

WINNERS AND LOSERS IN THE DEBATE OVER THE EXPANSION OF MEDICARE

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Over its nearly sixty years, Medicare's reach in terms of beneficiary groups and benefits has remained surprisingly stable, not for lack of attempts at expansion. This essay considers several of the most ambitious attempts at Medicare expansion, including adding benefits for prescription drugs, long-term care, and vision, dental, and hearing care. Some failures and some successful, these efforts considered in conjunction illuminate Medicare's changing identity, drifting gradually yet fundamentally from its social insurance roots. Understanding the winners and losers in the debates over Medicare expansion reveals the changing political economy and collective understanding of Medicare as a cornerstone of the welfare state.

I. Introduction

At its inception, some saw Medicare as the eventual platform for national health insurance. Others built guardrails to prevent an expansive future, with, for example, the simultaneous passage of Medicaid to provide benefits to low-income pregnant women, alleviating what

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might have been perceived as a more pressing need. In 1972, Medicare expanded to people with disabilities under age 65 and people with End Stage Renal Disease. But then in the decades that followed, most attempts at meaningful expansion failed. In the 1990s, for example, the Catastrophic Care Act (CCA) attempted to eliminate gaps in the program's cost-sharing structure, only to be repealed shortly after its passage. Efforts to include long-term care benefits are proposed and defeated on a regular basis. The attempt to add benefits for dental, hearing and vision care during the Biden Administration likewise has stalled out.

Each failed effort at expansion could be described independently. The CCA was repealed in part because of confusion over whom it would help and, even more, because it failed to address what was seniors' top concern: long-term care costs.¹ Ironically, in turn, long-term care reforms are repeatedly defeated because of the fiscal cost and because of conflicting views of whether such care should be the role of the state or the family.²

Understood together, however, these efforts tell a story of a program that failed to realize its social insurance potential and of American ambivalence with social insurance. When failed efforts at benefits expansion are compared with the one major effort that did succeed, the creation of prescription drug benefits under Medicare Part D, it illuminates how Medicare's evolution has been shaped by a broader privatization of the administrative state and faith in markets. Efforts to expand that do not fit this mold are political nonstarters.

In some ways, Medicare expansion was fated to stall out from its start. Once its contours were designed, it created vested interests which worked to block fundamental change, or to shape it in their favor. Interest groups did not significantly shape the form Medicare took in 1965,³ but ever since then, their stake in the shape of policies and potential influence over them has grown, most recently as campaign finance law changes allow industry to wield increasingly more power.⁴

1. THEODORE R. MARMOR, *POLITICS OF MEDICARE* 112 (Cambridge Univ. Press 2d ed. 2000).

2. Allison K. Hoffman, *Reimagining the Risk of Long-Term Care*, 16 *YALE J. HEALTH POL'Y, L., & ETHICS* 239, 243 (2016).

3. MARMOR, *supra* note 1 at 77.

4. *See generally*, *Citizens United v. Fed. Election Comm'n*, 558 U.S. 310 (2010) (lifting limits on corporate financing of campaigns by eliminating disclosure requirements under the Bipartisan Campaign Reform Act (BCRA)).

Medicare's design has enabled some groups outsized influence over its shape. For example, as the program relied more deeply on private insurers, their influence over policy design grew. The permeation of private insurance tools into Medicare, like prior utilization review and limited networks, muddles Medicare's identity as social insurance—something distinct from private insurance—in a way that paves the path for continued privatization.

On the flip side, efforts at social-insurance style expansion are thwarted by estimates of increased spending or by industry resistance to including more benefits in traditional, public Medicare like most recently, dental, vision, and hearing benefits. This resistance mutes the counterpoint view: that by excluding categories of care, like dental or vision or long-term care, the cost of such care rests squarely and sharply on the shoulders of beneficiaries who need it, and some forgo care altogether if they cannot afford it.

Each time that Medicare has seen the potential for expansion—whether it has succeeded or failed—offers a window into the evolving political economy of the program and our collective understanding of its nature as a cornerstone of the welfare state. This essay examines several of the most significant efforts at expansion in the past sixty years as case studies: the successful, albeit contentious expansion to include prescription drug benefits contrasted with the failures to limit cost sharing and add benefits, including for long-term care and vision, dental, and hearing care. It concludes that these case studies together illustrate in broad brush strokes the evolution of the program and how it has over time drifted away from social insurance ideals.

II. An Expansionary Moment: Medicare's Drug Program and Deepening Privatization

In 2003, Medicare saw the most fundamental benefits expansion since its passage and, with it, a major turning point in its core ideology.⁵ The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) created Medicare Part D to cover outpatient prescription drugs, calling on private insurers to deliver the new benefit.⁶ Signed into law by George W. Bush, the MMA marks a complicated moment in Medicare's history.

Although the expansion filled a critical gap in coverage, its design undermined Medicare's universal, public, social insurance character in three key ways: first, in the form of the new benefit; second, by funding it in part through means tested premiums on Medicare Part B, which is Medicare's program for outpatient care benefits; and third, through the MMA's efforts to bolster private Medicare Advantage plans.

Looking at the history of the MMA's passage illuminates why it came together in this complicated form. By 2003, it seemed certain that Congress would add a drug benefit to Medicare, although the exact form of the benefit was uncertain. Beneficiaries increasingly struggled to manage prescription drug costs and both Democrats and Republicans supported a Medicare drug benefit. The introduction of "blockbuster" drugs like Lipitor and Zoloft in the prior decade contributed to quickly rising drug spending.⁷ In 1990, drug expenditures totaled about \$40 billion; by 2000, that number had tripled to roughly \$120 billion.⁸ And while some Medicare beneficiaries had supplemental drug coverage through employer retiree benefits, Medicare Part C, or Medicaid,

5. See generally Thomas R. Oliver, Philip R. Lee & Helene L. Lipton, *A Political History of Medicare and Prescription Drug Coverage*, 82 MILBANK Q. 283 (2004); Theodore R. Marmor & Jacob S. Hacker, *Medicare Reform and Social Insurance: The Clashes of 2003 and Their Potential Fallout*, 5 YALE J. OF HEALTH POL'Y, L., & ETHICS 475 (2005); Jonathan Oberlander, *Through the Looking Glass: The Politics of the Medicare Prescription Drug, Improvement, and Modernization Act*, 32 J. HEALTH POLS. POL'Y & L. 187 (2007).

6. Oberlander, *supra* note 5, at 188; see also Richard L. Kaplan, *The Medicare Drug Benefit: A Prescription for Confusion*, 1 NAELA J. 167 (2005).

7. Austin Frakt, *Something Happened to U.S. Drug Costs in the 1990s*, N.Y. TIMES (Nov. 12, 2018), <https://www.nytimes.com/2018/11/12/upshot/why-prescription-drug-spending-higher-in-the-us.html>.

8. CTR. MEDICARE & MEDICAID SERV., OFF. OF ACTUARY, NAT'L HEALTH STAT. GRP., RETAIL PRESCRIPTION DRUGS EXPENDITURES; LEVELS, PERCENT CHANGE, AND PERCENT DISTRIBUTION BY SOURCE OF FUNDS: SELECTED CALENDAR YEARS 1970–2021, tbl.16 (2021).

over one-third of Medicare beneficiaries were shouldering the full costs of prescription drugs.⁹ Moreover, the percentage of large firms offering retiree health benefits dropped from sixty-six percent in 1988 to forty percent in 1998, threatening the largest source of drug coverage for seniors.¹⁰

Various versions of drug reform were proposed leading up to the MMA. Some were partial solutions, including a bill proposed by Representatives Patrick Kennedy, Tom Campbell, and Bernie Sanders to provide up to \$500 in pharmacy assistance to poor Medicare beneficiaries without drug coverage.¹¹ Representative Pete Stark proposed a comprehensive addition of a voluntary prescription drug benefit to Medicare's Part B, financed by higher Part B premiums.¹²

Also in the late 1990s, the National Bipartisan Commission on the Future of Medicare met and considered the more fundamental Medicare reforms. The Commission co-chairs, Democratic Senator John Breaux and Republican Representative Bill Thomas, were both in favor of market-oriented reforms, including converting Medicare to a premium support system under which beneficiaries would receive a set amount to spend on public or private coverage to help pay for prescription drug benefits.¹³ Although their premium support proposal failed to get the supermajority necessary for a formal Commission recommendation to Congress, it signaled a bubbling up of interest in market-based Medicare reforms where private companies would play a larger and more substantive role and beneficiaries would be tasked with navigating options among private plans.¹⁴

9. MARY LASCHOVER, KFF., TRENDS IN MEDICARE SUPPLEMENTAL INSURANCE AND PRESCRIPTION DRUG BENEFITS, 1996-2001 4, fig.2 (2004), <https://www.kff.org/wp-content/uploads/2013/01/trends-in-medicare-supplemental-insurance-and-prescription-drug-benefits-1996-2001data-update.pdf>.

10. KFF. & HEALTH RSCH. AND EDUC. TR., EMPLOYER HEALTH BENEFITS: 2002 ANNUAL SURVEY 144, exhibit 11.1 (2002).

11. See generally Making Affordable Prescriptions Available for Seniors Act, H.R. 2681, 105th Cong. (1997).

12. See generally Medicare Prescription Drug Coverage Act of 1998, H.R. 4753, 105th Cong. (1998).

13. See *Commission Report Signals the Future Look of Medicare*, 99 J. AM. DIETETIC ASS'N. 281 (1999) (listing Commission members).

14. Oliver et al., *supra* note 5, at 304; Stuart H. Altman, Karen Davis, Charles N. Kahn III, Jan Blustein, Jo Ivey Boufford & Katherine E. Garrett, *After the Bipartisan Commission: What's Next for Medicare?*, Commonwealth Fund Pub. #353, Oct. 19, 1999.

Various proposals to add prescription drug benefits over the next several years all fit this market-based model. In April 1999, Representative Stark again introduced a bill adding a prescription drug benefit to Part B, this time to be administered by private sector entities such as pharmacy benefit managers.¹⁵ In June 1999, President Clinton proposed a new “Part D” prescription drug benefit.¹⁶ Unlike in his 1993 Health Security Act, the benefit would be voluntary and administered by private pharmacy benefit managers, which the administration suggested could control costs through efficient management and competitive bidding. Following Clinton’s proposal, the idea of a separate drug benefit administered by private organizations took center-stage, displacing the notion of adding drug benefits to the existing, public Part B program.¹⁷

With the failure of more sweeping premium support proposals for the entire Medicare program, Senator Breaux introduced a softer version of the idea in 2000 focusing on a prescription drug benefit.¹⁸ The bill proposed that beneficiaries could secure drug coverage through either a “Medicare Prescription Plus” plan, offered by a private entity, or a Medicare+Choice (Part C) plan—Medicare’s private managed care option for coverage now called Medicare Advantage.¹⁹ The bill’s benefits structure was the same as in the legislation that would pass several years later: a \$250 deductible, fifty percent coverage of the next \$2,100 in spending and then a gap where beneficiaries would cover all costs up to a catastrophic coverage level.²⁰

15. Access to Prescription Medications in Medicare Act of 1999, H.R.1495, 106th Cong. (1999); see also ELIOT ENGEL, MEDICARE OUTPATIENT PRESCRIPTION DRUG COVERAGE ACT OF 1999, H.R.1109, 106th Cong. (1999) (another bill proposing a drug benefit under Part B).

16. *President Clinton’s Plan to Modernize and Strengthen Medicare for the 21st Century*, CLINTON WHITEHOUSE ARCHIVES (June 29, 1999), <https://clintonwhitehouse4.archives.gov/WH/New/html/medicare.html>. See also *Overview: President’s Plan to Strengthen and Modernize Medicare for the 21st Century*, CLINTON WHITEHOUSE ARCHIVES (June 29, 1999), <https://clintonwhitehouse4.archives.gov/WH/New/html/Medicare/overview.html>.

17. Medicare Modernization Act of 2000, S. 2342, 106th Cong. 2d. session (1999). The Senate Democrats plan, S. 2541 (proposing legislation that was “substantially the same” as the Administration bill); Medicare Expansion for Needed Drugs (MEND) Act of 2000, S.2541, 106th Cong., at 5 (2000)). See also Cong. Rsch. Serv., RL30584, Medicare: Selected Prescription Drug Proposals 3 (2000).

18. Medicare Prescription Drug and Modernization Act of 2000, S. 2807, 106th Cong. (2000).

19. *Id.*

20. *Id.*

In the House, Republicans supported a similar bill as that of Senate Republicans,²¹ while House Democrats pursued their own version of a drug benefit.²² Although the two House bills were described as “close, if not kissing, cousins,”²³ they differed in two important ways. The key difference was how the plans engaged the private sector—the very element that defined the eventually enacted program. The Democrats’ proposals generally envisioned that the federal government would retain the risk of coverage, but the program would be operated by private entities. In contrast, the Republican proposals imagined a drug benefit available through private plans, where private insurers managed the financial risk. Democratic plans created a uniform benefit for all enrollees. In contrast, the Republican plans only created a *minimum* benefit level, allowing for variation among private plans. The reliance on private insurers to tailor the benefit and to serve as risk-sharing partners constituted a more deeply substantive role, akin to the recently enacted Medicare+Choice (M+C) Program where beneficiaries could enroll in a private Medicare plan instead of the traditional, public version.

The debate over these two House versions of proposed legislation proved contentious, signaling the deep ideological difference between them. The House passed the Republican bill on June 28, 2000, almost entirely along party lines.²⁴ In response to the GOP’s refusal to hold a floor vote on the House Democrats’ plan,²⁵ the Democrats walked off the floor in protest.²⁶ Representative Kilpatrick remarked, “The Republican plan is all bread and no meat, a false promise to our senior citizens. The plan undermines the Medicare program by contracting out the program to private insurers who will repeat corporate subsidies and produce very little for the health security needs of the nation’s seniors.”²⁷ Other Democrats criticized the Republicans as engaging in “election

21. MEDICARE RX 2000 ACT, H.R. 4680, 106th Cong. (1999).

22. Medicare Prescription Drug Coverage Act of 2000, H.R. 4607, 106th Cong. (1999).

23. ROBERT D. REISCHAUER, MEDICARE REFORM AND PRESCRIPTION DRUGS: TESTIMONY BEFORE THE SENATE BUDGET COMM. (Urb. Inst. 2001).

24. Juliet Eilperin & Matthew Vita, *House Approves GOP Drug Plan*, WASH. POST (June 29, 2000), <https://www.washingtonpost.com/archive/politics/2000/06/29/house-approves-gop-drug-plan/5c4ed725-ca81-427e-b7f4-5444c217805c/>.

25. Medicare Prescription Drug Act of 2000, H.R.4607, 106th Cong. (1999).

26. *House Passes GOP Prescription Drug Bill*, CNN (June 28, 2000, 9:40 PM), <https://www.cnn.com/2000/ALLPOLITICS/stories/06/28/house.prescription/index.html>.

27. 146 CONG. REC. 5378 (2000).

year rhetoric” taking on prescription drug reform only because “pollsters told them that they could not ignore the issue any longer.”²⁸ Republicans criticized Democrats as opposing the House Republican bill on political grounds, even if they would otherwise support it on policy grounds. The Senate did not have a majority in favor at that moment,²⁹ but Medicare’s prescription drug reform had become a political hotbed.

In the 2000 election, Al Gore—a fierce critic of pharmaceutical companies—proposed a voluntary prescription drug benefit under Medicare, administered by the federal government although operated by private pharmacy benefit managers,³⁰ who were increasingly becoming a middleman for administering complex prescription drug benefits.³¹ After months of criticism for being without a drug plan, George W. Bush responded with an overhaul of Medicare to “modernize” the program.³² Building on the Breaux and Thomas Commission’s ideas, he proposed giving beneficiaries the option between traditional Medicare and using subsidies to buy private insurance plans, which would be required to cover drugs.³³ Senator Kennedy criticized the plan as “an empty promise for senior citizens. It is not Medicare—and it is not adequate. It is part of a broad plan to make regressive changes in Medicare that will raise premiums, force senior citizens to join HMOs, and further a radical right-wing program of privatization.”³⁴

In the first two years of the Bush presidency, various drug reform proposals stalled out, but the political landscape changed after the 2002 election when the Republican party newly controlled the Senate.³⁵ The policy director of the American Association of Retired Persons (AARP)

28. *Id.* at 5380.

29. Medicare Prescription Drug and Modernization Act of 2000, S. 2807, 106th Congress (2000); see also *106th Congress (1999–2001)*, UNITED STATES SENATE, <https://www.senate.gov/history/partydiv.htm> (last visited Mar. 28, 2023).

30. MEDICARE AT A CROSSROADS: THE GORE-LIEBERMAN PLAN (Gore/Lieberman, Inc. 2000).

31. Robin J. Strongin, Peter D. Fox, Chris O’Flinn, Terry S. Latanich & Phonzie Brown, *Issue Brief: The ABCs of PBMs*, NAT’L HEALTH POL’Y F. 1, 2 (Oct. 27, 1999), https://www.ncbi.nlm.nih.gov/books/NBK559746/pdf/Bookshelf_NBK559746.pdf.

32. Mike Ferullo, *Gore, Bush Health Care Solutions Reflect Disparate Visions of Government’s Role*, CNN (Sept. 19, 2000 9:52 AM), <http://edition.cnn.com/2000/ALLPOLITICS/stories/09/18/healthcare.special/index.html>; see also *Bush Spells Out Major Overhaul in Medicare Plan*, N.Y. TIMES (Sept. 7, 2000), <https://www.nytimes.com/2000/09/07/politics/bush-spells-out-major-overhaul-in-medicare-plan.html>.

33. *Bush Spells Out Major Overhaul in Medicare Plan*, *supra* note 32.

34. 146 CONG. REC. S7980 (statement of Sen. Ted Kennedy) (2000).

35. *United States Senate: Party Division*, U.S. S., <https://www.senate.gov/history/partydiv.htm> (last visited Mar. 21, 2023).

John C. Rother explained at the time, “The Republicans may not be able to afford everything the public expects, but the option of not acting on prescription drugs would be catastrophic for them. They have clear control of two branches of government. They pledged to act. Now they have to produce.”³⁶ By June, Senate Finance Committee Chair Chuck Grassley and Ranking Member Max Baucus announced a bipartisan agreement on a bill that would create a new Medicare Part D.³⁷ On June 27, the Senate passed the bill 76-21.³⁸ Senate Minority Leader Tom Daschle explained, “It’s not the kind of bill I would write. [But] we can simply no longer allow the perfect to be the enemy of the good.”³⁹ The House, after contentious debate, passed legislation that would have required traditional Medicare to compete with private plans.⁴⁰

The legislative process that reconciled the House and Senate bills and produced the final law was colored by a lack of transparency, poor participation among members of Congress, and the outsized influence of the pharmaceutical industry.⁴¹ The conference committee of the House and Senate failed to follow normal practices. The leader of House conferees, Republican Bill Thomas from California, excluded five of the senate Democratic Senate conferees, allowing only Senators Baucus and Breaux to participate, causing the House conferees from the Democratic caucus to refuse to participate.⁴² After a contentious four months during which participants close to the process believed negotiations would completely collapse, the committee finally produced a bill on November 21, 2003 called the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA)⁴³

36. Robert Pear, *The 2002 Election: Health Care; Republicans Plan to Push Through Prescription Drug Coverage for the Elderly*, N.Y. TIMES (Nov. 10, 2002), <https://www.nytimes.com/2002/11/10/us/2002-election-health-care-republicans-plan-push-through-prescription-drug.html>.

37. Prescription Drug and Medicare Improvement Act of 2003, S. 1, 108th Cong. (2003).

38. Robin Toner & Robert Pear, *House and Senate Pass Measures for Broad Overhaul of Medicare*, N.Y. TIMES (June 27, 2003), <https://www.nytimes.com/2003/06/27/us/house-and-senate-pass-measures-for-broad-overhaul-of-medicare.html>.

39. *Id.*

40. Prescription Drug and Medicare Improvement Act of 2003, Pub. L. No. 108-173.

41. Marmor & Hacker, *supra* note 5, at 476 n.3.

42. *Id.*

43. See Amy Goldstein, *For GOP Leaders, Battles and Bruises Produce Medicare Bill*, WASH. POST (Nov. 30, 2003), <https://www.washingtonpost.com/archive/politics/2003/11/30/for-gop-leaders-battles-and-bruises-produce-medicare-bill/a9b34a73-74b0-4951-8951-82469ac1546f/>.

Yet, problems continued as this bill moved toward passage. At least one House Republican became supportive of the legislation allegedly only after receiving bribes from the Administration.⁴⁴ The former head of Medicare, Tom Scully, threatened to fire the independent Medicare chief actuary, Richard Foster, if he shared with Congress his cost estimates that were \$156 billion higher than those produced by the Congressional Budget Office.⁴⁵ During voting, the House kept the roll-call open for nearly three hours, during which GOP leadership, including President Bush, cajoled defiant members.⁴⁶ The measure passed in the House by a hair, 220-215,⁴⁷ yet with considerable attention on the fraught process to this end.

On the Senate side, Senator Edward Kennedy led a filibuster, claiming (with prescience) that the bill would undermine and privatize the Medicare program.⁴⁸ Senator Daschle—who had voted for the original Senate bill—now remarked, “We are going to see the loss of Medicare as we know it today if this legislation passes.”⁴⁹ Still, the bill ultimately garnered the support of nine Democrats and Independent Jim

44. Robert Pear & Robin Toner, *A Final Push in Congress: The Overview; Sharply Split, House Passes Broad Medicare Overhaul; Forceful Lobbying By Bush*, N.Y. TIMES (Nov. 23, 2003), <https://www.nytimes.com/2003/11/23/us/final-push-congress-overview-sharply-split-house-passes-broad-medicare-overhaul.html>; Timothy Noah, *A Drug Company Bribe? The Medicare Vote Scandal, Continued*, SLATE (Dec. 8th, 2003, 7:08 PM) (explaining that representative Nick Smith claimed he was offered \$100,000 to switch his vote).

45. Timothy Noah, *Information Is Treason Why Bush is Worse than Reagan*, SLATE (Mar. 16, 2004, 7:51 PM), <https://slate.com/news-and-politics/2004/03/bush-s-war-on-empiricism.html>; Robert Pear, *Bush's Aides Put Higher Price Tag on Medicare Law*, N.Y. TIMES (Jan. 30, 2004), <https://www.nytimes.com/2004/01/30/us/bush-s-aides-put-higher-price-tag-on-medicare-law.html>; Amy Goldstein, *Foster: White House Had Role in Withholding Medicare Data*, WASH. POST (Mar. 19, 2004), <https://www.washingtonpost.com/archive/politics/2004/03/19/foster-white-house-had-role-in-withholding-medicare-data/af6d062c-4d4b-43f8-902f-72332abf7610/>.

46. Kate Schuler & Mary Agnes Carey, *Estimates, Ethics, and Ads Tarnish Medicare Overhaul*, CQ WKLY.—HEALTH (Mar. 20, 2004); Pear & Toner, *supra* note 44 (explaining that Representative Butch Otter, who changed his vote after receiving a phone call from Bush, explained, “I did not want to vote for this bill . . . But I was persuaded that if this bill went down, we would end up with a bigger, more expensive alternative with much less reform.”).

47. Oliver et al., *supra* note 5, at 321.

48. 149 CONG. REC. 15598 (2003).

49. *Id.* at 15594.

Jeffords and passed the Senate by a vote of 54-44.⁵⁰ President Bush signed the MMA into law on December 8, 2003.⁵¹

The insurance industry supported passage, since this version of reform offered them considerable benefit by increasing the reach of private insurance within Medicare in several ways.⁵² Most obviously, the drug benefits were only available through private plans, as Jon Oberlander marks as the first time that beneficiaries were not given a public option for available benefits.⁵³ The MMA created subsidies that beneficiaries could use to buy private health prescription drug plans, known as Part D Plans.⁵⁴ It generated new lines of business for insurers and pharmacy benefits managers and stream of guaranteed revenue for pharmaceutical companies. The legislation even prohibited Medicare from using its bargaining power to negotiate drug prices through a noninterference clause and catalyzed major inflation in drug spending.⁵⁵ For two decades, and despite overwhelming popular support for eliminating this clause,⁵⁶ the provision stood strong until the 2022 Inflation Reduction Act allowed negotiations for some drugs.⁵⁷

50. Jonathan Karl, John King, Kathleen Koch, Louise Schiavone, Suzanne Malveaux & Ted Barrett, *Senate Passes Medicare Bill*, CNN (Nov. 25, 2003, 9:16 PM), <https://www.cnn.com/2003/ALLPOLITICS/11/25/elec04.medicare/index.html>.

51. *Bush Signs Landmark Medicare Bill into Law*, CNN (Dec. 8, 2003, 1:23 PM), <https://www.cnn.com/2003/ALLPOLITICS/12/08/elec04.medicare/>.

52. Marmor & Hacker, *supra* note 5, at 478.

53. Oberlander, *supra* note 5, at 202.

54. JACK HOADLEY, *MEDICARE'S NEW ADVENTURE: THE PART D DRUG BENEFIT 1* (Health Pol'y Inst., Georgetown University eds., 2006).

55. See *National Health Expenditure Data: Historical*, Tbl. 16: *Retail Prescription Drugs Expenditures*, CTRS. FOR MEDICARE AND MEDICAID SERV., <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical> (last visited Mar. 21, 2023).

56. See, e.g., Ashley Kirzinger, Audrey Kearny, Mellisha Stokes, Liz Hamel & Mollyann Brodie, *The Public Weighs in on Medicare Drug Negotiations*, KFF. (Oct. 12, 2021), <https://www.kff.org/health-costs/poll-finding/public-weighs-in-on-medicare-drug-negotiations/> (describing 83 percent support for allowing the government to negotiate Medicare drug prices, even after respondents are exposed to arguments on both sides of the issue).

57. See, e.g., Juliette Cubanski, Tricia Neuman & Meredith Freed, *Explaining the Prescription Drug Provisions in the Inflation Reduction Act*, KFF. (Jan. 24, 2023, <https://www.kff.org/medicare/issue-brief/explaining-the-prescription-drug-provisions-in-the-inflation-reduction-act/>) (describing the key provisions of the Inflation Reduction Act of 2022).

Perhaps garnering less attention, the MMA revitalized enrollment in previously languishing private Medicare Part C plans,⁵⁸ through provisions authored in part by the lobbyists for the insurance industry.⁵⁹ These provisions increased subsidies to private insurers administering Medicare+Choice and renamed the program Medicare Advantage,⁶⁰ putting a financial and rhetorical thumb on the scale for this program where beneficiaries can enroll in private plans rather than staying in the public version of Medicare. Subsidies, rate increases, and the ability to charge beneficiaries for part of the share of premiums resulted in private insurers being paid considerably more to cover beneficiaries than what Medicare would have spent on them in the traditional fee-for-service programs, a result counter to the initial cost-saving goal of Medicare Part C.⁶¹ Plus, with the new private drug plans, an enrollee could choose one private plan for all of their benefits, rather than having to knit together public and private coverage. As a result, enrollment in these private plans shot up in the years following.⁶²

Finally, the MMA introduced means testing into Medicare for the first time, imposing higher premiums for Medicare Part B on wealthier beneficiaries. This change also got less attention than the addition of the prescription drug benefits but constituted a significant shift in the nature of the program. As Ted Marmor and Jacob Hacker noted at the time, the additional revenue from the higher premiums were not “worth their price in terms of administrative hassle, bad social insurance precedent, and any consequent undermining of Medicare’s political support.”⁶³ Yet, the MMA began a trend of relying on surcharges to raise program revenue. The Affordable Care Act later added similar surcharges to Medicare Part D, known clunkily as Income-Related Monthly Adjustment Amounts or “IRMAA”.⁶⁴

58. Thomas G. McGuire, Joseph P. Newhouse & Anna D. Sinaiko, *An Economic History of Medicare Part C*, 89 MILBANK Q.: A MULTIDISCIPLINARY J. OF POP. HEALTH AND HEALTH POL’Y 289, 313–14 (2011).

59. Oberlander, *supra* note 5, at 196.

60. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2675, 2913.

61. Oberlander, *supra* note 5, at 204–06.

62. McGuire et al., *supra* note 58, at 300 fig.4.

63. Marmor & Hacker, *supra* note 5, at 482; see also Richard L. Kaplan, *Means-Testing Medicare: Retiree Pain for Little Governmental Gain*, J. RETIREMENT PLANNING (2006).

64. See Regulations Regarding Income-Related Monthly Adjustment Amounts to Medicare Beneficiaries’ Prescription Drug Coverage Premiums, 75 Fed. Reg. 75884, 75844 (Dec. 7, 2010).

Although these types of surcharges do not limit program eligibility only to lower income beneficiaries, as in Medicaid, they share philosophical roots and undermine the universality of the program. Rather than having a social insurance benefit available equally to anyone who qualifies based on age or disability, the benefit now differs by wealth, with higher income people paying more for the same coverage.⁶⁵ This difference risks eroding enthusiasm for Medicare among the beneficiaries who pay the surcharges and, like other beneficiaries, still face significant out-of-pocket spending.

The surcharges are not needed for wealthier beneficiaries to pay in more to the program. Medicare Part A was already funded through progressive wage taxes of 2.9 percent split between employers and employees (The ACA added a high-earners surcharge to this Part A wage tax⁶⁶). The majority of Parts B and D are funded through general taxation, which is a progressive tax on all Americans, including the elderly.⁶⁷ Higher income beneficiaries contribute more than they will likely extract in benefits, and more than it would have cost them to privately insure during their retiree years.⁶⁸

Plus, premium surcharges raise only modest revenue. Premiums fund merely one-quarter of total Part B costs and less than one-fifth of Part D overall spending.⁶⁹ Only a small number of households are wealthy enough to be subject to these surcharges, which require beneficiaries to pay a higher share of prorated program costs as household income increases,⁷⁰ even as policies over the past decade have rendered more households subject to them. For example, the ACA froze inflation adjustment of the thresholds from 2010 until 2019 for Part B.⁷¹ Likewise, starting in 2018, the income thresholds for the top categories were lowered and a new highest band was added in 2019.⁷² Yet, in 2021, still only seven percent of total households were subject to adjustments for Part

64. *See id.*

66. Rules Relating to Additional Medicare Tax, 78 Fed. Reg. 71468, 71468 (Nov. 29, 2013).

67. Marmor & Hacker, *supra* note 5, at 480.

68. *Id.* at 481.

69. JULIETTE CUBANSKI, TRICIA NEUMAN, & MEREDITH FREED, KFF, THE FACTS ON MEDICARE SPENDING AND FINANCING 7 (2019).

70. JULIETTE CUBANSKI & TRICIA NEUMAN, KFF, MEDICARE'S INCOME-RELATED PREMIUMS UNDER CURRENT LAW AND CHANGES FOR 2019 3 (2018).

71. *Id.*

72. PATRICIA A. DAVIS, CONG. RSCH. SERV., R40082, MEDICARE PART B: ENROLLMENT AND PREMIUMS 22, 23 (2022).

B premiums and eight percent for Part D⁷³ (up from five percent and four percent, respectively in 2013⁷⁴).

For this small percentage of households subject to adjustments, their share of costs is escalating steeply, possibly unmanageably. As Medicare spending rises, so do the premium adjustments since they are calculated as a percentage of Part B program premiums. Annual combined premiums for Parts B and D can exceed \$7000 for an individual with a household income of over \$170,000, twice that amount if there are two beneficiaries in the household.⁷⁵ After \$14,000 in premiums, these two would still face substantial cost sharing for benefits plus the full cost of benefits not covered, like vision, hearing, or dental care. For a fixed income couple, even one earning \$170,000, these total costs can be considerable.

Raising premium revenue through adjustments risks undermining the very purpose of social insurance: to protect households from burdensome spending on medical costs. It could also undermine support for Medicare by breaking up the universal risk pooling that characterized the Medicare program in its nascence in two ways. First, since both Part B and Part D are voluntary⁷⁶, more people may opt out as premium costs grow, especially those beneficiaries who anticipate needing or using less medical care. Second, these adjustments could hasten the overall privatization of the program, sending more people into Medicare Advantage plans that promise to limit total out-of-pocket spending but do so by adopting smaller networks and denying benefits, leaving sicker beneficiaries especially vulnerable.⁷⁷

73. *2022 Medicare Parts A & B Premiums and Deductibles/2022 Medicare Part D Income-Related Monthly Adjustment Amounts*, CTRS. FOR MEDICARE & MEDICAID SERVS. (Nov. 12, 2021), <https://www.cms.gov/newsroom/fact-sheets/2022-medicare-parts-b-premiums-and-deductibles2022-medicare-part-d-income-related-monthly-adjustment> [hereinafter CTRS. FOR MEDICARE & MEDICAID SERVS.].

74. JULIETTE CUBANSKI, TRICIA NEUMAN, GRETCHEN JACOBSON, & KAREN E. SMITH, KFF, *RAISING MEDICARE PREMIUMS FOR HIGHER-INCOME BENEFICIARIES: ASSESSING THE IMPLICATIONS 1* (2014).

75. CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 73.

76. *Id.*; *An Overview of the Medicare Part D Prescription Drug Benefit*, KFF (Oct. 19, 2022), <https://www.kff.org/medicare/fact-sheet/an-overview-of-the-medicare-part-d-prescription-drug-benefit/#:~:text=Enrollment%20in%20Medicare%20Part%20D,a%20plan%20on%20their%20own.>

77. Austin Frakt, *Sicker Patients Seem at a Disadvantage with Medicare Advantage*, N.Y. TIMES (Apr. 4, 2016), <https://www.nytimes.com/2016/04/05/upshot/sicker-patients-signal-a-drawback-of-medicare-advantage.html>.

And for what? Total additional high-income premium adjustments raised 11 billion for Part B and 1.9 billion for Part D in 2021, about two and a half percent of total Part B spending and under two percent of Part D spending, and they add administrative burdens in sorting the population to charge differential premiums.⁷⁸

The MMA is often told as a success story, but its impact on Medicare's trajectory is much more complicated than mere expansion of benefits. It expanded prescription drug coverage at the cost of catalyzing the continued privatization and complexity of the program and chipping away at its universality. Other than the MMA, other modern efforts at benefits expansion have largely failed.

III. Medicare's Failed Efforts at Long-Term Care Expansion

What may most define Medicare's incompleteness is the continued exclusion of long-term care benefits.⁷⁹ Despite the common misconception, Medicare does not pay for long-term care, defined as support with activities of daily living—things like bathing, dressing, toileting, and eating. Rather, it only funds limited post-acute care after hospitalization and even that benefit has been debated and scaled back over time.

Medicare was intentionally not tailored to the needs of chronically ill elderly because of the expectation that it would eventually expand into a universal health insurance program for all Americans. Long-term nursing care was deemed more custodial than medical. Medicaid filled in some gaps for some people, but most people are left to manage long-term care privately.

Over time, however, as the program has solidified as one for older people and people with disabilities, its failure to cover long-term care—a core need of beneficiaries—has become glaring.

78. CONG. BUDGET OFF., MEDICARE BASELINE PROJECTIONS 2 (July 2021) (total program spending by part). THE BDS. OF TRS., FED. HOSP. INS. AND FED. SUPPLEMENTARY MED. INS. TR. FUNDS, THE 2021 ANN. REP. OF THE BDS. OF TRS. OF THE FED. HOSP. INS. AND FED. SUPPLEMENTARY MED. INS. TR. FUNDS 211, 214 (2021) (total raised through premium adjustment).

79. See Hoffman, *supra* note 2, at 151.

A. The Beginnings of Long-Term Care Benefits

Long-term care does not fit neatly with the American concept of social insurance. President Theodore Roosevelt described that social insurance should protect against the “hazzards [sic] of sickness, accident, invalidism, involuntary unemployment, and old age. . . .”⁸⁰ The focus became threats to the family wage, usually due to a breadwinner’s inability to work.⁸¹ Non-medical, often called “custodial” caregiving was assumed to be provided by non-wage-earning family members (read: wife).⁸² Public aid for long-term care remained largely in poorhouses in the early nineteenth century, a holdover of Elizabethan poor laws.⁸³

But over the course of the twentieth century, publicly funded support for long-term care grew.⁸⁴ Early state and local efforts funded new public hospitals, state mental asylums, and schools for the blind and the deaf. After the Great Depression, the federal government established both cash and in-kind assistance programs to support people with disabilities. The Social Security Act of 1935,⁸⁵ which included cash assistance programs, including the Old-Age Assistance⁸⁶ program for poor elderly, Aid to the Blind,⁸⁷ and Aid to Dependent Children.⁸⁸ Between local, state, and federal efforts, including the Works Progress Administration’s “Housekeeping Services,”⁸⁹ public support paid for nursing care, personal care, and even housework and childcare, in some cases, for ill or disabled mothers.

80. Theodore Roosevelt, Address Before the Convention of the National Progressive Party in Chicago, Illinois (Aug. 6, 1912), <http://www.ssa.gov/history/trspeech.html>.

81. MICHAEL A. GRAETZ & JERRY L. MASHAW, TRUE SECURITY: RETHINKING AMERICAN SOCIAL INSURANCE 235 (Yale Univ. 1999); ALICE KESSLER-HARRIS, IN PURSUIT OF EQUITY: WOMEN, MEN AND THE QUEST FOR ECONOMIC CITIZENSHIP IN TWENTIETH CENTURY AMERICA (2001).

82. EILEEN BORIS & JENNIFER KLEIN, CARING FOR AMERICA: HOME HEALTH WORKERS IN THE SHADOW OF THE WELFARE STATE 20 (Oxford Univ. Press 2012). E. FULLER TORREY, AMERICAN PSYCHOSIS: HOW THE FEDERAL GOVERNMENT DESTROYED THE MENTAL ILLNESS SYSTEM 4 (2013) (One early exception was the creation of public institutions for the care of the “feebleminded” in the early 1900s.).

83. David Barton Smith & Zhanlian Feng, *The Accumulated Challenges of Long-Term Care*, 29 HEALTH AFFS. 29 (2010).

84. Sidney D. Watson, *From Almshouses to Nursing Homes and Community Care: Lessons from Medicaid’s History*, 26 GA. STATE UNIV. L. REV. 937, 944 (2010).

85. The Social Security Act of 1935, 42 U.S.C. § 301.

86. *Id.* § 301.

87. *Id.* § 1302.

88. *Id.* § 601.

89. BORIS & KLEIN, *supra* note 82, at 22.

The mid-twentieth century rise of private medical insurance, however, began to undermine these home-based care programs. Medical insurance required that benefits be provided by licensed providers, which relocated the medical aspects of caregiving from homes to hospitals and left the care-intensive aspects out.⁹⁰ The 1960 amendments to the Social Security Act, including the Kerr-Mills Act, were modeled on this medicalized framework.⁹¹ It prioritized funding for long-term care in private, licensed institutions, in turn increasing the number of private nursing homes tenfold. Medicaid, which soon replaced Kerr-Mills, perpetuated this model, as did Medicare, as discussed below.

B. The Long, Sordid Exclusion of Long-Term Care from Medicare

Nursing home coverage was considered at Medicare's nascence.⁹² Senator Ribicoff of Connecticut, for example, campaigned for extending hospital and nursing home coverage in cases of catastrophic illness, stating "We, as U.S. Senators, shall be hiding our heads in the sands if we do not face up to the issue now."⁹³ Ultimately, the desire to insulate Medicare from the "open-ended" costs of long-term care led Congress to limit coverage to "post-hospital extended care services for up to 100 days during any spell of illness."⁹⁴ Custodial care was specifically excluded, and the Department of Health, Education, and Welfare (HEW)—the precursor to the Department of Health and Human Services—had to define what, in turn, constituted excluded custodial care. In 1967, HEW characterized custodial care as care designed to assist an individual in meeting the "activities of daily living,"⁹⁵ in contrast to services under the direct supervision of medical personnel. HEW issued stringent guidelines that provided that the primary purpose of covered

90. *Id.* at 49.

91. Matthew Gritter, *The Kerr-Mills Act and the Puzzles of Health-Care Reform*, 100 *SOC. SCI. QUARTERLY* 2210, 2200 (2019).

92. See GLENN R. MARKUS, *CONG. RSCH. SERV., HD 7106 D, NURSING HOMES AND CONGRESS: A BRIEF HISTORY OF DEVELOPMENTS AND ISSUES 36-60* (1972).

93. 111 *CONG. REC.* 15253 (1965).

94. William E. Aaronson, Jacqueline S. Zinn, & Michael D. Rosko, *The Success and Repeal of the Medicare Catastrophic Coverage Act: A Paradoxical Lesson for Health Care Reform*, 19 *J. HEALTH POL., POL'Y & L.* 753, 754 (1994); Social Security Amendment of 1965, Pub. L. No. 89-97, §1812(a)(2), 79 Stat. 286 (1965) (codified as amended at 42 U.S.C.A. § 1395 (Supp. 1990)).

95. U.S. Dep't of Health, Education, and Welfare, Intermediary Letter No. 211 (1967).

post-hospital extended care be “skilled services.”⁹⁶ These guidelines aimed to rein in the “run-away” costs of the extended care benefit, which was initially estimated to cost 25 to 50 million dollars in 1967, but halfway through its first year of implementation was newly projected to be 250 to 300 million dollars.⁹⁷

In 1969, HEW further attempted to narrow the scope of Medicare’s post-acute extended care benefit by clarifying, “The term ‘extended’ refers not to provision of care over an extended period, but to the provision of active treatment as an *extension* of inpatient hospital care.”⁹⁸ The guidelines explicitly excluded administration of oral medications, routine services in connection with indwelling bladder catheters, and routine changes of dressings, for example. Critics’ concerns that these guidelines would accelerate retrospectively denied extended care claims proved true; denials more than tripled between 1969 and 1970, and people were sent home unable to care for themselves.⁹⁹

One 1970 study found that only forty percent of discharged patients between 1968 and 1969 could perform activities of daily living.¹⁰⁰ Over the next five decades, policymakers and advocates continued to debate the appropriate role of Medicare in long-term care.

1. 1970-1980

At first, there was momentum toward an increased role, as the beginning of the 1970s brought on a push for Medicare long-term care reform. In 1971, leading up to the White House Conference on Aging, a Congressional Special Committee on Aging led by Chairman Frank Church of Idaho issued a pre-conference report in part motivated by fears that the Conference lacked gravitas. The Special Committee report recommended Medicare extended care reforms, including to remove the 3-day prior hospitalization requirement and to eliminate the 100-day limit on services, in both institutional and home-based settings.¹⁰¹

96. U.S. Dep’t of Health, Education, and Welfare, Intermediary Letter No. 257 (1967).

97. MARKUS, *supra* note 92, at 79–88.

98. U.S. Dep’t of Health, Education, and Welfare, Intermediary Letter No. 371 (1969).

99. *Extended Care Services and Facilities for the Aging: Hearing Before the S. Special Subcomm. on Aging*, 91st Cong. 76–102 (1970).

100. Michael B. Miller, *Changing Perspectives and Cross Currents in Nursing Home Care, 1968-1969*, 18 J. AM. GERIATRICS SOC’Y 124, 131–32 (1970).

101. S. SPEC. COMM. ON AGING, A PRE-WHITE HOUSE CONFERENCE ON AGING SUMMARY OF DEVELOPMENTS AND DATA, S. REP. No. 92–505 (1971).

The Committee also recommended that extended care and home care benefits be expanded to address the needs of chronically ill beneficiaries, such as covering homemaker services and the use of home health aides.¹⁰²

The 1971 Conference produced recommendations to federalize all institutional care aspects of Medicaid with uniform national benefits.¹⁰³ The delegates also recommended a feasibility study on transferring all long-term institutional care aspects of Medicaid to Medicare.¹⁰⁴ Although more divided on the issue, they also considered whether long-term care facilities should be public utilities. A recommendation to remove profit motivations from the provision of long-term care was defeated 49 to 25,¹⁰⁵ but delegates agreed that homemaker and home health aide services were a necessary benefit in any federal health and welfare program for the elderly.¹⁰⁶ The conferees wrote that any program of national health insurance, if pursued, should “meet the needs of those who require catastrophic, long-term physical and mental health care and social services both within and outside of institutions.”¹⁰⁷

The next decade saw the regular introduction of legislation for both national health insurance and more comprehensive long-term care policy. Senator Frank Moss, Chairman of the Senate Subcommittee on Long-Term Care and an original sponsor of Medicaid, said, “I firmly believe that Medicare should serve as the foundation for an expanded long-term care program for the elderly.”¹⁰⁸ Several bills were introduced in Congress to establish a long-term care benefit under Medicare,¹⁰⁹ including 1974 legislation introduced by Representative Wilbur

102. S. SPEC. COMM. ON AGING, HOME HEALTH SERVICES IN THE UNITED STATES, S. DOC. No. 74-331 (1972).

103. 1971 WHITE HOUSE CONFERENCE ON AGING, TOWARD A NATIONAL POLICY ON AGING: REPORTS OF THE SPECIAL CONCERNS SESSIONS ON HEALTH CARE STRATEGIES, S. DOC. No. 92-53, at 86 (1971).

104. *Id.*

105. *Id.* at 88.

106. *Id.* at 76-77.

107. *Id.* at 87.

108. Barriers to Health Care for Older Americans: Joint Hearing Before the Subcomm. on Health of the Elderly and the Subcomm. on Long-Term Care, 93rd Cong. 1529 (1973).

109. *See, e.g.*, Medical Long-Term Care Act, H.R. 17136, 93d Cong. (1974); Long-Term Care Amendments, S. 2702, 94th Cong. (1975); National Home Health Care Act, H.R. 3916, 95th Cong. (1977); Medicare Long-Term Care Act, H.R. 5458, 95th Cong. (1977); H.R. 9687, 95th Cong. (1977); Medicare Home Health Amendments, H.R. 13314, 95th Cong. (1978).

Mills and Senator Ted Kennedy to add a voluntary benefit for long-term care in noninstitutional settings, unless institutional care was medically necessary—an approach that foreshadowed deinstitutionalization of long-term care over the coming decades.¹¹⁰ The 1976 House Subcommittee on Health and Long-Term Care recommended adding homemaker services to Medicare, including assistance in household tasks, shopping, walking, and transportation.¹¹¹

In 1977, hearings held by the Subcommittee illustrated Medicare's inadequate coverage. The American Association of Homes for the Aging remarked that Medicare "is so fraught with durational limitations, entitlement preconditions, and service constraints that assistance to individuals needing long term care is severely restricted."¹¹² The AARP testified that "[t]he lack of coverage for long-term care and the absence of catastrophic protection have a devastating financial impact on those who have inadequate resources."¹¹³ That same year, the Congressional Budget Office reported, "Long-term care is . . . the major cause of catastrophic expenses among the elderly."¹¹⁴

When Congress passed the Omnibus Reconciliation Act of 1980, it finally eliminated the 100-visit limit and prior hospitalization requirement for home health services.¹¹⁵ Larger problems were left unaddressed.

110. Comprehensive National Health Insurance Act, H.R. 13870, 93d Cong. (1974).

111. Subcomm. on Health and Long-Term Care, *New Perspectives in Health Care for Older Americans* H.R. Doc. No. 66-559 at 49-53 (1976).

112. *Housing The Elderly: Integration of Health and Social Services: Joint Hearing Before the Subcomm. on Health and Long-Term Care and the Subcomm. on Housing and Consumer Interests*, 95th Cong. 104 (1977).

113. *Medicare Gaps and Limitations: Hearing Before the Subcomm. on Health and Long-Term Care*, 95th Cong. 4 (1977).

114. CONG. BUDGET OFF., *LONG-TERM CARE FOR THE ELDERLY AND DISABLED* iii (Feb. 1977).

115. Martin Ruther & Charles Helbin, *Use and Cost of Home Health Agency Services Under Medicare*, 10 HEALTH CARE FIN. REV. 105 (1988); Omnibus Reconciliation Act of 1980, Pub. L. No. 96-499, 94 Stat. 2599 (1980) (codified at 42 U.S.C. § 1395y(b) (2012)).

2. THE REAGAN YEARS AND THE MEDICARE CATASTROPHIC COVERAGE ACT OF 1988

The 1980s revealed that long-term care still ranked chief among Medicare beneficiaries' concerns when the Medicare Catastrophic Coverage Act of 1988 (MCCA) passed and then was quickly repealed, in part because of its failure to solve for long-term care.¹¹⁶

At first, the MCCA looked like it would be a story of expansionary success, filling in many of Medicare's significant coverage gaps. The legislation, inconsistent with the ideology of the Reagan administration, was spearheaded singularly by Dr. Otis Bowen, Reagan's Secretary of Health and Human Services.¹¹⁷ The 1982 National Commission on Social Security Reform, under Bowen's leadership, had recommended that Medicare hospitalization coverage be expanded to an unlimited number of days, that its hospital and skilled-nursing-facility co-insurance requirements be eliminated, and that Medicare beneficiaries be offered an optional Part B benefit (physician services) that would put a cap on out-of-pocket expenses.¹¹⁸

When Bowen became Secretary, he identified three major issues for reform: catastrophic acute care costs for the elderly; long term care costs for the elderly; and catastrophic health care costs for the general population.¹¹⁹ In his report, Bowen wrote:

The major source of catastrophic out-of-pocket expenses for the elderly . . . is personal care and supervision on a continuing basis—either at home or in a nursing home—in the event of functional impairment. These expenses over an extended period can wipe out the savings of a lifetime, and very few of the elderly have financial protection for such expenses.¹²⁰

Bowen also acknowledged that “almost all of the burden [of long-term care] now is borne by family members and friends. Society depends heavily on these unpaid and willing human resources.”¹²¹ Although, consistent with earlier reform proponents of long-term care in home settings, he feared that increased insurance protection may lead to formal institutional care replacing care at home.

116. MARMOR, *supra* note 1, at 110.

117. *Id.*

118. *Id.*

119. DEP'T OF HEALTH & HUMAN SERV., CATASTROPHIC ILLNESS EXPENSES: REPORT TO THE PRESIDENT, at iii (1986).

120. *Id.* at 35.

121. *Id.* at 6.

Bowen's efforts reflected growing dissatisfaction that Medicare neglected chronic conditions.¹²² The MCCA included benefits beyond those recommended by the 1982 National Commission, such as "provisions for hospice care, home health services, mammography screening, outpatient prescription drugs, guaranteed payment of Medicare premiums for the impoverished elderly, and protection against the impoverishment of a spouse from nursing home expenses."¹²³

The Act ultimately passed, however without the benefit perhaps most sought by the elderly: coverage of long-term care in nursing homes.¹²⁴ This exclusion was not for lack of effort. During debate, Representative Claude Pepper unsuccessfully fought to force a floor vote on the inclusion of comprehensive long-term care benefits like what he and others (Senators George Mitchell, John Melcher, and Ted Kennedy and Representatives Henry Waxman and Pete Stark) proposed in separate legislation.¹²⁵ To try to appease advocates, the Act instead extended skilled nursing facility coverage from 100 to 150 days and eliminated the requirement that beneficiaries first be hospitalized for three days.

Funding these new benefits required a careful balancing act since President Reagan agreed to support the legislation only so long as it did not add to the federal deficit, and increases to the Social Security payroll tax and general taxes were largely regarded as infeasible.¹²⁶ Instead, the MCCA increased beneficiaries' monthly Part B premiums, which had until that point been exclusively earmarked for outpatient care.¹²⁷ It also

122. MARMOR, *supra* note 1 at 110.

123. *Id.*

124. *Id.* at 112.

125. Medicare Long-Term Home Care Catastrophic Protection Act of 1987, H.R. 2762, 100th Cong. (1987) (including case management, nursing care, homemaker/home health aide services, physical and occupational therapies, as well as patient and family education and counseling); Linda Boise, *The Demise of the Catastrophic Coverage Act: A Reflection of the Inability of Congress to Respond to Changing Needs of the Elderly and Their Families*, 17 J. SOCIO. & SOC. WELFARE 107, 113-14 (1990); Long-Term Care Assistance Act of 1988, S. 2305, 100th Cong. (1988); Helping Expand Access to Long-Term Health Care Act of 1988, S. 2671, 100th Cong. (1988); Lifecare Long-Term Care Protection Act, S. 2681, 100th Cong. (1988); Elder-Care Long-Term Care Assistance Act of 1988, H.R. 5320, 100th Cong. (1988); Chronic-Care Medicare Long-Term Care Coverage Act of 1988, H.R. 5393, 100th Cong. (1988). See generally CONG. RSCH. SERV., 89-238 EPW, LONG-TERM CARE LEGISLATION: SUMMARY OF SELECTED BILLS (1989).

126. MARMOR, *supra* note 1, at 112.

127. *Id.*

imposed an additional supplemental premium—a surcharge—on wealthier beneficiaries.¹²⁸

The Act was swiftly repealed in 1989, in part for its failure to cover long-term care benefits and in part because of these financing mechanisms.¹²⁹ As Ted Marmor explained: “The sharpest criticism of the new Catastrophic Coverage Act came from some elderly groups themselves. . . . In providing coverage for extended hospitalizations rather than long-term institutionalized care, the legislation addressed a problem experienced by few of the elderly and left unaddressed a ‘catastrophic’ situation dreaded by many.”¹³⁰

Wealthier beneficiaries who would have faced a premium surcharge but were least likely to rely on the benefit because they already had supplemental coverage to fill Medicare’s gaps were politically capable objectors.¹³¹ As Marmor describes: “Ironically, the historical failure of Medicare to provide complete medical coverage for the elderly had itself created the demand for the supplemental insurance we call Medigap plans. The possession of Medigap insurance in turn motivated the affluent elderly to oppose an act providing just such expanded coverage to all Medicare beneficiaries.”¹³² These efforts were aided by misinformation spread by groups such as the National Committee to Preserve Social Security and Medicare that all beneficiaries would face premium surcharges.¹³³ The MCCA was repealed and with it what in retrospect would have been one of the most monumental benefits expansion, even without the inclusion of long-term care.

128. *Id.*

129. See Thomas Rice, Katherine Desmond & Jon Gabel, *The Medicare Catastrophic Coverage Act: A Post-Mortem*, 9 HEALTH AFFS. 75, 76 (1990); 133 CONG. REC. 20657 (daily ed. July 22, 1987) (“In fact, the most glaring omission in the committee bill is the lack of any program or incentive to cover the cost of long-term nursing-home care.”); 134 CONG. REC. 13792 (1988) (“[T]his legislation does not meet the most pressing long-term health care needs of my . . . constituents.”).

130. MARMOR, *supra* note 1, at 112.

131. *Id.*

132. MARMOR, *supra* note 1 (stating that by the time of MCCA’s repeal, opposition to the act was widespread among all elderly, and went well beyond the efforts of any particular group. As noted by the detailed postmortem of MCCA, the *perception* of Medicare beneficiaries (inaccurate in many cases) that the MCCA would increase their Medicare premiums in order to duplicate benefits they were already paying for was highly influential in their decision to oppose the act).

133. See *id.*

3. THE PEPPER COMMISSION AND THE DIMMING PROSPECT OF LONG-TERM CARE BENEFITS

When Representative Claude Pepper died in 1989, Medicare long-term care reform began to lose momentum. In the wake of the Clinton Administration's failure to address long-term care, one advocate shared, "When Representative Claude Pepper died, we lost our voice. For many years, we sought someone with his commitment, but we never identified a true successor."¹³⁴ The U.S. Bipartisan Commission on Comprehensive Health Care was later renamed the Pepper Commission in honor of its first chair.¹³⁵

Following Pepper's death, Senator Jay Rockefeller became Chairman of the Pepper Commission and issued a report, *A Call For Action*, in September 1990 that recommended creating a new federal long-term care insurance program, supported by an 11 to 4 vote in favor among commissioners.¹³⁶ Rockefeller wrote, "We can continue to duck our heads and hope this issue will not bring the nation to its knees, or we can use the commission's recommendations as the rallying point for building the political consensus that can make universal coverage for health and long-term care a reality."¹³⁷ The report said:

[M]ost Americans face the risk of impoverishment should they need long-term care. . . . Families exhaust themselves and their resources to provide care at home; long stays in a nursing home consume the savings of a lifetime. As the population ages and technology extends life for young and old disabled Americans alike, these burdens will only increase.¹³⁸

However, the Commission did not recommend adding long-term care benefits to Medicare, noting that the program has "structural limitations that prevent [it] from meeting the projected need."¹³⁹ The report instead recommended the creation of a new universal federally financed social insurance program at a total estimated cost in 1990 of \$43 billion, which would have covered home and community-based care

134. Joshua M. Wiener, Carroll L. Estes, Susan M. Goldenson & Sheryl C. Goldberg, *What Happened to Long-Term Care in the Health Reform Debate of 1993–1994? Lessons for the Future*, 79 MILBANK Q. 207, 242 (2001).

135. See Larry J. Polivka, *The Legacy of Claude Pepper and the Future of Aging Advocacy*, 39 J. AM. SOC'Y ON AGING 86, 87 (2015).

136. THE PEPPER COMMISSION, *A CALL FOR ACTION 10–11* (1990) [hereinafter PEPPER COMMISSION].

137. Senator John D. Rockefeller IV, *The Pepper Commission Report on Comprehensive Health Care*, 323 NEW ENG. J. MED. 1005, 1005 (1990).

138. THE PEPPER COMMISSION, *supra* note 136.

139. *Id.* at 13.

(including personal care), the first three months of nursing home care for all Americans, and protection against impoverishment for someone needing a longer nursing home stay.¹⁴⁰

Yet, when Senator Rockefeller introduced legislation based on the recommendations from the Commission, it focused only on health insurance and excluded long-term care. Although years later, he successfully fought to have the Department of Veterans Affairs expand coverage of long-term care benefits,¹⁴¹ in his retirement announcement in 2013, Rockefeller called the lack of a comprehensive long-term care system in the United States “one of our greatest failures.”¹⁴²

After the Pepper Commission report, it seemed a dim possibility that Medicare would ever cover long-term care benefits. Although President Clinton made such promises on the campaign trail, his proposed Health Security Act of 1993 did not include long-term care benefits in Medicare, instead sidelining it to a different program.¹⁴³

Attention turned for the next decades to the private market for long-term care insurance. The Health Insurance Portability and Accountability Act passed in 1996 extended tax preferred status to employer-sponsored long-term care insurance.¹⁴⁴ Other incremental efforts including a \$3000 tax credit proposed as part of President Clinton’s FY2001 budget failed, criticized as being only available to families with sufficient tax liability to be eligible.¹⁴⁵

The Final Report of the 2005 White House Conference on Aging noted that “[p]rivate financing such as long-term care insurance and personal savings may become more important funding sources over the next decade and beyond for older Americans who require long-term care services.”¹⁴⁶ Accordingly, legislative efforts focused on how to

140. *Id.* at 16.

141. Veterans Millennium Health Care and Benefits Act, H.R. 2116, 106th Cong. (1999).

142. See Rockefeller, *supra* note 137; see Scott Parkin, *Rockefeller: Keep pushing for Medicare expansion into long-term care*, MCKNIGHTS LONG-TERM CARE NEWS (Apr. 6, 2016), <https://www.mcknights.com/news/rockefeller-keep-pushing-for-medicare-expansion-into-long-term-care/>.

143. See Health Security Act, H.R. 3600, 103rd Cong. (1993).

144. See Health Insurance Portability and Accountability Act, Pub. L. No. 104-191, § 321, 110 Stat. 1936, 2054–60 (1996).

145. CAROL O’SHAUGHNESSY, BOB LYKE & CAROLYN MERCK, CONG. RSCH. SERV., RL30254, LONG-TERM CARE: THE PRESIDENT’S FY2001 BUDGET PROPOSALS AND RELATED LEGISLATION 1 (2000).

146. 2005 WHITE HOUSE CONF. ON AGING, REPORT TO THE PRESIDENT AND THE CONGRESS 1, 35 (2005).

create incentives for private long-term care insurance purchases, such as the long-term care partnership program created as part of the Deficit Reduction Act of 2005.¹⁴⁷ This program allows someone who buys a qualifying private long-term care policy a larger Medicaid asset disregard—which means they can retain more of their assets while qualifying for long-term care benefits under Medicaid—and protects those additional assets from Medicaid estate recovery when they die.¹⁴⁸ Even though most states developed incentive programs to encourage people to buy private policies, the share of older Americans with private policies decreased between 2008 and 2014.¹⁴⁹

In 2009, long-term care returned to the national policy stage, perhaps for the last time, during debates over what would become the Affordable Care Act.¹⁵⁰ A Special Committee on Aging, again chaired by Senator Herb Kohl, resurfaced the issue.¹⁵¹ At a committee hearing, Senator Wyden urged that long-term care not be left behind in health care reform debates.¹⁵² Harriet Komisar and Judy Feder, testifying on behalf of the Center for American Progress, offered several policy approaches, including, first, adding a long-term care benefit to Medicare to cover nursing home or home-based care, and second, a less ambitious *voluntary* public standalone long-term care insurance program.¹⁵³

The form proposed second became the Community Living Assistance Services and Supports Act (CLASS Act) and was passed as part of the Affordable Care Act.¹⁵⁴ It was a voluntary, employment-based opt-out program, where people who contributed enough during their working years would receive a daily cash benefit to help defray the

147. See Deficit Reduction Act of 2005, Pub. L. No. 109-171, § 6021, 120 Stat. 4, 68 (2006).

148. *Id.*

149. Richard W. Johnson, *Who is Covered by Private Long-Term Care Insurance?*, URB. INST. 1, 2–3 (Aug. 2016), <https://www.urban.org/sites/default/files/publication/83146/2000881-Who-Is-Covered-by-Private-Long-Term-Care-Insurance.pdf>.

150. See Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119.

151. *Health Care Reform in an Aging America: Hearing Before the Special Comm. on Aging*, 111th Cong. (2009).

152. *Id.*

153. *Id.* at 70; Harriet Komisar & Judy Feder, *The Role of Long-Term Care in Health Reform*, CTR. FOR AM. PROGRESS ACTION FUND (Mar. 25, 2009), <https://www.americanprogressaction.org/article/the-role-of-long-term-care-in-health-reform/>.

154. JOANNE KENEN, *THE CLASS ACT. THE LONG-TERM CARE INSURANCE PROGRAM CREATED BY THE AFFORDABLE CARE ACT WILL BE RESHAPED TO ADDRESS CONCERNS ABOUT SOLVENCY 1* (2011).

costs of long-term care. The primary focus was to support care needs for people living at home, not in nursing homes.

The program was doomed, however, by a requirement that it be self-sustaining through premiums, and, in 2011, HHS determined the program could not possibly meet that requirement and put it on hold pre-implementation.¹⁵⁵ In 2012, Congress formally repealed the CLASS Act, and, in a largely symbolic gesture, simultaneously established a 15-member Commission on Long-Term Care.¹⁵⁶ The Commission issued a report in 2013 but—like all those commissions and efforts that went before them—deadlocked on how to finance long-term care reforms.¹⁵⁷ They offered two approaches. The first returned to the pre-ACA idea of using incentives, including through annuities and public-private partnerships, to encourage people to buy private long-term care policies. The second was to create a “societal solution” through one of two possible social insurance models: a comprehensive benefit under Medicare Part A or a more limited benefit to insure against catastrophic risk, under either Medicare or a new public program. The report acknowledged, however, that social insurance “would not cover all service needs or eliminate the need for personal financial contributions of family care.”¹⁵⁸

Five members of the commission—Laphonza Butler, Henry Claypool, Judith Feder, Lynnae Ruttledge, and Judith Stein—subsequently published an alternative report.¹⁵⁹ The authors wrote: “We are convinced that no real improvements to the current insufficient, disjointed array of LTSS and financing can be expected without committing significant resources, instituting federal requirements, and developing social insurance financing.”¹⁶⁰ This report repeated the two social insurance proposals contained in the full report and reminded that the CLASS Act was proof that a voluntary approach is unworkable.¹⁶¹

155. See Lexie Verdon, *HHS Halts CLASS Act*, KFF (Oct. 14, 2011), <https://khn.org/news/hhs-halts-class-act/>.

156. American Taxpayer Relief Act of 2012, Pub. L. No. 112-240, 126 Stat. 2326.

157. See generally COMM’N ON LONG-TERM CARE, REPORT TO THE CONGRESS (2013).

158. *Id.* at 68.

159. LAPHONZA BUTLER, HENRY CLAYPOOL, JUDITH FEDER, LYNNAE RUTTLEDGE, & JUDITH STEIN, A COMPREHENSIVE APPROACH TO LONG-TERM SERVICES AND SUPPORTS (2013).

160. *Id.* at 1.

161. *Id.* at 7.

Since the repeal of the CLASS Act, there has been no serious legislative movement toward fundamental long-term reform. To the extent Medicare is discussed in the same breath as long-term care, it is part of a larger conversation on Medicare for All. Even in that context among the most devoted health insurance supporters, there exists fundamental disagreement over whether Medicare should cover long-term care.

4. THE INVISIBLE COPAYMENT OF LONG-TERM CARE

Medicare's failure to address long-term care needs has produced two unfortunate effects. Most obviously, the U.S. lacks a coherent financing mechanism for long-term care. Medicare—a program designed to serve older people and people with disabilities—would have been the logical locus for one. Medicaid, instead, has provided some coverage, incomprehensively. This, in turn, produces a second unfortunate result: informal caregivers—friends and family—in many cases fill remaining gaps at high personal costs.¹⁶²

Medicaid has emerged as the primary source of public long-term care financing, financing half of all paid services, and resulting in benefits that are limited and underfunded.¹⁶³ Benefits vary by state and are means-tested. Most Americans are neither poor enough to qualify for Medicaid nor wealthy enough to privately insure.

Medicaid was passed with an “institutional bias,” favoring long-term care in licensed nursing homes as a mandatory benefit that states had to cover to receive federal matching funds, while home-based care was optional for states.¹⁶⁴ Overtime, the balance of institutional and home-based care has changed dramatically due to several factors. In 1999, the Supreme Court decision *Olmstead* held that Medicaid failure to pay for care in less restrictive settings violates the Americans with Disabilities Act.¹⁶⁵ Both pre- and post-dating this decision, Congress increasingly encouraged state Medicaid programs to pay for care outside of institutions—in the form of what are called Home & Community-

162. See generally Hoffman, *supra* note 2, at 243 (discussing how policy has produced costs for informal caregivers and why we should consider and treat these costs as insurable risks).

163. Priya Chidambaram & Alice Burns, *10 Things About Long-Term Services and Supports (LTSS)*, KFF (Sept. 15, 2020), <https://www.kff.org/medicaid/issue-brief/10-things-about-long-term-services-and-supports-ltss/>.

164. *Id.*

165. *Olmstead v. L.C. ex. rel. Zimring*, 527 U.S. 581, 607 (1999).

Based Services (HCBS). This shift of care into homes was called “rebalancing,” and HCBS grew from eighteen percent of Medicaid’s long-term care spending in 1995 to over fifty percent in 2020.¹⁶⁶ Most Medicaid beneficiaries now receive care at home.¹⁶⁷

Although beneficiaries may prefer care at home, rebalancing has increased reliance on informal caregivers. State Medicaid waiver programs for HCBS must be budget neutral, which means that the programs cost states in total no more than what they would have spent on nursing home care. To meet budget neutrality requirements, considering that more people will use care if available at home rather than only in institutional settings, states have developed these programs with gaps, including exclusion of some disabling conditions, limits on enrollment, or prohibitions on aides or assistants from helping with certain personal care activities, such as bathing or dressing.¹⁶⁸

Rebalancing coincided with intensifying care needs among people with chronic illness and disability.¹⁶⁹ Medicare’s 1983 prospective payment system produced what has been called “quicker and sicker” discharge, where hospitals got paid a fixed amount for treating a particular condition and would discharge people sooner and in less stable condition.¹⁷⁰ Sociologist Cameron Macdonald calls this pattern “healthcare offloading” because of the way that it shifts the burden of

166. Molly O’Malley Watts, MaryBeth Musumeci, & Meghana Ammula, *Medicaid Home & Community-Based Services: People Served and Spending During COVID-19*, KFF (Mar. 4, 2022), <https://www.kff.org/report-section/medicaid-home-community-based-services-people-served-and-spending-during-covid-19-issue-brief/>.

167. NAT’L ALL. FOR CAREGIVING & AARP, INC., *CAREGIVING IN THE U.S.: 2020* 22, fig. 19 (2020).

168. Molly O’Malley Watts, MaryBeth Musumeci & Meghana Ammula, *Key State Policy Choices About Medicaid Home and Community-Based Services*, KFF (Feb. 4, 2020), <https://www.kff.org/report-section/key-state-policy-choices-about-medicicaid-home-and-community-based-services-issue-brief/> (reporting nearing 820,000 people on waiting lists in 41 states and hour, cost or geographic limits on HCBS in waivers in nearly three-quarter of states).

169. Sara M. Moorman & Cameron Macdonald, *Medically Complex Care and Caregiver Strain*, 53 *GERONTOLOGIST* 407, 417 (2012) (describing the increase of medicalization of home care and its effects on family caregivers).

170. Jacqueline Kosecoff, Katherine Kahn, William Rogers, Ellen Reinisch, Marjorie Sherwood, Lisa Rubenstein, David Draper, Carol Roth, Carole Chew, & Robert Brook, *Prospective Payment System and Impairment at Discharge: The ‘Quicker and Sicker’ Story Revisited*, 264 *JAMA* 1980, 1982 (1990) (reporting an over 40% increase in unstable discharges).

care from medical institutions to families.¹⁷¹ Caregivers have unsurprisingly reported over time that their adult care recipients have greater health and functional needs.¹⁷²

To make matters worse, Medicare's commitment to post-acute care at home has wavered, and visits have decreased over the past two decades.¹⁷³ Even though this funding is intended for medical care, not personal assistance, when it decreases it means less nursing assistance and rehabilitative care in the home. As a result of these policies, the average care recipient is experiencing a decline in formal paid care through Medicare and Medicaid and increasingly relying on informal caregivers.¹⁷⁴

The work for the average informal caregiver has increased not just in level but also in complexity, and intensity.¹⁷⁵ Fifty-eight percent of informal caregivers in one study were performing at least one medical task, including wound care, intravenous medication, and operating dialysis and home infusion machines.¹⁷⁶ Family members connect ventilators to tracheostomy sites, respond to alarms and failures, program feeding tubes and monitor for blockages or signs of infection, and monitor medical complications, including signs of pneumonia.¹⁷⁷

Families are not well situated for this work. Single-parent families and two wage-earner households are the new normal,¹⁷⁸ leaving little time to absorb caregiving in most cases. And the ratio of people needing care to those who can provide it is increasing as people live longer and have fewer kids.¹⁷⁹

171. Cameron Macdonald, *Is There A Doctor in the House?: Family Members Providing Complex Medical Care at Home* (unpublished manuscript) (on file with author).

172. NAT'L ALLIANCE FOR CAREGIVING & AARP, *supra* note 167, at 24.

173. Barbara Lyons & Diane Rowland, *Reset Medicare's Home Health Benefit*, HEALTH AFFS. FOREFRONT (July 14, 2022), <https://www.healthaffairs.org/doi/10.1377/forefront.20220712.36795>.

174. NAT'L ALL. FOR CAREGIVING & AARP, *supra* note 167, at 36.

175. *Id.* at 24, 37.

176. *Id.* at 37.

177. See Moorman & Macdonald, *supra* note 169, at 408.

178. See U.S. BUREAU OF THE CENSUS, DEP'T OF COM., STAT. ABSTRACT OF THE U.S. 527, tbl. 840 (2012) (documenting the rise in single-parent households); Howard Fullerton, *Labor Force Participation: 75 Years of Change, 1950-98 and 1998-2025*, MONTHLY LAB. REV. 3, 4 tbl. 1 (1999) (documenting the past and projected increasing participation of women in the U.S. labor force).

179. See Emily Brandon, *65-and-Older Population Soars*, U.S. NEWS (Jan. 9, 2012, 9:15 AM), <http://money.usnews.com/money/retirement/articles/2012/01/09/65-and->

As a result of increased obligations combined with the changing shape of families, informal caregivers, disproportionately women in the heart of their working years,¹⁸⁰ face staggering burdens. By one estimate, the financial losses alone—including forgone income, pensions, benefits, and retirement savings—sustained by the average informal caregiver who leaves the workforce to care for a parent are \$300,000.¹⁸¹ These monetary losses are just the beginning. Many informal caregivers experience permanent harm to their health, relationships, and general wellbeing.¹⁸² Unsurprisingly, informal caregivers who end up having to fill in medical care gaps face great stress.¹⁸³

The failure to expand Medicare coverage to meet these needs for long-term care is the most striking example of Medicare's shortcoming as a social insurance program for the elderly and disabled. It is also an area where the U.S. is out-of-step with peers, most of whom have at least some public long-term care financing. Long-term care is the only health care category where the U.S. underspends peers, spending 11.6 percent less in contrast, for example, to 76.4 percent more on inpatient and outpatient care.¹⁸⁴

older-population-soars (reporting that the proportion of Americans 65 and older has grown from 4.1% in 1900 to 13% in 2012).

180. NAT'L ALL. FOR CAREGIVING & AARP, *supra* note 167, at 10–11.

181. METLIFE MATURE MKT. INST., *THE METLIFE STUDY OF CAREGIVING COSTS TO WORKING CAREGIVERS: DOUBLE JEOPARDY FOR BABY BOOMERS CARING FOR THEIR PARENTS* 15 (2011), <https://www.caregiving.org/wp-content/uploads/2011/06/mmi-caregiving-costs-working-caregivers.pdf>. See also Meghan M. Skira, *Dynamic Wage and Employment Effects of Elder Parent Care*, 56 INT'L ECON. REV. 63, 82 (2015) (exemplifying a study models the median opportunity costs of two years of caregiving for a sick mother to be \$164,726). NAT'L ALL. FOR CAREGIVING & AARP, *supra* note 167, at 18 (noting that the average duration of caregiving is twice as long, which means the average caregiver would face opportunity costs twice this amount).

182. NAT'L ALL. FOR CAREGIVING & AARP, *supra* note 167, at 47, 49, 50, 53.

183. Jennifer L. Wolff, Brenda C. Spillman, Vicki A. Freedman, & Judith D. Kasper, *A National Profile of Family and Unpaid Caregivers Who Assist Older Adults with Health Care Activities*, 176 JAMA INTERN. MED. 372, 375 (2016); see NAT'L ALL. FOR CAREGIVING & AARP, *supra* note 167, at 47, 49, 50, 53 (documenting caregiver self-reported declines in health and emotional stress of caregiving).

184. Nisha Kurani & Cynthia Cox, *What Drives Health Spending In The U.S. Compared to Other Countries*, HEALTH SYS. TRACKER (Sept. 25, 2020), <https://www.healthsystemtracker.org/brief/what-drives-health-spending-in-the-u-s-compared-to-other-countries/>.

IV. Vision, Hearing, and Dental Benefits: How the Biden Administration Flirted with Meaningful Expansion and Came up Short

The most recent effort to expand Medicare benefits to cover vision, dental, and hearing benefits initially seemed promising, but stalled out due to factors including a delicate Congressional majority for Democrats and resistance from providers and insurers. In 2021 Congress toiled over two different bills¹⁸⁵ that were part of the Biden Administration's Build Back Better campaign. The first, an infrastructure bill, garnered bi-partisan support and was signed into law on Monday November 15, 2021. The second, focused on social programs, lacked any Republican support in the Senate. By necessity, it was fashioned as a budget reconciliation act that would need all 50 Democratic senators and the blessing of the Senate parliamentarian to pass. For the progressive Congressional caucus, adding vision, hearing and dental benefits to traditional Medicare was a top legislative priority, as Senator Bernie Sanders said in October 2021:

It is really insane that in the wealthiest country in the history of the world we have tens of millions of Americans, older Americans, who have no teeth in their mouth or are unable to digest the food that they're eating, people who cannot hear and communicate with their grandkids because they have no hearing aids, people unable to see this as America, the richest country in the world.

Bottom line is that ... a serious reconciliation bill must include expanding Medicare to cover dental, hearing aids and eye-glasses.¹⁸⁶

As ideas translated into draft legislation, however, dental and vision benefits were absent. Only hearing benefits remained at this stage. By the time the bill passed as the Inflation Reduction Act of 2022,¹⁸⁷ none remained.

Two aspects of this effort are particularly notable in the arc of Medicare's expansionary efforts, and failures. The first is how these benefits fit into progressives' overall agenda and why adding them became the centerpiece after a push for Medicare for All in the 2020

185. See, e.g., Infrastructure Investment and Jobs Act, Pub. L. 117-58, 135 Stat. 429; Press Release, White House, Fact Sheet: The American Families Plan (Apr. 28, 2021), <https://www.whitehouse.gov/briefing-room/statements-releases/2021/04/28/fact-sheet-the-american-families-plan/>.

186. The Hill (@thehill), TWITTER (Oct 27, 2021, 9:31 AM), <https://twitter.com/thehill/status/1453353538600460289>.

187. See generally Inflation Reduction Act of 2022, Pub. L. 117-68, 136 Stat. 1818.

primary contest failed. The second is understanding how adding these benefits could be a key to preserving the traditional fee-for-service public version of Medicare.

Efforts by Democrats, especially progressive Democrats, to add dental, hearing, and vision benefits to Medicare must first and foremost be considered in the context of what they are not: Medicare for All. After Joe Biden won the presidential election, the momentum toward Medicare for All halted. Yet it still seemed plausible that elements of the progressive caucus's agenda would carry forward. All eyes were on health care—both how President Biden would fill in the remaining gaps left the by ACA and whether he would support any fundamental changes to Medicare. Two changes that were discussed were lowering Medicare's eligibility age or adding benefits to traditional Medicare.

Lowering the eligibility age from 65 to 60 met with greater Congressional resistance,¹⁸⁸ despite popular support.¹⁸⁹ Sixty- to sixty-five-year-olds have the highest rates of uninsurance among adults and the highest health care costs, making them a logical target for reforms. A Kaiser Family Foundation poll suggests a large majority of the population favor lowering the eligibility age (eighty-five percent of Democrats and sixty-nine percent of Republicans).¹⁹⁰ But Republicans and hospital groups—concerned about Medicare displacing higher-reimbursing private insurance—made claims that lowering the age might prompt earlier retirement and shrink the labor force, using fear to fight back this change.¹⁹¹ The well-worn fear rhetoric about depletion of the trust fund followed not far behind, and support waned.

Attention turned to adding dental, hearing, and vision benefits to Medicare Part B. In 2021, Representative Lloyd Doggett proposed the Medicare Dental, Vision, and Hearing Benefit Act of 2021, with 109

188. Jonathan Oberlander, *Health Care Reform under the Biden Administration—Broad Ambitions, Narrow Majorities*, 386 N. ENG. J. MED 1773 (2022) (“There has been no movement in Congress on lowering the age of eligibility for Medicare from 65 years to 60 years.”).

189. See generally Ashley Kirzinger, Calley Muñana, & Mollyann Brodie, *KFF Health Tracking Poll—January 2019: The Public On Next Steps For The ACA And Proposals To Expand Coverage*, KFF (Jan. 23, 2019), <https://www.kff.org/health-reform/poll-finding/kff-health-tracking-poll-january-2019/>.

190. *Id.*

191. Stephanie Armour & Kristina Peterson, *Democrats Look at Lowering Medicare Eligibility Age in Healthcare Package*, WALL ST. J. (March 30, 2021, 9:00 AM), <https://www.wsj.com/articles/democrats-look-at-lowering-medicare-eligibility-age-in-healthcare-package-11617109207>.

cosponsors by the end of the year.¹⁹² The bill proposed coverage for routine and non-routine dental care; routine eye exams, glasses, and contact lenses; and hearing exams and aids.¹⁹³ In parallel, President Biden's proposed FY 2022 budget included improved access to care in all three areas. The initial agreements among Senate Democrats, announced in summer 2021, toward a \$3.5 trillion Build Back Better reconciliation bill included this expansion, without any policy details. By the time Build Back Better passed the House in a trimmed back \$1.7 trillion form in November 2021, only hearing benefits remained, proposing adding services to Medicare Part B beginning in 2023, including rehabilitation and treatment services and hearing aids once per ear every five years for qualifying individuals and subject to the Part B deductible and coinsurance.¹⁹⁴ These benefits, with an estimated federal cost of \$36.7 trillion over 10 years, were modest, as compared to where policy discussion began.¹⁹⁵ And at the end of the day, even they did not make the final cut.

What happened with these benefits? In part, the IRA shrunk to accommodate moderate Democrats, including Senators Joe Manchin and Kyrsten Sinema.¹⁹⁶ Senator Manchin said he would only consider a bill with a much smaller price than the initial proposal, prompting efforts to trim overall.

This shrinking dynamic combined with pressures from interest groups. The American Dental Association (ADA), which spends more on lobbying than every other dental group combined, according to the Wall Street Journal, quickly came out in opposition to anything other than a means tested dental benefit available in a separate, new part of

192. See Medicare Dental, Vision, and Hearing Benefit Act of 2021, H.R. 4311, 117th Cong. (1st Sess. 2021).

193. *Id.*

194. Build Back Better Act, H.R. 5376, 117th Cong. (1st Sess. 2021).

195. Cynthia Cox, Robin Rudowitz, Juliette Cubanski, Karen Pollitz, MayBeth Musumeci, Usha Ramji, Michelle Long, Meredith Freed, & Tricia Neuman, *Potential Costs and Impact of Health Provisions in the Build Back Better Act*, KFF (Nov. 23, 2021), <https://www.kff.org/health-costs/issue-brief/potential-costs-and-impact-of-health-provisions-in-the-build-back-better-act/>.

196. See, e.g., Daren Gregorian, *Biden's Build Back Better Bill: What Made It In and What Was Stripped Out*, NBC NEWS (Oct. 28, 2021, 6:21 PM), <https://www.nbcnews.com/politics/joe-biden/biden-s-build-back-better-bill-what-made-it-what-n1282643>; Jonathan Weisman & Emily Cochrane, *Benefits for All or Just the Needy? Manchin's Demand Focuses Debate*, N.Y. TIMES (last updated Nov. 1, 2021), <https://www.nytimes.com/2021/10/08/us/politics/manchin-democrats-means-testing.html?searchResultPosition=27>.

Medicare.¹⁹⁷ It is telling that the ADA did not fully oppose the addition of dental benefits to Medicare, a position that they may have considered unattractive. It was also unnecessary. As two dentists described in the *New England Journal of Medicine* (NEJM), with means tested eligibility, dentists could easily decline to accept Medicare for payment, as many do with Medicaid, taking only private pay, higher-earning patients.¹⁹⁸ Also notable was the ADA's use of familiar tropes to defend against full expansion. Dentists argued that they could not cover their own costs with Medicare reimbursement, without even knowing what reimbursement levels might be, and that the expansion would be too expensive overall if unbounded. They said that dental coverage for all beneficiaries is "wasteful," since some people can afford to pay for it on their own¹⁹⁹ (query why dentists should be especially concerned about such features).

The ADA failed to contend with the fact that Medicare eligibility is not means tested, and adding a means-tested sub-program just for dental benefits would be an administrative nightmare, way more wasteful than paying for some care that individuals might afford on their own. Even more, it would chip away at Medicare's universality—or what remains of it after the MMA. And, as the dentists wrote in NEJM, a standalone style benefit would perpetuate the separation of medical and dental care, both symbolically and practically, that has harmfully impeded the ability to provide coordinated healthcare since dental care is an important factor of overall health.²⁰⁰ Notably, and in contrast to the ADA, associations of Black and Latino dentists, the AARP, and coalitions of seniors were in favor of universal expansion.²⁰¹ In the end, dental benefits were pulled from the final package.

While the dental industry's efforts got more publicity, the American Optometric Association (AOA) was also working behind the scenes to ensure "sufficient guardrails" for any vision benefits included in Build Back Better. When vision benefits were scrapped, the AOA's

197. Julie Bykowicz, *Dentists' Group Fights Plan to Cover Dental Benefits Under Medicare*, WALL ST. J. (Sept. 27, 2021, 5:30 AM), <https://www.wsj.com/articles/dentists-group-fights-plan-to-cover-dental-benefits-under-medicare-11632735002>.

198. Lisa Simon & William V. Giannobile, *Is it Finally Time for a Medicare Dental Benefit?*, N. ENG. J. MED. (Dec. 2, 2021). <https://www.nejm.org/doi/full/10.1056/NEJMp2115048>.

199. Bykowicz, *supra* note 197.

200. Simon & Giannobile, *supra* note 198.

201. *Id.*

president's response was that "As the larger bill's price tag caused renewed debt and deficit concerns on Capitol Hill, it quickly became clear that Congress would likely be unable to deliver a fully funded benefit, and the provision was dropped entirely."²⁰² The AOA may have been worried about a middle ground with "insufficient" reimbursement or limited networks affecting their patient population or reimbursement levels.

The second important and less obvious aspect of this failed expansion is that it fuels the continued acceleration toward privatized Medicare by making Medicare Advantage plans seemingly more comprehensive than traditional Medicare. By 2021, forty-two percent of the Medicare population enrolled in private Medicare Advantage plans, contrasted with just twenty-five percent a decade earlier and fifteen percent two decades earlier.²⁰³ A Congressional Budget Office Report from March 2020 estimated that over half of Medicare beneficiaries would be enrolled in private plans by 2030.²⁰⁴

A critical driver of this growth is gaps in traditional Medicare, including the lack of dental, vision and hearing benefits, which are covered at least in part by nearly all Medicare Advantage plans.²⁰⁵ When private insurers target seniors to get them to enroll in their Medicare

202. *Congress' Medicare Vision Efforts Fizzle, 10% Pay Cuts Still Loom*, AM. OPTOMETRIC ASS'N. (Nov. 22, 2021), <https://www.aoa.org/news/advocacy/federal-advocacy/medicare-vision-efforts-fizzle-10-percent-pay-cuts-still-loom?sso=y>.

203. Meredith Freed, Jeannie Fuglesten Biniek, Anthony Damico, & Tricia Neuman, *Medicare Advantage in 2021: Enrollment Update and Key Trends*, KFF (Aug. 25, 2022), <https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2021-enrollment-update-and-key-trends/>.

204. CONG. BUDGET OFF., *MEDICARE—CBO'S BASELINE AS OF MARCH 6, 2020* (2020), <https://www.cbo.gov/system/files/2020-03/51302-2020-03-medicare.pdf>.

205. See Meredith Freed, Jeannie Fuglesten Biniek, Anthony Damico, & Tricia Neuman, *Medicare Advantage in 2022: Premiums, Out-of-Pocket Limits, Cost Sharing, Supplemental Benefits, Prior Authorization, and Star Ratings*, KFF (Aug. 25, 2022), <https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2021-premiums-cost-sharing-out-of-pocket-limits-and-supplemental-benefits/>; Meredith Freed, Juliette Cubanski, Nolan Sroczynski, Nancy Ochleng, & Tricia Neuman, *Dental, Hearing, and Vision Costs and Coverage Among Medicare Beneficiaries in Traditional Medicare and Medicare Advantage*, KFF (Sept. 21, 2021), <https://www.kff.org/health-costs/issue-brief/dental-hearing-and-vision-costs-and-coverage-among-medicare-beneficiaries-in-traditional-medicare-and-medicare-advantage/> [*hereinafter* *Dental, Hearing, and Vision Costs*]; Meredith Freed, Nancy Ochleng, Nolan Sroczynski, Anthony Damico, & Krutika Amin, *Medicare and Dental Coverage: A Closer Look*, KFF (Jul. 28, 2021), <https://www.kff.org/medicare/issue-brief/medicare-and-dental-coverage-a-closer-look/>.

Advantage plans, they highlight these benefits in their advertisements and marketing.²⁰⁶

Most of the Medicare population is income constrained, making coverage of these benefits critical. In a 2019 Kaiser Family Foundation survey, half of Medicare beneficiaries report difficulty hearing.²⁰⁷ Yet, only eight percent of all Medicare beneficiaries sought out hearing care, suggesting that these costs prevent beneficiaries from getting care they need. Nearly half of Medicare beneficiaries lack dental coverage, and just over half sought dental care, with lower rates of care among Black, Hispanic, and low-income beneficiaries.²⁰⁸ Among Medicare beneficiaries who used these services in 2018, the average someone spent out-of-pocket on hearing care was \$914, on dental care was \$874, and on vision care was \$230.²⁰⁹ Ninety percent of the population in one poll said that inclusion of these benefits in traditional Medicare should be an important or top priority, ranking second only to allowing the federal government to negotiate prescription drug prices.²¹⁰

The failure to pass a more comprehensive version of dental, vision, and hearing benefits is a great departure from public opinion. It reflects how interest groups like the ADA and private insurers have been increasing able to perpetuate a shape of the program that best serves them, even if detrimental to beneficiaries and to Medicare's social insurance ideology at its nascence.

V. Conclusion

Taken as a whole, these case studies of one successful expansion in the market-based, privately administered mold compared with many unsuccessful efforts at expanding the original program within its initial, public mold are a window into the deeply changing nature of

206. See generally XIAOMEI CAI, GARY KREPS, JIM MCAULEY, & XIAOQUAN ZHAO, KFF, *PITCHING PRIVATE MEDICARE PLANS: AN ANALYSIS OF MEDICARE ADVANTAGE AND PRESCRIPTION DRUG PLAN ADVERTISING* (2013), <https://www.kff.org/wp-content/uploads/2013/01/7805.pdf>.

207. *Dental, Hearing, and Vision Costs*, *supra* note 205.

208. *Id.*

209. *Id.*

210. Craig Palosky, *Two-Thirds of the Public Say the U.S. Should Play a Major Role in Distributing COVID-19 Vaccines Globally, But Not Most Republicans*, KFF (Jun. 3, 2021), <https://www.kff.org/health-costs/press-release/two-thirds-of-the-public-say-the-u-s-should-play-a-major-role-in-distributing-covid-19-vaccines-globally-but-not-most-republicans/>.

the Medicare program and the increasing skepticism of social insurance in the U.S., regardless of party affiliation.

With the latest round of expansionary defeats, it seems increasingly likely that the entire program will be privatized in the not-so-far future. For many beneficiaries, this switch will be invisible. They'll enroll in Medicare when eligible, will choose a plan (as many were used to doing during their working years), and they will follow the plan's rules and directions when they need care. For many beneficiaries, it will work fine (for some of the more vulnerable, it will not).

That version of Medicare is fundamentally different from what was imagined in 1965. Private insurance companies will have significant control over the shape of the program, including deciding—or, at the least, strongly influencing—who among beneficiaries will be physically and financially secure and who less so, and in what ways. And these decisions will be inextricably intertwined with preservation of corporate profit. The notion of handing over social insurance protections to the discretion of United or Humana may seem absurd, but that is exactly what has gradually occurred through the incremental types of decisions described herein.

These changes are possible because of disinterest in, or disbelief in, ideals of social insurance and faith in private markets to solve social problems. The only way to redefine the winners and losers in Medicare's evolution is to rewrite both factors: to create reinvigorated faith in the good of social insurance and healthy skepticism that private markets will produce the type of social protections we, collectively, might desire.