Medicare’s Future: Letting the Affordable Care Act Work, While Learning From the Past

By Alfred J. Chiplin Jr., Esq. and Bethany J. Lilly, Esq.

I. The Historical Debate Over Public Health Insurance in the United States... 28
   A. The Pre-Medicare Debate................................................................. 29
   B. The Current Medicare System...................................................... 38

II. Current Medicare Solvency Concerns ............................................. 41

III. The Affordable Care Act and Medicare ........................................ 45
   A. Medicare Shared Savings Program (MSSP) and Accountable Care
      Organizations (ACOs)........................................................................ 47
   B. ACOs and Quality Measures Reporting Under the ACA............... 48
   C. The Independent Payment Advisory Board (IPAB) and the ACA.... 49
      1. IPAB’s Duties .................................................................................. 50
      2. Congressional Control Over IPAB ................................................. 52
      3. What Might IPAB Do? ................................................................. 53
      4. Concerns About IPAB Accountability............................................ 53
   D. The ACA and Quality Review Mechanisms.................................... 53
      1. Incentive Payments to Hospitals .................................................. 54
      2. Limiting Payment for Hospital-Acquired Conditions ................. 55
      3. A National Strategy to Improve Health Care Quality ................ 56
      4. Interagency Work Group on Health Care Quality ....................... 56
      5. Quality Measure Development...................................................... 56
      6. Health Information Technology .................................................... 57
      7. Data Collection to Reduce Health Care Disparities .................... 58
      8. The Center for Medicare and Medicaid Innovation .................... 59
      9. Preventive Services ...................................................................... 60

IV. The Next Several Years .................................................................. 62

Alfred J. Chiplin Jr., Esq., is a senior policy attorney and managing attorney in the Washington, D.C., office of the Center for Medicare Advocacy, Inc. Mr. Chiplin focuses on Medicare coverage and appeals, issues of discharge planning, and quality of care across health care settings. His experience includes administrative and legislative advocacy, litigation and litigation support, writing, program planning and development, and workshop presentations. Mr. Chiplin is a Fellow in the National Academy of Elder Law Attorneys (NAELA), a winner of the NAELA Powley Award and its John J. Reagan Writing award, and a former NAELA board member. In addition, Mr. Chiplin is a member of the National Academy of Social Insurance (NASI), having served on its Medicare and Markets Study Panel. He is also a board member of the American Occupational Therapy Foundation. Mr. Chiplin is a former chairperson of the Public Advisory Group, of the Joint Commission (that certifies the quality of health care organizations). He holds a law degree from the George Washington University School of Law and a Master of Divinity degree from Harvard University. He also holds a Clinical Pastoral Education (CPE) certificate from University Hospital, University of Mississippi Medical School. With Judith A. Stein, Esq., he is Editor-in-Chief of the Medicare Handbook, now in its 12th edition, Wolters Kluwer Law and Business. He is a member of the Washington, D.C. Bar and the Mississippi State Bar.

Bethany Lilly was a legal fellow in fall 2012 at the Washington, D.C., office of the Center for Medicare Advocacy, Inc. She holds a law degree from Duke University School of Law and is a member of the Maryland State Bar.
Mrs. “P”— knowing that you are a health policy attorney — has asked your guidance on how to evaluate issues discussed at a recent seminar about the future of the Medicare program. She said that there were conflicting discussions about the stability of the Medicare program: whether it would be around much longer, whether rising costs could be contained, and whether rising costs would negatively impact the sustainability of the Medicare trust funds. In addition, the seminar ended in a heated discussion about whether certain Affordable Care Act (ACA) provisions on paying for quality, reducing hospital readmissions, and providing for alternative delivery systems are likely to make the Medicare program more sustainable by saving costs by ensuring that beneficiaries get the Medicare-covered services they need, including preventive services.

Medicare provides a foundation for the health and wellness of Americans who are 65 or older and for younger persons who qualify for Medicare on the basis of disability. The program currently covers a portion of health care costs for over 47 million individuals throughout the United States. While Medicare is a critical component of helping beneficiaries pay for necessary services, in many instances, beneficiaries are required to share in those costs through deductibles and copayments. In recent years, several fac-

---

1 Social Security Act § 1837(f), 42 U.S.C. 1395p(f).
4 Id. at 5–6. We are fortunate, nonetheless, that the Medicare program continues to add to its array of preventive services, many of which are offered without copayments. See e.g. Balanced Budget Act of 1997 (hereinafter BBA), Pub. L. No. 105-33, §§ 4101(a)–(b), 4103(a), 4104(a), 4105(a), 4106(a), 111 Stat. 251 (1997); Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), Pub. L. No. 106-554, § 4107, 114 Stat. 2764 (2000), amending §§ 1834, 1861, of the Social Security Act; Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), Pub. L. No. 108-173, § 612, 117 Stat. 2066 (2003), amending §§ 1861(s)(2), 1862(a)(1), and adding § 1861(xx)(1) to the Social Security Act, 42 U.S.C. §§ 1395x(s)(2), 1395l(a)(1), 1395w-4(j); Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), Pub. L. No. 110-275, § 101, 122 Stat. 2494 (2008). The Secretary has the authority to add preventive services that he or she determines are reasonable and necessary for the prevention or early detection of an illness or a disability, where such preventive services are recommended with a grade of A or B by the U.S. Preventive Services Task Force and appropriate for individuals entitled to benefits under Medicare Part A or enrolled under Part B. In the case of additional preventive services, the Medicare agency will pay 80 percent of the lesser of the actual charge for the service or the amount determined under a fee schedule established by the Secretary; see Patient Protection and Affordable Care Act (hereinafter ACA), Pub. L. No. 111-148, § 4103, 124 Stat. 119 (2010), amending 42 U.S.C. § 1395x(s)(2) of the Social Security Act. The constitutionality of the ACA was...
tors, including an economic downturn and resulting legislative efforts at deficit reduction, have shifted a larger portion of health care costs to beneficiaries. Moreover, many deficit reduction proposals include changes to Medicare cost sharing for beneficiaries. Increases in cost sharing and out-of-pocket spending place a heavy burden on beneficiaries and can have a negative impact on their health and daily living, chiefly through physical and emotional stress and through foregoing necessary health care services.

The Medicare program faces many challenges as it moves into its second half-century of service. It is buffeted by the cost of treating an expanded population of older beneficiaries, particularly as the “baby boom” cohort moves into retirement and begins to put greater demands on the system. In addition, the costs of providing care continue to rise at a rate that many find unsustainable. Cost issues are compounded by concerns about variations in quality of care. These challenges collide with major philosophical


9 MedPAC, A Data Book: Health Care Spending and the Medicare Program 8 (June 2012), http://www.medpac.gov/documents/Jun12DataBookEntireReport.pdf (“Beginning in 2010, the aging of the baby-boom generation, an expected increase in life expectancy, and the Medicare drug benefit are likely to increase the proportion of economic resources devoted to Medicare”). The baby-boom cohort is generally thought to be those people born between 1946 and 1964, and the last of the baby-boom cohort will become eligible for Medicare in 2029, bringing the total number of Medicare beneficiaries to approximately 80.6 million. MedPAC projects this as an increase of 30 million over 20 years. Medicare enrollment will continue to grow after 2029, but at a lesser degree, increasing by only 10 million over 20 years (from 2030 to 2050). See also Cong. Budget Off. (CBO), The 2012 Long-Term Budget Outlook 1 (June 2012) (“The aging of the baby generation portends a significant and sustained increase in the share of the population receiving benefits from Social Security and Medicare”); John Donvan and Maggy Patrick, Baby Boomers Expected to Drain Medicare, ABC News (Dec. 31, 2010), http://abcnews.go.com/US/baby-boomers-projected-drain-medicare/story?id=12507968#UWujMXR4rU.


11 Variations in quality are a function of many things — limitations in access that are a function of where one lives and the services available in various communities, norms and standards of treatment, health disparities that are tinged by race and ethnicity, and the biases of various health care professionals toward particular persons, groups, races, and ethnicities. For a broad discussion of variations and their impact on rising health care costs, see IOM, supra n. 10.
differences within our legislative and policy making bodies, leading to conflicting notions about how to respond to an expanding demand for services, how to establish sensible cost-containment strategies, and how to provide Medicare services that are comprehensive and of good quality.

This article will provide an overview of the policy debate that led to the creation of the Medicare program. It will also identify key cost and quality problems facing the program and review solutions included in the recently passed Affordable Care Act (ACA) that might provide solutions.\(^\text{12}\)

I. THE HISTORICAL DEBATE OVER PUBLIC HEALTH INSURANCE IN THE UNITED STATES

Over the past century, paying for health care has been a major concern for American families.\(^\text{13}\) Prior to the enactment of America’s “Great Society” legislation of 1965, including the Medicare program, families had few options for paying for necessary health care for their old and sick family members.\(^\text{14}\) Then, and now, health care is prohibitively expensive, with even a hospitalization of a short duration costing thousands of dollars\(^\text{15}\).

Much of the current structure of the Medicare program stems from a long and public debate about the creation of a social insurance system to address the problems of cost and quality.\(^\text{16}\) The on-going debate continues to raise questions about the necessary elements of a comprehensive program, including health care financing and accessing the quality of necessary services.\(^\text{17}\)


\(^{15}\) Id. (discussing health care costs and their impact on American households at various points in history). For data on the current situation, see Melissa B. Jacoby et al., Rethinking the Debate over Health Care Financing: Evidence from the Bankruptcy Courts, 76 N.Y. L. Rev. 375–418 (2001).


\(^{17}\) Id.
A. The Pre-Medicare Debate

In his definitive survey of the history of medicine in the United States, Paul Starr\(^{18}\) identified four major cost-related factors for the development of the health care system in American life: loss of personal income, high medical costs, indirect costs of illness to society, and the social costs of medical care.\(^{19}\) As discussed below, the costs of health care are many, including financial and social costs. These historic concerns reach into our current national dialog and influence the American debate over what should be done to provide necessary, high-quality services in ways that are cost-efficient. In the 1910s and 20s, medical science had developed to a point where the first two factors mentioned above were becoming determinative — medical procedures were becoming more advanced and expensive.\(^{20}\) Just as science had developed, the world economy had also shifted, and the new industrial society meant that medical procedures would need to be paid for with cash, rather than a barter for goods or services.\(^{21}\) Individuals and families were suddenly faced with a much higher risk of losing everything if they became sick. This increased risk lead many European countries to adopt various forms of government-run health insurance in the 1920s, but the United States did not follow suit.\(^{22}\)

While the United States did not adopt a government-run health insurance system, there was vigorous debate whether to adopt some form of government-run health insurance. This debate began in 1906, with the founding of the American Association of Labor Legislation (AALL), a progressive group that began pushing for state-run public insurance in the late 1910s.\(^{23}\) The proposed government-run insurance covered hospital care and maternity benefits, with program costs shared by the employer (two-fifths), the employee (two-fifths), and the state (one-fifth).\(^{24}\) The intent behind the bill was to address an individual’s lost wages through sickness or injury.\(^{25}\) The bill was considered by New York and California.\(^{26}\) This early effort for public health insurance was defeated.\(^{27}\)

---

\(^{18}\) Professor Starr is a health care historian and Professor of Sociology and Public Affairs and Stuart Professor of Communications and Public Affairs at Princeton University, https://www.princeton.edu/~starr.

\(^{19}\) Starr, supra n. 14, at 236.

\(^{20}\) Id. at 258.

\(^{21}\) Id.

\(^{22}\) Id. at 237–240. Germany was the first country to adopt compulsory health insurance in 1883. Austria followed suit in 1888 and Hungary in 1891. These programs only applied to workers initially, but as the programs were broadly adopted across Europe (Norway in 1909, Serbia in 1910, Britain in 1911, and the Netherlands in 1913), they also were adopted by society groups of artisans. The fact that the United States did not adopt such a program is surprising, given the almost universal European adoption. See also Social Health Insurance Systems in Western Europe (Saltman et al. eds., Open U. Press 2004), http://www.euro.who.int/__data/assets/pdf_file/0010/98443/E84968.pdf.


\(^{24}\) Starr, supra n. 14, at 244.

\(^{25}\) Id.

\(^{26}\) Starr, supra n. 14, at 247–253.

\(^{27}\) Id. at 244.
Many have attributed this defeat to the medical profession, but to do so is a simplification of the broader debate about government-run health insurance. The American Medical Association (AMA) was initially a supporter of the bills proposed by the AALL and even sent a three-person committee of AMA members to work with the AALL on the health insurance program. The labor unions, in contrast, strongly opposed a national health insurance system, arguing that such a program would amount to government interference in negotiations between unions and employers. This opposition was joined in 1912 by serious opposition from the state AMA chapters, which argued strongly against a public program. Another factor in the defeat of the bills was the outbreak of World War I in 1917, which resulted in extreme anti-German sentiments. Those sentiments enabled opponents, including many physicians, to tie the proposed health insurance programs to similar kinds of health insurance in Germany, issuing brochures describing health insurance as “a dangerous device, invented in Germany.” This demonization of health insurance was, in many ways, an early example of the “socialized medicine” propaganda that is still used today.

This initial defeat did not stop the advocates of a national health insurance system. Following many complaints about the increased costs of medical care in the 1920s, the idea of government-run health insurance was revisited in the 1930s. The AALL, while no longer directly involved in the development of health insurance policy, pushed private philanthropy to sponsor the Committee on the Costs of Medical Care (CCMC), the first national survey of medical costs in the United States. The CCMC worked from 1927 to 1932 and produced a set of recommendations. It did not recommend a national health insurance program but did recommend that the government push for the creation of a private health insurance system. The internal discussions of the CCMC were extremely heated. The AMA and the physician members of the CCMC strongly disagreed with the idea of any kind of insurance and several committee members who favored a national public health insurance program issued a dissent to the recommendations.

---

29 Starr, supra n. 14, at 247.
30 Starr, supra n. 14, at 249.
31 Corning, supra n. 28.
32 Starr, supra n. 14, at 253.
33 Id. at 253; Corning, supra n. 28.
34 Starr, supra n. 14, at 258 (“Estimates at the end of the 1920s now showed that medical costs were 20 percent higher than lost earnings due to sickness for families with incomes under 1,200 dollars a year and nearly 85 percent higher for families with incomes between 1,200 and 2,500 dollars”).
35 Corning, supra n. 28, at ch. 2. See also Joseph S. Ross, The Committee on the Costs of Medical Care and the History of Health Insurance in the United States, 19 Einstein Q. J. Biology & Med. 129 (2002). The CCMC counted several leading health economists among its board members, and many of those would become important figures in the debate over a national health insurance program: I.S. Falk (who later became one of the government’s primary health policy experts) served as CMCC’s Associate Director of Study; Michael M. Davis (future Executive Chair of the Committee for the Nation’s Health) was one of the founding members. Corning, supra n. 28, at ch. 2.
36 Id.
37 Id.
Outside forces began to converge, however, with a strong policy argument for a national health insurance system. Health care costs continued to rise in the 1920s and early 1930s as the market control by licensing boards and new scientific developments (and associated physician education costs) drove up the cost of care.38 The Great Depression compounded these costs in the early 1930s, and health insurance seemed a logical area of focus when President Franklin Roosevelt took office in 1932, due to his support of government programs and significant public demand.39 Initially, the chances of a health insurance proposal seemed likely. The Roosevelt Administration created the Committee on Economic Security (CES) to study unemployment and pension issues, which included a subcommittee on medical care and health insurance.40 Unfortunately, the same opposition arose again. Even as the CES studied health insurance, members of the committee acknowledged that the AMA’s opposition to health insurance legislation was clear and made it unlikely that any health insurance legislation could be passed.41 The appointment of two of the most liberal voices from the CCMC to head the CES’s research on health insurance drew massive AMA protests.42 The CES report on health insurance (which recommended an optional program for states that, once chosen, was compulsory for all state residents) was submitted confidentially to the President and not made public.43 As a result, the Social Security Act of 1935, part of the Roosevelt New Deal, did not include government-run health insurance.44

The Roosevelt Administration did not simply cede ground on the health insurance issue. A new committee, the Interdepartmental Committee to Coordinate Health and Welfare Activities (ICCHWA) was created in 1935 to help coordinate the collection of new federal social programs.45 The ICCHWA delegated the issue of medical care to the Technical Committee on Medicare Care (TCMC) in 1937.46 The TCMC conducted extensive research and ultimately presented a thorough report with legislative proposals to address the national health problems it identified.47 President Roosevelt published the report and ordered that a

38 Starr, supra n. 14, at 260 (arguing that licensing, which requires education, and the scientific developments were jointly responsible for the increase in health care costs, in addition to the rise of hospitals, which enabled more people to take advantage of health care services and allowed for more complicated procedures). See also Charles H. Baron, Licensure of Health Care Professionals: The Consumer’s Case for Abolition, 9 Am. J. Law & Med. 335 (1983), http://lawdigitalcommons.bc.edu/cgi/viewcontent.cgi?article=1127&context=lsfp. Baron argues that such licensure contributes to high medical care costs and stifles competition, innovation, and consumer autonomy.
39 Corning, supra n. 28, at ch. 2; Starr, supra n. 14, at 266–267.
40 Starr, supra n. 14, at 267.
41 Id. stating “Edwin Witte, the staff director [of the committee], recorded in a confidential memo in 1936 his ‘original belief’ that medical society opposition precluded any action on health insurance. This view was shared by Secretary Perkins.”
42 Id. at 267–268. Walton Hamilton and Edgar Syndenstricker were appointed to head the CES committee on medical care. They had been loud, dissenting voices contributing to the ultimate CCMC report, which did not recommend a national health insurance system. Id.
43 Id. at 269.
44 Id.
45 Id. at 275.
46 Id. Members of the TCMC included I.S. Falk, who had been on both the CCMC and the CES committees studying health insurance in the United States. Falk represented the Social Security Administration on the TMTC and was a strong supporter of a national, public health insurance program. Id.
47 Id. at 276.
conference be held later in 1938 on the proposal to publicize the recommendations.\(^{48}\) The National Health Conference was held in July 1938 and discussed the TMTC’s five-part legislative plan: 1) additional funding for mother-and-child health programs; 2) federal grants for hospital construction; 3) federal grants to states for medical assistance for the poor and severely ill; 4) federal grants to states for the development of publicly funded, state-wide insurance programs; and 5) federal disability insurance.\(^{49}\) The AMA, realizing the level of support for the proposals was high, attempted to be conciliatory and met with the Interdepartmental Committee to discuss the terms of a deal they would accept.\(^{50}\) The AMA agreed with all of the recommendations except for the development of statewide insurance systems, and the debate seemed to have shifted to a debate about that recommendation alone.\(^{51}\) The debate continued into 1939, and Sen. Wagner of New York introduced Senate Bill 1620, which contained all of the TMTC recommendations.\(^{52}\) The bill and the TMTC recommendations were derailed shortly thereafter, first by the Presidential election of 1940, a year during which little was done, and then by World War II in 1942, an enterprise that consumed the attention of President Roosevelt and the Nation.\(^{53}\)

After World War II and the election of 1944, there were many reasons to suspect that a National Health Care program would be a priority of the Roosevelt Administration. First, there were multiple reports from the Social Security Board discussing health issues and recommending national insurance.\(^{54}\) Second, President Roosevelt mentioned a social insurance system in his State of the Union Address in 1944.\(^{55}\) Lastly, in 1942, the release of the Beveridge Report, which set forth a detailed plan for reconstructing England following World War II, included a national health insurance system.\(^{56}\) Dr. Beveridge lectured extensively in the United States on the content of his report and on the need for social insurance.\(^{57}\)

In addition, legislative support for a national health insurance system had begun

---

48 Corning, supra n. 28, at ch. 2.
49 Id. In more detail, the proposals were “(1) Expansion of the maternal and child health and public health programs included in the original Social Security Act; (2) Federal grants-in-aid for hospital construction; (3) grants to the States for direct medical care programs for two categories of citizens, those on public assistance rolls and those who were ‘medically indigent’ (ordinarily self-sufficient but unable to meet the additional burden of paying for medical care — an estimated one-third of the population); (4) grants to the States to encourage (but not compel) the establishment of statewide health insurance programs financed either through general revenues or through social insurance taxes; and (5) Federal initiative to provide cash payments for disability due to illness. (It was suggested that temporary disability be established in a manner similar to unemployment insurance and that permanent disability be provided through the old-age insurance system.” See also Starr, supra n. 14, at 276.
50 Starr, supra n. 14, at 276.
51 Id. Compulsion was contemplated by various plans and was usually in the form of a tax or a penalty for failure to buy or enroll in insurance. Id. See also Corning, supra n. 28, at chs. 3, 4.
52 Id. at 277.
53 Id.
54 Corning, supra n. 28, at ch. 3.
56 Sir William Beveridge was a leading British authority on social insurance in the 1940s. His work was instrumental in laying the foundations of the British Health System. See e.g. Sir William Beveridge, Social Insurance and Allied Services (Nov. 1942), http://www.fordham.edu/halsall/mod/1942beveridge.html.
57 Corning, supra n. 28, at ch. 3.
to grow. In 1943, Sens. Wagner and Murray introduced Senate Bill 1161, in conjunction with their colleague Congressman Dingell introducing House Resolution 2861. The identical bills, known together as the Wagner-Murray-Dingell bill, proposed a national health insurance that would be operated as a part of Social Security, with revenue being collected from income to fund the program in the same method as Social Security. These bills died in committee in late 1943, due in large part to a lack of official support from the President. In 1944, however, President Roosevelt changed his mind and became an open supporter of a national health insurance program. It became an issue in his 1944 reelection campaign. Accordingly, his platform included an economic bill of rights, including a “right to adequate medical care.”

President Roosevelt’s death in 1945 changed the administration’s plans, largely because President Truman, while a supporter of a national health insurance program, lacked the power to push through a revised version of the Wagner-Murray-Dingell bill, which called for a compulsory national system. President Truman’s initial proposal in November 1945, following President Roosevelt’s death in April, was similar to the TMTC proposals from 1938, but created a single, national system, instead of state-specific systems. At the same time, there was extensive congressional interest in addressing the nation’s health care issues resulting in many alternative proposals. In 1946, Sen. Taft, the chairman of the Committee on Labor and Public Welfare, proposed a federally financed medical welfare system, run by the states, and compulsory for the poor. Similarly, from outside the United States Congress, financier Bernard Baruch recommended a national insurance system that was voluntary for high-income Americans and compulsory for low-income Americans. President Truman’s health policy advisor, Michael M. Davis, favored the Baruch proposal because it had a broader base of support. In addition, Sen.

58 S. 1161, 78th Cong. (1943).
59 H.R 2861, 78th Cong. (1943).
60 Id.; see also Starr, supra n. 14, at 280.
61 Corning, supra n. 28, at ch. 3. See also Starr, supra n. 14, at 280. Records suggest that President Roosevelt’s position stemmed from political calculation, since he commented in 1943 that “We can’t go up against the State Medical Societies” (Starr, supra n. 14, at 279), a position that makes sense given the extensive lobbying push by the AMA during the earlier parts of this debate. Id.
62 Corning, supra n. 28, at ch. 3; Starr, supra n. 14, at 280. The likely reason for this shift was an increase in support from reformers, including “organized labor, progressive farmers, and liberal physicians.” Starr, supra n. 14, at 280.
63 Starr, supra n. 14, at 280–281.
64 Id. While unclear, it is likely that Roosevelt’s change of heart stemmed from an assessment of his political capital. Following World War II, he once again had the freedom to focus on domestic social issues. In addition, his election in 1944 gave him a mandate to push for broader social reform, a major issue in his campaign. Corning, supra n. 28, at ch. 3.
65 Starr, supra n. 14, at 281–284.
66 Id. at 281.
67 Id. at 284. Taft argued that the poor “should be subject to ‘compulsory’ medicine and they should ‘have to take it the way that the State says to take it.’”
68 Id. at 285. This type of system was common in many Western countries at the time. It also was seen as a potential compromise position, since it exempted high-income citizens and drew more support from Southern Democrats.
69 Id. Michael M. Davis was a member of the CCMC.
Jacob Javits and Rep. Richard Nixon proposed a local, government-subsidized, privately run nonprofit insurance system with premiums scaled to subscribers’ incomes.\textsuperscript{70}

The debate about which health insurance proposal to adopt was fierce,\textsuperscript{71} as was the counterattack, which relied heavily on calling such proposals “socialized medicine.” Sens. Ferguson and Taft accused the Administration of pushing socialized medicine in 1947.\textsuperscript{72} Further, a House committee found that the Administration had worked to advance “the Moscow party line.”\textsuperscript{73} In 1948, President Truman ran on a platform that included a national health insurance system, and following his surprise reelection, he continued to push for his proposal.\textsuperscript{74} As before, the AMA strongly opposed the proposal. The AMA hired the first political consulting firm, Campaigns, Inc., run by Whitaker and Baxter, to run their campaign against President Truman’s proposal.\textsuperscript{75} Whitaker and Baxter were given a budget of more than $1 million, a massive sum in 1948, and created a plan that built on the early cries of socialized medicine with two objectives: the immediate objective of “the defeat of the compulsory health insurance program pending in Congress,” and the long-term objective of “a permanent stop to the agitation for socialized medicine in this country.”\textsuperscript{76} They succeeded with regards to the first objective. When Truman took office, the public supported a national health insurance system four to one.\textsuperscript{77} After Whitaker and Baxter became involved, support slipped, dropping to four to one against.\textsuperscript{78} The entire campaign cost the AMA almost $5 million.\textsuperscript{79} Even so, the amendments to Social Security in 1950 did not create a national health insurance program; instead, the amendments provided additional financial support to existing health care programs, providing assistance

\textsuperscript{70}Id.
\textsuperscript{71}Id.
\textsuperscript{72}Starr, \textit{supra} n. 14, at 283 (“It is to my mind the most socialist measure this Congress has ever had before it”), 284 (“a nationwide program of socialized medicine”).
\textsuperscript{73}Id. at 284. The accusation that the Administration was working for Moscow was based on one of I.S. Falk’s employees writing a memo that spoke positively about the national health care system in New Zealand. The employee was investigated by the FBI, which cleared him of being a communist sympathizer. \textit{Id.}
\textsuperscript{74}Id.
\textsuperscript{75}Starr, \textit{supra} n. 14, at 283–285; \textit{see also} Jill Lepore, \textit{The Lie Factory}; New Yorker (Sept. 24, 2012). Whitaker and Baxter were famous in political circles for defeating then-Gov. Earl Warren’s attempt to pass a compulsory, statewide insurance program in California. Their involvement in that campaign was funded by the California Medical Association, which like the AMA, was strongly opposed to any such program. \textit{See also} Karen S. Palmer, \textit{A Brief History of Health Reform in the US}, Physicians for a National Health Program (1999), http://www.pnhp.org/facts/a-brief-history-universal-health-care-efforts-in-the-us.
\textsuperscript{76}Lepore, \textit{supra} n. 75, citing the papers of Campaigns, Inc., available in the California State Archives, Sacramento. \textit{See} finding aids, available at scholar.harvard.edu/files/lepoire_lie_factory_source_note_0.pdf. (accessed Jan. 25, 2013). The same smear, “socialized medicine” had been used against Gov. Warren’s plan in California, but it became much more prominent in the 1949 battle over President Truman’s plan. \textit{Id.}
\textsuperscript{77}Id.
\textsuperscript{78}Id. Whitaker and Baxter sent mailers to millions, spoke to hundreds of doctors, and handed out millions of pamphlets. \textit{Id.}
\textsuperscript{79}Id. The campaign also turned the idea of “legislative reform [of health insurance and health care] into a bogeyman so scary that, even today, millions of Americans are still scared.” \textit{Id.}
to an additional 10 million elderly and disabled Americans.80

This grim picture misses several important outcomes from President Truman’s battle over a national health care system. The players were changing: The American Hospital Association (AHA), not a major player until this point, decided that it approved of government subsidies for private insurance, although it did not go as far as approving of a national health insurance system.81 Other organizations, such as the American Bar Association and the Chamber of Commerce, supported such a program.82 Among the many health care proposals presented was the idea of a government health care program for just Social Security beneficiaries. In 1950, I.S. Falk, a health economist for the Social Security Board, drafted a memorandum for Federal Security Administrator Ewing.83 Falk outlined just such a plan.84 While the proposal was widely discussed in the Administration and in Congress, lawmakers did not act upon it.85

There was little progress on national health insurance under President Eisenhower, who opposed the idea.86 Even so, the Eisenhower Administration could not ignore the debate about the need for national health care insurance and, accordingly, took limited action to try to increase private insurance coverage of low-income groups.87 These efforts failed, largely because critics argued that they would not improve the situation of low-income groups, as the proposals did not provide sufficient incentives to private insurance companies to insure low-income people.88 Congress, however, did act to provide “military Medicare” or health coverage for the dependents of servicemen, and additional payments to medical vendors who provided health care to welfare recipients.89 Perhaps even more importantly, Congress approved a new study of the problems of the aged.90

80 Starr, supra n. 14, at 286.
81 Starr, supra n. 14, at 283. The history of the AHA and its attempts to control the provision of medical care in the United States is beyond the scope of this summary, but Starr provides an extensive discussion of this tension, including a discussion of an anti-trust case against the AHA. Id. at 299–310.
82 Id.
83 Corning, supra n. 28, at ch. 4. As discussed above, I.S. Falk had been involved in health policy for many years. He was a leading figure in the health care reform movement and one of the original employees of the Social Security Board (later the Social Security Administration). He was responsible for drafting much of the Technical Committee on Medical Care (TCMC) report that led to Sen. Wagner’s first bill for national health insurance and drafted the Wagner-Murray-Dingle bill. See Milton I. Roemer, I.S. Falk, the Committee on the Costs of Medical Care, and the Drive for National Health Insurance, 75(8) Am. J. Pub. Health 841–848 (Aug. 1985).
84 Corning, supra n. 28, at ch. 3.
85 Id.
86 Id. While the basis of his opposition is not entirely clear, it is worth noting that Whitaker and Baxter consulted for Eisenhower’s campaign and generally all Republicans opposed government involvement in health insurance because they equated it with socialism. See Lepore, supra n. 75.
87 Corning, supra n. 28, at ch. 4.
88 Id.
89 Id.
90 Id. This study eventually resulted in the formation of the Special Committee on Aging because of the
In 1958, Rep. Forand of Rhode Island introduced a bill that was limited to covering the hospital costs of Social Security beneficiaries.\(^9\) This time, strong labor support and the involvement (if not direct support) of the AHA, which had been carrying the brunt of expenses for caring for the elderly, countered the lobbying efforts of the AMA.\(^9\) The AHA favored a social security beneficiaries-based system.\(^9\) While the Forand bill languished in committee, public demand for a legislative solution to address the medical needs of the elderly grew.\(^9\)

In addition, Congress demanded a study from the Department of Health, Education, and Welfare (HEW), which identified clear problems:

> Older persons have larger than average medical care needs. As a group they use about two-and-a-half times as much general hospital care as the average for persons under age 65, and they have special need for long-term institutional care. Their incomes are generally considerably lower than those of the rest of the population, and in many cases are either fixed or declining in amount. They have less opportunity than employed persons to spread the cost burden through health insurance. A larger proportion of the aged than of other persons must turn to public assistance for payment of their medical bills or rely on ‘free’ care from hospitals and physicians. Because both the number and proportion of older persons in the population are increasing, a satisfactory solution to the problem of paying for adequate medical care for the aged will become more rather than less important.\(^9\)

The study concluded that the federal government could either act by creating federal insurance for the elderly or could try to subsidize private insurance, as the Eisenhower administration attempted in the 1950s.\(^9\) In 1960, Congress attempted a third approach toward health care reform by extending federal funds to the state medical programs for welfare recipients, including the aged poor — generally similar to what Medicaid is today.\(^9\) That approach failed because most states did not take advantage of it.\(^9\)

\(^9\) Starr, supra n. 14, at 368.
\(^9\) Corning, supra n. 28, at ch. 4.
\(^9\) Id.
\(^9\) Id.
\(^9\) Starr, supra n. 14, at 368. A congressional staffer recalling visiting constituents said: “The old folks were lined up by the dozen everyplace we went … and they didn’t talk much about housing or recreational centers, or part time work. They talked about medical care.”
\(^9\) Corning, supra n. 28, at ch. 4.
\(^9\) Id.
\(^9\) Starr, supra n. 14, at 368; Corning, supra n. 28, at ch. 4. In an interesting twist of fate, that bill, the Kerr-Mills bill, was put to a vote alongside the Forand Medicare bill. The vote on the Forand bill was close, 51 against and 44 for, but the Kerr-Mills bill passed almost unanimously, 91 to 2. The close vote on the Forand bill convinced advocates of Medicare to push harder, since likelihood of passage was high. However, the votes were not present after the 1960 election. See Starr, supra n. 14, at 368.
\(^9\) Starr, supra n. 14, at 369; Corning, supra n. 28, at ch. 4. In 1964, only 32 states had enrolled in the program and just five states (large states that accounted for one-third of the nation’s population) had taken
As a result, there remained demand for Medicare and then-Sen. John F. Kennedy made it an issue of his presidential campaign.\textsuperscript{99} Momentum built in 1961 and 1962, with favorable public support of 69 percent.\textsuperscript{100} The momentum resulted in various bills being introduced in the Senate and House.\textsuperscript{101}

In May 1962, President Kennedy gave a speech in New York to 20,000 elderly people, which was broadcast live to another 20 million people.\textsuperscript{102} The House committees were deadlocked, however, and there were insufficient members to overcome the opposition.\textsuperscript{103} The Senate pushed for a vote before the election and the Medicare amendment was defeated by two votes.\textsuperscript{104} While Democrats picked up some seats and two on the all-important Ways and Means Committee, the action was mostly delayed by foreign affairs (specifically the Cuban Missile Crisis) until late in 1963.\textsuperscript{105}

President Johnson pushed repeatedly for Medicare in the months leading up to the 1964 election.\textsuperscript{106} It was not, however, until Democrats swept Congress in 1964 that there were finally sufficient votes to pass Medicare.\textsuperscript{107} The Mills bill, named after the Chairman of the Ways and Means Committee, combined several proposals that had been considered at various times, including the compulsory health insurance program run through Social Security that the Democrats and the President supported, the government-subsidized insurance program that Republicans supported, and a revised version of the federal assistance program for low-income persons.\textsuperscript{108} The proposals were revised and combined to form Part A and Part B of Medicare and Medicaid.\textsuperscript{109} The Mills bill passed the House on April 8, 1965, by a vote of 313-115 and went through three months of hearings and debate in the Senate before passing on July 9, 1965, by a vote of 68-21.\textsuperscript{110} The final bill, following a short reconciliation process, was approved on July 27 (in the House) and July 28 (in the Senate).\textsuperscript{111}

\textsuperscript{99} Corning, supra n. 28, at ch. 4 (“[Kennedy] repeatedly attacked the Kerr-Mills program as inadequate by itself to deal with the problem. Republican Governor Rockefeller concurred, and during the campaign, Vice President Nixon also conceded the point. Calling Kerr-Mills ‘most inadequate,’ he promised if elected to take further steps”).

\textsuperscript{100} Id.


\textsuperscript{102} Corning, supra n. 28, at ch. 4. The AMA responded two days later with a speech that was broadcast nationally. Id.

\textsuperscript{103} Id.

\textsuperscript{104} Id.

\textsuperscript{105} Id.

\textsuperscript{106} Id. President Johnson mentioned Medicare in his first speech to Congress, sending a message to Congress regarding his priorities. Id.

\textsuperscript{107} Id. The Democrats gained 37 seats in the House and 2 seats in the Senate. The Senate had passed a Medicare bill in September 1964; therefore, the additional seats in the House were far more important. Id.

\textsuperscript{108} Starr, supra n. 14, at 369.

\textsuperscript{109} Id.

\textsuperscript{110} Id.

\textsuperscript{111} Id.
B. The Current Medicare System

Given the intensity of the debates over creating a health insurance system, it is not a surprise that the Medicare Program, enacted in 1965, was a compromise approach to health care delivery. The original enactment of the Medicare program consisted of Parts A and B. Part A covers inpatient hospital care, inpatient care in a Skilled Nursing Facility (SNF), and home health care services after a period of hospitalization. Part A is funded by federal payroll taxes paid by employers and employees into Social Security’s Federal Hospital Insurance (HI) Trust Fund. At age 65, all US citizens and permanent legal residents (who have been permanent legal residents for five years) are eligible for Part A.

Part B covers medical care and services provided by physicians and other medical practitioners, durable medical equipment, a variety of outpatient care services, and home health services not otherwise covered under Part A. It is funded by general federal revenues and premiums paid by beneficiaries to the Supplementary Medical Insurance (SMI) Trust Fund. The premiums account for 25 percent of the aggregate spending (or total spending for Part B), through a progressive rate structure, and general revenues cover the other 75 percent of spending.

Over the past decade and a half, Congress has added new features and limitations to the Medicare program. A major change came in the Balanced Budget Act of 1997 (BBA ’97). BBA ’97 created Medicare Part C, comprising Medicare’s coordinated care delivery and financing options, then known as the Medicare+Choice program and now known as Medicare Advantage (MA). Medicare Part C allows for coordinated care plans, including Health Maintenance Organizations (HMOs), Provider Service Organizations (PSOs), Special Needs Plans (SNPs), and both local and regional Preferred Provider Organizations (PPOs), as options for receiving coverage. Other options include Medical Savings Accounts (MSAs) and Health Savings Accounts (HSAs) under the Internal Revenue Code. Private Fee-for-Service (PFFS) plans and Private Religious-Fraternal

112 42 U.S.C. §§ 1395(c), 1395(d).
113 MedPAC, supra n. 9, at 13.
114 42 U.S.C. § 1395i-e(a)(3); 42 C.F.R. § 207.10(a)(2)(i)–(iii).
116 See MedPAC, supra n. 9.
117 Id. See also 20 C.F.R. §§ 418.1115, 418.1120 (2007). For further discussion, see MedPAC, Beneficiaries’ Financial Resources and Liability for Health Care Costs, in Report to the Congress: New Approaches in Medicare app. B (June 2004), http://www.medpac.gov/publications/congressional_reports/June04_AppB.pdf. Medicare spending reached $525 billion in 2010 and $549 billion in 2011. In 2009, the most recent year for which data is available, beneficiary premiums were approximately $1,128 per year for beneficiaries who were in fair or poor health and $1,079 for beneficiaries in good or better health. Additional out-of-pocket spending for beneficiaries was $3,446 per year for those in poor or fair health and $1,643 for those in good or better health. Id
119 Medicare Part C; see BBA § 4001, enacting Social Security Act §§ 1851–1859. As discussed later, Medicare+Choice was renamed “Medicare Advantage” (MA) in December 2003. See MMA § 201.
120 Id.
121 MSA plans were made available for the first time in January 2006.
Order plans are also included.\textsuperscript{123}

In December 2000, Congress passed another bill that made significant adjustments to the Medicare Program, the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA).\textsuperscript{124} More changes occurred at the end of 2003 with the enactment of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA).\textsuperscript{125} Among other things, the MMA provided Medicare beneficiaries with assistance in paying for prescription drugs through a new Medicare Part D, also creating a gap in drug coverage, known as the Part D doughnut hole.\textsuperscript{126} The law also changed the name of private plans offered under Medicare Part C, from “Medicare+Choice” to “Medicare Advantage.”\textsuperscript{127} It also created additional benefits for certain beneficiaries.\textsuperscript{128}

In addition, it increased payments to Part C plans, with plans receiving an average of 115 percent of per capita costs under traditional fees for service.\textsuperscript{129} The legislation also increased beneficiary cost-sharing responsibilities.\textsuperscript{130}

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA)\textsuperscript{131} was primarily designed to address problems with the way Medicare pays physicians.\textsuperscript{132} It also made modest improvements for beneficiaries, including reducing the cost sharing

\textsuperscript{123} These options commenced January 1999, but in most areas of the country only managed care plans, including HMOs, PPAs, and PFFS plans developed. See Ctrs. for Medicare & Medicaid Servs. (CMS), Private Fee-For-Service – Beneficiary Questions and Answers (last updated Feb. 10, 2006), http://www.cms.gov/Medicare/Health-Plans/PrivateFeeForServicePlans/downloads/benqa.pdf; MedPAC, Private Fee-for-Service Plans in Medicare Advantage, State. of Mark E. Miller, Exec. Dir., Medicare Payment Advisory Commn. (May 22, 2007), http://www.medpac.gov/documents/052207_Testimony_WM_MedPAC_MA_PFFS.pdf. The BBA also created, outside the MA program, an option for “private contracts” between physicians and their Medicare patients for the receipt of Medicare-covered services for which no Medicare payment would be made. Physicians entering into such contracts must agree not to accept Medicare reimbursement for any Medicare-covered service for two years. BBA § 4507, amending § 1802 of the Social Security Act, 42 U.S.C. § 1395a.


\textsuperscript{126} Id. at § 1860D et seq. See also Jack Hoadley et al., Medicare Part D 2010 Data Spotlight: The Coverage Gap, Kaiser Fam. Found. (Nov. 2009). The Part D doughnut hole occurs when beneficiaries have spent a specific amount of money on prescription drugs. They are then responsible for the full price of their necessary prescription drugs until they reach another specified amount, at which point Part D begins to pay for necessary prescriptions again. Id.

\textsuperscript{127} MMA § 201.

\textsuperscript{128} Id. at § 211 et seq.


\textsuperscript{130} See MIPPA § 2256B.

\textsuperscript{131} MIPPA. See also Ctr. for Medicare Advoc., CMA Alerts, http://www.medicareadvocacy.org/articles/weekly-update-archive (accessed Aug. 23, 2011). These alerts describe MIPPA provisions of importance to beneficiaries and their advocates.

for mental health services and increasing the asset limits for eligibility for programs that assist with Part B premiums and cost sharing.\textsuperscript{133}

The Patient Protection and Affordable Care Act of 2010 (PPACA)\textsuperscript{134} and the Health Care and Education Reconciliation Act of 2010 (HCERA), collectively known as the Affordable Care Act (ACA), is the most significant health care reform legislation in recent years.\textsuperscript{135} In the main, the ACA changed the payment structure for private Medicare Advantage plans in order to reduce overpayments and to create greater payment equity between the MA program and traditional Medicare.\textsuperscript{136} In addition, the ACA provides for system delivery mechanisms, demonstration programs, and pilot projects to improve coordination of care and contains other initiatives to improve quality of care, including reducing unnecessary hospital readmissions.\textsuperscript{137} The ACA aims to reduce unnecessary hospital admissions primarily by limiting payment for hospital-acquired conditions and by expanding the standards and measures used for determining the quality of care of the services provided to Medicare beneficiaries.\textsuperscript{138} The ACA also added additional preventive

\begin{flushleft}
\textsuperscript{133}See MIPPA § 101 et seq.


\textsuperscript{136}ACA § 1103, amending 42 U.S.C. 1395w–27(e).


\textsuperscript{138}See ACA § 3008. The law requires the Secretary of Health and Human Services (the Secretary) to create incentives for applicable hospitals that receive inpatient hospital service payments on the basis of prospective rates set by the Medicare Geographical Classification Review Board. The incentives are meant to reduce hospital-acquired conditions with respect to discharges during fiscal year 2015 and subsequent fiscal years. The amount of payment for such discharges during the fiscal year must be equal to 99 percent of the amount of payment that would otherwise apply. An applicable hospital is one that is in the top quartile of hospitals relative to the national average of hospital-acquired conditions during the applicable period as determined by the Secretary. The term “hospital-acquired condition” means a condition identified or determined by the Secretary that an individual acquires during a stay in an applicable hospital. The term “applicable period” means a period specified by the Secretary with respect to a fiscal year. See
\end{flushleft}
measures starting in 2011, including coverage for a wellness visit. The ACA eliminates cost-sharing for most preventive services, adds consumer protections to Medicare Advantage plan benefit structures, and phases down the Part D coverage gap known as the “doughnut hole.”

II. CURRENT MEDICARE SOLVENCY CONcerns

Medicare solvency concerns highlight the need for congressional oversight and alignment of payment strategies and goals, but the current state of the Medicare Trust Funds is not as dire as both major political parties and news media outlets indicate. Medicare is not on the verge of bankruptcy. It has enough money to pay all of its bills through 2024 and to pay 87 percent of its costs for many years thereafter. Medicare is, nevertheless, facing two specific financial challenges: the insolvency of the HI Trust Fund in 2024 and rising health care costs. Since 2008, HI expenses have exceeded income and are projected to continue to do so. Once the reserves are gone, only the revenue raised by HI Trust Fund payroll taxes


139 See ACA §§ 3301, 3315; HCERA § 1101. Beginning in 2011, the doughnut hole slowly shrank: Beneficiaries got a 50 percent discount on brand-name and biologic prescription drugs purchased while in the doughnut hole in 2011. Starting in 2013, the federal government will gradually add to the discount so that by 2020, beneficiaries will pay not more than 25 percent of the cost of brand-name and biologic prescription drugs while in the doughnut hole. Beneficiaries purchasing generic prescription drugs got a 7 percent price cut starting in 2011. By 2020, the federal government will cover 75 percent of the cost of these drugs. By 2020, the doughnut hole will disappear for all drugs, both generic and brand name. The discounts do not affect a beneficiary’s ability to qualify for Part D catastrophic coverage if the actual costs of the individual’s drugs are high enough to reach that level. Hoadley et al., supra n. 126.


141 Merriam-Webster defines “bankruptcy” as “utter failure or impoverishment.” Synonyms include “insolvency,” “failure,” and “ruin.” However, Merriam-Webster defines insolvency as “inability to pay debts,” which more accurately describes what Medicare’s financial situation will be in 2024. Merriam-Webster, http://www.merriam-webster.com (accessed Jan. 2, 2013).

142 See Paul N. Van de Water, Ctr. on Budget and Policy Priorities, Medicare Is Not “Bankrupt”, (Apr. 24, 2012); see also Ctr. for Medicare Advoc., supra n. 140.

143 Van de Water, supra n. 142, at 1.

144 MedPAC, supra n. 9, at 13; CBO, supra n. 9, at 51. Medicare is funded by two trust funds, the HI Trust Fund and the SMI Trust Fund. The HI Trust Fund is funded by payroll tax revenues and fund reserves and is projected to have sufficient funds to meet 100 percent of projected costs until 2024. The ACA is responsible for increasing the solvency of the HI Trust Fund until 2024. Before the ACA, the fund was projected to become insolvent in 2016. See also Van de Water, supra n. 142, at 1.

145 CBO, supra n. 9, at 51.
will be available, and the program is projected to become insolvent in 2024.\textsuperscript{146} Payroll tax revenue will still cover approximately 74 percent of Medicare Part A costs after 2024, but there will be a deficit.\textsuperscript{147} Congress will have to step in and either raise the payroll tax to cover the difference or reduce costs so that the HI Trust Fund will remain sufficient to cover medical costs. This is not a new problem: since the creation of Medicare, experts have predicted solvency issues with the HI Trust Fund.\textsuperscript{148} As early as 1970, the Trustee’s report noted that the trust fund would become insolvent, but lawmakers have always stepped in to prevent bankruptcy.\textsuperscript{149}

In contrast to the HI Trust Fund, the SMI Trust Fund is not in danger of becoming insolvent. It is funded by set percentages paid every year: 25 percent by beneficiary premiums and 75 percent by general federal revenues.\textsuperscript{150} In discussing the SMI Trust Fund, the Medicare Payment Advisory Commission (MedPAC) consistently notes that the growing costs of health care will create significant burdens for both beneficiaries and the United States economy.\textsuperscript{151} This concern relates to projections that Medicare spending will equal 3.7 percent of Gross Domestic Product (GDP) in 2012, 4.2 percent in 2022, and 6 percent in 2037.\textsuperscript{152} This continues the trend of the last decade, during which Medicare spending rose from 1.7 percent GDP to 3.7 percent GDP.\textsuperscript{153} This is an increase of 9.1 percent per year from 2000-2005 and of 6.9 percent per year in 2006-2010.\textsuperscript{154} This growth has been

much slower “in expenditures on a per enrollee basis than private alternatives; a trend that is also projected to continue.”\textsuperscript{155} In fact, Medicare spending per beneficiary has grown more slowly for the past 10 years, growing only 7.2 percent from 2000-2005 (during which private insurance spending grew 9.1 percent) and only 4.2 percent from 2006-2010 (compared to 4.5 percent).\textsuperscript{156} Projections for the 2011-2020 years provided even more of a contrast: 2.7 percent growth in Medicare per beneficiary spending to 4.9 percent per enrollee spending by private insurance.\textsuperscript{157}

The CBO attributes 60 percent of the growth in the major health care programs (Medicare, Medicaid, and the Children’s Health Insurance Program) through 2037 to the increase in the population served, not to rising health care costs.\textsuperscript{158} In addition, “[t]hrough 2022, the aging of the population will cause spending on the major health care programs and Social Security to rise significantly … during that period, almost all of the projected growth in such spending as a share of GDP is effectively the result of aging.”\textsuperscript{159} This projection is especially relevant to Medicare, since the number of people enrolled in Medicare is projected to increase from 47 million (2010) to 64 million (2020) to 81 million (2030).\textsuperscript{160} In contrast, over the past 20 years, Medicare enrollment grew from 34 million (1990) to 39 million (2000) to 47 million (2010).\textsuperscript{161}

The massive increase in enrollees, combined with Medicare’s lower than most private alternatives per-beneficiary spending rate, means that alternatives to Medicare, including the premium support plans proposed during the 2012 presidential election, are unlikely to be more cost effective.\textsuperscript{162} Since Medicare has the lowest per-beneficiary costs, the program as a whole results in less spending on health care.\textsuperscript{163} Under a premium-support system, such as the one suggested in the 2011 budget proposal of Rep. Paul Ryan, beneficiaries would receive a set amount of money with which to buy private insurance.\textsuperscript{164}

\footnotesize{\textsuperscript{155} Holahan & McMorrow, supra n. 154.  
\textsuperscript{156} Id. at 3.  
\textsuperscript{157} Id. at 5.  
\textsuperscript{158} CBO, supra n. 9, at 14–15.  
\textsuperscript{159} Id. at 14.  
\textsuperscript{159} Id. at 14.  
\textsuperscript{159} Id. at 14.  
\textsuperscript{160} MedPAC, supra n. 9, at 24.  
\textsuperscript{161} Id.  
\textsuperscript{162} Holahan & McMorrow, supra n. 154, at 1.  
\textsuperscript{163} For a discussion of Medicare spending and costs, see MedPAC, supra n. 9, ch.1.  
\textsuperscript{164} Id. Paul Ryan, The Path to Prosperity: Restoring America’s Promise – Fiscal Year 2012 Budget Resolution 46 (2011). (“Starting in 2022, new Medicare beneficiaries will be enrolled in the same kind of health care program that members of Congress enjoy. Future Medicare recipients will be able to choose from a list of guaranteed coverage options, and they will be given the ability to choose a plan that works best for them. This is not a voucher program, but rather a premium-support model. A Medicare premium-support payment would be paid, by Medicare, to the plan chosen by the beneficiary, subsidizing its cost.”) While Rep. Ryan rejects the description of a voucher, his plan would effectively provide a set sum of money to beneficiaries to pay for a private insurance plan with some required benefits. This does meet the definition of a voucher in the context of education vouchers. See the Merriam-Webster definition of “voucher,” http://www.merriam-webster.com/dictionary/voucher. The updated 2012 proposal retains the option of traditional Medicare. (“When younger workers become eligible for Medicare a decade or more from
Since private insurance pays more for the same benefits that Medicare provides, the costs of health care will go up much more than they would if Medicare remains a player in the market.\textsuperscript{165} Since Medicare provides benefits to beneficiaries more cost effectively than private options, the way to keep health care spending down is to allow the massive number of new people becoming eligible to go onto Medicare.\textsuperscript{166} Retaining the Medicare system as it is now will lower health care costs as millions of people move to it from less cost-effective private insurance.\textsuperscript{167} It is important to note that rising health care costs are important, particularly as 40 percent of Medicare’s growth is attributed to “excess cost growth.”\textsuperscript{168} The continued growth is concerning given the current state of the United States deficit and the debate over what aspects of the federal budget to cut. The entire Federal Budget was equal to 24 percent of GDP in 2011 and Medicare accounted for 13.5 percent of the entire budget.\textsuperscript{169} This budget figure allowed Medicare to provide health care to approximately 47 million elderly and disabled Americans.\textsuperscript{170} Even so, almost all recent budget plans suggest changing or limiting Medicare in some way.\textsuperscript{171} The rising costs of health care are also a major concern for beneficiaries, since Medicare growth will outpace growth of the average monthly Social Security benefit.\textsuperscript{172} This will force elderly beneficiaries to pay a higher percentage of their income for health care.\textsuperscript{173} Currently, Medicare beneficiaries spend roughly the same percentage on health care needs as they spend on household expenditures such as food and transportation.\textsuperscript{174} With the essential costs of food and transportation also rising, beneficiaries are facing mounting challenges to maintaining their health and daily necessities. Out-of-pocket today, they will be able to choose from a list of guaranteed coverage options, including a traditional Medicare fee-for-service plan. This flexibility will allow seniors to enjoy the same kind of choices in their plans that members of Congress enjoy. Medicare will provide a payment to subsidize the cost of the plan, and forcing plans to compete against each other to serve the patient will help ensure guaranteed affordability.” It is unclear how the traditional Medicare plan will fit into the new system and whether it too will be paid for with a voucher and contribution from the beneficiary. Projections cannot be made due to this vagueness.

\textsuperscript{165} IOM, supra n. 10.

\textsuperscript{166} See e.g. Chris Fleming, \textit{Medicare Beneficiaries Less Likely to Experience Cost and Access Problems Than Adults with Private Coverage}, Health Affairs Blog (June 19, 2012), http://healthaffairs.org/blog/2012/07/19/medicare-beneficiaries-less-likely-to-experience-cost-and-access-problems-than-adults-with-private-coverage.

\textsuperscript{167} \textit{Id.}

\textsuperscript{168} CBO, supra n. 9, at 15.


\textsuperscript{170} Kaiser Fam. Found., \textit{supra} n. 3.

\textsuperscript{171} Kaiser Fam. Found., \textit{A Comparison of Medicare Provisions in Deficit and Debt Reduction Proposals} (Sept. 23, 2011). The five major plans came from the President, the Gang of Six, the House, Bowles-Simpson, and the Bipartisan Policy Center (the Domenici-Rivlin plan). The House, Bowles-Simpson, and Domenici-Rivlin plans all included premium support.

\textsuperscript{172} MedPAC, \textit{supra} n. 9, at 15.

\textsuperscript{173} \textit{Id.}

spending by Medicare beneficiaries as a percentage of income has risen sharply in recent years, from 11.8 percent in 1998 to 16.2 percent in 2006.\(^\text{175}\) Out-of-pocket premium costs as a share of income rose from 5.3 percent in 1998 to 8 percent in 2006.\(^\text{176}\) As a proportion of total spending, Medicare beneficiaries pay two times more out-of-pocket for health care than other Americans.\(^\text{177}\) A separate analysis puts the median out-of-pocket spending figure at 17 percent and shows variations among demographics.\(^\text{178}\)

The factors discussed above make stabilizing or reducing health care costs a major issue for the future of Medicare. Moreover, in September 2012, the Institute of Medicine (IOM) released the newest installment of their report on the quality of health care in the United States.\(^\text{179}\) The report focused on two major issues, one of which was the increasing costs of health care.\(^\text{180}\) The headline-grabbing conclusion was that the waste within the health care system totaled approximately $765 billion.\(^\text{181}\) It specifically critiqued Medicare for re-hospitalization rates.\(^\text{182}\) The report attributes these increased costs to a lack of coordination between physicians, which resulted in $15 billion in unneeded costs.\(^\text{183}\) The IOM report posits that inefficiencies and failure to pay for quality are the core elements of our current increased cost predicament.\(^\text{184}\) The IOM report also provides solutions and praises recent legislation, including the ACA, for addressing those problems by focusing on value-based initiatives, including the use of Accountable Care Organizations (ACOs)\(^\text{185}\) and bundled payment methods.\(^\text{186}\) As we will discuss below, these programs all work together to address the health care costs problem facing Medicare.

III. THE AFFORDABLE CARE ACT AND MEDICARE

As the discussion of solvency above suggests, Medicare does need to reduce costs. The current efforts to reduce costs include the variety of cost-containment methods in the ACA. These methods are all rooted in the theory that costs can be reduced by demanding a higher quality of care from providers. This section will begin by discussing the theory

---

179 IOM, supra n. 10.
180 Id. at S-2.
181 Id. at S-8, 3-10 (“Two other independent and differing analytic approaches — considering regional variation in costs and comparing costs across countries — produce similar estimates, with total excess costs approaching 750-760 billion dollars in 2009”).
182 Id. at 3-5.
183 Id. at 3-4.
185 IOM, supra n. 10, at 4-11.
186 Id.
of quality of care, highlight several of the major initiatives that the ACA created, and analyze the strengths and weaknesses of those indicatives in the face of additional political challenges.

The ACA introduces a variety of cost saving and quality of care enhancement mechanisms. In large part, these measures build upon notions that allow providers of service to share in savings achieved through providing health care services more efficiently. Having a “medical home” — a place or setting in which one’s care needs are managed — is a key concept. The concept of a medical home is part of a newer notion of care coordination referred to as the “patient-centered medical home” (PCMH). The Centers for Medicare & Medicaid Services (CMS) has created a series of demonstrations to test and evaluate medical homes. The medical home demonstration is intended to “redesign the health care delivery system to provide targeted, accessible, continuous and coordinated, family-centered care to high-need populations.” Under the demonstration, the terms “high-needs populations” and “family-centered care” define access criteria. “High-needs population” refers to beneficiaries with a chronic problem or problems being addressed by a variety of health care providers. Similarly, MedPAC, a group created to advise the Congress on Medicare payment policy, has defined medical homes as a construct that “serves as a central resource for a patient’s ongoing care.”

A Medicare beneficiary who receives services through a physician practice that has agreed to participate in a medical homes demonstration project will not lose eligibility upon entering a nursing home, provided the beneficiary receives primary care from the medical home. Similarly, a beneficiary retains eligibility if care is received through a home health agency or through hospice. In addition, the beneficiary may remain in the demonstration project if he or she recovers from the chronic condition(s) that enabled initial eligibility. A beneficiary who is dually eligible for Medicare and Medicaid and is in


188 Robert A. Berenson et al., A House Is Not a Home: Keeping Patients at the Center of Practice Redesign, 27 Health Affairs (2008). See also Ctr. for Medicare Advoc., Recommendations for a Coordinated Care Benefit in the Medicare Program, www.medicareadvocacy.org/recommendations-for-a-coordinated-care-benefit-in-the-Medicare-program/ (Mar. 2002). These recommendations were developed at a conference held by the Center for Medicare Advocacy and supported by The Commonwealth Fund, the Kaiser Family Foundation, and AARP. Dr. Berenson provided one of the papers for this conference.


190 Section 133 of MIPPA gives the Secretary the authority to expand the medical homes demonstration. This is reflected in the current demonstration design.


192 Id.

193 Id.

the traditional Medicare program may also participate in the demonstration project.\textsuperscript{195} To participate in the medical homes demonstration, a Medicare beneficiary: must participate in the traditional Medicare program; must be enrolled in Medicare Parts A and Part B; and must have at least one eligible chronic disease as defined by CMS.\textsuperscript{196}

\textbf{A. Medicare Shared Savings Program (MSSP) and Accountable Care Organizations (ACOs)}

The ACA requires the Secretary of Health and Human Services (the Secretary) to establish a Medicare Shared Savings Program (MSSP).\textsuperscript{197} The design of the MSSP is to promote accountability for a defined patient population, coordinate items and services under traditional Medicare Parts A and B, and encourage investment in infrastructure and redesigned care processes for high quality and efficient service delivery.\textsuperscript{198}

Under the MSSP, groups of providers of services and suppliers that meet criteria established by the Secretary may work together to manage and coordinate care for Medicare fee-for-service beneficiaries through ACOs.\textsuperscript{199} ACOs embrace notions and characteristics that are similar to those of the Medicare Advantage (MA), coordinated care plans. Because the MSSP programs operate only in the traditional Medicare program, beneficiaries enrolled in an MA plan, a competitive medical plan, or in a Program of All-inclusive Care for the Elderly (PACE) cannot receive services through an ACO.\textsuperscript{200} ACOs that meet quality performance standards established by the Secretary are eligible to receive payments for shared savings.\textsuperscript{201} The design of the MSSP is to promote accountability for a defined patient population, coordinate items and services under traditional Medicare Parts A and B, and encourage investment in infrastructure and redesigned care processes for high quality and efficient service delivery. ACOs that meet quality performance standards established by the Secretary are eligible to receive payments for shared savings. The ACA anticipates that ACOs will promote and foster cost-containment and quality of care initiatives.\textsuperscript{202}

ACO contracts are for three years.\textsuperscript{203} An ACO must have, among other things, a formal structure for receiving and distributing savings.\textsuperscript{204} An ACO is only eligible to receive payment for shared savings if its estimated average per capita Medicare expenditures are below the applicable benchmark set by the Secretary for a given year.\textsuperscript{205} As determined by the Secretary, certain groups of suppliers and providers of services who have established

\begin{itemize}
\item \textsuperscript{196} Id.
\item \textsuperscript{197} ACA § 3022.
\item \textsuperscript{199} Id.
\item \textsuperscript{200} ACA § 3022(a).
\item \textsuperscript{201} ACA § 3022.
\item \textsuperscript{202} Id.
\item \textsuperscript{203} ACA § 3022(b)(2).
\item \textsuperscript{204} Id.
\item \textsuperscript{205} ACA § 3022(d)(1)(B).
\end{itemize}
a mechanism for shared governance are eligible to participate as ACOs. The groups include: a) ACO professionals (physicians and other professionals recognized under the Medicare program) in group practice arrangements; b) networks of individual practices of ACO professionals; c) partnerships or joint venture arrangements between hospitals and ACO professionals; d) hospitals employing ACO professionals; and e) such other groups of suppliers or providers of services as the Secretary determines appropriate.

B. ACOs and Quality Measures Reporting under the ACA

The Secretary is to determine appropriate measures to assess the quality of care furnished by the ACO, including such measures as: a) clinical processes and outcomes; b) patient and (where practicable) caregiver experiences; and c) utilization, such as rates of hospital admissions for conditions for which good outpatient care could potentially prevent the need for hospitalization, or for which early intervention could prevent complications or more severe disease (“ambulatory care sensitive conditions”).

The Secretary may, as determined appropriate, incorporate reporting requirements and incentive payments related to the physician quality reporting initiative, including electronic prescribing, electronic health records, and other similar initiatives, and may use alternative criteria for determining whether to make such payments. Incentive payments shall not be taken into consideration when calculating payments otherwise made under the ACO provision. In most instances, beneficiaries will not necessarily know that they are part of an ACO, as the process is designed to be passive or benign to the beneficiary. Of course, beneficiaries remain free to change doctors or physician practices for any reason.

As the ACO program has been rolled out, concerns have been raised about the adequacy of the ACO networks. Even so, ACOs have been acquiring provider networks, physician practices, etc. Accordingly, the general scope of ACOs is likely to be suffi-

---

206 ACA § 3022.
207 ACA § 3022(b).
208 ACA § 3022(b)(3).
209 Id.
210 In addition to the ACA, ACOs exist in a variety of settings and are found in many states. See interactive map of innovation models by state, including ACOs, http://innovation.cms.gov/initiatives/map/index.html (accessed Feb. 6, 2013). See also David Glass & Jeff Stensland, Accountable Care Organizations, MedPAC (Apr. 9, 2008), http://www.medpac.gov/transcripts/0408_ACO_public_pres.pdf. The Secretary is to determine an appropriate method to assign participating traditional Medicare beneficiaries to an ACO, based on their utilization of primary care services provided by an ACO professional. See ACA § 3022(c). Under the program, payments shall continue to be made to suppliers and providers of services participating in an ACO, and a participating ACO is eligible to receive payment for shared savings if the ACO meets quality performance and contracting standards set by the Secretary. See ACA § 3022(d). In addition, the Secretary may terminate an agreement with an ACO if it does not meet the Secretary’s quality performance standards. Likewise, the Secretary may waive civil money penalties for false claims and the criminal penalties for fraud under the Medicare program as may be necessary to carry out the MSSP. See ACA §§ 3022(d)–(f).
cient in most instances. Additional concerns have also been raised about how ACOs will pass along savings to their constituent member providers.\(^{213}\) Despite these challenges, there is some optimism that the ACO experiment will yield positive cost and quality results as borne out by early, non-statistically significant surveys of the results of ACOs are positive.\(^{214}\) In the main, the most positive aspects of the ACOs are the incentives to create efficiencies, including care coordination.\(^{215}\)

C. The Independent Payment Advisory Board (IPAB) and the ACA

As a cost-containment measure, the ACA created a new entity, the Independent Payment Advisory Board (IPAB).\(^{216}\) IPAB is charged with making recommendations to limit the growth of Medicare costs beginning in 2014.\(^{217}\) The Secretary will adopt these recommendations unless Congress takes action.\(^{218}\) The IPAB does not have authority to change Medicare’s eligibility and benefit structures.\(^{219}\) Even so, there is concern that IPAB recommendations might result in changes that create barriers to receiving needed health care. Moreover, there is the additional concern that the IPAB approach may usurp the traditional function of the Congress to set Medicare spending policy.\(^{220}\) IPAB and other changes made by the ACA are designed to reduce Medicare spending and emphasize paying for quality care.

There has been a great deal of controversy in the media about the role and function of IPAB as a policymaking and cost-containment body.\(^{221}\) The IPAB is a 15-member board of health care experts, including physicians and representatives of consumers and the el-


\(^{214}\) Richard B. Salmon et al., *A Collaborative Account Care Model in Three Practices Showed Promising Early Results on Costs and Quality of Care*, 31 Health Affairs 2,379-2,387 (No. 11, 2012) (reporting on the promise showed by private insurance ACO models, which adopted the ACO model following the Medicare test pilots).


\(^{216}\) ACA § 3403 et seq.

\(^{217}\) ACA § 3403(c)(1)(B).

\(^{218}\) ACA § 3403(d).

\(^{219}\) See ACA § 3403 et seq.


Its mission is to “reduce the per capita rate of growth in Medicare spending.” The IPAB is to accomplish this by making “recommendations to reduce the Medicare per capita growth rate to the extent required.”

IPAB members are appointed by the President with the advice and consent of the Senate. In choosing IPAB members, the President must consult with the majority and minority leaders of both Houses about the selection of members. Members may serve up to two full, consecutive terms. In addition, the President must appoint a Chairperson from among the board members. In addition to the representatives of consumers and the elderly on the IPAB board, there will be a consumer advisory council. The council will meet twice a year in Washington, D.C., and will advise the Board on the impact of payment policies on consumers, but will have not decisional power. It will have 10 members, one from each of the 10 Department of Health and Human Services (HHS) regions. Members will represent “the interests of consumers and particular communities.”

1. IPAB’s Duties

The IPAB was put in place to keep the growth of Medicare spending low. It is required to make recommendations on how to reduce spending if Medicare spending is

222 ACA § 3403(g)(1)(B), “(i) IN GENERAL.—The appointed membership of the Board shall include individuals with national recognition for their expertise in health finance and economics, actuarial science, health facility management, health plans and integrated delivery systems, reimbursement of health facilities, allopathic and osteopathic physicians, and other providers of health services, and other related fields, who provide a mix of different professionals, broad geographic representation, and a balance between urban and rural representatives. (ii) INCLUSION.—The appointed membership of the Board shall include (but not be limited to) physicians and other health professionals, experts in the area of pharmaco-economics or prescription drug benefit programs, employers, third-party payers, individuals skilled in the conduct and interpretation of biomedical, health services, and health economics research and expertise in outcomes and effectiveness research and technology assessment. Such membership shall also include representatives of consumers and the elderly.”

223 ACA § 3403.

224 Id.

225 ACA § 3403(g)(1)(A).

226 ACA § 3403(g)(1)(c). Each leader is consulted about the selection of three different board members. Id.

227 ACA § 3403(g)(2)(D).

228 ACA § 3403(g)(3). The Secretary of Health and Human Services, the Administrator of the Centers for Medicare & Medicaid Services, and the Administrator of the Health Resources and Services Administration will serve as non-voting members of the IPAB. See ACA § 3403(g)(1)(B). This also highlights one of the major differences between IPAB and MedPAC. As is made clear by the presence of the Secretary and Administrators of HHS, IPAB is a federal executive branch entity. MedPAC, in contrast, is an agency of Congress, which advises Congress on Medicare. Created by the BBA, MedPAC has a broad mandate to examine Medicare payment policies, Medicare Advantage plans, other issues, and reports by the Secretary. See BBA, Pub. Law 105-33, 111 § 4022(b) Stat. 251. This is a much broader mandate than the pure deficit-reduction focus of IPAB. MedPAC also can recommend anything, which IPAB cannot. See Rosenthal, et al, supra n. 16. See ACA § 3403(g)(1)(B).

229 ACA § 3403(k).

230 ACA § 3403(k)(1). The consumer advisory council will have no power over the IPAB, and exactly what kind of role it will play remains uncertain.

231 ACA § 3403(k)(2)(A).

232 ACA § 3403(k)(2)(B).
projected to exceed certain targets. In order to make a recommendation, the IPAB must achieve a quorum with a majority of appointed Board members present. In reaching decisions, all proposals must be approved by a majority of the appointed members present.

Each year, beginning in 2013 (the first “determination” year), the Chief Actuary of CMS must project what Medicare spending will be in two years, starting in the ‘implementation year’. If the projected spending exceeds the set target for the implementation year, IPAB must make recommendations to Congress about how to reduce spending to the target level. IPAB, on the other hand, cannot recommend certain kinds of changes, such as raising Medicare beneficiary premiums or restricting benefits.

The IPAB cannot include “any recommendation to ration health care, raise revenues, raise Medicare beneficiary premiums, increase Medicare beneficiary cost-sharing (including deductibles, coinsurance, and copayments), or otherwise restrict benefits or modify eligibility criteria.” Similarly, any recommendation that would result in an increase in Medicare spending over the first 10 years of the implantation year would not be included. Ultimately, IPAB can recommend changes to how the following programs are run: “Medicare Advantage, the Part D prescription drug program, skilled nursing facility, home health, dialysis, ambulance and ambulatory surgical center services, and durable medical equipment (DME).” IPAB is to consider how the recommendations will affect Medicare beneficiaries by making changes in payments to providers, the direct effect on providers, and the specific and special issue of dual-eligible beneficiaries.

IPAB cannot recommend any spending cut that exceeds the savings targets set by law. The savings target is a set percentage of the total projected Medicare spending.

---

233 ACA § 3403(b).
234 ACA § 3403(h)(2).
235 ACA § 3403(h)(5).
236 ACA § 3403(b)(1) (“by requiring the Chief Actuary of the Centers for Medicare & Medicaid Services to determine in each year to which this section applies (in this section referred to as ‘a determination year’) the projected per capita growth rate under Medicare for the second year following the determination year (in this section referred to as ‘an implementation year’”).
237 ACA § 3403(c)(2)(A)(i).
238 ACA § 3403(c)(2)(A)(ii). The full list of restrictions is “any recommendation to ration health care, raise revenues or Medicare beneficiary premiums under section 1818, 1818A, or 1839, increase Medicare beneficiary cost-sharing (including deductibles, coinsurance, and copayments), or otherwise restrict benefits or modify eligibility criteria.” ACA § 3403(c)(2)(A)(iii) prohibits, as of 2018, “any recommendation that would reduce payment rates for items and services furnished, prior to December 31, 2019, by providers of services (as defined in section 1861(u)) and suppliers (as defined in section 1861(d)) scheduled, pursuant to the amendments made by section 3401 of the ACA, to receive a reduction to the inflationary payment updates of such providers of services and suppliers in excess of a reduction due to productivity in a year in which such recommendations would take effect.” Id.
239 ACA § 3403(c)(2)(A)(ii).
240 ACA § 3403(c)(2)(C).
242 ACA § 3403(c)(2)(B).
243 ACA § 3403(c)(7)(A).
for the implementation year. These caps would mean that IPAB could only recommend cuts to the program. Even so, only certain programs can be affected: Medicare Advantage; the Part D prescription drug program; skilled nursing facilities; home health; and other programs such as durable medical equipment, and hospice.

2. Congressional Control over IPAB

After drafting its recommendations, the IPAB must submit a draft copy of each recommendation to MedPAC. In September of a determination year, the IPAB must also submit its recommendations to the Secretary. Following that submission, on January 15 of the following year, the IPAB must submit the report to the President and to Congress. The report is to contain recommendations, explanations of and reasons for each recommendation, a legislative proposal version of the recommendations, and an actuarial opinion by the CMS Chief Actuary.

When the report is submitted to the Congress, a forthcoming legislative proposal must be introduced on the same day in both the House and Senate by the majority leaders or his or her designees. If Congress does not act on the recommendations of IPAB, on August 15 of the year in which IPAB makes recommendations, the Secretary must implement the IPAB proposal that was submitted to Congress and the President. Even so, the effect of the rules may be delayed until the beginning of the next year. Congress’ only remaining alternative is to discontinue the use of IPAB, but this requires a three-fifths majority of members. Specific procedural rules must be followed in doing so.

---

244 ACA § 3403(c)(7)(B).
247 Id.
248 Id.
249 Id.
250 MedPAC, supra n. 9.
251 ACA § 3403(c)(2)(D).
252 ACA § 3403(c)(2)(E).
253 ACA § 3403(c)(3)(A)(i).
254 ACA § 3403(c)(3)(B).
255 ACA § 3403(d)(1)(A). If a legislative proposal is not introduced by the leadership of the House and Senate, any member of the House or Senate may introduce the proposal based on IPAB recommendations. After introduction, the proposal must be referred to the relevant committees—Senate Finance, Senate Energy and Commerce, and House Ways and Means. The relevant committees must report on the proposal by April 1. Any amendments must meet the same criteria that IPAB recommendations must meet, unless voted for by three-fifths of the members. Senate debate is limited to 1 hour for the proposal and 30 minutes for each amendment, although the procedures for House debate are generally unregulated. See ACA §§ 3403(d)(1)(C)–(D).
256 ACA § 3403(e)(1). The Secretary may use the interim final rulemaking procedure. See ACA § 3403(d)(3)(D).
257 ACA § 3403(e)(2) (delaying the application of new rules until the next fiscal, calendar, or rate year following the August 15 implementation date).
258 ACA § 3403(f)(2)(F).
259 ACA § 3403(f).
3. What Might IPAB Do?

One of the more popular potential money-saving suggestions is allowing Medicare as a whole to negotiate the pricing of Part D drugs with pharmaceutical companies.\textsuperscript{260} This is unpopular with pharmaceutical companies and has not been seriously considered in Congress due to extensive lobbying.\textsuperscript{261} One estimate suggests that the savings for such a change would be $24 billion a year.\textsuperscript{262} This is far beyond the $11.5 billion savings target of the IPAB.\textsuperscript{263}

4. Concerns about IPAB Accountability

Other concerns have also been raised about IPAB, specifically the lack of political accountability for IPAB’s board members, lack of consumer protection during the recommendation-making process, and the speed with which IPAB recommendations must be made.\textsuperscript{264} Many physicians and providers are concerned about additional reductions in payment.\textsuperscript{265} No one has been nominated to the IPAB board and what concerns will be borne out by the actual reality of IPAB remain to be seen and should be closely watched.

D. The ACA and Quality Review Mechanisms

The ACA contains many congressionally mandated quality initiatives that emphasize establishing quality measurement mechanisms and paying only for those services and procedures that meet certain quality of care standards.\textsuperscript{266} Quality review mechanisms

\begin{footnotesize}


\textsuperscript{262} Nat’l Comm. to Preserve Soc. Sec. & Medicare, \textit{supra n. 260}.


are an important aspect of paying only for services of proven value.\textsuperscript{267} Enforcement of quality measures through payment constraints are believed to increase provider participation and adherence.\textsuperscript{268} An ongoing concern for all quality measures is the need to monitor the impact of such measures on beneficiary access to services.\textsuperscript{269}

1. Incentive Payments to Hospitals

Under the ACA, the Secretary is to establish a value-based purchasing program under which incentive payments are to be made to hospitals.\textsuperscript{270} Beneficiary advocates should follow value-based purchasing implementation carefully. In the main, advocates should be attuned to whether their clients are being admitted to various care settings appropriately, particularly hospitals. Health care providers are sensitive to variations in payment modalities.

Value-based purchasing incentives are to be in the form of a percentage add-on to the base operating Diagnostic Related Group (DRG) payment per discharge in each fiscal year.\textsuperscript{271} The program begins in fiscal year 2013 and applies to payments for hospital discharges occurring on or after October 1, 2012.\textsuperscript{272} Measures selected to qualify for incentive payments for fiscal year 2013 will cover the following five specific conditions: a) acute myocardial infarction; b) heart failure; c) pneumonia; d) surgery (as measured by the Surgical Care Improvement Project); and e) health-care-acquired infections.\textsuperscript{273} The program excludes any hospital that a) has not submitted the required data to the Secretary or b) has been cited by the Secretary for deficiencies that pose immediate jeopardy to the health or safety of patients, deficiencies for which no minimum number of measures apply for the performance period, or deficien-


\textsuperscript{268} Ctr. for Medicare Advocacy, supra n. 137.


\textsuperscript{270} See ACA § 3001. Note too that under ACA § 3006, the Secretary is to develop plans for a value-based purchasing program for skilled nursing facilities and home health and publish selected quality measures with respect to fiscal year 2014, including procedures for the public to review such data. The measures, to the extent feasible and practicable, must extend to all dimensions of quality and efficiency in skilled nursing facilities and hospices. In addition, the Secretary is to establish similar mechanisms for long-term care hospitals and inpatient rehabilitation hospitals. See ACA § 3004. Quality measurement mechanisms also are to be established for Prospective Payment Systems (PPS)-exempt cancer hospitals. See ACA § 3005.

\textsuperscript{271} \textit{Id.} ACA. In general, payment is bundled to reflect the amount of work involved in treating a patient with a particular diagnosis, including time, services, and provider expertise. See also MedPAC, supra n. 9.

\textsuperscript{272} ACA § 3005(3)(C).

\textsuperscript{273} ACA § 3001(a)(2)(B).
cies for which no minimum number of cases for the measures apply for the performance period under review. The Secretary is to conduct a study on the performance of the hospital value-based purchasing program, including a) ways to improve the program; b) ways to address unintended consequences; c) the appropriateness of the Medicare program’s sharing in any savings generated through the hospital value-based purchasing program; and d) any other area determined appropriate by the Secretary. The report to Congress of the study’s findings is due not later than January 1, 2016.

2. Limiting Payment for Hospital-Acquired Conditions

The ACA creates incentives for applicable hospitals that receive inpatient hospital service payments on the basis of prospective rates to reduce hospital-acquired conditions with respect to discharges occurring during fiscal year 2015 and subsequent fiscal years. The term “hospital-acquired condition” means a condition identified or determined by the Secretary that an individual acquires during a stay in an applicable hospital. An applicable hospital is one that is in the top quartile of hospitals relative to the national average of hospital-acquired conditions during the applicable period, as determined by the Secretary.

274 Id. The ACA also requires payment reduction to professionals, including allied health care providers, who do not comply with reporting requirements. For 2015, the penalty for failure to submit data is a reduction in payment to 98.5 percent of the fee-scheduled amount, and for 2016 and subsequent years, the penalty is a reduction to 88 percent of the fee-scheduled amount. See ACA § 3002.

275 ACA § 3001(a)(5)(A)(i)-(iv).

276 ACA § 3001(a)(5)(B). In addition, the Secretary is to establish an appeals process for eligible professionals to seek review of a determination that the professional did not satisfactorily submit data on quality measures as required. Reporting also can be accomplished through a maintenance of certification program operated by a specialty body of the American Board of Medical Specialties that meets certain criteria. The maintenance of certification provisions apply for years after 2010. The Secretary must develop a plan to integrate reporting on quality measures and Electronic Health Record (EHR) reporting related to the meaningful use of electronic health records. See ACA § 3002. Likewise, the Secretary must use claims data (and other data) to provide confidential reports to physicians (and, as determined appropriate by the Secretary, to groups of physicians) that measure the resources involved in furnishing care to individuals under the Medicare program. Beginning in 2012, the Secretary must provide reports to physicians that compare, as determined appropriate by the Secretary, patterns of resource use by an individual physician with patterns of use by other physicians. Id.

277 See ACA § 3008. Hospital-acquired infections are a subset of health-care-acquired infections.

278 Id. The amount of payment for such discharges during the fiscal year must be equal to 99 percent of the amount of payment that otherwise would apply. Id.

279 Id. Prior to fiscal year 2015 and in each subsequent fiscal year, the Secretary must provide confidential reports to applicable hospitals with respect to their hospital-acquired conditions and make information available to the public regarding these conditions. Information for the public will be posted on the Hospital Compare website. In addition, the Secretary must conduct a study on expanding the health-care-acquired conditions policy to other facilities under the Medicare program. The report, together with recommendations, is to be submitted to Congress not later than January 1, 2012. See ACA § 3008(a)(5).
3. A National Strategy to Improve Health Care Quality

As required by the ACA, the Secretary is tasked with establishing a national strategy to improve the delivery of health care services, patient health outcomes, and population health, through a transparent and collaborative process. The strategy is to be updated not less than annually. Any such update must include a review of short- and long-term goals prior to fiscal year 2015 and in each subsequent fiscal year, the Secretary must provide confidential reports to applicable hospitals with respect to their hospital-acquired conditions and make information available to the public regarding hospital-acquired conditions of each applicable hospital. Information for the public shall also be posted on the Hospital Compare Internet website. In addition, the Secretary must conduct a study on expanding the health-care-acquired conditions policy to other facilities under the Medicare program. The report, together with recommendations, is to be submitted to Congress not later than January 1, 2012.280

4. Interagency Work Group on Health Care Quality

As provided by the ACA, the President is charged with convening a working group to be known as the Interagency Working Group on Health Care Quality (referred to in this section as the “Working Group”).281 The goals of the Working Group are to achieve collaboration, cooperation, and consultation between federal departments and agencies with respect to developing and disseminating strategies, goals, models, and timetables that are consistent with the national priorities identified above.282

5. Quality Measure Development

The ACA provides that at least every three years, the Secretary, the Director of the Agency for Healthcare Research and Quality (AHRQ), and the Administrator of CMS must identify gaps where no quality measures exist.283 In addition, AHRQ is to identify existing quality measures that need improvement, updating, or expansion (consistent with the national strategy for health care quality, to the extent available) for use in Federal health programs.284 The Secretary must make available to the public on an Internet website a report on any gaps identified and the process used to make such identification.285

The ACA establishes that the quality measurement duties of AHRQ include obtain-
Medicare’s Future: Letting the Affordable Care Act Work, While Learning From the Past

Spring 2013

6. Health Information Technology

Health Information Technology (HIT) is an additional tool for improving individual care and the health care system overall. From the early 2000s, electronic medical records were seen as tools that could help the health care industry coordinate care, measure quality, and reduce medical errors. The most recent and direct legislation was the Health Information Technology for Economic and Clinical Health Act (HITECH) in 2009. HITECH was part of the Stimulus Bill of 2009 and was designed to incentivize the adoption of and meaningful use of electronic medical records. HITECH focuses on several different issues: development of interoperability standards, a voluntary certification process for HIT software and other products, and financial help and incentives to encourage providers to adopt HIT. The ACA reiterated this commitment to HIT development, augmenting HITECH with additional grants.

These investments are important because HIT provides one of the most widely agreed upon guarantees of improved quality of care and reduced health care costs. Potential benefits of HIT for individuals include increased care coordination, increased patient safety, and better management of chronic conditions. Studies have shown that

286 ACA § 3014.
287 Id. Other reporting and transparency obligations of the Secretary include a) not later than December 1 of each year, making available to the public a list of quality measures under consideration; b) not later than Feb. 1 of each year, transmitting to the Secretary the input of multi-stakeholder groups; c) not later than Mar. 1, 2012, and at least once every three years thereafter, conducting an assessment of the quality impact of the use of endorsed measures and making such assessments available to the public. See id.
288 See ACA § 3015. The Secretary may award grants or contracts for this purpose. Moreover, the Secretary must ensure that collection, aggregation, and analysis systems span an increasingly broad range of patient populations, providers, and geographic areas over time. The Secretary also must make available to the public, through standardized websites, performance information summarizing data on quality measures. Id.
292 Redhead, supra n. 289, at 10–1.
293 ACA § 1561.
HIT has the potential to slow the growth of health care expenditures by reducing hospital stays through increased patient safety, reducing administrative time spent collecting patient medical records, and more efficient use of diagnostic tools such as laboratory tests and medical imaging. A study of the Veterans Administration health programs suggested that $3.09 billion have been saved by investing heavily in HIT, which in turn created “reductions in unnecessary and redundant care, process efficiencies, and improvements in care quality.”

Despite the clear benefits, a shockingly high percentage of physicians and hospitals have chosen not to adopt electronic health records (EHRs): in 2009, only an estimated 78 percent of physician offices and 91 percent of hospitals had adopted EHRs. HITECH’s incentives programs, which benefit providers who adopt EHRs, will provide approximately $30 billion over nine years to Medicare and Medicaid providers. This has already drawn 115,000 professionals and about 1,000 hospitals in 2011 to sign agreements with regional centers for technical assistance. The case for HIT has become more widely recognized as important to improving care coordination, enhancing the measurement of quality of care, and fostering the reduction of medical errors.

7. Data Collection to Reduce Health Care Disparities

Effective March 23, 2012, the ACA requires the collection and reporting of certain data on race, ethnicity, sex, primary language, and disability status. The data collection and disaggregation will help address and reduce disparities faced by communities including lesbian, gay, bisexual and transgender (LGBT) Americans. In addition, the Secretary, at the request of the President, has identified agency-wide goals to address disparities and concerns among the LGBT community. Focusing on these issues in a systematic fashion may reduce overall Medicare program costs.

297 Colene M. Byrne et al., The Value from Investments in Health Information Technology at the U.S. Department of Veterans Affairs, 29 Health Affairs 629, 634 (2010).
299 Id. at 2.
300 Id. at 40–41.
301 See e.g. Pres.’s Council of Advisors on Sci. & Tech., Report to the President: Realizing the Full Potential of Health Information Technology to Improve Healthcare for Americans: The Path Forward (Dec. 2010), http://www.whitehouse.gov/sites/default/files/microsites/ostp/pcast-health-it-report.pdf.
302 ACA § 4302.
303 Id.
8. The Center for Medicare and Medicaid Innovation

A part of the strategy of the ACA is to create a host of synergistic mechanisms that would explore ways of program and service integration. A chief vehicle in this effort is the Center for Medicare and Medicaid Innovation (CMMI). The purpose of the CMMI “is to test innovative payment and service delivery models to reduce program expenditures under the applicable titles while preserving or enhancing the quality of care furnished to individuals.”306 In selecting models, CMMI is to give preference to models that also improve the coordination, quality, and efficiency of health care services furnished to “applicable individuals.”307 Applicable individuals are those who are entitled to or enrolled in benefits under Parts A or B of the Medicare program, who are eligible for medical assistance under a State Medicaid plan or waiver, or who meet the criteria of both programs.308

Under Phase I of its work, the CMMI is to test payment and service delivery models to determine the effect of applying such models to program expenditures under Medicare and Medicaid and the quality of care received by individuals receiving benefits under those programs.309 Selected models address a defined population for which evidence shows that there are deficits in care leading to poor clinical outcomes or potentially avoidable expenditures.310 Models may also include those that promote broad payment and practice reform in primary care, including: patient-centered medical home models for high-need applicable individuals, medical homes that address women’s unique health care needs, and models that transition primary care practice away from fee-for-service based reimbursement and toward comprehensive payment or salary-based payment.311

Delivery models are to support care coordination for applicable individuals who are chronically ill and at high risk of hospitalization.312 The models should operate through a health information technology-enabled provider network that includes care coordinators, a chronic disease registry, and home telehealth technology.313 Models may vary payment to physicians who order advanced diagnostic imaging services according to the physician’s adherence to appropriateness criteria for the ordering of such services, and models should include the use of medication therapy management services.314

Models for the delivery of care should also promote the establishment of community-based health teams to support small-practice medical homes.315 They may do so by assisting the primary care practitioner in chronic care management activities, including
patient self-management. Models should assist applicable individuals in making informed health care choices. This could be achieved by paying providers of services and suppliers for using patient decision-support tools, including tools that improve applicable individual and caregiver understanding of medical treatment options.

9. Preventive Services

The Medicare program, including many provisions in the ACA, has historically focused on using preventive care to cut costs to the overall population. With the BBA in 1997, Congress began an expansion of preventive benefits and services available through Medicare. In 2003, the MMA added additional preventive services and, in 2008, the MIPPA refined Medicare’s preventive services. Most recently, as discussed below, the ACA further expanded Medicare-covered preventive services and removed the co-pay for most of them.

Effective January 1, 2011, Medicare beneficiaries became entitled to an annual Wellness Visit that includes the development of a personalized prevention plan. The plan is based on an individualized health risk assessment prior to, or as part of, the visit with a health care professional (physician, health educator, registered dietician, or nutrition professional or a team of professionals). The Wellness Visit is not an annual physical, but should include the following: a) an assessment to establish or update medical and family history; list current providers and suppliers that are regularly involved in providing medical care to the individual; record height, weight, body mass index, blood pressure,
and other routine measurements; and indicate any cognitive impairment; and b) establish a screening schedule for the next five to 10 years.

In addition, beneficiaries are entitled to a one-time-only “Welcome to Medicare” Physical Exam. The “Welcome to Medicare” check-up or “initial physical examination” is available to beneficiaries once, within 12 months of their becoming covered under Medicare Part B. The exam consists of a physical examination, including measurement of height, weight, and blood pressure, and an electrocardiograph, with the goal of health promotion and disease detection. It also includes education, counseling, and referral with respect to screening and other preventive services, although it does not include clinical laboratory tests. Each beneficiary is entitled to only one “Welcome to Medicare” check-up.

The ACA eliminated cost sharing (such as deductibles and copayments) for most of the preventive services covered under Medicare, effective January 1, 2011. Some Medicare-covered preventive services, however, will continue to be subject to cost sharing. With the exception of hospice care, Medicare Advantage plans are required to provide all items and services that are covered under Medicare Parts A and B. Thus, Medicare Advantage plans are required to offer the new Annual Wellness Visit to their enrollees. Medicare Advantage plans are allowed to impose different cost sharing than Parts A and B, as long as the cost sharing is actuarially equivalent to cost sharing under traditional Medicare. While many Medicare Advantage plans have traditionally eliminated cost sharing for preventive benefits under their authority to offer an actuarially equivalent benefit package, some have not. CMS has issued regulations that prohibit plans from charging deductibles, copayments, or coinsurance for in-network Medicare-covered pre-

324 ACA § 4103, amending 42 U.S.C. § 1395x(s)(2), adding §§ 1395x(FF), 1395x(hhh).
325 42 U.S.C. § 1395x(hhh).
326 See 42 U.S.C. §§ 1395x(X), 1395x(hhh).
327 Id.
328 See 42 U.S.C. §§ 1395x(W), 1395x(ww).
331 See 75 Fed. Reg. 73169 et seq. (Nov. 29, 2010), amending 42 C.F.R. §§ 410.152, 410.160. Table 65 includes a complete list of codes for preventive services indicating whether the services are subject to cost-sharing starting in 2011. Such services include mammograms every 12 months for eligible beneficiaries age 40 and older; colorectal cancer screening, including flexible sigmoidoscopy or colonoscopy; cervical cancer screening, including a Pap smear and pelvic examination; cholesterol and other cardiovascular screenings; diabetes screening; medical nutrition therapy to help people manage diabetes or kidney disease; prostate cancer screening (for most codes); annual flu shot, pneumonia vaccine, and hepatitis B vaccine; bone mass measurement; abdominal aortic aneurysm screening; HIV screening for people who are at increased risk or who ask for the test; and smoking cessation counseling.
332 Id. The following services are subject to cost-sharing: digital rectal examination as part of prostate cancer screening, glaucoma screening, diabetes self-management training, and barium enemas as part of colorectal cancer screening. Id.
333 42 U.S.C. § 1395w-22(a); 42 C.F.R. § 422.101.
ventive services, as specified by CMS on an annual basis, effective January 2012.335

IV. THE NEXT SEVERAL YEARS

As discussed above, we are in the early stages of determining how to balance paying for quality of care and assuring beneficiary access to services with respect to Medicare. Now that the Obama Administration will be in place for another four years, it can be expected that implementation of the ACA will move forward with more deliberate speed and authority. Three aspects of ACA implementation, not specifically the focus of our main discussion, are particularly noteworthy in the near term.

A. The “Fiscal Cliff”

The nation is at a fiscal danger point with respect to sequestration and budget matters.336 While direct cuts to Medicare beneficiaries are exempted, structural changes in Medicare are anticipated and are viewed as elements for consideration in actions to bring our national budget into alignment.337 Raising the age of Medicare eligibility has been proposed, as has capping Medicare expenditures annually, and moving toward the use of vouchers and away from a defined benefit package.338 The consequence of such initiatives on beneficiaries is likely to be severe, particularly as many elderly people are experiencing declining incomes and resources.339

B. The Exchanges

Given the outcome of the 2012 presidential election, CMS is now set to move more deliberately toward getting health exchanges up and running by 2014.340 In the main, ex-

340 In late January 2013, the Dept. of Human Services began referring to health “exchanges” as “the Health Insurance Market Place.” See www.healthcare.gov/marketplace/about/index.html (accessed Jan. 25, 2013). States, on the other hand, continue to use the term exchanges, although some states have adopted state-specific names. The state of Oregon, for example, refers to its exchanges program as “Cover Oregon.” For a comprehensive review of federal activity toward the creation of exchanges, see Ctr. for Consumer Info. & Ins. Oversight (CCIIO), Affordable Insurance Exchanges, http://cciio.cms.gov/programs/
changes represent an insurance marketplace (either initiated by a state or group of states, the federal government, or the federal government in partnership with a state or states), in which citizens purchase health care insurance from preapproved vendors. These insurance vendors have agreed to the terms and conditions established by the Secretary, in consultation with relevant state and federal agencies, in particular the Departments of Treasury and Labor. Core conditions include a defined scope of benefits that are available without pre-existing condition limitations, prohibitions on capping the amount of benefits and services available, and assuring that a certain percentage of the insurance premium actually goes to providing coverage.

The agency’s ongoing task is to create and refine rules of operation, medical loss ratios, its notions about rates and costs, the ease of access and enrollment for users, complaint and appeals processes, beneficiary information, and the quality of the services provided. Similarly, states are in the throes of deciding whether to go forward with state exchanges. Moreover, private insurers and other business interests continue to ramp up in order to compete in the emerging market of exchanges.

C. Coordinating Services for Duals

Integrating services for persons eligible for Medicare and Medicaid (dual eligibles) is an ongoing part of CMS’s broader goal of providing a more focused effort at assuring that persons dually eligible for Medicare and Medicaid are not marginalized in terms of

---

342 See CCIIO, supra n. 340.
access to services and modes of service delivery.\footnote{352}{See ACA § 3021.}

The nearly nine million Medicare beneficiaries who are also eligible for some form of Medicaid are the subjects of federal, state, and local policy discussions because many of them are among the highest users of health care services in the country and thus are very costly to both Medicare and Medicaid. Persons dually eligible for Medicare and Medicaid are the most vulnerable people in the health care system.\footnote{353}{Kaiser Fam. Found. Program on Medicare Policy, The Role of Medicare for the People Dually Eligible for Medicare and Medicaid (Jan. 2011), http://www.kff.org/medicare/upload/8138.pdf.} Research suggests that for many, care is fragmented, with multiple physicians prescribing medications and procedures without knowledge of or coordination with each other.\footnote{354}{See e.g. Melanie Bella & Lindsay Palmer, Encouraging Integrated Care for Dual Eligibles, Ctr. for Health Care Strategies (July 2009), http://www.chcs.org/usr_doc/Integrated_Care_Resource_Paper.pdf; James. M. Verdier, Coordinating and Improving Care for Dual Eligibles in Nursing Facilities: Current Obstacles and Pathways to Improvement, Mathematica Policy Research (Mar. 2010), http://www.mathematica-mpr.com/publications/pdfs/health/nursing_facility_dualeligibles.pdf; see also Kaiser Commn. on Medicaid & the Uninsured, Proposed Models to Integrate Medicare and Medicaid Benefits for Dual Eligibles: A Look at the 15 State Design Contracts Funded by CMS (Aug. 2011), http://www.kff.org/medicaid/upload/8215.pdf.}

This lack of coordination can lead to poor outcomes and higher costs when the care provided is unnecessary or duplicative.\footnote{355}{See Melanie Bella, Examining Medicare and Medicaid Coordination for Dual Eligibles, before the Special Committee on Aging, United States Senate, July 18, 2012, www.hhs.gov/asl/testify/2012/07/t20120718a.html.} While not unique to duals, lack of care coordination is a significant problem in our entire health care system and one that is the subject of many initiatives authorized in the ACA.\footnote{356}{See e.g. ACA §§ 2703, 3021, 3022, 3024.} It takes on heightened importance in the context of dual eligible persons because, as a group, they are significantly more likely than other Medicare beneficiaries to have multiple chronic conditions, limitations with activities of daily living, and cognitive impairments.\footnote{357}{MedPAC, supra n. 9, ch. 3.}

The ACA, with its significant funding for innovations in serving persons dually eligible for Medicare and Medicaid, through the Medicare-Medicaid Coordination Office and Innovation Center, has spurred a number of states to propose innovative delivery approaches for testing.\footnote{358}{See ACA § 3021(f)(A) ($5 million for design, implementation, and evaluation of models in fiscal year 2010); ACA § 3021(f)(B) ($10 billion for activities initiated by the Innovations Center during fiscal years 2011 through 2019); see also Kaiser Commn. on Medicaid & the Uninsured, supra n. 354. Similarly, private health plan activities are under way to build on the approaches for duals integration contemplated by the ACA. See e.g. InsideHealthPolicy.com, AHIP Duals Plan Builds on CMS Steps While Seeking Legislation for New Program (Oct. 12, 2011), http://insidehealthpolicy.com/Inside-Health-General/Public-Content/ahip-duals-plan-builds-on-cms-steps-while-seeking-legislation-for-new-program/menu-id-869.html.}

Thirty-seven states are planning to participate in dual eligible initiatives, including but not limited to private managed care.\footnote{359}{See Katherine Jett Hayes, Update: Financial Alignment Demonstrations for Dual Eligible Individuals, HealthReformGPS (July 18, 2012), http://healthreformgps.org/resources/update-financial-alignment-demonstrations-for-dual-eligible-individuals; see also InsideHealthPolicy.com, supra n. 358.} Fifteen states are already...
developing new models of care for persons dually eligible for Medicare and Medicaid under contract with the CMS Innovation Center.\textsuperscript{360} It is important that any further legislation to extend options for duals is written broadly to allow for a variety of models and approaches.\textsuperscript{361}

V. TYING UP LOOSE ENDS

As we have shown above, Medicare has never been without controversy and the enactment of the ACA and the continuing arguments over the implementation of the ACA show that controversy will likely continue. However, what the ACA has provided to Medicare is a modified mandate — not only the mandate for access to health care that was passed by the Johnson Administration after decades of advocacy, but also a mandate for a higher quality of care as a method to reduce costs without harming beneficiaries.

We think that the next phase is to let the tools of the ACA work. Our suggestion is tinged with the recognition that our various health policies must address a broad and diverse population with myriad health concerns.\textsuperscript{362} We argue, however, that Medicare remains a core element of how to reduce overall health care costs. As the largest payer of health care costs, Medicare’s structure, payment rules, and scope of benefits and services have a significant impact on the policies and practices of other health care providers and insurers.\textsuperscript{363} The use of ACOs, IPAB, and the other cost-containment ideas from the ACA will influence (and in some cases already has) the entire health care market to improve quality.\textsuperscript{364}

Over the next several years, getting the health exchanges right, integrating services for persons dually eligible for Medicare and Medicaid, holding down Medicare costs while providing necessary services are all part of the complex and on-going effort to bring affordable health care to as many people as possible. It is a tough challenge, but doable, especially since much of the infrastructure of Medicare and its improvements from the ACA is already oriented to meet such challenges.

As to Mrs. P, her concerns are legitimate. As described throughout this article, the debate over how health care should be provided and paid for (including notions of social insurance), as well as emerging debates about what constitutes quality health care, has been going on for over a century. We expect that these debates will continue. Hopefully, our Mrs. P now has a background in the conflicting perspectives and issues. Furthermore,

\begin{itemize}
\item \textsuperscript{360} See Kaiser Commn. on Medicaid & the Uninsured, supra n. 354.
\item \textsuperscript{363} See Stuart Guterman et al., Using Medicare Payment Policy to Transform the Health System: A Framework for Improving Performance, 28 Health Affairs w238 (2009), http://content.healthaffairs.org/content/28/2/w238.full.
\item \textsuperscript{364} Salmon et al., supra n. 214.
\end{itemize}
we hope that she will be able to live with a certain amount of uncertainty as our nation continues to grapple with developing and implementing policies and practices that promote health care access, affordability, and quality.

The ACA is a vast experiment in paying for high-quality health care while preserving the Medicare program and expanding access to health care for other population segments. In the main, the ACA, including the Medicare program, represents an important step toward further health and financial stability for many Americans. Cutting Medicare costs, assuring quality of care, getting the health exchanges up and running, and integrating services for persons dually eligible for Medicare and Medicaid represent ongoing challenges. As to spending and cost-containment challenges, Congress has put in place, through the ACA and other vehicles, a variety of important steps that overtime should at least slow the spending curve. Our “watch words” remain: “Let the ACA and other programs work.”