

THE MEDICARE CATASTROPHIC COVERAGE ACT: A CASE FOR REPEAL (Part II)

The catastrophic Medicare Catastrophic Coverage Act (MCCA) should be repealed and replaced by legislation that is needed to deal with the problem of financing health care for the relatively small number of persons who are not poor enough to qualify for Medicaid but not well enough situated financially to purchase their own health insurance.

MCCA's Sins of Omission and Commission

Recent developments in the Congress have heightened the awareness of many Americans about questions of ethics in government. I certainly don't want to extenuate for the misdeeds of anyone in government, but I believe we must not focus only on personal misbehavior and overlook unethical legislation. Legislation that promises what it can't and won't deliver, that misrepresents its benefits and beneficiaries, and that disguises its costs is the ultimate in political immorality in a democratic republic. I respectfully submit that few if any pieces of legislation in the modern era can top MCCA as legislative fraud.

MCCA is represented by its defenders as a good deal for those eligible for its coverage. In fact, it is a bad deal, costing the average older citizen substantially more than the actuarially determined average value of the benefits he or she can expect to claim.

Widely presented as low-cost insurance, MCCA in fact has no attributes of a true insurance system. It is, instead, a tax-transfer scheme, requiring virtually all not-poor persons who are 65 or older to pay for the covered medical expenses of a small group of older persons who are not quite poor enough to qualify for Medicaid. Receipts under MCCA are expected to exceed its outlays in the first few years, with the excess revenues contributed by taxpayers who are 65 or older going to defray general expenses of the federal government.

Much of the MCCA revenues are obtained from an income tax surcharge payable only by persons who are 65 or older and solely by reason of their age and the fact that they have enough income to have to pay ordinary income tax. This highly

discriminatory income tax surcharge is called an "income-related premium." Try to think of any private, true insurance system in which the premiums are functions of the insured person's income rather than the probability of the insured event's occurrence and its cost. Truth in advertising obviously carries no weight in government.

The MCCA was promoted as essential to help large numbers of elderly Americans and some disabled persons to meet the extraordinary costs of catastrophic illnesses. In fact, only a very small percentage of this population will receive benefits under MCCA.

- o The Health Care Finance Administration estimates that only 7.2 percent of Medicare enrollees will incur hospital or nursing home costs high enough to receive Part A-related benefits under MCCA.
- o MCCA provides for annual increases in the copayment cap under Medicare Part B such that only 7 percent of enrollees will receive the benefit of the copayment cap.
- o MCCA's coverage of drug costs doesn't begin until next year; its deductible is high enough to leave uncovered a large fraction of drug expense for the average person 65 or older. Moreover, the deductible will be increased each year after 1993 to keep the number of persons claiming drug benefits from exceeding 16.8 percent of enrollees.

All but a small number of the allegedly large number of persons for whom MCCA is supposed to provide benefits were protected under other health insurance arrangements.

- o MCCA displaces about two thirds of the benefits formerly mandated for coverage by private medigap policies. The Act requires that medigap policies be cut back to avoid duplicating coverage provided by MCCA and that their premiums be reduced accordingly. MCCA goes a long way toward socializing health insurance for older citizens.
- o Ironically, privately issued medigap policies will still be needed by Medicare enrollees to pay for the significant deductibles and copayments not covered by Medicare, for most prescription drug costs, and for doctors' fees in excess of Medicare limits.

Is There a Case for Any MCCA?

Even this cursory examination of MCCA makes one wonder why it was proposed by President Reagan and why it was enacted by Congress. More basically, one must ask, "Why is the federal government in the health insurance business?"

A case might be made for government participation in the health insurance market if it could be shown that the health insurance market had failed and cannot be repaired without the government's intervention. Federal participation in the health insurance field, however, was not initiated on the basis of any such demonstration, nor does the growth of the federal role in this field appear to have been impelled by accumulating market failure. On the contrary, a strong case can be made that the federal government's participation is itself the primary source of some of the major problems now besetting health care and its financing.

I do not recall any claims made by the Administration or by members of Congress during the legislative development of MCCA that the private health insurance market was a failed market requiring government intervention if it were to operate efficiently. Market failure can occur for a number of reasons, but in general terms it results from distortion of the conditions of supply or demand of the product or service.

Such distortions may arise from limitations--imposed either by private entities or by government--on entry by new firms into the production and distribution of the product or service or on the availability of one or more inputs used in producing the product or service. They may arise because of nonmarket constraints or subsidies on individuals' or companies' purchases of the product or service. They may arise because of external economies or diseconomies which are not internalized by market operations into supply or demand conditions. I recall no effort during the legislation's progress toward enactment to demonstrate that any such sources of market failure prevailed and required the MCCA to overcome it and to allow the market to work more efficiently.

Any such effort, I am convinced, would have failed. The private markets for health care and its financing may not be perfect, but any imperfections they may have are not significant enough to warrant the federal government's intrusion. Moreover, the form of that intrusion--Medicare, now with the MCCA's addition--doesn't repair any of the private market's imperfections. These federal programs, on the contrary, impair the private markets.

The only case for the federal government's participation in the health insurance market, it seems to me, is that there are some people who can't afford adequate health care or the insurance to finance it--any more than they can afford adequate diets, shelter, clothing, education for themselves or their children, etc. Whether the health care they can't afford is to deal with commonplace ailments, critical medical episodes, or extended illnesses, whether they are young or old, or whether they are otherwise disabled should not determine their eligibility for this government financial assistance. The only relevant consideration should be whether their economic status is deemed to be so poor as to warrant support by the nation as a whole.

MCCA doesn't address this consideration at all. Instead, its focus is on types of medical episodes deemed to be catastrophic that should, for that reason, presumably, be covered under an expanded Medicare system.

What constitutes a catastrophic episode wasn't defined in the initial development of the plan. One possible interpretation is that the term was meant to refer to cases in which the appropriate care--at prevailing prices--would exceed the patient's financial resources. Clearly, any such concept would not apply generally throughout the aged 65 or over or disabled population. Defining catastrophic illness in terms of specific ailments makes little sense; the term is meaningful primarily as it applies to the economic status of the individual experiencing the ailment.

In this sense, by the way, prolonged illness requiring medical care is much likelier for many older or disabled persons to be catastrophic than any specifically designated ailment. There is substantial reason to believe that many older Americans who supported the MCCA did so in the mistaken belief that it was aimed at long-term health-care finance problems, not so-called catastrophic episodes.

If "catastrophic" is defined in terms of the financial capacity of the individual to obtain health care, the application of MCCA to the entire population of older and disabled Americans is without justification. At the time the MCCA was being developed, most older Americans were quite well protected against the financial strains of so-called catastrophic medical care. For instance:

- o About 70 percent of Medicare enrollees had purchased private insurance that covered most of the acute care costs that were not covered by Medicare.
- o A significant number of persons aged 65 or over were still employed and had employer-sponsored health insurance.
- o A substantial number of retired persons were covered by post-retirement, employer-sponsored health insurance plans and had not chosen to enroll in Medicare even though they were eligible to do so.
- o About 10 to 15 percent of Medicare enrollees without Medigap coverage were eligible for Medicaid under which states paid for the medical care not covered by Medicare.

In short, between 15 and 20 percent, at most, of older Americans were not covered by Medicaid and did not have medigap policies for protection against acute illness not covered by Medicare. Some of these persons believed themselves to be financially able to cover any medical costs out of their own resources. Only a small proportion of the population targeted by MCCA--those too poor to buy medigap policies but not poor enough to be covered by Medicaid--actually needed government-provided assistance.

The Real Reason for MCCA

It's hard to believe that the data concerning health insurance coverage of older Americans were unavailable to the technical experts in HHS or that they could not communicate these data to the Secretary. It's just as difficult to believe that Congressional sponsors of the legislation couldn't determine the scope of the problem the legislation might appropriately address.

I suspect that an important determinant of the shape of MCCA was the realization that if its benefits were to be explicitly confined to the indigent elderly and disabled, it would be difficult--if not impossible--to justify financing these benefits by imposing a discriminatory income tax surcharge on all taxpayers 65 or over or by increasing the Medicare Part B premium. A properly focused and designed catastrophic health-care provision would have called for financing out of the federal government's general revenues. This, in turn, would have required either a tax increase or cuts in other spending if an increase in the deficit were to be avoided. By distorting its focus, Congressional sponsors of MCCA were able to avoid these embarrassing fiscal requirements. By claiming that all older Americans were potential beneficiaries and would be better served than by private health insurance, moreover, these sponsors could justify the imposition of one of the most flagrantly discriminatory taxes dreamed up in modern times.

It took wholesale misrepresentation, deliberate or not, to get away with levying a special excise tax on persons 65 or older.

What Should Be Done?

MCCA has provoked a storm of outrage by older Americans who have found that the Act doesn't provide the long-term health care coverage they thought they would get and that close to half of them will be paying an income tax surcharge that can raise the top marginal rate to almost 54 percent. Most, if not all, members of the Congress have been alerted to the displeasure of a significant voting block; many of them have been searching for remedies. Unhappily, some of these remedies would create new problems, while few--if any--would address the real problem of inadequate health insurance.

The chairman of the Senate Finance Committee has announced that he'll ask the Committee to decide next month whether to cut the MCCA "premiums" or to make MCCA coverage optional. According to newspaper reports, Senator Bentsen is considering "premium" cuts by lowering the income tax surcharge rate, by applying it to income taxes in excess of some specified amount or by reducing the maximum amount of surcharge from the present \$800 in 1989. None of these options is relevant to the abundant difficulties in MCCA.

The alternative that Bentsen wants the Committee to consider--optional participation--carries the price tag that if one opts out of MCCA, one also loses Medicare Part B benefits. I find this Catch 22 option perfectly in keeping with the basically fraudulent character of MCCA, although I am confident that the Finance Committee chairman does not intend to take older Americans down a primrose path.

The appropriate concern to which any MCCA should be addressed is how to alleviate the financial distress of older or disabled persons who can't afford private insurance but are not poor enough to qualify for Medicaid. Appropriately addressing this concern requires outright repeal of MCCA. For the correctly identified group of persons, the sensible, economical approach is to provide them with vouchers to purchase medigap policies from private health insurance carriers.

If the majority of the Congress were to find this reprivatization of health insurance too bitter a pill to swallow, a less economical alternative would be to expand Medicaid eligibility to provide coverage for this target group. And while the Task Force is considering the problem of health insurance adequacy, it should take up the possibilities of providing tax incentives for employers to provide post-retirement health insurance, including long-term health care, for their employees. There are abundant opportunities for constructive, pro-market solutions to correctly identified health insurance problems. These problems can't be solved with snake oil.

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President

This bulletin was adopted from testimony that Dr. Norman B. Ture presented to the Republican Research Committee Task Force on Medicare Catastrophic Law on June 26, 1989.

Note: Nothing written here is to be construed as necessarily reflecting the views of IRET or as an attempt to aid or hinder the passage of any bill before Congress.