

TOP TEN MYTHS OF MEDICARE

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With the United States attempting to reduce its budgetary deficit and in light of recent health care reforms, Medicare has become one of the most controversial federal programs. Various misconceptions surround this important public initiative, and this Article seeks to debunk those misconceptions to facilitate an informed debate about the future of Medicare.

Professor Kaplan addresses and debunks the following myths: (1) there is one Medicare program, (2) Medicare is going bankrupt, (3) Medicare is government health care, (4) Medicare covers all medical costs for its beneficiaries, (5) Medicare pays for long term-care, (6) Medicare is politically immune to budgetary reduction, (7) Medicare wastes much of its money on futile care, (8) Medicare is less efficient than private health insurance, (9) Medicare is not means-tested, and (10) increased longevity will sink Medicare.

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As the United States struggles to get a handle on its budgetary deficits, both short-term and long-term, one major program has taken center stage: Medicare. This program pays for health care expenses incurred by most Americans who are sixty-five years and older, as well as those who are permanently disabled.¹ It is a classic entitlement program in that beneficiaries have no monetary cap on the value of the benefits that they receive from this program, as long as they meet the program's criteria for eligibility. Moreover, Medicare is beset with the increasing cost of health care services that bedevils most American health care financing systems. This combination of unlimited benefits and full exposure to U.S. health care costs makes the Medicare program uniquely susceptible to budgetary scrutiny.

At the same time, Medicare has hardly gone unnoticed by governmental budget overseers and policymakers more generally. Throughout the contentious and protracted debate that culminated in 2010 with passage of the Patient Protection and Affordable Care Act,² one of the major issues in the discussions about health care reform was what would happen to the Medicare program. Moreover, no less than \$575 billion of projected cuts over a ten-year budget window were included in that legislation to finance other reforms that it sought to implement.³ To be sure, certain enhancements in Medicare's coverage were included as well,⁴ but the overall impact of the 2010 health care reform legislation was to reduce the cost of Medicare by over a half-trillion dollars. Indeed, these severe Medicare cuts were the main reason that older Americans generally opposed passage of that legislation. They were also a contributing factor in the 2010 congressional elections that ushered in a new Republican majori-

1. 42 U.S.C. §§ 1395–1395aaa (2006). *See generally* LAWRENCE A. FROLIK & RICHARD L. KAPLAN, *ELDER LAW IN A NUTSHELL* 56–97, 104–09 (5th ed. 2010) (explaining the current Medicare program).

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

3. Memorandum from Richard S. Foster, Chief Actuary, Ctr. for Medicare & Medicaid Servs., Estimated Financial Effects of the "Patient Protection and Affordable Care Act," as Amended, at 8 (Apr. 22, 2010), available at https://www.cms.gov/ActuarialStudies/Downloads/PPACA_2010-04-22.pdf.

4. *See generally* Richard L. Kaplan, *Analyzing the Impact of the New Health Care Reform Legislation on Older Americans*, 18 *ELDER L.J.* 213, 218–21, 238–39, 242 (2010).

ty in the United States House of Representatives and additional Republican victories in the Senate.

Yet, less than one year after that landmark legislation, Medicare found itself the number one target of congressional budget-cutters once again. This time, the proposals were far more radical, seeking not merely to reduce the financial cost of the Medicare program but also to change its fundamental philosophical orientation. In place of its existing panoply of defined benefits and stipulated restrictions, the plan offered by the chair of the House Budget Committee, Paul Ryan of Wisconsin, offered Medicare enrollees a fixed sum in lieu of the existing program's benefits.⁵ This sum, described variously as "premium support" or vouchers depending on the describer's political orientation, would be used instead to purchase health insurance from a variety of private insurers in a yet-to-be-determined mechanism under yet-to-be-determined parameters. Because the cost of this "premium support" or voucher would be increased by the cost of inflation generally, rather than the inevitably higher cost of medical services, the government's expenditure on Medicare would decrease over time as more costs are borne by individual Medicare enrollees.⁶

The outcome of this rather dramatic change in the program's basic approach is very much in doubt, although the vast majority of the Republicans in the House voted for the so-called Ryan Budget,⁷ which included the Medicare proposal described above. In any case, the indisputable budgetary realities ensure that Medicare will be a focus of budget cuts in the near future if any serious action is undertaken to reduce projected shortfalls. To that end, it is critical that policymakers, commentators, affected beneficiaries, and voters more

5. See H. COMM. ON THE BUDGET, FISCAL YEAR 2012 BUDGET RES., 112TH CONG., THE PATH TO PROSPERITY: RESTORING AMERICA'S PROMISE 46-47 (Comm. Print 2011), available at <http://budget.house.gov/UploadedFiles/PathToProsperityFY2012.pdf>.

6. 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).

7. See 157 CONG. REC. H2900-01 (daily ed. Apr. 15, 2011) (vote on Ryan Budget, H. Con. Res. 34). All but four Republicans and no Democrats voted in the affirmative. See John R. Parkinson, *House Passes Paul Ryan Budget Proposal in Partisan Vote*, ABC NEWS (Apr. 15, 2011), <http://abcnews.go.com/Politics/paul-ryans-budget-proposal-passes-house-democrats-medicare/story?id=13384520>.

generally understand the nature of the Medicare program as it exists, rather than the various mythologies that seem to surround this important public initiative. This Article seeks to debunk ten of the more significant myths of Medicare so that an informed and realistic debate can ensue about the future of Medicare.

I. There Is One Medicare Program

One of the foundational myths surrounding Medicare is that there is one single Medicare program, a one-size-fits-all schematic typical of government programs, with little flexibility or opportunity to individualize the benefit package. In fact, Medicare has several distinct components, usually described as Part A through Part D, each with different types of coverage, limitations, and financing mechanisms. In briefest possible overview, Medicare Part A covers costs incurred in hospitals, nursing homes, home health services, and respite care.⁸ Part B applies to physicians' charges, ambulance services, some home health care, and durable medical equipment such as walkers, motorized carts, and the like.⁹ Part D deals exclusively with prescription medications,¹⁰ and Part C provides integrated "managed care" arrangements that encompass the benefits of Medicare Parts A, B, and D,¹¹ plus some other benefits that are often provided by supplemental "Medigap" insurance policies.¹²

The scope of these coverages varies greatly depending upon the specific Part of Medicare in question. For example, Part A covers almost all hospital charges during the first sixty days¹³ of a "spell of illness"¹⁴ after a per-admission deductible that increases each year with inflation and was \$1,156 in 2012.¹⁵ Inasmuch as the average hospital stay of a person age sixty-five years or older is less than six days,¹⁶ this

8. See generally FROLIK & KAPLAN, *supra* note 1, at 65–76.

9. See generally *id.* at 76–79.

10. See generally *id.* at 86–93.

11. See generally *id.* at 104–08.

12. See generally *id.* at 97–103.

13. 42 U.S.C. § 1395x(b) (2006).

14. Regarding the contours of a "spell of illness," see *id.* § 1395x(a).

15. *Medicare Premiums and Coinsurance Rates for 2012*, MEDICARE.GOV (Oct. 27, 2011), https://questions.medicare.gov/app/answers/detail/a_id/2309/~/medicare-premiums-and-coinsurance-rates-for-2012.

16. See ADMIN. ON AGING, U.S. DEP'T OF HEALTH & HUMAN SERVS., A PROFILE OF OLDER AMERICANS: 2010, at 12–13 (2010), available at http://www.aoa.gov/AoARoot/Aging_Statistics/Profile/2010/docs/2010profile.pdf (stating that the average hospital stay for someone age sixty-five or older was 5.6 days in 2010).

coverage is virtually complete. In contrast, Medicare's coverage of nursing home costs is subject to several separate qualifiers, not the least of which is that the person must enter a nursing home within thirty days of being treated in a hospital for the same or a related medical condition¹⁷ and needs "skilled" nursing care on a daily basis¹⁸—conditions that substantially reduce the scope of Medicare's nursing home coverage.

Meanwhile, Medicare Part D has no specific mandatory coverage elements for its drug coverage. Instead, certain parameters are set forth (and adjusted annually for inflation) in a prototype plan, and private insurers then offer that plan or an "actuarially equivalent" alternative.¹⁹ In fact, there is no one Medicare Part D plan, as each year private companies create particular plans with restricted formularies, specified dosage amounts, specified dosage frequency, and other elements that will appeal to some prospective customers and not to others.²⁰

At least as important are the different ways in which these components of Medicare are financed. Medicare Part A is paid by most persons while they are employed through the mechanism of a 2.9% tax on all wages and salaries, half being collected from the employee²¹ and half being nominally imposed on the employer.²² Self-employed persons pay the entire 2.9% tax on their net income from self-employment.²³ Once a person reaches age sixty-five, he or she is "entitled" to Medicare Part A without further charge as long as that person is eligible to receive Social Security retirement benefits.²⁴ This last condition typically means that the person earned at least forty "quarters of coverage," as that phrase is defined for Social Security purposes.

17. 42 U.S.C. § 1395x(i)(A); 42 C.F.R. § 409.30(b)(1) (2010).

18. 42 U.S.C. § 1395f(a)(2)(B); 42 C.F.R. § 409.31(b)(3). Examples of such care include catheterization, injections, administration of medical gases, and gastronomy feedings. 42 C.F.R. § 409.33(a)–(c).

19. See generally Richard L. Kaplan, *The Medicare Drug Benefit: A Prescription for Confusion*, 1 NAT'L ACAD. ELDER L. ATT'YS J. 167, 172–74 (2005).

20. See generally JACK HOADLEY ET AL., THE HENRY J. KAISER FAMILY FOUND., MEDICARE PART D 2010 DATA SPOTLIGHT, MEDICARE PRESCRIPTION DRUG PLANS IN 2010 AND KEY CHANGES OVER FIVE YEARS: SUMMARY OF FINDINGS (2010), available at <http://www.kff.org/medicare/upload/8096.pdf> (issue brief describing important design features of the various Medicare drug plans being offered by private insurers).

21. I.R.C. § 3101(b)(6) (2006).

22. *Id.* § 3111(b)(6).

23. *Id.* § 1401(b).

24. 42 U.S.C. § 1395c(1) (2006).

es.²⁵ As a practical matter, anyone who is part of the compensated workforce for at least ten years has satisfied this requirement. Moreover, the spouse of someone who has satisfied this requirement²⁶—or even the former spouse of such a person if their marriage lasted at least ten years²⁷—is eligible for Medicare Part A. But the main point is that Part A is financed before it is needed, essentially as prepaid health insurance.

In contrast, both Medicare Part B and Part D are financed through a combination of enrollee premiums and general federal tax revenues. The enrollee premium for Medicare Part B, for example, is adjusted annually for inflation and in 2012 was \$99.90 per month.²⁸ This premium is calculated to cover twenty-five percent of Medicare Part B's expenses for the coming year, with the remaining seventy-five percent coming from general tax revenues paid by taxpayers of all ages.²⁹ Higher-income beneficiaries of both Part B and Part D pay additional amounts for the same coverage depending upon their level of income two years prior to the current year.³⁰ Thus, the charge for affected beneficiaries in 2012 is determined by their income in the year 2010.

Finally, Medicare Part C encompasses a variety of “managed care” arrangements that differ substantially from the per-services-provided model that characterizes the other Parts of Medicare. Most commonly delivered through a health maintenance organization or a preferred provider organization, Medicare Part C offers integrated hospital, physician, and pharmaceutical coverage, along with extra benefits such as wellness classes, eyeglasses, and hearing aids, through a stipulated network of providers in exchange for a monthly fee.³¹ That fee typically reflects the federal government's calculated average cost of providing services through the “traditional” Medicare program, a cost that is determined by and paid directly to the Medicare Part C organization, leaving the enrollee to pay a single premium to that organization. Approximately one in four Medicare beneficiar-

25. 42 C.F.R. §§ 402(a)(1), 414(a)(2) (2010).

26. *Id.* § 402(b)(1), (c)(1).

27. *Id.* § 416(d)(1), (4).

28. *Medicare Premiums and Coinsurance Rates for 2012*, *supra* note 15.

29. See H.R. REP. NO. 108-391, at 746 (2003).

30. 42 U.S.C. § 1395r(i)(4)(B)(i) (2006). See generally Richard L. Kaplan, *Means-Testing Medicare: Retiree Pain for Little Governmental Gain*, 9 J. RETIREMENT PLANNING 22, 22 (May–June 2006).

31. See FROLIK & KAPLAN, *supra* note 1, at 104–05, 107.

ies participates in a Medicare Part C arrangement at the present time.³²

Thus, the individual components of Medicare reflect very different models of service delivery, as well as very different financing mechanisms, and must be analyzed separately when substantive changes are being considered. Otherwise, the tendency to conflate these very different approaches can spawn suspect and often wildly mistaken understandings of how Medicare works.

II. Medicare Is Going Bankrupt

One of the most frequently propounded contentions, usually with an air of absolute certainty, is that the Medicare program is going bankrupt, will soon run out of money, or some similar formulation of complete financial exhaustion. This myth combines the prior myth that there is a single program called Medicare with a preternatural concern with governmental trust fund accounting. As noted in connection with that prior myth,³³ Medicare consists of several distinct components with differing methodologies of financing their costs. In particular, Medicare Parts B and D utilize premiums paid by current-year enrollees and general tax revenues.³⁴ These components of Medicare make no pretense of pre-funding and rely on funds that are generated in the current fiscal year. In other words, Medicare Parts B and D are funded on a current-year basis and as a result cannot “go bankrupt” in any customary sense of that phrase. As long as the federal government receives tax revenues from *any* source and there are *any* enrollees in Medicare Parts B and D, those specific programs can be funded.

To be sure, general tax revenues are always subject to competing demands, whether for national defense or for other fundamental functions of government such as law enforcement and the judicial system. In addition, funding challenges may arise in the future as a result of financial demands caused by unparalleled natural disasters like Hurricane Katrina in 2005 or unanticipated fiscal crises like the global fi-

32. JULIETTE CUBANSKI ET AL., THE HENRY J. KAISER FAMILY FOUND., MEDICARE CHARTBOOK (4th ed. 2010), at 44 fig.4.1 [hereinafter MEDICARE CHARTBOOK], available at <http://www.kff.org/medicare/upload/8103.pdf>.

33. See *supra* text accompanying notes 21–32.

34. See *Medicare Premiums and Coinsurance Rates for 2012*, *supra* note 15; see also Kaplan, *supra* note 30, at 22.

nancial meltdown of 2008. Consequently, future Congresses may choose not to fund Medicare Parts B and D to the same extent that present and past Congresses have done. Those future Congresses might adjust the applicable funding formula to make those programs more reliant on enrollee premiums and less reliant on general tax revenues. The bottom line, however, is that Medicare Parts B and D can be financed indefinitely if they are deemed appropriate uses of federal funds.

Medicare Part A is essentially in the same position, but it presents an additional complication in that the payroll taxes imposed for this component are directed to a dedicated "trust fund" to pay for its expenditures.³⁵ In the normal course of trust fund accounting, if this fund lacks sufficient monies to pay the program's costs, those costs cannot be paid. A trust fund operated by a national government with the power to create money, however, does not necessarily play by the same rules that apply to trust funds generally. Much like the equally mythological and equally confusing trust fund that pays Social Security benefits,³⁶ such benefit payments are not realistically restricted to the monies that are "available" in the fabled trust fund.³⁷ Tax revenues go into the federal government, and that same government can choose to spend whatever sums it wants on whatever programs it deems worthy of funding.

After all, there is not now, nor has there ever been, a Department of Defense "trust fund" or any similar account for the Department of Homeland Security. The absence of such a dedicated funding source, however, has not presented any impediment to financing protracted and unusually expensive wars in Iraq, Afghanistan, or anywhere else.³⁸ Notwithstanding the wisdom or inefficacy of those military engagements, no objection was ever raised that funds were not available to pay for these engagements.

35. See CTRS. FOR MEDICARE & MEDICAID SERVS., U.S. DEP'T OF HEALTH & HUMAN SERVS., HOW IS MEDICARE FUNDED? 1 (2011).

36. See Richard L. Kaplan, *Top Ten Myths of Social Security*, 3 ELDER L.J. 191, 192-94 (1995).

37. See Richard L. Kaplan, *The Security of Social Security Benefits and the President's Proposal*, ELDER LAW REP., Apr. 2005, at 1-3, available at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=700323; see also DANIEL SHAVIRO, WHO SHOULD PAY FOR MEDICARE? 22-24 (2004).

38. See generally CONG. BUDGET OFFICE, ANALYSIS OF THE GROWTH IN FUNDING FOR OPERATIONS IN IRAQ, AFGHANISTAN, AND ELSEWHERE IN THE WAR ON TERRORISM (2008), available at http://www.cbo.gov/ftpdocs/89xx/doc8971/02-11-WarCosts_Letter.pdf.

In similar fashion, if Congress finds that the reported balance in the “trust fund” designated for Medicare Part A is insufficient, it can appropriate funds to cover the resulting “deficiency” just as it does for Medicare Parts B and D. Thus, Medicare cannot “go bankrupt.” It may, to be sure, become a serious and exploding drain on the federal government’s budget, but if future Congresses prioritize this program over other competing demands, Medicare can continue to pay its bills in full and on time.

III. Medicare Is Government Health Care

As the preceding sections have shown, the government pays for a wide variety of medical services through its Medicare program. In almost all of those cases, the actual delivery of the care in question is provided by institutions like hospitals and nursing homes that are owned by private organizations, non-profit entities, or investors. Moreover, the actual payment of funds is administered by intermediaries called “Medicare Administrative Contractors” and possibly reviewed by “Qualified Independent Contractors.”³⁹ These private organizations determine whether a submitted claim satisfies the criteria established by Medicare’s rules and regulations and then distribute the applicable funds.⁴⁰ In other words, the federal government does *not* provide the medical care in question or even administer the claim approval process.

As typically understood, the phrase “government health care” or “government-run health care” usually describes an arrangement in which the government provides the actual medical care through government-owned hospitals and nursing homes and where the physicians and nurses who provide that care are government employees. A prominent example of such a system in the United States is the Department of Veterans Affairs, a self-contained comprehensive health care system with delivery of care and financing completely integrated.⁴¹ Medicare, by contrast, relies almost exclusively on private providers and thus is not “government health care.”

39. See 2012 MEDICARE HANDBOOK 2–5, 6–70 (Judith A. Stein & Alfred J. Chiplin, Jr. eds., 2011).

40. *Id.*

41. See generally *Medical Benefits Package*, U.S. DEP’T VETERANS AFFS. (Dec. 22, 2011), http://www.va.gov/healthbenefits/access/medical_benefits_package.asp. Regarding eligibility for benefits under the programs administered by this department, see FROLIK & KAPLAN, *supra* note 1, at 342–58.

IV. Medicare Covers All Medical Costs for Its Beneficiaries

Although Medicare is the single largest funding source for health care services provided to its beneficiaries, it does not pay the entire bill for the services it covers. Like most health insurance plans in force today, Medicare sports an array of deductibles and co-payment obligations. For example, Medicare Part A covers all hospital costs incurred in a single stay except for an annually adjusted deductible that was \$1,156 in 2012,⁴² as noted previously. If that stay exceeds sixty days within the same “spell of illness,” there is also a per-day deductible for the next thirty days which is set at one-fourth of the per-admission deductible, or \$289 in 2012.⁴³ And if that hospital stay exceeds ninety days, the next sixty days impose a per-day deductible of one-half of the per-admission deductible, or \$578 in 2012.⁴⁴ Similarly, physician charges under Medicare Part B are split between the Medicare program and the patient, with the patient being responsible for twenty percent of the “approved charge” as determined by the Medicare program.⁴⁵ This co-insurance obligation, moreover, has no upper bound.

As a result of these various deductibles, co-payment obligations, and outright exclusions (such as most health care delivered outside the United States),⁴⁶ the Medicare program covers only forty-eight percent of the health care expenses of older Americans.⁴⁷ This overall number varies considerably for any particular Medicare beneficiary depending upon the specific services received by that person, but the bottom line is that Medicare never did, and most certainly does not currently, pay all of the health care costs incurred by its enrollees.

That is why nine out of ten Medicare beneficiaries have secured some type of supplementary coverage,⁴⁸ often in the form of private, non-subsidized “Medigap” insurance policies that vary in their scope and premium cost.⁴⁹ Lower-income Medicare beneficiaries may quali-

42. *Medicare Premiums and Coinsurance Rates for 2012*, *supra* note 15.

43. *Id.*

44. *Id.*

45. 42 U.S.C. § 1395l(a) (2006).

46. *Id.* § 1395y(a)(4).

47. See THE HENRY J. KAISER FAMILY FOUND., MEDICARE FACT SHEET: MEDICARE SPENDING AND FINANCING 1 (2010) [hereinafter MEDICARE FACT SHEET], available at <http://www.kff.org/medicare/upload/7305-05.pdf>.

48. MEDICARE CHARTBOOK, *supra* note 32, at 60 fig.6.1.

49. See generally FROLIK & KAPLAN, *supra* note 1, at 97–103.

fy under the Medicaid program for coverage of the patient's cost obligations under Medicare if they can satisfy the rather strict financial eligibility criteria of the Medicaid program.⁵⁰ Another significant group has opted for a managed care arrangement under Medicare Part C to minimize out-of-pocket cost exposure, but such arrangements typically impose co-payment obligations for specified services, such as \$10 per generic prescription or \$20 per physician visit.⁵¹ Still other Medicare beneficiaries have supplemental coverage from their former employers, but retiree health benefits have been under sustained reductions for nearly two decades⁵² and at this point represent a diminishing solution to Medicare's cost exposure.⁵³ Nevertheless, the fact remains that Medicare does *not* pay all of the costs of its enrollees. Very much to the contrary, Medicare beneficiaries continue to have some serious "skin in the game" and face potentially substantial individual cost exposure.⁵⁴

V. Medicare Pays for Long-Term Care

Long-term care covers a range of services that provide assistance with activities of daily living and run the gamut from a few hours a day of in-home help by a family member to full-blown care in a nursing home.⁵⁵ Intermediate options within the rubric of long-term care include eight-hour shifts from a home health care agency, adult day care centers, and assisted living facilities. Many Americans believe that Medicare covers the costs associated with these various options. In fact, the most recent survey of Americans age forty-five and over found that fifty-nine percent of respondents thought that Medicare

50. See *id.* at 119.

51. See generally *Medicare Advantage (Part C)*, MEDICARE.GOV, <http://www.medicare.gov/navigation/medicare-basics/medicare-benefits/part-c.aspx> (last visited Mar. 16, 2012).

52. See MEDICARE CHARTBOOK, *supra* note 32, at 64 fig.6.9.

53. 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). For the impact of the 2010 health care reform legislation on such plans, see Kaplan, *supra* note 4, at 222–24, 241–43; see also Susan E. Cancelosi, *The Bell Is Tolling: Retiree Health Benefits Post-Health Reform*, 19 ELDER L.J. 49, 110–16 (2011).

54. THE HENRY J. KAISER FOUND., HOW MUCH "SKIN IN THE GAME" IS ENOUGH?: THE FINANCIAL BURDEN OF HEALTH SPENDING FOR PEOPLE ON MEDICARE 4 (2011), available at <http://www.kff.org/medicare/upload/8170.pdf>.

55. See generally EMILY K. ABEL, WHO CARES FOR THE ELDERLY? 11–22 (1991); ROSALIE A. KANE ET AL., THE HEART OF LONG-TERM CARE 31–34 (1998); Carol Levine, *Introduction: The Many Worlds of Family Caregivers*, in ALWAYS ON CALL: WHEN ILLNESS TURNS FAMILIES INTO CAREGIVERS 1, 1–6 (Carol Levine ed., 2000).

pays for long-term care provided in a nursing home while fifty-two percent thought that it covers assisted living facility care.⁵⁶ The myth that Medicare pays for long-term care differs, however, from many of the other myths considered in this Article in two very important ways. First, this particular myth contains some element of truth, and second, it is a debilitating myth to those who believe it.

On that first point, Medicare does pay for some long-term care but not all types of such care and not without some rather severe restrictions. For example, Medicare provides no coverage whatsoever for adult day care visits or assisted living facilities, regardless of the presenting circumstances. Medicare does cover home health care, but it never pays relatives to care for their loved ones,⁵⁷ and it restricts coverage to services provided by Medicare-certified home health care agencies.⁵⁸ In addition, no fewer than five additional requirements apply:

- (1) the beneficiary must be confined to his or her home and need assistance from other people or appliances like wheelchairs and walkers to leave the residence;⁵⁹
- (2) a plan of care must be established by a physician;⁶⁰
- (3) this plan must be reviewed by that physician every sixty days;⁶¹
- (4) the home health care must follow a stay in either a hospital or a nursing home within the preceding fourteen days;⁶² and
- (5) covered services cannot exceed eight hours per day and are limited to twenty-eight hours per week in most circumstances.⁶³

Unless each and every one of these requirements is satisfied, Medicare does not cover home health care.⁶⁴

56. See AARP, *THE COSTS OF LONG-TERM CARE: PUBLIC PERCEPTIONS VERSUS REALITY IN 2006*, at 30, 43 (2006), available at http://assets.aarp.org/rgcenter/health/ltc_costs_2006.pdf.

57. Federal income tax credits have been proposed for family members who provide care for impaired adults, but these proposals have not been enacted thus far. See, e.g., H.R. 2682, 109th Cong. § 3(a) (2005); H.R. 2935, 109th Cong. § 3(a) (2005); S. 1244, 109th Cong. § 3(a) (2005); S. 1602, 109th Cong. § 122(a) (2005). See generally Richard L. Kaplan, *Federal Tax Policy and Family-Provided Care for Older Adults*, 25 VA. TAX REV. 509, 551–59 (2005).

58. 42 U.S.C. § 1395x(m), (o) (2006).

59. *Id.* §§ 1395f(a)(2)(C), 1395n(a)(2)(A).

60. *Id.* § 1395x(m).

61. 42 C.F.R. § 484.18(b) (2011).

62. 42 U.S.C. § 1395x(tt)(1).

63. *Id.* § 1395x(m) (penultimate sentence).

Similarly, Medicare does cover care in a nursing home but once again under fairly significant restrictions. First, the nursing home must participate in the Medicare program and agree to its schedule of stipulated payment rates.⁶⁵ Second, the nursing home stay must occur after discharge from a hospital within the preceding thirty days.⁶⁶ Third, that preceding hospital stay must have dealt with the same or a medically related condition for which the patient requires nursing home care.⁶⁷ Fourth, that hospital stay must have lasted at least three days,⁶⁸ not counting the day of discharge.⁶⁹ Perhaps most significantly, the care received in the nursing home must meet the medically intensive standard of “skilled nursing care,” meaning care that requires the skills of professional personnel, such as injections, administration of medical gases, gastronomy feedings, catheters, and so forth.⁷⁰ Equally important is the requirement that the patient need this level of care *every* day.⁷¹

If any one of these conditions is not met, Medicare does not pay for the nursing home costs. Thus, if a patient does not require “skilled nursing care” but rather the type of lower-skilled, so-called “custodial care” that is typically needed by patients with Alzheimer’s disease, that patient has no Medicare coverage for her nursing home costs. Moreover, even if all of these conditions set forth in the preceding paragraph are met, Medicare pays all of the nursing home costs for only the first twenty days within a “spell of illness.”⁷² After those first twenty days, Medicare covers nursing home costs for the next eighty days in excess of a patient-paid per-day deductible⁷³ that is adjusted annually for inflation and was \$144.50 in 2012.⁷⁴ After 100 days of skilled nursing care, Medicare pays nothing. The result of these nursing home restrictions is that Medicare does not pay for many older persons’ encounters with such facilities.

64. In any case, no more than 100 home health visits are covered by Medicare Part A, though additional visits can be covered by Medicare Part B. *Id.* § 1395d(a)(3).

65. See 2012 MEDICARE HANDBOOK, *supra* note 39, at 3–5.

66. 42 U.S.C. § 1395x(i)(A).

67. *Id.* § 1395f(a)(2)(B); 42 C.F.R. § 409.31(b)(2)(ii) (2011).

68. 42 U.S.C. § 1395x(i).

69. 42 C.F.R. § 409.30(a)(1).

70. See *id.* § 409.33(a)–(c).

71. 42 U.S.C. § 1395f(a)(2)(B); 42 C.F.R. § 409.31(b)(1).

72. 42 U.S.C. §§ 1395d(a)(2)(A), 1395e(a)(3).

73. *Id.* § 1395e(a)(3).

74. *Medicare Premiums and Coinsurance Rates for 2012, supra* note 15.

As noted previously, believing the myth that Medicare covers the costs of long-term care is not a harmless error. If people think—however mistakenly—that they have insurance coverage for a particular calamity, they will not make any effort to secure other insurance to cover that calamity. That is the dilemma that befalls many Medicare beneficiaries and their families. Only too late do most people learn of Medicare's many restrictions on its coverage of long-term care generally and nursing home care in particular.⁷⁵ I have argued elsewhere that the applicable restrictions on Medicare's coverage of nursing homes do not recognize the changed medical realities of today and should be repealed,⁷⁶ but such salutary changes are extremely unlikely to happen given present budgetary constraints.

Accordingly, it is imperative that older Americans plan to pay for their long-term care themselves or secure private long-term care insurance to pay such costs if they prefer to shift the risk to an insurance company.⁷⁷ That insurance, however, must be obtained when the prospective insured person does not manifest any immediate need for long-term care or can otherwise satisfy the medical underwriting criteria that insurance companies impose.⁷⁸ Medicare beneficiaries who believe that the program already covers long-term care costs have no reason to acquire such insurance and will likely not be interested in doing so until they are unable to qualify medically⁷⁹—a particularly pernicious effect of believing the myth that Medicare covers long-term care.⁸⁰

75. See Richard L. Kaplan, *Financing Long-Term Care in the United States: Who Should Pay for Mom and Dad?*, in *AGING: CARING FOR OUR ELDERS* 65, 66 (David N. Weisstub et al. eds., 2001), available at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=294056.

76. See Richard L. Kaplan, *Honoring Our Parents: Applying the Biblical Imperative in the Context of Long-Term Care*, 21 *NOTRE DAME J.L. ETHICS & PUB. POL'Y* 493, 510–13 (2007).

77. See generally Richard L. Kaplan, *Retirement Planning's Greatest Gap: Funding Long-Term Care*, 11 *LEWIS & CLARK L. REV.* 407, 430–48 (2007).

78. *Id.* at 435–36.

79. See Christopher M. Murtaugh et al., *Risky Business: Long-Term Care Insurance Underwriting*, 32 *INQUIRY* 271, 277 (1995) (finding that a quarter of Americans who are sixty-five years old might be medically disqualified for long-term care insurance).

80. As part of the 2010 health care reform legislation, the federal government was authorized to create a program for financing long-term care costs entitled the Community Living Assistance Services and Supports (CLASS) Act. 42 U.S.C. §§ 3001l to 3001l-9, added by the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 8002, 124 Stat. 119, 828–47 (2010). This program would provide a to-be-determined dollar benefit that would vary with a given beneficiary's degree of physical and mental impairment but does not pretend to cover any specific

VI. Medicare Is Politically Immune to Budgetary Reduction

Despite the notion that Medicare is “the third rail of American politics,”⁸¹ whereby any politician who dares to cut the program faces electoral electrocution, the Medicare program has faced substantial and repeated budget cuts throughout its existence. As noted at the beginning of this Article, the health care reform legislation of 2010 cut Medicare by more than a half-trillion dollars over ten years.⁸² But that was only the latest such episode. Under both Republican and Democratic administrations and with congressional support from both political parties, the Medicare program has been cut in successive budget acts,⁸³ usually without any effort to redirect those dollars to other health care programs or to other services for the program’s beneficiaries.

To be sure, neither political party has been especially eager to alienate these beneficiaries. Health care is a vital concern for most Americans and is one of the largest and most unpredictable costs for older Americans in particular.⁸⁴ As such, any cut to the Medicare program carries with it some political risk. After all, older Americans

long-term care services as such. 42 U.S.C. § 3001l-2(a)(1)(D)(ii). The amount provided, however, could be used for whatever long-term care services the person requires, including paying family members for the assistance that they provide. *See id.* § 3001l-4(g). But the CLASS program is aimed at less expensive long-term care alternatives to institutionalized settings such as assisted living facilities and nursing homes. *Id.* § 3001l(1), (2), (4). Moreover, the CLASS program is separate and distinct from the Medicare program and is intended to be financed entirely by premiums paid by persons who choose to enroll in it. *Id.* § 3001l-7(a), (b). *See generally* Richard L. Kaplan, *Financing Long-Term Care After Health Care Reform*, J. RETIREMENT PLANNING 7, 7 (July–Aug. 2010). In any case, the Obama Administration announced on October 14, 2011 that it would not implement the CLASS program because of projected actuarial imbalances. *See* Letter from Kathleen Sebelius, Sec’y Dep’t of Health & Human Servs., to Congress (Oct. 14, 2011), available at <http://www.hhs.gov/secretary/letter10142011.html>.

81. *See, e.g.*, RICHARD A. EPSTEIN, *MORTAL PERIL: OUR INALIENABLE RIGHT TO HEALTH CARE?* 147 (1997).

82. Memorandum from Richard S. Foster, *supra* note 3, at 8.

83. *See, e.g.*, Balanced Budget Act of 1997, Pub. L. No. 105-33, §§ 4601–4616, 111 Stat. 251, 466–75 (codified at 42 U.S.C. § 1395 et seq.). *See generally* Theodore R. Marmor & Gary J. McKissick, *Medicare’s Future: Fact, Fiction and Folly*, 26 AM. J.L. & MED. 225, 232–34 (2000).

84. *See, e.g.*, Casey Dowd, *Medicare Changes Every Boomer Needs to Know About for 2012*, FOX BUSINESS (Jan. 19, 2012), <http://www.foxbusiness.com/personal-finance/2012/01/19/medicare-changes-every-boomer-needs-to-know-about-for-2012/>.

vote in higher proportions than do younger cohorts of voters,⁸⁵ especially in primary elections.⁸⁶ Those elections have a disproportionate impact on congressional races, because they are less susceptible to the sort of legislative districting shenanigans that are known colloquially as “gerrymandering.”⁸⁷

It is not only older Americans who are sensitive to Medicare program cuts. The near-elderly who are closing in on Medicare’s eligibility age of sixty-five years are also vitally interested in what is happening to a program that they will soon need to rely upon for financing of their still-indeterminate health care needs. Moreover, the adult children of current Medicare beneficiaries are acutely interested in any programmatic changes to Medicare that might impose higher costs on their parents and perhaps indirectly on themselves.⁸⁸ As a result, cutting the Medicare program is indeed fraught with political danger, but it has been done and done repeatedly by politicians from both political parties.

What has customarily happened is that the government has cut the Medicare program somewhat surreptitiously. Instead of reducing Medicare’s expenditures by increasing the costs that are paid directly by beneficiaries, politicians have chosen to lower the payments or “reimbursement rate” that Medicare pays to various health care providers for the services that it covers⁸⁹—hospital charges, nursing home costs, physicians’ fees, drug expenses, and the like. In so doing, the government is able to reap substantial budget savings while avoiding any immediately obvious impact on Medicare’s beneficiaries.⁹⁰

85. See Robert H. Binstock, *Older People and Political Engagement: From Avid Voters to ‘Cooled-Out Marks,’* GENERATIONS 24, 24–25 (Winter 2006–07). Older persons also “make campaign contributions at higher rates than younger people.” *Id.* at 27.

86. E.g., James O’Toole, *Older Voters Reign at Polls: Study Shows How the Over-50s Exert Such Great Influence,* PITT. POST-GAZETTE, May 7, 2006, <http://www.post-gazette.com/pg/06127/688152-103.stm>.

87. See, e.g., Chunka Mui, *To End Gridlock, Start By Ending Gerrymandering,* FORBES, Dec. 9, 2011, <http://www.forbes.com/sites/chunkamui/2011/12/09/to-end-gridlock-end-gerrymandering>.

88. See Richard L. Kaplan, *Taking Medicare Seriously*, 1998 U. ILL. L. REV. 777, 787; see also Robert N. Butler, *On Behalf of Older Women: Another Reason to Protect Medicare and Medicaid*, 334 NEW ENG. J. MED. 794, 795 (1995).

89. See, e.g., Omnibus Budget Reconciliation Act of 1993, Pub. L. No. 103-66, §§ 13,500–13,581, 107 Stat. 312, 571–611 (1993); Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, §§ 4000–4361, 104 Stat. 1388, 1388-30 to 1388-141 (1990).

90. See Kaplan, *supra* note 88, at 785 (“The repeated reduction of provider payment rates . . . casts the federal government in the odd role of being the biggest

This well-worn formula, embraced by both political parties, has limits, however. The Medicare program pays private providers and does not employ providers directly or own the facilities that provide the services it covers.⁹¹ As a result, many health care providers try to make up the shortfall in their income from Medicare's unilateral payment reductions in various ways. Some providers increase their charges to patients who are not covered by the Medicare program,⁹² but there are limits to this approach, especially for providers who see primarily Medicare beneficiaries. Other providers reduce the number of Medicare beneficiaries that they accept as patients to minimize the revenue shortfall they will suffer.⁹³ Still other providers close their practices to Medicare beneficiaries entirely.⁹⁴ In fact, a recent survey of physicians found that fully thirty-six percent of respondents claimed that Medicare's reimbursement rates did not cover the actual cost of providing care and twelve percent had declined to enroll any more Medicare beneficiaries as patients.⁹⁵

Such practice-closings can have a cascading effect as more Medicare beneficiaries then seek medical attention from a diminishing pool of willing providers. This problem of reduced access to providers is the major impediment to cutting Medicare's budget by lowering payment rates to medical service providers year after year. A particu-

freeloader in the American health-care system."); *see also* WILL FOX & JOHN PICKERING, HOSPITAL & PHYSICIAN COST SHIFT: PAYMENT LEVEL COMPARISON OF MEDICARE, MEDICAID, AND COMMERCIAL PAYERS 2 (2008), *available at* <http://publications.milliman.com/research/health-rr/pdfs/hospital-physician-cost-shift-RR12-01-08.pdf> (noting that Medicare paid hospitals and physicians nearly \$35 billion less than commercial payers for the services it covered in 2006).

91. *See* CTRS. FOR MEDICARE & MEDICAID SERVS., MEDICARE AND OTHER HEALTH BENEFITS: YOUR GUIDE TO WHO PAYS FIRST 2-3, 33 (2011), *available at* <http://medicare.gov/publications/pubs/pdf/02179.pdf>.

92. *See* Ezekiel J. Emanuel & Jeffrey B. Liebman, *Cut Medicare, Help Patients*, N.Y. TIMES, Aug. 23, 2011, <http://www.nytimes.com/2011/08/23/opinion/cut-medicare-help-patients.html> (stating that cuts "just shift costs from the government to the private sector").

93. *See* Melinda Beck, *The Doctor Will Never See You Again*, WALL ST. J., Feb. 8, 2010, <http://online.wsj.com/article/SB10001424052748703630404575053221001720404.html>.

94. *See* Sylvia A. Law & Barry Ensminger, *Negotiating Physicians' Fees: Individual Patients or Society? (A Case Study in Federalism)*, 61 N.Y.U. L. REV. 1, 15 (1986) (noting that physicians may refuse to participate in insurance programs with inadequate payment rates).

95. THE PHYSICIANS' FOUND., THE PHYSICIANS' PERSPECTIVE: MEDICAL PRACTICE IN 2008, at 3 (2008), *available at* http://www.mendocinohre.org/rhic/200811/PF_Report_Final.pdf; *see also* MEDICARE CHARTBOOK, *supra* note 32, at 29 fig.2.15 (only seventy-four percent of physicians accept all or most new Medicare patients).

larly vivid example of this phenomenon involves Medicare's reimbursement rates for physicians. Designed to reduce the program's costs for doctors' services, the "sustainable growth rate" provision calls for relatively small fee reductions over several years.⁹⁶ Medicare beneficiaries, their physicians, and the AARP, the powerful senior advocacy organization, have regularly lobbied for so-called "doc fix" legislation to hold off the scheduled fee reductions, and Congress has responded accordingly for political reasons.⁹⁷ If the temporary suspensions lapse, the cumulative reduction that would take effect in 2012 would be over twenty-seven percent⁹⁸—a reduction that most certainly would be noticed by all parties concerned and would undoubtedly result in significant access limitations for Medicare beneficiaries.

Nonetheless, many of the Medicare cuts contained in the 2010 health care reform legislation are similar to the ill-fated doctors' fee reductions but apply this time to hospitals, nursing homes, and home health care agencies.⁹⁹ As the Chief Actuary for the Centers for Medicare & Medicaid Services concluded, those reductions "are unlikely to be sustainable on a permanent annual basis."¹⁰⁰ Thus, the bottom line remains that the federal government has indeed cut Medicare's budget repeatedly through the back-door mechanism of lowering provider fees, but this particular strategy may no longer be feasible.

VII. Medicare Wastes Much of Its Money on Futile Care

If Medicare wastes much of its money on pointless care, an easy budgetary fix would be to eliminate this expenditure of funds. Thus, it is extremely important to ascertain whether, in fact, Medicare wastes substantial funds on futile care.

96. See U.S. CONG. BUDGET OFFICE, ECON. & BUDGET ISSUE BRIEF, THE SUSTAINABLE GROWTH RATE FORMULA FOR SETTING MEDICARE'S PHYSICIAN PAYMENT RATES 2, 4–6 (Sept. 6, 2006), available at <http://www.cbo.gov/ftpdocs/75xx/doc7542/09-07-SGR-brief.pdf>.

97. See Jennifer Haberkorn, *Senate Approves Medicare Fix*, POLITICO, Dec. 9, 2010, <http://www.politico.com/news/stories/1210/46109.html>.

98. Robert Lowes, *10-Month Medicare 'Doc Fix' Passes House*, MEDSCAPE NEWS TODAY, Feb. 17, 2012, <http://www.medscape.com/viewarticle/758824>. A payment cut of twenty-five percent was postponed for one year by the Medicare and Medicaid Extenders Act of 2010, Pub. L. No. 111-309, § 101, 124 Stat. 3285, 3285–86 (2010).

99. See Memorandum of Richard S. Foster, *supra* note 3, at 9.

100. *Id.* at 20.

It should be emphasized at the outset that this contention is not about the ever-present specter of “waste, fraud, and abuse” that haunts governmental programs generally. That Medicare is targeted by scammers and schemers of all sorts is both indisputable and hardly surprising. As the famed bank robber, Willie Sutton, reportedly replied when asked why he robbed banks: “That’s where the money is.”¹⁰¹ Indeed, Medicare is where the money is—specifically \$509 billion in fiscal year 2010 alone.¹⁰² Any program that pays out this amount of money to a wide variety of service providers in literally every county in America will be very difficult to police. That reality notwithstanding, such violations of the public trust as are encapsulated in the phrase “waste, fraud, and abuse” should be ferreted out whenever possible and eliminated. No one excuses these leakages, just as no one has a sure-fire solution to stem them once and for all.

But the issue of “futile care” is very different from “waste, fraud, and abuse.” The claim that Medicare should not pay for pointless medical interventions presumes that funds were indeed spent on actual medical procedures. The issue is whether those procedures should not have been done for reasons of inefficacy or insufficient “bang for the buck.” It is certainly true that Medicare spends a disproportionate amount of its budget on treatments in the final months of its beneficiaries’ lives. Some twenty-eight percent of the entire Medicare budget is spent on medical care in enrollees’ final year of life,¹⁰³ and nearly forty percent of that amount is spent during a patient’s last month.¹⁰⁴ The critical issue, of course, is whether these expenditures are pointless.

In one respect, it is not surprising that the cost of a person’s final medical episode is unusually expensive. That person’s presenting condition must have been especially severe because he or she did in fact die during or shortly after treatment. Moreover, when circumstances are particularly bleak, more intensive and often much more expensive procedures, tests, and interventions seem appropriate. After all, the patient was literally fighting off death at that point, so med-

101. Barbara Mikkelson, *Willie Sutton*, SNOPE.COM, <http://www.snopes.com/quotes/sutton.asp> (last visited Mar. 9, 2012).

102. See MEDICARE FACT SHEET, *supra* note 47, at 1.

103. See MARILYN MOON & CRISTINA BOCCUTI, MEDICARE AND END-OF-LIFE CARE 16 (2002), available at http://www.urban.org/uploadedPDF/1000442_Medicare.pdf.

104. See James D. Lubitz & Gerald F. Riley, *Trends in Medicare Payments in the Last Year of Life*, 328 NEW ENG. J. MED. 1092, 1094 (1993).

ical personnel try everything in their armamentarium to win what was ultimately the patient's final battle. Only after the fact does one know that the battle in question was indeed the patient's last episode. Does that mean that the effort expended, and the attendant costs, were wasted?

This question is more difficult than some might suspect. A recent study of Medicare claims data examined the association between inpatient spending and the likelihood of death within thirty days of a patient's being admitted to a hospital.¹⁰⁵ It found that for most of the medical conditions examined, including surgery, congestive heart failure, stroke, and gastrointestinal bleeding, a ten percent increase in inpatient spending was associated with a decrease in mortality within thirty days of 3.1 to 11.3%, depending upon the specific medical condition in question.¹⁰⁶ Only for patients who presented with acute myocardial infarction was there no association of increased inpatient spending and improved outcomes. Thus, the authors concluded, "the amount [of waste] may not be as large as commonly believed, at least for hospitalized Medicare patients."¹⁰⁷ To be sure, the results might not be as encouraging in non-hospital settings, but Medicare does not cover the cost of nursing home patients who are lingering at death's door while receiving "custodial care."¹⁰⁸ In any case, hospital costs represent the single largest component of Medicare's expenditures—fully twenty-seven percent in the most recent year for which such data are available.¹⁰⁹

That is not to say that some of Medicare's expenditures near the end of beneficiaries' lives provide insufficient benefit to justify their cost. But the tough questions are how to determine those wasteful expenditures in advance and who should make that determination.¹¹⁰ Such considerations are beyond the scope of this Article,¹¹¹ but suffice

105. Robert Kaestner & Jeffrey H. Silber, *Evidence on the Efficacy of Inpatient Spending on Medicare Patients*, 88 *MILBANK Q.* 560, 570 (2010).

106. *Id.* at 578, 581.

107. *Id.* at 583.

108. *See supra* text accompanying notes 65–74.

109. *See* MEDICARE FACT SHEET, *supra* note 47, at 1.

110. *See* Marshall B. Kapp, *Health Care Rationing Affecting Older Persons: Rejected in Principle but Implemented in Fact*, 14 *J. AGING & SOC. POL'Y* 27, 33–34 (2002); George P. Smith, II, *The Elderly and Health Care Rationing*, 7 *PIERCE L. REV.* 171, 180–81 (2009). *See generally* DANIEL CALLAHAN, *SETTING LIMITS: MEDICAL GOALS IN AN AGING SOCIETY* (1987).

111. *But see* Peter H. Schuck, *The Golden Age of Aging, and Its Discontents*, 18 *ELDER L.J.* 25 (2010) (advocating that health care be rationed according to the

it to note that end-of-life care discussions are extraordinarily contentious and easily demagogued. After all, former Vice Presidential candidate Sarah Palin effectively scuttled a rather benign effort to include payment for end-of-life counseling in Medicare's newly provided "annual wellness visit[s]"¹¹² by contending that such counseling was a first step to rationing health care by "death panels" run by government bureaucrats.¹¹³ Thus, while patients can individually indicate in advance how much treatment they want at the end of their lives,¹¹⁴ any comprehensive effort to root out Medicare's wasteful expenditures on "futile care" might face serious political opposition.

In any case, an authoritative analysis published in *The New England Journal of Medicine* concluded that "the hope of cutting the amount of money spent on life-sustaining interventions for the dying in order to reduce overall health care costs is probably vain."¹¹⁵ The authors noted that "there are no reliable ways to identify the patients who will die" and that "it is not possible to say accurately months, weeks, or even days before death which patients will benefit from intensive interventions and which ones will receive 'wasted' care."¹¹⁶

That leaves age-based rationing of care or more precisely, denial of medical services on the basis of chronological age, as the only easily implemented pathway to eliminate what some might regard as inefficient expenditures of medical resources. Such age-based rationing of health care is practiced in other national health care systems, even though studies of prognostic models have demonstrated that "age alone is not a good predictor of whether treatment will be success-

number of "quality-adjusted life years," a metric that is often tied to a patient's chronological age).

112. 42 U.S.C. § 1395x(hhh), as added by the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 4103(b), 124 Stat. 119, 553-55 (2010).

113. See David Corn, *Palin Doubles Down on "Death Panels,"* MOTHER JONES, Oct. 12, 2010, available at <http://motherjones.com/mojo/2010/10/palin-death-panels-newsmax-health-care> (setting forth Sarah Palin's August 2009 Facebook entry). It is perhaps worth noting that such end-of-life counseling is available in Medicare's hospice program and in Medicare's "initial preventive physical examination" as well. 42 U.S.C. §§ 1395d(a)(5)(B), 1395x(ww)(3)(A) (Supp. III 2009) (amending 42 U.S.C. § 1395x(ww) (2006)).

114. See generally FROLIK & KAPLAN, *supra* note 1, at 25-44.

115. Ezekiel J. Emanuel & Linda L. Emanuel, *The Economics of Dying: The Illusion of Cost Savings at the End of Life*, 330 NEW ENG. J. MED. 540, 543 (1994).

116. *Id.*; see also Joanne Lynn et al., *Defining the "Terminally Ill": Insights from SUPPORT*, 35 DUQ. L. REV. 311, 326 (1996) (reporting that seven days before death, patients were as likely as not to survive the next two months and that even one day before death, the mean survival rate was seventeen percent).

ful.”¹¹⁷ In any case, polls of Americans have shown little support and significant opposition to the concept.¹¹⁸ One survey undertaken in late 1989 sought agreement with the following statement: “Life-extending medical care should be withheld from older patients to save money to help pay for the medical care of younger patients.”¹¹⁹ Only 5.7% of respondents under age sixty-five strongly agreed with this statement while 38.3% of that group strongly disagreed with it.¹²⁰ Interestingly, among respondents who were themselves age sixty-five and older, the gap between these opposing viewpoints was narrower: 8.8% strongly agreed with the statement in question while 35.4% strongly disagreed.¹²¹

Whether results would be substantially different today when the range of medical interventions has increased significantly and when the nation’s budgetary situation has worsened considerably is an open question. Yet, when the 2010 health care reform legislation created an Independent Payment Advisory Board to reduce Medicare’s expenses,¹²² the enabling statute was explicit that this Board may not make proposals that would “ration health care.”¹²³ Clearly, the prospect of eliminating Medicare expenditures that are medically futile will not be an easy task to accomplish.

VIII. Medicare Is Less Efficient than Private Health Insurance

The relevant syllogism is fairly straightforward:

Proposition One: Medicare is a government program.

Proposition Two: Government programs are inefficient.

117. See CYNTHIA X. PAN ET AL., INT’L LONGEVITY CENTER–USA, MYTHS OF THE HIGH MEDICAL COST OF OLD AGE AND DYING 7 (2007), available at <http://www.globalaging.org/health/us/2007/mytholdage.pdf>.

118. See, e.g., Linda Brasfield Kuder & Phillip W. Roeder, *Attitudes Toward Age-Based Health Care Rationing: A Qualitative Assessment*, 7 J. AGING & HEALTH 301 (1995).

119. Nancy R. Zweibel et al., *Public Attitudes About the Use of Chronological Age as a Criterion for Allocating Health Care Resources*, 33 THE GERONTOLOGIST 74, 76 (1993).

120. *Id.* at 78 tbl.3.

121. *Id.*

122. 42 U.S.C. § 1395kkk, as added by the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 3403(a)(1), 124 Stat. 119, 489 (2010).

123. 42 U.S.C. § 1395kkk(c)(2)(A)(ii). For some of the more important challenges that this new Board will face in effecting its mandate to cut Medicare’s growth rate, see Timothy Stoltzfus Jost, *The Independent Payment Advisory Board*, 11 YALE J. HEALTH POL’Y L. & ETHICS 21, 26–31 (2011).

Therefore, Medicare must be inefficient.

How can anyone argue with this logic? After all, Proposition One is indisputably true, and examples proving Proposition Two are everywhere to be found. Indeed, assailing government programs as inherently inefficient is akin to the proverbial exercise of shooting fish in a barrel. Little effort is required.

Nevertheless, Medicare has a significantly lower cost of administration than do private health insurance companies.¹²⁴ Medicare spends only 1.4% of medical benefits paid on administrative expenditures,¹²⁵ while private insurers spend 25% or more for such costs.¹²⁶ There are several distinct and not altogether favorable reasons behind this apparently excellent result. First, Medicare does not need to advertise for customers because it has a monopoly on Part A insurance services. Second, the cost of signing up customers and collecting premiums is borne by employers and the Internal Revenue Service regarding Medicare Part A, by the Social Security Administration regarding Medicare Part B, by managed care organizations regarding Medicare Part C, and by pharmaceutical providers regarding Medicare Part D.¹²⁷ Consequently, Medicare avoids two of the more significant costs of insurance administration: advertising and enrollment.

Of perhaps even greater significance is Medicare's commitment to take all comers who satisfy its rather limited eligibility criteria. That is, Medicare makes no effort to exclude anyone based on family health history, individual medical profile, or current health status.¹²⁸ Medicare knows nothing of preexisting conditions and cannot charge

124. See MARK E. LITOW, *MEDICARE VERSUS PRIVATE HEALTH INSURANCE: THE COST OF ADMINISTRATION* 6–7 (2006), available at http://www.cahi.org/cahi_contents/resources/pdf/CAHIMedicareTechnicalPaper.pdf; see also JACOB S. HACKER, INST. FOR AM.'S FUTURE, *THE CASE FOR PUBLIC PLAN CHOICE IN NATIONAL HEALTH REFORM* 5–6, available at http://institute.ourfuture.org/files/Jacob_Hacker_Public_Plan_Choice.pdf. But see ROBERT A. BOOK, THE HERITAGE FOUND., *MEDICARE ADMINISTRATIVE COSTS ARE HIGHER, NOT LOWER, THAN FOR PRIVATE INSURANCE* 3 (2009), available at http://s3.amazonaws.com/thf_media/2009/pdf/wm2505.pdf (Medicare's enrollees are sicker than the general population and therefore incur higher medical costs per person, so the program's cost of administration as a percent of benefits paid is lower than that of private insurers).

125. *MEDICARE CHARTBOOK*, *supra* note 32, at 80 fig.8.6.

126. See Kaplan, *supra* note 88, at 780–81.

127. See MERRILL MATTHEWS, COUNCIL FOR AFFORDABLE HEALTH INS., *MEDICARE'S HIDDEN ADMINISTRATIVE COSTS: A COMPARISON OF MEDICARE AND THE PRIVATE SECTOR* 4 (2006), available at http://www.cahi.org/cahi_contents/resources/pdf/CAHI_Medicare_Admin_Final_Publication.pdf.

128. Kaplan, *supra* note 88, at 781.

differential rates based on medical underwriting factors.¹²⁹ Once the Social Security Administration verifies that an applicant (or that person's spouse or divorced spouse) has earned the requisite forty "quarters of coverage" to be entitled to Social Security retirement benefits¹³⁰ and the applicant proves that he or she is sixty-five years old, that person can enroll in Medicare. Thus, Medicare avoids the expensive and time-consuming investigative process of determining whether a prospective applicant presents a medically unacceptable insurance risk. The corresponding impact on administrative costs is difficult to overstate.

On the other hand, another way to drive down administrative costs as a percent of claims paid is to pay virtually any claim presented with only minimal scrutiny. The regular and often well-publicized instances of serious Medicare fraud¹³¹ may be attributable, at least in part, to the program's practice of paying apparently reasonable claims for medical services with little verification of the claims' validity. As a governmental agency with an essentially uncapped budget, Medicare lacks the profit incentive and fiduciary obligation to shareholders that motivate private insurance companies to monitor closely the claims presented in an effort to ferret out and stop fraud before payment is made. Although Medicare ought to be conscientious regarding its outlays of taxpayer funds, this imperative is not as powerful as a private insurer's desire to retain the premium dollars it collects by denying claims.

To be sure, claims denial practices by private insurers are often a sore point with their policyholders. When those practices appear to be arbitrary and unwarranted, they bring disrepute upon the claims-denying insurers and protests from affected claimants and their families.¹³² The point remains that aggressive review of submitted claims

129. *See id.*

130. 42 U.S.C. § 1395c(1) (2006).

131. *See, e.g.,* 26 *Arrested in Three States in Medicare Fraud Schemes*, N.Y. TIMES, Dec. 16, 2009, at A33; *Dozens Arrested in Medicare Fraud Totaling \$251 Million*, N.Y. TIMES, July 17, 2010, at A20; *Wide Net of Arrests in Medicare Fraud Inquiry*, N.Y. TIMES, Feb. 18, 2011, at A19; John Carreyrou & Tom McGinty, *Medicare Records Reveal Troubling Trail of Surgeries*, WALL ST. J., Mar. 29, 2011, <http://online.wsj.com/article/SB10001424052748703858404576214642193925996.html>; Mark Schoofs, *Medicare Fraud Nets Guilty Plea*, WALL ST. J., May 14, 2011, <http://online.wsj.com/article/SB10001424052748704681904576321621961413458.html>.

132. *See, e.g.,* Charles Duhigg, *Aged, Frail, and Denied Care by Their Insurers*, N.Y. TIMES, Mar. 26, 2007, <http://www.nytimes.com/2007/03/26/business/>

is more typical of private health insurance companies than of Medicare,¹³³ and that review process increases companies' cost of administering claims as a percent of the sum of claims paid. Thus, Medicare enjoys distinct competitive advantages that contribute to its low cost of administration, but some of its apparent efficiency may be due to less rigorous scrutiny of submitted claims.¹³⁴

IX. Medicare Is Not Means-Tested

Whenever the issue of cutting Medicare is discussed, one of the first rejoinders by all parties concerned is that a better alternative would be to make the program's upper-income beneficiaries pay more for their benefits. Indeed, the claim is often propounded that it is silly, if not offensive, to have low-income workers pay higher taxes so that wealthy beneficiaries can receive subsidized benefits from the Medicare program. The underlying premise of these contentions is that Medicare is not means-tested presently. That is simply not the case.

Medicare Part A is financed by a 2.9% payroll tax imposed on *all* of a person's wages, salaries, and income from self-employment.¹³⁵ Thus, if Amy earns ten times what Alex earns, Amy will pay ten times as much Medicare tax as Alex. And beginning in 2013, individuals with annual income above \$200,000 and married couples with annual income above \$250,000 will owe an additional 0.9% Medicare tax on their income above those thresholds from wages, salaries, and self-employment.¹³⁶ These taxpayers will also owe a 3.8% Medicare tax on their investment income in excess of those same thresholds.¹³⁷ Moreover, those thresholds are not indexed for inflation¹³⁸ and will there-

26care.html (describing practices by some providers of long-term care insurance to delay payment of submitted claims).

133. See MATTHEWS, *supra* note 127, at 5.

134. See also David A. Hyman, *Does Medicare Care About Quality?*, 46 PERSP. BIO. & MED. 55, 64 (2003) (noting that Medicare's "shockingly low" cost of administering the program is "certainly not enough to pay for aggressive oversight of the quality of care").

135. See *supra* text accompanying notes 21–23.

136. I.R.C. §§ 1401(b)(2), 3101(b)(2) (Supp. IV 2010), added by the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, §§ 9015, 10906, 124 Stat. 119, 870–72, 1020 (2010).

137. I.R.C. § 1411(a)(1), (b) (Supp. IV 2010), added by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, § 1402(a)(1), 124 Stat. 1029, 1060–63 (2010).

138. Edward A. Zelinsky, *The Health-Related Tax Provisions of PPACA and HCERA: Contingent, Complex, Incremental and Lacking Cost Controls*, in 2010 NEW

fore become more important over time. In any case, the point remains that higher-income persons already pay more for their Medicare benefits than do lower-income persons, and that phenomenon will increase significantly after 2012.¹³⁹

In this connection, it should be noted that unlike Social Security benefits, which bear a close (though not isomorphic) relationship to one's pre-retirement earnings,¹⁴⁰ there is no correlation between one's pre-retirement earnings or one's Medicare taxes paid and the benefits a person receives from Medicare Part A. Indeed, the value of Medicare benefits received correlates with a person's health, not wealth, so a less-healthy retiree will receive more benefits from Medicare than a healthier retiree. Therefore, to the extent that wealthy people, and wealthy retirees especially, are healthier than their poorer counterparts,¹⁴¹ there is actually a *negative* relationship between the income earned prior to retirement and the benefits a person is likely to receive from the Medicare program. In any case, Medicare Part A is clearly means-tested at the front end when taxes are paid to secure future entitlement to program benefits.

YORK UNIVERSITY REVIEW OF EMPLOYEE BENEFITS & EXECUTIVE COMPENSATION §7.02[3] (Alvin D. Lurie ed., 2010).

139. See generally Richard L. Kaplan, *Rethinking Medicare's Payroll Tax After Health Care Reform*, TAXES, Aug. 2011, at 43.

140. See generally FROLIK & KAPLAN, *supra* note 1, at 295–99.

141. See MEDICARE CHARTBOOK, *supra* note 32, at 23–24 figs.2.3 & 2.4 (the highest-income Medicare beneficiaries have the lowest utilization rate of hospital and home health care services); see also *id.* at 12 fig.1.6 (for Medicare beneficiaries, self-reported health status of "fair" or "poor" health declines as income rises).

Medicare Part B and Part D employ a more direct form of means-testing—namely, increased premiums based on taxable income during one’s retirement years. Eschewing the precise mechanics of the applicable provisions, any Medicare beneficiary whose income exceeds some annually determined threshold pays an increased amount for coverage under these components of Medicare.¹⁴² The amounts charged are based on no fewer than five separate levels of income as illustrated in this chart for Medicare Part B for the year 2012.¹⁴³

TABLE 1

Income (if Single)	Monthly Payment
\$85,000 or less	\$99.90
\$85,001–\$107,000	\$139.90
\$107,001–\$160,000	\$199.80
\$160,001–\$214,000	\$259.70
Over \$214,000	\$319.70

Thus, once taxable income with certain adjustments, the most significant being inclusion of tax-exempt interest income,¹⁴⁴ reaches the specified threshold, the amount paid by enrollees in either Medicare Part B or Medicare Part D is increased according to a progressive formula. Moreover, this formula was made more severe when the health care reform legislation enacted in 2010 froze the applicable income thresholds for the next ten years.¹⁴⁵ To be sure, even enrollees at

142. Regarding Medicare Part B’s means-testing formula and some of the financial implications it engenders, see Kaplan, *supra* note 30, at 25–27; for details on Medicare Part D’s means-testing provision, see Kaplan, *supra* note 4, at 225–27.

143. Adapted by author from 2012 *Part B Premium Amounts for Persons with Higher Income Levels*, MEDICARE.GOV (Oct. 27, 2011), https://questions.medicare.gov/app/answers/detail/a_id/2310.

144. 42 U.S.C. § 1395r(i)(4)(A)(ii) (2006); I.R.C. § 103 (2006).

145. 42 U.S.C. § 1395r(i)(6), added by the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 3402(4), 124 Stat. 119, 489 (2010).

the highest income level receive some subsidy from general tax revenues, but the extent of this subsidy declines as their income increases.

Means-testing was not part of either Medicare Part B or Part D when those programs were first enacted but was added after considerable debate.¹⁴⁶ Some policymakers opposed the very concept of means-testing benefits, regardless of the specific formula that was suggested, arguing that Medicare was a social insurance program and should provide equal benefits to all participants regardless of their individual resources. Means-testing benefits, in their view, ran the risk of converting Medicare into another welfare-oriented program with possible erosion of popular support and potential exposure to the sort of reductions that such programs often suffer in difficult economic times. Other policymakers opposed means-testing Medicare because they regarded reducing promised benefits on the basis of income as a disguised tax, a penalty on "success" in their view.¹⁴⁷ Thus, the idea that Medicare benefits should be means-tested raises genuine philosophical issues and is not a policy "slam dunk."

Be that as it may, the bottom line is that the individual components of Medicare are means-tested currently, despite whatever concerns policymakers may have raised in the past. Some lawmakers, no doubt, might prefer that the degree to which Medicare is means-tested be increased, but the fact remains that Medicare *is* means-tested.

X. Increased Longevity Will Sink Medicare

The customary formulation of this myth is that Medicare is doomed by its own success in keeping its beneficiaries alive. Not only will the ranks of the program's beneficiaries increase as the vaunted baby boom generation reaches the statutory age of eligibility, but because people are staying alive longer, Medicare's costs will explode. The first part of this contention is indisputably true: entitlement to Medicare occurs when a person reaches age sixty-five,¹⁴⁸ and the baby boom generation that is generally calibrated as starting in 1946 has arrived at that threshold. As a result, additional Medicare beneficiaries enter that program every day, and because the baby boom generation dwarfs any preceding age cohort,¹⁴⁹ it is highly likely that more bene-

146. See generally Kaplan, *supra* note 30, at 23–25.

147. See Kaplan, *supra* note 88, at 793.

148. 42 U.S.C. § 1395c.

149. See ADMIN. ON AGING, *supra* note 16, at 3.

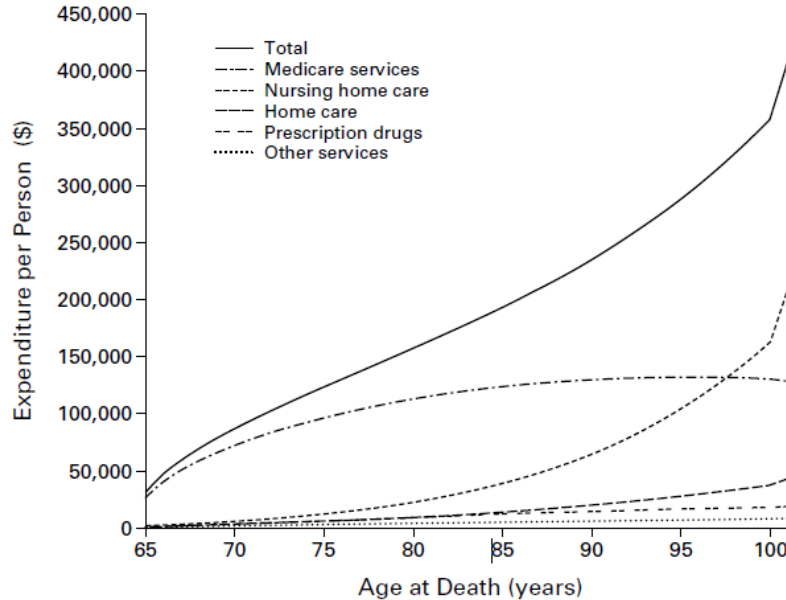
ficiaries will be added to the program than are lost as older beneficiaries pass away. Consequently, the number of Medicare beneficiaries will inexorably increase over the next decade or so. *Ceteris paribus*, more beneficiaries mean higher aggregate costs.

The second part of the contention, however, is myth. Just because today's Medicare beneficiaries live longer than did their predecessors does not necessarily translate into higher costs for the Medicare program. The source of this apparently counterintuitive proposition is the panoply of programmatic limitations that Medicare imposes on its coverages, regarding the myth that Medicare pays for long-term care.¹⁵⁰ More specifically, beneficiaries who live longer typically do incur higher cumulative health care costs over their post-sixty-five lifetimes, but many of those costs are not borne by the Medicare program. This phenomenon is well illustrated by the following graph from an important analysis that appeared in *The New England Journal of Medicine*:¹⁵¹

150. See *supra* text accompanying notes 57–74.

151. Brenda C. Spillman & James Lubitz, *The Effect of Longevity on Spending for Acute and Long-Term Care*, 342 NEW ENG. J. MED. 1409, 1411 (2000).

FIGURE 1:
 CUMULATIVE HEALTH CARE EXPENDITURES FROM THE AGE OF 65 YEARS
 UNTIL DEATH, ACCORDING TO THE TYPE OF HEALTH SERVICE
 AND THE AGE OF DEATH.

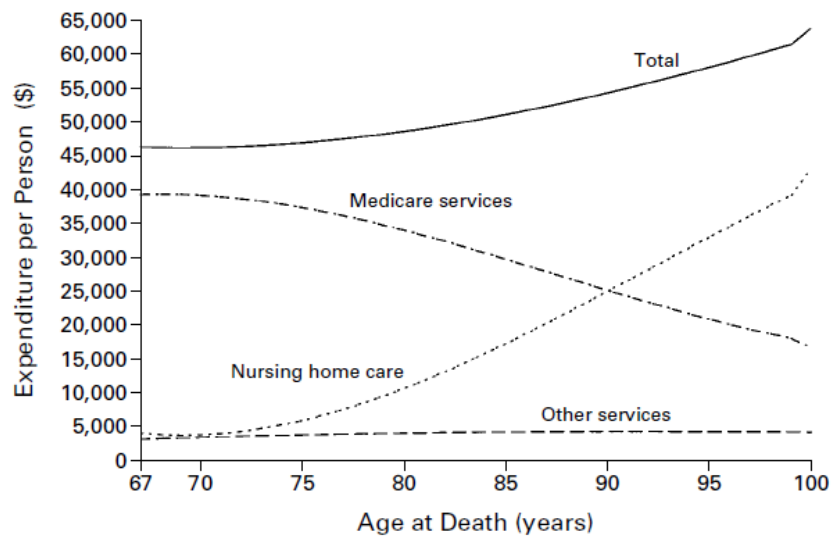


This graph shows that per-person cumulative health care expenditures—the solid line—rise as a person’s life lengthens. That is, the longer a person lives, the higher the total amount spent on health care expenses during the years after that person reaches age sixty-five, as one might surmise. In analyzing the impact on the Medicare program, however, it is essential to break out the components of total health care costs. Medicare covers most hospital costs but only a limited amount of nursing home expenses.¹⁵² The sum of such nursing home costs—the short-dashed line in the graph—increases with a person’s age, but those costs are generally *not* part of Medicare’s responsibility. As a result, the cumulative cost borne by the Medicare program actually plateaus around age eighty, meaning that there is virtually no additional cumulative cost to Medicare from a person who lives past age eighty.

152. See *supra* text accompanying notes 65–74.

Although the article did not attempt to explain this phenomenon, it is possible that after a person reaches some unspecified age, certain very expensive medical interventions are unlikely to succeed or may no longer be appropriate for other reasons. Indeed, the following graph¹⁵³ from the same article analyzes the sum of health care expenditures for a patient's final two years of life, once again according to the age at which that person died:

FIGURE 2:
Health Care Expenditures in the Last Two Years of Life, According to the Type of Health Service and the Age at Death.



As this graph shows, the total cost of nursing home care during a person's last two years is extremely sensitive to that person's longevity and rises steadily as that person's attained age increases. But the cost of that patient to Medicare during those final two years actually decreases. As the article concluded, "longevity after the age of 65 has a larger effect on the costs of nursing home care . . . than on the costs of services covered by Medicare."¹⁵⁴ Thus, the increasing number of persons eligible for Medicare in the future will certainly increase that program's costs, but their increasing longevity is itself a benign factor.

153. Spillman & Lubitz, *supra* note 151, at 1412.

154. *Id.* at 1414.

Or as Harvard economist David Cutler concluded, “longer life in itself will not add to Medicare costs.”¹⁵⁵

XI. Conclusion

Medicare is an important and complicated program. It has no counterpart in the American health care system, and its significance to Americans of all ages is impossible to overstate. At the same time, its very size and cost make it a natural target for serious reform and cost reduction. This Article has sought to create a context for informed discussion and analysis of proposals to control the cost of Medicare in the future while recognizing that it has not been a stranger to such efforts in the past. As the baby boom generation passes from indirect beneficiaries—as Medicare has covered some of the medical costs of its parents—to direct beneficiaries as program enrollees, it is essential that would-be reformers understand the program’s existing contours and limitations. Only if the many myths that surround this program are debunked can the difficult decisions and inevitable policy trade-offs be developed that will maintain the program’s singular importance for older Americans.

155. David M. Cutler, *Disability and the Future of Medicare*, 349 NEW ENG. J. MED. 1084, 1084 (2003); see also James Lubitz et al., *Health, Life Expectancy, and Health Care Spending Among the Elderly*, 349 NEW ENG. J. MED. 1048 (2003); Lisa R. Shugarman et al., *Differences in Medicare Expenditures During the Last 3 Years of Life*, 19 J. GEN. INTERNAL MED. 127, 131 (2004). See generally Peter Zweifel et al., *Population Ageing and Health Care Expenditure: New Evidence on the “Red Herring,”* 29 GENEVA PAPERS ON RISK & INS. 652 (2004).