States of the Union

THE HEALTH GIFT REPOSSESSED

BY RICHARD J. MARGOLIS

"...a cruel hoax and a delusion..."
THE AMERICAN MEDICAL ASSOCIATION'S DESCRIPTION OF MEDICARE SHORTLY BEFORE THE MEASURE'S PASSAGE.

"And just think, Mr. President, because of this document ... there are men and women in pain who will now find ease."
LYNDON B. JOHNSON TO HARRY S. TRUMAN AT THE MEDICARE SIGNING CEREMONY, JULY 30, 1965.

CATHERINE COTT is a small, white-haired woman with a quick smile and a colloquial manner. She loves company but is accustomed to living alone. Never married, she worked for 39 years as a secretary at the same San Diego insurance company, retiring in 1973. She will soon be 80.

Miss Cott's entire support comes from Social Security and amounts to less than $500 a month. She never goes to movies and she rarely eats at restaurants. For recreation she dons yellow slacks and a red sweater and takes early morning walks along the ocean beach, relying on tiny steps to carry her a long way. (In politics her mode of progress would be called "incrementalism.") When bored, she sometimes goes on a cleaning rampage, vacuuming rugs and washing down walls. Her apartment, she has told me, is usually "squeaky clean."

One morning not long ago Miss Cott slipped on the kitchen floor and broke her hip in two places. As she recalled months later, "I had arthritis in both knees—still do—so my pins were extra-shaky. But I was bound and determined to mop my kitchen floor. It was *filthy*. Well, you see where it got me."

The accident set in motion a perfectly ordinary train of medical and economic events. On inspection, they seem to typify both the shame and the glory of our everyday health care arrangements. For older Americans those arrangements revolve mainly around Medicare, the useful yet baffling Federal program that is second only to Social Security in elderly hearts, and also in the amounts of money it collects and distributes. As Medicare goes, so in large measure go the quality and the quantity of elderly health care.

At the moment Medicare is not going well, chiefly because its technicians and budget-watchers have grown adept at skimping on the program's original goals, which promised adequate coverage for the elderly and disabled. Medicare itself is partly to blame: Its careless reimbursement policies and its bias toward Cadillac-type medicine have boomeranged, serving to inflate health care prices to a point almost beyond the program's abundant means. During its first two decades Medicare's annual outlays have jumped by 1,850 per cent.

The drain of dollars has caused a parallel drain of ideals. Medicare's rationale has been turned inside-out, with considerations of "cost containment" now largely replacing those of pain containment. Looked at through the eyes of Catherine Cott and her contemporaries, the program's present scenario resembles the action that unfolds in a rewinding film: everything appears to be traveling backwards. We see benefits jumping out of pockets and speeding back to their source. We glimpse the giver repossessing the gift.

The consequences of running the reel backwards have been widely understood but weakly resisted. By now nearly everyone knows that older patients are in some respects no better off today than they were during the dark ages that preceded Medicare, when they were spending 15 per cent of their aggregate income on health care. Today they are spending 16 percent, or an average of $1,850 per person each year. And, as the House Select Committee on Aging, chaired by Representative Edward R. Roybal (D.-Cal.), has informed us, "The worst is yet to come." Over the next five years, a committee-sponsored study has concluded, "the elderly's health care payments will increase at twice the rate of their income."

Miss Cott, being poor, has felt the sting all the more. Yet her story is not one of unrelieved pain. The health care system did lurch to her rescue.

To begin with, the doctors made her whole again. Apparently her surgeons were also master carpenters and engineers; the hip bone x-rays I saw six months after the accident—when the breaks were nearly knit—revealed a veritable fretwork of steel screws, bolts and wires. I had the impression I was gazing into one of those subcutaneous mira-

cles that modern American medicine routinely performs.

Medicare, too, worked wonders. Without the program's timely support it is unlikely that Miss Cott would be walking today, for by herself she never could have met the five-figure price of deliverance. The total bill came to $12,293.87, of which Medicare paid $10,136.51.

But here, alas, the glory ends, because Medicare left Miss Cott with a king-sized bill of her own, amounting to $2,157, or 36 per cent of her total annual income. To get out from under her medical creditors, Miss Cott was compelled to shoulder one additional debt: She borrowed money at a local bank, at 17 per cent interest.

Most of her financial woes stemmed from the many extra tariffs Medicare levies on beneficiaries. Although these have always been a part of the Medicare package, as the price of health care has climbed so have the tariffs. For elderly patients with low incomes, the added costs have been devastating.

Medicare is really "Medipair." It contains two separate programs, one for hospital bills (Part A) and another for doctors' and outpatient bills (Part B). Both components of late have been inflicting heavy costs on beneficiaries.

Part A, for example, pays for all "reasonable" hospital charges during the first 60 days of a benefit period, but it also assesses a substantial deductible that the patient pays up-front. Along with just about everything else, that deductible has been soaring. In 1981 it was pegged at $204; by 1987 it had climbed to $520, an increase of 155 per cent. (The overall cost-of-living index, meanwhile, rose by a mere 30 per cent.) The hospital deductible accounted for about one-fifth of Miss Cott's total out-of-pocket expenditures.

At the doctors' end of the Medicare centaur (Part B), the required deductible is relatively modest, $75 per year. Part B can be expensive in other ways, however. For starters, the most it will pay is 80 per cent of the total bill, and then only if the charges conform to the program's official fee schedule—or, to use Medicare parlance, only if the physician "accepts assignment." Otherwise, the doctor can charge whatever he pleases, and the patient must bear the additional freight. Pity the patient whose doctor does not accept assignment.

CATHERINE COTT was lucky in her two surgeons: They adjusted their fees downward—by almost $500 between them—in order to stay within Medicare's assigned limits. Even so, the two reduced bills came to $2,183.90, and Miss Cott was responsible for 20 percent of the total.

Some of her doctors were not so obliging. The bookkeeper's ballet danced by

EDWARD R. ROYBAL

Medicare, Miss Cott and her anesthesiologist—to cite one of several such *pas de trois*—shows what can occur when a doctor does not accept assignment. The anesthesiologist charged $396 for his ministrations at the operating table, whereas Medicare's approved maximum fee for that service was $254. So Medicare paid $204 (80 per cent of the assigned fee) and Miss Cott paid the rest —$192. Had her doctor accepted assignment, the cost to Miss Cott would have been just $50.

Such shortfalls seem as much the rule as the exception. In their billing practices seven of every 10 doctors sometimes exceed Medicare maximums (leaving only 30 per cent who invariably accept assignment). According to 1986 tabulations made by the U.S. Health Care Finance Administration (HCFA), about one-third of all Part B claims—there were 299 million last year!—topped Medicare's assigned ceilings.

HCFA's deadpan way of expressing this is to speak of "balance billing," meaning that patients in those instances are required to pay the "balance" of the bill. Beneficiaries often prefer another term: "excess billing." In recent years excess billing has accounted for about 22 per cent of the elderly's out-of-pocket medical expenses.

It is easy to see how Medicare's rising imposts can congeal into an expensive headache for the patient. The deductibles, the coinsurance payments and the special conditions add up to a painful reckoning. For Miss Cott they constituted a tab of more than $2,100.

But the reckoning is not complete. Like all Part B participants, Miss Cott has to pay monthly premiums that totalled more than $200 a year. When Medicare got started in 1966, the annual premium was a mere $36.

In addition, Miss Cott discovered that the program does not pay for medicines. She spent an estimated $400 on prescription drugs in the months following her operation. (Medicare's list of reimbursable items is surprisingly short. For example, it does not cover what an elderly friend of mine refers to as her "spare parts"—eyeglasses, dentures and hearing aids.)

Miss Cott's predicament reflects Medicare's changing computations, and these tend to puncture the customarily cheerful assumptions of liberalism. For if progressives 20 years ago saw in Medicare a pleasing example of the incrementalism they had long been preaching—that is, of America's step-by-step march toward social perfection—then it is hard to escape the conclusion that the program is becoming its own opposite.

Medicare's slippage signals a "decrementalism" peculiar thus far to the 1980s. Whether it will be permitted to bestride future decades as well depends on what we as a society choose to do next.