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Medicare and Political Analysis: Omissions, Understandings, and Misunderstandings

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I. Introduction

The focus of this Article requires some explanation. It is not a recapitulation of the patterns of Medicare's politics from enactment in 1965 to the present (2003). That is the subject of Jonathan Oberlander's other article in

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this issue. Nor is the main focus on projections of Medicare's future politics, a daunting topic addressed only briefly here. Instead, the Article aims to make sense of the scholarly literature on the Medicare program and its politics by distinguishing among (and discussing) three categories of commentary:

> (1) Program and policy discussion without political analysis: the literature of straightforward omission.
>
> (2) Program and policy discussion with serious political analysis: the literature of commendable commission.
>
> (3) Program and policy evaluation that purports to incorporate political analysis, but fails to do so credibly: the literature of regrettable misunderstanding.

Why focus on the existing Medicare scholarship and, in particular, the quality of political analysis in that literature? Our fundamental premise is that the Medicare program is regularly misunderstood through ignorance of its political history, confusion about its fundamental values, and distortion of the program's choices by unsubstantiated presumptions about what Medicare's purposes were supposed to be. The future of Medicare is certain to be a matter of political concern in the decade ahead. Prudent reform depends crucially on clarifying what the program does and does not do. That, in turn, requires attention to Medicare's central social aims, actual historical experience, and recognizable political identity. Our literature search revealed serious difficulties on all three counts.

Our survey of the Medicare literature illustrates just how often Medicare is misunderstood and how rare cogent analysis of its politics is. If the public debate on Medicare is to be improved in these respects, we need to identify and understand common misconceptions about the program and explain their apparent staying power. That is the aim of this Article.

II. The Literature of Straightforward Omission: Program and Policy Discussion Without Political Analysis

The dominant literature on Medicare is what many call health services research.[1] The great majority of researchers working on Medicare understand the program predominantly from the perspective of systematic policy analysis

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1. This section on health services research draws on Jonathan Oberlander, Medicare and the American State: The Politics of Federal Health Insurance, 1965–1995, at 14–20 (1995) (Dissertation, Yale University) (on file with the author).

and consequently view public policy largely as collective problem solving. Often trained in economics, they have produced a vast literature on the impact of Medicare payment policies, the structure of its benefit package, and the economic behavior, demographic characteristics, and financial state of Medicare beneficiaries.[2] This line of scholarship suggests that if there were more factual understanding of Medicare's circumstances, the quality of problem solving would improve. And this work presumes that public policy can and should be studied as a matter of objective, technical inquiry.

Health services research rests on the assumption that policy is separable from politics. This is, as we will argue, in most respects an unsustainable division. The technocratic perspective has at least three consequences for understanding Medicare politics that we want to highlight. The first is that the politics of Medicare is willfully ignored. Since the two phenomena of policy and politics are presumed to be distinct, the analysis of policy, as a matter of division of labor, need not explicitly attend to political analysis. Medicare policy in this tradition is discussed independently of American political institutions, interests, and ideologies.

The literature on Medicare's reform of its system for paying physicians is an illuminating case in point. In 1989, the federal government replaced the existing method of paying physicians retrospectively for their costs with a prospectively determined fee schedule. The fee schedule—officially the Resource Based Relative Value Scale or RBRVS—was organized around the relative values assigned to all services that physicians provided. These valuations in turn were based on estimates of the resources (e.g., time, training, complexity) required by each service.

Health services researchers seriously debated whether the new payment scale accurately reflected differences in physician effort and if it represented an efficient means of reimbursement.[3] They never, however, raised obvious questions about the politics of the payment scheme: how did it change the balance of power in Medicare policymaking?; which interests and institutions did it advantage?; what were the implications for democratic accountability of adopting a highly complex payment system dependent on bureaucratic

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2. Major works on Medicare policy include DAVID BLUMENTHAL ET AL., RENEWING THE PROMISE: MEDICARE & ITS REFORM (1988); KAREN DAVIS & DIANE ROWLAND, MEDICARE POLICY: NEW DIRECTIONS FOR HEALTH AND LONG-TERM CARE (1986); MARILYN MOON, MEDICARE: NOW AND IN THE FUTURE (1993); LESSONS FROM THE FIRST TWENTY YEARS OF MEDICARE (Mark V. Pauly & William L. Kissick, eds., 1988); and MEDICARE REFORM: ISSUES AND ANSWERS (Andrew J. Rettenmaier & Thomas R. Saving eds., 1999).

3. WILLIAM C. HSIAO ET AL., FINAL REPORT: RESOURCE BASED RELATIVE VALUE SCALES OF SELECTED MEDICAL AND SURGICAL PROCEDURES IN MASSACHUSETTS (1985).

expertise?; why had the U.S. cloaked a fee schedule for Medicare in such highly technical terminology when other nations such as Canada and Germany did so via straightforward political bargaining and negotiation between providers and payors?[4] In short, the evaluative literature largely ignored the political implications of payment reform.

Marilyn Moon's *Medicare: Now and In the Future* provides another clear illustration of the literature of omission.[5] Moon's intent is to provide an overview of the program since its enactment in 1965. She aims to explain this "fascinating and complex healthcare program" on the presumption that it is "often not well understood."[6] In this task, Moon succeeds brilliantly, providing a lucid account of the policy challenges confronting Medicare.

A striking feature of this volume is its mix of clear description and political inattention. So, for example, Moon deftly describes the program's expansion of beneficiaries in the 1970s from an elderly constituency to both the disabled and those suffering from renal failure. Her book uses Medicare's fiscal realities to criticize two myths that appear regularly in Medicare debates. She notes correctly that after 1985, Medicare's annual rate of increase in per capita expenditures fell below that of private health insurance outlays for comparable coverage. Secondly, she debunks the claim that increasing numbers of Americans over sixty-five "must be a major factor in Medicare's growth."[7] With the number of beneficiaries at that time increasing by 1.1 percent per year, aging could not possibly account for the much larger annual growth in Medicare's expenditures. Moon's book is a financial and demographic account that sets the record straight on many key topics.

What Medicare spent, to whom and for whom, is what this book illuminates best. Moon's analysis is a comprehensive and compelling account of policy issues in Medicare reform, past and present. Yet, when discussing Medicare's possible future, Moon's analysis proceeds as if one were discussing the United States as a person, someone facing a set of future developments and wondering what would be best to do. Indeed, this mode is hardly restricted to Moon's volume, but rather is characteristic of the great bulk of contemporary

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4. *See* William A. Glaser, *Designing Fee Schedules by Formulae, Politics, and Negotiations*, 80 AM. J. PUB. HEALTH 804, 806–08 (1990) (pointing out the inherent limitations of the Harvard RBRVS).

5. *See generally* MOON, *supra* note 2 (providing an overview of Medicare's finances and programmatic development since 1967).

6. *Id.* at xv.

7. *Id.* at 23. *See also* MARILYN MOON, MEDICARE NOW AND IN THE FUTURE 25 (2d ed. 1996) (updating the data on aging). Between 1982 and 1996, the number of Medicare beneficiaries rose at a rate of 1.9%, suggesting that the aging of the population is not a major contributor to Medicare's growth. *Id.*

policy analysts. The political world in which programs operate is acknowledged, but not analyzed, and sophisticated policy analysis is not matched by the same commitment to political analysis. Instead, the approach is to start with the nation as a person, ask what are the problems at present, and assume that rational agents will review options and choose sensible means to agreed-upon ends. Moon, like others in this craft tradition, knows this is unrealistic. (In fact, she uses the term "messy" to describe the fight over catastrophic coverage in 1988–1989).[8] But, that does not carry over into explicitly taking the political advantages and disadvantages of options—past, present, or in the future—into account.

Not surprisingly, the citations of work in this policy analysis tradition overlook most of the political analysis of Medicare that has been published. As justification, analysts like Moon might well contend that disciplinary specialization has important benefits and that economists like her should write about what they know best. After all, it is better to leave out misunderstandings than, as we shall see in the discussion later, to generate political myths. As noted, Moon is not at all atypical in her inattention to political analysis. Indeed, it is possible to pick almost any health services research journal and find articles on the past, present, or future of Medicare that exhibit the same pattern. Consider, for example, the 1999 article, *Restructuring Medicare for the Next Century: What Will Beneficiaries Really Need?*, by Christine Cassel et al.[9] This exercise in futurology notes the "tight political and fiscal constraints surrounding Medicare reform," but leaves the matter there.[10] It describes unrealistically only two choices (for the nation?):

> One option would allow current and future generations to enter the existing system of fragmented and poorly prioritized care, which has proved to impose heavy cost burdens on families and society. The other would structure health care policy in a way that promotes healthy and successful aging, enabling older adults to remain productive and independent.[11]

This dichotomy is a rhetorical device. It is neither a realistic choice nor a forecast of the political and economic circumstances in which the favored direction might be actually chosen. The aim is to defend one particular policy option, not to estimate what it might take to have that option adopted or implemented. As a vision of what Medicare might be, this normative stance is

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8. MOON, *supra* note 2, at xvi.

9. Christine K. Cassel et al., *Restructuring Medicare For the Next Century: What Will Beneficiaries Really Need?*, HEALTH AFF., Jan./Feb. 1999, at 118, 118–31.

10. *Id.* at 119.

11. *Id.*

perfectly understandable. As a policy option whose prospects are understood, it lacks the understanding of what political context might favor the proposed change in Medicare's operations.

A second consequence of the technocratic perspective embodied by health services research is that the assumption that policy analysis should be undertaken separately from political analysis occasionally slips into the analytic assumption that policy is made—and therefore can be explained—without politics. Medicare policy is interpreted as technical responses to technical problems; efficiency substitutes for politics as explanation of how policy change occurs. To wit, in Arnold Epstein and David Blumenthal's account of physician payment reform, the "[r]ecognition of deficits in the CPR methodology" motivates policymakers to reform Medicare.[12] The authors dubiously cite methodological deficiencies as more important to the adoption of payment reform than the federal budgetary deficits that propelled policymakers' interests in Medicare during the 1980s.

If analysts explain Medicare primarily as a rational process of responding to the imperatives of efficiency, they overlook critical questions: how do issues come to be considered policy problems?; how do we account for the timing and form of policy proposals?; and what explains the relative political attractiveness of policy solutions? These are questions about the politics of ideas and the construction of policy issues and alternatives that a rationalist perspective on Medicare cannot answer, and usually does not ask.

A final consequence of the separation of policy from politics is the normative conclusion that policy should be separated from politics. Policy analysts often deplore the distorting impact of politics on their carefully designed policy solutions. There is palpable frustration that the political world will not accept the expert advice that the policy world offers. Policies are interpreted as failing to achieve their goals because politics prevents their adoption in the required form or ruins its implementation.

As a result, the policy prescriptions of health services researchers sometimes seek to quarantine policy from politics. Thomas Rice and Jill Bernstein exemplify this tendency in their 1990 discussion of an ideal reimbursement system for Medicare. They explain that "creation of an objective, fair way to establish performance standards [for setting limits on Medicare payments to hospitals and physicians] would minimize political influence," while the task remains of "ensuring that this formula rather than

12. Arnold Epztein & David Blumenthal, *Physician Payment Reform: Past and Future*, 71 MILBANK Q. 193, 196 (1993). "CPR" refers to Medicare's original system of paying physicians on the basis of their customary, reasonable, and prevailing charges. *Id.* at 194.

political influence is the driving force behind the standards and fee updates."[13] Medicare, in other words, must be isolated from politics if it is to operate efficiently. This conclusion leads the authors to favor a payment policy controlled by formula rather than by politics.

The attraction of policy analysts to politically-immune policies is grounded in economic understandings of politics. Economists tend to see public policies as the product of the preferences of social interests whose political power is in turn a function of their economic power.[14] Political institutions do not occupy a prominent place in these scholars' analyses and there is little consideration given to the independent potential of government actors to act apart from and even against the agenda of social interests. Nor is there attention to the role of ideas in the policy process. Policymaking is instead understood as driven by the pathologies of interest group politics. In the language of political economy, rent seeking economic interests influence governmental policy in order to maximize their financial welfare. The result is widespread skepticism about government regulation, preference for market solutions, and, where policies do reside within the government's sphere, preference for policies and institutions that are shielded from political influence.[15]

The failure, then, of much of the Medicare literature to attend to politics is not simply a failure of explanation. If prescription is the aim of policy commentary on Medicare, it is difficult to justify ignorance of the political institutions and circumstances through which policies are chosen and implemented. Useful policy analysis ultimately depends on political analysis, just as good political analysis must be informed by policy analysis. The disjunction between Medicare policy and politics is intellectually unsustainable. An understanding of Medicare requires knowledge of its politics because what has taken place and will take place emerges from the central political institutions of American government.

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13. Thomas Rice & Jill Bernstein, *Volume Performance Standards: Can They Control Growth in Medicare Services?*, 68 MILBANK Q. 295, 310 (1990).

14. *See* Mark V. Pauly, *Positive Political Economy of Medicare, Past and Future, in* LESSONS FROM THE FIRST TWENTY YEARS OF MEDICARE 49, 49–71 (Mark. V. Pauly & William L. Kissick eds., 1988) (developing an economic perspective on Medicare politics).

15. *But see* THOMAS RICE, THE ECONOMICS OF HEALTH RECONSIDERED 3 (1988) (arguing against the majority of American health economists who privilege market based health policies and contending that "one of the main reasons for the belief that market-based systems are superior stems from a misunderstanding of economic theory as it applies to health"); ROBERT EVANS, STRAINED MERCY: THE ECONOMICS OF CANADIAN HEALTH CARE 5 (1984) (providing an example of how, outside the U.S., faith in market-based systems of health care is less homogeneous).

Indeed, there is an argument that policy studies should take as their aim the narrowing of disagreement about what are the actual states of affairs, the elucidation of competing values represented in alternate courses of action, and the sensitizing of policymakers and other audiences to complex considerations that lie below the noise of policy warfare. "The contribution [to shaping public policy] is likely to come through more informed debate, more substantial argument, and more reasoned limits on unrealistic alternatives, not wholesale transformation of the processes of policy-making."[16]

III. The Literature of Commendable Commission: The Political Analysis of Medicare

This category of commentary is much less extensive than the apolitical approaches just discussed. One striking feature of the scholarship on Medicare's politics is the sharp disjunction between the substantial attention paid to the program's origins and the relative inattention to the politics of Medicare in operation. In the decade of the 1960s, a number of books discussed the legislative battle over what came to be known as Medicare.[17] In the three decades and more since, few books have sought to reinterpret the story of how Medicare came to legislative enactment. Sheri David's 1985 account is one, and Lawrence Jacobs's 1993 comparative study of the role of public opinion in the birth of Medicare and the British National Health Service is the other.[18] Both raise issues worth attending to in contemporary discussions of Medicare reform.

David contends that "[b]efore [the United States] can sensibly proceed to solve present and future health care problems," there must be an examination of

16. *See* Theodore Marmor, *Policy Analysis*, 6 J. OF POL'Y ANALYSIS AND MGMT. 112, 114 (1986) (reviewing three books on policy analysis); *see generally* DUNCAN MACRAE, JR. & JAMES A. WILDE, POLICY ANALYSIS FOR PUBLIC DECISIONS (Ch. 6) (1979) (discussing the conditions under which a policy alternative is likely to be enacted and implemented).

17. *See generally, e.g.*, THEODORE R. MARMOR, THE POLITICS OF MEDICARE (2nd ed., 2000) (discussing the debate over Medicare); M.J. SKIDMORE, MEDICARE AND THE AMERICAN RHETORIC OF RECONCILIATION (1970) (same); P.A. CORNING, THE EVOLUTION OF MEDICARE . . . FROM IDEA TO LAW (1969) (same); HERMAN SOMERS & ANNE SOMERS, MEDICARE AND THE HOSPITALS: ISSUES AND PROSPECTS (1967) (same); EUGENE FEINGOLD, MEDICARE: POLICY AND POLITICS (1966) (same); MARGARET GREENFIELD, HEALTH INSURANCE FOR THE AGED: THE 1965 PROGRAM FOR MEDICARE (1966) (same); RICHARD HARRIS, A SACRED TRUST (1966) (same); HERMAN SOMERS & ANNE SOMERS, DOCTORS, PATIENTS, AND HEALTH INSURANCE: THE ORGANIZING AND FINANCING OF MEDICAL CARE (1961) (same).

18. *See generally* SHERI I. DAVID, WITH DIGNITY: THE SEARCH FOR MEDICARE AND MEDICAID (1985) (interpreting Medicare's history); LAWRENCE R. JACOBS, HEALTH OF NATIONS: PUBLIC OPINION AND THE MAKING OF AMERICAN AND BRITISH HEALTH POLICY (1993) (same).

the "choices, options *and* compromises made during the entire Medicare debate."[19] An ample documentary account of those debates, David's book does not, however, make a persuasive case that understanding Medicare's origins is the necessary precondition for righting the wrongs of contemporary American medical care.

Jacobs's book is directly relevant to the politics of contemporary Medicare. His is a case study of the important role that public preferences and understandings play in creating health policy.[20] Jacobs relies on primary research to substantiate claims that the central political figures in the Medicare legislative struggle took (what they regarded as) public opinion into account.[21] Jacobs thus challenges the argument in the work of both Oberlander and Marmor that the mass public plays a minor (and largely restraining) role in the details of Medicare policy making.

Jacobs's findings, which were based on archival and interview sources, improve the understanding of developments that other commentaries ignore. He found, for example, important splits between the architects of Medicare in the Department of Health, Education, and Welfare (HEW) and fiscally cautious leaders in the Bureau of the Budget. The former favored conciliation and accommodation with American medical care providers—especially using private insurance companies as fiscal intermediaries—so as to make the road to their national health insurance dreams more likely. The latter—the federal budget officials—regarded the control of expected inflation as primary and thought the direct federal administration of Medicare would control costs more reliably. That was a fateful policy choice—a victory for HEW's accommodation policy. And, Jacobs's book reveals a hidden part of Medicare's administrative birth that remains an important issue today.

The political analysis of Medicare in operation has been modest in amount, almost all article length, and much less connected to the general features of American politics than was the case with the fight over the program's enactment. Jonathan Oberlander's book, published in 2003, is a recent development and his bibliography provides the basis for my generalization about the literature.[22]

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19. DAVID, *supra* note 18, at 156–57.

20. JACOBS, *supra* note 18, at 4.

21. *See id.* at 32–38 (finding that papers in the John F. Kennedy and Lyndon B. Johnson Presidential library files document the institutionalization of a public opinion apparatus in presidential decision making).

22. *See generally* JONATHAN OBERLANDER, THE POLITICAL LIFE OF MEDICARE (2003) (providing comprehensive political analysis of the development of Medicare since its enactment in 1965).

There are nonetheless a number of illuminating accounts of why the Medicare program has developed as it has. Timothy Jost's account of the administrative politics of Medicare—while concentrating on the role of courts—parallels the understandings of both the Marmor and Oberlander volumes about the patterns of policymaking. These include congressional domination of much of Medicare's policymaking, the prominence of fiscal politics in the period since 1983, and the relative weakness of public opinion in expanding Medicare's benefits and its relative strength in constraining large-scale reductions of benefits.[23] The importance of all three considerations in what Medicare's fate will be in the future makes this kind of work especially relevant to contemporary policy analysis.

Broader accounts of American politics in the 1990s provide additional understanding of the forces that shape Medicare's fate now and in the future. The work of Mark Peterson on changing patterns of congressional decision-making is one example.[24] Equally relevant is Lawrence Jacobs's and Robert Shapiro's recent scholarship on public opinion, which confirms the important role of the views of the mass public in constraining efforts to restrict Medicare's benefits and its lesser impact on other features of Medicare policymaking in the decade.[25] Also important is an article by Lawrence Brown in the Health Care Financing Review that explicitly addresses the theme of this essay: namely, the relative ease with which policy analysts describe the "problems" that "need" fixing and the truly complicated politics of Medicare reform in the first half of the 1990s.[26]

The purpose of this section is not to review the entire field of useful analysis of Medicare's politics. Rather, it is to sharply distinguish efforts that take politics into account and those that do not. David Smith's new book, *Entitlement Politics*, illustrates well the former category.[27] In dealing, for example, with how to explain the character of the Breaux-Thomas Bipartisan

23. Timothy Stoltzfus Jost, *Governing Medicare*, 51 ADMIN. L. REV. 39, 40 (1999).

24. Mark A. Peterson, *The Politics of Health Care Policy: Overreaching in an Age of Polarization*, *in* THE SOCIAL DIVIDE: POLITICAL PARTIES AND THE FUTURE OF ACTIVIST GOVERNMENT 181–229 (Margaret Weir ed., 1998).

25. *See generally* LAWRENCE R. JACOBS & ROBERT Y. SHAPIRO, POLITICIANS DON'T PANDER: POLITICAL MANIPULATION AND THE LOSS OF DEMOCRATIC RESPONSIVENESS (2000) (discussing the "partisan duel" over social policy in the 1990s).

26. *See* Lawrence D. Brown, *The Politics of Medicare and Health Reform, Then and Now*, 18 HEALTH CARE FIN. REV. 163, 164–68 (1996) (analyzing the political struggles that have shaped the debate over Medicare, past and present).

27. *See generally* DAVID G. SMITH, ENTITLEMENT POLITICS: MEDICARE AND MEDICAID 1995–2001 (2002) (examining partisan approaches to the future of federal health care entitlements).

Commission on The Future of Medicare in the late 1990s, Smith relies on the roles, personnel, and prior commitments of the actors.[28] He concentrates on explaining the commission, though he addresses the evaluation of policy options as well. The commission "as an exercise in bipartisan collaboration . . . was a dismal failure that, at best, provides cautionary lessons for the future."[29] Never "a serious effort to come together in a genuine bipartisan way," the commission, Smith rightly argues, was an "episode in the continuing struggle over the future of Medicare."[30] "[M]ost of the [commission's] appointees" were, in fact, "major players in that conflict, with strong political and program commitments of their own."[31]

Any appeal to bipartisan commissions in the future should attend to such a cautionary analysis. The same applies to interpreting the persistent appeal in contemporary Medicare debates to the advantages of "competition" in reforming the program. Smith's summary is contestable, but calls for serious analysis. "Despite the lack of systematic evidence or even persuasive argument," he contends, "confidence in the efficacy of market competition to constrain the costs of managed care plans seems to be an unexamined belief based upon occasional behavior, a few regional examples, or faith."[32]

Jonathan Oberlander has written the most comprehensive and extended account of what Medicare's politics have been like.[33] He divides the policies and politics into three categories: (1) disputes about benefit policies, with a pattern of what might be termed nondistributive politics;[34] (2) financing policy issues, where the pattern has been one of recurrent crisis politics;[35] and (3) federal payment policies, where the politics have centered on Medicare's impact on the federal budget.[36] Again, the point is not to explore the content of the patterns; Oberlander's article does that. Rather, it is to highlight the absence of such portraits in the conventional treatment of Medicare policy making.

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28. *Id.* at 350–51.
29. *Id.*
30. *Id.*
31. *Id.* at 353.
32. *Id.* at 354.
33. *See generally* OBERLANDER, *supra* note 22 (providing a comprehensive study of Medicare politics).
34. *See id.* at 36 (noting the lack of expansion in Medicare benefits).
35. *See id.* at 74 (discussing the various financing crises faced by Medicare).
36. *See id.* at 107 (discussing Medicare's payment practices and budget issues).

IV. The Literature of Regrettable Misunderstanding: Program and Policy Evaluation with Misleading Political Analysis

The current discussion of Medicare, like its history, includes considerable disagreement, with frustrating gaps between claims and evidence.[37] Here, we emphasize an especially important source of distortion, namely policy commentary that reflects careless and misleading political analysis. This problem is unmistakable in the arguments voucher proponents made in the debate over Medicare's future during the late 1990s.[38] In this section, we address four aspects of what we regard as myth-ridden debate: (1) the unsubstantiated invocation of public opinion to justify policy judgments; (2) misplaced confidence in long-term forecasts and inattention to the interaction of economic and political factors in forecasting; (3) contestable claims presented as "conventional wisdom"; and (4) explicit political analysis without understanding. We rely on arguments for vouchers to illustrate the problematic use of public opinion and the limits of political forecasting. Addressing misconceptions in the conventional wisdom and limited political analysis broadens our focus beyond vouchers. But, throughout, we aim to clarify the Medicare debate by approaching these topics as political scientists, a perspective too often absent from the larger national debate.

A. How Not to Use Public Opinion

Enthusiasm for converting Medicare into a system of voucher payments culminated, as noted, in the majority-supported proposal of the Breaux-Thomas Commission and its subsequent introduction as legislation.[39] To see how voucher advocates have justified these plans analytically, we turn to the work of economists Henry Aaron and Robert Reischauer, whose writings on vouchers have been especially extensive, if in the end still disappointing. The reputation for thoughtfulness of these scholars makes the imprecision of their Medicare

37. This section draws extensively on Theodore R. Marmor & Gary J. McKissick, *Medicare's Future: Fact, Fiction and Folly*, 26 AM. J.L. & MED. 225, 238–48 (2000).

38. *See* Theodore Marmor & Jonathan Oberlander, *Rethinking Medicare Reform*, HEALTH AFF., Jan./Feb. 1998, at 52, 53 (analyzing the proposed voucher plan). Under the Republican proposal, Medicare beneficiaries would receive a voucher to purchase health insurance from the private insurance market and this would replace the government-organized insurance Medicare currently provides. *Id.*

39. *See* NATIONAL BIPARTISAN COMMISSION ON THE FUTURE OF MEDICARE, BUILDING A BETTER MEDICARE FOR TODAY AND TOMORROW, *at* http://thomas.loc.gov/medicare/bbmtt31599.html (Mar. 6, 1999) (recommending changing Medicare into a premium support system) (on file with the Washington and Lee Law Review).

political analysis all the more troubling. Their 1995 *Health Affairs* article, *The Medicare Reform Debate: What is the Next Step?*,[40] is a particularly revealing illustration of misleading political analysis.

The scope of their article is quite broad: the proposal to convert Medicare "from a 'service reimbursement' system into a 'premium support' system."[41] They liken this proposal to "many that are now reshaping private employer-based insurance."[42] They purport not only to describe the technical issues that "cannot be solved quickly" and "preclude quick budget savings," but also to provide a brief history of Medicare and why it is unsustainable in its present form.[43] In short, they engage in historical characterization, political analysis, policy evaluation, and program forecasting. They also take pains to caution readers that "[t]he history of reforms in U.S. social policy is replete with exaggerated claims of the benefits the reform will produce. To muster enthusiasm, supporters of reform paint rosy pictures of the marvelous benefits that will ensue if only their recommendations are adopted."[44] They could have added that reform advocates regularly invent political analysis to bolster their claims of expertise. Aaron and Reischauer have many sensible things to say about how Medicare has operated and why cost savings are difficult under any implementable reform. However, their characterization of Medicare's political history and contemporary political circumstances is simply misleading.

The most striking feature of this kind of analysis is misplaced analytical confidence. Here we will summarize and focus on a subset of factual claims and their supposedly obvious "implications" to illustrate the weaknesses of this sort of political analysis.[45] The claim that Medicare's "popularity" is not only

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40. *See generally* Henry J. Aaron & Robert D. Reischauer, *The Medicare Reform Debate: What is the Next Step?*, HEALTH AFF., Winter 1995, at 8 (illustrating misleading political analysis).

41. *Id.* at 20.

42. *Id.* at 8.

43. *See id.* at 9–12 (using the history of Medicare to bolster their argument).

44. *Id.* at 27–28.

45. The claims we will analyze derive from two of the opening paragraphs of Aaron and Reischauer's examination of the Medicare reform debate in 1995. "Five central facts," the reader is told, "will shape the debate on the future of Medicare."

> First, Medicare enjoys overwhelming support among the American electorate, a popularity that is well deserved because the program has achieved all of its designers' major objectives. Second, the cost of providing Medicare benefits is projected to rise very rapidly and will exceed projected revenues by ever larger amounts. Third, legislative reform of the entire health care system is now off the political agenda and likely will remain so for years to come. Fourth, there exists a strong and broad consensus against raising taxes. Fifth, dramatic changes are taking place in the way health care is financed and delivered for the non-Medicare

"overwhelming" but "well deserved because the program has achieved all its designers' major objectives"[46] is clearly contestable. The authors cite no evidence to support their claims about the breadth and depth of the public's views.[47] While the work of Larry Jacobs and other public opinion scholars establishes that Medicare enjoys broad approval, that same work undercuts the easy connection between knowledge of the program (especially the extent to which objectives are understood to have been satisfied) and support for the program.[48] To the extent Medicare is broadly popular, that support mostly reflects a relatively superficial understanding of Medicare's role in helping America's elderly with large medical expenses.[49] Other than that, the public is largely uninformed.[50]

Nor can it be the case that the public is satisfied because the major objectives of Medicare's designers' have all been achieved. That, of course, is one of the major conclusions of the program's history: The key objective of

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population.

> The implications of these facts are straightforward. First, before changes are made in Medicare, policymakers will have to assure the general population and beneficiaries alike that the reforms will not compromise the attributes of the program that the public values so much. Second, Congress will have to act soon to restore Medicare's financial viability. Third, the measures that Congress adopts will not be part of any major legislative effort to reform the overall health care system. Fourth, most, if not all, of the budgetary savings on Medicare will come from reducing federal payments to providers and raising costs to beneficiaries, not from raising Medicare payroll taxes. Fifth, congressional reforms will—and should—bring Medicare more in line with the structure of health care financing and delivery that is evolving to serve the non-Medicare population.

Id. at 8–9.

46. *Id.* at 8.

47. *See* Theodore Marmor, *How We Got to Where We Are: American Health Care Politics, 1970 to 1990, in* UNDERSTANDING HEALTH CARE REFORM 21, 28–30 (Theodore Marmor ed., 1994) (criticizing public financing economists for not consulting public opinion findings or qualitative work on social beliefs from anthropology or social psychology).

48. *See* JACOBS, *supra* note 18, at 191–93 (noting wide-spread support for Medicare despite little public understanding of the program); Lawrence R. Jacobs et al., *The Polls—Poll Trends: Medical Care in the United States—An Update*, 57 PUB. OPINION Q. 394, 394–95 (1993) (giving the results of public opinion polls regarding health care issues in the 1992 presidential campaign); *see generally* KARLYN BOWMAN, PUBLIC OPINION AND MEDICARE RESTRUCTURING: THREE VIEWS, IN MEDICARE: PREPARING FOR THE CHALLENGES OF THE 21ST CENTURY 281 (Robert D. Reischauer et al. eds., 1998) (examining the significance of public support and public opposition to Medicare reforms).

49. *See* JACOBS, *supra* note 18, at 191–93 (noting Medicare's broad popularity).

50. *See* PUBLIC AGENDA, MEDICARE: RED FLAGS, *at* http://www.publicagenda.org/ (March 1997) (displaying the results of a 1997 Washington Post/Kaiser Family Foundation/Harvard University poll that found a full 53% of respondents willing to admit they knew "very little" about Medicare) (on file with the Washington and Lee Law Review).

expansion has not been achieved.[51] The original hope was that Medicare would grow into universal health insurance, not coverage only for the elderly, the disabled, and those suffering from renal failure.[52] Moreover, the reformers anticipated that Medicare would largely remove financial fearfulness from the lives of older Americans facing sickness, injury, and other medical burdens.[53] That, as Marilyn Moon and others have aptly demonstrated, has not been accomplished for a variety of reasons.[54] Because the claims are factually false, so are the causal connections.

Moreover, if Aaron and Reischauer's factual claims about politically relevant factors are questionable, the "implications" drawn are equally suspect. None of them are "straightforward"[55] in the sense that reasonable analysts could not find grounds for questioning their normative plausibility or predictive accuracy. Consider one claim where the grounds for objection are quite obvious: the assertion that "congressional reforms will—and should—bring Medicare more in line with the structure of health care financing and delivery that is evolving to serve the non-Medicare population."[56]

Underlying this claim is the view, later made explicit, that Medicare should be adapted to what itself is "evolving" as a practical matter of avoiding resentment.[57] This claim assumes, but does not substantiate, the belief that Medicare's operation should resemble the health insurance practices other Americans confront, *irrespective of any demonstrated superiority of the "evolving" practices and public support for them.* That assumption ought to invite skepticism on normative grounds, but the more important point for present purposes is an empirical one. Simply put, there is no credible evidence for the prediction that voucher enthusiasm will arise from resentment about the elderly having a broader set of choices than younger Americans. By our reading, what evidence there is actually suggests just the opposite.

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51. *See* Marmor & McKissick, *supra* note 37, at 227–30 (relating the expectation of incremental program expansion to Medicare's origins).

52. *See* MARMOR, *supra* note 17, at 6–10 (providing a narrative history and more extensive analysis of Medicare's origins and operations).

53. *See id.* at 12 (examining the factors that limited senior citizens' access to health insurance before Medicare).

54. *See* MARILYN MOON & JANEMARIE MULVEY, ENTITLEMENTS AND THE ELDERLY: PROTECTING PROMISES, RECOGNIZING REALITY 35, 89–93 (1996) (discussing the limited expansion of Medicare).

55. *See* Aaron & Reischauer, *supra* note 40, at 8 ("The implications of these facts are straightforward.").

56. *Id.*

57. Henry J. Aaron & Robert D. Reischauer, *"Rethinking Medicare Reform" Needs Rethinking*, HEALTH AFF., Jan./Feb. 1998, at 69, 69.

To understand the public's likely response to such ideas, one must recognize that Medicare vouchers presume a large shift to managed care organizations.[58] The interpretation of resentment by voucher enthusiasts thus requires a groundswell of support for moving the elderly into managed care. But therein lies an immediate puzzle. How can that be reconciled with the evidence about the public's critical views of the managed care industry? A managed care backlash has by now become a well-established finding in research on the public's views on healthcare.[59] The evidence of a backlash against managed care reflects considerable frustration with constraints on patient choice.[60] But, it is not at all obvious that such frustration has led to any resentment of Medicare's benefits. Indeed, the opposite seems more plausible. If the reactions embodied by the efforts to legislate a "patient's bill of rights" are any indication, the general public's dissatisfaction with "choice" will more likely produce more vigorous efforts to make private health care more like "traditional" Medicare.[61]

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58. *See* Marmor & Oberlander, *supra* note 38, at 59 (noting rosy predictions of rapid managed care growth).

59. *See generally* The Managed Care Backlash, 24 J. HEALTH POL., POL'Y & L. 860 (1999) (devoting its entire October 1999 issue to the reasons for and implications of the managed care backlash); *see also* Robert J. Blendon et al., *Understanding the Managed Care Backlash*, HEALTH AFF., July/Aug. 1998, at 80, 80–85 (reporting a 1998 Harris poll that illustrates the ill-regard with which the public views the managed care industry). In that poll, managed care firms ranked second from the bottom in terms of the public's positive feelings about them; only tobacco companies ranked lower. *Id.* *See also* Lawrence R. Jacobs & Robert S. Shapiro, *The American Public's Pragmatic Liberalism Meets its Philosophical Conservatism*, 24 J. HEALTH POL., POL'Y & L. 1021, 1024–25 (1999) (discussing poll results on America's reaction to managed care); Press Release, Kaiser Family Foundation, National Survey Suggests Need for Broad Public Debate About Medicare Reform, *at* http://www.kff.org/ medicare/1442-index.cfm (October 20, 1998) (presenting public opinion on managed care providers) (on file with the Washington and Lee Law Review).

60. *See generally* Gail R. Wilensky, *What's Behind the Public's Backlash?* 24 J. HEALTH, HEALTH POL'Y & L. 873 (1999) (providing further analysis on the backlash against managed care); Jacobs & Shapiro, *supra* note 59, at 1021 (1999) (same); Robert J. Blendon et al., *supra* note 59, at 80 (same).

61. When one considers the character of some of the other policy changes that the managed care backlash has helped produce, such as restrictions on insurers' ability to limit hospital stays after routine births, the odds increase that this alternative reaction will occur. *See* Eli Ginzberg & Miriam Ostrow, *Managed Care—A Look Back and a Look Ahead*, 336 NEW ENG. J. MED. 1018, 1020 (1997) (highlighting the public's dissatisfaction with managed care). Combine a general antipathy toward managed care firms with sympathetic target groups (new mothers, vulnerable patients) and the impulse toward restricting the practices of insurers fits with our general understanding of the ways in which lawmakers respond to public opinion. *See generally* R. DOUGLAS ARNOLD, THE LOGIC OF CONGRESSIONAL ACTION (1990) (discussing ways in which politicians anticipate and respond to the preferences of constituents and worry about the incidence of costs and benefits distributed across groups of voters). Despite the efforts of generational equity enthusiasts to paint the elderly as "greedy geezers," senior citizens remain,

What explains such ill-supported claims of resentment? Two accounts come to mind. The first (and, we hope, least likely) possibility is that voucher proponents, as trained economists, see little value in the systematic study of public opinion. In this view, appealing to public opinion is often little more than storytelling, a sort of fanciful speculation about what sorts of attitudes might exist that would justify a particular overhaul of Medicare. Casual speculation is not, however, a basis for credible policy analysis. The second, more generous interpretation, is that these claims rest on a distinctive reading of the available data. It is true, for instance, that younger cohorts typically express less support for Medicare and greater skepticism about the program's future than do older cohorts.[62] To note these differences is one thing. To interpret them as evidence of generational resentment is quite another.[63] In this case, the

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as a group, closer to the new mothers/vulnerable patients end of the scale than to the greedy insurers end. Jacobs & Shapiro, *supra* note 59, at 1024–25 (finding a lack of public confidence in managed care plans, HMOs, and health insurance companies); Kaiser Family Foundation, *supra* note 59 (reporting the generational differences in views on Medicare, showing support for Medicare in cohorts over and under the age of 65).

62. Note that Medicare is still quite popular among even the youngest cohorts. *See* Kaiser Family Foundation, *supra* note 59 (showing strong support for the preservation of Medicare). To say that younger voters are *less* supportive of Medicare is not to say that they are *unsupportive* of it. *See id.* at 10 (displaying public opinion data). Solid majorities remain for the program, even among young adults. As for the measures of skepticism about the program's future, it is harder to say what such expressions of doubt mean. After all, one may like a program and still have doubts about its future. *See id.* (showing that a majority of those polled believed that Medicare was headed towards a crisis). In that sense, expressions of skepticism do not provide meaningful direction for policymaking in the way that expressions of support and opposition do. As Karlyn Bowman has argued, concern about a program's future and talk of crisis may be "simply a way for people to say to their elected legislators: 'Pay attention. This issue is important to me.'" Karlyn Bowman, *Public Opinion and Medicare Restructuring: Three Views, in* MEDICARE: PREPARING FOR THE CHALLENGES OF THE 21ST CENTURY 283 (Robert D. Reischauer et al. eds., 1998). With these caveats in mind, we simply note that young adults show up as *more* skeptical than older adults. But skepticism among the latter age group is easy to find in the survey data as well. What the skepticism means remains open to debate, a debate that in our view is unlikely to be resolved without richer data. Robert J. Blendon has written a recent study that reports greater skepticism among other younger cohorts. *See generally* Robert J. Blendon, *Public Opinion and Medicare Restructuring: Three Views, in* MEDICARE: PREPARING FOR THE CHALLENGES OF THE 21ST CENTURY 288 (Robert D. Reischauer et. al. eds., 1998). He found, for instance, that the under thirty cohort was the only one in which a majority of individuals predicted bankruptcy for Medicare. *See id.* at 290 (discussing public opinion data).

63. It is also the case that neither the size nor the direction of the differences has operated in the past as the resentment advocates would claim. According to one scholar of public opinion and the elderly, based on survey data from the National Election Study through 1988, "the nonelderly were consistently more likely to say the federal government spends too little on Social Security and health care, Medicare, or care for the elderly." Laurie A. Rhodebeck, *The Politics of Greed? Political Preferences Among the Elderly*, 55 J. POL. 342, 350 (1993). Given the increased conservatism of younger cohorts in recent years, we do not want to make too much

inferential leaps do not withstand serious scrutiny. In the first place, they require stability in cohort-specific preferences over time that is unlikely. Second, they disregard the likelihood that the preferences of younger cohorts may largely reflect their relative ignorance of Medicare's operation.

If the problems with Aaron and Reischauer's treatment of public opinion were idiosyncratic, there would be no point belaboring them. Unhappily, the weakness of their approach is representative of many Medicare analysts. The failure to attend seriously to public opinion research on Medicare reflects a troubling tendency in much health services scholarship. In this sense, Aaron and Reischauer exemplify a broader problem. Economists, in particular, all too frequently practice a strain of policy analysis that treats the "political" part of political economy as barely more than an afterthought.[64] To be sure, one might expect a tilt toward a scholar's home discipline.[65] In our view, however, the emphasis on economic analysis at the expense of politics needs rebalancing.

That rebalancing requires eliminating casual appeals to mass attitudes, and, instead, substituting attention to the existing research on public opinion. This research makes clear that the mapping of attitudes expressed in public opinion surveys onto specific policy proposals is rarely straightforward.[66] Substantial uncertainty and unclear preferences can be masked in responses to questions about policies as removed from public understanding as is Medicare.[67] Moreover, as Jon Oberlander has argued, public opinion has, at

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of the patterns found by Rhodebeck. *See* Alan I. Abramowitz & Kyle L. Saunders, *Ideological Realignment in the U.S. Electorate*, 60 J. POL. 634, 639–42 (1998) (noting a trend toward the Republican party among younger cohorts). It is enough for our purposes simply to note that, in the not too distant past, younger cohorts seemed perfectly willing to support programs for the elderly.

64. *See* MARMOR, *supra* note 17, at 185–91 (discussing the tendency of economists to avoid political concerns); *see also* Anthony Beilenson, *Leadership and Politics: Four Views, in* MEDICARE: PREPARING FOR THE CHALLENGES OF THE 21ST CENTURY 280, 285 (Robert D. Reischauer et al. eds., 1998) (same). *But see* Uwe E. Reinhardt, A Primer for Journalists on Medicare Reform Proposals (April 2003) (unpublished manuscript, on file with the author) (providing an exception to economists' tendency to avoid political concerns and, instead, offering a good illustration of combining economic, political, and policy analysis).

65. Given the benefits of specialization it is hardly surprising—and it may even do some good—that economists tend to approach these questions by putting economics front and center. For a more extended discussion, see MARMOR, *supra* note 17, at 185–91.

66. *See* Marmor, *supra* note 47, at 28–30 (discussing the role of public opinion in Medicare policymaking).

67. *See* Jacobs & Shapiro, *supra* note 59, at 1022–26 (discussing public perceptions of managed care); *see generally* JACOBS & SHAPIRO, *supra* note 25 (arguing that politicians often produce—rather than respond to—public opinion, strategically manipulating polls and question wording to, in effect, create mass "preferences" consistent with their policy objectives).

moments, stopped Medicare reform, but it has never driven it.[68] It typically has a more negative impact on policymaking, serving to constrain policy options rather than create them.[69] To the extent it has been influential, it has set limits on efforts to transform Medicare, particularly serving to constrain program cutbacks.[70] In so far as voucher proposals can be seen as an attempt to cut back public benefits indirectly, there is no demand for them from the public.[71] As congressional Republicans learned during the 104th Congress, Medicare cutbacks are extremely difficult to achieve in the absence of clear public mandates for change.[72]

Public opinion, properly understood, may doom voucher reforms. But it did not produce them, and it provides little support for making Medicare into a system of vouchers. There may well be a defensible rationale for vouchers, but it cannot be found in the evidence available from research on American public opinion.[73]

B. The Perils of Prediction

Another issue raised by politically presumptive writing concerns predictions about the political agenda over time. The commentary on Medicare, as with other programs, is regularly accompanied by claims about

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68. *See* Oberlander, *supra* note 1, at 250–54 (discussing the role of public opinion in Medicare policymaking).

69. *See id.* (discussing Medicare's lack of growth despite mass support for expanded benefits).

70. *See id.* (noting the absence of cutbacks on Medicare benefits).

71. One experienced public opinion analyst characterizes the available evidence on the public's support for vouchers this way:

> A voucher system described in various ways in various polls seems to attract the support of about 30 percent of the population. It is not clear from the data I have seen exactly how firm that support is. Do these respondents reject the system we have now? Is the response simply a message to do something to save the system? Or is the 30 percent a measure of actual support for a voucher system or some alternative? I am not sure that we know the answers judging from the current questions in the public domain.

BOWMAN, *supra* note 48, at 285.

72. *See* Peterson, *supra* note 24, at 201–19 (discussing Republican strategies to enact health care reform).

73. *See generally* Marmor & Oberlander, *supra* note 38 (providing a deeper discussion of the many reasons not to support voucher plans). *But see generally* Aaron & Reischauer, *supra* note 57 (responding to Marmor and Oberlander's arguments and a defense of vouchers); Stuart M. Butler, *Medicare Price Controls: The Wrong Prescription*, HEALTH AFF., Jan./Feb. 1998, at 72, 73 (same).

what the future will be like years and decades into the future. Our contention is that configurations of partisan balance and economic circumstances cannot be easily anticipated, and that all-to-common overconfidence in speculation on these subjects is, at the very least, unwarranted. Aaron and Reischauer provide a reminder of the importance of prudent political analysis with the boldness of their claims about the future. Take, for instance, the assertion that "the cost of providing Medicare benefits is projected to rise very rapidly and will exceed projected revenues by ever larger amounts."[74] It was obvious in 1995 that Medicare's projected costs were rising and that the revenues would likely rise less rapidly than the forecasted costs. But, that merely illustrates a truism: Forecasts are not so much serious predictions as conditional claims whose truth depends entirely on the accuracy of the premises.[75] By 2000, the view that Medicare's costs would continue to rise at ten percent per year into the indefinite future[76] seemed odd indeed.

Likewise, the prediction that comprehensive health care reform would remain off the "political agenda . . . for years to come,"[77] illustrates easy extrapolation rather than serious forecasting. In 1995, Washington insiders, reeling from the Clinton reform debacle, were predisposed to think that health care reform was over for as far as the eye could see.[78] They turned out to be wrong, as health care issues returned to the agenda in limited form.[79] Indeed, by 2000, health reform issues arose again in connection with that year's election. Both candidates seeking the Democratic presidential nomination unveiled serious proposals for health care reform—this on top of months of congressional attention to reforms of the health insurance industry embodied in the so-called "Patients' Bill of Rights."[80] According to a November 1999 poll by the New York Times and CBS News, health care topped the list of issues the public most wanted Congress and the president to address.[81]

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74. Aaron & Reischauer, *supra* note 40, at 8.

75. *See* THEODORE R. MARMOR ET AL., AMERICA'S MISUNDERSTOOD WELFARE STATE: PERSISTENT MYTHS, ENDURING REALITIES 216–18 (1990) (discussing the inherent fallibility of long-term cost prediction).

76. *See* Aaron & Reischauer, *supra* note 40, at 10 (predicting long-term cost growth).

77. *Id.* at 8.

78. *See* Robin Toner, *Health Care Autopsy: Plenty of Targets to Blame for Failure*, PHOENIX GAZETTE, Sept. 27, 1994, at A1 (discussing the collapse of the healthcare reform agenda).

79. *See* Robin Toner, *The Hard Lessons of Health Reform*, N.Y. TIMES, July 4, 1999, Section 4, at 1 (discussing President Clinton's 1999 Medicare reform proposal).

80. Patients' Bill of Rights, S.1256, 105th Cong. (1999).

81. *See* Sean Wilentz, *For Voters, the 60's Never Died*, N.Y. TIMES, Nov. 16, 1999, at A27 (noting continued public support for health care reform and other traditionally liberal

The reappearance of health care reforms on the national agenda is a reminder that political forecasting is always an exercise fraught with uncertainty. Scholars of agenda-setting have established that the ebbs and flows of political agendas are a complex product of many forces. Each of these forces is subject to considerable uncertainty at any given time, and their combination is even more difficult to predict.[82] Periods of continuity can coexist with sudden and large changes in policy agendas.[83] While agenda scholars understand the families of factors that affect both the incremental and dramatic dynamics of policy debates, they are incapable of anticipating the precise timing and consequences of these factors as they interact. As a result, one should view point predictions of future political agendas with great skepticism.[84]

The futurology of Aaron and Reischauer, as with their use of public opinion, is important because it conforms to wider practices that have long plagued Medicare policy analysis. Medicare's harshest critics have regularly engaged in a form of "future dread," where they dress up projections of Medicare's financial status decades into the future with an unjustifiable certainty.[85] Such long-range projections are notoriously sensitive to even slight changes in their underlying components. Witness, for example, the difference between HCFA's 1995 projection that kick-started the current debate over massive changes and its report just four years later that projected an additional thirteen years of "solvency."[86] For good reason, sensible analysts approach long range forecasts with caution. But, the same logic that recommends caution in projecting a program's financial future also requires restraint in using those very same projections to make the case for major changes from current policy.

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issues).

82. *See generally* JOHN W. KINGDON, AGENDAS, ALTERNATIVES, AND PUBLIC POLICIES (1984) (discussing how political agendas depend on a confluence of problem recognition, policy solutions, and political conditions); FRANK R. BAUMGARTNER & BRYAN D. JONES, AGENDAS AND INSTABILITY IN AMERICAN POLITICS (1993) (proposing a punctuated equilibrium model of policy change, tracing the history of policy change in 20th century America, and analyzing the long-term changes in the structures and context of American political institutions).

83. *See* BAUMGARTNER & JONES, *supra* note 82, at 57 (proposing a punctuated equilibrium model of policy change and agenda setting).

84. *See generally* Theodore R. Marmor, *Forecasting American Health Care: How We Got Here and Where We Might be Going*, 23 J. HEALTH POL., POL'Y & L. 551 (1998) (providing a more extensive discussion of the dangers of forecasting).

85. *See* MARMOR ET AL., *supra* note 75, at 137 (1990) (refuting pessimistic projections of Social Security's future).

86. *See* Henry J. Aaron, *Budget Estimates: What We Know, What We Can't Know, and Why It Matters*, *in* POLICIES FOR AN AGING SOCIETY 71 (Stuart H. Altman & David I. Shactman eds., 2002). See Table 3.1 on projections of Medicare outlays.

To do otherwise, as when proponents of restructuring Medicare forecast a future of certain crisis, is to misuse such long-range projections. The need for an honest recognition of the limits of forecasting increases in the case of Medicare, where the environment is marked by frequent technological change and is embedded in a larger and changing world of private and public health care.[87] Of course, this point is not lost on analysts as experienced as Aaron and Reischauer. Indeed, Aaron himself recently issued similar cautions, going so far as to assert that "a fog of fundamental unknowability shrouds projections of Medicare costs beyond just a few years."[88]

The uncertainty about Medicare's future costs is but one limitation on confident forecasting. It is compounded by the dependence on such forecasts in the service of promoting current proposals for reform. Too often, the desire to rationalize policy prescriptions masks inherent risks of long-range forecasts—a danger that even the most thoughtful analysts face. When such impulses are combined with a failure to recognize the even greater difficulty in forecasting politics (as opposed to demographics or economics), the dangers of what we have described as unfounded futurology are maximized. The result is all too often fear-mongering masquerading as forecasting, a practice that distorts one's understanding of Medicare's current problems and future possibilities.[89]

C. Confusions of Conventional Wisdom

Another source of confusion in the Medicare debate arises from claims reported as current conventional wisdom about the program's future. One such mistaken view asserts that, because Medicare faces financial strain, the program requires dramatic transformation.[90] The experience of the 1980s and much of the 1990s showed that Medicare's administrators, when willing and able, could limit the pace of increase in the program's costs.[91] Consider, also, that Medicare controlled its spending growth more tightly than did private health insurance during most of the last two decades[92]—this even though private

87. For similar points about the consequences of Medicare's complex environment, see Jermoe P. Kassirer, *Managing Managed Care's Tarnished Image*, 337 NEW ENG. J. MED. 338–39 (1997); Aaron, *supra* note 86, at 16.

88. Aaron, *supra* note 86, at 70–71, 77.

89. *See id.* at 63–64, 68–70 (discussing the misuse of long-range projections).

90. *See* MARMOR, *supra* note 17, at 189–91 (describing "politically presumptive writing").

91. *See* MOON, *supra* note 7, at 19 (noting Medicare's superior ability to control costs through the early 1990s).

92. *See* MARILYN MOON, BENEATH THE AVERAGES: AN ANALYSIS OF MEDICARE AND PRIVATE EXPENDITURES 13 (The Henry J. Kaiser Family Foundations, Report No. 1505, 2000)

insurance was undergoing massive changes aimed at controlling costs during this period.[93] To be sure, controlling the program's future costs poses undeniable challenges to policymakers just as it has before. Mustering the political will to implement cost-control measures is no small feat. But, it is worth remembering that policymakers have managed the task in the past without having to reshape Medicare radically.[94]

The very language used to define the financial problems Medicare undoubtedly faces is another source of distortion. Republican, as well as a number of Democratic critics continue to use the fearful language of insolvency to describe Medicare's future.[95] That future, according to this group, is a dreaded one in which the program's trust fund will be literally "out of money."[96] This language represents the unfortunate triumph of metaphor over thought.[97] Thinking that Medicare's trust fund is its crucial fiscal variable is analogous to thinking that a thermometer's reading constitutes a heat wave or a freeze.[98] "The program's hospital 'trust fund'

(comparing expenditure growth rates in Medicare and private health insurance).

93. MOON, *supra* note 7, at 19.

94. Doubts about policymakers mustering the political will required to impose fiscal discipline on the program through marginal adjustments stand curiously at odds with radical reformers' strong faith in these same policymakers' willingness to summon the political courage to make fundamental changes to the program's design.

95. *Remarks on Returning without Approval to the House of Representatives the Taxpayer Refund and Relief Act of 1999*, 35 WEEKLY COMP. PRES. DOC. 1793 (Sept. 23, 1999).

96. *President Touts Successes in Remarks to LR Chamber*, ARK. DEMOCRAT-GAZETTE, Dec. 12, 1999, at A21.

97. *See generally* MARMOR, *supra* note 17 (describing further the ironies of the political evolution of Medicare's trust fund). The same social-insurance financing of hospital services that was so critical to gaining political support for Medicare in the first place has, through its artifact, the trust fund, ironically become one of its greatest political vulnerabilities and the nominal foundation to support the attacks of the program's harshest critics; *see also* Oberlander, *supra* note 1, at 129–50 (arguing that Congress adopted the Medicare trust fund to assure political stability, but it has actually turned out to be a source of instability). *But see generally* Eric Patashnik & Julian Zelizer, Paying for Medicare: Benefits, Budgets, and Wilbur Mills's Policy Legacy (1999) (unpublished manuscript, on file with author) (disputing the view that this development is an ironic legacy of the trust fund device). Patashnik and Zelizer argue instead that fiscal conservatives understood the implications of the trust fund mechanism from inception and its ability to impose discipline on Medicare's budget was crucial to their willingness to support the program. *Id.*

98. Another analogy is useful here. When the United States declares war, no one shouts that the Department of Defense will run out of money. There is, of course, debate over the wisdom of the military engagement and disputes over the willingness of Congress to pay for the additional war-related expenses. However, no one would contend that the increased expenses due to a new military engagement will "cause" the Department of Defense to become bankrupt.

refers to an accounting term, a conventional way to describe earmarked revenue and spending."[99]

The very notion of a public trust fund combines the language of trust with the funding-source reality of payroll taxes to underscore the solidity of commitment to finance promised benefits in social insurance programs.[100] The appeal to "insolvency" as a danger needs to be recognized for its symbolic and strategic value in framing the debate over Medicare. Such symbolic framing can be politically consequential.[101] For that very reason, though, policy analysts should guard against misleading symbols. Whatever its psychological and political importance, the trust associated with the fund is a fiscally neutral element in the goods and services Medicare finances. Congress can change the taxes that finance Medicare if it has the will. Likewise, it can change the benefits and reimbursement provisions of the program. Or it can do some of both, as it has at different times in Medicare's operational history. Channeling the program's revenues through something called a "trust fund" changes nothing in the real political economy. Thinking so is the cause of much muddle, unwarranted fearfulness, and misdirected energy.[102]

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99. MARMOR, *supra* note 17, at 135.

100. *See generally* ERIC M. PATASHNIK, PUTTING TRUST IN THE FEDERAL BUDGET: FEDERAL TRUST FUNDS AND THE POLITICS OF COMMITMENT (2000) (describing federal trust funds).

101. *See generally* MURRAY EDELMAN, THE SYMBOLIC USES OF POLITICS (1964) (exploring the symbolic processes underlying political claims); CHARLES ELDER & ROGER COBB, THE POLITICAL USES OF SYMBOLS (1983) (examining the importance of symbols as a basis for political activity); Gary J. McKissick, Defining Choices: Interest Group Lobbying and the Framing of Policy Alternatives (2000) (unpublished manuscript, on file with author).

102. The oddity of worrying about a Medicare bankruptcy is also apparent when one considers the different political responses to the funding shortfalls for Medicare's hospitalization coverage (Part A), on the one hand, and the shortfalls for its coverage for physician services (Part B), on the other. Hospitalization insurance alone is financed by payroll taxes earmarked for Medicare's Part A trust fund. This is a mechanism designed explicitly to echo the same social-insurance principles as Social Security pensions. In contrast, when Congress tacked on physician services as Part B of the 1965 Medicare bill, premium payments from current beneficiaries and from general federal tax revenues were to finance physician expenses. Because general tax revenues can only run *short*, but not *out*, projected shortfalls in paying for physician services have simply been covered by additional general revenues, by increased premiums, or by cutbacks in expenditures. As a consequence, there have never been Medicare-Part-B crises of the form associated with Part A. It is only the projected shortfalls in the hospital trust fund that have triggered the recurrent crises over Medicare and the use of bankruptcy language. Thus, the experience with the trust fund demonstrates how important the funding mechanisms can be for the politics of a program. In that sense, the use of a trust fund is more than an accounting term of art. It has very real political implications and consequences. For a cogent discussion of the different "crisis" politics of Medicare's component parts see Oberlander, *supra* note 1. For an insightful analysis of the politics of government trust funds see PATASHNIK, *supra* note 100.

D. Explicit Political Analysis Without Sufficient Evidence

A final category of regrettable misunderstanding of Medicare is analysis that is explicitly political in its aims, but that proceeds without sufficient appreciation of Medicare's actual experiences. Here political and programmatic analysis rests on deductive reasoning, economic assumptions, and theories about the behavior of government and political actors that substitute for empirical analysis of Medicare.

This type of analysis follows a predictable script with government programs portrayed as inefficient, financially uncontrollable, constraining of individual choice, and ineffective. The market is alternatively cast as efficient, effective at controlling the costs of medical care, and promoting choice. The irony of this tale is that its widespread prevalence in health economics contrasts with its amazing lack of veracity as a framework for accurately understanding health policy or describing modern health systems.[103] To name but one of many problems with this perspective, the presumption that market competition controls medical care spending coexists with the reality that the U.S. has more market competition in its health system than any other industrial democracy, and yet, far and away spends the most on medical care. This seeming conflict does not prompt rethinking the role of markets in medical care, because the political economy conclusion stems not from empirical analysis but from unsupported presumption. Health economist Roger Feldman thus scolds his fellow economists for not doing enough to prove the obvious by offering "a cogent analysis of why government control of health care does not work."[104]

This conflation of normative values with political analysis is abundantly evident in the literature of positive political economy on Medicare. So, for example, Ronald Vogel, a public choice analyst, presumes it is entirely predictable that "Medicare began with structural flaws and continues to contain structural flaws . . . ."[105] What is left unsaid is that that from this perspective all government social programs are, a priori, presumed to be inherently flawed because they disrupt the virtues of the competitive market. Accordingly, Vogel dismisses the ability of federal payment policies such as DRGs to control Medicare spending. Incredibly, he does so by citing a single study that is not primarily concerned with Medicare and without reference to the work of

103. *See generally* RICE, *supra* note 15 (providing an excellent critique of these assumptions in health care economics).

104. ROGER D. FELDMAN, AMERICAN HEALTH CARE: GOVERNMENT, MARKET PROCESSES AND THE PUBLIC INTEREST 2–3 (2000).

105. RONALD J. VOGEL, MEDICARE: ISSUES IN POLITICAL ECONOMY 3 (1999). Political choice perspective refers to an application of microeconomic theory to politics.

Marilyn Moon and others documenting Medicare's success in cost control relative to private insurance.[106] This illustration is an unfortunately egregious one of normative commitments masquerading as analysis, thereby producing conclusions based on presumption rather than careful engagement with the evidence.

Mark Pauly offers another illustration of explicit political analysis without understanding. Pauly sets out to explain, from a political economic perspective, "why the United States provides mixed public (Medicare) and private (Medigap) insurance for the elderly."[107] Finding that "there is no definitive efficiency rationale" for this phenomenon, Pauly alternatively notes that:

> there is a positive political economy explanation that suggests that . . . majority rule voting could lead to the choice of a mixed government and market system. The disturbing implication of this important finding is that outcomes from politically chosen mixes schemes are not necessarily efficiency improving . . . . The only rationale for the public program is that it might have avoided more adverse selection problems in the private insurance market.[108]

What is striking about Pauly's explanation for the development of Medigap policies alongside public Medicare is that it is not based on any examination of Medicare's political history. There is no attempt to describe the origins of Medicare or how its benefit structure developed over time. Nor does Pauly cite any of the Medicare politics literature, instead choosing to focus on theories of majority rule voting. In Pauly's view, there is no need to attend to the actual reasons why supplemental insurance developed, because once again, deductive reasoning is presumed to be an adequate basis for political analysis. Outcomes are simply taken to be reasonable grounds to assume intent and purpose, precluding the necessity to study legislative origins and policy history.

V. Conclusion

Medicare, a major program of American public life, continues to be systematically misunderstood. The serious literature on Medicare's politics is not available to most of the public, is not recognized in the writing of those who generate the bulk of policy proposals, and is underrepresented in health services research. Furthermore, much of that research is premised on the

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106. *Id.* at 17.

107. Mark V. Pauly, *The Medicare Mix: Efficient and Inefficient Combinations of Social and Private Health Insurance For U.S. Elderly*, 26 J. HEALTH CARE FIN. 26, 26–37 (2000).

108. *Id.* at 29.

assumption of unanimous agreement about what Medicare should do, leaving to be resolved only the question of what will work.

Our commentary has been sharply critical of the omission of systematic attention to Medicare politics in policy analysis.[109] Too much of this literature maintains an indefensible separation between policymaking and politics. Yet, simply engaging in political analysis is not the same as conducting sound political analysis. We are also sharply critical of a particular type of thinking about Medicare's politics, that of regrettable misunderstanding discussed in the preceding section. This sort of casual political analysis undermines the authority of careful policy analysis. The remedy for it is a mix of self-restraint and more serious attention to what political science can (and cannot) tell us about Medicare's likely future.[110] It hurts rather than helps public understanding of what should and can be done in American policymaking to substantiate program evaluation with politically superficial judgments. This is particularly important where the political analysis is presented as scholarship, but not bolstered by evidentiary support or defensible inferences. We do not argue that scholars should hide their normative preferences. They should state them clearly. Nor do we suggest that political scientists have a monopoly on commentary about American political realities (or Medicare's). Rather, our claim is that scholarly standards should apply to claims about politics by those invoking analytical authority for their policy conclusions.

This is especially so given the stakes involved in reforming Medicare as the baby-boom generation approaches retirement. If the future of Medicare depends on clarifying policy choices and values, we can ill afford to have a commentary on Medicare that is dominated by misunderstanding and mythology.

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109. This paragraph draws on Marmor & McKissick, *supra* note 37, at 248.

110. What should one expect from those who are experts on the details of Medicare's programmatic operation who commit the conceptually distinct sin of leaving out political analysis altogether? For this sin of omission, the answer is this: a clear acknowledgement of the limitations of such assessments for either predicting Medicare's future or prescribing reforms at any particular time. Such work makes a valuable contribution in providing careful attention to the programmatic details of Medicare's history. Nevertheless, the caution about limits remains.