**How our Laws Are Made: A Medicare Case Study**

Our nation's political process is based upon a system of checks and balances. In addition, many different groups (not just politicians) are involved in making and changing laws. There are also historical precedents that have caused past attempts at modernizing Medicare to be repealed.

**Summary**

How can you and your elected representatives change our laws?

The American system of lawmaking can be open, chaotic and formal all at once. New laws must pass through the complex Congressional process before they reach the president's desk. But at the same time, ideas about what kinds of changes we need in the country come not only from politicians but from citizens' groups, lobbyists, grass roots activists, petition drives, public opinion surveys, and the media. All of them, directly and indirectly, affect the process of "reform."

In most cases, it is a lengthy process. In the case of reforming Medicare, in the House of Representatives both the Ways and Means Committee and the Energy and Commerce Committee have jurisdiction over aspects of Medicare reform. In many instances, several committees will have jurisdiction over a piece of legislation, making the legislative process even more challenging. Add to this the rise of competing interest groups and citizen-activists and it is easy to see that new laws must clear many hurdles in their voyage from idea to federal statute.

A good example is the question of how to make prescription drugs more available to low-income seniors – a question the country has been struggling with for many years. Modernizing Medicare to add a prescription drug benefit is often an advocated approach. Unfortunately, changing Medicare, which now costs taxpayers more than $250 billion a year, is not easily done. In Medicare's history, Congress has made many changes to it. None of those changes has come easily and not all were successful.

For example, a celebrated case of Medicare-reform failure was the case of the Catastrophic Coverage Act, passed by Congress in 1988. Passed with bipartisan support, the program used a new tax on wealthy seniors to provide long-term hospital and physician care to Medicare recipients. But a year later, in the wake of fierce public protests from seniors who resented having to pay additional taxes for insurance they saw as an entitlement, the bill – the work of years of legislative activity – was quickly repealed.

These problems with reform efforts tell us much about the particular sensitivities surrounding Medicare. Yet they also reveal the nature of our political system. Bringing change to Medicare invariably depends not only on Congress and the President, but on the full array of interest groups, concerned citizens, industry lobbyists, and issue activists. Understanding past efforts and the forces that help shape legislative reform is critical to understanding how Medicare might be reformed today to better serve America's seniors.

## How a Bill Becomes Law

### *Who Makes Laws?*

The power that Congress has to enact laws is written in the U.S. Constitution. Article I, Section I plainly states that Congress has the sole power to pass legislation and then send it to the President where it can be signed or vetoed.

The process is never simple. The very fact that Congress is a bicameral body, with equal power divided between the House and Senate, virtually guarantees that the process of enacting legislation will require much negotiation, amending, debate, and procedural twists. Both the House and Senate have their own rules and traditions for introducing and debating legislation. Because both chambers rely on committee systems that give jurisdiction over specific areas of public policy, laws are rarely passed in haste.

In the case of more complex measures, separate pieces, or "titles" of the legislation may go to several committees. In every case, it is up to the committee chairman to decide which bills to "report out" and send to the full House or Senate for a vote. This process in both chambers virtually assures that complex legislation does not pass quickly. Many bills that are introduced never even come up for a vote before the full chamber. Those that do reach the floor of the House or Senate are subject to a complex amending process on the floor. The Senate in particular uses rules that allow the minority to delay passage of a bill through lengthy debate.

Those bills that pass the House and Senate must then be reconciled. In most controversial matters, this process, know as a "conference committee," can substantially change the legislation before it is voted on once more by both chambers and then sent to the President.

This labyrinth, yet fully transparent process, is the essence of our democracy. While some criticize the difficulty of simply "doing something" in American politics, our system remains very responsive to the demands of citizens and their representatives.

### *Who Influences Legislation?*

Although only a Member of Congress is permitted to introduce legislation, ideas for new laws or the reform of old ones can come from many places.

Perhaps the single greatest force on lawmaking is the President. As head of the executive branch of government, the President can often set agendas by sending legislation to Congress, proposing new policies in the State of the Union and other public addresses, and using the staff of the White House to lobby for or against specific measures. While the President often frames debate, many of the details emerge from the Congressional process.

In September 1993, for example, President Clinton presented Congress with a proposal for a national health care plan that was accompanied by hundreds of pages prepared by the White House staff. Once it arrived in Congress, the President's plan became a piece of legislation running nearly 1500 pages. It was criticized not only by some in Congress, but also by interest groups, the insurance industry, medical schools, patient groups, physicians, economists, and advocates who had alternative plans.

*The Case of Health Care*

The failure of national health care reform in 1994 revealed the full complexity of modern politics. Public opinion, we were reminded, is an intrinsic part of shaping legislation. The public's opinion can be expressed in many forms -- by published surveys, through political parties or interest groups, and through the media.

Debates over health care have generally provided the best examples of how public and political pressures can shape legislation. More than 30 years ago, a young Congressional aide named Eric Redman wrote one of the best descriptions of law making in his book *The Dance of Legislation.* In it he described the endless battles involved in passing the National Health Service Bill. Similarly, the passage of the Catastrophic Coverage Act of 1988 (followed the year later by its quick repeal) reflects the danger of misreading the public mind or poorly communicating the impact a piece of legislation will have on citizens. After spending months developing a bipartisan bill to provide seniors with additional Medicare benefits for catastrophic care and prescription drugs, Congress discovered an angry backlash from middle- and upper-income seniors who, under the new law, were being taxed to pay for the new benefits. The next year, with little debate, Congress repealed the bill.

The problems encountered with reforming Medicare in the late 1980s tell us a lot about the problems of reform in general. In almost every case, public influence plays an indispensable role. Congress never works in a vacuum. Despite some of its arcane procedures, no legislative body in the world is as susceptible to public input.

**Who Has Jurisdiction Over Medicare?**

Medicare is one of the largest programs financed by the federal government. Created in 1965, it now has an annual budget of $250 billion.

Efforts to reform Medicare must go through the appropriate committees of Congress before they can be enacted into law. In the House, both the Ways and Means Committee and the Energy and Commerce Committee have jurisdiction over Medicare. It is up to the House parliamentarian to assign bills or sections of bills to the appropriate committee. The House Rules Committee, as it does with all legislation, can also influence reform by placing constraint on how a bill is brought to the floor for debate.

In the Senate, the process is simpler. The Senate Finance Committee has complete jurisdiction over Medicare. The Members of Congress most knowledgeable about health care reform and Social Security almost always sit on the powerful Finance Committee.

**Case Study: The Catastrophic Health Care Act of 1988**

*Changing Medicare – A Congressional Experiment*

Changing the way Medicare works or altering the benefits it provides is a difficult pursuit. Perhaps the single best example of what is involved can be seen in the passage – and swift repeal -- of the Catastrophic Health Care Act of 1988.

In many ways, the furious effort to pass and then repeal the Catastrophic Health Care Act is a portrait of Congressional failure. In passing the bill, Congress believed that it was creating important and popular modernization of the government's largest health care program. Nothing in the original deliberations in the House or Senate prepared Members of Congress for the angry public backlash at what they had created. But the value of studying what happened with the experiment through catastrophic care is not merely to criticize the missteps of Congress. Rather, it lets us see just how difficult it is to reform broad, federally-sponsored programs. There are simply so many different stakeholders whenever Medicare is reformed that failure to understand the consequences of any change can trigger an unanticipated revolt from the citizens who depend on a given program.

*The Idea of Catastrophic Care*

In the late 1980s, some 32 million Americans were eligible for Medicare coverage. The program had expanded considerably since it was first passed in 1965 and its costs over that period have grown far beyond the original expectations. Nonetheless, most Members of Congress – and all Medicare recipients – were aware of how the program fell short. There were a wide variety of medical insurance needs that seniors faced that simply weren't covered by the Medicare program, specifically the costs of catastrophic care. But there were other omissions in Medicare's coverage that were also widely recognized, including the cost of prescription drugs and nursing-home care. Well-to-do

seniors had no problem purchasing Medicare “gap” insurance to cover some of these additional expenses. But both Congress and the Reagan Administration had recognized that these holes in Medicare were a problem.

Much of the impetus for the bill came from the commission headed by Otis Bowen, appointed by President Reagan to examine a number of questions regarding Medicare and Social Security. In 1986, President Reagan appointed Bowen to become Secretary of Health and Human Services. He immediately made Medicare reform a priority. In January 1987, he was able to get a mention of catastrophic care legislation in the President’s State of the Union Address.

His initial proposal was limited with a keen eye to containing both the costs on seniors and the costs government would have to expend to fund an expanded Medicare program. He proposed expanding Medicare to cover the rising costs of care and limiting the amount that seniors would have to pay out-of-pocket. These new programs would be paid for with a flat premium levied on all Medicare recipients.

The reception to this proposal in Congress was warm, but the process of building on the proposal was immediate. The most influential player in this new Congressional debate was Rep. Claude Pepper, a Florida Democrat, the chairman of the House Rules Committee and a leading advocate for the elderly in Congress. He insisted that any Medicare expansion also include long-term care. That was soon followed by proposals to include a drug-benefit provision for seniors, something that Medicare had never included.

The general outlines of this new bill seemed to win enthusiastic support from key constituents. The American Association of Retired Persons (AARP), always a critical voice in Medicare and Social Security debates, supported the measure. Its leadership and others had conducted polling that also showed the measure to be highly popular with seniors.

The most significant opposition came from the pharmaceutical industry and a then little-known group called the "National Committee to Preserve Social Security and Medicare," which was concerned that the new premium hikes and surtaxes on seniors departed from traditional social security principles.

*The Brief Life of Catastrophic Care Legislation*

In June, 1988, Congress passed the Catastrophic Health Care Act. The legislation had the support of both Democrats and Republicans and had the blessing of Ronald Reagan’s White House. One writer has described it as “the largest expansion of Medicare since the program’s establishment in 1965.” Indeed, the most notable feature of the bill was the way it expanded health coverage to the elderly, regardless of income. Under the new bill patients could have unlimited annual hospital coverage for catastrophic illness, 150 days of skilled nursing care, and 38 days of home health care. The bill also offered Medicare patients, for the first time, mammography screening, respite care, and outpatient prescription drug coverage.

But the full extent of the costs of the program, both to Congress and more importantly to seniors themselves, were only now being appreciated. Before the end of the year, a number of Congressmen and Senators, including those who had voted for the bill, were calling for changes or delays in implementation.

Yet it was the seniors themselves who had the harshest reaction. Many discovered only after the bill was passed that their tax liability would increase sharply. Although only a minority of affluent seniors would actually pay the steepest tax increases, the idea that seniors themselves were suddenly having a new financial burden thrust on them by Congress enraged many Medicare recipients. Senior protest groups broke out across the country. How representative they were of the general senior population is hard to say. No one, however, doubted their impact.

In one of the most famous and frequently rebroadcast pieces of news footage from the period, a group of seniors surrounded the car of Rep. Dan Rostenkowski, banging on his windows and shaking the vehicle until the powerful chairman of the House Ways and Means Committee got out and fled.

In October 1989, Congress voted to repeal the bill. Sixteen months earlier the House of Representatives passed the bill, and it sailed through on a 328-72 vote. Now, facing a hostile public backlash, the House vote to repeal was 360-66.

*The Reaction – and Repeal*

The Catastrophic Health Care Act was the result of enormous legislative energy over an 18-month period. Its details had been debated in Congress and the press. Even after its passage, the Department of Health and Human services, along with the AARP, promoted educational materials to inform seniors about the program.

The near-immediate rejection of the expansion of Medicare by both the public and the press has been the subject of much analysis. Some suggest that the key problem was the inability of Congress to estimate accurately the real costs of expanding the benefits of Medicare. In June 1988, when the bill was enacted, the prescription drug benefit was estimated to cost $5.7 billion over five years. Just twelve months later, the CBO estimate for the new catastrophic benefit jumped to $11.8 billion. Cost projections for other provisions were subject to even more drastic upward revisions.

The result would have initially created a 15% surcharge on the tax bill of upper income seniors in 1989, but that could have grown to 28% by 1993.

Although the public clearly is concerned about health care, their willingness to see dramatic change to their own health coverage arrangements is less certain. Congress may have also overestimated the strength of one very prominent interest group, the AARP. While AARP members can certainly influence the content of legislation, as they did in 1988, Congress hears from a plurality of voices. Once the initial unpopularity of the Catastrophic bill struck, numerous smaller, grassroots opposed to the legislation made their voices heard.

The most enduring lesson of the Catastrophic Health Bill, however, is that legislative change to government programs that impact the lives of millions of Americans are difficult to achieve but not impossible to reverse. Reform movement needs to do more than persuade lawmakers. They must win over the public who will understand exactly what reform means to them.