

CONTROLLING MEDICARE COSTS: MOVING BEYOND INEPT ADMINISTERED PRICING AND ERSATZ COMPETITION

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I. INTRODUCTION

Medicare has been at the epicenter of deficit reduction and health reform discussions for many years. Controlling Medicare spending figured prominently in the government “shutdown” and President Clinton’s veto of a Medicare voucher plan in 1995,¹ the ill-fated “grand bargain” discussed during the debt extension crisis of 2011,² the debate over enactment of the Affordable Care Act (ACA),³ and most recently negotiations about avoiding the “fiscal cliff.”⁴ This debate, to the extent it can be labeled as such, has been vacuous. Much has focused on whether premium support plans will deprive seniors of choice and financial security in their healthcare decisions. Other reform proposals, such as raising the eligibility age for Medicare beneficiaries, restricting Medigap coverage, and indiscriminately reducing provider reimbursement, are questionable from a deficit-reduction standpoint and detrimental in their collateral effects on access and equity. Missing from the discussion has been a serious treatment of how and how much providers should be paid. (Yes, “paid,” not “reimbursed;” the unspoken and politically discomfiting fact is that “cost control” necessarily spells lower incomes for many in the healthcare sector.) Proponents and opponents of market-based reform consistently fail to acknowledge the prerequisites of reducing the price and volume of services through private bargaining between payers (government or commercial) and providers and sellers of medical devices, pharmaceuticals, and supplies. Likewise, those

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1. Jonathan Oberlander, *The Politics of Medicare Reform*, 60 WASH. & LEE L. REV. 1095, 1120 (2003).

2. Jeanne Sahadi, *Debt Ceiling: Perils of a ‘Grand Bargain’*, CNNMONEY (July 8, 2011), http://money.cnn.com/2011/07/08/news/economy/debt_ceiling/index.html.

3. Robert A. Berenson, *Implementing Health Care Reform – Why Medicare Matters*, 363 NEW ENG. J. MED. 101, 101 (2010).

4. Josh Boak, *Medicare May Be a Silent Killer in Budget Battles*, FISCAL TIMES (Dec. 20, 2012), <http://www.thefiscaltimes.com/Articles/2012/12/20/Medicare-May-Be-the-Silent-Killer-in-Budget-Battles.aspx#page1>.

who support retaining traditional Medicare tend to ignore the grievous flaws of administered pricing and the government's repeatedly unsuccessful attempts at reform.

This essay seeks to refocus the discussion. Acknowledging that controlling Medicare spending is an important national priority, it deals with the core problem of rationalizing cost in a market-based system. Part II critiques the premium support proposal that figured prominently in the 2012 Presidential campaign, revealing the flawed assumptions that undermine reliance on purported market efficiency. Part III looks at the *bête noire* of provider payment under Medicare, fee-for-service (FFS) methodology, and the ineffective governmental efforts at administered pricing. The article next reviews the flaws in the design and administration of the managed care options offered to Medicare beneficiaries. Finally, it concludes by discussing the reforms embodied in the ACA, finding a ray of hope in its efforts to adjust provider payments in a way that potentially will transform healthcare delivery.

II. PREMIUM SUPPORT

2012 was a year in which Medicare dominated political and legislative discourse as never before. Concerns over the fiscal threat posed by growing expenditures and rising eligibility for the Medicare program focused national attention on proposals to "reform" Medicare. Although just two years earlier Congress had debated and ultimately made important changes to the program in enacting the ACA, the 2012 Presidential campaign brought the issue of cost control into sharp relief. For the most part, the debate centered on the "premium support" proposal advanced by Vice Presidential candidate Paul Ryan, a reform that had twice passed the House of Representatives⁵ and had been advanced for a number of years by groups examining ways to deal with the nation's budgetary problems.⁶

5. In 2011 and 2012, the House of Representatives passed H.R. 2 and H.R. 6079 respectively, which would adopt premium support for Medicare and repeal the ACA. Letter from Douglas W. Elmendorf, Dir., Cong. Budget Office, to John Boehner, Speaker, U.S. House of Rep. (July 24, 2012). Neither bill was acted upon by the Senate. For a list of other legislative proposals, see KAISER FAMILY FOUND., COMPARISON OF MEDICARE PREMIUM SUPPORT PROPOSALS (2012), available at <http://www.kff.org/medicare/upload/8284.pdf>.

6. The National Commission on Fiscal Responsibility, often referred to as the Simpson Bowles Commission from the names of its chairmen, Alan Simpson and Erskine Bowles, had proposed deficit reductions from Medicare by reforming the Sustainable Growth Rate mechanism, increasing cost sharing, restricting first dollar coverage in Medigap plans, and reducing provider payments. See NATIONAL COMM'N ON FISCAL RESPONSIBILITY AND REFORM, THE MOMENT OF TRUTH 35-45 (2010), available at http://www.fiscalcommission.gov/sites/fiscalcommission.gov/files/documents/TheMomentofTruth12_1_2010.pdf. The Bipartisan Policy Center's Debt Reduction Task Force, chaired by Senator Pete Dominici and Dr. Alice Rivlin,

The broad outlines of the premium support are as follows.⁷ It would replace Medicare's guarantee to pay for all defined medical benefits. Instead, beneficiaries would receive a fixed allowance ("voucher" for those less sympathetic to the concept) that would be used to purchase a health plan from commercial insurers. Vouchers would vary by age, health status, and, to some not specified extent, by the income of the recipient. Controversially, increases in the voucher would be pegged to increases in the GDP, not medical expense inflation. Medicare beneficiaries would shop on a new Medicare exchange, presumably a virtual marketplace akin to the exchanges that the ACA establishes for private insurance (notwithstanding the fact that the Romney-Ryan agenda promised repeal of that legislation⁸). As outlined in the latest iteration, the Ryan proposal contained an important change for traditional, FFS Medicare. Private plans would not only compete with each other under a bidding system, but also will in some sense "compete" with traditional FFS Medicare. Because there is no traditional FFS entity that could submit a "bid," the proposal presumably contemplated that the overall provider rates in each region would be reduced to the extent that the costs of traditional Medicare exceed the bids of the second lowest bid among private plans.

At the heart of Congressman Ryan's plan is a fairly straightforward proposition. By exercising their judgment as consumers — choosing private health plans and shopping for cost-effective high quality providers in their plans — Medicare beneficiaries can curb overuse of care, spur improve-

proposed substantial increases in Medicare Part B premiums and cost sharing, and converting Medicare into a premium support system. BIPARTISAN POL'Y CTR., RESTORING AMERICA'S FUTURE 17 (2010), available at <http://bipartisanpolicy.org/sites/default/files/bpc%20final%20report%20for%20printer%2002%2028%2011.pdf>.

7. The original legislative agenda put forth by Congressman Ryan, labeled "A Roadmap For America's Future," proposed to repeal most of the central features of the ACA, including subsidies for insurance purchases, insurance exchanges, and requirements that businesses provide insurance and that individuals buy it. See PAUL RYAN, A ROAD MAP FOR AMERICA'S FUTURE (2010), available at <http://roadmap.republicans.budget.house.gov/uploadedfiles/roadmap2final2.pdf>. Congressman Ryan amended his plan somewhat early in December 2011, when he introduced a "framework" for Medicare reform co-sponsored by Democratic Senator Ron Wyden. Unlike the voucher program contained in the original Ryan plan, which gave seniors a fixed amount of money to purchase health plans, the Wyden-Ryan plan would adjust premium support payments each year to reflect the actual cost of health insurance premiums. See RON WYDEN & PAUL RYAN, GUARANTEED CHOICES TO STRENGTHEN MEDICARE AND HEALTH SECURITY FOR ALL: BIPARTISAN OPTIONS FOR THE FUTURE (2011), available at <http://www.wyden.senate.gov/imo/media/doc/wyden-ryan.pdf>.

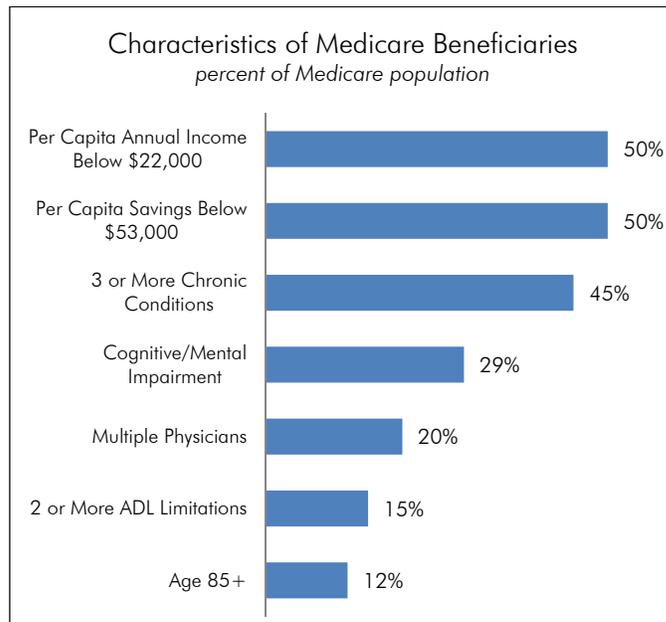
8. Timothy Jost, *Dismantling the Affordable Care Act: What Could A President Romney and Hill Republicans Do?*, HEALTH AFF. BLOG (Sept. 20, 2012), <http://healthaffairs.org/blog/2012/09/20/dismantling-the-affordable-care-act-what-could-a-president-romney-and-hill-republicans-do/>.

ments in the delivery of healthcare, and ultimately lower the cost of the program. Less widely noted is a necessary corollary of the Ryan plan: If the behavior of Medicare beneficiaries is not successful in lowering costs, medical inflation will be largely shifted to them. Looked at from this perspective it should be evident that the Ryan plan privatizes enormous financial risk, and the bearer of that new burden is a large and vulnerable sector of society. While the proposal raises abundant concerns based on notions of equity and the implicit social contract of the Medicare program, the following analysis focuses on several questionable behavioral and economic assumptions that underlie the proposal.

First, consider placing responsibility on the Medicare beneficiary for driving the health system change by her decisions as a consumer. She will do this at two junctures under a market-driven Medicare system. First, in choosing among plans, she will seek out the plan with the best network of providers, premium and co-payment responsibilities, and reputation for quality. Second, she will exercise her discretion at the point of service, that is, when she decides *whether* to seek medical care and from *what type* and *what particular* provider. Co-payments and deductibles are the standard means by which insurers encourage consumers to have an economic stake in the purchase of services (“skin in the game” is the unfortunate watchword). The assumption of premium support advocates is that seniors will pick plans with higher cost sharing requirements and also will be incentivized to shop more prudently for lower priced providers. Further, a fair assumption is that under premium support, private plans will follow what is becoming common practice in the commercial market: encouraging comparative shopping at the point of service by offering different co-pay responsibilities for providers grouped in different “tiers” and by requiring co-payments that will discourage overuse.

However, as the following table indicates,⁹ the typical Medicare beneficiary will make this choice under a variety of constraints. The chances are about 50/50 that she has income under \$50,000, less than \$53,000 in savings, and three or more chronic conditions. The probability is also that she has some cognitive or physical impairment and that she sees four or more different physicians. This data raises serious questions as to whether many beneficiaries will be well-positioned to make sound comparative judgments or to have a sufficient reservoir of resources to bear substantial co-payments based solely on the expected health benefits from treatment.

9. KAREN DAVIS, COMMONWEALTH FUND., THE FUTURE OF MEDICARE: CONVERTING TO PREMIUM SUPPORT OR CONTINUING AS A GUARANTEED BENEFIT PROGRAM 22 (2012), available at http://www.commonwealthfund.org/~media/Files/Publications/Testimony/2012/Oct/Davis_HouseDems_Medicare_testimony_10022012_FINAL.pdf.



Note also the highly skewed distribution of Medicare costs: 77% of all Medicare program expenditures are spent on 19.4% of beneficiaries while 69% of all beneficiaries spent less than \$5,000 per year on out-of-pocket costs.¹⁰ This fact has profound implications for both the effectiveness and equity of premium support. First consider the incentives facing beneficiaries with multiple chronic conditions. Proponents of premium support promise to place stop loss caps on beneficiaries' financial responsibilities at levels around \$6,000 per year. Consequently, beneficiaries with serious illnesses or chronic diseases would be likely to exceed cost sharing caps quickly and thus be relatively immune to cost sharing incentives.¹¹ Further, the overall impact of these incentives is questionable. If those with less than \$10,000 in costs reduce their spending by 20% — a very significant and probably unrealistic reduction — the total reduction to Medicare costs would only be 5%.¹² Second, the impact of premium support would be highly discriminatory; geographic variation in Medicare costs would produce significant variations in the burden borne by seniors in different regions. The Kaiser Family Foundation estimates that half of current FFS beneficiaries and

10. ROBERT A. BERENSON & JOHN HOLAHAN, URBAN INST., PRESERVING MEDICARE: A PRACTICAL APPROACH TO CONTROLLING SPENDING 4-5 (2011), available at <http://www.urban.org/uploadedpdf/412405-Preserving-Medicare-A-Practical-Approach-to-Controlling-Spending.pdf>.

11. *Id.*

12. *Id.* at 5.

most beneficiaries enrolled in Medicare Advantage plans would pay more under the Ryan premium support plan if implemented today and that there would be tremendous regional variations in costs.¹³ Finally, recent research concerning how Medicare beneficiaries comparative shop for managed care services adds additional grounds for questioning the efficacy of premium support. For example, a study by Heiss et al. finds that fewer than 10% of Medicare beneficiaries enroll in the Part D pharmacy plan that would be the most cost-effective plan for them.¹⁴ Using data on plan choice, drug use, health conditions, out of pocket costs, and premiums, the authors found enrollees lose an average of about \$300 per year. The study also suggests that seniors pay more attention to premiums than plan generosity, thus miscalculating the ultimate cost they would bear.¹⁵ Other studies show that seniors rarely shift once they have chosen a plan; they are only half as likely to change MA plans as federal employees.¹⁶

A second ground for skepticism about the efficacy of premium support proposals is based on what we know about healthcare provider markets. Inasmuch as the premium support model depends on competitive provider markets to promote cost efficiency, much depends on the vigor of market competition. A large body of literature documents the existence, scope, and effects of market concentration. Meta-analysis by Vogt and Town demonstrates a strong correlation between hospital market concentration and escalating costs of health insurance: hospital consolidation in the 1990s raised overall inpatient prices by at least 5%, and by 40% or more when merging hospitals were located close to one another.¹⁷ An important study undertaken by the Massachusetts Attorney General documents the effects of provider leverage on healthcare costs and insurance premiums,¹⁸ notably finding prices for health services are uncorrelated with quality, complexity, proportion of government patients, or academic status, but

13. KAISER FAMILY FOUND., TRANSFORMING MEDICARE INTO A PREMIUM SUPPORT SYSTEM: IMPLICATIONS FOR BENEFICIARY PREMIUMS 20-24 (2012).

14. Florian Heiss et al., *Plan Selection in Medicare Part D: Evidence from Administrative Data* 25 (Nat'l Bureau of Econ. Research, Working Paper No. 18166, 2012).

15. *Id.*

16. See, e.g., Chao Zhou et al., *The Vast Majority of Medicare Part D Beneficiaries Still Don't Choose the Cheapest Plans that Meet their Medication Needs*, 31 HEALTH AFF. 2259, 2263 (2012); Zirui Song et al., *Potential Consequences of Reforming Medicare Into a Competitive Bidding System*, 308 JAMA 459, 460 (2012).

17. WILLIAM B. VOGT & ROBERT TOWN, ROBERT WOOD JOHNSON FOUND., HOW HAS HOSPITAL CONSOLIDATION AFFECTED THE PRICE AND QUALITY OF HOSPITAL CARE? 4 (2006), available at <http://www.rwjf.org/files/research/no9researchreport.pdf>.

18. MA. ATTORNEY GENERAL, EXAMINATION OF HEALTH CARE COST TRENDS AND COST DRIVERS PURSUANT TO G.L. C. 118G, § 6½(b) (2010) [hereinafter HEALTH CARE COST TRENDS], available at <http://www.mass.gov/ago/docs/healthcare/final-report-w-cover-appendices-glossary.pdf>.

instead are positively correlated with provider market power.¹⁹ It concludes that the single most important cause of price escalation was “provider leverage.”²⁰ Another report, drawing on site visits by the Center for Studying Health System Change to six California markets in 2008, found that provider leverage has had a major impact on California premium trends.²¹ Private plans will inevitably face essentially the same difficulty in negotiating with entrenched, “must have” providers.

In sum, the bottom line for Ryan’s premium support plan is that (1) commercial payers will lack power to effectively bargain with providers whose costs drive the healthcare inflationary spiral and (2) seniors, as consumers, will exert only weak pressure on the demand side. Are there viable alternative strategies? Provider payment and beneficiary incentives are the key to controlling costs, whether we are in a market-driven system, the traditional FFS Medicare payment methodology, or some mix of the two. The following sections review the leading alternatives for successfully constraining these costs.

III. CONTROLLING FEE-FOR-SERVICE PAYMENTS

Over its nearly 50 year history, Medicare has been subject to a series of adjustments that attempt to deal with the serious deficiencies inherent in FFS payment. Paying physicians, and in some cases facilities, based on each procedure they perform is the *bête noire* of the system.²² By rewarding providers for the volume of service without regard to quality or outcomes, FFS payment skews incentives and inexorably raises costs. While Medicare does pay hospitals prospectively based on DRG bundles for hospitalization, e.g., hip replacement or craniotomy, that methodology also fails to cover entire episodes of care or bundle physician care and other services. Further, prospective payment does not reward or penalize providers based on quality or outcomes. Indeed, the empirical evidence suggests that Medicare geographic areas with higher volume do not have better outcomes.²³

Some of the changes in Medicare payment over the years that sought to redirect incentives, such as the shift to prospective payment for hospitals

19. *Id.* at 16-33.

20. *Id.* at 28.

21. Robert Berenson et al., *Unchecked Provider Clout in California Foreshadows Challenges to Health Reform*, 29 HEALTH AFF. 699, 704 (2010).

22. *Reforming the Health Care Delivery System: Hearing before the Comm. on Energy & Commerce*, 109th Cong. 5 (2009) (statement of Glenn B. Hackbarth, Chairman, MedPAC) [hereinafter Hackbarth statement]; see generally Harold Miller, *From Volume to Value: Better Ways to Pay for Health Care*, 28 HEALTH AFF. 1418 (2009) (suggesting that barriers that prevent Medicare from improving quality and controlling costs stem from the fee-for-service payment system).

23. Hackbarth statement, *supra* note 22, at 5.

under the inpatient prospective payment system (IPPS), have been moderately successful.²⁴ Paying one price for a defined bundle of services provided per hospital admission lowered hospital costs by reducing lengths of stay and encouraging to some extent conservation of health resources.²⁵ However, IPPS has necessitated close regulatory supervision and reform to deal with problems associated with a host of complexities including adjustments to account for wage differentials, new technology, case severity differences, upcoding by providers, and a variety of other factors.²⁶ Moreover, enthusiasm based on the IPPS success story should be tempered by considering the larger picture. As discussed *infra*, there is some evidence that Medicare hospital payments induce cost-shifting to private payers, although the degree and direction of shifting depends on the balance of market power between hospitals and health plans.²⁷ In addition, IPPS adds enormous administrative complexity to what is ultimately a process for setting a global budget. Further, it does so without adjusting for quality or outcomes among hospitals, paying the best and worst hospitals the same base payment regardless of performance (leading one former CMS administrator to call his agency a “big dumb price fixer”²⁸).

Other reforms such as paying physicians using the Resource Based Relative Value Scale (RBRVS) have been notorious failures because of inadequate controls over the volume of services and the disparity in payment between specialty and primary care services. The Medicare Physician Fee Schedule — which employs the RBRVS methodology adopted under the Omnibus Budget Reconciliation Act of 1989 — put in place a scale for differentiating the levels of payments to physicians under Medicare based on

24. *Id.* at 12-13.

25. See Stuart Altman, *The Lessons of Medicare’s Prospective Payment System Show That the Bundled Payment Program Faces Challenges*, 31 HEALTH AFF. 1923, 1928 (2012).

26. See *id.* at 1927 (explaining DRG system failure to reflect severity of illness resulting in overpayments and underpayments and necessitating increase from 538 DRGs to nearly 1000 groupings); David Frankford, *The Complexity of Medicare’s Hospital Reimbursement System: Paradoxes of Averaging*, 78 IOWA L. REV. 517, 577-78 (1993); see MEDICARE PAYMENT ADVISORY COMM’N, REPORT TO CONGRESS: PROMOTING GREATER EFFICIENCY IN MEDICARE 36 (2007), available at http://www.medpac.gov/documents/Jun07_entirereport.pdf; see generally CCH, 2011 MEDICARE EXPLAINED (Pam Carron et al. eds., 2011).

27. See Austin B. Frakt, *How Much Do Hospitals Cost-Shift? A Review of the Evidence*, 89 MILBANK Q. 90 (2011); Allen Dobson et al., *The Cost-Shift Payment ‘Hydraulic’: Foundation, History, and Implication*, 25 HEALTH AFF. 22, 27 (2006); Uwe E. Reinhardt, *The Many Prices Paid to Providers and the Flawed Theory of Cost Shifting: Is It Time For a More Radical All-Payer System?*, 30 HEALTH AFF. 2125, 2127 (2011).

28. Uwe Reinhardt, *The Medicare World From Both Sides: A Conversation with Tom Scully*, 22 HEALTH AFF. 167, 168 (2003).

the complexity, costs, and other factors for each procedure.²⁹ It was left to Congress to update the multiplier (conversion factor) for these value scales to determine what physicians would be paid. Congress came up with an astonishingly naïve mechanism, the Volume Performance Standard (VPS), to control the volume or intensity of services provided. As originally designed, the VPS sought to discourage physicians from overusing services by reducing per service payment levels if overall volume increases exceeded a specified threshold.³⁰ This approach ignored the patent collective action problem: there was simply no reason for an individual physician to reduce the volume of services based on a net reduction in per service payment levels nationally or even regionally.³¹

A few years later, CMS upped the ante by adopting the Sustainable Growth Rate (SGR) formula which imposes *cumulative* forced reductions in physician payments when total physician spending exceeds a fixed spending amount.³² That is, if the total spending on physician services in a given year exceeds an aggregate target based on the GDP and other factors, the formula requires recouping that excess spending by reducing fee levels the next year. Besides ignoring the collective action problem, the SGR process was doubly naïve in failing to anticipate Congress's response to proposed reductions in physician incomes resulting from the process. In each year since 2001 except one, Congress has passed legislation that overrode fee reductions, with the result that as of 2012, absent another override, physician fees would decline by 29.5%.³³ Another critical flaw of Medicare physician payment has been its failure to satisfy the central goal of the RBRVS experiment: rationalizing payment to reward cognitive services and reducing overpayments to procedure-oriented practices. Owing to its reliance on the American Medical Association's Relative Value Update

29. BLUE CROSS BLUE SHIELD ASS'N, RESOURCE BASED RELATIVE VALUE SCALE 1-2 (2009), available at <https://www.bcbsal.org/providers/newpaymentmethodology/RBRVSEducation.pdf>.

30. *Physician Payments: Hearing Before the Subcomm. on Health of the H. Comm on Ways & Means*, 107th Cong. 11 (2002) (statement of Dan L. Crippen, Dir., Cong. Budget Office).

31. See MEDICARE PAYMENT ADVISORY COMM'N, REPORT TO CONGRESS: ASSESSING ALTERNATIVES TO THE SUSTAINABLE GROWTH RATE SYSTEM 205 (2007), available at http://www.medpac.gov/documents/Mar07_SGR_mandated_report.pdf.

32. *Id.* at 11-12.

33. MEDICARE PAYMENT ADVISORY COMM'N, REPORT TO CONGRESS: MEDICARE AND THE HEALTH CARE DELIVERY SYSTEM 7 (2011), available at http://www.medpac.gov/documents/jun11_entirereport.pdf.

Committee, which is dominated by specialists, the process continues to over-weigh specialty procedures and undervalue primary care.³⁴

As the foregoing account suggests, FFS Medicare regulation has been mired in increasing administrative complexity and payment reform has failed to accomplish many of its key objectives. Perhaps the most damning criticism of FFS payment is that it has perpetuated a fragmented delivery system by incentivizing procedure-oriented medical practices and failing to reward outcomes or encourage integration.³⁵ Moreover, Medicare-administered pricing may play a less important role in inducing overall cost control than competition in commercial markets. Although administered pricing under Medicare does not differentiate among providers based on their market leverage, provider market competition has a significant effect on hospital Medicare margins. Examining the effect of hospital market concentration on Medicare payments, the Medicare Payment Advisory Commission (MedPAC) has found that high hospital margins on private-payer patients tend to induce more construction and higher hospital costs and that, “when non-Medicare margins are high, hospitals face less pressure to constrain costs, [and] costs rise.”³⁶ These factors, MedPAC observes, explain the counterintuitive phenomenon that hospital Medicare margins tend to be low in markets in which hospital market concentration is highest, while margins are higher in more competitively structured markets.³⁷

Given the government’s spotty experience with administered pricing, much attention has been paid to the market-based alternatives. The following section analyzes the performance of Medicare managed care, known as Medicare Advantage in its current incarnation.

IV. MEDICARE ADVANTAGE

Medicare beneficiaries have had the option of enrolling in private HMOs since the 1970s.³⁸ With the Balanced Budget Act of 1997³⁹ and the

34. MEDICARE PAYMENT ADVISORY COMM’N, REPORT TO CONGRESS: MEDICARE PAYMENT POLICY 133-150 (2006), available at http://www.medpac.gov/documents/Mar06_entirereport.pdf.

35. See generally THE FRAGMENTATION OF THE US HEALTHCARE SYSTEM: CAUSES AND SOLUTIONS (Einer R. Elhauge ed., 2010).

36. MEDICARE PAYMENT ADVISORY COMM’N, REPORT TO THE CONGRESS: ASSESSING ALTERNATIVES TO THE SUSTAINABLE GROWTH RATE SYSTEM xiv (2009), available at http://www.medpac.gov/documents/mar09_entirereport.pdf.

37. *Id.*; see also Stensland et al., *Private-Payer Profits Can Induce Negative Medicare Margins*, 29 HEALTH AFF. 1045, 1048-49 (2010).

38. See Robert A. Berenson & Bryan E. Dowd, *Medicare Advantage Plans at a Crossroads – Yet Again*, 28 HEALTH AFF. w29, w30 (2008).

39. *Id.* at w32.

Medicare Modernization Act of 2004,⁴⁰ Congress successively renamed this option and added incentives to enhance its attractiveness to beneficiaries. As of the end of 2012, 27% of all Medicare beneficiaries are enrolled in the program now called Medicare Advantage (MA).⁴¹ With HMOs constituting 65% of MA enrollment and PPOs representing the balance of the remainder, MA plans actively manage provider networks with programs designed to assure the delivery of Part A and B services while avoiding excess utilization. Operating under the budget constraint of capitated payments, these plans have incentives to integrate care and subject participating providers to financial incentives and other controls to achieve desired outcomes.

The experience with MA plans is a cautionary tale illustrating the problems of administering a program that is neither fish nor fowl. As discussed below, although built around a bidding model, MA falls short of replicating a competitive market outcome. While many MA plans have proved highly successful at delivering integrated care below FFS costs with equal or better quality measures⁴² and have demonstrated the capacity to avoid readmissions and other cost drivers endemic in FFS Medicare,⁴³ the regulatory design of benchmark bidding and several politicized regulatory adjustments have prevented the emergence of a fully cost-effective alternative.

As originally implemented, Medicare set payment rates for managed care at 95% of county-level FFS costs. The underlying policy concept was that private plans that were more efficient and innovative than traditional Medicare should be able to deliver care more cost efficiently, whose savings could be shared with beneficiaries in the form of added benefits or reduced premiums. It did not work out that way. Under an earlier incarnation, awkwardly named Medicare + Choice, HMOs failed to deliver on promises of expanded choice and superior quality.⁴⁴ Flawed risk adjustment policies

40. *Id.* at w32-w33.

41. MARSHA GOLD ET AL., KAISER FAMILY FOUND., *MEDICARE ADVANTAGE 2012 DATA SPOTLIGHT: ENROLLMENT MARKET UPDATE 1* (2012), available at <http://www.kff.org/medicare/upload/8323.pdf>. Some states have substantially higher enrollments. *Id.* at 5 (Minnesota 46%, Oregon 41%, Pennsylvania 38% California 36%).

42. Bruce E. Landon et al., *Analysis of Medicare Advantage HMOs Compared with Traditional Medicare Shows Lower Use of Many Services During 2003-2009*, 31 HEALTH AFF. 2609, 2609 (2012).

43. Marsha Gold, *Medicare Advantage – Lessons for Medicare’s Future*, 366 NEW ENG. J. MED. 1174, 1175 (2012); Jeff Lumieux et al., *Hospital Readmission Rates in Medicare Advantage Plans*, 18 AM. J. MANAGED CARE 96, 103 (2012).

44. Marsha Gold, *Medicare+Choice: An Interim Report Card*, HEALTH AFF., July 2001, at 120, 126 (cataloguing shortcomings of program following passage of the Balanced Budget Act of 1997).

allowed plans to earn more than the 95% standard because of their ability to obtain healthier than average beneficiary cohorts.⁴⁵ However Congressional reaction under the Balanced Budget Act of 1997, which caused Medicare growth to slow, caused many plans to withdraw from Medicare or abandon less profitable geographic areas.⁴⁶ In 2004, Congress overreacted again — this time in the opposite direction — when it adopted the Medicare Modernization Act.⁴⁷ Renaming the program “Medicare Advantage,” the Act added regional PPOs and private FFS plans to expand the availability of MA plans to previously unserved or underserved areas,⁴⁸ and adopted bidding and risk sharing regulations, all with a straightforward goal: promote MA enrollment by overpaying private plans. The changes achieved that goal: by 2009, MA plans were receiving payments in excess of 114% of FFS and some of the newly-configured MA plans were not even designed to provide integrated care.⁴⁹

Now this was all wrong for the self-evident reason that overpayments to HMOs do not accomplish the goal of saving money. But in addition, overpayments suffer from a dynamic flaw: they undermine incentives to innovate and provide care more efficiently.⁵⁰ The only rationale that can be ascribed to Congress is the desire to turbo-charge HMO enrollments, or to put it bluntly, to undermine traditional Medicare. (After all, it was Newt Gingrich who acknowledged that a central aim of his voucher plan was to make traditional Medicare unattractive so that it would “wither on the vine.”⁵¹). Another lesson can be gleaned from understanding the historical context: MA plans are not inherently more expensive than FFS Medicare but are the inexorable product of administratively set, high benchmarks. As one commentary aptly put it, “We pay these plans more because we choose to do so.”⁵²

45. MEDICARE PAYMENT ADVISORY COMM’N, REPORT TO CONGRESS: MEDICARE PAYMENT POLICY (2002), available at http://medpac.gov/documents/Mar11_EntireReport.pdf.

46. BRIAN BILES ET AL., THE COMMONWEALTH FUND, MEDICARE ADVANTAGE IN THE ERA OF HEALTH REFORM: PROGRESS IN LEVELING THE PLAYING FIELD 1 (2011), available at <http://www.commonwealthfund.org/Publications/Issue-Briefs/2011/Mar/Medicare-Advantage.aspx>.

47. Medicare Prescription Drug, Improvement and Modernization Act of 2003, Pub. L. 108-173, 117 Stat. 2066.

48. See Marsha Gold, *Medicare’s Private Plans: A Report Card on Medicare Advantage*, 28 HEALTH AFF. W41, W42 (2008). By 2008 all Medicare beneficiaries had multiple MA choices. *Id.*

49. See BILES, *supra* note 46, at 5.

50. *Id.* at 2.

51. POLITICS; *Gingrich on Medicare*, N.Y. TIMES (July 20, 1996), <http://www.nytimes.com/1996/07/20/us/politics-gingrich-on-medicare.html>.

52. Jeet S. Guram & Robert E. Moffit, *The Medicare Advantage Success Story – Looking Beyond the Cost Difference*, 366 NEW ENG. J. MED. 1177, 1178 (2012).

Seeking to return to the concept of creating a level playing field between traditional Medicare and MA plans, the ACA cut back substantially — though not completely — on overpayments to MA plans. MA plans will be paid based on current payments relative to FFS payments in those counties. The highest paid counties will have benchmarks at 95% of FFS and the lowest at 115%, with the others in between, so that by 2017, CMS will set payments at a national average of 101% of FFS costs.⁵³ In addition, plans that perform well on quality scores can offset some of the reduction with additional bonus payments for quality under the Star Rating program initiated under the ACA.⁵⁴ Yet all is not perfect with this reform. CMS exercised its authority to establish a demonstration program allowing bonuses to be paid to MA plans that performed below the ACA standard of four stars or higher.⁵⁵ This Lake Wobegone⁵⁶ scoring system allowed 91% of plans to get bonuses,⁵⁷ which essentially gives back about half of the projected savings from cuts to MA.⁵⁸

A closer look at the MA bidding system suggests that even with the ACA amendments, the process still falls short of replicating a competitive market. Under the current bidding system, payments to MA plans are determined by comparing each plan's bid (which reflects the plan's estimated costs) to a benchmark. Plans bidding below the benchmark receive their bid plus a "rebate" equal to 75% of the difference between the bid and the benchmark. Those bidding above the benchmark — a rare occurrence — receive the benchmark but must require that each plan enrollee pay a premium equal to the difference between the bid and the benchmark. The ACA adjusted the bidding framework by gradually lowering plan benchmarks to levels closer to the cost of enrollees in traditional Medicare in each county, setting relatively

53. Letter from Douglas W. Elmendorf, Dir., Cong. Budget Office, to Nancy Pelosi, Speaker, U.S. House of Rep. (Mar. 20, 2010).

54. See CTRS. FOR MEDICARE & MEDICAID SERVS., FACT SHEET 3-10 (2010), available at <http://www.cms.gov/apps/docs/Fact-Sheet-2011-Landscape-for-MAe-and-Part-D-FINAL111010.pdf>.

55. *Id.*

56. Jonathan Becher, *Lake Wobegon Effect*, FORBES (May 21, 2012), <http://www.forbes.com/sites/sap/2012/05/21/lake-woebegone-effect/>.

57. Gretchen Jacobson et al., KAISER FAMILY FOUND., MEDICARE ADVANTAGE STAR RATING AND BONUS PAYMENTS IN 2012, at 5 (2011), available at <http://www.kff.org/medicare/upload/8257.pdf>. Overall, however, the Star Rating System has produced some improvements in quality. See Paul Cotton et al., *Early Evidence Suggests Medicare Advantage Pay for Performance May be Getting Results*, HEALTH AFF. BLOG (Oct. 29, 2012), <http://healthaffairs.org/blog/2012/10/29/early-evidence-suggests-medicare-advantage-pay-for-performance-may-be-getting-results/>.

58. JAMES COSGROVE & EDDA EMMANUELLI-PEREZ, U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-12-964T, MEDICARE ADVANTAGE: QUALITY BONUS PAYMENT DEMONSTRATION HAS DESIGN FLAWS AND RAISES LEGAL CONCERNS 4 (2012).

lower benchmarks in counties with high FFS Medicare costs, and relatively higher benchmarks in counties with lower FFS costs.⁵⁹

Though an improvement over its predecessor, this bidding process falls short of creating effective incentives to lower costs. A central flaw is that benchmarks continue to be based in part on historic private plan payment rates and are subject to annual increases based on the growth in Medicare spending.⁶⁰ By retaining bidding against a preset benchmark, the bidding process does not fully encourage plans to compete as strongly as one in which payments are based on the average of plans' bids. The resulting misplaced economic incentives from retaining the linkage between payments to MA plans and spending on FFS Medicare ultimately reduce the potential savings that can be realized when private plans achieve lower costs than FFS Medicare.⁶¹ Notably the Senate version of the ACA contained a provision which was removed in the reconciliation process at the eleventh hour that would have required competitive bidding that set payments based on the average bid.⁶²

This was not the first time that Congress proved unwilling to adopt a full competitive bidding process for Medicare. In the 1990s, the predecessor agency to CMS was rebuffed by opposition in Congress in its attempt to establish a demonstration project for private plan competition in Baltimore, Maryland and in Denver, Colorado.⁶³ Prior to enactment of the ACA, the Obama Administration had embraced a plan to "allow the market, not Medicare, to set [Medicare Advantage] payment rates" by eliminating benchmarks based on FFS costs and instead requiring plans submitting bids above regional average bids make up the difference between the average

59. Under the revised bidding formula benchmarks will be 95% of fee-for-service costs per enrollee for the counties in the top quartile of fee-for-service costs; 100% for countries in the second highest quartile; 107.5% for the third highest quartile and 115% for the bottom quartile. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 3201, 24 Stat. 119, 442 (2010) (codified as amended in § 42 U.S.C. 1395w-23(j)(2011)) [hereinafter ACA].

60. See Robert A. Berenson, *From Politics to Policy: A New Payment Approach in Medicare Advantage*, 27 HEALTH AFF. w156, w160 (2008).

61. Guram & Moffit, *supra* note 52, at 1178.

62. See Austin Frakt, *Medicare Advantage Competitive Bidding: The Political Failure of a Good Idea*, KAISER HEALTH NEWS (April 12, 2010), <http://www.kaiserhealthnews.org/Columns/2010/April/041210Frakt.aspx> (speculating that removal may have been necessary to satisfy members of the House of Representatives who had endorsed administered pricing or were effectively lobbied by insurance industry representatives, or to accommodate the need for a more certain, favorable score for the ACA from the Congressional Budget Office).

63. See SUSAN JAFFE, ROBERT WOOD JOHNSON FOUND., COMPETITIVE BIDDING IN MEDICARE ADVANTAGE: IF HEALTH INSURANCE COMPANIES SUBMITTED COMPETITIVE BIDS TO OFFER MEDICARE COVERAGE, PRESIDENT OBAMA SAYS THE GOVERNMENT COULD SAVE BILLIONS OF DOLLARS 2 (2009), available at http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=3.

and their bids.⁶⁴ Estimated potential savings from these proposals over the then-existing methodology were significant. The CBO assessment of the proposed Policy Option issued by the Office of Management and Budget estimated that it would save over \$175 billion over ten years.⁶⁵ Initial bids in the Denver pilot test before Congressional action forced it to be abandoned were 25-38% below prevailing payment rates in the area.⁶⁶

Thus, the lessons of the flawed competitive mechanisms employed for MA are mixed. On the positive side, recent evidence demonstrates that MA plans have proved successful at delivering integrated care below FFS costs with equal or better quality measures.⁶⁷ Further, the literature suggests that, on average, HMOs are slightly more efficient, with some promising differences in their ability to innovate in delivering services to beneficiaries with chronic conditions, avoid readmissions, and deal with other cost drivers familiar in FFS Medicare.⁶⁸ As to quality of care under MA plans, a recent survey of the literature finds “promising results” from industry-sponsored studies, but in general no dramatic differences between MA plans and FFS.⁶⁹ On the other hand, the administrative and political supervision of MA has been characterized by considerable inconsistency. Confusion over the multiple goals of MA — providing additional benefits to enrollees, reducing government spending, introducing competitive incentives, leveling the playing field — has generated a roller coaster ride of changing regulations and incentives for health plans and beneficiaries.⁷⁰ HMOs have demonstrated that they can deliver cost effective care in the commercial sector and have had modest success in some regions in doing so under MA. As the national health insurance market consolidates and citizens become accustomed to coverage by plans, presumably many of which will also participate in MA, it seems likely that a market for seamless transition into Medicare managed care will develop.

64. *Id.* at 1.

65. CONG. BUDGET OFFICE, BUDGET OPTIONS VOL. I HEALTH CARE 122 (2008), available at <http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/99xx/doc9925/12-18-healthoptions.pdf>; see also OFFICE OF MGMT. & BUDGET, A NEW ERA OF RESPONSIBILITY: RENEWING AMERICA'S PROMISE 28 (2009), available at http://www.whitehouse.gov/sites/default/files/omb/assets/fy2010_new_era/A_New_Era_of_Responsibility2.pdf.

66. *Guest Post by Bryan Dowd, A Reply to Peter Orszag on Competitive Pricing in Medicare*, NATIONAL REVIEW (Aug. 22, 2012), <http://www.nationalreview.com/agenda/314704/guest-post-bryan-dowd-reply-peter-orszag-competitive-pricing-medicare-reihan-salam>.

67. Landon et al., *supra* note 42, at 2613.

68. See Gold, *supra* note 43, at 1175; Guram & Moffit, *supra* note 52, at 1178-79.

69. Gold, *supra* note 43, at 1175.

70. See Berenson & Dowd, *supra* note 38, at w30-w33.

V. REAL REFORM: MAKING MEDICARE ADVANTAGE WORK AND TRADITIONAL MEDICARE VIABLE

The vacuous debate during the 2012 Presidential campaign over the premium support proposal left many voters with the misimpression that they were choosing between market competition and regulation as remedies for the Medicare cost problem. In reality, a flurry of regulation is well underway pursuant to the ACA. But that regulation is aimed at systemic change that could allow *both* FFS Medicare and MA or other market-based arrangements to flourish. These changes are squarely aimed at correcting the flaws of FFS Medicare payment policy and encouraging delivery system change that will support competitive markets for alternative methods of payment including, MA.⁷¹ Indeed, what is commonly overlooked is that FFS Medicare and MA (as well as new payment arrangements such as the Medicare Shared Savings Program (MSSP)) all require change in the way healthcare is organized and delivered to produce cost-effective, quality care.

The ACA has initiated a large number of reforms in Medicare payment policies that aim to sharply refocus provider incentives and to encourage a fundamental reorganization of delivery of care. Some, like the MSSP, which encourages development of Accountable Care Organizations (ACOs), medical homes and financing changes such as bundled payments for certain diseases, are designed to deploy new payment incentives that will encourage the growth of seamless, efficient delivery systems.⁷² Others, such as changed payment policies for hospital readmissions, value based purchasing, and comparative effectiveness research, directly tackle flaws in the FFS system. If nothing else, this amalgam of pilots, experiments, and permanent programmatic reforms positions the government to rationalize Medicare based on evidence and experience.⁷³ Perhaps the most intriguing possibility is that the MSSP will ease the transition from FFS payment to a market-based platform. The ACO concept, which rewards providers for

71. See Thomas L. Greaney, *The Affordable Care Act and Competition Policy: Antidote or Placebo?*, 89 OR L. REV. 811, 825-36 (2011) (discussing the elements of the ACA that advance competition at the provider and payer levels).

72. See BARRY R. FURROW ET AL., HEALTH CARE REFORM; SUPPLEMENTARY MATERIALS 197-222 (2012) (summarizing ACA's changes to Medicare); PATRICIA A. DAVIS ET AL., CONG. RESEARCH SERV., R41196, MEDICARE PROVISIONS IN THE PATIENT PROTECTION AND AFFORDABLE CARE ACT: SUMMARY AND TIMELINE 26-27 (2011).

73. See Henry J. Aaron & Austin B. Frakt, *Why Now is Not the Time for Premium Support*, 366 NEW ENG. J. MED. 877 (2012) (explaining that multiple reforms to Medicare enacted under the ACA will provide information needed to assess whether premium support or other reforms are needed); see also KAREN DAVIS, *supra* note 9, at 20 (citing ACA's rapid and systematic testing of innovative models of payment and delivery as reason to maintain Medicare as a guaranteed benefit program).

accomplishing savings and delivering high quality care when done through integrative organizations, is built on a platform that retains FFS payment.⁷⁴

Some thorny questions remain. Can FFS Medicare coexist alongside MA and ACOs? In some ways the two approaches are complementary. MA assures that all beneficiaries receive the same minimum benefits and its beneficiaries are assured the right to return to traditional Medicare if they become dissatisfied with their private plans. FFS Medicare may come to look more like MA as providers join ACOs or otherwise configure themselves to respond to incentives for bundled payment and other reforms. Moreover, improvements in care processes, information collection, and effectiveness that may be realized in the competitive sector will have favorable spillover effects on FFS practices.

At the same time, there are obstacles to realizing this rosy scenario. A critical issue is whether risk adjustment tools will prove adequate to prevent efforts to engage in favorable selection that could give MA plans an unfair advantage and ultimately make traditional Medicare unsustainable. Moreover, as discussed earlier, excessive cost control can lead to cost shifting to the private sector. On the other side of the coin, the commercial market is beset with inefficiencies and MA plans may find it impossible to offer cost-effective alternatives in markets dominated by monopolistic hospitals and specialty physician groups. Equally worrisome is the possibility that some ACOs may develop market power by combining competing providers in a single bargaining unit.

VI. CONCLUSION

It is fair to interpret the outcome of the 2012 Presidential election as a vote of confidence in traditional Medicare and rejection of an approach that would replace it entirely with private plans. Yet, the necessity of controlling overall spending remains the paramount challenge for ongoing debt reduction negotiations, and some combination of market-based incentives and price controls is necessary. In examining the failures of administered pricing and market competition to control costs thus far, this article has sought to warn against viewing either as a panacea. The regulatory missteps that have plagued both approaches provide a cautionary tale for future reforms. However, the ACA begins to move both in the right direction,

74. See Donald M. Berwick, *Launching Accountable Care Organizations – The Proposed Rule for the Medicare Shared Savings Program*, 364 NEW ENG. J. MED. 1, 2 (2011); Stephen M. Shortell et al., *How the Center for Medicare and Medicaid Innovation Should Test Accountable Care Organizations*, 29 HEALTH AFF. 1293, 1294 (2010). For the view that ACOs may replace private insurance in the private market, see Ezekiel K. Emanuel & Jeffrey B. Liebman, *The End of Health Insurance*, N.Y. TIMES (Jan. 30, 2012), <http://opinionator.blogs.nytimes.com/2012/01/30/the-end-of-health-insurance-companies/>.

perhaps setting in motion changes in provider organizations and in beneficiary expectations that will permit market forces to assume the pivotal role in controlling costs.