Introduction

The American Society of Internal Medicine (ASIM) represents physicians who specialize in internal medicine, the nation’s largest medical specialty. Internists provide both primary and consultative care to more Medicare patients than any other physician specialty. Consequently, Medicare payment policies have a direct and disproportionate impact on the ability of internists to provide their elderly and disabled patients with the best care possible. ASIM’s testimony today will address the impact of two controversial Medicare fee schedule payment policies—resource-based practice expenses and a single conversion factor—on internists and their patients. The testimony will also address other reforms that are needed in Medicare payment policy.

Making Medicare Payments Resource-Based

Congress has an opportunity to make 1998 the year that Medicare payments truly become resource-based. Even though 1998 will represent nine years since Congress first said that it wanted Medicare payments, the fact is that some services continue to be reimbursed more for the resources involved than other services. ASIM believes that Congress should assure that the 1998 budget allows for correction of two distinct flaws in the Medicare fee schedule that have resulted in payments not being truly resource based:

1. Separate volume performance standards, conversion factors, and updates have resulted in surgical procedures being paid at a much higher rate than primary care and other nonsurgical services that require the same resources to perform.

2. Medicare payments for practice expenses continue to be based on historical charges, not resource costs. As a result, services that historically were overvalued prior to implementation of the resource-based relative value scale (RBRVS) continue to be overpaid for their overhead expenses, while services that were undervalued continue to be underpaid for their practice expenses. Concern about the inequities created by the current charge-based formula led Congress to enact legislation in 1994 that mandates implementation of resource-based practice expenses on January 1, 1998.

Single Conversion Factor

ASIM strongly supports the administration’s proposal to enact a single dollar conversion factor for the Medicare fee schedule, effective 1/1/98, and to establish the single conversion factor at a level that is no less than the current primary care conversion factor, updated for inflation. We appreciate this committee’s support in the past for enactment of a single conversion factor. Under the 1997 default conversion factors, surgical procedures are reimbursed at a rate that is 14% higher than primary care services, and 21% higher than other nonsurgical services, that involve the same amount of physician work. In an effort to correct this inequity, Congress included a single CF in the Balanced Budget Act.
of 1995. The single CF would have been effective on January 1, 1996. As the committee is well aware, however, President Clinton vetoed the BBA, with the result that the policy of separate conversion factors and updates remains in effect. There continues to be strong bipartisan support for enacting a single CF, however, as evidenced by the fact that it not only was included in the BBA and in the President’s current budget, but it has also been included in other proposals such as the recently-unveiled “Blue Dog” budget proposal.

Current law requires that separate target rates of increase in expenditures—or volume performance standards (VPSs)—be established for surgical procedures, primary care services, and nonsurgical services. If actual spending is below the applicable VPS, the services in that category get a bonus increase (the Medicare economic index plus the percentage that actual spending came in under the VPS). If spending exceeded the applicable VPS, the Medicare economic index (MEI) is reduced by the percentage that spending exceeded the VPS unless Congress specifies otherwise. After adjustment for demographic changes and changes in law that may affect annual growth in expenditures on physician services, the VPSs represent a target rate of growth that is equal to the previous five year historical average expenditures for the category of services, minus a performance standard adjustment factor.

Payments for surgical procedures benefited from this formula because changes in practice patterns over the past five years resulted in surgical volume increasing at a slower rate than other physician services. The reduction in surgical volume is due principally to changes in practice patterns—specifically, the substitution of non-surgical treatments for surgical procedures. The Physician Payment Review Commission, citing the Agency for Health Care Policy and Research, reported in 1994 that “Reductions in the volume of prostate-related procedures mostly reflect changes in treatment through increased use of drugs, less invasive surgical procedures, and watchful waiting” (PPRC, Fee Update and Medicare Volume Performance Standards for 1995, May 15, 1994). The evidence also suggests that much of the reduction in surgical volume is due to an inevitable “bottoming out” of the number of patients who have a need for cataract surgery and several other surgical procedures that experienced explosive growth in the mid-1980s. In the same 1994 report from the PPRC that is cited above, the Commission noted that “The period of greatest growth in volume for a new medical procedure or technology is often the first few years following introduction, largely because it is during this period of diffusion that patients with existing indications are treated along with those newly identified. In the mid-1980s, the volume of new technologies such as cataract surgery was growing at double-digit rates, because there were tens of millions of patients who needed—and could benefit—from those treatments. As time has passed, however, the demand for such procedures has naturally declined.”

ASIM opposes any additional transition or delay in mandating a single CF. Given that Congress intended for a single conversion factor to go into effect on January 1, 1996 (as would have been required under the BBA), physicians will already have had two years of a de facto transition to a single conversion factor under the administration’s proposals for implementation on January 1, 1998. We also urge Congress to support the administration’s proposal to establish the single conversion factor at a level that is no lower than the current primary care conversion factor, updated for inflation. Payments for primary care services, which have been undervalued in the fee schedule updates for most of the past five years, should not be rolled back below current levels. Establishing the conversion factor at anything less than the primary care conversion factor, as updated for inflation, would also require deeper cuts in payments for surgical procedures, and provide less relief for the other nonsurgical services that have been most disadvantaged under the current update formula, A
transition would also reduce the savings that the administration projects from a single CF by easing the reductions in payments for overvalued surgical procedures.

Implementation of Resource-Based Practice Expenses

ASIM continues to strongly support implementation of methodologically sound resource-based practice expenses. Because current practice expense payments are not truly resource-based, some services remain grossly overvalued while others remain substantially undervalued. An internist who provides 115 level 3 established patient office visits—typically requiring 29 hours of face-to-face time with patients—receives the amount of practice expense reimbursement that a surgeon gets for one bypass graft that takes only a few hours to perform. Medicare also ends up paying surgeons for operating room overhead expenses that the hospital, not the physician, incurs and that are already paid under Part A. In 1992, the Physician Payment Review Commission noted that “54% of the Medicare fee schedule payment for a coronary bypass graft in the final rule represents payments for practice expenses. However, this service is provided in hospital operating theaters that are equipped and staffed by the hospital, not the physician. In this case, the Medicare Part A payment includes the costs of virtually all of the expense payment for this service besides the physician work.”

Some have argued that because highly preliminary data released by HCFA in January indicate that major redistribution of income may occur under resource-based practice expenses, this means that the Health Care Financing Administration’s approach to this issue is fundamentally flawed. ASIM does not believe that the test of HCFA’s proposed methodology should be the degree that it does or does not redistribute payments. Rather, it should be whether or not the methodology that HCFA will propose is methodologically sound and more fair than the existing charge-based methodology. HCFA project staff have repeatedly stated that the data, methodological options, and specialty-impact estimates released in January for review and comments are “highly preliminary” and meant only to be “illustrative” of the impact of a range of approaches to determining RBPEs—and that none of the specific options presented will be adopted by HCFA to develop the proposed rule. Given the preliminary nature of the information that was released, we do not believe that it is appropriate to conclude now that implementation of RBPEs needs to be delayed. ASIM has provided HCFA with detailed recommendations for making improvements in the methodology and data that will be used to develop resource-based practice expenses.

We urge this Committee to withhold judgment on changing the timetable for implementation of resource-based practice expenses until a proposed rule is published, and until HCFA explains the process that will be used to refine the initial resource-based practice expenses. In its upcoming report to Congress, the Physician Payment Review Commission rejects any delay in implementation of RBPEs, on the basis that sufficient data are available and that no better data would be forthcoming should a delay be granted by Congress. We agree with the Commission’s view that the unfairness inherent in the current system demands that methodologically sound RBPEs be implemented as soon as possible, and that there is no reason to conclude now that this can’t be accomplished on January 1, 1998.

ASIM also strongly supports the Commission’s view that unproven assumptions of a behavioral offset should not be incorporated into the RBPEs. A behavioral offset will magnify the reductions for overvalued services and reduce the gains for undervalued ones. The Commission correctly points out that the administration’s contention that physicians offset 50 cents of every dollar that is lost when payments are reduced was not borne out when the RBRVS was implemented. HCFA should learn from its experience with the RBRVS, rather than repeating the same mistakes. If necessary, Congress should consider enacting legislation that would limit HCFA’s ability to apply a behavioral
We also agree with the Commission’s view that HCFA should propose a refinement process — allowing for sufficient input from practicing physicians and other experts on practice expenses—to permit re-examination of the proposed practice expense RVUs prior to implementation of the final rule. Such refinement panels should be used to address major areas of disagreement with the proposed RBPEs for specific codes or families of codes, if a specialty has compelling evidence to suggest that the proposed RBPEs may be incorrect. We also believe that a process should be developed so that further refinements can occur in 1998 of the interim RVUs.

Because all of the interim RVUs will be subject to further refinement, ASIM has urged HCFA to exercise caution in implementing the interim practice expense RVUs to avoid the problems that would be created by “overshooting” or “undershooting” in the interim RVUs. “Overshooting” would occur if HCFA implements interim practice expense RVUs that call for major reductions in payments that are later found upon refinement to have been set too low. This can be avoided if HCFA errs on the side of being cautious in the magnitude of the reductions required for services that will undergo refinement.

ASIM is not persuaded that a three-year transition to RBPEs is merited, as the Commission recommends. A transition not only would perpetuate current inequities for several more years, but it also makes the process of implementation far more complex, with the potential for creating the same kinds of unintended budget-neutrality problems that occurred with the transition to the RBRVS. When the proposed rule on implementation of the RBRVS was published in 1991, HCFA proposed a much larger budget neutrality adjustment than otherwise would have been necessary because the transition formula specified by Congress resulted in an asymmetrical transition (more services initially experienced gains in payments than received reduced payments, thereby creating a larger budget-neutrality offset). The result was that the reductions for some services were much greater than was appropriate, while the gains for others were less than intended. Expressions of concern by Congress ultimately led HCFA to apply a lesser offset to deal with the asymmetrical transition. The complexity of developing a transition that would not have unintended consequences supports the wisdom of Congress’ original plan to implement RBPEs on January 1, 1998 without further delay or transition.

Savings Should Target Higher-Growth Areas

ASIM believes that structural reforms are preferable to attempting to squeeze more savings out payments to “providers.” In repeated budget bills, Congress and the President have agreed to major reductions in the rate of growth in payments to physicians and other providers. Such approaches have done little or nothing to address the underlying problems with the Medicare program, however, and have taken a toll on the ability of physicians to provide their patients with the best care possible. We recognize, however, that some savings in the rate of growth in payments to providers is inevitable. In deciding where savings might be achievable without compromising access and quality, Congress should take into consideration which categories of spending are growing at a rate that may not be sustainable. By the same token, categories of spending that are growing so slowly that they are not contributing to Medicare’s fiscal problems are not the place to look for further reductions.

ASIM is pleased that the administration’s proposed budget takes into account the fact that expenditures on physician services are growing slower than any other category of Medicare spending. Of the $100 billion in Medicare savings over the next five years proposed in the
President's budget, seven billion comes from outlays on physician services. According to the administration, thirty-four percent of the savings will come from reductions in payments to HMOs; 33 percent from lowering payment updates to hospitals and from cuts in GME outlays; 14 percent from limits on outlays on home health agencies, 7 percent from physicians, 7 percent from skilled nursing facilities, 2 percent from "other providers," and 10 percent from maintaining the current law requirement (which would otherwise expire) that the beneficiary premium contribution covers 25 percent of program costs. Even without any additional budget savings, physician payments have already been reduced so much in the past that there just is not room to take much more. The January “baseline” projections from the Congressional Budget Office show how much spending on physician services has already been curtailed. According to the CBO, total outlays for physician services will grow by an average of only 2.4% per year over the next decade. By comparison, payments to hospital, home health agencies, skilled nursing facilities, and most particularly HMOs will all exceed the rate of inflation. The CBO estimates that Medicare fee schedule payments—as expressed by the weighted separate conversion factor updates—will actually decline by about one percent over this period of time—or by 21 percent after inflation is taken into account. Fee schedule payments to physicians therefore have the dubious distinction of being the only category of outlays that are projected to actually drop, in both real (after inflation) and nominal dollars. ASIM urges Congress to support the administration’s approach of targeting savings toward higher growth areas of expenditures. It is not reasonable to expect that total outlays on physician services—which will now barely keep pace with inflation—can be reduced further without compromising access and quality. Although we concur with the administration’s approach of targeting higher-growth areas for most of the savings, ASIM has concerns about the impact of several of the administration’s proposals for further limiting spending on physician services.

Replacing the VPSs with a Sustainable Growth Rate

ASIM agrees with the administration that the current volume performance standards (VPSs) should be replaced by a single sustainable growth rate (SGR). We are concerned, however, that the proposal to establish the SGR at an amount equal to per capita GDP plus one percent does not allow for sufficient growth in the volume of services that beneficiaries will require. As noted earlier in our testimony, after adjustment for demographic changes and changes in law that may affect annual growth in expenditures on physician services, the VPSs represent a target rate of growth that is equal to the previous annual growth in five year historical average expenditures for the applicable category of services, minus a performance standard adjustment factor. In OBRA 93, Congress increased the performance standard adjustment factor from 2 to 4 percent. To illustrate, if the average growth in expenditures on primary care services in a particular five year period was 4 percent, the VPS would allow for zero growth in volume and intensity of primary care services. No matter how low the growth in expenditures is during a five year period, physicians will always be required to reduce growth by another 4 percent in order to get an update equal to inflation as measured by the Medicare economic index.

It is not reasonable to expect that physicians can continually reduce growth by 4 percent per year from the prior, five year average. Because OBRA 93 established an unreasonable and unrealistic target rate of growth, expenditures will in most years exceed the VPSs, resulting in updates that do not keep pace with inflation— and a 21 percent reduction in the weighted conversion factors (in constant dollars), according to the CBO. It is essential that Congress enact legislation that would replace the VPSs with a single sustainable growth rate that would give physicians a reasonable opportunity to earn inflation updates if volume growth is kept to a reasonable level.
Although a single sustainable growth rate would appear to be better than the current VPS formula, ASIM is concerned that the administration’s proposed 1 percent add-on to per capita GDP for volume and intensity is too low to give physicians a realistic opportunity to earn updates equal to inflation. Although current estimates from the CBO, the administration, or the PPRC on the impact of an SGR based on GDP plus one percent were not available to ASIM when this testimony was prepared, estimates that were prepared by the PPRC in 1996 indicate that the add-on will need to be higher than one percent to allow for reasonable levels of growth in the number of services provided to beneficiaries. Assuming a per capita GDP growth of 1.5%, the add-on would need to be at least GDP plus two percent (or a total of 3.5%) to assure a full inflation update, based on the CBO’s projected average per annum increase in expenditures on physician services of 2.4% per year. An SGR of GDP plus one would require growth to stay within 2.5 percent, which is only slightly above the current baseline projections. Therefore, the administration’s proposal for an SGR of per capita GDP growth plus one percent would not appear to be sufficient to prevent the automatic cuts in the Medicare conversion factor under OBRA ’93. In its upcoming report to Congress, the PPRC will express a preference for the SGR to be set at GDP plus two percent. ASIM urges Congress to support the Commission’s preference for replacing the VPSs with a single SGR that is no lower than per capita GDP plus two percent.

ASIM is also concerned that the administration may apply its behavioral offset assumptions in an inconsistent manner for the purposes of calculating the SGR and the single conversion factor as proposed in its budget. The legislative language for the President’s budget indicates that the SGR in 1998 and subsequent years will include an allowance for “changes in expenditures for all physicians’ services in the fiscal year (compared with the previous year) which will result from changes in the law, determined without taking into account estimated changes in the expenditures due to changes in the volume and intensity of physicians’ services resulting from changes in the update in the conversion factor . . . “ (emphasis added). This would seem to indicate that the administration plans to assume that a behavioral offset will occur as a result of changes in the conversion factor (i.e., in response to the reduction in payments for surgical procedures that would occur under a single conversion factor), but that it does not intend to incorporate this change in calculations of the SGR. If the administration’s baseline projections assume an increase in volume due to a behavioral offset, this should be reflected in the SGR as well as the CF updates. Otherwise, physicians will have no opportunity to recoup the losses triggered by the behavioral offset adjustment to the conversion factor update should volume not increase as assumed by the administration in its behavioral offset. ASIM would prefer, of course, that the administration not incorporate a behavioral offset adjustment at all. But if an offset is assumed for the conversion factor update, then the administration should be consistent in applying this to the SGR.

Other Budget Proposals Affecting Payments to Physicians

ASIM has concerns about two other proposals in the administration’s budget affecting payments for physician services. One is the proposal to reduce payments to “high cost medical staffs.” This proposal, which has been included in past budgets from this administration, could have the effect of inappropriately reducing payments to hospitals with higher costs because they have a sicker patient population. In the absence of a sound methodology to measure differences in the severity of illness of the patient population being treated by the medical staff, it is too risky to put in place a formula-driven process that could inappropriately lower payments for physicians on hospital medical staffs that are treating patients who are more expensive to treat because they are sicker.

The budget also proposes that competitive bidding be instituted for certain covered services,
including clinical laboratory services. ASIM is not opposed in concept to competitive bidding for certain supplies and services. We are concerned, however, that the administration’s proposal could be unfair to physician office labs, which do not generate the volume of laboratory testing required to match the price that a commercial laboratory might be able to offer Medicare. If competitive bidding for laboratory services is mandated, payments for laboratory tests performed in physician office laboratories should be exempted from having to meet the “winning bid” price.

**Payments to HMOs**

The President’s budget proposes that the average adjusted per capita cost (AAPCC) be reformed by (1) setting local rates at 90 percent of the prevailing fee-for-service rates, rather than 95 percent under current policy (2) subtracting graduate medical education payments from the AAPCC and instead giving them directly to the training institutions and (3) lowering the AAPCC in certain high cost areas and increasing them in low cost areas.

ASIM has no specific policy on the proposal to lower payments from 95 percent to 90 percent of the prevailing fee-for-service rates. Given that the CBO projects that outlays on Medicare HMOs will increase at an average rate of 71 percent per annum, it is reasonable for the Congress and the administration to review ways to achieve savings in this category of spending, especially if this will reduce the need to further slash fee-for-service payments. Although not conclusive, there are some studies that suggest that Medicare HMOs do enroll a healthier patient population than the fee-for-service program, and that the current formula may on average overcompensate HMOs for the care of the healthier patients that they typically enroll. ASIM also supports the goal of reducing geographic inequities in AAPCC payments, but we have not yet determined if the administration’s proposal is the best way to correct such inequities.

ASIM is concerned that in the absence of a risk adjustment for the AAPCC payments to HMOs, HMOs that treat a sicker mix of patients will be penalized, especially if the AAPCC rate is lowered to 90 percent from 95 percent. This would increase the disincentive for HMOs to enroll sicker patients. ASIM supports the PPRC’s view that:

> regardless of how payment rates are set, as long as Medicare beneficiaries can choose among options, improved risk adjustment will be essential. Otherwise, health plans will not be fairly paid for enrollees with better or worse-than-average status (for example those with chronic conditions or functional disability). Without improvements in risk adjustment, plans will continue to have an incentive to avoid enrolling patients who will be expensive to care for. The commission recommends that improved risk adjustment be implemented immediately.

(Statement before the Subcommittee on Health, Ways and Means, on Medicare HMO Payment Policy, February 25, 1997)

ASIM supports the proposal to remove GME payments from the payments to Medicare HMOs and to instead dedicate them directly to the hospitals that conducting the training.

**Other GME Proposals**

ASIM believes that the administration’s proposal to cap the total number and the number of non-primary care residency positions reimbursed by Medicare at the current level is a step in the right direction toward controlling the overall surplus of physicians. We also support allowing GME
payments to non-hospitals for primary care residents in those settings, when a hospital is not paying for the resident’s salary in that setting. We believe, however, that the Congress and the administration must go further in addressing the problems created by an oversupply of physicians and the imbalance between the number of physicians who enter primary care and specialty practices. ASIM specifically believes that policies must be instituted so that the number of entry level positions in the country’s GME system should be more closely aligned with the number of graduates of accredited U.S. medical schools.

We also believe that a national all-payer fund should be established to provide a stable source of funding for the direct costs of GME. Payments should be made from this fund to the entities that incur the costs of GME, whether they are hospital based or not, or to other entities, such as consortia, that have been designated to receive funds on behalf of the entities incurring the costs.

**Oppose Repeal of Fraud and Abuse Provisions**

ASIM does not support the administration’s proposals to modify the fraud and abuse provisions enacted last year by Congress as part of the Health Insurance Portability and Affordability Act of 1996. Elimination of the requirement that the government prove that a provider “knowingly” intended to violate the law will open the door for physicians to be investigated and possibly subjected to civil monetary penalties for unintended mistakes. Similarly, elimination of the requirement that HHS issue “advisory opinions” would make it more difficult for physicians to get the guidance they need to prevent unintended violations of the fraud and abuse laws.

**Expanded Coverage for Preventive Services**

We commend the administration for its proposals to expand Medicare coverage of preventive services and to increase payments for flu shots. Coverage of services that will prevent or allow for early detection of diseases not only will improve health care for the elderly, but may save Medicare money as well. Adequate payments for the costs incurred by physicians in providing influenza, pneumococcal, and hepatitis B vaccinations will encourage more physicians to provide those shots in the office, which could significantly increase the number of elderly persons who are inoculated against potentially life-threatening diseases. ASIM supports the administration’s proposal for coverage of blood sugar self-management programs for diabetic patients, provided that it is modified to require that such programs be conducted under the direction and supervision of a physician.

**Expanded Choice of Health Plans**

ASIM supports the administration’s proposal to expand choices of health plans, including offering beneficiaries the option of enrolling in provider-sponsored organizations (PSOs). We are currently assessing the details of the administration’s proposal to assure that it adequately addresses the regulatory barriers at the state and federal level to the formation of PSOs, while still assuring that PSOs meet appropriate solvency and other standards to protect patients. PSOs have the potential of giving beneficiaries the option of enrolling in plans that are organized and directed by their own physicians as an alternative to the traditional insurer-directed HMO. We also support the administration’s proposals to move towards an open enrollment period for Medicare HMOs and to provide comparative information to beneficiaries to enable them to make an informed choice of plan. As discussed below, ASIM believes that the administration’s proposal falls short of instituting needed protections for beneficiaries who enroll in Medicare HMOs and other managed care plans.
ASIM believes there is a need for Congress and the administration to make improvements in the standards used to evaluate Medicare managed care organizations (MCOs). The federal government must implement revised standards to assure that beneficiaries are given the information they need to make an informed choice of health plan, that beneficiaries receive reasonable assurances that they will have access to the physicians and services that they need, and that requests for reconsideration of denied claims are heard in a timely manner.

In recent years, the enrollment of Medicare beneficiaries in health maintenance organizations (HMOs) and competitive medical plans (CMPs) has grown rapidly. Currently, approximately 14 percent of beneficiaries belong to a Medicare managed care plan. The CBO projects that the share of total Medicare outlays that goes to HMOs and other Medicare managed arrangements will increase from 9.4% in FY 1996 to 32.9% in FY 2007—even without enactment of additional incentives for beneficiaries to enroll in managed care.

With increased enrollment, there is an increased need for the federal government to exercise appropriate oversight over the care provided to Medicare beneficiaries who are enrolled in MCOs. Recent reports from the Institute of Medicine, the General Accounting Office (GAO), and the PPRC all support the need for improved standards for health plans that contract with Medicare. In its 1996 report to Congress, the PPRC recommended that all health plans that contract to provide services to Medicare beneficiaries meet standards relating to quality, access, disclosure of information and due process. The GAO, in a recent report titled “HCFA Should Release Data to Aid Consumers, Prompt Better HMO Performance” supports ASIM’s views that HCFA needs to do more to implement measures that will enable beneficiaries to make an informed choice of plan. The GAO concluded that HCFA can readily provide indicators of beneficiary satisfaction and other plan-specific information, including statistics on beneficiary disenrollments and complaints, medical loss ratios (the percentage of HMO revenues spent on medical care) and other financial data, and visit monitoring results. The percentage of claims that are appealed to HCFA, and then reversed or upheld upon appeal, is another indicator of HMO performance that can immediately be made available to beneficiaries. Although HCFA plans to require a standardized beneficiary satisfaction survey “beginning with the upcoming calendar year,” the GAO expressed concern that HCFA has no plans to provide this information automatically to beneficiaries, and that the comparison chart that HCFA plans to develop will be available only through the Internet—a forum that may not be easily accessible to most Medicare beneficiaries. We agree with the GAO’s conclusion that HCFA should provide comparative information on each plan directly to beneficiaries.

ASIM urges Congress to:

1. Direct the Secretary to mandate that Medicare MCOs disclose to current and prospective enrollees and providers information needed to make an informed choice of plans, including:

   A. Requirements that limit access to services (i.e. extent to which enrollees may select the provider of their choice, restrictions that limit coverage to prescription drugs approved by the MCO, and rules that limit access to laboratory tests in physicians’ offices);

   B. Indicators of health plan quality, access, and patient satisfaction (including disenrollment rates; number and percentage of claims that were denied and then reversed upon appeal to the Secretary;
the MCO's medical loss ratio—defined as the proportion of total revenue spent on medical care, as opposed to administrative expenses or funds retained or distributed to owners; and the results of standardized patient satisfaction surveys).

The GAO found that beneficiaries often are unaware of the restrictions on access to certain services that are typically required by MCOs. Disclosure of such restrictions will enable beneficiaries to make a more informed choice of plans, and will reduce subsequent misunderstandings and dissatisfaction. Information on disenrollment rates, claims denials, and medical loss ratios can be useful indicators of the quality of care rendered with a plan. HCFA has begun to provide beneficiaries with more information but its efforts to date fall short of providing the kinds of information discussed above.

2. Mandate that Medicare MCOs review pre-authorization requests for urgent care services within one hour and all other pre-authorization requests within 24 hours. Direct the Secretary to streamline the appeals process for denials by Medicare MCOs by reducing by half the days that MCOs are allowed to consider an appeal of an initial denial.

Although the administration has stated that it intends to make changes in the appeals process to provide more timely determinations on denials of care by Medicare MCOs, it is our understanding that the administration’s proposal will not go far enough in assuring timely rulings on pre-authorization requests, and in reducing the amount of time that MCOs have to rule on appeals of initial denials. According to the GAO and the PPRC, MCOs are currently given up to 60 days to make their initial determination. They have another 60 days to decide on an appeal of the initial determination—a total of four months when patients are effectively being denied access to care that they and their physician believe to be necessary. Cases that require HCFA review can take even longer—sometimes up to 270 days. Further, GAO found that MCOs and HCFA’s own contractor often failed to meet the current deadlines for review and reconsideration of denied claims, but HCFA has been unwilling to take action against MCOs or the contractor for failing to process reviews and reconsideration in a timely manner. In the meantime, beneficiaries are the ones hurt by the failure to get a timely answer to their request that payment be authorized for medical services that they and their physicians believe to be appropriate.

3. Mandate that Medicare MCOs establish mechanisms to incorporate the recommendations, suggestions and views of enrollees and participating physicians into the medical policies, medical management, utilization review, and quality and credentialing policies and criteria developed by the MCO.

Physician involvement in establishing managed care policies that have a direct impact on clinical decision-making is essential if patients are to have confidence in their HMO. Rather than attempting to legislate the lengths-of-stay for given procedures, it would be far better to mandate a process that would assure that managed care plans do not adopt restrictions on coverage that lack the support of the physicians who are ultimately responsible for patient care.

**Recommendations for Long-term Reforms**

ASIM believes that the proposals included in the administration’s budget fall short of the long-term restructuring of Medicare that is needed. ASIM has developed a detailed set of long-term proposals for keeping Medicare affordable and solvent. Our recommendations include:

1. Moving towards a defined federal contribution system. Beneficiaries would be given the option of
remaining in the traditional Medicare program, or using their voucher to purchase coverage from HMOs, PSOs, indemnity plans, PPOs, and other competing health plans in their community that meet Medicare's standards for participation. The defined contribution must be set at a level that would enable beneficiaries to afford a wide choice of competing plans in their own locality, and it should be updated annually to reflect increases in the average premiums charged by the plan.

2. Requiring that all competing health plans meet minimum federal standards relating to access, quality improvement, physician and patient involvement in utilization review protocols, minimum benefits, and disclosure of information required for patients to make an informed choice of plans.

3. Increasing premium contributions for higher-income beneficiaries.

4. Phasing in a delay in eligibility age for Medicare.

5. Maintaining the Medicare fee-for-service program as a viable alternative to purchasing coverage from competing health plans.

The reforms advocated by ASIM would hold physicians, other providers, and health plans to higher standards of accountability than is now expected. They would have the option of competing for enrollment of Medicare beneficiaries, but would have to show that they are able to meet some basic minimum standards of accountability to do so. Competition between health plans would create an incentive for the plans themselves—and the physicians who participate them—to seek innovative ways to deliver high quality services at lower costs.

ASIM strongly encourages the Congress and the President to make a commitment to build upon any agreement on short-term reforms that is reached this year to address the long-term solutions to Medicare's fiscal problems. We offer our assistance as you address the difficult choices that will be required.