When we add layers of protection for the elderly, let's remember that even minor illnesses may mean financial disaster for people without any health insurance.

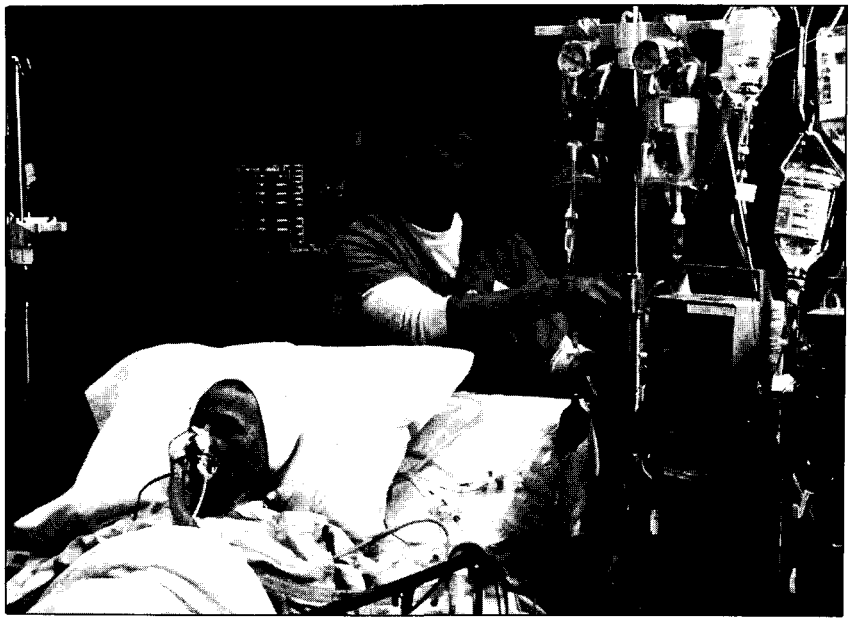

Photo: National Institutes of Health

by Janet Hook

CATASTROPHIC INSURANCE FOR ALL

In the current debate over providing catastrophic health insurance, the loudest critics have been conservatives who think this would be an unnecessary expansion of government. Ironically, the last time Congress seriously considered giving the federal government a role in paying for catastrophic health costs, it was liberal Democrats who were on the front line of opposition.

In 1979, legislation to guarantee catastrophic coverage for extraordinarily high medical bills was gathering steam in the Senate. But organized labor and other liberal forces objected to plans that provided only catastrophic coverage. They had long been pushing for a bigger prize, national health insurance, and feared any half-measure could take the impetus out of their drive. Senator Abraham Ribicoff pleaded with labor to drop its all-or-nothing strategy and support a politically achievable plan: "Isn't 50 percent of something better than 100 percent of nothing?" They got 100 percent of nothing.

Liberals may now conclude with regret that they missed a great opportunity to move in the direction of broader health insurance coverage. But they were on to something in 1979. The principle underlying their resistance was that it is hard to justify giving priority to expanding benefits for people who already have basic health insurance coverage when there are so many people who don't have even that.

That principle should not be forgotten as the current revival of interest in catastrophic insurance gathers momentum. The plan urged by Otis Bowen, the secretary of Health and Human Services, would expand medicare to cover catastrophic hospital bills for the elderly. Such an expansion would not do anything for the 30 million or so young and middle aged who have no health insurance and for whom even a $2,000 medical bill could be catastrophic. And for the

Janet Hook is a reporter for Congressional Quarterly.

elderly, the plan wouldn't even cover nursing home costs, which are a more serious problem for them. With more imaginative funding ideas we could afford a wide-ranging catastrophic plan.

A letter from Danny Thomas

Most people know someone who has been hit by an illness that requires long, expensive care. Victims of a car accident, cancer, or Alzheimer's disease have in common the tremendous expense of extended care. At a House Ways and Means hearing on the subject last year, Rep. Hal Daub, a Nebraska Republican, told his colleagues that his 67-year-old father had incurred almost $300,000 in medical bills from seven months in the hospital, including four in intensive care. Daub's father was covered by Medicare, and had a supplemental private insurance policy, which meant he "only" had to spend about $20,000 of his own.

Our current health care system provides basic coverage for 28 million elderly through Medicare. But there is now no ceiling on the out-of-pocket expenses they may face. Medicare beneficiaries have to pay at least 20 percent of their doctors' bills, a deductible for each hospitalization, and a hefty share of the tab for hospital stays longer than 60 days. After 150 days in the hospital, the elderly pay all their expenses.

Prodded by high-pressure sales techniques warning that disaster may be around the corner, many have turned to supplementary private insurance known as "Medigap" to cover what Medicare doesn't. Matilda Sutphin of Melvin, West Virginia, told the *Charleston Gazette-Mail* that she bought Medigap because "Danny Thomas kept writin' me about his insurance.... He said it [a hospital stay] would take all the savings I had and then I would have nothing. I wouldn't have nothing and being a burden on the kids and everything." But often the elderly are persuaded to buy several overlapping Medigap policies that fall far short when it comes to covering serious costs. Moreover, about 35 percent of all Medicare beneficiaries don't even have a Medigap policy.

Bowen's plan to provide catastrophic coverage under Medicare would help only the roughly 800,000 elderly who run up medical bills exceeding $2,000 a year. Bowen's proposal would cap out-of-pocket expenses for Medicare beneficiaries at $2,000 a year if they pay an additional $4.92 a month in premiums—on top of the $15.50 monthly premium they now pay for Medicare's "Part B" insurance for non-hospital expenses.

The principal conservative complaint is that Bowen's plan would offer a service already available through the private market's Medigap. But the government could give the elderly a better buy because much of the revenue from Medigap premiums goes to administrative costs and profits. The government, presumably, would also be less likely to sell the elderly policies they don't need.

Of course the real problem with Bowen's Medicare proposal is not what it does, but what it doesn't do.

Routine catastrophies

For the elderly, a more fearful prospect than long hospitalizations is paying for nursing home care for which there is now little government help. Some 1.4 million elderly people are in nursing homes, but Medicare doesn't pay for much of that care. Total nursing home costs hit $32 billion in 1984, roughly 40 percent of which was paid by Medicaid, 1 percent by private insurance, and the rest by patients and their families.

A 1985 survey for the House Aging Committee found that it took only 13 weeks in a nursing home for two out of three single elderly patients to impoverish themselves; within a year, more than 80 percent were impoverished. To get Medicaid to pay for nursing home care, the elderly now have to do just that: make themselves poor, through the humiliating, embittering process of "spending down."

Just as important, expensive illnesses and conditions hit the young as well as the elderly. Ten million people have basic health insurance but have inadequate coverage for exorbitant health bills. A Washington-area family, for example, faced $2,000-a-month medical expenses to care for a 17-year-old daughter who had severe brain damage after a car accident. The family brought the semi-comatose girl home and bore the brunt of the expense for at-home care, *The Washington Post* reported, after their insurance companies stopped paying for the $8,000-a-week cost of hospitalization.

The spread of AIDS will further increase the number of people without insurance who need expensive medical care. Studies have shown that the average cost of treating an AIDS patient is $70,000 but that many of these patients lose their jobs and therefore their health insurance soon after diagnosis. Estimates are that the AIDS population will grow to 100,000 or even half a million, the care of which will cost $15 billion or

more by 1991.

Bowen's Medicare plan also doesn't seriously address those who don't even have basic insurance. For that group, particularly those who are poor, even having a broken leg set or having a baby delivered can wreck the family budget. Contrary to the impression left by countless stray presidential anecdotes, the poor do not have all their medical problems taken care of by government. Medicaid only covers half the poverty population. Although the program, like welfare, is partly financed by the federal government, states have wide latitude to say how poor one has to be to qualify for benefits under the program. Income eligibility standards in some are shockingly low. In 1985, for example, a family of four generally could not qualify for Medicaid in South Carolina if it had more than about $5,000 in gross income. Because the program also focuses on narrow categories of the poor, some people—generally able-bodied men and their families—cannot qualify for Medicaid no matter how poor they are. For these poor, even routine costs can be catastrophic.

Uncle George's millions

If the need for catastrophic coverage is so broad and should therefore be politically appealing, one has to wonder why it has never been enacted.

The nation's most serious effort to institute a comprehensive plan to cover America's basic health needs was initiated in the late 1940s by Harry Truman, but was defeated by the American Medical Association in one of the most expensive lobbying campaigns in history. When health reformers sought a more modest proposal in a strategic retreat from full-blown national health insurance, they looked for limitations not only on what was covered but also on who was covered. They turned their attention to the elderly.

The elderly were particularly appealing because they were presumed to be needy—even without a means test, which was, and is, regarded as stigmatizing. They had the lowest earning capacity, the highest medical bills, and the most difficult time getting private insurance at affordable rates. Equally important, the elderly were beginning to emerge as a potent political force.

When Medicare was enacted in 1965, it focused on the limited but ground-breaking goal of covering short-term care for the elderly. It left them still exposed to the risk of catastrophic expenses, however.

During the Medicare debate, the one serious proposal to include both catastrophic and nursing home coverage was considered a deadly amendment. Critics said it was an expensive add-on that far exceeded what most people got under private health insurance.

While in the sixties catastrophic insurance was considered the lead weight that could sink the whole Medicare bill, it came to be regarded in the seventies as the middle-class sweetener that would make it easier for a reluctant populace to swallow national health insurance. Almost all of the comprehensive health schemes debated in the seventies included a catastrophic insurance feature. But passage of catastrophic insurance alone was generally opposed by proponents of broader care who feared it would undermine middle class support for improved coverage for the poor. Others complained that catastrophic health insurance would give hospitals new incentives to skew resources towards expensive, high-tech equipment and treatments, rather than basic care.

Since 1980, concerns about the inflationary ef-

Why should the deceased's relatives benefit from the money the government has spent on his care? If those nephews and nieces want to get Uncle George's millions, let them take care of him.

fect of covering catastrophic costs have become less compelling. Private businesses have tried to curb employee benefit costs, and since 1983, a new Medicare payment system has reduced incentives for hospitals to keep patients too long or to provide unnecessarily expensive treatments.

The old tactical objection that enacting catastrophic insurance would sabotage a broader health care program is less relevant. Almost everyone has given up on national health insurance, and in these austere times, health reformers are legitimately inclined to take whatever incremental gains they can get.

Politicians will likely be tempted to restrict catastrophic initiatives to the elderly and call it a day for the same reasons that health reformers in the 1950s and 1960s focused on that group. But unlike 20 years ago, the elderly as a group are not the neediest segment of the population; their poverty rate is now lower than that of those under 65.

That's not to say the elderly shouldn't get catastrophic protection but that those benefits should be self-financed for those who can afford it—and that any new direct federal spending should go first to such things as expanding Medicaid to improve basic health insurance for those lacking any coverage. Ideally, the current fervor for catastrophic insurance could provide an opportunity to link the political sex-appeal of helping the elderly to the less popular need to help the poor.

Well, that's all very nice, you say, but how could we possibly afford such truly comprehensive catastrophic insurance? There are ways to finance new health care that are not being used now. One is to tax Medicare benefits so that the government will recover amounts paid to wealthy recipients who don't need the aid. Another is to tax the estates of deceased recipients of government medical benefits to recover the difference between what the government spent on them and what they paid in premiums. So, for example, if a man had paid $9,000 in Medicare payroll taxes over his working years and received benefits worth $20,000, after his death $11,000 could be recovered. For humane reasons, such a tax should not be collectible until the surviving spouse also dies and the care and education of any remaining minor children has been provided for. But beyond these provisions, why should the deceased's relatives benefit from the money the government has spent on his care? If those nephews and nieces want to get Uncle George's millions, let them take care of him. If the government pays for the caring, it should get its money back before those nephews and nieces get a dime.

This proposal answers the conservative objection that government health care support undercuts the incentive for kids to care for their parents. Government support, the argument goes, helps children preserve their own wealth as well as keep intact that juicy bit of inheritance that awaits them. No one could argue that kids thrust their parents on the government dole just to safeguard their inheritance if that inheritance will be tapped to pay for the father's dialysis. A modest version of this plan suggested by Barbara Torrey, an analyst with the Census Bureau who formerly monitored HHS as an analyst at the Office of Management and Budget, would have raised an estimated $10 billion, while providing that no more than 25 percent of the estate could be taxed to recover the Medicare benefits. Obviously, removing the 25 percent cap would bring in a far heftier chunk of change.

It is important that whatever money is raised be devoted to the beginnings of catastrophic protection for people of all ages. Ideally, the government would expand eligibility for Medicaid and require all states to have "medically needy" programs. Such programs, already running in about two-thirds of the states, allow the near-poor to qualify for Medicaid if their medical expenses bring them within income eligibility standards.

Another option would be to allow the near-poor to buy into the program with premiums geared to their income. Secretary Bowen's report estimated such a plan would cost $15 billion if it included all people with income below 125 percent of the poverty line, with premiums capped at 5 percent of income. So a man earning $6,000 annually would pay no more than $300 to gain full medical coverage.

Because not all the uninsured are poor, some people may have to be reached by other mechanisms. States should be encouraged to set up insurance risk pools to make coverage available to people with chronic illnesses and those who cannot obtain a private policy at reasonable rates. But subsidies may be needed to keep the premiums affordable.

No program to plug the gaps in the health care system will be cheap, and this is not the time to be adding billions to the federal budget. But it is a measure of how far the political ground has shifted since the battle to enact Medicare that a Reagan administration official can agree with Ted Kennedy that the federal government has a role in filling some of those gaps. In all the coziness of consensus, let's make sure the right holes are patched. ■

When Truman taped Tommy Corcoran, he gave history a unique look at the beginning of executive branch lobbying, now Washington's major industry.

Photo: UPI/Bettman Newsphotos

TOMMY THE CORK

THE SECRET WORLD OF WASHINGTON'S FIRST MODERN LOBBYIST

by Allan J. Lichtman

"I know the corners of this town in the dark," boasted Thomas G. Corcoran, Washington's premier lobbyist, in a private phone conversation in 1945. His words are preserved today because Harry S. Truman had the FBI tap into the corners of Corcoran's Washington, recording conversations held on the power broker's home and office phones.

Corcoran, nicknamed "Tommy the Cork" by Franklin Roosevelt, had been FDR's chief political operative, guiding much of the New Deal legislation through Congress and serving as the President's primary deal maker and talent scout. He had joined Roosevelt's administration in 1933, seemingly an idealist recruited by Felix Frankfurter to help "cheat the cheaters." But by 1941 Corcoran had embarked on a career that would gain him a more dubious distinction as the prototype modern lobbyist and influence peddler.

Truman apparently tapped Corcoran because he feared that several of FDR's former aides were plotting against his administration. In so doing, Truman and FBI Director J. Edgar Hoover, who likely originated the idea for the taps, created the most extensive record of political surveillance in American history: 5,000 pages of wiretap transcripts, covering May 1945 through early 1947. They were deposited in the Truman Presidential library and opened to researchers two years after Corcoran's death in 1981.

The tapes provide a mini-course in the art of Washington lobbying with lessons hidden behind every deal, the most important being that lobbying is not pulling strings—it's scrambling. Corcoran enlisted a Catholic bishop in one lobbying effort, and used the off-the-cuff words of a tipsy

Allan J. Lichtman is professor of history and associate dean of the College of Arts and Sciences at the American University in Washington, D.C.