The Heritage Foundation Issue Bulletin

No. 139 | The Heritage Foundation • 214 Massachusetts Avenue • N.E. • Washington, D.C. • (202) 546-4400

April 18, 1988

CATASTROPHIC HEALTH LEGISLATION: CONGRESS'S CASE OF MEDICARE MALPRACTICE

INTRODUCTION

A House-Senate conference committee currently is reconciling the versions of the "Medicare Catastrophic Protection Act" (H.R. 2470) passed by the two chambers. The legislation would expand Medicare to provide federal protection against large medical costs incurred by elderly Americans. A compromise bill, to be submitted to Congress, is expected in late April.

While the two bills differ significantly in their specific provisions, both would provide the elderly with unlimited, virtually free hospital care, cap beneficiary copayments for covered services, and expand Medicare benefits to include payments for prescription drugs. The bills would finance these and other program changes by increases in the Medicare Part B premium and special, new income surtaxes imposed exclusively on Medicare beneficiaries.

Their differences aside, each bill would have enormous economic and political implications. Each would constitute the single largest expansion of a federal social welfare program since Medicare itself was created in 1965. The Senate version, for instance, is projected to cost $27.7 billion over the first five years alone; the House version over the same period would cost $40.8 billion. Both bills would raise taxes paid by the elderly through a device euphemistically called a "supplemental premium." Approximately 12 million elderly Americans would be forced to pay hundreds or even thousands of dollars in extra taxes each year and would be placed in a new, tax bracket higher than those for other Americans.

At the same time, the bulk of this new spending and taxing simply would go to finance benefits that 75 percent of the elderly currently receive from private "medigap" insurance policies. To make matters worse, both bills completely ignore the real catastrophic problem for the elderly — long-term nursing care costs.

Opposition is growing among retirees as more of them discover that the bills constitute a "bait and switch" deal, in which the elderly face heavy taxes for benefits most already have under private medigap insurance, instead of what they expect Congress to deliver — protection against the genuinely catastrophic expense of nursing home care.

Instead of pushing ahead with this unsound legislation, Congress should:

♦♦ Examine various proposals for expanding private long-term care insurance to protect the elderly against the high cost of nursing home stays.

♦♦ Redesign the current backward structure of Medicare deductibles and coinsurance so they no longer prevent access to needed care, penalize seriously ill patients, or encourage unnecessary spending.

♦♦ Expand Medicaid coverage for the poor elderly by providing them with vouchers to purchase private supplemental insurance.

PROVISIONS OF THE PROPOSED LEGISLATION

The current Medicare program is divided into two parts, Part A (Hospital Insurance or HI) and Part B (Supplemental Medical Insurance or SMI).

Part A pays for most hospital care for the elderly as well as for some skilled nursing and home health care. It is financed by a portion of the Social Security payroll tax imposed on all workers.[1] All retirees automatically qualify for Part A Medicare coverage when they become eligible for Social Security.

Part B of Medicare pays for a large portion of outpatient physician services and related items for the elderly. Part B is a voluntary program for Social Security recipients who pay the premium for it. Yet premiums cover only 25 percent of Part B benefits. The remaining 75 percent comes out of the general federal revenues. Over 90 percent of the elderly are enrolled in Part B.

New Benefits Under Part A

Hospital Care. Under existing law, Medicare Part A pays for up to 90 days of inpatient hospital care for each spell of illness, plus 60 additional "lifetime reserve days" to be used if required. Beneficiaries must pay an initial deductible of $520 for each hospital stay and $130 per day of "coinsurance" for the 61st through 90th days of a hospital stay and $260 for each lifetime reserve day. These deductibles and coinsurance rates are adjusted annually for inflation.

---

1 The current HI tax is 2.9 percent of all wages up to $45,000 with employees paying half directly and employers paying half.

Both the House and Senate versions of the "Medicare Catastrophic Protection Act" would eliminate this entire structure. Instead, Medicare would pay for unlimited hospital care after a beneficiary paid a single deductible of $520 for the first hospital stay of each year.[2] Any subsequent hospital stay during the same year would be covered fully.

Skilled Nursing Care. Medicare currently pays for up to 100 days of extended care in a skilled nursing facility (SNF) outside a hospital for each spell of illness. To qualify for such care, the beneficiary must have been transferred to the facility following a hospital stay of at least three days. For the 21st through 100th days of SNF care, the beneficiary is charged a coinsurance rate fixed at one-eighth of the hospital deductible; last year this was $65 a day.

Under both bills, the spell of illness concept and the three day prior hospitalization requirement would be eliminated. Instead, a beneficiary would be allowed a maximum of 150 days skilled nursing care per year. The coinsurance would be pegged to skilled nursing care costs, not the hospital deductible. The House bill would set the coinsurance rate at 20 percent of average daily costs for the first seven days. The Senate bill would make the rate 15 percent for the first ten days.

Home Health Benefits. Currently, Medicare pays for some home health visits for recuperating patients. The House bill would expand this benefit to provide up to 35 consecutive days of home care. The Senate bill would expand it to 21 days and, in some cases, up to 45 days.

Other Changes In Part A. Both bills would limit the "blood deductible" to require beneficiaries to pay for only the first three units of blood or blood products they use each year. Both bills would remove the 210-day lifetime limit on hospice benefits for patients certified as terminally ill.

New Benefits Under Part B

Currently, Medicare Part B pays 80 percent of approved charges for outpatient physician services and other related items such as X-rays, laboratory tests, and medical devices, subject to a initial deductible of $75 per year. Medicare also reimburses half the cost of outpatient psychiatric care, up to $250 per year. The House bill would raise this limit to $1,000.

The most significant changes in both bills are a completely new prescription drug benefit and a cap on beneficiary copayments (coinsurance and deductibles). There are significant differences, however, in how the House and Senate bills structure these two provisions.

Drug Benefit. Under the House proposal, Medicare would reimburse 80 percent of the "reasonable costs" of outpatient prescription drugs above an annual deductible of $500 for 1990; this deductible would be inceased in future years according to changes in an "index of prescription drug prices." "Reasonable costs" and the "index" would be determined by the

---

2 The amounts cited here for deductibles and coinsurance rates are the 1987 figures. This legislation would not go into effect before 1989, at which time the hospital deductible is projected to be $580.

Department of Health and Human Services (HHS) according to formulas included in the bill.

The Senate bill would delay introduction of a drug benefit until 1991 and phase it in over four years. The Senate proposal also would pay 80 percent of the reasonable costs for drugs, but would have a higher deductible of $600 in 1991, indexed thereafter according to the cost of the program. Finally, the Senate version would give the Secretary of HHS authority to change the deductible, and add or remove categories of drugs from coverage, to keep the cost of the benefits in line with revenues.

Copayment Cap. Under the Senate plan, deductibles and coinsurance for both Parts A and B would be capped at $1,850 in 1989. The cap would increase in future years to keep pace with the cost of the program. Beneficiary payments that would count toward the copayment cap include: the inpatient hospital deductible, the annual Part B deductible, the blood deductible, Part B coinsurance charges, coinsurance for skilled nursing facilities and hospices, the costs of immunosuppressive drugs for the first year following an organ transplant, and the costs of annual mammograms and corectal examinations.

Under the House plan, only the deductible and coinsurance for Part B would be capped. Beneficiary payments under Part A, such as the hospital deductible and SNF coinsurance, could not be counted toward the cap. The cap would be set at $1,043 in 1990 and, in future years, would be indexed to the annual Social Security Cost of Living Adjustment (COLA). Beneficiary payments for the deductible and coinsurance under the drug benefit would not count toward the cap in either bill.

Expanded Medicaid Benefits for the Elderly Poor

Medicaid "Buy-In." State Medicaid programs currently "buy in to" Medicare on behalf of many of the elderly poor, paying the costs of Medicare deductibles and coinsurance and the Part B premiums for millions of low-income retirees. However, eligibility requirements differ from state to state and not all of the elderly poor qualify for this assistance. Because the proposed catastrophic legislation would reduce Medicare deductibles and coinsurance charges, state Medicaid programs would achieve "savings" as some of their current costs would be transferred back to Medicare.

The Senate bill would require states to use these "savings" either to expand services for Medicaid-eligible retirees or to extend their current Medicaid coverage to more of the indigent elderly. The House bill is more specific and would require states to expand the Medicaid "buy-in" to include all Medicare beneficiaries with incomes below the federal Census Bureau poverty level, which in 1987 was $5,255 per year for single elderly individuals and $6,628 for couples.

Spousal Impoverishment. Medicaid also pays for the nursing home costs of the indigent elderly. In fact almost half (48 percent) of all money spent on U.S. nursing home care comes from Medicaid. To qualify for this assistance an elderly individual must have income and assets below a set amount specified in the state Medicaid program. Nursing home residents who do not meet these qualifications must pay for their care out of their own pockets until they "spend down" to the Medicaid eligibility level.

This is a major problem for a nursing home patient who shares his income or assets with a spouse not in a nursing home. The healthy spouse needs to retain a substantial part of those resources to just to live a normal, independent life. In such a situation, "spending down" income and assets impoverishes the spouse as well as the patient. To help relieve this burden, both bills include amendments allowing spouses of nursing home patients to keep a larger portion of the joint income and assets.

A COST TIME BOMB

The proposed Medicare legislation is likely to be a ticking fiscal time bomb. According to a Congressional Budget Office (CBO) study, the cost of the basic House bill would escalate from $1.3 billion to $9.4 billion per year in just five years, for a five-year total of $30.9 billion. The drug provision would add another $9.9 billion, making a total cost of $40.8 billion over the first five years. [3] (See Figure 1.)

While the Senate bill would be less expensive, because the benefits are not as generous, the costs still would be enormous. CBO estimates that the cost of the basic Senate bill would grow from $2.8 billion to $6.3 billion per year over five years for a cumulative total of $24.3 billion. Because the drug provision in the Senate bill is delayed several years and then phased in gradually, CBO calculates only an additional $3.4 billion cost for the Senate drug provision within five years.

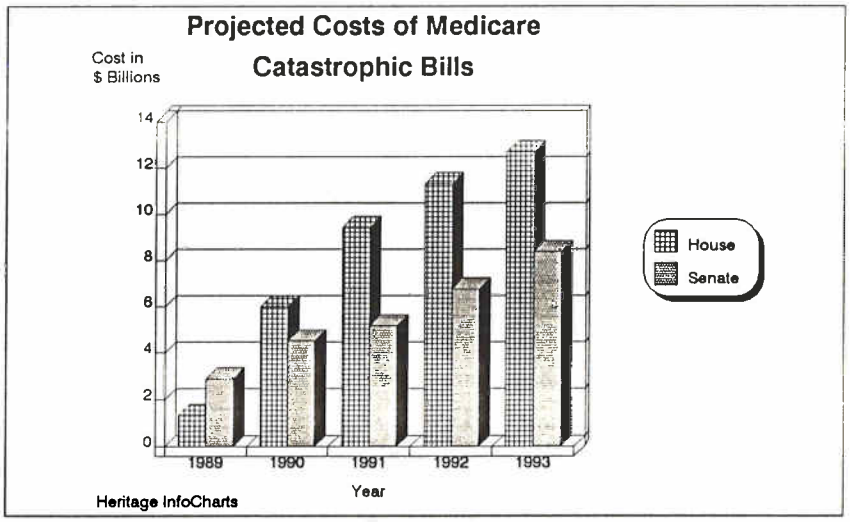

Figure 1

Source: Congressional Budget Office, March 14, 1988 estimates.

These projections of rapidly escalating costs, of course, represent only the first phase of the program. There is nothing to indicate that the annual cost would moderate after five years. On the contrary, the past history of Medicare, Social Security, and other federal entitlement programs suggests that costs will accelerate.

The main reason for pessimism over future costs stems from the provision to cap beneficiary copayments. After the second year, these caps account for over half the annual

3 Congressional Budget Office, *A Comparison of House and Senate Catastrophic Bills*, December 16, 1987. The study gave projections for the years 1988-1992, based on the assumption that the legislation would take effect on January 1, 1988. At the request of the conferees, CBO provided them on March 14, 1988, with revised budget estimates for the period 1989-1993, which assume an effective date of January 1, 1989. It is the revised estimates of March 14 which are cited throughout this paper.

costs (excluding drugs) of each bill. Figure 2 shows how the costs of the caps will increase much faster than the costs of limiting the hospital deductible and coinsurance. The reason for this is that while beneficiaries with long or multiple hospital stays currently have some of the highest individual out-of-pocket costs, they constitute a very small portion of all Medicare enrollees. Each year, only 0.5 percent of all enrollees incur hospital stays of more than two months, and only 6.9 percent go to a hospital twice in a year for stays no more than two months each. In contrast, 14.9 percent have single hospital stays of less than two months, while 49 percent never enter a hospital but use Part B Medicare services, for which they pay coinsurance and deductibles that would count toward the cap.[4]

What the Cap on Beneficiary Copayments Adds to the Cost of Medicare Catastrophic Bills

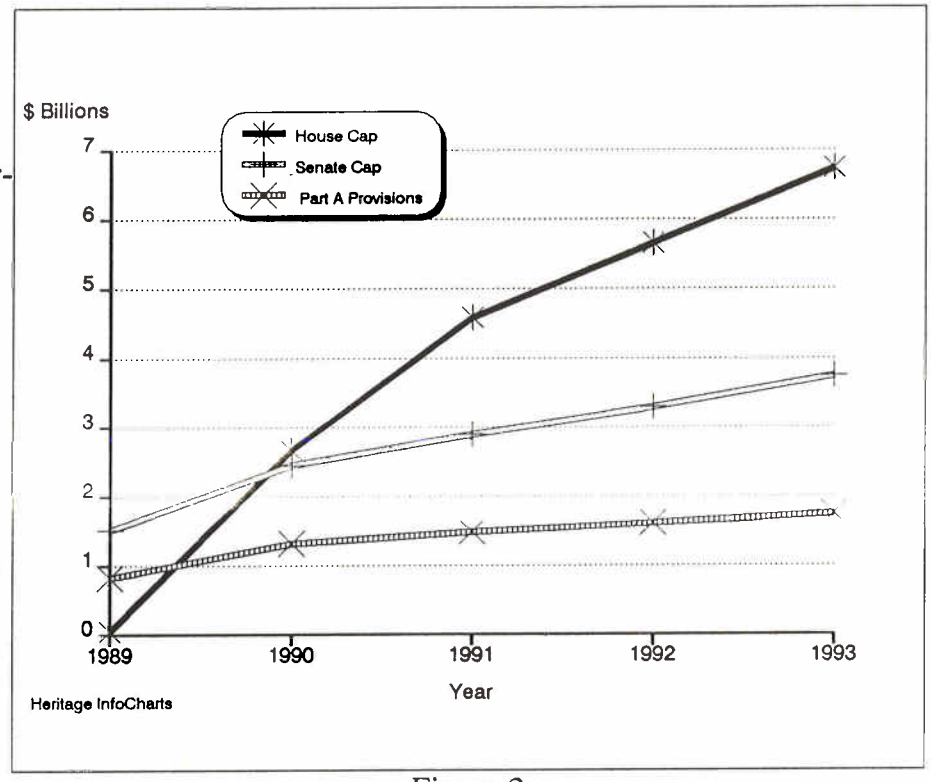

Figure 2

The cost of the Part A provisions limiting hospital deductibles and coinsurance increases at a slower rate because it affects only the small number of beneficiaries with truly catastrophic hospital bills. In contrast, the Part B cap would affect a much wider group of beneficiaries with truly catastrophic hospital bills. The House cap inflates cost even faster than the Senate because it starts at a lower point ($1,043 instead of $1,850) and is indexed to the COLA instead of program costs.

Source: Congressional Budget Office, March 14, 1988 estimates.

The biggest unknown in this legislation is exactly how much the drug provisions will cost. The estimates vary widely. The Congressional Budget Office originally projected the drug benefit in the House bill to cost $2 billion in 1990, while the Ad-

4 These distributional figures appear in CBO's December 16, 1987, study, p. 18.

ministration estimated it at $6.8 billion. And an independent analysis by the Project HOPE Center for Health Affairs, after examining the assumptions used in these official estimates, put the cost at about $5 billion.[5]

SOAKING THE ELDERLY

Despite the concern about program costs, this legislation in theory could be a good deal for the elderly. A close examination suggests otherwise. Except for the drug amendments, the catastrophic bills essentially would duplicate coverage already possessed by most of the elderly through private, supplemental medigap insurance policies. But the really bad news is the way that Congress proposes to finance the new benefits. Both bills require the elderly to pay for the new benefits through a combination of increases in the Part B premium and new income surtaxes, euphemistically called supplemental premiums, imposed exclusively on Medicare beneficiaries.

Under the House bill, only 20 percent of the cost of the new benefits would be paid for out of increases in the Part B premium. The remainder would come from increased income taxes on the elderly. In the Senate bill, 45 percent of the revenues would come from increases in the Part B premium and the remainder from new taxes. Figure 3 shows how the House and Senate bills would increase annual Part B premiums.

In either case, the elderly would be hit with major premium increases and a staggering new tax burden. According to the congressional Joint Committee on Taxation, the Senate bill would force the elderly to pay $11.4 billion in new premiums and $14 billion in new taxes during the first five years of the program.[6] Even worse, the House bill would force the elderly to pay $6.7 billion in new premiums and $28.7 billion in new taxes over the same period.

---

5 Project HOPE Center for Health Affairs, *The Medicare Catastrophic Drug Benefit: An Analysis of the Cost Estimates*, September 9, 1987. The study was commissioned by the Pharmeceutical Manufacturers Association. The authors concluded that one-third of the difference in the estimates by CBO and HCFA was due to the use of different data sources and half of the difference was due to different assumptions about the effect of the new drug benefit on drug utilization and demand. In explaining these differences the authors stated that, "It is important to emphasize that nobody really knows how much a drug provision would cost. In addition to the natural uncertainty attached to any projection, the uncertainty surrounding the likely cost of the drug provision is exacerbated because there is no recent or reliable data about prescription drug utilization or the way in which the Medicare population responds to changes in drug prices."

6 All of the tax and premium estimates cited in this paper are taken from five-year projections for each bill published by the Joint Committee on Taxation on November 30, 1987. The projections are for the period 1988-1992 and correspond to the budget projections in the December 16 CBO study. JTC has not yet prepared revised estimates for the period 1989-1993 to match CBO's revised estimates of March 14. It is anticipated that any new tax and premium projections for the period 1989-1993 will be about 15 to 20 percent higher than those for 1988-1992.

How the House and Senate Bills Add to Annual Part B Premiums for the Elderly

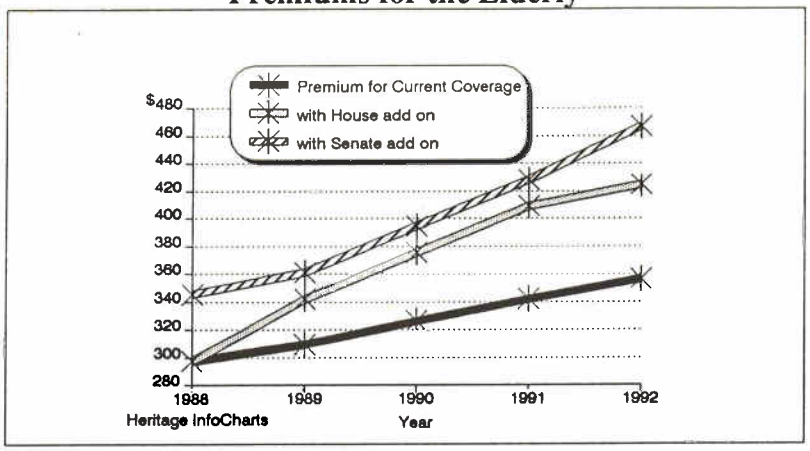

Figure 3

Source: Joint Committee on Taxation, November 30, 1987 estimates.

The House Tax Increase.

Under the House plan, every retiree, regardless of whether he or she were involved in the voluntary Part B, would be forced to pay an income surtax on all adjusted gross income (AGI) over $6,000 a year.[7] Initially, the tax would be $10 for every $143 of AGI up to a maximum of $580 at $14,166 of AGI. In the case of married couples filing a joint return, when both are covered by Medicare, each would pay the tax on their half of the joint income. This means that a married couple would start paying at $12,000 of AGI and pay double the amount up to a maximum of $1,160 at $28,332 of AGI.

The tax rates and tax brackets for these new surtaxes would be indexed in future years to keep pace with the costs of the program. Moreover, the surtax rate would be increased further to cover about 25 percent of the cost of the drug benefit. The Joint Committee on Taxation estimates that within five years the surtax would be $68.40 for every $169.77 of AGI, up to a maximum of $1,017 in new taxes for an elderly individual or $2,034 for an elderly couple.

The Senate Tax Increase

The surtax in the Senate bill differs significantly from the House version in two key respects. First, only those Medicare beneficiaries who purchase voluntary Part B coverage would receive the new benefits and pay the increased premiums and new taxes. Second, unlike the House bill, the surtax would be imposed on a beneficiary's taxable income, not on his or her adjusted gross income. Hence the Senate tax would be based on the amount of income after subtracting exemptions and tax deductions. Initially, the surtax would be $13.08 added to every $150 of tax they already owed, up to a maximum of $800 in new taxes. The maximum surtax would increase by $50 per year until it reached $1,000, and would then be indexed to increases in the cost of Medicare. The tax rate would increase to keep pace with the full cost of the catastrophic benefits and about half the cost of the drug benefit. The Joint Committee on Taxation estimates that within five years the maximum surtax would be $30.48 added to every $150 of tax owed.

---

7 Adjusted gross income is a taxpayer's total income before subtracting exemptions and deductions. Most Social Security payments are not counted as part of AGI for elderly taxpayers.

These new taxes would be added to the existing federal tax burden on the elderly. The Senate would allow retirees to deduct the Medicare surtax as a medical expense. But to do so, they would have to itemize deductions and to have total medical expenses of more than 7.5 percent of AGI to claim the deduction. As a result, it is unlikely that many of the elderly would receive significant tax relief through this provision.

Catastrophic Implications for Elderly Taxpayers.

These new taxes would have a devastating impact on elderly Americans. Approximately 12 million, or 40 percent, of the elderly would be forced to pay the Medicare surtax. The Joint Committee on Taxation projects that within five years:

- Under the Senate bill, 11.3 million elderly individuals (39.8 percent) would be paying an average of $395.70 in additional taxes each year, and 2.3 million of these (8.1 percent of all beneficiaries) would be paying the maximum surtax of $1,000.

- Under the House bill, 12 million elderly individuals (40.1 percent) would be paying an average of $686 in additional taxes each year, and 5.4 million of these (18 percent of all beneficiaries) would be paying the maximum surtax of $1,017.

At the same time, the elderly would be faced with annual Part B premiums for both the existing and new coverage of either $424.80 ($35.40 per month) under the House version, or $466.80 ($38.90 per month) under the Senate version.

The effect of the Medicare surtax would be to impose some of the highest marginal tax rates in the country on millions of the elderly. As a result of the 1986 tax reform legislation, this year all non-retired Americans face a tax system with marginal rates of 15, 28, and 33 percent. But, for most of the elderly the proposed Medicare catastrophic legislation would avoid the 1986 changes, increasing their marginal rates above those of other Americans. (See table below.)

Faster than Inflation. Moreover, marginal tax rates for the elderly would continue to increase each year indefinitely as a result of the legislation while non-elderly Americans enjoyed constant tax rates. The reason: the tax brackets of non-elderly Americans will be indexed to keep pace with inflation, but Medicare expenses likely will continue to grow faster than the general inflation rate, increasing the tax rates faced by the elderly.

It is hardly surprising that so many of the elderly are confused and dismayed by these bills. Few expected to be facing stiff new taxes. Most of the money for the new benefits will derive from these surtaxes; 55 percent under the Senate bill and 80 percent under the House bill. Moreover, these taxes will fall mainly on middle-class elderly Americans. The 40 percent of the elderly who would be paying these new taxes have total family incomes, including tax-free Social Security payments, of roughly $25,000 or more.

How the Medicare Catastrophic Legislation Would Increase Tax Rates for the Elderly
(Marginal Income Tax Rates in Percentages)

House Bill

	1988	1989	1990	1991	1992
Non-elderly	15	15	15	15	15
Elderly[8]	22.0	23.5	24.3	24.9	25.3

Senate Bill

	1988	1989	1990	1991	1992
Non-elderly	15	15	15	15	15
Elderly	16.3	16.5	17.0	17.6	18.0
Non-elderly	28	28	28	28	28
Elderly	30.4	30.7	31.8	32.8	33.7

Nor would most of the money go to purchase coverage that the elderly are lacking. Two-thirds of the new spending simply would be to replace benefits offered by existing private medigap insurance.[9] Currently about 75 percent of the elderly (roughly the same number as those with total family incomes of $12,000 or more) have medigap coverage, which covers most Medicare deductibles and coinsurance and pays for very long hospital stays. Premiums for medigap vary enormously depending on state regulations and extent of coverage. Policies that simply meet the minimum federal standards can cost as little as $160 per year. However, most medigap policies charge annual premiums of between $350 and $800.

8 Under the present tax code Americans pay taxes based on their taxable income (AGI minus exemptions and deductions). The new taxes in the Senate bill would follow this existing structure. They would increase the amount of taxes an elderly individual owed for the same amount of taxable income as a non-elderly individual, therefore raising the marginal tax rates of the elderly. However, the surtax in the House bill is based on adjusted gross income. As a consequence, the new marginal tax rates under the House bill are not strictly comparable to marginal tax rates under either the present tax code or the Senate bill, and are therefore referred to as "effective marginal tax rates." Also, these new "effective marginal tax rates" would fall exclusively on elderly tax payers who would normally be in the 15 percent tax bracket.

9 The expanded Medicaid buy-in and spousal impoverishment provisions represent only 5 percent of the cost of the bills, while the drug provision accounts for about 30 percent of the cost.

THE SLEEPING GIANT: ELDERLY OPPOSITION

Since the elderly will be both receiving the benefits and paying all of the costs, it may be instructive to ask what they think of these proposals.

The answer beginning to emerge will not please those Representatives who assumed that they would win friends among senior citizens by supporting these bills. The picture emerging during the past several months indicates that, although elderly Americans initially are inclined to support the legislation, the more they learn about it the less they like it. Congressional supporters of this legislation may find that, in seeking to placate the giant lobby of elderly America, they inadvertently may anger it instead.

When The Wirthlin Group, a major national polling firm, last October asked retirees if they favor or oppose the pending catastrophic legislation, they gave an overwhelmingly affirmative response; 51 percent said they "strongly favored" the legislation and 26 percent said they "somewhat favored" it. Those "somewhat" or "strongly" opposed amount to only 7 percent for each category. [10]

What the Elderly Desire. Further questioning, however, revealed that the elderly favor the bill because most of them misunderstand the bill. In fact, those services most desired by the elderly are not actually in the legislation. The Wirthlin Group survey finds that a 40 percent plurality feels that "providing for long-term nursing home care," should be the most important feature of catastrophic legislation; 24 percent says that the most important feature should be "paying for complete home care costs." The legislation, of course, provides neither for long-term nursing home care nor for unlimited home care costs. Only 23 percent say that the most important feature should be "paying for unlimited hospital stays," and 8 percent say that the most important feature should be "paying for prescription drug costs above $600." Yet these precisely are what the bill would do. [11]

The elderly then were told about six key provisions of the legislation and asked whether they were more or less likely to support the legislation as a result of the new information. While 46 percent say that they are "much more likely" to support the bill because it would

---

10 The survey was commissioned by the National Alliance of Senior Citzens and was conducted by telephone interviews on October 23-25, 1987. The question was, "Now, as you may know, Congress is currently considering legislation which would expand Medicare to provide catastrophic health coverage for the elderly. Do you favor or oppose this legislation? Would that be strongly (favor/oppose) or just somewhat (favor/oppose)?"

11 The question was, "Now, I'd like to read you four possible provisions of the catastrophic health insurance. Could you please tell me which is most important?"

pay for almost all hospital costs, a very significant 40 percent and 41 percent, respectively, say that they are "much more likely" to oppose the legislation because of the new taxes and the lack of long-term care. And 34 percent respond that they are "much more likely" to oppose the bill because of the higher Part B premiums. On the question of drug coverage, the bill gets only lukewarm support. Only 26 percent of the elderly respondents say that this factor makes it "much more likely" that they would back the bill and only another 26 percent say that it is "somewhat more likely" that they would do so. On the other hand, 23 percent say that they would be "much more likely," and 16 percent "somewhat more likely," to oppose it.[12]

When asked again if they support the legislation now that they understand it better, only 28 percent say that they "strongly favor it" (down from the original 51 percent); 38 percent say that they "somewhat favored" it (up from the original 26 percent). The responses "somewhat" and "strongly" opposed increased to 12 percent for each category.[13]

In short, the survey finds that most of the elderly want what the legislation does not offer (long-term nursing home care). The expensive items that the legislation does offer (notably the drug benefit) are not especially popular. Nor are the respondents particularly happy about how they would be paying for the program. On a question about their willingness to pay higher taxes for the new coverage, only about 3 percent of all respondents say that they are willing to pay more than $500 per year in taxes and only 17 percent are willing to pay more than $250.[14]

WHO SPEAKS FOR THE ELDERLY?

From the beginning, the catastrophic legislation has been supported by the largest of the elderly advocacy groups, the American Association of Retired Persons (AARP). While AARP's leaders are unhappy about the new surtaxes, they have accepted them as the price

---

12 The question was, "Now, I'm going to read you some additional information in the legislation on catastrophic health coverage. Please tell me whether the information makes you more likely to favor or more likely to oppose the legislation?" Respondents were then told, "The catastrophic health legislation would not add to the budget deficit. Funds for the program would come from an increase in income taxes up to $580 per person, paid by Medicare recipients. Funds for the program would also come from an increase in Medicare Part B payments by the elderly. The legislation would pay 80 percent of prescription costs after the first $600 paid by the individual. The legislation would pay little for long-term care in nursing homes. The legislation would pay for all hospital costs after an initial $520 a year."

13 The question was, "Now after all that you have heard, do you now favor or oppose this legislation?"

14 Respondents were asked, "And how about you personally – would you be willing to pay more in taxes to obtain government catastrophic health insurance?" Those that answered "yes" were asked, "And how much would you say that you would be willing to pay per year?" and were given the following options, "Under $100, $100-$250, $251-$500, $501-$1,000, $1,000-$2,000, over $2,000."

for expanded benefits, particularly the drug provision. AARP's leaders still consider the bill, on balance, to be beneficial.[15] However, two smaller yet significant senior citizen groups, the National Alliance of Senior Citizens and the National Committee to Preserve Social Security and Medicare, have been waging grass-roots lobbying campaigns against the legislation.

There are also signs that opposition is spreading within AARP. For instance, during the Senate's debate over its version of the bill, Senator William Roth, the Delaware Republican, reported on letters he had received from AARP officials in Delaware stating that their local chapters oppose the legislation.[16] At the same time, many of the nation's independent senior citizen newspapers have been running stories and columns criticizing the legislation. And in a significant development, AARP's Director of Communications James R. Holland recently sent the editors of those newspapers a lengthy, detailed analysis of the legislation, providing far more information on the high costs and limited coverage of the bills than anything AARP has printed in its own membership publications.[17]

Finally, critics inside and outside the senior citizen community charge that AARP, which runs on of the nation's largest mail order pharmacies, supports the legislation because it stands to profit directly from the new drug provisions it lobbied Congress to include in the bills.[18]

NEEDED: REAL SOLUTIONS FOR REAL PROBLEMS

If members of Congress genuinely want to help the elderly, there is still time for them to rewrite and improve these bills. Instead of pushing costly legislation that does not address the chief concerns of retirees, Congress could offer real solutions to the real problems of the elderly. Example: Congress could examine various proposals for expanding private long-term care insurance to protect the elderly against the high costs of nursing home

---

15 Barbara Coleman, "How a Modest Idea Evolved Into a Watershed Bill," *AARP News Bulletin*, February, 1988. The article ends with a quote from Martin Corry, director of AARP's office of Federal Affairs, "'The financing mechanism is far from perfect—it certainly wasn't our first choice,' Corry says. 'But the bill's benefits far outweigh the disadvantages of the financing approach.'"

16 *Congressional Record*, p. S. 15087 (daily ed. October 27, 1987).

17 Letter of March 11, 1987, to editors of senior newspapers from James R. Holland, director of AARP's Office of Communications.

18 This charge recently came from Joseph Califano, the former Secretary of Health, Education and Welfare, who as President Lyndon Johnson's Special Assistant for Domestic Affairs was one of the architects of the Medicare program. In a *New York Times* article critcizing how health policy is subordinated to political considerations, Califano cited the drug benefit as an example, "But though the Government would pick up the tab for the patient's pharmeceuticals, it would also pay a fee to the pharmacy or to the mail-order supplier of $4.50 a prescription—even though it is estimated that a mail-order supplier charges its corporate health-plan clients only 50 cents to fill a prescription and process a claim. The most energetic lobby behind the new drug benefit is the American Association of Retired persons, which runs the country's second largest mail-order drug-dispensing business (1986 revenues $200 million). That $4.50 dispensing fee represents a substantial windfall for the politically powerful AARP." Joseph A. Califano, Jr., "The Health-Care Chaos," *The New York Times Magazine,* March 20, 1988, pp. 44-58.

stays.[19] Surely, in their laudable attempt to make acute care more affordable, the lawmakers also could come up with a better acute care plan than simply replacing private medigap insurance with a more costly expansion of Medicare.

Restructure Coinsurance.

Under the present Medicare system, the beneficiary pays the entire cost of the first day in a hospital (the deductible) and then pays nothing for days two through 60. For longer hospital stays, the patient pays an increasing share of the cost through coinsurance rates of 25 and 50 percent. This structure has the following perverse effects:

- The high first-day deductible ($520 in 1987) discourages patients from entering the hospital until they are seriously ill, at which point the cost and length of their total hospital stay is likely to be greater than if they had sought treatment earlier.

- Once a beneficiary has made the decision to enter the hospital, he or she has absolutely no incentive to question any of the costs of treatment for the next two months.

- The coinsurance charges for hospital stays of more than two months essentially are a penalty imposed on the very seriously ill.

Changing the current structure to one based on a "tapered" set of coinsurance rates would help beneficiaries and control Medicare costs. A tapered coinsurance structure could charge beneficiaries, say, 20 percent of the first $2,000 of Medicare approved charges, 15 percent of the next $3,000, 10 percent of the next $5,000, and 5 percent of the next $10,000. The same thing could be done for Part B of Medicare, which currently charges beneficiaries a flat 20 percent coinsurance for all charges. Policy makers, of course would need to calculate the optimum rate structure before putting it into effect.

In this type of system, beneficiaries would not be discouraged from seeking hospital treatment. But by paying more of their front-end costs, they would have the incentive to question the need and expense of more lengthy treatment. Medicare could use the resulting savings to finance more of the costs for beneficiaries with very serious conditions.

Medigap Vouchers.

Congress would also need to adjust the Baucus Amendment of 1980, which sets minimum standards for "medigap" policies, to allow its provisions to accommodate the new coinsurance structure.[20] Congress then could consider expanding coverage for the low-income elderly by providing them with Medicaid vouchers to purchase private medigap policies.[21] Poor beneficiaries either could be given vouchers directly or they could be allowed to select

---

19 Proposals for financing long-term care will be discussed more fully in forthcoming studies by The Heritage Foundation.

20 For other proposals to modify the Baucus Amendment and encourage other private sector solutions, see, Peter Ferrara and Stuart Butler, "Making Catastrophic Health Care Affordable: A Nine Point Program," Heritage Foundation, *Backgrounder* No. 563, February 10, 1987.

21 For an extensive discussion of the potential for using vouchers to reform Medicare, see, Randall Bovbjerg, *Vouchers for Medicare: The Impossible Dream?* The Urban Institute, December, 1987.

from a "cafeteria menu" of approved plans as federal employees now do. Partial vouchers could be provided to the near-poor, based on their income. A voucher program would have the added benefit of increasing the market for medigap insurance, expanding the risk pool, and thus helping to keep the premiums for those policies affordable for the rest of the elderly.

CONCLUSION

Like a living parody of the old doctor joke, Congress's standard prescription for whatever ails America's health care system seems to be, "Pay more taxes and call us next year." This time it may not work. Not only would the "Medicare Catastrophic Protection Act" not live up to its name, it would set off an uncontrolled expansion of Medicare to provide benefits that the vast majority of the elderly neither want nor need. At the same time, it would pay for all the new spending by placing retirees among the highest taxed Americans.

There is a great deal Congress could do to help the elderly finance their health care. The first step is to start treating the problem with something other than the usual tax and spend prescription. Congress must face up to the fact that the only way to solve the pervasive problem of high health care costs, whether in the Medicare program or elsewhere, is to give both consumers and providers greater incentives to question those costs. Undertaking genuine reforms to restore competition and market principles to health care requires more effort on Congress's part than does expanding existing programs or adding new ones. But the reward will be a system that gives Americans more flexibility in meeting their own health care needs without becoming impoverished in the process or having to sacrifice quality for cost. Congress might even find such reforms to be politically popular.

Edmund F. Haislmaier
Policy Analyst