

his life in dedication to his family, his career and to his community.

I feel a kinship to Paul—and all in the Keahey family. I was born in a home built by a Keahey, and I have served as a State Senator and as a U.S. Congressman and have been privileged to get to work with Paul's mom, Florence Keahey, longtime resident of Fannin County. Paul has been an advisor and supporter—and close friend during my years of public service. I will miss him greatly.

Paul was a self-employed geologist who spent 30 years working in the oil and gas fields of East Texas. He was a member of the American Association of Petroleum Geologists, a former chairman of the Business and Economics Department at Jarvis Christian College, a member of the Marshall Historical Society, and a member of the Lighthouse United Pentecostal Church in Marshall. He was a veteran of the United States Army and a lifetime member of the National Rifle Association.

He was born April 8, 1937, in Bonham, TX, the son of Paul R. Keahey, Sr., and Florence Fogle Keahey. He is survived by his wife, Tanya of Marshall; son, Paul "Pauray" Keahey III, of Marshall; sister, Dottie Davis of Garland; uncle, Tim Bruce of Bonham; his mother; and a number of nieces and nephews.

Mr. Speaker, let us take a moment to remember and celebrate the life of Paul Keahey, a good man and good citizen who devoted his life to the area where he was born and raised and chose to live. His memory will live on in the hearts of his family and friends in East Texas.

CALLING FOR THE RELEASE OF  
AMERICAN CITIZEN EDMOND  
POPE OF GRANTS PASS

**HON. GREG WALDEN**

OF OREGON

IN THE HOUSE OF REPRESENTATIVES

*Thursday, June 29, 2000*

Mr. WALDEN of Oregon. Mr. Speaker, I rise today to call attention to a shameful violation of international government of Russia. For three months, an American citizen named Edmond Pope of Grants Pass, Oregon, has been unjustly incarcerated in Russia for the crime of espionage. He has been denied communication with his wife of 30 years and with his parents, who are in ill health. He has been denied legal representation, access to sufficient food and medical treatment and virtually every other right we commonly associate with the justice systems of civilized nations. Indeed, Ed's imprisonment is reminiscent of what used to pass for justice under Soviet communism, when men and women were dragged from their beds in the dark of night, never to be seen again.

Mr. Speaker, Ed Pope is no spy, and he should be returned to his family immediately. We must send a strong message to the government of Russia that now is not the time to return to a system of justice in which human rights are disregarded so indiscriminately.

I urge my colleagues on both sides of the aisle to join our colleague JOHN PETERSON and me in urging the Russian government to send Mr. Pope home.

MEDICARE RX 2000 ACT

SPEECH OF

**HON. BILL LUTHER**

OF MINNESOTA

IN THE HOUSE OF REPRESENTATIVES

*Wednesday, June 28, 2000*

Mr. LUTHER. Mr. Speaker, the time is long overdue to develop a truly meaningful voluntary prescription drug benefit for our nation's seniors. But as we ensure affordable prescription drug coverage that is accessible to each and every senior in America, let us also use this opportunity to remedy the serious disparities in the current Medicare+Choice program.

Just this week, one of the remaining HMOs offering a Medicare+Choice plan in my district announced that it would no longer offer its plan. The reason it gave for its withdrawal: Minnesota's appallingly low payment rates to Medicare HMOs. Citizens in Minnesota as well as other parts of the country are today subsidizing a system that unfairly penalizes them for living in areas of the country that have historically provided low-cost and efficient healthcare services.

Many counties in our country receive such low Medicare HMO payments that seniors either have no HMO option, or receive an unacceptably inadequate benefits package. Even the seniors who have the option to enroll in a Medicare+Choice plan pay high premiums for a relatively meager benefit. At the same time seniors in other parts of the country are receiving generous benefits including prescription drugs without having to pay an extra penny towards a premium.

This issue is about fairness and the efficient delivery of health care as care costs consume an ever increasing share of our country's resources. The development of a prescription drug benefit offers us the opportunity to address and correct the current unjust disparity in the Medicare program. No more federal dollars should go to the HMOs that are already offering a plan with a rich benefits package until we achieve fairness. Instead, let's develop a genuine prescription drug benefit that ensures that all seniors have fair and equitable access to healthcare services and prescription medication. Let's develop a Medicare system that rewards efficiency, not waste. We owe this to the citizens of our country, as well as future generations of Americans.

My office and the rest of the Minnesota Congressional Delegation have filed a Congressional amicus brief on behalf of Minnesota Attorney General Mike Hatch and the Minnesota Senior Federation's lawsuit seeking to change the current unfairness in our Medicare system. I insert the brief for the record, and I ask for my colleagues' support on this important issue.

UNITED STATES DISTRICT COURT, DISTRICT OF  
MINNESOTA

COURT FILE NO. 99-CV-1831 DDA/FLN

State of Minnesota, by its Attorney General, Mike Hatch; Minnesota Senior Federation—Metropolitan Region and Mary Sarno, Plaintiffs

vs.

The United States of America and Donna E. Shalala, Secretary of Health and Human Services, Defendants

STATEMENT OF INTEREST

This memorandum is respectfully submitted by the Members of the Congressional delegation of the State of Minnesota as amici curiae to support each of plaintiffs' constitutional claims. This case involves basic public health issues for senior citizens in Minnesota regarding the cost of and beneficiary access to health benefits.

The amici curiae have an interest in protecting and promoting the health, safety and welfare of their constituents, in ensuring that their constituents are not discriminatorily denied their rightful status within the federal system, and in securing the underlying incentives of the federal Medicare program for their constituents.

With this brief, the amici curiae wish to bring to the Court's attention the policy dimensions of this lawsuit. As legislators in the United States House of Representatives and Senate, the amici curiae have a unique perspective on the substance and political dynamics of the federal Medicare program. It is the hope of the amici curiae that this memorandum assists the Court in adjudicating this matter in favor of their constituents, the citizens of Minnesota. Amici urge the Court to rule in favor of Minnesota senior citizens who, by virtue of nothing else but their geographic residence, continue to suffer from the unequal and disparate treatment of the federal Medicare managed care funding scheme.

INTRODUCTION

This memorandum asserts that the current reimbursement formula for Part C of the federal Medicare Program ("Medicare+Choice") is not rationally related to the program's objective of uniformity, arbitrarily limits beneficiary options through low reimbursements for Medicare+Choice and thus violates equal protection under the law. More specifically, this memorandum asserts the following: (1) the reimbursement system of Medicare+Choice is patently irrational and does not remotely effectuate a key objective of the program; moreover, it does not promote efficiency in the health care system; (2) this irrational reimbursement system has disparate and adverse effects on the citizens of Minnesota and, consequently, has adversely and disproportionately affected their access to and enrollment in Medicare+Choice; and (3) legislative and political solutions to this irrational and unfair reimbursement system have been unsuccessful and leave no recourse but legal action before this Court.

(1) Irrationality. One of the key goals of Medicare+Choice, the roots of which stem from Congressional action in 1972 and 1982, is to furnish participating risk plans with uniform incentives to provide non-covered benefits to their beneficiaries. This goal is evident from (a) examining the initial, uniform structure and spirit of Medicare's Parts A and B, established in 1965, that are still in place today; Congress has done nothing since then to indicate a change in that spirit of uniformity; and (b) the utilization of the adjusted community rate ("ACR") mechanism

and the "required benefit value" that gives incentives to provide non-covered benefits. In other words, uniformity plus incentives equals uniform incentives. Under Medicare+Choice, the reimbursement system provides Minnesota with low capitation payments. As a result of static ACRs, the required benefit values for plans in Minnesota are extremely small or nil. Thus, participating plans in Minnesota have no incentive to offer non-covered benefits to their enrollees. As such, Medicare+Choice's reimbursement system is irrational, does not remotely effectuate one of the program's key goals, and cannot justify the unequal, disparate treatment of Minnesota citizens.

(2) Adverse Impact. This irrational system adversely impacts Minnesota citizens by saddling them with high co-payments and extra premiums that carry no extra benefits. Minnesota's burden is not one shared by states like Florida or New York, whose citizens enjoy a panoply of extra benefits at no extra cost. This inequitable treatment adversely affects access to and enrollment in Medicare+Choice plans in Minnesota.

(3) Failed Legislative Efforts. Political reform and legislative remedies have been unsuccessful. Until 1997 and the Balanced Budget Act ("BBA"), Congress was unable even to address the issue in a meaningful fashion. At its inception, the average adjusted per capita cost ("AAPCC") schedule was based on arbitrary tabulations. The BBA's modest reforms were wholly inadequate. Budget neutrality rules kept (and continue to keep) capitation payments low, and the BBA failed to substantively reform the ACR mechanism. Consequently, legal action is Minnesota's only recourse.

#### I. IRRATIONALITY OF THE MEDICARE+CHOICE REIMBURSEMENT SYSTEM

One of the key purposes of Medicare+Choice is to provide incentives for participating risk plans to offer non-covered benefits (e.g., prescription drug benefits) to beneficiaries at the lowest possible cost to beneficiaries. However, the reimbursement system under Medicare+Choice does not offer such incentives to participating plans in Minnesota. The result is that most participating plans in Minnesota either do not offer any non-covered benefits to beneficiaries, or they offer such non-covered and covered benefits with high premiums and co-payments. Such is not the case in other states. This disparate, unequal, and unfair result is the consequence of an irrational reimbursement system that does not provide the purported incentives of Medicare+Choice in Minnesota, which are provided in other states. Moreover, it is this disconnect that gives the federal government no rational basis for its disparate and unequal treatment of Minnesota senior citizens under Medicare+Choice.

##### A. PURPOSE

Medicare was established in 1965 as a national insurance program for elderly and disabled people. It is, in fact, the nation's largest health insurance program. Medicare Parts A and B provided covered benefits (e.g., general hospital services) to beneficiaries on a fee-for-service basis. Under Part B, participating beneficiaries partly fund the program with uniform, monthly premiums assessed against participating beneficiaries. This original structure of Medicare under Parts A and B is instructive. At its inception in 1965, Medicare was created to provide uniform health care services at uniform and equal costs to all qualified beneficiaries over the age of 65. There is no

reason to suspect that the intent behind Medicare's uniformity of benefits and inherent equality has changed.

In 1972, Congress amended the Social Security Act to incorporate managed care principles into the Medicare system. In so doing, the national legislature allowed health maintenance organizations ("HMOs") to be paid a flat, monthly capitation payment for Parts A and B services on either a cost or risk basis. Such capitation payments were based on an actuarial calculation of the average adjusted per capita cost ("AAPCC") per Medicare beneficiary. Congress set capitation payment rates at 95% of the estimated per capita costs of fee-for-service Medicare beneficiaries. This choice of 95% was purely arbitrary. (See Section 111, *infra.*)

In 1982, Congress again amended the Social Security Act to broaden the scope of participating organizations in Medicare. Specifically, while the Tax Equity and Fiscal Responsibility Act of 1982 ("TEFRA") retained the AAPCC formula and continued to provide participating plans with a monthly capitation payment on a county-by-county basis, TEFRA also incorporated the adjusted community rate mechanism into its reimbursement system. By so doing, Congress intended, *inter alia*, to provide participating risk plans with incentives to provide non-covered beneficiaries.

In 1997, Congress enacted the Balanced Budget Act of 1997, which modified the payment methodology for the first time and created Medicare Part C or Medicare+Choice. The BBA altered the reimbursement system for participating risk plans in a failed attempt to equalize vastly diverging capitation payments. However, the BBA did little if anything to substantively change or affect the ACR mechanism that determines the scope of non-covered benefits.

In sum, Medicare was established in 1965 to provide uniform medical benefits to all qualified senior citizens regardless of geographic residence. This is evident from the original structure of Parts A and B of the program that is still in place today. Furthermore, the subsequent incorporation of managed care principles into the federal program and the creation of Medicare+Choice did nothing to alter Medicare's spirit of uniformity. Thus, by examining Medicare+Choice within the context of uniformity for covered benefits under Parts A and B, one of the key purposes behind Medicare+Choice and its ACR mechanism becomes clear: Medicare+Choice, through the ACR mechanism, endeavors to give all participating plans relatively uniform incentives to provide their beneficiaries with extra, non-covered benefits at the lowest possible cost.

##### B. IRRATIONALITY OF THE SYSTEM

Given the above purpose of Medicare+Choice, the reimbursement system for participating plans provides no rational basis for the federal government's unequal and disparate treatment of Minnesota citizens. That is, the reimbursement system fails to effectuate the purpose behind Medicare+Choice—to furnish participating plans with uniform incentives to provide non-covered benefits. More specifically, Minnesota's chronically low, county-based capitation payments, when compared to Minnesota's various county-based ACRs, give absolutely no incentive to participating plans to provide non-covered benefits to qualified Minnesota senior citizens.

Moreover, the underlying and flawed AAPCC formula, upon which current payment rates currently rely, originates from

arbitrary tabulations. This arbitrary quality further underpins the irrationality of the reimbursement system. (See Section III, *infra.*)

The reimbursement system under Part C of Medicare has two components. The first component is an actuarial methodology used to calculate risk plan payment rates each year. This component actually determines the monthly capitation payment to each plan on a county-by-county basis. The second component is the ACR mechanism. This component determines the scope and/or amount of non-covered Medicare benefits and services a beneficiary receives.

Before the Balanced Budget Act of 1997, the capitation payment rate was known as the adjusted average per capita cost ("AAPCC"). The AAPCC was a relatively simple and crude formula whereby Medicare would pay a risk plan 95% of what a beneficiary would have received under a traditional fee-for-service arrangement. This actuarial project was calculated on a county-by-county basis.

Thus, the underlying methodological paradigm of the AAPCC was actuarially based on historical fee-for-service expenditures. This methodology accounted for (and continues to account for) the wild variations in payment rates for participating risk plans (See Section II, *infra.*) Minnesota counties, in particular, were and continue to be adversely affected by this wide disparity in payment rates from county to county. Minnesota's historically efficient system, including its early development of HMOs, was beneficial to the Medicare program because Minnesota's lower charges relative to the national average saved the program money. However, because Medicare managed care based its capitation amounts on historical charges, Minnesota counties were in effect punished for their efficiency with low capitation amounts. Other states and counties that had high service use patterns and inputs costs were paid generously for their inefficiency. Under current federal law and regulations, these rates are locked in perpetuity. Given the purpose of Medicare+Choice—to provide uniform incentives—this capitation payment methodology, based on data that punished historical efficiency, is irrational.

The BBA replaced the AAPCC methodology and created the current capitation payment methodology, but it retained the old AAPCC rates for its baseline, which are the substantive statistics on which the BBA's new tabulations rely. Specifically, the BBA created a Medicare Part C ("Medicare+Choice"), under which Medicare's monthly capitation payment is the greater of: (a) a blended capitation rate, which is the sum of a percentage of a county-specific rate and a percentage of a price-adjusted national rate, multiplied by a budget neutrality factor designed to ensure that the aggregate payments under this blended rate do not exceed the amount that would have been paid under an AAPCC rate alone; by the year 2003, a maximum blend will consist of a 50% county-based rate and a 50% national capitation rate; (b) a minimum monthly payment level, which in 1998 equaled \$367; or (c) a minimum 102% of the previous year's capitation rate.

That is, the BBA failed to jettison AAPCCs altogether and to recalculate plan payments derived from a new statistical baseline. The inherent inequities that result from county-based fee-for-service projections remain in the capitation payment structure. Minnesota continues to suffer from disparate treatment, although Medicare's mission is to provide an equitable entitlement for all American citizens regardless of residency. Even the adoption of the blended-rate rule under

the BBA has had no relative, immediate effect, because the combination of the low national growth percentage and the budget-neutrality rule has delayed its application. (See Section III, *infra*.)

The second component of Medicare's risk program payment methodology is the adjusted community rate mechanism. The ACR mechanism is the process through which health plans determine the minimum amount of Medicare non-covered benefits they provide to enrollees (the "required benefit value") and the premiums they are permitted to charge for those extra benefits. When compared to its low ACRs, Minnesota's low payment rates crystallize the unfair nature of basing capitation payment rates on Medicare fee-for-service data as a means of creating uniform incentives to participating risk plans.

The ACR process requires a plan to use its costs and revenues from its commercial business to estimate the cost of providing services to Medicare enrollees. This cost report is the actual "adjusted community rate." If the monthly capitation payment exceeds the ACR, Medicare requires risk plans do one of three things: (1) receive only the ACR amount from the government; (2) contribute all or a portion of the excess money into a stabilization fund; or (3) provide beneficiaries with additional benefits with a value equal to the difference between the ACR and AAPCC or the "required benefit value." Thus, one of the key purposes behind the ACR mechanism becomes all too clear. Congress created Medicare+Choice and the ACR mechanism to furnish participating plans with incentives to choose option three. If plans could reduce their ACRs, their static capitation payments would enable them to attract Medicare customers with additional non-covered benefits. The magnitude of the capitation payment/ACR difference (or the required benefit value per enrollee) is the crucial determination of the scope and amount of additional benefits one receives under Medicare.

As such, the disparate payment rates when compared with ACRs are evidence of an irrational and unfair reimbursement system that does not give Minnesota participating plans any incentive to provide non-covered benefits. (See Section II, *infra*.) The capitation payment rate punished Minnesota for efficiencies the state health care system had achieved in the 1970s and 1980s. Because counties outside Minnesota with historically high fee-for-service rates eventually enacted managed-care reforms and instituted cost-effective, efficient measures (as reflected in their continuously decreasing ACRs), the magnitude of their required benefit values are high. This allows risk plans in those counties to offer additional non-covered benefits to their beneficiaries for little or no additional cost. However, Minnesota counties could not undergo a similar evolution towards increased efficiency or cost-effectiveness. Counties in Minnesota had a long history of efficient health care (a legacy of the

state's pioneering efforts in managed care). As a result, Minnesota ACRs have been low for decades, and the difference between Minnesota's historically low capitation payments and its ACRs were, and continue to be, extremely small or nil. Consequently, the system is inherently unfair—Minnesota beneficiaries are not entitled to the same non-covered benefits that other citizens in other states' counties enjoy, because participating risk plans in Minnesota have no incentive to provide such services. That is, plans in different states have vastly different required benefit values. (See Section II, *infra*.)

Under a rational and equitable system, the ACR and the capitation payment rates should almost perfectly correlate, taking into account the differences in costs of commercial and Medicare beneficiaries. That is, the dollar difference between a risk plan's ACR and its capitation payment should have the same purchasing power regardless of the county in which a beneficiary resides. However, this is simply not the case. Instead, the required benefit values vary wildly from county to county, and this translate into inequitable access by senior citizens to non-covered benefits and services. (See Section II, *infra*.)

C. EFFICIENCY

The current reimbursement system for Medicare+Choice encourages inefficiency in an era when the federal government should be encouraging efficiency. The fact is that States are in effect rewarded for historically inefficient health care systems with high capitation payments, and Medicare+Choice essentially punishes Minnesota for its pioneering efforts in managed care. While Part C currently awards efficiency with large required benefit values (i.e., participating plans are encouraged to reduce their ACRs) the fact that capitation payments remain static perpetuates historical inefficiency built into the system.

Minnesota's unique history precludes the state from reaping the benefits of large required benefit values. Because the BBA shackled capitation payment increases with a budget neutrality rule (see Section III, *infra*), Minnesota counties continue to receive chronically low and inadequate reimbursement rates. A system that truly encouraged efficiency would take into account Minnesota's pioneering efforts in health care and reward the state with higher capitation payments. This would translate into larger required benefit values for participating plans.

One of the most pressing issues facing the United States today is the enduring trend of rising health care costs. These rising costs prevent the health care system from providing universal coverage; they stifle the expansion of life-saving and life-enhancing benefits, such as prescription drug coverage; and they burden covered beneficiaries with higher premiums and co-payments. Thus, Minnesota's chronically low payments prevent the state from capitalizing on its unique

place in history. Minnesota bucked the trend of rising health care costs and actually delivered high quality, affordable care to its citizens. Minnesota's success should be held as a model for the nation and an example of what our country can do to reign in health care costs. However, Medicare+Choice does just the opposite by undermining the drive for greater efficiency.

In sum, by ruling in favor of Minnesota in this lawsuit, the Court has the unique opportunity to accomplish what the United States Congress has to date been unable to do: promote quality health care that is equitably delivered in an era of rising health care costs.

II. CONSEQUENCES OF THE SYSTEM ON MINNESOTA

The effects of this irrational system have been devastating to the state of Minnesota and its citizens. Minnesota counties' capitation payments are alarmingly low when compared with the capitation payment rates of counties in other states, and its ACRs have remained static. As a consequence, access by Minnesota seniors and Minnesota's enrollment rates in Medicare+Choice are adversely and disproportionately affected.

A. DISPARATE CAPITATION PAYMENTS

The disparity of capitation payment rates for Minnesota and other states is striking. In 1997, the reimbursement rate for Dakota County, Minnesota was \$379.11; in Hennepin County, Minnesota, the rate was \$405.63. In 1997, the reimbursement rate for Richmond County, New York, was \$767.35, while in Dade County, Florida, the AAPCC rate was \$748.23. In 1997, every county in Minnesota had an AAPCC rate below the national average AAPCC rate. In 1999, despite the BBA reforms, little changed. The capitation payment rate in Dakota County was \$394.42, while the payment rate in Broward County, Florida, was \$676.64. (See Appendix A; see also Section III, *infra*.)

B. DISPARATE EFFECTS OF THE ACR MECHANISM

In addition, because of its historic efficiency, Minnesota's ACRs have remained static. Consequently, the difference between Minnesota's low capitation payments and its static ACRs is minimal or non-existent. Conversely, other states with recently improved efficiency have experienced falling ACRs, enabling them to enjoy large required benefit values as a result of their high capitation payments and low ACRs. The result is that different managed care plans in different states have different incentives with regard to non-covered benefits. In Minnesota, seniors face high Medicare premiums and co-pays and receive few or no non-covered benefits, while other states' citizens enjoy a multitude of life-saving and life-improving non-covered benefits with few or no extra payments. Nowhere is this more obvious than in coverage for prescription drugs.

The following chart illustrates the differences between required benefit values in different metropolitan areas:

TABLE 1.—RISK-PLAN BENEFITS AND MONTHLY PREMIUMS BASED ON ADJUSTED COMMUNITY RATE PROPOSALS BY MARKET, 1995

(Dollars per month)

Primary metropolitan statistical area	Number of plans	Required benefit value	Optional benefit value	Premium charged
United States .....	174	\$25.17	\$56.67	\$22.04
Boston .....	8	4.09	71.56	47.84
Chicago .....	3	24.45	38.31	0.00
Los Angeles .....	13	68.83	37.18	6.08
Miami .....	8	106.27	20.75	0.00
Minneapolis .....	3	0.00	75.89	60.97
New York .....	5	53.37	46.77	8.80
Philadelphia .....	6	19.30	66.85	10.00

TABLE 1.—RISK-PLAN BENEFITS AND MONTHLY PREMIUMS BASED ON ADJUSTED COMMUNITY RATE PROPOSALS BY MARKET, 1995—Continued

[Dollars per month]

Primary Metropolitan Statistical Area	Number of Plans	Required Benefit Value	Optional Benefit Value	Premium Charged
Portland, OR .....	7	9.38	64.52	46.00
San Francisco .....	8	21.50	56.96	20.25
Nonmetropolitan California .....	6	14.43	60.19	31.08
Nonmetropolitan Florida .....	5	12.46	73.61	9.80
Nonmetropolitan Pennsylvania .....	3	6.70	62.18	18.14

Note.—Required benefit values is equal to Medicare savings in the adjusted community rate proposal; optional benefit value is equal to the maximum monthly premium. Values are unweighted averages of all Medicare risk plans. Data Source: Physician Payment Review Commission (now Medicare Payment Advisory Commission) analysis of 1995 adjusted community rate proposal data from the Health Care Financing Administration. Table Source: United States House of Representatives Committee on Ways and Means, 1998 Green Book: Background Material and Data on Programs Within the Jurisdiction of the Committee on Ways and Means Washington, D.C.: U.S. Government Printing Office, May 19, 1998. P. 200, Table 2-36.

For example, a Medicare+Choice enrollee in Dakota County, Minnesota may choose the HealthPartners—Standard Option (“Minnesota Plan”) by paying—in addition to Medicare Part B’s premium—an annual premium of \$1,137. By contrast, a similar enrollee in Broward County, Florida pays no additional costs. The Minnesota beneficiary pays a \$10 co-pay per visit with his or her personal physician or specialist doctor, while the Florida beneficiary pays no additional co-pay. Except for injectable insulin, the Minnesota beneficiary pays all costs for all outpatient prescription drugs, while the Florida beneficiary pays nothing for a full outpatient prescription drug benefit. The Minnesota beneficiary pays 20% for out-of-area ambulance transportation, while the Florida beneficiary pays nothing for such transportation. The Minnesota beneficiary pays a \$10 co-pay for each individual outpatient mental health session, while the Florida beneficiary pays nothing for each session. The Minnesota beneficiary pays a \$30 co-pay for emergency services, while the Florida beneficiary pays nothing for such services. The Minnesota beneficiary pays a \$30 co-pay for “Urgently Needed Services” in the plan’s service area, while the Florida beneficiary pays nothing. (see Plaintiffs’ Complaint, paragraphs 32–40.)

#### C. EFFECTS ON ACCESS AND ENROLLMENT

The disparate effects of Medicare+Choice’s reimbursement system have adversely affected Minnesotans’ access to and enrollment in participating risk payment plans. Minnesota health plans have entirely withdrawn from or declined to participate in the Medicare+Choice program, have withdrawn from offering such plans in various counties in Minnesota, or have suffered a reduction in the available networks of health care providers that provide medical services to enrollees. Currently, only three health plans offer Medicare+Choice plans to seniors in Minnesota—and this figure represents a reduction from the previous figure of four. Such limited Medicare+Choice plans are available almost exclusively in the counties of the Minneapolis-St. Paul metropolitan area and are not generally available to beneficiaries in rural Minnesota counties. (Refer to Table I for a list of the number of participating plans by state or metropolitan area.)

#### III. POLITICAL AND LEGISLATIVE SOLUTIONS HAVE BEEN INADEQUATE

Legislative and political solutions to Minnesota’s low capitation payments have been largely unsuccessful. From its inception, AAPCCs were based on arbitrary tabulations, and early demonstration projects indicated that the payment methodology was problematic. Furthermore, when legislative relief came in 1997, the BBA failed to adequately ameliorate payment disparities.

#### A. EARLY HISTORY

From the first risk-contracting demonstration projects in the late 1970s, it was clear

that the method of reimbursement was flawed for use in rural- and conservative-practice areas. Risk contracting was first authorized in 1972, but due to poor provider participation, the Health Care Financing Administration (HCFA) solicited applications for new models for capitated payments in 1978. Five demonstration projects resulted, one of which, the Greater Marshfield (Wisconsin) Community Health Plan, was located in a rural area.

Reimbursement rates for all five projects were established at 95% of the average FFS costs for the counties involved in the demonstration, a schedule that became known as the AAPCC. This value of 95% of the average FFS was arbitrarily chosen and is not substantiated by research that would show this value represents an expected savings from coordination of care. The formula has failed to provide all Medicare beneficiaries equal access to the Medicare+Choice option.

Though Marshfield succeeded in reducing utilization of services by nearly 10 percent over the course of the demonstration the total loss for the plan and its sponsors was over \$3 million. With these losses in mind, the HCFA terminated the Marshfield demonstration. Marshfield responded by requesting experimentation with the AAPCC to see if some alternative or variation could more accurately predict cost. The HCFA rejected this suggestion without explanation.

In the early and mid-1980s, more demonstrations were established. Plans in the Twin Cities of Minnesota provided additional, non-covered benefits, such as outpatient prescription drugs, and competed aggressively for enrollment. Enrollment in risk products grew dramatically, to a peak of 60% of the Twin Cities metro area’s senior population by 1986–87. Nationally, in fiscal year 1986, \$1.3 billion was reimbursed to 142 risk contractors who provided care to nearly 75,000 beneficiaries.

In response to market interest, several plans expanded their Medicare risk service areas to rural counties, assuming that lower AAPCCs in those counties would correlate with lower cost to serve a rural population. However, the reverse proved to be true and seniors flocked to the plans’ comprehensive coverage with significant pent up demand. After a couple years of significant losses, most of the plans withdrew from rural counties, and again, the payment structure failed beneficiaries in rural areas.

The mid- and late-1980s saw several years of no increase in the AAPCCs, with payments actually falling in at least one year. As a result, health maintenance organizations (HMOs) which had long-since pulled out of rural areas began to reduce benefits and significantly raise member premiums. Enrollees began to pay more and more of the cost of the added benefits through their premiums. Increasing numbers of seniors moved to lower option risk products without prescription drug coverage as the higher option

products became unaffordable for many. Even with significant member cost-sharing, many of the HMOs experienced marked losses and began exiting the risk contract business.

Analysis by the Physician Payment Review Commission in 1997 shows that in June 1997, 33% of all Medicare beneficiaries lacked access to risk plans. At the same time, some 60% of beneficiaries had a choice of plans, and one-third had five or more available to them.

Patterns of enrollment differ across urban and rural locales, as well as across different regions in the nation. Enrollment in central urban areas was about 24% in June 1997, about twice the level in outlying urban areas. Urban areas with the greatest share of national enrollment growth tend to be those where Medicare payments are high. Enrollment is generally higher in western states and a few specific southern and eastern states. In fact, five states account for over two-thirds of all enrollees. (For statistics regarding access and enrollment rates, see United States House of Representatives Committee on Ways and Means, 1998 Green Book: Background Material and Data on Programs Within the Jurisdiction of the Committee on Ways and Means. Washington, D.C.: U.S. Government Printing Office, May 19, 1998. Section 2: Medicare.)

No actions taken to date have resolved the underlying arbitrary and flawed AAPCC formula, which is responsible for creating all the disparities in reimbursements to plans and benefits to beneficiaries. The old AAPCC formula, and the new configurations which rely upon the AAPCC, were not based on actuarially sound data. Given the discrimination the current system creates across the country and between beneficiaries enrolled in a national, uniform program, there is no reasonable basis for this formula.

#### B. THE BALANCED BUDGET ACT

The BBA was Congress’ first legislative attempt to comprehensively address the issue; however, the BBA failed to ameliorate the inherent deficiencies and irrationality of the reimbursement system. At present, participating risk plans in Minnesota do not have any incentives to offer non-covered benefits to their beneficiaries. This is because the BBA did nothing to substantially reform the ACR mechanism, nor did it adequately address the disparities in capitation payment rates.

The BBA sought to lessen payment disparity by de-linking AAPCC updates from local FFS spending. The BBA established a new mechanism for calculating Medicare’s monthly payments to HMOs and other managed care and capitated plan providers. A county’s Medicare+Choice payment was the higher of three different rates—a floor payment of \$367, a minimum annual increase of 2 percent, or a 50/50 blend of local and national rates that was to be fully phased-in by FY 2003.

Initially, many rural counties in Minnesota received significant reimbursement increases under the new floor payments. For example, Watonwan County saw AAPCC reimbursements increase from \$251.05 to \$367.00 (a 32 percent increase) in 1998, but this is still a far cry from the nearly \$800 rate paid to other counties in other states. Unfortunately, these payments were essentially frozen at these new floor levels, as the local/national blend was difficult to implement because of a budget-neutrality provision. (See Appendix B.)

In both 1998 and 1999, none of Minnesota's counties received a local/national blend rate. This outcome resulted from the budget neutrality provision of the BBA, which requires that Medicare+Choice payments not exceed payments that would have been made if payments were based solely on local rates. According to the House Committee on Ways and Means, a budget neutrality adjustment is "applied as necessary to the blended rates to ensure that the aggregate of payments for all payment areas equals that which would have been made if the payment were based on 100 percent of the areas-specific capitation rates for each payment area. In no case may rates be reduced below the floor or minimum increase amounts for the particular county. In some years, it may not be possible to achieve budget neutrality because no county rate may be reduced below its floor minimum increase. The law makes no provision for achieving budget neutrality after all county rates are at the floor or minimum increase." (see 1998 Green Book, supra.) In other words, if awarding each county the maximum rate (among its floor, blend, or minimum update) results in total payments that exceed the budget neutral target, counties which would otherwise receive the blend rate have their rates reduced to meet the target. The net result in 1998 was that Minnesota's urban counties (e.g. Hennepin and Ramsey Counties) received only a 2% increase and fell even further behind the highest reimbursed counties in other states. (see Appendix A.)

In 1999, the budget neutrality provision reduced Medicare+Choice rates for aged beneficiaries in 1,293 counties. These counties would have received blended-rate amounts if sufficient monies were available to fund all counties at the maximum of the floor, blend, or minimum update. Consequently, as a result of the budget neutrality provision, the gap between high and middle level AAPCC counties, contrary to Congressional intent, actually grew in the first year of BBA. Two years after enactment of the BBA, counties in Minnesota were still 21 percent below the national average reimbursement level for Medicare+Choice.

Essentially, these variations in reimbursements have created a two-tiered system of health care delivery, which is the foundation of the plaintiffs' lawsuit against the federal government. As the lawsuit rightly contends, these payment imbalances have created a geographical class system of Medicare benefits where beneficiaries in high cost areas receive extra benefits at no additional cost, while beneficiaries in low cost areas are denied these benefits.

#### IV. CONCLUSION

For the forgoing reasons, the undersigned *amici curiae* respectfully request this Court to deny Defendants' Motion to Dismiss.

### HONORING FATHER CARL VOGEL OF TEXAS

#### HON. RALPH M. HALL

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 29, 2000

Mr. HALL of Texas. Mr. Speaker, today I recognize the 50 years of ministry that Father Carl Vogel has given to the Catholic community in Texas. Since 1984, he has been with the St. Michael Parish in McKinney, which is part of the Fourth Congressional District of Texas. Father Vogel celebrated his 50th anniversary of ordination with a Mass on May 28 at St. Michael, followed by a reception attended by his devoted parishioners and many friends.

A list of credentials and milestones of Father Vogel's career would not begin to describe the many ways in which this man has served his parish—embracing not only the trials and troubles of his parishioners, but their joys as well. He is the ever-constant protector and confidant that people seek out in their pastor. He is faithful to the teachings of the church and faithful to his parish, and his service has been imbued with a characteristic sense of humor that has endeared him to all those who know him.

In addition to the May 28 celebration at St. Michael, other celebrations were planned at the Holy Family Mission in Van Alstyne, Texas, where Father Vogel is also pastor, and at Christ the King Church in Dallas, where he celebrated his solemn Mass in 1950.

Father Vogel grew up in the Oak Cliff section of Dallas and attended Blessed Sacrament Church and Our Lady of Good Counsel School. After his graduation from St. Joseph High School, he enrolled in college to study journalism. The calling to the priesthood prevailed, however, and he followed that call at St. John's Seminary in Little Rock, Arkansas. Father Vogel served as a military chaplain for nearly three decades and was a chaplain for the Armed Forces during the Cuban Missile Crisis of the early 1960s. Prior to his assignment at St. Michael, Father Vogel served at Our Lady of Victory in Paris, Good Shepherd in Garland, St. Patrick in Denison, St. Cecilia in Dallas and St. Patrick and St. Rita parishes in Fort Worth.

Mr. Speaker, it is an honor for me to pay tribute to this beloved priest from the Fourth District of Texas. Father Carl Vogel has devoted his life to the ministry. He has helped countless souls in his care and is loved and respected by so many who have known him and whose lives he has blessed. I know and love Father Vogel. I have changed schedules many times just to get to appear with him at public ceremonies. His prayers sustain me and all those who hear him. His devotion to his calling for 50 years warrants our recognition and appreciation today, so as we adjourn, let us do so in honor of Father Carl Vogel.

### NARCOTIC DRUGS

#### HON. MARK E. SOUDER

OF INDIANA

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 29, 2000

Mr. SOUDER. Mr. Speaker, I rise on behalf of the countless mothers, fathers, families, and individuals whose lives have been devastated by illegal drugs to introduce legislation to federally nullify movements in the states to legalize the use of narcotic drugs illegal under federal law.

It is undisputed that narcotic drugs devastate our families and rot our communities literally to the core through addiction and crime. Earlier this week, we passed the Commerce/Justice/State Appropriations bill that provided literally hundreds of millions of our tax dollars to fight drugs and drug-related crime, and we are finalizing action on \$1.3 billion in assistance to our allies in Colombia, where agents of the Colombian National Police are dying in numbers to keep them off of our streets in America.

Directly defying our efforts as a Congress and a nation, a small group of well-funded activists have engaged in deceptive, back door, efforts that pretend to legalize drugs under state law that are banned under federal law. These activists hide behind the myth of so-called "medical" use of marijuana and other drugs, despite the facts that there is no scientific proof that smoked marijuana provides any real medical relief, and that the active ingredient in marijuana is available in pill form. Increasingly, however, they have abandoned even this pretense, and made clear that their goal is the legalization or decriminalization of narcotic drugs.

One activist called it the "leaky bucket strategy . . . legalize it in one area, and sooner or later it will trickle down into the others." The bucket is now leaking faster.

The Governor of Hawaii just signed into law state legislation that purports to allow the "medical" use of marijuana, even though it's still illegal under federal law. Five states have enacted laws by ballot initiative that purport to allow so-called "medical" use of marijuana under state laws: Alaska, California, Maine, Oregon and Washington. In furtherance of that strategy, pro-drug activists are now attempting to pass ballot initiatives for the November elections in six states to virtually decriminalize marijuana by removing criminal penalties for its use in Alaska, Arizona, California, Colorado, Massachusetts, and Michigan.

These initiatives have already given us such Alice-in-Wonderland moments as the "nation's first bed and breakfast inn catering to medical marijuana users" in Santa Cruz, California. This "establishment" was featured in *People* magazine with a smiling couple holding marijuana plants in front of their home, which is said to contain cannabis-themed tiles on the sidewalk, and hemp curtains and towels. That really sounds like a "medical" facility to me. We've also seen the bizarre decision by the Oakland City Council to declare a "public health emergency" after a court closed the city's medical marijuana club, and the issuance of photo ID cards supposedly allowing marijuana use by the Arcata, California police chief.