Unlocking The Truth: Evaluating 2008 Election Issues For Elderly Minorities As A Key To Understanding Medicare Reform

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INTRODUCTION

In a child's game of pick-up sticks, success depends on identifying and extracting individual sticks without disturbing the remainder of the pile.¹ In the early 2008 United States presidential campaign, the candidates² approached Medicare reform similarly, treating the nation's health care system for the elderly like a pile of unrelated problems to resolve piecemeal.³ This strategy may skirt a political minefield in an election year,⁴ but just as moving one stick in the child's game often results in an unanticipated and unwanted shift elsewhere, so too it is with Medicare's tangled web of interrelated issues. As illustrated by the potential impact of certain proposals on elderly minorities,⁵

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⁴ See discussion infra Section II.

⁵ See, e.g., infra notes 165-167 and accompanying text.
Medicare reform that achieves its goals without unwanted side effects requires systemic analysis of issues, with recognition and careful balance of the competing tensions often entangled in a single proposed change.

The original Medicare program — today often referred to as "traditional Medicare" — exemplifies one version of public health insurance. Under traditional Medicare, everyone — no matter how sick or how healthy, no matter how poor or how wealthy — pays for and receives the same insurance coverage through the federal government. The federal government establishes what traditional Medicare will cover and reimburses private health care providers for providing needed care. On one hand, the basic benefit package in traditional Medicare falls short of comprehensive coverage. As a result, various reforms over the decades have targeted expansion of Medicare's benefits, particularly in 2003 with the introduction of an outpatient prescription drug benefit as part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (the "MMA"). On the other hand, traditional Medicare's expenses have troubled many onlookers since the program's introduction, prompting frequent cost-control proposals. Private market advocates have consistently argued for private insurance alternatives to traditional Medicare as a way to drive down costs through competition, and their efforts have resulted in significant changes to Medicare. Today, private insurers under a program called "Medicare Advantage" compete to offer a range of benefit packages to induce Medicare beneficiaries to join particular private plans instead of traditional Medicare. The federal government subsidizes the private insurers' costs through complicated reimbursement schemes.

In late 2007, despite a full slate of potential candidates in both major political parties, Medicare reform proposals were few and finite in scope. Almost all candidates who addressed Medicare steered away from system-wide considerations and confined their suggestions to either limited improvements in the existing structure or narrow cost-reduction strategies. They sidestepped inherent conflicts between improving benefits and cutting expenses as well as
underlying tensions between public and private insurance solutions. With an eye to the 2008 presidential election and its impact on the future direction of Medicare, this Article provides a brief overview of the current Medicare system, explaining the traditional government-run public pieces of the system and the private insurance components that have been implemented in recent years. Against this background, the Article surveys the early 2008 presidential candidates’ Medicare reform proposals and discusses how their piecemeal approach missed relevant systemic considerations and ignored important underlying policy tensions. The Article then considers the ramifications for elderly minorities of certain key proposals – particularly involving Medicare Advantage plans – when viewed against the backdrop of the overall Medicare system and in the context of competing considerations of benefit expansion, cost reduction, and public-private balance. The Article concludes that narrowly focused reforms put the entire system at risk because of the ramifications such proposals tend to miss.

I. MEDICARE BASICS

Enacted in 1965 as part of President Lyndon B. Johnson’s Great Society reforms, the Medicare system forms Title XVIII of the Social Security Act. Medicare in 2006 provided broad health insurance coverage to approximately 43 million individuals, including 36 million people age 65 or older. Of the 43 million, more than 20 percent belonged to racial or ethnic minority groups. That percentage is expected to increase. Projections indicate that by 2030 more than one in four older Medicare beneficiaries will belong to a racial or ethnic minority group and that by 2050 minorities will comprise almost 40 percent of the elderly population.

16. See discussion infra Section II.C.iii.
20. HENRY J. KAISER FAM. FOUND., DISTRIBUTION OF MEDICARE ENROLLEES BY RACE/ETHNICITY, STATES (2005-2006), U.S. (2006), http://www.statehealthfacts.org/comparebar.jsp?ind=297&cat=6 (last visited Dec. 13, 2007). Nationally, in 2006, ten percent of all Medicare beneficiaries were black, seven percent were Hispanic, and four percent belonged to other non-white racial or ethnic minority groups. Id.
A. Traditional Medicare (Medicare Parts A and B)

From the beginning, Medicare coverage has been available through what are called Medicare Parts A and B—sometimes collectively known as "traditional" Medicare. Medicare Part A provides coverage for a range of institutional services, such as inpatient hospital expenses, some skilled nursing facility care and home health care, and hospice care. Part B covers the cost of services from physicians and other health care providers, as well as various other medical expenses, including outpatient services and durable medical equipment. The Social Security Act specifies the broad scope of benefits covered by traditional Medicare, with administration through the Centers for Medicare & Medicaid Services ("CMS"). The federal government reimburses Part A providers generally under an "inpatient prospective payment system," with a set payment amount assigned to the treatment of a particular type of illness or injury (known as a "diagnosis-related group" or "DRG"). Part B providers receive payment from the government in most cases based on fee schedules established by CMS. In early 2007, an estimated 81 percent of all Medicare enrollees received coverage through traditional Medicare.

All beneficiaries enrolled in traditional Medicare are entitled to the same


29. 42 U.S.C. § 1395ww(a) (2000 & Supp. 5 2006). See also CMS, ACUTE INPATIENT PPS OVERVIEW http://www.cms.hhs.gov/AcuteInpatientPPS/01_overview.asp (last visited Apr. 28, 2008). Under certain circumstances, additional amounts can be paid to Part A providers to reflect unusually high costs of particular cases. Id.


coverage package without regard to their health or wealth.\textsuperscript{32} The coverage under Parts A and B is generous but not comprehensive. For example, the majority of Medicare Part A beneficiaries do not pay a monthly premium,\textsuperscript{33} but are subject to deductibles, cost-sharing payments, and benefit caps\textsuperscript{34} that are geared toward coverage of short-term, acute illnesses rather than chronic conditions.\textsuperscript{35} Medicare Part B enrollees pay a monthly premium, a yearly deductible, and 20 percent co-insurance for most services and equipment.\textsuperscript{36} Beyond these expenses, some health care costs fall outside traditional Medicare's coverage altogether.\textsuperscript{37} These coverage "gaps" – whether due to an individual's exceeding coverage limits or due to a policy choice that Medicare excludes a particular expense – mean that individuals with traditional Medicare

\begin{itemize}
\item \textsuperscript{32} Medicare is available to all "individuals who are age 65 or over and are eligible for retirement benefits under title II of this Act...." 42 U.S.C. § 1395c (2000). No income test applies. The requirement of eligibility "for retirement benefits under title II of this Act" means eligibility for Social Security retirement benefits. At the end of 2006, more than 90 percent of those aged 65 or older received Social Security retirement benefits. ALISON SHELTON, AARP PUB. POL’Y INST., SOCIAL SECURITY: BASIC DATA 1 & n.1 (June 2007), http://assets.aarp.org/rgcenter/econ/dd159_ss.pdf. The benefits available under Medicare Parts A and B are specified in the Social Security Act. See supra note 27 and accompanying text.
\item \textsuperscript{34} 42 U.S.C. § 1395e (2000).
\item \textsuperscript{35} Beneficiary cost-sharing in Part A depends on a "spell of illness," defined generally as a period of inpatient care that ends only when an individual has not been an inpatient of a hospital, skilled nursing facility or other similar institution for a period of at least 60 consecutive days. 42 U.S.C. § 1395x(a) (2000 & Supp. 5 2006). For each spell of illness, a beneficiary in 2008 will pay a $1,024 deductible for the first 60 days of inpatient hospital care, plus a $256 per day co-payment for each of the next 30 days (days 61-90). After 90 days of inpatient hospital care in a spell of illness, the beneficiary begins to dip into what are called "lifetime reserve days" for which a beneficiary must pay a $512 per day co-payment in 2008. Medicare limits each beneficiary to a maximum of only 60 lifetime reserve days, no matter how many spells of illness. Other Part A benefits – such as home health services, skilled nursing facility care, and hospice care – are subject to different cost-sharing requirements and caps on benefits. For example, skilled nursing facility care is covered for a maximum of 100 days in any spell of illness. Long-term or custodial care is completely excluded. CMS, MEDICARE AND YOU 2008, at 111 (Jan. 2008), available at http://www.medicare.gov/Publications/Pubs/pdf/10050.pdf (hereinafter MEDICARE AND YOU 2008).
\item \textsuperscript{36} Under Part B, a beneficiary is subject to an annual $135 (in 2008) deductible, then – for most services and equipment – to a 20 percent co-insurance amount based on the applicable fee schedule for the approved services or equipment. MEDICARE AND YOU 2008, supra note 35, at 112. Beneficiaries must also pay a premium for Part B ranging in 2008 from $96.40 to $238.40 per month, depending on income levels. Id. at 110. The income-based premium level became effective in 2007, a change implemented by the MMA. 42 U.S.C. § 1395r(i) (2000 & Supp. 5 2006); MMA, supra note 8, § 811(a).
\item \textsuperscript{37} For a summary of the key gaps in coverage, see CTR. FOR MEDICARE ADVOCACY, INC., MEDICARE SUPP. INS. "MEDIGAP", http://www.medicareadvocacy.org/FAQ_Medigap.html#Gaps (last visited Apr. 29, 2008).
\end{itemize}
can still incur significant out-of-pocket expenses.\footnote{38}

**B. Medicare Private Insurance (Medicare Part C)**

Medicare today offers an alternative to Parts A and B through Part C,\footnote{39} originally known also as "Medicare+Choice" but renamed at the end of 2003 as "Medicare Advantage."\footnote{40} Medicare Part C offers health insurance coverage through private insurers who contract with CMS\footnote{41} to provide at least the same benefits as are available under traditional Medicare Parts A and B.\footnote{42} Most Medicare Advantage plans also offer supplemental benefits not available under the traditional system, often including coverage for preventive dental care, vision care, and prescription drugs.\footnote{43} A Medicare beneficiary may elect to receive Medicare coverage either through traditional Medicare or through a Part C Medicare Advantage plan.\footnote{44}

With some variation depending on the type of plan,\footnote{45} the federal government pays Medicare Advantage plans a monthly amount per enrolled beneficiary. The monthly payment rate is calculated under a complex formula that takes into account the difference between a bid amount submitted by the plans to the government and a Medicare-determined administrative "benchmark."\footnote{46} Private plans receive a partial "rebate" of the difference between the


\footnote{40. MMA, supra note 8, § 201(b).}

\footnote{41. 42 U.S.C. § 1395w-27 (2000 & Supp. 5 2006).}

\footnote{42. 42 U.S.C. § 1395w-22(a)(1) (2000 & Supp. 5 2006).}


\footnote{44. 42 U.S.C. § 1395w-21(a) (2000 & Supp. 5 2006).}

\footnote{45. Common types of Medicare Advantage plans include health maintenance organizations (HMOs), preferred provider organizations (PPOs), private fee-for-service (PFFS) plans, medical savings account (MSA) plans and special needs plans (SNPs). MEDICARE AND YOU 2008, supra note 35, at 38-39.}

\footnote{46. 42 U.S.C. § 1395w-23 (2000 & Supp. 5 2006). See also GEO. WASH. UNIV., NAT’L HLTH POL’Y FORUM, THE BASICS: MEDICARE ADVANTAGE 1-2 (Nov. 29, 2005), http://www.nhpf.org/pdfs_basics/Basics_MA_11-29-05.pdf. Special computations apply to so-called regional Medicare Advantage plans, which cover large geographic areas in an effort to make Medicare Advantage available to rural beneficiaries. Id. See also MEDICARE PAYMENT}
bid and benchmark amounts if their bids come in lower than the benchmark.  

Plans must use the rebate to provide additional benefits beyond the traditional Medicare benefits or to reduce beneficiary cost-sharing, including premium costs. By mid-2007, slightly more than 8.3 million — approximately 19 percent of Medicare’s 43 million total — beneficiaries were enrolled in some type of Medicare Advantage plan.

As long as a Medicare Advantage plan covers at least the same expenses as traditional Medicare, the private insurer offering the plan may design the coverage almost any way it wishes. As a result, unlike traditional Medicare, Medicare Advantage plans vary in what they cover and what costs they shift to beneficiaries. Most beneficiaries in Medicare Advantage pay the basic Part B premium, plus an additional premium for any supplemental benefits they receive as well as various co-payments.

C. Medicare Prescription Drug Coverage (Medicare Part D)

Beginning in 2006, the MMA added a new Part D to Medicare through which Medicare beneficiaries can receive prescription drug coverage.
Medicare prescription drug coverage is available through private insurers, not through traditional Medicare Parts A and B. Beneficiaries electing general health insurance coverage under traditional Medicare must enroll separately in a free-standing Part D prescription drug plan through a private insurer to obtain the coverage; beneficiaries electing a Medicare Advantage plan either obtain drug coverage through that plan, if available, or also elect a stand-alone Part D plan. The federal government pays Part D insurers a monthly amount per beneficiary that takes into account a bid amount from the insurer, with a variety of technical adjustments intended to limit the insurer's risk, minus beneficiary premium payments. By January 2007, approximately 54 percent of all Medicare-eligible beneficiaries had enrolled in Medicare prescription drug coverage through Medicare Advantage plans or stand-alone Part D plans.

Private insurers offering either stand-alone Part D plans or prescription drug coverage through Medicare Advantage must provide coverage that is at least "actuarially equivalent" to the standard Medicare Part D benefit prescribed by the MMA, but have considerable freedom as to the details as long as the overall package meets the equivalence requirement and is approved by CMS. As a result, like Medicare Advantage plans, the details of Medicare prescription drug coverage vary from plan to plan.

58. FACT SHEET: THE MEDICARE PRESCRIPTION DRUG BENEFIT, supra note 56. Approximately 6.7 million (16 percent of all Medicare-eligible beneficiaries) obtained prescription drug coverage through their Medicare Advantage plans in 2007; the remainder were covered by stand-alone Part D prescription drug plans. Another 10.3 million beneficiaries obtained coverage through employer retiree health plans (including the federal employees retirement plan and TRICARE for military retirees), about 4.9 million were believed to have coverage from other sources (particularly the VA), and about four million were believed not to have prescription drug coverage at all in 2007. Id.
59. The term "actuarially equivalent" is defined for purposes of Medicare prescription drug coverage in 42 C.F.R. § 423.100 (2005).
60. 42 U.S.C. § 1395w-102(c) (Supp. 5 2006).
61. It has been said that "if you've seen one PDP, you've seen one PDP." STAHLMAN,
drug benefit for 2007 included a $265 deductible, covered 75 percent of all approved drug costs from $265 up to an initial coverage limit of $2,400, and then covered nothing until a beneficiary incurred $3,850 in out-of-pocket costs. After the out-of-pocket threshold is reached, Medicare coverage provides what might be considered catastrophic coverage, covering approximately 95 percent of all costs after the threshold. The period during which a beneficiary is responsible for 100 percent of all drug costs after exceeding the initial coverage limit and before reaching the catastrophic coverage threshold is often called the “donut hole.” Beneficiaries are also responsible for premiums established by the plans in accordance with CMS guidance.

D. Medicare Supplemental Insurance

Because of the gaps in Medicare coverage, Medicare beneficiaries have long sought supplemental coverage to offset their out-of-pocket costs. Supplemental coverage most often comes from employer-sponsored retiree health plans that wrap around Medicare and cover — up to the private plan limits — whatever Medicare does not. Almost as popular are private supplemental Medicare insurance plans, known as “Medigap” plans, that offer gap coverage under one of a fixed number of options specified and regulated by the federal government. Medicare beneficiaries may also

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supra note 57, at 6. In fact, relatively few Medicare prescription drug plans — only about 12 percent for 2008 — actually offer the standard benefit package. Deductibles vary considerably, with an estimated 59 percent of all Medicare prescription drug plans in 2008 requiring no deductible. Most insurers also require tiered co-payments in lieu of the standard benefit’s fixed 25 percent coinsurance up to the donut hole. FACT SHEET: THE MEDICARE PRESCRIPTION DRUG BENEFIT, supra note 56.

62. 42 U.S.C. § 1395w-102(b) (Supp. 5 2006). The numbers are updated each year.

63. Id.

64. About a third of plans offer some coverage in the standard benefit’s donut hole, but generally limit that coverage to generic drugs only. FACT SHEET: THE MEDICARE PRESCRIPTION DRUG BENEFIT, supra note 56.


67. In 2006, an estimated 12 million Medicare beneficiaries had employer-based supplemental coverage. KAISER/HEWITT SURVEY, supra note 56, at 1.

68. In 2003, an estimated 27 percent of Medicare beneficiaries obtained supplemental coverage through Medigap policies. CRAIG CAPLAN & NORMANDY BRANGAN, AARP PUB. POL’Y INST., OUT-OF-POCKET SPENDING ON HEALTH CARE BY MEDICARE BENEFICIARIES AGE 65 AND OLDER IN 2003, fig. 5 (Sept. 2004), http://assets.aarp.org/rgcenter/health/dd101_spending.pdf.

attempt to fill in Medicare’s coverage holes by electing a Medicare Advantage plan with supplemental benefits, and very low-income individuals can obtain supplemental coverage—other than prescription drug assistance—through state Medicaid programs. The Medicare program itself provides prescription drug assistance to low-income individuals. Relatively few Medicare beneficiaries face Medicare’s coverage gaps without any kind of supplemental insurance protection, but those who do often belong to racial or ethnic minority groups.

The most popular existing supplemental coverage options have their own limitations. Employer plans often impose their own premiums, deductibles, and cost-sharing requirements. In 2006, for example, the average large employer retiree health plan premium for new retirees age 65 or older totaled $3,240 per year. Federal law limits Medigap plans to one of twelve fixed benefit packages (denominated by the letters “A” through “L”), each with limited coverage. Medigap premiums also can be expensive. For example, in 2006, the national average Medigap Plan C annual premium was $1,766. In that same year, in households with the head of household age 65 or older, the median annual income was only $27,798. Some individuals thus may find


71. 42 U.S.C. § 1395w-114(a) (Supp. 5 2006). The MMA shifted responsibility for prescription drug assistance from Medicaid to Medicare, creating significant subsidies within Medicare to assist impoverished beneficiaries—generally those with incomes below 150 percent of the federal poverty level and with limited assets—Part D premiums, annual deductibles, and cost-sharing payments. See HENRY J. KAISER FAM. FOUND., LOW-INCOME ASSISTANCE UNDER THE MEDICARE DRUG BENEFIT (July 2007), http://www.kff.org/medicare/upload/7327_03.pdf. As of January 2007, about 13.2 million Medicare beneficiaries were eligible for some type of low-income subsidy under Part D. Id. at 2.

72. In 2003, only seven percent of non-institutionalized, elderly Medicare beneficiaries had no supplemental coverage at all. CRAIG CAPLAN & NORMANDY BRANGAN, supra note 68.

73. See infra notes 138-142 and accompanying text.

74. KAISER/HEWITT SURVEY, supra note 56, at 15.

75. Id.

76. 42 U.S.C. § 1395ss (2000 & Supp. 5 2006). Plans F and J also are available in high-deductible options. As an example of Medigap’s limitations, one of the most popular options—Plan C—covers the Part A coinsurance required after the first 60 days of inpatient hospital care and provides 100 percent payment for an additional 365 lifetime reserve days, but does not cover custodial care even during an at-home recovery period following illness, injury, or surgery and does not impose a cap on beneficiary’s total out-of-pocket costs. See CMS, 2008 CHOOSING A MEDIGAP POLICY: A GUIDE TO HEALTH INSURANCE FOR PEOPLE WITH MEDICARE (Sept. 2007), available at http://www.medicare.gov/publications/pubs/pdf/02110.pdf.


78. U.S. CENSUS BUREAU, INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN
that Medicare Advantage plans provide a preferable path to supplemental insurance.\textsuperscript{79} The average annual Medicare Advantage premium in 2006, for a plan including prescription drug coverage, was only $573.24, less than the average employer or Medigap plan premium.\textsuperscript{80} This potential for additional benefits at lower cost has fueled claims that Medicare Advantage plans particularly benefit minority members of the Medicare population.\textsuperscript{81}

\section*{E. Medicare's Financial Future}

Despite the gaps in coverage and the need for supplemental insurance for beneficiaries, many perceive Medicare as an expensive program.\textsuperscript{82} In 2006 alone, the Medicare program spent $408 billion, an amount equal to approximately 3.1 percent of the nation’s gross domestic product.\textsuperscript{83} Medicare is funded by a combination of payroll taxes, beneficiary premiums, and general government revenue.\textsuperscript{84} Payroll taxes are dedicated to a trust fund that supports traditional Medicare Part A. Beginning in 2007, Part A expenditures each year are expected to exceed the payroll taxes collected in that year, forcing the program to dip into the trust fund to meet expenses.\textsuperscript{85} By 2019, according to the 2007 Medicare Trustees’ Report, that trust fund is expected to run out of previously accumulated assets based on current spending and income levels.\textsuperscript{86}
A combination of beneficiary premiums and general government revenue finances the remaining parts of Medicare. Because Part B premiums continue to increase and contributions from general revenues can be adjusted upward as needed, Part B income is structured to balance expenditures each year. However, Part B costs have increased by an average of almost 11 percent per year over the past five years, and the Medicare Trustees' Report projects future growth of at least six to nine percent annually, requiring ever-higher premiums and government revenue contributions to ensure Part B solvency. Meanwhile, Part D expenses are projected to grow at 12.6 percent per year over the next decade. Taken together, Medicare expenses are expected to consume 11.3 percent of the nation's gross domestic product in 75 years, a matter of concern to many onlookers.

F. Recent Medicare Reform

Medicare's financial forecast makes reform a perennial issue. In traditional Medicare, reform efforts tend to focus on the provider side, striving to encourage cost-efficient care and limiting reimbursement rates. For example, after escalating costs raised concern in the program's early years, Medicare in the 1980s adopted the prospective payment system and DRGs to rein in reimbursement rates for certain institutional providers under Part A and then established fee schedules in the early 1990s to control other provider costs under Part B. Since then, Congress has continued to tinker with how providers in traditional Medicare are paid. For example, the Balanced Budget Act of 1997 (the "BBA") imposed a number of additional limits on payments to hospitals, all intended to reduce traditional Medicare's costs in that area, and expanded the prospective payment system method to home health agencies. The BBA also revised how fee schedules for Part B payments for physicians are updated from year to year. The MMA in 2003 also included numerous provisions changing how certain types of providers are paid under either Part A or B; and most recently President George W. Bush's Fiscal Year 2009 budget

91. The original Medicare program reimbursed hospitals on the basis of their reported costs, after the costs had already been incurred. Physicians were reimbursed on the basis of their "reasonable charge." THEODORE R. MARMOR, THE POLITICS OF MEDICARE 85 (1973). This approach led to tremendous annual increases in overall Medicare expenses—an average of 40.2 percent in 1968 and 1969. JONATHAN OBERLANDER, THE POLITICAL LIFE OF MEDICARE 47 (2003).


93. The Balanced Budget Act of 1997: A current look at its impact on patients and providers: Statement before the Subcomm. on Health & Environment of the H. Comm. on Commerce, 106th Cong. 1-2 (July 19, 2000) (statement of Gail R. Wilensky, Medicare Payment Advisory Commission), available at http://pages.stern.nyu.edu/~jasker/BBAl.pdf (hereinafter Wilensky Statement). Before the BBA, home health agencies were reimbursed on the basis of their costs, similar to the way hospitals and other institutional providers had been paid in the first two decades of Medicare. Id. at 8.

94. The BBA introduced a formula that takes into account changes in inflation and a factor (called the "Sustainable Growth Rate" or "SGR") based on the nation’s Gross Domestic Product to determine the appropriate update amount. 42 U.S.C. § 1395w-4(b), (d) (2000 & Supp. 5 2006). See also CMS, ESTIMATED SUSTAINABLE GROWTH RATE AND CONVERSION FACTOR, FOR MEDICARE PAYMENTS TO PHYSICIANS IN 2007 (Nov. 2006), http://www.cms.hhs.gov/SustainableGRatesConFact/Downloads/sgr2007f.pdf. The SGR formula has proved problematic in recent years as health care spending has outpaced the nation’s economic growth, and Congress has intervened to stabilize provider payments from year to year. See, e.g., MMA, supra note 8, § 601, and Tax Relief and Health Care Act of 2006, Pub. L. No. 109-432, 120 Stat. 2922 (2006).

95. See, e.g., MMA, supra note 8, §§ 401, 404, 411.
included yet more adjustments in Medicare provider payments.96

Alongside reform efforts directed at cost control in traditional Medicare, private insurance advocates have argued for introducing competition and private insurers into the system.97 In the mid-1990s, those advocates scored a degree of success with the passage of the BBA and its creation of Medicare Part C with Medicare+Choice.98 Proponents of Medicare+Choice saw it both “as a vehicle to provide Medicare beneficiaries with richer benefits” – at lower costs – than in traditional Medicare and as a way “to help set the stage for future changes in the structure of Medicare.”99 Private insurance supporters hoped Medicare+Choice would expand the availability and attractiveness of private plan options in Medicare,100 but Medicare+Choice did not fare well.101 Not only did many beneficiaries outside urban areas fail to obtain access to a Medicare+Choice plan,102 but large numbers of existing plans withdrew or increased premiums within a few years of the program’s enactment, often leaving beneficiaries with little if any choice other than to return to traditional Medicare.103 Medicare+Choice’s failures were largely blamed on expense: Many private insurers claimed that they could not sustain the plans under the prevailing reimbursement systems.104

The most significant reform effort in recent years came in 2003 with passage of the MMA. In addition to the introduction of Part D prescription drug coverage, the MMA created structural and financial incentives for beneficiaries to choose private plans.105 Perhaps most significant among the structural incentives was the MMA’s effective limitation of Part D prescription drug coverage to private insurers, not traditional Medicare.106 This structure

97. See JONATHAN OBERLANDER, supra note 91. As an example of mid-1980s interest in private market solutions, see Frank W. Porell & Stanley S. Wallack, Medicare risk contracting: determinants of market entry, 12 HEALTH CARE FIN. REV. 75 (Wint. 1990).
99. Wilensky Statement, supra note 93, at 12.
102. See, e.g., Michelle Casey et al., Medicare Minus Choice: The Impact of HMO Withdrawals on Rural Medicare Beneficiaries, 21 HEALTH AFF. 192 (May/June 2002).
103. See Wilensky Statement, supra note 93, at 12-14.
104. See supra note 101.
105. See infra notes 106-110 and accompanying text.
means that beneficiaries who wish to remain in traditional Medicare for their
general health insurance must navigate a wide range of private insurance options\textsuperscript{107} to select a stand-alone Part D prescription drug plan and must then
deal with two different sources of coverage for health care expenses –
traditional Medicare for everything other than outpatient drugs, and a private
insurer for drug benefits. Given the coverage gaps in traditional Medicare,
most beneficiaries enrolled in Parts A and B will also pursue some form of
supplemental coverage if they can afford it,\textsuperscript{108} bringing a third source of
insurance into the mix. In contrast to this complexity, beneficiaries who elect a
Medicare Advantage plan that includes prescription drug coverage can enjoy
“one-stop shopping” for all their health insurance needs, especially if the plan
they choose also provides needed supplemental benefits.

To counteract many of the perceived causes of the Medicare+Choice
failures, the MMA also increased reimbursement rates for Medicare Advantage
plans and authorized regional plans to ensure coverage for Medicare
beneficiaries outside urban areas.\textsuperscript{109} The effect of the bid/benchmark and
rebate payment system has resulted in payments to Medicare Advantage plans
that are estimated at approximately 112 percent of the average cost of covering
beneficiaries under traditional Medicare.\textsuperscript{110} By 2007, seemingly attractive
Medicare Advantage plan options proliferated, with at least one private plan
available to almost all beneficiaries.\textsuperscript{111}

The MMA also made other changes intended to improve Medicare. For
example, the legislation introduced demonstration projects – Medicare’s way of
testing new ideas – in chronic disease management\textsuperscript{112} and coordination of

\textsuperscript{107} The difficulties for Medicare beneficiaries in choosing among the stand-alone Part D
plan options has been widely reported. See, e.g., Tom Baxter & Bob Kemper, Medicare drug plan
draws yelps, ATLANTA JOURNAL-CONSTITUTION, Jan. 30, 2006, at 1A; and Robert Pear, Rolls
Growing For Drug Plan As Problems Continue, N.Y. TIMES, Jan. 18, 2006, at A17.

\textsuperscript{108} See discussion supra Section I.D.

\textsuperscript{109} See supra note 46 and accompanying text.

\textsuperscript{110} The Medicare Advantage Program and MedPAC Recommendations: Statement before
the H. Comm. on the Budget, 110\textsuperscript{th} Cong. 5 (June 28, 2007) (testimony of Mark E. Miller,
PAC_testimony_MA.pdf. Payments in 2006 to Medicare Advantage plans were calculated by
MedPAC to range “from 110 percent of FFS for HMOs to 119 percent of FFS for private fee-for-
service (PFFS) plans,” where “FFS” means the average cost for beneficiaries in traditional
Medicare. Id. at 6. See also The Medicare Advantage Program: Enrollment Trends and
Budgetary Effects: Statement before the S. Comm. on Finance, 110\textsuperscript{th} Cong. (Apr. 11, 2007)
testimony of Peter R. Orszag, Cong. Budget Off.), available at
Section I.B. for an explanation of the bid/benchmark payment system.

\textsuperscript{111} See Marsha Gold, Medicare Advantage in 2006-2007: What Congress Intended?, 26
HEALTH AFF. (May 15, 2007), http://content.healthaffairs.org/cgi/content/abstract/hlthaff.
26.4.w445, for a discussion of the pros and cons of Medicare Advantage plans, including both
benefits and drawbacks for beneficiaries.

\textsuperscript{112} MMA, supra note 8, §§ 648, 721, 723.
Specifically, the MMA required the Secretary of Health and Human Services (“HHS”) to “phase in chronic care improvement programs in traditional fee-for-service,” specifying a focus on “clinical quality and beneficiary satisfaction” (as well as cost management) for individuals with conditions such as congestive heart failure and diabetes. Coverage for a range of additional preventive screenings – including an initial physical exam and diabetes screenings – was also added to traditional Medicare.

II. MEDICARE AND THE PRESIDENTIAL CAMPAIGNS

Many of the presidential candidates in 2007 did not directly address Medicare even when they focused on health care issues. When they looked

113. MMA, supra note 8, § 646.
115. MMA, supra note 8, §§ 611-613, providing coverage of an initial preventive physical exam, cardiovascular screening blood tests, and diabetes screening tests.
at Medicare, they typically suggested either targeted corrections (or expansions) in the existing benefit structure or cost reduction measures. None of the candidates directly addressed how Medicare reform might affect elderly minorities.\textsuperscript{117} Even when their health care proposals for the younger uninsured involved broad policy discussions, the candidates steered clear of comparable debate in Medicare.\textsuperscript{118} As a result, their Medicare proposals seemed myopic and disjointed, with no apparent effort to place a particular suggested change in the context of the overall system or to evaluate how that change might alter the balance between competing policy concerns.

\textsuperscript{117} Although not addressing the issues of older minorities, several of the candidates at least acknowledged the serious health disparities that exist between members of racial and ethnic minority groups and other individuals in American society. John Edwards, for example, stated that "[p]eople of color are more likely to be diagnosed with cancer and less likely to receive timely and effective treatment." John Edwards, Universal Health Care Through Shared Responsibility, http://johnedwards.com/issues/health-care/health-care-fact-sheet (last visited Apr. 30, 2008) (hereinafter John Edwards, Universal Health Care). To address those concerns, Mr. Edwards called for "medical research into disparities, reduc[ing] the pollutions and toxins that disproportionately harm communities of colors, and support[ing] translation services to address language barriers." \textit{Id.} Mr. Edwards also linked universal health insurance efforts to disparities: "By helping all Americans get insurance, I will also address disparities in health caused by disparities in insurance." \textit{Id.} Bill Richardson echoed those statements: "All too often in the United States, health outcomes differ based on race and ethnicity. For example, minorities suffer disproportionately from diabetes, heart disease, and HIV/AIDS, are more likely to be uninsured, and are less likely to have a regular doctor than white Americans." Bill Richardson, Issues: Health Care: American Choices: Bill Richardson's Plan for Affordable Health Coverage for All Americans, http://www.richardsonforpresident.com/issues/healthcare?id=0002 (last visited Nov. 25, 2007) (hereinafter Bill Richardson, Plan for Affordable Health Coverage). Bill Richardson also said he would "work to reduce health disparities by ensuring access to affordable health care coverage for every American, supporting increased training for minority health professionals, and supporting efforts to increase the number of minorities who have medical homes, which will help to reduce health disparities by ensuring they receive timely medical care and appropriate preventive services." \textit{Id.} Hillary Clinton noted that "[t]he problem of affordability of insurance also contributes to racial disparities in health outcomes. ... Lack of access to health care due to lack of coverage, even for a short period of time, can lead to worse health outcomes and financial insecurity." Hillary Clinton, American Health Choices Plan: Quality, Affordable Health Care for Every American, http://www.hillaryclinton.com/feature/healthcareplan/AmericanHealthchoicesplan.pdf (last visited May 14, 2008) (hereinafter Hillary Clinton, Health Choices Plan).

\textsuperscript{118} See, e.g., infra notes 168-171 and accompanying text.
A. Proposals to Improve Existing Structure

A number of proposals focused on correcting perceived failures in Medicare’s existing benefit structure have been offered. For example, several candidates in mid-2007 called for eliminating the Part D prescription drug coverage “donut hole,” a source of confusion and concern since the MMA’s enactment. Slightly more than 30 percent of Part D eligible beneficiaries in 2007 were expected to have drug expenses that exceeded the initial coverage limit and reached into the donut hole. Individuals with chronic conditions requiring expensive maintenance medications are particularly at risk. Some beneficiaries may obtain coverage by electing a Medicare Advantage or stand-alone Part D plan that offers some level of coverage in the donut hole, and very low-income individuals qualify for subsidies that cover the gap. History, however, suggests that some number of remaining beneficiaries—those who do not qualify for government low-income assistance, yet do not have the resources to cover drug costs out of


124. About 29 percent of all Part D plans provide some coverage in the donut hole although that coverage is typically limited to generic drugs. FACT SHEET: THE MEDICARE PRESCRIPTION DRUG BENEFIT, supra note 56.

125. 42 U.S.C. § 1395w-114(a)(1)(C) (Supp. 5 2006). See also supra note 71.
pocket – may stop taking drugs when they are faced with costs they cannot afford,126 with adverse health effects.127

Some candidates suggested adding prescription drug coverage to traditional Medicare as a way to resolve Part D issues, a proposal that could undo one of the main privatization incentives of the MMA.128 Two candidates called in their campaign materials for traditional Medicare to establish a direct prescription drug benefit.129 Another candidate did not focus on the public plan option on the campaign trail, but co-sponsored a bill in October 2007 to create a new prescription drug benefit in traditional Medicare to compete with the private plans.130 That bill would not necessarily have closed the donut hole. Instead, it proposed allowing traditional Medicare to “offer supplemental prescription drug coverage in the same manner as other qualified prescription drug coverage offered by other prescription drug plans.”131

126. For example, pre-MMA studies of Medicare-eligible adults found that significant percentages failed to take their prescription drugs as prescribed when faced with drug costs without insurance coverage. HENRY J. KAISER FAM. FOUND., PRESCRIPTION DRUG TRENDS (Oct. 2004), http://www.kff.org/rxdrugs/upload/Prescription-Drug-Trends-October-2004-UPDATE.pdf.


128. See discussion supra Section I.F. Because the vast majority of Medicare beneficiaries remain in traditional Medicare for their general health insurance, allowing traditional Medicare to offer a drug benefit might easily take significant numbers of beneficiaries away from the stand-alone Part D plans in which they are currently enrolled. This could prove particularly true if Medicare’s bargaining power proved sufficient to drive down prescription drug costs in the traditional plan below what private insurers could achieve. See MEDICARE RIGHTS CTR., THE BEST MEDICINE: A DRUG COVERAGE OPTION UNDER ORIGINAL MEDICARE (Oct. 2007), http://www.medicarerights.org/TheBestMedicine.pdf, and Ruth Lopert & Marilyn Moon, Toward A Rational, Value-Based Drug Benefit For Medicare, 26 HEALTH AFF. 1666 (Nov./Dec. 2007), for additional discussions of the issues surrounding addition of a prescription drug option in traditional Medicare.


131. Medicare Prescription Drug Savings and Choice Act of 2007, S. 2219 and H.R. 3932, 110th Cong. (1st Sess. 2007). Because other Part D prescription drug plans can design coverage to at least partially cover the donut hole, presumably so, too, could traditional Medicare’s prescription drug coverage. The October 2007 legislative proposals specifically authorized CMS to “implement strategies similar to those used by other Federal purchasers of prescription drugs, and other strategies, including the use of a formulary and formulary incentives …, to reduce the purchase cost of covered part D drugs.” Id.
Several proposals included expanding Medicare coverage for low-income beneficiaries. Such expansion could come from relaxing eligibility requirements to bring more low-income individuals within the scope of Medicare’s existing low-income assistance, or it could involve direct enhancement of Medicare’s coverage for those low-income individuals currently eligible for assistance. Significant percentages of Medicare beneficiaries could be considered low-income. For example, in 2005, 33 percent of Medicare beneficiaries age 65 or older lived at or below 150 percent of the federal poverty level for individuals that year ($13,590). In 2006, 16 percent of all Medicare beneficiaries lived in households below 100 percent of the federal poverty level ($20,614 for a family of four in 2006), and another 30 percent lived in households below 200 percent of the federal poverty level. Members of racial and ethnic minority groups disproportionately fall into these low-income cohorts, with almost 70 percent of all Hispanic and African American/non-Hispanic Medicare beneficiaries in 2005 living below 200 percent of the federal poverty level. Many of these individuals are so poor

132. Hillary Clinton said she would loosen “overly restrictive asset-test rules” to expand eligibility for low-income assistance. Hillary Clinton, Health Choices Plan, supra note 117. Ms. Clinton specifically recommended implementing Medicare “policies to improve access to programs that provide cost-sharing protections to low-income beneficiaries.” Id. Similarly, John Edwards said he would use savings from other reforms “to ensure that low-income Medicare beneficiaries have access to the care they need.” John Edwards, Older Americans, supra note 129. Currently, the primary low-income subsidies in Medicare exist in Part D. See supra note 71. Most other assistance for low-income beneficiaries comes from state Medicaid programs that cover a range of health expenses not met by Medicare. See CMS, DUAL ELIGIBILITY: OVERVIEW, http://www.cms.hhs.gov/DualEligible/01_Overview.asp#TopOfPage (last visited May 18, 2008). See also LAURA SUMMER & LEE THOMPSON, COMMONWEALTH FUND, HOW ASSET TESTS BLOCK LOW-INCOME MEDICARE BENEFICIARIES FROM NEEDED BENEFITS (May 2004), http://www.commonwealthfund.org/usr_doc/summer-assettestsib_727.pdf?section=4039.

133. Bill Richardson proposed directly expanding Medicare’s coverage to “fill in gaps in care currently being funded by the states” for the so-called “dual eligibles” (those individuals who are eligible for full benefits under both Medicare and Medicaid). Bill Richardson, Plan for Affordable Health Coverage, supra note 117. Bill Richardson also said he would focus specifically on coordination of care for dual eligibles, claiming that the current system – where Medicare and Medicaid are responsible for different costs for the dual eligibles – results in “more fragmented care, extra hassles and double the bureaucratic paperwork for patients, providers and states.” Id.


137. In 2005, 34 percent of Hispanic Medicare beneficiaries age 65 or older had family incomes below 100 percent of the federal poverty level for a family of four that year ($19,971), and 35 percent had family incomes between 100 and 199 percent of the federal poverty level.
that they qualify for supplemental health coverage through state-run Medicaid programs, and in fact the ranks of the “dual eligibles” – people eligible for full benefits under both Medicare and Medicaid – are filled disproportionately with minority members.\textsuperscript{138} Many other low-income minorities, however, may have income or assets just high enough to keep them from qualifying for either state Medicaid coverage or Medicare’s current low-income assistance.\textsuperscript{139} Such individuals may have limited alternatives for supplemental health coverage:\textsuperscript{140} Medigap premiums are often expensive,\textsuperscript{141} and minorities are less likely to have employment-based health insurance while working,\textsuperscript{142} dooming their chances

Similarly, 30 percent of African-American/non-Hispanic elderly Medicare beneficiaries had family incomes below 100 percent of the federal poverty level for a family of four that year, and another 37 percent had family incomes between 100 and 199 percent. The numbers were somewhat better for Asian and Pacific Islander elderly Medicare beneficiaries (28 percent were below 100 percent of the federal poverty level, and 23 percent were between 100 and 199 percent) and for American Indian/Alaska Native elderly Medicare beneficiaries (26 percent were below 100 percent of the federal poverty level, and 33 percent were between 100 and 199 percent). By contrast, only 10 percent of white/non-Hispanic elderly Medicare beneficiaries had family incomes below 100 percent of the federal poverty level, and 28 percent were between 100 and 199 percent. HENRY J. KAISER FAM. FOUND., KEY FACTS: RACE, ETHNICITY & MEDICAL CARE fig. 5 (Jan. 2007), http://www.kff.org/minorityhealth/upload/6069-02.pdf (hereinafter KAISER KEY FACTS). The numbers have not been improved over time. In 2002, more than 60 percent of all African-American and Latino Medicare beneficiaries fell below 150 percent of the federal poverty level. HENRY J. KAISER FAM. FOUND., A PROFILE OF AFRICAN AMERICANS, LATINOS, AND WHITES WITH MEDICARE: IMPLICATIONS FOR OUTREACH EFFORTS FOR THE NEW DRUG BENEFIT 2 (Nov. 2005), http://www.kff.org/minorityhealth/upload/A-Profile-of-African-Americans-Latinos-and-Whites-with-Medicare-Implications-for-Outreach-Efforts-for-the-New-Drug-Benefit-Chartpack.pdf (hereinafter KAISER PROFILE). In 2002, the federal poverty level for an individual was $8,860. \textit{Id.}

138. In 2000, of Medicare dual eligibles age 65 or older, 19 percent were African American, 17 percent were Hispanic, and another eight percent belonged to other racial or ethnic minority groups. HENRY J. KAISER FAM. FOUND., DUAL ELIGIBLES: MEDICAID’S ROLE IN FILLING MEDICARE’S GAPS tbl. 1 (Mar. 2004), http://www.kff.org/medicaid/upload/Dual-Eligibles-Medicaid-s-Role-in-Filling-Medicare-s-Gaps.pdf. In 2002, 30 percent or more of both African-American and Latino Medicare beneficiaries age 65 or older received Medicaid coverage. KAISER PROFILE, supra note 137, at fig. 5.

139. Although significant percentages of elderly minority group members have low-income levels, Medicaid income qualification levels are often even lower. See supra note 137 for 2005 statistics on income levels for elderly Medicare beneficiaries who are also members of racial or ethnic minority groups. See CMS, DUAL ELIGIBLE CATEGORIES, http://www.cms.hhs.gov/DualEligible/02_DualEligibleCategories.asp (last visited May 17, 2008), for a summary of Medicaid eligibility rules.

140. See discussion supra Section I.D. Historically, as compared to whites, individuals belonging to racial or ethnic minority groups have been more likely to go without any form of supplemental Medicare coverage, less likely to have employment-based retiree health coverage, and far less likely to have Medigap coverage. See Nadereh Pourat et al., \textit{Socioeconomic Differences In Medicare Supplemental Coverage}, 19 HEALTH AFF. 186 (Sept./Oct. 2000).

141. See supra note 77 and accompanying text.

142. See KAISER KEY FACTS, supra note 137, at fig. 16. In 2005, for example, 69 percent of white, non-Hispanic individuals under age 65 had some form of employment-based health insurance as compared to 40 percent of Hispanics and 48 percent of African American/non-Hispanic individuals. \textit{Id.} Among low-income (defined as individuals with family income less than 200 percent of the federal poverty level) individuals in 2005, the statistics are worse: Only
of access to such coverage in retirement.

Other proposals clustered around encouraging preventive care,\textsuperscript{143} chronic disease management,\textsuperscript{144} and coordination of care.\textsuperscript{145} For example, one

20 percent of low-income Hispanic individuals under age 65 and 23 percent of low-income African American/non-Hispanics under age 65 had employment-based health insurance. \textit{Id.} at fig. 17.

143. Hillary Clinton did not expressly call for expanding Medicare coverage of preventive services, but in a document describing the impact of her proposed “American Health Choices Plan” on seniors, she stated that the “American Health Choices Plan will require coverage of preventive services that experts deem proven and effective, such [as] blood pressure, blood glucose, cholesterol, vision and hearing screenings and more.... Preventive efforts are useful to Americans of any age but are especially important to seniors, as many people tend to develop illnesses as they age.” Hillary Clinton, The American Health Choices Plan: Hillary Clinton’s Plan to Ensure Affordable, Quality Health Care for Seniors, http://www.hillaryclinton.com/files/pdf/senior_impactreport.pdf (last visited May 14, 2008) (hereinafter Hillary Clinton, Health Care for Seniors). Bill Richardson said he would require that “evidence-based preventive services [such as cancer screenings, tobacco cessation counseling, and immunizations] are covered in all public ... health plans.” Bill Richardson, Plan for Affordable Health Coverage, \textit{supra} note 117. Although not in connection with Medicare, Mike Huckabee called for the country to “get serious about preventive health care.” Mike Huckabee, Issues: Health Care, \textit{supra} note 116. John McCain also indirectly called for more preventive care: “Doctors must do a better job of managing our care and keeping us healthy and out of hospitals and nursing homes.” John McCain, John McCain on Health Care (Oct. 11, 2007), http://www.johnmccain.com/Informing/News/Speeches/8f5feb6-cdca-4136-b0d8-a9f75287235d.htm. Fred Thompson, while steering clear of Medicare, still called for a “healthcare system that: ... [i]mproves the individual health of all Americans by shifting to a system that promotes cost-effective prevention, chronic-care management, and personal responsibility.” Fred Thompson, On the Issues: Health Care, \textit{supra} note 116. Although Joe Biden did not call directly for more preventive care in his specific Medicare reform proposals, he highlighted his previous efforts in “protection and prevention,” noting that he “helped lead the effort to require Medicare to cover annual mammograms for women over the age of 65 and to exempt these procedures from the annual Medicare Part B deductible.” Joe Biden, Issues: Health Care, \textit{supra} note 119. Chris Dodd also did not directly call for expanding preventive care and chronic disease management in Medicare, but generally advocated a national health care plan that “will focus on chronic disease management and preventive measures.” Chris Dodd, Health Care for All: The Dodd Plan, http://chrisdodd.com/node/1924 (last visited Nov. 22, 2007) (hereinafter Chris Dodd, The Dodd Plan). Barack Obama wanted to put a greater emphasis on prevention to strengthen Medicare. \textit{See} Barack Obama, Seniors, \textit{supra} note 130.

144. Citing statistics that “84 percent of Medicare patients with common chronic diseases see at least six doctors, putting them at risk for medication errors, emergency room visits, and preventable hospitalizations,” Bill Richardson called for the expansion of “state-of-the-art chronic disease management programs already being provided to Veterans’ Administration and Medicare patients with severe chronic diseases” to all chronically ill Medicare beneficiaries. Bill Richardson, Plan for Affordable Health Coverage, \textit{supra} note 117. Hillary Clinton said her American Health Choices Plan “will ensure higher quality and better coordination of care by using state-of-the-art chronic care coordination models within federally-funded programs to provide care for Americans afflicted with these costly, multi-faceted illnesses.” Hillary Clinton, Health Care for Seniors, \textit{supra} note 143.

145. Hillary Clinton wanted to “align Medicare payments with performance to both promote quality and reduce the geographic variation in care.” She also wanted to “promote chronic care management programs as well as innovative models such as ‘medical homes.’” Hillary Clinton, Health Choices Plan, \textit{supra} note 117. Closely related was Bill Richardson’s proposal to require CMS “to lead a public-private effort to streamline ... regulations [involving reporting requirements for physicians and hospitals] to ensure patient safety and free health care providers to spend more time on patient care.” Bill Richardson, Plan for Affordable Health
candidate recommended changing Medicare payment systems "to compensate providers for diagnosis, prevention, and care coordination." The prevalence of chronic conditions - many of them arguably preventable or at least mitigated by preventive care - is a significant and growing problem among Medicare beneficiaries. A study reviewing the top 10 medical conditions among Medicare beneficiaries over a 15-year period found that more than half of all such individuals received medical treatment in 2002 for at least five different chronic conditions. The more health care an individual needs, the greater the chance that the individual will reach one of Medicare's gaps in coverage. Unless that individual has supplemental coverage, he or she must pay out of pocket for care or go without. Elderly minorities tend not only to be in worse health overall than other Medicare beneficiaries, but also to suffer

Coverage, supra note 117. John Edwards wanted to "promot[e] proactive disease management, ensuring that doctors regularly check up on their patients, encouraging doctors to communicate with each other, and making sure that every American with chronic conditions has a patient-centered 'medical home' allowing a doctor to coordinate their care and promote life-improving care as well as treat life-threatening emergencies." John Edwards, Older Americans, supra note 129.

146. John McCain, John McCain on Health Care, supra note 143. John McCain also said, "We need to change the way providers are paid to focus their attention more on chronic disease and managing their treatment. This is the most important care and expense for an aging population." Id. Bill Richardson called for "[i]mproving coordination of care and reducing bureaucracy for millions of seniors and persons with disabilities enrolled in both Medicare and Medicaid." Bill Richardson, Plan for Affordable Health Coverage, supra note 117.


148. Kenneth E. Thorpe & David H. Howard, The Rise in Spending among Medicare Beneficiaries: The Role of Chronic Disease Prevalence and Changes in Treatment Intensity, 26 HEALTH AFF. w378, exh. 1 (Aug. 22, 2006), http://content.healthaffairs.org/cgi/content/full/25/5/w378?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&author1=thorpe&andorexactfulltext=and&searchid=1&FIRSTINDEX=0&resourcetype=HWCIT. Common chronic conditions included heart disease, mental disorders, trauma, arthritis, hypertension, cancer, diabetes, pulmonary conditions, and cerebrovascular disease. The numbers were noticeably higher in 2002 than in 1987, attributed at least in part to "increases in obesity levels." Id. at w381.

149. Studies consistently show that lack of health care insurance correlates to lower use of health care services. See, e.g., Joseph S. Ross et al., Use of Health Care Services by Lower-Income and Higher-Income Uninsured Adults, 295 J. AM. MED. ASSOC. 2027 (May 3, 2006).

150. For example, in 2002, 43 percent of African-American Medicare beneficiaries and 38 percent of Latino Medicare beneficiaries were reported to be in fair or poor health as compared to 30 percent of all Medicare beneficiaries similarly reported. KAISER PROFILE, supra note 137, at 2. The disparities for Medicare beneficiaries are often attributed in part to the fact that many minorities do not have access to health insurance before they reach age 65. Once members of minority populations reach age 65 and become eligible for Medicare, there is some evidence that Medicare eligibility begins to improve health disparities. For example, Medicare policies in the late 1980s and 1990s are credited with some balancing of health care expenditures among all groups of Medicare beneficiaries. See, e.g., Jose J. Escarce et al., Racial and Ethnic Differences in Public and Private Medical Care Expenditures among Aged Medicare Beneficiaries, 81 MILBANK Q. 269 (2003). The Medicare system has made some effort to reduce racial and ethnic health disparities. See, e.g., Kathryn M. Langwell, Strategies for Medicare health plans serving

See, e.g., Kathryn M. Langwell, Strategies for Medicare health plans serving
disproportionately from chronic disease. For example, in 2002, studies indicated that approximately 30 percent of African-American and Latino Medicare beneficiaries suffered from diabetes as compared to only 18 percent of non-Latino whites. Such statistics make treatment of chronic illnesses critical for the minority population.

B. Proposals to Reduce Costs

Most other candidate proposals in 2007 fell under a cost-reduction umbrella. For example, several candidates argued that the federal government should negotiate prescription drug prices for Medicare Part D.

racial and ethnic minorities, 23 HEALTH CARE FIN. REV. 131 (Summer 2002). See also Timothy Stoltzfus Jost, supra note 81, for a careful analysis of the issue of racial and ethnic disparities in Medicare and approaches that CMS could take to improve the situation.

151. KAISER PROFILE, supra note 137, at 2. The same study indicated that 71 percent of African-American Medicare beneficiaries had hypertension as compared to 59 percent of non-Latino whites. Id. See INST. OF MED., UNEQUAL TREATMENT, CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE (Brian D. Smedley et al. eds., 2003), for a comprehensive discussion of racial disparities in health care.

152. Proposals that seemed to have quality of care as their primary motivation are grouped under the previous Section, whereas proposals with cost as their main incentive are placed here. An unusually technical cost-related reform proposal, and not one that clearly saves Medicare money, came from Joe Biden who called for MedPAC “to study and report to Congress on replacing the use of the sustainable growth rate as a factor in determining the update for such payments with a factor that more fully accounts for changes in the unit costs of providing physicians’ services.” Joe Biden, Issues: Health Care, supra note 119. See supra note 94 for a discussion of the SGR rate.

153. “Medicare must have the authority to negotiate with pharmaceutical companies for lower prescription drug prices,” according to Bill Richardson. Bill Richardson, A Strong Commitment to Our Nation’s Seniors, http://billrichardson.cachefly.net/pdf/issueflyers/Seniors Flyer.pdf (last visited May 14, 2008) (hereinafter Bill Richardson, Seniors). Mike Huckabee initially appeared to endorse the idea of permitting government negotiation, but later withdrew support and did not address the issue on his official website. Jeffrey Young, Candidates See Drug Plan as a Double-Edged Sword, THE HILL, Sept. 5, 2007, http://thehill.com/leading-the-news/candidates-see-drug-plan-as-a-double-edged-sword-2007-09-05.html. John McCain missed the vote early in 2007 on proposed legislation that would have allowed the government to negotiate prescription drugs, but later indicated he would have supported it. Id. See also Robert Pear, Senate Bars Medicare Talks for Lower Drug Prices, N.Y. TIMES, Apr. 19, 2007, at A20. Mr. McCain did not, however, address the issue on his official website. Although not specific to seniors, Hillary Clinton’s website claimed that her American Health Choices Plan would lower the cost of prescription drugs not only by allowing Medicare to negotiate prescription drug prices, but also by “creating a pathway for biogeneric drug competition; removing barriers to generic competition; and providing more oversight over pharmaceutical companies’ financial relationships with providers.” Hillary Clinton, Health Care for Seniors, supra note 143. Barack Obama said he believes that the federal government should negotiate for lower drug prices for seniors in the Medicare program. Barack Obama, Senators, supra note 130. So, too, Chris Dodd claimed that he would “ensure that Medicare harnesses the enormous purchasing power of the millions of seniors enrolled in the Part D Prescription Drug Benefit to bargain for lower drug prices.” Chris Dodd, Retirement Security, supra note 120. Joe Biden also called for negotiation of prescription drug prices by Medicare: “[T]he Medicare and Modernization Act of 2003 expressly forbids the federal government from interfering in drug negotiations between pharmaceutical companies and the numerous private insurers spread out across the country that offer Part D coverage. Simply
"America's seniors must never be forced to choose between groceries and the medication they need to stay healthy," said one candidate. Currently, each private insurer providing a Part D prescription drug plan negotiates its own prices with pharmaceutical manufacturers and develops its own formulary of covered drugs. The MMA expressly barred the Secretary of HHS from "interfer[ing] with the negotiations between drug manufacturers and pharmacies and [prescription drug plan] sponsors" and further prohibited the government from "requir[ing] a particular formulary or institut[ing] a price structure for the reimbursement of covered Part D drugs." Candidate proposals to change this part of the MMA followed unsuccessful Congressional efforts to do the same. Proponents of negotiation argue that the federal government's bargaining power would drive down costs.


Bill Richardson, Seniors, supra note 153.


42 U.S.C. § 1395w-111(i) (Supp. 5 2006).


Proponents of negotiation often point to the (VA), which does bargain for drugs, as a model for how using the bargaining power of the federal government can drive down costs. See, e.g., JIM HAHN, CONG. RES. SERV. REP. FOR CONG.: THE PROS AND CONS OF ALLOWING THE FED. GOV'T TO NEGOTIATE PRESCRIPTION DRUG PRICES (Feb. 18, 2005), available at http://www.law.umaryland.edu/marshall/crsreports/crsdocuments/RS2205902182005.pdf. For example, Joe Biden asked, "The federal government successfully uses its bulk purchasing power to keep costs low in the Veterans Administration health system - why not allow it to do the same for our nation's seniors who rely on Medicare?" Joe Biden, Health Care: Four Practical Steps, supra note 153. Barack Obama said that, "[t]o help lower the cost of pharmaceuticals, ... the federal government should negotiate for lower drug prices for seniors in the Medicare program, just as it does to obtain lower prices for our veterans." Barack Obama, Seniors, supra note 130. Despite its popularity, using the VA model as an example for Medicare is risky because the VA model is not the same as even traditional Medicare, much less the private options available under
Another popular candidate cost-reduction strategy targeted the MMA’s financial incentives for Medicare Advantage plans.\(^{159}\) Several candidates advocated lowering reimbursements to Medicare Advantage insurers to bring the costs in line with those under traditional Medicare.\(^{160}\) For example, charging that “excessive subsidies cost the government billions of dollars every year and create an incentive structure that has led to fraudulent abuses of seniors,” one candidate argued for paying Medicare Advantage plans “the same amount it would cost to treat the same patients under regular Medicare.”\(^{161}\) As with proposals to allow government negotiation of prescription drug prices, all of the calls from candidates to reduce Medicare Advantage payments mirrored failed Congressional proposals in this area.\(^{162}\)

**C. Concerns Raised by Current Approach**

*i. Understanding the Reasons*

Taken as a group, the proposals presented a somewhat random collection of reform ideas. Each proposal focused almost entirely on a single concern, with broader systemic considerations left either unrecognized or unacknowledged. Perhaps this reflects Medicare’s history: Until the mid-1990s, change in Medicare took place largely without fundamental policy conflict due to what has been perceived as a general bipartisan acceptance of Medicare Advantage and Part D. For example, although both traditional Medicare and the VA offer a fixed benefit package, Medicare uses only private providers (hospitals and doctors) to provide care whereas the VA uses its own doctors and medical facilities, exerting far more control over providers than Medicare does. See U.S. Dep’t of Veterans Aff., Current Benefits, http://www1.va.gov/opa/vadocs/current_benefits.asp (last visited May 18, 2008), for a description of VA system benefits.

159. See supra notes 109-111 and accompanying text. See also Staff, Clinton Details Proposed Changes in Medicare Advantage; Obama and Edwards Are Less Specific, MEDICARE ADVANTAGE NEWS (Sept. 17, 2007), http://www.aishealth.com/ManagedCare/Medicare/MAN_clinton_MA_changes.html.


Medicare as a universal, government-run, public health insurance program.\footnote{163} After the 1994 elections, however, that bipartisan agreement began to disintegrate with the growing dominance of at least a rhetorical ideological commitment to private market solutions, resulting eventually in the MMA.\footnote{164}

The political landscape shifted again with the 2006 Congressional elections, and the 2008 presidential candidates entered the campaign in an uncertain world where it may have been difficult to ascertain which approach to Medicare reform would play best to the electorate.\footnote{165} Medicare often is called the “third rail” in politics because of the perceived risk of reform proposals that anger powerful senior voters.\footnote{166} In the 2008 presidential election, perhaps the more narrow the Medicare target, the more limited the perceived risk.\footnote{167}

Myopia about Medicare may also reflect attention focused elsewhere. Expanding health insurance for the younger uninsured catapulted high on the issue list early in the campaign for the 2008 election.\footnote{168} Many of the candidates proposed detailed health care reform plans; others espoused general commitments to either public or private solutions.\footnote{169} On either side, because no

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\footnote{163.} JONATHAN OBERLANDER, supra note 91, at 156. See also Bruce C. Vladeck, The Struggle for the Soul of Medicare, 32 J. L. Med. & Ethics 410 (Fall 2004).


\footnote{165.} Public health care preferences in general may be difficult to ascertain. For example, recent Gallup polls suggest that, while the vast majority of Americans want change in the health care system on a theoretical level, they also don’t want change if it will impact their pocketbooks negatively. See, e.g., Kevin Freking, Health Care Dilemma Close-Up, SEATTLE TIMES, Dec. 12, 2007, at A3.


\footnote{167.} It is also possible that the more narrow the target, the easier it is to explain to beneficiaries. Medicare reform is so complex that even experts in the area may have difficulty addressing the subject adequately. See Theodore R. Marmor et al., supra note 90, for an overview and critique of Medicare scholarly literature as of 2003.


national health program for those under 65 exists, candidates had no choice but to focus broadly and address the underlying policy considerations. Any national health insurance reform for those under 65 would likely influence Medicare, but the candidates generally failed to mention that. At best they hinted at cost savings for Medicare through introducing preventive and chronic disease care for younger individuals.

ii. Raising Additional Questions

Approaching Medicare reform piecemeal tends to result in policy that prompts additional questions. For example, proposals to close the prescription drug donut hole, expand low-income assistance, or add preventive care and chronic disease management are all efforts to plug holes in traditional Medicare's existing benefit structure. For the individuals affected by the gaps, coverage may be critical. But the gaps currently drawing attention represent only a few of the holes in Medicare coverage, and no single gap affects a significant majority of Medicare beneficiaries. Why, then, these particular gaps and not others? Similarly, prescription drug costs and Medicare Advantage plan reimbursements represent only two parts of a much larger financial picture. Both involve costs the Medicare system incurred only after passage of the MMA, yet Medicare's finances were raising concern long before the MMA. The candidates largely ignored problems with traditional Medicare's payment structure. But why address Part D and Medicare


170. Barack Obama indirectly suggested the connection when, under the heading “Protect and Strengthen Medicare,” he said, “Ultimately we need to reduce waste in the Medicare system and tackle fundamental health care reform across the economy.” Barack Obama, Seniors, supra note 130.

171. For example, Barack Obama also wanted to “put a greater emphasis on prevention” to strengthen Medicare. Barack Obama, Seniors, supra note 130. Joe Biden argued for expanding Medicare to the near elderly (age 55-64) as a way to reduce chronic care costs for the Medicare program. “By the time people become eligible for Medicare at age 65, many are already dealing with numerous chronic health conditions,” according to Mr. Biden. “Providing an earlier window to participate in Medicare can allow treatment of chronic diseases to start at an earlier age that can save Medicare costs in the long run.” Joe Biden, Health Care: Four Practical Steps, supra note 153. Bill Richardson made similar arguments. See Bill Richardson, Plan for Affordable Health Coverage, supra note 117.

172. See discussion supra Section I.A.

173. See discussion supra Section II.A.

174. See discussion supra Section I.F.

175. One candidate did acknowledge issues in the existing system: “While it is tempting to control Medicare costs by simply reducing payments to providers, that approach does not address the issue of volume of services used – and also creates an access problem, as many providers drop out of publicly-run programs when reimbursement drops too low. Our current system reimburses
Advantage expenses and not those of the traditional system? And why advocate bringing Medicare Advantage payments in line with costs under traditional Medicare\textsuperscript{176}—without reference to whether or not those costs separately require reform?

Even suggestions to have the federal government negotiate Medicare prescription drug prices raise questions when evaluated in the context of the overall system. For example, given that prescription drug coverage currently exists in Medicare Part D only through private insurers who negotiate their own separate arrangements with pharmaceutical manufacturers, what exactly would the federal government negotiate? If the government negotiated system-wide drug prices for all Medicare beneficiaries, private insurers would be left with little basis on which to distinguish themselves from their competitors. Those currently able to negotiate lower prices for certain drugs would lose a competitive edge. Would private insurers continue to offer different formularies? There would be little value if the individual insurers no longer controlled the price of covered drugs. In many respects, each private insurer would become no more than an alternative plan administrator. What, then, would be the reason to reserve Part D plans to private insurers instead of adding a drug benefit to traditional Medicare? Day-to-day administration of traditional Medicare already takes place through a number of private insurance companies that contract with CMS.\textsuperscript{177}

\textit{iii. Ignoring Competing Tensions}

Taking a piecemeal approach to Medicare reform also ignores the relationship between issues. Competing tensions run throughout Medicare—between desires for benefit enhancement and cost reduction as well as between public and private insurance solutions. In the early 2008 campaign, candidates touched on each of these tensions almost entirely without acknowledgement of the counter positions. For example, despite general candidate consensus that Medicare’s finances pose a problem,\textsuperscript{178} their proposals appeared almost to providers on the volume of services used, without truly examining what services work best.” Joe Biden, Health Care: Four Practical Steps, \textit{supra} note 153. Mr. Biden was also the only candidate with a specific proposal directed at provider reimbursement: having the MedPAC review use of the SGR rate in updating payments. \textit{See supra} note 152. Admittedly, the proposals to improve preventive care, chronic disease management, and care coordination could be characterized as cost-reduction strategies for traditional Medicare. If so, is it possible that these few provisions alone are all that is needed to rectify traditional Medicare’s payment structure?

\textsuperscript{176} \textit{See discussion \textit{supra} Section II.B.}


\textsuperscript{178} John McCain, for example, said, “[B]y 2019, Medicare will be broke. We are currently spending more on Medicare than we are collecting in payroll taxes and cashing in the
ignore Medicare’s overall financial state and the inherent conflict between providing a better benefit package and reducing expenses.\textsuperscript{179} They recommended expansions in the existing benefit structure – for example, through eliminating the donut hole or expanding coverage for low-income beneficiaries – with at least limited consideration of the associated costs.\textsuperscript{180} Concurrently, the candidates sidestepped the potential impact of their cost-reduction proposals on benefits. In some cases, the same candidate argued for both lowering Medicare Advantage payments and expanding coverage, apparently overlooking the fact that Medicare Advantage plans – thanks to enhanced reimbursement rates – may provide needed supplemental coverage.\textsuperscript{181} When the government reduced reimbursement rates to Medicare+Choice plans in an earlier cost-savings reform, the additional benefits provided by Medicare+Choice plans vanished.\textsuperscript{182} The same could happen with Medicare Advantage plans.

The candidates also skirted the tension between private and public insurance solutions for Medicare.\textsuperscript{183} At most they indirectly referenced the conflict.\textsuperscript{184} For example, allowing the federal government to negotiate prescription drug prices would curtail the MMA’s privatization shift by eliminating the primary basis on which private insurers compete, converting those insurers into little more than administrators for a government-run benefit.\textsuperscript{185} This impact went unmentioned by the candidates. So, too, direct

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few IOUs left in the trust fund. In the meantime, more and more of our retirees’ social security checks will also go to pay for Medicare leaving our seniors with less money for their everyday expenses.” John McCain, John McCain on Health Care, supra note 143. John Edwards made similar statements: “Skyrocketing health care costs have put pressure on Medicare and threatened its long-term solvency.” John Edwards, Older Americans, supra note 129. Barack Obama said that “[e]nsuring the long-term solvency of the Medicare trust fund may be our toughest fiscal challenge.” Barack Obama, Seniors, supra note 130. See also supra note 90.


180. When costs were mentioned in connection with proposals for preventive care, chronic disease management and coordination of care, most candidates tended to frame the proposals in terms of cost reduction. See discussion supra Section II.A. and supra note 171 and accompanying text.

181. See discussion supra Section I.B.

182. See discussion supra Section I.F.

183. The significance of this conflict should not be underestimated. See supra note 157 and Bruce C. Vladeck, supra note 163.

184. John Edwards, for example, charged that “[i]nstead of strengthening Medicare for our seniors, George Bush has surrendered it to the drug companies and HMOs.” John Edwards, Older Americans, supra note 129. Talking generally about health care, but with Medicare clearly in mind, Mike Huckabee said, “We don’t need universal health care mandated by federal edict or funded through ever-higher taxes.” Mike Huckabee, Issues: Health Care, supra note 116. Dennis Kucinich stood alone in calling for a “universal, single-payer, not-for-profit health care system,” what he also calls “Medicare for All.” Dennis Kucinich, A Healthy Nation, supra note 116.

185. See discussion supra Section II.C.ii.
proposals to add a prescription drug benefit to Medicare tended not to consider
the effect on the system’s public-private balance. In fact, adding a
prescription drug benefit to traditional Medicare would make the traditional
system a direct competitor of the private insurer Part D prescription drug plans.
A significant majority of beneficiaries choose traditional Medicare for
everything other than prescription drugs, and many of those beneficiaries
might also elect traditional Medicare for prescription drugs if the option
existed. Were they to do so, the traditional system would enjoy considerable
bargaining power in negotiating the price of prescription drugs with
pharmaceutical manufacturers. That bargaining power would likely exceed the
bargaining power of any single private insurance company and drive the cost of
drugs in traditional Medicare below what private insurers could offer. This
would give traditional Medicare a competitive advantage that could eventually
undercut private insurers, counteracting a key privatization effort of the MMA.

Similarly, reducing reimbursement rates for Medicare Advantage plans
would remove a key MMA incentive for those plans. The candidates treated
these proposals primarily as cost-savings measures, focusing on the reports
that Medicare Advantage plans cost more to treat beneficiaries than traditional
Medicare. Lowering the reimbursement rates to the private insurers would
save money if traditional Medicare provides the same care at less expense, but
that is not all. The MMA increased reimbursement rates for Medicare
Advantage plans in an effort to correct a perceived major cause of the failure of
the predecessor Medicare+Choice private plans – i.e., not enough funding to
convince private insurers to remain in the Medicare market. Cost
considerations did not completely drive the analysis, however; proponents
hoped to push Medicare away from the government-run model of traditional
Parts A and B and toward private insurers. To now remove the financial
incentives for Medicare Advantage insurers would thus represent a policy
reversal, possibly resulting in the withdrawal of many such plans from the
Medicare market.

186. See discussion supra Section II.A. For example, both John Edwards and Bill
Richardson included adding prescription drugs to traditional Medicare in the same sentence with
allowing the federal government to negotiate prescription drug prices to cut costs. See supra note
129.
187. See supra note 31 and accompanying text.
188. See discussion supra Section I.F.
189. See discussion supra Section II.B.
190. See supra notes 160-161 and accompanying text.
191. See discussion supra Section I.F. and supra notes 99-100 and accompanying text.
192. See supra notes 110-111 and accompanying text.
III. ELDERLY MINORITIES AND MEDICARE REFORM ISSUES

Because of racial disparities in health and income status among the elderly, the potential impact of certain proposals on elderly minorities illustrates the risks of a piecemeal approach to Medicare reform that neither considers systemic ramifications nor attempts to balance competing tensions.

A. Systemic Analysis

Benefit expansion proposals may appeal to elderly minorities facing a combination of poor health, low-income status, and absence of supplemental coverage through traditional sources. Because of the high drug costs associated with chronic diseases, and the prevalence of chronic conditions among members of racial and ethnic minority groups, closing the Part D prescription drug donut hole or improving chronic disease management, preventive care, and coordination of care would help many in the minority population. Similarly, loosening the income and asset tests for Medicare’s low-income assistance would assist those elderly minorities currently without supplemental insurance. But what makes these particular coverage gaps the most crucial out of the wide array of traditional Medicare’s coverage holes? Other coverage limits might be equally relevant to these populations. For example, changing the structure of traditional Medicare Part A’s inpatient hospital benefit – a benefit that works well for acute care, but not necessarily for chronic illness – might prove a more valuable benefit improvement for elderly minorities than closing the donut hole. So, also, might expanding Medicare coverage for home health care help prevent certain medical complications and related expenses that eventually drain individuals’ resources and drive them toward Medicaid. A gap like the prescription drug donut hole may seem easier for a politician to explain than more complex parts of traditional Medicare, but coverage changes should be made taking into account the Medicare benefit structure in all its complexity. Expansions should target areas that will best improve the overall health status of the greatest number of beneficiaries, based on systemic analysis of the various populations’ needs.

193. See supra notes 137-142 and 150-151 and accompanying text.
194. See supra notes 137-142 and accompanying text.
195. See supra note 123 and accompanying text.
196. See supra note 151 and accompanying text.
197. See discussion supra Section II.A.
198. See supra note 35 and accompanying text.
199. The argument is not that one coverage gap deserves closure more than another, but rather that it is misleading to single out only one hole when there are so many that might be equally deserving.
B. Competing Tension: Benefit Expansion and Cost Reduction

Medicare reform that achieves its purpose without undesirable side effects requires evaluating and balancing the competing tensions pulling the system in various directions. For example, systemic analysis of Medicare’s coverage gaps as they affect elderly minorities might suggest that all of the 2008 candidate benefit expansion proposals should be adopted alongside a number of other proposals to close holes in the benefit structure. A richer benefit structure would assist all Medicare beneficiaries, but particularly those who are poorer and sicker. Financial constraints place complete coverage beyond reach, however, creating constant competition between benefit expansion and cost reduction proposals.

The debate over Medicare Advantage plans reflects this tension between benefit expansion and cost reduction. For the many elderly minorities without access to either Medicaid or employment-based retiree health insurance, and unable to afford Medigap premiums, a Medicare Advantage plan with comparatively low-cost supplemental benefits may offer a beneficiary a financially viable alternative. This possibility has attracted support for Medicare Advantage plans from advocates within the minority community. In the spring of 2007, the director of the Washington, D.C. bureau of the NAACP and the national president of LULAC sent letters to members of both the Senate and the House of Representatives in support of maintaining government funding for Medicare Advantage plans. The NAACP and LULAC both relied on insurance industry claims that Medicare Advantage plans “disproportionately provide coverage to low-income and racial and ethnic minority beneficiaries.” Those claims have since been disputed, but

200. See supra notes 139-142 and accompanying text.
201. See supra note 81.
202. “NAACP” is the commonly used acronym for the National Association for the Advancement of Colored People.
203. “LULAC” is the commonly used acronym for the League of United Latin American Citizens.
205. Id.
traditional Medicare remains riddled with coverage holes and Medicare Advantage plans may provide needed assistance.

Candidate proposals in 2007 to cut Medicare Advantage payments did not take into account the availability of supplemental benefits.\textsuperscript{207} If Medicare Advantage reimbursement rates drop, Medicare Advantage insurers could choose either to withdraw from the market altogether, to eliminate supplemental benefits, or to charge beneficiaries for more generous benefit packages. Under any of those options, the value of the plans to many elderly minorities would decline, if not vanish altogether. This concern is what prompted the NAACP and LULAC to protest reductions in Medicare Advantage reimbursement rates.\textsuperscript{208} They focused on the benefits provided by the plans; the 2008 presidential candidates focused on the cost of the plans. But the two concerns are inextricably linked with Medicare Advantage. Rather than focusing on one without considering the other, the goal of an expanded Medicare benefit package should be balanced with its costs, evaluating alternatives for providing enhanced benefits directly rather than proceeding as though cost-reduction strategies can be disconnected from concern over gaps in coverage.

\textit{C. Competing Tension: Public-Private Balance}

Similar tension runs between maintaining traditional Medicare with its government-managed structure and shifting to a system dominated by private insurance alternatives. Questions have long been raised as to whether private plans in Medicare offer the best solution for chronically ill and/or low-income beneficiaries.\textsuperscript{209} Despite the apparent attractiveness of Medicare Advantage plans for many elderly minorities, embracing private insurance as the long-term answer to Medicare could put low-income elderly minorities at long-term risk. If Congress eventually reduces Medicare Advantage plan reimbursements, plans that remain in the market and maintain enhanced benefit packages most likely will increase their premiums to compensate. At some point, poorer

\textsuperscript{207} See discussion supra Section II.B.

\textsuperscript{208} See supra notes 202-205 and accompanying text.

\textsuperscript{209} See, e.g., Marilyn Moon, \textit{Will The Care Be There? Vulnerable Beneficiaries And Medicare Reform}, 18 HEALTH AFF. 107 (Jan./Feb. 1999), and Peter D. Fox et al., \textit{Addressing The Needs Of Chronically Ill Persons Under Medicare}, 17 HEALTH AFF. 144 (Mar./Apr. 1998).
beneficiaries may be priced out of the Medicare Advantage plans and forced to return to traditional Medicare while wealthier beneficiaries gravitate toward the more generous private plans. Traditional Medicare over time could devolve into another Medicaid, viewed by many as a less desirable "welfare" program and vulnerable to cuts in benefits that today would be considered untenable.

The risk that traditional Medicare could eventually lose its broad-based support underlies all Medicare reform proposals that push the system toward private insurance alternatives and away from a uniform government-managed program. Proposals such as allowing the federal government to negotiate prescription drug prices or adding a prescription drug benefit to traditional Medicare may reverse the risk. For elderly minorities who have much to lose if the protections inherent in traditional Medicare fail over time, this shifting balance between government-managed and private insurance alternatives adds yet more complexity to the analysis of Medicare Advantage. Medicare Advantage plans in the short run may give lower-income minorities a much-needed opportunity to fill in Medicare's coverage gaps, but supporting those plans inherently favors private insurance over traditional government-run Medicare. For elderly minorities in poor health and with limited financial resources, that favoritism may cause concern because of the long-term risks.

CONCLUSION: TAKING A BROADER VIEW

Politicians shy away from tackling anything but limited issues in Medicare for politically sensible reasons. The complexity of the Medicare system — with its public-private hybrid approach and forty-year history of conflicting reform approaches — makes it a difficult program to address. Moreover, the United States is currently in the throes of conflict over the even-bigger health care dilemma of how to provide health insurance to the estimated 47 million currently uninsured individuals under age 65. Medicare is also an enormously popular entitlement program that is viewed as dangerous to touch. It still demands attention, however, and the 2008 presidential candidates could easily incorporate systemic Medicare reform into their broader health care proposals.


211. See supra note 166 and accompanying text.

212. U.S. CENSUS BUREAU, supra note 78, at fig. 6. Uninsured rates are higher for members of ethnic and racial minority groups. For example, in 2006, the Census Bureau estimated that 20.5 percent (or 7.6 million) of all African Americans, and 34.1 percent (or 15.3 million) of all Hispanics, were uninsured. Id. at 19.
To bring Medicare into the national debate and lead the program forward, the candidates must look beyond isolated proposals and instead embrace system-wide consideration of core issues and the complex tensions that tie those issues together. To do otherwise will result at best in reform that falls short of solving serious needs in the system — for example, by failing to identify and close the most critical gaps in coverage. At worst, ignoring relationships between Medicare issues could result in negative and unanticipated consequences for what is already a vulnerable population. The quandary of Medicare Advantage reform for elderly minorities spotlights this risk. Are the programs a positive source of much-needed, affordable supplemental benefits? Do they cost the system more than they should? Should they be supported by minorities for the potential short-term value? Or should they be opposed because of the long-term potential of shifting the Medicare program too much toward private insurance? Balancing these and other questions is the challenge of Medicare reform, a challenge that can be met only by looking at Medicare with a wide and clear lens.