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Introduction

In the East Room of the White House on March 23, 2010, President Barack Obama signed the Patient Protection and Affordable Care Act (ACA),[1] as amended by the Health Care and Education Reconciliation Act of 2010.[2] At the signing ceremony, Democrats and citizens sat by as the president signed the bill with twenty-two pens. While signing, the president said:

> The bill I'm signing will set in motion reforms that generations of Americans have fought for and marched for and hungered to see.... Today we are affirming that essential truth, a truth every generation is called to rediscover for itself, that we are not a nation that scales back its aspirations.[3]

Not one Republican was present in the East Room that day. Indeed, the Republicans were as dismal as the Democrats were jubilant. Representative John A. Boehner, the House Republican leader, stated:

> This is a somber day for the American people.... By signing this bill, President Obama is abandoning our founding principle that government governs best when it governs closest to the people.[4]

Republicans vowed to repeal and replace the ACA at the earliest opportunity. Indeed, the Republican House of Representatives has voted repeatedly in recent years for repeal.

In 1965, Congress enacted, and President Lyndon Baines Johnson signed, the Social Security Amendments of 1965 establishing the Medicare and Medicaid

[1] Patient Protection and Affordable Care Act (ACA), Pub. L. No. 111–148, 124 Stat. 119 (2010).
[2] Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111–152, 124 Stat. 1029 (2010).
[3] Sheryl Gay Stolberg & Robert Pear, Obama Signs Health Care Overhaul Bill, with a Flourish, *New York Times* (Mar. 23, 2010 at A19).
[4] Ibid.

TABLE 1.1. *Pub. L. No. 111–148, Patient Protection and Affordable Care Act (ACA) (2010)*

Title I. Quality, Affordable Health Care for All Americans
Title II. The Role of Public Programs
Title III. Improving the Quality and Efficiency of Health Care
Title IV. Prevention of Chronic Disease and Improving Public Health
Title V. Health Care Workforce
Title VI. Transparency and Program Integrity
Title VII. Improving Access to Innovative Medical Therapies
Title VIII. Community Living Assistance Services and Supports Act (CLASS Act)
Title IX. Revenue Provisions
Title X. Strengthening Quality, Affordable Care

programs.[5] These programs provided publicly funded health insurance coverage for the elderly, and some poor. The inauguration of the Medicare and Medicaid programs transformed the federal role in health care by making the federal government responsible for paying for the health care of a significant portion of the U.S. population.

The ACA has ten titles, which contain a variety of programs to expand and improve health insurance coverage for the uninsured. The ACA has provisions to improve the health sector workforce as well as the public's health. At Table 1.1 is a list of the titles in the ACA containing the various health reforms. These reforms are also discussed in greater detail in Chapter 7 of this book. The ACA made many changes in the Medicare program as part of comprehensive reform for the health care sector of the United States.[6] These changes are contained primarily in Titles III and IV of the ACA. Title III contains measures to improve the quality and efficiency of Medicare services. Title IV contains measures to improve program integrity and transparency.

The central thesis of this book is that the reforms in Titles III and IV will do much to reduce expenditures in the Medicare program and thereby make the Medicare program sustainable over the long term. A second thesis is that the changes in Titles III and IV also position Medicare to become a single-payer system should the coverage expansions in the ACA fail or Congress and policy makers decide to establish a single-payer system. This book also looks to Canada and the United

[5] Social Security Amendments of 1965, Pub. L. No. 89–97, 79 Stat. 286 (1965) (codified as amended at 42 U.S.C. §§ 1395 & 1396).

[6] Medicare Provisions in PPACA (P.L. 111–148), Congressional Research Service, R41196 (Apr. 21, 2010). See Michael J. DeBoer, Medicare Coverage Policy and Decision Making, Preventive Services, and Comparative Effectiveness Research before and after the Affordable Care Act, 7 *Journal of Health & Biomedical Law* 493 (2012).

Kingdom for a comparison of the approaches to health reform in these countries that could inform the progress of health reform in the American Medicare program and the American health care sector.

The ACA is clear in one principle when it comes to the Medicare program: Nothing in the ACA is intended to compromise Medicare benefits for Medicare beneficiaries. Subtitle G of Title III of the ACA contains two provisions that establish this dominant principle. Section 3601 states:

> (a) PROTECTING GUARANTEED MEDICARE BENEFITS. – Nothing in the provisions of, or amendments made by, this Act shall result in a reduction of guaranteed benefits under title XVIII of the Social Security Act.
>
> (b) ENSURING THAT MEDICARE SAVINGS BENEFIT THE MEDICARE PROGRAM AND MEDICARE BENEFICIARIES. – Savings generated for the Medicare program under title XVIII of the Social Security Act under the provisions of, and amendments made by, this Act shall extend the solvency of the Medicare trust funds, reduce Medicare premiums and other cost-sharing for beneficiaries, and improve or expand guaranteed Medicare benefits and protect access to Medicare providers.[7]

Similarly, Section 3602 affirms that the ACA will not cut guaranteed benefits in Medicare Advantage plans: "Nothing in this Act shall result in the reduction or elimination of any benefits guaranteed by law to participants in Medicare Advantage plans."[8]

Whether the federal government can keep this promise over the long term is unclear. Many Republicans have vowed to change the program significantly in ways that would compromise this promise in the ACA. For example, Paul Ryan, the vice presidential candidate in Mitt Romney's 2012 presidential bid, proposed transforming Medicare into a voucher program in which seniors obtain vouchers to purchase health insurance on the private market.[9] Experts are in general agreement that over time – and without federal intervention to enhance the vouchers – the value of Medicare benefits would decline.[10]

But the major challenge to this promise is the large federal budget deficit and debt, as well as the contribution of Medicare program spending to this deficit and debt. Medicare program expenditures in fiscal year (FY) 2013 were $498 billion and along with Medicaid and the Children's Health Insurance program, constituted 22 percent of the federal budget for FY 2013.[11] In FY 2012, the federal budget deficit

[7] ACA § 3601.
[8] ACA § 3602.
[9] Paul Ryan, The Path to Prosperity: Blueprint for American Renewal, Fiscal Year 2013 Budget Resolution (2012), House Budget Committee (Mar. 20, 2012).
[10] See Paul N. Van de Water, Converting Medicare to Premium Support Would Likely Lead to Two-Tier Health Care System, Center on Budget and Policy Priorities (Sept. 26, 2011).
[11] Policy Basics: Where Do Our Federal Tax Dollars Go? Center on Budget and Policy Priorities (Revised Mar. 31, 2014).

was $11 trillion and payment on the federal debt was $220 billion, about 6 percent of the FY 2012 budget.

Medicare program spending has been increasing exponentially since the program's implementation in 1967, as will be discussed further in Chapter 4. If Medicare expenditures continue to increase and threaten the federal government's fundamental ability to address the federal budget deficit and other budgetary issues, it is unlikely that the promises in Sections 3601 and 3602 of the ACA will be met.

The authors of the ACA were clearly aware of the challenge of the future sustainability of the Medicare program, as were policy makers from both parties in the past. The central impetus for the reforms of the Medicare program in the ACA was to control Medicare expenditures and make the program sustainable over the long haul. Thus, the ACA has made many changes in the Medicare program as part of comprehensive health reform for the U.S. health care sector. These reforms in Medicare address the three major problems facing the Medicare program since its inception: (1) cost and volume inflation, (2) quality assurance and improvement, and (3) fraud and abuse. These ACA changes should have a dramatic impact on the reform of the American health care sector. The provisions of the ACA that will have the greatest impact generally are in Titles III and VI.

Historically, since its inception in 1965, the Medicare program has been at the forefront of crafting strategies to address the major problems of the health care sector with respect to controlling escalating costs and improving quality, as well as preventing and punishing fraud and abuse. State Medicaid programs and private payers are greatly influenced by the policy developments in the Medicare program and often follow Medicare policy. At the very least, the ACA reforms in Titles III and VI will be influential in promoting reform throughout the health care sector.

However, the possibility exists that the coverage expansions in the ACA will prove inefficient in providing accessible and affordable health care and that balkanization of health care coverage will thwart efforts to improve health on a population basis. In this event, a reformed Medicare program would be in an excellent position to expand into a national single-payer system that provides universal coverage. As a single-payer system, Medicare would confront the same problems of cost and volume control, quality and improvement, as well as fraud and abuse. To the extent that the ACA reforms move toward addressing these problems effectively, they enhance the possibility that Medicare will become a strong and sustainable single-payer system. A single payer also enhances the opportunities for adopting strategies to improve population health that would be inefficient for payers covering small sectors of the population to provide.

This book analyzes the ACA Medicare reforms in the following manner. Part I describes the Medicare program and efforts to reduce costs, improve quality, and prevent and punish fraud and abuse. Chapter 1 introduces the mission and major themes of this book. Chapter 2 provides an introduction to the Medicare program and describes its enactment, current design, and contributions. Chapter 3 explains the Medicare policy-making procedures as well as processes for appeals and judicial review of Medicare policies and decisions. Chapter 4 addresses the historic and current challenges that rising Medicare expenditures have posed for the Medicare program. Chapter 5 addresses the historic and current challenges facing the Medicare program as it endeavors to improve the quality of health care for Medicare beneficiaries. Chapter 6 addresses the regulatory regime to control fraud and abuse in the Medicare program.

Part II addresses the changes in the Medicare program under the ACA. Chapter 7 reviews the ACA and explains how the changes in the Medicare program relate to other reforms in the ACA. Chapter 8 provides an overview of the changes in Title III, Improving the Quality and Efficiency of Health Care. Chapter 9 presents the major payment reform initiative of Title III, Value-Based Purchasing of Health Care Services. Chapter 10 discusses the three major demonstration projects in Title III: (1) the Shared Savings Program, (2) the National Pilot Program on Payment Bundling, and (3) the demonstration of Community Health Teams to Support Medical Homes. Chapter 11 outlines the major changes in Title VI, Improving Transparency and Program Integrity. Chapter 12 presents the major initiative of Title IV, the Patient Center Outcomes Research Institute.

Part III considers the future of the Medicare program as well as the Medicare program in an international context. Chapter 13 reviews the impact of the ACA on the Medicare program and the American health care sector and explores the feasibility of Medicare as a single-payer system. As a single payer, the Medicare program could achieve some of the efficiencies and population health outcomes that countries with single-payer systems achieve more easily. Chapters 14, 15, and 16 compare the American Medicare program with the public health insurance programs of the United Kingdom and Canada. The purpose of the comparison is to explore approaches to reform that the United States could adopt if it were not so constrained by ideological differences among stakeholders.

Chapter 17 explains how, despite different ideological inspirations for public health insurance programs in these countries, their health policy has converged in the sense that they are using the same pragmatic strategies to address the common problems of cost, quality, and access. Chapter 17 states the centrist consensus on approaches to health reform in data-driven health care sectors.

Chapter 18 discusses the role of entrepreneurship in health reform as it plays a strong role in exacerbating the problems of the American health care sector. The health sectors of the United Kingdom and Canada have managed to control unproductive entrepreneurship more effectively. Chapter 18 closes with recommendations on how the American Medicare program might capture the productive entrepreneurship of the medical profession and other stakeholders to advance true health reform.

PART I

The Medicare Program

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The Medicare Program

The Medicare program provides the insurance for a significant portion of the U.S. population.[1] In 2013, Medicare provided insurance for 43.5 million people older than sixty-five years old and 9.8 million disabled or otherwise Medicare eligible for a total of 52.3 million people.[2] Thus, at least one-sixth of the U.S. population depends on the Medicare program. Total Medicare expenditures in 2013 were $582.9 billion.[3] Medicare expenditures constituted 15 percent of total federal outlays in 2010 and more than 3 percent of the nation's gross domestic product (GDP).[4] By size alone, Medicare is a tremendously important program to millions of people as well as the providers, manufacturers, and suppliers who serve them.

2.1. ENACTMENT OF THE MEDICARE PROGRAM

After World War II, President Harry Truman had submitted several proposals to Congress for a comprehensive health insurance plan for all Americans.[5] One of the

[1] This chapter contains material from Eleanor D. Kinney, *Protecting American Health Care Consumers* (Duke University Press, 2002); Eleanor D. Kinney, Medicare Beneficiary Appeal Processes in Eleanor D. Kinney, ed., *Guide to Medicare Coverage Decision-Making and Appeals* 65 (ABA, 2002); Eleanor D. Kinney, Medicare Coverage Decision-Making and Appeal Procedures: Can Process Meet the Challenge of New Medical Technology? 60 *Washington & Lee Law Review* 1461 (2003); Eleanor D. Kinney, Medicare Managed Care from the Beneficiary's Perspective, 26 *Seton Hall Law Review* 1163 (1996); Eleanor D. Kinney, National Coverage Policy under the Medicare Program: Problems and Proposals for Change, 32 *Saint Louis University Law Journal* 869 (1988).

[2] The Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, 7 (July 31, 2014); 2014 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds.

[3] Ibid.

[4] Lisa Potetz et al., Medicare Spending and Financing: A Primer, The Henry J. Kaiser Family Foundation 1–2 (Feb. 2011).

[5] Harry S. Truman Library & Museum, This Day in Truman History, November 19, 1945, President Truman's Proposed Health Program, http://www.trumanlibrary.org/anniversaries/healthprogram.htm.

major motivations for this initiative was his surprise and concern about the fitness of young American men to serve in combat in World War II. In his message to Congress on introducing the legislation, he stated:

> The people of the United States received a shock when the medical examinations conducted by the Selective Service System revealed the widespread physical and mental incapacity among the young people of our nation. We had had prior warnings from eminent medical authorities and from investigating committees. The statistics of the last war had shown the same condition. But the Selective Service System has brought it forcibly to our attention recently – in terms which all of us can understand.[6]

His message also stated, "Our new Economic Bill of Rights should mean health security for all, regardless of residence, station, or race – everywhere in the United States."[7] His proposal failed primarily as a result of lobbying by the American Medical Association (AMA), which spent more to defeat these proposals than had ever been spent in a lobbying effort.[8] (Of interest, President Johnson signed the Social Security Amendments of 1965 in Independence, Missouri, with President Truman in attendance. President Truman received the first Medicare card.)

During the Republican administration of President Dwight D. Eisenhower, few proposals for national health insurance or public health insurance for the elderly were seriously considered. In 1958, Congress considered several bills for national health insurance for the elderly and the Ways and Means Committee of the House of Representatives even held hearings.[9]

With the election of the Democratic president John Fitzgerald Kennedy in 1960, the landscape for passage of some kind of public health insurance program changed. In the early 1960s, at a time when the economy was experiencing its fourth recession since World War II, the problem of access to high-quality health care services for the aged was especially severe. Although the aged had a greater risk of illness and far lower income than other population groups, 56 percent had health insurance.[10]

Mindful that earlier efforts to enact national health insurance during the Truman administration had failed,[11] President Kennedy ran on a platform advocating health

[6] Special Message to the Congress Recommending a Comprehensive Health Program, Pub. Papers 192 (Nov. 19, 1945).
[7] Harry S. Truman Library & Museum, This Day in Truman History.
[8] Ibid.
[9] Wilbur J. Cohen & Robert M. Ball, Social Security Amendments of 1965: Summary and Legislative History, *Social Security Bulletin* 1 (1965).
[10] Marian Gornik et al., Twenty Years of Medicare and Medicaid: Covered Populations, Use of Benefits, and Program Expenditures, *Health Care Financing Review* 13, 14 (1985).
[11] See Karen S. Palmer, A Brief History: Universal Health Care Efforts in the US, Physicians for a National Health Program (1999), http://www.pnhp.org/facts/a-brief-history-universal-health-care-effots-in-the-us.