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REGULATED TO DEATH: HOW MEDICARE'S BUREAUCRACY IS KILLING SENIORS' CHOICES

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The three-year-old Medicare+Choice program is in serious trouble. Hundreds of thousands of seniors are affected, and many are losing the freedom to pick and choose their private health care plans because of bad government policy.

Congress created the Medicare+Choice program in the Balanced Budget Act of 1997 to broaden patient access to health plans—including traditional managed care, new private fee-for-service, and medical savings account plans. But bureaucratic micromanagement and an inflexible system of administrative pricing undermine these intentions. The result: Many plans have dropped out of the program, and many more will likely drop out this summer. It lost 37 plans in 1999, and 47 plans have withdrawn for the year 2000. Only *one* fee-for-service option has been approved, and there are *no* medical savings account plans. While Washington offers lame excuses, the exodus of plans and the onslaught of counterproductive overregulation by the Health Care Financing Administration (HCFA) continue. HCFA controls the financing and delivery of medical services to America's seniors.

Instead of trying to blame private plans that are being strangled by red tape, lawmakers should build on the majority recommendations of the National Bipartisan Commission on the Future of Medicare chaired by Senator John Breaux (D–LA) and Representative William Thomas (R–CA). The commission proposed as a reform model the Federal Employees Health Benefits Program (FEHBP), a system of competing private plans with minimum regulation that covers the President, Congress, and about 9 million federal workers, retirees, and their families. This would create a system of Medicare coverage based on patient choice and genuine competition. At the very least, Congress should roll back excessive HCFA regulation and grant legislative relief to private plans that serve senior citizens.

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Structural Deficiencies. Seniors deprived of private options should be angry, but they should not be surprised. Congress may have sought to broaden patient choice in 1997, but the regulatory regime it created frustrated that goal as HCFA's powers over a new class of private health plans expanded.

The major deficiencies of Medicare+Choice are rooted in three bureaucratic features:

- **Medicare+Choice is governed by a rigid system of government pricing.** Congress created new options under Medicare+Choice but retained Medicare's complex system of administrative pricing, which locked plans into an inflexible arrangement that prevents price competition

and ignores changes in supply and demand. Since paying managed care plans cost taxpayers too much under the old formula, Congress substantially altered it and limited the annual rate of growth in payments to participating plans. According to the Congressional Budget Office, this resulted in a $97 billion *reduction* in projected Medicare payments to these plans over a 10-year period. Even after the plans complained that reimbursements were inadequate and incompatible with rapidly changing market conditions and rising costs, HCFA insisted the reimbursements were appropriate.

- **Congress allowed HCFA to impose costly, complicated, and unnecessary regulation over participating private plans.** In a brilliant paper, *Medicare+Choice Program: Is It Code Blue?* (Shaw-Pittman, 2000), former Director of HCFA's Center for Health Plans and Providers Bruce Fried and Janice Ziegler write, "The regulatory complexity of the M+C program has taken on mammoth proportions and made it difficult for M+COs [participating plans] to comply with all of the many program requirements.... [T]he breadth and depth of regulatory requirements have imposed a level of micro-management that significantly hampers—or, in some instances, restricts altogether—the ability of [the plans] to make essential business decisions regarding how care should be financed and operations structured. This level of micro-management, when coupled with [the] constantly changing nature of the program requirements and conflicting directions from HCFA, creates a significant disincentive for [the plans] to remain in the program or become new entrants." Beyond issuing regulations and "guidance" and making Medicare manual changes, HCFA has issued more than 100 operational policy letters (OPLs)—specific directives governing various aspects of plan administration. As of May 1, another 26 OPLs were under development. Fried and Ziegler note that HCFA issues these rules and letters with little thought for how they will affect costs. But every dollar spent to comply with HCFA's complex rules means one dollar less for drug benefit increases or premium reductions. Participating plans must meet HCFA's tight and often unrealistic deadlines for compliance, as well as state regulations that may also conflict with federal rules.

- **The level of detailed regulation imposed on private plans exceeds Congress's intent.** Just one example: The Secretary of Health and Human Services (HHS) by law was tasked with developing a risk adjustment mechanism for participating plans, taking into account variations in Medicare costs for different patients. Ignoring private-sector advice, HCFA developed a complicated mechanism requiring plans to collect and report "encounter data" for each medical service given to a patient. This imposes increased paperwork constraints on doctors, hospitals, and plans just to comply with the rules, at the expense of patients. "This requires," say Fried and Ziegler, that the plans "essentially create Medicare fee for service claims and submit them to HCFA—not for payment, but for the sole purpose of scoring each beneficiary's health risk. As a result, M+COs must redesign their data systems and train staff to handle complicated fee for service coding protocols, electronic formats, and specialized procedures (such as edit programs)." Though Congress did not intend "risk adjustment" to cut payments to plans, these authors note that HCFA's methodology will cut payments by an *additional* $11.2 billion between 2002 and 2004.

Conclusion. A combination of flawed legislation and complex regulation is driving out the already limited private options available to seniors in Medicare. For Congress, the best policy is to create a system based on patient choice and genuine market competition like the FEHBP, which offers a solid package of benefits that includes catastrophic coverage and drugs and is administered by a comparatively small number of officials with minimal regulation. At the very least, Congress should roll back HCFA's regulatory excesses and grant legislative relief to private health plans serving seniors.

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