

EXTENSION OF MEDICARE SELECT POLICIES

APRIL 6, 1995.—Ordered to be printed

Mr. BLILEY, from the Committee on Commerce,
submitted the following

REPORT

together with

SEPARATE AND ADDITIONAL VIEWS

[To accompany H.R. 483]

[Including cost estimate of the Congressional Budget Office]

The Committee on Commerce, to whom was referred the bill (H.R. 483) to amend title XVIII of the Social Security Act to permit medicare select policies to be offered in all States, and for other purposes, having considered the same, report favorably thereon with an amendment and recommend that the bill as amended do pass.

CONTENTS

	Page
Purpose and summary	2
Background and need	2
Hearings	4
Committee consideration	4
Rollcall votes	4
Committee oversight findings	6
Committee on Government Reform and Oversight	7
Committee cost estimates	7
Congressional Budget Office estimates	7
Inflationary impact statement	8
Section-by-section analysis and discussion	8
Changes in existing law made by the bill, as reported	8
Separate and additional views	9

The amendment is as follows:

Strike out all after the enacting clause and insert in lieu thereof the following:

SECTION 1. EXTENDING MEDICARE SELECT POLICIES TO ALL STATES FOR AN ADDITIONAL 5-YEAR PERIOD.

Section 4358(c) of the Omnibus Budget Reconciliation Act of 1990, as amended by section 172(a) of the Social Security Act Amendments of 1994, is amended—

- (1) by inserting “and those other States that elect them to apply” after “15 States (as determined by the Secretary of Health and Human Services)”, and
- (2) by striking “3½-year” and inserting “8½-year”.

PURPOSE AND SUMMARY

The purpose of H.R. 483, as amended, is to extend authority for a demonstration program under which insurers can market a Medigap product, known as Medicare Select. H.R. 483 extends authority for this program for five years and permits Medicare Select policies to be marketed and sold in all 50 states.

BACKGROUND AND NEED FOR LEGISLATION

MEDIGAP POLICIES

The majority of beneficiaries age 65 or older have some health insurance coverage in addition to Medicare. Such coverage can be obtained through current or former employers, unions, the Medicaid Program, or through the purchase of individual policies, known as Medigap or Medicare supplemental policies; about half of the beneficiaries with additional coverage purchase Medigap policies.

Medigap policies are designed to fill in specific gaps in the Medicare benefits structure. These policies typically offer coverage for Medicare's deductibles and coinsurance and may pay for some services not covered by Medicare. Prior to 1980, Medigap policies were governed only by State insurance regulations and not by Federal law. Congressional concern over marketing abuses of Medigap policies led to the enactment of voluntary Federal minimum standards developed by the National Association of Insurance Commissioners (NAIC) for Medigap policies. The Omnibus Budget Reconciliation Act of 1990 (OBRA 1990) included provisions that established mandatory standards for Medigap policies in order to prevent the sale of duplicative policies and to provide consumers with understandable choices. The implementing regulations for those plans limited the number of different types of Medigap plans that can be sold in a State to no more than 10 standard benefit plans. One of the 10 standard plans (known as Plan A) provides a core benefits package which covers Medicare Parts A and B coinsurance and blood products. The other nine plans (B through J) include the core package plus the Part A deductible and additional benefits, such as prescription drugs and preventive medical care. Not all 10 plans are available in all states. Massachusetts, Minnesota, and Wisconsin have received waivers from the requirement that their plans correspond to the 10 model plans because these States already had acceptable programs in place that restricted the number and types of plans that could be offered.

DESCRIPTION OF THE MEDICARE SELECT PROGRAM

OBRA 1990 established a demonstration project under which insurers could market a Medigap product known as Medicare Select. These policies closely resemble other Medigap policies; however, Medicare select policies only pay in full if the covered services are

provided by health professionals and facilities designated by the insurer. These are commonly known as preferred provider networks.

Select policies do not affect the obligation of Medicare to pay its portion of the bill. However, the amount, if any, of supplemental benefits paid or co-insurance/deductible paid depends on whether the beneficiary uses a preferred provider. Beneficiaries who obtain covered services through one of the network's preferred providers will generally have their benefits paid in full. Under OBRA 1990, the Select plan is also required to pay full benefits for emergency and urgent-out-of-area care provided by non-network providers. In all other cases, supplemental benefits and co-insurance/deductible will not be paid, or will not be paid in full, if a beneficiary uses a non-network provider.

Select policies do not remove a beneficiary's freedom to choose any fee-for-service provider. If a beneficiary is unhappy with a Medicare Select provider for any reason, he can go to any provider and Medicare will pay if it is a covered service; however, the beneficiary is liable for the deductible and coinsurance.

An insurer marketing a select policy is required under OBRA 1990 to demonstrate that its network of providers offers sufficient access to subscribers and that it has an on-going quality assurance program. It must also provide full and documented disclosure, at the time of enrollment, of: network restrictions; provisions for out-of-area and emergency coverage and availability; and cost of Medigap policies without the network restrictions.

In addition, Medicare Select policies are governed by the same types of regulations imposed on Medigap policies concerning: limitations on pre-existing conditions; loss ratios; portability; guaranteed renewal, and open enrollment.

OBRA 1990 also includes significant penalties for Select plans that: restrict the use of medically necessary services; charge excessive premiums; expel an enrollee except for non-payment of premiums; or withhold required explanations or fail to obtain required acknowledgements at the time of enrollment.

OBRA 1990 limited the demonstration project to three years and to 15 States. The following are Medicare Select demonstration States: Alabama, Arizona, California, Florida, Illinois, Indiana, Kentucky, Massachusetts, Minnesota, Missouri, North Dakota, Ohio, Texas, Washington, and Wisconsin. The program was extended for an additional six months at the end of the 103d Congress in P.L. 103-432.

As of October 1994, approximately 450,000 beneficiaries were enrolled in Medicare Select; while the majority are covered through Blue Cross/Blue Shield plans, approximately 50 companies offer Medicare Select products. In August 1994, Consumer Reports rated the top Medigap insurers nationwide. Eight out of the top rated 15 Medigap plans were Medicare Select.

OBRA 1990 required the Secretary of the Department of Health and Human Services (HHS) to conduct an evaluation of the Medicare Select demonstration program and to submit the results to Congress by January 1, 1995; HHS is not expected to submit the report until the end of this year. For this reason, the Committee decided not to extend the program on a permanent basis as proposed in the introduced version of H.R. 483. Instead, while the

Committee reported bill extends the program to all 50 States, its authority is only extended for a period of 5 additional years.

Current authority for the program expires in June 1995. Failure to extend the authority for the program would result in the inability of insurers to enroll new beneficiaries in Medicare Select programs as of July 1995, although they could continue to serve current enrollees. This would lead to higher premiums for enrollees and the potential withdrawal of insurers from the market.

HEARINGS

The Subcommittee on Health and Environment held an oversight hearing on February 15, 1995 on Medicare Select and Medicare Managed Care Issues. Witnesses included the sponsors of H.R. 483: Honorable Nancy Johnson and Honorable Earl Pomeroy.

Testimony was also heard from the following individuals: Dr. Bruce Vladeck, Administrator, Health Care Financing Administration; Honorable William Gradison, President, Health Insurance Association of America; Mr. Gordon Sprenger, Executive Officer, Allina Health System; Ms. Karen Ignagni, President, Group Health Association of America; Ms. Debbie Ahl, Executive Vice President, Olympic Health Management Systems, Inc.; Mr. David Bradford, Chief Operating Officer, Family Health Plan Cooperative; Ms. Mary Nell Lehnhard, Senior Vice President, Blue Cross/Blue Shield Association; Keven Cronin, National Association of Insurance Commissioners; Ms. Bonnie Burns, Senior Health Insurance Specialist, California Health Insurance Counseling Association; and Ms. Gail Shearer, Director, Health Policy Analysis, Consumer's Union.

COMMITTEE CONSIDERATION

On March 22, 1995, the Subcommittee on Health and Environment met in open markup session and ordered the bill, H.R. 483, as amended, reported to the Full Committee by a voice vote, a quorum being present.

Chairman Bilirakis offered an amendment in the nature of a substitute, which was approved by voice vote.

An amendment to the amendment in the nature of a substitute was offered by Mr. Waxman but was not approved by the Subcommittee. The amendment offered by Mr. Waxman would have banned attained age rating for Medicare Select policies. The Waxman amendment was defeated by rollcall vote of nine ayes to thirteen nays.

On April 3, 1995, the Full Committee met in open markup session and ordered H.R. 483, as amended, reported to the House by a voice vote, a quorum being present.

ROLLCALL VOTES

Pursuant to clause 2(l)(2)(B) of rule XI of the Rules of the House of Representatives, following are listed the recorded votes on the motion to report H.R. 483 and on amendments offered to the measure, including the names of those Members voting for and against.

COMMITTEE ON COMMERCE—104TH CONGRESS—ROLLCALL VOTE NO.

38

Bill: H.R. 483, Extension of Medicare Select Program.
Amendment: Amendment by Mr. Ganske re: access at time of disenrollment.

Disposition: Not Agreed To, by a rollcall vote of 19 ayes to 22 nays.

Representative	Aye	Nay	Present	Representative	Aye	Nay	Present
Mr. Bliley		X		Mr. Dingell	X		
Mr. Moorhead		X		Mr. Waxman	X		
Mr. Fields				Mr. Markey	X		
Mr. Oxley		X		Mr. Tauzin			
Mr. Bilirakis		X		Mr. Wyden	X		
Mr. Schaefer		X		Mr. Hall	X		
Mr. Barton		X		Mr. Bryant	X		
Mr. Hastert		X		Mr. Boucher		X	
Mr. Upton		X		Mr. Manton	X		
Mr. Stearns		X		Mr. Towns	X		
Mr. Paxon		X		Mr. Studds	X		
Mr. Gillmor		X		Mr. Pallone	X		
Mr. Franks		X		Mr. Brown	X		
Mr. Klug		X		Mrs. Lincoln			
Mr. Greenwood		X		Mr. Gordon	X		
Mr. Crapo				Ms. Furse	X		
Mr. Cox		X		Mr. Deutsch	X		
Mr. Burr		X		Mr. Rush			
Mr. Bilbray		X		Ms. Eshoo	X		
Mr. Whitfield		X		Mr. Klink	X		
Mr. Ganske	X			Mr. Stupak	X		
Mr. Frisa		X					
Mr. Norwood		X					
Mr. White		X					
Mr. Coburn	X						

COMMITTEE ON COMMERCE—104TH CONGRESS—ROLLCALL VOTE NO.

39

Bill: H.R. 483, Extension of Medicare Select Program.
Amendment: Amendment by Mr. Waxman re: limiting attained age rating.

Disposition: Not Agreed To, by a roll callvote of 17 ayes to 21 nays.

Representative	Aye	Nay	Present	Representative	Aye	Nay	Present
Mr. Bliley		X		Mr. Dingell	X		
Mr. Moorhead		X		Mr. Waxman	X		
Mr. Fields				Mr. Markey	X		
Mr. Oxley		X		Mr. Tauzin			
Mr. Bilirakis		X		Mr. Wyden	X		
Mr. Schaefer				Mr. Hall	X		
Mr. Barton		X		Mr. Bryant	X		
Mr. Hastert		X		Mr. Boucher	X		
Mr. Upton		X		Mr. Manton	X		
Mr. Stearns		X		Mr. Towns	X		
Mr. Paxon		X		Mr. Studds			
Mr. Gillmor		X		Mr. Pallone	X		
Mr. Klug		X		Mr. Brown	X		
Mr. Franks		X		Mrs. Lincoln			
Mr. Greenwood		X		Mr. Gordon	X		
Mr. Crapo		X		Ms. Furse	X		
Mr. Cox		X		Mr. Deutsch	X		

Representative	Aye	Nay	Present	Representative	Aye	Nay	Present
Mr. Burr		X		Mr. Rush			
Mr. Bilbray		X		Ms. Eshoo	X		
Mr. Whitfield		X		Mr. Klink	X		
Mr. Ganske				Mr. Stupak	X		
Mr. Frisa		X					
Mr. Norwood							
Mr. White							
Mr. Coburn							

COMMITTEE ON COMMERCE—104TH CONGRESS—ROLLCALL VOTE NO.

40

Bill: H.R. 483, Extension of Medicare Select Program.
Amendment: Amendment by Ms. Furse re: inclusion of diabetes outpatient self-management training services.
Disposition: Not Agreed To, by a rollcall vote of 17 ayes to 22 nays.

Representative	Aye	Nay	Present	Representative	Aye	Nay	Present
Mr. Bilely		X		Mr. Dingell	X		
Mr. Moorhead		X		Mr. Waxman	X		
Mr. Fields				Mr. Markey	X		
Mr. Oxley		X		Mr. Tauzin			
Mr. Bilirakis		X		Mr. Wyden	X		
Mr. Schaefer				Mr. Hall	X		
Mr. Barton		X		Mr. Byrant	X		
Mr. Hastert		X		Mr. Boucher	X		
Mr. Upton		X		Mr. Manton	X		
Mr. Stearns		X		Mr. Towns	X		
Mr. Paxon		X		Mr. Studds			
Mr. Gillmor		X		Mr. Pallone	X		
Mr. Klug		X		Mr. Brown	X		
Mr. Franks		X		Mrs. Lincoln			
Mr. Greenwood		X		Mr. Gordon	X		
Mr. Crapo				Mr. Furse	X		
Mr. Cox		X		Mr. Deutsch	X		
Mr. Burr		X		Mr. Rush			
Mr. Bilbray		X		Ms. Eshoo	X		
Mr. Whitfield		X		Mr. Klink	X		
Mr. Ganske		X		Mr. Stupak	X		
Mr. Frisa		X					
Mr. Norwood		X					
Mr. White		X					
Mr. Coburn		X					

COMMITTEE ON COMMERCE—104TH CONGRESS—VOICE VOTES

Bill: H.R. 483, Extension of Medicare Select Program.
Motion: Motion by Mr. Bilirakis to order H.R. 483 reported to the House, as amended.
Disposition: Agreed To, by a voice vote, a quorum being present.

COMMITTEE OVERSIGHT FINDINGS

Pursuant to clause 2(l)(3)(A) of rule XI of the Rules of the House of Representatives, that Subcommittee on Health and Environment held an oversight hearing and made findings that are reflected in this report.

COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT

Pursuant to clause 2(l)(3)(D) of rule XI of the Rules of the House of Representatives, no oversight findings have been submitted to the Committee by the Committee on Government Reform and Oversight.

COMMITTEE COST ESTIMATE

In compliance with clause 7(a) of rule XIII of the Rules of the House of Representatives, the Committee adopts as its own the cost estimate prepared by the Directive of the Congressional Budget Office pursuant to Section 403 of the Congressional Budget Act of 1974.

CONGRESSIONAL BUDGET OFFICE ESTIMATE

Pursuant to clause 2(l)(3)(C) of rule XI of the Rules of the House of Representatives, following is the cost estimate provided by the Congressional Budget Office pursuant to section 403 of the Congressional Budget Act of 1974:

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, April 4, 1995.

Hon. THOMAS J. BLILEY, Jr.,
*Chairman, Committee on Commerce,
House of Representatives, Washington, DC.*

DEAR MR. CHAIRMAN: The Congressional Budget Office has reviewed H.R. 483, a bill to permit Medicare Select policies to be offered in all states, as ordered reported by the House Committee on Commerce on April 3, 1995. CBO estimates that enactment of H.R. 483 would not significantly affect the federal budget or the budgets of state and local governments. Pay-as-you-go procedures would apply because the bill could affect direct spending. The estimated change in direct spending, however, is not significant.

Medicare Select policies are Medicare supplemental health insurance policies allowed under a demonstration program that Congress initiated in section 4358 of the Omnibus Budget Reconciliation Act of 1990. The program was limited to 15 states and was to run for three years beginning on January 1, 1992. The demonstration was extended for six months in section 172 of the Social Security Act Amendments of 1994. This bill would extend the program for five years and make it available to the entire country. This bill is similar to H.R. 483, as ordered reported by the House Committee on Ways and Means on March 8, 1995; the earlier version, however, would make the Medicare Select program permanent.

Except for Medicare Select policies, issuers of Medicare supplemental policies are not allowed to offer benefits that differ depending on the provider selected by the beneficiary. Under Medicare Select policies, insurers can, in effect, set up Medicare Preferred Provider Organizations (PPOs). If PPOs are successful in managing care, they can reduce Medicare costs, because Medicare pays for most of the cost of the services covered under the supplemental policies. The preliminary evaluation of the demonstration con-

ducted under contract to the Health Care Financing Administration (HCFA), however, has found very little management of care by the insurers and no cost savings to Medicare. On the other hand, Medicare costs could rise if enactment of this bill caused additional Medicare beneficiaries to purchase coverage that reduced their copayments and thus diminished their economic incentives to seek cost-efficient care. The preliminary evaluation of the demonstration found that few additional beneficiaries purchase Medicare supplemental policies. Because this bill could result in either costs or savings, and there is little evidence of either, CBO estimates that this bill would have no significant effect on the federal budget.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contact is Scott Harrison.

Sincerely,

JAMES L. BLUM
(For June E. O'Neill).

INFLATIONARY IMPACT STATEMENT

Pursuant to clause 2(l)(4) of rule XI of the Rules of the House of Representatives, the Committee finds that the bill would have no inflationary impact.

SECTION-BY-SECTION ANALYSIS OF THE LEGISLATION

SECTION 1. EXTENDING MEDICARE SELECT POLICIES TO ALL STATES FOR AN ADDITIONAL 5-YEAR PERIOD

Section 1 amends the Omnibus Budget Reconciliation Act of 1990 to permit Medicare Select policies to be sold and marketed in all 50 states and extends authority for the program for a period of 5 additional years.

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3 of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italics, existing law in which no change is proposed is shown in roman):

SECTION 4358 OF THE OMNIBUS BUDGET RECONCILIATION ACT OF 1990

SEC. 4358. MEDICARE SELECT POLICIES.

(a) * * *

* * * * *

(c) EFFECTIVE DATE.—The amendments made by this section shall only apply in 15 States (as determined by the Secretary of Health and Human Services) *and those other States that elect them to apply* and only during the [3¹/₂-year] 8¹/₂-year period beginning with 1992.

* * * * *

SEPARATE AND ADDITIONAL VIEWS

The Medicare Select program is an interesting experiment designed to learn whether elderly individuals may want to participate in restricted health care networks and, if so, to determine whether such networks can deliver cheaper Medicare supplemental products.

Currently, the program is set up as a time-limited demonstration program in only 15 states. Because it is set to expire in June of this year, we have no objection to and might even favor a timely extension of the demonstration in those states now participating. Some of us, however, have reservations about extending the program to all 50 states for the five years provided in the Committee-reported bill. With so little useful information yet available on the demonstration program, the permanent extension and expansion in the Ways and Means Committee's reported version is even more troublesome.

While we have a number of questions about the approach taken in Committee, the two most serious concerns are reflected in amendments offered in the Committee and defeated by Republican majorities.

First, we are concerned about the increased use of "attained age rating," a practice permitting regular rate increases based solely on a policyholder's age. An amendment was offered to ban this practice because it results in deceptive pricing practices, interferes with meaningful comparisons of products, and destabilizes the marketplace. The proliferation of Medicare Select products that compete on the basis of this kind of rating is a distressing trend that will hurt elderly people. With their defeat of this amendment, Republicans have endorsed that trend.

Second, we are concerned that as Medicare Select insurers achieve deeper penetration into the marketplace, more and more elderly people who are ill-served by restricted networks will find themselves lacking choices and unable to obtain affordable alternative coverage. We therefore supported an amendment by Representative Ganske to correct this inequity by establishing a mechanism whereby policyholders who wanted or needed to opt out of a restricted network arrangement could obtain alternative fee-for-service coverage on a basis comparable to that which they would have enjoyed had they first signed up for a fee-for-service plan. Regrettably, all but two Republicans, Messrs. Ganske and Coburn, voted against providing this choice to the elderly.

As Republican proposals to achieve savings in the Medicare programs through managed care or privatization are advanced, we are concerned that meaningful choice for beneficiaries may not be adequately protected. While the Medicare Select program deals only with a portion of an elderly person's medical bills, we view with alarm the Republicans' rejection of measures to stabilize the mar-

ketplace and protect beneficiaries. In short, defeat of these amendments presages a willingness to compromise quality of care and choice for elderly Americans when the Congress takes up a reconciliation bill later this spring.

As Democrats, we remain committed to strong consumer protections for elderly people purchasing Medicare supplemental policies, and we strongly oppose changes in the Medicare program itself that would undermine meaningful consumer choice.

JOHN D. DINGELL.
HENRY A. WAXMAN.
EDWARD J. MARKEY.
RON WYDEN.
JOHN BRYANT.
THOMAS J. MANTON.
EDOLPHUS TOWNS.
GERRY E. STUDDS.
FRANK PALLONE, Jr.
SHERROD BROWN.
ELIZABETH FURSE.
PETER DEUTSCH.
BOBBY L. RUSH.
ANNA G. ESHOO.
RON KLINK.
BART STUPAK.

ADDITIONAL VIEWS OF HON. ELIZABETH FURSE

I had hoped that the legislation before the Committee could have been improved before consideration on the floor of the House. I am concerned with the serious health problem that diabetes continues to be in America. Diabetes is our fourth leading cause of death, affecting 14 million Americans and costing our nation over \$100 billion annually. I had offered an amendment to improve H.R. 483 by requiring insurers offering a Medicare Select product to include, as part of their core benefits package, coverage of two of the most important disease-management tools available to people with diabetes: outpatient self-management training and blood testing strips. Unfortunately, the Committee defeated this amendment on a party line vote.

Contrary to what most people believe, insulin is not a cure for diabetes; it only helps those with diabetes properly manage their disease. If people with diabetes don't have the necessary tools and training to manage their disease, the results are costly—often fatal—complications: blindness, heart disease, leg and other extremity amputations, and stroke. The only way we can help reduce the burden of diabetes, and these costly complications, is to empower people with diabetes to manage their disease. That is the essence of what my amendment was about: reducing complications and saving money for a limited number of people with diabetes.

While the problem of access to these important tools is not limited strictly to managed care environments, a soon-to-be-released study by a major university substantiates that the needs of people with diabetes are not being met by current managed care arrangements, resulting in more complications. According to the National Diabetes Research Coalition, an organization of leading endocrinologists and other scientists active in diabetes research, 10% reduction in complications will save a staggering \$5 billion. Expanding access to self-management tools would have benefited everyone by reducing the long-term health care costs resulting from diabetes.

I was pleased that my amendment had the full support of the American Diabetes Association, and colleagues on the Committee stated their support for the goals of my amendment. I look forward to working with them in the upcoming months to ensure that all people with diabetes have access to these critical self-management tools.

ELIZABETH FURSE.

○