

Forum Session

NATIONAL
HEALTH
POLICY
FORUM

Reflections on HCFA: Former Administrators Speak Their Minds

Friday, February 23, 2001
9:30 am - Refreshments available
10:00 am to noon - Discussion
Hyatt Regency Capitol Hill
400 New Jersey Avenue, N.W.
Ticonderoga Room

A roundtable discussion featuring

Nancy-Ann Min DeParle
Former Administrator
Health Care Financing Administration

William Roper, M.D.
Dean
School of Public Health
University of North Carolina at
Chapel Hill

Bruce Vladeck, Ph.D.
Senior Vice President for Policy
Mount Sinai NYU Health

Gail Wilensky, Ph.D.
John M. Olin Senior Fellow
Project HOPE

Registration: Please call **Dagny Wolf** at **202/872-1392** as soon as possible.

The
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Reflections on HCFA

The Health Care Financing Administration (HCFA) was created in 1977 to administer the Medicare and Medicaid programs. Since that time, the number of Medicare and Medicaid beneficiaries has risen to more than 70 million individuals, and HCFA has taken on significant new administrative and regulatory responsibilities. In 1997, it oversaw federal spending of \$360 billion, roughly one-third of national health care expenditures. As HCFA's importance has increased, scrutiny of the agency has intensified and outright criticism has been frequent.

Although Medicare is an enormously popular program, within the Beltway HCFA is often dubbed the "agency everyone loves to hate." It has recently been blamed for a host of policy failures, such as the widespread withdrawals from the Medicare+Choice program, difficulties in establishing prospective payment systems for post-acute and outpatient services, over-regulation of State Child Health Insurance Programs, and a derailed competitive pricing demonstration.¹ Squaring the implementation of new congressional proposals with the responsibilities of running programs designed in the 1960s has not been easy. And as the complexities have multiplied, tensions between congressional interests and administrative managers have intensified, shifts in political party aside.

Several proposals have been offered in Congress in recent years to restructure and/or abolish HCFA as it is currently formulated. These proposals range from creating a Medicare Board to govern the program to moving certain activities, such as Medicare+Choice plans and proposed prescription drug coverage, outside of HCFA to establishing HCFA as an independent agency separate from the Department of Health and Human Services, similar to the Social Security Administration or the Federal Reserve Board.

Two years ago, in the January/February issue of *Health Affairs*, 14 leading Medicare policy experts—including two former HCFA administrators—published an open letter (which is attached) to Congress and the executive branch warning of a crisis "facing HCFA and millions of Americans."² They noted that over the past decade Congress has directed the agency to "implement, administer, and regulate an increasing number of programs," while failing to increase commensurately the agency's administrative budget. These experts, who represent a range of political perspectives, warned that this "mismatch between the agency's administrative

capacity and its political mandate" threatens to seriously undermine the Medicare program and leave HCFA in a state of disrepair.

The U.S. General Accounting Office, which has produced numerous investigative reports regarding HCFA's oversight of Medicare and Medicaid, has also raised awareness of the management challenges inherent in running a program of Medicare's size and political importance. In testimony before Congress last year, William J. Scanlon, GAO's director of health financing and public health issues, remarked that several of HCFA's key problems could be 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.³

Scanlon is not the only one taking note of such concerns. Others poised to weigh in on these issues include a study panel on Medicare governance and management convened by the National Academy of Social Insurance. But while certain proposals recommend separating Medicare from Medicaid, others stress the need to keep

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the programs together, as attention to continuum-of-care concerns for dual eligibles and other long-term care beneficiaries becomes more prevalent. Moreover, as technology and health care delivery modes evolve at a dizzying pace, administrative matters will inevitably grow in importance as public programs struggle to keep up.

THE FORUM SESSION

As the new Congress and the Bush administration take up HCFA governance and management issues, this Forum session will draw upon the expertise and experience of the last four administrators. Two served under Republican administrations and two under a Democratic administration, and they bring different approaches to addressing what ails the beleaguered agency. Each provides a unique perspective on the multi-faceted roles and functions of HCFA, how it has evolved over time, and what proposed changes might mean for the future of Medicare and Medicaid. The meeting will be conducted in an informal, question-and-answer format to allow for candor, perspective, and opportunity for maximum audience participation.

Speakers

William L. Roper, M.D., M.P.H., served as HCFA administrator from 1986 to 1989 under the Reagan administration. Currently, Roper is dean of the School of Public Health at the University of North Carolina at Chapel Hill (UNC). He also is professor of health policy and administration in the School of Public Health and professor of pediatrics in the school of Medicine at UNC. Before joining UNC in 1997, Roper was senior vice president of Prudential HealthCare and president of the Prudential Center for Health Care Research. Prior to that, he was director of the Centers for Disease Control and Prevention and served on the senior White House staff.

Gail Wilensky, Ph.D., served as HCFA administrator from 1990 to 1992 under the first Bush administration. Currently, she is the John M. Olin Senior Fellow at Project HOPE, where she analyzes and develops policies relating to health reform and ongoing changes in the medical marketplace. She also chairs the Medicare Payment Advisory Commission. Previously, she served as deputy assistant to Pres. George H. W. Bush for policy development, advising him on health and welfare issues.

Bruce C. Vladeck, Ph.D., served as HCFA administrator from 1993 to 1997 under the Clinton administration. He played a central role in the formulation and

enactment of the Medicare, Medicaid, and child health provisions of the BBA. Currently, Vladeck is senior vice president for policy of Mount Sinai NYU Health as well as director of the Institute for Medicare Practice and professor of health policy and geriatrics at the Mount Sinai School of Medicine. He also serves as a director of a number of nonprofit and for-profit organizations. Before assuming his position at HCFA, Vladeck served ten years as president of the United Hospital Fund of New York.

Nancy-Ann Min DeParle served as HCFA administrator from 1997 to October 2000 under the Clinton administration. She stepped down to take a fellowship at Harvard University's Kennedy School of Government. During her tenure at HCFA, DeParle oversaw the implementation of regulations and new payment systems mandated under the Balanced Budget Act of 1997. She came to HCFA from the White House Office of Management and Budget, where she had served as associate director of health and personnel since 1993. From 1987 to 1989, DeParle served in the cabinet of Gov. Ned McWherter of Tennessee as his commissioner of human services.

Key Questions

Among the key questions the speakers will address are the following:

- What surprised you the most about HCFA when you took over the helm?
- What were the most important changes you implemented and why?
- What were the chief stumbling blocks to making changes you deemed necessary?
- What does HCFA do well?
- How can HCFA balance its dual roles as regulator and purchaser?
- How might a Medicare board help or hinder HCFA's operations?
- What would be the impact of moving certain activities outside of HCFA, for example, management of the Medicare+Choice program? What would be the impact of moving Medicaid?
- What are the pros and cons of separating Medicare and Medicaid?
- What changes at HCFA might you recommend to the new president and Congress today?

ENDNOTES

1. For background information on each of these topics, see the following National Health Policy Forum (NHPF) Issue Briefs: "Medicare+Choice: Where to from Here?" Issue Brief No. 758, September 8, 2000; "HCFA's Outpatient PPS: Finally Ready to Roll?" Issue Brief No. 756, June 16, 2000; "SCHIP in the Formative Years: An Update," Issue Brief No. 759, September 21, 2000; "Implementing the BBA: The Challenge of Moving Medicare Post-Acute Services to PPS," Issue Brief No. 743, July 7, 1999; and "Medicare Competitive Pricing: Lessons Being Learned in Phoenix and Kansas City," Issue Brief No. 750, November 8, 1999. Each can be downloaded from the NHPF Web site (<http://www.nhpf.org>).
2. Stuart M. Butler et al., "Crisis Facing HCFA and Millions of Americans," *Health Affairs*, 19, no. 1 (January/February 1999), 8-10.
3. William J. Scanlon, "Medicare: 21st Century Challenges Prompt Fresh Thinking about Program's Administrative Structure," statement before the Committee on Finance, U.S. Senate, May 4, 2000, 1-2.

Crisis Facing HCFA & Millions Of Americans

THE SIGNATORIES TO THIS STATEMENT believe that many of the difficulties that threaten to cripple the Health Care Financing Administration (HCFA) stem from an unwillingness of both Congress and the Clinton administration to provide the agency the resources and administrative flexibility necessary to carry out its mammoth assignment. This is not a partisan issue, because both Democrats and Republicans are culpable for the failure to equip HCFA with the human and financial resources it needs to address what threatens to become a management crisis for the agency and thus for millions of Americans who rely on it. This is also not an endorsement of the present or past administrative activities of the agency. Congress and the administration should insist on an agency that operates efficiently and in the public interest.

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**CRISIS FACING
HCFA**

Over the past decade Congress has directed the agency to implement, administer, and regulate an increasing number of programs that derive from highly complex legislation. While vast new responsibilities have been added to its heavy workload, some of its most capable administrative talent has departed or retired; other employees have been reassigned as a consequence of reductions in force. At the same time, neither Democratic nor Republican administrations have requested administrative budgets of a size that were in any way commensurate with HCFA's growing challenge.

The latest report of the Medicare trustees points out that HCFA's administrative expenses represented only 1 percent of the outlays of the Hospital Insurance trust fund and less than 2 percent of the Supplementary Medical Insurance trust fund. In part, these low percentages reflect the rapid growth of the denominator—Medicare expenditures. But, even accounting for Medicare's growth, no private health insurer, after subtracting its marketing costs and profit, would ever attempt to manage such large and complex insurance programs with so small an administrative budget. Without prompt attention to these issues, HCFA will fall further behind in its implementation of the many significant reforms mandated by the Balanced Budget Act (BBA) of 1997. In the future the agency also has to cope with a demographic revolution that it is ill equipped to accommodate and with changes in medical

technology that will increase fiscal pressures on the programs it administers.

As the Bipartisan Commission on the Future of Medicare grapples with the problem of reshaping the Medicare program for the next millennium, it would do well to consider two important reforms concerning HCFA's administration. First, the commission should recommend that Congress and the Clinton administration endow the agency with an administrative capacity that is similar to that found in the private sector. Second, the commission should consider ways in which the micromanagement of the agency by Congress and the Office of Management and Budget could be reduced. Congress and the public would be better served by measuring the agency's efficiency in terms of its administrative outcomes (such as accuracy and speed of reimbursement of various providers), rather than by tightly controlling its administrative processes. Only if HCFA has more administrative resources and greater management flexibility will it be able to cope with the challenges that lie ahead.

The mismatch between the agency's administrative capacity and its political mandate has grown enormously over the 1990s. As the number of beneficiaries, claims, and participating provider organizations; quality and utilization review; and oversight responsibilities have increased geometrically, HCFA has been downsized. When HCFA was created in 1977, Medicare spending totaled \$21.5 billion, the number of beneficiaries served was twenty-six million, and the agency had a staff of about 4,000 full-time-equivalent workers. By 1997 Medicare spending had increased almost tenfold to \$207 billion, the number of beneficiaries served had grown to thirty-nine million, but the agency's workforce was actually smaller than it had been two decades earlier. The sheer technical complexity of its new policy directives is mind-boggling and requires a new generation of employees with the requisite skills.

HCFA's ability to provide assistance to beneficiaries, monitor the quality of provider services, and protect against fraud and abuse has been increasingly compromised by the failure to provide the agency with adequate administrative resources. Even with the addition of \$154 million to its administrative budget that Congress included in its latest budget bill, the likelihood that HCFA can effectively implement all of its varied assignments is remote. The Health Insurance Portability and Accountability Act of 1996 assigns many new regulatory responsibilities to HCFA, but a far

larger task is implementing the BBA of 1997. The BBA has more than 300 provisions affecting HCFA programs, including the Medicare+Choice option, which will require complex institutional changes and ambitious efforts to educate beneficiaries.

Medicare spending accounts for more than 11 percent of the U.S. budget. Workable, effective administration has to be a primary consideration in any restructuring proposal. Whether Medicare reform centers on improving the current system, designing a system that relies on market forces to promote efficiency through competition, or moving toward an even more individualized approach to paying for health insurance, Congress and the administration must reexamine the organization, funding, management, and oversight of the Medicare program. Doing anything less is short-changing the public and leaving HCFA in a state of disrepair.

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