United States General Accounting Office

GAO

Testimony

Before the Committee on Finance, U.S. Senate

For Release on Delivery
Expected at 9:30 a.m.
Thursday, May 4, 2000

MEDICARE

21st Century Challenges Prompt Fresh Thinking About Program's Administrative Structure

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Medicare: 21st Century Challenges Prompt Fresh Thinking About Program's Administrative Structure

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

[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).

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 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 highlights some of these activities.

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 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,

[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.

[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/T-HEHS-99-58, Feb. 11, 1999); Medicare: HCFA Faces Multiple Challenges to Prepare for the 21st Century (GAO/T-HEHS-98-85).

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.

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

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.

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 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]

[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 Managed Care: Implications for Regional Staffing (OEI-01-96-00191, April 1998).

[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.

Existing Contracting Authority Lacks FlexibilityNeeded 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

[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

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 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 issue	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 establish 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 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

[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.

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 Administrators 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

[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.

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.

Mr. Chairman, this concludes my prepared statement. I would be happy to answer any questions you or the Committee Members may have.

GAO Contacts and Acknowledgments

For future contacts regarding this testimony, please call William J. Scanlon at (202) 512-7114. Other individuals who made key contributions to this statement include Sheila K. Avruch, James C. Cosgrove, Hannah F. Fein, Richard N. Neuman, and Cameo A. Zola.

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