Modern aging policy in the United States confronts a paradox. Aging programs are popular, but face critical decisions. The aging of the Baby Boom generation and technological changes in health care may bankrupt federal programs for the elderly. At the same time, political support is being undermined by doubts about the solvency of Social Security and Medicare and by the very success of the programs at reducing aging poverty. Generational equity has become an increasingly important issue among political elites. Resolving the paradox will require creative political leadership; however, political decentralization and ideological polarization have reduced the likelihood of such leadership by reducing the chances of political compromise in Congress. The stalemate over Medicare that occurred in the 104th and 105th Congresses does not bode well for the future health of aging policy or the social insurance principle.

The Paradox of Aging Policy

As we are about to begin the twenty-first century, there is a serious paradox facing America’s policies toward its aging population. Policies that have furnished a safety net for America’s elderly continue to enjoy widespread popular support. At the same time, however, social spending on the elderly has never been more sensitive to political controversy nor more vulnerable to budgetary cutbacks.

Between 1984 and 1994, support for constant or increased spending on Social Security fluctuated at around 96% in the biennial American National Election Surveys and 93% in the annual General Social Surveys (Miller & National Election Studies, 1995; Davis & Smith, 1994). In both 1985 and 1990, support for the proposition that the government should provide a decent standard of living for the aged averaged over 87%. In the same two years, over 80% of the population believed that the government should spend the same or more on retirement benefits (Davis & Smith, 1994).

Despite this overwhelming support, current projections suggest that the Medicare trust fund will be bankrupt by 2001 unless major policy changes are enacted (United States General Accounting Office [GAO], February 1997: 12). Similar projections suggest that the Social Security Trust Fund will begin losing money in 2013 and will be exhausted by 2032 (GAO, July 1998: 12). Despite these imminent crises, the Clinton Administration and the Republican Congress have been unable to reach a consensus on how best to preserve the system. How is it possible for a set of policies with such broad public support to face such critical political decisions? This article will examine the roots of this paradox and speculate on its possible consequences.

Aging policy will confront a wave of demographic change. As Fernando Torres-Gil (1992) has noted, generational claims, diversity within the aging population, and longevity will have an enormous impact on the future of aging research and policy in the twenty-first century. The possibility of conflict between younger workers and retirees over the scope of aging entitlements, an increase in the minority segments of the older population, and rapid growth in size of the oldest age groups threaten the consensus that has sustained the aging policy network for over sixty years.

R. Steven Daniels, Ph.D.
Department of Government and Public Service
University of Alabama at Birmingham
Birmingham, AL 35294

The Southwest Journal on Aging Vol. 14 No. 2
Despite these impending changes, aging policy is a relatively low priority for most of the public. At no time in the past fifty years have aging issues been cited among the most important problems facing the country. This low level of political importance among the public means that aging policy may well be susceptible to future generational conflict over the allocation of scarce resources. The prospect of political conflict would not raise concern were it not for the barriers to political change that exist in the United States. The structure of the American political system slows the pace of major policy change. The major obstacles to change include decentralization in the American political system, the short-term focus of elected officials, and polarization in American politics.

The deteriorating political consensus over the future of aging policy and the increasing paralysis of the American policy process means that the aging policy network is losing its political support at the same time that the political system is losing its capacity to promote innovative solutions. This paradox is mirrored in the battle over Medicare reform from 1995 to 1997. The political deadlock that finally defeated major changes in the structure of the Medicare system may presage the coming future of aging policy.

Socioeconomic Changes in the Status of the Elderly

The Aging of the Baby Boom Generation

The bulk of the problems that will confront aging policy in the twenty-first century will arise from the aging of the Baby Boom generation. In 1993 the elderly represented about 13% of the population. By 2050, that same population will be over 22%. In absolute numbers, the number of senior citizens will rise from 33 million people to just over 69 million (Cockerham, 1997; Myers, 1990; Schulz, Borowski, & Crown, 1991; Steigel 1993). The sheer scope of this increase will place an enormous burden on existing programs for the elderly.

Population growth will not be the only source of change in aging policy. Significant transformations will also occur in the characteristics of the aging population. The key adjustment will be a rapid increase in the oldest segment of the aging population, commonly referred to as the oldest old (85+). In 1990, the population of the oldest old was roughly three million people. That number will increase to 4.3 million by 2000 and by 2050, most estimates project that nearly 17.7 million people will be eighty-five years old or older. The proportion of the population eighty-five and over will also increase from 1% to 5% between now and 2050 (Cockerham, 1997). By the latter date, the oldest old will represent about 23% of the elderly (Myers, 1990; Rubin & Nieswiadomy, 1997).

This rapid increase in the oldest segments of the population has profound policy implications. Numerous studies have established that those 85+ have a higher incidence of frailty, disability, and chronic conditions and use a greater proportion of health care services (Kane & Kane, 1990). The demands for these services will increase dramatically over the next fifty years.

Differentials in life expectancies between men and women will also have a significant influence on aging policy choices. In 1993 the average male life expectancy in the United States was 72.2 years, ranking 24th in the world. The average female life expectancy was 78.8 years, or 16th world-wide. This difference in life expectancies means that the older population will continue to be primarily female.

The long-range policy ramifications of a predominantly female population will reflect social patterns typical of the older female population in the United States. Older women are more likely to be single, live alone, and have incomes substantially below the national median (Rubin, 1997; Smeeding, 1990). They are also more likely to be poorly educated, live in poverty, and spend a greater percentage of their income on housing (Rubin, 1997). In addition, women have a greater probability of spending time in a nursing facility than men (0.5 versus 0.3) at some time before they die (Kane & Kane, 1990). As the overall aging population increases, escalating pressure will be placed on the social services, health expenditure, and income security provisions that most help older women.

Not only will the elderly population of the twenty-first century be older, but minorities will make up a
larger proportion of that population (Siegel, 1993). In 1985 nonwhites comprised slightly less than 10% of the elderly; by 2050, the proportion may be as high as 21% (Myers, 1990). Much of that growth will be among the Hispanic population, although elderly African-Americans and Asian-Americans will also increase as a proportion of the older population (Cockerham, 1997).

The policy implications will be very similar to those for older women. Minorities of all ages already face numerous disadvantages in American society. By and large, minority groups have much lower life expectancies than the white population. For example, the life expectancy for white females in 1993 was 79.5 years; for white males, it was 73.1 years. Among African-Americans the comparable figures were 73.7 years for women and 64.6 years for men (Cockerham, 1997). These lower life expectancies are the product of a complex interaction of low socioeconomic status and relatively unhealthy life styles.

The aging, feminization, and diversification of the older population will place additional burdens on government. As all groups in American society age, health care will become an increasingly critical issue. The aging of the Baby Boom generation by itself will place greater financial stress on government income security and health programs. The Social Security and Medicare trust funds are already in serious financial trouble; the problems will only get worse in the future.

**Aging and Economic Change**

The past three decades have brought substantial change in the economic status of America’s elderly. As recently as 1963, social commentator Gunnar Myrdal could condemn American society’s treatment of its elderly:

> The treatment of old people in American, many of whom have a hard life behind them, is remarkable. . . . [This is illustrated by] the terrifying extent to which old people are left in poverty and destitution. . . . It cannot possibly be the considered opinion of the majority of Americans that so many of those who in America are often called senior citizens should be left in misery, squalor and often forbidding loneliness, unattended though they are in need of care. The situation is overripe for radical reform of the old age security system (Myrdal, 1963; quoted in Schulz, 1992).

Myrdal’s analysis was not the first to note the poverty of the elderly population. Most commentators, analysts, and policy makers assumed the elderly to be poor and unhealthy, based largely on the extreme poverty of senior citizens during the Great Depression. Despite the substantial improvement of the economy, this stereotype persists. “Compassionate ageism,” the tendency to connect age to dependence, has provided the justification for much of the government’s interventions on behalf of the aged during the post-New Deal era (Binstock, 1983; Moody, 1988; Torres-Gil, 1992).

In reality, current data suggest that the elderly as a group have significantly improved their economic status vis-a-vis the non-aged. Real median income for all households in the United States only increased by about 6% from 1969 to 1996 (McNeil, 1998). By contrast, the real median household income for married couples sixty-five years of age or older rose by nearly 60%, whereas the income figures for single, elderly male and female households jumped by nearly 70% and 53%, respectively. The elderly clearly made substantial income gains over this time period compared to most other households. Many of these gains can be traced to the indexing of Social Security.

The gains made by older adults are confirmed by the substantial reductions in poverty that have occurred for America’s senior citizens. The overall household poverty rate from 1969 to 1996 fluctuated at around 13.2% (Lamison-White, 1997; McNeil, 1998). During the same period, poverty rates for elderly households dropped dramatically. Among older married couples, the poverty rate declined from 16% to 4.2%. Among single, elderly men, the rate fell from 39.1% to 13.4%; the reduction for households headed by elderly females was from 51.1% to 23.1% (McNeil, 1998).

In addition to improved economic status, the elderly also held a substantial advantage over
younger citizens in the accumulation of assets (Eller & Fraser, 1995). In 1993, the highest median net worth was for households headed by individuals between sixty-five and seventy-four years of age. The net worth of these households ranged from $92,000 to over $95,000. The net worth of younger households was considerably less, ranging from a low of $5,786 to a high of $91,481. Assets generally increased steadily with age, even with home equity excluded and income differences averaged.

The economic changes described above mean that the elderly, as a group, are no longer economically distinctive from the general population. Despite this economic convergence of the older and younger populations, the increases in income, the declines in poverty, and the accumulation of assets disguise increasing diversity of the aging population (Schulz, 1992; Torres-Gil, 1992). Many of the aged have not shared in the overall economic improvement. Although all elderly subgroups have improved economically, the bulk of the economic improvement has occurred among white, married couples. The most disadvantaged groups include women, minorities, and single individuals.

Whereas the overall poverty rate for all individuals was 13.7% in 1996, the rate for single males over sixty-five was 14.0% and for single females over sixty-five it was 23.3%. Poverty was much worse for older African-American and Hispanic families. Among African-Americans, the poverty rates for older female-headed households, single males, and single females were 28.9%, 25.4%, and 46.9%, respectively. Among Hispanics, the female-headed household poverty rate was 27.3%, the older single male rate was 38.9%, and the older single female rate was 46.7% (Lamison-White, 1997).

The situation for these groups is aggravated further by the general economic vulnerability of the elderly population. Although the vast majority of America's senior citizens are not poor, a significant percentage live within 150% of the poverty line, making them especially vulnerable to economic variations (Schulz, 1992). The overall percentage of the population below 150% of poverty in 1996 was 23.4%. Among all senior citizens it was 25.2%.

and among older women it was 30.3%. The percentage of older African-Americans below 150% of poverty was 45.9%; the Hispanic percentage was 44.6%.

Most commentaries on the “new elderly” ignore the diversification of the elderly population. The apparent economic security of the elderly population combined with the enormous pressure on social programs created by the aging of the Baby Boom generation has weakened political support for the network of aging programs in the United States. Increasing pressure has been brought to bear on policy makers to introduce income thresholds and means tests to limit access to aging programs (Longman, 1987; Price, 1997; Torres-Gil, 1992). These limits threaten to alter the nature of aging policy altogether.

For decades, Social Security, Medicare, and the programs of the Older Americans Act have been considered universal social insurance programs that provided aid to older persons regardless of economic status. The imposition of means tests will turn the programs into public assistance programs. Traditionally, welfare programs carry an enormous public stigma. The passage of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 suggests the future of means-tested public assistance. Unfortunately, the effects of the expenditure reductions that typically occur under public assistance programs will fall primarily on the segments of the elderly population that the introduction of means testing was intended to help.

The Political Vulnerability of Aging Policy

Public Indifference to Aging Issues

The expansion of the aging population in the next century and the apparent economic success of the network of aging programs will not have much impact on the long-term future of those programs if the policy network is supported by intense political demands from the general public and from the elderly population.

In reality, the expansion of the aging policy network has been driven primarily by policy elites. Because of the “compassionate ageism” cited above,
the elderly were the beneficiaries of political compromises during the formation of key aging programs (Torres-Gil, 1992). Unable to pass more comprehensive pension and health programs during the New Deal (1933-1935) and the Great Society (1964-1965), the national government settled on programs to help the elderly as an acceptable political alternative. The strategy proved very effective at insulating the older population from the vagaries of economic change.

As noted earlier, public support for these programs fluctuates between 93% and 96% with fewer than 10% of the population supporting reductions in Social Security. However, the political demand for expanding or maintaining the aging programs is surprisingly superficial. Over the past 60 years, the Gallup Poll has asked the following question, “What do you think is the most important problem facing this country today?” (Gallup Organization, 1998). If the American public believes that the elderly face special problems that require strong support for the maintenance or expansion of aging programs, the problems of the elderly should register strongly and consistently on this question.

During 1997 and 1998, only 4% to 8% of the population mentioned Social Security and Medicare as serious problems, despite considerable news coverage of the problems facing the trust funds of these two programs (Gallup Organization, 1998). No other problems or programs associated with the elderly received as much as 1% of the responses. Over the period 1980 to 1998, the problems of the elderly and social programs aimed at older people never appeared in the top five problems mentioned by respondents to the Gallup Poll. In early 1998, CBS News asked a sample of Americans to identify the likely areas of greatest domestic and global concern in the twenty-first century (CBS News, 1998). The dominant domestic concerns were the environment, crime, moral values, the economy, war, poverty, drugs, education, and jobs/unemployment. The problems of the elderly were mentioned by virtually none of the respondents.

To complicate the relative lack of importance, many Americans believe that Social Security and Medicare will not be available to them when they retire (CNN Interactive, 1998). In a survey released by the Americans Discuss Social Security project, more than half of the population, about 57%, believed that “big changes” were needed if the system is to be available when they retire. Fully one-third believed (incorrectly) that the trust fund would be bankrupt in twenty years.

The data above suggest that support for aging policy is broad, but very shallow. Despite the overwhelming approval expressed for Social Security, few of the respondents to national surveys consider the problems of the elderly to be of major importance. In addition, many citizens express pessimism about the overall health of the aging policy network. The low public salience and pessimism weakens the ability of national decision makers to make necessary changes in the system to meet the very real financial problems that face aging policy.

The Prospect of Generational Conflict

Demographic changes in the aging population, the economic improvement among the elderly, and the superficiality of support for the problems of the elderly have increased the prospect for generational conflict. Beginning in the early 1980s, gerontologists began to warn that demographic and geographic trends could generate considerable opposition to existing programs for the elderly. Hudson (1978), Neugarten (1982), and Binstock (1983) all warned of the risk of a political backlash against aging programs because of the increasing size and wealth of the elderly population. The title of Neugarten’s 1982 book stated the issue boldly: Age or Need: Public Policies for the Elderly.

Preston (1984) and Richman and Stagner (1986) framed the issue in terms of the elderly and children. Noting that poverty among children had increased since the mid 1960s whereas poverty among the elderly had declined. Preston (1984) argued that, in the current zero-sum environment of American public policy, resources for children were directly competitive with resources for the elderly. He suggested that spending on children was more efficient than spending on the elderly because spending on the elderly was primarily consumption...
whereas spending on children was both consumption and investment. Richman and Stagner (1986) expressed concern that children might come to be considered just another needy minority among the many supplicants for federal aid.

More recent authors have intensified the drumbeat for political change. Longman (1987) argued that the current system dissolves the bonds that exist between generations:

The aging of the population need not force the American dream to end in this century. But it does require that we invest far more of our available resources in educating the young and more generally in raising the productivity of the next generation of workers. And it requires that we be far more prudent in the claims that we make against the young, whether in the form of budget deficits, unfunded pension and health care promises, deferred maintenance of the public infrastructure, and or delayed cleanup of toxic wastes (Longman, 1987: 262).

Despite considerable press on generational conflict in the 1980s, the confrontation predicted by Longman and others has not materialized. Support for senior entitlements has remained at all-time high levels in the 1990s. According to Price (1997), the current system of elderly benefits runs the risk of bankrupting the economy and short-changing the post-Baby Boom generations. Despite competing interests between young and old, he suggested that the hypothesized "generation war" is not likely to occur in the near future. The low levels of political participation among members of "Generation X" and the overwhelming support they give to senior entitlements undermine their ability to organize and produce political change:

The term "generation war" is... inappropriate at present, since war requires combatants [sic] on opposing sides, and at the moment there is not sufficient organized political opposition to the interests of the elderly to signify that level of conflict. Many contend that "plunder" would be more apt, since resources are being seized in the absence of their rightful owners, or without their ability to respond (Price, 1997: 109).

While the generational conflict predicted by some authors has not occurred, major economic imbalances between the Baby Boom generation and their children and grandchildren remain a very real possibility. Without doubt, the Medicare and Social Security systems will go bankrupt without major changes. What is equally clear, however, is that the current political structure and climate make the prospects for such changes very unlikely.

Political Obstacles to Aging Policy Change

Decentralization, Short-Term Solutions, and Policy Incoherence

The defining characteristics of the American political system are its decentralization and its aversion to long-term planning. The Founding Fathers sought to prevent the concentration of power in a few hands by dispersing decision making capacity throughout the political system. Authority in the political process was divided between the federal government and the states (federalism) and, within the federal government, among the executive, legislative, and judicial branches (separation of powers). This division of political influence made policy change extraordinarily difficult and guaranteed that most policy solutions would be short-term.

Several policy consequences flow from this fragmentation of governmental authority. First, a divided political system generates splintered political demands by interest groups (Keefe, 1988, Ornstein & Elder, 1978). As Robertson and Judd (1989, p 7) noted, "Government rules affect the way that groups and citizens interact with one another and with government." Election rules, lobbying laws, and regulatory statutes define the conditions under which political organizing could take place. Political demands are made on those levels of government and those institutions whose rules allow interest groups to have the greatest leverage (Robertson and Judd, 1989).

Second, the decentralized nature of the American political process places limits on the means by which policy is made. In general, the system rewards short-term, ad hoc distributive policies (policies that
confers benefits) over long-term, comprehensive redistributive policies (policies that transfer wealth). Elections reward politicians for planning in two-year increments. Similarly, bureaucrats are compensated with incremental budget increases and agency survival.

Third, the American policy process severely limits policy making capacity and generates policy incoherence (Robertson and Judd, 1989). Capacity refers to the ability of a government to carry out its policy mandates. State governments, in particular, have severe restrictions on their ability to raise revenue because of limits on taxation and the requirement for a balanced budget. Even if capacity could be maximized at all levels of government, the division of authority among levels and across branches of government almost guarantees that policy will be uncoordinated. This policy disorganization becomes increasingly critical when the levels and branches of government exercise independent authority. Such fragmentation produces policy incoherence "because (1) it increases veto points, (2) it allows formal and informal changes in policy goals; and (3) it produces the need for expedient compromises (Robertson and Judd, 1989: 11)."

Beyond the general policy consequences, the decentralization of policy making directly affects aging policy in critical ways. Decentralization produces an uncoordinated, incomplete aging policy network that provides significant coverage in the areas of income and health, but generates only minimal government intervention in other areas, such as housing, social services, and transportation (Cockerham, 1997; Estes, 1979, 1992).

Decentralization also provides a convenient label to disguise policies designed to cut social spending at all levels of government. The so-called "Devolution Revolution" sparked by the 1994 Republican Contract with America sought to transfer many of the welfare functions of the federal government to state control as block grants (Schr姆 & Weissert, 1997); however, most of the Republicans' proposals retained significant federal control and appeared to support devolution as a means of reducing the overall size of government. The rhetoric of congressional debate clearly suggested that transferring control of federal programs to the states and under-funding the block grants would force the states to cut spending (Dileo, 1996).

**Political Polarization and Policy Gridlock**

Political decentralization merely promotes incoherent policies; political polarization yields policy gridlock. For decades political scientists have extolled the virtues of programmatic political parties, parties that adopt policy positions that clearly distinguish them from their opposition (American Political Science Association, 1950). The theoretical argument suggested that programmatic parties increased voter participation by offering voters a clear choice at the ballot box (Downs, 1957). To the degree that power was centralized in a single institution, as it was under a parliamentary government, programmatic parties achieved a high level of policy coherence.

The imposition of programmatic parties on the decentralized structure of American politics is more likely to yield policy stalemate than policy consistency. In the United States, the division of political sovereignty between the states and the federal government and the separation of powers within each level of government removes an important mechanism for unifying public policy. If a national policy must be implemented by a state or local government, the national government has few political levers other than the carrot of federal money to force a state government to administer the policy according to national standards. Moreover, separate branches and levels of government mean that a political decision by the Congress is not final. The losers can shift the political debate to the President, the courts, or the states.

With multiple political arenas in which to interact, political parties in Congress have no incentive to seek compromise with their opponents. Partisans can hold out for total victory by threatening to shift the political debate to another level of government or by bringing the government to a complete standstill. The incentives for compromise are also reduced by the ideological intensity of officials elected under the party label.
Even under the umbrella of the United States election-oriented political parties, elected officials have much more intense partisan and ideological attachments than the general public (King, 1997; Poole and Daniels, 1985; Poole and Rosenthal, 1991a, 1991b, 1996).

The recent trend in the United States has been toward more ideological political parties. Most of this polarization has been driven by the increasingly conservative Republican party. Over the course of thirty years, the moderate and liberal wings of the party were simply voted out of office by the conservative Republican primary electorate. During the same period, conservative Republicans began winning elections against moderate and conservative Democrats in the South. The 1994 election accelerated this transformation. For the first time since Reconstruction, the Republican party controlled the majority of the congressional delegations in the southern states.

These trends contributed to the ideological polarization of the U.S. Congress in the period from 1970 to 1997 (Burnham, 1996; Taylor, 1996). The Clinton administration and the 1994 Republican landslide raised party polarization to new levels. During 1995 fully 73% of the House votes and 69% of the Senate votes were party votes; whereas, party cohesion among Republicans increased to 91% compared to 80% for the Democrats. These high levels of partisanship produced deadlock rather than comprehensive policy, highlighted by the two government shutdowns in late 1995. Neither side showed any inclination to compromise, preferring to adopt extreme positions for the benefit of each party’s hard-core political supporters.

The prospect of increased policy deadlock in the near future has profound consequences for aging policy. Given the enormous population increase about to occur in the aging population, especially its oldest components, and the great improvement in the overall financial condition of the elderly population, the basis for broad public consensus on aging policy has eroded. Expenditures on the elderly make up about 40% of the total federal budget. Most of that expenditure (about 80%) is for Social Security and Medicare. Given the financial difficulties facing both programs due to their expanding number of beneficiaries and the rising cost of health care, policy deadlock represents a serious danger to the financial health of the two largest programs benefiting the elderly.

The Paradox of Aging Policy: A Case Study of Medicare Reform

The Structure of Medicare

The forces shaping aging policy in the last quarter of the twentieth century can be seen in microcosm in the debate over Medicare reform. The confluence of demographic, economic, social, and political forces creates an environment in which the Medicare program is faced with bankruptcy, but lacks the political support to make necessary changes. Moreover, the combination of split partisan control of the national government and intensified party conflict make the probability of successful change very slim.

The Medicare program was enacted in 1965 as part of Lyndon Johnson’s Great Society and went into effect in 1966. Proponents of universal health coverage were unable to generate the political support necessary to pass comprehensive government health insurance, so they limited coverage to the elderly as a politically acceptable compromise (Cutler, 1997). The program added the disabled and people with end stage renal disease as beneficiaries in 1972.

The structure of the program reflected existing experience with state Blue Cross plans (Cutler, 1997; Health Care Financing Administration [HCFA], 1998a). The program was divided between hospital insurance (part A) and supplementary medical insurance (part B). Hospital insurance paid for hospital care, skilled nursing facility care, home health care, and hospice care. Part B covered physician, outpatient, laboratory, or other ambulatory care. Hospital insurance accounted for approximately two-thirds of Medicare costs, whereas part B supplemental medical insurance absorbed the rest. Recipients sixty-five and over who received Social Security or railroad retirement benefits were eligible for Medicare.

The Medicare program has never offered comprehensive coverage. Part A has substantial deductible and coinsurance provisions. For example,
in 1998, the deductible for each benefit period is $764 (HCFA, 1998b). The coinsurance payment for each additional hospital day from the sixty-first to the ninetieth day is $19; the coinsurance for each nonrenewable, lifetime reserve day is $381. The copayment for skilled nursing facilities is $95.50 for the twenty-first through the one-hundredth days per benefit period. The part B deductible was $100 in 1998 with a $43.80 monthly premium. The most critical gaps in coverage for both part A and part B are the failure to cover prescription drugs and the absence of a “stop-loss” provision common in private insurance, a maximum out-of-pocket liability to the beneficiary. These disparities mean that Medicare covers something less than half of the medical costs of the elderly (Cutler, 1997: 200).

Both private insurance companies and the federal government have developed mechanisms for narrowing the shortfall in coverage. Private insurance companies have established private supplemental medical insurance, commonly called Medigap insurance, that covers much of the deductible and coinsurance costs and provides coverage for prescription medicines. Federal laws require the companies to offer one or more of ten standard packages (A through J) to ensure fairness and uniform coverage. Roughly two-thirds of all Medicare recipients have purchased medigap policies in the years following the passage of Medicare. Another 15% of recipients are sufficiently poor that they meet the means-test provisions for Medicaid insurance. The remaining 15% have no private supplemental coverage at all.

Congress’s first major attempt to limit the health care costs of the elderly was the Medicare Catastrophic Coverage Act of 1988 (MCCA) Day, 1993; Himelfarb, 1995; Street, 1993). For the first time, MCCA placed a cap on out-of-pocket expenses and provided reimbursement for prescription drugs. The Act also abandoned the social insurance financing mechanism, instead opting to fund the program by progressively taxing Medicare beneficiaries themselves. Many of those taxed would find that the program duplicated the benefits of their medigap insurance policies. The opposition of the affluent elderly population forced repeal of the Act in 1989.

In the wake of the repeal of MCCA, congressional attitudes toward Medicare began to shift. Confronted with repeated shortfalls in the Hospital Insurance Trust Fund, Congress abandoned the effort to expand Medicare coverage and began to explore mechanisms for limiting the growth of Medicare expenses. As much of American medicine began to shift to managed care programs, Congress began requiring the Health Care Financing Administration (HCFA) to provide more managed care alternatives (Cutler 1997). Until recently, the only available managed care alternative offered by HCFA has been the risk contract health maintenance organization ([HMO] HCFA, 1998a). HMOs limit costs by carefully monitoring the services offered to patients and by focusing on preventive rather than acute care. HCFA has contained its costs by paying the Medicare HMOs 95% of the average fee-for-service Medicare costs for similar individuals in the same geographic area. HMOs are relatively unpopular among Medicare recipients, accounting for only about 10% of all recipients (Cutler, 1997; GAO, March 1997). Limits on physician selection, insufficient health plan alternatives, and lack of financial incentives to join the program have produced little movement among beneficiaries toward Medicare HMOs.

The Funding Crisis in Medicare

The General Accounting Office (February 1997) has projected that the Hospital Insurance Trust Fund will be exhausted by 2001. By contrast, the Social Security Trust Fund is not projected to go bankrupt until 2032 (GAO, July 1998). The more rapid depletion of Part A of the Medicare program suggests that forces other than the aging of the population are affecting disbursements from the Hospital Insurance Trust Fund. In 1980, Medicare spending represented 1.3% of gross domestic product (GDP). In 1995, the percentage had risen to 2.5%. Under current projections, that percentage may jump to an astounding 8.4% by 2050 (Aaron & Bosworth, 1997). By contrast, spending on education at all levels of government has remained constant at 5% of GDP over the last two decades (Cutler, 1997).
The bulk of this growth can be traced to increases in the cost of health care (Aaron & Bosworth, 1997; Cutler, 1997). Health care costs for both the public and the private medical sectors have grown because patients are receiving more medical services than in the past:

Services that were not even dreamed of three decades ago are now commonplace. Services that were available but rarely used a decade ago are now routine. Some of these new and more intensively used services are expensive and thus have pushed up Medicare spending. Others are cheaper than previous treatments, but, because they are less risky, utilization has risen enough to drive up total spending (Cutler, 1997: 211).

Research by Cutler (1997: 211) and others has suggested that fully 50% of the growth rate in health care costs in recent years is due primarily to "technological change in the practice of medicine."

The addition of health cost increases to the other demographic, social, economic, and political changes confronting Medicare makes the medical program a major burden on the federal budget. Cutler (1997) identified several major problems arising from the enormous growth in Medicare. The current annual growth rate in real Medicare spending of 5% will lead to expanding budget deficits in the near future despite recent reductions in the size of the deficit. Without serious reductions in the growth of Medicare or tax increases or both, balancing the federal budget over the long run will be impossible.

In the long-run, the solvency of the Hospital Insurance Trust Fund will be compromised. Cutler (1997) found that, even though outlays from the trust fund currently equal revenues, outlays will exceed revenues by more than 8% of taxable payroll within seventy-five years. In real terms, outlays will outstrip revenues by a factor of four. The primary sources of these enormous increases are likely to be the ongoing growth in health care costs and the looming retirement of the Baby Boom generation. Unfortunately, the kind of tax increases or spending cuts necessary to balance the trust fund over the next twenty-five years will go beyond the bounds of political acceptability.

Finally, Cutler (1997) argued that, despite the substantial benefits of Medicare, the structure of the program encourages the over provision of services. For beneficiaries with supplemental insurance, the individual out-of-pocket costs are so low that they present few disincentives to seek expensive forms of medical care. Medicare pays providers based on the number and types of services provided, giving the providers few incentives to save costs. Combined with an enormous reduction in HCFA's audit rates for some types of Medicare payments, the overutilization of services has contributed substantially to the growth of Medicare payments (GAO, March 1997). Cutler (1997: 210) describes the overprovision of health services as "a waste of social resources."

**Medicare Reform, 1995-1997**

Observing these trends, both the Clinton Administration as well as the Republican Congress elected in 1994 recognized the necessity for immediate action on Medicare. Committed to balancing the federal budget within seven years under the Contract with America, the Republican majority in the House of Representatives needed to reduce discretionary spending to achieve their goal without raising taxes. The majority had already declared that the three largest sources of federal expenditures, Social Security, defense, and interest on the public debt, were off limits in the current budget negotiations. The largest remaining program was Medicare; moreover, Medicare had the highest growth rate of any of the major federal programs (Congressional Quarterly, 1995).

Given the structure of the program, House Republicans had only four basic mechanisms for controlling Medicare costs: reductions in payments to providers, increases in payments from beneficiaries, restructuring the program, and directly capping Medicare spending (Cutler, 1997). Under Medicare prior to 1997, hospitals were reimbursed on a prospective payment system that categorized hospital admissions into approximately 470 diagnostic related groups (DRGs). Each DRG was given a severity weight that related the patients' illnesses to the severity of the average admission.
The hospital received a reimbursement that was the product of these verity weight and the base payment per unit weight. Payment reductions could be achieved by controlling the growth of the base payment (Cutler, 1997). Payment reductions could also be achieved by expanding the prospective payment system to other medical providers such as rehabilitation hospitals, long-term care hospitals, and home health agencies.

Under the old program, increases in beneficiary payments could be achieved by increasing the deductibles for the various components of the program. The hospital insurance deductible was indexed; however, the supplemental medical insurance deductible of $100 was unusually low compared to private insurance plans. Some services such as clinical laboratories, skilled nursing facilities, and home health care had virtually no cost sharing. The out-of-pocket costs of beneficiaries could also be increased by accelerating the growth in the monthly premium of part B insurance. The increase could be a flat rate, progressive, age-based, or related to the use of medigap policies (Cutler, 1997). Perhaps the most radical way of increasing beneficiary spending would be to advance the age of eligibility from 65 to 67 or even older. A shift to 67, for example, would match the current transition in Social Security.

More dramatic reforms could be achieved by restructuring the Medicare program (Cutler, 1997). Most reform plans focused on the issue of choice. By allowing Medicare beneficiaries to choose among several competing types of health plans, reformers hoped to make the Medicare program more efficient and less costly. Medicare would achieve savings by paying less than 100% of the average fee-for-service Medicare costs. The managed care plans would be forced to become more efficient at providing quality care for less money. The alternative plans included several types of managed care programs, traditional fee for service Medicare, and fee-for-service Medicare supplemented by standard medigap policies.

The purpose of the new options was to provide incentives for beneficiaries to shift into managed care programs, thereby, presumably, reducing the overall cost to the Medicare program. Regardless of intent, Cutler (1997) has noted that the current Medicare HMO program apparently increased Medicare spending because the payment of 95% of average fee-for-service costs actually overestimated the cost of health care if the HMO members were still under the fee-for-service Medicare program. Thus, a greater shift to Medicare managed care may not substantially reduce costs.

The most controversial beneficiary option often discussed by Medicare reformers was the Medical Savings Account (MSA) coupled with a high-deductible catastrophic health insurance policy. The beneficiary’s Medicare benefit would be used to purchase the high deductible policy. The remainder of the benefit after the purchase of the policy would be placed in a nontaxable account to be used for noncatastrophic medical care. Some portion could be rolled over to subsequent years. The MSAs were controversial because the high deductible would attract more of the healthy elderly and prompt HCFA to overpay MSA plans (Cutler, 1997).

The final mechanism available to Republicans to control Medicare spending was direct spending caps (Cutler, 1997). One approach was to cap overall Medicare spending and to limit the value of Medicare payments to choice-based plans. The former was much more difficult to do than the latter because the government only controlled the service price and not the spending. A second approach was “global budgeting,” paying providers an annual fee for services rather than paying them by medical service provided. As Cutler (1997) noted, most European national health insurance plans use this method to control costs.

The Republican Medicare Reform proposal combined elements from all four approaches. The legislation proposed several mechanisms to reduce payments to providers. The program would have reduced payments to in-patient hospitals by recalculating price indices and limiting extra reimbursement to hospitals with a high percentage of indigent patients. The proposal also would have restricted inflation adjustments to hospices, required a negotiated fee structure for skilled nursing facilities, and established a prospective payment system for
home health services. Inflation adjustments for durable medical equipment would have been frozen (Congressional Quarterly, 1996).

Beneficiaries would have paid higher premiums for part B insurance because the planned reduction in the beneficiary share of the program from 31.5% to 25% would have been canceled under the new legislation. More significantly, the Republican legislation would have imposed means testing on part B insurance, requiring wealthy beneficiaries to pay the entire cost of the premium. At the low income end of the program, the entitlement that required Medicaid to pay Medicare premiums, deductibles, and coinsurance for qualified beneficiaries would have been repealed and replaced with a state pool of money that covered premium payments only (Congressional Quarterly, 1996).

The proposal would restructure the Medicare program to provide beneficiaries more choices. Medicare beneficiaries would be able to select from several managed care alternatives including HMOs, HMOs with a Point of Service Option (POS), Provider Sponsored Organizations (PSOs), and Preferred Provider Organizations (PPOs). In addition, beneficiaries could select the original Medicare plan, Medicare with medigap, private fee-for-service plans, MSAs, and Religious Fraternal Benefit Society plans.

Even with the substantive reductions offered under the Republican plan, the drafters of the legislation recognized that changes in medical utilization by beneficiaries and the likely overpayment of Medicare benefits to insurance plans selected by healthier Medicare recipients might well minimize the cost savings (Cutler, 1997: 228). To ensure budget reductions, the Republican leadership in the House of Representatives added a “fail-safe” mechanism that would automatically reduce payments to providers if congressional budget targets were not met. The Republicans hoped to save $270 billion over seven years.

The Republicans minimized interest group opposition to the legislation by offering concessions to key medical industry and aging groups. Managed care companies stood to gain additional patients; hospitals and doctors negotiated restrictions on medical malpractice lawsuits and damages. The American Association of Retired Persons withheld its criticism until later in the legislative debate because the plan only marginally affected the premium rates of current beneficiaries.

Despite these political precautions, the Clinton Administration and the congressional Democratic party actively opposed the changes from the beginning. Still smarting from the partisan attacks on Clinton’s health care proposal in 1994 and the Democratic Party’s loss of Congress in the 1994 midterm elections, the President and the Democratic leadership adopted a strategy designed to maximize their partisan advantage in the 1996 presidential election. Democrats argued that the proposed savings greatly exceeded the amount necessary to save the fund. They contended that the Republicans intended to use the Medicare savings to finance a tax cut for the wealthy.

In the House, the Republican plan marched through the Ways and Means and Commerce Committees on a series of party line and near-party line votes. The Democrats, unable to break the Republican unity on key votes, used their committee and floor time to publicly condemn various sections of the legislation. In a series of debate-limiting maneuvers and last minute concessions to rural Republican congressmen, Speaker of the House Gingrich held the votes of all but six Republican members of the House and gained four Democratic defecitons to pass the legislation (Congressional Quarterly, 1996).

The Senate version of the Republican legislation covered similar ground as the House version but in some ways, the Senate proposal was even stricter than the House bill. The Senate would have increased the eligibility age from 65 to 67 and set lower income limits in the means test for part B. In other ways, the Senate proposal was more liberal. For example, the Senate version contained no automatic “fail-safe” mechanism to guarantee savings.

The Senate committee work was more bipartisan than the mark-up sessions in the House and the looser Senate rules allowed more amendments to be considered. In the end, however, the Medicare reform package survived with little significant change.
The final roll-call vote on passage produced a partisan split with the exception of Senator William Cohen (R) of Maine, who voted against the Republican proposal.

The conference committee took two weeks to iron out differences before resubmitting the budget reconciliation bill (of which the Medicare reforms were a part) to both houses for approval. Both houses passed the reconciled bill on November 17, 1995. As he had threatened all along, President Clinton vetoed the legislation on December 6, 1995, citing the overly large reductions in Medicare, the distorting effects of the MSAs, and the introduction of means testing into a social insurance program.

Within days, the President countered with his own program that, surprisingly, had many of the same features as the Republican plan. Despite the partisan rhetoric of the entire process, both the Democrats and the Republicans agreed that Medicare needed significant reform to avoid bankruptcy and end the cycle of short-term fixes that had characterized policy decisions over the previous decade.

Clinton’s program also reduced Medicare growth, albeit by a smaller amount ($124 billion). The President’s reforms also increased the choice of health plans for Medicare beneficiaries. The key exception was the exclusion of MSAs by the President, who argued that the accounts would fragment the risk pool by attracting largely healthy seniors. Part B premiums also increased under the President’s plan, but at a slower rate. Like the Republican plan, the bulk of savings were to be achieved by reducing payments to providers. The Clinton plan also deviated significantly from the Republican proposal by avoiding automatic reductions in the budget and by proposing increases in some services. The additional services were in the areas of respite care for Alzheimer’s caretakers, mammography, colorectal cancer, and preventive vaccinations. The original Republican plan would have held Medicare growth to 5% per year; whereas, President Clinton’s plan would have limited growth to around 7% per year.

The partisan debate had been so intense and divisive in 1995 that, when the 1996 annual report of the trustees of the Federal Hospital Insurance Trust Fund suggested that the trust fund would be broke by 2001 rather than 2002, the occasion produced accusations rather than action (Congressional Quarterly, 1997). The Republicans scaled back their 1996 proposal, reducing the proposed savings to $168 billion. The Clinton administration proposals were similar.

Clinton’s reelection in 1996 and the continuation of Republican control of Congress promised further political conflict in 1997; however, both sides proved more willing to compromise. The final version of the 1997 Medicare reform legislation included provisions for all parties. Overall, the new legislation reduced the growth of Medicare spending by $115 billion over five years, staving off the bankruptcy of part A through 2007. The primary source of the reductions was a decrease in payments to providers of all types. In addition, the legislation required the development of prospective payment systems for psychiatric, rehabilitation, and long-term care hospitals as well as skilled nursing facilities. The funding of home health care was transferred from part A to part B, where its costs would be covered from beneficiary payments and general revenues. Home health care was also to be placed under prospective payment.

The new legislation also significantly expanded the choices available to Medicare beneficiaries by allowing different types of managed care options and by introducing PPOs and PSOs as competitors for HMOs. The legislation did include provisions for MSAs; however, the program was a pilot program to be terminated in 2002 and to be limited to 390,000 participants. The final version of the bill included some additional services such as prostate screenings, bone density tests, blood testing, and diet counseling. The legislation also specifically excluded Senate provisions that would have raised the eligibility age, introduced means testing, and required a $5 copayment for home health care visits.

Overall, even though the legislation was the biggest change in Medicare since its original passage in 1965, the effects were only short-term. Unable to reach compromises on the most critical issues and sensitive to the political fallout of the 1995 reform effort, President Clinton and Congress agreed to pass the responsibility for proposing changes to a
seventeen member bipartisan commission on the future of Medicare. The commission will file a report with Congress on March 1, 1999. Recommendations approved by eleven of the seventeen commissioners will be included in the report.

Discussion

The great irony of the debate over Medicare between 1995 and 1997 is the fact that both the Clinton Administration and the Republican Congress accepted the crisis in Medicare as real. Both sets of political actors recognized pending changes in the structure of the aging population and the potential of those changes to drive Medicare spending into an uncontrollable cost spiral. Both the Democrats and the Republicans proposed reforms that substantially reduced the growth rate in the program while significantly altering its structure. Yet, the shared philosophies were not enough to overcome the realities of modern American politics. The resulting reforms only temporarily delayed the day of reckoning.

The pressure for political action arose from the trends outlined earlier in this article. The pending retirement of the Baby Boom generation combined with the impact of technological change on health care costs placed the Medicare program on shaky financial ground. If unchecked, outlays from the program would exceed revenues by a factor of four by the middle of the twenty-first century. Trustees of the Federal Hospital Insurance Trust Fund repeatedly warned of the pending bankruptcy of the Fund over the previous decade. By the second Clinton Administration, the need for federal action had become critical.

At the same time, support for federal entitlements for the elderly weakened. Most elected politicians still considered Social Security and Medicare to be the “third rail” of politics -- touch them and you die. Widespread support for the programs made most members of Congress and even most presidents reluctant to consider reform. Therefore, any evidence of “wiggle room” in public opinion would provide the impetus for change. Despite nearly universal support for the principles of federal pensions and medical care, the public opinion consensus on these issues was permissive, rather than directive (Erikson and Tedin, 1995). That is, the typical citizen while supporting entitlements for the elderly, might not oppose reductions in the size of the programs. Although few survey respondents wished to spend less on these programs, they also rarely considered the programs to be central problems in American society.

Economic improvement among the elderly population removed another argument for entitlements for senior citizens. The political environment that allowed the development of the aging policy network between 1935 and 1965 rested firmly on the belief that the aged were more vulnerable and more dependent than the average citizen. As a result, the elderly were more deserving of federal assistance. This argument served as the justification for the passage of Medicare in 1965. The dramatic increase in median income among all segments of the older population and the correspondingly spectacular reduction in poverty levels weakened this presumption of “deservingness.” The fact that many segments of the older population remained in poverty provided some justification for continuing the entitlements, but also furnished convincing arguments for the introduction of means testing.

The generational equity debate also provided ammunition to the critics of Medicare and other entitlements. The great increase in poverty among America’s children coupled with a rapid decline in poverty among the elderly prompted many social and political commentators to suggest that too much was being spent on the elderly and too little on America’s children. Given that upwards of 40% of the federal budget funded the aging network, these challenges carried some weight. Although little evidence existed of generational warfare among the general public, the aura of undeservingness of the generational equity argument to opponents of elderly entitlements made the argument a potent one in political debates over the future of Medicare (Wisenbaker, 1999).

The demographic, social, and political changes that confronted the aging policy network should have made the passage of Medicare cuts much easier; but, the decentralization of the policy process and the partisan polarization in Congress effectively blocked
any long-term change in Medicare. The confrontation between a Democratic president and a Republican Congress guaranteed political friction even though both branches of government shared a common interest in rescuing Medicare. The search for common ground between these competing interests was complicated by the election in 1994 of the most partisan Congress in sixty years. The result was not reasoned policy debate, but political deadlock. Unable and unwilling to compromise, even on issues where they shared common interests, the President and Congress reached a policy impasse in December 1995 with President Clinton's veto of the Republican reform package.

Only in 1997 did the partisanship dissipate enough to allow the two branches of government to delay the Medicare financial crunch until 2007. The compromise had much more limited savings, deliberately sidestepped the issue of increasing beneficiary payments, and left the toughest questions to a special commission. The report of the commission and the future of Medicare were thus left to a later Congress and, ultimately, another President.

Conclusions
The failure of the recent Medicare reform effort suggests several conclusions about the paradox of aging policy. First, the aging policy network cannot survive in its current form. The principle of universality that has characterized aging policy for the past sixty years has come under increasing attack. In both the 1995 and the 1997 Medicare reform proposals, means testing was a significant element. Means testing of part B premiums actually passed Congress in 1995, only to be vetoed by President Clinton. Despite the political controversy over the 1995 Medicare package, the U.S. Senate added means testing again in 1997, although it was removed in conference at the insistence of both the House of Representatives and the Clinton Administration. The transformation of Social Security and Medicare from social insurance programs to public assistance programs seems inevitable. That transformation promises to change the nature of aging policy forever.

Second, political change will occur with or without effective political leadership. The political pressure to shift resources from the elderly to other segments of society will increase rather than decrease over time. Without political leadership, these changes will occur later rather than earlier, and will be more rather than less catastrophic. The natural tendency of the political system is to delay change until the situation is so critical that immediate action becomes both necessary and inevitable. Under those circumstances, rational policy planning is all but impossible and the changes will have ramifications that defy prediction.

Third, the political polarization of both the Congress and American society further minimizes the prospect for rational planning about the future of aging policy. Determining the proper balance among the competing interests of the elderly and other social groups in American society will require foresight and compromise. The short-term focus of most elected officials makes long-range planning relatively unattractive, but also makes compromise critical to achieve even short-range goals. At the same time, recent trends in American politics toward political polarization reduce the odds of compromise. The much more intense level of political debate in Congress, particularly, has made the bargaining a rarity. Few modern political actors appear willing to negotiate on crucial political issues. Given the looming crisis in aging policy, this trend toward rigid political positions is not a good sign.

The paradox of aging policy has no easy solution. The demographic trends are inevitable: Social Security and Medicare will overburden the federal budget during the next fifty years. The improved economic situation among the elderly has begun to undermine political support for the program. Although general support remains high, pessimism about the long-term health of both Medicare and Social Security has increased. These factors have made generational equity a critical issue for key decision makers. These trends will require thoughtful political leadership; however, the political polarization of national politics has created a leadership vacuum. Until that vacuum is filled, aging policy will continue to drift unguided toward an uncertain future. The
longer the political system waits to deal with the crisis, the more catastrophic the final solution will be. American society has the tools now to deal with the crisis; what national politicians may lack is the necessary political will.

Author’s Notes:
1. Because median household income and poverty figures fluctuate on an annual basis, trends over 27 years are calculated from regression equations using time as the independent variable.
2. Material from this section appeared in a slightly different form in Daniels (1993).
3. Party votes are votes where a majority of Democrats vote against a majority of Republicans. Party cohesion is the percentage of the time each Congress votes with his or her party majority on party votes.
4. Some of the material on the structure of Medicare, the funding crisis, and the available options for controlling Medicare costs in the next section are based on Cutler (1997).
5. All new plans will be phased in on January 1, 1999, except Medicare Medical Savings plans which were phased in on November 1, 1998.

References

The Southwest Journal on Aging Vol. 14 No. 2


---

**AARP**

The first place to call for the last word in aging

**American Association of Retired Persons**

Southwest Region Office • 8144 Walnut Hill Lane

Suite 700 - LB 39 • Dallas, TX 75231

Phone: 214-265-4060 • FAX: 214-265-4061

---

58 — The Southwest Journal on Aging Vol. 14 No. 2