"Obama Lies, Grandma Dies": The Uncertain Politics of Medicare and the Patient Protection and Affordable Care Act

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As savvy researchers, we Googled our topic: "Obama and Medicare." Our first hit was zazzle.com, which advertised a bumper sticker with an older woman in a wheelchair hurtling down a slope with the caption "Obama Lies, Grandma Dies."[1] The bumper sticker captures the politics of health care reform and Medicare. In the summer of 2009, congressional town hall events became shouting matches over health care reform, and the Medicare program found itself front and center in the political battle. Here are snapshots from August 2009:

> Snapshot 1:
> During Representative Dave Loebsack's (D-IA) sixteen scheduled town hall meetings in Iowa's 2nd Congressional District, his largest and most raucous stop was the first in Cedar Rapids, where more than five hundred people crammed into an auditorium. Even before Loebsack entered the room, Emma Nemecek, a Mount Vernon Republican who launched two prior unsuccessful campaigns for the Iowa House, drew applause and boos as she paraded with a sign that read, "Obama Lies, Grandma Dies" (Waddington 2009).

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1. See www.zazzle.com/obama_lies_grandma_dies_bumper_sticker-128299054886449359.

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Snapshot 2:
Former Alaska governor Sarah Palin posted on Facebook: "The America I know and love is not one in which my parents or my baby with Down Syndrome will have to stand in front of Obama's 'death panel' so his bureaucrats can decide, based on a subjective judgment of their 'level of productivity in society,' whether they are worthy of health care" (Palin 2009).

The controversy over the proposed Medicare funding of end-of-life counseling reflected Americans' deepest fears about the federal government's role in health care. But following adoption of the 2010 Patient Protection and Affordable Care Act (ACA), Republicans compounded these fears by using Medicare-related provisions in the ACA as grounds for attacking Democrats in the 2010 midterm elections. Republican candidates claimed that the law would gut the program by cutting $500 billion. Claiming that the law only slowed spending, Democrats accused Republicans of distortion (Serafini 2010). As in prior health care debates, both parties used these and other reform provisions to engage in partisan warfare. By stimulating seniors' political interests, changes to the Medicare program can transform a demographic category into a politically relevant group that is the object of political parties' efforts to mobilize voters (Campbell 2003).

But partisan politics fills an information gap for seniors. In a 2010 poll, only half of seniors polled (50 percent) are aware that the new law will gradually close Medicare's "doughnut hole." Only 14 percent of seniors know that the ACA extends the life of the Medicare Trust Fund, while nearly half (45 percent) of seniors think the health reform law weakens the program's financial condition (Kaiser Family Foundation 2010a). More problematic for Democrats, a sizable portion of seniors think that the law will both cut Medicare benefits (50 percent) and allow a government panel to make decisions about end-of-life care (36 percent) (ibid.).

It feels like only yesterday when hopeful liberal health care reformers were calling for universal health coverage with the popular Medicare program as a model or even the centerpiece — what the late Senator Ted Kennedy termed "Medicare for all." Economist and columnist Paul Krugman wrote a series of pieces calling for a single public insurer like Medicare (Krugman and Wells 2006; Krugman 2007). Jacob Hacker and Marc Schlesinger (2004; Schlesinger and Hacker 2007) argued that Medicare must be at the center of health reform — that expanding coverage to the uninsured through Medicare would powerfully link the health security of the aged and nonaged.

By 2010, Medicare and the ACA were connected, but not in the way many reformers had envisioned. The ACA affects the Medicare program in several ways, but the most critical connection is that "reductions" in Medicare spending are funding the expansion of coverage for the uninsured.[2] The Congressional Budget Office (CBO) estimates that the ACA will save the government a net $428 billion in Medicare spending over the first ten years, with annual Medicare spending growing about 5.5 percent, instead of 6.8 percent (Congressional Budget Office 2010a; Joint Committee on Taxation 2010). As one Associated Press reporter puts it, "Medicare is looking like a big fat piggy bank for health care overhaul" (Alonso-Zaldivar 2009). Medicare and ACA-style universal coverage are intertwined, but the political consequences of this shotgun marriage could be unclear for years to come. Here is a review of the key changes and their ongoing political uncertainty.

1. The "Base-Closing" Solution: Congress once created a base-closing commission to provide an objective, thorough, and nonpartisan review of the military installations slated for closure. In effect, Congress outsourced the political pain of military downsizing. The ACA established an independent payment advisory board to recommend ways to reduce spending if Medicare per capita spending exceeds certain targets. Beginning in August 2014, the Department of Health and Human Services (HHS) is required to implement recommendations unless Congress enacts alternative changes that provide the same level of savings (Kaiser Family Foundation 2010b).[3] The CBO estimates that the advisory board will achieve $15.5 billion in Medicare savings between 2010 and 2019, with all savings realized between 2015 and 2019. Given the history of (no) reductions in physician reimbursements, will either Obama's HHS or Congress want to impose real or perceived pain prior to the 2014 general election? Our guess is no.
2. Will Seniors Understand Medicare "Reductions" to Private Health Plans? Payment reductions to Medicare Advantage (MA) plans are predicted to decrease Medicare outlays by an estimated $136 billion by 2020 (Kaiser Family Foundation 2010c).[4] MA plans are private health plans that provide enhanced benefits to seniors but that are

2. For critiques on ACA cost-control efforts more broadly, see essays by Rice, Oberlander, and Pauly, all in this issue.

3. See Jost in this issue for further discussion on the development of agency discretion separate from congressional decision making.

4. The analysis is from the Congressional Budget Office 2010b.

also subsidized by the federal government. These changes are but another salvo in a long political conflict over, and competing visions of, the role of private health plans in Medicare (DeParle 2002; Berenson and Dowd 2009; Oberlander 2003). In the 1990s, Republicans saw private plans as a way to, among other things, enhance consumer choice and save costs. It was perhaps inevitable that a Democratic-controlled Congress would reverse ideological course and trim subsidies to these plans. While the Medicare Payment Advisory Commission estimates that MA on average costs taxpayers 14 percent more than traditional Medicare (Medicare Payment Advisory Commission 2009), 11.8 million Medicare beneficiaries, nearly one-quarter of the Medicare population, are enrolled in MA plans (Kaiser Family Foundation 2010c). Moreover, the chief actuary for the Center for Medicare and Medicaid Services (CMS) warns that the MA reductions will result in "less generous benefit packages" in 2011 (Foster 2010). For seniors enrolled in MA plans, costs are estimated to go up by hundreds of dollars on average in the coming years. Individual pain in the short term for nearly one-quarter of the Medicare population yields the gain of "aggregate" spending reductions in the long term: politically speaking, a dangerous equation.

3. Squeezing Grandma's Providers? The ACA reduces annual payment updates for hospitals, long-term care hospitals, rehabilitation facilities, psychiatric hospitals, home health agencies, skilled nursing facilities, hospices, and other nonphysician providers for an estimated savings of $196.3 billion over ten years (Congressional Research Service 2010).[5] As the CMS begins to estimate the financial impact for Medicare-participating hospitals, will Republicans claim that "Obamacare" is squeezing Grandma's local providers? And although the ACA does not address the ongoing issue of physician reimbursements, is it unreasonable to assume that seniors will conflate any (threatened) reductions to physicians with these health care reform provisions? According to John Rother of the AARP, "This has given Republicans a way to talk about positioning themselves as defenders of Medicare, which is quite unusual" (Serafini 2010).
4. After the Pain, Will Seniors Feel the Gain? Despite the real "reductions" in Medicare spending, seniors will see a number of new benefits materialize over time. According to Ron Pollack of Families

5. On ACA and Medicare physician payment reforms, see Laugesen in this issue.

USA, "Democrats who supported the law must let people know how it helps Medicare beneficiaries" (Serafini 2010). The following are potential benefits:

- The ACA phases in coverage of the Medicare Part D coverage gap or "doughnut hole."[6] After providing a $250 rebate to seniors in 2010, the ACA requires drug companies in 2011 to give a 50 percent discount on brand-name drugs, and the law subsequently phases in coverage for both brand-name and generic drugs. By 2020, Part D beneficiaries will be responsible for only 25 percent of the cost of drugs in the coverage gap (Kaiser Family Foundation 2010c). But only 10 percent of beneficiaries are now in the doughnut hole.
- Medicare will now cover comprehensive wellness visits and personal prevention plans (Kaiser Family Foundation 2010c).[7] Also, incentives are provided for better quality in services and for extension of services in underserved areas.
- The ACA also includes a number of pilot and demonstration programs, including bundling post–acute care payments, value-based purchasing for providers, and the establishment of accountable care organizations that would share in cost savings. The law creates a new Center for Medicare and Medicaid Innovation within CMS, and it establishes a new office within CMS to improve the integration of care for beneficiaries eligible for both Medicare and Medicaid.[8] As Janus and Brown (2007) note, Medicare has been an important but underappreciated innovator for the U.S. health system. We suspect that the ACA's innovations will suffer from a similar underappreciation.

If seniors perceive the concentrated losses to their Medicare program, will they also see the diffuse and gradually accruing benefits? Republicans have a strong incentive to ensure that seniors notice the immediate pain and not the gradual gain.

6. Enacted as part of the 2003 Medicare Modernization Act, Part D provides 75 percent of the coverage of prescription drugs up to $2,830 (the 2010 limit) after an initial deductible of $310, above which retirees are responsible for 100 percent of costs up to $4,550, which then triggers catastrophic coverage. Then, seniors are responsible for a co-pay of $2.40 for each generic drug and $6.00 for other drugs (or 5 percent, whichever is higher). See Kaiser Family Foundation 2005.

7. For details on ACA provisions related to health promotion and prevention, see Pollack in this issue.

8. On the topic of potential innovations, see Luft on accountable care organizations (ACOs) and Gusmano on cost-effectiveness research (CER), both in this issue.

5. Other Winners and Losers? Interest groups will be differentially affected, but the complexity of the Medicare-related changes makes it difficult to say how these changes will play out in terms of politics and policy.
   - Some suggest that reducing payments to hospitals, as discussed above, will cause hospitals to suffer (Saving and Goodman 2010), but others argue that hospitals can make money on Medicare through attention to efficiency and quality outcomes as well as from the increase in coverage (Mahar 2010b; Hackbarth 2009).
   - The health insurance industry may change some with the reductions to MA. Some carriers receive substantial income from MA, and the economic downturn has weakened the employer-based insurance market (Mahar 2010a). On the other hand, insurance firms will likely gain from the new exchanges and enrollees in Medicaid, so the overall effects will vary.
   - The pharmaceutical industry may have avoided government-negotiated drug prices, and it gained a larger market with the increase in coverage. While drug manufacturers shoulder the 50 percent discount for prescriptions covered under the doughnut hole, some suspect that firms will raise drug prices (Hilzenrath 2010).
6. Medicare Catastrophic Coverage Act Redux? The 1988 Medicare Catastrophic Care Act (MCCA) engendered a political backlash among older voters who resented financing new benefits, including a drug benefit (Himmelfarb 1995; Marmor 2000). The MCCA appeared to reflect a consensus for expanding social insurance in an era of high budget deficits. But the MCCA's substantial costs fell heavily on the seniors who were the program's biggest constituency. As Democrats were to learn, however, many seniors were content with existing coverage and resented a new tax to fund the new benefits—costs that kicked in before many of the benefits.

Will a similar politics unfold? The ACA increases the Medicare Hospital Insurance payroll tax from 1.45 to 2.35 percent on high-income individuals and couples, for an increase in revenue of $87 billion through 2019.[9] Thus, unlike the MCCA, the ACA's increase in the payroll tax broadens the burden to all high-income workers young and old, but high-

9. For further discussion of this form of progressive financing, see Rice in this issue.

income seniors also will pay a new Part D premium based on income. Moreover, as discussed above, health reform gains for Medicare may be imperceptible to the average beneficiary, while losses are up front and/or prominent. Sound familiar? "Based on Washington's record of health policymaking, ending or rolling back Obama-care is hardly implausible. The [MCCA] was enacted with huge bipartisan support in both the House and Senate and repealed one year later" (Moffit 2010).

In August 2009, the National Committee to Preserve Social Security and Medicare (2009), attempted to improve public understanding and answer the following questions:

- How can a half-trillion-dollar cut to Medicare not possibly hurt the program?
- What about death panels?
- Aren't we going to end up with health care rationing for seniors?
- I'm in a Medicare Advantage plan and am very happy with my coverage. My insurance company tells me these bills are going to take away my plan.
- Wouldn't it be better just to fix the Medicare program by itself?

Too many seniors are still uncertain of the answers to these questions. The economy still looms largest in voters' minds, but health care reform is right behind the economy in their list of concerns (Blendon and Benson 2010).

The nation's most prominent health economists suggested at the start of the health reform debate that "fiscally responsible health reform requires budget neutrality or deficit reduction over the coming years" (Rampell 2009). For some seniors, however, the bumper sticker vision of "fiscally responsible health reform" is an older woman in a wheelchair speeding downhill.

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