The Heritage Foundation Issue Bulletin

No. 141 | The Heritage Foundation • 214 Massachusetts Avenue • N.E. • Washington, D.C. • (202) 546-4400

June 7, 1988

PEPPER'S $30 BILLION HOME CARE TIME BOMB

Peter J. Ferrara
John M. Olin Fellow

INTRODUCTION

The House of Representatives is about to vote on a multibillion dollar measure that would create a new federal entitlement program to provide free home health care to the elderly and many others. Representative Claude Pepper, the Florida Democrat, has used his powerful chairmanship of the House Rules Committee to bypass any committee consideration of his legislation.[1] Speaker Jim Wright, the Texas Democrat, has promised Pepper a floor vote, trampling on the authority of House Ways and Means Chairman Dan Rostenkowski, the Illinois Democrat, among others.

This home health care legislation would greatly expand federal assistance for such daily living activities as cooking, cleaning, dressing, and eating for retired Americans at home, who ostensibly no longer can perform such activities themselves. Yet, the bill would provide no benefits to those in nursing homes, contrary to what many of the elderly have been led to believe. As designed, the bill is a time bomb, set to explode the federal budget. The bill, among other things, would have the federal government financing maids and cooks for the families of any individual over 65 who can make the case that he or she is somewhat disabled. This could cost $30 billion per year or more. And given the immense and growing political power of elderly Americans, it is hard to imagine any lawmaker seriously trying to restrain runaway costs once the legislation is enacted.

$ 8 Billion Tax Hike. The new program would be financed by a heavy, discriminatory tax increase imposed on a small group of American workers. The tax hike would total between $6 billion and $8 billion per year, raising the top marginal tax rate in the federal tax system. from 28 percent to 30.9 percent. Despite this hefty tax increase, the cost of promised benefits under the new program would still outstrip the revenue from this tax, adding to the

1 H.R. 2762, now part of H.R. 3436, "Technical Amendments to the Older Americans Act."

federal deficit. And once the baby boom generation reached retirement age, the revenue shortfall caused by the Pepper legislation would balloon rapidly.

Medicare already covers most medical care provided in the home. Admittedly there are gaps. But these deficiencies can be corrected with small, inexpensive changes in current law. A national program to finance such nonmedical services as cooking, cleaning, and feeding for every eligible retiree is unwarranted and undesirable. Most of the elderly receive such care from family members, relatives, and friends. The proposed new government program would displace this private informal care with an expanded industry of professionals, paid by the taxpayer. And monitoring the validity of claims for such in-home care would require an army of federal inspectors.

Government funding for such personal services would amount to taxpayer-financed personal maids and cooks for a privileged class. Most of the elderly who would qualify for financial assistance are not truly in need; they have family or friends to help or have sufficient resources of their own to finance care. The government should instead finance essential home health care services only for those who lack sufficient resources to finance needed care without hardship.

Specifically, Congress should:

1) **Re-examine Medicare, if necessary, to ensure that it provides adequate coverage for true medical services in the home, as well as in nursing homes.**

2) **Remove from Medicaid the provisions covering nursing home and home health care assistance for the poor** and place them in a new program guaranteeing coverage to the elderly poor in every state, with expanded benefits to finance essential care for those couples with modest incomes who do not qualify for Medicaid.

3) **Allow low-income families to qualify for the earned income tax credit when they provide care to an elderly parent.**

HOME HEALTH CARE TODAY

"Home health care" covers a broad spectrum of services provided in the home, ranging from intensive medical treatment and skilled nursing care to assistance with basic daily

living activities for the frail or disabled. About 4 million elderly Americans outside nursing homes need some form of assistance today.[2] But only 5 percent of these — or 200,000 — now pay home health care professionals to provide all their needed care.[3] About 75 percent receive their care exclusively from family and friends without any paid help, and 21 percent use some paid care and some free care from family and friends.[4] Over $10 billion per year is now spent on paid home health care.[5]

Medicare pays for an unlimited number of necessary home health care visits where medical treatment is involved, if the retiree cannot leave his or her home. This Medicare coverage includes physician's services, skilled nursing care, physical and speech therapy, necessary medical supplies, and 80 percent of the cost of medical equipment. Through these provisions, Medicare pays for about 25 to 30 percent of the cost of all professional home health services.[6]

Paying for "Softer" Services. Although Medicaid benefits vary from state to state, Medicaid will pay for the full range of home health care services for those low-income individuals and families who qualify for the program. This is in addition to the medical services provided to the elderly by Medicare. Medicaid will pay for such "softer" services as homemaker duties involving cooking and cleaning and personal assistance in other basic daily activities.

Still, there are deficiencies in this program. The main flaw is that an elderly couple with modest resources must exhaust most of its income and savings to qualify for help when one spouse is disabled. This can mean the healthy spouse ultimately may be left destitute. Also, variations in the program among the states may leave poor elderly individuals in many states without assistance for home health care.

THE PEPPER BILL

The home health care legislation sponsored by Claude Pepper would create a federal program to pay for virtually any home health care service provided for a retiree, regardless of the wealth and income of the recipient, or the availability of family or friends to help provide care. To be eligible to receive such services free, a retiree simply would have to "re-

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2 The Task Force on Long-Term Health Care Policies reported that in 1984 about 4.2 million of the elderly outside nursing homes had long-term care assistance needs, and about 14 percent of the elderly in the community had limitations in activities of daily living. This would be about 4.3 million today. Task Force on Long-Term Health Care Policies, "Report to Congress and the Secretary," U.S. Department of Health and Human Services, September 21, 1987, p. 66-67. See also Macro-Systems, Inc., *Data Book on the Elderly* , June 1987, Prepared for the Department of Health and Human Services, p.110.

3 Robert Maxwell, Statement of the American Association of Retired Persons on Long-Term Care Financing before the Senate Finance Committee on Health, Washington, D.C., June 12, 1987, p. l.

4 *Ibid.*

5 Total expenditures for professional home health care were $9 billion in 1985. Task Force on Long-Term Health Care Policies, *op. cit.*, p. 19.

6 Joseph C. Isaacs and Stephanie Tames, *Long-Term Care: In Search of National Policy* (Washington, D.C.: National Health Council, 1986), p. 8. Medicare will pay for $3.2 billion in home health care expenses this fiscal year. Personal communication, Office of Management and Budget.

quire assistance" with at least two activities of daily living, defined in the bill as bathing, dressing, toileting, moving around, and eating.

Freely Flowing Federal Funds

The potential costs of this proposed new program are incalculable and uncontrollable. The program immediately would assume the cost of all current home health care, totalling over $10 billion per year.[7] This is just the iceberg's proverbial tip. With Washington committed to pay for free home health care for all retirees, many of the elderly who now receive care from family or friends likely would switch to government-financed professional care. And with three-fourths of those elderly outside nursing homes who need personal assistance using informal, unpaid care, and most others now using professionals for only part of their care, there is the potential for a staggering increase in federal outlays under the program.

Facing Retiree Anger. And this only includes Americans who currently receive personal care in the home. The blanket entitlement nature of the Pepper bill would induce many retirees who do not receive home health assistance today to demand free government-financed professional care, especially as the legislation would cover the cost of such services as cooking and cleaning. To qualify for benefits would be very easy. A physician and a "home care management agency" (a state or local government agency or a nonprofit organization) merely would have to certify the person as "requiring assistance" in at least two daily living activities. Since these certifiers would incur none of the cost, but would face the anger of retirees and organizations for the elderly if they denied claims, their inclination would be to interpret program eligibility requirements as broadly as they could.

A 1986 study by the General Accounting Office found that one-third of Medicare funds spent on home health care are spent on services not covered by the program, despite its relatively more objective medically related criteria for coverage.[8] Indeed, the Social Security disability program, which includes an objective, strict requirement that beneficiaries not be able to work at all, has over the years been unable to avoid paying a substantial proportion of its benefits to those who are not disabled.[9] Imagine how much more easily an individual will be able to obtain designation as "requiring assistance" in two activities of daily living under the Pepper bill.

Inviting Abuse

The legislation would encourage a proliferation of taxpayer-financed services through a "consumer bill of rights" and other requirements. This bill of rights would entitle beneficiaries to receive "the most comprehensive services, as necessary to the needs of the individual...." The home care management agencies determining eligibility also would have to "maintain procedures that assure prompt access to long-term home care." And beneficiaries would have a right "to take an active part in creating and changing the plan of

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7 Close to $4 billion of this currently is paid by Medicare and Medicaid.

8 Peter J. Ferrara, "Social Security and the Private Sector," in Steve Hanke, ed., *The Political Economy of Privatization* (New York: The Academy of Political Science, 1987).

9 General Accounting Office, "Medicare: Need to Strengthen Home Health Care Payment Controls and Address Unmet Needs," December 1986.

care" and "in selecting and evaluating treatment, care and services" — in other words, write their own checks drawn on the federal government.

Moreover, peer review organizations, whose boards are to include home health care providers and beneficiaries, are to monitor the home care management agencies, in part to determine "the appropriateness and necessity of care denied under the program." The bill says nothing about monitoring to determine the appropriateness and necessity of care granted under the program. Just to make sure that these organizations keep the program as generous as possible, consumer boards in every state, composed of beneficiaries and their representatives, would monitor the peer review organizations in performing their functions and comment on whether their contracts should be renewed.

In short, the program could hardly be better designed to balloon uncontrollably under pressure from retirees who are not truly in need of care. The use of public funds in the privacy of the home is difficult enough to regulate. Thus any home care legislation needs to be carefully circumscribed, targeted, and monitored to avoid abuse. The Pepper bill, however, not only fails totally to provide for effective controls, it openly invites abuse.

Funding Price Inflation

With a massive increase in demand for professional home health care services sparked by the new program, combined with virtually no controls on services, prices for such care, of course, would soar, adding billions of dollars to total costs. These costs would be further increased by the elaborate bureaucracy necessitated by the legislation to administer the program. Government-financed home health agencies would provide care after referral from government-financed home care management agencies, which in turn would be monitored by government-financed peer review organizations, which in turn would be reviewed by government-financed state consumer boards.

These bureaucracies would be monitored under the bill by a government-financed Home Care Quality Assurance Council, appointed by Congress through the Office of Technology Assessment. The bureaucrats and pressure groups within this structure would have an overriding political and financial incentive to spend as much money as possible.

The legislation purports to restrain costs by "capping" the monthly benefit expenses per beneficiary at 62 percent of the average cost of skilled nursing home care. This is a ceiling in name only. It would not brake runaway costs. For one thing the cap is based on the most expensive form of nursing home care, costing close to $25,000 per recipient per year at present. So 62 percent of such costs would amount to about $15,000 per year. For another thing, such a cap is literally meaningless, given the entitlement nature of the bill. Trying to enforce any cap, in fact, probably would be politically unsustainable, given the electoral clout of the elderly lobbies.

A $30 Billion-Plus Annual Price Tag

Given the cost pressures, the Pepper bill's benefits easily could cost $30 billion per year, or more. If the proportion of the elderly outside of nursing homes using paid full-time assistance rose from its current 5 percent to just 10 percent, and the proportion using part-time

care doubled from 21 percent to 42 percent, home health care expenditures would increase from over $10 billion today to more than $20 billion. With the government offering free professional services to all who needed personal assistance, these proportions could increase much more. Those not now receiving assistance who convinced sympathetic review organizations to grant them help, plus the likely rapid rise in such care resulting from the program, would further add to benefit costs.

In estimating program expenditures, the Congressional Budget Office (CBO) finds only 1.3 million elderly who would qualify under the program. Moreover, it assumes only 30 percent of these would participate in the program to start, since only 30 percent of those eligible applied for Supplemental Security Income (SSI) benefits when that program was established nationally in 1972. But SSI participation is now up to 60 percent. A better model for estimating Pepper bill costs would be Medicare, where virtually all who have substantial medical costs seek reimbursement under the program. Adjusting for this alone would at least double the CBO estimate of $7 billion in increased costs from the Pepper bill in fiscal 1991, when it is fully phased in.

The CBO estimate, moreover, finds only 1.1 million elderly with one daily activity limitation and assumes that about 7 percent of these, or about 80,000, would be successful in gaining benefits, even though two activity limitations are required. But in practice, establishing that any of the entire group of over 4 million elderly now receiving long-term care assistance outside nursing homes would not qualify for home health care under the bill would be extremely difficult. Realistically, still others who do not now receive care ultimately would be able to win attractive benefits under the bill. Even assuming that only 25 percent of the elderly now receiving personal assistance, apart from the 1.3 million that CBO admits would qualify, received benefits under the bill, expenditures would increase by another $10 billion.

CBO also does not calculate the effect on prices of the likely surge in the demand for home health services. The CBO estimate, in other words, is so flawed that it is useless as a guide to probable expenditures under the legislation.

No Nursing Home Benefits

Despite the huge likely cost of the Pepper bill, it would not provide any benefits for those receiving long-term care in nursing homes. Many of the elderly have been misled into supporting the bill because they think it provides coverage for nursing home care, which costs over $20,000 per year on average. Instead of providing nursing home assistance for those in need, the legislation would spend huge sums on "soft" personal assistance that can be and is provided today by family and friends.

Supporters of the Pepper bill argue that it will save government funds by allowing many of the elderly to be cared for inexpensively at home, rather than in costly nursing homes financed by Medicaid. This contention is refuted by a number of studies. A recent study by the Institute for Research on Poverty at the University of Wisconsin (a decidedly liberal group), undertaken for the National Center for Health Services Research, concludes that few retirees who enter nursing homes would in fact remain in their own homes were home health care available. Moreover, notes the study, any savings that might result from reduced

nursing home admissions would be more than offset by increased government home health care assistance for retirees who would remain at home even without the expanded assistance available to all in the Pepper bill. [10]

REVERSING TAX REFORM AND DEFICIT REDUCTION

Medicare is financed by a payroll tax of 2.9 percent of wages up to $45,000 per year, split between employee and employer. The proposed new home health care benefits would be financed fully, say supporters, by a provision to eliminate the $45,000 cap for the 2.9 percent Medicare payroll tax, and instead impose this tax on all wages.

Reneging on Tax Reform

This method of financing effectively would increase the top marginal rate in the federal tax system. Currently, the payroll tax does not add to the top marginal tax rate because it does not apply to income over the $45,000 ceiling. Eliminating the ceiling for the Medicare payroll tax consequently would boost the top marginal tax rate by 2.9 percentage points, from 28 percent to 30.9 percent for the income tax and Medicare payroll tax combined. This would violate the 1986 tax reform compromise, under which the top marginal tax rate was reduced in return for the elimination of preferential deductions. To shatter the formula upon which the compromise rests means that Congress would open the door to restoring some of the tax preferences eliminated in 1986.

Sponsors of the bill argue that it is unfair to allow workers who earn more than the current $45,000 ceiling to avoid the Medicare tax on their income above the ceiling. But the truth is the reverse. Workers earning $45,000 and over are unfairly treated because they pay the highest Medicare taxes while receiving no more in Medicare benefits. Removing the income ceiling would impose a harsh discriminatory tax increase of $6 billion per year, to fall on a small group of workers. This huge tax increase, moreover, would violate the 1987 Budget Summit agreement between the President and Congress that Congress would not consider further tax increases through 1988.

A New Deficit Explosion

The $6 billion to $8 billion raised each year by the Pepper bill tax increase still would not cover all the benefits created by the legislation. Very likely the outlays would be several times the anticipated tax revenues. Thus the bill would reverse the substantial progress made in recent years in reducing the federal budget deficit. In future years, moreover, with the retirement of the baby boom generation, the revenue shortfall under the legislation would accelerate.

The bill provides that, if costs do exceed revenues from the payroll tax increase, the Secretary of Health and Human Services is to impose a copayment fee of up to 5 percent of the average charge for professional home health care. This means that beneficiaries would

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10 Peter Kemper, Robert Applebaum and Margaret Harrigan, "A Systematic Comparison of Community Care Demonstrations" (Madison, Wisconsin: Institute for Research on Poverty, June 1987).

have to contribute up to $5 out of their own pocket for every $95 paid by the government. But this small copayment would make only a small dent in program costs.

The Secretary also would be empowered to reduce the cap on the monthly costs of home health care for each beneficiary, planned as equal to 62 percent of the average cost of skilled nursing home care. But the program costs probably would be so high that, to balance costs and revenues, the cap would have to be reduced drastically, perhaps down to just 20 percent or less of skilled nursing home costs. This would mean that the benefits under the program, now being promised to the elderly, would be cut drastically as well.

Yet once the program were set up and expectations raised, any significant reduction in benefits would be politically infeasible. Advocacy by the huge and elaborate bureaucracy to be set up to administer the program, combined with pressure from organizations representing the elderly, would make it impossible for Congress to tear up the legislation's "bill of rights."

CRAFTING A RESPONSIBLE HOME HEALTH CARE POLICY

Home health care can be divided into two categories. The first is true medical care provided by licensed doctors and nurses. This is care for a specific illness or chronic problem. The second category covers such daily living services as cooking, cleaning the home, dressing, and feeding, which can be performed by a person without special skills.

Medicare already covers most true medical care given in the home. The program can and should be reevaluated to ensure that it performs this function adequately and comprehensively. But a national program to finance the softer, more personal services for everyone would be a serious mistake. For the most part these services can be and are provided by family members, relatives, and friends. Government financing thus would substitute paid professionals for private family care.

In addition, government funding for personal services in the home, such as maids and cooks, would be extremely difficult to monitor. Many who are not truly in need, because they can perform essential activities themselves, have family or friends to help, or have substantial resources of their own to finance care, would receive large subsidies from the taxpayer. Strictly monitoring such home-based services to prevent misuse, on the other hand, would be far too costly and would involve an unacceptable invasion of privacy.

Congress would be wiser to focus on steps to restructure Medicaid benefits to provide more comprehensive help to lower income individuals who otherwise would be in nursing homes at government expense. This would involve a manageable, objective test for benefits, since the beneficiary would have to qualify for nursing home assistance, on both medical and financial grounds, before receiving home health benefits. This targeted policy, in contrast to the Pepper blanket entitlement approach, would spend government resources where they are needed most.

Preventing Impoverishment. Preferably government home care assistance for the needy should be provided by a new program that would take the current nursing home and home

health care benefits out of Medicaid. This would allow the eligibility criteria to differ from those needed for general Medicare coverage. In this way, some of the current inequities could be avoided. For instance, when one member of an elderly couple needed help that could not be provided by the spouse, this new program could provide home care benefits to the couple without requiring that both spouses first spend virtually all their resources, as often happens under current Medicaid rules designed for poverty level families. Adequate assistance of this kind for those in need could be provided for only a little more than the government is already spending for home health care nationwide.[11]

While the government should guarantee the home care needs of those retirees without adequate resources or assistance from family or friends, most other cases should continue to be handled primarily through private arrangements. Many single disabled parents, for instance, live in the homes of adult children and receive care from family members. Such families are aided in part by the income, home equity, and savings of the parent. Providing care for an elderly parent may be more difficult for a two earner couple. But these couples generally have above average incomes, and their family responsibilities should not be laid at the door of the taxpayer.

Earned Income Tax Credit. In the case of lower income families looking after an elderly parent, Washington could provide assistance by allowing the family to qualify for the earned income tax credit. This credit, currently available to families with young children, provides a tax rebate each year equal to 14 percent of income, up to about $6,000, and is slowly phased out as the family income rises to $18,000. This tax credit is refundable, which means if the family does not have tax liability to be rebated the government pays it with cash instead.

For elderly couples, a healthy spouse usually can provide personal assistance to the disabled spouse. Adult children, relatives, and friends also can help on an occasional basis. And a professional caretaker can be hired from time to time, just as young parents employ part-time sitters to attend their children. Moreover, state and local governments, church groups, and other local organizations often offer programs to ease the burden on the healthy spouse. The Social Services Block Grant already permits federal funds to be used to help finance such programs.

Finally, the best way for elderly Americans with reasonable resources to protect themselves against costly professional care is to purchase home health care insurance. But for these Americans to press for legislation to force young workers to pay for uncontrollable benefits is inefficient and unfair.

CONCLUSION

A new federal entitlement program to finance free home health care benefits for every retiree, regardless of wealth and income or the availability of care from family or friends, would accelerate out of control quickly and become a massive boondoggle. Representative

11 For further discussion of this proposed new program, see Peter J. Ferrara "Providing for those in Need: Long-Term Care Policy", Heritage Foundation *Backgrounder*, No. 646, April 20, 1988.

Pepper's proposed program in addition would impose a harsh, discriminatory tax increase on the nation's most successful workers and violate the compromise of the 1986 tax reform by increasing top marginal tax rates. It also would reverse recent progress made in reducing the deficit.

In fact, most members of Congress, Democrat and Republican, know that Pepper's bill is bad legislation. They also are outraged that he used his position as Rules Committee Chairman to avoid established House of Representatives procedures that require hearings for such a potentially costly measure. Most offended should be the Ways and Means Committee members; they have been ignored even though the Pepper bill calls for a tax hike, a matter ordinarily fully under Ways and Means jurisdiction.

House members, however, apparently are afraid to challenge Pepper and thus confront the political theatrics and aggressive lobbying of the elderly organizations behind Pepper's bill. Yet the best way to serve the American people, young as well as elderly, is to support an approach to long-term care that would target federal help only where it is needed.