for Health Policy Studies at The Heritage Foundation. In that capacity, I supervise a staff of analysts who examine federal and state health care policies and programs, as well as developments in the private health insurance markets. The testimony I give today is my own and does not necessarily represent the views or opinions of the Heritage Foundation, its officers, or its trustees.

I deeply appreciate your invitation to appear and discuss Medicare reform and the lessons we can learn from the experiences of the Federal Employees Health Benefits Program (FEHBP), the largest group health insurance program in the world. In this connection, neither Medicare nor the FEHBP is for me simply a matter of academic interest. As a former federal employee, I served as Deputy Assistant Secretary for Legislation at the U.S. Department of Health and Human Services (HHS) during the Reagan Administration and also as an Assistant Director for the U.S. Office of Personnel Management (OPM), which has administrative responsibilities for the FEHBP. It was not until 1992, however, that my colleagues at The Heritage Foundation persuaded me to publish on the FEHBP, focus on its unique features of consumer choice and market competition, and outline key lessons for a broader reform of the American health care system.[1]

THE FUTURE PROBLEM

Within eight years, the first wave of the 77 million baby-boom generation will start to retire and become eligible for Medicare. This generation's retirement will double Medicare's enrollment, dramatically increase Medicare spending and costs, and impose enormous financial pressures on the Medicare Hospitalization Trust Fund, the general revenue fund, taxpayers and Medicare beneficiaries alike.

More important, the retirement of the baby-boom generation will stimulate the greatest demand for medical services in history. This is not only because of the sheer size of the baby-boom generation and the volume of services that such a large retiree population will require, but also because of the rapid changes in medical technology, the fruits of advancing biomedical research, and the expected level of quality of care and service that this next generation of retirees will wish to consume.

Today's $271 billion Medicare program is a universal, defined benefit program, financed largely by today's taxpayers for today's retirees. This, given America's rapidly changing demographic profile, presents its own formidable financial challenges, as the Medicare trustees, the Congressional Budget Office, and the U.S. General Accounting Office have already described in significant detail to Congress and the public.

But there is an equally, if not more serious, challenge for the Congress, as well as for doctors, hospitals, nurses, and other medical professionals: How do we assure the cost-effective and efficient delivery of high-quality medical services to this very diverse and rapidly aging population? Under the current system of Medicare governance, medical

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

benefits, treatments, and medical procedures must be authorized by law or approved through the regulatory regime developed and enforced by the Centers for Medicare and Medicaid Services (CMS). In short, Medicare is governed by a system of detailed central planning.

Moreover, beyond the definition and determination of medical benefits, treatments, and procedures, and the conditions under which such services are to be delivered to Medicare patients, Congress and the CMS must price more than 7,000 medical procedures offered by more than 800,000 physicians and other medical professionals; more than 500 hospital procedures; and various medical devices and technologies, skilled nursing and home health care services. In short, Medicare is also governed by a massive system of price regulation.

The central policy question facing Congress and the Administration is whether Medicare, as it exists today, can absorb the demographic shock of the baby-boom generation and continue to deliver high-quality medical care in an economically efficient fashion. I do not think that it can.

Neither Congress nor the Administration can control the popular and growing demand for medical services. For example, in the area of prescription drugs alone, of the 11.8 percent increase in drug spending in 2002, 8 percentage points were attributable to the use of new drugs as well as the expanded use of existing pharmaceuticals for a variety of medical conditions.[2]

In the face of an unprecedented demand for modern medical services, there is no question that Congress can control the supply of medical services, and thus the cost of the program itself, simply through tighter controls on reimbursement to doctors, hospitals, and other medical professionals.

The proposition that the government can control the growth in Medicare spending through the imposition of price controls or caps on overall Medicare spending is an intellectually unimpressive one; of course, it can. But, likewise, there is no reason to believe that Congress can impose such controls and cap such spending and simultaneously accommodate the rising demand for those services without reducing their quantity or compromising their quality.

THE NEED FOR A SUPERIOR MODEL

If Medicare's current structure of central planning and price regulation is not the best model for Medicare's future, however, it does not logically follow that conventional private-sector health insurance is a better one.

In the private-sector health insurance market, individuals and families generally do not have portability or security in their coverage. Nor do they exercise control over the terms and conditions of their benefits. Employers, corporate benefits managers, or managed care executives often make all of the key decisions over the terms and conditions of coverage, and therefore can create obstacles to their access to physicians and medical

[2] "Rx Spending Growth Slows to Lowest Level in Six Years," Pharmaceutical Research and Manufacturers of America, Spring 2003.

specialists, treatments, and procedures. In most instances, individuals and families, whose coverage is tied to their jobs, cannot "fire" poorly performing health insurance companies in the same way they can dump poorly performing firms in many other areas of insurance coverage or in the provision of all other services in an open market.

A Public-Private Partnership. If the private-sector experience cannot yield the best model for a better Medicare program, that does not mean we cannot enter into a public-private partnership that can yield solid results for the next generation of senior citizens.

The best serviceable model of a public-private partnership is, in fact, a government program. It is the 43-year-old Federal Employees Health Benefits program (FEHBP), which serves 8.3 million federal employees, retirees, and their families, including more than 172,000 persons who rely on FEHBP as their primary coverage in retirement. Created by an Act of Congress in 1959, the FEHBP is governed under the provisions of Chapter 89 of Title V of the United States Code. It is administered by the United States Office of Personnel Management (OPM) and annually financed through congressional appropriations. Based on choice and competition, it is a government program older than Medicare, Medicaid, or most private managed care arrangements.

BUILDING ON THE FEHBP EXPERIENCE

Building on the FEHBP experience, Congress and the Administration can work together to create a new and improved Medicare program that is characterized by patient choice, including plan choice in rural areas, market competition, and solid consumer information. Other features of the FEHBP model include an openness to change, administrative flexibility, stability in the insurance market, and rationality and predictability in the financing of care. Specifically:

- **The FEHBP model guarantees enrollees, regardless of where the live, a broad range of health plan choices.** The professional literature, including recent surveys of Medicare beneficiaries, proves conclusively that choice of health plans is highly valued and that there is a direct relationship between the choice of a health plan and patient satisfaction.[3] Not surprisingly, in the FEHBP, enrollee satisfaction is higher than that found among enrollees in the health insurance industry as a whole.[4]

  In any transition to a new program, Medicare patients may wish to remain in conventional Medicare, but they should also have the right to pick and choose from a diversity of options, a variety of health plans, the benefits, the doctors and medical specialists, and the medical treatments they think are better for them at the prices they wish to pay.

  The FEHBP is an excellent model for designing a system based on broad personal choice. Every FEHBP enrollee, rural or urban, has a multiple choice of national

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[3]For an overview of the recent surveys and the professional literature, see Derek Hunter, "Just the Facts: Health Care Choice and Patient Satisfaction," Heritage Foundation *Web Memo* No. 259, April 17, 2003, at *http://www.heritage.org/Research/HealthCare/wm259.cfm.*

[4]*Ibid.*

health plans.[5] Today, there are 12 national health plan options, mostly fee for service or preferred provider organization (PPO) options, available to all enrollees nationwide. About 70 percent of all enrollees are enrolled in fee for service or PPO plans.[6]

The FEHBP rules governing the participation of health maintenance organizations (HMOs) are very different. HMOs participate at the state level, and the number of participating HMOs, which today cover roughly 30 percent of all FEHBP enrollees, varies from year to year.[7] There is no reason, of course, why a reform of Medicare could not establish a similar structure for national plan options, as well as geographically based HMOs, for future Medicare enrollees.

In assuring choice, and in restructuring the Medicare program, Congress can improve on the experience of the FEHBP in two key areas:

First, it could integrate private retiree health insurance into the new system, creating a seamless continuity of coverage and care. If individuals have had a good experience with a private plan in their active working life, and want to carry that plan with them into retirement as their primary coverage and keep the doctors and specialists that they already have, they should be able to do so and get a government contribution to offset the costs of that plan.

Second, Congress can make sure that the new consumer-driven options are also easily accessible to retirees who want them. Such options include medical savings accounts, flexible spending accounts, health reimbursement accounts, or other forms of health care accounts. In any case, retirees should be able to take accumulated funds from these accounts with them into retirement to use as payment for medical services. Right now there are 1.5 million Americans with such options,[8] and there are prospects for significant growth.

- **The FEHBP provides for a benefits package significantly superior to that of Medicare, beyond prescription drug coverage.** Beyond the broad range of health care choice, basic FEHBP coverage is typically of greater value than Medicare. According to a recent Congressional Research Service (CRS) analysis, when drug coverage, home health, and skilled nursing care are factored into the comparative equation, FEHBP has a total actuarial value that is 28.8 percent more generous than Medicare.[9]

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[5]For a discussion of coverage in rural as well as urban areas, see Nina Owcharenko, "Giving Rural Seniors a Choice of Health Plans: The FEHBP Model for Medicare Reform," Heritage Foundation *Web Memo* No. 258, April 17, 2003, at *http:// www.heritage.org/Research/HealthCare/wm258.cfm.*

[6]U.S. General Accounting Office, *Federal Employees' Health Plans: Premium Growth and OPM's Role in Negotiating Benefits*, Report to the Subcommittee on International Security, Proliferation and Federal Services, Committee on Governmental Affairs, U.S. Senate, GAO-03-236, December 2002, p. 6.

[7]*Ibid.*, p. 7.

[8]See Jon R. Gabel *et al.*, "Consumer Driven Health Plans: Are They More than Talk Now?" *Health Affairs* Web Exclusive, at *http://www.healthaffairs.org/WebExclusives/Gabel_Web_Excl_112002.htm.*

[9]Derek Hunter, "Just the Facts: The Disparity in Value Between FEHBP and Medicare Coverage," Heritage Foundation *Web Memo* No. 262, April 23, 2003, at *http://www.heritage.org/Research/HealthCare/wm262.cfm.*

Perhaps even more significant is the ability of FEHBP enrollees to secure value for money. Drug coverage in the FEHBP (all plans have such coverage) provides an excellent case study. According to analyses conducted by the General Accounting Office (GAO), health plans in the FEHBP typically contract with pharmacy benefit managers (PBMs). These PBMs offer "generally non-restrictive drug formularies across a broad range of drugs and therapeutic categories."[10] The GAO found that for 14 selected major brand-name drugs sold in retail pharmacies, enrollees were able to secure discount prices at about 18 percent below what cash-paying customers would otherwise have paid; for four selected generic drugs, the discount prices were 47 percent below prices paid by cash-paying customers.[11] For mail order prescription drug options, the GAO found that the performance was even more impressive.[12]

- **The FEHBP has a record of reasonable administrative costs.** With a relatively small staff, OPM incurs administrative costs that are 1 percent of the "aggregate cost of plan premiums, but generally are less than that amount." [13] The administrative costs of the major health insurance carriers, the national fee for service and PPO plans, average about 7 percent.

  Parenthetically, it is worth noting that Medicare's administrative costs are routinely assumed to be much lower, running between 1.5 percent and 2 percent annually. Technically, as a percentage of administration to benefits, this is correct. This widely held assumption, however, neglects the administrative costs that are routinely incurred by doctors and medical practices, hospitals and clinics, home health care and skilled nursing facilities in complying with Medicare's regulatory regime and paperwork requirements.

  A 2001 study conducted by PricewatershouseCoopers for the American Hospital Association reports that for every hour of care delivered to a Medicare patient in an American hospital, hospital officials typically spend at least a half-hour or more complying with Medicare paperwork. Doctors and other medical professionals bear similar costs in time, energy, and effort. Every dollar spent on complying with the increasingly onerous requirements of Medicare's growing regulatory regime is a dollar that is not spent on patient care. None of these very real costs, of course, show up in the Medicare budget.

- **The FEHBP –model allows and encourages innovation in the delivery of health care.** In a restructured Medicare program, there should be ample room for plans and providers to innovate and make changes in delivery of medical services, such as the

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[10]David M. Walker, Comptroller General of the United States, "Medicare: Observations on Program Sustainability and Strategies to Control Spending on Any Proposed Drug Benefit," testimony before the Committee on Ways and Means, U.S. House of Representatives, GAO-03-650T, April 9, 2003, p. 20.
[11]*Ibid.*, p. 19.
[12]*Ibid.*, p. 20. The GAO analysis revealed that for mail order prescription drug options in the FEHBP, the prices were 27 percent lower for the selected brand-name drugs and 53 percent lower for the selected generic drugs.
[13]"These sums pay the personnel costs of OPM actuaries and employees who negotiate with carriers, monitor plans, and generally oversee all aspects of program administration. OPM adds a charge to each plan's premium to cover these administrative costs." Carolyn L. Merck, *The Medicare Program and The Federal Employees Health Benefits Program: Purpose, Design and Operations*, May 26, 1999, p. 34.

inclusion of new benefit combinations or increasingly sophisticated coordination of care for persons who are chronically ill. Medicare patients should also be able to take advantage of the latest in cutting edge technology or medical treatments without waiting literally for years for a central agency to make decisions about coverage, or about coding for procedures, or payments for these procedures or technologies.

In this respect, also, the FEHBP provides a solid working model. The program is not, strictly speaking, a pure defined contribution system; nor is it a pure defined benefit system. It is, in effect, a combination of both. While the law defines *categories* of benefits, such as hospitalization or physician services, that must be included in any plan wishing to participate in the FEHBP, the specific medical benefits, treatments, or procedures, including the kind of medical technologies that are available, are largely determined by the health plans themselves and subject to the satisfaction of consumer demand in a competitive market. In other words, the FEHBP provides a structure that accommodates and encourages innovation.

- **The FEHBP model provides a regulatory system that focuses on consumer protection rather than provider regulation.** Under its statutory authority, OPM is to contract with health plans that are licensed in the states; that are reinsured with other companies; that offer detailed statements of benefits with definitions of limitations and exclusions that OPM considers "necessary or desirable"; that charge rates that "reasonably and equitably" reflect the costs of the benefits; and that agree to provide benefits or services to persons entitled, as OPM determines, under the terms of its contract.

  OPM enforces fiscal solvency requirements and makes sure that plans can pay claims. The agency is authorized to levy a surcharge on plans of up to 3 percent of premiums to establish a contingency reserve fund for the payment of unforeseen claims.

  OPM is also solely responsible for the benefits available to federal employees and retirees. Under Section 8902 of Title 5, the terms of any contract between OPM and a competing plan pre-empt any state or local law governing health insurance or health plans.

  There is no reason why a new Medicare administrative agency could not perform the very same functions as OPM in a restructured Medicare program.

- **The FEHBP model provides for a stable health insurance market.** Adverse selection or risk segmentation is normally a concern with a system based on pluralistic, competing health plans with a variety of benefits packages and voluntary enrollment. The concern is that older and sicker enrollees will congregate in certain plans, drive up the cost of those plans, and drive younger and healthier enrollees out, further driving up costs and premiums with a resultant unraveling of the market.

  The FEHBP, however, offers a working model to alleviate this concern. Extensive research on the issue of adverse selection in the FEHBP shows that, in fact, the program is remarkably stable.[14] In the FEHBP, there is no risk-adjustment mechanism

[14]Curtis S. Florence and Kenneth E. Thorpe, "How Does the Employer Contribution for the Federal Employees Health Benefits Program Influence Plan Selection?" *Health Affairs*, Vol. 22, No.2 (Spring 2003), pp. 211-218.

to deal with the problem of adverse selection, yet it is characterized by features that should gravely aggravate problems of adverse selection: There is no standardized benefits package; premiums are governed by a crude form of community rating (older persons pay the same rates as younger ones); and all plans are required to enroll persons without regard to their health status.

Professor Kenneth Thorpe of Emory University found, however, that while more than half of regular active workers and older, Medicare-eligible workers are enrolled in low-cost health plans, the age distribution is roughly the same across all competing health plans in the FEHBP: low-cost, medium-cost, and high-cost plans. The research indicates that the generosity of the subsidy, a government contribution up to 75 percent of the cost of the health plan, is enough to encourage younger and healthier persons to pay extra for the attractive benefits in higher priced health plans.[15]

The FEHBP experience, therefore, has positive implications for Medicare reform, where proposed Medicare contribution formulas for competing health plans would likely be more generous than those in the FEHBP.

- **The FEHBP model provides for a regulatory environment that is light and flexible and that does not demoralize doctors and other medical professionals.** The FEHBP provides a solid working model of regulatory flexibility. Under Section 8902 of Title 5 of the U.S. Code, OPM "may prescribe reasonable minimum standards" for health benefits plans and for carriers. As the CRS observed in its comprehensive 1989 analysis of the FEHBP, the legislative language authorizing the FEHBP gave OPM "broad powers" to administer the FEHBP, and OPM has thus had "wide latitude to institute changes it felt were needed...."[16]

  Under Section 890.201 of the Code of Federal Regulations,[17] OPM has set forth rules to admit and negotiate with health plans that comply with the provisions of law. Under OPM rules, there are no mandatory government fee schedules or price controls and no flawed formulas governing reimbursement updates for the services of doctors, hospitals, or medical professionals.

  Medical professionals should not have to wrestle with literally tens of thousands of pages of incomprehensible rules, regulations, guidelines, and related paperwork governing virtually every aspect of their operations. They should also be paid on the basis of real market conditions, reflecting real consumer demand and provider supply, rather than the current system of administrative pricing which, because it often bears little or no relationship to existing real market conditions, often results in taxpayers and patients either overpaying or underpaying for medical services or benefits. In short, health plans and providers should be able to operate in a system governed by a small bureaucracy and minimal regulation. The FEHBP provides a model for designing such a system.

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[15] *Ibid.*

[16] *The Federal Employees Health Benefits Program: Possible Strategies for Reform*, A Report prepared by the Congressional Research Service for the Committee on Post Office and Civil Service, U.S. House of Representatives, 101st Cong., 1st Sess., Committee Print 101-5, May 24, 1989, p. 238.

[17] Code of Federal Regulations, Title 5, Volume 2, Parts 700 to 1199, revised as of January 1, 2001, pp. 410-412.

- **The FEHBP regulatory system is a model that provides a level playing field for competing health plans.** As noted, OPM rules focus primarily on consumer protection, but they also enforce a level playing field for private health plans. For example, all competing health plans have to accept enrollment of employees and retirees without discriminating against them on such grounds as age, race, sex, pre-existing physical or mental conditions, or health status. Health plans must also provide health benefits to enrollees "wherever they may be" and guarantee their right to renew coverage.

  Plans are also required to have a standard rate structure for individuals and family coverage and to maintain statistical records for the plan covering federal employees separate from their other insurance business. In order to insure their ability to pay claims, health plans must have "a special reserve fund" for operations and reinvest any fund income in the fund. Health plans must also provide for continued enrollment of persons during the contract period and ensure enrollment without a waiting period for covered persons.

- **The FEHBP model gives enrollees the ability to act on solid information in selecting plans, as well as doctors, hospitals, and medical treatments.** In the 21st century, information technology will accelerate and become a vehicle for increasingly sophisticated personal decision-making. As of September 2001, according to a U.S. Department of Commerce study, 143 million Americans, or more than half of the U.S. population, were using the Internet with a growth rate of roughly 2 million new Internet users per month.[18] About 70 percent of Americans in the workforce during their prime years, from their 20s into their 50s, use computers; and as the same study notes, Americans who used the computers when they were younger "will likely continue to do so as they age."[19]

  Already, 35 percent of Americans are going on-line to secure health information.[20] By the time the baby-boom generation starts to retire, information technology will almost certainly play an increasingly important role in decision-making among doctors and patients alike. They should have routine access to the best possible information from authoritative sources on plans, benefits, treatments, and procedures. Information on quality, price, and benefits should characterize plan choice for the next generation of Medicare patients, and that information should be provided not simply by health plans themselves, but also by various consumer and retiree organizations, union and employee organizations, and ethnic, fraternal, and even medical and religious organizations.

  Historically, enrollees in the FEHBP have had regular access to clear, comparative health information from both government and private-sector sources. OPM annually publishes a *Guide* to FEHBP plans. This is a simple, detailed, and plain-English comparison of health plans, rates, and benefits.

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[18]See *A Nation On-Line: How Americans Are Expanding Their Use of the Internet*, U.S. Department of Commerce, National Telecommunications and Information Information, Economics and Statistics Administration, February 2002, p. 1.
[19]*Ibid.*, p. 14.
[20]*Ibid.*, p. 2.

Prominent private-sector organizations publish comparative information on health plans. The National Association of Retired Federal Employees (NARFE) publishes *Federal Health Benefits and Open Season Guide*, which is oriented specifically to federal retirees and rates plans on benefit packages. The Washington Consumers Checkbook publishes *Checkbook's Guide to Health Insurance Plans for Federal Plans for Federal Employees*. Written in plain English, both of these guides provide excellent comparative information on price, benefits, and service. Beyond the published guides, FEHBP enrollees are now getting comparative information on the Internet. As a matter of policy, OPM is accelerating the provision of on-line information, particularly for retirees.

There is no reason why 21st century retirees, particularly the baby-boom generation, should not be able to take advantage of rapidly advancing information technology for periodic health plan comparisons, and even more detailed comparative information on quality, service, outcomes, and the availability of evidence-based medicine among providers.

- **The FEHBP model provides for a financially stable program.** The FEHBP trust fund is unified, and its administration is comparatively simple. Both the government contribution and all beneficiary premium payments are combined and deposited in the Federal Employee Health Benefits Trust Fund.

  For federal retirees, OPM administers their enrollment, provides for an automatic deduction of their portion of the premium from their monthly federal retirement checks, adds the applicable government contribution, and deposits that money in the FEHBP trust fund. Congress appropriates projected amounts for the FEHBP trust fund for federal retirees as part of the annual Treasury and Postal Appropriations process.

  While the FEHBP trust fund is administered by OPM, it is formally a part of the United States Treasury. The Secretary of the Treasury, in consultation with OPM, has the legal authority to invest the assets of the trust fund in federal government securities, and interest income from these government securities is also credited to the trust fund. During the contract year, payments to health insurance plans or carriers are made directly from the U.S. Treasury and charged to the FEHBP trust fund. OPM's administrative expenses are also charged to the FEHBP trust fund.

  Premium income and disbursements in the FEHBP trust fund are easily tracked. The fund's income is routinely subject to congressional action and oversight. If, for any reason, there is a need for a supplemental appropriation for the FEHBP trust fund, Congress can and does provide for it. In this respect, the FEHBP trust fund model is superior as a mechanism for monitoring the solvency and ensuring the financial stability of a modernized Medicare system.

CONCLUSION

The FEHBP is 43 years old. It is older than Medicare, Medicaid, and most private employment-based managed care arrangements. We know a great deal about it, both its strengths and its weaknesses. While the program is by no means perfect, there is little

doubt that it is a government program with a solid record of success. This success is evident in its ability over time to deliver high-quality health care within a pluralistic framework of consumer choice and market competition.

In designing a superior program for retirees, the challenge is to match the FEHBP in its performance. Specifically, the challenge is to match it in the breadth of choice available to enrollees, the flexibility of its administration, the ease with which benefits are added or modified, and the comparative absence of bureaucracy and red tape in its operations. In these areas, the FEHBP provides an excellent model for designing major improvements in the way in which we can finance and deliver medical benefits to America's senior citizens, particularly the first wave of the baby-boom generation set to retire in just eight years. Thank you.

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The CHAIRMAN. Bob, thank you very much for that testimony.

Now let us turn to some questions, and we will do 5-minute rounds. As I ask a question of one of you, if any of the others of you wish to join in and make comment to that question, please do so.

Ms. Block, let me first start with you. If Tom Scully were to walk into your office today and offer the current Medicare fee-for-service program for inclusion in FEHB, would it qualify?

Ms. BLOCK. I do not think it would for several reasons. For one thing, as I have pointed out and as the other members of the panel have pointed out, we have moved away from fee-for-service per se to a PPO type of arrangement, which is very different from traditional Medicare. With that arrangement, we are certainly able to offer a broader benefit package, obviously, including a prescription drug benefit, in all of our plans. So there would be a huge difference in terms of our floor benefit levels and what traditional Medicare offers.

There would be such differences as well in the way the plan is administered. We of course have nothing resembling the kind of administration that Medicare undergoes. It would not be a good fit, as far as I can see.

The CHAIRMAN. Largely because of the standard benefit features required?

Ms. BLOCK. Well, the benefit features are clearly a major difference between our program and Medicare, as has been pointed out, and it extends beyond just the prescription drug benefit, although that clearly is a key feature of all the FEHB plans that is missing from traditional Medicare. But the delivery system is also an issue. We are basically at this point in time PPO-based, we are network-based, and that makes a huge difference.

The networks when they started out in the early 1980's were primarily discount arrangements with providers. They have become so much more than that now, and we work very closely with the plans to ensure that they are more than just discount docs. There is a level of plan oversight; there is a level of provider education; there is a level of looking at and making sure that the providers in the network are current on medical practices, that they are using the best practices, that our customers are getting the right care at the right time. So there is a great deal more involved in running PPO networks today than just getting discounts from providers, and traditional Medicare just does not do that.

The CHAIRMAN. Mr. Francis, you are nodding your head.

Mr. FRANCIS. Yes, Senator, I agree 100 percent with what Abby said. If we could somehow wave a magic wand and make Medicare participate in the FEHB plan—and OPM would not approve it if they had a choice, because it would not meet their standards in many respects—and it were offered to Federal retirees as an option—you know, you can join Blue Cross Standard or you can join Medicare; pick one or the other—forget for the moment that the programs have some coordination, treating them as separate plans—no one would join it. It would rank last in our ratings of health plans for retirees.

The CHAIRMAN. So it would make the bottom of the list in your book.

Mr. FRANCIS. It would make the bottom of the list.

The CHAIRMAN. Mr. Moffit, any comment?

Mr. MOFFIT. Well, I think that on the basis of the facts, there is no debate. The FEHB system provides a superior quality of health care and delivery for retirees, and that is true. I do not think there is any question about it—including retirees who are no longer covered by Medicare. You have access to prescription drug coverage, you have access to coordinated care, you have access to catastrophic coverage. You do not have this kind of bizarre incentive system where you have very, very high deductibles to get into the hospital, but you have very, very low deductibles in Medicare Part B, which drive up health care costs. You do not have a situation where people have to go out and buy two sets of plans in order to make sure they cover gaps in coverage and pay two premiums. And you do not incur all the excessive administrative costs in that, and you do not have a situation where every, single major decision about the benefit, the treatment, or the procedure that you will get is subjected to a detailed regulatory intervention by the CMS. You do not have anything quite like that.

The CHAIRMAN. Then, maybe you have answered my follow-up question to you. OPM employs about 160 employees to manage the FEHB, compared to about 4,500 at CMS to regulate Medicare. Then, to what exactly do you attribute this very huge difference in employment?

Mr. MOFFIT. First of all, it is not just Medicare. CMS has awesome managerial responsibilities beyond Medicare.

The CHAIRMAN. Oh, yes.

Mr. MOFFIT. It has the Medicaid responsibility, it has the State Children's Health Insurance responsibility, it just has more than Medicare. But in fact my argument is that actually, CMS is in a managerial crisis largely because Congress has done two things. One, it has given CMS much too much to do, and second, Congress micromanages the Medicare Program in particular. The most recent reports that have been documented by the General Accounting Office and by independent analysts, both conservatives and liberals, indicate that the Medicare Program, no matter how you feel about it, is extremely micromanaged. This, however, imposes enormous costs on the health care system.

It is true that the administrative costs of the Medicare Program are between one and two percent, formally, but none of those administrative costs count the costs of doctors, hospitals, clinics, and home health care agencies complying with at least tens of thousands of pages of rules, regulations, guidelines, and regulatory paperwork. They have to do it.

Now, Senator Stabenow said she does not want to have all this bureaucracy. Senator, I agree with you—but if you are going to have a system where every benefit is carefully defined by the Congress and is going to be priced by the Congress, you are going to have to regulate that system. You are going to have to make sure that those prices are correct and that there is going to be monitoring of those prices to make sure that the doctors, all 800,000 of them, in the country are agreeing to charge those prices and are keeping within the regulatory guidelines.

It seems to me, with the kind of structure you have in Medicare, you cannot avoid a massive expansion of bureaucracy and red tape. But that expansion is costing the health care system. My point, Mr. Chairman, is that every dollar that goes into the compliance with this regulatory system on the part of doctors and hospitals and health clinics is a dollar that is lost to patient care in the system. We have to start to count that as well in terms of when we start talking about the additional costs of Medicare.

The CHAIRMAN. Thank you.

Let me turn to Senator Stabenow. Senator?

Senator STABENOW. Thank you, Mr. Chairman.

I would go back and again say that I believe there is much we can do in terms of the bureaucracy. There is much more micromanaging that happened even after 1997, with the changes that were made at that time, that I believe were very much micromanaging.

This has been very informative, and I appreciate the information that all of you have provided. When I look first at comparing Medicare and FEHBP, in the Federal system, the prescription drug benefit is available in every option; isn't that correct?

Ms. BLOCK. Yes.

Mr. FRANCIS. Yes.

Senator STABENOW. What has been at least put forward to date—and we have not yet put our mark on it in the Senate at this point—but what has been proposed by the administration is not that. They have said that if you stay in traditional Medicare, you would get a discount card, possibly some catastrophic help, but you would only get full comprehensive prescription drug benefit if you went into a private plan. So it is different than what you are suggesting, and I would certainly support more of a model of what you are saying, that regardless of the plan you pick, you receive comprehensive prescription drug coverage.

This goes back, though, to the experience that my mother had with Medicare+Choice that was not funded appropriately, and the private sector dropped Medicare. This goes back to what I believe is the larger question of are we trying to upgrade Medicare in quality because we want better health care, and we want prescription drug coverage, and we want it to be, as you all talked about, the best quality we can have, or are we trying to save dollars—because those are not necessarily the same thing.

Today in The New York Times in fact, there is a major article that talks about this very question and comparing private plans, the rates that are paid to doctors and hospitals and home health providers and so on to what is paid under Medicare, because we have taken the approach under Medicare of saving costs by just reducing provider reimbursements.

I would welcome anyone's information regarding cost, because I think this is important. We have been given at this point—I want to read you just a little bit from the article. There has been $400 billion set aside in the budget resolution for some proposal which in my mind does not begin, from the numbers that we are seeing, to do what you are talking about if you are really going to provide the same kind of care regardless of plan. But in The New York Times today, just to quote a paragraph, "The Medicare Payment Advisory Commission, a nonpartisan Federal advisory panel, re-

cently had a study done comparing fees paid by Medicare and private health plans. Zachary Deichman, the economist who did the study, collected data from 33 health plans of 31 million people. In an interview today, Mr. Deichman said he had found that private health plan fees are about 15 percent higher than Medicare fees"—and then they go on to show various categories. It is 26 percent higher for surgery fees in the private plans such as we have; radiology is 19 percent higher; other diagnostic services are 23 percent higher.

So as we look at these two issues—on the one hand, those saying that reform is about saving dollars versus reform is about improving quality and choice—how do you reconcile that?

Mr. FRANCIS. If I may comment, Senator Stabenow, that is a great question, and there was one point in my testimony that I forgot to cover that is very important. I updated a study for you, for this committee,that I had done a few years back comparing change in cost over time of the Medicare and FEHBP programs. It turns out that if you go back almost 30 years, the two programs have tied in cost containment. That is, the annual rate of growth measured in the way I detail in my testimony has been identical over time in the two programs. Yet on the one hand, we have a Medicare Program that pays providers less, that is micromanaged, that ceaselessly seeks—the Congress every year is forced to go through legislative contortions to come up with some dollar savings.

Your best efforts have barely tied the efforts of Abby Block and the system over which she presides, which painlessly obtains identical cost containment over time.

I will go beyond that. We have already talked about the benefits are better in FEHBP. They have improved over time. Medicare's have not.

So we have a program that has contained costs while improving benefits to a level that is far superior to Medicare.

Point No. 3—and this again picks up on something that Abby said—the managed care features in the plans in this program save lives. They are not just there to hold patients' hands. There are reasons why networks are set up, why certain kinds of reviews are undertaken.

For example, here is a benefit in this program that does not exist in Medicare—large-scale case management. If you have a serious problem that requires, either going into a nursing home or staying at home while you recover from open heart surgery—or go back into the hospital—and it is going to cost the plan tens of thousands of dollars, they can give you a benefit that is not even in their legal contract—for example, a home health care benefit to keep you out of the hospital—saving them money and saving you the trauma of that hospitalization.

The point is that Medicare could never pass the quality standards that the FEHBP plans pass, and OPM is working hard on improving those systems, working with the private accreditation bodies. I could go on and on, but let me just stop there—it controls costs better, provides better care, and provides better benefits.

Senator STABENOW. Just as a quick follow-up, are you suggesting, then, that it would cost no additional dollars in Medicare to have an average 15 percent increase in fees for providers and

increase—that it would not cost additional dollars under Medicare to get to this system?

Mr. FRANCIS. I cannot give you a guarantee. I would answer you in a slightly different way. The FEHBP uses a dynamic, competitive, market-driven, consumer-driven system over time, where consumers are always making choices—in open season, you face a choice of benefits, premium costs, out-of-pocket costs, quality of the network, is your physician in it, for example, and so on—and consumers make those choices. Only 5 or 10 percent switch every year. But that keeps the plans honest, if you will. It keeps immense pressure on the plans to keep costs down and quality up. And over time, there is no reason to think that that system could not outperform Medicare in cost containment.

Senator STABENOW. I would be happy, Mr. Chairman, to follow up further, but I would love to see some studies that compare people of all ages in all health conditions in one system right now that has better payouts in all areas to a system that is covering older people in the country and the disabled and compare both of those right now and say that somehow, for the current dollars going into Medicare and the current very low reimbursements to our providers, we could switch to that and it would not cost any more dollars. You are hired if we can do that.

The CHAIRMAN. Thank you.

Let me ask a couple more questions before we turn to our next panel.

I think that both you, Senator, and Mr. Francis, Mr. Moffit and Ms. Block—we have all touched on the same things in part here. While there is a cost component to this that we will debate, I do not want my seniors denied service, and yet they are being denied service by primary care providers today because they will not take them because they can no longer afford to take Medicare. In part, that is our fault; it is part of that micromanagement that we do around here. I cannot even believe that we sit here in Congress and debate the tiniest specifics of Medicare benefits, and services, but we do, and we have for 30 years. We add a few every year or we take away a few, and then we crunch down the costs by allocating a certain fixed amount of resources and expect all those services to comply into it.

What is unique—I think you have just said it, Mr. Francis—is that in this dynamic, the private sector has arrived at the same cost containment success that we have in Medicare, with its huge bureaucracy and a phenomenal layout of resource and less service as it relates to the total care package offered—and no options.

In designing flexibility and adding the component that I think both the Senator and I want, and that is prescription drugs, the question is how do you allow the market forces to deal with cost as it relates to innovation or additional services?

I am increasingly getting—as I suspect your office is—a bit of a panicked phone call on occasion from a senior who has just been told that his or her primary care physician is retiring, and now they are out shopping for one and cannot find one who will take new Medicare patients. We are getting that limiting factor, so I guess my question is as it relates to access through the private system versus access through Medicare and the denial of service. Is

there a growing disparity there, or are we simply getting physicians who will transfer costs over, if you will, to those who can afford to pay in relation to the less than comparable system that Medicare serves?

Can you react to that, any of you?

Mr. FRANCIS. One quick comment, and Abby might want to say more—I do not want to put her on the spot. I think that central to the FEHBP as it has evolved—this was not true 15 years ago, but it is true today—the fee-for-service plans basically have two sets of benefits—one for going to any doctor in the country—that is the traditional fee-for-service component—and one if you use preferred providers. You get a much better deal if you use preferred providers, and preferred provider panels are huge. We are not talking about little, teeny-weeny HMO groups; we are talking about 50 to 60 percent of physicians typically in these plans. But that is not 100 percent.

The difference is that if you go out of plan, out of the preferred panel, you will have to pay more. Your reimbursement share will be higher, and the physician may charge you a little more than he would have charged if you were preferred, although you do not see that on the preferred side.

So I do not want to claim that it is perfect for everybody—there is no guaranteed satisfaction of all problems in the world in any program. But because you have this double tier of benefits, for in and out of network, the plans are much more flexible and the choices that consumers face are much wider.

Mr. Chairman, and in that, you are arguing or at least believe that over time—we will go back to the New York Times article that I found fascinating this morning also—and it is a debate that we will get into; some will argue that we are going to get great cost savings benefits, that over time, it is a factor of competition that creates innovation within the system and has the potential for some cost containment—or, more than potential—it has proven to contain costs.

I think you mentioned the premium increase in the last year or two—and this program has been very high—you cannot look at one or two years. You have to look over long periods of time. My comparisons are sort of 10-year rolling averages, because the FEHBP had some very good years in the early nineties when Medicare was struggling with some very bad years. So if you were clever and you picked the right base year in a short period, you could prove almost anything. But if you are honest about it, over time, on average, this program saves money as well if not better than Medicare.

Senator STABENOW. Mr. Chairman, if I might.

The CHAIRMAN. Yes, Senator.

Senator STABENOW. Thank you.

First, let me go back and say that we do agree that these are different systems in the sense of one covering people of all ages, healthy people, sick people, and so on, and that with Medicare, it is older individuals by definition who are going to need more health care on average, have more health concerns, and the disabled. So they are different systems, and as we analyze this, we need to look at who the pool is that is being covered.

But I guess I would go back again and say that while I think private-public sector partnerships work, and I am very intrigued about doing this, the idea that somehow we could do this and bring everyone up to where government employees are without additional dollars I think is a rather naive or foolish kind of thought.

In the beginning—and I am not criticizing a panel member; I am saying as colleagues, as all of us—at this point, this has been argued as a way to save dollars, yet I would argue that if we increased the fees at least in Michigan by 15 percent for every health care provider, we would have no problem with access, whether it is up in the Upper Peninsula or in lower Michigan, if we increase fees—if we just went to the fees that are paid by Blue Cross, we would not have a problem right now.

So the problem has been that we have been cutting service, we have been cutting fees, and I am very much willing to look at different ways to gain cost savings and competition and the kinds of things—as long as we understand that in the end, this is a system that every plan has prescription drug coverage, it is a system that pays out more than so far we have been willing to do as a Congress.

The first step is to stop cutting if we want to stop losing access to care. That is the first step. Do not institute the next round of 15 percent cuts to home health; do not institute the next 5 percent cut to physicians; do not institute the next round for hospitals while we are figuring this out, if we care in fact about not losing access to care, which I know we all do.

So I would like, Mr. Chairman, to see us really analyze what we are talking about in terms of the dollars that are put aside versus what we are talking about here in the budget, and I feel very strongly that we have not decided that health care is important enough right now to really make sure that this works when we put a plan in place. I go back to Medicare+Choice, where there was an option put out there, not adequately funded, and it failed.

So we can put forward a structure, and if we are not willing to fund it, it does not matter what the structure is—it will fail. I hope that part of this is going to be a debate about how much we are willing to invest in health care for older Americans.

The CHAIRMAN. I thank you very much.

Yes, Ms. Block?

Ms. BLOCK. I would like to talk a little bit about the kinds of things that we can do very easily in the FEHB program that the Medicare Program as currently structured cannot do.

In the past several years, we have become very aware of programs that fall under the umbrella of what we call "care management"—and Walt mentioned earlier case management, which is one piece of care management; another important piece is disease management programs—because we started to believe that they had an enormous potential, first of all in keeping people with chronic illnesses healthy longer and also being able to avoid unnecessary costs that come about because people were not getting the right care for chronic diseases and so ended up with very costly hospitalizations, in the case of diabetics, amputations, blindness—consequences that can be avoided if people get the right care and

get it early enough and with enough continuity to ensure that they are under treatment and under appropriate treatment all the time.

We have worked very closely with our health plans. Blue Cross and Blue Shield and the Mail Handlers Plan which is underwritten by First Health have developed and are in the process of implementing and evaluating excellent care management programs that we think will have the dual benefit of keeping people healthier longer and also saving money, and that is one of the fiscal offsets that we can arrange by working in collaboration with our private health plans for the benefit of all.

So we do that very easily because we are so non-hierarchical. Our director, Kay James, has been extremely supportive of care management programs. We have talked about it in our call letter for the last couple of years. We just do that very easily. We look at it, we say this looks like a good idea, let us move in this direction, let us work with the plans, and let us see what we can implement. That is the kind of flexibility we have, and I think it is both beneficial to people, and there are also financial benefits.

The CHAIRMAN. Thank you.

Mr. FRANCIS. Just an amusing comment if I may, Mr. Chairman. When I was at HHS, one of my main functions was as regulatory review czar, and I did a study once that showed that it took what was HCFA, now CMS, on average 4 years to issue a regulation from the day that the idea was thought of until the final rules were set in place.

What Abby is talking about is night and day faster and more responsive and more workable than doing this kind of thing by regulation and trying to nail down every dot and cross every "t," and you get it wrong—end of speech.

The CHAIRMAN. We will let you have the last word on the panel, Mr. Moffit, and then we will move to our second panel. Go ahead.

Mr. MOFFIT. All right. I just want to say one thing. Our debate has been constantly in terms of the current demographic framework. The problem is not now. The problem is the future. The problem is 8 years from now. The important thing to understand is that 8 years from now, we are going to have an unprecedented demand for medical services unlike anything in human history or anything we have ever seen before.

The point here is—and that is why the structural issue is important—the only way that you can control cost in the current structure of Medicare is ultimately to reduce reimbursement—but reducing reimbursement ultimately means you are going to control costs by reducing the supply of services, the quality and the quantity of services. That is not an unintended consequence of price controls. That is an intended consequence of price controls—to make sure that we spend less in that sector of the economy. That has got to be understood.

The most important thing, and one argument that I hope myself and my colleagues here have made, is that within a structure that relies on a market, you can have fairly ruthless control of cost on the basis of an interaction of supply and demand, but in a system that is governed by price controls and central planning in effect, the only way you are ultimately going to control cost is to reduce the supply of services—and that is the problem.

Thank you.

The CHAIRMAN. That is a very important point in the whole issue of this debate, and we thank you very much for being with us this morning.

Now let us turn to our second panel, and if our colleague Senator Carper would wish to join us, we are pleased to have you with us. He is a back-bencher this morning—but rarely that.

The CHAIRMAN. Our second panel this morning will discuss a somewhat broader set of issues involving comparisons between Medicare and private insurance generally, looking at questions of comparative cost, the very issues that Senator Stabenow brought up a few minutes ago, quality, and value.

Marilyn Moon is a Senior Health Policy Fellow at The Urban Institute and a distinguished expert on Medicare and health care policy.

Joe Antos is currently a Scholar at the American Enterprise Institute but has had a long career in government work involving both CBO and the old HCFA.

Jeff Lemieux is a Senior Economist at The Progressive Policy Institute and was previously a senior staff member in the 1999 Presidential Medicare Commission and a CBO economist.

We look forward to your testimony, and I think your testimony follows well with the discussion just had with the last panel as it relates to costs and benefits as we deal with this important policy issue and debate.

So, Ms. Moon, if you would start, please proceed.

STATEMENT OF MARILYN MOON, SENIOR HEALTH POLICY FELLOW, THE URBAN INSTITUTE, WASHINGTON, DC

Ms. MOON. Thank you, Mr. Chairman.

It is my pleasure to be here today, and I appreciate the invitation.

I am going to be the skeptic on the panel today and argue essentially that private plans are not a magic bullet for Medicare, and that there are a lot of pros and cons that need to be assessed in analyzing whether or not we should rely on private plans and to what extent.

I do not think anyone any longer is saying there should be no participation of private plans, nor is anyone saying there should be no traditional Medicare—or at least I hope that is not the case. I think it is better to think about this issue in terms of the right balance between public and private shares.

But it is important to ask whether the benefits from greater participation of private plans be worth the additional problems and costs that could arise in some cases.

There are likely to be big negative impacts from a plan that relies extensively on private plans, particularly if it does damage to the traditional Medicare Program, in return for little positive reward. First of all, it is important, as Senator Stabenow did, to separate out the issue of the structure of the program from the benefits covered by the program. No one is going to argue that Medicare has a wonderful benefit package and therefore that we should stick with traditional Medicare because of its stunning benefit package. But adding additional benefits is not necessarily inherently some-

thing that can only be done in a private plan structure. In fact, people have estimated that it would cost in the range of $850 to $900 billion to add prescription drugs of the type that are available to Federal employees in a Medicare Program, and I believe that would be true whether we were talking about private plans or basic Medicare plans.

The simple fact of the matter is that drugs are expensive, seniors and persons with disabilities use extensive numbers of drugs, and if we make them more available to them, we will see costs go up over time.

I also argue in my testimony that Medicare rates of growth on a per capita basis are less than the private sector, and that claim has gotten me into some hot water. We agree that the data we use are not very good and we would like to have better data, but it simply does not exist. The additional dimensions that I have seen people add to tweak our study, are unconvincing. I still believe that our work indicates that Medicare does a little better than the private insurance sector over a long period of time. Over 30 years, on a cumulative basis, the difference amounts to about 19 percent.

Actually, looking at Mr. Francis' testimony, I think that he and I are actually pretty much on the same page. He argues that there is a 1-percentage point difference in Medicare over a long period of time, on an annual basis. That actually translates close to the 19 percent, because the 1 percentage point is on a basis of 5 percent versus 6 percent. That is a big difference over a very long period of time. I would like to have that compounding difference in the Medicare Program, for example, that you would get.

I think our study is consistent with the information today in The New York Times.

The other question I think is a relevant one to ask, and that is whether competition adds to this in terms of private plans competing, and that is an important issue and question. I will let others talk about the many advantages to competition, and I will mention just a couple of potential problems.

First is the issue of risk selection. This is a serious issue that needs to be taken into account. It cannot be simply said that there will be risk adjustments. Let us assume there will be a risk adjuster. Over 20 years of study and effort have gone into this, and we have not come very far as yet. Risk selection is going to be an issue, particularly to the extent to which benefits vary substantially. Younger, healthier folks will quite naturally be attracted to plans that have benefits that they like and not home health coverage, for example, which will appeal to a sicker population.

I do not see, again, very much advantage here from that perspective. In addition, the complexity that arises from competition is something that should not be understated. I would be happy to compare my experiences with choice and a PPO that pays essentially half of what Medicare pays my physician when I go to her. I will be better off when I go on to traditional Medicare from the PPO that I am in, Care First, and I would also be happy to discuss some of the other complexities and problems with that plan.

What we need to keep in place in Medicare is the universality and redistribution that occurs in the program that is an essential part of social insurance. The pooling of risks, also needs to be

maintained or a way found to adjust for the loss of risk pooling when relying on private plans. Finally, an important role for government in protecting the program over time also needs to be retained.

I would like to make two final comments. One is that the administrative costs of Medicare are often misunderstood and misinterpreted, because remember—Medicare is running an insurance program. If anything, it needs more dollars to run it well. Adding another layer of private plans will add to administrative costs.

I am all in favor of many changes in the traditional program, not the least of which would be coordination of care. But I see very little innovation in a lot of the private plans out there today to suggest they are already better than traditional Medicare.

The CHAIRMAN. Ms. Moon, thank you very much.

[The prepared statement of Ms. Moon follows:]

MEDICARE AND PRIVATE PLANS:

SEPARATING FACT FROM FICTION

Marilyn Moon

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The Urban Institute

Testimony for

The Senate Committee on Aging

May 6, 2003

The material presented in this testimony represents the opinions of the author and not of the Urban Institute, its officers or funders.

I am pleased to be here today to testify about the role that greater reliance competition among private plans to serve Medicare beneficiaries should play. I will argue that a number of issues need to be carefully weighed before moving in this direction. Market forces do not represent the magic bullet that will solve all of Medicare's problems. Rather, the issue is to what extent they can help at the margins. Difficult challenges arise in deciding how to reform Medicare to meet future demands that at aging population and rising health care costs inevitably will place on the system. Costs to society for the health care of older and disabled Americans will rise over time, both in dollars and as a share of our economy. This will put pressure both on financing issues and on other changes that will help the program move into the future.

Technological advances that raise the costs of care are the primary reason for higher costs over time, and this phenomenon is occurring system wide, not just in Medicare. Further, a beneficiary population that is growing now because of increased life expectancy and will be exacerbated in the future by the retirement of the baby boom raises issues well beyond any restructuring options.

Nonetheless, much of the debate on Medicare's future has focused on broad restructuring proposals. This restructuring would rely upon contracting with private insurance plans, which would compete for enrollees. Claims for savings from options that shift Medicare more to a system of private insurance usually rest on two basic arguments: first, it is commonly claimed that the private sector is more efficient than Medicare, and second, that competition among plans will generate more price sensitivity on the part of beneficiaries and plans alike. The federal government would subsidize a share of the costs of an average plan, leaving beneficiaries to pay

the remainder. More expensive plans would require beneficiaries to pay higher premiums. The goal of such an approach is to make both plans and beneficiaries sensitive to the costs of care, leading to greater efficiency.

It is most appropriate to think about reform in terms of a continuum of options that vary in their reliance on private insurance. Few advocate a fully private approach with little oversight; similarly, few advocate moving back to 1965 Medicare with its unfettered fee-for-service and absence of any private plan options. In between, however, are many possible options and variations. And although the differences may seem technical or obscure, many of these "details" matter a great deal in terms of how the program will change over time and how well beneficiaries will be protected.

A particularly crucial issue is how the traditional Medicare program is treated. Under the current Medicare + Choice arrangement, beneficiaries are automatically enrolled in traditional Medicare unless they choose to go into a private plan. Alternatively, traditional Medicare could become just one of many plans that beneficiaries choose among -- but likely paying a substantially higher premium if they choose to do so.

Restructuring could profoundly affect Medicare's future. In particular, the traditional Medicare program could be priced beyond the means of most beneficiaries, leaving only private plan options from which to choose. Further, if plans began to sort into two groups of higher cost and lower cost plans, beneficiaries would likely be segregated in plans on the basis of their ability to afford care. This would be quite different than today where at least the basic program treats all beneficiaries alike.

MEDICARE VS. THE PRIVATE SECTOR

Looking back over the period from 1970 to 2000, Medicare's cost-containment performance has been better than that of private insurance. Starting in the 1970s, Medicare and private insurance plans initially grew very much in tandem, showing few discernible differences (See Figure 1). By the 1980s, per capita spending had more than doubled in both sectors for comparable services. But Medicare became more cost-conscious than private health insurance in the 1980s, and cost containment efforts, particularly through hospital payment reforms, began to pay off. From about 1984 through 1988, Medicare's per capita costs grew much more slowly than those in the private sector. Thus, its base relative to the private sector contracted and a gap in the two growth lines shown in Figure 1 opened up.

This gap in overall growth in Medicare's favor stayed relatively constant until the mid 1990s when private insurers began to take seriously the rising costs of health insurance. At that time, growth in the cost of private insurance moderated in a fashion similar to Medicare's slower growth in the 1980s. Thus, it can be argued that the private sector was playing "catch up" to Medicare in achieving cost containment. Private insurance narrowed the difference with Medicare in the 1990s, but as of 2000, there was still a considerable way for the private sector to go before its cost growth would match Medicare's achievement of lower overall growth.

Criticism of the study that Cristina Boccuti and I recently completed that resulted in Figure 1 has focused on the crudeness of the data. To be sure, we would like to control for many additional factors, but by eliminating from the chart services such as prescription drugs that are more fully covered by the private sector than Medicare, we have controlled for some of the

changes in coverage over time. The data we used cannot be divided up to look at how out of pocket costs have changed over time, because it is not possible to distinguish, for example, the contributions made by Medicare, Medicaid and the private sector.

It should not be surprising that the *trends* in per capita rates over time are similar between Medicare and private sector spending, because all health care spending shares technological change and improvement as a major factor driving high rates of expenditure growth. To date, most of the cost savings generated by all payers of care has come from slowing growth in the prices paid for services and making only preliminary inroads in reducing the use of services or addressing the issue of technology.

Medicare has made some innovative strides towards affecting use of care, particularly through its emphasis on prospective payment, first in hospitals and now in skilled nursing facilities and home health care. Taking a different route, the private sector route relied on capitated managed care organizations (MCOs) to slow growth in use of services in the 1990s, but a strong backlash against MCOs attests to the problems they have had in addressing this issue.

WILL RELYING ON PRIVATE PLANS INHERENTLY LEAD TO SAVINGS FOR MEDICARE?

Some supporters of a private approach seem to assume that private plans inherently offer advantages that traditional Medicare cannot achieve. But there is no magic bullet to holding the line on the growth in health care spending. Per capita spending rises because of the growth in use of services, higher prices, or a combination of the two. Medicare's price clout is well known

and documented.

So what about use of services? Studies of managed care have concluded that most of them saved money by obtaining price discounts for services and not by changing the practice of health care. Reining in use of services represents a major challenge for private insurance as well as Medicare in the future, and it is not clear whether the public or private sector is better equipped to do this. The newest type of plans suggested as an improvement for Medicare beneficiaries, preferred provider organizations (PPOs), generally obtain their savings by paying very little for any patient who goes outside the network to get care. Thus, their strategy is often one of cost shifting onto beneficiaries. This may hold down PPO premiums, but from society's standpoint, does little to help with reducing health care costs.

Private insurers are interested in satisfying their own customers and generating profits for stockholders. When the financial incentives they face are very broad (such as receiving capitated payments), private insurers respond as good business entities should. They seek the easiest ways of holding down costs in the provision of services. This indeed is what competition is all about. Cream skimming of the market serves these goals very well: Medicare overpays, and plans can both make the healthier beneficiaries they enroll very satisfied while making good profits. The problem is that this response is not good for limiting overall costs to either the federal government or to society as a whole. Thus, care needs to be taken to use the market when we understand and approve of the direction that competition will take health care delivery.

In addition, private insurers will almost surely have higher administrative overhead costs than does Medicare. Insurers need to advertise and promote their plans. They would face a

smaller risk pool that may require them to make more conservative decisions regarding reserves and other protections against losses over time. These plans expect to return a profit to shareholders. All of these factors cumulate and work against private companies performing better than Medicare.

Finally, it is important to note that few private insurance companies escape problems of complexity and bureaucracy. Many patients, both young and old, find the requirements of their plans to obtain approval before getting some services, to determine which doctors and hospitals are in network and which are not, to understand the bills when they come due months later, and to use the appeals process to be cumbersome, complex and overly bureaucratic. Thus, problems with the complexity of our current health care system are by no means inherent only to government. So examining reform from the context of Medicare beneficiaries should consider whether more reliance on private plans will only complicate and confuse beneficiaries further. An assumption is often made that using private plans to provide services will ease the government's oversight burdens, but at what expense to beneficiaries?

USING COMPETITION TO GENERATE SAVINGS

Reform options such as the premium support approach seek savings not only by relying on private plans but also on competition among those plans. Often this includes allowing the premiums paid by beneficiaries to vary such that those choosing higher cost plans pay substantially higher premiums. The theory is that beneficiaries will become more price conscious and choose lower cost plans. This in turn will reward those private insurers able to

hold down costs. And there is some evidence from the federal employees system and the Calpers system in California that this has disciplined the insurance market to some degree in the 1990s. But the experiences in the last few years lend considerable doubt to that enthusiasm.

Studies that have focused on retirees, moreover, show much less sensitivity to price differences among older Americans. Older persons may be less willing to change doctors and learn new insurance rules in order to save a few dollars each month. Thus, what is not known is how well this will work for Medicare beneficiaries.

For example, for a premium support model to work, at least some beneficiaries must be willing to shift plans each year (and to change providers and learn new rules) in order to reward the more efficient plans. Without that shifting, savings will not occur. In addition, there is the question of how private insurers will respond. (If new enrollees go into such plans each year, some savings will be achieved, but these are the least costly beneficiaries, and may lead to further problems as discussed below.) Will they seek to improve service or instead focus on marketing and other techniques to attract a desirable, healthy patient base? It simply isn't known if the competition will really do what it is supposed to do. In fact, undesirable outcomes may be as common as desirable ones.

New approaches to the delivery of health care under Medicare may generate a whole new set of problems, including problems in areas where Medicare is now working well. For example, shifting across plans is not necessarily good for patients; it is not only disruptive, it can raise costs of care. Studies have shown that having one physician over a long period of time reduces costs of care. And if it is only the healthier beneficiaries who choose to switch plans, the sickest

and most vulnerable beneficiaries may end up being concentrated in plans that become increasingly expensive over time. The case of retirees left in the federal employees high-option Blue Cross plan and in a study of retirees in California suggest that even when plans become very expensive, beneficiaries may be fearful of switching and end up substantially disadvantaged.

Private plans should not be expected to meet larger social goals such as making sure that the sickest beneficiaries get high quality care if the financial incentives do not lead to such behavior. To the extent that such goals remain important, reforms in Medicare will have to incorporate additional protections to balance these concerns as described below.

WHAT IT IS CRUCIAL TO RETAIN FROM MEDICARE

The reason to "save" Medicare is to retain for future generations the qualities of the program that are valued by Americans and that have served them well over the past 37 years. This means that any reform proposal ought to be judged on principles that go well beyond the savings that they might generate for the federal government.

I stress three crucial principles that are integrally related to Medicare's role as a social insurance program:

- The universal nature of the program and its consequent redistributive function.
- The pooling of risks that Medicare has achieved to share the burdens across sick and healthy.
- The role of government in protecting the rights of beneficiaries--often referred to as its entitlement nature.

Although there are clearly other goals for and contributions of Medicare, these three are part of its essential core. Traditional Medicare, designed as a social insurance program, has done well in meeting these goals. What about options relying more on the private sector?

Universality and Redistribution

An essential characteristic of social insurance that Americans have long accepted is the sense that once the criterion for eligibility of contributing to the program has been met, that benefits will be available to all beneficiaries. One of Medicare's great strengths has been providing much improved access to health care. Before Medicare's passage, many elderly persons could not afford insurance, and others who could not obtain it were denied coverage as poor risks. That changed in 1966 and had a profound impact on the lives of millions of seniors. The desegregation of many hospitals occurred under Medicare's watch. And although there is substantial variation in the ability of beneficiaries to supplement Medicare's basic benefits, basic care is available to all who carry a Medicare card. Hospitals, physicians, and other providers largely accept the card without question.

Once on Medicare, enrollees no longer have to fear that illness or high medical expenses could lead to the loss of coverage--a problem that still happens too often in the private sector. This assurance is an extremely important benefit to many older Americans and persons with disabilities. Developing a major health problem is not grounds for losing the card; in fact, in the case of the disabled, it is grounds for coverage. This is vastly different than the philosophy of the private sector towards health coverage. Even though many private insurers are willing and able

to care for Medicare patients, the easiest way to stay in business as an insurer is to seek out the healthy and avoid the sick. And in a market system, once that becomes the dominant approach, even insurers who would like to treat sicker patients are penalized by the market if they do so. This can clearly be seen in the poor performance of the individual health insurance market in meeting the needs of persons in their early 60s.

Will reforms that lead to a greater reliance on the market still retain the emphasis on equal access to care and plans? For example, differential premiums could undermine some of the redistributive nature of the program that assures even low-income beneficiaries access to high quality care and responsive providers. Support for a market approach that moves away from a "one-size-fits-all" approach is a prescription for risk selection problems.

The Pooling Of Risks

One of Medicare's important features is the achievement of a pooling of risks among the healthy and sick covered by the program. Even among the oldest of beneficiaries, there is a broad continuum across individuals' needs for care. Although some of this distribution is totally unpredictable (because even people who have historically had few health problems can be stricken with catastrophic health expenses), a large portion of seniors and disabled persons have chronic problems known to be costly to treat. If these individuals can be identified and segregated, the costs of their care can expand beyond the ability of even well-off individuals to pay over time.

A major impetus for Medicare was the need to protect the most vulnerable. That's why

the program focused exclusively on the old in 1965 and then added the disabled in 1972. About one in every three Medicare beneficiaries has severe mental or physical health problems. In contrast, the healthy and relatively well-off (with incomes over $32,000 per year for singles and $40,000 per year for couples) make up less than 10 percent of the Medicare population. Consequently, anything that puts the sickest at greater risk relative to the healthy is out of sync with this basic tenet of Medicare. A key test of any reform should be who it best serves.

If the advantages of one large risk pool (such as the traditional Medicare program) are eliminated, other means will have to be found to make sure that insurers cannot find ways to serve only the healthy population. Although this very difficult challenge has been studied extensively; as yet no satisfactory risk adjustor has been developed. What has been developed to a finer degree, however, are marketing tools and mechanisms to select risks. High-quality plans that attract people with extensive health care needs are likely to be more expensive than plans that focus on serving the relatively healthy. If risk adjustors are never powerful enough to eliminate these distinctions and level the playing field, then those with health problems, who also disproportionately have lower incomes, would have to pay the highest prices under many reform schemes.

The Role of Government

Related to the two above principles is the role that government has played in protecting beneficiaries. In traditional Medicare, this has meant having rules that apply consistently to individuals and assure that everyone in the program access to care. It has sometimes fallen short

in terms of the variations that occur around the country in benefits, in part because of interpretation of coverage decisions but also because of differences in the practice of medicine. For example, rates of hospitalization, frequency of operations such as hysterectomies, and access to new tests and procedures vary widely by residence, race and other characteristics. But in general, Medicare has to meet substantial standards and accountability that protect its beneficiaries.

If the day-to-day provision of care is left to the oversight of private insurers, what will be the impact on beneficiaries? It is not clear whether the government will be able to provide sufficient oversight to protect beneficiaries and assure them of access to high-quality care. If an independent board -- which is part of many restructuring proposals -- is established to negotiate with plans and oversee their performance, to whom will it be accountable? Further, what provisions will be in place to step in when plans fail to meet requirements or who leave an area abruptly? What recourse will patients have when they are denied care? The need for this oversight will likely add to administrative costs; if not, beneficiaries will suffer.

ASSESSING THE PROMISED ADVANTAGES OF PRIVATE SECTOR APPROACHES

A number of advantages in addition to holding the line on costs are also often put forth to generate support for this type of approach. A private approach has the potential to reduce the role in government of "micromanaging" health care, often expressed as no more price fixing by government and greater flexibility for innovation and change in coverage of benefits. But even more frequently, this approach is emphasized as a means for moving away from a "one size fits

all" approach to insurance. In practice, however, some of these claims are likely to interfere with the functioning of effective competition aimed at holding down the costs of care. Tradeoffs will undoubtedly need to be made.

Choice

While choice and avoidance of uniformity is an appealing promise, it is important to examine exactly what that means. Many people have made the point that most beneficiaries want choice of providers of care—doctors and hospitals. They care much less about whether it is Aetna or Cigna that provides the insurance. (Actually, that may turn out to be quite short-sighted if plans vary in terms of the details of operations, such as how much they will pay for services when someone goes out of network. But those considerations are hard to build into a choice model since even aggressive consumers find it difficult to obtain such information.)

But the appeal for choice of plan is usually made on the argument that people will be able to get only the coverage they want and need, even if they have to pay a little more. The difficulty is that without standardization of the most important benefits, such choice will lead to risk selection. Young healthy 65 year olds will pass on home health coverage, for example, in exchange for other benefits or a lower premium. But until risk adjusters get much better (if ever), standardization is important. Moreover, to get plans to compete on price, consumers must be able to compare plans—another strong argument for standardization. It is not possible to realistically expect both variation in options and health competition.

Flexibility, Innovation and Oversight

One of the advantages touted for private plans is their ability to be flexible and even arbitrary in making decisions. This allows private insurers to respond more quickly than a large government program can and to intervene where insurers believe too much care is being delivered. But what looks like cost-effectiveness activities from an insurer's perspective may be seen by a beneficiary as the loss of potentially essential care. Which is more alarming: too much care or care denied that cannot be corrected later? Some of the "inefficiencies" in the health care system may be viewed as a reasonable response to uncertainty when the costs of doing too little can be very high indeed. This arbitrariness also means that providers can be dropped from a plan with little notice, potentially adding to disruptions for beneficiaries.

The need for strong government oversight will not go away under a private plan approach unless there are to be few beneficiary protections. Many insurers do not have a good track record in this area, for example. Patient problems and complaints under the Medicare+Choice option underscore the need to offer appeals rights, oversight and sometimes direct intervention in order to protect beneficiaries. For example, at present when plans are found to be inappropriately denying care to beneficiaries, the corrections are done on a case-by-case basis even after the same plan in the same area has been told multiple times to cover a particular service. If private plans are to be even more widespread, this will require a great deal of attention and effort.

Considerable investment in information and education would be needed—spending that goes well beyond what Congress has been willing to commit thus far. Information about plans should not be left solely to the responsibility of the plans themselves.

Unfortunately, there are too few examples of truly innovative new techniques, organizational strategies or other contributions from private plan competition. Many managed care plans, for example, have relied on price discounts and do not even have the data and administrative mechanisms to attempt any care coordination. And preferred provider organizations—the newest private form to be hailed as an improvement—rely not only on price discounts but on passing off very high costs to beneficiaries who choose to go out of network for their care. Here the misconception is that you can see any care provider you wish. That's true for those with substantial resources but not for the vast majority of Medicare beneficiaries who have only modest incomes.

If innovation is a major reason for relying on private plans, it may make most sense to provide incentives for plans to specialize and take on those with high risks or particular conditions. This is where innovation is needed and where care coordination potentially offers the greatest payoffs.

Avoiding Price Setting

Moving away from traditional Medicare will not eliminate the issue of administered prices in health care. There is no free market where doctors and plans negotiate openly on rates. In fact, many private plans use at least some aspect of Medicare payment systems in setting their rates. In a world of many private insurers, the likely result is hundreds of administered prices being set for each service by each plan.

In an industry like health care where there are many examples of "market failure"

(because of concentrated power, lack of good information and knowledge, product differentiation), the workings of supply and demand can lead to perverse results. For example, competing hospitals in a given area result in over-capacity as each hospital tries to have all the latest equipment to attract doctors and patients. As already mentioned, plans will tend to compete to attract healthy patients rather than to develop the best management and care coordination protocols. And yes, price setting is and will continue to be a part of the private insurance world as well as within Medicare.

CHANGES TO IMPROVE MEDICARE

Making changes to Medicare that can improve its viability both in terms of its costs and in how well it serves older and disabled beneficiaries should certainly be pursued. Further, it makes little sense to look for a solution that takes policy makers permanently out of Medicare's future. The flux and complexity of our healthcare system will necessitate continuing attention to this program. At present a number of areas in Medicare need attention.

What are the tradeoffs from increasingly relying on private plans to serve Medicare beneficiaries? The modest gains in lower costs that are likely to come from some increased competition and from the flexibility that the private sector enjoys could be more than offset by the loss of social insurance protection. The effort necessary to create in a private plan environment all the protections needed to compensate for moving away from traditional Medicare will be very challenging and cannot promise success. For example, even after six years, many of the provisions in the Balanced Budget Act of 1997 that would be essential in any

further moves to emphasize private insurance--generating new ways of paying private plans, improving risk adjustment, and developing information for beneficiaries, for example--still need a lot of work.

In addition, it is not clear that there is a full appreciation by policymakers or the public at large of all the consequences of a competitive market. Choice among competing plans and the discipline that such competition can bring to prices and innovation are often stressed as potential advantages of relying on private plans for serving the Medicare population. But if there is to be choice and competition, some plans will not do well in a particular market, and as a result they will leave. In fact, if no plans ever left, that would likely be a sign that competition was not working well. But plan withdrawals will result in disruptions and complaints by beneficiaries--much like those that have occurred with the withdrawals from Medicare+Choice. Beneficiaries must then find another private plan or return to traditional Medicare. They may have to choose new doctors and learn new rules. This situation has led to politically charged discussions about payment levels in the program even though that is only one of many factors that may cause plans to withdraw. Thus, not only will beneficiaries be unhappy, but there may be strong political pressure to keep federal payments higher than a well functioning market would require.

What I would prefer to see instead is emphasis on improvements in *both* the private plan options and the traditional Medicare program, basically retaining the current structure in which traditional Medicare is the primary option. Rather than focusing on restructuring Medicare to emphasize private insurance, I would place the emphasis on innovations necessary for improvements in health care delivery regardless of setting.

Critics of Medicare rightly point out that the inadequacy of its benefit package has led to the development of a variety of supplemental insurance arrangements which in turn create an inefficient system in which most beneficiaries rely on two sources of insurance to meet their needs. It is sometimes argued that improvements in coverage can only occur in combination with structural reform. And some advocates of a private approach to insurance go further, suggesting that the structural reform itself will naturally produce such benefit improvements. This implicitly holds the debate on improved benefits hostage to accepting other unrelated changes. That logic actually should run in the other direction. It is not reasonable to expect any number of other changes to work without first offering a more comprehensive benefit package for Medicare. In that way, payments made to private plans can improve, allowing them to better coordinate care. And the fee for service system will also be able to change in ways that might encourage better care delivery. For example, it is not reasonable to ask patients to participate in a program to reduce hypertension (which can save costs over the long run) without covering the prescription drugs that are likely to be an essential part of that effort. In addition, a better benefit package will also allow at least some beneficiaries to forego the purchase of inefficient private supplemental insurance. That itself should be a goal of reform.

In addition, better norms and standards of care are needed if we are to provide quality of care protections to all Americans. Investment in outcomes research, disease management and other techniques that could lead to improvements in treatment of patients will require a substantial public commitment. This cannot be done as well in a proprietary, for-profit environment where dissemination of new ways of coordinating care may not be shared.

Private plans can play an important role and may develop some innovations on their own, but in much the same way that we view basic research on medicine as requiring a public component, innovations in health delivery also need such support. Further, innovations in treatment and coordination of care should focus on those with substantial health problems -- exactly the population that many private plans seek to avoid. Some private plans might be willing to specialize in individuals with specific needs, but this is not going to happen if the environment is one emphasizing price competition and with barely adequate risk adjustors. Innovative plans would likely suffer in that environment. This is where I recommend work to enhance the effectiveness of private plans. Further, Finally, the default plan--where those who do not or cannot choose or who find a hostile environment in the world of competition--must, at least for the time being, be traditional Medicare. Thus, there needs to be a strong commitment to maintaining a traditional Medicare program while seeking to define the appropriate role for alternative options.

A good area to begin improvements in knowledge about the effectiveness of medical care would be with prescription drugs. Realistically, any prescription drug benefit will require efforts to hold down costs over time. Part of that effort needs to be based on evidence of the comparative effectiveness of various drugs, for example. Establishing rules for coverage of drugs should reflect good medical evidence and not just on which manufacturer offers the best discounts. Undertaking these studies and evaluations represents a public good and needs to be funded on that basis.

Within the fee-for-service environment, it would be helpful to energize both patients and

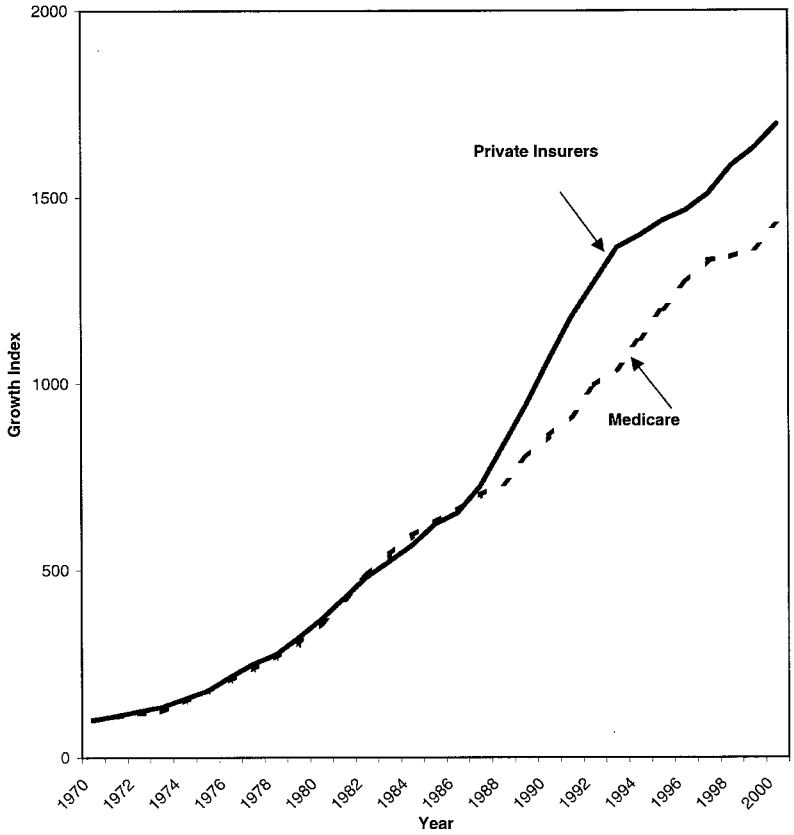
physicians in helping to coordinate care. Patients need information and support as well as incentives to become involved. Many caring physicians, who have often resented the low pay in fee for service and the lack of control in managed care, would likely welcome the ability to spend more time with their patients. One simple way to do this would be to give beneficiaries a certificate that spells out the care consultation benefits to which they are entitled and allow them to designate a physician who will provide those services. In that way, both the patient and the physician (who would get an additional payment for the annual or biannual services) would know what they are expected to provide and could likely reduce confusion and unnecessary duplication of services that go on in a fee for service environment. This change should be just one of many in seeking to improve care coordination.

Additional flexibility to CMS to manage and develop payment initiatives aimed at using competition where appropriate also could result in long term cost savings and serve patients well. In the areas of durable medical equipment and perhaps even some testing and laboratory services, contracting could be used to obtain favorable prices.

These are only a few examples of changes, none of which promise to be the magic bullet, but which could aid the Medicare program over time.

Figure 1

Cumulative Growth in Per Enrollee Payments for Comparable Services, Medicare and Private Insurers, 1970-2000*



* Includes hospital care, physician and clinical services, durable medical equipment, and other professional services. Does not include outpatient prescription drugs, home health, and skilled nursing facility services.
Source: C. Boccuti and M. Moon, "Comparing Medicare and Private Insurers: Growth Rates in Spending Over Three Decades," *Health Affairs* 22 (March/April 2003): 230-37. Analysis of National Health Expenditures data from CMS.

The CHAIRMAN. Now let us turn to Joe Antos, who is currently a scholar at the American Enterprise Institute.

Thank you, Joe.

STATEMENT OF JOSEPH R. ANTOS, WILSON H. TAYLOR SCHOLAR IN HEALTH CARE AND RETIREMENT POLICY, AMERICAN ENTERPRISE INSTITUTE, WASHINGTON, DC

Mr. ANTOS. Thank you, Mr. Chairman and members of the committee.

As I think the first panel pointed out quite well, the Medicare Program faces unprecedented challenges, challenges that simply cannot be avoided, and I think the first panel was correct in observing that the Federal Employees Health Benefits Program is a very, very capable program that is an excellent model for the Medicare Program.

However, as we know, people have raised concerns about whether competitive market reform would actually work in Medicare, and I want to address four of those concerns.

First, on the assertion that Medicare controls costs better than the private sector, it is true—I looked at Marilyn Moon's paper, and I am one of the people she was referring to, no doubt—it is true that, measured the way Marilyn measures it, Medicare's costs did grow somewhat less rapidly than private insurance.

However, let us keep in mind that over the last three decades, the nature of private coverage has changed dramatically. Private insurance has grown and now covers substantially more of the cost of services than it did in 1970. I am not talking now about adding benefits. I am talking about how much of your cost for a given service is covered by insurance.

So we need to be careful when we do our comparison shopping. Private insurance has become a bigger benefit in that sense, in that fair sense, and Medicare has not. It is not surprising that the larger product is more expensive. The big box of Rice Krispies in the supermarket costs you $3.69—I imagine; I have not been to the supermarket lately—while the regular-size box costs $2.99. The big box costs more, but the cost per ounce of cereal is lower if you buy the big box. For a fixed level of financial protection, private insurance costs may have grown less rapidly than Medicare.

You can look at other programs. You can look at the Federal Employees Health Benefits Program. You can look at the California Public Employees' Retirement System. The Medicare Payment Advisory Commission looked at those two programs, and what did they find? They found, according to their numbers, that FEHBP's costs grew slightly faster than Medicare's over the past 10 years; CalPERS' growth was somewhat lower than Medicare—again, no clear win for Medicare.

It is unreasonable to think that Medicare's administrative pricing could ultimately control spending better than a competitive market situation. Price controls have typically caused providers to find ways to deliver more services. We can talk about that more later. Tighter controls that also restrict the use of services could prevent that, but such restrictions would have adverse consequences for the health of beneficiaries, consequences that I do not think anybody would countenance.

The second criticism—Medicare beneficiaries would be forced to change doctors. It is not true under an FEHB-style reform, anyway. Beneficiaries in fee-for-service Medicare can select almost any provider in the country. They could have that same ability to choose providers under an FEHB-style reform through preferred provider organizations, for example, organizations that allow beneficiaries to go outside the panel of providers.

Of course, the Federal Employees Health Benefits Program offers a wide range of choices. You would expect the Medicare Program to do the same thing, including, I think, HMOs and the traditional fee-for-service plan for those who want to make those choices.

I think the argument is about giving people the option—not forcing them to do something that they do not want to do.

Now, it is true, as Marilyn says, that PPOs charge more if the beneficiary goes to an out-of-network provider. I am in Blue Cross Standard Option FEHB—I am still in the program—and that requires that I pay $15 for a standard office visit if I stay in network or 25 percent of the charge if I go out. That can add up to a lot of money if I got all of my health care out of network.

What should a Medicare beneficiary do about this situation? Well, that beneficiary would do what millions of Federal employees do every year—look in the book, look for the plans that include your doctors in the network.

Let us not forget that the flexibility that Medicare brings comes at a considerable cost. There are gaps in coverage, complicated and inequitable cost-sharing structures, and an exposure of beneficiaries to potentially unlimited financial risk. Nearly everyone wants different benefits than the traditional program offers. Nearly everyone buys some kind of supplemental coverage, and many pay a high price to do so. In the year 2000, for example, about 10 million people bought Medigap policies with a premium averaging $1,700.

My third point is Marilyn's point as well about risk selection. The concern is that private plans might not accept sicker beneficiaries. I think that is a concern. When we implement a choice-based system, we absolutely must be vigilant on this point. I share her concern.

It is comforting that the FEHB Program does not appear to have any significant risk selection problem. It is related to the design of that program; we could learn some lessons there.

The fourth criticism—competition cannot work in Medicare. As we all know, the experience with Medicare+Choice has been very sobering. Over the past 5 years, nearly 200 plans have dropped out of the program. Is that proof that competition cannot work? Well, it is proof that the plans cannot operate under Medicare+Choice, as Senator Stabenow pointed out. Plans will not be able to compete in Medicare unless we change the government's approach to managing the program.

Medicare+Choice did not break away from Medicare's history of top-down price-setting and complex regulations. The program is administratively inflexible; the payments were unrealistically low and did not reflect conditions in the local markets that you know about very well. It is not surprising that plans dropped out.

Let me conclude. Congress has an opportunity to help Medicare fulfill its promise to millions of seniors and people with disabilities. We can build on Medicare's successes, but we need not repeat its mistakes. The program must expand to cover prescription drugs, preventive benefits, and protection against uncapped medical costs. The program must be made financially sustainable if the taxpayers of today are to receive their Medicare benefits tomorrow.

I think the Federal Employees Health Benefits Program is a great place to start, but we cannot just stop there. We need to tailor it to the needs of the Medicare Program. I believe that all Medicare beneficiaries should be given solid drug benefits, but we should not make it a one-size-fits-all benefit. I believe that Medicare beneficiaries should have the choice to stay with the traditional program if they choose to do so.

There are certainly risks in attempting to reform a program as important as Medicare. But there are risks from failing to take the prudent actions necessary to make Medicare a better and more sustainable program. I think that effective competition can make a lasting and meaningful improvement in this essential public program.

Thank you.

The CHAIRMAN. Joe, thank you.

[The prepared statement of Mr. Antos follows:]

The Role of Market Competition in Strengthening Medicare

Joseph R. Antos, Ph.D.

Wilson H. Taylor Scholar

in Health Care and Retirement Policy

The American Enterprise Institute

Testimony Before

The Senate Special Committee on Aging

May 6, 2003

Mr. Chairman and Members of the Committee: Thank you for inviting me to appear before you. I am Joseph Antos, the Wilson H. Taylor Scholar in Health Care and Retirement Policy at the American Enterprise Institute. I am also adjunct professor in the School of Public Health at the University of North Carolina at Chapel Hill. I have previously served as the assistant director for health and human resources at the Congressional Budget Office, and earlier held several research and management positions in the Health Care Financing Administration, the precursor to the Centers for Medicare and Medicaid Services (CMS). The views I present today are my own, and do not represent the position of the institutions with which I am associated.

The Medicare program faces unprecedented challenges. Medicare's benefit structure is outmoded and inadequate, failing to cover outpatient prescription drugs or to provide adequate financial protection for millions of enrollees. Physicians, hospitals, and other providers have developed new and better ways to diagnose, treat, and cure diseases—causing Medicare spending per enrollee to grow rapidly. The impending retirement of 78 million baby-boomers, beginning in just 8 years, will rapidly escalate demands on Medicare's finances.

These challenges cannot be avoided. Steps must be taken to improve and strengthen Medicare so that it can meet the changing needs of seniors and the disabled, now and in the future. There is a model for such a reform in the Federal Employees Health Benefits Program (FEHBP), which has served the health insurance needs of federal workers, their dependents, and retirees for over 40 years.

Any proposal to modify a program as popular as Medicare raises concerns among policy experts and the general public. Much controversy has developed over the role private competition should play in reforming Medicare. Although the current and future problems of the program are widely acknowledged, there is concern that the cure might be worse than the disease. The following arguments have been raised against reform proposals that would enhance the role of private plans in Medicare:

- Private plans would be less successful than Medicare in controlling spending.
- Private plans would limit access to health care providers.
- Private plans would systematically exclude older, sicker Medicare beneficiaries.
- Private plans are unreliable and are likely to drop out of the program with little warning.

My testimony today will address these serious charges. It is essential that we craft a reform that assures a better Medicare program that is more responsive to the needs of beneficiaries, and that places the program on a sustainable financial footing for the long term. I will argue that private competition is an essential element in achieving those goals efficiently and equitably. But the way in which private competition is introduced matters greatly. A poorly designed reform proposal could make matters worse.

Does Medicare Control Costs Better than the Private Sector?

A recent analysis by Boccuti and Moon[1] argued that Medicare has been more successful than the private sector in constraining spending growth over the long term. They ascribe this success in part to the system of government price setting and regulation that has been the hallmark of the Medicare program. But a closer look at the evidence suggests that the private sector has performed as well or better than Medicare in constraining cost growth.

Between 1970 and 1999, private insurance spending grew 18 percent faster than Medicare spending. That figure accounts for differences in enrollment patterns and is restricted to comparable benefits, in this case hospital and physician services only (see the Appendix for details of the calculation).

But private insurance became more generous over that time period, covering a growing proportion of the total cost of health services. In 1970, private insurance paid for about 60 percent of the total private cost of hospital and physician services. By 1999, that had grown to 85 percent. This expansion in generosity is not the result of adding new types of benefits (such as a prescription drug benefit), since the analysis is confined to hospital and physician services. Instead, it reflects a shift away from out-of-pocket payments toward more first-dollar private insurance coverage—a shift promoted by federal tax preferences for employment-based insurance.

Accounting for the increasing generosity of private coverage appears to reverse the Boccuti/Moon conclusion. Although private insurance spending has risen faster than Medicare spending over the past thirty years, the unit cost of private coverage grew more slowly.[2] That suggests that Medicare does not have an advantage over the private sector in limiting the growth of health care spending.

This is like comparing two boxes of cereal in the supermarket. The large box is more expensive than the regular size. In other words, if you buy more cereal, it costs more. But the cost per ounce of cereal is lower with the large box.

We should be careful not to make too much of these calculations. It is difficult to make all the adjustments that would be necessary for a completely accurate comparison. In particular, adjustments should be made to reflect any changes in Medicare's generosity, parallel to the estimate for private insurance. That is not possible with the National Health Accounts data used here and in the earlier study. However, any error is not likely to be great since Medicare's benefit package has remained largely unchanged for decades.

Other comparisons confirm that Medicare does not have an advantage over the private sector in controlling spending. The Federal Employees Health Benefits Program and the California Public Employees' Retirement System (CalPERS) are large public programs that purchase health insurance on the private market. Over the past decade, FEHBP's average spending growth was slightly higher than Medicare's while CalPERS' spending growth was somewhat lower.[3]

Two glaring differences between Medicare and the other public programs should be noted. First, Medicare does not have a prescription drug benefit. Consequently, it did not have to deal with rapid spending increases in drug spending that occurred over the last few years. Second, Medicare has experienced serious disruptions in the delivery of care not shared by the other programs. Flawed government pricing formulas have helped drive HMOs from the Medicare program and threatened access to physician services in some markets.

Recent experience with physician payment reveals the difficulties of government price controls. (HMO payment issues are discussed in a later section.) In 2002, Medicare reduced physician fees by 5.4 percent following the congressionally-mandated "sustainable growth rate" formula. This unprecedented across-the-board reduction was intended to recoup excess spending for physician services that occurred in earlier years.

Reports from some parts of the country indicated that certain physicians were closing their practices to new Medicare beneficiaries. This did not show up as a decline in the overall participation rate of physicians, but it nonetheless was a disruption of service to some patients.

Ironically, the rate cut did not save money. Although some physicians were paring back their Medicare business, others reacted to the fee cut by increasing the volume of services paid by the program. Medicare physician payments increased by nearly $3 billion even though the average fee for each service was reduced. That was the result of an abnormally large increase in service volume—a 7.9 percent increase in 2002 compared to 3.5 percent increases in 2000 and 2001, when fees increased.[4] It would be difficult to argue that such a sharp increase in volume last year was justified solely on clinical grounds.

This illustrates a problem common to price setting methods in Medicare's fee-for-service system. If the administered price is reduced below the market price, providers find ways to make part of the reduction up by expanding services. Tighter controls that also restrict the use of services could prevent that, but such restrictions would have adverse consequences for the health of beneficiaries.

Would Medicare Beneficiaries Have to Change Doctors?

The fear of having to find a new doctor because of changes in Medicare policy is palpable. Medicare beneficiaries often develop close ties with their physicians, and there can be adverse health consequences if a patient shifts to another physician during the course of treatment. The traditional Medicare fee-for-service program places no direct limits on which providers a patient may see. This offers flexibility and an important sense of security to many beneficiaries, but it comes at a significant cost.

The structure of traditional Medicare reflects the insurance practices that existed in 1965 at the inception of the program. Medicare does not cover important services, including

outpatient prescription drugs and many preventive services. It imposes a confusing, inequitable, and inefficient cost-sharing structure on beneficiaries. And the program fails to provide financial protection for those with the highest health costs.

Most beneficiaries supplement their Medicare benefits to overcome many of those gaps. Such additional coverage is available through private Medigap insurance, employer-sponsored retiree plans, Medicaid, and Medicare managed care plans. About 91 percent of beneficiaries have supplemental coverage.[5]

The cost to beneficiaries of the traditional Medicare program depends to a large extent on whether they are eligible for or can afford to purchase supplemental coverage. The 4 million people who qualify for Medicaid benefits have relatively low out-of-pocket spending, roughly $750 in 2000.[6] About 10 million people buy Medigap policies, spending on average about $3,600 out-of-pocket in 2000. Supplemental insurance premiums accounted for about $1,700 of that total.

The conclusion is clear: Although traditional Medicare allows a wide choice of providers, nearly everyone is saying they want something different than what the government allows. The flexibility of the traditional program comes at an additional cost of thousands of dollars to millions of beneficiaries.

A reform modeled after FEHBP would offer beneficiaries a broad set of options, not just plans that restrict access to a specific panel of doctors. Health plans that rely on closed panels of providers and intrusive management of care have given way to more flexible plans that are the norm in the private market today. About 70 percent of workers with insurance from an employer are in preferred provider organizations (PPOs) or point-of-service plans (POSs), which allow beneficiaries to go to the provider of their choice.[7] Such options, as well as HMOs and the traditional fee-for-service plan, should be made available to Medicare beneficiaries. A beneficiary who wants to remain in the traditional program should be allowed to do so.

Should we give beneficiaries in traditional fee-for-service a prescription drug benefit that is similar to the benefit that would be offered by competing plans? Pharmaceuticals have become one of the essential tools of modern health care. If we did not add a drug benefit to traditional Medicare, we would not be able to take advantage of new therapeutic approaches and methods for controlling cost. Disease management programs, which manage the care of high-cost patients and promise both cost savings and better health outcomes, cannot function unless prescription drugs are part of the benefit. But health plans should be allowed to structure their benefits to foster efficiency, and they should be able to pass savings back to their enrollees (perhaps through lower premiums). A one-size-fits-all approach will not work.

A concern also has been raised that PPOs typically charge more when patients go out of network for treatment. The Blue Cross Standard Option in FEHBP, for example, requires an enrollee to pay $15 for a standard office visit to an in-network doctor or 25 percent of the charge for a doctor who is out of the network. Such differences in beneficiary cost sharing can amount to substantial sums for someone who chooses to receive most of her care out of the plan's

network. That places a responsibility on beneficiaries to make their plan choices carefully, assuring that they can stay within the network for most services and keep their out-of-pocket spending low.

Beneficiaries need good information to make sound choices. The Office of Personnel Management, which operates FEHBP, provides comparative information on health plans (including lists of preferred providers). Private groups also publish information to guide beneficiaries in selecting a plan.[8] A similar information strategy for a competitive Medicare reform would assure beneficiaries that the plan they chose included their personal physicians.

Would Private Plans Avoid Sicker Beneficiaries?

A market-based reform of Medicare would offer beneficiaries a choice of several competing health plans. Under premium support models, premiums would be partly subsidized. Beneficiaries would face higher premiums for more expensive plan options. Plans would have an incentive to keep premium costs down to remain competitive. They might accomplish that through improved efficiency. But they might also keep cost down by skimping on care and enrolling people with below-average health costs (the "good risks").[9] This is known as risk selection.

Medicare has dealt with risk selection primarily by improving the accuracy of payments to health plans. Methods have been developed to adjust federal payments to health plans based on the likely cost of providing services to enrollees. If plans received larger compensation for sicker people (whose expected health costs are above average), the plans would have a greater incentive to enroll them.

Medicare's current risk adjusters are based mostly on demographic factors (including the age, sex, and Medicaid status of the enrollee), with only limited information on the actual use of services. New methods have been developed that should be more effective in predicting differences in health spending among beneficiaries. CMS recently announced that it would begin to phase in a "selected significant condition" model in January. That new model is expected to make more accurate payments for the sickest patients, rewarding plans that can generate real cost savings through disease management. That could become an important tool under a more competitive Medicare program.

Risk selection is probably not a major problem for beneficiaries in the current Medicare program since most are enrolled in traditional fee-for-service. But how much of a problem would risk selection pose under a market-based reform? Evidence from FEHBP suggests that the problem could be negligible, depending on the design of Medicare's reform.

FEHBP provides a generous premium subsidy to enrollees, equal to 75 percent of the health plan's premium subject to a dollar cap. Payment risk adjusters are not used, and employees can freely choose among plans in their area during the annual open enrollment

season. One might expect to find substantial risk selection across plans under those circumstances, with higher-cost plans attracting an older and sicker group of enrollees. But a recent study by Florence and Thorpe[10] found very small differences in the average age of enrollees in low- and high-cost plans because FEHBP pays such a large portion of the premium.

The potential for risk selection in FEHBP (and other choice-based systems) is also limited by the inertia most people exhibit when given the opportunity to change health plans. Francis[11] found that many FEHBP enrollees who could save money by changing plans during open season fail to do so. Inertia in personal decision making helps to stabilize plan enrollment, reducing the chances that more generous plans would be driven out of the market by the cost of attracting sicker enrollees. But that also implies that beneficiaries would pay more than they would have if they were willing to change plans.

If most people don't change plans, how is a choice system supposed to work? Indeed, how do markets work if most consumers remain loyal to their favorite brands? A competitive market will generate pressures on plans to lower costs or improve their product so long as some consumers are prepared to shift to a competitor. The credible threat of a loss of market share—or the prospect of gaining market share—is sufficient incentive in a competitive market.

These arguments do not imply that we can be complacent about risk selection under a reformed Medicare program. Health markets are far from the competitive ideal, and the consequences of a poorly functioning choice system could be quite serious for an older population.

Beneficiaries and their families will need reliable user-friendly information about plan options. Techniques including improved payment risk adjusters will help, particularly in a program that provides large premium subsidies. The Medicare agency must be vigilant in its oversight, ready to take corrective action when necessary. But prudent oversight does not have to mean a large increase in administrative costs. The Office of Personnel Management (OPM) successfully manages FEHBP with a handful of staff and minimal regulatory requirements.

Would Private Plans Stay in the Program?

Recent experience with private health plans in Medicare+Choice has been sobering. In the mid- to late-1990s, Medicare HMOs were highly competitive with the traditional fee-for-service program, offering better benefits at a reasonable price. Congress created Medicare+Choice in 1997, intending to expand the number of private plan choices available to beneficiaries. Participation in Medicare+Choice peaked in 1998 at 346 plans, and that number has dropped ever since. This year only 153 contractors remain in the program.

Millions of Medicare beneficiaries have had to change health plans over the past five years as the Medicare+Choice program shrank. Although most beneficiaries affected by plan dropouts could turn to other managed care plans, and all beneficiaries could enroll in the traditional fee-for-service program, this kind of disruption could have adverse health

consequences for some people. These developments have been taken by some observers as evidence that competition cannot work in Medicare.

That's half right. Plans will not be able to compete in Medicare unless we also change the government's approach to managing the program. Medicare+Choice did not break away from Medicare's history of top-down price setting and complex regulations. Administrative inflexibility, unrealistically low payments, and an inability to adjust to changing market conditions were key factors leading to the decline of Medicare+Choice.

In broad terms, Medicare's experience with managed care parallels that of the private sector. After initial enthusiasm that HMOs would be able to control health costs, consumers and providers began to reject the constraints imposed by such plans. The goal of cost containment became less important in a booming economy and a tight labor market. Consumers shifted to less restrictive plan options, including PPOs and POSs. Providers demanded and got larger fee increases, driving premiums up.

Those changes were led by consumers, and the market responded by offering new options. Traditional managed care plans lost market share relative to the new plans, which offered a more attractive package of benefits, premiums, and cost containment practices.

In contrast, Medicare+Choice was locked into a set of requirements by the 1997 legislation and did not have the authority (or experience) to make changes necessary under the new circumstances. For example, most Medicare+Choice plans could expect only a 2 percent annual increase in federal payments even though their cost of providing care was growing at 10 percent a year or more. It is not surprising that plans left the program.

Medicare cannot be immunized from the pressures of the wider health care market. It can, however, become a smarter purchaser of health care, and it can become more responsive to the demands of its beneficiaries. Medicare should not be afraid to drive a hard bargain with health plans and expect them to provide excellent care. But Medicare must also be allowed to respond to changing circumstances before problems get out of hand that can result, as we have seen, in the exodus of plans from the program.

Elements of a successful Medicare choice program are contained in FEHBP. Rather than setting into law detailed pricing formulas and other requirements that often do not stand the test of time, OPM has broad discretion to negotiate rates and conditions of plan participation. It has the ability to accept new health plan options (other than new fee-for-service carriers) without new legislative authority, but it remains accountable to Congress. Such principles should be incorporated into a market-based reform of Medicare.

Conclusion

Congress has an opportunity to help Medicare fulfill its promise to millions of seniors and people

with disabilities. We can build on Medicare's successes, but we need not repeat its mistakes. The program must expand to cover prescription drugs, preventive benefits, and protection against uncapped medical costs. The program must be made financially sustainable if the taxpayers of today are to receive their Medicare benefits tomorrow.

The Federal Employees' Health Benefits Program is a good place to start. A Medicare reform modeled after FEHBP would provide both the incentive and the opportunity for seniors to choose health plans that best meet their needs. Beneficiaries would be able to select from competing plans, including a modernized fee-for-service Medicare that offers a sensible set of benefits. Such a reform would also create incentives for health care providers to produce high quality care at lower cost. Medicare would remain a government-run program under an FEHBP approach, assuring appropriate oversight and protection for the most vulnerable.

There are certainly risks in attempting to reform a program as important as Medicare. But there are also risks from failing to take the prudent actions necessary to make Medicare an effective and sustainable program. Adapting the FEHBP model to the specific circumstances facing the Medicare population can be a successful strategy for using effective competition to make lasting and meaningful improvements in an essential program.

Appendix

Data from the National Health Accounts confirm that private insurance spending grew more rapidly than Medicare spending over the past three decades, even when differences in enrollment and differences in the types of benefits covered by the different insurance programs are taken into account. Between 1970 and 1999, spending by private insurance for hospital and physician services grew 18.1 percent faster than comparable Medicare spending, both measured on a per-enrollee basis (see Chart 1).

But private insurance became more generous over that time period, covering a growing proportion of the total cost of health services (see Chart 2). In 1970, private insurance paid for about 60 percent of the total private cost of hospital and physician services. By 1999, that had grown to 85 percent. This expansion in generosity is not the result of adding new types of benefits (such as a prescription drug benefit), since the analysis is confined to hospital and physician services. Instead, it reflects a shift away from out-of-pocket payments toward more first-dollar insurance coverage in the employer market.

Accounting for the increasing generosity of private coverage, the unit cost of private coverage grew more slowly than Medicare (see Chart 3). The "unit" in this case refers to the percent of spending covered by insurance. An insurance policy that is more generous covers more of a person's total health spending, and thus has more "units" than a less generous policy.

We were unable to adjust Medicare spending for possible increases in that program's generosity because of data limitations of the National Health Accounts. However, we know that Medicare benefits did not appreciably increase over the three decades. Some preventive benefits were added, for example, but all the major health services have been covered by Medicare since its inception.

In an attempt to verify this observation, we examined other sources of information. Data on spending for all health services is available from the National Health Care Expenditures Study (NHCES) for 1977 and the Medical Expenditure Panel Survey (MEPS) for 1996. We calculated the percent of total spending paid by private insurance for people under age 65, and the corresponding percent of total spending paid by Medicare for people 65 and older. This estimate is not limited to hospital and physician spending, and is consequently not directly comparable to the earlier analyses.

The value of Medicare has not kept pace with private insurance (see Chart 4). For persons under age 65, the generosity of private health insurance grew by 41.5 percent between 1977 and 1996. For persons 65 and older, the generosity of Medicare grew by only 22.2 percent over the same period.

Comparisons using National Health Accounts data cannot prove the superiority of one model of cost containment over the other. Private insurance spending includes spending on behalf of Medicare beneficiaries, many of whom have private retiree policies or private Medigap

insurance that supplements their Medicare coverage. The spending data cannot account for differences in the age, health status, or other characteristics of the beneficiary population, which clearly affect the use of health services. The direction of any bias caused by inadequate data cannot be determined.

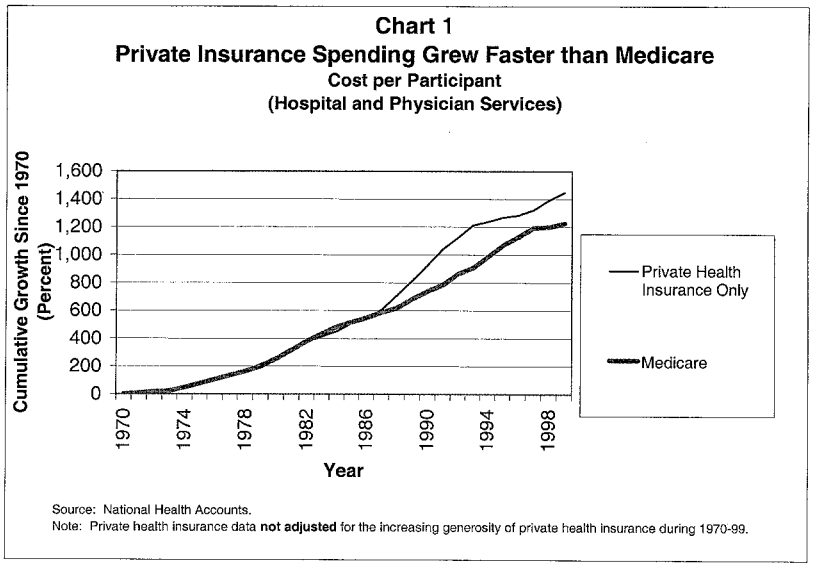


Chart 1
Private Insurance Spending Grew Faster than Medicare
Cost per Participant
(Hospital and Physician Services)
Cumulative Growth Since 1970 (Percent)
1,600
1,400
1,200
1,000
800
600
400
200
0
1970
1974
1978
1982
1986
1990
1994
1998
Year
Private Health Insurance Only
Medicare
Source: National Health Accounts.
Note: Private health insurance data **not adjusted** for the increasing generosity of private health insurance during 1970-99.

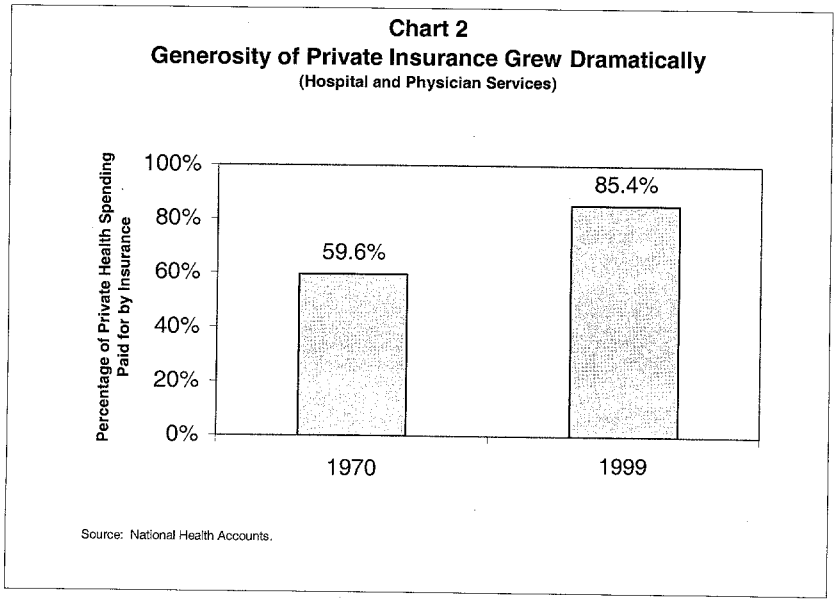
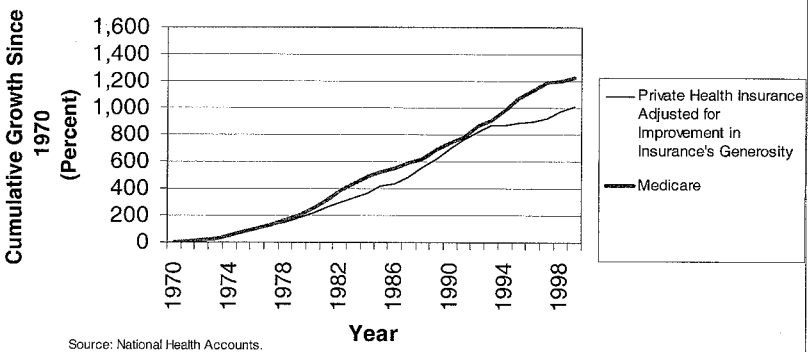


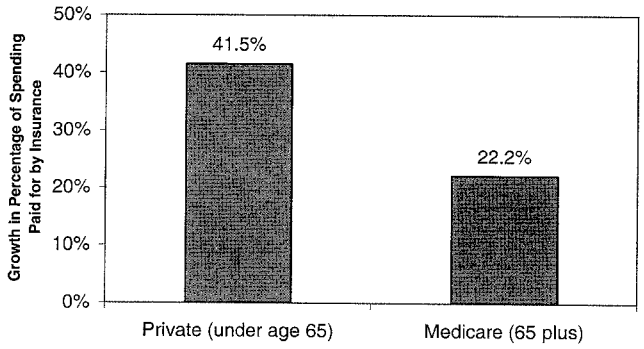
Chart 2
Generosity of Private Insurance Grew Dramatically
(Hospital and Physician Services)
Percentage of Private Health Spending Paid for by Insurance
100%
80%
60%
40%
20%
0%
59.6%
85.4%
1970
1999
Source: National Health Accounts.

Chart 3
Private Spending (Controlling for Generosity) Grew Slower than Medicare
Cost per Participant
(Hospital and Physician Services)



Source: National Health Accounts.
Note: Private health insurance data **adjusted** for the increasing generosity of private insurance during 1970-99; this adjustment was performed by accounting for displacement of private out-of-pocket spending by insurance.

Chart 4
Growth in Insurance Generosity, 1977-96
(All Health Spending)



Sources: National Health Care Expenditure Survey (1977), Medical Expenditure Panel Survey (1996).

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1. Cristina Boccuti and Marilyn Moon, "Comparing Medicare and Private Insurers: Growth Rates in Spending Over Three Decades," *Health Affairs* (March/April 2003), pp. 230-237.

2. "Unit" refers to the percent of spending covered by insurance. An insurance policy that is more generous covers more of a person's total health spending, and thus has more "units" than a less generous policy.

3. Medicare Payment Advisory Commission, *Report to Congress: Medicare Payment Policy*, March 2003, pp. 11-12.

4. The increase in the volume of services are estimated as the increase in total allowed charges less the fee update and the increase in fee-for-service enrollment. Unpublished data are available from the Office of the Actuary, CMS.

5. Medicare Payment Advisory Commission, *Report to Congress: Assessing Medicare Benefits*, June 2002, p. 17.

6. Glenn M. Hackbarth, Testimony before the Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, May 1, 2003.

7. The Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits: 2002 Annual Survey* (Menlo Park and Chicago: KFF and HRET, 2002), Exhibit 5.1, p. 69.

8. See, for example, *Checkbook's Guide to Health Plans for Federal Employees*, produced annually by the Center for the Study of Services, Washington, DC.

9. The term "risk" is often misused in discussions of health insurance. Risk denotes uncertainty. But insurers usually consider people who have a high expected cost of care to be "poor risks." For example, people with AIDS are virtually certain to incur high health care costs, but they are called poor risks. The text applies the term as it is commonly (mis)understood.

10. Curtis S. Florence and Kenneth E. Thorpe, "How Does The Employer Contribution For The Federal Employees Health Benefits Program Influence Plan Selection?," *Health Affairs* (March/April 2003), pp. 211-218.

11. Walton Francis, Testimony before the Subcommittee on the Civil Service, Census and Agency Reorganization, Committee on Government Reform, U.S. House of Representatives, December 11, 2002.

The CHAIRMAN. Our final panelist is Jeff Lemieux, a Senior Economist at Progressive Policy Institute and previously senior staff with the 1999 Presidential Medicare Commission and a CBO economist.

Jeff, welcome to the committee.

STATEMENT OF JEFF LEMIEUX, SENIOR ECONOMIST, PROGRESSIVE POLICY INSTITUTE, WASHINGTON, DC

Mr. LEMIEUX. Thank you, Mr. Chairman.

Mr. Chairman, your staff asked me to comment very specifically on the cost studies that Dr. Antos and Dr. Moon have done recently.

The CHAIRMAN. We know that that is an important part of this debate, and as Senator Stabenow point out, it is current within the discussion this morning with the New York Times article, so it is front and center to all considerations, I suspect.

Mr. LEMIEUX. Let me get right to that, but first let me make just three quick assertions in response to the discussion that we have heard in both panels.

I think that there are three conditions that are necessary to make an FEHB-style system workable in Medicare. First, the government-run plan needs added flexibility to shape its benefits and payment systems more along the lines that Abby Block told us are possible in FEHB.

Second, the private health plans in Medicare clearly need a stable, predictable, and fair platform from which to make business decisions, and that also is lacking.

The third thing that I think is lacking that we need to work on is that both Congress and the public will need a very thorough understanding of how a competitive choice system in Medicare would work. We need to create a win-win situation here for beneficiaries and taxpayers, and we need to know how an FEHB system would play out over time before policy decisions can be made, and we have not made that analytic effort yet in Congress.

To these comparisons, in my opinion, Dr. Moon and Dr. Antos essentially say the same thing. They say that if you look at Medicare and private insurance spending trends over 30 years, it looks like Medicare's are slightly better. I believe Dr. Antos is also correct when he says that when you fold in benefit generosity, the cost-benefit comparison, it looks like private plans are a little better.

So my analogy to this—and I am not trying to be funny, but I think this is appropriate—is that Dr. Moon is arguing that McDonald's is better than Burger King because its burger prices have increased by a few pennies less over 30 years, and that Dr. Antos is saying no, Burger King is actually a better value than McDonald's because Burger King's food is improving at a faster rate.

This is the sort of data that policy wonks on both sides of the political aisle are going to use for ideological ammunition. Backers of the government-run fee-for-service program will argue that McDonald's is better than Burger King, and backers of private plan options in Medicare will say that Burger King is better than McDonald's. But the larger point is that policymakers should not have to choose Burger King or McDonald's. Beneficiaries should be able to choose from Burger King, McDonald's, Popeye's, the gour-

met shop—you name it—and that our esteemed foundations and policy think tanks could do the most accurate and subtle computations possible, and we would never be able to determine a correct answer on something that is really a point of preference.

So in my opinion, comparisons of long-term spending cannot really possibly settle a debate over which sector is a better value because Medicare and private health insurance spending are interrelated. When Medicare finds ways to save money, private insurers face pressure, mostly from employers, to mimic those savings or to come up with alternative savings.

Likewise, when private health insurers find a way to save money or add value and benefits to their packages, then Congress faces pressure to improve Medicare, to find similar savings or similar benefit enhancements. The spending trends on both sides reflect these pressures, they tell us nothing intrinsic to government-run programs or private health insurance.

The first major move toward cost containment in the entire United States health sector was in the early 1980's when Medicare took the lead on cost containment and implemented a prospective payment system for inpatient hospital care. This was a payment control method that worked. Hospitals changed their behavior, and Medicare's costs slowed down from the double-digit rates to single digits, which was unheard of at the time.

That is why Medicare's cost performance moved better than private insurance for several years. After about 1993, private health insurance and Medicare have gone back to increasing at about the same rates. What happened was that private insurers became aware that Medicare was paying less for hospitalization, so they had to do something about it. Employers put pressure on them. Of course, they could not implement a massive payment control system of their own; they could not collude to gain market power to do that, and the market would not allow them to just impose payment restraints. But by the early 1990's, they found a solution. That solution was managed care. By targeting their enrollees to specific hospitals and doctors, they could gain leverage to get better deals with health care providers.

That sudden cost saving success in managed care then led to political actions that turned around and helped to reduce Medicare spending again, first in 1996 with the anti-fraud provisions, in 1997 with payment cuts. Also, it sparked a political debate on Medicare's benefits. If these private plans through managed care were able to save money and offer better benefits, that really pointed out how Medicare benefits had fallen behind.

Of course, some of those early managed care savings have proved fleeting, but there has been one durable item of cost saving that many people on this panel and the previous panel have mentioned, and that is care management—the ability to take care of people with one or more chronic diseases in a much better way. I think this is the new potential win-win in Medicare. PPI's health plan is focused on care management and healthy aging, and it goes through several different ways to do it—a way to do a drug benefit that would improve that sort of thing and would also help improve risk adjustment; an accountability system so the fee-for-service

plan can keep up with these sorts of innovations; and the new sorts of choices that we have talked about on the panel.

With that, I mention in my written statement a fair bit more about the PPI health plan, and I encourage you to take a look at it if you have a chance. Thank you very much.

[The prepared statement of Mr. Lemieux follows:]

Testimony
May 6, 2003

McDonald's v. Burger King

A "Nothing Burger" Debate on Medicare Reform

Testimony before the Special Committee on Aging, U.S. Senate

by Jeff Lemieux

Thank you Senator Craig, Senator Breaux, and committee members for inviting me. My name is Jeff Lemieux, and I am the senior economist for the Progressive Policy Institute (PPI). My statement focuses on (1) comparisons of spending trends between government-run Medicare and private health insurance coverage, and (2) Medicare competitive choice systems, within the context of a reformed and modernized Medicare system. Here are the main points:

- For policymaking, comparisons of long-term spending trends between Medicare and private health insurance cannot possibly settle a debate over which sector is a better value. That is because trends in Medicare and private health insurance spending are interrelated. When Medicare finds ways to save money and add value, private insurers face pressure from employers to mimic those efficiencies or find alternative savings. When private health insurers find ways to save money or add benefits and value, Congress faces pressure from the public to enact similar cost savings or benefit enhancements in Medicare. Spending trends reflect those pressures—they tell us nothing about anything intrinsic to either government-run or private health insurance.

- In my opinion, policymakers should assume that the advocates of government-run health insurance and private health insurance are both correct: Each type of insurance is more efficient than the other. Then, the logical conclusion for Medicare policy would be for the federal government to create a level playing field for both types of coverage, possibly patterned after the Federal Employees Health Benefits (FEHB) program. Let both government-run and private health plans compete for seniors' business, and let the competition directly and quickly pressure both types of coverage to find efficiencies, new and helpful benefits, and other value improvements for both seniors and taxpayers. Direct competition and choice would be a more efficient way for each sector to match the other's improvements. It would be faster, less cumbersome, and less error-prone than waiting for the political process to improve Medicare when it falls behind, or waiting for employers to force improvements in private health insurance when private plans lag.

- For direct competition and choice to work for the benefit of both seniors and taxpayers, the government-run plan needs added flexibility to shape its benefits and payment systems. Likewise, private health plans in Medicare need a stable, predictable, and fair platform from which to make business plans. Congress and the public need a thorough understanding of how competitive choice systems in Medicare would work and play out over time before policy decisions can be made. These conditions are not present in Medicare.

- The main efficiency improvements in both Medicare and private health insurance over the last two decades have been reductions in overpayments to health care providers. Although there may still be overcompensated providers in some parts of the health care system, that method of efficiency gain has largely run its course.

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- Future gains in efficiency will probably result from improvements in the quality of health care, especially for patients with chronic illnesses. These improvements will range from basic error reduction measures to rudimentary educational or disease management programs for seniors with a particular chronic illness, such as diabetes, to sophisticated case management, home-based monitoring, and community support services for patients with multiple chronic conditions.

PPI believes that the next great challenge for Medicare will be shifting the program's emphasis toward chronic care. Medicare has always been a reliable bill payer when beneficiaries suffered an acute health care crisis requiring hospitalization or extensive medical procedures. Now, Medicare must learn how to better help the increasing number of seniors with chronic illnesses stay out of the hospital and maintain the best possible health and quality of life. This, we believe, is key to improved health outcomes, higher quality health care, and greater value for every health dollar spent.

PPI's Medicare reform proposal, the "ABC" proposal, is focused on chronic care and healthy aging.[1] Its three main elements are:

- ***Accountability:*** a radical decentralization of Medicare's administration, so that local Medicare administrators and medical directors are directly empowered to create disease management and health improvement programs targeted to the needs of beneficiaries in their area;

- ***Benefits:*** a drug benefit structure that helps link, not fragment, Medicare benefits and provides information to target disease management programs; and

- ***Choices:*** a much expanded menu of private insurance plans in Medicare, along with locally-run comprehensive disease and care management programs for fee-for-service beneficiaries with specific or multiple chronic conditions.

Medicare reform is an attempt to create better health for seniors and better value for both seniors and taxpayers. By my definition, reform is an attempt to create a "win-win" situation. By contrast, current proposals for Medicare drug benefits generally create a "win-lose" scenario: Beneficiaries win by getting new benefits (maybe) and taxpayers lose by incurring new obligations with little or no hope for offsetting savings. Setting aside the important question of which group of citizens is more deserving, citizens as Medicare beneficiaries or citizens as taxpayers, we have switched the Medicare debate from reform to redistribution.

I believe that two fundamental reforms should be considered: (1) the development of an FEHB-style competitive choice system, and (2) the development of an infrastructure for improvements in chronic care, both in private plans and the government-run system. Both of these reforms have potential to create "win-win" outcomes.

The primary impediment to an FEHB-style system is analytic: Medicare is too important to launch into reforms without careful planning and analysis of the likely impact of change. We must be very sure that a "win-win" situation would result. In the absence of the needed analysis, Medicare reform has been stymied, to the detriment of the Medicare debate.

Medicare and Private Health Insurance Spending: McDonald's vs. Burger King

Both Marilyn Moon of the Urban Institute and Joe Antos of the American Enterprise Institute calculate that per-enrollee Medicare and private health insurance spending for some comparable

services grew at nearly identical rates until the mid-1980s.[2] After that point, Medicare spending grew slightly more slowly for several years. But starting in about 1993, growth in spending in each sector returned to a roughly equivalent rate. Because Medicare grew more slowly between 1986 and 1993, its per-enrollee spending has risen by a little less over a 30-year period, so by that measure, Medicare's cost performance seems slightly better.

However, Dr. Antos is correct that the actuarial value of private health insurance benefits grew more rapidly than the value of Medicare benefits during this period. Therefore, when growth in benefit generosity is taken into account, the private health insurance "cost-benefit" performance seems better.

By analogy, Dr. Moon argues that McDonald's is better than Burger King because its burger prices have increased by a few pennies less over time. Dr. Antos counters that Burger King isn't less efficient than McDonald's if you consider that Burger King's food has improved at a faster rate; in fact, by his calculations Burger King is a better value.

Policy wonks on both sides of the political aisle will use these calculations as ideological ammunition in the meta-struggle for or against government-run or private health insurance. Backers of the government-run Medicare fee-for-service program argue that Medicare should be like McDonald's. Backers of private insurance options in Medicare argue that policymakers should choose Burger King.

Of course, health insurance is more important than convenience food, and I don't mean to demean the importance of these calculations.

But the larger point is: Policymakers should not have to choose whether Medicare beneficiaries get their insurance from government-run or private health plans. Instead, *beneficiaries* should be able to choose from among the health insurance equivalent of McDonald's *and* Burger King, as well as Wendy's, Popeye's, Taco Bell, the organic market, the gourmet shop, or even a home-cooked snack.

Our great foundations and policy institutes and scholars could do the most accurate and subtle calculations, but they could never definitively determine whether McDonald's was better than Burger King, or if the Beatles were better than the Rolling Stones, or, for that matter, whether fat guys really drink Lite beer because it "tastes great" or is "less filling."

One other point is clear: Competition and rivalry between different types of fast food joints or health insurance plans helps spur innovation and progress. Certainly, the spending and benefit trends in Medicare and private health insurance bear this out.

Medicare and Private Cost Containment Efforts and Benefit Enhancements are Related

Prior to the mid-1980s, both Medicare and private health insurance were the same type of product: fee-for-service insurance with a relatively narrow scope of benefits and few limits.

Medicare made the first move toward cost savings in 1983, with the enactment of the Prospective Payment System (PPS) for inpatient hospital payments. This was the first innovative, large-scale payment control method anywhere in the U.S. health sector, and it was effective. The number of hospital inpatient beds, which had grown steadily for decades, suddenly started contracting as the PPS system was implemented. Medicare's costs dipped from double digit to previously unheard of single digit growth rates in the mid-1980s.

Gradually, private insurers became aware that Medicare was paying considerably less for hospital care. A series of studies in the early 1990s by what was then called the Prospective Payment Assessment Commission (ProPAC) asserted that Medicare typically paid about 90 percent of the hospitals' costs of treating Medicare patients, while private insurers paid about 130 percent of costs. (Those studies were somewhat off base, because they seemed to assume that hospital costs were independent of Medicare and private insurers' willingness to pay. But

nevertheless, it was clear to employers that the private insurers were paying much more than Medicare for inpatient hospital care.)

Of course, private insurers could not collectively implement a massive payment control system of their own. They could not collude to gain sufficient market power, and they could not independently impose payment restraints because of market conditions.

However, by the early 1990s, private insurers found a way to get payment reductions of their own: managed care. By steering patients to certain hospitals or doctors, health plans gained leverage to negotiate better deals.

As a result, the growth private health insurance spending for employer-based coverage tumbled in the mid-1990s. (In the statistics used by Drs. Moon and Antos, continued rapid growth in private Medigap and retiree insurance spending on behalf of Medicare beneficiaries offset some of the decline in employer-based premiums.)

With managed care savings, private plans were able to slow cost growth and offer enhanced benefits, usually with low co-payments for each service. The growth of private insurance plan enrollment in Medicare skyrocketed.

Managed care's sudden cost-saving success led to political actions that dramatically reduced Medicare's spending. First, anti-fraud and abuse controls were tightened in 1996. In 1997, the Balanced Budget Act sharply reduced payments to health providers. As a result, the growth Medicare spending tumbled in the late-1990s.

Medicare's benefits also became a political topic. The absence of retail prescription drug benefit in the government-run plan suddenly became a political issue in late 1998 and early 1999, and it has remained a hot issue to this day.

At the same time, some of the early managed care savings proved fleeting, as health care providers consolidated and rebelled against tight payment controls from private insurers. However, one private sector approach has proved durable: helping provide coordinated care for patients with chronic illnesses.

Although Medicare started the cost-cutting trend in the 1980s, it is private-sector innovations with disease and case management for patients with chronic illnesses that offer the best hope for quality improvements and savings looking forward.

Chronic Care, Healthy Aging, and PPI's Medicare Proposal

To foster improved chronic care and disease management in Medicare, PPI encourages Congress to consider two simple tests for any legislative proposal:

- **No new silos.** Separated, unlinked, or uncoordinated benefits can thwart disease management efforts. Congress should scrap the idea of a premium-based stand-alone drug benefit. In general, health benefits should be integrated under one administrative structure, so that the insurer has the ability and the incentive to evaluate tradeoffs—for example, adding drug benefits known to reduce the incidence or cost of hospitalizations. Even if benefits cannot be fully integrated under one insurance carrier, at the very least they should be linked, so that information can be shared between primary and supplemental insurers. Adding another separate, add-on benefit to Medicare's current, outdated structure would work against disease management and comprehensive, coordinated care for people with chronic illnesses.

- **No new benefits without accountability.** It doesn't make sense to add benefits without making fundamental changes to Medicare's processes, so that we can learn whether or not the benefits improved seniors' health. Even preventive and screening benefits should be accompanied by permanent evaluation systems designed to identify and help people

who are at risk for particular problems or are coping with multiple ailments. All new benefits must help reorient the Medicare program toward more optimal care of chronic illness and be accompanied by new processes to spur systematic improvements in health care quality and outcomes.

The Centers for Medicare and Medicaid Services (CMS) needs the flexibility to create disease and care management programs for Medicare beneficiaries. However, Congress is not going to give the CMS bureaucracy vast new powers without greatly enhanced accountability and oversight systems. Moreover, disease management is inherently a local system, requiring cooperation between local health providers, community institutions, consumer and seniors' groups, and, in some cases, local government agencies. The Centers for Medicare and Medicaid Services cannot run effective localized disease management and health improvement programs from its headquarters in Baltimore.

The Progressive Policy Institute's proposal is explained in greater detail in the report *An 'ABC' Proposal to Modernize Medicare,* which contains several similarities with a prescription drug bill introduced by Rep. Cal Dooley (D-Calif.) in the House last month (H.R. 1568). Here are the basic elements of the PPI proposal:

Accountability. Medicare officials should be held accountable for measuring and improving the health of older Americans. They should be given the freedom to make improvements at the local level, in accordance with local needs, with clear public disclosure of results and Congressional oversight. The model for the PPI's proposal is the "CompStat" system developed in New York City to help fight crime. In that system, crime trends were tracked in real time, and local police commanders were given flexibility to deploy resources as needed in their precincts in exchange for real accountability for their crime-fighting plans and success. Unsuccessful commanders who did not have a credible plan for performance improvement were replaced.

We propose that Congress create approximately 150 local Medicare administrative regions and staff each local area with a Medicare medical director and Medicare local administrator. We believe those officials should be given flexibility to create new programs to improve health in their areas, with budget authority to create local programs that are budget-neutral within a 10-year period. Local officials would be ranked annually on their ability to foster improvements in health quality and outcomes in their regions, and Congress would establish a new congressional agency, patterned after the Joint Committee on Taxation, to oversee the local officials' actions, proposals, programs, and ratings. Local administrators with poorer performance results would be replaced. Medicare's central bureaucracy would be reduced as the local officials were put in place.

Benefits. The Progressive Policy Institute believes the most realistic and workable Medicare drug benefit would be a universal, zero-premium catastrophic benefit, provided mostly through the supplemental insurers that already serve Medicare beneficiaries, including employment-based plans, Medigap plans, and state programs. (Seniors without any supplemental benefits would choose a discount card that also provided the catastrophic drug benefit.) The catastrophic benefit would be based on total drug spending; PPI proposes that the catastrophic benefit explicitly allow seniors to have additional coverage under the catastrophic "deductible" without forfeiting their catastrophic benefits. By contrast, congressional proposals that base a catastrophic drug benefit only on "out-of-pocket" drug spending would be unfair to beneficiaries who have and want additional drug coverage, and could disrupt the employment-based retiree coverage many seniors receive. The Progressive Policy Institute's preferred approach is more expensive for the government, but it is more practical and workable. Under PPI's proposal, low-income seniors would be eligible for additional drug benefits, including "up-front" benefits that started at much lower levels of drug spending.

We believe that universal catastrophic drug coverage would create tremendous side benefits by building an information-based infrastructure for disease and care management programs. The CMS would obtain real-time data from the supplemental insurers and other plans and discount cards administering the benefit, so that Medicare would know when a patient hit the catastrophic deductible, and Medicare's liability was triggered. Therefore, Medicare would have a nearly real-time database of all beneficiary drug expenditures, which would help local Medicare administrators target quality improvement and disease management programs to particular demographic groups or regions. The new data could also dramatically improve risk adjustment methods, which would help private comprehensive plans stay in Medicare.

Choices. The Progressive Policy Institute proposes to revitalize Medicare's HMO program and expand the PPO demonstration program nationwide. We would establish a new type of Medigap coverage that included some up-front drug benefits; however, to keep the cost down, the "New Medigap" plan would not have absolute first-dollar coverage of beneficiaries' coinsurance for Medicare's other benefits. Beneficiaries could enroll annually in private plans, New Medigap options, and new comprehensive disease management programs, and have premiums deducted from their Social Security checks.

Ultimately, Medicare should switch toward the FEHB model. Of course, the government-run plan would remain the dominant offering (it currently enrolls almost 90 percent of Medicare beneficiaries). But switching Medicare to a direct menu-based purchasing system, with all health plans—including the government-run plans—treated as equals, would be more efficient and would allow a more rapid evolution of Medicare benefits toward those needed for proper chronic care.

Jeff Lemieux is senior economist at the Progressive Policy Institute.

Endnotes

[1] Lemieux, Jeff, David B. Kendall, Kerry Tremain, and S. Robert Levine, M.D., "An 'ABC' Proposal to Modernize Medicare," *Progressive Policy Institute*, February 14, 2003, *www.ppionline.org*. Kendall, David B., Kerry Tremain, Jeff Lemieux, and S.Robert Levine, M.D., "Health Aging v. Chronic Illness: Preparing Medicare for the Next Health Care Challenge," *Progressive Policy Institute*, February 14, 2003, *www.ppionline.org*.

[2] Boccuti, Cristina and Marilyn Moon, "Comparing Medicare and Private Insurers: Growth Rates in Spending Over Three Decades," *Health Affairs*, March/April 2003, *www.healthaffairs.org*. Antos, Joseph R., with Alfredo Goyburu, "Comparing Medicare and Private Health Insurance Spending," *The Heritage Foundation*, Webmemo #250, *www.heritage.org*.

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The CHAIRMAN. Thank you all very much for your testimony this morning.

Let me ask questions that all three of you may respond to if you wish. The first one, I would suggest, is taking everything into consideration—cost growth, benefit packages, and flexibility—who is getting greater value for each dollar spent on his or her health care at this time—a Medicare beneficiary or a person covered under a typical private insurance plan, and why is this the case?

Ms. MOON. I will go first and say I think it would be Medicare, because Medicare has remained truer to a benefit package with access to providers of services over time. It is much easier to stay with the same physician.

Joe Antos tells us, for example, that you can change doctors in a PPO. But to see the doctor that I have seen for 10 years under my PPO, I pay a 65 percent copay, not because of the stated copayment but because of what the PPO determines is usual, customary and reasonable. You cannot find out this amount before the fact. I know; as a good consumer, I have tried—from Care First, because that is proprietary.

That is one of the reasons. I also believe that over time, there are probably a lot of counterbalancing influences. The managed care reaction and then reaction against in terms of many people rejecting the very tight controls that some managed care plans put on individuals, often in arbitrary fashion, meant that there was a deterioration in some of the benefits that people received.

The reason that I undertook the study to show that there is not a lot to assume that the private insurance market will just instantly solve Medicare's financing problems. This was to counter the argument that some people have made that you can just put Medicare beneficiaries into private plans, and poof—everything will be wonderful. I think both sides have a struggle to hold down costs, as Jeff Lemieux said.

The CHAIRMAN. Joe.

Mr. ANTOS. Mr. Chairman, believe it or not, I agree with Marilyn but not for the reasons she gives. Marilyn is actually, I think, probably typical of most people in private employer-sponsored plans today. They do not have any choices. That is not the kind of reform——

Ms. MOON. Actually, I have a choice of 14 plans; all of them are crappy. [Laughter.]

Mr. ANTOS. OK.

The CHAIRMAN. You are not in that high rate of general approval.

Ms. MOON. Satisfaction—no, I am not.

The CHAIRMAN. All right.

Mr. ANTOS. You have a choice of 14 plans, and you do not like any of them. There is a considerably wide range of choice in the Federal Employees Health Benefits Program, and as Walt Francis said, "The level of satisfaction is very high."

But my point is let us not talk about ourselves—let us talk about the average American worker. The average American worker does not have a choice of plans. The average American worker has the plan that is settled upon by the employer. Typically, if there appears to be a choice, it is three flavors of the same kind of plan.

That is not a good situation. Medicare beneficiaries would do better under a Federal Employees Health Benefits type of system where there is a much wider range of choices and where there is, frankly, the kind of Federal oversight that is going to be necessary for this population. Many of these people are frail and have difficulties generally with their health and may need some greater protection. That is why we have the Medicare Program in the first place. That is how it could work under a FEHB style of reform.

On balance, however, people walk with their feet, and they talk with their money. Over 90 percent of Medicare beneficiaries get some kind of supplemental coverage. More than 25 percent of them have to buy some form of coverage, and 10 million of them spend an average of $1,700 a year to make up for the inadequacies as they see it in the Medicare Program.

The CHAIRMAN. Jeff.

Mr. LEMIEUX. Well, Mr. Chairman, I think Marilyn is going to say that Medicare is a better value, and Joe is going to say that choices are good and that private options are a better value, and I am going to say that there is no way that any committee of Congress could determine which sector has the better benefits and values intrinsically and that therefore, choice is probably the best approach; allow people to choose.

What we need to do in Congress is set up the oversight structures, set up the consumer information to make sure that the consumer protections are there so that whatever choices people make will be decent ones, sort of like what Federal employees make.

The CHAIRMAN. In other words, you are suggesting that all will be served better in the health care environment if there is a clear competitive market between Burger King and McDonald's?

Mr. LEMIEUX. In general, yes, that sort of competition and choice tends to lead to innovation and progress that is probably a less error-prone and awkward way of making progress than we have made it in Medicare over the last years with responses to private innovations and back and forth in a political way.

The CHAIRMAN. Thank you.

Senator Carper.

Senator CARPER. Thanks, Mr. Chairman. I enjoyed being a backbencher earlier for a brief while.

The CHAIRMAN. Well, we appreciate you attending this morning.

Senator CARPER. My pleasure. Thanks for holding the hearing. By the way, was a very good panel. I missed most of the first panel, but I know some of these people pretty well and am very grateful to you and our staff for bringing them all together. They have given us a nice menu of ideas.

I am going to start with Jeff Lemieux and ask him if he will to just talk a little bit about what the Progressive Policy Institute believes we should do with respect to Medicare reform.

Mr. LEMIEUX. We have a three-point plan, perhaps not too cleverly labeled the "ABC Plan." The "A" part of the plan is an attempt to create in the fee-for-service program the sort of accountability—"A" stands for accountability—system that would allow the fee-for-service plan to modify its benefits and its payment systems in a way so that it could compete and evolve and innovate within the fee-for-service plan.

Senator CARPER. If you could hold for just a second, for our other witnesses, Dr. Moon and Dr. Antos, I am going to ask you to critique this for us, so if you do not mind, I just want to give you a heads-up.

Thanks. Go ahead, Jeff.

Mr. LEMIEUX. So point No. 1, accountability, is making within the fee-for-service program and within Medicare as a whole a way to allow the Medicare administrators to evolve more quickly without congressional directive and to improve things.

"B" is a benefit package. We are advocating that the most practical form of a Medicare prescription drug benefit would be a zero premium catastrophic benefit available to all Medicare beneficiaries under Part B, that this would be universal—everyone would get some sort of Medicare catastrophic benefit card, either through a supplemental insurer or as a discount card—and there would also be an extra program for low-income beneficiaries who have incomes too high to qualify them for Medicaid but too low to really benefit much from a catastrophic benefit.

The third element is choices. We think that the sorts of choices that have been put forward in terms of additional PPO options and expanding that demonstration nationwide and to fix up the HMO program so that Senator Stabenow's mother has a choice back there in Michigan or wherever she lives, that these are good things and that they should ultimately lead in the direction of an FEHB-style competitive system over time.

So it is accountability, benefits, and choices.

Senator CARPER. Thanks.

Mr. Antos.

Mr. ANTOS. I think those are great principles. The details matter. The details matter a great deal. I have got to say that I am not as familiar with the ABC Plan as Jeff is, so correct me, Jeff, if I get something wrong here. But I guess the thing that I would focus on, the thing that I at least know a little bit about, is the idea of having a universal zero premium drug benefit type of plan. I think there are some aspects of that that are very good, but ultimately, there are concerns that I would have especially about the way that that might run.

As I say, this is my interpretation, and I am not sure I am getting it right, but the concern that I would have is that, as I understand the proposal, there would be the appearance of competition. I think this has been characterized as that virtually any kind of organization could offer this drug benefit to Medicare beneficiaries, including current Medicare carriers, Medicare HMOs in the M Plus C program, or employer groups, or you name it—presumably association health plans, something like that.

That sounds good, but this is a program, as I understand it, where the government would take all of the financial risk, and I think that ultimately, this is of great concern. One of the principles of market competition is that the plans have to have skin in the game; otherwise, they cannot get very interested about trying to control costs if all of their costs are covered ultimately by the Federal Government, by whom I mean the taxpayer.

There is a great risk if we have a drug benefit program where 100 percent of the risk is borne by the taxpayer. There is a great

risk that Congress in its due diligence to assure that the taxpayer is not paying too much decides that we have to have some kind of a national drug pricing scheme to make sure that everything is fair and to make sure that all beneficiaries are treated fairly and they reach their catastrophic cap, the uniform national cap, at the same time as anybody else.

It sounds like equity, but it has the seeds, I think, of potential disaster. I think this is part of the plan that I would hope that Jeff and others would work on much more carefully to try to preserve the kinds of market incentives that now exist, especially in the drug benefits business, to encourage drug benefit organizations to aggressively manage the benefits, aggressively seek out discounts and rebates from pharmaceutical manufacturers and to tailor their benefit to best meet the needs of the beneficiaries.

Senator CARPER. Thank you, Dr. Antos.

Mr. Lemieux, would you like to respond to any of the comments that Dr. Antos has made?

Mr. LEMIEUX. Yes. I believe that his concerns are greatly overwrought. Some of them are valid, but they are generally greatly overwrought.

Senator CARPER. Dr. Antos, have you ever had that accusation leveled at you before?

Mr. ANTOS. No. I am considered a very calm guy.

Mr. LEMIEUX. I do not know, Senator, if you want us to debate each point by point, but I think that in general——

Senator CARPER. As a matter of fact, I would, but we do not have time for that—just a couple of points, if you would.

Mr. LEMIEUX. I think in general that beneficiaries would still be responsible for copayment even after they have hit the catastrophic cap, so that should help restrain costs. All such plans would have to be approved by CMS to make sure that they are doing a fair job, a good job, by getting discounts for their beneficiaries and therefore also for the taxpayer. Employers certainly would not be anxious to suddenly go lax when their retirees suddenly got to a point where the government was reimbursing. We also favor risk corridors, other sorts of performance based approaches with the government, to make sure that all these plans would have a good incentive to save money.

On the equity issue, I really think that that is a very, very small issue and that any sort of pluralistic health care program run by government is going to have some people having slightly better benefits than others in certain different ways, but I think that that sort of diversity and plurality is generally a good thing that will not cause mischief.

Senator CARPER. Thank you.

Dr. Moon, your reaction to what Mr. Lemieux has just laid out, please.

Ms. MOON. I would say first of all that a number of the principles that he is talking about are desirable ones. But I am not sure that I would go the direction that he would in all cases.

Medicare does need considerably more flexibility in terms of running and managing the basic program, the traditional part of the program, but I would be very cautious about——

Senator CARPER. Does that mean you endorse the "A" in ABC?

Ms. MOON. Well, I would be very cautious, though, about doing it differentially at the local level. We have a lot of concerns around the country already about differential treatment of Medicare beneficiaries, and that is something that needs to be looked at very closely. But I do think that finding ways to be more flexible and to have less micromanagement is definitely a good idea.

On the benefits side, certainly my preference would be a well-run drug benefit program that is an integral part of the rest of the benefits. I think it is a mistake to try to pull it out. That is true for whether the drug benefit is in a private plan or in the traditional Medicare Program.

For one thing, the risks that occur in terms of the costs of insurance are much better blended together, because high users of drugs are not necessarily high users of the rest of health care, and you can pool the risks better that way.

You would also have to be very careful to have better protections for those with low incomes than it is my understanding that his plan has. You need to recognize that if you go as far up the income scale in order to cover people in need, you are going to be talking about perhaps half of the population being covered. It may be difficult to be that generous.

Finally, in terms of the choice issue, I think that he is on the right track. We should encourage more private participation, but focus it in areas where there is supposed to be innovation, and that is in disease management and coordination of care. We have seen too little of such innovation in Medicare+Choice and in many of the commercial HMOs and PPOs. That is where I think you would need to challenge them to do more.

Senator CARPER. My time has expired; otherwise, I would ask Mr. Lemieux to respond if he wanted to.

The CHAIRMAN. Please go ahead.

Senator CARPER. Do you have any response to what Dr. Moon has said?

Mr. LEMIEUX. I am pleased that that sounded like a partial bit of endorsement that I appreciate a great deal. I think I agree greatly that benefits to the extent possible should be linked and coordinated if possible under one plan, and if not possible, they should be linked with information systems that allow people running these sorts of benefit programs to evaluate tradeoffs. If I have a little bit better drug benefit over here, will I save money in hospitalization over here?

The only other point I wanted to mention—we have spoken a lot about the New York Times article this morning and how it says that private fees are higher—I think there more to it than just fees, and that is a trap we fall into when we are congressional estimators and policy wonks around town, that there is price and then there is quantity, and then there is quality, and these things all go together to form how much we actually spend on something, and just because a fee is higher or lower may not be indicative of the whole mix of spending that goes on behind that. I just wanted to point that out.

Senator CARPER. Thank you.

Mr. Chairman, I will finish up where I started off. This is a good panel, and I do not think it would be possible to get the three of

them to agree on what we ought to do, but if we could, I would endorse it.

Thanks very much, and my thanks to all of you.

The CHAIRMAN. Tom, thank you.

I have a couple more questions of you, and all three can respond. Critics of any form of competitive model seem to worry that health plans will pick and choose the healthiest patients.

We have also heard FEHB say this does not really happen, or it happens very little. What do you think of this adverse selection problem, and can you address it?

Is this a red herring in the arguments, or is that a legitimate concern, the issue of adverse selection?

Ms. MOON. I think you raise a very good point. I would say that one of the things that makes FEHBP work relatively well is that a large number of individuals are willing to shift plans. But studies of seniors have shown they are much less willing to do so. In fact, in the FEHBP a few years ago, when there was a high-option Blue Cross/Blue Shield, plan people stayed in those plans even though when Medicare was primary they did, they got not one penny more in benefits by paying the substantial additional premiums. People did not want to shift because they were comfortable, as you said, with what they have. Since choice to make bad decision is also a function of the market; then you let people be in those situations.

Similarly, if there is risk selection, it means that the people who are reluctant to leave are going to stay in the plans that get to be higher and higher cost over time, which is exactly what happened. So there has been some risk selection in FEHBP.

It is also the case that FEHBP has less risk selection, because over time, the plans tend to eliminate things that attract high risks. We have seen that in terms of some of the mental health benefits, for example, in the past. In 1990, for example, OPM told everyone they had to have drug benefits.

So it is not as if not intervention is needed. I agree with Joe that there are some things that you can do. But one of the problems with competition is how much control you want to place on it. In a purely competitive market where you are going to get the best price competition, you do not want much variation in benefits, because you want people to choose only on the basis of price. If you are going to allow them to choose on the basis of benefits, you are going to have a lot more variation and a lot less lower potential for savings.

So there are a lot of decisions that need to be made, in terms of thinking about this.

The CHAIRMAN. Mr. Antos.

Mr. ANTOS. This is a very complicated issue. Your point is absolutely correct that we have to distinguish between the normal functioning of people making choices, just as they do when they go to the supermarket or when they buy automobiles, from the adverse consequences of a poorly designed health program. We ought to keep those distinctions very separate and very clear.

What we do want to do is prevent a system from causing big problems for our seniors, but we also do not want to prevent our seniors from exercising their judgment about how they want to handle their health care.

The FEHB story is a complicated story, but I think there are several clear bottom lines to it. One is that it is a government program; Medicare will always be a government program; government oversight is very important.

Second, FEHB provides a very generous premium subsidy just like Medicare.

Third, FEHB exercises considerable oversight over the program, as Marilyn pointed out, but they do it at considerably less administrative cost than Medicare does.

Fourth—and this is the question that you were alluding to about if people do not move and how does this work out—FEHB actually takes advantage of the competitive market incentives that are in place for that program that are fundamentally not in place in Medicare. An operating competitive market does not require masses of people to bolt from their health plans every year. In fact, that would be disruptive. If that happened, that would not be a well-functioning competitive market.

In other markets, there is plenty of brand loyalty. I have my favorite brand of cereal—I guess it is Rice Krispies. I buy that every time. I am very loyal to Rice Krispies, but that does not mean there are not 20 other varieties of cereal out there.

Why are there other varieties of cereal? Because there are people who are closer to the edge on how they feel about Rice Krispies, and maybe they want sugar in their cereal without having to add a spoonful.

The CHAIRMAN. It is the noise.

Mr. ANTOS. Yes, exactly right.

That is the point. Of course, we can stay with government controls. We have done that for 30 some-odd years now. The question is does that mean that Medicare beneficiaries will really be able to make their preferences known in an effective way. I think the prescription drug debate demonstrates that that is not the case, and it cannot be the case.

The CHAIRMAN. Jeff.

Mr. LEMIEUX. To your point on adverse selection, I do think it is a serious issue. I think it goes both ways. In the past, we always used to say that private health plans were always going to seek out the cheaper people, and I think that as the Medicare HMO experiment has played out, they have ended up with some very, very sick people from low-income neighborhoods especially in the Medicare HMO program.

So I think that adverse selection problems go both ways. It is a way to protect the fee-for-service plan from getting too many sick beneficiaries. It is also a way to protect private plans from getting too many sick beneficiaries without due compensation.

I do believe that the sorts of risk adjusters that have been worked on for the last 20 years are gradually getting better, and I also believe that if we had a universal catastrophic drug benefit so that the risk adjusters would know which sorts of medications patients are on—anonymously, of course—but for the purposes of risk adjustment, that would be a very powerful, instantaneous sort of real-time tool for adjusting payments to health plans based on the diagnoses and illnesses of the beneficiaries they serve.

The CHAIRMAN. Time is going to demand that this be my last question, but let me ask this of all of you.

Assuming for a moment that Congress does decide to incorporate a competitive component in the Medicare reform legislation, are there particular features that you think we should include to maximize effective cost restraints while still fostering quality and full access?

Ms. MOON. First of all, I believe you have to have a good basic benefit package that every plan must adhere to, including traditional Medicare. Prescription drugs' absence is one of the things that really caused problems to Medicare+Choice plans. They were being paid enough to provide Medicare-services, but they were not being paid enough to provide a good benefit package. So that is an essential piece, and it could even be a first piece before you move to expand private plans.

I think there will need to be a considerable amount of accountability, and I think people who think that you can operate with the 140 people that OPM does are fooling themselves, because for one thing, these choices are going to be individually offered to people all over the country without the mechanism that the Federal employees now have to work with their own benefits offices to sort through their choices. So there will need to be a lot more oversight and considerably more effort and information efforts to help people make wise choices.

Finally, I think there needs to be a lot better appeals process and information for people than we have under the current M Plus C program. For example, today a problem can be resolved for a beneficiary who is being denied care inappropriately by an M Plus C plan, but there is no follow-up to make sure that every other beneficiary gets that same treatment by the same managed care plan. People who do this kind of counseling will tell you that they will get the same problem from the same HMO at the same location six and seven and ten times and not get it resolved except on a patient-by-patient basis.

There are a number of things that ought to be put in place that will not get government out of the business, and in fact those in Congress who think that folks will stop beating down your door if you turn Medicare over to the private sector would have a rude awakening in the not-too-distant future.

The CHAIRMAN. Thank you.

Joe.

Mr. ANTOS. I think the issue is not just cost, but also one of value, and I do not think we want to lose that important theme. So that, yes, it is important to include many of the features that I think Marilyn is talking about—to try to maximize the ability of the entire system to slow down the growth in cost; however, that is where the private competitive market really comes into play.

I think the real emphasis that I would place is to look carefully at what needs to be done to have prudent and appropriate competition. That does not mean that the government can let its guard down. After all, the health market is far from a purely competitive market, so there are some real issues there related, for example, to antitrust. There are all sorts of very complicated policies that

are probably not normally considered when people think about Medicare reform that have to be dealt with.

Nonetheless there are some important things. I think the most important thing is to assure that beyond those basic safeguard, we modernize the program. Medicare beneficiaries in the fee-for-service program should be exposed to reasonable incentives even in their program to use services wisely. That does not mean an $840 first day payment for a hospital visit. People do not go to the hospital because it is a voluntary act. It probably does mean a larger combined deductible, larger than the $100 Part deductible. It almost certainly means more reasonable cost-sharing arrangements across all of the services.

Those sorts of things can enlist the individual beneficiary in both seeking better care for themselves and being on the side of the taxpayers—they are taxpayers, too—being on the side of the taxpayers to use those resources prudently.

The CHAIRMAN. Joe, thank you very much.

Jeff.

Mr. LEMIEUX. Mr. Chairman, I think if you do decide to go with stepping stones toward an FEHB system in a Medicare reform package this year, you will have to do some communication with people, because the way the current baselines are set up by the Congressional Budget Office and the Joint Committee on Taxation is that we fundamentally understate the amount of spending that we are likely to do in our current baseline, including on Medicare, because we presume that rules that require us to cut physician payments for years on end and so on actually go into place.

Then, we overstate the revenue we are likely to receive because we assume that various sunset provisions actually occur, when we all know that drafters of tax law do not intend for sunset provisions to occur.

So from a baseline perspective, it looks like anything you do to fix Medicare is going to cost a lot of money; the baseline is already too low. However, we will have to explain to people that we are going to spend some money according to these budget accounts in the short run in an attempt to create a situation that, 10 or 20 years down the road, will give us a slightly lower rate of growth to the program and help provide better value.

So I think that when you come back with cost estimates saying that we are improving our private plan options in Medicare, and it is costing us a fair amount of money in the short run, that that has to be balanced with a 10- or 20-year analysis of how that could gradually save money in the longer period.

That is my only comment about putting an FEHB plan in this year and what it might mean.

The CHAIRMAN. To all three of you, thank you very much for your time this morning, your testimony, your commitment to the issue, and serving as a resource for this committee and for Congress as we work our way through this issue.

Thank you very much, and the committee will stand adjourned.

[Whereupon, at 11:56 a.m., the committee was adjourned.]

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