

A PHILOSOPHY OF PRIVATIZATION: RATIONING HEALTH CARE THROUGH THE MEDICARE MODERNIZATION ACT OF 2003

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I. INTRODUCTION

An enduring duality continues to define the debate over how to pay for American health care. On one side stands the traditional American ideals of individuality and personal autonomy; these strong cultural values support the idea that our accomplishments, including our ability to pay for our own health care, should reflect personal effort rather than the benefits of a charity state.¹ On the other side stands the evolving belief that health care represents a “public good.”² As such, the need for health care may be considered a basic need, like food or shelter, and there may even exist an innate right to such care.

In many ways, our current system of private commercial insurance epitomizes these ideals of individuality and personal accomplishment. Private insurance policies are acquired either as part of an employment package or purchased from a private insurer at personal cost.³ Whether structured along managed care lines or

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¹See Philip Lee, *Politics, Health Policy, and the American Character*, 17 STAN. L. & POL’Y REV. 7, 8, 9-13 (2006) (arguing that Americans rely on market forces to reflect personal responsibility and individual effort, that the growing political polarization we are witnessing results from this continuing dichotomy between personal independence and shared societal merit, and that this move towards a more conservative philosophy of personal autonomy “is the impetus for a series of public policy initiatives that may further exacerbate existing social inequalities”).

²*Id.* at 16.

³See CARMEN DENAVAS-WALT ET AL., U.S. CENSUS BUREAU, INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2005, 20 (2006), <http://www.census.gov/prod/2006pubs/p60-231.pdf> (“Census Bureau broadly classifies health insurance coverage as private coverage or government coverage. Private health insurance is a plan provided through an employer or a union or purchased by an individual from a private company. Government health insurance includes the federal programs Medicare, Medicaid,

traditional fee-for-service, these policies generally delineate with care a list of supported services for which the policy will pay. The policy may only partially cover the cost of a particular treatment in which case the remaining costs incurred become the responsibility of the individual.

In contrast, Medicare was born in the era of President Lyndon B. Johnson's "Great Society."⁴ Its passage marked a commitment to the idea that ensuring adequate health care for the American populace was more an issue of societal merit than personal economic resourcefulness. Even so, that commitment was far from unanimous and the birth of Medicare also marked the beginning of an enduring and public debate over health care as a matter of social justice or market economics.⁵ Increasingly, the question of continuing national health care coverage would turn on whether health care constituted a public good "differentiated by society for its own highest purposes, not a business to be exploited" or a matter of market economics, to be shaped by "the fundamentals of our political economy – capitalistic, pluralistic, and competitive."⁶

Both systems struggle to cope with rising health care costs today. The cost of private insurance has placed it outside the reach of many individuals.⁷ Rising premiums have also made it impossible for many small corporations to continue to offer employer-sponsored health insurance which has resulted in a steady increase in the number of uninsured Americans since 2000.⁸ Furthermore, recent studies suggest that uninsured Americans who later become eligible for Medicare benefits often incur greater health care costs than those who had been insured prior to attaining Medicare coverage status.⁹ Approximately forty-seven million Americans

and military health care; the State Children's Health Insurance Program (SCHIP); and individual state health plans").

⁴See Charlotte Twight, *Medicare's Origin: The Economics and Politics of Dependency*, 16 CATO J. 309, 313 (1997) ("Medicare's passage was anything but a spontaneous societal embrace of one of the pillars of President Lyndon Johnson's 'Great Society'").

⁵Lee, *supra* note 1, at 16-17.

⁶*Id.* at 16, 18.

⁷See CENTER ON BUDGET AND POLICY PRIORITIES, THE NUMBER OF UNINSURED AMERICANS CONTINUED TO RISE IN 2004, (2005), <http://www.cbpp.org/8-30-05health.htm> (stating that, in addition to a reduction in the percentage of individuals with employer-sponsored health insurance plans, "there are signs that private coverage is weakening for those who have coverage," that "[a] recent survey found that more than one-third of adults have problems paying medical bills and encounter related problems of access to care," and that both the uninsured as well as insured individuals with high deductibles are more likely to encounter problems when attempting to obtain and afford necessary health care)[hereinafter CBPP].

⁸See NATIONAL COALITION ON HEALTH CARE, FACTS ON HEALTH INSURANCE COVERAGE (2007), http://www.nhc.org/facts/coverage_fact_sheet_2007.pdf (reporting a steady increase in the number of uninsured Americans since 2000 primarily as a result of decreasing numbers of employer-sponsored health plans and noting an increased likelihood of health care insurance coverage with increasing income).

⁹See Ed Edelson, *Uninsured Americans Raise Medicare Expenditures*, HEALTHDAY REPORTER (July 11, 2007), available at http://www.covenanthealth.org/healthday/7_2007/606311 (stating that "Americans who weren't insured before they reached age sixty-five and gained access to Medicare cost the program a lot more than those who did have health insurance" with thirteen percent more physician visits, twenty percent more hospitalizations,

went without health care insurance coverage in 2005.¹⁰ Another sixteen million Americans had insufficient health care insurance coverage.¹¹

Similarly, the escalating cost of Medicare expenditures has become legendary. Current Medicare costs total approximately \$374 billion, which is equivalent to fourteen percent of the federal budget.¹² Medicare costs are expected to escalate to \$524 billion by 2011.¹³

The trend in coping with these rising Medicare costs has been to increase the role that private insurance plays in providing coverage for Medicare recipients. Much of this movement towards an increased “privatization” of Medicare has been born of the belief that the private sector of health care insurance coverage has been made more efficient by existing market forces and will provide a way to both continue providing health care to elderly Americans while containing Medicare costs through these increased efficiencies as exemplified through the managed care model.

This premise will be further explored in this article. First, this article will review an abbreviated history of private sector managed care as well as the origins of Medicare. Second, it will review the basic structure of the Medicare Modernization Act of 2003 (MMA) as it was first introduced and discuss how the MMA continues to evolve in the face of escalating health care demands. Finally, it will address how the MMA seeks to ration health care within the Medicare system and how such rationing has proven problematic in the private sector as well as discussing some of the troubling implications of our current parameters for rationed health care.

Ultimately, a detailed analysis of Medicare’s foundations lies outside the scope of this article as does any prediction regarding its extended future. Even a cursory review of the complex issues that have helped to form today’s Medicare program proves that defining the future of that program would be daunting at best.¹⁴ All too

and fifty-one percent higher total medical expenses incurred by those previously uninsured)[hereinafter NIH]. See also J. Michael McWilliams et al., *Use of Health Services by Previously Uninsured Medicare Beneficiaries*, 357 NEW ENG. J. MED. 143, 151 (2007) (“Near-elderly adults who were uninsured required more intensive and costlier care in the Medicare program after the age of sixty-five years than previously insured adults who were otherwise similar at ages fifty-nine to sixty. Therefore, providing health insurance coverage for uninsured near-elderly adults may improve their health outcomes and reduce their health care use and spending after age sixty-five and that “these benefits may be substantial and may partially offset the costs of expanding coverage.”).

¹⁰See NATIONAL COALITION ON HEALTH CARE, *supra* note 8.

¹¹See DEMOCRATIC POLICY COMMITTEE, NUMBER OF UNINSURED AMERICANS INCREASES, AGAIN (Sept. 6, 2005), http://democrats.senate.gov/dpc/dpc-printable.cfm?doc_name=fs-109-1-85. See also Cathy Schoen et al., *Insured But Not Protected: How Many Adults are Underinsured?*, HEALTH AFFAIRS (PROJECT HOPE), Jun. 14, 2005, at w5-299 (June 14, 2005) (reporting that fifty-four percent of the underinsured and fifty-nine percent of the uninsured describe going without needed medical care, that “having inadequate insurance as well as being uninsured undermines access to care, satisfaction, and confidence in the quality of care obtained,” and that “[a]ccess barriers reported by the underinsured at times approach rates observed among uninsured adults.”).

¹²NIH, *supra* note 9.

¹³*Id.*

¹⁴See Theodore Marmor, *Medicare and Political Analysis: Omissions, Understandings, and Misunderstandings*, 60 WASH. & LEE L. REV. 1137, 1156 (2003).

often, however, the ongoing debate regarding Medicare's future reduces to an oversimplified balancing of economic forces alone, present and anticipated. After only cursory examination, considerations of public policy increasingly fall to the side. Without doubt, Medicare's future will continue to be shaped by the tides of economics, politics, and public policy. This article argues only for open consideration of the implications of those resulting policies and how these will reflect our society and its most enduring values.

II. PAYING FOR HEALTH CARE IN THE UNITED STATES

Technological advances, a growing elderly population and increasing public expectations have worked together to increase the cost of health care.¹⁵ With rising costs has come the question of how to afford the health care we need. In the private sector, commercial insurance plans have relied on managed care models to ration health care services which utilize a combination of explicit rationing, such as limiting the range of reimbursable services, and implicit rationing, such as physician discretion in allocating the resources available with respect to covered services. On the other hand, government health plans have relied on stream-lining reimbursement and have only recently begun to consider price-sharing and other forms of rationing as a means of controlling escalating health care costs.¹⁶

A. A Brief History of Managed Care

Rationing may be defined in several ways. Webster's dictionary defines rationing as "to distribute equitably" or "to use sparingly."¹⁷ Additionally, Webster's defines a ration as "a share especially as determined by supply."¹⁸ We ration many things in everyday life from determining monthly grocery budgets to allocating available vacation time. In many instances, the idea of rationing evokes impressions of self-restraint and preparedness for an uncertain future.

However, as a nation, we dislike the idea of rationing health care. When used in the context of health care, rationing strikes an unpleasant chord in many of us and often raises the unanswerable question – how much is life worth? Life is precious and we would like to believe that we will implement any treatment that offers the chance of preserving that life regardless of cost.¹⁹ Most of all, we would like to believe that we live in a society that does not ration health care and that the absence

¹⁵See David Mechanic, *Professional Judgment and the Rationing of Medical Care*, 140 U. PA. L. REV. 1713, 1713 (1992) (discussing several approaches to health care rationing in the private sector including "cost-sharing with patients (price rationing); administrative limits on technological expansion, reimbursable services, and provider remuneration (explicit rationing); and discretionary allocation of services within the constraints of established budgets (implicit rationing)").

¹⁶See Jonathan Oberlander, *The Politics of Medicare Reform*, 60 WASH. & LEE L. REV. 1095, 1102 (2003) (describing Medicare's foundation as a public insurance program and reflecting that "[t]he most compelling argument in favor of public medical insurance for the elderly was that the market had failed to meet their needs").

¹⁷WEBSTER'S DICTIONARY (2005), available at <http://www.m-w.com/dictionary/rationing>.

¹⁸WEBSTER'S DICTIONARY (2005), available at <http://www.m-w.com/dictionary/ration>.

¹⁹Mechanic, *supra* note 15, at 1745 (discussing the "rule of rescue").

of rationing renders us one of the best health care systems in the world, regardless of statistics that may suggest otherwise.²⁰

In fact, Americans have been rationing health care for almost ninety years. In 1929, several hundred Oklahoma farmers and their families enrolled in a prepaid health care plan under which routine patient care was administered for a predetermined, prepaid flat fee.²¹ In 1933, Harold Hatch, an insurance agent, proposed paying a flat, fixed fee in advance for the medical care of construction workers building the Los Angeles Aqueduct in the Mojave Desert.²² The idea of prepaid health care captured the imagination of Henry Kaiser who persuaded the same physician to offer a similar service for construction workers building the Grand Coulee Dam 5 years later.²³

Continued technological advancements in the medical field fueled escalating health care costs and spurred the Nixon administration to propose the development of health maintenance organizations (HMOs) in 1971.²⁴ The concept of managed care continued to develop over the next few decades until the 1997 Balanced Budget Act introduced managed care options to the Medicare market.²⁵

Ultimately, prepaid health plans and managed care rationing reflect the often unacknowledged reality that the cost of health care can easily spiral out of control. Managed care represents an attempt to limit those costs while promising continued delivery of some necessary health care services in the future.²⁶ The introduction of managed care plans into the Medicare program suggested for the first time that the escalating health care costs faced by the elderly were no longer costs that our society could afford to shoulder to the same degree as it had in the past; the cost of some medical treatments would increasingly fall on individual Medicare beneficiaries.

²⁰See Stephen Ohlemacher, *U.S. 42nd in Global Life Expectancy*, ASSOCIATED PRESS, (August 11, 2007), http://www.presselegram.com/news/ci_6603357 (reporting that the United States currently ranks forty-second internationally with respect to life expectancy and infant mortality and that contributing factors include the country's rising epidemic of obesity, the lower life expectancy and increased infant mortality among African Americans, and the absence of a national health insurance program). See also U.S. CENSUS BUREAU, *GLOBAL POPULATION PROFILE: 2002* (March 22, 2004), <http://www.census.gov/ipc/prod/wp02/tabA-12.pdf>.

²¹See TUFTS MANAGED CARE INSTITUTE, *A BRIEF HISTORY OF MANAGED CARE*, (1998), <http://www.tmc.org/downloads/BriefHist.pdf> [hereinafter *Tufts*].

²²*Id.*

²³*Id.* See also Kaiser Permanente Founding & History (2007), <http://www.kaisersantarosa.org/about/kaiser/history>.

²⁴Tufts, *supra* note 21.

²⁵Oberlander, *supra* note 16, at 1121.

²⁶See Thomas R. McLean & Edward P. Richards, *Health Care's "Thirty Years War": The Origins and Dissolution of Managed Care*, 60 N.Y.U. ANN. SURV. AM. L. 283, 285 (2004) (declaring that "medicine is not a stable industry, and its development is shaped by economic and political factors as much as by science. Medical insurance does not just pay for medical care – it shapes the medical care delivery system, determines what treatments are developed, and formulates our view of what constitutes medical care.").

B. The Founding of Medicare

The institution of Medicare represents far more than our nation's attempt to fund the health care needs of its elderly. Like commercial health insurance, its evolution as an institution reflects changes in the economic current, public policy, and political climate of this nation.²⁷ Also like commercial health insurance, it "does not just pay for medical care" but also impacts the future shape and continuing evolution of our medical care delivery system, including the sort of technological advancements we will seek and the expectations we will hold as a society about what constitutes adequate health care.²⁸ Certainly, Medicare's current Byzantine architecture defies any accurate analysis without some understanding of the societal forces that formed it and the historical and political forces that continue to shape it.²⁹

The idea of government-sponsored health insurance first drew national attention in the 1930s.³⁰ The Committee on Economic Security was formed by President Franklin Roosevelt to draft a Social Security bill and included in its original report a promise of some future national health care plan.³¹ A strong initial negative reaction to the proposal prompted an eventual revision of this report, but the idea had already taken hold, and vigorous debates followed on the issue of national health care.³² Even then, these debates polarized along the lines of socialized health care, an idea which the American Medical Association strongly opposed, and continued adherence to a private commercial insurance model, which, at that time, most often consisted of fee-for-service payment.³³

Proposals for a national health care system experienced significant setbacks when many of its supporters suffered political defeats in the 1950s.³⁴ This reversal of political fortunes prompted many to propose restrictions on any eventual national coverage that may be formed to an elderly sub-population alone.³⁵ Finally, Social Security added disability benefits to its coverage in 1956, easing the path to some form of a limited national health care coverage program.³⁶

In 1964, Lyndon B. Johnson won his bid for the presidency and brought into office his concept of a "Great Society."³⁷ Liberal candidates won widespread victories in the 1964 elections which temporarily quieted the continuing ideological

²⁷Marmor, *supra* note 14, at 1143.

²⁸McLean, *supra* note 26, at 285.

²⁹Marmor, *supra* note 14, at 1138.

³⁰See Twight, *supra* note 4, at 313 (proposing that initial forays into the idea of a national health care coverage plan was inspired in part by "Bismarck's 1883 program in Germany.").

³¹*Id.*

³²*Id.* at 315. See also Oberlander, *supra* note 16, at 1099.

³³Oberlander, *supra* note 16, at 1099.

³⁴Twight, *supra* note 4, at 315-16.

³⁵*Id.*

³⁶*Id.*

³⁷*Id.* at 313.

debate over national health care.³⁸ Rather than settling existing disagreements, however, the enactment of the Medicare program in 1965 marked not only the birth of national health care benefits in the United States but also continued the debate over whether national health care was a matter of social justice or market economics.³⁹

As initially enacted, Medicare provided two types of benefits. Under Part A, Medicare covered basic hospital costs for those over age sixty-five.⁴⁰ These benefits were later extended to apply to those with end-stage renal disease.⁴¹ Currently, Part A covers in-patient hospital care for up to 150 days, home health care, hospice care, and in-patient psychiatric care for a lifetime limit of 190 days.⁴² Part A is funded by tax revenue placed into the Federal Hospital Insurance Trust Fund.⁴³

Medicare Part B differs from Part A in three key ways. First, enrollment in Part B is voluntary.⁴⁴ Second, Part B benefits require the payment of a premium.⁴⁵ Third, Part B benefits cover primarily outpatient physician services, including some outpatient rehabilitative services and some medical equipment needs.⁴⁶ Part B is funded by the Federal Supplementary Medical Insurance Trust Fund.⁴⁷

Funding health care soon became a problem in both private and public arenas. Throughout the 1980s and 1990s, rising health care costs prompted commercial insurers to offer managed care options alongside traditional fee-for-service plans, and gradually managed care plans became the dominant available form of commercial insurance.⁴⁸ At the same time, rising health care costs resulted in shortfalls in Medicare funding in the 1970s and 1980s that in turn prompted

³⁸*Id.* at 318. See also Oberlander, *supra* note 16, at 1099 (describing this “liberal landslide” as helping to settle a “high-profile, ideological, and highly partisan political contest” and led to “Medicare’s enactment . . . with a much broader scope and a more generous benefit package than even program advocates had thought possible.”).

³⁹Lee, *supra* note 1, at 16-17.

⁴⁰42 U.S.C.A. § 1395c (West 2000).

⁴¹*Id.* See Oberlander, *supra* note 16, at 1102-3 (discussing the initial ideological debate as to whether Medicare should be fashioned as an adjunct to commercial insurance or take the form of a public insurance program, its initial coverage limits which extended only to the elderly, and the eventual addition of coverage for the disabled and those with end-stage renal disease). See also Marmor, *supra* note 14, at 1151 (detailing key objections in Medicare’s initial formulation and discussing how those objectives have remained largely unattained beyond the general provision of health care coverage “for the elderly, the disabled, and those suffering from renal failure.”).

⁴²42 U.S.C.A. § 1395d (West 2000).

⁴³42 U.S.C.A. § 1395i (West 2000).

⁴⁴42 U.S.C.A. § 1395o (West 2000).

⁴⁵42 U.S.C.A. § 1395r (West 2000).

⁴⁶42 U.S.C.A. § 1395k (West 2000).

⁴⁷42 U.S.C.A. § 1395t (West 2000).

⁴⁸Oberlander, *supra* note 16, at 1114.

increased regulation of medical providers and a prospective fee payment schedule.⁴⁹ Medicare remained a single-payor, public insurance program managing relatively impressive cost savings with the instituted reforms.⁵⁰

However, persistent, recurrent shortfalls in Medicare funding during the 1990s resulted in far more upheaval.⁵¹ Discussions regarding the future of national health care coverage in this country became increasingly polarized and echoed in many ways the ideological debates of the 1950s and 1960s that had preceded the initial enactment of the Medicare program.⁵² Medicare's ballooning costs were perceived as a key cause of the ever-deepening national deficit.⁵³ Furthermore, concerns over the impending retirement of the Baby Boomer generation raised specters of Medicare trust fund insolvency in the near future.⁵⁴ Controlling health care costs became a fiscal imperative, and an increasingly conservative political landscape favored allowing market forces a greater role in shaping the reform of the Medicare program.⁵⁵

⁴⁹*Id.* at 1104-05.

⁵⁰*Id.* at 1107. See also Robert Pear, *Bush to Propose Curbing Growth in Medicare Cost*, N.Y. TIMES, Feb. 4, 2006, at A1, available at <http://www.nytimes.com/2006/02/04/politics/04budget.html> (summarizing briefly the history of cutting Medicare costs in order to forward a proposed budget plan). See also Amy Goldstein, *2007 Budget Favors Defense: Medicare Takes Biggest Hit in \$2.7 Trillion Plan*, WASH. POST (Feb. 5, 2006) at AO1, available at <http://www.washingtonpost.com/wp-dyn/content/article/2006/02/04/AR2006020401179.html> (describing proposed future cuts in Medicare costs in order to eliminate the national deficit by 2012). See also Robert Pear, *Bush's Medicare Budget Would Raise Premiums*, N.Y. TIMES (Feb. 4, 2007), at A1, available at <http://www.nytimes.com/2007/02/04/washington/04budget.html> (reflecting on the continuing shift in Medicare policy whereby an increasing percentage of incurred health care costs must be born by the individual Medicare beneficiary, including the burden of rising Medicare premiums).

⁵¹The increasing cost of funding Medicare and the subsequent shortfalls in that funding would also prompt many to question the wisdom of continuing to provide such entitlements to a select portion of our population at particular cost to rest of our society. See Robert H. Binstock, *Public Policies on Aging in the Twenty-First Century*, 9 STAN. L. & POL'Y REV. 311, 312 (1998) (discussing Americans' progression as a society from conceptualizing the elderly during the New Deal and Great Society eras as dependent on societal support to more recent stereotyping of the elderly as the country's retirement "elite"). See also Joseph White, *(How) is Aging a Health Policy Problem?*, 4 YALE J. HEALTH POL'Y, L. & ETHICS 47, 47-49 (2004) (arguing that aging poses less of a threat to health care costs escalation than other factors such as pension expenses and how to deliver necessary health care).

⁵²Oberlander, *supra* note 16, at 1108.

⁵³*Id.* at 1110.

⁵⁴*Id.* at 1112. See also CONGRESSIONAL BUDGET OFFICE, THE BUDGET AND ECONOMIC OUTLOOK: FISCAL YEARS 2008-2017 (2007), <http://www.cbo.gov/ftpdoc.cfm?index=7731> (stating that Baby Boomers will become eligible for Social Security benefits in 2008, triggering an increase in Social Security spending and, by implication, Medicare spending from four and one-half percent in 2008 to six and one-half percent by 2017 and arguing that "[e]ither a substantial reduction in the growth of spending, a significant increase in tax revenues relative to the size of the economy, or some combination of spending and revenue changes will be necessary to promote the nation's long-term fiscal stability.>").

⁵⁵Oberlander, *supra* note 16, at 1109.

This tense political and national climate set the stage for the introduction of managed care plans into the Medicare program. The 1997 Balanced Budget Act proposed creating a new Medicare + Choice option that offered a range of managed care options to Medicare beneficiaries.⁵⁶ However, the plan failed to include a price incentive or terms obligating private insurers to remain in the program even in the case of net loss.⁵⁷

Furthermore, Medicare + Choice plans lacked the necessary economic impetus that had made managed care a relatively successful strategy in the private market. “Managed competition seeks to control health care costs by having patients pay the costs of choosing more expensive health plans that compete in a regulated private market.”⁵⁸ In the absence of defined contributions and the subsequent financial pressure that would encourage Medicare beneficiaries to move out of the traditional Medicare payor scheme, Medicare + Choice programs “lacked the key cost control mechanism of managed competition.”⁵⁹ Medicare’s first foray into managed care failed to effectively bring into the Medicare arena cost-containment strategies from the private sector in part because of the absence of similar competitive market forces on which private insurers heavily relied.

After a brief fiscal rally, the pressures of escalating health care costs and a worsening deficit again precipitated interest in Medicare reform as a crucial factor in the national budget. Medicare reform emerged as an important factor in the 2000 election.⁶⁰ Although only ranked fourth overall by voters, control of rising health care costs in general and prescription drug costs in particular remained high-profile issues in the 2004 election.⁶¹ Although supplemental insurance plans existed that offered prescription coverage, their premiums were increasing rapidly. This increase in supplemental insurance premiums in combination with rising Medigap⁶² premiums and the increasingly palpable gap between Medicare’s absence of outpatient prescription coverage and the standard coverage already available in the private sector set the stage for the introduction of a national prescription drug coverage program and, with it, increasing the role of privatization in Medicare’s public insurance program.⁶³

⁵⁶*Id.* at 1121.

⁵⁷*Id.* at 1126-27.

⁵⁸*Id.* at 1123.

⁵⁹*Id.* at 1127.

⁶⁰*Id.* at 1128.

⁶¹See Robert J. Blendon, *Health Care in the 2004 Presidential Election*, 351 NEW ENG. J. MED. 1314, 1314 (2004) (analyzing data from twenty-two national opinion surveys and concluding that voters considered the cost of health care and prescription drugs, Medicare, and the uninsured’s access to health care among the most concerning health care issues).

⁶²Medigap is supplemental health insurance sold by private insurance companies to help pay costs that the individual’s Medicare plan would not otherwise cover. See Centers for Medicare and Medicaid Services, Medicare Supplement Health Insurance Medigap - Overview at <http://www.cms.hhs.gov/Medigap> (defining Medigap as a “policy is health insurance sold by private insurance companies to fill the ‘gaps’ in Original Medicare Plan coverage.”).

⁶³Oberlander, *supra* note 16, at 1129-30.

III. INTRODUCING THE MEDICARE MODERNIZATION ACT OF 2003

Congress passed the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) in 2003, incorporating prescription drug coverage benefits into the Medicare program for the first time since its inception.⁶⁴ The MMA also heralded a striking change in the ideological mindset guiding Medicare policy in that it promoted increased reliance on private sector insurers, and the efficiencies of market economics on which they rely, to slow down Medicare's rocketing costs.

The MMA created Medicare Part D which provides for voluntary enrollment in one of several plans covering outpatient prescription drug costs.⁶⁵ Under Part D, private insurers offer prescription drug benefits to Medicare beneficiaries either through Prescription Drug Plans in a traditional Medicare fee-for-service Part A and B coverage plan or through Medicare Advantage plans under a Medicare Part C managed care option.⁶⁶ These private plans must provide coverage for drugs listed under the established Medicare formulary.⁶⁷ These private plans may include additional drugs that exceed Medicare requirements within their chosen formularies but may also cease coverage of these non-formulary medications without forewarning the Medicare beneficiaries who have enrolled to receive prescription drug coverage under their particular plan.⁶⁸

For many, the proposed Part D coverage raised two immediate concerns. First, the required Medicare formulary promised to be more restricted than many state Medicaid formularies.⁶⁹ However, Medicaid recipients would eventually be required to enroll in Medicare prescription plans that would increase their drug costs while decreasing their selection.⁷⁰ Second, Part D's payment scheme allowed for a "doughnut hole" in coverage that would result in higher out-of-pocket expenses for many beneficiaries. Under Part D as initially proposed, beneficiaries remained responsible for the first \$250 incurred in prescription drug costs.⁷¹ Part D would

⁶⁴*Id.* at 1133.

⁶⁵Susan Adler Channick, *The Medicare Prescription Drug, Improvement, and Modernization Act of 2003: Will It Be Good Medicine for U.S. Health Policy?*, 14 ELDER L. J. 237, 246 (2006).

⁶⁶*See* 42 U.S.C.A. § 1395w-101 (West 2006). *See also* Channick, *supra*, note 64, at 237 (describing the basic coverage structure provided for under the MMA).

⁶⁷*See* THE CENTERS FOR MEDICARE & MEDICAID SERVICES, HEALTH CARE PROFESSIONAL'S PART D FACT SHEET, http://www.cms.hhs.gov/MLNProducts/downloads/Part_D_Resource_Fact_sheet_revised.pdf (including under covered drugs "[s]ix drug classes of special concern . . . in which all or substantially all drugs will be on a plan's formulary: anti-neoplastics, anti-HIV/AIDS drugs, immunosuppressants, anti-psychotics, anti-depressants and anti-convulsants" but not covering "barbiturates; benzodiazepines; drugs used for anorexia, weight loss or weight gain; fertility drugs; drugs used for cosmetic purposes or hair growth; cough and cold medicines; prescription vitamins and minerals, and over-the-counter drugs.") (last visited on Sept. 10, 2007).

⁶⁸42 U.S.C.A. § 1395w-102 (West 2006).

⁶⁹Channick, *supra* note 65, at 248.

⁷⁰*Id.* at 250-51.

⁷¹42 U.S.C.A. § 1395w-102(b)(1)(A)(i) (West 2006). In order to simplify the discussion, 2006 coverage stipulations are used when detailing out-of-pocket expenses in this paragraph.

cover seventy-five percent of the next \$2000 of incurred prescription drug costs.⁷² The beneficiary would then bear the full burden of further drug costs until the beneficiary's total out-of-pocket costs (not simply costs charged) exceeded \$3600.⁷³ Past that point, Part D would pay ninety-five percent of any additional prescription drug costs incurred.⁷⁴

Although supplemental "doughnut hole" coverage is available, coverage under such plans would generally be limited to generic drugs only and would come at a considerable premium.⁷⁵ Furthermore, should a Medicare beneficiary elect not to enroll for Part D benefits when first eligible, that beneficiary would be subject to a late enrollment penalty of one percent of the beneficiary's base premium.⁷⁶ This penalty may be waived if the beneficiary can show alternate prescription drug coverage for the pertinent time period.⁷⁷

The MMA marks a striking change in Medicare policy, most critically it brought to life "the conservative vision of Medicare as a competitive market in which the federal government subsidizes beneficiaries to purchase private insurance."⁷⁸ Some are concerned that the MMA signals "a clear commitment to the private market to solve social problems."⁷⁹ Certainly, MMA and Medicare Part D introduce two fundamental changes with respect to Medicare policy.

First, by mandating enrollment in Part D by those individuals with dual eligibility for both Medicare and Medicaid benefits, Part D introduces a new level of federalism into the mix of state and federal health care assistance programs.⁸⁰ Congress enacted the Medicaid program in 1965 in a political climate that looked favorably upon the idea of universal health insurance.⁸¹ Medicaid programs function primarily at a state level with the individual states defining eligibility levels and determining optional expansions, sometimes supported in their decisions by federal

⁷²42 U.S.C.A. § 1395w-102(b)(2)(A) (West 2006).

⁷³42 U.S.C.A. § 1395w-102(b)(4)(B) (West 2006).

⁷⁴42 U.S.C.A. § 1395w-102(b)(4)(A)(i)(II) (West 2006). *See also* Channick, *supra* note 64, at 249-50 (explaining catastrophic coverage for prescription drugs and the impact of the MMA on those eligible for both Medicare and Medicaid assistance).

⁷⁵*See* Christopher Lee, *Group Says Gap in Medicare Drug Coverage Will Be Costly*, WASHINGTON POST (Nov. 2, 2006) at A11, available at <http://www.washingtonpost.com/wp-dyn/content/article/2006/11/01/AR2006110103324.html> (referring to a Families USA report that found that premiums for plans that included gap coverage would increase by as much as eighty-seven percent and that such gap coverage may not be available at all in several states).

⁷⁶42 U.S.C.A. § 1395w-113(b)(3)(A)(ii) (West 2006).

⁷⁷42 U.S.C.A. § 1395w-113(b)(3)(B) (West 2006).

⁷⁸Oberlander, *supra* note 16, at 1133.

⁷⁹*See* Channick, *supra* note 65, at 237 (arguing that the MMA "will ultimately shift costs from the government and employers to individual citizens and employees, particularly the elderly").

⁸⁰Channick, *supra* note 65, at 251.

⁸¹*See* Colleen Grogan & Eric Patashnik, *Between Welfare Medicine and Mainstream Entitlement: Medicaid at the Political Crossroads*, 28 J. HEALTH POL. POL'Y & L. 821, 824 (2003).

mandates.⁸² State funds for many of these programs may be matched on occasion by federal funds.⁸³

However, the MMA requires that states contribute funds to the Part D prescription benefit program for those seniors who previously received their drug benefits under state Medicaid plans, and it also includes a complex formula to determine the amount states must pay to the federal government as part of their Part D contribution.⁸⁴ The only factor within that formula that remains under state control is the number of individuals meeting state eligibility criteria for dual enrollment in both Medicaid and Medicare programs.⁸⁵ As states confront worsening budget crises of their own, this mandatory contribution to the Part D prescription drug plan will likely result in notable retrenchment in eligibility requirements for existing Medicaid programs.⁸⁶

Second, by allowing private entities to negotiate drug pricing with pharmaceutical companies and thereby define the tiered system by which beneficiaries' out-of-pocket expenses are determined, Part D fundamentally redefines a government health care program's method of reimbursement with respect to private pharmaceutical companies.⁸⁷ For example, the Veteran's Affairs model represents a more centralized public health care model in which a single government entity, such as the Secretary of Veteran's Affairs, negotiates directly with pharmaceutical manufacturers to determine drug pricing.⁸⁸

Although such a system has proven relatively successful in negotiating favorable prescription drug prices for plan beneficiaries, the MMA implements a "decentralized competitive pricing model" in which the private insurers providing prescription drug coverage under Part D negotiate drug costs independently with pharmaceutical manufacturers.⁸⁹ Clearly, the hope would be that market forces should ensure competitive drug pricing in such a setting; however, where a particular drug lacks competition or is unique in its benefits, the decentralized system may not afford significant cost-containment benefits.⁹⁰

The MMA put into effect a federal prescription drug benefit program in response to apparently high public demand for such benefits. However, the actual benefits of

⁸²*Id.* at 833.

⁸³*Id.*

⁸⁴Channick, *supra* note 65, at 251.

⁸⁵*Id.*

⁸⁶*Id.* See also Grogan, *supra* note 81, at 850-55 (postulating that increased fiscal pressures may force Medicaid programs into large-scale cuts but that as the number of uninsured Americans continues to rise and Medicare continues to struggle to provide "needed services to the elderly, it will become increasingly difficult for policy makers not to grasp the vital importance of Medicaid to working-class and middle-class families" and going on to suggest that Medicaid may prove a useful stepping stone to universal health insurance in this country).

⁸⁷Channick, *supra* note 65, at 253.

⁸⁸*Id.* at 254.

⁸⁹*Id.* at 255.

⁹⁰*Id.* at 255-56.

the Part D program may be mitigated by several factors including a limited formulary; a sizeable “doughnut hole” in mid-coverage during which Part D beneficiaries remain 100 percent responsible for out-of-pocket costs of prescribed medications; potential cutbacks in Medicaid programs as a result of mandatory contributions to the Part D program; and the mixed efficacy of a decentralized competitive pricing model for negotiated drug costs.

IV. RATIONING HEALTH CARE UNDER MEDICARE

In the midst of these turbulent debates over the future of our existing national health care program, a general consensus appears to exist on one issue alone: Medicare cannot survive as it is currently structured. The Secretary of Health and Human Services has stated that “Medicare is simply not sustainable in the long-term in its present form” because of its persistently escalating costs.⁹¹ In discussing the proposed 2008 Medicare budget, he stated that “[t]here will never be enough money to satisfy all wants and needs, and we had to make some tough choices.”⁹² The issue then is not if health care should be rationed, but how to best go about formulating a plan of rationing and who should determine the ultimate allocation of our available health care resources.

Rationing can take many forms. At least one attempt has been made to divide potential methods of rationing into three specific approaches.⁹³ These approaches include cost-sharing with beneficiaries, administrative constraints on technological expansion and remuneration for services (explicit rationing), and health provider discretion in the allocation of services under an established budget (implicit rationing).⁹⁴ Explicit rationing includes administrative constraints on a particular health care plan in an effort to limit expenditures under that plan, including precise limitations on what treatment modalities may be covered.⁹⁵ Implicit rationing relies on the clinical relationship between physician and patient to streamline the health care services a particular individual may require or should be offered.⁹⁶ Under implicit rationing, the physician exercises her professional discretion in determining the health care options for which a particular patient may be considered.⁹⁷

⁹¹See Michael Leavitt, Sec’y of the U.S. Dep’t of Health & Human Services, FY 2007 Budget Announcement, <http://www.dhhs.gov/news/speech/sp20060206a.html> (stating in addition that “[t]here is a tendency to assume that any reduction constitutes a lack of caring. But reducing a program does not imply an absence of compassion.”).

⁹²See Michael Leavitt, Sec’y of the U.S. Dep’t of Health & Human Services, Statement on FY 2008 Budget before the Comm. on Appropriations, Subcomm. on Labor, Health & Humans Services, Education, and Related Agencies, and the U.S. House of Representatives (February 27, 2007), <http://www.hhs.gov/asl/testify/2007/02/t20070227a.html> (stating in addition that “[t]he single largest challenge we face is the unsustainable growth in entitlement programs such as Medicare and Medicaid.”).

⁹³Mechanic, *supra* note 15, at 1713.

⁹⁴*Id.*

⁹⁵*Id.*

⁹⁶*Id.* at 1714.

⁹⁷*Id.*

Both explicit and implicit rationing bring with them particular pitfalls. Repeated, successful litigation against managed care entities has caused many private insurers to shy away from the more explicit forms of health care rationing.⁹⁸ As a result, many private insurers now prefer to follow a more implicit model of rationing where the physician serves as both patient advocate and resource administrator.⁹⁹ Some argue that the relationship between physician and patient includes a unique bond of trust that can withstand the dual role that physicians would fill under an implicit rationing model.¹⁰⁰ However, others have argued that the bond of trust between physician and patient is not so resilient as to allow a persistent reliance on this duality.¹⁰¹

Current efforts to curb Medicare expenditure have focused on three potentially cost-saving measures. First, efforts to improve national health information technology continue to receive broad-ranging support under the assumption that increased efficiency in this area will translate into general cost savings.¹⁰² Second, efforts to reduce health care fraud and abuse continue to be viewed as a potentially major source of savings.¹⁰³ Third, expanding on the initial forays into privatization under Medicare Part D may also provide further, much-needed savings.¹⁰⁴

Introducing privatization into a public insurance program poses several important questions, however. As first enacted, Medicare functioned as a form of national health insurance.¹⁰⁵ Payment collected through tax revenues or voluntary premiums were in turn meted out through a government plan.¹⁰⁶ Although including private insurers in the program allows for some shifting of health care costs to the beneficiary as well as the private sector, the continued success of the program will likely still require some government funding to ensure continued private sector participation. As demonstrated by the failed Medicare + Choice program, the inevitable escalation of health care costs demands that the government provide some incentive for private insurers to remain in the business of providing health care

⁹⁸McLean, *supra* note 27, at 314.

⁹⁹*Id.*

¹⁰⁰See Mark A. Hall, *Law, Medicine, and Trust*, 55 STAN. L. REV. 463, 488 (2002) (arguing that while “system level” trust may be affected by implicit rationing, the “interpersonal trust” between physician and patient “has a distinctly different psychological basis” that would not be similarly impacted).

¹⁰¹See M. Gregg Bloche, *Trust and Betrayal in the Medical Marketplace*, 55 STAN. L. REV. 919, 941 (2002) (arguing that implicit rationing through physicians’ discretionary allocation of health care resources may “make health care rationing less visible” and that “[b]y making rationing less visible . . . [it] obscures the stratification of standards of care according to economic class.”).

¹⁰²Leavitt, *supra* note 93.

¹⁰³*Id.*

¹⁰⁴*Id.* (stating that “[t]he President’s Affordable Choices Initiative would help States make basic private health insurance available” to many individuals who are currently uninsured in our present health care system).

¹⁰⁵Oberlander, *supra* note 17, at 1102.

¹⁰⁶See 42 U.S.C.A. § 1395i (West 2000). See also 42 U.S.C.A. § 1395t (West 2000).

benefits to the elderly, a sub-population that is already more likely to utilize available health care resources.¹⁰⁷ As such, funding Part D promises to continue being a challenge.

Part D also presents a risk of increasing the number of uninsured or underinsured Americans. The convoluted Part D benefits system has already proven difficult for many beneficiaries to navigate.¹⁰⁸ These beneficiaries may become underinsured or uninsured under the Medicare program either because they are bewildered by the choices before them, unclear as to what benefits their Medicare plan actually affords them, or simply unable to afford the additional coverage they now require to provide the coverage they initially expected under Part D.

Finally, Part D may be premised on a comforting but inaccurate assumption – that private sector market economics provides a more efficient paradigm under which to allocate health care resources. The private sector suffered greater losses during the initial eras of managed care than did Medicare under its policy of streamlined reimbursement and increased administrative controls.¹⁰⁹ Furthermore, private, commercial insurance costs continue to rise, pricing themselves out of the market for many Americans and resulting in an escalating number of uninsured or underinsured citizens.¹¹⁰ In turn, that lapse in health care coverage has resulted in an increased burden on the Medicare system.¹¹¹

Increasingly, personal resources determine access to health care. With the gradual erosion of services provided under public insurance programs, those who depend on those services and whose personal resources do not allow them to seek health care in the private market are often left not seeking essential health care when necessary.¹¹² However, those with greater personal resources may obtain a better quality of health care through an emerging market of more personalized health care delivery systems such as concierge medicine.¹¹³ In the end, the private health care insurance market has ensured a system where the more prosperous Americans are able to live longer lives, in better health, simply because they have the money to afford to do so. Reliance on such a system as a means of supporting the health care needs of the elderly in our society promises to be worrisome at best.

¹⁰⁷See Alexander R. Shekhdar, *Strategic Choices for Managed Care Plans Under the Modernization Act of 2003*, 37 J. HEALTH L. 429, 431 (2004).

¹⁰⁸See Oberlander, *supra* note 17, at 1097 (discussing the implications for Medicare with the retirement of the “baby boom generation”).

¹⁰⁹White, *supra* note 52, at 53.

¹¹⁰CBPP, *supra* note 8.

¹¹¹McWilliams, *supra* note 10, at 151.

¹¹²Schoen, *supra* note 12.

¹¹³See Sandra J. Carnahan, *Law, Medicine, and Wealth: Does Concierge Medicine Promote Health Care Choice, or Is It a Barrier to Access?*, 17 STAN. L. & POL’Y REV. 121, 154 (2006) (stating that “[o]verall access to medical care in a community may be compromised when a physician converts to a retainer practice that serves a patient panel now reduced by as many as 2500 patients” but also noting that existing data does not suggest that these physicians are less likely to provide indigent care and that they may even be in a better position to do so than many of their colleagues).

Currently, our national health care policy appears to have been dictated by the winds of the prevailing political climate and relatively short-term economic considerations. The absence of any enduring guiding principle to our health care agenda has resulted in an arcane system that appears impossible to meaningfully comprehend and even more impossible to reform in a productive fashion. Most health care reform proposals either propose unrealistically that we start the system over from scratch or appear unbelievable in their Byzantine architecture as necessitated by the existing intricacies of our Medicare network.¹¹⁴

Privatization of our existing system may promise short-term relief of our current cost concerns. However, it also promises to potentially curtail access to basic health care services without a burdensome drain on beneficiaries' personal resources, a drain that many beneficiaries may not be able to afford.¹¹⁵ Although such cost-sharing may appear reasonable at first glance, its long-term effects may include reduced access to care for some of our most vulnerable citizens who currently rely on government-subsidized health care programs, particularly the disabled and the elderly, especially elderly women whose life expectancy continues to exceed their male counterparts.¹¹⁶ In the end, cost containment through privatization of existing government-subsidized programs may come at the price of increasing socioeconomic stratification within our society through rationing access to health care, arguably one of our most fundamental needs.

V. CONCLUSION

The continuing debate over national health care raises several critical questions. Is access to health care a right? Should the quality of an individual's health care be dictated by socioeconomic standing? Do we as a society bear any responsibility for ensuring equal access to existing health care resources?

Our answers to these questions will define our culture and reflect what we value most as a society. How we choose to address these issues of national health care policy promises to become our most enduring legacy, both to future generations in our country as well as to the world at large. We should not allow these answers to be dictated by narrow economic considerations alone. We must confront these questions with full acknowledgment of their ideological ramifications and not allow ourselves the luxury of oversimplification.

¹¹⁴See Oberlander, *supra* note 17, at 1121-32 (reviewing the evolution of Medicare reform with the advent of a market economics health care coverage model).

¹¹⁵See White, *supra* note 52, at 68 (arguing that although "an aging society poses an array of challenges . . . health finance is neither a major factor nor the proper lens through which to perceive the most important financial and ethical dilemmas" and that the projected shortfall in health care providers may prove more relevant when considering how to meet anticipated health care needs of the elderly in the future).

¹¹⁶See U.S. DEP'T OF HEALTH & HUMAN SERVICES, HEALTH, UNITED STATES, at 60 (2006), <http://www.cdc.gov/nchs/data/hus/hus06.pdf#027> (describing longer life expectancy for American women despite a narrowing gap in life expectancy between the genders from 1990 to 2003).