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# THE MEDICARE CATASTROPHIC COVERAGE ACT: A POST-MORTEM

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by Thomas Rice, Katherine Desmond, and Jon Gabel

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**Prologue:** *The saga of the Medicare Catastrophic Coverage Act from its initial unveiling in President Reagan's 1986 State of the Union address to its congressional repeal in November 1989 represents a remarkable chapter in the history of federal health policy making. The seeds of its destruction seemed to lie in the unwillingness of elderly individuals who already were protected against the economic consequences of catastrophic illness to accept a new tax that would have financed such Coverage for the entire Medicare population. But this article that reports on the attitudes of elderly individuals indicates they had other reservations as well. Authors Tom Rice, Katherine Desmond, and Jon Gabel discuss the results of a survey of elderly individuals that sought their views about the Medicare catastrophic law nearly six months before Congress repealed the measure. The elderly's reluctance to accept a tax is dearly reflected in the survey results, as is their lack of knowledge about the law. Rice, an associate professor of health policy and administration at the University of North Carolina School of Public Health, recently completed a project for the Health Care Financing Administration on the impact that supplemental private health insurance coverage has on Medicare costs. He has studied the Medicare supplemental health insurance market for almost a decade. Rice spent the East year at the Physician Payment Review Commission during a sabbatical leave. Desmond is a candidate for a master of science degree in biostatistics at the University of North Carolina. She was previously employed by the Department of Health and Human Services, SRI International, and the Research Triangle Institute. Gabel, an economist, is the associate director for research at the Health Insurance Association of America (HIAA). Since Gabel joined the association in 1986, HIAA has sharply increased its commitment to health services research based on a belief that private interests can most effectively influence public policy making through analysis and data.*

**L**ess than a year and a half after enacting the Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360), Congress was forced by a ground swell of negative public reaction to retract the legislation, the first major enhancement in Medicare benefits since the program's inception in 1965. A retrenchment of this magnitude is unprecedented in postwar social welfare policy. The experience also appears to have soured Congress toward enacting further increases in Medicare benefits for elderly and disabled beneficiaries. Passage of major long-term care legislation is probably the most serious near-term casualty.

Several factors explain the repeal. Many elderly resented the idea of paying additional taxes to finance the new coverage. This would have represented a hefty burden on some, and, unlike the rest of the Medicare program, the additional benefits mandated by the act would have been financed entirely by the elderly. Resentment appeared to be highest among people who already had comprehensive health insurance coverage from a former employer. Not only did they bear the brunt of the financing, but the benefits of the new legislation added little to their existing coverage.<sup>1</sup> Although the inclusion of a Medicare prescription drug benefit as part of the catastrophic package was a major accomplishment, the legislation provided little additional coverage for long-term care, one of the greatest worries among the elderly and the one for which they are least well insured. These perceived flaws spurred some seniors' organizations to lead a campaign that led to the legislation's demise.

In this article, we take a deeper look at some of the reasons for the failure of the Medicare Catastrophic Coverage Act. Our conclusions are based on a representative national telephone survey of 500 Medicare beneficiaries conducted in spring 1989, just over halfway between the time the legislation was signed (July 1988) and eventually repealed (November 1989). We pay particular attention to the prescription drug benefits, which would have been the first major new service ever added to Medicare. The other major components of the legislation concerned hospital and physician services, benefits that historically have formed the core of the Medicare program.

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### **The Medicare Catastrophic Coverage Act**

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The Medicare Catastrophic Coverage Act altered both program benefits and financing, phasing in changes over a several-year period beginning in 1989. The three most important new benefits involved hospital care (Medicare Part A), physician care (Part B), and prescription drugs. Beginning in January 1989 (and continuing until repeal in November of that year), beneficiaries were no longer responsible for substantial daily

copayments for hospital stays in excess of sixty days, and they had to pay the \$560 initial deductible only once in a calendar year. Starting in 1990, a \$1,370 annual cap was to be placed on Part B copayments.

Congress had planned to phase in prescription drug coverage beginning in January 1991. (Coverage for home intravenous therapy drugs and immunosuppressive drugs would have begun in January 1990.) The coinsurance rate would have been set at 50 percent during 1991, declining to 40 percent in 1992 and 20 percent thereafter. This coverage was subject to an annual deductible, set at \$600 in 1991 and \$652 in 1992. In subsequent years, the deductible would have been indexed so that approximately 17 percent of beneficiaries would exceed it in any given year.

Although there were some modest changes in the Medicare nursing home benefit, one of the primary complaints about the legislation was that it did not extend Medicare coverage to long-term nursing home care. This is the type of care that is most likely to impoverish the elderly.<sup>2</sup> One final noteworthy benefit enhancement was not repealed by Congress: liberalization of Medicaid regulations to allow the spouse of a nursing home resident to retain enough income to avoid impoverishment.

In a new precedent, Medicare beneficiaries would have financed the new benefits in their entirety. The controversial "supplemental premium"—actually an additional amount of income tax to be paid by an estimated 40 percent of the elderly—would have been the primary funding source. The legislation established a maximum tax liability, which would have been paid by less than 10 percent of the elderly, at \$800 per person (\$1,600 for a couple). In addition to the supplemental premium, the Part B monthly premium, charged to all program beneficiaries whose incomes were above the poverty level, would have risen by four dollars.

Even after the phase-in period, beneficiaries could have borne significant expenses: the initial \$560 hospital deductible; the \$75 Part B deductible and 20 percent coinsurance payment until annual expenses of \$1,370 were incurred; all nonassigned physician charges above what Medicare deemed to be reasonable; the first \$650 or so of prescription drug costs; and 20 percent of all additional prescription drug costs during a year,

Repeal of the legislation will hit the poor and near-poor elderly the hardest, since they are least likely to have supplemental private insurance.<sup>3</sup> These policies cover many of the expenses that would have been part of the catastrophic coverage benefit package. In contrast, those who will be least affected are the better-off elderly who have supplemental insurance policies through an employer or former employer. Our survey results indicate that in 1989, 45 percent of policy owners received their coverage through such an employer.<sup>4</sup> Not only do most receive a pre-

mium subsidy, but their employer coverage tends to be more comprehensive. For example, data from the 1977 National Medical Care Expenditure Survey indicate that whereas over 70 percent of employer group policies covered prescription drugs, this was true of less than 25 percent of individual policies.<sup>5</sup> More recent data from a 1988 survey of employers conducted by the Health Insurance Association of America (HIAA) and The Johns Hopkins University show that 94 percent of retirees with employment-related insurance have prescription drug coverage.<sup>6</sup>

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### Survey Of Medicare Beneficiaries

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To address a number of issues related to the catastrophic coverage act, we conducted a telephone survey of 500 Medicare beneficiaries in April and May of 1989. The survey, carried out by Response Analysis, was based on a nationally representative sample chosen using random-digit dialing. In conducting the survey, we found that only a small fraction of those households contacted were eligible, because only those households that had at least one person age sixty-five or over and on Medicare were accepted into the sample.<sup>7</sup> Those dually eligible for Medicare and Medicaid were not interviewed because they do not normally purchase private health insurance to supplement Medicare. (Determining the relationship between the legislation and private insurance was one of the primary motivations for conducting the survey.)

To assess the respondents' level of understanding of the recent changes in Medicare, we employed a "split-sample" technique. Interviewers briefed half of the private insurance owners (78 percent of respondents owned one or more policies) on the details of the new legislation's benefits but did not brief the other half (the "control group"). The control group members were quizzed on their level of understanding of the legislation. Nonowners (22 percent of the sample) also took the quiz. The split sample allowed us to determine how a more complete understanding of the new benefits might have changed the opinions and behavior of the elderly.

**The elderly did not understand the legislation.** One purpose of the survey was to ascertain the degree to which the elderly understood the changes in Medicare brought about by the new law. On the one hand, one might have expected knowledge levels to be high, given the extensive amount of press coverage concerning the changes. On the other hand, previous research has shown that the elderly appear to understand few of the specifics of their Medicare coverage.<sup>8</sup> To assess knowledge levels, we asked eight questions about the recent changes in Medicare to 303 individuals: the half of the split sample of private insurance owners whom we did not brief and those who did not own private insurance

policies. For each item, interviewers asked respondents to indicate whether statements about the legislation were correct or incorrect, or whether they did not know. We explicitly gave the “don’t know” choice to reduce the amount of guessing.

The eight questions (with correct true/false answers in brackets and the percentage of correct answers in parentheses) represented five aspects of the legislation.<sup>9</sup> (1) When the new legislation is fully phased in, Medicare will cover some of the costs associated with prescription drugs {True} (38.6 percent). (2) Medicare will pay 80 percent of all reasonable prescription drug costs during a year {False} (23.5 percent). (3) With the new catastrophic coverage, Medicare will cover all costs of a hospital stay, except for an initial payment of about \$500 {True} (34.1 percent). (4) Medicare will cover all costs that your physician charges you for services [False] (46.5 percent). (5) Medicare will cover all reasonable costs of physician services after the first \$1,400 or so per year is paid {True} (15.5 percent). (6) Medicare will cover most of the costs associated with a six-month nursing home stay {False} (19.1 percent). (7) All people who have Medicare will be required to contribute toward the cost of the new Medicare benefits through an increase in the monthly premium {True} (48.5 percent). (8) All people who have Medicare will be required to contribute toward the cost of the new Medicare benefits through an increase in their federal tax payments {False} (8.9 percent).

What is most noteworthy about these responses is the very low knowledge level exhibited. For the eight questions, the average number of correct answers was only 2.4. Knowledge levels varied a great deal, however, from question to question, as the percentages above show. Only 9 percent were aware that not everyone had to pay more in federal taxes to finance the program, which may explain many of the act’s subsequent problems. Furthermore, despite the fact that much of the debate centered on Medicare’s lack of coverage for long-term nursing home care, only 19 percent of respondents knew that Medicare would not cover most of the costs of a six-month nursing home stay.

Some observers claim that the centerpiece of the new legislation was prescription drug coverage. Whereas the other major components of the legislation reduced copayments for services already covered by Medicare, the prescription drug benefits were entirely new to Medicare. Furthermore, this aspect of the legislation was perhaps the most widely covered by the press. Yet only 39 percent of the sample knew that Medicare was planning to include any such benefits. It is perhaps less surprising that only 24 percent had a deep enough understanding of the legislation to correctly respond that Medicare would not pay a full 80 percent of prescription drug costs (due to the existence of the deductible).

We examined whether knowledge of the prescription drug benefit (the first of the two questions about prescription drug coverage) varied along a number of characteristics. Those who responded correctly tended to be better-educated and married, had higher incomes, and owned a supplemental insurance policy (all results significant at the 5 percent level). Education was a particularly important determinant of knowledge. Beneficiaries who had attended at least some college answered the question correctly 54 percent of the time, compared to 26 percent for those who did not finish high school. Nevertheless, the fact that only about half of the best-educated understood that prescription drug benefits were included in the legislation underscores how poor knowledge levels were.

**Even when briefed about the new benefits, the elderly did not support the legislation.** Many proponents of the legislation contended that it was indeed popular but that support was not heard over the din created by a vocal minority. To test this, the survey asked the following question: “Taking into account both the benefits and costs to you, which of the following describes your opinion about the changes in Medicare? Do you (1) strongly support the changes, (2) support the changes somewhat, (3) oppose the changes somewhat, or (4) strongly oppose the changes?” Our results indicate that Congress was following “the will of the people” when it finally decided to repeal the legislation.

In examining the responses of three groups—the briefed owners of private insurance, the control group of owners, and nonowners—we see that most of those with an opinion opposed the legislation. Whereas 33 percent of respondents were strongly or somewhat supportive of the changes, 42 percent strongly or somewhat opposed them. Furthermore, there was more fervor among the opponents: whereas 7 percent were strongly supportive, 24 percent were strongly in opposition. About one-fourth of respondents did not venture an opinion. Lack of knowledge about the details of the legislation does not appear to have been directly responsible for this opposition. The half of the sample that was briefed on benefits showed no more enthusiasm than the others (Exhibit 1).

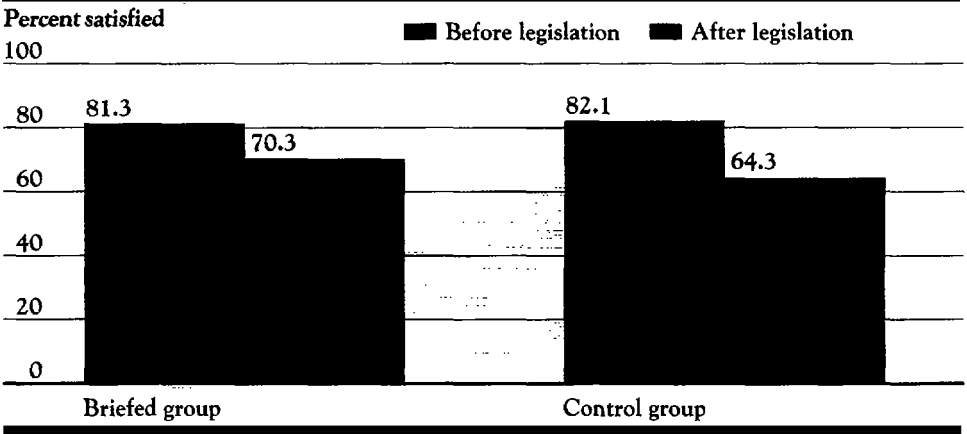
One puzzling finding is that respondents claimed to prefer prelegis-

**Exhibit 1**  
**Overall Opinion About The Medicare Catastrophic Coverage Act**

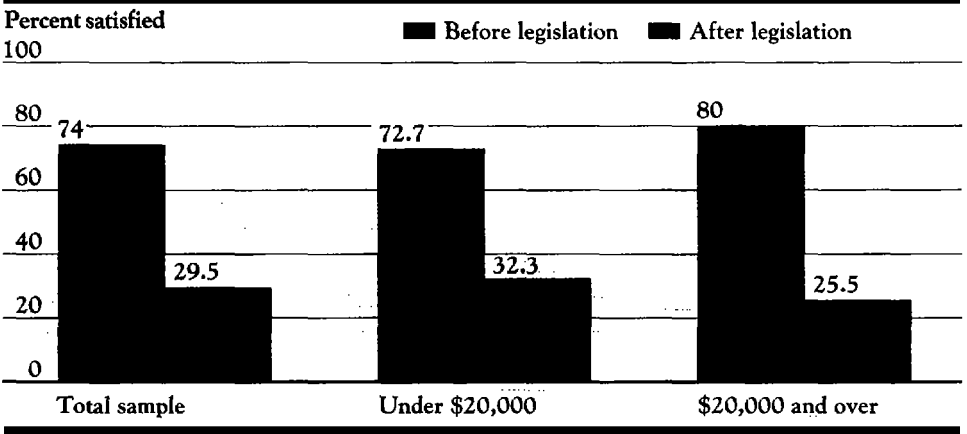
	Briefed owners	Control group owners	Policy nonowners	Total
Strongly support	9.2%	6.7%	5.5%	7.4%
Somewhat support	24.5	27.8	24.8	25.9
Somewhat oppose	21.9	17.5	11.9	18.0
Strongly oppose	25.0	25.8	18.3	23.9
Don't know	19.4	22.2	39.4	24.9

lation benefits over the more extended ones included in the legislative package; this was true even for the group that was briefed on the details of the benefit package (Exhibit 2). This may be due, in large part, to the fervent opposition to the financing package. As shown in Exhibit 3, there was strong dissatisfaction with Medicare costs after passage of the legislation.” Curiously, this opposition was almost as strong among those with incomes under \$20,000, a group that would have paid little if any in supplemental premiums.

**Exhibit 2**  
**Percentage Of Elderly Satisfied With Medicare Benefits Before And After Catastrophic Legislation**



**Exhibit 3**  
**Percentage Of Elderly Satisfied With Medicare Benefits Before And After Catastrophic Legislation, By Income Group**



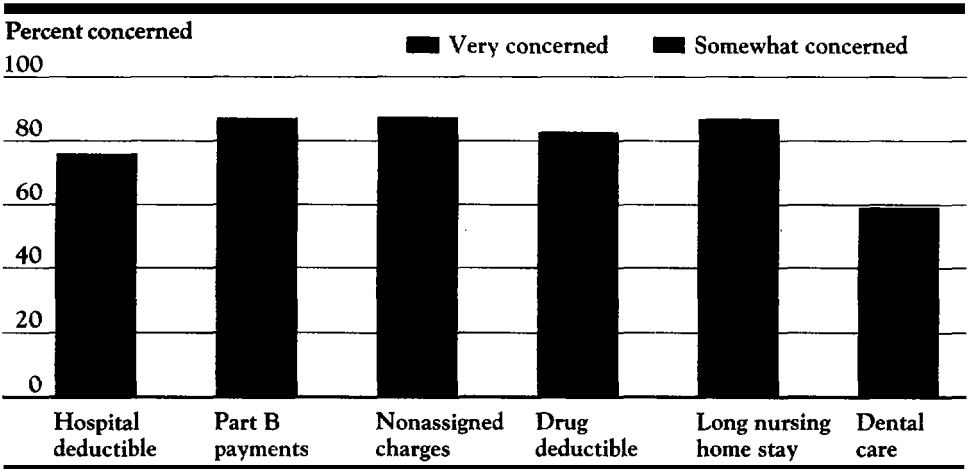
In the months preceding the legislation’s repeal, news stories focused on many of the factors responsible. Some that were noted most often were (1) opposition to the supplemental premium; (2) anger over the fact that the elderly had to finance the entire benefit package; (3) lack of long-term care coverage; (4) the availability of comparable benefits to some retirees from their former employers at little cost; and (5) an intense publicity campaign aimed at repeal. Although there is little doubt that each of these factors contributed to the legislation’s ultimate repeal, the survey indicates that two less-apparent factors may also have been instrumental.

**The elderly fear deductibles and coinsurance.** First, although the act would have reduced the risk of incurring catastrophic costs from illness, it kept in place most deductible and coinsurance requirements. We asked respondents six questions regarding their concern about some of the gaps that remained in Medicare even after passage of the legislation.<sup>11</sup> The specific expenses addressed were the first \$600 in prescription drug costs; the first \$560 of a hospital stay; the \$1,370 in Part B payments; doctor bills higher than the Medicare-allowed amount; paying for a long nursing home stay; and paying for dental care.

Exhibit 4 shows the proportion of respondents who were either very concerned or somewhat concerned about these expenses. The message that emerges is that the elderly are very worried about incurring *any* out-of-pocket costs. Stated in a different way, it appears that they strongly desire complete insurance coverage (with no deductibles or coinsurance).

Looking just at the proportion of the sample who said they were “very concerned,” it is perhaps not surprising that 78 percent expressed this

**Exhibit 4**  
**Percentage Of Elderly Concerned About Remaining Gaps In Medicare**



feeling about long nursing home stays, and even that 71 percent felt that way about excessive physician charges. Both of these expenses are unknowns and have the potential of causing great financial hardship. We were surprised, however, by the concern expressed over expenses that were fixed and, by most standards, not terribly high, especially when compared to supplemental health insurance premiums. (Our respondents reported paying mean annual premiums of \$718.) Two-thirds (66 percent) were very concerned about the first \$600 of prescription drug costs, and 56 percent were very concerned about the hospital deductible.

The high level of concern shown in Exhibit 4 may underlie many of the legislation's problems. If a person is very concerned about incurring certain health care expenses, such as deductibles, and if insurance to cover the deductible amount is available at an affordable cost, that person is likely to purchase such coverage. The elderly's fear of the several deductibles included in the legislation implies that they would have continued to purchase private coverage after the legislation's passage. This is consistent with our finding, which we discuss below, that few elderly planned to drop their private insurance coverage even after the new benefits were fully phased in.

We also examined whether the less-well-off elderly were most concerned about deductibles, or if this fear was endemic to the entire population. Using prescription drugs as an example, we found that concern does indeed vary inversely with income. Less than half of those with annual incomes exceeding \$30,000 were very concerned about the \$600 prescription drug deductible, compared to over three-fourths of those with incomes below \$20,000 (significant at the 1 percent level).

We do not mean to imply that the elderly are mistaken in their concern about facing fixed deductibles. Obviously, this is a subjective assessment. Rather, our findings show a group of people whose understanding of the Medicare program is weak and who appear to deal with the resulting uncertainty by desiring complete coverage for remaining gaps.

**The elderly are satisfied with their private insurance policies.** It has been widely reported that one of the factors that resulted in much discontent among the elderly is that many already had supplemental health insurance coverage that was subsidized by previous (or current) employers. As noted earlier, our survey results indicated that 45 percent of policy owners received their coverage through such an employer and thus most likely received a premium subsidy.<sup>12</sup>

We asked policy owners several questions about their satisfaction with their private insurance policies. The first two questions concerned satisfaction with policy benefits and costs. (Respondents who answered "don't know" have been excluded from these tabulations.) We found that nearly

90 percent of owners reported satisfaction with policy benefits, and almost three-quarters were satisfied with policy costs. These figures are a little higher than the Medicare satisfaction levels that existed before the legislation and much higher than after the legislation was passed.

We were interested in whether satisfaction with policy costs was associated with whether the person's policy was obtained from an employer or former employer (which usually indicates that premiums are subsidized) or whether the person said his or her policy premiums had increased during the past twelve months. Not surprisingly, we found that those with employer policies showed more satisfaction with their policy costs (84 percent versus 67 percent) and that people whose policy premiums had not increased were twice as likely to be "very satisfied" with policy costs (both results significant at the 1 percent level).

Another question on the survey addressed whether the respondent's private insurance policy "met all your expectations." For a large majority of owners (73.1 percent), this was the case. Only 14 percent said that it did not meet expectations; the remaining 13 percent did not know, possibly because they had not yet used any policy benefits. Those who said that their policy failed to meet all of their expectations indicated that physician care most frequently fell short, followed by hospital care, prescription drugs, and dental services.

**Very few elderly planned to drop their private insurance.** One of the central purposes of the survey was to find out what sample members planned to do about their private health insurance policies once the catastrophic benefits were fully phased in. Needless to say, it would be impossible to determine whether they would have followed through on their responses; the survey was fielded only four months after the first of several sets of benefits were put into place. Nevertheless, opinions as to whether the new benefit would have provided sufficient protection against out-of-pocket costs—and thus have obviated the need to purchase supplemental insurance—provide important clues as to why the legislation was repealed.

We employed the split-sample technique to determine if there were differences among those who were briefed about the new Medicare benefits versus those who did not receive additional information. We were particularly interested in the responses of the group that was briefed on the benefits of the legislation, for two reasons. First, the information given to them in the survey provided objective information upon which they could make more informed judgments about the need for supplemental insurance. Second, their responses should better reflect how the elderly population would behave in the future, since over time most people would learn more about the new benefits.

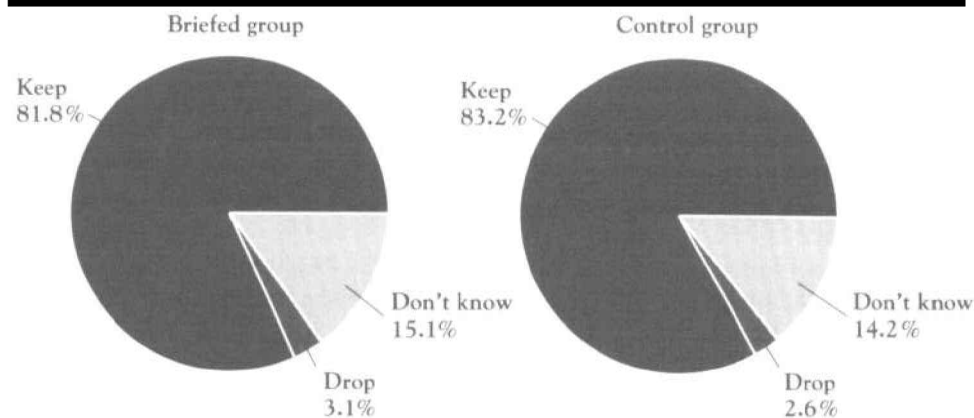
Respondents were asked one of two questions. If a respondent owned one policy, we asked, "What do you think you are likely to do once the new Medicare benefits are fully implemented? Do you plan to keep the additional health insurance policy that supplements Medicare, or do you plan to drop it?" If a respondent owned more than one policy, the wording was, "Do you plan to keep all of the additional health insurance policies you have that supplement Medicare, drop some of them, or drop all of them?"

We have combined answers to these questions into three categories: keep all policies, drop one or more policies, or don't know. Exhibit 5 shows the responses for the two groups, which are nearly identical. The vast majority of respondents reported that they planned to keep their private insurance policies. Only 3 percent of each group said they planned to drop one or more policies, and about 15 percent did not know what they would do. In response to an open-ended question, most who said they planned to keep their policies either referred to the need for additional protection or stated that Medicare did not cover all costs.

The only variable that had a large impact on the "keep/drop" decision was whether the policy met all of the owner's expectations. Among the 14 percent of respondents who reported that their policy did not meet all of their expectations, 40 percent planned to drop a policy or did not know whether they would; only 14 percent of those whose policy had met all expectations said they would drop the policy or did not know (significant at the 1 percent level).

Therefore, it appears that the primary factor explaining why some individuals would not retain their private insurance policies was not the

**Exhibit 5**  
**Percentage Of Private Insurance Owners Who Plan To Keep Or Drop Their Policies**



legislation's benefits, but dissatisfaction with particular private insurance policies. One could easily imagine these people purchasing another policy to replace their current one. Even though the legislation would have changed the content of policies, people were still planning to continue to purchase them. It is therefore not difficult to understand why many of the elderly resented the legislation: their Medicare premiums and perhaps their income taxes would rise, but they would still feel the need to spend money on private insurance. Of course, one must interpret these results with some caution, because it was too early for most people to have made final decisions about their insurance.

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### Implications For Future Medicare Reform

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The Medicare Catastrophic Coverage Act was supposed to be a popular piece of legislation. Our results—and its swift repeal—show that it was not. One of the primary reasons was that most Medicare beneficiaries had already arranged to have private supplemental coverage. Moreover, many of them perceived this coverage to be superior to that provided by the legislation: often it was subsidized by former employers; there were few if any deductibles; and, by and large, most owners had been satisfied with their policies.

It is unlikely that Congress, with the unpleasantness of the repeal process fresh in its mind, will want to resurrect the legislation in the near future. Indeed, current congressional efforts are focusing on further regulation of the private insurance market, especially for Medicare supplemental coverage. Nevertheless, two final observations can be gleaned from the survey that have a bearing on future congressional efforts to expand Medicare.

First, the elderly seem likely to react to the inclusion of beneficiary cost-sharing provisions in new program benefits by purchasing private coverage to pay for them. Unless Medicare provides full coverage without deductibles and coinsurance—which is unlikely, given the cost-demand will continue for private insurance to supplement Medicare benefits. This, in turn, will continue to stimulate the demand for more services.<sup>13</sup> Second, there is likely to be less opposition to future legislation if benefit enhancements focus on services for which few beneficiaries have private coverage. Long-term care services are perhaps the most notable example.

## NOTES

1. M.A. Morrissey, G.A. Jensen, and S.E. Henderlite, "Employer-Sponsored Health Insurance for Retired Americans," *Health Affairs* (Spring 1990): 57.
2. T. Rice and J. Gabel, "Protecting the Elderly against High Health Care Costs," *Health Affairs* (Fall 1986): 5.
3. For a review of the literature, see T. Rice and N. McCall, "The Extent of Ownership and the Characteristics of Medicare Supplemental Policies," *Inquiry* (Summer 1985): 188.
4. This figure closely matches that collected from the 1987 National Medical Expenditure Survey, in which 46 percent of policy owners had employment-related coverage. A. Monheit and C. Schur, "Health Insurance Coverage of Retired Persons," *National Medical Expenditure Survey*, Research Finding 2, DHHS Pub. no. (PHS)89-3444 (Washington, D.C.: U.S. Department of Health and Human Services, September 1989).
5. G.L. Cafferata, "Private Health Insurance Coverage of the Medicare Population," *Data Preview* 18, National Health Care Expenditures Study, National Center for Health Services Research, DHHS Pub. no. (PHS)84-3362 (Washington, D.C.: DHHS, September 1984).
6. S. DiCarlo et al., "Facing Up to Postretirement Health Benefits," *Research Bulletin*, Health Insurance Association of America (Washington, DC.: HIAA, September 1989).
7. For a more complete discussion of survey methodology, contact Thomas Rice, Department of Health Policy and Administration, University of North Carolina, School of Public Health, C.B. #7400, Chapel Hill, NC 27514.
8. N. McCall, T. Rice, and J. Sangl, "Consumer Knowledge of Medicare and Supplemental Health Insurance Benefits," *Health Services Research* (February 1986, Part I): 633.
9. Admittedly, some of the issues are more ambiguous than we indicate. For example, only those above the federal poverty level were required to contribute four dollars a month in additional premiums. We did not believe that this nuance would affect our results, particularly because people who received Medicaid benefits were excluded from the survey. Another example concerns the nursing home benefit. Although the new legislation could, in theory, have provided coverage for up to five months, the press has made it clear that the majority of nursing home stays still would not have qualified for Medicare coverage.
10. Respondents were given four choices to each of the questions concerning Medicare benefits and costs before and after passage of the legislation: "very satisfied," "somewhat satisfied," "not too satisfied," and "not at all satisfied." For purposes of presentation, we have combined the first two categories into an overall "satisfied" category, and eliminated any "don't know" responses, so that the percentages indicate the level of satisfaction among those who ventured an opinion.
11. These questions were asked of all 500 respondents. Owners of private policies were asked what their level of concern would have been had they not owned any insurance to supplement Medicare.
12. This figure closely matches that collected from the 1987 National Medical Expenditure Survey, in which 46 percent of policy owners had employment-related coverage. See Monheit and Schur, "Health Insurance Coverage of Retired Persons."
13. C.R. Link, S.H. Long, and R. Settle, "Cost Sharing, Supplementary Insurance, and Health Services Utilization among the Medicare Elderly," *Health Care Financing Review* (Fall 1980): 25; and S. Christensen, S.H. Long, and J. Rodgers, "Acute Health Care Costs for the Aged Medicare Population: Overview and Policy Options," *The Milbank Quarterly* 65, no. 3 (1987): 397.