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MEDICARE: WHAT ARE THE REAL PROBLEMS? WHAT CONTRIBUTION CAN LAW MAKE TO REAL SOLUTIONS?

TIMOTHY STOLTZFUS JOST*

In certain circles it is popular to present Medicare as a problem. The Report of the Trustees of the Medicare Trust Fund, for example, is regularly full of gloom and doom.¹ The 2007 Medicare Trust Fund Report predicts:

The projected date of HI [Hospital Insurance] Trust Fund exhaustion is 2019, one year later than in last year's report, when tax income will be sufficient to pay only 79 percent of HI costs. HI tax income falls short of outlays in this and all future years. The program could be brought into actuarial balance over the next 75 years by an immediate 122 percent increase in the payroll tax, or an immediate 51 percent reduction in program outlays or some combination of the two.²

Pro-market advocacy groups, such as the Heritage Foundation and the Cato Institute, argue that the Medicare program in its current form is "unsustainable" and must be changed, preferably through the use of

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1. See, e.g., BD. OF TRS. OF THE FED. OLD-AGE & SURVIVORS INS. & FED. DISABILITY INS. TRUST FUNDS, STATUS OF THE SOCIAL SECURITY AND MEDICARE PROGRAMS: A SUMMARY OF THE 2007 ANNUAL SOCIAL SECURITY AND MEDICARE TRUST FUND REPORTS (2007), available at www.ssa.gov/OACT/TRSUM/tr07summary.pdf (last visited Oct. 12, 2007) [hereinafter 2007 TRUST FUND REPORTS SUMMARY]. Although the name of this body suggests neutral and dispassionate fiscal analysis, four of the six Trustees are political appointees of the President of the United States: the Secretary of the Treasury, the Secretary of Labor, the Secretary of Health and Human Services, and the Commissioner of Social Security. *Id.* at 1. One of the two public Trustees, Thomas R. Saving, is one of the most radical academic critics of social insurance in the United States. His views are exemplified in *MEDICARE REFORM: ISSUES AND ANSWERS* (Andrew J. Rettenmaier & Thomas R. Saving eds., The University of Chicago Press 1999). In the late 1990s, Saving received \$431,230 in Medicare Reform Grants from the Lynde & Harry Bradley Foundation, one of the nation's most influential right-wing advocacy foundations. Thomas R. Saving, Resume, at <http://econweb.tamu.edu/saving/saving%20resume.htm> (last visited Oct. 8, 2007); Media Transparency, The Lynde and Harry Bradley Foundation, Inc., at www.mediatransparency.org/funderprofile.php?funderID=1 (last visited Oct. 8, 2007).

2. 2007 TRUST FUND REPORTS SUMMARY, *supra* note 1, at A MESSAGE TO THE PUBLIC, MEDICARE.

“market” solutions.³ Health law scholar David Hyman has written a book (published by the Cato Institute) contending that Medicare embodies the seven deadly sins and undermines the cardinal virtues.⁴

It is important, nevertheless, to remember that, for most of its constituencies, Medicare is not a problem but rather the solution to a problem. Medicare continues to be popular with beneficiaries and, indeed, with the American public generally.⁵ It provides greater freedom of choice than virtually any private insurer as well as reasonably good coverage, particularly for hospital and physician services.⁶ Healthcare professionals and providers have done quite well financially under the Medicare program in its current form, which offers payment levels close to those offered by private insurers, pays more quickly than most private insurers, and almost never second-guesses treatment decisions.⁷ Moreover, Medicare is a real, although often largely invisible, boon to the families of the elderly and disabled. For example, my life would be quite different if I would have had to spend the past two decades worrying about the medical expenses of my parents while they were still alive and of my mother-in-law who is now well into her nineties.

When viewed from a larger public policy perspective, however, Medicare does present a problem; indeed, it presents several. First, Medicare is a program with many coverage gaps and comparatively high

3. See J.D. Foster, *The Social Security and Medicare Trustees Report Again—and Again Problems Have Worsened*, WEB MEMO (The Heritage Found. Wash., D.C.), Apr. 24, 2007, at 1, 3, available at www.heritage.org/Research/Budget/upload/wm_1430.pdf (last visited Aug. 31, 2007); Cato Institute, *Health Care: Medicare* (2007), at www.cato.org/healthcare/medicare.html (last visited Aug. 31, 2007).

4. DAVID A. HYMAN, *MEDICARE MEETS MEPHISTOPHELES* (2006).

5. Jill Bernstein & Rosemary A. Stevens, *Public Opinion, Knowledge, and Medicare Reform*, 18 HEALTH AFF. 180, 181 (1999) (stating that three-quarters of Americans believe that Medicare is “important to their own families”).

6. Traditional Medicare, unlike most private managed care plans, offers free choice of provider. See 42 U.S.C. § 1395a (2000). Of physicians surveyed in 2006 for the Medicare Payment Advisory Commission (MedPAC), only 3.3% claimed they were not accepting new Medicare patients, whereas 13.7% claimed they were not accepting any new private health maintenance organization (HMO) patients. MEDICARE PAYMENT ADVISORY COMM’N, REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY 104 (Mar. 2007), available at www.medpac.gov/documents/Mar07_EntireReport.pdf (last visited Oct. 12, 2007) [hereinafter MEDICARE PAYMENT POLICY].

7. In 2005, the last year for which data is available, Medicare physician payment rates were equivalent to approximately 83% of private insurance rates. MEDICARE PAYMENT POLICY, *supra* note 6, at 97. Physicians, however, were more likely to report that they were “not very concerned” or “not at all concerned” about billing and paperwork or timeliness of payments with respect to Medicare than with respect to private commercial or Medicaid patients. *Id.* at 105, 110. The number of physicians and hospitals accepting Medicare patients is increasing steadily. *Id.* at 53, 108.

cost-sharing. Although some of the biggest gaps in the program, including lack of coverage for prescription drugs and preventive care, have been partially plugged in recent years, the program still fails to cover chronic, long-term nursing home care and dental and vision care, has high coinsurance levels on the Part B side, and lacks a catastrophic benefit.⁸ Medicare still covers only about 45% of the total healthcare costs of beneficiaries.⁹ Those who have good Medicare Advantage, retiree, Medicaid, or Medigap coverage are less burdened by cost-sharing. But, those who do not qualify for or cannot afford these forms of gap coverage, often the group least capable of paying the excess cost, disproportionately bear the burden of cost-sharing in terms of proportion of income spent on healthcare.¹⁰

Second, Medicare's methods of paying for services are problematic. Medicare pays for services through administered price systems or through managed care programs.¹¹ As other articles in this Symposium demonstrate, the Medicare Advantage program costs much more than traditional Medicare while offering few off-setting advantages.¹² Indeed, the Medicare Advantage Program is best understood either as the product of a naive blind faith or as a response to aggressive and well-funded lobbying by the health insurance industry.¹³ Administered price systems, on the other

8. THE HENRY J. KAISER FAMILY FOUND., *MEDICARE: MEDICARE AT A GLANCE* 1 (Feb. 2007), available at www.kff.org/medicare/upload/1066-10.pdf (last visited Aug. 31, 2007) [hereinafter KAISER FAMILY FOUNDATION, *MEDICARE AT A GLANCE*]; see Susan Adler Channick, *The Ongoing Debate Over Medicare: Understanding the Philosophical and Policy Divides*, 36 J. HEALTH L. 59, 73-75 (2003) (discussing the failed Medicare Catastrophic Coverage Act).

9. KAISER FAMILY FOUNDATION, *MEDICARE AT A GLANCE*, *supra* note 8, at 2.

10. See MEDICARE PAYMENT ADVISORY COMM'N, *REPORT TO THE CONGRESS: NEW APPROACHES IN MEDICARE* 199 (June 2004), available at www.medpac.gov/documents/June04_Entire_Report.pdf (last visited Oct. 12, 2007) [hereinafter NEW APPROACHES IN MEDICARE]; Thomas Rice & Katherine A. Desmond, *The Distributional Consequences of a Medicare Premium Support Proposal*, 29 J. HEALTH POL. POL'Y & L. 1187, 1213-14 (2004).

11. TIMOTHY S. JOST & SHARON L. DAVIES, *THE LAW OF MEDICARE AND MEDICAID FRAUD AND ABUSE* 7 (3d ed. 2002); Channick, *supra* note 8, at 66.

12. See Robert A. Berenson & Melissa A. Goldstein, *Will Medicare Wither on the Vine? How Congress Has Advantaged Medicare Advantage—and What's a Level Playing Field Anyway?*, 1 ST. LOUIS U. J. HEALTH L. & POL'Y 5, 5 (2007); Timothy D. McBride, *Medicare Advantage: What are We Trying to Achieve Anyway?*, 1 ST. LOUIS U. J. HEALTH L. & POL'Y (forthcoming May 2008).

13. See Alain C. Enthoven & Sara J. Singer, *Market-Based Reform: What to Regulate and by Whom*, 14 HEALTH AFF. 105, 106 (1995) (“[M]arket forces in health care if left unchecked can produce undesirable results.”). In 2006, the health sector (doctors, drug companies, and hospitals, among other groups) spent \$351.1 million on lobbying the federal government (13.8% of total spending on lobbying across all sectors). Robert Steinbrook, *Election 2008—Campaign Contributions, Lobbying, and the U.S. Health Sector*, 357 NEW ENG. J. MED. 736, 738 (2007); see also Steven H. Landers & Ashwini R. Sehgal, *Health Care Lobbying in the*

hand, also present problems. Underservice results when Medicare pays too little or does not pay at all (e.g., Medicare generally does not pay for the time involved in email or telephone communications between doctors and patients, thus such communications rarely occur).¹⁴ When Medicare pays too much, market distortions arise. For example, overpayment for certain procedures has contributed to the increase in physician-owned specialty hospitals, such as those specializing in cardiac services.¹⁵ Fraud and abuse seem to follow both overpayment and underpayment.¹⁶

The biggest problem with Medicare, according to the consensus of opinions, is that the program is unsustainable in the long-term as currently funded.¹⁷ While the Medicare Trust Fund Report must be recognized as a political statement, it also reflects the reality that the cost of Medicare will continue to increase dramatically in the future. Moreover, the problematic nature of the Medicare program's fiscal situation is accepted not just by right-wing advocacy groups, but also by the Comptroller General of the United States and centrist think tanks.¹⁸

United States, 116 AM. J. MED. 474 (2004) (using Lobbying Disclosure Act reports to assess healthcare lobbying at the federal level).

14. Robert A. Berenson & Jane Horvath, *Confronting the Barriers to Chronic Care Management in Medicare*, 2003 HEALTH AFF. (WEB EXCL.) w3-37, w3-40, available at <http://content.healthaffairs.org/cgi/reprint/hlthaff.w3.37v1> (last visited Aug. 31, 2007). Paying for these services appropriately, however, is very difficult. Cf. *id.* at w3-39 to -40 (noting that physicians will suffer financially when telephone and email communications are non-reimbursable, therefore threatening to freeze "innovation in how clinical care is practiced").

15. See Jack Hadley & Stephen Zuckerman, *Physician-Owned Specialty Hospitals: A Market Signal for Medicare Payment Revisions*, 2005 HEALTH AFF. (WEB EXCL.) w5-491, available at <http://content.healthaffairs.org/cgi/reprint/hlthaff.w5.491v1> (last visited Oct. 9, 2007).

16. JOST & DAVIES, *supra* note 11, at 8-12; see also Elizabeth A. Weeks, *Gauging the Cost of Loopholes: Health Care Pricing and Medicare Regulation in the Post-Enron Era*, 40 WAKE FOREST L. REV. 1215 (2005) (discussing the role of Medicare payment incentives in stimulating fraud and abuse).

17. See Foster, *supra* note 3, at 1, 3.

18. See Medicare: Comptroller General Walker Warns About Increasing Medicare, Social Security Costs on 'Fiscal Wakeup Tour', KAISER DAILY HEALTH POLICY REPORT (The Henry J. Kaiser Family Found., Menlo Park, CA), June 1, 2007, at www.kaisernetwork.org/daily_reports/rep_index.cfm?hint=3&DR_ID=45293 (last visited Aug. 31, 2007); see also Joseph White, *Protecting Medicare: The Best Defense is a Good Offense*, 32 J. HEALTH POL. POL'Y & L. 221, 221-22 (2007) (noting that the challenge to Medicare comes not just from the right-wing, which has long opposed the program, but also from centrists who are legitimately concerned about Medicare's long-term fiscal viability).

Medicare was created as a social insurance program.¹⁹ Part A,²⁰ which covers inpatient hospital care and other institutional services, is funded through employer and employee payroll taxes, just like Social Security and European social insurance programs.²¹ Parts B²² and D²³ are funded by a mixture of general revenue funds and beneficiary premiums.²⁴ In 2006, funding was approximately 76% general revenue and 21% premiums.²⁵ All of this income is put into trust funds out of which payments for Parts A, B, and D services are made.²⁶

As the population ages; as the baby boomers have moved through youth and middle age and are now approaching retirement; as Congress uses the trust funds to finance chronic deficit spending and tax cuts;²⁷ and, most importantly, as the cost of healthcare continues to grow at a rate far in excess of the rate of general inflation (reflecting price and utilization increases as well as changes in the nature of healthcare and of disease), two concerns become obvious. First, the cost of the Medicare program as a proportion of the gross domestic product will continue to grow; and, second, funding Medicare as it was funded in the past will be impossible.²⁸

Too much can be, and usually is, made of these problems. In fact, the Medicare program will not go bankrupt and shut down. Medicare is an

19. TIMOTHY S. JOST, *DISSENTLEMENT? THE THREATS FACING OUR PUBLIC HEALTH-CARE PROGRAMS AND A RIGHTS-BASED RESPONSE* 63-64 (2003) (discussing the historical foundations of the Medicare Program).

20. 42 U.S.C. §§ 1395c to i-5 (2000).

21. 2007 TRUST FUND REPORTS SUMMARY, *supra* note 1, at 2; JOST, *supra* note 19, at 50-51, 71-72, 85.

22. 42 U.S.C. §§ 1395j to w-4.

23. *Id.* §§ 1395w-101 to w-152 (Supp. IV 2004).

24. See 2007 TRUST FUND REPORTS SUMMARY, *supra* note 1, at 1. Part C, the Medicare Advantage program, covers Part A and B services through managed care. These services are funded in the same way that Part A and B services would otherwise be funded. See Medicare Information Service, Medicare Part C, at www.medicare.org/content/view/17/51 (last visited Sept. 4, 2007).

25. See 2007 TRUST FUND REPORTS SUMMARY, *supra* note 1, at 3; JENNIFER O'SULLIVAN, CONGRESSIONAL RESEARCH SERVICE, *MEDICARE: PART B PREMIUMS* CRS-3-CRS-4 (Sept. 2004).

26. The Hospital Insurance (HI) Trust Fund pays for Part A services. The Supplemental Medical Insurance (SMI) Trust Fund pays for both Part B and Part D services. 2007 TRUST FUND REPORTS SUMMARY, *supra* note 1, at 1.

27. See Channick, *supra* note 8, at 59-60, 67.

28. 2007 TRUST FUND REPORTS SUMMARY, *supra* note 1, at A MESSAGE TO THE PUBLIC, MEDICARE; Channick, *supra* note 8, at 62. On the relationship between the Medicare Trust Funds and the Federal budget, see OFFICE OF ECONOMIC POLICY, U.S. DEP'T OF THE TREASURY, *SOCIAL SECURITY AND MEDICARE TRUST FUNDS AND THE FEDERAL BUDGET: AN EXPANDED EXPOSITION* (Mar. 2004), available at www.treas.gov/offices/economic-policy/reports/budget_trust_fund_3_23.pdf (last visited Aug. 31, 2007).

entitlement under federal law²⁹ and will continue to pay its beneficiaries' bills until Congress repeals or amends the law, regardless of the balance of the trust funds.³⁰ Moreover, one must take seventy-year cost projections, common in political discussions about Medicare,³¹ with a grain of salt.³² To see why, consider that over the past five years housing prices in Los Angeles (L.A.) have increased 116%.³³ The median home price in L.A. is currently \$575,000.³⁴ If one simply projects forward a compounded appreciation in the value of housing at this rate for seventy years, the median home in L.A. will cost \$49 billion. The conclusion drawn from this projection using the same analysis often applied to Medicare is clear—every homeowner in L.A. should sell now before housing becomes unaffordable.

From the perspective of the sober policy (or financial) analyst, however, two things seem relatively clear. First, housing costs are unlikely to continue to increase to the point where housing becomes completely unaffordable. In fact, housing price increases in L.A. have recently begun to stabilize.³⁵ (Similarly, healthcare price increases have stabilized in most other developed countries over the past two decades in comparison to price growth in the United States.)³⁶ Second, if housing costs do continue to increase, we will find a way to deal with the higher costs. For one thing, incomes will continue to grow, and, while housing might consume a larger proportion of income as it now does in many other countries,³⁷ it will still be affordable. We may also eventually start using one-hundred-year, inter-

29. 42 U.S.C. §§ 426, 426-1(a), 1395c (2000).

30. See 42 U.S.C. §§ 426, 1395d, 1395k, which establishes Medicare entitlements without conditioning them on a particular funding source. The word entitlement occurs over 100 times in Title XVIII of the Social Security Act (which creates the Medicare program) and refers to the rights of beneficiaries and sometimes providers. See JOST, *supra* note 19, at 31.

31. See, e.g., 2007 TRUST FUND REPORTS SUMMARY, *supra* note 1, at A MESSAGE TO THE PUBLIC, MEDICARE.

32. *What is the Role of the Federal Medicare Actuary?*, ISSUE BRIEF (Amer. Acad. of Actuaries, Wash. D.C.), Jan. 2002, at 3, available at http://actuary.org/pdf/medicare/medicare_actuary_jan02.pdf (last visited Sept. 1, 2007) ("Seventy-five-year projections based on a large number of demographic and economic variables should be regarded with caution.").

33. MSN Money Staff, *Home Prices by City*, MSN MONEY, Aug. 30, 2007, at <http://articles.moneycentral.msn.com/Banking/HomebuyingGuide/HomePricesByCity.aspx> (last visited Sept. 5, 2007).

34. HousingTracker.net, *Los Angeles, California*, June 1, 2007, at www.housingtracker.net/old_housingtracker/location/California/LosAngeles (last visited Sept. 5, 2007).

35. See *id.*

36. Chapin White, *Health Care Spending Growth: How Different is the United States from the Rest of the OECD?*, 26 HEALTH AFF. 154, 156 (2007).

37. See U.N. DEP'T. OF ECON. & SOC. AFF., STATISTICAL YEARBOOK at 201-205 tbl.22, U.N. Doc. ST/ESA/STAT/SER.S/26, U.N. Sales No. E/F.06.XVII.1 (50th ed. 2006).

generational mortgages, as do homeowners in Switzerland and Japan,³⁸ but we will, nevertheless, develop solutions to the problem. We will not see everyone sleeping in the streets while houses sit empty because no one can afford them.

We will also solve the problem of financing Medicare. But how? A number of possible approaches currently are being discussed. First, more of the costs could be shifted onto beneficiaries by increasing cost-sharing or decreasing benefits. Indeed, one of the core beliefs of the consumer-driven healthcare (CDHC) movement is that we need more cost-sharing across the board.³⁹ Increased cost-sharing, CDHC advocates contend, has many benefits. It makes healthcare purchasers more prudent shoppers, less likely to waste money on unnecessary care, and more likely to shop around for the best prices and even for the best quality care.⁴⁰ Some also argue that Medicare beneficiaries are quite wealthy compared to the working population and that they can and should be required to bear a greater share of the cost of their care.⁴¹

However, there are several problems with increasing Medicare cost-sharing. First, although some Medicare beneficiaries are in fact quite wealthy, most are not. Nearly half of all beneficiaries (approximately 47%) have incomes at 200% of the federal poverty level (FPL) or less.⁴² Less than one quarter have incomes exceeding 400% of the FPL.⁴³ In 2001, the median net worth of households headed by a person age sixty-five to seventy-four was \$176,000; however, on average, \$129,000 of that value was tied to equity in their primary residence.⁴⁴ Furthermore, as the head of the household gets older, this net worth declines.⁴⁵ On average, Medicare beneficiaries spend nearly 20% of their income on healthcare; although, the median beneficiary spends only 10%.⁴⁶ The beneficiaries who spend the most on healthcare, including older beneficiaries and those with chronic

38. James Daley, *The Mortgage Gift Your Kids Won't Thank You for*, THE INDEPENDENT (London), Aug. 26, 2006, Features at 3.

39. See MICHAEL F. CANNON & MICHAEL D. TANNER, HEALTHY COMPETITION: WHAT'S HOLDING BACK HEALTH CARE AND HOW TO FREE IT 46-54 (2005); JOHN C. GOODMAN & GERALD L. MUSGRAVE, PATIENT POWER: SOLVING AMERICA'S HEALTH CARE CRISIS 231-59 (Cato Institute 1992).

40. CANNON & TANNER, *supra* note 39, at 51-57; GOODMAN & MUSGRAVE, *supra* note 39, at 249-51.

41. See, e.g., David A. Hyman, *Medicare Meets Mephistopheles*, 60 WASH. & LEE L. REV. 1165, 1175 (2003).

42. NEW APPROACHES IN MEDICARE, *supra* note 10, at 199.

43. *Id.*

44. *Id.* at 196.

45. *Id.* (noting that for households headed by a person aged seventy-five or older, median net worth declined to \$151,000).

46. *Id.* at 197.

medical conditions, tend to have lower than average incomes and resources. Statistics illustrating these facts show that beneficiaries with incomes below the federal poverty line spend nearly 45% of their income on healthcare; beneficiaries aged eighty-five years and older spend over 30%; and beneficiaries in poor health spend almost 30%.⁴⁷ Medicare currently only covers about 45% of the total healthcare costs of its beneficiaries,⁴⁸ and many beneficiaries have a limited financial margin to cover additional costs.

Second, shifting more costs to Medicare beneficiaries may not, in fact, improve efficiency. Empirical arguments for cost-sharing are usually based on the findings of the Rand Health Insurance Experiment (HIE) from the 1970s and 80s.⁴⁹ The HIE, however, intentionally excluded persons over age sixty-two and the disabled, and, thus, cannot tell us exactly how those groups would respond to higher cost-sharing.⁵⁰ Although the experiment found that, in general, persons who face higher cost-sharing spend less, it also found that they spend less on essential care to the same extent that they spend less on nonessential care.⁵¹ Moreover, although the experiment found that participants generally did not suffer adverse health consequences when they spent less on healthcare, it did find some adverse health consequences for the poor and persons with chronic diseases.⁵² Subsequent studies, particularly of pharmaceutical cost-sharing, have shown that increased cost-sharing can, in fact, contribute to serious health problems.⁵³ Finally, increasing Medicare cost-sharing will certainly result in both higher Medicaid expenditures (as Medicaid usually covers cost-sharing costs for dual eligibles)⁵⁴ and higher Medicare “bad debt” reimbursement to hospitals.⁵⁵

A second and related approach to solving the problem of financing Medicare is to means test, i.e., charge wealthier beneficiaries higher

47. NEW APPROACHES IN MEDICARE, *supra* note 10, at 198.

48. KAISER FAMILY FOUNDATION, MEDICARE AT A GLANCE, *supra* note 8.

49. See, e.g., JOSEPH P. NEWHOUSE ET AL., FREE FOR ALL? LESSONS FROM THE RAND HEALTH INSURANCE EXPERIMENT 341 (RAND 1993).

50. *Id.* at 11.

51. *Id.* at 162.

52. *Id.* at 201, 204, 208, 219, 243, 251, 259, and 339-40.

53. John Hsu et al., *Unintended Consequences of Caps on Medicare Drug Benefits*, 354 NEW ENG. J. MED. 2349, 2349 (2006); Robin Tamblyn et al., *Adverse Events Associated with Prescription Drug Cost-Sharing Among Poor and Elderly Persons*, 285 JAMA 421, 421 (2001).

54. See KAISER COMMISSION ON MEDICAID & THE UNINSURED, THE HENRY J. KAISER FAMILY FOUND., DUAL ELIGIBLES: MEDICAID'S ROLE FOR LOW-INCOME MEDICARE BENEFICIARIES (2005), available at [www.kff.org/medicaid/upload/4091-04%20Final\(v2\).pdf](http://www.kff.org/medicaid/upload/4091-04%20Final(v2).pdf) (last visited Sept. 28, 2007).

55. 42 C.F.R. § 413.89 (2007) (“[B]ad debts attributable to the deductibles and coinsurance amounts are reimbursable under the program.”).

premiums for program participation. Critics of the current program structure argue that millionaires should not be able to get Medicare coverage on the same terms as the poor.⁵⁶ The Medicare Modernization Act (MMA) took a step towards means-testing Medicare by increasing Part B premiums for individual beneficiaries who annually earn more than \$80,000 and couples who earn over \$160,000 beginning in 2007, with further increases to be phased in over the next five years.⁵⁷ The MMA also provided subsidies for low-income enrollees in the Part D drug program, effectively means-testing the Part D program since higher income beneficiaries receive less than those with lower incomes.⁵⁸

There are two primary problems with means testing as a strategy for saving Medicare. First, as has already been noted, most Medicare beneficiaries are not very wealthy. Therefore, increasing the premiums born by higher income beneficiaries is unlikely to make a substantial dent in the cost of the program. The increased premiums for wealthier beneficiaries built into the MMA are projected to yield about \$2 billion a year, which is only about one-half of 1% of program cost.⁵⁹ Second, if premium costs for higher income beneficiaries become high enough, a market is likely to develop for private health insurance for seniors, allowing wealthier and healthier beneficiaries to opt out of Medicare.⁶⁰ Thus, Medicare will be left with a more costly group of beneficiaries and, most likely, with weakened political support.⁶¹ Wealthy Medicare beneficiaries should, of course, contribute to the cost of the program. However, they should do so as taxpayers, not as premium payers.

A third proposal to “save Medicare” that has been around for a long time is to turn Medicare into a managed competition program similar to the Federal Employees Health Benefits Program, in the hope that competition will bring down costs.⁶² This was the goal of the Medicare+Choice

56. See, e.g., Stuart M. Butler, *Time is Running Out for Medicare Reform*, THE HERITAGE FOUND., Apr. 30, 1997, at www.heritage.org/Research/HealthCare/BG1112.cfm (last visited Sept. 28, 2007).

57. 42 U.S.C. § 1395r(i) (Supp. III 2003); see also O’SULLIVAN, *supra* note 25, at CRS-7–CRS-8.

58. 42 U.S.C. § 1395w-114.

59. Mark V. Pauly, *Means-Testing in Medicare*, 2004 HEALTH AFF. (WEB EXCL.) w4-546, w4-547, available at <http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.546v1.pdf> (last visited Sept. 28, 2007).

60. See Theodore R. Marmor & Jerry L. Mashaw, *Understanding Social Insurance: Fairness, Affordability, and the ‘Modernization’ of Social Security and Medicare*, 2006 HEALTH AFF. (WEB EXCL.) w114, w131; Robert Pear, *Medicare Costs to Increase for Wealthier Beneficiaries*, N.Y. TIMES, Sept. 11, 2006, at A10.

61. See Marmor & Mashaw, *supra* note 60.

62. See *Medicare Reform and Competition: Separating Fact from Fiction: Hearing Before the S. Spec. Comm. on Aging*, 108th Cong. 72 (2003) (statement of Joseph R. Antos,

program when it was established in 1997 and is the goal of the Medicare Advantage program today.⁶³ As other articles in this Symposium establish, however, there is no evidence that Medicare Advantage is saving or can save money for Medicare.⁶⁴ Indeed, Medicare Advantage is increasing program expenses.⁶⁵ There may be reasons for having a Medicare managed care program, but saving money is not one of them.

Another proposal put forth from time to time is to reduce costs by slowing Medicare's adoption of new technologies.⁶⁶ There is a good deal of comparative data that indicates that one of the reasons why the United States has the most costly healthcare system in the world is because we adopt new medical technologies sooner, disseminate them more quickly and broadly, and use them more frequently than most other countries.⁶⁷

Currently, Medicare does assess new technologies for coverage, but assessment is limited mainly to procedures and devices covered by Part B.⁶⁸ Part A providers are paid on a prospective payment basis and make their own judgments as to technology acquisition based on the funding that they have available.⁶⁹ Part D drug plans are also free to make their own coverage decisions as long as basic categories and classes of drugs are covered.⁷⁰

Although new technologies generally add rather than save costs, they also often add considerable value.⁷¹ Therefore, any strategy aimed at cutting Medicare costs by limiting access to technology must consider how much we would be losing in potential enhanced value. Controlling technology adoption, moreover, is very difficult politically. An eight nation

American Enterprise Institute); Stuart M. Butler & Robert E. Moffit, *The FEHBP as a Model for a New Medicare Program*, 14 HEALTH AFF. 47, 55-56 (1995).

63. See Brian Biles et al., *Medicare Advantage: Déjà Vu All Over Again*, 2004 HEALTH AFF. (WEB EXCL.) w4-586, w4-595, available at <http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.586v1.pdf> (last visited Sept. 28, 2007).

64. Berenson & Goldstein, *supra* note 12, at 5-12; McBride, *supra* note 12.

65. Biles et al., *supra* note 63.

66. See Mark V. Pauly, *What if Technology Never Stops Improving? Medicare's Future Under Continuous Cost Increases*, 60 WASH. & LEE L. REV. 1233, 1242 (2003).

67. See TIMOTHY S. JOST, HEALTH CARE AT RISK: A CRITIQUE OF THE CONSUMER-DRIVEN MOVEMENT 176 (2007).

68. See Timothy S. Jost, *The Medicare Coverage Determination Process in the United States*, in HEALTH CARE COVERAGE DETERMINATIONS 207, 211 (Timothy S. Jost ed., 2005).

69. *Id.*

70. 42 U.S.C. § 1395w-104(b)(3) (Supp. III 2003); see also JACK HOADLEY ET AL., THE HENRY J. KAISER FAMILY FOUND., THE MEDICARE DRUG BENEFIT: AN IN-DEPTH EXAMINATION OF FORMULARIES AND OTHER FEATURES OF MEDICARE DRUG PLANS, at i, 1 (2006), available at www.kff.org/medicare/upload/7489.pdf (last visited Sept. 28, 2007).

71. DAVID M. CUTLER, YOUR MONEY OR YOUR LIFE: STRONG MEDICINE FOR AMERICA'S HEALTH CARE SYSTEM 73, 75 (2004).

study of public-insurance program technology-coverage policies concluded that most other developed countries do not even try to apply cost-benefit analysis in deciding whether or not to cover technologies in their public programs, but instead only assess effectiveness.⁷² In most instances, moreover, technology advocates, be they technology sponsors, providers looking for new tools, or patients hoping for new cures, overwhelm those who try to hold the line on program costs in coverage proceedings.⁷³

Technology manufacturers are unlikely to give up the largest health insurance market in the United States without a fight.⁷⁴ It is also hard to believe that Medicare beneficiaries would be willing to settle for second-class medical care. Hospitals will, in all likelihood, continue to purchase new technologies based on their own judgments of whether or not they are valuable, and once hospitals acquire such technologies it will be difficult to deny Medicare beneficiaries access to them. Doctors will also worry that they will be held to the evolving standard of care of their profession, despite what Medicare may decide to pay for, and will do what they can politically to assure Medicare coverage.⁷⁵ Thus, thinking that technology assessment alone will save Medicare is unrealistic.

In the end, I believe three approaches show the most promise for addressing the increased costs of Medicare; although, none of them offer a magic bullet and all will be difficult to implement. First, and probably most importantly, we will need to raise taxes. We have chosen, I believe wisely, to finance healthcare for the elderly and disabled through a public program. Since Medicare began in the 1960s, an ever greater percentage of our population has become elderly and disabled.⁷⁶ Over the next couple of decades this percentage will continue to grow.⁷⁷ Thus, even if healthcare costs were not increasing at a rate in excess of general inflation, we would be paying more for healthcare costs from public funds because an ever

72. See Timothy S. Jost, *What Can We Learn From Our Country Studies?*, in *HEALTH CARE COVERAGE DETERMINATIONS* 236, 251 (Timothy S. Jost ed., 2005).

73. See *id.* at 259-60.

74. See *id.* at 229-30 (describing the participation of technology proponents in the current system).

75. See Miriam J. Laugesen & Thomas Rice, *Is the Doctor in? The Revolving Role of Organized Medicine in Health Policy*, 28 *J. HEALTH POL. POL'Y & L.* 289, 300 (2003).

76. In 1965, 9.5% of the U.S. population was over age sixty-five. U.S. CENSUS BUREAU, TABLE HS-3, POPULATION BY AGE: 1900 - 2002, available at www.census.gov/statab/hist/HS-03.pdf (last visited Sept. 29, 2007). In 2005, this age group made up 12.4% of the population. ADMINISTRATION ON AGING, STATISTICS ON THE AGING POPULATION, at www.aoa.gov/prof/Statistics/statistics.asp (last visited Sept. 29, 2007).

77. It is estimated that by 2030 the number of persons over age sixty-five in the United States will double and constitute 20% of the population. ADMINISTRATION ON AGING, *supra* note 76.

greater percentage of the population will be above age sixty-five, and, therefore, covered by public insurance. But, at the same time, the proportion of GDP spent on healthcare is rising in the United States.⁷⁸ In other words, we are increasing the percentage of public funds used to pay for the increasing percentage of GDP spent on healthcare, and we are foolish to think we can do so without increasing public revenues.

How we increase public revenues is vitally important. It might have made sense in 1965 to pay for Medicare from payroll taxes. Today, however, a greater percentage of our national income is received in forms other than wages,⁷⁹ and an ever greater share of our national income is going to an ever smaller proportion of the population.⁸⁰ It is unjust to finance Medicare with a regressive tax on wages because many poor workers would not otherwise even be paying taxes given that their incomes are so low.⁸¹ Over the past several years, a growing share of the program has been funded using general revenue; although, the MMA has tried to limit this growth.⁸² New program revenues, however, should come primarily

78. See White, *supra* note 36, at 157 tbl.2.

79. In 1965, employee compensation represented 71.9% of national personal income, but today it only represents 67.7%. Conversely, interest and dividends represented 10.7% of national personal income in 1965; today they represent 16.4%. See BUREAU OF ECON. ANALYSIS, U.S. DEP'T OF COMMERCE, NATIONAL INCOME AND PRODUCTS ACCOUNTS TABLE, TABLE 2.1: PERSONAL INCOME AND ITS DISPOSITION, www.bea.gov/National/nipaweb/TableView.asp?SelectedTable=58&FirstYear=2005&LastYear=2007&Freq=Qtr (Under "Data Table Options," choose "1965-Q & A" as "First Year" and "2006-Q & A" as "Last Year." Then click "Update").

80. See AVIVA ARON-DINE & ISAAC SHAPIRO, CTR. ON BUDGET & POL'Y PRIORITIES, NEW DATA SHOW EXTRAORDINARY JUMP IN INCOME CONCENTRATION IN 2004, 1 (2006), available at www.cbpp.org/7-10-06inc.pdf (last visited Sept. 29, 2007). Americans with the highest incomes have also benefited disproportionately from recent tax cuts and would benefit most from extension of those tax cuts. See AVIVA ARON-DINE, CTR. ON BUDGET AND POL'Y PRIORITIES, THE SKEWED BENEFITS OF THE TAX CUTS, 2008-2017, 2-4, available at www.cbpp.org/2-5-07tax.pdf (last visited Sept. 29, 2007).

81. Economists estimated that 121 million Americans would not have federal income tax liability in 2006, including 91 million people represented by 43.4 million filed income tax returns with zero or negative tax liability. SCOTT A. HODGE, TAX FOUND., NUMBER OF AMERICANS PAYING ZERO FEDERAL INCOME TAX GROWS TO 43.4 MILLION (2006), available at www.taxfoundation.org/files/ff54.pdf (last visited Sept. 29, 2007). All employed and self-employed persons, however, must pay the Medicare payroll tax.

82. Medicare Part A is funded by payroll taxes and Parts B and D are funded through premiums and general revenue funds. The Trustees' spending projections for 2007 are \$208 billion by the Part A (HI) Trust Fund and \$230 billion by the Parts B and D (SMI) Trust Fund. In 2016, the Trustees project, the Part A Trust Fund will spend \$385 billion and the SMI Trust Fund will spend \$478 billion. 2007 TRUST FUND REPORTS SUMMARY, *supra* note 1, at 5 tbl. "Estimated Operations of Trust Funds". The Trustees project that general revenue contributions to Medicare will rise from 1.3% of the GDP in 2007 to 4.7% in 2081, while payroll tax contributions will remain stable at 1.5% of GDP over that period. *Id.* at 9. The

from a progressive income tax, perhaps combined with a consumption tax if it can be designed to be non-regressive.

Of course no one likes taxes. While they do impose a burden on the economy, the proportion of GDP spent on taxes in the United States is still lower than in most developed countries.⁸³ At the high end, income tax rates are lower now than they were for most of the last century,⁸⁴ a century that saw unprecedented economic growth.⁸⁵ Even if Americans pay more in income tax to finance healthcare, their incomes are still likely to continue to grow as they have over the past century, leaving an ever larger amount of discretionary income for non-health expenditures.⁸⁶ Also, we must remember that more money spent on healthcare means more jobs in healthcare—already one of the strongest growing sectors of our economy.⁸⁷ In particular, healthcare sector growth means more domestic jobs, since it is harder to outsource healthcare provision than, say, textiles or automobile production. Additionally, more money spent on healthcare, including

MMA requires the Trustees of the Medicare Trust Funds to project each year whether during that year or any of the six succeeding years the proportion of Medicare expenditures funded by general revenue funds (i.e., that part not covered by beneficiary premiums, Part A payroll taxes, or from other dedicated sources) is likely to exceed 45%. Medicare Prescription Drug, Improvement, and Modernization Act, Pub. L. No. 108-173 § 801, 117 Stat. 2066, 2357-60 (2003). If, for two years in a row, the Trustees project that this will happen during the succeeding six years, the President must present to Congress within fifteen days proposed legislation to eliminate the “excess general revenue funding” problem. The Senate and House will then handle the legislation under special rules and engage in very limited debate. *Id.* at §§ 802-804. The Trustees have found excess general revenue spending for 2006 and 2007, but no action has been taken by the President as of this writing.

83. Sonya Hoo & Eric Toder, *The U.S. Tax Burden is Low Relative to Other OECD Countries*, TAX NOTES (Tax Pol’y Ctr., Wash. D.C.), May 8, 2006, at 695, available at www.taxpolicycenter.org/UploadedPDF/1000976_Tax_Fact_05-08-06.pdf (last visited Sept. 29, 2007).

84. See TruthAndPolitics.org, Top U.S. Marginal Income Tax Rates, 1913–2003, at www.truthandpolitics.org/top-rates.php (last visited Sept. 29, 2007).

85. See, e.g., Robert J. Gordon, *U.S. Economic Growth Since 1870: One Big Wave?*, 89 AM. ECON. REV. 123 (1999).

86. Between 1970 and 2005 the proportion of the GDP spent on healthcare grew from 7.2% to 16%. Over the same period, however, the real GDP grew from \$3.7 trillion to \$11 trillion in constant dollars. Assuming healthcare costs will continue to increase in the future at rates in excess of inflation, it is reasonable to expect discretionary income to continue to increase as well. See Aaron Catlin et al., *National Health Spending in 2005: The Slowdown Continues*, 26 HEALTH AFF. 142, 143 tbl.1 (2007).

87. Between 2001 and 2006, the healthcare sector added 1.7 million jobs, while the rest of the private sector economy had zero job growth. Michael Mandel & Joseph Weber, *What’s Really Propping Up the Economy?*, BUS. WK., Sept. 25, 2006, at 54, available at www.businessweek.com/magazine/content/06_39/b4002001.htm (last visited Oct. 13, 2007).

Medicare, will result in more money collected in taxes; although, of course, the Medicare program will not be self-financing.

A second strategy is to limit the growth of provider payments. One fact that clearly emerges from comparative analysis is that the United States pays higher prices for healthcare than any other developed nation.⁸⁸ We consume about the same volume of drugs, hospital days, and physician visits as other countries, but we pay more for them.⁸⁹ If we could cut our payment levels to those found in France or Germany, or even Canada or Switzerland, we could cut Medicare costs dramatically.⁹⁰ Obviously how much and how fast Medicare can cut costs is limited. But in the long run, American healthcare professionals, providers, and drug companies will have to learn to live with incomes and profits more like those enjoyed by their counterparts in other developed countries.

Medicare has primarily controlled costs through, as noted above, administered prices. Beginning with its DRG (diagnosis-related group) prospective payment system in 1982, Medicare has developed a series of prospective payment systems now covering virtually all of the services for which Medicare pays.⁹¹ While these prospective payment systems can be used effectively to cut costs, as was done following the Balanced Budget Act of 1997,⁹² the cost-cutting goal has rarely been accomplished. The annual dance around the physician payment update, in which Congress invariably intervenes to raise prices paid to physicians even though physicians are already receiving higher incomes because of increased volume,⁹³ illustrates the serious difficulty inherent in cutting, or even controlling, payments to providers.

Medicare should use its prospective payment system more aggressively to slow down the growth of healthcare costs—it should actually deny physicians price increases if volume continues to increase dramatically. However, Medicare should also look to other purchasing approaches, as discussed later in this article.

A third strategy for achieving Medicare savings is to focus on improving the quality of treatment beneficiaries receive. A generation of work by Jack

88. Gerard F. Anderson et al., *It's the Prices, Stupid: Why the United States is so Different from Other Countries*, 22 HEALTH AFF. 89, 90 (2003).

89. *Id.* at 93-103.

90. *Id.* at 91 tbl.1.

91. See, e.g., 42 U.S.C. § 1395w-4 (2000) (payment for physician's services), § 1395ww (payment for inpatient hospital services), § 1395yy (payment for skilled nursing facility services for routine service costs). See generally, RICK MAYES & ROBERT A. BERENSON, *MEDICARE PROSPECTIVE PAYMENT AND THE SHAPING OF U.S. HEALTH CARE* (2006) (analyzing the history of Medicare prospective payment).

92. MAYES & BERENSON, *supra* note 91, at 115.

93. See *id.* at 142-45.

Wennberg and his associates has shown conclusively that the use of Medicare services varies dramatically from one geographic area to another in ways that have little to do with actual medical need.⁹⁴ In particular, Wennberg has identified dramatic variations in what he terms “supply-sensitive” services, i.e., services that tend to be provided in greater volume where the capacity to provide them is greater.⁹⁵ Patients with non-surgical medical conditions, for example, are more likely to be hospitalized in regions with more hospital beds, and Medicare enrollees are seen by cardiologists more often in areas with more cardiologists.⁹⁶ Supply-sensitive care accounts for a surprisingly high proportion of Medicare spending.⁹⁷ Most disconcerting, however, is the finding that some measures of quality, including mortality rates, may be worse in regions where supply-sensitive service use is higher.⁹⁸ This finding leads to the conclusion that excess spending is doing harm, not good.

At the same time that research has been demonstrating that a great deal of healthcare spending is on apparently unnecessary services, another body of research has shown that the nature of services provided to Medicare beneficiaries has been changing. We have long known that a high percentage of Medicare payments go to beneficiaries with chronic diseases and with disabilities that limit their daily living activities.⁹⁹ Nearly 80% of Medicare beneficiaries have at least one chronic disease,¹⁰⁰ and one-fifth of Medicare beneficiaries with five or more chronic conditions account for two-thirds of Medicare spending.¹⁰¹ There is evidence, however, that in recent years Medicare expenditures have grown most rapidly for beneficiaries who

94. John E. Wennberg et al., *Geography and the Debate Over Medicare Reform*, 2002 HEALTH AFF. (WEB EXCL.) w96-98, available at <http://content.healthaffairs.org/cgi/reprint/hlthaff.w2.96v1> (last visited Sept. 29, 2007).

95. *Id.* at w101-02.

96. THE DARTMOUTH ATLAS OF HEALTH CARE, SUPPLY-SENSITIVE CARE 2-3, available at www.dartmouthatlas.org/topics/supply_sensitive.pdf (last visited Oct. 13, 2007).

97. *Id.* at 1.

98. Elliott S. Fisher et al., *The Implications of Regional Variations in Medicare Spending. Part 2: Health Outcomes and Satisfaction With Care*, 138 ANNALS OF INTERNAL MED. 288, 291-93 (2003) (noting, however, that this conclusion “must be interpreted with caution”).

99. STUART GUTERMAN & MICHELLE P. SERBER, THE COMMONWEALTH FUND, ENHANCING VALUE IN MEDICARE: DEMONSTRATIONS AND OTHER INITIATIVES TO IMPROVE THE PROGRAM 3 (2007), available at www.commonwealthfund.org/usr_doc/990_Guterman_enhancing_value_Medicare.pdf?section=4039 (last visited Sept. 29, 2007).

100. Nora Super, *Medicare’s Chronic Care Improvement Pilot Program: What is Its Potential?*, NHPF ISSUE BRIEF (Nat’l Health Pol. Forum, Wash. D.C.), May 10, 2004, at 3, available at www.nhpf.org/pdfs_ib/IB797_ChronicCare.pdf (last visited Sept. 30, 2007).

101. GUTERMAN & SERBER, *supra* note 99, at 2 fig.3.

do not have serious diseases or functional limitations.¹⁰² Much of this cost is attributable to the management of metabolic disorders, such as high blood pressure or high cholesterol, which are not themselves symptomatic diseases.¹⁰³

In a number of recent articles, Kenneth Thorpe and associates contend that a major factor in the increase of Medicare expenditures is the rise in obesity among the elderly.¹⁰⁴ While, as just noted, chronic diseases are responsible for a significant proportion of Medicare costs, these costs are to some extent self-limiting. That is, people with chronic diseases tend to die earlier; although their medical care costs more per year, they live fewer years.¹⁰⁵ On the other hand, healthy people live longer; although their medical care costs less per year, their expenses accrue for more years.¹⁰⁶ In the end, all beneficiaries die, and dying is usually expensive.¹⁰⁷

However, obese people, who often suffer from diabetes and hypertension among other conditions, not only need high cost medical care on a continual basis, but they also tend to live as long, probably even longer, than persons of normal weight.¹⁰⁸ On the other hand, they tend to spend more years with disabilities limiting their daily activities.¹⁰⁹ Thus, over a lifetime, they are very expensive to care for. The proportion of Medicare beneficiaries who are obese has been growing rapidly in recent years, a fact

102. Kenneth E. Thorpe & David H. Howard, *The Rise in Spending Among Medicare Beneficiaries: The Role of Chronic Disease Prevalence and Changes in Treatment Intensity*, 2006 HEALTH AFF. (WEB EXCL.) w378, w382-83, available at <http://content.healthaffairs.org/cgi/reprint/25/5/w378> (last visited Sept. 29, 2007).

103. See *id.* at w380; see also, Kenneth E. Thorpe et al., *The Impact of Obesity on Rising Medical Spending*, 2004 HEALTH AFF. (WEB EXCL.) w4-480, available at <http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.480v1> (last visited Oct. 1, 2007) (an earlier report by Thorpe and colleagues on the impact of obesity on healthcare costs generally); Darius N. Lakdawalla et al., *The Health and Cost Consequences of Obesity Among the Future Elderly*, 2005 HEALTH AFF. (WEB EXCL.) w5-R30 (a similar report from a RAND research group).

104. See, e.g., Thorpe & Howard, *supra* note 102, at w381-82.

105. Geoffrey F. Joyce et al., *The Lifetime Burden of Chronic Disease Among the Elderly*, 2005 HEALTH AFF. (WEB EXCL.) W5-R18, W5-R27, available at <http://content.healthaffairs.org/cgi/reprint/hlthaff.w5.r18v1> (last visited Oct. 1, 2007); James Lubitz et al., *Health, Life Expectancy, and Health Care Spending Among the Elderly*, 349 NEW ENG. J. MED. 1048, 1052-54 (2003) (discussing the relationship between age, health, and health expenditures).

106. Lubitz et al., *supra* note 105, at 1054.

107. However, death at an older age may be less costly. See Donald Reed House, *The Cost of Dying on Medicare: An Analysis of Expenditure Data 182* (Aug. 2005) (unpublished Ph.D. dissertation, Texas A&M University), available at <http://txspace.tamu.edu/bitstream/1969.1/2559/1/etd-tamu-2005B-ECON-House.pdf> (last visited Sept. 30, 2007).

108. "Overweight" people aged seventy years tend to live the longest, followed by the obese, normal weight, and underweight persons aged seventy years, in that order. Lakdawalla et al., *supra* note 103, at w5-R35.

109. *Id.*

that may account for a considerable share of recent increases in Medicare costs.¹¹⁰

One way to respond to the increase in obesity is to focus on better public health education for beneficiaries.¹¹¹ As is true with many of the rest of us (or, in any event, me), many Medicare beneficiaries need to eat less and exercise more. But changing lifestyles is very difficult at any age, and is unlikely to be easier for the elderly.

In addition to focusing on improving beneficiaries' health as a way to reduce costs, Medicare reform must also target the behavior of providers to assure that services are provided as appropriately, effectively, and efficiently as possible so that the number and intensity of Medicare services do not exceed the care level beneficiaries actually need. Controlling the growth in provider payments; decreasing the frequency of the provision of unnecessary, inappropriate, or ineffective services; and providing more appropriate care for chronic diseases and metabolic disorders are all components of the effort to improve value purchasing within Medicare.¹¹² A number of private sector programs and public demonstration projects are currently attempting to improve value purchasing, for example, through better chronic care and disease management or by paying for performance.¹¹³ Competitive purchasing programs also hold the promise of allowing Medicare to focus on value, i.e., higher quality at a lower price, in purchasing.¹¹⁴ Finally, fee-for-service Medicare might benefit from using traditional managed care tools—using limited networks of providers or tiered networks, or pre-procedure or admission review processes, for example, to maximize the value of purchased care.¹¹⁵

There are three problems with implementing the value purchasing approach to saving Medicare. First, we are not very good at it yet. For

110. See Thorpe & Howard, *supra* note 102, at w382.

111. See, e.g., RAND CORP., *FUTURE HEALTH AND MEDICAL CARE SPENDING AMONG THE ELDERLY: IMPLICATIONS FOR MEDICARE 5* (2005), available at www.rand.org/pubs/research_briefs/RB9146-1/RAND_RB9146-1.pdf (last visited Sept. 30, 2007) (noting that prevention and screening for chronic conditions could be effective public health measures).

112. See MILBANK MEMORIAL FUND, *VALUE PURCHASERS IN HEALTH CARE: SEVEN CASE STUDIES 2* (2001), available at www.milbank.org/reports/2001ValuePurchasers/ValuePurchasers_Mech.pdf (last visited Sept. 30, 2007) (defining value purchasing as “an organized attempt by a private- or public-sector purchaser to ensure quality and to improve health outcomes, as well as negotiating prices, as an explicit part of its health care buying strategy”).

113. See GUTERMAN & SERBER, *supra* note 99, at 6-7, 13, 16 (describing Medicare chronic-care and provider-performance initiatives).

114. See GOV'T ACCOUNTABILITY OFFICE, *MEDICARE: PAST EXPERIENCE CAN GUIDE FUTURE COMPETITIVE BIDDING FOR MEDICAL EQUIPMENT AND SUPPLIES 2* (2004), available at www.gao.gov/new.items/d04765.pdf (last visited Sept. 30, 2007).

115. See Robert A. Berenson & Dean M. Harris, *Using Managed Care Tools in Traditional Medicare—Should We? Could We?*, 65 *LAW & CONTEMP. PROBS.* 139 (2002).

example, a recent Congressional Budget Office review of the literature on disease management concluded that although there is some evidence that it improves care for those with chronic diseases, there is no significant evidence that it saves money.¹¹⁶ Although Medicare has conducted several demonstration projects using case or disease management, there is no definitive evidence that these approaches can save money.¹¹⁷ While there is a great deal of interest in paying for performance, there is also concern that if not done right, it might increase disparities in healthcare or result in underservice for persons whose health problems are not targeted by the payment mechanism.¹¹⁸ Also, as recent British experience seems to have shown, paying for performance can offer opportunities for gaming the system which can result in increased costs.¹¹⁹

Second, there is tremendous political opposition to value purchasing, at least insofar as it results in losers as well as winners on the provider side.¹²⁰ Everyone is in favor of competition, but no one wants to be a loser. Attempts to introduce competitive purchasing into Medicare have been blocked by politicians whose constituents complain about losing Medicare business.¹²¹ Medicare's Centers of Excellence program, which seems to have been quite successful in improving care, had to be renamed because excluded providers complained that they, too, were excellent.¹²² Thus, across Medicare, limited-provider networks, tiered networks, or limited formularies would face tremendous political opposition.

Finally, there are legal barriers to using value purchasing. At its creation in 1965, Medicare offered benefits very similar to the contemporary Blue

116. CONGRESSIONAL BUDGET OFFICE, AN ANALYSIS OF THE LITERATURE ON DISEASE MANAGEMENT PROGRAMS 9 (Oct. 13, 2004), available at www.cbo.gov/ftpdocs/59xx/doc5909/10-13-DiseaseMngmnt.pdf (last visited Sept. 30, 2007).

117. See RANDALL BROWN ET AL., MATHEMATICA POL. RES., INC., COORDINATING CARE FOR MEDICARE BENEFICIARIES: EARLY EXPERIENCES WITH 15 DEMONSTRATION PROGRAMS, THEIR PATIENTS, AND PROVIDERS 7 (2004), available at www.mathematica-mpr.com/publications/PDFs/bestpraccongressional.pdf (last visited Sept. 30, 2007); GUTERMAN & SERBER, *supra* note 99, at 9; Marsha Gold et al., *Challenges in Improving Care for High-Risk Seniors in Medicare*, 2005 HEALTH AFF. (WEB EXCL.) w5-199.

118. Lawrence P. Casalino et al., *Will Pay-for-Performance and Quality Reporting Affect Health Care Disparities?*, 2007 HEALTH AFF. (WEB EXCL.) w405, w406-09.

119. See Robert Galvin, *Pay-for-Performance: Too Much of a Good Thing? A Conversation with Martin Roland*, 2006 HEALTH AFF. (WEB EXCL.) w412, w413.

120. See MILBANK MEMORIAL FUND, *supra* note 112, at 4, 7.

121. Barbara S. Cooper & Bruce C. Vladeck, *Bringing Competitive Pricing to Medicare*, 19 HEALTH AFF. 49, 52-54 (2000).

122. Robert A. Berenson, *Paying for Quality and Doing it Right*, 60 WASH. & LEE L. REV. 1315, 1331 (2003).

Cross and Blue Shield plans, focusing on hospital and physician services.¹²³ The program's creators went to great lengths to mollify the concerns of the doctors and hospitals whose cooperation was necessary for the program to succeed.¹²⁴ The first provision of the Medicare statute prohibits government interference in the practice of medicine, while the second provision enshrines the principle of free choice of provider.¹²⁵ The third provision of the statute guarantees beneficiaries the right to purchase private insurance.¹²⁶ The 1965 statute established Medicare Parts A and B—two completely different programs with different financing mechanisms and different administrative, payment, and cost-sharing structures—to cover institutional services (Part A) and professional and related services (Part B).¹²⁷ Like contemporary employment-related insurance programs, Medicare was designed to cover acute care and specifically excluded long-term custodial care.¹²⁸ The program did not include a catastrophic benefit; it imposed limits on hospital, nursing care, and home health benefits; and it did not establish limits on beneficiary cost-sharing.¹²⁹ Furthermore, it did not cover outpatient drugs, preventive services, or nursing home care aside from 100 days of post-hospital extended care.¹³⁰

The program has evolved a great deal over the years, but much remains the same. Although Medicare now has a drug benefit and covers more preventive care, it still provides only limited coverage for long-term care and offers no catastrophic benefit.¹³¹ It still takes a silo approach to care. Indeed, with the evolution of prospective payment systems over the years on a service-by-service basis, Medicare is more balkanized than ever.¹³² Further, Medicare prospective payment legislation defines very specifically how each provider is to be paid,¹³³ leaving little room for creativity and flexibility. Although the Medicare program is pursuing a number of demonstration projects to explore better coordination of care, these are

123. See Judith R. Lave, *The Structure of the Medicare Benefit Package: Evolution and Options for Change*, in *LESSONS FROM THE FIRST TWENTY YEARS OF MEDICARE* 3, 4 (Mark V. Pauly & William L. Kissick, eds., 1986); PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* 375 (1982).

124. STARR, *supra* note 123, at 374-78.

125. 42 U.S.C. §§ 1395, 1395a (2000).

126. *Id.* § 1395b.

127. See Lave, *supra* note 123, at 3, 4.

128. 42 U.S.C. § 1395y(a) (2000); Lave, *supra* note 123, at 4.

129. See Lave, *supra* note 123, at 4-5, 11.

130. *Id.*

131. *Id.* at 11.

132. See generally MAYES & BERENSON, *supra* note 91.

133. See, e.g., 42 U.S.C. § 1395w-4 (2000) (payment for physician's services), § 1395ww (payment for inpatient hospital services), § 1395yy (payment for skilled nursing facility services for routine service costs).

narrow in their scope and usually limited by budget neutrality requirements that greatly constrain their flexibility.¹³⁴ The Medicare program is also governed by the Administrative Procedures Act¹³⁵ and its incrustations, which currently make formal regulatory action very difficult (particularly under an administration that is not a friend of social insurance).

Constitutional impediments are unlikely to block value purchasing in Medicare. Not all courts have found that providers have a property or liberty interest in Medicare participation, and even those courts that do find a constitutionally protected interest tend to defer to program decisions.¹³⁶ But the current Medicare statute does impose a straitjacket on the Medicare program that deprives it of much of the flexibility that would be needed to make value purchasing a reality.¹³⁷

From the 2000 election through the 2006 election, those in power in Washington have appeared to place their hopes for Medicare reform on moving Medicare toward defined contribution or consumer-driven models in the long run and on Medicare managed care in the short run.¹³⁸ Medicare managed care has failed, and moving to consumer-driven or defined-contribution models is neither advisable as a matter of policy nor possible as a matter of politics.¹³⁹ It is time to turn our attention to how to make traditional Medicare work better. The focus should be on allowing traditional Medicare to engage in value purchasing, which will require changing the Medicare statute. Section 1,¹⁴⁰ for example, should be amended to remove the non-interference provision and replace it with a positive statement that Medicare is responsible for assuring that providers, professionals, and suppliers offer beneficiaries effective, appropriate, and high-quality care. Section 2¹⁴¹ should be amended to remove the free choice of provider language and replace it with a statement that beneficiaries are entitled to a choice of high-quality and efficient providers,

134. See BROWN ET AL., *supra* note 117, at 10, 15; GUTERMAN & SERBER, *supra* note 99, at 25.

135. Administrative Procedures Act, 5 U.S.C. §§ 551-596 (2000).

136. See Timothy S. Jost, *Administrative Law Issues Involving the Medicare Utilization and Quality Control Peer Review Organization (PRO) Program: Analysis and Recommendations*, 50 Ohio St. L.J. 1, 38-39 (1989); Timothy S. Jost, *Governing Medicare*, 51 ADMIN. L. REV. 39, 45-65 (1999); Ruqaiyah A. Yearby, *A Right to No Meaningful Review Under the Due Process Clause: The Aftermath of Judicial Deference to the Federal Administrative Agencies*, 16 HEALTH MATRIX 723, 724 (2006).

137. See MILBANK MEMORIAL FUND, *supra* note 112, at 108.

138. See THE HENRY J. KAISER FAMILY FOUND., *MEDICARE: MEDICARE ADVANTAGE* (June 2007), available at www.kff.org/medicare/upload/2052-10.pdf (last visited Sept. 30, 2007) (outlining the growth in the types of Medicare plans since 1999).

139. See JOST, *supra* note 67 (critiquing the consumer-driven movement).

140. 42 U.S.C. § 1395 (2000).

141. *Id.* § 1395a.

suppliers, and professionals. Whole sections of the statute need to be amended to allow more flexibility in purchasing. In particular, the Centers for Medicare and Medicaid Services should be given broad statutory authority to fund demonstration projects in value purchasing without being tied down by immediate budget neutrality requirements. Instead, budget neutrality should be assessed over the long term because a little extra spending now might save a great deal in the future.

In conclusion, while Medicare has been a success overall, it does have problems. The long-term survival of the Medicare program does depend on increased tax funding, but provider costs also need to be controlled. Medicare also needs to improve its value-purchasing ability in order to both save money and improve beneficiary care. In the end, however, changes in Medicare policy will require changes in the Medicare law. This article has suggested where these changes might begin.

