

August 4, 1994

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 Koziem, draped over the hood.

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 plan¹ 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 <i>The Federal Register</i> .	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

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.

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.

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.*

