

YALE JOURNAL OF HEALTH POLICY, LAW, AND ETHICS

VOLUME XV

WINTER 2015

EXECUTIVE EDITORIAL BOARD

Editors-in-Chief

Claudia Kraft
Alix Rogers

Executive Editors

Yunsoo Kim
Tehreem Rehman

Managing Editors

Divya Srinivasan
Dvora Toren

Symposium Editors

Jeffrey Chen
David Christie

Research Editor

Kimberly Wachtler

SENIOR EDITORIAL BOARD

Article Editors

Elizabeth Dervan
William Hudson
Victoria Pasculli
Alex Setzepfandt
Annabel Xulin Tan

Guest Editors

Sean M. Arenson
Rose Carmen Goldberg
Nicholas Hodges
Elena Zarabozo

Submissions Editors

Marina Romani
Christine Monahan (Notes)

YALE JOURNAL OF HEALTH POLICY, LAW, AND ETHICS

VOLUME XV

WINTER 2015

STAFF EDITORS

Avni Bavishi
Eileen Condon
Lydia Cristobal
Kathy Doan
Julia Eichenfield
Maxwell Farina
Cory Gordon
Jennifer Mandelbaum
Nathan Nash
Adedotun Ogunbajo

Eunsong Park
Grayson Price
Joel Ramirez
Micha Sam Brickman Raredon
Miriam Rosenbaum
Joya Sonnenfeldt
Kara Stencil
Sophia Tonnu
Celeste Wong
Omer Zaidi

ADVISORY BOARD

- Henry J. Aaron, Ph.D., *Senior Fellow, Brookings Institution*
- Lori B. Andrews, J.D., *Professor, Chicago-Kent College of Law*
- George J. Annas, J.D., M.P.H., *Professor, Boston University Schools of Law, Medicine, and Public Health*
- John D. Arras, Ph.D., *Porterfield Professor of Biomedical Ethics, University of Virginia*
- M. Gregg Bloche, M.D., J.D., *Professor of Law, Georgetown University, and Co-Director, Georgetown-Johns Hopkins Joint Program in Law & Public Health*
- Troyen A. Brennan, M.A., M.D., J.D., M.P.H., *Executive Vice President and Chief Medical Officer, CVS Caremark*
- Scott Burris, J.D., *Professor, Temple University School of Law*
- Robert A. Burt, J.D., *Alexander M. Bickel Professor of Law, Yale Law School*
- James F. Childress, Ph.D., *Professor, University of Virginia*
- Paul D. Cleary, Ph.D., *Dean and C.E.A. Winslow Professor of Epidemiology and Public Health, Yale University School of Public Health*
- Ruth R. Faden, Ph.D., M.P.H., *Philip Franklin Wagley Professor of Biomedical Ethics and Director, The Phoebe R. Berman Bioethics Institute, Johns Hopkins University*
- Lawrence O. Gostin, J.D., L.L.D., *Professor and Director, Center for Law and the Public's Health, Georgetown and Johns Hopkins Universities*
- Christine Grady, R.N., Ph.D., *Head, Section of Human Subjects Research, Department of Clinical Bioethics, National Institutes of Health*
- Dean M. Hashimoto, M.D., J.D., M.P.H., *Associate Professor of Law, Boston College, and Chief of Occupational and Environmental Medicine, Massachusetts General Hospital and the Brigham and Women's Hospital*
- Timothy S. Jost, J.D., *Robert L. Willett Family Professor of Law, Washington and Lee University School of Law*
- Ruth Katz, J.D., M.P.H., *Dean and Walter G. Ross Professor of Health Policy, George Washington University School of Public Health and Health Services*
- David Kessler, M.D., J.D., *Dean, University of California, San Francisco School of Medicine, and Former Commissioner of the U.S. Food and Drug Administration*
- Alvin K. Klevorick, Ph.D., *John Thomas Smith Professor of Law and Professor of Economics, Yale Law School and Yale University Department of Economics*
- C. Everett Koop, M.D., Sc.D., *Senior Scholar, C. Everett Koop Institute at Dartmouth College and Former Surgeon General of the United States*
- Stephen R. Latham, J.D., Ph.D., *Deputy Director, Yale's Interdisciplinary Center on Bioethics*
- Jerold R. Mande, M.P.H., *Director of Policy Programs, Yale University School of Medicine*
- Theodore R. Marmor, Ph.D., *Professor, Yale University School of Management and Yale Law School*
- Leslie Meltzer, J.D., M.Sc., *Greenwall Fellow in Bioethics and Health Policy, Georgetown University Law Center and the Johns Hopkins Bloomberg School of Public Health*
- Theodore W. Ruger, J.D., *Professor, University of Pennsylvania Law School*
- Elyn R. Saks, M.Litt., J.D., *Orrin B. Evans Professor of Law, Psychology, and Psychiatry and the Behavioral Sciences, University of Southern California Gould School of Law*

TABLE OF CONTENTS

INTRODUCTION

- 1 Symposium Issue Introduction: The Law of Medicare and Medicaid at Fifty**
Abbe R. Gluck

KEYNOTE SPEECHES

- 21 Obamacare, Medicare, and Baseball's Greatest Pitchers**
Jonathan Cohn
- 27 Opening Remarks**
Ezekiel Emanuel

ARTICLES & ESSAYS

- 37 Medicare Advantage, Accountable Care Organizations, and Traditional Medicare: Synchronization or Collision?**
Thomas L. Greaney
- 57 The Reverberating Risk of Long-Term Care**
Allison K. Hoffman
- 67 The Universality of Medicaid at Fifty**
Nicole Huberfeld
- 89 Multiple Medicaid Missions: Targeting, Universalism, or Both?**
John V. Jacobi
- 111 The Accidental Administrative Law of the Medicare Program**
Eleanor D. Kinney
- 141 Medicare at 50: Why Medicare-for-all Did Not Take Place**
Theodore R. Marmor & Kip Sullivan
- 185 Medicaid at 50: No Longer Limited to the "Deserving" Poor?**
David Orentlicher

197 Clash of the Titans: Medicaid Meets Private Health Insurance

Sara Rosenbaum

213 Out of the Black Box and Into the Light: Using Section 1115 Medicaid Waivers to Implement the Affordable Care Act's Medicaid Expansion

Sidney D. Watson

HEALTH AFFAIRS BLOG POSTS

233 Social Insurance Is Missing a Piece: Medicare, Medicaid, and Long-Term Care

Judy Feder

237 1332 Waivers and the Future of State Health Reform

Heather Howard & Galen Benshoof

241 Medicare, Medicaid, and Pharmaceuticals: The Price of Innovation

Daniel J. Kevles

247 Challenges for People with Disabilities within the Health Care Safety Net

Michael R. Ulrich

Symposium Issue Introduction: The Law of Medicare and Medicaid at Fifty

Abbe R. Gluck*

INTRODUCTION

An exploration of the *law* of Medicare and Medicaid, fifty years in, will be viewed by some as asking for trouble. The search for “law” in health has had a quixotic quality: many forests have been sacrificed in service of arguments that the concept of health law has as much purchase as the concept of a law of concrete.¹

I do not subscribe to this view, but in any event, it is beside the point here. Whatever the merits of such arguments for some aspects of health, one should not be able to make claims about the difficulty of finding the “law” in Medicare and Medicaid. These two major health programs are *themselves laws*: they are major federal statutes. But for some reason, although thousands of pages have been written about Medicare and Medicaid *policy*, strikingly little has been written about their *source* and their *status* as federal statutes: what makes them different, as *laws*, than what came before?

Medicare and Medicaid began the transformation of health law from a field of local and private law (including professional self-regulation) to the field of *federal, statutory, public* law that it now undoubtedly has become, even if it is rarely described as such. The Affordable Care Act of 2010 (ACA)² stands as evidence of the completeness of this transformation and, from a legal perspective, this

* Abbe R. Gluck, Professor of Law, Yale Law School. This Introduction is dedicated to the health-law students at Yale Law School, without whose tireless energy and partnership over the last three years we would not have the remarkable Health Law Program that we now do. Thanks also to Jerry Mashaw, Sara Rosenbaum, Julian Polaris and especially to Michael Ulrich, our Senior Fellow in Health Law, whose assistance was instrumental to the conference, this volume, and this piece.

1. My colleague Jerry Mashaw deserves credit for this colorful analogy. The “law of the horse” is another favorite comparison. See Nan D. Hunter, *Risk Governance and Deliberative Democracy in Health Care*, 97 GEO. L.J. 1, 2 (2008). For a 2006 symposium devoted to health law’s lack of coherence, see Symposium, *Rethinking Health Law*, 41 WAKE FOREST L. REV. 446 (2006); cf. Theodore Ruger, *Health Law’s Coherence Anxiety*, 96 GEO. L.J. 625 (2008).

2. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), amended by Health Care and Education Reconciliation Act (HCERA) of 2010, Pub. L. No. 111-152, 124 Stat. 1029. PPACA, as amended, is often referred to as the “Affordable Care Act,” or the “ACA,” and will be referred to as such herein.

evolution changes much about where health law comes from and what influences it. Medicare and Medicaid injected an entirely new array of federal actors into the health arena—not just the federal courts (always the most obvious choice for lawyers) but, more importantly, Congress, federal administrators and even states, in their role as federal-law implementers. Although the ACA has drawn the attention, it was Medicare and Medicaid that started the legal conversation over the merits of government interference (and if so, which government) in health care.

Nevertheless, there has been little apparent academic interest in the federal statutorification of health law thus wrought in 1965. For one example of what has been absent, these two progenitor statutes lack much deep legal theorization relating to the norms that underlie them.³ In other subject-matter areas, legal scholars have developed theories of the particular field's "superstatutes"—the field of legislation's terminology for transformative federal laws.⁴ What values drive the federal immigration laws, voting rights legislation, environmental statutes, the Civil Rights Act, financial regulation and so on? No one feels compelled to seek out the "law" in these other areas, either, because we know where the law is—in the federal statutes.

So too, now, with health. In the context of the ACA, scholarship has in fact begun to emerge about that statute's normative basis. But the ACA builds squarely on the world of law and policy that Medicaid and Medicare created fifty years ago. It was Medicare and Medicaid that paved the way for the many federal statutes that followed in the interim, including the Health Maintenance Organization (HMO) Act of 1973,⁵ the Employee Retirement Income Security Act (ERISA) of 1974,⁶ and the Health Insurance Portability and Accountability Act (HIPAA) of 1996.⁷ Together, and long before the ACA, these moves fundamentally changed the players in health governance and the legal structures that control them.

And so, what are these two fraternal-twin statutes about? What norms defined them at the start, and do the same norms define them today? How has the federal intervention—and also, importantly, the nature and attendant pathologies of federal *institutions*—changed how health law and policy has developed? And what

3. For important exceptions, see THEODORE MARMOR ET AL., *SOCIAL INSURANCE: AMERICA'S NEGLECTED HERITAGE AND CONTESTED FUTURE* (2014); and Michael J. Graetz & Jerry L. Mashaw, *Ethics, Institutional Complexity and Health Care Reform: The Struggle for Normative Balance*, 10 J. CONTEMP. HEALTH L. & POL'Y 93 (1994).

4. See William N. Eskridge & John Ferejohn, *Superstatutes*, 50 DUKE L. REV. 1215 (2001).

5. Health Maintenance Organization (HMO) Act of 1973, Pub. L. No. 93-222, 87 Stat. 914 (1973) (codified as amended at 42 U.S.C. § 300(e) (2006)).

6. Employee Retirement Income Security Act (ERISA) of 1974, Pub. L. No. 93-406, 88 Stat. 829 (1974) (codified as amended at 29 U.S.C. §§ 1001-1461 (2006)).

7. Health Insurance Portability and Accountability Act (HIPAA) of 1996, Pub. L. No. 104-191, 110 Stat. 1936 (1996).

effect has the injection of Congress, federal courts, federal administrators and states had on matters ranging from scientific research and innovation to how the programs and rights created by the federal laws are paid for, modified and enforced?

If one looks to the caselaw for the answers to these questions one will be disappointed. Indeed, the propensity of legal scholars to look for “federal law” in only the federal courts may be a reason that health “law” has been so hard to find. As my own contribution to this conference illustrates, the U.S. Supreme Court is not intervening frequently or significantly in the field’s major questions. When the Court does intervene, it does so with little apparent interest in health itself and with no coherent or theoretical approach to how the web of health statutes that began with Medicare and Medicaid but progressed through the alphabet soup of laws that culminated (for now) with the ACA relate to one another. Eleanor Kinney’s contribution to the conference illustrates the same point with respect to how administrative law in the field has developed.⁸

This is another reason that focusing on the *statutorification* of the field is so important. Emphasizing the statutory source of Medicare and Medicaid broadens the legal landscape of health lawmakers. Congress emerges as paramount: Federal budget rules and Congress’s politics and internal structures—all matters completely unrelated to health law—are institutional forces that have a profound impact on how health law develops. So too federal administrators have their own toolbox of policy levers—ranging from administrative waivers to payment incentives—that they have deployed in this context to influence state and private actors in ways only possible for the federal government, with its unique leverage, to do.

Such was the genesis of the Yale Law School conference on The Law of Medicare and Medicaid at Fifty, and it is in this spirit that this Introduction frames the twenty-nine outstanding contributions to the event.⁹ Not every contribution—indeed, not most of them—wears the law on its sleeve. Approximately one-third of the panelists were not lawyers at all.¹⁰ But law this most certainly is. There is legal theory that lies within the conference debates about the values that now drive Medicare and Medicaid as well as the institutional analyses that the conference produced. Understanding the theoretical payoff of these explorations helps to chart

8. Eleanor D. Kinney, *The Accidental Administrative Law of the Medicare Program*, 15 YALE J. HEALTH POL’Y, L. & ETHICS 111 (2015).

9. Not all twenty-nine presentations are published as essays in this volume, but this Introduction discusses them all, except for one contributor who requested that his presentation not be discussed. Some of the shorter contributions to the volume also appeared first on *Health Affairs Online*, which accounts for the variability of length among the essays.

10. Other contributors included historians, physicians, economists, political scientists, policymakers and members of the media.

a path toward a deeper understanding of what the law of the field really is.

Two major themes emerge. The first is the unsettled nature of the modern *identities* of the two programs. How entrenched are the programs and what is driving their operation today? At least in the eyes of our contributors, the answer seems very different for each half of the pair. Medicare, the program that has traditionally stood on more solid ground, may now be more politically vulnerable than ever before. It also seems to be in the midst of an identity crisis; embracing no fewer than three different payment models, each of which reflects a very different set of values from the other. On the other hand, Medicaid, which, as Sara Rosenbaum put it, “has always had to fight for its life,”¹¹ may be on the threshold of achieving a “universality” (Nicole Huberfeld’s term¹²) that once was associated with Medicare’s animating theory but that Medicare never achieved.

What is more, the values and questions driving the programs, if ever linked, seem to have diverged significantly—as least as seen by our diverse and interdisciplinary group of contributors. The Medicare papers for the conference are almost singularly obsessed with markets and cost. In contrast, the Medicaid papers have an entirely different center of gravity, focused more on the social-welfare question of inclusion and exclusion of different populations. The second major theme goes to the legal *players*, especially those that (because they are not courts) have been overlooked in the past. This kind of modernized, statute-focused institutional analysis is common in some fields of legislation, but has yet to be applied to health law as a field. But consider how Congress’s own institutional limitations deriving from sources totally unrelated to health law profoundly affect how the statutory law of health develops. Several participants, including Keynote Speaker Ezekiel Emanuel and myself, focused on how Congress’s general tendency toward policy incrementalism has had lasting effects on health law’s evolution.¹³ Others, especially Tim Westmoreland, focused on the impact of the federal budget rules which, as Westmoreland put it, have given rise to a world of “health economics instead of a broader view of health policy.”¹⁴

Federal and state administrators emerge in the contributions as other key players, with the recurring theme being the different ways in which government

11. Sara Rosenbaum, *Panel 2: Medicaid, Then and Now*, Medicare and Medicaid at 50 Conference, held by Yale Law School (Nov. 6–7, 2014), http://www.law.yale.edu/news/medicare50_video.htm; see also Sara Rosenbaum, *Clash of the Titans: Medicaid Meets Private Insurance*, 15 YALE J. HEALTH POL’Y, L. & ETHICS 197 (2015).

12. Nicole Huberfeld, *The Universality of Medicaid at Fifty*, 15 YALE J. HEALTH POL’Y, L. & ETHICS 67 (2015).

13. Ezekiel Emanuel, *Opening Remarks*, 15 YALE J. HEALTH POL’Y, L. & ETHICS 27 (2015).

14. Timothy M. Westmoreland, *Panel 3: Historical Context, Legislation, Administration*, Medicare and Medicaid at 50 Conference, held by Yale Law School (Nov. 6–7, 2014), http://www.law.yale.edu/news/medicare50_video.htm.

uses its own policy levers—most notably its capacity to generate data and to leverage its power through payment incentives and federalism bargaining—to effectuate change both at the level of government policy but also on the ground, in the medical profession itself. This is a modern shift in the statutes’ original missions that should not be overlooked. By the statutes’ own terms, Medicare and Medicaid were not to “be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided.”¹⁵ Today, the government clearly views the programs as tools that influence how doctors work.

Finally, of course, courts and more formal aspects of administrative law also are present. But, notably, every paper to discuss them lamented the “accidental” (Kinney’s term¹⁶) and haphazard manner in which the caselaw and the administrative law have developed around the two programs. The incoherent doctrinal development, such as it is, provides further evidence that those who seek to know the “law” of Medicare and Medicaid—and likely the rest of health law—need to take a broader view of what health law is, where it comes from, and what influences it.

I. THEORIES OF MEDICARE AND MEDICAID—AND THEORIZING THEM TOGETHER

Medicare and Medicaid are fraternal twins that, like so many such pairs, have distinct personalities and life stories. The contributions to the conference strike recurring themes about the distinctive identities and modern preoccupations of each. Lawyers should care about these narratives because they have implications for legal interpretation and change. Understanding Medicaid, for example, as animated by the norm of universality would counsel a set of interpretations of that statute that might be different from an understanding of Medicaid as primarily occupied with certain needy populations. Understanding Medicare’s focus to be on the health care market has different implications for judicial review and legislative reform than an understanding of Medicare as animated by the questions of who the statute’s beneficiaries are or should be—for instance, Allison Hoffman’s argument in this volume that we should reconceptualize Medicare as a benefit not only for elderly but also for those who care for them.¹⁷

15. Social Security Amendments of 1965, Pub. L. No. 89–97, § 1801, 79 Stat. 286, 291 (codified as amended at 42 U.S.C. § 1395 (2012)).

16. Kinney, *supra* note 8.

17. Allison K. Hoffman, *The Reverberating Risk of Long-Term Care*, 15 YALE J. HEALTH POL’Y, L. & ETHICS 57 (2015).

In other words legal scholars need a *theory* of each statute. Medicare in particular, at least among our contributors, seems to lack a coherent theory of its own purpose—or even a set of theories. Both Ezekiel Emanuel and Jonathan Cohn suggested that Medicare may be politically vulnerable for the first time in its life, making the question of its underlying normative foundation particularly important. Medicaid’s future always has seemed more precarious but, as several contributors pointed out, Medicaid has shown a remarkable ability to adapt and evolve to ensure its own survival.

A. Medicare’s Competing (or Lacking) Normative Visions

The most salient theme that emerges from the contributions about Medicare is the lack of a clear modern normative vision of what the program is trying to do, beyond its initial mission of coverage (the success of which no one seems to dispute). The program’s original emphasis, which was grounded in the hope of eventual universal health insurance, has given to way several different, and arguably conflicting, internal models each based on a different view of the relationships among social insurance, the marketplace, and the profession.

1. Medicare’s Multiple Models

Nicholas Bagley¹⁸ and Thomas Greaney¹⁹ each detail the three different “mini” programs within Medicare today: the original fee-for-service model; Medicare Advantage (added approximately thirty years later²⁰), which has a competition component; and the Accountable Care Organization (ACO) model (introduced by the ACA²¹), which incentivizes integration and coordination by providers in return for cost savings. As Greaney observes, each mini-program has a different normative foundation. Fee-for-service embraces the traditional value of the independent physician and the open market, with little emphasis on cost savings. Medicare Advantage aims to introduce more competition but is not a fully

18. Nicholas Bagley, *Panel 6: Looking Ahead, Medicare and Medicaid at 50 Conference*, held by Yale Law School (Nov. 6–7, 2014), http://www.law.yale.edu/news/medicare50_video.htm.

19. Thomas L. Greaney, *Medicare Advantage, Accountable Care Organizations, and Traditional Medicare: Synchronization or Collision?*, 15 YALE J. HEALTH POL’Y, L. & ETHICS 37 (2015).

20. Part C and the managed care plan were created in the Balanced Budget Act of 1997, which established Medicare+Choice. Some changes were made and the program was renamed Medicare Advantage by the 2003 MMA. See *Medicare Advantage Fact Sheet*, KAISER FAM. FOUND. (May 2014), <http://kff.org/medicare/fact-sheet/medicare-advantage-fact-sheet>.

21. Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, § 3022, 124 Stat. 120, 395 (codified as amended at 42 U.S.C. § 1395jjj (2012)).

competitive model because plans must bet against an administratively determined price. ACOs embrace an entirely different view of what the system should look like: a vertically and horizontally integrated system of health care that puts a premium on cost savings.

Although not mentioned by the participants, it seems likely that the incremental way in which Congress tends to expand major federal programs bears at least some of the blame for Medicare's internal fragmentation. Each of the above-listed models was added during a different moment of expansion. Medicare's basic structure is also itself fragmented: Each of Medicare's four parts—Part A for hospital coverage; Part B for physicians; Part C for the Advantage Plans; and Part D for prescription drugs—has a different aim and the sources of funding vary across the programs. Only Parts A and B were added at the same time.

The way in which these papers highlight Medicare's internal variations also suggests an interesting link to Medicaid that has not yet been explored. Medicaid has always tolerated, even embraced, its own internal variety, because it is explicitly designed to allow flexible and diverse implementation by the states. Medicare, on the other hand, has always been theorized as the all-federal, someday-“universal” program with homogeneous benefits nationwide. But these distinctions seem overstated. As the contributions illustrate, Medicare in fact has its own story of internal diversity, not only in the different payment models but also, as Bagley notes, in its history of experimenting with different forms of peer review. I would also note here that Medicare benefits review determinations have a local character. Most coverage decisions are made by local-level clinicians who work with the Medicare administrative contractors that process Medicare claims.²² This is another way in which Medicare has resisted uniformity in its development even as universality has always been its dominant norm.

2. Medicare's Unaccomplished Universality

As noted, Medicare originated with a strong normative vision of universality of coverage in a social insurance model. In their contributions, James Morone and Ted Marmor and Kip Sullivan each detail how, in 1965, Medicare was assumed to be the first step toward an eventually-universal expansion.²³

22. Michael J. DeBoer, *Medicare Coverage Policy and Decision Making, Preventative Services, and Comparative Effectiveness Research Before and After the Affordable Care Act*, 7 J. HEALTH & BIOMED. L. 493, 506 (2012).

23. Ted Marmor & Kip Sullivan, *Medicare at 50: Why Medicare-for-all Did Not Take Place*, 15 YALE J. HEALTH POL'Y, L. & ETHICS 141 (2015); Jim Morone, *Panel 1: Medicare, Then and Now*, Medicare and Medicaid at 50 Conference, held by Yale Law School (Nov. 6–7, 2014), http://www.law.yale.edu/news/medicare50_video.htm.

What changed? Relevant to the importance of identifying a compelling normative vision for the statute, Marmor and Sullivan argue that it was a set of *competing norms*—most importantly, the pro-competition philosophy of the 1970s—that undermined Medicare’s universalist vision.²⁴ Morone levies a different charge, one joined by Jonathan Cohn in his keynote address: changing politics.²⁵ Both argue that the particular circumstances of 1965 made this dual enactment possible in ways that could not be accomplished today and that could not sustain the original vision: A Democratic president who simply had to unite his *own* divided party (rather than overcome today’s partisan gridlock) in a political moment that—largely because of the triumph of the Civil Rights Act of 1964—was temporarily marked by a lack of racialized politics and so, relatedly, a temporary lack of suspicion of social welfare programs.

Whatever the reason, the problem for Medicare now is its vision for the next fifty years. The various models of payment detailed in the previous section open the possibility of different futures for Medicare that span the range from the social insurance model to a highly integrated regime driven primarily by cost. Morone argues that the Republicans have a clear vision of what Medicare should look like going forward—one grounded in privatization, a vastly different norm than that which underlay the program at its founding. The Democrats, he charges, have no such clear, competing view.²⁶ The other panelists made similar observations, with Cohn in particular emphasizing that Medicare is more at risk than ever to be fundamentally transformed.

3. Medicare, Markets, and its Modern Influence Over The Profession

The other striking aspect of the Medicare contributions is the almost singular focus on *cost* and *markets*. Almost no attention is given to the extent of Medicare coverage or to questions of inclusion and exclusion of populations under Medicare’s umbrella. Two exceptions come from Judith Feder and Allison Hoffman, who discuss the lack of coverage for long term care, and Michael Ulrich, who discusses the insufficiency of benefits for disabled persons.²⁷ But all three contributors focus on deficiencies in both programs; their arguments are not about Medicare per se. In the long term care context, in particular, Medicaid currently

24. Marmor & Sullivan, *supra* note 23.

25. Jonathan Cohn, *Obamacare, Medicare, and Baseball’s Greatest Pitchers*, 15 YALE J. HEALTH POL’Y, L. & ETHICS 21 (2015); Morone, *supra* note 23.

26. Morone, *supra* note 23.

27. Judy Feder, *Health Affairs Blog Post: Social Insurance is Missing a Piece: Medicare, Medicaid, and Long-Term Care*, 15 YALE J. HEALTH POL’Y, L. & ETHICS 233 (2015); Hoffman, *supra* note 17; Michael R. Ulrich, *Health Affairs Blog Post: Challenges for People with Disabilities Within the Health Care Safety Net*, 15 YALE J. HEALTH POL’Y, L. & ETHICS 247 (2015).

carries most of the water with respect to coverage.

The other contributions focus on Medicare's impact on markets—and, interestingly, on the program's related impact on the profession. David Hyman and Tim Westmoreland focus on Medicare's complex and nontransparent budgeting, which is driven by the particulars of the federal budget process, further detailed below.²⁸ Jacob Hacker emphasizes cost control, but also argues that the focus on Medicare costs has been disproportionate to Medicare's influence, and urges for that debate to be brought into the broader health-policy context.²⁹ Bagley and Greaney focus on provider markets,³⁰ while Daniel Kevles discusses Medicare's influence over the development of prescription drugs,³¹ and Harlan Krumholz and Rahul Rajukumar focus on how CMS uses payment incentives and big data to influence the practice of medicine.³²

Almost all of these contributions are notable for their theorization of Medicare's market power as a tool of *leverage over the profession*, despite Medicare's own statutory promise not to affect the practice of medicine. This presents another big question for any developing theory of Medicare. Medicare's initial fee-for-service model indeed seems consistent with its initial vision of leaving the profession untouched. But now, the program seems to have evolved with a very different set of views both about the role of government in affecting the way that doctors practice and about the need for change in the profession, whether it comes in the form of cost savings or in the use of more evidence. Ted Ruger's contribution to the symposium calls this the triumph of a "Weberian" vision—an organized, hierarchical model of the profession—over the system's initial focus on the "Madisonian" values of pluralism and individualism.³³ Whatever it is, it signifies an important theoretical shift that has gone mostly unmined.

28. David Hyman, *Panel 1: Medicare, Then and Now*, Medicare and Medicaid at 50 Conference, held by Yale Law School (Nov. 6–7, 2014), http://www.law.yale.edu/news/medicare50_video.htm; Westmoreland, *supra* note 14.

29. Jacob S. Hacker, *Panel 3: Historical Context, Legislation, Administration*, Medicare and Medicaid at 50 Conference, held by Yale Law School (Nov. 6–7, 2014), http://www.law.yale.edu/news/medicare50_video.htm.

30. Bagley, *supra* note 18; Greaney, *supra* note 19.

31. Daniel J. Kevles, *Health Affairs Blog Post: Medicare, Medicaid, and Pharmaceuticals: The Price of Innovation*, 15 YALE J. HEALTH POL'Y, L. & ETHICS 241 (2015).

32. *Panel 4: Policymaking and Innovation*, Medicare and Medicaid at 50 Conference, held by Yale Law School (Nov. 6–7, 2014), http://www.law.yale.edu/news/medicare50_video.htm.

33. Theodore Ruger, *Panel 6: Looking Ahead*, Medicare and Medicaid at 50 Conference, held by Yale Law School (Nov. 6–7, 2014), http://www.law.yale.edu/news/medicare50_video.htm.

*B. Medicaid's "Mission Uncertainty"*³⁴

The Medicaid story seems completely different, at least from the perspective of our contributors. Here, there is a clear theoretical question staked out by virtually everyone who discusses the program: namely, whether Medicaid should be reconceptualized in its next half-century as a universal program or whether it should stay true to its initial mission of focusing on the poor. So understood, the heart and soul of Medicaid theorization—at least in this moment—is the question of “Medicaid’s mission uncertainty” (John Jacobi’s term).³⁵ The focus on inclusion and exclusion and on the program’s ultimate aims strikes a very different note from the Medicare papers.

1. Universality versus a Program Focused on the Poor

Medicaid’s own history supports a story of step-by-step expansion toward a universal paradigm to some extent. The program began with coverage for a small segment of the “deserving poor”—pregnant women and children—and then expanded over fifty years to include many more special populations. The expansion, of course, culminated with the ACA’s universalist-leaning expansion to *all* persons, regardless of special category, with incomes up to 138% of the poverty level.³⁶ The Supreme Court made the expansion optional,³⁷ but even so there has been a domino-effect among the states in expanding (just as in the case of Medicaid’s first iteration, with Arizona not adopting the program until 1982). In other work, Tom Baker, Nicole Huberfeld, Ted Ruger and I illustrate how this current expansion is highly dynamic and likely to culminate in complete adoption.³⁸

In this volume, our contributors disagree about Medicaid’s fundamental aims. Huberfeld’s vision of Medicaid’s “universality” is underpinned by a hope of continued expansion but also one that sees Medicaid as universal, even now. As she puts it, because Medicaid now pays for so much—almost 50% of births in the United States and 60% of long term care, “most of us are all going to be on Medicaid eventually.”³⁹ Thus, Huberfeld’s work re-theorizes Medicaid beyond its “poor-person” paradigm, pushing toward a broader acceptance on the part of most

34. John V. Jacobi, *Multiple Medicaid Missions: Targeting, Universalism, or Both?*, 15 YALE J. HEALTH POL’Y, L. & ETHICS 89 (2015).

35. *Id.*

36. Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, § 2001, 124 Stat. 120, 271 (codified as amended at 42 U.S.C. § 1396a (2012)).

37. Nat’l Fed’n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566, 2601–08 (U.S. 2012).

38. Tom Baker et al., *New Health Federalism* (unpublished manuscript on file with author).

39. Huberfeld, *supra* note 12.

Americans that they will benefit not only from Medicare, but Medicaid as well. In many respects, it is part of a project to remove Medicaid's stigma.

Other contributors take a different view. David Orentlicher still sees two-tiers in the program, which leads him to doubt its potential for true universality.⁴⁰ He details how the Medicaid expansion is distinct from the traditional Medicaid population, which means that the two groups may receive different benefits.⁴¹ He also argues that because Medicaid still only covers the less well off, the middle class and the rich continue to have no stake in the program, as they do in Medicare. Both factors, in his view, reduce the likelihood that the stigma will be erased.

Mark Hall and Tim Jost both emphasize Medicaid's relationship to racism, another barrier to a truly universal conceptualization. Hall sees a bias against the poor (often minority) population in states that resist expansion.⁴² Jost argues that the historical roots of state administration of Medicaid programs are found in racism and that the continued resistance of conservative states to Medicaid expansion carries on a history of discrimination.

Jacobi takes a stronger view in opposition to Huberfeld, urging that we cling to a theory of Medicaid grounded in its original mission to serve those without means.⁴³ In his view, a driving norm of universality might undercut that mission, resulting in less focus on the unique health needs of the extreme poor—Medicaid's initially-intended beneficiaries. Jacobi's vision of Medicaid expands beyond mere health coverage, too. He sees Medicaid's potential as the cornerstone of a program of interlinked social services which he calls Total Accountable Care Organizations (TACOs), which are designed to address not only health issues but also food, housing, and other social supports that have a large impact on health status and wellbeing. Economist Amanda Kowalski's contribution, which studies Medicaid's positive impact on the production of other social goods, such as tax payments later in life and college attendance,⁴⁴ lends support to this notion.

2. Medicaid's Flexibility and Its Federalism

Medicaid's "scrappiness" (Rosenbaum's term) emerges from the

40. David Orentlicher, *Medicaid at 50: No Longer Limited to the Deserving Poor?*, 15 YALE J. HEALTH POL'Y, L. & ETHICS 185 (2015).

41. As in the Medicare context, here too one sees health law's multiplicity of programming even when the ostensible goal is universality.

42. Mark Hall, *Panel 5: Are There Any Plausible Reasons for States to Refuse Medicaid Expansion?* available at http://www.law.yale.edu/news/medicare50_video.htm.

43. Jacobi, *supra* note 34.

44. David Brown, Amanda Kowalski & Ithai Lurie, *Medicaid as an Investment in Children: What is the Long-Term Impact on Tax Receipts?*, (Nat'l Bureau of Econ. Research, Working Paper No. 20835, 2015).

contributions as another distinguishing feature. Rosenbaum describes Medicaid as the “big shock absorber” that has had to “fight for its life,” and so learned to adapt and “do what no other program can.”⁴⁵ “Law” plays an important role here, in the sense that Medicaid’s dynamism is no doubt attributable in large part to its governance structure. Medicaid is the quintessential statutory federalism program, structured as joint enterprise between states and the federal government (in contrast to Medicare, which is essentially federal all the way down⁴⁶). Like most cooperative federalism programs, Congress designed Medicaid to take advantage of existing state programming in the subject-matter area and so the program preserves and facilitates ongoing policy variation.

Several contributors highlight Medicaid’s federalism as its defining characteristic, but also one that poses some interesting challenges for the future. Sidney Watson discusses the successful history of Medicaid’s Section 1115 demonstration waivers—the administrative waiver provision that has allowed many states to evolve their programs (and in fact, as I have discussed elsewhere,⁴⁷ often has facilitated the states as “testers” for the kinds of expansions later adopted by the federal government). Heather Howard focuses on how the ACA’s new section 1332 State Innovation Waiver provisions might likewise facilitate adaptation.⁴⁸

From a doctrinal perspective, however, waivers raise tricky questions. My own work has highlighted the legal black hole into which waivers fall: there are generally no process provisions, no guarantee that states will have equal bargaining power, and no requirements for transparency to or input from the public. Watson’s piece is very important on this point, as it highlights an until-now undernoticed provision of the ACA that for the first time makes waiver applications public; sets forth what must be specified in them; requires CMS to be similarly specific and publicly disclose what is being approved and why, along with public comments; and requires CMS to create a process for notice-and-comment at both the state and federal levels.⁴⁹ This is an important example of Medicaid leading the way on a

45. Sara Rosenbaum, *Panel 2: Medicaid, Then and Now*, Medicare and Medicaid at 50 Conference, held by Yale Law School (Nov. 6–7, 2014), available at http://www.law.yale.edu/news/medicare50_video.htm.

46. *But cf. supra* note 23.

47. Abbe R. Gluck, *Federalism from Federal Statutes: Health Reform, Medicaid, and the Old-Fashioned Federalists’ Gamble*, 81 *FORDHAM L. REV.* 1749, 1763–65 (2013).

48. Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, § 1332, 124 Stat. 120, 203 (codified as amended at 42 U.S.C. § 18052 (2012)); Heather Howard, Panel 4, *Health Law Federalism, Especially after NFIB*, Medicare and Medicaid at 50 Conference, held by Yale Law School (Nov. 6–7, 2014), http://www.law.yale.edu/news/medicare50_video.htm.

49. *See* Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, § 10201, 124 Stat. 120, 917 (amending § 1115 of the Social Security Act, 42 U.S.C. § 1315 (2014), on Medicaid demonstrations); Sidney Watson, *Out of the Black Box and Into the Light: Using Section 1115*

cutting edge legal issue that has occupied federalism theories in general but has received little attention in the health context.

Alan Weil lauds Medicaid's successful history of policy experimentation, but also reprises another theme that has occupied the general federalism literature of late; namely, that state-led policy experiments, although they occur frequently in cooperative federalism programs, are rarely done with the scientific rigor of proper policy experiments.⁵⁰ Weil describes the lack of data management in, and the often-too-quick interstate adoption of, state experiments. This offers another contrast to Medicare. As Weil points out, Medicare is very good at formal experiment design, but has much less success than Medicaid in the uptake of successful experiments. Ted Ruger's contribution again comes to mind here, in the sense of whether this aspect of the health care system—innovation—best occurs through a top-down model or a more federalist structure.

Not all participants were so sanguine about Medicaid's federalism structure. As noted, Mark Hall and Tim Jost associate it with racism; Abigail Moncrieff simply finds it unsustainable, especially in light of recent Supreme Court decisions making it more difficult to enforce the statute against lax states. As she argues, the Court in *NFIB v. Sebelius*⁵¹ effectively eliminated HHS's power to cut off Medicaid funding from uncooperative states. Just a few months earlier, in *Douglas v. Independent Living Center*,⁵² the Court also implied that it would be very difficult for Medicaid providers or beneficiaries to challenge state implementation of the program in court.⁵³ As such, Moncrieff predicts the eventual federalization of Medicaid to ensure that the federal government can properly enforce it. Understood through the lens of these contributors, Medicaid's federalism structure adds yet another layer of complexity to understanding how the program can achieve its intended results and outcomes. Even as Medicaid federalizes the law of health finance, it still must interact with and remain heavily dependent on state law.⁵⁴

In the end, the apparent consensus (or resignation) as to Medicare's coverage scope seems to be driving Medicare theory into different areas than Medicaid, where the theoretical inquiries remain focused on themes of inclusion and

Medicaid Waivers to Implement the Affordable Care Act's Medicaid Expansion, 15 YALE J. HEALTH POL'Y, L. & ETHICS 213 (2015); see also ERIN RYAN, *FEDERALISM AND THE TUG OF WAR WITHIN* (2011) (discussing the state-federal administrative bargaining process).

50. Gluck, *supra* note 47, at 1764.

51. 132 S. Ct. 2566 (2012).

52. 132 S. Ct. 1204 (2012).

53. Another case currently pending before the Court raises the same issue. See *Armstrong v. Exceptional Child Care Center, Inc.*, No. 12-35382 (U.S. Jan. 20, 2015).

54. Thanks to Sara Rosenbaum for this insight.

exclusion. When Medicare was first proposed, its own debate, too, focused on how many to cover and whether to expand. But, today, the question for Medicare appears not to be about transformational change but, rather, about modest internal improvements that may increase the program's stability and leverage over both the broader health market and the profession. Medicaid was barely discussed in terms of either markets or the profession, but at the same time was repeatedly referenced as more dynamic and more vibrant. As a whole, the papers thus map some rather striking differences in the modern identities of these fraternal twins.

II. INSTITUTIONAL THEORY: THE PLAYERS

Health law has not lacked for institutional analysis, but the institutions that have garnered most of the academic attention in the field are not the same intuitions at the center of the federal statutory field of health law that Medicare and Medicaid created. Health law scholars tend to talk about patients, doctors, insurers, markets, courts, and sometimes states in their field analyses.⁵⁵ Most lacking from this inquiry has been a study of how Congress's institutional pathologies affect health policy, and to a lesser extent (Jost and Kinney offer important exceptions⁵⁶) the role of federal administrators. In organizing the conference, we hoped that participants would bring out this more modern institutional story of health law.

A. Congress

Three themes emerge with respect to Congress's influence. Critically, these are elements of Congress as an institution that have nothing do with health law *per se* but that affect health law dramatically, thereby substantiating the importance for modern health law scholars of gaining a better understanding of how Congress works.

Of most importance was the role of the federal budget process in setting health policy. Tim Westmoreland's contribution details how the difference between mandatory and discretionary spending on federal programs has an enormous impact on how health policy develops.⁵⁷ Westmoreland describes mandatory spending as a "promise," whereas discretionary spending remains subject to the annual whims of politics. To me, this raises an important *expressive* aspect to the

55. See M. Gregg Bloche, *The Emergent Logic of Health Law*, 82 S. CAL. L. REV. 389 (2009); Mark A. Hall, *Law, Medicine, and Trust*, 55 STAN. L. REV. 463 (2002); Rand E. Rosenblatt, *The Four Ages of Health Law*, 14 HEALTH MATRIX 155 (2004).

56. Timothy S. Jost, *Health Law and Administrative Law: A Marriage Most Convenient*, 49 ST. LOUIS U. L. J. 1 (2004); Eleanor D. Kinney, *Administrative Law and the Public's Health*, 30 J. L. MED. & ETHICS 212 (2002).

57. Westmoreland, *supra* note 14.

fiscal structure of any government program. Programs grounded in mandatory spending, as are Medicare and Medicaid, wear their entrenchment on their sleeve by virtue of their financing structure.

At the same time, Westmoreland and also David Hyman highlight how the way in which mandatory spending is budgeted—over a ten-year window—may skew aspects of health policy. For Hyman, the problem is a lack of transparency—a creative accounting that he views on par with the accounting related to the Enron scandal.⁵⁸ For Westmoreland, the issue is both the short-term nature of the budget—it must be costed out over ten years—and also the strange ways in which the budget deincentivizes programs that increase lifespan, because longer lives increase the short-term cost of federal programs. Coverage for vaccinations, for example, while sound health policy, creates budget difficulties for precisely this reason. Moreover, because the federal budget (not just the Medicaid/Medicare budget) must be balanced over a ten-year period, longer-term savings from certain proven interventions (such as reducing children's exposure to lead paint) face challenges at adoption because they must be paid for upfront.⁵⁹

Two other features of Congress's internal structure also emerge as relevant to understanding health law's development. Both Ezekiel Emmanuel's keynote address and my own contribution emphasize the well-known, institutionalized inertia of the legislative process. In the nation's libertarian tradition, Congress is structured to make legislation difficult. Fewer than 10% of bills escape committee review and make it to the floor for consideration by the full membership. As a result, sweeping legislative changes are highly unlikely in American governance; instead, ours is a tradition of policy incrementalism and path dependence.⁶⁰ That tradition explains in large part why Medicare and Medicaid, though born together, have such different governance structures. Medicaid followed the path of already-existing state-charity care programs and so built its structure on that pre-existing state terrain. It also explains why both programs were initially designed to reach smaller populations, with the hope of later expansion. And it explains why Congress left the status quo—the employer-provided insurance system—intact when it added the two new layers of federal insurance.

In this sense, Congress's tendencies toward policy incrementalism and path dependence also explain how Medicare and Medicaid put us on the path toward the kind of health governance fragmentation that so many health experts criticize. Understanding how Congress legislates as the explanation and also the obstacle

58. Hyman, *supra* note 28.

59. Westmoreland, *supra* note 14.

60. I have detailed this elsewhere. See Gluck, *supra* note 47, at 1760–65; see also Charles E. Lindblom, *The Science of "Muddling Through,"* 19 PUB. ADMIN. REV. 79, 84 (1959) (discussing the incremental change in U.S. policies).

further explains why the ACA itself could not possibly have swept that fragmentation away (as many advocate it should have⁶¹) and started from scratch.

A third essential institutional feature of Congress is its division into policy-expert committees. My own work highlights how the committee system also has contributed to fragmentation and difficult implementation issues in the health arena and beyond.⁶² Different committees have jurisdiction over different aspects of health statutory law, and these committees oversee a variety of different agencies that are candidates to implement the laws. The result is fragmentation and complex administrative overlap. For instance, in the House of Representatives, Medicare and Medicaid are not even themselves completely under the jurisdiction of the same congressional committee. With respect to administration, ERISA is administered by the Department of Labor; Medicaid and Medicare by HHS; and the ACO provisions of the Affordable Care Act are administered by a range of agencies, including IRS, FTC, HHS; and DOJ. This type of institution-driven lawmaking and administrative fragmentation may well contribute to a lack of coherence in health policy in general, and also the particularly haphazard way in which the relevant caselaw and administrative law doctrines have developed.

B. Administrators, New Governance, and Innovation

Any statutory theory of health law also must include the administrators. I already have detailed several key features of the administrative landscape that emerge from the contributions. Kinney emphasizes the “accidental” evolution of health administrative law from 1965, when Congress envisioned only a small role for administrators, to today, when administrative law seems to do much more health-law work than the judicial system. Howard, Rosenbaum, and Watson, as discussed, focus on the landscape of federal and state administrative negotiations, which is critical to any legal understanding of Medicaid’s administrative law.

The additional theme that I wish to highlight here is what I would call health law’s “new governance” model of administration. The new governance literature is rarely extended to health law,⁶³ but many of the presentations from the

61. EINER ELHAUGE ET AL., *THE FRAGMENTATION OF THE U.S. HEALTH CARE: CAUSES AND SOLUTIONS* (Einer Elhauge ed., Oxford Univ. Press 2010).

62. Abbe R. Gluck & Lisa Schultz Bressman, *Statutory Interpretation from the Inside—An Empirical Study of Congressional Drafting, Delegation and the Canons: Part I and Part II*, 65 STAN. L. REV. 901 (2013) and 66 STAN. L. REV. 725 (2014).

63. An important exception is Louise G. Trubek, *New Governance and Soft Law in Health Care Reform*, 3 IND. HEALTH L. REV. 139 (2006), who discusses other ways that new governance appears in health law; cf. Nan D. Hunter, *Risk Governance and Deliberative Democracy in Health Care*, 97 GEO. L.J. 1, 56 (2008) (drawing on new governance literature to advocate “risk-pool governance structures” in the insurance context to “enhance[e] democratic norms in health care policymaking”).

conference point toward it as an appropriate and helpful frame. New governance is a term that emphasizes collaboration with third parties in addition to the government to manage traditional regulatory challenges in a new manner.⁶⁴ It is characterized by a recognition that multiple layers of review and multiple stakeholders—typically both inside and outside the federal government, including states and the private sector—can together produce, through redundancy and sometimes informal interaction, better and more innovative policy solutions than the federal government acting alone. Across the contributions to this volume, new governance emerged as an important way in which the federal government is working, through Medicare and Medicaid, to spur scientific research and medical innovation.

Two policy levers of health administrators seem to be paramount: data and payment. Krumholz and Weil both detail the way in which federal health-law administrators have used data to partner with both states and the private sector in encouraging policy and practice innovation.⁶⁵ Weil's contribution, as noted, goes to the respective advantages of CMS versus the states in conducting policy experiments. Krumholz focuses on one particular disease: he tells the story of the path-breaking Health Care Quality Improvement Initiative (HCQII)'s Cooperative Cardiovascular Project (CCP), a massive CMS-led, data-driven study of treatment of heart attacks that had a profound effect on how the profession treats the disease.

Daniel Kevles and Rahul Rajukumar detail the power of payment in innovation policy. Kevles details how Medicare and Medicaid had relatively little impact on the pharmaceutical industry until 2003, when Congress enacted Medicare Part D, the prescription drug benefit. Part D not only spurred pharmaceutical R&D but in particular, Kevles emphasizes, it also promoted R&D with respect to drugs related to the specific population—the elderly—associated with Medicare.

Rajukumar describes CMMI's use of payment mechanisms to incentivize physicians to collaborate, save money and use evidence-based practice methods. This more modern vision of what role Medicare is playing in the broader system relates directly to Bagley and Greaney's discussion of how Medicare's new payment models reflect how new norms are animating the program.

There is a broad health policy literature on how difficult it is to change the

64. Lester M. Salamon, *The New Governance and the Tools of Public Action: An Introduction*, 28 FORDHAM URB. L. J. 1611, 1623 (2001); see also Orly Lobel, *The Renew Deal: The Fall of Regulation and the Rise of Governance in Contemporary Legal Thought*, 89 MINN. L. REV. 342, 343 (2004) (discussing how the new governance model challenges the standard focus on formal regulation as the primary method of creating change).

65. Panel 4: *Policymaking and Innovation*, Medicare and Medicaid at 50 Conference, held by Yale Law School (Nov. 6–7, 2014), available at http://www.law.yale.edu/news/medicare50_video.htm.

culture or practice of the medical profession.⁶⁶ Although none of the contributors engage that literature in the context of these topics, the link to it seems obvious. New governance strategies appear to be particularly effective tools here. All of the contributors on these topics reference physicians as “partners” in the programmatic efforts—a way of thinking about regulation that is quite consistent with a new governance model. Moreover, as relevant to this Introduction’s focus on where the “law” is, as Louise Trubek notes, “new governance is transformative of law in that it challenges what we think of as law”—in particular, informal processes, interactions, and negotiations take on much deeper significance, even though most cannot be challenged or enforced in court.⁶⁷

C. Courts

Courts make only a minor appearance among the contributions, further suggestive evidence that courts are not the primary lawmakers when it comes to Medicare and Medicaid (and likely not the rest of the health statutes, either). The main themes here are the lack of doctrinal coherence and what might be called a lack of “health-law-awareness.”

Moncrieff, as noted, juxtaposes the Supreme Court’s decisions in the *Sebelius* case⁶⁸ and the *Independent Living Center* case⁶⁹ to illustrate how the Court has effectively eviscerated the federal government’s ability to enforce Medicaid. She argues that the Court likely has done so unwittingly, without attention to how one decision affects other aspects of the program, or how the two decisions relate to one another.⁷⁰

My own contribution, which relays the results of an empirical study of all of the Court’s decisions concerning Medicare and Medicaid since 1965, corroborates Moncrieff’s intuition.⁷¹ The Court almost never references a sibling health-law statute when it interprets another. Thus, the Court does not consider how its Medicaid decisions might affect Medicare, and so on. Nor does the Court invoke health policy, or interpret the statutes through the lens of any of the traditional

66. See Richard S. Saver, *Health Care Reform’s Wild Card: The Uncertain Effectiveness of Comparative Effectiveness Research*, 159 U. PA. L. REV. 2147, 2155 (2011).

67. Trubek, *supra* note 63, at 149.

68. 132 S. Ct. 2566, 2601–08 (U.S. 2012).

69. 132 S. Ct. 1204 (2012).

70. Abigail R. Moncrieff, *Panel 3: Historical Context, Legislation, Administration, Medicare and Medicaid* at 50 Conference, held by Yale Law School (Nov. 6–7, 2014), available at http://www.law.yale.edu/news/medicare50_video.htm.

71. Abbe R. Gluck, *Panel 3: Historical Context, Legislation, Administration, Medicare and Medicaid* at 50 Conference, held by Yale Law School (Nov. 6–7, 2014), http://www.law.yale.edu/news/medicare50_video.htm; see Abbe R. Gluck, *Health Law as Public Law* (unpublished manuscript on file with author).

norms long utilized and advocated by health-law professors (including solidarity, dignity, trust, vulnerability of health consumers, quality of life, the value of health, health economics and so on). Instead, the Court appears to treat each health-statutory case as a “one-off” case of routine statutory construction.

One takeaway, then, is that health lawyers need to pay more attention to the *law of statutes* in this modern age of federal statutory health law. Just as I have emphasized how Congress’s pathologies unrelated to health law profoundly affect health law’s development, so too, the Court has its own institutional preferences when it comes to statutory cases that do not stem from health law but may strongly influence it. For instance, the rise of textualism as the dominant interpretive philosophy on the Court means that the Court may now take a more text-centric approach to interpreting Medicare and Medicaid, even if it had not done so when the statutes were first enacted. The Court’s panoply of administrative-law deference doctrines, which continues to grow, also has a significant effect on health-law case outcomes. Understanding these statutory-law doctrines may now be as important to health lawyers as understanding health policy. Another takeaway, of course, is that health lawyers have an important role to play in educating the courts about the health statutes themselves, and the relationships among them.

CONCLUSION

To an important extent, the Supreme Court’s shortcoming in the Medicare and Medicaid context is a red herring. The Court has decided remarkably few cases concerning the programs over the past fifty years: fewer than thirty Medicare cases and fewer than fifty Medicaid cases. These numbers provide further evidence that one must look beyond traditional legal domains to find much of the “law of Medicare and Medicaid.”

But that does not mean that the law is not there. The twenty-nine insightful contributions to this conference reveal a legal landscape far richer than one that could be created by courts alone. These are *federal statutes*, and so we find much of their law in public law’s central institutions and in theories of the statutes themselves. As such, we find the law of Medicare and Medicaid in the Congress, the agencies, and the states—and in their interactions with one another and with the profession. And we find it when we look into the statutes and push for a deeper normative account of what values and questions drove them at their enactment and what drives them today. These are the legal lessons of Medicare and Medicaid’s first fifty years, and they have only begun to be uncovered. Far more lie ahead in the next fifty, should we choose to look in the right places.

Obamacare, Medicare, and Baseball's Greatest Pitchers

Jonathan Cohn*

What follows is a story about health policy and baseball—and how the latter can help us to understand the former.

The primary subject of debate in health policy these days is about the Affordable Care Act (ACA)—or, as it's come to be known, "Obamacare." Mostly it has been a debate between those who, broadly speaking, support the idea of a universal health insurance system and those who do not. But even among those of us who support universal coverage, the ACA generates decidedly mixed feelings.

When we feel good about the ACA, we can point to data showing that it is achieving its primary goals. Surveys indicate that the number of people without health insurance has declined substantially—by somewhere between eight and fourteen million, depending on which numbers we want to believe. Then there is the evidence that people are getting more health care and that, as a result, they are better off physically, financially, or both. Health care costs—for employers, for governments, and ultimately for the country as a whole—are rising at historically low rates. New research even suggests that the incidence of hazardous medical errors is falling. The ACA is not responsible for all of this progress, but it explains a great deal. That makes many of us happy.¹

But we also know that the ACA has some big shortcomings, too. Tens of millions of people will remain uninsured, even after the law has fully phased in. Some of these people will be undocumented workers. Some will not. All will lack health insurance, putting them at risk of financial catastrophe and adding strain to the safety net. Even those who have insurance will find their coverage leaves them exposed to high out-of-pocket costs—lower than before, perhaps, but still high enough to cause hardship. A paper co-authored by MIT economist Jonathan Gruber—as fierce an ACA defender as you will find—concluded that about 10% of families would not have enough money for premiums and out-of-pocket expenses if they got severely ill.²

* Jonathan Cohn is a Senior National Correspondent for the Huffington Post.

1. David Blumenthal & Sara Collins, *Assessing the Affordable Care Act: The Record to Date*, COMMONWEALTH FUND (Sept. 2014), <http://www.commonwealthfund.org/publications/blog/2014/sep/assessing-the-affordable-care-act>.

2. Jonathan Gruber & Ian Perry, *Will the Affordable Care Act Make Insurance Affordable?*, COMMONWEALTH FUND (Apr. 2011), http://www.commonwealthfund.org/~media/files/publications/issue-brief/2011/apr/1493_gruber_will_affordable_care_act_make_hlt_ins_affordable_reform_brief_com

The deals necessary to enact the law have been well documented. Many industries, particularly the drug industry, seem to have gotten off awfully light. And those industries that took harder hits—like the device industry—may yet get Congress to roll back cuts or taxes that affect them. Meanwhile, the law relies heavily on regulators who might not be up to the task—whether it is at the state level, particularly in some more conservative states, or even at the federal level, where an Administration so nervous about high premiums has been reluctant to deploy the authority that the law theoretically allows. One case of this is the problems with “narrow networks” and balance billing. As Elisabeth Rosenthal of the *New York Times* has documented, newly insured people have been showing up at emergency rooms and unexpectedly getting huge bills afterwards, because their hospitals were in network but the physicians were not.³

And, of course, the law is just very confusing. Health care is complicated; any reform was bound to require intricate legislation and yet more intricate regulation. But from an operational standpoint—from the standpoint of a consumer trying to get and use an insurance policy, or a small business owner trying to buy coverage for employees—it is a mess.

What makes this all particularly upsetting is that we know it is possible to do better. Need proof? Just consider the program that celebrates its 50th anniversary in 2014: Medicare.

Medicare is truly universal coverage and it was that way from the get-go. By 1970, 97% of senior citizens had health insurance through the program.⁴ From the beneficiary’s standpoint, Medicare is also easy to use. The program has no physician or hospital networks, for example. You can see any doctor who will accept it, which in practice has meant nearly all doctors—despite rumors that physicians are fleeing the program. And Medicare has historically done a good job of controlling costs, arguably a little better than the private sector, by using its leverage with doctors and hospitals to set prices.⁵

So if given a chance to have a program like Medicare—Medicare for all—rather than the Affordable Care Act, would most of us have jumped at it? Probably. And this is likely one reason the Affordable Care Act has less than a stellar

pressed.pdf.

3. Elisabeth Rosenthal, *Costs Can Go Up Fast in ER When Hospital Is In Network But the Doctors Are Not*, N.Y. TIMES, Sept. 29, 2014, <http://www.nytimes.com/2014/09/29/us/costs-can-go-up-fast-when-er-is-in-network-but-the-doctors-are-not.html>.

4. Marilyn Moon, *What Medicare Has Meant to Older Americans*, 18 HEALTH CARE FIN. REV. (Winter 1996), <http://www.ssa.gov/history/pdf/WhatMedicareMeant.pdf>.

5. *Per Enrollee Growth in Medicare Spending and Private Health Insurance for Common Benefits, 1970-2012*, KAISER FAM. FOUND. (Mar. 2014), <http://kff.org/health-costs/slide/per-enrollee-growth-in-medicare-spending-and-private-health-insurance-premiums-for-common-benefits-1970-2012/>.

reputation, even among advocates.

But maybe, just maybe, we should stop and think. We are comparing Medicare, which became law in 1965, to the Affordable Care Act, which became law in 2010. Is that fair?

Here is where a little knowledge about baseball can help us.

In 1999, the best pitcher in baseball played for the Boston Red Sox. His name was Pedro Martinez and he was the kind of pitcher who could shut down the very best hitters in the game. He proved this memorably during the 1999 All-Star Game, which happened to be at Fenway Park, and during which he struck out five of the first six batters in the National League lineup. Pedro finished the season with an astonishingly low Earned Run Average (ERA) of 2.07. People said it was the best pitching season of the modern era.

Fifteen years later, in 2014, the best pitcher in baseball was Clayton Kershaw, of the Los Angeles Dodgers. He performed some similarly unfathomable feats, including a no-hitter in which he struck out fifteen batters. Kershaw, like Pedro, could strike out the best hitters in the game. And by the time the season was over, Kershaw was sitting on an ERA of 1.77—yes, even lower than Pedro's Herculean achievement from 1999. Afterwards, many people concluded that it was Kershaw, not Pedro, who had posted the best season of the modern era.

At first blush, the revision made sense. But was the comparison really fair? Consider that Kershaw pitched in the National League, while Pedro was in the American, which uses the Designated Hitter. Every lineup Pedro faced had nine serious batters, not eight plus a weak-hitting pitcher.

Kershaw pitched at Dodger Stadium, with far-off, equidistant homerun fences and lots of foul ground for catching pop-ups. Pedro pitched in Fenway Park, a century-old stadium with almost no foul ground and a close-in left field fence, the Green Monster, which famously turned routine fly-outs into singles. Note, too, that Kershaw pitched after the league had introduced widespread steroid testing, dramatically reducing the use of performance enhancing drugs. Pedro had pitched at the peak of the steroid era. As *The Atlantic's* Derek Thompson has observed, in his own comparison of the two seasons, Pedro's historic success against such drug-boostered competition "is kind of like somebody breaking the Boston Marathon record in the middle of a snowstorm."⁶

Most important of all, baseball in 2001 began introducing computer monitors to track pitches and display the strike zone. The results caught everybody's

6. Derek Thompson, *Did Clayton Kershaw Just Have the Greatest Season in Baseball History?*, THE ATLANTIC, Sept. 26, 2014, http://www.theatlantic.com/entertainment/archive/2014/09/did-clayton-kershaw-just-have-the-best-summer-in-baseball-history/380812/?single_page=true

attention: Umpires had been routinely narrowing the strike zone, so that pitches at a batter's knees—a strike, according to the rule book—would be a ball. Chastened by the computer data, and subsequently held to new league-wide performance standards, umpires began changing their behavior, as the University of Florida sports economist Brian Mills has documented.⁷ The ultimate effect was to expand the strike zone between 2008 and 2014 from 436 square inches to 475 square inches.⁸ That is a lot larger, and makes it a lot easier on pitchers.

In a straightforward comparison of the numbers, Kershaw's season was better. But given the circumstances—specifically, changes in the playing environment, the level of competition, the rules of the game—Pedro had performed just as well, maybe even better.⁹ To judge his season without taking account of this context would be unfair.

And so it is with our comparisons of Medicare to Obamacare.

Health care was a very different enterprise back in the 1960s. For one thing, it was much, much less expensive. Medicare's architects didn't have to worry so much about what the plan might cost, because overall health care spending was still pretty modest (around 6% of GDP) as was public debt (around 40% of GDP). By 2010, when President Obama and his allies were trying to construct legislation, health care spending was more than 15% of GDP and the public debt was approaching 90% of GDP.¹⁰

Those numbers imposed constraints, real and imagined, on what the designers of Obamacare could accomplish. They had to devise a program that could to pay for itself—or come pretty darn close—and they had to at least attempt to control underlying health care costs, both for the sake of stabilizing the federal budget and offering relief to individuals and businesses paying for insurance and out of pocket

7. Brian M. Mills, *Expert Workers, Performance Standards, and On-the-Job Training: Evaluating Major League Umpires*, SSRN WORKING PAPERS SERIES (Aug. 27, 2014), http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2478447.

8. Joe Roegel, *The Strike Zone Expansion Is Out of Control*, *HARDBALL TIMES*, Oct. 13, 2014, <http://www.hardballtimes.com/the-strike-zone-expansion-is-out-of-control/>.

9. Pedro's "seasonally adjusted ERA" for 1999 was 291, the second-best ever, behind only Tim Lincecum, who pitched for the Seattle Mariners in 1999. Kershaw's seasonally adjusted ERA for 2014 was 197—which, though still very impressive, merely ties for 39th on the all-time list. The statistics are available at the online site. See *BASEBALL-REFERENCE.COM.*, http://www.baseball-reference.com/leaders/earned_run_avg_plus_season.shtml (last visited Jan. 2, 2014).

10. See *FEDERAL RESERVE BANK OF ST. LOUIS*, <http://research.stlouisfed.org/fred2/series/GFDEGDQ188S> (last visited Jan. 2, 2014); *National Health Expenditure Accounts*, CENTERS FOR MEDICARE AND MEDICAID SERVICES, <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html> (last visited Jan. 2, 2014).

expenses.

The political environment was different too. Back in the 1960s, the majority of Americans believed that government usually did the right thing—and raising taxes, although never popular, were understood to be a routine part of government. By the time Obama became president, faith in government had plummeted and calls to taxes, except on the very rich, were politically toxic.¹¹

The 1960s had their political divisions, particularly later in the decade, but at the time Medicare became law there was still something that could be called a political establishment—and, along with it, a business establishment—that counted both liberals and conservatives as members in good standing. That kind of establishment does not exist today, in Congress or in the business community. Or in the media, for that matter—online and on cable news, partisan media now drive the conversation, amplifying fringe voices and sensationalizing news of the extreme.¹²

Can you imagine trying to pass Medicare today, in this environment, let alone implementing it? Senator Joe Lieberman, the conservative Democrat from Connecticut who gave Obama and Democratic leaders fits in 2009 and 2010, would have insisted the program be run through private insurance companies—carrying water for the hospital and drug industries and speaking for a whole bunch of senators (even liberal ones) who did not want public programs setting prices. Senator Ben Nelson, another conservative Democrat, would have held up the whole thing until the architects agreed to raise reimbursements for his home state of Nebraska.

Former Alaska Governor Sarah Palin, spokesperson of the far right, would have insisted Medicare was actually going to impose death panels—and Fox News, leader of the conservative media, would have interviewed every single person who had good insurance previously, even though there were not very many, and run stories bemoaning the fact they would have to switch to that terrible new government program.

That is not to say that passing or implementing Medicare was easy. Nobody who has read the histories written by Ted Marmor, Jonathan Oberlander, and other scholars could say such a thing.¹³ But the obstacles to what became the Affordable Care Act were arguably even greater—which meant that, in order to pass

11. *Public Trust in Government, 1958-2014*, PEW RESEARCH CENTER FOR THE PEOPLE AND THE PRESS (Nov. 13, 2014), <http://www.people-press.org/2014/11/13/public-trust-in-government/>.

12. For a discussion of the changing American establishment, see JOHN B. JUDIS, *THE PARADOX OF AMERICAN DEMOCRACY: ELITES, SPECIAL INTERESTS, AND THE BETRAYAL OF PUBLIC TRUST* (1991).

13. See THEODORE MARMOR, *THE POLITICS OF MEDICARE*, 2ND EDITION (2000); JONATHAN OBERLANDER, *THE POLITICAL LIFE OF MEDICARE* (2003).

legislation, the architects had to make sacrifices that Medicare's architects did not.

Sometimes these compromises actually worked out for the better. The determination to reduce the cost of medicine, for example, has led to changes like penalties for hospitals with high rates of readmission. Those penalties may be one reason that medical errors and failures of follow-up care are becoming more frequent. But frequently the compromises meant that the ACA did less—or accomplished a key goal like expanding insurance coverage in a less effective way.

There is nothing wrong with comparing the ACA and Medicare. But you cannot truly measure an accomplishment without taking account of the obstacles overcome along the way. Just ask Barack Obama. Or Pedro Martinez.

Opening Remarks

Ezekiel Emanuel¹

November 7, 2014

I want to thank Dean Post and Abbe Gluck for the invitation. Today, I will present a talk in four parts.

The first part is to go back and think about the puzzle of why we have Medicare and Medicaid in the crazy way we do. It defies logic, and as my grandmother would have said, “what is this *meshuga’as* (craziness)”? You have Medicare Part A, which is a trust fund based upon payroll tax, and if you are over 65, then you are in. Part B is an insurance model, where the beneficiary pays some premium and it is therefore voluntary. Both are administered and financed exclusively by the federal government with uniform eligibility, requirements and benefits. Then you have Medicaid, this joint federal-state monstrosity, a categorical program with federal minimal requirements for both eligibility and benefits, and there is great variation by the states. The consequences—human, medical, and economic—of these different structures and these different ways of organization are not trivial. Millions of people have been adversely affected by being excluded, especially the poor by being excluded from insurance by the design of Medicaid the way it is. We have very different levels of efficiency in the program, very different levels of coverage, and very different levels of benefit design. As you have heard from other speakers, the data are very different. We actually have data, albeit claims data, from Medicare and very little research on Medicaid because the data is just not very worthwhile. No rational health policy person would have designed it this way. So what accounts for these variable structures? Pure and simple—politics.

I want to recount the history a little bit because I think it is important that every time you explore a health system and the government’s role, and Medicaid in particular, you understand where it came from.

We got, by accident, an employer based health insurance system that was then resisted mightily by the medical profession all the way through. Once it got started, a number of decisions, without as much conscious effort, turbo-charged the system, especially the 1954 tax exclusion that made health insurance really valuable—more valuable than income. That corresponded to a time when the government was financing hospital expansion, and medicine was becoming more

1. Vice Provost for Global Initiatives and chair of the Department of Medical Ethics and Health Policy at the University of Pennsylvania.

effective through more drugs and interventions, financed largely by the federal government. At that time, if you had an employer-based system, there were two groups excluded, those who are unemployed or unemployable, and the elderly. All through the 1950s, pressure grew because hospital care was becoming expensive and it was actually effective—and that combination of it being effective and therefore desirable and increasingly expensive made it combustible, especially around the elderly. Hospitals become increasingly financially bothered by the fact that they were providing more and more charity care.

Medicare was initially proposed in 1957 by Rhode Island Democratic Congressman Aime Forand. He proposed the social security framework, which had been proposed for health insurance before, and he focused in on healthcare for the elderly, eligibility at 65, covering only hospital care. That was the initial bill. It is quite clear what it owes to social security, which in turn is quite clear what it owes to Otto von Bismarck. He proposed it in 1957, a lot of debate ensued, and in June of 1958 the House actually held hearings on the bill, even though it never held hearings on a health bill before. Interestingly and predictably, the American Medical Association (AMA), the Chamber of Commerce, pharmaceutical companies and the health insurance companies of America were against it. The American Hospital Association (AHA) was equivocally supportive—equivocal in the sense that they were not so confident in the government financing it, but they knew that something had to be done because they were hemorrhaging money. This stayed on the agenda through 1958 and 1959 and really exploded in the election year in 1960. This is a case in which election years really mattered in getting something done. In March of 1964, the House voted, and the bill got defeated 17 to 8. In the 1960 presidential election, healthcare was actually a very large focus. The American Federation of Labor and Congress of Industrial Organizations (AFL-CIO) campaigned, forced all the Democratic candidates to endorse the social security based approach and interestingly, two Texans, Sam Rayburn, who was Speaker of the House, and the majority leader, Lyndon Johnson, also supported this social security based approach to health insurance.

Because it was an election year and because this support for healthcare for the elderly was popular even then, Richard Nixon and the Republicans needed their alternative. For all of their eight years, the Eisenhower administration studiously avoided health insurance for reasons related to Truman, but the avoidance strategy was not going to be tenable in the 1960 election. Arthur Flemming, an interesting guy, noted as a Republican that government action on healthcare for the poor and the elderly would be necessary, that an exclusively private solution would not be possible, and that voluntary insurance probably would not solve the issue. Nonetheless, he ended up with a program that was a re-tread of the Republican approach to health insurance over the decades, something that ironically Richard Nixon and others in the party had been advocating for going back to the late 1940s: that the Federal government provide income league subsidies to the elderly individuals so that they could go into the market and purchase private health

insurance. The program would be voluntary so that individuals could decide whether or not to participate and it would be financed by general revenues. Does that sound familiar to anyone? Literally Richard Nixon had proposed this as early as 1948.

So that is where it was. The Democrats wanted the social security structure and Richard Nixon, Fleming, and Republicans wanted this voluntary insurance with government subsidies. Political pressure was building. Wilbur Mills, who some of you may know from the Fanny Fox affair, was a conservative Democrat from Arkansas, highly respected, Chairman of the House Ways and Means Committee, and political pressure had built such that he could not avoid dealing with the issue. After the defeat of Forand's social security bill in his committee, he nonetheless thought something had to be done and he began working with the AMA to develop a bill for state-run public assistance programs to provide payments to physicians and hospitals on behalf of poor elderly people. His view was that it was voluntary on the states to adopt, and again this is a case of funding coming from general revenues. It was an interesting combination of a Democratic bill with AMA support, and an extremely powerful member of the house supporting it. The insurance debate was extremely intense throughout 1960.

After the conventions that nominated Kennedy and Nixon, Congress came back into session—this was a highly unusual event—to vote on health care in the Senate. They had the three alternative bills before them. They had the Democratic bill, they had the Republican bill, and they had Wilbur Mills' bill. Kennedy, Johnson, and Nixon were all there during this unique August session. The Republican bill was brought up first and it went down to a strict party line vote, 67-28. The Democratic social security inspired bill was defeated 51-44 with a bunch of conservative Democrats going over to the Republican side. As a consolation, the Mills bill, giving money to the states so that they could then pay doctors and hospitals on behalf of the elderly (it was called the Kerr-Mills bill, because Senator Kerr from Oklahoma, a conservative Democrat, had supported it in the Senate) passed 91-2. That did not satisfy the election. Health insurance turned out to be a key issue in the Nixon-Kennedy debate on September 26th. That presidential debate was mainly focused on healthcare, and Nixon, Lodge, Kennedy and Johnson all said that the Kerr-Mills bill was completely inadequate and that they would do something more on healthcare. Just as predictably, with the election nothing happened. Democrats introduced their bill, Republicans had their bill, and not much happened. Part of it was we got to see what happens with the Kerr-Mills bill.

In 1961, the AMA, true to form, organized AMPAC, their first political action committee, to lobby and campaign against Medicare. They surreptitiously funded a guy called Ronald Reagan to make a record, a ten-minute speech and diatribe against the federal government providing health coverage, denouncing it as socialized medicine, and never revealing the fact that it was funded by the AMA. But pressure continued to build. The Kerr-Mills bill was a pretty big failure—it

was even called by some government Senate reports “a big failure.” By 1964, hospitals days had increased by 33% between 1960 and 1964. It went from 29 dollars a day to 40 dollars a day, just an amazing increase. Half the elderly had insurance and most of that insurance was not worthwhile because it could not even cover a hospital day. There was a growing consensus in the government that only the government could solve this problem. The landslide victory of Lyndon Johnson, the largest plurality, 61.2%, 486 electoral votes or something in that range, changed everything. Wilbur Mills heard the message loud and clear. In January 1965, the first bill introduced into the House and the first bill introduced into the Senate were health care, the health care Democrat reform bill; Mills took over control of writing the legislation. Within two months, on March 23, 1964, (for those of you who want to know, March 23 is a very important day in the history of medicine and health care legislation), he had the House Ways and Means Committee pass the bill. And he organized the bill. The Democrat’s Social Security-based bill is Part A. The Republican private insurance subsidized by the government with premiums is Part B. Medicaid is the old Kerr-Mills bill. And there you have the monstrosity that we have that we have had to live with, with all its positives and defects.

So this three prong, very different kind of structure, really traces back to Mills taking the path of least resistance, merging the three bills to reduce political opposition, giving something to everyone. It then took, from that period on, seventeen years to get all the states to adopt Medicaid because the states were not required to introduce Medicaid. In 1982, the good state of Arizona, not Texas, was the last state to expand Medicaid. This time, I believe Texas will be the last state to adopt the Medicaid expansion.

Whatever else you think about Medicare, it has been a huge success on the main dimension it was meant to address. I want to remind people that the main motivation was not to provide the elderly health care. It was financial risk protection. And that really is the fundamental basis on which it was passed: to relieve the elderly of the fiscal burden of paying for health care. One way I like to point out its success is that in 1964, just about 30% of the elderly were living in poverty in this country, even with Social Security. Now, today, with the combination of Medicare and the increases in Social Security, the indexing of Social Security, which is largely, though not exclusively by any means, determined by health care costs, 9% of the elderly are in poverty. It is the lowest demographic in the United States in poverty. Conversely, in 1964, 19% of the general population, non-elderly population was in poverty. And today it is 15%. Among children, it was 23% in 1964 and today it is an embarrassingly shameful 20%. So at least regarding financial risk protection, Medicare has had a huge impact as witnessed by the relative, much better financial position of the elderly in this country.

Let me say one other thing, not about the passage of Medicare and Medicaid, but about their initial implementation. As all of you know, the AMA was

steadfastly against Medicare and Medicaid, was not willing to compromise, and Lyndon Johnson, to his credit, was able to get Medicare and Medicaid passed.

Hospitals were more ambiguous; they wanted the money but did not want the government involved. There were lots of threats that they would not take the Medicare payment when it opened for enrollment in 1966. To counter this, the politicians decide the best approach to the medical profession was bribery. On the one hand, the government would not pay directly—this is how we got the intermediaries such as Blue Cross Blue Shield paying doctors as carriers to ameliorate the opposition. The doctors were taking money from the insurance companies and not from the government. But may I remind you that the doctors opposed these insurance companies in the beginning as well. More importantly, in my opinion, was the decision that the government would pay hospitals cost plus, cost plus with depreciation on their capital investments. Think about what type of incentive this creates for a hospital! Not only did the Hill Burton Act from 1946 create this huge incentive to build hospitals, especially in poorer states, but this idea that cost plus capital expenditures would be paid for just hugely incentivizes adding new wings to the hospitals, and doing whatever you can to build capital to your hospitals. As my good friend, the late Rashi Fein, used to tell me is that in the 1960s, a lot of hospitals had expansion ideas and their dreams and the plans were in the desk drawer of the president and they might go out and fundraise. But after Medicare they did not need to go out and fundraise! They had a funder! The federal government would reimburse them!

The impact was significant on the structure of Medicare and Medicaid. We had this fragmented system paying doctors separately from hospitals. We paid proceduralists more than primary care doctors. We paid in this mechanism of cost plus depreciation that hugely incentivized expansion and the resulting healthcare inflation. There was no control mechanism built into the system. None. This is the end of part one, the history of how we got to the crazy puzzle.

In part two of this talk, I want to present the problem of the bureaucracy that was created. I will start in an unusual place for someone who swings from the left. Today, Medicare and Medicaid are a combined 850 billion dollars in federal outlays. When I was growing up, I remember people complaining: “do not build that aircraft carrier, build hospitals instead for the same price!” Today, that is not true. Today, it is: “do not build that hospital, instead we can solve the military budget problems for that price!” It dwarfs what we spend on Social Security and on the military budget! It is an enormous amount of money.

The fact is that the Centers for Medicare and Medicaid Services (CMS) oversee 850 billion dollars with 6,000 employees. That is an administrative budget of 4 billion dollars. More money is spent paying carriers than others. That is 140 million dollars spent per employee administering the program. Now, someone might look at that and say wow, what an efficient program! But no organization can run that lean; by any standard, that is absurd! There is under-employment and under-administration of the system. Just to give you metrics, United Healthcare

has 123 billion dollars in revenue and 156,000 employees. Sigma has 32 billion dollars in revenue and 36,000 employees; they are running at about 1 million dollars per employee. Think about the most efficient companies out there, tech companies. Facebook has 8 billion dollars in revenue per year with 2,000 employees—that is 4 million dollars per employee. Google has 60 billion in revenue, about 48,000 employees. That is 1 million dollars per employee. You just cannot administer a program like that! As a consequence there are real problems at Medicare!

I will give you some examples. Until a few weeks ago, there was not a single oncologist employed by Medicare. I am an oncologist. Between 10-15% of the Medicare budget goes to cancer, and they did not have a single oncologist thinking about that! They just hired one, and it turns out he is a pediatric oncologist. He might be a genius but he has never seen ovarian, prostate, breast or colon cancer. It is very hard to run a program where regarding 15% of your budget, you do not have someone with expertise there. No company would run like that. There are many other consequences to limited manpower: limited updates on payment, and reliance on the ruck for payment updates. Updates on the Relative Value Units (RVU) for physician practice overhead are done very slowly, and are not done very well. The revisions on the RVU are largely outsourced to the AMA and the ruck with a huge conflict of interest. Giving data back—they are running these large experiments on ACOs, but can they give the data back in a timely fashion? No. Anyone who is working at Medicare will tell you how ridiculously outdated their data systems are.

Part three, I will discuss the politicization of their decisions at all levels. We legalize overpayments to part C plans. It is legalized! In the Affordable Care Act (ACA), we had to bring it down to merely overpay from 114% on average to 101%. A great achievement, but this is still overpaying! Again, I see everything through the lens of cancer. Consider the coverage of Avastin for breast cancer—this is a drug for which the Food and Drug Administration pulled its indication for breast cancer because the data suggests it does not work, yet the CMS is still willing to pay for it. There are many other areas where treatment—such as proton beam for prostate cancer—have never been shown to work better—and still we're paying out the wazzoo for it. A comparison between the US Preventative Services Task Force indication for screening tests and what is covered by Medicare shows that there is no alignment. The Task Force says PSA not for any man, yet Medicare pays a fortune for it. Colon cancer screening for people over age 75 is not indicated, but it is covered. Pap smear for all women over 65 is not recommended and certainly not for women with a hysterectomy, but it is still paid for. Recent data commented on in *JAMA Internal Medicine* showed that between 34 and 56 percent of women aged 65 and over had a pap smear, still paid for. So, I think Harlan (Krumholz) was right, Medicare was instrumental in improving cardiology, and that is a very important achievement. But in my view, the glass is half full. There

are so many things we can do to improve the quality of care and to reduce costs that are not done.

Let me give you another example here pursuant to fraud and abuse. We have no idea how much fraud and abuse there is in Medicare, but it is not trivial. The return on investment for doing fraud and abuse in Medicare is seventeen dollars for every single dollar spent. What venture capitalist would not like that return on investment? And that is just overt fraud, not subtle fraud. How much do we spend each year on combatting fraud in the Medicare system? 388 million dollars. Why do we spend so little on combatting fraud and abuse? I am not 100% sure but I will give you my hypothesis. Medicare pays 1 billion claims a year. Let us say it has the best fraud recognition program, that would be 99.99% accurate. So in only 1 out of 10,000 charges that a claim is a fraud, is a mistake made. Out of 1 billion claims, it still makes 100,000 errors, even at that great accuracy. That is 100,000 honest claims flagged as fraud or potential fraud with a fantastic performance record. What happens? What do these 100,000 honest hospitals or doctors do? All you need is one or two of these honest doctors or hospitals calling their congressman saying “do you know what!” That is why we do not do more, I think: because of the fear of attack. There is also a pervasive fear of failure created by the Washington environment. In Washington, any failure will be attacked. A 90% success rate is not good enough.

The last thing I want to say is that the bureaucracy is really subject to Newton’s first law of motion: the law of inertia. The object in motion will stay in motion unless acted on by an outside force. The bureaucracy is that in spades, very resistant to shaking off fee-for-service (FFS). I think that has been a big problem. In the 1990s, CMS ran a bundles program plan and it turned out to be hugely successful; on average, it saved 10% and quality was as good if not better. But what happened? Nothing! The experiment never got expanded. When I was in the administration, we were thinking about how to structure the payment perform section. I was 100% behind bundles because I thought it was the easier way for doctors and hospitals to change off of FFS onto another option that would not incentivize overuse. The bureaucracy was very resistant to doing that. Why? Because they did not have the structure. They had three main excuses: (1) hospitals and doctors are not ready, (2) we can not pay that way because we do not have computers we have to pay by hand, and (3) they were very unclear that it would save money. However, we would never known unless we ran the experiment!

The best I got out of multiple arguments and debates was up to ten experiments with bundled payments. They have done a bundle payment called the Acute Care Episode (ACE) demonstration with orthopedic procedures, and the results are in: moderate savings and better quality. But still they cannot get it generalized. The actuary will not certify that it will save money, only five systems participated, lots of other worries. It is very hard to get change done. In addition, there is a large suspicion of the private sector. All through Medicare, we put into the Bill the importance of releasing Medicare data so people could use it. We have regulations

that have substantially restricted who could get the data because there is a fear in Medicare that if the private sector uses the data and makes a profit on it, that is a bad thing. So I am a little worried.

I also think you have an incentive structure that does not encourage what we want to do. Yes we have the Center for Medicare and Medicaid Innovation (CMMI), and I fought very hard for it, but no one in the bureaucracy is rewarded or promoted to control total cost of Medicare or to improve the quality of healthcare delivered via Medicare. It is hard to know what the chief objective is; the number one goal of most people was not to limit options of Medicare beneficiaries. It has influenced the design of the Accountable Care Organization (ACO) experiment so that there is not prospective assignment, only retrospective assignment, which makes it very hard to make money. So I think there are serious problems with the bureaucracy.

What do we need from Medicare going forward? Payment change, payment change, payment change! Nothing else matters as much as payment change! Medicare has to collaborate with the private sector.

Here is my list of what we need going forward.

1. We need a timeline. Providers out there—doctors and hospitals—need to know what our timeline for shifting off FFS is. They need to plan now. It is very hard to motivate your physician if you do not set a deadline if they can still make a hefty margin on FFS. You have to say by x date, half your payments will be off FFS.
2. Second, I do not think this voluntary demonstration project is going to go well enough. The requirement of mandatory demonstrations was put in the ACA bill. In combination with articulating a timeline, we need a mandatory demonstration, which needs to be on something that is high margin to the medical system—orthopedic procedures, cardiac procedures, cancer. That will get everyone's attention and communicate the timeline and show that it is real. It will also give us data on which to make an evaluation. I think it will completely change the expectations. The expectation for change in payment, you have to fulfill it so that people will believe you.
3. Third, we need to push on Part C. Alan Weil said we know that Medicare Part C is managed care mainly paying the providers care FFS. We need to change the Part C to really do two things. One is to competitively bid the prices instead of paying them in the complicated way we do them. Let them set the prices, let us have a competitive marketplace. Second, have them shift their own payments off FFS so we use their leverage.
4. Fourth, we need more competitive bidding for all the other services. We have seen successful bidding around durable medical equipment, bringing

prices down 40%. We can do better than that. And the Part C parts needs Congressional approval.

5. The last thing is the accountable-care states: states should run programs like those in Maryland, Oregon, and Arkansas, where they share a portion of the savings if they can keep down their GDP. Those are worth hundreds of millions of dollars to states and can be very motivational. We have outlined how that system can work.

Let me conclude with two observations to bring home these points.

One is the importance of never underestimating path dependence. The way structures get put in place has a very important effect way into the future because it can become virtually impossible to change those structures. We have seen that in the creation of Medicare and Medicaid, we use a Social Security apparatus with Part A. We use public assistance for Medicaid. Once you have that structure you are stuck with it, and I do not think that within our policy making process we think hard enough about the consequence of that and it can really create perverse incentives over time.

The last thing I would like to conclude with is somewhat more controversial. I did not want to disappoint anyone, it is not something that anyone predicted I would say. I think the closer you look at Medicare, the more you have to be hesitant about the notion of the single payer built on the Medicare model, meaning Part E, Medicare for everyone. As I said, the system is chronically, habitually, and structurally under-administered, it is subject to a lot of politicization, it is resistant to reform, and it obeys Newton's first law. If you have one system for 310 million people, it will become even harder to change and more controversial with every change because of the interest groups that exist. Are there downsides to the proliferation and problems we have with too many insurance companies and different payment models? Absolutely. Fragmentation has made it very difficult to get enough scale and enough influence from any one payer to change the provider side. On the other hand, it does have slightly more flexibility and slightly more experiments and I think that over the next decade that will be more important as we try to move off and to change the whole healthcare system.

Medicare Advantage, Accountable Care Organizations, and Traditional Medicare: Synchronization or Collision?

Thomas L. Greaney*

INTRODUCTION

Despite its size and immense influence over health care in America, Medicare today is no monolith. It is comprised of three distinct payment programs though which it provides services to beneficiaries: “traditional,” fee-for-service (FFS) Medicare; Medicare Advantage (MA); and the Medicare Shared Savings and Pioneer accountable care organizations (ACO) programs. These models, which strongly influence provider delivery arrangements and program costs, differ significantly along many dimensions important to beneficiaries and providers. In the wake of changes spurred by the Affordable Care Act (ACA) and the evolution of the health care delivery system, all three are evolving rapidly and subject to regulation that will affect their interaction with each other. It is not clear whether their paths will eventually cross and, if so, whether they will link together or collide.

What is clear is that regulations affecting payment, quality, and delivery methods for each model will influence their success and interplay with each other. Navigating this dynamic terrain, Medicare’s overseers, the Centers for Medicare and Medicaid Services (CMS) and Congress, have choices to make. They may find useful guidance in a roadmap being developed by MedPAC, the independent agency that advises Congress on Medicare payment policies. That proposal, analyzed in this essay, would “synchronize” payment, quality and risk adjustment rules to assure a level playing field for the three payment options. Eliminating subsidies that tip the scale in favor of one model is an appropriate albeit tremendously complicated technical task as diverse regulations apply to the three models. However, this undertaking involves policy judgments that extend beyond making technical adjustments to payment rules. Further, achieving a completely neutral payment policy, to the extent that is even possible, will run afoul of a number of entrenched and often conflicting norms that underlie Medicare policy.

* Chester A. Myers Professor of Law and Co-Director Center for Health Law Studies, Saint Louis University School of Law. Thanks to Rachel Polzin for research assistance and to Abbe Gluck and the organizers and participants in the Medicare and Medicaid at 50 Symposium at Yale Law School.

I. MEDICARE'S THREE PAYMENT MODELS

A. Fee-for-Service (Traditional) Medicare

Borrowing from the design of indemnity insurance plans offered by Blue Cross and Blue Shield at the time of its enactment, Medicare initially reimbursed hospitals for their “reasonable costs” and physicians for their “reasonable charges”¹ for all “medically necessary” care.² Although myriad adjustments have been made, including prospective payment for hospitals and other facility reimbursement and fee schedule payments for physician services, the fundamental structure of “traditional Medicare” under Parts A and B remains rooted in paying providers for the volume of services they provide, regardless of quality or outcomes. A near unanimous consensus among politicians and policy experts lays the blame for Medicare cost and related problems of quality and fragmentation in the delivery of care on the skewed incentives associated with FFS payment.³ Equally problematic is the fact that because Medicare payment policy strongly influences commercial insurance, fee-for-service payment has long persisted in the private sector. Finally, the separation of physician and hospital payments promotes major inefficiencies. Not only are payment incentives for quality-improving coordination of care lacking, but hospitals are hamstrung in efforts to control costs because staff physicians, paid on a FFS basis even for practice in the hospital, have no financial incentives to make decisions that will reduce hospitals’ costs. In some cases, the effects are especially perverse: physicians may be reimbursed at higher rates when employed by hospitals than when doing the same procedures as independent practitioners, thus giving hospitals a financial incentive to employ physicians and share the higher reimbursements with them.⁴

Attempts to improve upon the administered pricing mechanisms for provider reimbursement under Medicare have had at best mixed results. Inpatient prospective payment to hospitals has had some success in reducing the length of

1. Social Security Amendments of 1965, Pub. L. No. 89-97, §§ 102a, 1814(b), 1832(a)(1), 1833, 79 Stat. 286, 291, 296, 302 (codified as amended in scattered sections of 42 U.S.C.).

2. *See id.* § 1862(a)(1) (excluding medical care “not reasonable and necessary for the diagnosis or treatment of illness or injury”).

3. Glenn Hackbarth, Chairman of MedPAC, concisely summarized the flaws of Medicare payment: “Care coordination is rare, specialist care is favored over primary care, quality of care is often poor, and costs are high and increasing at an unsustainable rate...[FFS] payment systems reward more care, and more complex care, without regard to the value of that care.” *Reforming the Health Care Delivery System: Hearing Before the H. Comm. on Energy & Commerce*, 111th Cong. 1 (2009) (statement of Glenn M. Hackbarth, Chairman of the Medicare Payment Advisory Commission).

4. Amanda Cassidy, *Health Policy Brief: Site-Neutral Payments*, HEALTH AFF. (July 24, 2014), http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_121.pdf.

admissions, but has not discouraged use of expensive technologies and has resulted in cost shifting to private payers⁵ and site shifting of Medicare-reimbursed procedures to other locations such as ambulatory care and physician offices.⁶ Other reforms, such as the introduction of a fee schedule to rationalize physician payment and the attempt to control volume by a sustainable growth rate mechanism, have been abysmal failures.⁷

The Affordable Care Act initiated a large number of measures to address problems associated with FFS payment methodology. These include efforts to correct specific shortcomings of the physician fee schedule and other payment mechanisms. Other initiatives include pilot programs and demonstrations to test moving provider reimbursement, which is under traditional Medicare, from unit payments to global or bundled payments for services. For example, under the title “Improving Payment Accuracy,”⁸ the Act directs the Secretary of HHS to regularly review fee schedule rates, focusing especially on those with the fastest growth and strengthening the Secretary’s ability to adjust rates found to be misvalued or inaccurate.⁹ Also notable is a provision adding a “value-based payment modifier” to fee schedule payments under Part B.¹⁰ Beginning in 2017, this adjustment will reward or penalize physicians based on the relative value of the care they provide

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

6. See Nicholas Bagley, *Bedside Bureaucrats: Why Medicare Reform Hasn’t Worked*, 101 GEO. L.J. 519, 541 (2013) (deeming prospective payment a “qualified failure” with modest effects on costs or how physicians practice medicine).

7. See Thomas L. Greaney, *Controlling Medicare Costs: Moving Beyond Inept Administered Pricing and Ersatz Competition*, 6 ST. LOUIS J. HEALTH L. & POL’Y 229 (2013) [hereinafter Greaney, *Controlling Medicare Costs*] (discussing the failure to address collective action problems in the volume performance standard originally relied upon to control the amount of procedures and the political impediments undermining the sustainable growth rate mechanism). See also *Reviewing the Work Relative Values of Physician Fee Schedule Services*, in MEDICARE PAYMENT ADVISORY COMM’N, REPORT TO CONGRESS: MEDICARE PAYMENT POLICY 133-50 (Mar. 2006) (explaining how CMS’ reliance on the American Medical Association’s Relative Value Update Committee, which is dominated by specialists, has caused the fee schedule to over-weigh specialty procedures and undervalue primary care).

8. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, §§ 3131-602, 124 Stat. 119, 427-538 (2010).

9. *Id.* § 3134 (“Misvalued Codes Under the Physician Fee Schedule”).

10. See *Value-Based Payment Modifier*, CTRS. FOR MEDICARE & MEDICAID SERVS., <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html> (last visited Dec. 10, 2014).

using measures of adherence to recommended clinical processes.¹¹ The ACA also seeks to fill the void of quality oversight by adding new regulatory measures such as a penalty for hospitals ranking in the top twenty-fifth percentile for rates of hospital infections.¹²

In what is potentially the most far-reaching change, the Act initiates several programs designed to move away from the FFS concept. For example, the ACA requires the Secretary of HHS to establish, test, and evaluate a five-year pilot program “for integrated care during an episode of care . . . around a hospitalization in order to improve the coordination, quality, and efficiency of health care services,”¹³ and further directs the Secretary to make a recommendation no later than January 1, 2016 as to whether to expand the pilot program.¹⁴ CMS has begun to test four different “bundled” payment models in a three-year program that allow such payments to be made to physicians, hospitals, and post-acute care providers. Under bundled payment, a single payment is made for an “episode of care”—i.e., a defined set of services for treating a patient’s medical condition or performing a major surgical procedure that are delivered by designated providers in specified health care settings and often time periods.¹⁵ Other programs are also underway to develop payment modalities such as gainsharing and acute care bundling that encourage and reward integration of care.¹⁶

B. Medicare Advantage

Although Congress has allowed private organizations to provide Medicare services to beneficiaries for over thirty years, Medicare managed care has proved

11. See Robert A. Berenson & Deborah R. Kaye, *Grading a Physician's Value—The Misapplication of Performance Measurement*, 369 NEW ENG. J. MED. 2079 (2013) (endorsing the concept of value based reimbursement but criticizing the measurements to be used in the program).

12. Patient Protection and Affordable Care Act § 3008 (codified at 42 U.S.C. § 1395ww (2012)).

13. *Id.* § 3023 (codified at 42 U.S.C. § 1395cc—4a (2012)).

14. *Id.* See generally, Melanie Evans, *Interest Surges in Medicare Bundled Payment Initiative*, MODERN HEALTHCARE (July 31, 2014), <http://www.modernhealthcare.com/article/20140731/NEWS/307319832> (reporting CMS will add 4,100 providers to 2,400 already exploring use of bundled payments).

15. Patient Protection and Affordable Care Act § 3023 (codified at 42 U.S.C. § 1395cc—4(c)(3)(C)) (2012). Under this program, CMS and providers set a target payment amount for a defined episode of care. Applicants propose the target price, which would be set by applying a discount to total costs for a similar episode of care as determined from historical data. Participants in these models are paid for their services under Medicare fee-for-service payments, but at a negotiated discount. At the end of the episode, the total payments would be compared with the target price.

16. See *Innovation Models*, CTR. FOR MEDICARE & MEDICAID INNOVATION, <http://innovation.cms.gov/initiatives/index.html#views=models> (last visited Oct. 30, 2014) (providing descriptions of demonstrations underway at CMS including the Medicare Hospital Gainsharing demonstration, the Acute Care Episode (ACE) demonstration, and the Physician Hospital Collaboration Demonstration).

something of a roller coaster ride. The Tax Equity and Financial Responsibility Act of 1982¹⁷ authorized capitated payments to health maintenance organizations calculated at ninety-five percent of county fee-for-service expenditures under Part A and Part B. Born in the belief that private plans could be more efficient and innovative than traditional Medicare and the promise that significant savings would be shared with beneficiaries in the form of added benefits or reduced premiums, the program attracted health maintenance organizations (HMOs), which grew rapidly in limited areas of the country. Enthusiasm for managed care eventually dampened when it became apparent that the success of HMOs was in part attributable to their ability to enroll a disproportionately healthy cohort of beneficiaries.¹⁸ Congress responded with the Balanced Budget Act of 1997, renaming the program Medicare+Choice, instituting a risk adjustment methodology that paid less to plans with relatively healthier enrollees, and severely limiting annual increases in program payments to plans.¹⁹ The law proved to be an overreaction, as many plans, unable to earn profits, abandoned the program.²⁰

In 2003, Congress again sharply reversed course, adopting the Medicare Modernization Act,²¹ which once again renamed the program (Medicare Advantage) and provided significantly enhanced payments to attract greater participation by private plans. In addition, the new law added regional preferred provider organizations and private FFS plans to expand the availability of Medicare Advantage (MA) plans to previously unserved or underserved areas,²² and adopted new bidding and risk sharing regulations. In the end, the law achieved its unstated but transparent goal of promoting managed care enrollment by overpaying private plans.²³ By 2009, MA plans were receiving payments in excess of 114% of FFS and some of the newly-configured MA plans were not even

17. 42 U.S.C. §1395mm(a)(1)(C) (2006).

18. MEDICARE PAYMENT ADVISORY COMM'N, REPORT TO CONGRESS: MEDICARE PAYMENT POLICY (Mar. 2002).

19. 42 U.S.C. §§ 1395w-23(a)(3), 1395w-23(c) (2006). See generally Marsha Gold, *Medicare+Choice: An Interim Report Card*, 20 HEALTH AFF. 120, 126 (2001) (cataloguing the shortcomings of the program following passage of the Balanced Budget Act of 1997).

20. See *id.* at 126 (discussing the effects of the Balanced Budget Act of 1997 on Medicare managed care).

21. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. 108-173, 117 Stat. 2066 (codified as amended 42 U.S.C. § 1395w-23 (2006)).

22. See Marsha Gold, *Medicare's Private Plans: A Report Card on Medicare Advantage*, 28 HEALTH AFF. w41, w42 (2008). By 2008 all Medicare beneficiaries had multiple MA choices. *Id.*

23. A corollary goal of undermining traditional Medicare can be seen in Speaker Newt Gingrich's justification for voucher plans that he hoped would make traditional Medicare "wither on the vine." *Gingrich on Medicare*, N.Y. TIMES (July 20, 1996), <http://www.nytimes.com/1996/07/20/us/politics-gingrich-on-medicare.html>; see Greaney, *Controlling Medicare Costs*, *supra* note 7, at 229.

designed to provide integrated care.²⁴

With passage of the Affordable Care Act (ACA) in 2010, Congress once again reversed course, cutting back substantially on overpayments to MA plans²⁵ and instituting a quality-based bonus program to reward plans demonstrating superior performance.²⁶ But in yet another mid-course correction, the significant cuts in MA plan payments mandated by the ACA were substantially mitigated when the Obama administration initiated a demonstration program that allowed 90 percent of plans to receive bonuses and took other steps that ultimately gave back half of projected savings from cuts to MA plans.²⁷

Although the MA payment model relies on plans submitting bids, the process diverges from a strictly competitive model in that payments to MA plans are determined by comparing each plan's bid to a statutorily determined local benchmark. Importantly, that benchmark is calculated based on the Part A and Part B fee-for-service spending in each county in which a plan proposes to operate. Plans bidding below the benchmark receive their bid plus a "rebate" equal to a fixed percentage—50 percent, 65 percent, or 70 percent, depending on the plan's quality rating—of the difference between the bid and the benchmark. Those bidding above the benchmark—a rare occurrence—receive the benchmark but must require that each plan enrollee pay a premium equal to the difference between the bid and the benchmark. Once the rebate amounts are determined, plans must return the rebates to their enrollees in the form of supplemental benefits or lower premiums. As noted above, the ACA made important adjustments to the bidding framework by lowering plan benchmarks to levels closer to the cost of enrollees in traditional Medicare in each county, setting relatively lower benchmarks in counties with high FFS Medicare costs, and setting relatively higher benchmarks in counties with lower FFS costs.²⁸ Nevertheless, because benchmarks continue to be based in part on historic

24. See Brian Biles et al., *Medicare Advantage in the Era of Health Reform: Progress in Leveling the Playing Field*, THE COMMONWEALTH FUND 5 (2011), <http://www.commonwealthfund.org/Publications/Issue-Briefs/2011/Mar/Medicare-Advantage.aspx>.

25. The highest paid counties will bid against benchmarks set at 95% of FFS and the lowest at 115%, with the others in between, so that by 2017, CMS will set payments at a national average of 101% of FFS costs. *Medicare Advantage Fact Sheet*, KAISER FAM. FOUND., (2014), <http://kff.org/medicare/fact-sheet/medicare-advantage-fact-sheet/>.

26. Plans that perform well on quality scores under the Star Rating program can offset some of the reduction with additional bonus payments. See Gretchen Jacobson et al., *Medicare Advantage Star Rating and Bonus Payments in 2012*, KAISER FAM. FOUND. (2011), <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8257.pdf>.

27. JAMES COSGROVE & EDDA EMMANUELLI-PEREZ, U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-12-964T, *MEDICARE ADVANTAGE: QUALITY BONUS PAYMENT DEMONSTRATION HAS DESIGN FLAWS AND RAISES LEGAL CONCERNS* 4 (2012); see Meghan McCarthy, *Medicare Advantage and the 'Potomac Two-Step,'* MORNING CONSULT (Apr. 13, 2014), <http://themorningconsult.com/2014/04/medicare-advantage-and-the-potomac-two-step>.

28. Under the revised bidding formula, benchmarks will be 95% of fee-for-service (FFS) costs

spending and are subject to annual increases based on the growth in Medicare spending,²⁹ the bidding process does not encourage plans to compete as vigorously as one in which payments are based on the average of plans' bids.³⁰

II. DISTINGUISHING THE THREE MODELS

The three payment models differ in many important respects relevant to devising synchronization policy discussed later in this article. This section first outlines the attributes that distinguish the models and the subsequent section highlights four dimensions of particular relevance to policy development.

First, Medicare applies distinct payment methodologies to each model. As shown in the following chart, provider payment under traditional FFS Medicare pays for individual services based on government-set prices. ACO providers are reimbursed using an identical methodology but receive a bonus or penalty depending on their ACO's overall level of spending, which is measured against the historical FFS costs of their beneficiaries, and the ACO's performance on CMS quality measures. Medicare Advantage plans are paid a capitation amount determined by the difference between their bids and the FFS spending in the counties in which the plan operates subject to adjustment based on quality metrics. Each payment model is subject to regulatory controls though the nature and extent of those requirements differ significantly.

per enrollee for the counties in the top quartile of FFS costs; 100% for counties in the second highest quartile; 107.5% for the third highest quartile and 115% for the bottom quartile. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 3201, 24 Stat. 119, 442 (2010) (codified as amended in 42 U.S.C. § 1395w-23(j)(2012)).

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

30. See Greaney, *Controlling Medicare Costs*, *supra* note 7 (contending that "ersatz competition" in MA bidding lacks the requisite incentives to replicate competitive process). A provision in the Senate's version of the Affordable Care Act that was removed in the reconciliation required competitive bidding that set payments based on the average bid. See Austin Frakt, *Medicare Advantage Competitive Bidding: The Political Failure of a Good Idea*, KAISER HEALTH NEWS (Apr. 12, 2010), <http://www.kaiserhealthnews.org/Columns/2010/April/041210Frakt.aspx>.

TABLE 1: COMPARING THE THREE PAYMENT MODELS

	Traditional Fee-for-Service (FFS) Medicare	Accountable Care Organizations (ACOs)	Medicare Advantage (MA)
Medicare Program Payment	<ul style="list-style-type: none">• Pays for individual services at set payment rates	<ul style="list-style-type: none">• Pays for individual services at set payment rates (FFS)• Plus bonus payments/penalty based on spending & quality targets	<ul style="list-style-type: none">• Pays risk-adjusted capitation payments per enrollee• Based on MA benchmarks & bids• Star Quality Bonus
Benefits and Requirements	<ul style="list-style-type: none">• Medicare benefit package (Pt. A&B)• Any participating provider• Beneficiaries buy supplemental coverage	<ul style="list-style-type: none">• Same as under FFS• Beneficiaries “attributed” to ACOs• Providers informally encourage staying within the ACO	<ul style="list-style-type: none">• Part A & B• Extra benefits if the plan bid is less than the MA benchmark• Catastrophic coverage• Limited network of providers• Beneficiaries must enroll

A second important distinction concerns the allocation of risk. No financial risk is assumed by providers under traditional Medicare. By contrast, MA plans are required to assume risk annually by virtue of accepting fixed capitated payment. ACOs under the MSSP may choose not to accept downside risk in the

initial year of operation; in subsequent years they must accept risk as measured by their improved cost and quality performance over the previous year. The MSSP ACO model requires that risk be measured by the ACO's performance with respect to its own cohort of assigned beneficiaries. Risk is determined for MA plans based on their bids against a benchmark based on all beneficiaries in the counties in which they operate. Thus, in choosing in which models to participate, providers encounter significant differences in the amount of risk they must assume.

The three models also differ in the way they provide incentives to lower costs and who gets to share in savings achieved. Beneficiaries in MA plans share savings in the form of extra benefits or reduced premiums or cost-sharing, while plans presumably gain more business with lower costs as they are able to offer more attractive products in the MA market. By contrast, savings are distributed to ACOs. Under FFS, providers in low cost areas that achieve savings for the Medicare program receive no benefits although the beneficiaries they serve are indirectly rewarded in that services provided by low cost providers will entail lower co-payments.

Other differences among the payment models affect beneficiaries in important ways. For example benefits are not uniform across models. While beneficiaries are entitled to receive the identical package of Part A and Part B services from traditional Medicare, MA plans, and ACOs (with the exception of hospice benefits), MA plans that bid below their benchmarks are required to provide extra benefits and/or reduced premiums. In addition, MA plans must provide catastrophic coverage unavailable under traditional Medicare.³¹ Although not required to provide specific additional benefits, ACOs must have in place a variety of quality assurance processes. Due to their responsibility for the full panoply of care, ACOs also need to have strong incentives to offer cost saving services that are not reimbursed under traditional Medicare such as social services, phone call assistance, and other support services

Finally, the models place different constraints on beneficiaries' choice of provider and on their ability to switch models. Under traditional Medicare, beneficiaries can receive services from any participating provider, which in most communities includes the vast majority of all hospitals and physicians. The same is true for beneficiaries attributed to ACOs; however, their providers have financial

31. Medicare Advantage enrollees have a maximum out-of-pocket limit for all Medicare covered services of \$6,700 and "encouraged" by CMS to be no more than \$3,400. *Fact Sheets: Strengthening Medicare Advantage*, CTRS. FOR MEDICARE & MEDICAID SERVS. (2014), <http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2014-Fact-sheets-items/2014-04-07.html>; see also, *Medicare Advantage Spotlight*, KAISER FAM. FOUND. (2014), <http://kff.org/medicare/issue-brief/medicare-advantage-2014-spotlight-plan-availability-and-premiums/#LimitsOnOOPSpending>.

incentives to refer them to providers affiliated with their ACO. In addition, most MA plans are HMOs that limit access to out of network providers. However, some MA plans adopt a PPO or HMO POS model, which permits access to non-network providers. Beneficiaries must enroll or dis-enroll for MA plans during limited annual periods or under special circumstances such as a change in residence. Under the attribution process, beneficiaries make no election to participate in an ACO and, hence, have no restrictions on choice of providers. Beneficiaries receive notice of their attribution to an ACO and, although not allowed to opt out, may prohibit sharing of clinical data among ACO providers.

III. DIMENSIONS FOR A POLICY FRAMEWORK

As will be discussed in the following section, MedPAC has begun to investigate the desirability of “synchronizing” policies affecting the three models. Although the Commission is at an early stage in developing this concept, a core premise is that Medicare policy should adopt a position of “financial neutrality.” Explaining its rationale, MedPAC’s annual report states, “to encourage beneficiaries to choose the model that they perceive as having the highest value in terms of cost and quality, the Medicare program should pay the same on behalf of each beneficiary making the choice.”³² However, the heterogeneous characteristics of the three models and the policies embedded in them evince the daunting task the agency has undertaken. Synchronization will encounter a number of widely shared program objectives that may make achieving a “level playing field” an elusive goal. Below I discuss three important policy goals that will require careful balancing as payment reform proceeds.

A. Affording Beneficiaries Choice and a Range of Benefits

A laudable feature of Medicare today is that it offers a range of options that serve the heterogeneous preferences of its beneficiaries. The three models provide differing mixes of choice and benefits. Traditional Medicare offers practically no formal limitations on choice of providers, while MA plans constrict choice to provider panels. ACOs are in an intermediate position, not formally limiting choice but operating in the background to steer patients to ACO providers. With respect to benefits, traditional Medicare offers the range of part A and B services. Yet, it fails to reimburse providers for so-called “non-medical” services and, thus, undervaluing certain primary care services like cognitive medicine may underprovide those services. By contrast, MA plans have incentives to provide

32. *Synchronizing Medicare Policy Across Payment Models*, in MEDICARE PAYMENT ADVISORY COMM’N. REPORT TO THE CONGRESS: MEDICARE AND THE HEALTH CARE DELIVERY SYSTEM 1, 5 (June 2014) [hereinafter MedPAC, *Synchronizing Medicare Policy*].

add-on services. They are mandated to provide extra benefits or reduced premiums and catastrophic coverage unavailable in traditional Medicare, though their financial incentives may encourage under-provision of care. ACOs again occupy a middle position, having managed care incentives to provide cost-effective non-medical and coordinating care services, while also sharing incentives to underprovide care. Although developed over time in a rather haphazard fashion, the three payment models thus serve to provide choice and flexibility for a diverse population.

B. Limiting Subsidies and Disparate Payments

Strong objections to “overpayment” or subsidies for private plans fueled cutbacks enacted under the Affordable Care Act. As discussed above, the Medicare Modernization Act enhanced payments to MA plans with the explicit goal of spurring enrollments. To the extent such payments exceeded the reimbursement that providers would have received under FFS plus compensation for providing additional services and assuming risk, CMS payments for MA plans is commonly seen as a subsidy for private plans.³³ Although less widely acknowledged, ACOs also benefit from the services provided by CMS in the form of billing assistance and assignment of beneficiaries. By contrast, MA plans must shoulder the costs associated with soliciting beneficiaries and servicing their accounts. Reforms aimed at attaining absolute financial neutrality would face the intractable task of untangling and harmonizing the levels of direct and indirect support the federal government supplies for participants in each payment model.

Another perceived anomaly is found in payment policies that provide disparate reimbursement and skew incentives for provider participation. For example, high cost providers are rewarded with the opportunity to share savings through ACOs because they can more readily cut costs to their attributed beneficiaries by eliminating the “low hanging fruit” of their cohort’s excess costs. By contrast, providers that have historically contained costs find it difficult to

33. See e.g. *Eliminate Private Medicare Advantage Plan Subsidies*, NAT’L COMMITTEE TO PRESERVE SOCIAL SECURITY & MEDICARE (2009), <http://www.ncpssm.org/Document/ArticleID/754>. The extent of this subsidy must take into account differences in the product sold by MA plans. That is, because they provide extra benefits and more complete insurance, to some extent “extra” payments made to MA plans in the form of “rebates” compensate for those additional benefits. However extra benefits received by beneficiaries appears to be only a small proportion of the higher payments. See Steven D. Pizer et al., *Nothing for Something? Estimating Cost and Value for Beneficiaries from Recent Medicare Spending Increases on HMO Payments and Drug Benefit*, 9 J. INT’L HEALTH FIN. & ECON. 59 (2009) (finding only 14% of added spending on MA plans goes to consumers).

receive financial rewards for their cost effective practices. Adjustments to the benchmark applicable to ACOs would of course alter these incentives. However, the determination of whether to maintain incentives for both high cost and low cost providers to join ACOs is a judgment that will turn on policy-driven appraisals of the long term benefits of ACOs as a transformative payment model.

C. Reducing Payment Variations

Decades of research has revealed that Medicare spending varies enormously across different regions of the country. Recent studies show variations in county-level FFS spending ranging from a high of \$1,300 per month to a low of \$500 per month, with most counties showing variations in the range of \$600-800 per month and with 44 percent of beneficiaries living in the highest spending quartile.³⁴ Because of the interaction of local FFS and payments to the other two models, local variations affect the distribution and costs of MA and ACO alternatives in local markets. For example, MA plans serving markets in which benchmarks were set higher than local FFS spending unsurprisingly tended to cost more than FFS. In low cost areas, this phenomenon might be justified as a necessary inducement for MA plan entry. Early evidence indicates that Pioneer ACOs tended to be located in higher FFS spending areas but historically have cost less than MA plans. However, these results are subject to important caveats. Changes in MA benchmarking will likely change the dynamics among the models as might proposed reforms of the MSSP ACO program and improvements in ACO capabilities as they mature and learn from successful models. Equally important, FFS payment reforms underway³⁵ have the potential to reduce payment variations and influence payments to the other models. Thus efforts at payment reform must entail educated guesses about the speed and extent of change in FFS payments.

In sum, payment reform take place against a backdrop of widely agreed upon policy objectives and other reforms well underway. Next, we consider how some of the norms that affect payment policy may complicate the task of synchronization.

IV. THE CHALLENGE OF SYNCHRONIZING PAYMENT POLICY

A. Regulation: Benchmarks, Quality, and Risk Adjustment

All three models are subject to extensive but divergent regulation. MedPAC's

34. MedPAC, *Synchronizing Medicare Policy*, *supra* note 32, at 8. *See also* INST. OF MED., VARIATIONS IN HEALTH CARE SPENDING: TARGET DECISION MAKING, NOT GEOGRAPHY (2013) (reporting significant and persistent variations in spending).

35. *See* notes 9-17 and accompanying text.

initiative to synchronize policy across the models is rooted in several principles inherent in its responsibility to advise Congress on payments to private health plans and providers on issues affecting quality, cost, and access.³⁶ One is “financial neutrality,” the belief that the Medicare program should not subsidize one model more than another.³⁷ A related concern is that beneficiaries’ choice of models should not be influenced by diverging payment policies, including rules governing quality and risk adjustment.³⁸

A central consideration underlying the financial neutrality inquiry is the “benchmarks” used in payment policies for Medicare Advantage plans and ACOs. Defined as the “level of program spending that will trigger a bonus or penalty” in the two models, benchmarks are set according to statutory formulas that differ in several dimensions. For each ACO, the benchmark is the historical FFS spending *on its beneficiaries*, i.e. those attributed to it,³⁹ while MA plans bid against a benchmark based on *overall FFS spending* in the county in which the plan will operate.⁴⁰ Providers being reimbursed under administered (FFS) pricing of course face no benchmark.

In addition, payment to both MA plans and ACOs are adjusted based on quality standards that also differ in administration and measurement. MA plans are rewarded with a higher benchmark for attaining higher quality scores, while ACOs are penalized by reductions in their shared savings if they do not meet quality benchmarks. From the beneficiaries’ perspective, these distinctions have several

36. *About MedPAC*, MEDPAC, <http://www.medpac.gov/-about-medpac-> (last visited Oct. 30, 2014).

37. MedPAC, *Synchronizing Medicare Policy*, *supra* note 32, at 5. MedPAC raised concerns about financial neutrality in its June 2005 Report, which questioned benchmarks for Medicare Advantage plans that exceeded 100%. See *The Medicare Advantage Program*, in MEDICARE PAYMENT ADVISORY COMM’N. REPORT TO THE CONGRESS: ISSUES IN A MODERNIZED MEDICARE PROGRAM 59, 79-80 (June 2005) [hereinafter MedPAC, *Medicare Advantage*].

38. MedPAC, *Synchronizing Medicare Policy*, *supra* note 32, at 5.

39. For MSSP ACOs, benchmarks are set on a historical cost spending under Parts A and B for its beneficiaries, a determination that is based on a retrospective “attribution” of beneficiaries to an ACO. Beneficiaries who received a plurality of their care from a primary care physician (or in some cases a non-physician or specialist) are attributed to that provider’s ACO. As a result, each ACO’s benchmark determining payment or penalty will be calculated using the three year historical costs, trended forward, for its beneficiaries. Because of uncertainties and inefficiencies associated with this process, MedPAC has recommended that CMS exercise its administrative authority to change to prospective attribution, as is done for ACOs in the Pioneer program. Letter from Glenn M. Hackbarth, Chairman, MedPAC, to Marilyn Tavenner, Adm’r, CMS 7-8 (June 16, 2014) (<http://www.medpac.gov/documents/comment-letters/comment-letter-to-cms-on-accountable-care-organizations-%28june-16-2014%29.pdf?sfvrsn=0>).

40. Beginning in 2017, the county benchmark for MA plans will be at set at four quartile levels—95 percent, 100 percent, 107.5 percent, or 115 percent of the FFS rate projected for that county for the year; quartiles will be based on the relative FFS spending levels among counties during the preceding year. MedPAC, *Synchronizing Medicare Policy*, *supra* note 32, at 8.

implications. The quality scores for MA plans serve a dual purpose: first, as indicia of quality that helps beneficiaries select their plans, and second, as an enhancement of the plan's value because greater rebates to plans must be passed along to beneficiaries in lower costs or enhanced benefits. In the case of ACOs, payment adjustments have only the indirect effect of creating incentives for better performance. Further complicating the picture is the fact that different metrics of quality metrics are used for adjusting payments to MA plan and ACOs.⁴¹ Noting the shortcomings of existing quality measures⁴² that rely primarily on provider-based clinical processes rather than outcomes, MedPAC has proposed shifting to population-based outcome measures.⁴³ However, synchronizing such quality measurement for FFS payment poses an intractable problem because FFS providers do not belong to entities capable of coordinating care for a defined population and have not agreed to do so.⁴⁴

The three payment models are subject to a third important form of regulation, risk adjustment. Risk adjustment plays a critical role in Medicare payment policy as it serves to counter the well-documented tendency of providers and payers that assume financial risk for the costs of treating beneficiaries to avoid beneficiaries expected to incur relatively high medical expenditures and to seek out those likely to have low costs.⁴⁵ Medicare adjusts the capitated payments to MA plans by

41. See MedPAC, *Synchronizing Medicare Policy*, *supra* note 32, at 14 (recommending use of same population-based outcome measures for calculating bonuses and penalties for MA plans and ACOs).

42. MedPAC's principal criticisms of current quality measurement are that (1) it relies too heavily on clinical process measures that are "weakly correlated with health outcomes" and reinforces incentives to increase the volume of services, (2) it is administratively burdensome, and (3) it encourages providers to focus resources on processes being measured and neglect potentially important means for improving outcomes. *Measuring Quality of Care in Medicine*, in MEDICARE PAYMENT ADVISORY COMM'N. REPORT TO THE CONGRESS: MEDICARE AND THE HEALTHCARE DELIVERY SYSTEM 39, 41 (June 2014) [hereinafter MedPAC, *Measuring Quality*].

43. *Id.* at 45-48.

44. MedPAC therefore recommends continued reliance on provider-specific payment policies for FFS providers that control for quality deficiencies such as reductions in hospital payments for high readmissions or infection rates. *Id.* at 14.

45. Reforms in Medicare's risk adjustment system using the CMS-HCC model for adjusting payments for clinical diagnoses and demographic factors and instituting an enrollment lock in have achieved some success in reducing incentives for favorable selection. See J. Michael McWilliams, *New Risk-Adjustment System Was Associated with Reduced Favorable Selection in Medicare Advantage*, 31 HEALTH AFF. 2630 (2012). However, MedPAC has concluded that the HCC methodology "still substantially overpredicts the cost of the least costly beneficiaries and underpredicts the cost of the most costly beneficiaries" but was unable to find alternatives that performed better. *Improving Risk Adjustment in the Medicare Program*, in MEDICARE PAYMENT ADVISORY COMM'N. REPORT TO THE CONGRESS: MEDICARE AND THE HEALTHCARE DELIVERY SYSTEM 21, 32-33 (June 2014) [hereinafter MedPAC, *Improving Risk Adjustment*]. It is currently investigating administrative measures such as penalties for disenrollment of high cost beneficiaries.

calculating a risk score based on the demographic factors and medical history for each enrollee relative to the national average that it multiplies by the base rate payment for the plan. Payment to ACOs adjusts for risk based on the demographics alone calculated for all beneficiaries attributed to the ACO. MedPAC has indicated that synchronization may require reducing differences in the methods for risk adjustment and coding practices for all Medicare beneficiaries.⁴⁶

B. Synchronization and Financial Neutrality

As noted MedPAC has begun an investigation of whether and how regulation of the three payment models might be “synchronized.”⁴⁷ It has long advocated “financial neutrality” between MA and FFS payments, urging in 2005, for example, that overpayments to Medicare Advantage plans be curtailed and the MA benchmark be set at 100 percent of local FFS costs.⁴⁸ However, it has been careful to qualify its position on financial neutrality by stating that while benchmarks should be equal across payment models, “equal benchmarks... do not mean equal payments because payments may be adjusted for quality and other factors.”⁴⁹ Recent work by the MedPAC staff has involved simulation studies examining the relationship among the three models and comparing several benchmarks that may be used. It has concluded that no single payment model would always be the low-cost model in all situations. Instead, the relative cost of the models will depend on “regional differences in care delivery, on the effectiveness of MA plans and ACOs in restraining cost growth, and on decisions regarding how quality bonuses and risk adjustment factor into the benchmarks.”⁵⁰ This led MedPAC to conclude that “efficiency can be gained by synchronizing the benchmarks to level the playing field,” thus leaving it to beneficiaries’ choice of which model best suited their needs.⁵¹

However, the choice of a benchmark has important policy implications. For example, using local FFS spending as the benchmark for ACOs (as opposed to the current benchmark which consists of the historical spending for each ACO’s beneficiaries) would encourage ACOs comprised of low cost providers to enter the program. This is the opposite response seen under existing arrangements where

Id. at 33. See also U.S. GOV’T ACCOUNTABILITY OFFICE, GAO-13-206, MEDICARE ADVANTAGE: SUBSTANTIAL EXCESS PAYMENTS UNDERSCORE NEED FOR CMS TO IMPROVE ACCURACY OF RISK SCORE ADJUSTMENTS (2013).

46. MedPAC, *Synchronizing Medicare Policy*, *supra* note 32 at 13-14.

47. See *supra* note 37 and accompanying text.

48. MedPAC, *Medicare Advantage*, *supra* note 37, at 79.

49. MedPAC, *Synchronizing Medicare Policy*, *supra* note 32, at 5.

50. *Id.* at 12.

51. *Id.*

high cost ACOs have the incentive to participate and low cost providers do not. However, as discussed below, using local FFS benchmarks will discourage participation of MA plans in low cost areas because of the difficulty of “beating” the locally determined capitation rate. By contrast, setting a benchmark based on a national average of FFS costs would perversely penalize beneficiaries in low spending areas, where costs are already low, by chilling the incentives facing MA plans and ACOs. Given the wide variation in spending in the country, any benchmark that is chosen will have significant effects on the incentives providers face and distributional consequences for beneficiaries. Finally, an underlying policy issue is whether the deeply flawed FFS spending serve as a benchmark. Benchmarks calculated on the basis of bidding experience or a calculation of an efficient level of spending would better serve program objectives by making each ACO’s success hinge on its ability to be cost efficient in relation to its local market.

C. Divergent Background Norms

A more fundamental question remains. Why should Medicare policy pursue a level playing field at all? The myriad differences in the characteristics of the models discussed in the previous section reflect an amalgam of policies underlying those differences. These divergent norms, lurking in the background of Medicare payment policy, suggest that any attempt to level the playing field encounters a bumpy terrain of widely shared policy objectives that may prove impossible to reconcile.

Integration and FFS Payment. Virtually all policy analysts agree that a central failing of the American health care system is the absence of coordination among providers. Particular fault rests with traditional fee-for-service Medicare, which rewards providers for volume and ignores the potential benefits accruing from integration of services. Indeed, many sections of the ACA are designed to shift the focus of traditional Medicare by testing global and value-based payments and fostering new delivery arrangements.⁵² In addition, Medicare payment policy decisions take on added importance because of their influence on the organization of delivery systems serving the commercial sector. Those who view it as an important objective of Medicare payment policy to move delivery in the direction of encouraging efficiency-enhancing integration might well argue that the synchronization project should adjust the neutrality principal to encourage the proliferation of ACOs and Medicare Advantage plans.

52. See. BARRY R. FURROW ET AL. HEALTH LAW (3d ed. 2014) §§. 8-16 – 8-17.; U.S. Dept. of Health and Human Services, Hospital Value-Based Purchasing Program, http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Hospital_VBPurchasing_Fact_Sheet_ICN907664.pdf.

Equity and Regional Variation. As discussed above, the variation in health care costs across regions of the country might cause significant variability in the availability and generosity of Medicare Advantage plans under synchronization.⁵³ For example, lowering the benchmark to (or below) fee-for-service levels might result in some areas being deprived of the extra benefits provided by MA plans.⁵⁴ Thus, from the consumers' standpoint, it would be inequitable if benchmark adjustment deprived some Medicare beneficiaries of the enhancements that come with MA enrollment. Likewise, providers find inequity in the imbalance of opportunity under certain payment arrangements. For example, ACOs have generally grown up in areas where high cost providers can more readily lower costs for their attributed beneficiaries and share in the savings they achieve. However, providers that have maintained lower costs in other regions without forming ACOs are not rewarded for their economizing efforts and are less likely to form ACOs. Were synchronization to set ACO benchmark at local FFS levels, it would address this perceived inequity but would give rise to criticism that benchmarks did not provide adequate incentives for participation of high cost providers. More generally, a related set of concerns focuses on the wide disparities in payment across regions. This view emphasizes the need to reduce inequity in the wide variation in Medicare spending across regions and advocates leveling federal provider reimbursements, though allowing for some differences based on some localized factors.

Competition and Innovation. Not widely appreciated is the interplay of Medicare payment policy and the competitiveness of provider markets in the commercial sector. Although administered pricing under Medicare does not differentiate among providers based on their market leverage, provider market competition has a significant effect on hospital Medicare margins. Examining the effect of hospital concentration on Medicare payments, MedPAC has found that high hospital margins on private-payer patients tend to induce more construction and higher hospital costs and that, "when non-Medicare margins are high, hospitals face less pressure to constrain costs, [and] costs rise."⁵⁵ These factors, MedPAC

53. See Robert E. Moffit & Alyene Senger, *Progress in Medicare Advantage: Key Lessons for Medicare Reform*, HERITAGE FOUND. (Sept. 4, 2014), <http://www.heritage.org/research/reports/2014/09/progress-in-medicare-advantage-key-lessons-for-medicare-reform> (reducing the MA benchmarks as provided under the ACA may result in reduction in the number of plans around the country).

54. As MedPAC Chairman HackbARTH characterized the argument, "People... in areas of the country where there are low fee- for-service costs are...not crazy by any stretch...what they're saying is that we pay equal taxes in Medicare...In some parts of the country, people are getting a whole lot more health care services for it than in other parts of the country." *Transcript of Medicare Payment Advisory Commission Public Meeting*, MEDICARE PAYMENT ADVISORY COMMISSION 93-94 (Mar. 7, 2014), www.medpac.gov/documents/0314medpac_transcript.pdf.

55. *Report to the Congress: Assessing Alternatives to the Sustainable Growth Rate System* xiv,

observes, explain the counterintuitive phenomenon that hospital Medicare margins tend to be low in markets in which concentration is highest, while margins are higher in more competitively structured markets.⁵⁶ Further, low “Medicare margins” attributable to expense preference behavior—the tendency of firms with market power to allow costs to increase⁵⁷—by dominant hospitals may translate into higher Medicare costs because updates to hospital administered pricing under prospective payment are sensitive to these margins. Finally, as CMS noted in promulgating its Final Rule on ACOs, because monopolists face regulatory constraints in raising prices, they often reduce the quality or amount of inputs for their services.⁵⁸ In this way, inadequate competition in the private sector may lead to diminution in quality of care and access for Medicare beneficiaries. Hence Medicare payment policy encouraging formation of MA and ACOs serves to support the beneficial effects of the dynamic between Medicare and private markets.⁵⁹

Beneficiary Choice and Preserving Traditional Medicare. The widespread support for traditional Medicare among the public and politicians suggests that payment reform will not encroach on the choice that option provides. In addition, traditional Medicare operates as an important constraint on cost increases in alternative models. Most obviously, the benchmarks for MA plans and ACOs limit the ability of dominant hospitals and physician groups to exercise their market power vis-a-vis Medicare. In markets with limited provider competition, the availability of traditional Medicare may also encourage somewhat more competitive bidding from MA plans and cost control from ACOs due to the freedom of choice afforded to beneficiaries by traditional Medicare. Further, MA plans’ contract prices with hospitals are strongly influenced by FFS Medicare pricing. A MedPAC study demonstrated that MA plans pay hospitals the same, significantly discounted rates that FFS Medicare pays.⁶⁰ Hospitals have no alternative, higher paying alternatives because FFS rates are administratively determined, and regulations prohibit them from charging out of network rates for

MEDICARE PAYMENT ADVISORY COMMISSION (2009), http://www.medpac.gov/documents/mar09_entirereport.pdf.

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

57. See Harvey Leibenstein, *Allocative Efficiency vs. X-Efficiency*, 56 AM. ECON. REV. 392 (1966).

58. Center for Medicare & Medicaid Services, Medicare Shared Savings Program: Accountable Care Organizations, 76 Fed. Reg. 67,802, 67,806-961 (Nov. 2, 2011).

59. Thomas L. Greaney, *Regulators as Market Makers: Accountable Care Organizations and Competition Policy*, 47 AZ. ST. L. J. 1 (2013).

60. *Transcript of Medicare Payment Advisory Commission Public Meeting*, MEDICARE PAYMENT ADVISORY COMMISSION 93-94 (Nov. 1, 2014), <http://www.medpac.gov/documents/november-2012-meeting-transcript.pdf>.

emergency services.

CONCLUSION

The trajectory of the three payment models is anyone's guess. Some hazard predictions that all ACOs will eventually morph into MA plans; others suggest that MA plans cannot best traditional Medicare on cost, so in the absence of overly generous benchmarks, Medicare managed care will flounder; still others see payment reform of FFS Medicare inevitably pushing providers to integrate and eventually migrating to ACOs or MA plans. MedPAC's proposal to avoid subsidizing any model appropriately backs away from an explicit endorsement of any one model. However, its aspiration that regulators and Congress will endorse a truly level playing field is likely to be frustrated given the powerful norms that have driven Medicare policy in the past.

The Reverberating Risk of Long-Term Care

Allison K. Hoffman*

The Fiftieth Anniversary of Medicare and Medicaid offers an opportunity to reflect on how American social policy has conceived of the problem of long-term care. In this essay, I argue that current policies adopt too narrow a conception of long-term care risk, by focusing on the effect of serious illness and disability on people who need care and not on the friends and family who often provide it. I propose a more complete view of long-term care risk that acknowledges how illness and disability reverberates through communities, posing insecurity for people beyond those in need of care.

Social insurance programs aim to create greater security for American families.¹ But programs for long-term care have had mixed results. The most recent attempt at reform, which Ted Kennedy ushered through as a part of the Patient Protection and Affordable Care Act (PPACA),² was the Community Living Assistance Services and Supports (CLASS) Act.³ Participation was optional,

* Assistant Professor of Law, UCLA School of Law. The author thanks Samuel Bray and Joanna Schwartz for comments on an earlier draft, Erynn Embree and Lynn McClelland for research assistance, and Abbe Gluck for the opportunity to present this project at the Yale Conference on the Law of Medicare and Medicaid at 50. She is also deeply grateful to the many people who have engaged in valuable conversations about, read drafts of, and supported research for the larger article on which this essay is based.

1. Social insurance is a term typically used to refer to government programs that spread risk—for example, Medicare or Social Security—and is what I mean when I use the term “social insurance” herein. See generally MICHAEL A. GRAETZ & JERRY L. MASHAW, *TRUE SECURITY: RETHINKING AMERICAN SOCIAL INSURANCE* (1999); THEODORE R. MARMOR ET AL., *SOCIAL INSURANCE: AMERICA’S NEGLECTED HERITAGE AND CONTESTED FUTURE* (2014). Because these programs are also redistributive, some argue that they are more like tax and transfer programs than “real” (meaning private) insurance. This view, however, fails to recognize that all insurance, whether private or public, redistributes resources from low-risk to high-risk people and from the lucky to the unlucky. That is the purpose of insurance. Pricing can attempt to diminish such redistribution by charging risk-rated premiums or to enhance it by charging community-rated prices. Redistribution of risk to any extent is a defining and critical feature of all insurance. See James Kwak, “*Social Insurance*,” *Risk Spreading and Redistribution*, in *RESEARCH HANDBOOK ON THE LAW AND ECONOMICS OF INSURANCE* (Daniel Schwarcz & Peter Siegelman, eds., forthcoming 2015).

2. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), amended by Health Care and Education Reconciliation Act (HCERA) of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010).

3. Patient Protection and Affordable Care Act § 8002(a).

which made it actuarially unsound and led to its repeal.⁴ Medicaid, which is currently the primary government program to finance long-term care, has fallen short for people who need long-term services or supports—the care recipients.⁵

Even more troublesome is the fact that long-term care policy, especially with Medicaid's recent evolution toward home-based care, has intensified a second type of insecurity for Americans. This insecurity affects people who are responsible for the long-term care of a loved one.⁶ Such responsibility results in staggering costs—both monetary and nonmonetary. The latter include health and emotional harms as well lost opportunities that are more difficult to measure but nonetheless significant. In a longer forthcoming article, I explore these costs in greater detail and make the case for why we should consider these stochastic harms a collective problem—a social risk—that threatens Americans' wellbeing and needs to be addressed. I call this threat “next-friend risk.”⁷

Current long-term care social policy ensures heavy reliance on family and friends. Of course, people have long relied on family for care.⁸ Yet throughout the early twentieth century, local and federal governments began to experiment with systems of long-term care that had the potential to lessen reliance on families.⁹

4. The American Taxpayer Relief Act of 2012, Pub. L. No. 112-240, § 642, 126 Stat. 2313, 2358 (2013).

5. This widely-acknowledged shortcoming is what led to the aforementioned CLASS Act and the creation of a Commission on Long-Term Care by President Barack Obama and the United States Senate after the CLASS Act was repealed. The Commission's Report outlines problems with the current system and recommended solutions. LONG-TERM CARE COMM'N, REPORT TO THE CONGRESS (2013). The Commission did not, however, reach consensus, leading to a second set of recommendations from one-third of the commissioners looking for more comprehensive social insurance solutions. LONG-TERM CARE COMM'N, A COMPREHENSIVE APPROACH TO LONG-TERM SERVICES AND SUPPORTS (2013).

6. Some people respond to this responsibility by paying for care, but most have no choice but to provide it because they cannot afford to pay for any or all of the necessary care. Two-thirds of informal caregivers are women. NAT'L ALLIANCE FOR CAREGIVING IN COLLABORATION WITH AARP, CAREGIVING IN THE U.S. 4 (2009).

7. I borrow the phrase “next friend” from a legal term for a person who in litigation represents someone with a disability who is otherwise unable to represent himself. Although not a legal guardian, the next friend protects the interests of an incompetent person. I use this term to recognize that those responsible for another's long-term care are sometimes family and sometimes friends. I also use it instead of “informal caregiver” to imply the possibility that in an ideal world a next friend might choose to pay for care, rather than to provide it herself.

8. See HENDRIK HARTOG, SOMEDAY ALL THIS WILL BE YOURS: A HISTORY OF INHERITANCE AND OLD AGE (2012).

9. At the beginning of the twentieth century, most long-term care needs were met by family, though some poor and mentally ill people were cared for in almshouses. By the mid-twentieth century, state institutions for long-term care were built, relying on local and state funding to pay for care. Subsequently, long-term care shifted to private nursing homes when federal programs began reimbursing some care provided in these private facilities, but not when provided in public state institutions. See David B. Smith & Zhanlian Feng, *The Accumulated Challenges of Long-Term Care*,

Medicaid emerged as the primary payer for long-term care, largely displacing other efforts.¹⁰ It is worth noting that Medicare only funds long-term care “tangentially,”¹¹ despite the common misconception that it pays for long-term care for older Americans.¹²

Thus, over the past half century, Medicaid has transformed long-term care financing. Because Medicaid is means-tested, all but the poorest Americans have no social insurance for long-term care, with the exception of a small number with private insurance.¹³ In turn, most Americans who need long-term care either “spend down” until they qualify for Medicaid or, more often, rely on family and friends to help.

Even those who are eligible for Medicaid are increasingly likely to rely on friends and family. Medicaid initially favored the provision of long-term care in licensed nursing homes or similar institutional settings, often referred to as Medicaid’s “institutional bias.”¹⁴ Care in such institutions is a mandatory benefit—one that states must cover to receive federal matching funds.¹⁵ In contrast, in-home personal care (e.g., bathing, dressing, feeding, doing light housework, shopping for groceries, etc.)¹⁶ and “home and community-based services” are optional benefits.¹⁷ States receive matching funds if they offer these benefits but they are not required to offer them. For some time, states mostly paid for care in institutional settings.¹⁸ But over the past few decades, Medicaid’s bias toward institutional care has yielded an increased reliance on home and community-based services, which in most cases just means long-term care at home. Incentives in the

29 HEALTH AFF. 29 (2010); Sidney D. Watson, *From Almshouses to Nursing Homes and Community Care: Lessons from Medicaid’s History*, 26 GA. ST. U. L. REV. 937 (2010); see also EILEEN BORIS & JENNIFER KLEIN, CARING FOR AMERICA: HOME HEALTH WORKERS IN THE SHADOW OF THE WELFARE STATE (2012).

10. *Medicaid and Long-Term Care Services and Supports: A Primer*, KAISER FAM. FOUND. 1 (2012), http://kaiserfamilyfoundation.files.wordpress.com/2014/07/8617-medicaid-and-long-term-services-and-supports_a-primer.pdf.

11. Judith Feder et al., *Long-Term Care in the United States: An Overview*, 19 HEALTH AFF. 40, 44 (2000).

12. *Id.* Medicare pays for post-acute care in hospital settings and to a very limited degree in home settings. *Id.*

13. KATHLEEN UJVARI, AARP PUB. POL’Y INST., LONG-TERM CARE INSURANCE: 2012 UPDATE 1 (2012) (reporting that 7-9 million Americans hold private insurance policies).

14. Samuel R. Bagenstos, *The Future of Disability Law*, 114 YALE L.J. 1, 61 (2004).

15. JULIE STONE, CONG. RESEARCH SERV., R40718, LONG-TERM CARE (LTC): FINANCING OVERVIEW AND ISSUES FOR CONGRESS 7 (2010). They must also fund home health care for people who would otherwise be eligible for nursing facility services. 42 U.S.C. § 1396(a)(10)(D) (2012).

16. 42 U.S.C. §1396d(a)(24) (2012).

17. 42 U.S.C. §1396d(a)(22) (2012).

18. Bagenstos, *supra* note 14, at 61.

Deficit Reduction Act of 2005 and PPACA in 2010 to move people from institutional care to home care amplified this trend.¹⁹

The move toward long-term care at home offers considerable promise. People with illness and disability can stay in their homes and live as independently as possible. The stories of lives transformed when people are moved from nursing homes into home care are undeniable successes.²⁰ Some believe that home-based care also saves states money, although the evidence is mixed on this front.²¹

On the other hand, Medicaid's evolving approach cements reliance on family and friends of people who need care in several ways. First, programs tend to be underfunded and many have long waiting lists for services.²² Some advocates of home-based care support it because of its potential as a cost-effective alternative to institutional care, and are generally resistant to increased public expenditures for these programs. Second, without the economies of scale that enabled twenty-four-hour care in nursing homes, it is difficult for states to finance the wraparound care that people might need in a home setting. Finally, as noted above, the provision of non-medical care, such as bathing or getting dressed, is an optional Medicaid benefit; that is, states might choose not to cover this care at all, even as they shift toward home-based care.²³ Family and friends often step in to fill these gaps.

But family and friends can no longer bear such burdens without risking their own financial stability, emotional stability, health, and general wellbeing. The world has changed in ways that make de facto reliance on families and friends increasingly untenable. Care needs are becoming more intensive. Demand for long-term care has increased as medicine saves people who previously would not have survived. In 2010, the life expectancy at birth for an American was nearly 79 years,²⁴ ten years longer than it was in the mid-twentieth century and twenty years longer than at the beginning of the century.²⁵ Heroic trauma care and miracle drugs

19. Terence Ng et al., *Medicaid Home and Community-Based Services Programs: 2010 Data Update*, KAISER FAM. FOUND. (Mar. 27, 2014), <http://kff.org/medicaid/report/medicaid-home-and-community-based-service-programs>.

20. Watson, *supra* note 9, at 937-38.

21. See e.g., Andrea Wysocki et al., *Long-Term Care for Older Adults: A Review of Home and Community-Based Services Versus Institutional Care*, AGENCY FOR HEALTHCARE RES. AND QUALITY (2012), http://www.effectivehealthcare.ahrq.gov/ehc/products/369/1277/CER81_Long-Term-Care_FinalReport_20121023.pdf.

22. Ng et al., *supra* note 19, at 3.

23. *Medicaid Benefits*, MEDICAID.GOV (Oct. 29, 2014), <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Medicaid-Benefits.html>.

24. Sherry L. Murphy et al., *National Vital Statistics Reports: Deaths: Preliminary Data for 2010*, CTRS. FOR DISEASE CONTROL & PREVENTION 51 (2012), http://www.cdc.gov/nchs/data/nvsr/nvsr60/nvsr60_04.pdf.

25. Elizabeth Arias, *National Vital Statistics Reports: United States Life Tables 52-53*, CTRS. FOR DISEASE CONTROL & PREVENTION (2007),

are preserving and extending lives of people with serious injuries.²⁶ And the “old old,” defined as those over 80 years old, is growing as a percentage of the population.²⁷ More Americans suffer from chronic disease than ever before, and the proportion of Americans with chronic conditions is projected to continue to rise.²⁸

At the same time, families are less able to address the needs of the chronically ill. The number of single-parent families and two wage-earner households has increased significantly over the past several decades, leaving little cushion for unanticipated caregiving needs.²⁹ Families have dispersed geographically.³⁰ Moreover, the ratio of people needing care to those who might provide it is increasingly disproportionate, as people live longer and have fewer kids.³¹

As a result, the average informal caregiver for a parent who reduces working hours or leaves the workforce faces monetary losses—foregone income, pensions, benefits, and retirement savings, including Social Security—of as much as \$200,000 to \$300,000.³² Considering that the median household net worth in the

http://www.cdc.gov/nchs/data/nvsr/nvsr59/nvsr59_09.pdf.

26. See Andrew I. Batavia et al., *Toward a National Personal Assistance Program: The Independent Living Model of Long-Term Care for Persons with Disabilities*, 16 J. HEALTH POL. POL’Y & L. 523, 523 (1991) (citing studies about the changing nature of disability).

27. Arias, *supra* note 25, at 44 (of those born in 1900, only 13,529 lived to 80. The number will more than double for those born in the mid-1900s and will double again for those born in the early 21st century). But see DONALD L. REDFOOT & ARI HOUSER, AARP PUB. POLICY INST., MORE OLDER PEOPLE WITH DISABILITIES LIVING IN THE COMMUNITY: TRENDS FROM THE NATIONAL LONG-TERM CARE SURVEY, 1984-2004 2 (2010) (suggesting that decreasing disability rates have offset this aging to some degree, so even with a 17% increase in the older population, rates of disability increased only 1.4% between 1989 and 2004).

28. See Gerard Anderson & Jane Horvath, *The Growing Burden of Chronic Disease in America*, 119 PUB. HEALTH REP. 263, 267 (2004) (reporting 125 million Americans or 45% of the population with one or more chronic conditions in 2000 and that prevalence is projected to increase over the next 30 years). For example, the proportion of informal caregivers reporting to care for someone with Alzheimer’s Disease or dementia rose from 6% to 12% from 2004 to 2009. NAT’L ALLIANCE FOR CAREGIVING IN COLLABORATION WITH AARP, *supra* note 6, at 41.

29. U.S. CENSUS BUREAU, STATISTICAL ABSTRACT OF THE U.S. 840 tbl.1337 (2012); Howard N. Fullerton, Jr., *Labor Force Participation: 75 Years of Change, 1950-98 and 1998-2025*, MONTHLY LAB. REV. 4 tbl.1 (1999)..

30. Ping Ren, *Lifetime Mobility in the United States: 2010*, U.S. CENSUS BUREAU (2011), <http://www.census.gov/prod/2011pubs/acsbr10-07.pdf>.

31. See, e.g., WILLIAM O’HARE, ANNIE E. CASEY FOUND., *THE CHANGING CHILD POPULATION OF THE UNITED STATES: ANALYSIS OF DATA FROM THE 2010 CENSUS* 4 (2011) (reporting a decrease in the percentage of the population under age 18 from 40% in 1900 to 24% in 2010, as a result of fewer children per family and increased longevity); Emily Brandon, *65-and-Older Population Soars*, U.S. NEWS & WORLD REP., (Jan. 9, 2012, 9:15 AM), <http://money.usnews.com/money/retirement/articles/2012/01/09/65-and-older-population-soars> (reporting that the proportion of Americans 65 and older has grown from 4.1% in 1900 to 13% in 2012)..

32. METLIFE MATURE MKT. INST., *THE METLIFE STUDY OF CAREGIVING COSTS TO WORKING*

U.S. was just under \$70,000 in 2011,³³ losses at this level are devastating for all but the wealthiest households. More than one-third of people caring for aging parents leave the workforce or reduce working hours, and women are more likely than men both to become caregivers and to leave the workforce altogether.³⁴ Informal caregivers also face significant non-economic costs, including health and psychosocial consequences.³⁵ For example, research shows that 40% to 70% of people caring for older adults have symptoms of depression and 25% to 50% meet the diagnostic criteria for major depression, far outpacing the rates in the general population.³⁶ And people providing long-term care for another undoubtedly miss out on the ability to engage in other relationships or opportunities that bring meaning to their lives. These are, in effect, the invisible copayment of a long-term care policy.

These costs threaten Americans' financial, emotional, and physical wellbeing as seriously as any of the other phenomena that have motivated the creation of social insurance programs, including unemployment, outliving one's savings, and medical spending in retirement. As we think of the next era of reform efforts, we should consider these costs collectively as posing a social risk—not as a private problem. This perspective illuminates that next-friend risk could be mitigated through better long-term care social insurance and suggests at least four implications for the development of future policy:

1. The Scale of the Problem. Current policy hides costs borne by next friends. By one estimate, the total costs of informal caregiving in the United States in 2009,

CAREGIVERS: DOUBLE JEOPARDY FOR BABY BOOMERS CARING FOR THEIR PARENTS 15 (2011) [hereinafter METLIFE DOUBLE JEOPARDY] (estimating total loss, including wage, Social Security, and pensions, of \$283,716 for men and \$324,044 for women among Baby Boomers caring for their parents who leave the workforce for any period of time). Some studies estimates are even higher. METLIFE MATURE MARKET INSTITUTE, THE METLIFE JUGGLING ACT STUDY: BALANCING CAREGIVING WITH WORK AND THE COSTS INVOLVED 5-6 (1999) [hereinafter METLIFE JUGGLING ACT] (reporting average wage loss of \$566,443, Social Security loss of \$25,494, and pension loss of \$67,202; median reported wage loss is \$243,761).

33. *Wealth and Asset Ownership*, U.S. CENSUS BUREAU, <http://www.census.gov/people/wealth> (last visited Nov. 9, 2014) (follow link to *Net Worth and Asset Ownership of Households: 2011*).

34. METLIFE DOUBLE JEOPARDY, *supra* note 32, at 10.

35. See METLIFE JUGGLING ACT, *supra* note 32, at 5-6; NAT'L ALLIANCE FOR CAREGIVING IN COLLABORATION WITH AARP, *supra* note 6, at 47 (2009); ROSALYNN CARTER INST. FOR CAREGIVING, *AVERTING THE CAREGIVING CRISIS: WHY WE MUST ACT NOW* 12-13 (2010)..

36. Steven H. Zarit, *Assessment of Family Caregivers: A Research Perspective*, in 2 CAREGIVER ASSESSMENT: VOICES AND VIEWS FROM THE FIELD: REPORT FROM A NATIONAL CONSENSUS DEVELOPMENT CONFERENCE 12, 14 (2006) (summarizing studies on informal caregiving and depression). The rates of major depression in the general population are under 7%. *Major Depression Among Adults*, NAT'L INST. OF MENTAL HEALTH (Dec. 7, 2014), <http://www.nimh.nih.gov/health/statistics/prevalence/major-depression-among-adults.shtml>.

if hours were compensated at average care work wages, was \$450 billion.³⁷ Accounting for this invisible copayment would require funding at double or triple its current levels. Such funding is admittedly unlikely, but this sum could anchor policymakers on a number that more realistically reflects the scale of long-term care demand.

2. Insurance. Most of us *could* end up responsible for the long-term care for another, even if not all of us *will*. This widespread stochastic harm—plus the failure of private long-term care insurance markets—makes social insurance an apt tool to mitigate the impact of this risk. More so, the inability of nearly all Americans to manage next-friend risk well privately implies that a universal social insurance program approach like Medicare or Social Security is a better fit than a means-tested program like Medicaid. Tactically, social insurance policy more sensitive to next-friend risk could be integrated into existing programs or could be created as part of a new, freestanding program.³⁸ Politically, seeing the problem from the next-friend perspective could make it more relatable for voters and policymakers, many of whom might worry about the possibility themselves. This relate-ability might in turn generate support both for increased funding and improved policies.

3. Flexibility. With or without additional funding, long-term care policies could be designed more flexibly to better mitigate next-friend risk. When someone becomes responsible for another, she can provide the care herself, pay for care, or do some combination of these two. If insurance were designed so that a next friend could toggle more freely between these choices, she could use benefits to minimize her own long-term harm, however she might define it. Current policies do not recognize the need for this toggle. As a result, responses to next-friend risk are often biased, most often incentivizing a next friend to provide the care herself. A realistic goal would be to aim to reduce such biases in current policies.

One way to curtail these biases is to create flexible funding, such as a voucher program in which benefits may be used to pay either a next friend or a professional care provider. Some programs, including the In-Home Supportive Services (IHSS) Program in California and the long-term care voucher system in Germany, are designed with such a toggle. While promising, these programs reveal how the details of policy design can limit choice, even with a toggle in place.³⁹ For example, in the IHSS program, household income calculations used to determine program eligibility include wages a cohabiting family caregiver earns outside the home, but

37. LYNN FEINBERG ET. AL., AARP PUB. POLICY INST., VALUING THE INVALUABLE: 2011 UPDATE, THE GROWING CONTRIBUTIONS AND COSTS OF FAMILY CAREGIVING 2 (2011).

38. These ideas are explored further in my forthcoming article.

39. See Joshua M. Wiener & Alison E. Cuellar, *Public and Private Responsibilities: Home- and Community-Based Services in the United Kingdom and Germany*, 11 J. AGING & HEALTH 417 (1999).

do not account for IHSS benefits paid to the family member.⁴⁰ This means the IHSS benefits paid to a wife to care for her husband would not disqualify the husband from receiving benefits, but wages from the wife's work in a job outside the home likely would. This rule creates a strong incentive for her to provide care directly, even if doing so threatens her long-term security. Admittedly, even well-designed vouchers would be layered on underlying social norms and institutions that have long compelled women to take on caregiving, even at high personal costs.⁴¹ Nevertheless, long-term care policies could be designed so that they do not reinforce, and perhaps counterbalance, this gendered bias.

Another way to create flexibility is to invest in better community-based infrastructure for long-term care. This might take the form of a small-scale group home or a day care for care recipients, allowing a next friend to go to work and still have time with the care recipient in the evening and on weekends. The next friend would better be able to balance her career with caregiving, minimizing impact on her earnings and the long-term harm to her own wellbeing. In the absence of appealing options for paid care, next friends have little real choice. Such models exist in experimental form, but should be expanded and replicated to help mitigate next-friend risk.⁴²

4. Tradeoffs. Finally, taking next-friend risk seriously forces the (admittedly uncomfortable) question of whether social policy should more intentionally balance the needs of care recipients and next friends, even if it results in a solution that is suboptimal for the care recipient in some cases. For example, if an elderly widower has a stroke, the primary goal of *current* long-term care law and policy is to ensure that he has adequate care supports in the least restrictive setting appropriate.⁴³ If his daughter moves him into her home, as Medicaid policies

40. 20 C.F.R. § 416.1161(a)(16). Under this same rule, "in-kind support and maintenance" is not deemed income either.

41. Tomes of scholarship document how social, religious, moral, cultural, and other influences inscribe caregiving of all kinds as a personal and gendered obligation. A couple of illustrative examples from different disciplines include BORIS & KLEIN, *supra* note 10; MARTHA FINEMAN, *THE AUTONOMY MYTH: A THEORY OF DEPENDENCY* (2005); HARTOG, *supra* note 8; JOAN WILLIAMS, *UNBENDING GENDER* (2001). See also Vicki Schultz, *Life's Work*, 100 COLUM. L. REV. 1881, 1899-1919 (2000) (describing different feminists schools of thought on caregiving).

42. For example, On Lok Lifeways provides a mix of at-home, group care, and residential care to meet an individual's need. On Lok was developed to help the Asian American community in San Francisco and formed the basis for a larger Medicaid demonstration program, the Program for All-Inclusive Care for the Elderly. The Green House Project is another emerging model with small group homes across the country that are designed so that residents get nursing-home style care but still feel at home. COMM. ON THE FUTURE HEALTH CARE WORKFORCE FOR OLDER AMERICANS BD. ON HEALTH CARE SERVS., INST. OF MED., *RETOOLING FOR AN AGING AMERICA: BUILDING THE HEALTH CARE WORKFORCE* 81-85 (2008).

43. *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581 (1999) (holding that institutionalization, when avoidable, can be a form of discrimination under the Americans with Disabilities Act of 1990).

increasingly encourage, the widower's needs could be fully met at the lowest possible public cost. But his daughter may have to reduce working hours or leave a secure job with benefits, threatening her family's long-term finances and, possibly, her own health and wellbeing. Such results, where each generation sacrifices its security for the last one, are simply not sustainable.

Long-term care is an elusive problem, both because of its high cost and because these costs can be hidden as they are passed on to next friends. Seeing the problem of long-term care from the perspective of next friends reveals its full complexity. Serious illness and disability have reverberating effects. They create insecurity not only for the afflicted individual, but also for his or her family and friends. The next era of social insurance policy for long-term care must grapple with the reverberations of long-term care risk to create meaningful security for Americans.

The Universality of Medicaid at Fifty

Nicole Huberfeld*

INTRODUCTION

Fragmentation has aptly described the United States' historically decentralized, disjointed, and disintegrated approach to health care.¹ While fragmentation has endured in multiple dimensions—political, economic, organizational, relational, regulatory, and philosophical, to name a few—the exclusionary characteristic of American health care facilitated by fragmentation has been one of the greatest hurdles to access to needed care. Private health care providers have defended their prerogative to treat whomever, whenever, and the law largely has protected them from systemic integration² in either care or finance that could facilitate more “unified decision making.”³ Moreover, the United States has lacked a unifying theory of access to health care, existing in an ordered chaos sustained by a century-long political rejection of collective response to the human

* H. Wendell Cherry Professor of Law and Bioethics Associate, University of Kentucky College of Law. Thanks to the participants in the Law of Medicare and Medicaid at 50 Symposium and to Jessica Roberts for helpful insights. Comments are welcome: nicole.huberfeld@uky.edu. Thanks always DT and SRHT.

1. See generally THE FRAGMENTATION OF U.S. HEALTH CARE (Einer Elhauge ed., 2010) (essays examining the “fragmented” healthcare system and prescribing institutional changes to eliminate fragmentation).

2. See Einer Elhauge, *Why We Should Care about Health Care Fragmentation and How to Fix It*, in THE FRAGMENTATION OF U.S. HEALTH CARE 1, 1-6 (Einer Elhauge ed., 2010) (discussing various dimensions of fragmentation). Applying economic theory of “firms and team production,” Professor Elhauge discusses the deeply entrenched institutional problems of fragmentation:

[H]ealth care raises the mother of all team production problems where input contributions are difficult to measure. . . . [I]n health care, shirking is likely to consist of failing to coordinate with others involved in the team effort on strategy, timing, and information-sharing in order to maximize health benefits per costs expended. . . . U.S. health care couples the mother of all team production problems with the mother of all refusals to use centralized ownership structures to solve them

Id. at 7. Both law and politics have protected health care providers from engaging in the integration commonly proposed during health care reform efforts that could facilitate a systemic approach. For example, Medicare’s enabling statute began with assurance to physicians that the federal government will not interfere in the practice of medicine. 42 U.S.C. § 1395 (2012).

3. Elhauge, *supra* note 2, at 1 (defining fragmentation as “having multiple decision makers make a set of health care decisions that would be made better through unified decision making”).

need for care through unitary health reform.⁴

The harmful effects of exclusion have been well studied and documented, but exclusion has remained an entrenched feature of American health care.⁵ As a result, individuals have always been excluded from health care based on various measures unrelated to their actual need for medical care, such as ability to pay, employment, parental status, or race.⁶ Even those covered by the nation's medical safety net—Medicaid—could only enroll if they were deemed “deserving” of governmental assistance. However, in 2010, the Patient Protection and Affordable Care Act (ACA) created universal access to health insurance, facilitated through a federal takeover of health insurance law.⁷ The ACA shifted the law away from state-based private law to federally-based public law, shunned exclusion, and began to embrace a concept of health care as a public good, one that is inclusive and leveling. This shift started occurring incrementally through various federal laws over the years, but prior legislation rendered relatively small changes, and none universalized access to health care or health insurance until the ACA was enacted. In short, Congress legislated a new approach to health care through the ACA: universality.⁸

The ACA's statutory design of universal access to health insurance was a

4. For a discussion of historic health care reform successes and failures leading to the Patient Protection and Affordable Care Act, see PAUL STARR, REMEDY AND REACTION pt. I-II (2011) [hereinafter STARR, REMEDY].

5. Andrew P. Wilper et al., *Health Insurance and Mortality in U.S. Adults*, 99 AM. J. OF PUB. HEALTH 2289, 2291-94 (2009) (finding that over 45,000 people die each year due to access issues resulting from uninsurance). See generally INST. OF MED., CARE WITHOUT COVERAGE: TOO LITTLE TOO LATE (2002) (documenting how lack of insurance coverage creates barriers to access to health care that have measurably detrimental effects on health).

6. Even Medicare, the politically popular social insurance program for the elderly, is rooted in the individual's prior employment status. Americans must work in jobs that pay into the social security system for forty quarters to qualify for Medicare at age sixty-five, or they may pay premiums to access Medicare Part A (which typically does not require premiums). Because Medicare has permitted buy-in for people legally present in the United States, it is significantly less exclusionary than Medicaid; the point here is simply that work status has been a determinant of health care access in the United States. See 42 U.S.C. § 1395c (2012).

7. Not truly universal, as not every person within United States borders is eligible for health insurance. The largest excluded population is undocumented immigrants, who are excluded from Medicare, Medicaid, and exchanges through which insurance can be purchased. See, e.g., Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1323(f)(3), 124 Stat. 119, 184 (2010) (excluding unlawful residents from access to insurance through exchanges). Medicaid covers emergency services that hospitals provide to undocumented immigrants, but they cannot enroll in Medicaid by receiving such services, unless the state in which the patient seeks care has opted to cover pregnant women and children who are undocumented. 42 U.S.C. § 1396b(v) (2012).

8. See generally Nicole Huberfeld & Jessica L. Roberts, *Medicaid Expansion as Completion of the Great Society*, 2014 U. ILL. L. REV. SLIP OPINIONS 1 (2014) [hereinafter Huberfeld & Roberts, *Great Society*], <http://www.illinoislawreview.org/wp-content/uploads/2014/10/Huberfeld.pdf> (analyzing universality as a civil right for Medicaid beneficiaries).

propitious step toward addressing the persistent exclusion facilitated by fragmentation in health care.⁹ For example, private health insurance markets and practices have been rendered more uniform and inclusive by the ACA. But, the most important changes arguably have been effectuated in Medicaid, because it is no longer limited to certain categories of qualifying people or illnesses. The law of Medicaid is now inclusive rather than exclusive, because the ACA as written rendered all people earning up to 133% of the federal poverty level (FPL) eligible to enroll. This relatively simple statutory modification was a metamorphosis for the program that enrolled only the “deserving poor” for its first forty-nine years.¹⁰

This essay explores how the law of Medicaid at fifty creates a meaningful principle of universalism by shifting from fragmentation and exclusivity to universality and inclusivity. The universality principle provides a new trajectory for all of American health care, one that is not based on individual qualities that are unrelated to medical care but rather grounded in non-judgmental principles of unification and equalization (if not outright solidarity). To that end, this Essay first will study the legislative reformation that led to universality and its quantifiable effects. The Essay then will assess and evaluate Medicaid’s new universality across four dimensions, namely governance, administration, equity, and eligibility. Each reveals a facet of universality that underscores this new principle’s importance for health care into the future.

I. FROM FRAGMENTATION TO UNIVERSALITY

The United States has sustained a fragmented health care system that has excluded many people from both health insurance and health care. When other countries adopted social insurance or socialized medicine under the philosophy of solidarity after World War II, Americans rejected it, instead opting to continue the employer-provided private insurance apparatus encouraged by federal tax

9. The ACA built on the existing structure of hybrid public/private insurance to achieve universal coverage. The majority of Americans will access insurance through their employers, by virtue of a penalty placed on large employers who do not offer affordable health insurance benefits, or through purchasing private insurance on health insurance exchanges with premium assistance for people earning 100% to 400% of the federal poverty level (FPL). The elderly and permanently disabled are still covered by Medicare. The poor are covered by Medicaid; and, as this essay discusses, Medicaid will cover all of the poor earning up to 138% of the FPL for the first time in Medicaid’s history. Thus, the ACA maintains fragmented insurance coverage through large, small, and individual markets as well as through private and public plans, but it also unifies insurance customs through federal rules that make all Americans insurable and that prohibit insurance practices that made some people uninsurable through, for example, preexisting condition exclusions and other discriminatory practices. For a deeper explanation of the ACA’s architecture, see STARR, REMEDY, *supra* note 4, at 239-46.

10. See Nicole Huberfeld, *Federalizing Medicaid*, 14 U. PA. J. CONST. L. 431, 444-53 (2011).

benefits.¹¹ The employment-based private health insurance design excluded a large proportion of Americans, namely those who were elderly, poor, or otherwise outside worker-focused health insurance mechanisms. Historically, the elderly and poor were assisted by state-based medical welfare programs, but by the 1950's, states could not cover everyone who could not afford health care for lack of insurance. It was no secret that the elderly and the poor were bankrupted by their encounters with medicine, and state safety nets often failed for lack of funds, political support, and budgetary shortfalls.

When Congress enacted Medicaid, it aided some of those individuals who were excluded from health insurance by virtue of their poverty, but Medicaid's coverage was far from universal. Medicaid was a program for those outside of the private care, private insurance realm, and despite being part of the Great Society's push for legislative civil rights, Medicaid eligibility depended on the dual characteristics of being both poor and within states' historic, welfare-related definition of "deserving."¹² For the first forty-nine years of its existence, Medicaid never covered more than half of the poor because the program only protected low income Americans who were also pregnant women, children, blind, disabled, elderly, or deemed medically indigent.¹³ Due to the ACA, however, Medicaid has become available to anyone who financially qualifies,¹⁴ which had been proposed but was never passed.¹⁵ This Part documents the move from fragmentation to universality, grounding its analysis in the universal coverage Medicaid now provides.

A. Medicaid's Statutory Transformation

Medicaid was created at the same time as Medicare, but the political capital was invested in creating social insurance for the elderly, who successfully lobbied for a national, universal health insurance program in Medicare.¹⁶ The safety net for

11. PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* 235-89 (1982) [hereinafter STARR, *TRANSFORMATION*].

12. ROBERT STEVENS & ROSEMARY STEVENS, *WELFARE MEDICINE IN AMERICA* 46-47 (1974).

13. See, e.g., David Orentlicher, *Rights to Healthcare in the United States: Inherently Unstable*, 38 AM. J.L. & MED. 326, 332 (2012) (discussing Medicaid's coverage limitations).

14. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 2001(a), 124 Stat. 119, 271-75 (2010). The companion legislation, the Health Care and Education Reconciliation Act (HCERA) of 2010, added a 5% income disregard, effectively raising new Medicaid eligibility to 138% of the FPL. See Health Care and Education Reconciliation Act (HCERA) of 2010, Pub. L. No. 111-152, § 1004(e), 124 Stat. 1029, 1036.

15. STARR, *REMEDY*, *supra* note 4, at 105, 175 (describing prior plans to expand Medicaid to deal with the uniquely American problem of the uninsured).

16. STEVENS & STEVENS, *supra* note 12, at 53.

the remainder of the poor was an afterthought.¹⁷ By many accounts, no one expected Medicaid to last very long in its dual governmental, exclusionary structure.¹⁸ Medicaid was a continuation of the Kerr-Mills program, which provided federal funding to the states to continue their medical assistance to the poor.¹⁹ The Medicaid Act created a stronger federal framework, and Congress intended to ensure that states provided minimal economic security to the needy who qualified. But, even with strengthened federal rules, many decisions were left in the hands of the states, continuing fragmentation through patient exclusion and disunified administration that existed in health care long before Medicaid was enacted.²⁰

While Medicaid offered generous federal funding to states and created a federal regulatory superstructure that states had to accept to receive funding, decisions about eligibility and provision of medical care echoed states' preexisting medical welfare programs. This meant that the stigmatizing concept of the "deserving poor" was carried forward into Medicaid, so only a limited portion of the poor would be eligible to enroll.²¹ Also, limiting Medicaid to the deserving poor meant that "able bodied" adults were not eligible unless a state opted to spend its own funds on them, with no federal match. Medicaid's safety net clearly was not intended to catch everyone. Further, due to categorization of the poor to qualify for Medicaid, beneficiaries were marked as poor and either deserving or undeserving, isolating them from the rest of the population who received health coverage through private mechanisms.²² Even though Medicaid was supposed to funnel the neediest into mainstream medicine, in many ways it sustained fractured medical care by virtue of its welfare-related stigma and such signifiers of lower status as the minimal reimbursement rates states paid to participating providers.²³

17. See generally Huberfeld, *supra* note 10, at 444 (detailing Medicaid's path dependence).

18. Rosemary Stevens & Robert Stevens, *Medicaid: Anatomy of a Dilemma*, 35 LAW & CONTEMP. PROBS. 348, 420 (1970) (predicting that Medicaid would be quickly "phased out").

19. See STEVENS & STEVENS, *supra* note 12, at 51.

20. Before Medicaid, states provided medical welfare to indigent patients who fit within the deserving poor categories. The states could not afford to provide medical welfare when the Great Depression hit, and from the passage of the first Social Security Act through 1965, the federal government provided more money and more rules to the states to support medical welfare programs. Each state had its own rules regarding medical welfare, though the provision of benefits to only the deserving poor was remarkably consistent. See Huberfeld, *supra* note 10, at 436-44 (discussing medical welfare programs that predated Medicaid).

21. Huberfeld, *supra* note 10, at 439-40 (illuminating the deserving poor standard).

22. DAVID G. SMITH & JUDITH D. MOORE, MEDICAID POLITICS AND POLICY 29-30, 39 (2010).

23. *Id.* at 47. Before Medicaid, the uninsured had few choices for health care. Many availed themselves of the care available in emergency departments under Emergency Medical Treatment and Labor Act's (EMTALA) strictures. 42 U.S.C. § 1395dd (2012) (requiring all hospitals that accept Medicare and that have emergency departments to treat anyone who presents with an emergency condition). Because many hospitals were nonprofit and tax-exempt, some indigent uninsured

Those who could qualify for Medicaid found that they were treated as “others,” and those who were not eligible often were not treated at all.

Over time, Congress expanded Medicaid eligibility²⁴ by requiring states to provide comprehensive medical coverage to children under age twenty-one;²⁵ to expand coverage of the aged, blind, and disabled;²⁶ to expand eligibility standards for pregnant women and for children;²⁷ and to financially support drug coverage for people enrolled in both Medicare and Medicaid after the Medicare drug benefit was enacted.²⁸ Due to many small expansions through the years, Medicaid now financed the most health care of any payor, public or private, in the health care sector.²⁹ Even so, Medicaid excluded childless, non-elderly, non-disabled adults from its funding for most of its existence.

In 2010, Congress enacted another eligibility increase through the ACA, which required states to count as eligible everyone under age sixty-five earning up to 133% of the FPL. Thus, the ACA abandoned long-standing exclusion of non-elderly childless adults by making any low-income citizen (or legal resident) eligible to enroll in Medicaid. The ACA eliminated Medicaid’s qualifying categories for purposes of eligibility (though not for other administrative purposes),³⁰ rejecting old judgments regarding who is “deserving” of medical

received charity care that was absorbed by hospitals or written off as bad debt by hospitals. See generally Lisa Kinney Helvin, *Caring for the Uninsured: Are Not-For-Profit Hospitals Doing Their Share?*, 8 YALE J. HEALTH POL’Y L. & ETHICS 421 (2008) (discussing failure of nonprofit hospitals to provide adequate charity care and the result of such failures). But, many uninsured Americans who would not have been classified as indigent attempted to pay their medical debts and filed for bankruptcy in so doing because hospitals charged full, non-negotiated prices to private pay patients. See generally Melissa B. Jacoby, Teresa A. Sullivan & Elizabeth Warren, *Rethinking the Debates over Healthcare Financing: Evidence from the Bankruptcy Courts*, 76 N.Y.U. L. REV. 375 (2001) (presenting the third part of an empirical study showing that medical costs were the primary source of individual bankruptcy).

24. Nicole Huberfeld, Elizabeth Weeks Leonard & Kevin Outterson, *Plunging into Endless Difficulties: Medicaid and Coercion in National Federation of Independent Business v. Sebelius*, 93 B.U. L. REV. 1 (2013) (discussing Medicaid expansions).

25. Social Security Act Amendments of 1967, Pub. L. No. 90-248, §§ 301-02, 81 Stat. 821, 921-29 (1967) (codified in various sections of 42 U.S.C.).

26. Social Security Act Amendments of 1972, Pub. L. No. 92-603, §§ 201, 301, 86 Stat. 1329, 1370-74, 1465-78 (1972) (codified as amended in various sections of 42 U.S.C.).

27. Medicare Catastrophic Coverage Act of 1988, Pub. L. No. 100-360, § 302, 102 Stat. 683, 750-51 (1988) (codified at 42 U.S.C. § 1396a(a)(10)(A)(i)(I) (2012)).

28. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066.

29. *Medicaid Moving Forward*, KAISER FAM. FOUND., (2014) [hereinafter *Medicaid Moving Forward*], <http://kaiserfamilyfoundation.files.wordpress.com/2014/06/7235-07-medicaid-moving-forward2.pdf>.

30. Under the Social Security Amendments of 1965, the different categories of qualifying poor have varying qualifying levels of earnings as well as options states can exercise to cover more categorically poor at higher earning levels; for example, the median coverage level for pregnant

assistance and starting movement toward the policy of inclusion that is universality. The post-ACA Medicaid shed its Elizabethan trappings,³¹ inviting all comers to find security in its coverage.

In *NFIB v. Sebelius*,³² the Supreme Court effectively rendered the ACA's Medicaid expansion optional for states, but, paradoxically, neither the ACA's nor Medicaid's statutory language was struck down or modified. The Court's unusual administrative remedy for its conclusion that the expansion was unconstitutionally coercive slowed the process of Medicaid expansion, because the Secretary of the Department of Health and Human Services could not penalize states that choose not to expand eligibility. But, the law of the Medicaid expansion that created the principle of universality was untouched. Whether states immediately expand Medicaid to the newly eligible or not,³³ universality is a statutory policy change that will have multiple, potentially long-lasting effects.

One obvious and immediate effect is the increase in coverage that is the inevitable result of expanding eligibility, regardless of state choice to opt in or out of expansion. Medicaid was already a key program for certain populations, but the expansion will have the effect of spreading Medicaid patients across the health care sector. Because they are no longer labeled worthy or unworthy of medical assistance, Medicaid patients will not be limited to the obstetrics unit, long term care, or pediatricians' offices. The infiltration of Medicaid patients throughout the health care sector will facilitate integration for the Medicaid population. The next subsection studies the numbers behind Medicaid's universality for both historically covered populations and the newly eligible to understand the implications of eligibility expansion in the context of universality.

B. Universality in Medicaid by the Numbers

A significant proportion of Americans will enroll in Medicaid to access medically necessary health care at some point in any given year—as many as one in four when the Medicaid expansion is completed. But, even before 2014, Medicaid covered approximately 20% of Americans, and for pregnant women, children, and the elderly, Medicaid was already ubiquitous.³⁴ As of 2010, Medicaid

women is 185% FPL, which combines the 133% FPL mandatory coverage level with state options to cover women at higher levels of income. See 42 U.S.C. § 1396a(a)(10) (2012).

31. See Huberfeld, *supra* note 10, at 439.

32. *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566 (2012).

33. For a study of the federalism dimensions of Medicaid expansion, see Tom Baker, Abbe R. Gluck, Nicole Huberfeld & Theodore Ruger, *The New Health Care Federalism: An Empirical and Theoretical Assessment of How Federalism Has Changed in Health Care and Beyond* (forthcoming 2015), <http://ssrn.com/abstract=2511003>.

34. See *Medicaid: A Primer: Key Information on the Nation's Health Coverage Program for*

covered 48% of all births in the United States³⁵ and nearly two-thirds of all unintended pregnancies.³⁶ Non-pregnant and childless women have not qualified for Medicaid and many have been uninsured. With the Medicaid expansion, approximately 4.6 million women of reproductive age will become eligible for Medicaid, which will increase the percentage of births covered by Medicaid as well.³⁷ Medicaid also has covered more than half of all complex deliveries, though that number may decrease after expansion because women are likely to become healthier due to the preventive care they will receive as part of the newly eligible population.³⁸

As of 2013, Medicaid and the Children's Health Insurance Program (CHIP), which are separately funded but often have unified operations, provided health care coverage to more than 37% of all children under eighteen.³⁹ Public coverage of children has been extensive and especially concentrated among the approximately 20% of children who live in families earning less than 100% of the FPL.⁴⁰ For example, 73% of children in families earning less than 100% of the FPL are covered by Medicaid/CHIP,⁴¹ and 45% of children in families earning between

Low-Income People, KAISER FAM. FOUND., 8, (2013) [hereinafter *Medicaid: A Primer*], <http://kaiserfamilyfoundation.files.wordpress.com/2010/06/7334-05.pdf>.

35. Anne Rosier Markus et al., *Medicaid Covered Births, 2008 Through 2010, in the Context of the Implementation of Health Reform*, WOMEN'S HEALTH ISSUES, Sept.-Oct. 2013, at e273–e280, [http://www.whijournal.com/article/S1049-3867\(13\)00055-8/pdf](http://www.whijournal.com/article/S1049-3867(13)00055-8/pdf). This rate is high in part because states have historically increased income eligibility levels for pregnant women and in part because poor women have less access to birth control and higher rates of unintended pregnancies. See *id.* at e274; *Medicaid: A Primer*, *supra* note 34, at 9.

36. Adam Sonfield et al., *The Public Costs of Births Resulting from Unintended Pregnancies: National and State-Level Estimates*, 43 PERSPS. ON SEXUAL & REPROD. HEALTH 94 (2011).

37. *Id.*

38. *Id.*

39. Robin Rudowitz, Samantha Artiga & Rachel Arguello, *Children's Health Coverage: Medicaid, CHIP and the ACA*, KAISER FAM. FOUND. (2014), http://kaiserfamilyfoundation.files.wordpress.com/2014/03/8570-children_s-health-coverage-medicaid-chip-and-the-aca1.pdf.

40. Carmen DeNavas-Walt & Bernadette D. Proctor, *Income and Poverty in the United States: 2013*, U.S. CENSUS BUREAU 14 (2014), <https://www.census.gov/content/dam/Census/library/publications/2014/demo/p60-249.pdf>.

Children are proportionally overrepresented in the low-income population: "Children represented 23.5 percent of the total population and 32.3 percent of people in poverty." *Id.*

41. Children who are eligible may not be enrolled if their parents are not also eligible; this is a different aspect of the welcome mat effect that the ACA would have because newly covered parents would have the knowledge and incentive to enroll both themselves and their already eligible children in Medicaid. See, e.g., Genevieve M. Kenney et al., *A First Look at Children's Health Insurance Coverage under the ACA in 2014*, URBAN INST. 2 (2014), <http://hrms.urban.org/briefs/Childrens-Health-Insurance-Coverage-under-the-ACA-in-2014.pdf>; see also Nicole Huberfeld & Jessica Roberts, *An Empirical Perspective on Medicaid as Social Insurance*, 46 U. TOLEDO L. REV. [hereinafter Huberfeld & Roberts, *Empirical Perspective*] (forthcoming 2015),

100-250% of FPL are enrolled, but only 16% of children in households earning between 250-399% of FPL are Medicaid enrollees.⁴² Medicaid will now cover more children aged five to eighteen, whom prior to the ACA were only covered up to 100% of the FPL. Estimates are that about 600,000 children enrolled due to the ACA in 2014,⁴³ and predictions indicate that millions more will be covered when hold out states opt in to Medicaid expansion given the concentration of uninsured children in the South.⁴⁴

Many people over age sixty-five will require institutional long-term care,⁴⁵ which Medicare reimburses only when skilled nursing is required; consequently, Medicaid has been funding at least 40% of all long-term care costs in the United States.⁴⁶ That means Medicaid finances care for more than 60% of long-term nursing home residents, despite their Medicare coverage⁴⁷; in some states, that number is higher.⁴⁸ Neither the ACA nor Medicaid expansion will change this coverage much, given that expansion is concentrated in people under sixty-five. Non-elderly people who become disabled are eligible for Medicaid, and they have been included in Medicaid's long-term care coverage for decades. While the ACA facilitated experimentation with community-based long-term care rather than institutionalized care, long-term care coverage was not radically reformed by the ACA.⁴⁹ As such, it contributes to Medicaid's universality going forward because it was already so important for the elderly and disabled populations.

Covering only the "deserving poor," Medicaid provided health care coverage to more than one in five Americans before the ACA,⁵⁰ and the Congressional

<http://ssrn.com/abstract=2532495>.

42. RUDOWITZ et al., *supra* note 39.

43. *Recent Trends in Medicaid and CHIP Enrollment: Analysis of CMS Performance Measure Data through August 2014*, KAISER FAM. FOUND. 4 (2014), <http://files.kff.org/attachment/recent-trends-in-medicaid-and-chip-enrollment-analysis-of-cms-performance-measure-data-issue-brief>.

44. See, e.g., Joan Alker et al., *Uninsured Children 2009-2011: Charting the Nation's Progress*, GEO. UNIV. HEALTH POL'Y INST. CTR. FOR CHILDREN AND FAMILIES 4-5 (2012), <http://ccf.georgetown.edu/wp-content/uploads/2012/10/Uninsured-Children-2009-2011.pdf>.

45. DONALD REDFOOT & WENDY FOX-GRAGE, AARP PUB. POL'Y INST., *MEDICAID: A PROGRAM OF LAST RESORT FOR PEOPLE WHO NEED LONG-TERM SERVICES AND SUPPORTS I* (2013) (stating that seven out of ten people turning sixty-five will need long-term care at some point in their lives).

46. *Medicaid: A Primer*, *supra* note 34, at 4.

47. *Id.*

48. See 155 CONG. REC. E2468, E2469-70 (daily ed. Oct. 8, 2009) (statement of Rep. Mike Rogers attaching letter by Gov. Charlie Crist, dated September 17, 2009) (describing Medicaid as financing long term care for both seniors and disabled people).

49. *Community-Based and Long-Term Services and Supports*, MEDICAID.GOV, <http://www.medicaid.gov/affordablecareact/provisions/community-based-long-term-services-and-supports.html> (last visited Nov. 1, 2014).

50. For deeper discussion of the demographics of Medicaid's enrollment, see Huberfeld & Roberts, *Great Society*, *supra* note 8; Huberfeld & Roberts, *Empirical Perspective*, *supra* note 41.

Budget Office estimates the number of new Medicaid enrollees at more than eighteen million by 2018 and another two million by 2024, which will increase Medicaid's enrollment to one in four Americans.⁵¹ In addition to covering over half of all pregnancies, more than a third of all children, and well over half of all long-term nursing home residents, previously excluded low-income parents and childless adults who cannot obtain health insurance through employers will now be included in Medicaid's medical assistance.

Of the newly eligible adults, most are either the working poor or employees of small businesses, as uninsured adults generally fall into two categories: workers who are self-employed or work for small companies that cannot offer insurance benefits, or those in low wage jobs that do not offer insurance or that do not offer affordable insurance. Among newly eligible Medicaid beneficiaries, 79% have at least one worker in the family, with 63% in full time employment and 16% in part time employment.⁵² Many of the newly eligible are workers who want health insurance but are not offered it or cannot afford it, and Medicaid now acts as the employment benefit of health insurance that wealthier workers have enjoyed since the 1940s.

In short, Medicaid covers more lives than any other health insurance mechanism in the United States, and it has surpassed Medicare in enrollment and total spending.⁵³ The statutory philosophy behind that increase was a federal policy choice to include all Americans in health insurance coverage so that they are no longer excluded based on individual characteristics or subject to the physical and economic insecurity of inconsistent health care access.⁵⁴ The universality encompassed by this policy choice is broader in some respects than social insurance because it is not grounded in work status (in contrast to Medicare, large group, and small group insurance). Medicaid is now a *de facto* form of social insurance in our health care system given that it is covering a substantial portion of the working poor. But, it also covers those who cannot work, cannot find work, or are unable to work, and it provides more thorough grounding in access to health

51. *The Budget and Economic Outlook: 2014 to 2024*, CONG. BUDGET OFF 58 (2014), http://www.cbo.gov/sites/default/files/cbofiles/attachments/45010-Outlook2014_Feb.pdf ("By 2024, about 89 million people will be enrolled in Medicaid at some time during the year.").

52. *Key Facts About the Uninsured Population* KAISER FAM. FOUND. 2, 4, (2013), <http://kaiserfamilyfoundation.files.wordpress.com/2013/09/8488-key-facts-about-the-uninsured-population.pdf>.

53. *Medicaid Moving Forward*, *supra* note 29, at 1.

54. President Barack Obama, On Behalf of My Mother, Remarks at the Signing of Patient Protection and Affordable Care Act (Mar. 23, 2010), <http://www.whitehouse.gov/blog/2010/03/23/behalf-my-mother> ("And we have now just enshrined, as soon as I sign this bill, the core principle that everybody should have some basic security when it comes to their health care.").

care than insurance coverage that is linked to worker status. It is less fragmentary and more equalizing than employment-based insurance, which makes it an important source of economic and social stabilization for low income workers. The principle of universality has bypassed the resistance to solidarity that stymied health care reform for many years, and instead of being “phased out,” Medicaid has embodied this new legislative principle.⁵⁵

II. UNIVERSALITY IN FOUR DIMENSIONS

Medicaid’s expansion to capture individuals who historically have fallen into gaps enlarged by fragmentation demonstrates a move from exclusivity to inclusivity in the American health care system. Yet, non-exclusion contains important ramifications beyond enrollment. This part explores four dimensions of universality—governance, administration, equity, and eligibility—that provide useful lenses through which to consider the multi-layered implications of universality.

A. Universality in Governance

Medicaid has long been considered a classic cooperative federalism program.⁵⁶ To the Supreme Court, this has meant that the federal government can drive policy with large sums of money, but it cannot force states to partner in Medicaid.⁵⁷ To the federal government, this has meant that Congress occasionally drives health care policy forward by expanding Medicaid eligibility or medical coverage, and then HHS negotiates with the states to enforce the reform. To the states, this has meant large transfers of federal funding that help to balance state budgets by covering indigent patients while states engage in diverging and largely uncontested interpretations of the Medicaid Act.

In addition to these inter-governmental dynamic negotiations, Medicaid has been partially privatized by waiver. The ACA ushered in negotiations with HHS to expand eligibility, rendered more aggressive on states’ part by the holding in *NFIB v. Sebelius*. Each of the expansion-related waiver requests thus far contains a privatization element, whether by placing newly eligible enrollees in qualified health plans in the exchanges, or by funneling the newly eligible into Medicaid

55. See Stevens & Stevens, *supra* note 18, at 420.

56. See Nat’l Fed’n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566, 2629 (2012) (Ginsburg, J., concurring in part and dissenting in part); Harris v. McRae, 448 U.S. 297, 308 (1980).

57. See, e.g., Sebelius, 132 S. Ct. at 2604-07 (Roberts, C.J., holding the Medicaid expansion as written in the ACA unconstitutionally coercive because the states could not choose whether to expand their categories of eligibility without losing all of their Medicaid funding).

managed care plans, or by seeking a health savings account format for them.⁵⁸ Medicaid has been a hybrid program, weaving together federal and state policy and administration, public and private systems, and the deserving poor with others in the health care system. HHS's authority to grant section 1115 waivers, which provide states with flexibility in Medicaid and other programs governed by the Social Security Act to create demonstration programs, always has included the ability to authorize privatization, but the federal/state, public/private hybrid has not been subject to the universality backstop until now. The multifaceted policy implementation in Medicaid could be deemed an example of new governance,⁵⁹ or it could be viewed as a facet of health care fragmentation.

Over time, federal rules have increased in the Medicaid program, and the states often have pushed back against greater federal superstructure.⁶⁰ While this dynamic is a gripping study in modern federalism, experimentation often occurs for budgetary reasons and not for the benefit of Medicaid enrollees. States need federal funding to provide medical assistance, but they often reject or attempt to bypass the federal rules that come with copious funding for political reasons. Medicaid is the largest transfer of wealth from the federal government to the states in American history. But, the states remain part of Medicaid's administration for path dependent reasons—they have always been involved in welfare medicine, and so they remain involved in welfare medicine. This bifurcated governance is inefficient both administratively and economically and is exacerbated by states' slow path to expansion, which prolongs exclusionary policy in opt-out states.

HHS has been expending tremendous effort negotiating with states in the wake of *NFIB v. Sebelius* to convince them that they should expand Medicaid eligibility and to consider their various proposals for demonstration waivers.⁶¹ If the program were fully federalized, as I have discussed elsewhere,⁶² expansion would be complete by now. HHS administrators could instead spend time on administering the program rather than negotiating with reticent, self-serving states

58. See Baker et al., *supra* note 33.

59. See THE TOOLS OF GOVERNMENT: A GUIDE TO THE NEW GOVERNANCE 15 (Lester M. Salomon ed., 2002) (offering a way station between "command and control" governance and pure privatization through a negotiated management format).

60. For example, the National Governors Association has a standing policy statement regarding health care that demands both "proper[]" federal funding and safeguarded state "flexibility." National Governors Association, NGA Policy Position HHS-05 Health (2013), <http://www.nga.org/cms/home/federal-relations/nga-policy-positions/page-hhs-policies/col2-content/main-content-list/health.html> (adopted at NGA's Winter 2013 meeting).

61. See, e.g., Nathaniel Weixel, *Burwell Urges Hesitant Governors to Work with HHS on Medicaid Expansion*, BLOOMBERG BNA HEALTH CARE DAILY REP., Nov. 4, 2014 (reporting on Secretary Burwell's remarks to the fall meeting of the National Association of Medicaid Directors that invited any state interested in Medicaid expansion to talk with her).

62. See generally Huberfeld, *supra* note 10.

who hold out for political purposes. Allowing states to maintain a co-governance role in Medicaid is not supported by finance or by medical standards.⁶³ Universality provides a developing legislative structure that informs HHS's management of Medicaid in its negotiations with states, and it can provide a new direction for Medicaid's governance by clarifying the national government's role in public health insurance, which is already substantial. The ongoing reliance on states in health care governance should be reconsidered in light of the principle of universality. While some states have accepted the new federal law of Medicaid as their guide for Medicaid enrollment, the continued role of states creates a tension with the goals of health care reform by slowing Medicaid expansion for political purposes. Governance viewed through the lens of universality supplies another reason that the experiment of the states is no longer appropriate in Medicaid.

B. Universality in Administration

The principle of universality provides a new path for battling administrative fragmentation in health care. Health care in the United States has been decentralized in decision-making, delivery, finance, information sharing, and other ways. Medicaid has been a particularly exaggerated form of fragmented administration, because each state creates its own structure for complying with the federal Medicaid Act. Although the Medicaid Act has provided a baseline for states regarding standards for medical welfare, the program has allowed huge amounts of state variation within the federal rules so long as states have not provided less (on paper) than the federal statute requires.⁶⁴

While some aspects of Medicaid historically have been unwaivable—such as eligibility and enrollment for people who meet the terms of the Medicaid Act, statewide benefit consistency, and freedom of choice among health care providers participating in Medicaid—states have been able to designate for HHS how they will comply with the many aspects of the Medicaid program with little pushback so long as the state's plan was budget neutral.⁶⁵ States have often divided different categorically eligible enrollees into more or less deserving categories. For example, every state has chosen to increase the income level at which pregnant women will be covered. But, only some states have provided benefits to parents of

63. *See id.* at 743-49.

64. *See generally* John Holahan, *Variation in Health Insurance Coverage and Medical Expenditures: How Much Is Too Much?*, in *FEDERALISM & HEALTH POLICY* (John Holahan, Alan Weil & Joshua M. Wiener, eds. 2003).

65. Ctrs. for Medicare and Medicaid Servs., *Section 1115 Waivers*, MEDICAID.GOV, <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/1115/section-1115-demonstrations.html> (last visited Dec. 1, 2014).

eligible children above the level dictated by the Medicaid Act.⁶⁶ These options and inconsistencies make for overly complex administration at both federal and state levels, as well as inequitable medical coverage for enrollees (discussed further below).

HHS cannot manage each state at a granular level.⁶⁷ Only when it is quite clear that a state is running afoul of the Medicaid Act does HHS confront a state regarding compliance. Further, HHS never pulls state funding, because its policy goals are different from a state's—HHS wants to ensure that bodies are in the program, getting covered for as much health care as possible, while states habitually are using federal funding to balance their budgets.⁶⁸ Each state makes some individualized decisions regarding the medical coverage of its Medicaid population, the payment rates for health care providers who participate in the Medicaid program, and the way that the state will contract with managed care entities that will cover the state population. These decisions, to which HHS generally defers, have created a fifty state patchwork of Medicaid benefits, eligibility, and rules that renders the Medicaid program quite fragmented, especially if an enrollee ever changes residency.

This highly decentralized approach to Medicaid makes health care for low-income citizens administratively inefficient.⁶⁹ This aspect of fragmentation creates wildly varying standards of health care access and care that impact patient care. For example, the Office of the Inspector General (OIG) recently issued an evaluation entitled *State Standards for Access to Care in Medicaid Managed Care*, in which the OIG appraised each state's Medicaid managed care contracting and found state oversight of quality control and access to care lacking.⁷⁰ Not only did many states fail to set standards for access to care, but also the OIG stressed that HHS must “strengthen oversight” of the program to ensure protection of enrollees

66. *Medicaid Income Eligibility Limits for Adults at Application, as of August 28, 2014*, KAISER FAM. FOUND. (2014), <http://kff.org/medicaid/state-indicator/medicaid-income-eligibility-limits-for-adults-at-application-2014> (last visited Nov. 1, 2014).

67. See generally Brief of Former HHS Officials as Amici Curiae in Support of Respondents, *Douglas v. Indep. Living Ctr. of S. Cal., Inc.*, 132 S. Ct. 1204 (2012), (Nos. 09-958, 09-1158, 10-283), 2011 WL 3706105.

68. See, e.g., Teresa A. Coughlin & Stephen Zuckerman, STATES' USE OF MEDICAID MAXIMIZATION STRATEGIES TO TAP FEDERAL REVENUES: PROGRAM IMPLICATIONS AND CONSEQUENCES, URBAN INST. (2002), http://www.urban.org/uploadedPDF/310525_DP0209.pdf.

69. See Randall R. Boyberg et al., *State and Federal Roles in Health Care: Rationales for Allocating Responsibilities*, in *FEDERALISM & HEALTH POLICY* 25, 44 (John Holahan, Alan Weil & Joshua Wiener, eds. 2003); Marilyn Moon, *Making Medicaid a National Program: Medicare as a Model*, in *FEDERALISM & HEALTH POLICY* 325, 330 (John Holahan, Alan Weil & Joshua Wiener eds., 2003).

70. Suzanne Murrin, *State Standards for Access to Care in Medicaid Managed Care*, DEP'T HEALTH & HUMAN SERVS. (2014), <http://oig.hhs.gov/oei/reports/oei-02-11-00320.pdf>.

when state administration fails.⁷¹

The theory of universality can simplify Medicaid's administrative morass. Although HHS has conciliated states in the interest of policy entrenchment and increased health care access through maximizing the lives covered, HHS now must exercise greater control in the administrative choices and procedures in Medicaid. HHS is responsible for directing and monitoring states' compliance with universalism. Though *NFIB v. Sebelius* limited HHS's authority to enforce state participation in Medicaid's expansion, once a state does signal interest in eligibility expansion, HHS has a stronger hand to play. State proposals that could diminish the inclusivity of Medicaid expansion should not be entertained, and HHS could do much to centralize the multitudinous state decisions to ensure the basic care for Medicaid beneficiaries is not full of gaps.

While universality does not speak directly to these internal administrative issues, and the *NFIB* spin on universality has complicated Medicaid administration temporarily because of the subsequent executive branch invitation to negotiate through waiver proposals, ultimately, universality will furnish a backstop to state requests for flexibility through welfare-like "experiments" with requirements that are unrelated to health care. Proposals such as work-search requirements are not only outdated in light of the principle of universality, but they also increase the need for administrative oversight and further diversify it by virtue of the tailoring required of such requests. Other requirements, such as wellness programs or co-payments enforceable for portions of the newly eligible population, also can increase administrative complications due to increased diversification of state Medicaid programs, which are harder for the limited HHS staff to manage.⁷²

HHS must enable enrollment in Medicaid in order to entrench the new federal policy of universality, but it cannot do so at the expense of enrollees' health status, which is jeopardized when states take a laissez faire approach to Medicaid administration. Now that universality has detached Medicaid from old stigmatizing, disequalizing, welfare-like conditions, the states should not be permitted to negotiate new welfare conditions into the expansion, which only complicate administration of the program. While the negotiations between HHS and the states display a blazingly dynamic federalism, which is both vertical and horizontal, that federalism is not necessarily of value to enrollees, especially without assurance that HHS will provide real oversight as states negotiate, respond, and react.⁷³

71. *Id.* at 17-20 (instructing the Centers for Medicare and Medicaid Services, a sub-agency of HHS, to increase oversight of state managed care programs).

72. See generally *Premiums and Cost-Sharing in Medicaid*, KAISER FAM. FOUND. (2013), <http://kaiserfamilyfoundation.files.wordpress.com/2013/02/8416.pdf>.

73. See Baker et al., *supra* note 33.

C. Universality in Equity

Upon enactment in 1965, one clear goal for Medicaid was to mainstream eligible beneficiaries into the medical care available to everyone else. Over the past fifty years, America's fragmented health care system has facilitated continued segregation for people of means in private insurance and people who are low income, whether uninsured or in Medicaid.⁷⁴ It is widely understood that the uninsured do not have consistent access to health care and that they delay care or do not receive needed care due to cost.⁷⁵ Thus, the greatest health care inequity currently exists for low income populations in states that have not yet expanded their Medicaid eligibility standards. Until those states expand, Medicaid's inclusivity is thwarted, and people will not receive medically necessary care due to lack of insurance coverage. The holdout states correlate strongly to the states that have high Medicaid federal matching rates and high levels of uninsurance, raising questions about the political theater being staged in the opt out states.

Yet, once enrolled in Medicaid, enrollees still can experience difficulty finding health care providers who will accept them as new patients.⁷⁶ This inequity in access and care could increase instability as expansion progresses over the next several years. Some doctors are unable or unwilling to treat Medicaid patients, and Medicaid beneficiaries sometimes face obstacles in finding basic preventive services.⁷⁷ While this may result in part from Medicaid patients residing in medically underserved areas, Medicaid patients in health care rich environments reportedly experience some under-service as well.⁷⁸

The ACA attempted to address inequitable access by increasing Medicaid's primary care physician payments to Medicare levels for 2013 and 2014, and some evidence indicates that the increased payments drew physicians into Medicaid who

74. See, e.g., INST. OF MED., *UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTHCARE* (Brian D. Smedley et al. eds., 2003).

75. See, e.g., *Health Insurance and Access to Care*, CTFS. FOR DISEASE CONTROL & PREVENTION (2012), http://www.cdc.gov/nchs/data/factsheets/factsheet_hiac.pdf; COMM. ON HEALTH INSURANCE & ITS CONSEQUENCES, INST. OF MED., *AMERICA'S UNINSURED CRISIS: CONSEQUENCES FOR HEALTH AND HEALTH CARE* (2009).

76. The Office of the Inspector General's (OIG) report on state oversight of managed care for Medicaid populations discussed this problem to a degree. See *STATE STANDARDS FOR ACCESS TO CARE IN MEDICAID MANAGED CARE*, *supra* note 70, at 8-14 (discussing findings that states do not ensure adequate access to physicians); see also Robert Pear, *For Medicaid Enrollees, Access to Care Is Hard to Find*, N.Y. TIMES, Sept. 28, 2014, at A26 (discussing the OIG report).

77. See, e.g., Sandra L. Decker, *Two-Thirds of Primary Care Physicians Accepted New Medicaid Patients in 2011-12: A Baseline To Measure Future Acceptance Rates*, 32 HEALTH AFF., 1183, 1184-86 (2013) (discussing various physicians' willingness to accept new Medicaid patients).

78. See, e.g., Leighton Ku et al., *The States' Next Challenge—Securing Primary Care for Expanded Medicaid Populations*, 364 NEW ENG. J. OF MED. 493 (2011).

would not ordinarily have participated.⁷⁹ But, without congressional action or voluntary state continuation, this reimbursement increase will diminish in 2015 and may leave new enrollees with renewed inequities.⁸⁰ It is possible that Medicaid enrollees purchasing insurance from qualified health plans through premium assistance in the exchanges in waiver states may face less discrimination accessing care, in which case those demonstration waivers will have served a more important purpose than the political negotiation and strategizing discussed above. But it is too soon to know if the cloak of private insurance coverage is enough to facilitate equal access for Medicaid beneficiaries.

An additional source of inequity is Medicaid providers' and enrollees' tenuous ability to enforce the Medicaid Act against noncompliant states in federal court. The Supreme Court will hear again the question of whether private parties can enforce the Medicaid Act by Supremacy Clause actions this term, and the prospects are dim for continued viability of private actions.⁸¹ Just two terms ago, the Court barely upheld such private actions in *Douglas v. Independent Living Center* by allowing HHS to exercise primary jurisdiction and bypassing the Supremacy Clause question in deference to the agency's interpretation of the statutory question of adequate reimbursement in that case.⁸² Losing the ability to enforce the terms of the Medicaid Act through private rights of action would decrease HHS oversight, as the agency has stated publically that it relies on private actions to alert it to state mistreatment of the Medicaid program and its providers and beneficiaries. Without on the ground, de facto private enforcers, HHS would have a much harder job ensuring that the newly universal program achieves equitable care for its new and old populations. In recognition of this potential regulatory failure, Congress incorporated new reporting requirements through the ACA into the Medicaid Act that require states to report on equal access to care for Medicaid beneficiaries.⁸³ But, HHS has not clearly indicated how it will use state reports to increase equal access to care for Medicaid beneficiaries.

The universality principle should ensure adequate and equal access to care,

79. Adam S. Wilk, *Differential Responses Among Primary Care Physicians to Varying Medicaid Fees*, 50 INQUIRY 296 (2013) (studying evidence of physician uptake due to the increase in payments).

80. *The ACA Primary Care Increase: State Plans for SFY 2015*, KAISER FAM. FOUND. (Oct. 28, 2014), <http://kff.org/medicaid/perspective/the-aca-primary-care-increase-state-plans-for-sfy-2015>.

81. *Exceptional Child Ctr. v. Armstrong*, 567 Fed. App'x 496 (9th Cir. 2014), *cert. granted*, 83 U.S.L.W. 3077 (U.S. Oct. 2, 2014) (No. 14-15).

82. 132 S. Ct. 1204 (2012); *see also* Nicole Huberfeld, *Where There Is a Right, There Must Be a Remedy (Even in Medicaid)*, 102 KY. L. J. 327 (2014); Nicole Huberfeld, *Post-Reform Medicaid Before the Court: Discordant Advocacy Reflects Conflicting Attitudes*, 21 ANNALS HEALTH L. 513 (2012).

83. Medicaid Program; Methods for Assuring Access to Covered Medicaid Services, 76 Fed. Reg. 26,342 (proposed May 6, 2011) (to be codified at 42 C.F.R. pt. 447).

but if states refrain from expanding their Medicaid programs for very long, then a different aspect of equity is also jeopardized. States could sustain the exclusionary practices in health care that the ACA is meant to end, thereby decreasing equity in health care access. Though all states will eventually expand (it took many years for all states to participate in the first iteration of Medicaid fifty years ago), until they do, health care equity will not be achieved. In addition to harming the health of low-income residents who would qualify for Medicaid in opt in states, state reticence to expand could affect private insurance plans. Enrollees often move in and out of Medicaid due to fluctuations in income, a phenomenon known as churn. Without Medicaid expansion, the newly eligible population in opt out states will be sicker when it moves into private insurance through exchanges or employers, raising costs for all.

D. Universality in Eligibility

Medicaid contains eight statutory categories of eligibility now, with the eighth being childless adults under the age of sixty-five earning up to 133% of the federal poverty level—the newly eligible population.⁸⁴ Medicaid eligibility should be integrated in light of universality. The categories of eligibility, which were proxies for policy determinations as to who was considered “deserving” of medical assistance, are no longer germane. Condensing eligibility into one level, uniform category would reinforce the philosophy of universality and would complement the other dimensions of governance, administration, and equity.

Under current law, state Medicaid agencies determine whether an applicant meets the particular standards for financial eligibility in a given state in light of their categorical status, a status that is now antiquated and unnecessarily complicated. Eligibility should be a straightforward financial criterion, with no discrimination among the poor depending on whether they are pregnant, disabled, elderly, childless, or something else.

Single category eligibility would require reconsideration of technical differences between existing categories. For example, the Medicaid Act requires very specific medical care for children, which should be retained in recognition of their unique vulnerability.⁸⁵ Another example is the optional coverage of pregnant women earning more than 133% of the FPL that most states provide (median coverage level was approximately 200% of the FPL as of June 2014).⁸⁶ Eligibility

84. 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII) (2012). The ACA also expanded coverage of poor children aged 5 to 18 up to 133% of the FPL from 100% of the FPL, but children were already covered, so this is not new eligibility, just expanded eligibility. *See id.*

85. 42 U.S.C. § 1396d(r) (2012).

86. *Where Are States Today? Medicaid and CHIP Eligibility Levels for Children and Non-Disabled Adults as of April 1, 2014*, KAISER FAM. FOUND. (2014),

unification should not occur at the expense of patients who have benefitted from state largess through optional Medicaid coverage. But, if the ACA's private insurance reforms succeed over time, then states will not need to cover certain populations above 133% of the FPL, because they will become privately insured through employers or be able to purchase individual or small group insurance on the health insurance exchanges.

Unified eligibility would be a logical conclusion to many aspects of the ACA's and Medicaid's new universality. For example, the "no wrong door" enrollment facilitated by the ACA, which allows uninsured people to enter into the health insurance system by submitting one application that will direct them to the type of insurance coverage that they may acquire given financial circumstance, would be greatly simplified and enhanced by a single category of eligibility for Medicaid.⁸⁷ Unified eligibility would be consistent with the new universality and inclusion embodied by the law of Medicaid.

In sum, universality suffuses multiple dimensions of Medicaid, diminishing the program's fragmentation while also revealing a fragility in the ACA's expansion. HHS is engaged in a highly pragmatic set of negotiations with states that invites expansion in order to cover lives and entrench the new federal policy of inclusion. Contrariwise, the agency must develop its underused ability to do more than implore—it can and should enforce the ACA's statutory principle of universality and rejection of exclusion. HHS can strengthen Medicaid as it expands and settles into expansion over the coming years. But, if HHS does not, then fragmentation in Medicaid will continue, not only to the detriment of enrollees, but also to the detriment of the program's finances.⁸⁸ Though universality could appear costly in terms of increasing enrollment, it is also very likely to produce economic benefits through such effects as streamlining, long term benefits related to preventive care, and unified policy clarification.⁸⁹ Not only is universality the

<http://kaiserfamilyfoundation.files.wordpress.com/2014/06/7993-05-where-are-states-today-fact-sheet-june-2014.pdf>.

87. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 2201, 124 Stat. 119, 289-91 (2010).

88. States have long struggled to finance Medicaid, especially during economic recessions. *See, e.g.,* Moon, *supra* note 69, at 329.

89. *See* Sherry Glied & Stephanie Ma, *How States Stand to Gain or Lose Federal Funds by Opting In or Out of the Medicaid Expansion*, THE COMMONWEALTH FUND (2013), http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2013/Dec/1718_Glied_how_states_stand_gain_lose_Medicaid_expansion_ib_v2.pdf (quantifying and explaining why Medicaid expansion is an economic net gain for most if not all states); Robin Rudowitz et al., *Issue Brief: Implementing the ACA: Medicaid Spending & Enrollment Growth for FY 2014 and FY 2015*,

new law of Medicaid, but regardless of theoretical design, it is economically sensible too.

CONCLUSION

The elderly and the poor were once in the same bucket; undesirable as patients, often expensive or complex to treat, and often unable to afford their own care. The elderly were elevated to Medicare's social insurance, a program unique in America's historically limited redistributive policy, through effective lobbying that federalized and standardized their benefits. While the principle of inclusion was codified for the elderly in Medicare in 1965, it took almost another fifty years to codify the precept that non-elderly people also merit non-exclusionary coverage.⁹⁰ Medicaid's de facto social insurance is not as stable as Medicare's, though, because Medicare beneficiaries do not age out of their coverage and form a politically cohesive group. From an enrollment standpoint, the Medicaid population is less consistent than Medicare's. Further, Medicaid is a different kind of insurance because of the variation that state participation introduces into the program.

This essay has explored the shift from fragmentation and exclusion to universality and inclusion across four different spheres. While this shift is a positive normative development in health care, an obvious downside to Medicaid's new universality is that a person must be very low income to benefit from it. Another disadvantage of building universality on Medicaid is that it has not been a particularly stable program, often instead approximating a political hot potato. Nevertheless, expanding Medicaid has long been on the health reform radar, and the ACA took considerable steps toward both nationalizing and universalizing Medicaid. Medicaid's new universality will be felt not only by the sheer number of people in the program as it grows over the next several years, but also in the possible defragmenting effects it will have in the health care system as a whole.

HHS must recognize its key role in effectuating universality, which is now the law of Medicaid. Centralized guidance with universality as its focal point will help

KAISER FAM. FOUND. (2014), <http://files.kff.org/attachment/implementing-the-aca-medicaid-spending-issue-brief> (Medicaid spending increases in opt out states in 2014-15 will be greater than in expansion states due to lack of federal funding); Reid Wilson, *Study: Refusing Medicaid Expansion Will Cost States Billions of Dollars*, WASH. POST (Dec. 6, 2013), <http://www.washingtonpost.com/blogs/govbeat/wp/2013/12/06/study-refusing-medicaid-expansion-will-cost-states-billions-of-dollars> (explaining that states spend more on attempting to draw new businesses to the state than they will spend on Medicaid expansion).

90. The original Medicaid Act contained a provision that admonished states to expand Medicaid to everyone who qualified financially by 1975, but the provision was postponed and then repealed. SMITH & MOORE, *supra* note 22, at 50.

this newly inclusive form of medical assistance accomplish the principal philosophical underpinning of the ACA, which initiates a shared responsibility for health care, if not fully recognizing health care as a public good. Medicaid's transition to universality is a story still in the writing—one that will potentially shape health care for more than a quarter of Americans for years to come.

Multiple Medicaid Missions: Targeting, Universalism, or Both?

John V. Jacobi*

INTRODUCTION

Medicaid began as a poverty program for the poorest of the “worthy poor.” In the next five decades, it extended its reach to cover a broad population for some of its services, including, for example, about half of all childbirths in the United States,¹ and almost half of all long-term care services.² The Affordable Care Act (ACA)³ pushed Medicaid’s breadth further, although that extension was at least delayed in many states by the Supreme Court.⁴ Some scholars embrace Medicaid’s role as advancing toward universal coverage by filling the gap between Medicaid’s traditional poverty population and the population able to access employment-based coverage. Others, however, are concerned that asking Medicaid to cover broader population groups runs the risk of diminishing its essential mission of providing coverage for the poorest, who face unique health needs.

This disagreement suggests a need to choose between a Medicaid targeted to particular needs of the poor and one increasingly universal in scope. Yet, under the ACA, Medicaid can achieve both a universal and targeted mission by following Theda Skocpol’s “targeting within universalism” model.⁵ “Targeted” social policies address poverty issues through “highly concentrated . . . services devised especially for the poor,” while “universal” policies address poverty through broader programs that link the plight of the poor with those of the middle class.⁶ Skocpol argues for targeted programs “within certain universal policy

*Dorothea Dix Professor of Health Law & Policy, Seton Hall Law School.

1. See Anne Rossier Markus et al., *Medicaid Covered Births, 2008 Through 2010, in the Context of the Implementation of Health Reform*, 23 WOMEN’S HEALTH ISSUES e273, e275 (2013).

2. See *Medicaid’s Long-Term Care Users: Spending Patterns Across Institutional and Community-Based Settings*, KAISER FAM. FOUND. 1 (2011), <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/7576-02.pdf>.

3. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), amended by Health Care and Education Reconciliation Act (HCERA) of 2010, Pub. L. No. 111-152, 124 Stat. 1029. PPACA, as amended, is often referred to as the “Affordable Care Act,” or the “ACA,” and will be referred to as such herein.

4. Nat’l. Fed. of Indep. Bus. v. Sebelius, 132 S. Ct. 2566, 2603-04 (2012) (Roberts, C.J., holding the ACA to be unconstitutionally coercive for requiring the states to expand Medicaid coverage).

5. See Theda Skocpol, *Targeting Within Universalism: Politically Viable Policies to Combat Poverty in the United States*, in THE URBAN UNDERCLASS 411, 411-36 (Christopher Jencks & Paul E. Peterson, eds., 1991).

6. *Id.* at 412-13.

frameworks” to combine the benefits to the poor of targeted and universal policies.⁷ Medicaid, I argue, can become a broad—and broadly popular—health insurance while consciously targeting the very poor, whose health challenges are different in kind from those of the rest of society.

This Article will, in Part I, briefly outline the path of Medicaid’s development from 1964 to today, as its mission has broadened, with particular attention to the 2010-14 period of ACA implementation. Part II will describe the health status of America’s poor. Medicaid is undoubtedly successful in connecting its beneficiaries to health care services, but the poor continue to experience health outcomes far worse than those of the rest of society. This apparent paradox is easily explained: health coverage permits the treatment of illnesses, but the poor carry an increased burden of illness due to social factors, including substandard housing, the unavailability of healthy food, and few recreational resources. Health insurance has not historically addressed those “upstream” factors that drive a significant portion of the poor’s excess burden of ill health. Part III outlines the dispute among advocates for the poor between advocacy for programs targeting the poor (providing resources where they are most needed, but risking the loss of political support) and advocacy for more universal programs (risking resource loss to higher-income, less needy persons, but likely gaining political viability). I argue that in the case of Medicaid, Skocpol’s “targeting within universalism” best serves the poor.

Part IV illustrates how a broadening Medicaid that sweeps in a growing class of the near poor can nevertheless provide special benefits for the very poor. This strategy entails the use of new models of health care finance and delivery, such as Accountable Care Organizations (ACOs). ACOs are designed to combat health care’s fragmentation, evidenced by poor communication and care coordination that can reduce the effectiveness of care and drive up costs. For non-poor recipients of care, financing innovations can improve the quality of care by fostering more integrated treatment. Similar medical treatment gains and cost savings are available when Medicaid adopts ACO methods. But an additional benefit is available for the poor. Community organizations forming Medicaid ACOs may receive supplemental reimbursement if they can improve the health status of populations of Medicaid recipients in a geographic area. This population orientation incents the organizations creating Medicaid ACOs to adopt a broader perspective toward health care, directly addressing some of the social factors beyond medical treatment that directly affect population health status. For the non-poor, ACOs can improve medical care. For the poor, ACOs can use the financial freedom created by population health rewards to incorporate social services not traditionally covered by Medicaid into their body of work. ACOs can be adapted to the needs of the poor by those in their community to help reduce the burden of disease and ill-health for those most in need. This functional targeting permits

7. *Id.* at 414 (emphasis in original).

expansion of Medicaid services not at the level of state regulatory design, but through the community-based choice of Medicaid ACOs' management.

I. SPECIFIC TO GENERAL: MEDICAID'S EVOLUTION

American Progressives sought a path to a general "sickness insurance" program for much of the twentieth century. As European democracies adopted various forms of social insurance and national health plans, America resisted for a range of social, political and economic reasons that are well-described elsewhere.⁸ While other wealthy nations experimented and finally settled on systems for the provision of health care as a public or social expense, Americans maintained a marketplace notion of health care, supplemented by a variety of public and private charity ventures for the most obviously disadvantaged.⁹

The adoption of Medicare and Medicaid in 1964 represented an expansion of the federal footprint in health finance. Medicare is a very popular social insurance program for a discrete population of beneficiaries. Some hope has persisted that it could be a vehicle for expansion to reach a broader demographic. Thus far, Medicare has been expanded only to the permanently and totally disabled (after a two-year waiting period) and to persons diagnosed with end-stage renal disease or amyotrophic lateral sclerosis.¹⁰ Medicaid's eligibility rules have evolved in a more complex fashion.

Medicaid was the successor to previous federal programs that provided grants in aid to states. These grants recognized the primacy of states in supporting the needy, and represented the furthest reach of the federal government into the patchwork of private and public charities directed to the plight of widows, orphans, and other particularly vulnerable—and "worthy"—poor.¹¹ Initially, eligibility was limited to very low-income single-parent families and the aged, blind, or disabled.¹² Even so, it was seen by some as a "sleeper" program, carrying with it the seeds of a more expansive public insurance program because of the breadth of its coverage structure. As Sara Rosenbaum has described, for some contemporary commentators "the program became the exemplar of a national health program of

8. PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* 237-89 (1982).

9. See Edward Berkowitz, *Medicare and Medicaid: The Past as Prologue*, 27 *HEALTH CARE FIN. REV.*, no.2, 2005-2006, at 11, 11-15.

10. *Id.* at 19-21.

11. See Nicole Huberfeld, *Federalizing Medicaid*, 14 *U. PA. J. CONST. L.* 431, 438-45 (2011); Nicole Huberfeld, *Bizarre Love Triangle: The Spending Clause, Section 1983, and Medicaid Entitlements*, 42 *U.C. DAVIS L. REV.* 413, 418-19 (2008); John V. Jacobi, *Medicaid Evolution for the 21st Century*, 102 *KY. L. J.* 357, 359 (2013-2014); Sara Rosenbaum, *Medicaid At Forty: Revisiting Structure and Meaning in a Post-Deficit Reduction Act Era*, 9 *J. HEALTH CARE L. & POL'Y* 5, 8-9 (2006).

12. See Jonathan Gruber, *Medicaid*, in *MEANS-TESTED TRANSFER PROGRAMS IN THE UNITED STATES* 15, 16 (Robert R. Moffitt ed., 2003).

the future, covering large population segments under a comprehensive scheme of government financing.”¹³

Medicaid expanded in the ensuing decades, although the expansions fell short of reaching its potential as an anchor for a universal coverage system. Eligibility rules evolved, extending Medicaid coverage to higher-income children, pregnant women, and two-parent poor families with children. A further cluster of expansions followed through the adoption of optional aspects of the program and through statutorily permitted waivers from general federal eligibility and coverage rules. These expansions included long-term care benefits for the elderly and disabled well above the income-eligibility limits for the program generally and the expansion of new ranges of home and community-based services for people who otherwise would have been eligible for care in nursing homes.¹⁴

By the time the ACA was adopted in 2010, Medicaid had grown far beyond its 1964 roots. It was a large program, covering over 68 million people by fiscal year 2011. About half the enrollees were children, about a quarter were adults without disabilities, about fifteen percent were people with disabilities, and about ten percent were elderly.¹⁵ Total federal and state program costs for fiscal year 2011 were approximately \$414 billion.¹⁶ A broad range of services—some beyond the norm for private insurance—were mandatory for all states, including:

- Hospital, physician, laboratory and imaging services;
- A broad range of services for children (enrollees under 21) under EPSDT;¹⁷
- Family planning services and supplies;
- Nurse midwife services;
- Transportation services;

13. Rosenbaum, *supra* note 11, at 10 (quotations and citations omitted).

14. See Gruber, *supra* note 12, at 19-25 (describing expansion of eligibility and covered services); Rosenbaum, *supra* note 11, at 11-15 (summarizing the range of Medicaid expansion in its first four decades); Diane Rowland & Rachel Garfield, *Health Care for the Poor: Medicaid at 35*, 22 HEALTH CARE FIN. REV. 23 (2000); Sidney D. Watson, *From Almshouses to Nursing Homes and Community Care: Lessons from Medicaid's History*, 26 GA. ST. U. L. REV. 937, 959-67 (2010) (describing expansion of nursing home and home care services).

15. ELICIA J. HERZ, CONG. RESEARCH SERV., RL33202, MEDICAID: A PRIMER 13-14 (2011).

16. *Medicaid: A Primer*, KAISER FAM. FOUND. 25 (2013), <http://kaiserfamilyfoundation.files.wordpress.com/2010/06/7334-05.pdf>.

17. Early and periodic screening, diagnostic, and treatment (“EPSDT”) services comprise a broad range of scheduled diagnostic and treatment services for enrollees under 21 years of age. 42 U.S.C. § 1396d(r) (2012). Perhaps most significantly, after setting out a range of services that must be made available, the statute provides a final, catch-all category of required services:

Such other necessary health care, diagnostic services, treatment, and other measures described in subsection (a) of this section to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan.

Id.

- Nursing facility services for those 21 years of age and above, and home health care services for those eligible for nursing home level of care; and
- Services provided by federally qualified health centers (“FQHCs”) and rural health clinics (“RHCs”).¹⁸

Most or all states also elected to cover a range of services beyond those required. These services include:

- Prescription drugs;
- Dental services;
- Eyeglasses and durable medical equipment;
- Case management;
- Personal care services and hospice services;
- Nursing facility and psychiatric facility services for those under age 21; and
- Home and community based services.¹⁹

By 2010, then, Medicaid was still a needs-based program, but one that had extended its eligibility rules to reach nearly one in seven Americans. It had also, in recognition of the broader needs of the poor, expanded its menu of covered services beyond core medical treatment to include health benefits other Americans are expected to purchase out of pocket. By the time the ACA was passed, it was a dominant payer of some services, covering about half of all births, and almost half of all nursing home services.²⁰ In addition, the eligibility criteria for Medicaid, which encompass poverty, disability, and old age, ensured that it disproportionately covers high-risk and high-cost persons.

The ACA significantly expanded Medicaid. In *National Federation of Independent Business v. Sebelius*, Justice Ginsburg and Chief Justice Roberts disagreed as to whether the expansions were part of a gradual evolution of the program, or representative of a dramatic shift in the nature of Medicaid. Justice Ginsburg described Medicaid as “a single program with a constant aim—to enable poor persons to receive basic health care when they need it.”²¹ In contrast, Chief Justice Roberts read the ACA as creating an entirely new program:

Here, the Government claims that the Medicaid expansion is properly viewed merely as a modification of the existing program because the States agreed that

18. 42 U.S.C. § 1396d (2012). See HERZ, *supra* note 15, at 5-6; *Medicaid: A Primer*, *supra* note 16, at 13-14.

19. 42 U.S.C. § 1396d (2012). See HERZ, *supra* note 15, at 6; *Medicaid: A Primer*, *supra* note 16, at 14.

20. See Markus et al., *supra* note 1, at e275; *Medicaid's Long-Term Care Users*, *supra* note 2, at 1.

21. See *Nat'l Fed. of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566, 2630 (2012) (Ginsburg, J., concurring in part and dissenting in part).

Congress could change the terms of Medicaid when they signed on in the first place. . . . The Medicaid expansion, however, accomplishes a shift in kind, not merely degree. The original program was designed to cover medical services for four particular categories of the needy: the disabled, the blind, the elderly, and needy families with dependent children. Previous amendments to Medicaid eligibility merely altered and expanded the boundaries of these categories. Under the Affordable Care Act, Medicaid is transformed into a program to meet the health care needs of the entire nonelderly population with income below 133 percent of the poverty level. It is no longer a program to care for the neediest among us, but rather an element of a comprehensive national plan to provide universal health insurance coverage.²²

The Chief Justice's finding that the ACA's modification of Medicaid was one of "kind, not merely degree" allowed him to find that Congress's conditional spending powers do not extend to the enforcement of the ACA's Medicaid amendments on all states continuing to participate in Medicaid.²³ Whether the ACA's change was best characterized as evolutionary or revolutionary, it certainly added significantly to the scope of Medicaid's mission.

Under the ACA as written, then, states were required to sweep in all persons not previously eligible who have an income at or below 133 percent of the federal poverty level.²⁴ The extent to which each state's Medicaid enrollment would have been affected by this change hinged on the prior state-specific eligibility levels, but the estimates for total increases ranged as high as 21.3 million by 2022.²⁵ Those predictions had to be adjusted after the Supreme Court rendered the ACA's Medicaid expansion optional at the election of each state.²⁶ As of this writing, twenty-eight states have agreed to expand Medicaid to the income limits of the ACA, and two additional states are in discussions to do the same.²⁷ Whether and how the additional states will come into the fold is beyond the scope of this article.²⁸

22. *Id.* at 2605-06 (opinion of Roberts, C.J.).

23. *Id.* at 2606.

24. 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII) (2012), *invalidated by* Nat'l Fed. of Indep. Bus., 132 S. Ct. 2566 (2012).

25. See *Medicaid's Long-Term Care Users*, *supra* note 2, at 11 (citing John Holohan et al., *The Cost and Coverage Implications of the ACA Medicaid Expansion: National and State-by-State Analysis*, KAISER FAM. FOUND. 4 (2012), <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8384.pdf>).

26. *Nat'l Fed. of Indep. Bus.*, 132 S. Ct. at 2635.

27. *Current Status of State Medicaid Expansion Decisions*, KAISER FAM. FOUND. (2014), <http://kff.org/health-reform/slide/current-status-of-the-medicaid-expansion-decision>.

28. See, e.g., Maia Crawford & Shannon M. McMahon, *Alternative Medicaid Expansion Models: Exploring State Options*, CTR. FOR STATE HEALTH CARE STRATEGIES (2014) http://www.chcs.org/media/Alternative_Medicaid_Expansion_Models_Exploring_State_Options.pdf (describing alternative state models for expanding Medicaid); Stan Dorn et al., *What Is the Result of States Not Expanding Medicaid?*, ROBERT WOOD JOHNSON FOUND. & URBAN INST. (2014),

A central success of the ACA has been the decrease in America's uninsurance rate. The uninsured percentage has dropped by about five percent as a result of increased private enrollment (through the federal and state exchanges or marketplaces and through off-exchange purchases of ACA compliant coverage) and through expanded Medicaid enrollment.²⁹ However, as Medicaid pushes into demographics beyond the very poor, care must be taken to preserve the aspects of "original" Medicaid that target the needs of the poorest and most vulnerable. The next Part addresses the particular vulnerability of that population.

II. BARRIERS TO HEALTH FOR THE POOR

As Medicaid's role in American health finance expands, we must be cognizant of the fact that the poor have health needs that are different from those of the non-poor. This Part will acknowledge the health access gains the poor have experienced from Medicaid coverage, but will demonstrate that the health status of the poor continues to lag behind that of the non-poor. It will argue that special services are therefore in order, and point out that some of those special services are embedded in the ACA's design.

Many studies have demonstrated that Medicaid coverage increases access to most types of health care. This research was recently summarized in the following terms:

Consistently, research indicates that people with Medicaid coverage fare much better than their uninsured counterparts on diverse measures of access to care, utilization, and unmet need. A large body of evidence shows that, compared to low-income uninsured children, children enrolled in Medicaid are significantly more likely to have a usual source of care . . . and to receive well-child care, and significantly less likely to have unmet or delayed needs for medical care, dental care, and prescription drugs due to costs. . . . Nonelderly adults covered by

http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2014/rwjf414946 (describing financial cost to federal and state governments of states' Medicaid expansion decisions); Sherry Glied & Stephanie Ma, *How States Stand to Gain or Lose Federal Funds by Opting In or Out of the Medicaid Expansion*, COMMONWEALTH FUND (2013), http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2013/Dec/1718_Glied_how_states_stand_gain_lose_Medicaid_expansion_ib_v2.pdf; Carter C. Price & Christine Eibner, *For States That Opt Out Of Medicaid Expansion: 3.6 Million Fewer Insured And \$8.4 Billion Less In Federal Payments*, 32 HEALTH AFF. 1030 (2013).

29. See Sara R. Collins, et al., *Gaining Ground: Americans' Health Insurance Coverage and Access to Care After the Affordable Care Act's First Open Enrollment Period*, THE COMMONWEALTH FUND (July 2014), http://www.commonwealthfund.org/~media/files/publications/issue-brief/2014/jul/1760_collins_gaining_ground_tracking_survey.pdf. See also *Health Insurance Marketplace: Summary Enrollment Report for the Initial Open Enrollment Period*, ASSISTANT SECRETARY FOR PLAN. & EVALUATION (May 2014), http://aspe.hhs.gov/health/reports/2014/marketplaceenrollment/apr2014/ib_2014apr_enrollment.pdf.

Medicaid are more likely than uninsured adults to report health care visits overall and visits for specific types of services; they are also more likely to report timely care and less likely to delay or go without needed medical care because of costs.³⁰

The link between access and health outcomes is somewhat harder to quantify. A recent, widely-publicized study of Oregon's pre-ACA Medicaid expansion compared otherwise similar populations that differed on the basis of whether or not they had gained access to Medicaid. The Medicaid-insured cohort predictably had better access to health care services than the uninsured cohort.³¹ The measurable health outcomes were less clear-cut:

Medicaid coverage did not have a significant effect on measures of blood pressure, cholesterol, or glycated hemoglobin. Further analyses involving two prespecified subgroups—persons 50 to 64 years of age and those who reported receiving a diagnosis of diabetes, hypertension, a high cholesterol level, a heart attack, or congestive heart failure before the lottery (all of which were balanced across the two study groups)—showed similar results.³²

The study did find some health benefits, including a significant increase in the rate of diagnosis of depression and successful reduction over time in the manifestations of depression symptoms compared to the uninsured cohort.³³

Other studies have reported additional correlations between positive health outcomes and Medicaid membership. A team of researchers at the Harvard School of Public Health recently assessed the effects of pre-ACA Medicaid expansions and found improvements in the expansion states.³⁴ In particular, they found decreased mortality rates associated with the Medicaid expansions, determining that the mortality improvements were “greatest among non-whites and older adults.”³⁵ The effects of Medicaid will continue to be the subject of study, as the

30. *What is Medicaid's Impact on Access to Care, Health Outcomes, and Quality of Care?*, KAISER FAM. FOUND. 6 (2013), <http://kaiserfamilyfoundation.files.wordpress.com/2013/08/8467-what-is-medicaid-impact-on-access-to-care1.pdf>. See Marc L. Berk & Claudia L. Schur, *Access To Care: How Much Difference Does Medicaid Make?*, 17 HEALTH AFF. 169 (1998); Teresa A. Coughlin et al., *Assessing Access To Care Under Medicaid: Evidence for the Nation and Thirteen States*, 24 HEALTH AFF. 1073 (2005); Sharon Long et al., *How Well Does Medicaid Work in Improving Access to Care?*, 40 HEALTH SERV. RES. 39, 54 (2005).

31. Katherine Baicker et al., *The Oregon Experiment—Effects of Medicaid on Clinical Outcomes*, 368 NEW ENG. J. MED. 1713, 1718 (2013).

32. *Id.* at 1716.

33. *Id.* at 1716-17. Another significant difference over time between the groups with Medicaid and without was a reduction in “financial strain” related to health expenditures, and in particular a reduction in the rate of catastrophic medical expenses. *Id.* at 1718.

34. See, e.g., Benjamin D. Sommers et al., *Mortality and Access to Care Among Adults After State Medicaid Expansions*, 367 NEW ENG. J. MED. 1025 (2012).

35. *Id.* at 1028.

expansion of Medicaid continues to be a sharply divisive political issue, and claims continue that Medicaid is “broken.”³⁶

Evaluating the effects of Medicaid is difficult in part because Medicaid historically has covered the most vulnerable of Americans. The non-elderly enrollment in Medicaid is over fifty-three percent Black or Hispanic, and the long history of race- and ethnicity-based health disparities in American health care strongly suggests that this overrepresentation of people of color will result in poorer health outcomes regardless of the faults or inefficacy of the Medicaid program itself.³⁷ In addition to the effects of race and ethnicity, socioeconomic status has a demonstrable effect on health status, independent of insurance status.³⁸ People covered by Medicaid, then, are more medically fragile, have more complex health conditions, and are affected by determinants of poor health independent of their access to health coverage or care.

The inability of Medicaid to make healthy populations of the poor and vulnerable is not surprising. Health status is a function of many factors other than medical care. These other factors, in fact, can be more powerfully determinative of the health of a population than the delivery of traditional health services.³⁹ One recent commentary observed that “[a]n enormous body of literature supports the view that differences in health are determined as much by the social circumstances that underlie them as by the biologic processes that mediate them.”⁴⁰ These “determinants of health” that drive health status include the quality of housing stock, the availability of employment opportunities, the stresses of social and racial inequities, the availability of fresh and wholesome food, and a range of other non-medical factors.⁴¹ The research on social determinants of health suggest that advocates of health care for the poor should broaden their perspective on what constitutes health services. In particular, the research demonstrates that medical

36. See Jacobi, *supra* note 11, at 364-69 (describing the contours of the argument that Medicaid is “broken”).

37. See, e.g., BRIAN D. SMEDLEY ET AL., *UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE*, INST. OF MED. (2003); see also Sidney D. Watson, *Section 1557 of the Affordable Care Act: Civil Rights, Health Reform, Race, and Equity*, 55 HOW. L.J. 855, 857 (2012); David R. Williams & Pamela B. Jackson, *Social Sources of Racial Disparities in Health*, 24 HEALTH AFF. 325, 327-29 (2005).

38. See Paula Braveman et al., *The Social Determinants of Health: Coming of Age*, 32 ANN. REV. PUB. HEALTH 381, 382-84 (2011); Williams & Jackson, *supra* note 37, at 327-28.

39. See Kelly M. Doran et al., *Housing as Health Care—New York’s Boundary-Crossing Experiment*, 369 NEW ENG. J. MED. 2374, 2374 (2013) (“experts estimate that medical care accounts for only 10% of overall health, with social, environmental, and behavioral factors accounting for the rest”).

40. David A. Asch & Kevin G. Volpp, *What Business Are We In? The Emergence of Health as the Business of Health Care*, 367 NEW ENG. J. MED. 888, 888 (2012).

41. See Clare Bambra et al., *Tackling the Wider Social Determinants of Health and Health Inequalities: Evidence from Systematic Reviews*, 64 J. EPIDEMIOLOGY & COMMUNITY HEALTH 284 (2010); Nicole Lurie, *What The Federal Government Can Do About The Nonmedical Determinants*, 21 HEALTH AFF. 94 (2002).

care should no longer be viewed in isolation but should be part of a system that coordinates a variety of medical and social services.⁴² This systematizing of services can be achieved through the coordination of services provided by previously separate public agencies,⁴³ or through state Medicaid agencies' fostering of community organizations empowered and incited to integrate health and social services.⁴⁴ Both options would rethink the financing of health care for the poor to take into account the true barriers to good health.⁴⁵

III. TARGETED OR UNIVERSAL MEDICAID?

Medicaid was, is, and undoubtedly will be a program of health care for the poor and near-poor. But whether it will be dedicated to the interests of society's most vulnerable or serve as one of the launching pads for truly universal healthcare is a question of great moment. The previous Section described the particular health needs of the poor, and identified strategies to make Medicaid more effective in addressing those needs. Such a turn in Medicaid policy to a deeper commitment to the poorest and most vulnerable is in potential conflict with the trend, exemplified by the eligibility expansion in the ACA, to extend Medicaid to the less poor—a population potentially less affected by substandard housing, food deserts, and other plagues of the poor. A Medicaid program reconfigured to address the particular needs of the poor would be a *targeted* program; one that is more configured to extend traditional health coverage to a broader population would be a *universal* program. On one hand, a more targeted Medicaid program might better serve the needs of the poorest and most vulnerable by sweeping in coordinated access to non-medical social programs in their particular interest. On the other, a universal Medicaid program would serve the health care needs of broader class of Americans, helping to knit together a more universal health insurance system, and perhaps thereby place the Medicaid program on a firmer political footing.

The tug between a targeted or universal Medicaid system is not a new one. Colleen Grogan, a leading Medicaid scholar, has observed that mission uncertainty has been present since Medicaid's inception. In an influential 2003 article, Colleen Grogan and Eric Patashnik observed that mission uncertainty has been present since Medicaid's inception, and that it has since the beginning been "not one

42. See Lurie, *supra* note 41, at 105.

43. See *infra* text accompanying notes 63-68 (discussing Health in All Policies ("HiAP") initiatives).

44. See *infra* text accompanying notes 79-85 (discussing Medicaid Accountable Care Organizations).

45. Lurie, *supra* note 41, at 105 ("Donald Berwick's often-quoted adage, 'The system is perfectly designed to achieve exactly the results it gets. If you don't like the results, change the system,' applies not only to health systems, but also to the 'stovepiped' way in which policy and budget development often occurs." (citation omitted)).

program but many.”⁴⁶ Grogan and Patashnik outlined one perspective on the choice between focused coverage of the poorest and most vulnerable, and expansion to other tiers of the uninsured:

Two distinct paths for Medicaid’s future evolution are in view, and they lead in opposite directions. If policy makers decide to continue taking incremental steps toward coverage expansion . . . Medicaid could serve as a path to a more universal health care system for millions of Americans. Alternatively, if policy makers opt for the second path, Medicaid could revert back to “welfare medicine.”⁴⁷

Grogan and Patashnik argued that Medicaid’s role in American health finance is unsettled because of two ambiguities built into the program. First, the original statute failed to “provide precise definitions of the two concepts of medical indigence and comprehensive benefits.”⁴⁸ Second, it failed to “resolve Medicaid’s place in the overall U.S. welfare state and to determine whether or in what sense Medicaid benefits should be universal or targeted.”⁴⁹ Grogan and Patashnik clearly favored the more universal vision of Medicaid. They posited that policy makers will be driven to expand Medicaid because of the failures of the private insurance markets and the inadequacy of Medicare coverage for vitally important long term care services: “it will be increasingly difficult for policy makers not to grasp the vital importance of Medicaid to working-class and middle-class families.”⁵⁰ This prediction proved prescient; the ACA certainly responded to the logic of the argument for the expansion of both medical and long-term coverage to populations not previously within Medicaid’s mandate.

Grogan and Patashnik approve, at least implicitly, of Medicaid’s evolution as a “path to a more universal health care system for millions of Americans” and disapprove of a “reversion to ‘welfare medicine.’”⁵¹ There are, however, arguments for adhering to a narrower conception of Medicaid’s mission. As is described above, the poorest and most vulnerable are in need of a different range of health and social services than are the working poor or middle class. They have housing, environmental, community resource, and other deficits that affect their health status significantly. Community health advocates increasingly argue for a broader range of responses to the complex health needs of the poor, informed by analyses of the social health determinants that drive their health status deficits.

46. Colleen Grogan & Eric Patashnik, *Between Welfare Medicine and Mainstream Entitlement: Medicaid at the Political Crossroads*, 28 J. HEALTH POL. POL’Y & L. 821, 824 (2003).

47. *Id.* at 822 (citing ROBERT STEVENS & ROSEMARY STEVENS, *WELFARE MEDICINE IN AMERICA: A CASE STUDY OF MEDICAID* (1974)).

48. *Id.* at 852.

49. *Id.*

50. *Id.* at 854-55.

51. *Id.* at 822.

A proposal to reconfigure Medicaid to reach broadly into social services would fit imperfectly with universalist Medicaid vision. Such a proposal would likely split Medicaid into a program for the very poor on one hand and the working poor and middle class on the other hand.⁵² It would therefore drive Medicaid in a more targeted direction, as the additional social services would be significantly more appropriate for the traditional low-income Medicaid recipients, but less appropriate for working-class and middle-income recipients for whom Medicaid might otherwise be a path to ordinary health insurance coverage.⁵³

The distinction between a Medicaid program focused on the “neediest among us”⁵⁴ or one that is “an element of a comprehensive national plan to provide universal health insurance coverage”⁵⁵ is a real one. Targeted social welfare programs have the virtue of concentrating limited resources and programmatic design toward those most in need of social welfare benefits; however, targeted programs face uncertain political viability, as the majority of voters do not benefit from such programs. Universal programs, on the other hand, tend to enjoy broader electoral support, while allowing the poor to avoid stigma by participating in mainstream programs. However, universal programs tend to devote the majority of their funding and programmatic attention to the non-poor, diminishing opportunities for high-level change in their circumstances.⁵⁶ But is the choice between those two visions a real or false one? That is, can Medicaid serve both the function of providing the range of services peculiarly appropriate for the poorest and most vulnerable, while also serving as a piece of the puzzle for expanding health insurance to the working poor and middle class? The answer is yes.

Policy makers face a dilemma in choosing between targeted social welfare programs and universal programs. Theda Skocpol describes the contours of this dilemma,⁵⁷ while also providing a possible third way—targeting within universalism:

52. Medicaid is not a unitary program as it stands. The Deficit Reduction Act of 2006 allowed states to substitute weaker “benchmark” benefits patterned on employment-based coverage for the richer traditional Medicaid coverage, although the most vulnerable Medicaid beneficiaries are exempted from this change. 42 U.S.C. § 1396u–7(a) (2012) (exempting, e.g., blind, medically frail, and disabled recipients). The ACA similarly permits states to provide weaker “benchmark” benefits, and not the full traditional Medicaid benefits to the new eligible class, comprising mostly non-elderly adults not previously categorically eligible. 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII) (2012). The proposal described in the text would clearly exacerbate this distinction.

53. The distinction, too, could be overstated. Clearly, some working-class consumers in some markets suffer from poor housing stock and other social barriers to good health status. But the very poor are clearly more exposed to these barriers to good health.

54. *Nat’l Fed. of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566, 2606 (opinion of Roberts, C.J.).

55. *Id.*

56. See Skocpol, *supra* note 5, at 412–14.

57. *Id.* at 414.

[R]oom has been made *within* certain universal policy frameworks for extra benefits and services that disproportionately help less privileged people without stigmatizing them. What I shall call “targeting within universalism” has delivered extra benefits and special services to certain poor people throughout the history of modern American social provision, and new versions of it could be devised today to revitalize and redirect U.S. public social provision.⁵⁸

Skocpol recommends that policy makers structure necessary supports in a way that apply to universal needs, but that can be particularly beneficial to those most in need. While benefits can be general in nature, they could be provided more substantially to those in need. The earned income tax credit, for example, is operated through an income tax system in which all participate. The credit is available to all when and if their income drops to threshold levels, but the benefits accrue most powerfully to the neediest.⁵⁹

Targeting within universalism for Medicaid, then, would allow for expanded services for the poor *within* the increasingly universal framework of Medicaid as a broadly available health insurance program. There are two models to accomplish this task. In the next section, I describe a form of Medicaid ACO that permits Medicaid funding to be spent to provide broad services for the poor without changing the general medical coverage mission for the broader population.⁶⁰ In the remainder of this section, I describe an alternative whereby Medicaid funds are not spent on new social services, but rather Medicaid partners with other social programs and agencies to address the social needs of the poor.

The City of Richmond, California is a poor city. It has adopted a novel plan to integrate social and medical services to address broader barriers to health. About nineteen percent of Richmond’s residents are unemployed, and thirty-eight percent of its children live in poverty. Over half of its residents pay more than thirty percent of their income for housing.⁶¹ Residents face “environmental pollution, neighborhood violence, unemployment, [and] unsafe physical infrastructure,” and they lack access to affordable health care, nutritious food, and childcare.⁶² Richmond has adopted a Health in All Policies (“HiAP”) ordinance. HiAP calls for broad social policies across all public sectors that take into account determinants of health,⁶³ and further calls for cooperation among agencies

58. *Id.*

59. *Id.* at 428-31.

60. *See infra* Part IV.

61. Jason Corburn et al., *Health in All Urban Policy: City Services Through the Prism of Health*, 91 J. URBAN HEALTH 623, 625 (2014).

62. *Id.* at 627.

63. *Id.* at 624-25 (citing Ilona Kickbusch, *Health in All Policies: Setting the Scene*, 5 PUB. HEALTH BULL. S. AUST. 3 (2008)) (published by the South Australian Department of Health).

responsible for health, food, income, environmental, and housing policies.⁶⁴ Its governing philosophy has been described in the following terms:

The main principle behind the slogan ‘Health in All Policies’ is really very simple: Health is greatly influenced by lifestyles and environments, e.g. how people live, work, eat and drink, move, spend their leisure time etc. These are not only individual choices, but they often have strong social, cultural, economical, environmental etc. determinants. Accordingly, decisions influencing people’s health do not concern only health services or ‘health policies’, but decisions in many different policy areas have their influence on these health determinants.⁶⁵

Richmond’s HiAP program advanced these principles through the convening of a process that produced a coordinating strategy and a HiAPP ordinance. The ordinance developed programmatic and policy strategies to incorporate a health orientation in six focus areas:

- Governance and Leadership: all city agencies must incorporate and further HiAP methods and goals;
- Economic development and education: city will invest in workforce development, particularly for people of color and women, child care, and community schools;
- Safe communities: city will promote reduction in environmental stress and improve services such as health food through rezoning and community investment;
- Residential and built environment: city will address substandard housing and lead paint abatement, develop homelessness programs, and improve recreational opportunities;
- Environmental health and justice: city will reroute truck routes, improve air quality through improved toxic waste monitoring, and remediate hazardous waste sites; and
- Health home and social services: city will assist in ACA-related health insurance enrollment and enrollment in other safety net programs.⁶⁶

The ordinance was only recently adopted,⁶⁷ and the city’s ability and willingness to follow through on the requirements are therefore unknown. In addition, there are few mature models of HiAP-driven integrated programs in the United States with which to compare the Richmond initiative, although such

64. Lawrence O. Gostin et al., *Restoring Health to Health Reform: Integrating Medicine and Public Health to Advance the Population’s Well-Being*, 159 U.P.A. L. REV. 1777, 1819-20 (2011).

65. Pekka Puska, *Health in All Policies*, 17 EUR. J. PUB. HEALTH 328, 328 (2007).

66. Corburn, *supra* note 61, at 629-30.

67. The ordinance was adopted in April 2014. Corburn, *supra* note 61, at 623-24.

programs are beginning to emerge, following on decades of development in other nations.⁶⁸

The adoption of HiAP policies in the United States holds promise as a mechanism to foster cooperate among agencies that, collectively, could integrate health and social services central to improving the health status of the poor.⁶⁹ Those attempting to create HiAP-governed cooperative efforts, however, do face difficulties:

HiAP implementation faces a number of challenges at the local, state, and national levels, including public health's limited connectivity to other sectors, organizational and technical barriers (eg, information systems, planning horizons, funding mechanisms), and intersectoral differences in values and cultures. Furthermore, intersectoral collaboration can be resource intensive, particularly in terms of staff time and expertise, which is a challenge in an era of decreasing public resources across government agencies.⁷⁰

If governmental leadership is present, and if agency staff cooperation is forthcoming, HiAP collaboratives dovetail nicely with the targeting within universalism model: Medicaid continues to exist as a general insurance program, and additional services particularly needed by very poor Medicaid recipients can be provided by other agencies. In the absence of a broad willingness and capacity for inter-agency cooperation, other methods of addressing the needs of the poor are necessary. The next section describes addresses another model.

IV. TACOs

Medicaid is a vital program for the poor, even as expands to become a source of health coverage for the near-poor and middle class. Advocates for the poor may favor a targeted approach to Medicaid development to concentrate attention and funding on the neediest. They may also favor a universalist approach to reduce the program's stigma and to gain political support from the expanded program's broader constituency. Targeting within a universal Medicaid will permit special services for the poor without diminishing the program's universal reach.⁷¹

The previous section described how HiAP policies can target within a universal Medicaid program. HiAP programs permit Medicaid to expand medical services to the non-poor while coordinating with other public agencies to provide supplemental services to the poor. Logistical and operational difficulties may limit

68. Lauren N. Gase et al., "Health in All Policies:" *Taking Stock of Emerging Practices to Incorporate Health in Decision Making in the United States*, 19 J. PUB. HEALTH MGMT. PRAC. 529, 530 (2013).

69. *Id.*

70. *Id.* at 537.

71. See Skocpol, *supra* note 5, at 413-14.

the proliferation of HiAP programs. This section describes Medicaid Accountable Care Organizations as alternative methods of targeting the poor within a general Medicaid program.

This section first describes the general problem of fragmentation in our health care delivery system, particularly for people with chronic illness. It then describes clinical innovations that integrate care for people with chronic illness, and explains how ACOs create organizational and financial support for such integration. Next, this section will demonstrate how the ACO model of integrating care for the chronically ill can be applied to Medicaid—a program that covers many people with chronic illness. Finally, it argues that the financing mechanism for Medicaid ACOs provides a promising means by which community-based organizations can be given the incentive and the Medicaid-provided financial capacity to provide poor and vulnerable Medicaid beneficiaries with the social services they need to thrive—without altering Medicaid’s general medical insurance mission for the expansion population.

The fragmentation of the American health care system is one of its major faults. The Institute of Medicine’s ground-breaking report *To Err is Human* described the nature and effects of that fragmentation:

The decentralized and fragmented nature of the health care delivery system . . . contributes to unsafe conditions for patients, and serves as an impediment to efforts to improve safety. Even within hospitals and large medical groups, there are rigidly-defined areas of specialization and influence . . . At the same time, the provision of care to patients by a collection of loosely affiliated organizations and providers makes it difficult to implement improved clinical information systems capable of providing timely access to complete patient information.⁷²

Fragmentation leads to bad decision-making due to a lack of coordination and communication among health care providers and institutions.⁷³ This fragmentation is further exacerbated by payment policies, which encourage fragmentation and increase costs.⁷⁴

Fragmented care creates particular health dangers for patients with chronic illnesses, who by the nature of their condition require frequent care. The danger arises through lost opportunities for appropriate care and conflicting treatments that can do more harm than good:

72. INST. OF MED., *TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM* 3 (Linda T. Kohn et al. eds., 2000).

73. See Einer Elhauge, *Why We Should Care About Health Care Fragmentation and How to Fix It*, in *THE FRAGMENTATION OF U.S. HEALTHCARE: CAUSES AND SOLUTIONS* 1-2 (Einer Elhauge ed., 2010).

74. See Donald M. Berwick et al., *The Triple Aim: Care, Health, and Cost*, 27 *HEALTH AFF.* 759, 764-65 (2008).

Rarely in a fragmented, poorly coordinated health care system is a single health care professional or entity responsible for a patient's overall care. . . . Imprecise clinical responsibility increases the chance that some services may not be provided at all. Among people with chronic conditions 71% report having no help coordinating their care. . . and 17% say they have received contradictory medical information from health care professionals.⁷⁵

Robert Kane, one of the leading clinical researchers into care for patients with chronic illness, has described the problem as a myopic focus on isolated symptoms rather than the whole person:

Patients with chronic conditions suffer from fragmented services . . . when they are treated not as persons but instead are segmented or compartmentalized into discrete organs or body systems. If health care professionals treat a malfunctioning system of the body rather than the person as a whole, (i.e., treat the disease in the patient rather than treat the patient with the disease), treatment can become a series of medical interventions that target only the disease and ignore the ill person.⁷⁶

The cure for the harm of fragmentation generally,⁷⁷ and for people with chronic illness in particular,⁷⁸ is the coordination of care across providers, disciplines, and institutions.

ACOs are one mechanism to remedy fragmentation. ACOs are organizations comprising a broad range of health care providers with the capacity to manage and be held accountable for improving health quality.⁷⁹ ACOs contain the raw material for reversing fragmentation, as they are provider-led organizations including primary care, specialty care, hospital care, and the range of other health services necessary to render coordinated care. Integrated delivery systems are not new; the innovation of ACOs is in the payment, by which the participating providers receive incentives for providing high-quality care in a cost-effective manner. The payment mechanisms can include gainsharing—the ability of the ACO to retain a portion of the cost-savings created by its efficient care management—or risk-based partial capitation, by which the ACO receives a set amount of compensation for each patient covered to spend as it judges best to provide some of the cost of care for

75. ROBERT L. KANE ET AL., MEETING THE CHALLENGE OF CHRONIC ILLNESS 50 (2005).

76. *Id.* at 50-51.

77. Berwick, *supra* note 74, at 765.

78. Kane, *supra* note 75 at 71-74.

79. See Mark McClellan et al., *A National Strategy To Put Accountable Care Into Practice*, 29 HEALTH AFF. 982, 982-83 (2010); Kelly Devers & Robert Berenson, *Can Accountable Care Organizations Improve the Value of Health Care by Solving The Cost and Quality Quandaries?*, URBAN INST. 1-2 (Oct. 2009), http://www.urban.org/uploadedpdf/411975_accountable_care_orgs.pdf.

the patients under its care.⁸⁰ At bottom, the payment is intended to provide incentives for ACOs to manage patient care well and efficiently, while devolving to the ACO substantial discretion on the means by which it can reduce costs while maintaining or improving quality.

The ACA created an ACO payment program in Medicare,⁸¹ but did not create a similar program in Medicaid. Experimental programs are growing in several states, however, built on the structure of coordinated care, shared clinical decision-making among a large group of Medicaid providers, and some form of reward for delivering high-quality care while containing cost.⁸² Much of the success of these ACOs is premised on their medical management, their ability to constrain health expenditures, and their ability to deliver coordinated care to improve the health status of Medicaid recipients.⁸³

Medicaid disproportionately covers the poor, disabled, and elderly, and therefore the chronically ill.⁸⁴ As with Medicare ACOs, Medicaid ACOs are structured to integrate care, and therefore have the capacity to improve care for people with chronic illnesses. The financing mechanisms for Medicaid ACOs reverse the incentive to avoid high-cost patients, and instead encourage them to seek out and care for the sickest, including those with chronic illness. The incentive derives from the population-based reimbursement for most models of Medicaid ACO. The range of payment methodologies can include pay-for-performance agreements, global payments, and gain-sharing payments with state Medicaid agencies, Medicaid managed care organizations, and other payers, as well as grant funding from foundations.⁸⁵ This population-based model attributes all Medicaid recipients in a designated community to the ACO, and any gains, or risk-based reimbursement, is dependent on the ACO's ability to maintain or improve quality while driving down the aggregate cost of care in that community.⁸⁶

A community-based Medicaid ACO model, then, combines clinical integration with a financial incentive to reach out to the chronically ill in the ACO's geographic area to provide integrated chronic care. But the Medicaid ACO model

80. See Devers & Berenson, *supra* note 79, at 6-7.

81. 42 U.S.C. § 1395jjj (2012) (Medicare shared savings program, authorizing Medicare ACOs).

82. See Jacobi, *supra* note 11, at 374-76; Alexis Skoufalos & Kate Cecil, *The Journey to Creating Safety Net Accountable Care Organizations in New Jersey*, 16 POPULATION HEALTH MGMT. S-12, S-14-S-16 (2013); Tricia McGinnis & David M. Small, *Accountable Care Organizations in Medicaid: Emerging Practices to Guide Program Design*, CTR. FOR HEALTH CARE STRATEGIES 5-8 (2012), http://www.chcs.org/media/Creating_ACOs_in_Medicaid.pdf.

83. McGinnis & Small, *supra* note 82, at 2-3.

84. See John Billings & Tod Mijanovich, *Improving Care for High-Cost Medicaid Patients*, 26 HEALTH AFF. 1643, 1644-45 (2007).

85. See Valerie A. Lewis et al., *The Promise And Peril of Accountable Care For Vulnerable Populations: A Framework For Overcoming Obstacles*, 31 HEALTH AFF. 1777, 1781 (2012).

86. See N. J. REV. STAT. § 30:4D-8.5 (2013) (describing community-based gain-sharing program in New Jersey's Medicaid ACO program); Jacobi, *supra* note 11 at 375-76; McGinnis & Small, *supra* note 82, at 2.

can go beyond the provision of coordinated medical care. The financing structure that rewards Medicaid ACOs for reaching and treating people with chronic medical conditions can also reward it for reaching beyond medical care to the provision of social services to ameliorate the effects of the social determinants of health. By expanding the scope of their vision and their activities to include the social determinants of health, Medicaid ACOs can be transformative in their communities.

Poor and vulnerable populations can benefit much more from the broad integration of social and health services than they can from the integration of health services alone. Medicaid ACOs are designed to address the needs of both the clinically vulnerable and the socially vulnerable.⁸⁷ As is described above, the former group is a population that could be targeted by the medical care aspects of ACOs: those with chronic conditions or risk factors that can be addressed with sophisticated coordinated care.⁸⁸ The second group—the socially disadvantaged—require a stretching of the model.

Organizations that pursue this melding of social and medical coordination for the benefit of clinically and socially vulnerable patients have been christened “totally accountable care organizations,” or “TACOs.”⁸⁹ These organizations recognize that “much of what impacts health outcomes occurs outside of the health care system,” including in-jail diversion programs, improved substance use disorder services, and housing support services.⁹⁰ The flexibility created by population-based reimbursement systems allow TACOs to be responsive to the broad range of clinical and social barriers that affect their vulnerable target populations and that cause the population to absorb such a large portion of the cost of care.

Rewarding TACOs for reducing the overall burden of Medicaid costs gives them the flexibility to use their resources to address the particular cost-drivers of poor populations. They will have the funding, the capacity, and the incentive to target a broad range of social services:

[The reimbursement incentives available to Medicaid ACOs] may foster closer collaboration among health care providers and social service organizations, addressing a more holistic set of patient needs. For example, ACOs serving a sizeable homeless population may be able to use a portion of their shared savings

87. See Lewis et al., *supra* note 85, at 1778.

88. *Id.*

89. See Jennifer DeCubellis & Leon Evans, *Investing In The Social Safety Net: Health Care's Next Frontier*, HEALTH AFF. BLOG (July 7, 2014), <http://healthaffairs.org/blog/2014/07/07/investing-in-the-social-safety-net-health-cares-next-frontier>; Stephen Somers & Tricia McGinnis, *Broadening the ACA Story: A Totally Accountable Care Organization*, HEALTH AFF. BLOG (Jan. 23, 2014), <http://healthaffairs.org/blog/2014/01/23/broadening-the-aca-story-a-totally-accountable-care-organization>.

90. DeCubellis & Evans, *supra* note 89.

to work with local housing agencies to help patients get into stable housing and thereby reduce related, unnecessary medical spending—such as a longer-than-necessary hospital stay that occurs simply because a patient doesn't have a home to go to.⁹¹

TACOs, then, can achieve these improvements in the lives of the members of their communities through the melding of medical and social services. Further, they can do so without necessitating the creation of a separate, targeted, form of Medicaid. TACOs can coexist with other Medicaid provider organizations and share methods with them. All Medicaid providers—indeed, all health care providers—can explore the value of integrated care as a means to improve care for patients with chronic conditions, even though organizations serving higher-income beneficiaries are less likely to engage in housing or jail diversion efforts. Higher-income Medicaid ACOs may serve their populations well without the need to graduate to the status of TACOs.

TACOs are distinct from other Medicaid clinical providers not by virtue of their legal or regulatory mandate, but by virtue of the means they adopt to satisfy exactly the same mandate. That is, TACOs would not be required by Medicaid statutes or regulations to add social services to their activities. Instead, they would be empowered by state law to gain financially for improving care and reducing cost for a population of Medicaid-eligible residents of a community. They could use the gains they realize for achieving improvements to fund non-Medicaid services with their own funds, garnered through the gains they realize from care improvement and cost reduction.

Their special targeting of very vulnerable Medicaid recipients, then, satisfies the requirements described above⁹² to achieve targeting within Medicaid without impeding the goal of using Medicaid as a path to insurance expansion. TACOs serve Medicaid goals by correcting providers' perverse financial incentives and thereby reducing fragmentation of care. Once TACOs obtain a financial reward for reducing the cost of care to Medicaid, they can employ those rewards to use social services to counteract the effects of the social determinants of health. They could follow a virtuous cycle of employing gains from reducing costs of care for the poor to further reduce those costs by attacking the social impediments to health. By using a return on investment and not funds directed to social services by a state Medicaid agency, they can accomplish particular gains for the poor within the existing legal structure of the Medicaid program.

91. *Id.*

92. *See supra* Part IV.

CONCLUSION

The very poor often live with clinical and social vulnerabilities that require care that is different in kind from that required by the less poor and less vulnerable “expansion” populations added by the ACA. The ACA uses the Medicaid program to expand opportunities for access to health insurance to populations of higher-income working poor persons, and it may be so used in the future. The poor can benefit from this broadening, as a broader Medicaid is likely to be less stigmatizing to the poor and will gain political support through its wider reach into the American voting population. The broadening may, however, risk the reduction in Medicaid’s focus on the particular needs of the poor. Total Accountable Care Organizations—TACOs—in Medicaid can continue and enhance Medicaid’s services to the poorest and most vulnerable while allowing Medicaid to morph into a broader health insurance system, thereby achieving targeting within universalism. TACOs can employ general tools to coordinate care and expand access—tools that are available to all Medicaid providers under the ACA, and would also be available to Medicaid ACOs. In the case of TACOs serving very vulnerable populations, however, providers can choose to use their funds to address social concerns, such as substandard housing and food deserts that are less likely to affect higher-income Medicaid beneficiaries.

By allowing TACOs to serve social needs, Medicaid can create incentives and capacity for community organizations to provide specialized clinical and social services to our most vulnerable, while also providing general public health insurance to those shut out of private coverage. Organizations devoted to the care of the poor and vulnerable are moving toward the creation of functioning TACOs. Their actions should be supported and applauded without fear for the broader, equally important insurance-expansion mission of Medicaid.

The Accidental Administrative Law of the Medicare Program

Eleanor D. Kinney, JD, MPH*

INTRODUCTION

On July 30, 1965, President Lyndon B. Johnson signed the Social Security Amendments of 1965, which established the Medicare and Medicaid programs.¹ This legislation was the result of multiple efforts by the Democratic Party to bring government sponsored health insurance coverage to the American people. The legislation, by today's standards, was simple. The *Statutes at Large* version of the legislation is less than 30,000 words.

Today, the Medicare program is massive. The number of Medicare beneficiaries increased from 19.1 million in 1966 to about 52.3 million in 2013, a 174 percent increase.² The Medicare program now partially funds and regulates one fifth of the US health care sector, which constituted over 17.2 percent of the US economy in 2012, as measured by percentage of GDP.³

Today, the Medicare program is governed by a complex web of legislative rules, interpretive rules and manuals, policy guidance and computer programs which guide a host of decisions on issues related to the operation of the Medicare program. The Medicare program also maintains multiple appeals processes for beneficiaries, physicians, institutional providers, suppliers, and contractors over a variety of issues including payment amounts to providers, determinations of status for Medicare administrative contractors, and coverage appeals of Medicare beneficiaries. Medicare also has vigorous civil and criminal enforcement programs for reducing fraud and abuse.

This Article traces the evolution of administrative procedures for policy-making and adjudication in the Medicare program since its inauguration. Part II of

* Hall Render Professor of Law Emerita, Indiana University McKinney School of Law; 2014-2015 Bernard J. Beazley, Visiting Professor in Health Law and Policy, Loyola University Chicago School of Law.

1. Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286 (codified as amended at 42 U.S.C. §§ 1395, 1396 (2012)).

2. Ctrs. for Medicare & Medicaid Servs. *CMS Statistics 2013*, U.S. DEP'T HEALTH & HUM. SERVS. (2014), http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMS-Statistics-Reference-Booklet/Downloads/CMS_Stats_2013_final.pdf.

3. Ctrs. for Medicare & Medicaid Servs., *National Health Expenditures 2012 Highlights*, U.S. DEP'T HEALTH & HUM. SERVS. (2013), <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/highlights.pdf>.

this article provides background information on the Medicare program that is relevant to Medicare's administrative functions. Part III traces the evolution of administrative procedures for policy-making and adjudication in the Medicare program since its inauguration. Part IV addresses how some Medicare appeals systems are not meeting the needs of the program or its beneficiaries nor of its providers, suppliers and contractors. Finally, Part V will explore the collaborative approaches to policy-making that have occurred since 2000 and, in particular, in the Patient Protection and Affordable Care Act (ACA),⁴ as amended by the Health Care and Education Reconciliation Act of 2010.⁵

I. THE MEDICARE PROGRAM

The architects of the Medicare program saw themselves as designing a government benefit program in the Social Security system. The original Medicare program contained two parts. Part A, Hospital Insurance for the Aged and Disabled, covers hospital and related services such as skilled nursing and home health care.⁶ Part B, Supplementary Medical Insurance, covers physician and other outpatient services.⁷ Part A and Part B together are called "Original Medicare" or "Fee-for-Service" Medicare. Pursuant to contract, Medicare administrative contractors handle claims and pay providers as well as adjudicate appeals and make program policy.⁸ Congress later added a managed care plan option in 1997 in a new Part C of the Medicare statute,⁹ which was enhanced in the Medicare Modernization Act of 2003.¹⁰ Also in this legislation, Congress added a voluntary prescription drug benefit in Part D of the Medicare statute.¹¹ The Centers for Medicare and Medicaid Services (CMS) within the U.S. Department of Health and Human Services (HHS) administers the Medicare program.¹² Figure 1 summarizes the Parts of the Medicare program and the benefits they cover.

4. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010).

5. Health Care and Education Reconciliation Act (HCERA) of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010).

6. Codified as amended at 42 U.S.C. §§ 1395c-i (2012).

7. Codified as amended at 42 U.S.C. §§ 1395j to 1395w-4 (2012).

8. 42 U.S.C. §§ 1395h, 1395u (2012).

9. Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4001, 111 Stat. 251, 275 (codified as amended at 42 U.S.C. § 1395w-21 (2012)).

10. Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003, Pub. L. No. 108-173, §§ 201-241, 117 Stat. 2066, 2176-221 (2003) (codified as amended at 42 U.S.C. § 1395w-21 (2012)).

11. *Id.* § 101 (codified as amended at 42 U.S.C. § 1395w-101 (2012)).

12. HHS was formerly the U.S. Department of Health, Education and Welfare (HEW). CMS was formerly the Health Care Financing Administration (HCFA).

FIGURE 1¹³: THE PARTS OF THE MEDICARE STATUTE ESTABLISHING PARTS OF THE MEDICARE PROGRAM

<p align="center">Part A—Hospital Insurance Benefits for Aged and Disabled (§§ 1395c-1395j5)</p> <p>Part A covers most medically necessary hospital, skilled nursing facility, home health and hospice care. Part A is financed by a payroll tax and is free to those eligible for Social Security.</p>
<p align="center">Part B—Supplementary Medical Insurance Benefits for Aged and Disabled (§§ 1395j-1395w5)</p> <p>Part B covers most medically necessary doctors' services, preventive care, durable medical equipment, hospital outpatient services, laboratory tests, x-rays, mental health care, and some home health and ambulance services. Beneficiaries pay a monthly premium for this coverage.</p>
<p align="center">Part C—Medicare Choice Program* (§§ 1395w21-1395w29)</p> <p>Part C is not a separate benefit but a program that allows private health insurance companies to provide Medicare benefits. These private health plans are called Medicare Advantage plans. Medicare Advantage plans must offer at least the same benefits as Original Medicare (those covered under Parts A and B) but can do so with different rules, costs and coverage restrictions. Part D prescription drugs can be included in Medicare Advantage plans. Many different kinds of Medicare Advantage plans are available. Beneficiaries may pay a monthly premium for this coverage, in addition to their Part B premium.</p>
<p align="center">Part D—Voluntary Prescription Drug Benefit Program (§§ 1395w101-1395w154)</p> <p>Part D covers outpatient prescription drug coverage. Part D is provided only through private insurance companies that have contracts with the government. As per Part C, Medicare Advantage plans can offer Part D prescription drug benefits.</p>
<p align="center">Part E—Miscellaneous Provisions (§§ 1395x-1395kkk1)</p> <p>Part E contains a variety of provisions, such as definitions, that apply to all parts of the Medicare program.</p>
<p>*The Medicare Modernization Act changed the name of this program to the "Medicare Advantage" program but the title of Part C was never changed, and reflects the name of the 1997 program.</p>

13. *What does Medicare cover (Parts A, B, C and D)?*, MEDICARE INTERACTIVE (2014), http://www.medicareinteractive.org/page2.php?topic=counselor&page=script&script_id=214 (last visited Dec. 14, 2014).

Initially, Medicare paid institutional providers their reasonable costs and physician and other outpatient providers their usual and customary charge.¹⁴ The only stipulation was that costs and charges be “reasonable and necessary.”¹⁵ These payment methods, which gave control of payment amounts with providers, generated inflation in Medicare program expenditures. Expenditures grew from 7.5 billion dollars in 1970 to an estimated 572.9 billion dollars in 2010. In 2013, Medicare program costs were about 500 billion dollars or roughly 14 percent of the federal budget.¹⁶

A. The Medicare Program as Benefit Program

Congress designed the Medicare program as a benefit program and located the program in the Social Security system. Historically, federal benefit programs provide funds for certain categories of people to achieve social goals.¹⁷ The federal government defines “assistance” or “benefits” as follows:

“Assistance” or “benefits” refers to the transfer of money, property, services, or anything of value, the principal purpose of which is to accomplish a public purpose of support or stimulation authorized by Federal statute. Assistance includes, but is not limited to grants, loans, loan guarantees, scholarships, mortgage loans, insurance, and other types of financial assistance, including cooperative agreements; property, technical assistance, counseling, statistical, and other expert information; and service activities of regulatory agencies. It does not include the provision of conventional public information services.¹⁸

The Medicare program falls within this definition of a “benefit” or “assistance.” Medicare is essentially “insurance,” a product included in the definitional list.

Given that the Medicare program was essentially a benefit program, the architects of the Medicare program in 1965 were not inclined to open up administrative processes for Medicare beneficiaries and particularly Medicare providers, suppliers and other contractors to challenge decisions and policies of the Medicare program. Because Medicare was a benefit program, as discussed in Part III.A, they were not required to do so under the procedural due process

14. Social Security Amendments of 1965, Pub. L. No. 89-97, § 102(a), 79 Stat. 286, 291 (codified as amended at 42 U.S.C. §§ 1395(f)(b), 1395x(v), 1395l(a) (2012)).

15. *Id.* § 1862 (codified as amended at 42 U.S.C. § 1395y(a)(1) (2012)).

16. *Id.*

17. See JERRY L. MASHAW, CREATING THE ADMINISTRATIVE CONSTITUTION: THE LOST ONE HUNDRED YEARS OF AMERICAN ADMINISTRATIVE LAW (2012).

18. CFDA Overview, CATALOGUE OF FED. DOMESTIC ASSISTANCE, <https://www.cfda.gov/?s=generalinfo&mode=list&tab=list> (last visited Nov. 17, 2014).

jurisprudence at the time.¹⁹

However, there is one major distinction between Medicare and other programs that provide health care items or services and many other federal benefit programs. Specifically, Medicare must purchase covered items or services from independent vendors whereas other benefit programs generally distribute cash to program beneficiaries. This fact, as discussed below, means that Medicare eventually had to become a procurement program and finally a regulatory program. Because of the inflationary costs and charges presented by providers and suppliers for compensation, the Medicare program had to resort to rate regulation to control Medicare expenditures.²⁰

B. The Medicare Program as Procurement Program

Medicare had to become a procurement program and face all the problems exhibited in procurement programs—profit-seeking and/or fraudulent vendors and cost and volume inflation. Today, there are more recoveries under President Lincoln’s False Claims Act²¹ for the Medicare and Medicaid programs than government procurement for the defense department. In 2013, recoveries for health care fraud were \$2.6 billion compared to procurement fraud (related primarily to defense contracts) of \$890 million.²² In his satirical account of the Medicare program, David Hyman explains the process:

Congress initially failed to appreciate how avarice would affect the Medicare program. When Medicare was enacted in 1965, a single provision prohibited making false statements to secure reimbursement. Matters did not remain in this pristine form for long, as the Medicare honeypot quickly attracted the more feloniously inclined members of the profession. In relatively short order, there developed a complicated interlocking array of health care-specific civil, criminal, and administrative anti-fraud laws and regulations enacted by the states and the federal government, along with multiple levels of investigative and enforcement agencies.²³

The only anti-fraud provision pertaining to the Medicare program was in the Social Security Act of 1935 prohibiting false statements in connection with seeking

19. See *infra* notes 33-48 and accompanying text.

20. See *infra* notes 131-39 and accompanying text.

21. False Claims Act, ch. 67, 12 Stat. 696 (1863) (codified as amended at 31 U.S.C. §§ 3729-33 (2012)).

22. Office of Pub. Affairs, *Press Release: Justice Department Recovers \$3.8 Billion from False Claims Act Cases in Fiscal Year 2013*, U.S. DEP’T JUSTICE (Dec. 20, 2013), <http://www.justice.gov/opa/pr/justice-department-recovers-38-billion-false-claims-act-cases-fiscal-year-2013>.

23. DAVID HYMAN, *MEDICARE MEETS MEPHISTOPHELES* 31 (2005).

reimbursement for services.²⁴ In the Social Security Amendment of 1972, Congress established tougher authorities for punishing fraudulent acts and false statements, the first of many statutes to enhance Medicare fraud and abuse enforcement.²⁵ Providers and suppliers disciplined for fraud and abuse infractions have rights to administrative and judicial review before the Civil Remedies Division of the HHS Department Appeals Board (DAB).²⁶

In 1997, Congress accorded HHS Inspector General (OIG) authority to issue advisory opinions about the application of OIG's fraud and abuse authorities to a requesting party's existing or proposed business arrangement.²⁷ Advisory opinions are widely used in regulatory agencies to facilitate compliance. With this authority, OIG can behave much like other procurement agencies that give guidance to vendors and other regulated parties about the legality of their proposed transactions.

The OIG, established in 1976,²⁸ has not experienced the difficulties with administrative law that CMS and previously Health Care Financing Administration (HCFA) have. A major reason for this phenomenon is because OIG was established with an exceptionally clear purpose: to conduct audits and investigations of department programs as an independent unit within HHS.²⁹

24. Social Security Act of 1935, Pub. L. No. 74-271, § 209, 49 Stat. 620, 625. The provision stated: "Whoever in any application for any payment under this title makes any false statement as to any material fact, knowing such statement to be false, shall be fined not more than \$1,000 or imprisoned for not more than one year, or both." *Id.*

25. Social Security Amendments of 1972, Pub. L. No. 92-602, § 242, 86 Stat. 1329, 1419 (codified as amended at 42 U.S.C. § 1395ii (2012)).

26. *The Civil Remedies Division*, U.S. DEP'T HEALTH & HUM. SERVS., <http://www.hhs.gov/dab/divisions/civil/> (last visited Nov. 17, 2014).

27. Health Insurance Portability and Accountability Act (HIPAA) of 1996, Pub. L. No. 104-191, § 205, 110 Stat. 1936, 2000 (codified as amended at 42 U.S.C. § 1320a-7d (2012)).

28. HEW Inspector General Act of 1976, Pub. L. No. 94-505, §§ 201-207, 90 Stat. 2429, 2429-34, *repealed by* Inspector General Amendments of 1988, Pub. L. No. 100-504, §102(e)(2), 102 Stat. 2515, 2517. The functions of the HEW Inspector General were transferred by the Inspector General Act of 1978, Pub. L. No. 95-452, 92 Stat. 1101; *see* James R. Naughton, *The Origin and Implementation of the Inspector General Act*, 47 GOV. ACCT. J. 12 (1998); Genevieve Nowolinski, *A Brief History of the HHS Office of Inspector General*, U.S. DEP'T HEALTH & HUM. SERVS. (2001), <http://www.kinneyassoc.com/MedEdHistory/historyhhoig.pdf>.

29. The original statute creating the OIG for HEW provided:

In order to create an independent and objective unit--

- (1) to conduct and supervise audits and investigations relating to programs and operations of the Department of Health, Education, and Welfare;
- (2) to provide leadership and coordination and recommend policies for activities designed (A) to promote economy and efficiency in the administration of, and (B) to prevent and detect fraud and abuse in, such programs and operations; and
- (3) provide a means for keeping the Secretary and the Congress fully and currently informed about problems and deficiencies relating to the administration of such programs and operations and the necessity for and progress of corrective action;

Consequently, the Medicare program's experience with fraud and abuse control will not be discussed further in this article.

C. The Medicare Program as Regulatory Program

Congress did not intend for Medicare to regulate the American health care sector. Medicare was intended to behave like any other federal benefit program and simply pay claims on a retrospective basis. Indeed, the first section of the Medicare statute states:

Nothing in this subchapter shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or manner in which medical services are provided, or over the selection, tenure, or compensation of any officer or employee of any institution, agency, or person providing health services; or to exercise any supervision or control over the administration or operation of any such institution, agency, or person.³⁰

However, as Medicare responded to escalating costs, the program transformed from a passive distributor of benefits to a major regulator of the health care sector. In the Social Security Amendments of 1972, Congress enacted several regulatory programs to reduce costs.³¹ These programs included limits on payment of institutional provider costs,³² limits on physician charges,³³ limits on payments for unapproved capital expenditures,³⁴ and establishment of professional standards review organizations for utilization review of hospital care.³⁵

Throughout this transformation, and with the mindset of a benefits program, Medicare policy-makers wrestled with associated administrative law issues with a poor sense of how administrative law functions in a regulatory context. The result of their deliberations was the development of unanticipated and often unique procedures for making rules and policy, enforcing regulatory requirements and adjudicating disputes.

II. THE EVOLUTION OF MEDICARE ADMINISTRATIVE LAW

To understand the accidental nature of the administrative law of the Medicare, a historical analysis is appropriate. The original Medicare program was quite

there is hereby established in the Department of Health, Education, and Welfare an Office of Inspector General.

HEW Inspector General Act of 1976 § 201 (codified as amended 42 U.S.C. § 3521 (2012)).

30. 42 U.S.C. § 1395 (2012).

31. Social Security Amendments of 1972, Pub. L. No. 92-602, 86 Stat. 1329 (codified as amended in scattered sections of 42 U.S.C.).

32. *Id.* § 223 (codified as amended at 42 U.S.C. § 1395x(v)(1) (2012)).

33. *Id.* § 224 (codified as amended at 42 U.S.C. § 1395u(b) (2012)).

34. *Id.* § 221 (codified as amended at 42 U.S.C. § 1301 (2012)).

35. *Id.* § 249F (codified as amended at 42 U.S.C. § 1320c (2012)).

different than the Medicare program today. Further, the development of the Medicare program coincided with major changes in federal administrative law in the postwar period.

A. Administrative Law Provisions in the Social Security Amendments of 1965

In 1946, to clarify agency procedure that had grown idiosyncratically during the New Deal and World War II, Congress enacted the Administrative Procedure Act.³⁶ The Administrative Procedure Act targeted regulatory programs that affected parties' life, liberty and property. At the time, administrative law did not recognize government benefits as property subject to constitutional protection.

The Administrative Procedure Act provided that rules for government benefits need not be made pursuant to section 553 rule-making procedures.³⁷ Following a recommendation of the Administrative Conference of the United States,³⁸ HEW agreed to use notice-and-comment rulemaking when promulgating a legislative-type rule for its programs.³⁹ However, this exemption is still technically in effect. Further, the federal Administrative Procedure Act of 1946 contained only formal, trial-type adjudication procedures only for disputes over recognized property and liberty rights.⁴⁰

During the 1950s and early 1960s, in large part due to a reaction to the activities of Senator Joe McCarthy and the House Un-American Activities Committee, legal scholars and advocates, as well as the Supreme Court of the United States,⁴¹ were reexamining the jurisprudence of the procedural due process doctrine.⁴² In 1964, Yale law professor Charles A. Reich articulated a new conception of government largess as protected property under the Due Process Clause of the Fifth Amendment.⁴³

The Supreme Court eventually adopted this conception of property in its 1970

36. Administrative Procedure Act (APA), Pub. L. No. 79-404, 60 Stat. 237 (1946) (codified as amended in scattered sections of 5 U.S.C.).

37. *Id.* § 4.

38. § 305.69-8 Elimination of Certain Exemptions from the APA Rulemaking Requirements, 38 Fed. Reg. 19,784-85 (July 23, 1973).

39. Public Participation in Rulemaking, 36 Fed. Reg. 2532 (Feb. 5, 1971).

40. *See id.* § 5.

41. *See, e.g.,* Cafeteria and Restaurant Workers Union, Local 473 v. McElroy, 367 U.S. 886 (1961); Barsky v. Bd. of Regents, 347 U.S. 442 (1954); Joint Anti-Fascist Refugee Comm. v. McGrath, 341 U.S. 123 (1951).

42. *See* STUART BANNER, AMERICAN PROPERTY (2011); Elizabeth Bussiere, *The "New Property" Theory of Welfare Rights: Promises and Pitfalls*, 13 GOOD SOC'Y 1 (2004); Robert J. Harris, *The Impact of the Cold War upon Civil Liberties*, 18 J. POL. 3 (1956).

43. Charles A. Reich, *Individual Rights and Social Welfare: The Emerging Legal Issues*, 74 YALE L.J. 1245 (1965); Charles A. Reich, *The New Property*, 73 YALE L.J. 733 (1964).

decision, *Goldberg v. Kelly*.⁴⁴ In *Goldberg*, the Court recognized welfare government benefits as protected property and even quoted Reich's article in footnote 8 of the decision: "It may be realistic today to regard welfare entitlements as more like 'property' than a 'gratuity.'"⁴⁵

Goldberg represented the high water mark in procedural due process protections accorded to individuals with grievances over prospective government action.⁴⁶ The Supreme Court later moved away from requiring a pre-termination evidentiary hearing in benefits cases.⁴⁷ Over the years, procedural due process rights have been diluted further.⁴⁸

However, in the early 1970s, *Goldberg v. Kelly* signaled a constitutional preference for evidentiary hearings where procedural due process was implicated. Thus, as Congress added appeals procedures for providers with the establishment of the Provider Reimbursement Review Board, it adopted trial-type procedures for institutional provider payment disputes.⁴⁹ Similarly, when Congress reestablished administrative and judicial review in 1986 for beneficiaries and their professional providers and suppliers under Part B of the Medicare program, it adopted the model of evidentiary hearings for these appeals.⁵⁰

At the time that Congress enacted the Social Security Amendments of 1965, *Goldberg v. Kelly*, and thus the notion that procedural due process rights should be granted for disputes over federal benefits, was in the distance. The Medicare statute only provided for appeals of Medicare beneficiaries under section 1869 of the Social Security Amendments of 1965,⁵¹ and the contractors that administered the program on behalf of HEW.⁵²

44. 397 U.S. 254 (1970).

45. 397 U.S. at 262, n.8 (citing Charles Reich, *Individual Rights and Social Welfare*, *supra* note 43, at 1255).

46. William Van Alstyne, "Cracks in the New Property": *Adjudicative Due Process in the Administrative State*, 62 CORNELL L. REV. 445 (1977); Henry J. Friendly, *Some Kind of Hearing*, 123 U. PA. L. REV. 1267 (1975).

47. See *Cleveland Bd. of Education v. Loudermill*, 470 U.S. 532 (1985); *Mathews v. Eldridge*, 424 U.S. 319 (1976).

48. See Richard J. Pierce, Jr., *The Due Process Counterrevolution of the 1990s?*, 96 COLUM. L. REV. 1973 (1996); Sidney A. Shapiro & Richard E. Levy, *Government Benefits and the Rule of Law: Toward a Standards-Based Theory of Due Process*, 57 ADMIN. L. REV. 107 (2005).

49. Social Security Amendments of 1972, Pub. L. No. 92-602, § 243(a), 86 Stat. 1329, 1420-22 (codified as amended at 42 U.S.C. § 1395oo (2012)).

50. Omnibus Budget Reconciliation Act of 1986, Pub. L. No. 99-509, § 9341(a), 100 Stat. 1874, 2037-38, (codified as amended at 42 U.S.C. § 1395ff(b) (2012)).

51. Social Security Amendments of 1965, Pub. L. No. 89-97, § 1869, 79 Stat. 286, 33 (codified as amended at 42 U.S.C. § 405 (2012)).

52. Section 1869 provided:

(a) The determination of whether an individual is entitled to benefits under part A or part B, and the determination of the amount of benefits under part A, shall be made by the Secretary in accordance with regulations prescribed by him.

Further, there was no requirement upon HEW, in managing Medicare benefits, to engage in rulemaking procedures to promulgate effective rules under the Administrative Procedures Act. Specifically, section 553(a)(2) of the Administrative Procedure Act exempts rules from rulemaking procedures that pertain to “a matter relating to agency management or personnel or to public property, loans, grants, benefits, or contracts.”⁵³ In 1972, the Administrative Conference of the United States (ACUS) recommended elimination of this exemption.⁵⁴ In a 1972 notice, HEW agreed to follow the ACUS recommendation and use notice-and-comment rulemaking when promulgating a legislative-type rule for its programs.⁵⁵ However, CMS is technically not bound to this commitment.

The Social Security Amendments of 1965 contained three provisions pertaining to administrative law issues. One section addressed the administration of the Medicare program.⁵⁶ Another two-sentence section authorized the promulgation of regulations.⁵⁷ A third section authorized appeals of decisions on

(b) Any individual dissatisfied with any determination under subsection (a) as to entitlement under part A or part B, or as to amount of benefits under part A where the matter in controversy is \$100 or more, shall be entitled to a hearing thereon by the Secretary to the same extent as is provided in section 205(b), and, in the case of a determination as to entitlement or as to amount of benefits where the amount in controversy is \$1,000 or more, to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g).

(c) Any institution or agency dissatisfied with any determination by the Secretary that it is not a provider of services, or with any determination described in section 1866(b)(2), shall be entitled to a hearing thereon by the Secretary (after reasonable notice and opportunity for hearing) to the same extent as is provided in section 205(b), and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g).

Id. § 1869 (codified as amended at 42 U.S.C. § 1395ff (2012)).

53. 5 U.S.C. § 553(a)(2) (2012).

54. Elimination of Certain Exemptions from the APA Rulemaking Requirements, ACUS Recommendation No. 69-8, 38 Federal Register 19784 (July 23, 1973).

55. Public Participation in Rulemaking, HEW Notice, 36 Federal Register 2532 (Feb. 5, 1971).

56. Section 1874, Administration, provided:

(a) Except as otherwise provided in this title, the insurance programs established by this title shall be administered by the Secretary. The Secretary may perform any of his functions under this title directly, or by contract providing for payment in advance or by way of reimbursement, and in such installments, as the Secretary may deem necessary.

(b) The Secretary may contract with any person, agency, or institution to secure on a reimbursable basis such special data, actuarial information, and other information as may be necessary in the carrying out of his functions under this title.

Id. § 1874 (codified as amended at 42 U.S.C. § 1395kk (2012)).

57. Section 1871 provided authority for the promulgation of regulations: “The Secretary shall prescribe such regulations as may be necessary to carry out the administration of the insurance programs under this title. When used in this title, the term ‘regulations’ means, unless the context

claims under the Social Security Act.⁵⁸

B. Rule and Policy-Making under the Medicare Program in the Twentieth Century

The evolution of Medicare rule and policy-making process is convoluted. In the early years of the Medicare program, policy-making was quite informal and decentralized. For example, the original policy on hospital payment was based on principles of cost reimbursement from the American Hospital Association (AHA) and Blue Cross and Blue Shield Association.⁵⁹ The local contractor administering the Medicare program made coverage and other program policy.

In its early years, HCFA would often issue major policy with little notice in inaccessible manuals and other guidance documents. In the mid-1980s, Congress enacted stricter requirements for promulgating substantive Medicare policy.⁶⁰ In later years, CMS promulgated interim final rules that have immediate effect with an opportunity to comment. In the Medicare Modernization Act, Congress imposed a timeline and process through which interim final regulations would convert to final rules or become invalid.⁶¹

1. Medicare Coverage Policy-Making

In the early 1980s, HCFA realized that Medicare was paying for heart transplants in some states but not in others, and thus issued a ruling denying coverage of heart transplants on a national basis.⁶² It later issued a new ruling covering heart transplants.⁶³ Initially, the Medicare contractors handling claims on a state-wide basis were to make local coverage decisions and did so for the first

otherwise requires, regulations prescribed by the Secretary.” *Id.* § 1871 (codified as amended at 42 U.S.C. § 1395hh (2012)).

58. Social Security Amendments of 1965, Pub. L. No. 89-97, § 1869, 79 Stat. 286, 330 (codified as amended at 42 U.S.C. § 1395ff (2012)). See *supra* note 51.

59. See JUDITH M. FEDER, *MEDICARE: THE POLITICS OF FEDERAL HOSPITAL INSURANCE* 54-80 (1977); SYLVIA A. LAW, *BLUE CROSS: WHAT WENT WRONG?* 59-65 (2d ed. 1976); HERMAN M. SOMERS & ANNE R. SOMERS, *MEDICARE AND THE HOSPITALS* 154-58 (1967).

60. Omnibus Budget Reconciliation Act of 1987, Pub. L. No. 100-203, §4035(b)-(c), 101 Stat. 1330, 1330-78 (codified as amended at § 1395hh(a)(2)-hh(c) (2012)).

61. Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003, Pub. L. No. 108-173, § 902, 117 Stat. 2066, 2375 (codified as amended at 42 U.S.C. § 1395hh(a) (2012)); see Timothy S. Jost, *The Most Important Health Care Legislation of the Millennium (So Far): The Medicare Modernization Act*, 5 YALE J. HEALTH POL’Y, L. & ETHICS 437, 437-49 (2005).

62. Exclusion of Heart Transplantation Procedures from Medicare Coverage, 45 Fed. Reg. 52,296 (Aug. 6, 1980); see Ward Casscells, *Heart Transplantation: Recent Policy Developments*, 315 NEW ENG. J. MED. 1365 (1986).

63. Criteria for Medicare Coverage of Heart Transplants, 52 Fed. Reg. 10,933, 10,935 (Apr. 6, 1987) (notice of administrative ruling); see Gregory de Lissovoy, *Medicare and Heart Transplants: Will Lightning Strike Twice?*, 7 HEALTH AFF. 61 (1988).

fifteen years of the Medicare program.

However, with the heart transplant controversy and the burgeoning advances in medical technology, coverage of expensive new technologies surfaced as an important issue for Medicare policy makers. This was spurred in part by the Medicare program's infusion of money into the health care sector. The medical device industry was very interested in Medicare coverage policy-making, especially because, as of 1976, manufacturers had to get the approval of the Food and Drug Administration under the Medical Device Amendments of 1976 in order to market their products in the United States.⁶⁴

In the early 1980s, a committee of physicians who worked for HCFA made national coverage decisions in a stunningly secretive process that purposely excluded any participation or input from vitally interested medical device manufacturers. HCFA justified its secretive process by saying that HCFA has no obligation to medical device manufacturers to let them participate in the coverage decision-making process.⁶⁵ Their obligation was strictly to Medicare beneficiaries. In *TAP Pharmaceuticals v. U.S. Department of Health and Human Services*,⁶⁶ the United States Court of Appeals for the Fourth Circuit affirmed a lower court ruling that a pharmaceutical manufacturer challenging a Medicare policy regarding the price of a drug did not fall within the "zone of interests" protected by the Medicare statute.⁶⁷ This decision on standing reinforced the Medicare program's conception of itself as answerable primarily to Medicare beneficiaries.

In the 1980s, the Administrative Conference of the United States⁶⁸ and the American Bar Association,⁶⁹ among others, called for more regularity and transparency in Medicare coverage policy and decision-making processes. As part of a settlement of a lawsuit,⁷⁰ HCFA developed public procedures for making coverage policy but the effort was derailed over a proposed criterion of cost effectiveness.⁷¹ Indeed, neither HCFA nor CMS has promulgated a final rule due

64. Medical Device Amendments (MDA) of 1976, Pub. L. No. 94-295, 90 Stat. 539 (codified as amended at 21 U.S.C. § 301 (2012)).

65. See Darrel J. Grinstead, *Evolution of the Medicare Coverage Policy-Making Process*, in GUIDE TO MEDICARE COVERAGE DECISION-MAKING AND APPEALS 1, 6 (Eleanor D. Kinney ed., 2002).

66. 163 F.3d 199 (4th Cir. 1998).

67. *Id.* at 200.

68. Recommendation 87-8, National Coverage Determinations Under the Medicare Program, 1 C.F.R. § 305.87-8 (1987); Recommendation 86-5, Medicare Appeals, 1 C.F.R. § 305.86-5 (1986).

69. AM. BAR ASS'N, RECOMMENDATIONS ON MEDICARE PROCEDURES BY THE ABA HOUSE OF DELEGATES (Aug. 1988).

70. *Jameson v. Bowen*, No. CV-F-8-547, 1987 WL 108970 (E.D. Cal. Feb. 20, 1987).

71. Criteria and Procedures for Making Medical Services Coverage Decisions That Relate to Health Care Technology, 54 Fed. Reg. 4302 (Jan. 30, 1989) (to be codified at 42 C.F.R. pts. 400, 405); see Procedures for Medical Services Coverage Decisions; Request for Comments, 52 Fed. Reg. 15,560 (Apr. 29, 1987).

to the opposition of medical device industry over cost effectiveness.⁷²

HCFA did establish an internal policy-making process with its Technical Advisory Committee, comprised of medical directors from Medicare contractors and representatives of other interested federal agencies.⁷³ In 1998, the U.S. General Accounting Office (GAO) found that the Technical Advisory Committee violated the Federal Advisory Committee Act.⁷⁴ In response to this report, HCFA agreed to reformulate the committee's composition of only federal officials and develop a new compliant advisory committee in the future. The GAO agreed to this approach.⁷⁵

The medical device industry was completely frustrated with the coverage policy and decision-making process. The medical device industry is huge and economically important. To illustrate, 70 percent of all surgeries in the U.S. involve an implant, which is a medical device, and these implants account for up to 70 percent of the total cost of surgical care.⁷⁶ An industry this large and so dependent on Medicare reimbursement for its success was clearly going to marshal the lobbying effort to crack open an essentially secret process for regulatory decision-making.

In 1999, attorneys for the Indiana Medical Device Manufacturers Council petitioned HCFA for a rule to establish a transparent coverage decision-making process.⁷⁷ The petition and other lobbying efforts resulted in congressional hearings,⁷⁸ and subsequent legislative reforms. CMS did issue a notice establishing a process for making national coverage decisions.⁷⁹ However, it generally stated

72. See Susan B. Foote, *Why Medicare Cannot Promulgate a National Coverage Rule: A Case of Regula Mortis*, 27 J. HEALTH POL. POL'Y & L. 707 (2002); Sean R. Tunis, *Why Medicare Has Not Established Criteria for Coverage Decisions*, 350 NEW ENG. J. MED. 2196 (2004).

73. *Issues Relating to Medicare's Coverage Policy: Hearing Before the Health Subcomm. of the H. Comm. on Ways and Means*, 105th Cong. 12 (1997) (statement of Hon. Bruce C. Vladeck, Administrator, Health Care Financing Administration); see Grinstead, *supra* note 65, at 14.

74. *Advisory Committee Act: Violation by the Health Care Financing Administration*, U.S. GEN. ACCT. OFF. 1-2 (1998), <http://www.gao.gov/decisions/archive/278940.pdf>.

75. Letter from Barry R. Bedrick, Assoc. Gen. Counsel, U.S. Gen. Accounting Office, to Hon. Bill Thomas, Chairman, Subcomm. on Health, Comm. on Ways and Means, on the Advisory Committee Act: Violation by Health Care Financing Administration (Jan. 13, 1998), <http://www.gao.gov/decisions/archive/278940.pdf>.

76. Prakash Patel, *A Disrupted Landscape: The New Medical Device Industry*, BECKER'S HOSP. REV. (Oct. 16, 2013), <http://www.beckershospitalreview.com/news-analysis/a-disrupted-landscape-the-new-medical-device-industry.html>.

77. Citizen's Petition from Bradley Merrill Thompson, Baker & Daniels, to Nancy-Ann Min DeParle, Adm'r, Health Care Fin. Admin. (Mar. 4, 1998) (on file with author).

78. *The Medicare Coverage Decisions and Beneficiary Appeals: Hearings Before the Subcomm. on Health of the H. Comm. on Ways and Means*, 106th Cong. 21-128 (1999); *Patient Appeals in Health Care: Hearing Before the Subcomm. on Health of the H. Comm. on Ways and Means*, 105th Cong. 4-76 (1998).

79. Medicare Program; Procedures for Making National Coverage Decisions, 64 Federal Register 22,619 (Apr. 27, 1999).

HCFA's commitment to provide notice of its activities regarding national coverage determinations but offered little with respect to active participation in the process. The notice did not satisfy manufacturers who continued to press for reforms.

In 2000, a Republican Congress established statutory Medicare coverage policy and decision-making procedures.⁸⁰ These requirements intended to make the coverage policy-making process more transparent to device manufacturers and other interested parties. In the MMA of 2003, Congress made major changes, including stricter deadlines for the national coverage policy-making process.⁸¹

The history of coverage policy-making is exemplary of HCFA's not understanding itself as a regulatory program. CMS did not appreciate the interests of device manufacturers and perceived its only obligation in the coverage decision-making process as protecting beneficiaries from unreasonable, unnecessary and unduly costly health care services. At every turn in the development of the Medicare coverage decision-making and appeals processes during the last century, CMS resisted opening the processes in any way to accommodate the interest of medical device manufacturers.

In recent years, CMS has become much more open in its coverage policy-making process and today, coverage policy-making is far more collaborative. CMS publishes its deliberations on a public website,⁸² and the statutory policy process accords multiple opportunities for input and participation of stakeholders.

2. Medicare Payment Policy-Making

Over time, cost containment became more and more imperative as Medicare expenditures escalated. Congress enacted numerous payment reforms that were increasingly regulatory in scope and intensity. In the Social Security Amendments of 1972, Congress also authorized HEW to conduct demonstrations of different ways Medicare could pay for inpatient hospital and skilled nursing care services.⁸³ Developed at Yale University,⁸⁴ and tested in New Jersey,⁸⁵ HCFA developed a

80. Consolidated Appropriations – FY 2001, Pub. L. No. 106-554, § 522(a), 114 Stat. 2763, 2763H-72 to -85 (2000) (codified as amended at 42 U.S.C. § 1395y(a) (2012)).

81. Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003, Pub. L. No. 108-173, § 731(a)(1), 117 Stat. 2066, 2349 (codified as amended at 42 U.S.C. § 1395y (2012)).

82. *Medicare Coverage Center*, CTRS. FOR MEDICARE & MEDICAID SERVS., <http://www.cms.gov/Center/Special-Topic/Medicare-Coverage-Center.html> (last visited Nov. 17, 2014).

83. Social Security Amendments of 1972, Pub. L. No. 92-602, § 222, 86 Stat. 1329, 1390 (codified as amended at 42 U.S.C. § 1395b-1 note (2012)).

84. John D. Thompson, *The History of the Development of DRGs, in COMPELLED BY DATA: JOHN D. THOMPSON—NURSE, HEALTH SERVICES RESEARCHER AND HEALTH ADMINISTRATION EDUCATOR 71* (William D. White ed., 2003).

85. William C. Hsiao et al., *Lessons of the New Jersey DRG Payment System*, 5 HEALTH AFF. 32 (1986).

new prospective payment system for inpatient hospitals based on Diagnosis Related Groups (DRGs). DRGs are units of a classification system that group similar clinical conditions and resources furnished by the hospital during a patient's stay.⁸⁶

Following the HHS proposal for a prospective payment system based on DRGs,⁸⁷ Congress adopted the prospective payment system for acute care inpatient hospitals in the spring of 1983.⁸⁸ Under this payment system, the Medicare program pays acute care hospitals a fixed price, adjusted for geographic and wage cost differences, for each Medicare case based on the DRG in which the patient's particular condition falls.⁸⁹

In 1989, Congress enacted a revised payment system for physician services that paid physicians based on the time and resources involved in treating specific conditions.⁹⁰ Congress enhanced the system in 1990.⁹¹ Congress replaced the charge-based fee schedule with the Resource Based Relative Value Scale (RBRVS). The RBRVS is based on relative value units (RVUs) for three cost components of medical care—physicians' work effort, physicians' practice expenses, and malpractice liability insurance expenses.

Historically, HCFA was not transparent in promulgating payment policy. One reason for this lack of transparency was that, ostensibly, the insurance companies that administered the Medicare program pursuant to contract made payment policy on a local basis. To address the lack of transparency in payment policy-making, Congress required HCFA to publish and make available manual provisions and other guidance every three months.⁹² HCFA also applied rules retroactively and inappropriately, according to the Supreme Court.⁹³

In adopting the inpatient hospital prospective payment system, Congress was concerned about HCFA overreaching in setting payment rates. The AHA urged

86. Ctrs. for Medicare & Medicaid Servs., *Acute Care Hospital Inpatient Prospective Payment System*, U.S. DEP'T HEALTH & HUM. SERVS. (2013), <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/AcutePaymntSysfctsht.pdf>; *Acute Inpatient PPS*, CTRS. FOR MEDICARE & MEDICAID SERVS., <https://www.cms.gov/AcuteInpatientPPS> (last visited Nov. 17, 2014).

87. *Hospital Prospective Payment for Medicare: Report to Congress Required by the Tax Equity And Fiscal Responsibility Act of 1982*, U.S. DEP'T HEALTH & HUM. SERVS. (1982). https://archive.org/stream/reporttocongress00schw/reporttocongress00schw_djvu.txt.

88. Social Security Amendments of 1983, Pub. L. No. 98-21, § 601(c)(1), 97 Stat. 65, 150 (codified as amended at 42 U.S.C. § 1395ww (2012)).

89. 42 U.S.C. § 1395ww(d)(1) (2012); Prospective Payments for Medicare Inpatient Hospital Services, 48 Fed. Reg. 39,752 (Sept. 2, 1983).

90. Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, § 6202, 103 Stat. 2106, 2234 (codified as amended at 42 U.S.C. § 1395u(b) (2012)).

91. Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, §§ 4101-12, 104 Stat. 1388-54 to -68 (codified as amended at 42 U.S.C. § 1395u(b) (2012)).

92. 42 U.S.C. § 1395hh(b) (2012).

93. See *Bowen v. Georgetown Univ. Hosp.*, 488 U.S. 204 (1988).

that outside experts should participate in updating payment rates.⁹⁴ Congress created the Prospective Payment Assessment Commission as a congressional commission to oversee the rate setting process.⁹⁵ In 1986, Congress established another comparable commission to oversee the new physician payment system.⁹⁶ In 1997, Congress consolidated the two commissions into the Medicare Payment Advisory Commission (MedPAC) an independent Congressional agency.⁹⁷ Like its predecessors, the MedPAC is comprised of experts in the financing and delivery of health care services from the fields of economics, health policy, public health, and medicine. The commission advises Congress on all payments to all providers and health plans.⁹⁸

C. Adjudication under the Medicare Program in the Twentieth Century

The managers of the Medicare program, as benefit program managers, downplayed appeal procedures. Indeed, as discussed above, in 1965, there was no legal requirement to have appeal procedures because the Supreme Court had yet to rule that government benefits were constitutionally protected property interests.⁹⁹

1. Beneficiary Appeals

The original statute provided appeal procedures for Medicare beneficiaries under the Social Security Act.¹⁰⁰ When the Medicare Advantage program and voluntary prescription drug benefit were enacted, Congress established grievance procedures for these programs. All Medicare Advantage plans must have “meaningful procedures” to adjudicate beneficiary complaints with the health plan.¹⁰¹ For prescription drugs offered through Medicare Advantage plans, beneficiaries appeal disputes over drug cost and coverage to the plan’s appeal

94. *Hearings on the Hospital Prospective Payment System Before the Subcomm. On Health of the S. Comm. on Finance, Part I*, 98th Cong. 128, 135 (1983) (statement of J. Alexander McMahon, President, American Hospital Association).

95. Social Security Amendments of 1983, Pub. L. No. 98-21, § 601(e), 97 Stat. 65, 152-53 (codified as amended at 42 U.S.C. § 1395ww(e)(2) (2012)); Eleanor D. Kinney, *Making Hard Choices Under the Medicare Prospective Payment System: One Administrative Model for Allocating Medical Resources Under a Government Health Insurance Program*, 19 IND. L. REV. 1151 (1986).

96. Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, § 9305, 100 Stat. 82, 190 (codified as amended at 42 U.S.C. § 1395w-1 (2012)).

97. Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4022, 111 Stat. 251, 350 (codified as amended at 42 U.S.C. § 1395b-6 (2012)).

98. MEDPAC, <http://www.medpac.gov/about-medpac/> (last visited Dec. 14, 2014).

99. See *supra* notes 43-44.

100. Social Security Amendments of 1965, Pub. L. No. 89-97, § 1869, 79 Stat. 286, 330 (codified as amended at 42 U.S.C. § 1395ff (2012)).

101. 42 U.S.C. §§ 1395w-22(f)-(g) (2012).

process.¹⁰² Prescription drug plans must have a similar appeals process with comparable steps, timetables, and other characteristics for their fee-for-service Medicare beneficiaries.

In 1972, due to a high volume of appeals over physician services, Congress precluded administrative and judicial review for these disputes.¹⁰³ However, as physician services became more complex and more procedures were performed on an outpatient basis, Medicare beneficiaries, physicians, and other outpatient providers called for the establishment of administrative and judicial review for appeals under the Medicare Program.¹⁰⁴ In 1986, Congress expanded appeal rights for Medicare beneficiaries and established administrative and judicial review of Part B claims above a specified monetary level.¹⁰⁵

Also in 1986, pursuant to HCFA's request, Congress imposed significant limitations on judicial review of national coverage determinations.¹⁰⁶ Specifically, these limitations precluded judicial review of Medicare's national coverage determinations and procedural challenges to Medicare policy for failure to comply with Administrative Procedure Act rulemaking procedures. Further, an administrative law judge (ALJ) cannot review any HHS decision on whether a service or procedure is a covered benefit under the Medicare. Additionally, a reviewing court must remand a disputed coverage policy back to CMS for augmentation of the record before making a final decision on the validity of the policy. Congress justified these limitations on the fact that HCFA specifically solicited input from physicians and occasionally technology assessments in the Medicare coverage policy-making process.¹⁰⁷

Despite these changes, the Part B appeals process continued to be problematic. The Subcommittee on Administrative Law and Government Relations of the House Judiciary Committee held hearings on the appeals process.¹⁰⁸ The U.S. GAO criticized the process as unduly lengthy.¹⁰⁹ In the 1980s and early 1990s, both the Administrative Conference of the United States and the American Bar Association formally expressed concerns and recommended changes in the appeals

102. 42 U.S.C. §§ 1395w-101(f)-(h) (2012).

103. Social Security Amendments of 1972, Pub. L. No. 92-603, § 2990, 86 Stat. 1329, 1464 (codified as amended at 42 U.S.C. § 1395ff (2012)).

104. See, e.g., *Medicare Appeals Provisions: Hearings Before the Subcomm. on Health of the S. Comm. on Finance*, 99th Cong. 270 (1985) (statement of Alan P. Spielman, Executive Director of Government Relations, Blue Cross and Blue Shield Association).

105. Omnibus Budget Reconciliation Act of 1986, Pub. L. No. 99-509, § 9341(a), 100 Stat. 1874, 2037 (codified as amended at 42 U.S.C. § 1395ff(b) (2012)).

106. *Id.*

107. H.R. REP. NO. 99-1012, at 350-51 (1986).

108. *Adjudicatory Procedures of the Department of Health and Human Services: Hearings Before the Subcomm. on Admin. Law and Gov't Relations of the H. Comm. on the Judiciary*, 101st Cong. (1989).

109. *Statistics on the Part B Administrative Law Judge Hearings Process*, U.S. GEN. ACCT. OFF. (1989), <http://gao.gov/assets/220/211946.pdf>.

process.¹¹⁰

In 2000, Congress enacted major changes in the Medicare appeal process, primarily in response to the concerns of medical device manufacturers.¹¹¹ This legislation consolidated the beneficiary appeals processes for Parts A and B and mandated major reforms such as strict deadlines to expedite the process.¹¹² This legislation also established an expedited review process for Medicare coverage determinations for beneficiaries with an immediate need for the service without raising it in the context of a claim.¹¹³ This legislation also established “qualified independent contractors” to conduct reconsiderations of contractors’ initial determinations or redeterminations. These contractors are independent of any existing Medicare contractors that make initial determinations and are comprised of panels of physicians and other health care professionals.¹¹⁴

In the Medicare Modernization Act of 2003, Congress made additional reforms to the Medicare appeals process. Specifically, the act established expedited judicial review for beneficiaries and, remarkably, the beneficiaries’ providers or suppliers. Expedited review may occur when the ALJ or other adjudicator determines that no material facts are in dispute and the HHS Departmental Appeals Board has no authority to decide the question of law or regulation relevant to the matters in controversy.¹¹⁵ This extraordinary provision accommodated the reality that suppliers of new medical devices and providers offering new medical technologies also have important and ongoing interests in disputed coverage issues.

Another problem addressed in the Medicare Modernization Act was the ALJs for Medicare appeals.¹¹⁶ CMS, and previously HCFA, maintained that the Social Security ALJs who heard Medicare appeals were too independent in reversing many determinations and did not appreciate the reality of escalating costs facing the Medicare program. Also, ALJs often disregarded HCFA manuals as well as

110. Recommendation 86-5, *supra* note 68; AM. BAR ASS’N, *supra* note 69.

111. Medicare, Medicaid, and SCHIP Benefits and Improvement Act (BIPA) of 2000, Pub. L. No. 106-554, §§ 521-22, 114 Stat. 2763, 2763A-534 to -547 (codified as amended at 42 U.S.C. §1935ff (2012)); see *Patient Appeals in Health Care: Hearings before the Subcomm. on Health of the H. Comm. on Ways and Means*, 105th Congress (1998).

112. 42 U.S.C. § 1935ff(b)(1)(A) (2012); see Office of Inspector Gen., *Medicare Administrative Appeals: The Potential Impact Of BIPA*, U.S. DEP’T HEALTH & HUM. SERVS. (2002), <http://oig.hhs.gov/oei/reports/oei-04-01-00290.pdf>.

113. 42 U.S.C. §§ 1395ff(f)(4)-(5) (2012); see The National and Local Coverage Determination Review Process for an Individual with Standing as Defined in Section 522 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protections Act of 2000, 66 Fed. Reg. 54,253 (U.S. Dep’t Health & Hum. Servs. Oct. 26, 2001) (notice of ruling).

114. 42 U.S.C. § 1935ff(g) (2012).

115. Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003, Pub. L. No. 108-173, § 932, 117 Stat. 2066, 2399 (codified as amended at 42 U.S.C. § 1395ff (2012)).

116. 42 U.S.C. §§ 1395ff(b)(1)(B)-(C) (2012).

local coverage determinations in their decisions because they were only bound by the law, legislative rules, and HCFA rulings. HCFA sought to create its own corps of administrative judges in an effort to attain perhaps inappropriate control over ALJ decisions.¹¹⁷

The Medicare Modernization Act required the transfer of the functions of ALJs hearing Medicare appeals from the Social Security Administration to HHS.¹¹⁸ The Medicare Modernization Act required that ALJs be located in an office organizationally and functionally separate from CMS that reports directly to the Secretary. The Secretary must also provide for an appropriate geographic distribution of ALJs throughout the U.S. to ensure timely access for beneficiaries. Today, Medicare appeal provisions are consolidated and integrated due to these reforms.¹¹⁹

The history of the Medicare appeals process for beneficiary appeals exhibits a pattern of resistance from HCFA in opening up the appeals process for examination by ALJs and courts. HCFA's attempt to substitute its own ALJs for the Social Security ALJs was somewhat heavy-handed and not in the spirit with administrative law principles such as separation of functions and judicial independence. As a result, Congress has had to step in over the years to reform the appeals process to make it conform to administrative law principles.

2. Provider Appeals

The Social Security Amendments of 1965 contain no provision for providers to appeal any determinations of the Medicare program. Providers objected to the informality of intermediary hearing proceedings and the lack of administrative and judicial review for the intermediary's final payment determination.¹²⁰ In 1972, a federal district court decision ruled that extant intermediary hearing procedures with no appeal to the Secretary violated providers' rights to procedural due process.¹²¹

Responding to these provider concerns and acknowledging that it had overlooked resolving provider disputes when originally designing the Medicare

117. Office of Inspector Gen., *Medicare Administrative Appeals: ALJ Hearing Process*, U.S. DEP'T HEALTH & HUM. SERVS. (Sept. 1999), <https://oig.hhs.gov/oei/reports/oei-04-97-00160.pdf>.

118. Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 § 931 (codified as amended at 42 U.S.C. § 1395ff note (2012)); see Eleanor D. Kinney, *Changes in the Adjudication of Medicare Beneficiary Appeals in the New Medicare Prescription Drug Legislation: Reform or Retreat?*, ADMIN. & REG. L. NEWS, Spring 2004, at 6.

119. See CMS, *Medicare Appeals Process*, U.S. DEP'T HEALTH & HUM. SERVS. (Aug. 2014), <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedicareAppealsprocess.pdf>.

120. See Leonard Homer & Peter Platten, *Medicare Provider Reimbursement Disputes: An Analysis of the Administrative Hearing Procedures*, 63 GEO. L.J. 107, 111 (1974).

121. Coral Gables Convalescent Home, Inc. v. Richardson, 340 F. Supp. 646 (S.D. Fla. 1972).

appeals system,¹²² Congress established the PRRB in the Social Security Amendments of 1972 to adjudicate payment disputes arising between providers and intermediaries.¹²³ All institutional providers paid under Part A can appeal to the PRRB.¹²⁴ Congress also authorized judicial review of PRRB decisions.¹²⁵ Congress has also specified that physicians and other Part B providers can appeal payment determinations if the beneficiary has assigned the claim and agreed to be represented by the provider.¹²⁶

III. A CALAMITY IN MEDICARE ADJUDICATION

Today, the Medicare appeals system is swamped—mostly with provider appeals. One reason for the congestion is the large number of hospital appeals over decisions of contractors regarding Medicare admissions. The Medicare Modernization Act of 2003 established the recovery audit demonstration for the FFS Medicare providers to specifically test the idea of paying Recovery Audit Contractors on a contingency fee basis.¹²⁷ In 2006, Congress established the Medicare fee-for-service recovery audit program nationwide.¹²⁸ Section 6411 of the ACA expanded the recovery audit program to include Parts C and D of the Medicare program and the Medicaid program.¹²⁹ The U.S. GAO estimated that CMS and its recovery audit contractors recovered \$70 billion in improper

122. S. REP. NO. 92-1230, at 248 (1972).

123. Social Security Amendments of 1972, Pub. L. No. 92-603, § 243(a), 86 Stat. 1329, 1420 (codified as amended at 42 U.S.C. § 1395oo (2012)).

124. *Id.*

125. *Id.* (codified as amended at 42 U.S.C. § 1395oo(f) (2012)).

126. 42 U.S.C. § 1395ff(b)(a)(C) (2012).

127. Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003, Pub. L. No. 108-173, § 306, 117 Stat. 2066, 2256; see Ctrs. for Medicare & Medicaid Servs., *The Medicare Recovery Audit Contractor (RAC) Program: An Evaluation of the 3-Year Demonstration*, U.S. DEP'T HEALTH & HUM. SERVS. (2008), <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/recovery-audit-program/downloads/RACEvaluationReport.pdf>.

128. Tax Relief and Health Care Act of 2006, Pub. L. No. 109-432, § 302, 120 Stat. 2922, 2991 (codified as amended 42 U.S.C. § 1395ddd(h) (2012)).

129. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 6411, 124 Stat. 119, 775 (2010) (codified as amended at 42 U.S.C. § 1395ddd(h) (2012)); see Ctrs. for Medicare & Medicaid Servs., *Medicare Claim Review Programs: MR, NCCI Edits, MUEs, CERT, and Recovery Audit Program*, U.S. DEP'T HEALTH & HUM. SERVS. (Jan. 2014), http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MCRP_Booklet.pdf; Abby Pendleton & Jessica L. Gustafson, *The Future of the Recovery Audit Contractor Program*, 7 A.B.A. HEALTH ESOURCE 12 (Aug. 2011), http://www.americanbar.org/newsletter/publications/aba_health_esource_home/aba_health_law_esource_1108_pendleton.html.

Medicare and Medicaid payments in FY 2010.¹³⁰

Recovery Audit Contractors (RACs) have focused extensively on the appropriateness of inpatient hospital admissions versus outpatient “observational” status in an inpatient hospital bed. Hospital admissions, paid for under Part A, cost the Medicare program more than hospital stays on “observational status” paid under Part B with considerable and often unexpected cost-sharing for beneficiaries.¹³¹ Also, three nights in the hospital under observational status do not count toward the requisite three days of inpatient hospitalization for subsequent admission covered to a skilled nursing facility due to the statutory provisions defining the benefit.¹³² In *Bagnall v. Sebelius*, the plaintiff unsuccessfully tried to convince a federal district court that observational status violated the Medicare statute.¹³³ CMS has sought to clarify the rules for distinguishing between observational status and admissions in a rule.¹³⁴

Nevertheless, a consequence of the recovery audit program has been a dramatic increase in the number of provider appeals before the Office of Medicare Hearing and Appeals (OHMA).¹³⁵ In congressional testimony, OMHA’s chief ALJ reported that OMHA would focus only on beneficiary appeals and postpone hearing provider appeals for several years.¹³⁶ Legislators are very concerned about

130. *Fraud Detection Systems: Centers for Medicare and Medicaid Services Need to Ensure More Widespread Use*, U.S. GOV’T ACCT. OFF. (June 2011), <http://www.gao.gov/assets/330/320854.pdf>.

131. See Zhanlian Feng et al., *Sharp Rise in Medicare Enrollees Being Held in Hospitals for Observation Raises Concerns about Causes and Consequences*, 31 HEALTH AFF. 1251 (2012); Mary D. Naylor et al., *Unintended Consequences of Steps to Cut Readmissions and Reform Payment May Threaten Care of Vulnerable Older Adults*, 31 HEALTH AFF. 1623 (2012); see also Office of Inspector Gen., *Hospitals’ Use of Observation Stays and Short Inpatient Stays for Medicare Beneficiaries*, U.S. DEP’T HEALTH & HUM. SERVS. (July 2013), <https://oig.hhs.gov/oei/reports/oei-02-12-00040.pdf>.

132. 42 U.S.C. § 1395d(a) (2012).

133. No. 3:11CV1703, 2013 WL 5346659 (D. Conn. Sept. 23, 2013).

134. Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Fiscal Year 2015 Rates, 78 Fed. Reg. 50,495, 50,906-54 (Aug. 19, 2013); see Andrew B. Wachler & Jesse A. Markos, *CMS’s Final Rule Regarding the Payment of Part B Inpatient Services and the Revised Standard for Hospital Inpatient Admissions*, 10 A.B.A. HEALTH ESOURCE 1 (Sept. 2013), http://www.americanbar.org/content/newsletter/publications/aba_health_esource_home/aba_health_law_esource_1309_wachler.html.

135. See Judith A. Waltz, *Office of Medicare Hearings and Appeals: “Growing Pains” as Appeals Workload Increases to Record Levels*, 16 RAP SHEET 8 (2013).

136. *Office of Medicare Hearings and Appeals Workloads: Hearing Before the Subcomm. on Energy Policy, Health Care, & Entitlements of the H. Comm. on Oversight & Government Reform*, 113th Cong. 4 (2014) (statement of Nancy J. Griswold, Chief Administrative Law Judge, Office of Medicare Hearings and Appeals).

the congestion of appeals,¹³⁷ as is the AHA.¹³⁸ The major reason for the concern is that provider appeals will be delayed further as the OMHA focuses on beneficiary appeals.

CMS has offered to settle all claims for a fixed percentage. Specifically, on August 29, 2014, CMS announced a settlement with affected hospitals and health systems of sixty-eight percent of their so-called inpatient-status claims in the appeals process. CMS is offering this settlement pursuant to the Social Security Act and CMS's regulations regarding claims collection and compromise.¹³⁹ In return, providers have to withdraw all of their appeals.¹⁴⁰

There are alternative dispute resolution processes available in the federal government to streamline adjudicative procedures and get to settlement quicker. The Administrative Dispute Resolution Act of 1996 authorizes all agencies to use alternative dispute resolution (ADR), which might be invoked in the resolution of provider claims.¹⁴¹ This statute amends section 556 to authorize the use of ADR in formal hearings under sections 556 and 557 of the Administrative Procedure Act.¹⁴² According to the statute, "[a]n agency may use a dispute resolution proceeding for the resolution of an issue in controversy that relates to an administrative program, if the parties agree to such proceeding."¹⁴³ This act also identifies situations, such as when "a definitive or authoritative resolution of the matter is required for precedential value,"¹⁴⁴ where ADR should not be used.¹⁴⁵

The Administrative Dispute Resolution Act creates an interagency working group chaired by the Attorney General to promote the use of ADR across the federal government. The working group currently focuses on the following four

137. Paul Demko, *Legislators Decry Broken Medicare Payment Appeals Process*, MODERN HEALTH CARE (May 20, 2014), <http://www.modernhealthcare.com/article/20140520/NEWS/305209963/legislators-decry-broken-medicare-payment-appeals-process>.

138. Letter from Rick Pollack, Exec. Vice President, Am. Hosp. Ass'n, to Marilyn Tavenner, Adm'r, Ctrs. for Medicare & Medicaid Servs., on Significant Delay in Assignment of Hospital Appeals to Administrative Law Judges (Jan. 14, 2014), <http://www.aha.org/advocacy-issues/letter/2014/140114-let-aljdelays.pdf>.

139. See 42 C.F.R. §§ 401.601, 401.613 (2011) (claims collection and compromise); 42 C.F.R. § 405.376 (2004) (compromise of overpayments).

140. Ctrs. for Medicare & Medicaid Servs., *Frequently Asked Questions: Hospital Appeals Settlement for Fee-For-Service Denials Based on Patient Status Reviews for Admissions Prior to October 1, 2013*, U.S. DEP'T HEALTH & HUM. SERVS. (2014), http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/Downloads/HospitalAppealsSettlementFAQs_090814_508.pdf.

141. Administrative Dispute Resolution Act (ADRA) of 1996, Pub. L. No. 104-320, 110 Stat. 3870 (codified as amended at scattered sections of 5 U.S.C.).

142. *Id.* § 4 (codified as amended at 5 U.S.C. §§ 556(c)(7)-(8) (2012)).

143. 5 U.S.C. § 572(a) (2012).

144. *Id.* § 572(b)(1).

145. *Id.* § 572(b).

areas: (1) workplace disputes, (2) contracts and procurement disputes, (3) regulatory enforcement disputes, and (4) claims against the government. RAC appeals involve matters similar to the last three categories and clearly would be appropriate candidates for ADR.

HHS has an ADR division with the DAB, which is associated with the interagency working group convened by Department of Justice. The services of this DAB ADR Division could be made available to resolve a body of appeals on a controversial issue such as RAC appeals by hospitals.¹⁴⁶ Of note, OMHA has launched a “Settlement Conference Facilitation Project” to resolve appeals.¹⁴⁷

Given that courts have firmly established that providers do not have a property interest in payment,¹⁴⁸ Congress and HHS have much more flexibility in designing expeditious dispute resolution procedures that would mitigate the congestion in provider appeals that the Medicare program is experiencing today. CMS might carefully consider how to design an inquisitorial system, for example, that would enable an examiner to review claims on paper with written input from providers and their counsel. Also, rules that more clearly establish criteria for inpatient admissions and observational stays would greatly help the adjudication process and reduce appeals.

Of interest, the recovery audit program appeals controversy arose as a result of Medicare behaving as a procurement program, seeking to control excessive vendors’ costs and profit seeking conduct. The fact that the Medicare program paid recovery audit contractors on a contingent fee basis is more consistent with Medicare as a procurement program. Certainly the use of a contingent fee payment system is not consistent with a truly collaborative relation that the CMS seeks to achieve with the shared savings program as described below.¹⁴⁹

As a government benefits program, procedural due process requires some kind of hearing when government takes adverse action against a beneficiary. The Medicare program, while not required, has accorded comparable hearing rights to health care providers. Because providers and suppliers do not have constitutionally protected property, CMS has great flexibility in designing dispute resolution procedures that will expedite the appeals process while being fair to providers.

146. *Alternative Dispute Resolution Division*, U.S. DEP’T HEALTH & HUM. SERVS., <http://www.hhs.gov/dab/divisions/adr/> (last visited Nov. 17, 2014).

147. Office of Medicare Hearings and Appeals, *Settlement Conference Facilitation Pilot: Fact Sheet*, U.S. DEP’T HEALTH & HUM. SERVS., (Aug 2014) http://www.hhs.gov/omha/OMHA%20Settlement%20Conference%20Facilitation/settlement_conference_facilitation_pilot_fact_sheet.pdf.

148. *See* *St. Francis Hosp. Ctr. v. Heckler*, 714 F.2d 872 (7th Cir. 1983), *cert. denied*, 465 U.S. 1022 (1984); *Geriatrics, Inc. v. Harris*, 640 F.2d 262, 265 (10th Cir. 1981), *cert. denied*, 454 U.S. 832 (1981). In only one case, *Fischer v. United States*, and in dicta, did the Supreme Court even suggest otherwise. 529 U.S. 667 (2000).

149. *See infra* notes 154-161 and accompanying text.

IV. A SEA CHANGE IN MEDICARE RULE AND POLICY-MAKING

Historically, the Medicare program used a regulatory approach to control the utilization of health care services and improvement of the quality of services for Medicare beneficiaries. In 1972,¹⁵⁰ and again in 1981,¹⁵¹ Congress established medical peer review organizations with independent physicians to review Medicare utilization retrospectively. These programs were very unpopular with physicians.¹⁵² By the 1990s, HCFA concluded that these programs and their strategy of retrospective utilization review had been unsuccessful in identifying quality breaches or improving the quality of care.¹⁵³ At that point, HCFA determined to refocus the work of its peer review contractors on quality improvement only.¹⁵⁴ This development presaged a new conception of provider relations and collaboration that CMS pursued after 2000.

At the beginning of the new century, HHS policy makers inaugurated a sea change in their approach to providers. Under the Republican President and Congress, the approach moved from regulatory and controlling to collaboration between CMS and providers in addressing the issues of the cost and quality of medical care. Addressing fraud and abuse was a different matter, with the OIG having primary responsibility for enforcement of fraud and abuse law. The newly named Center for Medicare and Medicaid Services (from the Health Care Financing Administration) handles Medicare policy-making. The Medicare Modernization Act of 2003,¹⁵⁵ a Republican vision of what the Medicare program should be, implemented many complex and technical programs to improve quality and control costs. These programs marked a shift in how CMS viewed providers, now as colleagues in seeking to improve the quality of health care rather than as regulated parties.

150. Social Security Amendments of 1972, Pub. L. No. 92-602, § 249F, 86 Stat. 1329, 1429 (codified as amended at 42 U.S.C. §§ 1320c-1 to -19 (2012)).

151. Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982, Pub. L. No. 97-248, § 1151, 96 Stat. 324, 382 (codified as amended at 42 U.S.C. § 1320c (2012)).

152. JONATHAN OBERLANDER, *THE POLITICAL LIFE OF MEDICARE* 119 (2003).

153. See Anita J. Bhatia et al., *Evolution of Quality Review Programs for Medicare: Quality Assurance to Quality Improvement*, 22 *HEALTH CARE FIN. REV.* 69 (2000); Stephen F. Jencks & Gail R. Wilensky, *The Health Care Quality Improvement Initiative: A New Approach to Quality Assurance in Medicare*, 268 *JAMA* 900 (1992); Claire Snyder & Gerard Anderson, *Do Quality Improvement Organizations Improve the Quality of Hospital Care for Medicare Beneficiaries?*, 293 *JAMA* 2900 (2005).

154. Health Care; Medicare and Medicaid Programs; Peer Review Organizations: Name and Other Changes—Technical Amendments, 67 Fed. Reg. 36,539 (May 24, 2002) (to be codified at 42 C.F.R. pts. 4-5); see Elizabeth H. Bradley et al., *From Adversary to Partner: Have Quality Improvement Organizations Made the Transition?*, 40 *HEALTH SERVS. RES.* 459 (2005).

155. Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003, Pub. L. No. 108-173, 117 Stat. 2066.

There are many reasons why this sea change has occurred. Increasingly, hospitals and health care organizations are run by executives with training in business administration. The power of doctors over hospitals and their own practices has diminished as health services research has provided an empirical methodology to assess whether care is of high quality and/or too expensive. Also, younger physicians are more accepting of, or perhaps more accustomed to, the business approach to medicine so resisted by their predecessors.

Finally, the ACA has sealed the deal on the collaborative model for administering the Medicare program and making health policy.¹⁵⁶ Many of the programs are established with minimal guidance in the form of legislative rules and provide considerable space where providers can innovate so long as they meet cost and quality targets.

The Medicare Shared Savings program that establishes Accountable Care Organizations (ACO) is a case in point. This program facilitates coordination and cooperation among providers to improve the quality of care for fee-for-service Medicare beneficiaries. Eligible providers, hospitals, and suppliers may participate in the Shared Savings Program by creating and/or participating in an ACO.¹⁵⁷ The legislative history describes Congress' expectations for the program:

The ACO pilot program is designed to be flexible enough that a variety of physicians and other providers can participate. Many large, multispecialty group practices are well positioned to participate in the pilot program since most already provide integrated, coordinated care for their patients. The ACO pilot will recognize and reward efforts already underway by such groups, often in conjunction with hospitals, to provide efficient, high quality care. It will also allow providers to be rewarded for using advances in health information technology such as electronic medical records, telemedicine, and home monitoring equipment in ways that improve patient care. The Secretary should allow for the use of such technologies in order to facilitate coordinated, patient-centered care.¹⁵⁸

Moreover, the ACA provides that the Shared Savings Program will not be subject to oversight from the Office of Information and Regulatory Affairs in the Office of Management and Budget.¹⁵⁹ The Affordable Care Act accords the Secretary the authority to waive virtually any statutory requirement for the

156. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), *amended by* Health Care and Education Reconciliation Act (HCERA) of 2010, Pub. L. No. 111-152, 124 Stat. 1029.

157. Shared Savings Program, CTRS. FOR MEDICARE & MEDICAID SERVS. (2014), <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/index.html?redirect=/sharedsavingsprogram/>.

158. H.R. REP. NO. 111-443, pt. 1, at 417 (2010).

159. 42 U.S.C. § 1395jjj(e) (2012).

Medicare program.¹⁶⁰ Finally, section 3022 expressly precludes administrative and judicial review under the Medicare statute for the determinations set forth in Figure 2.¹⁶¹

FIGURE 2: DETERMINATIONS FOR WHICH ADMINISTRATIVE AND JUDICIAL REVIEW PRECLUDED

- The specification of criteria for ACOs.
- The assessment of the quality of care furnished by an ACO and the establishment of performance standards.
- The assignment of Medicare fee-for-service beneficiaries to an ACO.
- The determination of whether an ACO is eligible for shared savings and the amount of such shared savings, including the determination of the estimated average per capita Medicare expenditures under the ACO for Medicare fee-for-service beneficiaries assigned to the ACO and the average benchmark for the ACO.
- The percent of shared savings specified by the Secretary and any limit on the total amount of shared savings established by the Secretary.
- The termination of an ACO.

The ACA has essentially cut off traditional mechanisms by which regulated parties seek redress from government overreaching. From a positive perspective, this limitation on remedies requires providers to resolve differences with CMS politically without recourse to courts. In a traditional regulatory regime with command and control regulation, denying access to judicial review would probably be inappropriate as an affected party would have no other recourse to correct an injustice. However, under the shared savings program, CMS has broad statutory parameters in which to operate and great flexibility to change policy. Consequently, there is space for providers to negotiate with CMS as in a business context to resolve differences. Further, CMS has exhibited a willingness to negotiate with providers in a productive manner.

This flexibility on the part of CMS is evident in the rule-making proceedings for the rules for the shared savings program. Program policy has primarily been made in program guidance and consultation with providers. CMS promulgated final rules to implement the program in November 2011.¹⁶² The text of the final

160. 42 U.S.C. § 1395jjj(f) (2012).

161. 42 U.S.C. § 1395jjj(g) (2012).

162. Medicare Shared Savings Program: Accountable Care Organizations, 76 Fed. Reg. 67,802 (Nov. 2, 2011) (to be codified at 42 C.F.R. pt. 425); see Ctrs. for Medicare & Medicaid Servs *Summary of Final Rule Provisions for Accountable Care Organizations under the Medicare Shared*

rule contains only two pages of text but has a long discussion of the comments submitted to the proposed rule. The preamble reads more like the minutes of a professional conference than a conventional preamble of a rule of a regulatory agency.

Although initially skeptical of ACOs,¹⁶³ the provider community has developed numerous ACOs with measured enthusiasm across the United States. One reason for provider participation may be how responsive CMS was in addressing provider concerns in the final rule for ACOs. Specifically, Dr. Donald Berwick, the former CMS administrator, has indicated that CMS made many changes in the final rules for ACOs to accommodate provider comments and facilitate provider participation.¹⁶⁴ One interesting report from an industry study is remarkably positive about ACOs and their initial accomplishments:

For many of us in the healthcare industry, the real potential game-changer in the Affordable Care Act was not the highly publicized provisions—the creation of insurance exchanges or its embrace of guaranteed issue, community rating, and regulated medical loss ratios. Rather, it was the way ACA opened the door to accountable care organizations (ACOs) in Medicare. Here at last was a development in US healthcare that would shift the focus to delivery and encourage provider organizations to compete on quality and price—something the traditional fee-for-service system has failed at rather spectacularly. We believed—and still do—that as this sort of competition is successfully introduced into the US system, it will inevitably spread, enabling and accelerating a movement toward healthcare that is priced and paid for in terms of value, not volume of services rendered.¹⁶⁵

In 2014, CMS issued a new proposed rule modifying the shared savings

Savings Program, U.S. DEP'T HEALTH & HUM. SERVS. (Nov. 2012), http://www.cms.gov/medicare/medicare-fee-for-service-payment/sharedsavingsprogram/downloads/aco_summary_factsheet_icn907404.pdf.

163. Elliott S. Fisher & Stephen M. Shortell, *Accountable Care Organizations: Accountable for What, to Whom, and How*, 304 JAMA 1715 (2010).

164. Donald M. Berwick, *Making Good on ACOs' Promise: The Final Rule for the Medicare Shared Savings Program*, 365 NEW ENG. J. MED. 1753 (2011); see also Donald M. Berwick, *Launching Accountable Care Organizations: The Proposed Rule for the Medicare Shared Savings Program*, 364 NEW ENG. J. MED. e32 (Apr. 21, 2011), <http://www.nejm.org/doi/full/10.1056/NEJMp1103602>; Douglas Hastings, *The Medicare ACO Proposed Rule: Legal Structure, Governance, and Regulatory Sections*, HEALTH AFF. BLOG (Apr. 5, 2011), <http://healthaffairs.org/blog/2011/04/05/the-medicare-aco-proposed-rule-legal-structure-governance-and-regulatory-sections/>.

165. Niyum Gandhi & Richard Weil, *The ACO Surprise*, OLIVER WYMAN I (2012), http://www.oliverwyman.com/content/dam/oliver-wyman/global/en/files/archive/2012/OW_ENG_HLS_PUBL_The_ACO_Surprise.pdf; see Bruce Japsen, *Obamacare's Accountable Care Approach Reaches 1 in 10 In U.S.*, FORBES (Nov. 26, 2012, 9:00 AM), <http://www.forbes.com/sites/brucejapsen/2012/11/26/obamacares-accountable-care-approach-reaches-1-in-10-in-u-s/>.

program significantly based on the experience of the program in since its inception in 2012.¹⁶⁶ The CMS press release announcing the rule talked about CMS' desire to be collaborative:

The proposed rule reflects input from program participants, experts, consumer groups, and the stakeholder community at large. CMS is seeking to continue this important dialogue to ensure that the Medicare Shared Savings Program ACOs are successful in providing seniors and people with disabilities with better care at lower costs.¹⁶⁷

At this point in time, the program seems headed for success. The Shared Savings Program includes more than 330 ACOs in 47 states, providing care to more than 4.9 million beneficiaries in the Medicare fee-for-service program.¹⁶⁸ In the program's first year, 55 ACOs met the goals and earned shared savings payments of more than \$315 million and another 60 ACOs had reduced expenditures but not enough to earn shared savings.¹⁶⁹ The proposed rule contains extensive provisions to waive program requirements and other measures to create more flexibility to design care for Medicare beneficiaries that will reduce savings.¹⁷⁰

As an approach to achieving regulatory goals, this collaborative model is quite revolutionary especially since the model cuts off access to judicial review and other measures to protect the interests of regulated parties. If successful, it could have great relevance to the future of regulation.

CONCLUSION

Over the years, HHS and CMS have come to appreciate their roles as regulatory and procurement agencies when it comes to the administration of the Medicare program. But the history of the program suggests that HHS and CMS did not come easily to this realization. In the early years of the program, the

166. CMS, *Proposed Rule, Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations*, U.S. DEP'T HEALTH & HUM. SERVS (2014), [http://www.ofr.gov/\(X\(1\)S\(tofvuj12vvyo3oiwkp3jkl3\)\)/OFRUpload/OFRData/2014-28388_PI.pdf](http://www.ofr.gov/(X(1)S(tofvuj12vvyo3oiwkp3jkl3))/OFRUpload/OFRData/2014-28388_PI.pdf); see *Fact Sheet: Proposed Changes to the Medicare Shared Savings Program Regulations*, CTRS. FOR MEDICARE & MEDICAID SERVS. (Dec. 2, 2014), <http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2014-Fact-sheets-items/2014-12-01.html>.

167. *Press Release: CMS Releases New Proposal to Improve Accountable Care Organizations*, CTRS. FOR MEDICARE & MEDICAID SERVS. (Dec. 1, 2014), <http://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2014-Press-releases-items/2014-12-01.html>.

168. *Id.*

169. *Id.*

170. See sources cited *supra* note 166.

managers of the Medicare program sought to control policy-making as well as appeal outcomes more than was appropriate. The best example of this development is Medicare coverage policymaking and the beneficiary appeals process.

Today, with respect to provider appeals, HHS and CMS have some flexibility to depart from evidentiary hearings in appeals and experiment with dispute resolution techniques that could expedite the appeals process. The back-up of recovery audit appeals discussed above demonstrates the need for expedition. Clearly, a more collaborative approach to approaching appeals is in order. The same kind of collaboration that CMS has exhibited with respect to ACOs could be brought to bear on resolving the calamity over recovery audit appeals. HHS and CMS now have the authority to use ADR procedures under Administrative Dispute Resolution Act and might well be advised to use them in the future. Of note, as this article goes to press, OMHA reports that it has cut the wait time for appeals of beneficiaries in half and deferring provider appeals.¹⁷¹

Finally, the more collaborative approach to policy-making and achieving regulatory goals, such as cost containment, are noteworthy. Since 2000, CMS has worked more collaboratively with providers to launch projects that engage the providers in the pursuit of common goals such as higher quality care at lower cost rather than the command and control approach to cost containment of earlier generations. If successful, this type of collaboration may be useful in other reform efforts for the health sector.

171. Susan Jaffe, *Seniors' Wait For A Medicare Appeal Is Cut In Half*, KAISER NETWORK NEWS (Dec. 23, 2014), <http://kaiserhealthnews.org/news/seniors-wait-for-a-medicare-appeal-is-cut-in-half/>.

Medicare at 50: Why Medicare-for-all Did Not Take Place

Theodore R. Marmor & Kip Sullivan*

INTRODUCTION

In the fifty years since Medicare was enacted, Congress has not, with two exceptions in the 1970s, extended Medicare beyond the elderly. In those fifty years Congress has not even engaged in a serious discussion about expanding Medicare beyond the elderly. This disinterest persisted even during those periods when national health insurance was at the top of the national agenda. In other words, even when the conditions for health care reform were promising, Congress did not make Medicare-for-all a prominent option. In recent years, there has been at least as much discussion about raising Medicare's eligibility age as there has been about expanding the program to even a small fraction of the non-elderly.

Why has Congress never seriously debated, and why has the White House never seriously proposed, expanding Medicare? The answer cannot be that Medicare is an unpopular program. Over the five decades since Medicare was enacted, large majorities have supported the program and opposed spending cuts. On rare occasions, Congress has expanded the services Medicare covers. Part D's prescription drug legislation in 2003 is perhaps the most notable example.

Nor can the answer be that the American public has been unconcerned about the threat that rising health care costs—and worsening access to health care—pose to the health and financial welfare of all Americans. Since modern polling began in the 1930s, polls have indicated large majorities of Americans believe access to health care is a right and government should guarantee that right.¹ For the last quarter-century, polls have indicated that a very large majority of Americans believe the US health care system is in crisis and requires fundamental reform,² and a majority support addressing the crisis by expanding Medicare to the nonelderly³ or replacing the current system with a system like Canada's.⁴

* Ted Marmor, Professor Emeritus of Public Policy and Management, and Professor Emeritus of Political Science, Yale University; Kip Sullivan, Board Member, Minnesota Chapter of Physicians for a National Health Program.

1. See Daniel Yankelovich, *The Debate that Wasn't: The Public and the Clinton Plan*, 14 HEALTH AFF. 7, 7 (1995).

2. See Robert J. Blendon et al., *Satisfaction with Health Systems in Ten Nations*, 9 HEALTH AFF. 185, 185 (1990); Robert J. Blendon & Humphrey Taylor, *Views on Health Care: Public Opinion in Three Nations*, 8 HEALTH AFF. 149, 150 (1989).

3. For example, 65 percent of respondents to an AP-Yahoo poll said yes to this question: "The

Nor can the answer be that Medicare emerged from a reform movement that focused solely on coverage for the elderly. Medicare's enactment in 1965 was the culmination of a half-century of work by activists who sought health insurance for all. In the quarter-century prior to 1965, this aspiration had the support of presidents Roosevelt and Truman, their advisors, and numerous advocates in Congress and among the public at large. Medicare's proponents thought the program was a first step toward universal health insurance.

Nor can the answer be that the movement for universal health insurance died out in 1965. The enthusiasm for universal coverage did wax and wane but never disappeared. For approximately a decade after Medicare was enacted, the movement for what was then called "national health insurance" continued, led prominently by Senator Ted Kennedy and his labor union allies. The movement came back to life again in the late 1980s, subsided after the death of the Clintons' Health Security Act in 1994, and rose again in the mid-2000s.

In this article, we provide an overview of the political and ideological developments that have kept Medicare expansion off the national agenda. We distinguish the explanatory power of short-term conditions, such as the stagflation of the 1970s, from longer-term developments that shaped the policy reform debate, such as the expansion of pro-competitive thinking in health care reform. Short-term circumstances are helpful in explaining particular, important events; for example, why Medicare was enacted in 1965 (and not earlier), why a change in the program occurred when it did, or why national health insurance rose to the top of the congressional agenda in the early 1970s.

Situational factors alone, however, cannot explain why Medicare remains a program only for the elderly, the disabled, and those with renal failure. For a fuller explanation of that puzzle, we turn to factors that prevailed throughout all or most of the last fifty years. Here, we focus primarily on two important developments: the rise of the managed care movement and the resurgence of a longstanding campaign promoting the idea that market competition in health insurance can right the wrongs of American medical care.

The managed care movement contributed to the hemming in of Medicare's expansion primarily through its influence on the proponents of national health insurance. It did so by persuading potential proponents of Medicare expansion to

United States should adopt a universal health insurance program in which everyone is covered under a program like Medicare that is run by the government and financed by taxpayers." *The Associated Press - Yahoo Poll Wave 2*, KNOWLEDGE NETWORKS (2007), http://surveys.ap.org/data/KnowledgeNetworks/AP-Yahoo_2007-08_panel02.pdf; see *Washington Post-ABC News Poll: Health Care*, WASH. POST (Oct. 20, 2003), <http://www.washingtonpost.com/wp-srv/politics/polls/vault/stories/data102003.html>.

4. Blendon & Taylor, *supra* note 2, at 152; Blendon et al., *supra* note 2, at 185; Patrick Howe, "Citizens Jury" Supports Wellstone's Health Care Proposal Over Clinton Plan, MINNEAPOLIS STAR TRIB., Oct. 15, 1993, at 10A; Michael McQueen, *Voters, Sick of the Current Health-Care System, Want Federal Government to Prescribe Remedy*, WALL ST. J., June 28, 1991, at A4.

pursue a different reform strategy. Insurance companies practicing managed care, the rhetoric claimed, were more efficient than Medicare. Conversely, because Medicare did not employ managed care policies, it had to be inefficient compared to the “innovative” managed care industry. Managed care robbed Medicare expansion of enough of its proponents, we will argue, to keep it off the congressional agenda.

The rise of what we refer to as the pro-competition movement constituted another significant, long-term political impediment to Medicare’s expansion. It did so by strengthening the belief that market competition among private health insurance firms could be invigorated, largely by shifting more costs back to patients and eliminating tax subsidies for insurance, and that vigorous competition would make the health care sector much more efficient than Medicare could ever be. But because this movement attracted and appealed primarily to conservatives who did not support universal coverage in the first place, its impact on the debate about Medicare’s expansion, although substantial and powerful, was less direct. Unlike managed care, the pro-competition movement did not decimate the ranks of those who supported expanding Medicare beyond the elderly. Instead, it fenced Medicare in by limiting support for government-financed health coverage. This influence has been so pervasive that substantive debate about universal health insurance has been limited to three relatively short periods over the last fifty years: the periods 1970-1973, 1992-1994, and 2008-2010.

The combined effects of the pro-competition and managed care movements were powerful: The pro-competition movement limited the debate about universal coverage to a few “windows of opportunity” and, when those windows arrived, the managed care movement provided a solution at the expense of Medicare-for-all.⁵

In Part II of this paper, we offer a brief narrative of Medicare’s origins and the major developments in the program’s history. Parts III and IV present the conceptual weaknesses of the managed care and pro-competition theories and the role these defects have played in sustaining, rather than dampening, belief in those theories. Each movement, we argue, proceeded from its own particular set of unexamined assumptions, cultivated its own habits of thought, and contributed its own misleading jargon. In short, each movement generated an assumptive world and a mentality that encouraged adherents to discount evidence incompatible with their fundamental assumptions. This attitude toward evidence

5. The success of the pro-competition and managed care movements in blocking the expansion of Medicare was facilitated by structural constraints within the American political system, notably the fragmentation of decision-making authority and a lopsided distribution of resources between the forces supporting and opposing expansion of Medicare. A detailed discussion of these long-term factors is outside the scope of this paper. For further discussion, see THEODORE R. MARMOR, *THE POLITICS OF MEDICARE* 171-82 (2000).

is inconsistent with each movement's ostensible embrace of the rules of science and scientific discourse. We offer concluding remarks in Part V.

I. MEDICARE'S ORIGINS AND HISTORY SINCE 1965

In 2015, Medicare will mark its fiftieth birthday. It has played a crucial role in giving millions of elderly Americans—as well as those with disabilities and end-stage renal disease—access to basic medical care. Medicare has been innovative in introducing payment reforms that, compared to private insurance, have moderated the rate of growth in spending on medical care. For many reformers, Medicare's simplicity, low administrative costs, risk pooling, and social insurance arrangements still provide a sensible model for reforming American health care more broadly.

Yet Medicare's fiftieth birthday will take place amidst considerable controversy. Since 1995, there has been open and unusually sharp partisan and ideological conflict over Medicare; its reform has become a recurrent battleground over the proper role of government and markets in health care. That conflict—simmering for decades—was readily visible during debate over the 2003 Medicare Modernization Act (MMA), which added, among other controversial elements, a complicated prescription drug benefit to the program. The MMA was enacted only by the narrowest of margins, leaving behind a deeply polarized Congress divided mainly along partisan lines. That partisan divide is unlikely to end anytime soon. The aging of the baby boomers into Medicare will substantially increase the program's beneficiary population (Medicare enrollment is expected to rise from 54 million in 2014 to 82 million by 2030).⁶ This will raise the political stakes of Medicare reform.

While many liberal reformers still view Medicare as a model for the rest of American medicine, conservative critics typically regard Medicare as evidence of what is wrong with American medical care. The original Medicare program, they believe, should not be expanded, but instead recast to reflect more conservative principles. The debate and controversy over Medicare thus persists almost fifty years after the program's enactment.

Our purpose in this section is to provide an historical and political context for understanding this controversy.⁷ We begin by sketching out Medicare's historical roots in the American campaign for national health insurance that began early in the last century. Next, we describe the sea change in the debate about health policy—from one dominated by the issue of how to improve access to one dominated by the question of how to reduce costs—that occurred in the

6. *Annual Report of 2014*, BOARD OF TRUSTEES OF THE FED. HOSP. INS. AND FED. SUPPLEMENTARY MED. INS. TR. FUNDS 198 tbl.V.B4, <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2014.pdf>.

7. This section draws substantially from MARMOR, *supra* note 5.

immediate aftermath of Medicare's enactment. Then, we sketch Medicare's development over the next fifty years, including the reform of its payment policies for medical providers.

A. The Origins of Medicare

Perhaps the best way to understand Medicare's political origins is to appreciate how peculiar the program is from an international perspective. The United States is the only industrial democracy that began compulsory health insurance by covering its elderly citizens only. Almost all other nations began with coverage of their work force or, as in the case of Canada, went from special programs for the poor to universal programs for one service (hospitals) and then to another (physicians). This means that peculiarly American circumstances, rather than some common feature of modern societies, explain why it is that compulsory government health insurance began in the United States with those eligible for Social Security pensions.

The roots of this unique history lie in the United States' distinctive rejection of national health insurance in the twentieth century. First discussed in the years before World War I, national health insurance fell out of favor in the 1920s. When the Great Depression made economic insecurity a pressing concern, the Social Security blueprint of 1935 broached both health and disability insurance as controversial items of social insurance that should be included in more complete schemes of income protection. From 1936 to the late 1940s, liberal defenders of the New Deal repeatedly called for incorporating universal health insurance within America's emerging welfare state. However, the conservative coalition in Congress—comprised of Republicans and conservative, often Southern Democrats—regularly blocked these initiatives.

Leading figures within the movement for American social insurance—Oscar Ewing, Wilbur Cohen, Robert Ball, and Nelson Cruikshank most prominently—were well aware of this opposition and redesigned a reform strategy during President Harry Truman's second term of office. By 1952, they had set out a plan to implement national health insurance in stages. Looking back to a 1942 proposal that called for extending medical insurance to all Social Security contributors, the proponents of what became known as Medicare shifted the category of proposed beneficiaries to elderly retirees while retaining the link to social insurance as well as its contributory, non-means-tested form of eligibility.

Medicare thus became a proposal to provide retirees with limited hospitalization insurance—a partial plan for the segment of the population whose financial fears of illness were as well-grounded as their difficulty in purchasing private health insurance at an affordable cost. With this, the long battle to turn a proposal acceptable to the nation into one passable in Congress began, evolving from its strategic birth in the early 1950s into a fully developed legislative plan

by 1958.

These origins have much to do with the initial design of the Medicare program and the expectations of how it was to develop over time. The incremental strategy assumed hospitalization coverage was the first step in benefits and that more would follow under a common pattern of Social Security financing. Likewise, the strategy's proponents presumed that eligibility would be gradually expanded. Eventually, they believed, Medicare would take in most if not all of the population, extending first perhaps to children. In other words, by the 1960s Medicare was envisioned as the cornerstone of national health insurance in the United States.

All the Medicare enthusiasts took for granted that the rhetoric of enactment should emphasize the expansion of access, not the regulation and reform of American medical practice. Their goal was to reduce the risks of financial disaster for the elderly and their families, not to alter the practice of medicine. They assumed that Congress would demand a largely hands-off posture (following the example of private insurers at the time) toward the doctors and hospitals providing the care that Medicare would finance. Five decades later, that vision seems old-fashioned. It is now taken for granted by most policy makers and health policy analysts that insurers, both public and private, have a responsibility to oversee and influence the practice of medicine. But in the period up to enactment in 1965, no such presumption existed.

The incremental strategy of the fifties and early sixties assumed not only that most of the nation was sympathetic to the health insurance problems of the aged, but also that social insurance programs enjoyed vastly greater public acceptance than did means-tested social programs. Social insurance in the United States was acceptable to the extent it was differentiated from the demeaning world of public assistance. "On welfare," in American parlance, is largely a pejorative expression, and the leaders within the Social Security Administration made sure Medicare fell firmly within the tradition of benefits that are "earned" and not given as a matter of charity. The aged could be presumed to be both needy and deserving because, through no fault of their own, they had on average lower earning capacity and higher medical expenses than any other age group. The Medicare proposal avoided a means test by restricting eligibility to persons over age 65 (and their spouses) who had contributed to the Social Security system during their working life. The initial plan limited benefits to sixty days of hospital care, and physician services were originally excluded in hopes of softening the medical profession's hostility to the program.

The form adopted—Social Security financing and eligibility for hospital care, and beneficiary premiums plus general revenues for physician expenses—had a political explanation, not a coherent philosophical rationale. The very structure of the benefits themselves, insuring acute hospital care (Part A of the legislation) and physician treatment as an unexpected afterthought (Part B), was not tightly

linked to the special circumstances of the elderly. Left out were provisions that would have addressed the problems of the chronically sick elderly—those whose medical conditions would not dramatically improve and who needed to maintain independent function more than triumph over discrete illness and injury. Viewed as a first step, of course, the Medicare strategy made sense. But after fifty years, with holes remaining in Medicare's coverage of medical services, and with the program having failed to expand to cover the general population, the incremental assumptions behind the Medicare strategy appear somewhat more problematic.

In the next four subsections, we present a short history of Medicare's first fifty years.

B. 1966-1971: A Half Decade of Accommodation

Medicare's first period—roughly from 1966 to 1971—was one of accommodation to the medical profession rather than of efforts to change it. To ease the program's implementation in the face of continued resistance from organized medicine even after the enactment of Medicare, Medicare's first administrators resisted making any radical changes. This resulted in benefits and payment arrangements that exerted inflationary pressure and hindered the government's ability to control increases in program costs over time. For example, Medicare's policy of paying hospitals their "reasonable costs" and physicians their "reasonable charges" prompted many American hospitals and doctors to raise their fees. Unusually generous allowances for hospitals' depreciation and capital costs were a further built-in inflationary impetus. The use of private insurance companies as financial intermediaries provided a buffer between the government and American physicians and hospitals, but it weakened the capacity of government to control reimbursement. It was left to these intermediaries—Blue Cross/Blue Shield and private commercial health insurers—to determine the reasonableness of hospital costs under Part A and physician charges under Part B.

The truth is that in the early years of Medicare's implementation, the program's leaders were not disposed to face the confrontation necessary to restrain costs. They felt they needed the cooperation of physicians and hospitals for Medicare's implementation to proceed smoothly; vigorous efforts at cost control would have threatened this relationship. Even though they were fully aware of the need for cost control, Medicare's first administrators were initially reluctant to take effective steps to control costs for fear of enraging Medicare providers.

With the benefit of hindsight, it is easy to criticize this posture of accommodation. At the time of the program's enactment, however, Medicare's legislative mandate was to protect the nation's elderly from the economic burdens of illness without, as noted above, interfering significantly with the

traditional organization of American medicine. It was with this aim in mind that Medicare's leaders ensured a smooth, speedy start to the program by being accommodating.

The result was quite predictable: efficient implementation of Medicare with inflation built in. Between 1965 and 1971, the daily service charges of American hospitals rose by an average of 14 percent per year.⁸ Medicare's deference to physicians in determining reasonable charges paved the way for steep increases in physicians' fees as well. In the first five years of operation, total expenditures rose from \$3.4 billion in 1966 to \$7.9 billion in 1971.⁹

C. The 1970s: Controlling Costs Dominates Health Policy

During the five years after Medicare was enacted, inflation in total national spending on medical care also rose dramatically. During that five-year period, national expenditures on medical care rose at an annual rate of 7.9 percent compared with 3.2 percent during the seven years prior to 1965.¹⁰ By 1970, there was broad agreement among students of American politics and medicine that medical inflation had become a serious problem. Criticism of Medicare was part of this dialogue, and, in the minds of some, Medicare was the cause of what became a pattern of all medical prices rising at twice the rate of general consumer prices (as measured by the Consumer Price Index).¹¹ Total spending by private payers increased sharply. The unexpectedly high cost of Medicare and the acceleration of inflation in the private sector radically altered the health policy debate.

Prior to the enactment of Medicare and Medicaid (Medicaid was enacted in the same legislation that created Medicare), the debate had emphasized access-making insurance available to more Americans. By the late 1960s, cost had become the principal focus. The shift from access to cost dramatically altered the arguments employed by both sides of the health care debate. Neither side had previously felt compelled to couple their position on expanding health insurance with a credible plan for cost containment. Proponents of national health insurance had felt it was sufficient to make fairness and quality-of-life arguments; opponents believed it was sufficient to invoke the specter of "socialism" and "communism." But, by the late 1960s, both liberals and conservatives were under great pressure to offer credible proposals to reduce medical inflation.

Politicians and experts across the political spectrum declared that American

8. See Howard West, *Five Years of Medicare – A Statistical Review*, SOC. SECURITY BULL. Dec. 1971, at 17, 21 tbl.6, <http://www.ssa.gov/policy/docs/ssb/v34n12/v34n12p17.pdf>.

9. *Id.* at 19.

10. See PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE: THE RISE OF A SOVEREIGN PROFESSION AND THE MAKING OF A VAST INDUSTRY* 396, 384 (1982).

11. See MARMOR, *supra* note 5, at 97.

medical care was in “crisis.” Richard Nixon said in a 1969 speech: “We face a massive crisis. . .and unless action is taken. . .within the next two to three years, we will have a breakdown in our medical system which could. . .[affect] millions of people. . . .”¹² According to a 1969 report released by the Department of Health, Education and Welfare (HEW, now the Department of Health and Human Services, or HHS), the country faced a “crippling inflation in medical costs.”¹³ The media, especially the business press, echoed this sentiment. In its January 1970 edition, *Fortune* declared, “America’s medical system ... stands on the brink of chaos.”¹⁴ It was this environment that produced the two long-term factors we discuss in later sections—the managed care movement and a stronger and more sophisticated pro-competition movement. By 1970, the Nixon administration was taking the first steps to endorse the “health maintenance organization,” a decision that would give rise to the managed care movement. By the mid-1970s, conservatives were aggressively portraying competition as the solution to the crisis.

With the national debate focused on cost containment in both the public and private sectors, disputes about Medicare took a subordinate political position to discussions about nationwide health reform. That does not mean Medicare was inert. Experimentation with different reimbursement techniques, the expansion of Medicare eligibility to the disabled and those suffering from kidney failure, and the movement of Medicare out of the Social Security Administration and into the newly created Health Care Financing Administration (HCFA) are examples of changes in the program that occurred during the 1970s. They were the subject of intense but low-visibility debates among special interest groups, including the burgeoning medical industry and groups representing the elderly.

By the end of the 1970s, alarm had grown over both the troubles of American medical care generally and the costs of Medicare specifically. The struggle over national health insurance ended in stalemate by 1975, and by 1979 the effort to enact national cost controls over hospitals had also failed. With the failure of these broader reforms, federal cost control attention turned to Medicare.

D. The 1980s: Budget Deficit Politics and Medicare Cost Control

During the 1980s, the politics of the federal budget deficit drove Medicare policy. This had two consequences. The first was that Medicare was no longer an intermittent subject of policy makers’ attention, but instead became a constant target of the annual battles over the federal budget. Second, concerns over

12. See JOSEPH FALKSON, HMOs AND THE POLITICS OF HEALTH SYSTEMS REFORM 6 (1979).

13. Robert H. Finch & Roger O. Egeberg, *The Health of the Nation’s Health Care System*, 111 CAL. MED. 217, 217 (1969).

14. *It’s Time to Operate*, FORTUNE, Jan. 1970, at 79.

Medicare's impact on the deficit facilitated far-reaching changes in how the program paid medical providers. In contrast to the accommodating policies of the early years, federal policy makers implemented aggressive measures to hold down Medicare expenditures in the 1980s. They gave priority to the government's budgetary problems over the interests of hospitals and physicians. The result of these changes was a considerable slowdown in the rate of growth in Medicare expenditures that did not compromise the program's accessibility.

While these changes in Medicare payment policy received little public attention, they had enormous consequences for both Medicare and the American health care system generally. Medicare's regulatory transformation began in 1983 with the adoption of the Prospective Payment System for hospitals. Medicare's historic reimbursement formula, which had paid hospitals retrospectively on the basis of their costs, was replaced with a prospective formula that instead paid hospitals fixed sums per diagnosis. While the change was shrouded in technical details, those details could not obscure the policy significance of this change: Medicare had adopted administered pricing and rather than pay providers what amounted to a blank check, the federal government was now limiting its payments to a predetermined fee. In 1989, the federal government adopted the Medicare Fee Schedule for physicians. Medicare's new payment systems were moderately successful in controlling program expenditures. As federal budget deficits persisted through the 1980s and 1990s, Congress used Medicare's prospective payment systems to limit program spending in the name of fiscal discipline. A Congressional Budget Office study found that excess cost growth in Medicare (growth beyond inflation and demographic changes) declined from 5.5 percent during 1975-1983 to 0.9 percent during 1992-2003.¹⁵ Medicare's experience demonstrated that the federal government, if the political will was there, could effectively deploy regulatory strategies for cost containment. But this was never widely appreciated. The promotion of the two panaceas we discuss in this paper—managed care and competition—had much to do with that result.

E. 1995-2014: Medicare and the Market

The payment reforms that Medicare adopted during the 1980s were similar in many respects to those used by national health programs in other countries. Medicare policy, as in other industrialized democracies, emphasized prospective payment, predetermined fee schedules, and budgeting. But in 1995 Medicare politics tacked sharply rightward, a shift that was largely a response to the managed care and pro-competitive movements we will explore at length below.

In the 1994 elections, for the first time in forty years, the Republican Party

15. Chapin White, *The Slowdown in Medicare Spending Growth* (Cong. Budget Office, Working Paper No. 2006-08, 2006), <http://www.cbo.gov/sites/default/files/2006-08.pdf>.

gained majorities in both the House of Representatives and the Senate. The Republican congressional leadership, led by House Speaker Newt Gingrich, celebrated competitive markets, deregulation, and privatization. Medicare, in their eyes, was an outdated program operating on liberal principles. Not surprisingly, then, in the context of efforts to cut taxes and balance the budget, Republican leaders sought to remake Medicare into a program that more closely expressed their conservative political and ideological commitments. In 1995, Gingrich proposed a series of sweeping reforms, including \$270 billion in proposed cuts in program spending, that aimed to move more Medicare beneficiaries out of traditional Medicare and into private insurance plans.

President Bill Clinton eventually vetoed those reforms, but that did not end the debate. The ensuing two decades in Medicare politics has, in essence, been one long extended struggle over the program's identity. Should the federal government continue to operate Medicare as a federal health program according to social insurance principles, or should it alternatively subsidize the purchase of private insurance by Medicare beneficiaries with vouchers? Should Medicare control costs via its traditional method of regulation and administered pricing, via competition and market forces, or with greater use of managed care tools?

The divisiveness of these questions was readily apparent in the political conflict over adding a prescription drug benefit to Medicare. As enacted in 1965, Medicare did not pay for outpatient prescription drugs. Early efforts to extend Medicare benefits were forestalled by concerns over the program's rapidly escalating costs. In 1988, Congress and the Reagan administration agreed to add prescription drug coverage as part of the Medicare Catastrophic Coverage Act, but in 1989 the bill was repealed amidst a backlash over its financing arrangements (benefits were to be funded entirely by Medicare enrollees, with a surtax assessed on higher-income beneficiaries). The Clinton administration proposed to expand Medicare to incorporate prescription drug coverage as part of its 1993 Health Security Act, but when health reform died so too did that proposal. However, rising drug costs in the 1990s and a budgetary surplus at the end of the decade worked in combination to return Medicare prescription drug coverage to the agenda in the 2000 presidential elections.

The question at the time was how to add drug coverage to Medicare. The position taken by Democrats was that prescription drug coverage should be universally available to all Medicare beneficiaries, with the benefit added to the traditional program and administered in much the same way as the federal government administers hospital and physician insurance. The Republican position, on the other hand, was that drug coverage should be offered by private companies rather than the federal government, and benefits should be limited to lower-income beneficiaries.

The outcome in 2003, named Medicare Part D, was a convoluted form of a prescription drug benefit tied to a series of other Republican reforms that had

nothing to do with prescription drugs. The legislation, entitled the Medicare Modernization Act (MMA), passed the House by one vote and emerged from the conference committee without anything close to a bipartisan consensus. The universality of the drug benefit was a concession to Democratic demands. The funds available were half what the Democrats had insisted upon, a concession to President Bush's budget constraints. The result was a benefit that was both cumbersome (with its unusual "doughnut hole" design)¹⁶ and less generous than what many beneficiaries desired. Moreover, the program attracted criticism both from liberals (who thought the benefits stingy but certain provisions too generous toward drug companies) and conservatives (who thought the insurance program was too expensive and disliked creating a new entitlement).

Republicans had hoped to eliminate the perception that they are less capable of managing Medicare than Democrats. But this hope has not been realized. Ironically, by pushing through such an unwieldy and costly reform, the Republicans added to Medicare's expense and thereby ensured that Medicare would remain a contentious issue in American politics. Some Democrats were hopeful that the MMA would, in the long term, prove to be a stepping-stone to a more workable drug benefit and more sensible, broader Medicare reforms. Making the benefit simpler and more generous, especially for low-income seniors and those with high, near catastrophic drug costs, remains an unfinished reform goal among social insurance advocates.

The issue from 2003 until 2009 was not the expansion of the MMA's benefits (efforts to upgrade the benefit ran headlong into massive budget deficits and the fact that the profligate legislation has no effective cost-control mechanisms), but rather how to make the enormously complex legislation work. In the summer of 2009, Democrats announced legislation that would become the Affordable Care Act (ACA), which would shrink the "doughnut hole." The 2003 legislation did substantially expand Medicare beneficiaries' enrollment in private plans, and the MMA's introduction of income-related premiums set the stage for future debates over the universal nature of Medicare eligibility.

In the latter half of the 2000s, the debate about health care reform shifted back to universal coverage. Every Democratic candidate for president running in the 2008 election felt compelled to have a position on universal coverage, and every Republican candidate felt compelled to offer a solution to system-wide health care inflation. But with the exception of Representative Dennis Kucinich, no candidate proposed expanding Medicare to the non-elderly. Medicare was treated as a separate issue prior both to the 2008 election and during the

16. To minimize the cost of the MMA, Congress required that Medicare beneficiaries who enroll in Part D pay a portion of their drug expenses. The bulk of the portion they pay is defined by the gap in the coverage known as the "doughnut hole." In 2015, the lower threshold of the "doughnut hole" will be \$2,960 and the upper limit will be \$4,700. See *How to Find the Best Medicare Drug Plan*, CONSUMERREPORTS.ORG, <http://www.consumerreports.org/cro/2014/10/best-medicare-drug-plans/index.htm> (last visited Dec. 11, 2014).

subsequent debate about the enactment of the ACA.

During this period, the issue, broadly defined, was how much to rely on market forces and managed care to reduce both system-wide and Medicare-specific costs. Greater reliance on Medicare's traditional cost-control methods was not on the table, either as an option for Medicare or for the entire system. The disinterest among policy makers and influential organizations in Medicare's traditional methods, and the great interest in managed care and competition testify to the power the managed care and pro-competition movements had acquired. We discuss these movements in the next two sections.

II. THE MANAGED CARE MOVEMENT

In this section we address two questions: Why did the managed care philosophy—its diagnosis and its solutions—spread so rapidly and persist over decades despite there being little evidence to support it? And what role did the success of managed care ideas play in thwarting the expectations of Medicare's founders that Medicare would eventually be extended to all Americans?

We begin by describing the managed care philosophy and its origins in the campaign for the "health maintenance organization" (HMO). We focus on the decision by the first HMO proponents to give the HMO concept a name suggesting it could achieve highly valued outcomes, but to refrain from describing how the HMO was supposed to achieve those outcomes. That decision, and its rapid adoption by leaders of both parties, encouraged—and to some degree, forced—HMO advocates to make their case with hope-based opinion and abstract marketing jargon.

Next, we demonstrate that the 1970-73 debate, raucous and partisan as it was, failed to question the undocumented premises underlying the claims made for HMOs, and failed to reveal how HMOs were supposed to achieve the claims made for them. We conclude that the quick political victories scored by the managed care movement during the 1970-1973 period reinforced the decision by the first HMO proponents to speak in abstractions, to use value-laden labels, and to downplay or ignore evidence.

Next, we offer two examples of subsequent managed care solutions ("pay for performance" and the "accountable care organization") that also succeeded politically (that is, they were endorsed by Congress and the president) but failed to work as advertised. We demonstrate that proponents of these solutions exhibited the same habits of thought and expression that emerged in the early 1970s: a reliance on hope rather than evidence, abstract rather than concrete language, and labels designed to persuade rather than illuminate. We conclude with a comment on the changing make-up of the managed care movement over the last four decades, and a discussion of the role the movement played in turning leading proponents of universal coverage away from Medicare-for-all.

A. *The Managed Care Philosophy*

Although the phrase “managed care” did not enter the health policy lexicon until the late 1980s, and despite the phrase’s ambiguity, we will use it to describe the movement and the school of thought that emerged in the wake of the Nixon administration’s quiet endorsement of HMOs in 1970, and the more public endorsements of the concept by leaders of both parties in 1971. The claims made for managed care, as well as the jargon in which those claims are couched, have evolved over the intervening years, but the movement’s diagnosis of the crisis and its principal recommendations for addressing the crisis have remained constant. The diagnosis is overuse—the ordering of unnecessary services and the failure to order preventive services, and the failure to “coordinate”¹⁷ care as a result of the FFS system. The solution is shifting financial risk to doctors and other providers and direct intervention in treatment decisions by third parties.

These premises support numerous secondary or derivative assumptions. Based on their premise that FFS and overuse are the problem, managed care advocates have developed secondary diagnoses such as “fragmentation” and a

17. “Coordinate” is an example of the amorphous, value-laden jargon introduced into the American health policy lexicon by the managed care movement. “Coordinate” is almost never defined but is nevertheless used incessantly. It is frequently used to criticize doctors who are paid FFS (those doctors allegedly fail to “coordinate care”) or to praise managed care (who would want to defend “uncoordinated care”?).

“Coordinate” is such a vague, sprawling term used in so many contexts it is not clear whether it is something only doctors and health care professionals do, only employees of insurance companies do, or is something both insurers and providers do. It apparently means both insurance companies requiring that doctors get prior authorization before providing a service as well as doctors attempting to extract prior authorization from insurance companies. It apparently includes activities, such as giving patients instructions at discharge, for which “coordination” makes little sense and for which more informative labels, such as “patient education,” would be much more appropriate.

Here is an example of the use of “coordinated” from a recent paper promoting “accountable care” (another evanescent concept invented by the managed care movement): “Payment reforms allow accountable care providers to more effectively support the coordination of care and other important patient services that are not well funded under traditional payment mechanisms.” Mark McClellan et al. *Accountable Care Around the World: A Framework to Guide Reform Strategies*, 33 HEALTH AFF. 1507, 1508 (2014).

Note that “coordination” is not the only highly abstract or value-laden phrase packed into this single sentence. “Payment reforms,” “allow,” “accountable care providers,” and “support,” all of which beg for definition, precede “coordination.” Nowhere in their paper do McClellan et al. define “coordination” or refer the reader to a document that does. Nor do they document their claim that “coordination,” whatever it is, is “important.” The only other statement in the paper that sheds any light on the authors’ understanding of “coordination” is one that claims, “improved coordination of care should allow more task shifting within and between the collaborating provider organizations....” *Id.* at 1512. If the authors had asserted that mergers or hiring more staff “allow more task shifting,” their assertion would be understandable. To attribute “task shifting” to “coordination” is tautological.

critical view of physician professionalism under the influence of FFS (physicians are alleged to cave in routinely to the desire to make money at their patient's expense by ordering unnecessary services). Based on their premise that the solution is to shift risk to doctors and authorize third-party control over them, managed care advocates have promoted numerous derivative or supporting solutions, the more important of which include:

- preventive services, which allegedly suffer under FFS, flower under capitation;
- quality improvement (including the provision of more preventives services) cuts health care costs;
- monitoring quality for more than a tiny portion of medical services is feasible both technically and financially;
- doctors and hospitals should buy electronic medical records (EMRs) because EMRs improve quality, and because quality improvement allegedly leads to lower cost, the cost of medical care will drop by more than the cost of acquiring and maintaining EMRs; and
- doctors and hospitals should be aggregated into large organizations so that they can bear risk.¹⁸

18. Our summary of the most important assumptions made by managed care proponents is based primarily on inferences we draw from the context in which observers and managed-care proponents speak about managed care. In other words, our summary is not based on a clear, coherent statement of those assumptions by managed care proponents or neutral observers. We are unaware of a description of the principal tenets of managed care that is as detailed as ours. The failure of the managed care movement to define and document its most fundamental assumptions is symptomatic of the mores we criticize in this paper—a penchant for unnecessarily abstract concepts, labels designed to persuade rather than illuminate (who wants to speak up for “unmanaged care”?), and assertions based on little or no evidence. In this footnote we offer four examples of how “managed care” is used in the literature to illustrate our statement that writers who use the term rarely define it, or that when they do, their definitions are so abstract that they are almost useless.

In 1976, Paul Ellwood and George Lundberg (the former editor of the *Journal of the American Medical Association*) urged their readers to reject the widespread anger at “managed care” that erupted in the mid-1990s. Readers might have expected that an article which referred to “managed care” in the title and in the text, and which pleaded with readers to view “managed care” favorably, would have defined the term. It did not. Paul Ellwood & George Lundberg, *Managed Care: A Work in Progress*, 276 JAMA 1083 (1976).

In *Crossing the Quality Chasm*, the Institute of Medicine (IOM), an early and very influential proponent of managed care, urged readers not to blame “managed care” for the defects in quality documented elsewhere in the book. In a section entitled, “How managed care affects quality,” the IOM exonerated “managed care.” INST. OF MED., *CROSSING THE QUALITY CHASM* 238-39 (2001). Given the importance of the question, one might have expected the IOM to define the term. It did not.

In a book entitled *Medicare Prospective Payment and the Shaping of U.S. Health Care*, Rick Mayes and Robert Berenson offered this definition of “managed care”:

The term managed care is problematic because it conflates and confuses two separate forms of organizational behavior: selective contracting to drive down prices, which became the source of most managed care savings, and actual management of treatment, which became the subject

Research did not support these assumptions when they were first asserted or implied in the early 1970s by proponents of the “health maintenance organization,” and research does not support them now.

As we shall explore more fully in the next section, the early HMO proponents relied heavily on opinion to make their case for the HMO. They marshaled very little evidence. As a spokesman for the American Medical Association put it in testimony to Congress in 1971, “At best, what we have are comparisons of the HMO to being ‘something like’ the Kaiser Permanente group.”¹⁹ Two years later Uwe Reinhardt characterized the research on HMOs as virtually non-existent. In a 1973 paper, he wrote, “[F]ar too many of the proposed reorganization schemes—particularly the much touted idea of a national network of presumably competitive Health Maintenance Organizations—appear to have been proffered on the basis of intuition or faith than on the basis of convincing empirical evidence.”²⁰

What little evidence the early HMO advocates presented consisted primarily of anecdotes and claims about Kaiser Permanente. Kaiser was said to save money by reducing hospital use and offering more preventive services, and the cause of this efficiency was allegedly its method of payment. This method of payment was said to be “prepayment,” a vague term which is now rarely used. “Prepayment” appeared in some contexts to be synonymous with “premiums paid to the insurance company known as Kaiser Permanente” (premiums are, after all, “pre-paid”) and in other contexts to mean “capitation paid to doctors who work for Kaiser.”

of most of the manage care hype and hysteria. For the purposes of this book, however, we mean by managed care a payment model that is distinct from the traditional indemnity health insurance by virtue of the fact that it attempts to influence the way health care is provided and often even restricts patients’ access to and choice of medical provider.

RICK MAYES & ROBERT BERENSON, *MEDICARE PROSPECTIVE PAYMENT AND THE SHAPING OF U.S. HEALTH CARE* 6-7 (2006).

This definition boils down to: Managed care refers to “attempts” to influence “the way” medical care is provided, and does not include using oligopsony power to drive provider fees down.

Finally, we call the reader’s attention to a book by Robert Cunningham III and Robert M. Cunningham, Jr. The authors define “managed care” as “the . . . piecemeal, incremental cost disciplines of the 1970s and 1980s [that] created widening opportunities to apply in new ways the principles underlying the HMO” ROBERT CUNNINGHAM III & ROBERT M. CUNNINGHAM, JR., *THE BLUES: A HISTORY OF THE BLUE CROSS AND BLUE SHIELD SYSTEM* 209-10 (1997). “Piecemeal, incremental cost disciplines” based on “principles underlying the HMO” tells us very little.

Mayes and Berenson and the Cunninghams deserve credit for trying to define this slippery term, but their definitions remain amorphous.

19. *Statement of the American Medical Association on S. 1182—Health Maintenance Organization Assistance Act of 1971, Before the Subcommittee on Health, Committee on Labor and Public Welfare*, 92 Cong. (1971) United States Senate, November 17, 1971, in WILLIAM R. ROY, *THE PROPOSED HEALTH MAINTENANCE ORGANIZATION ACT OF 1972* (1972) at 162, 172.

20. Uwe Reinhardt, *Proposed Changes in the Organization of Health-Care Delivery: An Overview and Critique*, 2 MILBANK MEMORIAL FUND Q. 169, 169 (1973).

Today, nearly a half century later, research still does not support the assumptions underlying managed care. This is true of the managed care movement's diagnosis and its solutions. It is true of research which addresses managed care's most expansive concepts, such as HMOs, "managed care," "coordination," and "accountable care organizations," as well as research that examines the more specific assumptions itemized above (for example, FFS causes overuse, and quality improvement lowers costs). The failure of the large-scope concepts to work as advertised suggests the more specific assumptions behind them are not accurate. In the remainder of this subsection we offer a cursory review of the evidence with regard to the movement's more overarching concepts, and then a brief review of the research on the assumptions listed above.

The evidence indicates that managed care's most important and encompassing propositions, such as "HMOs" and "managed care," have failed to cut costs, and have at best had a mixed effect on quality. By the early 1990s, by which time tools pioneered by HMOs had spread throughout the insurance industry, evidence still did not support the claim that managed care saved money. In 1993 the US General Accounting Office (now the Government Accountability Office) reported, "Although many employers believe, in principle, managed care plans save money, little empirical evidence exists on the cost savings of managed care..."²¹ Research on the impact of managed care on Medicare's costs demonstrated that managed care either saved no money or raised total costs.²² Research on the effect of managed care on quality shows mixed or negative results when quality is measured by outcome and process measures, and negative

21. *Managed Health Care: Effect On Employers' Costs Difficult To Measure*, U.S. GEN. ACCT. OFF. 3 (Oct. 1993), <http://www.gao.gov/assets/220/218707.pdf>.

22. For example, in a 2012 report, the Congressional Budget Office concluded that "coordination" and disease management (the labels for the activities HMOs were alleged to engage in because they were "prepaid") either saved no money or raised Medicare's costs. Here is an excerpt:

This paper summarizes the results of Medicare demonstrations of disease management and care coordination programs. Such programs seek to improve the health care of people who have chronic conditions or whose health care is expected to be particularly costly, and they seek to reduce the costs of providing health care to those people. In six major demonstrations over the past decade, Medicare's administrators have paid 34 programs to provide disease management or care coordination services to beneficiaries in Medicare's fee-for-service sector. All of the programs in those demonstrations sought to reduce hospital admissions by maintaining or improving beneficiaries' health.... On average, the 34 programs had no effect on hospital admissions or regular Medicare expenditures (that is, expenditures before accounting for the programs' fees).... After accounting for the fees that Medicare paid to the programs, however, Medicare spending was either unchanged or increased in nearly all of the programs.

Lyle Nelson, *Lessons from Medicare's Demonstration Projects on Disease Management and Care Coordination* 1 (Cong. Budget Office, Working Paper No. 2012-01, 2012), http://www.cbo.gov/sites/default/files/WP2012-01_Nelson_Medicare_DMCC_Demonstrations.pdf.

results when quality is measured by patient satisfaction.²³

The managed care movement's diagnosis has always consisted of two related assumptions: overuse is rampant and is the primary cause of the high cost of American health care, and overuse is caused by the FFS system. Neither assumption has ever been supported by research. At least four types of evidence contradict these assumptions:

- Evidence that citizens of many other industrialized nations consume medical services at or below American rates, and yet per capita spending on medical care in these countries is far below the American level;²⁴
- research showing that underuse of medical care in the US is far more common than overuse, even among the insured;²⁵
- evidence that research demonstrating overuse of specific medical services is virtually non-existent compared with the myriad goods and services delivered by clinics and hospitals and other providers in industrialized nations;²⁶ and
- evidence that overuse occurs as often among providers paid FFS as among providers subject to the restrictions and incentives of managed

23. See Kip Sullivan, *Managed Care Plan Performance Since 1980: Another Look at Two Literature Reviews*, 89 AM. J. PUB. HEALTH 1003 (1999).

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

25. See Elizabeth A. McGlynn et al., *The Quality of Health Care Delivered to Adults in the United States*, 348 NEW ENG. J. MED. 2635 (2003).

26. Here are three quotes from the literature on this issue: "The robust evidence about overuse in the US is limited to a few services." Deborah Korenstein et al., *Overuse of Health Care Services in the United States: An Understudied Problem*, 172 ARCH. INT. MED. 171, 171 (2012).

What is most striking about this report is how hard the authors searched for data on overuse of health care and how little they found. They viewed 21 years of the medical literature and evaluated 114,831 publications, yet found only 172 articles that addressed overuse of health care.

Mitchell H. Katz, *Overuse of Health Care: Where Are the Data?*, 172 ARCH. INT. MED. 178, 178 (2012). (Referring to Korenstein et al. *supra*)

One factor that has often been cited as a probable cause of overuse is ... FFS payment....

In fact, a direct association between FFS payment and overuse has never been established. No study has used formal appropriateness criteria for specific procedures to compare rates of overuse in FFS financing versus other forms of payment.

Elise C. Becher & Mark R. Chassin, *Improving the Quality of Health Care: Who Will Lead?*, 20 HEALTH AFF. 164, 166-67 (2001).

Demonstrating the overuse of specific goods and services is complicated by the fact that uncertainty plays a role in many medical decisions. Many services, for example hospitalization and additional tests, are ordered to rule out a diagnosis or to otherwise reduce uncertainty. The fact that the patient turned out not to be so sick as to need hospitalization, or did not have the suspected disease, is not evidence of overuse.

Over the last decade, the evidence most often invoked by those who claim overuse is rampant are studies that show regional variation in the utilization rates of medical care. But this research does not tell us how much of the variation is due to overuse and how much to underuse.

care.²⁷

Taken together this evidence indicates the managed care movement's assumptions about FFS and overuse are at best undocumented, and at worst contradicted by the evidence. We turn now to the more specific assumptions about solutions that follow from the managed care movement's FFS-overuse diagnosis.

Managed care advocates have long asserted that HMOs, and later "managed care organizations," provide more preventive services because (a) preventive services allegedly save money and (b) the HMO or insurance company (or the doctors who work for them; it is not clear which was intended) are paid capitation fees rather than FFS, and being paid capitation creates an incentive to save money. But the premise that preventive services save money is not accurate. A review of the literature on this question concluded, "Although some preventive services do save money, the vast majority reviewed in the health economics literature do not."²⁸

Even the minority of preventive services that save money may not save money for a particular insurer or provider. Preventive services take time to pay off, and during that time many patients leave the insurance company that paid for the service or the provider who administered it.

With this evidence in mind, it is not surprising that there is little support within the literature for the claim that HMOs or managed care providers deliver more preventive services than FFS doctors.²⁹

It is routinely claimed by managed care proponents that quality improvement saves money. It appears this assumption is based on the same faulty logic behind the claim that prevention saves money. Just as preventive services cost money to administer, so the interventions that bring about quality improvement cost money. And just as the return-on-investment in prevention is often not high enough to offset the cost of the preventive service, so the return-on-investment in quality improvement (foregone medical costs due to improved health) may not offset the cost of the intervention that improved quality. Donald Berwick dismissed this claim out of hand a decade ago. "Right from the start, it has been one of the great illusions ... that quality and cost go in opposite directions," he

27. Salomeh Keyhani et al., *Overuse and Systems of Care: A Systematic Review*, 51 MED. CARE 503 (2013).

28. Joshua T. Cohen et al., *Does Preventive Care Save Money? Health Economics and the Presidential Candidates*, 358 NEW. ENG. J. MED. 661, 662-63 (2008). Preventive services raise rather than lower costs for three reasons: (1) Preventive services must be administered to many people who would never have caught or developed the targeted disease; (2) some preventive services, notably cancer screens, reveal disease, which in turn triggers tests and in some cases expensive treatment, which can in turn create side effects that require more treatment; and (3) like most other forms of medicine, preventive medicine is not 100 percent effective.

29. Kathryn A. Phillips et al., *Use of Preventive Services by Managed Care Enrollees: An Updated Perspective*, 19 HEALTH AFF. 102 (2000).

said in an interview with *Health Affairs*. “There remains very little evidence of that.”³⁰ Research confirms Berwick’s impression.³¹

A third critical assumption made by managed care proponents is that the quality of insurance companies and clinics can be measured and reported to the public and to regulators, and can be used to reward and punish providers, and that these uses will induce improvements in quality and lead to lower costs. But proponents of medical “report cards” have never articulated what portion of the thousands of medical goods and services must be measured in order to avoid “teaching to the test,” nor have they estimated the cost of measuring even the relatively small handful of conventionally accepted quality measures. The cost of reporting on a single procedure can run into the millions of dollars.

There is little evidence that report cards improve quality and some evidence they damage quality.³² This is true both of report cards that are published in the hope they will induce patients to choose “high quality” providers, and those that are used internally by payers to reward and punish providers. Given this evidence, and the evidence that quality improvement does not always lower costs, we may conclude that report cards are probably raising costs.

The managed care movement has enthusiastically recommended EMRs on the assumption that they will lower costs and improve quality. The research does not support either claim.³³ Because EMRs are expensive to buy and maintain, the failure of EMRs to improve quality on balance almost certainly means the spread of EMRs is raising total health care costs.

The last assumption on the itemized list above is that providers should join large horizontal and vertically integrated groups or corporations. This recommendation is more often implied than stated. Paul Ellwood and colleagues, to take an early example of the endorsement of this assumption, asserted their “HMO strategy” would lead to “a course of change ... that would have some of the classical aspect of the industrial revolution,” including “conversion to larger units of production.”³⁴ Ellwood et al. predicted this outcome presumably because they understood that small organizations cannot bear insurance risk. Proponents of the successor to the HMO, the ACO, have offered an additional rationale:

30. Robert Galvin, *Interview: “A Deficiency of Will and Ambition”: A Conversation with Donald Berwick*, HEALTH AFF. W5-1 (2005).

31. See Peter S. Hussey et al., *The Association between Health Care Quality and Cost*, 158 ANNALS INT. MED. 27 (2013).

32. David Dranove et al., *Is More Information Better? The Effects of “Report Cards” on Health Care Providers*, 111 J. POL. ECON. 555, 577 (2003).

33. David U. Himmelstein et al., *Hospital Computing and the Costs and Quality of Care: A National Study*, 123 AM. J. MED. 40 (2010); Sumit R. Majumdar & Stephen B. Soumerai, *The Unhealthy State of Health Policy Research*, 28 HEALTH AFF. w900, w904-05 (2009); Max J. Romano & Randall S. Stafford, *Electronic Health Records and Clinical Decision Support Systems: Impact on National Ambulatory Care Quality*, 171 ARCH. INT. MED. 897 (2011).

34. Paul M. Ellwood, Jr. et al., *Health Maintenance Strategy*, 9 MED. CARE 291, 298 (1971).

Measurement of ACO quality and cost by third parties requires large numbers of patients in order for measurement to be accurate.

But the assumption that consolidation should be tolerated or encouraged rests on several of the previously discussed assumptions, notably the FFS-overuse diagnosis and the assumption that the solution to FFS is to shift insurance risk to doctors and hospitals. It also rests on another assumption that cannot be justified—that consolidation does not create its own negative effects, or that the negative effects are so trivial they are outweighed by the benefits of shifting insurance risk to providers.

However, from 1970 on, proponents of HMOs and later iterations of managed care asserted or relied on all of the unexamined assumptions we have just discussed, almost always without reference to research. From the earliest days of the managed care movement, its participants have consistently displayed a tendency to diagnose and to prescribe without evidence or on the basis of evidence that can at best be described as inconclusive. This casual attitude toward evidence is also revealed in the movement's disinterest in identifying the mechanisms that are supposed to cause HMOs and kindred entities to function as advertised, and to ignore or minimize side effects of its proposals. This includes denial of necessary services to patients, the deprofessionalization of medicine, rising administrative costs, the risks electronic medical records pose to patient safety and patient privacy, and, as we just mentioned, consolidation.

Because of the movement's reliance on unexamined assumptions as well as its affinity for abstract and value-laden marketing jargon ("health maintenance organization," "managed care," "coordinated care," "integrated care," "silo," "medical home," "accountable care organization," "patient-centered," "transformation," etc.), it is very difficult to create testable hypotheses for the movement's fundamental premises and, therefore, very difficult to engage in scientific discourse. It is, in short, very difficult to hold the movement accountable. If we view the managed care movement as a political phenomenon, that has worked to its advantage. But as a source of policy, it has been a serious defect.

B. The Origins of the Managed Care Movement: The Birth of the HMO

As we saw in Part II, the acceleration of medical inflation in the late 1960s forced policy makers and activists across the political spectrum to develop positions on cost containment. Neither liberals nor conservatives looked to Medicare for answers. With Medicare still in its accommodationist phase, Democrats felt compelled to look outside of Medicare for solutions to the cost crisis. For Republicans, Medicare was part of the cost crisis, not part of the solution. A proposal first marketed by Paul Ellwood in 1970 under the label "health maintenance organization" gave both parties the solution they were

looking for. Between 1970 and 1973, both parties viewed the HMO as a promising reform option.

The partisan motivations supporting the conception of health maintenance organizations differed. The possibility that the medical cost crisis would soon lead to national health insurance worried Republicans and prompted attention to new policies. Their worries were not unfounded. The decades-old movement for national health insurance had been reinvigorated in 1968 by the formation of the Committee of 100 by the United Auto Workers and Senator Ted Kennedy. In September 1969 the National Governor's Conference endorsed New York Governor Nelson Rockefeller's national health insurance proposal.³⁵ In 1970, Senator Kennedy introduced what would today be called a single-payer bill.

For conservatives, the enactment of Medicare and Medicaid and the resurrection of the national campaign for national health insurance were red flags. In a 1968 speech to doctors in his congressional district organized by the president of the Marshfield Clinic, Republican Representative Melvin Laird warned that the "federal government is going to nationalize medical care within the next few years unless the profession itself takes responsibility for controlling runaway medical costs."³⁶ Within months of taking office in 1969, Nixon administration officials began searching for a solution that might thwart both medical inflation and the threat of national health insurance. A report prepared by Health, Education and Welfare officials Robert Finch and Roger Egeberg in 1969 made this clear: it claimed that what is at stake "is the pluralistic, independent, voluntary nature of our health care system. We will lose it to pressures for monolithic, government-dominated medical care unless we can make the system work for everyone."³⁷ In early 1970, Ellwood, who coined the phrase "health maintenance organization," came to the administration's rescue with his "HMO strategy."³⁸ Ellwood's arguments appealed directly to conservatives' opposition to national health insurance.³⁹

Democrats' support of the HMO concept was driven by an entirely different motive. HMOs, or "prepaid group practices" as they were generally known before 1970, were in large part the creation of populist organizations and labor. Because the American Medical Association (AMA) so vociferously opposed HMOs, and because other organizations with a history of supporting national health insurance were enthusiastic about HMOs, leading Democrats, including

35. See STARR, *supra* note 10.

36. See JAN GREGOIRE COOMBS, *THE RISE AND FALL OF HMOs: AN AMERICAN HEALTHCARE REVOLUTION* 14 (2005).

37. Finch & Egeberg, *supra* note 13, at 219.

38. See STARR, *supra* note 10, at 394-95; FALKSON, *supra* note 12, at 13-43.

39. For example, in the closing paragraph of a 1971 paper, Ellwood et al. wrote: "Most important, the health maintenance strategy offers a common cause for . . . the health industry in alleviating the medical care crisis in a rational and timely manner, as a feasible alternative to a nationalized health system." Ellwood et al., *supra* note 34, at 298.

Senator Kennedy, had little doubt that HMOs deserved the claims made for them by their proponents.⁴⁰ Whereas endorsement of HMOs turned out to be a brief love affair for Republicans (an affair they would resume in the late 1990s), for many Democrats the endorsement of HMOs was deeply felt and long-lasting.

The Nixon administration had reduced its support for HMOs by 1973, thanks primarily to the opposition by the AMA. The temporary alliance of Nixon and big business conservatives with congressional Democrats and unions, however, legitimized the managed care movement's diagnosis of and solution to the health crisis. The HMO Act of 1973, produced by the brief liaison between liberal and conservative proponents, was a mere shadow of the massive program originally proposed by Nixon and congressional HMO supporters.⁴¹ But that legislation, as well as the 1972 legislation authorizing HMOs to participate in Medicare, were beachheads upon which the newly formed managed care movement would build in decades to come.

C. The Managed Care Movement's Habits of Thought

The habits of thought within the managed care movement that we are examining—disregard for evidence, and the use of highly abstract concepts with manipulative labels—emerged at the very beginning of the movement. The label chosen for the movement's first and most formative proposition—the “health maintenance organization”—was deliberately constructed to be ambiguous. The decision by a handful of influential men to promote a concept as ambiguous as the HMO and to bestow upon it such a presumptuous label, and the immediate political success of that strategy, set a precedent that deeply influenced the managed care movement for decades.

The HMO label was invented at a meeting held at the Washington Plaza Hotel on February 5, 1970 at which Ellwood presented his “health maintenance strategy” to three representatives of the Nixon administration: HEW Undersecretary John Veneman, Assistant Secretary Lewis Butler, and an assistant to Veneman. Ellwood initially argued that Kaiser Permanente should be the model for the HMO, but Butler objected to defining any feature of an HMO. As Butler stated in a 1973 interview:

Why should we specify how to put it together? Let the doctors—let everybody do it, figure out how to put it together. *Let's specify what we want it to do.* And we don't give a damn how they put it together . . . Let's describe the thing by what we want it to do, not how it's formed (emphasis added).⁴²

As Falkson reported later, “By leaving the specification of the organizational

40. See FALKSON, *supra* note 12, at 123.

41. See COOMBS, *supra* note 36, at 51.

42. See FALKSON, *supra* note 12, at 31.

structures to the delivery system itself but defining incentives designed to accomplish particular objects, it could be argued that the federal government was removing itself from interference in the direct delivery of health care and confining itself to the role of catalyst and purchaser. The idea could be sold . . . as a market reform strategy rather than yet another federal program requiring a large bureaucracy . . . to manage it.”⁴³

Thus, at the dawn of the HMO movement, making the concept more attractive was invoked as justification for manipulative language. The HMO would be defined by what its proponents hoped it would accomplish, not according to how it operated or what empirical evidence said it could do.

Defining something by “what we want it to do” is ordinarily not a promising first step in generating a useful debate. Consider a medical analogy. If a drug company defined a pill to reduce arthritis pain not by describing its ingredients and its mechanism of action, but by what “we want it to do,” how does the Food and Drug Administration evaluate the pill? Or, consider an engineering analogy: What if a bridge-building firm defined its bridge not by its dimensions, the materials to be used and the mechanisms used to ensure strength, but instead by “what we want it to do”? Unless that approach—presenting one’s aspirations for something as a substitute for a definition of it—is abandoned at some point, that approach guarantees that the proponents of the idea in question will have to speak at a high level of abstraction. And, worse, they will have to defend the original wishful thinking with more wishful thinking. But conservative and liberal proponents of HMOs inside and outside Congress swiftly adopted this linguistic convention. Ellwood, for example, in a paper published a year later, defined the HMO as an entity that “agrees to provide comprehensive health maintenance services to its enrollees in exchange for a fixed annual fee.”⁴⁴ Similarly, in response to a letter from the Senate Finance Committee asking the Nixon administration for a definition of “HMO,” Veneman replied that “an HMO is one [*sic*] which assumes responsibility for the maintenance of health of a defined population.”⁴⁵ According to these “definitions,” an HMO can be defined by what it “agrees to” or “assumes responsibility for.” This definition tells us nothing about who the HMO is “agreeing with,” whether the HMO will or can live up to its agreement, and by what mechanisms it will attempt to do so. The same can be said of other hope-based claims that were made by HMO proponents—that HMOs would provide “comprehensive services,” “emphasize prevention,” implement “quality assurance” and “accept prepayment.”

Ellwood and the other participants in the 1970 meeting debated what to call the thing that would be defined by their hopes for it. Ellwood recommended

43. *Id.* at 31-32.

44. Ellwood et al., *supra* note 34, at 295.

45. Letter from John Veneman, Under Sec’y of U.S. Dep’t of Health, Educ., & Welfare, to Tom Vail, Chief Counsel, Senate Fin. Comm. (Sept. 13, 1971), in ROY, *supra* note 19, at 261, 264.

putting “health maintenance” in the name because “health maintenance” implied that HMOs would make greater use of preventive services. The group endorsed this choice and the biases it implied (prevention and high-quality care wither under FFS and flourish when doctors bear insurance risk and are supervised by third parties), and then discussed what noun to tack on to “health maintenance.” They settled on “organization” because that word did not imply any particular structure. The three words together—health maintenance organization—“was a politically nebulous and, therefore, desirable phrase,” according to Falkson, and therefore “not immediately assailable from either the left or the right.”⁴⁶

Before the meeting broke up Ellwood agreed to write a paper summarizing the case for HMOs. He submitted the paper to the Nixon administration in March 1970 and published a version of it in *Medical Care* in 1971. That paper, influential for decades after it was published, confidently asserted the fundamental assumptions that would fuel the managed care movement for decades to come. And yet Ellwood’s paper contained not a single footnote.⁴⁷ Patricia Baumann noted in a 1976 article, “Ellwood’s rhetoric is more important in explaining why HMOs were initially denoted as a major strategy by the Nixon administration than is the substance of the concept.”⁴⁸ The same could be said about the willingness of Democrats to endorse the HMO. Leaders of both parties eagerly accepted the idea that the HMO could be defined by the aspirations of its proponents. Rhetoric trumped scientific discourse.

Once it was clear the ambiguously defined HMO had bipartisan support, grandiose claims for HMOs—claims which often implied severe criticism of FFS doctors—became commonplace. President Nixon, for example, stated that HMOs “keep their clients healthy.”⁴⁹ Similarly, Dr. Merlin Duval Jr., Assistant Secretary for HEW, claimed: “It is reasonable to expect that with this [prepayment] incentive, HMOs are most likely to immunize members’ children, rather than have them contract a disease . . .”⁵⁰

Legislation subsequently introduced by both parties perpetuated the novel idea of defining an important concept according to the aspirations of its

46. FALKSON, *supra* note 12, at 32.

47. Ellwood et al., *supra* note 34.

48. Patricia Baumann, *The Formulation and Evolution of the Health Maintenance Organization Policy, 1970-1973*, 10 SOC. SCI. & MED. 129, 132 (1976).

49. *Id.* at 133.

50. *Testimony before Subcommittee on Health, Senate Committee on Labor and Public Welfare*, in ROY, *supra* note 19, 103, at 103. Some wishful thinking about HMOs verged on the outlandish. Dr. Harry C. Stamey, a psychiatrist affiliated with Geisinger Clinics, asserted that HMO doctors would become responsible for eliminating hunger in their patients: “Say we get a child in the clinic who is undernourished. Because we are now oriented toward crisis intervention, once the child leaves, the cause of the undernourishment is not our responsibility.... But under the HMO it will be.” *Health Maintenance Organizations: What They Will Mean to Doctors in Quality, Hours, Dollars*, MED. WORLD NEWS, Oct. 29, 1971, at 39, 45.

proponents. The Nixon Administration's 1971 HMO bill (HR 5615) defined HMOs as organizations that would meet a half-dozen aspirations of HMO proponents.

HR 5615 . . . was purposely general in specifying types of organizational entities that could qualify as HMOs Six conditions were established. The entity must: (1) provide service on a per capita prepaid basis; (2) provide or arrange for a prescribed range of services; (3) provide physicians' services . . . ; (4) demonstrate financial and operational competence; (5) ensure access, prompt services, and quality, and (6) have open enrollment⁵¹

Democrats adopted the same strategy. As Representative William Roy, the chief HMO proponent in the House of Representatives said, his bill sought "to describe what HMOs must do (provide comprehensive health services, with quality assurance, etc.) but not to say how these general characteristics are to be achieved by any given organization."⁵²

What did "operational competence," "ensure access," and "comprehensive services" mean, how would we know it if we saw it, and what mechanisms in HMOs were supposed to produce these outcomes? What did it mean to say HMOs were different from insurance companies because they were "prepaid"? Was it not true that premiums paid to insurance companies were also "prepaid," that is, paid prior to the provision of medical services?⁵³ How did the phrase "assume responsibility for a defined population" distinguish the legal liability that HMOs assume from the liability traditional insurers assume? How did the phrase "defined population" or "enrolled population" distinguish the finite "populations" insured by HMOs from the finite "populations" insured by

51. See FALKSON, *supra* note 12, at 108.

52. Roy's definition of "HMO" was as abstract as Nixon's. In his 1972 book explaining his HMO bill, he wrote: "The general characteristics which would make an organization an HMO regardless of its particular make-up include:

1. Open enrollment of a defined, heterogeneous population which receives its health services from the HMO;
2. Assumption by the HMO of the responsibilities and risks involved in caring for the enrolled population;
3. Prepayment by the enrolled members....;
4. Provision by the HMO of ... comprehensive health services....;
5. Quality assurance programs....;
6. Provision of health education, health maintenance and preventive health services....;
7. Provision of meaningful grievance procedures and policy-making roles for members; and
8. Evaluation of its performance in key areas."

ROY, *supra* note 19, at 32.

53. HMO proponents were deliberately vague about whether "prepayment" described how HMOs were paid, how clinics and hospitals were paid, or how both HMOs and providers were paid. Referring to the Nixon Administration's proposal as of 1971, Baumann wrote, "[T]he method of provider reimbursement ... is not specified." Baumann, *supra* note 48, at 129.

traditional insurance companies?⁵⁴

The congressional debate that took place during 1971-1973 failed to refine the definition of HMOs. The debate focused on these questions:

- Whether HMOs would be required to limit patient choice of provider to “closed panels,” or would be allowed to let enrollees see providers outside HMO networks;
- whether subsidies and loan guarantees for HMOs would be limited to non-profits;
- whether enrollment had to be “open” during a certain period (that is, whether HMOs would have to accept all applicants) if the same requirement was not imposed on other insurers;
- whether employers would be required to offer HMOs along with traditional insurance (a mandate known as “dual choice”);
- how broad the required coverage should be; and
- whether to eliminate state laws that outlawed the “corporate practice of medicine,” an impediment to the formation of HMOs.⁵⁵

None of these issues forced HMO proponents to describe specific mechanisms (as opposed to abstract concepts such as “coordination” and limiting patient choice of provider) that HMOs would use to lower costs and “maintain health” and otherwise raise quality of care. Consequently, proponents were not forced to abandon abstraction and value-laden jargon, and, most importantly, they were not forced to defend their optimistic predictions of what HMOs would do.

And yet, the emerging managed care movement notched two significant legislative victories: the 1972 legislation permitting HMOs to enroll Medicare beneficiaries, and the HMO Act of 1973.⁵⁶ The lesson was clear: Being vague, using marketing-like labels, and exaggerating or ignoring evidence paid off politically. These habits of thought and argumentation became deeply ingrained in the culture of the managed care movement. We illustrate this statement with two examples from the more recent past—“pay for performance” (P4P) and “accountable care organizations” (ACOs).

54. The Senate Finance Committee posed thirty-four similar questions in a July 20, 1971 letter to HEW Under Secretary John Veneman. The questions included: “Exactly what is the difference between a premium payment and a capitation payment...?”; “How do ‘health maintenance’ services differ from what are ordinarily regarded as diagnostic and therapeutic services?” and, not surprisingly; “[H]ow is a health maintenance organization defined?” Veneman in ROY, *supra* note 19, at 272, 279, 264.

55. See COOMBS, *supra* note 36, at 39-57; FALKSON, *supra* note 12, at 89-164.

56. The HMO Act of 1973 subsidized the formation or expansion of HMOs, and required employers with more than 24 employees to offer HMO coverage if they offered insurance coverage of any kind.

D. The Managed Care Culture at Work: Wishful Thinking About Pay-for-Performance and “Accountable Care Organizations”

The HMO experiment, which by the 1980s had become the managed care experiment, was badly damaged by a hailstorm of negative publicity in the latter half of the 1990s. The damage was so severe that observers in the professional and lay media questioned whether the managed care revolution was “dead” or “over”.⁵⁷ The managed care movement, which by now included virtually the entire health insurance industry, searched for cost-control tactics that were less visible and less provocative than those pioneered by HMOs, but which would be equally effective at shifting risk to providers.

Within the first decade of the 2000s, managed care advocates from both the public and private sectors cooperated to develop two seemingly new concepts that held the promise of shifting financial risk to providers without infuriating patients—P4P and the ACO. Unlike utilization review, gate-keeping and pre-authorization, P4P could be administered in back offices out of sight of patients. And, unlike capitation, P4P could be described as an attempt to improve quality.⁵⁸ Unlike the HMO, the ACO would not require enrollment and would not limit patient choice of provider.

P4P emerged first. Between 2000 and 2003 it was endorsed by, among others, the Leapfrog Group (a creation of the Business Roundtable),⁵⁹ the Integrated Healthcare Association (an association of eight insurers in California),⁶⁰ the Medicare Payment Advisory Commission (MedPAC), and a group of prominent managed care advocates, including Donald Berwick, Paul Ellwood, and Alain Enthoven.⁶¹ As was the case with HMOs, this wave of endorsements of P4P by the health policy elite was not supported by evidence that P4P in medicine was safe, effective, or affordable. For example, in the paper mentioned above by Berwick et al., the authors did not cite one study supporting their assertion that “payment for performance should become a top national priority.”⁶² To take another example, MedPAC’s justification for recommending P4P in its June 2003 and March 2005 reports to Congress was that the private

57. See, e.g., James C. Robinson, *The End of Managed Care*, 285 JAMA 2622 (2001).

58. Robert Galvin, an executive at General Electric, a co-founder of the Leapfrog Group, and an advisor to the Institute of Medicine, attributed the rise of P4P in part to “the collapse of managed care.” Robert S. Galvin, *Evaluating the Performance of Pay for Performance*, 63 MED. CARE RES. & REV. 126S, 126S (Supp. Feb. 2006).

59. *Fact Sheet*, THE LEAPFROG GROUP (Feb. 2007), http://www.leapfroggroup.org/media/file/leapfrog_factsheet.pdf.

60. *California Pay For Performance Overview*, INTEGRATED HEALTHCARE ASS’N (2014), http://www.ihc.org/p4p_california.html.

61. Donald M. Berwick et al., *Paying for Performance: Medicare Should Lead*, 22 HEALTH AFF. 8 (2003).

62. *Id.* at 9.

sector was doing it. MedPAC cited no research supporting its claims for P4P.⁶³

P4P proponents did not justify their policy reform with evidence because there was none to invoke. As the three guest editors put it in a 2006 edition of *Medical Care Research and Review* devoted entirely to P4P, “P4P programs are being implemented in a near-scientific vacuum.”⁶⁴ As the Institute of Medicine stated in 2007 in the course of restating its support for P4P, “most studies have failed to demonstrate any significant effects on processes of care.”⁶⁵ The justification for P4P boiled down to, “the status quo is terrible; P4P can’t be worse than the status quo.”⁶⁶

Today, a sizable body of research on P4P has been published, and it does not support the claims made for P4P.⁶⁷ Nevertheless, P4P—like the HMO—gathered so much support from the health policy elite that the concept quickly made its way into federal law. The ACA mandates the implementation of P4P in the Medicare program.

The ACO emerged on the heels of the P4P fad. Like the HMO concept, the ACO rocketed to fame overnight. The ACO label was invented at a November 2006 meeting of the MedPAC commissioners; the first paper about the ACO appeared a month later in *Health Affairs*;⁶⁸ by 2009, Democrats in both houses were supporting it; and in 2010, the ACO concept was written into federal law with the enactment of the ACA.

63. MEDICARE PAYMENT ADVISORY COMM’N, REPORT TO CONGRESS: VARIATION & INNOVATION IN MEDICARE 107-22 (2003); MEDICARE PAYMENT ADVISORY COMM’N, REPORT TO CONGRESS: MEDICARE PAYMENT POLICY 183-214 (2005).

64. Dan Berlowitz et al., *Introduction*, 63 MED. CARE RES. & REV. 11S, 11S (Supp. Feb. 2006).

65. INST. OF MED., REWARDING PROVIDER PERFORMANCE: ALIGNING INCENTIVES IN MEDICARE 46, (2007), *quoted in* Ruth McDonald et al., *Paying for Performance in Primary Medical Care: Learning about and Learning from “Success” and “Failure” in England and California*, 34 J. HEALTH POL., POL’Y & L. 747, 769 (2009).

66. Glenn Hackbarth, chairman of MedPAC, offered the “the status quo is terrible” rationale in a 2006 paper:

Why is MedPAC confident that P4P is the proper thing to do, especially given the limited amount of hard evidence on its impact? Two reasons. First, there is overwhelming research documenting the poor performance of our health care system The status quo is unacceptable Second, there is abundant evidence that health care providers respond to incentives. For people with substantial experience in health care delivery and policy, like the MedPAC commissioners, it does not seem like much of a leap to conclude that P4P is a step in the right direction.

Glenn Hackbarth, *Commentary*, 63 MED. CARE RES. & REV. 117S, 118S (Supp. Feb. 2006).

67. See Ashish K. Jha et al., *The Long-Term Effect of Premier Pay for Performance on Patient Outcomes*, 366 NEW ENG. J. MED. 1606 (2012); Grace M. Lee et al., *Effect of Nonpayment for Preventable Infections in US Hospitals*, 367 NEW ENG. J. MED. 1428 (2012); Andrew Ryan et al., *The Early Effects of Medicare’s Mandatory Hospital Pay-for-Performance Program*, HEALTH SERVS. RES. (2014), <http://onlinelibrary.wiley.com/doi/10.1111/1475-6773.12206/abstract>.

68. Elliot Fisher et al., *Creating Accountable Care Organizations: The Extended Hospital Medical Staff*, 26 HEALTH AFF. W44 (2007).

Like the early HMO proponents, the inventors of the ACO concept deliberately refrained from defining the ACO's structure and mechanisms. They chose a name for the concept that manipulated rather than enlightened (who would want to be for "unaccountable care?"). Like the HMO, the definition of the ACO is aspirational. ACOs are said to "take responsibility" for improving quality and lowering costs for a "defined population," etc.⁶⁹ As was the case with the HMO, the ACO is said to counteract the alleged negative consequences of the FFS system, including overuse and "fragmentation."⁷⁰ And, as was the case for HMOs, the claims made for ACOs could not be substantiated at the time they were first made and were subsequently contradicted by research.⁷¹

69. See Ed Adashi & Elliott S. Fisher, *An ACO Visionary Talks Implementation, Healthcare Reform*, MEDSCAPE, Jan. 25, 2012, <http://www.medscape.com/viewarticle/757056>.

70. Here is a typical aspirational definition of "ACO":

ACOs consist of providers who are jointly held accountable for achieving measured quality improvements and reductions in the rate of spending growth. Our definition emphasizes that these cost and quality improvements must achieve overall, per capita improvements in quality and cost, and that ACOs should have at least limited accountability for achieving these improvements while caring for a defined population of patients.

ACOs may involve a variety of provider configurations, ranging from integrated delivery systems and primary care medical groups to hospital-based systems and virtual networks of physicians such as independent practice associations.

Mark McClellan et al., *A National Strategy to Put Accountable Care into Practice*, 29 HEALTH AFF. 982, 983 (2010).

This definition contains the ingredients common to virtually all ACO definitions, notably, language depicting a (poorly defined) group of providers being "held accountable" (by unidentified means by unidentified parties) for "measured improvements" (measured at an unknown cost to providers and the measurer) in the "cost and quality" of health care delivered to a "population."

71. The Physician Group Practice Demonstration, which ACO proponents themselves acknowledged was a test of the ACO concept, failed to cut Medicare's costs but did demonstrate that ACOs engage in upcoding to create the illusion that they cut costs. Carrie H. Colla et al., *Spending Differences Associated with the Medicare Physician Group Practice Demonstration*, 308 JAMA 1015 (2012). Similarly, preliminary second-year results from the Medicare ACO programs mandated by the Affordable Care Act indicate ACOs achieved tiny savings for Medicare. Jordan Rau, *One-quarter of ACOs Save Enough Money to Earn Bonuses*, KAISER HEALTH NEWS (Sept. 16, 2014), <http://capsules.kaiserhealthnews.org/index.php/2014/09/one-quarter-of-acos-save-enough-money-to-earn-bonuses>. According to MedPAC, the ACO program is raising the costs of participating providers by "one to two percent" and cutting Medicare expenditures by only 0.3 to 0.5 percent. Transcript of Medicare Payment Advisory Commission Public Meeting, MEDICARE PAYMENT ADVISORY COMMISSION 118, 123, 133 (Sept. 11, 2014), http://www.medpac.gov/documents/092014-medpac_transcript.pdf. (statement of David Glass & Jeff Stensland on Medicare Accountable Care Organizations (ACOs), Public Meeting of Medicare Payment Advisory Commission). Neither Colla et al., *supra*, nor Glass & Stensland, *supra*, reported on the administrative costs to Medicare of running the PGP Demonstration and the ACO programs. These results suggest ACOs are raising total health care costs.

E. The Effect of the Managed Care Movement on Liberals

Managed care was a response to, and came of age during, a time when policy makers and payers had fallen under unprecedented pressure to reduce health care costs. That pressure made them vulnerable to the message presented by the managed care movement, namely, that there was widespread consensus among experts that managed care would work, and that this consensus was based on evidence, not mere opinion or ideology. At the same time, the growing influence of the pro-market movement put pressure on lawmakers and activists to turn away from the cost-control tools that Medicare eventually developed—low administrative costs and negotiated fees and prices. The managed care message—“You don’t need to endorse Medicare-for-all, and thereby annoy conservatives, to contain costs”—was music to the ears of legislators who supported universal coverage (that is, liberal legislators) but who knew they had to appear to be interested in cutting costs if they wanted to expand coverage.

This was the principal mechanism by which the rise of the managed care movement played a significant role in keeping Medicare-for-all off the nation’s agenda during the 1970s. The influence of this mechanism became even greater in the 1980s and 1990s with the addition of the health insurance industry and many large corporations to the ranks of the managed care movement. It did so by inducing leaders and groups that supported universal coverage to abandon Medicare-for-all as a solution in favor of the “win-win” managed care vision—costs would go down because quality would go up. If the feel-good managed care vision had not existed, the people and groups who were pulled into the managed care movement might otherwise have overcome their anxiety about anti-government rhetoric from the right differently. They might have examined more closely the cost-containment tools of the traditional Medicare program, and, having done so, they might have endorsed an expansion of Medicare.

Senator Ted Kennedy and Presidents Bill Clinton and Barack Obama are prominent examples of political leaders who might well have endorsed Medicare-for-all but did not because they were misled by managed care rhetoric. All three men were passionate proponents of universal coverage, and all three felt keenly the need to restrain health care inflation. All three men held powerful positions during those rare moments in American history when universal coverage had a chance of being enacted. But none of them endorsed the obvious benefits of a Medicare-for-all system. Instead, they became powerful advocates of managed care.

Kennedy’s conversion to managed care’s diagnosis and solution occurred early in the 1970s, thanks to widespread support for it within the labor movement and other liberal groups supporting universal coverage.⁷² The legislation

72. See FALKSON, *supra* note 12, at 123.

Kennedy introduced with Representative Griffiths—legislation which is often characterized as a single-payer bill—would have subsidized non-profit HMOs. Kennedy would later throw his support behind the ACA, a bill that promoted numerous unproven managed care nostrums, including the ACO.

By the early 1990s, when President Clinton developed his position on health care reform, the managed care movement had become larger and more powerful. It had evolved from a relatively small coalition of policy entrepreneurs, politicians, and liberal groups committed to universal coverage into a much richer and more influential coalition led by large employers and the health insurance industry. (As we shall see in the next section, the pro-competition movement had also become more influential by the early 1990s.) By the time Clinton began formulating his response to the health care crisis, the influence of the managed care movement was no longer based primarily on the exaggerated claims made for it. By then, the movement's influence was based as well on the immense political muscle it acquired during the 1980s and 1990s.

Candidate Bill Clinton seemed to entertain the Medicare-for-all proposal briefly, then rejected it in favor of a version of managed competition. In 1991 he invited one of the authors (Marmor) to a meeting at the Washington Court Hotel in Washington, DC to present the case for a single-payer system. He also invited Ron Pollack, then and now the director of Families USA, to present the case for relying on a multiple-payer solution. After a two-hour debate, Clinton told Marmor, "Ted, you win the argument," but then gesturing to Pollack he said, "but we're going to do what he says."⁷³ Barely a year later, candidate Clinton endorsed "managed competition." In 1993 President Clinton built his universal coverage legislation, the Health Security Act, on the managed competition theory.

Candidate Obama followed a path much like the one Senator Kennedy followed: Encouraged by large labor unions, Families USA, and a long list of other groups that supported universal coverage, many of whom joined the Herndon Alliance and Health Care for America Now, Obama turned away from Medicare-for-all and endorsed a grab-bag of managed care concepts, including P4P and ACOs. Like Kennedy and Clinton, Obama enthusiastically promoted the basic premises of managed care.

III. THE PRO-COMPETITION MOVEMENT

During the 1970s, competitive reforms became a dominant feature of policy debates about American medicine. Although Medicare was largely insulated in the 1980s from these newer ideological currents, the genesis of those pro-competitive ideas and how they came to be applied to American medicine proved

73. See Tom Hamburger et al., *What the Death of Health Reform Teaches Us About the Press*, WASH. MONTHLY, Nov. 1994, at 35, 35.

to be crucial to Medicare's fate in the late 1990s, and will continue to be important. In this section we describe the rise of pro-competitive ideas in American medicine over the last quarter of the twentieth century.

As we saw in Part 2, Ellwood's vague HMO proposal stirred up enough support among conservatives to ensure enactment of the HMO Act of 1973, but by that year conservative support for HMOs was already waning. Simultaneously, conservative support for universal coverage reverted to the traditional conservative position, which was to promote more cost-sharing for patients and to oppose universal health insurance, either explicitly or implicitly by blaming the health care system's defects on government regulations and public programs, namely Medicare and Medicaid. At least three factors contributed to the resurgence of conservative interest in pro-competition theory during the 1970s. The first we have already discussed in Parts I and II: the dramatic shift in the focus of the health care reform debate from access to cost during the five years after the enactment of Medicare. This put pressure on both liberals and conservatives to adopt credible cost-containment policies.

A second factor was the general ascendancy in academic writing of a particular microeconomic approach to analyzing public policy. This phenomenon reflected the influence of "neoclassical economics," a school of thought that distinguished itself from "classical economics" by its assumptions about the ability and willingness of human beings to attach prices or "utility" to their choices. Economists who subscribed to these assumptions tended to argue that any action by government that constrained individual choice reduced society's ability to maximize society-wide "utility" or welfare. Politicians and regulators, they argued, could not possibly guess accurately how millions of people would choose, for example, between an extra unit of housing and an extra unit of food, or an extra unit of hospital coverage and an extra unit of drug coverage. These questionable assumptions led many economists who subscribed to them to a variety of proposals designed to reduce government influence, including proposals to rescind regulations and reduce taxes.⁷⁴ The anti-government, free market enthusiasms of economists identified with the University of Chicago represented this development, but others who would hardly be associated with that movement, like Brookings economist Charles Schultze, were also influential.⁷⁵ Indeed, it is fair to say that the neoclassical training of most

74. "Neoclassical economics" became the dominant school of economic thought during the last century. The primary difference between "classical" and "neoclassical economics" is that the latter relies heavily on the assumption that human beings can and do calculate the value in dollar terms of virtually any decision and compare that value to the value of other decisions. Moreover, in calculating the values of various options, neoclassical economics assumes human beings do so "at the margin," that is, they calculate the value of one additional unit of item A versus one additional unit of items B through Z before deciding to buy one more unit of A.

75. See E.M. Melhado, *Competition Versus Regulation in American Health Policy*, in *MONEY, POWER & HEALTH CARE* 145 (E. M. Melhado et al. eds., 1988).

American economists of this period made the growth of economic analyses of public policy a factor in this shift. All of this provided the intellectual groundwork for making pro-competitive reforms more plausible in medical care.

A third factor bolstering the pro-competition movement was the spread of the anti-government, anti-regulatory sentiment to the wider political arena. Although for many this development is synonymous with Ronald Reagan's presidency, it in fact had earlier roots. Richard Nixon's two presidential victories celebrated the limits of government and the appeal of market competition even if his administration's domestic policy actions actually expanded federal social policy significantly. During the mid-1970s, big business greatly increased its influence in American politics, indirectly by contributing money to conservative groups and candidates, and directly by traditional lobbying methods. Commentators often forget the extent to which Jimmy Carter ran for president on an anti-Washington, anti-government platform, portraying himself as a down-home farmer who, with pitchfork in hand, was headed to the nation's capital to slay the federal leviathan. The increased legitimacy of this general political ideology—most obviously consequential in traditional areas of governmental regulation like trucking, airlines, and finance—made its application to medical care less difficult than would have been the case at the time of Medicare's birth.

The pro-competitive ideology that arose out of the ashes of the 1970s came to have considerable political and rhetorical appeal. The simplest version of the "competitive" answer to social problems was that all public institutions needed to be restructured to accommodate market incentives. Proponents of competition in medical care confidently claimed that a return to the market would lead to lower costs, a more equitable allocation of scarce medical resources, the creation of a more rational delivery system, and the delivery of more appropriate (and perhaps better) medical care. The acceptability of these pro-competitive presumptions had become broad enough by 1980 that the *Report of the President's Commission for a National Agenda for the Eighties* could un-self-consciously assert:

An expansion of the role of competition, consumer choice, and market incentives rather than government control is more likely to create the much needed stimulus toward greater efficiency, cost consciousness, and responsiveness to consumer preferences so visibly lacking in our present arrangements for providing medical care.⁷⁶

Similar claims received widespread coverage in trade journals, in the popular press, and on Capitol Hill.⁷⁷

76. PRESIDENT'S COMM'N FOR A NAT'L AGENDA FOR THE EIGHTIES, REPORT OF THE PRESIDENT'S COMMISSION FOR A NATIONAL AGENDA FOR THE EIGHTIES 78-79 (1990).

77. See, e.g., J.B. Christianson & W. McClure, *Competition in the Delivery of Medical Care*, 301 NEW ENG. J. MED. 812 (1979) (for trade journals); L. E. Demkovich, *Competition Coming On*, 12 NAT'L J. 1152 (1980) (for coverage in the popular press and on Capitol Hill).

The pro-competition movement shares with the managed care movement a fascination with financial incentives and a belief that changing those incentives will lead to lower utilization and higher quality. Whereas the managed care movement focuses on the financial incentives affecting *doctors* created by the FFS method of payment, the pro-competition movement focuses on incentives affecting *patients* created by “excessive” health insurance and the tax subsidies that allegedly encourage the purchase of “too much” health insurance. As the managed care movement recommends shifting risk from insurance companies to doctors, so the pro-competition movement recommends shifting risk from insurance companies to patients via greater out-of-pocket payments. As the managed care movement assumes, without evidence, that shifting risk to doctors will cause doctors to eliminate only unnecessary services, so the pro-competition movement assumes, without evidence, that when patients are forced to pay more of their own medical bills they will eliminate only unnecessary services.

The most fundamental premise underlying the claims made for competition is that health insurance and medical care are no different from household appliances, restaurant meals, entertainment services, and myriad other goods and services sold in this country with minimal government assistance to buyers and minimal government regulation of sellers. Pro-competition enthusiasts assume that patients could and would restore competition to the health insurance and medical markets if they were exposed to the same incentives to shop that they are exposed to in other markets. But, according to pro-competition theory, this incentive is missing in the health insurance markets because patients lack “cost consciousness.”

This problem is caused by tax subsidies which artificially lower the real price of insurance and thus encourage patients to buy richer coverage than they need; “excessive” coverage in turn reduces “cost consciousness” or sensitivity to price in patients when they are “shopping” for medical care. The net result of this reduced sensitivity to price is that patients demand surgery and other medical services they do not need and would not pay for if they had to pay for it out of their own pockets.

Most pro-competition advocates, then, called for ending or reducing the tax subsidies for private health insurance, resisting any further expansion of Medicare and Medicaid in their traditional form, and encouraging the sale of insurance that exposed patients to large out-of-pocket costs. By the 1990s conservatives were regularly calling for “transparency,” by which they meant the publication of accurate information on the price and quality of medical services. Transparency will help the newly cost-conscious consumer shop intelligently for insurance and medical care, and when millions of consumers begin to shop intelligently, competition will be restored and prices will drop without damaging patients, says the theory.

But as was the case with the fundamental premises underlying the diagnosis

and solution endorsed by the managed care movement, the basic premises underlying the diagnosis and solution promoted by the pro-competition movement were assumed. The most fundamental premise, that medical care is like the markets for food, entertainment, and myriad other goods and services, is obviously wrong much of the time. It is wrong in two respects: (1) The role that price plays in influencing the demand for medicine is nowhere near as powerful as the role it plays in other markets, such as the markets for food and entertainment; (2) “consumers” of medical care have nowhere near the expertise to evaluate the appropriateness and quality of medical care ordered by their doctors that they have to evaluate food, entertainment, and myriad other consumer items.

Let us consider the first mistake. For example, while it is true that people will consume a lot more chocolate if it is given away for free or is sold at a price below its production costs, the same cannot be said about most medical goods and services. Unlike chocolate etc., many medical goods and services put patients at risk of death, pain and prolonged side effects. The demand for medical services with those risks clearly does not respond to price signals the way the demand for chocolate does. To take an obvious example, if the price of gall bladder surgery fell to zero for the entire American population, demand would, at most, increase by a small amount among that small portion of the population that badly needed it and had managed to put it off. Even medical services that entail little pain and minimal side effects, such as blood draws to check for cholesterol, are viewed by most patients as the equivalent of chores.

This characterization of patient attitudes is supported by a large body of research. Patients, even well insured patients, have so little attraction to medical care that they avoid seeking it for a wide variety of serious symptoms. According to the well-known RAND Health Insurance Experiment, eighty percent of patients with first-dollar coverage failed to see a doctor after experiencing “serious symptoms” such as loss of consciousness, shortness of breath, and unexplained bleeding.⁷⁸ As we noted earlier, other research indicates underuse of medical care is rampant, so common in fact that it exceeds overuse, even among the insured.⁷⁹ In short, the pro-competition movement’s most fundamental assumptions—that underuse is so trivial it can be ignored, that overuse drives health care inflation, and that overuse is caused by “overinsurance”—are not consistent with a large body of research on the role that price plays in patient demand for medical services.

The pro-competition movement has had little to say about these fundamental defects in its argument. It appears leading proponents found the analogy to other goods and services irresistible, and rather than examine their attraction to the

78. Martin F. Shapiro et al., *Effects of Cost-Sharing on Seeking Care for Serious & Minor Symptoms*, 104 ANNALS INT. MED. 246 (1986).

79. See MCGLYNN, *supra* note 25, at 348.

analogy, they built an entire health policy on it. Mark Pauly's 1968 paper on "moral hazard" is an early and prominent example of a leading pro-competition scholar who claimed insurance induced overuse even while he ignored the difference between consumer demand for chocolate and demand for colonoscopies. "The quantity of medical care an individual will demand depends on his income and tastes, how ill he is, and the price charged for it," Pauly wrote. "The effect of an insurance which indemnifies against all medical care expenses is to reduce the price charged to the individual at the point of service from the market price to zero."⁸⁰ That statement is true—insurance which covers all medical expenses reduces the effective, or point-of-service charge, to zero—but it begs the essential question: Do patients want to use—much less overuse—medical care just because the price is zero or below its cost of production? Pauly and his followers simply assumed the answer was yes.⁸¹

80. Mark V. Pauly, *The Economics of Moral Hazard: Comment*, 58 AM. ECON. REV. 531, 532 (1968).

81. Pauly wrote the paper cited in the previous footnote in response to Kenneth Arrow's influential 1963 paper on the role that uncertainty plays in weakening competition in the insurance and medical care sectors. Pauly took issue with Arrow's statement that the economic argument "for insurance policies of all sorts is overwhelming" and that "government should undertake insurance," including health insurance, when markets fail to do so. Kenneth Arrow, *Uncertainty and the Welfare Economics of Medicare Care*, 5 AM. ECON. REV. 941, 961 (1963). Total social "welfare" is maximized, wrote Arrow, when government provides services, such as health insurance, that people want but which markets have not provided or have provided in insufficient quantities.

Pauly made the opposite argument. He claimed that because all forms of insurance, including health insurance, create "moral hazard," national health insurance would lower, not raise, total welfare. "Moral hazard" is the economist's more technical term for cost unconsciousness or insensitivity to price induced by insurance. Pauly defined "moral hazard" as the "increase in usage" that occurs when health insurance lowers "the marginal cost of care to the individual." Pauly, *supra* note 81, at 535. To illustrate his undocumented assumption that the demand for medical care responds to price just as the demand for all other consumer goods and services does, Pauly presented the graph familiar to every economics 101 student: "price or cost" on the vertical axis, "quantity of medical care" on the horizontal axis, and a straight line with a downward slope of about 45 degrees indicating the consumption of medical care rises steadily as price falls. *Id.* at 533.

But Pauly made no effort to document his claim that the consumption of medical care bears such a strong correlation with price. He simply asserted that medical care is subject to the usual rule that demand for a good or service rises as its prices falls, and vice versa. Here is how he articulated that assumption: "[T]he response of seeking more medical care with insurance than in its absence is a result not of moral perfidy, but of rational economic behavior. Since the cost of the individual's excess usage is spread over all other purchasers of that insurance, the individual is not prompted to restrain his usage of care." *Id.* at 535. But is this true? Is it in fact "rational" to purchase an unneeded colonoscopy, prostate exam, mastectomy, or dose of radiation just because the cost will be "spread over all the other purchasers of the insurance?" Pauly assumed, without any explanation, that it is.

The habit of assuming that the demand for medical care is like the demand for food or clothing and that reduced price sensitivity guarantees overuse, and offering no documentation for those assumptions, persisted long after Pauly published his influential paper. In a 1994 paper advocating high-deductible policies known at the time as "medical savings accounts (MSAs)," former Texas Senator Phil Gramm made the case for MSAs by asking readers to contemplate what would happen

Consider now the second mistake in the assumption that medical care is like other goods and services: That patients know as much as their doctors about what services they need, and if costs are shifted to patients, patients will know the difference between necessary and unnecessary care and will cut back only on the latter.⁸² Common sense tells us that cannot be true, and numerous studies confirm common sense. The RAND Health Insurance Experiment, often cited by market enthusiasts as evidence that cost-sharing does not harm patients,⁸³ demonstrated that patient cost-sharing aggravates the underuse of preventive services,⁸⁴ causes patients to forgo necessary and unnecessary services in roughly equal measure,⁸⁵ and damages the health of sicker and poorer people.⁸⁶ Other research demonstrates that even a small increase in co-payments causes insured patients to reduce their use of prescription drugs⁸⁷ and preventive services.⁸⁸

Another important but infrequently mentioned premise underlying the claims for competition is that the supply sides of the insurance and medical markets are

to food prices if “we all carried grocery insurance.” Gramm claimed, “In my case, not only would I eat better but so would my dog. In fact, if every American had grocery insurance, no grocery store in the country would sell dog food. Nothing less than steak would do Very soon the cost of grocery insurance would begin to climb.” Phil Gramm, *Why We Need Medical Savings Accounts*, 330 NEW ENG. J. MED. 1752, 1752 (1994).

82. The immense difference between the patient’s and the physician’s expertise in medicine played a central role in Arrow’s critique of the claim that the conditions for a competitive market are met in the insurance and medical sectors. Arrow, *supra* note 82. This knowledge imbalance is often referred to as “asymmetry of information.” In his 1968 paper, Pauly completely ignored this issue. He ignored as well as the possibility that making patients more sensitive to price might lead to underuse. Focusing on the patient’s role and ignoring or downplaying the asymmetry-of-information issue continued to be standard practice within the pro-competition movement thereafter. By contrast, the managed care movement has always focused on the physician’s role in medical decision-making. Like the pro-competition movement, the managed care movement blames overuse for medical inflation. But unlike the pro-competition theorists who blame overuse on patients exposed to “moral hazard,” managed care theorists attribute overuse to doctors exposed to the FFS method. (As we noted earlier, the evidence indicates both movements exaggerate the role of overuse in medical inflation.)

83. See John F. Cogan et al., *Making Markets Work: Five Steps to a Better Health Care System*, 24 HEALTH AFF. 1447 (2005).

84. See Nicole Lurie et al., *Preventive Care: Do We Practice What We Preach?*, 77 AM. J. PUB. HEALTH 801 (1987).

85. See Kathleen N. Lohr et al., *Effect of Cost-Sharing on Use of Medically Effective and Less Effective Care*, 9 MED. CARE S31 (1986); Shapiro et al., *supra* note 79, at 247; Albert L. Sui et al., *Inappropriate Use of Hospitals in a Randomized Trial of Health Insurance Plans*, 315 NEW ENG. J. MED. 1259 (1986).

86. See Shapiro et al. *supra* note 79, at 246, 251; Emmett B. Keeler et al., *How Free Care Reduced Hypertension in the Health Insurance Experiment*, 254 JAMA 1926 (1985); Willard Manning et al., *Health Insurance and the Demand for Medical Care: Evidence from a Randomized Experiment*, 77 AM. ECON. REV. 251 (1987).

87. See Haiden A. Huskamp et al., *The Effect of Incentive-Based Formularies on Prescription-Drug Utilization and Spending*, 349 NEW ENG. J. MED. 2224 (2003).

88. See Amal N. Trivedi et al., *Effect of Cost-Sharing on Screening Mammography in Medicare Health Plans*, 358 NEW ENG. J. MED. 375 (2008).

populated by numerous small suppliers no one of which is so big it can set, or influence the setting of, its own prices. This condition—an atomized supply side—is implied in the phrases “consumer choice,” “consumer power,” and “consumer-driven.” These phrases are frequently invoked by market enthusiasts even though choice is in fact severely limited throughout much of the markets for insurance and medical goods and services.

Despite these seemingly obvious defects in competition theory, it began to attract more attention during the health care reform debate of the early 1990s, and drew even more attention after the failure of the Clintons’ Health Security Act in September 1994 and the Republican takeover of Congress in the elections two months later. By the early 1990s, Republicans were promoting high-deductible policies known first as “medical savings accounts” and later as “health savings accounts” (HSAs).⁸⁹ By the late 1990s Republicans had linked these high-deductible policies with the notion of vouchers and tax credits. These two ideas—high-deductibles and either vouchers or tax credits—are the main planks in the most prominent pro-competition proposals today, including those put forth by Representative Paul Ryan,⁹⁰ the Cato Institute,⁹¹ and Avik Roy.⁹²

The pro-competition movement’s endorsement of high-deductibles, vouchers, tax credits, and “transparent” cost and quality data has forced at least some within the movement to endorse the requirement that some third party (government is the obvious candidate but is not always mentioned) adjust deductibles, vouchers, tax credits, prices and “grades” on quality measures to reflect patient health and income, a process known as “risk-adjustment.” Without accurate risk-adjustment, competition becomes a race to the bottom as providers and insurers seek to avoid sicker and poorer patients. But those who promote risk-adjustment as a solution to the “adverse selection” problem fail to address the question of whether accurate risk-adjustment will ever be technologically and financially feasible. The treatment of this issue by Mark Pauly and John Goodman, two of the most prominent HSA proponents, is typical. In the following excerpt from a 1995 paper, they concede risk-adjustment is essential to their reform proposal, and then they walk away from the issue.

Some critics fear that increased use of catastrophic insurance coverage protected by MSAs will worsen a serious social problem of risk segmentation

89. See Harris Meyer, *GOP Reformers Push Medical IRA Plans*, AM. MED. NEWS, Jan. 3, 1994, at 1.

90. Letter from Douglas W. Elmendorf, Director, U.S. Cong. Budget Office, to Rep. Paul Ryan (Jan. 27, 2010), <http://www.cbo.gov/sites/default/files/01-27-ryan-roadmap-letter.pdf>.

91. Chris Edwards & Michael Cannon, *Medicare Reforms*, CATO INST. (Sept. 2010), <http://www.downsizinggovernment.org/hhs/medicare-reforms>.

92. Timothy Jost, *Transcending Obamacare? Analyzing Avik Roy’s ACA Replacement Plan*, HEALTH AFF. BLOG (Sept. 2, 2014), <http://healthaffairs.org/blog/2014/09/02/transcending-obamacare-analyzing-avik-roys-aca-replacement-plan>.

and adverse selection in the private health insurance market. ... The natural tendency in competitive insurance markets is for premiums to reflect risks. To the degree that this process creates unreasonable burdens for some people, government interventions such as tax-financed risk pools and or risk-related tax credits for unusually high risks are the correct solutions.... A full treatment of this *exceedingly complex and confusing issue* is beyond the scope of this paper.⁹³

As is the case with the pro-competition movement's assumption that medicine is like food and other consumer goods, the movement's assumption that accurate risk-adjustment is technologically and financially feasible is not based on anything resembling rigorous evidence. Accurate risk-adjustment cannot be done without rich information on patient health, which is to say without access to the medical records of the American population. Accurate risk-adjustment requires information on patient income as well.⁹⁴ Even assuming that someday electronic medical records become universal and interoperable, it is extremely unlikely America, or any other country, will ever be able to afford the cost of adjusting vouchers, tax credits, deductibles, prices, and quality measures for either patient health status or income.

But without risk-adjustment of vouchers and the other variables mentioned above, competition-based proposals cannot work well, and may not work at all. For example, without risk-adjustment of vouchers for seniors to buy private insurance, insurers will be under great pressure to refuse to accept sicker seniors, and to chase away those sicker seniors they cannot avoid enrolling. If they fail to ward off a sufficient number of sicker seniors, they could be forced to withdraw from the Medicare program or go bankrupt. Similarly, if report cards on physician services are not adjusted to reflect differences in the health and incomes of the patients physicians treat, the "grades" will misrepresent the true quality of the services. Physicians who treat sicker and poorer patients will be unfairly portrayed as inferior doctors.

The pro-competition movement's willingness to gloss over the assumptions that have to be true for the medical "market" to function like other markets gives it its appeal, especially to citizens and policy makers who favor reducing

93. Mark V. Pauly & John C. Goodman, *Tax Credits for Health Insurance and Medical Savings Accounts*, 14 HEALTH AFF. 126, 136 (1995). In *A Roadmap for America's Future*, Representative Paul Ryan treats the risk-adjustment issue in the same manner. He acknowledges that risk-adjustment of premiums is essential to his proposals for the non-elderly and Medicare, and he implies risk-adjustment of medical price and quality measures is necessary to make "data on the pricing and effectiveness of health care services widely available." But he offers no information on how any of that is to be done, whether it can be done accurately, and what it might cost.

94. *Risk Adjustment for Socioeconomic Status or Other Socioeconomic Factors: Technical Factors*, NAT'L QUALITY FORUM (Aug. 15, 2014), http://www.qualityforum.org/Publications/2014/08/Risk_Adjustment_for_Socioeconomic_Status_or_r_Other_Sociodemographic_Factors.aspx.

government's role. But when the glossed-over assumptions are pulled up for examination, it becomes clear that the reformed market imagined by competition theorists either cannot function as advertised, or can function only with considerable assistance from and regulation by the government. The irony of this posture is obvious: to address and eliminate "market failures" that arise in any unregulated medical environment, defenders of competition must offer programs and regulations administered by the very public administrators they deride.

CONCLUSION

Many countries that now have universal health insurance programs built those programs in increments. Germany at first covered only workers in certain high-risk industries, and Canada at first covered only hospital services in one province. It was not unreasonable, therefore, for the architects of the American Medicare program to anticipate that Medicare would eventually be expanded, possibly in stages, to cover all Americans. True, phasing universal coverage in first for the elderly was unorthodox by international standards, but there was no obvious reason why phasing in by age should be any more difficult than phasing in by occupation, geography, or type of service.

However, fifty years later, it has not happened. The rapid increase in Medicare's costs in its first half decade (a period we have referred to as a period of accommodation) took Medicare-for-all off the table during the early 1970s when Congress was seriously considering extending universal health insurance to the non-elderly. In the decade after Medicare's enactment, even advocates of national health insurance did not propose expanding Medicare. They proposed insuring the non-elderly through a program that was separate and substantially different from Medicare.

But the disinterest in expanding Medicare persisted long after Medicare brought its expenditures under control. Since the late 1980s, the traditional Medicare program has operated more efficiently than the insurance industry. Its annual inflation rate has been, on average, slightly below that of the private sector,⁹⁵ and it has insured its enrollees at a cost per enrollee that is lower than that of the insurance companies that participate in the program known today as Medicare Advantage.⁹⁶ But despite this track record, Congress has expressed no

95. Christina Boccuti & Marilyn Moon, *Comparing Medicare and Private Insurers: Growth Rates in Spending Over Three Decades*, 22 HEALTH AFF. 230 (2003); *The Facts on Medicare Spending and Financing*, KAISER FAMILY FOUND. (2014), <http://kaiserfamilyfoundation.files.wordpress.com/2014/07/7305-08-the-facts-on-medicare-spending-and-financing.pdf>.

96. Fred J. Hellinger, *Selection Bias in Health Maintenance Organizations: Analysis of Recent Evidence*, 9 HEALTH CARE FINANCING REV. 55 (1987); PHYSICIAN PAYMENT REVIEW COMM'N, ANNUAL REPORT TO CONGRESS 255-79 (1996); *Changes to HMO Rate Setting Method are Needed to Reduce Program Costs*, U.S. GEN. ACCT. OFF. (1994).

interest in Medicare-for-all, not even during the 1992-1994 and 2008-2010 periods when national health insurance was debated. In fact, Congress has moved in the other direction: Over the last two decades it has accelerated the expansion of the relatively inefficient Medicare Advantage program, and it has passed numerous bills that require the relatively efficient traditional Medicare program to experiment with managed care schemes, the vast majority of which either saved no money or raised costs.⁹⁷

The unexpectedly high cost of the Medicare program during its first five years is the obvious explanation why Medicare-for-all was not seriously considered by Congress during the first decade or so after Medicare was enacted. But what accounts for lawmakers' disinterest in expanding Medicare over the last four decades, a period in which the traditional Medicare program has proven to be a relatively efficient program?

We attribute that disinterest primarily to the two movements we have discussed in this paper. The primary contribution of the pro-competition movement has been to render Congress reluctant to debate universal coverage at all. The primary contribution of the managed care movement has been to induce influential liberals to promote managed care rather than Medicare-for-all during those rare periods when national health insurance has been seriously debated by Congress. We attribute the success of these movements in large part to their willingness to promote questionable assumptions as fact, and to compare their dream worlds with the real world—the Medicare program. The acquisition of enormous resources by both movements over the last quarter century has greatly enhanced their power. Those resources dwarf the resources available to the groups and individuals who support the expansion of Medicare to the non-elderly.

The irony is that these movements came to life shortly after Medicare was enacted, thanks in part to the rapid inflation that Medicare suffered during its first five years. As we have seen, Medicare's first administrators decided it was more important to win the cooperation of providers than to control costs. It is instructive to ponder these questions: What if Medicare's costs had not soared so unexpectedly in its early years? What might have happened if Congress had given Medicare's original administrators the authority to control spending? Would Medicare-for-all have remained on the table? Would a managed care movement have materialized, much less gone on to dominate the health care

Medicare operates at a lower cost for two reasons: Its overhead costs are small compared with those of the insurance industry. Kip Sullivan, *How to Think Clearly about Medicare Administrative Costs: Data Sources and Measurement*, 38 J. HEALTH POL., POL'Y, & L. 479 (2013); CTBS. FOR MEDICARE & MEDICAID SERVS., HEALTH CARE INDUSTRY MARKET UPDATE: MANAGED CARE (2003). Additionally, since it acquired the authority to regulate payments to hospitals (1983) and physicians (1989), it has paid providers substantially less than private insurers pay. MEDICARE PAYMENT ADVISORY COMM'N, REPORT TO CONGRESS: MEDICARE PAYMENT POLICY 81 (2006).

97. Nelson, *supra* note 22.

reform debate for the next fifty years? Would the pro-competition movement have had as much ammunition to use against expanding Medicare?

It is possible that the answer to the last three questions is no. But it is also possible that if the authors of the Medicare legislation had attempted to bestow upon the program the tools it needed to control spending, the bill might never have passed and we would not be celebrating Medicare's fiftieth birthday next year.

Medicaid at 50: No Longer Limited to the “Deserving” Poor?

David Orentlicher, MD, JD*

INTRODUCTION

For the first fifty years of its existence, Medicaid suffered from a serious defect—while it was adopted to meet the health care needs of the poor, it was designed only to meet the needs of the so-called “deserving” poor. Rather than providing Medicaid benefits to all persons who fell below the federal poverty level of income (or met some other measure of indigence), Congress limited eligibility to those categories of the poor that were viewed as especially deserving of assistance. These categories included children, pregnant women, single caretakers of children, and disabled persons.¹

Poor people in these groups could not fairly be held accountable for their inability to afford health care insurance, for they were not expected to be gainfully employed in the workplace. Whether because of age, medical condition, or responsibilities in the home, the deserving poor could not be blamed for their indigence.²

Nor would providing assistance create perverse incentives. If poor, able-bodied, and childless adults could qualify for Medicaid, they might be less inclined to seek employment and an income that would permit them to afford a private health insurance plan. But Medicaid recipients were not supposed to be looking for jobs.

The Medicaid program’s distinction between the indigent who deserved public assistance and those who did not has a long pedigree. Rooted in England’s Elizabethan Poor Laws at the turn of the seventeenth century and colonial practices in America, the idea of a deserving poor had been institutionalized in state cash assistance laws throughout the United States by the early twentieth century.³ The

* David Orentlicher, Samuel R. Rosen Professor of Law, and Co-director of the William S. and Christine S. Hall Center for Law and Health, Robert H. McKinney School of Law: Indiana University.

1. Jane Perkins, *Medicaid: Past Successes and Future Challenges*, 12 HEALTH MATRIX 7, 11-13 (2002).

2. David Orentlicher, *Rights to Healthcare in the United States: Inherently Unstable*, 38 AM. J. L. & MED. 326, 331 (2012).

3. ROBERT STEVENS & ROSEMARY STEVENS, WELFARE MEDICINE IN AMERICA: A CASE STUDY OF MEDICAID 5-6 (2003). For a detailed discussion of the Elizabethan Poor Laws, see Jacobus

deserving poor included seniors, children and their single mothers, and the unemployable blind—indigent persons who “could not be labeled social deviates or paupers by choice.”⁴ Similar categories for eligibility appeared in the cash support provisions of the Social Security Act of 1935, with the addition of a category for the totally and permanently disabled in 1950. Limiting assistance to the deserving poor would ensure that benefits were available “for those made dependent through no fault of their own.”⁵ When Medicaid was passed in 1965 as a hastily drafted amendment to the Medicare bill,⁶ Congress grafted Medicaid’s eligibility standards onto existing welfare categories.⁷

With its cramped criteria for eligibility, pre-ACA Medicaid never realized its public perception as a health care program for the poor. Indeed, it extended its coverage to less than half of the poor in the United States during its first fifty years of existence.⁸

The Affordable Care Act (ACA) seemingly has abandoned Medicaid’s conception of the deserving poor with its expansion of the Medicaid program to all persons up to 138% of the federal poverty level. One no longer needs to be a child, disabled, pregnant, or a caretaker of a child to be eligible for Medicaid; it is sufficient simply to be poor. Or as Chief Justice John Roberts observed in *National Federation of Independent Business v. Sebelius*, the Supreme Court’s primary ACA case, Medicaid “is no longer a program to care for the neediest among us.”⁹ The Medicaid expansion is a “shift in kind, not merely degree.”¹⁰

In this essay, I consider the significance of this major modification of the Medicaid program. Does the ACA signal a more generous view of the deserving poor, or even an abandonment of the distinction between the poor and the “deserving” poor? Or does the ACA tell us more about the nature of health care

tenBroek, *California's Dual System of Family Law: Its Origin, Development, and Present Status: Part I*, 16 STAN. L. REV. 257, 258-87 (1964).

4. STEVENS & STEVENS, *supra* note 3, at 6. For an analysis of the “mothers’ pension” laws, see Children’s Bureau, *Laws Relating to “Mothers’ Pensions” in the United States, Denmark and New Zealand*, U.S. DEP’T. LAB. (1914), <http://www.mchlibrary.info/history/chbu/20375.pdf>.

5. STEVENS & STEVENS, *supra* note 3, at 7. The cash support programs included the federal welfare program, originally “Aid to Dependent Children” (ADC), then “Aid to Families with Dependent Children” (AFDC), and since 1996, “Temporary Assistance to Needy Families” (TANF). Edward J. McCaffery, *The Burdens of Benefits*, 44 VILL. L. REV. 445, 473-81 (1999).

6. See, e.g., JONATHAN ENGEL, POOR PEOPLE’S MEDICINE: MEDICAID AND AMERICAN CHARITY CARE SINCE 1965 49-50 (2006); Emily Friedman, *The Compromise and the Afterthought: Medicare and Medicaid after 30 Years*, 274 JAMA 278, 280 (1995).

7. STEVENS & STEVENS, *supra* note 3, at 61-62; Friedman, *supra* note 6, at 279.

8. In 1999, Medicaid provided coverage to only 37 percent of non-elderly Americans with incomes below the federal poverty level. Perkins, *supra* note 1, at 13. By 2012, coverage reached 45 percent of the non-elderly poor. *Medicaid: A Primer*, KAISER FAM. FOUND. 8 (2013), <http://kaiserfamilyfoundation.files.wordpress.com/2010/06/7334-05.pdf>.

9. Nat’l Fed’n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566, 2606 (2012).

10. *Id.* at 2605.

than about societal views of the poor? And what do the answers to these questions tell us about the durability of the Medicaid expansion? Can we expect Congress to maintain the ACA's revision of Medicaid for the next fifty years? As I will discuss, it seems that the Medicaid expansion reflects concerns about the high costs of health care rather than an evolution in societal thinking about the "deserving" poor. As a result, the expansion may not provide a stable source of health care coverage for the expansion population.

I. DOES THE MEDICAID EXPANSION REPRESENT A RECONCEPTION OF THE DESERVING POOR OR EVEN A REJECTION OF THE DISTINCTION BETWEEN THE DESERVING POOR AND THE OTHER POOR?

Perhaps Congress realized that Medicaid's definition of the deserving poor was too narrow and excluded many people who were just as deserving of assistance as those who qualified for pre-ACA Medicaid. With Medicaid reaching less than half of those who fell below the federal poverty level, there were many indigent persons who did not have access to health care insurance and lacked any meaningful prospect of becoming able to afford coverage.

Moreover, their limited prospects for obtaining coverage could persist for a long time. Among American children whose families fall in the bottom fourth of the income distribution, only about 10% achieve a key qualification for good employment—a college degree.¹¹ The United States is not a land of opportunity for many people at the bottom of the economic ladder, with lower levels of economic mobility than other Western, developed countries, including Canada, Denmark, and France.¹² In the United States, people's chances of prospering depend much more on the wealth of their parents than upon their character.

The idea that if poor families were ineligible for traditional Medicaid, it meant that they lacked initiative was also belied by other data. Among the non-elderly uninsured,¹³ for example, 63% lived in families with one or more full-time workers, and another 16% lived in families with part-time workers.¹⁴ Working hard and playing by the rules did not guarantee that someone would have health care

11. Martha J. Bailey & Susan M. Dynarski, *Gains and Gaps: Changing Inequality in U.S. College Entry and Completion*, 26 fig.3 (Nat'l Bureau of Econ. Research, Working Paper No. 17633, 2011), <http://www.nber.org/papers/w17633>. For children whose families are in the top fourth of the income distribution, the college graduation rate exceeds 50 percent. *Id.*

12. *Economic Mobility: Is the American Dream Alive and Well?*, PEW CHARITABLE TR. 4-5 (2007), http://www.pewtrusts.org/~media/legacy/uploadedfiles/wwwpewtrustsorg/reports/economic_mobility/EMPAmericanDreamReportpdf.pdf.

13. Almost all of the elderly are insured, primarily because of Medicare. *The Uninsured: A Primer*, KAISER FAM. FOUND. 1 (2013), <http://kaiserfamilyfoundation.files.wordpress.com/2013/10/7451-09-the-uninsured-a-primer-key-facts-about-health-insurance.pdf>.

14. *Id.* at 6.

insurance in pre-ACA America.

The Great Recession that immediately preceded the enactment of the ACA only reinforced this reality. Millions of Americans became unemployed and millions more became underemployed because of economic forces beyond their control. As a result, they lost their health care benefits, as well as the ability to replace those benefits with the purchase of an individual policy. The ranks of the uninsured rose by nearly six million between 2007 and 2010.¹⁵

Not only were fewer people employed; as the average duration of unemployment lengthened to post-WWII highs,¹⁶ chronic unemployment became a more serious problem, especially for persons over age fifty-five.¹⁷ Through no fault of their own, many Americans who had worked productively for decades could no longer secure gainful employment and the health care coverage that comes with it.

In addition, the concept of a “deserving” poor rested in part on inaccurate stereotypes about indigent persons exploiting the existence of public welfare programs by turning to them instead of finding a job. People generally prefer gainful employment that allows them to pay for their benefits rather than relying on government subsidies. Indeed, the stigma of being a recipient of food stamps, Medicaid, or other programs deters many eligible people from enrolling.¹⁸

In short, for a number of reasons, it became clear that it did not make sense to hold more than half of the poor personally responsible for their lack of health care insurance because they were not part of the “deserving” poor. Rather, it made much more sense to expand the definition of the deserving poor or simply jettison that concept entirely.

II. DOES MEDICAID REFLECT A REJECTION OF THE CONCEPT OF A DESERVING POOR ONLY FOR HEALTH CARE?

Instead of considering the Medicaid expansion in isolation, it may make more sense to consider the expansion in its overall ACA context. Perhaps Congress no longer tries to distinguish between the deserving poor and the rest of the poor under Medicaid because health care services are special in a way that other social services are not. And indeed, as Justice Roberts observed, Congress did not simply expand the Medicaid program by itself in 2010. Rather, it passed the expansion as “an

15. *Id.* at 9.

16. Don Lee, *Long-term Unemployed Still at Record Levels*, L.A. TIMES, Sept. 10, 2014, <http://www.latimes.com/business/la-fi-longterm-jobless-20140910-story.html>.

17. In February 2010, the average duration of unemployment for workers 55 years and older was 35.5 weeks, compared to 30.3 weeks for workers age 25 to 54 and 23.3 weeks for workers between 16 and 24. Emily Sok, *Record Unemployment Among Older Workers Does Not Keep Them Out of the Job Market*, U.S. BUREAU LAB. STAT. (Mar. 2010), http://www.bls.gov/opub/ils/summary_10_04/older_workers.htm.

18. Orentlicher, *supra* note 2, at 332.

element of a comprehensive national plan to provide universal health insurance coverage."¹⁹

Pre-ACA America had a multi-tiered system of health care coverage. Most Americans relied on their employment to obtain their health care benefits, and there were public programs for those who did not—as long as they were deserving of assistance. As discussed, pre-ACA Medicaid was a program for the deserving poor. The VA health care system is a program for veterans whose benefits are given in recognition of their service to the country. Medicare is a program for another “deserving” class of citizens—the elderly.

Medicare recipients are seen as deserving of their coverage for a number of reasons. First, because of their age, seniors have relatively high medical costs—when Medicare was passed, average health care expenses for people sixty-five or older were twice the average expenses for younger persons.²⁰ At the same time, the elderly are less able to afford health care bills. Medicare kicks in when people may no longer be working and are experiencing a greatly reduced income. Moreover, their reduced income does not reflect a lack of initiative or an attempt to exploit the system. Rather, Medicare recipients have made their contributions to society and moved into a well-deserved retirement.²¹ Medicare is a program based on just deserts for a third reason: people qualify themselves and their spouses for Medicare in the same way that they qualify themselves and their spouses for Social Security—by making payments to the government during their working lives.²² In other words, while a public assistance program for younger persons might stifle initiative and promote dependence, the Medicare program became available for persons who were not expected to be active workers and who in fact had earned their eligibility.²³ Medicare recipients would truly be “deserving” of their benefits.²⁴

If one is trying to create a system of universal coverage,²⁵ one cannot make distinctions among citizens in terms of their deserts. One cannot reserve public assistance only for seniors, veterans, or a limited concept of the deserving poor. As mentioned, when Congress took that approach, the Medicaid program did not

19. *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. at 2606.

20. JONATHAN OBERLANDER, *THE POLITICAL LIFE OF MEDICARE* 23-24 (2003).

21. *Id.*; THEODORE R. MARMOR, *THE POLITICS OF MEDICARE* 11-12 (2d ed. 2000).

22. More precisely, people become eligible for premium-free Medicare Part A (coverage for hospital care) through their Medicare payroll deductions or those of their spouses. In the absence of the required payroll deductions, seniors pay a premium for their Part A benefits. John Bigler et al., *An Overview of Social Security, Medicare and Medicaid*, N.Y. ST. B.A. J., Sept.-Oct. 1993, at 14, 16.

23. MARMOR, *supra* note 21, at 15-16, 96.

24. OBERLANDER, *supra* note 20, at 24-25.

25. In fact, the ACA is not a plan for universal coverage. Because of exemptions, exclusions, and the limits of its subsidies for middle-income families, the ACA will leave about 26 million US residents uncovered, even with full implementation of its provisions. *The Uninsured: A Primer*, *supra* note 13, at 20.

reach even half of the indigent. If the country wants a system of universal coverage, it has to ensure that everyone has meaningful access to a health care insurance policy or program.

Thus, rather than determining benefits in terms of *how* a person came to need assistance procuring health care coverage, the ACA determines benefits simply on the basis of *whether* the person needs help in affording coverage. If a person earns no more than 138 % of the federal poverty level, the person qualifies for Medicaid, regardless of why the person is poor.²⁶ And the ACA does not limit its financial assistance just to all of the poor. Middle-income families that have to purchase their own insurance plans because they do not receive coverage as a benefit of employment are eligible for governmental subsidies as long as they earn no more than 400% of the federal poverty level.²⁷

In this health-care-is-special view, Congress may have come to the conclusion that because health care has become so expensive, it is no longer reasonable to assume that most families can afford health care coverage on their own or that the uninsured can be held personally responsible for their lack of coverage. Indeed, two-thirds of Americans fall below the ACA's maximum threshold of 400% of FPL to qualify for financial subsidies.²⁸

The special nature of health care may also reflect the interconnected nature of the health care system. Even when people cannot pay for medical care, they still receive emergency treatment and other kinds of care. Hospitals, doctors, and other providers meet many of the health care needs of the indigent, whether out of charitable impulse, the duty to provide care under the Emergency Medical Treatment and Active Labor Act (EMTALA), or for other reasons. But doing so comes at a cost that is ultimately borne in large part by the insured. To some extent, the costs of caring for the uninsured are made up by higher prices for the insured, translating into higher insurance premiums, and to some extent, the costs of caring for the uninsured are made up through taxes on the insured to pay for public programs. As long as the insured cannot isolate themselves from the uninsured in the health care system, there is greater pressure to design a system that works well

26. 42 U.S.C. § 1396a(a)(10)(A)(i)(VII) (2012) (establishing Medicaid eligibility for those whose income does not exceed 133 percent of the poverty line). In addition, 5 percent of an applicant's income is disregarded, effectively raising the eligibility threshold to 138 percent. *Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision*, CONG. BUDGET OFF. 7 n.13 (2012),

<http://www.cbo.gov/sites/default/files/cbofiles/attachments/43472-07-24-2012-CoverageEstimates.pdf>.

27. 26 U.S.C. § 36B (2012).

28. *Distribution of the Total Population by Federal Poverty Level (above and below 400% FPL)*, KAISER FAM. FOUND., <http://kff.org/other/state-indicator/population-up-to-400-fpl> (last visited Dec. 7, 2014). This does not mean that two-thirds of families will actually receive subsidies. Many families who earn less than 400 percent of FPL will obtain their health care coverage from their employer and therefore not need subsidies to purchase their coverage on health insurance exchanges.

for everyone.

Which of the two explanations seems more plausible? Has America discarded previous concepts of the deserving poor, or does the ACA tell us more about our views about health care than about the poor?

The latter seems more plausible. While the ACA extends health care coverage to all of the poor, the country has not revised its eligibility criteria for food stamps, housing, cash assistance, or other social welfare programs. Nor does it seem inclined to do that.²⁹ Moreover, much of the support for the ACA was driven by the fact that health care was becoming unaffordable for too many, even those in the middle class. A diagnosis of heart disease, cancer, or other “pre-existing condition” would lead insurers to double premiums or drop coverage entirely, leaving many people unable to secure the health care coverage they or their family members needed. Without adequate coverage—whether due to uninsurance or underinsurance—many people found themselves forced into bankruptcy by substantial medical bills. Rather than reflecting concern for the uninsured poor, the ACA may have been driven more by concern for the uninsurable middle class. Indeed, it is much easier to enact major social welfare programs when they serve the general public and not just the indigent. Most importantly, the primary goal of the ACA was to create a system of universal coverage, with the Medicaid expansion being just one element of the new system. Concern for the poor played a role but only as part of a broad concern about access to health care insurance.

III. IMPLICATIONS FOR THE FUTURE

An important question is whether the ACA’s promise of health care for all of the poor will be realized over the next fifty years. Will Medicaid truly become a program for every poor person, not just the “deserving” poor?³⁰

29. The experience of the Great Depression reinforces this view. With poverty widespread during that period, a federal relief program was established that provided assistance to the poor without trying to distinguish between the deserving poor and the other poor. Once prosperity returned, however, the traditional distinction between the deserving poor and the other poor reemerged. STEVENS & STEVENS, *supra* note 3, at 7.

30. Of course, in states that do not take up the ACA expansion, Medicaid will remain as it was before the ACA. However, there is good reason to think that many of the hold-out states will opt for the expansion within the next few years. Expansion states will reduce the size of their uninsured population, and for a few reasons, they also should be better off fiscally. The federal government will pick up 90 percent of the costs of the expansion, the expense of uninsured care will decrease, and expansion states will enjoy an economic stimulus from the new Medicaid spending. Mark Hall, *States’ Decisions Not to Expand Medicaid*, 92 N.C. L. REV. 1459, 1471-75 (2014). Moreover, the Department of Health and Human Services has allowed states flexibility to design their own versions of the Medicaid expansion. Arkansas, for example, will insure its new Medicaid recipients with private coverage purchased on the state’s health insurance exchange. David K. Jones, Phillip M. Singer & John Z. Ayanian, *The Changing Landscape of Medicaid Practical and Political Considerations for Expansion*, 311 JAMA 1965 (2014).

Unfortunately, there are reasons to be concerned. Two reasons in particular stand out. First, the ACA did not roll all of the poor into a single Medicaid program. Rather, it preserved the traditional paths into Medicaid for pregnant women, children, caretakers of children, and disabled persons, while adding a new path for the rest of the poor.³¹ Thus, the old “deserving” poor will rely on different statutory provisions than will the newly eligible for their Medicaid coverage. If a future Congress wants to revive the distinction between the deserving poor and the other poor and cut back on the ACA’s Medicaid expansion, it can do so without having to simultaneously reduce the program’s coverage for the old deserving poor. For example, if a future Congress decides to add a requirement that the expansion population be working or engaged in job training to qualify for Medicaid benefits, it can make that change without changing the eligibility criteria for pre-ACA Medicaid programs.³²

Just as Congress maintained the distinction between the deserving poor and the other poor, so too did it maintain the distinction between the poor and the non-poor. The ACA preserved Medicaid as a program for the poor rather than creating a single Medicare-for-all, or even Medicare Advantage-for-all,³³ program that would provide health care coverage for everyone, rich or poor. Rather than putting all Americans into the same health care coverage boat, our health care system will continue to rely on many boats, albeit bigger boats and boats with fewer holes in them.

This is a problem because Americans will not all sail or sink together. The ACA does better by the poor than did pre-ACA Medicaid, but the interests of the poor still are divorced from the interests of the well-to-do. Those with means will continue to receive health care coverage through their employer or themselves, while those of limited means will continue to rely on public subsidies for their coverage. Those who are better off will continue to see Medicaid as a program that they pay for but that primarily serves the needs of the poor.³⁴

31. 42 U.S.C. § 1396a(a)(10)(A)(i) (2012).

32. Of course, even with a reduction from 90 percent, the federal match contribution might still be higher than for pre-ACA Medicaid, for which the federal government picks up roughly 50-75 percent of the costs, with richer states paying a higher share of their Medicaid costs. *Medicaid: A Primer*, *supra* note 8, at 31.

33. Medicare Advantage, or Part C of Medicare, permits Medicare recipients to have Medicare pay for their enrollment in a private health care plan. *Medicare: A Primer*, KAISER FAM. FOUND. 1 (2010), <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/7615-03.pdf>. In other words, Medicare Advantage is akin to a voucher system.

34. WILLIAM JULIUS WILSON, *THE TRULY DISADVANTAGED: THE INNER CITY, THE UNDERCLASS, AND PUBLIC POLICY* 119 (1987) (noting that taxpayers viewed Medicaid as paying for services provided to welfare recipients but not to themselves). To be sure, there are benefits to everyone when the poor have good health care coverage. As mentioned, most of the uninsured are employed, and they can be more productive and contribute more to the national economy when they are healthier. In addition, the fiscal burden of the Medicaid expansion will be lessened by the fact that there are substantial costs imposed on the public from the expense of the health care that

Government programs such as this in the United States generally lack sufficient political support to ensure adequate funding over time.³⁵ The poor have little influence in the halls of Congress or the statehouses, and the wealthy are inclined to disfavor programs that benefit only the poor. Thus, for example, programs like Social Security and Medicare that serve recipients at all income levels have been far more successful than programs like Medicaid, which target the indigent.³⁶ The Medicaid coverage expansion depends to a substantial extent on the willingness of persons with political influence to fund programs for other people, and experience suggests that their willingness to do so over the long run may be limited.

Indeed, when states have faced challenges to their budgets in difficult economic times, they have often responded by reducing Medicaid eligibility. The Oregon Health Care Plan provides a useful example.³⁷ In the 1990s, Oregon decided to expand its Medicaid program to reach all of its poor residents (i.e., those with a family income up to one hundred percent of the federal poverty level).³⁸ Instead of providing generous benefits for a limited number of the poor, Oregon would provide limited benefits for all of the poor.³⁹ At first, the program was well-funded, and the percentage of uninsured in the state dropped from seventeen percent to eleven percent.⁴⁰ As the Oregon economy stalled and government revenues dropped, however, Oregon raised eligibility thresholds, and within ten years of the plan's implementation Oregon's rate of uninsured had risen to pre-plan levels.⁴¹ Similarly, fiscal pressures led thirty-eight states to reduce or restrict Medicaid eligibility between 2002 and 2005.⁴² States also have responded to fiscal pressures by reducing benefits and decreasing payments to physicians who provide care to Medicaid recipients.⁴³ In future years, Congress might cut funding for the

the uninsured receive. But these offsetting benefits have not been substantial enough to create a sense that the Medicaid program is a program for everyone.

35. *Id.* at 118-20.

36. *Id.* at 118.

37. Lawrence Jacobs et al., *The Oregon Health Plan and the Political Paradox of Rationing: What Advocates and Critics Have Claimed and What Oregon Did*, 24 J. HEALTH POL. POL'Y & L. 161, 163 (1999); David Orentlicher, *Controlling Health Care Costs Through Public, Transparent Processes: The Conflict Between the Morally Right and the Socially Feasible*, 36 J. CORP. L. 807, 813-14 (2011).

38. Orentlicher, *supra* note 37, at 813-14.

39. *Id.*

40. Jacobs et al., *supra* note 37, at 165-68.

41. Orentlicher, *supra* note 37, at 814.

42. Vernon Smith et al., *The Continuing Medicaid Budget Challenge: State Medicaid Spending Growth and Cost Containment in Fiscal Years 2004 and 2005*, KAISER FAM. FOUND. 26 (2004), <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/the-continuing-medicaid-budget-challenge-state-medicaid-spending-growth-and-cost-containment-in-fiscal-years-2004-and-2005-results-from-a-50-state-survey.pdf>

43. Laura Katz Olson, *Medicaid, the States and Health Care Reform*, 34 NEW POL. SCI. 37, 48-51 (2012). To be sure, states also have taken steps to expand Medicaid eligibility, especially for

ACA's Medicaid expansion when the federal budget is squeezed, just as it has cut funding for food stamps in tight budgetary times.⁴⁴

The willingness of the financially secure to sustain the ACA's coverage provisions for the poor may be tested in another way by the ACA's preservation of a dual health care system, with both public and private coverage, rather than adoption of a system based primarily on public coverage. As has happened with Medicaid expansions in the past,⁴⁵ the ACA's new public benefits may to some extent "crowd out" private coverage. That is, people who now have unsubsidized private health care coverage may switch to the expanded Medicaid program or qualify for subsidized private health care coverage. For an employer with a high percentage of low-wage workers, it will be financially advantageous not to provide health care benefits, but to let the employees enroll in Medicaid or purchase a subsidized policy on a health insurance exchange. Indeed, there is anecdotal evidence suggesting that many employers are moving their low-wage employees into Medicaid in response to the ACA's employer mandate.⁴⁶ If crowding out exceeds projections made at the time the ACA was adopted, public subsidies will become more expensive than anticipated for the federal and the state governments, and therefore less sustainable over time.⁴⁷

CONCLUSION

Through the Medicaid expansion, the ACA has done much to ensure that access to health care for the poor is not limited only to a narrow conception of the "deserving" poor. But by still distinguishing between the deserving poor and the other poor under Medicaid's eligibility rules, the ACA may not provide a durable source of health care coverage for the other poor.

How the different interests and pressures will play out over time is uncertain. On one hand, the poor will remain vulnerable in the political process. When budgets are tight, it will continue to be easier for elected officials to reduce spending on the poor than on the middle or upper class. On the other hand, the Medicaid expansion differs in an important way from pre-ACA Medicaid—it is much more of a federal program than a federal-state partnership. While eligibility

children. John E. McDonough, *A Progress Report On State Health Access Reform*, 27 HEALTH AFF. w105, w108 (2008).

44. Ron Nixon, *Senate Passes Long-Stalled Farm Bill, With Clear Winners and Losers*, N.Y. TIMES, Feb. 5, 2014, <http://www.nytimes.com/2014/02/05/us/politics/senate-passes-long-stalled-farm-bill.html>

45. Jonathan Gruber & Kosali Simon, *Crowd-Out 10 Years Later: Have Recent Public Insurance Expansions Crowded Out Private Health Insurance?*, 27 J. HEALTH ECON. 201 (2008).

46. Anna Wilde Mathews & Julie Jargon, *Companies Try to Escape Health Law's Penalties*, WALL ST. J., Oct. 21, 2014, <http://www.wsj.com/articles/companies-try-to-escape-health-laws-penalties-1413938115>.

47. Mark V. Pauly & Adam A. Leive, *The Unanticipated Consequences of Postponing the Employer Mandate*, 369 NEW ENG. J. MED. 691, 692-93 (2013).

for adults under pre-ACA Medicaid varied from state to state, the Medicaid expansion establishes a uniform standard for eligibility (income up to 138% of the federal poverty level). In addition, the federal government picks up almost all of the costs of the expansion. The federalization of Medicaid should help protect it from erosion because the federal government is better able than states to maintain spending when budgets are stretched.⁴⁸ And that factor may be sufficient to sustain the Medicaid expansion over time.

48. In part, this reflects the fact that many states are required under constitutional mandates to balance their budgets. James M. Poterba, *Balanced Budget Rules and Fiscal Policy: Evidence from the States*, 48 NAT'L TAX J. 329, 330-31 (1995); Helen F. Ladd & Fred C. Doolittle, *Which Level of Government Should Assist the Poor?*, 35 NAT'L TAX J. 323, 329 (1982).

Clash of the Titans: Medicaid Meets Private Health Insurance

Sara Rosenbaum*

INTRODUCTION

Throughout its first forty-eight years of life, the federal Medicaid statute lacked a viable insurance pathway for most low-income adults¹ ineligible for employer-sponsored coverage. In what is arguably the most important public health achievement since the enactment of Medicare and Medicaid fifty years ago, the Patient Protection and Affordable Care Act (ACA)² fundamentally alters this picture. Building on earlier breakthroughs for children, the ACA restructures Medicaid to cover poor adults and juxtaposes its new architecture against an affordable and accessible private insurance market for people ineligible for employer-sponsored or government insurance.

These reforms have already produced measurable results. But they also hold important implications for the future of Medicaid. Since its creation, Medicaid has permitted states to use federal funding to purchase private health insurance. Until the ACA, however, there was essentially nothing to buy. Now, by pairing the largest of all need-based programs—one infused with the concept of social contract—with an affordable private insurance market, the ACA undoubtedly has set the stage for profound changes over time in how Medicaid functions. This transformation in how Medicaid is designed and administered was, in fact, discussed during the legislative run-up to the ACA's enactment, but nothing came of it. Now, through a terrible twist of fate, this transformation is happening anyway, in the form of large-scale federal demonstrations—negotiated in the main out of public view³—in an intense bid to undo the damage to the Medicaid

* Harold and Jane Hirsh Professor and Founding Chair, Department of Health Law and Policy, Milken Institute School of Public Health, George Washington University.

1. In this essay the term includes people who live in families with household incomes up to twice the federal poverty level.

2. The ACA actually consists of two laws: The Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), and the Health Care and Education Reconciliation Act (HCERA) of 2010, Pub. L. No. 111-152, 124 Stat. 1029, enacted immediately following the ACA's passage.

3. Federal regulations require that demonstration proposals submitted by states and authorized by section 1115 of the Social Security Act, 42 U.S.C. §1315 (2012), be publicly posted for notice and comment. 42 C.F.R. §431.416(b) (2012). States also must permit comments once the demonstration begins. 42 C.F.R. §431.420(c) (2012). But like other CMS Medicaid policy-making regulatory processes, the actual negotiation process is closely held.

expansion caused by the United States Supreme Court's decision in *National Federation of Independent Business v. Sebelius*.⁴

The demonstrations approved to date have largely succeeded in generating state buy-in to the adult expansion without unraveling core Medicaid safeguards for the poor. But whether the Obama Administration, now in its twilight and eager to get states on board,⁵ can or will continue to hold the line is anyone's guess. And with a private insurance market there to impose direct pressure on Medicaid, will a new Congress—politically light years away from the one that enacted the ACA—sweep away Medicaid's remaining vestiges for that part of the Medicaid population whose eligibility is based on income alone? If so, what will be lost?

Following a background, on public and private health insurance for the poor prior to enactment of the ACA, I discuss the competing visions for low-income Americans created under the Act and the extent to which the U.S. Department of Health and Human Services (HHS) Secretary's use of her Medicaid demonstration powers may be moving Medicaid increasingly in the direction of a subsidy program for private insurance products. I also describe the ways in which the HHS Secretary has held the line on Medicaid's foundational elements and what this political deal-making means for the 114th Congress that convenes in January 2015, which promises to be one in which many of Medicaid's basic tenets will be re-examined, and potentially, fundamentally altered.

I. BACKGROUND

A. Private Health Insurance for the Poor, Pre-ACA

Although legally it always could do so, Medicaid did not face real pressure to buy private insurance in the pre-ACA time period because, for its beneficiaries, there was basically nothing to buy.⁶ The “accident of history”⁷ that became the voluntary system of employer coverage we know today has always been inherently irrational for low-wage workers. Employer insurance reached a zenith of sorts around the mid-1970s, covering around 70 percent of the U.S. working-age population, and has been declining since.⁸ In 1984, following a deep recession that

4. 132 S. Ct. 2566 (2012).

5. Just how eager the Administration may be to use its section 1115 authority to move further on the Medicaid expansion can be seen in HHS Secretary Sylvia Burwell's Medicaid expansion outreach to Republican Governors immediately following the 2014 mid-term elections. Susan Ferrechio, *HHS Secretary to Tuesday's Gubernatorial Winners: Call Me*, WASH. EXAMINER, Nov. 4, 2014, <http://www.washingtonexaminer.com/hhs-secretary-to-tuesdays-gubernatorial-winners-call-me/article/2555681>.

6. Sara Rosenbaum & Benjamin D. Sommers, *Using Medicaid to Buy Private Health Insurance—The Great New Experiment?*, 369 NEW ENG. J. MED. 7, 8 (2013).

7. David Blumenthal, *Employer-Sponsored Health Insurance in the United States—Origins and Implications*, 355 NEW ENG. J. MED. 82, 82 (2006).

8. Jon Gabel, *Job-Based Health Insurance, 1977-1998: The Accidental System Under Scrutiny*,

significantly increased the number of uninsured people, less than a quarter of nonelderly low-wage earners reported workplace coverage.⁹ By 2012, after several more recession and recovery cycles, the proportion of poor nonelderly Americans with workplace coverage had fallen by half, to slightly more than 13 percent.¹⁰ The decline was equally precipitous among the near-poor; among workers with family incomes between one and two times the federal poverty level, employer coverage rates fell from nearly 62 percent to less than one-third.¹¹ These figures were consistently worse for children, a fact that helped propel the Medicaid expansions of the 1980s.¹² In 2012, less than 9 percent of poor children had employer coverage; among near-poor families, children's coverage stood at less than 30 percent.¹³

Without employer insurance there was no private insurance alternative to speak of. Health insurance trend data covering the same 1984-2012 time period show that even when all sources of private insurance were taken into account, the proportion of low-income Americans with private coverage rose only marginally.¹⁴ In order to guard against adverse selection,¹⁵ individual private insurance was unavailable to most and unaffordable even when people could qualify for it.

Medicaid did relatively little to relieve this misery. Grounded in cash welfare traditions,¹⁶ Medicaid essentially left out working-age adults unless they were either totally disabled or caretakers of minor children. Pregnancy would later be added as an eligibility category in its own right along with reforms for children, and welfare reform enabled states to broaden coverage of parents. But in the main, Medicaid excluded poor adults, even within those eligibility categories for which

18 HEALTH AFF. 62, 65 (1999). The trends found by Gabel persisted into the 21st century. See, e.g., *Health, United States, 2013*, U.S. DEP'T HEALTH & HUM. SERVS. 353 tbl.123 (2013), <http://www.cdc.gov/nchs/data/abus/abus13.pdf>.

9. *Id.*

10. *Id.*

11. *Id.*

12. Sara Rosenbaum & Genevieve Kenney, *The Search for a National Child Health Coverage Policy*, 33 HEALTH AFF. 2125 (Dec. 2014).

13. *Health, United States, 2013 supra* note 8, at 354 tbl.123.

14. In 2012, for example, considering all sources of private health insurance, the proportion of poor privately insured people stood at 16.5 percent (compared to 13.6 percent) while the proportion of near-poor people with private coverage rose from 32.2 percent to 36.7 percent. *Health, United States, 2013, supra* note 8, at 350 tbl.122.

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

16. ROBERT STEVENS & ROSEMARY STEVENS, WELFARE MEDICINE IN AMERICA: A CASE STUDY OF MEDICAID (1974). The welfare philosophy underlying Medicaid was vividly on display in Chief Justice Roberts' Medicaid opinion, which focused on the degree to which the ACA Medicaid expansion departed from a philosophy of helping "the neediest among us," thereby imposing an entirely "new program" on the states in an unconstitutionally coercive fashion. *Nat'l Fed. of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566, 2604-09 (2012).

federal funding was available, such as parents.¹⁷ A handful of states extended Medicaid to poor adults through federal demonstrations undertaken pursuant to section 1115 of the Social Security Act.¹⁸ But low-income, nonelderly adults were relatively invisible in Medicaid unless they were fully disabled; as of 2012, Medicaid reached only 52 percent of poor adults, and 30 percent of those who were near-poor,¹⁹ and about 3 in 10 poor and near-poor adults remained completely uninsured.²⁰ Furthermore, because of a phenomenon known as “churning”—the rapid movement on and off various forms of insurance coverage—adults who did obtain Medicaid rapidly lost it, victims of even slight shifts in life circumstances such as income fluctuation, marriage, divorce, or a child reaching adulthood.²¹

B. The Affordable Care Act

The ACA has utterly changed this picture for low-income adults, at least those who are U.S. citizens or legal U.S. residents.²² By creating an affordable insurance market, extending Medicaid to all nonelderly low-income adults with family incomes up to 138 percent²³ of the federal poverty level,²⁴ and establishing a system of tax credits for persons with incomes between 100 percent and 400 percent of poverty and ineligible for minimum essential coverage through employer plans or government insurance,²⁵ the ACA uses Medicaid to create coverage for the poor while building subsidized insurance next door.

Family income delineates the two markets down to the dollar: family income up to 138 percent of the federal poverty level qualifies a 63-year-old woman for Medicaid, while family income starting at 139 percent of poverty results in

17. Sara Rosenbaum, *Medicaid and National Health Reform*, 361 NEW ENG. J. MED. 2009, 2010 (2009).

18. See John Holahan et al., *Insuring the Poor Through Section 1115 Medicaid Waivers*, 14 HEALTH AFF. 199 (1995).

19. See *Health, United States, 2013*, *supra* note 8 at 356 tbl.124.

20. *Id.* at 359 tbl.125.

21. Benjamin D. Sommers et al., *Medicaid and Marketplace Eligibility Changes Will Occur Often in All States; Policy Options Can Ease Impact*, 33 HEALTH AFF. 700, 700-01 (2014).

22. Thirteen percent of the uninsured remain ineligible for assistance under the ACA because of immigration status. See *How Will the Uninsured Fare Under the Affordable Care Act?*, KAISER FAM. FOUND. (2014), <http://kaiserfamilyfoundation.files.wordpress.com/2014/04/8531-how-will-the-uninsured-fare-under-the-aca.pdf>.

23. Technically, the Medicaid statute specifies 133 percent of poverty as the Medicaid eligibility stopping point. 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII) (2012). However, the ACA’s legislative companion, the Health Care and Education Reconciliation Act (HCERA), reset the upper income threshold at 138 percent of poverty. Health Care and Education Reconciliation Act (HCERA) of 2010 § 1004(e), 42 U.S.C. § 1396e(14) (2012).

24. Patient Protection and Affordable Care Act (ACA) § 2001, 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII) (2012).

25. Patient Protection and Affordable Care Act § 1401, (codified at 26 U.S.C. § 36B(c)(2)(B) (2012)).

subsidized private insurance. People entitled to Medicaid receive the full benefits of Medicaid enrollment: the right to apply at any time; retroactive eligibility to help with incurred medical bills; comprehensive coverage without cost-sharing; and other benefits that are unusually broad. They also experience Medicaid's shortcomings, in particular, greater problems with access to care,²⁶ although early reports suggest that physicians in some regions of the country may be balking at patients insured through Exchanges as well.²⁷

Low-income individuals who qualify for premium subsidies receive subsidies toward the cost of coverage, as well as cost sharing assistance. Neither premium subsidies nor cost sharing reduction assistance are what they should be for lower income people. Using my home town of Alexandria, Virginia as an example, a 45-year-old mother of two earning \$39,600 in 2014 (203 percent of the federal poverty level)²⁸ will still have to pay over \$200 per month (more than 6 percent of her monthly household income) for family coverage in 2015. Because her income slightly exceeds twice the federal poverty level, her children will not qualify for the Children's Health Insurance Program in Virginia, which the state cuts off at 200 percent of the federal poverty level. Furthermore, she will qualify for a family health plan with only a 73 percent actuarial value, since the ACA's more generous cost-sharing subsidy assistance ends at twice the federal poverty level.²⁹ This will leave her facing steep cost-sharing for covered services as well as sizable premiums. Even if we assume self-only coverage (because her children qualify for public insurance) and a much lower household income—\$27,000 (143 percent of

26. See, e.g., Robert Pear, *For Many New Medicaid Enrollees, Care is Hard to Find*, *Report Says*, N.Y. TIMES, Sept. 27, 2014, <http://www.nytimes.com/2014/09/28/us/for-many-new-medicaid-enrollees-care-is-hard-to-find-report-says.html> (reporting on a new report from the HHS Office of the Inspector General examining managed care and health care access); see also *State Standards for Access to Care in Medicaid Managed Care*, U.S. DEP'T HEALTH & HUM. SERVS. (2014), <http://oig.hhs.gov/oei/reports/oei-02-11-00320.pdf>.

27. *ACA Exchange Implementation Survey Report*, MED. GRP. MGMT. ASS'N. (May 2014), http://www.mgma.com/government-affairs/issues-overview/aca/aca-exchange-implementation-report/aca-surveyreport_online_2?ext=.pdf.

28. In this hypothetical the family has household income equal to 203% of the federal poverty level for a family of 3 in 2014. *Health Reform Subsidy Calculator*, KAISER FAM. FOUND., <http://kff.org/interactive/subsidy-calculator/#state=va&zip=22314&income-type=dollars&income=39%2C590&employer-coverage=0&people=3&alternate-plan-family=individual&adult-count=1&adults%5B0%5D%5Bage%5D=45&adults%5B0%5D%5Btobacco%5D=0&child-count=2&child-tobacco=0> (last visited Dec. 7, 2014). The Children's Health Insurance Program (CHIP), known in Virginia as Family Access to Medical Insurance Security (FAMIS), subsidizes insurance coverage for Medicaid-eligible low-income children with household incomes up to twice the federal poverty level. In Virginia, children in a family of 3 do not qualify if their household incomes exceed 200 percent of the federal poverty level (\$39,580 in 2014). For a family of 3, CHIP eligibility ceases at \$39,580.

29. Patient Protection and Affordable Care Act § 1402(c)(1)(B)(i), (codified at 42 U.S.C. § 18071 (2012)).

poverty)—the woman in my example still would have to pay nearly \$100 per month for her own coverage. Were her income to drop below 139 percent of poverty in Virginia, she would qualify for nothing, since Virginia is a non-adult-expansion state.

With the near-derailment of the adult Medicaid eligibility expansion by *Sebelius*, the Medicaid expansion, initially projected to reach some 16 million people when fully implemented,³⁰ has not worked as intended. As of November 2014, 23 states continued to refuse to extend coverage to poor adults,³¹ who are eligible for nothing at all if their incomes fail to reach the 100-percent-of-poverty threshold that defines the subsidy entitlement; states' refusal to expand left an estimated 4 million persons (85 percent of whom reside in the South) in what has become known as the "coverage gap."³² Despite this setback, the ACA has had an enormous impact on insurance coverage for those of low income, especially in the Medicaid expansion states, where the proportion of poor residents who were uninsured fell by 4.7 percent.³³

II. COMPETING VISIONS OF HEALTH INSURANCE COVERAGE FOR LOW INCOME PEOPLE

The creation of complementary pathways to insurance for low and moderate income people—Medicaid for the poorest, juxtaposed at the 138-percent-of-poverty point with tax-subsidized private insurance for those with low and moderate incomes—thus can be judged a landmark success. But real implications for Medicaid also lie in this juxtaposition, especially for people who need coverage far more extensive than what they will be able to purchase in the subsidized private market, and for whom the subsidy system is insufficient to meet the cost of necessary health care. Furthermore, below the surface of these two aligned pathways to coverage can be found millions of low-income people who experience income fluctuation to constantly move between Medicaid and the subsidized private insurance market.

Although more detailed studies emerged after passage of the ACA, income

30. Letter from Douglas W. Elmendorf, Dir., Cong. Budget Office, to Harry Reid, Majority Leader, U.S. Senate (Mar. 24, 2010), http://www.cbo.gov/sites/default/files/reid_letter_hr3590.pdf.

31. Rachel Garfield et al., *The Coverage Gap: Uninsured Poor Adults in States That Do Not Expand Medicaid—An Update*, KAISER FAM. FOUND. (Nov. 12, 2014), <http://kff.org/health-reform/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid-an-update/>. Twenty-seven states and the District of Columbia have expanded coverage. As of that date, five of the Medicaid expansion states were proceeding with the expansion as part of a section 1115 demonstration authority. Anita Cardwell & Kaitlin Sheedy, *Where States Stand on the Medicaid Expansion*, STATE REFORM, <https://www.statereform.org/Medicaid-Expansion-Decisions-Map> (last visited Nov. 7, 2014).

32. Garfield et al., *supra* note 31.

33. Benjamin D. Sommers et al., *Health Reform and Changes in Health Insurance Coverage in 2014*, 371 NEW ENG. J. MED. 867, 871 fig.1, (2014).

fluctuation, along with its consequences for health insurance coverage for lower income populations, was already a well-known problem when the ACA was being designed.³⁴ A widely cited post-ACA study places the national churn problem over the course of a year at 50 percent of low-wage workers.³⁵ Yet another study documents the problem of post-ACA churn in all states, even those that do not expand Medicaid to include low-income adults.³⁶ Indeed, in Massachusetts, home of the ACA prototype, even after years of implementation experience, churn continues to create breaks in coverage for a significant portion of the affected population. Health reform has mitigated this problem by shortening the coverage breaks considerably.³⁷

The great advance of the ACA is that, as with Massachusetts, the law has the potential to dramatically reduce periods without coverage. But the bifurcation of the affordable insurance system means that breaks are essentially baked into the design of the program unless effective mitigation strategies can be developed. And coverage breaks are a major cause for concern—not only because of their implications for the continuity and quality of coverage and care but also because of their impact on risk estimates. As people cycle on and off coverage, the risk also increases that they will delay necessary health care until insurance is subsequently regained, a danger to their health and an added element of financial risk for the private insurance market.

The problem of post-ACA churn—created by the use of dual, subsidized coverage arrangements juxtaposed against one another but significantly different in design and operation—was considered during the legislative process. But in the intense atmosphere surrounding enactment, efforts to more meaningfully address the problem were set aside. The principal mitigation strategy adopted was the ACA's redesign of the process by which individuals enroll in coverage and retain it.³⁸ As we know, however, for a constellation of reasons—technical, operational, political, structural—the American health insurance system is light years away from the ideal of streamlined enrollment. Furthermore, streamlined enrollment

34. See, e.g., Gerry Fairbrother et al., *How Stable is Medicaid Coverage for Children?*, 26 HEALTH AFF. 520 (2007); Pamela Farley Short & Deborah R. Graefe, *Battery-Powered Health Insurance? Stability in Coverage of the Uninsured*, 22 HEALTH AFF. 244 (2003); Pamela Farley Short et al., *Churn, Churn, Churn: How Instability of Health Insurance Shapes America's Uninsured Problem*, COMMONWEALTH FUND (2003), http://www.commonwealthfund.org/~media/files/publications/issue-brief/2003/nov/churn--churn--churn-how-instability-of-health-insurance-shapes-americas-uninsured-problem/short_churn_688-pdf.pdf.

35. Benjamin D. Sommers & Sara Rosenbaum, *Issues in Health Reform: How Changes in Eligibility May Move Millions Back and Forth between Medicaid and Insurance Exchanges*, 30 HEALTH AFF. 228 (2011).

36. Benjamin D. Sommers et al., *supra* note 21.

37. John A. Graves & Katherine Swartz, *Health Care Reform and the Dynamics of Insurance Coverage—Lessons From Massachusetts*, 367 NEW ENG. J. MED. 1181 (2012).

38. Patient Protection and Affordable Care Act § 1413, 42 U.S.C. § 18083 (2012).

does nothing to address the fact that two distinct subsidy systems—Medicaid along with subsidized private insurance—might mean two entirely different supplier markets.

The challenges posed by the creation of two distinct markets for coverage and their implications—including the inadequacy of assistance for near-poor families—might also have been lessened through use of the Basic Health Program.³⁹ Modeled after a pre-ACA program sponsored by Washington State, the Program offers states the option of receiving per capita premium subsidy payments (in lieu of having these subsidies flow directly to eligible individuals and families through the Exchange), and to use the subsidies to effectively expand Medicaid coverage to reach all people with incomes up to twice the federal poverty level. The evidence suggested that such an approach would significantly smooth the subsidy transition problem by pushing the point of churn higher, to a level at which far more people qualify for employer coverage.⁴⁰ It was also clear that the Program would enable states to far more significantly assist lower income families. But the Obama Administration delayed in implementing the Program;⁴¹ as of fall 2014, no state has moved ahead.

Since passage of the ACA, another strategy to reduce churn has emerged: that of using multi-market health plans. In many markets, a distinct managed care industry serves Medicaid, while companies specializing in subsidized private insurance plans operate in the Exchange. The problem of distinct supplier markets and their implications for a churning population received virtually no attention during the legislative process. However, subsequent research suggests that companies may now be developing multi-market strategies under which the same, or linked, products are marketed and sold to families and individuals as a means of reducing the care disruptions caused by churn. But the problem facing these companies is building networks of providers willing to accept all plan members regardless of source of subsidization, since the source of the subsidy (Medicaid versus private insurance) almost always determines provider payment levels.⁴²

Discussions during the legislative development process about how to mitigate churn through state options building on the program's historic flexibility to

39. Patient Protection and Affordable Care Act § 1331, 42 U.S.C. § 18051 (2012).

40. Ann Hwang et al., *Creation of State Basic Health Programs Would Lead to 4 Percent Fewer People Churning Between Medicaid and Exchanges*, 31 HEALTH AFF. 1314 (2012).

41. Final regulations implementing the Basic Health Program (BHP), a complex program that requires complicated funds transfers between federal and state governments, were not issued until 2014. See Basic Health Program: Federal Funding Methodology for Program Year 2014, 79 Fed. Reg. 13,887 (Mar. 12, 2014). It was not clear whether the Administration simply was unable to develop implementation standards in time or sought to discourage the removal of lower income workers from the Exchange pool out of concern about the impact of doing so on the viability of Exchanges.

42. Sara Rosenbaum, *Addressing Medicaid/Marketplace Churn Through Multi-Market Plans: Assessing the Current State of Play* 40 J. HEALTH POL., POL'Y & L. 233 (2015).

purchase private health insurance⁴³ might have gotten some traction had it not been for the problem of cost. Allowing Medicaid under certain controlled circumstances to purchase coverage from private health plans inevitably entails a significant increase in costs because of the marked differential between Medicaid provider payment and rates paid by private insurance.⁴⁴ Just how big an investment would be needed to position Medicaid to purchase Exchange coverage was not known, since the Congressional Budget Office (CBO) never released formal cost estimates. But the magnitude of the additional spending that would be needed became clear following *Sebelius*, when CBO re-calculated the financial impact on the federal government of states' refusal to expand Medicaid. The CBO concluded that the absence of a Medicaid expansion would result in the movement into the Exchange of millions of people with incomes between 100 percent and 138 percent of the federal poverty level, and that per capita spending for this population would be 50 percent higher on average.⁴⁵ This estimate exposed the fact that the Medicaid expansion was a principal means by which federal outlays for low-income people had been contained.

III. THE SECTION 1115 PROCESS POST-*SEBELIUS*

Here matters would have sat but for section 1115 of the Social Security Act, which enables the HHS Secretary to waive certain, otherwise-applicable provisions of law governing Medicaid and other state grant-in-aid programs in order to carry out an "experimental, pilot, or demonstration project which, in the judgment of the Secretary, is likely to assist in promoting the objectives of" the program in question.⁴⁶ With a long and storied history, section 1115 was put to work in order to overcome the terrible blow of *Sebelius* while also permitting states to do the very thing originally discussed during the legislative process but set aside. Essentially, this redesigned the point of contact between Medicaid for the poor and a private insurance market poised to surge into being.

Predating Medicaid's enactment, section 1115 has long been a source of energy for propelling dynamic program change. The most obvious example of this tendency is that the Medicaid amendments of 1997,⁴⁷ which vastly reshaped the Medicaid managed care legislative framework, rested heavily on a series of section

43. Rosenbaum & Sommers, *supra* note 6.

44. See Peter Cunningham & Ann S. O'Malley, *Do Reimbursement Delays Discourage Medicaid Participation By Physicians?*, 28 HEALTH AFF. w17 (2009). Physician acceptance of Medicaid patients historically has been depressed, with payment levels presumed to play a major, but by no means the only, role in low participation. See MEDICAID AND CHIP PAYMENT AND ACCESS COMM'N, REPORT TO THE CONGRESS ON MEDICAID AND CHIP 123 (Mar. 2011).

45. CONG. BUDGET OFFICE, ESTIMATES FOR THE INSURANCE COVERAGE PROVISIONS OF THE AFFORDABLE CARE ACT UPDATED FOR THE RECENT SUPREME COURT DECISION 4 (2012).

46. 42 U.S.C. § 1315(a) (2012).

47. Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4757(a), 111 Stat. 251, 527.

1115 Medicaid managed care demonstrations (some but not all of which combined managed care structures with eligibility expansions for low-income adults)⁴⁸ conducted during the early years of the Clinton Administration. Despite many problems,⁴⁹ these large-scale mandatory-enrollment managed care demonstrations showed that states could organize and run managed care systems, at least for beneficiaries whose eligibility was based on low family income. The demonstrations also paved the way for a gigantic Medicaid managed care industry⁵⁰ that would emerge in response to invitations to sell private-health-plan-like products to government sponsors of health care for the poor.

Arkansas has become the poster child for the modern section 1115 pathway to expanded Medicaid coverage.⁵¹ In contrast to previous expansions, the Arkansas model uses purchased private insurance rather than Medicaid managed care as the means of achieving coverage. In this sense, Arkansas represents the ideal test case, since the state lacked a large-scale Medicaid managed care market to begin with and necessarily rested on an individual private insurance market. The model, influenced by the post-ACA churning studies showing that most newly eligible beneficiaries were working-age adults in relatively good health,⁵² was designed to take advantage of the new insurance market while extending Medicaid to the poor. In this way, the demonstration combined the tradition of Medicaid as the means of insuring the poor with a resurgent private market.

It will be years before lawmakers can fully know the impact of the Arkansas experiment on access, costs, and quality. But the Arkansas model contains extremely important features⁵³ that should guide future policymaking. First, the model establishes Medicaid for all non-elderly low-income people who would have qualified for Medicaid under the basic terms of the ACA. The state was not permitted to proceed with this structure without agreeing to cover all non-elderly low-income adults who would have qualified for Medicaid had the state expanded the program under the ACA's original terms. In other words, the demonstration achieved a dramatic reduction in the proportion of Arkansans without health insurance precisely because it achieved coverage of the federally targeted population under the ACA itself.

48. See Rosenbaum, *supra* note 17, at 2011.

49. See John Holahan et al., *Medicaid Managed Care in Thirteen States*, 17 HEALTH AFF. 43 (1998).

50. By 2012 the industry was responsible for covering 60 million people. *Medicaid Managed Care: Key Data, Trends and Issues*, KAISER FAM. FOUND. (2012), <http://kaiserfamilyfoundation.files.wordpress.com/2012/02/8046-02.pdf>.

51. Rosenbaum & Sommers, *supra* note 6, at 7-8.

52. See Short et al., *supra* note 34, at 4 (providing a profile of people most likely to churn. Essentially, the high churning group consists of younger, whiter, healthier, married people without children and with fairly high levels of education—in other words, just whom insurers want).

53. Letter from Marilyn Tavenner, Admin., Ctrs. for Medicare and Medicaid Servs., to Andy Allison, Dir., Ark. Dep't Hum. Servs. (Sept. 27, 2013), <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/ar-private-option-ca.pdf>.

Second, the Arkansas model effectively breathes life into the state's Exchange by default-enrolling those who do not select coverage on their own into private health plans.⁵⁴ In this way the demonstration links hundreds of thousands of healthy low-income Arkansans to coverage, using a compulsory system that connects those entitled to assistance to a health plan and its network. The use of private health plans to secure coverage for people entitled to Medicaid—as opposed to a distinct Medicaid managed care industry that operates much like private insurance—means that continuity of coverage and care are available regardless of changes in family income that move an individual or family from Medicaid to tax subsidies and back again. Because of the problem of deep medical under-service across the state, its safety net providers are able to participate in health plans. These plans are bound by the essential community provider network requirement applicable to plans sold in the Exchange.⁵⁵ Furthermore, for the time being at least, the demonstration does not waive the special Medicaid payment methodology for community health centers. This methodology, along with Medicaid eligibility expansions, has propelled health centers to the nation's largest system of primary health care for medically underserved communities and populations.

Third, and intimately bound up with the second achievement, the demonstration exempts from this compulsory private plan arrangement those residents (estimated at around 20 percent of the population)⁵⁶ who are deemed to be “medically fragile” because of one or more conditions that limit health activity. In other words, the design succeeds precisely because it introduces a pre-existing condition exclusion of sorts. But in this case, the exclusionary tool is used simply to determine the *type* of coverage an individual will receive, not whether coverage will be available at all. To be sure, this screening mechanism makes the entire enterprise attractive to the private insurance industry, which in turn avoids the highest risk populations. However, such screening also insulates that part of the newly eligible Medicaid population with the greatest health vulnerabilities from the harsher terms of private coverage. It may be that such screening is less than perfect in predicting higher health needs, but at least there is a tool whose impact and accuracy can be evaluated.

Fourth, the demonstration preserves Medicaid's open-access feature, arguably its single most important attribute. The fundamental principle of Medicaid enrollment at any time, regardless of health need, remains intact. This safety net feature is of incalculable value, even taking into account the special enrollment

54. Andrew Allison, *Arkansas's Alternative to Medicaid Expansion Raises Important Questions About How HHA Will Implement New ACA Waiver Authority in 2017*, 39 J. HEALTH POL. POL'Y & L. 1089 (2014).

55. 42 U.S.C. § 18031(c)(1)(C) (2012).

56. Testimony of Andrew Allison before the Medicaid and CHIP Payment and Access Commission (MACPAC), (Sept. 18, 2014), <http://www.macpac.gov/home/meetings/sept/>.

periods established under the ACA.⁵⁷

Fifth, the terms of the demonstration guarantee the continuation of certain benefits unique to Medicaid (early and periodic screening, diagnosis and treatment for children and adolescents, highly accessible family planning services, non-emergency medical transportation), which have no equal in the commercial insurance market. Finally, the terms and conditions of the demonstration ensure that—again, at least at the moment—patient cost-sharing responsibilities remain within established Medicaid boundaries. These boundaries hold Medicaid cost-sharing well below the level that insurers are imposing on the premium subsidy population, even that portion of the population that receives the most significant level of subsidization.

Two basic problems loom, however: cost and politics. It seems inevitable that the Arkansas demonstration, by binding Medicaid premium payments to the competitive rate for silver plans established within the state Exchange, will result in costs that exceed what Medicaid would have spent for the same population under traditional coverage arrangements. In order to adhere to the budget neutrality rules that, by Executive action, have applied to section 1115 demonstrations since the late 1970s,⁵⁸ the Administration essentially permitted the state to project significant cost increases under traditional Medicaid. These cost increase projections were based on the assumption that a surge in Medicaid enrollment inevitably would have created pressure for provider fee increases in order to ensure patient access to care. Not surprisingly, this decision by the Administration has come under intense scrutiny by the General Accounting Office,⁵⁹ since it has effectively “back-doored” the same spending increases that CBO flagged in its post-*Sebelius* cost estimates.

The second cause for concern is the politics of premium assistance. Arkansas potentially represents the high-water mark for the demonstration model. The Arkansas demonstration features open enrollment, preservation of full Medicaid benefits for the medically frail, no premiums, and cost-sharing held to Medicaid’s relatively modest levels. The model also maintains coverage of certain supplemental benefits for beneficiaries receiving premium support, including free choice of family planning benefits, comprehensive supplemental coverage for children and adolescents up to age 21 (typically those with serious and chronic health conditions), and non-emergency medical transportation. Furthermore, the

57. *Having a Major Life Change? You May Qualify for a Special Enrollment Period*, HEALTHCARE.GOV BLOG (Sept. 5, 2014), <https://www.healthcare.gov/blog/special-enrollment-period/>.

58. *Section 1115 Demonstrations*, MEDICAID.GOV, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Section-1115-Demonstrations.html> (last visited Nov. 2, 2014).

59. Katherine Iritani, *HHS's Approval Process for Arkansas's Medicaid Expansion Waiver Raises Cost Concerns*, U.S. GOV'T ACCOUNTABILITY OFF. (Aug. 8, 2014), <http://www.gao.gov/assets/670/665265.pdf>.

demonstration preserves the special Medicaid payment mechanism for community health centers, a core element of the U.S. health care safety net and a major source of care for insured and uninsured patients alike. Preservation of these elements—in particular, Medicaid’s safety net financing feature—is key. Indeed, if Massachusetts’ near-decade-long experience with health reform offers any lesson, health reform will produce enormous achievements while still leaving considerable gaps. States will still have a population of considerable size that remains completely uninsured for longer or shorter periods of time owing to both ineligibility for coverage (in the case of persons not lawfully present in the U.S.) and breaks in coverage as a result of churn. There will also be a considerable low-income population that, even if insured, continues to need health care (such as vision and dental care) that remains uncovered by public and private health insurance. This care will therefore be inaccessible to low-income populations in the absence of community health centers or other publicly funded providers that can make primary health care available on a heavily discounted basis.⁶⁰

As other demonstrations have proceeded, the Arkansas model has lost a bit of ground. Later demonstration proposals approved by HHS for Iowa, Pennsylvania, and Michigan have included approvals to impose premiums on certain portions of the demonstration population and eliminate benefits such as dental care for 19 to 21-year-olds.⁶¹ States routinely have sought to impose higher cost sharing than permitted under Medicaid. Indeed, the second phase of the Arkansas demonstration includes precisely this proposal, through the establishment of health savings accounts coupled with higher cost sharing requirements that apply to the poor.⁶²

Although many states initially sought to limit the expansion to adults under 100 percent of the federal poverty level (the Exchange threshold), no state has yet come forward seeking to limit the expansion to only certain newly eligible adults falling within actuarial norms (i.e., excluding the medically frail). Nor has any state sought to eliminate Medicaid’s basic open access feature, although rumors persist that such a proposal could be in the offing. Under section 1115, at least as interpreted by the current Administration, these types of proposals almost certainly would be rejected as not consistent with program goals. But the discretion to decide

60. Julia Paradise et al., *Providing Outreach and Enrollment Assistance: Lessons Learned from Community Health Centers in Massachusetts*, KAISER FAM. FOUND. (2013), <http://kff.org/health-reform/issue-brief/providing-outreach-and-enrollment-assistance-lessons-learned-from-community-health-centers-in-massachusetts/>; Leighton Ku et al., *How is the Primary Care Safety Net Faring in Massachusetts? Community Health Centers in the Midst of Health Reform*, KAISER FAM. FOUND. (2009), <http://www.kff.org/health-reform/report/how-is-the-primary-care-safety-net/>.

61. Sara Rosenbaum & Carla Hurt, *How States Are Expanding Medicaid to Low-Income Adults Through Section 1115 Waiver Demonstrations*, COMMONWEALTH FUND (2014), <http://www.commonwealthfund.org/publications/issue-briefs/2014/dec/how-states-are-expanding-medicaid>.

62. See Allison, *supra* note 54.

when a Medicaid demonstration advances Medicaid's objectives lies with the Secretary as a matter of law.

The close scrutiny brought to bear on the cost of Arkansas' Medicaid demonstration may signal the end of section 1115 premium assistance demonstrations as generous as the Arkansas model. Yet as the Obama Administration comes to a close, the temptation to get as many of the remaining non-expansion states into the fold will be great. A "big tent" demonstration strategy might provide some insurance against repeal efforts in a Republican controlled Congress, but broadening section 1115 significantly beyond where the Arkansas demonstration has taken the program is a risky business. Indeed, greater leeway to reduce financial support and benefits could produce the opposite effect, emboldening states and conservative lawmakers to demand broader state flexibility to accomplish without demonstration authority what today can be done only under the Secretary's special terms and conditions. In other words, this would be a replay of the Balanced Budget Act of 1997, but arguably with far greater stakes. It could culminate in Medicaid adult expansion legislation that broadly enables Medicaid's full conversion to premium assistance. Under such a scenario, the ACA coverage and financial assistance standards might become the floor, assuming that these standards survive.

There are, in fact, limits to how extreme a Medicaid makeover might be. For one thing, the Arkansas demonstration shows willingness on the part of insurers and networks to accept the poor, but only if the medically frail remain in Medicaid. This should provide some protection against a wholesale route with exceptions only for the nonelderly population that meets the Social Security Insurance disability test. Under this scenario, Medicaid presumably would remain accessible to those deemed inappropriate for a financing system that rests on principles of private financial risk, whose most important risk mitigation tools—risk corridors and reinsurance⁶³—are set to expire after 2016.

For another, there is the cost entailed in such a transformation. Just as both the Government Accountability Office and the CBO have identified the relatively high costs associated with Medicaid as premium support, any effort to move Medicaid more decisively toward a premium assistance model inevitably will cost a good deal. This is not insurmountable either, of course. There simply need to be cost offsets. Securing funding for such a transition, if carried out with adequate safeguards, may have a significant effect on opening access to health care for the poor, at least in states in which insurers and their provider networks are willing partners in a premium assistance model. But when one is considering policy reforms in the land of the poor, offsets are hard to come by, and they have the potential to be even more damaging than the immediate policy at hand.

63. Patient Protection and Affordable Care Act §§ 1341-42, 42 U.S.C. §§ 18061-62 (2012).

IV. LOOKING FORWARD

It is difficult to say with certainty where all of this will end up. There are a lot of moving parts, and potentially, reforms that make it easier for states to use Medicaid to purchase qualified health plans sold in the Exchange may carry a larger price tag, for Medicaid at least. (This price tag could be offset by savings in federal premium subsidies if the movement of the healthiest beneficiaries into Exchange plans results in lower overall per capita costs for Exchange health plans). But there are also two fundamental truths. The first is that the nation has decisively moved away from the social contract principles that undergird Medicaid. And as the entire nation seemingly drifts inexorably in the direction of high deductible health plans that create huge holes in coverage, why should the poor not experience the same thing? I used to be asked by reporters how Medicaid reforms might help the populations that stood to benefit from them. Now I am asked why the poor should have good coverage when most Americans do not.

The second fundamental truth is Medicaid's remarkable endurance. Over its fifty-year existence, Medicaid has survived multiple near-death experiences and endless rounds of reinvention. Its eligibility rules have been reconfigured, as have its coverage parameters and delivery mechanisms. The program has struggled with periodic crises that have their roots in ideology and a particular viewpoint regarding what the government should invest in. But Medicaid has survived because it must. In a very real sense, the entire market-oriented system of health care financing—as seen clearly in the Arkansas model—depends on Medicaid's ability to fund health care for those whom markets literally do not want to touch.

How well Medicaid rises to the new challenge of joining itself to a private health insurance market, and whether its essential principles – comprehensive coverage; protection of the poorest Americans against cost-sharing; and availability at the time of need -- can survive remains to be seen. In an ideal world the ACA might have met these issues head-on and would have attempted to frame the point of juxtaposition in ways that gave these principles a somewhat better chance at survival. But the ACA was not born in an ideal world, and so taking Medicaid through its next iteration simply gets added to the to-do list.

Out of the Black Box and Into the Light: Using Section 1115 Medicaid Waivers to Implement the Affordable Care Act's Medicaid Expansion

Sidney D. Watson*

INTRODUCTION

What price Medicaid expansion? The Supreme Court's decision in *National Federation of Independent Business (NFIB) v. Sebelius*,¹ sparked intense debate about how the Secretary of Health & Human Services (HHS) would respond to pressure from recalcitrant states. Policy experts and Sunday-morning pundits predicted that Red States would demand Section 1115 waivers of federal Medicaid rules as the quid pro quo for implementing the Affordable Care Act's (ACA) Medicaid expansion that covers adults with incomes up to 133% of the federal poverty level (FPL). They prophesized that the Obama Administration, desperate to move implementation forward, would have little leverage in its negotiations with states.

So far, a handful of states—Arkansas, Iowa, Michigan, Pennsylvania, Indiana and Arizona—have led the way in requesting Section 1115 demonstration waivers that would tie the ACA's Medicaid expansion to Medicaid coverage that offers thinner benefits, higher cost-sharing, premiums, and work requirements. The negotiations have been wild and wooly, but the four states that have obtained Section 1115 waivers—Arkansas, Iowa, Michigan, and Pennsylvania—have won relatively few concessions because the ACA changed the law of Section 1115. The Secretary of HHS has only very limited authority to approve waivers that reduce benefits, and she has no legal authority to approve waivers that increase cost sharing, impose premiums, or implement work rules. HHS simply does not have the leeway to negotiate that some had hoped for—and others feared.

This Essay explores the new legal limits on the Secretary's Section 1115 authority to grant waiver requests for implementation of the ACA Medicaid expansion for adults. Part I describes the Section 1115 waiver process, and explains how provisions in the ACA make this process more transparent, and the federal government more accountable to the law of Section 1115. New notice and comment requirements, and a more robust administrative record for judicial review

* Professor of Law, Saint Louis University School of Law. My special thanks to Srishti Miglani, JD/MPH 2015, and Daniel Sheffner, Esq., for their help and advice.

1. 132 S. Ct. 2566 (2012).

require that both states and the Secretary attend more carefully to the legal requirements for Section 1115 waivers.

Part II explains how the ACA amended Section 1902 of the Medicaid Act and broadened the Act's purposes, and, in so doing, constrained the Secretary's authority to grant Section 1115 waivers for benefits, cost-sharing, premiums, and work rules. Part III demonstrates why the Secretary does not have legal authority to grant states' Section 1115 waiver requests for benefit reductions, higher cost-sharing, premiums, and work requirements for those made eligible by the ACA Medicaid expansion.

I conclude by predicting that the bloodiest battleground for Section 1115 waivers will be requests to impose premiums where the Secretary's attempt to accommodate states has resulted in waivers allowing premiums-lite—monthly charges that are not quite full-blown premiums, but still are not authorized by the Medicaid statute or Section 1115.

I. BRINGING SECTION 1115 WAIVERS INTO THE LIGHT: HOW THE ACA CHANGES SECTION 1115

Medicaid is a joint federal-state program that provides federal financial assistance to states operating approved medical-assistance plans. Federal law outlines broad mandatory requirements that state Medicaid programs must follow, but states retain considerable flexibility to cover additional eligibility groups and benefits. States may also seek waivers from the Secretary of HHS to use federal Medicaid funds to cover additional people and services, and to use delivery system models not otherwise authorized by federal law.

Section 1115 of the Social Security Act permits the Secretary to waive provisions in Section 1902 of the Medicaid Act for a limited period of time to allow states to engage in innovative “experimental, pilot, or demonstration” projects that are “likely to assist in promoting the objectives of [the Medicaid Act].”² Although not required by statute or regulations, Section 1115 waivers, under long standing agency policy, are supposed to be budget neutral for the federal government.

Section 1115 began as a limited and targeted tool to test small-scale research hypotheses. However, since the Clinton Administration, the use of Section 1115 Medicaid waivers has skyrocketed. In February 2012, thirty-four states had at least one Section 1115 Medicaid waiver.³

As the size and number of Section 1115 waivers have grown, so have concerns about the lack of transparency in the waiver approval process. Section 1115

2. Social Security Act § 1115(a), 42 U.S.C. § 1315(a)(1) (2012).

3. Kaiser Comm'n on Medicaid and the Uninsured, *The New Review and Approval Process Rule for Section 1115 Medicaid and CHIP Demonstration Waivers*, KAISER FAM. FOUND. 2 (2012), <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8292.pdf>.

Medicaid waiver requests have typically been negotiated behind closed doors: demonstration goals were often not clearly stated, the terms of the waivers were sometimes vague, and evaluations of demonstrations were often either not done, or not shared with the public or HHS.

The growth in waivers combined with an opaque approval process also raised concerns over the types of waivers that were being granted. Waivers no longer seemed to be about testing new and innovative ideas likely to further the purpose of the Medicaid Act. Instead, waiver approvals seemed to reflect a particular administration's policy preferences: President Clinton's for simply allowing states more flexibility from federal rules to pursue their own priorities and President George W. Bush's for promoting private insurance models with thinner benefits and higher cost-sharing.⁴ Successive federal administrations seemed chronically unconcerned about whether waivers were budget neutral for the federal government. Some waivers have continued for decades with no public evaluation of their impact on Medicaid access, cost, or quality.

In response, the ACA added a new Section 1115(d) providing significant new procedural requirements for Section 1115 waiver requests and renewals. These amendments require public notice, meaningful opportunities for public input, posting of the administrative record online, and evaluations of Section 1115 waiver programs.⁵

Section 1115(d) now requires that states make publicly available a draft waiver request, described in sufficient detail to allow "meaningful input from the public," prior to submission of a waiver to the federal government. Among other things, the draft waiver request must include the demonstration's goals and objectives, the specific waiver and expenditure authorities sought, and the research hypothesis and evaluation parameters.⁶ States must post the draft waiver application on a state website and allow the public to sign up for an email list to be kept apprised of the waiver application process. A 30-day public notice and comment period is required, and the state must also hold at least two public hearings. The final waiver application submitted to the federal government must include similar details to those in the draft waiver proposal, but must also document the public process, including the state's responses to public comments.⁷

4. See, e.g., Samuel R. Bagenstos, *Federalism by Waiver After the Health Care Case*, in *THE HEALTH CARE CASE: THE SUPREME COURT'S DECISION AND ITS IMPLICATIONS* 227 (Nathaniel Persily et al. eds., 2013).

5. Patient Protection and Affordable Care Act (ACA), Pub. L. 111-148, § 10201(i), 124 Stat. 119, 922 (2010) (codified at 42 U.S.C. § 1315(d) (2012)) (adding a new subsection, Section 1115(d), to the Social Security Act). Implementing regulations are at 42 C.F.R. §§ 431.400–431.428 (2014). These ACA Amendments apply only to Medicaid and CHIP Section 1115 waivers.

6. 42 C.F.R. § 431.408 (2014).

7. *Id.*

After a waiver application is submitted to the federal government, Section 1115(d) provides for another 30-day comment period. The Centers for Medicare and Medicaid Services (CMS) is required to post the waiver application and supporting documents on its website along with an email address through which the public may comment.⁸ A federal decision on the waiver cannot be made until fifteen days after the close of the public comment period, although the federal government does not need to respond to comments made at the federal or state level.⁹

CMS must post online the administrative record of the waiver process, including, among other things, the waiver application and public comments.¹⁰ For approved waivers, CMS posts the “special terms and conditions” outlining the terms of the approval, a list of the specific sections of the Medicaid Act and applicable regulations being waived or modified, the types of federal expenditures, including the budget neutrality agreement, and requirements for evaluation design and reports.¹¹

States are now required to have a CMS-approved Section 1115 evaluation strategy in place.¹² State evaluations are to be submitted to CMS and shared with the public via online posting by the state and CMS.¹³ The “special terms and conditions” approving the waiver include specific requirements for implementation reviews, evaluation design, quarterly progress reports, and evaluation reports.¹⁴ States are also required to submit an annual report to HHS that includes, among other things, the changes occurring under the demonstrations and their impact on outcomes, quality, and access; beneficiary satisfaction surveys; grievance and appeals data; financial data; audits; and other relevant developments.¹⁵ States are also required to conduct a stakeholder forum within six months of implementation and annually thereafter.¹⁶

The ACA’s new transparency provisions force states and CMS to pay attention to the law of Section 1115. Section 1115 waiver requests and approvals must specify the provisions of Section 1902 to be waived. States must set forth the experimental purpose, specify how this purpose furthers the goals of the Medicaid Act, and describe how the experiment will be evaluated. Budget neutrality assumptions and calculations must be provided.

8. *Id.* § 431.416.

9. *Id.*

10. *Id.* § 431.416(f).

11. *Id.* See also Kaiser Comm’n on Medicaid and the Uninsured, *supra* note 3, at 2 (explaining some of the documents referred to by this rule).

12. 42 C.F.R. § 431.424 (2014).

13. *Id.* § 431.424(e).

14. *Id.* § 431.416.

15. *Id.* § 431.428.

16. *Id.* § 431.420(c).

The new notice and comment provisions have opened up the Section 1115 negotiation process, influencing the development of states' waiver requests and making the process more transparent. Arkansas dropped three of its six original waiver requests in response to comments during the state notice period that HHS did not have Section 1115 authority to grant them.¹⁷ Iowa received comments during its state comment period that the state's proposed reductions in benefits were harmful to patients and not authorized by Section 1115. However, unlike Arkansas, Iowa retained these proposed reductions in its final waiver request, responding to public comments by noting that the state had to seek these waivers because state legislation authorizing the Medicaid expansion directed that they do so.¹⁸

Of course, states and the federal government sometimes try to skirt requirements of federal Medicaid law. Pennsylvania's draft waiver application fell far short of the new requirements for public comment—it did not identify the specific waivers sought, provided no research hypothesis, and was simply too general to allow “meaningful input from the public.”¹⁹ The U.S. Government Accountability Office (GAO) has already called CMS to task for failing to ensure budget neutrality in the Arkansas waiver approval.²⁰ Michigan used a waiver amendment for its ACA Medicaid expansion rather than request a new waiver, skirting Section 1115's public notice and comments rules because waiver amendments are not subject to these new transparency requirements.²¹

Given the states' and CMS's proclivity to try to skirt the law, it is significant

17. *Compare Arkansas Draft 1115 Waiver for Public Comment*, ARK. DEP'T OF HUM. SERVS. 28, http://posting.arktimes.com/images/blogimages/2013/06/24/1372102611-1115_waiver_draft_june_24_2_.pdf with *Arkansas 1115 Waiver Application*, ARK. DEP'T OF HUM. SERVS. 30–31, <https://www.medicaid.state.ar.us/Download/general/comment/FinalHCIWApp.pdf>.

18. *See Iowa Marketplace Choice Plan 1115 Waiver Application*, IA. DEP'T OF HUM. SERVS. 42 (2013), <http://dhs.iowa.gov/sites/default/files/IAMktplaceChoice1115Final.pdf>.

19. *See supra* text accompanying notes 6–7. For Pennsylvania's draft waiver, see *Healthy Pennsylvania: Reforming Medicaid*, PA. DEP'T OF PUB. WELFARE, http://www.dpw.state.pa.us/cs/groups/webcontent/documents/document/p_039348.pdf.

20. U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-14-689R, *MEDICAID DEMONSTRATIONS: HHS'S APPROVAL PROCESS FOR ARKANSAS'S MEDICAID EXPANSION WAIVER RAISES COSTS CONCERNS*, *MEDICAID DEMONSTRATIONS: HHS'S APPROVAL PROCESS FOR ARKANSAS'S MEDICAID EXPANSION WAIVER RAISES COSTS CONCERNS* (2014).

21. *See* Letter from Cindy Mann, Dir., Ctr. for Medicaid & CHIP Servs., Ctrs. for Medicare & Medicaid Servs., to State Medicaid Dirs. & State Health Officials, (Apr. 27, 2012), <http://www.medicaid.gov/federal-policy-guidance/downloads/sho-12-001.pdf> (Re: Revised Review and Approval Process for Section 1115 Demonstrations) (explaining that while Section 1115 amendments are not subject to the new notice and comment requirements, states are encouraged to comply with them, and CMS will provide an opportunity for public comment on amendments). For a sense of the more limited notice and comment provided by Michigan, see *Healthy Michigan Plan Waiver Protocols*, MICH. DEP'T OF CMTY. HEALTH, http://www.michigan.gov/mdch/0,4612,7-132-2943_66797-327655--,00.html (last visited Dec. 9, 2014).

that the ACA's new Section 1115 transparency provisions provide a more meaningful administrative record for purposes of judicial review. The Secretary's grant of a Section 1115 waiver is subject to judicial review pursuant the Administrative Procedure Act,²² and courts will reverse the Secretary's grant of a waiver when it is either contrary to law or "arbitrary and capricious."²³ The question of whether the waiver is for a provision in Section 1902 is a matter of law and is reviewed *de novo*.²⁴ The administrative record must also demonstrate that the Secretary has examined the record and made a determination that the waiver is for "an [e]xperimental, [p]ilot or [d]emonstration project," is "[l]ikely [t]o [a]ssist in [p]romoting [t]he [o]bjectives [o]f [t]he Act," and has an appropriate "extent and period."²⁵ While courts have not required formal findings, the record must be sufficient to support the agency action, show that the agency considered the relevant factors, and enable the court to review the agency decision.²⁶

Under these standards, courts have overturned the Secretary's approval of some Section 1115 waivers. In *Beno v. Shalala*, the Ninth Circuit held that the Secretary abused her discretion when she granted a waiver to allow benefit cuts for the purpose of saving the state money without any consideration of the research or demonstration value.²⁷ In *Newton-Nations v. Betlach*, the Ninth Circuit held it was an abuse of discretion for the Secretary to approve a waiver allowing copays when the only evidence in the administrative record was public comments submitted on behalf of a public health expert stating that thirty-five years of health policy research had established the detrimental effects of cost-sharing on the poor. The administrative record contained no finding that the waiver had an experimental purpose that would demonstrate anything different.²⁸

The new Medicaid Section 1115 transparency provisions should usher in a

22. *Beno v. Shalala*, 30 F.3d 1057 (9th Cir. 1994); *see also* *Wood v. Betlach*, 922 F. Supp. 2d 836 (D. Ariz. 2013). The Administrative Procedure Act provides for judicial review of federal agencies' actions. 5 U.S.C. §§ 701-706 (2012). Medicaid beneficiaries may also have a right of action under 42 U.S.C. § 1983 or the Supremacy Clause, U.S. CONST. art. VI, cl. 2. *See* *Spry v. Thompson*, 487 F.3d 1272 (9th Cir. 2007) (holding that Medicaid beneficiaries have a federal right of action enforceable under § 1983).

23. *Newton-Nations v. Betlach*, 660 F.3d 370, 378 (9th Cir. 2011); *see also* *Wood*, 922 F. Supp. 2d at 836 (holding that it is an abuse of discretion to approve heightened copays as "experimental" when there is evidence in the administrative record of 35 years of research).

24. *Spry*, 487 F.3d at 1276.

25. *Newton-Nations*, 660 F.3d at 380 (quoting *Beno*, 30 F.3d at 1069).

26. *Id.* at 381.

27. *Beno*, 30 F.3d at 1071. The court noted that under Section 1115, "the Secretary must make some judgment that the project has a research or a demonstration value" and found that "[a] simple benefits cut, which might save money, but has no research or experimental goal, would not satisfy this requirement." *Id.*

28. *Newton-Nations*, 660 F.3d. at 380-82. *But see* *Wood*, 922 F. Supp. 2d at 836 (approving waiver after remand to the Secretary and development of more robust administrative record about demonstration goals).

new era of transparency and accountability. Instead of the negotiations staying behind closed doors, the details of waiver requests are now available for public comment. For example, Pennsylvania's original waiver application requested twenty-four waivers of fifteen provisions of federal Medicaid law. More than eight hundred comments were filed during the federal comment period.²⁹ After almost a year of protracted negotiations, Pennsylvania's approved waiver authorizes only four waivers of federal Medicaid law, one of which allows the use of Medicaid managed care, something that does not require a waiver because it is already authorized by the Medicaid statute.³⁰

Recalcitrant states are not getting much of what they want from waivers to implement the ACA Medicaid expansion for adults. With a more robust administrative record, CMS seems to be attending more closely to the new, post-ACA law of Section 1115, and courts have shown willingness to enforce this imperative.

II. HOW THE ACA TRANSFORMS SECTION 1902 AND THE MEDICAID ACT

Prior to the ACA, Section 1902 of the Medicaid Act allowed states to extend coverage only to those who fit within the old welfare categories of the worthy poor—children, parents, pregnant women, the elderly, and people with disabilities. States needed a Section 1115 waiver to cover others, like childless adults. The George W. Bush administration encouraged states to use Health Insurance Flexibility and Accountability (HIFA) waivers—a type of Section 1115 waiver—to expand coverage to childless adults, granting states “virtually unlimited flexibility” via these waivers to reduce benefits, impose premiums, and increase cost-sharing.³¹ CMS took the position, and courts agreed, that statutory protections provided outside of Section 1902—and therefore not waivable under Section

29. See *Public Comments: Healthy Pennsylvania Demonstration*, MEDICAID.GOV, <https://public.medicaid.gov/connect.ti/public.comments/view?objectId=1852995> (last visited Dec. 9, 2014).

30. See 42 U.S.C. § 1396u-2 (2012) (authorizing mandatory managed care enrollment for most Medicaid beneficiaries). The waiver application and Pennsylvania's Special Terms and Conditions approving the waiver are both available online. Letter from Tom Corbett, Governor, Commonwealth of Pa., to Kathleen Sebelius, Sec'y, U.S. Dep't of Health & Human Servs. (Feb. 19, 2014) [hereinafter *Healthy Pennsylvania 1115 Demonstration Application*] (waiver application), http://www.dpw.state.pa.us/cs/groups/webcontent/documents/document/c_071204.pdf; Letter from Marilyn Tavenner, Adm'r, Ctrs. for Medicare & Medicaid Servs., to Beverly Mackereth, Sec'y, Pa. Dep't of Pub. Welfare (Aug. 28, 2014), <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/pa/pa-healthy-ca.pdf> [hereinafter *Healthy Pennsylvania Special Terms and Conditions*] (waiver approval).

31. Cindy Mann, *The New Medicaid and CHIP Waiver Initiatives*, KAISER FAM. FOUND. 24 (2002), <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/the-new-medicaid-and-chip-waiver-initiatives-background-paper.pdf>.

1115—applied only to those “described” as mandatory categories of eligibility in Section 1902(a)(10) of the Medicaid Act or as optional categories of eligibility in other sections of the Act.³² Since childless adults eligible only through Section 1115 waivers were not “described” in Section 1902(a)(10) or anywhere else in the statute, CMS concluded they were not protected by any of the non-waivable statutory provisions that applied to groups eligible under Section 1902.³³

In light of this history, the ACA added Section 1902(a)(10)(A)(i)(VIII) to the Medicaid Act, creating a new mandatory category of Medicaid eligibility for adults aged 19-64 with incomes up to 133% of the FPL.³⁴ States no longer need a Section 1115 waiver to cover childless adults and others. Furthermore, the statute provides states that opt to cover this group of adults with extremely generous federal funding, covering 100% of the cost of the expansion for 2014-2016, reducing gradually to 90% in 2020 and thereafter. Finally, adults eligible under Section 1902(a)(10)(A)(i)(VIII) are now “described” in the Medicaid Act and entitled to the full range of protections provided by the statute to those eligible under Section 1902(a)(10). As a result, adults covered under the ACA Medicaid expansion are entitled to a higher coverage baseline than under pre-ACA HIFA waivers.

As Justice Roberts noted in *NFIB v. Sebelius*, the ACA does not just expand Medicaid; it also transforms the objectives of Medicaid from a welfare program that only covered some poor people to an inclusive social insurance model.³⁵ In Justice Roberts’ words, the ACA Medicaid expansion was “a shift in kind, not merely in degree,” transforming an old Medicaid program into something new.³⁶ Rather than seeking to exclude people based on categories of eligibility or old notions of worthiness, the ACA re-creates Medicaid as the foundation of a multi-layer insurance system that seeks to offer access to affordable health insurance to *all* Americans and documented immigrants.

A host of ACA provisions seek to create a seamless web of coverage so people do not fall through the cracks and become uninsured when their income fluctuates.

32. *See, e.g.*, *Spry v. Thompson*, 487 F.3d 1272, 1276 (9th Cir. 2007)

33. *Id.* at 1276–77. Moreover, any issue about the Secretary’s Section 1115 authority to waive protections codified outside of Section 1902 was not relevant to these waivers. *Id.*

34. Section 1902(a)(10)(A)(i)(VIII) originally *required* that states extend Medicaid coverage to this group, but the Supreme Court in *NFIB v. Sebelius* made the provision permissive. *See* 132 S. Ct. 2566, 2572 (2012).

35. *Nat’l Fed’n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566, 2606 (2012) (“[Medicaid] is no longer a program to care for [only] the neediest among us, but rather an element of a comprehensive national plan to provide universal health insurance coverage”). The Medicaid Act’s stated purpose, which has been part of the Act since it was enacted in 1965, provides that it is “[f]or the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish . . . medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services.” 42 U.S.C. § 1396-1 (2012).

36. *Nat’l Fed’n of Indep. Bus.*, 132 S. Ct. at 2575.

These provisions make it easier to qualify for Medicaid, and align Medicaid eligibility rules with those for Marketplace premium tax credits. Both Medicaid and premium tax credit eligibility are determined based on the same “modified adjusted gross income” (MAGI) formula. Income is electronically verified, obviating the need to submit paperwork to the welfare office. Burdensome and intrusive asset tests have been eliminated for Medicaid and do not apply for premium tax credits. People can apply for both Medicaid and premium tax credits via the Marketplace, and state Medicaid applications have been streamlined.

However, the ACA also retains Medicaid’s purpose as a safety net insurer, with a benefit and cost-sharing structure distinct from that offered through new Marketplace premium credits and designed to meet the specific needs of the poor. The ACA did add a provision to Section 1902 to establish an “alternative benefit package” benchmarked to private insurance for adults eligible under the ACA’s Medicaid expansion, but it also provides that these new benefit packages are subject to pre-existing protections under Section 1937(b) of the Medicaid Act.³⁷ The ACA also left in place Sections 1916 and 1916A of the Medicaid Act, which provide special premium and cost-sharing protections for Medicaid eligible individuals “described” in Section 1902(a)(10), and which are more stringent than the financial protections afforded those receiving Marketplace premium tax credits.³⁸

In sum, the ACA transformed the objective of Medicaid to include covering all those with incomes up to 133% of the FPL. At the same time, the ACA maintains Medicaid’s purpose as a safety net insurer, with a unique set of benefits and protections designed to meet the needs of the nation’s poor and to support the nation’s safety net providers.

III. ACA MEDICAID EXPANSION WAIVERS AND THE LIMITS OF LAW

To some extent, states and the public are still catching up with the changes to Section 1115 and the Medicaid Act brought about by the ACA. In the immediate

37. See Patient Protection and Affordable Care Act (ACA), Pub. L. 111-148, § 2001(a)(2), 124 Stat 119, 271-72 (2010) (codified at 42 U.S.C. § 1396a(k)(1) (2012)).

38. Social Security Act §§ 1916, 1916A, 42 U.S.C. §§ 1396o, 1396o-1 (2012). In general, these sections prohibit premiums for those with incomes below 150% of the FPL, limit cost-sharing for those at or below FPL to “nominal” amounts, and cap both premiums and out-of-pocket costs at 5% of household income, computed on a quarterly or monthly basis at the state’s option. *Id.* Marketplace premium tax credits are benchmarked at 2% of income for the second lowest cost Silver Plan, with individuals paying more or less depending on the plan they select. Cost-sharing tax credits increase the actuarial value of plans to 94% for those earning between 100-150% of the FPL, which translates into an out-of-pocket cap of \$2,500 for individual coverage and \$4,500 for family coverage. See *Explaining Health Care Reform: Questions about Health Insurance Subsidies*, KAISER FAM. FOUND. (2014), <http://files.kff.org/attachment/explaining-health-care-reform-questions-about-health-insurance-subsidies-issue-brief>.

aftermath of *NFIB v. Sebelius*, some thought that states would be able to obtain Section 1115 expansion waivers resembling pre-ACA HIFA waivers, offering fewer benefits and requiring higher cost-sharing and premiums. But the ACA changed the legal landscape. Post-ACA Medicaid expansion waivers raise different legal issues under Section 1115 than did pre-ACA waivers to cover childless adults. ACA Medicaid expansion adults are now eligible by virtue of Section 1902(a)(10)(A)(i)(VIII), and are therefore entitled to a variety of protections in other parts of the statute that the Secretary has no Section 1115 authority to waive.

A handful of states have taken the lead in requesting Section 1115 waivers as the price for implementing the ACA's Medicaid expansion for adults. Arkansas, Iowa, Michigan, and Pennsylvania have received approved waivers, and expansions are moving forward in those states.³⁹ Indiana and Arizona have waiver requests pending, and Arkansas and Iowa are seeking additional waivers.⁴⁰

39. *Healthy Pennsylvania Special Terms and Conditions*, *supra* note 30; Letter from Marilyn Tavenner, Adm'r, Ctrs. for Medicare & Medicaid Servs., to Andy Allison, Dir., Ark. Dep't of Human Servs. (Sept. 27, 2013), <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/ar-private-option-ca.pdf> [hereinafter *Arkansas Private Option Special Terms and Conditions*]; Letter from Cindy Mann, Dir., Ctr. for Medicaid & CHIP Servs., Ctrs. for Medicare & Medicaid Servs., to Jennifer Vermeer, Medicaid Dir., State of Iowa, Dep't of Human Servs. (May 1, 2014), <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ia/ia-wellness-plan-ca.pdf> [hereinafter *Iowa Wellness Plan Special Terms and Conditions*] (approving the Iowa Wellness Plan for those earning up to 100% FPL); Letter from Cindy Mann, Dir., Ctr. for Medicaid & CHIP Servs., Ctrs. for Medicare and Medicaid Servs., to Jennifer Vermeer, Medicaid Dir., State of Iowa, Dep't of Human Servs. (May 1, 2014), <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ia/ia-marketplace-choice-plan-ca.pdf> [hereinafter *Iowa Marketplace Choice Special Terms and Conditions*] (approving Iowa Marketplace Choice for those earning between 100-133% FPL); Letter from Marilyn Tavenner, Adm'r, Ctrs. for Medicare & Medicaid Servs., to Stephen Fitton, Dir., Mich. Med. Servs. Admin. (Dec. 30, 2013), <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mi/mi-healthy-michigan-ca.pdf> [hereinafter *Healthy Michigan Special Terms and Conditions*]. These and other Section 1115 approved waivers can be viewed and downloaded at Medicaid.gov. *Waivers*, MEDICAID.GOV, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers_faceted.html (last visited Nov. 2, 2014).

40. *Arizona Section 1115 Waiver Amendment Request: Cost Sharing for Arizona's Expansion Population* (Jan. 2014), <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/az/az-hccc-pa-cost-sharing-request.pdf>; *HIP 2.0: Healthy Indiana Plan*, IND. FAM. & SOC. SERVS. ADMIN. 27-29 (July 2, 2014), <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2.0/in-healthy-indiana-plan-support-20-pa.pdf>; Iowa Dep't of Human Servs., *Health and Wellness Plan: NEMT Waiver Amendment Request*, ST. OF IOWA (Sept. 4, 2014), http://dhs.iowa.gov/sites/default/files/IA_NEMT_WaiverAmendment090414.pdf; Letter from Dawn Stehle, Dir. Div. of Med. Servs., Ark. Dep't of Human Servs., to Sylvia Mathews Burwell, Sec'y, U.S. Dep't of Health & Human Servs. (Sept. 15, 2014), <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/ar-private-option-pa.pdf>.

This Part provides a survey of waiver requests from these path-breaking states—requests that seek to reduce benefits, impose premiums and work requirements, and increase cost-sharing. This analysis is made possible by new transparency requirements in Section 1115(d). Waiver requests and approvals must now expressly address each Section 1115 waiver requirement, demonstrating that the waiver is (1) of a provision in Section 1902, (2) for a limited period of time, (3) for an experimental, pilot, or demonstration purpose, (4) likely to assist in promoting the purposes of the Medicaid Act, and (5) budget neutral for the federal government. This analysis draws heavily on the public comments and administrative record posted by the states and HHS in compliance with these new requirements.

A. “Private Option” via Marketplace Premium Assistance: Benefits, Cost-Sharing and Premiums

Arkansas was the first state to request a Section 1115 waiver as a condition for implementing the ACA's Medicaid expansion for adults. Arkansas asked HHS for a waiver that would allow it to use premium assistance to purchase Marketplace plans for adults newly eligible for Medicaid under the ACA's expansion. This proposal, dubbed the “Private Option,” caught the public and policy wonks by surprise. Many saw it as a “son of HIFA waiver” designed to provide Medicaid coverage that looked like private insurance with fewer benefits and higher costs for the beneficiary.⁴¹ However, a few months before Arkansas and HHS reached an agreement for a waiver, CMS issued proposed regulations that identified Section 1905(a)(29) of the Medicaid Act as the statutory authority for a new option that would allow states to give Medicaid beneficiaries the choice between premium assistance to purchase individual plans, including plans sold on the new Health Insurance Marketplaces, or traditional Medicaid coverage.⁴² The now-final regulations specify that Section 1905(a)(29) Marketplace premium assistance enrollees are entitled to all Medicaid benefits and cost-sharing protections, and states must assure that wrap-around services are available to the extent that Marketplace plans offer fewer benefits or require greater cost-sharing than the state

41. See, e.g., Avik Roy, *Should Arkansas Take the Obamacare Medicaid Deal? Probably Not*, FORBES: THE APOTHECARY (Apr. 3, 2013, 12:01 AM), <http://www.forbes.com/sites/theapothecary/2013/04/03/should-arkansas-take-the-obamacare-medicare-deal-probably-not/>.

42. Medicaid, Children's Health Insurance Programs, and Exchanges: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes for Medicaid and Exchange Eligibility Appeals and Other Provisions Related to Eligibility and Enrollment for Exchanges, Medicaid and CHIP, and Medicaid Premiums and Cost Sharing, 78 Fed. Reg. 4594, 4624 (proposed Jan. 22, 2013).

Medicaid plan.⁴³

Both Arkansas and Iowa have Section 1115 waivers that allow them to require some ACA expansion adults to obtain their Medicaid coverage via Marketplace plans. Arkansas uses its “Private Option” for all those who are not medically frail with incomes up to 133% FPL. Iowa uses its “Marketplace Choice” only for those who are not medically frail with incomes between 100-133% FPL.

The Secretary authorized this mandatory use of Marketplace premium assistance by waiving Section 1902(a)(23)(A) which guarantees Medicaid beneficiaries “freedom of choice” among all Medicaid participating providers. The waiver allows the states to limit Medicaid enrollees’ choice of providers to only those that participate in the networks of their Marketplace plans.⁴⁴ These freedom of choice waivers are very similar to early, and some ongoing, Medicaid managed care waivers that allow mandatory enrollment in HMOs.

The Section 1115 waivers authorizing Arkansas’ “Private Option” and Iowa’s “Marketplace Choice” demonstrations do not—and cannot—waive regulations promulgated pursuant to Section 1905(a) that guarantee premium assistance enrollees all Medicaid benefits and cost-sharing protections. Marketplace premium assistance waivers do not—and cannot—change the benefit package or cost-sharing rules that are codified in sections other than Section 1902 of the Medicaid Act.

While Marketplace premium assistance waivers have not been vehicles for benefit reductions or cost increases, policy experts remain interested in Marketplace demonstration projects to learn how well this new option may work in terms of access, quality, and cost for Medicaid beneficiaries. Pilots offering Marketplace coverage to Medicaid beneficiaries seem to further the objectives Medicaid Act because they may improve continuity of provider networks for those who move from Medicaid eligibility into new Marketplace premium tax credits. In addition, they may offer access to a better network of providers, depending upon

43. 42 C.F.R. § 435.1015 (2014); *see also* Medicaid, Children’s Health Insurance Programs, and Exchanges: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes for Medicaid and Exchange Eligibility Appeals and Other Provisions Related to Eligibility and Enrollment for Exchanges, Medicaid and CHIP, and Medicaid Premiums and Cost Sharing, 78 Fed. Reg. 42,160, 42,184-86 (July 15, 2013) (explaining that individuals who get premium assistance via the Section 1905(a) option remain Medicaid beneficiaries entitled to the full range of statutory protections).

44. *Arkansas Private Option Special Terms and Conditions*, *supra* note 39, at 1; *Iowa Marketplace Choice Special Terms and Conditions*, *supra* note 39, at 2. Iowa’s waiver also waives Section 1902(a)(10)(A)(i)(VIII) to the extent necessary to provide that enrolling in a Marketplace plan is a condition of eligibility for those eligible pursuant to the ACA Medicaid expansion. *Id.* at 1. Both waivers also waive the Section 1902 comparability requirement to allow the states to provide different benefits for different groups, a frequently waived provision in Section 1115 waivers. The waivers also allow the states to reimburse primary care providers in Marketplace plans at market rates.

how Marketplace plans develop.

However, the biggest Section 1115 hurdle for Marketplace premium assistance waivers is cost neutrality for the federal government. HHS has played fast and loose with the budget neutrality requirement, allowing Arkansas and Iowa to use cost assumptions with little to no basis in fact. The GAO has already raised red flags about the potential cost to the federal government from Section 1115 waivers allowing Marketplace premium assistance.⁴⁵

B. Benefit Reductions

While Marketplace premium assistance waivers have not been vehicles for benefit reductions, a number of states have requested other waivers to reduce benefits. Pennsylvania sought a wholesale reduction in Medicaid benefits for existing beneficiaries as well as ACA expansion adults.⁴⁶ Iowa sought to eliminate Early Periodic Screening, Diagnostic, and Treatment (EPSDT) benefits for those aged 19–21 who are part of the ACA expansion group, only leaving such coverage in place for younger adolescents and children.⁴⁷ Iowa and Pennsylvania both sought to exclude from coverage some federally qualified health centers, rural health centers, and family planning providers, and to eliminate coverage for non-emergency medical transportation for patients to get to and from care.⁴⁸

Except for non-emergency transportation, these requests to reduce benefits implicate statutory provisions in Section 1937, and are therefore outside the Secretary's Section 1115 authority to waive provisions in Section 1902. The ACA provides that Medicaid expansion adults are to receive an alternative benefit package benchmarked to private insurance as described in Section 1937(b)(1) or equivalent coverage as described in Section 1937(b)(2), and subject to all other requirements of Section 1937.⁴⁹ EPSDT benefits are required by Section 1937(1)(A)(ii), coverage of all rural health and federally qualified health clinics is required by Section 1937(b)(4), and coverage of all family planning providers is required by Section 1937(b)(7). The Secretary has no Section 1115 authority to waive any of the provisions in Section 1937.

By contrast, the statutory authority for non-emergency transportation is

45. U.S. GOV'T ACCOUNTABILITY OFFICE, *supra* note 20.

46. *Healthy Pennsylvania 1115 Demonstration Application*, *supra* note 30.

47. *Iowa Wellness Plan 1115 Waiver Application*, IA. DEP'T OF HUM. SERVS. (Aug. 2013), http://dhs.iowa.gov/sites/default/files/IAWellnessPlan1115_Final.pdf; *Iowa Marketplace Choice Plan 1115 Waiver Application*, *supra* note 18.

48. *Iowa Wellness Plan 1115 Waiver Application*, *supra* note 46; *Healthy Pennsylvania 1115 Demonstration Application*, *supra* note 30. Arkansas had included similar requests in its draft waiver request but deleted them in response to public comments that they were not authorized by law.

49. See Patient Protection and Affordable Care Act (ACA), Pub. L. 111-148, § 2001(a)(2), 124 Stat 119, 271-72 (2010) (codified at 42 U.S.C. § 1396a(k)(1) (2012)).

Section 1902(a)(4). Non-emergency transportation is not listed in Section 1937 as a basic benchmark or benchmark-equivalent service, nor is it mentioned anywhere else in Section 1937 as a service that states must provide. The Secretary has Section 1115 authority to waive Section 1902(a)(4), and she used this authority to allow both Iowa and Pennsylvania a one-year waiver of the requirement to provide non-emergency transportation.⁵⁰

Even though the Secretary has Section 1115 authority to waive the Section 1902(a)(4) non-emergency transportation requirement, it is arguably an abuse of discretion for the Secretary to find that such a waiver comports with other elements of Section 1115. The waiver must also further an “experimental, pilot, or demonstration” purpose and be “likely to assist in promoting the objectives of [the Medicaid Act].” Lack of transportation has been consistently identified in the research literature as a key barrier to care for low-income individuals and families.⁵¹ The research has been done and there is no need for a pilot or demonstration. Moreover, creating barriers to care flies directly in the face of Medicaid’s purpose to provide access to medical care. Medicaid, unlike private insurance, has covered non-emergency transportation since the program was created in 1965. Coverage for non-emergency medical transportation is one of the unique benefits that Medicaid covers because it is the country’s safety net insurer.

On the other hand, the waivers for non-emergency transportation are limited to a one-year period, allowing the states and CMS to quickly determine whether the lack of transportation is creating barriers. Pursuant to new Section 1115(d) requirements, the states must submit and make public an evaluation of these transportation demonstrations. Iowa’s data after the first six months of its waiver show that 20% of those earning below poverty, and 10% of those earning between 100-133% FPL, were unable to get transportation to or from medical care.⁵² Iowa has filed a request to extend its waiver for non-emergency transportation for a second year.⁵³ It will be interesting to see how CMS responds to this and other states’ requests for additional waivers of coverage for non-emergency transportation in light of Iowa’s early experience demonstrating that such waivers create barriers to care.

50. *Iowa Wellness Plan Special Terms and Conditions*, *supra* note 39, at 1; *Iowa Marketplace Choice Special Terms and Conditions*, *supra* note 39, at 1; *Healthy Pennsylvania Special Terms and Conditions*, *supra* note 30, at 1.

51. Richard Wallace et al., *Access to Health Care and Non-Emergency Medical Transportation: Two Missing Links*, TRANSP. RES. REC. no. 1924, 76 (2005); Samina T. Syed et al., *Traveling Towards Disease: Transportation Barriers to Health Care Access*, 38 J. COMMUNITY HEALTH 976 (2013).

52. Iowa Dep’t of Human Servs., *supra* note 40, at 2-3.

53. *Id.*

C. Work Requirements

A number of states have expressed interest in attaching work incentives, work requirements, and work referrals to Medicaid. Pennsylvania requested a Section 1115 waiver to impose a work requirement on adults aged 21-64 as a condition of Medicaid eligibility.⁵⁴ Those who failed to comply would be banned from Medicaid for nine months. After several months of unsuccessful negotiations with CMS, the state changed its request to instead seek a waiver to use a work incentive to “positively encourage” these adults to work by charging those who were neither working nor searching for work higher premiums and cost-sharing.⁵⁵ In the end, neither waiver was approved.

The Secretary has no Section 1115 authority to allow a work requirement or work incentive. Section 1115 only gives the Secretary authority to *waive* federal rules contained in Section 1902. It does not give the Secretary authority to allow states to impose new conditions on Medicaid eligibility beyond those already authorized by Section 1902.⁵⁶

Moreover, work requirements and incentives are not “likely to assist in promoting the objectives” of the Medicaid program, particularly post-ACA. Pennsylvania argued that studies have shown that people who work are healthier than those who do not, and thus, incentivizing people to work furthers the objectives of the Medicaid Act because it is likely to make them healthier.⁵⁷ However, these studies do not establish a causal relationship between work and health. It may be that people who are healthier are able to get and maintain jobs, rather than work causing people to be healthier.

More importantly, an unemployment exclusion directly contravenes the objectives of the Medicaid Act in the post-ACA world. The ACA transformed Medicaid for working age adults from a welfare program that sought to exclude

54. See *Healthy Pennsylvania 1115 Demonstration Application*, *supra* note 30. Under the “Encouraging Employment” prong of the proposed waiver, adults with disabilities would be exempt but others would have to prove they are working or searching for work to be eligible to obtain and keep Medicaid. *Id.*

55. See Letter from Tom Corbett, Governor, Commonwealth of Pa., to Kathleen Sebelius, Sec’y, U.S. Dep’t of Health & Human Servs. (Mar. 5, 2014), <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/pa/Healthy-Pennsylvania-Private-Coverage-Option-Demonstration/pa-healthy-submit-ltr-encourage-03052014.pdf>.

56. When states have tried to impose additional conditions of eligibility, like wellness checkups, school attendance, and refraining from substance abuse, courts have struck down such “extra” eligibility requirements as inconsistent with, and thus preempted by, federal law. See, e.g., *Camacho v. Texas Workforce Comm’n*, 408 F.3d 229 (5th Cir. 2005). See generally *Carleson v. Remillard*, 406 U.S. 598 (1972) (invalidating state law that denied Aid to Families with Dependent Children (AFDC) benefits to children whose fathers were serving in the military where no such bar existed in federal law governing eligibility).

57. *Healthy Pennsylvania 1115 Demonstration Application*, *supra* note 30.

the “undeserving poor”—i.e. childless adults who might be able to work—into part of a new social health insurance system that seeks to offer coverage to all Americans. Work requirements and incentives contradict the ACA’s new inclusive social insurance system. They seek to exclude or penalize those deemed unworthy because they are not working enough. They reinforce the old welfare stigma that paints all those not in the paid work force as lazy and shiftless, and seek to withhold support services so as not to make people “dependent” on government services.

The rationales used to justify work rules also ignore that there are many reasons that people are not in the paid work force, and thus need to be covered by the safety net building block of the ACA’s new social insurance system. Some people are out of the workforce because of a recent layoff, short-term illness, or the need to be a caretaker for a family member. Others, like those with severe mental illness, substance abuse, or physical health problems, need health insurance as a way to get the care that will help them become healthy enough to work.

D. Premiums and Cost-Sharing

Requests to impose higher cost-sharing and premiums are a recurring theme in states’ post-ACA Medicaid expansion waiver requests. Federal Medicaid law provides that Medicaid enrollees with incomes below 150% FPL cannot be charged premiums or deductibles, and provides that many groups and services are exempt from other cost-sharing requirements. Where co-pays are permissible, those with incomes under 100% FPL can only be charged “nominal” co-pays of no more than \$4 for most outpatient services, and \$75 for inpatient care. Those with incomes between 100–150% FPL can be charged up to 10% of the cost of both inpatient and outpatient services. Both groups can be charged up to \$8 for non-preferred drugs and non-emergency use of the emergency room. Federal rules also cap out-of-pocket costs from both premiums and cost-sharing at 5% of household income, calculated on a monthly or quarterly basis, at the state’s option.⁵⁸

Both Iowa and Pennsylvania requested waivers to increase co-pays for non-emergency use of the emergency room from \$8 to \$10, and to impose an annual, rather than monthly or quarterly, cap on cost-sharing.⁵⁹ Arizona has a pending waiver application that requests permission to impose a \$200 copay for non-emergency use of the emergency room for expansion adults with incomes between 100-133% FPL.⁶⁰

58. Premium and cost-sharing rules are codified at 42 U.S.C. §§ 1396o, 1396o-1 (2012). Regulations are at 42 C.F.R. 447.52–.54 (2014).

59. *Iowa Wellness Plan 1115 Waiver Application*, *supra* note 46, at 22; *Healthy Pennsylvania 1115 Demonstration Application*, *supra* note 30, at 56-57.

60. *Arizona Section 1115 Waiver Amendment Request*, *supra* note 40.

While the Secretary has not yet authorized any waivers to impose higher cost-sharing, she has granted Iowa, Michigan, and Pennsylvania waivers that allow them to impose premiums on ACA-eligible adults.⁶¹ These premiums are tied to wellness incentives—they are not charged during the first year of eligibility and are only imposed if the individual fails to complete prescribed “healthy behavior” incentives, like getting a wellness checkup. In Michigan, those who fail to pay premiums do not lose their Medicaid. In Iowa, those with incomes below 100% of the FPL cannot be terminated for failure to pay premiums, but those with incomes between 100-133% of the FPL can be, although they can file for a hardship waiver to avoid losing coverage.⁶² In Pennsylvania, those with incomes over 100% of the FPL can lose their Medicaid for failure to pay premiums, but, as in Iowa, they may reapply immediately to avoid any gap in coverage.⁶³

The problem with these premium waivers is that the Secretary has no Section 1115 authority to grant waivers for premiums or cost-sharing, because statutory protections against premiums and cost-sharing are found in Sections 1916 and 1916A of the Medicaid Act, not Section 1902.⁶⁴ These protections reside outside of the Secretary’s Section 1115 authority due to express Congressional action. In the early 1980s, the Secretary granted several Section 1115 waivers allowing states to impose higher cost-sharing than authorized by federal law. In response, Congress enacted new premium and cost-sharing protections, moving the substantive provisions out of Section 1902 into a new Section 1916 to put them outside the Secretary’s Section 1115 waiver authority.⁶⁵ In 2005, Congress enacted a second provision, Section 1916A, giving states increased options and flexibility to impose premiums and higher cost-sharing—but again chose to place the

61. See *Iowa Wellness Plan Special Terms and Conditions*, *supra* note 39, at 2; *Iowa Marketplace Choice Special Terms and Conditions*, *supra* note 39, at 1; *Healthy Michigan Special Terms and Conditions*, *supra* note 39, at 1; *Healthy Pennsylvania Special Terms and Conditions*, *supra* note 30, at 1.

62. Compare *Iowa Wellness Plan Special Terms and Conditions*, *supra* note 39, at 12, with *Iowa Marketplace Choice Special Terms and Conditions*, *supra* note 39, at 16-19. For more details on premiums in Iowa, see Dep’t of Human Servs., *Iowa Medicaid Healthy Behaviors Program and Premium Monitoring Protocols*, STATE OF IOWA 13-15, <http://dhs.iowa.gov/sites/default/files/FINALHealthyBehaviorsProgramProtocolYear1.pdf> (last visited Dec. 9, 2014).

63. *Healthy Pennsylvania Special Terms and Conditions*, *supra* note 30, at 10.

64. Section 1902(a)(14) specifies that “enrollment fees, premiums, or similar charges, and deductions, cost sharing, or similar charges, may be imposed only as provided in section 1916.” 42 U.S.C. § 1396a(a)(14) (2012).

65. See Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. No. 97-248, §133, 96 Stat. 324, 373-74 (adding 42 U.S.C. § 1396o). The House of Representatives’ Committee on Energy and Commerce noted: “[A] large number of States have sought waivers of current law relating to the imposition of cost sharing under the demonstration authority at §1115 of the Act. The Committee believes that this bill gives the Secretary sufficient flexibility in this regard to make further exercise of the Secretary’s demonstration authority unnecessary.” H.R. REP. NO. 97-757, at 6 (1982).

provisions outside the Secretary's Section 1115 authority.⁶⁶ Not only did Congress move the premium and cost-sharing protections to Section 1916 and 1916A, but it also created a special waiver for cost-sharing demonstrations with even more stringent requirements than Section 1115.⁶⁷ Section 1916 provides no mechanism for waivers of its premium protections.

Prior to the ACA, the Secretary approved HIFA waivers that allowed states to impose premiums and cost-sharing on childless adults and others in amounts above those authorized by Section 1916 and 1916A. These sections provide protections to "individuals described in" Section 1902(a)(10) and other sections of the Medicaid Act. Because childless adults and others not listed in Section 1902 were eligible only because of a waiver, they were not subject to the protections of Section 1916 and 1916A.⁶⁸ However, post-ACA, expansion adults are described in Section 1902(a)(10)(A)(i)(VII). They are entitled to the cost-sharing and premium protections in Section 1916 and 1916A. The Secretary therefore has no authority to grant waivers authorizing higher cost-sharing or premiums.

As a practical matter, it may be that premiums have become the price for Medicaid expansion. HHS may be trying to circumvent Section 1115 by allowing states to impose something that is called a premium, but that does not function like a traditional premium, which must be paid in advance, and for which non-payment results in loss of coverage. In Iowa, Michigan, and Pennsylvania, "premiums" are only imposed after a year of eligibility, and only on those who fail to comply with "healthy behavior" incentives. In Iowa and Pennsylvania, those earning under 100% FPL do not lose their Medicaid for non-payment. In Michigan, even those with incomes between 100-133% cannot lose coverage for failure to pay.

These charges might be better characterized as "premiums lite," because even though they are paid monthly (like premiums), they do not have to be paid in advance to obtain coverage and do not result in a loss of insurance if not paid. However, Sections 1916 and 1916A forbid not only premiums but also any "enrollment fee" or "similar charge." Moreover, both CMS and the states are calling these charges premiums, prompting a public perception that they are traditional premiums.

66. See Deficit Reduction Act of 2005, Pub. L. No. 109-171, § 6041(a), 120 Stat. 4, 81-84 (adding 42 U.S.C. § 1396o-1).

67. See 42 U.S.C. § 1396o-1 (2012). Pursuant to Section 1916A, any waiver for a "deduction, cost sharing or similar charge" may only be granted if the Secretary finds (1) it will test a unique and previously untested use of copayments; (2) it is limited to no more than two years; (3) the benefits to enrollees can reasonably be expected to equal or exceed the risks; (4) it is based on a reasonable hypothesis which the demonstration is designed to test in a methodologically sound manner, including the use of control groups of similar Medicaid enrollees; and (5) it is voluntary or provides for payments for preventable damage to the health of Medicaid enrollees resulting from involuntary participation.

68. See *Spry v. Thompson*, 487 F.3d 1272 (9th Cir. 2007).

In addition to the Section 1902 issues, premiums raise other Section 1115 concerns. State waiver applications assert that using premiums as an incentive to engage in healthy behaviors (or a punishment for failing to do so, depending on your viewpoint) is an innovative experiment that deserves to be tested via a waiver. However, decades of research show that premiums create substantial barriers to enrollment for low-income adults and children.⁶⁹ These healthy behavior premiums are likely to create similar obstacles to coverage, undermining the objectives of the Medicaid Act in a post-ACA world. Instead of reducing barriers to enrollment and streamlining the process, healthy behavior premiums add layers of complexity and bureaucracy that are likely to deter enrollment.

CONCLUSION

What price Medicaid expansion? The Secretary does not have much legal room to maneuver in response to state requests to reduce benefits, impose work rules, increase cost-sharing, and impose premiums. Section 1115(d)'s new notice and public comment requirements make the law of Section 1115 more transparent and more central to the waiver approval process. The ACA's changes to Medicaid, amending Section 1902 to add a new eligibility category of low-income adults and transforming it from a welfare program to a social insurance model, have created new substantive limits on the Secretary's Section 1115 authority.

Premiums have become the flash point for waiver requests because the Secretary has opened the door by acting contrary to law and beyond her legal authority. Section 1115 provides HHS with a clear legal limit: Section 1916 and 1916A prohibit premium charges on those earning below 150% FPL, and connecting the premiums to healthy behavior incentives does not change the nature of the charges. The Secretary has no Section 1115 authority to grant waivers that impose premiums as part of healthy behavior incentives or otherwise.

But now that the Secretary has stepped across this legal line, how far will HHS go in allowing states to impose premiums on Medicaid recipients? What leverage does HHS have as recalcitrant states demand larger premiums and more punitive sanctions for failure to pay?

Arizona recently filed a waiver amendment requesting permission to impose traditional premiums of 2% of income on newly eligible adults with incomes between 100-133%.⁷⁰ Indiana is requesting a waiver to impose traditional premiums on expansion adults, with payments required prior to coverage

69. See David Machledt & Jane Perkins, *Medicaid Premiums and Cost Sharing*, NAT'L HEALTH LAW PROGRAM (Mar. 26, 2014), <http://www.healthlaw.org/publications/browse-all-publications/Medicaid-Premiums-Cost-Sharing> (reviewing research literature on cost-sharing and premiums for low income populations).

70. *Arizona Section 1115 Waiver Amendment Request*, *supra* note 40, at 1.

beginning. For those with incomes between 100-133% FPL non-payment would result not just in loss of coverage, but disqualification from Medicaid for six months. Those with incomes below 100% FPL who fail to pay premiums would not lose coverage, but would have their benefits cut and their cost-sharing increased.⁷¹ Arkansas is also asking for an additional waiver to impose premiums on expansion adults with incomes over 50% FPL.⁷² Premiums would be \$5 per month for those earning below 100% FPL, and \$10-25 per month for those earning 100-133% FPL. The penalty for nonpayment for those earning 100-133% FPL would be a requirement that they pay higher Marketplace cost-sharing rather than being protected by Medicaid rules.

The law of Section 1115 is clear. Will the courts be asked to step in and review the Secretary's actions to determine if they are contrary to the law, or arbitrary and capricious? With the benefit of the more fulsome administrative record now required by Section 1115(d), courts are now in a more informed position to review the Secretary's Section 1115 decisions.

71. *HIP 2.0: Healthy Indiana Plan*, *supra* note 40, at 27-29.

72. Letter from Dawn Stehle, *supra* note 40.

Health Affairs Blog Post: Social Insurance Is Missing a Piece: Medicare, Medicaid, and Long-Term Care¹

Judy Feder*

Medicare and Medicaid are partners in providing health insurance protection to older people and people with disabilities. But when it comes to helping the very same people with long-term care—assistance with the basic tasks of daily life (like bathing, eating and toileting)—no such partnership exists. Instead, there is a gaping hole in protection that leaves people who need care, along with their families, at risk of catastrophe.

That hole is not an accident. From Medicare's inception, long-term care was explicitly excluded from its social insurance benefits, despite the close tie of many long-term care needs to medical conditions. With some short-lived lapses, Medicare rules have restricted the program's benefits to avoid financing long-term care, even as it has overpaid long-term care providers for medically-related "post-acute" services.² Ironically, Medicare has fueled growth in expenditures on long-term care providers without actually covering long-term care.

By contrast, since 1965 Medicaid has become the nation's long-term care safety net. But access to its services varies enormously from state to state and, in general, falls demonstrably short of providing needed care. Families, accordingly, bear enormous responsibility for caregiving at substantial physical and economic cost, and impoverishment remains a condition for receipt of its essential services. Rather than protecting people and their families from catastrophe, Medicaid provides support only after catastrophe strikes.³

1. The issues covered in this post will be more fully treated in Judith Feder, *The Missing Piece: Medicare, Medicaid and Long-Term Care*, in *MEDICARE AND MEDICAID AT 50: AMERICA'S ENTITLEMENT PROGRAMS IN THE AGE OF AFFORDABLE CARE* (Alan B. Cohen et al. eds., 2015).

* Founding Dean and Professor, Georgetown University McCourt School of Public Policy and Urban Institute Fellow.

This essay was originally published on Health Affairs Online, in conjunction with this symposium. See Judy Feder, *Social Insurance is Missing a Piece: Medicare, Medicaid, and Long-Term Care*, Health Aff. Blog, Nov. 6, 2014, <http://healthaffairs.org/blog/2014/11/06/social-insurance-is-missing-a-piece-medicare-medicaid-and-long-term-care/>, Copyright (c)2010 Health Affairs by Project HOPE - The People-to-People Health Foundation, Inc.

2. Judy Feder, *Bundle with Care – Rethinking Medicare Incentives for Post-Acute Care Services*, 369 NEW ENG. J. MED. 400, 400–01 (2013).

3. Judy Feder & Harriet L. Komisar, *The Importance of Federal Financing to the Nation's Long-Term Care Safety Net*, THE SCAN FOUNDATION (Feb. 2012), http://www.thescanfoundation.org/sites/thescanfoundation.org/files/Georgetown_Importance_Fede

Often forgotten is that the need for extensive, expensive long-term care is precisely the kind of catastrophic, unpredictable risk for which we typically rely on insurance to spread costs. These costs are obviously unpredictable for people under the age of 65,⁴ only two percent of whom need Long-Term Services and Support (LTSS). But they're also unpredictable after age 65.⁵ An estimated three in ten people aged 65 today are likely to die without needing any LTSS, while two in ten will likely need care for five or more years. Half of the people turning age 65 will have no private out-of-pocket spending for LTSS, while a small percentage are projected to spend hundreds of thousands of dollars.

If, as is often claimed, we want people to be financially "prepared" to manage this risk, we need a reliable insurance mechanism to which they can contribute. Private insurance does not provide that mechanism for long-term care. Fledgling efforts have never really gotten off the ground and—in recent years—several insurance companies have given up on trying to market a successful product.⁶

To effectively spread risk and reach the broadest possible population, public social insurance must be at the core of future policy. Private insurance can play a complementary role, but even its proponents recognize that building future policy around a private market will likely leave eight in ten Americans uninsured for long-term care.⁷

In an environment in which existing Medicare and Medicaid commitments are under attack, the necessity for greater public investment is hard—and unpleasant—for policymakers and even the voting public to accept. At the same time, it is hard to label as over-funded a system that underserves people in need, overburdens family caregivers and underpays workers. Support for better policy requires that the public and policymakers come to recognize the need for long-term care as the kind of unpredictable, catastrophic risk that individuals and families cannot be left to bear by themselves—that it is, a shared, not just a personal, responsibility.

As baby boomers become caregivers and then care recipients, political leaders may come to demand better access to affordable quality care on their

ral_Financing_LTC_2.pdf.

4. *Id.*

5. Peter Kemper et al., *Long-Term Care Over an Uncertain Future: What Can Current Retirees Expect?*, 42 INQUIRY 335, 336 (2005).

6. Kelly Greene, *Long-Term Care: What Now?*, WALL ST. J., Mar. 9, 2012, <http://online.wsj.com/news/articles/SB10001424052970203961204577269842991276650>.

7. Richard Frank et al., *Making Progress: Expanding Risk Protection for Long-Term Services and Supports through Private Long-Term Care Insurance*, THE SCAN FOUNDATION (Mar. 2013), http://thescanfoundation.org/sites/thescanfoundation.org/files/tsf_ltc-financing_private-options_frank_3-20-13.pdf.

behalf and gain support for the additional revenues required to finance it. If baby boomers mobilize, they will have allies in their children who will face the financial challenges of raising their own families, younger people with disabilities who regard support for independent living as a civil right and workers who have a right to expect decent pay in decent jobs. Together, we may yet fill the long-term care hole in the nation's social insurance.

Health Affairs Blog Post: 1332 Waivers and the Future of State Health Reform

Heather Howard & Galen Benshoof*

The Affordable Care Act (ACA) turbocharges state innovation through a number of provisions, such as the creation of the Center for Medicare & Medicaid Innovation, funding for states to establish customized insurance exchanges, and Medicaid initiatives such as health homes. Yet, another component of the law holds even more potential for broad reform. Buried in section 1332 of the law is a sparkplug for innovation called the Waiver for State Innovation program.¹

Also known as 2017 waivers or Wyden waivers, 1332s offer wide latitude to states for transforming their health insurance and health care delivery systems. According to the statute, states can request that the federal government waive basically every major coverage component of the ACA, including exchanges, benefit packages, and the individual and employer mandates. But the cornerstone of 1332 waivers is the financing. To fund their reforms, states can receive the aggregate amount of subsidies—including premium tax credits, cost-sharing reductions, and small business tax credits—that would have otherwise gone to the state’s residents. Depending on the size of the state, the annual payment from the federal government for alternate coverage reform could reach into the hundreds of millions or even billions of dollars.

A better name for this program might be Waivers for State Responsibility, because they do not exempt states from accomplishing the *aims* of the ACA, but give them the ability (and responsibility) to fulfill them in a different manner, while staying between certain guardrails. State reforms must ensure that coverage and cost-sharing protections are “at least as affordable,” cover a “comparable” number of people as statutory ACA implementation would have, and not increase the federal deficit.² So far, the Health and Human Services (HHS) and Treasury

* Heather Howard, Lecturer in Public Affairs, and Director, State Health Reform Assistance Network and State Health & Value Strategies programs, Woodrow Wilson School of Public and International Affairs, Princeton University; Galen Benshoof, Senior Program Manager, State Health Reform Assistance Network and State Health & Value Strategies programs, Woodrow Wilson School of Public and International Affairs, Princeton university.

This essay was originally published on Health Affairs Online, in conjunction with this symposium. See Heather Howard, *The Law of Medicare and Medicaid at 50*, HEALTH AFFAIRS BLOG (Nov. 4, 2014), <http://healthaffairs.org/blog/2014/12/05/section-1332-waivers-and-the-future-of-state-health-reform/>, Copyright (c)2010 Health Affairs by Project HOPE - The People-to-People Health Foundation, Inc.

1. Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, § 1332, 124 Stat. 120, 203 (codified as amended at 42 U.S.C. § 18052 (2012)).

2. *Id.*

Departments have issued guidance on the application process³ but little on the substance of 1332s. How HHS and Treasury define affordability and comparability, and which computational models they use to assess budget neutrality, will shape how states can use these waivers.

Nevertheless, some states are already pressing forward. In Hawaii, the legislature created a task force to explore how the state could better provide individual insurance coverage through a 1332 waiver, with fruitful discussions already underway. Minnesota has also expressed interest in a waiver to build on the state's Basic Health Plan to smooth out the coverage continuum for low-income residents and support the state's broader delivery system reforms. Vermont considered using 1332 waivers to implement single-payer,⁴ but recently put those plans on hold given funding and sustainability concerns.⁵

Nevertheless, some states are already pressing forward. In Hawaii, the legislature created a task force to explore how the state could better provide individual insurance coverage through a 1332 waiver,⁶ with fruitful discussions already underway.⁷ Minnesota has also expressed interest in a waiver to build on the state's Basic Health Plan to smooth out the coverage continuum for low-income residents and support the state's broader delivery system reforms.⁸ Vermont considered using 1332 waivers to implement single-payer,⁹ but recently put those plans on hold given funding and sustainability concerns.¹⁰

1332 waivers may also appeal to states with alternate Medicaid expansions, such as Arkansas and Iowa. So far, these so-called private option expansions, which enroll Medicaid-eligible individuals into private coverage, operate through Section 1115 waivers,¹¹ which predate the ACA. But states may find the budget

3. 45 C.F.R. § 155.1308 (2014).

4. Chris Kardish, *With Innovation Waivers, States Can Go Their Own Way on Obamacare*, GOVERNING (Sep. 2014), <http://www.governing.com/topics/health-human-services/gov-innovation-obamacare-waivers.html>.

5. The Official Website of the Governor of Vermont, *Gov. Shumlin Details Health Care Financing Report To Business and Consumer Advisory Councils*, VERMONT.GOV, <http://governor.vermont.gov/node/2163> (last accessed Dec. 24, 2014).

6. *HB2851 HD3 SD2 CDI*, HAW. STATE LEGISLATURE (July 2014), http://www.capitol.hawaii.gov/measure_indiv.aspx?billtype=HB&billnumber=2581&year=2014 (last visited Nov. 18, 2014).

7. *Meeting 2 Draft Minutes*, STATE INNOVATION WAIVER TASK FORCE (Oct. 2014), http://governor.hawaii.gov/wp-content/uploads/2014/12/Meeting-2_Meeting-Minutes-Approved.pdf.

8. John E. McDonough, *Wyden's Waiver: State Innovation on Steroids*, 39 J. HEALTH POL. POL'Y & L. 1,9 (2014).

9. Kardish, *supra* note 4.

10. VERMONT.GOV, *supra* note 5.

11. Robin Rudowitz, Samantha Artiga, & MaryBeth Musumeci, *The ACA and Recent Section 1115 Medicaid Demonstration Waivers*, KAISER FAM. FOUND. (Nov. 24, 2014),

neutrality requirements of 1115 waivers to be overly restrictive. The ACA calls for a streamlining of the waiver process, whereby states can ask for 1115 and 1332 waivers in one application. As John McDonough wrote earlier this year, this combined waiver process could give states much more flexibility.¹² For example, an 1115 waiver proposal that would not be independently budget-neutral could become acceptable in conjunction with a related 1332 waiver proposal. States will have greater ability to craft applications that meet the needs of their intended reforms.

But next year's Supreme Court term could have major ramifications on alternate expansion states and for 1332s more broadly. The innovation waivers offer states unparalleled flexibility in large part because they let them repurpose hundreds of millions of dollars in tax credits. In *King v. Burwell*, though, the Court will determine the availability of tax credits to residents of states that have not established exchanges.¹³ A ruling in favor of the plaintiffs would decimate the funding source for 1332-based reforms in those states.

Thus, such a ruling would hamstring red states in particular. Policymakers seeking conservative, market-oriented changes to ACA at the state level would be stymied even before their reforms get off the ground. Only states that have established their own exchanges would have the freedom and funding to undertake broad 1332-based reforms.

In the past, President Obama expressed support for legislation moving up 1332 waivers, which the statute authorizes to take effect January 1, 2017, in order to give states more time to innovate.¹⁴ That timing has not been changed, but 1332 waivers still give the administration the opportunity to engage more states in reforms during the president's final years in office, in spite of a hostile Congress. Anticipated regulations from HHS and Treasury will signal the extent of state flexibility. Before 2017, states will need to build in sufficient time for legislative and stakeholder engagement, as well as negotiations with the federal government over the contours of a waiver proposal. The handful of states with biennial sessions have even less time, as their legislatures would need to pass authorization next year, in 2015. For innovative state-level reform, the clock is ticking.

<http://kff.org/medicaid/issue-brief/the-aca-and-recent-section-1115-medicaid-demonstration-waivers/>.

12. McDonough, *supra* note 7.

13. *King v. Burwell*, No. 14–1158 (4th Cir. 2014), cert. granted (U.S. Nov. 7, 2014) (No. 14–114).

14. Kathleen Sebelius, *Empowering States to Innovate*, WHITE HOUSE BLOG (Feb. 28, 2011), <http://www.whitehouse.gov/blog/2011/02/28/empowering-states-innovate>.

Medicare, Medicaid, and Pharmaceuticals: The Price of Innovation

Daniel J. Kevles*

INTRODUCTION

Through much of the last half century, Medicare and Medicaid have not for the most part supported research intended to lead to new drugs. For their role in drug development, we need to look to infrastructure and incentives. The record of the National Institutes of Health (NIH) illustrates the potential of both for pharmaceutical innovation. The current budget of NIH, the big elephant in the zoo of the federal biomedical enterprise, is \$30 billion, but apart from a dozen small programs devoted to targeted drug development, most of these billions are not aimed directly at pharmaceutical innovation.¹

Yet the NIH investment in biomedicine has indirectly fueled drug development in the private sector to a huge degree. It has paid for the training of biomedical scientists and clinicians, many of whom went on to staff the drug industry, especially its laboratories. NIH-sponsored research has also generated basic knowledge and technologies and it has encouraged universities to spin out their potentially useful findings into the industry by allowing for the patenting and licensing of the findings.²

Like NIH, Medicare and Medicaid have helped fuel drug development indirectly by supporting selected experimental cancer treatments, medical

* Professor of History, Yale University; Senior Research Scholar in Law, Yale Law School.

This essay was originally published on Health Affairs Online, in conjunction with this symposium. See Daniel Kevles, *Medicare, Medicaid, and Pharmaceuticals: the Price of Innovation*, Health Aff. Blog, Nov. 20, 2014, <http://healthaffairs.org/blog/2014/11/20/medicare-medicaid-and-pharmaceuticals-the-price-of-innovation/>, Copyright (c)2010 Health Affairs by Project HOPE - The People-to-People Health Foundation, Inc.

* Professor of History, Yale University; Senior Research Scholar in Law, Yale Law School. This essay was originally published on Health Affairs Online, in conjunction with this symposium. See Daniel Kevles, *Medicare, Medicaid, and Pharmaceuticals: the Price of Innovation*, Health Aff. Blog, Nov. 20, 2014, <http://healthaffairs.org/blog/2014/11/20/medicare-medicaid-and-pharmaceuticals-the-price-of-innovation/>, Copyright (c)2010 Health Affairs by Project HOPE - The People-to-People Health Foundation, Inc.

1. OFFICE OF TECH. ASSESSMENT, OTA-H-522, PHARMACEUTICAL R&D: COSTS, RISKS AND REWARDS 234 (Feb. 1993), http://govinfo.library.unt.edu/ota/Ota_1/DATA/1993/9336.pdf [hereinafter PHARMACEUTICAL R&D].

2. *Id.*

education, and some clinical research and training.³ But investment in these activities has been small and their impact on drug development apparently very limited. In contrast to NIH, the Medicare and Medicaid stimulus to drug innovation has resided not in the production of new scientists or the patented uses of new knowledge but principally in markets and pricing.

The sizable expansion in the medical market that came with Medicare and Medicaid drew a number of companies into the generic drug business, a type of innovation, many of them from outside the pharmaceutical sector. The *Sunday Herald Tribune* noted in January 1966: “Whatever the future trend of generic-drug sales may be, many companies are jumping into the swim. Only last week Cott Corp., chiefly a dispenser of soft drinks, announced it was forming a unit to sell ‘a full line’ of generic drugs.”

Not long after the passage of Medicare and Medicaid, the U.S. Department of Health, Education, and Welfare called for the use of generic drugs “whenever it is practicable and economical.” Champions of generic substitutes predicted that the shift from brand names would save taxpayers some \$100 million annually.⁴ Generics now comprise some 80% of U.S. prescriptions.⁵

During the latter third of the twentieth century U.S. pharmaceutical companies devised hundreds of new drugs that won Food and Drug Administration (FDA) approval. One might think that the growth was stimulated in part by the increase in the size of the population over 65, which rose from about 18 million in 1965 to about 46 million in 2013, an increase of 28 million people, or 255%. The effective measures and drugs for overcoming infectious disease helped extend life spans and allowed for the expression in much higher frequencies of chronic disease. During this period, pharmaceutical companies stepped up their investments in research and development (R&D)—between 1975 and 1990, in constant dollars from \$2 billion to \$6.6 billion.

But neither the general increase in the size of the senior population nor Medicare and Medicaid was responsible for this output, or within it for new drugs for the treatment of diseases that occur with greater frequency among older or impoverished Americans.⁶

3. *Id.* See also *Medicare and the American Social Contract: Final Report of the Study Panel on Medicare’s Larger Social Role: Restructuring Medicare for the Long Term Project*, NAT’L ACAD. OF SOC. INS., 16 (1999), http://www.nasi.org/usr_doc/med_report_soc_contract.pdf.

4. JEREMY A. GREENE, *GENERIC: THE UNBRANDING OF MODERN MEDICINE* 67, 295 n.8 (2014).

5. John Lechleiter, *Beyond the Fiscal Cliff, Pharmaceutical Innovation is the Key to Long-term Fiscal Health*, FORBES (Dec. 11, 2012), <http://www.forbes.com/sites/johnlechleiter/2012/12/11/beyond-the-fiscal-cliff-pharmaceutical-innovation-is-the-key-to-long-term-fiscal-health>.

6. PHARMACEUTICAL R&D, *supra* note 1, at 30, 43; Daron Acemoglu et al., *Did Medicare Induce Pharmaceutical Innovation?*, 96 AM. ECON. REV. 103, 103–07 (2006).

I. WHY THE WEAK ROLE OF MEDICARE AND MEDICAID IN PHARMACEUTICAL INNOVATION?

It is difficult to explain a negative and the data is sketchy, but enough is available to suggest that a plausible answer lies in Medicare and Medicaid policies for prescription drugs. In the case of Medicare, the reason seems to have been a restricted market; in the case of Medicaid, it was seemingly limitations on pricing. Federal support of prescription drugs for Medicare patients was for the most part confined to drugs that were incidental to in-patient medical services provided in hospitals and approved clinics.⁷ Otherwise, resources for prescription drug payments were limited. In 1987, family funds paid the costs of 56% of pharmaceuticals; private insurance, which presumably involved negotiated prices and by and large did not likely cover seniors, only 27%.⁸

As for Medicaid, federal policies established between 1990 and 1992 compelled drug manufacturers to negotiate rebates with HHS for drugs given to state Medicaid patients by safety net providers and sell drugs to comparable outpatient clinics at discounted prices.⁹

The development and FDA approval costs for a new drug run upwards of a billion dollars. Thus, given the government's Medicare and Medicaid market and pricing policies, we should not be surprised that drug companies did not focus their efforts at innovation on drugs targeting the afflictions of the elderly or the poor—who suffer, for example, high rates of mental health problems such as bipolar disorder.¹⁰ Manufacturers evidently counted the prospective payoffs inadequate to warrant the investment; they looked for their principal profits to the general and open pharmaceutical market, where they could charge whatever prices the market or private insurance companies would bear for products under patent.

II. A GAME CHANGER: THE MEDICARE DRUG BENEFIT

Circumstances changed dramatically with the passage of the Prescription Drug Act, or PDA, in December 2003.¹¹ The act was a response to the increasing dependence of senior outpatients on a long list of costly medications, including those for heart disease, cancer, osteoporosis, hypertension, arthritis, diabetes,

7. Margaret Blume-Kohout & Neeraj Sood, *The Impact of Medicare Part D on Pharmaceutical R&D*, (Nat'l Bureau of Econ. Research, Working Paper No. 13857, 2008).

8. PHARMACEUTICAL R&D, *supra* note 1, at 28.

9. 340B DRUG PRICING PROGRAM, <http://www.hrsa.gov/opa> (last visited Dec. 14, 2014).

10. Milt Freudenheim, *A Windfall from Shifts to Medicare*, N.Y. TIMES, July 18, 2006, <http://www.nytimes.com/2006/07/18/business/18place.html>.

11. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat 2066.

gastrointestinal disease, and Alzheimer's disease.¹² It provided them assistance in paying for prescription drugs through a combination of tax breaks and subsidies. It went into effect in 2006 through Medicare Part D.

The PDA, which passed by a hair-thin margin, had been highly contested, not least over the key issue of pricing. The pharmaceutical industry lobbied hard against any arrangements that, like those governing drug prices under Medicaid after 1990/1992, would subject prescriptions to prices negotiated by Washington. The industry won its battle.¹³ The PDA prohibited the federal government from negotiating discounts with drug companies for Medicare and Medicaid patients and from establishing a formulary—that is, a list of acceptable prescription drugs for particular conditions. Both functions were left to private providers such as insurance companies and HMOs.

The PDA also turned 6.5 million Medicaid patients who were eligible for Medicare into so-called “dual eligibles,” people whose medical services remained in Medicaid but who, for their prescription drugs, were moved out of the Medicaid class of regulated drug prices into Medicare Part D. The migration significantly enlarged the market for drugs sold at uncontrolled prices.¹⁴

In response to the PDA's enormous expansion in the prescription drug market for seniors and the free-for-all pricing it allowed, the pharmaceutical industry increased its research-and-development expenditures sharply beginning in 2004. And the increase went heavily for drugs used by Medicare beneficiaries.¹⁵

All the while, the PDA produced a windfall for the drug industry. In 2006, when the PDA went into effect, Medicare Part D enrolled about 22.5 million people, 29% of them the dual-eligibles (total enrollment reached 30 million by 2013). The price of brand-name drugs had climbed about three times faster than the rate of inflation and pharmaceutical revenues had skyrocketed.¹⁶

III. INNOVATION—BUT AT THE RIGHT COST AND FOR THE RIGHT PURPOSES?

The pharmaceutical industry defended its high prices, revenues, and profits by insisting that all were necessary for its investment in the research and development that would produce new prescription drugs. The industry deployed multiple arguments: such drugs saved considerable money in other health-care costs and improved quality of life. A vibrant and innovative drug industry also helped grow

12. Blume-Kohout & Sood, *supra* note 7, at 16.

13. Morgan Cook, *Medicare Part D: Profit Trumps Public Interest*, ORANGE COUNTY REG., Dec. 30, 2013, <http://www.ocregister.com/articles/beneficiaries-594505-drug-drugs.html>.

14. Another 45 million people remained eligible for prescription drugs in rebate-covered state Medicaid programs. Freudenheim, *supra* note 10.

15. Blume-Kohout & Sood, *supra* note 7, at 12, 15-16.

16. *Id.* See also Cook, *supra* note 13; Freudenheim, *supra* note 10.

the American economy and make the nation more globally competitive. According to a study by the Congressional Budget Office, imposing price controls on Medicare Part D would reduce pharmaceutical investment in R&D, risking costs to the economy and to the availability of new, life-saving drugs.¹⁷

But from a public-interest point of view, the price of innovation has been remarkably high, perhaps indefensibly so. The Department of Veterans Affairs is legally permitted to negotiate drug prices and establish a formulary for allowable medications. It pays on average between 56% and 63% of the prices charged for drugs under Medicare Part D.¹⁸

Costs aside, much of the pharmaceutical industry's increased investment in R&D appears to have been concentrated in medical areas where effective medications already existed. Companies aimed to gain market share by producing me-too drugs rather than by seeking new drugs with consequential benefits for the treatment of disease.¹⁹

In 2013, nineteen Senators introduced a measure—the Medicare Drug Savings Act—that would curb the price increases by at least returning the dual-eligibles to the Medicaid rebate arrangement, but it has stalled in the face of assiduous lobbying by the drug industry. Senator Jay Rockefeller of West Virginia, one of the cosponsors, noted that even with the restoration of rebates, the economic and policy environment for drug innovation would remain highly encouraging. He says that the drug industry could well afford R&D, noting it spends far more on advertising and marketing than it does on drug innovation.²⁰

Drug-cost savings would of course be all to the good, helping to curb the mounting fiscal threat to Medicare and Medicaid, but forcing pharmaceutical companies to pay their fair share of the health system would not address the question of how to encourage the development of new, medically consequential drugs. Dealing with that conundrum might well require rethinking our approach to drug innovation. Guidance might be found in how the military obtains the technologies it needs. It does not rely solely on the initiatives of defense firms. It provides incentives in the form of grants and contracts targeted at the innovation

17. Lechleiter, *supra* note 5.

18. Austin Frakt et al., *Should Medicare Adopt the Veterans Health Administration Formulary?*, 21 HEALTH ECON. 485, 487 (2012).

19. David Dranove et al., *Pharmaceutical Profits and the Social Value of Innovation* (Nat'l Bureau of Econ. Research, Working Paper No. 20212, 2012).

20. Press Release, Jay Rockefeller for West Virginia, Rockefeller and 18 Other Senators Introduce Legislation to Protect Seniors & Reduce Deficit By \$141.2 Billion (Apr. 16, 2003), <http://www.rockefeller.senate.gov/public/index.cfm/2013/4/rockefeller-and-18-other-senators-introduce-legislation-to-protect-seniors-reduce-deficit-by-141-2-billion>; WV-Sen: Join Jay Rockefeller's (D) Call to Stop Medicare Price Gouging, DAILY KOS, July 19, 2013, <http://www.dailykos.com/story/2013/07/19/1224995/-WV-Sen-Join-Jay-Rockefeller-s-D-Call-To-Stop-Medicare-Price-Gouging#>.

of specific weapons systems and their components. The United States might consider a similar strategy in the ongoing war against disease, introducing public-interest considerations into the dominantly private, market-oriented system of drug innovation that now prevails.

Health Affairs Blog Post: Challenges for People with Disabilities within the Health Care Safety Net

Michael R. Ulrich, JD, MPH*

Medicare and Medicaid were passed to serve as safety nets for the country's most vulnerable populations, a point that has been reemphasized by the expansion of the populations they serve, especially with regards to Medicaid. Yet, even after 50 years, the disabled population continues to be one whose health care needs are not being met. This community is all too frequently left to suffer health disparities due to cultural incompetency, stigma and misunderstanding, and an inability to create policy changes that covers the population as a whole and their acute and long-term needs.

Nearly 57 million Americans had disabilities in 2010,¹ and this number is likely to grow due to an aging population, advances in technology, and negative health trends such as obesity. While the diversity of the group's demographics and health issues can make it difficult to define "disabled," how it is defined in policy can have significant implications for benefits, as well as stigma. For example, the Social Security Administration narrowly defines disability as "the inability to engage in substantial gainful activity due to a medically determinable physical or mental impairment,"² which disregards those who work in spite of their disabilities. Meanwhile, the Americans with Disabilities Act (ADA) defines disability as "a physical or mental impairment that substantially limits one or more major life activities,"³ focusing on the condition rather than what a person can and cannot do.

The disparities for the disabled community are abundant: in comparison to nondisabled Americans, they are more likely to be unemployed, impoverished, have less than a high school education,⁴ and have higher levels of risk factors such as obesity,⁵ smoking,⁶ and being physically inactive.⁷ Moreover, disability

*Research Scholar in Law and Senior Fellow in Health Law, Yale Law School.

This essay was originally published on Health Affairs Online, in conjunction with this symposium. See Michael Ulrich, *Challenges for People with Disabilities Within the Health Care Safety Net*, HEALTH AFF. BLOG, Nov. 18, 2014, <http://healthaffairs.org/blog/2014/11/18/challenges-for-people-with-disabilities-within-the-health-care-safety-net/>.

1. Matthew W. Brault, *Americans with Disabilities: 2010*, U.S. CENSUS BUREAU CURRENT POPULATION REPORTS 4 (2012), <http://www.census.gov/prod/2012pubs/p70-131.pdf>.

2. SOC. SEC. ADMIN., DISABILITY EVALUATION UNDER SOCIAL SECURITY, <http://www.ssa.gov/disability/professionals/bluebook/general-info.htm> (last visited Dec. 10, 2014).

3. Americans with Disabilities Act of 1990 § 3, 42 U.S.C. § 12102 (2012).

4. Brault, *supra* note 1, at 22.

5. *Obesity and People with Disabilities: A Tip Sheet for Public Health Professionals*, CTRS.

prevalence is higher in minority groups such as blacks, American Indians, and Alaska Natives.⁸ However, their vulnerability does not stem simply from having a disability, but more importantly, like other vulnerable populations, they are not well integrated into the health care system because of certain characteristics.⁹ It is this inability to integrate the disabled into the health care system, and in turn society at large, that must be a focus of policymaking, including the Medicare and Medicaid programs, moving forward.

The Affordable Care Act (ACA) has taken steps that should help, such as expanding coverage, but disparities arise from health status and access to care as well. To illustrate, one study looked at disparities between the disabled and nondisabled within Medicare to minimize the effect of coverage. Nearly 50% of the disabled population reported putting off or not seeking care due to cost concerns, and they were more likely to have negative consequences as compared to nondisabled Medicare beneficiaries who delayed care due to costs.¹⁰ Furthermore, disabled beneficiaries were three times as likely to have difficulties finding a doctor who accepted Medicare than nondisabled, and for the lucky beneficiaries that did, 15% had difficulties finding doctors who actually understood their disability or how to treat it.¹¹ The difficulty in finding access to adequate care is exacerbated by other obstacles arising from inadequate equipment and facilities,¹² and insufficient communication,¹³ which is critical to patients' rights of informed consent and bodily integrity.

The ACA contains provisions aimed at tackling some of these barriers to care, including standards for accessible medical diagnostic equipment, and developing trainings to provide culturally competent care to the disabled. Proper

FOR DISEASE CONTROL & PREVENTION, http://www.cdc.gov/ncbddd/documents/obesity-tip-sheet-_phpa_1.pdf.

6. *Cigarette Smoking and People with Disabilities: A Tip Sheet for Public Health Professionals*, CTRS. FOR DISEASE CONTROL & PREVENTION, http://www.cdc.gov/ncbddd/documents/smoking-tip-sheet-_phpa_1.pdf.

7. *Physical Inactivity and People with Disabilities: A Tip Sheet for Public Health Professionals*, CTRS. FOR DISEASE CONTROL & PREVENTION, http://www.cdc.gov/ncbddd/documents/physical-inactivity-tip-sheet-_phpa_1.pdf.

8. Lisa I. Iezzoni, *Eliminating Health and Health Care Disparities Among the Growing Population of People with Disabilities*, 30 HEALTH AFF. 1947, 1947–48 (2010).

9. *Vulnerable Populations*, URBAN INST., http://www.urban.org/health_policy/vulnerable_populations (last visited Dec. 7, 2014).

10. Juliette Cubanski & Patricia Neuman, *Medicare Doesn't Work as Well for Younger, Disabled Beneficiaries as it Does for Older Enrollees*, 29 HEALTH AFF. 1725, 1729 (2010).

11. Kaiser Family Foundation, *Medicare and Nonelderly People with Disabilities: Fact Sheet*, <http://www.kff.org/medicare/upload/8100.pdf> [hereinafter *Medicare and Nonelderly*].

12. *Disability Healthcare Access Brief*, DISABILITY RIGHTS EDUC. & DEF. FUND (2007), http://dredf.org/healthcare/Access_Brief.pdf.

13. Iezzoni, *supra* note 8, at 1948.

training is critical as many of the health disparities that the disabled suffer are due to the fact that the health care system is not designed to care for this population effectively. The disabled suffer from others' belief that they lack the ability to achieve high-functioning lifestyles, which is illustrated by the fact that health care staff rarely, if ever, emphasizes health promotion.¹⁴

This is not to insinuate that the issue of coverage, or coverage of the needs of the disabled, has been rectified. A combination of states' right to implement eligibility criteria, Medicaid being a target for budget cuts, and the disabled costing more than any other group,¹⁵ has left many in the disabled community without much needed coverage. The ACA originally expanded Medicaid to anyone at 133% of the federal poverty line (FPL), but the Supreme Court made this optional. With 23 states still not moving forward on expansion,¹⁶ there is a need for advocacy and persuasion to try to limit the force of partisan politics. While other safety net features are available, Medicaid can offer assistance to the disabled through long-term care as well as standard necessities. Medicare on the other hand requires nonelderly disabled individuals receive Social Security Disability Insurance (SSDI) benefits for at least 24 months, where they must be unable to engage in gainful activity for at least 12 months to qualify for SSDI, and long-term institutional or community-based services are uncovered.¹⁷

This perverse incentive to avoid work, or punish those that do work, is an issue the disabled community faces all too often. Expanding employment options for the disabled is important not only monetarily, but also to enhance their ability to live independently and interact with their social environment. Too often they are cut-off from large parts of society, which undoubtedly lead to their higher rates of depression and mental illnesses.¹⁸ The Community Living Assistance Services and Supports (CLASS) Act aimed to help alleviate some of the concerns over long-term care,¹⁹ but it was ultimately deemed unsustainable.²⁰ Nevertheless, with the disabled population growing, leaving their long-term medical needs to linger until they become more costly is not an economically efficient solution.

14. *Id.* at 1950.

15. *Medicaid Moving Forward*, KAISER FAM. FOUND. (2014), <http://kff.org/medicaid/fact-sheet/the-medicaid-program-at-a-glance-update>.

16. *Status of State Action of the Medicaid Expansion Decision*, KAISER FAM. FOUND. <http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act> (last visited Dec. 10, 2014).

17. *Medicare and Nonelderly*, *supra* note 11.

18. Cubanski & Neuman, *supra* note 10, at 1727.

19. Kaiser Family Foundation, *Health Care Reform and the CLASS Act*, Focus on Health Reform (2010), <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8069.pdf>.

20. Lexie Verdon, *HHS Halts CLASS Act*, KAISER HEALTH NEWS, Oct. 14, 2011, *available at* <http://kaiserhealthnews.org/news/hhs-halts-class-act/>.

The safety net that Medicare and Medicaid aimed to create fifty years ago is still filled with far too many gaps when it comes to the disabled. The ACA has taken some important steps, but more needs to be done to ensure the health care system, including Medicare and Medicaid, reduces its barriers to health. Coupling policy changes with better information and training should also contribute to a much needed normative change, so that we no longer perceive those with disabilities as having something wrong with them or unable to function “normally.” It is essential that as a country we recognize that health disparities for the disabled are associated less with their disability and more with our inability to structure the societal and health care framework to allow them to function optimally.