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CONTROLLING CATASTROPHIC HEALTH COSTS: OTIS BOWEN'S GRAND OPPORTUNITY

INTRODUCTION

Health and Human Services (HHS) Secretary Otis Bowen has been instructed by Ronald Reagan to report by year's end "on how the private sector and government can work together" to address the problem of affordable insurance coverage for those whose families are financially ruined by illness--so-called catastrophic health costs. As Bowen begins preparing this report, he seems to be headed on a course contradicting some of the most important Reagan principles. Instead of seeking a mainly private sector solution to catastrophic health costs, Bowen appears to be bending to intense pressure from members of his staff as well as congressional liberals to expand federal programs such as Medicare and to preempt the private insurance policies that currently provide catastrophic coverage. He is doing so at the very moment when the official Reagan Administration policy is to privatize--not increase--federal activities.

While action is indeed necessary to reform the health care system for the elderly, the mooted HHS initiative would be a major mistake. The traditional political dynamics would soon lead such an initiative to burgeon into a new entitlement program, ultimately imposing a heavy and uncontrollable drain on the taxpayer. Moreover, the proposal is based on an entirely fallacious rationale, reflecting faulty analysis.

Fortunately, Bowen may not yet be committed to an expanded federal program. He thus has a grand opportunity to try other options, based on market-oriented approaches. One is the concept of Health Individual Retirement Accounts (IRAs), now embodied in bipartisan legislation introduced in the House. This legislation would

provide for catastrophic coverage for the elderly in the context of allowing the private sector a far greater role in performing the whole range of services now provided by Medicare. Another option would be health care vouchers. Bowen should examine these ideas carefully and explore still other possible options in consultation with the private sector.

The catastrophic insurance study assignment is a key test for Bowen. He should reject another expansion of the welfare state based on an outdated 1960s policy mindset. In so doing, he would provide imaginative, innovative leadership to strengthen the role of the private sector, consistent with the overall philosophy of the President.

THE MEDICARE GAP

The issue of catastrophic insurance issue for the elderly arises because of the design of the Medicare benefit structure. Medicare consists of two components, Part A and Part B. Medicare Part A is the Health Insurance program (HI), which pays for up to 90 days of inpatient hospital care for each illness. Part A also will pay for an additional 60 days of hospital care, which the patient can use at any time. This coverage is currently subject to a deductible of $492 per hospital stay. In addition, the patient must pay co-insurance fees of $123 a day for the 61st to 90th days of hospital stay and $246 each day toward the cost of the lifetime reserve of days. HI also pays some costs for home health care, nursing facilities, and hospice care. HI is financed through part of the Social Security payroll tax, which includes an earmarked HI payroll tax rate of 1.45 percent each on the employer and employee.

Medicare Part B is the Supplementary Medical Insurance program (SMI), which pays for physician services, outpatient hospital services, home health care services, and other nonhospital services. This coverage is optional and subject to a statutorily fixed annual deductible of $75 and co-insurance fees equal to 20 percent of claims. Those who choose to accept coverage must pay a monthly premium of $15.50. These premiums now cover about one-fourth of SMI expenses, with general revenues financing the rest. Over 90 percent of the U.S. elderly population has opted for SMI coverage.

Neither HI nor SMI, however, covers long-term care in nursing homes or other institutions. After Medicare coverage is exhausted, the patient is on his or her own. Private health insurance is available to supplement Medicare coverage. The private insurance generally covers medical expenses when Medicare coverage runs out, as well as the Medicare deductible and co-insurance fees. This insurance business is highly competitive, with numerous firms offering such coverage, and is subject to state and federal regulation. In most

states, catastrophic health insurance policies are required to provide a minimum of 365 days of hospital care beyond the Medicare limits.

About 70 percent of the elderly are covered by private supplemental health insurance policies. Insurance coverage is also available to the elderly through subscriptions to Health Maintenance Organizations (HMOs), which provide medical services in return for a fixed monthly fee. Private insurers also are beginning to experiment with long-term nursing home care policies.

THE PROBLEM WITH A FEDERAL PROGRAM

Under a proposal now being pushed by some HHS staffers, federal catastrophic coverage would be offered under Medicare to those elderly who agree to pay an additional premium. This would include coverage for unlimited hospital days under Medicare, elimination of co-insurance fees for such hospitalization, and a cap on total SMI co-insurance fees. The premiums are intended to finance 100 percent of the costs of such extended coverage. The intention is to set the premiums well below private premiums and to drive the private insurers out of the business, replacing them with the public program.

While a low-cost federal program to replace more expensive private plans may seem like a bargain, there are fundamental flaws in the proposal being considered by Bowen. There can be little doubt that, if such a program is adopted, its outlays would soon race beyond current estimates. The costs of new programs are routinely underestimated. The Medicare program itself, for instance, was originally estimated to cost $4 billion by 1980; it actually cost about eight times as much in that year. Another example is the kidney dialysis treatment program, where costs have soared well past original estimates. There are several good reasons to assume that an extension of Medicare would follow the same pattern.

Faulty Behavior Assumption

One of the key errors is that HHS estimators assume a static world--that doctors and patients will not change their behavior in response to the expanded Medicare coverage. Thus the cost estimates for the new coverage are based on the small number of elderly beneficiaries who currently exceed Medicare coverage limits. But if elderly Americans are guaranteed coverage beyond these limits, physicians, hospitals, and patients would be far more inclined to opt for more prolonged care in many instances where it is not strictly necessary. And because current estimates of the cost of the expanded program are based on a low number of expected beneficiaries, a small number of additional, unexpected beneficiaries would result in a large percentage increase in costs.

Costly Innovation

Guaranteed unlimited coverage would also induce the development of new and highly expensive medical technologies and techniques. In an age of artificial organs, genetic transplants, and other medical esoterica, extended hospitalization and medical care could become rapidly more costly.

Marketing Costs

The bureaucratic estimators also have failed to account for any sales costs in the proposed new program. They are counting on the experience of Medicare Part A and Part B, where there are little or no such costs. But these programs are quite different from the proposed Medicare expansion for catastrophic insurance. Participation in Part A is mandatory, so naturally there are no selling costs. The premium for Part B covers only 25 percent of the costs, with the rest financed by the federal government--so it hardly requires hard selling. But if the premiums for the proposed Medicare expansion are to finance 100 percent of costs, HHS will have to persuade the elderly that its plan is superior to well-advertised plans that purport to offer the same deal. This means that the government will need sales agents and a promotional campaign. The officials pushing the proposed Medicare expansion have had no experience in marketing an insurance product and cannot offer a realistic appraisal of the costs.

THE POLITICAL DYNAMICS OF MEDICARE

Once the new coverage is formally proposed, there will be tremendous political pressures to expand it. Congressional liberals and elderly groups already are calling for additional and heavily subsidized coverage for expensive long-term nursing home care. Some Administration officials, meanwhile, already have agreed that it will be necessary to address this issue in any formal proposal for catastrophic care. House Aging Committee Chairman Edward Roybal (D-CA), moreover, is using the HHS study to raise the issue of national health insurance once again. He is introducing a bill to replace all private medical insurance with a single federal government insurance program for all. Any Medicare expansion initiative could quite easily turn into a fiasco for the Administration.

The proposed expansion also will raise issues concerning additional Medicare coverage for extremely expensive, high technology medical operations and treatments not now covered. A recent report by a Harvard Task Force on Medicare has added to the political pressure by calling for a massive increase in Medicare to provide for

catastrophic coverage, long-term care, and other items--ultimately costing an additional $50 billion per year.[1]

These problems and pitfalls of the proposed Medicare expansion plan should not be surprising. They reflect fundamental aspects of the process by which government programs are adopted and then expand. Typically a small new effort is proposed with seriously underestimated costs. Once the program is enacted, interest groups gain from it and work arduously to widen the program and thereby increase their benefits. Similarly, groups or institutions that just fall short of inclusion clamor to expand coverage to include themselves. These interests groups form coalitions to expand the program over the years. As the ultimate true costs of the program become clear, it is too late to reverse course.[2] The program has become entrenched and it costs politically uncontrollable. In her Policy Making for Social Security, Brookings Institution scholar Martha Derthick explains how Social Security and Medicare rapidly exceeded initial cost estimates through precisely this process.[3]

Similar political dynamics also belie the notion that the proposed Medicare expansion would be "cost-neutral" to the federal government, as new revenues from higher premiums would offset any increased expenditures. Over time, as program costs increase or the original underestimation of costs becomes apparent, it will be too difficult politically to raise the monthly premiums to match the increased costs. The only alternative then available would be to subsidize the program from general revenues.

This precisely has been the experience under Medicare Part B, where premiums paid by the elderly now cover only about one-fourth of actual program costs. Some congressional liberals are in fact already opposing any rise in Medicare premiums to pay for catastrophic insurance.

Such a significant expansion of Medicare would contradict one of the President's basic policy goals: to reduce government spending and interference in the private sector. Thus an Administration priority is the privatization of government functions wherever feasible. The proposed Medicare expansion would reverse privatization. It would

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1. Harvard Medicare Project, Medicare: Coming of Age, A Proposal for Return (Cambridge, Massachusetts: Division of Health Policy Research and Education, Harvard University, 1986).

2. For a discussion of this process, see Stuart M. Butler, Privatizing Federal Spending (New York: Universe Books, 1985), pp. 11-25.

3. Martha Derthick, Policy Making for Social Security (Washington, D.C.: The Brookings Institution, 1979).

shift functions and activities now performed in the private sector to the public sector, creating a state-owned enterprise to sell health insurance--ironically at the time that governments around the world, including even socialist governments, are moving such functions to the private market.

Expanding Medicare in the way that Bowen may be considering is also unlikely to win many points with the elderly. Most organizations representing the elderly take a very broad view of what constitutes "catastrophic" costs. From the moment the Administration formally made such a proposal, therefore, it would likely find itself immediately under attack--rather than thanked--for not expanding the program to cover long-term nursing home care and other costs and for not subsidizing the program out of general revenues. Congressional liberals and elderly groups already reveal in congressional hearings and public statements that this will be their response. The Administration will either resist such demands, and be caricatured as heartless, or it will give in to them, unleashing a new and massive round of federal spending.

THE ATTACK ON PRIVATE INSURANCE

Those proposing Medicare coverage for catastrophic health costs offer horror stories of fraudulent private insurance agents selling duplicative or misrepresented health insurance policies to the elderly. But while there are abuses in the private sector--as there are in many public sector ventures--the industry overall is professional and responsible with many established and respected insurance companies offering health coverage to the elderly. Professional bodies instruct and certify insurance agents. And thorough state and federal regulation limits abuses.

Can Government Monopoly Insure Americans More Efficiently?

The principal argument made for the proposed Medicare catastrophic plan is that a government monopoly under Medicare can provide the service less expensively than the private sector. In support of this view, HHS Chief of Staff Thomas Burke argues that the coverage under the proposed Medicare catastrophic insurance expansion could be provided for a premium of about $150 per year, compared with $500 to $800 per year for most private catastrophic policies supplementing Medicare.

This comparison is fallacious. The private policies cover far more than the Medicare catastrophic coverage proposed by Burke, including usually the $492 first day deductible for hospital care--which is very costly to cover because it is incurred frequently. The $150 premium for the government plan is also based on the structural underestimate of the ultimate costs of the plan.

The notion that a government monopoly can provide service less expensively than the competitive private market is directly rebutted by the performance of Health Maintenance Organizations (HMOs) in the private sector. Under a recently adopted initiative, the elderly can now elect to have their Medicare coverage provided by an HMO of their choice. In return for taking the responsibility of providing Medicare coverage to an elderly beneficiary, the HMO receives from the government a payment of 95 percent of the average cost per beneficiary under Medicare. To attract elderly customers under this program, most HMOs offer catastrophic coverage--at no extra charge. In other words, the HMOs are providing the health care obtainable under Medicare coverage, plus catastrophic coverage, for only 95 percent of what it costs the government to provide Medicare coverage alone.

Do Private Plans Face High Administrative Costs?

The rationale offered by advocates of the expanded Medicare approach is that administrative costs are lower for Medicare than for private insurance policies, and so Medicare would be more economical than private insurance policies (if not HMOs). This argument, however, is based on inadequate analysis.

By defining administrative costs as everything but benefit outlays, HHS officials report such costs at about 2 percent of total program expenditures for Medicare Part A and about 5 percent for Medicare Part B. Private group health insurance policies supplementing Medicare have administrative costs closer to 10 percent of total expenditures, and private policies sold on an individual basis generally have administrative costs around 30 percent. It seems, on the face of it, that Medicare is a bargain--but there is a catch.

Advocates of expanded Medicare claim that the apparently low administrative costs of the federal program stem from simple economies of scale. But it is not clear why a large federal program would reduce costs through economies of scale. Bigger enterprises or programs do not necessarily mean lower costs. Over 20 companies sell private health insurance supplementing Medicare, and hundreds if not thousands of companies sell private insurance generally. If economies of scale were such a major factor, the industry would be dominated by just a couple of companies, if not just one monopoly. The administrative cost differences are explained by other factors than economies of scale.

For one thing, many Medicare administrative costs are simply not reported. For instance, they do not include the full costs of such expensive items as retirement benefits for program personnel or the building space and equipment used by Medicare employees. Nor do they include the full cost of public and congressional relations activities for the program or program structure analysis and possible changes. They also fail to include the costs of collecting program taxes and

premiums, hiding both the costs of government revenue officials and costs borne by private employers in withholding and forwarding the taxes. This, of course, is analagous to the billing and collection costs of private insurance companies. The administrative costs for the private insurance companies, moreover, include the taxes paid by those companies to the government--part of which helps to fund Medicare. The Medicare system, of course, provides no such revenues to finance other government activities. It is little wonder, then, that the Medicare system seems to have such low administrative costs.

The apparent difference in administrative costs also derives from the cost of carrying the much higher relative level of funding reserves held by the private companies as compared with those of Medicare. Beneficiaries of the the government program must live with the likelihood that sooner or later the program under current law will be unable to pay its promised benefits. The increased safety resulting from the higher level of private reserves benefits consumers.

Finally, part of the difference is certainly because of the selling costs involved in marketing the private policies. These costs primarily explain the difference in the administrative costs of the group and individual insurance policies. Significant expenses are involved when an insurance agent meets individually with a customer and personally explains the pattern of Medicare coverage and the range of private policies to supplement it. If Medicare is to provide similar voluntary coverage, financed 100 percent out of premiums, it is going to face similar costs in explaining to elderly Americans why they will get value for money.

COULD AN EXPANDED MEDICARE REALLY COMPETE?

The purchaser enjoys choice in the private sector. Some may prefer more comprehensive coverage, some less. Some may prefer more coverage of routine, front-end costs, others may prefer coverage only of more severe or catastrophic expenses. With individual policies, the consumer gets more personally tailored coverage; this costs more. Consumers also obtain advice about Medicare coverage through the private policies.[4]

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4. The American Association of Retired Persons (AARP), for example, with 22 million members maintains a hotline with 2,000 sales agents to provide information about Medicare and the supplemental group insurance it sells. Former Social Security Chief Actuary Robert Myers contends that without such private information services, the government would have to add personnel to local Social Security offices to provide basic essential information about Medicare to the public, which it does not do now.

The proposed Medicare expansion would, if enacted, soon involve selling costs similar to those of the private insurance policies. If the program is to be truly voluntary and unsubsidized, then it will not enjoy the negligible sales and promotional expenses of the mandatory Medicare Part A or the heavily subsidized Part B. The government would need an army of agents to explain Medicare coverage and the offered supplemental coverage and to convince the elderly to buy it. And it would need publicity and advertising campaigns to promote voluntary insurance. All this costs money.

In a truly voluntary and unsubsidized program, open to everyone, the government actually might find it difficult to match the premiums offered by many private companies that specialized in low-risk patients--and thus charge low premiums. The government also would have to compete with HMOs that provide the catastrophic coverage today without any extra premiums at all. This means that a great deal of selling, publicity, and promotional expense would have to be borne by a truly voluntary and unsubsidized government plan to meet such competition.

There is, in fact, no reason why such a government plan should have any lower administrative or less selling costs than the private insurance companies. Indeed, the proposed government plan is not based on any group insurance principles and could consequently be expected to have full sales costs closer to those of the higher cost individual policies. The selling expenses of a federal plan could be reduced or eliminated only by mandating coverage in the government program, or heavily subsidizing it sufficiently to undercut the entire private market. But in either case, a costly government monopoly is substituted in place of private competition.

A mandatory government monopoly would entail different costs of its own. Workers and their employers are already forced to pay payroll taxes into the Medicare program throughout the workers' careers. But because these funds are not saved and invested to finance the future benefits of these workers, but instead immediately paid out to finance current benefits, the workers lose the full market investment returns they could have received on these funds over the years. For today's young workers, who will bear the full tax burden for their entire careers, this loss dwarfs any savings on sales and promotional expenses.

The administrative cost savings that allegedly would result from expanding Medicare to provide catastrophic coverage are thus illusory. Any apparent savings would derive from the failure to account fully for the administrative costs under Medicare or to recognize the benefits consumers receive for the private sector costs and the choices they have whether to pay such costs and receive the associated benefits.

MARKET-ORIENTED ALTERNATIVES

With 70 percent of the elderly already covered by private catastrophic insurance, and 15 percent covered by Medicaid, plus the new and expanding availability of catastrophic insurance coverage through HMOS, the Administration needs to focus more carefully on what problem it would solve by expanding Medicare. A private, competitive market with a wide range of options already provides catastrophic coverage to most of the elderly. Undermining this competitive private market with a government monopoly will not help to solve any problems--it will simply create an enormous new one.

The government should, of course, seek to improve existing private market coverage and help reduce costs where possible. But this is not the real problem, as the elderly groups themselves have stated. The real problem lies in the need for long-term nursing home care, the lack of proper market incentives and competition, the long-term Medicare financing crisis, the reduced quality of care resulting from excessive regulation under Medicare, and the heavy burden of government taxation and spending imposed by Medicare. Many health analysts also feel that the current HHS approach is the exact inverse of what it should be. These experts argue that the great bulk of retirement medical expenses involving merely routine costs should be financed through the private sector, rather than through Medicare, with government performing the back-up catastrophic role. The discussion at HHS seems to center instead on the federal government taking the primary role in health care for the elderly.

Fortunately there are private sector approaches to deal with such gaps as do exist in health care coverage for the elderly. One is the concept of Health IRAs, now embodied in bipartisan legislation introduced by Representative French Slaughter (R-VA). This legislation would allow workers and their employers to contribute funds to accounts analogous to today's regular IRAs, in return for special income tax credits. To the extent such contributions were made during a worker's career, the deductible under Medicare for that worker would be increased under a proportional formula. As a result, workers exercising the Health IRA option throughout their careers would have deductibles of several thousand dollars a year under Medicare.[5]

Workers could then use their Health IRA funds to purchase private health insurance to cover the added deductible. The Health IRA funds in most cases would be far more than enough to cover the extra deductible, leaving workers who exercised the option far better off. Those who exercised Health IRAs to a minimum degree would receive

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5. Peter Ferrara, "How to Avert the Medicare Crisis," Heritage Foundation Backgrounder No. 385, October 4, 1984.

catastrophic coverage under Medicare. And workers could use their surplus Health IRA funds to finance long-term nursing home care. The Health IRAs also could eliminate the long-term Medicare funding crisis, as the increased deductibles would sharply reduce the program's financial obligations.

The IRA alternative provides for catastrophic insurance and for a much greater role for the private sector through the increased deductibles. It would leave the government with only a back-up role. The private sector would take the major responsibility for health insurance coverage in retirement, just the opposite of policy today. And over the long run, total Medicare spending would be dramatically reduced as Americans made more extensive use of private plans.

Another option is the concept of health care vouchers. This would involve expanding the program under which the elderly can choose HMOs to provide their Medicare coverage. The HMOs provide catastrophic coverage to the elderly to attract their patronage. Private insurance companies should be given the same incentive to do so, by expanding the HMO initiative into a full-fledged Medicare voucher, which could be used to purchase private insurance.

Still other market-oriented options could be devised. To do so, Bowen should consult closely with the private insurers who are interested in helping to develop such alternatives.

CONCLUSION

The catastrophic insurance study now underway is a key test for Otis Bowen. The Medicare expansion plan being urged by some of Bowen's staff contradicts Ronald Reagan's overall philosophy of greater reliance on the private sector. Bowen himself has indicated several times that he has a philosophical preference for utilizing the private sector. Indeed, as Chairman of the 1983 Social Security Advisory Council, he supported the Health IRA concept when Council Member Richard Rahn, Chief Economist for the U.S. Chamber of Commerce, advanced the idea.

Bowen now can confirm his earlier statements with action. If ultimately he supports yet another expansion of the welfare state, based on an outdated policy mindset from the 1960s, he will have undermined Ronald Reagan's goal to reverse the growth of federal government. Instead Bowen must provide imaginative, innovative leadership to strengthen the role of the private sector in health care.

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