A TAXPAYER'S GUIDE TO THE MEDICARE CRISIS

By John C. Liu and Robert E. Moffit

INTRODUCTION

Medicare is going broke. The huge national health insurance program that covers over 38 million elderly and disabled Americans will be insolvent by 2002, according to the 1995 report of the Medicare Board of Trustees, a seven-member federal body that includes three Clinton Administration Cabinet secretaries. Not only does hospitalization insurance (HI, or Part A) face bankruptcy,[1] but the cost of supplemental medical insurance (SMI, or Part B), which covers doctors' fees and other services, is exploding. And while recent surveys show that most elderly Americans believe they already have paid for their health benefits,[2] the truth is that the system is subsidized heavily by the taxpayers. Without significant program changes, the taxes working families will have to pay in coming years—just to sustain Medicare benefits at current levels—will be enormous.[3]

Members of Congress realize increasingly that quick fixes, including price controls and cost shifting, no longer work. Serious policymakers also realize that Medicare's mounting problems are fundamental and structural. Even Medicare's trustees recognize that the "program is clearly unsustainable in its present form."[4] The majority in Congress is searching for ways to preserve health insurance benefits for the elderly by changing Medicare from a highly bureaucratic government program to a dynamic system based on the market principles of consumer choice and competition. One prominent model recommended by Heritage Foundation analysts is the Federal Employees Health Benefits Program (FEHBP), the 35-year-old system that serves 1.6 million retired Members of Congress and federal workers.[5]

A Single-Payer System. Medicare is America's first major experiment with single-payer, government-run health insurance. Created in 1965 as part of President Lyndon Johnson's so-called Great Society—in essence, a major expansion of domestic social programs—Medicare emerged as a compromise among Members of Congress who wanted to establish full-scale national health insurance. Thus, from its inception, the system assumed the need for central planning.

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1 *1995 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund*, April 3, 1995, p. 2; cited hereafter as *Trustees' Report*. The three Clinton Administration Cabinet members are Health and Human Services Secretary Donna Shalala, Treasury Secretary Robert Rubin, and Labor Secretary Robert Reich.

2 For example, according to a survey undertaken by Public Opinion Strategies on behalf of the American Hospital Association, 67 percent of seniors and 58 percent of all voters believe that Medicare is a benefit "that they have already paid for." Morton M. Kondracke, "GOP Poll Warns Cutting Medicare Could be Fatal," *Roll Call*, April 17, 1995, p. 6.

3 For a discussion of the high levels of taxation that necessarily would result from not reforming Medicare, see Stuart M. Butler, "The High Cost of Not Reforming Medicare," Heritage Foundation *F.Y.I.* No. 56, May 4, 1995.

4 Social Security and Medicare Boards of Trustees, *Status of the Social Security and Medicare Programs: A Summary of the 1995 Annual Reports*, April 1995, p. 13; cited hereafter as *Trustees' Report Summary*.

5 For a description of how to transform Medicare into a program that resembles the FEHBP, see Stuart M. Butler, Robert E. Moffit, and John C. Liu, "What To Do About Medicare," Heritage Foundation *Backgrounder* No. 1038, June 26 1995.

According to its authors in Congress, Medicare also was designed to be "fiscally responsible," so Members of Congress and government actuaries attempted to project both costs and revenues well into the future. This was especially true of Part A, the hospitalization program. In 1965, the House Ways and Means Committee reported that "Congress has very carefully considered the cost aspects of the proposed hospital insurance system [and] very strongly believes that the financing basis of the new hospital insurance program should be developed on a conservative basis." Initial cost projections proved to be wildly wrong. For example, federal actuaries projected that a hospital stay would cost $155 per day in 1985 and that Part A costs would reach $9 billion by 1990. Instead, the costs of a hospital stay reached $600 per day in 1985, and Part A costs reached $63 billion in 1990.[6] Given the heavily subsidized structure of the Medicare system, it is unlikely that any government planner could have projected the explosion in costs that has characterized the part of Medicare that reimburses physicians (supplemental medical insurance, or Part B).

Moreover, changing demographics guarantee enormous future tax burdens on working families. In 1965, there were almost six workers for every retiree. Today, there are only four workers for every retiree, and by 2030, when the nation's 77 million "baby boomers" are well into their retirement, there will be only two. The Washington-based Committee for Economic Development warns that payroll taxes just to finance Medicare and Social Security could consume up to 28 percent of a worker's paycheck by that time.[7]

Planning and Price Controls. Federal officials have had even less success in controlling the true costs of the Medicare program. Instead of relying upon competition and consumer choice to control costs, Congress has relied on a complex array of price controls. Since the inception of the program, Congress has adopted 75 options to cut reimbursement to doctors alone. This system of controls has ranged from simple freezes on physician reimbursement to increasingly complex formulas governing hospital reimbursements. In theory, Health Care Financing Administration (HCFA) officials are trying to find the right price for thousands of different medical procedures and treatments, or specialists and other providers. In practice, this invariably means that Medicare pays doctors, hospitals, and other health care providers either too much or too little. Such a system encourages doctors, hospitals, and other providers to attempt to "game" the elaborate fee schedule and price control systems by such things as picking a diagnosis that will maximize their payments. This helps explain why it also has proven largely ineffective in controlling overall program costs. At the same time, like all price control systems, it has proven very effective in shifting rising costs to the less-regulated private health insurance system serving workers and their families.

Taxpayers should not be surprised that Medicare cannot control costs, since all of the system's incentives are designed to drive up costs. Congress created Medicare as a generous new entitlement to health care services without sufficient incentives to offset the new demand:

> The planners seemed to have overlooked the fact that if you shift the demand curve outward without moving the supply curve, prices will go up. The original 1965 cost projections allowed for a 10 percent increase in hospital admission rates among the elderly, but in fact hospital admission rates among the Medicare eligible rose immediately by 25 percent, the rates for surgical procedures by 40 percent, and the number of hospital days by 50 percent.[8]

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6 Steven Hayward and Erik Peterson, "The Medicare Monster: A Cautionary Tale," *Reason*, January 1993, pp. 21-22.

7 Lawrence A. Weinbach, "Who Will Pay for Your Retirement? The Looming Crisis," Research and Policy Committee Report by the Committee for Economic Development, May 4, 1995, p. 4. This does not include federal, state, or local taxes levied for other purposes.

8 Hayward and Peterson, "The Medicare Monster: A Cautionary Tale," pp. 23-24.

Under current law, expenses for supplemental medical insurance (Part B) are projected to double by the year 2002. Like Part A, this will mean a bigger tax burden for working families. In establishing the financing arrangements for Part B, Congress deliberately undermined its original copayment requirements, making sure that the taxpayers would subsidize 75 percent of the premium rather than the 50 percent agreed to in the original legislation. Moreover, Congress has held deductible and coinsurance requirements at artificially low levels.

Today, the deductible for Part B services is only $100. This figure not only has nothing to do with economic reality, but also is an incentive to increase demands on the system. The major reasons for the explosion in Medicare costs—far beyond the federal government's own cost projections—are rising demand and the increase in the volume and intensity of medical services.[9]

Bureaucracy and Red Tape. While Medicare relies on central planning and price controls to project and control costs, it also must rely upon a huge and elaborate system of federal regulation. Thousands of pages of federal rules, regulations, and guidelines, as well as a huge and growing body of case law, now govern the behavior of doctors, hospitals, and patients. To administer this complex system of planning, Congress in 1977 created the HCFA, an agency within the United States Department of Health and Human Services (HHS). With over 4,000 employees, HCFA is responsible for managing the giant health care trust funds and the Medicaid program, in addition to: 1) writing rules and regulations for the system; 2) contracting with private insurance companies in the states and regions to serve Medicare beneficiaries; 3) improving the productivity of Medicare contractors; 4) overseeing the surveys and certification of doctors, hospitals, and other medical providers; 5) enforcing standards of eligibility for providers and care for patients; 6) determining what medical services to the elderly will or will not be reimbursed; 7) deciding whether or not Medicare beneficiaries will have access to new treatments or procedures; 8) combating the admittedly rampant waste, fraud, and abuse in the Medicare system; 9) collecting reams of data on doctors and patients; and (10) conducting research, demonstrations, and evaluations. In other words, virtually no aspect of the financing and delivery of medical services to the elderly is free of HCFA's interference.

Government-Standardized Benefits. Medicare's standardized health care benefits are set by law and government regulation. Either Congress or the Health Care Financing Administration must decide whether a new benefit, treatment, medical procedure, or technology will be included in the Medicare package for reimbursement. Since the program's inception, Congress has taken approximately 70 actions to increase or modify benefits. Unfortunately for the elderly, this is a highly politicized process. The addition or subtraction of a benefit, procedure, or medical device invariably is a political event. Perhaps the most notorious example of this politicization was the celebrated debate over the addition, and then the repeal, of the Medicare Catastrophic Benefit in 1988 and 1989.[10] That disaster proved that both Congress and HCFA are subjected to intense lobbying by doctors, hospital groups, special interests, or medical specialty societies. As Jeremy Rosner, formerly of the Progressive Policy Institute and now an official in the Clinton Administration, has written, "The history of Medicare is replete with cases of organized groups acting through Congress to add coverage for specific illnesses or procedures, or to affect changes in specific prices."[11]

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9 According to former HCFA Chief Actuary Guy King, "It is the growth of volume and intensity—not the increase of the prices paid to providers—that is putting so much strain on the program." Cited in "The New Medicare Trust Fund Report: Have Things Really Changed?" American Enterprise Institute *Conference Summary*, April 13, 1995, p. 4.

10 For a detailed discussion of the politics surrounding the adoption and repeal of the Medicare Catastrophic Coverage Act of 1988, see Robert E. Moffit, "The Last Time Congress Reformed Health Care: A Lawmaker's Guide to the Medicare Catastrophic Debacle," Heritage Foundation *Backgrounder* No. 996, August 4, 1994.

11 Will Marshall and Martin Schram, eds., *Mandate for Change* (New York: Berkley Books, 1993), p. 122.

Cumbersome Process. The congressional process for deciding whether a particular health insurance benefit should be available to the elderly and disabled is inherently cumbersome. First come committee hearings, followed by mark-up and reporting of bills to add or subtract benefits, and then House and Senate floor consideration and amendment of these measures. This process is followed by a House-Senate conference to resolve any differences and then, finally, by another vote by both chambers on a final package. HCFA's decision-making process, with its notice of proposed rule making, internal deliberations, and public comment on items published in the *Federal Register*, is deeply flawed. With its size and complexity, the federal regulatory regime inherently resists change, flexibility, and innovation.

A New Model. If Members of Congress want to retain the single-payer, government-run structure of the Medicare program, they must resort to much higher taxes or to even more draconian price controls on doctors and hospitals, including a direct limitation of available services that resembles limitations found in the British National Health Service. For example, while coverage for end-stage renal dialysis is an entitlement in Medicare, it is not available to elderly citizens in the British national health system. For the British government, this is a clear public policy choice.

The private, employer-based health insurance market is not a model of free-market efficiency. It is plagued by distortions born of the perverse tax treatment of employment-based insurance, which drives up health care costs and contributes directly to rising insurance rates.[12] But even this distorted market, encumbered by a restrictive tax policy, is capable of a level of experimentation and innovation that is virtually unimaginable in the Medicare system. The rapid change and flexibility in the private health insurance market, including the experimentation with managed care plans, is nowhere to be seen in the Medicare system.

If private employer-based insurance is not the best model for Medicare reform, Members of Congress should examine their own system, the popular Federal Employees Health Benefits Program. Long proposed by Heritage Foundation scholars as a model for reform, the FEHBP is also the model now proposed by the American Medical Association.[13] To an increasingly broad range of policy analysts, including those associated with the Progressive Policy Institute, think tank of the moderate Democratic Leadership Council,[14] the FEHBP has a number of advantages. Congressional and federal retirees and their dependents do not have a government-standardized benefits package imposed on them, but can choose from a wide variety of health care plans and options. Unlike most Medicare enrollees, they do not have to buy supplemental packages like Medi-gap coverage, extra insurance plans that cover services that Medicare cannot or will not provide. More important, they can pocket the savings resulting from their choices, a fact that gives them incentive to choose their medical coverage wisely. In Medicare, there are no meaningful choices. The imposing bureaucratic structure and deep regulatory reach of the Medicare program are nothing like the relative openness and flexibility of the FEHBP system. Unlike Medicare, the FEHBP is administered by 164 staffers at the Office of Personnel Management (OPM). It is highly flexible and is governed by less than 100 pages of federal regulations. In terms of economic efficiency, Medicare's bureaucratic and highly centralized system cannot compete with the FEHBP's market-based system.

Cost Controls. The Federal Employees Health Benefits Program has a much broader range of choice; better packages of benefits, including catastrophic coverage and prescription drugs; and a superior record in controlling health care costs.[15] While Medicare costs have been rising almost 11 percent per

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12 John C. Liu, "What the CBO Says About the Tax Treatment of Employment-Based Health Insurance," Heritage Foundation *F.Y.I.* No. 16, May 25, 1994.

13 American Medical Association, *Transforming Medicare and Other Budget Proposals*, June 1995.

14 "Medicare Voucher Proposal Gaining Political Support," *Washington Health Week*, Vol. 3, No. 12 (July 3, 1995), p. 2.

15 For a discussion comparing cost control in Medicare and FEHBP, see Walton Francis, "The Political Economy of the

year, overall private-sector costs rose just 4.4 percent this year and FEHBP premium costs actually declined by 3.3 percent. And according to OPM, the average premium cost will rise only four tenths of one percent in 1996.[16] If Members of Congress wish to reform Medicare so that the security of America's elderly can be assured and the taxpayers' money can be used as efficiently and productively as possible, they must act now to harness the market forces of consumer choice and competition.

HOW MEDICARE IS FINANCED

The Medicare trustees admit that the Hospital Insurance (Part A) Trust Fund will be insolvent by the year 2002. But "The roots of Medicare's crisis...go back to its creation in the 1960s as an open-ended federal entitlement. With Uncle Sam paying all bills, the private market in medical care for the elderly was destroyed. Patients and providers have had no incentive to restrain their use of care, and...costs to the taxpayer have risen relentlessly."[17] The reasons for this looming fiscal crisis include congressional mandates expanding covered benefits without providing offsetting changes in copayments or coinsurance, medical inflation, longer life expectancies, and the continually increasing use of medical services by a rapidly aging population.

Medicare provides payments for inpatient hospital care, some inpatient care in a skilled nursing facility, home health care, hospice care, physician and supplier services, and outpatient services. The program is divided into two parts. Part A finances the hospital insurance (HI) portion, and Part B finances the supplemental medical insurance (SMI) portion which covers physicians' fees.

Part A: Generally, Part A of Medicare provides premium-free coverage for part of the costs associated with certain hospital stays and limited follow-up services. Part A is financed through mandatory payroll taxes levied on employees and employers and paid into a so-called trust fund. When Medicare was enacted, federal actuaries estimated future expenditures for Part A so that a payroll tax could be established based on potential costs. But the government's estimates fell far short of the actual costs of running this portion of the Medicare program.

Before January 1, 1994, the HI tax rates of 1.45 percent on employees, 1.45 percent on employers, and 2.9 percent on the self-employed were applied on earnings of up to $135,000. As part of President Clinton's effort to reduce the deficit, the Administration proposed that all earnings be subject to the HI tax beginning on January 1, 1994. This tax increase was approved by Congress in 1993 and signed into law on August 19, 1993, as part of the Clinton Administration's Omnibus Budget Reconciliation Act of 1993 (P.L. 103-66). Since the HI tax took effect in 1966, the maximum taxable income level has been increased on 23 separate occasions.[18]

Contrary to widespread belief, HI revenues and expenditures do not go into a real trust fund. As a matter of fact, no real trust fund exists.[19] According to the annual reports issued by the Board of Trustees of the Federal Hospital Insurance Program, the federal government has never saved the tax revenues needed to cover the future health care needs of employees. The reason: Medicare began paying out HI benefits at the same time it began collecting taxes.[20] Retirees in 1965 were collecting Medicare benefits

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Federal Employees Health Benefits Program," in Robert B. Helms, ed., *Health Policy Reform: Competition and Controls* (Washington, D.C.: AEI Press, 1993), p. 269.

16 OPM news release, "1996 Federal Employees Health Benefits Program Open Season Highlights," September 11, 1995.

17 Editorial, "Medicare's Gordian Knot," *The Wall Street Journal*, April 24, 1995, p. A12.

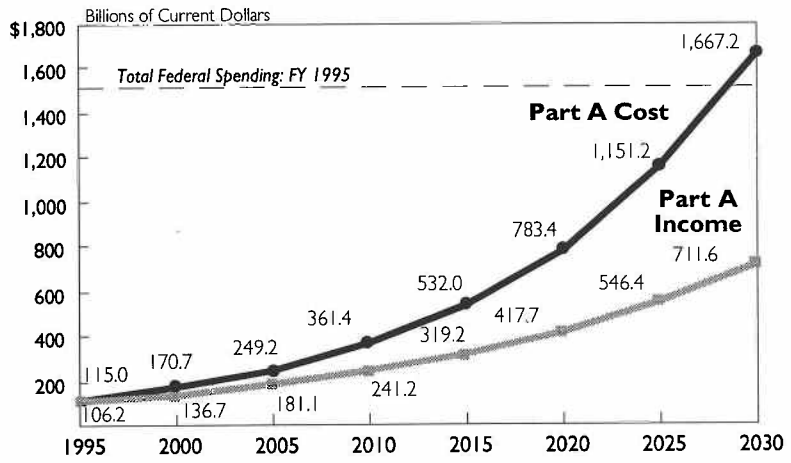
18 The HI tax was first levied in 1966 at a rate of 0.35 percent (for both employee and employer) on earnings of up to $6,600 a year.

19 David Koitz, "Medicare: President Clinton's Proposal to Eliminate the Hospital Insurance Taxable Earnings Base," *CRS Report for Congress*, May 5, 1993, p. 4.

without having paid into the system. As a result, younger workers on average are contributing more to the Social Security and HI fund each year as their earnings increase, but these contributions are not being saved. The trust fund is a myth. The funds are being transferred and spent almost immediately on the current Medicare population.[21] Despite the constant transfer of revenues, therefore, the future outlook for the program is grim.

Chart 1

Income and Cost of Medicare's Part A Program



Source: *1995 Trustees Report on the HI Trust Fund,* Table I.C2; calculations from Table I.D2.

HI taxes go toward the general federal revenue pool. When the government receives new revenues, it posts new interest-bearing federal securities to the HI fund; when it spends monies on HI, it writes off some of these securities. In other words, these securities are not assets, but future obligations the government has issued to itself. As long as the HI trust fund maintains a balance, the U.S. Treasury is authorized to make HI payments for it. The higher limit on earnings subject to the HI tax proposed by the Clinton Administration was designed to reduce the deficit, not the HI trust fund.

A Graying America. According to the Trustees' Report, long-range HI projections show that Medicare's hospital costs will rise at a much higher rate than inflation.[22] Compounding this troubling statistic is the near-term issue of insolvency confronting the HI trust fund. The trustees examine the solvency of the HI trust fund under three alternative sets of assumptions: low-cost, intermediate, and high-cost. For purposes of illustration, consider the intermediate set of assumptions as the most reasonable. These assumptions reflect the trustees' best estimate of the expected future economic and demographic trends that will affect the financial status of the program. Under them, the present financing structure for the HI program is sufficient to ensure the payment of benefits only over the next seven years: "As a result, the HI trust fund does not meet the trustees' short range test of financial adequacy."[23] Thus, structural reforms will have to be made in the immediate future because the demographics supporting the existing HI program will shift radically downward. Currently, the approximate ratio of workers to people 65 or over is 4:1. This ratio is projected to decrease to 2.4:1 in 2035.[24] In short, the only way to sustain the solvency of the HI trust fund is to increase the HI tax rate (currently set at 2.9 percent) or significantly

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20 Michelle Davis, "Medicare's Self-Destruction," Citizens for a Sound Economy *Economic Perspective*, January 22, 1993, p. 4.

21 C. Eugene Steuerle, testimony before Committee on the Budget, U.S. House of Representatives, March 22, 1995.

22 *Trustees' Report,* p. 47, Table II.D1.—"Components of Historical and Projected Increases in HI Inpatient Hospital Payments."

23 *Trustees' Report*, p. 3.

24 David Koitz, "The Financial Outlook for Medicare," *CRS Report for Congress*, June 24, 1993, p. 4.

reduce benefits and payments. Not only are the anticipated reserves and financing of the HI program inadequate to offset this demographic change, report the trustees, but under all the sets of assumptions, the trust fund will become exhausted even before the major demographic shift begins to occur.[25]

Q: When will the HI trust fund go bankrupt?

A: According to the trustees, it starts going broke in 1996 and is bankrupt by 2002.

Q: So the HI trust fund will go broke even before the retirement of the nation's 77 million baby boomers?

A: Correct. "Under all the sets of assumptions," say the trustees, "the trust fund is projected to become exhausted even before the major demographic shift begins."[26] If nothing is done, the situation simply will go from bad to catastrophic.

Q: Is the Clinton Administration proposing measures to insure the solvency of the HI trust fund?

A: The Clinton Administration recently proposed to reduce Medicare spending by a claimed $128 billion over a period of seven years. According to the Administration, however, Medicare reform must take place within the context of "overall health care reform"[27] broadly similar to the Clinton plan that Congress rejected last year.[28]

Q: Isn't Clinton's $128 billion savings plan far less draconian than the $270 billion reduction proposed by the majority in Congress?

A: Not really. If you use the same nonpartisan CBO baseline rather than the White House baseline, the Administration actually is calling for $192 billion in savings, not $128 billion; this is a difference of just $78 billion over a period of 7 years.[29]

Q: Isn't it true that taxes paid by beneficiaries during their working years cover the cost of the hospital insurance portion of Medicare?

A: No. Many elderly Americans think they are only getting back what they paid into the system, but seniors are getting much more than they contributed, if they contributed at all. The Medicare health benefit package offered tomorrow will be more valuable than the one granted today, which is much more valuable than the one offered yesterday.[30] Benefits are generous and have risen consistently over time. The average benefit (Parts A and B) per enrollee is expected to be worth approximately $4,800 in 1995. According to the HCFA, spending is expected to continue rising at such a rapid pace that the total expected value of Medicare benefits for a couple retiring at age 65 in 1995 is over $185,000.[31] As the

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25 *Ibid.*, p. 3.

26 *Trustees' Report*, p. 3.

27 Robert E. Rubin, Secretary of the Treasury, written testimony before Committee on Finance, U.S. Senate, June 6, 1995, p. 1, and Robert B. Reich, Secretary of Labor, written testimony before Committee on Finance, U.S. Senate, June 6, 1995, p. 1.

28 For a description of the Clinton health care plan, which embodies key features of the current Medicare system, see Robert E. Moffit, "A Guide to the Clinton Health Plan," Heritage Foundation *Talking Points*, November 19, 1993.

29 Stuart M. Butler, "Comparing Apples With Apples on Medicare," Heritage Foundation *F.Y.I.* No. 58, August 4, 1995.

30 Steuerle, testimony before House Budget Committee, March 22, 1995, p. 1.

31 C. E. Steuerle and J. M. Bakija, *Retooling Social Security for the 21st Century: Right and Wrong Approaches to Reform*

following table indicates, the benefits received over a beneficiary's lifetime are far greater than his contributions to the system.

LIFETIME MEDICARE BENEFITS, TAXES, PREMIUMS, AND TRANSFERS (in thousands of constant 1993 dollars)

	Persons Turning 65 in 1995			
	Single Male	Single Female	One-earner Couple	Two-earner Couple
Benefits	75	110.7	185.7	185.7
Taxes and Premiums	34.7	45.6	59	68.5
Net Transfer	40.3	65.1	126.7	117.2

Source: C.E. Steuerle and J. M. Bakija, *Retooling Social Society for the 21st Century: Right and Wrong Approaches to Reform* (Washington, D.C.: Urban Institute Press, 1994).

Q: If HI trust funds are depleted, won't HCFA officials pay Medicare hospital bills anyway?

A: No. "Under present law," according to the trustees, "there is no authority to pay hospital insurance benefits if the assets of the HI trust fund are depleted."[32]

Q: Can't HCFA just borrow the money?

A: Under current law, no.

Q: Do the Medicare trust funds operate like a private pension trust fund?

A: No. Medicare is a pay-as-you-go system. Coverage and services come from revenues raised through direct payroll taxes or otherwise taken from general revenues. What an individual pays into Medicare bears no relation to what he receives from it.

Q: Medicare's trustees say the HI trust fund will go bankrupt in just seven years. Why hasn't Congress heard of this problem before now?

A: It has. The trustees have been warning Congress for years that the HI trust fund would be exhausted shortly after the end of the century. During both the Reagan and Bush Administrations, Congress was told that corrective action was vital to avoid the onset of serious and devastating adjustments in the Medicare program, and President Clinton himself published an account of the seriousness of the matter well before he took office.

Q: So Congress has failed to heed the trustees' warnings?

A: Unfortunately, yes, and these attitudes persist. For example, Representative Sam Gibbons (D-FL), former Chairman of the House Ways and Means Committee, which has jurisdiction over Medicare, says the insolvency issue is exaggerated: "I've read these trustees' reports for years. They're all pessimistic. I don't panic over the insolvency question."[33]

(Washington, D.C.: Urban Institute Press, 1994).

32 *Trustees' Report,* p. 13.

33 Quoted in Major Garrett, "Medicare Bill Prods Clinton To Find Savings," *The Washington Times*, May 11, 1995, p. A10.

Q: What are the short-term cash flow projections for the HI trust fund?

A: According to the Trustees' Report, the positive cash flow is expected to be $3.4 billion in 1995. It becomes a negative flow in 1996. According to Robert Helms, former Assistant Secretary for Planning and Evaluation at HHS and currently resident scholar at the American Enterprise Institute, "The situation is expected to get progressively worse—annual losses are estimated to be $26 billion in the year 2000 and $65 billion in the year 2004."[34]

Q: What burdens will Americans have to assume to keep the HI program afloat?

A: Big tax burdens for working Americans or big benefits cuts for the elderly. According to former HCFA Chief Actuary Guy King, "Just to keep the income and outlays in balance over the next twenty-five years (that is, before the baby boomers have all retired) will require either a 30 percent reduction in expenditures or a 44 percent increase in the HI tax."[35]

Q: What would this mean for ordinary families?

A: It depends. The Medicare trustees have outlined three tax increase scenarios. As a short-term, 25-year solution to the trust fund crisis, Congress could adopt a 1.3 percent tax increase. This would mean an extra $585 per year in taxes for a person making $45,000 per year. To put the trust fund on a permanently sound basis would require an additional 3.52 percent tax increase, or $1,584 for a person making $45,000 per year. If the trust fund went broke, the tax increase required would be an additional 3.9 percent, or $1,760 for anyone making $45,000 per year.[36]

Part B: Part B is voluntary. All persons 65 or over may enroll in the supplemental medical insurance (SMI) program by paying a monthly premium—as of January 1, 1995, $46.10 per month. This contribution level constitutes a mere 29 percent of the actual cost of the Part B premium; the remaining 71 percent is paid by taxpayers. Part B provides coverage for physician, laboratory, outpatient hospital, and other medical services. It pays 80 percent of the allowed charge as determined by the federal government (after the annual $100 deductible is met), and beneficiaries are responsible for the remaining 20 percent coinsurance required by law.

Congress established Part B to create a subsidy for the nation's elderly, but at a significantly lower rate than is currently being provided. Until 1973, SMI premiums were set by law to finance one-half the benefit and administrative costs, in addition to a small contingency amount to go into a separate trust fund. When costs began to increase faster than inflation, Congress decided to limit the percentage increase in the premium to the same percentage as Social Security cost-of-living adjustments. Under this new formula, revenues from Part B premiums decreased from 50 percent to 25 percent of expenditures. This is because Part B costs, much like Part A costs, increased at a much faster rate than inflation as measured by the Consumer Price Index (CPI). Beginning in the early 1980s, Congress has taken the politically safe path of voting to set enrollees' Part B premiums at a level which would cover only 25 percent of program costs. Thus, enrollees in 1995 pay only $46.10 per month for insurance that covers 80 percent of allowable charges with a deductible of only $100. The illusion that their Medicare benefits package is inexpensive explains why the elderly have little incentive to control costs—and why working families must pay even larger shares of the Part B cost out of general revenues.

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34 Robert Helms *et al.*, "The New Medicare Trust Fund Report: Have Things Really Changed?" American Enterprise Institute *Conference Summary*, April 13, 1995, pp. 1-2.

35 *Ibid.*, pp. 3-4.

36 Butler, "The High Cost of Not Reforming Medicare."

Q: How has the SMI trust fund grown?

A. Total receipts of the SMI trust fund grew from $324 million in 1966 to $58 billion in 1993. Expenditures for medical benefits were $56 billion in 1993.[37]

Q: What will Medicare enrollees pay for SMI (Part B) services next year?

A: Beneficiaries will pay just 25 percent of program costs. Under current law, that means enrollees will be paying $43.70 per month in 1996. The premium will rise to $60.80 per month by the year 2002 and $113.90 per month in the year 2005.

Q: Has this 25 percent cost-sharing rule always been the case?

A: No. The premium for Part B was designed to cover 50 percent of the program's cost. In 1972, Congress limited the annual premium increase to the percentage increase in the Social Security COLA. As a result, the beneficiaries' share of the premium cost fell, reaching a low point of 24 percent in 1981. In 1984, Congress set the premium for beneficiaries to cover 25 percent of the program's cost. In 1990, Congress reinstituted the linkage between the Part B premium increase and the Social Security COLA. Unless Congress changes this, premiums actually will fall next year, even though the program's costs will rise.

Q: Is the SMI trust fund financially sound?

A: Yes. Because it is funded mostly by general revenues, the taxpayers are forced to subsidize the program, thereby ensuring the trust fund's solvency.

Q: So the SMI program is in good shape?

A: Not from the standpoint of taxpayers. The problem with the SMI trust fund has been the program's explosive growth, which dwarfs both the rise in medical inflation and the growth in the economy. According to the Medicare trustees, "Growth rates have been so rapid that outlays of the program have increased 53 percent in the aggregate and 40 percent per enrollee in the past five years."[38]

Q: How will this affect the rest of the national economy?

A: According to Guy King, the SMI trust fund will grow from 0.99 percent of GDP in 1995 to 3.18 percent of GDP in 2025, rising to 3.97 percent of GDP by "the middle of the next century."[39] While Medicare Part B does require a modest premium, it is now an income transfer program, taxing away income from the working segment of the population and redirecting it to the retired segment without regard to retirees' income.[40]

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37 Carolyn Pemberton and Deborah Holmes, *EBRI Databook on Employee Benefits*, 3rd ed., Employee Benefits Research Institute, 1995, p. 417.

38 *1995 Annual Report of the Board of Trustees of the Supplemental Medical Insurance Trust Fund*, April 3, 1995, p. 3.

39 American Enterprise Institute *Conference Summary*, April 13, 1995, p. 4.

40 David Koitz, "Medicare Taxes, Premiums, and Government Contributions for 1995," *CRS Report for Congress*, December 20, 1994, p. 2.

Q: Why can't Congress just freeze or reduce payments to Medicare providers, doctors as well as hospitals?

A: That's precisely what Congress has done since the inception of the program. But price controls do not work. Since 1966, Congress has imposed 75 different actions to cut Medicare payments to doctors alone.[41] In spite of congressional efforts to contain costs through price controls, fee schedules, and caps, Part B growth has shown no signs of slowing and is projected to get far worse. No serious health policy analyst regards this rate of growth as sustainable.

Q: But aren't price caps on provider payments the most effective way to reduce outlays?

A: No. As King notes, "If we merely reduce payments to providers (as has been tried in the past), we would have to save between $330 billion and $340 billion over the next seven years."[42]

Q: If Congress raised Medicare enrollees' portion of the Part B premium, adjusting the increase for enrollees' income, wouldn't that amount to a tax increase for our elderly?

A: No. An increase in the Part B premium is not a tax. Individuals receiving an explicit service from government—especially one which could be provided by the private sector—should pay the full cost of that service absent a compelling reason for a subsidy (such as poverty).[43] As noted earlier, Part A hospitalization is a forced savings program in which workers contribute mandatory, income-related payments. Therefore, there is reason to argue against means testing Part A or reducing its benefits. Part B is voluntary. Reducing the taxpayer-provided subsidy as income increases simply reduces Medicare outlays.

Unsustainable Spending. Medicare is growing at an alarmingly fast rate. The Congressional Budget Office has projected an annual growth rate of approximately 10 percent over the next seven years:

ANNUAL GROWTH RATE OF MEDICARE FROM 1995-2003									
	1995	**1996**	**1997**	**1998**	**1999**	**2000**	**2001**	**2002**	**2003**
Medicare HI	**$112.4**	$124.1	$135.5	$148.9	$156.8	$170.9	$183.6	$197.4	$212.1
Medicare SMI	$65.8	$74.9	$83.9	$93.5	$104.6	$117.1	$131.4	$147.7	$165.9
Source: Congressional Budget Office, Extension of Baseline Budget Projections, March 13, 1995.									

Q: Has the federal government been able to forecast how much Medicare will cost?

A: As the table on the following page demonstrates, government projections vary significantly from Medicare's actual expenditures.

Q: Why are actual expenditures far greater than projected expenditures and growing at over ten percent each year?

A: While the easily identifiable reasons are congressional mandates expanding covered benefits and eligibility requirements, medical inflation, and a rapidly aging population that is living longer, the main reason is the structure and design of the overall program. Medicare is an open-ended entitlement. The demand for health care services, already high among the elderly, is significantly greater among the very ill

41 American Medical Association, *Perspectives on Medicare*, May 1995, p. 6.

42 *Ibid.*

43 Stuart M. Butler, testimony before Committee on Ways and Means, U.S. House of Representatives, February 7, 1995.

HOSPITAL INSURANCE EXPENDITURES (PART A) (in millions)			
	1965 HI estimates	Actual HI expenditures	Difference
1966	$1,037	$999	-3.7%
1967	$2,276	$ 3,430	50.7%
1968	$2,478	$ 4,277	72.6%
1969	$2,702	$ 4,857	79.8%
1970	$2,946	$ 5,281	79.3%
1971	$3,169	$ 5,900	86.2%
1972	$3,402	$ 6,503	91.2%
1973	$3,646	$ 7,289	99.9%
1974	$3,902	$9,372	140.2%
1975	$4,168	$11,581	177.9%
1980	$5,466	$25,577	367.9%
1985	$7,066	$48,414	585.2%
1990	$9,061	$66,997	639.4%

Sources: Jennifer O'Sullivan, CRS Report for Congress, "Health Care Fact Sheet: Original Medicare Cost Estimates," September 22, 1993, p. 2; House Ways and Means, *Actuarial Cost Estimates and Summary of Provisions of the Old-Age, Survivors, and Disability Insurance System as Modified by the Social Security Amendments of 1965 and Actuarial Cost Estimates and Summary of Provisions of the Hospital Insurance and Supplementary Medical Insurance Systems as Established by Such Act*, Committee Print 51-291, 89th Cong., 1st Sess., 1975, p. 33; House Document 102-89, *1991 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund*, p. 27.

who also require more expensive medical treatment and services during the latter stages of life. Since the program is structured around a fee-for-service and third-party payment system, patients and providers do not have to worry about the price or quantity of services being provided as they spend the taxpayers' money.[44] In other words, there is virtually no incentive, absent a minimal cost-sharing requirement, for the Medicare population to help contain costs. Combining a government-organized fee-for-service structure with a third-party payment system serves as a catalyst for unlimited increases in the volume and intensity of services provided to patients, without regard for the efficacy or cost-effectiveness of those services.[45]

44 Guy King, testimony before Subcommittee on Health and Environment, Committee on Commerce, U.S. House of Representatives, March 28, 1995.

45 *Ibid.*

HOW THE FEDERAL BUREAUCRACY RUNS MEDICARE

In 1977, Congress established the Health Care Financing Administration (HCFA) to run the Medicare and Medicaid programs. HCFA is an agency within the United States Department of Health and Human Services (HHS). Its Administrator, nominated by the President and confirmed by the Senate, is a powerful federal official who directs the "planning, coordination and implementation" of Medicare, Medicaid, and other HCFA programs and "directs the development of effective relationships between these programs and private and federally supported health related programs."[46] The Administrator is assisted by a "general deputy Administrator" and reports directly to the Secretary of HHS.

HCFA currently operates with a budget of $262 billion, mostly to pay for Medicare and Medicaid services, and a staff of 4,129. For FY 1996, the Clinton Administration is requesting a total of $274 billion for Medicare and Medicaid benefits and operating costs, an increase of $28 billion over FY 1995. Spending for Medicare represents 64 percent of the HCFA budget, and spending for Medicare and Medicaid combined represents 38.2 percent of the total HHS budget.[47]

HCFA is comprised of 25 offices and bureaus, including the Office of the Administrator, and ten regional offices. The direct administrative cost of HCFA is projected at $3 billion.[48]

Q: Does HCFA have a large overhead?

A: No. Administration consumes an estimated $3 billion—only 1 percent—of the agency's budget.

Q: So, as far as bureaucracy is concerned, HCFA is cheap?

A: Not at all. Known and direct administrative costs—those shown on the federal budget—do not include transactional costs incurred by doctors, hospitals, and other providers forced to comply with HCFA rules, regulations, requirements, standards, and guidelines. In identifying a regulation for elimination, Vice President Al Gore cited the fact that just one requirement, a physician attestation form for persons being discharged from hospitals, is responsible for 11 million forms which consume an estimated 220,000 hours of physician time and $22,500 in labor costs per hospital per year.[49]

Trust Fund Management. HCFA's mission, beyond program management, is to administer the Medicare trust funds. The Hospital Insurance (HI) Trust Fund is financed by federal payroll taxes and overseen by the Medicare Board of Trustees, a panel composed of the Secretaries of the Departments of Treasury, Labor, and Health and Human Services, the Administrators of the Social Security and Health Care Financing Administrations, and two "public" (non-government) members. Medicare is set up so that taxes paid by current workers are used to pay the hospitalization benefits of current beneficiaries. Any income not immediately needed to pay for these benefits is held in the HI trust fund.

Also administered by HCFA and governed by the Medicare Board of Trustees is the Supplemental Medical Insurance (SMI) Trust Fund. This fund holds all income not immediately needed to pay physician and outpatient medical benefits under the Supplemental Medical Insurance Program and all related expenses. Unlike the HI trust fund, the SMI trust fund is financed by annually established standard monthly premiums paid by Medicare beneficiaries and by federal government contributions based on actuarial rates estimated by HCFA.

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46 Health Care Financing Administration program description, March 8, 1994.

47 U.S. Department of Health and Human Services, *The Fiscal Year 1996 Budget*, February 6, 1995, p. 52.

48 *Ibid.*

49 White House press release, July 11, 1995.

HCFA's Regulatory Regime. The major source of regulatory authority for the Health Care Financing Administration is Title XVIII of the United States Code. Medicare regulations are developed within HCFA but, because HCFA is an operating division of the Department of Health and Human Services, issued as HHS regulations. According to an analysis conducted by Jeremy Rosner of the Progressive Policy Institute, Medicare is governed by 1,050 pages in the U.S. Code, 1,156 pages in the Code of Federal Regulations, and guidelines in the form of 19,150 pages in HCFA "manuals" and another 1,000 pages of HCFA "rulings." Beyond these are approximately 2,000 more pages of "Provider Reimbursement Review Board Hearing Decisions" and "HCFA Administrator Decisions."[50]

HCFA's regulations are developed in accordance with the Administrative Procedures Act (APA). The Secretary of HHS approves all regulations developed by HCFA, after which they are submitted to the Office of Management and Budget (OMB) for review. Following OMB approval, they are published in the *Federal Register* and open to public comment before taking effect.

HCFA regulations have generated a large body of case law because they have the practical force of law. For example, the five-volume *Commerce Clearing House (CCH) Medicare and Medicaid Guide* for members of the legal profession is twice the size of the *Encyclopedia Britannica*: more than 43,196 pages, approximately two thirds of which are devoted to Medicare-related topics.

Beyond formal federal regulations published in the *Federal Register*, HCFA develops and publishes "guidelines" that govern doctors, hospitals, insurance contractors, and other health care providers in the program. Like HCFA regulations, these guidelines are numerous, extensive, and intricate. And like the regulations, for all practical purposes, they control doctors and hospitals.

Q: What is the legal status of an HCFA regulation published as a Final Rule?

A: It has the force of federal law.

Q: Are HCFA guidelines for doctors and hospitals subject to the Administrative Procedures Act?

A: No. For example, revisions in the *Medicare Reimbursement Manual* are exempt from the public notice and comment requirements of the Act, and the Supreme Court has upheld this exemption.[51] Not surprisingly, legal experts fear that this could be a way for HCFA officials to avoid going through the more public process of publishing formal regulations.

HOW HCFA CONTRACTS WITH INSURANCE CARRIERS

HFCA delivers hospital and physician services through more than 80 contracts with private health insurance carriers in all 50 states. These contractors process insurance claims, make benefit payments, review Medicare payments to make sure they are "necessary and appropriate," and make improvements in the delivery and productivity of Medicare services under HCFA guidelines and regulations. They also are responsible for reviewing payments to providers in accordance with HCFA rules. HCFA thus relies upon a huge number of contractors to process Medicare's claims and perform a series of ancillary services. As the GAO has observed, "The Medicare program operates through a complicated administrative structure."[52]

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50 Cited in Marshall and Schram, *Mandate for Change*, pp. 365-366.

51 *Shalala v. Guernsy Memorial Hospital*, U.S. Sup. Ct. No. 93-1251, March 6, 1995.

52 U.S. General Accounting Office, *Medicare Claims*, GAO/HR-93-6, December 1992, p. 10.

HCFA funds a "payment safeguards" program for Medicare contractors to combat waste, fraud, and abuse. The GAO has described the safeguards as cost-effective but insufficient and has criticized HHS budget reductions in the "safeguards program."[53] The program funds auditing, reviewing bills to make sure that services are "medically necessary," and establishing procedures to make sure that other health insurers who cover the elderly "pay first" if that payment is appropriate. This is directed primarily at employer-provided insurance. In 1965, Medicare was to be the "secondary payor" for beneficiaries covered by both Medicare and Workers Compensation. In the 1980s, Congress made Medicare secondary payor to certain employer-based plans and under automobile insurance. Under the Omnibus Budget Reconciliation Act of 1990, Congress specified that employer-provided benefits would continue to be primary to Medicare (meaning that Medicare would be a "secondary payor" of health bills) until October 1, 1995. Employers, under current law, are required to provide beneficiaries with information to that effect.

Q: What are the civil penalties for private employers who do not pay first for beneficiaries, or who fail to supply information to eligible beneficiaries that Medicare is a secondary payer?

A: A private employer can be fined up to $1,000 per employee for failing to supply such information. Moreover, the federal government can impose an excise tax of 25 percent on private health plans that fail to comply with secondary payer rules.[54] HCFA is seeking to extend the data match among itself, the IRS, and the Social Security Administration (SSA) to identify the "primary payers" for Medicare enrollees.

Q: How serious are waste, fraud, and abuse?

A: Very serious. Senator William Cohen (R-ME) says that, based on federal investigations of the problem, Medicare fraud costs taxpayers $45 million per day.[55]

Q: The GAO has estimated the cost-effectiveness of the HCFA safeguards program. Has either the Congressional Budget Office or the HCFA Actuary ever quantified the savings produced by the general payment safeguard program?

A: No. While HCFA officials are likely to claim that these procedures have had a positive effect on Medicare costs, independent reports suggest that they are not enough. For example, according to a 1992 GAO report, "In recent years, the Medicare program has lost billions of dollars to waste, fraud and abuse. Though Medicare's losses cannot be quantified precisely, health industry experts estimate that fraud and abuse could account for as much as 10 percent of the nation's total health care costs."[56]

Q: How do these abuses occur?

A: According to the GAO, HCFA does not follow up adequately on Medicare beneficiary complaints about waste and abuse; nor do Medicare's contractors. In one case, for example, hospitals owed Medicare over $170 million in overpayments, but contractors "did little to reclaim the money." In another, contractors paid an estimated $2 billion in claims that "should have been paid by other health insur-

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53 U.S. General Accounting Office, *Medicare: Further Changes Needed to Reduce Program and Beneficiary Costs*, Report to the Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, GAO/HRD-91-67, May 1991, p. 7.

54 Thomas Darold (ed.), *The Health Insurance Answer Book: 1993 Cumulative Supplement,* New York: Panel Publishers, 1993), Q. 10:53.

55 *LTC News and Comment: News and Views on the Financing of Longterm Care*, Vol. 5, No. 9 (May 1995), p. 4.

56 GAO, *Medicare Claims*, December 1992, p. 6.

ers."[57] Some abuses are particularly brazen. For example, a chain of home health care agencies billed Medicare $85,000 for gourmet popcorn for doctors and another $3,200 for "expenses incurred at a golf shop."[58]

Q: How many complaints from senior citizens about fraud and abuse are we talking about?

A: Millions. In FY 1990 alone, Medicare contractors reported getting 18 million complaints. Over half of these complaints were not referred to the contractors' investigative staffs. Furthermore, those that were referred often were not "adequately investigated."[59]

Q: But why wouldn't the private insurance contractors in Medicare follow up aggressively on fraud, waste, and abuse?

A: The incentives are not strong in Medicare. It's not their money; it's the government's—which means the taxpayer's—money.

Q: What does the GAO recommend to combat these problems?

A: Stronger policing and even tighter regulation by HCFA. This includes improving oversight of contractor activities, reducing excessive payments, and instituting tighter controls over who is allowed to bill under Medicare.[60] Given the program's monopolistic structure, such recommendations are hardly surprising.

Claims Processing. Medicare claims processing, despite congressional attempts to improve it, remains very complex. Hundreds of millions of claims are processed annually in an explosion of confusing paperwork for doctors, hospitals, and insurance contractors alike. In a June 1990 review of the system, the GAO reported that the "paperwork required to process claims under the Medicare program is burdensome and confusing to many of Medicare's beneficiaries, as well as to providers of Medicare-covered services."[61] Because doctors and patients were often unclear as to what was required on the forms, claims were submitted with incorrect or insufficient information. HCFA then requested additional information to clear up the confusion, further delaying the process. In responding to beneficiaries, HCFA communications also were often unclear, and this generated even more frustration and delay. Doctors likewise have found that the information from Medicare contractors was "frustrating and burdensome."[62]

In recent years, HCFA has imposed uniformity on this process simply by putting the burden on doctors to submit all Medicare claims. It also has been moving aggressively toward electronic claims processing. Before 1990, doctors who did not "participate" in the Medicare program (did not accept Medicare "assignment" or payment for services as full and final payment) were not subject to Medicare billing requirements. But in September 1990, pursuant to congressional authorization, HCFA began requiring doctors to submit all claims on behalf of their patients, even when patients wished to submit their own

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57 *Ibid.*, p. 7.

58 *LTC News and Comment*, May 1995, p. 4.

59 U.S. General Accounting Office, *Health Insurance: Vulnerable Payers Lose Billions to Fraud and Abuse*, Report to the Chairman, Subcommittee on Human Resources and Intergovernmental Relations, Committee on Government Operations, U.S. House of Representatives, GAO/HRD-92-69, May 1992, p. 23.

60 GAO, *Medicare Claims*, December 1992, p. 8.

61 U.S. General Accounting Office, *Medicare: HCFA Can Reduce Paperwork Burden for Physicians and their Patients*, Report to Congressional Requesters, GAO/HRD-90-86, June 1990, p. 2.

62 *Ibid.*

claims and even when doctors were not "participating physicians" in Medicare. In other words, Medicare claims submitted by patients could no longer be accepted legally. Under current law, claims are to be submitted within one year of providing medical care. Doctors may not charge for, or be reimbursed by HCFA for, the costs of completing and submitting claims. Civil monetary penalties may be imposed on any doctor who fails to submit all Medicare claims properly.

Q: What if a physician fails to submit an assigned claim as required by law and regulation?

A: The Secretary of HHS is to reduce the amount of reimbursement by 10 percent.

Q: What kind of penalty can be imposed on doctors who refuse to submit claims properly?

A: A fine of up to $2,000 per claim.

Q: What if a doctor does not submit the Medicare claim?

A: Doctors who "knowingly and willfully" violate the statute are subject to exclusion from Medicare for up to five years. They also are subject to exclusion from state health programs and can be assessed civil monetary penalties.

Q: What will happen if a Medicare patient, rather than his doctor, submits a claim?

A: HCFA can investigate the doctor to see whether the failure was deliberate and therefore warrants legal sanction.

Q: What if a doctor wants to treat an elderly person for free as an act of personal charity? Is he still required to submit a Medicare claim?

A: Yes. Under the Omnibus Budget Reconciliation Act of 1989, all physicians must submit claims for services to all Medicare beneficiaries.

Q: What is the law concerning the right of an elderly person to purchase the services of a physician or other entity independent of Medicare?

A: Section 1395(b) of Title 42 of the United States Code provides: "Nothing contained in this subchapter shall be construed to preclude any state from providing, or any individual from purchasing or otherwise securing, protection against the cost of any health service." Moreover, in *Stewart v. Sullivan*, a landmark 1992 case in Newark, New Jersey, federal Judge Nicholas Politan, examining the legal question of the right of elderly persons to contract independently with physicians in 1991, noted that there was no regulation and no clearly articulated policy against private contracting.[63]

Q: Even so, do HCFA or Medicare's contractors allow elderly citizens to contract privately with physicians?

A: Statutory language and recent federal case law to the contrary, HCFA officials consistently deny that the elderly have any such right unless they drop out of Part B; they also threaten doctors who assert any such right with sanctions.[64] Congress thus far has failed to clarify the matter.

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63 For an excellent account of the circumstances surrounding this case, see Lois J. Copeland, M.D., "Please Do No Harm," *Policy Review* No. 65 (Summer 1993), pp. 4-11, esp. pp. 9-10.

64 When Washington Dr. Michael Schlitt asked to withdraw from Medicare, Washington State Medicare contract officials

Q: How will the general movement toward electronic claims processing affect efforts to combat Medicare fraud and abuse?

A: FBI Director Louis Freeh is concerned that electronic claims processing may make it even harder to deal with fraud and abuse precisely because there is no "paper trail."[65]

NO COMPETITION FOR CUSTOMER SERVICE

Unlike private plans which compete directly for consumers' dollars in the FEHBP, Medicare contractors do not compete on the basis of price, quality, or service. Instead, Congress establishes detailed standards for their performance in such matters as paying bills or processing claims. For example, Congress has established claims processing timeliness standards for Medicare contractors, and HCFA is responsible for seeing to it that they meet these standards. The Omnibus Budget Reconciliation Act of 1986 established timeliness ceilings for claims payments, specifying that 95 percent of Medicare claims were to be paid in no more than 30 days in 1987, 26 days in 1988, 25 days in 1989, and 24 days in 1990 and thereafter. Moreover, "participating physicians" were to be paid 7 days faster than "non-participating" physicians, beginning in FY 1988. Then, in the Omnibus Budget Reconciliation Act of 1987, not satisfied with ceilings, Congress mandated that Medicare operate on the basis of claims payment floors. Contractors implemented a floor of ten days in July 1988; by September, 59 percent of the carriers were meeting the ten-day floor. But the law increased the floor level to 14 days. By November 1988, 80 percent of Medicare's contractors were meeting the 14-day requirement. HCFA officials have said that the change from 10 to 14 days caused some difficulties, but that contractors have been working to meet congressional specifications.

Q: So congressional rules are designed to ensure that bills are paid as quickly as possible?

A: Not necessarily. As noted, there are ceilings as well as floors in Medicare's claims processing. Incredibly, Congress has imposed statutory limitations on paying bills too fast. In 1989, for example, bills were to be paid no later than 25 days but no sooner than 14 days after receiving a health provider's claim.

Q: Do these congressional timeliness rules apply to plans in the Federal Employees Health Benefits Program (FEHBP) for Members of Congress and federal workers?

A: No. Consumers in this unique market can punish and reward plans annually, based on their service. Both *Consumer Reports* and *Washington Consumers Checkbook* survey customer services in FEHBP plans in such diverse claims-related areas as simplicity of claims procedures, speed and fairness of claims payment, procedures for providing information on benefits and procedures, and the courtesy, helpfulness, and competence of the company's staff. Moreover, *Washington Consumers Checkbook* lets

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warned him in an April 6, 1992, letter that "any agreement between you and a beneficiary not to involve Medicare is not considered binding, nor does it relieve you of your obligations such as mandatory submission of claims, limiting charges and other requirements....Because we are required by law to refer violators of Medicare statutes and regulations to the Office of the Inspector general for determination of civil money penalty and sanctions, we are keeping your name on [our] mailing list." Similarly, in response to a letter on the subject of private contracting from Elsie Rittman of Tucson, Arizona, former HCFA Bureau of Policy Development Director Kathleen A. Buto warned the 95-year-old Medicare enrollee that "the existence of an agreement between a beneficiary and a physician of the kind described will be viewed as prima facie evidence that any violations of Medicare requirements by the physician with respect to that beneficiary were intentional." Letter from Kathleen A. Buto to Elsie Rittman, September 30, 1993.

65 Cited in *AAPS News*, Vol. 51, No. 5 (May 1995), p. 3; originally cited in *Medicare Compliance Alert*, March 20, 1995.

consumers compare performance by listing or ranking plans by the number of disputed claims per 1,000 federal employees and retirees. Medicare does not make public similar information.

Q: What is the Clinton Administration doing to reform HCFA claims processing?

A: The Clinton Administration, as part of its effort to reform HCFA's unwieldy regulatory process, has proposed a new national Medicare Transaction System (MTS) to replace the nine different claims processing systems now operated by 72 insurance companies at 57 sites around the country. The object is to simplify administration and improve Medicare services. In January and March of 1994, contracts were awarded to private companies for "design, development, testing and implementation" of the MTS.[66]

Q: Are there any estimates of the potential savings in Medicare's computer software for claims processing?

A: Yes. The General Accounting Office estimates that with an investment of $20 million in "off-the-shelf commercial software," Medicare could save nearly $4 billion over five years by "detecting fraudulent claims by physicians—primarily manipulation of billing codes."[67]

Regulating Quality. Beyond entering into contracts with and establishing standards for Medicare contractors and imposing price controls, HCFA is responsible for assuring the "quality" of health care services to the elderly and disabled. It attempts to fulfill this responsibility in a variety of ways. First, it certifies health care providers who are qualified to deliver medical services: doctors, hospitals, ambulatory surgical centers, clinical laboratories, renal dialysis facilities, home health agencies, intermediate care facilities for the mentally retarded, and nursing homes. Each provider must meet HCFA requirements or "conditions of participation." To assure quality, HCFA negotiates with the several states to perform surveys of the approximately 2,000 health care facilities that deliver Medicare and Medicaid services to the elderly and the poor. The states thus become instruments by which HCFA can ensure compliance with its rules, regulations, and instructions.

In recent years, this survey and certification role has expanded. During the second Reagan Administration, HCFA issued its first state-by-state guide to the nation's 15,000 nursing homes. Designed to assess the quality of care given to the elderly, the guide was billed as a snapshot of conditions using 32 "key measures of the quality of care." The first report was issued as a screening tool for consumers. Under the Omnibus Budget Reconciliation Act 1987, HCFA also recertifies skilled nursing facilities and home health agencies. Under the Clinical Laboratory Improvement Amendments (CLIA) of 1988, Congress expanded the agency's survey and certification responsibilities to include clinical laboratories serving Medicare beneficiaries. Approximately 38,000 laboratories around the country are registered with HCFA, all subject to routine inspections on an annual basis. These broad efforts are funded by HCFA out of its Program Management account. HCFA thus has an oversight role over state agencies it funds to do this work.

Q: With Medicare administered by contractors at the state level, what about quality of care and access to medical technology?

A: It is very uneven. Despite thousands of pages of HCFA rules and guidelines, notes Dr. Lonnie Bristow, President of the American Medical Association, in actual practice dozens of Medicare contractors often set their own rules and standards: "For example, an older woman is 180 times more likely to be

66 President Bill Clinton and Vice President Al Gore, *Reinventing Health Care Regulations*, July 1995, p. 3.

67 U.S. General Accounting Office, *Medicare Claims: Commercial Technology Could Save Billions Lost to Billing Abuse*, GAO/AIMD-95-135, May 5, 1995.

turned down for a mammogram in southern California than in northern California. A chest X-ray that's billable in South Carolina is 500 times more likely to be denied in Illinois."[68]

How Medicare Standardizes Benefits

Since the enactment of Medicare in 1965, Congress has adjusted the system by increasing benefits, expanding eligibility, and then implementing price controls to offset the effects of its own initiatives. Benefits are unrelated to income or prior contributions and are applied uniformly toward all enrollees. Every participant is subject to a standardized package with no ability to make adjustments in price or in the scope or range of benefits.

Medicare benefits are divided into two parts: Part A, the Hospital Insurance (HI) program, and Part B, the Supplemental Medical Insurance (SMI) program.

Part A will pay for:

1. **All reasonable expenses for the first 60 days** of inpatient hospital care, minus a deductible ($696 in calendar year 1994) in each benefit period. For days 61-90, a coinsurance amount ($174 in calendar year 1994) is deducted. When more than 90 days are required in a benefit period, a patient may elect to draw upon a 60-day lifetime reserve. A coinsurance amount ($348 in calendar year 1994) also is deducted for each reserve day.

2. **Up to 100 days (following hospitalization) in a skilled nursing facility** for persons in need of continued skilled nursing care or rehabilitation services on a daily basis. After the first 20 days, there is a daily coinsurance ($87 in calendar year 1994).

3. **Home health visits** for persons who need skilled nursing care, physical therapy, or speech therapy on an intermittent basis.

4. **Hospice care services** provided to terminally ill Medicare beneficiaries with a life expectancy of 6 months or less, up to a 210-day lifetime limit. A subsequent period of hospice coverage is allowed beyond the 210-day limit if the beneficiary is recertified as terminally ill.

Part B generally will pay 80 percent of the approved amount (fee schedule, reasonable charges, or reasonable cost) for covered services in excess of an annual deductible ($100). Services covered include the following:

1. **Doctor's services,** including surgery, consultation, and home, office, and institutional visits. Certain limitations apply for services rendered by dentists, podiatrists, and chiropractors and for the treatment of mental illness.

2. **Laboratory and other diagnostic tests,** X-ray and other radiation therapy, outpatient services at a hospital, rural health clinic services, home dialysis supplies and equipment, artificial devices (other than dental), physical and speech therapy, and ambulance services.

3. **An unlimited number of medically necessary home health visits** for persons not covered under Part A. The 20 percent coinsurance and $100 deductible do not apply for such benefits.[69]

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68 Lonnie R. Bristow, M.D., "Transforming Medicare: Will the Train Derail Rounding the Next Political Turn," address to Commonwealth Club of California, January 13, 1995, p. 8.

Congress has established Medicare as a program of defined benefits, in essence promising the nation's senior citizens a laundry list of benefits under Part A and Part B without informing them of or effectively offsetting the true cost. As opposed to protecting the elderly from catastrophic accidents and unforeseen illnesses, Medicare is much like a pre-paid medical services program. Over 95 percent of the elderly receive Medicare benefits today because Congress has created financial incentives for seniors to enroll in the program. The combination of rigid reimbursement—actually price controls—for health providers and artificially low premiums and deductibles for enrollees has resulted in a popular but financially unstable and costly social insurance program.

Q: How has the structure of Medicare affected private health insurance and working Americans?

A: Unfortunately, it has led to overuse of health services by a price-immune population, severe distortion in the private-sector health care market, and an ever-increasing financial burden (tax) on today's and tomorrow's work force, including the almost 40 million uninsured Americans who are mostly workers. Most of these households lack insurance coverage because they cannot afford it; they must spend hundreds of dollars a year to purchase health care for the elderly through the Medicare payroll tax.[70] If Congress had increased Part B medical deductible and premiums to keep pace with inflation and acted to end or decrease the open-ended subsidy of Medi-gap plans, Part B outlays would be significantly less than they are projected to be.[71] As the following table indicates, however, premiums and deductibles have not kept pace with inflation, so Medicare's beneficiaries have been shielded from the true costs of their health care.

HISTORICAL AND PROJECTED AMOUNTS OF PART A (HI) AND PART B (SMI) DEDUCTIBLE AND PREMIUMS

Benefit periods beginning in calendar year	HI Deductible (1st 60 days)	SMI Deductible	SMI Premium
1966	$40	$50	$3.00
1970	$52	$50	$5.30
1975	$92	$60	$6.70
1980	$180	$60	$9.60
1985	$400	$75	$15.50
1990	$592	$75	$28.60
1995	$720	$100	$46.10
1996	$748	$100	$42.80
1997	$788	$100	$47.10
1998	$836	$100	$52.10
1999	$884	$100	$53.80

69 *1994 Green Book, Overview of Entitlement Programs*, Committee on Ways and Means, U.S. House of Representatives, Committee Print 103-27, July 15, 1994, p. 130.

70 Stuart M. Butler and Edmund F. Haislmaier, *A National Health System for America* (Washington, D.C.: The Heritage Foundation, 1989), p. 3.

71 King, testimony before House Commerce Subcommittee on Health and Environment, March 28, 1995.

Decisions often are political, not medical or scientific, in setting benefits. Since Congress defines the Medicare benefits package, it can add or subtract from it. Historically, however, Congress has added benefits instead of trimming them.

Because it is politicians, not doctors and patients, who make the key decisions, the Medicare population—unlike congressional and other federal retirees, who are covered by plans offering benefits and services for different conditions and needs—is locked into a government-standardized benefits package. Beyond electing to participate in the voluntary SMI program with its standardized benefits, the only choice elderly Americans make in health insurance is whether they will purchase a supplemental Medigap policy to get services and benefits not covered by Part B. Depending on the scope of benefits and services provided in these policies, millions of elderly Americans can spend over $1,000 a year on Medigap insurance.

Furthermore, the standardized Medicare package does not cover routine benefits included in most health plans in the Federal Employee Health Benefits Program. For example, the Blue Cross/Blue Shield Standard Option plan available in the FEHBP includes preventive screening (stool tests for blood, prostate specific antigen tests); routine physical exams, including a history and risk assessment only, and a serum cholesterol test, annually at age 65 and over; smoking cessation; catastrophic protection; outpatient prescription drugs; and routine dental care. None of these benefits is available in Medicare.

Q: What happens when a new treatment is discovered or an old one becomes obsolete?

A: Once a standard benefits package has been established, modifying and updating it becomes an administrative, bureaucratic, and political nightmare. Medicare establishes and excludes certain types of services from coverage. HCFA officials must overcome a myriad of internal bureaucratic obstacles whenever they seek to add or withdraw a benefit. Should HCFA decide to expand coverage for a promising medical breakthrough, it must request an evaluation from the Office of Health Technology Assessment (OHTA), part of HHS's Agency for Health Care Policy and Research (AHCPR). This is a cumbersome process. Any HCFA official wanting to eliminate a benefit or medical service must be prepared to defend his proposal before Congress and special interests lobbying for the inclusion of their particular benefit or service.

Controlling Medical Technology. While Medicare benefits are established by Congress, the addition or subtraction of medical treatments or procedures rests with HCFA. The problem of adding a treatment or procedure becomes acute for Medicare patients when the medical technology in question is new.

Under Medicare's complex reimbursement rules, it is not always clear that a medical procedure or device is reimbursable under HCFA guidelines. HCFA's staff can do an internal review and determine that a medical technology, particularly a conventional technology, is reimbursable. But the decision to cover it is not left to the regional office; it is referred to the headquarters in Baltimore. The technology assessment is done for HCFA by HHS's Office of Health Technology Assessment. After reviewing the information, OHTA makes its recommendations to HCFA's Office of Coverage Policy.

Under current law, the Food and Drug Administration (FDA) approves prescription drugs and medical devices for safety and effectiveness before they can be marketed in the United States. Outpatient prescription drugs are not covered by Medicare, so FDA decisions in this area apply only to inpatient drugs. Medicare private-sector patients therefore are affected differently. For medical devices, there are special FDA Investigational Device Exemptions (IDEs) for "breakthrough" or "investigational" devices, subject to patient consent and initial FDA approval. These exemptions are available for doctors and hospitals to treat patients enrolled in private health plans. Historically, hospitals have billed Medicare for new medical devices and for the use of investigational devices otherwise approved by the FDA in clinical studies. In July 1994, the HHS Office of Inspector General issued a subpoena to 130 hospitals and leading medical centers requesting "nearly a decade's worth of billing records on cardiac devices."[72] HCFA's

position was that billing such "investigational devices" constituted "fraud" against the Medicare program. Spokesmen for HCFA asserted that billing Medicare for investigational devices had always been prohibited and that the hospitals and medical centers should have "known better."[73] HCFA now denies Medicare reimbursement to doctors and hospitals that use these investigational medical devices, even if doctors think they are warranted in treating an elderly patient's disease or medical condition. Because Medicare refuses to pay for these newer medical devices, Medicare patients, unlike patients in the private sector, experience delays in getting such treatments or access to such devices, and sometimes are denied access to them altogether.

If Medicare does agree to pay for a medical device, the payment must be the government-determined rate, regardless of market supply and demand conditions. The law thus limits elderly patients' access to advanced medical technologies.

Q: How have leading medical research centers and hospitals responded to HCFA rules and HHS subpoenas governing billing for new or "investigational" medical devices?

A: Clinical trials have been shut down and Medicare patients excluded from access to these devices. According to one account, "The subpoenas created a domino effect—hospitals closed studies, limiting access to devices by Medicare patients. Doctors were no longer able to provide what they considered the latest treatments to many older patients."[74]

Q: How has the medical device industry responded to FDA and HCFA regulatory processes?

A: According to a survey of the Health Industry Manufacturers Association (HIMA), which represents more than 700 medical device companies, 50 percent have moved some trials of clinical devices to other countries. This means that patients in other countries are the first to benefit from technological innovations developed in the United States.[75]

Q: Many physicians use "investigational" drugs and medical devices in difficult or life-threatening cases. Does Medicare make any exception to the ban on reimbursement for such devices?

A. No. According to Thomas A. Ault, Director of the Bureau of Policy Development at HCFA, "The Medicare manuals do not allow any exceptions to this policy."[76] Dr. John Rowe of New York's Mount Sinai Hospital testified recently that even using a pacemaker with a new form of electrical contact could run afoul of the rules if the manufacturer was comparing the effectiveness of different contacts. In such a case, the hospital could be turned down for the cost of the entire treatment, not just the pacemaker.[77]

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72 Tom Friend, "Clinical Trials in U.S. Called 'Endangered,'" *USA Today*, May 10, 1995, p. 2A.
73 *Ibid.*
74 *Ibid.*
75 *Ibid.*, p. 1A.
76 Thomas A. Ault, memorandum to HCFA Regional Administrators, "Medicare Coverage of Investigational Devices," December 28, 1994, p. 1.
77 John Rowe, M.D., in testimony before Committee on Finance, U.S. Senate, May 16, 1995.

Q: So Medicare does not always provide reimbursement for the latest medical technologies, procedures, and pharmaceutical breakthroughs?

A: Right. Americans should be extremely cautious about accepting a comprehensive, standardized government benefits package for all plans, especially in an era when medical technology is improving and making rapid advances. According to a recent study of the Medicare system by former U.S. Senator David Durenberger (R-MN) and former congressional health policy analyst Susan Bartlett Foote, Medicare technology evaluation has been underfunded because of competing budgetary priorities, such as payment for a growing volume of state-of-the-art medical services. Durenberger and Foote note that such evaluation has been hampered by ineffective assessments of the cost-effectiveness of technology, due in large part to the politicization of HCFA's decision-making process, and that technology assessments often have been painfully slow. OHTA performed only 10 assessments in 1991 and 8 in 1992, and some have been buried for over three years. Furthermore, a bureaucratic approach to technology policy that affects all Americans, especially the Medicare population, raises serious health-related concerns.[78]

MEDICARE'S EXPERIMENT WITH MANAGED CARE

In recent years, in an effort to catch up with the private sector, HCFA has tried to promote managed care plans in the form of Health Maintenance Organizations (HMOs) as an alternative way to deliver medical services to the elderly. Within HMOs, doctors and other health care providers are paid on a "capitated basis," and their incentives are quite different from those found in the traditional fee-for-service system that characterizes Medicare. HCFA officials think the efficiencies of HMOs would allow them to lower their premiums and attract Medicare beneficiaries into their managed care networks. The Reagan and Bush Administrations encouraged enrollment in HMOs as a "private plan option" for Medicare beneficiaries because they saw managed care as a way to slow the rapid growth of Part B spending. In 1982, in the Tax Equity and Fiscal Responsibility Act, Congress permitted Medicare to allow HMOs and Competitive Medical Plans (similar managed care-type plans which contract with physicians) to accept Medicare patients but at full financial risk to themselves. By 1989, over 1 million beneficiaries had enrolled in approximately 133 managed care plans. More recently, Congress established a Medicare Select option—in practice, a Preferred Provider Option.

Q: How many Medicare beneficiaries are enrolled in HMOs or managed care plans compared to enrollees in private-sector insurance and the FEHBP?

A: Only about 7 percent of Medicare beneficiaries are enrolled in HMOs or managed care plans. In the private sector, 63 percent of all workers and their families are enrolled in such plans; in the FEHBP, 33 percent of all enrollees are in HMOs. Of the 1.6 million federal retirees, approximately 18 percent are enrolled in HMOs.[79]

78 David Durenberger and Susan Bartlett Foote, "Medical Technology Meets Managed Competition," *The Journal of American Health Policy*, May/June 1993, pp. 24-25.

79 Francis, "The Political Economy of the Federal Employees Health Benefits Program," p. 277.

Q: What is wrong with HCFA's payment to HMOs?

A: Under Medicare rules, the capitation rate for doctors in HMOs is 95 percent of local fee-for-service costs. Medicare officials are constantly trying to find the right price for medical services. As former HCFA Administrator Gail Wilensky says, "Inadequate payments for risk appears to produce overpayments to many HMO's, probably underpayments for some HMO's."[80]

Q: If an HMO offers a premium for its package below the Medicare payment, can the Medicare beneficiary get a price rebate from the HMO?

A: No. The elderly are not allowed to take advantage of actual or potential savings in the Medicare program.

Q: How has the Medicare Select PPO option fared?

A: As well as could be expected in a bureaucratic system driven by political rather than market considerations. The PPO option originally was limited to 15 states. Congress just extended Medicare Select to all 50 states for 3 years, subject to congressional review at the conclusion.

Q: Are "point of service" managed care plans, in which Medicare patients can choose personal doctors outside their own managed care networks, allowed?

A: No.[81]

Q: May private employers contract with an HMO and enroll their retirees, who also are Medicare beneficiaries, in an HMO or Competitive Medical Plan?

A: No.[82]

Q: What if Congress just forced the elderly into managed care plans, as many private employers are doing now to workers and their families? Wouldn't that save money?

A: Not necessarily. It is not clear that managed care will guarantee long-term savings, either in the Medicare system or in the private health care system. "Managed care will not provide an instant magic bullet," notes Urban Institute health policy analyst Marilyn Moon. "Health maintenance organizations (HMO's) and other types of managed care have more experience dealing with younger, healthier populations that may not translate easily into treatment of the aged and disabled."[83]

Q: Why have HMOs been more widespread in the FEHBP than in Medicare, and why do they seem to have reduced costs?

A: Because of personal choice. In the FEHBP, not only is joining an HMO voluntary, but federal employees and retirees can pocket the savings from picking a private managed care plan.

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80 Gail R. Wilensky, "Alternative Financing and Delivery Strategies for Medicare," testimony presented to Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, February 7, 1995, p. 2.

81 *Ibid.*

82 *Ibid.*

83 Marilyn Moon, "Medicare, Its Trust Fund, and Deficit Reduction," Urban Institute *Policy and Research Report*, Winter/Spring 1995, p. 32.

Q: Do HMOs in the FEHBP assume all financial risks for enrolling employees and retirees?

A: Yes. All private carriers, including traditional fee-for-service plans competing in the FEHBP, assume the financial risk of enrolling federal employees and retirees. This risk is not assumed by the taxpayers.[84]

HOW HCFA PAYS DOCTORS AND HOSPITALS

Medicare's most prominent regulatory feature may be its complex system of reimbursement for doctors, hospitals, and other health care providers. Its experiences in setting prices for these providers are object lessons both in the deficiencies of conventional third-party payment arrangements that still characterize employer-based insurance and in the failures of administered pricing and central planning as found in Medicare's reimbursement schedules. The administered prices are either too high or too low; the process for setting them inevitably is flawed or lacks sufficient data; the guidelines are confusing or insufficient; or the payment process is compromised by HCFA's managerial ineffectiveness. For example, in a May 1991 report on the pricing of medical technology, the General Accounting Office found that in some localities, Medicare was paying more than twice as much as others for magnetic resonance imaging (MRIs), thereby stimulating greater use of this technology.[85] In November, GAO found that six suppliers of durable medical equipment realized higher profits from their Medicare business than from their non-Medicare business.[86] The next year, in June 1992, GAO found that "HCFA could reduce Medicare expenditures on durable medical equipment subject to unnecessary payments by developing more detailed coverage criteria that give carriers a clear, well-defined, objective basis for paying or denying claims."[87]

If the quality and quantity of information are insufficient, the basis for planning is flawed and payment policies will be wrong. In an examination of Medicare payments to teaching hospitals, GAO reported in 1991 that "Supplemental medicare payments to teaching hospitals are based on inaccurate and unverifiable data, and are causing Medicare to pay millions more in indirect medical education costs than it should."[88]

Occasionally, Medicare pricing policies are bizarre. For example, in a March 1992 report examining payment practices for certified registered nurse anesthetists (CRNAs) and doctors, GAO found that "Medicare pays more for anesthesia services performed by CRNA's or residents under concurrent medical direction by an anesthesiologist than for identical services personally provided by an anesthesiologist."[89] Just as suppliers of durable medical equipment had been overpaid by Medicare, clinical laboratories were doing quite well under Medicare's fee schedules: "Medicare and other retail

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84 During the Bush Administration, OPM officials wanted the federal government to "self insure," just as a private corporation does. But the federal government is not a private corporation; if the OPM had succeeded in promoting this scheme, all of the FEHBP's risk and financial obligations would have been assumed by America's taxpayers.

85 U.S. General Accounting Office, *Medicare: Excessive Payments Support the Proliferation of Costly Technology*, Report to the Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, GAO/HRD-92-59, May 1992.

86 U.S. General Accounting Office, *Medicare: Effect of Durable Medical Equipment Fee Schedules on Six Suppliers Profits*, Report to Congressional Committees, GAO/HRD 92-22, November 1991, p. 8.

87 U.S. General Accounting Office, *Durable Medical Equipment: Specific HCFA Criteria and Standard Forms Could Reduce Medicare Payments,* Report to Congressional Committees, GAO/HRD-92-64, June 1992, p. 3.

88 U.S. General Accounting Office, *Medicare: Flawed Data Add Millions to Teaching Hospital Payments,* Report to the Secretary of Health and Human Services, GAO/IMTEC-91-31, June 1991, p. 7.

89 U.S. General Accounting Office, *Medicare: Payments for Medically Directed Anesthesia Services Should be Reduced,* Report to Congressional Committees, GAO/HRD 92-25, March 1992, p. 11.

customers are essentially subsidizing laboratory sales to discount customers. Based on the principle that Medicare should pay its own way but not subsidize services for other customer groups, we believe that Medicare's fee schedule payment rates are, on average, too high."[90] Payment also can affect the kind and quality of care given to the elderly. GAO found that Medicare's reimbursement to oncologists determines whether cancer patients are treated in higher cost hospital settings or lower cost outpatient settings: "What is clear from our results...is that HCFA's reimbursement policies for chemotherapy have unintended consequences that extend beyond whether and how much oncologists are reimbursed by Medicare. Specifically, the policies may affect where a cancer patient gets treated and, as a result, Medicare costs for that patient care."[91]

Hospital Payments. Historically, hospital care has been the single largest item in the Medicare budget. Elderly citizens are more prone to hospitalization, and HCFA officials estimate that approximately one fourth of all Medicare beneficiaries are hospitalized once a year. Not surprisingly, Medicare payments to approximately 6,000 hospitals nationwide account for almost 40 percent of all hospital income.

In 1983, with the support of the Reagan Administration, Congress enacted the Prospective Payment System (PPS), a new Medicare reimbursement system for hospitals. The program was phased in over a period of five years and fully implemented in 1988. HCFA, of course, administers this system of hospital payments. Under the PPS system, hospitals are paid a standardized amount for each admission. That per capita amount is adjusted by the "wage index" for the geographic area in which the hospital is located and multiplied by a weight assigned to the case according to its diagnostic related group (DRG). Under Medicare, approximately 500 DRGs determine all hospital payments.

The DRGs are at the heart of the PPS system, and HCFA officials often are concerned with ways to "refine" the payment formula. For example, classifications do not distinguish between differences in the severity of cases even though, on paper, patients may be classified under the same DRG for purposes of medical treatment. The levels of care are different, but reimbursement is the same. HCFA officials are aware of this deficiency and have sponsored research at Yale University on adjustments that would allow for differing levels of severity in medical condition.

Another key element in a hospital's standardized Medicare payment is whether it is located in an urban or a rural area. Standardized amounts have been significantly higher for urban hospitals. "Sole community hospitals," designated by HCFA as the only hospitals available in given geographic (rural) areas, are paid a separate PPS rate.

HCFA planners adjust the PPS rates on the basis of the "hospital market basket," an index that measures annual changes in the "cost of inputs," including such items as the cost of labor, prescription drugs, medical supplies, and even the energy consumed by the hospital in delivering medical services. The hospital market basket is a major component of the PPS update, or rate of increase in hospital payments from year to year. In assessing what hospitals should be paid, Members of Congress are advised by a special government commission, the Prospective Payment Assessment Commission (ProPAC), independent of HCFA. Based on its analyses, ProPAC may recommend an average update factor at some percentage, taking into account recent HCFA market basket estimates. Congress is free to accept or reject these recommendations.

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90 U.S. General Accounting Office, *Medicare: Payments for Clinical Laboratory Test Services Are Too High,* Report to Congressional Committees, GAO/HRD-91-59, June 1991, p. 12.

91 U.S. General Accounting Office, *Medicare: Reimbursement Policies Can Influence the Setting and Cost of Chemotherapy*, Report to the Chairman, Committee on Finance, U.S. Senate, GAO/PEMD-92-28, July 1992, p. 5.

Q: What about hospitals with a "disproportionate share" of low-income clients?

A: The PPS system allows additional payments to help cover the indirect costs of teaching and to help hospitals with a disproportionate share of low-income patients. Because urban and teaching hospitals tend to give low-income and uninsured people uncompensated care, Medicare reimburses them with additional payments. These hospitals have enjoyed higher levels of profitability under the PPS system than other types of hospitals. At the same time, federal law forbids hospitals from transferring, or "dumping," any patient who arrives in an emergency room. Moreover, under the Hill-Burton Act, they must provide free care to uninsured or low-income people to qualify for low-interest federal construction loans.

Q: What is HCFA's experience with PPS rates?

A: Troublesome. HCFA officials must know the right price for hospitalization services in order to set the right rates. To be at all efficient, central planning and pricing policies require a daunting level of precision in data collection and analysis. The first technical problem for HCFA planners was that they based their initial standardized payment amounts on 1981 hospital cost data and then continued to do so in subsequent years. Thus, annual payments were made on outdated assumptions, rendering them—at least for purposes of government pricing—economically meaningless. HCFA planners then argued that they had to "rebase" the PPS standardized amounts, taking into account more recent and more accurate data. For the special interests, rebasing was not a scientific question, but a matter of income. The American Hospital Association, for example, originally opposed rebasing but then reversed itself and supported it because it would increase Medicare payment levels.

Q: In other words, by basing its estimates on 1981 hospital data, HCFA set PPS amounts too high?

A: Yes. During the first two years, Medicare hospitals' profit margins were about 15 percent. This led HCFA officials to believe they had set the rates too high. In response to PPS, the average length of patient stays fell, and hospitals did what they could to get "heavier" DRG weighting for certain classes of medical services in a fashion that HCFA planners did not anticipate.

Q: How have hospitals tried to get a heavier DRG weighting?

A: Through a process called "up-coding." Hospital officials try to document each case thoroughly, noting every complication in the patient's status that would require specific services. This gives the patient's DRG a heavier weight, and thus a higher Medicare payment.

Q: How has PPS affected rural hospitals?

A: Rural hospital administrators initially thought that PPS reimbursement was too low. In the late 1980s, HCFA officials conceded that Medicare payment levels were disadvantaged by the PPS system. But they also argue that other factors, not the PPS system, are responsible for the financial difficulties of rural hospitals. During the first four years of PPS, admissions declined significantly at rural hospitals, which have much lower occupancy rates than urban hospitals.

Q: How has Congress responded to this problem?

A: By further modifying and adjusting the PPS system to get the right price for rural hospitalization and by expanding the federal bureaucracy. In FY 1988 and FY 1989, Congress mandated higher annual rate increases for rural hospitals than for urban hospitals; accordingly, the methodology for calculating basic rates was revised in FY 1988, resulting in increased rates for rural hospitals. Moreover, in August 1987, HHS established an Office of Rural Health Policy to coordinate HHS activities relating to rural

health policy. In 1988, Secretary Otis R. Bowen established the National Advisory Committee on Rural Health to advise him on the impact of Medicare and Medicaid policies on rural hospitals and other health care facilities.

Q: Did these changes in PPS methodology help rural hospitals?

A: No. In the Omnibus Budget Reconciliation Act of 1987, Congress authorized a special Medicare demonstration program to award small grants to rural hospitals to help them close and convert facilities and develop alternative types of medical services. In FY 1989, Congress appropriated $9 million for this program.

Q: What else did Congress do for rural hospitals?

A: Congress simply authorized a change in the definition of "rural" for purposes of PPS. In FY 1989, HCFA standards for designating counties as rural or urban were changed so that 57 hospitals in 38 rural counties would be paid by Medicare as if they were urban hospitals.

Q: What has been the effect of the PPS system?

A: HCFA officials invariably say it has been consistently effective in controlling costs. For example, between 1979 and 1983, HI benefit outlays increased by over 17 percent per year. For the first five years of PPS, HCFA reported that the growth rate for HI outlays dropped to an annual average of 6.5 percent. HCFA attributes this both to decreases in hospital admissions and the average length of hospital stays and to a shift to outpatient services covered under Part B.

Q: In other words, the PPS system shifted costs to elderly patients—in the form of less hospitalization—and to the part of Medicare not covered by PPS?

A: Yes. One of the system's first noticeable features was a more rapid turnover in hospitalization among Medicare patients. As John Merline of *Investor's Business Daily* writes, "Hospitals, according to several studies, are releasing some Medicare patients earlier and in less stable condition than they formerly would."[92]

Q: So in coping with PPS standardized reimbursements, hospitals simply shift costs from one part of Medicare to the other?

A: Yes. Under the PPS system, hospitals have every incentive to shift costs from Part A inpatient hospital services to Part B outpatient services. From 1985 through 1990, outpatient hospital services jumped 20 percent per year. Historically, the big shift in the use of outpatient services has been in diagnostic, surgical, endoscopic, and cataract procedures.

Q: Under the Medicare DRG system, hospitals are forbidden to charge more than the Medicare-approved price, even if patients are willing to pay more. But can they charge less than the Medicare-approved price and give rebates to the elderly?

A: No.[93]

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92 John Merline, "Pay or Pay," *National Review*, May 29, 1995, p. 47. Merline is Washington correspondent for *Investor's Business Daily*.

93 "Although the DRG system pays one fixed price for treatment of a specific condition, the actual cost to hospitals of delivering medical care can vary enormously, depending on the patient." John Goodman *et al.*, *An Agenda for Solving*

Payments to Doctors. Since 1966, Congress has taken approximately 75 different actions to cut Medicare payments to doctors.[94] These legislated caps and freezes on reimbursement schedules have reduced compensation in the Medicare program to about 59 percent of private-sector rates.[95] Yet costs continue to grow at unsustainable rates. Rather than introduce free-market forces into the program to control costs efficiently, however, liberal Members of Congress have devised even more complex and cumbersome systems of price controls over the past decade.

Historically, physicians in Medicare were reimbursed according to the "usual, customary, prevailing, and reasonable" rates based on behavior in the private market.[96] In 1975, Congress established a Medicare Economic Index (MEI) and then required Medicare to limit its annual increases in prevailing rates to this MEI. Throughout the 1980s, Congress tried to change, modify, or cap these rate increases. This effort failed. Spending on Part B services continued to soar at about 13 percent per year.[97] Since there is no genuine health care market (at least as economists normally understand the term) in the private sector, Medicare since 1992 has attempted to pay physicians on the basis of a special formula called the Resource-Based Relative Value Scale (RBRVS):

How to Calculate Physicians' Fees Under Medicare

$$\text{Payment}=(\{RVUw_s \times GPCIw_a\} + \{RVUpe_s \times GPCIpe_a\} + \{RVUm_s \times GPCIm_a\}) \times CF$$

Source: *Federal Register*, "Medicare Program; Fee Schedule for Physicians; Proposed Rule," June 5, 1991.

> Since January 1, 1992, payments for physicians services under Medicare have been based on a national fee schedule that is being phased in through 1996. Under the fee schedule, each service is first assigned a *relative value.* The *relative value* for a service has three components: (1) a physician work component that reflects the time, skill, and intensity of the physician's effort in providing the service; (2) a practice expense component that includes costs such as office rent, salaries, equipment, and supplies; and (3) a malpractice component that reflects malpractice insurance premium costs. A *geographic adjustment* is made to each of the three components of the relative value. The geographically adjusted relative values are then multiplied by the conversion factor. The conversion factor is a dollar figure that converts the geographically adjusted relative value for a service into a dollar payment amount for that service.[98]

Perhaps the most interesting feature of this entire process is the attempt by HCFA staff, using the methods of social science, to measure and weigh the "value" of labor as the key element in reimbursing an entire class of professionals, an enterprise long since abandoned even by practitioners of socialist economics.[99]

America's Health Care Crisis: *Task Force Report*, National Center for Policy Analysis, 1990.

94 American Medical Association, *Perspectives on Medicare*, May 1995, p. 6.

95 "Medicare: Reform Is Essential to Preserve the Program," American Medical Association *Talking Points*, 1995, p. 4.

96 "In essence the CPR (customary, prevailing and reasonable), became a system in which doctors were paid whatever they charged as long as it was not too outrageous. Together with the cost-plus systems used until the 1980's to pay hospitals, CPR historically has been one of the main causes of escalating U.S. health care spending and costs. When Congress created Medicare and Medicaid in 1965, it simply replicated this flawed payment system in the new government programs." Edmund F. Haislmaier and Robert E. Moffit, "The Medicare Relative Value Scale: Comparable Worth for Doctors," Heritage Foundation *Backgrounder* No. 732, October 25, 1989, pp. 5-6.

97 *Ibid.*, p. 1.

98 Mark Merlis *et al.*, "Medicare: President's FY 1995 Budget Proposal," *CRS Report for Congress*, 94-223 EPW, February 25, 1994, p. 8.

99 Robert E. Moffit, "Back to the Future: Medicare's Resurrection of the Labor Theory of Value," *Regulation*, Vol. 15, No. 4 (Fall 1992), pp. 54-63.

Two other elements of the new reimbursement formula are Volume Performance Standards (VPS) and restrictions on balanced billing, or the ability of the physician to charge more than the Medicare-approved price for a medical service. Under Medicare's physician reimbursement system, HCFA projects the appropriate rate of growth for the volume of physicians services to the elderly and the disabled. If physicians as a group exceed the projected volume of medical services set by the HCFA in any given year, the aggregate reimbursement is reduced proportionately, as a percentage, two years later. HCFA officials have never been clear as to how a future reduction in fees for all physicians in the Medicare program is supposed to prevent an individual physician from increasing his volume of services in order to offset potential future losses in Medicare income. Nonetheless, this is the Volume Performance Standards' central function. Congress adopted this mechanism in 1989 to offset the likely increase in the volume of medical services encouraged by reductions or restraints in fee schedules and billing. A related measure was a limitation on balanced billing. Thanks to the RBRVS fee schedule and balanced billing restrictions, the Medicare fee schedule became nothing more than a complicated price-fixing scheme.

For over 500,000 physicians, HCFA assigns regularly updated "relative values" for approximately 7,000 medical procedures. Refining these values in the RBRVS is a tedious and never-ending task because, as with previous Medicare reimbursement schemes, the values, and thus the Medicare payments, are rarely right and often controversial. When RBRVS was implemented in 1991, physicians complained that the government's "conversion factor" (translating HCFA value scales into specific dollar amounts) was not high enough. Beyond that, the Physician Payment Review Commission (PPRC), and even HCFA, conceded in 1991 that many of the values assigned to the thousands of medical procedures were simply wrong.[100]

Under the RBRVS, HCFA must rely on physicians to participate in setting and adjusting medical service codes. This is a complicated process that forces physicians, operating outside of anything that resembles a market, to function as judges in their own interest and at public expense.

Like all such price-control schemes, Medicare's RBRVS fee schedule encourages doctors to game the system by such means as trying to bill Medicare or patients in creative ways; upcoding, or using a medical service code that guarantees higher reimbursement when more than one medical service code applies to the treatment of a case; and "unbundling," or making charging separately for services that otherwise would be part of, and billed as, a single package of treatment for a given medical condition.

Q: The market rewards suppliers which provide high quality goods or services that consumers find beneficial. Does HCFA or Congress attempt to incorporate the quality or benefit of a medical service to elderly patients?

A: No. Neither the quality nor the benefit of a service is a part of Medicare's RBRVS formula for setting fees for physicians. Patient demand, in an economic sense, is simply ignored. Proponents of the RBRVS say that, with more time, more research, and a better refinement of social science methodology, they hope to incorporate quality and benefit indices for purposes of calculation.[101] But no such indices exist today.

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100 *Ibid.*, p. 57.
101 *Ibid.*, p. 60.

Q: Does the Medicare RBRVS fee schedule make any distinctions among physicians on the basis of their professional skills in treating patients?

A: No. Medicare reimburses doctors without regard to differences in skills or experience. Highly skilled surgeons with a great deal of experience are paid the same as relatively inexperienced surgeons of lesser reputation.

How to Expand Choice and Strengthen Medicare's Financial Condition

Absent any structural reform of the Medicare program, Congress will be forced to choose between two very unpleasant and unpopular alternatives: a massive tax increase on working Americans, surpassing the Clinton tax bill of 1993, or a similarly masive reduction in benefits to the elderly. Halfway measures cannot restore solvency to Medicare's trust funds. Nor can they achieve the necessary savings needed to help balance the budget and reduce the deficit. Moreover, failure to pass structural reforms allows HCFA's bureaucracy—with its arcane regulations burdening physicians, hospitals, and other health care providers—to become even more entrenched.

According to the Medicare trustees, "it is now clear that Medicare reform needs to be addressed urgently as a distinct legislative initiative."[102]

Q: Private-sector experience often is used as a point of comparison with Medicare. How do Medicare's costs compare with the private sector's?

A: In the private sector, large employer health premiums in 1995 dropped by 1.1 percent while overall health care prices rose 4.4 percent. Medicare, meanwhile, experienced more than 10 percent overall growth and is projected to grow at the same rate for the next five years.[103]

Q: What other options do retirees have if they choose not to purchase the Medicare Part B package?

A: They can buy a private plan. But if they do so, they lose the 75 percent subsidy for premiums available under Part B.

Q: Are all retirees treated equally when it comes to purchasing health insurance?

A: No. Retired Members of Congress and other federal retirees have access to the FEHBP. Unlike Medicare, this unique, consumer-driven health care system is not run on the principles of central planning and price controls. It is based on the market principles of consumer choice and competition. The FEHBP includes over 400 private health insurance plans nationwide, ranging from traditional indemnity insurance and fee-for-service plans, to plans sponsored by federal unions and employee organizations, to various managed care plans (HMOs, PPOs). Instead of attempting to constrain costs by controlling prices and specifying services to be covered, it sets very broad guidelines over how plans must be structured and marketed and specifies only a brief set of core benefits, permitting federal workers and retirees to choose the plan and benefits that are right for them. Costs are held down through the operation of con-

102 *Trustees' Report Summary*, p. 13.

103 Deborah Steelman, presentation to Speaker's Resource Group on Health, May 18, 1995.

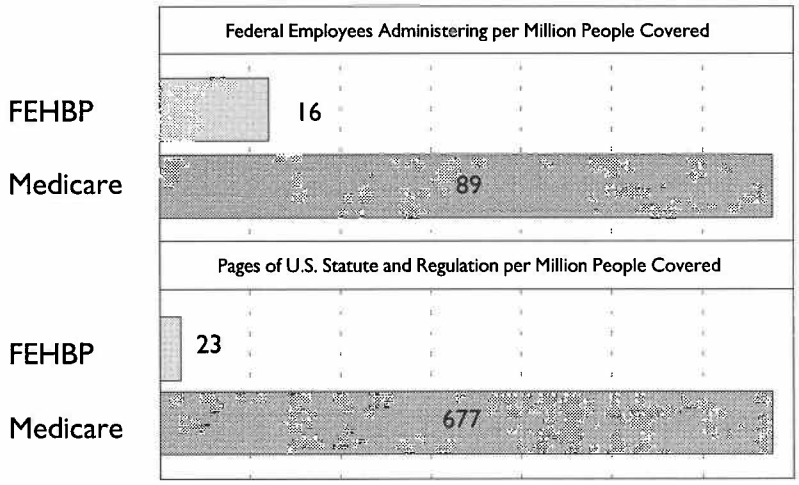
sumer choice in a market of competing plans. Total costs in the FEHBP have been rising at about half the rate of costs in Medicare, and premiums recently have been flat or falling.

Q: Since both the FEHBP and Medicare are run by the federal government, aren't they essentially similar?

A: No. The FEHBP works on entirely different principles. For one thing, Medicare is a defined benefits program in which each enrollee has access to a standardized set of health services that are paid for, in whole or in part, by the federal government. The FEHBP, on the other hand, is a defined contribution program in which the government agrees to provide retired Congressmen, Senators, or federal employees with a financial contribution toward the purchase of health plans of their choice.

Chart 2

Federal Employees Health Benefits Plan: Quality Care with a Fraction of the Bureaucracy of the Medicare System



Sources: *1992 Green Book*; unpublished data from U.S. Office of Personnel Management, October 1992. Cited in *Mandate for Change*, Progressive Policy Institute, 1993.

The FEHBP is open to all congressional and federal retirees who retired after July 1, 1960. Under current rules, a retiree is eligible to enroll in an FEHBP plan if he retired on an annuity with at least five years of continuous service at the time of retirement, or if he retired on a civil service disability. Retirees can assume coverage for spouses by electing survivor benefits for them, and any survivor annuitant can request FEHBP coverage for grandchildren, under certain conditions, on or after August 11, 1994.[104]

Q: What features make an FEHBP-style program more desirable than Medicare for retirees?

A: **First,** retirees would have a wide choice of health plans. Except for federal retirees no other group of retirees enjoys this feature. Private plans range from fee-for-service to different types of managed care plans. Plans sponsored by federal unions and employee organizations and associations are particularly popular; almost one third of federal workers and retirees are enrolled in such plans.

Second, retirees could choose the services they want covered. Unlike the Medicare population enrolled in a single, standardized government benefits package, federal retirees have various private options available to them. Beyond the normal range of hospitalization and physician services, they can pick from plans that cover such services as dental care, outpatient mental health benefits, routine physi-

104 Adding a child to a survivor's family plan depends on family status: "The deciding factor now is whether or not the grandchild would have qualified as a family member if the retired employee were still alive." National Association of Retired Federal Employees, *Federal Health Benefits Information and Open Season Guide, 1995*, p. 28.

cal examinations, durable medical equipment, hospice care, outpatient prescription drugs, mail order prescription drugs, treatment for alcoholism and drug abuse, and—most important—catastrophic coverage.

Third, retirees would have a range of options as to what they will pay in premiums, deductibles, copayments, coinsurance, and, in some cases, maximum out-of-pocket expenses. Under the FEHBP's financing formula, the government will contribute each year up to a maximum dollar amount. If a federal retiree chooses a very expensive benefit package that exceeds this contribution, he makes up the difference. On the other hand, if a retiree chooses a less expensive plan, he saves money on his portion of the premium.

Building a Better System

Q: How can retirees get the same types of options Members of Congress and other federal employees enjoy upon retirement?

A: Congress can give the elderly greater control over their Medicare dollars so they can select the plans and services that are right for them. Changing Medicare from a defined benefit program into a defined contribution program would allow the elderly to use payments to enroll in private health plans with the benefits and services they want, rather than those chosen for them by bureaucrats or politicians. On the other hand, if they wish to remain in the traditional Medicare plan, they should be free to do so.

Q: Would a defined government contribution cover the costs of retirees' health insurance?

A: Yes, unless the senior chose a very expensive plan. The size of the government contribution could be the combination of two amounts, reflecting the financing of the existing Part A and a reformed Part B. Medicare currently spends $4,800 per person, or $9,600 per couple.

Part of the defined contribution could be an amount (adjusted by age, gender, and geography) intended to cover the actuarial equivalent of the hospital and other services in today's Part A. This portion of the voucher would not be subject to a means test. Another part could be based on an amount (also adjusted by age, gender, and geography) intended to cover the actuarial equivalent of services currently included in the voluntary and subsidized Part B program. This base amount should be subject to a means test to determine the dollar amount of this portion.

Under such a scenario, the elderly finally would be able to purchase health insurance plans of their choice. HCFA would be reduced to a clearinghouse that distributes information regarding these plans to the elderly. A checklist of benefits would be provided to inform beneficiaries as to what type of plan is in their best interest. Enrollees who choose a health insurance plan which costs less than the size of their defined contribution would receive the difference in cash, tax free.

Q: What kinds of protection would Congress have to establish to make sure that the elderly aren't being conned by rogue insurance companies?

A: Health insurance plans participating in a new consumer choice, or "Medi-Choice," system would have to meet certain basic requirements to be marketed as approved plans:

- **Requirement #1:** They would have to meet basic financial strength requirements to assure fiscal solvency. A similar requirement exists today in the FEHBP.
- **Requirement #2:** They would have to specify benefits, services, and costs in a standardized manner, enabling the elderly to choose a plan without confusion. This is done today in the FEHBP.

- **Requirement #3:** They would have to provide information on their benefits, premiums, and patient satisfaction to Medicare. They also would have to adjust premiums by age, geography, etc., but not by health condition.
- **Requirement #4:** They would have to contain a core set of benefits, including catastrophic coverage. This also is not unlike the FEHBP. This core benefit package should be leaner than the current Medicare package, enabling individuals to purchase a less expensive plan and pocket the savings. With the help of the defined government contribution, it also would enable the elderly to supplement their basic plans with various services.

Q: What would a Medi-Choice system, broadly similar to the FEHBP, mean for the elderly population?

A: Elderly Americans would be able to choose the type of private health insurance that meets their individual needs. With advice and counsel from private doctors and family members, they could pick either a basic benefits package or a broader package with a range of services and treatments that are readily available on the open market. Consulting with doctors rather than waiting for approval from government bureaucrats in Washington means that the elderly could enjoy the immediate advantages of state-of-the-art treatments, medical procedures and devices, and service delivery innovations.

Financially, America's elderly would be able to pocket any savings from their personal decisions in the form of contributions to Medical Savings Accounts (MSAs). While the cost of health care on average is higher for the elderly than for the working population, the level of the government contribution to their health plans also will increase accordingly, based on their age factor. With the establishment of a Medi-Choice system, the powerful market forces of consumer choice and competition should yield the free-market dynamics and positive effects the private sector now enjoys.

CONCLUSION

After thirty years of existence, Medicare is in crisis. The message—even from Medicare's own trustees—could not be clearer: Without fundamental structural reform, this program will be bankrupt by the year 2002. It is mired in bureaucracy, immune to shifts and changes in the market, and subject to runaway costs that show no sign of slowing down. Furthermore, its 38 million beneficiaries soon will be joined by a huge influx of retirees from the baby boomer generation, severely straining the funds and resources of an already financially troubled system.

It is imperative that all retired Americans be afforded the same types of choices and opportunities now enjoyed by retired Members of Congress and all other federal retirees. Allowing private-sector providers to compete freely and fairly for the opportunity to cover the health care concerns of the nation's elderly would reduce the need for a centralized bureaucracy like HCFA. And the pending insolvency crisis could be avoided simply by converting the current defined benefits system into a defined contribution system, broadly similar to the FEHBP.

America's taxpayers deserve a Medicare system that is financially stable. At the same time, America's elderly deserve an opportunity to choose the health coverage and range of benefits best suited to their individual needs and situations. Only serious structural reform of the Medicare system can accomplish these goals.