

Medicare Reform: Fact, Fiction and Foolishness

Jacob S. Hacker and Theodore R. Marmor

Public Policy and Aging Report

(Washington, DC: National Academy on an Aging Society)

The enactment in December 2003 of the biggest overhaul of Medicare since its inception almost 40 years ago shows decisively that the politics of Medicare has entered a new phase. Medicare has always been the object of intense political interest. Yet, increasingly, this interest has had little to do with legitimate concerns about budget deficits and Medicare's real (if usually overstated) faults. Instead, it is now fueled principally by the alarmist rhetoric of conservative critics of Medicare who wish to mask their underlying hostility to the program with a veneer of public-minded concern.

The rhetoric of crisis first became starkly evident in the early 1980s. Yet it did not reach a fever pitch until the mid-1990s, when Republican proposals to provide vouchers for enrollment in private health plans emerged. Since then, the language of crisis has pervaded every debate over Medicare, including the current discussion of whether and how to provide prescription drug coverage. Unfortunately, crisis rhetoric has clouded rather than illuminated what is fundamentally at issue in these disputes.

In this brief essay, we want to discuss one such confused aspect of the recent debate that we think is emblematic of the changed politics and discussion of the program: the debate over "means-testing" within Medicare—or, more accurately, over the imposing of sharply higher premiums on wealthy beneficiaries. The means-testing dispute was actually only a minor part of the struggle over the shape of the prescription drug benefit that President George W. Bush signed into law in early December. Yet, in the way in which it was discussed (and not discussed), it was symbolic of the larger muddle that surrounds the issues of whether and how Medicare ought to be restructured.

Let us begin with the term itself. "Means-testing" is usually understood to denote setting eligibility on the basis of financial need, not scaling health insurance premiums to income—the idea incorporated into the final bill. Yet for advocates of income-related premiums, speaking of "means-testing" is a politically canny semantic move, implicitly connecting the "undeserving poor" of traditional welfare conceptions with the supposedly undeserving rich on Medicare. This connection may well be why so many within the Washington political community view charging higher premiums to upper-income elderly as simply common sense. Why, many ask, should we have a flat premium when some of the elderly are so rich?

Here is why: The idea of means-testing is fiscally misleading, programmatically threatening, and—if taken to its natural extreme, as advocates desire—philosophically at odds with the ideals that have made Medicare such a popular and successful program.

The Fiscal Case

To understand the fiscal fraudulence that lies behind means-testing requires first comprehending how Medicare is actually financed. What is called Part B—or "supplemental medical insurance"—covers physicians' fees and other outpatient costs.

Each Medicare beneficiary pays the same individual premium, with general taxes covering the remainder of Part B costs. Premiums, unfortunately, receive most of the Part B discussion, even though the major source of financing—75 percent—comes from general revenues. And those general revenues are of course raised largely through the income tax. In short, most of Part B's costs are financed by a progressive tax on the income of all Americans, including the upper-income elderly.

Furthermore, soak-the-rich rhetoric distorts the picture of Medicare's overall financing, not just Part B's. Medicare's hospital insurance—Part A—is financed by a small proportional tax on *all* taxable wage and salary income (not the first \$90,000 or so of such income, as is the case with Social Security). For this reason, by the time higher-income Americans reach 65, they have paid far more into the program than lower-income Americans. By ignoring the realities of Medicare's financing over the course of the lifespan, Medicare critics present a false image of who pays what for the program. Evaluating social insurance programs requires not a financial snapshot at one point in time, but a view of who pays and who receives over the typical life-course.

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. They amount to no more than 1 to 2 percent of program costs. It is a simple mathematical fact that because the Part B premium pays for only a quarter of program costs and because most Medicare beneficiaries have low incomes, targeting the richest of those who pay the premium simply makes little difference for Medicare's financial future. Even those who, like Henry Aaron, do not reject “means-testing” out of hand, agree that “the number of well-to-do elderly is too small” to make a big difference in Medicare's fiscal future.¹

The Pragmatic Case

The revenues raised by such income-scaled premiums are, to be sure, scarcely trivial in absolute dollar terms. One to two percent of Medicare's costs over ten years easily reaches \$20 billion. As Everett Dirksen famously said in the 1950s, “a billion here and a billion there, and suddenly it is real money.” The relevant fiscal question for Medicare, then, is not whether \$20 billion might improve the program's finance—it certainly could, if only modestly. It is whether the revenues are worth the price to be paid in terms of administrative hassle, bad precedent, and undermining of Medicare's political support. Even a glance at the possible effects of means-testing demonstrate that the answer is transparently and resoundingly no.

When Medicare was created, it was deliberately designed to encompass rich and poor and sick and well. That is clear in the Part A hospital program, which is mandatory and funded by contributions during the working life. Part B was unexpectedly included

¹ Aaron's remarks come from a issue brief he wrote on The Century Foundation's website the week of October 15, 2003. It is only fair to note that Robert Reischauer, with whom we are publicly disputing the merits of “means testing,” concedes the point about the insignificance of income related premiums for Medicare financial problems: “But the fact is, if you strip out the hyperbole and demagoguery, making affluent beneficiaries pay more than those with fewer resources is eminently sensible. It is not the long-term solution — it will provide only a drop in the bucket toward Medicare's long-run solvency — but it will help.” The Reischauer position, published along with ours, included more hyperbolic language than our op ed. The suggestion that other views were for example, “demagogic” may well reflect editing rather than authorship. Los Angeles Times, October 19, 2003.

with Republican backing, and it introduced premiums—rather than payroll contributions—as a source of financing. Part B was also left voluntary, though with substantial subsidies. And that makes a difference, because income-related contributions in a compulsory social insurance program are perfectly acceptable; they are simply proportional or progressive payments from which one cannot exit. They may not be wise, but they do not violate pooling principles.

It is wrong to believe, however, that this is true of voluntary plans. Faced with stiff new premium hikes, healthy and wealthy senior citizens would suddenly have a reason to opt out of Part B, especially if conservatives and private insurers get their way and enact large new tax breaks for IRA-like medical savings accounts. And therein lies the greatest threat both to Medicare's programmatic design and to its long-term political stability: a breakup of the Medicare risk pool.

The first threat to the unified constituency would come from the healthy elderly. Part B is, after all, voluntary, though subsidized, and the medical expenses of individual Medicare beneficiaries varies more than twenty-fold. Relatively health and wealthy senior citizens faced with stiff new premium hikes would therefore have reason to consider opting out of Medicare, which could leave the program with a less healthy population, raising its costs and promoting further departures. Over time, this dynamic could seriously compromise Medicare's broad risk pool, especially if those who leave the program lose interest in supporting the program politically or even advocate the support of private insurance alternatives.

Moreover, it is a little-mentioned fact that 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 that would not only eat up some of the modest savings that the higher premiums promise, but, more important, create the basis for further distinctions in the future.

Once the richest paid a premium surcharge, for example, conservatives could—and almost certainly would—call for lowering the income level at which the surcharge applies, pushing more and more seniors into the ranks of those hit with higher charges.

The Philosophical Case

For those who believe in social insurance, in short, high principles are at stake in the means-testing provision of the recently passed legislation. Traditionally, social insurance advocates have rejected means-testing when it refers to limits on enrollment based on wealth or income. Although the current legislation does not go this far, it shares important philosophical roots. And as we have argued, they could very well open the door to 'real' means-testing down the line.

At a time of much debate about Medicare but little clarity about the program's goals and logic, we need a renewed understanding of how social insurance differs from commercial insurance. In commercial insurance, premiums are supposed to reflect the likely costs of individuals or groups. In social insurance, broad pooling of risk is ensured through contributions that do not vary by risk and by the principle of universality (backed up by mandatory contributions, something private insurance obviously cannot require). Threats to that broad risk pool are threats to social insurance—no matter how well cloaked they are in the language of egalitarianism, or the rhetoric of necessary reforms.

Conclusion: The Prescription Drug Bill

Not since Medicare was enacted in 1965 has Medicare been such prominent front-page news and the source of such confusion. The dispute about “means-testing—its misleading premises, its semantic sleights-of-hand, and the clear misunderstandings about Medicare’s current realities and historical foundations that it reflects—illustrates well the muddle and Orwellian contradictions of the current debate over Medicare. In these concluding words, we want to comment on that larger debate itself.

In 1965, Medicare’s enactment was certain because the Democratic Party had routed the Republicans the year before and the Congress was overwhelmingly Democratic. In 2003, the serious push to legislate a drug benefit for Medicare arose because of the *absence* of large partisan majorities in either the Senate or the House. For years prior, each 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 the Congress and the Administration decided that continued stalemate might well provide the other side with an electoral battle weapon for 2004. Both consequently were prepared to sacrifice crucial features of their traditional policy aspirations. For Democrats, that meant giving up on a generous drug benefit. For Republicans, it meant strategic compromise, agreeing on expanding an entitlement program they have long criticized and no longer insisting that a Medicare drug benefit be strictly restricted only to those willing to join private plans.

The result was a piece of legislation with two warring sides. The first is 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. But while this new benefit is generous for some low-income seniors, it would end up raising out-of-pocket drug costs for other poor beneficiaries. And because it is poorly designed and does not include effective ways of controlling drug costs, the plan would ultimately leave most seniors little better off than they are today, and some worse off.

The second, darker side of the new Medicare bill is a slew of provisions that have little or nothing to do with drug coverage and everything to do with special-interest demands and ideological animus toward Medicare. These include huge new subsidies for private insurers, and provisions that ensure that drug companies will be spared from their greatest fear: that Medicare will use its massive buying power to demand reductions in prices. Perhaps most ominous, the bill also contains elements that risk further degeneration of Medicare’s all-in-the-same-boat structure, including efforts to shift the balance sharply in favor of private plans, six sizable “demonstration projects” introducing greater competition into Medicare that will likely raise costs for seniors who remain in the traditional program, and a new standard for program “insolvency” that could force big cost-shifts from Medicare to seniors.

To be sure, politics usually requires compromises. But what is shameful about the present bill is just how deeply the compromises—or more accurately, the concessions to knee-jerk beliefs and private interests—undercut the stated goal of the bill: drug coverage for seniors. By our back-of-the-envelope calculations, the roughly \$400 billion in new spending over the next ten years (not to mention the \$140 billion in new premiums paid by Medicare beneficiaries themselves) will buy only about half as much coverage as a sensibly designed bill could. This is not only because of the subsidies for private health plans and for Health Savings Accounts in the bill, but also because of the

five-to-six-times higher overhead costs of private plans and the 20-to-30-percent higher prices for drugs that seniors will have to pay because Medicare is forbidden from using its bargaining power to negotiate for lower pharmaceutical prices.

All this helps explain why the drug benefit itself is so convoluted and ultimately so meager—covering, for example, only a small share of seniors’ expected drug spending overall, and reimbursing the 300th dollar of drug spending but not the 3,000th. It also helps explain why, according to polls, seniors already don’t like the benefit much. A recent University of Pennsylvania survey, for example shows opposition to the bill outweighing support among the public by 2 percentage points, but by a whopping 16 points among Americans over 65.

Indeed, a significant share of Medicare beneficiaries will almost certainly be worse, not better off, under the bill. This includes about several million low-income seniors who will lose the generous coverage they now enjoy under state Medicaid programs. It also includes millions who now have pretty good drug protection but whose employers will likely drop retiree coverage in response to the bill (despite subsidies for employers that retain coverage).

Even if these clear losses are ignored, all credible estimates suggests 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. This is not just because the benefit is so meager, 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.

So are some hopeful Democrats right that the bill will, in the long term, prove to be a stepping stone to a good drug benefit and sensible Medicare reforms? Making the benefit more rational and generous, especially for low-income seniors and those with high but not catastrophic drug costs, is essential. But for three important reasons, the new bill is unlikely to be a good foundation for refinement and improvement down the line.

The first is the dismal historical record of Medicare’s attempts to encourage private plans within the program. If the past is any guide, the near-term issue will not be the expansion of benefits but figuring out how to make the amazingly complex legislation actually work. And there will be considerable pressure from conservatives to delay any major changes until the demonstration projects designed to showcase the benefits of market competition occur—in 2010.

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.

And, finally, the legislation’s one bow to cost control is guaranteed to create conflict on terrain highly unfavorable to those seeking to expand and rationalize benefits. In a relatively unnoticed provision that was not in either the original House or Senate legislation, the bill creates a new standard for Medicare “insolvency.” It would define the program as insolvent whenever, in two consecutive years, more than 45 percent of its spending was financed by income tax revenues—which, not incidentally, are the most progressive source of Medicare financing. When this ceiling was hit, probably sometime in the next decade, the President would be compelled to propose spending cuts and tax increases within the program. That is likely to cause benefit cuts and premium hikes, not benefit expansions.

It is also certain to cause political conflict—which may be the ultimate contradiction of the bill. Republicans hope to take off the table an issue with which they had been battered for years, and they may well do so through 2006. But by pushing through such an unwieldy bill, they are virtually ensuring that Medicare will be the biggest issue in American politics in the coming decades. Sadly, at the present juncture, that seems to promise more acrimony, confusion, and disappointment, rather than the constructive steps forward that Medicare so desperately needs.

Jacob S. Hacker, PhD, is Peter Strauss Family Assistant Professor, Department of Political Science, Yale University.

Theodore R. Marmor, PhD, is Professor of Public Policy and Management and Professor of Political Science, Yale University.

Endnotes:

1. The figures from the end of the 1990s that demonstrate how unrealistic it is to think that there is much financial leverage in going after the affluent aged in Medicare are: More than three out of four Medicare beneficiaries then had annual incomes below \$25,000 and only 3% of Medicare spending went to recipients with incomes over \$50,000. Only 8 percent of the elderly now are in households with annual incomes over \$50,000. Moreover, the average senior citizen is already paying a lot for medical care. Despite Medicare's income protection against the costs of hospital and physician care, that average senior is spending roughly 20% of household income on medical care, up from 15% at the end of the 1980s. And, as beneficiaries age, their medical costs rise while their income on average falls. This background information suggests that modifying the upper-two percent of Medicare's beneficiaries is financially beside the point. That makes all the more puzzling the comment by Henry Aaron of the Brookings Institution that "requiring the well-to-do elderly to pay more than they do for Medicare coverage is surely worth considering." Why one might ask, given these facts?

2. Aaron's remarks come from an issue brief he wrote on The Century Foundation's website in the week of October 15, 2003. It is only fair to note that Robert Reischauer, with whom we are publicly disputing the merits of "means testing," concedes the point, too.