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MAKING CATASTROPHIC HEALTH CARE AFFORDABLE: A NINE POINT PROGRAM

INTRODUCTION

Pressure is growing in Congress for legislation to address the problem of catastrophic health care costs, the high medical bills that can force Americans into bankruptcy or onto welfare. There is wide agreement that action on this is needed to deal with the financial problems of three groups: elderly Americans facing enormous hospital bills exceeding their Medicare coverage, the elderly who need expensive long-term nursing care, and working Americans with inadequate or no health insurance. But while there is agreement on the need, intense debate rages over the most effective approach.

In last year's State of the Union Address, Ronald Reagan instructed Health and Human Services Secretary Otis Bowen to prepare a study on how the issue might be tackled. Bowen's report, issued late last year, contained some valuable proposals for encouraging the private sector to provide better coverage for working Americans and for long-term care costs. But the main thrust of Bowen's proposal significantly expanded the Medicare system. This was embraced eagerly by many liberals who welcome it as a first step toward a taxpayer-financed national health service. Bowen's scheme was criticized by conservatives who fear that it would displace existing private insurance for the elderly and open the door to enormous deficits in the Medicare system, since lawmakers would have the incentive to hold premiums down while voting for more and more generous coverage.

In his 1987 State of the Union Address, Reagan reaffirmed his intention to offer legislation soon to deal with catastrophic health costs. He wisely stopped short of endorsing the Bowen plan,

recognizing the danger of an open-ended financial commitment by the federal government. Yet Reagan did not spell out his alternative to Bowen.

This alternative is needed. Elderly Americans who believe that the potential financial threat they face would be ended by Bowen's Medicare plan are being misled. Between Medicare, Medicaid, and private insurance, the vast majority of America's elderly are covered for catastrophic expenses for doctors and hospitals. The few who remain exposed to catastrophic costs could be covered by changing the law governing private Medicare supplemental (Medigap) policies, to enable them to provide inexpensive catastrophic protection rather than requiring them to provide high cost first-dollar coverage for the copayments charged by Medicare. This change would reduce dramatically the cost of private insurance for the elderly. Indeed, the cost of supplemental private insurance giving coverage comparable to the Bowen plan would cost no more than the Medicare premium increase envisioned by the Secretary, and there would be no need to expand the federal role.

The catastrophic costs associated with long-term care are more difficult to solve. Paying for long-term care through Medicare would lead to staggering outlays, financed only by huge increases in Medicare premiums or large hikes in the payroll tax. Needed instead are ways to encourage employers and working Americans to set aside funds, or to obtain insurance, which would become available when they retired. This insurance would protect them against the enormous cost of several years in a nursing home. Long-term care insurance would encourage Americans to plan for their future; by contrast, using Medicare to cover such costs would encourage Americans to wait until it is too late and then force the next generation to pay the bills.

As with acute hospital care costs for the elderly, the problem of catastrophic health costs for underinsured working-age Americans can be solved largely without increasing federal involvement. Steps such as requiring tax-deductible group insurance to provide catastrophic coverage would involve little, if any, increase in premiums yet would solve most of the problem. And encouraging state risk pools, which spread the insurance costs of such hard-to-insure individuals as those with existing medical problems, would address the difficulties of many Americans who are unable to obtain insurance.

The catastrophic and long-term care needs of Americans thus should be addressed not by transforming Medicare into a veiled form of national health insurance. Congress should instead consider a nine point program that would:

1) Change the law governing private policies supplementing Medicare to require insurance companies marketing policies to provide catastrophic hospital coverage.

2) Provide vouchers through Medicare to assist the elderly to purchase private catastrophic insurance policies.

3) Make greater use of Medicare vouchers, to encourage the elderly to obtain better health care at lower cost.

4) Encourage private long-term care insurance.

5) Require tax-deductible company health plans to provide catastrophic protection.

6) Establish "Health Banks" to encourage workers to obtain inexpensive catastrophic coverage and save for their out-of-pocket health care costs.

7) Encourage states to establish risk pools to provide protection for uninsurable Americans.

8) Amend the law to permit corporations to make tax-deductible contributions to fund retirement health plans for their employees.

9) Create private Health Care Savings Accounts, which workers could use instead of a portion of Medicare.

This package of reforms would not expand Medicare or the federal role. It therefore would not run the risk of opening the Medicare door for future runaway expenditures and deficits. Medicare has already shown itself susceptible to the tendency of politicians to try to win applause by keeping premiums artificially low while permitting outlays to rise. The Bowen plan proposes what it claims is an "actuarially sound" addition to Part B of Medicare to cover the full cost of catastrophic protection. But the Part B premium already has a record of falling woefully short of covering outlays. It is supposed to cover 50 percent of physicians' costs reimbursable under Medicare, for example, but only pays for half of that. There can be little doubt that premiums to cover catastrophic costs soon also would fail to keep up with outlays.

Government certainly has a role in dealing with catastrophic health care costs. But its role should be to provide a framework that will stimulate efficient and appropriate private sector solutions. Utilizing the private sector will foster competition and innovation, while ensuring that the finances of health care will remain sound. Turning to the government to raise and spend the money to pay for catastrophic care invites politicians to engage in a bidding contest to promise ever more generous benefits, leaving the next generation to pick up the tab.

THE NATURE OF THE PROBLEM

Medicare Part A (Hospital Insurance or HI) now pays for up to 90 days of inpatient hospital care for each spell of illness, with 60 additional "lifetime reserve days" which an elderly American can use at any time. This coverage is subject to a deductible of $520 per hospital stay, plus co-insurance fees of $130 per day for the 61st to 90th days of hospital stay, and $260 for each lifetime reserve day. Medicare Part B (Supplementary Medical Insurance or SMI) pays for physician or other health related services, subject to an annual deductible of $75 and a co-insurance fee of 20 percent of approved charges.

Part A, or HI, is financed by a portion of the payroll tax on working Americans, while a portion of Part B or SMI is paid for by a monthly premium of $17.90 charged to each elderly beneficiary, which pays for about 25 percent of program costs; the remainder is financed by general revenues. The Medicare deductibles, co-insurance fees and premiums (except the $75 Part B deductible) are indexed to current health costs.

Most elderly Americans have additional protection. Over 70 percent have private supplemental health coverage. Under law, this private protection must reimburse the elderly for the Part A and Part B co-insurance fees, and 365 days of hospital care beyond Medicare's coverage. Though private policies must provide this minimum, most give additional coverage, such as for unlimited hospital stays and the Part A deductible of $520. The coverage is provided to the elderly through many insurance companies and organizations for the retired, including Blue Cross/Blue Shield and about 200 other companies, the American Association of Retired Persons (AARP) and the National Council of Senior Citizens (NCSC). In addition, group coverage is provided by Health Maintenance Organizations (HMOs) and by many employers as part of pension benefits. Moreover, over half of those elderly without private supplemental health coverage are covered by Medicaid, which provides health care benefits to low-income Americans.

Thus between Medicare, Medicaid, and the private insurance, the elderly basically are covered for catastrophic expenses for acute care provided by doctors and hospitals for specific illnesses. The expenses for such care can still be a big burden, of course, but it is very rare for an elderly American today to have substantial life savings wiped out by hospital expenses. Very few elderly Americans are in hospitals long enough to exhaust even their Medicare coverage. Those with savings generally have the resources to buy private insurance providing further protection, and those without such resources ultimately are backed up by Medicaid. To be sure, it would be desirable to ensure that no elderly person falls through the gaps in coverage for catastrophic hospital costs. It must be recognized by policymakers, however, that this part of the problem is small and can

be remedied by changes in current law. It does not require a massive extension of the federal government.

The main problem for the elderly, in fact, is not catastrophic acute care expenses, but expenses for long-term care in nursing homes. Neither Medicare nor the private insurance generally covers such long-term care expenses. Many private insurers are beginning to offer such coverage, but very few of the elderly have elected to obtain it. That can be a mistake. Nursing home expenses are very high, usually between $1,500 and $3,000 per month, and can soon deplete life savings of most of the elderly, leaving the burden on children or other relatives, or on Medicaid.

It would be enormously expensive for the government simply to pick up all long-term care expenses. That would increase federal spending by probably close to $20 billion per year to start. A more sensible approach would be to spur the growth of long-term care insurance, so that the elderly need not face the risk of having their savings exhausted by a debilitating sickness near the end of their lives. It should also be made easier for Americans during their working lives to accumulate savings that would be available to purchase long-term care insurance in retirement or to pay into insurance plans that take effect upon retirement.

The third element of the catastrophic health care problem comprises working-age Americans lacking adequate insurance. About 90 percent of non-elderly Americans have health insurance coverage through the private sector or Medicaid. The great majority of these do have catastrophic coverage for acute care expenses in their insurance plans. Those who do not can face enormous medical bills if they or their families encounter serious illnesses.

WHY EXPANDING MEDICARE IS NOT A CURE

Much attention has focused recently on a proposal within the report on catastrophic medical expenses, authorized by Health and Human Services Secretary Otis Bowen and presented to President Reagan late in 1986.[1] Bowen explained his ideas on Capitol Hill last month. Bowen proposes to expand Medicare to cover all current deductible and co-insurance fees, except the first $2,000 in such expenses each year. Bowen also would allow unlimited days of hospital care. This extra coverage, says Bowen, could be financed by increasing the Medicare Part B premium by $60 per year.

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1. U.S. Department of Health and Human Services, Catastrophic Illness Expenses, Report to the President, Washington, D.C., November 19, 1986.

Bowen's proposal is seriously flawed. It not only would not solve the main financial problems facing the elderly, but almost surely would increase the federal role and open the sluices for a sea of red ink in the Medicare account. As bad, it would transfer to the government program the private insurance coverage which the elderly already have.

Many supporters of the Bowen plan do note, correctly, that the private policies cost substantially more than the $60 per year change estimated by Bowen. But these private policies are required by law to cover most of the first $2,000 in expenses, which Bowen's plan does not. Many plans, in fact, cover virtually all these costs. Since there is a relatively high probability that a retiree will incur some or all of such up-front costs each year, these costs are quite expensive to cover. By contrast, catastrophic coverage is not expensive, since insurers rarely need to pay out on such claims. It is first-dollar insurance that pushes up costs. As every motorist knows, insurance policies with no deductible are far more expensive than those without first-dollar coverage. Changing the legal requirements by allowing private insurers to offer policies with higher deductibles but catastrophic coverage would bring down the cost considerably.

The Bowen proposal would offer unlimited coverage while the private policies are often subject to caps of 365 days of hospital care and $5,000 of expenses on the Medicare Part B 20 percent co-insurance fee. But as a practical matter, very few of the elderly exceed the limits of such private policies. To exceed the hospitalization coverage provided by Medicare plus private policies, for example, would require hospitalization of 516 days for a single spell of illness. Moreover, the law known as the Baucus Amendment, which sets the minimum requirements for private Medicare supplemental policies, could be changed to require unlimited coverage for the private policies. Since virtually no one ever exceeds the current limits, health insurers say they would support such a change and would not increase their premiums as a result. In fact, many private policies already offer unlimited coverage for the Part B 20 percent co-insurance fee.

The Bowen proposal thus would provide little or no additional protection for all but a handful of Americans--and these could be helped with alternative approaches. All Bowen would accomplish would be to replace private coverage with a government program and put the taxpayer at risk by inviting Congress to play politics with future premiums and outlays.

AN ALTERNATIVE TO MEDICARE EXPANSION

Congress could deal with the problem of high hospital costs for the elderly without any expansion of Medicare, without revenue losses to the Treasury and without any change in the tax reform enacted last year. Congress could do this by:

o Changing the minimum standards for Medicare supplemental (Medigap) policies to require catastrophic coverage.

The Baucus Amendment, passed by Congress in 1980, and companion state regulations set minimum standards for the private policies sold to the elderly to supplement Medicare. These standards could be modified to require such policies to cover unlimited days of hospital care after Medicare runs out and unlimited expenses for the Medicare Part B 20 percent co-insurance fee. Since very few of the elderly ever exceed the current policy limits, there would be little, if any, increase in premiums. Yet it would enhance confidence that these private policies provide complete catastrophic acute care protection. If the Baucus standards were modified further to allow insurers to offer catastrophic policies with a deductible, say the same $2,000 per year envisioned in Bowen's Medicare proposal, these policies would cost far less than currently available policies, enabling more of the elderly to afford private insurance protection.[2] In fact, Robert Shapland, chief actuary for Mutual of Omaha, one of the nation's largest insurance firms, told the Senate Special Committee on Aging last month that his company could provide exactly the same coverage envisioned by the Bowen Medicare proposal for exactly the same $60 per year premium. Private Medigap policies currently are costly because they must cover almost all of a patient's out of pocket expenses. This proposed change, of course, would not prevent the elderly from purchasing first-dollar coverage. The law simply would not force them to do so in order to obtain catastrophic protection.

o Providing vouchers for Medicare supplemental policies.

Vouchers could be given to those elderly not on Medicaid to help them pay the premiums of private Medicare supplemental policies with catastrophic coverage. The voucher could provide each elderly retiree with $60 per year toward such premiums. Medicare deductible and co-insurance fees could be raised to provide the funds for the vouchers. Private insurance would be available, as it is today, to cover the deductible and co-insurance fees.

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2. For further discussion, see Private Sector Task Force on Catastrophic and Long-Term Health Care, Catastrophic and Long-Term Health Care (Washington, D.C.: National Chamber Foundation, 1986), p. 20.

The voucher program could be fashioned after the federal employee health benefit system, where each employee receives a list of competing private health plans eligible for employee health benefits. The employee chooses the plan he or she feels is most attractive and the cost is offset by the benefit package. Similarly, Medicare could provide the elderly with details of eligible plans and allow individuals to use their vouchers to help pay the cost of whichever plan they preferred.

o Widening the use of Medicare vouchers.

Under the Medicare amendments passed in 1982, Medicare beneficiaries have the option of choosing prepaid Health Maintenance Organizations (HMO) to provide Medicare coverage. The HMO chosen receives from the federal government each year 95 percent of the amount paid out annually for the typical Medicare beneficiary. In accordance with federal requirements and to attract elderly customers, virtually all HMOs now offer catastrophic acute care coverage without extra charge to each retiree who signs up with the HMO.

This could be expanded into a full-fledged Medicare voucher system with retirees free to choose to have their Medicare coverage provided by any qualified insurer, including HMOs, former employers as part of pension coverage, and regular insurance companies. Each insurer, however, would be required to provide acute care catastrophic coverage without charge to each retiree choosing that insurer to provide Medicare coverage.[3] This would help the elderly to obtain catastrophic coverage under the umbrella of Medicare with no extra premium, while decreasing total Medicare costs.

DEALING WITH LONG-TERM CARE COSTS

The greatest financial threat facing the elderly is not the cost of hospital care but long-term nursing home care. This is not easily addressed; neither the Bowen proposal nor rival plans offered by lawmakers would help today's elderly. The best approach to the issue would be to tackle its cause--inadequate financial preparation for retirement by working Americans. To do this, Congress could:

o Promote long-term care insurance.

The private sector is beginning to offer insurance to cover long-term care. Federal studies and technical assistance could spur the development of such insurance. Washington also could conduct education campaigns among the elderly concerning the need for such

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3. Ibid., pp. 16-18.

coverage. Surveys show that most of the elderly erroneously believe Medicare provides such coverage. Washington also should consult more closely with the private insurers to remove unnecessary government-imposed barriers to the development of such insurance.

PROTECTION FOR WORKING AMERICANS

The issue of inadequate insurance protection for working Americans centers on two problems. First, though most workers and their families have health plans, the Health Insurance Association of America estimates that about 5 percent of these plans do not provide catastrophic coverage. And second, just over 10 percent of working Americans do not have health insurance, due to uninsurable chronic health problems, inadequate income, or other reasons. These problems could be addressed by:

o Enacting minimum standards for tax-deductible employer coverage.

Health insurance for those below 65 normally is obtained through group coverage provided by employers, who receive a tax deduction for the premiums. The availability of the tax deduction could be limited to insurance plans that include a minimum degree of coverage against catastrophic illnesses. This would result in little or no extra cost to employers because the slight probability of any individual worker incurring catastrophic expenses makes catastrophic coverage inexpensive. A small increase in front-end deductible or co-insurance fees, moreover, would provide sufficient savings to the employer to offset whatever the cost of the catastrophic coverage would be. This policy option would extend catastrophic protection for those under 65.

o Establishing "Health Banks" to encourage workers to obtain inexpensive catastrophic coverage and save for their out-of-pocket health costs.

The existing tax deduction for employer-provided insurance could be modified so that workers individually or their employers could make tax-deductible contributions to a Health Bank instead of purchasing health insurance directly. Health Bank funds would be used to buy catastrophic-only health policies for retirement, with high annual deductibles of $1,000 or more, and to pay for out-of-pocket health expenses, such as the deductible. Any funds remaining after 65 could be used for retirement health insurance or medical expenses, including long-term care. This option would provide a new vehicle to help uninsured workers to obtain coverage, and help to restore incentives to counter rising health costs.

o Encouraging states to create uninsurable risk pools.

Many states, including Maryland, Iowa, Florida, and Wisconsin, have established uninsurable risk pools under which all insurers in the state contribute to a pool that offers insurance to Americans who are uninsurable due to chronic medical conditions. The premiums normally are set at between 150 to 200 percent of the usual rates, but this still does not cover the full cost of the insurance. The remainder must be met out of insurer contributions to the pool by insurance companies operating in the state. The federal government could encourage all states to set up such pools in a number of ways. The Employee Retirement Insurance Act (ERISA), which regulates private employer pension benefits, currently prevents states from requiring large companies which self-insure from contributing to such pools. Pool insurance should have a reasonably high deductible, however, to minimize the subsidies while still providing essential coverage.[4]

LOOKING AHEAD

These proposals constitute a package of steps that would provide an immediate remedy to most of the catastrophic cost problems associated with acute hospital and physician care needs, and begin to deal with the issue of long-term care costs. The package would do this without basic changes in the tax law or revenue losses to the Treasury. Beyond this, Congress should take the opportunity offered by the debate over catastrophic health costs to begin considering actions that could involve revenue losses and could change Medicare but would provide a more complete answer to the problem of catastrophic health care costs.

Action is also needed to address the Medicare financing crisis. According to the latest government reports, Medicare will likely run short of funds by the mid-1990s.[5] The long-term financing gap for Medicare is now much greater than the long-term gap faced by Social Security before the crisis bailout amendments of 1983.[6] Paying all

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4. Ibid., pp. 27-28.

5. 1986 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund (Washington, D.C.: U.S. Government Printing Office, March 31, 1986). Under the most widely cited, intermediate, Alternative IIB assumptions in the report, the Hospital Insurance program runs short of funds to pay promised benefits by 1996. Under the supposedly pesimistic Alternative III assumptions, the program runs short of funds of 1993.

6. Ibid.

the Medicare benefits promised to today's young workers likely will require raising Medicare payroll taxes 250 percent to 500 percent.[7] This problem needs to be addressed now so that rational reforms will have sufficient time to work. If action is delayed until the last minute, then the only options will be sharp payroll tax increases or draconian benefit cuts.

Effective actions would include:

o Amending DEFRA.

In the Deficit Reduction Act of 1984 (DEFRA), companies were stopped from taking deductions for contributions made to a fund during and employee's working years to pay for retirement health coverage. As a result, DEFRA has discouraged firms from providing such insurance. Employers should be allowed a deduction up to some reasonable limit for contributions to prefund catastrophic acute care coverage and long-term care coverage for future retired employees. This would increase such coverage significantly among future retirees.[8]

o Creating Health Care Savings Accounts.

The step that would have the most dramatic effect was contained in bipartisan proposal introduced in the House of Representatives last year by Representative French Slaughter, a Virginia Republican. This proposal would permit workers and their employers to contribute to private Health Care Savings Accounts in return for income tax credits. The worker would use the funds in his account to purchase private health insurance in retirement or to pay medical expenses directly. To the extent that the worker exercised this option for private coverage, his Medicare coverage would be reduced.

If a worker exercised the account option to the minimum level throughout his career, he would receive catastrophic acute care coverage under Medicare for medical expenses above the payments from his Health Care Savings Account. The funds in the account would also be available for long-term care expenses. If a retiree spent less than a specified proportion of funds in his account each year on medical expenses or insurance, he could withdraw the difference at the end of the year without restriction.

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7. 1986 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Disability Insurance Trust Funds (Washington, D.C.: U.S. Government Printing Office, March 31, 1986), Appendix E; Harry C. Ballantyne, Chief Actuary, Social Security Administration, "Long-Range Estimates of Social Security Trust Fund Operations in Dollars," Actuarial Note 127, Social Security Administration, April 1986.

8. Catastrophic and Long-Term Health Care, op. cit., pp. 10-11, 22.

The Slaughter plan would address catastrophic and long-term care costs for the elderly. It would give the private sector responsibility for the great majority of health expenses for the elderly, reserving the back-up catastrophic role for the government.

The private accounts would also create strong new incentives to counter rapidly rising health care costs. Retirees would likely seek to avoid expensive first-dollar insurance coverage and unnecessary or overly expensive medical charges to retain greater reserves in their private accounts and even pay themselves cash rebates.[9]

Most important, the long-term Medicare financing crisis could be eliminated through this option, without cutting benefits for the elderly or increasing payroll taxes for workers. Since workers would receive an income tax credit for their contributions, Medicare payroll tax revenues would not be cut. But Medicare spending would be reduced by the increased deductibles, as workers relied more on their private sector accounts and less on Medicare.[10]

CONCLUSION

There is no disagreement about the need to deal with the problem of catastrophic health care costs. Huge hospital and physician bills can devastate a family, and the specter of medical or long-term care costs haunts many elderly Americans. But agreeing that the problem exists does not mean that lawmakers should rush to accept the idea of a significant expansion of the federal government. Expanding Medicare to address the catastrophic cost problems of the elderly inevitably would be the first step on a very slippery and expensive slope. It would be difficult to draw the line on benefits. Lawmakers would be under continuous pressure to increase coverage, but likely they would flinch from raising premiums to pay for these benefits. And younger Americans, believing that federal programs would take care of their retirement health needs, would have even less incentive than they do now to make adequate provision for their retirement. The result would a federal program which grows steadily larger while sliding deeper into the red.

The alternative is for the federal government to create a framework in which the private sector is encouraged to provide adequate insurance protection on a financially sound basis, and younger Americans are given the incentive to set aside funds to pay

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9. Ibid., pp. 12-16, 23.

10. For futher discussion, see ibid.

for their retirement needs. Congress should move swiftly to enact such a framework.

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