

REFLECTIONS ON MEDICARE AT 50: BREAKING THE CHAINS OF PATH DEPENDENCY FOR A NEW ERA

Richard L. Kaplan

The 50th anniversary of the enactment of Medicare provides an occasion for serious evaluation of Medicare, a governmental program that is so pivotal to the retirement security of older Americans. Paying for health care in retirement has only increased in importance since 1965, yet the fundamental structure of Medicare is essentially unchanged from its origins, even after the enactment of comprehensive health care reform legislation, the Affordable Care Act (ACA), in 2010. Evaluating Medicare is particularly timely as the Baby Boom generation migrates into this program.

This Article begins by explaining the evolution of Medicare over the past half-century in the context of how other health insurance options operate today. It then analyzes what the ACA did and did not change in Medicare and how those changes affect the program's overall appeal to new beneficiaries. It then offers two major recommendations to bring Medicare's offerings into greater alignment with the health care challenges and needs that older Americans face going forward.

Richard L. Kaplan is the Peer and Sarah Pedersen Professor of Law at the University of Illinois at Urbana-Champaign.

Apart from Social Security, no governmental program is as vital to the retirement security of older Americans as Medicare. Health care costs are the single largest and most unpredictable expense of retired persons,¹ and Medicare is the foundation for the payment of those costs.² This program celebrates its 50th anniversary in 2015,³ and that occasion is sufficient reason to evaluate its features and limitations. But this anniversary takes on additional significance as the front wave of the Baby Boom population reaches Medicare's eligibility age⁴ and begins to enroll in this program. The Baby Boom population has transformed virtually every aspect of American life as it matured and now approaches a Medicare program that was developed at a very different time in our nation's history in terms of fiscal stability and medical practice.⁵

This Article seeks to bring the perspective of 2015 to a program that was fashioned a half-century ago and has retained many of its most salient characteristics throughout that period. Part I begins by explaining how Medicare and its constituent parts evolved as well as the political and economic factors that shaped that evolution. Part II of this Article examines the impact on Medicare of the major health reform legislation generally known as the Affordable Care Act (ACA) that was enacted in 2010⁶ and is currently on the precipice of full implementation. Part III sets forth recommendations to simplify seniors' lives and rationalize Medicare as it begins its second half-century.

1. See Richard L. Kaplan, *Desperate Retirees: The Perplexing Challenge of Covering Health Care Costs in a YOYO World*, 20 CONN. INS. L.J. 433, 434–36 (2014).

2. See *The Facts on Medicare Spending and Financing*, THE HENRY J. KAISER FAMILY FOUND. 1 (2014), <https://kaiserfamilyfoundation.files.wordpress.com/2014/07/7305-08-the-facts-on-medicare-spending-and-financing.pdf>.

3. See, e.g., 50 Insights for Medicare's 50th Anniversary, CTR. FOR MEDICARE ADVOCACY (2015), <http://www.medicareadvocacy.org/50-insights-for-medicare-50th-anniversary/>.

4. Medicare's age of eligibility is 65 years. 42 U.S.C. § 1395c(1) (2012). The oldest Baby Boomers were born in 1946 and therefore became eligible for Medicare in 2011.

5. See *The Story of Medicare: A Timeline*, THE HENRY J. KAISER FAMILY FOUND. (Dec. 20, 2012), <http://kff.org/medicare/video/the-story-of-medicare-a-timeline/>.

6. Patient Protection and Affordable Care Act, Pub. L. No. 111–148, 124 Stat. 119 (2010).

I. Medicare's Disjointed Evolution

One of the enduring myths surrounding Medicare is that it is a single, integrated program created at one moment in time and largely impervious to change.⁷ That is simply not the case. For better or worse, Medicare has evolved since its original enactment in 1965⁸ to encompass several distinct programs, usually denominated Parts A through D, that stand largely separate from one another in terms of their coverages, exclusions, and costs.⁹ Those Parts are explained in brief overview below with a focus on their most important features to current and prospective enrollees.

A. Original Program: Part A

Medicare Part A is the original component and represents the height of the social insurance model as applied to health care for older Americans; i.e., it is structured as a mandatory program with its own dedicated source of financing.¹⁰ In both of these aspects, Part A is unique among Medicare's constituent components. Every person who receives income from wages, salaries, or self-employment must pay a "contribution," or tax, to fund this program,¹¹ and eligibility is based on attaining a specified age—namely, 65 years¹²—that has remain unchanged since the program's original enactment.

Medicare's tax is currently 2.9% of income from earnings, which is collected half from employees¹³ and half from employers¹⁴ or paid in its entirety by self-employed persons.¹⁵ An additional 0.9% tax¹⁶ is collected on earnings in excess of \$200,000 per year for unmarried persons¹⁷ and \$250,000 per year for married couples.¹⁸ This

7. See Richard L. Kaplan, *Top Ten Myths of Medicare*, 20 ELDER L.J. 1, 4, 15 (2012).

8. Social Security Amendments of 1965, Pub. L. No. 89-97, § 100, 79 Stat. 286, 290 (enacting Health Insurance for the Aged Act).

9. See generally LAWRENCE A. FROLIK & RICHARD L. KAPLAN, ELDER LAW IN A NUTSHELL 57-98, 105-110 (6th ed. 2014); JUDITH A. STEIN & ALFRED J. CHILPIN, JR., 2015 MEDICARE HANDBOOK (2015) (discussing the different Medicare programs).

10. See *A Brief History of Medicare in America*, MEDICARE RESOURCE CTR., <http://www.medicareresources.org/basic-medicare-information/brief-history-of-medicare> (last visited Feb. 23, 2015).

11. I.R.C. §§ 3101(b), 1401(b) (2012).

12. 42 U.S.C. § 1395c(1) (2012).

13. I.R.C. § 3101(b)(1).

14. *Id.* § 3111(b)(6).

15. *Id.* § 1401(b)(1).

16. *Id.* §§ 1401(b)(2)(A), 3101(b)(2).

17. *Id.* §§ 1401(b)(2)(A)(i), 3101(b)(2)(A).

additional Medicare tax, it should be noted, was added only recently by the ACA.¹⁹ But the main point is that Medicare Part A is financed entirely from this dedicated revenue stream, with funds deposited into a “trust fund” that the federal government administers.²⁰

To receive Part A benefits, a person must have paid the Medicare payroll tax long enough to be eligible for retirement benefits under Social Security,²¹ which requires earning a sufficient amount²² (\$1,220 in 2015)²³ for at least 40 calendar “quarters.”²⁴ Customarily, this requirement translates into ten years of employment in the United States. Persons who have not met this requirement may nonetheless be eligible for Medicare Part A benefits derivatively through marriage to a person who is eligible for such benefits²⁵ or a former marriage to such a person, as long as their marriage lasted at least ten years.²⁶

Persons who cannot qualify for Medicare Part A benefits through these means can nevertheless receive such benefits by paying a monthly premium that is adjusted annually for inflation.²⁷ In 2015, that premium is \$407.²⁸ This option is available only to U.S. citizens or resident aliens who have resided in this country during the preceding five years.²⁹ Other than in this particular circumstance, a person who reaches age 65 is eligible for Medicare Part A benefits with no premiums owing. While Part A is often described as “premium-free” for this reason,³⁰ a more accurate description would be that enrollees prefunded their entitlement to Medicare benefits. The key point,

18. *Id.* §§ 1401(b)(2)(A)(iii), 3101(b)(2)(C).

19. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 9015(a)(1)(A)-(D), (b)(1)(A)-(B), 124 Stat. 119, 870-71 (2010) (codified at 26 U.S.C. §§ 3101, 1401 (2012)). See Richard L. Kaplan, *Rethinking Medicare's Payroll Tax After Health Care Reform*, TAXES, Aug. 2011, at 43.

20. 42 U.S.C. § 1395i(a) (2012).

21. *Id.* §§ 426(a)(2)(A), 1395c.

22. *Id.* § 413(d)(2).

23. See *Automatic Determinations In Recent Years*, SSA, <http://www.socialsecurity.gov/OACT/COLA/autoAdj.html> (last visited Mar. 3, 2015).

24. 42 U.S.C. § 414(a)(2).

25. *Id.* § 402(b)(1), (c)(1).

26. *Id.* § 416(d)(1). Persons under age 65 can qualify for Medicare if they are unable to perform “any substantial gainful activity by reason of a medically determinable physical or mental impairment and have received Social Security disability payments under this standard for at least 24 months. *Id.* §§ 416(i)(1)(A), 426(b)(2)(A)(i), 1395c(2).

27. *Id.* § 1395i-2(a).

28. *How Much Does Part A Cost?*, MEDICARE.GOV, <http://www.medicare.gov/your-medicare-costs/part-a-costs/part-a-costs.html>.

29. 42 U.S.C. § 1395i-2(a)(3) (2012).

30. See, e.g., *How Much Does Part A Cost?*, *supra* note 28.

however, is that Medicare Part A is self-financed, almost entirely, through taxes paid on wages and other earned income throughout a person's working life.³¹ Indeed, if a person continues to work after age 65, perhaps on a part-time basis, the earnings that person receives continue to bear Medicare's payroll tax.³²

The scope of Medicare Part A's coverage consists of four principal components, each with its own limitations, exclusions, and cost-sharing features. Those components pertain to: (1) hospitalization, (2) nursing homes, (3) home health care, and (4) hospice care. The pertinent aspects of these coverages follow below.³³

1. HOSPITALIZATION

There is no question that most people's largest medical expenditures are likely to involve hospital stays,³⁴ but Medicare Part A provides fairly comprehensive coverage for such expenditures. The program covers almost all services incurred during the first 60 days of a "spell of illness."³⁵ This pivotal phrase begins when a patient is admitted into the hospital and continues until that patient has been out of the hospital, a nursing home, or other rehabilitative facility for at least 60 consecutive days.³⁶ So, if Charles enters the hospital on March 10, leaves on March 15, and does not return until May 25, the May 25 admission starts a new "spell of illness."³⁷ On the other hand, if he returns to the hospital on April 7, whether for the same or an unrelated medical condition, that April 7 admission would be part of the same "spell of illness" that began on March 10.³⁸

This "spell of illness" determination is important for two independent reasons. First, Medicare Part A's full coverage of hospital costs applies only to the first 60 days of a "spell of illness."³⁹

31. *Id.*

32. 42 U.S.C. §§ 1401(b)(2)(A), 3101(b)(2).

33. *What Part A Covers*, MEDICARE.GOV, <http://www.medicare.gov/what-medicare-covers/part-a/what-part-a-covers.html> (last visited Mar. 3, 2015).

34. CELESTE TORIO & ROXANNE ANDREWS, HEALTHCARE COST AND UTILIZATION PROJECT, STATISTICAL BRIEF #160 1 (2013), *available at* <http://www.hcup-us.ahrq.gov/reports/statbriefs/sb6160.pdf>

35. 42 U.S.C. § 1395x(b) (2012).

36. *Id.* § 1395x(a)(1).

37. The 60-day period begins with the day of discharge, so the "spell of illness" in this example ended on May 13. *See id.*

38. *See id.*

39. *Id.* § 1395e(a)(1)(A).

Any hospital days within a “spell of illness” after the first 60 days are subject to per-day deductibles that are adjusted annually for inflation as follows: the next 30 days (i.e., days 61–90)⁴⁰ have a per-day deductible of \$315 in 2015,⁴¹ and the next 60 days are eligible as “lifetime reserve days”⁴² with a per-day deductible of \$630 in 2015.⁴³ Medicare Part A pays only for hospital costs that exceed these per-day deductibles.⁴⁴ Note that a second admission within the same “spell of illness” counts against the 60 days of full Medicare coverage, while a new “spell of illness” effectively restarts the 60-day limit.⁴⁵

Second, each “spell of illness” has a deductible⁴⁶ that is also adjusted annually for inflation and is \$1,260 in 2015.⁴⁷ A new “spell of illness” in the same calendar year imposes another deductible.⁴⁸ For example, if Charles in the previous example is admitted to the hospital on March 10 and August 10 for five days each time, he had two separate “spells of illness” that year. In this situation, he would be liable for two separate deductibles of \$1,260 each, or \$2,520. On the other hand, if he returns to the hospital on September 20, no deductible will be charged because that stay is within the same “spell of illness” that began on August 10. Incidentally, full Medicare coverage for this last admission would be limited to 55 days, because the five days in August count against the 60 days that would otherwise be available for the September 20 admission.

This simple example demonstrates that Medicare enrollees could face substantial out-of-pocket costs from repeated hospital stays. The 60-day full-coverage limitation is less problematic, because the average hospital stay for a patient age 65 and over was less than

40. *Id.*

41. *Medicare 2015 Costs at a Glance*, MEDICARE.GOV, <http://medicare.gov/your-medicare-costs/costs-at-a-glance/costs-at-a-glance.html>.

42. 42 U.S.C. §§ 1395d(a)(1), 1395e(a)(1)(B).

43. *Medicare 2015 Costs at a Glance*, *supra* note 41.

44. UNITED HEALTH CARE SERVS., INC., *Getting started with Medicare*, 6 (2014), available at <https://www.aarphealthcare.com/content/dam/aarphealthcare/docs/medicare-made-clear.pdf>.

45. CTRS. FOR MEDICARE & MEDICAID SERVS., *Chapter 8-Coverage of Extended Care (SNF) Services Under Hospital Insurance*, in MEDICARE BENEFIT POLICY MANUAL, <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c08.pdf>.

46. 42 U.S.C. § 1395e(b)(1) (2012).

47. *Medicare 2015 Costs at a Glance*, *supra* note 41.

48. THOMAS D. BEGLEY, JR. & JO-ANNE HERINA JEFFREYS, *REPRESENTING THE ELDERLY CLIENT-LAW AND PRACTICE 1* (Panel Publishers 1999).

six days, according to the most recent data available.⁴⁹ But the deductibles for each new “spell of illness” can add up. In the preceding example, Charles owed \$2,520, but if he had another hospital admission, say on December 3, he would owe another deductible, making his expense this year for this one item \$3,780.⁵⁰ Not only is this amount substantial, it also illustrates a very important aspect of Medicare Part A—namely, that this program has no “stop loss” provision that limits how much an enrollee is obligated to pay,⁵¹ unlike most private health insurance plans.

For that reason, most Medicare beneficiaries obtain some type of supplemental coverage,⁵² often private policies that are usually denominated “Medigap” insurance.⁵³ Such insurance comes in ten distinct and standardized configurations of various benefits,⁵⁴ but all “Medigap” policies provide the “core” benefits,⁵⁵ which include the per-day deductible for hospital stays of 61-90 days as well as the per-day deductible for the “lifetime reserve” hospital days.⁵⁶ Coverage of the deductible for each “spell of illness” is not one of the “core benefits,” but it is included in every “Medigap” policy other than the basic version (Plan A), which has only these “core benefits.”⁵⁷

The cost of “Medigap” coverage depends on how extensive the particular package of coverages is, but it can exceed several thousand

49. See ADMIN ON AGING, U.S. DEP'T OF HEALTH & HUMAN SERVS., A PROFILE OF OLDER AMERICANS: 2013 12 (2014), available at http://www.aoa.gov/Aging_Statistics/Profile/2013/docs/2013_Profile.pdf (reporting that persons aged 65 to 74 averaged stays of 5.4 days, persons aged 75 to 84 averaged 5.7 days, and persons aged 85 and over averaged 5.6 days).

50. $\$2,520 + \$1,260 = \$3,780$.

51. Katherine Baicker & Helen Levy, *The Insurance Value of Medicare*, 367 NEW ENG. J. MED. 1773, 1773 (2012).

52. JULIETTE CUBANSKI ET AL., THE HENRY J. KAISER FAMILY FOUND., MEDICARE CHARTBOOK 60 fig.6.1 (4th ed. 2010), available at <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8103.pdf> (showing that nine out of ten Medicare enrollees have such coverage).

53. See generally FROLIK & KAPLAN, *supra* note 9, at 98–104.

54. See CTRS. FOR MEDICARE & MEDICAID SERVS., MEDICARE & YOU 2015 92–93 (2015), available at <http://www.medicare.gov/pubs/pdf/10050.pdf> [hereinafter cited as MEDICARE & YOU].

55. *Id.* at 93; FROLIK & KAPLAN, *supra* note 9, at 101.

56. FROLIK & KAPLAN, *supra* note 9, at 101; MEDICARE & YOU, *supra* note 54, at 93. Another “core benefit” is full coverage for an additional 365 days of hospitalization after the “lifetime reserve” days are exhausted. FROLIK & KAPLAN, *supra* note 9, at 101; MEDICARE & YOU, *supra* note 54, at 93.

57. FROLIK & KAPLAN, *supra* note 9, at 102; MEDICARE & YOU, *supra* note 54, at 93.

dollars per year in some states.⁵⁸ On the other hand, no one is required to buy supplemental coverage, though the unlimited nature of Medicare Part A's cost exposure makes such coverage very appealing to many older Americans.⁵⁹ At a minimum, the existence and appeal of "Medigap" insurance says something significant about the limits of Medicare Part A's coverage, especially with regard to hospitalization expenses.

2. NURSING HOMES

No component of Medicare Part A is more misunderstood than its coverage of "skilled nursing facilities,"⁶⁰ more commonly called nursing homes. Medicare does indeed cover the cost of nursing homes, but under structures that reflect the state of care that such facilities provided when Medicare was first enacted, and are increasingly outdated as Americans live longer and need nursing homes for more extended periods of time. For example, Medicare covers nursing home care only if a patient is admitted to the nursing home within 30 days of that person's being discharged from a hospital.⁶¹ Moreover, the patient must require care in the nursing home for a condition that was treated originally in the hospital or is medically related to that condition.⁶² But today, many older people transition from their own home or apartment directly to a nursing facility without needing to go to a hospital first,⁶³ especially when the underlying ailment is a neurodegenerative condition such as Alzheimer's or Parkinson's disease.⁶⁴ Nevertheless, if the patient is not discharged from a hospital within 30 days of going to the nursing

58. See, e.g., *View All Medigap Policies*, MEDICARE.GOV, <http://medicare.gov/find-a-plan/results/medigapresults/medigap-view-all-policies.aspx> (last visited Feb. 23, 2015) (displaying prices for all policies in zip code 61820).

59. See, e.g., *What is Medigap Insurance*, MEDIGAP INS. POLICIES, <http://www.medigapinsurancepolicies.com/what-is-medigap-insurance/> (last visited Feb. 23, 2015).

60. 42 U.S.C. § 1395i-3(a) (2012).

61. *Id.* § 1395x(i)(A); 42 C.F.R. § 409.30(b)(1)(2015).

62. 42 U.S.C. § 1395f(a)(2)(B); 42 C.F.R. § 409.31(b)(2)(ii).

63. See Nathalie D. Martin, *Funding Long-Term Care: Some Risk-Spreaders Create More Risks Than They Cure*, 16 J. CONTEMP. HEALTH L. & POL'Y 355, 373 (2000) (noting that "two-thirds of those who enter a nursing home are not coming from a hospital").

64. *Id.*

home, Medicare does not cover any of the costs of that nursing home admission.⁶⁵

Nor can a patient simply “drop by” a hospital on the way to the nursing home. First, the care in the nursing home must be for a condition that was treated in the hospital or is related to that condition.⁶⁶ If, for example, a person has Alzheimer’s disease and enters a hospital complaining of chest pains, a subsequent nursing home stay that is unrelated to the chest pains complaint will not be covered by Medicare. Second, the hospital stay in question must last at least three days,⁶⁷ not counting the day of discharge.⁶⁸ So, assume that Mary falls and is rushed to the hospital. There, she is examined but is found not to have broken any bones. She may be kept in the hospital overnight for observation but when she is discharged the next day and enters a nursing home for recuperative care, her stay in the nursing home will not be covered by Medicare because the antecedent hospital stay was not at least three days.⁶⁹

Even if the antecedent hospital stay is at least three days, Medicare pays only for “skilled nursing care” in a nursing home.⁷⁰ Such care must be ordered by a physician and require the skills of a licensed practical nurse, a registered nurse, a physical therapist, or some similar professional.⁷¹ The sorts of services required are medically intensive, e.g., catheters, gastronomy feedings, injections, medical gas administration, medicated dressings, and the like.⁷² The care received by most nursing home residents does not rise to this level of technical skill and is often described as “custodial” or “intermediate” care.⁷³ Medicare does not cover the cost of such non-

65. Medicare will cover nursing home stays that do not meet this criterion if beginning care in a nursing home during the 30 days immediately after being discharged from the hospital would not have been “medically appropriate.” 42 U.S.C. § 1395x(i)(B); 42 C.F.R. § 409.30(b)(2).

66. 42 U.S.C. § 1395f(a)(2)(B); 42 C.F.R. § 409.31(b)(2)(ii).

67. 42 U.S.C. § 1395x(i).

68. 42 C.F.R. § 409.30(a)(1) (2015).

69. See Soc. Sec. Rul. 69–63, reprinted in [1969–1972 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 26,066 (noting that a hospital stay of two days did not qualify subsequent skilled nursing facility charges for Medicare coverage).

70. 42 U.S.C. § 1395f(a)(2)(B) (2012); 42 C.F.R. § 409.31(b)(3).

71. 42 U.S.C. § 1395f(a)(2)(B); 42 C.F.R. § 409.31(a)(2).

72. 42 C.F.R. § 409.33(a)–(c).

73. Richard L. Kaplan, *Taking Medicare Seriously*, 1998 U. ILL. L. REV. 777, 795.

“skilled” care.⁷⁴ Moreover, Medicare pays for skilled care only if the patient requires and receives such care on a *daily* basis.⁷⁵ Therapy three days a week, in other words, does not qualify for Medicare coverage.

Finally, even if the patient meets every one of the criteria described above, Medicare’s coverage of nursing homes is time-limited. Medicare covers all costs for the first 20 days in a “spell of illness,”⁷⁶ as that phrase was defined previously in the context of hospitalization coverage.⁷⁷ After the first 20 days in a “spell of illness,” Medicare pays for 80 additional days but with a per-day deductible⁷⁸ that is adjusted annually for inflation.⁷⁹ In 2015, that deductible is \$147 per day.⁸⁰ Many, but not all, “Medigap” policies cover this per-day deductible,⁸¹ but neither Medicare nor “Medigap” cover any nursing home costs for stays after 100 days. Clearly, Medicare’s coverage of nursing homes was built on a model of post-hospitalization rehabilitative care and does not encompass the sort of long-term confinement that characterizes many older Americans’ nursing home experience today.

3. HOME HEALTH CARE

Medicare Part A covers home health care services subject to three major caveats. First, the recipient of such care must be unable to leave his or her home without assistance from other people or devices such as canes, walkers, or wheelchairs.⁸² Second, the home health care services must be provided by a Medicare-certified home health care agency.⁸³ In other words, help provided by family members, friends, neighbors, or church groups does not qualify for payment by Medicare. Third, home health care services must be provided pursuant to a written plan of care that was prepared by the patient’s

74. *What’s Not Covered by Part A and Part B*, HEALTHCARE.gov, <http://www.medicare.gov/what-medicare-covers/not-covered/item-and-services-not-covered-by-part-a-and-b.html>.

75. 42 U.S.C. § 1395f(a)(2)(B); 42 C.F.R. §§ 409.31(b), 409.34(a)(1) (2015).

76. 42 U.S.C. §§ 1395d(a)(2)(A), 1395e(a)(3) (2012).

77. *Id.* § 1395x(a).

78. *Id.* § 1395e(a)(3).

79. *Id.* § 1395e(b)(1).

80. *Medicare 2015 Costs at a Glance*, *supra* note 41.

81. FROLIK & KAPLAN, *supra* note 9, at 102; MEDICARE & YOU, *supra* note 54, at 93.

82. 42 U.S.C. §§ 1395f(a) (flush language), 1395n(a)(2)(A).

83. *Id.* § 1395x(m), (o).

doctor,⁸⁴ and that is reviewed by that doctor every 60 days.⁸⁵

If these requirements are met, Medicare pays for occupational, physical, and speech therapy,⁸⁶ along with medical supplies,⁸⁷ and “part-time and intermittent” nursing care.⁸⁸ This last item is more problematic because it requires the supervision of a registered nurse,⁸⁹ though home health aides can be included if the services that the physician orders do not require a licensed nurse.⁹⁰ Moreover, “part-time and intermittent” nursing care is less than eight hours per day, with a weekly maximum of 28 hours⁹¹ or 35 hours per week in specifically reviewed cases.⁹²

Medicare Part A does not, however, cover many home health care services that older patients need to stay in their homes, such as around-the-clock nursing care, meal preparation, or laundry. On the other hand, for the home health care services that Medicare does cover, there are no deductibles or copayment obligations.⁹³

4. HOSPICE

One of the less well-known coverages within Medicare Part A is hospice care for persons whose doctors have certified that they have no more than six months to live.⁹⁴ Under this coverage, such persons can receive various home care and other benefits,⁹⁵ including services that are generally not covered by Medicare, that attempt to mitigate a dying person’s pain rather than remedy his or her underlying illness.⁹⁶ Hospice care can include homemaker assistance, custodial care items, and counseling,⁹⁷ along with the more typical panoply of doctor’s and nurse’s services.

84. *Id.* §§ 1395f(a)(2)(C), 1395x(m).

85. 42 C.F.R. § 484.18(b) (2015).

86. 42 U.S.C. § 1395x(m)(2) (2012).

87. *Id.* § 1395x(m)(5).

88. *Id.* § 1395x(m)(1).

89. *Id.*

90. *Id.* § 1395x(m)(4). *See also* H. Gilbert Welch et al., *The Use of Medicare Home Health Care Services*, 335 NEW ENG. J. MED. 324, 328 (1996) (noting that home health aides account for almost half of Medicare’s home health care visits).

91. 42 U.S.C. § 1395x(m) (penultimate sentence).

92. *Id.*

93. CTRS. FOR MEDICARE & MEDICAID SERVS., MEDICARE AND HOME HEALTH CARE 8-9 (2010), available at <http://www.medicare.gov/pubs/pdf/10969.pdf>.

94. 42 U.S.C. § 1395x(dd)(1), (3)(A) (2012).

95. *Id.* § 1395x(dd)(1)(A)-(D).

96. *Id.* § 1395x(dd)(1)(G).

97. *Id.* § 1395x(dd)(1)(H).

Medicare enrollees elect to receive hospice care in lieu of their regular Medicare benefits, and no one can be forced to accept such care. Those who do, however, find that their cost-sharing obligations decline significantly, because Medicare Part A's hospice benefit pays almost all the cost of the services provided.⁹⁸ Moreover, if a patient's family members need a break from their caregiving responsibilities, the patient can be admitted to a care facility for no more than five consecutive days and Medicare Part A will pay all but 5% of the cost of such "respite care."⁹⁹ There is also a nominal copayment for outpatient drugs,¹⁰⁰ but the basic point is that Medicare's hospice care benefit is unusually comprehensive and uncomplicated. To be sure, this benefit can last for no more than 180 days,¹⁰¹ but extensions are available if a physician certifies that the patient's remaining life expectancy does not exceed six months.¹⁰²

B. Optional Coverage for Physicians' Charges: Part B

Medicare Part A excludes many common medical expenses, the most significant being doctors' charges.¹⁰³ This exclusion seems unfathomable in today's world, but doctors' fees were apparently not as significant in the pre-Medicare era and were often not covered by the typical private health insurance plans that were marketed as "major medical" policies.¹⁰⁴ In formulating Medicare Part A, its creators consciously tried to replicate those policies,¹⁰⁵ so physicians' charges were not included in Medicare Part A.

Instead, an optional coverage called Medicare Part B was fashioned to cover such charges,¹⁰⁶ as well as other less common

98. See MEDICARE HANDBOOK, *supra* note 9, at § 5.15 ("The hospice patient is liable for coinsurance amounts only for drugs and biological and respite care. No other services provided by the hospice for the palliation and management of the patient's terminal illness may be billed to the patient.").

99. 42 U.S.C. § 1395e(a)(4)(A)(ii). All "Medigap" policies cover this 5% cost-sharing element as one of the "core" benefits of such policies. FROLIK & KAPLAN, *supra* note 9, at 102; MEDICARE & YOU, *supra* note 54, at 93.

100. See Richard L. Kaplan, *Financial Planning for the Non-Retiree*, THE ELDER LAW REP., Oct. 2013, at 2.

101. 42 U.S.C. § 1395d(a)(4) (2012).

102. *Id.* § 1395f(a)(7)(A)(ii); 42 C.F.R. § 418.3 (2015).

103. What's Not Covered by Part A & Part B, *supra* note 74.

104. THE CENTURY FOUND., MEDICARE TOMORROW: THE REPORT OF THE CENTURY FOUNDATION TASK FORCE ON MEDICARE REFORM 47 (2001).

105. *Id.*

106. 42 U.S.C. § 1395k(a)(1).

expenses, such as ambulance service¹⁰⁷ and durable medical equipment (hospital beds, wheelchairs, scooters, and so forth).¹⁰⁸ Medicare Part B has no relationship to the Medicare payroll tax and is financed strictly on a current-year basis.¹⁰⁹ Premiums are paid by those who have enrolled in Medicare B and are adjusted annually for inflation.¹¹⁰ In 2015, this premium is \$104.90 per month,¹¹¹ an amount that was calculated to cover approximately 25% of the program's projected costs for the coming year.¹¹² The remaining 75% of the program's funding comes from general tax revenues of the federal government, which are paid by all U.S. taxpayers regardless of their age or likely enrollment in Medicare.¹¹³ Most of Part B's financing, in other words, comes from society as a whole, or at least that portion of society that pays income taxes.¹¹⁴ This arrangement constitutes a substantial subsidization of Medicare Part B for those who elect its coverage.

No one is required to enroll in Medicare Part B, but most eligible persons do so¹¹⁵ because of this substantial public subsidy. Those who do not are generally over age 65 but still employed, and their current employer provides health insurance to them.¹¹⁶ Such persons typically enroll in Medicare Part A, but use employer-provided health insurance to cover the costs that Part B would cover.¹¹⁷ Anyone who is not in this position can choose to defer enrolling in Part B, but such action might subject that person to a delayed enrollment penalty based on how many months after

107. 42 C.F.R. § 410.40.

108. 42 U.S.C. § 1395x(n) (2012).

109. PATRICIA DAVIS, CONG. RES. SERV., R40082, MEDICARE PART B PREMIUMS 1, 2014.

110. 42 U.S.C. § 1395r(a)(1).

111. *Medicare 2015 Costs at a Glance*, *supra* note 41.

112. 42 U.S.C. § 1395r(a)(1), (3); see 2015 MEDICARE HANDBOOK, *supra* note 9, at ¶ 6.02[C][1], at 6–11.

113. DAVIS, *supra* note 109.

114. Jeanne Sahadi, *43% Pay No Federal Income Taxes*, CNN (Aug. 29, 2013), <http://money.cnn.com/2013/08/29/pf/taxes/who-doesnt-pay-federal-income-taxes/>.

115. See *Original Medicare (Part A & B) Eligibility and Enrollment*, CTRS. FOR MEDICARE & MEDICAID SERVS., <http://www.cms.gov/Medicare/Eligibility-and-Enrollment/OrigMedicarePartAEligEnrol> (explaining that individuals residing in the United States who become entitled to premium-free Part A are automatically enrolled in Part B).

116. See *Labor Force Statistics from the Current Population Survey*, BUREAU OF LABOR STATS., <http://data.bls.gov/timeseries/LNU02000097> (showing that over eight million Americans ages 65 and older are employed).

117. See Kaplan, *supra* note 100, at 1, 4.

becoming eligible for Part B the person did not enroll in that program.¹¹⁸ On the other hand, if a person never enrolls in Part B, no delayed enrollment penalty is applicable.

In any case, the substantial subsidization referenced above is reduced for upper-income enrollees.¹¹⁹ All such enrollees continue to receive some subsidy from the federal government, but the amount of their subsidy is reduced depending on how much their annual income,¹²⁰ as determined for federal income tax purposes,¹²¹ exceeds certain thresholds. Those thresholds begin at \$85,000 and rise in four steps to \$214,000.¹²² These thresholds are doubled for married couples¹²³ and are adjusted annually for inflation.¹²⁴ The ACA, however, froze those thresholds until the year 2020.¹²⁵ Though the precise workings of this subsidy reduction need not concern us here,¹²⁶ the point remains that all enrollees in Medicare Part B pay only a portion—generally, a minor portion—of that program's costs.

As with Medicare Part A, an enrollee who receives benefits under Part B has some cost exposure from certain copayment obligations. Beyond an annual deductible¹²⁷ that is adjusted annually (\$147 in 2015),¹²⁸ Medicare Part B beneficiaries pay 20% of any doctors' fees covered by Medicare.¹²⁹ So, if Medicare approves \$150 as the doctor's fee for a particular consultation, the patient owes \$30 (\$150 × 20%) for this service.¹³⁰ This 80%–20% split is common in private health insurance policies, though many such plans employ fixed-dollar amounts, such as \$20 per doctor visit, to implement their cost-

118. 42 U.S.C. § 1395r(b) (2012).

119. See Richard L. Kaplan, *Means-Testing Medicare: Retiree Pain for Little Governmental Gain*, 2006 J. RETIREMENT PLAN. 22 (2006).

120. 42 U.S.C. § 1395r(i)(1).

121. *Id.* § 1395r(i)(4). For this purpose, certain adjustments are made, such as adding otherwise tax-exempt interest income. *Id.* § 1395r(i)(4)(A)(ii).

122. See *Part B Costs*, MEDICARE.GOV, <http://www.medicare.gov/your-medicare-costs/part-b-costs/part-b-costs.html>.

123. 42 U.S.C. § 1395r(i)(2)(B).

124. *Id.* § 1395r(i)(5).

125. *Id.* § 1395r(i)(6), enacted in the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 3402(4), 124 Stat. 119, 489 (2010).

126. For an illustration of how this subsidy reduction is calculated, see FROLIK & KAPLAN, *supra* note 9, at 63.

127. 42 U.S.C. § 1395l(b) (2012).

128. See *Part B Costs*, MEDICARE.GOV, <http://www.medicare.gov/your-medicare-costs/part-b-costs/part-b-costs.html>.

129. 42 U.S.C. §§ 1395l(a)(1), 1395x(s)(1) (2012).

130. The significance of Medicare's approved rate charges is explained in FROLIK & KAPLAN, *supra* note 9, at 82.

sharing objectives.¹³¹

More significantly, private health insurance plans almost always have a “stop loss”¹³² provision, but Medicare Part B does not. Accordingly, a patient who sees many physicians in a given year faces an unlimited cost-sharing obligation under this program. On the other hand, the 20% copayment obligation under Medicare Part B is one of the “core” benefits that are included in every “Medigap” policy,¹³³ which is another reason why so many Medicare beneficiaries obtain such supplementary coverage.

C. The Managed Care Alternative: Part C

As managed care plans were introduced into the private health insurance marketplace, this option became available to Medicare beneficiaries on a contractual basis.¹³⁴ This approach was formalized in Medicare Part C as “Medicare + Choice”¹³⁵ and then re-labeled “Medicare Advantage”¹³⁶ as part of the George W. Bush Administration’s initiative to boost enrollment in such plans. But regardless of the specific appellation, Medicare’s managed care program essentially parallels its private sector counterpart.

For example, Medicare managed care plans promise better coordination of care and simpler paperwork when claiming benefits in exchange for restricting their enrollees to specific doctors, hospitals, home health agencies, and usually pharmacies as well.¹³⁷ Older Americans often have established relationships with numerous physicians, so such restrictions may present a difficult dilemma. Perhaps that is why managed care plans represent only a minority of Medicare beneficiaries—approximately three in ten according to the most recent data available.¹³⁸

On the other hand, Medicare managed care represents a major simplification of elders’ health care financing by substituting a

131. BEN G. BALDWIN, *THE LAWYER’S GUIDE TO INSURANCE* 84 (1999).

132. *Id.* at 67–68.

133. FROLIK & KAPLAN, *supra* note 9, at 102; *MEDICARE & YOU*, *supra* note 54, at 93.

134. See MARILYN MOON, *MEDICARE: A POLICY PRIMER* 68 (2006).

135. 42 U.S.C. § 1395w–21 (2012). (added by Balanced Budget Act of 1997, Pub. L. No. 105–33, § 4001, 111 Stat. 251, 275–327).

136. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108–173, § 201(b), 117 Stat. 2066, 2176.

137. See FROLIK & KAPLAN, *supra* note 9, at 105.

138. *Medicare at a Glance*, THE HENRY J. KAISER FAMILY FOUND. (2014), <http://kff.org/medicare/fact-sheet/medicare-at-a-glance-fact-sheet/>.

monthly premium and modest copayments for Medicare's convoluted array of annual deductibles and unlimited coinsurance obligations.¹³⁹ Managed care also eliminates the need for supplemental "Medigap" policies and their related claims-filing procedures.¹⁴⁰ Moreover, Medicare managed care plans offer benefits that historically were not available in "traditional" Medicare, such as annual physical examinations and prescription drugs.¹⁴¹ Indeed, access to such drugs was a major reason that many older Americans enrolled in managed care plans before Medicare Part D became effective in 2006.¹⁴² Even today, managed care plans provide a variety of benefits that Medicare generally does not, including vision and dental care,¹⁴³ exercise classes,¹⁴⁴ and other services that are intended to keep enrollees healthy.

In any case, a serious drawback to Medicare managed care arrangements has been the scope of providers included and, often, the availability of this option itself. These arrangements necessarily exclude certain health care providers, and changes in a plan's roster occur annually.¹⁴⁵ Though enrollment in a Medicare Part C plan is only for the calendar year and enrollees may switch plans during the annual open enrollment period,¹⁴⁶ the need to monitor who is in and out of each plan creates additional hassles for enrollees who want to continue using particular health care providers.

Medicare managed care plans similarly commit only for the plan year and may choose not to remain in the program after that year ends.¹⁴⁷ When that happens, enrollees in the former plan must make

139. See FROLIK & KAPLAN, *supra* note 9, at 105.

140. *Id.*

141. See Timothy S. Jost, *Public Financing of Pain Management: Leaky Umbrellas and Ragged Safety Nets*, 26 J. L. MED. & ETHICS 296, 290-307 (1998) (describing the additional prescription drug benefits available with managed care plans).

142. See Nancy Ann Jeffery, *Seniors in Medicare HMOs Should Know the Drugs That Prescription Plans Cover*, WALL ST. J., May 16, 1997, at C1; Melynda Dovel Wilcox, *Choosing a Medicare HMO*, KIPLINGER'S PERSONAL FIN., Aug. 1996, at 73.

143. See FROLIK & KAPLAN, *supra* note 9, at 106; see also Amanda McCluskey Schwob, Note, *Open Wide—I Meant Your Pocketbook: Repercussions of the Dental Exclusion to the Medicare Act*, 9 ELDER L.J. 83 (2001).

144. See Alicia L. Cooper & Amal N. Trivedi, *Fitness Memberships and Favorable Selection in Medicare Advantage Plans*, 366 NEW ENG. J. MED. 150 (2012).

145. See FROLIK & KAPLAN, *supra* note 9, at 106-7.

146. The annual enrollment period is October 15 to December 7. 42 U.S.C. § 1395w-21(e)(3)(B)(v) (2012).

147. Mary Laschober, *Estimating Medicare Advantage Lock-In Provisions Impact on Vulnerable Medicare Beneficiaries*, 26 HEALTH CARE FINANCING REV. 63, 63 (2005), available at <http://www.cms.gov/Research-statistics-Data-and-Systems/Research/HealthCareFinancingReview/downloads/05springpg63.pdf>.

other arrangements for the coming plan year and may not find an acceptable Medicare Part C plan in their service area.¹⁴⁸ In that circumstance, these enrollees must return to “traditional” Medicare with all of its complexity and probably obtain a “Medigap” policy to cover related deductibles and other cost-sharing expenses. At that point, however, some former managed care plan enrollees might be precluded from securing the “Medigap” policies they want due to then-existing medical conditions.¹⁴⁹

D. Adding Prescription Drugs: Part D

No single aspect of Medicare better illustrates the ossification of its programmatic development than the failure to provide generally available coverage of prescription medications until Medicare Part D took effect in 2006¹⁵⁰—four decades after Medicare was enacted! During those intervening years, pharmacological innovations included important maintenance drugs for a wide range of chronic conditions that often affect the Medicare population, such as arthritis, asthma, diabetes, heart disease, and hypertension, among others.¹⁵¹

Moreover, when Part D was finally created, it reflected a very different orientation than Medicare Parts A and B regarding the role of government and the appeal of personal choice.¹⁵² Instead, Part D is a quasi-voucher approach that provides subsidies to private prescription drug plans that compete on various parameters including monthly premiums, specific drug coverage, pharmacy location, and

148. See John Rother, *Advocating for a Medicare Prescription Drug Benefit*, 3 YALE J. HEALTH POL’Y L. & ETHICS 279, 283 (2003); Michael Waldholz, *Medicare Seniors Face Confusion as HMOs Bail Out of Program*, WALL ST. J., Oct. 3, 2002, at D4.

149. Federal law provides that persons who apply for “Medigap” coverage during their first six months of enrollment in Medicare Part B cannot be declined on the basis of pre-existing medical conditions. 42 U.S.C. § 1395ss(s)(2)(A). But after that period, only four specific “Medigap” policy types are available regardless of an applicant’s medical condition. Id. § 1395ss(s)(3)(A), (B)(iii), (C)(i).

150. 42 U.S.C. § 1395w-102, enacted in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108–173, § 101(a)(2), 117 Stat. 2066, 2071–2150.

151. See N. LEE RUCKER, AARP PUB. POL’Y INST., MEDICARE’S PART D’S MEDICATION THERAPY MANAGEMENT: SHIFTING FROM NEUTRAL TO DRIVE, (2012), available at http://www.aarp.org/content/dam/aarp/research/public_policy_institute/health/medicare-part-d-shifting-from-neutral-to-drive-insight-AARP-ppi-health.pdf.

152. For an explanation of how this provision developed, see Richard L. Kaplan, *The Medicare Drug Benefit: A Prescription for Confusion*, 1 NAELA J. 167, 170–72 (2005) [hereinafter *Medicare Drug Benefit*].

other factors.¹⁵³ During the annual open enrollment period, new plans become available to Medicare enrollees, though the precise number of different plans that are available to any given enrollee depends upon his or her state of residence.¹⁵⁴

Medicare Part D plans regularly change their offerings to attract a financially optimal mix of enrollees. Thus, some plans offer only certain drugs and in specific dosage amounts and frequencies.¹⁵⁵ For example, one plan might cover 40 milligrams of Lipitor® twice a day while another plan covers 80 milligrams of that same drug once a day, and a third plan does not cover this drug at all. The following year, all three plans might change their offerings in this and other important respects. Indeed, some plan providers might withdraw from the Medicare program entirely, reminiscent of the Medicare managed care plans considered immediately above.

That said, Medicare Part D's plethora of choices has generally been popular with enrollees, despite its inherent complexity and curious financial structure.¹⁵⁶ This latter aspect has been the focus of persistent confusion and annoyance, because it resembles no other prescription drug benefit in private or other governmental programs. First, there is no single cost structure attached to Medicare Part D.¹⁵⁷ There is a four-part prototype, but individual plans can alter its format or disregard it entirely as long as their alternative structure is "actuarially equivalent" to the prototype.¹⁵⁸ So, for example, the prototype includes an annual deductible that is increased every year

153. See *Medicare Plan Finder*, MEDICARE.GOV., <https://medicare.gov/find-a-plan/questions/home.aspx>.

154. JACK HOADLEY ET AL., *MEDICARE PART D: A FIRST LOOK AT PLAN OFFERINGS IN 2015* 2, 13–14 (2014), available at <http://files.kff.org/attachment/medicare-part-d-a-first-look-at-plan-offerings-in-2015-issue-brief>.

155. *Medicare Part D Plans*, EHEALTH, <http://www.ehealthinsurance.com/medicare/part-d> (last visited Feb. 23, 2015).

156. See KRC RESEARCH, *SENIORS' OPINIONS ABOUT MEDICARE PRESCRIPTION DRUG COVERAGE 13* (2013), available at <http://www.medicaretoday.org/MT2013/KRC%20Survey%20of%20Seniors%20for%20Medicare%20Today%20%20FINAL.pdf> (reporting that 90% of seniors are "satisfied" with Medicare Part D, including 59% who are "very satisfied").

157. *Medicare 2015 Costs at a Glance*, *supra* note 43.

158. 42 U.S.C. § 1395w-102(a)(1)(B), (c)(1) (2012).

for inflation.¹⁵⁹ In 2015, this deductible is \$320,¹⁶⁰ but 42% of Medicare Part D plans do not have a deductible this year.¹⁶¹

Second, the prototype provides three coverage tiers after the annual deductible, and those coverage tiers are based on cumulative drug expenses for the plan year.¹⁶² That is, the amount that an enrollee pays for a given prescription depends upon how much that person has spent up to that point. So, after the annual deductible is met, the first coverage tier extends until annual drug costs reach \$2,960 (in 2015)¹⁶³ and includes a 25% copayment obligation for those costs.¹⁶⁴ At that point, a coverage gap known colloquially as the “donut hole” begins¹⁶⁵ and continues until the enrollee’s annual drug costs reach \$7,062 (in 2015).¹⁶⁶ Beyond that point is a catastrophic coverage tier, which limits an enrollee’s copayment to 5% of any further prescription drug expenses.¹⁶⁷

As originally designed, the “donut hole” was equivalent to a 100% copayment tier, a phenomenon that had no intrinsic logic or economic justification and was simply a result of the conflicting political factors that led to Medicare Part D’s enactment.¹⁶⁸ Many Medicare beneficiaries find themselves in this “donut hole,” and that is why seniors’ advocacy groups made addressing this coverage gap a key policy objective when the ACA was being developed.¹⁶⁹ But the most critical point here is that the Medicare Part D prototype plan has no maximum cost exposure for its enrollees.¹⁷⁰

Apart from the cost exposure associated with the “donut hole,” Medicare Part D plans require monthly premiums that vary by the

159. *Id.* § 1395w-102(b)(1)(A)(ii), (6).

160. Q1 Group LLC, *Education and Decision Support Tools for the Medicare Community*, Q1 MEDICARE.COM, <http://www.q1medicare.com/PartD-The-2015-Medicare-Part-D-Outlook.php> (last visited Feb. 23, 2015).

161. HOADLEY ET AL., *supra* note 154, at 7.

162. Amy Rubino, *Covering the Bases: Costs of Medicare Part D, phasing out the ‘doughnut hole,’* CAPITAL GAZETTE, Nov. 9, 2014, <http://www.capitalgazette.com/lifestyle/health/ph-ac-cl-covering-1109-20141109,0,6862756.story>.

163. Q1 Group LLC, *supra* note 160.

164. 42 U.S.C. § 1395w-102(b)(2)(A), (3)(A) (2012).

165. *Id.* § 1395w-102(b)(4)(B).

166. Q1 Group LLC, *supra* note 160.

167. 42 U.S.C. § 1395w-102(b)(4)(A)(i)(II).

168. *See Medicare Drug Benefit, supra* note 152, at 172; Thomas R. Oliver et al., *A Political History of Medicare and Prescription Drug Coverage*, 82 MILBANK Q. 283, 317 (2004).

169. 42 U.S.C. § 1395w-102(b)(4)(A)(i)(II).

170. *Id.*

scope of the plan selected and range in 2015 from \$12.60 to \$171.90.¹⁷¹ Higher-cost plans often eliminate the “donut hole” and feature copayments that stay the same throughout the plan year rather than as prescription costs accumulate.¹⁷²

Be that as it may, no older person is required to purchase any Medicare prescription drug coverage. While elders tend to be heavier users of pharmacological interventions than the general public,¹⁷³ not every elder is in this category. Similar to the structure that pertains to Medicare Part B,¹⁷⁴ an elder can decline to obtain a prescription drug plan under Medicare Part D until some later date, but a delayed enrollment penalty¹⁷⁵ may apply if the elder did not have “creditable” coverage before then.¹⁷⁶ Of course, if the elder never purchases prescription drug coverage under Medicare Part D, no delayed enrollment penalty will apply.

E. Summary

To summarize the current situation, retirees who become eligible for Medicare benefits must make a number of important decisions, including:

1. Whether to enroll in Part B presently or wait until some later year and incur a delayed enrollment penalty.
2. Whether to purchase a supplemental “Medigap” policy to cover the unlimited cost exposure of Parts A and B.
3. If a “Medigap” policy is desired, which one of the ten benefit packages is most appropriate?
4. Whether to enroll in Part D presently or wait until some later year and incur a delayed enrollment penalty.

171. See HOADLEY ET AL., *supra* note 154, at 15.

172. See THE HENRY J. KAISER FAMILY FOUND., THE MEDICARE PRESCRIPTION DRUG BENEFIT FACT SHEET (2014), available at kff.org/medicare/fact-sheet/the-medicare-prescription-drug-benefit-fact-sheet/.

173. See HOADLEY ET AL., *supra* note 154, at 15.

174. See *supra* text accompanying notes 114-17.

175. 42 U.S.C. § 1395w-113(b)(1), (3)(A) (2012). The calculation of this penalty is illustrated in FROLIK & KAPLAN, *supra* note 9, at 89.

176. 42 U.S.C. § 1395w-113(b)(2). “Creditable” coverage meets or exceeds the actuarial value of Medicare’s Part D coverage. *Id.* § 1395w-113(b)(5).

5. If a Part D plan is desired, which one of the various plans available is most appropriate in light of current and anticipated drug regimens?
6. Whether to opt for a managed care plan under Medicare Part C in lieu of Parts A, B and D plus a “Medigap” policy.
7. If a Part C plan is desired, which one of the various plans available is most appropriate in terms of current health care provider relationships?

II. Impact of the Affordable Care Act on Medicare

Against the backdrop set forth in the prior section, this Article now turns to one of the most complicated and comprehensive pieces of social legislation enacted in the United States in many decades—namely, the ACA.¹⁷⁷ Given the staggering scope of the ACA and the signal importance of Medicare in the U.S. health care financing system, it is inconceivable that the ACA would not affect Medicare in some significant ways. This likelihood is increased further by the extraordinary interest of older Americans in how their health care needs are met as well as their out-sized role in national elections.¹⁷⁸

Similarly, expanding coverage to one subset of the U.S. population necessarily affects existing coverages of other subsets of the population. Thus, increasing health insurance coverage for younger Americans might impact existing governmental support for the health care needs of older Americans. In this context, this Article now analyzes how the ACA changed Medicare and then considers what the ACA did not change regarding this program.

A. What the Affordable Care Act Changed

From the perspective of a beneficiary in the Medicare program, the ACA made significant changes in four discrete areas, to wit:

177. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010).

178. See, e.g., Gerard F. Seib, *Entitlement Costs Are Out of Sight, Out of Mind*, WALL ST. J., Feb. 10, 2015, at A4 (noting the influence of voters age 65 years and older on recent election results); U.S. CENSUS BUREAU, *Table 399. Voting-Age Population—Reported Registration and Voting by Selected Characteristics: 1996 to 2010*, in STATISTICAL ABSTRACT OF THE U.S.: 2012, 246, available at <http://www.census.gov/compendia/statab/2012/tables/12s0399.pdf>. See also Emily Brandon, *Why Older Citizens are More Likely to Vote*, U.S. NEWS & WORLD REPORT, Mar. 19, 2012, <http://money.usnews.com/money/retirement/articles/2012/03/19/why-older-citizens-are-more-likely-to-vote>.

(1) prescription drugs, (2) wellness visits, (3) managed care, and (4) program financing.

1. PRESCRIPTION DRUGS

As explained above, when prescription drugs were finally included in Medicare, the structure of the benefit provided was highly unusual and unlike any comparable coverage in the United States, whether in private or public plans. The single most peculiar aspect of the benefit structure was the “donut hole.”¹⁷⁹ The effort to address this programmatic anomaly came to fruition in the ACA, but on an extended phase-in schedule that actually increases the drug benefit’s complexity through dichotomous treatment of generic and brand-name medications.¹⁸⁰

First, it should be noted that the ACA made no attempt to rethink or redesign the basic Medicare Part D prototype. Thus, an annual deductible¹⁸¹ that is increased each year for inflation, a coverage tier with a 25% copayment obligation,¹⁸² a coverage gap or “donut hole,”¹⁸³ and then a catastrophic coverage tier¹⁸⁴ all remain. Only the “donut hole” was affected by the ACA.

Second, the “donut hole” is *modified* but not filled. A significant copayment obligation of 25% remains even after the ACA’s changes are fully effective,¹⁸⁵ but it will be no higher than 25% and will therefore correspond to the first coverage tier. This change is genuine progress and results in a more sensible structure: an annual deductible, followed by a large coverage tier with a 25% copayment obligation, followed by the current law’s catastrophic coverage tier. On both cost exposure and simplification grounds, the ACA’s change represents a major improvement in Medicare Part D’s basic structure.

On the other hand, this change is phased in over a decade and

179. See *Costs in the Coverage Gap*, MEDICARE.GOV, <http://www.medicare.gov/part-d/costs/coverage-gap/part-d-coverage-gap.html> (last visited Feb. 23, 2015).

180. 42 U.S.C. § 1395w-102(b)(2)(C)(ii) (generic drugs), (D)(i)(I), (ii) (brand-name drugs) (enacted by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, § 1101(b)(3), 124 Stat. 1029, 1038-39 (2010)).

181. 42 U.S.C. § 1395w-102(b)(1) (2012).

182. *Id.* § 1395w-102(b)(2)(A), (3)(A).

183. *Id.* § 1395w-102(b)(4)(B).

184. *Id.* § 1395w-102(b)(4)(A)(i)(II).

185. *Id.* § 1395w-102(b)(2)(C)(ii) (generic drugs), (D)(i)(I), (ii) (brand-name drugs) (enacted by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, § 1101(b)(3), 124 Stat. 1029, 1037-38).

the copayment obligation does not reach 25% until the year 2020.¹⁸⁶ More peculiarly, this phase-in schedule differs for brand-name and generic medications¹⁸⁷—a distinction that Medicare Part D did not make prior to the ACA. The phase-in process began in 2011 and continues according to the following table:¹⁸⁸

Table 1. Enrollee Copayment for Prescription Drugs in the Donut Hole

<i>Year</i>	<i>Brand-Name</i>	<i>Generic</i>
2015	45%	65%
2016	45%	58%
2017	40%	51%
2018	35%	44%
2019	30%	37%

Note that Medicare Part D continues to base its coverage on a patient's cumulative expenditures for prescription drugs for the year, a complicating feature that most health care plans eschew in favor of fixed copayments for different types of drugs, e.g., generic, brand-name preferred, brand-name not preferred, and not covered. To be sure, these classifications provide their own complications when trying to determine a person's cost for any given prescription, but at least that cost exposure does not vary over the course of the year once the plan's annual deductible has been satisfied. That is, once a plan's annual deductible is met, the copayment for Lipitor® is a fixed dollar amount, in contrast to Medicare Part D's copayment of 25% until the

186. *See id.*

187. Adapted by author from MEDICARE RIGHTS CTR., *The Affordable Care Act: Closing the Doughnut Hole*, 1–2 (last modified Jan. 1, 2014), available at <http://www.medicarerights.org/pdf/Closing-the-Doughnut-Hole-Chart.pdf>.

188. *Id.*

enrollee's cumulative drug costs for that year reach the catastrophic coverage tier, after which the copayment drops to 5%.¹⁸⁹

Moreover, Medicare Part D continues to require an enrollee to decide annually whether to obtain drug coverage at all and, if so, which of several distinct plans to choose. In other words, the phenomenon of choice overload in Medicare's prescription drug coverage was not ameliorated by the ACA.

2. WELLNESS VISITS

The ACA took a small step away from Medicare's historical orientation of sickness care toward the modern orientation of health maintenance or prevention by adding "annual wellness visits" to the list of benefits that are available under Medicare Part B.¹⁹⁰ These visits consist of forward-looking assessments of a Medicare enrollee's medical condition and feature various biometrical measurements, such as body mass index and blood pressure,¹⁹¹ as well as cognitive impairment examinations¹⁹² and plans for screening tests to be completed over the next five to ten years.¹⁹³ These services are provided under the rubric of a "personalized prevention plan"¹⁹⁴ and impose no cost on the enrollee.¹⁹⁵ That such periodic reviews of an older person's medical condition were not a regular feature of Medicare's coverage until that program was 45 years old speaks volumes about the frightfully outdated orientation of Medicare.¹⁹⁶ Nevertheless, it is better late than never, as these wellness visits clearly move Medicare in the right direction.

3. MANAGED CARE PLANS

Although Medicare managed care accords with many enrollees' desire to obtain the bulk of their health insurance coverages from a

189. 42 U.S.C. § 1395w-102(b)(4)(A)(i)(II) (2012).

190. *Id.* § 1395x(hhh).

191. *Id.* § 1395x(hhh)(2)(C).

192. *Id.* § 1395x(hhh)(2)(D).

193. *Id.* § 1395x(hhh)(2)(E)(i).

194. *Id.* § 1395x(hhh)(1).

195. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 4103(c)(1), (3), (4), 124 Stat. 119, 555-56 (2010).

196. An "initial preventive physical examination" is provided when a person first enrolls in Medicare Part B, but that feature was not added until 2003. *See* 42 U.S.C. § 1395x(ww) (2012) (added by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, § 611(b), 117 Stat. 2066, 2303-04).

single source, the creators of the ACA had an almost visceral distaste for Medicare managed care arrangements.¹⁹⁷ This antipathy stemmed in part from a genuine policy preference for universally oriented insurance schemes that put everyone in a common risk pool.¹⁹⁸ Persons with this policy preference see managed care as atomizing the insurance pool into segments so certain plans can skim off the healthier and therefore less costly Medicare beneficiaries and leave the less healthy and therefore more costly beneficiaries in the “traditional” Medicare program.¹⁹⁹ This process then increases the per-beneficiary cost of the “traditional” Medicare program.

To this point, the ACA’s proponents sought to reverse policies enacted only a few years earlier during the George W. Bush Administration that promoted Medicare managed care plans at the expense of “traditional” Medicare.²⁰⁰ Under those policies, managed care plans were given financial incentives to boost their enrollment of Medicare beneficiaries.²⁰¹ These policies were quite effective, largely because the federal government was overpaying for those beneficiaries.²⁰² At the time the ACA was being developed, Medicare was paying approximately 14% more per beneficiary for each managed care plan enrollee.²⁰³

Accordingly, the ACA imposed new cost controls and other financial constrictions on Medicare Advantage plans. New mandates for maintaining minimum expenditure levels for patient care, called “medical loss ratios,”²⁰⁴ and similar provisions are intended to reduce the appeal of Medicare managed care to provider organizations. These requirements, it should be noted, apply exclusively at the provider level²⁰⁵ and do not directly affect Medicare beneficiaries but

197. Nicholas Bagley, *Bedside Bureaucrats: Why Medicare Reform Hasn't Worked*, 101 GEO. L. J. 519 (2013).

198. Jordan Rau, *Research Finds Link Between Poor Health And Seniors Switching Out of Private Medicare Plans*, KAISER HEALTH NEWS (Feb. 4, 2013), <http://kaiserhealthnews.org/news/medicare-advantage-disenrollment>.

199. *Id.*

200. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub L. No. 108–173, § 211, 117 Stat. 2066, 2176–80.

201. *Id.*

202. OFFICE OF HEALTH REFORM, DEPT. OF HEALTH & HUMAN SERVS., HEALTH INS. REFORM & MEDICARE: MAKING MEDICARE STRONGER FOR AMERICA’S SENIORS 1, available at <http://www.healthreform.gov/reports/medicare/medicare.pdf>.

203. *Id.*

204. 42 U.S.C. § 1395w-27(e)(4) (2012) (requiring a minimum ratio of 85%).

205. See, e.g., Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111–152, § 1102(b)-(e), 124 Stat. 1029, 1040–46 (changing applicable payment benchmarks and quality ranking system).

will impact them indirectly through higher costs and fewer health care financing options.²⁰⁶ In fact, the ACA prohibits Medicare Advantage plans from discontinuing any “guaranteed Medicare benefits,”²⁰⁷ which are basically the benefits that are provided by “traditional” Medicare. Managed care plans are free, however, to discontinue the “extra” benefits that they typically provide,²⁰⁸ such as eyeglasses, hearing aids, exercise classes, and gym memberships. In response, some Medicare Advantage plans may drop these non-“guaranteed” benefits, raise premiums, or even discontinue their participation in the Medicare program entirely.²⁰⁹ Should these changes occur, they should not be considered unintended consequences because the ACA intentionally sought to preference “traditional” Medicare over Medicare managed care arrangements.²¹⁰

4. FINANCES OF MEDICARE

In addition to the financial impact on Medicare managed care plans just described, the ACA used Medicare more generally to fund the ACA’s insurance expansion initiatives for the pre-Medicare population.²¹¹ This transfer of resources from Medicare enrollees to younger cohorts—a point of major and often misleading contention during the 2012 Presidential election campaign—represented an unprecedented intergenerational shift in the allocation of health care

206. See ROBERT A. BOOK & JAMES C. CAPRETTA, REDUCTIONS IN MEDICARE ADVANTAGE PAYMENTS: THE IMPACT ON SENIORS BY REGION (2010), available at http://thf_media.s3.amazonaws.com/2010/pdf/bg2464.pdf (analyzing the impact of the ACA’s changes on Medicare beneficiaries).

207. See CTR. FOR MEDICARE & MEDICAID SERVS. *Medicare and the New Health Care Law—What It Means for You*, (2010), available at www.cardin.senate.gov/download.health-care-reform-for-seniors.

208. See, e.g., Janet Adamy, *Health Law Augurs Transfer of Funds from Old to Young*, WALL ST. J., July 26, 2010, at A1 (reporting that Medicare Advantage plans “are preparing to pare dental, vision and certain prescription-drug coverage”).

209. See Avery Johnson, *Private Medicare Plans Are Retrenching*, WALL ST. J., Nov. 19, 2010, at B1 (reporting that some Medicare Advantage plans are closing down in response to the ACA, displacing 700,000 enrollees).

210. Indeed, when the ACA was being considered, Medicare’s Chief Actuary predicted that enrollment in Medicare Advantage plans would decline by half when the ACA’s cuts were fully implemented. See Richard S. Foster, *Estimated Financial Effects of the “Patient Protection and Affordable Care Act,” as Amended*, CTRS. FOR MEDICARE & MEDICAID SERVICES, OFFICE OF THE ACTUARY 11 (Apr. 22, 2010), available at http://www.cms.gov/ActuarialStudies/Downloads/PPACA_2010-04-22.pdf.

211. See *id.* at 4.

resources in this direction.²¹²

The ACA accomplished this transfer first by reducing Medicare's reimbursement rates to health care providers other than physicians; i.e., hospitals, nursing homes, and home health agencies.²¹³ Such rate reductions do not apply to physicians, because their fees had already been reduced for purposes unrelated to funding the ACA.²¹⁴ Those rate reductions comprise the ongoing budget charade known as the "doc fix," whereby reductions in Medicare's payments to doctors are postponed to avoid having doctors decline or severely limit their acceptance of Medicare patients.²¹⁵ Recent survey data show that increasing numbers of U.S. physicians have reacted to these perennially threatened fee reductions by limiting the number of Medicare beneficiaries they accept as patients²¹⁶—a phenomenon that is extremely sensitive to those beneficiaries. After all, Medicare's health insurance is less appealing if the pool of available providers is constricted.

The ACA also seeks to reduce future Medicare expenditures through a potentially frightful mechanism known as the Independent Payment Advisory Board (IPAB).²¹⁷ The IPAB is charged with reducing the per-person rate of growth in Medicare expenditures,²¹⁸

212. See Richard L. Kaplan, *Intergenerational Conflicts in the U.S. Health Care Reform Law: Allocating Health Care Resources in an Ageing Society*, in INTERNATIONAL AND COMPARATIVE LAW ON THE RIGHTS OF OLDER PERSONS 111 (Ralph Ruebner et al. eds., 2015).

213. See Jessica Banthin et al., *Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision*, CONGRESSIONAL BUDGET OFFICE (July 24, 2012), available at <http://www.cbo.gov/sites/default/files/cbofiles/attachments/43472-07-24-2012-CoverageEstimates.pdf>.

214. KENT CLEMENS, CTRS. FOR MEDICARE & MEDICAID SERVS. ESTIMATED SUSTAINABLE GROWTH RATE AND CONVERSION FACTOR, FOR MEDICARE PAYMENTS TO PHYSICIANS IN 2015, (2014), available at <http://www.cms.gov/Medicare/Medicare-Fee-For-Service-Payment/SustainableGRatesConFact/Downloads/sgr2015.pdf>.

215. See Mike Shields, *U.S. Senate Votes to Delay ICD-10 and Medicare Doc Cuts*, KANSAS HEALTH INST. (Apr. 1, 2014), <http://www.khi.org/news/article/us-senate-votes-delay-icd-10-and-medicare-doc-cuts/>. Under legislation enacted on April 16, 2015, these payment reductions were eliminated. See Medicare Access and CHIP Authorization Act of 2015, Pub. L. No. 114-10, § 101(a)(1).

216. See THE PHYSICIANS FOUND., 2014 SURVEY OF AMERICA'S PHYSICIANS 54 (2014), available at http://www.physiciansfoundation.org/uploads/default/2014_Physicians_Foundation_Biennial_Physician_Survey_Report.pdf (reporting that "[a]bout a quarter of physicians . . . no longer see Medicare patients or limit the number they see," including 34.1% of primary care physicians).

217. See 42 U.S.C. § 1395kkk(a) (2012).

218. See generally Timothy S. Jost, *The Independent Payment Advisory Board*, 363 NEW ENG. J. MED. 103 (2010).

though the enabling legislation did not indicate how the Board should accomplish this ever-elusive goal. The statute does, however, authorize the IPAB to devise policy changes that lower the cost of Medicare,²¹⁹ and those policy changes can then be implemented without requiring approval from Congress.²²⁰ For example, the IPAB could simply declare that Medicare will no longer pay for some critical medical procedure.

In point of fact, the ACA states that the Board may not “ration health care, raise revenues or Medicare beneficiary premiums . . . increase Medicare beneficiary cost-sharing (including deductibles, coinsurance and copayments), or otherwise restrict benefits or modify eligibility criteria.”²²¹ So, what *can* the IPAB do? The answer is not clear, but reducing provider reimbursement rates seems to be one of the few, if not the only, cost control mechanism that the statute allows, notwithstanding the possible negative effects such reductions will have on Medicare beneficiary access to health care providers.²²² President Obama has not named any of the 15 appointees he is charged with making to this controversial body²²³ and has not announced any plans for doing so thus far. Nonetheless, the IPAB continues to exist as a matter of law and can lower Medicare’s expenditures whenever it becomes operational.

Another mechanism the ACA uses to transfer resources from Medicare is a new tax on “net investment income.”²²⁴ This tax is imposed at the same 3.8% rate²²⁵ that applies to the wages and salaries of upper-income taxpayers to pay for their Medicare Part A entitlement.²²⁶ In fact, this new tax on non-wage income such as interest, dividends, capital gains, annuities, and the like²²⁷ is officially labeled the “Unearned Income Medicare Contribution.”²²⁸ That appellation notwithstanding, the revenues derived from this tax do

219. 42 U.S.C. § 1395kkk(b)(2).

220. *Id.* § 1395kkk(b)(3).

221. *Id.* § 1395kkk(c)(2)(A)(ii).

222. See 2014 SURVEY OF AMERICA’S PHYSICIANS, *supra* note 216.

223. 42 U.S.C. § 1395kkk(g)(1)(A)(i) (2012). The Board was to begin making recommendations in 2014. *Id.* § 1395kkk(c)(1)(B).

224. I.R.C. § 1411(a)(1)(A) (2012).

225. *Id.* § 1411(a)(1).

226. 2.9% Medicare tax + 0.9% surcharge on income over \$200,000 = 3.8%. See *id.* §§ 1401(b)(1), (2)(A) (self-employed), 3101(b)(1), (2), 3111(b)(6) (employees and employers).

227. *Id.* § 1411(c)(1)(A)(i), (iii).

228. Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111–152, § 1402(a)(1), adding Chapter 2A to the Internal Revenue Code.

not help fund Medicare, but go instead into the federal government's general revenues where they can be used to pay, inter alia, for the ACA's outlays.²²⁹ In other words, a newly created revenue source that is denominated a "Medicare contribution" helps fund the ACA rather than Medicare per se.

B. What the Affordable Care Act Did Not Change

Perhaps the most significant aspect of the ACA in terms of Medicare was what it did not change—namely, the basic structure of Medicare Parts A through D, the continuing need for supplemental insurance if the managed care option of Medicare Part C is not selected, and the maddening array of ever-rising deductibles and copayment obligations. The ACA was the most comprehensive health reform legislation since Medicare and Medicaid were enacted in 1965, and yet its impact on the basic design of Medicare was minimal. To be fair, the ACA's major objective was expanding health insurance to the previously uninsured—a situation that does not really apply to older Americans because of Medicare. But the fact remains that, apart from the financing effects delineated above,²³⁰ the contours of the Medicare program itself, as well as most of the subcategories of Medicare's coverage, were essentially unaffected by the ACA.

In one area, however, the ACA did attempt an important expansion of benefits pertaining to long-term care, but it did so outside of Medicare's framework. Specifically, the ACA authorized a new program to cover some long-term care services for people who enroll at least five years prior to needing these services.²³¹ Denominated the Community Living Assistance Services and Supports,²³² or CLASS, this program provided modest benefits that could cover several hours of home health care and certain community-based services like adult day care.²³³ It was not, however,

229. Lewis Stewart, *What 3.8 Medicare Surtax Means for You and Your Investments*, FORBES (Mar. 4, 2013), <http://www.forbes.com/sites/lewissaret/2013/03/14/code-sec-1411-what-the-new-3-8-medicare-surtax-mean-for-you-and-your-investments/>.

230. See *supra* text accompanying notes 211–228.

231. 42 U.S.C. § 30011-1(6)(A)(i) (2012).

232. *Id.*

233. *Id.* § 30011-2(a)(1)(D)(i). See generally Richard L. Kaplan, *Analyzing the Impact of the New Health Care Reform Legislation on Older Americans*, 18 ELDER L.J. 213, 229–30 (2011) (describing possible uses of the CLASS program's benefits).

intended to pay for expensive institutionalized long-term care in assisted living facilities or nursing homes.²³⁴

Many of the key elements of CLASS were left to the Secretary of Health and Human Services (HHS) to devise, including benefit amounts for particular services²³⁵ and the cost of enrolling in the program. But the enabling legislation contained a critical requirement that proved fatal to this program's implementation: CLASS had to be self-sustaining.²³⁶ That is, premiums received by CLASS had to match projected benefit expenditures and could not be supplemented by general tax revenues.²³⁷ That mandate might have been difficult to satisfy if enrollment in CLASS was mandatory, but CLASS was set up as a voluntary insurance program.²³⁸ The resulting "adverse selection" problem—namely, a propensity to attract too many enrollees who present an above-average likelihood of needing the program's benefits²³⁹—forced the Secretary of HHS to conclude in October 2011 that CLASS could not be implemented as enacted.²⁴⁰ Barely a year later, Congress repealed the by-then moribund CLASS provisions²⁴¹ rather than revise the program to make it workable.

Notwithstanding this sorry history, CLASS was never intended to be part of Medicare or even primarily directed to older persons. CLASS required that enrollees pay premiums for five years prior to claiming benefits²⁴² and be "actively employed"²⁴³ at least three years during their initial enrollment in CLASS.²⁴⁴ Thus, CLASS was really aimed at the pre-retirement population rather than Medicare beneficiaries who generally are no longer employed. Even in this very

234. Kaplan, *supra* note 233 at 229.

235. 42 U.S.C. § 30011-2(a)(3) (first sentence).

236. *Id.* § 30011-7(a).

237. *Id.* § 30011-7(b).

238. Paul N. Van De Water, *CLASS: A New Voluntary, Long-Term Care Insurance Program*, CTR. ON BUDGET & POL'Y PRIORITIES (Apr. 16, 2010), <http://www.cbpp.org/cms?fa=view&id=3156>.

239. See Letter from Am. Acad. Of Actuaries to U.S. S. Comm. On Health, Edu., Labor and Pensions, Actuarial Issues and Policy Implications of a Federal Long-Term Care Insurance Program 1-2 (July 22, 2009), available at http://www.actuary.org/pdf/health/class_july09.pdf.

240. Letter from Kathleen Sebelius, Sec'y Dep't of Health & Human Servs., to Congress (Oct. 14, 2011), available at <http://www.hhs.gov/healthcare/facts/blog/2011/10/class10142011.htm>.

241. American Taxpayer Relief Act of 2012, Pub. L. No. 112-240, § 642(a), 126 Stat. 2313, 2358 (2013).

242. 42 U.S.C. § 30011-1(6)(A)(i) (2012).

243. *Id.* §§ 30011-1(2), 30011-3(c)(3).

244. *Id.* § 30011-1(6)(A)(ii).

limited context, therefore, the ACA made no attempt to rethink Medicare and orient it to the future. That task awaits.

III. Recommendations Going Forward

Medicare has been controversial from its start, and some critics might prefer abandoning the program entirely.²⁴⁵ That is not the approach of this Article, because Medicare continues to speak to a very important societal concern: providing health insurance for a population that, by dint of advanced years and absence from the compensated workforce, presents a risk profile that private insurance schemes do not want.²⁴⁶ Nevertheless, the evolution of American medical care and changing models of health insurance suggest that Medicare's approach to this problem merits re-examination and revision.

One very different approach was popularized by Congressman Paul Ryan when he chaired the House Budget Committee.²⁴⁷ He proposed that Medicare beneficiaries receive a fixed-dollar voucher to use in purchasing a health insurance plan from among various to-be-determined options,²⁴⁸ though there was no guarantee that suitable insurance would be available for the amount of the voucher. This approach, often termed "premium support,"²⁴⁹ has much to admire if you chair the House Budget Committee and are concerned primarily with reining in the cost of Medicare to the federal government.²⁵⁰

Instead, this Article takes what might be described as an Elder Law perspective; that is, what is best for older Americans, the intended beneficiaries of Medicare, as they navigate their advanced

245. See, e.g., David A. Hyman, *Medicare Meets Mephistopheles*, 60 WASH. & LEE L. REV. 1165 (2003).

246. See MOON, *supra* note 134, at 47–48.

247. See H. COMM. ON THE BUDGET, 112TH CONG., *THE PATH TO PROSPERITY: RESTORING AMERICA'S PROMISE* 46–47 (Comm. Print 2011), available at <http://budget.house.gov/UploadedFiles/PathToProsperityFY2012.pdf>.

248. *Id.*

249. See Joseph R. Antos et al., *Bending the Cost Curve Through Market-Based Incentives*, 367 NEW ENG. J. MED. 954 (2012); Henry J. Aaron & Austin B. Frakt, *Why Now Is Not the Time for Premium Support*, 366 NEW ENG. J. MED. 877 (2012).

250. See DEMOCRATIC CAUCUS, H. COMM. ON THE BUDGET, *COMPARING THE REPUBLICAN MEDICARE VOUCHER PLAN AND THE MEDICARE PRESCRIPTION DRUG BENEFIT* 1–2 (2011), available at <http://democrats.budget.house.gov/sites/democrats.budget.house.gov/files/05.13.2011%20-%20Republican%20Medicare%20Plan%20vs%20Part%20D.pdf>. See also Jacob S. Hacker, *Restoring Retirement Security: The Market Crisis, the "Great Risk Shift," and the Challenge for Our Nation*, 19 ELDER L.J. 1, 39 (2011).

years through the U.S. health care system? To that end, this Article suggests: (1) simplifying the Medicare program by replicating the single-source integrated arrangements that typify the pre-retirement health insurance marketplace, and (2) expanding its coverage of long-term care to reflect contemporary realities.

A. Single-Source Integrated Health Insurance Arrangements

Most newly eligible Medicare beneficiaries are absolutely flabbergasted, if not overwhelmed, by the whole range of decisions required when first confronting Medicare.²⁵¹ This reaction derives in large part from the literally “so last century” structure that characterizes this program. In short, the need to decide whether to purchase coverage for something as common as physicians’ fees and prescription drugs is completely alien to what exists in the pre-retirement health insurance marketplace.²⁵² Choices and options are often considered optimal mechanisms for ensuring consumer satisfaction, but the scope and range of alternatives that Medicare entails may actually be counterproductive, if not antithetical, to consumer satisfaction.

Health insurance to many people new to the Medicare program has meant some type of single-source integrated arrangement that encompasses hospital coverage, doctors’ charges, prescription drugs, and similar expenses, all for a single monthly premium. Indeed, many of the plans that are currently available through the ACA’s health insurance exchanges have these very characteristics, and options are restricted to a few, specifically demarcated financial parameters such as annual deductibles and copayment percentages.²⁵³ The contents of the insurance coverages, however, are fairly standardized because all the plans must include the statutorily delineated “essential health benefits.”²⁵⁴ Medicare should be reconceptualized along these same lines.

251. See Judith H. Hibbard et al., *Is the Informed-Choice Policy Approach Appropriate For Medicare Beneficiaries?*, 20 HEALTH AFFAIRS 199, 203 (2001).

252. *What’s Not Covered by Part A & Part B*, *supra* note 74.

253. See *What Marketplace Health Plans Cover*, HEALTHCARE.GOV, <https://www.healthcare.gov/coverage/what-marketplace-plans-cover/>.

254. 42 U.S.C. § 18022(b)(1)(A)–(J) (2012).

Yet, when I suggested this fundamental change in Medicare's orientation to the National Policy Council of AARP in May of 2012,²⁵⁵ the reaction was less than enthusiastic and often somewhat hostile. I should clarify that the members of this Council were generally long-term participants in the current Medicare program, accustomed to its curious contours, and clearly preferred maintaining the status quo, however bizarre and convoluted it might be. They were certainly not new entrants to Medicare who need to compare what they had before retiring to what Medicare offers.

Moreover, the very concept of coordinated or integrated care seemed to conjure up frightening notions of managed care, which was seen—perhaps correctly—as simply managed *cost*, meaning artificial restrictions on provision of needed care.²⁵⁶ Given the importance that Americans of every age attach to having their health care needs met and the special significance of health care to older persons, their sensitivity in this regard is certainly understandable. Thus, a move to single-source integrated care arrangements might be seen as a Trojan Horse of benefit limitations disguised as simplification. In this context, the dreaded R-word of health care—rationing—can make current Medicare enrollees suspicious of major changes in a program that, while not ideal, is known and vital to their very existence.²⁵⁷

That said, no one would design the Chinese menu that characterizes Medicare today if he or she were beginning with a blank slate. How can health insurance regard doctors' visits as an optional expenditure, to say nothing of prescription medications? Such medications are an integral component of medical treatment today, especially for controlling the chronic diseases that affect the vast majority of Medicare beneficiaries.²⁵⁸ The idea that such drugs are an

255. Richard L. Kaplan, *How Should Medicare Be Financed?*, Presentation to AARP National Policy Council, May 24, 2012 (PowerPoint® presentation on file).

256. See Karen Visocan, *Recent Changes in Medicare Managed Care: A Step Backwards for Consumers?*, 6 *ELDER L.J.* 31, 37 (1998); see also Robert O. Morgan et al., *The Medicare-HMO Revolving Door—The Healthy Go In and the Sick Go Out*, 337 *NEW ENG. J. MED.* 169 (1997). See generally GERALDINE DALLEK ET AL., *THE COMMONWEALTH FUND, LESSONS FROM MEDICARE+CHOICE FOR MEDICARE REFORM* (2003), available at http://www.commonwealthfund.org/~media/files/publications/issue-brief/2003/jun/lessons-from-medicare-choice-for-medicare-reform/dallek_lessons-m-c_658-pdf.pdf.

257. See Peter H. Schuck, *The Golden Age of Aging, and Its Discontents*, 18 *ELDER L.J.* 25, 45–49 (2010).

258. See Gerard F. Anderson, *Medicare and Chronic Conditions*, 353 *NEW ENG. J. MED.* 305, 305 (2005) (83% of Medicare enrollees have at least one chronic condition); Kenneth E. Thorpe et al., *Chronic Conditions Account for Rise in Medicare*

optional coverage, one that can be foregone at an enrollee's discretion, is unfathomable in any context outside of Medicare.

Nevertheless, the specter of "managed care" looms large. The question to ask is what is so scary about managed care? The integration of coverages for doctors' visits, hospital care, rehabilitative care, and prescription drugs is an advantage to most people and a major simplification. But limiting the scope of available providers is a genuine concern, especially for older enrollees who may have longstanding relationships with particular health care providers.

The issue, then, is how much disruption in such relationships is acceptable to achieve the simplification benefits that single-source integrated care arrangements would provide? Some relationships should be preserved in the interest of continuity of care and maintenance of patient-provider trust, but must that deference be extended to all health care providers? Primary care physicians would seem to be the highest priority in this regard, and regularly seen specialists might merit similar treatment. Specific hospitals, however, present a less compelling case, as long as basic competencies and geographic accessibility are maintained. Similar considerations apply to pharmacies and other providers, such as home health care agencies, rehabilitative care services, and the like.

But these changes might still be a bridge too far as even minor restrictions on available health care providers might prove unacceptable. That reality suggests that access to any willing provider needs to be accommodated. Nevertheless, "traditional" Medicare—that is, Parts A, B, and D—should be phased out in favor of the comprehensive health insurance plans that are available to non-Medicare persons.

Along these same lines, the current unlimited cost exposure that "traditional" Medicare presents should be eliminated. Many health insurance plans in the pre-retirement market have high annual deductibles, often several thousand dollars, but they also have "stop loss" provisions that limit how much an insured might need to pay out of pocket.²⁵⁹ As a result, insurance purchasers know at the beginning of the year the worst case financial scenario that they might confront and can budget accordingly, perhaps by setting aside this

Spending from 1987 to 2006, 29 HEALTH AFFAIRS 718, 723 (2010) (93.4% of Medicare beneficiaries use prescription medications).

259. See BALDWIN, *supra* note 131, at 67–68.

amount in a Health Savings Account²⁶⁰ or some other dedicated financial arrangement. Medicare enrollees deserve no less forewarning of their potential cost exposure.

With a “stop loss” provision in place, Medicare beneficiaries would no longer need “Medigap” insurance or any other type of supplemental coverage. After all, the idea of needing health insurance to supplement other health insurance is passing strange and is not the norm outside of Medicare.²⁶¹ Medicare should therefore be reformed to eliminate the unlimited cost exposure that creates the need for supplemental coverage.²⁶²

B. Long-Term Care

As more Americans live long enough to require assistance with daily life activities, the issue of long-term care will continue to cast its foreboding shadow over extended age and the families of older people. Though most people would rather not think about ever needing some type of long-term care, even the most fortunate among us will confront this issue in one context or another. As former First Lady Rosalyn Carter has written, “There are only four kinds of people in this world: those who have been caregivers, those who currently are caregivers, those who will be caregivers, and those who will need

260. See generally Richard L. Kaplan, *Who's Afraid of Personal Responsibility? Health Savings Accounts and the Future of American Health Care*, 36 MCGEORGE L. REV. 535 (2005).

261. In fact, owners of Health Savings Accounts (HSAs) are statutorily prohibited from buying supplemental insurance, other than coverage for dental and vision care, which are not included in the high-deductible health insurance plans that are associated with their HSAs. See I.R.C. § 223(c)(1)(A)(ii)(II), (B)(ii) (2012).

262. Legislation enacted 27 years ago limited the Part A hospitalization deductible to one per calendar year and placed an annual limit on Part B copayments. See Medicare Catastrophic Coverage Act of 1988, Pub. L. No. 100-360, §§ 102(1), 201(a), 102 Stat. 683, 685-86, 699-701. But that legislation was fiercely opposed by many elders, and Congress repealed it retroactively. See Medicare Catastrophic Coverage Repeal Act of 1989, Pub. L. No. 101-234, §§ 101(a)(1), 201(a)(1), 103 Stat. 1979, 1979, 1981. Much of that opposition was attributable to the prevalence of employer-provided retiree health benefits that were generally seen as more extensive than what the legislation provided. See Thomas Rice et al., *The Medicare Catastrophic Coverage Act: A Post-Mortem*, HEALTH AFFAIRS 75, 76 (Aug. 1990). Since that time, employer-provided retiree health benefits have been severely curtailed or eliminated, even for already-retired persons. See generally Richard L. Kaplan et al., *Retirees at Risk: The Precarious Promise of Post-Employment Health Benefits*, 9 YALE J. HEALTH POL'Y L. & ETHICS 287 (2009). Accordingly, a “stop loss” provision for Medicare would likely be received more favorably today.

caregivers.”²⁶³ The issue, therefore, becomes whether Medicare’s extremely restrictive coverage for long-term care should be expanded and if so, how far.

As I have noted elsewhere, nursing homes today often provide care that could be rendered in the past only by credentialed hospitals.²⁶⁴ There is little justification for continuing the enormous financial distinction in Medicare’s coverage between hospitals and nursing homes. Medicare enrollees go to hospitals for medical reasons and find that almost all of their expenses are covered, especially if they have even a basic “Medigap” policy. Upon discharge from the hospital, these enrollees often enter nursing homes, *again for medical reasons*, and their reasonable expectation is that their personal financial exposure should be similar to what they experienced in the hospital setting. Accordingly, the current strictures on that program’s coverage of nursing homes should be eliminated. If a person’s health care needs can be met only in a nursing home rather than in a less medically intensive setting, Medicare should cover those costs without regard to any 30-day prior hospitalization, a three-day hospital stay, or even the specific “level” of care that person is receiving.²⁶⁵

The case for comparable treatment of hospitals and nursing homes can be illustrated by the following tale of two sisters. Susan is a lifelong smoker who develops emphysema. She requires several hospitalizations and “skilled nursing care” in a nursing home. Sharon, on the other hand, suffers from Alzheimer’s disease. She faces extended confinement in a nursing home where she receives assistance with daily life activities but no “skilled nursing care.” At the present time, Medicare pays for almost all of Susan’s care and virtually none of Sharon’s. It defies logic for Medicare to thus discriminate on the basis of disease and to *further* discriminate in favor of the disease that might have been prevented by different lifestyle choices. Medicare should be changed so that nursing home costs are treated comparably to hospital expenses.

263. ROSALYN CARTER WITH SUSAN K. GOLANT, *HELPING YOURSELF HELP OTHERS: A BOOK FOR CAREGIVERS* 3 (1994).

264. Richard L. Kaplan, *Cracking the Conundrum: Toward a Rational Financing of Long-Term Care*, 2004 U. ILL. L. REV. 47, 83.

265. Some of the financing considerations pertaining to this proposal are discussed in *id.* at 88.

On the other hand, less medically oriented arrangements such as assisted living facilities and continuing care retirement communities should remain a private responsibility.²⁶⁶ If elders and their families do not want to bear the potential cost of these long-term care alternatives, repurposed long-term care insurance might be an appropriate product to consider.²⁶⁷ Freeing such insurance from needing to cover expensive nursing home care would make such insurance both less expensive and more appealing, because it would then pay for care that people prefer rather than dread. Long-term care insurance would still need to be reformed to better ensure carrier solvency and prevent large unanticipated premium increases, but that is a subject quite apart from reimagining Medicare.²⁶⁸

IV. Conclusion

Medicare as it stands today is one of the federal government's most popular programs. The Pew Research Center recently undertook a major survey that asked adults whether Medicare has "been good for the country" over the years. The following chart displays the results by age of respondent:²⁶⁹

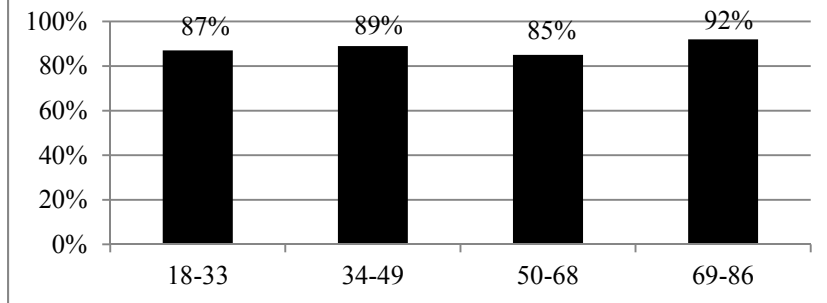
266. See *id.* at 85–86.

267. See *id.* at 86–88.

268. See generally Richard L. Kaplan, *Retirement Planning's Greatest Gap: Funding Long-Term Care*, 11 LEWIS & CLARK L. REV. 407, 440–42, 449–50 (2007).

269. Adapted by author from Glenn Ruffenach, *The Generation Gap Closes (a Bit)*, WALL ST. J., Oct. 13, 2014, at R7.

Figure 1. Agreement that Medicare has "been good for the country" by age of respondent.



Two conclusions are clear: (1) Medicare is overwhelmingly seen as "good for the country," and (2) this sentiment holds true across all age groups.²⁷⁰ Clearly, Medicare is enormously important not only to the older Americans who are its direct beneficiaries²⁷¹ but also to younger persons who anticipate becoming Medicare beneficiaries in the future or appreciate its current payment of their older relatives' medical expenses. Little wonder, therefore, why radical restructuring of Medicare is unlikely to gain much political traction. That said, reforming Medicare to make it more consonant with modern medical practice and the needs of today's elders is both timely and appropriate.

To that end, the separation of important medical expenses into distinct programs is an accident of history that should no longer dictate Medicare's design. Single-source integrated care arrangements, along the lines of managed care plans but without the tight restrictions on provider availability that characterize those plans, should be the predominant paradigm. Similarly, Medicare should institute a limit on a beneficiary's out-of-pocket expenses, thereby conforming Medicare to today's private health insurance models and largely eliminating the need for supplemental "Medigap" insurance. Finally, Medicare should acknowledge the changes in nursing homes

270. *Id.*

271. See KRC RESEARCH, *supra* note 156, at 11 (reporting that 92% of seniors are "satisfied" with Medicare, including 58% who are "very satisfied").

that have taken place over the past half-century and cover expenses in those facilities more comparably to its coverage of hospitalization costs. An ambitious agenda, to be sure, but one in keeping with the program's original premises as reconceptualized 50 years later.

