

## HIDDEN IN PLAIN SIGHT: TWO MODELS OF MEDICARE PRIVATIZATION

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### Abstract

Medicare and private insurance are often cast as diametrically opposed forces. This framing is not only inaccurate, but it obscures the dynamic relationship that has existed between these entities for several decades. Private insurers have been playing an active role in Medicare delivery since its passage in 1965, and their role has expanded over time.

This Article seeks to illuminate the way privatization has impacted Medicare and what current privatization policy choices mean for its future. This Article draws from the copious literature on government administration and privatization to explain two key models of privatization within the Medicare program. Highlighting the way that privatization has impacted both forms of delivery will allow for more constructive conversations about striking the right role for private insurance in the future of American health care.

The main argument of this Article unfolds in three parts. First, Part I begins by arguing that privatization should be understood as a spectrum of various models, rather than a finite, static instrument. This section argues that models of privatization that delegate high degrees of control to the hands of private insurers risk reduced public accountability through misaligned incentives and lower levels of transparency. Part II illuminates the two distinct models of privatization in Medicare and how each model responds to measures of public accountability. This analysis draws attention to the weaknesses of each model resulting from program design and highlights how Medicare Advantage—the more privatized model—has proven to be the most vulnerable to fraud and abuse due to a greater degree of misaligned incentives and more limited transparency.

Finally, Part III seeks to fill a major gap in existing scholarship by offering recommendations for improving the privatized aspects of Medicare. Much attention has been paid to improving Medicare Advantage, but little has focused on the program's older and more time-tested model. Stabilizing the role of private insurers in this program is a more responsible policy approach than continuing to tolerate the accountability challenges posed by Medicare Advantage.

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INTRODUCTION .....	82
I. THE SPECTRUM OF PRIVATIZATION .....	86
A. <i>Connecting Privatization to Public Accountability</i> .....	88
II. TWO COMPETING MODELS OF PRIVATIZATION IN MEDICARE.....	95
A. <i>Original Medicare: The Public-Private             Partnership Model</i> .....	96
B. <i>Medicare Advantage: The Open Competition             Model</i> .....	107
III. RECOMMENDATIONS FOR THE PATH FORWARD: IMPROVE ORIGINAL MEDICARE .....	114
A. <i>Suggested Improvement Number One: Improve MAC             Coordination Through Extended Contracts</i> .....	116
B. <i>Suggested Improvement Number Two: Mitigate             Instances of Fraud and Abuse Through             Stricter Reporting Requirements</i> .....	117
CONCLUSION.....	118

## INTRODUCTION

Medicare is often held up as the quintessential public program. Its passage in 1965 was heralded as ushering in a new era in American health care. Today, it continues to enjoy massive popularity, delivering health benefits in a social insurance model to over 37.9 million people over sixty-five.<sup>1</sup> Unsurprisingly, seniors are more satisfied with their health care coverage than any other group.<sup>2</sup> Because of this programmatic success, many scholars and policymakers have advocated for expansion.

“Medicare for All,” once a distant goal, has become a real platform for many leaders in Congress.<sup>3</sup> And yet, opponents and skeptics abound.

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1. Medicare provides federal health insurance to beneficiaries over the age of sixty-five, regardless of income, medical history, or health status, and individuals under sixty-five with a long-term disability. See Meredith Fried et al., *A Dozen Facts About Medicare Advantage in 2020*, KAISER HEALTH NEWS (Jan. 13, 2021), <https://www.kff.org/medicare/issue-brief/a-dozen-facts-about-medicare-advantage-in-2020/> [https://perma.cc/J8NV-PETF].

2. Nancy Ochieng et al., *Medicare-Covered 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 HEALTH NEWS (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/> [https://perma.cc/M9QT-57CD].

3. Robert Draper, *How “Medicare for All” Went Mainstream*, N.Y. TIMES (Nov. 1, 2019), <https://www.nytimes.com/2019/08/27/magazine/medicare-for-all-democrats.html> [https://perma.cc/8LBS-WVXV].

Fearing disruption on a massive scale, some claim that “Medicare for All would abolish private insurance.”<sup>4</sup> This understanding has proliferated across the public sphere.

However, this fear is misguided. Some individuals are perhaps unaware of the scope of private insurers’ involvement in Medicare and misunderstand, or have never questioned, their role. Private insurers have played an active role in Medicare delivery since its passage in 1965, and the importance of private insurance has only grown over time.<sup>5</sup>

This Article seeks to illuminate the way privatization has impacted Medicare. This Article explains the two key models of privatization within the Medicare program. As this Article argues, one model strikes an appropriate level of privatization. The other has proved vulnerable to fraud and abuse due to misaligned incentives and limited transparency. It has exposed the dangers of allowing private insurers almost free reign over an integral public benefit. But importantly, neither, if implemented universally, would abolish private insurance.

The first model this Article explores is the public-private partnership of Original Medicare. Original Medicare, the term used to describe the program’s first delivery model, is perceived by many policymakers and citizens alike as a purely publicly administered program. But since Medicare’s passage, this program has operated with extensive administrative assistance from private insurers, acting as private partners behind the scenes. These private partners, at the direction of the Centers for Medicare & Medicaid Services (CMS), manage the claims process and over fifteen other major aspects of the program.<sup>6</sup> There have been many speedbumps since 1965, but this public-private partnership has improved in recent years through greater consolidation and better incentive alignment. Most notably, throughout this partnership, the government has remained at the wheel.

In 1997, Congress approved Medicare Advantage, modeled as a form

4. Reed Abelson & Margot Sanger-Katz, *Medicare for All Would Abolish Private Insurance. ‘There’s No Precedent in American History.’*, N.Y. TIMES (Mar. 23, 2019), <https://www.nytimes.com/2019/03/23/health/private-health-insurance-medicare-for-all-bernie-sanders.html> [<https://perma.cc/X4NQ-G2C4>]; see Rachana Pradhan, *Medicare for All’s Job Problem*, POLITICO (Nov. 25, 2019), <https://www.politico.com/news/agenda/2019/11/25/medicare-for-all-jobs-067781> [<https://perma.cc/F8W3-8X5M>] (“If the health care system were actually restructured to eliminate private insurance, the way Medicare for All’s advocates ultimately envision it, a lot of people with steady, good-paying jobs right now might find themselves out of work.”).

5. *How Does Medicare and Private Insurance Work?*, MEDICARE.ORG, <https://www.medicare.org/articles/how-does-medicare-and-private-insurance-work/#:~:text=Medicare%20works%20with%20private%20insurance%20carriers%20either%20by,program%20that%20was%20written%20into%20law%20in%201965> [<https://perma.cc/9CLK-MJWE>] (last visited Oct. 31, 2022).

6. See *infra* Part II.

of open competition privatization, which is the second model this Article explores.<sup>7</sup> Enrollees who choose Medicare Advantage plans receive their benefits directly from a private insurer who offers and manages a certified Medicare plan.<sup>8</sup> This model was built on the premise that competition among private plans on the market would incentivize insurers to deliver the best plans at the lowest prices.<sup>9</sup> The government's role is sequestered to funding and oversight—with a lighter touch regarding the latter. Private insurers, on the other hand, have moved from passenger to driver.

In recent years, Medicare Advantage has skyrocketed in popularity. In 2020, over thirty-six percent of all Medicare-aged adults chose to enroll in a Medicare Advantage plan.<sup>10</sup> Estimates suggest that by 2030, fifty-one percent of Medicare eligible adults will choose Medicare Advantage over Original Medicare.<sup>11</sup> Many policymakers and scholars on both sides of the ideological spectrum support Medicare Advantage, too.<sup>12</sup> “Medicare Advantage For All” has even been suggested as a way to address the public failings of our health system.<sup>13</sup> Proponents of the program are attracted to the perceived benefits of privatization. They point to the promise of using a market-based approach to control costs, increase flexibility, and promote greater competition on value and benefits.<sup>14</sup> Often overlooked are the ways that the program has not been

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7. Medicare Advantage was initially titled “Medicare+Choice.” The Medicare Modernization Act of 2003 refashioned it into Medicare Advantage. This Article uses the term “Medicare Advantage” throughout for consistency and clarity. See *Health Plans – General Information*, CTRS. FOR MEDICARE & MEDICAID SERVS. (Jan. 1, 2021), <https://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo> [https://perma.cc/LND6-CXL9].

8. *How Do Medicare Advantage Plans Work?*, MEDICARE.GOV, <https://www.medicare.gov/types-of-medicare-health-plans/medicare-advantage-plans/how-do-medicare-advantage-plans-work> [https://perma.cc/AET7-F2X2] (last visited Jan. 21, 2023).

9. Travis Broome & Farzad Mostashari, *Spurring Provider Entry into Medicare Advantage*, HEALTH AFFS. (July 6, 2017), <https://www.healthaffairs.org/doi/10.1377/hblog20170706.060925/full/> [https://perma.cc/L5X8-FMAX].

10. Meredith Freed, *A Dozen Facts About Medicare Advantage*, KAISER FAM. FOUND. (Jan. 13, 2020), <https://www.kff.org/medicare/issue-brief/a-dozen-facts-about-medicare-advantage-in-2020/> [https://perma.cc/7L76-X59W].

11. *Id.*

12. Stuart M. Butler, *Medicare Advantage for All, Perhaps?*, 324 JAMA 1275–76 (2020); Caitlin Owens, *Medicare Advantage Isn't Just a Republican Idea Anymore*, MORNING CONSULT (Feb. 20, 2016), <https://morningconsult.com/2016/02/20/medicare-advantage-isnt-a-republican-idea-anymore/> [https://perma.cc/UP97-8A23].

13. Steve Forbes, *Medicare Advantage for All Can Save Our Health System*, FORBES (June 11, 2020), <https://www.forbes.com/sites/steveforbes/2020/06/11/medicare-advantage-for-all-can-save-our-health-care-system/?sh=635a1ccb4d12> [https://perma.cc/N2R6-MPGU].

14. See Greg Zahner et al., *Medicare Advantage for All: A Potential Path to Universal Coverage*, 327 JAMA 29, 29 (Dec. 16, 2021) (arguing that Medicare Advantage offers “several advantages” over traditional Medicare plans).

truly competitive: its administrative bulk wastes public dollars, it incentivizes providers to misrepresent the level of care provided to patients (“upcoding”), and its policies sometimes deny urgent care to those who need it most.<sup>15</sup>

If privatization is what policymakers and beneficiaries really want, they need not look further than Original Medicare. The path forward is not a choice between public or private. The future of Medicare is a choice of degree. It is a choice between two different models of privatization: a public-private partnership or the misleadingly-named open competition model.

The public interest is best served by choosing the model that promotes greater public accountability. This Article argues that the public-private partnership of Original Medicare better promotes public accountability because of its transparency and better-aligned incentives between the government and its private partners. Thus, in the years ahead, federal dollars should be spent improving the existing role for private contractors under Original Medicare, rather than trying to expand Medicare Advantage—a privatized system that has already proved vulnerable to fraud and abuse.

Government privatization usually works best when private contractors operate in bounded ways with clear rules and incentives aligned with the government’s interests. Medicare has lasted over sixty years because it has imposed such restrictions on its private partners. Additionally, Medicare has reigned in agency costs effectively under this structure.<sup>16</sup> Medicare Advantage, however, is criticized as lacking these guardrails, and although the evidence is limited by the lack of transparency, the evidence that exists suggests that weak governmental oversight powers impair program administration and lead to detrimental effects on enrollees.<sup>17</sup> Without such guardrails, the program risks losing public trust and crumbling through excessive funding cuts which fail to target wasteful spending. It risks letting unaligned incentives between private insurers and the government get in the way of quality care and trust in the government.

This Article unfolds in three parts. First, Part I argues that privatization should be understood as a spectrum of various models. Models of privatization differ in their degree of public accountability.

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15. See *infra* Part III.

16. Jeannie Fuglesten Biniek et al., *Higher and Faster Growing Spending Per Medicare Advantage Enrollee Adds to Medicare’s Solvency and Affordability Challenges*, KAISER FAM. FOUND. (Aug. 17, 2021), <https://www.kff.org/medicare/issue-brief/higher-and-faster-growing-spending-per-medicare-advantage-enrollee-adds-to-medicare-solvency-and-affordability-challenges> [https://perma.cc/CQ4V-W37Q].

17. Austin Frakt, *Sicker Patients Seem at a Disadvantage with Medicare Advantage*, N.Y. TIMES (Apr. 4, 2016), <https://www.nytimes.com/2016/04/05/upshot/sicker-patients-signal-a-drawback-of-medicare-advantage.html> [https://perma.cc/B7YE-CUTF].

This section argues that models of privatization which delegate a high degree of control to private contractors risk reduced public accountability through misaligned incentives and lower transparency. Part II illuminates the two distinct models of privatization in Medicare and the extent to which each may be exposed to or protected from public accountability. This analysis draws attention to the weaknesses of each model and highlights how Medicare Advantage—the more privatized model—has proven more vulnerable to fraud and abuse due to a greater degree of misaligned incentives and more limited transparency. Finally, Part III seeks to fill a hole in existing scholarship by offering recommendations for improving the privatized model of Original Medicare. Many scholars have suggested ways to improve Medicare Advantage, but very few have focused on the program’s older and more time-tested model, Original Medicare. Recommendations include greater coordination among private insurers to limit competition and extending contract lengths to foster innovation. These enhancements will improve program administration and allow Medicare to achieve an ideal level of private sector participation for years to come.

#### I. THE SPECTRUM OF PRIVATIZATION

Any productive discussion of privatization first requires defining it. Yet if you asked ten legal scholars to define privatization, it is likely that no two responses would be the same.<sup>18</sup> This lack of unity reveals a great deal about privatization. Namely, that the decision by a government to privatize a specific service or government program is not a binary decision. Rather, privatization exists on a spectrum.

Consider an example. Suppose a government owns a national airline and wants to privatize.<sup>19</sup> It has a few options. First, it could sell off the entire airline to one or more private owners.<sup>20</sup> This sale could include the nationalized airline’s brand and could include subsidies.<sup>21</sup> Alternatively, the government could lease its assets, such as the planes, to private owners. The airline could continue to operate under government

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18. See Donald F. Kettl, *Performance and Accountability: The Challenge of Government by Proxy for Public Administration*, 18 AM. REV. PUB. ADMIN. 9, 12 (1988) (“[T]he term [privatization] has been given an array of meanings, only some of which fit the logic of the privatization movement.”).

19. The British government made this choice when they privatized British Airways. See generally Stephen Martin & David Parker, *Privatization and Economic Performance Throughout the UK Business Cycle*, 16 MANAGERIAL & DECISION ECON. 225, 225–37 (1995) (describing the privatization of British Airways and the subsequent period of immense privatization in Europe).

20. See generally Robert Poole & Chris Edwards, *Privatizing U.S. Airports*, 76 CATO INST. 1–7 (2016) (advocating for the privatization of the U.S. aviation industry).

21. *Id.*

ownership, but contract with private operators who provide pilots and flight attendants. There are a number of other ways this could be done.<sup>22</sup>

As this example highlights, privatization is not a fixed, static choice. Privatization should therefore be understood as the choice to give private contractors control and responsibility over some portion of the administration of a government service or program.<sup>23</sup> Just *how much* control and responsibility is delegated to a private contractor varies according to the chosen model of privatization. Each of the airline models above vary in their degree of delegation. The government may choose a more privatized model, such as when the government sells the airline altogether, or it could select a more minimal model, such as when the government contracts with an outside firm for flight staff.

The government has been trying out different models of privatization since 1789, when Congress passed a law allowing the Secretary of the Treasury to award private contracts to build and maintain lighthouses, public piers, and buoys.<sup>24</sup> Privatization, through many different models, has touched every sphere of government, from prison administration to garbage collection to highway construction.<sup>25</sup> The growing influence of different models of privatization has led some to call private contractors “the fourth branch of government.”<sup>26</sup> Four out of every ten people working for the government are considered private contractors.<sup>27</sup> In fiscal

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22. See generally CONG. RSCH. SERV., R43545, AIRPORT PRIVATIZATION: ISSUES AND OPTIONS FOR CONGRESS 1 (2021) (describing four different levels of airport privatization and their use by U.S. airports).

23. Gillian Metzger uses this definition to define one form of privatization she identifies, but the Author believes that it can more broadly define privatization based on an understanding that what distinguishes different forms of privatization from each other is the *degree* of delegated control and responsibility. With this understanding, it can encompass all forms of privatization. See Gillian E. Metzger, *Privatization as Delegation*, 103 COLUM. L. REV. 1367, 1370 (2003) (“Privatization can take a variety of forms.”).

24. The Lighthouse Act of 1789, ch. 9, 1 Stat. 53 (1789); see KEVIN R. KOSAR, CONG. RSCH. SERV., RL33777, CSR REPORT FOR CONGRESS: PRIVATIZATION AND THE FEDERAL GOVERNMENT, AN INTRODUCTION (2006) (discussing the early roots of privatization in the United States).

25. See generally John B. Goodman & Gary W. Loveman, *Does Privatization Serve the Public Interest?*, HARV. BUS. REV. (1991), <https://hbr.org/1991/11/does-privatization-serve-the-public-interest> [<https://perma.cc/SW8J-Q6GS>] (describing several areas of government privatization around the world).

26. Scott Shane & Rob Nixon, *U.S. Contractors Becoming a Fourth Branch of Government*, N.Y. TIMES (Feb. 4, 2007), <https://www.nytimes.com/2007/02/04/world/americas/04iht-web.0204contract.4460796.html> [<https://perma.cc/34PB-QWVQ>].

27. See PAUL LIGHT, THE TRUE SIZE OF THE GOVERNMENT: TRACKING WASHINGTON’S BLENDED WORKFORCE 1984–2015 3 tbl.1 (2017) (showing that the U.S. government spends more money per year paying contractors than it does compensating federal employees); see also *Contractors: How Much Are They Costing the Government?: Hearing Before the Ad Hoc Subcomm. on Contracting Oversight*, 112th Cong. 3 (2012) (statement of Sen. Rob Portman, Member, S. Comm. on Homeland Sec. & Gov’t Affs.) (detailing that the U.S. government spends

year 2018, federal agency contracts for goods and services accounted for forty percent of the government's discretionary spending.<sup>28</sup>

Yet despite privatization's many models and the United States' increasing reliance on them,<sup>29</sup> discussions on privatization lack nuance. Privatization is assumed to be a yes or no choice by the government, rather than a choice of degree. Nonetheless, how a government program is privatized matters just as much as whether it is privatized at all. Some models reach into the "core aspects of government programs,"<sup>30</sup> while others have a minimal effect on the programs they touch.<sup>31</sup> So, what distinguishes these models from each other? The degree of public accountability they possess.

### A. *Connecting Privatization to Public Accountability*

Public accountability is the means to the end of good government. It is the ultimate responsibility of a government to its people. Public accountability is high when public administration "outcomes match the policies defined by responsible public officials."<sup>32</sup> Public accountability is low when officials are not responsive, when the public is unable to access policy information, and when policies do not align with public values.

Public accountability ensures that elected officials promote public values such as efficiency, effectiveness, capacity, responsiveness, trust, confidence, and equity.<sup>33</sup> The promotion of these public values is a sign that democracy is working well. When democracy works, trust in government is high and leaders are more likely to stay in power.<sup>34</sup> Because of this incentive, government leaders are motivated to pursue policies which align with public values.<sup>35</sup>

Government transparency, a pillar of democracy, helps voters

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about \$320 billion dollars per year on service contracts, and just \$200 billion per year to compensate federal employees.).

28. *Federal Government Contracting for Fiscal Year 2018*, U.S. GOV'T ACCOUNTABILITY OFF.: WATCHBLOG (May 28, 2019), <https://blog.gao.gov/2019/05/28/federal-government-contracting-for-fiscal-year-2018-infographic/> [<https://perma.cc/S45Y-L4A2>].

29. Metzger, *supra* note 23, at 1379.

30. *Id.* at 1369.

31. *Id.* at 1371.

32. Kettl, *supra* note 18, at 9.

33. See DONALD F. KETTL, SHARING POWER: PUBLIC GOVERNANCE AND PRIVATE MARKETS 18–20 (1993) (discussing six public values that an effective government should strive to meet, and that privatization risks disrupting).

34. OECD, GOVERNMENT AT A GLANCE 2013 21 (2013), [https://www.oecd-ilibrary.org/governance/government-at-a-glance-2013\\_gov\\_glance-2013-en](https://www.oecd-ilibrary.org/governance/government-at-a-glance-2013_gov_glance-2013-en) [<https://perma.cc/C334-TQL3>].

35. *U.S. Transparency and Accountability*, COAL. FOR INTEGRITY, <https://www.coalitionforintegrity.org/what-we-do/transparency-and-accountability/> [<https://perma.cc/L9H8-H796>] (last visited Oct. 13, 2022).



determine whether public values are being met. Transparency ensures that information is available for the public.<sup>36</sup> This information might include data used to measure program performance against stated goals, or information used to identify signs of fraud and abuse of power.<sup>37</sup> Transparency is especially important in American government because of the paradoxical expectations of American citizens. Americans are increasingly distrustful of the government, but at the same time, they expect a lot from it.<sup>38</sup> Transparency reduces this distrust by providing tangible metrics to measure whether public values are being met, and government dollars are being well-spent.<sup>39</sup>

Privatization disrupts this balance. Privatization reduces public accountability through two mechanisms. First, it does so through reduced transparency.<sup>40</sup> The more privatized a program is, the more autonomy a private contractor has to avoid revealing the extent or cost of its work to the public. The result: the public cannot hold leaders and government agencies accountable if they do not know what valuable public goods are

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36. However, the availability of information does not mean the public will utilize it. See Hannah Leibson & Allison K. Hoffman, *Price Transparency's Illusory Promise*, HEALTH JUST. MONITOR (July 20, 2021), <http://healthjusticemonitor.org/2021/07/20/price-transparencys-illusory-promise/> [<https://perma.cc/3E8T-V7QT>] (discussing the limits of providing transparency in the health care field).

37. See *U.S. Transparency and Accountability*, *supra* note 35 (“Transparency is a powerful weapon against corruption. When government processes are transparent, it is difficult for corruption to thrive.”).

38. See NPR ET AL., AMERICANS DISTRUST GOVERNMENT, BUT WANT IT TO DO MORE 1 (2000), <https://www.kff.org/wp-content/uploads/2013/01/americans-trust-government-but-want-it-to-do-more.pdf> [<https://perma.cc/D3MH-WDME>] (noting how a new survey finds that while many Americans distrust the government, they also desire greater government regulation and government involvement to solve national problems). See generally SUZANNE METTLER, THE GOVERNMENT-CITIZEN DISCONNECT 23 (2018) (“Over the past four decades, Americans’ relationship to the federal government has evolved in a deeply paradoxical manner.”).

39. See Martin Alessandro et al., *Transparency and Trust in Government. Evidence from a Survey Experiment*, WORLD DEV., Feb. 2021, at 2 (“Given that ‘there is an assumption that if government organizations open up and show the public what decisions are made, how they are made[,] and what the results are, people will automatically have more trust in government,’ transparency . . . has consequently been pushed by international organizations, governments, and donors as standard practice for increasing trust.”).

40. See Jon D. Michaels, *Deforming Welfare: How the Dominant Narratives of Devolution and Privatization Subverted Federal Welfare Reform*, 34 SETON HALL L. REV. 573, 577 n.7 (2004) (citing another article about the “concerns with privatization, including how greater privatization leads to less public accountability and how privatization leads to a shrinking of opportunities for meaningful public engagement”).

being privatized.<sup>41</sup> Several scholars have documented the reduced transparency that accompanies privatization.<sup>42</sup>

Suzanne Mettler is a political scientist who has identified a nexus of indirect federal policies, like incentivizing tax breaks and corporate subsidies, that give rise to “the submerged state.”<sup>43</sup> The submerged state thrives in an environment of low transparency. Mettler describes how the submerged state affects public accountability; it “eludes most ordinary citizens: they have little awareness of its policies or their upwardly redistributive efforts, and few are cognizant of what is at stake in reform efforts.”<sup>44</sup> Transparency is reduced when private contractors appear more distant from the government, and when programs no longer seem public.<sup>45</sup> When a program is seen as more privatized, transparency may be seen as less important; the assumption may be that the market is supposed to correct for failures. But often, the market will not correct for failures if a private contractor has a monopoly or a large degree of

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41. JOHN D. DONAHUE, *DISUNITED STATES* 130–33 (1997); see MARTHA MINOW, *PARTNERS, NOT RIVALS: PRIVATIZATION AND THE PUBLIC GOOD* 153 (2002) (arguing that privatization of social services decreases the government’s commitment to those services).

42. See Martha Minow, *Outsourcing Power: How Privatizing Military Efforts Challenges Accountability, Professionalism, and Democracy*, 46 B.C. L. REV. 989, 999–1000 (2005) (discussing how the lack of transparency in the use of private contractors compounds the problem of assessing the impact of their increasing role in the U.S. government). Preeminent privatization scholars have recognized the veiled nature of privatization and how strategic government use capitalizes on this dynamic. See, e.g., Jon D. Michaels, *Privatization’s Pretensions*, 77 U. CHI. L. REV. 717, 719 (2010) [hereinafter Michaels, *Pretensions*] (arguing that privatization “workarounds” allow policymakers to substantively change the policies they are supposed to be neutrally administering); Jon D. Michaels, *Privatization’s Progeny*, 101 GEO. L.J. 1023, 1088 (2013) [hereinafter Michaels, *Progeny*] (arguing that the government today is “commingling political and businesslike agendas in ways both liberating and threatening”); Jon D. Michaels, *Running Government Like a Business . . . Then and Now*, 128 HARV. L. REV. 1152, 1155 (2015) [hereinafter Michaels, *Running Government*] (“In [the] rush to re-embrace business-like government, [the United States is] either forgetting or affirmatively repudiating the principles and practices that legitimized American public administration as a distinct normative and legal enterprise.”); Suzanne Mettler, *Reconstituting the Submerged State: The Challenges of Social Policy Reform in the Obama Era*, 8 AM. POL. SCI. ASSOC. 803, 804 (2010) (arguing that many policies of the U.S. government lie beneath the surface, hidden in plain sight—the policies of privatization). See generally Metzger, *supra* note 23 (discussing how expansions in privatization of government programs mean that the constitutional paradigm of a sharp separation between public and private is increasingly at odds with the blurred public-private character of modern governance); Gillian E. Metzger, *Private Delegations, Due Process, and the Duty to Supervise*, in *GOVERNMENT BY CONTRACT: OUTSOURCING AND AMERICAN DEMOCRACY* 291, 292 (Martha Minow & Jody Freeman eds., 2009) [hereinafter Metzger, *Private Delegations*] (explaining the “two prisms through which constitutional law currently approaches privatization”).

43. Mettler, *supra* note 42; see SUZANNE METTLER, *THE SUBMERGED STATE: HOW INVISIBLE GOVERNMENT POLICIES ARE UNDERMINING AMERICAN DEMOCRACY* 1–30 (2011) [hereinafter METTLER, *THE SUBMERGED STATE*].

44. Mettler, *supra* note 42, at 803.

45. Metzger, *Private Delegations*, *supra* note 42, at 307.

autonomy on the delegated government task.<sup>46</sup> Mettler argues that ignorance, apathy, and wasteful spending from limited transparency stand in the way of a “vibrant and visible” democracy.<sup>47</sup> Similarly, Alfred C. Aman and Landyn W. Rookard argue that privatization creates a “transparency deficit.”<sup>48</sup> They argue that limited transparency is the first “hurdle” that must be overcome if citizens are to play an active role in democratic decisions that affect their lives.<sup>49</sup>

Professor Jon D. Michaels, a prominent privatization scholar, has highlighted how notions of the submerged state and transparency deficit are not merely detrimental but also might, in some instances, be purposeful and even desired by government officials.<sup>50</sup> High degrees of privatization give the government more power to govern without public gaze and potential disapproval.<sup>51</sup> With minimal transparency, the government can more easily shield the public from its choices and its failures. Accordingly, public accountability suffers because limited transparency has “the effect of hiding executive decisions and concealing vital information from the public, which might otherwise be in a position to oppose the decisions or punish the executive at the ballot box.”<sup>52</sup>

Notably, none of these scholars or the frameworks they propose are calling for a boycott of privatization. Nor do they posit that transparency itself will fix the problems posed by privatization. Instead, they offer reasons for caution and for questioning the recent ramp-up of government privatization.<sup>53</sup> When the government selects a model of privatization, there should be mechanisms in place that require transparency as a condition for participation to correct and mitigate the effects of the submerged state. Only then will the public be able to measure whether public values are being met. Granted, transparency, like public accountability, is only a means to an end. But until more than seventeen percent of Americans think that democracy in the United States sets a

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46. *Id.* at 296.

47. METTLER, *THE SUBMERGED STATE*, *supra* note 43, at 27.

48. Alfred C. Aman & Landyn W. Rookard, *Private Government and the Transparency Deficit*, 71 ADMIN. L. REV. 437, 437, 442 (2019) (arguing that public transparency mechanisms have not kept pace with the increasing level of government privatization).

49. *Id.* at 442–43.

50. Michaels, *Pretensions*, *supra* note 42, at 718–19.

51. *See id.* at 719 (arguing that privatization workarounds “enable the executive to exercise greater unilateral discretion—at the expense of the legislature, the judiciary, the people, and successor administrations”).

52. *Id.* at 733.

53. *See generally* DONALD COHEN & ALLEN MIKAELIAN, *THE PRIVATIZATION OF EVERYTHING: HOW THE PLUNDER OF PUBLIC GOODS TRANSFORMED AMERICA AND HOW WE CAN FIGHT BACK* (2021) (arguing that ever since former President Ronald Reagan labeled government a dangerous threat, privatization has touched every aspect of our lives, from water and trash collection to the justice system and the military).

good example for the rest of the world,<sup>54</sup> transparency should be prioritized.

In addition to reduced transparency, high degrees of privatization risk reducing public accountability through misaligned incentives.<sup>55</sup> This misalignment between the government and the private sector can open the door to wasteful government spending, fraud, and abuse.<sup>56</sup> Unlike the government, whose ultimate incentive is to deliver on public values, the private sector's ultimate incentive is profit.<sup>57</sup>

The ideal model of privatization is one where the government can promote public values while the private contractor simultaneously profits from the arrangement. But when these incentives stand in tension without adequate safeguards, the pursuit of profit may displace the government's own goals. For example, some scholars have documented how private prisons, operating with limited government oversight, have an incentive to increase their incarcerated populations because they receive greater profits through higher rates of detention.<sup>58</sup> In this scenario, the pursuit of profit has replaced or overridden any public value of justice.

The more control and responsibility a private contractor has over a program, the greater the risk of replacing public values with the pursuit of profit. This is not because private contractors are inherently evil. Far from it. But policymakers must recognize that “[m]arkets and democracy are not the same.”<sup>59</sup> When operating with high degrees of control and autonomy, private contractors have more latitude to pursue their market-based objectives. Conversely, the less autonomy a contractor has, the more they are bounded by the incentives and goals the government provides. Fraud and abuse perpetuated by the pursuit of profit are less likely to develop when the government has a direct line to the contractor and when the private contractor is bound by the government's incentives. Part II illuminates this phenomenon.

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54. Richard Wike et al., *What People Around the World Like—and Dislike—About American Society and Politics*, PEW RSCH. CTR. (Nov. 1, 2021), <https://www.pewresearch.org/global/2021/11/01/what-people-around-the-world-like-and-dislike-about-american-society-and-politics/> [https://perma.cc/4UJ3-TTHH].

55. Some advocates of privatization argue that government incentives are already misaligned. See Alex Kozinski & Andrew Bentz, *Privatization and Its Discontents*, 63 EMORY L.J. 263, 264 (2013) (“Efficiency isn’t something you can usually count on in the government because the incentives are misaligned. If you’re the government and your costs increase, you can just raise taxes. But if you’re a private company, you have to figure out how to reduce costs or increase revenue, or you’ll go bankrupt.”).

56. *Id.*

57. Aman & Rookard, *supra* note 48, at 481 (discussing how citizens and consumers are not the same thing).

58. Patrice A. Fulcher, *Hustle and Flow: Prison Privatization and the Prison Industrial Complex*, 51 WASHBURN L.J. 589, 625 (2012).

59. Aman & Rookard, *supra* note 48, at 481.

To mitigate the risk of misaligned incentives, leaders should take certain steps when choosing the route of privatization. First, government leaders should set clear rules and standards rooted in public values as a condition for private sector participation in public programs. Removing any ambiguity over the role and responsibilities of private contractors will reduce the risk of contractors exploiting their power to pursue private aims. Similarly, the government should have clear mechanisms to remove contractors if they are not acting in alignment with public values. This may require pre-contract planning for how a government agency would absorb a delegated body of work in the event of contractor malfeasance—significantly more difficult in a high-privatization model. Furthermore, any chosen model of privatization should have a high degree of coordination between the public and private sector partners. Coordination is more likely when private contractors are directly accountable to the government. This oversight serves to bound the delegated authority. Finally, in many instances, the government should take steps to reduce competition between contractors. Competition creates the opportunity for winners and losers. In a government program, all citizens should be winners.

These recommendations provide a simple framework to address problems that have common but often overlooked roots.<sup>60</sup> The pursuit of privatization is often fueled by the promise of economic efficiency.<sup>61</sup> This view comes from reductive and ahistorical arguments that private industry operates more efficiently and effectively than government bureaucracy.<sup>62</sup> Proponents of privatization argue that competition, choice, and innovation are vital to increase efficiency<sup>63</sup> and that

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60. See *infra* Part II.

61. See Teresa Curristine et al., *Improving Public Sector Efficiency*, 7 OECD J. ON BUDGETING 1, 4 (2007) (describing efficiency to mean “providing more public services with less public spending”).

62. Michaels, *Pretensions*, *supra* note 42, at 725 (discussing that one of the lures of privatization is market competition and the mistaken belief that “private firms can provide good and services ‘better, faster, and cheaper’ than the government”); see Mark Moore, *Symposium: Public Values in an Era of Privatization – Introduction*, 116 HARV. L. REV. 1212, 1218 (2003) (“Much of the appeal of privatization is based on claims that some form of privatization will increase the efficiency and effectiveness of government.”).

63. See KETTL, *supra* note 33 (discussing the overly simplistic characterization of the government and the private market as opposing forces); see also J. PETER GRACE, BURNING MONEY: THE WASTE OF YOUR TAX DOLLARS 85–87 (1984) (arguing that public agencies suffer diseconomies of scale and that privatization mitigates this problem); Ronald A. Cass, *Privatization: Politics, Law and Theory*, 71 MARQ. L. REV. 450, 466 (1988) (discussing how many contracting proposals “posit that the mission can be accomplished better at lower cost” under a privatized structure); JOSÉ GÓMEZ-IBÁÑEZ & JOHN R. MAYER, GOING PRIVATE: THE INTERNATIONAL EXPERIENCE WITH TRANSPORT PRIVATIZATION 2–7 (1993) (arguing that there is greater innovation in the private sector and that privatization often saves money); E.S. SAVAS,

government alone cannot deliver on these terms.<sup>64</sup>

This argument is much too narrow and severely flawed. First, some models of privatization may be more efficient than others. Proponents of privatization often assume that all models of privatization inherently promote efficiency because of market competition.<sup>65</sup> Yet not all forms of privatization involve market competition. And not all markets are truly competitive.<sup>66</sup> Many are not.<sup>67</sup> Increasing trends toward greater consolidation in many industries, including health care, further reduce the likelihood of a truly competitive market.<sup>68</sup> Unless competition is guaranteed, relying on the “competitive market” to promote public values is like playing roulette.

Furthermore, efficiency is but one goal of good government.<sup>69</sup> By narrowly focusing on efficiency, other public values, such as equity, are swept aside.<sup>70</sup> Private prisons represent one area of government control where privatization has negatively impacted equity.<sup>71</sup> A 2016 report from the Department of Justice found that private prisons have a twenty-eight percent higher rate of assault between incarcerated individuals, and incarcerated individuals in these prisons possessed twice as many illicit weapons than their counterparts in federally-run facilities.<sup>72</sup> Surely, efficiency should not matter more than the actual livelihood of

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PRIVATIZATION: THE KEY TO BETTER GOVERNMENT 288–91 (1987) (describing privatization as a benefit to the output of and delivery of public services).

64. Fifty-six percent of Americans believe that the government is almost always wasteful and inefficient. There is a partisan divide to this belief; nearly seven-in-ten Republicans say government is wasteful and inefficient, while only forty-seven percent of Democrats say so. *Views of Government and the Nation*, PEW RSCH. CTR. (Dec. 17, 2019), <https://www.pewresearch.org/politics/2019/12/17/views-of-government-and-the-nation/> [https://perma.cc/VTU9-QZ4V].

65. ELLIOT D. SCLAR, *YOU DON’T ALWAYS GET WHAT YOU PAY FOR: THE ECONOMICS OF PRIVATIZATION* 15 (2000).

66. See David Wessel, *Is Lack of Competition Strangling the U.S. Economy?*, HARV. BUS. REV. (2018), <https://hbr.org/2018/03/is-lack-of-competition-strangling-the-u-s-economy> [https://perma.cc/38PS-QX2E] (noting how most American industries have become more concentrated and less competitive and arguing that “the government’s approach to antitrust violations is due for an overhaul”).

67. *Id.*

68. *Id.*

69. See Rafeal La Porta et al., *The Quality of Government*, 15 HARV. J.L. ECON. & ORG. 222, 223 (1999) (discussing how good government performance can be measured through a multitude of metrics including “lower inequality, greater diversity among people, or maintained traditions” as well as more economic measures including property rights, low taxes, effective spending, and democracy generally).

70. See KETTL, *supra* note 33, at 6 (noting how equity is a public value for a government operating in the public interest).

71. OFF. OF THE INSPECTOR GEN., U.S. DEP’T OF JUST., *REVIEW OF THE FEDERAL BUREAU OF PRISONS’ MONITORING OF CONTRACT PRISONS* 18 (2016).

72. *Id.*

individuals. Efficiency at all costs should not be the mantra or purpose of the government.

As this discussion highlights, the benefits achieved from focusing on public accountability are greater than the benefits of focusing narrowly on efficiency alone. A broader focus on accountability leads to the promotion of other values such as equity, quality, and responsiveness, that prioritizing efficiency alone might not. Models of privatization with high degrees of public accountability are most likely to promote these values *and* be efficient. Strong oversight of private contractors reduces the likelihood that government funds will be used for private profit. Models of privatization without such oversight risk misaligned incentives and wasteful spending.

The stakes are high. Diminished public accountability through high degrees of privatization short-circuits the democratic process and leaves efficiency to chance.

## II. TWO COMPETING MODELS OF PRIVATIZATION IN MEDICARE

Concerns about efficiency, rather than public accountability, are common when policymakers discuss the future of Medicare.<sup>73</sup> Whether Medicare is more efficient than private insurance is a common debate in the public arena.<sup>74</sup> And scholars continue to vehemently disagree on the answer.<sup>75</sup> As Part II will highlight, this is the wrong question to be asking. This question's framing obscures the true relationship between Medicare and private insurance.

Private insurance and Medicare are not two diametrically opposed forces. As Part II seeks to illuminate, private insurers play a major role in both Original Medicare and Medicare Advantage—just through two different models of privatization. This section looks beyond efficiency to the broader discussion of privatization and public accountability in Medicare.

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73. See generally JESSICA MITTLER, THE COMMONWEALTH FUND, *MEDICARE: MAKING IT A FORCE FOR INNOVATION AND EFFICIENCY passim* (July 2005) (discussing the importance and profound impact of Medicare efficiency).

74. John C. Goodman & Thomas Saving, *Is Medicare More Efficient Than Private Insurance?*, HEALTH AFFS. (Aug. 9, 2011), <https://www.healthaffairs.org/doi/10.1377/forefront.20110809.012862/full> [<https://perma.cc/23JP-8FVW>].

75. Compare Diane Archer, *Medicare Is More Efficient Than Private Insurance*, HEALTH AFFS. (Sept. 20, 2011), <https://www.healthaffairs.org/doi/10.1377/forefront.20110920.013390/abs> [<https://perma.cc/Q36M-2ZVL>] (arguing that Medicare is more efficient than sole reliance on private insurers), with Michael F. Cannon, *Private Insurance Is More Efficient than Medicare—By Far*, CATO INST. (Sept. 21, 2011), <https://www.cato.org/blog/private-insurance-more-efficient-medicare-far> [<https://perma.cc/GM84-49QB>] (arguing that private insurance is superior to Medicare administration on efficiency grounds).

Little attention has been paid to the structural design of each model of Medicare delivery and the implications each presents for accountability and the promotion of public values. Part II will fill this gap. It begins by illuminating the design of each privatization model before delving into the weaknesses each presents and the vulnerabilities that have been exposed over the years.

Original Medicare, operating as a public-private partnership, has better promoted public accountability through providing more transparent data measurement, placing the government's hand at the wheel, and establishing clear rules of the road. Medicare Advantage, operating as a form of open-competition privatization, has not realized its promise of private sector efficiency due to limited transparency, insufficient oversight, and misaligned incentives between the government and its contractors.

Tracing the history and impact of these models serves two purposes. First, greater knowledge will silence opponents of Medicare who claim that it wipes out the role of the market and private insurance. But more importantly, illuminating the models of privatization in each program will better allow for more constructive conversations about the role of private insurance in the future of American health care.

Part II defines the characteristics of Original Medicare and Medicare Advantage's privatization models and each model's impact on public accountability. This section then examines why the models were adopted, how they have evolved over the years, and the resulting vulnerabilities that persist today.

#### A. *Original Medicare: The Public-Private Partnership Model*

Original Medicare, the program's first delivery method, was imagined from its conception as a public-private partnership.<sup>76</sup> The U.S. Government Accountability Office broadly defines a public-private partnership as a "a contractual arrangement that is formed between public and private-sector partners . . . typically involv[ing] a government agency contracting with a private partner to renovate, construct, operate, maintain, and/or manage a facility or system, in whole or in part, that provides a public service."<sup>77</sup> As this definition highlights, public-private

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76. K. Ignagni, *Medicare Part D: A Successful Public-Private Partnership*, THE COMMONWEALTH FUND (July 1, 2006), <https://www.commonwealthfund.org/publications/other-publication/2006/jul/medicare-part-d-successful-public-private-partnership> [<https://perma.cc/59T9-KR69>].

77. U.S. GOV'T ACCOUNTABILITY OFF., GAO/GGD-99-71, PUBLIC-PRIVATE PARTNERSHIPS: TERMS RELATED TO PUBLIC-PRIVATE PARTNERSHIPS 13 (Apr. 1999); see Anika Guevara, *Public-Private Partnerships, An Innovative Solution for Declining Infrastructure*, 47 URB. LAW. J. 309, 310 (2015) (providing the same definition to describe public-private partnership privatization structures).



partnerships are broad.<sup>78</sup> They characterize many forms of contracts and vary widely in their degree of delegation to the private sector.<sup>79</sup> Two aspects of this definition shed light on how Original Medicare encourages public accountability.<sup>80</sup>

First, the government remains the driver of the relevant program.<sup>81</sup> This creates direct accountability from the contractor to the government. Regardless of how minimal or far-reaching the delegation of control and responsibility is, this direct accountability structure seeks to minimize the risk of misaligned goals and rogue contractor behavior because the government is the entity setting the agenda. The government remains the leader of the program, with a private partner there to help the government meet its bottom line.<sup>82</sup>

As the driver, the government can adjust the level of delegated control and responsibility at any point if things go wrong, if goals start to diverge, and if the private contractors begin to amass too much power. And if things go well, the government can delegate further duties to the private contractor.

In an ideal scenario, the private contractor is merely the means to the end of the government program running smoothly. But with a high degree of delegation, the private contractors may also seize a larger leadership role. This role can grow with time, and without adequate controls set by the government, it can disrupt the government's authority to reign it in. For this reason, some scholars consider public-private partnerships to be "shared-authority" structures.<sup>83</sup> Too much delegation, however, risks compromising public accountability. It is up to the government to strike the right balance to achieve its own goals.

Second, public-private partnerships require a high degree of government transparency because the government exists as the face of the program.<sup>84</sup> Because public-private partnerships often operate with the private partner behind the scenes, acting as an intermediary, the public is less likely to perceive the relevant program as privatized. As Part I illustrated, when the government is perceived as the deliverer of a good, there is heightened pressure from the public for the program to prioritize transparency, quality measurement, and efficient operation.

The public-private partnership model has been a part of Original

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78. U.S. GOV'T ACCOUNTABILITY OFF., *supra* note 77.

79. *Id.*

80. *Id.* at 13–14.

81. *Id.*

82. *Id.*

83. Jens K. Roehrich et al., *Are Public-Private Partnerships a Healthy Option? A Systematic Literature Review*, 113 *SOC. SCI. & MED.* 110, 112 (2014).

84. See MANAL FOUAD ET AL., INT'L MONETARY FUND, *MASTERING THE RISKY BUSINESS OF PUBLIC-PRIVATE PARTNERSHIPS IN INFRASTRUCTURE* 37–39 (2021).

Medicare since its passage in 1965.<sup>85</sup> Recognizing what it would take to get enough votes in Congress, Medicare architect Wilbur Cohen<sup>86</sup> conceived Medicare at the outset as a public-private partnership between CMS<sup>87</sup> and the private insurance industry.<sup>88</sup> A purely government administered program was never a realistic possibility—nor Cohen’s desired end goal.<sup>89</sup> To avoid great market disruption and to appease the powerful American Medical Association (AMA), CMS imagined a role for private insurers to manage and oversee the Medicare claims process.<sup>90</sup> This arrangement was envisioned so that private insurers could continue to play a role in the health insurance marketplace as it transitioned to a more publicly controlled space.<sup>91</sup>

When the time of legislative possibility<sup>92</sup> arrived in Congress, the Medicare statute codified this arrangement.<sup>93</sup> Two sections of the Original Medicare bill codified the public-private partnership: Sections 1816 and 1842.<sup>94</sup> These sections created Fiscal Intermediaries (FIs) and carriers<sup>95</sup> whose principal goal was to manage Medicare claims

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85. Susan Bartlett Foote has played a pivotal role in tracing the history of contracting in Original Medicare until 2007, but few other scholars have devoted any attention to this area of Medicare policy. See Susan Bartlett Foote, *The Impact of the Medicare Modernization Act’s Contractor Reform on Fee-For-Service Medicare*, 1 ST. LOUIS U. J. HEALTH L. & POL’Y 67, 67 (2007) (discussing how for almost a decade prior to Medicare’s passage, legislators and the American Medical Association clashed over the appropriate role that the federal government should play in the health care sector).

86. See THEODORE R. MARMOR, *THE POLITICS OF MEDICARE* 9, 17, 30 (2d ed. 2000) (detailing Wilbur Cohen’s involvement in the legislative passage of Medicare).

87. Until 2001, CMS was known as the Health Care Financing Administration (HCFA). CTRS. FOR MEDICARE & MEDICAID SERVS., DEP’T HEALTH & HUMAN SERVS., AB-01-133, PROGRAM MEMORANDUM 1 (Sept. 24, 2001).

88. There is evidence this partnership was not meant to be temporary either, but rather, a strategic long-term choice by the government. Wilbur Cohen, one of the central architects of Medicare, reportedly said to President Johnson, that insurer Blue Cross Blue Shield “would have to do all the policing so that the government wouldn’t have its long hand [in there].” Nicholas Bagley, *Bedside Bureaucrats: Why Medicare Reform Hasn’t Worked*, 101 GEO. L.J. 519, 528 (May 2003).

89. *Id.*

90. *Id.*

91. *Id.*

92. See MARMOR, *supra* note 86, at 84–85 (discussing the multiple-decade challenge to passing a workable Medicare bill in both chambers of Congress).

93. *Id.*

94. 42 U.S.C. §§ 1395h(a)–(k), 1395u(a)–(u).

95. 42 U.S.C. §§ 1395h(a)–(k), 1395u(a)–(u). Section 1816 granted authority to FIs to manage the claims process for Part A, and Section 1842 allowed carriers to administer Medicare and oversee the claims process for Part B. For Part A, hospital groups, extended care facilities, and home health agencies were given the power to nominate FIs to manage key administrative processes such as hospital relations, reimbursements, utilization, and audits. The government would directly contract with carriers under Part B, and each carrier would be assigned to specific geographic areas.

processing for Medicare Part A<sup>96</sup> and Part B.<sup>97</sup> At first, the FI and carrier selection process gave substantial deference to Medicare's private partners.

Most fundamentally, the contracting arrangement side-stepped the typical requirements agencies must follow under the Federal Acquisition Regulation (FAR).<sup>98</sup> The FAR requires that private contractors in government programs have "a track record of successful past performance" or "demonstrate a current superior ability to perform."<sup>99</sup> This requirement promotes quality private sector participation in public-facing programs. In keeping with this spirit, FAR also compels contractors to "promote and provide for full and open competition in soliciting offers and award[s]."<sup>100</sup>

Yet, to ensure that Original Medicare's private partners were interested in participating, the government initially granted provider associations the authority to select FIs.<sup>101</sup> Because the AMA was the preeminent provider association at the time challenging the passage of Medicare, they led this selection process.<sup>102</sup> But all along, CMS knew exactly how the selection process was going to play out. The AMA selected Blue Cross Blue Shield Association (Blue Cross) to serve as the first and primary FI for Part A.<sup>103</sup> Blue Cross subcontracted with local Blue Cross insurers across the country to manage the hospital insurance program on a local level.<sup>104</sup> This was expected; Blue Cross was the primary health insurer that hospital groups trusted, and competition among other insurers was minimal.<sup>105</sup> Carriers were selected by the Secretary of the Department of Health and Human Services (HHS) from

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96. Part A, "Hospital Insurance for the Aged and Disabled," covers most medically necessary hospital, skilled nursing facility, home health, and hospice care. Part A is financed through a payroll tax and is free to beneficiaries eligible for social security. 42 U.S.C. §§ 1395(c)–(i)(4).

97. Part B, "Supplementary Medical Insurance Benefits for the Aged and Disabled," covers physician and outpatient services. Part B includes most medically necessary doctors' services, preventive care, durable medical equipment, hospital outpatient services, laboratory tests, X-rays, mental health care, and some home health and ambulance services. Beneficiaries pay a monthly premium to receive this coverage. 42 U.S.C. §§ 1395(j)–(w)(5).

98. *See generally* 48 C.F.R. § 1.1 (2009) (detailing the purpose, authority, and issuance of the FAR requirements).

99. 48 C.F.R. § 1.102(b)(1)(ii) (2009).

100. 48 C.F.R. § 6.101(a) (2009).

101. CHRISTY FORD CHAPIN, *ENSURING AMERICA'S HEALTH: THE PUBLIC CREATION OF THE CORPORATE HEALTH CARE SYSTEM* 194–232 (2015).

102. Wilbur J. Cohen, *Reflections on the Enactment of Medicare and Medicaid*, 1985 HEALTH CARE FIN. REV. 3, 3–11.

103. *Id.*

104. Foote, *supra* note 85, at 69.

105. *Id.*

“a small pool of health insurers.”<sup>106</sup> As these particular selection decisions highlight, the selection process lacked full and open competition.<sup>107</sup>

At no point was CMS willing to compromise its leadership authority. Rather, this initial contracting arrangement allowed private insurers to be a secondary—the shared authority partner.<sup>108</sup> CMS made this initial choice to give private insurers a role in selecting contractors with the posterity of Medicare in mind.<sup>109</sup> Allowing private contractors the authority to assist in the contract selection process would help assuage the fear of private insurers uneasy about Original Medicare’s passage that they would stand to lose business. And in time, the control granted to private contractors could be reduced if issues arose.

Beyond deference in the contractor selection process, the government also provided great deference to the private contractors in other areas. Specifically, the initial Medicare statute provided limited authority for the government to terminate FI and carrier contracts, while the contractors themselves could easily terminate the contract.<sup>110</sup> Contractors were also paid initially based on allowable costs, mitigating any incentives that would boost quality of performance.<sup>111</sup> Furthermore, the contracts themselves required cost-reimbursement, meaning that the government was on the hook for all of the risk.<sup>112</sup> This delegated control was intended to increase providers’ acceptance of Original Medicare and minimize disruption to payors.<sup>113</sup>

Over the next thirty years, the public-private contracting arrangement

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106. The Johnson administration divided the nation into sixty-four unique carrier regions. One hundred and forty private insurers submitted proposals to become Medicare carriers, and forty-nine were selected by the Secretary of HHS. ROBERT CUNNINGHAM III & ROBERT M. CUNNINGHAM JR., *THE BLUES: A HISTORY OF BLUE CROSS AND BLUE SHIELD SYSTEM* 147, 181 (1997).

107. *Patients First: A 21st Century Promise to Ensure Quality and Affordable Health Coverage Before the Subcomm. on Health & Subcomm. on Oversight & Investigations of the H. Comm. on Energy & Com.*, 107th Cong. 13 (2001) (testimony of Michael F. Mangano, Acting Inspector Gen., Dep’t of Health & Hum. Servs., & Leslie G. Aronovitz, Dir., Health Care Issues, U.S. Gen. Acct. Off.) [hereinafter *Hearing*].

108. Foote, *supra* note 85, at 68.

109. *Id.* at 69.

110. See U.S. GOV’T ACCOUNTABILITY OFF., GAO-15-372, *MEDICARE ADMINISTRATIVE CONTRACTORS: CMS SHOULD CONSIDER WHETHER ALTERNATIVE APPROACHES COULD ENHANCE CONTRACTOR PERFORMANCE 1* (2015) (“CMS could not terminate contracts with fiscal intermediaries or carriers unless the contractors were first provided with an opportunity for a hearing.”).

111. *Hearing, supra* note 107, at 13.

112. U.S. GOV’T ACCOUNTABILITY OFF., *supra* note 110, at 6.

113. Foote, *supra* note 85, at 68–69.

led to a continuous tug-of-war between the public and private partners.<sup>114</sup> Just how much control and responsibility delegation was appropriate became the constant question.<sup>115</sup> And just how much privatization would cause an effective public-private partnership to crumble?

At first, the government allowed the level of control given to private contractors to grow further.<sup>116</sup> The government permitted the most “successful” contractors to acquire additional contracts.<sup>117</sup> Multi-state networks of FIs and carriers became common, as did the degree of variation between contractors.<sup>118</sup> As contractors’ networks grew, so too did their ability to shape the program. Over time, their administrative control extended beyond claims processing duties to wide-reaching aspects of Medicare administration.<sup>119</sup> By the late 1990s, FIs and carriers were responsible for five distinct functional areas: claims processing, payment safeguards, fiscal responsibility, beneficiary services, and administrative activities.<sup>120</sup> By this time, leaders at CMS and HHS were recognizing that FIs and carriers were the entities who “actually operate [Medicare].”<sup>121</sup> There were approximately fifty contractors operating as FIs and carriers at the time.<sup>122</sup> All the while, the organization and selection of contractors “remained much the same.”<sup>123</sup>

As the administrative power of the FIs and carriers grew, the government began to desire greater safeguards on contractor authority because goal alignment between the government and the private insurers had started to disperse.<sup>124</sup> The government wanted to ensure that it retained enough direct authority to supervise the contractors’

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114. *Id.* at 68, 71. *See generally* *Hearing, supra* note 107, at 123 (discussing the enactment of the Health Insurance Portability and Accountability Act, which put restrictions on Medicare contractors).

115. Foote, *supra* note 85, at 70–71.

116. *Id.* at 70.

117. *Id.*

118. *See id.* (“Successful contractors took advantage of departures to acquire additional carrier and FI contracts to build multi-contract networks. The growth of multi-state networks led to significant variations in the size, sophistication, resources, and productivity of contracting services.”); *see also* Susan Bartlett Foote et al., *Resolving the Tug-of-War Between Medicare’s National and Local Coverage*, 23 *HEALTH AFFS.* 108, 111, 115, 118 (2004) (discussing the disparities between national and local coverage determinations among contractors).

119. *See Hearing, supra* note 107, at 9 (describing the various roles FIs and carriers play in Medicare Administration: “they conduct reviews and hold hearings on appeals from physicians and providers; they respond to beneficiary inquiries; they make coverage decisions for new procedures and devices in local areas; and they conduct a variety of different providers services, such as enrolling new providers in the program, and educating them on Medicare’s rules and regulations and billing procedures”).

120. *Id.* at 14.

121. *Id.* at 12.

122. *Id.* at 14.

123. *Id.* at 12.

124. *Id.*

management of the Original Medicare program, rather than exist as merely the public face of the program.<sup>125</sup> At HHS, “fix it” became the daily order from Secretary Tommy G. Thompson to Administrator Thomas A. Scully.<sup>126</sup>

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 took an incremental step toward this goal through the creation of the Medicare Integrity Program.<sup>127</sup> This program aimed to boost overall program integrity by improving the payment safeguard functions of contractors.<sup>128</sup> But in the eyes of leaders at CMS at the time, this reform was just the tip of the iceberg for what was needed to dramatically improve the program and tip the scales back toward a more stable public-private partnership.<sup>129</sup>

In 2001, a joint hearing by leaders of HHS and CMS brought several bubbling criticisms of the FI and carrier contracting arrangement to light.<sup>130</sup> Michael F. Mangano, the Acting Inspector General at HHS, summarized several of the issues he saw with contractor administration, including:

[L]apses in the contractor’s own integrity and involvement in such things as misusing government funds while concealing their actions, altering documents and falsifying statements of specific work that was performed, preparing bogus documents to falsely demonstrate superior performance . . . and adjusting their claims processing so that systems edits, designed to prevent inappropriate payments were turned off.<sup>131</sup>

He also emphasized that CMS had recently settled suits with fourteen Medicare contractors for over \$350 million dollars.<sup>132</sup> With a high degree of delegation, the contractors’ pursuit of profit kept the government from adequately curtailing fraud and abuse. The bottom line from the government’s testimony was simple: “[a] strong Medicare demands a rational contracting system.”<sup>133</sup> “Rational” meant greater government authority to direct the public-private partnership according to the

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125. *Hearing, supra* note 107, at 12.

126. *Id.* at 8; Foote, *supra* note 85, at 72.

127. *Health Insurance Portability and Accountability Act (HIPAA)*, NURSE KEY, <https://nursekey.com/health-insurance-portability-and-accountability-act-hipaa/> [https://perma.cc/5DA4-BLVP] (last visited Dec. 28, 2022).

128. *Hearing, supra* note 107, at 14.

129. *Id.* at 14–15, 21.

130. *See id.* (including testimony by Leslie G. Aronovitz, Alfred J. Chiplin, Timothy F. Cullen, Michael F. Mangano, Scott P. Serota, Thomas Scully and additional materials submitted by the American Dental Association and the Medical Device Manufacturers Association).

131. *Id.* at 12.

132. *Id.*

133. *Id.* at 8.

government's terms only.<sup>134</sup> The government's desired solution was legislation.<sup>135</sup> Legislation was desired to "provide CMS with greater flexibility, promote competition, increase CMS's ability to negotiate incentives, and improve their contractor performance evaluation process."<sup>136</sup> Several decades removed from Medicare's passage, the new era of Medicare leadership was no longer interested in appeasing the AMA. They wanted their hands firmly on the controls.<sup>137</sup>

But at the same time, leaders at HHS and CMS in the early 2000s did not seem to want absolute control and responsibility over program administration back in the hands of the government. There appeared to be no desire to fully untangle the public-private partnership that had been built over the last thirty years and banish any semblance of privatization. Rather, the government wanted more control to be able to steer the program and dictate the terms of the multimillion dollar contracts it was providing to the insurance industry.<sup>138</sup>

CMS wanted a true public-private partnership, not one in name only.<sup>139</sup> Leaders were explicit about this: "CMS needs to be given greater flexibility in the methods it uses to *select, organize, and supervise* its Medicare contractors."<sup>140</sup> A more organized, competitive, and rational contracting system would allow leaders at CMS to better steer the ship.

After a few failed attempts at passing contractor reform,<sup>141</sup> in 2003, CMS finally received what it asked for. Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA)—aptly titled "Increased Flexibility in Medicare Administration"—significantly reformed not only the contractor selection process but the nature of the contractors themselves.<sup>142</sup> The MMA directed CMS to merge and replace FI and carriers with Medicare Administrative Contractors (MACs) by 2011.<sup>143</sup> The MACs were

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134. *Hearing, supra* note 107, at 7.

135. *Id.* at 13.

136. *Id.*

137. *Id.* at 10, 16–18.

138. For starters, CMS wanted the ability to contract with "entities other than insurance companies." *Id.* at 12.

139. *Id.* at 6.

140. *Hearing, supra* note 107, at 12 (emphasis added).

141. *See* Foote, *supra* note 85, at 71–73 (discussing failed proposals to pass contracting reform prior to 2003 and noting how the Medicare contracting reforms in the MMA incorporated most of a 2001 bi-partisan House bill (H.R. 2768) introduced by Subcommittee Chairman Nancy Johnson (R-CT) and Ranking Member Pete Stark (D-CA) that never gained traction in the Senate).

142. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, 42 U.S.C. § 1395kk-1.

143. There are two primary types of MACs: A/B MACs and DME MACs. A/B MACs process claims for Medicare Parts A and B which together comprise "Original Medicare." Currently, there are 12 A/B MACs that collectively process ninety-five percent of all fee-for-

envisioned to be the “single point-of-contact” for providers across both Part A and Part B.<sup>144</sup> They would continue to administer the far-reaching responsibilities that FIs and carriers previously were responsible for, just in a more unified way.<sup>145</sup> The MAC structure was supposed to simplify the contracting structure. To achieve this aim, the MMA called for fifteen distinct, non-overlapping MAC geographic regions,<sup>146</sup> rather than the “incoherent” and variable geographic regions that FIs and carriers previously controlled.<sup>147</sup>

The MMA also included reforms that sought to address some of the quality concerns and instances of fraud and abuse that had taken root.<sup>148</sup> Unlike the FI and carrier selection process, the Medicare contracting reforms gave the Secretary of HHS the authority to monitor contractor quality through “contract performance requirements.”<sup>149</sup> To “provide incentives for [MACs] to provide quality service and to promote efficiency,”<sup>150</sup> the reforms structured the new MAC contracts as cost-

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service claims. DME MACs make claims to durable medical equipment suppliers. There are four current DME MACs that process five percent of all fee-for-service claims. This Article will primarily analyze the A/B MACs due to the high volume of claims they oversee, and the greater interface they have with beneficiaries. For simplicity and clarity, this Article will refer to the A/B MACs as the MACs. U.S. GOV'T ACCOUNTABILITY OFF., *supra* note 110; *What's a MAC*, CMS.GOV (Jan. 12, 2023, 9:44 AM), <https://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/What-is-a-MAC#:~:text=Currently%20there%20are%2012%20A,36%20million%20Medicare%20FFS%20beneficiaries> [<https://perma.cc/EK2A-TN2M>].

144. Each MAC is responsible for setting up and managing a Medicare provider customer service program in its jurisdiction that must include: (1) a provider outreach and education program, (2) a contact center to handle provider inquiries, and (3) sufficient self-service technology for twenty-four-seven provider access to Medicare information. U.S. GOV'T ACCOUNTABILITY OFF., *supra* note 110, at 12. Today, MACs support CMS across six functional areas: provider enrollment, provider customer services, payment integrity, financial management, claims payment and payment notices, and claims processing. Across these six areas MACs have eleven primary responsibilities: process Medicare claims, enroll providers in Medicare, respond to provider inquiries, handle redetermination requests (first stage of appeals), review medical records for selected claims, perform provider reimbursement services, review and audit institutional provider costs, educate providers about Medicare fee-for-service billing requirements, establish local coverage determinations, support CMS demonstration projects, and coordinate with CMS and other fee-for-service contractors. *See* MICHAEL O. LEAVITT, *MEDICARE CONTRACTING REFORM: A BLUEPRINT FOR BETTER MEDICARE III-2* (2005) (discussing how MAC contracts would be focused on three core areas: customer service, operational excellence, and financial management).

145. U.S. GOV'T ACCOUNTABILITY OFF., *supra* note 110, at 2.

146. *Id.* at 22.

147. Foote, *supra* note 85, at 75.

148. U.S. GOV'T ACCOUNTABILITY OFF., *supra* note 110, at 34.

149. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, 42 U.S.C. § 1395kk-1(b)(3)(A)(i).

150. *Id.* § 1395kk-1(b)(1)(D)(i).



plus-award fee contracts.<sup>151</sup> Under a cost-plus-award fee contract, CMS now has the authority to offer a MAC a financial bonus if they provide exceptional performance above what is outlined in their statement of work.<sup>152</sup> This new award fee structure sought to provide a financial motivation for quality administration and to replace the incentive to cut corners and pursue profit through other mechanisms.<sup>153</sup>

These substantial programmatic changes can be seen as delivering on the government's desire to better "select, organize, and supervise" its contractors.<sup>154</sup> Rather than managing fifty contractors, CMS now only manages eight.<sup>155</sup> Today, there are eight unique MAC contractors who hold contracts across twelve A/B and four durable medical equipment (DME) geographic regions.<sup>156</sup> All of the current MACs are health insurance subsidiaries, meaning they exist solely or in part to process Medicare claims.<sup>157</sup> Most of the current MACs are subsidiaries of the most powerful health insurers in the country.<sup>158</sup> While there is some

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151. 48 C.F.R. § 16.405-2 (2022). "CMS and each MAC negotiate the dollar amount allocated for the MAC's award fee pool—the amount of the potential award fee." They may receive this in whole or in part. Beginning in July 2009, CMS began to structure award fee plans so that MACs "must receive a CPARS rating of satisfactory or higher in all areas of their statement of work to be eligible to earn any award fee." OFF. OF INSPECTOR GEN., DEP'T OF HEALTH & HUM. SERVS., OEI-03-11-00740, MEDICARE ADMINISTRATIVE CONTRACTORS' PERFORMANCE 4–5 (Jan. 2014).

152. *Award Fee Average MAC Earned Overall*, CMS.GOV (Dec. 1, 2021, 8:00 PM), <https://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/Award-Fee-Average-MAC-Earned-Overall-> [<https://perma.cc/L8EH-YZJJ>].

153. *Id.*

154. *Hearing*, *supra* note 107, at 13.

155. *Who Are the MACs*, CMS.GOV (Dec. 1, 2021), <https://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/Who-are-the-MACs> [<https://perma.cc/X24Y-QU3Q>].

156. *Id.* A resident of Illinois, for example, belongs to Jurisdiction 6, covering Illinois, Wisconsin, and Minnesota. MEDICARE ADMINISTRATIVE CONTRACTORS (MACs) AS OF JUNE 2019 1 (2019), <https://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/Downloads/MACs-by-State-June-2019.pdf> [<https://perma.cc/5NQQ-VVXU>].

157. *See* MEDICARE ADMINISTRATIVE CONTRACTORS, *supra* note 156 (listing the current MACs: Noridian, National Government Services, Palmetto GBA, Novitas, CGS, WPS, FSCO, and JF); *see also* Ted Doolittle, *Want to Expand Medicare? You'll Need to Hire the Insurance Companies, Not Fire Them*, THE HILL (Oct. 19, 2020), <https://thehill.com/opinion/healthcare/466576-want-to-expand-medicare-youll-need-to-hire-the-insurance-companies-not> [<https://perma.cc/3H8N-XW9H>].

158. National Government Services (NGS), for example, employs just 2,000 people. NGS, however, is not an independent company; NGS is a subsidiary of Anthem—the second largest health insurance company by membership, and third largest by revenue. This structure is not unique to NGS. Palmetto GBA employs about 2,500 people and exists solely to provide "technical and administrative services for the federal government." Palmetto is owned by Celerian Group, which is a subsidiary of Blue Cross. Blue Cross has retained their strong contracting status through the transition from FIs to MACs. For example, Novitas is owned by Blue Cross of Florida, CGS

evidence that the drafters tried to avoid such concentration,<sup>159</sup> this structure has allowed CMS to lead a more stable public-private partnership.

The new MAC structure has prioritized transparency between the private contractors and CMS. As a requirement for participation, MACs must collect and submit yearly encounter data to CMS for public disclosure.<sup>160</sup> And under Section 509 of the MMA, MAC contracts now require greater contractor performance transparency across eighty metrics.<sup>161</sup> These new safeguards allow CMS to better supervise and measure the effectiveness of their MACs.

In addition, to course correct from learned experience, there has been an increased focus on goal alignment between CMS and the MACs. Specifically, CMS and MAC executives meet annually to discuss process improvements, and working groups have been created for MAC collaboration.<sup>162</sup> CMS has also strived to see all of the MACs as a collective private partner, rather than individual private insurers with their own bottom lines.<sup>163</sup> In this vein, the MACs have all participated in working groups with CMS to share best practices.<sup>164</sup> And CMS has made efforts to incorporate innovations from one MAC into other MAC's

is owned by Celerian Group, and Noridian owns Blue Cross of North Dakota. Doolittle, *supra* note 157; David Brailer, *The Myth of Medicare for All—Why CEOs Should Fight to Preserve Health Care's Public-Private Partnership*, HEALTH EVOLUTION (Mar. 2, 2020), <https://www.healthevolution.com/insider/the-myth-of-medicare-for-all-why-ceos-should-fight-to-preserve-health-cares-public-private-partnership/> [<https://perma.cc/L2JE-DQ4Y>]. See generally Sterling Price, *Largest Health Insurance Companies of 2021*, VALUE PENGUIN (Dec. 20, 2020), <https://www.valuepenguin.com/largest-health-insurance-companies> [<https://perma.cc/NZU9-H2HX>] (indicating the market share percentages of the largest health insurance companies).

159. The reform implemented caps on the number of MAC contracts that a single health insurer can hold. A single MAC cannot control more than twenty-six percent of the entire Medicare A/B workload, and affiliated MACs cannot together account for more than forty percent of the country's A/B workload. This decision was made by CMS with an eye towards mitigating risk exposure of having too great a reliance on any single MAC contract. FACT SHEET: CMS' PLANS FOR THE A/B MEDICARE ADMINISTRATIVE CONTRACTOR (MAC) ROUND II PROCUREMENTS 2–3, <https://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/Downloads/CycleOne-CycleTwo/Round2ProcurementsBackgroundSheet.pdf> [<https://perma.cc/5G42-H563>]; U.S. GOV'T ACCOUNTABILITY OFF., B-415700, DECISION: MATTER OF NATIONAL GOVERNMENT SERVICES 2 (2018), <https://www.gao.gov/assets/b-415700.pdf> [<https://perma.cc/4Z5W-U6SC>].

160. *MAC Performance Compliance*, CMS.GOV (Sept. 29, 2021), <https://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/MACPerformanceCompliance> [<https://perma.cc/JDE8-AN6M>].

161. *Id.*

162. U.S. GOV'T ACCOUNTABILITY OFF., *supra* note 110, at 19.

163. *Id.* at 18–20.

164. *Id.* at 19.

statement of work.<sup>165</sup> In other words, when one MAC raises the bar of performance, the same is expected of the others. The public-private partnership is far from perfect, but it is now stable. Part III will examine continued vulnerabilities and propose recommendations aimed at further incentive alignment between CMS and the private contractors.

### B. Medicare Advantage: The Open Competition Model

Many policymakers support Medicare Advantage, viewing it as a “private” counterpart to Original Medicare.<sup>166</sup> Over the years, it has developed in popularity under “the premise that the private sector can compete with Medicare in providing health care to seniors.”<sup>167</sup> Today, beneficiaries who choose to enroll in a Medicare Advantage plan receive their Part A and B benefits directly through private insurers who compete with each other in defined geographic regions,<sup>168</sup> compared to Original Medicare—where the benefits are offered by the government directly.<sup>169</sup> Many Medicare Advantage plans also offer bundled Part D coverage.<sup>170</sup>

To best assess the program’s privatization, Medicare Advantage should be understood not as merely the “private” form of Medicare, but rather, as a form of open competition privatization. In this model, private companies are granted rights by the government to provide goods and services in specified geographic regions.<sup>171</sup> Open competition privatization involves a high degree of delegated control and responsibility placed in the hands of private contractors with minimal

165. *Id.*

166. Jeff Lagasse, *Medicare Advantage Receiving Bipartisan Support in House of Representatives*, HEALTHCARE FIN. (Jan 31, 2022), <https://www.healthcarefinancenews.com/news/medicare-advantage-receiving-bipartisan-support-house-representatives> [https://perma.cc/QHJ5-P94V].

167. Travis Broome & Farzad Mostashari, *Spurring Provider Entry into Medicare Advantage*, HEALTH AFFS. (July 6, 2017), <https://www.healthaffairs.org/doi/10.1377/hblog20170706.060925/full/> [https://perma.cc/RKS6-W2UG].

168. Robert A. Berenson et al., *Can Insurance Market Competition Coexist with Provider Price Regulation? Evidence from Medicare Advantage*, 56 INQUIRY 1, 1 (2019).

169. *How Original Medicare Works*, MEDICARE.GOV, <https://www.medicare.gov/what-medicare-covers/your-medicare-coverage-choices/how-original-medicare-works> [https://perma.cc/J84L-W8NF] (last visited Oct. 12, 2022).

170. *How Do Medicare Advantage Plans Work?*, *supra* note 8.

171. See Richard C. Brooks, *Privatization of Government Services: An Overview and Review of the Literature*, 16 J. PUB. BUDGETING, ACCT. & FIN. MGMT. 467, 472 (2004) (describing this model of privatization as “open competition whereby many private firms are allowed to compete for customers within a government’s jurisdiction”); see also, e.g., U.S. GOV’T ACCOUNTABILITY OFF., GAO-20-104, DOD UTILITIES PRIVATIZATION 1 (2020) (“Utilities privatization is the process of transferring ownership and operations of utility systems from the government to a private or public entity.”).

government oversight.<sup>172</sup> Under this model, privatization is supposed to spur competition by allowing private companies to compete for customers in these regions.<sup>173</sup> Similar to public-private partnerships, this model's design has two distinct characteristics that affect its accountability to the public.

First, the private contractor moves from passenger to driver. With greater delegation in the hands of the private contractor, there is limited transparency, less ability for the government to monitor program quality, and greater likelihood that the power of the private contractor will amass over time. With amassed power, private contractors are free to redefine their role and have little direct accountability to the government once they are granted rights to operate. This may cause misaligned goals between the government and private contractor, leading to wasteful spending.

Second, competition is not guaranteed. Open competition privatization merely provides the *opportunity* for private sector competition. It is up to the market and the contractors themselves to spur competition. Because the government only acts as a gatekeeper, not as a manager—there is no guarantee that true competition will come to fruition. As this section seeks to highlight, Medicare Advantage has not realized its promise of true competitiveness. With limited direct oversight by the government, the program has been minimally transparent and vulnerable to divergence between CMS and the private insurers it contracts with.<sup>174</sup>

Medicare Advantage's open competition model was driven by policymakers' desire to bring greater choice, competition, and innovation into the Medicare marketplace.<sup>175</sup> A memorandum from the

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172. See U.S. GOV'T ACCOUNTABILITY OFF., GAO/GGD-97-48, PRIVATIZATION: LESSONS LEARNED BY STATE AND LOCAL GOVERNMENTS 16 (1997) (“[M]onitoring and oversight that not only evaluates compliance with the terms of the privatization agreement but also evaluates a private firm’s performance in delivering services is needed when a government’s direct role in the delivery of services is reduced through privatization.”).

173. See ILL. COMM’N ON GOV’T FORECASTING & ACCOUNTABILITY, GOVERNMENT PRIVATIZATION: HISTORY, EXAMPLES, AND ISSUES 3 (2006) (“Open competition is similar to pure competition as many private firms are allowed to compete for customers within a governmental jurisdiction.”).

174. See U.S. GOV’T ACCOUNTABILITY OFF., GAO-22-106026, MEDICARE ADVANTAGE: CONTINUED MONITORING AND IMPLEMENTING GAO RECOMMENDATIONS COULD IMPROVE OVERSIGHT 2 (2022) (“Due to our concerns about the program’s susceptibility to mismanagement and improper payments as well as its size and complexity, we have designated Medicare, including Medicare Advantage, as a high-risk program. We . . . have identified significant concerns with CMS’s oversight of the MA program. As a part of our work, we have made a number of recommendations to prompt CMS action to improve MA monitoring and oversight.”).

175. AMANDA STARC, WHO BENEFITS FROM MEDICARE ADVANTAGE 2 (2014). Managed care can be understood as an umbrella term to describe the blending of health care financing and delivery. When you enroll in a managed care plan, your insurance company not only pays for your

Congressional Budget Office noted that “[o]ne of the motivations” for Medicare Advantage was “the desire to give Medicare beneficiaries the same variety of insurance options now available in the private sector.”<sup>176</sup> It was imagined as an “alternative” to Original Medicare that would give beneficiaries a wider range of health plan choices through which to obtain their Medicare benefits.<sup>177</sup> A broad range of choices was supposed to correspondingly reduce spending as consumers sought out the best plans.<sup>178</sup> Between 1966 and 1997, policymakers experimented with unique forms of managed care models<sup>179</sup> before Medicare Advantage was officially codified into law through Section 4001 of the Balanced Budget Act (BBA) of 1997. Over the next few years, enrollment levels were low due to “[u]nstable offerings, reduced benefits and higher premiums.”<sup>180</sup>

But in 2003, the MMA reforms significantly reformed the contracting process of Medicare Advantage, just as it did for Original Medicare.<sup>181</sup> Most notably, it expanded the scope of the program into the nationwide, regional-based program that exists today.<sup>182</sup> The reforms created twenty-six Medicare Advantage regions spanning states and clusters of states.<sup>183</sup> Finally, the reforms paved the way for Medicare Advantage providers to become the drivers of the program for the years ahead. The MMA imagined a minimal role for CMS: certifier and auditor.<sup>184</sup>

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care, but they take a stronger role in deciding where and when you can access services. Often, many services require prior authorization. There are many models of managed care including Health Maintenance Organization (HMOs), Preferred Provider Organizations (PPOs), and Point of Service (POS) Organizations. Joseph Heaton & Prasanna Tadi, *Managed Care Organization*, NAT'L LIBR. OF MED. (2021), <https://www.ncbi.nlm.nih.gov/books/NBK557797/#article-34791.s1> [<https://perma.cc/MB4C-YQXC>].

176. Memorandum from Sandy Christensen, Cong. Budget Off., to Interested Parties 16 (Nov. 12, 1997).

177. *See id.* (“[E]nrollees will have more alternatives to the original fee-for-service program . . . enrollees will have more kinds of plans from which to choose, so that they will be more likely to find one that suits them.”).

178. Robert A. Berenson, *When Competition Is Not Competition: The Curious Case of Medicare Advantage*, 11 ST. LOUIS U. HEALTH L. & POL'Y 141, 144 (2017).

179. YASH M. PATEL & STUART GUTERMAN, THE COMMONWEALTH FUND, THE EVOLUTION OF PRIVATE PLANS IN MEDICARE 2 (Dec. 2017), [https://www.commonwealthfund.org/sites/default/files/documents/\\_\\_\\_media\\_files\\_publications\\_issue\\_brief\\_2017\\_dec\\_patel\\_evolution\\_private\\_plans\\_medicare\\_managed\\_care\\_ib.pdf](https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_issue_brief_2017_dec_patel_evolution_private_plans_medicare_managed_care_ib.pdf) [<https://perma.cc/TBR9-C96M>].

180. MARSHA GOLD & LINDSAY HARRIS, MATHEMATICA POL'Y RSCH., KAISER FAM. FOUND., THE MEDICARE R<sub>X</sub> DRUG LAW: PROFILE AND ANALYSIS OF THE 26 MEDICARE ADVANTAGE REGIONS i (Mar. 2005).

181. *Id.*

182. *Id.*

183. *Id.*

184. *See How Do Medicare Advantage Plans Work?*, *supra* note 8 (“Medicare Advantage Plans . . . are offered by Medicare-approved private companies that must follow rules set by

As a certifier, CMS determines which private insurers can become Medicare Advantage providers.<sup>185</sup> An interested private insurer must submit an application that attests they will (1) provide all of the Part A and B services that Original Medicare covers and (2) provide additional services they list in their benefits contract.<sup>186</sup> As an auditor, CMS has the authority to audit Medicare Advantage providers to ensure they are compliant and submitting accurate diagnosis codes to the government.<sup>187</sup>

Once an application has been approved by Medicare, the private insurer takes the keys from CMS. They become the driver of the program; Medicare Advantage providers become responsible for the entire administration of the plan.<sup>188</sup> They must take over claims processing from the MACs and create their own provider contracts.<sup>189</sup> They are solely responsible for advertising and attracting enrollees.<sup>190</sup> Beyond these two roles, there is minimal direct accountability from Medicare Advantage providers to the government.<sup>191</sup> This hands-off, highly-privatized model has given rise to several negative externalities over the past years.<sup>192</sup>

First, competition has been minimal. In 2003, there were an estimated 146 Medicare Advantage plans offered across the country.<sup>193</sup> This

Medicare. If you join a Medicare Advantage Plan . . . you'll get most of your Part A and Part B coverage from your Medicare Advantage Plan, not Original Medicare.”).

185. See generally DEP’T OF HEALTH & HUM. SERVS., PART C – MEDICARE ADVANTAGE AND 1876 COST PLAN EXPANSION APPLICATION 4–16 (2022), <https://www.cms.gov/files/document/cy-2023-medicare-advantage-part-c-application.pdf> [<https://perma.cc/642L-AL56>] (providing requirements and resources for submission of MA applications).

186. *Id.* at 25.

187. Cf. Thomas Sullivan, *OIG Continues to Audit Medicare Advantage*, POL’Y MED. (June 13, 2021), <https://www.policymed.com/2021/06/oig-continues-to-audit-medicare-advantage-plans.html> [<https://perma.cc/2R22-EFMG>] (describing an investigation carried out by the Office of the Inspector General (OIG) for the HHS, in which the OIG used investigative techniques similar to historic auditing procedures utilized by CMS).

188. Travis Broome & Farzad Mostashari, *Spurring Provider Entry into Medicare Advantage*, HEALTH AFFS. (July 6, 2017), <https://www.healthaffairs.org/doi/10.1377/hblog20170706.060925/full/> [<https://perma.cc/5Q8L-JJHE>].

189. *Id.*

190. *Id.*

191. *Id.*

192. See Fred Schulte, *Medicare Advantage’s Cost to Taxpayers Has Soared in Recent Years, Research Finds*, NPR (Nov. 11, 2021, 5:00 AM), <https://www.npr.org/sections/health-shots/2021/11/11/1054281885/medicare-advantage-overcharges-exploding> [<https://perma.cc/GC3J-PFKZ>] (“Medicare Advantage billing data estimates that Medicare overpaid the private health plans by more than \$106 billion from 2010 through 2019 because of the way the private plans charge for sicker patients.”).

193. Alice M. Rivlin & Willem Daniel, *Could Improving Choice and Competition in Medicare Advantage Be the Future of Medicare?*, 18 FORUM FOR HEALTH ECON. & POL’Y 151, 153 (2015).

number has risen to an estimated 3,843 plans in 2022.<sup>194</sup> With so many approved plans, one might expect that competition should have similarly increased in each region. Instead, between 2009 and 2017, up to seventy percent of Medicare Advantage enrollees were in highly-concentrated markets with only two or three insurers.<sup>195</sup> Up to 147 counties, mostly rural, have no Medicare Advantage provider at all.<sup>196</sup> This limited competition is worrisome. Medicare Advantage’s payment system relies on competition between insurers to drive premiums down toward actual costs.<sup>197</sup> Without competition, there is fear that enrollees are overpaying.<sup>198</sup>

Limited competition has also been accompanied by limited data on plan information and limited quality measurement. With limited oversight, Medicare Advantage providers are free to design their websites as they see fit. Many websites are not easily accessible for potential enrollees and fail to include vital information, such as which physicians accept the plan.<sup>199</sup> In general, provider directories must be complete,

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194. *A Record 3,834 Medicare Advantage Plans Will Be Available in 2022, Up 8 Percent From 2021, While the Number of Medicare Part D Stand-Alone Plans Is Decreasing Mainly Due to Firm Consolidations*, KFF (Nov. 2, 2021), <https://www.kff.org/medicare/press-release/a-record-3834-medicare-advantage-plans-will-be-available-in-2022-up-8-percent-from-2021-while-the-number-of-medicare-part-d-stand-alone-plans-is-decreasing-mainly-due-to-firm-consolidations/> [<https://perma.cc/N85D-K5MB>].

195. RICHARD G. FRANK & THOMAS G. MCGUIRE, THE COMMONWEALTH FUND, MARKET CONCENTRATION AND POTENTIAL COMPETITION IN MEDICARE ADVANTAGE 1 (Feb. 2019), [https://www.commonwealthfund.org/sites/default/files/2019-02/Frank\\_market\\_concentration\\_medicare\\_advantage\\_ib\\_0.pdf](https://www.commonwealthfund.org/sites/default/files/2019-02/Frank_market_concentration_medicare_advantage_ib_0.pdf) [<https://perma.cc/4HGE-3N98>].

196. Gretchen Jacobson & Tricia Neuman, *Some Counties May Lack an ACA Marketplace Insurer Next Year – But Many More Lack Medicare Advantage Plans Today*, KFF (Aug. 1, 2017), <https://www.kff.org/medicare/issue-brief/some-counties-may-lack-an-aca-marketplace-insurer-next-year-but-many-more-lack-medicare-advantage-plans-today/> [<https://perma.cc/HHP5-587C>].

197. Richard J. Frank & Thomas M. McGuire, *Regulated Medicare Advantage and Marketplace Individual Health Insurance Markets Rely on Insurer Competition*, 36 HEALTH AFFS. 1578, 1580 (Sept. 2017) (“Markets with more insurance carriers have lower premiums.”).

198. *Id.*

199. See Trudy Lieberman, *Shopping for Medicare Advantage Plans Is a Maze of Confusion for Seniors*, CTR. FOR HEALTH JOURNALISM (Nov. 23, 2021), <https://centerforhealthjournalism.org/2021/11/22/shopping-medicare-advantage-plans-maze-confusion-seniors> [<https://perma.cc/3BXJ-VANG>] (“[T]he websites of the State Health Insurance Assistance Program (SHIP), set up in each state by the federal government to help seniors choose Medicare plans, did not offer the necessary caveats for choosing Medigap and Advantage plans, ‘which a discerning consumer would like to know.’”); see also Bernard J. Wolfson, *Health Insurance Provider Directories Are Required by Law, But They Often Have Errors*, CHI. SUN TIMES (July 29, 2022, 3:00 PM), <https://chicago.suntimes.com/consumer-affairs/2022/7/29/23279223/consumer-health-insurance-provider-directories-guide-inaccuracies> [<https://perma.cc/7ZF6-DTWA>] (“If you have medical insurance, chances are you’ve become exasperated at some point trying to find an available doctor or mental health practitioner in your

accurate, and updated annually.<sup>200</sup> However, despite such a requirement, Medicare Advantage providers have not always followed this requirement, and it has been hard to police.<sup>201</sup> One study in the American Journal of Managed Care found that Google has more up-to-date information on provider networks than some Medicare Advantage provider directories.<sup>202</sup> CMS has also reported that up to fifty-two percent of Medicare Advantage provider directories had at least one major inaccuracy, such as an incorrect phone number or address.<sup>203</sup> Without such information, plans cannot be accountable to their enrollees. Enrollees might not be able to reach a doctor when an urgent situation arises or to reach a representative to dispute a charge, should they be overbilled.<sup>204</sup>

Transparent quality measurement itself has also been minimal in Medicare Advantage. Medicare Advantage providers typically do not have to release comprehensive claims data and encounter-level data to the public.<sup>205</sup> Medicare Advantage organizations are only required to submit “bids,” which are estimates of coverage costs used to calculate payment rates and risk scores for enrollees to CMS.<sup>206</sup> With no requirement to release quality data, Medicare Advantage providers have no incentive to release data if it is less-than-stellar. Yet without this data, enrollees and policymakers have had difficulty determining how well the program is performing.<sup>207</sup> Lack of public data has provided a major roadblock to measuring the program’s effectiveness, and how well it is performing on quality-of-care metrics.<sup>208</sup>

Finally, CMS’s audits have revealed a further negative side effect of delegating so much authority to private contractors: vulnerability to fraud

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health plan’s network. You find multiple providers in your plan’s directory, and you call them. All of them. But the number is wrong. Or the doctor has moved or retired or isn’t accepting new patients. Or the next available appointment is three months away. Or the provider isn’t actually in your network.”).

200. See 42 C.F.R. § 422.111(a)(1)–(3) (2023) (specifying that an MAO must disclose certain information to “each enrollee electing an MA plan it offers” in a manner that is “clear, accurate, and standardized” at “the time of enrollment and at least annually thereafter, by the first day of the annual coordinated election period”).

201. See Wolfson, *supra* note 199 (“Despite state and federal regulations that require more accurate health plan directories, they still can contain errors and often are outdated.”).

202. Michael Adelberg et al., *Improving Provider Directory Accuracy: Can Machine-Readable Directories Help?*, 25 AM. J. MANAGED CARE 241, 243 (2019).

203. CTRS. FOR MEDICARE & MEDICAID SERVS., ONLINE PROVIDER DIRECTORY REVIEW REPORT 1 (2018).

204. Wolfson, *supra* note 199.

205. Niall Brennan et al., *Time to Release Medicare Advantage Claims Data*, 319 JAMA 975, 975 (2018).

206. *Id.*

207. *Id.*

208. *Id.*



and abuse.<sup>209</sup> Upcoding, the process of submitting more expensive diagnoses or procedures to CMS than were actually performed by a physician, has been rampant.<sup>210</sup> The open competition structure of privatization has allowed for upcoding because of the unaligned goals between Medicare Advantage providers and CMS.<sup>211</sup> CMS desires participation in the program, and they pay beneficiaries for each expected cost.<sup>212</sup> On the other hand, Medicare Advantage providers are paying for this care, so they are incentivized to make it appear that enrollees are sicker than normal and have high expected costs.<sup>213</sup> Once they secure the funds, they may be incentivized to provide as little care as possible to boost profits. Upcoding is not a minor problem.<sup>214</sup> Some reports estimate that up to 9.5 percent of payments from CMS to Medicare Advantage providers are improper due to unsupported diagnoses submitted by Medicare Advantage organizations.<sup>215</sup> Others estimate that Medicare Advantage plans overcharged Medicare by thirty billion dollars between 2013 and 2016.<sup>216</sup> One recent investigation found that thirty-five out of thirty-seven audited Medicare Advantage plans had upcoded for certain diseases.<sup>217</sup> Auditors confirmed that sixty percent of the “more than 20,000 medical conditions plans were paid to treat.”<sup>218</sup> According to *The New York Times*, “[e]ight of the 10 biggest Medicare Advantage insurers—representing more than two-thirds of the market—have submitted inflated bills . . . . And four of the five largest players . . . have faced federal lawsuits alleging that efforts to overdiagnose their customers crossed the line into fraud.”<sup>219</sup>

CMS’s role as auditor has brought this fraud to light. But audits should

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209. *Id.*; Reed Abelson & Margot Sanger-Katz, “*The Cash Monster Was Insatiable*”: How Insurers Exploited Medicare for Billions, N.Y. TIMES (Oct. 8, 2022), <https://www.nytimes.com/2022/10/08/upshot/medicare-advantage-fraud-allegations.html> [https://perma.cc/K623-FSPG].

210. Brennan et al., *supra* note 205; Fred Schulte, *Medicare Advantage Audits Reveal Pervasive Overcharges*, CTR. FOR PUB. INTEGRITY (Aug. 29, 2016), <https://publicintegrity.org/health/medicare-advantage-audits-reveal-pervasive-overcharges/> [https://perma.cc/BN7P-Z7NE].

211. Brennan et al., *supra* note 205; Abelson & Sanger-Katz, *supra* note 209; Schulte, *supra* note 210.

212. Brennan et al., *supra* note 205; Abelson & Sanger-Katz, *supra* note 209.

213. Brennan et al., *supra* note 205; Abelson & Sanger-Katz, *supra* note 209.

214. See Schulte, *supra* note 210 (“[F]ederal officials have struggled to stamp out inflated coding.”).

215. *Id.*

216. Fred Schulte & Lauren Weber, *Medicare Advantage Plans Overbill Taxpayers by Billions Annually, Records Show*, NPR (July 16, 2019, 5:00 AM), <https://www.npr.org/sections/health-shots/2019/07/16/740964958/records-show-medicare-advantage-plans-overbill-taxpayers-by-billions-annually> [https://perma.cc/RCU9-VPJB].

217. Schulte, *supra* note 210.

218. *Id.*

219. Abelson & Sanger-Katz, *supra* note 209.

not be confused with oversight. Oversight, as the public-private partnership of Original Medicare demonstrates, requires continual responsiveness on the part of the private partners as a term of participation. Auditing is a more limited way to identify goal divergence, and because of their random nature, audits are likely to only identify some instances of fraud and abuse. As Medicare currently exists, without reform to the contracting structure of Medicare Advantage, the government is stuck taking a reactionary posture.

Despite these substantial problems, the appeal of Medicare Advantage is still rising.<sup>220</sup> Medicare Advantage providers have been able to steer the narrative to a focus on their perceived benefits. Proponents point to the perceived “advantage” of the plans. First, they highlight that many have access to a Medicare Advantage plan that covers dental, fitness, vision, and hearing benefits—which are not always covered by traditional Medicare.<sup>221</sup> Proponents also highlight that, unlike Original Medicare, Medicare Advantage has out-of-pocket spending caps for physician and hospital services (Medicare Part A and B benefits).<sup>222</sup> A final major benefit is that generally, enrollees do not need to submit claims unless a service is used outside of their network.<sup>223</sup> Unfortunately, these “advantages” have overshadowed the program’s governance problems, to the detriment of beneficiary care and federal dollars.

### III. RECOMMENDATIONS FOR THE PATH FORWARD: IMPROVE ORIGINAL MEDICARE

Medicare faces a more privatized future ahead if the status quo remains unchanged. As Part II illuminated, both models of privatization

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220. *See id.* (“If trends hold, by next year, more than half of Medicare recipients will be in a private plan.”).

221. Meredith Freed et al., *Dental, Hearing, and Vision Costs and Coverage Among Medicare Beneficiaries in Traditional Medicare and Medicare Advantage*, KFF (Sept. 21, 2021), <https://www.kff.org/health-costs/issue-brief/dental-hearing-and-vision-costs-and-coverage-among-medicare-beneficiaries-in-traditional-medicare-and-medicare-advantage/> [https://perma.cc/PNL3-M5GK].

222. Meredith Freed et al., *Medicare Advantage in 2022: Premiums, Out-of-Pocket Limits, Cost Sharing, Supplemental Benefits, Prior Authorization, and Star Ratings*, KFF (Aug. 25, 2022), <https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2022-premiums-out-of-pocket-limits-cost-sharing-supplemental-benefits-prior-authorization-and-star-ratings/#:~:text=Since%202011%2C%20federal%20regulation%20has,%2Dof%2Dnetwork%20services%20combined> [https://perma.cc/S5RM-Z8TN].

223. Jason Baum, *When and How to File a Medicare Claim*, EHEALTH (July 14, 2022), <https://www.ehealthinsurance.com/medicare/cost/when-and-how-to-file-a-medicare-claim/#:~:text=If%20you%20get%20your%20Medicare,with%20a%20set%20monthly%20amount> [https://perma.cc/YAD4-E5FL].

have exposed weaknesses and cracks in their design. But Medicare Advantage far surpasses Original Medicare both in the degree of privatization, weaknesses of the structure, and surprisingly, public appeal. Medicare Advantage's open competition model continues to draw more supporters in Congress and in enrollees alike,<sup>224</sup> despite misaligned incentives and limited transparency.

The answer to these vulnerabilities should not be to privatize further. Greater oversight and accountability will only go so far to substantially improve a model that relies on the market and competition to drive down costs and deliver quality care. Much has already been written on how to better manage Medicare Advantage providers with minimal corresponding change.

Less attention has been paid to improving the role for private insurers in Original Medicare. Discussion of MACs has been largely absent from policy conversations focused on the future of Medicare. Not once during the 2020 presidential debates, where health care took center stage, was the word MAC uttered or the public-private nature of Original Medicare discussed.<sup>225</sup> Even Bernie Sanders, who has been an outspoken advocate of Medicare for All, has been vague on the specific role that MACs would play under an even more public structure, and whether he believes they have done a good job administering the program for the last fifteen years.<sup>226</sup> As Part II highlighted, the transition to the MAC structure was a major step forward for the program, but weaknesses remain. To improve public accountability, continuing to perfect this model should be a priority of Congress in the years ahead.

Improving Original Medicare's public-private partnership will also prove to privatization advocates that private insurers can play a productive role in a public Medicare program. It will show by example that privatization does not require free-market competition and a regressive government role to be effective. It is true that the model of

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224. Abelson & Sanger-Katz, *supra* note 209; Robert King, *Most of Congress Warns CMS Against Any Medicare Advantage Cuts, Calls for Benefit Flexibility*, FIERCE HEALTHCARE (Feb. 22, 2022, 4:00 PM), <https://www.fiercehealthcare.com/payers/most-congress-warns-cms-against-any-medicare-advantage-cuts-calls-benefit-flexibility> [<https://perma.cc/3ZUQ-G749>].

225. Paige Winnfield Cunningham, *The Health 202: Health Care Was First Up in Last Night's Caustic Presidential Debate*, WASH. POST (Sept. 9, 2020), <https://www.washingtonpost.com/politics/2020/09/30/health-202-health-care-was-first-up-last-night-caustic-presidential-debate/> [<https://perma.cc/2S65-6BS4>].

226. See Edward M. Murphy, *The Reality of Medicare for All is Not What You Think*, COMMONWEALTH (Sept. 7, 2019), <https://commonwealthmagazine.org/health-care/the-reality-of-medicare-for-all-is-not-what-you-think/> [<https://perma.cc/2N7A-VCAF>] (“The proposed statutory language is unclear about eliminating the insurers who now administer the convention program as regional Medicare Administrative Contractors . . . . The proposed law is silent on the day to day administration of the new service beyond establishing that enrollees ‘are entitled to have payment made by the Secretary’ of the US Department of Health and Human Services.”).

Original Medicare imagines a less robust role for private insurers.<sup>227</sup> But it imagines a role, nonetheless.<sup>228</sup> Finding the right role should be the highest priority for Medicare's longevity. In addition, by demonstrating the productive role that private insurers can play in Original Medicare, a Medicare for All future could be more likely to carve out a larger role for private insurers.

Because transparency is already a requirement for MAC contracts with CMS, future improvements to the program's design should focus on mitigating misaligned incentives that have not yet been addressed. This process can be done through greater performance coordination among MACs and through contract extensions.

*A. Suggested Improvement Number One: Improve MAC Coordination Through Extended Contracts*

As Part I highlighted, models of privatization should ensure a high degree of coordination between public and private sector contractors, and between private sector contractors themselves, to mitigate any competitive advantages that get in the way of program equity for enrollees. Coordination seeks to mitigate misaligned incentives by keeping private contractors narrowly focused on the government's bottom line and the promotion of public values. By working more directly with each other, each party will be more likely to view each other as symbiotic partners delivering a public good.

As Part II identified, in recent years, CMS has identified instances of MACs failing to share certain innovations or operational improvements with other MACs to protect their own competitive advantage.<sup>229</sup> So far, CMS has convened working groups between MAC executives and CMS officials. CMS has made a point to share operational improvements and innovations between the MACs.<sup>230</sup> These coordination efforts are a positive step forward, but they will not meaningfully change the status quo in an environment where MACs are competing with each other every five years for new contracts.

In 2015, the Government Accountability Office (GAO) recommended that CMS extend contract lengths to better incentivize coordination between MACs and CMS and to allow MACs more time to implement process improvements.<sup>231</sup> Heeding the advice of the GAO, the Medicare Access and CHIP Reauthorization Act increased the maximum MAC

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227. *Id.*

228. *Id.*

229. *See supra* Part II.

230. U.S. GOV'T ACCOUNTABILITY OFF., *supra* note 110, at 19; *see supra* Part II.

231. U.S. GOV'T ACCOUNTABILITY OFF., *supra* note 110, at 21.

contract award length to ten years.<sup>232</sup> Yet despite this change, new MAC contract awards have not been extended to ten years; the two most recent MAC contract awards were for seven years.<sup>233</sup> To improve coordination between MACs, future MAC awards should be extended to the ten-year maximum. A ten-year period will more effectively allow MACs and CMS to develop long-term coordination plans and view their relationship as permanent, rather than temporary. If operational efficiency and coordination improves over the next several years with such a change, CMS should consider advocating for legislation that would further increase MAC contract length.

*B. Suggested Improvement Number Two: Mitigate Instances of Fraud and Abuse Through Stricter Reporting Requirements*

Part II highlighted that incidences of fraud and abuse are far lower in Original Medicare than Medicare Advantage. This has been due in part to greater oversight by CMS and the requirement that MACs have to prevent and curb improper billing.<sup>234</sup>

Once they are awarded a contract, a MAC is required to create provider education and medical review departments.<sup>235</sup> Together, these departments are supposed to work together in educational efforts to prevent and curb improper provider billing.<sup>236</sup> Despite these stated goals of coordination, a 2017 GAO Report found minimal evidence of efforts to curb improper billing through both of these departments.<sup>237</sup>

In part, this has persisted because MACs do not have enough incentive to report instances of fraud and abuse. In many instances, reporting is optional.<sup>238</sup> The CMS Provider Customer Service Program Manual specifies that only MACs with improper payment rates above a certain threshold are required to submit quarterly or monthly provider education

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232. Medicare Access and CHIP Reauthorization Act of 2015, Pub. L. No. 114-10, § 509(a)–(b), 129 Stat. 87, 170 (2015).

233. See AWARD OF MEDICARE ADMINISTRATIVE CONTRACTOR (MAC) CONTRACT FOR JURISDICTION K 2, <https://www.cms.gov/files/document/jk-award-fact-sheetdecember-2021.pdf> [<https://perma.cc/C2XQ-GZEZ>] (last visited Jan. 27, 2023) (describing the contract length of Jurisdiction K, awarded to National Government Services on December 15, 2021); see also AWARD OF MEDICARE ADMINISTRATIVE CONTRACTOR (MAC) CONTRACT FOR JURISDICTION JL 2, <https://www.cms.gov/files/document/jl-award-fact-sheetjuly-2021.pdf> [<https://perma.cc/2Q6F-4FZ7>] (last visited Jan. 27, 2023) (describing the contract length of Jurisdiction L, awarded to Novitas Solutions on July 27, 2021).

234. See *supra* Part II.

235. U.S. GOV'T ACCOUNTABILITY OFF., GAO-17-290, MEDICARE PROVIDER EDUCATION: OVERSIGHT OF EFFORTS TO REDUCE IMPROPER BILLING NEEDS IMPROVEMENT 2 (2017).

236. *Id.*

237. *Id.* at 8.

238. MEDICARE ADMINISTRATIVE CONTRACTOR (MAC) BENEFICIARY AND PROVIDER COMMUNICATIONS MANUAL 21 (2019), <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/com109c06.pdf> [<https://perma.cc/Q43H-HFR4>].

department status updates.<sup>239</sup> CMS officials have admitted, however, that in practice they do not require these reports and are considering removing this expectation from the manual.<sup>240</sup> As a direct result of this, CMS remains in the dark as to the extent that MACs are actually working to reduce improper billing.

The issue here is one of incentives. MACs are motivated in part to prolong their contract with the government, and evidence of improper billing would jeopardize such extension. Given the option to opt-out of disclosure, it is not surprising MACs choose to withhold information. To better align the incentives of CMS and the MACs, the government should more forcefully require disclosure of improper payments. This will both improve transparency, and increase efforts by the MACs to show they are doing a good job.

This is also another area where coordination would seek to better align the incentives between the MACs and CMS. According to CMS policy, CMS staff typically visit MAC sites for in-person onsite reviews with MAC managers every two months.<sup>241</sup> Topics discussed can include “monthly status report[s], progress on significant and/or ongoing issues, new issues or concerns, and innovations.”<sup>242</sup> Until the rates of improper billing decrease substantially, CMS should require MAC management personnel to provide detailed accounts of their up-to-date improper payment rates at onsite meetings and what they are doing to decrease these percentages.

#### CONCLUSION

The future of Medicare hinges on the choice between two distinct models of privatization. Neither model operates without private sector participation, and both models carve out a significant role for private insurers. This role has only expanded in recent years. As this Article seeks to illuminate, both models are far from perfect, but Original Medicare more effectively promotes public accountability than Medicare Advantage. Original Medicare is more transparent, and better aligns incentives between the government and private contractors to promote public values and minimize fraud and abuse. Further reform and refinement of this model should be the focus of policymakers in the years ahead if Medicare is to remain stable; otherwise, Medicare Advantage is positioned to continue to grow in popularity, fueled by the appeal of competition, choice, and perceived private sector efficiency. Are policymakers willing to abandon oversight, transparency, and stability in an illusory pursuit of these values? Are they willing to ignore how

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239. *Id.*

240. U.S. GOV'T ACCOUNTABILITY OFF., *supra* note 235, at 8.

241. OFF. OF INSPECTOR GEN., DEP'T OF HEALTH & HUM. SERVS., *supra* note 151, at 6.

242. *Id.*

Medicare Advantage has not delivered on these important metrics? And are they happy to just hand over the keys to private insurers motivated by profit? This is an irresponsible path. Course correction now is still possible, but only if there is the political will to take back the keys.