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MEDICARE AT 40: A MID-LIFE CRISIS?

NANCY-ANN DEPARLE*

Medical care will free millions from their miseries. It will signal a deep and lasting change in the American way of life. It will take its place beside Social Security and together they will form the twin pillars of protection upon which all our people can build their lives and their hopes.

President Lyndon B. Johnson¹

If you see the President, thank him for Medicare. Because our parents didn't have anything, but thanks to Medicare, we don't have to worry.

Medicare beneficiary, Marconi Senior Citizens Center²

[AUTHOR'S NOTE: When this lecture was delivered in October 2002, there appeared to be no possibility of major change to Medicare on the horizon. But in November 2003, to the surprise of many policy analysts and pundits, Congress enacted the Medicare Prescription Drug Improvement and Modernization Act of 2003 (DIMA). Like the legislation that created Medicare in 1965, DIMA was passed after several months of acrimonious debate by a Congress divided along party lines – though this time the Republicans controlled the Congress and drove the process of drafting the bill.

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1. Nancy-Ann Min DeParle, *Celebrating 35 Years of Medicare and Medicaid*, 22 HEALTH CARE FINANCING REV. 1, 1 (Fall 2000) (quoting President Lyndon Johnson's remarks to the National Council of Senior Citizens shortly before implementation of the Medicare program in June 1966).

2. Statement of Medicare beneficiary, Marconi Senior Citizen's Center in Philadelphia, PA (January 1998) (during Question & Answer period following author's speech).

DIMA creates a prescription drug benefit for Medicare beneficiaries that begins in 2006 and is estimated to cost approximately \$400 billion from 2004 through 2013. The drug benefit will be delivered by newly-created private prescription drug plans or coordinated care plans, and it has a \$250 deductible and estimated monthly premium of \$35. The law also establishes a new Medicare Advantage program to replace the existing Medicare+Choice program of managed care plans. The Medicare Advantage plans receive substantial additional funding in 2004 and 2005, and beginning in 2006, they will be paid through a system of benchmarks and bids. One of the most controversial elements of the House bill was its requirement that the traditional Medicare fee-for-service program compete against the new Medicare Advantage plans, which critics feared could subject beneficiaries to higher premiums if they chose to stay with traditional Medicare. In the end, DIMA created a 6-year demonstration program in which the concept of premium support would be applied in a limited number of areas.

In addition to the prescription drug benefit and managed care changes, DIMA contains a host of provisions to increase fee-for-service Medicare payments, particularly for rural providers, make long-overdue changes to the Medicare contracting process, and increase the Medicare Part B premium for higher-income beneficiaries beginning in 2007. Finally, the law includes a measure that would require Congressional consideration of legislation if general revenue funding for the entire Medicare program exceeds 45 %.

Many questions remain about the new Medicare law, and at this writing, several proposals to repeal or revise parts of it are pending in Congress. The prescription drug benefit, while decent, is hardly generous by the standards of middle-class Americans with drug coverage and may not be well-received by beneficiaries. The AARP, which supported the passage of DIMA, has already begun lobbying Congress for improvements to the benefit. Organizing the new system of prescription drug plans (none of which exist in the market today) and educating beneficiaries will be major challenges for CMS. There are subsidies for low-income beneficiaries and for employers (to encourage them to continue providing prescription drug coverage for retirees), but it is not clear how these will be administered or how effective they will be.

While the DIMA is similar in some respects to the approach that I recommend in Part IV of this piece – notably, it modernizes the contracting process and initiates a demonstration of the premium support concept so that it can be evaluated – in other respects it is very different. The prescription drug benefit is complicated and has major gaps – unlike any product in the commercial market today – Medicare beneficiaries will have no coverage for out-of-pocket costs between \$2250 and \$3600. This so-called “donut hole” means that beneficiaries

will have to spend \$5100 before reaching the catastrophic limit where coverage resumes. The law does little to address Medicare's impending financial challenges, and indeed, arguably it exacerbates them. It also imposes substantial new responsibilities on CMS but provides only a small proportion of the resources the agency will need to carry them out. Still, the new law is probably the best that could have been done with the current Congress and Administration. It takes a step toward providing guaranteed prescription drug coverage for many millions of Medicare beneficiaries who have none today, and if the coverage is improved over time – as the history of Medicare and other popular social programs suggests it will be – then it will have been a good thing. Much more remains to be done by future Congresses and Administrations to strengthen Medicare for the next generation.]

I. INTRODUCTION

It is appropriate that this lecture about the future of Medicare is dedicated to the memory of Stuart Rome, who cared so much about the community of Baltimore and our larger national community, and who was passionate about health care. Both the values of community and caring for the health of others achieve their highest expression in Medicare. And of course, like Stuart Rome, Medicare is a product of Baltimore, having been conceived off Interstate 695 on Security Boulevard.

Medicare has made an incredible journey since its birth in 1965. It ranks as one of the most important social programs ever invented, one that touches the lives of every senior citizen, every hospital, every physician, and virtually every family in this country.

Now Medicare is pushing forty, facing the prospect of middle age. Middle-age is supposed to be the time for relaxing and enjoying life--knowing what you want and being more financially secure. It is also a time to take stock of where you are headed and sometimes, to change directions. Although this can be a healthy process, in some cases middle age can also be a time of crisis: think of expensive sports cars, plastic surgery, divorce, or steering wildly off course.

Is Medicare facing a mid-life crisis? To answer this question, I begin in Part II by exploring where Medicare has been and where it is going. In Part III, I will describe some alternate visions of the future, highlighting similarities and differences and offering some criteria by which we can evaluate these visions. I argue that the challenges Medicare faces are daunting, but not insurmountable. Medicare's middle years should be a time of opportunity rather than crisis. The leading reform proposals probably have only a modest chance of success; that is just as well because most do not meet the test of modernizing and strengthening Medicare. Finally, in Part IV, I posit that instead of continuing to debate these proposals, we should move forward to implement changes we know Medicare

needs now, while conducting robust demonstrations of some of the reform proposals designed to inject more cost consciousness into Medicare.

II: MEDICARE PAST & PRESENT

A. From a "Bull-Moose" to a "Three-Layer Cake"

Medicare's roots can be traced to Theodore Roosevelt's unsuccessful presidential campaign in 1912, and his "Bull Moose" platform which called for health insurance coverage for working Americans.³ Legislation providing compulsory health insurance was considered and rejected in several states and in Congress many times over the next half-century.⁴ But even as the dream of health care for all increasingly became the Democratic ideal, it was blocked by the fear of what would happen once the government became entwined in health care--a fear keenly felt and loudly expressed by organized medicine.⁵ Hospitals mostly saw government-subsidized health care as a positive development because it enabled many additional patients to use their services and directed millions of dollars to their coffers.⁶ Physicians, however, were concerned that government bureaucrats would try to exert too much control over their practice of medicine and that payments would be inadequate.⁷ Even a president as popular and with as grand a conception of a vastly expanded social welfare state as Franklin Roosevelt left health care out of his "New Deal," fearing it would hurt prospects for enacting Social Security.⁸

However, President Roosevelt did not completely abandon the movement for health insurance coverage. He instructed his staff to work on a proposal for health insurance that was ultimately incorporated into a national health insurance bill originally introduced in the Congress in 1943, known as the Wagner, Murray, Dingell bill.⁹ And before he died, President Roosevelt publicly embraced the

3. Emily Friedman, *The Compromise and the Afterthought: Medicare and Medicaid After 30 Years*, 274 JAMA 278, 278 (1995). See also, Richard Harris, *Annals of Legislation: Medicare I--All Very Hegelian*, THE NEW YORKER, July 2, 1966, at 29.

4. See Friedman, *supra* note 3, at 278-79.

5. Richard Harris, *Annals of Legislation: Medicare II ~ More Than a Lot of Statistics*, July 9, 1966, at 30-31 (chronicling efforts by the American Medical Association (AMA) to block proposals for expanded or universal health insurance coverage).

6. See Friedman, *supra* note 3, at 278-79.

7. *Id.* at 278.

8. *Id.* at 279; Harris, *supra* note 3, at 31.

9. Harris, *supra* note 3, at 42.

notion of national health insurance in his 1944 State of the Union address, calling for “the right to adequate medical care.”¹⁰

Roosevelt’s successor, President Harry Truman, became the first president to send a national health insurance bill to Congress. In 1952, Truman proposed an incremental bill that would provide health insurance for all Social Security beneficiaries--in other words, widows, orphans, and the elderly.¹¹ That bill was not successful. The next president, President Eisenhower, was opposed to health insurance for the elderly and even campaigned against it.¹²

The turning point for Medicare came in 1960 when Representative Wilbur Mills, the shrewd chairman of the House Ways and Means Committee, engineered passage of the Kerr-Mills legislation to provide federal funds to help states pay for health care for low-income individuals.¹³ Later that year, John F. Kennedy was elected president. He spoke out about health care early in his presidency and staged an important speech on May 20, 1962 at Madison Square Garden advocating universal access to health care for seniors.¹⁴ The newly-formed National Council of Senior Citizens (NCSC), spearheaded by labor union retirees, filled the Garden to capacity with 20,000 cheering senior citizens, presaging the downright combustible political chemistry between Medicare and the elderly that energizes (and some would say, terrorizes) the current debate about Medicare’s future.¹⁵ The American Medical Association (AMA) delivered a televised rejoinder a few days later opposing the effort, but the politics had turned.¹⁶ On the day President Kennedy was assassinated, Congress held hearings on a bill to provide federal coverage of hospital, nursing home, and home care services for seniors.¹⁷ Though it failed to pass, a similar plan came close in 1964, and in November of that year, President Lyndon Johnson won a landslide victory in an election that brought a substantial Democratic majority and many fresh faces to the Congress.¹⁸

President Johnson, the ultimate Congressional insider, took the oath of office in January 1965 in front of a Congress ready for action on health care.¹⁹ Soon after, Representative John Byrnes, a Wisconsin Republican, introduced a bill that

10. Friedman, *supra* note 3, at 279.

11. Harris, *supra* note 5, at 31-32.

12. *See id.* at 33.

13. *See* Friedman, *supra* note 3, at 279.

14. *Id.*; Richard Harris, *Annals of Legislation: Medicare III ~ We Do Not Compromise*, THE NEW YORKER, July 16, 1966, at 58-59.

15. Harris, *supra* note 14, at 58-59.

16. *Id.* at 59.

17. *See* Friedman, *supra* note 3, at 279.

18. *Id.*

19. *See* Richard Harris, *Annals of Legislation: Medicare IV ~ A Sacred Trust*, THE NEW YORKER, July 23, 1966, at 35.

provided a federal subsidy for private health insurance for the elderly, but financed it in part through deductions from Social Security checks.²⁰ Chairman Mills borrowed Byrnes' idea of requiring beneficiaries to pay premiums and put it together with the Administration's proposal and his own ideas, concocting what he called a "three-layer cake."²¹ The first layer, called Medicare Part A, was the Johnson Administration's proposed Medicare program, a mandatory plan to cover the elderly's hospital (but not physician) costs.²² For the second layer, labeled Medicare Part B, Mills took the voluntary plan proposed by Representative Byrnes and favored by the AMA and Republicans, and turned it into voluntary coverage for the elderly's physician costs.²³ The third layer, called Medicaid, expanded existing federal funds provided through the Kerr-Mills legislation to the states to care for poor, elderly, disabled, and welfare recipients.²⁴

The AMA made a last-ditch, unsuccessful attempt to derail Mills' efforts with a proposal called "Eldercare," that would have subsidized (but not guaranteed) private coverage for the elderly with federal and state funds.²⁵ After Chairman Mills' "three-layer cake" passed the House and the Senate on successive days in late July 1965, President Johnson sat down with AMA leaders in a private session.²⁶ There was widespread speculation that the AMA would lead physicians in a boycott of Medicare.²⁷ President Johnson expressed his deep respect for their profession and appealed for their cooperation. Emphasizing patients would be able to go to any physician or hospital authorized to participate in Medicare, Johnson read: "Nothing in this title shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided. . . ."²⁸ After a hurried final weekend drafting session, the conference committee adopted the bill and President Johnson signed it into law on July 30, 1965, in Independence, Missouri.²⁹ Former

20. See Friedman, *supra* note 3, at 279.

21. *Id.*

22. See *id.*

23. See *id.*

24. *Id.*

25. See Friedman, *supra* note 3, at 279.

26. See Liz Carpenter, Medicare Remarks for 35th Anniversary, Dallas, TX, at 7 (July 12, 2000) (remarks on file with the Journal of Health Care Law & Policy).

27. *Id.*

28. Friedman, *supra* note 3, at 280. Despite President Johnson's efforts, the AMA made it known to its members that they were free to refuse on their own to participate in the program. In fact, fevered opposition among physicians at this time may have led to a boycott of the program if not for the suggestion of Dr. Edward Annis, an AMA member who was quite vocal in his opposition to Medicare, that the organization cooperate with the government if only to "get inside the camp of the enemy" to "find the vital, vulnerable spots." Harris, *supra* note 19, at 62-63.

29. Liz Carpenter, who served as President Johnson's spokesperson in the White House, recalls: "[I]t was LBJ's idea to come to Independence to sign Medicare into law. Even the name Independence

President Truman and Mrs. Truman received the first Medicare cards,³⁰ which are showcased today in the headquarters of the Centers for Medicare and Medicaid Services (CMS)³¹ in Baltimore.

Before the ink from the President's signature was dry, officials at the Social Security Administration began to work on implementing the massive new legislation. Some twenty million potential beneficiaries had to be notified and signed up, conditions for participation had to be promulgated so that hospitals and physicians could apply to serve beneficiaries, contracts had to be entered into with insurance companies to pay claims, and thousands of details about benefits and coverage had to be worked out before the program was to begin on July 1, 1966.³²

The first Medicare beneficiaries saw a program that was very similar in important respects to the one their children use today. Pursuant to the law, beneficiaries received coverage for physician services and hospital care with rather large deductibles and copays for the latter.³³ They also received coverage for some nursing home care following a hospitalization, and some home health care.³⁴ Outpatient drugs were not covered unless administered by a physician, nor were hearing aids or eyeglasses covered (except following cataract surgery).³⁵

Overall, Medicare's original benefit package was comparable to a standard Blue Cross and Blue Shield benefit package; the gaps in coverage were not as noticeable then, because many of the preventive treatments, screening tests, and pharmaceutical innovations, such as cholesterol-lowering drugs, that we now take for granted were not yet available. Acceptable coverage gaps in 1965, however, have widened into yawning chasms today, as Medicare faces the challenges of middle age.

For hospitals, physicians, and other providers, 1965 was the beginning of a tumultuous love-hate relationship. In the beginning, Medicare looked a lot like the Blue Cross-Blue Shield plans to which physicians and hospitals were accustomed.

was symbolic for it was independence from fear and anxiety that Medicare gave the nation's senior citizens." See Carpenter, *supra* note 26, at 2.

30. HEALTH CARE FINANCING ADMIN., *MEDICARE 2000: 35 YEARS OF IMPROVING AMERICANS' HEALTH AND SECURITY* 4 (July 2000). A copy of President Truman's Medicare cards is on file with the Journal of Health Care Law & Policy.

31. Throughout this article, the agency that administers Medicare is referred to as the Centers for Medicare and Medicaid Services (CMS). From 1977 through 2001, the agency was called the Health Care Financing Administration (HCFA). Its name was changed by the Bush Administration in 2001.

32. For a comprehensive description of Medicare's implementation, see NAT'L ACAD. OF SOC. INS., *STUDY PANEL ON MEDICARE MANAGEMENT AND GOVERNANCE, REFLECTIONS ON IMPLEMENTING MEDICARE*, at iv-v, (Jan. 2001); EDWARD D. BERKOWITZ, *ROBERT BALL AND THE POLITICS OF SOCIAL SECURITY* (2003).

33. See Harris, *supra* note 19, at 61.

34. *Id.*

35. Social Security Amendments of 1965, Pub. L. No. 89-97, § 1862, 79 Stat. 286, 325 (1965) (current version codified at 42 U.S.C. § 1395d (2000)).

Medicare's creators worried that physicians would refuse to participate in the program, so they bent over backward to make it simple: physicians sent bills for their usual and customary fees to patients, and money flowed back from the government.³⁶ As spending soon outpaced projections, however, the government began to take a more active role in managing the program, and the tensions between Medicare and providers developed into the uneasy alliance it has become today.

B. What's Right?

On July 30, 1965, when he signed the bill into law at the Truman Library in Independence, Missouri, President Johnson declared:

"No longer will older Americans be denied the healing miracle of modern medicine. No longer will illness crush and destroy the savings they have so carefully put away over a lifetime so they might enjoy dignity in their later years. No longer will young families see their own incomes, and their own hopes, eaten away simply because they are carrying out their deep moral obligations to their parents, and to their uncles, and to their aunts. . . . No longer will this Nation refuse the hand of justice to those who have given a lifetime of service and wisdom and labor to the progress of this progressive country."³⁷

In the almost forty years since President Johnson spoke, Medicare has provided more than ninety-nine million elderly and disabled Americans with affordable health coverage and access to medical care.³⁸ Today, Medicare serves forty million beneficiaries, or 14 % of the population; and in thirty years the number of Americans covered is expected to nearly double to seventy-seven million, or 22 % of the population.³⁹

However, Medicare's impact on the nation's health care system and social fabric extends far beyond the fact that millions of Americans are or have been card-carrying beneficiaries. To put it bluntly, on any given day, one-third of the revenues received by the average hospital or physician are from Medicare.⁴⁰ Medicare spent \$241 billion in 2001, making it a very significant proportion of the

36. Harris, *supra* note 19, at 61-62.

37. DeParle, *supra* note 1, at 1 (quoting President Lyndon Johnson's remarks at the Medicare Signing Ceremony in Independence, MO on July 30, 1965).

38. See Email from Richard Foster, Chief Actuary, CMS, to Nancy-Ann DeParle, Senior Advisor, JP Morgan Partners, LLC and Adjunct Professor of Health Care Systems, Wharton School of the University of Pennsylvania (Oct. 7, 2002, 16:28:30 EST) (on file with Journal of Health Care Law & Policy).

39. *Id.*; HEALTH CARE FINANCING ADMIN., *supra* note 30, at 6.

40. MEDICARE PAYMENT ADVISORY COMM'N, RELATIONSHIPS AMONG MEDICARE INPATIENT, OVERALL MEDICARE AND TOTAL MARGINS FOR HOSPITALS 3 fig.4, available at http://www.medpac.gov/publications/other_reports/Aug03_hosp_marg_2pgr_AW.pdf (last visited Jan. 31, 2004).

\$1.1 trillion spent annually on health care, which in turn is a very significant proportion of the U.S. economy.⁴¹ Thus, any change in Medicare has ripple effects throughout the health care sector and the larger economy.

1. Access to Health Insurance

Before Medicare was enacted, nearly half of Americans over sixty-five did not have hospital insurance.⁴² In contrast, 75 % of Americans under sixty-five had such coverage, primarily through their employer.⁴³ Seniors who needed hospital services often faced the choice between foregoing health care altogether or turning to family, friends, or charity for help.⁴⁴ Indeed, in 1966, more than one in four seniors were estimated to have skipped medical care because of cost concerns.⁴⁵ If they did have access to individual health insurance, it was--as it is today for all but the youngest and healthiest people under sixty-five--prohibitively expensive. When Medicare was launched in 1966, the proportion of persons aged sixty-five or over with health insurance almost immediately doubled.⁴⁶ By 2000, approximately 97 % of seniors were enrolled in Medicare, making the elderly the population group most likely to have health insurance coverage.⁴⁷

2. Access to Medical Care.

Social Security officials who worked on Medicare's implementation in 1966 recall the concern expressed by President Johnson about what would happen when millions of seniors flooded hospitals and doctors' offices with their new Medicare cards on July 1, 1966.⁴⁸ Elaborate plans were made to triage patients and move them to veterans' and Department of Defense hospitals, but the worries turned out to be misplaced.⁴⁹ As Administrator Robert Ball had predicted, the influx of seniors turning out for care in the first few days was manageable.⁵⁰

41. OFFICE OF RESEARCH, DEV., AND INFO., CTRS. FOR MEDICARE AND MEDICAID SERVS., PROGRAM INFORMATION ON MEDICARE, MEDICAID, SCHIP, AND OTHER PROGRAMS OF THE CENTERS FOR MEDICARE & MEDICAID SERVS., § III.C, at 3, 5, available at <http://cms.hhs.gov/charts/series/sec3-C.pdf> (last visited Jan. 31, 2004).

42. HEALTH CARE FINANCING ADMIN., *supra* note 30, at 33.

43. *Id.*

44. *Id.*

45. *Id.*

46. Marilyn Moon, *Medicare Matters: Building on a Record of Accomplishments*, 22 HEALTH CARE FINANCING REV. 9, 9 (Fall 2000).

47. HEALTH CARE FINANCING ADMIN., *supra* note 30, at 33.

48. See NAT'L ACAD. OF SOC. INS., *supra* note 32, at 13-14 (reprinting a transcript of a dialogue between social security officials regarding implementing medicare)

49. *Id.* at 14.

50. *Id.* See also Carpenter, *supra* note 26, at 8. It is possible that low turnout resulted because July 1, 1966 fell close to the July 4th holiday and on a weekend, both low-volume times for elective health care visits.

In 1964, hospital discharges averaged 190 per 1000 elderly persons; by 1973, the average had jumped to 350 per 1000.⁵¹ Between 1963 and 1970, the proportion of the elderly using physician services increased from 68 to 76 percent.⁵² By 2000, it was estimated that more than 94 % of Medicare beneficiaries received at least one health care service per year paid for by Medicare.⁵³

3. *Improved Economic Well-Being.*

It is estimated that the elderly were the group most likely to be living in poverty in 1965, with nearly one in three seniors classified as poor.⁵⁴ Health costs were estimated to consume 24 % of the average elderly person's Social Security check shortly before Medicare was enacted.⁵⁵ By 1975, however, that share had dropped to 17 %.⁵⁶ The advent of Medicare, combined with improvements in Social Security, has driven the poverty rate for seniors down to about 10 %, a level similar to that of persons aged eighteen to sixty-four.⁵⁷ Before Medicare was enacted, the elderly paid an average of 53 % of the cost of their health care.⁵⁸ That percentage dropped continuously through the decades that followed the enactment of Medicare--to 29 % in 1975, and 18 % in 1997.⁵⁹ Unfortunately, as will be discussed later in this paper, the proportion of health costs paid by seniors is rising again, due to spending by seniors on prescription drugs that Medicare does not cover.⁶⁰

4. *Increased Life Expectancy.*

Over the past three decades since Medicare was implemented, there has been significant progress increasing life expectancy in the United States. In 1960, a sixty-five year-old American woman could expect to live an additional 15.9 years, to reach the age of 80.9 years.⁶¹ A sixty-five year-old man could expect to live an

51. HEALTH CARE FINANCING ADMIN., *supra* note 30, at 33.

52. *Id.*

53. *Id.*

54. See U.S. CENSUS BUREAU, U.S. DEP'T OF COMMERCE AND U.S. DEP'T OF HEALTH & HUMAN SERVS., SERIES NO. P23-199RV, CENTENARIANS IN THE UNITED STATES 1990, CURRENT POPULATION REPORTS, 15 fig.12 (July 1999), available at <http://www.census.gov/prod/99pubs/p23-199.pdf> (last visited Jan. 31, 2004).

55. HEALTH CARE FINANCING ADMIN., *supra* note 30, at 33-34.

56. *Id.* at 34.

57. *Id.* at 33.

58. Marian Gornick, et al., *Twenty Years of Medicare and Medicaid: Covered Populations, Use of Benefits, and Program Expenditures*, HEALTH CARE FINANCING REV., 1985 Annual Supplement, at 52.

59. HEALTH CARE FINANCING ADMIN., *supra* note 30, at 33.

60. See, e.g., John A. Poisal & Lauren Murray, *Growing Differences Between Medicare Beneficiaries With and Without Drug Coverage*, 20 HEALTH AFFAIRS 74, 81-83 (2001); Moon, *supra* note 46, at 10.

61. HEALTH CARE FINANCING ADMIN., *supra* note 30, at 33.

additional 12.9 years to the age of 77.9.⁶² By 2000, the average life expectancy of an American woman over the age of sixty-five increased nearly 20 %, to 84.2 years; the average life expectancy of a sixty-five year-old man increased three years, to 80.9.⁶³

5. *Minority Access to Medical Care.*

In 1965, many hospitals were segregated, and African-Americans and other racial or ethnic minority groups were denied access to the health care services whites received.⁶⁴ One of the great, courageous decisions that Medicare's architects on Security Boulevard made was to require hospitals participating in Medicare to comply with the Civil Rights laws.⁶⁵ More than 1000 government officials worked with hospitals in the spring and summer of 1966 to end discriminatory practices such as segregating African-Americans in a separate wing of the hospital.

In 1963, minorities aged seventy-five years and older averaged 4.8 visits to the doctor, but by 1971, that number had increased to 7.3, a level comparable to Caucasian utilization rates.⁶⁶ Although racial and ethnic disparities in medical treatment persist, Medicare has indisputably helped to open the doors of America's medical establishment for African-Americans and other minorities.

6. *Income for Hospitals and Physicians and Support for Graduate Medical Education.*

Medicare has become an important, perhaps the most important, source of income for millions of health care providers. In 2001, Medicare spent \$242 billion to provide services for forty million beneficiaries; of that total, \$135 billion went to hospitals, \$64 billion to physician and clinical services, \$12 billion to skilled nursing facilities, and \$10 billion to home health providers.⁶⁷ Medicare spends nearly \$10 billion annually to support the costs of training physicians and other health professionals at our nation's academic medical centers.⁶⁸ All told, Medicare provides 32 % of all hospital revenue in the United States and 22 % of all spending on physicians' services.⁶⁹ Medicare also pays a substantial portion of the revenues

62. *Id.*

63. *Id.*

64. *See id.* at 34.

65. *See* NAT'L ACAD. OF SOC. INS., *supra* note 32, at 7-10.

66. HEALTH CARE FINANCING ADMIN., *supra* note 30, at 34.

67. Katherine Levit et al., *Trends in U.S. Health Care Spending, 2001*, 22 HEALTH AFFAIRS 154, 158 exhibit 5 (2003).

68. *See* HEALTH CARE FINANCING ADMIN., *supra* note 30, at 39.

69. *Id.* at 41 fig.20.

of home health agencies, hospices, renal dialysis facilities, and the like.⁷⁰ Moreover, Medicare protects the health care “safety net” by providing special financial support to urban and rural health care providers (such as \$5 billion annually in so-called “disproportionate share payments”), enabling them to care for millions of uninsured and underinsured Americans.⁷¹

The annual battles over updates to the various payment formulas and the periodic, ferocious battles over legislation to control costs (of which the Balanced Budget Act of 1997 (BBA) was the most recent and most significant example) have tended to obscure the fact that for nearly forty years, Medicare has pumped millions, then billions, and now hundreds of billions of dollars into the U.S. health care system on an annual basis. The rate of growth of Medicare spending has had its ebbs and flows, but Medicare spending in the aggregate has consistently grown in the range of 7-10 % annually, almost always at a rate higher than the rest of the economy (though often at a lower rate than private health insurance).⁷² Indeed, Medicare has spawned whole new sub-sectors of the health care economy, and is credited with launching the for-profit hospital industry, which began soon after Medicare was enacted on the promise of reliable payment flows for large numbers of patients and generous support for capital costs to build new facilities.⁷³

7. *Enhanced Quality of Life.*

As legend has it, when President Johnson signed Medicare into law, *New York Times* reporter Max Frankel approached him and said: “My mother thanks you.” The President replied: “No. It is you *who* should be thanking me.”⁷⁴ Medicare relieved the children of seniors from the burden of financing their parents’ medical costs and freed them to devote those funds to financing college educations, mortgages, and minivans. Although the children of seniors were compelled to begin paying the payroll tax that financed Medicare, there is no question that the removal of this burden and the stigma of dependency was a relief to many American seniors and their families.

The original Medicare program covered only those Americans aged sixty-five and older, until Congress expanded eligibility in 1972. At this time, Congress determined that other groups of people with disabilities, such as End Stage Renal Disease (ESRD), should be entitled to Medicare coverage without regard to their

70. *See id.*

71. *See id.* at 39.

72. *See* Richard S. Foster, *Trends in Medicare Expenditures and Financial Status, 1966-2000*, 22 HEALTH CARE FINANCING REV. 35, 35 (2000).

73. Friedman, *supra* note 3, at 280-81.

74. Secretary Donna E. Shalala, Remarks at Medicare 35th Anniversary Event (July 12, 2000) (transcript on file with the Journal of Health Care Law & Policy).

age or Social Security eligibility.⁷⁵ In 1973, nearly two million persons with disabilities were enrolled in Medicare; today, Medicare covers more than five million people with disabilities.⁷⁶ Since the beginning of the ESRD program in 1973, more than one million Americans have received life-saving renal replacement therapy, either dialysis or transplantation.⁷⁷ Currently, there are more than 350,000 persons alive receiving renal replacement therapies, and 90,000 of these persons have received kidney transplants.⁷⁸

8. *A Driver of Quality.*

Medicare sets minimum standards of participation for health care providers and either inspects them through State-contracted survey and certification agencies, or through entities such as the Joint Commission on the Accreditation of Health Organizations (JCAHO).⁷⁹ In addition, Medicare has a Quality Improvement Organization (QIO) program designed to measure performance in the hospital setting (and in some limited ambulatory and preventive care settings) and track improvements over time.⁸⁰ Starting in 1998, the QIO program worked with a broad number of clinicians to develop a group of twenty-four quality indicators supported by strong evidence and deep consensus.⁸¹ Using these indicators, CMS was able to determine that the proportion of Medicare beneficiaries receiving appropriate care improved significantly between 1999 and 2001, though the rate of improvement varied widely across states and by indicator.⁸² No other entity currently measures quality at the individual hospital level, and there is evidence that Medicare's leadership in developing and using quality measures through the QIO program has been effective in promoting better quality health care for the

75. HEALTH CARE FINANCING ADMIN., *supra* note 30, at 8. For more information on Medicare and the ESRD program, see Paul W. Eggers, *Medicare's End Stage Renal Disease Program*, 22 HEALTH CARE FINANCING REV. 55 (2000).

76. See HEALTH CARE FINANCING ADMIN., *supra* note 30, at 34.

77. *Id.* at 8.

78. *Id.*

79. NAT'L ACAD. OF SCIENCES, MEDICARE: A STRATEGY FOR QUALITY ASSURANCE, VOLUME I, 119, 119-20 (1990), available at <http://www.nap.edu/openbook/0309042305/html/119.html> (last visited Jan. 31, 2004). JCAHO is a non-profit organization that accredits healthcare facilities for participation in the Medicare program.

80. LISA SPRAGUE, NAT'L HEALTH POLICY FORUM, ISSUE BRIEF NO. 774, CONTRACTING FOR QUALITY: MEDICARE'S QUALITY IMPROVEMENT ORGANIZATIONS, 2 (June 3, 2002).

81. See Stephen F. Jencks et al., *Change in the Quality of Care Delivered to Medicare Beneficiaries, 1998-1999 to 2000-2001*, 289 JAMA 305, 306 (2003). The original study on which this longitudinal evaluation is based was published in October 2000 at Stephen F. Jencks et al., *Quality of Care Delivered to Medicare Beneficiaries: A Profile at State and National Levels*, 284 JAMA 1670 (2000).

82. *Id.* at 309.

population as a whole.⁸³ Since the late 1990's, HCFA and now CMS, has published information about the quality of care delivered in nursing homes on its "Nursing Home Compare" website,⁸⁴ and the agency has recently launched a broader initiative to publish additional information relating to quality indicators for nursing homes, dialysis facilities, hospitals, and other providers.⁸⁵ These efforts should stimulate additional quality improvement as well as provide helpful information to assist patients and families choosing health care providers.

Medicare has had more difficulty in publicizing the outcomes of care produced by hospitals and other providers. For example, an effort to publish hospital mortality data in the late 1980's had to be abandoned because of measurement difficulties and political sensitivities.⁸⁶ Much remains to be done. Nevertheless, Medicare's QIO program and related activities focused on data collection and quality monitoring, constitutes the country's main infrastructure for health care quality measurement and improvement.

9. *Efficient Administration.*

Medicare's overall administrative costs hover around 1 to 1.5% of total benefit payments.⁸⁷ This "administrative load" is significantly lower than that of private insurers; the Blue Cross and Blue Shield Association has estimated that its plans spend about 12 % of benefit payments on administration.⁸⁸ Medicare's administrative costs, as a proportion of benefit costs, have continued to decline as Medicare and its payment contractors pay increasing numbers of claims at a lower cost per claim. Medicare pays exponentially more claims through electronic processing than other payers. In fiscal year 1999, Medicare processed more than 148 million claims at a unit cost per claim of \$.84 for Part A fiscal intermediaries.⁸⁹ During the 1990's, the number of Part A claims doubled while

83. See Thomas Marciniak et al., *Improving the Quality of Care for Medicare Patients with Acute Myocardial Infarction: Results from the Cooperative Cardiovascular Project*, 279 JAMA 1351, 1351,1355 (1998). See also David C. Hsia, *Medicare Quality Improvement, Bad Apples or Bad Systems?*, 289 JAMA 354, 354 (2003).

84. The CMS Nursing Home Compare website can be accessed online at <http://www.medicare.gov/NHCompare/home.asp>. (last visited Jan. 31, 2004).

85. See Press Release, U.S. Dep't Health & Human Servs., HHS Launches National Nursing Home Quality Initiative (Nov. 12, 2002) available at <http://www.hhs.gov/news/press/2002pres/20021112.html> (last visited Jan. 31, 2004).

86. MARY DARBY, NAT'L HEALTH POLICY FORUM, HEALTH CARE QUALITY: FROM DATA TO ACCOUNTABILITY 7 (2002).

87. See NAT'L ACAD. OF SOC. INS., FINAL REPORT OF THE SURVEY PANEL ON MEDICARE'S GOVERNANCE AND MANAGEMENT, MATCHING PROBLEMS WITH SOLUTIONS: IMPROVING MEDICARE'S GOVERNANCE AND MANAGEMENT 35 (July 2002).

88. *Id.*

89. HEALTH CARE FINANCING ADMIN., *supra* note 30, at 40.

the cost to process each claim was cut in half.⁹⁰ Despite the government's reputation for requiring paperwork, Medicare paved the way in promoting the electronic submission of claims by hospitals, physicians, and other providers. Electronic submission of claims to Medicare reached more than 97 percent for Part A and 80 percent for Part B in 1999.⁹¹

10. *A Prudent Purchaser.*

Medicare has led the way for other health insurers by developing innovative payment methodologies aimed at controlling costs and creating incentives for appropriate utilization of the health care services it covers. During the 1980's and 1990's, prospective payment systems were developed to replace the old "cost plus" reimbursement systems that encouraged over-utilization of services. There is also considerable evidence that Medicare's administered payment systems have been more effective than private sector market competition in constraining health care cost growth.⁹² Moreover, Medicare has shown its fiscal accountability by significantly reducing waste, fraud, and abuse. In 1997, the U.S. Department of Health and Human Services (HHS) Inspector General's first-ever audit of Medicare's payments revealed a fee-for-service claims error rate of 14%, which translated into \$23 billion in improper payments in 1996.⁹³ By the 1999 audit, however, that error rate was only 7%, due to a considerable increase in Medicare's vigilance and several high-profile prosecutions of hospitals and other providers.⁹⁴

C. *What's Wrong?*

For almost forty years, Medicare has guaranteed health insurance for the nation's seniors that is universal, dependable, affordable, and often of high quality. However, Medicare is far from perfect, as the list that follows makes clear.

1. *Looming Financial Problems.*

Medicare is financed by a combination of payroll taxes (for Medicare Part A, or Hospital Insurance (HI)), beneficiary premiums, and contributions from the general fund of the U.S. Treasury (for Medicare Part B, or Supplementary Medical

90. *Id.*

91. *Id.*

92. See Christina Boccuti & Marilyn Moon, *Comparing Medicare and Private Insurers: Growth Rates in Spending Over Three Decades*, 22 HEALTH AFFAIRS 230, 232-33 (2003).

93. NAT'L ACAD. OF SOC. INS., *supra* note 87, at 49.

94. See *Patients First: A 21st Century Promise to Ensure Quality and Affordable Health Coverage: Joint Hearings Before the Subcomm. on Health and the Subcomm. on Oversight and Investigations of the House Comm. on Energy and Commerce*, 107th Cong. 3 (2001) (statement of Nancy-Ann DeParle, Former-Administrator, Health Care Financing Admin.) [hereinafter *Patients First*]; See also NAT'L ACAD. OF SOC. INS., *supra* note 87, at 49.

Insurance (SMI)). The HI Trust Fund was initially estimated to be in actuarial balance from 1966 through 1968, but then, as utilization and medical cost inflation skyrocketed, a steady escalation of spending occurred over the next twenty years.⁹⁵ The annual growth rate of Medicare expenditures over the entire forty-year period has been characterized by a steady upward trajectory. For the first three years, as the program was launched and pent-up demand for medical services among seniors was satisfied, the growth rate was about 32%.⁹⁶ For the next three years, as the Nixon Administration imposed wage and price controls and a Part B deductible increase (which were partly counterbalanced by rapid growth in the use of outpatient services), the growth rate declined to 10%.⁹⁷ From the mid-1970's through the early 1980's, eligibility expanded to cover the disabled and there was rapid utilization growth and price inflation, and the growth rate jumped back up to about 20%.⁹⁸ During the 1980's through the mid-1990's, despite the introduction of a prospective payment system for hospitals, a physician fee freeze, and the introduction of a volume-driven resource-based fee schedule, the growth rate was 10 %, driven by an explosion in skilled nursing and home health spending.⁹⁹ Finally, the period after the enactment of the BBA in 1997 and stepped-up efforts to combat fraud, waste and abuse in Medicare resulted in the lowest growth rate in the program's history at 2%.¹⁰⁰ Given Medicare's history, however, and the fact that the American public will continue to demand--and likely receive--the benefits of new medical technologies as they are developed, it seems reasonable to expect that Medicare spending will continue to grow at a rate higher than the rest of the economy for the foreseeable future.

Throughout Medicare's existence, the number of beneficiaries has consistently grown about 2% per year.¹⁰¹ This rate is about to change in a big way. Like Social Security, Medicare faces significant long-term financing challenges that are driven by the demographic trends just beyond the horizon. Between 2010 and 2030, the number of persons aged sixty-five and older is expected to increase from forty-six million to seventy-eight million, an average of 1.5 million more seniors every year for the twenty-year span.¹⁰² During the same period, the

95. Foster, *supra* note 72, at 45-46.

96. *Id.* at 38-39 tbl.1.

97. *Id.*

98. *Id.*

99. *Id.*

100. Foster, *supra* note 72, at 38-39 tbl.1.

101. *Id.* at 38, 41 tbl.2.

102. See THE BDS. OF TRS. OF THE FED. HOSP. INS. AND FED. SUPPLEMENTARY MED. INS. TRUST FUNDS, 2002 ANNUAL REPORT, H.R. DOC. NO. 107-197, at 35 (2002) [hereinafter THE 2002 ANNUAL REPORT].

Medicare actuaries project that Medicare spending will increase from \$324 billion to \$793 billion, in constant 2002 dollars.¹⁰³

This shift of the demographic tectonic plates begins in the next decade as the “Baby Boomer” generation retires, but it does not end there. Rather, it may be a longer-term phenomenon, accentuated by a number of other trends. The great advances in medicine that we have seen in the 20th century are expected to lead to significant increases in life expectancy in the 21st century.¹⁰⁴ Demographers now project that persons born in the year 2000 will live, on average, to age seventy-seven.¹⁰⁵ This is almost six more years than those born in 1970.¹⁰⁶ As a result, unless there is another, even bigger “Baby Boom” almost immediately, there is projected to be a permanent shift in the ratio of workers to Medicare beneficiaries, from four workers to each beneficiary today, to two workers to each beneficiary in 2070.¹⁰⁷ Concern about these trends has been one of the central driving factors in the calls for Medicare reform.

Much has been made of the fact that the initial estimates of Medicare’s costs were wrong by several orders of magnitude.¹⁰⁸ It has been very difficult to estimate the impact of policy changes to Medicare over the years, and there is little to suggest that we have figured out a better way to estimate costs in the future. Although Medicare has seen robust growth rates in the past, it seems clear that the combination of growth in the number of beneficiaries, along with the increase in available treatments and demand for services, will result in even higher spending levels and growth rates in the future. Some view this problem as evidence that Medicare is fiscally “unsustainable” and contend that radical changes must be made to reduce benefits and increase beneficiary responsibility for costs in order to maintain the program.¹⁰⁹ Others (but not many politicians) argue that the program’s revenues should simply be increased through some combination of higher payroll taxes and more Federal support.¹¹⁰

103. See Email from Richard Foster, *supra* note 38.

104. See THE 2002 ANNUAL REPORT, *supra* note 102, at 33, 35.

105. See THE BDS. OF TRS. OF THE FED. OLD-AGE AND SURVIVORS INS. AND FED. DISABILITY INS. TRUST FUNDS, 2003 ANNUAL REPORT, H.R. DOC. NO. 108-49, at 85 (2003) (outlining assumptions about life expectancy underlying actuarial estimates for Social Security and Medicare).

106. See *id.*

107. See THE 2002 ANNUAL REPORT, *supra* note 102, at 18.

108. See, e.g., RICHARD A. EPSTEIN, MORTAL PERIL: OUR INALIENABLE RIGHT TO HEALTH CARE? 149, 155 (1997).

109. *Affordability of Medicare and a Prescription Drug Benefit: Hearing on “Medicare and the Federal Budget” Before the House Comm. on the Budget, 107th Cong. 6* (2002) (statements of Judith Feder, Dean of Public Policy, Georgetown University and Jeanne M. Lambrew, Associate Professor, George Washington University) (summarizing the arguments of many Medicare opponents) [hereinafter *Medicare and the Federal Budget*]; See Moon, *supra* note 46, at 9.

110. See Moon, *supra* note 46, at 20, 21.

2. Inadequate Benefits.

When President Johnson signed Medicare into law, he proclaimed: "No longer will seniors be denied the healing miracle of modern medicine."¹¹¹ That was true in 1965, but it is not true in 2003. In one sense, the omission of benefits like outpatient prescription drugs can be viewed as benign in that the list of drug therapies at the time was not long. Indeed, it has been suggested only somewhat in jest, that there was nothing available in 1965 to treat chronic conditions other than digitalis and the iron lung (the former was not covered, the latter was). Others have suggested that Medicare's creators did not think it was necessary to cover prescription drugs because they were so inexpensive in 1965 that the transaction cost of paying the claims would be higher than the cost of the drugs.¹¹² But it also appears that Medicare's benefit package was specifically designed, as was private insurance generally, to avoid covering some of the common medical conditions of the elderly. For example, hearing aids, eyeglasses, dentures, and most dental services were excluded from coverage.¹¹³ Long-term nursing home care was not covered -- most private health insurance policies excluded it as well. There was no limit on beneficiary liability, leaving beneficiaries vulnerable to catastrophic expenses, and the 1965 law stated that Medicare would pay only for "items and services necessary for the diagnosis or treatment of a disease or malformed body member."¹¹⁴ In other words, what we now know as preventive services - flu shots, mammograms, cancer screening - were not covered. It took an act of Congress to extend Medicare's coverage to such basic preventive services as screening mammograms or flu and pneumonia shots that most clinicians regard as essential to maintaining good health.¹¹⁵

The lack of a prescription drug benefit is the most glaring manifestation of Medicare's inadequate benefits. Seniors disproportionately need and rely on prescription drugs. According to the Congressional Budget Office (CBO), Medicare beneficiaries account for 15 % of the population but 40 % of the spending on outpatient prescription drugs.¹¹⁶ The average Medicare beneficiary

111. DeParle, *supra* note 1, at 1 (quoting President Lyndon Johnson's Remarks at the Medicare Signing Ceremony, Independence, MO on July 30, 1965).

112. Telephone Interview with Philip Lee, M.D., Professor of Social Medicine Emeritus, University of California at San Francisco (October 30, 2003). Dr. Lee served as Assistant Secretary for Health in the Johnson Administration, and was involved in crafting the Medicare legislation.

113. See Social Security Amendments of 1965, Pub. L. No. 89-97, § 1862, 79 Stat. 286, 325 (1965) (current version codified at 42 U.S.C. § 1395d (2000)). In the case of dental services, the exclusion was made at least in part because dentists actively fought against coverage.

114. *Id.*

115. Congress extended coverage to these items in the Balanced Budget Act of 1997. This language is currently codified at 42 U.S.C.A §§ 1395m & 1395x (West 2003).

116. *Projections of Medicare and Prescription Drug Spending Before the Senate Comm. on Finance*, 107th Cong. 8 (2002) (statement of Dan. L. Crippen, Director, Cong. Budget Office) [hereinafter *Projections of Medicare*].

will spend more than \$2,400 on prescription drugs next year, and nearly one in five beneficiaries are expected to spend more than \$5,000 annually on prescription drugs by 2005.¹¹⁷ Not only are Medicare beneficiaries the group most in need of prescription drugs, they are the group least likely to have reliable coverage. An estimated 25 to 42 percent of Medicare beneficiaries lack prescription drug coverage for all or part of the year.¹¹⁸ This problem is more acute for older and rural beneficiaries.¹¹⁹

Over the next decade, Medicare beneficiaries are expected to spend approximately \$1.8 trillion on prescription drugs.¹²⁰ Many beneficiaries face financial barriers to obtaining needed medications today, and those barriers will only grow worse over time as more effective (and inevitably, it seems, expensive) pharmaceutical therapies become available. The only real question is when, not whether, Medicare will be extended to provide seniors with prescription drugs, and how we will finance what will surely be a mammoth increase in Medicare spending.

3. *Inadequate Administrative Resources.*

CMS's responsibilities have increased dramatically over the past few years. The massive workload created by the Medicare and Medicaid changes in the BBA, along with the creation of the new State Children's Health Insurance Program (SCHIP)¹²¹ and the insurance reforms of the Health Insurance Portability and Accountability Act (HIPAA),¹²² have stretched the agency's staff and contractor resources far beyond their limits. For a number of years, even working in a bipartisan manner, neither the Administration nor the Congress has provided adequate funding for CMS to meet these new responsibilities, much less responsibly carry out its other duties in administering Medicare. For example, in 1998, the peak year of BBA implementation, CMS had 3,942 full-time equivalents (FTEs), compared with 4,961 in 1980.¹²³ The 1998 staffing level was inadequate

117. *Id.* at 9, 12.

118. See *Medicare and the Federal Budget*, *supra* note 108, at 6. There is some discrepancy on how lack of coverage is defined. Compare *Projections of Medicare*, *supra* note 115 (defining lack of coverage as having no drug coverage throughout the year) with BECKY BRIESACHER ET AL., THE COMMONWEALTH FUND, DRUG COVERAGE FOR MEDICARE BENEFICIARIES: WHY PROTECTION MAY BE IN JEOPARDY (January 2002) (defining lack of coverage as lacking coverage for part of the year).

119. See, e.g., *Medicare and the Federal Budget*, *supra* note 109, at 6.

120. See *Projections of Medicare*, *supra* note 116, at 9.

121. Balanced Budget Act of 1997, § 4901, 42 U.S.C.A. §§ 1397aa – 1397jj (West 2003).

122. Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936 (1996) (codified in scattered sections of 29 U.S.C. and 42 U.S.C.).

123. *Patients First*, *supra* note 94, at 7.

even to write and publish the dozens of regulations and notices mandated by the BBA.¹²⁴

Current resources are particularly inadequate to meet Medicare's customer service needs. As Administrator, I wanted to send out a postcard to all beneficiaries announcing the new preventive care benefits Medicare began to cover in 1998, including enhanced coverage for mammography and screening tests for colorectal cancer. It was a good idea, and would have helped beneficiaries, but I did not implement it, because I was advised that sending the postcards would cost around \$13 million.

The complexity of Medicare, and the need to spend Trust Fund dollars prudently necessitates clear and specific program requirements and intensive beneficiary and provider education. At present, the various rules and regulations that providers need to know in order to comply with Medicare are scattered throughout a dozen or more manuals and guidance memoranda.¹²⁵ In 1996, the agency launched an effort to streamline these manuals so that, for example, home health agencies would have a manual (available both in hard copy and online) setting forth everything they needed to know. This effort had to be interrupted so that CMS staff could work on implementing the BBA and preparing the massive and fragmented claims payment system for Y2K. By the time work resumed, the BBA had rendered much of the previous effort irrelevant and out-of-date. In summary, it is simply not possible to perform the kind of customer service Medicare needs with CMS's current level of staffing and resources.

Medicare's low administrative costs are often highlighted as one of the program's strengths. However, this efficiency has sometimes come at the expense of sound management. For example, the cost to process a Medicare claim has been driven down to about \$1 per claim, but this means that customer service and fraud and abuse prevention have been compromised. During the time that I ran the agency, CMS had trouble getting the mail opened and answered in any sort of timely fashion. We spent considerable effort analyzing the workflow and making changes to improve the process, but the bottom line is that the agency simply did not have adequate resources to respond to tens of thousands of comments on each proposed regulation while at the same time answering hundreds of pieces of incoming Congressional mail each week.

Further, even if the absolute level of staff were adequate, CMS has not had the ability to hire and retain staff with the skills it needs. This is a problem shared by other government agencies, but I believe both the need and the inability to meet the need are worse at CMS. For example, the agency made major changes in the

124. *Patients First*, *supra* note 94, at 7-8 (noting with pride that, in the end, CMS managed to publish 39 regulations and 71 notices).

125. For a listing of Medicare and Medicaid program manuals, transmittals, and memoranda, see <http://www.cms.gov/manuals/> (last visited Feb. 3, 2004).

process Medicare uses to make decisions about covering new technology in mid-1999.¹²⁶ These changes were designed to create a process that is open, transparent, dependable, and evidence-based; the new process was modeled on a similar advisory board process used by the Food & Drug Administration (FDA). The FDA has hundreds of clinicians and other scientifically trained personnel to evaluate new technologies. At last count, CMS had only thirty.¹²⁷ In addition to the FDA, other agencies, such as the Agency for Health Care Research & Quality (AHRQ), have the ability to hire staff for statistics and research at salaries above the Federal guidelines, but despite the importance of its mission, CMS does not.¹²⁸

As Medicare seeks to improve its customer service and move to being a prudent purchaser of quality health care for beneficiaries, as opposed to simply a payer of medical bills, CMS needs to hire beneficiary counselors, clinicians, and experts from private health plans and providers. The agency has made some progress in hiring staff who have this type of experience, but it is not enough. Qualified staff often leave the agency due to comparatively low salaries, and from my experience, carrying out the agency's responsibilities in an atmosphere of constant criticism and distrust is demoralizing and counter-productive.

4. *Inflexible Administration.*

In the beginning, small groups of Social Security staff negotiated with provider groups over the details of the rules and regulations that would guide Medicare's initial implementation. This type of negotiation could never happen today. Medicare law has become more complex and prescriptive over time for many reasons: (1) because of the hundreds of billions of dollars at stake and the zero-sum way in which the pie is distributed; (2) because of the need to achieve "savings" through Medicare policy changes that can be "scored" by the Congressional Budget Office (CBO); and (3) because of Congress' distrust of the agency's decision-making capability. In addition, the Administrative Procedures Act (APA),¹²⁹ the Federal Advisory Committee Act (FACA),¹³⁰ and other statutes governing the way CMS and other agencies must conduct business, have made it very difficult for CMS to relate to the public in an informal way. For example, if,

126. Press Release, U.S. Dep't of Health & Human Servs., Medicare's Process for Making Coverage Decisions (May 1, 2000) available at <http://www.cms.gov/media/press/release.asp?Counter=381> (last visited Feb. 3, 2004).

127. *Patients First*, *supra* note 94, at 10.

128. *Patients First*, *supra* note 94, at 9-10; See also NAT'L ACAD. OF SOC. INS., *supra* note 32, at 58, 59 (describing the difference in hiring flexibility between CMS and The National Institute of Health, The Senior Biomedical Research Service, and the Public Health Service).

129. Administrative Procedure Act, Pub. L. No. 89-554, 8 Stat. 381 (1966) (codified as amended in scattered sections of 5 U.S.C.). The APA was originally passed in 1946, but Congress repealed the 1946 act and re-passed a nearly identical version in 1966.

130. Federal Advisory Committee Act, 5 U.S.C. app. 2 §§ 1-16 (2000).

in developing a regulation to implement a provision of the BBA, CMS finds that the payment methodology specified in the law is mistaken and does not reflect Congressional intent--or even that it does reflect Congressional intent, but will have unintended consequences that no one wants--there is nothing the agency can do. And if, with respect to this hypothetical BBA provision, the agency wanted to meet with industry representatives on a regular basis as it was drafting the regulation to get their input in advance, the agency would be required to charter a Federal advisory committee complete with financial disclosure forms, Federal Register notices, and the like.¹³¹ The process of establishing such a committee could take at least six to eight months, if not longer. This has a chilling effect on communications with Medicare providers and the public. Of course, statutes like the APA and FACA are intended to protect the public from arbitrary and capricious actions by agencies, deal making behind closed doors, and policymaking that does not afford the public an opportunity to comment. Nevertheless, my experience was that these process rules often impeded, rather than promoted, responsive good government.

A related problem arises when a statute specifies a precise way it wants CMS to implement a Medicare policy and then Congress does not like the results. For example, the BBA specified in extensive detail the new county-based payment formula for Medicare+Choice plans.¹³² When this formula produced payment rates that were lower than what was expected or desired, CMS was criticized for creating thousands of payment zones and then underpaying them. A similar situation occurred after the agency spent almost two years in a BBA-mandated negotiated rulemaking with the ambulance industry. This process turned the typical take-it-or-leave-it issuance of an edict from the agency to providers on its head. But it, too, fell short from the providers' perspective: soon after the negotiations ended, several members of Congress sought to pressure CMS to alter the rule because ambulance providers in their states did not like the results of the negotiated rulemaking.¹³³ In these situations, CMS could not win: it is impossible

131. *Id.* at § 9(a)(2).

132. Balanced Budget Act of 1997, Title IV, § 4001, 42 U.S.C.A 1395w-23 (West 2003). Medicare + Choice plans provide care under contract to Medicare. They provide many benefits including coordination of care, reductions in out-of-pocket expenses, or even prescription drugs. There are two types of Medicare + Choice plans: Medicare managed care plans (like HMOs), and Medicare Private Fee-for-Service plans. For more information, see CTRS. FOR MEDICARE & MEDICAID SERVS., U.S. DEP'T OF HEALTH & HUMAN SERVS., MEDICARE PLAN CHOICES, *available at* <http://www.medicare.gov/choices/Overview.asp> (last visited Feb. 3, 2004).

133. *See e.g.*, AMERICAN AMBULANCE ASSOCIATION, CALL TO ACTION: TELL CONGRESS TO INCREASE MEDICARE REIMBURSEMENT RATES FOR AMBULANCE PROVIDERS, *at* <http://www.the-aaa.org/Oncapitolhill/calltoaction.htm> (last visited on Feb. 3, 2004).

As a result of pressure from organizations like the American Ambulance Association, two bills, both entitled The Medicare Ambulance Payment Reform Act of 2003, were introduced in the House and

to satisfy all 535 members of Congress, especially if they each have a different interpretation of what a Medicare law directs the agency to do. I wish I had a nickel for every time a member of Congress called and asked me to “fix” a statutory provision because it adversely affected a hospital or home health agency in his or her district. They were almost always shocked when I advised them that the law was so prescriptive that I did not have the discretion to adjust anything, no matter how warranted it might seem.

III: PROPOSALS FOR REFORMING MEDICARE

A. Some Visions of Medicare’s Future

Over its first four decades, Medicare has become the program politicians and beneficiaries love, while CMS--the only barrier standing between more than one million physicians, hospitals, and other health providers and almost \$300 billion in annual spending--has become the agency everyone loves to hate. Looking out over the next two decades, Medicare faces a doubling of its beneficiary population, increased demand for more and better services, and a strained administrative budget and Trust Fund. Accordingly, policymakers have begun to focus on how to put the Medicare program on sounder financial and administrative footing.

The BBA was the first major step. The BBA had its roots in the “Contract with America” launched by the new Republican majority in the House of Representatives in 1995. Led by former-Speaker Newt Gingrich, Congressional Republicans pledged to balance the budget in seven years and, arguing that Medicare was broken, proposed to reduce Medicare spending by an unprecedented \$270 billion over seven years.¹³⁴ After a Presidential veto and an unprecedented impasse that led to the shutdown of the Federal government, the BBA was enacted in 1997.¹³⁵

Working within the existing Medicare framework, the BBA reduced payment updates for virtually all providers and replaced the remaining cost-based reimbursement methodologies with prospective payment systems, added beneficiary protections and education, and strengthened preventive benefits.¹³⁶ It also re-christened the existing Medicare managed care program, in which 15% of

Senate in an effort to change the Ambulance fee schedule. S. 171, 108th Cong. (2003); H.R. 1301, 108th Cong. (2003).

134. Charles N. Kahn III & Hanns Kutter, *Budget Bills and Medicare Policy: The Politics of the BBA*, 18 HEALTH AFFAIRS 37, 39-40 (1999).

135. See generally *id.* (discussing the 1994 “Contract with America” and the events leading to the passage of the BBA in 1997).

136. *Id.* at 44-45 exhibit 1.

beneficiaries were enrolled, as Medicare+Choice, making a number of changes intended to increase the availability of managed care plans.

At the time of its enactment, the CBO estimated that the BBA would reduce Medicare spending by \$115 billion in the period 1998-2002; in fact, the rate of growth of Medicare spending dropped much more dramatically, almost falling in absolute dollars for the first time ever between 1998 and 1999.¹³⁷ How much of this was attributable to the direct impact of the policies in the BBA is debatable, given that the HHS Inspector General and Department of Justice had launched an assault on Medicare fraud, waste and abuse with several high-profile investigations a few months earlier.¹³⁸ That said, in 1997, before the BBA was enacted, the Medicare actuaries estimated that the HI Trust Fund would be insolvent in 2001 but by 1999, they estimated that Medicare's solvency had been extended almost sixteen years, to 2015.¹³⁹ Most recently, in the 2003 report, the actuaries pegged a 2026 date for insolvency.¹⁴⁰

Thus, it is important to acknowledge that substantial progress has already been made in securing Medicare's future. Recent progress should give us confidence that policymakers will be able to transcend partisan politics to work together again on the best plan for Medicare's future.

1. The Politics of Reform.

Over the past five years, roughly a dozen competing plans have been introduced in Congress or proposed by President Clinton or President Bush to reform the Medicare program and add a prescription drug benefit. These plans have a number of similarities and differ mainly in whether they place the emphasis on reforming Medicare, or on adding a prescription drug benefit.¹⁴¹

137. See *id.* at 45 exhibit 1; Foster, *supra* note 72, at 37-38.

138. See Office of Inspector Gen., U.S. Dep't of Health & Human Servs., Apr. 1 – Sept. 30, 1997 OIG SEMIANN. REP. (reporting on OIG fraud and abuse investigations conducted in the months preceding the passage of the BBA).

139. See THE BDS. OF TRS. OF THE FED. HOSP. INS. TRUST FUND, THE 1998 ANNUAL REPORT, H.R. DOC. NO. 105-245, at 2 (1998); THE BD. OF TRS. OF THE FED. HOSP. INS. TRUST FUND, THE 1999 ANNUAL REPORT, H.R. DOC. NO. 106-47, at 2 (1999).

140. See THE TRS. OF THE FED. HOSP. INS. AND FED. SUPPLEMENTARY MED. INS. TRUST FUNDS, THE 2003 ANNUAL REPORT, H.R. DOC. NO. 108-48, at 13 (2003) [hereinafter THE 2003 ANNUAL REPORT]. The 2003 Annual Report advanced the Trustees' 2002 projection of the insolvency date from 2030 to 2026, in part because of increased spending resulting from two successive bills to ease the impact of the BBA on providers, The Balanced Budget Refinements Act of 1999 (BBRA) and the Benefits Improvement and Protection Act of 2000 (BIPA).

141. For a comprehensive summary of the various Medicare prescription drug proposals that were considered by Congress, see HENRY J. KAISER FAMILY FOUND., PRESCRIPTION DRUG COVERAGE FOR MEDICARE BENEFICIARIES: A SIDE-BY-SIDE COMPARISON OF SELECTED PROPOSALS (July 2002), available at <http://www.kff.org/medicare/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=14180> (last visited Feb. 3, 2004). The bills aimed at Medicare reform were passed by the House and Senate, and eventually resulted in passage of the Medicare Prescription Drug Improvement and

a. Republican plans.

While the Republican plans include a prescription drug benefit for most beneficiaries, they tend to place the emphasis on reform. These plans focus on enticing beneficiaries out of traditional fee-for-service Medicare into managed care plans where Medicare's payments will be determined by competitive bidding.¹⁴² Proponents argue that this will save Medicare money because plans will have to compete on price, and beneficiaries will choose less expensive plans because Medicare's payments will be pegged to those plans.¹⁴³ All of the Republican plans are rooted in one or another incarnation of the Medicare Preservation and Improvement Act (S. 1895), which was introduced by Senators John Breaux and Bill Frist in November 1999. This legislation, also called "Breaux-Frist I," was in turn based on the plan approved by a majority of members of the National Bipartisan Commission on the Future of Medicare.¹⁴⁴ In 2000, Senators Breaux and Frist unveiled "Breaux-Frist II," a somewhat gentler version of their earlier plan, which offered a more generous prescription drug plan and less of a penalty for beneficiaries who chose to stay in traditional fee-for-service Medicare.¹⁴⁵

The bill passed by the House of Representatives in the summer of 2002, the Medicare Modernization and Prescription Drug Act of 2002 (H.R. 4954), is a version of Breaux-Frist II. The 21st Century Medicare Act (S. 2729, also known as the "Tripartisan Plan" because it was introduced by Senator John Breaux (a Democrat), Senator Charles Grassley (a Republican), and Senator Jim Jeffords (an Independent)), is another example of a premium support plan.

Most recently, the Bush Administration introduced its "Framework to Modernize and Improve Medicare" in early 2003.¹⁴⁶ Like the other Republican premium support proposals, it creates incentives for seniors to leave traditional

Modernization Act of 2003. For a comparison of the prescription drug coverage provisions contained in these bills, see HENRY J. KAISER FAMILY FOUND., A SIDE-BY-SIDE COMPARISON OF THE PRESCRIPTION DRUG COVERAGE PROVISIONS OF S. 1 AND H.R. 1 (2003) [hereinafter HENRY J. KAISER FAMILY FOUND., SIDE-BY-SIDE COMPARISON], available at <http://www.kff.org/content/2003/6103/6103.pdf> (last visited Feb. 3, 2004).

142. HENRY J. KAISER FAMILY FOUND., SIDE-BY-SIDE COMPARISON, *supra* note 141, at 30.

143. See Press Release, Sen. John Breaux, News from Senator John Breaux, (Feb. 15, 2001) available at <http://www.senate.gov/~breaux/releases/010215c.html> (last visited Feb. 2, 2004).

144. NATIONAL BIPARTISAN COMMISSION ON THE FUTURE OF MEDICARE, BUILDING A BETTER MEDICARE FOR TODAY AND TOMORROW (1999), available at <http://medicare.commission.gov/medicare/bbmtt31599.html> (last visited Feb. 3, 2004) (detailing the Commission's recommendation for the improvement and reform of the Medicare program, including the design of a premium support system). The National Bipartisan Commission on the Future of Medicare was created by Congress in the Balanced Budget Act of 1997 and is staffed with members of Congress who examine the Medicare program and make recommendations to strengthen and improve it.

145. Medicare Prescription Drug and Modernization Act of 2000, S. 2807, 106th Cong. (2000).

146. Press Release, The White House, 21st Century Medicare: More Choices—Better Benefits, A Framework to Modernize and Improve Medicare (Mar. 3, 2003) [hereinafter The Bush Plan], available at <http://www.whitehouse.gov/news/releases/2003/03/20030304-1.html> (last visited Feb. 3, 2004).

Medicare and join private plans because that is the only route to a meaningful drug benefit.¹⁴⁷

b. Democratic plans.

The Democratic plans are based on President Clinton's "Plan to Modernize and Strengthen Medicare for the 21st Century," which included a generous prescription drug benefit and a version of premium support called a "competitive defined benefit."¹⁴⁸ These plans place the emphasis on providing an attractive and affordable prescription drug benefit for all beneficiaries, with broader Medicare reform as a secondary goal. The prescription drug benefit would be administered by private-sector pharmacy benefit management companies operating on a regional basis, selected through competitive bidding, with the government bearing the risk of any spending that exceeds the plan's bid.¹⁴⁹ The plan offered by House Democrats in 2002, the Medicare Rx Drug Benefit and Discount Act of 2002 (H.R. 5019), closely resembles the Clinton plan but showcases a substantially richer prescription drug benefit as well as catastrophic or "stop-loss" coverage to protect beneficiaries who incur extremely high costs. Similarly, the Medicare Outpatient Prescription Drug Act of 2002 (S. 2625), introduced by Senator Bob Graham and Senator Olympia Snowe, had a slightly less generous drug benefit than the House Democrats' plan but follows the basic outlines of that proposal.

c. Common Ground

Of course, this analysis simplifies and glosses over the many differences among the leading plans on both sides of the aisle in design details such as the structure of the co-payments for the prescription drug benefit. Without minimizing the significance of those differences, there are at least two important areas of agreement among the Republican and Democratic plans. First, the proposals agree that the existing Medicare benefit package is inadequate, and all would add a prescription drug benefit, new preventive benefits, and catastrophic protection to help beneficiaries with high spending. Second, several of the proposals agree that the future structure of Medicare should include some version of competition among different types of health plans with incentives for beneficiaries to choose more cost-efficient plans--at a minimum between various types of private managed care plans, and maybe even between private plans and traditional fee-for-service Medicare.

147. For a description of premium support plans, *see infra* pp. 28-29.

148. *See* NAT'L ECON. COUNCIL, DOMESTIC POL'Y COUNCIL, THE PRESIDENT'S PLAN TO MODERNIZE AND STRENGTHEN MEDICARE FOR THE 21ST CENTURY 8-11 (July 2, 1999) [hereinafter The Clinton Plan].

149. *Id.* at 11-12.

Given these similarities, it is possible to see a consensus emerging that would combine a more generous drug benefit than the Republican plans have put forward, and more reform than the Democratic plans have so far embraced. But that is not likely to occur, for several reasons. First, the current Federal fiscal scenario could hardly be worse; it is unlikely that the budget can finance a Medicare prescription drug benefit that is meaningful enough to draw Democratic support. When the Bush Administration took office in January 2001, the Congressional Budget Office projected a \$5.6 trillion surplus over the next ten years.¹⁵⁰ Now the surplus is gone--thanks in no small part to a \$1.7 trillion tax cut--and the government faces deficits as far as the CBO computers can calculate.

Second, we are beginning the 2004 Presidential election cycle, with a number of Senators vying for the Democratic nomination.¹⁵¹ In the closely divided Senate, every vote counts, and each of these candidates is more likely to be preoccupied with getting his own plan before the voters of New Hampshire than on working to pass a consensus plan before the election.

Third, notwithstanding protestations to the contrary from President Bush's advisers, Medicare does not appear to rank near the top of his Administration's domestic policy priority list. After promising in the 2000 campaign to deliver a prescription drug benefit to Medicare beneficiaries, he waited almost three years before putting out an anemic eleven page outline that said it would spend \$400 billion to add prescription drugs and a catastrophic benefit--about \$300 billion less than most policy experts believe it would take to accomplish this.¹⁵² He has barely mentioned Medicare since his plan was rolled out to a tepid reception from seniors and Congressional Republicans alike. Given the choice between spending another half trillion dollars on a Medicare drug benefit or on further embellishing his legacy as the President who cut taxes, it is hard to believe he will choose the former.

Finally, the sense of urgency concerning the solvency of the Medicare Trust Fund dissipated following the BBA's comprehensive and substantial reductions that led actuaries to extend projections of the life of the Trust Fund for a quarter century. Thus, it appears likely that we will continue to suffer through the finger-pointing from the Right ("Medicare is broken and we have to make big reforms

150. *The Budget and Economic Outlook Fiscal Years 2002-2011, Before the Senate Comm. on the Budget*, 107th Cong. 7 tbl.1 (2001) (statement of Barry B. Anderson, Deputy Director of the Congressional Budget Office), available at <http://www.cbo.gov/showdoc.cfm?index=2728&sequence=0> (last visited Feb. 4, 2004).

151. As of October 24, 2003 three Senators were seeking the Democratic nomination for President: Sen. John Edwards, Sen. John Kerry, and Sen. Joe Lieberman. DEMOCRATIC NATIONAL COMMITTEE, WHITE HOUSE 2004: THE CANDIDATES, available at <http://www.democrats.org/whitehouse/candidates.html> (last visited Oct. 26, 2003).

152. See *The Bush Plan*, supra note 146. See also *Medicare and the Federal Budget*, supra note 109, at 7.

before it becomes bankrupt”) and the Left (“Republicans want to privatize Medicare and let it wither on the vine”) for several more years.

2. *Evaluating the Proposals.*

If none of the leading plans has much chance of being enacted, is that a bad thing? The answer depends on how one evaluates each of the reform proposals. There are a number of possible criteria, but if we view this proposition from the perspective of Medicare’s current and future beneficiaries, three simple questions emerge. First, does the proposal modernize Medicare’s benefits and add a meaningful, affordable prescription drug benefit? Second, does it make Medicare more competitive and efficient? And third, does the proposal strengthen Medicare’s financing and extend the life of the Medicare Trust Fund?

None of the leading proposals satisfies all three of these criteria. All of the plans can claim that they add a prescription drug benefit to Medicare, as well as catastrophic protection. Most of the plans offer additional preventive benefits as well. But, only a few of the plans add what beneficiaries would consider a meaningful and affordable prescription drug benefit. It would cost an estimated \$750 billion over ten years to provide seniors with a drug benefit comparable to the benefit members of Congress receive through the Federal Employee Health Benefits Program (FEHBP).¹⁵³

Similarly, many of the plans claim that they make Medicare more competitive and efficient through the premium support structure that each uses to a greater or lesser degree. Premium support is a theory that owes much to the FEHBP. Under it, Medicare beneficiaries will be offered (or induced to choose, depending on which proposal is being considered) competing private plans, and their premiums could be higher if they choose more expensive plans.

Many health policy analysts postulate that a premium support model would introduce greater cost consciousness to Medicare without directly taking anything away from beneficiaries. But that is not exactly the lesson of the FEHBP, on which this idea is modeled. In FEHBP, spending per capita has grown faster than Medicare in recent years.¹⁵⁴ In addition, Medicare’s experience demonstrates that an effort to privatize Medicare by coaxing beneficiaries into HMOs is not likely to succeed. Even in the mid-1990’s, when Medicare HMOs routinely received 9-10 % increases and offered generous prescription drug benefits, only about 13 % of beneficiaries signed up.¹⁵⁵ House Commerce Committee Chairman Billy Tauzin explains: “You couldn’t move my mother out of Medicare with a bulldozer. She

153. See *Medicare and the Federal Budget*, *supra* note 109, at 7.

154. *Medicare and the Federal Budget*, *supra* note 109, at 3.

155. HOUSE COMM. ON WAYS & MEANS, 105th CONG., MEDICARE AND HEALTH CARE CHARTBOOK 161 (Feb. 27, 1997), available at <http://www.access.gpo.gov/congress/house/ways-and-means/sec4.pdf> (last visited Feb. 3, 2004).

trusts it, believes in it. It's served her well."¹⁵⁶ Given Medicare's low administrative costs and strong market leverage, it is unlikely that private plans can deliver benefits at a lower cost. To guarantee savings, the government would have to limit the growth in payments to plans. The government has not done this with FEHBP, and it is unlikely it will with Medicare.

That said, beneficiaries should have access to HMOs as an alternative to traditional Medicare. HMOs can focus on preventive care, chronic care management, and other things that traditional Medicare has not done well. Providing a drug benefit solely in managed care plans does not strengthen Medicare and it will not save money. Indeed, the Medicare+Choice experience suggests that it will take huge increases in what the government pays HMOs to attract them to join. Therefore, not only would these plans fail to improve Medicare's solvency, they would potentially undermine it.

Furthermore, at least one of the plans--the Bush proposal--does very little to make traditional fee-for-service Medicare more competitive and efficient. The plan incorporates none of the strategies for moving toward more competitive, market-based pricing for fee-for-service Medicare, none of the structural reforms to rationalize cost sharing, and none of the changes to improve Medicare's management. It is crucial that we strengthen Medicare for all beneficiaries, not just those who choose HMOs.

Finally, not one of the leading plans can claim that it improves Medicare's solvency or extends the life of the Medicare Trust Fund. Indeed, most of them would probably make Medicare's financial straits worse. The Clinton plan devoted \$300 billion in additional revenues from the Federal budget surplus to shore up the Medicare Trust Fund for another fifteen years,¹⁵⁷ but the surplus is now history, thanks in no small part to the \$1.7 trillion tax cut enacted in 2002.

IV: THE PATH TO SUCCESSFUL REFORM

A. An Alternate View: The Stepwise Approach to Strengthening Medicare

The recent experience with the BBA yielded one major accomplishment and one major lesson, both of which must inform our next steps to strengthen and improve Medicare. First, the accomplishment: the BBA made sweeping and comprehensive changes in the way Medicare pays providers, which (in combination with a major attack on waste, fraud, and abuse) extended the solvency

156. Robert Pear & Robin Toner, *Bush Medicare Proposal Urges Switch to Private Insurers*, N.Y. TIMES, Mar. 5, 2003, at A19.

157. See *The Clinton Plan*, *supra* note 148, at 37.

of the Medicare Trust Fund for at least another quarter century. Second, the lesson: the wrenching experience of implementing and undergoing the BBA--along with the dismaying experience of learning that some of the policies did not work as intended, with negative effects on both beneficiaries and providers--taught us that we should avoid trying to do too many things with Medicare at once, especially when we cannot predict the impact.

With the BBA behind us, we now have the time to figure out the most appropriate next steps in modernizing Medicare, recognizing that there is no perfect solution and that a stepwise approach is likely to be most effective with a dynamic system like Medicare that influences so large a part of the U.S. health care economy. Acknowledging this leads to a more realistic and intelligent approach to strengthening Medicare. This approach has several phases. In Phase I, a number of aggressive steps should be taken to improve Medicare's administration, starting by guaranteeing CMS additional resources to do the job, along with more flexibility, and requiring greater accountability from the agency in return. In Phase II, a prescription drug benefit should be implemented and other improvements made to the Medicare package while simultaneously conducting robust, large-scale demonstrations of the premium support concept, chronic care and disease management, and other ideas for increasing the cost consciousness of beneficiaries and the quality and cost-effectiveness of services. Finally, in Phase III, new models that have been tested and shown that they can improve efficiency and constrain costs on a nationwide basis, should be implemented, and as new problems surface and other improvements are needed, another cycle of demonstrations must begin.

If we begin today, we can complete all three Phases of this stepwise approach to strengthening Medicare by 2010, just as the first wave of Baby Boomers are beginning to settle into their La-Z-Boys for retirement. It would be substantively foolish, and politically untenable, to impose major changes on current Medicare beneficiaries, but it is critical that we begin to test and introduce changes now, before the expectations of the great mass of Baby Boomers who will be joining Medicare's ranks in the next decade are solidified. There is much we can learn, and much we can do, about strengthening and modernizing Medicare before 2010 - - if we get started now.

1. Phase I: Improving Administration, Crossing the Quality Chasm (2003-2005).

a. Increase Administrative Funding.

More than anything else, Medicare needs better and more dependable financing for its administrative apparatus. That could be achieved very simply by dedicating a small percentage of funds from the Medicare Trust Fund toward

Medicare's administrative budget on an annual basis, just as has been done with funding for program integrity and fraud-related law enforcement activities under the HIPAA. Funds for Medicare administration would no longer have to compete with such Congressional and Executive Branch favorites as the National Institutes of Health and the Centers for Disease Control & Prevention and the President's education initiatives in the annual Labor and Health and Human Services appropriations process.

b. Improve Contractor Operations and Oversight.

Medicare's framers promised that Medicare would not be administered by a large Federal bureaucracy like Social Security. The Blue Cross and Blue Shield plans that dotted (and continue to dominate) the country were viewed as the best and least threatening vehicles for performing the day-to-day activities, such as serving as Medicare's face to the provider community and paying the nearly one billion claims submitted by providers to Medicare annually. As part of the deal, the Medicare contractors (called "carriers" if they pay Part B claims, and "intermediaries" if they pay Part A claims) were accorded a status that is unlike anything else in the Federal government. The Medicare law limits the pool of entities that can be a Medicare contractor to essentially the Blue Cross and Blue Shield insurance companies.¹⁵⁸ Further, they are not subject to the Federal Acquisition Regulations, which govern every other Federal contractor and provide safeguards to ensure that the government is getting its money's worth. If a contractor decides not to continue in the program, the Blue Cross and Blue Shield Association--not CMS--decides who will replace it. While many of the contractors have maintained good records of efficiency and integrity, others have performed terribly--failing to meet minimum performance standards and in some cases literally stealing from Medicare.¹⁵⁹

Starting in 1993 with his first budget submission to Congress, and virtually every year thereafter, President Clinton requested that Congress overhaul the Medicare contractor statute to broaden the pool of qualified private sector entities that can become Medicare contractors, permit incentive based contracts, and require more accountability from contractors.¹⁶⁰ Finally, in 2002, a version of this

158. See Centers for Medicare & Medicaid Servs., 42 C.F.R. § 421.3 (2002).

159. *Medicare Waste, Fraud & Abuse: Testimony Before the S. Appropriations Comm., Subcomm. on Labor, Health and Human Servs., Educ.*, Mar. 9, 2000 (statement of June Gibbs Brown, Inspector General, Dep't. of Health and Human Servs., available at <http://oig.hhs.gov/reading/testimony/2000/00309fin.htm> (last visited Feb. 3, 2004)); See *Medicare Fraud: Continuing Efforts: Testimony Before the H.R. Comm. on Gov't. Reform, Subcomm. on Gov't. Mgmt. Info. and Tech.*, July 25, 2000 (statement of John E. Hartwig, Deputy Inspector General for Investigations, Dep't. of Health and Human Servs., available at <http://oig.hhs.gov/reading/testimony/2000/00725fin.htm>).

160. President Bill Clinton, Remarks by the President on Medicare Fraud (Dec. 7, 1998), available at <http://clinton4.nara.gov/WH/New/html/19981207-18194.html>.

contractor reform legislation passed the House of Representatives, but it was never taken up by the Senate.¹⁶¹ It is long overdue and must be enacted to strengthen Medicare for the future.

c. Improve CMS's flexibility.

CMS must have more flexibility to make decisions without Congressional direction. For example, the Secretary should have the authority to add services to the Medicare benefit package, within certain parameters (such as cost below a specified threshold; e.g., \$1 billion per year), without needing an Act of Congress. The Secretary should have the authority to adjust reimbursement rates, using something like an enhanced “inherent reasonableness” authority, when they are seriously out of alignment with the market (whether too high or too low). The base-closure process employed by the Department of Defense, whereby it notifies Congress of a decision to close a military base and Congress has a specified time within which to disapprove the Department’s action or forever hold its peace, is a good model. CMS should also be granted greater flexibility related to the Federal Advisory Committee Act and the Paperwork Reduction Act, as well as greater autonomy in hiring and compensating outside employees, in exchange for increased accountability.

d. Crossing the Quality Chasm.

CMS should publish a national “report card” for Medicare, beginning with high-level, state-based information about care delivered to Medicare beneficiaries, but moving quickly to more granular, provider-based data. Building on the efforts already underway, the report card would serve as the basis for analytical work that could lead to demonstrations of methods to reward providers for high quality and cost-effectiveness. Under the current system, Medicare pays the same amount for an almost unlimited amount of care no matter how excellent or how poor the quality of care is; if surgery is performed on the wrong hip, Medicare pays the hospital and surgeon anyway. Medicare will subsequently pay the same hospital and the same surgeon to perform surgery on the other hip. For this situation to change, Medicare must find a way to pay for performance. As CMS makes cautious moves in this direction, Congress and the public should support and demand deliberate and speedy results.

161. See Medicare Modernization and Prescription Drug Act of 2002, H.R. 4954, 107th Cong. (2002).

e. Other improvements.

Expediting development of new information systems to allow the agency to manage its information and program dollars more effectively ranks at the top of the long list of other improvements that should be made now to strengthen Medicare. We must also enhance the National Medicare Education Program to provide beneficiaries with more effective information about Medicare and health care, so that they can become more intelligent consumers of health care services. CMS must continue its efforts to rationalize rules and regulations and make provider education more accessible and effective.

In addition, the agency should be given the authority to move ahead with implementation of the various market-based pricing models that have already been demonstrated successfully, such as the competitive pricing system for durable medical equipment and the so-called “centers of excellence” demonstration for coronary artery bypass graft surgery. These demonstrations have shown that, at least on a small scale and for certain services, Medicare can save money without undermining the quality of care offered to beneficiaries. CMS should move forward with market-based pricing models in as many markets as possible and should cover as many items and services as makes sense, recognizing that there will be markets that do not make sense and items and services that are so customized or unique that they are not good targets for this approach.

Finally, a review of the Medigap market and the selections available to beneficiaries who wish to supplement their Medicare coverage is needed. Medigap coverage is no longer very attractive and in many states it is no longer affordable.¹⁶² An effort should be launched immediately to work with state insurance commissioners so that Medigap improvements can be enacted along with the new Medicare prescription drug benefit.

2. Phase II: Strengthening Benefits, Extending Trust Fund Solvency (2005-2008).

a. Improving Medicare's benefits.

Medicare beneficiaries need a drug benefit as soon as possible. It must be an integral part of the Medicare program, available to all beneficiaries (not just those in managed care). It must be voluntary and affordable. Details such as how many pharmacy benefit managers should compete to provide the benefit in a given

162. See The Clinton Plan, *supra* note 148, at 33. See generally *Hearing on Medicare Supplemental Insurance (Medigap) Before the Subcomm. on Health of the House Comm. on Ways & Means*, 107th Cong. (2002) (statement of Bobby P. Jindal, Asst. Sec'y for Planning and Evaluation, Dep't of Health & Human Servs.) (describing the rising cost of Medigap), available at <http://waysandmeans.house.gov/legacy.asp?file=legacy/health/107cong/3-14-02/3-14jind.htm> (last visited Feb. 3, 2004).

region and how much risk they should bear are important and will take some time to work out. Rather than spending another five years arguing over the best solution or picking one and pretending we know the optimal answer *ab initio*, why not initiate two or three different versions of the benefit in large areas of the country, allowing Medicare beneficiaries and the market to tell us what works best?

In addition, Medicare's cost-sharing structure has not been updated since the program's launch in 1966. It makes no sense to have separate deductibles for hospital and physician care; and Medicare's cost-sharing for hospital care is quite high, while that for physician care is low. There should be a single deductible, indexed for inflation, and cost-sharing should apply to all services at more uniform rates. All beneficiaries should have catastrophic protection that would shield them from extremely high costs. Coverage of preventive benefits should be enhanced as well, and instead of leaving these decisions to Congress, either the Secretary of Health and Human Services or an advisory board created to increase CMS's accountability should be empowered to make these changes upon the recommendation of a credible group of clinicians (such as the U.S. Preventive Services Task Force).¹⁶³

b. Testing premium support.

Many health policy experts and members of Congress are intrigued by the possibility that the premium support model will show that there is a way to make private plans available throughout the country and structure a Medicare benefit that will give beneficiaries and providers incentives to be more cost conscious. I confess that I seriously doubt that it will; I fear that the only way to control Medicare costs in more than a marginal way is to pay providers (whether fee-for-service or managed care plans) less and shift more costs onto beneficiaries.¹⁶⁴ Nevertheless, there may be other reasons to pursue premium support--for example, the private plans it promotes may offer ways of organizing and delivering care and making evidence-based decisions about coverage of new technology that are superior to what Medicare has so far been able to achieve. Other ideas, such as disease management and chronic care management have also shown promise as ways of generating savings for private and public health plans and employers as well as better health outcomes for participants and beneficiaries. Rather than

163. For a detailed discussion of the gaps in Medicare's current benefit package and some ways to address them, see MEDICARE PAYMENT ADVISORY COMM'N, REPORT TO THE CONGRESS: ASSESSING MEDICARE BENEFITS (2002). The United States Preventative Services Task Force is an independent panel of private sector experts in primary care and prevention convened by the U.S. Public Health Service to systematically review evidence regarding the effectiveness of clinical preventative services. *Id.* app. A at 69.

164. See generally *Medicare and Private Plans: Separating Fact from Fiction Before the Senate Comm. on Aging*, 108th Cong. (2003) (statement of Marilyn Moon, Senior Fellow, The Urban Institute) (criticizing privatization reforms to Medicare).

wasting another five years arguing about theory, let us conduct some robust, large-scale (meaning statewide or larger) demonstrations to get a better sense of how effective these models are and whether they would work for Medicare and its beneficiaries and providers.

c. Strengthening the Trust Fund.

The most recent report of the Medicare Trustees projects that the Medicare Trust Fund will be solvent through 2026, a slightly worse projection than in 2002, as a result of increased rates of spending for inpatient hospital and physician care.¹⁶⁵ Given the large number of retirees that will join Medicare around 2025, we need to identify additional revenues to support the program. Repealing the \$1.7 trillion tax cut enacted by the Congress in 2002 would be a good start. Then we could make the choice, as President Clinton did, to devote surplus revenues to support Medicare. When President Clinton first proposed this in 1999, the Medicare actuaries reckoned that dedicating a small proportion of the surplus then projected (roughly \$330 billion over fifteen years) to Medicare would extend the solvency of the Trust Fund for another twelve years.¹⁶⁶

Finally, Congress should continue to review Medicare's payment systems on an annual basis to ensure that they pay adequately, but do not overpay, for efficient and high quality care. As noted earlier, these efforts could be strengthened considerably if Congress would give CMS more authority to make relatively modest adjustments, on its own, through the rulemaking process to keep spending in line with projections and ensure that Medicare's rates are not wildly out of line with market pricing.

3. Phase III: Evaluation, Adjustment, and Continuous Improvement (2008-2010).

Starting around 2010, Medicare will have approximately 6 million more beneficiaries than it has today. These Baby Boomers will transform what it means to be retired just as they have transformed everything else they have touched, from banking (think ATMs) to food (think prepackaged peanut butter and jelly sandwiches). Educating these soon-to-be Medicare beneficiaries now about the challenges Medicare faces is critical. And it is vital that we evaluate what we have done in Phases I and II—the premium support demonstrations, the various incarnations of the prescription drug benefit, and any other innovations that are tried—quickly and objectively. We will not be done with strengthening Medicare in Phase III, but if we have succeeded, we will know much more than we know today about how to administer Medicare efficiently and how to constrain its costs

165. THE 2003 ANNUAL REPORT, *supra* note 140, at 13.

166. See The Clinton Plan, *supra* note 148, at 37-38.

while maintaining a high quality health care delivery system. We will then be in a position to move forward with the next round of changes that will be necessary to improve Medicare as it heads toward the half-century mark.

V. CONCLUSION

As Medicare approaches its 40th birthday, there are more plans for overhauls and facelifts than parties and celebrations. Media coverage is filled with policy disagreements (such as the arguments over how to provide a prescription drug benefit) or Medicare's failings (such as the departure of HMOs from the Medicare+Choice program), and Congress is polarized over how best to strengthen and modernize Medicare. With this track record, one wonders why policymakers would even waste time reforming Medicare—why not scrap it altogether? The reason is that for almost forty years, Medicare has provided the nation's elderly with something most of them did not have: health insurance that is guaranteed, affordable, and often high quality.

Medicare is not perfect, but it has done enormous good. Its very existence makes an important statement about American values. As we explore changes that could inject greater cost sensitivity into beneficiaries' decisions about their health care, improve accountability and efficiency at CMS, and improve the quality and cost effectiveness of the health care services Medicare purchases, we should avoid radical changes based on elegant but unproven theories. Change in Medicare is best achieved incrementally, in a stepwise fashion, after we have tested the new ideas and know enough to make more widespread changes responsibly. This was one of the lessons of the BBA, and thanks to the BBA, we have the time to test and evaluate new ideas that policy experts believe hold promise for Medicare's future. At the same time, we can and should move ahead now to add a prescription drug benefit and make other changes to modernize the program and strengthen its administration. In this way, we can hold fast to the best of Medicare's past while embracing the best of the future for the millions of beneficiaries and their families who depend on Medicare now and tomorrow.