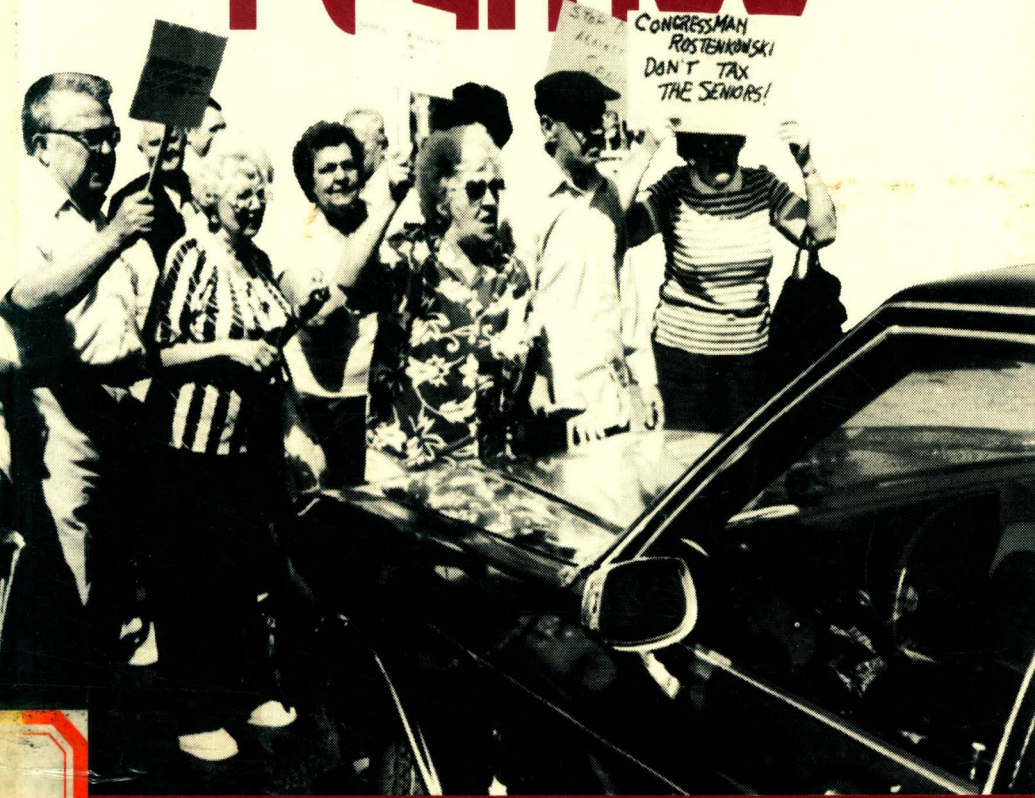
# CATASTROPHIC POLITICS




## The Rise and Fall of the Medicare Catastrophic Coverage Act of 1988

Richard Himelfarb

RICHARD HIMELFARB

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# CATASTROPHIC POLITICS

# Preface

In July 1988, congressmen and advocates for senior citizens heralded the enactment of the Medicare Catastrophic Coverage Act (MCCA) as the first major expansion of government health care for the nation's elderly since the creation of Medicare in 1965. The legislation effectively plugged many of the holes in the existing Medicare system by providing protection against a number of catastrophic health-care expenses, including those associated with acute hospital care, physician services, and prescription drugs. Support for the MCCA was virtually universal. The measure passed the House by a margin of more than 2 to 1 and the Senate passed it by almost 8 to 1; it was endorsed by President Ronald Reagan, by leading members of Congress, and by the 28-million-member American Association of Retired Persons (AARP); and public-opinion surveys indicated widespread and growing support for the MCCA among the nation's elderly. Backed by this apparent consensus, passage appeared to establish a precedent for expanding social-insurance programs in an era of high federal deficits. Indeed, some of the program's strongest advocates viewed the event as a precursor to the enactment of long-term care legislation in the near future.

Less than eighteen months later, the House and the Senate, responding to a torrent of criticism from the elderly, were voting by similar margins to repeal virtually all the legislation. At the same time, support within Congress for expanding Medicare to cover long-term care quickly evaporated. At least in the short run, the repeal had foreclosed the prospects for such a program.

How did such a remarkable turnabout occur, and why were MCCA supporters unable to foresee it? This study attempts both to answer these questions and to examine the larger implications of the episode. It argues that the key to understanding the passage and eventual repeal lies in the decision of Congress to depart from previous practice in the area of social-insurance policy-making. Specifically, in an attempt to expand Medicare in a deficit-neutral manner without imposing costs on younger generations,

the new program imposed all costs on elderly beneficiaries themselves. In addition, costs were distributed in a progressive manner, in order to avoid burdening low-income senior citizens and to establish a precedent for future policy-making in social-insurance programs. With more than 60 percent of the elderly due to receive benefits from the program well in excess of its personal costs to them, MCCA architects envisioned widespread support for the program from most senior citizens.

Explaining the ensuing public outcry and the failure of MCCA architects to counter such criticism effectively is the central aim of this case study. More general issues, concerning the federal government's ability to expand programs for the elderly in an era of high deficits, and the nature of public opinion and its relationships to public policy, are addressed as well.

I have relied on a number of sources, primary among which are the interviews I conducted with principals and close observers of the MCCA representing both congressmen and interest groups. The interviews took place in Washington, D.C., between March 1990 and January 1992. Because none of the discussions was tape-recorded, the material mentioned here consists of reconstructed written notes taken during and immediately following the sessions. Because all subjects spoke on condition of anonymity, none has been quoted directly. Another source was survey microdata obtained from the American Association of Retired Persons (AARP), which provide the basis for the chapter discussing the dissatisfaction expressed by the elderly after passage. These data detail the trend of increasing senior-citizen opposition to the program and provide insights regarding its underlying causes. To examine how the legislation and subsequent repeal were portrayed to the public, I also reviewed videotape of approximately thirty-five stories appearing on the nightly network news between December 1986 and December 1989. The tapes were obtained from the Vanderbilt Television News Archives. I also rely on a considerable number of primary and secondary written resources. These include the significant public record of the MCCA contained in congressional hearings, government reports, and the *Congressional Record* as well as a number of unpublished documents obtained from congressional staff. In addition, journalistic accounts of the episode were studied extensively. Particularly useful was the reporting of the *New York Times,* the *Washington Post,* the *Wall Street Journal,* and the *Congressional Quarterly.* Invaluable as well was the AARP's monthly newsletter, the *AARP Bulletin.*

Chapter 1 outlines the public-policy context in which the MCCA was formulated. In Chapter 2 the evolution of the legislation is traced from the

initial efforts of Otis Bowen to place the issue on the political agenda, through the "Christmas tree" expansion of the Bowen plan by Congress.

The political constraints and considerations that led the congressional architects of the MCCA to finance the legislation by imposing all costs on the elderly and by structuring premiums according to ability-to-pay principles are the topic of Chapter 3, which emphasizes the degree to which financing represented a departure from previous social-insurance policy-making. This chapter also explains the decision of the influential AARP to support (at least tacitly) the legislation's financing mechanism.

Chapter 4 focuses on the decisions of rank-and-file members of Congress to support MCCA. It begins with an analysis of the congressional debates over the legislation, paying particular attention to the degree of controversy surrounding financing. This is followed by a discussion of the influence of Claude Pepper, other political leaders, the AARP, and early public-opinion surveys (conducted by this organization) on rank-and-file congressional support for the legislation. Early media coverage of the program's development and passage is analyzed to explain the high degree of early public support for the program.

The rise of opposition to the MCCA on the part of the elderly in the months after passage is the topic of Chapter 5. The phenomenon of increasing opposition even among low-income elderly, virtually all of whom stood to receive significant benefits at little personal cost, is emphasized, and the degree to which this opposition resulted from misperceptions of the impact the legislation would have on them personally, particularly with respect to costs stemming from its supplemental premium, is examined.

Chapter 6 discusses the causes of increasing senior-citizen opposition to the MCCA, and the continuing confusion concerning its financing, which ultimately led to the repeal. Explanations emphasized include the program's failure to provide a comprehensive long-term-care benefit, in spite of being labeled "catastrophic coverage"; the role of the National Committee to Preserve Social Security and Medicare in misleading many of the elderly about the program's costs and encouraging grass-roots opposition; and, perhaps most important, the inability and failure of MCCA architects to explain clearly and frankly the redistributive implications of the program's financing. Also addressed is the failure of legislators to agree on an alternative that preserved more than a small fraction of the program's benefits.

Finally, Chapter 7 discusses the implications of the MCCA episode for future policy-making affecting the elderly.

*To my parents*

# Acknowledgments

While writing a book is a distinctly solitary experience, completing a project of such magnitude is impossible without the assistance of many people. My first set of debts lie with the numerous Washington professionals, congressional staffers, and interest group representatives alike, who through personal interviews (and in some cases written documents) provided me with significant insight into the episode under study. Only their desire for anonymity prevents me from naming them.

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At the University of Rochester, where this work originated, my thanks begin with some of the numerous graduate students I have been privileged to study with and know as friends. In particular, Melinda Cuddy, Rich Forgette, Roger James, Bill Kubik, Carol Silva, and especially Carolyn Whitfield deserve my gratitude for providing encouragement and support during this project. Wendy Schiller deserves special thanks for getting me a foot in the door with a number of influential staffers who may have been less open to speaking with me otherwise.

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out my effort. He deserves profuse thanks both for his eagerness to help and for his abundant patience with the author.

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# 1

# SETTING THE STAGE FOR THE MEDICARE CATASTROPHIC COVERAGE ACT OF 1988

Among Western democracies, the United States is unique in its tendency to make the elderly the focus of public social-welfare programs. In the words of Theodore Marmor (1988, 178), "No other industrial democracy has compulsory health insurance for its elderly citizens alone, and none started its program with such a beneficiary group. Almost all other nations started with coverage of their work force, or, as in the case of Canada, went from special programs for the poor to universal programs for one service (hospitals) and then to another (physicians)." In contrast to other demographic groups in the population (for example, single mothers), Americans have historically viewed the elderly as a population deserving of public support. According to Marmor (1973, 16), Americans have subscribed to the belief that the elderly comprise "one of the few population groupings about whom one could not say the members should take care of their financial-medical programs by earning and saving more money."

This consensus has been further reinforced by the distinct design of the nation's Social Security system and the popular beliefs surrounding it. The fact that participation is virtually universal and that all participants are required to contribute something toward their retirement through payroll taxes[1] has conferred a degree of legitimacy and public acceptance on the system, absent in other social-welfare programs. Despite the significant redistribution occurring both between and within cohorts of participants,

1. According to Bernstein and Bernstein (1989, 14), Social Security in 1986 "covered 95 percent of the working population." The only significant groups remaining outside the system are "some public employees: the minority of employees of state and local governments that have not chosen such coverage and those employed by the federal government prior to 1984."

the public perceives all Social Security recipients as having "earned" their benefits through contributions to the system. This remains the case even though recipients have historically received benefits well in excess of the economic value of their contributions to the program (U.S. House, Committee on Ways and Means 1993, 1301–6).

Historically, advocates for the elderly and their political supporters have maintained a significant interest in perpetuating these beliefs by downplaying the degree of redistribution occurring within the system. To the extent that system participants are able to calculate exactly who gains more or less financially, Social Security could degenerate into a zero-sum game in which financial losers demand political redress or the opportunity to opt out of the system. Program advocates understand that voluntary participation would undermine one of Social Security's key goals, that of providing an adequate income to relatively poor elderly citizens through redistribution. If only low-income citizens were left to rely on Social Security, general revenues would probably be increasingly necessary to fund the program. Social Security advocates believe that such a program would pay smaller benefits to needy elderly as funding became dependent on the vicissitudes of federal budget-making. As Marmor, Mashaw, and Harvey (1990, 160) note, "No targeted welfare program, including those for the aged, provides anything approaching Social Security's benefit levels."

At the same time, because under a voluntary system participation would acquire a stigma similar to that occurring in federal public assistance programs (Bernstein and Bernstein 1989, 210–11), efforts to blur or hide the degree of redistribution in Social Security have preserved the program's antipoverty purpose.[2]

From the creation of Social Security through the mid-1970s, a number of factors combined to defuse potential conflicts concerning program goals. Part of the explanation has to do with the decision-making process surrounding the program itself. During most of Social Security's early history, "policy-making was undertaken by a relatively constricted and autonomous set of actors" within the Social Security Administration whose choices regarding the program "were generally made in isolation from decisions about other government activities" (Derthick 1979a, 7).

Other significant factors included (1) the decision to change Social

2. This impact is substantial. According to a calculation by the Congressional Budget Office, in 1991, social-insurance programs—the largest of which is Social Security—removed from poverty 72.9 percent of elderly Americans with pre-transfer incomes below the poverty line. See U.S. House, Committee on Ways and Means 1993, 1350.

Security from a fully funded system (where money held in trust funds is sufficient to pay all current and future benefit claims) to one utilizing the principle of pay-as-you-go; (2) periodic expansion of benefits and coverage to previously uncovered groups; and (3) economic growth. Together, these factors permitted the system to pay benefits to early cohorts of retirees well in excess of their contributions to the system without unduly burdening younger workers. Indeed, the "good deal" that older generations received throughout this period has probably increased support for the program among younger generations, even though most are not likely to receive similar returns when they retire.

As a result, the Social Security system has always been extremely popular among Americans of all ages. "In fact," report Page and Shapiro (1992, 119), "according to responses to some four dozen surveys by various organizations between 1961 and 1989, many more people always wanted to *increase* than wanted to decrease Social Security spending." At the same time, "very large majorities, on the order of 80–90 percent, have opposed cuts" in the program.[3] It is important to note that levels of support for Social Security among younger Americans have generally varied little from the support senior citizens have expressed. Indeed, one recent study of 1982 survey data reveals that the elderly were *less* likely than younger citizens to favor increases in program spending (Day 1990, 47).

Given the widespread public support for Social Security, it is not surprising that those seeking to design a health-care program for the elderly sought to do so within a social-insurance framework. However, because the structure of the Medicare program adopted in 1965 had "a political explanation, not a philosophical rationale" (Marmor 1988, 182), their efforts were only partially successful. On the one hand, Part A of the Medicare program, which covers hospital insurance, was structured similarly to Social Security, with universal participation and financing by younger cohorts through a payroll tax. Just as in Social Security, pay-as-you-go financing allowed early and, indeed, current beneficiaries to reap a considerable windfall from the program (in terms of the ratio of benefits to taxes paid [U.S. House, Committee on Ways and Means

3. Most such data probably represent "poor quality public opinion," because the survey questions on which they are based "fail to confront respondents with difficult trade-offs that directly challenge wishful thinking" (Yankelovich 1991, 42–43). For example, such items fail to ask how Social Security benefits are to be maintained or increased—through payroll-tax increases, benefit reductions, or some other method. Nevertheless, the consistency of such responses over time appears to demonstrate broad-based if somewhat vague public support for the program.

1993, 1301–4; Congressional Budget Office 1989; Vogel 1988]) while at the same time believing that they "earned" their benefits through payroll tax contributions. On the other hand, Part B (covering physician services) represented a departure from the intergenerational financing of Social Security and Medicare A. Under Part B, the elderly themselves paid a flat premium equivalent to 50 percent of physician costs (lowered to 25 percent in 1981), and general revenues from the federal government subsidized the remainder of the expenses.[4] Like these other programs, however, participation was a good deal for all beneficiaries because it provided coverage costing well in excess of recipients' actual contributions to the program. In addition, while the existence of subsidies in Medicare B was more apparent than in Social Security and Medicare A, most participants likely were unaware of their presence.

Two additional aspects of the early Medicare program also made it similar to Social Security at its beginning. First, there was the limited scope of Medicare benefits. While Medicare covered a portion of hospital and physician fees, significant deductibles and co-payments were included, in an effort to control program costs. Equally as important is that Medicare failed to provide any coverage in a number of areas, the most noteworthy being nursing-home stays and prescription-drug costs. Despite such limitations, a number of lawmakers predicted that the new program would expand incrementally to fill such gaps (Derthick 1979a, 334–35). Second, as with Social Security, Medicare's proponents "assumed that eligibility would be gradually expanded to take in most if not all of the population" (Marmor 1988, 179). In the case of Medicare, coverage would be extended "first, perhaps, to children and pregnant women."

By the late 1970s, however, a failing American economy and increasing inflation precipitated a significant retrenchment in federal programs affecting the elderly. In Social Security, inflation caused benefit payments to rise faster than expected, while unemployment caused revenues to decline relative to expectations. Observers predicted that, in the absence of reform, the Social Security retirement trust fund would be bankrupt by the mid-1980s. At the same time, the Medicare system, while not in immediate

4. The decision to finance Medicare B in this manner, instead of through payroll taxes, represented an intentional departure from a system relying solely on intergenerational financing. This change can be attributed to the desire of House Ways and Means Committee Chairman Wilbur Mills "to build a fence around the program" and "insure against later expansion of the social security program to include physician coverage" (Marmor 1973, 80). However, because 75 percent of Medicare B's cost is paid from general Treasury revenues, tax and fee payments from all age-groups (only a small percentage of which come from taxpayers age 65 and over) provide the bulk of funding for this program too.

danger, was faring even worse than Social Security as soaring health-care costs threatened to undermine the long-run integrity of the program.

The economic troubles of this period transformed the politics of federal programs serving the elderly. Whereas the 1960s and early 1970s had been marked by significant expansion of federal aid to the aged, the late 1970s and 1980s constituted an era of scarcity in which public officials struggled to maintain the gains of an earlier era. In short, from the Carter years onward, legislators would face no more "easy votes" on programs affecting the elderly (Derthick 1979b).

The Social Security Amendments of 1977 marked the first instance of policy-making in this new era. Intended to shore up the long-term solvency of the program through the year 2030, the legislation precipitously raised payroll taxes paid by workers in what at the time constituted the biggest peacetime tax increase in American history. Unfortunately, it became apparent almost immediately that the legislation would fall well short of expectations. By the early 1980s, increasing inflation and a stagnant economy were causing Social Security benefit payments to exceed contributions by $10 billion to $15 billion yearly. In the absence of further reforms, experts predicted the system would be bankrupt by as early as 1982.

President Ronald Reagan assumed office in 1981 with a mandate to reduce the size of government and cut taxes. In an attempt to confront Social Security's fiscal problems, as well as a growing deficit in the overall federal budget, Reagan set forth proposals to reduce benefits for early retirees and eliminate the program's minimum benefit. Both were quickly rejected and denounced, particularly by Democrats in Congress who accused Reagan of attempting to destroy Social Security and break the federal government's contract with the elderly. Indeed, the issue became a centerpiece in Democratic attacks on Reagan and the Republicans in the 1982 mid-term elections (Light 1985, 152–62).

Stung by public criticism of its proposals, the Reagan administration sought to distance itself from the Social Security issue, refusing to propose further reforms in the absence of Democratic cooperation. At the same time, however, the program's declining fiscal status required action. By late 1981, experts believed that the government had only months to avert bankruptcy in Social Security's retirement trust fund. These circumstances led Reagan to cede Social Security's problems to a bipartisan commission led by Alan Greenspan that would issue recommendations following the 1982 election.

A crisis atmosphere drove the deliberations of the Greenspan Commis-