WOULD "MEDICARE FOR ALL" MEAN QUALITY FOR ALL? HOW PUBLIC-OPTION PRINCIPLES COULD REVERSE MEDICARE'S NEGATIVE IMPACT ON QUALITY

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Abstract

Medicare has had a negative impact on health care quality. By the time Congress created Medicare in 1965, research had demonstrated many U.S. physicians and hospitals were providing medical care that was so low-quality as to be dangerous to patients' health. Congress nonetheless incorporated into the new program features that ensured traditional Medicare would exacerbate existing quality problems. Research accordingly continued to document widespread quality problems, in particular those forms of low-quality care that traditional Medicare rewards with higher payments. Congress and Medicare administrators have resisted correcting these perverse incentives. Only in recent years has Congress attempted to emulate payment rules and quality-improvement tools private insurers have developed, though these efforts have had little if any effect. Congress can reverse Medicare's negative impact on quality by applying "public option" principles to Medicare, such that traditional Medicare and private insurers compete on as level a playing field as possible.

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Table of Contents

Introduction

There is a quality even meaner than outright ugliness or disorder, and this meaner quality is the dishonest mask of pretended order, achieved by ignoring or suppressing the real order that is struggling to exist and to be served.[1]

In terms of dollars, the traditional "fee for service" Medicare program is the largest purchaser of medical goods and services in the world.[2] It holds this distinction even though more than 40 percent of Medicare enrollees opt out of traditional Medicare in favor of Medicare Advantage plans,[3] where the federal government subsidizes

[1] JANE JACOBS, THE DEATH AND LIFE OF GREAT AMERICAN CITIES 15 (1961).

[2] Total outlays for traditional Medicare exceed health spending from all sources in all foreign countries except China, Japan, and Germany. In 2019, the most recent year for which there are comparable data, total Medicare outlays were $787 billion, of which traditional Medicare accounted for $417 billion, or 53 percent. (The remainder was payments to private plans under Medicare Advantage and the Part D prescription drug program.) MEDPAC, A DATA BOOK: HEALTH CARE SPENDING AND THE MEDICARE PROGRAM 14 (JULY 2021), https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/data-book/july2021_medpac_databook_sec.pdf. In purchasing power parity terms, China's national health expenditures totaled $1.3 trillion. *Global Health Expenditure Database*, WORLD HEALTH ORG., https://apps.who.int/nha/database/Select/Indicators/en. The single largest purchaser of medical care—government—accounted for $353 billion (28 percent). Hai Fang, *China*, COMMONWEALTH FUND (Jun. 5, 2020), https://www.commonwealthfund.org/international-health-policy-center/countries/china. Japan's national health expenditures were $582 billion. *Global Health Expenditure Database,* WORLD HEALTH ORG., https://apps.who.int/nha/database/Select/Indicators/en. Eighty-four percent, or $489 billion, came from insurance schemes—of which there are some 3,000. Ryozo Matsuda, *Japan*, COMMONWEALTH FUND (Jun. 5, 2020), https://www.commonwealthfund.org/international-health-policy-center/countries/japan; and Haruka Sakamoto et al., *Japan: Health System Review*, ASIA PACIFIC OBSERVATORY ON HEALTH SYSTEMS AND POLICIES, 43 (2018), https://apps.who.int/iris/bitstream/handle/10665/259941/9789290226260-eng.pdf ("Japan does not have a single insurance fund; insurers are divided into approximately 3000 organizations."). Germany's national health expenditures were $559 billion. *Global Health Expenditure Database,* WORLD HEALTH ORG., https://apps.who.int/nha/database/Select/Indicators/en. Government accounted for 74 percent, or $413 billion, of that spending. Moreover, the government divides those funds among insurance plans, including 109 sickness funds, who do the actual purchasing of medical care. Miriam Blümel and Reinhard Busse, *Germany*, COMMONWEALTH FUND (Jun. 5, 2020), https://www.commonwealthfund.org/international-health-policy-center/countries/germany; and authors' calculations. The next-highest spending nation was France, at $369 billion. *Global Health Expenditure Database,* WORLD HEALTH ORG., https://apps.who.int/nha/database/Select/Indicators/en.

[3] CMS, 2021 ANNUAL REPORT OF THE BOARDS OF TRUSTEES OF THE FEDERAL HOSPITAL INSURANCE AND FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUNDS 157 (2021),

private insurance companies who then purchase medical care for enrollees. All told, Medicare will spend approximately $797 billion taxpayer dollars[4] on behalf of 66 million enrollees[5] in 2022, or roughly $12,100 per enrollee.

Medicare has had a negative impact on health care quality. By the time Congress created Medicare in 1965, research had demonstrated many U.S. physicians and hospitals were providing medical care that was of such low-quality that it was dangerous to patients' health. Congress nonetheless incorporated into the new program two features that ensured traditional Medicare would exacerbate existing quality problems. The first was that traditional Medicare would directly subsidize health care providers according to a single set of payment rules. As we discuss in detail below, if a provider's failure to deliver preventive services or to prevent iatrogenic injury leads to a patient needing additional services, traditional Medicare's fee-for-service payment system often pays the provider more than if the provider had delivered higher-quality care. Purchasing medical care according to a single, one-size-fits-all set of payment rules rewards low-quality care and discourages many quality improvements, regardless of which particular rules the payer chooses. The second feature was an explicit prohibition on government officials working within Medicare's fee-for-service payment rules to improve quality.

As traditional Medicare grew to play a dominant role in the delivery of medical care, so did these perverse incentives. Research accordingly continued to document widespread quality problems, in particular, those forms of low-quality care traditional Medicare rewards with higher payments. For example, conventional estimates

https://www.cms.gov/files/document/2021-medicare-trustees-report.pdf (projecting 45 percent of enrollees will enroll in Medicare Advantage plans in 2022).

[4] Figure is the sum of $783 billion in projected spending net of offsetting receipts, such as enrollee premiums (CONG. BUDGET OFF., THE BUDGET AND ECONOMIC OUTLOOK: 2021 TO 2031 5 (2021), https://www.cbo.gov/system/files/2021-02/56970-Outlook.pdf) plus $14 billion in projected payments to Medicare Part D from state governments (CMS, 2021 ANNUAL REPORT OF THE BOARDS OF TRUSTEES OF THE FEDERAL HOSPITAL INSURANCE AND FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUNDS 111 (2021), https://www.cms.gov/files/document/2021-medicare-trustees-report.pdf).

[5] CMS, 2020 ANNUAL REPORT OF THE BOARDS OF TRUSTEES OF THE FEDERAL HOSPITAL INSURANCE AND FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUNDS 150 (2020), https://www.cms.gov/files/document/2020-medicare-trustees-report.pdf (enrollment figure).

suggest that preventable medical errors: are currently the third-leading cause of death in the United States;[6] cause roughly as many deaths each year as Covid-19 caused in 2020;[7] and exceed by an order of magnitude the number of preventable deaths due to uninsurance.[8] In addition, non-lethal harm from medical errors "seems to be 10- to 20-fold more common than lethal harm."[9]

Historically, Congress and Medicare administrators have resisted correcting these perverse incentives. Only in recent years has Congress made even marginal attempts to have traditional Medicare emulate payment rules and quality-improvement tools that Medicare Advantage plans and other private insurers have developed, though these efforts have had little, if any, effect. Researchers of various political stripes have concluded Medicare's attitude toward quality improvement ranges from indifferent to hostile.[10]

Others regard traditional Medicare as a model for reform. In the 2020 presidential campaign, U.S. Sens. Bernie Sanders (I-VT) and Elizabeth Warren (D-MA) proposed to enroll all 330 million U.S.

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[6] Since 1999, estimates of the number of patients who die each year in the United States from preventable medical errors have ranged from 98,000, LINDA T. KOHN ET AL., TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM 26 (2000), to 251,000, Martin A. Makary & Michael Daniel, *Medical error—the third leading cause of death in the US*, 353 BMJ 1, 5 (May 3, 2016), https://www.bmj.com/content/353/bmj.i2139, to 400,000, John T. James, *A New, Evidence-based Estimate of Patient Harms Associated with Hospital Care*, 9 J. PATIENT SAFETY 122 (Sept. 2013), https://journals.lww.com/journalpatientsafety/Fulltext/2013/09000/A_New,_Evidence_based_Estimate_of_Patient_Harms.2.aspx. If even the middle estimate is correct, preventable medical errors kill more Americans than any other cause except heart disease and cancer. *See* CDC, DEATHS: FINAL DATA FOR 2017 29-34 (Jun. 24, 2019), https://www.cdc.gov/nchs/data/nvsr/nvsr68/nvsr68_09_tables-508.pdf.

[7] *Cf.* Farida B. Ahmad et al., *Provisional Mortality Data — United States, 2020*, 70 MMWR MORB. MORTAL. WKLY. REP. 519-22 (2021), https://www.cdc.gov/mmwr/volumes/70/wr/mm7014e1.htm ("COVID-19 was reported as the underlying cause of death or a contributing cause of death for an estimated 377,883…deaths" in 2020).

[8] *Cf.* Janice Hopkins Tanne, *More than 26,000 Americans die each year because of lack of health insurance*, 336 BMJ 849, 855 (Apr. 19, 2018), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2323087/pdf/bmj-336-7649-news-0855a.pdf (estimating 26,260 annual deaths of those aged 25 to 64 were due to being uninsured); and Andrew P. Wilper et al., *Health Insurance and Mortality in US Adults*, 99 AM. J. PUB. HEALTH 2289, 2292 (Dec. 2009), https://doi.org/10.2105/AJPH.2008.157685 (estimating 44,789 annual deaths in 2005 of those aged 18 to 64 were due to being uninsured).

[9] James, *supra* note 6.

[10] *See infra* Part I.D.

residents in traditional Medicare.[11] Sanders' and Warren's "Medicare for All" proposals would go so far as to eliminate all enrollee cost-sharing and to prohibit all private health insurance, including Medicare Advantage plans.[12] President Joe Biden (D) campaigned on smaller expansions of traditional Medicare, such as lowering the age of eligibility from 65 to 60 years[13] and allowing all Americans to enroll in "a public health insurance option like Medicare."[14] Biden's more limited expansions of traditional Medicare would leave consumers the choice of enrolling in private Medicare Advantage plans and/or certain private commercial health insurance plans.[15]

To date, scrutiny of proposals to expand Medicare has focused primarily on issues of cost and access.[16] Expanding traditional

[11] *See* Michael F. Cannon, *M4A Would Deliver Authoritarian, Unaffordable, Low-Quality Care*, CATO UNBOUND (Apr. 6, 2020), https://www.cato-unbound.org/2020/04/06/michael-f-cannon/m4a-would-deliver-authoritarian-unaffordable-low-quality-care.

[12] *Id.*

[13] Joe Biden, *Joe Biden Outlines New Steps to Ease Economic Burden on Working People*, MEDIUM (Apr. 9, 2020), https://medium.com/@JoeBiden/joe-biden-outlines-new-steps-to-ease-economic-burden-on-working-people-e3e121037322. Vice president Kamala Harris (D) initially endorsed abolishing all private insurance in favor of a single-payer Medicare program but moderated her position to match that of her running mate. *See* Robert Laszewski, *Kamala Harris Has Had Some Difficulty with the Health Care Issue*, FORBES (Aug. 15, 2020), https://www.forbes.com/sites/robertlaszewski2/2020/08/15/kamala-harris-has-had-some-difficulty-with-the-health-care-issue/#6c96f19c5cce ("So, in a few short months during 2019, Harris co-sponsored the Sanders' single-payer plan that would have completely eliminated private insurance, enthusiastically raised her hand in support of single-payer during a debate, the next day walked that back in a difficult to understand explanation of why she wouldn't entirely eliminate private insurance, and then proposed her own hybrid Medicare plan that would have eventually offered today's insurance company-run Medicare Advantage plans to everyone.").

[14] Joe Biden, *Health Care*, (2020), https://joebiden.com/healthcare/. Presidential candidate and former South Bend, Indiana mayor Pete Buttigieg (D) proposed to open "Medicare for all who want it." *See* Dylan Scott, *Pete Buttigieg's Medicare-for-all-who-want-it plan, explained*, Vox (Sept. 9, 2019), https://www.vox.com/2019/9/19/20872881/pete-buttigieg-2020-medicare-for-all; and Pete Buttigieg, *Pete Buttigieg: Here's a better way to do Medicare-for-all*, WASH. POST (Sept. 9, 2019), https://www.washingtonpost.com/opinions/2019/09/19/pete-buttigieg-heres-better-way-do-medicare-for-all/.

[15] *See generally* Biden, *supra* note 14.

[16] *See* Kenneth E. Thorpe, *An Analysis of Senator Sanders Single Payer Plan* (Jan. 27, 2016), https://www.healthcare-now.org/296831690-Kenneth-Thorpe-s-analysis-of-Bernie-Sanders-s-single-payer-proposal.pdf; John Holahan et al., *The Sanders Single-Payer Healthcare Plan: The Effect on National Health Expenditures*, URBAN INST. (2016), https://www.urban.org/sites/default/files/publication/80486/200785-The-Sanders-Single-Payer-Health-Care-Plan.pdf; Katie Keith & Timothy Jost, *Unpacking the Sanders Medicare-for-All Bill*, HEALTH AFF. BLOG (Sept. 14, 2017), https://www.healthaffairs.org/do/10.1377/hblog20170914.061996/full/; John Holahan & Linda J. Blumberg, *Estimating the Cost of a Single-Payer Plan*, URBAN INST. 1, 4 (Oct. 2018), https://www.urban.org/sites/default/files/publication/99151/estimating_the_cost_of_a_single-

Medicare, however, would have a negative impact on quality for the same reasons its creation did.[17] To the extent Congress enrolls more Americans in traditional Medicare, an increasing share of patients would receive medical care through a program with a five-decade history of rewarding low-quality care, discouraging high-quality care, and resisting efforts to improve quality or even to measure quality.

Rather than expand traditional Medicare, Congress should reverse the program's negative impact on quality. It can do so by applying traditionally Democratic "public option" principles to Medicare, such that traditional Medicare and private insurers compete on as level a playing field as possible.

This article proceeds as follows. Part I explains how traditional Medicare promotes low-quality care; furnishes evidence of low-quality care that researchers tie to the program's payment rules; offers expert assessments of traditional Medicare's negative impact on quality; and explains why the program resists quality improvement. Part II shows that despite considerable implementation costs, Medicare's belated forays into quality improvement—with a

payer_plan_0.pdf; *see generally* CBO's Single-Payer Health Care Systems Team, *How CBO Analyzes the Costs of Proposals for Single-Payer Health Care Systems That Are Based on Medicare's Fee-for-Service Program* (Cong. Budget Off. Working Paper, Paper No. 2020-08, Dec. 2020), https://www.cbo.gov/system/files/2020-12/56811-Single-Payer.pdf.

[17] *Cf.* The nonpartisan Congressional Budget Office (CBO) concludes that, relative to the status quo, Medicare for All could cause quality to improve in some ways and deteriorate in others. Depending on benefit, price, and cost-sharing levels, a single-payer system could increase medical consumption by 4 percent to 12.7 percent over current law and "the health of some people might improve under a single-payer system if their use of care increased." CBO's Single-Payer Health Care Systems Team, *supra* note 16, at 164. On the other hand, such marginal care can be net harmful. *See* JOHN E. WENNBERG, TRACKING MEDICINE § 10 (2010); Michael E. Chernew & Joseph P. Newhouse, *What Does the RAND Health Insurance Experiment Tell Us about the Impact of Patient Cost Sharing on Health Outcomes?*, 14 AM. J. MANAGED CARE 412 (Jul. 2008), https://www.ajmc.com/view/jul08-3414p412-414, https://cdn.sanity.io/files/0vv8moc6/ajmc/5bb731b1bc58cd36695e9274807910e2fc1501ed.pdf/AJMC_08jul_Chernew_412to414_.pdf; and Robin Hanson, *Cut Medicine in Half*, CATO UNBOUND (Sept. 10, 2007), https://www.cato-unbound.org/2007/09/10/robin-hanson/cut-medicine-half. See David Goldhill, *How American Health Care Killed My Father*, THE ATLANTIC (Sept. 2009), https://www.theatlantic.com/magazine/archive/2009/09/how-american-health-care-killed-my-father/307617/, for a concrete example of how marginal care can be fatal. Medicare for All could also create shortages that leave some consumers with less access: "Increases in congestion in the health care system could result in poorer health outcomes if they caused beneficial care to be forgone or treatment of time-sensitive conditions to be delayed." CBO's Single-Payer Health Care Systems Team, *supra* note 16, at 74-75. The CBO ultimately concludes it "is unable to determine whether quality would improve or worsen under…single-payer options…in part because the ways in which quality would be monitored and reported are difficult to predict."

particular focus on the Patient Protection and Affordable Care Act's (ACA) quality-improvement initiatives—have had little if any positive impact on quality. Part III compares Medicare's quality-improvement efforts to those of private insurers. Part IV discusses how applying public-option principles to traditional Medicare offers a more reliable framework for promoting quality. Part VI concludes by placing this article's findings in the broader context of health reform.

I. Medicare's Negative Impact on Quality

Upon signing Medicare into law in 1965, President Lyndon B. Johnson (D) declared, "No longer will older Americans be denied the healing miracle of modern medicine."[18] Subsidizing medical care for the elderly fulfills, at best, half of that promise.[19] The other half requires ensuring the medical care Medicare purchases for enrollees is indeed a healing miracle.

Medicare has not delivered on that promise. If anything, it made existing quality problems worse. In this section, we discuss how Medicare's structure undermines quality improvement in two principal ways. First, at the behest of industry, Congress tied Medicare's considerable subsidies to a single set of fee-for-service payment rules.[20] Second, Congress and program administrators have

[18] Lyndon B. Johnson, 36th President of the U.S., *Remarks with President Truman at the Signing in Independence of the Medicare Bill* (Jul. 30, 1965) (transcript available online by Gerhard Peters & John T. Woolley, The American Presidency Project, UC SANTA BARBARA).

[19] *But see* Nancy Ochieng et al., *Medicare-Covered Older Adults Are Satisfied with Their Coverage, Have Similar Access to Care as Privately Insured Adults Ages 50 to 64, And Fewer Report Cost-Related Problems*, KAISER FAM. FOUND. (May 17, 2021), https://www.kff.org/report-section/medicare-covered-older-adults-are-satisfied-with-their-coverage-have-similar-access-to-care-as-privately-insured-adults-ages-50-to-64-issue-brief/ (finding many Medicare enrollees report needing medical care but not getting it because of cost); Hannah Nelson, *Cost-Sharing Burden Limits Access to Care for Medicare Members*, HEALTH PAYER INTELL. (Apr. 19, 2021), https://healthpayerintelligence.com/news/cost-sharing-burden-limits-access-to-care-for-medicare-members (Medicare enrollees just above the Medicaid-eligibility threshold receive 55 percent fewer outpatient services than Medicaid-eligible enrollees); and Jibby E. Kurichi et al., *Perceived Barriers to Healthcare and Receipt of Recommended Medical Care Among Elderly Medicare Beneficiaries*, 72 ARCH. GERONTOL. GERIATR. 45, 45-51 (Sept. 2017), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5522756/ (finding financial barriers within Medicare reduce access to highly effective care).

[20] Congress has adjusted traditional Medicare's payment rules and allowed limited competition from other payment rules, chiefly via the Medicare Advantage program. *See, e.g.*,

resisted using their plenary control over Medicare's payment systems to improve quality. We then show both that Medicare consistently pays for low-quality care, and that the academic literature ties much of that low-quality care to Medicare's features that encourage low-quality care. We close this section by examining why Medicare resists quality improvement.

A. The Siren Song of the Perfect Payment System

One consequence of the mind-boggling complexity of medicine is that no single method of paying providers is capable of rewarding all dimensions of quality. Promoting all dimensions of quality requires open competition on a level playing field between different payment rules. Heavily favoring just one method of payment predictably and persistently rewards certain forms of low-quality care and discourages improvement on those dimensions of quality. Whereas an alternative subsidy structure could have encouraged quality improvement, Congress' decision to tie traditional Medicare's subsidies to a single set of payment rules undermined quality improvement.

To illustrate how every method of paying health care providers encourages some dimensions of quality while discouraging others, consider fee-for-service payment, which pays providers a separate fee for each additional service. In some respects, fee-for-service payment promotes quality by offering patients a broad choice of providers and creating incentives for providers to offer patients all necessary services.

In other respects, fee-for-service promotes low-quality care. Fee-for-service encourages providers to deliver unnecessary services that offer little benefit to the patient and can result in harm.[21] When a provider's failure to deliver preventive services or to prevent

Thomas G. McGuire et al., *An Economic History of Medicare Part C*, 89 MILBANK Q. 289, 289-332 (Jun. 2011), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3117270/.

[21] *See, e.g.*, WENNBERG, *supra* note 17; and Kelsey Chalmers et al., *Adverse Events and Hospital-Acquired Conditions Associated With Potential Low-Value Care in Medicare Beneficiaries*, 2 JAMA HEALTH FORUM 1 (July 23, 2021), https://jamanetwork.com/journals/jama-health-forum/fullarticle/2782409 ("Patients with flagged, potential low-value procedures were harmed while in hospital, resulting in an extended length of stay and additional costs.").

iatrogenic injury leads to a patient requiring more services, fee-for-service rewards the provider with additional fees for those additional services. The nonpartisan, congressionally chartered Medicare Payment Advisory Commission (MedPAC) explains that Medicare's fee-for-service payment systems pay providers more "when complications occur as the result of error" and pay providers less when they prevent medical errors.[22]

As a result, fee-for-service payment creates disincentives for providers to invest in cost-saving preventive services or in processes that avoid misdiagnoses, iatrogenic injuries, medical errors, and other forms of low-quality care. Under fee-for-service, providers who invest in those quality-improvement measures end up worse off than providers who do not, due to the cost of developing and deploying those measures and to the fact that avoiding additional services means they collect less revenue. Fee-for-service payment thus discourages any quality improvements that reduce the volume or intensity of services. (For concrete examples, see Parts I.C. and I.D.) "The doctor who prevents the patient's costly medical problem or solves it quickly and inexpensively does not prosper in this model."[23]

Not all methods of paying providers operate this way. More than 100 years before Congress created Medicare,[24] markets developed other payment systems that reward quality improvements

[22] MEDPAC, REPORT TO THE CONGRESS: VARIATION AND INNOVATION IN MEDICARE 108 (June 2003).

[23] Alain C. Enthoven & Alan Glaseroff, *Bring Medicare Into the Twenty-First Century*, HEALTH AFF. BLOG (Aug. 16, 2012), https://www.healthaffairs.org/do/10.1377/hblog20120816.022170/full/.

[24] Jerome L. Schwartz, *Early History of Prepaid Medical Care Plans*, 39 BULL. HIST. MED. 450 (1965), https://www.jstor.org/stable/44449211?seq=1 ("prepaid hospital and medical plans have been functioning continuously in this country for over a hundred years"). *See also* PETER D. FOX & PETER R. KONGSTVEDT, THE ESSENTIALS OF MANAGED HEALTH CARE 2 (6th ed., 2013), http://samples.jbpub.com/9781284043259/Chapter1.pdf ("The Western Clinic in Tacoma, Washington, is often cited as the first example of a prepaid medical group practice. [It] started in 1910"); and George B. Moseley III, *The U.S. Health Care Non-System, 1908-2008*, 10 AMA J. ETHICS 324, 327 (2008), https://journalofethics.ama-assn.org/article/us-health-care-non-system-1908-2008/2008-05 ("In 1929, the Ross-Loos Medical Group had established a prepaid health plan that provided medical services to Los Angeles city and county employees for $1.50 a month…In 1945, the Kaiser Foundation Health Plan was founded to provide prepaid health benefits to workers in Kaiser shipyards…Yet from 1945 until the 1970s, these plans, which combined the financing and delivery functions of health care, were idiosyncratic players in the health care market.").

that fee-for-service payment discourages.[25] "Prepayment," or "capitation," pays providers a fixed fee per patient. Under this system, when a misdiagnosis, medical error, iatrogenic injury, or another type of low-quality care results in a patient requiring additional services, providers receive no additional payments. Prepayment internalizes those costs to the providers, in that providers themselves bear the cost of those additional services. Prepayment rewards providers who invest in cost-saving preventive services, and in processes that avoid misdiagnoses, medical errors, iatrogenic injuries, and other forms of low-quality care, because providers themselves keep the savings.

One result is that integrated, prepaid health systems perform well on dimensions of quality where fee-for-service is weak, and lead other providers to improve quality via competitive pressure and by generating new knowledge that other providers can use. Between 1992 and 1997, the prepaid health system Group Health Cooperative of Puget Sound implemented a blood-sugar-control program that improved the health of Type 2 diabetics and reduced the volume of services they required.[26] "During the last 4 years of the study, better glycemic control resulted in average cost savings [] of $685-$950 per patient per year."[27] Fee-for-service payment would have penalized these quality improvements.[28] Prepayment allowed Group Health to

[25] *See* Alain C. Enthoven & Michael F. Cannon, *Life-Saving Insurers*, AM. SPECTATOR (May 13, 2008), https://spectator.org/43641_life-saving-insurers/ ("Markets developed an antidote to this perverse incentive decades ago by creating arrangements that force hospitals and insurers to bear the financial costs of their own errors. In prepaid group practices like Kaiser Permanente, providers receive a fixed amount of money per patient. If an error leads to additional services, the added expense comes right out of Kaiser's bottom line.").

[26] *See* Edward H. Wagner et al., *Effect of Improved Glycemic Control on Health Care Costs and Utilization*, 285 JAMA 182 (Jan. 10, 2001), https://jamanetwork.com/journals/jama/fullarticle/193448.

[27] *Id.* at 186.

[28] INST. OF MED., CROSSING THE QUALITY CHASM: A NEW HEALTH SYSTEM FOR THE 21ST CENTURY 18 (2001) (explaining a similar glycemic-control program from the perspective of a physician group under fee-for-service: "The project was costly to the medical group in two ways. First, expenses to conduct the project, including extra clinical time for tighter management, fell to the physician group. Second, over time, as diabetic complication rates fell, the project would reduce patient visits and, thus revenues as well. The savings from avoided complications would fall to the insurer or a self-funded purchaser."). *See* Parts I.C. and I.D. for more examples of fee-for-service payment creating financial disincentives to improve quality. *See also* William B. Weeks & James P. Bagian, *Making the Business Case for Patient Safety*, 29 JOINT COMM'N J. QUAL. PATIENT SAFETY 51, 51–54 (2003), https://doi.org/10.1016/S1549-3741(03)29007-9 ("unless the hospital obtains the majority of its revenues through a capitated arrangement,

profit from them.[29] These incentives partly account for why prepaid health systems have been "the source of considerable research on quality of care, far more so than the . . . fee-for-service system."[30]

Like fee-for-service, prepayment also discourages some dimensions of quality. While fee-for-service payment allows patients a broader choice of providers, prepayment generally limits one's choices to providers that belong to the system that receives the capitated payment. Prepayment can also reward providers for withholding high-value services.

In hypothetically perfect markets, payment rules would not affect quality. Different payment systems would reward different dimensions of quality and each would generate new knowledge about how to meet patient needs. Competitive pressures would push all providers to emulate each other's quality improvements.[31] In even reasonably competitive markets, competition among different payment systems would drive providers to improve all dimensions of quality, even those their own payment rules discourage.[32]

Where regulation or government subsidies favor or punish particular payment systems, however, those interventions block both

economic benefits [of a patient-safety investment] are not likely to accrue to the hospital that made the investment.").

[29] *See generally* Wagner, *supra* note 26.

[30] FOX & KONGSTVEDT, *supra* note 24, at 33. *See also* Michael F. Cannon, *A Better Way to Generate and Use Comparative-Effectiveness Research*, 632 CATO INST. (Feb. 6, 2009), https://www.cato.org/sites/cato.org/files/pubs/pdf/pa632.pdf ("Prepayment ensures that if a health plan delivers low-or zero-value services, the cost comes directly out of the health plan's bottom line. [Prepaid group plans] therefore face enormous financial incentives to conduct research that will enable them to distinguish high-value from low-value services.").

[31] *Cf.* Kenneth Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 AM. ECON. REV. 941, 941-73 (1963), https://www.jstor.org/stable/1812044?seq=1 ("In hypothetically perfect markets these three forms of insurance [prepayment, indemnities according to a fixed schedule, and insurance against costs] would be equivalent.").

[32] On providers responding to competitive or other incentives to improve quality in ways their payment rules discourage, *see, e.g.*, Sheila Leatherman et al., *The Business Case For Quality: Case Studies And An Analysis*, 22 HEALTH AFF. 17, 17-30 (2003), https://www.healthaffairs.org/doi/10.1377/hlthaff.22.2.17 ("Despite inability to recoup costs in the short run, Group Health [Cooperative of Puget Sound] has remained committed to smoking cessation, with senior managers believing strongly in such (unmeasured) collateral benefits as institutional reputation, higher member retention, appeal to patients and employers, and employee pride."). *See also* Artemis March, *The Business Case for Tobacco Cessation Programs: A Case Study of Group Health Cooperative in Seattle*, COMMONWEALTH FUND 22, 38 (Apr. 2003), https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_fund_report_2003_mar_the_business_case_for_tobacco_cessation_programs__a_case_study_of_group_health_cooperative_in_seattl_march_bcs_tobaccocessation_614_pdf.pdf.

the generation of new knowledge about how to improve quality and the competitive pressures that would otherwise push providers to improve quality. In such an environment, the types of low-quality care the dominant payment system rewards persist longer than they would in a competitive market.

Such was the state of affairs in 1965, by which point decades of state and federal interventions had already distorted the market to the extent that fee-for-service was the dominant form of payment.[33] The result was that health care markets not only failed to eliminate but actively rewarded those forms of low-quality care that fee-for-service payment rewards.

Had Congress structured Medicare's subsidies as cash transfers, as it does with Social Security, Medicare might have had a salutary effect on quality. Such an approach would have created a large market of cost-conscious seniors who could have applied their subsidy to whatever health plans and payment systems they wished.

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[33] Government interventions—ranging from state licensing of clinicians to state licensing of health insurance plans to "corporate practice of medicine laws" to the tax exclusion for employer-paid premiums—have favored fee-for-service payment and blocked competition from prepaid health plans. *See, e.g.*, CHRISTY FORD CHAPIN, ENSURING AMERICA'S HEALTH: THE PUBLIC CREATION OF THE CORPORATE HEALTH CARE SYSTEM 20, 23, 24, 28 (2015) ("Prepaid doctor groups. . .drew the [American Medical Association's] ire and organized doctors worked fervently to destroy them," to the point that "many of these models would subsequently die out or become marginal players in health care, relegated to the status of 'alternative delivery' arrangements"; "state laws passed during the first decades of the twentieth century and certain articulations of licensing regulations prohibited 'the corporate practice of medicine.' After 1939, organized physicians convinced twenty-six state governments to pass additional laws regulating insurance to [favor fee-for-service and block prepaid groups] . . . Seventeen states effectively banned prepaid groups by requiring that insurance plans allow all area doctors to participate. Sixteen states obliged insurance organizations to obtain medical society approval"; "state and county medical societies continued rejecting applicants who participated in prepaid groups"; "Because of AMA influence over licensing boards and hospital administrators, association officials could often have a physician's medical license or hospital admitting privileges revoked if he transgressed [AMA] guidelines" against prepaid group practice; "numerous lesser-known enterprises folded under medical society pressure while would-be prepaid group organizers simply abandoned their aspirations"); Alain C. Enthoven, *What is an Integrated Health Care Financing and Delivery System (IDS)? and What must would-be IDS Accomplish to Become Competitive with them?*, 2 HEALTH ECON. OUTCOME RES. 1, 7 (2016), https://www.iomcworld.org/open-access/what-is-an-integrated-healthcarefinancing-anddelivery-system-idsand-what-must-wouldbe-ids-accomplish-to-become-competitive-with-heor-1000115.pdf ("Using every means they could—[including] political action—organized medicine fought to defend their traditional preferred model of fee-for-service"; "Exclusion of employer contributions to employee health insurance from the taxable incomes of employees" likewise favors fee-for-service payment); and Enthoven & Glaseroff, *supra* note 23 ("most employers lock their employees into traditional [fee-for-service] without a choice and without an opportunity to keep the savings if they choose a more economical system").

Medicare enrollees would have shopped for coverage (in part) on the basis of quality.[34] Demand for prepaid plans would have increased[35] and could have mitigated the quality-suppressing effects of prior government interventions that entrenched fee-for-service payment. The resulting competitive pressures could have pushed fee-for-service providers to improve on dimensions of quality where fee-for-service is weak. (In Part IV, we propose a cash-transfer approach could still do so today.)

Instead, Congress' decision to tie traditional Medicare's subsidies to a single set of fee-for-service payment rules increased the rewards to those forms of low-quality care, discouraged efforts to eradicate them, and caused poor-quality care to persist. The result has been a medical marketplace with drastically sub-optimal incentives to improve quality. One study estimated that hospitals inflict an average of $2,013 in injuries *per admission* yet bear only $238 (12 percent) of those costs themselves.[36] The remaining 88 percent of the financial costs of provider errors fell on "health insurers, disability insurance programs, and injured patients and their families."[37]

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[34] CONG. BUDGET OFF., A PREMIUM SUPPORT SYSTEM FOR MEDICARE: UPDATED ANALYSIS OF ILLUSTRATIVE OPTIONS 9 n.15 (Oct. 2017), https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53077-premiumsupport.pdf, ("On the basis of past research, CBO anticipates that in choosing plans, [Medicare] beneficiaries would consider additional characteristics beyond premiums, including a plan's quality, its reputation, or the providers included in its network").

[35] Enthoven, *supra* note 33 (entry by integrated, prepaid group plans "requires access to a large population" of individual consumers "who are offered a cost-conscious choice of plan").

[36] Michelle M. Mello et al., *Who Pays for Medical Errors? An Analysis of Adverse Event Costs, the Medical Liability System, and Incentives for Patient Safety Improvement*, 4 J. EMPIR. LEG. STUD. 835, 850 (2007), https://doi.org/10.1111/j.1740-1461.2007.00108.x (NB: the article's text and tables indicate, "On average, hospitals externalized 78 percent of the costs of all injuries," but the underlying figures indicate the ratio is 88 percent).

[37] *Id.* at 837. Many injury-related costs that hospitals externalize are due not to fee-for-service payment but to the medical malpractice system's failure to internalize those costs to the hospital. Such failures make robust competition from prepaid health systems more urgent because prepayment makes hospitals internalize injury-related costs even when the medical malpractice system fails to do so. *Cf.* Chunliu Zhan et al., *Medicare Payment For Selected Adverse Events: Building The Business Case For Investing In Patient Safety*, 25 HEALTH AFF. 1386–93 (2006), https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.25.5.1386 (hospitals internalized two-thirds of the costs of the follow-up care patients received after five types of adverse events, and externalized just one third of those costs to Medicare). This study "did not examine injury-related costs other than additional inpatient costs incurred during the initial hospitalization," however, such as "future medical expenses." For example, it did not examine the cost of readmissions to which patient-safety events are an important contributor. *See* Bernard Friedman et al., *Do Patient Safety Events Increase Readmissions?*, 47 MED. CARE 583, 583-90 (May 2009),

The second way Medicare undermined quality is by making no serious effort to use the market power it possesses to improve quality. From its inception, Medicare has shown more concern for the needs of the industry that produces low-quality care than for the taxpayers who subsidize such care or the patients who suffer from it. To placate physicians who opposed the legislation, Congress guaranteed the payment system Medicare used would be the one the physician lobby preferred—fee-for-service.[38] To placate the industry further, Congress included statutory language prohibiting government officials from exercising "any supervision or control over the practice of medicine or the manner in which [subsidized] medical services are provided."[39] That prohibition signaled that Medicare would make no serious effort to ensure the medical care it purchased would be a "healing miracle." What few quality-related provisions Congress included in the original statute proved ineffectual, such that Medicare "did little to improve the quality of care that the newly insured could receive."[40]

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https://journals.lww.com/lww-medicalcare/Abstract/2009/05000/Do_Patient_Safety_Events_Increase_Readmissions_.12.aspx ("The 3-month readmission rate was about 17% for those with no safety event, but about 25% when a safety event was recorded…Hospital readmissions are one way that safety events can have costly consequences.").

[38] TheLBJLibrary, *Excerpt: Joseph A. Califano, Jr. Reveals How LBJ Convinced Head of the AMA to Support Medicare*, YOUTUBE (Apr. 7, 2015), https://youtu.be/w5cQTZjj7Vo ("And so, we gave. We gave. We gave doctors their usual, customary, and ordinary fees."). The Medicare statute went so far as to ensure that even salaried physicians could bill Medicare separately for individual services. *See* Paul Starr, *The Health-Care Legacy of the Great Society, in* RESHAPING THE FEDERAL GOVERNMENT: THE POLICY AND MANAGEMENT LEGACIES OF THE JOHNSON YEARS 8 (2014), https://www.princeton.edu/~starr/articles/articles14/Starr_LBJ_HC_Legacy_1-2014.pdf ("Fulfilling a promise to the AMA, Mills insisted that hospital-based specialists such as pathologists, radiologists, and anesthesiologists, who were typically paid by salary at the time, instead be paid fee-for-service under Medicare Part B—a provision that led to the vast enrichment of those specialties in years to come.").

[39] Social Security Act § 1801, 42 U.S.C. § 1395. *See also* Rick Mayes, *The Origins, Development, and Passage of Medicare's Revolutionary Prospective Payment System*, 62 J. HIST. MED. ALLIED SCI. 21, 25 (2006), https://facultystaff.richmond.edu/~bmayes/pdf/JHMAS_Jan2006_RMayes.pdf (quoting President Johnson's Secretary of Health, Education, and Welfare Wilbur Cohen: "The sponsors of Medicare, including myself, had to concede in 1965 that there would be no real controls over hospitals and physicians. I was required to promise before the final vote in [committee] that the Federal agency [that operated Medicare] would exercise no control").

[40] Mark R. Chassin & Jerod M. Loeb, *The Ongoing Quality Improvement Journey: Next Stop, High Reliability*, 30 HEALTH AFF. 559, 559-68 (2011), https://www.healthaffairs.org/doi/10.1377/hlthaff.2011.0076.

Economics texts instruct that the inherent complexities of medical care bedevil market forces and "call for government policies to ensure that health care resources are allocated efficiently and equitably."[41] Medicare provides evidence of government's incompetence to navigate health care's complexities. If incentives matter, Medicare is responsible for countless misdiagnoses, medical errors, and iatrogenic injuries. Taking President Johnson's "healing miracle" pledge[42] as the standard of care, Congress and the Medicare program are guilty of gross negligence.

B. Evidence of Low-Quality Care within Medicare

It's not as if Congress wasn't aware of serious quality problems. By the time President Johnson spoke those words, researchers had identified ample evidence of the types of low-quality care that economic theory predicts would persist after decades of government intervention favoring fee-for-service payment.[43] For example:

- A 1952 report found surgeons frequently performed unnecessary hysterectomies, even on women in their twenties with no evidence of disease.[44]
- A study of family physicians in the 1950s concluded, "Despite being observed by internists as they saw patients, 45 percent of the doctors failed to meet minimum standards."[45]
- A 1958 study by the state of Michigan concluded, "Many hospitals are not properly using many of the techniques of

41 N. Gregory Mankiw, *The Economics of Healthcare* 2 (2017).

42 *See* Johnson, *supra* note 18.

43 *See generally* MICHAEL L. MILLENSON, DEMANDING MEDICAL EXCELLENCE: DOCTORS AND ACCOUNTABILITY IN THE INFORMATION AGE 150, 155-56 (1999); Lincoln E. Moses & Frederick Mosteller, *Institutional Differences in Postoperative Death Rates: Commentary on Some of the Findings of the National Halothane Study*, 203 JAMA 492, 492-4 (Feb 12, 1968), https://jamanetwork.com/journals/jama/article-abstract/337934; and Elihu M. Schimmel, *The Hazards of Hospitalization*, 60 ANNALS INTERN. MED. 100, 100-10 (1964), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1743667/pdf/v012p00058.pdf.

44 MILLENSON, *supra* note 43. *Cf.* MARTIN LOUIS GROSS, THE DOCTORS 7 (1966) (reporting the study graded "more than *60 percent* of the therapeutic treatment…as below acceptable medical standards").

45 MILLENSON, *supra* note 43.

quality control that have been devised…Direct control of quality by doctors and hospitals is not likely to reach full expression without external inducements."[46]

- A study of six common surgical conditions at 34 hospitals from 1959 through 1962 found 1,750 "excess deaths" from poor surgical techniques, a figure that implied 75,000 unnecessary deaths annually from such surgeries.[47]
- A 1964 study of a leading teaching hospital found "20 percent of the patients admitted to the medical wards experienced one or more untoward episodes" of "hospital-induced complications."[48] Using that study as a baseline, one researcher extrapolated that "doctor-caused iatrogenic disease" caused or contributed to the deaths of 100,000 hospital patients each year.[49]

Whereas prepayment would have imposed the financial costs of unnecessary hysterectomies and unsafe procedures on providers themselves, decades of government intervention enabled providers to pass those costs on to insurers and patients.

Medicare only enhanced their ability to do so. After Medicare took effect in 1966, researchers continued to identify widespread evidence of the forms of low-quality care that fee-for-service payment encourages—now in Medicare itself.

- In 1984, researchers estimated more than one in five hospitalizations of Medicare patients resulted in readmission.[50]

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[46] *Id.*

[47] *See* Moses & Mosteller, *supra* note 43; and MILLENSON, *supra* note 43.

[48] *See* Schimmel, *supra* note 43. The study measured harms that came from "acceptable diagnostic or therapeutic measures deliberately instituted in the hospital." It explicitly excluded medical errors, which would have pushed the rate of low-quality care higher.

[49] GROSS, *supra* note 44, at 238.

[50] Gerard F. Anderson & Earl P. Steinberg, *Hospital Readmissions in the Medicare Population*, 311 NEW ENG. J. MED. 1349, 1349-53 (1984), https://www.nejm.org/doi/full/10.1056/NEJM198411223112105. ("Twenty-two per cent of Medicare hospitalizations were followed by a readmission within 60 days of discharge…The recently enacted prospective-payment legislation, however, creates economic incentives that could increase readmission rates."). *See also* Stephen F. Jencks et al., *Rehospitalizations among Patients in the Medicare Fee-for-Service Program*, 384 NEW ENG. J. MED. 1418, 1418-28 (Apr. 9, 2009), https://www.nejm.org/doi/full/10.1056/nejmsa0803563.

- A 1990 study estimated avoidable hospital readmissions accounted for up to half of all readmissions for Medicare patients with congestive heart failure.[51]
- In the 1990s and 2000s, studies identified persistent underuse of highly effective, low-cost treatments among Medicare patients with acute myocardial infarction "even in the absence of discernible contraindications,"[52] and underuse of dozens of other effective treatments for more than a dozen various acute and chronic conditions.[53]

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[51] *See* Janice M. Vinson et al., *Early Readmission of Elderly Patients With Congestive Heart Failure*, 38 J. AM. GERIATR. SOC'Y 1290, 1290-95 (1990), https://agsjournals.onlinelibrary.wiley.com/doi/abs/10.1111/j.1532-5415.1990.tb03450.x.

[52] Edward F. Ellerbeck et al., *Quality of Care for Medicare Patients With Acute Myocardial Infarction: A Four-State Pilot Study From the Cooperative Cardiovascular Project*, 273 JAMA 1509, 1509-14 (1995), ("In cohorts of 'ideal candidates' for specific interventions, 83% received aspirin, 69% received thrombolytics, and 70% received heparin during the initial hospitalization; 77% received aspirin and 45% received β-blockers at discharge…many Medicare patients may not be ideal candidates for standard AMI therapies, but these treatments are under-used, even in the absence of discernible contraindications."); Harlan M. Krumholz et al., *Aspirin in the Treatment of Acute Myocardial Infarction in Elderly Medicare Beneficiaries: Patterns of Use and Outcomes*, 92 CIRC. 2841 (1995), https://www.ahajournals.org/doi/full/10.1161/01.CIR.92.10.2841 ("About one third of elderly patients with acute myocardial infarction who had no contraindications to aspirin therapy did not receive it within the first 2 days of hospitalization. The elderly patients with the highest risk of death were the least likely to receive aspirin. After adjustment for differences between the treatment groups, the use of aspirin was associated with 22% lower odds of 30-day mortality."). *See also* Thomas A. Marciniak et al., *Improving Quality of Care for Medicare Patients with Acute Myocardial Infarction: Results From the Cooperative Cardiovascular Project*, 279 JAMA 1351, 1351-7 (1998), https://jamanetwork.com/journals/jama/article-abstract/187491; and Gerald T. O'Connor et al., *Geographic Variation in the Treatment of Acute Myocardial Infarction: The Cooperative Cardiovascular Project*, 281 JAMA 627, 632 (1999), https://jamanetwork.com/journals/jama/fullarticle/188789 ("Substantial geographic variation exists in the treatment of patients with acute myocardial infarction, and these gaps between knowledge and practice have important consequences. Therapies with proven benefit for AMI are underused despite strong evidence that their use will result in better patient outcomes…It is undoubtedly true that some AMI patients experience unnecessary morbidity or mortality because they receive substandard medical care. This study finds that there is currently unrealized potential for more effective care of patients with AMI.").

[53] Steven M. Asch et al., *Measuring Underuse of Necessary Care Among Elderly Medicare Beneficiaries Using Inpatient and Outpatient Claims*, 284 JAMA 2325 (2000), https://jamanetwork.com/journals/jama/article-abstract/193249 ("For 16 of 40 necessary care indicators (including preventive care indicators), beneficiaries received the indicated care less than two thirds of the time. Of all indicators, African Americans scored significantly worse than whites on 16 and better on 2; residents of poverty areas scored significantly lower than nonresidents on 17 and higher on 1; residents of federally defined Health Professional Shortage Areas scored significantly lower than nonresidents on 16 and higher on none (P<.05 for all)."); Stephen F. Jencks et al., *Quality of Medical Care Delivered to Medicare Beneficiaries: A Profile at State and National Levels*, 284 JAMA 1670 (Oct. 4, 2000), https://jamanetwork.com/journals/jama/article-

- A 2003 study found Medicare fared poorly relative to the Veterans Health Administration on a series of quality indicators.[54]
- Perhaps most troubling, a 2008 study found no evidence that Medicare improved the health of enrollees.[55] Researchers found that from 1966 through 1975, while Medicare produced "a 40% decline in out of pocket spending for the top quartile of the [elderly] out of pocket spending distribution," it "had no discernible impact on elderly mortality."[56] Researchers estimated the reduction in the risk of out-of-pocket expenditures could justify at most only two-fifths of the total social cost of the program.[57]

The latter study casts doubt on the prospect that Medicare created benefits that offset its negative impact on quality and raises the

abstract/193138 ("Across all states for all measures, the percentage of [Medicare] patients receiving appropriate care in the median state ranged from a high of 95% (avoidance of sublingual nifedipine for patients with acute stroke) to a low of 11% (patients with pneumonia screened for pneumococcal immunization status before discharge). The median performance on an indicator is 69% (patients discharged with heart failure diagnosis who received angiotensin-converting enzyme inhibitors; diabetic patients having an eye examination in the last 2 years). Some states (particularly less populous states and those in the Northeast) consistently ranked high in relative performance while others (particularly more populous states and those in the Southeast) consistently ranked low."); Stephen F. Jencks et al., *Change in the Quality of Care Delivered to Medicare Beneficiaries, 1998-1999 to 2000-2001*, 289 JAMA 305 (Jan. 15, 2003), https://jamanetwork.com/journals/jama/fullarticle/195799 ("Care for Medicare fee-for-service plan beneficiaries improved substantially between 1998-1999 and 2000-2001, but a much larger opportunity remains for further improvement. Relative rankings among states changed little…Health care in the United States can be improved substantially, and even people with apparently good access to care receive care that falls far short of what it could be."); Elizabeth A. McGlynn et al., *The Quality of Health Care Delivered to Adults in the United States*, 348 NEW ENG. J. MED. 2635, 2635-45 (2003), https://www.nejm.org/doi/full/10.1056/nejmsa022615 ("Among elderly participants, only 64 percent had received or been offered a pneumococcal vaccine; nearly 10,000 deaths from pneumonia could be prevented annually by appropriate vaccinations… among elderly participants, only 15 percent had a note in any chart indicating that an influenza vaccination had been received, but 85 percent reported having received one").

[54] *See* Ashish K. Jha et al., *Effect of the Transformation of the Veterans Affairs Health Care System on the Quality of Care*, 348 NEW ENG. J. MED. 2218, 2218-27 (2003), https://www.nejm.org/doi/full/10.1056/NEJMsa021899.

[55] *See generally* Amy Finkelstein & Robin McKnight, *What did Medicare do? The initial impact of Medicare on mortality and out of pocket medical spending*, 92 J. PUB. ECON. 1644 (2008), https://www.sciencedirect.com/science/article/abs/pii/S0047272707001764 (original title: "What Did Medicare Do (And Was It Worth It)?").

[56] *Id.* at 1645, 1653, 1658.

[57] *Id.* at 1645.

question of whether expanding access to medical care for the elderly was worth the concessions Congress made to the health care industry.

C. Evidence of Medicare's Negative Impact on Quality

As evidence of low-quality care in Medicare has grown, researchers have tied these quality problems directly to Medicare favoring a single set of fee-for-service payment rules that inherently discourage many quality improvements.

- In 1995, Intermountain Health Care implemented new treatment guidelines that reduced pneumonia severity and mortality.[58] Since the guidelines also reduced the number and complexity of admissions, Medicare paid Intermountain *less* than it would have if Intermountain had allowed more patients to die.[59]
- In 1998 and 1999, the Duke Heart Failure Program used clinical teams, health coaches, and patient outreach (including regular telephone calls) to emphasize patient education, lifestyle changes, medication adherence, and follow-up visits for congestive heart failure (CHF) patients.[60] Clinic visits per patient-year increased from a median of 4.3 to 9.8.[61] β-Blocker use increased from 52 percent to 76 percent.[62] Hospitalizations per patient-year fell from a median of 1.5 to

[58] *See* Michael E. Porter & Elizabeth Olmsted Teisberg, *Intermountain Sanpete Pneumonia Hospitalizations*, *in* LEADERSHIP, STRATEGY, AND INNOVATIONS: HEALTH CARE COLLECTION (Nov. 10, 2015).

[59] *See id.*; INST. OF MED., *supra* note 28, at 17-18 (providing additional detail on the Intermountain experience and the deterrent effect perverse payment incentives can have on improving diabetes management); and Reed Abelson, *Medicare Says Bonuses Can Improve Hospital Care*, N.Y. TIMES (Nov. 15, 2005), https://www.nytimes.com/2005/11/15/business/medicare-says-bonuses-can-improve-hospital-care.html ("When Intermountain. . .improved care for its pneumonia patients by making sure they received the right drugs, it lost money because Medicare continues to pay less when patients have fewer complications and require less extensive care").

[60] *See generally* David J. Whellan et al., *The Benefit of Implementing a Heart Failure Disease Management Program*, 161 ARCH. INTERN MED. 2223 (2001), https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/649163.

[61] *Id.* at 2223, 2225.

[62] *Id.* at 2226.

zero.[63] The program cut the average cost of treating CHF patients nearly in half, by almost $8,600.[64] Duke University nevertheless shuttered the program because delivering higher-quality care at a lower cost meant lower payments from Medicare and other fee-for-service payers: "the healthier its patients were, the more money Duke lost. Ultimately, it decided that this program was unsustainable because the hospital was losing too much money by reducing readmissions and therefore opportunities for billable care."[65]

- A 2002 experiment in Bellingham and surrounding Whatcom County, Washington used electronic medical records and care coordinators to emphasize lower-cost preventive care and simplify the patient experience.[66] Across 600 participants, including Medicare enrollees, the program "improved or stabilized health status while reducing overall costs by $3,000 per patient."[67] The program "reduced doctor visits and medical complications. Patients with diabetes have lower glucose levels; those with congestive heart failure have remained stable rather than getting worse."[68] In a two-month period, "two nurses, seeing 70 patients, reported seven incidents in which they prevented costly options like calls to 911, emergency room visits and emergency visits to a doctor's office."[69] One patient reported her care coordinator "saved my life—twice."[70] Yet participating doctors stood to lose $2,000 a year or more due to the required investment in electronic medical records and because Medicare and other fee-for-

[63] *Id.* at 2224.

[64] *Id.* at 2223.

[65] Gary Wang, *Treating Congestive Heart Failure at Duke: A Case Study of Delivery and Payment Reform*, DUKE CTR. FOR PERSONALIZED HEALTH CARE (Mar. 21, 2017), https://dukepersonalizedhealth.org/2017/03/treating-congestive-heart-failure-duke-case-study-delivery-payment-reform/.

[66] *See* Bertha Safford, *Pursuing Perfection: Report from Whatcom County, Washington on Patient-Centered Care*, INST. FOR HEALTH IMPROVEMENT, http://www.ihi.org/resources/Pages/ImprovementStories/PursuingPerfectionReportfromWhatcomCountyWashingtononPatientCenteredCare.aspx (last visited Sept. 27, 2021).

[67] *Id.*

[68] Gina Kolata, *Health Plan That Cuts Costs Raises Doctors' Ire*, N.Y. TIMES (Aug. 11, 2004), http://www.nytimes.com/2004/08/11/health/11model.html.

[69] *Id.*

[70] *Id.*

service payers paid them less when higher-quality care avoided unnecessary physician visits.[71] The program ultimately shuttered.

- In 2009, Baylor Medical Center implemented a new post-discharge care program for heart-failure patients that cut readmissions in half with no increase in mortality.[72] As if to punish this quality improvement, Medicare paid Baylor an average of $227 less per heart-failure patient.[73]
- A 2013 study found that, on average, when a Medicare patient develops post-operative complications, hospitals nearly double their margins (revenue net of variable costs) from $1,880 to $3,629.[74] Conversely, investing in processes to reduce complications cuts a hospital's margin in half.
- A 2016 study found that after controlling for patient and hospital characteristics, "patients who had major surgery at high-quality hospitals cost Medicare less than those who had surgery at low-quality institutions."[75] Medicare paid low-quality hospitals an average of $2,698 more per patient, mostly because patients at low-quality hospitals required more post-acute care and readmissions.[76]
- A 2018 study found Medicare paid a large urban hospital system less when it prevented urinary-tract and bloodstream

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[71] *Id.*

[72] *See* Brett D. Stauffer et al., *Effectiveness and Cost of a Transitional Care Program for Heart Failure*, 171 ARCH. INTERN. MED. 1238 (July 25, 2011), https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/1105852?appId=scweb.

[73] *Id.*

[74] *See* Sunil Eappen et al., *Relationship Between Occurrence of Surgical Complications and Hospital Finances*, 309 JAMA 1599, 1600, 1602, 1604 (Apr. 17, 2013), https://jamanetwork.com/journals/jama/fullarticle/1679400 (The surgeries are "craniotomy, colorectal resection, total or partial hip replacement, knee arthroplasty, coronary artery bypass graft, spinal surgery (laminectomy, excision of intervertebral disk, or spinal fusion), hysterectomy (abdominal or vaginal), appendectomy, and cholecystectomy and common bile duct exploration.") ("Contribution margin, defined as revenue minus variable costs, describes the financial resources generated by hospital activities that are available to pay for a hospital's fixed costs. Hospital managers seeking to improve financial performance typically prioritize contribution margin when evaluating hospital activities. For hospitals with substantial unused capacity, which comprises the majority of US hospitals, any activity with a positive contribution margin is financially beneficial, regardless of total margin.").

[75] Thomas C. Tsai et al., *Better Patient Care at High-Quality Hospitals May Save Medicare Money and Bolster Episode-Based Payment Models*, 35(9) HEALTH AFF. 1681 (2016), https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.0361.

[76] *Id.* at 1686, 1688.

> infections, and more when it didn't. The additional payments to hospitals "reduce[d] their incentive to avoid complications."[77]
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> - A 2020 study of "elderly Medicare patients who present at the emergency room with respiratory conditions" found "the marginal hospital admission increases the number of hospital days by seven days and increases charges by $42,240, but has no effect on the risk of death," suggesting the existence of many profitable but low- or zero-quality admissions.[78]

Indeed, since at least 1973, researchers have documented that Medicare spends vast sums on low-value services.[79] By 2005, research on regional variations within Medicare demonstrated the program persistently rewards low-quality care:

> Medicare enrollees in regions with a high-intensity pattern of practice have slightly worse access to care, no better satisfaction with care, and receive lower-quality care than those in regions with the more conservative practice patterns . . . In other words, when comparing identical patients in high- and low-spending regions, those in high-spending regions spent more time in the hospital and saw more physicians (more frequently) but received lower-quality care and achieved worse health outcomes.[80]

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[77] Catherine Crawford Cohen et al., *Financial Incentives to Reduce Hospital-Acquired Infections Under Alternative Payment Agreements*, 39 INFECTION CONTROL HOSP. EPIDEMIOLOGY 509, 510 (2018), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6047523/ ("In many systems, including Medicare, extremely costly cases qualify for additional…payments. Under these arrangements, some costs of complications may be offset, and in extreme cases, hospitals may even profit, which reduces their incentive to avoid complications. In 2008, Medicare sought to address this situation…Empirical research suggests that this strategy has had limited effect on quality improvement, in part because the impact on payments has been limited.").

[78] Janet Currie & David Slusky, *Does the Marginal Hospitalization Save Lives? The Case of Respiratory Admissions for the Elderly* 1 (Nat'l Bureau of Econ. Rsch., Working Paper No. 26618, 2020), https://www.nber.org/papers/w26618.pdf.

[79] *See generally* John E. Wennberg & Alan Gittelsohn, *Small area variations in health care delivery*, 182 OPEN DARTMOUTH: PEER-REVIEWED ARTICLES BY DARTMOUTH FACULTY 1102 (Dec. 14, 1973), https://digitalcommons.dartmouth.edu/cgi/viewcontent.cgi?article=3596&context=facoa.

[80] Elliot Fisher, *More Care is Not Better Care: Regional differences show that spending more does not improve – and may hurt – patients. More accountability can help.*, NAT'L INST.

Among those worse outcomes were "a higher risk of death over time."[81]

Researchers estimate that, in effect, one out of every three dollars Medicare spends produces no benefit in terms of health or patient satisfaction.[82] For reference, spending on traditional Medicare reached roughly $417 billion in 2019.[83] The U.S. Food and Drug Administration's approval of the arguably ineffective but wildly expensive drug Aduhelm (aducanumab) for Alzheimer's patients raises the prospect of Medicare purchasing more low-quality care.[84]

Similarly, Congress discourages quality by imposing "community rating" price controls on Medicare Advantage plans. Community rating is a system of price controls that effectively penalizes plans for providing high-quality coverage to the sickest patients.[85] The threat of those implicit penalties pushes insurers to

FOR HEALTH CARE MGMT. (Jan. 2005), https://www.kff.org/wp-content/uploads/sites/2/2011/07/expertv7.pdf.

[81] *Id.*

[82] *Id.* ("We may be wasting perhaps 30% of U.S. health care spending on medical care that does not appear to improve our health.").

[83] *See* MEDPAC, JULY 2020 A DATA BOOK: HEALTH CARE SPENDING AND THE MEDICARE PROGRAM 4 (July 2020).

[84] Nicholas Bagley & Rachel Sachs, *The Drug That Could Break American Health Care*, THE ATLANTIC (June 11, 2021), https://www.theatlantic.com/ideas/archive/2021/06/aduhelm-drug-alzheimers-cost-medicare/619169/ ("[I]n 2020, Medicare spent about $90 billion on prescription drugs for 46 million Americans through the Part D program…We could wind up spending more than that for Aduhelm *alone*.") (emphasis in original). *See also* Paige Minemyer, *CMS Official Says Medicaid Must Cover Aduhelm as Industry Awaits National Coverage Decision*, FIERCE HEALTHCARE (Sept. 23, 2021), https://www.fiercehealthcare.com/payer/cms-says-medicaid-must-cover-aduhelm-as-industry-awaits-its-national-coverage-decision. *Cf.* Zachary Brennan, *Scoop: VA Decides against Adding Biogen's Aduhelm to Its Formulary as PBM Shuns Controversial Alzheimer's Drug*, ENDPOINTS NEWS (Aug. 12, 2010), https://endpts.com/exclusive-va-decides-against-adding-biogens-aduhelm-to-its-formulary-as-pbm-shuns-controversial-alzheimers-drug/ ("Aduhelm has been under constant fire since its approval, as two major health systems — the Cleveland Clinic and Mount Sinai — are now refusing to administer the drug, and as affiliates of Blue Cross Blue Shield are declining to cover it").

[85] On the negative impact community-rating price controls exert on quality, *see generally* Michael Geruso & Timothy Layton, *Selection in Health Insurance Markets and Its Policy Remedies* 4 (Nat'l Bureau of Econ. Rsch., Working Paper No. 23876, 2017), https://www.nber.org/system/files/working_papers/w23876/w23876dw23876w23876.pdf ("In a market [with community-rating price controls], all insurers may offer symmetrically poor coverage for classes of drugs like immunosuppressants to discourage such patients from joining their plans. Deviations from that strategy could yield the unhappy outcome for the insurer of cornering the market on these unprofitable patients…This dynamic could result in an inefficient equilibrium where all of the available insurance contracts provide too little coverage for

make Medicare Advantage plans less attractive to the sickest patients. Community rating rewards Medicare Advantage plans that take such steps as excluding from their networks higher-quality hospitals and nursing home facilities[86] and maintaining provider-network directories where half of listed providers are not in-network.[87]

Community-rating price controls may explain why "beneficiaries in poorer health disproportionately disenroll from [Medicare Advantage] to join [traditional Medicare]."[88] Medicare Advantage enrollees in their last year of life (a period when they are presumably very ill) switch to traditional Medicare at a rate two to three times higher than other Medicare Advantage enrollees.[89] Medicare Advantage enrollees who recently used high-cost services switch to traditional Medicare at a rate two to six times higher than

immunosuppressants.") and Michael F. Cannon, *Is ObamaCare Harming Quality? (Part 1)*, HEALTH AFF., (Jan. 4, 2018). Community-rating price controls also improve quality, albeit inefficiently, by leading insurers to provide coverage that cost-conscious enrollees would not be willing to purchase.

[86] *See* David J. Meyers et al., *Comparison of the Quality of Hospitals That Admit Medicare Advantage Patients vs Traditional Medicare* Patients, 3 JAMA NETWORK OPEN 1, 8-9 (Jan. 15, 2020) (showing that Medicare Advantage enrollees were less likely to be admitted to high-quality hospitals); *see also* David J. Meyers et al., *Medicare Advantage Enrollees More Likely To Enter Lower-Quality Nursing Homes Compared To Fee-For-Service Enrollees*, 37 HEALTH AFF. 78, 78-85 (Jan. 2018) (showing that Medicare Advantage enrollees were less likely to be admitted to high-quality nursing home facilities).

[87] Jack S. Resneck et al., *The Accuracy of Dermatology Network Physician Directories Posted by Medicare Advantage Health Plans in an Era of Narrow Networks*, 150 JAMA DERMATOL. 1290 (Oct. 29, 2014) ("Among 4754 total physician listings, 45.5% represented duplicates in the same plan directory. Among the remaining unique listings, 48.9% of physicians were reachable, accepted the listed plan, and offered an appointment for our fictitious patient…For 1 plan, our caller was unable to obtain an appointment with any listed dermatologist."); THE CTRS. FOR MEDICARE & MEDICAID SERVS., ONLINE PROVIDER DIRECTORY REVIEW REPORT 1 (Jan. 13, 2017), https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/Downloads/Provider_Directory_Review_Industry_Report_Final_01-13-17.pdf (reviewing online provider directories for one third of Medicare Advantage-participating insurers and finding "45.1% of provider directory locations listed in these online directories were inaccurate"); *see also* U.S. GOV'T ACCOUNTABILITY OFF., GAO-15-710, MEDICARE ADVANTAGE: ACTIONS NEEDED TO ENHANCE CMS OVERSIGHT OF PROVIDER NETWORK ADEQUACY 32 (Aug. 2015), https://www.gao.gov/assets/gao-15-710.pdf (Medicare "performs systematic reviews of network adequacy for only a small fraction of [Medicare Advantage] networks, relying on information that is supplied by [insurers] but is not fully checked for accuracy. For the vast majority of plans, [insurers] annually attest that they have an adequate network, and CMS accepts that statement without verification.").

[88] U.S. GOV'T ACCOUNTABILITY OFF., GAO-21-482, MEDICARE ADVANTAGE: BENEFICIARY DISENROLLMENTS TO FEE-FOR-SERVICE IN LAST YEAR OF LIFE INCREASE MEDICARE SPENDING 3 (Jun. 28, 2021), https://www.gao.gov/assets/gao-21-482.pdf.

[89] *Id.* at 15.

similar enrollees who switch in the opposite direction.[90] Researchers have found that the "family and friends of people who died while enrolled in Medicare Advantage reported lower quality of care in the last month of life compared with family and friends of those who died while enrolled in traditional Medicare."[91] (See Part IV.A.)

D. Expert Assessment of Medicare's Impact on Quality

Since at least 2003, MedPAC and others have issued repeated and increasingly stern warnings that traditional Medicare is harming quality.[92] In 2003, MedPAC reported:

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[90] Momotazur Rahman et al., *High-Cost Patients Had Substantial Rates Of Leaving Medicare Advantage And Joining Traditional Medicare*, 34 HEALTH AFF. 1675 (Oct. 2015), https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2015.0272 ("[t]he switching rate from 2010 to 2011 away from Medicare Advantage and to traditional Medicare exceeded the switching rate in the opposite direction for participants who used long-term nursing home care (17 percent versus 3 percent), short-term nursing home care (9 percent versus 4 percent), and home health care (8 percent versus 3 percent)").

[91] Claire K. Ankuda et al., *Family and Friend Perceptions of Quality of End-of-Life Care in Medicare Advantage vs Traditional Medicare*, 3 JAMA NETWORK OPEN 1 (Oct. 13, 2020), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2771443.

[92] Uwe E. Reinhardt, *The Medicare World From Both Sides: A Conversation with Tom Scully*, 22 HEALTH AFF. 167, 167-74 (2003), https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.22.6.167 (CMS administrator Tom Scully: "Every hospital gets the same payment for a hip replacement, regardless of quality…We are very good at fixing prices and paying quickly. But we have zero ability to monitor utilization or understand or differentiate payment based on quality."); MEDPAC, MARCH 2004 REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY xv, 31-2, 214 (Mar. 2004), ("[C]urrent payment systems are largely neutral or negative toward quality. It is crucial for the Medicare program to build incentives for improving quality into the payment systems."), ("Although the Medicare program is working to improve quality, current efforts are largely grafted onto a payment system that is neutral or negative toward quality. The Commission has concluded that it is crucial for the Medicare program to build incentives for improving quality into the payment system."), ("The Commission is concerned that current Medicare payment systems are neutral or sometimes even negative towards quality. Providers are paid the same regardless of the quality of their services and paid more if complications occur. Furthermore, the payment systems include no incentives for providers to coordinate care among sites or episodes of care. Health plans also are paid the same regardless of their quality."), ("Generally, the current payment system is neutral or negative toward quality and fails to financially reward plans or providers that improve quality."); MEDPAC, MARCH 2005 REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY 33, 184 (Mar. 2005), ("Medicare's payment systems are largely neutral or negative toward quality—differences in quality of services provided do not result in differences in payments."), (Medicare creates "few incentives for delivering high-quality care. Medicare, the largest single payer in the system, pays all of its health care providers without differentiation based on quality. Providers who improve quality are not rewarded for their efforts. In fact, Medicare often pays more when a serious illness or injury occurs or recurs while patients are under the system's care. The incentives of this system are neutral or negative toward improving the quality of care."); MEDPAC, JUNE 2006 REPORT TO THE CONGRESS: INCREASING THE VALUE OF MEDICARE xv, xvi, 105 (Jun. 2006), ("Medicare

> In the Medicare program, the payment system is largely neutral or negative towards quality. All providers meeting basic requirements are paid the same regardless of the quality of service provided. At times providers are paid even more when quality is worse, such as when complications occur as the result of error.[93]

Medicare "generally fails to financially reward higher-quality plans or providers"[94] because "plans and providers furnishing higher-quality care are paid no more than those furnishing lower-quality care. In fact, if a hospital reduces readmissions or complications, total payments might decrease."[95]As traditional Medicare entered its fifth

must increase the quality and value of the care it purchases."), (Medicare's "Fee-for-service payment systems…are barriers to care coordination among providers and to care management for beneficiaries with complex needs."), ("Most of Medicare's payments are neutral or negative toward quality."); MEDPAC, MARCH 2007 REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY 22-3 (Mar. 2007), ("Medicare's payment systems are neutral and sometimes negative toward quality, paying the same or more for lower quality care as for higher quality care…Medicare's [fee-for-service] payment systems do not provide incentives to coordinate care, which can lead to unnecessary care and sometimes even iatrogenic illness."), ("Fundamentally, the incentives of traditional Medicare pay providers more for furnishing more services, even when the services are of limited value."); MEDPAC, MARCH 2019 REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY 39, 57 (Mar. 2019), (encouraging Congress to "move the Medicare program beyond just blindly paying [fee-for-service] rates."), ("[H]istorically, Medicare payment systems have created little or no incentive for providers to spend additional resources on improving quality."); and MEDPAC, MARCH 2020 REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY xiii, 37 (Mar. 2020), ("The Commission recognizes…what have historically been fundamental problems with Medicare [fee-for-service] payment systems—that providers are paid more when they deliver more services, often without regard to the value of those additional services, and that payment systems seldom include incentives for providers to coordinate services across time and care settings."), ("Services that have been widely recognized as low value continue to be performed regularly" because Medicare continues to pay for them.).

93 MEDPAC, JUNE 2003 REPORT TO THE CONGRESS: VARIATION AND INNOVATION IN MEDICARE 108 (Jun. 2003).

94 *Id.* at xviii.

95 *Id.* at 110 ("[W]hen an entity makes improvements that decrease overall health care costs, often the resulting savings do not go to the entity that made the investment. If a physician group practice improves its protocols for managing diabetic patients, the result is often fewer hospitalizations. Yet, although the group practice invested the time and resources into improving care (without higher payments), the savings would go to the Medicare program. In addition to the lack of incentives to improve care within settings, payment on a [fee-for-service] basis does not support or encourage health care providers to work with each other and the patient to deliver high-quality care across settings and episodes of care. The payment system provides no reward for those providers who act on their own or with others to provide such care."). *See also* U.S. FED. TRADE COMM'N & U.S. DEP'T OF JUST., IMPROVING HEALTH CARE: A DOSE OF COMPETITION 30 (2004), https://www.ftc.gov/sites/default/files/documents/reports/improving-health-care-dose-

decade in 2006, MedPAC warned that these perverse incentives were affecting enrollee care:

> Evidence shows beneficiaries do not always receive the care they need, that too often the care they do get is not of high quality, and that in some places where they receive more care there are also poor outcomes…Patient safety also continues to present a troubling picture.[96]

In 2021, MedPAC found:

> [s]ubstantial use of low-value care among Medicare beneficiaries. Low-value care is…service that has little or no clinical benefit or . . . in which the risk of harm from the service outweighs its potential benefit…[L]ow-value care has the potential to harm patients by exposing them to risks of injury from inappropriate tests or procedures and can lead to a cascade of additional services.[97]

"Historically," traditional Medicare "has relied on providers to ensure that beneficiaries received high-quality care"[98]—even as it creates financial disincentives to improve quality and financial rewards for providing low-quality care.

Although some may categorize Medicare's posture toward quality as indifferent, "hostile" seems more accurate given that the program rewards providers for doing the *wrong* things and disables market forces that would otherwise improve quality.

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competition-report-federal-trade-commission-and-department-justice/040723healthcarerpt.pdf (statement of former Medicare administrator Tom Scully: "[Medicare pays] the exact same amount for hip replacement and the same amount for a heart bypass, if you're the best hospital or the worst hospital.").

96 MEDPAC, JUNE 2006 REPORT TO THE CONGRESS: VARIATION AND INNOVATION IN MEDICARE xv (Jun. 2006).

97 MEDPAC, MAR. 2021 REPORT TO THE CONGRESS: VARIATION AND INNOVATION IN MEDICARE 97, 113 (Mar. 2021), ("We estimate that, in 2018, between 22 percent and 36 percent of beneficiaries in traditional Medicare received at least one low-value service, and Medicare spending for these services ranged from $2.4 billion to $6.9 billion."). *Cf.* Fisher, *supra* note 80 ("We may be wasting perhaps 30% of U.S. health care spending [specifically, Medicare spending] on medical care that does not appear to improve our health.").

98 MEDPAC, JUNE 2003 REPORT TO THE CONGRESS: VARIATION AND INNOVATION IN MEDICARE 113 (June 2003).

E. Why Medicare Resists Quality Improvement

Medicare does not merely indulge poor-quality care. It actively resists quality improvement. Consider for a moment just how slow Congress is to address low-quality care. In 1968, Medicare's second year of operation, President Lyndon B. Johnson wrote to Congress: "I recommend that the Congress authorize the Secretary . . . to employ new methods of payment as they prove effective in providing high quality medical care more efficiently and at lower cost."[99] Nearly four decades later, in 2005, MedPAC was still requesting that Congress "give the Medicare program the ability to pay providers differentially based on performance."[100] In 2012, MedPAC recommended Medicare pay ambulatory surgical centers differentially based on quality. [101] As of March 2021, Medicare had yet to do so.

Medicare is slow to address quality problems, and its quality-improvement efforts have produced meager results (see below), because "political considerations make it extremely difficult . . . to make sustained headway."[102] Reforms that would differentially reward high-quality care typically represent a threat to the incomes of low-quality providers. Providers eagerly support quality-improvement measures that would increase their incomes and vigorously lobby to block any quality-improvement measures that might disrupt their revenue streams.[103]

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99 Lyndon B. Johnson, 36th President of the U.S., *Special Message to the Congress: Health in America* (Mar. 4, 1968) (transcript available online by Gerhard Peters & John T. Woolley, The American Presidency Project, UC SANTA BARBARA).

100 MEDPAC, MARCH 2005 REPORT TO THE CONGRESS: VARIATION AND INNOVATION IN MEDICARE 184 (Mar. 2005).

101 MEDPAC, MARCH 2021 REPORT TO THE CONGRESS: VARIATION AND INNOVATION IN MEDICARE 152 (Mar. 2021).

102 David A. Hyman, *Does Medicare Care about Quality?*, 46 PERSP. IN BIOLOGY MED. 55, 56 (2003), https://muse.jhu.edu/article/38641/pdf.

103 *See, e.g.*, David A. Asch et al., *Asymmetric Thinking about Return on Investment*, 374 NEW ENG. J. MED. 606, 606-8 (2016), https://www.nejm.org/doi/full/10.1056/NEJMp1512297 ("Some might argue that one reason that cancer care is reimbursed so heavily is the presence of the same kind of political pressure that led to prohibiting the Centers for Medicare and Medicaid Services (CMS) from considering cost in coverage determinations. Efforts to help chronically ill patients receive the right level of care [by keeping them out of the hospital] do not seem subject to the same pressures."); and Charles Lane, *Medicare reform's slow progress*, WASH. POST (Mar.

Improving quality within Medicare requires an act of Congress, which enables low-quality providers to block any serious quality-improvement efforts. As the late health economist Uwe Reinhardt explained, "Medicare is a large insurance company whose board of directors [Congress] accepts payments from vendors to the company."[104] The next section explains that this dynamic creates upside-down situations where even Medicare's quality-improvement programs pay low-quality providers more than high-quality providers, and award quality bonuses to low-quality hospitals and mediocre health plans.

II. Belated and Ineffectual Steps to Improve Quality

Despite the ACA's quality-improvement programs and other recent efforts, Medicare continues to discourage quality. Only in recent years has Congress even attempted to correct the perverse incentives Medicare creates that encourage low-quality care. In 2003, for example, Congress required Medicare-participating hospitals to report various quality indicators to the Inpatient Quality Reporting Program (IQRP).[105] Hospitals that did so received larger annual increases in Medicare payments and those that failed to do so received smaller increases.

In 2010, Congress passed the ACA, which created several programs that attempt to correct Medicare's payment incentives.[106] These programs include the "three H's": the Hospital Readmissions

4, 2013), https://www.washingtonpost.com/opinions/charles-lane-medicare-reforms-slow-progress/2013/03/04/9624c4c4-84f8-11e2-999e-5f8e0410cb9d_story.html ("One man's absurd waste of taxpayer funds, however, is another man's rice bowl.").

104 Ezra Klein, *Is the U.S. too corrupt for single-payer health care?*, WASH. POST (Jan. 16, 2014), https://www.washingtonpost.com/news/wonk/wp/2014/01/16/is-the-u-s-too-corrupt-for-single-payer-health-care/ (statement of Uwe Reinhardt: : "In the private market, that would get you into trouble.").

105 Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003, Pub. L. No. 108-173 § 501(b), 117 Stat. 2066 (2003).

106 J.B. Silvers, *The Affordable Care Act: Objectives and Likely Results in an Imperfect World,* 11 ANNALS FAM. MED. 402, 403-4 (2013), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3767707/; *see also* Patient Protection and Affordable Care Act (ACA), Pub. L. 111-148, 124 Stat. 119, (2010), https://www.congress.gov/bill/111th-congress/house-bill/3590/text.

Reduction Program (HRRP),[107] the Hospital Value-Based Purchasing Program (HVBP),[108] and the Hospital-Acquired Condition Reduction Program (HACRP).[109]

While they impose large compliance burdens, these programs have had little if any effect on quality. Even when they do coincide with improvements in quality metrics, it is unclear whether those gains resulted from those programs, other factors, or simply from providers gaming the system. The HVBP illustrates that even when Medicare attempts to improve quality, it rewards low-quality care while penalizing high-quality care.

A. Case Study: The Hospital Value-Based Purchasing Program

Hospital services are the largest category of health care spending in the United States, accounting for 31 percent of national health expenditures.[110] Medicare accounts for a quarter of all hospital spending.[111] Medicare's Inpatient Prospective Payment System (IPPS) generally pays hospitals a fixed fee per admission. The size of the fee is a function of the average resource use by Medicare patients with the same diagnosis at discharge.

MedPAC has explained that Medicare's system of paying hospitals a fixed fee per admission "gives providers incentives to deliver care [during each admission] more efficiently. Even so, providers . . . are still paid more for furnishing each additional bundle of services."[112] Paying hospitals on this basis creates incentives to maximize admissions, to maximize diagnoses, and to select the most

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[107] Patient Protection and Affordable Care Act, H.R. 3590, 111th Cong. § 3025 (2010), https://www.govinfo.gov/content/pkg/BILLS-111hr3590enr/pdf/BILLS-111hr3590enr.pdf.

[108] Patient Protection and Affordable Care Act (ACA), Pub. L. 111-148 § 1886(o), 124 Stat. 119 (2010).

[109] Patient Protection and Affordable Care Act (ACA), Pub. L. 111-148 § 1886(p), 124 Stat. 119 (2010).

[110] CMS, NATIONAL HEALTH EXPENDITURES 2020 HIGHLIGHTS, https://www.cms.gov/files/document/highlights.pdf (last visited Nov. 14, 2021).

[111] CMS, NATIONAL HEALTH EXPENDITURES BY TYPE OF SERVICE AND SOURCE OF FUNDS: CY 1960-2019, CMS (last updated Dec. 6, 2020), https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.

[112] MEDPAC, MARCH 2007 REPORT TO THE CONGRESS: VARIATION AND INNOVATION IN MEDICARE 23 (Mar. 2007).

profitable diagnoses, while creating disincentives to reduce unnecessary admissions and avoidable readmissions.

The "three H's" all base incentive payments largely on quality metrics from the IQRP. By July 2021, 38 of the 64 quality metrics that the HVBP program has used or plans to use, and five of its six active metrics, had appeared among the 260 quality measures the IQRP has used or plans to use.[113] In 2020, these three programs in combination could reduce a hospital's payments by as much as 5.5 percent or increase them by up to 3 percent depending on the information the hospital reports to Medicare.[114]

Of the three, the HVBP program has the largest impact on a hospital's IPPS payments.[115] Hospitals that participate in the HVBP receive an automatic 2 percent reduction in their base operating Medicare severity diagnosis-related group (MS-DRG) payment.[116] Medicare estimated that the funds available from these payment reductions across approximately 3,000 HVBP-participating hospitals totaled $1.9 billion in 2018.[117] Medicare then redistributes those funds to hospitals based on 65 quality metrics across four domains. Each of the following domains accounts for a quarter of a hospital's Total Performance Score (TPS):

- Clinical Outcomes – 25%
- Person and Community Engagement – 25%
- Safety – 25%
- Efficiency and Cost Reduction – 25%

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[113] *Measures Inventory Tool*, CMS (last updated Jun. 30, 2021), https://cmit.cms.gov/CMIT_public/ListMeasures.

[114] MEDPAC, MARCH 2020 REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY 80 (Mar. 2020).

[115] *Hospital-Acquired Condition Reduction Program,* CMS (Dec. 1, 2021), https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/HAC-Reduction-Program (showing HACRP can only reduce hospitals' payments, and by a maximum 1 percent); and *Hospital Readmissions Reduction Program (HRRP),* CMS (Dec. 1, 2021), https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program (showing HRRP can only reduce payments and by a maximum 3 percent.).

[116] *Payments*, CMS, https://qualitynet.cms.gov/inpatient/hvbp/payment (last visited Nov. 14, 2021).

[117] *CMS Hospital Value-Based Purchasing Program Results for Fiscal Year 2018*, CMS (Nov. 3, 2017), https://www.cms.gov/newsroom/fact-sheets/cms-hospital-value-based-purchasing-program-results-fiscal-year-2018.

Each domain includes specific quality measures participating hospitals must report. Hospitals accumulate Achievement Points (which reflect performance relative to the national average) and Improvement Points (which reflect a hospital's improvement over baseline).[118]

Medicare uses TPS reports[119] to determine the operating payment update—either a negative update (i.e., a reduction) or a positive update (i.e., a bonus)—for a hospital's discharges that occur during the following fiscal year.[120] Hospitals that score below the national average can receive up to a 1.5 percent reduction to their base operating payment, while high-scoring hospitals can receive up to a 3 percent bonus.[121] In 2018, the largest HVBP bonus was $4 million and the largest penalty was $1.4 million.[122]

MedPAC projected that in 2020, about one quarter of participating hospitals would receive higher net payments due to the

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[118] *Performance Standards*, CMS, https://qualitynet.cms.gov/inpatient/hvbp/performance (last visited Nov. 14, 2021).

[119] *See* OFFICE SPACE (20th Century Fox 1999) ("I'm just not sure that he's the caliber person that we would want for upper management. He's also been having some problems with his TPS reports.").

[120] *Hospital Value-Based Purchasing Program*, CMS (Feb. 18, 2021), https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/Hospital-Value-Based-Purchasing-.

[121] MEDPAC, MARCH 2020 REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY 80 (Mar. 2020). Hospitals that meet all the reporting requirements set by the hospital IQR program and demonstrate that they are making meaningful use of certified Medicare electronic health records (EHR) are eligible to receive the full operating payment update during the applicable year. For example, in 2020, hospitals participating in the IQR program and demonstrating meaningful use can receive the full operating payment update of 3.1 percent. *See* DHS Dep't of Health & Hum. Servs., 42 C.F.R. pts. 412, 413, 424, 495 (2018), https://www.govinfo.gov/content/pkg/FR-2018-08-17/pdf/2018-16766.pdf; *see also Fiscal Year (FY) 2020 Medicare Hospital Inpatient Prospective Payment System (IPPS) and Long Term Acute Care Hospital (LTCH) Prospective Payment System (CMS-1716-F)*, CMS NEWSROOM (Aug. 2, 2019), https://www.cms.gov/newsroom/fact-sheets/fiscal-year-fy-2020-medicare-hospital-inpatient-prospective-payment-system-ipps-and-long-term-acute-0. Hospitals that do not demonstrate they are making "meaningful use" of EHRs will see the annual increase in their IPPS base payment reduced by 75 percent to 0.775 percent. *See 2019 Medicare Electronic Health Record (EHR) Incentive Program Payment Adjustment Fact Sheet for Hospitals*, CMS NEWSROOM (Nov. 16, 2018), https://www.cms.gov/newsroom/fact-sheets/2019-medicare-electronic-health-record-ehr-incentive-program-payment-adjustment-fact-sheet-hospitals.

[122] Eric Fontana, *Map: The 2,800 hospitals facing VBP penalties (or bonuses) in 2019*, ADVISORY BOARD (Dec. 5, 2018), https://www.advisory.com/daily-briefing/2018/12/05/p4p.

"three H's," with an average net increase of just over $100,000.[123] About three-quarters of hospitals would receive lower net payments, with an average net decrease of just under $500,000.[124] The three programs would reduce IPPS spending by roughly $917 million, or 0.8 percent.[125]

Medicare has repeatedly changed HVBP requirements since it implemented the program in 2012. In 2013, there were only two domains: Clinical Process of Care and Patient Experience of Care.[126] To be eligible for bonus payments, hospitals had to report on at least four of 13 Clinical Process measures and provide at least 100 standardized patient-satisfaction surveys.[127] In 2014, Medicare added a third domain, Outcomes, and required hospitals to report at least two of three mortality measures within the domain.[128] In 2015, Medicare adopted a fourth domain, Efficiency, and required hospitals to report measures from at least two of the four domains.[129]

In 2015, Medicare also began "re-weighting" the TPSs of hospitals that report incomplete information.[130] If a hospital reported on only two or three domains, Medicare allocated those scores to the remaining domains. In 2017, Medicare started requiring that participating hospitals report on three of the four domains, allowing hospitals to receive a reweighted TPS for the remaining domain.[131]

B. The HVBP Program's Performance

In 2020, MedPAC concluded that since the HVBP and its companion programs took effect, hospital quality has improved

123 MEDPAC, MARCH 2020 REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY 80 (Mar. 2020).

124 *Id.*

125 Fontana, *supra* note 122.

126 CMS, *Frequently Asked Questions Hospital Value Based Purchasing Program* 6 (Feb. 28, 2012), https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/hospital-value-based-purchasing/downloads/HVBPFAQ022812.pdf.

127 *Id.* at 6-10.

128 CMS, *National Provider Call: Hospital Value-Based Purchasing* 8 (July 11, 2012), https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/hospital-value-based-purchasing/Downloads/NPCSlides071112.pdf (30-day mortality rates for acute myocardial infarction, heart failure, and pneumonia).

129 *Previous Scoring,* CMS, https://qualitynet.cms.gov/inpatient/hvbp/participation#tab5.

130 *See id.*

131 *Id.*

"modestly" and that "at least part of this improvement appears to be due to financial incentives from Medicare quality incentive programs."[132] From 2016 to 2018, for example, risk-adjusted 30-day post-discharge mortality rates declined from 6.7 percent to 6.1 percent, while risk-adjusted readmission rates fell from 14.0 percent to 13.7 percent.[133] Measures of patient satisfaction, however, remained unchanged. "In 2018," for example, "the care transitions measure result remained low, with only 53 percent of surveyed patients responding with 'Strongly Agree' that they understood their care when they left the hospital."[134]

Other researchers have described the HVBP's performance as "discouraging."[135] Further, there is evidence – including evidence MedPAC itself has compiled – that suggests improvements in quality measures have been due to other factors, and that the HVBP and its companion programs have had little, if any, impact on quality.

- A study of 4,267 acute care hospitals found that, between 2008 and 2013, the differences in inpatient mortality rates among myocardial infarction, heart failure, and pneumonia patients between HVBP-participating and non-participating hospitals were "small and non-significant."[136] The authors concluded, "In no subgroups of hospitals was HVBP associated with better outcomes, including poor performers at baseline."[137]

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132 MEDPAC, MARCH 2020 REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY 80 (Mar. 2020).

133 *Id.* at 80-81.

134 MEDPAC, MARCH 2020 REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY 81 (Mar. 2020).

135 *See* Matthew Fiedler, *Medicare Physician Payment Reform After Two Years: Examining MACRA Implementation and the Road Ahead*, Hearing Before the U.S. Sen. Comm. on Finance 5 (May 8, 2019) (transcript available at Brookings Inst.), https://www.finance.senate.gov/imo/media/doc/08MAY2019FIEDLERSTMNT.pdf ("Research examining the Hospital Value-Based Purchasing Program (HVBP), which adjusts Medicare hospital payments upward and downward based on a similarly broad set of measures, has reached…discouraging conclusions.").

136 *See* Jose F. Figueroa et al., *Association between the Value-Based Purchasing pay for performance program and patient mortality in US hospitals: observational study*, 353 BMJ 1 (2016), https://www.bmj.com/content/353/bmj.i2214.

137 *Id.*

- The Government Accountability Office (GAO) found that among hospitals participating in the HVBP, the quality-measure trends remained consistent from 2005—i.e., well before the program took effect—through 2014.[138]
- Another study found that, between 2008 and 2015, participating and non-participating hospitals saw similar improvements in HVBP quality measures.[139] Participation did not correlate with improvements in clinical process or patient-experience quality measures.[140] Hospitals that participated in the HVBP did not demonstrate a significant improvement on two of the three 30-day risk-standardized mortality measures (acute myocardial infarction and heart failure), but did demonstrate a reduction in patient mortality on the third (pneumonia).[141] The study concluded that the HVBP has had "little tangible benefit over its first four years."[142]

Researchers have similarly found evidence suggesting that improvements in HRRP quality metrics have been due to factors other than the program itself. For example, MedPAC found readmissions fell slightly faster across the five conditions that the HRRP measures after the program created financial disincentives for such readmissions.[143] Specifically, risk-adjusted readmission rates for those conditions fell about 0.12 percentage points faster between 2010-2016 than 2008-2010.[144] MedPAC notes, however, "it is not possible to say what portion of the reduction in readmissions was due to the HRRP and what portion was due to other concurrent factors

138 U.S. GOV'T ACCOUNTABILITY OFF., GAO-16-9, INITIAL RESULTS SHOW MODEST EFFECTS ON MEDICARE PAYMENTS AND NO APPARENT CHANGE IN QUALITY-OF-CARE TRENDS (Oct. 2015), https://www.gao.gov/assets/680/672900.pdf.

139 Andrew M. Ryan et al., *Changes in Hospital Quality Associated with Hospital Value-Based Purchasing,* 376 NEW ENG. J. MED. (SPECIAL ARTICLE) 2358, 2361, 2363 (2017), https://www.nejm.org/doi/full/10.1056/NEJMsa1613412.

140 *Id.*

141 *Id.* at 2363.

142 *Id.* at 2366.

143 MEDPAC, JUNE 2018 REPORT TO THE CONGRESS: MEDICARE AND THE HEALTH CARE DELIVERY SYSTEM 16 (2018), https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun18_medpacreporttocongress_rev_nov2019_note_sec.pdf.

144 *Id.* at 23.

such as ACOs [accountable care organizations] or changes in coding practices,"[145] including efforts to game the HRRP's quality metrics.

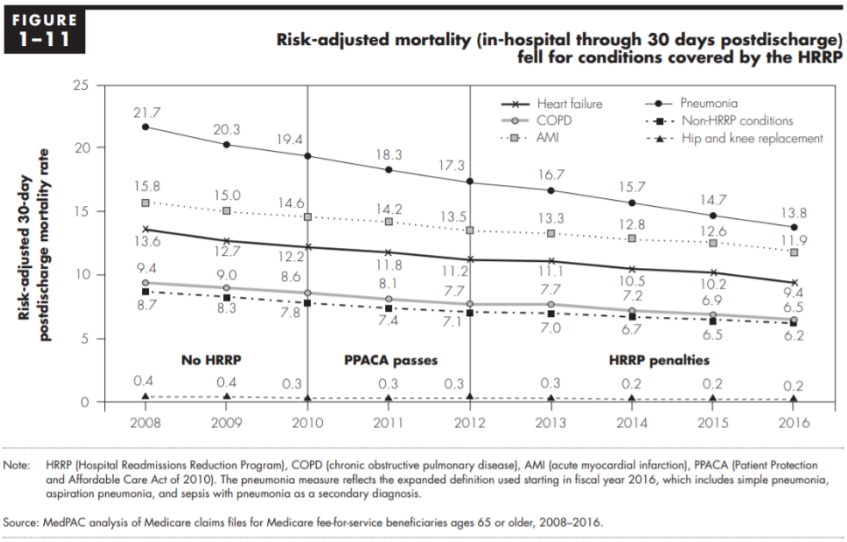
One indication that other factors may have caused such improvements is that many appear to be the continuation of preexisting trends. Before the HRRP took effect, risk-adjusted mortality in-hospital through 30 days post-discharge was already falling for HRRP and non-HRRP conditions. In Figure 1, MedPAC illustrates that after the HRRP took effect, mortality for both HRRP and non-HRRP conditions continued to fall at the same rates as before the program took effect.[146] An indication that gaming behavior may be creating an illusory reduction in readmissions is that "although readmission rates have decreased for [HRRP-]targeted conditions, rates of observation stays and ED visits after inpatient stays have increased [such that] the proportion of patients who return to a hospital within 30 days after discharge has not changed."[147]

[145] *Id.*

[146] *Id.* at 25 fig.1-11.

[147] Rishi K. Wadhera et al., *The Hospital Readmissions Reduction Program — Time for a Reboot*, 380 NEW ENG. J. MED. 2289 (2019), https://www.nejm.org/doi/10.1056/NEJMp1901225; *see also* Ann M. Sheehy et al., *The Hospital Readmissions Reduction Program and Observation Hospitalizations*, 16 J. HOSP. MED. 409, (2021), https://www.journalofhospitalmedicine.com/jhospmed/article/241439/hospital-medicine/hospital-readmissions-reduction-program-and-observation ("by ignoring observation hospitalizations. . .nearly one of five HHRP hospitalizations is missed.").

FIGURE 1. RISK-ADJUSTED MORTALITY FOR HRRP AND NON-HRRP CONDITIONS, 2008-2016



Note: HRRP (Hospital Readmissions Reduction Program), COPD (chronic obstructive pulmonary disease), AMI (acute myocardial infarction), PPACA (Patient Protection and Affordable Care Act of 2010). The pneumonia measure reflects the expanded definition used starting in fiscal year 2016, which includes simple pneumonia, aspiration pneumonia, and sepsis with pneumonia as a secondary diagnosis.

Source: MedPAC analysis of Medicare claims files for Medicare fee-for-service beneficiaries ages 65 or older, 2008–2016.

Additional research suggests the modest improvements in traditional Medicare's hospital quality measures may be due to factors other than these programs. A study of Florida hospitals from 2008 through 2014 found that although readmissions fell coincident with the HRRP, "the readmission reduction disappeared or reversed when compared with Medicare Advantage enrollees and privately insured patients" because "readmission rates for Medicare Advantage (MA) beneficiaries and privately insured patients with heart attack and heart failure decreased even more than [for traditional Medicare] patients with the same target condition."[148] The researchers concluded that "the larger effect among Medicare Advantage and privately insured patients may suggest some other contemporaneous downward trend in readmissions for these particular conditions that is unrelated to the HRRP."[149] They further raise the prospect that, in

[148] Min Chen & David C. Grabowski, *Hospital Readmissions Reduction Program: Intended and Unintended Effects*, 76 MED. CARE RSCH. REV. 643, 654 (2019), https://pubmed.ncbi.nlm.nih.gov/29199504/.

[149] *Id.* at 654.

the *absence* of the HRRP, readmissions rates among traditional Medicare patients would have fallen even more—i.e., at a rate consistent with that of Medicare Advantage patients.[150]

C. Gaming the System

Even where Medicare's quality-improvement programs appear successful, it is unclear whether the improvements are real or the result of providers gaming the program. Tying payment to quality metrics that providers self-report creates incentives for providers to engage in strategic behavior that improves their quality scores without improving quality.[151]

There are several ways hospitals can game the HVBP program. First, hospitals can adjust their screening and treatment protocols. The Medicare and the Centers for Disease Control and Prevention (CDC) noted that hospitals use such strategies to hide hospital-acquired infections (HAIs).[152] The Department of Health and Human Services' Office of Inspector General (HHS-OIG) explained hospitals can hide HAIs by:

- *Overculturing*, which
  > departs from standard clinical practice by ordering diagnostic tests in the absence of clinical symptoms . . . For example, hospitals may obtain a urine specimen taken from a patient who shows no symptoms of a urinary tract infection. Many results are negative, subjecting patients to unnecessary tests. Hospitals might use positive results to game their data

[150] *Id.* (finding results that "partially validate[] the identifying assumption that, in the absence of the HRRP, the treatment and comparison groups would have had similar trends in readmission").

[151] Arnold Kling, *When Health Care Becomes Personal*, CATO INST. (Jan. 29, 2008), https://www.cato.org/publications/commentary/when-health-care-becomes-personal, ("The health care providers…control the information flows ('you want to see reports that demonstrate quality? We'll give you reports that demonstrate quality.')").

[152] BETH P. BELL & PATRICK CONWAY, ADHERENCE TO THE CENTERS FOR DISEASE CONTROL AND PREVENTION'S (CDC'S) INFECTION DEFINITIONS AND CRITERIA IS NEEDED TO ENSURE ACCURACY, COMPLETENESS, AND COMPARABILITY OF INFECTION INFORMATION 1 (Oct. 6, 2015), https://www.cdc.gov/nhsn/pdfs/cms/NHSN-Reporting-signed.pdf.

> by claiming that infections that appeared many days later during hospitalization were present on admission, and thus not reportable . . . [153]

- *Underculturing*, or "cases in which a patient has likely developed an infection during the hospital stay," but "[b]y not ordering the test, the hospital does not learn whether the patient truly has an infection and therefore the hospital does not have to report an infection . . . "[154] and
- *Adjudication*, when ". . . administrative or clinical superiors inappropriately overrule the hospital staff who are responsible for reporting HAIs . . . with the result that the hospital does not report infections that should be reported."[155]

Second, a hospital that performs well in three HVBP domains but poorly in a fourth can boost its score by not reporting data for the fourth domain.[156] In that event, Medicare's "re-weighting" formulas impute a score for the fourth domain based on the other three.[157] The GAO found that prior to 2017, when Medicare required hospitals to report data for only two domains, hospitals with missing domain scores were more likely to have higher "reweighted" TPSs than hospitals that reported data for all domains.[158] In 2017, 68 percent of hospitals with missing domain scores received bonus payments,

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153 DANIEL R. LEVINSON, DEPT. OF HEALTH AND HUM. SERVS., OEI-01-15-00320, CMS VALIDATED HOSPITAL INPATIENT QUALITY REPORTING PROGRAM DATA, BUT SHOULD USE ADDITIONAL TOOLS TO IDENTIFY GAMING 6 (Apr. 2017), https://oig.hhs.gov/oei/reports/oei-01-15-00320.pdf.

154 *Id.*

155 *Id.*

156 *Hospital Value-Based Purchasing*, CMS (Sept. 2017), https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Hospital_VBPurchasing_Fact_Sheet_ICN907664.pdf ("hospitals with sufficient data in at least three out of the four domain scores can receive a TPS. Hospitals that only have scores in three domains will have their scores proportionally reweighted.").

157 U. S. GOV'T ACCOUNTABILITY OFF., GAO 17-551, *Report to Congressional Committees: Hospital Value-Based Purchasing CMS Should Take Steps to Ensure Lower Quality Hospitals Do Not Qualify for Bonuses* 21 (Jun. 2017), https://www.gao.gov/assets/690/685586.pdf.

158 *Id.* at 22.

compared to only 50 percent of hospitals that reported all domain measures.[159]

Ironically, Medicare's re-weighting process enables low-quality hospitals to receive bonuses Congress (presumably) created for high-quality hospitals. Following the addition of the Efficiency domain in 2015, "[s]ome hospitals with high efficiency scores received bonuses, despite having relatively low quality scores, which contradicts the Centers for Medicare & Medicaid Services' stated intention to reward hospitals providing high quality care at a lower cost."[160] Part of the effect was due to some of those low-quality hospitals having relatively high Efficiency scores.[161] But part was likely due to under-reporting. For example, in 2017, "182 of the 345 lower-quality hospitals that received a bonus (53 percent) were missing at least one quality domain score."[162] Low-quality hospitals—specifically, those with quality scores below the national median—accounted for 20 percent of all hospitals receiving bonus payments.[163] In the name of promoting quality, Medicare reduced payments to high-quality hospitals to fund bonuses for low-quality hospitals. In the name of promoting efficiency, Medicare offered low-quality hospitals additional money in exchange for no additional output. Medicare's quality-improvement programs for physicians have created similar perverse incentives and outcomes.[164]

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159 *Id.* at 23.

160 *Id.* at 4. (The GAO compared hospitals' scores on the three quality-focused domains to their TPS, which incorporates the often reweighted Efficiency domain. "To develop a weighted composite quality score for each hospital, we subtracted hospitals' weighted efficiency scores from their total performance scores to calculate a median composite quality score for all hospitals for fiscal years 2015 through 2017. Hospitals with composite quality scores above the median were considered higher quality, while hospitals with composite quality scores below the median were considered lower quality.").

161 *Id.* at 20. ("Hospitals that received a bonus despite having composite quality scores below the median for all hospitals had sufficiently high efficiency scores to achieve total performance scores that made them eligible for bonuses. Across all hospital types and years, the median efficiency scores for these hospitals ranged from 1.50 [to] 6.00 times higher than the median efficiency scores for hospitals overall. For example, in fiscal year 2017, the overall median efficiency score for small rural hospitals was 30.00. In contrast, the median efficiency score for small rural hospitals that received a bonus with a composite quality score below the all-hospital median was more than twice as high at 70.00.").

162 *Id.* at 23.

163 *Id.*

164 *See, e.g.*, Eric T. Roberts et al., *Changes in Patient Experiences and Assessment of Gaming Among Large Clinician Practices in Precursors of the Merit-Based Incentive Payment*

Third, hospitals can game self-reported measures by overstating the severity of patients' illnesses or their degree of improvement. "Since 2014," MedPAC noted, "home health agencies reported improvements in provider-reported measures such as transferring and walking, even though more objective, claims-based outcome measures (such as the use of emergency department care and hospital admissions) have not improved or have worsened."[165] Providers can even game seemingly objective measures like mortality, because Medicare's per-admission hospital payment rules and hospital quality-improvement programs create incentives for hospitals to "upcode," or overstate a patient's disease burden. This results in higher initial payments from the former, and higher bonus payments from the latter. MedPAC posits "greater coding intensity over time may be responsible for some of the [measured] decline in risk-adjusted mortality" during 2010 to 2016.[166] (See Figure 1.)

Finally, hospitals can game the HVBP program and other quality-improvement programs by avoiding patients who are likely to bring down a hospital's score. Medicare's efforts to control for patient characteristics that might influence outcomes or process measures are "imperfect."[167] Some researchers complain, for example, that

System, 2 JAMA HEALTH FORUM e213105 (Oct. 8, 2021), https://jamanetwork.com/journals/jama-health-forum/fullarticle/2784983 (in Medicare physician-quality-improvement programs with voluntary reporting, practices that performed highly on patient-satisfaction measures were more likely to report those measures, "enabl[ing] practices to earn bonuses or avoid penalties without improving care"); and U.S. GOV'T ACCOUNTABILITY OFF., GAO-22-104667, *Medicare: Provider Performance and Experiences Under the Merit-Based Incentive Payment System* (Oct. 01, 2021), https://www.gao.gov/assets/gao-22-104667.pdf ("to maximize payment adjustments, providers may choose to report on performance measures on which they are performing well or that are easy to achieve, rather than measures in areas where they may need improvement or that are clinically relevant. This may help explain, in part, why our analysis of CMS data shows that over 90 percent of providers scored above the performance threshold from 2017 through 2019."; "About 72 to 84 percent of providers received an exceptional performance bonus in a given year."). *See also Lake Wobegon effect*, A DICTIONARY OF PSYCHOLOGY (3d ed. 2014), https://www.oxfordreference.com/view/10.1093/oi/authority.20110810105237549 ("The term ['Lake Wobegon effect'] was introduced by the U.S. physician John Jacob Cannell…commenting on the fact that all 50 U.S. states reported elementary school results above the national average.").

165 MEDPAC, REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY 57 (Mar. 2019).

166 MEDPAC, REPORT TO THE CONGRESS: VARIATION AND INNOVATION IN MEDICARE 24 (June 2018)

167 CONG. BUDGET OFF., A PUBLIC OPTION FOR HEALTH INSURANCE IN THE NONGROUP MARKETPLACES: KEY DESIGN CONSIDERATIONS AND IMPLICATIONS 21, 26 (Apr. 2021),

"poverty, disability, housing instability, residence in a disadvantaged neighborhood, and hospital population from a disadvantaged neighborhood [all correlate] with higher readmission rates," yet Medicare does not incorporate such "social risk factors" in its risk-adjustment formulas. [168]

Accordingly, the GAO found that hospitals that serve disproportionately large shares of uninsured patients (i.e., safety-net hospitals) received larger HVBP-related base-payment reductions or smaller bonuses compared to non-safety net hospitals.[169] Researchers estimate that accounting for "social risk" factors would cut in half the estimated difference in avoidable readmissions between affluent and safety-net hospitals. Additionally, half of safety-net hospitals would see smaller reductions in their base payments, while as many as 7.5 percent would see such reductions disappear.[170]

Researchers have found evidence suggesting that hospitals engage in patient selection. A study of Florida hospitals found "the HRRP reduced the likelihood of Hispanic patients with target conditions [heart failure, COPD, or total hip or knee replacement] being admitted by 2% to 4%."[171] The authors conclude, "[b]ecause the current penalty formula does not adjust for hospitals that serve large shares of indigent or minority patients, they may avoid such patients who they believe will reduce their performance and result in financial penalties."[172] If so, "the HRRP may divert resources away from the small percentage of U.S. hospitals caring for the large majority of elderly Black and Hispanic patients and exacerbate health care related disparities in access and outcomes."[173]

https://www.cbo.gov/system/files/2021-04/57020-Public-Option.pdf ("risk adjustment does not perfectly capture differences in individual health risk").

168 Karen E. Joynt Maddox et al., *Adjusting for Social Risk Factors Impacts Performance and Penalties in the Hospital Readmissions Reduction Program*, 54 HEALTH SERVS. RSCH. 327, 327-36 (2019), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6407348/.

169 U.S. GOV'T ACCOUNTABILITY OFF., GAO-16-9, SEE INITIAL RESULTS SHOW MODEST EFFECTS ON MEDICARE PAYMENTS AND NO APPARENT CHANGE IN QUALITY-OF-CARE TRENDS (Oct. 2015), https://www.gao.gov/assets/680/672900.pdf.

170 Maddox, *supra* note 168, at 332.

171 Chen & Grabowski, *supra* note 148, at 643.

172 *Id.* at 655.

173 *Id*. ("Studies have found that Black and Hispanic patients experienced higher readmission rates than Whites for many diagnoses including the target conditions (heart failure, AMI, pneumonia) covered by the CMS readmissions policies. In addition, many providers believe that

Until such time as Medicare perfects risk-adjustment, hospitals will be able to improve their quality ratings, without improving quality, by avoiding certain patients, while Medicare will reward hospitals not only for quality, but also for having affluent or otherwise desirable patients.

Consistent with its historical posture toward quality, traditional Medicare shows little interest in detecting or reducing gaming of its quality-improvement programs. Despite "strong financial incentives"[174] that encourage providers to game those programs, and despite Medicare's awareness that hospitals are doing so, the HHS-OIG reports Medicare is not using readily available tools to identify and stop gaming behavior.[175]

D. Compliance Costs

It is even less certain that Medicare's quality-improvement programs produce benefits that justify the considerable costs of complying with those programs. Quality reporting is costly both for providers and Medicare. In 2020, the Centers for Medicare and Medicaid Services required various health care providers to report on a total of 2,249 quality metrics.[176] States and regional collaboratives

minority patients tend to be less educated and less likely to comply with treatment and thus have higher risks for readmissions." Internal citations omitted. The authors found "no evidence of selection against low-income or Black patients under the HRRP.").

174 MEDPAC, REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY 59 (Mar. 2020).

175 DEP'T OF HEALTH & HUM. SERVS., OEI-01-15-00320, CMS VALIDATED HOSPITAL INPATIENT QUALITY REPORTING PROGRAM DATA BUT SHOULD USE ADDITIONAL TOOLS TO IDENTIFY GAMING (Apr. 2017), https://oig.hhs.gov/oei/reports/oei-01-15-00320.asp. Every year, in addition to reviewing records from a random sample of 400 hospitals, Medicare can also select a "targeted sample" of hospitals that the program has reason to suspect may be gaming quality-reporting requirements. "Although CMS can include up to 200 hospitals in its targeted sample, it selected only 49 hospitals for payment year 2016. Furthermore, CMS selected none of these hospitals using analysis-based criteria, such as aberrant data patterns or rapid changes in reporting. CMS staff told us that they identified 96 hospitals with aberrant data patterns but did not select any of them for the targeted sample." The HHS-OIG concluded, "CMS made limited use of [available] analytical tools in its validation for payment year 2016," despite the fact that such tools can "[t]ease out hidden patterns in the data, which could help determine when the cause of variation might be the result of manipulation."

176 CMS, *supra* note 117.

require an additional 1,367 quality measures.[177] One survey found that private health plans that account for two thirds of commercial enrollment employ a total of 546 quality measures.[178]

Many quality-reporting requirements are duplicative.[179] MedPAC writes, "too many overlapping hospital quality payment and reporting programs create unneeded complexity for hospitals and the Medicare program itself."[180] For a time, CMS required hospitals to report hospital-acquired infection rates to the HACRP, the IQRP, and the HVBP programs.[181] In 2019, more than 25 quality measures were duplicates across more than one hospital payment program.[182]

Medicare does not track the costs of compliance with its quality-improvement programs. Nevertheless, in 2017, the American Hospital Association reported that an average-sized community hospital (161 beds) spent $709,000 annually, including hiring 4.6 full-time-equivalent employees, to perform administrative tasks required for quality reporting.[183] Such employees wrangle with "duplicative and misaligned reporting requirements, many of which require manual data extraction, create inefficiencies and consume significant financial resources and clinical staff time."[184] If such hospitals are representative, a back-of-the-envelope calculation suggests the nearly 3,000 hospitals that participated in the HVBP program would have spent on the order of $2 billion on quality reporting programs.[185]

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177 Kate Bazinsky & Michael Bailit, *The Significant Lack of Alignment Across State and Regional Health Measure Sets*, BAILIT HEALTH PURCHASING 1, 3 (Sept. 10, 2013), http://www.bailit-health.com/articles/091113_bhp_measuresbrief.pdf.

178 *See* Aparna Higgins et al., *Provider Performance Measures In Private And Public Programs: Achieving Meaningful Alignment With Flexibility To Innovate*, 32 HEALTH AFF. 1453, 1453-61 (Aug. 2013), https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2013.0007.

179 *Regulatory Overload: Assessing the Regulatory Burden on Health Systems, Hospitals and Post-acute Care Providers*, AM. HOSP. ASS'N 1, 4 (Oct. 2017). https://www.aha.org/system/files/2018-02/regulatory-overload-report.pdf.

180 MEDPAC, REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY 431 (Mar. 2019).

181 MEDPAC, REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY 189 (Jun. 2018).

182 CMS, FISCAL YEAR 2019 MEDICARE HOSPITAL INPATIENT PROSPECTIVE PAYMENT SYSTEM AND LONG-TERM ACUTE CARE HOSPITAL PROSPECTIVE PAYMENT SYSTEM FINAL RULE (Aug. 2, 2018), https://www.cms.gov/newsroom/fact-sheets/fiscal-year-fy-2019-medicare-hospital-inpatient-prospective-payment-system-ipps-and-long-term-acute-0.

183 AM. HOSP. ASS'N, *supra* note 179, at 4.

184 *Id.* at 18.

185 *Id.*

E. Medicare' Ongoing Hostility to Quality

Medicare's hostility to quality improvement is evident across the entire program, and even in its failure to measure quality in a serious way. Just as Medicare grants quality bonuses to low-quality hospitals, it has awarded quality bonuses to mediocre Medicare Advantage plans. The ACA created a program that offers quality bonuses to high-performing Medicare Advantage plans. Medicare administrators soon thereafter changed the rules to offer such bonuses to mediocre plans nationwide.[186] Even as researchers find that Medicare's five-star rating system for nursing homes can reflect real quality differences,[187] an exposé found inspectors cited more than two thirds of 5-star homes for infection-control or patient-abuse violations; nursing homes routinely submit false data; and "government rarely audits the nursing homes' data."[188]

MedPAC notes that Medicare fails even to measure quality in a comprehensive or serious way.[189] Traditional Medicare's quality-measurement programs use process measures that "are burdensome to report,"[190] "are weakly correlated with outcomes of interest such as mortality and readmissions,"[191] and "can lead to biased reporting in response to strong financial incentives."[192] MedPAC argues "all-condition mortality and readmissions measures are more appropriate

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[186] JAMES COSGROVE & EDDA EMMANUELLI-PEREZ, GAO-12-964T, MEDICARE ADVANTAGE: QUALITY BONUS PAYMENT DEMONSTRATION HAS DESIGN FLAWS AND RAISES LEGAL CONCERNS 4 (July 25, 2012), https://www.gao.gov/assets/600/592920.pdf ("the expanded bonuses…mainly benefit average-performing plans," both directly and indirectly, by leading to higher enrollment in those plans).

[187] *See* Portia Y. Cornell et al., *Do report cards predict future quality? The case of skilled nursing facilities*, 66 J. HEALTH ECON. 208, 208-21 (2019), https://www.sciencedirect.com/science/article/abs/pii/S0167629618304107.

[188] Jessica Silver-Greenberg & Robert Gebeloff, *Maggots, Rape and Yet Five Stars: How U.S. Ratings of Nursing Homes Mislead the Public*, N.Y. TIMES (Mar. 13, 2021), https://www.nytimes.com/2021/03/13/business/nursing-homes-ratings-medicare-covid.html.

[189] *See* MEDPAC, REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY 431 (Mar. 2019), http://www.medpac.gov/docs/default-source/reports/mar19_medpac_entirereport_sec_rev.pdf; MEDPAC, REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY 44 (Mar. 2021), http://medpac.gov/docs/default-source/reports/mar21_medpac_report_to_the_congress_sec.pdf. *See, e.g.*, MEDPAC, *supra* note 114.

[190] MEDPAC, REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY 431 (Mar. 2019).

[191] MEDPAC, REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY 44 (Mar. 2021).

[192] MEDPAC, REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY 431 (Mar. 2019).

to score in pay-for-performance programs than [the current] condition-specific (e.g., acute myocardial infarction) measures"[193] and that Medicare should measure overuse and inappropriate use of services, not just under-use.[194] "Overuse is also a quality concern because of the potential for harm to beneficiaries—both directly from the tests and procedures performed on them and indirectly from unnecessary treatments for false-positive diagnoses and for clinically insignificant findings."[195] Since 2019, MedPAC has recommended eliminating the HRRP, HVBP, and HACRP programs and replacing them with a single "hospital value incentive program (HVIP)" consistent with those principles and that "adjust[s] . . . for social risk factors."[196] So far, Congress has declined.

Medicare's quality-measurement failures appear in its management of Medicare Advantage, as well. According to MedPAC:

> The current state of quality reporting in [Medicare Advantage] is such that the Commission can no longer provide an accurate description of the quality of care in [Medicare Advantage] . . . the current quality program is not achieving its intended purposes and is costly to Medicare . . .[197]

The quality bonuses Medicare administers for Medicare Advantage plans, like Medicare's other quality programs, create opportunities to game the scoring rules. "There is evidence that plans have engaged in activities that increase quality scores without increasing underlying quality."[198]

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193 *Id.* at 57.

194 *Id.* ("Many current process measures are weakly correlated with outcomes of interest such as mortality and readmissions, and most process measures focus on addressing the underuse of services, while the Commission believes that overuse and inappropriate use are also of concern").

195 MEDPAC, MEASURING QUALITY OF CARE IN MEDICARE 46 (June 2014).

196 MEDPAC, REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY 68 (Mar. 2021).

197 *Id.* at xxv.

198 Prior to recent reforms, "some insurers consolidated plans in different counties into the same contract so that average quality scores increased. Because quality scores are calculated at the contract level, lower-quality plans in those consolidated contracts received higher payments, and enrollees in those lower-quality plans were shown quality scores that were inflated relative to local plans' performance." Recent reforms "should reduce insurers' incentives to consolidate

Medicare's indifference toward careful quality measurement extends even to pilot programs whose purpose is to improve quality. The ACA's Centers for Medicare and Medicaid Innovation has launched 54 pilot programs to improve quality and/or reduce spending, only five of which "resulted in substantial financial savings . . . with several on pace to lose billions of dollars."[199] In addition, "the majority of models do not show significant improvements in quality."[200]

Complicating the evaluation of those programs is the fact that CMMI "has data for the control group for only approximately 55% of the quality metrics that are used across its models."[201] In addition, CMMI typically bases payments to providers on different measures than those it uses to determine whether the program improves quality:

> [f]or example, across a representative sample of nine models, 71 quality metrics were used to determine performance-based quality payments, but only 39 of those metrics were included in [program] evaluations. In addition, 99 of the 138 quality metrics that were used in the Center's evaluations were not included in the models' performance-based quality payments.[202]

COVID-19 provides further evidence of Medicare's ongoing hostility to quality. Among other things, the pandemic highlighted that while Medicare has recently begun requiring acute-care hospitals to report infection rates, "[o]utpatient surgery, ambulatory surgery centers, emergency rooms, nursing homes, assisted living and

plans to increase quality scores. However, insurers will still have an incentive to engage in other activities that increase quality scores without necessarily increasing quality." *See* CONG. BUDGET OFF., OPTIONS FOR REDUCING THE DEFICIT: 2019-2028: REDUCE QUALITY BONUS PAYMENTS TO MEDICARE ADVANTAGE PLANS (Dec. 13, 2018), https://www.cbo.gov/budget-options/2018/54737.

199 Brad Smith, *CMS Innovation Center at 10 Years —Progress and Lessons Learned*, 384 NEW ENG. J. MED. 759 (2021), https://www.nejm.org/doi/full/10.1056/NEJMsb2031138.

200 *Id.*

201 *Id.* at 763.

202 *Id.*

hospice centers have not been required to report infections."[203] In addition, once the pandemic struck, Medicare quickly suspended many quality-improvement activities, including elements of the HVBP.[204] "Never has there been a moment in history when Americans care more about hospital infection rates," yet Medicare suspended requirements that hospitals track and report infection rates.[205] Medicare suspended other quality reporting programs in ways that created additional opportunities for providers to game those programs.[206]

Medicare officials described these steps as providing "relief for clinicians, providers, hospitals and facilities" from "bureaucratic red tape."[207] When Medicare administrators refer to quality-improvement programs as bureaucratic red tape, it suggests either that those programs offer little substantive benefit to enrollees or that Medicare officials have little enthusiasm for them (or, charitably, both). When Medicare officials praise the suspension of quality-improvement programs for providing relief to providers, it raises questions about whom those officials consider their primary clientele.

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[203] Steve Burrows, *We Deserve to Know Infection Rates*, MORNING CONSULT (Sept. 11, 2020), https://morningconsult.com/opinions/we-deserve-to-know-infection-rates/.

[204] Regarding physicians and other clinicians, including Accountable Care Organizations (ACOs), *see* CMS QUALITY PAYMENT PROGRAM, UPDATED: 2020 PERFORMANCE YEAR FLEXIBILITIES (last updated Feb. 25, 2021), https://qpp.cms.gov/resources/covid19 ("we have finalized our proposal to waive the requirement for ACOs to field a Consumer Assessment of Healthcare Providers and Systems (CAHPS) for ACOs survey. Consequently, ACOs would receive automatic full credit for the patient experience of care measures."). Regarding facilities, see *Exceptions and Extensions for Quality Reporting Requirements for Acute Care Hospitals, PPS-Exempt Cancer Hospitals, Inpatient Psychiatric Facilities, Skilled Nursing Facilities, Home Health Agencies, Hospices, Inpatient Rehabilitation Facilities, Long-Term Care Hospitals, Ambulatory Surgical Centers, Renal Dialysis Facilities, and MIPS Eligible Clinicians Affected by COVID-19*, CMS Memorandum (Mar. 27, 2020), https://www.cms.gov/files/document/guidance-memo-exceptions-and-extensions-quality-reporting-and-value-based-purchasing-programs.pdf.

[205] Burrows, *supra* note 203.

[206] *E.g.*, CMS QUALITY PAYMENT PROGRAM, *supra* note 204 ("MIPS eligible clinicians reporting as individuals will only be scored on performance categories for which data was submitted. All other performance categories will be reweighted to 0 percent of their final score."); and CMS, CMS ANNOUNCES RELIEF FOR CLINICIANS, PROVIDERS, HOSPITALS AND FACILITIES PARTICIPATING IN QUALITY REPORTING PROGRAMS IN RESPONSE TO COVID-19 (Mar. 22, 2020), https://www.cms.gov/newsroom/press-releases/cms-announces-relief-clinicians-providers-hospitals-and-facilities-participating-quality-reporting [hereinafter CMS Press Release].

[207] CMS Press Release, *supra* note 206.

In sum, MedPAC writes, "Medicare does not consistently measure quality across [Medicare Advantage] plans, [fee-for-service] populations, and providers, so we cannot report trends about the entire Medicare program's quality of care."[208] Medicare "does not support sufficient accountability or transparency, such as providing beneficiaries with information that compares the quality of care provided by different models such as [fee-for-service], health plans, or ACOs."[209] Medicare neither assesses whether the quality metrics it selects advance its quality-measurement objectives, nor tracks all the resources it spends on quality-measurement,[210] nor collects data on the cost of complying with its quality-improvement programs, nor makes a serious effort to detect and prevent provider gaming of those programs.

More than 50 years after President Johnson requested that Congress give traditional Medicare authority to reward quality, observers still blame the program for continuing to subject enrollees to low-quality care, including iatrogenic illnesses such as avoidable hospital-acquired infections.[211] Medicare's decisions in 2008 and 2009 to cease payments for certain "never events" and hospital-

208 MEDPAC, REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY 32 (Mar. 2019).

209 MEDPAC, REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY 7 (Jun. 2020).

210 U.S. GOV'T ACCOUNTABILITY OFF., GAO-19-628, REPORT TO CONGRESSIONAL COMMITTEES: HEALTH CARE QUALITY CMS COULD MORE EFFECTIVELY ENSURE ITS QUALITY MEASUREMENT ACTIVITIES PROMOTE ITS OBJECTIVES (Sept. 2019), https://www.gao.gov/assets/710/701512.pdf ("CMS officials also told GAO that the information it maintains does not identify all of the funding the agency has obligated for quality measurement activities. Further, it does not identify the extent to which this funding has supported CMS's quality measurement strategic objectives…CMS does not have procedures to ensure systematic assessments of quality measures under consideration against each of its quality measurement strategic objectives, which increases the risk that the quality measures it selects will not help the agency achieve those objectives").

211 MEDPAC, REPORT TO THE CONGRESS: INCREASING THE VALUE OF MEDICARE xv (Jun. 2006), http://www.medpac.gov/docs/default-source/reports/Jun06_EntireReport.pdf ("Paying providers the same regardless of the quality of their care perpetuates poor care for some beneficiaries, misspends program resources, and is unfair to high-performing providers."); MEDPAC, REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY 22 (Mar. 2007), http://www.medpac.gov/docs/default-source/reports/Mar07_EntireReport.pdf ("Medicare's [fee-for-service] payment systems do not provide incentives to coordinate care, which can lead to unnecessary care and sometimes even iatrogenic illness."); MEDPAC, REPORT TO THE CONGRESS: MEDICARE AND THE HEALTH CARE DELIVERY SYSTEM 7 (June 2020), http://www.medpac.gov/docs/default-source/reports/jun20_reporttocongress_sec.pdf ("The incentive to provide more services also potentially exposes beneficiaries to unnecessary health risks, such as hospital-acquired infections.").

acquired infections[212] merely highlight how limited those measures are compared to prepayment; how it took Medicare more than 40 years to enact them; and how throughout those four decades, Medicare rewarded low-quality care that a competitive market would not.

MedPAC continues to identify ways traditional Medicare undermines quality that the ACA did not address, such as the Commission's "longstanding concern" that Medicare sets relatively low prices for primary care and pays for primary care on a fee-for-service basis, both of which threaten the quality of care for enrollees with chronic conditions.[213] In traditional Medicare's sixth decade, MedPAC is still urging Congress to "move the Medicare program beyond just blindly paying [fee-for-service] rates."[214] In 2020, MedPAC wrote that while "the Medicare program has begun to implement quality-based payment policies in a number of sectors . . . the Commission has been increasingly concerned that Medicare's approach to quality measurement is flawed."[215]

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[212] *See* John Crist, *Never Say Never: "Never Events" in Medicare*, 20 HEALTH MATRIX: J. L. MED. 437, 437-65 (2012), https://scholarlycommons.law.case.edu/cgi/viewcontent.cgi?article=1151&context=healthmatrix ("hospitals will likely find Never Events policies confusing, vague, difficult to implement, and ultimately, unhelpful to patient care."); *see also* Peter D. McNair et al., *Medicare's Policy Not To Pay For Treating Hospital-Acquired Conditions: The Impact*, 28 HEALTH AFF. 1485, 1485-93 (2009), https://www.healthaffairs.org/doi/full/10.1377/hlthaff.28.5.1485 ("In its present form, the policy applied by the CMS to not pay for avoidable complications will have limited financial impact").

[213] MEDPAC, REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY 119 (Mar. 2018) ("The Commission has a long-standing concern that evaluation and management (E&M) office visits, which make up a large share of the services provided by primary care clinicians and certain other specialties…are underpriced by the Medicare fee schedule for physicians and other health professionals compared with other services such as procedures. The Commission has also become concerned that the fee schedule—with its orientation toward discrete services that have a definite beginning and end—is not well designed to support primary care, which requires ongoing care coordination for a panel of patients.") ("The Commission has a long-standing concern that evaluation and management (E&M) office visits, which make up a large share of the services provided by primary care clinicians and certain other specialties…are underpriced by the Medicare fee schedule for physicians and other health professionals compared with other services such as procedures. The Commission has also become concerned that the fee schedule—with its orientation toward discrete services that have a definite beginning and end—is not well designed to support primary care, which requires ongoing care coordination for a panel of patients.").

[214] MEDPAC, REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY 39 (Mar. 2019).

[215] MEDPAC, REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY 59 (Mar. 2020).

III. Private-Sector Quality-Improvement Efforts

Private third-party payers have shown greater interest and initiative in quality improvement by, for example, developing innovative payment systems. The CBO reports that as a share of revenues, private insurers spend at least one third more than traditional Medicare on quality-improvement activities.[216] As we note above (Part II.A.), a century before Congress created Medicare, the private sector developed payment systems that reward the dimensions of quality Medicare discourages.

The private sector has been more innovative when it comes to reforming fee-for-service payment as well. Private insurers and employers began tying fee-for-service payments to quality at least as early as the early 1990s—two decades before Medicare did.[217] After Intermountain Health Care reduced pneumonia mortality in 1995, private fee-for-service insurers worked with Intermountain to address how their payment rules discouraged such innovation.[218] In 2003, MedPAC offered a lengthy list of quality-improvement initiatives that private insurers and employers had deployed and traditional Medicare had not, including "financial and nonfinancial incentives to improve quality."[219] By that year, "the private sector [wa]s using utilization review, selective contracting, and performance-based compensation to enhance quality of care [while traditional] Medicare [wa]s not

[216] CBO's Single-Payer Health Care Systems Team, *supra* note 16 at 156 ("Roughly 0.8 percent of private insurers' spending as a percentage of premiums is devoted to quality-improvement activities," while "Under the Medicare [fee-for-service] program…spending on quality-improvement programs…accounts for about 0.6 percent of total spending." The gap in quality-related spending is wider than these figures suggest, CBO notes, because the private-insurers figure does not include "additional spending to other quality-improvement activities, such as improving consumers' experience or promoting IT interoperability," while the government figure includes non-quality-related "spending on fraud-prevention programs.").

[217] *See Medicare Value-Based Purchasing for Physicians' Services Act of 2005: Hearing on H.R. 3617 Before the Subcomm. on Health of the H. Comm. on Ways and Means*, 109th Cong. (2005) (statement of Karen Ignagni, President and CEO of America's Health Insurance Plans) ("Highmark Blue Cross Blue Shield…adopted a Quality Incentive Payment System that rewards primary care physicians for demonstrating improvement in measures for preventive screenings, treatment of chronic conditions, and other quality and service issues" in 1994).

[218] Porter & Teisberg, *supra* note 58. *See also* INST. OF MED., *supra* note 28 (providing additional detail on the Intermountain experience and the deterrent effect perverse payment incentives can have on improving diabetes management).

[219] *See* MEDPAC, REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY 122-25 (Jun. 2003).

really using any of these tools."[220] A 2017 survey found "value-oriented payments" account for 53 percent of payments private insurers make to health care providers.[221]

Private Medicare Advantage plans have likewise been more innovative than traditional Medicare. In 2020, MedPAC wrote:

> [Medicare Advantage] plans have a number of management tools that are not available in [traditional Medicare] but permit plans to improve the quality of care for their enrollees—tools such as selective contracting, care management, information systems shared across providers, and utilization management that can prevent overutilization of potentially harmful care.[222]

Striking a familiar note, MedPAC continued, "We would therefore expect quality in [Medicare Advantage] to be better than in [fee-for-service], but a lack of sufficient data severely limits any definitive comparisons."[223]

Even so, a systematic review found studies comparing traditional Medicare and Medicare Advantage plans tend to give the latter the edge on quality:

> [I]n most or all comparisons, [Medicare Advantage] was associated with higher use of preventive care

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220 Hyman, *supra* note 102, at 62.

221 *See National Scorecard on Payment Reform 2.0 – Lookback Edition*, CATALYST FOR PAYMENT REFORM, INC. (2019), https://www.catalyze.org/product/national-lookback-payment-reform/; *see also National Scorecard on Commercial Payment Reform 2.0 Lookback Edition: Data from 2012, 2013, 2016, & 2017 (Methodology)*, CATALYST FOR PAYMENT REFORM, INC. (2019), https://www.catalyze.org/wp-content/uploads/woocommerce_uploads/2019/12/CPR-Lookback-National-Scorecard-Payment-Reform.zip ("[The] eValue8 health plan survey…is a voluntary survey and is not designed to ensure a representative sample of health plans, but it is one of the largest national surveys of health plans…The 2017 dataset aggregates payment reform data from 46 health plans that responded to the 2018 eValue8 RFI or provided payment reform data to CPR through an identical survey. These 46 plans represented approximately 89 million covered lives in the commercial market, which was approximately 50 percent of total commercial lives in the US at that time.").

222 MEDPAC, REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY 397 (Mar. 2020).

223 *Id.*

> visits, fewer hospital admissions, fewer emergency department visits, shorter hospital and skilled nursing facility lengths-of-stay, and lower health care spending relative to traditional Medicare. Although [Medicare Advantage] plans outperformed traditional Medicare in most studies comparing quality-of-care metrics, their enrollees were more likely to receive care in average-quality hospitals and lower-quality nursing facilities and home health care agencies. The evidence on readmission rates, mortality, experience of care, and racial/ethnic disparities did not show a trend of better performance in [Medicare Advantage] plans than traditional Medicare, despite the higher payments to [Medicare Advantage] plans.[224]

Echoing MedPAC, the reviewers call for "complete and comparable data" across the two programs.[225]

Quality is obviously a challenge for private insurers as well. While the study of Florida hospitals above found greater reductions in readmissions among patients with Medicare Advantage and private health plans than among patients in traditional Medicare,[226] MedPAC writes that overall, "[e]fforts to promote the use of [value-based purchasing)] in the commercial sector have had relatively modest effects to date."[227]

A potential impediment to private-sector quality-improvement efforts are government interventions that distort the medical marketplace in favor of fee-for-service payment and deny consumers the opportunity to choose their own health plans. Former Medicare administrator Donald Berwick and his coauthors explain:

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[224] Rajender Agarwal et al., *Comparing Medicare Advantage And Traditional Medicare: A Systematic Review*, 40 HEALTH AFF. 942, 937-44 (2021), https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2020.02149.

[225] *Id.*

[226] Chen & Grabowski, *supra* note 148, at 656.

[227] MEDPAC, REPORT TO THE CONGRESS: MEDICARE AND THE HEALTH CARE DELIVERY SYSTEM 8 (Jun. 2020).

> Even if payment schemes were sensitive to quality, and even if consumers could see the difference between better and worse care, [incentives for quality] improvement would be weakened by the distance between the patients and the payment rules. People and payers who might be quite willing to pay a premium for more fully integrated chronic disease care, for the option of a group visit, or for detailed management of their lipid medications do not have the option to do so because of fixed fee schedules and complex payment rules. This is particularly true under Medicare. In effect, people do not have the option to pay for what they want, even if what they want is better than what they have.[228]

This is also true for workers whom the federal tax code locks into generally fee-for-service plans that their employers choose.

IV. A "Public Option" Framework for Medicare

Congress can reverse Medicare's negative impact on quality by reorganizing the program along "public option" principles that President Biden and other policymakers have endorsed.[229] Advocates of a public option propose robust competition between a government-run health plan and private health insurance plans on a level playing

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[228] Leatherman et al., *supra* note 32 ("If transparency about care quality and program configuration were available, it ought to be possible for consumers to select more customized care packages if they could be released from the handcuffs of pure administrative pricing. If patient A wants e-mail care, and patient B does not, why should each not be able to choose what he or she most values? One way to improve quality is to allow customization; the current payment mechanisms do not.").

[229] BIDEN-SANDERS UNITY TASK FORCE RECOMMENDATIONS 31 (Aug. 2020), https://joebiden.com/wp-content/uploads/2020/08/UNITY-TASK-FORCE-RECOMMENDATIONS.pdf ("we will give all Americans the choice to select a high-quality, affordable public option through the Affordable Care Act marketplace. The public option will provide at least one plan choice without deductibles, will be administered by the traditional Medicare program, not private companies, and will cover all primary care without any copayments and control costs for other treatments by negotiating prices with doctors and hospitals, just like Medicare does on behalf of older people.")

field.[230] In the absence of government favoritism toward any market competitor, consumers would act as the ultimate arbiters of quality and efficiency.[231]

A completely level playing field between a government-run health plan and private insurers is likely unattainable. Government programs can benefit from advantages over private competitors that reflect neither greater quality nor efficiency.[232] Traditional Medicare will likely always enjoy such advantages. Regardless, a measure of competition already exists between traditional Medicare and private Medicare Advantage plans, and there are indications that even this limited competition may be improving quality for Medicare enrollees in ways that otherwise would not have occurred (see discussion of Medicare Advantage plans' quality-improvement tools above).

Congress can make the playing field more level by making Medicare enrollees fully cost-conscious and removing distortions that push enrollees in the direction of particular plans. At present, various policies can make either traditional Medicare or Medicare Advantage plans seem more attractive for reasons unrelated to efficiency. Such distortions can push enrollees to choose lower-quality plans. Eliminating those distortions would promote quality by leading enrollees to choose (and moving the market toward) higher-quality and/or lower-cost plans.

In particular, public-option principles require eliminating favoritism toward fee-for-service payment, or whatever payment rules the government plan happens to employ. Applying that principle to Medicare would increase demand for prepaid group plans and other non-fee-for-service arrangements, promoting dimensions of quality Medicare currently discourages. In a Medicare program that operates

230 *See id.*

231 *See* Michael F. Cannon, *Fannie Med? Why a 'Public Option' Is Hazardous to Your Health*, 642 CATO INST. 1, 8 (Aug. 6, 2009), https://www.cato.org/sites/cato.org/files/pubs/pdf/pa642.pdf.

232 Government entities can enjoy special advantages even when Congress has not yet created any. In 1996, the Treasury Department estimated Fannie Mae and Freddie Mac saved $6 billion annually in borrowing costs due solely to the widespread belief that Congress would intervene if those institutions ever encountered financial difficulty. *See Government Sponsorship of the Federal National Mortgage Association and the Federal Home Loan Mortgage Corporation*, U.S. DEPT. OF THE TREASURY 10, (July 11, 1996), http://archive.org/stream/governmentsponso00uni#page/10/mode/1up. A government-operated "public option" may benefit from similar perceptions.

under public-option principles, enrollees would make tradeoffs between different payment systems based on their values and without political interference from low-quality providers. Such a framework would, as MedPAC recommends, "giv[e] accountable entities stronger incentives to control costs and improve quality and then rely on those entities to develop the most effective payment arrangements to meet those goals."[233] As in other markets, competition for the most discerning consumers would improve quality and reduce costs for less-sophisticated consumers as well.

While advocates typically propose creating a public option to compete with private insurers in the non-Medicare market, Medicare offers a better opportunity to test public-option principles. Medicare already boasts an established if imperfect public option (traditional Medicare) that competes against private insurers (Medicare Advantage plans) to cover a large population of patients with experience choosing between a government-run plan and private plans. Medicare already offers "what is essentially a risk-adjusted voucher program" where enrollees choose between these options.[234] Unlike proposals to create a public option in the non-Medicare market, applying public-option principles to Medicare would not require new government spending[235] and could even reduce government spending.[236] The foregoing discussion illustrates that Medicare enrollees are in desperate need of the quality innovations and improvements such competition would generate. Finally, unlike creating a public option to compete in the non-Medicare market,

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233 MEDPAC, REPORT TO THE CONGRESS: MEDICARE AND THE HEALTH CARE DELIVERY SYSTEM 8 (June 2020).

234 MARK V. PAULY, MARKETS WITHOUT MAGIC: HOW COMPETITION MIGHT SAVE MEDICARE 13 (2008), https://www.aei.org/wp-content/uploads/2014/03/-markets-without-magic_102727716432.pdf ("While Medicare has for a long time offered what is essentially a risk-adjusted voucher program for private…insurance options, it has treated the traditional government-managed fee-for-service insurance plan differently.").

235 *See* CONG. BUDGET OFF., A PUBLIC OPTION FOR HEALTH INSURANCE IN THE NONGROUP MARKETPLACES: KEY DESIGN CONSIDERATIONS AND IMPLICATIONS 15 (Apr. 2021), https://www.cbo.gov/system/files/2021-04/57020-Public-Option.pdf.

236 CONG. BUDGET OFF., A PREMIUM SUPPORT SYSTEM FOR MEDICARE: UPDATED ANALYSIS OF ILLUSTRATIVE OPTIONS 9, 11 (Oct. 2017), https://www.cbo.gov/system/files/115th-congress-2017-2018/re+ports/53077-premiumsupport.pdf.

applying public-option principles to Medicare could garner support from both major political parties.

Applying public-option principles to Medicare requires several steps.

A. Subsidize Enrollees Directly

Leveling the playing field between traditional Medicare and Medicare Advantage plans requires subsidizing enrollees directly. Medicare currently makes payments on behalf of enrollees either to providers (traditional Medicare) or insurance companies (Medicare Advantage). Each option uses different rules that determine an enrollee's net subsidy. In such a system, it is inevitable that enrollees will receive a larger subsidy under one option or the other. On average, the subsidy enrollees receive under Medicare Advantage is 4 percent larger, with much of the additional subsidy appearing as extra coverage.[237] The lure of larger subsidies partly accounts for projections that enrollment in Medicare Advantage will rise from the current 40 percent to more than half of all Medicare enrollees (56 percent) in 2031.[238]

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[237] Alain Enthoven, *To Reform Medicare, Reform Incentives and Organizations*, COMM. FOR ECON. DEV. 11 (2011), https://core.ac.uk/download/pdf/71359958.pdf____and https://www.ced.org/pdf/To-Reform-Medicare-Reform-Incentives-and-Organization.pdf ("Insurers have argued for Medicare Advantage payments from government higher than the cost of [fee-for-service] Medicare"); MEDPAC, REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY xxv, 356 (Mar. 2021) ("aggregate [Medicare Advantage] payments (including rebates that finance extra benefits) are about 4 percent higher than expected [fee-for-service] expenditures for similar beneficiaries, an increase of more than 1 percentage point from last year"); MEDPAC, REPORT TO THE CONGRESS: VARIATION AND INNOVATION IN MEDICARE 371, 395 (Mar. 2021) ("Throughout the history of Medicare [Advantage], the program has paid more—sometimes much more—than it would have paid for beneficiaries to have remained in [traditional] Medicare"; "Further, the value of extra benefits offered to [Medicare Advantage] enrollees—now equal to approximately $1,700 annually per enrollee, or 14 percent of the basic benefit— has reached a historical high for the fourth consecutive year"); Jacob S. Hacker, *There's a simple fix for Obamacare's current woes: the public option*, VOX (Aug. 18, 2016), https://www.vox.com/2016/8/18/12520820/public-option-health-care-obamacare ("We shouldn't give the public option special breaks, but we shouldn't give them to private plans either."). *See also* Ken Terry & David Muhlestein, *Medicare Advantage For All? Not So Fast*, HEALTH AFF. BLOG (Mar. 11, 2021), https://www.healthaffairs.org/do/10.1377/hblog20210304.136304/full/ ("[Medicare Advantage] plans offer beneficiaries a better deal than traditional Medicare").

[238] CONG. BUDGET OFFICE, MEDICARE BASELINE PROJECTIONS – JULY 2021 3 (July 2021), https://www.cbo.gov/system/files/2021-07/51302-2021-07-medicare.pdf (projecting 44 million out of 79 million Medicare enrollees will choose group plans by 2031).

At the same time, sicker enrollees appear to receive larger subsidies under traditional Medicare. In part, this appears to be due to the negative impact of community-rating price controls on the quality of Medicare Advantage plans (see Part I.C.). Medicare Advantage enrollees who switch to traditional Medicare in their last year of life nearly triple their subsidy. Traditional Medicare spends an average of $25,000 more on such enrollees than Medicare would if they had remained in Medicare Advantage.[239]

This bifurcated, haphazard system of determining an enrollee's net subsidy encourages enrollees to choose inefficiently high-cost and/or low-quality plans. The lure of larger subsidies creates incentives for enrollees to sort themselves into plans according to the size of the subsidy they receive instead of which plan offers the optimal balance of quality and cost.

Eliminating those perverse incentives requires that each enrollee's subsidy be the same regardless of what plan she chooses, and that traditional Medicare and private plans receive no revenue other than what enrollees voluntarily contribute in premiums. Any subsidies, whether explicit or hidden, that favor either traditional Medicare or private plans will distort enrollees' plan choices in the direction of inefficiently low-quality or high-cost plans. A level playing field requires that all plans survive solely on the premium dollars enrollees voluntarily contribute, and that plans earn revenue solely by pleasing enrollees.

Economists have proposed eliminating these perverse incentives by having Medicare directly pay each enrollee a fixed subsidy the enrollee can apply to either traditional Medicare or private insurance.[240] Program administrators would take the money Medicare otherwise would pay to providers and insurers and give those funds directly to enrollees as a monthly payment, just as Social Security does. In 2022, they would divide $797 billion among the program's 66 million enrollees, such that enrollees would receive an

[239] U.S. GOV'T ACCOUNTABILITY OFF., GAO-21-482, MEDICARE ADVANTAGE: BENEFICIARY DISENROLLMENTS TO FEE-FOR-SERVICE IN LAST YEAR OF LIFE INCREASE MEDICARE SPENDING 12, 15 (June 28, 2021), https://www.gao.gov/assets/gao-21-482.pdf.

[240] *See* PAULY, *supra* note 234, at 12 ("While Medicare has for a long time offered what is essentially a risk-adjusted voucher program for private…insurance options, it has treated the traditional government-managed fee-for-service insurance plan differently.").

average subsidy of $12,100.[241] Medicare would then adjust individual allotments according to each enrollee's health status and income (see below), such that all enrollees could afford a standard health insurance plan comparable to traditional Medicare. The net effect is that enrollees would receive approximately the same subsidy they would under current law.

Enrollees could then combine their subsidy with the funds they would otherwise spend on premiums for Medicare Part B, Medicare supplemental insurance, and/or Medicare Advantage plans. These additional funds would leave enrollees with an average of $14,300.[242] They could use those combined funds to enroll in either traditional Medicare or a private plan. Enrollees who like traditional Medicare could keep it. [243]

B. Cost-Consciousness

Insulating consumers from the cost of health insurance and medical care suppresses quality. Medicare insulates enrollees from most of those costs, then makes enrollees cost-conscious with gaps in coverage that discourage highly effective care. Public-option principles and quality improvement require making Medicare enrollees fully cost-conscious. On net, full cost-consciousness would likely improve enrollee health by increasing incentives to consume beneficial care and avoid harmful care.

Recall that (1) fee-for-service payment creates insufficient incentives to deliver many highly effective treatments, (2) in some cases it creates perverse incentives not to deliver highly effective treatments, (3) integrated, prepaid systems such as Group Health

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241 *See* CONG. BUDGET OFF., *supra* note 4 (numerator: $797 billion in governmental Medicare outlays, i.e., excluding enrollee premiums); and CMS, *supra* note 5 (denominator: 66 million enrollees).

242 *See* CONG. BUDGET OFF., *supra* note 4 at 4 (numerator: $943 billion in Medicare outlays, including enrollee premiums); and CMS, *supra* note 5 (denominator: 66 million enrollees).

243 *Cf.* Angie Drobnic Holan, *Lie of the Year: 'If You Like Your Health Care Plan, You Can Keep It*,' POLITIFACT, (Dec. 12, 2013), https://www.politifact.com/article/2013/dec/12/lie-year-if-you-like-your-health-care-plan-keep-it/. Whereas the ACA forced consumers out of their existing coverage by prohibiting certain health plans, a public-option framework would create no barriers to traditional Medicare remaining in the market. Were traditional Medicare to cease operations, it would be because enrollees decided it does not meet their needs.

Cooperative of Puget Sound and Kaiser Permanente are weak on some dimensions of quality but strong on dimensions that fee-for-service discourages, and (4) promoting all dimensions of quality requires open competition between all payment and delivery systems on a level playing field. (See Part I.)

Medicare insulates enrollees from the cost of health insurance in ways that tilt the playing field in favor of fee-for-service payment. For many enrollees, it does so by granting them larger subsidies if they enroll in traditional, fee-for-service Medicare (see Part IV.A.).

Even within Medicare Advantage, Congress uses cost-insulation in a manner that tilts the playing field in favor of fee-for-service plans and providers. For integrated, prepaid plans to enter new markets, "scale must be achieved quickly," which "requires access to a large population" of consumers "who are offered a cost-conscious choice of plan."[244] Congress allows Medicare Advantage enrollees who choose lower-cost plans to see only 50-70 percent of the savings, with only one-sixth of that amount returning to the enrollee as cash. The lion's share goes toward extra coverage or insurer administrative costs and profits.[245] Insulating Medicare Advantage enrollees from the cost of their health plan choices makes them less likely to choose integrated, prepaid systems. Lack of cost-consciousness thus inhibits the ability of those plans to compete and to deliver the dimensions of quality where they excel.

After using insulating enrollees from cost in a manner that undermines quality, Medicare then exposes enrollees to cost in a manner that discourages effective care. Traditional Medicare contains cost barriers in the form of gaps in coverage that lead enrollees to forgo beneficial care:

- 11 percent of Medicare enrollees overall, 20 percent of enrollees "in fair or poor self-assessed health," and 23 percent of Black enrollees report "delaying getting medical care because of cost, needing medical care but not getting it

244 Enthoven, *supra* note 33.

245 MEDPAC, REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY 360, 367 (Mar. 2021), ("Two other uses of rebate dollars are for reductions in Part D premiums (15 percent of projected rebates)…and reductions in Part B premiums (2 percent of projected rebates).").

because of cost, or problems paying or inability to pay any medical bills."[246]

- 5 percent of Medicare enrollees, 7 percent of Black enrollees, and 11 percent of enrollees "in fair or poor self-assessed health" report "having a problem for which they should have seen a doctor but didn't."[247]
- "Medicare beneficiaries whose incomes slightly exceed Medicaid's supplemental coverage eligibility threshold . . . incur an additional $1,100 in out-of-pocket healthcare costs every year," "utilize[] outpatient services 55 percent less often than those with Medicaid coverage," and "fill[] fewer prescriptions."[248]
- Such barriers appear to reduce access to effective care. "Having trouble obtaining or delaying healthcare because of financial reasons was also significantly associated with [21 percent] reduced odds of receiving [measured] recommended medical care."[249]

Projections indicate the average amount enrollees spend out-of-pocket on medical care will "rise as a share of average per capita Social Security income, from 41 percent in 2013 to 50 percent in 2030."[250] (Barriers to care would persist even if Congress eliminated all cost-sharing: the CBO estimates 54 percent of the additional demand Medicare for All would generate would go unmet due to "delays and forgone care."[251]) The combined effect of these perverse

246 Ochieng, *supra* note 19.

247 *Id.*

248 Nelson, *supra* note 19.

249 Kurichi, *supra* note 19, at 7.

250 Juliette Cubanski et al., *Medicare Beneficiaries' Out-of-Pocket Health Care Spending as a Share of Income Now and Projections for the Future*, KAISER FAM. FOUND. i (Jan. 26, 2018), https://files.kff.org/attachment/Report-Medicare-Beneficiaries-Out-of-Pocket-Health-Care-Spending-as-a-Share-of-Income-Now-and-Projections-for-the-Future.

251 CONG. BUDGET OFF., HOW CBO ANALYZES THE COSTS OF PROPOSALS FOR SINGLE-PAYER HEALTH CARE SYSTEMS THAT ARE BASED ON MEDICARE'S FEE-FOR-SERVICE PROGRAM 8, 137 (Dec. 2020), https://www.cbo.gov/system/files/2020-12/56811-Single-Payer.pdf.

incentives and cost barriers is that underuse of highly effective treatments is widespread in Medicare and has been for decades.[252]

Making enrollees fully cost-conscious would improve quality by creating targeted incentives both to increase the use of effective services and to reduce the use of harmful services. Cost-conscious enrollees would increase demand for integrated, prepaid health systems that profit by developing and delivering quality improvements—such as Group Health Cooperative's treatment protocols for Type 2 diabetics (see Part I.A.), Intermountain's pneumonia-treatment guidelines, the Duke and Baylor heart-failure-treatment programs, the Bellingham care-coordination program (see Part I.C.), and countless other examples of high-quality care that traditional Medicare discourages.

Reducing consumption of harmful care is as important to promoting quality and health as ensuring Medicare enrollees receive beneficial care. Full cost-consciousness would reduce harmful care through two mechanisms. Research suggests cost-consciousness leads patients themselves to effect "a beneficial reduction in use of harmful medical services."[253] The RAND Health Insurance Experiment showed that without any expert guidance, cost-conscious patients reduced their consumption of harmful care so dramatically, the benefits of avoiding harmful care offset any harm from forgoing beneficial care.[254] The net result was that cost-consciousness had no adverse effect on health.[255]

Full cost-consciousness would improve on that performance by providing enrollees expert guidance. Integrated, prepaid health systems face greater incentives than fee-for-service providers to avoid unnecessary and harmful services because they internalize the

[252] *See especially* Ellerbeck et al., *supra* note 52; Krumholz et al, *supra* note 52; Marciniak et al., *supra* note 52; O'Connor et al., *supra* note 52; Asch et al., *supra* note 53; Stephen F. Jencks et al., *supra* note 53 (2000); Jencks et al., *supra* note 53 (2003); and McGlynn et al., *supra* note 53.

[253] *See* Chernew & Newhouse, *supra* note 17.

[254] *Id.*

[255] *Id.* ("RAND researchers interpreted the failure to find an effect of cost sharing on health status as reflecting a beneficial reduction in use of harmful medical services that offset the negative consequences associated with a reduced use of beneficial services. Specifically, some of the services forgone because of higher cost sharing might have led to worse health outcomes, suggesting a benefit from charging patients more.").

savings. They also face greater incentives to conduct research that identifies harmful practices. (See Part I.A.). Competing and constantly updating treatment guidelines from multiple integrated, prepaid systems could steer enrollees toward highly effective care and away from harmful care. Public-option principles could reverse the practice patterns in high-spending regions that lead to "worse health outcomes" including "a higher risk of death over time."[256]

Full cost-consciousness requires allowing enrollees to keep 100 percent of the savings from choosing efficient plans and providers. Ideally, Medicare enrollees would have as much control over their Medicare checks as their Social Security checks. They could put whatever funds they do not spend on health insurance or medical care toward whatever uses they wish, including savings and passing those funds down to their heirs.

A complete accounting suggests full cost-consciousness would not harm and could improve overall health. In addition to virtuous incentives to increase the use of effective care and reduce the use of harmful care, other factors would protect Medicare enrollees. Those factors include the vast inefficiency of the current Medicare program and supply-side responses from self-interested providers.

Ironically, the inefficiency of the current Medicare program would create a wide margin of safety that would protect the health of fully cost-conscious enrollees. Research indicates one third of Medicare spending appears to produce no net benefit; it does nothing to make enrollees healthier or happier.[257] (See Part I.C.) In the RAND Health Insurance Experiment, cost-conscious patients, again without expert guidance, reduced their consumption of medical care by one third without any adverse effect on overall health.[258] Setting each enrollee's Medicare subsidies roughly equal to what they would receive under current law therefore implies enrollees could reduce their aggregate medical consumption by one third—that is, enrollees could spend up to $261 billion of their Medicare subsidies each year

256 Fisher, *supra* note 80.

257 *Id.* ("We may be wasting perhaps 30% of U.S. health care spending on medical care that does not appear to improve our health.").

258 *See generally* Willard G. Manning et al., *Health Insurance and the Demand for Medical Care: Evidence from a Randomized Experiment*, 77 AM. ECON. REV. 259, 260 (1987), https://www.rand.org/content/dam/rand/pubs/reports/2005/R3476.pdf, and authors' calculations.

on items other than medical care—without harming their overall health. The actual share of Medicare spending that is net wasteful may be even larger. If so, enrollees would have an even wider margin of safety.

The self-interest of insurers and providers would protect enrollees. If enrollees forgo care because they are ignorant about the benefits—if the "overall impact on welfare [is] different from the price elasticity of demand"[259]—the profit motive would lead insurers and providers to solve that problem by educating enrollees about the benefits of spending more of their subsidy on health insurance and medical care. Providers would face incentives to reduce the costs and prices of those services to appeal to reluctant consumers.[260] Nonconsumption of primary care spurred the creation of lower-cost retail clinics. [261] Nonconsumption of other forms of effective care would likewise spur innovations that reduce prices and expand access. Insurers, particularly prepaid plans, would face incentives to encourage enrollees to consume preventive services that avoid more expensive interventions.

While some enrollees would forgo beneficial care in ways that could harm their health,[262] such cases are likely to be either not a significant policy concern or not a problem to which cost-insulation presents a solution. Decisions to forgo care frequently reflect enrollees' true preferences.[263] In such cases, insulating enrollees from

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[259] *See* Amitabh Chandra, et. al., *The Health Costs of Cost-Sharing*, 1 (Nat'l Bureau of Econ. Rsch., Working Paper No. 28439, 2021), https://www.nber.org/system/files/working_papers/w28439/w28439.pdf.

[260] *Id*. Obvious examples are low-cost statins and antihypertensives.

[261] *See* CLAYTON M. CHRISTENSEN ET AL., THE INNOVATOR'S PRESCRIPTION: A DISRUPTIVE SOLUTION FOR HEALTH CARE 120, 134 (2016), https://www.amazon.com/Innovators-Prescription-Disruptive-Solution-Health/dp/1259860868 ("60 percent of patients who receive care at retail clinics do not have a personal care physician at all"; "When there is no nonconsumption of a product…then the height of the hurdle to success [for cost-reducing innovations] is a lot higher").

[262] Chandra, *supra* note 259, at 1 (finding an increase in cost-sharing for Medicare enrollees led to higher mortality due to "cutbacks in life-saving medicines like statins and antihypertensives").

[263] *See, e.g.*, ABC7 San Francisco, *90-Year-Old Woman Chooses Trip of a Lifetime over Cancer Treatment*, ABCNEWS7 (Feb. 29, 2016), https://abc7news.com/90-year-old-woman-cancer-treatment-road-trip/1223910/ ("Just two days after Norma's husband of 67 years passed away, she was diagnosed with uterine cancer. Doctors gave her the options of surgery, radiation or chemotherapy. She decided she would forgo any treatment, telling the doctors, 'I'm 90 years old, I'm hitting the road.'").

cost induces them to consume services whose net social cost is negative—i.e., whose costs exceeds the benefits enrollees expect to receive. In all cases, insulating enrollees from the costs of health insurance and medical care diminishes incentives for insurers to increase consumption of effective care and reduce harmful care, for providers to reduce prices, and for both insurers and providers to educate consumers about the benefits of effective care.

C. Removing Incentives for Low-Quality Care

Public-option principles also require eliminating regulations that reduce the quality and relative appeal of private insurance. The community-rating price controls Congress imposes on Medicare Advantage plans differentially reduce the quality of those plans relative to traditional Medicare. The dynamic of high-cost enrollees disproportionately switching from Medicare Advantage to traditional Medicare is evidence of the quality problems community-rating price controls foster in Medicare Advantage plans. (See Part I.C.) Eliminating those price controls would improve the quality of Medicare Advantage plans and remove an artificial distortion that favors traditional Medicare.

Absent those price controls, Medicare Advantage plans would charge premiums that correspond to each individual enrollee's expected medical expenses. Congress can ensure that all enrollees could afford a minimum level of health insurance coverage by adjusting enrollees' Medicare checks to reflect their health status. Congress already uses "risk adjustment" to ensure the total premium Medicare Advantage plans receive for insuring each individual enrollee reflects that enrollee's expected medical expenses.[264] Risk-adjustment attempts to mimic the actuarially fair premiums markets would generate in the absence of price controls. An example: in 2018, on average, Medicare paid Medicare Advantage plans $5,707 to cover a typical 84-year-old male but $9,796 if he had diabetes and

[264] MEDPAC, REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY xxiv (Mar. 2021), ("Medicare payments to [Medicare Advantage] plans are enrollee-specific, based on a plan's payment rate and an enrollee's risk score. Risk scores account for differences in expected medical expenditures and are based in part on diagnoses that providers code.").

vascular disease. Other diagnoses "increase payment by $10,000 or more."[265]

Congress should repurpose the Medicare Advantage risk-adjustment program to ensure the subsidies Medicare issues directly to enrollees reflect each enrollee's health status. In the case of 84-year-old males with diabetes and vascular disease, Medicare would use the same risk-adjustment formula but transfer the $9,796 to the enrollee rather than an insurance company. Each enrollee would receive a subsidy proportionate to her expected medical expenses, and thus proportionate to the actuarially fair premiums insurers would charge her, such that each enrollee could afford a health insurance plan actuarially comparable to traditional Medicare. The premiums insurers charge for enrollees with various illnesses would act as benchmarks for calibrating the higher subsidies Medicare issues enrollees with various diagnoses.

Similar to risk-adjustment is income-adjustment. After adjusting subsidies for risk, Congress could then reduce subsidies of higher-income enrollees by the same amount that current means-testing of Part B premiums reduces their net subsidy. Medicare checks would thus reflect both medical and financial need.

Enrollees would then combine their Medicare checks with whatever funds they would otherwise apply toward premiums for Medicare, supplemental insurance, and/or Medicare Advantage plans to purchase the health insurance plan of their choice. The net effect of these changes would be that enrollees would receive subsidies roughly equal to what they would under current rules, but with fewer distortions reducing quality or steering enrollees toward lower-quality coverage.

D. Excessive Coverage

Various Medicare rules further reduce quality by tilting the playing field toward excessive coverage and overuse of medical

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265 MEDPAC, THE MEDICARE ADVANTAGE PROGRAM: STATUS REPORT IN REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY 387 (Mar. 2020), ("a simplified example using average [fee-for-service] Medicare spending"; "The payment per [Medicare Advantage] enrollee for most [hierarchical condition categories] is between $1,000 and $5,000.").

services. Traditional Medicare offers enrollees an effectively open-ended entitlement to covered services, for example, while at the same time favoring fee-for-service payment, which encourages providers to provide more services. Overuse reduces quality because marginal services are more likely to be low-quality and net harmful.[266] Though "evidence of overuse also has been found in capitated payment arrangements," MedPAC explains "overuse is more likely to occur in payment models such as [fee-for-service] Medicare that create incentives to overprovide services with little or no benefit for patients."[267]

Medicare also encourages excessive coverage and overuse in Medicare Advantage by requiring Medicare Advantage plans to provide coverage at least as comprehensive as traditional Medicare. This restriction tilts the playing field toward comprehensive coverage by effectively prohibiting lower-cost catastrophic plans from competing to cover Medicare enrollees. Allowing enrollees to choose low-cost catastrophic plans, and keep 100 percent of the premium savings, would further level the playing field and go a long way toward reducing excessive coverage and overuse.

Ideally, Congress would not restrict the types of health plans enrollees can purchase with their Medicare subsidy nor even require enrollees to purchase a health plan, any more than Congress dictates how seniors spend their Social Security checks. Any such restrictions would limit innovation and encourage overuse by requiring enrollees to purchase more coverage than they prefer. Imposing a requirement to purchase a health plan, moreover, would require Congress to define a minimum level coverage that satisfies the requirement. Any such definition would inhibit consumer choice and competition among insurers. It would also lead to intense lobbying by providers to ensure Medicare requires enrollees to purchase coverage for *their* services and more comprehensive coverage generally.

If Congress chose not to require enrollees to purchase health insurance but wished to require them to spend their subsidy only on medical care and health insurance, it would need to develop a

[266] *See* Chernew & Newhouse, *supra* note 17; MEDPAC, REPORT TO THE CONGRESS: VARIATION AND INNOVATION IN MEDICARE 97 (Mar. 2021); and Fisher, *supra* note 80.

[267] MEDPAC, REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY 40 (June 2014).

definition of "health insurance" that would be eligible for purchase with those funds. In that case, Congress could define qualified health insurance as any health plan licensed for sale anywhere in the United States or U.S. territories. Such a definition would allow enrollees to purchase health plans free from many of the above restrictions, without further action by Congress.[268]

E. Plan Switching

Congress imposes complex restrictions on when Medicare enrollees may switch plans. In general, enrollees may switch from a Medicare Advantage plan to traditional Medicare or between Medicare Advantage plans only within three months of enrolling in Medicare; or from January through March; or during a seven-week period running from October to December. Enrollees can generally only switch from traditional Medicare to a Medicare Advantage plan during the latter period.[269] These restrictions tilt the playing field by making it easier to enroll in traditional Medicare than to leave it, and generally prevent enrollees from switching from lower-quality plans to higher-quality plans.

Congress imposes these restrictions primarily to mitigate the adverse selection that results from the price controls it imposes on traditional Medicare and Medicare Advantage plan premiums.[270] Requiring plans to charge identical premiums to high-cost and low-cost enrollees creates opportunities for enrollees to switch to comprehensive plans when they require expensive services, then switch back to less-comprehensive plans when they no longer do. The

[268] Plans available in U.S. territories are exempt from many of the costliest federal health insurance regulations. Letter from Marilyn Tavenner, Ctr. for Medicare and Medicaid, Letter to Gregory R. Francis, Comm'r, Off. of Lieutenant Gov'r (July 16, 2014), https://www.cms.gov/CCIIO/Resources/Letters/Downloads/letter-to-Francis.pdf ("the following Affordable Care Act requirements will not apply to individual or group health insurance issuers in the U.S. territories: guaranteed availability (PHS Act section 2702), community rating (PHS Act section 2701), single risk pool (Affordable Care Act section 1312(c)), rate review (PHS Act section 2794), medical loss ratio (PHS Act section 2718), and essential health benefits (PHS Act section 2707).").

[269] *See Joining a Health of Drug Plan*, MEDICARE (Oct. 22, 2021) https://www.medicare.gov/sign-up-change-plans/joining-a-health-or-drug-plan.

[270] Congress imposes similar restrictions on switching between plans in the ACA's health insurance Exchanges.

resulting adverse selection can increase premiums for comprehensive plans to the point where those plans become unsustainable.

Eliminating the price controls Congress imposes on traditional Medicare and Medicare Advantage plan premiums would further improve quality by freeing enrollees to switch to higher-quality plans throughout the year.

F. Quality Innovation

Innovative health insurance designs could allow even enrollees with very expensive conditions to switch to higher-quality health plans throughout the year. Markets long ago developed "renewal guarantees" that protect consumers against the risk that a negative health shock would increase their premiums. So long as an enrollee who gets an expensive diagnosis remains with the same insurer, a renewal guarantee protects her from risk reclassification and allows her to continue paying healthy-person premiums.[271]

However, renewal guarantees do not protect against risk-reclassification if the enrollee wishes to switch insurers. If a Medicare enrollee who received an expensive diagnosis wished to switch to a higher-quality plan with a different insurer, a renewal guarantee would not protect her from the higher premiums the new insurer would charge. Risk-adjustment guarantees that the subsidy she receives from Medicare would eventually rise to enable her to afford the higher premiums that reflect her poorer health status. But during that lag, many Medicare enrollees would not be able to switch to higher-quality plans.

Renewal guarantees nevertheless provide a platform for allowing enrollees to switch to higher-quality plans with different

[271] *See* Bradley Herring and Mark Pauly, *Incentive-Compatible Guaranteed Renewable Health Insurance Premiums*, 25 J. Health. Econ. 395-417 (2006), https://pubmed.ncbi.nlm.nih.gov/16584793/ ("a guaranteed renewability provision…stipulates that no insured's future premium for the given policy will increase more than any other insured's premium increases. Thus, people who unexpectedly become high-risk will pay the same premium as those who remain low-risk…[G]uaranteed renewability provisions appear to be effective in providing protection against reclassification risks in individual health insurance markets"). *See also* JACK HUNGELMANN, INSURANCE FOR DUMMIES 249 (2001), ("Individual policies come out on top with regard to renewability. Most are guaranteed-renewable contracts that you can continue to hold…regardless of your health.").

insurers before—or even without—an upward adjustment in their Medicare subsidy. At little or no additional cost beyond that of renewal guarantees, insurers could offer Medicare enrollees total-satisfaction guarantees that enable enrollees who receive very expensive diagnoses to switch to higher-quality plans whenever they choose.[272]

Total-satisfaction guarantees would operate as follows. If, for any reason, an enrollee becomes unhappy with her current coverage, her insurer will provide her an immediate cash payment. The amount of the payment would equal the difference between (1) the present value of the stream of premium payments she would make toward her current plan for the rest of her life expectancy and (2) the present value of an actuarially fair premium for the rest of her life expectancy. Since (1) would reflect her health status at enrollment and (2) would account for any deterioration in her health status since enrollment, that cash payout would enable her to afford the higher premiums a new insurer would charge.[273]

Total-satisfaction guarantees could improve quality by finally disciplining Medicare plans that shortchange the sick. Research suggests consumers' plan-selection decisions could impose significant discipline on low-quality plans.[274] Twenty percent of Medicare Advantage enrollees switch plans each year.[275] Enrollees with multiple chronic conditions and those in plans with low quality ratings are much more likely to switch plans than other enrollees.[276]

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[272] *See* John H. Cochrane, *Health-Status Insurance: How Markets Can Provide Health Security*, CATO INST. (Feb. 18, 2009), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=1462376.

[273] *See* Michael F. Cannon, *Health Care's Future Is So Bright, I Gotta Wear Shades*, WILLAMETTE L. REV. 559, 565 (2015), https://www.cato.org/sites/cato.org/files/articles/cannon-williamattelawreview-2015.pdf (describing total-satisfaction-guaranteed health insurance in a market without community-rating price controls: "If you don't think your health plan is managing your diabetes or cancer care well, if you think their network is too narrow, or if you are unsatisfied with your health plan for any reason, you can fire your health plan, and other health plans will compete to *cover* you, rather than avoid you").

[274] *See generally* David J. Meyers et al., *Analysis of Drivers of Disenrollment and Plan Switching Among Medicare Advantage Beneficiaries*, 179 JAMA INTERN. MED. 524 (Feb. 25, 2019), https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2725083.

[275] *See id.*

[276] *Id.*

The community-rating price controls Congress imposes on Medicare Advantage plans mutes the impact of those decisions on insurers. Under those price controls, low-quality plans often benefit rather than suffer when high-cost enrollees take their business elsewhere.[277]

Removing those price controls would enable total-satisfaction guarantees that both allow high-cost enrollees to switch to higher-quality plans whenever they choose and force insurers to make large payouts to those enrollees. Total-satisfaction guarantees could provide this discipline at a cost no greater than that of renewal guarantees, which insurers have offered for decades. Eliminating the price controls Congress imposes on Medicare-plan premiums, making enrollees fully cost-conscious, and removing other barriers to innovation would enable insurers to offer these and other protections.

G. Other Preferentialism

Additional steps would be necessary to ensure a level playing field between traditional Medicare and Medicare Advantage plans. For example, traditional Medicare would have to abide by whatever state-level rules Medicare Advantage plans must follow, including reserve-fund requirements and making payments to states equivalent to, and on the same terms as, any taxes and fees private insurers must pay.[278]

H. Cost Control

In addition to improving quality, public-option principles could contain Medicare spending. If reform "induced [more efficient] plans to enter the right markets and the right beneficiaries to choose

[277] *Id.* ("Although risk adjustment has mitigated some cream skimming, plans may still not have an incentive to retain their high-need enrollees, leading to adverse selection not on who enrolls in plans but on those who disenroll…If a plan receives higher risk-adjusted payments for carrying a larger burden of high-need enrollees, and these enrollees are disenrolling at higher rates, then these payments may not be well targeted.").

[278] Some "public option" proposals counterintuitively would exempt a public option from state taxes and fees that private insurers must pay. *See* Choice Act, H.R. 2085, 116th Cong. § 2795(c)(3)(B) (2019), https://www.congress.gov/bill/116th-congress/house-bill/2085/text.

those plans, creating choice for the beneficiaries could save Medicare money."[279]

Medicare's current system for determining enrollee subsidies prevents efficiencies in the delivery of care from translating into savings for taxpayers. Medicare Advantage plans limit utilization more than traditional Medicare. Research indicates Medicare Advantage plans' utilization controls have spillover effects. Greater enrollment in Medicare Advantage plans leads to significant reductions in resource use—e.g., less-intensive inpatient resource use and shorter hospital stays—in *traditional* Medicare (and even commercial insurance). Under traditional Medicare's payment systems, those efficiencies do not necessarily lead to spending reductions in traditional Medicare.[280] The fact that Congress bases subsidies for Medicare Advantage enrollees in part on how much traditional Medicare spends on similar patients "prevents policymakers from using any efficiencies generated by the [Medicare Advantage] program to reduce program spending"[281] in either part of Medicare.

Calibrating individual subsidy amounts through a competitive bidding process between traditional Medicare and private insurers would enable Congress to adjust Medicare spending to reflect efficiencies that reduce the cost of delivering care to enrollees, whether the efficiencies come from private insurance or traditional Medicare. In 2017, the CBO estimated similar reforms could reduce the level of net federal spending on Medicare by up to 15 percent and

279 McGuire et. al, *supra* note 20.

280 Katherine Baicker et al., *The Spillover Effects of Medicare Managed Care: Medicare Advantage and Hospital Utilization*, 32 J. HEALTH ECON. 1, 11 (Dec. 2013), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3855665/pdf/nihms526733.pdf ("a 10% increase in [Medicare Advantage] penetration is associated with a 4.5% decrease in [traditional Medicare] hospitalization costs…while these represent reductions in real resource use (such as fewer days in the hospital), the savings do not all accrue immediately to the Medicare program"). *See also* Katherine Baicker & Jacob A. Robbins, *Medicare Payments and System-Level Health-Care Use: The Spillover Effects of Medicare Managed Care*, 1 AM. J. HEALTH ECON. 399, 399-431 (2015), https://www.journals.uchicago.edu/doi/pdf/10.1162/AJHE_a_00024 ("in areas with greater enrollment of Medicare beneficiaries in managed care, the non–managed care beneficiaries have fewer days in the hospital but more outpatient visits, consistent with a substitution of less expensive outpatient care for more expensive inpatient care…This substitution would imply a reduction in resource use of about $250 per FFS enrollee.").

281 MEDPAC, REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY 395 (Mar. 2021).

additionally "would probably reduce the growth of Medicare spending."[282] Congress can guarantee slower spending growth by assigning to overall Medicare outlays "a prior and prespecified rate of growth."[283] If experience demonstrates public-option principles provide equivalent (or superior) access to care at a lower cost, Congress could adjust that rate of growth downward, whether for new enrollees or all enrollees. If Medicare Advantage plans are correct that they provide equal or better access to care for 20 percent to 40 percent less than traditional Medicare spends,[284] those savings would redound to enrollees and taxpayers rather than insurance companies.

Renewal guarantees and total-satisfaction guarantees could also help reduce Medicare spending. If experience shows these features effectively protect enrollees against the financial impact of negative health shocks that occur post-enrollment, Congress could adjust each enrollee's subsidy to reflect their health status just once, at enrollment, rather than each year.[285] Renewal guarantees could thus reduce Medicare spending, at least for wealthier enrollees, by having the private sector manage the financial risk of post-enrollment changes in health status.

I. Quality-Improvement Activities

Allowing flexible benefit designs would give private insurers an even freer hand to innovate with quality measures and incentives. Making 66 million Medicare enrollees maximally cost-conscious would increase the demand for quality-improvement efforts that focus on overuse, as MedPAC recommends. Plans that reduce overuse would pass the savings on to enrollees through lower premiums.

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[282] CONG. BUDGET OFF., A PREMIUM SUPPORT SYSTEM FOR MEDICARE: UPDATED ANALYSIS OF ILLUSTRATIVE OPTIONS 8-9 (Oct. 2017), https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53077-premiumsupport.pdf ("Although the options also could affect beneficiaries' access to care and the quality of that care, CBO does not have the tools to study such effects and does not anticipate having them in the near future.").

[283] PAULY, *supra* note 234, at 13.

[284] Terry, *supra* note 237. ("[T]he lion's share of those savings seems to be flowing to insurance companies, partly in the form of profits.").

[285] As a backstop, Congress could still allow readjustment of enrollee subsidies in cases where an insurer defaults on a renewal guarantee, such as by filing bankruptcy.

Subsidizing enrollees directly could also create greater demand for independent organizations to evaluate the quality of providers and plans. Private organizations such as the Leapfrog Group would see greater demand for meaningful quality measures and useful quality comparisons between traditional Medicare and private Medicare Advantage plans, including information on the breadth and quality of providers in different plans' provider networks.[286]

There is reason to believe such private-sector initiatives are already improving quality more than traditional Medicare's quality programs. One potential explanation for the positive secular trends in hospital quality, which predate traditional Medicare's financial incentives, is that providers have been responding to the reputational and other incentives that both transparency initiatives (e.g., New York State reporting on cardiac-surgery outcomes since the 1980s and Medicare publicly reporting IQRP quality measures since 2013)[287] and private-sector financial incentives create. If the HVBP and its companion programs had little effect on quality, the reason may be that those other efforts left little room for improvement, at least within existing regulatory and payment strictures.

Congress could also give traditional Medicare a freer hand to reevaluate its approach to quality improvement. It could maintain its current programs or adopt technical recommendations that MedPAC, GAO, and others have offered.[288] Since traditional Medicare is a

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[286] *See* Meyers et al., *supra* note 86. (Finding Medicare Advantage enrollees are less likely to enter both low- or highly rated hospitals than TM enrollees and inferring that Medicare Advantage plans may exclude both low- and high-quality hospitals from their networks).

[287] *See* David M. Cutler et al., *The Role of Information in Medical Markets: An Analysis of Publicly Reported Outcomes in Cardiac Surgery*, 94 AM. ECON. REV. 342, 342-46 (2004), https://scholar.harvard.edu/files/cutler/files/the_role_of_information_in_medical_markets.pdf; *see also* Tina Rosenberg, *Reducing Early Elective Deliveries*, N.Y. TIMES (Mar. 12, 2014), https://opinionator.blogs.nytimes.com/2014/03/12/reducing-early-elective-deliveries/.

[288] MedPAC recommends a complete overhaul of the IQRP, the HVBP, the HPPR, and HACRP to shift Medicare's quality-improvement systems away from measuring inputs (e.g., process measures) toward inclusive, all-condition quality measures (e.g., all-cause mortality) that provide a more accurate assessment of hospital performance. *See* MEDPAC, REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY 75 (Mar. 2018). MedPAC further recommends simplifying quality measurement by removing even more metrics, removing penalties for low performers, and evaluating and rewarding hospitals in comparison to other hospitals with similar patient bases (to avoid penalizing hospitals for characteristics of their patients, and to reduce incentives for hospitals to avoid such patients). *See also* MEDPAC, REPORT TO THE CONGRESS:

creature of the political process, the same political forces that gave rise to the problems those recommendations seek to correct would be present during efforts to translate them into policy. Low-quality providers would still have considerable means to block any reforms that would apply real pressure to them to improve. The successful bipartisan effort to repeal the ACA's Independent Payment Advisory Board demonstrates the infeasibility insulating decisions about government purchasing of health care from provider influence.[289] Public-option principles could nevertheless reduce such lobbying. Eliminating the advantages traditional Medicare enjoys over private plans would reduce the incentives for industry to lobby against meaningful quality-improvement efforts because the returns to such lobbying expenditures would be less certain.

Alternatively, traditional Medicare could step back from trying to reward quality directly and instead simply provide enrollees information about provider quality. Various research suggests furnishing providers and patients with quality information can itself drive quality improvements.[290] Divorcing traditional Medicare's

MEDICARE PAYMENT POLICY 432 (Mar. 2019). The GAO recommends Medicare make the HVBP program less vulnerable to gaming. Its recommendations include changing the program's "reweighting" methodology to reduce the number of poor-preforming hospitals that receive bonus payments based on the clinical efficiency domain, and to ensure the program does not penalize hospitals for reporting on all quality measures. *See also* U.S. GOV'T ACCOUNTABILITY OFF., GAO-17-551, HOSPITAL VALUE-BASED PURCHASING CMS SHOULD TAKE STEPS TO ENSURE LOWER QUALITY HOSPITALS DO NOT QUALIFY FOR BONUSES 25 (June 2017), https://www.gao.gov/assets/690/685586.pdf.

289 *See* Henry J. Aaron, *The Independent Payment Advisory Board — Congress's "Good Deed,"* 364 NEW ENG. J. MED. 2377, 2377-9 (2011), https://www.nejm.org/doi/full/10.1056/NEJMp1105144 ("the leverage that the country's largest single buyer of health care [Medicare] could wield to effect reforms has gone largely unused [and] some [members of Congress] are in thrall to campaign contributors and producers and suppliers of medical services"); and Ian Spatz, *IPAB RIP*, HEALTH AFF. BLOG (Feb. 22, 2018), https://www.healthaffairs.org/do/10.1377/hblog20180221.484846/full/ ("Powerful interests—whether they be providers or beneficiaries—do not want to relinquish their ability to appeal to political actors for relief.").

290 *See* Cutler et al., *supra* note 287, at 345 (public reporting of cardiac-surgery outcomes in New York hospitals from 1991 through 1999 "had an impact on both the volume of cases and future quality at hospitals identified as poor performers"); *Case Study: How the Leapfrog Hospital Survey Helped Virginia Hospital Center Lower Its NTSV C-Section Rate*, LEAPFROG GRP., https://www.leapfroggroup.org/vhc-case-study (last visited Nov. 17, 2021) (making one hospital's caesarean-section delivery rate transparent to hospital administrators led one hospital to reduce its rate from 33 percent to 20.9 percent, below both the national average (25.8 percent) and the rate advisors recommend (23.9 percent or less)); Rosenberg, *supra* note 287 (reporting hospitals' rates of risky early elective deliveries led rates to fall from 17 percent in 2010 to 4.6

quality metrics from direct financial incentives could further reduce the lobbying that surrounds the development of such measures, because the entities that choose to reward or punish plans and providers would be enrollees rather than government officials. Traditional Medicare could potentially develop quality measures that are more comprehensive, meaningful, and reliable than those it currently uses. Such an approach is also more likely to satisfy the cost-benefit pressures traditional Medicare would face in a reformed system.

Conclusion

Medicare's negative impact on quality has not penetrated public consciousness. Advocates of Medicare expansion believe "Medicare is high-quality coverage."[291] Some Medicare for All critics share the belief that "Medicare serves its beneficiaries well" and "does not need wholesale revision."[292]

percent in 2013; "The federal government is also starting to reform payments for early elective deliveries — through Medicare. It might seem odd that Medicare has anything to say about this issue. (How many 65-year-olds have babies?) But Medicare does pay for some births, to disabled women…the Centers for Medicare and Medicaid Services requires hospitals to report early elective deliveries…"); *Early Elective Deliveries*, LEAPFROG GRP., https://www.leapfroggroup.org/influencing/early-elective-deliveries (last visited Nov. 17, 2021) (early elective delivery rates fell further to 1.9 percent in 2016 as "public reporting accelerated longstanding efforts by a network of organizations working to eliminate unnecessary [early] deliveries"). Evidence suggests consumers are increasingly likely to use quality information. *See* David Betts & Leslie Korenda, *Findings from the Deloitte 2018 Health Care Consumer Survey*, DELOITTE (Sept. 25, 2018), https://www2.deloitte.com/insights/us/en/industry/health-care/patient-engagement-health-care-consumer-survey.html (consumers are looking for health care quality and pricing tools at a higher rate than ever; respondents who had looked up quality ratings for hospitals or physicians in the past year rose from 18 percent in 2015 to 23 percent in 2018; 53 percent are likely to use such ratings in the future; share of consumers looking online for price information nearly doubled from 14 to 27 percent); *see also* Anna D. Sinaiko et al., *Association Between Viewing Health Care Price Information and Choice of Health Care Facility*, 176 JAMA INTERNAL MED. 1868, 1868-70 (2016), https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2571612 (patients "searching for prices on imaging services and sleep studies chose health care facilities with lower prices" compared to other patients).

[291] *Sen. Merkley Speaks About Legislation on Medicare Part E Public Health Plans*, TARGETED NEWS SERV. (Apr. 20, 2018), https://insurancenewsnet.com/oarticle/sen-merkley-speaks-about-legislation-on-medicare-part-e-public-health-plans (quoting U.S. Sen. Jeff Merkley (D-OR)).

[292] James C. Capretta, *Expand Medicare? How about We Fix It First?*, DISPATCH (July 19, 2021), https://thedispatch.com/p/expand-medicare-how-about-we-fix.

Those who pay close attention to Medicare have a more nuanced view. "Medicare is not as good as many of the private insurance plans that we currently have," says former U.S. Rep. Donna Shalala (D-FL), who ran the Medicare program as U.S. Secretary of Health and Human Services under President Bill Clinton (D) from 1993 to 2001. To match the performance of private insurance plans, "We would have to upgrade Medicare."[293]

Generations of Medicare enrollees have died waiting for such an upgrade. Traditional Medicare is in its sixth decade of penalizing high-quality care and thwarting the competitive forces that would otherwise improve quality. Congress has spent most of Medicare's history ignoring the program's negative impact on quality and the resulting harms. Even after a decade of trying to reduce those harms, Medicare's "development of new payment and care delivery models has had relatively little impact on the average beneficiary and has lagged well behind what is possible and desirable."[294] The fact that, to this day, congressional debate over Medicare focuses on enrolling more patients in such a program and expanding the range of services it subsidizes, rather than improving the quality of care enrollees receive, is itself an indication that Medicare's current structure leads Congress to prioritize the needs of industry over the needs of patients.

The negative impact that expanding or replicating traditional Medicare could have on quality should give the staunchest Medicare for All advocates pause. Policymakers should consider the possibility that a program that took four decades to answer President Johnson's call for quality-based payments may suffer from fundamental design flaws that make it the wrong instrument for expanding coverage, much less promoting quality.

Applying public-option principles to Medicare, and giving enrollees a true choice between traditional Medicare and private options, can provide the quality upgrade Medicare enrollees need.

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293 *Representative Donna Shalala on the Future of Health Care*, C-SPAN WASH. J., at 00:38 (May 16, 2019), https://www.c-span.org/video/?c4798127/user-clip-rep-shalala-medicare ("Why should we spend money when people have good private health insurance?").

294 MEDPAC, REPORT TO THE CONGRESS: MEDICARE AND THE HEALTHCARE DELIVERY SYSTEM 7 (June 2020).