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Executive Summary

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WHY AN UNREFORMED MEDICARE SYSTEM IS HAZARDOUS TO YOUR HEALTH

SANDRA MAHKORN, M.D., M.P.H., M.S.

Too many Medicare patients are unaware that the quality of their health care is in jeopardy. The almost 40 million older adults and disabled persons who are covered by Medicare are subject to the most aggressively managed and overregulated health plan in the United States. In fact, the federal health care regulations, rulings, and paperwork pertaining to Medicare require over 111,000 pages, many times more than even the federal income tax code. The complexity of the system makes it difficult for both patients and their health care providers to understand what procedures and treatments will be covered under Medicare, and which ones will be ruled "medically unnecessary."

According to 1997 statistics from the Health Care Financing Administration (HCFA), over 19 percent of all denied physician and supplier claims are for services deemed "medically unnecessary." And this amount increases to 45 percent if claims that are denied for "reason of statutory exclusion" are excluded. Auditors for the U.S. Department of Health and Human Services' Office of Inspector General reported in February 1999 that if HCFA rules and regulations were followed in all cases, even more claims would be denied for lack of "medical necessity."

Members of Congress determine in legislation what can be covered under Medicare and at what price. They have avoided making the tough decisions affecting patients, however, by shifting responsibility for Medicare coverage to HCFA, which, in turn, regulates the delivery of health care by imposing voluminous rules, regulations, and guidelines on doctors, hospitals, and other health care providers. It is a profound mistake to think that Medicare patients are insulated from the negative effects of this huge regulatory system in Washington. If Members of Congress are genuinely concerned with improving health care for all Americans, they should examine the many roadblocks to quality care that the Medicare system imposes on those who provide health care to senior citizens and disabled Americans. For example:

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- In Medicare, "medical necessity" often is determined by distant bureaucrats using standards that are arbitrary and ill-defined.
- Doctors who treat Medicare patients face a *Catch-22* dilemma of choosing treatments based on their best professional judgment and facing fraud and abuse charges if the Medicare bureaucracy says the treatments were "unnecessary," or if it prescribes the treatments. This undermines the professional independence of physicians and imposes a de facto gag rule.
- Patients who challenge Medicare denials of their claims face an arduous review and appeals process. For Medicare Part B claims, which covers physicians' and other outpatient services, the average time for administrative law judges to render a decision is 524 days.
- Even if an appeal is decided in their favor, Medicare beneficiaries can hope to recover only the cost of the benefit itself, regardless of the extent of injury that resulted from the claim's original denial.

The real fix for Medicare is not more rules and regulations, another insufferable pile of paperwork, some palliative treatment, or tinkering at the edges. Radical surgery of the program's bureaucratic control is needed. The best approach to the problem of patient care in both the private and public sectors is the expansion of patient choice, which would enable individuals and families to pick the kinds of plans and benefits they personally want and need.

The National Bipartisan Commission on the Future of Medicare came close to a formal recommendation of expanding choice when 10 of its 17 members supported a model for reform similar to the consumer-driven system enjoyed by federal employees, Members of Congress, and congressional and White House staff—the Federal Employees Health Benefits Program. In Medicare, choice would mean patients could keep the traditional plan, choose a superior private plan, or bring their private health plan with them into retirement for primary coverage but obtain a government contribution to offset its cost.

Today, real Medicare reform is medically necessary and should put patients first. Members of Congress should create a new system based on choice and competition that respects the personal liberty and privacy of Medicare patients as well as the medical expertise of their doctors.

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Too many Medicare patients are unaware that the quality of their health care is in jeopardy. The almost 40 million older adults and disabled persons who are covered by Medicare are subject to the most aggressively managed and overregulated health plan in the United States. In fact, the federal health care regulations, rulings, and paperwork pertaining to Medicare consume over 111,000 pages, many times more than even the federal income tax code.[2] The complexity of the Medicare system makes it difficult for both patients and their health care providers to understand what procedures and treatments will be covered, and which ones will be ruled medically unnecessary.

Members of Congress determine in legislation what can be covered under Medicare and at what price. They avoid making the tough decisions affecting patients, however, by shifting responsibility for Medicare coverage to the Health Care Financing Administration (HCFA). HCFA, in turn, regulates the delivery of health care by imposing voluminous rules, regulations, and guidelines on doctors, hospitals, and other health care providers. But it is a profound mistake to think that Medicare patients are insulated from the negative effects of this huge regulatory system in Washington by their physicians and providers. Their treatment is often at the mercy of distant federal bureaucrats and Medicare contractors.

If Members of Congress want to find ways to improve health care for all Americans, they should examine the many roadblocks to quality care that Medicare imposes on those who provide health care to senior citizens and disabled Americans. For example:

- **Medicare's standards for determining "medical necessity" are arbitrary and ill-defined.** Curiously, Members

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1. Robert E. Moffit, Director of Domestic Policy Studies at The Heritage Foundation, contributed to this paper.
2. Dr. Robert Waller, President of the Mayo Foundation, in testimony before the National Bipartisan Commission on the Future of Medicare, on August 10, 1998.

of Congress are considering private-sector health care legislation that would shift the responsibility of determining medical necessity to physicians, not bureaucrats.

- **Doctors who treat Medicare patients face the dilemma of choosing treatments based on their best professional judgment, and risking fraud and abuse charges if the Medicare bureaucracy says the treatments are "unnecessary," or if it prescribes the treatments.** This *Catch-22* undermines the professional independence of physicians and imposes a de facto gag rule.

- **The many complicated Medicare provider payment schemes include perverse incentives that interfere with the provision of medical services.** The complex "resource-based relative value scale" (RBRVS), for example, is a method of determining physician payment based on a statistical calculation of the "value" of factors that go into a medical service, outside the normal forces of supply and demand or patient benefit.

- **Patients who challenge Medicare denials of their claims face an arduous review and appeals process.** HCFA concedes that, in 1998, the average processing time for appeals of claims denied under Medicare Part A, which pays for hospital services, was 310 days. For Medicare Part B claims, which covers physicians' services, the average time for administrative law judges to render a decision was 524 days.[3]

- **Even if an appeal is decided in their favor, Medicare beneficiaries can hope to recover only the cost of the benefit itself, regardless of the extent of injury that resulted from the claim's original denial.** Yet in the context of private health plans, Senator Edward M. Kennedy (D–MA) has declared, "Health plans should not be allowed to escape responsibility for their actions when their decisions kill or injure patients."[4]

HCFA is not a user-friendly institution. Medicare policies and procedures stand as a regulatory gate between patients and quality care, with HCFA bureaucrats and HCFA contractors functioning as gatekeepers. Patients and doctors are poorly informed about issues as basic as the services that are covered and the financial disincentives doctors and hospitals face. Almost 24 percent of all physician and supplier claims were denied in 1997. Even excluding those denied for "reason of statutory exclusion," the rate of Medicare carrier denial is more than 1 in 10 claims.[5] And patients or doctors who can afford the inordinate time and energy involved in filing appeals of denied claims recoup only the cost of the service or benefit.

Although Members of Congress and HCFA officials routinely give lip service to quality, practical experience with the Medicare program tells a different story. Today's problems with Medicare are minor compared with what they are likely to become with the retirement of the 77 million–strong baby-boom generation and the corresponding demand for medical services. Shortsighted reimbursement and coverage decisions, poor communication with doctors, and intimidation of providers combine with intermittent managerial crises, invasion of patient privacy, and restrictions on patients' liberty to make the program a national concern. More than three decades' worth of circuitous and contradictory policies confuses doctors and patients alike. And Medicare has no competition to force it to improve. If Medicare beneficiaries want alternative health insurance coverage for their physicians' services, for all

3. Mike Hash, Deputy Administrator, Health Care Financing Administration, "Medicare Coverage Decisions and Beneficiary Appeals," statement before the House Ways and Means Health Subcommittee, 106th Cong., 1st Sess., April 22, 1999, pp. 8–9.
4. Senator Edward M. Kennedy, *Press Release,* September 2, 1998.
5. Information supplied to Sarah E. Youssef, then Research Assistant for The Heritage Foundation, from the Health Care Financing Administration, Office of Financial Management, July 1998.

practical purposes they are stuck, for better or for worse.

In early 1999, 10 of the 17 members of the National Bipartisan Commission on the Future of Medicare, chaired by Senator John Breaux (D–LA) and Representative Bill Thomas (R–CA), endorsed a serious proposal that would reform Medicare substantially.[6] That proposal would give Medicare beneficiaries roughly the same types of choices enjoyed by millions of government workers and retirees in the Federal Employees Health Benefits Program (FEHBP).[7]

If Congress is serious about improving America's troubled health care system, it should offer expanded personal choice to all Americans, regardless of whether they are enrolled in a federal plan, private plans, or the Medicare program. In the private sector, expanded choice should be accompanied by personal selection and ownership of health plans, and portability of benefits when workers change jobs. In Medicare, it would mean that patients could keep the traditional plan if they wanted to do so, but it also would mean that they could pick and choose superior private plans or bring their private health plan with them into retirement for primary coverage and get a government contribution to offset its cost.

MEDICARE: THE MOTHER OF ALL MANAGED HEALTH CARE

Medicare originally was designed in 1965 as a program to provide health insurance for the elderly. It since has evolved into a huge, financially troubled, overly bureaucratic system of rules and regulations governing virtually every facet of financing and delivering medical services to senior citizens and disabled patients. Medicare's tight control of benefits and providers is secure, with its burgeoning regulatory morass and unintelligible payment schemes.

Medicare is administered by the powerful Health Care Financing Administration. The regulatory history of HCFA has been a series of failed attempts to control and manage all aspects of medical practice, from the numbers and types of providers and the frequency of treatments and tests to the rates of reimbursement. Medicare's missteps have resulted in new layers of regulations to "correct" the unintended consequences of prior attempts. In study after study, the U.S. General Accounting Office (GAO) finds that Medicare frequently pays providers too much or too little.[8]

Testifying before the National Bipartisan Commission on the Future of Medicare, Dr. Robert Waller, President of the Mayo Foundation, pointed out that federal health care regulations consume over 132,000 pages. The vast majority of these rules, regulations, and related paperwork—more than 111,000 pages—pertain to Medicare. Between 1994 and 1998, 30,000 more pages were published in the *Federal Register,* compared with 2,000 the previous four years.[9] This explosion of health care regulation is occurring despite White House promises in 1995 to simplify the regulations governing Medicare.[10] The ever-growing pile of Medicare paperwork dwarfs that of any other government agency, including the Internal Reve-

6. The proposal fell one vote short of the supermajority necessary to proceed as a recommendation to Congress and the Administration. See *http://medicare.commission.gov.*
7. On the potential elements of a major Medicare reform, see Stuart M. Butler, Ph.D., "Principles for a Bipartisan Reform of Medicare," Heritage Foundation *Backgrounder* No. 1247, January 29, 1999.
8. See, for example, William J. Scanlon, Associate Director of Health Care Financing and Policy Issues, U.S. General Accounting Office, "Medicare: High Spending Growth Calls for Aggressive Action," testimony before the Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, 104th Cong., 1st Sess., February 6, 1995, p. 5.
9. *Ibid.* This itemization of Medicare regulations and supporting documents was compiled in support of the testimony of Dr. Robert Waller, President of the Mayo Foundation, before the National Bipartisan Commission on the Future of Medicare, on August 10, 1998.
10. Press Release, The White House, July 11, 1995.

nue Service (IRS), which accounts for 17,000 pages of laws and regulations in the tax code. As a result, Medicare rules are becoming increasingly unintelligible to doctors and patients alike.

HCFA's regulatory regime is far more aggressive and intrusive than ever before. The Medicare bureaucracy has gone so far as to extend its regulatory reach into private transactions taking place *outside* the confines of the Medicare program, such as its private contract agreements between doctors and patients in which no taxpayer dollars are involved.[11] Even worse, HCFA now proposes to collect detailed and sensitive personal information from Medicare patients served by home health care agencies and transmitting it to a huge federal data base without the knowledge of the patients.[12]

Micromanaging Treatment

Federal and state legislators often chide private insurance plans for payment or reimbursement schemes that appear to reward doctors for withholding expensive tests or treatments. For example, in some managed care plans, a portion of "capitation" allotments are "withheld" until the end of the provider's contract year. Payment of these withholdings is contingent on the managed care plan's achieving certain medical spending targets. Curiously, Congress has allowed HCFA to utilize financial and punitive disincentives for expensive care and treatments for more years than most managed care plans have been in existence.

HCFA's Prospective Payment System is a case in point. Hospitals are paid a set amount on the basis of a patient's final diagnosis at the time of discharge instead of the actual number of services, tests, and treatments the patient may require. For example, HCFA reimburses a hospital more generously for the inpatient costs to treat one type of pneumonia over another, even when the patient with the lower-cost pneumonia may require more care and services and longer hospitalization.

The prospective payment methodology for hospitals encourages strict, sometimes draconian, utilization reviews for sick, hospitalized patients. It is not uncommon for admitting physicians to order unnecessary intravenous lines or urinary catheterizations—placing the patient at unnecessary risk for such problems as phlebitis or urinary tract infections—to prevent the patient from being discharged when they believe it is not in the patient's best medical interest. The reason: Hospitals have an economic incentive to "evict" patients as quickly as possible to avoid financial loss or to maximize monetary gain.

HCFA is notorious for developing elaborate payment schemes to influence the care-giving behavior of physicians and other providers by using a series of rewards, punishments, and even threats of punishment. It is doubtful that private-sector managed care plans, faced with even minimal free-market competition, could have imposed most of HCFA's highly aggressive cost-containment measures without hearing a resounding public and political outcry. Medicare's large and growing captive membership provides effective immunity from the consumer pressures regularly experienced by private-sector plans. There is no existing private insurance market for seniors outside Medicare, a fact admitted by the Clinton Administration's counsel in recent litigation over the rights of Medicare patients.[13] Today, American seniors

11. For a comprehensive discussion of this issue, see Robert E. Moffit, Ph.D., "How Congress Can Restore the Freedom of Senior Citizens to Make Private Contract Agreements with Their Doctors," Heritage Foundation *Backgrounder* No. 1209, August 3, 1998; see also John S. Hoff, *Medicare Private Contracting: Paternalism or Autonomy* (Washington, D.C.: AEI Press, 1998).

12. See Robert E. Moffit, Ph.D., "HCFA's Latest Assault on Patient Privacy," Heritage Foundation *Executive Memorandum* No. 580, March 22, 1999.

13. Thomas Bondy, an attorney for the Clinton Administration, told the U.S. Court of Appeals in the District of Columbia, "I don't think there is anything out there that's in anyway a meaningful equivalent to Medicare," Transcript of oral argument, *United Seniors Association* v. *Shalala* (Case No. 98–5142), U.S. Court of Appeals for the District of Columbia Circuit, October 23, 1998, pp. 17–19.

have no real alternative to Medicare for private coverage. The lack of real choice for Medicare beneficiaries makes congressional attentiveness to a patient's right to quality care in Medicare even more important.

Managing "Medical Necessity"

HCFA and its contractors routinely deny payment for covered care and services that doctors say are "medically necessary." Despite its lengthy list of "covered" services, giving the impression that Medicare has a generous benefits package, Medicare's rate of payment denial is high.

Although the Medicare statute provides for payment for services that are "medically necessary," in practice just because Medicare formally "covers" a medical treatment does not mean it must cover it or will pay for it. Under certain circumstances, HCFA and Medicare contractors may determine that the medical treatment or procedure is not to be covered for purposes of payment. Consequently, doctors and patients never really can know whether a treatment will be covered. In typical bureaucratic doublespeak, the Medicare patient/provider "helpline" gives this definition of "medical necessity" to callers: "Medically necessary treatment is medical treatment thought to be needed before the carrier or insurer will pay claims."[14]

Congress largely ignores this problem. In perhaps the most exhaustive examination ever published, Timothy Blanchard, a California-based specialist in Medicare law, concludes,

> The process of Medicare decision-making about coverage, and in particular medical necessity determinations, has been shrouded in mystery since the inception of the Medicare program.[15]

Blanchard reports that HCFA's notices on the topic reveal a profoundly disturbing pattern:

> [T]hese notices reflect HCFA's tenacious effort to maintain to the greatest extent possible what is one of the most expansive bodies of secret law ever developed for application against a broad segment of the American population.[16]

In January 1989, Medicare proposed a rule to define "medical necessity" for patient care,[17] but this rule never has been finalized. Despite this fact, lack of "medical necessity" is a common reason for payment denials. According to HCFA's 1997 statistics, over 19 percent of all denied physician and supplier claims were for services deemed "medically unnecessary."[18] And subtracting 1997 claims denied for "reason of statutory exclusion" causes the percent denied for lack of medical necessity to increase to 45 percent.[19] Auditors for the U.S. Department of Health and Human Services' (HHS) Office of Inspector General (OIG) reported in February 1999 that, if HCFA rules and regulations were followed in all cases, even more claims would be denied for lack of "medical necessity." In fact, OIG auditors claim carriers should have denied almost $7.5 billion of additional claims in 1997 for "lack of medical necessity."[20]

14. Information obtained by calling the Medicare patient help line at 1-800-MEDICARE on April 19, 1999.
15. Timothy P. Blanchard, "Medical Necessity Denials as a Medicare Part B Cost-Containment Strategy: Two Wrongs Don't Make It Right or Rational," *Saint Louis University Law Journal,* Vol. 34, No. 4. (1990), p. 981.
16. *Ibid.,* pp. 981–982.
17. The Secretary of Health and Human Services has the authority to make determinations of the "reasonableness and necessity" of medical services under 42 U.S.C., Sec. 1395u(1).
18. Information supplied via telephone to The Heritage Foundation from the Health Care Financing Administration Office of Financial Management, July 1998.
19. *Ibid.*
20. U.S. Department of Health and Human Services, Office of the Secretary, Office of the Inspector General, "Improper Fiscal Year 1998 Medicare Fee-for-Service Payments," Report No. A–17–99–00099, February 9, 1999, Appendix 1.

HCFA's definition of "medical necessity," and the definition of its Medicare carriers, is a rolling one, both vigorous and arbitrary in its application and often contrary to "accepted principles of professional medical practice," a standard proposed in the Daschle–Dingell Patient's Bill of Rights.[21] Moreover, Medicare coverage, based on definitions of "medical necessity," varies from state to state. Such major medical groups as the Mayo Clinic that operate in more than one state often are faced with conflicting coverage policies about what is, and what is not, "medically necessary."

Numerous examples abound:

- **Treatment of precancerous lesions.**[22] Removal of precancerous skin lesions[23] is considered the standard of care among dermatologists trying to protect patients against skin cancer. Medicare's insurance carrier in Florida, as an agent of HCFA, refuses to cover the removal of these lesions in some instances. The very same insurer, however, administers a Medicare health maintenance organization (HMO) that does pay to remove these same precancerous dermatoses. And most other state Medicare carriers, even those outside the Florida Sunbelt, pay for the same procedures not covered in Florida.

- **Pre-surgical testing.**[24] Some Texas physicians complain that Medicare no longer covers certain routine preoperative tests, such as an electrocardiogram (EKG), which surgeons order when they believe it is medically necessary and consistent with generally accepted principles of medical practice.

- **Preventive medical services.** In Florida, the Medicare carrier published a coverage policy for blood lipid tests, which states that diabetes is not among the approved covered diagnoses for the test.[25] As Dr. William G. Plested III, a member of the Board of Trustees of the American Medical Association, testified before Congress,

  > This policy is in direct conflict with published guidelines from the American Diabetes Association, and, in 1999, physician claims for lipid tests are still being routinely denied for diabetic patients in Florida.[26]

- **Prostate cancer.** Dr. Plested also testified that it is "standard clinical practice" to give a man suffering from lower urinary tract symptoms a prostate-specific antigen test.

  > But in many localities, patients have no idea whether the test will be covered because Medicare's coverage policy depends on the test result. Moreover, nearly half the carriers will not pay for the test if the diagnosis turns out to be an enlarged prostate.[27]

- **The use of anesthesia.** Anesthesiologists favor use of "monitored anesthesia care" for certain of cases in which sedated patients may have to be revived. Says Dr. Plested,

  > Coverage was denied for a number of important services for which anesthesia is clearly a requirement, such as breast biopsies and pacemaker insertions. Although some carriers have

21. S. 6, sponsored by Senator Thomas Daschle (D–SD). The House version (H.R. 358) is sponsored by Representative John Dingell (D–MI).

22. Information from the American Academy of Dermatology in discussions with the author in October 1998.

23. Clinically known as actinic keratoses.

24. Information provided by the Texas Medical Association, April 9, 1999.

25. William G. Plested III, statement on Medicare Coverage Decisions and Beneficiary Appeals, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, 106th Congress, 1st Sess., April 22, 1999, p. 5.

26. *Ibid*.

27. *Ibid*.

> subsequently abandoned the policy due to concerted informational campaigns by anesthesiologists, uneven coverage across localities is likely to persist.[28]

- **Psychiatric care.** As Dr. Plested observed in his testimony,

> In many localities, carriers establish arbitrary limits on psychotherapy services, even though the Congress has not limited the number of Medicare covered psychotherapy services for psychiatric patients.[29]

Curiously, Members of Congress are considering legislation for private-sector, employer-based insurance plans that would ensure that doctors, not bureaucrats, determine medical necessity.[30] The legislation would define "medically necessary or appropriate services" as treatments "consistent with the generally accepted principles of medical practice." And the proposed legislation would prohibit a private plan from interfering with

> the decision of the treating physician regarding the manner or setting in which particular services are delivered if the services are medically necessary or appropriate for treatment and diagnosis.[31]

Although politicians in Congress and state legislatures routinely chastise private-sector health plans for arbitrary payment denials, the evidence in fact suggests that such denials are not excessive. For example, data gathered under a state reporting law indicate that denials of care among the six largest New York health plans are "strikingly low"—only 2.5 appeals for every 1,000 patients. And reports from other states suggest similar coverage denial rates.[32] A survey of over 2,000 physicians, published in the fall 1997 issue of *Inquiry,* reports denial rates of 3 percent or less, with lower rates for many individual procedures. Even such expensive tests as magnetic resonance imaging are denied in only 2 out of 100 cases.[33]

Consider also the experience of the FEHBP, the consumer-driven system that serves Members of Congress, congressional staff, and federal employees. Out of a dozen plans surveyed in the 1999 *Checkbook's Guide to Health Insurance Plans for Federal Employees,* the number of disputed claims filed with the Office of Personnel Management (OPM) ranges from 0.58 per 1,000 beneficiaries for the Mailhandlers' plan (a large union plan), to 2.99 per 1,000 beneficiaries for the Foreign Service plan (an option restricted to foreign service employees).[34] The FEHBP, administered by the OPM, offers a choice of private health plans that are rated by consumers and consumer groups annually on quality, price, and benefits. Medicare reformers would do well to consider the merits of such a consumer-driven system as the FEHBP, in which patient satisfaction with quality and service are crucial to the plan's competitive position. The FEHBP is also the model for reform chosen by Senator Breaux and Representative Thomas, the chairmen of the National Bipartisan Commission on the Future of Medicare, and the majority of the commission's members.

The effective Medicare definition of "medical necessity," as applied by HCFA and HCFA carriers,

28. *Ibid.*

29. *Ibid.*

30. See the Patient's Bill of Rights Act of 1999 (S. 6/H.R. 358), introduced by Senator Thomas Daschle and Representative John Dingell (respectively).

31. See Section 151 of Patient's Bill of Rights Act of 1999.

32. Michael Weinstein, "Managed Care's Other Problem: It's Not What You Think," *The New York Times,* February 28, 1999.

33. R. Dahlia et al., "What Do Managed Care Plans Do to Affect Care? Results from a Survey of Physicians," *Inquiry,* Vol. 34 (Fall 1997), pp. 196–204.

34. Francis Walton, ed., *Checkbook's Guide to 1999 Health Insurance Plans for Federal Employees,* 20th edition, (Washington, D.C.: Washington Consumers' Checkbook, 1999), p. 73.

is decidedly more restrictive than, say, that proposed in the Daschle–Dingell Patient's Bill of Rights. In sharp contrast to reports indicating extremely low HMO denial rates, HCFA carriers report that they denied almost 24 percent of all claims from physicians and suppliers in 1997. As noted, over 19 percent of those denied claims were for a supposed lack of "medical necessity."[35] If OIG auditors had their way, even more claims would have been denied—another $20 billion in 1997 and $12.5 billion in 1998.[36] Moreover, if Medicare carriers followed HCFA rules and regulations, more than 16 percent of all the claims paid in 1998 would not have been paid.[37] The OIG says that lack of "medical necessity" was the most common reason for payment "errors" in 1998 (over 55 percent) and the second most common reason in 1997 (over 36 percent).[38]

Doctors on the front lines of medical care often become demoralized by pressures to practice medicine backward—that is, compliance with reimbursement-based guidelines becomes more important than care for patients. They must devise ways to fit the patient to the care plan rather than fitting the care plan to the patient. For example, one Wisconsin physician advised an elderly patient to continue to take aspirin, which can cause gastrointestinal bleeding, prior to administering a test to check for blood in the stool. This would ensure the doctor could document the blood in the patient's gastrointestinal tract. Without that crucial finding, the patient would not fit HCFA's criteria for a colonoscopy even though, in the physician's best clinical judgement, it was the medically necessary and appropriate course of action.[39]

Such absurd developments are, of course, a direct result of bureaucratic benefit setting. Medicare law, as noted above, ensures patients access to what are called "reasonable and necessary" medical services. Beyond the broad categories set forth in Medicare law, such as hospital, nursing home, and physician services, the Secretary of Health and Human Services is legally entitled to specify the allowed medical treatments and procedures. In practice, this means HCFA determines treatments and procedures. Unfortunately, HCFA standards are not necessarily the standards of medical practice, and so HCFA's decisions periodically set the stage for inappropriate medical micromanagement by Congress.

Because HCFA was considered so out-of-touch with standards of practice for the treatment of cancer, Congress in 1997 stepped in to mandate Medicare coverage for certain cancer screening. Since 1998, Congress has mandated coverage for many screening procedures for such common cancers as breast, colon, and prostate. More recently, for example, Representative Pete Stark (D–CA) introduced a bill to mandate coverage of retinal eye examinations for Medicare patients who suffer from diabetes and thus are threatened with blindness.[40] An unfortunate feature of the existing Medicare system is that crucial medical treatments often are held hostage to such political and bureaucratic decision-making.

Hindering the flow of information in Medicare has a chilling effect on the free-flow of information between patients and doctors. Politicians harangue private health plans for interfering with the patient–doctor relationship by restricting a physician's communication with a patient about the

35. Information from HCFA's Office of Financial Management, supplied to The Heritage Foundation via telephone, July 1998.

36. U.S. Department of Health and Human Services, Office of Inspector General, "Improper Fiscal Year 1998 Medicare Fee-for-Service Payments."

37. *Ibid.* (Auditors report that 915 of the 5,540 records reviewed contained payment "errors.")

38. *Ibid.*, Appendix 1.

39. This real-life example of the impact of Medicare regulations on physician treatment decisions was reported to the author in a personal conversation.

40. Representative Fortney "Pete" Stark (D–CA), "Medicare Coverage of Diabetic Retinal Exams," Extension of Remarks in the House of Representatives, 106th Cong., 1st Sess., April 22, 1999.

diagnosis and test and treatment options. Fears of such "gag rules" persist, despite a GAO review of 1,500 health plan contracts that failed to find even one example of such a provision.[41] Senior citizens do not know that inherent in the carrot and stick–laden maze of Medicare is an insidious gag rule. Open communication between physicians and patients about the right course of action is inhibited by the doctor's fears of payment denial and prosecution for fraud and abuse. As Dr. William Plested recently reminded the Health Subcommittee of the House Ways and Means Committee,

> In its management of the Medicare program, HCFA seems to approach virtually every issue, whether it involves national or local coverage policy, payment, coding, or quality, as an issue of waste, fraud and abuse. This singular focus on fraud has become even more pervasive among Medicare part B carriers than it is within the HCFA central office.[42]

This obsession with fraud affects patient care. Doctors who recommend tests or treatments considered by HCFA carriers to be "medically unnecessary" now must worry about not getting paid for services provided and avoiding charges of fraud and abuse when they talk to a Medicare patient. A July 1998 GAO report indicates that provider concerns about overzealous enforcement are justified.[43] Such "hot-button" issues as home health care have had an especially chilling effect on patient–provider communications. For a doctor, certifying the need for home health care is akin to an IRS red flag on a 1040 tax return. But this may change in light of reports of high percentages of emergency room visits and hospitalizations among home health patients in Tennessee[44] and an October 30, 1998, HHS-proposed rule that expands the definition of fraud and abuse to include providing "medically unnecessary" services.[45]

Consider this dilemma: A doctor believes a simple blood test is important for ruling out a diagnosis of temporal arteritis in an elderly patient who has a headache. Failure to diagnose temporal arteritis, an inflammatory condition of the temporal artery, could have serious consequences, including blindness. Testing a patient's blood sedimentation rate determines if the patient suffers from temporal arteritis. The doctor must recommend the blood test to the patient, but at the same time explain that Medicare believes the test is not "medically necessary" and will not pay for it. When the patient gets the bill for the procedure, HCFA sends a note about the Medicare "HOT-TIPS" line, from which the patient may get a monetary reward for reporting fraud and abuse.

Fortunately, most doctors will place the patient's well-being first and compliance with potentially harmful bureaucratic mandates second. But an increasingly "big stick" approach to physicians threatens to compromise health care by making doctors fearful of recommending the appropriate care because HCFA or its carriers claim it is not medically necessary. Congress should reverse this practice and require HCFA to develop a more reasonable definition of fraud and abuse.

41. U.S. General Accounting Office, "Managed Care: Explicit Gag Clauses Not Found in HMO Contracts, But Physicians' Concern Remain," GAO/HEHS 97–175, August 29, 1997.

42. Plested, p. 2.

43. U.S. General Accounting Office, "Application of the False Claims Act to Hospital Billing Practices," GAO/HEHS–98–195, July 1998, p. 14.

44. G. Sasser and C. King, "Tennessee's Venipuncture Patient Outcome Study," report prepared for Tennessee U.S. Legislators, Tennessee Association for Home Care, November 1998.

45. Department of Health and Human Services, Office of the Secretary, Office of the Inspector General, "Health Care Fraud and Abuse Data Collection Program: Reporting of Final Adverse Actions," Notice of Proposed Rulemaking, *Federal Register,* Vol. 63, No. 210 (October 30, 1998), pp. 58341–58342.

HOW HCFA INFLUENCES TREATMENT DECISIONS

Few seniors are aware of Medicare's provider disincentives and how payment schemes often influence doctors' treatment decisions. Medicare has a large captive patient audience—the portion of the U.S. population that needs health care the most—so it has, for the most part, a captive provider audience as well. In a significant portion of employer-based health insurance plans, Americans have at least some choices.

According to the consulting group KPMG, 57 percent of employer-based health plans serving 200 or more employees provide at least two options to their workers, and 32 percent offer three or more plans.[46] So even in employment-based insurance, many people have a choice that does not exist for Medicare patients. Surveys show a variety of reimbursement arrangements for doctors and other providers. Providers who contract with a plan are at liberty to negotiate reimbursement and payment schemes and can choose to contract with some health plans but not others. At least for physicians, even in a distorted health insurance market, there is the possibility of a modicum of market-based competition.

In Medicare, however, doctors and other providers have no negotiating power. Medicare offers a stark "take-it-or-leave-it" proposition. Reimbursement is dictated by federal regulations and spending caps.

As it is, Medicare is a tangled web of incentives devised by HCFA to modify the type, amount, and manner of medical treatment for seniors. Cost control ultimately means control over the supply of Medicare services. Take the immensely complex RBRVS, a method to determine physician payment based on a statistical calculation of the "value" of the factors that go into a medical service completely outside the normal forces of supply and demand or patient benefit.[47] The RBRVS, and the price controls that accompany this strange Medicare fee system, is replete with incentives and disincentives for performing the entire range of medical tests and procedures. Even contracting doctors who are quite knowledgeable of the intricacies of the Medicare program would be hard-pressed to explain the complex calculations and models designed to encourage or discourage physicians from performing specific diagnostic and therapeutic services for beneficiaries. Seniors should know that as well.

Likewise, few Medicare patients grasp the complexity of Medicare's hospital payment schemes. The problem becomes acute in medical technology, an area in which payments for hospital services designated under a specific diagnostic-related group may not reflect the real cost of the services; indeed, they may be less than the cost of the services. As Terry Coleman, a Washington-based specialist in Medicare law, recently reminded the Subcommittee on Health of the House Ways and Means Committee,

> When payment amounts are significantly less than the costs incurred by hospitals, they may refrain from using the new procedures, to the detriment of Medicare beneficiaries. For example, when Medicare first decided to cover bone marrow transplants for certain conditions, they were assigned DRGs [diagostic-related groups] for the underlying conditions, which had average payment levels of about $5,000 to $10,000.... [T]his amount was far below the actual cost of a bone marrow transplant, but HCFA adhered to its policy of making no changes until actual claims data were collected. Eventually, that data became available, in 1990 HCFA created a new DRG for bone marrow transplants and assigned it the average payment amount of about $45,000.[48]

46. KPMG, *Health Benefits* 1997, at *http://www.us.kpmg.com.*

47. For a discussion of the theory underlying the Medicare physician payment system, see Robert E. Moffit, Ph.D., "Back to the Future: Medicare's Resurrection of the Labor Theory of Value," *Regulation*, Vol. 15, No. 4 (Fall 1992), pp. 54–63.

As discussed above, Medicare's hospitalization payment system gives hospitals a financial incentive to provide fewer inpatient services and days of care. In many cases, the faster a patient with a specific diagnosis is discharged, the better the bottom line for the hospital. Seniors should know that, too.

Managed care reimbursement schemes have been criticized for resulting in inappropriate care. Politicians have bandied about anecdotal horror stories and such slogans as "drive-by" deliveries and mastectomies to portray officials of private-sector health plans as interested only in money. If those concerns are genuine, and not just fodder for press releases, lawmakers should note that most outpatient mastectomies occur in the traditional fee-for-service Medicare program, and not in Medicare managed care. For example, in New York in 1996, 72 of 74 Medicare outpatient mastectomies were performed on women in the fee-for-service Medicare program. These 72 mastectomies made up the majority (58 percent) of all outpatient mastectomies in New York that year.[49] Similar data from the Maryland Health Services Cost Review Commission show that all outpatient mastectomies were performed on Medicare beneficiaries enrolled in the fee-for-service plan; and none were enrolled in the Medicare HMO plan.[50]

Curiously, in addressing the problem of financial incentives in private-sector health plans, Members of Congress are considering legislation to require private health plans to tell patients how they pay providers and to disclose related financial incentives.[51] Medicare patients also deserve this information.

INCENTIVES FOR BUREAUCRATIC "ERRORS"

Medicare gives carriers and professional review organizations (PROs) economic incentives to detect billing "errors" that are broadly defined and that include providing "medically unnecessary" services as well as detecting mistakes in billing and shortfalls in documentation. Incentive payments for finding reasons to deny payments retroactively can be formidable. As reported in an article in *American Medical News* in 1998,

> PRO's that cut their state's 'error rate' by at least 10 percent will be eligible for incentive payments totaling up to 2.5 percent of their overall contracts.[52]

HCFA insurance carriers (intermediaries contracted by HCFA to process Medicare claims) also dissuade physicians from contesting payment denials. Alice Gosfield, a Philadelphia attorney who specializes in helping physicians to comply with HCFA regulations and to avoid fraud and abuse charges, warns physicians, "Don't call the carrier to find out what to do. Carriers don't know the answers, and they view questions as good targets for investigations."[53]

HOW HCFA MAKES IT DIFFICULT TO APPEAL DECISIONS

Medicare patients and providers who challenge the bureaucracy's coverage decisions face a mesmerizing process of reviews and appeals. Medicare recipients already have the right to an external review—a right now being aggressively promoted in Congress for patients in private, man-

48. Terry Coleman, "The Medicare Process for Coverage Decisions and Beneficiary Appeals," statement before the Subcommittee on Health of the Committee on Ways and Means, U.S. House of Representatives, 106th Cong., 1st Sess., April 22, 1999, p. 9.

49. American Association of Health Plans, "Mastectomy Length of Stay: Information and Analysis," *Issue Brief*, February 1997, p. 1.

50. *Ibid.*, p. 1.

51. The Patient's Bill of Rights Act of 1999.

52. "PROs Arm to Help Curb Payment Errors," *American Medical News*, December 7, 1998, pp. 1, 58, 59.

53. "What Washington Plans for Doctors," *Medical Economics*, April 15, 1996.

aged care programs. But this process of review in the traditional Medicare program is anything but timely or user-friendly.[54] Notes Walter M. Rosebrough, Jr., President of Hill-Rom Company and a spokesman for the Health Industry Manufacturers Association,

> Data obtained from HCFA show that in Fiscal 1997, on average for a part B carrier claim, it took 119 days for a beneficiary to get through the carrier review and fair hearing. HCFA has previously testified before Congress that it takes 664 days, on average, to receive a decision from an administrative law judge, measured from the date the hearing is requested. Thus, combined, it takes an elderly patient on average 783 days, well over two years, to obtain a decision from an [administrative law judge] after initiating the appeals process. That is simply too long to be an effective option for most beneficiaries. Moreover, most small medical device companies could not afford to take assignment of claims in these circumstances, and survive long enough to be paid.[55]

This cumbersome and lengthy process is an old story for Medicare patients who take the time to challenge adverse decisions on their claims.[56] Current Medicare law does allow a patient to take a case disputing a national coverage decision to federal court, although there are no federal judicial appeals for Medicare's coverage decisions in states and localities.[57] After exhausting this bureaucratic appeals process, if Medicare patients wish to file an action in federal court, all they can recover is the cost of the denied benefit, not other damages inflicted on them by virtue of the adverse decision.

CONCLUSION

Unless it is substantially reformed, the existing Medicare bureaucracy threatens the quality of health care for the growing millions of Americans who depend on Medicare for their primary coverage. Medicare patients and doctors alike are ill-informed about what really is covered. Bureaucratic doublespeak results in arbitrary payment denials. Expanded definitions of fraud and abuse and circuitous definitions of "medical necessity" create a *Catch-22* situation for doctors and result in a de facto gag rule. The many Medicare contractors and professional review organizations that are supposed to promote care quality have become bounty hunters. Few Medicare patients know or understand what really is going on within the program. And worse, those who want better treatment have no real choices.

The real fix for Medicare is not more rules and regulations, another insufferable pile of paperwork, some palliative treatment, or tinkering at the edges. Radical surgery of the program's heavy bureaucratic control is needed. The best approach to the problem of patient care in both the private and public sectors is the expansion of patient choice, which would enable individuals and families to pick the kinds of plans and benefits they personally want and need. The National Bipartisan Commission on the Future of Medicare came close to a formal recommendation of expanding choice when the majority of its members supported a

54. The situation is different, interestingly enough, with the Medicare+Choice program, which allows private plans to participate in a highly restricted form of competition within the Medicare program. Those plans are required to respond within 72 hours to appeals of care denials that could jeopardize life, health, or the "ability to regain maximum function" within 14 days for initial decisions and within 30 days for reconsideration of appeals.

55. Walter M. Rosebrough, Jr., "Medicare Coverage and Beneficiary Appeals," statement on behalf of the Health Industry Manufacturers Association before the Subcommittee on Health of the Committee on Ways and Means, U.S. House of Representatives, 106th Cong., 1st Sess., April 22, 1999, p. 5.

56. U.S. General Accounting Office, "Medicare Statistics on the Part B Administrative Law Judge Hearing Process," HRD–90–18, September 1989.

57. Rosebrough, p. 5.

model for reform that is similar to the consumer-driven system enjoyed by federal employees, Members of Congress, and White House staff—the Federal Employees Health Benefits Program.

Real Medicare reform is medically necessary, and it should put patients first. Members of Congress should create a new and better system based on patient choice and market competition, one that respects the personal liberty and privacy of Medicare patients as well as the medical expertise of their physicians.

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