Again, he contributed in a major way to both delegations’ understanding of the complexities of our relationships with Russia and the republics of the former Soviet Union.

Mr. Speaker, Dr. Billington should be congratulated for his exceptional successes during his 10-year tenure at the Library of Congress. I want to add a few personal comments about Dr. Billington as a friend. A number of those remaining in FFS because HMOs attracted the least costly enrollees within each health status group. Even among beneficiaries belonging to either of the groups with chronic conditions, HMOs attracted substantially higher among those with chronic conditions. While only 6% of new enrollees returned to FFS within 6 months, the percentage ranged from 4% for beneficiaries without a chronic condition to 10.2% for those with two or more chronic conditions. Also, enrollees who returned to FFS had substantially higher mean per member per enrollee costs compared to those who remained in their HMO. These data indicated that favorable selection still exists in California Medicare HMOs because they attract and retain the least costly beneficiaries in each health status group.

Since we pay Medicare managed care risk contractors [HMO’s] 95 percent of the average cost of treating Medicare patients in an area, it is obvious that if they do not sign up the average type of Medicare beneficiary, but sign up healthier people, then the taxpayer will end up paying the HMO’s too much. Many HMO’s, of course, make a fine art of finding the healthier people to enroll—and encouraging the unhealthy to disenroll. Because we do not adjust the payments to HMO’s to reflect the true risk they face of providing needed health care services, risk adjustment, we overpay. We have overpaid HMO’s billions of dollars—and as enrollment grows, the Medicare trust fund will lose an escalating amount.

The at end of my statement I would like to include in the record a recent summary from the Physician Payment Review Commission, a congressional advisory panel, that further documents the problem.

The just-passed Balanced Budget Act requires HHS to begin to collect data to correct this problem and in the year 2000, implement a risk adjustment system to stop the abuse and overpayment that plagues the current program.

The GAO report is just further proof that we need to move faster—and that even a partial risk adjustment program, which can be refined over time, is better than the current reimbursement of Medicare trust fund moneys. Therefore, I am introducing today—as part of our efforts to stop Medicare waste, and in some cases fraud, a bill to require that the risk adjustment changes be implemented January 1, 1999. This amendment will easily save $1 billion and probably more—and it will help force an end to the outrageous overpayment of those HMO’s who have, for whatever reason, managed to avoid the average Medicare beneficiary.

PHASING OUT METERED DOSE INHALERS

HON. PATRICK J. KENNEDY
OF RHODE ISLAND
IN THE HOUSE OF REPRESENTATIVES
Tuesday, September 16, 1997

Mr. KENNEDY of Rhode Island. Mr. Speaker, I would like to take this opportunity to offer my position on an issue that I know is of great concern to my constituents in Rhode Island and to the nation at large.

The U.S. Food and Drug Administration has recently proposed regulations which would impact the lives of thousands of Rhode Islanders.