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Executive Summary

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REORGANIZING THE MEDICARE SYSTEM TO ENSURE A BETTER PROGRAM FOR SENIORS

STUART M. BUTLER, PH.D.

The current discussions in Washington, D.C., about adding an outpatient prescription drug benefit to Medicare underscore how out of date the program has become. Most health insurance plans for working Americans, and even such other government-run health programs as the Federal Employees Health Benefits Program (FEHBP), routinely add new benefits and services as soon as they become widely available. Yet Medicare, a program that provides health care coverage for over 40 million senior citizens and disabled Americans, is organized and run in such a way that even the smallest changes regularly lead to political gridlock and inaction.

Recently, the National Bipartisan Commission on the Future of Medicare, chaired by Senator John Breaux (D–LA) and Representative William Thomas (R–CA), considered significant changes in the program that would improve its operation as well as its finances. Unfortunately, even though a bipartisan majority of the commission's members supported a proposal to restructure Medicare along the lines of the FEHBP—which covers about 9 million federal workers, retirees, and their dependents, including Members of Congress—the supermajority needed for a formal endorsement of the proposal fell one vote short. Nevertheless, Senator Breaux and Representative Thomas have indicated their intention to push for legislation based on the majority's view.

With some modifications, that majority proposal would provide a sound basis for structural reform of the Medicare system. Specifically:

1. **Adopting a "premium support" approach would guarantee a Medicare entitlement and introduce incentives for beneficiaries to make cost-conscious decisions.** The Medicare commission's "premium support" proposal combines the twin objectives of assuring seniors they would have a basic package of benefits they could afford and encouraging them to pick cost-effective coverage. The degree of financial support could be refined in various ways. For example, it could be indexed to adjust for changes in medical costs, for

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income levels, and for high-cost medical conditions. It could be designed even as a base amount plus a percentage of a premium (a version of the FEHBP's formula).

2. **Assembling a "Benefits Board" to recommend future changes in benefits would depoliticize the process and facilitate the evolution of benefits that better mirror the private market.** Such a semi-independent board would develop proposals each year to modify Medicare's benefits package, which then should be subject to an up-or-down vote in Congress without amendment. This is similar to the principle behind the Base Closing Commission in the 1980s. Although the bipartisan Medicare commission did not propose this change, the creation of such a board would address problems inherent in benefit modernization. For example, were such a board in place today, Congress could require it to offer proposals for adding a drug benefit to Medicare's fee-for-service program within budget constraints. Senator Bob Graham (D–FL) is developing legislation to create a similar procedure for adding a prevention benefit for the elderly, using the Institute of Medicine (IOM) as the board and "fast track" procedures for legislating the IOM's recommendations.

3. **Creating a "Medicare Board" that would manage the market of competing plans and negotiate services and prices would ensure seniors have the best benefits for the most reasonable cost.** This responsibility should be taken away from the Health Care Financing Administration (HCFA) to remedy the current problem of having HCFA manage a market of competing plans at the same time it is developing and marketing one of those competing plans—Medicare's fee-for-service program. Such conflicting roles prevent HCFA from satisfactorily carrying out a consumer information function. For example, HCFA spent $95 million in a futile attempt to produce a consumer handbook for Medicare beneficiaries; yet a private organization, the Washington Consumers' Checkbook, completed the same task for the FEHBP with just one analyst working for two months with some clerical assistance. A Medicare Board separate from HCFA would carry out functions similar to those of the Office of Personnel Management in managing the FEHBP: It would negotiate benefits, service areas, and prices with the various plans, rather than impose regulations and price formulas as HCFA does.

4. **Empowering the traditional fee-for-service Medicare program to compete with private plans would promote innovation.** Relieving HCFA of the responsibility of organizing the market for plans should be combined with giving it greater freedom to introduce innovation into the fee-for-service program to enable it to compete with private plans. Many municipalities and states give public agencies flexibility to compete with private bidders. Charter schools, for example, function as public competitors of private schools. Of course, HCFA should be given this freedom only if its power to organize and regulate the competitive marketplace were taken away.

The Medicare program continually faces financial problems and its benefits package is persistently out of date. It is time for Congress to recognize that this is not strictly because Medicare is a government run-program. The FEHBP is a government-run program that provides state-of-the-art benefits to federal employees with levels of efficiency that rival the best corporate plans—and far surpass Medicare. Medicare, by comparison, is highly regulated and micromanaged by Congress.

The majority of members of the National Bipartisan Commission on the Future of Medicare recently agreed that the model for restructuring Medicare should be the FEHBP. Congress would be wise to act on a modified version of the majority's proposal. If it does not act soon, the window of opportunity for reform will begin to close as the aging baby-boom generation nears retirement.

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STUART M. BUTLER, PH.D.

There is considerable pressure on Congress to add an outpatient drug benefit to Medicare.[1] This pressure underscores how out of date the Medicare program has become. Most health insurance plans for working Americans, and even such other government-run health programs as the Federal Employees Health Benefits Program (FEHBP), routinely add new benefits and services as soon as they become widely available. Yet Medicare, which serves over 40 million elderly and disabled Americans, is organized and run in such a way that even the smallest desired changes regularly lead to political gridlock and inaction.

Recently, the National Bipartisan Commission on the Future of Medicare, chaired by Senator John Breaux (D–LA) and Representative William Thomas (R–CA), considered significant changes to the program that would improve its operation as well as its finances. Unfortunately, even though a bipartisan majority of the commission supported a proposal to restructure Medicare along the lines of the FEHBP—which covers about 9 million federal workers, retirees, and their dependents, including Members of Congress—the supermajority needed for a formal endorsement of the proposal fell one vote short. Senator Breaux and Representative Thomas have indicated their intention to push for legislation based on the commission's majority view.

With some modifications, the majority proposal would provide a sound basis for structural reform of Medicare. Specifically, Congress would be wise to adopt the majority proposal for "premium support," the creation of a "Medicare Board" to negotiate with the covered plans for benefits and prices, and giving the Health Care Financing Administration (HCFA) greater flexibility to adopt innovations in the traditional fee-for-service Medicare program. But Congress also should create a "Benefits Board" to recommend changes in Medicare's benefits

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1. See James Frogue, "How to Provide Prescription Drug Coverage Under Medicare," Heritage Foundation *Backgrounder* No. 1293, June 16, 1999.

package, which would depoliticize the process. Congress learned many years ago with the Base Closing Commission that such an approach is key to facilitating changes in sensitive programs.

THE NECESSARY STEPS FOR REFORM

As Members of Congress work to reform Medicare, they should give serious consideration to four changes in the way the program is organized and financed that would greatly improve benefits and services for America's seniors.

1. Adopting a premium support approach would be the most effective way to achieve the twin objectives of (a) guaranteeing seniors an entitlement to an affordable core set of benefits and (b) giving seniors an incentive to seek the most cost-effective way to obtain Medicare services.

For some time, the Medicare debate has been portrayed as the clash of two irreconcilable approaches to providing the elderly with financial support for their health care needs. One approach—known as "defined benefits"—guarantees eligible beneficiaries a comprehensive set of specific benefits without regard to the cost to Medicare of those benefits. Although this approach protects seniors from future increases in the cost of those services, it has been criticized for placing a huge financial risk on the shoulders of taxpayers. The other approach—known as "defined contribution"—would provide beneficiaries with a specific amount of financial help to pay for specified benefits. Although this approach limits the risks for taxpayers and creates incentives for seniors to seek more cost-effective plans, it has been criticized as shifting all the future financial risk to beneficiaries.

A sensible compromise between these two approaches is implicit in the premium support approach, which is favored by the majority of members of the National Bipartisan Commission on the Future of Medicare. Under this arrangement, Medicare beneficiaries would receive financial assistance that blends the two approaches. Although several variants are possible, under a premium support system seniors could receive a contribution to the cost of a plan, but this contribution could be adjusted each year—or indexed—to cover the market price of a core set of benefits. In that way, the elderly would continue to have an entitlement and know that the costs of standard coverage would be covered, but they would also have a strong incentive to choose a cost-effective plan.

Congress should recognize that the premium support approach does not mean the elderly and disabled simply would receive an "arbitrary" voucher and be at risk for unbudgeted changes in the cost of their health coverage. In fact, the basic idea of premium support could be modified to address a variety of policy goals and protect enrollees. For example:

- The base amount of premium support could be adjusted by income, so the low-income senior would have a larger amount of assistance.
- The base amount could be adjusted (that is, indexed) to account for the higher costs of certain medical conditions.
- A variant would combine an indexed fixed amount of support with a percentage of the cost of a chosen plan above the standard amount, up to a certain dollar limit. Seniors who felt it necessary to choose a more expensive plan because of their medical condition or personal preferences would pay only part of the extra cost. Such a percentage support system is also used in the FEHBP.

Although these varied forms of the premium support approach address the concerns of lawmakers who prefer a defined benefits system, covering only an indexed base premium or a percentage of a higher premium also would achieve in large part the incentives of a defined contribution. As federal workers in the FEHBP well know, the premium support approach creates incentives for beneficiaries to seek the best value because they would gain financially by choosing a more economical plan.

2. Creating a Benefits Board to recommend future changes in benefits would depoliticize the process and enable Medicare's benefits package to be revised and improved steadily over time to better mirror the private market.

The current discussion about the need to add an outpatient drug benefit to Medicare underscores two related failings in the design of the program. First, since its inception, Medicare's benefits package has slipped further behind what would be acceptable in typical plans for the working population. Second, the benefits package will remain out of date so long as it takes an act of Congress to accomplish benefits changes in Medicare—changes that, in the private sector, are made in a few routine management meetings.

When Medicare was created in 1965, its benefits package was based on the prevailing Blue Cross/Blue Shield package for working Americans in large firms. As such, it was state-of-the-art coverage. But since then, it has slipped further behind the benefits routinely offered to working Americans. For example, Medicare provides no outpatient drug benefit. Yet it would be virtually unthinkable today for a plan to be offered to workers in large corporations that did not have at least some coverage for outpatient pharmaceuticals as well as catastrophic medical costs.

The main reason that the benefits package is out of date—despite general acceptance that it needs to include such items as a drug benefit—is that major changes require acts of Congress. Consequently, discussions about changing benefits (and especially about introducing new benefits by reducing coverage for less important ones) become necessarily entangled in the political process. Providers who are included fight hard, and usually effectively, to block attempts to scale back outdated coverage for their specialties. Meanwhile, talk of upgrading the Medicare benefits package unleashes an intense lobbying battle among other specialties seeking inclusion in Medicare's package. Invariably, the result depends as much—if not more—on shrewd lobbying than it does on good medical practices. The understandable reluctance of most lawmakers to subject themselves to this pressure further slows the process of modernizing benefits.

Just as problematic is HCFA's complex administrative process of modifying benefits and determining whether certain medical treatments or procedures are to be covered in the Medicare benefits package, and under what conditions or circumstances they are to be reimbursed. This unusually complex process is marked by intense pleading by medical specialty societies, occasionally accompanied by congressional intervention.

A long-term reform of Medicare must end the structurally inefficient and politicized system of changing or modifying benefits over time. The best way to do this involves three steps. Specifically, Congress should:

- **Set only broad benefit categories.** Instead of setting specific benefits in legislation, Congress could confine itself to describing the broad categories of benefits (such as emergency care and drug benefits) that private plans competing in Medicare should provide. This is the approach Congress takes with the FEHBP.
- **Create a semi-independent board to propose specific incremental changes in core Medicare benefits.** Instead of relying on Congress or the Administration to specify Medicare's detailed benefits, Congress could create a Benefits Board whose recommendations would be subject to an up-or-down vote without amendment. This would reduce political pressures on Congress's benefit decisions and take lawmakers out of the process of making detailed medical decisions. Yet Congress would have the final say in any benefit changes. Essentially, the practical logic for such a board was used to create the Base Closing Commission in the 1980s. The Adminis-

tration and Congress would select the board's members for specific terms.

- **Establish Medicare as a combination of core and optional benefits.** The broad categories for core benefits determined by Congress or a Benefits Board could be confined to the "must-have" basic benefits expected of Medicare, instead of the comprehensive benefits most seniors actually would obtain. In other words, Medicare coverage for a senior (that is, someone eligible for premium support) would consist of a base set of benefits in every plan or in the traditional fee-for-service coverage, plus a variety of negotiated supplemental benefits according to the needs and desires of that senior. Over time, it could be expected that the typical supplementary coverage would adapt to changing needs, desires, and medical practice.

This two-tier benefits package would allow gradual adjustments in benefits according to the desires of individual seniors and would not require legislation by Congress to permit changes over time. This process essentially is used in the FEHBP, in which broad categories of coverage are required but the specific levels of benefits, including the kinds of medical treatments and procedures offered by typical plans, change with the times. The plans know they must keep up with medical developments and remain cost-effective if they are to be selected by seniors and stay in business.

Had Medicare been able to evolve gradually, like the FEHBP, through these ways of significantly depoliticizing changes in benefits, today the program no doubt would be a modern and efficient system of providing benefits and services—more like the FEHBP is now and Medicare was at its inception.

Creating a Drug Benefit in the Fee-for-Service Program. The first task for a Benefits Board should be to determine the best way to introduce a drug benefit into the traditional fee-for-service segment of Medicare. Once the board was in place, Congress could instruct it to develop a modified benefits package that included drug coverage within a specified budget. Working within the budget constraints, the board could develop a plan to make small changes in a number of features in order to develop a well-balanced benefits package that achieved Congress's objectives. The plan would be sent to Congress for an up-or-down vote without amendment. Should it fail to win approval, the board would continue to develop and submit modified versions until an agreement could be reached.

A very similar idea to the proposed Benefits Board is being developed by Senator Bob Graham (D–FL) as a way to improve and extend preventive care benefits under Medicare (including drugs). This proposal by Senator Graham could be modified easily to incorporate a full outpatient drug benefit. In draft legislation, the Graham proposal would instruct the Institute of Medicine (IOM) to study options and then recommend legislation to improve preventive care. Once the legislation had been presented to Congress, it would be treated as an "implementing bill" under the same terms of "fast track" legislation to facilitate trade agreements. This procedure sharply curbs the ability of Congress to modify the legislation and subjects it to an up-or-down vote.

3. Removing from HCFA the function of managing the market of competing plans and placing this function under a new Medicare Board—with the power to negotiate prices and services—would allow HCFA to improve the fee-for-service program.

HCFA currently is responsible for operating the traditional fee-for-service program. But it also is responsible for establishing and managing the market for the increasing range of plans offered to seniors at a monthly premium. This combination of tasks is inherently unsound and explains many of the problems and shortcomings of HCFA.

Conflicting Roles. It is a basic principle of economic organization in a market that those responsible for setting the rules of competition, and providing consumers with information on rival products, should have neither an interest in promoting a particular product nor even a close relationship with one of the competitors. That is why the Securities and Exchange Commission maintains a wall of separation between itself and individual companies. It is why *Consumer Reports* accepts no advertising from products it evaluates. And it is why umpires in baseball do not own baseball teams. It also is the reason that state and local governments (and the federal government under the A–76 program) have different agencies evaluate competitive bids for government services other than the agencies that provide those services in-house. Entangling the running of a market with the management of any of the competing providers is a recipe for problems.

It is interesting to note that for the FEHBP, which operates a market with dozens of competing health insurance plans for federal workers, the agency that is responsible for running that market and providing information on the various plans to its beneficiaries (the Office of Personnel Management, or OPM) does not run a plan itself. This separation is necessary not only because it avoids a conflict of interest, but also because the managerial cultures are very different for staff engaged in these two very different functions. Managers charged with dispassionately operating a market must display evenhandedness and pay close attention to the information that consumers need to make wise decisions. On the other hand, managers engaged in marketing a particular plan, including a government-sponsored plan, must be highly competitive and concerned with the long-term viability of their particular product and the continued satisfaction of their customers. This cultural difference is much like separating the functions of a judge and a trial attorney.

The simple fact is that HCFA cannot—and should not—perform both these tasks. Over the years, the agency has developed a culture and expertise that focuses on regulating prices and services and identifying fraud and abuse. The training and skills of its staff reflect this general function. Moreover, HCFA has a shortage of the experience and skills needed to establish ground rules for a competitive market, develop businesslike relationships with competing private plans, and provide consumers with the information they need to get the best value in such a market. For example, HCFA's efforts to create a handbook of information for beneficiaries that they actually could understand turned out to be a $95 million fiasco. Not only was HCFA's handbook initiative a waste of money, it also was completely unnecessary: Significantly, in addition to a brief booklet prepared by the OPM, such a handbook has been available for many years for FEHBP's enrollees. A private consumer organization—the Washington Consumers' Checkbook—provides a comprehensive guide that includes patient-rating surveys of FEHBP plans that is assembled by one analyst working for two months, backed by a few clerical staff.

It is not that HCFA's employees are inherently incompetent; but they have little training and expertise in these functions. It is a little like expecting experienced divorce lawyers suddenly to become good marriage counselors. Staff members at the OPM who operate the FEHBP, by contrast, have very different skills and backgrounds and the agency has a different culture—which is the reason the OPM is so successful at running a nationwide program with many competing plans in each area.

But HCFA should not carry out those functions even if it had the skills to do so because it would be extremely unwise to permit an organization to be responsible for setting the rules of a competitive market when it had direct interest in the success of one of the competitors. So long as HCFA runs the traditional fee-for-service program of Medicare, it hardly can be expected to be benign in creating a market

in which other plans competed directly with its own fee-for-service program.

Congress must accept much of the blame for HCFA's problems. The agency's current organizational structure and statutory obligations do not allow it to maintain a proper separation between these important tasks and are impediments to its ability to carry out either task very effectively. This internal conflict stems from HCFA's history of acting as bill payer and regulator rather than a market referee and consumer information agency. As the IOM noted in its 1996 analysis of the Medicare market,

> In the past HCFA has made little effort to inform Medicare enrollees of their choices regarding health care providers, treatment options, or competing private plans.[2]

And the U.S. General Accounting Office noted in 1997 that HCFA amasses vast amounts of information but has a poor track record in providing information to beneficiaries that is useable.[3]

HCFA certainly has taken steps to provide better information to Medicare beneficiaries, including data on high-mortality hospitals and benefits. This compilation falls far short, however, of what is needed to enable elderly Americans to make sensible choices when an increasing number of options are available. Moreover, even with the recent reorganization of HCFA, the conflicting functions of dispassionate market management and plan operation remain hopelessly entwined.

Drawing on the OPM's Approach. It is interesting to contrast the way in which HCFA functions as a manager of a market with the manner in which the OPM functions in the FEHBP. According to James Morrison, the career civil servant who ran the FEHBP during the Reagan Administration, the contrast stems not from any inherent deficiency of HCFA staff as civil servants, but from differences in the structure imposed on the agencies running the two programs. This contrast suggests that Congress must modify the program design if it is to achieve a change in the way HCFA functions. As Morrison explained in a 1998 letter to the author:

> There is a profound difference in the way the Health Care Financing Administration (HCFA) deals with the private sector intermediary in the Medicare program and the way in which the Office of Personnel Management (OPM) deals with the private sector plans in the Federal Employees Health Benefits Program (FEHBP). This difference derives, in large measure, from the statutory difference between the two programs.[4]

Medicare is a highly prescribed, statutorily defined program with benefit levels and payment rates essentially fixed by law. The FEHBP, on the other hand, has very few statutory prescriptions. Beyond the bare outlines of a core benefits package, specifics of the plan's offering and its price must be negotiated between the government and the private-sector carrier.

These fundamental differences shape the values, roles, responsibilities, and indeed the operating culture of the administering agencies. Thus, HCFA employs legions of regulators bent on prescribing every detail of the Medicare program and scores of health policy "experts" to determine the needs of beneficiaries. The OPM employs a small number of contract specialists who can assess the price

2. Stanley B. Jones and Marion Ein Lewin, eds., *Improving the Medicare Market* (Washington, D.C.: National Academy Press, 1996), p. 72.
3. "HCFA Missing Opportunities to Provide Consumer Information," statement by William Scanlon before the Special Committee on Aging, U.S. Senate, 105 Cong., 1st Sess., April 10, 1997 (GAO/T–HEHS–97–109).
4. Letter to Stuart Butler, January 27, 1998.

and value of a plan offering while leaving the determination of customer needs to individual consumers. HCFA places a premium on employees with advanced degrees in health policy; the OPM values private-sector health plan experience.

The Need for a Medicare Board. The National Bipartisan Commission on the Future of Medicare recognized HCFA's inherent conflict of interest when the majority of its members voted to establish a board to take over many of its marketing functions and the management of the private plans. Congress should create within the Medicare program a body that is the functional equivalent of the OPM within the FEHBP. The function of this body, and the focus of its staff, should be to organize the market of competing plans, including the traditional fee-for-service plan, and to provide Medicare beneficiaries with the information they need to make the wisest choice possible.

This proposal is very similar to a recommendation of the IOM's Committee on Choice and Managed Care in 1996. In making its recommendation, the committee emphasized that HCFA tries to undertake two very different functions that demand very different approaches and skills. The committee noted, among other things:[5]

- "The administration of the multiple choice program and the management of the traditional Medicare program involves very different missions and orientations."
- "The two functions require different types of management, staff expertise, backgrounds, and knowledge. The committee is concerned that staff and senior managers with extensive experience in managing various aspects of multiple choice in the private sector be recruited and employed for this effort."
- "The functions call for different organizational and corporate cultures, one operating a stable traditional public indemnity insurance program and the other a purchaser- and customer-oriented program that is required to be responsive to a diverse group of private programs in a rapidly changing and dynamic market place."[6]

The creation of a Medicare Board would permit the function of managing a market of competing plans to be separate from the operation of the traditional fee-for-service program as one of those competing plans. This would accomplish the economic and managerial objectives of Medicare reform presented earlier in this study.

The new board could either answer directly to the Secretary of the U.S. Department of Health and Human Services (HHS) or be independent, but it would have functions similar to those of the OPM within the FEHBP. Among these functions, the board should:

- **Set standards for all plans offered to Medicare beneficiaries and certify that all plans meet those standards.** The standard-setting function should apply to the traditional fee-for-service program as well as the new choice programs created by Congress.
- **Negotiate with competing plans regarding benefits and prices.** Just as the OPM negotiates with individual plans before they are offered to federal employees during open enrollment season, so too should this board use Medicare's purchasing power to push plans to provide the best options for seniors. This would have the primary benefit of ensuring that plans competed for business by offering good value, instead of by introducing dubious marketing techniques (such as artificial boundaries for marketing areas or benefits

5. Jones and Lewin, *Improving the Medicare Market,* pp. 107–108.
6. *Ibid.*

designed only to attract low-risk customers). The California Public Employees' Retirement System (CalPERS) carries out a similar function for state employees, as do many large corporate purchasers of health care.

- **Organize payments to chosen plans.** The board would be responsible for the government's share of premium payments and remitting to these plans. The board also should evaluate and propose refinements of the payment system to plans, including the traditional fee-for-service plan, and recommend these to the Secretary of HHS and Congress.
- **Provide data and information to consumers.** The board would take on the function of providing consumer and benefits information to seniors and guidance on how to make wise choices. This function would include examining techniques to measure quality and incorporating prudent techniques into the information made available to beneficiaries, such as the patient surveys used in the FEHBP.

In order to carry out its mission effectively, the Medicare Board itself should contain certain elements. One of these should be an Advisory Council representing mainly consumers but also organizations that have a general interest in creating a market for high-quality health care. The board and Advisory Council, however, should receive policy and technical advice on issues affecting the market for Medicare plans from an outside advisory body that has experience with other health care markets. The Medicare Payment Advisory Commission (MedPAC), with an expanded staff, could play this role.

The Medicare Board would need a full staff to undertake its broad functions. Some members of this staff could be recruited from among current HCFA personnel. But for the reasons mentioned earlier and emphasized by the IOM's Committee on Choice and Managed Care, it would be wise to recruit some staff from outside the Department of HHS in order to introduce new skills and experience. Individuals might be recruited from the OPM and the private sector.

A Drug Benefit for Plans. Although there is no statutory requirement in the FEHBP for plans to include an outpatient drug benefit, the plans do include such a benefit. The benefit simply emerged as plans came to realize they could not compete without a drug benefit in a market in which federal employees had a wide range of choices each open season. In other words, plans gradually included most of the FEHBP's current benefits to reflect prevailing customer demand. On some occasions, the OPM actively encourages the inclusion of particular benefits by including them in its annual call letter to plans. Not all plans respond by proposing to include the OPM-suggested benefit; but typically, leading plans that seek to market themselves as the most comprehensive will do so. In the other cases, the OPM actively negotiates with plans on ways they might include a benefit, with the result that it may be offered in different ways by different plans that reflect local conditions and market factors.

The Medicare Board could encourage the inclusion of a drug benefit in the private plans in the same way. It could request plans to include outpatient drugs, and it could negotiate with plans for ways to do this in the least costly way.

4. Empowering the traditional fee-for-service Medicare program to compete with private plans would promote innovation.

Because of the statutory basis of the fee-for-service benefits package and the many requirements Congress places on HCFA, it currently is very difficult for the agency to make improvements in the fee-for-service program to make it more competitive and modern. Thus, the program is inherently at a disadvantage when competing with the more flexible private plans available for seniors today. The bipartisan Medicare commission discussed giving HCFA more flexibility to enable the fee-for-service

program to compete more effectively. This makes sense, but (for reasons discussed earlier) only if the agency were relieved of the power to set the rules for competition.

If Congress gave HCFA more flexibility in this respect, HCFA would have the same ability to compete that states and local governments routinely give to their "in-house" public agencies when they are subject to competitive bids from the private sector. There is no reason that public enterprises cannot be competitive and enterprising. Such innovation is evident in virtually every state, from the delivery of municipal services to the management of public education. Congress should give HCFA the same kind of flexibility and opportunities that public school districts around the country provide teachers and principals to create charter schools.

Specifically, Congress should refrain from locking HCFA into a statutory straightjacket, in which its primary function was the rigid and increasingly onerous and ineffective micromanagement of the financing and delivery of health care services for seniors under fee-for-service. Instead, Congress should give HCFA greater flexibility to run the traditional fee-for-service program in ways that would make it an aggressive competitor of managed care plans and other emerging private-sector health care options in the next century.

Whenever a competitive market is introduced, a government-provided service must receive every opportunity to redesign itself to compete effectively. This should be the case with Medicare. HCFA should be permitted to introduce innovations into the management of traditional fee-for-service Medicare. It should be allowed, for example, to make extensive use of preferred provider organizations of physicians and hospitals that gave the best value for the money. It also should be allowed to contract out the management of the traditional program in areas in which doing so might improve Medicare.

There is one caveat to this, however. It would be totally inappropriate to give HCFA this increased power to compete if the agency retained its current responsibility to write the rules governing the competitive market. That would be a conflict of interest. Thus, creating the Medicare Board, and transferring the functions mentioned earlier from HCFA, should be a condition for giving HCFA greater flexibility.

CONCLUSION

The Medicare program constantly faces financial problems and its benefits package is perennially out of date. It is time for Congress to recognize that this is not strictly because Medicare is a government-run program. The Federal Employees Health Benefits Program is a government-run program that offers federal employees state-of-the-art health benefits with levels of efficiency rivaling the best corporate plans—and far surpassing Medicare. Medicare's problem is that it is run very differently from the FEHBP. Medicare is highly regulated by an agency that has a very different management culture from the OPM, the agency that runs the FEHBP. Moreover, Congress has sought to micromanage virtually every facet of Medicare, which it does not do in the FEHBP.

The majority of members of the National Bipartisan Commission of the Future of Medicare recently agreed that the FEHBP should be the model used to restructure the Medicare system. The chairmen of that commission, Senator Breaux and Representative Thomas, have said they intend to push for legislation that would restructure Medicare to incorporate the central features of the FEHBP. Congress would be wise to act on a modified version of the commission's majority proposal. If it does not do so soon, the window of opportunity for reform will begin to close as the aging baby-boom generation nears retirement and becomes increasingly resistant to change. This will make it even more difficult to legislate any significant reform—even those reforms that would improve Medicare for the elderly.

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