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Abstract

American culture and public policy have long held a split vision about the aged: vulnerability, dependency, and special need for law and policy to act as a protective shield versus the aged as independent, self-reliant, and capable of choice, with law acting as a source of individual empowerment. In terms of health care financing, the 2010 Patient Protection and Affordable Care Act (PPACA) clearly leans toward protecting older persons from risk, rather than empowering them to act autonomously. This article compares the PPACA vision of elder vulnerability to alternative policy proposals for financing health care for the aged that are built on a vision of elder abilities and capacity for self-determination. The author advocates for the latter social vision and associated health care financing policy alternatives, arguing that a rebuttable presumption of elder capacity that recognizes and provides for individual variations better serves important societal values than does the PPACA's categorical conclusion that the aged as a population are unable to fend for themselves.

Key Words: Health care financing; Health reform; Medicare; Public policy; Ethics

In a civilized society, law and public policy reflect, promote, and help to shape cultural norms or values. American law and policy have long contributed to contrasting, incongruent social attitudes about the aged by codifying and enshrining those attitudes or visions with a formal, official, and enforceable status. On one hand is the negative image of a population defined mainly, if not solely, by chronological age and characterized by vulnerability, dependency, and a special need for law and policy to act as a protective shield against the constantly threatening vicissitudes of life. On the other hand is a positive image of older individuals as robust, self-reliant, and (with appropriate information and support) capable of making choices, with law acting as a source of individual empowerment. In the realm of health care financing, the 2010 Patient Protection and Affordable Care Act (PPACA)¹ clearly embodies a paternalistic bias toward protecting older persons from the risks of wrong decisions, rather than empowering them to engage in self-determination regarding the delivery and financing of their own health services.

This article compares the PPACA vision of elder vulnerability to alternative, strength-based policy proposals for financing health care for the aged that are built on a vision of elder abilities and capacity for autonomous decision making. The author advocates for the latter social vision and associated health care financing policy alternatives, arguing that a rebuttable presumption of elder capacity that recognizes and provides for individual variations better serves important societal values than does the PPACA's categorical conclusion that the aged as a population are immutably unable to fend for themselves.

PPACA and Its Negative Image of Aging

As is well known by now, the PPACA represents a very complicated attempt to address the vexing and historically elusive challenge of assuring Americans that they will have affordable access to good quality health services. The unifying approach taken in this legislation, both generally and regarding older persons particularly, is one of central (i.e., primarily at the federal level) planning and control of the supply side of the health services equation through close regulation of health care providers, insurers, and third-party financiers. In the design of this paradigm, the demand side of the equation—that is, any meaningful role for consumer choice and control—was overwhelmingly rejected; there are no provisions in the PPACA that could be fairly construed as promoting consumer direction by Medicare beneficiaries. On the contrary, several programmatic examples from the PPACA illustrate the strong policy prejudice of the Act’s protagonists that actual and potential (overall and especially the aged) patients are so hopelessly uneducable that they need to be sheltered by government against the folly they might engage in as autonomous health care consumers.

For one example, in the PPACA the Congressional majority and the administration sought to diminish the role of Medicare Advantage (MA) plans. Traditional Medicare Part A and Part B tightly delineate the details of a beneficiary’s coverage. Part C of Medicare was created in the form of Medicare+Choice by Congress in the Balanced Budget Act (BBA) of 1997. Medicare enrollees had previously held the option of joining health maintenance organizations in communities where HMOs existed and chose to participate in the Medicare program but, under the BBA, for the first time beneficiaries could enroll for their publicly financed health care coverage through private fee-for-service (FFS) plans, medical savings accounts coupled with high-deductible health plans, preferred provider organizations, and point-of-service plans, with coverage being paid for by the federal government. Power of the purse

options for Medicare beneficiaries' choice of FFS and managed care plans were further expanded by the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA), which changed the name of Medicare Part C to Medicare Advantage.²

Participation in one of the private health plans authorized by the BBA and/or the MMA in lieu of receiving the benefits prescribed by traditional Medicare Part A and Part B is totally optional on the part of the individual beneficiary. MA plans must provide the benefits assured under traditional Medicare; most MA plans compete for business by offering consumers some combination of additional benefits and cash rebates. Approximately a quarter of eligible Medicare beneficiaries select an MA plan rather than traditional Medicare.³

Advocates of the PPACA projected that the greatest amount of Medicare savings achieved by the legislation would come about from changes in government payments to MA plans.⁴ The PPACA cuts \$ 145 billion over 10 years in payments from the Centers for Medicare & Medicaid Services (CMS) to MA plans. As a result of those cuts (the savings all being used to finance expanded benefits to individuals not eligible for Medicare coverage), “[i]nsurers were expected to shift the burden to beneficiaries in the form of fewer services and higher out-of-pocket costs, triggering an exodus back to traditional Medicare.”⁵ That dynamic predictably would trigger an exodus of MA plans from the marketplace, thereby depriving some Medicare beneficiaries of that option. In implicit acknowledgement of that probability and the disruption it would entail, CMS has announced it will infuse \$ 6.7 billion into the MA plan industry by awarding quality bonuses to hundreds of MA plans rated only average. The political motivations behind this one-time bonus arrangement do not negate the general philosophy of the PPACA that most older individuals ought to be protected against the choices required by the health care marketplace by instead having the terms of their coverage dictated to them under traditional

Medicare; the CMS Chief Actuary projected that the PPACA cuts would cause a decline in MA enrollment of one-third by 2017.⁶

A second example of the PPACA's peremptory dismissal of a vision of older persons as potentially intelligent consumers regarding their own health care coverage is evident in the matter of the Independent Payment Advisory Board (IPAB). The IPAB is one many dozens of new governmental bodies⁷ established by the PPACA to centralize power over major features of health care financing and delivery in the United States. The PPACA places faith in this Presidentially-appointed, unaccountable bureaucracy to allocate health resources better than marketplace participants such as patients and their physicians.⁸ Specifically, the IPAB is charged with submitting recommendations for containing Medicare costs to Congress for an up-or-down vote, with the recommendations automatically going into effect unless Congress adopts an equivalent plan. The IPAB's recommendations are not subject to any judicial or administrative review. Neither would there be opportunity for any input or review by the Medicare beneficiaries whose coverage details would be dictated by those recommendations.⁹

Alternative Proposals

Images of the Aged

In stark contrast to the negative, needy vision of aging lying at the heart of the PPACA's rejection of individual choice, alternative policy proposals embodying a more positive vision of older individuals and their capacities have been set on the table for consideration. The most significant of these proposals, predicated on the idea of older persons as adults presumed to be capable of autonomous action, would change traditional Medicare's defined benefit structure into a defined contribution opportunity for individual control.¹⁰

The Debt Reduction Task Force and Bipartisan Policy Center established (and immediately abandoned) by the Obama administration suggested transitioning Medicare to a premium support program under which the government would purchase health care coverage from private insurers on behalf of Medicare beneficiaries, while maintaining traditional defined (by the federal government) benefit Medicare as a default option.¹¹ At the same time, former Congressional Budget Office Director Alice Rivlin and Congressman Paul Ryan issued a bipartisan proposal under which people who become eligible for Medicare after 2021 would receive a voucher from the government to directly purchase private health insurance.¹²

These two proposals served as precursors for the proposal issued on January 27, 2011 by Congressman Ryan in his capacity as Chair of the House Budget Committee.¹³ Under this premium support proposal, “When younger workers become eligible for Medicare, they will be able to choose from a list of guaranteed coverage options, enjoying the same kind of choices in their plans that members of Congress enjoy today. Medicare would then provide a payment to subsidize the cost of the plan.” (p. 25)

Although it has been labeled as such by its critics, the latest Ryan proposal is not radical. It builds on and fits compatibly with several existing models of publicly funded benefit programs that respect, empower, and depend upon the informed, voluntary, and competent exercise of private choice rights by individuals. Consequently, adopting a premium support approach to Medicare would be less a departure from the status quo than a conforming to successful examples of what is already demonstrably working.

One prominent example may be drawn from the Medicare arena itself. The 2003 MMA, besides creating the MA program under Medicare Part C, also added Part D to establish limited coverage (expanded by the PPACA) for certain prescription drugs. In passing this legislation,

Congress set up a program for older Americans that allows Medicare beneficiaries to select their own drug plans from the offerings in the competitive private marketplace and have the federal government subsidize the cost of the plan selected by the beneficiary. This arrangement has worked well. One might question why the same older individuals who (with informational and social support) are able to navigate the complicated waters of prescription drug plans are—across the board—too hopelessly feeble-minded to pick intelligently among comprehensive health plan alternatives.

An even larger and better established example of publicly financed consumer direction is that of the Social Security Old Age, Survivors, and Disability Insurance (OASDI) program.¹⁴ Although the OASDI program does not trust participants to individually invest or manage the funds they pay into the program through mandated Federal Insurance Contributions Act (FICA) payroll tax deductions, it does trust participants enough to provide them with their benefits in the form of cash payments that the beneficiaries are free to spend as they please. It is logical to ask why the same individuals (most of them past retirement age) who can be trusted to make unconstrained spending decisions about the disposition of their government issued OASDI checks ought to be categorically classified as incapable of managing their own health care coverage dollars. A similar query might be posed regarding treatment of beneficiaries of the federal Food Stamp program, in whom legislators apparently have sufficient confidence to pay government benefits in the form of cash-equivalent vouchers that can be spent at the program beneficiary's discretion within extremely broad limits.¹⁵

Increasingly, Medicaid waiver dollars and dedicated state appropriations are being used to finance consumer directed forms of home- and community-based long term care. Through programs such as Cash and Counseling, older individuals across the United States have proven

their ability (with appropriate assistance) to manage their public benefits in the context of hiring, supervising, and managing their own service providers.¹⁶

Finally (although this list is not exhaustive), the defined contribution nature of the Ryan proposal is modeled on the longstanding, popular Federal Employees Health Benefits Program (FEHBP). Under that arrangement, the federal government subsidizes the payment of premiums to private health insurers selected by individual employees on the basis of competitive factors that are material to the particular employee. There is no good reason to devote public resources to respect and enable the choice-based privileges of federal employees but to deny similar health care coverage selection opportunities to older individuals solely on the basis of age.¹⁷

Ethical Considerations

Most of the debate to date has concentrated on the relative economic and political merits and flaws of the PPACA versus a defined contribution approach to health care coverage for older Americans. However, there are also powerful ethical arguments that favor the defined contributions approach. These arguments come into focus when we realize that the paramount issue is accomplishing the goals or fulfilling the social covenant of the Medicare program—namely, health security for older Americans—rather than preserving the Medicare program in all its current detail for its own sake.

Both approaches to Medicare serve the principle of social justice by redistributing resources to assure universality of coverage and pooling risk to avoid the problem of adverse selection. By guaranteeing health care coverage to all older Americans, both approaches also serve the principle of beneficence or doing good.

The ethical distinction, however, concerns the principle of autonomy. The PPACA essentially treats the aged, insofar as health care coverage is involved, as wards of the state to be protected against all risks (even assuming *arguendo* that a government defined benefit program subject to national debt crises and political machinations could ever provide such protection). By contrast, “[d]efined contributions (at any level) require more choice and therefore are less paternalistic than defined benefits.”¹⁸ The defined contribution approach envisions the main role of government as economically empowering older individuals so that everyone has reasonable access to marketplace participation.¹⁹ Thus, this latter approach both promotes individual self-determination and improves the social status of older persons by using public policy to send an unambiguously positive message about trust in the capacity of most elders to responsibly make decisions about the most important matters in their respective lives.

Caveats

To be ethically praiseworthy, a defined contribution approach to health security for older Americans cannot equate to unadorned Social Darwinism. Government would need to retain several roles to assure that Medicare’s original social covenant is served.

First, a marketplace only works properly when it is populated by informed consumers. It would be essential to make certain that older individuals are provided with access to sufficient information, education, and assistance so they can use their economic empowerment knowledgeably. Second, a marketplace only works properly when it is populated by consumers with meaningful purchasing power; under a valid defined contribution plan, the government subsidies would need to be sufficient in size to empower older consumers to buy worthwhile

health care coverage products and adjusted in amount for beneficiaries with the greatest financial need and health risks.

The pervasive, paternalistic command and control form of regulation characterizing the traditional Medicare program and expanded by the PPACA is objectionable on beneficiary autonomy grounds. Reasonable or smart, targeted regulations, though, may simultaneously balance the ends of promoting beneficiary autonomy and a positive vision of the aged, on one hand, and responsibly safeguarding both beneficiaries who really need assistance and the public dollars we spend on behalf of those beneficiaries, on the other. Such smart regulation should encompass, in broad terms, such matters as what services may be purchased with designated public dollars (e.g., health care versus television repair), from whom services may be purchased (e.g., licensed versus unlicensed personnel), how services may be marketed to consumers, the sale of health insurance policies across state boundaries, guaranteed insurability regardless of the applicant's medical condition or history, and protection for older persons who—in fact in their specific cases—lack capacity to make autonomous choices.

Conclusion

Law and public policy in the United States reflects a schizophrenic, sometimes negative, attitude about older Americans and their capacity for self-determination. The present debate about the future of public financial support for health care of our aging population, pitting the PPACA central planning and control paradigm against a defined contribution approach, gives us the chance to adapt social policy to redefine a coherent image of older age in America. We can treat, as does the PPACA, older persons as categorically in need of government protection from their own choices. Or, we can acknowledge that there are wide variations within the older

population for which exceptions must be made, but nonetheless adopt and convey, as does the defined contribution approach to health care financing, a general image of older Americans as a group that is overwhelmingly still robust and capable of self-determination.

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