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DEALING WITH THE PROTESTS OVER THE MEDICARE CATASTROPHIC COVERAGE ACT

INTRODUCTION

Responding to a flood of angry phone calls and letters from their elderly constituents, a growing number of Congressmen and Senators are seeking to repeal or revise the "Medicare Catastrophic Coverage Act of 1988" enacted in June of that year. The amount and the tenacity of elderly opposition to the law, particularly to the new taxes that will fund it, took many Congressmen by surprise. It also has provoked an open and widespread grass-roots rebellion within the nation's largest senior citizen lobby, the American Association of Retired Persons (AARP), whose national office pushed hard for the original legislation.

Already, some 30 bills have been introduced to repeal the catastrophic act in whole or in part or to change the way it is financed. More bills are expected. Meanwhile, the House Ways and Means Committee this July 25 approved, by a slim margin, a measure to scale back some of the benefits and taxes of the original legislation.

Much More Expensive. Congressional concern over the catastrophic act has been heightened by new revenue and spending estimates from the Congressional Budget Office (CBO). These show that the program generally will be much more expensive than was originally portrayed. Example: new CBO cost estimates for the act's prescription drug program are more than double the level projected by CBO when the law was passed. CBO previously had projected the drug program would cost $5.7 billion over the first four

years. Its new estimate: $11.8 billion for the same period.[1] In addition, the CBO calculates that the new income surtax on the elderly, designed to fund two-thirds of the program, will collect more revenue and affect more senior citizens than previously expected.[2]

Faced with this alarming cost overrun and elderly opposition to the tax surcharge, even the program's original sponsors have moved to revise the catastrophic act. In deciding what action to take, Congress now has essentially three options:

1) Repeal the entire act.

2) Keep all benefits and financing provisions but scale back their scope.

3) Eliminate some of the benefits and financing provisions and restructure the remaining program.

Repealing the entire act has the virtue of simplicity, and support in Congress for this approach is growing within both parties. This, however, would not address the underlying problems in Medicare that led to the original catastrophic legislation. As for the second option, this was at the heart of the proposal narrowly approved by the House Ways and Means Committee, which would retain the benefits and financing provisions of the law but scale back their scope. This is meeting with strong opposition from both the elderly and members of Congress. Senior citizens are concerned that keeping the surtax on the statute books means it could be increased again in the future. Meanwhile, many members of Congress are worried that, if some of the benefits are only scaled back, their costs could rise rapidly in the future.

The best option is the third: to eliminate the current surtax and the drug benefit scheduled for next year, reduce or eliminate the increases in the flat Part B premium, and then restructure the remaining program so that middle- and upper-class beneficiaries would pay directly for more of their routine, front-end medical care.

Meeting Retirees' Health Needs. These changes would yield enough savings in the Medicare program to fund the new catastrophic benefits already available to seniors – coverage for extended hospital stays, improved skilled nursing benefits, a cap on beneficiary copayments under Part B, and expanded coverage for the poor elderly and spouses of nursing home patients.

The advantages of option three are that it would not only quell elderly anger, but it would also more appropriately meet the health care needs of America's retirees. At the same time, it would put Medicare on a better financial footing. Congress should next turn its attention to the unfinished

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1 Congressional Budget Office, "Background Material on the Catastrophic Drug Insurance Program," July 1989, Table 2.

2 Joint Committee on Taxation, "Overview of Present Law and Estimated Budget Effects of the Medicare Catastrophic Insurance Program and Description of Possible Premium Options," May 25, 1989, p. 12.

business of assisting the elderly in obtaining the health care coverage they need most – protection against the costs of long-term care.

MAJOR PROVISIONS OF THE 1988 CATASTROPHIC ACT

Medicare 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 workers.[3] All retirees automatically qualify for Part A Medicare coverage when they become eligible for Social Security. Nonelderly, disabled Americans also become eligible for Medicare Part A after receiving Social Security disability payments for more than two years.

Part B of Medicare pays for a large share of physician services and related items for the elderly. Part B is a voluntary program available to all Part A beneficiaries. Those who choose to enroll in Part B must pay a flat premium ($27.90 a month this year) for coverage. Premium revenues fund 25 percent of the cost of Part B benefits; the remainder is funded out of general federal revenues. Over 95 percent of the elderly currently are enrolled in Part B.

New Medicare Part A Benefits

1) Unlimited Hospital Care. As a result of the Medicare Catastrophic Coverage Act of 1988, and starting in January of this year, Medicare now provides beneficiaries with unlimited free hospital care, after the payment of an annual deductible ($560 this year) the first time they enter a hospital in any year. Previously, they had to pay a deductible for each period of hospitalization, and they were also required to pay an increasing share of the bill after the first 60 days of a hospital stay.

2) Expanded Skilled Nursing Care. Under the new act, and starting in January of this year, Medicare pays for up to 150 days a year of extended care in a skilled nursing facility (SNF). For the first eight days of SNF care, beneficiaries are charged 20 percent of average daily costs ($25.50 this year). When a beneficiary pays a portion of a medical bill in this, it is known as coinsurance. Previously, beneficiaries could only receive skilled nursing care if they were transferred to a SNF following a hospital stay of three or more days. They were also limited to 100 days of SNF care per spell of illness, and they were charged higher coinsurance rates for SNF stays longer than 20 days.

3) Increased Home Health and Hospice Benefits. Beginning in 1990, the new act expands coverage for home health visits from five to seven days a week, and from three weeks to 38 days for each spell of illness. The act also

3 The current HI tax is 2.9 percent of all wages up to $48,000, with employees paying half directly and employers paying half.

removes, starting in January of this year, the previous 210-day lifetime limit on hospice benefits for patients certified as terminally ill.

New Medicare Part B Benefits

1) New Copayment Cap. Medicare Part B currently pays 80 percent of approved charges for physician services, after an initial deductible of $75 per year. Beneficiaries must pay the remaining 20 percent.[4] Starting next year, the new law caps these copayments at $1,370 a year. The cap will increase in future years so that a constant 7 percent of Medicare enrollees exceed the cap and thus benefit from the new coverage.

2) New Drug Benefit. The legislation adds a new prescription drug benefit to Medicare, to be phased in between 1990 and 1993 as follows. Starting in 1990, Medicare will cover home administered intravenous therapy drugs (with a 20 percent coinsurance rate), and immuno-suppressive drugs used after a transplant (50 percent coinsurance), after a $550 deductible each year. In 1991, coverage will be expanded to include all other prescription drugs, subject to a $600 deductible and a 50 percent coinsurance rate. The coinsurance rate will be reduced to 40 percent in 1992, and to 20 percent for 1993 and all subsequent years. The annual drug deductible will also be adjusted each year after 1990, so that a constant 16.8 percent of Medicare enrollees exceed the deductible and thus benefit from the new coverage.

Expanded Medicaid Benefits for the Elderly Poor

1) Expanded Medicaid Buy-In. State Medicaid programs currently "buy into" Medicare on behalf of many of the elderly poor, paying the costs of their Medicare Part B premiums and any deductibles or coinsurance. This means the federal Medicare program pays for most of the health care costs of a state's poor retirees, freeing state Medicaid funds for use elsewhere. However, eligibility requirements for this buy-in differ among the states, and not all of the elderly poor qualify for this assistance. Because the new law reduces Medicare deductibles and coinsurance charges, state Medicaid programs will save even more money as additional current costs are transferred to Medicare. The catastrophic law requires states to use these savings to expand the Medicaid buy-in to include, by 1993, all Medicare beneficiaries with incomes below the Census Bureau poverty level.[5]

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4 Physicians also are allowed to charge more than the approved Medicare rates and beneficiaries are responsible for paying any such extra amounts themselves. This is often referred to as "balanced billing." In 1988, doctors charged more than the Medicare approved rates in 23.7 percent of all cases. See: *Background Material and Data on Programs Within the Jurisdiction of the Committee on Ways and Means* (Committee on Ways and Means, U.S. House of Representatives) 1989 edition, March 15, 1989, p. 393.

5 In 1988, the poverty level for an elderly single person was $5,671, and for an elderly married couple was $7,154.

2) Protection for Spouses. Medicaid currently pays the nursing home costs of the indigent elderly.[6] To qualify for this assistance, an elderly individual must have income and assets below an amount specified in the state's Medicaid program. Nursing home residents who do not meet these qualifications must pay for their own care until they "spend down" to the Medicaid eligibility level. This requirement poses a major problem for a nursing home patient who shares his income or assets with a spouse who is not institutionalized.

To help relieve this burden, the new law requires states to increase the amount of income and assets that noninstitutionalized spouses can keep. By 1992, when these provisions take effect fully, a noninstitutionalized spouse will be allowed to retain an annual income of at least $14,000 in today's dollars. He or she also will be able to keep half of the couple's savings, with a minimum of $12,000 and a maximum of $60,000, as well as a home and a car.

How the New Benefits Are to Be Financed

The benefits in the catastrophic act are to be paid for entirely out of increased premiums and taxes on Medicare beneficiaries. This is done in two ways. First, the flat Part B premium is increased in stages each year to cover about one-third of the cost of the new benefits. Second, a new income surtax, called a "supplemental premium," is imposed on all Medicare eligible individuals to cover the remaining costs.[7]

1) Increased Premiums. These premium and tax increases went into effect on January 1, 1989. Table 1 gives the current and projected Part B premiums for 1989 through 1993.

2) New Surtax. The income surtax, or "supplemental premium," is an added tax on each $150 of federal income tax normally owed by a beneficiary. In essence, it is a tax on a tax. Example: this year, when the surtax is $22.50, a beneficiary owing $150 in federal income taxes instead will pay $172.50 ($150 + $22.50). If he owes $300 in taxes, he will pay $345 ($300 + $45). Beneficiaries this year will pay this tax until they reach a maximum surtax of $800. Both the surtax rate and the cap will increase by specified amounts for

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6 In fact, in 1987, 46 percent of all money spent on U.S. nursing home care came from Medicaid, and 42 percent of all Medicaid outlays went to paying for nursing home care. See Committee on Ways and Means, *op. cit.*, pp. 254, 1149.

7 A portion of the new premiums and taxes are allocated to a special trust fund to pay for the new drug benefits, and the remainder is allocated to special accounts within the existing HI and SMI trust funds to pay for the other catastrophic benefits.

the first five years of the program. After 1993, the tax rate is to be increased by a maximum of 1 percent of tax liability each year ($1.50 per $150 of tax liability), and the cap will increase to keep pace with growth in the cost of the Medicare Part B program. Table 2 gives the surtax amounts and rates for the years 1989 through 1993.

Table 1
Current and Projected Medicare Part B Premiums[8]

	1989	1990	1991	1992	1993
Monthly Basic Premium	$ 27.90	$ 29.00	$ 30.40	$ 31.90	$ 33.40
Monthly Catastrophic Premium	$ 4.00	$ 4.90	$ 7.40	$ 9.20	$ 10.20
Monthly Total	$ 31.90	33.90	$ 37.80	$ 41.10	$ 43.60
Annual Total	$382.80	$406.80	$453.60	$493.20	$523.20

Table 2
The Amounts and Rates of the New Medicare Surtax[9]

	1989	1990	1991	1992	1993
Surtax Amount per $150 of Tax Liability	$22.50	$37.50	$39.00	$40.50	$42.00
Surtax Rate	15%	25%	26%	27%	28%
Maximum Additional Taxes	$800	$850	$900	$950	$1,050

8 Committee on Ways and Means, *op. cit.*, p. 150. In this table, the figures for the monthly basic premium assume that future increases in the basic premium will be indexed to the annual Social Security Cost of Living Adjustment (COLA). If instead the basic premium were indexed to the growth in Part B outlays, as it has been in the past, then the monthly basic premiums for the years 1990-1993 would be significantly higher than those shown in this table. The result likely would be that, by 1993, the elderly would be paying total premiums (basic plus catastrophic) of between $50 and $60 a month, or $600 to $720 a year.

9 Congressional Budget Office, "The Medicare Catastrophic Coverage Act of 1988, Staff Working Paper," October 1988, p. 8.

WHY THE ELDERLY ARE ANGRY

Survey data show growing opposition to the act among the elderly. Graphs 1 through 4 compare the responses to three key questions from two surveys that asked the elderly for their opinions of the catastrophic act.

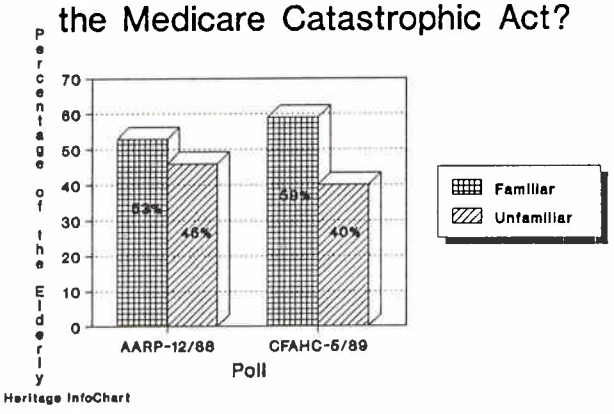
The first survey was commissioned by the American Association of Retired Persons (AARP) and was conducted by the firm of Hamilton, Frederick & Schneiders between December 2 and December 18, 1988. The second survey was commissioned by the Coalition For Affordable Health Care (CFAHC), an ad hoc coalition of 37 politically diverse senior citizen groups, which is lobbying for changes in the catastrophic act. The survey was conducted by The Wirthlin Group between May 9 and May 11, 1989.[10]

Graph 1 shows that a substantial, though decreasing, percentage of the elderly still are unfamiliar with the act. This is significant because other results (not shown on these graphs) from both polls indicate that increased familiarity with the act leads to increased opposition.

Familiarity Breeds Opposition. In the AARP poll, familiarity with the act led to a 2 percentage point increase in "somewhat support," a 5 percentage point increase in "strongly oppose," and the other responses equal for both the total sample and those who were familiar with the act. In the CFAHC poll, while 55 percent of the total sample felt the benefits were not worth the cost, 63 percent of those who were familiar with the act felt the benefits were not worth the cost. Furthermore, all but one percentage point of this difference was recorded in the "strongly not worth" column, which response was given by 44 percent of the total sample compared with 51 percent of those familiar with the act.

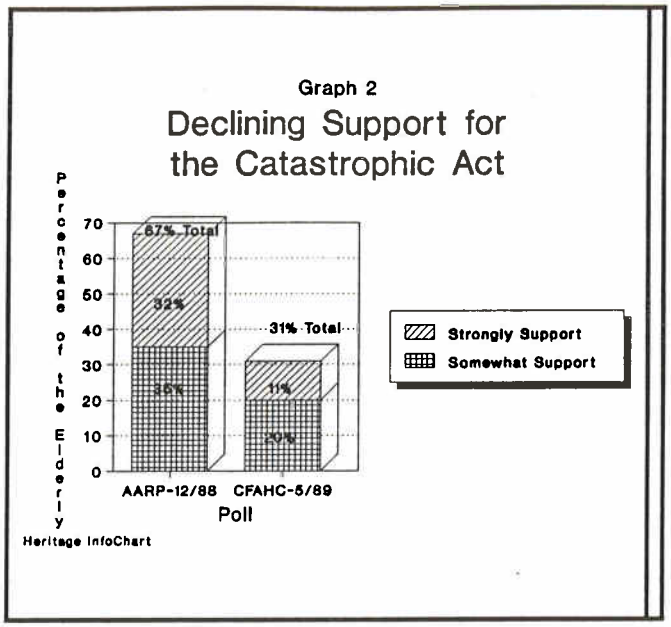
Graph 1

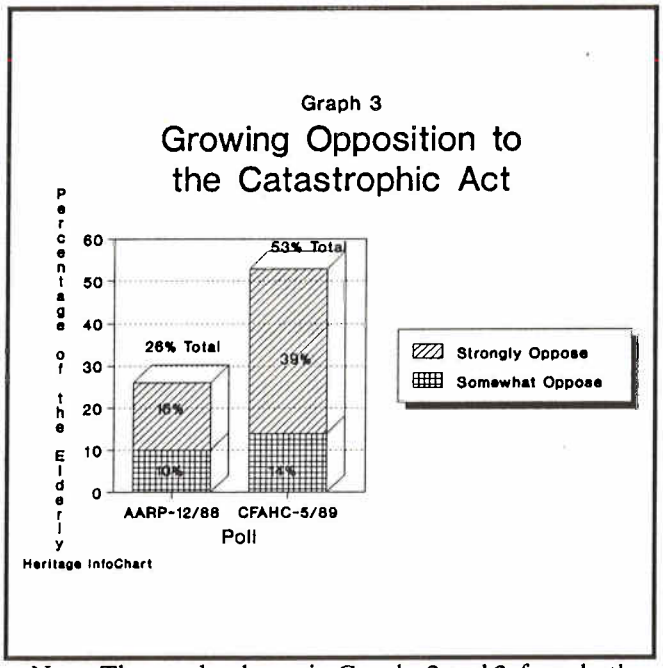
Are Senior Citizens Familiar with the Medicare Catastrophic Act?



A comparison of graphs 2 and 3 shows that support for the act is relatively "soft," while the opposition is relatively "solid." That is, in both polls the majority of those favoring the act say they only "somewhat support" it, while the majority of those opposing the act say they "strongly

10 The sample size for the AARP survey was 657 individuals age 65 or over. The margin of error is given as ± 4.0 percent. The sample size for the CFAHC survey was 1,008 individuals age 65 or over. The margin of error is given as ± 3.1 percent.





Note: The results shown in Graphs 2 and 3, from both polls, are only for those respondents who said they are familiar with the act.

oppose" it. Graph 4 shows the remarkable reversal of support for the act among the elderly in just a six-month period.

This growing elderly outrage concerning the catastrophic act has been fanned by three main objections. First, and most important, senior citizens object to being forced to pay for the new coverage through an income surtax. Second, many retirees feel that the new law does not provide the benefits they really want. And third, many of the elderly object to the fact that the program is mandatory, in some cases forcing them to pay taxes for benefits that duplicate those they already receive under company pension plans.

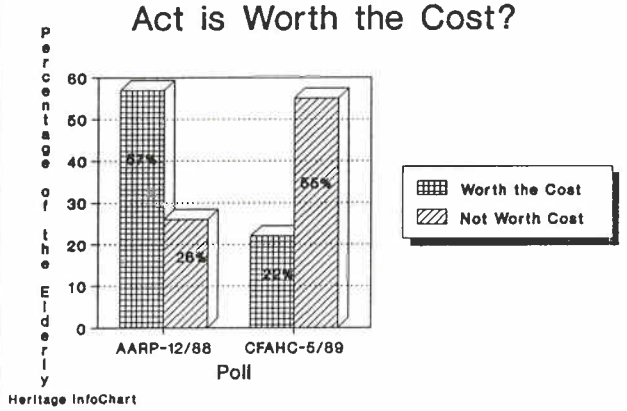
Pernicious Tax. The elderly understandably are most upset about the new income surtax used to fund two-thirds of the catastrophic act. The surtax penalizes prudent senior citizens who saved and invested for their retirement and those who choose to supplement their income by continuing to work. Worse still, the surtax rate is scheduled to increase annually with no limit. This makes the surtax a constantly escalating assault on the financial health and independence of America's retirees.

Furthermore, and contrary to claims by the law's defenders that only wealthy retirees pay the new tax, middle-class retirees will be hard hit. In fact, the number of senior citizens paying the escalating surtax will grow in future years. Last October the congressional Joint Committee on Taxation (JCT) estimated that 35.6 percent of Medicare beneficiaries will pay the surtax. This

year, that number will grow to 42.5 percent by 1993. The JCT has recently revised its estimates upward to 41.2 percent this year and 47.6 percent by 1993.[11] An independent study published this February indicates that the percentages will be higher: 46.8 percent this year and 53.7 percent by 1993.[12]

Graph 4

Do the Elderly Think the Catastrophic Act is Worth the Cost?



Note: The results shown in Graph 4, from both polls, are for all respondents including those who said they are unfamiliar with the act.

New estimates of the total tax burden imposed on the elderly by the surtax show that it will be greater than Congress originally anticipated. When the program was enacted, the Congressional Budget Office estimated that the surtax would collect $21.7 billion in revenues in fiscal 1989 through 1993. The CBO now estimates that the new tax will collect $25.9 billion during that period. The Bush Administration puts the amount at $28.3 billion.[13]

Wrong Benefits. Many elderly also complain that the program gives them benefits they either do not need or do not want. The health cost of greatest concern to most retirees is the enormous potential cost of long-term nursing home care. Yet, except for the Medicaid spousal impoverishment provision, the catastrophic act does nothing to address this concern. Instead, the new law establishes a prescription drug program, even though polling data shows that such a program has the least support of any provision among the elderly.

In addition, while the new law expands coverage for the elderly poor, the major costs of the catastrophic act are benefits to be paid to middle- and upper-class retirees. Before the catastrophic legislation was enacted, almost all of those middle- and upper-class retirees purchased some form of private "Medigap" insurance. This reimbursed them for Medicare deductibles and coinsurance, and for extensive hospital stays. Thus the elderly were already paying for at least the most important of these benefits before Congress enacted the Medicare catastrophic legislation. In fact, many senior citizens, particularly those who were employed by large companies or by the federal

11 Joint Committee on Taxation, *op. cit.*, pp. 14-15.

12 National Committee to Preserve Social Security and Medicare, "Medicare Catastrophic Coverage Act: More Out-of-Pocket Costs, Little or No Benefit," February 1989.

13 Joint Committee on Taxation, *op. cit.*, p. 12.

or state governments, have retiree health benefits that paid their Medigap coverage for them.

Mandatory Program. The mandatory nature of the catastrophic act adds to the anger of elderly Americans. Admittedly, only the retirees who "choose" to enroll in Part B are eligible for the new cap on Part B expenses and the new drug benefits (all will receive the hospital benefits under Part A). Thus it is possible for retirees to avoid paying the increases in the flat Part B premium by dropping their Part B coverage. To do so, however, they must also give up all of the other, heavily subsidized noncatastrophic Part B benefits as well. Over 95 percent of retirees are enrolled in Part B. This effectively makes the increases in the Part B premium mandatory.

The surtax, on the other hand, is mandatory for all Americans eligible for Medicare. This means that a senior citizen who receives health insurance benefits through his current or former employer still must pay the surtax. In other words, he or she must pay twice for the same benefits. Furthermore, these surtax payments are not treated as a deductible medical expenses for income tax purposes.

PROPOSALS TO AMEND OR REPEAL THE CATASTROPHIC ACT

In response to pressure from retirees, some 30 bills so far have been introduced in Congress to repeal the Medicare Catastrophic Coverage Act in whole or in part or to change the way it is financed. More bills are expected. To date, a total of 260 Congressmen and 36 Senators have sponsored or cosponsored at least one of the pending bills. Among them are 115 Congressmen and 23 Senators who last year voted for the catastrophic legislation on final passage.

Of these proposals, some would repeal outright the entire catastrophic act, while others would make the program voluntary.[14] Others would retain the new extended hospitalization and skilled nursing benefits that took effect in January of this year, together with the increase in the Part B flat premium needed to pay for them. A number of these bills also would retain some of the other benefits, particularly the Medicaid buy-in and spousal impoverishment provisions. All of these bills would eliminate or postpone

14 The numbers and sponsors of the bills that would repeal the catastrophic act are: H.R. 169, Rep. Fawell; H.R. 332, Rep. Ritter; H.R. 557, Rep. Stump; H.R. 697, Rep. Luken; H.R. 864, Rep. McCandless; S. 43, Sen. Reid. The following bills would make the program voluntary for all or some beneficiaries: H.R. 267, Rep. Lloyd; H.R. 558, Rep. Tallon; H.R. 1809, Rep. Cardin; S. 608, Sen. Wallop; S. 1149, Sen. Baucus. In addition, two bills, H.R. 2069, Rep. Watkins and S. 445, Sen. Nickles, would delay the implementation of the entire act for two years.

the surtax as well as the Part B cap on out-of-pocket expense and the new drug benefit.[15]

Two other bills would retain a modified drug benefit for the poor elderly, raise the Part B cap on out-of-pocket expenses, and reform the tax treatment of long-term care insurance. The bills would finance these benefits by further increasing the Part B flat premium.[16] Yet other bills simply would shift all or most of the cost of the program to the nonelderly. These propose to pay for the program out of increases in income taxes, payroll taxes, or excise taxes on alcohol and tobacco.[17]

Finally, the House Ways and Means Committee on July 25 approved changes that would scale back the surtax and benefits but retain all of the main elements of the original catastrophic act. This proposal would reduce the surtax by one-half, from 15 percent to 7.5 percent starting this year, raise the drug deductible from $600 to $800 in 1991 and from $650 to $950 in 1992, and increase the catastrophic portion of the Part B flat premium from $4.90 to $8.40 a month in 1990, from $7.40 to $11.40 a month in 1991, from $9.20 to $13.30 a month in 1992, and from $10.20 to $14.30 in 1993.

Evaluating the Reform Proposals

While all of these proposals seem sincere attempts to address the serious concerns of the elderly, many contain undesirable features. Among them:

♦♦ Bills that only delay, rather than repeal, the surtax and future benefits obviously do not solve the problems; they simply buy time. While lawmakers may want more time to consider alternatives, if they approve one of these bills, they must realize that they are only prolonging the dispute.

♦♦ A number of the bills contain a provision to establish a commission to study alternatives to the catastrophic act. Congress has used this tactic before to try to depoliticize such controversial issues as Social Security and military base closings. But in this case, it is not a question of Congress trying to find the political courage to tackle a new issue. Rather, it is a question of Congress trying to avoid responsibility for previous actions. Sooner or later Congress will have to vote on a bill to repeal or change the program. Creating a commission will not allow those who voted for the act to escape the anger of the elderly. It is in the interest of these members of Congress themselves to fashion the reform — not to appoint a commission to receive the credit or perhaps generate more anger by proposing an unworkable alternative.

♦♦ Shifting the cost of the catastrophic act to the nonelderly, as some bills propose, also is no solution. The surtax is not the only problem with the legislation. As the Congressional Budget Office's new drug estimates make

15 These bills are: H.R. 63, Rep. Archer; H.R. 1564, Rep. DeFazio; H.R. 2212, Rep. Johnston; H.R. 2770, Rep. Fawell; S. 335, Sen. McCain; S. 1011, Sen. Exon; S. 1038, Sen. Roth; S. 1187, Sen. Domenici; S. 1219, Sen. Mack.

16 These bills are: H.R. 2055, Rep. Rhodes and S. 1174, Sen. Coats.

17 These bills are: H.R. 974, Rep. Frank; H.R. 1808, Rep. Cardin; H.R. 2547, Rep. Bonior; S. 660, Sen. DeConcini; S. 1125, Sen. Harkin.

clear, the benefit structure is out of control. Sticking someone else with the tab will not make a bad program any better.

Similarly, the recent Ways and Means Committee proposal will only scale back the scope of the catastrophic act while retaining its current flawed structure. This most likely will prove unacceptable to the elderly. If the history of existing government programs and taxes is any guide, as long as the surtax mechanism is in place, it is virtually certain that in future years the rates will climb and the tax will be imposed on an ever increasing proportion of the elderly population.

AN AGENDA FOR GENUINE REFORM

If Congress is to correct the flaws of the catastrophic act, while genuinely improving health care coverage for the elderly, it must start with a clear understanding of what is wrong with the legislation and the Medicare program as a whole. Congress also should have a clear set of principles on which to base meaningful reform.

The current debate over the catastrophic act shows clearly that Congress must face up to the fact that Medicare, the federal government's second largest program, is a shambles. The cost of Medicare Part B continues to escalate at the staggering rate of 13 percent or more each year. Indeed, Medicare Part B is the single fastest growing component of the federal budget. At the same time, Medicare Part A is projected to be bankrupt within the next ten to fifteen years without new and economically damaging increases in the Medicare payroll tax on today's workers. Rather than addressing these serious problems, last year's catastrophic legislation only compounds them.

Congress's Targets. The reason why Medicare is in financial trouble and why the price tag for the catastrophic act goes up with each new estimate is that the program is providing the wrong benefits. It continues to pay for substantial quantities of routine medical care, thus removing any incentive for beneficiaries to be cost-conscious by avoiding unnecessary treatments or seeking lower-cost providers. Yet so far Congress's solution to Medicare's cost crisis has been to try to restrain provider charges with cumbersome and inefficient top-down bureaucratic price controls. In 1983, for instance, Congress enacted the Prospective Payment System of price fixing for Medicare payments to hospitals. It is now considering a system for reducing payments to doctors if Medicare Part B spending exceeds specified "expenditure targets" for the program in future years.

While it may be easy politically to blame providers for Medicare's runaway costs, they are only responding rationally to the faulty system Congress has designed. Tightening controls on the system simply will exacerbate the existing distortions in the program while multiplying costly paperwork and confusion for both patients and providers. In the end, it is the elderly who will lose.

In devising reform legislation to correct the flaws of the catastrophic act, improve health care coverage for the elderly, and place Medicare on a more sound financial footing, Congress should be guided by the following principles:

Principle #1: The elderly poor must be protected.

Congress must ensure that all of America's poor retirees have comprehensive medical coverage. Because of mismatches in the design of the Medicare and Medicaid programs, too many indigent retirees have, in the past, fallen through the cracks and been left without adequate assistance. Congress needs to permanently rectify this structural defect.

Principle #2: The middle- and upper-class elderly should pay for only their Medicare coverage expansion.

Some retirees have objected to the catastrophic legislation on the grounds that only the elderly are paying for the new program. They believe instead that the nonelderly should be required to pay for all or part of the cost. Defenders of the legislation correctly point out, however, that nonelderly Americans already are paying for most of the health care of retirees through the rest of the Medicare program. Hence it would be highly unfair to raise their taxes even higher to fund this new expansion of Medicare.

What is objectionable about the catastrophic act is not that the middle- and upper-class elderly are paying for it, but rather, the way in which they are paying and the benefits they will receive in return. Prior to the legislation, almost all of these retirees purchased private Medigap policies that provided them with the essential supplemental coverage they needed. The catastrophic act is objectionable because it now forces middle- and upper-class retirees to pay through escalating taxes for a "one size fits all" coverage. They no longer have the option of paying only for the coverage that best suits their financial and medical condition. Instead, they are forced to pay for such items as the expensive new drug benefit, which many of them neither need nor want, and the cost of unnecessary or overpriced treatments charged to the program by other beneficiaries.

The middle- and upper-class elderly have the resources to pay for new Medicare coverage for truly catastrophic illnesses. But instead of paying for it through taxes, they should pay either through flat insurance premiums or through reduced coverage for non-essential or routine medical care.

Principle #3: The surtax must be completely repealed.

The annual rate increases in the catastrophic surtax make it a particularly damaging tax. As long as even a reduced surtax remains in place, the elderly have good reason to fear that it will escalate even further in future years.

Steps to Reform

Based on these three principles, Congress should take the following steps to rectify the errors of last year's catastrophic health care legislation:

♦ ♦ **Repeal the surtax and freeze benefits at the 1989 level.**

At a minimum, Congress should freeze the catastrophic benefits at this year's levels, repeal the surtax, and eliminate the drug benefit and other provisions scheduled to be phased in starting next year. Several bills have been proposed that would do this. Such legislation would bring political relief to Congressmen and eliminate the worst provisions of last year's catastrophic act. The benefits that went into effect this year can be financed entirely out of the nondrug portion of the increase in the Part B flat premium, as shown in Table 3.

Table 3
Financial Effects of Freezing the Catastrophic Program at 1989 Levels[18]
(Premium increase in dollars. Revenue and spending estimates in millions of dollars)

	1989	1990	1991	1992	1993
Monthly Premium Increase	$4.00	$4.90	$5.46	$6.75	$7.18
Revenue from Increased Premium	$1,106	$1,810	$2,120	$2,601	$2,909
New Hospital Benefits	-$948	-$1,396	-$1,504	-$1,635	-$1,774
New Skilled Nursing Benefits	-$259	-$398	-$448	-$489	-$531
Total New Spending	-$1,207	-$1,794	-$1,952	-$2,214	$-2,305
Budget Effect of Proposal	-$101	$16	$168	$477	$604

♦ ♦ **Restructure Medicare.**

Beyond simply eliminating the surtax and freezing the benefits of the catastrophic act at 1989 levels, Congress also should undertake a structural reform in Medicare. Such reforms should be designed to pay for catastrophic illnesses and expanded coverage for the poor, without imposing new taxes or premiums. Three reforms would accomplish these objectives and would have the added benefit of putting the entire Medicare program on a more sound financial footing.

1) Expand coverage for the poor elderly. Congress should do one of three things: set the Medicaid buy-in permanently at 100 percent of the poverty threshold (under the catastrophic act this is now scheduled to take place in 1992); provide full coverage for the poor elderly under Medicare; or give these retirees vouchers with which they can purchase their own private

18 Data from: Congressional Budget Office, "The Medicare Catastrophic Coverage Act of 1988, Staff Working Paper," October 1988, pp. 6, 8.

supplemental insurance. The advantage of the first approach is that it involves a relatively minor change in the existing system. The advantage of the second approach is that it would be a more effective means of assuring that all elderly poor are adequately covered and would reduce confusion and paperwork for providers and program administrators. The third approach would be the simplest and most efficient by making the program more flexible for both beneficiaries and the government.

2) Restructure Medicare Part B. Congress should increase the Part B deductible for the middle- and upper-class elderly to at least $250 and then index it to growth in the Part B program in future years. This deductible, which currently is $75, has increased only twice since the program began in 1966, at which time it was set at $50. Had the deductible increased in the intervening years simply at the rate of general inflation, it would today be $183. The CBO estimates that increasing the deductible to $200 would lower Medicare outlays by $16.4 billion over the next five years.[19] For most of the middle- and upper-class elderly, the deductible could be raised even higher without imposing any hardship. The money Medicare saves with this reform could be used either to fund a cap on beneficiary copayments under part B (as is contained in the catastrophic act) or to reduce the Part B flat premium paid by the middle- and upper-class elderly.

3) Restructure Medicare Part A. Congress should replace the current annual Inpatient Hospital Deductible (now $560) with coinsurance rates of 20 percent or 30 percent for the first week of a hospital stay. The resulting savings could be used to pay for the catastrophic act's expanded coverage for extended hospital stays and skilled nursing care without having to increase the Part B flat premium. Eliminating the Inpatient Hospital Deductible would remove a significant financial barrier to hospital care now imposed on the elderly. Replacing it with coinsurance for the first week would encourage elderly patients and their doctors to be more conscious of the cost of total treatment during a hospital stay, since the vast majority of hospital stays under Medicare are for nine days or less.

♦ ♦ Introduce a long-term care initiative

Once Congress has corrected the defects of last year's legislation, it should turn its attention to the unfinished business of assisting the elderly in obtaining the health care coverage they need and want most – protection against long-term nursing care costs. In doing so, Congress must focus not only on the needs of today's elderly, but also on ways to make sure that when today's workers reach retirement age they will have adequate savings and insurance coverage to protect them from potentially crippling long-term care

19 Congressional Budget Office, "Reducing the Deficit: Spending and Revenue Options," February 1989, p. 123.

bills. Congress should take several steps to promote the growth of long-term care insurance.[20]

Among them:

1) Establish a separate long-term care program for the elderly poor. To improve services for the long-term care needs of the elderly poor, current government assistance should be separated from Medicaid and established as a separate program. Medicaid was originally designed to provide basic health care services to the nonelderly poor; it was not designed to pay for long-term care for the low-income elderly. Separating these two very different functions into different programs would allow the federal and state governments to more effectively address the needs of each group.

2) Extend the same tax incentives to long-term care insurance that are now given to life insurance. The Internal Revenue Service recently has taken a significant step in this direction by ruling that insurance company reserve funds for long-term care policies will no longer be taxed, just as life insurance reserve funds are not taxed. This should be confirmed by legislation. Furthermore, benefit payments from long-term care insurance policies should not be taxed either. These steps would make long-term care insurance more affordable and thus more attractive.

3) Allow Americans to use their retirement funds to make tax-free purchases of long-term care insurance. Workers and retirees should be allowed to use funds in pension plans, 401(K) plans, Individual Retirement Accounts (IRAs), and other retirement plans to make tax-free purchases of long-term care insurance. Similarly, employers should be allowed to use excess reserves in overfunded pension plans to fund long-term care health insurance benefits for their employees in retirement. This would provide a tax incentive for the purchase of long-term care policies.

4) Encourage the development of life insurance policies that convert to long-term care insurance upon retirement. This can be accomplished by removing taxes on benefit payments under such policies. Families buy life insurance to protect themselves against the loss of earning capacity during working years. Such protection is generally not needed to the same extent in retirement, when family income is no longer dependent on the employment of the head of household and family obligations are reduced. It would make sense for life insurance companies to offer policies that gradually reduce the benefits payable at death and phase in the benefits payable for long-term care. Some insurance companies already have started to offer such convertible policies. The government should encourage this trend by removing the taxes paid on the benefits under such policies, thus making them more affordable.

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20 See Peter J. Ferrara, "Providing for Those in Need: Long-Term Care Policy," Heritage Foundation *Backgrounder* No. 646, April 20, 1988; and Peter J. Ferrara, "Health Care and the Elderly," in Stuart M. Butler and Edmund F. Haislmaier, eds., *A National Health System for America* (Washington, D.C.: The Heritage Foundation, 1989).

5) Promote home equity conversions to fund the cost of long-term care. The government should encourage the development of financial instruments to enable the elderly to use the equity in their homes to finance long-term care insurance or services. A reverse annuity mortgage would not pay elderly homeowners a lump sum loan secured by the equity in their homes, but instead pay them a regular monthly sum from a finance company. Thus secured by the equity on the house, the debt would be recovered after the death of the retiree and his or her spouse. The monthly income received could pay for long-term care insurance premiums.

Such reverse annuity mortgage plans are now available where state law permits them. The federal government recently has given them a considerable boost by providing federal insurance for such loans and by allowing the Federal Home Loan Mortgage Corporation (Freddie Mac) and the Federal National Mortgage Association (Fannie Mae) to purchase such loans for the secondary market. This makes the plans more secure and thus far more attractive to mortgage companies. The federal government should continue to promote equity conversions and should undertake a publicity campaign to educate the elderly and to encourage them about this option for paying long-term care costs.

CONCLUSION

It is now clear to members of Congress that they miscalculated seriously in constructing last year's Medicare Catastrophic Coverage Act. They are faced with intense – and growing – anger of the elderly over the onerous and damaging surtax Congress chose to use to fund most of the program. Furthermore, many of the elderly do not want most of the benefits that Congress put into the bill. At the same time, the estimated cost of those benefits, particularly the new drug benefit, continues to increase with each new projection from the Administration and the Congressional Budget Office. In short, it has become evident to more and more members of Congress that the legislation is politically and economically unsupportable.

There is now a growing movement in Congress to eliminate the surtax in the catastrophic act, and scale back the benefits to a more appropriate level, and focus assistance on the services needed most. But at the same time, Congress has an opportunity to undertake even more important reforms.

Seeking Affordable Long-Term Care. Congress should take a long, hard look at how it can restructure Medicare to put it on a better financial footing and to more appropriately meet the health care needs of the elderly. In

addition, Congress should devote its attention to the issue it should have been most concerned with all along – finding ways to meet the need for affordable, long-term care insurance.

If Congress takes these steps, it will have benefited from the failings of the catastrophic act and its work on these issues during the past two years will not have been in vain.

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