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HEALTH CARE FINANCING ADMINISTRATION'S ROLE AND READINESS IN MEDICARE REFORM

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HEALTH CARE FINANCING ADMINISTRATION'S ROLE AND READINESS IN MEDICARE REFORM

THURSDAY, MAY 4, 2000

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 9:30 a.m., Hon. Charles E. Grassley presiding.

Also present: Senators Hatch, Moynihan, Rockefeller, Breaux, Graham, and Bryan.

OPENING STATEMENT OF HON. CHARLES E. GRASSLEY, A U.S. SENATOR FROM IOWA

Senator GRASSLEY. I thank everybody for coming to this, our fifth Medicare reform hearing planned by the Finance Committee this spring. We have always had good attendance and good witnesses and good discussions, and we have had even debate among ourselves who are members of the committee, and we think it is a very healthy process as we work forward to what we all understand is ultimate decisions somewhere down the road, and hopefully not so far down the road, when we make policy decisions on Medicare.

Now, today we will take testimony on a very critical question, and that question is, what is the Health Care Financing Administration's role and readiness in Medicare reform.

I am pleased to chair this hearing, and I am doing it because Senator Roth has been away for an operation. He is coming along very well and we thank God that he is coming along well, and will return to us very shortly.

But I am doing it at his request in order to continue the public record that he has established as Chairman, preparing members for meetings and decision making that has to take place on Medicare reform, which he hopes to do shortly after he returns.

Many members believe that major reforms are required to modernize the Medicare program and keep it viable. Enormous fiscal and benefit design pressures will be exerted by the doubling of the beneficiary population to over 80 million individuals, and that is going to occur when baby boomers start to retire after the year 2010.

So in less than 20 years, it is estimated that fully one-fifth of all Americans will be enrolled in Medicare. It is crucial that we have governance structures in the executive branch that will be effectively and efficiently managing the Medicare of the future.

Certain reforms under consideration, such as health plan competition and prescription drug benefits, may require resources, flexibility, and surely expertise, that do not now exist in HCFA.

In fact, many members question whether it is possible to instill such changes in HCFA and instead have suggested other management principles. I would suggest to my colleagues as they listen to the testimony that there are four broad possible options, and we have a chart here that I will not necessarily refer to, but you can refer to it. Variations on each of these options and combinations are possible, so the chart is not a definitive statement.

First, we can work to effect marginal changes inside the agency we have, which is the Health Care Financing Administration. Second, we could establish a Medicare board with oversight responsibilities. Let me emphasize the word oversight, because that would be designed mainly to inject new external expert perspectives into the Health Care Financing Administration planning and decision making.

Third, we could establish a Medicare board which would be fit with operational responsibilities and which would provide the fiscal and staffing resources that those responsibilities would require.

Then, lastly, it has been 23 years since the Health Care Financing Administration was assembled from its predecessor agencies, the Bureau of Health Insurance in the Social Security Administration, and the Social Security Rehabilitation Services Agency.

Perhaps our fourth option could be then to reassess the diverse responsibilities that have been added to the Health Care Financing Administration since then and fundamentally reengineer both where and how in the executive branch these programs would be managed in the future.

This would require an evaluation of the Health Care Financing Administration's numerous non-Medicare responsibilities, as an example, Medicaid health insurance, portability regulations, clinical laboratory standards, among others, and whether those functions could be better handled elsewhere in the Department of Health and Human Services. This longer term effort would not preclude decisions now on a Medicare board.

In closing, I would like to have you keep these things in mind: the significance of the Medicare program to American families, a social contract between government and people, or let us say a social contract among the American people; second, the magnitude of the responsibilities and resources required to administer an enterprise the size of the Medicare program; third, the role of Congressional oversight in ongoing Medicare modernization efforts. Everybody knows that I feel that our oversight roles are equally as important as our legislative responsibilities.

Fourth, the necessity of ensuring continuity in services to beneficiaries, and in relationships with health care plans and providers.

I would like to thank our witnesses in advance for their contribution to this very important debate.

Now I turn to our distinguished Ranking Member, Senator Moynihan.

OPENING STATEMENT OF HON. DANIEL PATRICK MOYNIHAN, A U.S. SENATOR FROM NEW YORK

Senator MOYNIHAN. Mr. Chairman, I would just like to continue what you have said, having completely agreed with it all, and would mention that it was our revered Chairman who began this series and it has been open, exploratory, and certainly bipartisan.

I do not know whether we are up to this. The capacity for large institutional change comes intermittently, at most. If you think of the history of social insurance in this country, and I really have to go back and read up on it, and many of our witnesses will know it better than I, but I see sort of a 30-year cycle at work, starting, I think, in 1905.

I think Wisconsin adopted a workman's compensation law, the first in the country. That was John R. Commons and that group at the university, the American Association for Social Insurance, which would meet simultaneously with the American Economic Association, and they began to bring in the ideas that had developed in Europe. Bismarck had established an old-age pension.

In 1911, the British adopted unemployment insurance. They had good enough databases to do it. Churchill, actually, then a liberal, carried the bill.

We started talking about health insurance in the 1920's, but there was a lot of opposition. The American Medical Association, then located in Chicago—still may be; Washington did not seem relevant—was quick to go on about socialized medicine, not very intelligently.

But the AF of L, under Samuel Gompers, was against government health insurance. An old union man, he thought people should get benefits such as that from their union contract.

Then came the convulsion of the Great Depression in 1935. It was very chancy, finding a way to put together unemployment insurance and widows' pensions. Widows' pensions had begun rather the same way as workman's compensation, as State measures, to take care of children, and Social Security as a retirement benefit.

Probably the only reason it happened was that Frances Perkins, at a tea party, had a conversation with a justice of the Supreme Court, Hardin, I believe, and he asked her what she was doing. She was a master—I should say mistress—at getting great men to do things for her because she was so small and helpless and did not understand. It was big Tim Sullivan at Tammany Hall under Al Smith, and things like that.

She explained this wonderful new idea for social insurance retirement benefits. She said, but you great men, every time we do something, you say it is unconstitutional. He said, tell me a little more.

She told him. Then he leaned over and whispered to her, the taxing power, my dear. All you need is the taxing power. That is why we are holding hearings on health insurance. [Laughter.]

She learned it. About half of the members of the U.S. Senate do not know it. [Laughter.] It may be we are not the persons best equipped to do it, but we are the only ones that constitutionally can.

Thirty years after that, we created Medicare. I was in government at the time and knew the people who did it. They thought

they were starting a program that might cost about $4 billion a year. Of course, it has grown into a huge program.

Then 30 years go by. But this time, in the 30-year cycle, instead of adding some new provision like the things that Senator Kerrey and I have been talking about, thrift savings plans where you acquire a little wealth, we repealed the provision for children in the Social Security Act.

The major social legislation of this last decade was the repeal of Title 4(a) of the Social Security Act, something you could not believe. No Republican would be so bad as to do that. It took a Democrat.

I am sorry I am rambling a bit. But I am telling you, as I look about, I do not see the institutional capacity, but I would love to hear what our witnesses have to say.

Senator GRASSLEY. Probably the answer to your question is, what did we get 51 votes to do?

Senator MOYNIHAN. No, sir. I went through that in health care. We had that health care initiative which crashed. It got out of this committee, but they would not touch it because it was not perfect.

But our argument with the administration, which did not know that these matters came to the Finance Committee, was that on things like this, either you have 80 votes or you have 40.

Senator GRASSLEY. All right. Well, I will accept the 80-vote rule, too, as well.

Now, all of you be prepared. You will not get out of the room until Professor Moynihan passes out his test and you respond in a passing way.

Thank you very much for that background.

Senator MOYNIHAN. Thank you, sir.

Senator GRASSLEY. We have Nancy-Ann Min DeParle, Administrator of the Health Care Financing Administration. She will be our first witness. Would you come, please?

Then we have Ed Flynn, the Associate Director of the Retirement and Insurance, Office of Personnel Management. Would you come? We will take you in that order, and we thank you very much.

Administrator Min DeParle, you have been before us many times and have been very cooperative, and we appreciate very much your expertise in working with us, not only in this committee, but I have had outstanding cooperation with you in my capacity as chairman of the Aging Committee on a lot of HCFA rules and enforcement efforts. Thank you.

STATEMENT OF NANCY-ANN MIN DePARLE, ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION (HCFA), WASHINGTON, DC

Ms. DEPARLE. Thank you, Mr. Chairman and Senator Moynihan. I want to thank you for inviting me here to discuss the management of the Medicare program, and also thank you, Mr. Chairman, for the fine and vigilant oversight that you have shown in your various capacities here.

My written testimony outlines a number of the administration's concerns about some of the proposals that this committee has been carefully considering, so I will not go into detail about those this morning.

Instead, I would like to put today's discussion in context as we look together at where Medicare has been and where it is going.

Medicare is strong and it is getting stronger. We are providing beneficiaries with better and clearer information about the program and their rights and options. In fact, you and many other members of this committee have helped us with those efforts.

We are streamlining and becoming more accessible to the public through such things as our new open coverage determination process. We are getting our financial house in order. We met the Y2K challenge. We worked very hard to implement the Balanced Budget Act, and the Medicare trust fund is now projected to be solvent until 2025.

The people who work at HCFA care deeply about the beneficiaries we serve. I am proud of what we have achieved and we are committed to making further improvements because we know those are necessary.

This summer, for example, we will have a new 1-800 number for every physician, and hospital, and provider so they will have a place to call with questions. We are assessing our work force and bringing in more new staff with private sector expertise.

Physicians now oversee the critical areas of Medicare payment, both for fee-for-service and managed care contractors and coverage. We are committed to finding more ways to streamline the bureaucracy and simplify our rules.

I also want to acknowledge your concerns about the impact that the Balanced Budget Act has had on health care providers in your States. I have heard your concerns about the impact on these same providers as well as our unprecedented efforts to reduce waste, fraud, and abuse.

Those efforts were necessary, as was the Balanced Budget Act, but, in fact, I believe I have spoken with every single member of this committee over the last year about concerns you have about the impact of them on your constituents.

HCFA has worked hard to be faithful to Congress' intent in developing each of the BBA's 335 statutory changes, which represent the most significant reforms since Medicare's enactment 35 years ago.

To put this all in context, Mr. Chairman, we have done this while launching the new State Children's Health Insurance program, meeting our Y2K challenge, implementing a new, open, and accountable Medicare coverage process, and working to improve quality in our Nation's nursing homes.

We have done all this while undergoing more than 1,100 oversight reviews and audits from our Inspector General and the General Accounting Office in the past two and a half years that I have been the Administrator.

Mr. Chairman, we have done all of this with an administrative budget that hovers around 1.5 percent, much lower than any insurance company in the private sector, so I am proud of our record.

Implementing the BBA has been hard and unprecedented work, but it has been necessary work that is paying off for beneficiaries today and in the future. I think we have turned a corner now, with most provisions in place or about to be completed.

The adjustment period for providers around the country is coming to a close, and I think it is important for us to keep that in mind as we consider how to improve HCFA's administration of Medicare.

Yes, we can do more to help providers. We are going to continue improving our accessibility and simplifying things so that we are more accountable to providers and beneficiaries. We are going to strengthen, with your help, our National Medicare education program.

We are going to continue to conduct more town hall meetings with provider groups, more visits to senior centers, national conference calls with physicians and home health agencies and others, so that we can hear directly from beneficiaries and providers about their concerns. To do all this, we will need stable and adequate funding. The President's budget asks for this funding, and we hope that you will again provide it to us.

What we should not do is just move the boxes around or engage in change just for the sake of change. I believe we must be sure that, if we are making changes to Medicare's governance, that we make them with the 39 million Americans who depend on Medicare in mind.

I appreciate the help many members of this committee have given me over the past year. You have helped us to identify problems and get resources to deal with them. You have been understanding about the difficulty and the magnitude of the job that we are trying to do, and I think your remarks this morning reflect that.

We share the same goals. We all want Medicare, Medicaid, and the State Children's Health Insurance Program to be strong, well-managed, and fiscally sound. We all want to put the beneficiary first, and we all share the vision of HCFA as an efficient, accountable, and effective agency.

So on behalf of the 4,500 HCFA employees who have worked so hard this past year, I want to thank you for your interest and support and for your help in achieving the goals that we all share. Thank you.

Senator GRASSLEY. Thank you, Ms. DeParle.

Now we will turn to Mr. Flynn.

[The prepared statement of Ms. DeParle appears in the appendix.]

STATEMENT OF ED FLYNN, ASSOCIATE DIRECTOR OF RETIREMENT AND INSURANCE SERVICES, OFFICE OF PERSONNEL MANAGEMENT (OPM), WASHINGTON, DC

Mr. FLYNN. Thank you, Mr. Chairman and members of the committee. I appreciate very much your invitation to be here today and to discuss the Federal Employees Health Benefits Program and its relationship to Medicare.

Frequently cited is a model that others might emulate. Many aspects of the program can be useful in other contexts, and some of them have been adapted in the Medicare program. While there are areas of similarity, it is important to understand each program's fundamental differences as well.

Federal Employees Health Benefits Program is part of the compensation package offered by the government. It enables the government to employ and retain individuals who carry out vital public work.

We arrange health care for a population of approximately 9 million, including 2.3 million employees, 1.9 million retirees and members of their families. In 1999, the program accounted for about $18 billion in annual premium revenue.

Now, in preparation for this hearing, the Congressional Research Service provided you with an excellent summary of the Federal Employees Health Benefits Program and how it operates. Rather than repeat that, I would like to summarize just a few points.

First, while all participating plans provide a core set of benefits, there is no standard benefit package. Even where coverage is nearly identical, cost sharing provisions may differ significantly among plans.

Second, premiums are negotiated with our fee-for-service plans based on their claims experience. About 93 cents out of every dollars is paid out in direct benefits; the remaining 7 cents covers the plan's administrative costs.

For health maintenance organizations, negotiations are based on a community rate and adjusted for any number of reasons, including changes we might require to their basic benefit package.

Our administrative expenses for this program amounted to $20 million last year, and that includes salaries for about 176 full-time staff. We rely heavily on employing agencies to provide a variety of enrollment services to members. Processing enrollment activity and disseminating information are chief among these, particularly during the annual open season.

The participating health plans handle most elements of plan design and delivery. We work closely with plans to develop materials which assist our members in comparing available options.

The introduction of Medicare+Choice provides a number of health plan alternatives to traditional Medicare. With an annual open enrollment period, Medicare+Choice parallels key features of our program, competition among health plans and informed consumer choice.

HCFA disseminates general and comparative information in advance of enrollment periods, incorporating quality and performance indicators for plans. HCFA promotes an active, informed selection among available options.

In these areas, OPM's roles and that of HCFA are very similar. However, OPM's job is eased greatly because most individuals enroll in our program as active employees and are very familiar with it; no similar parallel exists for retirees with Medicare.

It is also worth noting that we benefit greatly from HCFA's power and resources in a number of ways. For example, HCFA funds research to develop standards for treating chronic diseases like diabetes that we can then in turn disseminate to our health plans. HCFA creates standards for hospitals that define national norms, not just to the benefit of our members, but to others as well.

Similarly, we and HCFA participate in a number of collaborative efforts. We sponsored a two-day conference with the Agency for Health Care Research and Quality entitled "Making Quality

Count," the outgrowth of which has been continuing collaboration on information and a web site for consumers.

HCFA and OPM co-chair the Patient and Consumer Information Work Group of the President's Quality Interagency Coordination Task Force. In this capacity, we developed information about health care quality and the Patient's Bill of Rights for consumers and health care purchasers. In addition, the work group has developed a glossary of common terms for use in consumer information.

Also, since the FEHB program serves a large Medicare-covered population, our membership on the Coordinating Committee for the National Medicare Education Program has helped us inform our members about their Medicare benefits.

These are only a few of the ways in which our similarities have allowed us to partner, and we will continue this collaboration.

Although there are similarities, there are also fundamental differences. While the Federal Employees Health Benefits Program is part of a compensation package, Medicare is a national entitlement program many times our size. Medicare serves a much broader population under different conditions, making its administrative structure necessarily more complex.

Finally, there are some aspects of Medicare that may benefit the Federal Employees Health Benefits Program. Standardizing benefits and contracting for certain services are both matters we have considered that have been used in the Medicare program.

Nevertheless, the differences in our mission, our customer base, our size, and our funding mechanisms all argue for careful consideration before adoption.

Mr. Chairman, that concludes my opening remarks. I would be happy to answer questions you or other members of the committee may have.

[The prepared statement of Mr. Flynn appears in the appendix.]

Senator GRASSLEY. All right. We will take 5-minute turns and do it in the order that Senators have arrived.

My first question would be to Administrator Min DeParle, and this is in reference to a letter that was sent by Secretary Shalala to Representative Andrew Jacobs. He was then chairman of the Ways and Means Subcommittee on Social Security.

This letter expressed the administration's support for making the Social Security Administration an independent agency. Now, of course, we have legislated it as an independent agency. We have done that within the executive branch, but outside of the Department of Health and Human Services.

So my first question, is an explanation from you for the administration why the administration supported the establishment of an independent agency in that context, but would apparently not support a similar concept for Medicare.

Ms. DEPARLE. Well, Mr. Chairman, I did look at this letter last night. I actually believe that it is consistent with the analysis that we have provided of some of the proposals that you are considering.

I think that this SSA independent agency is very different than the kinds of proposals that I have heard at least so far for HCFA. The Secretary's letter says, "The administration supports a single executive, a commissioner appointed by and responsible to the President." She makes the point that we have concerns about the

establishment of a new advisory board. She raises some concerns about constitutional issues. So I actually think it is consistent.

The administration believes that there must be accountability, that the appropriate place for a program of this size is in the executive branch, reporting to the President. I believe that this letter about SSA and the independent agency is consistent with that position for Medicare as well.

Senator GRASSLEY. Can I interpret what you just said then as saying, since we did do it with the Social Security Administration, that it would be all right, in your judgment, then, to do it for Medicare?

Ms. DEPARLE. Well, no, sir. I have not spent time looking at that because, as I said, this is the first I have heard of that as an idea, of making HCFA like SSA.

Senator GRASSLEY. Well, we are kind of thinking along terms of number three. I mean, my question, I think, would be most reflective of the third option.

Ms. DEPARLE. The third option, though, as I see it, is different than the way the independent SSA is. We have experts in the room on that, so I am a little bit timid about venturing there.

Senator GRASSLEY. All right.

Ms. DEPARLE. But I do not believe SSA has an operational board running it. In fact, one of the interesting things I found about the information for this hearing the CRS materials about the history of SSA and the original, I guess, three-member board that ran it, and how those members themselves said it does not work to try to have three people operating something.

So if that is what number three means, then no, sir, I would have concerns about that from an operational standpoint.

Senator GRASSLEY. All right. I will leave it for now and maybe follow-up later on with something.

I want to move on now to Mr. Flynn. This is along the lines of what you have had experience with. One of the issues that this committee is examining at present is how to enhance the availability of outpatient prescription drug coverage for Medicare beneficiaries, so I would like to have you describe for the committee your experience in administering such a benefit through the Federal Employees Health Benefits Program.

Mr. FLYNN. I will try and do that very quickly, Senator Grassley.

You are correct that the Federal Employees Health Benefits Program does provide a prescription benefit. It has ever since its inception in 1960. Like any other health care purchaser, we have seen the tremendous value that prescription drugs have in terms of helping people through acute medical situations and in helping people deal with chronic diseases, extending life, and so on, and so forth. We have also seen the cost impact of that.

But I think the overriding point that I would make, is that prescription drugs are an important component of health. In the Federal Employees Health Benefits Program, it is an integral part of the benefits package. We have seen in recent years increases in the costs of drugs.

We are wrestling with that, as any health care purchaser would, in terms of encouraging our 300 health plans to manage that benefit appropriately, instituting co-payments where that seems appro-

priate, encouraging the use of generic as opposed to brand-name drugs where there is a therapeutic equivalent in terms of their effectiveness, using pharmacy benefit managers to pull together large purchasing power and achieve discounts so that we can get cost savings.

And, as I said in my testimony, we have looked at, from time to time, ways in which we might even be able to aggregate the entire purchasing power of the FEHB.

I guess, in summary, we have a comprehensive prescription drug benefit. It is important to the health of our members. In recent years, we have seen cost increases and we are doing everything we can to attempt to manage them, but it is an integral part of our program.

Senator GRASSLEY. Let me quickly follow up with just one related to something you suggested. Since you have younger, healthier enrollees that you have in your program, what has been your recent experience then with prescription drug costs of the program?

Mr. FLYNN. In general, in the program, Senator Grassley, prescription drugs account for about one dollar out of every four in claims cost in the program.

Senator GRASSLEY. Twenty-five percent?

Mr. FLYNN. About 25 percent. Yes, sir.

Senator GRASSLEY. All right. I am going to follow up after the other members have had some time. I will follow up with you, Ms. DeParle, on some questions.

Senator Moynihan?

Senator MOYNIHAN. Yes, I think that is wonderful, that one in four. There was a nice moment in the hearings we had on the President's health care proposal, and we had three wonderful deans down there. I asked them, what are we going to do about Baumoli's disease. There was this wonderful moment, and they all looked to the left and right, and did I miss that lecture, what on earth? [Laughter.]

Baumol is, of course, an economist, a distinguished one, president of the American Economic Association, getting interested in the performing arts, as he was in the 1960's. He and his wife were opera fans, and they were wondering, why is the Metropolitan Opera orchestra always on strike?

The more they looked into it, he said, I am an economist, I ought to know something about that. He came up with the simple proposition of the cost disease of the personal services. In some things, productivity just does not appear. If you play the Minute Waltz in 50 seconds, it is not the same. You have not really improved things.

So the more people take pills, the less they have to see doctors. You can turn out pills with vast efficiencies of size and so forth, but doctors remain a very necessary, but increasingly costly, activity as compared to those activities in which you have productivity gains. There is no way around that.

There is more for my friend from Louisiana here. Last Tuesday, the New York Times had a long interview with Victor Fuchs, who is an economist. You recognize him, Ms. DeParle. He is emeritus at Stanford, but he is head of the Stanford Center for Biomedical Ethics. He is a research associate with the National Bureau of Eco-

nomic Research, and past president of the American Economist Association, and so forth.

He was recently visiting Princeton and lecturing and said, what are the prospects of major health care reform? He answered, the Clinton plan was a combination of ignorance and arrogance and it turned out to be a disaster. He goes on to say, I have been on record for a long time saying that I only see a major health care reform coming to the U.S. in the wake of a war, a large-scale recession, or a large-scale civil unrest.

Now, if you could go out and get one of those three, or all three, going, I think the Breaux plan would have great prospects. [Laughter.]

But what I would like to ask is, the one thing I found missing from your comments, Ms. Deparle, was any reference to teaching hospitals and medical schools, because that is one crisis that has come along.

In this whole era of managed care and so forth, we have markets emerging. Markets do not provide for what economists call a public good, which everybody shares in, but nobody is going to pay for. We have been paying for our teaching hospitals and medical schools through Medicare and Medicaid. It was not designed to be that way, it was just that we could work it out in the committees, and so forth. You are nodding. I would like to tell the people back there, Ms. DeParle is nodding in agreement.

Do we not have to have some separate mode of providing for medical schools and teaching hospitals?

Ms. DEPARLE. I think eventually we do, Senator. I was elliptical in my reference to——

Senator MOYNIHAN. Now, remember, eventually we are all dead.

Ms. DEPARLE. I think Professor Fuchs, or his colleagues, or Professor Baumol said something about that as well. In fact, my reference to academic health centers and teaching hospitals was perhaps too elliptical. When I said that over the past year I have felt the pain of the providers who have been going through the Balanced Budget Act——

Senator MOYNIHAN. Wait. Wait. Wait. Wait. We will not hear any more about, I feel your pain. [Laughter.]

Ms. DEPARLE. That is part of what I meant. I have met with the ones in New York, as well as many around the country.

I approached this the same way you did. I asked one day, what were we thinking when we said Medicare was going to be the place where this was funded? What I was told by someone who was historian was, at the time there was a surplus in Medicare, there was extra money there, and it seemed like a good place to go.

But I think, over the long run, it is a public good and we need to work together on a better way of financing it. You have had a proposal, the administration has talked about it.

Senator MOYNIHAN. I could not agree more and am delighted that you say so. Could you get that historical reference: that there were surplus monies in Medicare?

Ms. DEPARLE. I probably can. Yes, sir.

Senator MOYNIHAN. I mean, this is the way many, many things happen in the world. It is nothing unusual. But it is no longer the

case, and we ought to address this matter independently, I think, and you seem to agree. Life is wonderful.

Mr. Flynn, do you agree?

Mr. FLYNN. Well, I think, Senator Moynihan, as I said in my remarks, that we have benefitted very much from some of the programs that HCFA does administer. I think the teaching hospitals, the academic centers, and how that permeates the health care economy provides benefits to our members and is not something that you see necessarily in our costs.

Senator MOYNIHAN. It is a public good. Thank you very much.

Thank you, Mr. Chairman.

Senator GRASSLEY. Thank you.

Now I go to Senator Breaux, then after Senator Breaux it will be Senator Bryan, then after Senator Bryan, it will be Senator Rockefeller.

Senator BREAUX. Thank you, Mr. Chairman. Thank the witnesses.

In response to Senator Moynihan's statement about what would have to happen before something else happened, I am reminded of the two members of the Louisiana legislature who were arguing about whether a bill was going to pass. One of the State representatives said, this will pass only over my dead body, to which the other fellow said, all right. [Laughter.] I am not sure it has to go to that extreme.

I thank Nancy and Mr. Flynn for being here. Let me start, Mr. Flynn. We are wrestling over trying to decide how to design a prescription drug program for the Medicare plan. The Federal Employees Health Benefits Program has one for Federal employees.

I strongly believe that Medicare should also have a prescription drug plan. The question is, how much do we spend on it? The number of $40 billion is a number that has been bandied around.

The next question is, how do we design that program? Now, because of the fact you have a program, I note that the FEHBP statute that sets it up is pretty simple. It says, types of benefits. In Section A of the title that deals with it it says, "E, Prescribed Drugs." It is pretty simple.

So the question I would like to ask you to elaborate on for the benefit of the members is, when you put the call out in March or April every year, how do you describe the prescription drug plan that you want people to submit responses to?

Do you spell out in detail what the premium should be, or what the co-payment should be, or what the deductibles should be, or do you, rather, talk in terms of an actuarial value or a combination thereof? Tell us how you put that call out; what does it contain?

Mr. FLYNN. Senator Breaux, let me try and answer that by giving a little historical perspective.

Senator BREAUX. Not too long, now. We do not want to go back to the beginning of time, because I do not have that much time.

Mr. FLYNN. No, sir. Not at all.

You are right, in terms of the statute providing just simply a general description of the benefit. The structure of the program, as you know, relies heavily on private insurers.

So in the early years of the program, essentially what we were doing was emulating the prescription drug benefit that private in-

surers offered their employees. That has largely been the design of the program from that time to the present.

Our annual call letters are not annual redescriptions of everything that we want, they are really annual statements of our new negotiating objectives for the coming year. So, to the extent that that is built into our base, it moves forward without change.

The prescription drug benefit, nonetheless, has evolved and it has evolved primarily the way in which private employer-sponsored health insurance has evolved.

Senator BREAUX. All right. So when a call letter goes out, what type of proposals do you get coming back; do they vary or do they all have the same deductible, the same co-insurance, and the same stop-loss, or what have you?

Mr. FLYNN. They will vary. In fact, that is one of the strengths of this program, is that there is not a core benefit. There is required to be a prescription drug benefit, but the benefits proposed, particularly the prescription drug benefits by the 300 or so health plans that participate in the program, will vary from one to another.

Senator BREAUX. Then you have the ability to negotiate the best deal.

Mr. FLYNN. Absolutely, and we do. Most of the variation in the prescription drug benefit has to do with the use of formularies and has to do with the use of co-payments and deductibles.

Senator BREAUX. But since those vary, then the beneficiary, the Federal employee, gets to pick and choose the drug benefit that best suits what their particular family needs.

Mr. FLYNN. Absolutely correct. Yes, sir.

Senator BREAUX. All right. Do you think, Ms. DeParle and Mr. Flynn, both, on that important question, that that type of concept could be adaptable to a prescription drug program under the Medicare program or do we have to again micro-manage it or be proscriptive with a prescription drug program and spell out what the deductible should be, what the co-payment should be, and what the stop-loss should be, or does something like what Mr. Flynn described seem to have merit?

Ms. DEPARLE. Well, I would be concerned, Senator, about something that was too open-ended and had too much variation. Our population is different.

Senator BREAUX. That is——

Ms. DEPARLE. Well, no, it is not because of a desire to micromanage it. In fact, the administration's proposal would have pharmacy benefit managers who would manage this. So it would not be done from HCFA.

But my concern is that Medicare has been a program where people have had an entitlement to a core set of benefits, and you and Senator Grassley both have spent some time helping us on our education program. One thing we find, is that beneficiaries are confused by having too many choices and too many different opportunities.

Senator BREAUX. This is a classic example of the difference in how the two programs work. I mean, you are saying they give the people some options and give them different choices and help educate them as to what they are.

Nancy, you are talking about micro-managing it. You want us to spell out what the deductible is, what the co-payment is, what the stop-loss is, what the premium is going to be, so we can change it every year and fight over it with your agency every year.

Ms. DEPARLE. Well, sir, I would not present it that way. But I do think it is important for Medicare beneficiaries to know what they are getting and what they are paying for.

I also think, and I think Mr. Flynn would say this too, that having so many different variations introduces risk selection and adverse selection into this, and I think Professor Fuchs, Professor Baumol, and some of the others Senator Moynihan mentioned would have something to say about that.

Senator BREAUX. Thank you.

Senator GRASSLEY. Thank you, Senator Breaux.

Now, Senator Bryan.

Senator BRYAN. Thank you very much, Mr. Chairman. Thanks to our two distinguished witnesses.

I am looking at an open letter that is addressed to the Congress and to the executive that appeared in Health Affairs. I think you are probably somewhat familiar with this.

What struck me, was the broad range of philosophical perspectives that are represented by the signatories. There are people here from the Heritage Foundation, Health Insurance Association of America, Brookings, one of your predecessors, Ms. Min DeParle, and others. The point being, there is a broad range of philosophies and perspectives here.

Let me just share its opening premise here. "The difficulties that threaten to cripple HCFA stem from an unwillingness of both the Congress and the Clinton Administration to provide the agency with the resources and the administrative flexibility necessary to carry out its mammoth assignment."

That suggests, as Shakespeare would have said, that the fault lies not so much in our stars, but in ourselves. The responsibilities may rest here and with the president as much as with HCFA in terms of its ability to do the job.

Then it goes on to make an observation I think is significant. Many of us have a great respect for the dynamics of the private sector and the entrepreneurial spirit which makes America the most competitive country in the world. I think the private sector deserves so much credit for keeping our economy the most vibrant one.

But it does go on to say, and some of these people represent very conservative philosophies, that "no private health insurer, after subtracting its market in cost and profit, would ever attempt to manage such a large and complex insurance program with such a small administrative budget." This is not written by the liberal caucus, this is written by a group of people who share very conservative principles as well.

Then, finally, and I will get to the question, is that in 1997, Medicare spending had increased almost ten-fold, to $207 billion. The number of beneficiaries served had grown to 39 million, but the agency's workforce was actually smaller than it had been two decades ago.

Now, I am not here as a member of the committee arguing that the answer is more people. But it is interesting, as I say. There are folks who have very conservative philosophies who are saying, that is part of the problem, and the other is the lack of administrative flexibility.

First, let me ask you, what about your staff, your administrative budgets, too small?

Ms. DEPARLE. It is very, very small to try to do the job that we are doing. In fact, I am reminded of the last time, I think, I was before this committee, Senator Chafee and I had that discussion.

As I told him, I think that HCFA and Medicare are very efficient. That is both a strength and a weakness. It is a weakness in some ways because we cannot do all the things that I think we should be able to do.

Senator BRYAN. All right. So staffing is part of the problem, and we will have a chance to explore that. The other, is administrative flexibility. There seems to be some universality in terms of, how much flexibility do you have inherently within your ability to do administratively without asking additional Congressional support? Anything that you can do that you have not done that, in your judgment, would provide more flexibility in terms of administering the program?

Ms. DEPARLE. We cannot do anything significant. There are things we would like to do, such as demonstrations to modernize Medicare, to do competitive pricing for services and goods that Medicare receives. We have not been able to do those things, so we would like more authority.

I would like authority to reform our contractors. We have a contracting system that is very different than anybody else in the Federal Government. I think this is the eighth year that the President has asked Congress for a change in that. So, I believe there are a lot of ways we could improve our flexibility.

Senator BRYAN. What struck me in this letter is that, whatever reforms we adopt, we cannot do it on the cheek. It is going to cost some money. I realize it is popular to say, just make some changes and we can do everything for less.

In a perfect world, I think we would all like to do that because nobody likes to see additional expenditures in terms of administrative costs, but if that is part of the answer, I think we have to look at that.

Second, let me talk about the administrative flexibility in more precise, rather than general, terms. If you had a priority, one, two, three, or four things that you would ask us to do in terms of changing your administrative flexibility that you think would give us the greatest impact in terms of change, and again, if you can be as non-bureaucratic—and I say this with great respect—but with precision so that people who are watching this may have as much of an understanding as those of us who have spent some time studying the system, what three things would you ask us to do?

Ms. DEPARLE. Well, I would ask you to enact the President's contractor reform legislation that would allow us to have a broader pool of contractors to choose from to administer the Medicare program, the carriers and intermediaries that we deal with across the country.

I would ask you for the authority to do competitive pricing for more of the goods and services that Medicare buys, and to do PPOs and some of those other new techniques that the President has proposed in his budget.

Senator BRYAN. And in your judgment those three things would be the most important additional tools that we could give to you?

Ms. DEPARLE. I actually said two, but if I could say one more, we have also asked for more flexibility in personnel. This is one of the things—Senator Grassley mentioned the Social Security Administration—that they have that I wish we had, is more flexibility and more SES positions and more ability to hire in the private sector and to pay more money. That has constrained me in trying to bring people in with more managed care and other providers' expertise.

Senator BRYAN. Thank you very much for your response.

Thank you, Mr. Chairman.

Senator GRASSLEY. Now, Senator Rockefeller.

Senator ROCKEFELLER. Thank you, Mr. Chairman.

I need to say, in that I came from a Commerce Committee hearing, that I am very much against the idea, not necessarily over my dead body but close to that, of a board because I think that the whole concept of a board will lead us, if we are not careful, towards kind of a bottom-line philosophy. That is, making the bottom line as profitable as possible.

I think the IRS has a board, but they have nothing to do with tax policy. It worries me very, very much, what is trying to be done here. There is an enormous difference between FEHBP and what they do, the $41,000 average population, less than 65, which is average of what they serve, and what Medicare, which is 10 percent of the Federal budget, has to do.

There is enormous difference between selecting in an actuarial manner in FEHBP and what it is that seniors, who often do not understand their choices as well or pay attention to their choices as well, therefore, the concept of a defined benefit. There is an enormous difference between some kinds of situations.

I mean, there are people, for example, who want to privatize the Federal Aviation Administration. And it sounds good, because people get mad at the FAA because of plane delays. So they say, let us privatize it, therefore, it will get better.

Well, you will not find me on that bandwagon, either. I think that would be disaster. There is something called democracy, there is something called 37 million people who are depending upon elected representatives, and the concept of removing Medicare and the decisions about Medicare, much less the defined benefits that I want to see in Medicare, decided not by a board but by the Congress, not tinkering but making fundamental democratic representative decisions based upon the good of senior citizens, that I think is absolutely essential to this.

Therefore, I think that the concept of what we do to make HCFA work—we are very quick in politics to say that if we do not like something or if we have an agenda, to privatize something or to give some powers to other groups, give 10 percent of the power of the Federal budget to somebody else, to say, well, let us just create a board and do something, and we will make it benign, and we can

work it out so it will be constitutional and we can do this, and we can do that.

People often talk about slippery slopes. This is genuinely a slippery slope, in my judgment. I think you are fundamentally altering the nature and future of the people I represent. And as I often say when it comes to Medicare, there is no margin at all. They have, after out-of-pocket expenses, about $8,600 a year to spend on every aspect of living.

I am not interested in putting them at risk in any way. I am not interested in experimentation that would turn their lives over to, even if Presidentially-appointed, nevertheless, proscriptive in terms of private sector, public sector, who would win. Would mega-companies be making decisions about what Medicare provided for the people of my State?

Well, as Senator Breaux said recently, and I will modify it slightly, my body will not be dead, but it will be fighting and grabbing at anything that moves in that direction. I say that, not to be cantankerous, but because I really believe that there is an enormous difference between Social Security, the IRS, and the FAA. Well, not so much the FAA, but certainly Medicare.

So my concerns are what Senator Bryan was asking you. How can we make Medicare work better? You and your predecessors, each one, I have said, you come in, you are not given enough flexibility, and you are not given enough time, you are not given enough money, you cannot appoint enough people, you cannot get into that bureaucracy, which of course everything is which is over 500 people, it is a bureaucracy by definition, except in your case it is 4,000. They are located in Baltimore.

Then to say that we cannot make them more responsive and to make better decisions within a defined benefit aspect and respond more effectively to Congress or to my clinical trials where, Nancy-Ann Min DeParle, I have been working on you for several years and have not made much result either.

My instinct, still, is that seniors need to be protected, benefits need to be protected. We have to be very careful about this. Turning something over to a board has an appeal, but I think it is appeal which is very, very dangerous.

With that question, I will come to a halt.

Senator GRASSLEY. Now we go to Senator Hatch.

Senator HATCH. Thank you, Mr. Chairman.

Welcome, Ms. DeParle. Thank you for what cleanly is, a very difficult job. I just want to focus on some of the contractor issues, first.

As you know, in my home State of Utah we have a number of complaints from the provider community over the role of the Medicare contractor in processing Medicare claims. Clearly, HCFA is not very popular these days, and is an easy target for criticism.

But, in all fairness to you, I think we need to spend more time looking at the accountability of the Medicare contractors. I think there needs to be more oversight to ensure that contractors are accountable to providers so that claims are processed in a timely manner, using generally accepted accounting methods.

Can you tell the committee in more detail what HCFA is doing to oversee the work of contractors to improve financial and con-

tractor management? I would also like to hear more about the creation of the Medicare contractor oversight board that you referred to in your testimony.

Ms. DEPARLE. You are right, Senator, that that is an enormous area of responsibility. Unfortunately, many people do not even recognize that it is there. HCFA is a very small agency, and most of what we do where we interact with your constituents and with providers, is really through these contractors. I want to thank the GAO for some of the work that it has done over the last year in trying to help us look at how can we improve this.

What we are trying to do is, starting with the contracts that we have with the contractors, is to write into them more precisely what we expect of the contractors and then to monitor that much more aggressively than we have in the past.

Before you got here, I mentioned that this is the eighth year that the President has sent up legislation to the Congress asking for reform of this process. It is one aspect of the law that dates back to 1965; for 35 years it has not been changed and it needs to be updated.

But they are very different than other types of government contractors. We have to do business with a certain prescribed set of contractors. The Secretary does not have the ability to look at a broader pool. Frankly, I think that impedes the government from getting the best deal sometimes in its negotiations.

We do have, as you mentioned, a Medicare contractor oversight board. Dr. Bob Berenson, a physician who I brought in from private practice here in Washington to head up Medicare policy, is the chairman of that.

The point of that is, on a day-to-day basis, to really stay on top of what these contractors are doing, because the essence of our business is dealing with your physicians and hospitals in Utah and making sure that they are getting the service that they need, and getting their questions answered.

We have not done as good a job of that as we need to do. We need your help and we need more resources to do a better job, but we can do a better job and we are going to.

Senator HATCH. Let me follow up on that question. In your testimony, you state that the agency is "making strides strengthening oversight of the private insurance companies who process Medicare claims."

Would you give the committee some indication of what you have done thus far and what you intend to do in the future?

Ms. DEPARLE. Well, we have moved from a very loose oversight, Senator, to a system where we have national teams that are headed by a physician who used to work at one of the contractors in our central office, and where we have a protocol and go out and monitor what these insurance companies are doing, and require them to give us a corrective action plan if they are not doing what they are supposed to be doing.

This relates in some ways to the notion, I think, of political accountability that this committee has been considering. Senator Lott called me about a year ago and said that, in Mississippi, the contractor that was dealing with some of his physicians was not responding to physicians who were trying to find out answers about

how to do proper billing. I called them up and found out that, sure enough, he was right, they were not adhering to the contracts.

So we are getting much more aggressive about going out there, finding what they are doing wrong, then requiring them to correct it. I have seen some results from those efforts and I hope that you and your constituents will begin to see some results from it as well.

Senator HATCH. It is my understanding that one of the reasons for HCFA's last reorganization was to give the agency a new focus on service to beneficiaries. Would you tell the committee what steps you have taken recently to improve services to beneficiaries?

Ms. DEPARLE. Well, the biggest step I think we have taken is the work we are doing in our National Medicare Education Program and our Internet site, Medicare.gov, where we, I think, just in the last few months, had 21 million hits. I believe we answered more than 20 million inquiries from beneficiaries over the last year.

We have really stepped up our efforts to be accessible and accountable to beneficiaries, and I think we can do an even better job.

Senator HATCH. One last question. I am interested in your comments on page 6 of your testimony in which you state that HCFA is "conducting a comprehensive assessment of workforce needs, bringing in new employees with private sector experience and enhancing training for current staff."

Would you tell the committee in more detail what you are considering in terms of enhancing your resources and your workforce needs?

Ms. DEPARLE. I will. In fact, I am very proud of that, and our colleagues at OPM have recognized our work. We are starting, from top to bottom, assessing the skills of our current workforce, and we have a strategic plan for the kinds of hiring we need to do for the future.

We are trying to achieve the right mix of skills. In my view, that involves some new people who have expertise from the private sector, as well as some of our experienced people working together. We have been recognized for our efforts in this workforce assessment in our strategic plan.

Senator HATCH. Thank you so much.

Thanks, Mr. Chairman.

Senator GRASSLEY. Thank you.

Now that my colleagues have asked some questions, there were some that I wanted to ask that did not get asked, and a couple of new points that have come up in my mind. So let me make a couple of points, first of all, without asking a question.

Let me see if I can state the intellectual divide we have here on the question. I think we are trying to figure out whether on the one hand, we should have a large centralized plan that is administered centrally, that is, through the Health Care Financing Administration, or maybe somewhat restructured, or whether or not the Federal Government should be a purchaser of health plans for its beneficiaries.

That is really what we are talking about here, in the simplest terms. Now, we have got to find an answer to that. I mean, the answer is, continue the status quo or try something else.

Now, another point I wanted to make, and I accept your answer to my first question, Ms. DeParle. I might have a disagreement if there is not some inconsistency between a position today of the administration on an independent board versus what they had in 1994 for the Social Security Administration, but I do accept your answer.

But I do want to point out that we are going to have some testimony, probably not orally, given today by GAO, but in their long draft where they talk about Congress looking at restructuring the Social Security Administration.

One of the points they make in summary at the end of their one paragraph that deals with this, they say, going back, I suppose, to 2 or 3 years ago when Congress was dealing with it, "Committee chairmen expressed a desire to have the Social Security Administration more accountable to the public for its actions and more responsive to Congress' attempts to address the Social Security Administration's management and policy concerns."

So then you get back to the basic question. Do we do that under the structure we have? Can Congress seek its goals under the structure we have now or does it take some new structure?

Can I follow up with you, Mr. Flynn, where you left off with me? As I recall, you said one out of four dollars that are expended in the Federal health plan for Federal employees, 25 percent, was for pharmaceuticals.

Could you give us, over maybe a recent 3- or 4-year period of time, kind of how that has reached 25 percent, or the rate of increase each year, or something along that line?

Mr. FLYNN. Senator Grassley, I would be happy to do that. If you do not mind, I would perhaps give you a more precise answer for the record later. But we have, over the past three or 4 years, seen a prescription drug trend increase running between 18, 20, to 22 percent. That is atypical from what it had been in previous years, but over the past several years, that is what we have seen.

Senator GRASSLEY. All right. Thank you very much.

Now, a question for Ms. DeParle. If I could make clear that I do not want this to be a repeat of the first question I asked you, the one I just commented on, but a little bit the same way because you have highlighted for us today the management initiatives you are undertaking to complete the agency's responsibilities and eventually reduce the strain that the Health Care Financing Administration's workforce systems and infrastructure are facing.

Could modernization of Medicare include a reorganization of the functions of the agency, even with the Department of Health and Human Services, or do you believe the agency is capable of handling all of the diverse functions it handles now, plus new ones under discussion?

Ms. DEPARLE. Well, I believe we are capable of handling the functions we have now, plus new ones, but I think we would need more resources and more support to do that. But, yes, sir, I think we can do it. I think the agency is very talented and committed and could do that.

I read with interest Dr. Wilensky's testimony—I assume that is what you are referring to—about splitting up the agency and putting various functions in different places.

Senator GRASSLEY. Yes.

Ms. DEPARLE. Of course, those kinds of ideas have been thought about before. The problem is, for example, survey and certification of nursing homes, I am working with the States on that, which is something that you and I have spent a lot of time thinking about. It is not clear to me that that is an obvious thing to go to the Centers for Disease Control, which is where I think Dr. Wilensky, in her testimony, mentions it might go.

Medicare is responsible for conditions of participation, for looking at what are the minimum standards that nursing homes and other providers should have to meet. We have a long history of experience there.

Now, did we need more resources to do a better job of it? We did, and you helped us get them. I think that is more the answer and we should be accountable to you for that, and I think we have been.

Senator GRASSLEY. Could I ask, in a summary form them, following on your answer, you are kind of referring to number one as being the only possibility that you would support, the only one option up there that is acceptable to you.

Ms. DEPARLE. From what I have heard so far, number one is the one that makes the most sense to me. If we are going to make changes, I would say the changes should be in giving HCFA more flexibility, more resources, more authority to do its job and do it well. We are happy to be accountable to the Congress and to the American people for that.

Senator GRASSLEY. All right.

Mr. Flynn, the Federal Employees Health Benefits Program is sometimes hailed as a model managed competition designed for administering group health benefits. However, unlike Medicare, the Federal Employees Health Benefits Program has no requirement for coverage of a specific core benefit package.

Has there been any consideration of standardizing the Federal Employees Health Benefits Program's benefit package, and what are the implications of standardization versus this flexible design model?

Mr. FLYNN. Senator Grassley, you are correct, there is no requirement for a standard benefit design currently. But we do have a core benefit package that really does not vary much from one plan to another.

In periods of time where we have seen rapid cost increases in the program, premiums jumping double digits, high single digits from 1 year to the next, and there seems to be some cyclical reflection of that in the 1970's, the 1980's, the 1990's, and we may be in a period of that now, one of the things that we have looked to do as a way of controlling the rate of growth in the program because consumers make decisions, is standardizing the benefits so that the differences in premiums from one plan to the next really are a reflection of the relative degree of efficiency with which plans operate.

That is a feature that many employer sponsors use. It is something that we have looked at, it is something we have talked with HCFA about. Any discussion or proposal along those lines has been

met with great opposition in the program, primarily from among the health insurance plans who administer the program.

Their view is that this variation is an underlying foundation strength of the program, and there is some validity to that argument. So we have never really quite solved the issue of whether there ought to be variation or standardization, but it is something we continue to look at.

Senator GRASSLEY. This will be my last question, and it will be to Mr. Flynn. To some extent in your testimony, you made the Federal Employees Health Benefits Plan sound much more similar to Medicare+Choice than I really think it is. You may disagree with that. For instance, who sets the premiums for the health plans, the plans or the Federal Employees Health Benefits Plan?

I would like to have you note in answering the question that Medicare+Choice operates on a highly regulatory administered premium system, which is not the case as I understand the Federal Employees Health Benefits Plan.

Mr. FLYNN. Senator Grassley, the premiums in the Federal Employees Health Benefits Program are the result of bilateral negotiation between us, OPM, and the individual health plans that participate. There is a lot of examination of financial data, actuarial information, and so on and so forth, but ultimately it is a consensus bilateral negotiation that produces the premium.

Senator GRASSLEY. Now, do either of my two colleagues have follow-up questions you want to ask? Yes. Go ahead. I guess it does not matter if we go quite in order.

Senator ROCKEFELLER. Well, I am out of order. Is that all right?

Senator GRASSLEY. Yes. Go ahead.

Senator ROCKEFELLER. All right. I just wanted to establish one more point with Nancy-Ann, if I might. We think of Medicare and then we think of that $210 billion. But, in fact, HCFA is also responsible for Medicaid and CHIPs, is it not?

Ms. DEPARLE. Yes, sir.

Senator ROCKEFELLER. So we are talking about an entire public health system when we consider how that is to be run, how it is to be managed, whether there is a board, whether HCFA should be doing it itself, as I think it should.

Ms. DEPARLE. That is correct. That is why this all bears the careful consideration this committee is giving it.

Senator ROCKEFELLER. Thank you very much, Mr. Chairman.

Senator GRASSLEY. Now, Senator Breaux.

Senator BREAUX. Thank you.

In a discussion we had on the call that you put out for the prescription drug plan and the type of responses to that call, I would like to get the committee some examples of that. What does a call consist of? I mean, I would like to actually see the document that you send out to all the people who have come in and make a response to that call, a typical call.

Mr. FLYNN. Senator Breaux, I would be happy to do that. We can give you the last 3 years' call letters. I think that would give you a good flavor.

Senator BREAUX. Yes. That might be a good idea. I do not need 10,000 pages of documents, but just an example of what the call

encompasses and then some examples of the responses to that call. I mean, the call is fairly simple, I think, but the responses to that.

I mean, what kind of proposals do you get in response to that call? I do not want to be overloaded with a thousand different responses, but just some typical responses about how people offer different types of combinations to meet that response. Did you understand that?

Mr. FLYNN. Sure. We can do that.

Senator BREAUX. And we can talk with the staff if you need some guidance on that.

Thank you, Mr. Chairman.

Senator GRASSLEY. Senator Graham of Florida, I was ready to dismiss this panel, but since you came in, if you want to ask some questions, you should be entitled to do that.

Senator GRAHAM. Mr. Chairman, I will pass on my questions and start the next panel.

Senator GRASSLEY. All right.

Thanks to both of you, very much. This has been a very influential discussion on this whole debate and we thank you very much, even though there are differences of opinion. Thank you both very much.

Ms. DEPARLE. Thank you.

Mr. FLYNN. Thank you, Senator Grassley.

Senator GRASSLEY. Now it is my privilege to call, and would all four of these people on the second panel come even before I call your name, Bill Scanlon, Director of Health, Financing and Public Health at the U.S. General Accounting Office; Rogelio Garcia, Specialist in American National Government, the Government and Finance Division at the Congressional Research Service; Gail Wilensky, a John M. Olin Senior Fellow, Project Hope in Bethesda, MD; and Judith Feder, Professor and Dean of Policy Studies, Georgetown Public Policy Institute, Georgetown University here in Washington, DC.

I would like to have you go in the order that I just announced, and you are sitting in that order. Then we will ask questions at the end of the four presentations.

So, Dr. Scanlon, would you please start?

STATEMENT OF BILL SCANLON, DIRECTOR, HEALTH FINANCING AND PUBLIC HEALTH, U.S. GENERAL ACCOUNTING OFFICE (GAO), WASHINGTON, DC

Dr. SCANLON. Yes. Thank you very much, Mr. Chairman and members of the committee. I am pleased to be here today as you discuss ways to improve the administration of the Medicare program. Examining how Medicare is managed and the potential improvements are important elements of the ongoing discussion of Medicare reform.

As you know, GAO has conducted numerous studies of different aspects of Medicare operations and management, and over the last few years we have also focused more broadly on all of the responsibilities HCFA has as an agency and its ability to fulfill them.

A number of issues have emerged that appear to hamper HCFA's effectiveness and that might be ameliorated by some structural

changes. First, HCFA's management is divided across multiple programs and responsibilities, as we have heard today.

It is remarkable that, despite Medicare's share of the Federal budget, its impact on millions of beneficiaries, and its impact on health care markets nationwide, there is no official whose sole responsibility it is to run Medicare.

In addition to Medicare, the HCFA administrator oversees the 50-plus Medicaid programs, a similar number of State Children's Health Insurance programs, the compliance of individual and group insurance plans with HIPAA standards in several States without conforming legislation, and the compliance of tens of thousands of hospitals, nursing homes, home health agencies, clinical laboratories, and managed care plans with Federal quality standards.

Furthermore, HCFA has experienced little continuity of leadership. In the 23 years since HCFA's inception, there have been 17 administrators or acting administrators. On average, their tenure has been a little more than a year. You can see the tenures of these HCFA administrators in our written statement.

About 10 percent of the time, HCFA has been led by an acting administrator. As this turnover suggests, it would seem difficult for HCFA to develop and implement a consistent, long-term vision for managing Medicare.

A third problem, is the agency's capacity or its human resources. Medicare has both grown and evolved considerably over the years. That evolution was accelerated with a host of new Medicare responsibilities given HCFA under the BBA. A consensus has also developed that HCFA needs to operate as a prudent purchaser of health care and not just a third party payor.

To fulfill these new missions, the agency needs a workforce populated by many new breeds of specialists, individuals with expertise in cutting-edge information technology, managed care delivery, marketing and communication, and payment methodologies, to name several. In today's tight labor market, the government faces stiff competition from the private sector to attract such talent.

Elements of the Breaux-Frist proposal and the President's proposal for Medicare reform, to varying degrees, address these focused leadership and capacity issues. There is a figure illustrating this on page 12 of my written statement.

Neither proposal, however, is detailed enough to fully describe how certain functions will be performed and what additional steps might be desirable, but they accomplish the important step of making Medicare governance a part of the Medicare reform discussion.

Since this is the first broad consideration of Medicare governance in a long time, it may be worthwhile to consider other options as well. For other Federal agencies such as Social Security or the IRS, Congress has acted to create more separation between policy making and administration, allowing agency leaders to focus more on the latter. It has extended those leaders' tenure to overlap Presidential administrations and given them more flexibility to build and manage their agency's capacity.

Let me end by noting that experience tells us there is no simple formula for bringing about the needed improvements. While the Breaux-Frist and the President's proposals envision taking advan-

tage of competitive forces to make the program more efficient, Medicare governance will remain an immense challenge.

In particular, the huge challenge of managing the Medicare fee-for-service program, with all its administered prices, will not go away. In fact, the benefits of competition and the success of Medicare in serving beneficiaries will only be achieved if traditional Medicare is operated efficiently and effectively.

It is important also to point out that, regardless of Medicare's governance structure, whether it is the one that has been in place since 1977 or one that may grow out of program reform, the entity that administers this program with its $200 billion budget and its vast universe of stakeholders will be the target of parties that feel disadvantaged or harmed by some of its decisions, even when those decisions are made in the program's best interests.

Nevertheless, it is critical that we find the governance structure that best enables Medicare to fulfill the promises made to both current and future beneficiaries.

Mr. Chairman, that concludes my statement. I would be happy to answer any questions you or members of the committee may have.

Senator GRASSLEY. Thank you, Dr. Scanlon.

Now, Mr. Garcia?

[The prepared statement of Dr. Scanlon appears in the appendix.]

STATEMENT OF ROGELIO GARCIA, SPECIALIST IN AMERICAN NATIONAL GOVERNMENT, GOVERNMENT AND FINANCE DIVISION, CONGRESSIONAL RESEARCH SERVICE (CRS), WASHINGTON, DC

Mr. GARCIA. Thank you, Mr. Chairman and members of the committee, for allowing me to participate in this hearing.

Congress has broad authority to establish agencies in many different forms in order for them to carry out their duties and responsibilities. It possesses broad constitutional powers with respect to the configuration of the agencies, their structure, and their decision-making processes.

A glance through the government manual or various organizational charts quickly demonstrates that Congress has exercised its powers to establish many different types of agencies.

Generally, executive agencies fall under the direction and control of the President in order to enable him to carry out his duties and responsibilities as chief executive.

The President exerts this control in the following ways. First, by appointing, with the advice and consent of the Senate, the principal officers in the executive agencies and by removing them whenever he wishes.

Second, by reviewing, through the Office of Management and Budget, the agency budgets which determine program priorities, as well as funding and staffing needs. This reviewing also includes, in effect, clearing the budget requests that are submitted to Congress.

Third, by requiring agencies to submit for review and clearance their communications with Congress, including testimony, legislative recommendations, and other comments.

Fourth, by requiring agencies to submit proposed and final regulations to OMB for review before those regulations can be published.

Fifth, by requiring agencies to submit to OMB information collection request forms. These forms are sent out to the general public to enable the agencies to better carry out their duties and responsibilities.

Finally, by having agencies in most instances rely on the Department of Justice to defend and enforce agency programs that are challenged in the courts.

The most effective of these tools, are two: the President's ability to remove the head of an agency and OMB involvement in the agency process when it is preparing its budget.

To protect against unwarranted Presidential involvement in the activities of some executive agencies, Congress has granted those agencies various degrees of independence from the President. All but two of the agencies granted these exemptions are multi-headed, that is, several members govern the agency and the decision making is by majority vote.

Most of these agencies are independent regulatory agencies such as the Federal Deposit Insurance Corporation, the Board of Governors of the Federal Reserve System, the Federal Trade Commission, and the Securities Exchange Commission.

The one important single-headed agency in government that has been granted some of these exemptions from Presidential control, is the Social Security Administration.

Presidential control over the agencies has been limited, first by providing for a fixed term of office for the agency heads, and by placing restrictions on the President's ability to remove those agency heads. Generally, the President can remove these agency heads only for inefficiency, neglect of duty, or malfeasance in office.

Second, by enabling a few of these agencies to generate their own operating funds. That is, they are permitted to assess fees and levies on institutions they regulate and use those funds for their own operating expenses, thereby avoiding the appropriations process and avoiding the need to submit their budgets to OMB.

This independence has been granted primarily to regulatory banking agencies. Five such multi-headed agencies are the Farm Credit Administration, the Federal Deposit Insurance Corporation, Board of Governors of the Federal Reserve, the Federal Housing Finance Board, and the National Credit Administration.

In addition, two agencies or units within an executive department are also granted this authority, the Office of Comptroller of the Currency and the Office of Thrift Supervision.

Finally, a certain degree of independence has been granted by creating the agency as a multi-headed agency. This generally enables the agency to submit their budget requests to Congress concurrently as they are submitted to the OMB, and also allows the agencies to avoid review and clearance of regulations by OMB.

The important thing to consider when determining whether to establish a single-headed or a multi-headed agency, is that a multi-headed agency generally takes more time to make a determination on a particular policy.

It is essential to assign clear lines of authority and responsibility among the members. Even under the best of circumstances, however, agency effectiveness may be limited because of differences in viewpoint and personality clashes.

Finally, accountability and independence are inversely linked. The more independence an agency is granted, the less accountability it has to the President and, to a lesser extent, to Congress.

If an agency head may be removed only for cause and if the agency is able to generate its own operating expenses, it avoids the need to go through OMB, and it avoids the Congressional appropriations process. The agency, therefore, is better able, not necessarily to ignore, but at least to be less attuned, to the direction and guidance of Congress and the President.

Thank you, Mr. Chairman.

Senator GRASSLEY. Thank you.

Now, Dr. Wilensky.

[The prepared statement of Mr. Garcia appears in the appendix.]

STATEMENT OF GAIL WILENSKY, JOHN M. OLIN SENIOR FELLOW, PROJECT HOPE, BETHESDA, MD

Dr. WILENSKY. Thank you, Mr. Chairman and members of the committee. As has been stated, I am a senior fellow at Project Hope and currently chair of MedPAC, but as has also been stated, a former administrator of the Health Care Financing Administration.

I would like to talk about some of the issues raised in Medicare governance options, and particularly a reorganization of some of HCFA's functions. I would like it clear that I am not here as a HCFA basher, but rather as somebody who knows only too well the enormity of the task that the Congress has assigned to this single agency.

I strongly believe that it would be preferable to have some of HCFA's current responsibilities reallocated elsewhere in the executive branch, whether or not Medicare is reformed. But, depending on the type of reform you adopt, it is even more important that this reorganization of HCFA occur.

As has been raised this morning, a Medicare board has been suggested as one of the vehicles of reorganization. It has been proposed, either as the place to house Medicare+Choice programs, a premium support structure for Medicare, or perhaps as the place to house an outpatient prescription drug benefit.

Although I am on record as having favored a Medicare board, I am no longer quite as sure that it represents the best vehicle to house the kind of reform that I think needs to occur.

The CRS has done a number of documents, but in reading those documents and in talking with people and giving it further thought, the issue that has troubled me the most is one of accountability. It is a difficult issue. As the Congress goes forward in thinking about this, I hope it will give serious consideration as to whether or not the needed amount of accountability occurs in the board structure.

But in assessing the potential value of a board, I think it is most important not to focus so much on the board, per se, but what problem you were trying to fix in thinking about the board as the answer

It seems to me that there are a variety of reasons that have been given, but the two that are most compelling to me and have helped me in trying to think of other allocations is that HCFA has historically been regarded as too sluggish and unresponsive, and second, that there is an inherent conflict of interest in having HCFA both run the traditional fee-for-service Medicare program and be the agency that is responsible for overseeing Medicare replacement programs.

So I think if you look at it in this line, that you may be able to think about some alternatives in addition to having a board as a concept.

But you need to do that within the context of all of the assignments that HCFA now takes on, and those include not just administering Medicare, $220 billion, roughly, and 39 million people under the program, the Choice program as well as the traditional program, but also overseeing Medicaid, approving the Children's Health Insurance Plans submitted by the States, conducting or contracting for survey and certification activities, enforcing HIPAA laws and the CLIA laws, and also enforcing some fraud and abuse prevention activities, and I am sure there are others that I have not touched on.

That just seems to me to be an enormous requirement for any agency, particularly one that has not had a lot of financial support, as has been raised. I was one of the signatories to the letter that was referenced by Senator Bryan indicating concern about the financial support for administrative functions of HCFA.

But I think, perhaps, a better way to look at this is to think about the functions that ought to belong to HCFA and others that may be as well assigned elsewhere. Clearly, HCFA needs to be the agency that runs the public fee-for-service program.

Now, I believe it would be better to have a modernized fee-for-service program, one that included an ability to create centers of excellence, perhaps to do selective contracting, to engage in disease management, that is, to act like other modern-day insurance companies.

It would require a degree of flexibility the Congress has not been willing to grant to HCFA in the past. It would require less microproscriptive behavior by the Congress. It would require a change in attitude not just by the Congress, but, frankly, also by the people who operate in HCFA. They also would have to take a less bureaucratic and rigid posture in terms of how they respond as well.

If Medicare reform leads to the adoption of a premium support or a Federal Employees Health Care Benefit model, as I personally hope that it will, it may make the most sense to have the administration of this particular function in a place like an expanded, and probably renamed, OPM.

After all, that is where a lot of these functions are going on for the Federal Employees Health Benefits Program. But, yes, I do understand that this will place very different kinds of requirements on that. Alternatively, you could have a new agency developed, or, of course, a board could serve that function.

It seems to me that, as we move beyond this, that we need to think about whether it is reasonable to have all the functions that have been currently assigned to HCFA stay there.

Medicaid, for example, could go to the agency that houses welfare, the Agency for Youth, Children and Families, or a new grouping of agencies could be put together that contains all of the programs that are State-related health programs, like the HRSA program, like the SAMHSA, Substance Abuse and Mental Health Services Program, and that also this could be a place that could review the Children's Health Insurance proposals submitted by the States.

As was mentioned by Nancy-Ann Min DeParle, I favor moving the survey and certification and the CLIA functions elsewhere. I think that the survey and certification might well go to FDA as opposed to CDC. They do a lot of inspection for manufacturing as part of their clearance functions.

Although, it would be possible to put both FDA and CDC into a single assistant secretary. That might make it easier to choose, because I think CLIA might better go to the CDC.

I recognize the proposals that I have laid out represent a lot of change. This is a serious issue. It requires a lot further thought than I have been able to give it. But I think a good place to start would be a thorough review of the functions that HCFA now has responsibility for. Again, depending on where you go in Medicare reform, some of them will be more urgent to consider earlier rather than later.

Thank you very much.

Senator GRASSLEY. Thank you, Dr. Wilensky.

Now, Dr. Feder.

[The prepared statement of Dr. Wilensky appears in the appendix.]

STATEMENT OF JUDITH FEDER, PROFESSOR AND DEAN OF POLICY STUDIES, GEORGETOWN PUBLIC POLICY INSTITUTE, GEORGETOWN UNIVERSITY, WASHINGTON, DC

Professor FEDER. Thank you, Mr. Chairman. Mr. Chairman, members of the committee, it is a pleasure to discuss my views on Medicare governance with you this morning. I speak to you today as a political scientist, a scholar of the Medicare program, and a former public official.

Medicare decisions involve critical choices about resource allocation and unavoidable trade-offs among competing goals. Choices about who gets what and who pays for it are fundamentally political. A responsible political process must be held accountable to the American people.

Unfortunately, proposals to replace a decision process subject to the authority of the President and the Congress with an independent Medicare board would remove that accountability while leaving the politics intact. Let me explain how.

First, decisions about Medicare are decisions about how to allocate substantial taxpayer dollars. These decisions are not technical and they influence much more than how the Medicare program will perform. They determine how much revenue will be available to pursue all other national priorities.

Through the budget process, the President and the Congress make choices in response to the public interest as they see it, weighing Medicare concerns against equally pressing concerns.

In the Balanced Budget Act of 1997, for example, Congress and the President chose to spend less on Medicare in order to balance the Federal budget and in order to pursue other priorities, like the new Children's Health Insurance program.

Similarly, when Congress and the President determined that some of the BBA cuts threatened institutions and access to care, they chose to expand Medicare resources. If Medicare were removed from Presidential and Congressional authority, political accountability for decisions that dictate 12 percent of the Federal budget would be substantially reduced and the ability of elected officials to make choices about national priorities would be severely limited.

Second, Medicare policy decisions affect not just health services for the elderly and the disabled, but also health services for the Nation. Medicare payment policies, as you well know, affect the financial well-being of all health care institutions, of teaching institutions, of vulnerable institutions such as rural hospitals and community health centers, and of vulnerable communities like urban and rural health professional shortage areas.

Each of these programs and policies is motivated, at least in part, by factors other than assuring access to care for Medicare beneficiaries. These are the kinds of decisions for which we hold elected officials accountable.

There is no reason to expect that an unaccountable board narrowly charged with responsibility to manage Medicare would take these broader issues into account, nor that an unaccountable Health Care Financing Administration, subject to increasing competitive pressures, would continue to pursue them.

Third, an independent board would promote narrow interest group politics above consideration of the broader public interest. Board members representing different areas of the health care system would negotiate policy among themselves. Although members might include individuals selected to represent the public, it is difficult to know what that representation would mean or how to make it effective.

Unlike with MedPAC, where although interest group politics does indeed occur) the decisions are only, recommendations to the Congress, in a board, the special interest-driven decisions would be binding.

Consider such issues as fraud and abuse, distribution of resources through risk adjustments, patient protections issues on which board members associated with the health insurance industry or with providers would be expected to have particular self-interests.

An independent board would not simply give these interests a hearing. By creating an interest-driven decision process that is binding, it would give these special interests priority over the public interest.

Even if creation of a board were enacted, with restrictions on Congressional oversight, it is also difficult to believe that Congress would not seek to reassert its control over at least some of the policy decisions.

Our recent experience with the competitive bidding demonstration shows that the temptation to intervene is overwhelming, even when a decision has been explicitly de-politicized.

That is because the stakes involved in Medicare policy decisions are so large and elected officials cannot ignore these stakes, nor should they. To structure the process as if the will stymies, rather than supports, consistent and effective oversight.

The fundamental point is that a change in Medicare's governance would not, and should not, take the politics out of Medicare. Rather, it would take the accountability out of politics.

Problems that arise in Medicare do not reflect the limitations of its structure. Rather, they reflect a need for a greater commitment to making that structure work.

Recent experience with nursing home policy provides an excellent example of that commitment. As you consider Medicare's future, I urge you to build on that model. Do not abandon it.

Thank you.

[The prepared statement of Dr. Feder appears in the appendix.]

Senator GRASSLEY. Thank you, Dr. Feder.

We will have 5-minute turns, including myself. I have several questions, so I will probably have to take a couple of turns, but I think we have got time enough to go into this and still get done on time.

I am going to start with Dr. Scanlon. In your testimony, you outlined some of the capacity and performance concerns that you have with the Health Care Financing Administration, but you also raise concerns about some of the reform proposals that we are examining.

Now, which of the options that I described in my opening statement, and for reference that is a summary of them, would you recommend as the best way to improve governance of the Medicare program?

Dr. SCANLON. Well, Mr. Chairman, I think as you indicated at the outset, these are not mutually exclusive options. There really is the potential to think about combinations, as well as overlap. There is almost a continuum between the incremental changes and the fundamental reengineering.

I think, given what I discussed in my testimony in terms of problems of focus and continuity, that reengineering, to some extent, is a critical element of thinking about how to strengthen HCFA, because incremental changes may add to the capacity, giving HCFA the flexibility to hire more personnel and to hire different types of personnel.

But it does not deal with the issues of the fact that HCFA has multiple responsibilities which have to detract from leadership attention, and that that leadership has not been present on a continuous enough basis for many changes to be implemented.

We are in a situation right now where we have looked at much of what HCFA has done over the last few years. Administrator DeParle has responded extremely effectively in terms of trying to implement change.

But here we are, we are about to see the end of her tenure as HCFA administrator, and then there will be a period of time before we have someone new who will instill their vision as to how HCFA

should be managed, how it should respond to the Congress, and how it can guarantee the success of Medicare.

Senator GRASSLEY. Thank you, Dr. Scanlon.

Now I would like to go to Dr. Feder, first, then Dr. Scanlon, second, for the first question. It would be in regard to what I think was a description of option number four, which Dr. Wilensky described, and to hear your reaction.

Professor FEDER. I think it is important to consider the range of functions that HCFA is charged with today, Mr. Chairman, but I think we sometimes lose sight of the fact that those responsibilities are intersecting and overlapping.

If we look, for example, at some of the Medicare and Medicaid functions, we have to recognize that, although those programs are different, we have a substantial number of older senior citizens who are served by both programs, that health care institutions operate in both programs. So, I think it is very difficult to take some of these functions apart and treat them very separately.

My general attitude toward what is termed reengineering, is a concern that we have not adequately supported in recent years the structure that we now have.

When I spoke about commitment, consistent with the letter that we talked about or that was presented earlier that Dr. Wilensky said she signed with respect to resources and support for the existing administration, it feels as though we have not adequately gotten behind the system we have. I do not think we have tested it. So to abandon it without testing it would seem to me to be a mistake.

Senator GRASSLEY. Now, Dr. Scanlon.

Dr. SCANLON. Mr. Chairman, I think that in terms of trying to separate some of the functions with HCFA, of course, we need to approach this with considerable care. I mean, there are some that I think are much easier to consider as being separable.

In fact, HCFA has received the responsibility under the Health Insurance Portability and Accountability Act legislation, just as recently as 1996, that has turned them into the equivalent of State insurance commissioners for States that do not have conforming legislation. That is something that does not directly overlap with any of their other functions.

The activities with respect to certification of providers is something that they do for certain types of providers and not for others. In many States, the separation between the administration of Medicaid and the responsibility for certifying providers is between two different departments. Whether there is something about the models in the States that we should learn before we decide on this, is something we could address in the future.

On the question of the interaction between Medicare and Medicaid, I agree with Dr. Feder: there is a significant population—in fact, the most vulnerable portion of the Medicare population—that is probably the dual eligibles. However, I do not think we have taken advantage of any synergies that may have existed between those two programs to date, so I think we need to think about whether we are going to take advantage of those synergies or whether we actually can enhance beneficiaries in both programs'

experience by allowing HCFA—or an entity, I should not say HCFA—to focus more exclusively on the Medicare program.

Senator GRASSLEY. Now, Dr. Feder, even without enactment—I think I will finish this. I will do one more question and then I will go to you, Senator Breaux.

Even without enactment of an outpatient prescription drug benefit, the Health Care Financing Administration actuary estimates that, within 15 years, expenditure of Medicare A and B will exceed $638 billion annually.

Do you have any concerns about the Federal Government's capacity to administer essentially a single benefit plan of that magnitude of enrollment and spending, and do you recommend that we consider evolving Medicare into a purchaser of health plans with all that that implies about decentralized administration of plans and benefits?

Professor FEDER. I absolutely do not recommend moving in that direction. I think that, while it is very important to be concerned about adequate administrative capacity, there is a broader issue that is raised by a single benefit program as opposed to competing benefit plans and beneficiary selection or shopping among plans.

The Medicare program is a guaranteed entitlement of benefits to all seniors in a plan that spreads risks and protects people regardless of their health status and regardless of their income, with a little help from Medicaid, in a way that could not be achieved by reliance on competing health plans, which we know from considerable experience tend to fragment risk, separate the healthy from the sick, and the poor from the better off.

So I think that we definitely have administrative challenges, political challenges, ahead of us. In pursuing them, we ought to pursue them with administrative commitment and also a continued commitment to a social insurance program.

Senator GRASSLEY. Thank you, Dr. Feder.

Now, Senator Breaux?

Senator BREAUX. Thank you, Mr. Chairman. And thank all of the witnesses for their presentations.

I want to talk a little bit about the proposal in S. 1895, the Breaux-Frist bill, which is constantly being modified, and hopefully updated, as we hear more and more testimony.

The idea of creating a Medicare board is not to make it independent of anybody. The intent, and the legislation will reflect that, is to make it independent of HHS and to create an independent board within the executive branch.

The executive branch would have the authority over that board, as they would have the authority over any other board that they create. There are numerous examples, as CRS has said earlier, of independent boards.

That is not to say that we want to give them independence so they are not responsible to anyone, but rather to create an independent board that is a part of the executive branch of government which would give them responsibility to be responsible to the executive branch.

I feel that that is necessary because, if you take an agency which for 20-some odd years has administered a government-run administered pricing system and say that, all of a sudden, you are also

going to oversee private competition, it is like asking my wife's cat to go out and fetch. It is not going to do it. It is not its nature.

So what we are trying to do, is to allow the HCFA administration to do what it is attempting to do, and that is to run a fee-for-service where they fix prices on charges, then create a new, independent executive branch board which would supervise the private competition.

The fact that it would be an independent agency within the executive branch, Dr. Feder, does it make any difference, in your opinion?

Professor FEDER. Well, Senator, I hear two concerns that you have. When you are talking about simply separating it from HHS but making it an agency within the executive branch, that seems different to me from my reading of the bill as written. I hear you say it is evolving.

Senator BREAUX. Yes.

Professor FEDER. I think many of the concerns that we have expressed, that many of us have expressed, have to do with, in the current legislative language, there is really removal from the President's——

Senator BREAUX. I wanted to point that out. You are right, the intent is that it should be an independent board within the executive branch, and responsible to the executive branch.

Professor FEDER. So commenting then on what you have posed as an alternative, really, to the language as it is written and having the program be independent of HHS, one broad thought and concern I have about that, and it is partly addressed in my testimony, or it is relevant to what I said in my testimony, is that Medicare is part and parcel of our Nation's health care system, a big piece of it. The Department of Health and Human Services and the Secretary of Health and Human Services are responsible for health policy. So I have a concern about distinguishing them.

Senator BREAUX. They are also responsible to the executive branch.

Professor FEDER. They are. I am saying that these are separate issues, I think that the accountability to the executive is critical. I am hearing as a distinct question whether this should be an independent operation. I am saying I think there is value, and indeed perhaps necessity, to having it linked to broader health care issues.

On the third issue (and I would have to be dead not to know that there is a concern about the ability of the Health Care Financing Administration to balance, to operate, both a traditional fee-for-service system and a competitive system): I think that the degree to which the marketplace has changed in recent years requires changes and responsiveness on HCFA's part. I think there is no question about that.

I think that the right way to achieve that, though, is through the accountability to the executive, to elected officials. I think sometimes there is a confusion in terms of HCFA's role. It is treated as if it has allegiance to a fee-for-service system.

What it has through the executive and Congressional oversight process, is an accountability to taxpayers and to beneficiaries, regardless of the kind of health plan through which its beneficiaries get services. It is critical to recognize that that is where the ac-

countability belongs and not to elevate or distinguish one kind of plan from the other. The whole system has to work.

Senator BREAUX. I would just make the point that accountability is the Congress' responsibility.

Professor FEDER. And the President's.

Senator BREAUX. With all due respect to the agency who is appointed by the executive branch and the Congress who writes the laws. I mean, the problem we have, just as an aside, is that every year we sit in this back room and try to micro-manage this program.

We talk about whether we are going to increase drugs by 0.4 or 0.5, whether we are going to increase co-payments on home health, whether we are going to extend the number of days and hours in a hospital, or how much we are going to provide for ambulatory surgical procedures, or whether we are going to allow for payments of injectable drugs but not orally-administered drugs.

Every lobbyist in America is standing out there in the hall trying to slip us papers, trying to say it should be 5 percent, 6 percent, not 4 percent. It is the ultimate in micro-management and it is not working.

Professor FEDER. May I respond, Senator?

Senator BREAUX. That is just my opinion. It is not a question. I do not have a question. Maybe the second round we will have time to do that. I am sorry.

Thank you, Mr. Chairman.

Senator GRASSLEY. Senator Rockefeller?

Senator ROCKEFELLER. I would ask for your response.

Professor FEDER. Thank you, Senator Rockefeller.

Senator GRASSLEY. I did not mean to cut anybody off. She could have responded.

Professor FEDER. No, you did not. You did not cut anybody off.

Senator GRASSLEY. All right. We will not count this against Senator Rockefeller's time.

Professor FEDER. Under current law, many of the decisions you take up, you are not required to take up. You take them up because, as you say, you have industry spokespeople. You have industries who are tremendously concerned with and affected by what Medicare's policies are. That is, I believe, why you respond to them.

I do not think we can, by changing organizational structure, wish those decisions away. We are spending over $200 billion on the Medicare program. It is of enormous importance to everybody. That is, with due respect, why we elect you, to make those decisions.

The accountability lies with both the Congress and the President and his appointees, and we do, and should, hold you accountable through the electoral process for making what are inevitably difficult trade-offs and decisions about how our Nation's resources are used. I do not think there is an alternative to having that be an accountable, and yes, a political, process.

Senator GRASSLEY. Now, Senator Rockefeller.

Senator ROCKEFELLER. Thank you, Mr. Chairman. Thank you for that, Dr. Feder.

I am not completely sure of this, but it is my impression, Dr. Wilensky. As I think back on the 14 years I have been on the Fi-

nance Committee, this is really the first time that we have ever focused, in this case through the route of "a board" on HCFA.

John, I think, talks very appropriately about micro-management. In America, generally, when you say the government is micro-managing things, that brings out automatic responses. People say, let us go and try another route. Then I would come back to the point that we have an enormous responsibility for what goes on in Medicare.

But I really wonder, if you took to the American people the word HCFA, or if you were more generous and took to them the words Health Care Financing Administration, what percentage of them would know what it was, what it did, for what it had responsibility.

Professor FEDER. About one.

Senator ROCKEFELLER. Yes. About 1 percent.

So the concept of trying to figure out what it is that HCFA can do better and how it can do better, it strikes me as not an irrational or irresponsible course to consider.

For example, the idea that HCFA can only do one thing, and I do not want to think about some of the ideas that you suggested about what we should separate, et cetera. But the idea that HCFA can do fee-for-service but cannot do something else, or it cannot do private competition, et cetera.

I mean, why does that have to be true? Because it has not been true. Why does that have to be true? The fact is, the members of this committee probably have virtually no idea of what goes on in HCFA.

My guess would be that most of the members of this committee have never been to HCFA. You come to us in terms of the head of HCFA, the administrator of HCFA.

So it is a little bit like the Surface Transportation Board, which is enormous in American life, or the Federal Aviation Administration, which is enormous in American life. Well, people do know what the FAA is, but they have no idea what the Surface Transportation Board is, which has to do with railroads and all kinds of things. The chairman of the Surface Transportation Board and I have been carrying on this battle to get, as John Breaux knows, something called CAPTR SHIPRA legislation.

She comes to us every year and says, if you would just give me the authority, Congress, to do what I need to do, plus a few more dollars, I could change the way this system works. But we do not do it because we have no interest in the Surface Transportation Board, and nobody shows up at the committee hearings. Witness our large gathering here today.

I would just, I guess, pose to any of you, do you basically disagree with that idea, that looking at what HCFA could do and do better in a serious, responsible, short- and long-term manner, understanding that the world of health care has changed, that there are many more ideas now on the table, that many of those ideas are good—not all of them, but many of them—and that HCFA can indeed adjust, or perhaps can adjust? In any event, I would appreciate your comments on this.

Dr. WILENSKY. Let me respond. When I would go out when I was the administrator of HCFA and introduce myself, I would typically say, I am the administrator or director of Medicare and Medicaid,

because every knows that. They may get them confused as to which is which, but there is really no recognition of HCFA, per se.

My concern about the current organization, is that while I do not think an organization need focus on only one thing, this one thing is bigger than most other cabinet-level departments in this country. I mean, we are talking about a very big one thing, running traditional Medicare.

The second thing, is that it has been very much the focus of the people who have been in the agency. It is the dominant part of Medicare, the traditional program. It requires a lot of decisions about proper pricing and whether the quality is as it should be, and whether or not services are provided in an appropriate way. It involves, in its nature, decisions at a very small-unit level. It is why I am concerned, in part, because of this focus.

If you want to have Medicare alternatives—I do not believe the present program is a stable option. I think that we will either migrate to something like a Federal Employees Health Benefits Program or a modernized fee-for-service plan. I am doubtful you can have both—that you need to have the kind of expertise, understanding, and experience in negotiation.

Now, maybe you could put that into HCFA. I will tell you, it does not, for the most part, or maybe for any part, exist now.

Medicaid, if I may finish this one thought, while it is true that there is overlap and that there is some rationale for putting it together with Medicare, it is not that it was a foolish idea, the fact is, Medicaid has always been HCFA's stepchild.

When I was there, I went back to an earlier organizational form. I set up a Medicaid bureau because I wanted to focus more attention, because it had been getting the short shrift, in my view, for a long time.

But, even so, I think there has been the sense that Medicaid remains the stepchild of HCFA, because running Medicare is such an overwhelming, unrelenting task that it just does not command the presence.

It was why I thought that having somebody who has, as a main focus, this very important program, oversight of Medicaid, might help it. But I absolutely agree with your last statement, this is a very serious issue.

I do not, for any moment, want you to take my recommendations and think that I mean you ought to act on them in short course. It is something that ought to start as a processing, reviewing the functions of HCFA and trying to decide if we could not do them better.

Senator ROCKEFELLER. Mr. Chairman, with your indulgence.

I think, in the Taiwan Relations Act, ambiguity is critical for our Nation, the concept of ambiguous law. What is the United States going to do? We do not have to tell the Chinese what we are going to sell the Taiwanese. But ambiguity there is in many ways what protects security in the Taiwan Straits, which is the most dangerous place on earth at the present time.

I think the ambiguity in terms of figuring out what we are going to do in terms of handling HCFA, Medicare, all of that, is, in fact, the enemy of security for our senior citizens. I think that point needed to be made, so I made it.

Thank you, sir.

Senator GRASSLEY. We appreciate your reiteration of the support of the Taiwan Relations Act of 1979.

Senator BOB GRAHAM?

Senator GRAHAM. Thank you, Mr. Chairman.

I would like to ask two questions; one is forward-looking, the other is backward-looking. Let me start with the forward-looking question.

It is my opinion that the two primary changes that need to be made in the Medicare program, which respond to changes in the characteristics of the population that it serves, the desires of that population, and changes in medical science, are, first, to begin to have Medicare respond to the fact that we are now dealing with an aging process among our older Americans as opposed to the single event of death.

With so many elderly, the average female now living 20 years beyond the age of 65 and many hundreds of thousands living substantially longer than that, we need to have a Medicare program that responds to the fact that this is a gradual process, not an instantaneous process.

The second, is we need to reorient from a program which, from its origins, was predominantly an acute care program to one that is more balanced with a focus on prevention and the maintenance of health throughout this long aging process.

Those are my prejudices as to what the primary reforms of Medicare should be. If you would accept those prejudices, do they affect what you believe the governance structure should be?

Should Medicare, taking into account its responsibility to respond to the aging process and to be more preventive in its orientation, do they require a different governance structure than the one we have today, and if so, what?

Professor FEDER. I think they are legitimate premises, so I would agree with them. I do not think they affect the administrative structure insofar as accountability is concerned.

I do think that they have relevance in a discussion or a review of the responsibilities that are within a single agency or within a single department that is held accountable. I think we have focused a little bit here but on the Medicare and Medicaid issues in that context.

As you talk about the aging of the population, as you well know, the need for and concern about long-term care rises high on the screen along with the concern about prescription drugs in terms of an aging population with chronic illness.

I agree with what Dr. Wilensky said about Medicaid having long been a stepchild. I recall when she tried to elevate attention to it; I think that has happened more than once in different organizational structures.

What is of current concern to me there is not so much organization as the fact that Medicaid, as a means-tested program in which authority is shared between the Federal Government and the States, gets short shrift. Means-tested programs tend to be mean programs, and we do not give them the attention that they deserve.

So to go back to the question that you asked, I think it matters a lot to try, as we examine functions, to keep those functions that

treat people and institutions, the same institutions, together, giving all aspects of it attention in a way that makes sense.

Dr. WILENSKY. But I think also, if I may continue on it, is why I am so concerned about the multi-functions that HCFA faces. You have indicated, both in terms of the fact people are living longer, therefore they are going to be beneficiaries longer, there are more of them coming on, as you well know, that will, in and of itself, enlarge the pool.

Our focus on an acute medical care model, which has been the tradition of Medicare, it is based still on the 1965 basic model, means that there is a lot of change this agency has to accommodate. It will require help from the Congress. I personally believe the Congress has been extremely micro-proscriptive.

There were portions of the RBRVS that were inherently inconsistent in statute because it had been written at such a micro level, that in fact there were parts that you literally could not implement as they were written in statute. That is just sort of taken in the extreme, the kind of micro-involvement that the Congress has had.

I appreciate why there has been tension in divided government and a sense of mistrust, but it breeds a whole series of other problems. I think that Congress needs to think about what functions it wants to have HCFA focus on.

As you know, I support other options besides the traditional Medicare program. Where and how that should occur, and just how much flexibility and authority the Congress is willing to give HCFA, it is one of the favorite topics of bashing, but it does operate under a lot of constraints, financial being only one of them.

Senator GRASSLEY. I have a couple of questions, then we will conclude.

I would ask Dr. Scanlon to look at number three. I think our third option—I should not say our third option, the third option that I have listed—is conceptually close to what the Breaux-Frist legislative proposal might be.

Does the General Accounting Office have an estimate of how many FTEs might be involved in overseeing a plan competition and/or a drug benefit?

Dr. SCANLON. Mr. Chairman, we do not have a very exact estimate. Currently within HCFA now covering the functions of an operational board as envisioned under Breaux-Frist and the operations that they would undertake, the personnel are dispersed throughout the various entities within HCFA.

Before HCFA reorganized in 1997, there was an Office of Managed Care which had several hundred people between the central office and the regions. Those kinds of functions would be something that that board would have to engage in, so certainly you would need that many people.

In addition, you may need many, many more because those people in the Office of Managed Care were supported by people in information technology, personnel, and other agency units. This board, as an independent entity, would have to be able to perform all of those functions internally.

It would also probably require regional presence. I mean, we would need to think about it in terms of oversight of the plans that are participating in the program. The magnitude of the Medicare

program suggests that there needs to be adequate oversight. So this board, in exercising its function, is probably going to have to have a presence around the country, as well as centrally.

Senator GRASSLEY. All right. Thank you very much.

I would like to ask Dr. Wilensky, do you have any thoughts about the time line and the process involved in reengineering HCFA? And maybe answer that question even independently of the reforms being enacted.

Dr. WILENSKY. I think the part that should take the most time is deciding how you want to reallocate the functions of HCFA. That is a very serious issue. I assume we are talking about a minimum of 12 to 18 months to assess the functions and to reassess where else they might belong.

I believe that the actual reallocation could occur relatively soon. I think that once you decided where to have these functions housed, all of these are existing agencies, at least in the immediate term as I have envisioned them so the move could take place over a relatively short period, so I believe the whole process would not exceed 2 years, but it may be shorter. It is really that first stage, deciding what you want to do, that is the hard one.

Senator GRASSLEY. All right.

My last question would be to Mr. Garcia. Some proponents of a Medicare board or independent agency approach cite the Health Care Financing Administration performance problems as the question they are hoping to answer with the new administrative approach, a new independent agency.

However, you have in your discussion raised that such a governing concept raises new questions of accountability, so that gets me to my point. If a new entity were to be designed, are there structures that could be included to bridge the gap between enhancing performance and still preserving necessary accountability that you have to have in government? I mean, it is our constitutional responsibility to make sure that we have that accountability.

Mr. GARCIA. Well, Mr. Chairman, the key area of accountability here is based on the fact that an individual, the head of the agency, is responsible to the President and also to the Congressional branch. By providing a fixed term of office with removal only for cause, it makes it very difficult to remove that person.

By adding to it the fact that the agency is able to generate its own budget so that it does not need to go through OMB and also does not need to come to Congress, means that accountability to the President is severely restricted, and to Congress, it is diminished.

So one way of making an agency more accountable would be, first, by requiring that it go through the normal appropriations process.

For Congress to be aware of what the agency deems necessary for its operations, Congress could indicate that when the agency submits its request to OMB, that concurrently the request be submitted to Congress so that Congress is aware of the exact needs that the agency feels that it has.

Or it could even provide that when the agency submits the budget to OMB for inclusion in the President's overall budget, that

OMB cannot to revise the budget, but merely present it in the budget to Congress as it has been presented to OMB.

Senator GRASSLEY. Thank you very much.

Now, do either one of my colleagues have anything before we adjourn?

Senator ROCKEFELLER. Might I make one observation?

Senator GRASSLEY. Senator Rockefeller.

Senator ROCKEFELLER. Thank you very much, Mr. Chairman. This goes back to the whole question that all of what we are talking about is a part of the democratic process, or the accountability. It is involved in politics in which mistakes are made, and undue influences can be involved. It goes a little bit back to the point that you were making, Dr. Feder, that that would not stop if you had a board. It would just be concentrated on a much more select group. As there are thousands of health care trade associations in town, it would be an interesting process.

But what strikes me, actually, the subject of the BBA was brought up. We basically, trying to do the right thing, that is, to extend the solvency of Medicare, et cetera, made some mistakes. We made basic—the Congress, that is—damage to home health agencies, skilled nursing facilities, and the hospitals are what I had particularly in mind.

Last year, in a very inelegant process which came at the final moment as things so often do, we did a $27 billion fix. Now what has happened, is the crisis continues but we have withdrawn. But, whereas that would seem to be bad, and is, indeed, if we do not do anything further, it is also the essence of the accountability that we are talking about.

In other words, the American Hospital Association and others say that up to 60 percent of their hospitals—and this is a very hard figure to deal with, but there are three different organizations that have said so—may close by the year 2002 if we do not do something more. But our reaction has sort of been, well, we did what we did last year, therefore, we gave at the office, so let us just kind of leave it for a while and see what happens.

Well, that precise tension between what is actually happening out there when I go to a rural hospital in Webster or Calhoun Counties and I see their books, and I see what is happening to them, and I see they are going from a $500,000 profit to a $1.8 million loss from last year to this year.

It is the precise active accountability of me discovering what is happening to rural hospitals in rural West Virginia as one Senator, and therefore the effect on me that we should, in fact, not be leaving BBA, but we should be doing more to fix some of the mistakes that we made.

But my point is not so much to lobby, although partly, for doing more on that, but to say that we do make mistakes in Congress. We did make a mistake in RBRVS. We were too proscriptive. But we were saying, it is generalist versus specialist. We want more generalists and fewer specialists, and that was right. So the thrust was right. Some of the innuendoes or some of the precision was wrong, so we work at that.

But we are here for a reason, and you just said it, Mr. Chairman: accountability. We are here for a reason. We are here presiding

over this enormous program, this enormous amount of money, the lives of 39 million people, and that cannot be either handed off or taken lightly.

It is our responsibility, beginning on this committee, to figure out how we can make it better. I think the primary way of doing that is to figure out how to do HCFA better. I thank you for that.

Senator GRASSLEY. If you keep admitting we make mistakes, you are going to reduce the cynicism of the American people towards Washington.

Senator, you are done?

Senator ROCKEFELLER. Yes.

Senator GRASSLEY. All right.

Well, I have no closing statements. We are in the process here of getting to a point where we want to consider some Medicare legislation. Obviously you have helped us very much in that process. We thank you for it, and thank the audience for their attendance and their interest in it.

The hearing is adjourned.

[Whereupon, at 11:50 a.m., the hearing was concluded.]

APPENDIX

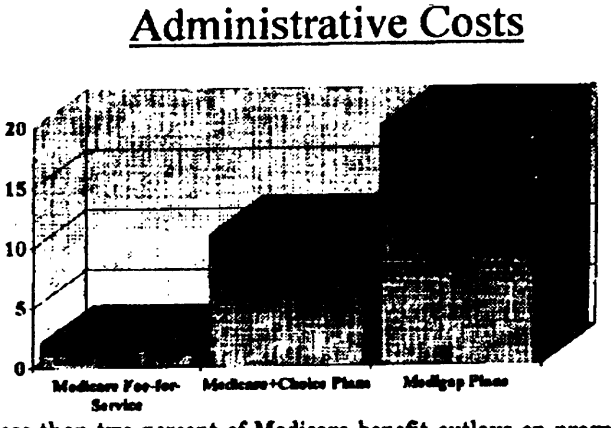
ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

PREPARED STATEMENT OF NANCY-ANN DEPARLE

Chairman Roth, Senator Moynihan, distinguished Committee members, thank you for inviting me to discuss our efforts to strengthen and improve Health Care Financing Administration (HCFA) management. I greatly appreciate your support in these efforts and your concern for the management challenges facing Medicare, which will celebrate its 35th birthday this year. I believe we share the goals of increasing flexibility in purchasing and management, maintaining and improving the program's high level of efficiency, and modernizing Medicare's benefits while ensuring access to high-quality, accessible services for all beneficiaries.

The people who work at HCFA care deeply about serving the 39 million senior citizens and people with disabilities who rely on Medicare for health care coverage, and I am very proud of our record of accomplishments. HCFA is the largest health insurer in the nation, providing coverage for some 74 million Americans through Medicare, Medicaid, and the State Children's Health Insurance Program, and paying about $368 billion for health care services this year.

For Medicare alone, the agency pays more than $210 billion in claims to some 700,000 physicians, 6,000 hospitals, and thousands of other providers and suppliers each year. We contract with 55 private health insurers to process nearly 1 billion Medicare fee-for-service claims each year, and with 346 private health plans that provide managed care. Innovations we have developed in quality improvement and prospective payment systems that promote efficiency have been widely adopted by other insurers.



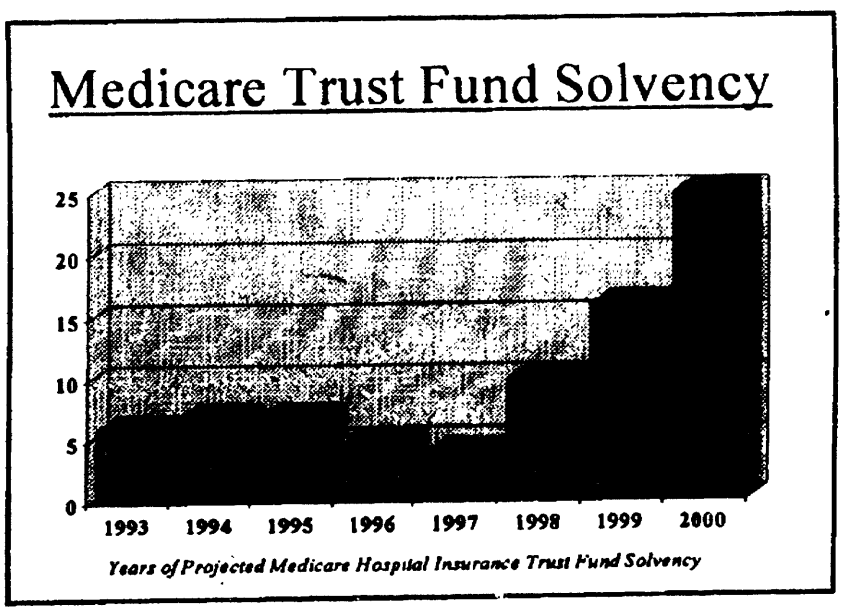
We spend less than two percent of Medicare benefit outlays on program management. This compares to Medicare+Choice plan administrative costs that average 11 percent and are sometimes 25 percent or more, and supplemental Medigap plan administrative costs that average 20 percent and are sometimes 40 percent or more. HCFA's administrative costs still compare favorably, even when adjusted to account for differences such as marketing expenses, profits, and other costs that private plans may incur.

SUCCESS AND SOLVENCY

We also have had solid success in meeting the priorities that I articulated at my 1997 confirmation hearing before this Committee: modernizing and strengthening Medicare, starting with implementation of the Balanced Budget Act of 1997 (BBA); sharpening our focus on fraud, waste, and abuse to ensure that Medicare dollars are spent appropriately; launching the State Children's Health Insurance Program; and, meeting the Year 2000 computer challenge.

- Our National Medicare Education Program is an unprecedented enterprise designed to help Medicare beneficiaries understand Medicare and their options under the Medicare+Choice program, as well as the important new preventive benefits included in the BBA.
- We have implemented the vast majority of provisions in the BBA, which modernizes Medicare and Medicaid and strengthens the solvency of the Medicare Trust Fund.
- We have approved State Children's Health Insurance Program plans for all states and territories and enrolled 2 million children.
- We have made substantial progress in implementing new prospective payment systems for skilled nursing facilities, hospital outpatient departments, and home health care that include incentives to provide care efficiently.
- We have had solid success in fighting fraud, waste, and abuse. Our Medicare payment error rate is down by about half. We have many new tools to prevent improper payments and keep unscrupulous providers out of our programs. And we have a comprehensive program integrity plan in place that will help us bring the payment error rate down further.
- And we achieved this while successfully meeting a daunting Year 2000 computer challenge. Despite many predictions of failure, we met this challenge and in the process developed what our independent verification and validation contractor decided were best practices that they in turn recommended to their other clients.

The BBA and our successes in fighting fraud, waste, and abuse, have together contributed to the strongest projection of Medicare Trust Fund solvency in the program's history. The Part A Hospital Insurance Trust Fund, which was projected to become insolvent in 1999 when President Clinton took office, is instead now projected to remain solvent until 2025.



We have also tackled other long-standing challenges with success—improving services to beneficiaries, improving nursing home quality, improving financial and contractor management, and creating a more open Medicare coverage determination

process. We continue to implement management improvements outlined in the President's FY 2000 and FY 2001 Budgets. This initiative is specifically aimed at improving our internal communication, increasing our flexibility to operate, and perhaps most important, increasing accountability to our constituencies.

- We fostered a new focus on serving beneficiaries in all we do through our new Center for Beneficiary Services. This Center has improved the quality of materials for beneficiaries, and its director is a leading member of our Executive Council, bringing a beneficiary focus to all senior level deliberations. And it has made advances in health promotion, for example, by developing tear-cards for colon cancer awareness posters so beneficiaries can take information with them to help start difficult conversations with physicians. We are already seeing results of this sharper beneficiary focus, with numerous awards for our beneficiary web site, www.medicare.gov, and a high rating for beneficiary services in the 1999 American Customer Satisfaction Index.
- We launched a major initiative to improve nursing home care and safety. We tightened rules, clarified guidance, increased surveyor training, required prompt action on complaints alleging harm to residents, and posted survey results on the Internet, and acted to protect residents in facilities with financial difficulties.
- We greatly improved internal financial management and oversight of claims processing contractors. I am determined to meet the same high accounting standards required of major private corporations. This year, for the first time, we obtained an unqualified audit opinion, which means that auditors determined that our books and records adequately reflect Medicare assets and liabilities. But we intend to do even better. We are developing an integrated financial management system to better coordinate and reconcile contractor data. We consolidated contractor management responsibility by appointing a Deputy Director for Medicare Contractor Management and creating a Medicare Contractor Oversight Board. We are determining payment error rates and developing performance report cards for every contractor. And the President's fiscal 2001 budget includes funding for new positions at contractors and at HCFA to further tighten financial controls and ensure swift, coordinated responses to fraud, waste, and abuse.
- We have made the Medicare coverage determination process open and accountable. Every member of the public can request a national coverage policy decision and submit new data for review by our Medicare Coverage Advisory Committee. Information on the status, evidence, and rationale for all determinations is posted on the Internet. And there are timeliness standards for actions on determination requests.

PREPARING FOR THE FUTURE

Building on our success in meeting our goals and tackling longstanding management challenges and, thanks to additional resources Congress provided in 1999 and 2000, we are now eagerly preparing for the future. We are conducting a comprehensive assessment of workforce needs, bringing in new employees with private sector experience, and enhancing training for current staff.

We also are consulting with experts across the country and preparing for structural reforms that Medicare will need to address the demographic and health challenges of this new century. We are pleased to see a bipartisan consensus emerging on the need to modernize and strengthen the program. As we work together to act on this consensus, we must not only ensure that the proposals meet the goals of strengthening and modernizing Medicare, but do not undermine the basic commitment of guaranteed access to high-quality health services that has made Medicare the success that it is.

The President has proposed such a plan. It includes:

- **Adding a voluntary, affordable prescription drug benefit available to all beneficiaries.** No one would design Medicare today without a drug benefit. Pharmaceuticals are essential to modern medicine, and no Medicare modernization package is complete unless it ensures that a comprehensive drug benefit is available and affordable to all beneficiaries, both in Medicare+Choice plans and the traditional fee-for-service program.
- **Improving access to preventive services.** We need to focus more on avoiding problems, instead of paying too much to treat preventable problems after they occur. The President and Congress added several important preventive benefits and eliminated copayments for others in the BBA, but there is much more that we can do to promote access to these services. The President's plan

would eliminate all existing cost sharing for preventive services and evaluate coverage of additional preventive services.

- **Creating the Competitive Defined Benefit system.** The President's plan would replace the complicated statutory formula used to pay managed care plans with a payment system based on price competition. For the first time, beneficiaries would shop for a health plan based on its price and quality by paying lower Part B premiums for more efficient plans. Managed care plans would also benefit since their payments would be based on what they bid and, unlike today, they would receive an explicit payment for covering prescription drugs.
- **Using proven private-sector purchasing tools.** Primary care and disease management programs are proven to improve health care outcomes while controlling costs. We also need to use bidding to determine what we pay to suppliers and health plans, rather than fee schedules or formulas that result in payment rates that bear no resemblance to true market value. We know this works in the private sector, and we are seeing substantial savings for both beneficiaries and the program in our competitive bidding demonstrations for medical equipment.
- **Reforming Medicare contracting rules.** The plan would bring Medicare contracting in line with standard contracting procedures used throughout the Federal government. While we are making strides in strengthening oversight of the private insurance companies who, by law, process Medicare claims, the General Accounting Office and HHS Inspector General agree with us that we need an open marketplace so we do not have to rely on a steadily shrinking pool of insurance companies and can use all firms capable of processing claims and protecting program integrity.
- **Dedicating non-Social Security surplus to strengthen Medicare's trust fund.** In addition to modernizing the basic program structure, we must shore up its financing and prepare for the inevitable influx of new beneficiaries as the Baby Boom generation reaches retirement age. The President's plan does so by dedicating $299 billion over 10 years of the on-budget surplus to the program to help extend the solvency of the Hospital Insurance Trust Fund through at least 2030. It makes sense to use the budget surplus to help prepare Medicare for the Baby Boom's retirement, since the surplus was largely generated by the Baby Boom. It also helps contribute towards the President's goal of eliminating the national debt by 2013 because these dollars would be used to buy down debt.

The details of the President's reform plan were outlined last June, in the President's FY 2001 budget, and in legislative language sent to Congress last month. We hope that it serves as the basis for comprehensive reform this year.

Another Medicare reform proposal introduced recently is the Medicare Preservation and Improvement Act of 1999, whose primary sponsors are Senators Breaux and Frist. This plan is the next iteration of the Breaux/Thomas plan and is, in my view, a significant improvement over that proposal. It no longer raises the age of eligibility for Medicare, restricts assistance for drug coverage to low-income beneficiaries, or includes a home health copay. It also, like the President's plan, injects price competition into Medicare. Its focus on the need for Medicare reform is a contribution to the debate.

We are, however, concerned about the plan's Medicare Board proposal, which I would like to discuss. The Administration also has concerns about its premium support proposal, which would have the effect of increasing premiums for the traditional program from 25 to 47 percent, according to the independent Medicare actuary. The GAO and CRS have also testified that traditional program premiums would increase. The plan would offer a 25 percent subsidy for private drug plans, which neither guarantees that a drug option will be available nor affordable to all beneficiaries, unlike all other Medicare benefits. And the plan merges the Medicare trust funds and caps general revenue for Medicare, causing this new trust fund to become insolvent in 2008, according to the GAO. In contrast, the President's plan would extend the Medicare trust fund's life.

CONCERNS WITH A MEDICARE BOARD

Given the topic of this hearing, I would like to focus on the Board proposal in the Breaux-Frist plan as well as other options being contemplated by Congress. This Committee has been considering proposals to fundamentally change the administration of Medicare, including a proposal to separate administration of original fee-for-service Medicare from oversight of Medicare+Choice plans, and instituting a new Medicare Board to manage the Medicare program. I believe Congress has been contemplating such changes to solve certain perceived problems with the way Medicare

is administered today. These include the desire to insulate Medicare from "politics," and make it function more like a private sector company, make the program more responsive to providers, and to address the perceived conflict of interest that exists for a single agency to run both the fee-for-service and Medicare+Choice programs.

However, I believe that some of these issues can be addressed without an overhaul of Medicare's management, and others are inherent in the running of any major program, so that even the most radical Medicare board would not "solve" them. We can and should build our efforts to adopt the best private sector management practices. We have created the new Medicare Coverage Advisory Committee and Citizens Advisory Panel on Medicare Education to get public and private input on these important topics. Our reform plan would give Medicare additional management tools that would allow it to operate more like a private health plan. And, we continue to explore ways to incorporate both advice and practices that have proven successful in the private sector.

An issue that cannot be solved under either the current structure or a Board is the influence of "politics" on Medicare. Politics are a part of any major public or private institution and no amount of restructuring can change that. In a public program like Medicare, "politics" is part of public accountability. It is appropriate for a public program of Medicare's size and importance to be accountable to beneficiaries and taxpayers through their elected representatives—Congress and the President.

Furthermore, I do not believe the alleged conflict of interest between fee-for-service and managed care exists at HCFA. Our "clients" are beneficiaries and the taxpayers who support them. Our goal is to give beneficiaries and taxpayers the best health care for their dollars, whether it be through managed care or the traditional program. We have worked very hard to revise regulations and take other steps to help plans participate in the Medicare+Choice program, and believe managed care is an important option for beneficiaries next to the traditional Medicare program.

For these reasons, I do not think that a Medicare Board is necessary. Moreover, as it is structured in the Breaux-Frist plan, a Board would create significant risks to Medicare. The Board would be a 7 member, independent group, not subject to any civil service rules or "sunshine laws" whose members could only be removed for cause. It would administer the competitive premium system and oversee the operations of all Medicare plans, including enrollment, contract oversight, and beneficiary education; and approve and authorize payments for all plans, including traditional Medicare. HCFA would be reorganized into two divisions: one that runs the new health plan operating Medicare fee-for-service and a second that would manage graduate medical education, Medicaid, the State Children's Health Insurance Program, and other functions. Rather than explicitly modernizing the traditional program, the proposal would have HCFA submit a business plan directly to Congress every year, beginning in 2002, for approval.

The major concern with this Board is accountability. With the Board outside the Executive Branch, the President would have virtually no authority over one of the most important Federal programs. In fact, under the proposal sponsored by Senators Breaux and Frist, the Board and its members would be accountable to no one, including Congress. Seniors and people with disabilities rely on their elected officials to respond to their concerns about the care and service they receive in Medicare. This is an extraordinary change given that Medicare is one of the largest government programs, accounting for up to 11 percent of the federal budget, and is of critical importance to millions of our nation's most vulnerable citizens.

This Board would create its own substantial conflict of interest concerns, both with the Board and with original Medicare. Unlike existing Federal boards, the proposal sponsored by Senators Breaux and Frist would create a Medicare board with virtually no conflict of interest requirements for Board members, such as financial disclosure, limits on any management role or financial interest in regulated entities, or limits on member activities after service. That would allow members to make decisions based on personal financial interests or potential benefits from future employment with regulated plans. The proposal sponsored by Senators Breaux and Frist creates a potential conflict of interest for original Medicare, as well. That is because it gives the program a fixed annual budget and that could create undue incentives to put cost concerns ahead of beneficiary rights, quality concerns, and other oversight obligations.

Finally, a Board would detract from administrative efficiency. One of Medicare's greatest strengths is its very low administrative costs. A Board, however, would need to hire staff to perform many duplicative functions, such as beneficiary education, that the original program would need to continue. Under the proposal sponsored by Senators Breaux and Frist, the Board's staff would be hired outside the Civil Service system, further increasing costs. Above this redundant bureaucracy

would be a top-heavy Board with seven highly paid members which would not be more nimble than the current administrative structure. In fact, CRS notes that "Difficulties in administering the program are more likely to arise and produce conflicts more difficult to resolve when a program is divided between two distinct federal entities than when located within one entity." Such a situation would likely not address the concern that Medicare be more responsive to providers or beneficiaries.

CONCLUSION

In considering how to strengthen and improve Medicare's administration, we must carefully and honestly confront the question of what we are trying to fix. Change for the sake of change does not make the improvements necessary to strengthen and modernize Medicare and its administration. We must modernize Medicare governance with effective reforms: injecting competition into the system; giving HCFA other private sector purchasing tools; contracting reform; and administrative flexibility to manage the program. We must secure stable, adequate funding to manage the program and meet demographic changes. We must continue to improve information technology, staff development, and other infrastructures for effective, efficient management. And we must work together to give Medicare the state-of-the-art management this program, its beneficiaries, providers, and other partners deserves.

Medicare is a complex program and its administration is complex. On any given day, someone will disagree with a decision or feel we were not responsive enough. In the two and a half years that I have been Administrator, HCFA has been the subject of more than 1100 audits and oversight reviews by the General Accounting Office and HHS Inspector General. We receive, on average, more than 700 letters a month from members of Congress, and our contractors receive thousands more. This intense oversight and interest is appropriate, given the billions of dollars at stake and the influence Medicare has on the lives of so many Americans. This is an important point. I believe part of the context for the interest in Medicare governance today has to do with our work implementing the truly historic Balanced Budget Act of 1997, combined with our unprecedented efforts to fight fraud, waste, and abuse.

The BBA represented the agreement of Congress and the Administration to slow the growth in Medicare. Reducing spending by such an unprecedented amount in such a relatively short time was an unequaled challenge. Virtually every hospital, physician, home health agency, skilled nursing facility, durable medical equipment supplier, and other health care provider in the country has been affected, and almost all have seen an impact on their revenues. Such significant change with such an ambitious implementation schedule has created pressures and dissatisfaction. And HCFA, of course, was the face of the BBA for these providers and, as such, the focus of much of their unhappiness.

But the BBA was the right thing to do. Medicare is now solvent through 2025 because of it, and that gives us time to consider other changes that should be made to further strengthen the program for the future. I believe HCFA did a good job, albeit not a perfect job, in implementing the BBA given the time frames, the competing interests of program stakeholders, and the complexity of the changes. The BBA served to put HCFA administration in the spotlight. I do believe, however, that we have done well in implementing the law and remaining true to the law's intent. The past two years have not been easy for us, providers, beneficiaries, or members of Congress, particularly members of this Committee.

Our heightened focus on program integrity also marked a substantial change from past dealings with providers. Moving in just a few short years from relatively lax efforts to a zero tolerance policy on fraud, waste, and abuse has created its own pressures and dissatisfactions, and it has been challenging for both us and providers.

We are proud of our record of strengthening Medicare for beneficiaries and management of its operations. We are committed to meeting the management challenges that lie ahead. And we are eager to continue working with you to build upon our achievements and further strengthen and modernize this essential program. I thank you again for holding this hearing, and I am happy to answer your questions.

RESPONSES TO QUESTIONS FROM SENATOR HATCH

Question: I am concerned about the issue of coverage for injectable drugs. I know you are aware of this issue and that you have heard from members expressing concern about both HCFA's policy on this matter and seemingly arbitrary decisions by Medicare carriers to deny coverage. Patients are suddenly being denied coverage of critical drugs, even in cases where they previously had coverage. I'd like to see this resolved.

I know the Administration wants to enact a Medicare prescription drug benefit, but this should not be an excuse for allowing existing drug coverage to be reduced or taken away. The President is proposing in his plan for a drug benefit that existing Medicare coverage would not be affected.

Can you tell me what HCFA is doing to bring closure to this matter and to ensure that Medicare beneficiaries retain coverage for drugs that are administered by health care professionals in sites such as doctors' offices, clinics, and hospital outpatient settings?

Answer: Our policy regarding injectable drugs has not changed over the years. We have neither increased nor curtailed coverage, other than indicating that self-injectable drugs may be covered temporarily while the physician instructs the patient how to self-administer the drug. Technology has advanced to the point that we felt the need to address this matter by issuing a proposed rule to solicit input from a broad spectrum of stakeholders. Issuing the proposed rule was prohibited by section 219 of the FY 2000 Appropriations Act. However, as required by the Act's conference report, we are attempting to solicit input via town hall meetings instead. Additionally, if Congress lifted the restrictions on our discussion of this issue as imposed by section 219 of the Appropriations Act we would go forward and publish a proposal in the FEDERAL REGISTER laying out different options for defining the term "self-administered." Such a proposal would allow the broadest spectrum of stakeholders to provide input.

We believe that drug therapy is an essential component of health care and that the Medicare program should have a modern drug benefit. We do not believe that this problem can be solved in a piecemeal fashion, or in a way that helps some beneficiaries while leaving others with no coverage. A comprehensive Medicare prescription drug benefit, such as the President has proposed and that you mention in your question, is truly the best remedy for this situation.

Question: It seems to me one way HCFA could address the problem of inappropriate denials of coverage for injectable drugs is by clarifying, once and for all, that the applicable standard for coverage is the one that appears in the Medicare Carriers Manual. The manual is quite clear, stating that "Whether a drug or biological is of a type which cannot be self-administered is based on the usual method of administration . . ."

This seems to be the most appropriate way of dealing with this issue because it leaves the decision about what is in the best interest of the patient up to the physician. If the usual, or standard, method of administering a particular drug to patients is by professional administration, then the drug is covered under Medicare. Will you explain to me why this cannot be clarified right now?

Answer: We made the clarification you suggest in our August 13, 1997 memo. However, currently under Section 219 of the FY 2000 Appropriations Act as implemented in our March 17, 2000 Program Memorandum, that memo is no longer effective. Rather, our carriers are to follow guidance in existence prior to the August 1997 memo, such as the Medicare Carriers Manual language.

Under such policy, Medicare coverage for pharmaceuticals is severely restricted outside of hospitals and nursing facilities. Congress has created only a limited number of exceptions, each spelled out in the law. One exception is for drugs that cannot be self-administered. Section 1861 (s)(2)(A) of the statute says Medicare may pay for drugs "which cannot, as determined in accordance with regulations, be self-administered" when furnished "as an incident to a physician's professional services, of kinds which are commonly furnished in physicians' offices and are commonly either rendered without charge or included in the physicians' bills." Medicare's long-standing policy for coverage under this exception has addressed only whether a drug usually is self -administered, not whether an individual patient can self-administer the drug. And Congress has not provided an explicit exception for those who cannot self-administer drugs that generally are self-administered.

The shortcomings of such a policy become clearer every day with dramatic new advances in drug therapies. Medicaid and most private insurers pay for all prescription drugs, regardless of whether they are self-administered. The current Medicare policy is most troubling for conditions such as multiple sclerosis, where some patients sometimes can administer their drugs and others cannot. It is enough of a burden to cope with the effects of such a disease without the worry of paying for expensive drugs.

This issue is, in fact, a small part of a much larger problem for which patchwork solutions will not suffice. As many Medicare beneficiaries lack drug coverage today as senior citizens lacked hospital coverage when Medicare was created. All beneficiaries, regardless of health or income, need access to an affordable, comprehensive outpatient drug benefit, as the President has proposed.

RESPONSES TO QUESTIONS FROM SENATOR GRAHAM

Question: In her testimony, Dr. Wilensky suggested that the activities that are currently the responsibility of the Health Care Financing Administration (HCFA) could be disaggregated and distributed to the other, more appropriate, more effective agencies. I would like your opinion as to whether this proposal is appropriate and if so, if fraud suppression is one activity that might be redirected to an alternative agency?

During my tenure in the Senate, fraud suppression has been a difficult issue to combat in both the Medicare and Medicaid programs. Many regulatory and enforcement agencies from the Los Angeles police department to the CIA—have experienced problems in monitoring internal security; HCFA appears to suffer from similar difficulties. Finally, fraud in particular health care financing program even one as large as Medicare—is rarely confined to that single area. Rather, the fraudulent scheme typically recurs in several programs administered by the governing agency. This suggests that a department which had enforcement authority across programmatic lines (Medicare, Medicaid, Veterans Affairs, Railroad, and other employment specific plans) might be more vigilant and effective than an investigative division that is a branch of a particular agency.

Please discuss what is currently being done by HCFA to combat fraud and abuse. How could the agency in its current structure be more effective in its efforts? Finally, would you recommend that fraud suppression responsibilities of HCFA be reorganized? If so, how?

Answer: First, it is important to note that HCFA does not have law enforcement authority. Investigations for Medicare fraud are carried out by other agencies; such as the OIG, FBI, DOJ; who already coordinate efforts across the programs you mention, and even into private sector insurance plans. Those agencies and we place a great deal of emphasis on cooperating and sharing information on potentially fraudulent activities operating in different parts of the country.

The program integrity activities we do carry out, including data analysis for the identification of fraud and case development for referral to law enforcement, should not be separated from program management. Whoever runs the program, including processing claims, developing payment strategies, and enrolling and setting standards for providers, must consider and respond to vulnerabilities associated with fraud. However, program managers should not also have responsibility for the actual investigation and prosecution of fraud. That role is best left in the hands of experts in law enforcement; but detection and prevention of fraud should continue to be an expectation of the administrators of the program, coordinated with law enforcement and balanced with the need for fair and efficient program operation.

In this role, we have made great strides in our fight against fraud, waste, and abuse in the Medicare program. Since 1996, we have cut our payment error rate in half. We also have initiated a number of targeted activities to help us protect the integrity of the Medicare trust funds, including the implementation of a focused integrity program guided by a "zero-tolerance" philosophy toward fraud. These efforts, performed within our current structure, are helping us to become more effective in our fraud, waste, and abuse fighting efforts. We are:

- **Contracting with specialized entities to perform program integrity activities** by using our authority under HIPAA. To date, these entities have been focused on particular areas of concern (e.g., audits of large chain providers, CMHC site visits, or assessing Y2K risks). In the coming year, we will be moving a greater share of our program integrity efforts to these specialized contractors;
- **Strengthening contractor oversight** through tighter performance evaluation standards, national evaluation teams, and mandatory corrective action plans to address weaknesses identified by the CFO audits and other financial reviews;
- **Measuring the error rate at the contractor and benefit category level** enabling us to better target our corrective actions. We will begin with claims for durable medical equipment (DME) this summer;
- **Enhancing provider education campaign** so that providers are fully apprised of their responsibilities and have the information they need to bill appropriately. Our Progressive Corrective Action educational effort is based on the premise that the key to appropriate billing is provider feedback, both at the individual and community level. And our belief that our success in decreasing the error rate rests in part on actions taken by the provider community as the result of our increased educational efforts;
- **Training our Medicare contractors to improve the quality of case referrals made to law enforcement.** This is the second year of an ongoing effort

to help increase consistency across contractors and improve the quality of fraud cases that are referred to law enforcement agencies;

- **Cataloging and scientifically evaluating externally developed fraud detection technologies** to assure that we are taking advantage of the latest in anti-fraud technology. Promising technologies will be pilot tested for implementation by our contractors. And we will be showcasing these technologies this summer during a conference we are cosponsoring with the Department of Justice;
- **Increasing the overall level of claims review,** including expanding the number and scope of computer "edits" that identify improper claims before they are paid; and targeting problem areas like DME, home health services, and community mental health centers;
- **Increasing the number of unannounced on-site visits** along with mandatory site visits to new DME suppliers, CMHCs, Independent Diagnostic Testing Facilities, and other types of providers; and
- **Strengthening provider enrollment provisions** to make sure that only qualified and reputable providers enter the program in the first place, including tightened standards for home health agencies entering the program.

These activities represent strong steps in the right direction, and are working to better protect the integrity of Medicare. I would not recommend further reorganizing our fraud suppression activities. While we need to continue improving, we have dedicated a great deal of time, innovation, and resources to establishing our current initiatives, and our continued efforts should produce even better results in the coming years. As always, we need your support to continue these efforts. HIPAA provided the authority for us to establish the Medicare Integrity Program; but as you know, we operate on a very slim administrative budget, and that includes our budget for fighting fraud. Additionally, this year, as for the past several years, the President has proposed Medicare carrier and intermediary contracting reform that would allow expand our choice of entities who serve as these contractors. This reform would strengthen our ability to contract with the most highly qualified intermediaries and enhance our ability to successfully fight fraud, waste, and abuse.

PREPARED STATEMENT OF JUDITH FEDER, PH.D.

Chairman Roth, Senator Moynihan, distinguished Committee members, thank you for inviting me to discuss my views on Medicare governance. I speak to you today as a political scientist, a scholar of the Medicare program, and a former public official. There is little question that the dynamic nature of the health care market and the vast demographic changes in our future pose considerable challenges for the Medicare program. Some have asserted that Medicare needs a new form of governance to meet these challengesBspecifically, an independent Medicare Board that would be shielded from direct oversight and control by the President and Congress.

In my view, this proposal would undermine rather than strengthen our capacity to deal responsibly with the challenges that lie ahead. Given the size of Medicare's expenditures, the program's importance to the health of 40 million beneficiaries, and its impact on the nation's health care system, Medicare decisions involve critical choices about resource allocation and unavoidable tradeoffs among competing goals. Choices about who gets what and who pays for it are fundamentally political, and a responsible political process must be held accountable to the American people. Unfortunately, proposals like S. 1895 that would replace a decision process subject to the authority of the President and the Congress with an independent Medicare Board would remove that accountability, while leaving the politics intact. Let me explain how.

In one proposal (S. 1895), responsibility and oversight for the Medicare program would be under the control of a seven member Board. Although the President would appoint the Board, members would serve seven-year terms and could only be removed for cause. The Board would not be subject to the executive authority of the President, either with respect to budget or policy. The President could not remove Board members no matter how the policies of the Board affected beneficiaries, health care institutions, or taxpayers. The Office of Management and Budget could not review the Board's actions, many of which are explicitly exempted from review in the proposed bill. And since the Board would raise its own operating funds through assessment of participating Medicare plans, its accountability through the appropriations process would be minimal.

In S. 1895, HCFA management of the traditional Medicare program would also be largely removed from Presidential policy and budget oversight. Congressional oversight also would be severely reduced: restricted to an annual up or down vote

on an annual business plan proposed by HCFA. The agency would be free to propose major adjustments to the traditional programBincluding payment rules and rates, beneficiary liability, and the scope and duration of servicesBwithout review of the President, and Congress would be limited to accepting or rejecting the plan in total. (And I would note that after 8 years, it appears that Congress would have no role whatsoever in overseeing HCFA decisions over the traditional Medicare program.)

These would be profound changes not simply in Medicare decisions and how we make them butBjust as importantCin the nation's budget policy and policy toward the broader health care system.

- **Medicare policy decisions are critical to the allocation of taxpayer dollars.** Medicare spending accounts for about 12% of the federal budget. Decisions about how much and how to spend on Medicare are not technical; they determine not only how the Medicare program will perform but how much revenue will be available for other national priorities. Through the budget process, the President and the Congress balance priorities in response to the public interest as they see it, weighing Medicare concerns against others that are equally pressing. For example, the cost control policies contained in the Balanced Budget Act of 1997 made a substantial contribution toward balancing the federal budget, while at the same time permitting the Congress and the President to pursue new priorities, such as the State Children's Health Insurance Program (SCHIP). Similarly, when Congress and the Administration determined that some of the BBA cuts threatened institutions and access to care, targeted modifications to the original cuts were made in the BBRA.

  If Medicare were removed from Presidential and Congressional authority, political accountability for decisions that dictate a significant portion of the federal budget would be substantially reduced and the ability of elected officials to respond quickly to national priorities would be severely limited.
- **Medicare policy decisions affect not just health services for the elderly and the disabled but also health services for the nation.** Although Medicare primarily is a program to provide health benefits to elderly and disabled people, its decisions have a profound impact on the broader health care system. Medicare payment policies fundamentally affect the financial well-being of health care institutions, and changes in those policies can have significant consequences for access to services by beneficiaries and nonbeneficiaries alike. Medicare has special payment categories to support vulnerable institutions, such as rural hospitals and community health centers, outpatient rehabilitation facilities, and community mental health centers. Medicare provides bonus payments in urban and rural health professional shortage areas and supplements outpatient hospital rates to assure 24 hour access for all.

  Each of these programs and policies implements important policy decisions that support vulnerable parts of our health delivery system, and they are motivated at least in part by factors other than assuring access to care for Medicare beneficiaries. These are the kinds of decisions for which we hold elected officials accountable. There is no reason to expect that an unaccountable Board, narrowly charged with responsibility to manage Medicare, would take these broader issues into account, nor that an unaccountable HCFA, subject to increasing competitive pressures, would continue to pursue them.
- **An independent board would promote narrow interest group politics above consideration of the broader public interest.** Proponents of the Board concept argue that independent administration would allow Board members to make policy decisions about the program without regard to political interests. Experience tells us that it is far more likely to turn Medicare policymaking into a negotiation process among vested interests. Board members would likely be chosen on the basis of their expertise in different areas of the health care system. Although members might include individuals selected to 'represent' the public, it is difficult to know what that representation means and to make it effective. The result would be program decisions that balance the interests of stakeholders. What would be missing would not be politics but political responsiveness to the beneficiaries and the public at large.

  We may look to a recent recommendation from MedPAC for an example of decision-making without regard to national priorities. The creation of MedPAC and its predecessors stemmed from Congress's desire for an independent nonpolitical source of guidance on Medicare payment policies. The Commission's recent proposal to increase inpatient hospital rates by as much as 4 percent, however, appears to reflect interest group influence far more than objective analysisBan outcome that apparently concerns the House health leadership of both political parties.

An independent Board could be expected to similarly reflect the interest of stakeholders. And, unlike with MedPac, whose decisions are only recommendations to the Congress, special interest-driven decisions by a Medicare Board would be binding. Decisions on risk adjustment, for example, while partly technical, distribute resources between health plans and the traditional program. Health plan representatives on any board would likely promote plans' interest. Similarly, health plans have their own interests with respect to patient protections. An independent Board does not simply give these interests a hearing. By creating an interest-driven decision process that is binding, it gives special interests priority over the public interest.

Finally, even if S. 1895 were enacted, it is hard to believe that Congress could long refrain from reasserting control over at least some of the policy decisions made by the board and HCFA. Under current law, Congress is not required to take up many of the issues HCFA is authorized to address. But it does. Our recent experience with the competitive bidding demonstration shows that the temptation to intervene is overwhelming even when a decision has been explicitly "depoliticized." That is because the stakes involved in Medicare policy decisions are enormous, and elected officials cannot ignore the consequences of such decisions. Nor should they. But to structure the process as if they will stymies, rather than supports, consistent and effective oversight.

The fundamental point is that a change in Medicare's governance would notBand should notBtake the politics out of Medicare. Rather, it would take the accountability out of politics. Selective intervention is no substitute for consistent oversight; and an independent board is no substitute for the exercise of responsibility by officialsBin the Executive and in the CongressBelected for that purpose.

By arguing to retain the President's and the Congress' authority over Medicare, I am not saying that current governance is perfect. Rather I am saying that problems that arise in Medicare do not reflect the limitations of its structure; rather, they reflect the need for a greater commitment to making that structure work. Accountable management and oversight of that management take time, attention and, most important, resourcesBideally, with the Congress and the Executive working in collaboration.

An example of governance that works comes from recent experience on nursing home policy. Congress recognized a problem with the quality of care provided to nursing home residents. Investigations conducted by the GAO helped determine the scope and character of the problem. Public hearings focused attention on the problem. Congress and the Administration ensured that more resources were available to increase survey and certification activity and provide more and better training to those responsible for these activities. Quality problems are not likely to go away. But increased oversight by the Administration and the Congress can significantly reduce their likelihood.

This is an excellent example of how the system can and should work. Policymakers in the Executive and Legislative branches of government recognized their responsibility for program oversight and acted on a bipartisan basis to protect the health and welfare of some of our most vulnerable citizens. By exercising rather than abdicating their responsibility, both branches of government proved that an accountable form of governance can work effectively and efficiently. As you consider Medicare's future, I urge you to build on that model. Do not abandon it.

PREPARED STATEMENT OF WILLIAM E. FLYNN, III

Mr. Chairman and members of the committee: I am pleased to be here today to discuss the Federal Employees Health Benefits Program and its relationship to the Medicare Program. The FEHB Program is frequently cited as a model that others might emulate. Many aspects of the program's structure, delivery systems, and administration can be useful in other contexts, and some of them have been adapted in the Medicare Program. While there are areas of similarity, it is also important to understand each program's fundamental differences.

Our Health Benefits program is now in its fortieth year of operation. It is an employer-sponsored program and forms an important part of the compensation package offered by the government, enabling it to employ and retain individuals who carry out the vital work of government. We have developed widely-recognized expertise in the complexities of arranging health coverage with hundreds of private sector health plans across the nation and around the world for a covered population of approximately 9 million, including 2.3 million federal employees, 1.9 million annuitants, and members of their families. In 1999, the program accounted for $18 billion in annual premium revenue.

FEDERAL EMPLOYEE PROGRAM STRUCTURE

Of the approximately 300 health plans presently available in the program, most are HMO's serving limited geographic areas. Thirteen plans are nationwide fee-for-service plans, including the Blue Cross and Blue Shield Service Benefit Plan, six plans that are limited to members of sponsoring organizations, and six others that are not limited. Depending on where they live, members may choose from among as many as a dozen HMOs and at least seven fee-for-service plans. There is an opportunity to enroll in the program, change health plans, or change enrollment status at least once a year during the 4-week annual open season that begins in November.

The design of the FEHB Program permits OPM to focus on three key elements: policy design, contract administration, and financial oversight. In addition to contracting, policy development, and financial management responsibilities, OPM also resolves benefit disputes between members and their health plans.

While all participating plans provide a core set of benefits required by OPM, benefits vary among plans because there is no standard FEHB benefits package. Even where coverage is nearly identical, cost sharing provisions may differ significantly among plans.

Rates are negotiated annually for our fee-for-service plans based primarily on their claims experience. About 93 percent of premium, or 93 cents out of every dollar, reflects benefit costs. The remaining 7 percent cover the plan is administrative costs.

For the community rated plans, rate negotiations are based on a base per member per month community rate. Adjustments are negotiated to the base rate for a variety of reasons, including changes we require to their standard benefits package.

We administer the FEHB Program in a way that mirrors other employer-sponsored health insurance programs. We also are in compliance with all applicable federal laws and meet all the standard federal accountability requirements.

OPM's administrative expenses for this program amounted to $20 million in 1999. This amount includes salaries for 176 full-time-equivalent staff consisting of program managers, contract specialists, budget and policy analysts, accountants, actuaries, programmers, administrative support staff, and staff in OPM is Inspector General's office.

The program has always been heavily dependent upon employing agencies and Federal Retirement Systems to provide a variety of enrollment services to members. Representative activities at this level include:

- Ordering, stocking, program forms and literature, disseminating information, and providing counseling to eligible enrollees,
- Processing enrollment actions and determining eligible dependents and effective dates,
- Providing reconsideration rights for individuals who are denied coverage or change of enrollment,
- Performing reconciliation of enrollee status with health plans,
- Submitting premium withholdings and government contributions to the employees health benefits fund in a timely manner, and
- Maintaining necessary records.

The participating health plans are responsible for most elements of their plan design and for preparing their benefits brochure. We work very closely with the carriers to develop standard brochure formats and text that will assist members in comparing plans. In addition, OPM develops health plan comparison guides and other information in paper and electronic formats to help individuals make an informed choice among health plans.

MEDICARE/FEHB PARALLELS

The Balanced Budget Act of 1997 authorized a new Medicare+Choice Program for 1999 that incorporates several features of the FEHB model. Medicare+Choice contemplates an array of private health plan alternatives to traditional fee-for-service medicare, and provides an annual open enrollment period for Medicare Beneficiaries. Medicare+Choice parallels two key features that have contributed to the continued success of the FEHB Program: competition among health plans for members and informed consumer choice. In order to accomplish that, HCFA arranges for broad dissemination of general and comparative information in advance of annual enrollment periods. This material incorporates quality and performance indicators for Medicare+Choice plans, in order to promote an active, informed selection among available options.

In these areas, OPM is role and that of HCFA are very similar. However, OPM's job is greatly facilitated by the fact that most individuals enroll in our program as active employees and are very familiar with the FEHB program's benefits, structure

and administration. No parallel exists for retirees becoming eligible for the Medicare Program, and the choices available under it.

We benefit from HCFA's power and resources in a number of specific ways. For example, HCFA funds research to develop standards for measurement and treatment of chronic diseases, such as diabetes, that we can disseminate to our health plans. HCFA also develops standards for the participation of hospitals in the medicare program. The standards define national norms to the benefit of FEHB members and others.

We and HCFA participate in a number of collaborative efforts. We jointly sponsored a 2-day conference with the agency for healthcare research and quality, entitled "making quality count." This conference brought together health care purchasers, researchers, and consumer experts to discuss how to effectively deliver quality information to consumers. The outgrowth of the conference has been continuing collaboration on a research agenda for consumer information and a planned web site available to all those interested in communicating information on health care quality to consumers.

HCFA and OPM co-chair the patient and consumer information workgroup under the President's quality interagency coordination task force. In this capacity, we have developed a web page about health care quality issues, including the patients' bill of rights, for the Federal Trade Commission's consumer gateway web site. In addition to a site for health care purchasers, our workgroup has also developed a glossary of common terms for use in consumer information that Federal healthcare agencies generate.

Since the FEHB Program serves a large Medicare-covered population, our membership on the coordinating committee for the National Medicare Education Program has helped us stay current on Medicare issues and better inform our members about benefits coordination. With committee collaboration, we have included Medicare information in our health plan comparison guides for the past 2 years. We also developed a special pamphlet, the Federal Employees Health Benefits Program and Medicare, that debuted during our 1999 open season. These are only a few of the ways where our similarities have allowed us to partner with HCFA and others to the benefit of the FEHB members, and we will continue to do so.

Both HFA and OPM have experienced reductions in the number of HMO's participating in our respective programs. New plans have had difficulty establishing market share and the HMO segment of the overall FEHB market has been unchanged at 30 percent for more than five years. Although our concerns about HMO participation are somewhat different, this is an area where OPM and HCFA already share information and have the potential for greater collaborative efforts.

MEDICARE-FEHB DIFFERENCES

Although there are similarities in our respective programs, there are also fundamental differences in them. While the FEHB Program is an employer-sponsored component of the compensation package, Medicare is a national entitlement program many times the size of the FEHB Program. Our members are almost equally divided between employees and retirees, and many of our retirees are younger than age 65. Because Medicare serves a much broader population under very different conditions, its administrative structure is necessarily more complex.

While HCFA in large measure drives a significant portion of the health care economy, OPM is primarily a health care purchaser. We operate under legislation that permits benefits to evolve in response to the changing health care environment and member needs. Because we can implement most changes through negotiation, we have been able to streamline our administrative structure.

Since OPM arranges health plan coverage through contracts with private sector insurers, our program benefits significantly from market forces, many of which are encouraged by HCFA initiatives. Changes to the structure of the health insurance industry and to the systems for delivering health care continue to contribute to cost containment and access to quality medical care. Without HCFA's actions in these areas, it is an open question as to whether or not these changes for the better would have occurred.

THINGS TO CONSIDER

As well, there are some aspects of Medicare that might be usefully considered in the context of the FEHB. Standardizing benefits, and contracting for certain services are both matters we have considered in the FEHB Program. Nevertheless, the differences in our mission, our customer base, our size, and our funding mechanisms all argue for careful consideration before adoption.

In summary, we will continue to collaborate and work together where it makes sense. Our joint efforts on patient and consumer activities associated with the QUIC and the National Quality Forum have already been useful and offer considerable potential.

Thank you for inviting me to testify at this hearing. I will be pleased to answer your questions.

PREPARED STATEMENT OF ROGELIO GARCIA

Mr. Chairman, thank you for inviting me to testify regarding the factors that determine the degree of an executive agency's independence from the President and, to a lesser extent, Congress, and the possible consequences of that independence. I use the term "agency" in a generic sense to include executive departments, units within a department, and agencies—whether single- or multi-headed-located inside or outside departments. Let me note that the term "independent agency," as used regarding such single-headed agencies as the Environmental Protection Agency or Small Business Administration, refers to the fact that they are independent of executive departments, not to their independence from the President.

When creating a new agency or reorganizing an existing agency, important factors to consider include the startup time for the organization to become operational; the resources required, such as personnel, buildings, equipment, and similar matters; the type of organizational structure-whether single- or multi-headed; the amount of independence the organization is to be given from the President and Congress, and how that independence is likely to affect its accountability. While all of these questions are important, I address only the question of independence.

Concern over how much independence to grant an agency is crucial, because it will determine the accountability of the agency to the President and Congress. Depending on an agency's responsibilities, it may need some, or perhaps almost total, independence in order to protect it from unwarranted influence from the President or Congress. While it is important to protect against such influence, it is equally important to assure some degree of accountability. Too much independence may result in an agency with little or limited accountability, while too little may encourage unwarranted influence on its activities. The difficulty, therefore, is in achieving an acceptable balance between independence and accountability, since generally the two are inversely linked. The greater the independence, the lower the accountability.

The degree of an agency's independence may be assessed by analyzing the following major variables: (1) the term of office of the agency head, or heads if multi-headed;[1] (2) how the agency head or heads may be removed from office; and (3) control over the agency's budget. These three variables arguably constitute the most important factors affecting an agency's independence. Four additional, but less important factors affecting agency independence include the role of the Office of Management and Budget in the agency's (1) communications with Congress, (2) rulemaking, and (3) information collection requests, as well as (4) the role, if any, exercised by the Department of Justice in litigation matters affecting the agency.

Before discussing each of these factors, let me address briefly some of the basic differences between single-headed and multi-headed agencies. The major difference between them is that single-headed agencies, except for the Social Security Administration and the Office of Special Council, have little, if any, independence from the President, while multi-headed agencies have a great deal of independence. Generally, the head of a single-headed agency is appointed for an indefinite term of office and may be removed by the President at any time. On the other hand, members of a multi-headed agency are appointed to fixed terms of office, and, in almost all instances, cannot be removed by the President except for cause. Consequently, single-headed agencies are less independent and, therefore, more accountable to the President than multi-headed agencies. Arguably, as we shall see, greater independence from the President may also mean more independence from Congress.

A second major difference between single-headed and multi-headed agencies is that their leadership structure greatly affects their decisionmaking and accountability. Generally, the larger the number of decisionmakers, the more difficult it is to reach a decision. At the same time, the more decisionmakers involved, the greater the difficulty in determining responsibility for a decision or lack of a decision. Decisionmaking difficulties can result not only from the fact that various officials have to agre e before a decision is made, but also that authority, duties, and responsibil-

[1] By "heads," I am referring to the collegial group-usually consisting of between three to five officials, frequently referred to as "members" or "commissioners"—that governs the agency.

ities have to be divided among the various members. For a multi-headed agency to carry out its mandate effectively, it is essential to assign clear lines of authority and responsibility among the members. Even with the most reasonable division of such authority and responsibility, however, differing viewpoints and personality factors may lead to power struggles that may prevent an agency from effectively carrying out its programs and other responsibilities. Thus, by its structure, a multi-headed agency generally will encounter greater difficulty in reaching a decision, and accountability for that decision will be more difficult to determine than if the decision were made by a single-headed agency.

Aware of these problems, Congress has considered it appropriate to establish multi-headed agencies to oversee certain federal activities that it felt should be carried out by agencies somewhat removed from presidential direction and control. Moreover, because many of those activities affected different geographic sectors of the country, and various economic, social, political, and safety interests, Congress believed it was important to establish agencies headed by several members, often representing different interests and geographic areas. These agencies, resolving issues by majority vote of their members, were seen as the most effective way to assure that decisions would be based on compromise and accommodation of varying views and opinions.

Let us now turn to each of the factors involved in determining the degree of agency independence.

TENURE OF OFFICE, REMOVAL OF INCUMBENT, AND BUDGET CONTROL

As Chief Executive, the President has broad authority to appoint the heads of executive agencies, subject to the advice and consent of the Senate. Inherent in the power to appoint an executive official is the power to dismiss or fire that official. The power to dismiss is the most effective control the President exercises over his appointees and, therefore, over the agencies. In an effort to provide some protection to the agencies against unwarranted presidential involvement in their activities, Congress has established fixed terms of office for the members of all multi-headed agencies and for the heads of some single-headed agencies. At the same time, it has placed restrictions on the President's power to remove the members of most multi-headed agencies and the heads of two single-headed agencies.

Congressional reluctance to provide greater protection to the head of single-headed agencies stems from the view that most agencies should remain under the close direction and supervision of the President. Congress is also mindful that such a restriction may be declared unconstitutional because it may violate the President's core constitutional responsibilities. In a series of decisions, the Supreme Court has established the following criteria to determine when such a restriction may be unconstitutional: (1) was the agency created to exercise its judgment without hindrance by any other executive official? (2) does the restriction impede the President's ability to carry out his constitutional duties? and (3) if the President's core constitutional powers are impeded, is the imposed restriction justified by an overriding need to promote objectives within the constitutional authority of Congress?[2]

Let me now focus on the ways Congress provides for fixed terms of office and imposes restrictions on the President's power to remove an incumbent from office.

Fixed Term of Office

While most fixed terms vary from five to seven years, some vary from as little as two years to as much as 14 years.[3] A fixed term offers some, but not complete, protection from summary removal by the President. Courts have ruled that, absent certain conditions, a fixed-term alone only sets the outer limits of an incumbent's tenure, and that he or she may be removed by the President at any time during that tenure. While removal is rare because of the political cost involved, an incumbent in a fixed-term position has occasionally been removed before his or her term expired. In 1993, the President removed William Sessions as director of the Federal Bureau of Investigation after he had served less than six years of a 10-year term.[4]

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[2] See *Humphrey's Executor* v. *United States*, 295 U.S. 602 (1935); *Wiener* v. *United States*, 357 U.S. 349 (1958); *Morrison* v. *Olson*, 487 U.S. 654, 685–86 (1988); and *Mistretta* v. *United States*, 488 U.S. 361, 383 (1989) n. 13 (quoting *Nixon* v. *Administrator of General Services Administration*, 433 U.S. 443 (1979)).

[3] The U.S. Executive Director and the Alternate Director of the International Monetary Fund serve 2-year terms, while directors of the Board of Governors of the Federal Reserve Board serve 14-year terms. See Tables 1 and 2 in the Appendix.

[4] Sessions was dismissed allegedly because "ethical lapses" had compromised his ability to lead the agency. "Clinton Picks Freeh for FBI After Ousting Sessions," *Congressional Quarterly Weekly Report*. July 24, 1993, vol. 51, p. 1962.

The degree of independence conferred by a fixed term is likely to depend on the number of years involved. A longer term is likely to confer greater independence. An official serving a short term is more susceptible to presidential direction, especially if the incumbent wishes to be reappointed. On the other hand, when the term is longer than the term of the President making the appointment, an incumbent generally may feel less allegiance to the new President and, therefore, is less likely to take direction from him. Regardless of the length of a fixed term, however, the incumbent may be removed by the President at any time.

Restriction of the President's Removal Authority

The greatest degree of independence is provided the agency when statutory restrictions are placed on the President's power to remove an incumbent before his or her term expires. Such independence carries a price, however. It becomes very difficult to remove an incumbent who may be incompetent, divisive, or, for whatever reason, unable to lead an agency effectively. Moreover, legitimate efforts by the President or Congress to guide or persuade an agency may be ignored or too easily dismissed, since the head cannot be readily removed. Such restriction of the President's power may also affect Congress, because it is denied the ability to pressure the President to remove an uncooperative or hostile official. A determined President may be able to persuade the head of an agency to resign, but it would be much more difficult and costly to the agency than if no restriction had been placed on the President's removal power.

A further factor to consider regarding the degree of an agency's independence is that agencies generally need strong presidential support in order to promote their programs and achieve their goals. This applies equally whether an agency is located inside or outside an executive department. However, the President is not likely to expend much, if any, of his time and effort to promote or defend the programs and goals of an agency over which he has little direction or control. An independent agency may, in fact, pursue a program or a goal that may be perceived by the President as inimical to his own policies or interests. In such circumstances, the President may actively seek to defeat that program or goal. For this reason, it is important to consider carefully the need for agency independence before it is established.

Statutory provisions restricting the President's power to remove an incumbent apply to only two single-headed agencies and to all multi-headed regulatory agencies. Some provisions limit the President's authority to remove an incumbent "only" for the causes cited in the statute. These causes may be *only for neglect of duty, or malfeasance in office*;[5] *only for inefficiency, neglect of duty, or malfeasance in office*;[6] *only for inefficiency, neglect of duty, malfeasance in office, or ineligibility*;[7] or *only for cause*.[8] Other statutes omit "only" as a qualifier. These include *for inefficiency, neglect of duty, or malfeasance in office*;[9] *if the President finds the member guilty of appointing or promoting an official on the basis of a political test or qualification*;[10] or simply *for cause*.[11]

Whether the President may remove an official for shortcomings other than those specified when the qualifier "only" is lacking, is uncertain. In 1940, the Supreme Court let stand a circuit court decision allowing the President to remove an official for causes other than those specified in statute, because the official was "performing predominately executive or administrative functions."[12] More recent decisions, however, indicate that the Court may rule differently today.[13]

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[5] Consumer Product Safety Commission (15 U.S.C. 2053(a)); National Labor Relations Board (29 U.S.C. 153(a)); and Social Security Administration (42 U.S.C. 902(a)).

[6] Chemical Safety and Hazard Investigation Board (42 U.S.C. (r)(6)(B)); Federal Energy Regulatory Commission (42 U.S.C. 7171(b)); Federal Labor Relations Authority (5 U.S.C. 7104(b)); Merit Systems Protection Board (5 U.S.C. 1202(d)); and Office of Special Counsel (5 U.S.C. 1211(b)).

[7] National Mediation Board (45 U.S.C. 154(First)).

[8] Postal Rate Commission (39 U.S.C. 3601).

[9] Federal Maritime Commission (46 U.S.C. 111); Federal Mine Safety and Health Review Commission (30 U.S.C. 823(b)(1)); Federal Trade Commission (15 U.S.C. 41); National Transportation Safety Board (49 U.S.C. 1111(c)); Nuclear Regulatory Commission (42 U.S.C. 5841(e)); Occupational Safety and Health Review Commission (29 U.S.C. 661(b)); and Surface Transportation Board (49 U.S.C. 702(b)).

[10] Tennessee Valley Authority (16 U.S.C. 831c).

[11] Federal Reserve System (12 U.S.C. 242)

[12] *Morgan* v. *Tennessee Valley Authority*, 115 F.2d 990 (6th Cir. 1940), *cert. denied*, 312 U.S. 701 (1941).

[13] See *Morrison* v. *Olson*, 487 U.S. 654, 685–686 (1988), and *Mistretta* v. *United States*, 488 U.S. 361, 383 (1989) n. 13 (quoting *Nixon* v. *Administrator of General Services*, 433 U.S. 443 (1979).

The fact that a fixed-term position may not carry with it a provision regarding removal does not mean that the President may arbitrarily remove an incumbent. In 1958, the Supreme Court ruled that, unless specifically authorized by statute, the President may not remove members of a body created to exercise purely adjudicatory functions that are not subject to review by any other executive branch official.[14] Since then, the Court has expanded and extended the grounds under which Congress can impose limits on the President's power to remove an incumbent before his or her term of office expires.[15] As a result, heads of at least 13 multi-headed agencies having no statutory provisions regarding their removal apparently are protected against arbitrary removal.[16]

Let me turn now to the budget as the third key determinant in the degree of an agency's independence.

Control over Budget and Staff

The yearly appropriations process provides a powerful tool for the President and Congress to influence and direct executive agencies. The agencies are required by statute to submit their budgets to the President, who is authorized to change the requests before submitting them to Congress.[17] When preparing the budget, the agencies work closely with the Office of Management and Budget (OMB), which exercises considerable control over agency budgets. The agencies cannot submit their budgets directly to Congress unless specifically authorized to do so. When consolidating the various agency budgets into the budget document that the President forwards to Congress, OMB often makes final adjustments to each budget, possibly reducing the amount of funding and staffing requested, and changing agency priorities by directing funds from one activity to another. While cutting a request appears to be the most direct way to influence an agency, sometimes a more effective way is by directing funds among the various programs.[18] After receiving the budget document, Congress makes the final decisions regarding each agency's funding, staffing, and programing requests. The appropriations process is, therefore, a powerful tool for assuring the accountability of an agency and its head to both the President and Congress.

To provide some executive agencies with greater independence, Congress has granted them certain waivers from the budget preparation process. Again, these waivers apply primarily to the multi-headed regulatory agencies. At least eight multi-headed agencies are authorized to submit their budget requests concurrently to OMB and Congress. Consequently, when considering their budget requests, Congress is able to compare the dollar amounts and staffing needs requested by the agencies with those presented in the President's budget.[19] Such information is important because it alerts Congress to an agency's original request and the changes imposed by OMB. Two other agencies, while subject to the appropriations process, are shielded by statute from having their budget requests changed by OMB.[20]

Almost completely exempted from the appropriations process are five multi-headed banking regulatory agencies, and two single-headed agencies within the Treasury

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[14] *Wiener* v. *United States*, 357 U.S. 349 (1958). See also *Securities Exchange Commission* v. *Blinder, Robinson, and Co.*, 855 F.2d 677 (10th Cir. 1988). (SEC commissioners may only be removed for cause despite statutory silence on removal.)

[15] See *Morrison* v. *Olson*, 487 U.S., 654, 685–86 (1988), and *Mistretta* v. *United States*, 488 U.S. 361, 363 (1989) n. 13 (quoting *Nixon* v. *Administrator of General Services*, 433 U.S. 443 (1979).

[16] These agencies include the Commodity Futures Trading Commission, Defense Nuclear Facilities Safety Board, Equal Employment Opportunity Commission, Farm Credit Administration, Federal Communications Commission, Federal Deposit Insurance Corporation, Federal Housing Finance Board, Federal Election Commission, National Credit Union Administration, Railroad Retirement Board, Securities Exchange Commission, United States International Trade Commission, and United States Parole Commission.

[17] The Budget and Accounting Act of 1921, as amended, and codified at 31 U.S.C. 1108(b)(1).

[18] William E. Brigman, "The Executive Branch and the Independent Regulatory Agencies," *Presidential Studies Quarterly*, vol. 11, Spring 1981, p. 256.

[19] Commodities Futures Trading Commission (7 U.S.C. 4a(h)(1)); Consumer Product Safety Commission (15 U.S.C. 2076(k)(1)); Federal Election Commission (2 U.S.C. 437d(d)(1)); Federal Energy Regulatory Commission (42 U.S.C. 7171(j)); Merit Systems Protection Board (5 U.S.C. 1205(j)); National Transportation Safety Board (49 U.S.C. 1113(c)); Railroad Retirement Board (45 U.S.C. 231f(f)(1)); and Surface Transportation Board (P.L. 104–88, Title II, sec. 2, 109 Stat. 934). The Federal Energy Regulatory Commission, which is located inside the Department of Energy, submits its budget request to the Secretary of Energy, who, before sending it concurrently to OMB and Congress, incorporates it into the department's budget (42 U.S.C. 7171(j)).

[20] United States International Trade Commission (19 U.S.C. 2232) and the United States Postal Service. The Postal Rate Commission sends its budget request to the United States Postal Service, which may revise the request, but OMB may not revise the budget of the Postal Service (39 U.S.C. 203 and 3604).

Department-the Office of the Comptroller of the Currency and the Office of Thrift Supervisio n. These agencies are authorized to generate their own budget revenue through assessments and levies on the private institutions that they regulate.[21]

While the degree of independence from the appropriations process is relatively minimal in the case of agencies authorized to submit their budget requests concurrently to the President and Congress, the independence granted to the banking agencies raises a ccountability questions. Agency accountability to the President and, to a lesser extent, Congress is closely linked to the degree of independence an agency exercises over its budget. An agency that processes its budget request through the President and relies on Congress for appropriations is more likely to be closely attuned and responsive to direction and guidance from both sources. On the other hand, an agency that generates its own operating budget may feel that it can afford to be less responsive, or even ignore such direction and guidance. When an agency is not subject to the appropriations process and, at the same time, its head or heads may be removed only for cause, its independence from the President is almost complete, and its accountability to Congress may be greatly diminished.

Before turning to the other variables affecting an agency's independence, let me turn briefly to agency staffing needs. An agency's senior staffing needs are also affected by an office closely aligned to the President, the Office of Personnel Management (OPM). Every two years, OPM, in consultation with OMB, reviews each agency's request regarding the number of Senior Executive Service (SES) positions it wants, and sets the specific number of such positions for each agency.[22] This review gives the President another tool with which to influence an agency.

Congress has sought to lessen this influence on the Social Security Administration (SSA) by directing OPM to authorize the agency a substantially greater number of positions than it had before it became independent.[23] Moreover, it has also directed OPM to report to the Senate Finance Committee and the House Ways and Means Committee the number of SES positions it grants SSA.[24] OPM is, therefore, on notice that the number of SES positions it authorizes in response to SSA's request is subject to congressional scrutiny.

Congress has gone further in the case of multi-headed regulatory agencies, by passing legislation that the

> Appointment or removal of a person to or from any Senior Executive Service Position in an independent regulatory commission shall not be subject, either directly or indirectly, to review or approval by any officer or entity within the Executive Office of the President.[25]

Finally, the five multi-headed banking regulatory agencies which generate their own budgets do not fall under OPM review regarding senior level positions because their senior executives belong not to the Senior Executive Service, but to an equivalent syst em that is independent of OPM and OMB control. This independence also permits the agencies to pay higher salaries to their senior executives.

Let me now turn to the other important, but less crucial, factors that help to determine the degree of an agency's independence from the President.

OTHER IMPORTANT FACTORS TO CONSIDER REGARDING AGENCY INDEPENDENCE

These factors include (1) agency communications with Congress, (2) agency rulemaking, (3) agency information collection requests, and (4) agency litigation authority. The degree of independence an agency exercises in the first three areas depends on whether its actions are subject to OMB review. The degree of independence regarding litigation depends on whether the agency must rely on the Department of Justice in order to litigate.

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[21] Farm Credit Administration (12 U.S.C. 2250(b)(1)); Federal Deposit Insurance Corporation (12 U.S.C. 12 U.S.C. 1817(c)(2)); Federal Housing Finance Board (12 U.S.C. 1422b(c)); Federal Reserve System, Board of Governors (12 U.S.C. 243); and National Credit Union Administration (12 U.S.C. 1755); Office of the Comptroller of the Currency (12 U.S.C. 482); Office of Thrift Supervision (12 U.S.C. 1462a(i))

[22] 5 U.S.C. 3133(c).

[23] 42 U.S.C. 904(a)(3) provides that, without regard to 5 U.S.C. 3133, OPM is to authorize for SSA a substantially greater number of Senior Executive Service positions than the agency had immediately before August 15, 1994, while it was still in the Department of Health and Human Services, "to the extent that the greater number of such authorized positions is specified in the comprehensive work force plan as established . . . by the Commissioner under" 42 U.S.C. 904(b)(2).

[24] 42 U.S.C. 904 note, 108 Stat. 1472.

[25] 5 U.S.C. 3392(d).

Communications with Congress

To assure adherence to the President's policies, OMB works closely with executive agencies when they are preparing their legislative communications regarding recommendations, comments, and testimony. The agencies are required to submit the communications to OMB for review and clearance before being sent to Congress.[26] OMB exercises full control over testimony presented by most officials in single-headed agencies, but by law it may not alter the transcript of the actual testimony of witnesses.[27]

Here, again, the multi-headed regulatory agencies are largely exempt from OMB review. Nine of the multi-headed agencies are exempted from the clearance procedure by provisions in their enabling statutes that prohibit another executive agency or official from reviewing or approving legislative communications before they are submitted to Congress.[28] An additional three such agencies have statutory authority to send their communications concurrently to Congress and OMB. Finally, five others, whose statutes are silent on the matter, reportedly rely on their status as independent regulatory agencies to send their communications directly to Congress.[29] As a matter of courtesy, these five agencies also send copies of their congressional communications to OMB.

Congress may be able to exempt most single-headed executive agencies from the need to obtain review and clearance from OMB. On the other hand, it may grant some agencies authority to submit communications concurrently to the President and Congress, thereby allowing the agencies some measure of independence by which to indicate some differences the agencies may have with the administration. Major differences are unlikely to be revealed, however, unless the agency also enjoys some of the major independent features discussed above.

Rulemaking

Another factor in determining the degree of an agency's independence concerns the amount of control it exercises over its rulemaking activities. Since 1981, executive agencies have been required by executive order to send their regulations to OMB for rev iew before they are published.[30] OMB review was imposed because of the perceived cost of federal regulations and the belief that the only way to reduce or control that cost was by assuring that an agency would issue a regulation only when it was cost-effective and, unless prohibited by law, when its benefits exceeded its costs. Such review, however, may also be used to force substantive changes in a regulation, thereby undermining an agency's rulemaking authority.

All multi-headed regulatory agencies have been exempted from OMB review.[31] Congress may, if it wishes, exempt other agencies from such review. At the present time, marketing orders and certain other regulations issued by the Agricultural Marketing Service in the Department of Agriculture are specifically exempted from review by statute.[32] Congress can exempt any new agency from such OMB review. This action, however, might raise questions because of the continuing concern regarding regulatory costs.

Information Collection

Another area of OMB control over executive agencies deals with information collection from the public by means of questionnaires, surveys, and similar forms. In an effort to reduce the cost of paperwork imposed by such requests, Congress passed

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[26] OMB Circular A–19, revised, Sept. 20, 1979.

[27] 113 Stat. 447 (1999).

[28] Commodity Futures Trading Commission (7 U.S.C 4a(h)(2)); Consumer Product Safety Commission (15 U.S.C. 2076(k)(2)); Federal Deposit Insurance Corporation (12 U.S.C. 250)); Federal Election Commission (2 U.S.C. 437d(d)(2)); Federal Reserve System's Board of Governors (12 U.S.C. 250); National Credit Union Administration (12 U.S.C. 250); National Transportation Safety Board (49 U.S.C. 1113(c)); Railroad Retirement Board (45 U.S.C. 231f(f)); and Securities and Exchange Commission (12 U.S.C. 250).

[29] Agencies with statutory authority to send their communications concurrently include the Farm Credit Administration (12 U.S.C. 2252(a)); Federal Energy Regulatory Commission (42 U.S.C. 7171(j); and Merit Systems Protection Board (5 U.S.C. 12059(k)). Those relying on their independent status include the Federal Maritime Commission, Federal Trade Commission, Nuclear Regulatory Commission, Surface Transportation Board, and United States International Trade Commission. (Information regarding agencies relying on their independent status is based on telephone conversations with officials in each agency.)

[30] Executive Order 12291, 46 Fed. Reg. 13139 (1981), and Executive Order 12866, 58 Fed. Reg. 51735 (1993), which revoked the earlier order, but continued the clearance process.

[31] Sec. 1(d) Executive Order 12291, and Sec. 3(b) of Executive Order 12866. The agencies are cited under 44 U.S.C. 3502(10).

[32] Provisions attached to Executive Office Appropriations Act for FY 1999 (P.L. 106–58) and earlier acts.

the Paperwork Reduction Act, which requires agencies, before releasing new information request forms, to submit them to OMB for approval. Information collected on these forms often is crucial for agencies to pursue certain policies. Those policies, however, can be blocked if OMB refuses to approve a form. Without such approval, the public is not required to comply with agency information requests.

The unique, independent status of the multi-headed regulatory agencies is also reflected in this area. While OMB disapproval of a form prevents a single-headed agency from further action, a multi-headed regulatory agency, by majority vote of its members, may override OMB's disapproval and send out the form.[33] As with the review of regulations and information collection requests, Congress may increase an agency's independence by exempting it from the review process. Such an action, however, may hamper the effort to reduce the paperwork burden imposed on the public.

Litigation Authority

Finally, an executive agency's independence is affected by the degree of litigation authority it possesses, because this authority may enable it to protect and promote its programs. Under Sections 516, 518, and 519 of Title 28, United States Code, the Justice Department serves as the central litigating authority for executive agencies. While the general litigating authority is vested in the Attorney General, many of the agencies enjoy a certain measure of independent litigating authority on civil matters. Although the examples cited below focus exclusively on multi-headed regulatory agencies, the same type of mixed authority is also found among executive departments and single-headed agencies. However, these instances should not obscure the fact that litigation authority remains centered in the Justice Department.

An agency's authority to litigate varies considerably, depending on whether it is involved in litigation defending or enforcing agency regulations or programs, or appeals to the Supreme Court. Some agencies have complete or near complete authority in all three areas, while others have partial authority in some or all of the areas, and a few have no formal authority without the approval of the Attorney General. In some instances, it is unclear whether agencies have certain litigation authority.[34] Many agencies have litigation authority to defend their activities,[35] while the rest apparently do so as a matter of custom without having the specific authority.[36]

An agency with limited litigation authority may be more susceptible to presidential influence than one with greater litigation authority. The former may have to rely on the Justice Department to promote or protect its interests in court, but these interests may be jeopardized if the President directs the Justice Department to ignore the agency's request. An agency with greater litigation authority is, therefore, in a stronger position to protect its own interests than one with lesser authority. Here, again, Congress may increase an agency's independence by granting it greater litigation authority. Arguably, however, granting such authority, might detract from the Justice Department's role in the area of litigation and possibly create situations where differing interests might result in litigation conflicts between an agency and the President.

As noted above, executive agency authority to initiate and conduct lawsuits and other enforcement litigation varies considerably. Six agencies have complete or nearly complete authority to initiate and conduct lawsuits independently of the Justice

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[33] 44 U.S.C. 3507(c)

[34] While the *Study on Federal Regulation*, vol. 5, Regulatory Organization, U.S. Congress, Senate, 95th Cong., 2nd sess. (Washington: GPO, 1977), remains a key source regarding commission litigation authority, two more recent sources include a CRS memorandum, *Litigating Authority of Federal Entities*, by P.L. Morgan of the American Law Division, dated July 7, 1988; and U.S. Administrative Conference of the United States, *Multi-Member Independent Regulatory Agencies: A Preliminary Survey of Their Organization*, revised edition, May 1992.

[35] Federal Communications Commission (28 U.S.C. 2348 and 2350, and 47 U.S.C. 154(f)(1)); Federal Deposit Insurance Corporation (12 U.S.C. 1819); Federal Energy Regulatory Commission (42 U.S.C. 7101 et seq. and 7171(i)); Federal Labor Relations Authority (5 U.S.C. 7105(h)); Federal Maritime Commission (28 U.S.C. 2348 and 2350); Federal Trade Commission (15 U.S.C. 56); National Labor Relations Board (29 U.S.C. 29 U.S.C. 154(a)); Nuclear Regulatory Commission (28 U.S.C. 2348 and 2350); and Securities and Exchange Commission (12 U.S.C. 1109(a), 1125(d), and 1129(d)). See *ACUS Preliminary Survey, pp. 5, 9, 12, and 15; and Study on Federal Regulations*, vol. V, *Regulatory Organization*, pp. 57–58.

[36] See P.L. Morgan, *Litigating Authority*, p. 7, 9, 11, and 13; *ACUS Preliminary Survey*, pp. 6, 11, 13, and 18; and *Study on Federal Organization*, vol. V, *Regulatory Organization*, pp. 57–58. The Department of Justice will often agree to allow agency counsel to participate in, or even totally conduct, litigation where the knowledge, expertise, and interest on the subject matter resides inside the agency.

Department.[37] Five others have partial or uncertain authority to do so.[38] Only four have no independent authority to sue in their own name without the approval of the Attorney General.[39]

Finally, under 28 U.S.C. 2350(a), three agencies may petition the Supreme Court for a writ of certiorari,[40] and three others appear to have almost complete authority to appeal and argue directly before the Court.[41]

SOME FINAL FACTORS AFFECTING INDEPENDENCE OF MULTI-HEADED AGENCIES

Two more factors affect the independence of multi-headed agencies: how the chairperson of the agency is selected, and whether political balance is required when appointing members.

At the present time, the chairperson of most multi-headed agencies is designated by the President alone. Seven multi-headed agencies have the chairperson appointed by the President with the advice and consent of the Senate,[42] while two agencies designate their own chairperson.[43] In addition, political balance is required for most multi-headed agencies to assure that the members represent a wide variety of ideological as well as other interests. Nearly all of the members are affiliated either with the Democratic Party or the Republican Party. In some instances, however, members may be independent and belong to neither major political party.

In many instances, the chairperson of a multi-headed agency has broad administrative powers, including control over the agency's agenda, budget, and staff. The chairperson is selected by the members themselves, by the President alone, or by the President with the advice and consent of the Senate. If the members select the chairperson, he or she is less likely to share the same views as the President or to feel beholden to him for his or her selection. On the other hand, if the President alone designates the chairperson, the opposite would most likely be the case. Consequently, how the chairperson is selected is likely to affect the agency's independence and character.

By statute, most multi-headed agencies are required to have balanced political membership, meaning that no more than a simple majority of their members may belong to the same political party (i.e., two out of three, or three out of five). One agency that lacks a statutory provision requiring political balance—the Federal Reserve System—by tradition has a balanced membership. Requiring political balance most likely tends to make an agency more independent of the President, especially on those issues where there is a strong division between the parties. Sometimes, it may become necessary to rely on various coalitions to deliver the votes needed to implement new policy initiatives. Without the requirement for political balance, a President is more likely to appoint individuals of his own party, who will be more responsive to his policies and goals.

CONCLUSION

Let me conclude by saying that Congress has broad authority to determine the type of executive agency it wishes to establish. Within constitutional limits, Con-

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[37] Federal Deposit Insurance Corporation (12 U.S.C. 1819); Federal Energy Regulatory Commission (42 U.S.C. 7101, et seq., and 7171(i), and 15 U.S.C. 717 *et seq.*, and 717s); Federal Labor Relations Authority (5 U.S.C. 7105(h) and 7123(b), 7123(c), and 7123(d)); Federal Trade Commission (15 U.S.C. 56); National Labor Relations Board (29 U.S.C. 154(a), 160(e), 160(j), and 160(l), and 161(2)); and Securities Exchange Commission (15 U.S.C. 77t(b), 77t(c), 78u(c), 78u(d), and 78u(e); 11 U.S.C. 1109(a), 1125(d), and 1129(d)). See P.L. Morgan, *Litigating Authority*, pp. 7–10 and 13–14; *ACUS Preliminary Survey*, pp. 7–8, 11, 13, and 18; and *Study on Federal Regulation*, vol. V, *Regulatory Organization*, p. 62.

[38] Commodity Futures Trading Commission (7 U.S.C. 4a(c) and 13(a)(1)); Consumer Product Safety Commission (15 U.S.C. 2061, 2064(g), 2071, and 2076(b)); Farm Credit Administration (12 U.S.C. 224(c)); Federal Maritime Commission (46 U.S.C. 1705(k)); and Federal Reserve Board (12 U.S.C. 1828(c)(7)(D)). See P.L. Morgan, *Litigating Authority*, pp. 3–4, 9, and 11; ACUS Preliminary Survey, pp. 2–3, 9, and 12; *Study on Federal Regulation*, vol. V, *Regulatory Organization*, p. 62.

[39] Federal Communications Commission, National Transportation Safety Board, Nuclear Regulatory Commission, and Occupational Safety and Health Administration.

[40] Federal Communications Commission, Federal Maritime Commission, and Nuclear Regulatory Commission.

[41] Federal Deposit Insurance Corporation (12 U.S.C. 1819); National Labor Relations Board (29 U.S.C. 154(a), 160(e), 160(j), and 161(2)); and Federal Trade Commission (15 U.S.C. 56).

[42] Commodity Futures Trading Commission (7 U.S.C. 4a(2)); Consumer Product Safety Commission (15 U.S.C. 2053(a)); Federal Deposit Insurance Corporation (12 U.S.C. 1812); Federal Reserve Board (12 U.S.C. 242); Merit Systems Protection Board (5 U.S.C. 1203(a)); National Transportation and Safety Board (49 U.S.C. 1111(d)); and Railroad Retirement Board (49 U.S.C. 1902(b)(3)).

[43] Federal Election Commission (2 U.S.C. 437c); and National Mediation Board (45 U.S.C. 154)

gress may determine how independent the agency will be from Presidential direction and control. The political environment helps to determine the duties and responsibilities assigned to an agency, its location in the executive branch, and the degree of independence it enjoys. In determining the degree of independence to grant, an important consideration is the need for such independence, because the accountability of the agency to the President and Congress is inversely linked to its independence. Moreover, whether the agency is single-headed or multi-headed will likely affect its decisionmaking ability, and the accountability of the official or officials making decisions. Finally, presidential support for the agency and its policies will be affected by the degree of independence granted the agency.

APPENDICES

TABLE 1. Fixed-Term Full-Time Positions Requiring Senate Confirmation in Executive Departments and Independent Agencies[a]

Departments and Independent Agencies	Position	Term	Statute
Department of Agriculture			
Rural Electrification Administration	Administrator	10	7 U.S.C. 901
Department of Education			
National Center for Education Statistics	Commissioner	4	20 U.S.C. 122e-1(2)(A)
Department of Health & Human Services			
Indian Health Services	Director	4	25 U.S.C.
Office of Surgeon General	Surgeon General	4	42 U.S.C. 205
Department of Housing and Urban Development			
Office of Federal Housing Enterprise Oversight	Director	5	12 U.S.C. 45129A094)
Department of the Interior			
National Indian Gaming Commission	Commissioner	3	25 U.S.C. 2704(b)(2)(B)(4)
Department of Justice			
Community Relations Service	Director	4	42 U.S.C. 2000g
Federal Bureau of Investigation	Director	10	28 U.S.C. 532 note
Office of Immigration Related Unfair Employment Services	Special Counsel	4	8 U.S.C. 1324b(C)(1)
Executive Office for U.S. Attorneys	U.S. Attorney (94)	4	28 U.S.C. 541(b)
United States Marshals Service	U.S. Marshal (94)	4	28 U.S.C. 561(d)
Department of Labor			
Bureau of Labor Statistics	Commissioner	4	29 U.S.C. 3
Department of Transportation			
Bureau of Transportation Statistics	Director	4	49 U.S.C. 111(b)(4)
Saint Lawrence Seaway Development Administration	Administrator	7	33 U.S.C. 982
Department of the Treasury			
Internal Revenue Service	Commissioner	5	26 U.S.C. 7803(a)(1)(A)
Office of Comptroller of the Currency	Comptroller	5	12 U.S.C. 2
Office of Thrift Supervision	Director	5	12 U.S.C. 1462a(c)(2)
United States Mint	Director	5	31 U.S.C. 304(b)
Department of Veterans Affairs			
Court of Appeals for Veterans Claims	Chief Judge[1]	15	38 U.S.C. 7253
Court of Appeals for Veterans Claims	Judge	15	38 U.S.C. 7253
Court of Appeals for Veterans Claims	Judge	15	38 U.S.C. 7253
Veterans Benefits Administration	Under Secretary	4	38 U.S.C. 306(c)
Veterans Health Administration	Under Secretary	4	38 U.S.C. 305(c)
National Endowment for the Arts	Chairman	4	20 U.S.C. 954(b)(2)
National Endowment for the Humanities	Chairman	4	20 U.S.C. 956(b)(2)
National Science Foundation	Director	6	42 U.S.C. 1864(a)
Office of Personnel Management	Director	4	5 U.S.C. 1102(a)
Office of Government Ethics	Director	5	5 U.S.C. App. 5 401(b)
Office of Special Counsel	Special Counsel	5	5 U.S.C. 1211(b)
Social Security Administration	Commissioner	6	42 U.S.C. 902(a)
	Deputy Commissioner	6	42 U.S.C. 902(b)

[1]Besides the chief judge, the court is to have at least two, but not more than six, associate judges (38 U.S.C. 7253(a))

TABLE 2. Fixed-Term Full-Time Positions Requiring Senate Confirmation on Multi-headed Regulatory and Other Boards and Commissions			
Collegial Board or Commission	Position	Years	Statute
African Development Bank	U.S. Director	5	22 U.S.C. 290i-1(a)
Chemical Safety and Hazard Investigation Board	Members (5)	5	42 U.S.C. 7412(r)(6)(B)
Commodity Futures Trading Commission	Commissioners (5)	5	7 U.S.C. 4a(a)
Consumer Product Safety Commission	Commissioners (5)	7	15 U.S.C. 2053(b)
Defense Nuclear Facilities Safety Board	Commissioners (5)	5	42 U.S.C. 2286(b)
Equal Employment Opportunity Commission	Commissioners (5) General Counsel	5 4	42 U.S.C. 2000e-4(a) 42 U.S.C. 2000e-4(b)
Export-Import Bank	Directors (5)	4	12 U.S.C. 635(c)
Farm Credit Administration	Members (3)	6	12 U.S.C. 2242
Federal Communications Commission	Commissioners (5)	7	47 U.S.C. 154(c)
Federal Deposit Insurance Corporation	Directors (2)	6	12 U.S.C. 1812
Federal Election Commission	Commissioners (6)	6	2 U.S.C. 437(c)(a)
Federal Energy Regulatory Commission	Commissioners (5)	4	42 U.S.C. 7171(b)
Federal Labor Relations Authority	Members (3)	5	5 U.S.C. 7104(c)
Federal Maritime Commission	Commissioners (5)	4	46 U.S.C. 1111 note
Federal Mine Safety and Health Commission	Commissioners (5)	6	30 U.S.C. 823(a)
Federal Reserve System	Directors (7)	14	12 U.S.C. 242
Federal Trade Commission	Commissioners (5)	7	15 U.S.C. 41
Foreign Claims Settlement Commission	Chairman	3	22 U.S.C. 1622 note
Inter-American Development Bank	U.S. Executive Director	3	22 U.S.C. 283a
International Bank for Reconstruction and Development	U.S. Executive Director U.S. Alternate Exec. Dir.	2 2	22 U.S.C. 286(a) 22 U.S.C. 286(a)
International Monetary Fund	U.S. Executive Director U.S. Alternate Exec. Dir.	2 2	22 U.S.C. 286a(a) 22 U.S.C. 286a(b)
Merit Systems Protection Board	Members (3)	7	5 U.S.C. 1202(c)
National Credit Union Administration	Members (3)	6	12 U.S.C. 1752(a)
National Labor Relations Board	Members (5) General Counsel	5 4	29 U.S.C. 153(a) 29 U.S.C. 153(d)
National Mediation Board	Members (3)	3	45 U.S.C. 154
National Transportation Safety Board	Members (5)	5	49 U.S.C. 1902(b)
Nuclear Regulatory Commission	Commissioners (5)	5	42 U.S.C. 5841(c)
Occupational Safety and Health Review Commission	Commissioners (3)	6	29 U.S.C. 661(a)
Postal Rate Commission	Commissioners (5)	6	39 U.S.C. 3601(b)
Railroad Retirement Board	Members (3)	5	45 U.S.C. 231f(a)
Securities and Exchange Commission	Commissioners (5)	5	15 U.S.C. 78d(a)
Surface Transportation Board	Members (3)	5	49 U.S.C. 701(b)
Tennessee Valley Authority	Directors (3)	9	16 U.S.C. 831a
U.S. International Trade Commission	Commissioners (6)	9	19 U.S.C. 1330(b)
U.S. Parole Commission	Commissioners (9)	6	18 U.S.C. 4202

Note: Number in parenthesis under "Position" indicates number of positions requiring Senate confirmation.

TABLE 3. STATUTES LIMITING PRESIDENT'S AUTHORITY TO REMOVE OFFICIALS APPOINTED WITH ADVICE AND CONSENT OF SENATE

A. Positions where statutes stipulate that the President may remove an official "only" for the cause or causes cited:

1. Only for misconduct, inefficiency, neglect of duty, or engaging in the practice of law or for physical or mental disability

U.S. Court of Appeals for Veterans Claims, Judges, 38 U.S.C. 7253(c)

2. Only for inefficiency, neglect of duty, malfeasance in office, or ineligibility

National Mediation Board, Members, Act of June 21, 1934, 48 Stat. 1193, 45 U.S.C. 154(First)

3. Only for inefficiency, neglect of duty, malfeasance in office

Federal Energy Regulatory Commission, Commissioners, P.L. 95–91, title IV, 91 Stat. 582, 42 U.S.C. 7171(b)

Federal Labor Relations Authority, Members, P.L. 95–454, title VII, 92 Stat. 1196, 5 U.S.C. 7104(b)

Merit Systems Protection Board, Members, P.L. 95–454, title II, Sec. 202(a), 92 Stat. 1122, 5 U.S.C. 1202(d)

Merit Systems Protection Board, Chairman of Special Panel, P.L. 95–454, Title II, Sec. 7702, 5 U.S.C. 7702(d)(6)(A)(iii)

Office of Special Counsel, Special Counsel, P.L. 95–454, 92 Stat. 1122, 5 U.S.C. 1211(b)

4. Only for neglect of duty or malfeasance in office

Consumer Product Safety Commission, Commissioners, P.L. 92–573, 86 Stat. 1210, 15 U.S.C. 2053(a)

National Labor Relations Board, Members, P.L. 86–257, title VII, 73 Stat. 542, 29 U.S.C. 153(a)

Social Security Administration, Commissioner, P.L. 103–296, 108 Stat. 1466, 42 U.S.C. 902(a)

5. Only for general cause

Postal Rate Commission, Commissioners, P.L. 94–421, 90 Stat. 1304, 39 U.S.C. 3601

B. Positions where statutes omit the term "only" before the cause or causes cited for removal:

1. Inefficiency, neglect of duty, or malfeasance in office

Chemical Safety and Hazard Investigation Board, Members, 42 U.S.C. 4712(r)(6)(B)

Federal Maritime Commission, Commissioners, 46 U.S.C. 1111, Reorganization Plan No. 7 of 1961

Federal Mine Safety and Health Review Commission, Commissioners, P.L. 91–173, title 1, 91 Stat. 1313, 30 U.S.C. 823(b)(1)

Federal Trade Commission, Commissioners, Act of Sept. 26, 1914, 38 Stat. 717, 718; 15 U.S.C. 41

National Transportation Safety Board, Members, P.L. 93–633, 88 Stat. 2167, 49 U.S.C. 1111(c)

Nuclear Regulatory Commission, Commissioners, P.L. 93–438, 88 Stat. 1242, 42 U.S.C. 5841(e)

Occupational Safety and Health Review Commission, Commissioners, P.L. 91–596, 84 Stat. 1603, 29 U.S.C. 661(b)

Surface Transportation Board, Members, P.L. 104–88, 109 Stat. 932–933, 49 U.S.C. 702(b)

2. For cause

Federal Reserve System, Board of Governors, Act of June 3, 1922, 42 Stat. 620; 12 U.S.C. 242

C. Positions where President need only communicate reasons for removal to the Senate or to both Houses of Congress:

Archivist of the United States, P.L. 98–497, 98 Stat. 2280, 44 U.S.C. 2103

Chief Benefits Officer, Department of Veterans Affairs, 38 U.S.C. 306(c)

Chief Medical Officer, Department of Veterans Affairs, 38 U.S.C. 305(c)

Comptroller of the Currency, Act of June 3, 1864, 13 Stat. 99; R.S. Sec. 325; Aug. 23, 1935, 49 Stat. 707, 12 U.S.C. 2

Director of the Mint, Act of Feb. 12, 1873, 17 Stat. 424; P.L. 97–258, 96 Stat. 879, 31 U.S.C. 304(b)(1)

Director of Operational Testing and Evaluation, Department of Defense, P.L. 98–94, title XII, 79 Stat. 684, 10 U.S.C. 138

Inspector General Act; P.L. 95–452, 92 Stat. 1101, 5 U.S.C. App. 3, 3(b)

Office of Inspector General and Deputy Inspector General, Department of Energy, P.L. 95–91, title II, 91 Stat. 575, 42 U.S.C. 7138

D. Positions where removal probably requires cause or causes even though statutes are silent on the matter:

Commodity Futures Trade Commission, Commissioners

Defense Nuclear Facilities Safety Board, Members

Equal Employment Opportunity Commission

Farm Credit Administration, Commissioners

Federal Communications Commission, Commissioners

Federal Deposit Insurance Corporation, Board of Directors

Federal Election Commission, Commissioners

National Credit Union Administration, Board of Directors

Railroad Retirement Board

Securities and Exchange Commission, Commissioners

United States International Trade Commission, Commissioners

United States Parole Commission, Commissioners

The absence of a removal provision regarding a fixed-term position does not mean that the President can remove an incumbent whenever he wishes. In 1958, the Supreme Court ruled that unless specifically authorized by statute, the President may not remove members of a body created to exercise purely adjudicatory functions that

are not subject to review by any other executive branch official.[44] Since then, the Court has expanded and extended the grounds under which Congress can impose limits on the President's power to remove incumbents before their terms of office expire.[45]

PREPARED STATEMENT OF WILLIAM J. SCANLON

Mr. Chairman and Members of the Committee: We are pleased to be here as you discuss ways to improve the administration of the Medicare program. In recent years, we have reported to the Congress on the capacity of the Health Care Financing Administration (HCFA), the agency that administers Medicare, to carry out its multiple, complex missions. Today's discussion is particularly significant because reform proposals are being made to substantially restructure the program. For example, the President and Senators Breaux and Frist (among others) have proposed comprehensive Medicare reform.[1] As the Comptroller General discussed before this Committee in February,[2] both proposals would use a competitive process to set health plan payments, while each offers its own approach to administering traditional Medicare. We also reported to this Committee on the complex issues that would be involved in administering a new outpatient prescription drug benefit.[3]

In this context, my remarks today will focus on (1) the issues HCFA faces in administering Medicare today and (2) the extent to which proposed reforms or alternative models might address these issues. My comments are based primarily on our recent work analyzing Medicare reform proposals, our numerous studies over the past few years regarding HCFA program management issues, an array of our studies on payment and pricing issues pertinent to traditional Medicare and Medicare+Choice, and our studies of other government agencies.

In brief, Medicare is an inherently difficult program to manage, regardless of its governance structure. Any entity administering a public program of Medicare's size and with its vast universe of stakeholders will be the target of affected parties that feel disadvantaged or harmed by some of its decisions, regardless of their merits. However, there are key problems that impair HCFA's ability to manage Medicare effectively that are amenable to solutions. Currently, (1) no one senior official in HCFA is responsible for managing only Medicare; instead, the HCFA Administrator oversees Medicaid and other state-centered programs—worthy competitors for agency management attention; (2) frequent changes in agency leadership make it difficult to develop and implement a consistent long-term vision; and (3) constraints on HCFA's ability to acquire appropriate resources and expertise limit the agency's capacity to modernize Medicare's existing operations and carry out the program's growing responsibilities. Elements of recent Medicare reform proposals, together with alternatives from existing federal agencies, suggest ways of addressing the focus, leadership, and capacity issues. Options could include creating an entity that would administer Medicare without any non-Medicare responsibilities; establishing a tenure for the program's administrator that, at a minimum, would overlap presidential terms; and granting the entity administering Medicare greater operational flexibility.

PROGRAM SIZE AND PUBLIC NATURE MAKE MEDICARE INHERENTLY CHALLENGING TO MANAGE

As a by-product of the debate on Medicare reform, policymakers are shining a spotlight on HCFA's management of the Medicare program. With respect to management challenges, two factors are obvious from the outset: Medicare's size and its obligations as a public program.

Each year, Medicare accounts for over $200 billion in federal outlays, or an estimated 12 percent of the federal budget in fiscal year 2001; covers about 40 million

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[44] *Wiener* v. *United States*, 357 U.S. 349 (1958). See also *Securities Exchange Commission* v. *Blinder, Robinson, and Co.*, 855 F.2d 677 (10th Cir. 1988). (SEC commissioners may only be removed for cause, despite statutory silence on removal.)

[45] See *Morrison* v. *Olson*, 487 U.S. 654, 685–86 (1988), and *Mistretta v. United States*, 488 U.S. 361, 383 (1989) n. 13 (quoting *Nixon* v. *Administrator of General Services*, 433 U.S. 443 (1979).

[1] The President's proposed legislation is called the Medicare Modernization Act of 2000, S. 2342. With Senators John B. Breaux and Bill Frist, Senators J. Robert Kerrey, Chuck Hagel, Christopher S. Bond, Judd Gregg, and Mary L. Landrieu are cosponsors of the Medicare Preservation and Improvement Act of 1999, S. 1895.

[2] *Medicare Reform: Leading Proposals Lay Groundwork, While Design Decisions Lie Ahead* (GAO/T-HEHS/AIMD-00-103), Feb. 24, 2000).

[3] *Prescription Drugs: Increasing Medicare Beneficiary Access and Related Implications* (GAO/T-HEHS/AIMD-00-99, Feb. 15, 2000).

beneficiaries; and processes about 900 million claims submitted by nearly 1 million hospitals, physicians, and other health care providers. Medicare's largest component is its traditional fee-for-service program. Traditional Medicare enrolls over 82 percent of Medicare beneficiaries and is administered largely by private insurance companies with which the government contracts to process and pay claims. Medicare+Choice, which enrolls over 20 percent of Medicare beneficiaries, consists principally of private managed care plans that contract with the government and are paid a set, monthly per-beneficiary rate. The range and complexity of activities involved in managing Medicare are considerable.

Table 1.—EXAMPLES OF SELECTED MEDICARE RESPONSIBILITIES AND ACTIVITIES ILLUSTRATE MAGNITUDE OF WORK INVOLVED IN ADMINISTERING MEDICARE

Program activity	Example
Contractor oversight	HCFA's central office and its regional offices—which also oversee the monitoring of nursing homes and other institutions—are responsible for monitoring the 50-some Medicare claims administration contractors. Among other things, HCFA staff must determine whether the contractors • process most of their claims within a month or less of receipt, • are not reversed on more than a small fraction of their claims decisions, • generate correctly nearly all of their notices to beneficiaries explaining benefits, • identify insurers that should have paid claims that were mistakenly billed to Medicare, • operate fraud units that explore leads and develop and refer cases to law enforcement agencies, and • identify instances or patterns of inappropriate billing that could result in unnecessary payments and serious financial losses to the program.
Rate-setting	HCFA must set literally tens of thousands of payment rates to pay suppliers for Medicare-covered items and to pay providers—including physicians, hospitals, outpatient and nursing facilities, and home health agencies, among others—for Medicare-covered services. If Medicare's rates are set too high, taxpayers lose; if set too low, providers lose and beneficiary access is threatened. Following are examples of health care providers for which HCFA must establish Medicare payment rates and the analytical tasks involved: ***Physicians.***—Develop rates that reflect the resources involved in providing individual services as well as current practice costs in local markets. ***Acute care hospitals.***—Update base rate and adjust payments to reflect inflation and geographic cost differences. Update patient classification mechanism that adjusts payments to reflect patient need. ***Home health agencies.***—Calculate base payments that reflect the average costs of an episode of home health care. Modify patient classification mechanism to better reflect patient need. ***Medicare+Choice plans.***—Set base price by estimating future growth in fee-for-service spending. Refine methodology that adjusts the base rate to reflect an enrollee's higher or lower-than-average expected costs.
Consumer information and protection of beneficiary rights.	HCFA is responsible for providing beneficiaries with general information regarding benefits and rights under the traditional program, Medicare supplemental insurance policies (Medigap), Medicare Select, and Medicare+Choice plans. As part of these responsibilities, HCFA must— • conduct an annual national educational and publicity campaign to inform beneficiaries about their Medicare options and the availability of Medicare+Choice plans in local areas, • ensure the proper functioning of the process for appealing payment and coverage decisions, • operate a toll-free hot-line to answer beneficiary questions, • distribute comparative information on Medicare+Choice plans, • review for accuracy the promotional literature and membership materials that each plan distributes to beneficiaries, and • ensure that plans have adequately informed beneficiaries of their right to appeal adverse coverage or payment decisions.

As health care delivery grows more complex, HCFA accumulates new responsibilities—sometimes, however, without receiving the resources or the tools to adapt. For example, contractor budgets for claims administration have been falling in proportion to the volume of claims they process. Relative to the size of private health insurers and their administrative budgets, HCFA runs Medicare on a shoestring.[4] As

[4] In 2000, the HCFA Administrator testified that the agency spends less than 1 percent of Medicare benefit outlays on Medicare program management, compared with private sector administrative costs of 12 percent and higher.

we and others have reported, too great a mismatch between the agency's administrative capacity and its designated mandate could leave HCFA unprepared to handle Medicare's future population growth and medical technology advances.[5]

Recently, the Congress added new Medicare responsibilities to HCFA's existing list. According to the HCFA Administrator, the Balanced Budget Act of 1997 (BBA) called for HCFA to implement 335 provisions, and the Balanced Budget Refinement Act of 1999 included 133 provisions for HCFA implementation. In 1998 and 1999, we reported that HCFA was essentially overwhelmed in its efforts to handle the number and complexity of BBA requirements. For example, BBA expanded the health plan options in which Medicare beneficiaries could enroll to include—in addition to health maintenance organizations (HMO)—preferred provider organizations, private fee-for-service plans, and medical savings accounts, among others. However, HCFA's staff had no previous experience overseeing these diverse entities. In 1998, the Inspector General of the Department of Health and Human Services (HHS) reported, in a study on Medicare's oversight of managed care, that nearly all of the staff hired to work in the Medicare managed care area in the 2 previous years lacked previous HMO experience, half the regional offices lacked managed care staff with clinical backgrounds, and few managed care staff had training or experience in data analysis.[6]

Moreover, providing HCFA the tools to adapt to health care's new business environment is not a straightforward matter. Because Medicare is a public program, changes require public input—which is a sometimes cumbersome, but necessary, requirement. On the one hand, the process of drafting regulations and obtaining public comment can prevent an agency from acting swiftly—for example, to reprice services and supplies when market rates suggest they should be significantly lower. On the other hand, without the requirement for public comment on proposed federal regulations, there would be a greater risk of rash policymaking that could result in undesirable consequences. Medicare's particular dilemma is that the number of special interests affected and the dollars involved make it difficult even to test on a limited basis the prudent purchasing techniques employed by the private sector. For example, pressure from special interest groups prevented HCFA, for more than a decade, from testing the pricing of services through a competitive bidding process. Just last year, under BBA authority, HCFA was able to begin a competitive pricing demonstration in one county for certain medical supplies.

HCFA'S MANAGEMENT OF MEDICARE IS WEAKENED BY DIFFUSED FOCUS, FREQUENT LEADERSHIP CHANGES, AND CAPACITY CONSTRAINTS

Besides the challenges inherent in managing a massive public program like Medicare, other factors diminish HCFA's ability to administer the program effectively. Namely, Medicare competes with other programs for HCFA managers' attention, the agency experiences frequent changes in administrator, and the agency is constrained in several ways from improving its capacity.

HCFA's Management Focus Is Divided Across Multiple Programs and Responsibilities

Despite Medicare's public policy significance—share of the federal budget, impact on millions of beneficiaries and health care practitioners nationwide, and impact on the overall health care market—there is no official whose sole responsibility it is to run Medicare. In addition to Medicare, the HCFA Administrator and top-level management have oversight, enforcement, and credentialing responsibilities for other major programs and initiatives. These include:

- overseeing the 50-plus Medicaid programs, which are jointly financed by the federal government and the states;
- overseeing a similar number of State Children's Health Insurance Programs;
- ensuring that individual and group insurance plans comply with standards in the Health Insurance Portability and Accountability Act in states that have not adopted conforming legislation; and
- ensuring that hospitals, nursing homes, home health agencies, and managed care plans that participate in Medicare and Medicaid, as well as all of the nation's clinical laboratories, meet federal quality standards.

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[5] Gail Wilensky et al., "Crisis Facing HCFA & Millions of Americans," *Health Affairs*, Vol. 18, No. 1 (Jan./Feb 1999); *HCFA Management: Agency Faces Challenges in Managing Its Transition to the 21st Century* (GAO/HEHS–99–58, Feb. 11, 1999); *Medicare: HCFA Faces Multiple Challenges to Prepare for the 21st Century* (GAO/HEHS–98–85)

[6] *Medicare's Oversight of Managed Care: Implications for Regional Staffing* (OEI–01–96–00191, April 1998).

The multiple issues involved in administering these other programs could reasonably be expected to occupy much of a senior manager's attention, thus siphoning off time that would otherwise be spent meeting the demands of the Medicare program.

HCFA Has Experienced Little Continuity of Leadership

Frequent changes in HCFA leadership have inhibited the implementation of long-term Medicare initiatives or the pursuit of a consistent management strategy. The maximum term of a HCFA Administrator is, as a practical matter, only as long as that of the President who appointed him or her, and historically, their terms have been even shorter. In the 23 years since HCFA's inception, there have been 17 Administrators or Acting Administrators, whose tenure has been, on average, little more than 1 year (see table 2).

Table 2.—ON AVERAGE, TENURE OF HCFA ADMINISTRATOR IS 1.4 YEARS

Year	Administrator
1977	Don Wortman, Acting
1977	Robert Derzon
1978	Leonard Schaeffer
1980	Earl Collier, Acting
1980–81	Howard Newman
1981	Paul Willging, Acting
1981–85	Carolyn K. Davis
1985–86	C. McClain Haddow, Acting
1986	Henry F. Desmarais, Acting
1986–89	William L. Roper, M.D.
1989	Terry Coleman, Acting
1989–90	Louis Hays, Acting
1990–92	Gail R. Wilensky, Ph.D.
1992	J. Michael Hudson, Acting
1992–93	William Toby, Acting
1993–97	Bruce C. Vladeck
1997–present	Nancy-Ann Min DeParle

With programs as complex and expensive as Medicare and Medicaid, each new Administrator needs time to learn the programs' intricacies and interactions with the health care markets in which they operate. The historically short tenures of HCFA Administrators have not been conducive to carrying out whatever strategic plans or innovations they have individually developed for administering Medicare efficiently and effectively. Moreover, about 10 percent of the time, HCFA has had an Acting Administrator. A short tenure can compromise an Administrator's ability to lead and can dampen the incentive to develop a vision.

HCFA's Capacity to Manage Medicare Is Limited Relative to Multiple, Complex Responsibilities

HCFA seeks to modernize and operate as a prudent purchaser of health care in the rapidly evolving health care marketplace, but whether its staff possesses the skills necessary to reach these goals is in question. At the same time, the agency's efforts to modernize its information systems have not succeeded. As for outside resources, HCFA's pool of claims administration contractors is shrinking, owing to outdated contracting arrangements that essentially restrict the agency from attracting new companies to process claims or conduct the related administrative functions.

HCFA Faces Gaps in Staff Expertise and Information Management Resources

Our prior work, studies by the OIG, and statements by HCFA officials suggest that the agency lacks sufficient staff—such as information technology specialists, rate-setting methodologists, and market analysts, among other specialties—to help the agency carry out its newer responsibilities.[7] At the same time, HCFA faces the loss of staff with valuable institutional knowledge. In February, the HCFA Administrator testified that more than a third of its current workforce is eligible to retire

[7] *HCFA Management: Agency Faces Challenges in Managing Its Transition to the 21st Century* (GAO/T-HEHS–99–58, Feb. 11, 1999); *Medicare: HCFA Faces Multiple Challenges to Prepare for the 21st Century* (GAO/T–HEHS–98–85); *Medicare's Oversight of Manaed Care: Implications for Regional Staffing* (OEI–01–96–00191, April 1998).

within the next 5 years. She also noted that the agency seeks to increase "its ability to hire the right skill mix for its mission."

To assess its needs systematically, HCFA is conducting a four-phase workforce planning process that includes identifying current and future competencies needed to carry out the agency's mission and analyzing the gaps between them.[8] HCFA has initiated this process using outside assistance to develop a comprehensive data base documenting the agency's work roles, skills, and functions.[9]

In addition, HCFA's information needs are not being met with Medicare's fragmented and aged set of computerized information systems. In the early 1990s, HCFA launched a systems acquisition initiative to replace Medicare's multiple contractor-operated claims processing systems with a single, more technologically advanced system. Although the proposed acquisition was based on a sound concept, it failed operationally, through a series of planning and implementation missteps,[10] leaving Medicare with numerous aging information systems that needed year-2000 renovation. Among Medicare's aging systems are those that track private health plan information for today's Medicare+Choice program.[11]

Existing Contracting Authority Lacks Flexibility Needed to Modernize Program Operations

HCFA faces other constraints on its capacity to improve Medicare operations, namely those related to managing the 50-some health insurance companies under contract that pay providers' claims and perform other functions, including customer service, fraud and abuse prevention and detection activities, financial management, and other administrative activities. These contractors run the day-to-day operations of traditional Medicare, which accounts for over 80 percent of the program. In the 1990s, several contractors defrauded the government or settled cases alleging fraud for hundreds of millions of dollars. However, because of contracting authority constraints that essentially preclude HCFA from contracting with new companies, "firing" contractors for poor performance has been a measure of last resort.[12] At Medicare's inception in the mid-1960s, the Congress intended for the government to use existing health insurers to process and pay claims under the assumption that these experienced private companies could administer the program effectively—an asset at the time for obtaining Medicare's acceptance by a medical provider community that feared excessive government interference in medical practices. Since that time, regulations and agency practices have built barriers against using companies other than health insurers and separately contracting for the various claims processing, payment, and customer service functions.[13] Constraints also make it difficult to maintain participation by the current contractors. For example, claims administration contractors are not permitted to earn a profit from their Medicare business. Initially, the prestige of serving as a Medicare contractor and the advantages of having the government pay a share of overhead costs and being introduced to new automation technology were sufficient to encourage companies to contract with Medicare. Today, however, some of these companies are refocusing their business interests on more lucrative enterprises, such as managed care plans and physician networks, according to the Blue Cross and Blue Shield Association and commercial insurer representatives. When these companies consider whether to renew their Medicare contracts, HCFA is not in a position to offer financial incentives for their continued participation.

The initial rationale for using existing health insurers to process claims has faded against the backdrop of today's health care business environment. In the 3 decades since Medicare's creation, the explosion in information management technology, coupled with the diversification of the health insurance industry into activities such as the provision of health services, has generated the potential for Medicare to use new

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[8] HCFA's workforce planning efforts are consistent with our guidance on this subject, as articulated in *Human Capital: A Self-Assessment Checklist for Agency Leaders* (GAO/GGD–99–179, Sept. 1999).

[9] With OPM, HCFA developed an interagency agreement with the National Security Agency (NSA) that will enable it to use the subcontractor that developed NSA's workforce planning system.

[10] We discussed these problems in *Medicare Transaction System: Success Depends Upon Correcting Critical Managerial and Technical Weaknesses* (GAO/AIMD–97–78, May 16, 1997)

[11] An outside firm's assessment found, among other problems, that the current system used for health plans makes it difficult to extract information for policy decisions and program management; is labor-intensive to modify and validate; and, because of its batch processing structure, does not provide timely information on beneficiary enrollment or other plan transactions.

[12] *Medicare Contractors: Despite Its Efforts, HCFA Cannot Ensure Their Effectiveness or Integrity* (GAO/HEHS–99–115, July 14, 1999)

[13] The Health Insurance Portability and Accountability Act of 1996 granted HCFA new authority to contract separately for program safeguard functions.

types of business entities to administer its claims processing and related functions. The President's 2001 budget proposes legislation that would introduce competition into the Medicare contracting environment and allow HCFA to select contractors from a wider pool.

RECENT REFORM PROPOSALS SEEK TO ADDRESS MEDICARE MANAGEMENT PROBLEMS

Two leading proposals to reform Medicare—the President's Medicare Modernization Act of 2000 and S.1895, or the Breaux-Frist proposal—include elements that could improve program management. How effective these might be, of course, depends on many operational details that have yet to be specified. Although the proposals are broadly similar in that they would institute competitive pricing for Medicare plans and provide for a prescription drug benefit, they differ in the manner and extent to which they would address current management problems. Moreover, both proposals leave some problems unresolved.

Management Focus

One important difference between the proposals is the administrative structure envisioned for Medicare. Under the President's plan, Medicare's administrative structure would remain the same as today's: HCFA would continue to oversee Medicare+Choice plans and administer the traditional program in addition to its other responsibilities. Under Breaux-Frist, an independent Medicare Board would manage competition among plans; traditional Medicare would exist as one of the competing health plans. The proposal would also divide HCFA into two parts: the Division of HCFA-Sponsored Plans would administer the traditional Medicare plan; the Division of Health Programs would carry out HCFA's other non-Medicare responsibilities. Thus, the Breaux-Frist proposal would create entities whose sole focus was the Medicare program.

Management Continuity

A second major difference concerns the extent to which the two proposals address greater Medicare management continuity. The President's proposal would not change the tenure of HCFA's leadership and thus does not address this issue. Longer-tenured leadership is partially addressed under the Breaux-Frist proposal: members of the Medicare Board would serve staggered 7-year terms; there is no mention of changes in the terms of the HCFA leadership.

Management Capacity

Finally, the proposals differ in how they seek to improve HCFA's capacity to manage the traditional program. Of the three broad management issues, this one is perhaps the most challenging. The Breaux-Frist proposal relies on a process in which HCFA would develop, and initially submit for congressional approval, an annual business plan. Although the agency would likely continue to be subject to standard government personnel practices, it could propose changes in provider payment rates, contracting provisions, or purchasing strategies in its business plan. In addition, HCFA would no longer be subject to the annual appropriations process for its administrative expenses. HCFA instead would include these expenses in the premium it proposed in its business plan. Until 2008, HCFA would submit its business plan to the Congress, where the plan would be subject to an up-or-down vote. After that, HCFA could implement its business plan without explicit congressional approval. In contrast, HCFA's administrative budget under the President's proposal would continue to be set through the appropriations process. However, the President's proposal would likely grant HCFA some new flexibility in personnel, contracting, and purchasing practices.[14]

[14] The President's 2001 budget notes HCFA's initiative to evaluate personnel requirements and the potential need for "flexibility." HCFA is in the process of identifying the personnel constraints it may face before specifying the flexibilities it is seeking.

Table 3.—NEITHER PROPOSAL FULLY ADDRESSES MEDICARE'S CURRENT MANAGEMENT ISSUES

Management	Breaux-Frist proposal	President's Medicare Modernization Act of 2000 (including President's 2001 budget)
Focus	For proposed Board: • Management focus is trained on Medicare only For traditional Medicare: • Management focus is trained on Medicare only, as provided for under a proposed HCFA division.	Not addressed
Continuity	For proposed Board: • Staggered, 7-year terms established management continuity for competitive rate-setting function For traditional Medicare: • Not addressed	Not addressed
Capacity	For proposed Board: • New operational infrastructure required • Provides flexibility to hire needed expertise • Provides independence from appropriation process For traditional Medicare: • Personnel flexibility not addressed • Provides independence from appropriation process • Until 2008, HCFA proposals regarding provider payment rate changes, prudent purchasing strategies, and claims administration would be incorporated in annual business plan and subject to congressional approval • Beginning 2008, HCFA could change payment rates, adopt new prudent purchasing strategies, and modify the claims administration contracting process without Congressional approval	• Leaves existing operational infrastructure in place • The potential for obtaining personnel flexibility accounted for in President's 2001 budget • Provides for the adoption of prudent purchasing options (e.g., competitive bidding, preferred providers, and centers of excellence) under traditional program • Provides broader authority to contract for claims administration services

As table 3 shows, neither proposal on its own addresses Medicare's key administrative shortcomings. However, the building blocks of administrative reform are present. Separate elements of each proposal offer opportunities to improve Medicare's management. For example, under an approach where HCFA continued to run the traditional program and oversee private plans, the agency could be organized so that a single Administrator focused exclusively on Medicare. Alternatively, if a Medicare Board was established and HCFA charged with running only the traditional program, broader authority to adopt prudent purchasing strategies could improve the agency's effectiveness in operating what would be, by far, the single largest Medicare health plan.

Neither proposal is currently specific enough to do more than sketch the general direction of reform. Detailed blueprints would need to be drafted before the proposals' reform concepts could be translated into an implementation plan. For example, the Medicare Board envisioned by the Breaux-Frist proposal would have considerable administrative and oversight responsibilities that would need to be conducted nationwide. The seven-member Board would clearly need significant staff and other resources to fulfill these functions. Details—such as the number of staff needed to carry out the Board's assigned duties and the way the staff would be organized—have not been discussed.

Experience, however, suggests that a new agency with several hundred staff may be needed. Before HCFA was reorganized in 1997, one of its units—the Office of Managed Care (OMC)—performed some of the functions envisioned for the Medicare Board.[15] Although OMC was staffed by nearly 150 individuals in Baltimore, Maryland and supported by another 120 HCFA employees in 10 regional offices, it was not self-sufficient. OMC relied on an unknown number of employees in other HCFA

[15] After the reorganization, OMC's functions were distributed among three new HCFA units: the Center for Health Plans and Providers, the Center for Beneficiary Services, and the Center for Medicaid and State Operations.

units who were responsible for systems support, personnel matters, training, contracting, financing and budgeting, and many other tasks. Thus, a new agency supporting a Medicare Board—if it is to be self-sufficient—would likely be considerably larger than HCFA's previous OMC.

Experience also suggests that the period needed to establish a Board-run agency and make it fully functional could be 2 years or longer, depending on the number of staff devoted to planning such an enterprise. The developmental phase would involve a range of issues—from deciding the size and composition of the agency's workforce to finding and furnishing office space and hiring employees. Although the President's proposal does not include sweeping organizational changes, it too would require additional planning time before many of its provisions could be implemented. For example, the proposal calls for additional study to determine the specific personnel flexibilities that might best facilitate the agency's ability to attract and retain the skill mix it needs.

Existing Federal Agencies Suggest Options for Balancing Flexibility With Accountability

The operational and governance structures of certain federal agencies may be useful to consider as policymakers consider Medicare governance issues. Fundamental to the discussion is the need to find a balance between giving Medicare's administering entity adequate flexibility to act prudently and ensuring that the entity can be held accountable for its decisions and their implementation. Consistent with this theme, some Members of Congress have expressed the desire to reduce their micromanagement of Medicare while remaining adequately vigilant over an entity that runs a program of Medicare's size and impact.

In the past, the Congress has addressed governance issues for certain programs by separating their administration from a larger body. In 1995, for example, the Social Security Administration (SSA) was reestablished as an independent agency outside the Department of Health and Human Services (HHS). The impetus for SSA's independence stemmed from concerns expressed in congressional hearings and reports about a variety of issues, including the need to (1) improve management and continuity of leadership at SSA, (2) foster greater public confidence in the long-term viability of Social Security benefits, and (3) reduce the program's bureaucratic encumbrances in the executive branch. Committee chairmen expressed a desire to make SSA more accountable to the public for its actions and more responsive to the Congress' attempts to address SSA's management and policy concerns.

Following the establishment of SSA as an agency outside HHS, SSA officials noted that independence gave the agency heightened visibility within the executive branch, allowing it to express agency concerns and views directly to the Office of Management and Budget (OMB)—part of the Executive Office of the President—and the Congress. The issues below illustrate the degree of autonomy granted to SSA.

- *Approval chain for agency's budget request.* The SSA Commissioner prepares an annual budget, which is to be submitted without revision by the President to the Congress along with the President's own budget request for the agency. Under this arrangement, SSA remains subject to the appropriations process but the Congress has the opportunity to consider OMB's view of the agency's needs in the context of the agency's own view.
- *Clearance requirements for newly promulgated regulations.* Even though independent, SSA remains an agency within the executive branch and continues to work with OMB on all budget, legislative, and policy matters. SSA obtains OMB clearance before communicating with the Congress, presenting testimony, promulgating regulations, and making legislative recommendations. According to agency officials, the legislation that created an independent SSA did not exempt it from the executive order requiring these OMB clearances. In contrast, the authorizing statutes of some independent agencies or boards explicitly prohibit any requirement that they obtain clearance before undertaking these actions.
- *Tenure of agency head.* In creating an independent SSA, the Congress strengthened the role of the Commissioner, who is appointed by the President and confirmed by the Senate. Until independence, the President could remove the Commissioner for any reason at any time. The independence law provided for a fixed 6-year term and protection from arbitrary removal. The Commissioner can now be removed by the President only for cause—neglect of duty or malfeasance in office.

The Congress has acted in the past to fix the tenure of other agency heads and thus help insulate them from immediate political pressures. In 1976, the term of the Director of the Federal Bureau of Investigation (FBI) was set at 10 years. Since 1978, there have been five Directors and Acting Directors, serving on average 4.2 years. This is substantially longer than the 1.4-year average tenure of HCFA Ad-

ministrators over roughly the same time period. Within their 10-year terms, however, FBI Directors remain accountable to the President and are not completely insulated from the political environment. The President can remove a Director and did so in 1993 when the then Director faced allegations of ethics violations.

The Congress has also created advisory boards to help guide an agency's operations. In 1998, for example, the Congress passed legislation providing for an Internal Revenue Service (IRS) oversight board as well as introducing other changes in agency governance.[16] The board, which has not yet been formed, is intended to help bring accountability, continuity, and expertise to executive governance and oversight of the agency and to give the Congress more confidence in IRS day-to-day operations.[17] The nine-member board will consist of the Secretary of the Treasury or designee, the IRS Commissioner, and seven individuals appointed by the President and confirmed by the Senate. The seven appointed individuals will serve staggered 5-year terms and will be selected for their expertise in management, customer service, federal tax law, information technology, or other areas. [18]

In general, the board's role is to ensure that the IRS carries out its mission effectively. More specifically, the board will (1) review and approve IRS' strategic plans, including performance standards; (2) review operational functions, including plans for modernization, training, and outsourcing; (3) recommend candidates for the Commissioner's post and review selection of senior executives; (4) approve the Commissioner's budget request, and (5) ensure proper treatment of taxpayers.

CONCLUSIONS

Medicare reform proposals recognize that, to meet the financing challenges caused by an aging population and increasingly expensive medical technology, the program must be modernized. No single proposal offers complete solutions to current Medicare management problems, but each has elements that can serve as a point of departure for further consideration, particularly in combination with alternative structures that exist in other federal agencies. In sum, restructuring government is complicated, particularly when the program in question has been one of the nation's most popular and successful. Experience tells us there is no simple formula for bringing about needed improvements, but considering a combination of options may be a first step. We would be pleased to continue to work along with you and your Committee in providing information on the best ways to proceed.

PREPARED STATEMENT OF GAIL R. WILENSKY, PH.D.

Mr. Chairman and members of the committee, thank you for inviting me to appear before you. My name is Gail Wilensky. I am the John M. Olin Senior Fellow at Project HOPE, an international health education foundation, and I chair the Medicare Payment Advisory Commission. I am also a former Administrator of the Health Care Financing Administration (HCFA). My testimony reflects my views as a health policy analyst as well as my experiences directing HCFA and chairing MedPAC. I am not here in any official capacity and my testimony should not be regarded as representing the position of either Project HOPE or MedPAC.

I am here today to discuss possible ways to reallocate some of the functions that historically have been assigned to HCFA in order to make the agency function more effectively. I believe such a reallocation would be desirable, irrespective of reforms to the Medicare program but would be particularly important with some of the reforms currently under consideration.

I would like to make it clear that I am not here as a "HCFA-basher" but rather as someone who understands only too well the enormity of the tasks that have been given to HCFA.

WHAT'S THE PROBLEM?

A substantial amount of attention has been given to the proposal for the creation of a Medicare Board to oversee some functions of Medicare. The functions most frequently regarded as appropriate to transfer to the Board are the administration of the Medicare+Choice program, or the overall administrative functions associated with the transformation of Medicare to a premium support program. Recently, the

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[16] Internal Revenue Service Restructuring and Reform Act of 1998.

[17] *A Vision for a New IRS,* National Commission on Restructuring Internal Revenue Service, June 25, 1997.

[18] One of the seven slots is reserved for a full-time federal employee or representative of federal employees. The remaining six individuals may not be federal officers or employees.

Board has also been mentioned as a potential administrative agency for a new outpatient prescription drug benefit.

I have testified before this committee in favor of the concept of a Medicare Board as the major administrative structure supporting a premium-support type of Medicare program. But in further consideration, I believe that the Medicare Board may not be the best choice of organizational structure to provide oversight and to negotiate with the private plans and the traditional Medicare program.

The Congressional Research Service has described some of the difficulties of using a Board structure for an entity that has significant administrative and operational functions. While CRS has listed a number of problems they perceive would arise from the split in functions between HCFA and the Medicare Board, I am concerned about the problems of accountability that they have raised. As frustrated as the Congress is sometimes by HCFA, having a Medicare Board completely independent of the Congress and the President, aside from the appointment of the members, may represent a cure that's worse than the disease. This is an issue worthy of more review by the Congress.

In reconsidering the appeal of a Medicare Board, I think it is important to focus on the problems the Medicare Board was trying to fix. More broadly, what kind of organizational reforms would make HCFA function better and also provide an administrative structure for a reformed Medicare program? As part of this testimony, I am proposing a series of structural and administrative changes that attempt to respond to these questions.

Sometimes the need for administrative change is justified by the charge that HCFA is too political and too partisan in its operations. While I wouldn't want to say the agency has never acted in political or partisan ways, I do not believe this has occurred very often. The more legitimate charge, to my mind, is that the agency is often too bureaucratic and sluggish in its operations and unresponsive to legitimate concerns of the various stakeholders involved in Medicare. There has also been legitimate concern about whether some of the functions of a reformed Medicare program should lie within the agency that has organizational and administrative responsibility for the traditional Medicare program.

A discussion of possible places to house the oversight functions for a premium-support type of Medicare, if that is the direction the Congress chooses to take, is discussed later in my testimony. But the reorganization will not change a serious problem that HCFA faces—the enormity and diversity of the functions assigned to it by the Congress.

HCFA'S CURRENT FUNCTIONS

HCFA's foremost responsibility is administering the Medicare program. This program covers 39 million people and is expected to cost $218 billion in FY 2000. The agency employs almost 4500 people but has contracted the services of thousands of others who act as its fiscal intermediaries and carriers. These are the individuals who actually pay the bills and provide financial oversight for the services provided. In addition, HCFA manages the participation of some 263 plans involved in the Medicare+Choice program. This makes HCFA itself bigger than most cabinet level departments in terms of both money and personnel.

The proper oversight and administration of Medicare is a full-time job for any agency. The problem is that HCFA is also responsible for providing oversight to the Medicaid program, conducting surveys and certification of certain types of health care facilities, approving the Children's Health Insurance Proposals submitted by the States, and enforcing federal health insurance portability laws and some fraud and abuse prevention activities. These activities require a wide variety of talents, skills and experience and present a management problem to even the most talented administrator.

These problems will only get worse if organizational changes are not put in place that are consistent with whatever type of Medicare reform Congress chooses to enact. The number of people on Medicare will increase dramatically as the baby-boomers start to retire and will make the world's biggest insurance company, HCFA, even more difficult to manage. Determining the most appropriate reallocation of functions will depend in part on how Medicare ultimately is reformed.

ORGANIZATIONAL STRUCTURES THAT SUPPORT REFORM

Medicare

HCFA should remain focused on running the public, administered-price, fee-for-service system. This program needs to be a modernized version of the traditional Medicare program.

Some have also suggested that the administration of the traditional Medicare program could be put out for competitive bid to the states or to private entities. The attraction of the privately or state administered fee-for-service plans is that they may be able to introduce changes in local markets that HCFA may not be able to do. But for many people, this is also the fundamental drawback of a private or state administered plan. The public oversight and control of a federally administered plan provides a sense of protection that will be difficult to ignore. I also suspect the Congress and Administration would be reluctant to give up this much control of the program.

The more difficult issue is whether HCFA can administer a modernized fee-for-service system. A series of changes would be needed to modernize the traditional Medicare program. These include the authority to use selective contracting, centers of excellence, disease management programs, best-practice programs and other changes that are commonplace in better-run private sector plans.

If HCFA or any other governmental agency is to run a modernized fee-for-service program, Congress will need to change its relationship with HCFA and retreat from its very micro-prescriptive directives. This would require both changes in statute and changes in attitude. It would also require changes in attitude and behavior by the employees of HCFA.

The critical question, which Congress must decide, is the following: in addition to modernizing the traditional Medicare program, how else does it wishes to reform Medicare. I believe that the current combination of a Medicare+Choice program, which provides a highly regulated environment with payments set independent from the traditional program, and a traditional Medicare program is not a stable long-term option. Two other possibilities are a publicly administered modernized fee-for-service system alone or a premium support model that would include the publicly administered fee-for-service system as one of its choices. I am already on record as strongly preferring the latter.

If the Congress chooses to adopt a premium-support or Federal Employees Health Care model for Medicare, care needs to be given as to where that program can be best administered. A Medicare Board is one possibility, but a better choice may be an independent agency, or even better, an expanded Office of Personnel Management. This would place the entity that provides oversight to the managed health care and other traditional Medicare-replacement plans and to leveling the playing field between the traditional program and Medicare-replacement programs, in the executive office of the President, reporting directly to the President. It is also the place that currently is involved in negotiations with private plans and with providing oversight and education about the plans.

I recognize this would divide the responsibility of administering the overall program between two entities, but I believe this is far preferable than to lodge both with HCFA. HCFA has little experience in negotiating with outside entities. Furthermore, the functions for government in running and monitoring a premium support system are so fundamentally different from the experiences and mind-set of HCFA personnel that to keep them together would detract rather than enhance the successful operation of a premium-support program. OPM, on the other hand, has had exactly this type of experience administering the FEHB program.

An expanded (and renamed) OPM would also be a logical entity to house the health insurance monitoring activities of HIPAA.

Medicaid

There are two alternative places to locate Medicaid. One is with the Administration for Children, Youth and Families, the agency which runs the welfare program. This agency, however, has no experience providing oversight to health programs. Alternatively, a new agency could be created that housed Medicaid, and also approved the proposals submitted by the states under SCHIP. This new entity might also house other state health programs like HRSA (Health Resources and Services Administration), and SAMSA (Substance Abuse and Mental Services Administration).

Other current HCFA functions

Finally, the survey and certification functions and CLIA (Clinical Lab Improvement Act) activities currently performed by HCFA could be housed with the FDA or with the CDC or with a new authority that housed both of these agencies.

WHAT NEXT?

I recognize I am suggesting major changes in the allocation of responsibilities currently assigned to HCFA as well as major reassignments of other parts of Health and Human Services. Part of the reallocation of responsibilities and duties will de-

pend on the type of Medicare reform ultimately adopted by the Congress; some of the changes that have been suggested are independent of those decisions.

What should happen next is a full-fledged review of the agency. This will be a difficult and important undertaking and needs to be performed in as non-partisan and objective manner as is possible. Starting this now, as we go into an election phase, knowing there will be changes no matter what the outcome of the election, may be a good time to start.