No. 1583 September 9, 2002

Congress Should Think Twice About Allowing the Medicare Bureaucracy To Manage a Drug Benefit

Robert E. Moffit, Ph.D.

Many Members of Congress want the current Medicare bureaucracy to manage a new Medicare prescription drug benefit. However, a major government-wide survey of federal managers conducted by the U.S. General Accounting Office (GAO) found that the Centers for Medicare and Medicaid Services (CMS)—the federal agency that runs the Medicare program—is one of the most poorly performing agencies of the federal government.

In May 2001, the GAO, the fiscal watchdog agency of Congress, released a major survey of federal managers in 28 federal agencies entitled *Managing for Results: Federal Managers' Views on Key Management Issues Vary Widely Across Agencies*. GAO investigators were trying to determine the degree to which federal agencies were meeting their management objectives under current law. The GAO found that the CMS ranks at or near the bottom in many managerial categories. For example:

- **The Medicare bureaucracy ranks at or near the bottom in key measures of managerial performance.** The GAO found that the CMS ranked dead last in terms of the percentage of managers who reported having key performance measures for their work.
- **The Medicare bureaucracy ranks near the bottom in measures of customer service.** The GAO ranked the CMS next to last in having a measure for customer service as part of its managerial culture. Of CMS managers surveyed, 16 percent reported having customer service measures to a "great extent" or to "a very great extent." Only the Nuclear Regulatory Commission, with just 14 percent of managers reporting the presence of such measures, scored lower in this category.

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- **The Medicare bureaucracy ranks near the bottom in measures of accountability for results.** The GAO report found that the CMS ranked next to last among federal agencies in having a management team that was held accountable by performance measures.

The Need for a Better Program. For years, the Medicare trustees and responsible officials at the GAO and the Congressional Budget Office (CBO) have warned Congress that it would be a profound mistake simply to add a Medicare prescription drug benefit to the current Medicare program without serious structural reform. Not only would such an additional responsibility aggravate the growing financial pressures on the program, but it would also complicate what has already become a serious and largely neglected Medicare managerial problem. In a recent National Academy of Social Insurance (NASI) report, a philosophically diverse panel made several recommendations on how to improve the governance of the Medicare program. This report declared:

> In the absence of a decision by Congress to fundamentally reform Medicare, or provide substantial new investment of resources, both financial and human, *the study panel urges Congress not to enact major changes in the program in the near term because CMS does not currently have either the resources or the capacity to implement such changes in a timely fashion*. [Author's emphasis]

The Best Solution. The best solution is to transform Medicare into a program that more closely resembles the popular and successful Federal Employees Health Benefits Program (FEHBP) that covers members of Congress, federal workers, and retirees. These enrollees not only have access to solid prescription drug coverage, but can also choose better health plans if they wish to do so. Not surprisingly, the GAO ranked the Office of Personnel Management (OPM) (the agency that administers the FEHBP) the highest among federal agencies in terms of the percentage of federal managers who reported that they had the authority to get results. The OPM also ranked first among agencies in its use of performance information in managing its responsibilities.

Intermediate Steps to Reform. If Congress is reluctant to re-create the fundamental structure of Medicare on the FEHBP model in a single legislative act, it could at least start the transformation to a new and better system. It could do this by allowing new retirees to keep their private health plan and drug coverage and to take it with them into retirement as their primary coverage should they wish to do so. To offset the cost of this, Congress would provide a government contribution in the form of premium support. Congress could thus phase in Medicare reform gradually, enabling the first wave of retirees from the huge baby boom generation to take advantage of a flexible new program with richer and more varied benefits. Meanwhile, Congress would have an opportunity to make any necessary adjustments to the program over time.

Congress could also help the CMS function more effectively by streamlining CMS responsibilities and allowing CMS staff to concentrate time, effort, and resources on the traditional Medicare fee-for-service program rather than trying to run the "Medicare+Choice" system of private health plans or implementing a complex new drug benefit.

—Robert E. Moffit, Ph.D., is Director of Domestic Policy Studies at The Heritage Foundation.

NOTE: Nothing written here is to be construed as necessarily reflecting the views of The Heritage Foundation or as an attempt to aid or hinder the passage of any bill before Congress.

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Many Members of Congress want the current Medicare bureaucracy to manage a new Medicare prescription drug benefit. However, a major government-wide survey of federal managers conducted by the U.S. General Accounting Office (GAO) found that the Centers for Medicare and Medicaid Services (CMS)—the federal agency that runs the Medicare program— is one of the most poorly performing agencies of the federal government. Millions of senior citizens who would be dependent on the CMS for their future drug coverage should be aware that, based on the government's own survey data, the Medicare bureaucracy is not characterized by a managerial culture that places a high priority on customer service, the achievement of results, or performance-based management.

Like other federal agencies, the Centers for Medicare and Medicaid Services, formerly known as the Health Care Financing Administration (HCFA), is subject to the Government Performance and Results Act of 1993. Nearly a decade ago, Democratic majorities in Congress enacted this legislation to improve the management and efficiency of the federal government. The 1993 law was intended both to improve the overall performance of federal agencies and to hold federal managers accountable to taxpayers and to the citizens they serve for their performance. The CMS is not merely struggling to carry out its existing responsibilities on the level designated by this legislation: It is in a serious management crisis.

In 2001, the GAO, the fiscal watchdog agency of Congress, conducted a major survey of managers in 28 federal agencies to determine the degree to which they were meeting their management objectives under the Government Performance and Results Act. The GAO report, *Managing for Results: Federal Managers' Views on Key Management Issues Vary Widely Across Agencies*, not only compares the results for the 28 agencies against one another, but also compares the results to counterparts in a similar GAO study conducted in 1997.

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In general, the GAO found that many federal agencies face "significant challenges" in inculcating management practices that would contribute to "a performance-based culture."[1] Yet the CMS stands out among troubled agencies. With regard to performance management, the CMS ranked ahead of only one agency—the Federal Aviation Administration (FAA)—and far below such other agencies as the Internal Revenue Service (IRS) and the General Services Administration.

A TRACK RECORD OF POOR PERFORMANCE

House and Senate liberals have objected to the proposal that any future prescription benefit be placed under private-sector management, and they have strived to label private-sector health plans or entities risky or unreliable.[2] This congressional hostility to private health plans emerged as a key feature of the recent congressional debate regarding Medicare. But Members of Congress should keep in mind (and seniors should be aware) that the current Medicare program faces mounting managerial problems. For example:

- **The Medicare bureaucracy ranks at or near the bottom with regard to key measures of managerial performance.** Among many federal agencies that are often considered sluggish by private-sector standards, the GAO found that the CMS ranked dead last in terms of the percentage of managers who reported having key performance measures for their work.
- **The Medicare bureaucracy ranks near the bottom in measures of customer service.** The GAO ranked the CMS next to last in having a measure for customer service as part of its managerial culture. Just 16 percent of CMS managers reported having customer service measures to a "great extent" or "a very great extent."[3] Only the Nuclear Regulatory Commission (with 14 percent of managers reporting the presence of such measures) scored lower. Clearly, customer service is not a key feature of the managerial culture at the CMS. No private firm that provides vital services to the public and depends on consumer choice and satisfaction for continued operation could survive with such a management culture.
- **The Medicare bureaucracy ranks near the bottom in measures of accountability for results.** The GAO found that the CMS ranked next to last among federal agencies in having a management team that was held accountable to performance measures.[4] In contrast, major private firms rely on measures of performance in staffing and allocating resources.

THE NEED FOR A BETTER PROGRAM

For years, the Medicare trustees and responsible officials at the GAO and the Congressional Budget Office (CBO) have warned Congress that it would be a profound mistake simply to add a prescription drug benefit to the current Medicare program in the absence of serious structural reform. Not only would such an additional responsibility aggravate the growing financial pressures on the program, but it would also complicate what has already become a serious, and largely neglected, managerial problem.

Among a dozen recommendations offered to improve the governance of the Medicare program, a philosophically diverse panel of the National Academy of Social Insurance (NASI) has stated:

> In the absence of a decision by Congress to fundamentally reform Medicare or provide

1. U.S. General Accounting Office, *Managing for Results: Federal Managers' Views on Key Management Issues Vary Widely Across Agencies*, GAO-01-592, May 2001, p. 8; cited hereafter as *Managing for Results*.
2. Curiously, congressional critics of private health plans often point to the problems besetting plans in the Medicare+Choice program created under the Balanced Budget Act of 1997. In fact, this criticism amounts to self-criticism. It is precisely flawed congressional payment policies and bureaucratic regulatory excesses that have discouraged private plan participation in the Medicare+Choice program. On this point, see Bruce Merlin Fried and Janice Ziegler, *The Medicare+Choice Program: Is It Code Blue?* (Washington, D.C.: ShawPittman, 2000); see also Sandra Mahkorn, M.D., "How Not To Reform Medicare: Lessons from the Medicare+Choice Experiment," Heritage Foundation *Backgrounder* No. 1319, September 15, 1999.
3. *Managing for Results*, p. 25.
4. U.S. General Accounting Office, *Medicare Management: CMS Faces Challenges to Sustain Progress and Address Weaknesses*, GAO-01-817, July 2001, p. 20.

> substantial new investment of resources, both financial and human, the study panel urges Congress not to enact major changes in the program in the near term because CMS does not currently have either the resources or the capacity to implement such changes in a timely fashion while managing the existing program and the changes enacted in the last few years.[5]

THE BEST OPTION

The best solution would be to change the fundamental Medicare structure and transform the program into one that more closely resembles the popular and successful Federal Employees Health Benefits Program (FEHBP), which covers members of Congress, federal workers, and retirees. Those enrolled in this program have access to reliable prescription drug coverage in a modern health care program and are able to choose an alternative health plan that better meets their needs if they wish to do so.

Seniors should be aware that the GAO ranked the Office of Personnel Management (OPM)—the agency that administers the FEHBP—highest among federal agencies in terms of the percentage of federal managers who reported that they had the authority to get results. The OPM also ranked first among agencies with regard to the use of performance information in managing program responsibilities.[6]

Intermediate Steps to Reform. If Congress is reluctant to re-create the Medicare program according to the FEHBP model in a single major legislative act, it could take intermediate steps toward the transformation to a new and better system. It could do so by allowing new retirees to keep their private health plan and drug coverage as their primary coverage if they wish to do so, with the government contributing premium support to offset its costs.

Congress could thus phase in Medicare reform gradually, enabling the first wave of retirees in the huge 77-million-strong baby boom generation to take advantage of a flexible new program that provides a spectrum of plans with varied benefits. Over time, Congress would have the opportunity to make any necessary adjustments in the program to expand such coverage to more retirees.

In addition, Congress should scale back the responsibilities given to the Medicare bureaucracy regarding Medicare Part C—the Medicare+Choice program of private health plans that serve senior citizens. Congress could create a separate agency to negotiate rates and benefits with these health plans, just as the OPM currently does with health plans in the FEHBP.[7] Congress could, thereby, help the CMS function more effectively, allowing its staff to concentrate its time, energy, and resources on efforts to improve the efficiency of the traditional Medicare fee-for-service program.

MEDICARE'S AILING MANAGERIAL CULTURE

If Congress establishes a new prescription drug benefit within the Medicare program, it would entrust the drug benefits of seniors to the CMS's managerial culture, which received the lowest rankings of federal agencies on key measures of performance—based on reports by its own managers. This is especially troubling with regard to such key items as setting goals, executing tasks, and establishing standards of customer satisfaction and quality control.

On the issue of management, the GAO findings with regard to the CMS were particularly pointed. For example:

- **The Medicare bureaucracy ranks next to the bottom in managerial performance.** According to the GAO report:

  > Overall, the Health Care Financing Administration (now called the

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5. Final Report of the Study Panel on Medicare's Governance and Management, *Matching Problems With Solutions: Improving Medicare's Governance and Management* (Washington, DC: National Academy of Social Insurance, 2002), p. 15; cited hereafter as *Final Report*.
6. *Managing for Results*, p. 157.
7. A variant of this approach is already embodied in the Medicare Modernization and Prescription Drug Act of 2002 (H.R. 4954), passed by the House on June 28, 2002. The House bill would create a new Medicare Benefits Administration to oversee both the Medicare drug benefit, delivered by private entities, and the health plans in the Medicare+Choice program.

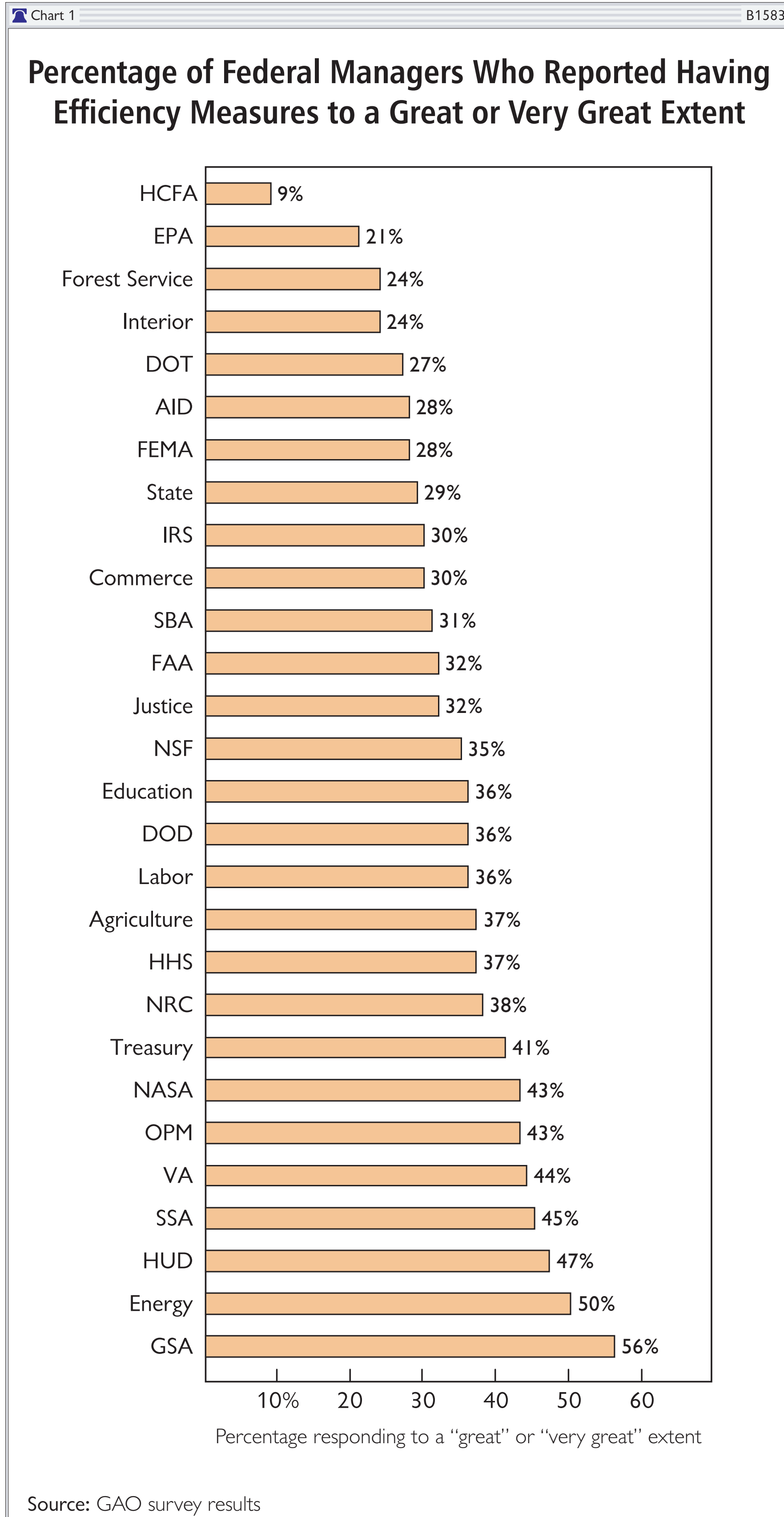


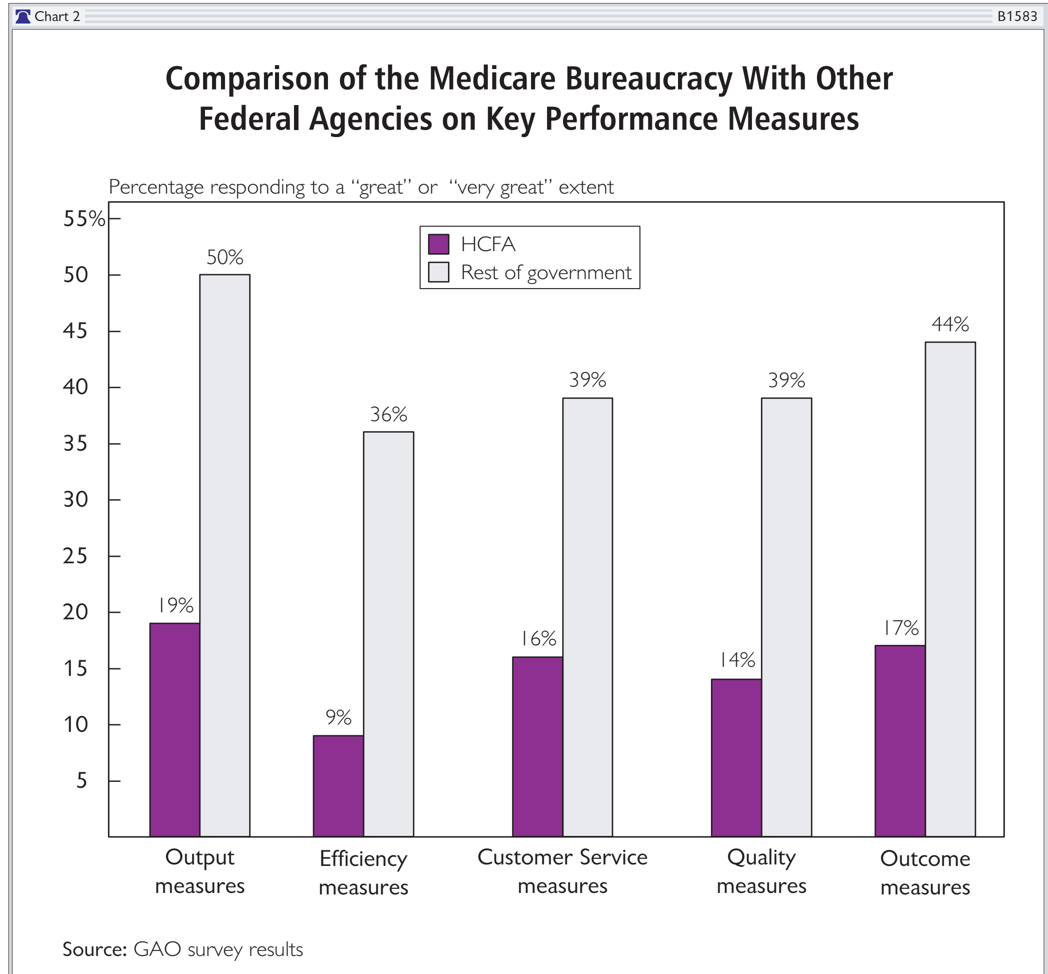
Chart 1
B1583
Percentage of Federal Managers Who Reported Having Efficiency Measures to a Great or Very Great Extent
HCFA 9%
EPA 21%
Forest Service 24%
Interior 24%
DOT 27%
AID 28%
FEMA 28%
State 29%
IRS 30%
Commerce 30%
SBA 31%
FAA 32%
Justice 32%
NSF 35%
Education 36%
DOD 36%
Labor 36%
Agriculture 37%
HHS 37%
NRC 38%
Treasury 41%
NASA 43%
OPM 43%
VA 44%
SSA 45%
HUD 47%
Energy 50%
GSA 56%
10% 20 30 40 50 60
Percentage responding to a "great" or "very great" extent
Source: GAO survey results

Centers for Medicare and Medicaid Services or CMS) was below the rest of the government in aspects of agency climate, the use of performance information, and especially performance measurement. The agency ranked statistically significantly lower than the rest of the government for survey items concerning the percentages of managers who reported that managers were held accountable for results; reported having five different types of performance measures; and indicated that they used performance information for four management tasks. In all other areas, HCFA was not significantly different from the rest of the government. Of the 28 agencies surveyed, HCFA rated significantly lower than the rest of the government on more of the survey items…than any other agency except for the Federal Aviation Administration.[8]

- **For years, the Medicare bureaucracy has failed to improve its managerial performance in any significant way.** Since 1997, there have been numerous congressional inquiries and investigations into the managerial and governance problems of the Medicare bureaucracy. These oversight efforts apparently have made little difference in the managerial culture of the agency. According to the GAO report, the CMS, despite being one of the poorest performers among the 28 federal agencies studied, had made little or no managerial improvement since 1997 (the last year that the GAO conducted a similar review of the performance of federal agencies).
- **The Medicare bureaucracy scored low among federal managers in having measures for efficiency.** The GAO report surveyed federal managers to determine whether they had included "efficiency" measures within their management evaluation system. Only 9 percent of CMS managers reported that they had specific types of performance measures for efficiency to a "great extent" or a "very great extent."
- **The Medicare bureaucracy ranks at the bottom in key management performance measures.** The CMS recorded the lowest percentage among managers in the 28 agencies in reporting key performance measures. For example, when asked whether they had specific performance measures to "a great extent or a very great extent," only 17 percent of CMS managers said that they had "outcome measures" that would "demonstrate to someone outside of the agency whether or not the intended results were being achieved";[9] only 19 percent of CMS managers responded that they had "output measures that tell how many things were produced or services provided";[10] and only 14 percent of CMS managers reported that they had "quality measures that tell about the quality of the products or services provided."[11]
- **The Medicare bureaucracy scores next to last in measuring accountability for the results of their work.** When asked whether or not they were held accountable for results to "a great extent" or a "very great extent," 63 percent of surveyed federal managers said that they were held accountable. Of all the federal managers, CMS ranks next to the bottom in terms of accountability for results. Only 42 percent of CMS managers reported positively on that measure. (The lowest percentage—40 percent—was reported by the federal managers in the Forest Service.[12] Managers at the IRS, the Veterans Administration, and the Department of Housing and Urban Development all reported higher positive percentage responses.)

8. *Managing for Results*, p. 101.
9. *Ibid.*, p. 10.
10. *Ibid.*
11. *Ibid.*

- **The Medicare bureaucracy ranks low in the use of performance information.** In managing programs, federal managers typically use "performance information" to set priorities, allocate resources, or adopt new programs. As the GAO investigators reported, "The fundamental reason for collecting information on a program's performance is to take action in managing the program on the basis of that information."[13] CMS management ranks very low in the use of such information. Just 27 percent of CMS managers reported that they used "performance information" to "a great extent" or to a "very great extent" in setting program priorities. Only the National Science Foundation, with a 26 percent response rate, ranked lower.[14] Similarly, only 29 percent of CMS managers reported that they used "performance information" to a great extent or a very great extent in allocating the agency's resources. Once again, only the National Science Foundation, with a 24 percent response rate, ranked lower.[15]



MICROMANAGED AND OVERWHELMED

The less than impressive CMS showing in meeting the performance objectives of the Government Performance and Results Act of 1993 is evidence of systemic structural weaknesses. It is also another indication that the Medicare bureaucracy today is simply overwhelmed by congressionally imposed responsibilities. This latter view is also broadly shared by prominent health policy analysts—regardless of their views on Medicare reform or their political or philosophical differences.[16]

12. *Ibid.*, p. 18.
13. *Ibid.*, p. 29.
14. *Ibid.*, p. 30.
15. *Ibid.*, p. 31.
16. See Stuart Butler *et al.*, "Crisis Facing HCFA and Millions of Americans" *Health Affairs*, Vol.18, No.1 (January/February 1999), pp. 8–10. The piece is subtitled "Open Letter to Congress and The Executive" on the subject of the Medicare bureaucracy and its governance problems, signed by a diverse group of 14 top health policy analysts, including two former directors of HCFA (now CMS).

In recent years, the CMS's regulatory responsibilities have multiplied. According to a recent report of the National Academy of Social Insurance, the Balanced Budget Act of 1997 alone included 359 actions that required CMS implementation; the Balanced Budget Refinement Act of 1999 included an additional 126 provisions that required CMS implementation; and the Medicare, Medicaid, and SCHIP Benefits Improvement Act of 2000 included another 152 provisions that required CMS implementation.[17] As the authors of the NASI report also note, in recent years, congressional statutory construction has become increasingly specific, narrowing the agency's options and undercutting its ability to react and respond to the rapidly changing environment in which it must operate.

While no academic or public policy institution has yet released an analysis of the projected CMS managerial requirements under the various House and Senate Medicare prescription drug proposals debated in 2002, seniors can be certain that they would be formidable.

STEPS CONGRESS CAN TAKE TO ENSURE SUPERIOR MEDICARE DRUG MANAGEMENT

The problems of Medicare's management cannot be solved simply by spending more money, raising Medicare officials' salaries, hiring more staff, or securing better computers or superior software. The problems of the Medicare bureaucracy, including its inflexibility and managerial backwardness, are deeply rooted in an outdated system of central government planning and price regulation—the institutional legacy of the 1960s.

Medicare's serious managerial problems have crucial implications for the prospects of a Medicare prescription drug policy. Rather than massively increasing the regulatory obligations of CMS in the administration of a complex prescription drug benefit under a new Part D Medicare program, Members of Congress should look for a less expensive, quicker, more reliable, and more efficient way to deliver prescription drugs to senior citizens, independent of an agency that is struggling with its existing responsibilities.

STEP #1. Target dollars to poor seniors who do not have access to drug coverage. The best short-term option is to create a federally subsidized system of prescription drug accounts for low- and moderate-income seniors that can be accessed through a Medicare prescription drug debit card. The card could be used to purchase prescription drugs directly at a pharmacy or through a health plan of choice. This system has the advantage of maximizing flexibility and innovation in the delivery of prescription drugs while targeting taxpayers' dollars to seniors who need the most help. In comparison to most other Medicare drug proposals, it is administratively simple. Moreover, it would not displace existing drug coverage for seniors and would allow for adjustments to the program over time. Health policy analysts at the American Enterprise Institute and the Galen Institute have developed plans for such a program at a cost, estimated by Price/Waterhouse/Coopers, of $302 billion over a ten-year period.[18]

STEP #2. Scale back CMS management responsibilities and allow the agency to focus on traditional Medicare. The CMS has a responsibility to comply with the Government Performance and Results Act of 1993, as other federal agencies do. When overwhelmed with a variety of disparate responsibilities, it is hard for the CMS managers and staff to make headway in transforming their organizational culture, as the GAO urges, "to improve decision-making, maximize performance, and assure accountability.[19]

17. *Final Report*, pp. 7-8.

18. For a brief description of the plan, see Joseph Antos, Grace-Marie Turner, and Robert E. Moffit, "Time for a Sensible Medicare Drug Benefit," Heritage Foundation *Backgrounder* No. 1573, July 23, 2002.

19. *Managing for Results*, p. 5.

The CMS is supposed to accomplish this transformation while administering or overseeing a variety of disparate health care programs: Medicaid, the huge federal-state health care program for the poor and the indigent; the State Children's Health Insurance Program (SCHIP); the enforcement of certain provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA); and the administration of Medicare Part C, the Medicare+Choice program, a heavily regulated system of private health plans for seniors.

Congress should at least scale back CMS management responsibilities such as those under Part C, the beleaguered Medicare+Choice Program. The best way to do this would be to create a separate agency that would negotiate rates and benefits with competing plans in the Medicare+Choice program, just as the high-performing U.S. Office of Personnel Management currently does with private health plans in the FEHBP. This would allow the CMS to concentrate on administering the huge and complicated Part A and Part B components of the traditional fee-for-service program more effectively.

It is worth noting that the House of Representatives has already taken a major step in this direction with the recent passage of the Medicare Modernization and Prescription Drug Act of 2002 (H.R. 4954). The House bill would create a Medicare Benefits Administration that would both oversee the implementation of a prescription drug benefit through private-sector entities and plans and improve the administration of the troubled Medicare+Choice program. Under the House bill, there is also a limited demonstration program for an FEHBP-type payment formula for competing health plans in several areas of the country.

STEP # 3. Start the process of Medicare reform by allowing new retirees to bring their private coverage into retirement with them and receive support to offset the cost of premiums. Medicare patients would be far better served by a managerial system and climate that rewards performance, innovation, and customer service. That kind of system can best be achieved through the discipline of market competition, where patients can pick and choose their health plans so that health plans could maintain their market share only by providing quality, service, and customer satisfaction.

Paradoxically, in the area of health insurance today, this sort of direct accountability to customers prevails not in conventional private-sector health insurance managed by employers, but in the unique public-sector Federal Employees Health Benefits Program. By allowing newly retired Americans to keep their private health care coverage–including drug coverage–and bring it into retirement as their primary coverage, Congress could start the process of transforming Medicare into a program that resembles the FEHBP.

For the next generation of seniors, in particular, there is much to be gained from such a transformation. For one thing, the management and administration of the program could be conducted by a high-performing agency such as the Office of Personnel Management, the agency that administers the FEHBP. The OPM does not pump out tens of thousands of pages of rules and regulations, bury doctors in paperwork, or micromanage every facet of the financing and delivery of health care for FEHBP enrollees as the CMS does today with regard to those enrolled in the Medicare program. The OPM, in effect, shares the administration of the FEHBP with private plans that have powerful economic incentives to perform in a highly competitive environment. Performance measures are often a key to success for private firms, for whom failure to get results means lost revenues.

In an open, pluralistic, and competitive system, Medicare patients would have the right to choose the health plan that best meets their needs. If patients were dissatisfied with a health plan's quality, service, or benefit package (including its drug coverage), they could secure a better one. In this scenario, health plans would have a powerful incentive to respond to patients' wishes. In a competitive environment, poor performance or unresponsiveness to customers is quickly punished by a loss of market share.

CONCLUSION

Seniors rarely, if ever, come face to face with an employee of the CMS, the powerful regulatory agency that runs the Medicare program upon which they depend. In this sense, the Medicare bureaucracy is largely insulated from its "customers." For the most part, the agency's interaction with senior citizens is indirect—its interaction is with Medicare contractors and the doctors, hospital officials, and other health care professionals who deliver medical services to senior citizens.

But seniors' insulation from the Medicare bureaucracy is superficial. Seniors today are, in fact, profoundly affected by what officials of the CMS do or do not do and how well they do it. Seniors cannot escape the managerial culture that pervades the powerful regulatory apparatus governing the Medicare program. The impact of the CMS on their personal lives will be even greater if the agency is entrusted with the management of financing and delivering their prescriptions, if it is given broad authority to regulate the drugs to which they will have access, and if it is allowed to determine what kinds of formularies will be used in controlling the costs of drugs or how drugs will be priced.

Medicare's financial and managerial problems are broadly acknowledged among health policy analysts, regardless of their political opinions or philosophical leanings. In addition, there is strong evidence that an unhealthy managerial culture and climate also lies beneath Medicare's programmatic difficulties. The management of the Medicare bureaucracy is far below that of other federal agencies. It is the weakest in terms of having standards for efficiency, and it ranks well below the rest of federal agencies in having measurable standards for performance—particularly, in terms of achieving results, in measures of quality, and in customer satisfaction.

However, in spite of Medicare's work overload and management problems, many Members of Congress still hold fast to the unfounded belief that the CMS would somehow outperform private organizations in managing a drug benefit within the current structure of the Medicare program. Too many view the Medicare management problem as primarily a problem of resources. However, Capitol Hill partisans of the Medicare bureaucracy are profoundly mistaken if they believe that the answer to Medicare's serious management problems is simply an increase in CMS funding and staff.

If Congress wants to ensure reliable prescription drug coverage for the nation's senior citizens and guarantee that this coverage will be managed efficiently with a clear focus on patient satisfaction, it should design a new system that incorporates personal choice and market competition, as the FEHBP does. Medicare patients should have the right to choose a better health plan. They should have the means to choose one that best meets their needs and secure the drug coverage that their doctors think is best for them. These crucial decisions should not be entrusted to a Medicare bureaucracy that, even now, is overwhelmed and facing a managerial crisis.

—*Robert E. Moffit, Ph.D., is Director of Domestic Policy Studies at The Heritage Foundation.*