TRYING to understand the economics of Medicare is a difficult business, but nearly everyone agrees that things do not look good. In March 2004, the Medicare Board of Trustees issued its annual report on the financial health of Medicare Part A, which funds primarily hospital expenses, and Medicare Part B, which funds outpatient care. The prognosis was grim: The Hospital Insurance (HI) "trust fund is projected to be exhausted in 2019—7 years earlier than estimated in last year's report.... The long-range projections for HI continue to show a very substantial imbalance.... The Part B premium and corresponding general revenue transfers will need to be increased sharply for 2005 to match projected costs." To fix this "imbalance," the report concluded, "would require very substantial increases in revenues and/or reductions in benefits."

The Medicare Modernization Act (MMA), signed into law in December 2003, has no doubt made this financial
crisis even worse. The new law provides partial prescription drug coverage for all desiring seniors—with an estimated cost between $395 billion and $534 billion over the next decade, before most of the drug-hungry baby boomers even retire. Many analysts believe these estimates are already far too low, and that policy makers have conveniently avoided discussing the benefit’s costs in the second decade and beyond. The bill also includes a combination of other reforms: higher premiums for wealthy seniors who participate in Part B; rule changes that allow more private health plans to offer Medicare coverage; subsidies for employers that continue drug coverage for retirees; medical savings accounts for people of all ages; and a six-city “demonstration project” of voucher-style competition starting in 2010, which many analysts believe will be killed before it begins.

None of these additional reforms changes the fundamental character of Medicare as a government-funded and government-run entitlement program, though the ideas behind them may be significant in shaping efforts at large-scale reform in the future. And all of these additional measures are overshadowed by the new drug benefit that begins in 2006—the largest expansion of Medicare since the program was created in 1965. Specifically, the new benefit will cover 75 percent of drug costs between $250 and $2,250, provide no coverage between $2,250 and $5,100 (the so-called “hole in the doughnut”), and cover 95 percent of drug costs of $5,100 and over. Participation in the program is voluntary; the benefit will be administered by publicly approved private companies; and the premiums are estimated to cost $35 per month, with different private-sector plans competing to offer the best drug prices, and each plan required to offer drugs in every therapeutic category.

Not surprisingly, the debate over MMA was politically bitter and complex in legislative terms. It was pushed hard by the Bush administration, the Republican establishment, and some moderate Democrats—who saw it as the best way to give seniors the drug benefit they desire (a political plus), without breaking the bank or engineering a government takeover of the drug industry. The law was bitterly opposed by
the majority of Democrats, who believe the drug benefits are too small and the “pay-off” to pharmaceutical companies too big; and it was attacked by many conservatives, who believe it will expand the grip of the welfare state and eventually lead to price controls, tax hikes, and a slowed economy.

MMA is a significant achievement, and in many ways an improvement. It corrects a genuine gap in Medicare, a program that was created before prescription drugs were a central part of modern medicine. And it significantly helps those seniors who are currently ineligible for Medicaid but still too poor to buy prescription drugs without economic hardship.

But one can also understand why so many people—Left, Right, and center—see the bill as irresponsible or inadequate, and why no one really believes it is what Medicare needs over the long-term. “We are building a new expansion onto a house that’s teetering on a cliff,” says Republican Senator Don Nickles. “It cynically uses the elderly’s need for prescription drugs as a Trojan horse to reshape Medicare,” says Democratic Senator Ted Kennedy. “Medicare has become pork barrel. It plays to retirees’ desires and raises their discretionary income. The question of generational justice is nearly absent,” says centrist columnist Robert J. Samuelson. The new law expands an entitlement that is already the fastest growing part of the federal budget. It leaves middle-class citizens with significant drug bills to pay, and thus invites future demands to “sweeten the benefits.” And it punts the hardest social questions down the road—not only about the economics of Medicare, but about the intersection of modern medicine, an aging society, and the character of American society as a whole. These deeper questions are what lie at the core of the Medicare “crisis.”

How Medicare works

To understand the implications of the new Medicare bill and the political disagreements surrounding it, one needs to understand how Medicare works as a whole. This is no easy task, but a few salient points are worth noting.

First, Medicare is primarily a federally funded, third-party payer, fee-for-service program. In other words, when
seniors get sick, they go to the doctor and the government pays most of the bill. Beneficiaries pay some premiums: an $876 deductible for major hospital visits under Part A; $66.60 per month, a $100 annual deductible, and 20 percent co-payments for most outpatient treatment under Part B. But the value of the government subsidies rises the more care one uses. Seniors who participate in traditional Medicare (roughly 88 percent) have the freedom to see any doctor who will see them. This is generally wonderful for beneficiaries: They have access to all the care they desire. But it is problematic for society as a whole, since there are limited incentives for seniors to cut their own health-care costs, and there is limited room within the heavily regulated system for private insurers to improve efficiency by creating health-care networks or tailoring services to individual needs. This economic problem will only get worse, many believe, as expensive new medical technologies become available, as the percentage of the national population on Medicare increases, and as the average age of Medicare beneficiaries rises and their health deteriorates.

Second, Medicare is a major part of the “hidden subsidy” and “price control” system that now shapes American health care. The government sets the prices by fiat for all the medical services covered under Medicare—with different physician groups lobbying constantly for increases to the reimbursement rate for their own specialties, and the government trying constantly to keep up with ongoing changes in the nature of medical care. This system allows government to exert some control over Medicare costs—though reimbursement cuts in the past have often resulted in reduced access to care, reduced quality of care, or increased billing for a larger volume of services. And of course, government doesn’t get the prices right. This means the system only works because those services that are over-reimbursed subsidize those services that are under-reimbursed—for example, over-payment for cancer drugs subsidizes under-payment for cancer treatment. This system of cross-subsidizing exists both within Medicare and between Medicare and private-sector health insurance.
Third, Medicare’s system of government-controlled pricing also shapes how patients are treated, and not always for the better. In some cases, people seek not the best or cheapest treatments for a given condition but those treatments that are covered by Medicare. In other cases, avoiding inexpensive but uncovered therapies leads to expensive but covered emergencies in the future. As Joseph Antos, an analyst for the American Enterprise Institute (AEI), explains about cancer therapy: “There is widespread agreement that Medicare overpaid for Part B drugs, although oncologists argued that those overpayments helped compensate for the extra costs of administering the drugs and caring for patients that were not reflected in fees paid by Medicare for office visits.” The problem is that when the federal government reduced payments for cancer drugs, as it did in MMA, there was “a shift of patients out of the doctor’s office and back to the inpatient hospital care, which reduces patient satisfaction and could increase federal outlays.”

Finally, the current Medicare system does not pay for long-term care. If someone suffers a stroke, for example, Medicare covers the expenses incurred in its immediate aftermath—hospital care, 21 days of skilled nursing care with no deductible, and 79 additional days of skilled nursing care for a subsidized rate of $109.50 per day. However, once the patient no longer requires skilled medical treatment but still requires constant personal care, Medicare pays nothing. This leaves individuals and families with a range of hard choices: family caretaking by a spouse or child; professional caretaking paid for out-of-pocket; or self-impoverishment until one qualifies for Medicaid, which does pay for long-term care, either by spending down one’s assets or moving them in advance to one’s children or siblings. The result is that a significant number of seniors who live to 65 end up on Medicaid—a welfare program—at some point before dying, including many who were self-sufficient throughout most of their lives. And looking forward, it suggests that the next Medicare entitlement debate will be about whether to add a long-term care benefit—which could prove far more expensive than paying for drugs.
The rich and the poor

In trying to make sense of the significance of MMA, it is perhaps useful to begin with the two dimensions of the bill that have won nearly universal support: extra subsidies for low-income seniors to purchase prescription drugs and additional premiums for high-income seniors who participate in Medicare Part B. During the 2002 debate about prescription drug coverage, liberal commentator Michael Kinsley told policy makers the following: "When Congress takes up a drug benefit again, it should keep things simple and concentrate on the risk, approaching a certainty, that it wishes to prevent: people doing without drugs—or without food—because of the cost. That means concentrating on poor people."

In the MMA, Congress took his advice—about helping the poor, if not keeping things simple. Beginning in June 2004, the bill created a temporary "drug discount card" that aims to give all participating seniors a 10 to 25 percent discount and low-income seniors a $600 direct subsidy. The permanent drug benefit, which includes substantial out-of-pocket "cost-sharing" for middle-income and high-income seniors, requires only minimal cost-sharing for those below 150 percent of the poverty level. This includes roughly a third of all Medicare beneficiaries.

Conservative critics of MMA have largely embraced this particular element of the bill. "Instead of displacing existing drug coverage with a universal entitlement, Congress could target federal subsidies to low-income seniors or those without drug coverage," wrote Robert E. Moffit, a health-care analyst for the Heritage Foundation, in a recent policy memo urging Congress to fix MMA before it is enacted. AEI's Joseph Antos has urged that the temporary "discount-plus-subsidy" program be made permanent and expanded.

No doubt the liberal and conservative reasons behind such support are not identical. Conservatives see subsidies for the poor as a way to limit the expansion of Medicare in general—by eventually making it a welfare program, not a universal entitlement. They believe that government action should be limited to helping those who cannot help
THE POLITICS AND REALITIES OF MEDICARE

themselves, while leaving individuals with middling means to plan, invest, and make choices in the marketplace. Liberals believe that society has a special obligation to help those who have been "left behind," and that the rich have a special obligation to support them. But both liberals and conservatives typically accept the notion that subsidizing the elderly poor (who are also chronically poor, with incomes likely to fall rather than rise) is a proper responsibility of the state. They disagree about whether MMA does this in the best possible way. Democrats believe that state-controlled drug prices are crucial to control costs, while Republicans believe America needs a subsidized voucher system that allows the poor to purchase drugs in the marketplace. But they both agree that drug benefits should be means-tested, with the poor paying less and everyone else paying more.

MMA also singles out wealthy seniors in a novel way by means-testing Medicare Part B benefits. Part B (also called "Supplementary Medical Insurance," or SMI) is a voluntary program, covering physician and outpatient care, in which nearly all seniors participate. At present, the premium is 25 percent (or $66.60 per month) of the total cost of the benefit—the same for all seniors, regardless of health, income, or the amount of medical care they need (though patients pay roughly 20 percent co-insurance per doctor visit). In this way, Medicare has always been (in both Parts A and B) a universal entitlement, not a welfare benefit.

Beginning in 2007, however, Part B beneficiaries with incomes over $80,000 for individuals (or $160,000 for a married couple) will pay gradually escalating premiums, with individuals earning over $200,000 (or couples earning over $400,000) paying premiums of 80 percent. The cost savings of such a change are likely minor compared to the cost of Medicare as a whole, since the higher premiums will affect only an estimated 1.2 million seniors out of the 35 million now on Medicare. But the principle it establishes for future reform may be significant: namely, the idea that means-testing is a potential route for further cost-cutting. As liberal Democratic Senator Dianne Feinstein
and the aforementioned conservative Senator Don Nickles wrote together in the *Washington Post*, "Why should low-income families pay 75 percent of the bill for Ross Perot to have a checkup?"

Of course, this idea still makes both sides a bit nervous—liberals because they fear the unraveling of Medicare as a universal entitlement, conservatives because they fear out-of-control taxes on successful wage-earners. But in such a bitter debate, this is a crucial point of consensus. It suggests that the real fights are not about the rich (who can take care of themselves) and the poor (who everyone agrees need public assistance) but the middle-class, whose prospects and obligations are more complex and ambiguous. And it suggests that the real disagreements are not about state subsidies for health care, which everyone agrees should exist, but how these subsidies should be spent and how health care should be delivered.

**Liberals and conservatives**

The MMA debate also made clear that liberals and conservatives have fundamentally different ideas about the relationship between medicine, the state, and the elderly. They disagree both in their assumptions about how the world works and their priorities regarding what is most important. Neither side is finally happy with the Medicare bill as passed, but more conservatives than liberals perceived MMA as better than nothing and less disastrous than it could have been. It was, overwhelmingly, a Republican bill. That said, there were many exceptions—including conservative lawmakers who bitterly opposed the legislation as excessive, unnecessary, and misguided, and liberal lawmakers who supported it as a way to put a drug entitlement in place that could be expanded in the future.

The conservative idea of Medicare reform is rooted in three basic principles: First, government control over medical pricing and inadequate incentives for individuals to control their own health-care costs lead to waste and inefficiencies. Conservatives seek to replace traditional Medicare with a "premium support" system—which basically means giving all seniors vouchers, then allowing them to
purchase the private-sector health-care plan that most suits their needs. They believe this will improve the "efficiency of health care delivery," as Antos has put it, and thus maintain or improve the quality of care while both cutting costs and freeing resources for investment in new medical technologies.

Second, conservatives believe that government control over drug prices—whether by purchasing Medicare drugs directly or setting prices for drugs the way Medicare sets prices for physician services—would cripple the pharmaceutical industry. They argue that the price of many drugs is artificially high because such profits are necessary to recoup the money spent on past research failures and to make the investments necessary for finding more and better drugs in the future. If government sets drug prices too low, investors will pull out of the drug business for fear of making abnormally low returns. The result would be a great slow-down of medical progress.

Finally, conservatives believe that medicine must be balanced against other human goods—both by individuals and by society as a whole. They worry that the benign tyranny of medicine will crowd out other public necessities or limit other human aspirations. And they believe that a more privatized system would ensure adequate public resources for defense, education, and other priorities, and allow individuals to decide whether to put their own discretionary income toward marginally better health care or toward other goods (education for grandchildren, vacations, home improvements, for example) that give them a higher "subjective value." A voucher or premium support system, they argue, would better balance the obligation of society to provide "basic health care" for the elderly with the need for individuals to make personal decisions about always limited resources.

Liberals tend to share the same central goal as conservatives—better medicine for the elderly—but differ both in their priorities and their assumptions. First, they believe that only a government-run program can ensure that all seniors have access to quality care. A voucher system, they believe, would leave the poorest and sickest seniors
worse off. Private plans would cherry-pick the healthiest seniors; premiums for the very sick would increase; and the poor would be left with great disruptions and great inadequacies in care—including high out-of-pocket costs, restrictions on doctors, and caps on certain therapies.

Second, liberals believe that government should use its buying power to demand lower drug prices and lessen the economic burden for poor seniors. They believe drug companies are both too profitable and too manipulative—charging too much for drugs, and producing drugs that promise advantages over generic alternatives that are often more fanciful than real. They point to lower drug prices in Canada and Western Europe—where state-run health-care systems negotiate the prices directly—and believe America should do the same. While they believe drug access in the present is more important than drug development in the future, most liberals do not accept that there is a trade-off between the two.

Finally, liberals see health care as a "right," and they are less likely to weigh it against other economic, civic, or human goods. They believe the real luxuries of life are enjoyed by a small percentage of wealthy Americans, and that raising their taxes would fund a more egalitarian and constantly improving health-care system for the elderly. They also believe valuable resources are squandered on unnecessary wars and corporate pork—money that could be used to pay for health care at home. When it comes to controlling rising health-care costs, they believe government can exert its buying power to reduce prices, and they do not believe this will lower the quality of care.

In the real world, of course, those who wish to govern must moderate their theories, and those who are in power have a much greater incentive to do so, since they can claim credit for "delivering the goods." In the MMA, neither conservatives nor liberals got their ideal reforms. Conservatives wanted open-ended competition between private plans and traditional Medicare, but they lost. Liberals wanted government-negotiated drug prices and drug benefits with virtually no deductibles, but they too lost. The new law does tinker around the edges—for example, cre-
ating a new "Medicare Advantage" program to replace the existing "Medicare+Choice," with the new program allowing seniors to choose from a slightly greater variety of tightly regulated health maintenance organizations (HMOs) or preferred provider organizations (PPOs) as alternatives to traditional Medicare. And the new law creates health savings accounts on a small scale. Over the long run, these limited measures may prove to be the seeds of more fundamental reforms. But for now, the major feature of the Medicare bill—the new drug benefit—overshadows them all. The new benefit combines liberal and conservative elements, but satisfies the theoretical orthodoxies of neither. It includes a real, but limited, drug entitlement—with drugs prices set in the marketplace, not by government fiat. It is a moderate, if expensive, reform. But whether it is prudent or addresses the deeper issues remains an open question.

Success or failure?

The fact is that, if Medicare were being created from scratch, it would almost certainly include a prescription drug benefit. But there are also good reasons to believe that adding a universal drug benefit was unnecessary or unwise, and that the sense of urgency in doing so was more artificial than real—a battle for senior-friendly voters (young, not old) who presumed a crisis that never really existed. As Samuelson reported in the Washington Post, a government survey of Medicare recipients in 2002 asked the following question: "In the last six months, how much of a problem, if any, was it to get the prescription medicine you needed?" The answers: 86.4 percent, not a problem; 9.4 percent, a small problem; 4.2 percent, a big problem. And so one could have imagined a targeted subsidy for low-income seniors in need, and national acceptance that drugs are just one of those things on which seniors will have to spend their own money.

But for the politically ambitious, drug coverage had already become a "must deliver" issue, and for the country, it had become a political expectation. Moreover, it is unclear how the above survey from 2002 meshes with other realities,
such as the high number of low-income Medicare beneficiaries who will now be eligible for drug subsidies, or the deepening erosion of employee-based drug coverage for retirees. Clearly, there existed some real hardship, though hardly a national crisis. And clearly, both parties believed they needed to pass a prescription drug benefit in order to remain attractive to senior and senior-friendly voters.

Given these realities, there is a certain wisdom in the way MMA’s drug benefit is designed. It establishes a baseline of coverage for all seniors, and thus assures universal access to at least the most urgently needed medications. It provides genuine insurance against catastrophic drug costs—that is, against suddenly losing all of one’s financial resources in a desperate effort to stay alive. But MMA also establishes the principle that not everything can be paid for by government; that medicine must be balanced against other national priorities and other human goods; and that middle-class individuals will have to support their own middling drug bills. The “hole in the doughnut,” for all the mockery it has received, is sensible in its guiding principles.

But in practice, of course, many unanswered questions remain, and it is far too early to make any clear predictions about the long-term consequences of the new law. Will it drive companies that offer drug benefits to retirees to stop doing so? Will it create an artificial demand for expensive drugs with limited medical benefits? Will the private-sector organizations that the drug benefit relies upon come into existence? Will the “doughnut hole” eventually be filled? Will government impose price controls if the cost of the new drug benefits far outstrips current expectations? Will the modest changes, like means-testing benefits and medical savings accounts, pave the way toward more fundamental reforms? How will increased access to prescription drugs affect the overall health of seniors and thus the trajectory of aging and death? Will the drug benefit reduce the costs of Medicare Part A and Part B by keeping seniors healthy? Or will it increase Medicare costs by preventing acute causes of death in favor of long, expensive, chronic diseases?

This last question is an important one. One of the strongest arguments for adding a prescription drug benefit to
Medicare was that doing so would prevent beneficiaries from needing or using more expensive therapies for ailments that could be ameliorated or prevented using less expensive drugs. This is certainly true in some cases, but it is also difficult to quantify for Medicare as a whole. Drugs that keep people alive or prevent certain diseases also mean new costs for new diseases down the road that never would have existed. (Early death, after all, would be the best way to solve Medicare's economic woes.) Some drug therapies may indeed cut costs or allow individuals to remain self-sufficient. But the notion that we will cure our way out of the economic problems involved in caring for the elderly is a fallacy. People will simply be sicker later in life; they will die from chronic conditions instead of acute episodes.

Such questions—unanswerable for now, but important to ask—point to the grave shortcomings of the new law. MMA puts off any serious confrontation with the pending financial problems of Medicare as a whole, and it fails to reckon with the deeper human, generational, and medical realities that underlie our sense of impending “crisis.” More deeply, it fails to grasp or even consider the novelty of the world to come: a world of aging baby-boomers, with fewer children, geographically scattered, with high rates of divorce, and a greater likelihood of living long enough to suffer diseases (like Alzheimer's) that create long-term states of dependence.

The hardest decisions about Medicare in the future may ultimately be faced by the middle-class members of the middle-aged generation—and specifically, by members of Generation X in their 40s and 50s. They will have to decide what they are willing to pay and what they are willing to give up, and they will have to balance the demands of aging parents and dependent children. When the financial balance finally hits, they may have to choose between higher taxes or lower benefits; between sending their child to Harvard or their parent to Sunrise Assisted Living; between raising their own retirement age or cutting funding for national defense; between forcing their proud father to become eligible for Medicaid or giving up their inheritance to pay for the nursing home.
The dilemmas of progress

Despite the bitter disagreements over Medicare, liberals and conservatives share two basic assumptions: the ideal of self-determination and the ideal of medical progress. They both want more choice for the aging, and they both believe that more drugs for more people is an unequivocal good, even if they disagree about how best to achieve these goals. And so they are both, in different ways, prone to utopianism, believing that the right policies will create a world where the Medicare crisis is largely solved. This is a fantasy shared by liberal and conservative thinkers alike, whether packaged in the rhetoric of new vouchers or new entitlements.

In reality, the Medicare crisis is permanent. So long as we continue to see aging and death as crises, we will feel the need to spend increasing amounts on the aging ill. Medicare confronts us with the impossibility of winning the war against time, and the limited capacity of rapidly improving medical technologies to fulfill our rapidly rising expectations. Our problems are largely those of success, and success seems to bring its own novel miseries—whether dying alone in a nursing home, or living through a heart attack to suffer years of dementia, or betraying our aging, declining parents to meet the demands of our growing children. This is the real human cost of our prescription-drug world—a cost we would be fools not to pay, but also fools to ignore.