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Executive Summary

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How Not to Reform Medicare: Lessons From the Medicare+Choice Experiment

Sandra Mahkorn, M.D., M.P.H., M.S.

Medicare, the huge and financially troubled health program that covers almost 40 million elderly and disabled citizens, is in desperate need of reform. A growing number of Members of Congress agree with recommendations put forth by a majority of the members of the National Bipartisan Commission on the Future of Medicare. These recommendations—which include a "premium support" mechanism to enable Medicare patients to select from a variety of superior private plans—provide a good starting point for serious Medicare reform.

Legislators should realize, however, that if they do not draft their reform proposals correctly, or if they shift too much of the responsibility for getting the crucial details right to the Health Care Financing Administration (HCFA), the powerful regulatory agency that runs Medicare, their efforts to create a new system with real patient choice and genuine market competition could be undone. An excellent example of how a reform initiative could be thwarted is the existing "Medicare+Choice" program (Medicare Part C), which today is drowning in a congressionally created sea of red tape and bureaucratic micromanagement.

Medicare+Choice, the health policy centerpiece of the Balanced Budget Act (BBA) of 1997, was touted originally as a major reform of Medicare that would increase options for beneficiaries. Instead, it expanded HCFA's regulatory power and *reduced* the number of options available to Medicare beneficiaries. Since the inception of the program, over 100 health maintenance organizations (HMOs) serving more than half a million voluntarily enrolled Medicare patients either have left the areas they served or have retreated from parts of those regions.

Both Democrats and Republicans hailed the BBA as proof of Congress's fiscal responsibility. Its sponsors projected that its Medicare "reforms" would save $116 billion between 1998 and 2002, with the bulk of these "savings" to be generated by reductions in payments to health plans for medical services. Plans participating in Medicare's HMO program were expected to provide a greater array of services at increasingly lower prices. Today, the

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HMOs expect $33 billion of the projected $116 billion in "savings" to come from their programs by 2003 as a result of the complicated new and lower reimbursement formula.

In general, the effects of the BBA on Medicare beneficiaries include:

- **Fewer HMO choices.** According to the U.S. General Accounting Office, HMO plans were more likely to vacate areas they had served since 1992. Some plans left even though the per capita reimbursement would be high.
- **Fewer participating health plans.** Twenty other health plans did not renew their HCFA contracts. Nearly 500,000 Medicare patients in 29 states found themselves with fewer options. According to the Medicare Payment Advisory Commission, senior citizens in 71 percent of all counties now have no Medicare managed care option, compared with 68 percent in 1998.
- **More seniors need Medigap coverage.** About 50,000 Medicare HMO patients reportedly had to return to the traditional Medicare plan and find affordable Medigap insurance.
- **Fewer applications from provider sponsored organizations (PSOs).** Although it anticipated 50 applications from PSOs, HCFA received only four by October 1998 and approved one.
- **No private fee-for-service plans or medical savings accounts (MSAs).** There were no takers for medical savings account plans or other fee-for-service insurance.
- **Benefit cuts.** Faced with rate cuts and the cost of complying with HCFA regulations, the remaining HMOs dropped important benefits. For example, 21 percent of Medicare enrollees lost coverage for glasses, and 12 percent lost coverage for hearing aids.

Half a million seniors who thought they had solid private health care coverage were surprised by this turn of events at the end of 1998. The combination of HCFA micromanagement and unwise congressional mandates demonstrated once again that Washington was "out of sync" with the best practices of private-sector health care delivery.

And the bad news continues. HCFA recently announced that, in 2000, 99 Medicare contracts are not being renewed by the companies or else the companies are reducing their service areas. According to a recent report in *American Medical News*, over a quarter of a million more Medicare patients will lose their health plan coverage in 2000 because of the plan withdrawals, and almost all other enrollees will experience a reduction in benefits, an increase in payments, or both.

Real Medicare Reform. Real Medicare reform should not be based on outdated regulatory policy that achieves such poor results. Congress should ensure that senior citizens and the disabled have access to solid private-sector health plans and, at the very least, have the same range of superior health care options Members themselves enjoy in the Federal Employees Health Benefits Program (FEHBP). That exemplary "premium support" program—which offers federal employees, maintenance workers at the White House, federal retirees, congressional staff, and their families a variety of affordable choices—is governed by a minimum of regulation.

In considering how to improve the Medicare system, Members of Congress should learn three lessons from the Medicare+Choice fiasco:

- **Don't tinker with Medicare; reform it.**
- **Base Medicare reform on real patient choice and market competition.**
- **Don't expand HCFA's regulatory powers; restrain them.**

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How Not to Reform Medicare: Lessons From the Medicare+Choice Experiment

Sandra Mahkorn, M.D., M.P.H., M.S.

Medicare, the huge and financially troubled health program covering almost 40 million elderly and disabled citizens, is in desperate need of reform. In recognition of this fact, a majority of members of the National Bipartisan Commission on the Future of Medicare have proposed significant structural changes in Medicare based on expanding patient choice and relying on superior private insurance plans to cover the next generation of America's retirees.[1] The model for the Commission's recommendations is the 40-year-old Federal Employees Health Benefits Program (FEHBP), which covers Members of Congress, congressional staff, and almost 9 million federal workers and retirees.

President Bill Clinton opposes the bipartisan proposal and favors making marginal changes in Medicare's current structure, adding a major prescription drug benefit, and financing benefits by relying on projected budget surpluses.[2] However, a growing number of legislators agree with the recommendations of the Bipartisan Commission chaired by Senator John Breaux (D–LA) and Representative William Thomas (R–CA).

Legislators should realize, however, that if they do not draft their reform proposals correctly, or if they shift too much of the responsibility for getting the crucial details right to the Health Care Financing Administration (HCFA), the powerful regulatory agency that runs Medicare, their efforts to create a new system with real patient choice and genuine market competition could be undone.

An excellent example of how a reform initiative could be thwarted is the existing Medicare+Choice program (Medicare Part C), which is drowning in a congressionally created sea of red tape and

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1. For a discussion of how Medicare reform should be structured, see Stuart M. Butler, Ph.D., "Principles for a Bipartisan Reform of Medicare," Heritage Foundation *Backgrounder* No. 1247, January 29, 1999.
2. For a discussion of the Clinton Administration's proposed Medicare financing, see Robert E. Moffit, "GAO to President Clinton: Why Your Plan Would Make Medicare Worse," Heritage Foundation *Backgrounder* No. 1276, April 23, 1999.

bureaucratic micromanagement. The program is the health policy centerpiece of the Balanced Budget Act (BBA) of 1997. Touted originally as a major reform of Medicare that would increase options for beneficiaries, the program instead has expanded HCFA's regulatory powers. Under HCFA, moreover, options available to Medicare beneficiaries have been *reduced*, not expanded.

In 1997, Congress identified two reasons for initiating Medicare+Choice:

- To "allow beneficiaries to have access to a wide array of private health plan choices in addition to traditional fee-for-service Medicare"[3] and
- To "enable the Medicare program to utilize innovations that have helped the private market contain costs and expand health care delivery options."[4]

Although these are noble goals, Medicare+Choice has neither provided access to additional choices nor facilitated cost-containing innovations in the health market. Worse, since the program's inception, over 100 health maintenance organizations (HMOs) serving more than half a million voluntarily enrolled Medicare patients either have left the regions they served or have retreated from certain areas.[5]

Sadly, a flood of mandates from Congress coupled with HCFA's increasing micromanagement of private-sector health plans has hobbled the Medicare+Choice program and now threatens to undermine every good intention of Congress to establish a system of patient choice and competition. The slew of unintended consequences that followed the BBA stunned legislators, who began to promote such inadequate "fixes" as changing deadlines and tinkering with rates.

These changes have not empowered Medicare patients with more choice. Rather, they have empowered HCFA to centralize rate-setting even further and to increase its invasive micromanagement of the program through its promiscuous promulgation of new regulations, rules, operational policy letters, procedural manuals, and other quasi-regulatory activities. The results from this activity are clear:

- Many Medicare beneficiaries have been forced to leave the health plans they liked;
- Senior citizens have been left with fewer health options;
- Health maintenance plans have reduced important benefits for Medicare patients in order to adjust to dramatic payment reductions and finance costly and unproven federal data collection projects; and
- HMOs have shifted their attention from quality improvement to compliance.

Real Medicare reform should not be based on outdated regulatory policies that achieve such poor results. Congress should ensure that the senior citizens and the disabled in their districts have access to solid private-sector plans and, at the very least, to the same range of health care options Members themselves enjoy in the FEHBP. That exemplary "premium support" program is conspicuously governed by a minimum of regulation. Indeed, it is so successful that most of the members on the Bipartisan Commission recommended that it be used as a model for improving the Medicare system.[6]

In considering how to improve Medicare, Members of Congress should learn three lessons from the failings of the Medicare+Choice program:

- Don't tinker around the edges of Medicare; reform it.

3. Medicare Payment Advisory Commission, *Report to Congress: Medicare Payment Policy*, March 1999, p. 42.
4. *Ibid.*
5. For an excellent summary of the initial response of the private sector, see Carrie J. Gavora, "Medicare Minus Choice," Heritage Foundation *Backgrounder* No. 1218, September 1, 1998.
6. For more on "premium support," see Butler, "Principles for a Bipartisan Reform of Medicare."

- Base Medicare reforms on real patient choice and market competition.
- Don't expand HCFA's regulatory powers; restrain them.

HOW MEDICARE HMOS RESPONDED TO THE BALANCED BUDGET ACT

The Balanced Budget Act of 1997 is a massive body of legislation touted by both Democrats and Republicans as proof of Congress's fiscal responsibility. The sponsors of the law projected that its Medicare "reforms" would save $116 billion between 1998 and 2002,[7] with the bulk of these "savings" to be generated by reductions in payments to plans for medical services. In fact, however, these restrictive "reforms" include:

- Cuts in covered services engineered by redefining "medically necessary" services;[8]
- Cuts in "provider" reimbursements;
- The development of new prospective payer systems;
- Provider taxes (politely termed "user fees");
- Creative accounting procedures involving temporary postponements of payments to the next fiscal year;
- A crackdown on doctors and other health care practitioners using an expanded definition of "fraud and abuse";[9] and
- The shifting of large segments of the Medicare population to a variety of managed care plans (many of which no longer exist).

Although HCFA expected the plans participating in the Medicare HMO program to provide a greater array of services to patients at increasingly lower prices, the issue of reimbursement for those services is evolving into a major controversy because, under the current arrangement, the HMOs now expect $33 billion of the $116 billion in projected "savings" to come from their own programs.[10]

Managed Care's Unexpected Response

Medicare HMOs have been available to some seniors for decades. Kaiser Permanente and United Healthcare, for example, started enrolling Medicare patients in 1977 and 1982, respectively.[11] Nationwide, Medicare managed care plans enrolled as many as 85,000 new enrollees a month.[12] Five years ago, 7 percent of Medicare's population had enrolled in a managed care plan; by 1998, that number had grown to 17 percent, or 6.5 million of the 39 million beneficiaries.[13] HMOs are popular in states such as California and Minnesota, where commercial membership in managed care plans is high and members of the commercial plans who retire can stay in the plans.[14] This option has enabled many of these retirees to escape the discontinuity of care experienced by working Americans with employer-based health care.

7. U.S. General Accounting Office, *Medicare Managed Care Plans: Many Factors Contribute to Recent Withdrawals; Plan Interest Continues*," GAO/HEHS–99–91, April 1999, p. 1.
8. For a discussion of the arbitrary nature of HCFA's definition of medical necessity and its impact on covered services, see Sandra Mahkorn, M.D., M.P.H., M.S., "Why an Unreformed Medicare System Is Hazardous to Your Health," Heritage Foundation *Backgrounder* No. 1295, June 18, 1999.
9. "Notice of Proposed Rulemaking," *Federal Register*, October 30, 1998.
10. PacifiCare Health Systems, "Legislative Correction Needed for Medicare+Choice Program," Fact Sheet, April 19, 1999.
11. Health Care Financing Administration, *Medicare Managed Care Monthly Report*, July 1998.
12. Sougata Mukherjee, "Federal Government May Be Overpaying Medicare HMO Plans," *The Business Journal*, Vol. 15, No. 4 (May 26, 1997), p. 28.
13. Karen Ignani, American Association of Health Plans, testimony before the Subcommittee on Health and Environment, Committee on Commerce, U.S. House of Representatives, October 2, 1998.

Surveys of senior HMO enrollees demonstrate high levels of satisfaction with their managed care plans. In fact, 96 percent of HMO Medicare enrollees rated their overall health care as "good" to "excellent."[15] According to one recent study, chronically ill Medicare HMO enrollees were as satisfied as or more satisfied than their counterparts in traditional Medicare or Medicare supplemental plans—a finding that should dispel the simplistic perception that HMO Medicare enrollees are more satisfied only because they have fewer medical problems.[16]

Despite such anecdotal evidence, Washington's approach to health care for seniors is based on a presumption that Medicare patients *need* the federal government to interpret the medical world and make their medical choices for them. But Medicare patients, like most seniors, are proving to be smart shoppers, as demonstrated by the numbers who stayed with the plans they had during their working years. Moreover, the cost-benefit differential—or "medigap"—between managed care plans and supplemental insurance influences their decisions regarding Medicare HMO enrollment. Studies indicate that Medicare patients most often choose managed care options when that differential is the greatest.[17]

As of October 1997, more than two-thirds of Medicare's managed care plans did not charge a supplemental monthly premium.[18] Medicare managed care plans also are able to provide services not available in traditional Medicare. For example, over two-thirds cover prescription drugs, 83 percent pay for routine eye exams, 72 percent cover ear exams, and almost all cover routine physicals.[19] These added benefits are usually provided at little or no extra cost to beneficiaries. On average, Medicare HMO enrollees receive more benefits for far less in out-of-pocket expenses than if they had purchased a Medicare supplemental (medigap) package.[20]

Until recently, Medicare HMO enrollees could quit an HMO and join another plan at any time (commercial arrangements may require a one-year lock-in period). Disenrollments were relatively infrequent, amounting to 14.2 percent in one study.[21] The same study found that HMO disenrollees returned to traditional fee-for-service Medicare in only 5.4 percent of cases.[22] Some disenrollees from fee-for-service plans (25 percent in one study[23]) had moved out of their HMO's service area and thus were no longer eligible for plan membership. Other research shows large variations in disenrollment rates among HMOs in large urban areas, where competition among plans is more likely.[24]

Although HMOs may be criticized for disenrollment rates, a better interpretation of the disenroll-

14. Carlos Zarabozo and Jean LeMasurier, "Medicare and Managed Care," in Peter Kongstvedt, ed., *The Managed Health Care Handbook* (Gaithersburg, Md.: Aspen Publishers, 1993), p. 337.
15. L. Nelson *et al.*, "Access to Care in Medicare Managed Care," Physician Payment Review Commission, November 1996.
16. "New Study Shows Chronically Ill Are Equally Satisfied with Medicare HMOs as with Other Medicare Alternatives," *Business Wire*, September 23, 1998; study conducted by the Sachs Group, Evanston, Illinois.
17. Zarabozo and LeMasurier, "Medicare and Managed Care."
18. American Association of Health Plans, "Managed Care Facts," January 1998, p. 7.
19. Jeff Dufur, "Politics and Policy—Medicare+Choice: Seniors Lobby for Restored Funding," *American Healthline*, February 10, 1999.
20. Medicare Payment Advisory Commission, *Report to Congress: Medicare Payment Policy*, p. 42.
21. Gerald Riley *et al.*, "Disenrollment of Medicare Beneficiaries from HMOs," *Health Affairs*, Vol. 16, No. 5 (September/October 1997), pp. 117–124.
22. *Ibid.*
23. Lyle Nelson *et al.*, "Access to Care in Medicare HMOs," *Health Affairs,* Vol. 16, No. 2 (March/April 1997), pp. 148–156.
24. Eric Weinstein, "Enrollees Switching Medicare HMOs Fast," *Modern Healthcare*, December 8, 1997, p. 14.

ment data is that market forces are working. Seniors leave their HMOs to find better health care bargains. The HMOs do not make money on disenrollments, which in fact can be quite costly. Depending on the market, "attracting an enrollee can cost $700 to $1,300 so high attrition is costly to health plans."[25]

By most measures, then, Medicare HMOs have been a success. It is therefore not surprising that the expected congressional expansion of Medicare options through new managed care plans in Medicare+Choice was greeted with optimism by analysts in industry and government, as well as among health care professionals. For example, the Congressional Budget Office (CBO) and officials at HCFA predicted a 20 percent growth rate for Medicare risk-based plans.[26] The American Hospital Association reported that 33 percent of its members (1,500 hospitals) planned to initiate point-of-service (POS) plans. With such an initial response, HCFA predicted 50 POS applications in 1999.[27]

But the repercussions of the Balanced Budget Act of 1997 did not bear out this initial optimism. Whatever Congress's intent in enacting the health policy changes, the effect was to enable HCFA to reverse Medicare's steady progress in managed care.

Medicare HMOs serving more than 6 million patients were repackaged under Medicare+Choice. HCFA's overly optimistic and erroneous assumptions led many analysts to expect that the new program would allow beneficiaries to participate in popular plans already available to privately insured working Americans—such as preferred provider organizations (PPOs), provider sponsored organizations (PSOs), and new HMOs with point-of-service options. Over half of the 70 million Americans enrolled in Blue Cross/Blue Shield's managed care plans chose to participate in PPOs rather than traditional HMOs.[28] Medicare patients generally remained locked in more traditional HMO models, with Medicare Parts A and B covering most inpatient and many outpatient services. As of January 1, 1999, Medicare+Choice was scheduled to make popular private-sector options available as well—including medical savings accounts (MSAs), PSOs, POS options, and new fee-for-service insurance plans.

Unfortunately, the initial response was disheartening. Just before the August 31, 1998, deadline for private plan participation in the new program, HCFA announced that only three private plans had submitted applications.[29] Nor did Medicare HMOs jump on board. In late October 1998, almost 100 HMOs had exited the program in some part.

The system quickly unraveled. Instead of holiday shopping at the end of 1998, hundreds of thousands of seniors faced a last-minute search to find alternative health plan coverage. Fifty thousand *had no choice* but to return to traditional Medicare. Not only did existing HMOs withdraw from the program in the first year, but no new options such as PSOs, fee-for-service plans, or MSAs became available.

In general, the BBA's Medicare mandates resulted in:

- **Fewer choices.** By the end of 1998, many HMOs that had serviced Medicare patients for years had withdrawn altogether or partially from their service regions. An HMO plan was

25. Chris Rauber, "Information, Please: Survey Shows Health Plans Can Build Customer Loyalty by Providing Large Doses of Information," *Modern Healthcare*, March 29, 1999, p. 56.

26. Congressional Budget Office, "Medicare Projections and the President's Medicare Proposals," *An Analysis of the President's Budgetary Proposals for Fiscal Year 2000*, April 1999, at *www.cbo.gov.*

27. John McCormack, "PSO Organizers Find Big I.T. Investments Essential," *Health Data Management*, September 1998.

28. Stephen Barlas, "Counting Down, Ground Zero for Medicare+Choice Approaches," *Managed Healthcare News*, Vol. 14, No. 10 (October 1998), p. 12.

29. See Gavora, "Medicare Minus Choice," p. 1.

more likely to vacate areas it had served since 1992.[30] The number of withdrawals was also unprecedented (in previous years, only two or three plans quit the system).[31] But the expected cuts in payments were not the only reason for their flight. Although the average per capita Medicare payment was projected to be $413 across all U.S. counties at the time, the average payment rate in the 72 counties with plan withdrawals was $434. Health plans even left counties that had payment rates as high as $721 per member per month.[32]

- **Fewer participating plans.** In addition to HMO withdrawals, 20 other health plans, including 15 health care prepayment plans (Part B only), did not renew their contracts with HCFA.[33] Instead of finding themselves with expanded choice, nearly 500,000 Medicare patients in 29 states found themselves with fewer options.
- **More counties with no Medicare managed care option.** Senior citizens in 71 percent of all counties now have no Medicare managed care option, compared with 68 percent in 1998.[34]
- **More seniors needing medigap coverage.** About 50,000 Medicare HMO patients were forced to return to traditional Medicare and find affordable medigap insurance.[35]
- **Fewer applications from PSOs.** Rather than the 50 applications HCFA expected from provider sponsored organizations, only four applications[36] came in by October 1998, and HCFA approved only one.[37]
- **No private fee-for-service plans or medical savings accounts (MSAs).** There were no takers for medical savings account plans or other fee-for-service insurance.
- **Benefit cuts.** Faced with rate cuts and the compliance costs, the remaining HMOs dropped important benefits. For example, 21 percent of Medicare enrollees lost coverage for glasses, and 12 percent lost coverage for hearing aids. Fewer plans offered prescription drug coverage in 1999.[38]

The repercussions of the Balanced Budget Act of 1997 surprised half a million seniors who thought they had solid private health care coverage. Perhaps HCFA officials assumed that HMOs' complaints about the effects of the cuts and regulations were exaggerated. But the deadly combination of HCFA micromanagement and overly broad congressional mandates demonstrated once again how Washington was "out of sync" with the best practices of private-sector health care delivery.

And the bad news continues. HCFA recently announced that, for the year 2000, 99 Medicare contracts are not being renewed or else the companies are reducing service areas covered.[39] According to a recent report in *American Medical News*, over a quarter of a million more Medicare patients will lose their health plan coverage in 2000

30. General Accounting Office, *Medicare Managed Care Plans*, p. 22.
31. Julie Rovner, "The Medicare HMO Disappearing Act," *Medical Economics*, Vol. 16, No. 12 (December 1, 1998), p. 25.
32. Health Care Financing Administration, "Status of Medicare Managed Care Non-Renewals as of October 8, 1998," briefing for congressional staff, October 8, 1998.
33. *Ibid*.
34. Medicare Payment Advisory Commission, *Report to Congress: Medicare Payment Policy*, p. 41; MedPAC computations based on HCFA public data.
35. Rovner, "The Medicare HMO Disappearing Act."
36. HCFA, "Status of Medicare Managed Care Non-Renewals."
37. General Accounting Office, *Medicare Managed Care Plans*, p. 22.
38. T. McBride, "Disparities in Access to Medicare Managed Care Plans and Their Benefits," *Health Affairs*, Vol. 17, No. 6 (November/December 1998), pp. 170–180.

because of program plan withdrawals, and almost all other enrollees will experience a reduction in benefits, an increase in payments, or both.[40]

ANATOMY OF A HEALTH POLICY FAILURE

The Clinton Administration was quick to blame greed for the massive flight of HMOs from Medicare+Choice. But simple sound bites and rhetorical flair cannot explain why an increasingly popular managed care market went into a sudden tailspin.

The U.S. General Accounting Office (GAO) concluded that "many factors" contributed to the high number of plan withdrawals,[41] but it was no mere coincidence. The plans' problems followed a massive expansion of regulation at the federal and state levels. Lawmakers suddenly became "experts" on a wide range of patient management issues—including the number of hours a patient should remain hospitalized after a specific surgical procedure. This sort of intervention increases costs. Not surprisingly, the states that imposed the most extensive regulation of the health insurance market now face the largest increases in health care costs.[42]

HCFA officials also were caught by surprise when the HMO departures were announced. The most obvious early warning sign—financial problems—was ignored. According to InterStudy Publications, a Minnesota-based researcher and publisher of data, directories, and analyses for the managed care field, 51 percent of HMOs experienced operating losses in 1997. The trend had started in 1994, when 61 percent of HMOs reported operating profits (down from 88 percent the year before). Even the large not-for-profit Kaiser Permanente lost over $250 million in 1997—the first deficit in its 50-year history. And in Minnesota, which had outlawed for-profit health plans, all but one plan reported operating losses.[43]

Despite such warnings, HCFA implemented new rate increases, provider taxes (politely called "user" fees), and Congress's unfunded mandates encompassing every minute detail of health plan administration, even "quality" improvement.

Cutting Payments

Before passage of the BBA, Congress set per capita payments to Medicare HMOs at 95 percent of a county's average Medicare Part A and Part B per capita fee-for-service cost. Payments were adjusted for demographic factors, such as patients' age and sex and whether they were on Medicaid or institutionalized. At the time, most Medicare HMOs were providing many more services than traditional Medicare provided. For example, 67 percent of HMOs covered outpatient medication, 83 percent covered eye exams, 72 percent paid for ear exams, and 97 percent covered routine physicals.[44]

Yet providing such additional services at a 5 percent discount did not prevent federal officials from criticizing Medicare's HMOs for receiving too much money. In 1997, the GAO concluded that the HCFA would have paid less, on average, for the care of HMO enrollees if those patients had remained in the fee-for-service program,[45] because Medicare HMO enrollees generally were healthier than their fee-for-service counterparts, even those with the same age and demographic characteris-

39. "Medicare + Choice in 2000: Plan Participation Summary," Press Office, Health Care Financing Administration, U.S. Department of Health and Human Services, July 15, 1999, p. 1.

40. Geri Aston, "More HMOs Pull Out of Medicare: Who's at Fault?" *American Medical News*, July 19, 1999, pp. 1, 50.

41. General Accounting Office, *Medicare Managed Care Plans*.

42. For an in-depth discussion of "regulations" with respect to "health care costs," see Melinda L. Shriver and Grace-Marie Arnett, "Uninsured Rates Rise Dramatically in States with Strictest Health Insurance Regulations," Heritage Foundation *Backgrounder* No. 1211, August 14, 1998.

43. InterStudy Publications, "Part II: The HMO Industry Report," InterStudy Competitive Edge 8.2, 1998.

44. Dufur, "Politics and Policy—Medicare+Choice."

tics. While HMO enrollments have doubled,[46] the trend in the so-called overpayments to HMOs had decreased from the late 1980s to the early 1990s, according to the GAO.[47] A recent Sachs Group report published in *Business Wire*, which was based on more timely data, also found that most of these health plans have numbers of chronically ill and aged patients that are similar to those found in the Medicare fee-for-service program.[48]

Congress's objectives in passing the BBA included saving $116 billion on Medicare. For the HMOs, this translated into the six "provider" reimbursement cuts that are listed above and an escalating difference between spending in fee-for-service Medicare and HMO reimbursements. Even the CBO acknowledged that if current payment policies remain in effect, by 2004 Medicare will pay HMOs only 75 percent of what they pay their fee-for-service providers.[49] A PriceWaterhouse study finds a similar difference; it shows that payments in the traditional Medicare program will outpace payments to some Medicare managed care health plans by 20 percent by the year 2003.[50] These projections, moreover, do not take into account the impact of an "evolving risk adjuster," which will decrease HMO payments by an additional 7.5 percent.

In most cases, the HMOs—burdened with rapidly rising medical costs, negative bottom lines, and costly regulatory mandates—were expecting a 2 percent rate hike, which did not reflect everything else occurring in the health care sector of the economy. In the private sector, rates were projected to be increasing from 8 percent to 10 percent. Managed care drug costs were increasing because the costs for pharmaceuticals in general had increased 14 percent in 1997 and from 12 percent to 17 percent in 1998.[51] Although traditional Medicare does not cover pharmaceuticals, over two-thirds of Medicare HMOs do. Americans over age 65, who make up 12 percent of the U.S. population, consume 30 percent of all prescription drugs; ambulatory elderly patients take an average of 4.5 prescribed drugs each day.[52]

The HMOs, facing rate increases that were out of touch with private-sector health care costs, to say nothing of costly regulatory mandates, therefore confronted a Catch-22: They could reduce benefits and raise supplemental payments, or they could discontinue contracting with HCFA altogether.

For understandable reasons, most notably the country's broader budgetary and fiscal problems, Congress historically has focused on Medicare spending. As a result, Medicare policy too often has been subsumed by budget policy. A far more fruitful use of Congress's time would be to improve the way in which quality care is delivered to Medicare patients.

Congress delegates broad discretionary authority to HCFA to run Medicare; and under Congress's broad mandates, HCFA makes detailed decisions about the plans, the level of care, and the kind of physician and specialty payments that will

45. U.S. General Accounting Office, *Medicare HMOs: HCFA Can Promptly Eliminate Hundreds of Millions in Excess Payments*, GAO/HEHS–97–16, April 1997.

46. Louise Kertesz, "California Medicare HMOs Overpaid by $1 Billion—GAO," *Modern Healthcare,* March 3, 1997, p. 6.

47. General Accounting Office, *Medicare HMOs*.

48. "New Study Shows Chronically Ill Are Equally Satisfied."

49. American Association of Health Plans, "AAHP Analysis Measures Size of 'Medicare+Choice Fairness Gap'," *Washington Bulletin*, April 19, 1999, p. 4.

50. PriceWaterhouse, "Congress Reforms Medicare Capitated Payments: How Will It Affect Managed Care Plans?" *Health Policy Series* No. 6, April 1999, p. 6.

51. *Ibid*.

52. Kevin J. Ennis and Rita A. Reichard, "Maximizing Drug Compliance in the Elderly," *Temple University Series*, Vol. 102, No. 3 (September 1997), p. 211.

be reimbursable under Medicare. Because of this micromanagement, in the normal course of business, doctors, hospitals, and private insurance officials are locked in an inevitable conflict over administrative and reimbursement issues. Although Congress may intervene periodically as a reluctant referee among these competing interests, Medicare patients are caught in the middle. Whatever Members of Congress conclude about the cost-effectiveness of HMOs, the central issue should be the reorientation of congressional policy to give Medicare beneficiaries more control.

Problems with Pricing, User Fees, and Regulation

HCFA Medicare payment schemes are more complex than the IRS tax code. Yet HCFA officials are not solely to blame for this regulatory mess. Congress is at fault as well for enabling several of HCFA's complicated formulas that often base payments to HMOs on miscalculations, misperceptions, and a poor understanding of managed care. Consider a few of the problems facing managed care organizations today:

- **Miscalculating adjustments.** One intent of Congress in passing the BBA was to improve payments to Medicare HMOs serving seniors in rural counties, compared with payments to HMOs in urban areas. These higher payments, Congress reasoned, would make serving Medicare patients in rural areas more attractive. Provider sponsored organizations would be quick to jump into the market, and existing HMOs would expand their service areas to include more seniors.

  In fact, the opposite occurred. HCFA's promised "adjustments" were based on spending in traditional Medicare, and because of cuts in that program, its projections were off the mark.[53] The Medicare Payment Advisory Commission reported to Congress in March 1999 that there "has been no reduction in the disparity between high and low rates above the floor"[54] set by the BBA. For Medicare HMOs, the expected 2 percent rate increase was much lower than the rate of inflation in private-sector health care—and it would be even less when "user fees" and the enormous costs associated with regulatory compliance were factored into the equation. Consequently, fewer HMOs joined the program.

- **Provider taxes for an elusive Medicare education campaign.** The BBA authorized a provider tax as a "user fee" to fund a campaign to educate seniors. Medicare HMOs have been assessed nearly $190 million ($95 million in 1998 and another $95 million in 1999) to fund a patient information program for all 39 million Medicare beneficiaries. The HMOs were expected to pay the *entire* cost, despite enrolling only 17 percent of Medicare patients.

  For this multimillion-dollar investment in its centrally controlled campaign, HCFA produced a small 35-page information handbook for Medicare beneficiaries in five test areas, initiated a Medicare "helpline," and set up a Web site on the Internet. Despite HCFA's original predictions that the "helpline" would receive 20,000 calls a day (or about 7.9 million calls in the first two months, for which HCFA planned to hire 3,000 additional personnel), the number of calls averaged about 250.[55] Many callers are referred back to their own health plans or to local community groups for the information they seek.[56]

53. Congressional Budget Office, "Medicare Projections and the President's Medicare Proposals."
54. Medicare Payment Advisory Commission, *Report to Congress: Medicare Payment Policy*, p. 29.
55. Laura Goldstein, "Politics and Policy—Medicare+Choice: Federal Education Effort Underway," *The Washington Post*, December 14, 1998.
56. Geraldine Dallek, "Consumer Information in Medicare+Choice," testimony before the Special Committee on Aging, U.S. Senate, May 6, 1998.

On its Medicare Web site, HCFA lists several HMO quality measures to help consumers choose from among the available plans. Noticeably absent is a comparable rate for each type of service under traditional Medicare, even when such comparisons may be available. For example, one study reports a 62 percent mammography rate for women enrolled in managed care health plans versus a 39 percent rate in traditional Medicare.[57] A more recent study suggests an even greater disparity: "The latest edition of the Dartmouth Atlas of Health Care…reports that less than one third of women between the ages of 65 and 69 obtain mammograms every two years."[58] Published rates for other important preventive care services are off by similar amounts, or worse.[59] And it is not clear that the information produced by HCFA would be of any interest to seniors even if it were available.[60]

By comparison, federal workers and retirees enrolled in the popular FEHBP system receive easy-to-use guides on private-sector plans that include information on prices, benefits, quality, and service. The Washington Consumers' Checkbook publishes such a guide annually to supplement the comparative information produced for FEHBP enrollees by the Office of Personnel Management (OPM), the federal agency that administers the FEHBP. As Walton Francis, former Department of Health and Human Services official and current editor of the Washington Consumers' Checkbook *Guide to Health Insurance for Federal Employees*, notes:

> It is unclear why HCFA did not copy the economical and effective OPM system…10 years or more ago. I was once told by a HCFA official that the reason why no usable information was provided was because the plans didn't want to make comparisons easy, and HCFA felt obliged to defer to the plans' wishes. This theory is so scandalous that it is hard to believe. I am more inclined to believe in tight budgets and weak imagination. Another theory is that a well-run Choice program would drive Medicare (a grossly inferior insurance product) into the ground and that agency staff are unwilling to foster fair competition. Regardless, the record on Medicare HMO information is atrocious.[61]

- **Projections of rates sought before HMOs knew the rules of the game.** HCFA asked the Medicare HMOs to submit information about anticipated costs, premiums, and benefits packages by May 1, 1998. But these projections were based on HCFA's early miscalculation; the deadline meant HMO plan actuaries would have to forecast their plan expenditures for the coming year based on three months of information from the previous year.[62] Many Medicare HMOs took that leap of faith after assessing the BBA mandates.

  Then, in June 1998, one month *after* the HMOs had committed themselves to specific benefit packages and premiums, HCFA published a rule requiring numerous changes in HMO administrative systems, contracts, quality improvement plans, and medical

57. Nelson *et al.*, "Access to Care in Medicare HMOs."

58. Dartmouth Atlas of Health Care, "The Quality of Medical Care in the United States: A Report on the Medicare Program," *American Health Line*, April 19,1999.

59. *Ibid.*

60. Eric Weissenstein, "Word for Washington: Wisdom Proves More Useful in Selecting HMO than Surveys," *Modern Healthcare*, November 11, 1996.

61. Walton Francis, statement on the Medicare Plus Choice Program before the Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, March 18, 1999, p. 3.

62. Medicare Payment Advisory Commission, *Report to Congress: Medicare Payment Policy*, p. 34.

information systems. The HMOs then found that payment reimbursements would be much lower than anticipated. They asked HCFA whether they could submit new information about their benefits and premiums based on the new rules and rates, but HCFA denied these requests, prompting many plans to forego the opportunity to participate in Medicare+Choice. In any other context, Members of Congress would denounce such "bait and switch" activity.

- **Risk adjustments with no relevance to managed care.** In January 1999, HCFA imposed "risk adjusters" that would remain in effect until 2004. HCFA predicted that the application of these "temporary" adjusters would decrease HMO reimbursements another 7.5 percent.[63] The HMOs complained that these risk adjusters would "reduce payments to health plans even further than intended by Congress."[64]

  HCFA's risk adjustment method would use hospitalization data from the previous year to indicate that capitated payments for previously hospitalized patients should be higher. There are numerous problems with this approach.[65] It rewards plans that allow patients to become sick enough to require hospitalization, and because it does not count short stays in hospitals, it provides incentives for plans to keep people hospitalized longer than needed. Such risk adjustments contradict the very nature of managed care. HCFA's post-2004 risk adjustment scheme also is highly complex and will require the infusion of large amounts of personal information from Medicare beneficiaries.

MICROMANAGING PATIENT CHOICE MEANS *LESS* CHOICE

Although the CBO still predicts that Medicare+Choice will see enrollment improvements by 2004,[66] new enrollments reached an all-time low of 38,000 in December 1998[67]—just two months after the "October surprise" in which HMOs withdrew from the program. HCFA may be asking too much of financially strapped provider organizations and HMOs by expecting them to venture into this artificial and risky "market." It is understandable for seniors to worry about joining health plans that, faced with future cuts and burdensome regulations, could leave the Medicare+Choice program. In addition, if the differences between the rates of reimbursement for traditional Medicare and Medicare HMOs continue to rise as high as the CBO and private-sector economists predict,[68] the number of benefits plans provide over traditional Medicare will decline.[69]

Bureaucratic, Not Patient, Control

In Medicare Part C, the part of the Medicare law that governs the new Medicare+Choice program, Congress did not provide the statutory basis for a genuine system of patient choice. HCFA's implementation of Medicare Part C—effectively imposing new regulations, directives, data specifications, and operational policy letters to govern every detail of plan administration—mocks the concept of patient choice. Patient choice has meaning only if there are different plans and benefits from which

63. Congressional Budget Office, "Medicare Projections and the President's Medicare Proposals."
64. Heidi Margulis, Humana Health Plan, "Risk Adjustments Affects on Health Plans," testimony before the Subcommittee on Health and Environment, Committee on Commerce, U.S. House of Representatives, February 25, 1999.
65. For an extensive discussion of HCFA's proposed "risk adjustment" methodology, see Medicare Payment Advisory Commission, *Report to Congress: Medicare Payment Policy*, p. 30.
66. Congressional Budget Office, "Medicare Projections and the President's Medicare Proposals."
67. Medicare Payment Advisory Commission, *Report to Congress: Medicare Payment Policy*, p. 42.
68. American Association of Health Plans, "AAHP Analysis Measures Size of 'Medicare+Choice Fairness Gap'."
69. See also McBride, "Disparities in Access to Medicare Managed Care Plans and Their Benefits."

to choose. Imagine, for example, if consumers could choose between Apple or IBM computers but both brands used the same operating systems, microprocessors, and modems. Would the consumer have a real "choice?"

True, health plans do have some flexibility, but Medicare Part C mandates represent a stranglehold on the way care is delivered. In the process of implementation, HCFA added over 100 pages of new regulations and dozens of operational policy letters ranging in length from a few pages to as many as 50 pages each. Thousands of additional pages of detailed instructions describe mandated data sets and collection processes, surveys, and quality improvement studies. HCFA even promulgates regulations governing plan-provider relationships that have no statutory basis.[70] The Medicare Payment Advisory Commission has described Medicare Part C regulations as involving "far more extensive compliance than under earlier risk programs."[71] For this reason, health plans direct their priorities more at compliance than at quality, and compliance consumes so many resources that creativity and innovation are cast aside.

Congress's statutory construction of Medicare+Choice and HCFA's broad interpretation of the BBA together make HMOs little more than conduits for bureaucratically controlled health care of the elderly. Providers at every level will have to submit to additional chart reviews and assure that the patient encounter data they send to the HMOs conform to HCFA specifications. Such efforts run contrary to Congress's intent, which (in the words of the Medicare Payment Advisory Commission) is to "enable the Medicare program to utilize innovations that have helped the private market contain costs and expand health care delivery options."[72]

Mandated HMO Data Collection

The various reports, data and information sets, analyses, and documents that HCFA requires HMOs to submit cannot be described in detail in this study. Although HCFA collected volumes of such information from Medicare HMOs for some time, little of it is available to the public.

As far back as October 1996, the GAO recommended that HCFA release useful information about Medicare HMOs to aid consumers in making choices.[73] HCFA, however, has not done so. It also provides little or no feedback to the HMOs on the information they submitted for more than three years, such as detailed information about patient encounters with providers that include diagnoses, treatments, and procedures. In addition, HCFA is requiring the HMOs to perform and possibly pay for at least five additional data submission projects. Ostensibly, the data will be used to set rates, perform risk adjustments, assess quality of care, provide information to the public, and hold managed care organizations accountable.

Before the BBA, an HMO was required to initiate its own quality assurance program, which then was evaluated as part of its qualification process.[74] The general guidelines for this program were compatible with commonly accepted principles of quality improvement. The HMOs were required to submit detailed data on patient encounters, enrollments, and disenrollments, information on appeals and grievances, and benefits publications. More recent HCFA regulations added the Health Plan Employer Data and

70. Karen Ignani, American Association of Health Plans, testimony before the Subcommittee on Health and Environment, Committee on Commerce, U.S. House of Representatives, October 2, 1998.

71. Medicare Payment Advisory Commission, *Report to Congress: Medicare Payment Policy*, p. 28.

72. *Ibid.*, p. 42.

73. U.S. General Accounting Office, *Medicare: HCFA Should Release Data to Aid Consumers, Promote Better HMO Performance*, GAO/HEHS–97–23, October 22, 1996.

74. Carlos Zarabozo and Jean LeMasurier, "Medicare and Managed Care," in Kongstvedt, ed., *The Managed Health Care Handbook*, pp. 321–344, esp. p. 328.

Information Set (HEDIS) and the Quality Improvement System for Managed Care (QISMC).

HEDIS. The Health Plan Employer Data and Information Set is a quality measurement survey developed for employers, especially large companies, to assist them in choosing a health plan for their employees. It is the most widely used data instrument for assessing quality. But HEDIS does have some drawbacks:

1. It was not designed with seniors or the disabled in mind.
2. It is extremely costly to administer (some estimate that it could cost millions of dollars[75]).
3. It includes few true measures of outcomes, even though outcomes are the usual standard for evaluating quality.
4. It relies on costly chart reviews that are disruptive to physicians and a threat to patient privacy.
5. It presents problems for preferred provider organizations and managed care options that deviate from a rigid HMO model.
6. Large employers depend only infrequently on HEDIS data in selecting a health plan.[76]
7. Many employers do not see HEDIS as an accurate measure of quality.[77]

As Steve Wetzell, executive director of policy and public affairs at the Buyers Health Care Action Group (BHCAG), points out, HEDIS does not meet the information needs of the health customer, the consumer.[78] Seniors, for example, want to know whether their doctors are in the plan, what their benefits under the plan would be, how much they will have to pay out of pocket, and whether their friends are happy with the plan.[79]

HCFA Quality Standards. HCFA sets standards for HMOs in the Quality Improvement System for Managed Care, a nearly 100-page highly proscriptive plan. Although the QISMC is based on quality improvement measures generally accepted by most experts in that field, it is a particularly burdensome measure. It sets 70 standards for HMOs, prescribes how many quality improvement studies are to be performed, picks some of the issues that HMOs must study (regardless of whether an issue is a concern for a particular HMO), and stipulates exactly how much improvement is to be achieved.

QISMC is nearly impossible for less restrictive managed care options such as PPOs to fulfill. Its prescriptive nature runs counter to the very principle of quality improvement that it promotes. Some HMOs scale back their ongoing quality improvement projects just to comply with its costly requirements.

Even worse, QISMC's proscriptive nature creates an inherent perverse incentive for HMOs to pick less difficult or challenging areas to measure. Plans are required to achieve a 10 percent reduction in adverse outcomes each year. If they fail to meet this target, they could lose Medicare contracts. The result, however, would be a greater number of seniors with fewer choices. By setting a 10 percent target (or any target, for that matter), HCFA removed the market incentive to do better than the chosen target. Because plans are unlikely to choose more difficult or challenging projects, QISMC is little better than a mandate for mediocrity instead of excellence in health plans.

75. From author's personal conversations with administrators and medical directors of Medicare+Choice health plans during the spring of 1999.
76. Dwight McNeill, "What's Happening to Employers Push for Quality," *Business and Health*, Vol. 17, No. 4 (April 1, 1999), p. 26.
77. *Ibid.*
78. *Ibid.*
79. Weissenstein, "Word for Washington."

Unrealistic Expectations. The HMOs, the GAO, and the Medicare Payment Advisory Commission have pointed out several problematic and unreasonable HCFA mandates on Medicare HMOs.[80] An example is the requirement that the health plans certify that the encounter (claims) data they submit are 100 percent accurate—an unrealistic request. Ironically, even HCFA's Medicare Transaction System (the Medicare claims system) has been criticized for exceeding its budget. Although it was expected to cost $36.6 million, as of the spring of 1997 the program had spent almost $102 million and showed little improvement.[81]

HCFA requires plans to perform a costly certification process for each physician—which plans claim costs them at least $80 per participating physician and rarely yields additional useful information.[82] Curiously, HCFA requires no similar system in the credentialing of providers under traditional Medicare.

HCFA also requires HMOs to contract with a designated subcontractor for the collection of detailed information about a patient's health—including sensitive information about mental health—on consumer satisfaction and health outcomes surveys. This expensive and burdensome data collection system had a lot to do with why the PPOs and PSOs did not enter the Medicare+Choice program. According to Bruce David, senior vice president of Blue Cross and Blue Shield in Florida, QISMC is designed for a "tightly managed HMO product. Broad access PPOs are simply not set up to monitor, measure and assure improvement in enrollee health status and physician outcomes."[83]

LESSONS FOR CONGRESS

In creating Medicare+Choice, Congress hoped to enable beneficiaries to have access to a variety of private health plans and to enable the Medicare program to look for innovative private-sector methods of containing costs and expanding delivery options. Neither of these objectives has been accomplished. In fact, the opposite has occurred: The options promised to beneficiaries have not materialized, and HCFA's onerous regulatory schemes have increased administrative costs without any demonstrable benefits.

In considering how to improve the Medicare system, Members of Congress should learn three lessons from the Medicare+Choice fiasco:

1. **Don't tinker with Medicare; reform it.** Congress continues to consider various legislative solutions to some of the BBA's many problems. In general, the initial proposals have been woefully inadequate. Tinkering with deadlines, rules, and mandates is a poor substitute for good health policy.

   Before Congress adds more insult to injury and passes additional laws to try to fix the BBA's problems, it should reexamine the problems that followed the creation of Medicare+Choice. HCFA's top-heavy managerial control comes with a high cost in terms of economic efficiency and the best use of public and private resources. Health plans and providers are forced to shift their attention to regulatory compliance at the expense of quality improvement. There is little point in trying to empower consumers with more choice if the choices will be stymied by government mandates that dilute differences between plans,

80. U.S. General Accounting Office, *HCFA Management: Agency Faces Multiple Challenges in Managing Its Transition to the 21st Century*, testimony before the Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, GAO/T–HEHS–99–58, February 11, 1999, p. 7; see also Medicare Payment Advisory Commission, *Report to Congress: Medicare Payment Policy.*

81. Eric Weissenstein, "HCFA Computer Quandary: Medicare Claims System Won't Do the Job, Detractors Claim," *Modern Healthcare*, May 5, 1997, p. 58.

82. Personal discussion with chief medical officer of a major Medicare HMO provider, April 1999.

83. Barlas, "Counting Down, Ground Zero for Medicare+Choice Approaches," p. 12.

stifle innovation and creativity, and compromise providers' rapid responses to their needs.

2. **Base Medicare reform on real patient choice and market competition.** Congress has a fundamental responsibility to improve the Medicare system, but legislative tinkering and bureaucratic micromanagement are no longer acceptable solutions. It is only through a major reform of Medicare that seniors will have health choices unencumbered by unnecessary regulatory mandates.

   Thus far, the bipartisan majority of the National Bipartisan Commission on the Future of Medicare has agreed on the best framework for reform.[84] The key element of its proposal is a new "premium support" mechanism, whereby senior citizens are given direct financial support to choose a private health plan that best meets their personal needs. A majority of Commission members suggested as a model for this mechanism the Federal Employees Health Benefits Program (FEHBP), a consumer-driven system of hundreds of competing private plans that serves Members of Congress, their staff, and nearly 9 million federal workers and retirees. The FEHBP's solid record of performance over the past four decades has been characterized by minimum bureaucratic intervention and government regulation. There is no reason to deny Medicare's beneficiaries this type of health care system.

3. **Don't expand HCFA's regulatory powers; restrain them.** As the experience of the Medicare+Choice program demonstrates, the success of a reform lies in its crucial details. For Congress, this means that it is not enough to establish statutory conditions for patient choice and market competition. Real Medicare reform must include legislative provisions that prevent the sort of regulatory micromanagement that could undo Congress's objectives of assuring real patient choice and genuine market competition.

   Specifically, in the context of Medicare reform, Congress should rein in the reach of HCFA. For example:

   - HCFA should not be allowed to micromanage health care services by imposing price controls, fee schedules, premium caps, or spending restrictions on competing private health plans;
   - HCFA should not be allowed to create insurance cartels, oligopolies, or restrictive government-sponsored purchasing cooperatives;
   - HCFA should not be allowed to impose medical practice guidelines on doctors who are working with private health plans;
   - HCFA should not be allowed to impose any comprehensive or detailed standardized benefits package on Medicare beneficiaries beyond the core categories of benefits required or negotiated as a condition of plan participation;[85] and
   - In no case should HCFA be allowed to run the traditional Medicare fee-for-service plan and—at the same time—regulate its competition.

Even before Congress finishes a major reform of Medicare, it can improve the existing system by cutting away the red tape that inhibits innovation, flexibility, and efficiency in Medicare+Choice and traditional Medicare. Members of Congress should rein in HCFA's overly aggressive regulatory power and cut through the mountain of paperwork it imposes on the Medicare system—over 111,000 pages worth.[86] Congress should exercise aggressive oversight of HCFA and intervene whenever the agency expands its interpretation of its authority beyond Congress's reasonable intent.

84. See Butler, "Principles for a Bipartisan Reform of Medicare."

85. On limits of federal regulatory authority under a reformed Medicare system, see also Robert E. Moffit, "Giving Baby Boomers a Retiree Health System Fit for Senators," statement before the Special Committee on Aging, U.S. Senate, August 25, 1997.

CONCLUSION

Medicare+Choice is a policy failure. It does not, in any meaningful way, either increase consumer choice or improve the quality of health care for seniors. It is not an open system. It is, instead, another case history of faulty federal micromanagement of the delivery of health care services in the Medicare program. At least on the basis of the optimistic rhetoric from Congress about a new era of choice for American seniors, this is not the result Congress intended when it initiated the program in the 1997.

Tinkering with rate structures or imposing detailed regulatory restrictions—ranging from reporting requirements to quality improvement measures—is standard operating procedure for a closed, "single-tiered," government-run health care system that is legally sealed off from either patient choice or market competition. In truth, some Members of Congress still favor such a closed system. But there is a much better policy: Promote freedom for doctors and patients and opportunities for seniors to get the best value for their money from superior private health plans operating under the discipline of the market. The majority of members of the National Bipartisan Commission on the Future of Medicare already have set forth the basis for such a reform.

Rather than trying to fix a system that is collapsing under the weight of overregulation and miscalculation, Congress should loosen HCFA's bureaucratic stranglehold on the delivery of health care services to seniors. Reducing mandates that raise plan costs, providing subsidies for those who need them, and allowing seniors to choose plans that meet their needs will deliver a superior level of quality health care for generations of senior citizens to come.

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86. Dr. Robert Waller, president of the Mayo Foundation, in testimony before the National Bipartisan Commission on the Future of Medicare, August 10, 1998.