

Medicare Reform and Social Insurance: The Clashes of 2003 and Their Potential Fallout

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Medicare pays for at least half of the hospital and medical expenses incurred by America's elderly and disabled.¹ It is also periodically the object of intense political debate, marked by exaggerated claims about how the sky will fall unless some fundamental change is made in the financing, benefits, or administration of the program. Over the past decade and a half, this political attention has had less and less to do with legitimate concerns about budget deficits and Medicare's real (if usually overstated) faults. Instead, it has become principally fueled by the alarmist rhetoric of those who ideologically oppose Medicare's social insurance structure. Most of these critics, mindful of Medicare's broad popularity, mask their underlying hostility to the program with a veneer of public-minded concern. Unfortunately, their rhetoric of crisis clouds more than it illuminates what is fundamentally at issue in all these disputes.

In this Essay, we concentrate on one such confused aspect of the recent debate that is emblematic of the contemporary politics of Medicare: the debate over "means-testing" Part B of Medicare, the medical insurance program. In a significant break with Medicare's history, the reform legislation of 2003—the Medicare Modernization Act (MMA)—imposes sharply higher premiums on wealthy beneficiaries.² The story of how this

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1. CRAIG CAPLAN, AARP PUB. POL'Y INST., WHAT SHARE OF BENEFICIARIES' TOTAL HEALTH CARE COSTS DOES MEDICARE PAY? 1 (2002), http://research.aarp.org/health/dd78_costs.pdf.

2. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, § 811, 117 Stat. at 2364-65. Income scaling more than tripled the monthly premium for participants with incomes over \$80,000 (single) or \$160,000 (couples). Julie Appleby, *The Ins and Outs of Medicare Changes*, USA TODAY, Nov. 25, 2003, at 3B ("Instead of

came to pass has been largely lost in the crowded pages of American journalism. But at least one journalist noted that “House and Senate negotiators, struggling for accord on a plan to redesign Medicare, have agreed in principle that wealthy older Americans should pay more for doctor visits and other outpatient care, reprising an idea that has proved politically explosive.”³ The income or means-testing dispute was just one small part of the larger struggle over the shape of the prescription drug benefit that President George W. Bush signed into law in early December 2003.⁴ Yet the dispute was symbolic of the confusion that surrounds the questions of whether and how Medicare ought to be restructured.

THE ORIGINS OF MEDICARE AND THE 2003 REFORM LEGISLATION

The historical context of Medicare’s overarching structure is worth considering—it enables one to evaluate subsequent reforms, and the

paying the current 25% of the Medicare Part B premium, . . . wealthier seniors would pay up to 80% of that premium”). Together, these beneficiaries comprise only a small fraction of the current Medicare population. See Ctr. for Medicare Advocacy, *Quick Reference Medicare Facts & Statistics* (Nov. 8, 2004), at http://www.medicareadvocacy.org/FAQ_QuickStats.htm (reporting that, in 1999, ten percent of Medicare beneficiaries had incomes greater than \$80,000).

3. Amy Goldstein, *‘Means Test’ Deal Near on Medicare; Wealthy Seniors Would Be Charged More Under Plan*, WASH. POST, Oct. 16, 2003, at A1. The fact that this provision emerged from the conference committee of the House and Senate requires additional comment. The leader of the House conferees, Republican Congressman Bill Thomas from California, managed to exclude all but two of the designated Senate conferees, and the House conferees from the Democratic caucus refused to participate in such an imbalanced and, in their view, illegitimate practice. The counter-factual—what would have emerged from an ordinary conference bargaining process—is necessarily speculative. But the process employed was irrefutably controversial and contrary to long-established congressional norms. Moreover, as became known later, the passage of this legislation was marked by a number of apparently scandalous actions, ranging from alleged bribes to House Republicans initially opposed to the legislation to widely believed claims that the former head of Medicare, Tom Scully, threatened to fire the independent actuary if he sent Congress his cost estimates, which were much higher than those of the Congressional Budget Office. See Ted Marmor, *The US Medicare Programme in Political Flux*, 10 BRIT. J. HEALTH CARE MGMT. 140, 142 (2004); Timothy Noah, *A Drug-Company Bribe?: The Medicare Vote Scandal, Continued*, SLATE, Dec. 8, 2003, at <http://slate.msn.com/id/2092242>; Timothy Noah, *Information Is Treason: Why Bush Is Worse Than Reagan*, SLATE, Mar. 16, 2004, at <http://slate.msn.com/id/2097268>.

4. Ctrs. for Medicare & Medicaid Servs., *Medicare Modernization Act*, at <http://www.cms.hhs.gov/medicarereform/> (last modified Nov. 5, 2004).

agendas they reflect, in light of the aims of the program's framers. The development of hospital insurance, Medicare's Part A, was the focus of attention from the beginning of the Kennedy Administration in 1961 and became the legislative aim of President Johnson in the mid-1960s.⁵ As such, it incorporated the traditional elements of American social insurance programs—compulsory taxes known as “FICA” (for “Federal Insurance Contributions Act”) contributions, a ceiling on the wage and salary income on which those taxes were paid, and broad eligibility without restrictions based on means or assets.⁶ Part B, or supplemental medical insurance, pays for physicians' fees and a variety of other outpatient expenses.⁷ This feature, unexpectedly included with Republican backing, introduced premiums—rather than payroll contributions—as a source of financing.⁸ Part B was enacted as a voluntary insurance program, though with subsidies so substantial that the overwhelming proportion—some ninety-six percent of those eligible—have enrolled.⁹

In 1965, an overwhelmingly Democratic Congress secured enactment of Medicare.¹⁰ In 2003, the concerted push to legislate a prescription drug benefit for Medicare arose because of the *absence* of clear partisan control of either the Senate or the House: For a decade or more, each political party had fought to make sure the other could not take credit for introducing such an expansion of insurance coverage, with stalemate regularly the result. In 2003, however, Republican and Democratic leaders in Congress and in the Administration came to believe that continued stalemate might well provide the other side with an effective electoral

5. *See generally* THEODORE R. MARMOR, *THE POLITICS OF MEDICARE* 45-85 (2d ed. 2000) (describing the origins and subsequent fate of Medicare).

6. *See* MARMOR, *supra* note 5, at 15-16 (describing the early appeal of financing Medicare hospital insurance through Social Security contributions); Ctr. for Medicare Advocacy, Medicare Summary (Dec. 3, 2004), at http://www.medicareadvocacy.org/FAQ_MedicareSummary.htm (providing an overview of Part A's financing, eligibility, and benefits). *But see* Cathy A. Cowan et al., DataView, *Business, Households, and Government: Health Spending, 1994*, HEALTH CARE FINANCING REV., Summer 1996, at 157, 161 (noting that “the cap on the maximum amount of taxable earnings” for the Medicare Hospital Insurance Trust Fund was eliminated in 1993).

7. *See* Ctr. For Medicare Advocacy, The Medicare Part B Benefit (Sept. 22, 2004), at http://www.medicareadvocacy.org/FAQ_PartB.htm#Payment.

8. *See* MARMOR, *supra* note 5, at 45-61.

9. *See* David J. Gross & Normandy Brangan, AARP Pub. Pol'y Inst., The Medicare Program (Apr. 1998), at http://research.aarp.org/health/fs45r_medicare.html.

10. *See* Theodore R. Marmor & Jerry L. Mashaw, Commentary, *Prescription Drug Bill Makes Only Politicians Feel Better*, L.A. TIMES, June 17, 2003, at B15.

battle weapon for 2004.¹¹ Opposing the other's reform, without offering a feasible alternative, appeared electorally dangerous. Both parties consequently were prepared to sacrifice crucial features of their traditional policy aspirations. Democrats, who otherwise might have insisted on a generous drug benefit for all beneficiaries, agreed to a plan that largely failed to satisfy this goal. For Republicans, passing any drug benefit represented a strategic compromise; they ultimately agreed to expand an entitlement program that they had long criticized.¹²

The decisions of the two parties to promote legislative change altered the calculations of pharmaceutical industry strategists. The industry for years had opposed adding drug coverage to Medicare. However, once the enactment of a drug benefit seemed likely, as it did in 2003, the industry threw its support behind the Republican version—recognizing that this would be preferable to a drug benefit that might be passed in the future by a potentially Democratic-controlled Congress.¹³

The resulting legislation purports to expand Medicare by offering a drug benefit, yet it includes an array of provisions that clearly constrain and even obstruct the Medicare program. The first portion of the MMA provides a much-needed, if modest and complex, drug benefit that will allow Medicare beneficiaries to buy government-guaranteed—although, in most cases, privately provided—drug plans.¹⁴ While this new benefit is generous for some low-income seniors, it appears likely to raise out-of-

11. See Robert Pear, *Tentative Medicare Pact Offers Drug Benefit to Elderly*, N.Y. TIMES, Nov. 13, 2003, at A28.

12. Proponents of charging the affluent elderly more seem to have forgotten the politics of catastrophic coverage reform in 1987-1988. Then, as now, reformers argued that it was commonsensical to charge the affluent elderly more. Then, unlike now, there was much to be said for the real improvement in Medicare that catastrophic coverage would have brought for all Medicare beneficiaries. But, within a year of passage, Congress "took the extraordinary step of repealing the law." Goldstein, *supra* note 3. Such "[e]fforts to charge comparatively wealthy Medicare [beneficiaries] more for their care have a long, divisive history." *Id.*

13. See Ctr. for Am. Progress, *Medicare Bill Greased by Corporate Dollars* (June 23, 2004), at <http://www.americanprogress.org/site/pp.asp?c=biJRJ8OVF&b=98500>.

14. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, § 101, 117 Stat. 2066, 2071. Although the comprehensive drug benefit does not take effect until 2006, a purchasable drug discount card and limited assistance for low-income seniors were to be offered in the interim. Pub. L. No. 108-173, § 101(a)(2), 117 Stat. at 2072 (initiation date of Jan. 1, 2006); *id.* at 2131-48 (discount card and transitional assistance programs); see also Andrea Stone, *Benefits Start in '06, but Help Available Sooner*, USA TODAY, Nov. 26, 2003 at A3.

pocket drug costs for some other poor beneficiaries, namely several million low-income seniors who will lose the generous coverage they now enjoy under state Medicaid programs.¹⁵ Further, because the initiative is poorly designed for controlling drug costs—it does not allow Medicare to use its massive buying power to demand price reductions¹⁶—the plan is likely to ultimately leave many seniors little better off than they are today.

The remainder of the MMA consists of provisions that have little or nothing to do with drug coverage, but seem consistent with the demands of interest groups and aligned with a basic ideological hostility toward Medicare. In addition to sparing drug companies their greatest fear (i.e., Medicare’s utilization of its monopsony power), the MMA contains other elements that risk further degeneration of Medicare’s all-in-the-same-boat structure. To begin, the legislation provides for substantial new subsidies for private insurers—thereby favoring those who use private health insurance plans.¹⁷ The bill also introduces a new standard for program “insolvency” that could force substantial shifts of expense from Medicare to seniors.¹⁸ Finally, and central to our discussion, the MMA uses what is essentially a ‘means-test’ to determine premiums for Part B premiums.¹⁹ This reform threatens the basic principle of social insurance that holds that having large pools, with common benefits and regulations, is crucial. It seems to represent a stealth effort to transform the fundamental structure of Medicare in the long-term.

The rhetorical appeal of means-testing is obvious and may explain why so many political pundits came to accept charging higher premiums to upper-income elderly as common sense: Why, many asked, should we have a flat premium when some of the elderly are so rich?²⁰ Why shouldn’t we

15. Ctr. for Medicare Advocacy, *Will the Medicare Act of 2003 Really Do That? Myths and Realities About the New Law* (Apr. 1, 2004), at http://www.medicareadvocacy.org/reform_Actof2003_WillItReallyDoThat.htm. In addition, despite the bill’s subsidies for employers who retain coverage, some employers will likely drop retiree drug coverage in response to the MMA; some seniors who presently have good coverage under such plans may thus be made worse off.

16. Pub. L. No. 108-173, § 101(a)(2), 117 Stat. at 2098 (2003).

17. *Id.* § 222, 117 Stat. at 2913.

18. In a provision that has received relatively little attention and was not in either the original House or Senate legislation, the bill creates a new standard for Medicare “insolvency.” It defines the program as insolvent whenever, in two consecutive years, general revenues finance more than forty-five percent of Medicare’s Part B costs. *Id.* §§ 801-04, 117 Stat. at 2357.

19. *Id.* § 811, 117 Stat. at 2364-65.

20. This idea appears to unite those New Democrats who rail against “corporate

link Medicare benefits to ability to pay? However, as we shall argue, the idea of means-testing Medicare is fiscally misleading, programmatically threatening, and—if extended as its advocates desire—philosophically at odds with the very principles that have made Medicare such a popular, relatively stable, and successful program.

THE IMMEDIATE FISCAL IMPACT

The fiscal fraudulence that lies behind the means-testing in the MMA is only apparent if one understands how Medicare is financed. Medicare Part B—or supplemental medical insurance—pays for physicians' fees and a variety of other outpatient expenses. As passed in 1965, Part B is a voluntary program that is, as noted, substantially subsidized by the government. Each Medicare beneficiary pays the same individual premium,²¹ with general taxes covering the remainder of the costs. The original idea was that premiums would finance half of Part B's outlays, and general taxes would pay for the other half. Over time, the ratio has shifted so that currently one-fourth is covered by premiums, and three-fourths are covered by general taxes.²² As a result, Part B is financed largely through the federal income tax, which is a progressive tax on all Americans, including the upper-income elderly. Similarly, Medicare's Part A—hospital insurance—is financed by a small proportional tax on taxable wage and salary income.²³

welfare," fiscal conservatives worried about future deficits, and a number of Republicans who are usually staunch defenders of the well-to-do. (The latter two groups do not spend equal time lamenting the Bush-era tax cuts, which are undoubtedly more consequential to the nation's fiscal future).

21. The Medicare Part B premium for 2004 was \$66.60 per month. *Medicare Buy-In Part II: Using Examples To Illustrate Key Eligibility Issues*, 3 BENEFITS PLANNER 82, 84 (2003), http://www.ilr.cornell.edu/edi/publications/BenefitsPlanners/BenefitsPlanner_Fall2003.pdf.

22. See Jill Berstein, *Should Higher Income Beneficiaries Pay More for Medicare?*, NAT'L ACAD. SOC. INS. MEDICARE BRIEF 3 (May 1999) ("When Medicare was first created, the Part B Premium was designed to cover about half the Part B program costs. As these costs increased faster than inflation, Congress chose to limit the increases charged to beneficiaries to the Social Security cost-of-living increases"), http://www.nasi.org/usr_doc/medicare_brief_2.pdf; see also Robert Pear, *Medicare Premium To Increase By 13.5 Percent Next Year*, N.Y. TIMES, Oct. 16, 2003, at A22 (noting that "The basic Medicare premium" is statutorily "set at the level needed to cover about 25 percent of the cost of Part B").

23. It is a 2.9% payroll tax split evenly between employer and employee. CRAIG CAPLAN & RYAN COOL, AARP PUB. POL'Y INST., THE STATUS OF MEDICARE PART A AND PART B TRUST

For this reason, by the time higher-income Americans reach the age of sixty-five, they have generally paid far more into the program than would have been required for private health insurance and far more than lower-income Americans. In other words, viewing the financing of Medicare over different time periods shifts the resulting portrait of its distributive features. By ignoring the realities of Medicare's financing over the course of the lifespan, advocates of "means-testing" present a misleading image of who contributes what to the program.²⁴ Evaluating social insurance programs properly requires not a financial snapshot at one point in time, but a view of who pays and who receives what over time. We will return to the question of why this fact is not adequately weighed in the public discourse on Medicare and other social insurance programs.

The means-testing idea is fiscally misleading in other respects as well. The revenues raised by such proposals would—from the standpoint of Medicare's overall fiscal viability—be trivial.²⁵ Because the premiums for Part B pay for only a quarter of program costs and because most Medicare beneficiaries have modest incomes,²⁶ targeting the richest of those who pay the premium makes little difference for Medicare's financial future. Many, like Henry Aaron of the Brookings Institution, who do not reject means-testing out of hand, still agree that "the number of well-to-do elderly is too small" to make a big difference in Medicare's fiscal future.²⁷

To be sure, the revenues raised by such income-scaled premiums would scarcely be trivial in absolute dollar terms. One to two percent of Medicare's outlays over ten years could easily amount to twenty billion dollars.²⁸ The relevant fiscal question, however, is not whether twenty

FUNDS: THE TRUSTEE'S 2004 ANNUAL REPORT 1 (2004), http://research.aarp.org/health/dd96_medicare.html.

24. See, e.g., Editorial, *Medicare Robbery*, WASH. POST, July 17, 2002, at A20.

25. Henry J. Aaron, Op-Ed, *The Grand Delusion*, CENTURY ISSUES, Oct. 15, 2003, <http://www.brook.edu/views/op-ed/aaron/20031015.htm>; see also Berstein, *supra* note 22, at 8 tbl.2, http://www.nasi.org/usr_doc/medicare_brief_2.pdf (describing two possible income-scaling plans and projecting that neither would raise revenues by more than two percent of expected Medicare outlays over a five-year period).

26. As of 1995, more than three out of four Medicare beneficiaries had annual incomes below \$25,000, and only three percent of Medicare spending went to recipients with incomes over \$50,000. The Commonwealth Fund, *Medicare Turns Thirty*, at http://www.cmwf.org/publications/publications_show.htm?doc_id=221620 (last visited Dec. 5, 2004) (excerpts from Senate Finance Committee testimony of Karen Davis, Commonwealth Fund President on February 28, 1995).

27. Aaron, *supra* note 25.

28. The late Senator Everett Dirksen is often reported to have said, "[A] billion here

billion dollars might improve Medicare's fiscal circumstances. It certainly could, if only modestly. Rather, the important evaluative question is whether the revenues raised are worth their price in terms of administrative hassle, bad social insurance precedent, and any consequent undermining of Medicare's political support. A glance at the expected effects of means-testing suggests that all except those ideologically opposed to social insurance would answer these questions in the negative.²⁹ Even Robert Reischauer, a defender of means-testing who argues that "making affluent beneficiaries pay more than those with fewer resources is eminently sensible," concedes that it is "not the long-term solution" to Medicare's solvency.³⁰

THE LONGER-TERM POLITICAL CONSEQUENCES

Certainly when one considers the long-term ideological and political ramifications of means-testing, the 2003 reform is unlikely to help sustain Medicare. When Medicare was created, it was deliberately designed to encompass both rich and poor, sick and well among its senior citizen beneficiaries. This universalistic impulse remains clear in the Part A hospital program, which is mandatory and financed by proportional contributions during one's working life.³¹

The use of proportional contributions³² or progressive contributions³³

and a billion there, and pretty soon you're talking real money." See The Dirksen Congressional Ctr., "A billion here, a billion there . . .", at http://www.dirksencenter.org/print_emd_billionhere.htm (last visited Nov. 23, 2004) (noting that Dirksen would have approved of the quotation's sentiment, although he never actually made the attributed statement).

29. One cannot rule out the possibility that some who would disagree here are simply uninformed about the principles of social insurance, rather than opposed to them. Teaching about social policy for more than thirty years suggests that this might well be the case for many college-educated persons under the age of fifty. Although for anyone educated in the social sciences between 1900 and 1960, there was a high probability that sociology, economics, and political science courses would comment on social insurance, its differences from private insurance, and the significance of social insurance in the American public household, coverage of these topics in the classroom has declined sharply since World War II. See THEODORE R. MARMOR ET AL., *AMERICA'S MISUNDERSTOOD WELFARE STATE: PERSISTENT MYTHS, CONTINUING REALITIES* (1992).

30. Robert D. Reischauer, Commentary, *This Isn't Such a Bitter Pill*, L.A. TIMES, Oct. 19, 2003, at M5.

31. JULIE LEE ET AL., *THE DISTRIBUTIONAL EFFECTS OF MEDICARE 3* (Nat'l Bureau of Econ. Research, Working Paper No. 6910, 1999), <http://www.nber.org/papers/w6910.pdf>.

32. Proportional contributions are also required for American social security pensions.

is workable for mandatory social insurance programs. By their very nature, such programs (unlike commercial insurers) do not take into account the specific characteristics of the individual or evidence about individual risks and circumstances.³⁴ For risks that all of us face—like disability, job accidents, unemployment, retirement, and medical expenses—social insurance provides income protection which reflects policy decisions, not the risk selection and underwriting that characterize private commercial insurance.

While particular distributive models vary, social insurance programs are generally premised on mandatory contributions. The important assumption underlying this is that the political stability and economic security of such programs depend upon the broad acceptance of the legitimacy of the programs themselves. In the history of the welfare state, social insurance emerged as an alternative to private and public charity—the hated poor house and the benevolent squire distributing alms at holiday time. A sense of entitlement to a benefit was widely presumed to flow from contributing to the common fund. Hence, what are otherwise compulsory taxes become, in the language of social insurance, “contributions.”³⁵

This set of considerations, however, does not apply to voluntary plans. The introduction of steep income-related premiums will likely prompt those with high incomes, good health, and catastrophic health insurance options to consider not paying the new, higher Part B premium. Faced with stiff new premium hikes, healthy and wealthy senior citizens would have good reason to opt out of Part B.³⁶ This, in turn, could very well

33. Progressive contributions are employed by Western European sickness funds.

34. In commercial insurance, premiums reflect the expected costs of individuals or groups. For example, residents of high-crime areas pay substantially higher theft insurance premiums than those in low-crime areas. In social insurance, the aim is to protect against the risk, but not to concentrate higher costs on those who happen to incur the risk more frequently.

35. See ROBERT BALL, *SOCIAL SECURITY: TODAY AND TOMORROW* (1978); THEODORE R. MARMOR ET AL., *supra* note 29, at 1-53.

36. In 1999, one source reported that ten percent of Medicare beneficiaries generate sixty-percent of the program's costs, while half of the program's beneficiaries “account for only 1.6% of the expenses.” Harold C. Sox, *Defined Contribution Programs and Their Effects on Medicare*, ACP-ASIM OBSERVER, Feb. 1999, <http://www.acponline.org/journals/news/feb99/defined.htm>. The exit motive would be particularly salient if congressional conservatives were to enact large new tax breaks for IRA-like medical savings accounts, which are favored by private insurers. The MMA already provides for a type of health savings account that allows “individuals or families to establish a tax fee fund for the entire

undermine the diversified risk pool and widespread popular support that has sustained Medicare since its inception.³⁷ This incentive structure potentially initiates a vicious cycle; a reduction in the overall health of the program's population produces higher premiums over time, which, in turn, could trigger further departures. American insurers would no doubt deliver high-deductible plans for the healthy and wealthy, plans that protect against devastating illness costs, but at relatively low monthly premiums. Therein lies the greatest threat both to Medicare's programmatic design and to its long-term political stability—a breaking up of the Medicare risk pool.³⁸

So what, the skeptic might ask, given that the premiums paid by two percent of the elderly are a trivial part of the financing of Part B? The answer, of course, is political:³⁹ Over time, this dynamic could seriously compromise Medicare, especially if those who leave the program lose

amount of their health insurance deductible over \$1,000 (or \$2,000 for families)" up to the lesser of \$2250 individually or \$4500 per family. Melissa Ganz, iBrief, *The Medicare Prescription Drug, Improvement, and Modernization Act of 2003: Are We Playing the Lottery with Healthcare Reform?*, 2004 DUKE L. & TECH. REV. 11, ¶ 19 & nn.58-60, at <http://www.law.duke.edu/journals/dltr/articles/2004dltr0011.html>; see Pub. L. No. 108-173, § 1201, 117 Stat. at 2469-79 (2003) (establishing and describing health savings accounts).

37. Medicare's Part A, the hospital insurance program, clearly reflects social insurance principles. Payments are compulsory for wage earners during their working life, and there is no connection between the proportional taxation and what is covered or what is paid during retirement. All providers are paid according to the same rules, and there are no wedges between beneficiaries in connection with current income. This inclusiveness greatly increases the attention to Medicare in congressional tussles about its future. AARP, for example, closely monitors the program's politics, figuring rightly that its millions of members care a lot. This would be less true for a divided Part B program.

38. Even experienced Democratic social policy strategists who arguably should have recognized this risk, including former Social Security Commissioner Robert Ball and budget specialist Robert Greenstein, saw no fundamental problem in, for example, tripling the premiums wealthy beneficiaries would pay from about \$700 per year to over \$2100 per year. Robert Pear, *Medicare Plan Raises the Cost for the Affluent*, N.Y. TIMES, Oct. 6, 2003, at A1.

39. Anyone who has observed the fate of Medicaid in the decades since its enactment (with Medicare) in 1965 will know the differences in experience. Medicaid has had a boom and bust cycle and is poorly protected when state revenues are threatened by economic downturns. In part, this precarious situation is the consequence of state constitutional prohibitions against deficit financing. But another part of the explanation is that Medicare's supporters are more numerous, more powerful, and more obvious. Why, we ask, should supporters tinker with the program in a way that threatens the source of its political stability? While there has not been paralysis in Medicare policymaking, reformers have faced organized, committed backers when promoting change.

interest in supporting the program electorally or even choose to advocate for the increased support of private insurance alternatives.⁴⁰ Moreover, an income-related premium would require the creation of new administrative machinery for distinguishing among beneficiaries on the basis of current income in order to charge differential premiums. Doing so would use of some of the modest savings that the higher premiums themselves promise. More importantly, once this program feature is created, it would provide the ideological basis and administrative means for further distinctions in the future. Once the richest two percent were charged a premium surcharge, for example, the advocates of means-testing could, and almost certainly would, call for lowering the income level at which the surcharge applies—making more and more seniors the targets of private options.⁴¹

For proponents of social insurance, important principles are at stake in the means-testing provision of the recently passed legislation. Because of fundamental concerns about maintaining a broad risk pool, social insurance scholars have long rejected means-testing when it refers to limits on eligibility based on wealth or income. Although the current legislation does not go so far as to place wealth or income limits on eligibility, it shares important philosophical roots with the critics of social insurance. The new program of income-conditioned premiums, at least rhetorically, sets the stage for more substantial means-testing in the future. No matter how well cloaked they are in the language of egalitarianism, populist hostility to the rich, or the rhetoric of necessary reforms, these are serious threats to the future of social insurance.

CONCLUSION: THE PRESCRIPTION DRUG BILL

That the reforms of 2003 were the result of political bargaining is not surprising. Politics frequently requires, and results in, compromises. What is startling about the 2003 legislation is just how deeply the compromises—

40. On CNN's *Inside Politics* program, William Schneider suggested a likely reason for Republican interest in changing Medicare's financing: "Democrats suspect that by imposing a means test, Republicans are not trying to save Medicare. They're trying to destroy it. How? By turning Medicare into welfare . . ." *Judy Woodruff's Inside Politics: Is it Payback Time for Iraq? Interview with John Edwards* (CNN television broadcast, Oct. 16, 2003), <http://transcripts.cnn.com/TRANSCRIPTS/0310/16/ip.00.html>.

41. It is naïve to believe, however, that such plans, if enacted, would remain limited to only the very high income elderly. The typical policy pattern is not to index the threshold income levels to inflation. As a result, more and more elderly will likely be affected by this change in policy over time. And therein lies a central political issue for the future of Medicare.

or more accurately, the concessions to ideology and private interests—undercut the stated goals of the law, namely drug coverage for seniors.

The MMA, as written, will yield a drug benefit program rife with inefficiencies that will likely benefit private interests at the public's expense.⁴² This is a consequence, in part, of the MMA's subsidies for health savings accounts⁴³ and private health plans,⁴⁴ which have markedly higher overhead costs than the public Medicare program.⁴⁵ Ultimately, the MMA's drug benefit is convoluted and rather meager—covering only a limited share of seniors' expected overall drug spending.⁴⁶ Credible estimates

42. A more sensibly designed bill could yield far greater coverage—perhaps twice as much—with the expected increases in Congressional and personal Medicare spending over the next decade. In 2004, the *Washington Post* projected that the total ten-year cost of the drug benefit would be \$564 billion. Ceci Connolly, *Premiums To Rise by 17.5%; Percentage Increase Biggest in 15 Years*, WASH. POST, Sept. 4, 2004, at A1. An oft-cited Congressional Budget Office projection estimated that the prescription drug benefit would result in \$400 billion in new spending over ten years. See, e.g., Robert Pear, *Deal 'In Principle' for Medicare Plan To Cover Drug Costs*, N.Y. TIMES, Nov. 15, 2003, at 1. The 17.5% increase in monthly premiums for Medicare beneficiaries in 2005 is the “largest premium increase in 15 years.” Connolly, *supra*.

43. “A health savings account is a tax-sheltered savings account similar to the IRA, but earmarked for medical expenses.” MSA (&HAS) Info.net, Info on Health Savings Accounts, at <http://www.msainfo.net/> (last visited Nov. 22, 2004).

44. See *supra* note 17 and accompanying text.

45. Critics allege that the overhead costs of private plans are at least five times those of public insurance. David Himmelstein of the Harvard Medical School asserts, “Medicare is actually much more efficient than the HMOs—it has 2 percent overhead, whereas they have 15 percent overhead.” Press Release, Common Dreams, Assessing Bush's Pharmaceutical Cards (July 12, 2001), <http://www.commondreams.org/news2001/0712-04.htm>. Elise Gould of the Economic Policy Institute similarly reports that the overhead costs of traditional Medicare, at less than four percent, are “super-low.” Elise Gould, *Bush Strikes Out on Health Care, Making Sense*, Dollars & Sense (May 2004), reprinted in Viewpoints, Economic Policy Institute, at http://www.epinet.org/content.cfm/webfeatures_viewpoints_healthcare_reform. She asks, “[I]f private insurance companies are so efficient, why do they need higher reimbursement fees?” *Id.* According to the federal Medical Payment Advisory Commission, Medicare payments to private plans total “an average of 107 percent of what it would cost to cover their patients under the traditional fee-for-service program.” Robert Pear, *Private Plans Costing More for Medicare*, N.Y. TIMES, Sept. 17, 2004, at A16.

46. It promises to reimburse the 251st dollar of drug spending, but not the 2251st dollar: For 2006, standard coverage under Part D of the MMA provides for a \$250 deductible, seventy-five percent coverage of allowable costs between \$251 and \$2250, zero percent coverage of costs between \$2251 and \$5100 (referred to as the “doughnut hole”), and ninety-five percent coverage above \$5100 in allowable costs. For allowable costs above \$5100, members are actually expected to pay the greater of either five percent of costs or

suggest that, except for the very poor and very sick, drug spending will consume a larger share of seniors' incomes in the coming years than it does now, despite the new legislation.⁴⁷ This is not just because of the gaps in coverage, but also because the bill fails to authorize the very negotiation strategies that large corporations and public programs like the veterans' health plan use to moderate skyrocketing drug prices:⁴⁸ Under the MMA, Medicare is expressly forbidden from using its bargaining power to negotiate for lower pharmaceutical prices.⁴⁹

These limitations help to explain why, according to polls, seniors are so critical of the reform. A University of Pennsylvania survey in December 2003, for example, showed opposition to the bill outweighing support by two percentage points among the general public, while opposition outweighed support by sixteen points among Americans over sixty-five.⁵⁰

co-payments of \$2 for generics and \$5 for brand name drugs. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, §101(a)(2), 117 Stat. 2066, 2076-77. For references to the "doughnut hole," see, for example, Patricia Barry, *The New Medicare—And You*, AARP BULL., Jan. 2004, <http://www.aarp.org/bulletin/medicare/Articles/a2003-12-24-newmedicare.html> (last visited Dec. 4, 2004); Patricia M. Danzon, *Closing the Doughnut Hole: No Easy Answers*, HEALTH AFF. W4-405 (Web Exclusive, July 21, 2004), at <http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.405v1>.

47. See, e.g., GAIL SHEARER, SKIMPY BENEFITS AND UNCHECKED EXPENDITURES: MEDICARE PRESCRIPTION DRUG BILLS FAIL TO OFFER ADEQUATE PROTECTION FOR SENIORS AND PEOPLE WITH DISABILITIES, Consumer's Union (June 2003), <http://www.consumersunion.org/pdf/medicare-603.PDF>.

48. See Robert B. Reich, *Buying Drugs in Bulk: It's Time To Negotiate*, AM. PROSPECT ONLINE, June 16, 2004, reprinted at Global Action on Aging, at <http://www.globalaging.org/health/us/2004/bulk.htm>.

49. Ironically enough, the *New York Times* reported in July 2004 that Medicare officials were announcing a plan to reduce the payments the program would be making in the future for drugs—especially cancer-related ones—administered in physicians' offices. Gardiner Harris, *Proposal Would Cut What Medicare Pays for Cancer Drugs*, N.Y. TIMES, July 27, 2004, at C1. This program, itself a part of Medicare known primarily by experts, patients, and their families, was part of the original 1965 legislation and has been gradually expanded to cover more and more drugs. See Thomas R. Oliver et al., *A Political History of Medicare and Prescription Drug Coverage*, 82 MILBANK Q. 283 (2004).

50. See Press Release, Annenberg Public Pol'y Ctr. of the Univ. of Pa., National Annenberg Election Survey, Public Split on Medicare Bill but Elderly Are Opposed, Annenberg Survey Shows (Nov. 24, 2003), http://www.annenbergpublicpolicycenter.org/03_political_communication/archive/naes/2003_03_support-medicare_pr.pdf; cf. Press Release, Annenberg Public Policy Ctr. of the Univ. of Pa., National Annenberg Election Survey, Public Initially Supports Medicare Law but Quickly Shows Its Doubts (Dec. 27, 2003), http://www.annenbergpublicpolicycenter.org/naes/2003_03_support-for-new

Ironically, Republicans who hoped to take Medicare off the political agenda, as it was an issue with which they had been battered for years, are similarly likely to see their hopes for the legislation frustrated. By pushing through such an unwieldy piece of legislation, they virtually ensured that Medicare will remain a contentious issue in American politics in the coming decade.

Some Democrats are hopeful that the bill will, in the long term, prove to be a stepping stone to a good drug benefit and more sensible Medicare reforms.⁵¹ Making the benefit more rational and generous, especially for low-income seniors and those with high, but not catastrophic, drug costs, is essential. The MMA, however, is unlikely to be a strong foundation for refinement and improvement down the line. The near-term issue will not be the expansion of benefits, but figuring out how to make the enormously complex legislation work. Furthermore, efforts to upgrade the benefit will run headlong into the massive budget deficit, and the fact that the profligate legislation has no effective cost-control mechanisms. The legislation's one concession to cost control—its resetting of the standard for program insolvency—will, in any case, create conflict highly unfavorable to those seeking to expand and rationalize benefits.⁵² Finally, the MMA's means-testing for Part B premiums may itself constitute a substantial barrier to future improvements, refinements, or expansions of Medicare. Practically speaking, by creating Medicare Part B premiums that will vary with income, Congress has established a system that will surely be cumbersome to administer. More broadly, as we have argued, the introduction of means-testing may provide a convenient cover for parties trying to produce an objectionable ideological transformation in the Medicare program.

Those committed to the central role of social insurance in modern America should understand the challenge to social insurance principles implicit in this debate. Advocates of means-testing on the right found a political wedge issue that split Medicare supporters on the left. But individuals, regardless of political orientation, who are genuinely concerned about America's low-income citizens should recognize that making well-to-do Medicare beneficiaries pay much more for Part B

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51. Conversation with John Rother, Chief Legislative Official, AARP, at Case Western Univ. (Oct. 4, 2004).

52. *See supra* note 18 and accompanying text. The requirement of presidential response to such insolvency is more likely to cause benefit cuts and premium hikes rather than benefit expansions.

coverage is not a sensible expression of decent social priorities. In light of both the historical structure of the Medicare program and its current fiscal circumstances, this seemingly innocent step forward represents a fundamental step backward.

