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THE MEDICARE CATASTROPHIC COVERAGE ACT OF 1988: ISSUES OF EQUITY IN A POLICY REVERSAL

Joseph C. Morreale, Ph.D. *

In his February 1986 State of the Union Address to Congress, President Ronald Reagan directed his Secretary of Health and Human Services, Otis R. Bowen, to develop proposals to better protect Americans against catastrophic health care expenditures.[1] In November 1986 Secretary Bowen released a report that addressed three separate needs: (i) catastrophic acute care costs for the Medicare population; (ii) long term care costs for the Medicare population; and (iii) catastrophic costs for the non-Medicare population.[2]

The Medicare Catastrophic Coverage Act[3] (MCCA or Act) was the resulting legislation passed by Congress that focused on the first of these three concerns. President Reagan signed this bill into law on July 1, 1988, calling it a program that will "help remove a terrible threat from the lives of elderly and disabled Americans."[4] The Act represented the largest expansion of the federal Medicare program since its inception in 1965. Yet, only sixteen months later, on November 22, 1989, Congress repealed this "landmark" health insurance program for the elderly and disabled.[5]

This article investigates the causes and consequences of this swift and unprecedented health care policy reversal. In particular, the article will focus

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1. R. REAGAN, *Address Before a Joint Session of Congress on the State of the Union, February 4, 1986*, in 1 PUBLIC PAPERS OF THE PRESIDENTS OF THE UNITED STATES 128 (1986).

2. *See* Rovner, *Issue is Gaining Political Momentum: Lawmakers Taking Hard Look at Problem of Long-Term Care*, 46 CONG. Q. 938, 938 (1988); Rovner, *House Adopts Conference Report: Catastrophic-Costs Measure Ready for Final Hill Approval*, 46 CONG. Q. 1494, 1494-95 (1988); Rovner, *Reagan Threatens a Veto: House OKs Medicare Expansion Despite Reservations Over Cost*, 45 CONG. Q. 1637, 1637 (1987); *Catastrophic-Costs Bill Is Sent to White House*, 46 CONG. Q. 1606, 1606-11 (1988).

3. Medicare Catastrophic Coverage Act of 1988, Pub. L. No. 100-360, 102 Stat. 683 (codified as amended in scattered sections of 42 U.S.C.).

4. *Reagan Signs Catastrophic-Care Bill*, 46 CONG. Q. 1865, 1865 (1988).

5. Medicare Catastrophic Coverage Repeal Act of 1989, Pub. L. No. 101-234, 103 Stat. 1979.

on the equity issues involved in catastrophic health care expenditures by addressing the following questions: Who would have benefitted from this program?; Who was to pay for the program?; Why was it reversed?; And, finally, what have we learned? The article concludes that Congress and the President broke with traditionally held principles of economic equity in American policy-making when they drafted the MCCA. They erred significantly in placing the financial burden on the elderly—especially on the affluent elderly—while only a minority of the elderly actually benefitted from this program. While the costs were front-loaded, some of the benefits were to be phased-in over a period of years. To the elderly, this financing strategy made the costs appear more expensive relative to the Act's benefits. Finally, the Act raised the elderly's fear of further rising costs, in the form of premium and tax payments, and failed to address their real concern—long-term care.[6]

This article proceeds in six sections. Section I defines the general concept of economic equity and describes four types relevant to this analysis. Section II describes the economic position of the elderly and their health care expenditures. Section III presents the Medicare Catastrophic Coverage Act and offers an analysis of its financial impact on the elderly. Section IV discusses the causes of the MCCA's reversal. Section V analyzes the continuing and unresolved issues of economic equity for the elderly, and Section VI offers some conclusions and suggestions for future policy consideration.

I. CONCEPTS AND DEFINITIONS

A. Defining Economic Equity

The concern for equity is fundamentally important to policy-making. H. George Frederickson, in his twenty-year retrospective article on the concept of *social* equity in public policy, has again brought this concern to our attention.[7] The public finance literature in the field of economics has long recognized the just distribution of society's scarce resources as one of the generally accepted functions of government.[8] Proceeding from an economic perspective, this article analyzes a public policy which includes catastrophic health care expenditures for the elderly, emphasizing economic equity rather than social equity.

6. For a discussion of long-term care, see generally Meiners & Trapnell, *Long-term Care Insurance: Premium Estimates for Prototype Policies*, 22 MED. CARE 901 (1984).

7. *See generally* Frederickson, *Public Administration and Social Equality*, 50 PUB. ADMIN. REV. 228 (1990).

8. R. MUSGRAVE & P. MUSGRAVE, PUBLIC FINANCE IN THEORY AND PRACTICE 9-11 (5th ed. 1989).

"Economic equity," generally defined as a fair distribution of economic outcomes in a society, has two dimensions. The first, distributional equity, relates to adjustments in the outcomes of the market system to create a better distribution of goods and services. The second, contributional equity, involves establishing a fair system of required revenue contribution for the provision of public goods and services.

There are two general approaches to distributional equity, both of which focus on defining a fair entitlement to publicly provided services. The universal approach provides entitlement to social benefits primarily as an earned right, regardless of income, to an entire category of citizens. The advantages of this approach are that the public services are high quality, equal for all, and easy to administer. The disadvantages are that the services are often very costly and protect many individuals who are not generally considered "in need."

In contrast, the selective (categorical) approach provides social benefits to a specified group based upon financial need. This approach better serves the poor and is much less costly. However, it frequently suffers from an inability to garnish political support for the dependent population. Even when the approach is successful, it sometimes results in "second-class" services for this population.

With contributional equity, there are also two general approaches—the benefits principle and the ability-to-pay principle. The benefits principle rests upon an equitable financing system that receives taxpayer contributions in line with the benefits derived from the public service. A truly equitable system depends upon the expenditure structure; tax revenues and tax expenditures are therefore determined simultaneously, with tax policy and tax expenditure policy determining the extent of the benefits. However, in order to allocate the tax bill equitably, the benefits for each taxpayer must be determined in advance, which is a central problem with contributional equity. In addition, those who are the beneficiaries are also the least likely to be able to pay. In effect, the benefits principle assumes that a proper state of distribution exists a priori.

In contrast, the ability-to-pay principle maintains that individuals should contribute to the provision of a public service in accordance with their financial resources. The tax funding problem is viewed independently from expenditure-determination because two sub-principles, horizontal and vertical equity, develop the ability-to-pay principle. The former requires people with equal financial capacity to make the same financial sacrifices. The latter requires people with unequal capacity to pay different amounts—those with a greater financial capacity will pay more, while those with a lesser financial

capacity will pay less. While the ability-to-pay approach better addresses the redistribution problem, it undermines the provision of appropriate funding for public services. Moreover, it is difficult to measure an individual's ability to pay.

B. Types of Economic Equity

Four types of economic equity will be addressed in this article. The first focuses on the equity within the elderly population—*intraelderly equity*. Intraelderly equity relates to horizontal equity by attempting to treat each aged person equally through the provision of equal benefits while making an equal distribution of the financial burden. There is also a dimension of vertical equity; different members of the aged have different levels of economic ability-to-pay, and therefore, those elderly persons with more ability-to-pay would pay more for their health care.

The second type of economic equity is the equity across the United States in both the elderly and non-elderly populations. In this context, it is important to recognize the relationship between the economic status of the elderly vis-à-vis the non-elderly in the population. This relates to vertical equity, and is referred to as *intergroup equity*. Those members of society who are more able to pay for health care would contribute accordingly.

The third aspect of economic equity is familial, e.g., between the elderly and their offspring. This type of equity is based upon the potential transfer of wealth within the family from one generation to the next. Since catastrophic health care expenditures pose a threat to the maintenance of the wealth of the elderly, the children have a vested interest not only in the health of their elderly parents but also in the financial stability and protection of their wealth. This makes the transfer of funds for services and financial protection an equity issue across extended families. This is *interfamily equity*.

The final type of economic equity involves concern for equity across generations. This differs from the previous type of equity because it focuses on the distribution of resources between the elderly and the children within the entire society. There is increasing concern about the "over-allocation" of resources toward the elderly and the "under-allocation" of resources to the Nation's children. This has become a growing political issue and has direct bearing on the competition for health care resources between the young and the old. This type of equity will be referred to as *intergenerational equity*.

All of these views of equity will be considered in light of the health care expenditures of the elderly, especially as evidenced in Federal Medicare policy.

II. INCOME AND HEALTH CARE EXPENDITURES OF THE ELDERLY

A. The Financial Capacity of the Elderly

The traditional view of the elderly is that they are a relatively poor and dependent group in the population:

> Despite gains in recent years, the elderly, for the most part, are not a prosperous group. Half of the families with an elderly member had incomes below twice the poverty level in 1981 . . . . In contrast, 30 percent of persons in families without an aged member have incomes under twice the poverty level.[9]

Data concerning the more recent economic status of the elderly in comparison to the non-elderly population are reported in Table 1. Median and mean income increase as the age of the head of household rises, and they peak in the forty-five to fifty-five age bracket. The elderly have the lowest median income, and their mean income is the second lowest of all income groups by age. Average annual expenditures on health care also rise as age increases, and the elderly incur the highest average annual health care expenditures. After calculating the percentage of health care expenditures for average income, the result shows that, of all the groups, the elderly spend the greatest percentage of their income on health care.

Wealth status is another indicator of financial state. Median net worth is also reported in Table 1 across all age groups. This wealth measure increases as age increases, but it peaks in the fifty-five to sixty-four age bracket. While the elderly have low median and mean incomes, the elderly still have substantial relative wealth, which averages almost twice the net worth position of the average for all age groups.

A reliable indicator of relative economic position in society is the percentage of income distribution of a specific age group relative to the distribution in the total population. Table 2 demonstrates that the income distribution of the elderly is much lower than that of the whole population. Approximately one-third of the elderly have incomes below $10,000, while less than one-fifth of the entire population have an income below this amount. Approximately one-quarter of the elderly have incomes of $25,000 or greater, whereas over half of the total population have these incomes. Overall, the median income of the elderly is only fifty-five percent of the median income of the population.

One study estimated the income of the elderly from unpublished Social

9. K. DAVIS & D. ROWLAND, MEDICARE POLICY: NEW DIRECTIONS FOR HEALTH AND LONG-TERM CARE 35 (1986).

TABLE 1: HOUSEHOLD INCOME AND AVERAGE ANNUAL HEALTH CARE EXPENDITURE BY AGE GROUP: U.S. (1986 & 1987)

Age Group	Median Income 1987[1]	Mean Income 1984[1]	Avg. Annual H.C. Exp. 1986[2]	Avg. Ann. H.C. Exp. % of Median Income[4]	Median Net Worth[3]
15-24	16,204	19,504	336	1.72	
25-34	26,923	30,200	686	2.27	(<35)5,764
35-44	34,929	39,529	1005	2.54	35,581
45-54	37,250	43,796	1172	2.68	56,791
55-64	27,538	34,818	1303	3.74	73,664
65 +	14,334	20,333	1650[4]	8.11	60,266
Total	25,986	32,144	1062	3.30	32,667

SOURCE: [1] U.S. DEP'T OF COMMERCE, STATISTICAL ABSTRACT OF THE UNITED STATES 441-42 (1989)
[2] *Id.* at 437
[3] *Id.* at 459
[4] Author's calculations

TABLE 2: INCOME DISTRIBUTION OF ELDERLY AND TOTAL POPULATION: U.S. (1987)

Income Group	Elderly (%)	Total Population (%)	Inequality Relative Position of the Elderly[1] (Elderly/Total Pop.)
<5000	9.9	6.9	1.43
5,000-9,999	24.5	11.5	2.13
10,000-14,999	17.8	10.6	1.68
15,000-24,999	22.1	19.2	1.15
25,000-34,999	11.5	16.1	0.71
35,000-49,999	7.9	17.2	0.46
50,000-74,999	4.1	12.2	0.34
75,000 +	2.3	6.3	0.37
Median Income	$14,334	25,986	0.55
Mean Income	20,333	32,144	0.63

SOURCE: U.S. DEP'T OF COMMERCE, STATISTICAL ABSTRACT OF THE UNITED STATES 441-42 (1989)
[1] Author's estimates

Security Administration data covering the year 1984.[10] Table 3 portrays the average income and distribution of income of the elderly by age bracket. The median income of the elderly in 1984 was $13,460, with over one-third having incomes below $10,000. As age increases, the median income falls, and the percentage with income below $10,000 increases to almost half. Since the risk of illness (especially chronic illness) rises with age, these data reveal that, as this risk rises, there is a reduction in the ability of the elderly to finance their health care needs.

TABLE 3. FAMILY TOTAL MONEY INCOME BY AGE, SEX, AND MARITAL STATUS (1984)

	Percentage distribution of aged units					
Groups	Median Income	Less than $5,000	$5,000-$9,999	$10,000-$14,999	$15,000-$29,000	$30,000 or more
All persons						
Age 65 +	$13,460	11.8%	25.9%	17.1%	26.5%	18.6%
65-69	$16,420	8.6	20.8	16.4	31.7	22.7
70-74	$13,600	11.1	25.7	18.3	26.8	18.2
75-79	$11,810	12.9	29.5	18.2	24.7	14.5
80 +	$10,810	16.7	30.4	15.8	20.4	16.9
Married couples						
Age 65 +	$18,670	2.1	14.6	20.4	37.0	25.8
65-69	$21,880	1.9	9.2	16.4	40.9	31.5
70-74	$18,670	1.8	15.1	20.1	37.7	25.5
75-79	$15,910	2.0	19.1	26.2	33.5	19.3
80 +	$14,140	4.3	24.1	26.2	27.4	18.1
Non-married individuals						
Age 65 +	$ 9,580	18.4	33.3	14.9	19.7	13.7
65-69	$10,450	15.7	32.8	16.2	22.1	13.3
70-74	$ 9,500	18.4	34.0	16.9	18.2	12.5
75-79	$ 9,030	18.9	35.0	13.9	20.1	11.9
80 +	$ 9,250	20.4	32.3	12.7	18.2	16.4

SOURCE: Cohen, Tell, Greenberg & Wallack, *The Financial Capacity of the Elderly to Insure for Long-Term Care*, 27 GERONTOLOGIST 494, 496 (1987)

B. Defining Catastrophic Health Care Expenditures

What are financially catastrophic health care expenditures? A distinction

10. Cohen, Tell, Greenberg & Wallack, *The Financial Capacity of the Elderly to Insure for Long-Term Care*, 27 GERONTOLOGIST 494, 496-97 (1987) [hereinafter Cohen].

must be made between financially catastrophic health expenditures and high cost health care.

Frequently, catastrophic expenditures are considered a high threshold amount of health care expenditures. Some argue that a certain level, e.g., $5000 per year, is catastrophic. Others argue that it should be based on ability to pay, contending that anything above a certain amount, e.g., ten percent of annual income, is catastrophic to a household. The first assertion takes the position that equity is determined by the benefits principle. That is, all elderly are treated equally when they are faced with equally high cost health care expenditures. In contrast, the latter position asserts that equity is determined by the ability-to-pay principle.

However, high cost health care is neither a necessary nor sufficient condition for health care expenditures to be considered catastrophic to an individual or household. S.E. Berki states that a health care expenditure is considered catastrophic "when it endangers the family's ability to maintain its customary standard of living."[11] Leon Wyszewianski concurs, arguing that financially catastrophic health care expenditures should be restricted to "situations in which expenditures are considered large relative to the patient's ability to pay, as determined by the extent of third-party coverage and other resources available to pay for care."[12]

Expenditures that are burdensome to family economic resources should be of primary concern. In this way, health care expenditures are considered in relation to a measure of family economic resources. Individual or family income is the most generally accepted measure of family financial ability, but household wealth, health insurance coverage, and tax burden need to be analyzed as well. These factors will provide a more accurate view of an individual's ability to pay.

To note, only out-of-pocket health care expenditures require examination since the remainder is paid by third parties. Out-of-pocket expenditures would include health insurance premiums. Hence, three different thresholds are often used in discussions of catastrophic health expenditures, namely, out-of-pocket health expenditures that exceed five, ten, or fifteen percent of household income.

Another issue considers the type of health care expenditures analyzed. Most discussions of the general issue of catastrophic health expenditures focus on acute health care expenditures. For the elderly, however, expendi-

11. Berki, *A Look at Catastrophic Medical Expenses and the Poor*, 5 HEALTH AFF. 138, 138 (1986).

12. Wyszewianski, *Financially Catastrophic and High-Cost Cases: Definitions, Distinctions, and Their Implications for Policy Formulation*, 23 INQUIRY 382, 383 (1986).

tures on maintenance care become critically important. This is seen particularly in long-term care where expenditures can be exceedingly large both in absolute terms and in terms relative to family financial resources. Since, under the MCCA, long-term care was left uncovered, coverage was mainly for acute-care health expenditures for non-institutionalized elderly patients.[13] Consequently, much of this article focuses on acute health care expenditures.[14]

C. Health Care Expenditures By the Elderly

The elderly clearly have much higher health care expenditures than other members of the population. The latest data available from Health Care Financing Administration (HCFA), a division of the Department of Health and Human Services (HHS), are presented in Table 4. Of the almost $450 billion spent on personal health care in the United States in 1987, $162 billion was spent on the elderly. Thus, the aged, who comprise about twelve percent of the population, account for a little over one-third of all health care expenditures. Moreover, the per capita health care spending for the elderly was three times the national average. However, these data are very general and provide very broad estimates which include both acute and long-term care expenditures.

TABLE 4: PERSONAL HEALTH CARE EXPENDITURES BY AGE: U.S. (1987)

Age Group	Population		Personal Health Care Expenditures		Per Capita Amount
	(m)	(%)	($b)	(%)	($)
< 19 years	69.7	27.7	51.9	11.6	745
19-64	151.9	60.3	231.1	52.2	1,535
65 +	30.2	12.0	162.0	36.2	5,360
All ages	251.7	100.0	447.0	100.0	1,776

SOURCE: *Health Expenditures by Age Group, 1977 and 1987*, 10 HEALTH CARE FIN. REV. 167 (Fall 1987)

Karen Davis and Diane Rowland, in their analysis of Medicare policy, found two characteristics of acute-care health expenditures for Medicare re-

13. *See* Pepper, *Adding Indigence to Injury: America's Long-Term Insurance Gap*, 15 J. LEGIS. 15, 18 (1988) ("The new legislation does address the issue of long-term care, but it does so in an inadequate fashion.").

14. Acute health care contemplates "health services other than preventive or long-term care." Christensen, Long & Rodgers, *Acute Health Care Costs for the Medicare Population: Overview and Policy Options*, 65 MILBANK Q. 397, 397.(1987) [hereinafter Christensen].

cipients.[15] First, health care expenditures on the aged are very unevenly distributed. The authors report that for 1983, seven percent of the aged accounted for sixty-five percent of all Medicare payments. Second, high cost health care affected only a minority of the elderly. In 1980 seven percent of the elderly spent over $5,000 on health care, and fifteen percent spent between $1,000 and $5,000.[16]

A third characteristic of acute-care expenditures, verified in other studies, is that catastrophic burdens do not necessarily derive from high cost health expenditures. Another study, using an analysis similar to that employed by Davis and Rowland, compared the health care expenditures of the population under sixty-five years of age with the population sixty-five years of age and older.[17] It found that the health care expenditures incurred by the elderly were two to four times greater than those which the population under sixty-five years of age incurred. Moreover, the top ten percent of the elderly accounted for over two-thirds of total acute-care health expenditures of the elderly population, and the top ten percent of the non-elderly account for almost three-quarters of the total acute health care expenditures of their group.

Sandra Christensen, Stephen Long, and Jack Rodgers reached similar conclusions.[18] They reported that in 1987 the average acute-care expenditures per elderly Medicare enrollee was $3,351. Hospitalization was the most important factor in the high cost of such care. Average expenditures for the nonhospitalized aged Medicare recipient was $817, but for the hospitalized recipient they were $12,213. Analyzing the distribution of acute-care expenditures across the elderly, the twenty-two percent who were hospitalized accounted for eighty percent of the total acute-care costs for the aged. In terms of out-of-pocket expenditures, Medicare enrollees pay nearly eleven percent of acute-care expenditures. Another seventeen and one-half percent of these expenditures are paid by Medicare enrollees for insurance premiums. The latter include premiums for Medicare Part B coverage or for private supplementary coverage.[19]

The Cohen study also reported the proportion of income which the elderly spent on necessities by income class based on the Consumer Expenditure Survey for the elderly from 1980-1981.[20] By focusing on the percentage of

15. DAVIS & ROWLAND, *supra* note 9, at 34.

16. *Id.* at 34-35.

17. Garfinkel, Riley & Iannacchione, *High-Cost Users of Medical Care*, 9 HEALTH CARE FIN. REV. 41 (Summer 1988).

18. Christensen, *supra* note 14, at 399.

19. *Id.*

20. Cohen, *supra* note 10, at 497-98.

out-of-pocket medical expenses by income class, the overall average is nine and two-tenths percent, with most elderly income groups amounting to between eight and twelve percent. This percentage falls below ten percent (ranging between four and seven percent) only for the highest income group.[21] In addition, Judith Feder, Marilyn Moon, and William Scanlon (Feder study) reported that the elderly spent an average of eleven and two-tenths percent of their per capita income on acute health care.[22] Over one-fifth spent more than fifteen percent of their income on acute health care.[23] Moreover, over ninety percent of the elderly with catastrophic health care expenditures had per capita incomes of less than $10,000.[24]

The Feder study also confirmed that catastrophic burdens do not come from large dollar expenditures.[25] Two-thirds of the elderly spent less than $1,500 on health care, and only fifteen and six-tenths percent spent $2,000 or more on health care.[26] Elderly with per capita incomes of $10,000 or less (poor elderly) incurred out-of-pocket expenses which averaged fourteen percent of income.[27] This rate was roughly two times the share paid by the elderly with incomes greater than $10,000 (non-poor elderly).[28] Using an amount greater than fifteen percent of income as a measure of catastrophic health care expenditures, there is a sharp differential impact on the poor as opposed to the non-poor elderly. Almost one-quarter of all elderly incurred catastrophic expenses. Of this group, over one-third of the poor elderly had this expense, compared with only about six percent of the non-poor elderly.[29]

What accounts for the high expenditures on acute-care for the elderly? Davis and Rowland reported that Medicare cost sharing and the Medicare Part B premium accounted for over half of high cost acute-care expenses. Moreover, spending on uncovered services (particularly prescription drugs) accounted for almost another third of these expenses.[30]

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21. Author's calculations are based on data reported at Christensen, *supra* note 14, at 399.
22. Feder, Moon & Scanlon, *Medicare Reform: Nibbling at Catastrophic Costs*, 6 HEALTH AFF. 5, 7 (Winter 1987).
23. *Id.*
24. *Id.* at 8.
25. *Id.*
26. *Id.*
27. *Id.* at 7-8.
28. *Id.* at 8.
29. *Id.*
30. DAVIS & ROWLAND, *supra* note 9, at 35.

III. THE MEDICARE CATASTROPHIC COVERAGE ACT OF 1988

A. Health Care Financing for the Elderly Prior to MCCA

Before the passage of MCCA, many of the elderly were able to finance catastrophic health care expenditures through the purchase of private Medigap insurance.[31] These policies were designed to cover the deductibles and copayments required under Medicare. Christensen, Long, and Rodgers analyzed the acute-care catastrophic health care expenditures of the elderly in terms of their present insurance coverage.[32] Based on their source of health insurance coverage, three categories of elderly were identified:

1. Medicare only coverage;
2. Medicare and Medigap coverage; and
3. Medicare and Medicaid coverage.[33]

The distribution of the elderly in these three categories was twenty percent, seventy-two percent and eight percent, respectively.[34] Nearly eleven percent of acute-care costs were paid out-of-pocket by the enrollees.[35] Moreover, aged Medicare enrollees paid another seventeen and one-half percent of acute-care costs in insurance premiums for Medicare Part B and/or Medigap insurance.[36]

Table 5 summarizes the study's results for the three categories of the elderly. The elderly with only Medicare coverage incur the highest percentage of health expenditures from out-of-pocket costs.[37] They pay relatively more than twice as much of their health expenditures as those who have Medigap policies.[38] Yet, both groups finance about thirty percent of their total expenditures when health insurance premiums are included. Nonetheless, those who have the supplemental coverage are potentially less vulnerable to high health care expenditures because of this added protection. Yet, only those elderly who are covered by both Medicare and Medicaid are fully covered for their health care expenditures.[39]

There is an additional equity concern with the elderly. Tables 6 and 7 show the unequal distribution of health insurance coverage according to the three populations analyzed in the Christensen study. The lower income eld-

31. Christensen, *supra* note 14, at 415; *see also* Rice & Gabel, *Protecting the Elderly Against High Health Care Costs*, 5 HEALTH AFF. 5, 10 (Fall 1986).
32. Christensen, *supra* note 14, at 398.
33. *Id.*
34. *Id.* at 404-05.
35. *Id.* at 399.
36. *Id.*
37. *Id.* at 402.
38. *Id.* at 401.
39. *Id.* at 402.

TABLE 5: ESTIMATED AVERAGE ACUTE HEALTH CARE COSTS AND MEANS OF PAYMENT, FOR AGED MEDICARE ENROLLEES, BY INSURANCE COVERAGE (1987)

	Enrollee group, by insurance coverage			
	All Enrollees	Only Medicare	Medicare + Medigap	Medicare + Medicaid
Total acute health care costs (in dollars per enrollee)*				
All enrollees	3,351	3,254	3,220	4,725
With no hospital stays	817	752	808	1,090
With hospital stays	12,213	12,082	12,185	12,600
Share (in dollars) of enrollees' costs paid by**				
Medicare	2,414	2,346	2,288	3,677
Medicaid	87	0	0	1,048
Premiums	585	215	757	0
Out-of-pocket	361	693	310	0
Share (in percent) of enrollees' costs paid by**				
Medicare	72.0	72.1	71.0	77.8
Medicaid	2.6	0.0	0.0	22.2
Premiums	17.5	6.6	23.5	0.0
Out-of-pocket	10.8	21.3	9.6	0.0

SOURCE: Christensen, Long & Rodgers, *Acute Health Care Costs for the Aged Medicare Population: Overview and Policy Options*, 65 MILBANK Q. 397, 400 (1987)

*Includes all costs for Medicare-covered services (including cost for all inpatient days and for balance-billing by physicians) and for prescription drugs, whether paid as insurance benefits or out-of-pocket by Medicare enrollees.

**The shares sum to more than 100% of total costs for Medigap enrollees and for all enrollees because of administrative expenses (above benefit costs) included in Medigap premiums.

TABLE 6: PERCENT DISTRIBUTION OF AGED BY DEMOGRAPHIC CHARACTERISTICS, INCOME AND HEALTH INSURANCE COVERAGE (1984)

		Insurance Group		
Family Income	All Enrollees	Only Medicare	Medicare + Medigap	Medicare + Medicaid
< 5,000	12	17	7	42
5,000-8,999	22	33	18	31
9,000-14,999	24	25	25	11
15,000-24,999	23	16	27	8
25,000 +	19	10	23	8
Total	100	100	100	100
By Poverty Status				
Poor	12	18	6	47
Non Poor	88	82	94	53

SOURCE: Christensen, Long & Rodgers, *Acute Health Care Costs for the Aged Medicare Population: Overview and Policy Options*, 65 MILBANK Q. 397, 407 (1987)

TABLE 7: PERCENT DISTRIBUTION OF AGED BY INCOME AND HEALTH INSURANCE COVERAGE (1984)

Family Income	All Enrollees	Only Medicare	Medicare + Medigap	Medicare + Medicaid
< 5,000	100	29	44	28
5,000-8,999	100	30	59	12
9,000-14,999	100	21	76	4
15,000-24,999	100	14	83	3
25,000 +	100	10	87	3
By Poverty Status				
Poor	100	32	35	33
Non Poor	100	19	77	5
All Enrollees	100	20	72	8

SOURCE: Christensen, Long & Rodgers, *Acute Health Care Costs for the Aged Medicare Population: Overview and Policy Options*, 65 MILBANK Q. 397, 408 (1987)

erly have a much higher chance of coverage only through Medicare.[40] Nearly thirty percent of aged enrollees with incomes under $9,000 lacked private insurance coverage and were ineligible for Medicaid in 1984. These results indicate that potentially large out-of-pocket expenditures for acute-care exist primarily for the twenty percent of the elderly without supplemental coverage. Moreover, this group tends to be older, sicker, and less affluent than the group that purchases Medigap coverage.[41]

Thomas Rice and Nelda McCall found in a study of six states that those residents who were least able to afford the cost of a major illness—and therefore most in need of supplemental coverage—were the least likely to have it.[42] The group included non-white, low-income elderly in poor health.[43] Analysis of data from the 1980 National Medical Care Utilization and Expenditure Survey (Garfinkel study) confirmed these results.[44] The private Medicare supplement was smaller than average for low-income persons who were less educated, unemployed, non-white, older (75+ years), and in poorer health.[45] Moreover, most of the Medigap policies did not provide coverage where Medicare was obviously lacking—physician charges above the Medicare payment, prescription drugs, and nursing home care.[46]

B. The Impact of the MCCA

Table 8 provides a brief summary of the major changes in health care coverage and financing introduced by the Medicare Catastrophic Coverage Act of 1988.[47] The Act focused primarily on acute-care and thus expanded the benefits received under Medicare Parts A and B.[48] The major changes in coverage in Part A were: (i) covered hospital days were made unlimited and (ii) beneficiary copayments for hospital stays were eliminated.[49] There was increased coverage for qualified stays in a certified skilled nursing facility,

40. *Id.* at 403.

41. *Id.* at 406.

42. Rice & McCall, *The Extent of Ownership and the Characteristics of Medicare Supplemental Policies*, 22 INQUIRY 188, 196 (Summer 1985).

43. *Id.* at 193.

44. Garfinkel, Bonito & McLeroy, *Socioeconomic Factors and Medicare Supplemental Health Insurance*, 9 HEALTH CARE FIN. REV. 21 (Fall 1987).

45. *Id.* at 22-23.

46. *Id.* at 22; *see also* Christensen & Kasten, *Covering Catastrophic Expenses Under Medicare*, 7 HEALTH AFF. 79, 86 (Winter 1988).

47. Pub. L. No. 100-360, 102 Stat. 683 (codified as amended in scattered sections of 42 U.S.C.).

48. S. Christensen & R. Kasten, The Medicare Catastrophic Coverage Act of 1988 1 (Congressional Budget Office Staff Working Paper, Oct. 1988) [hereinafter Working Paper].

49. Pub. L. No. 100-360, § 101(1)(a), 102 Stat. 683, 685.

hospice care, and home health care.[50] The MCCA added to Part B a provision for prescription drug coverage[51] and limited out-of-pocket expenses for physician services.[52] The Act also added new coverage for mammography screening[53] and a new respite care provision for payment to a family member caring for an elderly person.[54]

Medicare enrollees (elderly and disabled) had the burden of financing these new and expanded coverages.[55] This approach was in accord with the philosophy of the benefits principle of equity practiced by the Reagan Administration. Secretary Bowen had originally proposed an additional fixed monthly premium to be paid by all enrollees.[56] Congress retained the idea of an overall benefits principle of equity but altered this proposal by adopting one more focused on the ability-to-pay approach, thereby creating a more complex financing mechanism. As passed by Congress, the flat financing mechanism of the MCCA called for gradual increases in the fixed monthly premium for the optional Part B coverage.[57] This began as a four dollar increase per month in 1989, and would have risen to ten dollars and twenty cents per month in 1993 for catastrophic benefits.[58] But Congress, fearful of the eventual impact on the lower income elderly, decided to collect sixty-three percent of the cost via an income related supplemental premium.[59] It was estimated that about two-fifths of the elderly would be liable for this supplemental premium,[60] which cost twenty-two dollars and fifty cents per $150 of federal tax liability up to a cap of $800 per year for individuals and $1,600 for couples.[61] This amounted to an income surtax that was mainly aimed at the upper income elderly.

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50. Pub. L. No. 100-360, §§ 205-206, 102 Stat. 683, 729-32; *see also* Iglehart, *Medicare's Benefits: "Catastrophic" Health Insurance*, 320 NEW ENG. J. MED. 329, 330 (1989).

51. Pub. L. No. 100-360, § 202, 102 Stat. 683, 702-21.

52. Pub. L. No. 100-360, § 201(a), 102 Stat. 683, 700; *see also* Christensen & Kasten, *supra* note 45, at 80.

53. Pub. L. No. 100-360, § 204, 102 Stat. 683, 725-29.

54. Pub. L. No. 100-360, § 205, 102 Stat. 683, 729-31.

55. Working Paper, *supra* note 48, at 7.

56. Christensen & Kasten, *supra* note 46, at 80.

57. Working Paper, *supra* note 48, at 7.

58. *Id.*

59. H.R. CONF. REP. No. 661, 100th Cong., 2d Sess. 160, *reprinted in* 1988 U.S. CODE CONG. & ADMIN. NEWS 923, 938.

60. For a discussion of disproportionate payments, see Rovner, *Senate Finance Tilting Toward A Cut in Medicare Surtax*, 47 CONG. Q. 1329 (1989); *see also* U.S. House of Representatives, Select Committee on Aging, Press Release (Aug. 16, 1989) (detailing proposed "Catastrophic Fairness Amendment" to shift costs of MCCA away from poor and middle income persons).

61. Pub. L. No. 100-360, § 111(a), 102 Stat. 683, 689-98; *see also* H.R. CONF. REP. No. 661, 100th Cong., 2d Sess. 153, *reprinted in* 1988 U.S. CODE CONG. & ADMIN. NEWS 923, 931.

TABLE 8: A COMPARISON OF THE MEDICARE PROGRAM AFTER THE ENACTMENT AND REPEAL OF MEDICARE CATASTROPHIC HEALTH INSURANCE (1988-1990)

CATEGORIES OF SERVICES AND FINANCE	MEDICARE HEALTH INSURANCE PROGRAM (1988)	MEDICARE CATASTROPHIC HEALTH INSURANCE PROGRAM (1989)	MEDICARE AFTER REPEAL OF MEDICARE CATASTROPHIC HEALTH INSURANCE (1990)
MEDICARE PART A: HOSPITAL COVERAGE			
SERVICES			
Inpatient Hospital Services	90 days per spell of illness plus 60 day lifetime reserve days.	Covers all hospitalization cost after patient pays a single deductible.	Repeals unlimited hospital coverage and returns to original Medicare Care Act restrictions.
Psychiatric Care	190 day limit.	Psychiatric limit remains.	
Skilled Nursing Care	100 days for qualified stays in a skilled nursing facility. Requirement that a beneficiary be hospitalized for at least 3 days prior to entry into a skilled nursing facility.	150 days for qualified stays in a skilled nursing facility. Eliminates requirement that a beneficiary be hospitalized for at least 3 days prior to entry into a skilled nursing facility.	Repeals expanded coverage of skilled nursing home care.
Hospice Care	210 day limit.	Unlimited stay.	Repeals expanded coverage of hospice stay.
Home Health Care	Consecutive 21 day limit.	Extends consecutive day limit to 38.	Repeals expanded coverage of home health care.
FINANCE			
Deductible	Inpatient deductible of the average cost of a patient day per spell.	Retains inpatient deductible.	Retains inpatient deductible.
	Blood deductible up to 3 units per spell.	Blood deductible reduced to 3 units per year.	Retains new blood deductible.
Coinsurance	Hospital coinsurance paid for 61-90 days and for reserve days.	Eliminates hospital coinsurance.	Reverts to original hospital coinsurance.
	Skilled nursing facility copayment for 21-100 days.	Skilled nursing facility copayment for 1-8 days.	Reverts to original skilled nursing home coinsurance.
Premium	Basic flat premium.	Imposes a supplemental income-related premium based on tax liability up to a cap of $800 per enrollee.	Repeals supplemental premium.

Categories of Services and Finance	Medicare Health Insurance Program (1988)	Medicare Catastrophic Health Insurance Program (1989)	Medicare After Repeal of Medicare Catastrophic Health Insurance (1990)
Supplemental Medical Insurance Part B: Physician and Outpatient			
Services			
Physician and Outpatient Services	Physician services. Hospital outpatient services. Laboratory services. Ambulatory surgical services. Drugs for transplant patients.	Adds coverage for mammography screening. Adds prescription drug coverage (to be phased in over 1991-1993). New coverage for respite care (up to 80 hours per year) to unpaid family member.	Repeals new coverage for mammography screening. Cancels future prescription drug coverage. Repeals extended coverage for respite care.
Finance			
Deductible	Annual deductible of $75.	Annual deductible of $75 counts toward out-of-pocket cap. Adds prescription drug deductible ($600 in 1991).	Repeals out-of-pocket cap on all expenses. Reverts to unlimited liability.
Coinsurance	20% of physician charges plus excess of physician charges. No copayment cap.	20% of physician charges but sets a cap on out-of-pocket costs at $1370 after which Medicare pays full cost of approved charges for covered services. 50% copayment in 1991 to be reduced to 20% in 1993 for prescription drug coverage. Stipulates cap is to be raised to hold constant 7% proportion of beneficiaries.	
Premium	Basic flat premium.	Flat premium in staged increases (1989-1993) to pay for new catastrophic and prescription drug coverage.	

CATEGORIES OF SERVICES AND FINANCE	MEDICARE HEALTH INSURANCE PROGRAM (1988)	MEDICARE CATASTROPHIC HEALTH INSURANCE PROGRAM (1989)	MEDICARE AFTER REPEAL OF MEDICARE CATASTROPHIC HEALTH INSURANCE (1990)
MEDICARE-MEDICAID CHANGES			
SERVICES			
Medicaid coverage for Pregnant Women and for Infants	Varies according to stipulated States' eligibility requirements and coverages.	Requires States to provide Medicaid coverage for prenatal care and coverage for infants up to 1 year of age.	Maintains requirement for States to provide Medicaid coverage for pregnant women and infants up to one year of age if income is below the federal poverty level.
Spousal Impoverishment for Nursing Home Care	Spouse must exhaust his/her income and most assets in order to be eligible for Medicaid coverage of nursing home care.	Curbs assets and income "spend down" requirements for eligibility for Medicaid coverage for nursing home care.	Maintains higher limits on income and assets permitted to spouse of Medicaid nursing home recipient.
FINANCE			
Premiums	Elderly and disabled must meet States' eligibility standards for Medicaid coverage. Non-eligible poor elderly and disabled are required to pay Medicare premiums, deductibles, and coinsurance.	Requires States to pay Medicare premiums, deductibles, and coinsurance charges for elderly and disabled beneficiaries whose incomes are below the federal poverty line but who are not poor enough to otherwise qualify for Medicaid coverage.	Maintains State payments of Medicare premiums, deductibles, and coinsurance for elderly and disabled poor.
MISCELLANEOUS			
		Establishes a bipartisan Commission on Comprehensive Care to examine shortcomings in the current health care delivery and financing mechanisms that limit or prevent access to comprehensive care.	Maintains this Commission as the Pepper Commission to make recommendations for legislation to cover the costs of long-term care for the elderly and to ensure adequate health insurance coverage for the estimated 37 million uninsured Americans.

SOURCE: Adapted from S. Christensen, Impact of the Medicare Catastrophic Coverage Act on Enrollees by Selected Demographic Characteristics (Congressional Budget Office Memorandum, Jan. 5, 1989); S. Christensen & R. Kasten, The Medicare Catastrophic Coverage Act of 1988 (Congressional Budget Office Staff Working Paper, Oct. 1988); *Catastrophic-Costs Bill Is Sent to White House*, 46 CONG. Q. 1606 (1988)

The Act also established a new limit of $1,370 on out-of-pocket costs related to the twenty percent coinsurance feature of physician charges.[62] Above this cap Medicare would pay all approved charges for covered services. In addition, a prescription drug deductible of $600 (for 1991) and a fifty percent copayment provision were added.[63]

The Act also called for certain changes in the relationship between the Medicare and Medicaid programs.[64] It set a much higher limit on the amount of income and assets that the spouse of a Medicaid beneficiary could retain and still be eligible for nursing home care under Medicaid.[65] The Act required the states to pay Medicare required premiums, deductibles, and coinsurance charges for the elderly and for disabled Medicare beneficiaries with income below the federal poverty line but who were not poor enough by state standards to qualify for Medicaid coverage.[66] Each of these changes were to be financed through the states rather than through Medicare premiums.[67]

Table 9 reveals the impact of the financing mechanism for the MCCA. Two-thirds of the single elderly and almost half of the married elderly paid only the base premium. At the other extreme, only five to six percent of single or married elderly paid the maximum supplemental premium. Table 10 provides a more accurate picture of the impact on the elderly by income class. All elderly with incomes at or below $10,000 would have been spared the supplemental premium. Those hardest hit would have been single beneficiaries with incomes of $40,000 and those married beneficiaries with incomes of $80,000. The combined increase in the basic and supplemental premium contributions would have amounted to about two percent of their incomes.

C. Estimating the Financial Impact of MCCA on the Elderly: Costs vs. Benefits

Sandra Christensen and Rick Kasten simulated the effects of the passage of the MCCA on the elderly population for the calendar year 1988.[68] Their analysis assumed that all of the benefits would be available to the elderly in the first year and that no enrollee would be liable for copayments in excess of

62. Pub. L. No. 100-360, § 201(a), 102 Stat. 683, 699-702.
63. Pub. L. No. 100-360, § 202(b), 102 Stat. 683, 704-13.
64. Working Paper, *supra* note 48, at 5.
65. *Id. See generally* MUSGRAVE & MUSGRAVE, *supra* note 8.
66. Working Paper, *supra* note 48, at 5.
67. *Id.*
68. Christensen & Kasten, *supra* note 46; *see also* S. Christensen, Impact of the Medicare Catastrophic Coverage Act on Enrollees by Selected Demographic Characteristics (Congressional Budget Office Memorandum, Jan. 5, 1989).

TABLE 9: IMPACT OF MCCA PREMIUMS ON ELDERLY (1989)

Premium Charged	Percent Distribution of Premium: Married Enrollees (%)	Single Enrollees (%)
Basic Premium Only	47.5	66.3
< 250	27.2	21.0
250-499	9.4	4.6
500-799	9.9	2.6
800	5.9	5.4

SOURCE: Rovner, *Catastrophic Insurance Law: Costs vs. Benefits*, 46 CONG. Q. 3450, 3451 (1988) (data collected by American Association of Retired Persons)

TABLE 10: INCIDENCE OF SUPPLEMENTAL PREMIUM BY HOUSEHOLD INCOME GROUP OF ELDERLY (1989)

Household Income	Married Enrollees (Prems./Person)	Single Enrollees (Prems.)
$10,000	0	0
15,000	N/A	$68
20,000	23	N/A
45,000	N/A	800
90,000	800	800

SOURCE: Rovner, *Catastrophic Insurance Law: Cost vs. Benefits*, 46 CONG. Q. 3450, 3450 (1988)

$2,500.[69] One of the major objectives of the MCCA was to protect those Medicare enrollees currently without supplemental coverage against very high copayment costs.[70] A key finding was that the net result of the MCCA was to reduce the out-of-pocket costs (direct costs plus premiums) for the poor and the near poor enrollees while increasing costs for other groups.[71]

Table 11 is an extension of the simulation provided by Christensen and Kasten.[72] The MCCA would generate a financial gain for lower income enrollees and a financial loss for the higher income group.[73] In effect, there would have been an income transfer from the more fortunate to the less

69. Christensen & Kasten, *supra* note 46, at 85, 88.

70. *Id.* at 88-89.

71. *Id.* at 89-90.

72. *Id.*

73. *Id.* at 90.

TABLE 11: SIMULATED BENEFITS AND PREMIUM COSTS IMPACTS ON MEDICARE ENROLLEES UNDER MEDICARE CATASTROPHIC HEALTH INSURANCE ACT (1989)

Per Capita[1] Income	Average[1] Income	Percent of[1] Enrollees	Benefits[1] per Enr.	Premium[1] Costs per Enr.	B/C[2]	Net[2] Benefits	Net[2] Benefits as % of Income
0 to 10	2,881	10	2,295	204	11.25	2,091	72.6
11 to 30	5,623	20	2,660	436	6.10	2,224	39.6
31 to 50	8,575	20	2,837	614	4.12	2,223	25.9
51 to 70	12,604	20	2,924	753	3.88	2,171	17.2
71 to 90	19,579	20	2,945	1,000	2.95	1,945	9.9
91 to 100	52,291	10	2,744	1,262	2.17	1,482	2.8
By Poverty Status							
Poor		12.8	2,040	122	16.72	1,918	—
Near Poor		19.4	2,946	522	5.64	2,424	—
Other		67.8	2,869	870	4.05	1,999	
	All	100.0	2,777	708	3.92	2,069	—

SOURCE: [1] S. Christensen & R. Kasten, The Medicare Catastrophic Coverage Act of 1988 (Congressional Budget Office Staff Working Paper, Oct. 1988)

[2] Author's calculations

fortunate elderly.[74] Yet, all enrollees would continue to receive a subsidy in total benefits from Medicare.[75]

Since the program was defined as budget-neutral—i.e., it would leave unaffected net federal expenditures—the new premiums were designed to exceed the overall projected benefit payments.[76] The new premium liabilities would have been less than the new projected benefits for the lower income enrollees and would have been higher than the projected benefits for the higher income elderly.[77] This is seen in Table 12.

Having analyzed the impact of the MCCA, the causes of its repeal are next examined.

IV. The Causes of the MCCA Reversal

Seven key factors that led to the reversal of MCCA bear significantly to the equity issues discussed in this article.

First and foremost, the method of financing a health insurance program for a presumed dependent subgroup of the population was unprecedented and clearly reflected a change in the then applied concept of economic equity. President Reagan and Secretary Bowen applied a benefits principle toward intergroup equity; those who benefitted from the provision of this program would pay for it. Moreover, applying a fixed-premium payment to all elderly suggested an intraelderly equity principle based on an equal dollar sacrifice.

Congress' view of financial equity stemmed from both the benefits principle and the ability-to-pay principle. The former was applied to intergroup equity across income classes and age groups in society; only those receiving immediate benefits would be required to pay. The compromise financing mechanism of the fixed premium and income-adjusted supplemental premium applied the ability-to-pay principle to intraelderly equity. This payment mechanism required a minimum equal dollar payment of which all elderly contributed and an additional payment based on a progressive tax on the elderly who pay federal income tax.

Only in terms of the truly indigent Medicare population did the generally accepted ability-to-pay principle of intergroup equity apply. The out-of-pocket health care expenditures of the near poor elderly and disabled were to be financed by the rest of the population.

The view of economic equity which applied to the elderly under the

74. *Id.*
75. *Id.*
76. *Id.* at 91.
77. *Id.*

TABLE 12: SIMULATED MARGINAL BENEFITS AND MARGINAL PREMIUM COST IMPACTS ON MEDICARE ENROLLEES UNDER MEDICARE CATASTROPHIC HEALTH INSURANCE NET (1989)

			Impact Measures					
Per Capita Income Percentiles[1]	Average Income[1]	% of Enr.[1]	Marginal Bene./ Enr.[1]	Marg. Bene. as % of Inc.[2]	Marginal Premium Cost/ Enr.[1]	Marg. Prem. Cost as % of Income[2]	Net Charge Out of Pocket Exp./Enr.[2]	Net Charge Out of Pocket Exp./Enr. as % of Income[2]
0 to 10	2,881	10	243	8.43	−139	−4.83	−382	−13.26
11 to 30	5,623	20	160	2.85	−34	−0.60	−194	−3.45
31 to 50	8,575	20	113	1.32	+23	+0.27	−90	−1.05
51 to 70	12,604	20	112	0.89	+89	+0.71	−23	−0.17
71 to 90	19,579	10	101	0.51	+302	+1.54	+201	+0.33
91 to 100	52,291	10	91	0.18	+522	+1.00	+431	+0.17
By Poverty Status								
Poor		12.8	225	—	+194			
Non Poor		19.4	124	—	+19			
Other		67.8	105	—	+199			
All Enrollees		100.0	130	—				

Net Change in Out-of-pocket Expenses/ENR = − (Marginal Benefits/ENR − Marginal Premium Cost/Enr)
Near Poor: Poverty Level < Income < 1.5 Poverty level
SOURCE: [1] S. Christensen & R. Kasten, The Medicare Catastrophic Coverage Act of 1988 15, 22 (Congressional Budget Office Staff Working Paper, Oct. 1988)
[2] Author's calculations

MCCA clearly represented a break with tradition. Historically, the equity principle for financing the health care of the elderly under Medicare was based on intergroup equity. That is, the elderly would be asked to finance a small amount of their health care, but the vast majority of the population would be required to subsidize the elderly's health care expenditures. The financing equity principle was to be based on one's ability to pay, with the elderly considered more dependent and financially vulnerable. Therefore, equity across groups in the United States would call for a financing mechanism which transferred income from the generally more affluent and younger population to the less affluent and older population. This viewpoint was based upon the Government's accepted function of creating a fair distribution of public services. The MCCA, however, altered this long-standing view of equity as applied in public distribution policy.

In addition to asking the elderly to shoulder the burden of their own health benefits package, their marginal tax rates were increased at a time when the marginal tax rates for the rest of the population were being reduced. While the rest of the population was placed into three tax brackets of fifteen percent, twenty-eight percent, or thirty-three percent after the 1986 Tax Reform Act,[78] the elderly's marginal tax rate increased from fifteen percent to twenty-two percent in the very first year.[79] Their tax liability continued to grow every year thereafter because taxes were to increase automatically each year to pay for the anticipated future benefits. The Treasury Department estimated that the elderly would face a marginal tax rate of twenty-five percent by 1992.[80] The supplemental premium amounted approximately to a fifteen percent surtax (a tax on a tax liability) of those with at least a $150 tax liability. As a result, the elderly faced a higher income tax burden at various income ranges than did many other taxpayers, creating a great tax inequity.

Third, the more affluent elderly opposed the MCCA. Many elderly complained of the sharp increase in premiums that they would be forced to pay; a minority of the elderly (the top forty percent) were being asked to subsidize the cost of new benefits for the majority (the other sixty percent).[81] Yet, the very subgroup of the elderly bearing this burden were the least in need of

78. Pub. L. No. 99-514, 100 Stat. 2085.

79. Ferrara, *Commentary*, 24 INQUIRY 321, 322 (1987).

80. *Id.*; *see also* Ostrow, *Reagan Scores House Medical Plan*, L.A. Times, July 26, 1987, at I4, col. 1.

81. On the eve of the Congressional repeal of the MCCA, Arizona Senator John McCain warned that a total repeal would "cause a backlash of enormous proportions when the 60 percent who were never going to have to pay the surtax find out that they lose these benefits." Rich, *Congress Nears Repeal of "Catastrophic" Tax and Major Benefits*, Wash. Post, Nov. 22, 1989, at A5, col. 1.

the program. The analysis contained in this article shows that the elderly most covered by Medigap policies had higher incomes, more education, and were in better health while the net benefits of MCCA would accrue to the near poor elderly who could not afford Medigap supplemental policies.

In addition, there were other intragroup inequities generated by the Act. The Act affected members of the affluent elderly differently, thereby violating horizontal equity. For the working elderly, similar or better coverage was already provided by their employers. Moreover, for many of those who were retired and were covered with Medigap policies, the premiums were paid or subsidized by a former employer. Many federal retirees had generous health plans provided by the Government, which at least partially offset the costs.

Congress also made a severe political blunder by front-loading the increased cost of the program. Facing the dilemma of the huge federal budget deficit and the budgetary constraints demanded by the Gramm-Rudman-Hollings Act,[82] Congress raised the premiums for the MCCA much faster, and much sooner, than the actual receipt of benefits by the elderly. This was done to ensure that the MCCA would be sufficiently financed for the projected costs of present and future beneficiaries. The elderly were also aware that future premiums would be increased to help cover future phased-in benefits. Both the high present premiums and the future rising premiums made it difficult for the elderly to assess their benefits relative to the costs. Moreover, many of the affluent elderly believed that they would pay more for catastrophic coverage than they were paying for Medigap policies—some with superior coverage. They also perceived that they were being asked to finance the health care expenditures of a large and more expensive group of beneficiaries.

The original Medicare Act called for coverage of the aged (65 years or older).[83] In the 1972 Social Security Act Amendments, Congress added coverage for disabled persons who had received cash benefits for at least twenty-four months under the disability insurance provisions of the Social Security Act.[84] Opponents of the MCCA raised the specter of the high cost of AIDS care being forced upon the elderly.[85] This was because, under Social Security Disability coverage, individuals with various disabling diseases (including

82. Balanced Budget and Emergency Deficit Control Act of 1985, Pub. L. No. 99-177, 99 Stat. 1037 (codified principally at 2 U.S.C. § 901 (Supp. 1990)).

83. Pub. L. No. 89-97, 79 Stat. 286 (1965) (current version at 42 U.S.C. § 1395c (Supp. 1990)).

84. 42 U.S.C. § 1395c (Supp. 1990).

85. *See, e.g.*, Rovner, *Reagan Threatens a Veto: House OK's Medicare Expansion Despite Reservations Over Cost*, 45 CONG. Q. 1637, 1638-39 (1987).

AIDS) were eligible for Medicare after the two-year waiting period.[86] Congress also expanded coverage to include indigent mothers and infants.[87] Since future increases in MCCA premiums were tied to the growth of Medicare health care expenditures, the affluent elderly were greatly concerned that they were being asked to finance the benefits of two potentially very expensive (and dependent) groups in the population.

They were greatly misled. The expanded coverage for indigent mothers and infants was to come under Medicaid and was thus financed by general revenues of federal and state governments, not Medicare premiums. In addition, the Social Security Disability provision was not disease-specific (in other words, not only related to AIDS victims).[88] Many AIDS victims die long before the two-year waiting period is realized, an unfortunate reality that indirectly benefitted the elderly in economic terms. It has been estimated that AIDS patients would account only for one percent of the projected 1993 Medicare expenditures.[89]

Finally, the Act failed to address the elderly's real perceived need for catastrophic health care coverage related to long-term care.[90] When the MCCA was introduced, many elderly believed that it would cover long-term nursing home care.[91] In actuality, it did not. This left the elderly as financially vulnerable to the danger of needing long-term care as they were before the passage of the Act. Although many elderly are acutely aware of the need to "spend down" their assets below the stringent welfare requirements in order to receive Medicaid, this eligibility requirement could force them into poverty and dependency, two of the elderly's greatest fears.[92] Estimates have

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86. *Id.*

87. 42 U.S.C. § 1396d(n) (Supp. 1990).

88. The insurance program for which entitlement is established by sections 426 and 426-1 of this title provides basic protection against the costs of hospital, related post-hospital, home health services, and hospice care in accordance with this part for . . . (2) individuals under age 65 who have been entitled for not less than 24 months to benefits under subchapter II of this chapter (or would have been so entitled to such benefits if certain government employment were covered employment under such subchapter) or under the railroad retirement system on the basis of the disability . . . .

42 U.S.C. § 1395c (Supp. 1990); *cf.* 42 U.S.C. § 1395c(3) (Supp. 1990) ("certain individuals who did not meet the conditions specified in either clause (1) or (2) but who are medically determined to have end stage renal disease").

89. Rovner, *Catastrophic-Insurance Law: Costs vs. Benefits*, 46 CONG. Q. 3450, 3451 (1988).

90. "Long-term care refers to care, medical or otherwise, needed by chronically ill or disabled individuals who need assistance in dressing, bathing, feeding themselves and other tasks of daily living." Rovner, *Issue is Gaining Political Momentum: Lawmakers Taking Hard Look At Problem of Long-Term Care*, 46 CONG. Q. 938, 938 (1988).

91. Cohen, *supra* note 10, at 501.

92. Rice & Gabel, *supra* note 31, at 6.

indicated that the probability of an elderly person entering a nursing home or some type of long-term care facility is between twenty-five and forty-three percent.[93] Medicare Catastrophic Health Insurance, like the entire program itself, failed even to address this problem.

In summary, the Medicare Catastrophic Health Insurance Act was repealed because:

1. It applied to the elderly a new benefits principle of equity instead of the established ability-to-pay principle.

2. It violated principles of horizontal equity by treating all elderly equally when they were very unequal in terms of the health insurance premiums and tax burdens they shouldered.

3. In terms of intergroup tax equity, it raised the elderly's tax burden relative to the rest of the population during an era of tax reduction.

4. It attempted to solve a problem—catastrophic health expenditures for acute-care—that was perceived to affect all of the elderly but which, upon closer examination, only affected the less affluent (and less vocal) minority of the elderly.

5. It raised fears in the affluent elderly that they would be forced to pay much higher premiums than they actually would have incurred for coverage of their less fortunate aged group members as well as other dependent populations.

6. It front-loaded the costs of the program and delayed some of the benefits, making it appear that the benefits were not worth the costs.

7. It failed to address the elderly's major fear of financial catastrophe—long-term care.

V. Catastrophic Health Care Expenditures and Unresolved Equity Issues

So the question remains: Do the elderly need catastrophic health insurance coverage? And, if so, who should finance such a program? The answer appears to be twofold. For acute-care, only a minority of the elderly require additional coverage. For long-term care, there is a much greater need for the vast majority of the elderly. Yet, contained within this issue are the unresolved economic equity issues raised at the beginning of this article.

A. Intergroup Equity

Are the elderly as a group relatively poor as some analysts have claimed?

93. Cohen, Tell & Wallack, *The Lifetime Risks and Costs of Nursing Home Use Among the Elderly*, 24 Med. Care 1161, 1167 (1986) [hereinafter *Lifetime Risks*].

Or are they now more affluent and not in need of a subsidy from the rest of the population? The critical equity concern here is whether the elderly are still a dependent group. If they are, then the rest of society should finance their health expenditures under the ability-to-pay principle. If they have the capacity to finance their own care, then they should finance their own health care expenditures under the benefits principle; society should use its scarce resources to subsidize the care of other truly needy dependent groups.

Stephen Crystal argues that "[e]conomic disadvantage is widely perceived to be typical of the elderly."[94] When Medicare was implemented, poverty was widespread among the elderly. In 1967 roughly thirty percent of the elderly were classified at or below the official poverty line. With the persistence of this view, society's response through public policy has been to upgrade greatly the relative economic status of the elderly. Large subsidies to the elderly, both in income and in-kind goods and services, have greatly reduced, if not eliminated, the economic gap between the elderly and the rest of the population. This was evident even during the Reagan years of budget reallocation away from social services and general assistance to the poor.[95]

In addition, Paul Feldstein argues that the income of the elderly, relative to the non-elderly, has been largely underestimated, thereby making it appear that the elderly are relatively poorer than they actually may be.[96] He cites five reasons for this downward bias: (i) the aged pay on average much lower taxes compared to the rest of the population; (ii) they have a much higher proportion of fully owned homes; (iii) imputed rent on such in-kind value would substantially raise their incomes; (iv) they receive many in-kind subsidies such as housing, food stamps, meal services, and health care; and (v) they earn a disproportionate share of different types of income (e.g., pensions, interest, and dividends) that typically are underreported.[97]

Crystal attempted to adjust the income of the elderly for differential tax rates and underreporting of income and found that the after-tax average household income of the elderly in 1983 would rise to ninety-three percent of the non-elderly compared to seventy-one percent without these adjustments.[98] In general, he reported that the income of the elderly is underreported by roughly eleven percent. Moreover, the sources of income that are most underreported constitute a greater proportion of income for the higher

94. Crystal, *Measuring Income and Inequality Among the Elderly*, 26 GERONTOLOGIST 56, 56 (1986).

95. Moon, *Impact of the Reagan Years on the Distribution of Income of the Elderly*, 26 GERONTOLOGIST 32, 34 (1986).

96. P. FELDSTEIN, HEALTH CARE ECONOMICS 564-65 (3d ed. 1988).

97. *Id.*

98. Crystal, *supra* note 94, at 56-59.

income elderly. As a result, the unequal income distribution of the elderly reported earlier is even greater. Feldstein concludes: "The stereotype of the elderly as a poor group is clearly wrong, although there are certainly many poor elderly."[99]

There is a similar debate about the relative affluence of the elderly. Thomas Getzen proposes that there is a "middle classing"[100] of the elderly and that they are "the wealthiest segment of American society."[101] He reported the distribution of income and wealth for elderly couples and single persons based on a survey of retirees by the Social Security Administration for 1982.[102] Table 13 reveals three characteristics of elderly wealth: (i) it is more unequally distributed than income; (ii) couples have much higher wealth per capita than single elderly; and (iii) single men have much higher wealth than single women. The latter of these is particularly noteworthy because women typically outlive men by five to seven years, and elderly single women presently constitute the greatest proportion of the old aged (seventy-five years of age and over).

More recent data on wealth distribution of the elderly, relative to the rest of the population, also indicate that the elderly are comparatively more affluent than previously believed. Table 14 shows that the wealth distribution of the elderly is much higher than for the rest of the population. Over half of the elderly have wealth accumulations of $50,000 or more, compared to about forty percent of the total population. The relatively higher affluence of the elderly and the value of their assets suggest that they may be much more able to finance long-term care from their wealth.

B. Intraelderly Equity: Rich vs. Poor

Even if the elderly as a group are not as relatively impoverished as first believed, there still remains a very unequal distribution of economic resources among the elderly population itself. In terms of income, Table 13 reflects the wide distribution of income of the elderly, ranging from the lowest group with $8,900 to the highest group with $52,500 for couples in 1982. A relatively lower income position of the single elderly and a relatively poorer status of elderly females also exists. Wealth is even more unevenly distributed; the lowest thirty percent of elderly couples have assets of $6,000 or less and, of elderly singles, have zero financial assets.

While the elderly poor have the fewest resources, the financial burden of

99. FELDSTEIN, *supra* note 96, at 565.

100. Getzen, *Longlife Insurance: A Prototype for Funding Long-Term Care*, 10 HEALTH CARE FIN. REV. 47, 47 (1988).

101. *Id.* at 54.

102. *Id.* at 52.

TABLE 13: DISTRIBUTION OF INCOME AND WEALTH AMONG THE ELDERLY: UNITED STATES (1982)

	Annual Income			Financial Assets			Total Net Worth Including House		
Decile	Couple	Single Male	Single Female	Couple	Single Male	Single Female	Couple	Single Male	Single Female
First	$8,900	$3,800	$3,700	$0	$0	$0	$11,200	$0	$0
Second	12,200	5,300	5,000	1,200	0	0	30,700	0	800
Third	14,800	6,500	6,200	6,000	0	0	46,900	2,200	8,700
Fourth	17,300	8,400	7,500	14,400	900	1,100	61,800	11,000	19,800
Fifth	20,500	10,400	8,800	26,100	5,200	4,800	81,400	20,500	31,900
Sixth	24,200	12,900	10,400	44,200	12,600	10,400	106,800	41,000	44,600
Seventh	29,200	16,100	12,400	89,500	24,700	19,800	140,700	69,800	59,900
Eighth	37,300	21,600	15,900	114,000	55,000	34,600	197,000	102,300	81,800
Ninth	52,500	33,700	21,600	256,500	117,000	68,500	360,000	193,000	126,000
Mean	(28,746)	(16,934)	(11,832)	(126,980)	(52,338)	(27,808)	(186,855)	(85,498)	(55,268)

SOURCE: Getzen, *Longlife Insurance: A Prototype for Funding Long-Term Care*, 10 HEALTH CARE FIN. REV. 47, 52 (Winter 1988)

TABLE 14: WEALTH DISTRIBUTION OF ELDERLY AND TOTAL POPULATION: U.S. (1984)

Income Group	Elderly (%)	Total Pop. (%)	Relative Wealth Position of Elderly[1] (Elderly/Total Pop.)
negative or zero	6.7	11.0	0.61
1 < 4,999	8.7	15.3	0.57
5,000 - 9,999	4.0	6.4	0.63
10,000 - 24,999	9.1	12.4	0.73
25,000 - 49,999	15.5	14.5	1.07
50,000 - 99,999	24.7	19.3	1.28
100,000 - 249,999	23.1	15.3	1.51
250,000 +	8.2	5.9	1.39

SOURCE: U.S. DEPARTMENT OF COMMERCE, HOUSEHOLD WEALTH AND ASSET OWNERSHIP, 1984 18-19 (1986)

[1] Author's estimates

health care disproportionately affects them. Davis and Rowland cite a Congressional Budget Office study showing that out-of-pocket acute-care health expenditures represent two percent of total income in families with incomes in excess of $30,000, while they represent twenty-one percent in families with income of less than $5,000.[103]

Moreover, as seen from the previous discussion of Medigap coverage, potentially large out-of-pocket expenditures for acute care exist primarily for the twenty percent of the elderly who lack private Medigap coverage and are ineligible for Medicaid. This group is older, sicker, less educated, and less affluent than those covered by private supplemental policies. Thus, an intraelderly equity concern remains, which stems from the inequality within the elderly population and the inequity of Government Medicaid policy between the poor and the near poor.

The previous analyses only account for acute-care health expenditures of the elderly. Yet, the elderly's concern about long-term care expenditures and the lack of protection against these expenditures was one of the main causes of their rejection of the MCCA. So, the question arises: What are the economic equity impacts of long-term care expenditures? Very little research has been completed on this question, and much more needs to be done. Rice and Gabel offer an attempt at a much more comprehensive study of the catastrophic health care expenditures faced by the elderly by including both acute-care and long-term care expenditures from two separate data

103. DAVIS & ROWLAND, *supra* note 9, at 35.

sets.[104] They find that the elderly as a group are at the highest risk of incurring high health care expenditures in the population. Even with Medicare, Medicaid, and Medigap policies, twenty-five percent of the elderly's health care expenditures is paid out-of-pocket.[105]

Table 15 presents the out-of-pocket health expenditures by the elderly. This Table shows the types of services that are responsible for high out-of-pocket expenditures. For those with out-of-pocket expenditures of less than $500, ninety-five percent of these expenditures are attributable to physician, drug, and dental services. For the expenditure categories of $500-$1,000 and $1,001-$2,000, these three services still dominate, accounting for eighty-five percent and seventy percent of out-of-pocket expenditures, respectively. Yet, "a dramatic change occurs in the category of people with out-of-pocket expenses over $2,000 a year."[106] Nursing home costs were responsible for over eighty percent of out-of-pocket expenditures.

TABLE 15: PERCENTAGE OF OUT-OF-POCKET HEALTH EXPENDITURES OF THE ELDERLY BY TYPE OF SERVICE (1980)

Category	Less than $500	$501-1,000	$1,000-2,000	More than $2,000
Hospital	2.9	11.5	20.9	10.0
Physician	40.9	34.6	40.9	5.9
Dental	14.0	19.3	12.6	1.7
Drugs	41.1	31.2	16.2	1.2
Nursing Home	1.1	3.5	9.5	81.2
Total	100.0	100.0	100.0	100.0

SOURCE: Adapted from Rice & Gabel, *Protecting the Elderly Against High Health Care Costs*, 5 HEALTH AFF. 5, 16 (1986)

Moreover, the Cohen study found that the expected lifetime costs of nursing home care across all ages are estimated to be between $10,500 and $13,600.[107] Yet, only thirteen percent of the elderly account for ninety percent of all nursing home expenditures. It has also been estimated that, on average, it would take two years of nursing home expenditures to eliminate the average wealth of the elderly.

In sum, these results indicate that the real threat to the financial stability of the elderly is the cost of nursing home care. It is very expensive and has

104. Rice & Gabel, *supra* note 31, at 5.
105. *Id.* at 6.
106. *Id.* at 17.
107. *Lifetime Risks*, *supra* note 93, at 1169.

the potential of being truly catastrophic to the elderly. Despite this threat, the elderly are virtually unprotected from this catastrophic expenditure in terms of insurance coverage, and eventually must rely either on extended family resources or Medicaid. The MCCA would not have been effective in alleviating this risk.

This analysis demonstrates that the distribution of income within the elderly population (intraelderly equity) now poses a more serious concern than the distribution of income between the elderly and the non-elderly population (intergroup equity). Therefore, given the great strides made by the elderly over the past twenty-five years, the fundamental equity concern has shifted from correcting the economically disadvantaged position of the elderly in relation to the rest of the population to the equity concern for a minority of the near-poor disadvantaged elderly. Perhaps it is time to uncouple the concern for old age from the concern for low income.

C. Interfamily Equity: The Inheritance Factor

Another equity issue involves the transfer of the elderly's wealth to their offspring. The wealth of the present elderly generation will be at the disposal of the succeeding generation. Consequently, adult children of the elderly have an economic stake in the protection of this potential inheritance of wealth: Should they be unwilling to finance a health insurance program to protect their elderly parents from economic disaster? The real incentive is to protect elderly parents from having to "spend down" their wealth in order to become eligible for Medicaid. Clearly, the major risk facing the elderly is long-term care expenditures. This concern raises two questions, one conceptual and the other practical.

Conceptually, what is the proper familial unit for analyzing the economic state of the elderly and, ultimately, for creating public policy? Do we focus on the elderly individual or household, or the extended family of the elderly? Past policy analysis has tended to accept the former. Yet, Congress took a small step toward acknowledging the latter view in the MCCA by providing a benefit under the respite care provision for custodial care by a family member.[108] This recognized the link between the elderly parent and the adult child who often has to provide home care.

Practically, the adult children of elderly parents might be willing to finance a catastrophic health insurance program. Clearly, even in this time of budget tightening and new taxes, the adult children of the elderly would be more willing to finance such a program if the program genuinely protected the wealth of the elderly. They might have to be educated about the benefits

108. Pub. L. No. 100-360, § 205(c)(3), 102 Stat. 683, 731 (1988).

of this insurance in the protection of their own future inheritances. However, this requires an approach that would protect against not only catastrophic health expenditures for acute-care, but also long-term care. This protection, for at least some of the elderly, could be purchased privately by the affluent or the extended families of the elderly.

D. Intergenerational Equity

At issue in intergenerational equity is whether too much money is spent on the elderly, foregoing aid to other, more vulnerable (and perhaps more valuable) members of the society, like children. An analysis of the most recent data on poverty status (Table 16) indicates that children are our most impoverished age group in the population.

TABLE 16: NUMBER AND PERCENT OF PERSONS AND FAMILIES BELOW POVERTY LEVEL BY AGE GROUP: U.S. (1988)

Persons			Families		
Age Group	No. (m)	%	Age Group	No. (m)	%
<5 years	10.96	20.5	15-24	0.89	29.7
15-24	5.62	15.7	25-34	2.27	15.0
25-44	7.77	9.8	35-44	1.50	9.2
45-54	1.90	7.7	45-54	0.78	0.9
55-64	2.15	10.0	55-64	0.76	7.8
65 +	3.48	12.0	65 +	0.70	6.6
Total	31.88	13.1	Total	6.88	10.4

SOURCE: U.S. DEP'T OF COMMERCE, MONEY INCOME AND POVERTY STATUS IN THE UNITED STATES: 1988 57, 68 (1989)

The determination of which criteria should be used to guide difficult choices over the allocation of resources in the aging society is at the heart of this question. Echoing the previous discussion of the relative economic position of the elderly, B.L. Neugaerten has "suggested that the heterogeneity of the elderly population means that age is becoming increasingly irrelevant as a criteria for distributing social benefits and that more emphasis should be placed on need."[109]

This concern for intergenerational equity has lead some analysts to conclude that too many resources are consumed by the elderly to the disadvantage of the young. This in turn has raised serious questions about the large

109. Kingson, *Generational Equity: An Unexpected Opportunity to Broaden the Politics of Aging*, 28 GERONTOLOGIST 765, 766 (1988).

allocation of scarce health care resources to the dying elderly. Victor Fuchs has asserted that the United States spends about one percent of its GNP on health care for the elderly who are in their last year of life. He concludes that "[o]ne of the biggest challenges facing policy makers for the rest of this century will be how to strike an appropriate balance between care of the (elderly) dying and health services for the rest of the population."[110] In concurrence, Daniel Callahan has proposed that we set "prudent limits" on the allocation of health care resources to the elderly.[111] These limits would be applied in cases where: "beneficiaries are primarily the elderly, indefinite life extension is sought, the costs are high, and the population-wide benefits are slight."[112] This view has raised serious concerns over the emphasis on a zero-sum view of health care resource allocation across the generations.

Another view, instead of stressing intergenerational competitiveness, focuses on intergenerational interdependence.[113] This argument holds that all generations have a common interest in publicly funded intergenerational transfers and rests on the public good concept often used by economists to determine the proper role of Government in various markets. This view is also similar to the position argued in this article concerning the role of adult children in financing a program for catastrophic health care expenditures for their elderly parents.

Finally, there is the political reality of interest group politics. The rise and fall of the MCCA presents an example of the use of the political power of the affluent elderly to stifle a program that would have benefited the poorer and more vulnerable elderly. Because the poor generally tend to be politically weaker than the affluent in all groups, policy makers prefer to take a universalist approach (one that serves the whole) when allocating health care services rather than a selective approach (one serving just the poor). In this way, the poor are aided by the meshing of their interests with those of the affluent. Perhaps in the case of the elderly, the universality approach needs to be applied across all groups rather than simply across the elderly. Somehow, the affluent elderly believe that they should not be required to finance the health care expenditures of the poor elderly.

VI. CONCLUSION: FUTURE POLICY DIRECTION

This article has investigated the economic equity concerns of the elderly in relationship to catastrophic health care expenditures. It has analyzed the

110. D. CALLAHAN, SETTING LIMITS: MEDICAL GOALS IN AN AGING SOCIETY 130 (1987).

111. *Id.* at 223.

112. *Id.*

113. Kingson, *supra* note 109, at 772.

impact of the passage and the repeal of the Medicare Catastrophic Coverage Act, both on the distribution of health care resources and the distribution of health care financial burdens. The continuing unresolved issues of equity concerning the elderly versus the rest of the population have also been considered. In conclusion, the following policy proposals are offered for creating greater equity in regard to health care for the elderly.

Future policy toward catastrophic health care expenditures could take one of two general directions: First, the creation of an expanded but targeted health insurance program for the low income (near poor) elderly, financed by the population through general revenues; second, a universal health insurance program funded by all members of society. The Government's failure to provide critical health and social services, not widely available through the private sector, simply shifts most of the cost to individuals and their families. This ultimately may increase the total cost to society as more elderly spend their last years in nursing homes paid with Medicaid funds. The main question centers on the appropriate mix of public, familial, and individual responsibility emphasized by society. A general principle of acceptance of the elderly as a responsibility of the nation through the federal and state governments is consistent with the universal entitlement of the Medicare program. However, programs that recognize the role of the extended family in providing care for their elderly parents should be encouraged.

The elderly population is not a homogeneous group. Actually, many of the elderly have become much more affluent and should no longer be considered as dependent upon the rest of the population. However, the lower quintile or quarter of the elderly are very poor and do require such assistance. The group most at risk, from an economic perspective, is the near poor because they must rely solely on Medicare, whereas the poor elderly receive supplementation by Medicaid, and the affluent elderly are covered by Medigap policies. Yet, even the poor elderly are at risk in an era of budget reduction because of state cutbacks in funding Medicaid programs.

Therefore, to improve intraelderly equity, I propose a national program of catastrophic health insurance as Part C of Medicare. "Part C" would stipulate that any acute-care expenditures, totalling more than ten percent of the elderly household income, would be covered by the federal government. All elderly who are below 150% of the federal poverty line would be eligible. Flat premiums would be charged to this group but paid for by the respective state governments. Though this would increase state expenditures, the federalization of elderly poor Medicaid expenditures would reduce state expenditures to a greater extent.

This program would greatly improve equity for acute-care health expenditures. However, the greatest crisis facing all of the elderly is that of long-term care expenditures. The goal of any catastrophic care policy must therefore be to maintain the elderly as a financially viable population, without forcing them into poverty either by absorbing all of their financial resources to pay for costly nursing home care or by requiring them to "spend down" in order to meet state Medicaid requirements. Moreover, policy makers must recognize the interdependence of the elderly and their children in providing, and paying for, long-term care. To create more interfamily equity, the federal government should also enact an optional Medicare Part D long-term care insurance program. The elderly would have the option of selecting "Part D" or obtaining their own coverage through private insurance.[114] The premiums for this program would increase with elderly ability to pay. Those poor and near-poor elderly (below 150% of the federal poverty line) would have their premiums paid by their state governments. Expenditures for long-term care for the poor would be paid by the federal government.

Children of elderly parents would be given two types of financial incentives to aid their parents. First, they would be allowed a tax deduction for paying the premiums of long-term care insurance (public or private) for their elderly parents. Second, those who chose to care for their parents in their own homes would receive an elderly parent care tax credit.[115] This provision would recognize the important contribution that adult children make in providing care for their parents, and also offer the children a subsidized alternative to institutional care. These proposals would go far in achieving interfamily equity.

The main funding mechanism for both of these proposals would be attained through the removal of the income ceiling on the Social Security-Medicare Tax. This would greatly improve the tax equity in financing Medicare as a whole. It would also provide large revenues because taxation would occur at much higher incomes than the present tax rate related to Medicare.

More attention must be given to the relative distribution of income and health care resources with regard to children and the elderly—i.e., the in-

114. For further discussion of the possibility of private long-term care insurance for the elderly, see generally Wiener, Ehrenworth & Spence, *Private Long-Term Care Insurance: Cost, Coverage, and Restrictions*, 27 GERONTOLOGIST 487 (1982); Weiner & Meiners, *Private Long-Term Care Insurance: Simulations of a Potential Market*, 27 MED. CARE 182 (1989); Cohn, *One Proposal for Elder Care: Private-Public Compromise*, Wash. Post, Sept. 19, 1989, Health, at 11, col. 2.

115. For further discussion of family-oriented policies, see generally Wisensale, *Generational Equity and Intergenerational Policies*, 28 GERONTOLOGIST 773 (1988).

tergenerational equity issue. While this has important ethical implications for society in terms of efficient health care resource allocation, it is essential that the extended family of the elderly have greater decisionmaking authority. As a Nation, we have attempted to provide so many entitlements to dependent groups that we sometimes fail to recognize the need to define limits to resource use, especially in health care. In order to address the problems of intergenerational equity, it is time to establish uniform guidelines for the use of health care resources in the last year of a person's life. The Pepper Commission or a similarly appointed organization could investigate this concern.[116]

In conclusion, these proposals would facilitate the creation of greater equity in the distribution of health care resources and health care financial burdens not only for the elderly but for all members of our society.

116. U.S. Bipartisan Commission on Comprehensive Health Care, Pub. L. No. 100-360, 102 Stat. 765 (codified at 42 U.S.C. § 1395b note (Supp. 1990)); *see also* Relman, *Universal Health Insurance: It's Time Has Come*, 320 NEW ENG. J. MED. 117 (1989).