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BEYOND DRUG COVERAGE: THE CUMULATIVE EFFECT OF PRIVATIZATION REFORMS IN THE MEDICARE MODERNIZATION ACT

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I. INTRODUCTION

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA)¹ is most widely known for its implementation of outpatient prescription drug coverage.² The MMA's most controversial aspect is its use of private plans, rather than the federal government, to administer the benefit.³ By providing for the management of coverage by private prescription drug plans,⁴ the MMA effectuates a substantial new role for the private sector in Medicare. The law also permits beneficiaries to obtain drug coverage through more comprehensive private coverage arrangements that combine medical and drug benefits.⁵ These arrangements, known as

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1. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066 (codified in scattered sections of 42 U.S.C. and 26 U.S.C.).

2. See 42 U.S.C. §§ 1395w-101–1395w-152 (Supp. IV 2004) (implementing Medicare Part D, the outpatient prescription drug coverage program).

3. See John K. Iglehart, *The New Medicare Prescription-Drug Benefit—A Pure Power Play*, 350 NEW ENG. J. MED., 826, 826-28 (2004) (discussing Republican-favored competition between private plans and traditional Medicare and how Democrats railed the privatization of the program).

4. See Susan Adler Channick, *The Medicare Prescription Drug, Improvement, and Modernization Act of 2003: Will it be Good Medicine for U.S. Health Policy?*, 14 ELDER L.J. 237, 247 (2006) ("Under the MMA, private . . . [PDPs] administer the Part D drug benefit . . .").

5. See *id.* (discussing how beneficiaries may choose to enroll in Medicare Advantage plans, which provide Part A, Part B, and Part D benefits).

Medicare Advantage plans (MA plans), expand the private sector role even further.

Less obvious, however, are numerous other privatization reforms sprinkled throughout the MMA. Each reform is fairly limited in scope when considered separately. However, when viewed in combination, these provisions hold the potential for a synergistic effect that is considerably greater than the sum of the parts. No single privatization reform could transform Medicare by itself, but the cumulative outcome could push enrollment in private managed care plans to reach a critical mass at which beneficiaries begin to view them as an accepted part of the Medicare landscape. This potential effect has significant implications for future efforts to promote privatization as a long-term alternative to Medicare's traditional structure.

II. PRIVATIZATION AND MEDICARE

The notion of privatizing Medicare is not new.⁶ Even at its inception in 1965, Congress balanced public and private roles in the program's administration.⁷ Legislators compromised to grant overall responsibility to the federal government, originally through the Social Security Administration, but delegated considerable portions of the day-to-day administration to private insurance companies that administered claims and made many coverage determinations.⁸ These private contractors were officially designed as "intermediaries" for inpatient coverage under Part A of the program and as "carriers" for outpatient coverage under Part B.⁹

Beginning in the 1980s, experiments in using private managed care companies to administer all aspects of benefits in a unified manner boosted privatization efforts.¹⁰ Beneficiaries choosing to participate in a managed

6. See Bryan E. Dowd et al., *Fee-for-Service Medicare in a Competitive Market Environment*, 27 HEALTH CARE FIN. REV. 113 (2005) (commenting that since the beginning of Medicare there has been a debate over the relationship between traditional Medicare and private plans).

7. See Arthur E. Hess, *Medicare After One Year*, 35 J. RISK & INS. 119, 121 (1968) (background on the enactment of Medicare and how the population is best served by balancing private and government plans).

8. See *id.* at 121-22 (discussing the role of private plans as intermediaries and carriers that are responsible for routine administrative activities such as claims processing).

9. *Id.* at 122.

10. For background on the use of managed care in Medicare, see Jo Ann Lamphere et al., *The Surge in Medicare Managed Care: An Update*, 16 HEALTH AFF. 127 (1997). See also Melissa M. Ostrowski, *Medicare Advantage Private Fee-for-Service Plans: What Privatization Means for Today's Beneficiaries*, 8 MARQ. ELDER'S ADVISOR 375, 376 (2007) (discussing the attraction of Medicare beneficiaries to Medicare HMO plans and how enrollment in the HMO plans grew from 1 million members in 1987 to 5.2 million by 1997).

care plan received Medicare coverage through health maintenance organizations (HMOs) rather than through the traditional, government-run fee-for-service program.¹¹ In return for accepting the restrictions that HMOs impose, such as requiring prior authorization for expensive services and referrals for visits to specialists, beneficiaries received a more comprehensive set of benefits at lower premiums. The experiment, designated as Medicare Part C, expanded in the early 1990s, and the Balanced Budget Act of 1997 renamed it Medicare+Choice.¹² The Bipartisan Commission on the Future of Medicare also debated this model as a response to Medicare's long-term solvency challenges in the late 1990s, but the issue's contentiousness contributed to the Commission's failure to achieve consensus.¹³

Proponents of privatization contend that market competition can engender better, more efficient coverage at lower cost.¹⁴ They also see it fostering innovations over time that the traditional government-run program is hard-pressed to match.¹⁵ Opponents of privatization counter that, in practice, private plans tend to be more expensive and inefficient than traditional Medicare and that the profit motive is likely to make investor-owned companies less responsive to beneficiary needs.¹⁶ They fear that privatization could ultimately lead to traditional Medicare's demise, as it evolves into a program that simply provides vouchers for the purchase of private coverage.¹⁷

11. See Lamphere et al., *supra* note 10, at 129.

12. See Balanced Budget Act of 1997, Pub. L. No. 105-33, 111 Stat. 251, 275 (codified as amended at 42 U.S.C. §§ 1395w-21 to w-29 (2000)) (establishing the Medicare+Choice program); see also Marsha Gold, *Medicare+Choice: An Interim Report Card*, 20 HEALTH AFF. 120, 121 (2001) (providing background on Medicare+Choice and participating managed care plans' experiences).

13. Barbara Markham Smith & Sara Rosenbaum, *Potential Effects of the "Premium-Support" Proposal on the Security of Medicare*, 282 JAMA 1760, 1760 (1999).

14. See Press Release, Office of Press Sec'y, The White House, Fact Sheet: Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Dec. 8, 2003), at www.whitehouse.gov/news/releases/2003/12/print/20031208-3.html (last visited Oct. 9, 2007) (asserting that market-place competition will ensure better and more affordable coverage to strengthen and modernize Medicare).

15. See *id.* ("Private sector competition will result in more innovation and flexibility in coverage.").

16. See *Medicare Advantage Private Fee-for-Service Plans: Hearing Before the Subcomm. on Health of the H. Comm. on Ways and Means*, 110th Congress (May 22, 2007) (statement of Mark E. Miller, Executive Director, Medicare Payment Advisory Commission), available at <http://waysandmeans.house.gov/media/pdf/110/MillerTestimony.pdf> (last visited Oct. 9, 2007).

17. See Press Release, Ctr. for Health Policy & Ctr. for Primary Care and Outcomes Research, Stanford Univ., Health Vouchers Plan Would Cover all Americans and Preserve Choice, Competition (Mar. 24, 2005), at http://healthpolicy.stanford.edu/news/health_vouchers_plan_would_cover_all_americans_and_preserve_choice_competition_20050324/

The MMA is a triumph for privatization proponents, as it affords an unusual opportunity to gain public acceptance under extremely favorable conditions. Supporters already point to substantial growth in private plan enrollment under the MMA as evidence of privatization's appeal.¹⁸ Within the next few years, both the proponents and opponents of privatization will point to experience under the MMA as evidence of either the wisdom or folly of this approach. The key public policy question is whether private plan performance truly reflects beneficiary attitudes or is actually an artifact of legislative incentives.

At least seven privatization incentives are embodied in various MMA provisions.¹⁹ One of the most significant incentives is a set of enhanced government subsidies to MA plans that enable them to charge artificially low premiums.²⁰ While recent initiatives in Congress would reduce their funding level, the real impact of these subsidies lies in the potential for a cumulative effect through their interaction with other MMA provisions. An appreciation of this phenomenon, not just of each incentive in isolation, is essential to understanding the true nature of the market's ultimate response to private plans. While the more subtle synergistic effect of the MMA's privatization incentives so far has received relatively little public attention, it could be the deciding factor in assessing the private plans' experiences.

This article briefly reviews the MMA and the key private plan enhancements it contains. It then considers how these enhancements may act synergistically to entice beneficiaries to join Medicare Advantage. The article concludes by observing that this legislative structure could produce a level of beneficiary acceptance of Medicare privatization that does not reflect actual market conditions.

(last visited Oct. 9, 2007) (stating that if healthcare would move to a voucher system, Medicaid would "disappear" and Medicare would be "phased out").

18. See *Medicare Advantage: Hearing Before the Subcomm. on Health of the H. Comm. on Ways and Means*, 110th Congress (Mar. 21, 2007) [hereinafter *CBO Testimony*] (statement of Peter R. Orszag, Director, Congressional Budget Office) available at www.cbo.gov/ftpdocs/78xx/doc7879/03-21-Medicare.pdf (last visited Oct. 9, 2007) (private fee-for-service plans membership increased from 200,000 at the end of 2005 to upwards of 1.3 million members at the beginning of 2007, and membership is projected to reach 5 million members by 2017).

19. See *infra* Part IV (discussing the MMA's private plan incentives). See generally NAT'L COMM. TO PRESERVE SOC. SEC. & MEDICARE, *VIEWPOINT: THE PRIVATIZATION OF MEDICARE* (June 2006), at www.ncpssm.org/news/archive/vp_medprivatization/ (last visited Oct. 11, 2007) [hereinafter NAT'L COMM.] (discussing the MMA's increased incentives for MA plans, such as the stabilization fund and the comparative cost adjustment project).

20. See 42 U.S.C. § 1395w-23 (Supp. IV 2004) (payments to Medicare Advantage organizations); see also NAT'L COMM., *supra* note 19 (discussing how both the stabilization fund and comparative cost adjustment project subsidize private plans and afford these plans an unfair competitive advantage because they are able to offer better benefits at a lower cost).

III. BACKGROUND ON THE MMA

The MMA was enacted on December 8, 2003 following a highly partisan and contentious gestation.²¹ After an intense and sometimes emotional debate, it passed the House of Representatives by only five votes.²² Much of the controversy surrounding its passage focused on the legislation's reliance on the private market rather than on the government as a means of Medicare administration.²³ Traditional Medicare is administered by the federal Centers for Medicare and Medicaid Services (CMS) within the Department of Health and Human Services (HHS).²⁴ The MMA transferred important new roles from CMS to private insurance plans.²⁵

The MMA's primary thrust was to implement outpatient prescription drug coverage,²⁶ but it also addressed an array of unrelated issues. Some elements were included to attract political support, but many reinforce an underlying privatization agenda. The drug benefit, labeled Medicare Part D, creates the platform for larger reform through its reliance on private plan administration.²⁷ These plans may operate on a stand-alone basis as prescription drug plans (PDPs) or as part of broader MA plans that replace Parts A and B of Medicare with their own integrated coverage structure.²⁸

21. JENNIFER O'SULLIVAN ET AL., CONG. RESEARCH SERV., OVERVIEW OF THE MEDICARE PRESCRIPTION DRUG, IMPROVEMENT, AND MODERNIZATION ACT OF 2003, CRS-1 (Dec. 2003). For an overview of the heated political environment in which the MMA was passed, see ANDREA LOUISE CAMPBELL & KIMBERLY MORGAN, THE SHIFTING LINE BETWEEN PUBLIC AND PRIVATE: THE POLITICS OF THE 2003 MEDICARE MODERNIZATION ACT AND PRESCRIPTION DRUG REFORM (prepared for the Social Science History Association Annual Meeting, Portland Oregon, Nov. 3-6, 2005).

22. O'SULLIVAN ET AL., *supra* note 21 (the House of Representatives voted 220 to 215 to approve H.R. 1).

23. See generally 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, W118, W130-32 (asserting that the MMA's promotion of private insurance undermines the social insurance concept that created Medicare).

24. EARL DIRK HOFFMAN ET AL., CTRS. FOR MEDICARE & MEDICAID SERVS., BRIEF SUMMARIES OF MEDICARE & MEDICAID: TITLE XVIII AND TITLE XIX OF THE SOCIAL SECURITY ACT 3 (Nov. 1, 2003), available at www.cms.hhs.gov/MedicareProgramRatesStats/downloads/MedicareMedicaidSummaries2003.pdf (last visited Oct. 9, 2007).

25. See Letter from Kathleen M. King, Dir. Health Care, U.S. Gov't Accountability Office, to Max Baucus, Senator, Ranking Minority Member, Comm. on Fin. (Dec. 16, 2005), available at www.gao.gov/new.items/d06278r.pdf (last visited Oct. 9, 2007) (discussing potential problems with the transition of responsibilities from CMS to private Part D plans).

26. See Channick, *supra* note 4, at 238.

27. *Id.* at 263-65.

28. *Id.* at 264.

Two of Part D's key features are that participation is voluntary and that beneficiaries who enroll choose from a wide assortment of plans.²⁹ Each plan structures its own benefits and premiums based on a minimum statutory design that includes an annual deductible, tiered co-payments, and, in a unique departure from traditional coverage, a "doughnut hole" with no reimbursement between the initial and catastrophic layers of coverage.³⁰ In 2007, this gap extended between \$2,400 and \$5,451 in annual expenditures.³¹ Coverage is also limited by each plan's formulary that lists which drugs are reimbursable without an appeal.³² Premiums vary with the generosity of coverage, and subsidies are available for beneficiaries with incomes close to the poverty line and those on Medicaid.³³

IV. KEY MMA PRIVATIZATION PROVISIONS

A. *Medicare Advantage Reimbursement*

The most significant privatization reform is the transformation of Medicare Part C into Medicare Advantage at considerable government expense.³⁴ The MMA increased subsidies for participating plans by 10.6%,³⁵ amounting to a \$1.3 billion increase in payments to plans in 2005.³⁶ The total cost of the new subsidies for the program's first ten years is estimated at \$14 billion.³⁷ The MMA also buffered plans from the financial consequences of adverse risk selection during the first two years

29. CTRS. FOR MEDICARE & MEDICAID SERVS., DEPT. HEALTH & HUMAN SERVS., MEDICARE & YOU 43-44 (2007) [hereinafter MEDICARE & YOU].

30. See Scott A. Berkowitz et al., *Medicare Prescription Drug Coverage Gap: Navigating the "Doughnut Hole" with Patients*, 297 JAMA 868, 868-69 (2007) (discussing Medicare Part D and the doughnut hole).

31. MEDICARE & YOU, *supra* note 29, at 45 (After a beneficiary and plan have spent up to \$2,400 for covered drugs, the beneficiary must pay out-of-pocket drug costs up to \$3,051.25 before catastrophic coverage kicks in.).

32. *Id.* at 46.

33. See Dep't. of Health & Human Servs., Prescription Drug Coverage: Basic Information, at www.medicare.gov/pdp-basic-information.asp (last visited Oct. 9, 2007) (noting that qualified beneficiaries with "limited income and resources . . . may not have to pay a premium or deductible").

34. See Channick, *supra* note 4.

35. Iglehart, *supra* note 3, at 831.

36. THE HENRY J. KAISER FAMILY FOUND., MEDICARE: MEDICARE ADVANTAGE (Sept. 2005), available at www.kff.org/medicare/upload/Medicare-Advantage-April-2005-Fact-Sheet.pdf (last visited Oct. 9, 2007).

37. BRIAN BILES ET AL., THE COMMONWEALTH FUND, THE COST OF PRIVATIZATION: EXTRA PAYMENTS TO MEDICARE ADVANTAGE PLANS—2005 UPDATE 2 (2004), available at www.cmwf.org/usr_doc/750_Biles_costofprivatization_update_ib_pdf.pdf (last visited Oct. 9, 2007).

with a \$10 billion “stabilization fund” that limits losses.³⁸ While Congress reduced the stabilization fund to \$3.5 billion in 2006,³⁹ its cost to the government remains substantial.

In addition to these financial rewards, the MMA granted private MA plans considerable advantages over PDPs in structuring drug coverage. These plans can integrate prescription benefits with physician and hospital services to coordinate the continuum of care and can implement innovations such as disease management.⁴⁰ They enjoy greater leeway to tailor co-payments and deductibles to beneficiary needs and can even eliminate the doughnut hole in their more generous offerings.⁴¹ They have greater flexibility to cover some drugs, such as benzodiazepines, for which Medicare Part D otherwise prohibits reimbursement.⁴² The MMA also encouraged plans to offer an expanded array of designs beyond restrictive HMOs by making it easier to structure more flexible preferred provider organization (PPO) models and even fee-for-service (FFS) plans that mimic traditional Medicare.⁴³

The private market responded quickly to these incentives.⁴⁴ The number of CMS contracts with Part C plans rose by over 25% during the first year after the MMA’s enactment;⁴⁵ and enrollment increased even more rapidly

38. O’SULLIVAN ET AL., *supra* note 21, at CRS-14.

39. THE HENRY J. KAISER FAMILY FOUND., MEDICARE: MEDICARE ADVANTAGE (Mar. 2007), available at www.kff.org/medicare/upload/2052-09.pdf (last visited Oct. 9, 2007).

40. See *Medicare Advantage and the Federal Budget: Hearing Before the H. Comm. on the Budget*, 110th Cong. 8 (2007) (statement of Peter R. Orszag, Director, Congressional Budget Office), available at <http://cbo.gov/ftpdocs/82xx/doc8265/06-28-MedicareAdvantage.pdf> (last visited Oct. 9, 2007) (noting that “[h]ealth plans may be more able to manage care through . . . centralized administrative arrangements”).

41. See O’SULLIVAN ET AL., *supra* note 21, at CRS-3 (discussing the opportunity for plans to substitute cost-sharing requirements and to apply tiered co-payments if both are actuarially consistent). But see NAT’L COMM. TO PRESERVE SOCIAL SECURITY & MEDICARE, VIEWPOINT: MEDICARE’S DOUGHNUT HOLE: A BITTER PILL TO SWALLOW (Sept. 2006), at www.ncpssm.org/news/archive/vp_donuthole/ (last visited Oct. 11, 2007) (noting that 85% of private Part D plans have a doughnut hole and the plans that do not are “very expensive”).

42. See MEDICARE & YOU, *supra* note 29, at 53.

43. See MARSHA GOLD, THE HENRY J. KAISER FAMILY FOUND., THE MEDICARE DRUG BENEFIT: PREMIUMS AND COST-SHARING FEATURES IN MEDICARE’S NEW PRESCRIPTION DRUG PROGRAM, 2006, at 6-8 (2006), available at www.kff.org/medicare/upload/7517.pdf (detailing the different types of private MA plans in existence, such as HMO, local PPO, and private FFS) (last visited Oct. 11, 2007).

44. See *CBO Testimony*, *supra* note 18, at 7 (discussing the increase in Medicare Advantage enrollment from 2005–2007, attributed to the MMA).

45. THE HENRY J. KAISER FAMILY FOUND., MEDICARE HEALTH AND PRESCRIPTION DRUG PLAN TRACKER [hereinafter DRUG PLAN TRACKER], at www.kff.org/medicare/healthplantracker/georeults.jsp?r=1&n=&i=&c=&pt=8&yo=2&x=14&y=10 (last visited Oct. 10, 2007) (the

in 2006.⁴⁶ Similarly, total plan enrollment and market penetration have grown steadily.

Table 1: Medicare Advantage Plan Contract and Enrollment Activity

Month	Enrollment ⁴⁷	Penetration (% of beneficiaries) ⁴⁸	Number of CMS contracts with plans ⁴⁹
July 2003 (before MMA)	5,301,138	12.6	235
July 2004	5,376,650	12.7	234
December 2004	5,498,494	12.8	234
May 2005	5,763,113	13.3	273
December 2005	6,121,678	14.0	273
April 2006 (with drug coverage)	6,831,626	15.5	364
October 2006 (with drug coverage)	7,611,200	17.3	364
June 2007 (with drug coverage)	8,678,224	19.7	424

B. Part B Premium Structure

Participation in Medicare Part B is voluntary and subject to a premium.⁵⁰ However, other than Medicare Advantage, there is no private market for comparable coverage. Therefore, 95% of those eligible choose to

number of CMS contracts with Coordinated Care Plans (CCPs) rose from 143 in 2004 to 182 in 2005, which is approximately a 27% increase).

46. See *infra* tbl.1.

47. This data comes from the *Monthly Tracking Reports* prepared by researchers at Mathematica Policy Research, Inc. For links to the reports for the months cited in the table, see THE HENRY J. KAISER FAMILY FOUND., MEDICARE HEALTH AND PRESCRIPTION DRUG PLANS MONTHLY TRACKING REPORTS, at www.kff.org/medicare/advantagetrackingreport_archive.cfm (last visited Oct. 10, 2007).

48. *Id.*

49. DRUG PLAN TRACKER, *supra* note 45.

50. MEDICARE & YOU, *supra* note 29, at 10.

participate.⁵¹ The MMA, for the first time in Medicare's history, scales Part B premiums according to income with a five-year phase-in period, leading to substantial cost differentiation.⁵² In 2007, higher-income beneficiaries were paying \$814.80 more than lower-income beneficiaries in annual premiums.⁵³ In 2009, the difference is projected to reach \$3,073.⁵⁴ Proponents of scaled premiums argue that public assistance should vary according to need.⁵⁵ However, the premiums for upper income beneficiaries may increase to a level that will rival rates capable of sustaining a private market.⁵⁶ If a private market emerges, it would siphon patients from and weaken the traditional program's financial base.

C. *Health Savings Accounts*

Perhaps the most far-reaching MMA reform promotes the paradigm of "consumer-driven" healthcare beyond Medicare as an alternative to traditional employer-sponsored insurance for the non-elderly population.⁵⁷ The underlying concept of the consumer-driven model is to replace third-party reimbursement for routine medical expenses with payment by the

51. HOFFMAN ET AL., *supra* note 24, at 13.

52. See O'SULLIVAN ET AL., *supra* note 21.

53. See Press Release, Ctrs. for Medicare & Medicaid Servs., Medicare Premiums and Deductibles for 2007 (Sept. 12, 2006), at www.cms.hhs.gov/apps/media/press/release.asp?Counter=1958 (last visited Oct. 10, 2007) (showing that lower income beneficiaries pay a monthly premium of \$93.50 (\$1,122 per year), whereas the higher income beneficiaries pay a monthly premium of \$161.40 (\$1,936.80 per year)).

54. SENIOR CITIZENS LEAGUE, MEDICARE PREMIUMS EXPECTED TO JUMP 450 PERCENT FOR SOME SENIORS AS MEANS TESTING TAKES EFFECT FOR FIRST TIME IN HISTORY (Sept. 6, 2006), at www.tscl.org/newcontent/102743.asp (last visited Oct. 10, 2007) (showing that in 2009 the projected monthly premium for lower income beneficiaries is \$116.50 (\$1,398 per year), whereas the projected monthly premium for higher income beneficiaries is \$372.60 (\$4,471.20 per year)).

55. See generally Mark V. Pauly, *Means-Testing in Medicare*, 2004 HEALTH AFF. (WEB EXCL.) W4-546, W4-548 (discussing common arguments for and against means-testing and also noting that Sen. John Kerry (D-MA) promoted limiting social insurance benefits for the wealthy during his presidential campaign in 2004).

56. See generally SENIOR CITIZENS LEAGUE, *supra* note 54 (recognizing that "as wealthy seniors abandon Medicare as it becomes more expensive and choose private insurance instead, only the poorest and sickest will be stuck in Medicare, driving up costs for everyone left behind").

57. See Karen Davis, *Consumer-Directed Health Care: Will It Improve Health System Performance?*, 39 HEALTH SERVICES RES. 1219, 1219 (2004) (discussing consumer-driven health plans as an option offered by some employers and noting that a few employers have replaced traditional coverage entirely with a consumer-driven plan).

patient directly from a tax-advantaged savings account.⁵⁸ Congress authorized a limited trial of this approach in 1996, but its market uptake was modest.⁵⁹ The MMA significantly enhanced and re-titled the accounts “health savings accounts” (HSAs).⁶⁰ The new HSAs are portable across employers, can accumulate funds until the beneficiary achieves Medicare eligibility at age sixty-five, and earn tax-free interest and dividends. After age sixty-five, money can be withdrawn for any purpose, not just to meet medical expenses.⁶¹

Workers who remain healthy over the course of their careers can amass a substantial HSA upon retirement, especially if they supplement employer contributions with deposits of their own. At the same time, affluent retirees will face a considerable cost for Part B coverage under the newly tiered premium structure. For these beneficiaries, direct payment of medical expenses from an HSA could become an attractive alternative to traditional Medicare, further stressing the traditional system.

D. Medicaid Coverage

Medicaid, which is administered by the states, covers several categories of beneficiaries with extremely low incomes and low levels of assets.⁶² Benefits include medical expense and prescription drug coverage.⁶³ Approximately 7.5 million people are eligible for both Medicaid, based on income, and Medicare, based on age or disability.⁶⁴ The MMA assigned drug coverage for these “dual eligibles” to Medicare, offering them premium support and suspension of deductibles and most co-payments.⁶⁵

58. See, e.g., UPMC HEALTH PLAN, HSA: A REVOLUTION IN HEALTH CARE 2, available at www.upmchealthplan.com/plan/commercial/pdf/Health%20Savings%20Account.pdf (last visited Oct. 9, 2007) (describing the tax advantages of health savings accounts (HSAs)).

59. See Alexandra Minicozzi, *Medical Savings Accounts: What Story do the Data Tell?*, 25 HEALTH AFF. 256, 257-58 (2006).

60. *Id.* at 256 (describing HSAs as an expanded and broader version of medical savings accounts (MSAs)).

61. See BOB LYKE & CHRIS L. PETERSON., CRS REPORT FOR CONGRESS: TAX-ADVANTAGED ACCOUNTS FOR HEALTH CARE EXPENSES: SIDE-BY-SIDE COMPARISON CRS-4 tbl. (2007), available at www.nahu.org/legislative/MSAs/HSAs-HSSAs/CRS-hsaTaxAdvantage.pdf (last visited Jan. 31, 2008).

62. THE HENRY J. KAISER FAMILY FOUND., THE MEDICAID PROGRAM AT A GLANCE (Mar. 2007), available at www.kff.org/medicaid/upload/7235-02.pdf (last visited Oct. 10, 2007).

63. *Id.*

64. JOHN HOLAHAN & ARUNABH GHOSH, THE HENRY J. KAISER FAMILY FOUND., DUAL ELIGIBLES: MEDICAID ENROLLMENT AND SPENDING FOR MEDICARE BENEFICIARIES IN 2003, at 1 (2005), available at www.kff.org/medicaid/upload/7346%20Dual%20Eligibles_Enrollment%20and%20Spending_Beneficiaries_Final_revised%207_28.pdf (last visited Oct. 10, 2007).

65. See *id.* at 6 (outpatient prescription drugs were not covered under Medicare until the MMA's implementation in January 2006).

Because they are guaranteed the drug benefit, dual eligibles are automatically assigned to a Part D plan if they neglect to affirmatively enroll.⁶⁶ Assignment is random among qualified plans participating in their region.⁶⁷ However, dual eligibles may choose to join an MA plan.⁶⁸ When Part D was implemented in 2006, about 10% of dual eligibles were enrolled in MA plans.⁶⁹ In addition, some states require the dual eligibles to join a Medicaid managed care plan.⁷⁰ The result is increased enrollment in MA plans of members who receive full premium subsidies. In addition, dual eligibles have the ability to enroll in Special Needs Plans (SNPs), which, as discussed below, offer benefits that typically exceed those of traditional fee-for-service Medicare and Medicaid.

E. Special Needs Plans

The MMA defined a new category of coverage that MA plans, but not traditional Medicare, may provide.⁷¹ SNPs structure flexible benefit arrangements for vulnerable populations, including patients residing in institutions, dual eligibles, and those with severe and disabling conditions.⁷² In addition to having greater leeway in designing benefits, private plans that offer SNPs are eligible for supplemental payments called "frailty adjusters."⁷³ This additional funding facilitates even more flexibility that the MMA denied to the traditional Medicare program. To provide further support, 110,000 dual eligibles were passively enrolled in SNPs upon Part D's launch in January 2006.⁷⁴

66. 42 U.S.C. § 1395w-101(b)(1)(C) (Supp. IV 2004); see VERNON SMITH ET AL., THE HENRY J. KAISER FAMILY FOUND., THE TRANSITION OF DUAL ELIGIBLES TO MEDICARE PART D PRESCRIPTION DRUG COVERAGE: STATE ACTIONS DURING IMPLEMENTATION 1 (2006), available at www.kff.org/medicaid/upload/7467.pdf (last visited Oct. 10, 2007).

67. 42 U.S.C. § 1395w-101(b)(1)(C).

68. Adam Atherly & Bryan E. Dowd, *Effect of Medicare Advantage Payments on Dually Eligible Medicare Beneficiaries*, 26 HEALTH CARE FIN. REV. 93, 95 (2005).

69. See VERNON SMITH ET AL., *supra* note 66.

70. Atherly & Dowd, *supra* note 68.

71. See CTRS. FOR MEDICARE & MEDICAID SERVS., IMPROVING ACCESS TO INTEGRATED CARE FOR BENEFICIARIES WHO ARE DUALY ELIGIBLE FOR MEDICARE AND MEDICAID (2006), at www.cms.hhs.gov/pf/printpage.asp?ref=http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=1912 (last visited Oct. 10, 2007).

72. *Id.*

73. See MEDICARE PAYMENT ADVISORY COMM'N, REPORT TO THE CONGRESS: NEW APPROACHES IN MEDICARE 87-89 (June 2004), available at www.medpac.gov/publications/congressional_reports/June04_ch3.pdf (last visited Oct. 11, 2007) (describing the concept of frailty adjusters).

74. VERNON SMITH ET AL., *supra* note 66, at 13.

F. Medicare Solvency

Medicare is financed through a combination of sources, including a dedicated payroll tax for Part A, premiums for Part B, and general government revenues.⁷⁵ Beginning in 2005, the MMA required the program's trustees to project general revenue as a percentage of total Medicare spending in future years.⁷⁶ If the projections foresee that in two consecutive years within the next six these funds will exceed 45% of the total, the president must respond with a remedial legislative proposal, and Congress must act within a designated timeframe.⁷⁷

In 2007, the Medicare Board of Trustees reported that the 45% threshold would be triggered by 2013;⁷⁸ therefore, the president is obligated to present a solvency proposal by 2009.⁷⁹ At that time, Medicare reform will almost certainly rise on the political agenda. The atmosphere will be officially designated as involving financial peril, albeit based on an arbitrary criterion. This atmosphere will give supporters of private plans an exceptional opportunity to promote their version of structural reform as an alternative.

G. Competitive Demonstration Project in 2010

Finally, the MMA encourages private plans by creating a demonstration project involving six regional markets that is scheduled to begin in 2010 and last for six years.⁸⁰ The project will permit private plans to compete directly with traditional Medicare.⁸¹ Beneficiaries will choose a coverage provider, either governmental or private, under a premium formula that

75. 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 REPORTS (2007), available at www.ssa.gov/OACT/TRSUM/tr07summary.pdf (last visited Oct. 10, 2007) [hereinafter SOCIAL SECURITY & MEDICARE BOARD OF TRUSTEES].

76. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066, 2357, 2360 (codified at 42 U.S.C. § 1395).

77. *Id.* at 117 Stat. at 2357-60.

78. See SOCIAL SECURITY & MEDICARE BOARD OF TRUSTEES, *supra* note 75.

79. THE HENRY J. KAISER FAMILY FOUND., MEDICARE: MEDICARE SPENDING AND FINANCING (June 2007), available at www.kff.org/medicare/upload/7305-02.pdf (last visited Nov. 3, 2007).

80. See *Board of Trustees 2004 Annual Reports: Hearing Before the H. Comm. on Ways and Means*, 108th Cong. 12 (Mar. 24, 2004) (statement of Douglas Holtz-Eakin, Director, Congressional Budget Office).

81. See Thomas A. Scully & Colin T. Roskey, *New Directions in Medicare Managed Care: The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 Makes Regional, Open Network Plans A Reality*, HEALTHCARE FIN. MGMT., May 2004, at 64, 66 (discussing how the project forces private MA plans to compete against traditional Medicare through benefits, quality, and cost).

could make traditional Medicare the more expensive option⁸² and, in effect, slant the competitive playing field to give private plans a formidable advantage.

V. SYNERGISTIC EFFECT

The cumulative effect of these MMA provisions could be substantial. With each provision, MA plans become more attractive to beneficiaries relative to the traditional program. As plans grow in size, they will also gain greater leverage in negotiations with healthcare providers and drug companies, which may enable them to enhance their appeal even further.

A possible scenario would be the following: Medicare Advantage enrollment continues to grow, in part due to premiums that are kept artificially low through government subsidies. Plan numbers are further inflated through the automatic enrollment of some Medicaid beneficiaries and SNPs. At the same time, traditional Medicare faces growing financial challenges that could reduce its appeal. These challenges include some healthier and wealthier beneficiaries opting out because of rising Part B premiums; some beneficiaries using HSA funds, combined with high-deductible insurance policies to purchase services directly in lieu of participating in traditional Medicare; a disadvantaged position in the 2010 competitive demonstration project; and possible coverage reductions in response to a presidential Medicare solvency proposal. This scenario would reinforce a process of adverse selection in which the healthiest beneficiaries withdraw from the traditional Medicare program, leaving it with a smaller, more expensive risk pool. This result would make the traditional program increasingly difficult to maintain.

In effect, the crescendo of private plan enhancements could push enrollment to a critical mass. At that point, private plans could become more widely viewed as an established part of Medicare rather than as an experiment and be interpreted by the public as evidence of privatization's widespread appeal. The political case for wholesale market-based reform would then find a more receptive political environment.

VI. CONCLUSION

Notwithstanding this substantial set of privatization incentives, both explicit and subtle, the MMA does not guarantee the long-term success of private plans. As of early 2007, private plans remained considerably more

82. See *id.* (describing a possible increase in traditional Medicare premiums if MA plans are more efficient).

costly than traditional Medicare.⁸³ In 2006, payments to MA plans averaged 12% higher than the cost of the government-run program.⁸⁴ The plans' long-term economic viability depends on the capacity to generate profits on their own as the MMA's subsidies are not likely to continue indefinitely.⁸⁵ Pressures will grow over the next several years to reduce the rate of Medicare spending growth, and subsidies to private plans are an obvious target for congressional cost-cutters. Plans could institute increased coverage restrictions to maintain profitability, but this could subject them to the kind of public backlash that managed care experienced in the late 1990s and cause public acceptance to evaporate rapidly.

In essence, the MMA gives market-based Medicare reform an opportunity to prove its worth under highly favorable conditions. However, this approach remains an experiment. Both supporters and critics will point to experience under the MMA as evidence of the experiment's results.

In analyzing private plans' experiences under the MMA, the less visible privatization incentives reflected in the cumulative impact of several smaller reforms deserve more widespread policy attention. Beneficiary acceptance of MA plans is only relevant to the debate over privatization if it reflects a true market response rather than reactions to a structured set of legislative incentives. Policy analyses should carefully consider that the full impact of these incentives might include effects that are more subtle than their explicit provisions suggest.

83. *CBO Testimony*, *supra* note 18, at 4 (calculating that expenditures for private plans in 2007 will be about 12% higher than traditional FFS Medicare costs).

84. *An Examination of the Medicare Advantage Program: Hearing Before the S. Comm. on Finance*, 109th Cong. 2 (statement of Glenn M. Hackbarth, Chairman, Medicare Payment Advisory Commission).

85. See FAMILIESUSA, SPECIAL REPORT: WHOSE ADVANTAGE? BILLIONS IN WINDFALL PAYMENTS GO TO PRIVATE MEDICARE PLANS 5 (June 2007), available at www.familiesusa.org/assets/pdfs/medicare-private-plans.pdf (last visited Oct. 11, 2007) (discussing how private MA plans largely rely on government subsidies to be profitable).