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THE LAST TIME CONGRESS REFORMED HEALTH CARE: A LAWMAKER'S GUIDE TO THE MEDICARE CATASTROPHIC DEBACLE

> Congressman Dan Rostenkowski, one of the most powerful politicians in the United States, was booed and chased down a Chicago street Thursday morning by a group of senior citizens after he refused to talk with them about federal health insurance....Eventually, the six-foot four-inch Rostenkowski cut through a gas station, broke into a sprint and escaped into his car, which minutes earlier had one of the elderly protesters, Leona Kozien, draped over the hood.
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> *The Chicago Tribune*, August 18, 1989.

INTRODUCTION

Members of Congress soon will consider health care reform legislation that will affect the lives of over 257 million Americans.

The major bills reported out of the key committees of Congress, such as the Kennedy plan[1] and the House Ways and Means and Energy and Commerce Committee bills, as well as the bills developed by the House and Senate majority leaders, basically are versions of the Clinton plan.[2] They would make sweeping changes in the American health

1 For a detailed description of the Kennedy plan, as reported out of the Senate Committee on Labor and Human Resources, see John C. Liu, with David H. Winston and Christine L. Olson, "Clinton Heavy: The Kennedy Health Bill," Heritage Foundation *Issue Bulletin* No. 197, July 21, 1994.

2 "Four committees, two in the House and two in the Senate, cleared five different health care measures—one of them preferring to approve two, rather than one. No two are identical, and many have provisions that are flatly incompatible." See David S. Broder, "Health Care Disarray," *The Washington Post*, July 13, 1994, p. A-17. But the paradigm of

care system, including new mandates on employers, a comprehensive standardized benefits package, an expansion of government programs, government controls on health care spending, prices or insurance premiums, and the creation of a powerful national health board or commission with broad regulatory powers.

None of these more recent measures has been subject to the same level of intense study or econometric analysis as the Clinton bill. Nevertheless, the congressional leadership in both houses indicate that they intend to meld these measures, many of which are contradictory, into a single piece of legislation. When they vote on the legislation, Members of Congress will have had little time to analyze and digest the legislative details, to evaluate hastily prepared cost projections, or to discuss the implications of the measure with their constituents.

RECALLING CATASTROPHIC

Before lawmakers cast their fateful votes, they should recall the last time Congress enacted a major health bill. That was the Medicare Catastrophic Coverage Act of 1988. Compared with today's Administration-backed bills, the 1988 legislation was a very modest, limited reform and it affected only 32 million elderly Americans. Unlike the legislation now being pushed by the White House and its allies, the 1988 legislation had overwhelming support from the public and from interest groups. It had bipartisan backing, and it was the result not of a few weeks' feverish work on Capitol Hill but months of careful deliberation. It turned out to be a disaster, and it was largely repealed the following year. Newer Members of Congress should note that the central features of the disastrous 1988 bill actually are contained in the majority leadership bills now before Congress. Yet these provisions occupy just a small proportion of the new bills—and so there are many more opportunities for things to go wrong.

Lawmakers should ponder the hard lessons of the Medicare Catastrophic debacle. The parallels with today are disturbing, and there is the same potential for a fiasco. The only difference is that it will be on a much larger scale.

Among the lessons lawmakers should draw from the Medicare catastrophic disaster:

- ✔ **Even a national debate on reform options with open forums, held before detailed legislation is introduced, does not assure real public support.** By contrast, the Clinton Administration plan and the leadership bills today were the product of closed task force deliberations and back-room deals.

  The open consultations with the public and 18 months of deliberation did not protect the 1988 legislation from a backlash once it was passed. The closed approach used today virtually guarantees a backlash.

- ✔ **Cost estimates are likely to be well off the mark.** The Congressional Budget Office's (CBO) estimate of the annual cost of the 1988 drug benefit

congressional reform efforts is the original Clinton plan. For a detailed discussion of the Clinton plan, see Robert E. Moffit, "A Guide to the Clinton Health Plan," Heritage Foundation *Talking Points*, November 19, 1993.

jumped from $5.7 billion when the bill was passed to $11.8 billion just twelve months later. The CBO raised the cost of a new skilled nursing benefit from $2.1 billion to $13.5 billion, or by 642 percent, in just 14 months. The revisions were prompted by new assumptions based on the final version of the bill.

These huge changes were in a bill that was much simpler and far less sweeping than the legislation being considered today, and so the scope for error today is much larger.

✔ **Seemingly little problems can mushroom into big disasters.** While minor concerns were raised about the potential cost of the drug benefit when the 1988 legislation was under deliberation, CBO, Department of Health and Human Services (HHS) actuaries, and other experts downplayed the problem. But within months of the bill's passage, the projected cost overruns increased dramatically.

In the legislation now on Capitol Hill, the number of uncertainties and potential problems is far larger, and thus so is the potential for financial disaster.

✔ **Do not be misled by favorable polls.** A few months before the 1988 catastrophic bill was enacted, it had 80 percent support among Americans, with only 9 percent opposed. Just a few months after enactment, it garnered four-to-one support among the elderly. But that support collapsed once the details of the program and its costs became clear.

Today a majority of Americans actually oppose the Clinton plan and many of its central elements. With current proposals lacking even the base of support the 1988 legislation enjoyed before it "hit the streets," lawmakers should recognize that groups of middle-class Americans who feel hurt by the specifics of a new program can quickly generate a backlash.

✔ **Special interest endorsements do not guarantee grass-roots support.** The Medicare catastrophic legislation had very wide support among such interest groups as the American Association of Retired Persons (AARP). But once the program was enacted and the provisions became clear, the endorsements of these groups counted for little.

Today the major reform bills do not have consensus support. There are very active opponents, and the average members of groups supporting major reforms cannot be counted on.

✔ **A standard government benefits package can mean explosive politics.** The 1988 legislation effectively required elderly Americans to buy additional Medicare benefits whether they wanted them or not. Many already enjoyed the benefits through private retirement programs to which they already had contributed, and yet they had to pay again. Others had to pay a special surcharge well above the value of any extra benefits. It was this feeling of unfairness that ignited the strongest demands for repeal.

Congress will invite a repeat of this backlash if it insists on requiring all working Americans, with their employers, to buy a comprehensive standard benefits package. Many Americans will pay more for fewer benefits that they want and will have to pay for benefits they do not want. That is a recipe for political trouble.

✔ **Beware of making people pay for benefits they just may not want.** During the congressional debate on the 1988 Medicare Catastrophic law, new Medicare levies were benignly called "supplemental premiums" rather than taxes. But this new premium turned out to be a substantial income tax increase, collected by the IRS, for taxpayers over 65. Most Members of Congress did not appreciate the specific impact of the new tax on supposed beneficiaries. It turned out that the new Medicare law would result in a sharp increase in the average extra tax liability for America's senior citizens. Representative Dan Rostenkowski and other lawmakers learned the hard way what many elderly thought of the new levy.

The committee and majority leadership bills on Capitol Hill, like the Clinton bill, are replete with new costs that may enrage supposed beneficiaries. Millions of working Americans, for instance, will be required to pay for benefits they may not want—the same tinderbox that led to the explosive elderly reaction to Medicare Catastrophic.

With just a few weeks left in this session of Congress, sweeping health care legislation is being rushed to the floor for a vote. The last time a major health care bill was enacted, in 1988, it had broad bipartisan and public support. Yet that support collapsed and the law was repealed. It is important for today's Members of Congress to take to heart the lessons of that debacle. If they do not, the measure they will soon vote on —which is far larger and more complex than the 1988 reform, and deeply divides the nation — will likely prove to be a political disaster.

THE DANGER SIGNALS

The Medicare Catastrophic Coverage Act of 1988 (H.R. 2470) was sent to the White House for President Ronald Reagan's signature in June 1988 after 18 months of detailed legislative work. The House of Representatives passed H.R. 2470 by a lopsided margin of 302 to 127. And after House and Senate conferees wrestled with the details, the Senate passed the Conference Report on the bill, 86 to 11, on June 8, 1988.[3]

The initially popular new Medicare bill provided unlimited annual hospital coverage for catastrophic illness, 150 days of skilled nursing care, unlimited hospice care, and 38 days of home health care. It capped Medicare beneficiary out-of-pocket expenses for Medicare Part B (physicians' services) at $1,370 in 1990.

Beyond the generous new hospitalization and home health care services, the bill added a variety of new benefits to beneficiaries of the Medicare system, including mammography screening, respite care, and outpatient prescription drugs. Moreover, states

3 "Catastrophic-Costs Bill Is Sent to White House," *Congressional Quarterly*, June 11, 1988, p. 1606.

were mandated to pay the Medicare premiums, plus deductibles and coinsurance, for millions of low-income elderly and disabled individuals.

The new benefits were to be financed through a three-tiered payment system. First, all Medicare beneficiaries were to pay an additional monthly premium of $4 for the catastrophic coverage. Second, Medicare beneficiaries were to pay a new income-related supplemental premium. This was in fact a sliding-scale tax, up to $800 per person or $1,600 per couple annually. And third, senior citizens were to pay a flat monthly drug premium of $1.94, beginning in 1991 and a drug deductible of $550 and copayment of 50 percent.

The Need for More Bureaucracy

As soon as the measure became law, the danger signals became apparent. One of the first was that actually implementing the bill would be much more complex than sponsors initially assumed. Lawmakers today should note that the legislation now being debated by Congress is far more sweeping than the 1988 Medicare law.

The new Medicare program in 1988 was to be administered by the Health Care Financing Administration (HCFA), the federal agency that runs the Medicare program. But HCFA's new administrative responsibilities were considerable, including the development of implementation plans; new monitoring and reporting systems; the development of revised computer software programs to process the new claims; a comprehensive "public information program" to make sure that over 32 million elderly and the disabled Americans, as well as doctors and hospitals, understood the new law and its benefits; contracts for the development of computer software to track new Medicare out-of-pocket expense limits; special instructions to the states regarding the new state mandates covering low income individuals; and HHS coordination with the Department of the Treasury to establish the Federal Catastrophic Drug Insurance Trust Fund, as well as procedures for collecting the new supplemental premium.

Although HCFA officials were given primary responsibility for implementing the new legislation, the broad scope of the new law meant that employees of other HHS agencies and even other federal departments had to coordinate their efforts with HCFA.[4] The Social Security Administration (SSA), for example, was to be responsible for telling the elderly and the disabled what benefits they would receive under the new law and for deducting the premiums for physicians' services from their Social Security checks. The Office of the Inspector General of HHS was to have responsibilities for enforcing a number of new civil monetary penalties for various offenses of "commission or omission" such as pharmacies charging any amount above the government determined price for prescription drugs. The Public Health Service (PHS) was to assist HCFA officials in administering the new mammography screening and prescription drug benefit. The Department of the Treasury was to be responsible for setting up two new trust funds: the Federal Hospital Insurance Catastrophic Coverage Reserve Fund and the Federal Catastrophic Drug Insurance Trust Fund. The IRS was to develop new tax forms and collect the new "Medicare Supplemental Premiums"—official Washington did not call these

4 "Medicare Catastrophic Coverage Act Implementation," *Talking Points*, The Health Care Financing Administration, 1989, p. 1.

The administrative responsibilities, required by Medicare Catastrophic Coverage Act of 1988:

Administrative Task	Action Steps
Develop and release instructions to intermediaries, HMOs/CMPs, and providers for Part A catastrophic coverage.	19
Develop and release Federal Register notices/regulations implementing Part A catastrophic coverage changes.	9
Prepare and Release public information materials regarding catastrophic health insurance to the media and beneficiaries.	19
Implement the Home IV and Immunosuppressive Drug Therapy Provisions (Section 203) by January 1, 1990.	34
Develop and implement Part B common cap module (CCM).	11
Develop and implement carrier of record process and software for Part B catastrophic coverage.	48
Begin procurement of drug processors and initiate actions to implement Medicare prescription drug benefit in 1991.	49
Revise Medicare beneficiary premiums and implement supplemental premium.	11
Publish required cost notices/rules in *The Federal Register*.	11
Revise financial management and reporting activities, and establish and manage the Health Insurance (HI) Reserve and Catastrophic Drug Trust Fund.	21
Revise contracts and financial management/reporting activities for 1990 implementation of the new home intravenous and immunosuppressive drug benefit.	16
Coordinate and monitor the catastrophic Medigap provisions.	7
Develop and release instructions to HMOs/CMPs for the Part B Medicare catastrophic coverage effective January 1, 1990.	8
Implement the Medicaid provisions of the Medicare Catastrophic Coverage Act.	24
Implement the coverage of screening mammography provisions.	9
Implement the Medicare respite care provisions (section 205).	10
Conduct congressionally mandated research projects.	9
Implement diagnostic coding on all physician bills.	7
Complete work on Advisory Committee on Medicare Home Health Claims.	4
Prepare and release public information materials regarding the catastrophic health insurance provisions effective on or before January 1, 1990 to the media and Medicare beneficiaries.	15

Note: A detailed description of these administrative tasks is found in a February 1, 1989, Memorandum, "Progress Report on the HCFA Catastrophic Implementation Plan," from Louis B. Hays, Associate Administrator for Operations at HCFA, to William L. Roper M.D., Administrator of HCFA.

new assessments taxes—for deposit in the new Reserve Fund. The Office of Personnel Management (OPM), the agency that administers the federal civil service, was to reduce health insurance rates for federal retirees eligible for Medicare by advising private sector insurance companies competing in the Federal Employee Health Benefits Program (FEHBP) of the proposed rate reductions. Likewise, the Federal Railroad Retirement Board was to perform similar functions for railroad retirees.

The Prescription Drug Mess

In addition to the disturbing complexity involved in implementing the general provisions of the bill, the centerpiece of the program—the new drug benefit—began to impose huge difficulties. Again, lawmakers today should note that this benefit represented a relatively trivial change when compared with the major reform bills now before Congress.

During the congressional debate in 1988, Reagan Administration officials warned Congress that the administrative problems of designing and implementing a new prescription drug benefit would be "immense." HHS officials specifically warned Members and senior congressional staff that a "complex and costly administrative system would have to be established. Depending on its design, Medicare could have to process as many as 300 million claims per year and monitor about 67,000 pharmacies."[5] HHS Secretary Otis R. Bowen also warned Congress that the administrative cost of the new drug program surely would exceed $500 million. Among other things, HCFA would have to establish a claims processing and data system to handle a very large number of small, detailed transactions. Members of Congress ignored these warnings.

In 1989, Bush Administration officials described implementing the new Medicare prescription drug program as one of the most "complex and difficult tasks" confronting HHS. Still, officials insisted that Congress had given them the "tools and the lead time to do the job."[6] This turned out to be untrue. Not only did the new prescription drug benefit exceed its initial cost estimates, but administering the new program became a bureaucratic and unworkable nightmare.

THE POLITICAL DEBACLE

The idea of extending catastrophic coverage in the Medicare program initially was very popular, and had broad bipartisan support. For example, Senators Lloyd Bentsen (D-TX), Thad Cochran (R-MS), Robert Dole (R-KS), Edward Kennedy (D-MA), and Jim Sasser (D-TN) all expressed interest in introducing or sponsoring legislation to expand Medicare to include catastrophic coverage. Likewise, in the House of Representatives, both "Pete" Stark (D-CA) and Willis Gradison (R-OH), the top-ranking mem-

5 "Should Drugs Be Added To A Catastrophic Bill?" HHS *Talking Points*, transmitted in a Memorandum to Health Policy Legislative Assistants, U.S. Senate, from Dr. Ronald F. Docksai, Assistant Secretary for Legislation, Department of Health and Human Services, July 29, 1987.

6 "Implementation of the Medicare Prescription Drug Benefit," *Talking Points*, The Health Care Financing Administration, 1989.

bers of the Ways and Means Health Subcommittee, backed a new catastrophic coverage benefit. Today, of course, there are deep partisan differences on proposed reforms.

After the Reagan Administration sent its proposal to Capitol Hill, the initiative became caught up in pressure to push through a measure and to enhance the original plan. In developments eerily similar to recent committee action on the Clinton bill, House and Senate committees rewrote and expanded major sections of the legislation. In spite of the substantive and detailed changes made by congressional committees, and despite strong veto threats by Reagan Administration officials,[7] many Members of Congress—including Republicans—insisted on passing the sweeping Medicare reform because they believed that failure to do so would be politically unacceptable to millions of elderly Americans.

After the bill passed with overwhelming support in both the House and Senate, the political situation changed quickly and dramatically. Within weeks, when elderly Americans started to learn the details of the new health care legislation, many became outraged when they discovered the new financial burdens they would have to bear to pay for the new program. Faced with this completely unexpected backlash, Members of Congress, including those who had enthusiastically backed the program, quickly started expressing doubts or even hostility to their own handiwork.[8] For example:

On June 23, 1988, Senator Daniel Inouye (D-HI) complained that in its haste to pass the Medicare Catastrophic Coverage Act, Congress had, among other things, changed the government reimbursement formulas for certified registered nurse anesthetists (CRNAs) without the benefit of "proper study." This technical oversight was damaging to these health professionals, he said, and should be rectified.

On September 26, 1988, Representative Marilyn Lloyd (D-TN) used her "Extension of Remarks" on the House floor to declare that senior citizens would be "taken to the cleaners" by the new Medicare legislation, and proposed instead to make the catastrophic provisions of Medicare voluntary.

On September 29,1988, Representative Robin Tallon (D-SC) blasted the program as "flawed" because of its new tax increase, and introduced H.R. 5400, a bill to make the coverage and the participation in the new Medicare program voluntary.

On September 30, 1988, Representative Bill Archer (R-TX) along with 32 cosponsors, introduced legislation (H.R. 5426) to delay implementation of the law and

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7 "H.R. 2470, The Medicare Catastrophic Protection Act of 1987, scheduled for House floor consideration this week, is totally unacceptable to the Administration. Unless the concerns...are addressed in a satisfactory manner, we will recommend to the President that he veto this bill." Letter from Otis R. Bowen M.D., Secretary of the U.S. Department of Health and Human Services, to Representative Robert Michel, Minority Leader, U.S. House of Representatives, July 21, 1987.

8 Memorandum from Jeff Hollingsworth, Office of Congressional Liaison (HHS) to Mary Goedde, Assistant Secretary for Legislation at the Department of Health and Human Services, October 5, 1988.

set to up a bipartisan commission to review the provisions of the recently enacted legislation.

STICKER SHOCK

The focus of anger among senior citizens was the impact of the Medicare law on their pocketbooks, compared with the benefits they were to receive. Members of Congress apparently had little appreciation of the actual fiscal impact of the bill on elderly households. The grass-roots "National Committee To Preserve Social Security and Medicare," chaired by James Roosevelt, found that the number of senior citizens who would be required to pay the new "supplemental premiums" was much larger than originally forecast:

> The Congressional Budget Office (CBO) underestimates the number by 24 percent. The widespread tax consequences affect almost half of all seniors in 1989. In addition, 30 percent to 40 percent of Medicare enrollees—most of the seniors paying the surtax—will suffer out-of-pocket costs for Medicare covered services. This is true even after taking into consideration all the new benefits and the reductions in medigap premiums.[9]

In defending the new Medicare law, Senator David Durenberger (R-MN) remarked, "The financing principles embodied in this legislation were carefully crafted to assure that amounts contributed by beneficiaries were affordable and fair."[10] Likewise, while escaping a pursuing crowd of elderly citizens in downtown Chicago, Representative Dan Rostenkowski (D-IL), the Chairman of the powerful House Ways and Means Committee, told the *Chicago Tribune*: "These people don't understand what the government is trying to do for them."[11]

Many of the most vociferous elderly apparently thought otherwise.

Chairman Rostenkowski was unwilling to entertain any change in the law, or even hold hearings on the subject in the spring of 1989. These congressional views were naturally mirrored, or reinforced, by the senior congressional staff, particularly on the House Ways and Means Committee, the House Energy and Commerce Committee and, to a lesser extent, on the Senate Finance Committee. During the spring and summer of 1989, it was the prevailing opinion of these senior staff that there should be no reconsideration or repeal of catastrophic; that at every stage of the legislative process—in congressional discussions in 1986 and 1987, at the subcommittee level, the full committee level, and in the House/Senate conference on the bill—the issues of financing and the implementation of the prescription drug benefit were carefully considered and were resolved to the general satisfaction of Members of Congress.

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

10 Senator David Durenberger, Statement Regarding the Supplemental Premium Under the Medicare Catastrophic Coverage Act, Senate Finance Committee, June 1, 1989.

11 William Recktenwald, "Insurance Forum Turns Catastrophic for Rostenkowski," *The Chicago Tribune*, August 18, 1989, p. 1.

In fact, the new supplemental premiums turned out to be substantial tax increases. According to Representative Al McCandless (R-CA), elderly taxpayers were to be saddled with a 15 percent surcharge on their income tax liability in 1989, rising to 28 percent in 1993. McCandless observed that the "average" additional tax liability for 1989 would be $355, rising to $630 in 1993. By that time, 56 percent of the elderly would be paying 28 percent of the additional income tax, and approximately 13 percent (four million elderly taxpayers) would be paying the maximum $1,050.[12] McCandless introduced a bill (H.R. 864) to repeal the Medicare Catastrophic Coverage Act on February 6, 1989. The supplemental premiums thus turned out to be a substantial hit on middle-income senior citizens. Overall, the fiscal outlook continued to darken; the costs of the new Medicare program were skyrocketing. The Treasury Department estimated that the overall cost of the new catastrophic program would reach $12 billion in 1992 and jump to $17 billion in 1995. Given the projected growth in costs, the Treasury also estimated that by the year 2005, couples would be paying close to $8,000 per year.[13]

Congressional staff soon were reporting a surge in letters and calls to their offices. Some Members were accosted by angry constituents in their districts. The trickle became a flood, as constituent anger spread and intensified over the costs of the new entitlement plan. As a result, Members of Congress were soon caught up in a mad scramble to scrap the Medicare legislation, and Congress did indeed repeal the main elements of the legislation.

KEY LESSONS FOR LAWMAKERS

Why did this happen? What caused a highly popular reform of Medicare to turn into a political disaster? Lawmakers supporting sweeping reform today need to consider the reasons and lessons carefully. The current reform proposals dwarf the 1988 Medicare law. And if Members of Congress ignore the hard lessons on 1988—as they seem determined to do—they could become engulfed in a disaster that is far more painful than the Medicare debacle.

Given the wealth of experience provided by the debate over the Medicare catastrophic, Members of Congress can learn some key lessons about health care reform.

LESSON #1: If an "open" process of designing major health reform did not work, a "closed" approach is even less likely to succeed.

In response to President Reagan's State of the Union address in February of 1986, HHS Secretary Otis Bowen and his senior staff produced a brilliant 117-page detailed report to the President the following November on "Catastrophic Illness Expenses."[14]

The HHS report was comprehensive and listed 54 specific options and recommendations for White House consideration. Secretary Bowen also assembled a team of tech-

12 Representative Al McCandless, "Why I Voted Against the Conference Report on H.R. 2470," June 2, 1988.

13 Editorial, *The Wall Street Journal*, June 17, 1988.

14 *Catastrophic Illness Expenses:Department of Health and Human Services Report to the President*, Department of Health and Human Services, Washington D.C., November 1986.

nical experts in the health policy field. Likewise, the Clinton Administration organized a 500-odd-member task force on health care reform. The Reagan-Bowen team was put under the direction of an Executive Advisory Committee chaired by HHS Chief of Staff Thomas R. Burke. Three technical working groups worked under the direction of this Executive Advisory Committee, and the work was supplemented by a special Private/Public Sector Advisory Committee, composed of consumers, employers, members of the medical profession, and elected officials.

The Reagan advisory panel was quite open in its procedure to gain ideas to hone its plan and to build public support for its approach. The Advisory Committee held public hearings around the country to solicit advice and ideas for Medicare reform from interested citizens and private organizations. This process helped clarify the alternatives for the public and enhanced the credibility of the effort within Congress. It was only after the presentation of the HHS report to the President, that the staff at the HHS started working on the formal legislative language to send to Capitol Hill. But even with this careful groundwork, the final legislative product was a disaster.

The Clinton approach has been very different. Rather than first conduct an open national discussion of specific options followed by detailed legislation—the approach with the best chance of success—the Clinton White House adopted the strategy of developing a detailed plan first, drafted by Washington insiders, and then "selling" the plan to the public. Under the day-to-day direction of White House aide Ira Magaziner, the 500-member Task Force, drawn mainly from liberal congressional staff and civil servants, labored in secrecy for over nine months on a restructuring of the entire health care economy. The result: a mammoth 1,342-page legislative document.

In an analysis of the Clinton plan for Multinational Business Services Inc., a Washington-based consulting firm, Jim Tozzi, who is a former career civil servant at the U.S. Office of Management and Budget (OMB), identified 818 new regulatory mandates on federal and state governments, and 59 new offices at the federal, state, and regional alliance levels to oversee the new system.[15]

Rather than discussing these complex reforms and other options with the American people before the plan's introduction, the Clinton Administration has chosen instead to try to keep the public debate on generalities, such as "security" and "universal coverage." The 1988 Medicare experience shows that even with a thorough debate of options first, seemingly broad public support can collapse once Americans confront the specifics. When there is no such public debate on specific options, there is even less chance that the public will applaud the final result.

Congress has decreased the likelihood of public approval even further by its own approach. Rather than debating a range of legislative approaches with constituents, and developing support for key building blocks, lawmakers kept the arcane Clinton bill as the only real plan under discussion for months. In recent weeks, however, that bill essentially has been sidelined amid a flurry of back-room committee and leadership action resulting in confusing bills with central provisions that few people understand

15 See *The Regulatory Requirements of The Health Security Act, Volume I: Methodology and Findings*, Executive Summary, Multinational Business Services Inc., Washington, D.C., March 1, 1994, pp. 1-2.

and on which there is no public consensus. For example, the Senate Finance Committee recently produced a bill which the CBO now finds would cost the taxpayers $124 billion over the projected costs for Medicaid, the joint federal-state program for the poor and the indigent, by the year 2000. But, according to *The Washington Post*, "[t]he CBO also found the Finance Committee bill largely unworkable. Some members who voted to pass it said they found over the weekend that much of the 961-page plan does not conform to the concepts the committee approved and that it will need to be redrafted."[16] Compared with this the process in 1988 was a model of careful deliberation—and even that failed to retain public support.

LESSON #2: Beware official cost estimates of government health care programs.

The 1988 Medicare Catastrophic Coverage Act is a classic case study of government cost estimates that prove to be wildly wrong.

In June 1988, when the bill was enacted, the prescription drug benefit was estimated to cost $5.7 billion over five years. Just twelve months later, the CBO estimate for the new catastrophic benefit jumped to $11.8 billion. Cost projections for other provisions were subject to even more drastic upward revisions. In June 1988, for instance, the skilled nursing benefit was estimated to be $2.1 billion. But in August 1989, when CBO reestimated the cost of the benefit, it had jumped to a staggering $13.5 billion. The reason: Congress had "unintentionally created a new Medicare entitlement for long-term care which covered individuals for 150 days per year."[17] In drafting the final bill, Congress eliminated the prior hospitalization requirement, increased the maximum stay, and sharply reduced the copayment requirements for beneficiaries.[18] While these adjustments in this benefit were popular at the time, few Members of Congress had the slightest notion of their fiscal consequences.

In comparison with the health reform bills now being pressed forward by the White House and the congressional leadership, the Medicare Catastrophic Coverage Act contained only tiny changes to the health system. The versions of the Clinton bill reported out of the House and Senate committees create huge new entitlements, a comprehensive benefits package approximating that of a *Fortune 500* company, and a new long-term care program. And in a supreme historical irony, it even contains a Medicare prescription drug benefit that is similar to the 1988 legislation—yet the benefit is so small in the context of today's overall legislation that it is barely mentioned in public discussion. Obviously, given the vast scale and complexity of the current legislation, even a few minor cost miscalculations like those of 1988 would mean huge costs to taxpayers, businesses, and family budgets.

There are plenty of signs that lawmakers should assume the worst. The Clinton plan's original cost estimates were described as a "fantasy" by Senator Daniel Patrick Moynihan (D-NY), who chairs the Senate Finance Committee. Since the plan was un-

16 Dana Priest, " Mitchell Outlines Scaled Down Health Care Plan," *The Washington Post*, August 1, 1994, p. A-13.

17 See *Health Care Reform Charts, Diagrams and Questions*, produced by the Minority Staff of House Committee on Energy and Commerce, 1994, p. 92.

18 *Ibid.*

veiled on Capitol Hill last October, its financing estimates have undergone several cost analyses. These vary widely depending, among other things, on the assumptions used. The Congressional Budget Office last February estimated that the Clinton plan would add over $70 billion to the budget deficit. And, as *Newsweek* economist Robert J. Samuelson observes, "Five outside groups re-estimated the Clintons' 'basic package' of insurance benefits. All found higher costs than the White House did. For individual coverage the costs were put from 9 percent to 26 percent higher; for two parent families, the costs were 13 to 59 percent higher. No matter. The Clintons set Congress's agenda."[19] And now legislation is being pushed by the congressional leadership that is sufficiently different that there are no careful comprehensive projections available at all, and likely none will be available before key votes take place. Thus there can be little doubt that if a major bill is passed soon, given historical experience, it will only be a few months before there will be drastic changes in the cost projections.

LESSON #3: Seemingly little problems can turn out to be big disasters.

During the debate on the Medicare Catastrophic bill, Members of Congress decided to add, against the advice of the Reagan Administration, a new prescription drug benefit for the Medicare program. Nevertheless, Secretary Otis Bowen advised President Reagan to sign the Medicare Catastrophic Coverage Act with the new drug benefit, but cautioned the President that the Department's evaluation of the prescription drug coverage indicated that benefit costs would continue "to exceed" estimates of the Congressional Budget Office.[20] While there was concern about the fiscal implications of this one benefit, Secretary Bowen did not indicate to Reagan that these were unmanageable.

During the early months of 1989, the potential cost problems of the new prescription drug benefit in Medicare continued to worry HCFA actuaries. They indicated that the Drug Trust Fund would have a "slight negative" balance in Fiscal Year 1992. One concern was that the premium rates for the Trust Fund were specified in the legislation through 1993, yet HCFA's actuaries estimated that the premiums were fixed too low to generate the revenue to cover the costs. Another concern was that the newly created Drug Trust Fund was prohibited by law from borrowing money from the Treasury to cover the shortfall. Members of Congress apparently had not foreseen the need to provide any such borrowing authority. CBO officials, on the other hand, believed that the premium rates Congress enacted were enough to cover the costs of the new drug program.

By August 1989, however, the financial situation had become both grave and clear: "The prescription drug benefit alone, when it starts in 1991," wrote Phillip Longman in *The New Republic*, "could swallow up the program's entire revenue base."[21] The

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19 Robert J. Samuelson, "Congress Should Simply Start Over," *The Washington Post*, July 13, 1994, p. A17.

20 For an excellent analysis of the roots of the controversy over the cost of the prescription drug benefit, including the disparity between HCFA and CBO actuaries, see Gail R. Wilensky, et al., "The Medicare Catastrophic Drug Benefit: An Analysis of the Cost Estimates," Project Hope, Center for Health Affairs, September 9, 1987.

21 Phillip Longman, "Catastrophic Follies," *The New Republic*, August 21, 1989, p. 18.

"slight negative balance" appeared, like Pac-Man, destined to devour the entire program.

The Clinton Administration also proposes a new Medicare prescription drug benefit. Under the Clinton plan, by July 1, 1996, Medicare benefits will include prescription drug coverage, with a $250 deductible, a 20 percent co-payment, and cap of $1,000 for annual out-of pocket expenses. While the drug benefit was indeed a substantial and hotly debated provision of the Medicare Catastrophic Coverage Act, the Clinton Administration's proposed Medicare drug benefit and related administrative provisions comprise only a small part of the huge Clinton bill. In fact, it occupies just 45 pages out of Clinton's 1,364-page bill.[22] And, like the Medicare Catastrophic Act, the Clinton plan requires the government to contract and set up a "point of sale" system for electronic drug claim processing and imposes counseling requirements for pharmacies. The Clinton White House initially estimated the cost of the prescription drug benefit at $66 billion.[23]

It remains to be seen if this estimate will change. But it is also important for lawmakers to remember that the drug benefit that alone proved to be such a financial bombshell in 1988 occupies just one-thirtieth of the Clinton health bill.

LESSON #4: Don't be misled by broad support for popular health reform concepts registered in public opinion polls.

Few legislative proposals enjoy the level of broad support enjoyed by the plan to include catastrophic insurance coverage in the Medicare program. An October 13, 1987, survey conducted by *Cambridge Reports* found 80 percent of Americans backing the initiative; only 9 percent opposed it. Likewise a survey conducted on behalf of the American Association of Retired Persons, in December 1988—just a few months after the bill's passage—found that Americans aged 45 and over supported the Medicare Catastrophic Coverage Act by a margin of over four to one.[24] Yet Congress was soon overwhelmed by opposition to the new program, once its provisions became clearer to many elderly Americans.

Lawmakers should learn from this that public support for broad concepts and catch phrases is not the same as support for a program. There was broad public backing for the idea of "catastrophic coverage" that would guarantee "peace of mind" to the nation's elderly. There is similar broad popular support today for politically attractive concepts like "universal coverage" or "health benefits guaranteed at work." But the polls and surveys today also show growing popular concern about the details and likely consequences of health care reform. For example, surveys indicate that Americans are not willing to accept government rationing of medical services or reductions in the quality of their health care. And few Americans are willing to accept limits on health care, especially if those limits are imposed by government agencies or govern-

22 The prescription drug benefit and related provisions can be found in Title II, Subtitle A, "Medicare Outpatient Prescription Drug Benefit," of the Health Security Act (H.R.3600), Sections 2001, 2002, 2003, 2004, 2005, 2006, and 2007.

23 Moffit, "A Guide to the Clinton Plan," p. 33. This is a six-year estimate.

24 *Opinions of Americans Age 45 and Over on The Medicare Catastrophic Coverage Act*, Report on a survey conducted by Hamilton, Frederick and Schneiders for the AARP, January 1989.

ment-sponsored organizations. In what should be a clear warning to lawmakers, an analysis of the survey research also indicates that the more Americans know about the details of the Clinton plan, the less they like it.[25]

LESSON #5: Special interest endorsements of health care bills should not be assumed to represent genuine grass-roots support.

During the Medicare Catastrophic Coverage Act debate, there was powerful support for the legislation in Congress and among various interest groups in Washington. The American Association of Retired Persons (AARP) was perhaps the most prominent player in a drama that included a variety of senior citizen organizations, consumer groups, medical societies, and even powerful groups within the health care industry. Likewise, most of Washington's health care policy experts were favorable to the enactment of the Medicare Catastrophic Coverage Act.

But these Washington, D.C.-based groups severely misjudged the reactions of ordinary Americans, including those they claimed to represent. The AARP staff in particular found itself on the defensive when millions of elderly Americans started complaining bitterly to Members of Congress about the new Medicare law. Writing at the time in *The New Republic*, Phillip Longman observed that "Congress and the AARP have been besieged. The abuse heaped on the AARP by its members this summer has been so unrelenting that its Washington policy staff—most of them idealistic, liberal-minded baby boomers—have begun to talk back like unrepentant granny-bashers. Some congressional offices have been receiving up to 1000 letters a week from mostly middle and upper income retirees demanding that the bill should be repealed or its cost should be shifted onto someone else."[26]

Today, with the Clinton plan and its several versions, most Members of Congress have begun to recognize the same mental disconnect between Washington-based lobbyists and the ordinary Americans they claim to represent. The Washington representatives of professional medical organizations, for instance, can be found backing greater government control over the health care system—or at least willing to accept it. Yet lawmakers would be hard-pressed to find many physicians in private practice actually supporting such positions.[27] Likewise, organized labor officially supports the Clinton plan, but many public sector unions, such as the federal employees unions, are desperately trying to avoid the main provisions of the Clinton plan.[28]

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25 See *American Attitudes Towards Health Care, Health Care Reform and The Clinton Plan*, Prepared for The Heritage Foundation by Fabrizio, McLaughlin and Associates, January 19, 1994; see also, Michael G. Franc, "Americans Overwhelmingly Support Health Reform That Puts The Consumer in Charge'" Heritage Foundation *FYI*, April 1, 1994.

26 Phillip Longman, "Catastrophic Follies," *The New Republic*, August 21, 1989, p. 17.

27 For a revealing discussion of the discrepancy between the interests of private medical practitioners and their Washington representatives, see Glenn C. Griffin M.D., "Our Own Organizations Are Campaigning for a Health Care Bureaucracy, and You and I are Paying For It!" *Postgraduate Medicine*, Vol. 95, No.2 (February 1994), pp. 9-16. "Some physicians wonder whether their specialty society's leadership have talked to any of the rank-and-file active practice members before announcing their unfortunate position on the Clintons' plan." Martin A. Murcek M.D., "Scattershot Approach Pleases Clintons," *Pennsylvania Medicine*, Vol. 97, No.6 (June 1994), p. 8.

28 This entire episode of congressional and federal worker coverage has its delicious ironies. For detailed discussion of the topic see, Robert E. Moffit, "Why Federal Unions Want to Escape the Clinton Health Plan," Heritage Foundation

LESSON #6: Beware of Administration officials who confidently insist they can administer complex health care programs.

Among its many new administrative duties in implementing the Medicare Catastrophic Act of 1988, HCFA had responsibility for working with state governments to make sure that a new "buy-in program" for low-income individuals would be established.

Under the new Medicare law, states were mandated to pay Medicare premiums, deductibles, and coinsurance for all elderly and disabled persons with incomes at or below 100 percent of the federal poverty level. With some special exceptions, this state "buy-in" requirement, a new state mandate, was to be phased in according to a fixed, statutory schedule between 1989 and 1992. By early November 1988, HHS officials saw that implementing the Medicaid buy-in provision was going to be administratively difficult for states, and expressed the view that some states were not likely to meet the January 1, 1989 deadline set by Congress.

There were two problems. The first was the notification of eligible beneficiaries. Even more problematic was actually determining who met the criteria for eligibility. State officials were urging the SSA to make the determinations of those eligible under the new buy-in requirement. But SSA wanted to avoid this complicated task and indicated that officials would provide the states with a computer tape identifying all possible Social Security beneficiaries (as many as 15 million persons) and let the states try to figure out who was eligible.

Likewise, HCFA officials were tasked with setting up a system for processing the new prescription drug claims. Specifically, HCFA was to make sure the prescription drug claims processing system would be a "point of sale" system with the technology for micro-electronic processing prescription drug claims. HHS was authorized to contract with "drug processors," a number of different firms that would provide the claims processing technology to the pharmacists in every state. The new claims processing system had to be able to establish the eligibility of the Medicare beneficiary as a claimant, the status of the prescription drug deductible, the availability of generic equivalents, and the amount of payment required. Pharmacists were to participate in the new system on the condition that they would meet two legal criteria. They were to be authorized by the state to dispense outpatient prescription drugs and they were to enter into a specific agreement with the Secretary of HHS.[29]

The conditions of the pharmacists' agreement with the federal government were specific. They would have to accept Medicare payment, bill electronically on the mandatory point of sale system, dispense drugs to all eligible persons covered by Medicare, charge no more for the Medicare-purchased drugs than the drugs charged the general public, keep patient records, offer counseling to Medicare beneficiaries, ad-

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Backgrounder No. 953, August 4, 1993; see also, Robert E. Moffit, "Why Members of Congress and Federal Workers Don't Want the Clinton Health Plan," Heritage Foundation *Backgrounder Update* No. 220, March 29, 1994.

29 For a discussion of the establishment of the new claims processing system, see Robert E. Moffit, "The Medicare Catastrophic Act: Developing a National Data Base," a paper delivered at the national conference on "Managed Health Care" sponsored by the College of Pharmacy at Ohio State University, April 14, 1989, pp. 5-6.

vise the Medicare beneficiaries of the availability of therapeutically equivalent substitutes, and give information to the HHS during the conduct of government studies and surveys. Congress stipulated that the apparatus for the prescription drugs program, including setting up the new claims processing system, had to be in place by January 1, 1991.[30] Superficially, these requirements did not appear to be administratively burdensome.

But HCFA officials soon found themselves confronted with a host of technical and political problems in administering the new drug benefit. A dispute arose over who should pay for the additional telecommunications costs that pharmacists incurred when transmitting the drug claims to the contracting drug processors. And then, there was the additional complication about whether or not Congress had given HCFA the authority to pay pharmacists any reimbursement for the cost of modifying their existing software, if they had any, in order to integrate approximately 150 different systems into the new national program.[31] Members of Congress apparently had overlooked this kind administrative difficulty in establishing the "point of sale" program.

In addition, HCFA staff originally projected a voluntary participation rate of 90 percent to 95 percent among pharmacists. But after a number of unforeseen problems became apparent, enthusiasm among pharmacists declined. HCFA officials started to worry about their 90 or 95 percent participation goal. Instead, if they reached a lower level of participation, between 65 and 75 percent of all pharmacists, the HCFA staff conceded that they would have to "rethink the claims processing system."[32]

In a related development, HCFA staff discovered technical and fiscal problems in sharing data with states, as well as incorporating the drug utilization review functions required by Congress in the new point of sale system. Indeed, HCFA representatives confessed doubt that the new system would be able to meet the statutory deadline of including such functions by January 1, 1991.[33]

Still, throughout the spring of 1989, HCFA officials continued to insist that they could establish the prescription drug benefit within the time frame given by Congress. But by the summer, an internal HHS evaluation concluded otherwise. In July, HHS Inspector General Richard Kusserow reported serious technical difficulties and managerial problems in HCFA's plans to implement the drug benefit. Instead, the HHS Inspector General's Report recommended a one-year delay and numerous changes.[34]

LESSON #7: Be prepared for angry letters from constituents about the government's standard benefits package.

The Medicare Catastrophic Coverage Act of 1988 gave Congress a taste of the dangerous politics of a comprehensive government standardized benefits package.

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30 "Prescription Drug Talking Points," Health Care Financing Administration, 1989.

31 *Medicare Update*, The Pharmaceutical Manufacturers Association, Issue 11: "Status of Point of Sale System and HCFA Medicare Policy Meeting on March 9, 1989," February 21, 1989.

32 *Ibid.*, p. 2.

33 *Ibid.*

34 *America's Health Care Crisis: A Congressional Update*, prepared by The Jefferson Group, Washington, D.C., August 28, 1989, p. 23.

Shortly after the Medicare Catastrophic Coverage Act was passed, millions of elderly citizens started to realize that they would be paying for benefits that they did not want or did not need. In drafting the bill, Congress overlooked the simple fact that millions of elderly Americans already had, through private insurance, the same benefits that they were now required to have in Medicare and for which they were being charged new surtaxes. Lawmakers soon heard from these senior citizens. As Representative John Rhodes (R-AZ) told the Senate Finance Committee:

> Senior citizens who are supposed to foot the bill for the 1988 Catastrophic Act are flooding congressional offices with angry letters and phone calls that relay an unmistakably clear message: They do not want and will not use the coverage provided under the Medicare Catastrophic Act of 1988. Many of the provisions of the Act duplicate coverage that many senior Americans have through less expensive private insurance. Furthermore, the mandatory surtax unfairly penalizes Americans who have been prudent in their savings.[35]

Under the Clinton plan, as well as the committee-passed measures and leadership bills, the government will establish, in statute, a comprehensive standardized government health benefits package. Americans will be required to purchase this "one-size-fits-all" package. That means that Americans will be required to buy certain benefits, treatments, and procedures (even abortion coverage) whether they want to buy them or not. The process for deciding which medical treatments, procedures, or health benefits should or should not be included in the government standardized benefits package inevitably will become a politicized process. The political pressure—especially from medical specialty societies and disease groups—to expand the package, and thus its cost, will be enormous. To escape this political pressure, some congressional proponents of a government-standardized benefits package want to avoid the tough decisions and turn over all of the reductions or additions in benefits, the serious decision-making, to a non-elected federal government board or commission. This will mean, of course, that ordinary Americans will have even less power to influence the crucial decisions that will affect their lives.[36] Like the elderly in 1989, they are not likely to be happy with that situation.

LESSON #8: Beware following the advice of senior Members of Congress and senior congressional staff.

Many of the current congressional champions of the Clinton plan, and versions of the Clinton plan reported out of the House and Senate Committees, are the very same lawmakers who were responsible for enacting the Medicare Catastrophic Coverage Act of 1988. The same is true of many of the senior congressional staff involved.

Liberal Members of Congress and staff rejected President Reagan's reasonable acute care catastrophic program and turned his modest initiative into a massive expan-

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35 Rep. John Rhodes (R-AZ), "Changing The Medicare Catastrophic Coverage Act," Statement before the Senate Finance Committee, July 11, 1989, pp. 1-2.

36 For a discussion of the role of such a commission or board, see Robert E. Moffit, "Beware the Senate Labor Committee's Supreme Court of Health," Heritage Foundation *Executive Memorandum* No. 382, May 26, 1994.

sion of the Medicare program. After 18 months of deliberation on the Medicare catastrophic issue, these Members of Congress insisted on enacting a massive new government program, replete with duplicative benefits, administratively unworkable provisions within unrealistic time limits, new federal spending, and gross miscalculations of cost. And, they appear prepared to do it again—only this time on a far larger scale.

Many of the technical details of health care reform will have a profound impact on the lives of ordinary Americans. With mind-boggling complexity of health care reform legislation, especially proposals that transfer even greater federal regulatory authority over the insurance market and the delivery system, Members of Congress will have to rely on senior congressional staff to write the crucial technical details. Observes *The Washington Post*'s Spencer Rich, "The bills that will contend for passage in the House are being written frantically in a matter of days—and they will be rewritten at each turning point of the legislative path. The players in this script writing are a few dozen little-known health committee staff members and members of the House Legislative Counsel's Office."[37] A veteran Washington columnist David Broder writes, "So, it is a case study in the power and influence of one of the most anonymous parts of Washington—the men and women on congressional staffs."[38] The senior congressional staff may make mistakes but, of course, they do not have to answer directly to constituents.

LESSON #9: If you make a big mistake, quickly admit it and fix it.

If Members of Congress sense they have made a mistake in supporting the creation of a huge, complex, new health care financing and delivery system, they should resist the inevitable argument that the political "investment" they have made is so high that keeping a bad system is somehow better than doing away with it.

After pressure started mounting for the repeal of the Medicare Catastrophic Act in the spring and summer of 1989, senior Members of Congress and officials in the Bush Administration started to argue that it would be a mistake to end the program. Among these was the plea that Congress and the Administration had expended an enormous amount of time, energy, and effort in setting up the Catastrophic program, including the Part B benefits and the prescription drug program. Some Members of Congress and Administration officials argued that since parts of the program had already gone into effect, it would be administratively burdensome and unfair to dismantle it.

LESSON #10: Better still, do not repeat the catastrophic mistake. Be more modest.

Many top officials in Washington, including senior Members of Congress, genuinely believe that the federal government can handle health care far more efficiently than a competitive private sector, and thus they stubbornly resist market-oriented reforms that would introduce real consumer choice and genuine competition into the system. For example, House Ways and Means Health Subcommittee Chairman "Pete" Stark (D-CA) criticizes market-based approaches as "some dream of people who say

37 Spencer Rich, " The House Health Plans' Ghostwriters," *The Washington Post*, August 2, 1994, p. A-13.
38 Broder, *op. cit.*

competition and free enterprise can do better than any government can do. That's not true. The government can run circles around an Aetna or Pru (Prudential insurance companies) and the rest of them."[39] And, during the development of the Clinton plan, Judith Feder, Deputy Assistant Secretary for Health Policy at HHS, explained its rationale: "What we are doing is replacing the inept wasteful, and ineffective bureaucracy, if you will, of the unfettered marketplace."[40]

Senior Members of Congress who insist that they can design an efficient and cost effective system of quality health care for every American, and thus manage one-seventh of the national economy, are making a breathtaking claim. It is particularly surprising in light of the simple fact that they have shown little ability to control costs effectively in Medicare and Medicaid. It is even more remarkable when one recalls the disastrous episode of the Medicare catastrophic legislation, where they attempted health care reform within an existing government program on a far more modest scale.

CONCLUSION

The debacle of Medicare Catastrophic Coverage Act of 1988 should be studied carefully by lawmakers now contemplating sweeping health care reform. If reform today is to be successful, Members of Congress must level with the taxpayers. Going beyond the rhetorical promises of entitlements, they must make clear to taxpayers exactly what any new program is going to cost them and precisely how it will affect their health care. Beyond that, Members of Congress must recognize how hard it is to get the legislative details right. Federal agencies and the departments they task with carrying out such programs will be hard pressed to do the job effectively and efficiently. Any sensible lawmaker should be very concerned about the ability of HHS to implement a program of the scale being considered. The administrative complexities associated with the Medicare prescription drug benefit in 1988 overwhelmed HHS, yet they pale into insignificance in comparison with the requirements of the bills now in Congress.

A sweeping reform of the U.S. health care system means Congress must restructure one-seventh of the nation's economy, the equivalent of rewriting the rules for the entire economy of an average European country. The congressional leadership has set itself the task of pushing through such a measure within the next eight weeks, based on measures cobbled together during hurried committee markups and back-room deals. Lawmakers will be asked to vote on this radical overhaul of the health care system without the chance to study the measure carefully, without any opportunity to discuss the specific elements in detail with their constituents, on the basis of cost projections prepared by overworked CBO analysts who have not had the opportunity to think through all the ramifications of the bill, and on the assumption that HHS and other agencies can implement the final legislation reasonably smoothly.

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39 Dana Priest, "Key House Democrat Attacks 'Managed Competition' Health Plan," *The Washington Post*, May 14, 1993, p. A18.

40 *The New York Times*, December 5, 1992.

In 1988, Congress enacted a health care plan which was a model of simplicity compared with the huge and complex reform bills today. The 1988 Medicare Catastrophic bill had wide public and interest group support. It was the product of months of careful, bipartisan deliberation. HHS officials were confident about their ability to establish and administer the new programs. And it was a disaster.

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