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Publication Date
1985-04-01

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The Cases of the End-Stage Renal Disease
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Jack C. Chow
Chapter One: The End Stage Renal Disease Program: A Medical - Surgical Entitlement

End stage renal disease describes the kidney as it is in its dying moments, unable to filter and process the body's metabolic wastes and allowing the waste to accumulate in the blood to fatal levels. Only medical and surgical intervention can save the person's life. Two methods are prevalent today - hemodialysis and transplantation. Hemodialysis is the filtering of the patient's blood after it has been diverted from the body to an outside machine. The process takes six to eight hours per session and requires the patient's return to the machine three to four times a week. Transplantation is the surgical grafting of a new kidney from a volunteer or cadaver. While the successful transplant often results in permanent restoration of kidney function, the patient must face all of the attendant risks of such surgery: infection, immunological rejection and other physiological complications.

Provisions of the End Stage Renal Disease Program

Both dialysis and transplantation are very expensive and can cost hundreds of thousands of dollars for hospital, doctor, and supply needs over a lifetime. Needless to say, very few Americans can pay such astronomical costs. In 1972, Congress and President Nixon enacted into law the End Stage Renal Disease program (ESRD) of Medicare, as part
of an overall Social Security amendment package.

Briefly, Medicare provides for a patient's medical costs after the age of 65 or after disability occurs. Eligibility is based on the number of months and years the person has contributed to Social Security while working. If someone is over 65 but has not accumulated enough work time to be automatically eligible for Medicare, that person can still enroll for a fee that covers Part A (hospital insurance) and a monthly premium that covers Part B (medical benefits).

To be eligible for ESRD benefits, a person must be over 65, disabled, worked under the Social Security or railroad retirement system, or be the spouse of dependent child of a worker with enough Social Security or railroad retirement work credits. This covers nearly 93% of all patients needing kidney treatment. The remainder are usually covered by the Veteran's Administration, Department of Defense (CHAMPUS) or other forms of coverage.

Medicare's Part A/Hospital Insurance covers hospital expenses incurred during inpatient dialysis or surgical transplantation, after the patient assumes a deductible and any costs during a waiting period.

Part B/Medical Insurance is the voluntary portion of Medicare and requires a monthly premium, an annual deductible, and a 20% coinsurance on the patient's part. Part B covers physician services, outpatient hospital services, outpatient maintenance dialysis, durable medical equipment and most items necessary for home dialysis. (1)
Financing for ESRD is derived from the Medicare drawing account which is comprised of payroll taxes, premiums, and other federal funds. The drawing account is overseen by the Health Care Financing Administration of the Department of Health and Human Services. HCFA administers the Medicare program, sets its policies and contracts with intermediaries and carriers that process claims from medical providers. HCFA then draws funds from the Medicare drawing account and disburses them to certified providers and suppliers of ESRD services. (2)

With its enactment, ESRD enrollment grew from 11,000 at the start of the program to 63,200 at the end of 1980. More spectacularly, the total cost of ESRD rose from $283 million in fiscal 1974 to $1.8 billion in fiscal 1982. (3) It is estimated that by 1986, the Federal government will be obligated to pay over $3 billion for 87,000 kidney patients. Although the costs of this entitlement program are small compared to the entire Federal entitlement juggernaut, the unabated growth of ESRD will present future health policymakers with a difficult, if not intractable, dilemma - how much is the government willing to spend to sustain human life?

The remainder of this chapter will examine the ESRD program with respect to the circumstances leading to its enactment as an entitlement, the strategies used by Congress to slow rising costs, and the strategies used by benefactors of the entitlement to maintain favorable provisions once it became evident that amendments would be forthcoming.
Part I - The Drive Towards Entitlement

The pre-enactment development of the ESRD entitlement is special because there was no vociferous champion to part the legislative seas on its behalf. What occurred was an insidious, albeit checkered, transition of influence from the "expenditure-control" groups - the House and Senate Appropriations Committees, the medical research community, and the Public Health Service - to the "pro-entitlement" groups - the House Ways and Means and Senate Finance Committees, community dialysis centers, the Social Security Administration, and the renal physicians. There was no rallying cry for entitlement; instead, there was a convergence of political changes and medical innovations over a 9-year period between 1963 and 1972 that predisposed the government to embody kidney disease benefits as an unrestricted entitlement. Furthermore, the identification and publicity of individuals dependent upon renal treatment made it virtually impossible for politicians immediately before the 1972 elections to openly challenge the entitlement without political cost.

The Primacy of Appropriations

Throughout the scientific development of hemodialysis and kidney transplantation in the 1960's the Congressional appropriations committees were generous in supporting basic medical research but they balked at extending funds for patient care financing. Both modes of treatment were
considered "experimental" and not established therapies. The implicit assumption was that additional time, money, and effort were needed to develop the most efficacious (and cheapest) method in treatment kidney disease.

To that end, the House and Senate Appropriations Committee in 1964 added $2 million to the budget request of the National Institute of Allergy and Infectious Diseases to help establish a Transplant Immunology Program in order to study the specifics of immunosuppression in organ transplantation. (4) Although the allotment was not specific to kidney research, Congress anticipated advances in immunology that would solve the persistent rejection problem in transplantation.

Specific funds for kidney research had started earlier in FY 1963 with the Senate appropriation of an additional $1 million to the National Institute of Arthritis and Metabolic Diseases for general research on kidney diseases. It was not until FY 1966 before Congress pushed for an Artificial Kidney/Chronic Uremia Program within NIAMD. To reiterate their support for such a program, the House Appropriations Committee added an extra $2 million to NIAMD for "the development of a better artificial kidney than the machines which now exist." The Senate Appropriations Committee added another $1 million in hopes of speeding research. (5)

The medical research community in the early years of experimentation and development were unsettled as to whether hemodialysis and / or transplantation constituted more of an
experiment than definitive therapy. There were uncertainties about the ultimate outcome of kidney research and whether there could ever by a cure for end stage renal disease. But as rates of survival for dialysis and transplantation improved, the opinion that these modes of treatment could be considered contemporary therapy grew stronger.

The importance of such a debate within the medical community becomes more apparent in this excerpt from a 1965 House Appropriations hearing:

Congressman Laird: "Do you consider dialysis a research program or a treatment program?"

Dr. Tsaltas (a doctor undergoing dialysis himself): "I believe that chronic dialysis has gone beyond the actual experimental stage and it is now at the point where we can apply it to save lives. The kidney machine is no longer an experiment ... it keeps people alive." (6)

The melding of moral duty and the technological imperative to use contemporary treatment in order to save lives would later prove to be a powerful force towards Congressional approval of the ESRD entitlement. But in light of the Appropriations committees' desire to "wait and see", Dr. Tsaltas' thinly veiled plea to substantially expand access to renal treatment was barely heeded.

In terms of expanding access to renal dialysis and transplantation, the appropriations committees moved very cautiously and provided only limited support to the first 14
community dialysis centers administered by the Public Health Service. The Senate Appropriations Committee in 1964 was explicit in limiting the Public Health Service's use of appropriated monies in renal treatment strictly towards "demonstration and training programs" and not towards patient care financing. The overriding concern was cost: "The Federal Government has borne the cost of treatment for its legal beneficiaries and shared these treatment costs when it has been in connection with research investigation or demonstration. Traditionally, payment for illness has been the responsibility of the patient or the local community. If the Federal Government were to share the full costs of lifetime treatment for all who suffer from these chronic diseases and conditions, the financial burden would be excessive." (7)

Even the money provided in 1964 for demonstration and training was meant to be temporary: it was expected that by 1967 community financial support would replace the federal funds. When such support was not forthcoming, the appropriations committees continued their allocations until 1969. At that time the Health Services and Mental Health Administration, which had assumed administrative but not legal responsibility for the kidney programs, moved to end federal involvement in the centers by terminating the original grant contracts. (8) The director of the Regional Medical Program Service was adamant against funding patient care: "Our present system of health care controls costs in cases like this by
setting up barriers to adequate care by making accessibility and financing difficult or impossible. The costs in dollars, facilities, and health manpower of a national kidney program which would remove these barriers to patients with end stage kidney disease are so great that for the time being we may have to leave them erect." (9)

At this point in 1969 the Appropriations committees had effectively checked federal involvement in community end stage renal disease to only 14 dialysis center and no provisions for financing patient care. However, other factors had developed enough influence that would remove ESRD from the control of the Appropriations committees and establish it as a full fledged entitlement.

The Transition to Entitlement

Amidst the quelling of ESRD patient care financing for the general public, the Federal Government as early as 1963 had already established a small ESRD entitlement program for veterans eligible for medical benefits. According to Richard Rettig of the Rand Corporation, the Veterans Administration had provided for ESRD treatment with the concurrence of the Bureau of the Budget. By 1972, dialysis units were established in 30 VA hospitals and maintained nearly 15% of all dialysis patients in the U.S. (10)

The VA ESRD entitlement was significant because it catalyzed discussion between BOB and the Office of Science and Technology over the cost implications of sustaining the
units. BOB and OST drew together a panel of experts known as the Gottschalk Committee to make recommendations on government dialysis and transplantation therapy policy. In 1967 the Gottschalk group endorsed the VA use of dialysis and transplantation and also urged use of home dialysis, a much cheaper mode of treatment. More significantly, the Gottschalk Committee called for patient care financing for renal disease through Medicare. (11) The Committee thus linked the Johnson Administration recommendation for disability benefits with end stage renal disease, a linkage that provided the impetus for conferring Medicare benefits to the severely disabled.

Another significant factor favoring ESRD entitlement benefits was the growing number of clinically oriented renal physicians. As opposed to the research physicians, the clinicians' primary concern was the advancement of therapy for their patient. As the efficacy of renal therapy improved, the clinicians advocated a stronger federal role in ESRD (12) and became increasingly frustrated by the consistent denial of patient care financing.

In 1970 community based dialysis centers, threatened with termination by the Health Services and Mental Health Administratio, were transferred through legislation from the Public Health Service to the Regional Medical Programs Service. This transfer broke dialysis and transplantation away from the restrictive, research orientation of the PHS and the Appropriations Committees to the capacity building, patient orientation of the RMPS. The transfer allowed decentralized
funding through the established regions of the service, but patient care financing continued to be excluded. (13)

In retrospect, an existing entitlement framework (VA benefits), a growing cohort of clinically oriented renal physicians, and expanded capacity for dialysis and transplantation brought Federal kidney programs to the brink of entitlement. What was needed was a new framework for ESRD to garner legitimacy as therapy and thus eligibility for patient care financing. As Rettig denotes: "As long as kidney disease programs were authorized and funded under the authority of the Public Health Service Act, it was possible to confine the government's responsibility to activities that stopped short of patient care financing. To bridge that gap, it was necessary to shift the context of the policy debate from that provided by Title XVIII of the Social Security Act, but even this was not sufficient to ensure the commitment made in section 299-I (the ESRD entitlement). The ability of the Congress and its staff to relate end stage renal disease to disability and prospectively to catastrophic health insurance was also necessary." (14)

The Embodiment as Entitlement

When capacity for renal treatment increased and the number of patients, and medical costs both grew accordingly, public attention became focused upon the quality of life and inability to pay issues. Interestingly, each of these issues influenced
the chairs of the key Congressional authorization committees to favor ESRD as an entitlement. Senator Russell Long, chair of the Senate Finance Committee and long-time advocate of catastrophic health insurance, viewed kidney disease not only as a disablement but also as a catastrophic disease that few people could finance on their own. He favored inclusion of kidney benefits under Medicare not only to financially protect people from kidney engendered disability but also to serve as a forerunner of catastrophic health insurance funded by Medicare.

The plight of people who must undergo dialysis became highly publicized and introduced an emotional element to the issue. A demonstration of dialysis before a hearing of the House Ways and Means Committee apparently convinced the chair, Wilbur Mills, to favor inclusion of benefits under Medicare. (15)

The final embodiment of ESRD as an entitlement began in early 1971 with the introduction of HR 1 by the Nixon Administration. HR 1 was a package of major amendments to the Social Security Act and included new benefits for needy aged, blind, and disabled. HR 1 also liberalized payments and introduced incentives for health maintenance organizations. But the most controversial proposal called for the revamping of the family welfare system. Debate lingered on for a year and a half between liberals and conservatives and by the time the proposal was dropped in mid-1972, vigilence and scrutiny towards other aspects of HR 1 was considerably lessened.

At no time during the hearings on HR 1 did the House or
Senate hear testimony on renal disease. And it was not until the entire bill reached the Senate floor that an ESRD amendment, introduced by Senator Vance Hartke, was considered. The Senate accepted the amendment after 30 minutes of debate and the House-Senate conference committee approved ESRD with only 10 minutes of deliberation and with one minor alteration. Nixon signed the entire package on October 30, 1972.

The ease of entry of ESRD onto the Medicare ledger seems anticlimactic after years of struggle under the control of the PHS-Appropriations partnership. What facilitated approval was a general acceptance of dialysis and transplantation as contemporary therapy and the concomitant need to finance the tremendous patient care costs. What also helped ESRD is what Aaron Wildavsky terms as the "policy eclipse". As the issues of the day become more and more complex, the Congress must often consider major bills simultaneously with little time for deliberation and investigation. Debate usually focuses upon the most controversial provisions of the package, leaving the other proposals unscathed. (16) After the battle over the controversial family welfare proposal in HR 1 was over and elections approached, Congress was not inclined to renew political conflict over other facets of the bill that had the general support of the rest of the members.

The implication is clear: entitlements that are enacted on the coattails of a larger initiative and that have not been subjected to legislative scrutiny often can generate unanticipated cost escalation in later years. (17) Underlying
assumptions about the provisions of the entitlement go unchecked and Congress must deal with the financial consequences \textit{ex post facto}, not always successfully or without political difficulty.

Part II - The Drive Towards Containing Costs

In the brief Congressional dialogue over the ESRD amendment, Senator Hartke along with Senators Jackson and Magnuson assumed that new advances in medical technology would eventually drive down the costs of dialysis. Hartke also asserted that 40\% of people being dialyzed could return back to their jobs while the other 60\% could be retrained before reentering the work force. Hartke estimated that first year costs would be about $75 million and fourth year costs to be around $250 million. (18)

Unfortunately, the rosy forecast was not accurate at all. The 1974 Federal expenditure (first full year) was $283 million while in 1978 the cost had ballooned to $947 million, (19) a far cry from the original estimate advanced by Hartke. What factors belied the very rapid growth of the ESRD entitlement? One of the overlooked factors is the sharp drop of patients using home dialysis, a much cheaper mode of treatment than dialysis at a hospital or proprietary clinic. The ESRD amendment, while liberalizing provisions towards care in a hospital or outpatient dialysis did not provide economic incentives such as full reimbursement to facilities providing
equipment and supervision for home dialysis. As a result, many patients who would otherwise consider home dialysis continued to be dependent upon medical or proprietary center dialysis, thereby hiking government costs.

Another therapy that did not live up to the optimistic expectations was cadaveric transplantation. Successful transplants allow the recipient to live an independent life with only regular immunosuppressant therapy needed to maintain the new kidney. It is the general rule in surgery that as a new procedure is carried more often, the success rate increases. But for transplantation there has been a slight decrease in the success rate to nearly 45% of cadaveric grafts from a high of 53% (20) A greater percentage of patients who attempted transplantation soon returned to dialysis.

There was hope when ESRD was enacted that a cure for renal disease would arise. The entitlement then could pose itself as a temporary life-sustaining measure until a cure could be found. But today there has been no medical or surgical breakthrough to free patients on dialysis. Such stagnation in scientific progress allows a steady increase in the patient pool and continued rise in federal spending.

Rise of Proprietary Dialysis: Reimbursement as "Entitlement"

While the entitlement are generally thought of as benefits conferred upon individuals or families who meet certain eligibility criteria, the reimbursement mechanism of
payment to enterprises and institutions that secure or provide the promised benefit becomes a form of "entitlement" for the providers. In ESRD, as long as the providers carry out their treatments to the designated beneficiaries the providers are guaranteed reimbursement for their service. The providers became a vested interest group and are often more vocal in promoting the entitlement program than the beneficiaries.

The National Medical Care corporation (NMC) grew phenomenally after the 1972 enactment of ESRD. By keeping their costs low and opening centers in populous areas, NMC was able to make substantial profits with the reimbursement from the government. By 1980, NMC earned over $20 million on revenues of $245.5 million while its 120 dialysis centers treated nearly a fifth of the nation's dialysis patients. (21)

Thus, NMC had a substantial interest in maintaining and raising the reimbursement rate on terms favorable to itself. In response to criticism from policy makers, especially the HCFA, that NMC was making too much money from dialysis, Constantine Hampers, chairman of NMC, asserted: "Physicians in for-profit units have a strong incentive to learn about costs and control them. They are involved in medical economic management as well as clinical management; this results in integrated administration of health care. The success of the ESRD program in expanding service to meet demand while controlling costs and maintaining quality has been due primarily to the combined effect of setting a price and creating a system of incentives that involve physicians in the medical marketplace." (22)
centers did not have to deal with suppliers and the centers assumed responsibility for billing the government. ESRD paid doctor fees for supervision in a center and not for routine house calls, except if the patient was sick, became hospitalized or needed an examination. Whereas ESRD reimbursed specialized nursing and technical support in a center, no provision was allowed for such assistance given in the home. Finally, the 3 month eligibility waiting period for benefits forced candidates to wait until the period was over to begin home training. (24) Similar coverage problems were identified for transplantation, including post-surgical coverage, coverage after transplant failure, and the waiting period.

Pressure focused upon the Senate Finance Committee and the House Ways and Means Committee to redress the economic disincentives towards home dialysis and transplantation. In 1974, the Renal Physicians Association urged Senator Long to liberalize coverage of equipment, supplies, and medical assistance for home dialysis. While Long introduced a bill in April 1975 that included these provisions, no hearings were held and no further action in the Senate seemed likely. (25)

In the House, the decentralization of Ways and Means into various subcommittees after Wilbur Mills's resignation as chairman led to new initiatives in examining ESRD. Rep. Charles Vanik, chairman of the Subcommittee on Oversight, held hearings on ESRD with particular focus upon the declining percentage of patients on home dialysis. Vanik subsequently introduced a bill more extensive than Long's bill. Vanik's proposal provided for the coverage of all supplies and equipment
The medical and technical expertise of NMC also translated into increased political influence. In the early years, Hampers and his colleagues were able to use their medical credentials and their network of peers at the Harvard Medical School to establish support for their pioneering company. As NMC expanded into new regions they recruited renal physicians from the top medical schools to run the local NMC center. This strategy effectively lessened opposition to NMC from area doctors because of the prominent renal physicians behind it. (23)

Thus NMC became a potent lobbying force, able to call upon the most prestigious names in nephrology to testify about ESRD.

Cutting Costs by Expanding Benefits: The Battle for Home Dialysis

The acceleration of ESRD costs coupled with the vast differential between the average payment for home dialysis and center dialysis precipitated a drive in Congress to encourage home dialysis. It was hoped that greater use of home dialysis would lower costs and promote higher quality of life.

As early as 1973, renal physicians identified five key obstacles that impeded use of home dialysis: (1) equipment, (2) operational costs, (3) doctor fees, (4) dialysis assistance costs, and (5) the entitlement waiting period. Patients had to pay 20% of the fixed equipment costs and had to assume maintenance costs. Patients also had to assume the 20% copayment for supplies but often had to pay suppliers in full and apply to the government for the other 80%. Patients treated at
accessory to home dialysis. He predicted that liberalizing benefits for home dialysis would result in annual savings of $147 million by FY 1981 if 50% of ESRD patients were to participate in self-dialysis. (26) The 50% figure would later become a major sticking point between Ways and Means and the medical provider groups.

Vanik's bill laid the groundwork for a major Ways and Means initiative in 1977 led by Rep. Dan Rostenkowski, who was chairman of the Health Subcommittee. The Rostenkowski-Vanik bill proposed much of the same provisions as previous bills and extended coverage of home dialysis equipment and supplies purchased by facilities.

The Rostenkowski-Vanik bill included:

Incentives for Home/Self Dialysis -

a. Waiver of the three month waiting period prior to qualifying for Medicare payments once the patient enters self-care training.

b. Coverage of disposable supplies used in home dialysis.

c. Coverage of supportive services and equipment maintenance for home patients.

d. Coverage of self-care dialysis provided by centers.

e. Full reimbursement to facilities purchasing equipment for home patients.

Elimination of Disincentives to Transplantation -

a. Coverage for a transplant patient beginning with the month he is hospitalized if surgery occurs within 3 months. The waiting period is waived.

b. Extension of Medicare coverage for transplant patients
from 12 to 36 months.

c. Immediate resumption of coverage, without a waiting period whenever a transplant fails.

d. Coverage for live kidney donors including the period of the donors' recovery. (27)

The Rostenkowski-Vanik bill also called for a national quota of 50% of all ESRD patients in renal disease networks to be on home dialysis or in self-dialysis training. All major groups who testified on behalf of the elimination of disincentives were opposed to the establishment of quotas. (28) The medical groups argued that quotas would intrude upon the doctor-patient relationship and possibly push patients with more severe conditions away from the intensive supervision of a medical center.

But fierce opposition to the home-dialysis quotas arose from the National Medical Care Corporation. Ostensibly, a Federal mandate of a 50% home dialysis rate would substantially cut into NMC's patient load, revenues, and profit margin. NMC's strategy was to oppose quotas on the ground that home dialysis patients survival rate was lower than that of center dialysis patients, a controversial medical point at that time. Dr. Edmund Lowrie, a prominent Harvard nephrologist testifying on behalf of NMC, stated, "After careful analysis, the only obvious reason for this inferior patient survival that we can think of is the indiscriminate use of home dialysis therapy." (29)

NMC's assertion stymied the legislative process. Sen.
Dole ordered a GAO study on the comparative mortality rates between center and home dialysis: the study showed that mortality was slightly lower for home treated patients. Nonetheless, when the Senate approved their version of the bill it replaced the quota with a "national goal" towards 50% home dialysis rate. (30)

Even a national goal was unacceptable to NMC. NMC successfully lobbied Sen. Herman Talmidge, chair of the Senate Finance Health Subcommittee to reject quotas altogether in the final bill. In its place was the statement, "It is the intent of Congress that the maximum practical number of patients who are medically, socially and psychologically suitable candidates for home dialysis or transplantation should be so treated." (31) President Carter signed the watered-down bill on June 13, 1978.

NMC's strategy was successful - they prevented a quota and they enhanced their revenues by getting 100% reimbursement for home dialysis supplies and equipment they purchased for their patients, instead of the previous 80%.

It is not clear whether the home dialysis liberalization had any real impact upon the growth of ESRD expenditures. The percentage of patients on home dialysis has not approached 50% and costs continue to rise. HCFA predicts that by 1986, ESRD costs will reach $3 billion, compared to $1.8 billion spent in 1982. (32) Interestingly, there were no proposals during the policy debate to loosen or tighten eligibility standards. One reason for this is that nearly the entire population was
deemed eligible by the original entitlement legislation in 1972, and for politicians to call for the tightening of standards would have invited intense opposition from all quarters of the health policy arena. This again underscores the basic moral dilemma of medical entitlement programs: how much can the government afford to save human lives?

**Slowing Costs by Fostering Competition: the Battle for Prospective Reimbursement**

Consonant with Congressional intent to reduce ESRD costs and to promote efficiency following the passage of the 1978 amendments, the Carter Administration set about establishing a single national rate of payment of $129 per treatment for both hospitals and proprietary facilities. Hospitals were reimbursed at that time at 80% of their costs or $138 per treatment, whichever was lower, while proprietary and other independent facilities were paid 100% of their charges, or $138 per treatment, whichever was lower. Exceptions were made if the unit could document special circumstances or costs. (33)

Although HCFA felt a single rate would force more efficiency from providers, the hospitals were vehemently opposed to a single rate, claiming that they have higher overhead and specialized personnel costs in caring for more sick patients than do the proprietary centers. The hospitals strenuously argued for a dual rate (with the higher rate for themselves) that would take into account their particular
economies. Otherwise, the hospitals warned, the single rate would force many of them to close down their units and leave many patients without convenient access to their dialysis. (34)

Proprietary dialysis centers, particularly National Medical Care, strongly preferred a single rate. Aside from their usual pro-competition, pro-efficiency stand, NMC argued that a dual rate would draw more patients to the specialized medical centers even if those patients did not need such highly technical care. Such a trend would reduce NMC's patient load and cut revenues. Conversely, a single rate would enhance NMC's competitive standing and thus draw more patients to NMC even at the expense of the hospital centers' demise. NMC also refuted the hospitals' argument concerning their overhead and patient mix. NMC chairman Constantine Hampers argued that there was no demonstrable difference in overhead or caseload between hospitals and NMC, since the main cost of ESRD is in labor and supplies. "Overhead is not the major difference," Hampers said, "It's a question of efficiency, and the hospitals just don't focus that." (35) NMC went on to threaten closure of 60 of its centers if a dual rate were adopted. (36)

HCFA, assigned by Congress in the 1978 amendments to administer the new reimbursement rates, found itself in the middle of the hospital - proprietary battle and delayed a policy decision for 2 years to try to come up with a proposal amenable to both sides. In January 1980, HCFA relayed to HHS Secretary Patricia Harris a four-rate reimbursement proposal - hospital and nonhospital categories with each divided into
capita fee regardless of the mix of medical services provided. The doctor also received less under ARM for home care than under the initial period. (40)

Schweiker eliminated the initial method of payment in favor of a consolidated prospective payment under ARM for home and center care. (41) The intention was to engender a greater incentive on the physician's part to shift their patients to home dialysis if medically allowable.

The Reagan Administration strategy was clear: use prospective reimbursement for both institutions and physicians, rather than liberalizing benefits, to foster the cheapest mode of treatment. While a single rate of provider reimbursement was preferable, aligning the dual rates very close to one another signaled a pro-competition environment for the hospitals.

In retrospect, when costs rose very quickly after the ESRD entitlement was enacted, the two main authorization committees, House Ways and Means and Senate Finance, used the strategy of liberalizing the provisions surrounding the cheapest mode of therapy to encourage higher demand from dialysis patients. Administrative agencies like HCFA and HHS preferred the strategy of enticing providers of care to have their patients use home dialysis by offering prepayment for services.

Interestingly, on the beneficiary side, the kidney patients themselves were not a particularly active nor powerful force in the ESRD debate. This was probably because eligibility
was never questioned by the politicians and policymakers, thus their entitlement seemed assured. On the other hand, the providers of renal therapy had both a profit and capacity-building interest in opposing "undue" encouragement of home care. NMC's strategy was to criticize the efficacy of home dialysis and efficiency of medical hospitals, thereby enhancing their own stature. NMC also used a dubious threat to halve their dialysis capacity unless policy was ameliorated to their approval. The administrative policymakers held sway only by involving a profit incentive for NMC and other proprietary centers in home dialysis.

Whether prospective payment slows the growth of the ESRD entitlement to the satisfaction of present and future political administrations remains to be seen. But as ESRD beneficiary enrollment enlarges by an average of 12,000 cases a year while dialysis and transplantation keep their cohorts alive, total costs will continue to grow. There may be a time when policy makers must grapple with reexamination of the eligibility standards themselves. Americans might have to "ration" dialysis capacity and funds by denying treatment to the elderly, as is done in Great Britain. The moral day of reckoning seems far away as the increased expenditures are subsumed in the federal deficit, but if ESRD and other medical entitlements cannot be restrained within reasonable bounds, that day could draw uncomfortably closer.
Chapter Two: The Federal Coal Miner Black Lung Entitlement

"Black lung" disease or pneumoconiosis, refers to the same pathological process: inhaled coal dust lines the airways of the lung and causes a nonspecific reaction of either epithelial or parenchymal tissue. If the reaction is extended to a very significant degree, the respiratory capacity of the lung is irreversibly lowered and the person becomes increasingly restricted in his activities. In extreme cases, fibrotic changes can be so overwhelming as to inhibit blood flow from the heart to the lungs, resulting in right heart failure and eventual death.

But the great majority of pneumoconiosis cases, even in coal miners, is simply "dust retention" with no pathology or symptoms. These "category 1" people may or may not progress to the disabling manifestations of the disease and there is no predictive correlation between the presence of category 1 pneumoconiosis and disability from other factors such as smoking, lifestyle, and the sex of the individual. (1)

Black Lung: An Entitlement Engendered by Disaster

On November 20, 1968, a catastrophic coal mine explosion at Farmington, West Virginia killed seventy-eight miners and sparked a nationwide outcry over the working conditions in the mines. The television pictures of smoke, rescuers, and weeping families ingrained a powerful sense of social injustice and corporate negligence into the national psyche
at the time. It was almost inevitable that the Federal Government would be called upon to redress the miners' plight with regulation and compensation. However, it was intended that any Federal participation would be temporary and limited in scope while the states and the coal mining industry negotiated a compensatory mechanism for on the job disability and coal dust pneumoconiosis. Once these arrangements were settled, it was thought, the Federal Government would withdraw its administrative and financial involvement. Seventeen years later, the Government has contributed nearly $1.8 billion a year to support disability payments to miners through a trust fund and is not expected to fully recover its monies until 1995, if ever. (2)

Creation of Black Lung Benefits - the Funding of a "Moral Obligation"

Even before the 1968 Farmington disaster, the United Mine Workers' Union (UMW) had long established itself as the leading advocate of coalmine safety and health care benefits for its members. But the UMW's use of wildcat strikes and implacable demands worsened their adversarial relationship with the coal companies and hardened positions on both sides. Militancy within the union grew throughout the 1960's as higher economic demand for coal increased industry profits without raising coal miner wages or benefits by any appreciable amount. At the same time, public awareness of black lung disease in the coal mining regions grew with the efforts of
physicians from the UMW's Welfare and Retirement Fund. By 1968, these doctors were successful in persuading the union to lobby the coal-mining states, especially West Virginia, to accept coal workers' pneumoconiosis as an occupational disease covered by the states' worker-compensation programs. (3) However, the black lung issue failed to make any progress with the legislators in Charleston.

Black lung soon became a major issue among the rank-and-file immediately after the Farmington explosion. In addition to being linked with safety conditions in the mines, black lung became a focal point of rank-and-file opposition against not only the operators but against UMW president W.A. Boyle. Boyle came to the scene of the disaster and absolved the Consolidation Coal Company of wrong-doing by stating Consolidation was "one of the best companies to work with as far as cooperation and safety are concerned." (4)

When Boyle refused to lead on health and safety matters, two intra-union groups were formed to advocate black lung compensation: 1) the Physicians' Committee for Miners' Health and Safety and 2) West Virginia Black Lung Association. Both groups, in cooperation and consultation with each other began to crusade among coal mine communities to publicize the issue. The movement succeeded in uniting the miners over the necessity for black lung compensation and the inadequacy of UMW leadership to push for reform. (5)

By early 1969, the black lung issue became a passion when scattered, spontaneous walkouts at various mines ignited
into a massive series of "black lung strikes" involving over 45,000 miners in West Virginia, Pennsylvania, and Ohio. Miners besieged Charleston to clamor for inclusion of black lung as a compensable occupational illness. The WVBLA introduced a bill before the West Virginia legislature that included a "presumptive diagnosis" clause which would award benefits to a miner on the basis of 1) the number of years worked in the mines and 2) the presence of a "lung disease". The coal companies opposed the bill and called for a series of diagnostic procedures aside from X-rays to firmly establish presence of pneumoconiosis. A compromise bill was arranged whereby a liberal definition of black lung was adopted along with acceptance of an array of diagnostic criteria to be considered as evidence of disability. West Virginia Governor Arch Moore signed the bill in March 1969 and effectively ended the strikes. (6)

The West Virginia laws took on greater significance in Washington because it established a black-lung entitlement framework that the miners took to be a central tenet of their health care interests. As federal policy on the black lung issue evolved, a broad-based definition of black lung as adopted by West Virginia was a lever by which the miners could establish and liberalize their federal benefits. Furthermore, the fervent demonstration of militancy by the miners instilled a popular notion of "moral obligation" by the Federal government to insure safety and compensation. The public image of the miner as an economic instrument of the coal
companies put the industry and the expenditure control
groups in Congress on the defensive for the coming decade.

Entitlement by "Default"

It was inevitable with the great publicity over the
Farmington disaster that federal initiatives would be forth-
coming. The perception of a need to improve mining environs
and to promote miner health set the stage for the creation
of a Federal entitlement as an apparatus to administer
benefits fairly and within Congressional intent. The question
was not whether there should be an entitlement but how a
forthcoming entitlement should be structured, funded, and
administered, and what categories of diseases were to be
covered.

The duration of Federal participation added another
dilemma for policy makers. This issue was very much dependent
upon the ultimate assignment of responsibility for the
miners' disabilities. If the coal companies were to be
liable, it was argued, then Federal participation should be
circumscribed to the temporary provision of benefits until the
industry develops the means to deal with compensation. But
if the health and safety of the miners was deemed a social
insurance issue, then the Federal Government should be obligated
to commit support through either a standing agency like the
Social Security Administration or an independent agency
specifically geared to black lung.
In December 1968, while the UMW rank-and-file campaigned in West Virginia, the Johnson Administration backed Interior Department recommendations to endorse UMW's call for regulation of allowable coal dust in the air of mines to 3 milligrams of dust per cubic meter. (7) Congressional initiatives throughout 1969 included what the miners demanded from the state of West Virginia - the acceptance of black lung as a compensable, occupation derived affliction. The coal companies vigorous denied liability for any lung affliction by asserting that such lung diseases do not have a "100 percent correlation" with mining, and are more likely to be derived from personal habits, like smoking. (8)

By December 1969, Congress crafted the landmark Federal Coal Mine Health and Safety Act of 1969, the forerunner to the Occupational Safety and Health Act of 1970. Title IV of the coal mine act was entitled "black lung benefits" and mandated that the disease be compensable with funds from general revenues. Congress asserted that the extent of pneumoconiosis was such that it was impossible for the states and the coal industry to be able to pay even partial benefits. (9) Congress was drived by a sense of urgency to provide benefits to long-suffering miners without incriminating the coal industry. The industry was pleased with compensation provisions for it relieved them of any financial liability in exchange for acceptance of the extremely strict air standards. (10)
In late December 1969, President Nixon was prepared to pocket-veto the bill because of its costly implications to the budget, but a new series of wildcat strikes in West Virginia in response to the delay quickly changed his mind. (11) Nixon signed the bill on December 29, 1969, marking a new era of Federal entitlements in occupational disease.

It seems evident in the drama of the entry of black lung onto the entitlement ledger that the antagonism between a coalition of workers and the presiding industry was a primal political force behind the Federal assumption of financial responsibility. The existence of established agencies, financing mechanisms, and fervent political support from key Congressmen facilitated implantation of the entitlement. The failure of the government to assign responsibility outside of itself predisposes the government to "entitlement by default" when vested interests disagree upon liability provisions. While government assumption of medical entitlements may be seen as short-term compromise for political expediency, the more likely pathology is long-term commitment with financial hemorrhage.

Provision of the Black Lung Program - A Framework for Expansion

Administration:

When Nixon signed the coal mine act, the Social Security Administration was given two week notice to prepare to process and disburse funds to thousands of applicants. The SSA
already had a nationwide network of offices and fieldworkers knowledgeable in disability insurance programs and evaluation of medical criteria. Thus, the agency was deemed suitable as the intake valve for the program.

Since the federal benefit was intended as a temporary mechanism until the states adopted new laws that included black lung as a compensable disease, the participation of the Government would continue only until the states were financially and administratively ready to accept the miners. The SSA was also scheduled to stop processing claims by the end of 1972, after which the Department of Labor was to assume responsibility for program administration. (12) To accentuate the temporary nature of the program, funding was to come from general revenues and not from the Social Security Trust Fund (13). The source of funds reflects a difference in approach in social insurance. Social Security is based upon contributions from both employee and employer while the black lung benefit is similar to workmen's compensation whereby the employer is assessed indemnity for the injury or illness suffered by his employees. In this instance, the financial indemnity is not from the coal companies but from the coffers of the Federal Treasury. (14)
Benefits and Beneficiaries:

The black lung provisions of the Coal Mine Health and Safety Act entitles two main groups of people: totally disabled coal miners from pneumoconiosis derived from underground mines, and widows of underground coal miners who died from pneumo-
coniosus. Basic benefit amounts are linked to the Federal Civil Service disability benefit levels with increases as Federal salaries rise with adjustments. (15)

To simplify the verification of occupational causality of black lung disease and presence of total disability, there are three key "presumptive" clauses in the law that automatically qualifies the applicant to benefits. One clause assumes that pneumoconiosis is derived from mining if the worker spend 10 or more years in an underground mine. Another clause assumes that the miner is totally disabled if the prevailing pneumoconiosis is "complicated", (classified as Category A,B, or C in the International Classification of Radiographs of Pneumoconiosis). The remaining clause entitles a widow to benefits if the miner had "complicated" pneumoconiosis or had already been drawing benefits from the law. This clause also presumed that the pneumoconiosis was derived from mining if the miner worked 10 years in an underground mine and died of a "chronic lung disease". (16)

For those miners and widows not covered by the clauses of irrefutability, the presentation of medical evidence of disability caused by pneumoconiosis from working in an underground mine is necessary for evaluation by the SSA. If applicants are rejected by SSA, they are empowered with the right to an administrative review. If they are still denied, they may seek a hearing before a hearings-examiner, the appeals council, and the Federal judiciary system. (17)
Provisions for Benefit Reduction:

Since it was anticipated that many people applying for coal miner benefits were also receiving or applying for social security or state workmen's compensation benefits, both the Social Security and Coal Mine Acts contain clauses to reduce overlapping and duplication of benefits. On the Social Security side, the law limits the amount of combined income from social security disability benefit and workmen's compensation program to 80% of the worker's current earnings. If the combined amount exceeded 80%, the Social Security benefit would be reduced. The Coal Mine Health and Safety Act ordains a dollar for dollar reduction of federal coal mine benefits if the miner is also receiving money from a state disability program. (18)

Overall, several aspects of the entitlement lends itself to future growth and to demands for eligibility liberalization. First, the clauses of irrefutability between the presence of pneumoconiosis and the amount of time spent in the mines, and the assumption of total disability upon demonstration of "complicated" pneumoconiosis denies the government a method of adequate review. Second, unlike most workmen's compensation programs where there is an inherent adversarial relationship between the worker and the companies, the black lung entitlement removes such antagonism by forcing the government to pay out benefits without assessing responsibility upon the coal mine operators. Although the government reserves the right to recover monies paid to workers from the responsible operator,
the lengthy and costly appeals process available to the operators makes such a recovery a very costly enterprise. Third, the appeals process available to unsuccessful applicants incurs additional legal and administrative expenses. Backlogs of cases add to the frustration of both worthy miners and claims-adjustors and fuel political pressure to simplify the process by liberalizing eligibility criteria. Fourth, the very specificity of the entitlement - pneumoconiosis and disability derived from underground coal mining - entails substantial effort to document, review, and assess medical criteria (often incomplete) relevant to the benefit. Altogether these factors will present difficult political and economic constraints upon entitlement policymakers.

**Expansion of the Program to Relieve Administrative Frustration**

After the Coal Mine Health and Safety Act was enacted into law, it was expected that by mid-1970 over 165,000 applications would be filed. In reality over 183,000 were filed by June and 250,000 were filed by the beginning of 1971. (19) The backlog of claims created innumerable delays for thousands of miners and their dependents as well as frustration for many who were qualified but could not demonstrate X-rays showing dust opacities in their lungs. (20)

The first key liberalization of the black lung entitlement occurred in May 1972, when President Nixon signed PL 92-303 which specified that negative X-rays could not be the basis for denial of benefits. The 1972 amendment also declared that surface miners would be eligible for benefits too. It
also delayed by one year the implementation of the Department of Labor's responsibility for the program until July 1973. (21) The amendment also strengthened the government's authority to specify the "last responsible operator" as being liable for benefits the government already disbursed to an individual miner. The Federal government would honor claims presented to it by December 31, 1973, thereafter claims would be paid by operators via state worker's compensation laws or federal laws if state laws were inadequate. If no operator could be found, the benefits would be paid by the government. The operator's right to appeal remained intact. (22)

The 1972 amendment's liberalization of medical criteria needed to establish eligibility foretold a key development in the expansion of the entitlement. By accepting the eligibility of some miners who could not demonstrate radiographic evidence of coal worker pneumoconiosis, the amendment effectively expanded the definition of "black lung" to include dust-induced bronchitis and emphysema. (23) This phenomenon of expanding the number of compensable diseases under a generic category adds not only financial responsibility for the government but it also greatly enhances the applicant's accessibility to the entitlement through looser standards of medical criteria and administrative review.

The amendment did not alleviate the administrative problems that continued to plague the program. Under the Department of Labor's aegis, the average processing time for a single claim was over 645 days. Between 1973 and 1977, of
the 106,700 new claims, 53,500 were rejected, 49,200 were still pending and only 4000 were approved. Sixty percent of the approved claims were cases where the government could not locate the last responsible operator. The remainder were miners being paid by the government while proceedings were in progress to recover monies from the identified operators. Only 138 cases were fully covered by the operators themselves. The operators appealed government claims in nearly 92% of all cases brought before them for compensation. (24)

By 1975, both liberals and conservatives in Congress were concerned about the black lung entitlement but each group had a focus that was diametrically opposed to the other. Liberals, especially Democrats from the coal-mining states, railed against the long waiting periods and the seeming arbitrariness by which the SSA or Department of Labor judged the eligibility of miners. The Democrats on the House Education and Labor Committee with support from the UMW pushed for an amendment that would automatically presume that a miner who worked for 25 years in an anthracite coal mine or 30 years in a bituminous mine has pneumoconiosis and is therefore eligible for benefits. One would be eligible whether or not one actually had the disease. Those who did not have the required "seniority" would still be eligible to file under the Coal Mine Health and Safety Act of 1969 as amended in 1972. (25)

Carl Perkins, chair of the Education and Labor Committee and staunch advocate of the "30 year rule", asserted that a presumption of disability after a period of work was "medically
sound", based on what the Committee found to be "the historically demonstrated and exceedingly high probability of total disability (80.9%) and ... an equally probable risk of error in the remaining cases." Furthermore, the Committee heard testimony from physicians attending to miners supporting positive correlation of the disease with time worked in the mines. (26) Perkins believed that such a presumption would speed up the review process and award benefits to all eligible miners.

Conservatives, led by Rep. John Erlenborn (R-Ill), were opposed to the plan on two fronts: 1) it would allow some miners without the disease or disability to be eligible for disability funds and 2) it would convert the character of the entitlement from a temporary disability program to a permanent Federally financed pension plan for miners. Erlenborn was adamant against such a fundamental change: "We should not award disability benefits not based on disability." Seven other Republicans on the Committee concurred, stating, "there is no justification for extending benefits to miners who did not suffer from pneumoconiosis ..." (27)

The Democrats on the committee also proposed to transfer financial responsibility of the entitlement from the government to the coal industry by establishing a black lung trust fund financed by a coal tax. Such a trust fund would be designed to support those miners whom the government could not find the last responsible operator. The Democrats and the UMW reasoned that the trust fund would not only end federal obligations but
it would also force the industry to enhance the safety and environment for the miners if the companies had to pay for the benefits. (28)

The National Coal Association opposed this proposal, asserting that a trust fund would dissolve their right to due process and to contest eligibility determinations. The NCA also argued against raising taxes as being inflationary and damaging to marginally profitable operators. The cost-conscious Republicans, interestingly enough, sided with the operators and asserted that the trust fund would not speed the administration of the program. (29)

The Education and Labor Committee of the House, on Dec 31, 1975, voted for a bill incorporating the 30 year rule and the trust fund by a vote of 31 to 9. The Ford Administration remained silent on the issue but both the Department of Labor and HEW opposed the bill, stating that the bill would extend federal responsibility and exacerbate the backlog. The departments preferred to review the progress of the states' workmen's compensation fund before considering a trust fund to pay for benefits. (30)

The full House, after intensive lobbying by the UMW and Congressional members of the major coal-mining states, passed the Education and Labor Committee's recommendations by a 210-183 vote. The House also voted for a major amendment to the bill that would weaken review of medical criteria submitted for eligibility determination. The amendment would force the government to accept the miner's physician's reading of an X-ray review process solely to deny claims. The Congressional
Budget Office estimated that loss of review alone would cost the government $200 millions by FY 1978. (31)

The Senate Labor and Public Welfare Committee tightened the House bill by requiring some proof of disability as well as length of service in the mines. The Senate Finance Committee recommended financing the trust fund through an excise tax upon ton of coal to be collected by the Treasury. But because of time pressure, the full Senate tabled the bill after only one hour of debate. (32)

Congressional action in 1977 laid the foundation for the 1978 amendment to the 1969 Act. Action on eligibility standards by the House and Senate authorization committees effectively bypassed the more conservatively appropriations committee. In the Senate eligibility provisions were under aegis of the Human Resources Committee while trust-fund details were the responsibility of the Finance Committee. By splitting the two key elements of th entitlement proposal to separate committees, there was little leverage among expenditure control groups to limit fiscal obligations. Any limitations imposed in one committee could be negated by the liberalizations passed by another.

When the House Education and Labor Committee took up the black lung entitlement in 1977, it reaffirmed its support for the 30 year rule and the ban on government review of X-rays. The committee also eliminated a 1981 expiration date for the program, thus proposing to make the entitlement a permanent liability of the government. The committee liberalized disability standards for miners, making benefits available at
at earlier stages of pneumoconiosis instead of during the terminal stages, as mandated by the 1972 amendments. (33)

But to ensure full House approval, sponsors relented to pressure from conservative Democrats, Republicans, and the Carter Administration and dropped the automatic entitlement provisions of the bill. Representative Erlenborn aroused nagging doubts about Congressional intentions by stating, "The main issue ... is whether Congress should turn what was originally a one-shot disability benefit program into a permanent pension program, partially funded by taxpayers, for one class of workers - the coal miners. I say 'pension program' because there is no other way to describe benefits that are automatically awarded to workers solely on the criteria of years of service." (34)

The full Senate generally acquiesced with the proposals of the House but adopted a proposal by John Chaffee (R-RI) to restrict the ban of government X-ray rereadings only to miners who spent 25 years or more in the mines. It was argued that without some review, miners would "shop around" for a radiologist who would interpret the films as indicative of black lung. (35)

Congress eventually passed both the new eligibility standards and the trust fund provisions in early 1978. The eligibility standards finally signed into law included more lenient standards of disability, restricted governmental review of X-rays, allowed survivors of miners who spent 25 years in the mines to become eligible for benefits and allowed some miners who continued to work to be eligible as well. The new
Black Lung Disability Trust Fund was to be financed through a federal excise tax on coal - 50 cents a ton on underground coal and 25 cents a ton on surface coal. It also allowed tax exemptions to companies that establish their own fund to cover obligations towards miners it was found responsible for payment. The industry-wide trust fund was to pay for miners whom the government could not assign responsibility to an individual operator. (36)

Another key provision of the amendment commits the Treasury to cover any deficits produced by the trust fund. Unfortunately, the trust fund began to bleed almost immediately committing the government to pay nearly $420 million after FY 1979, $1 billion after FY 1980 (37), and $1.5 billion after FY 1981 with projections of a $9 billion deficit by FY 1995. (38) Lagging coal sales reduced income for the fund while operators continued to contest a high percentage of claims, thus transferring more cases to the trust fund's responsibility. The number of cases financed by the trust fund nearly doubled from 69,500 in 1979 to 138,000 in 1980. (39)

The burden almost worsened in 1980 when the House approved a bill transferring 8,000 to 11,000 black lung disability claims from the individual operators to the trust fund - a move which would have cost an additional $190 million a year. But the Senate did not take further action on the bill, as it was wary of the impending obligations. (40)
The advent of the Reagan Administration transformed the political environment surrounding entitlement programs. The focus shifted from increased Federal participation in social insurance issues to a desire to delegate obligations to responsive parties. Reagan's FY 1982 budget proposals called for restricting benefits to the "truly medically disabled" and increasing the coal tax for the trust fund. The budget stated, "Lax statutory and administrative procedures have expanded the program from its original purpose - to compensate people who are medically disabled because black lung disease - into a general coal miner's benefit program that approaches an automatic pension."

The benefit proposals, although vague, angered the UMW and the rank-and-file. Demonstrations in Washington and field strikes forced the Administration to hedge on their commitment to pare the rolls. (41) Nonetheless, the Reagan proposals set the tone over the course of 1981 to bring the trust fund back into solvency. In Congress, the once dominant House Education and Labor Committee was bypassed in favor of the Ways and Means Committee to examine proposals for coal tax increase. Administration strategists felt that the Education and Labor Committee would have resisted any benefit cuts and could have even expanded benefits to offset revenue gains. (42)

In exchange for sharp reversal of benefit and eligibility standards, Congress transferred 10,200 unresolved cases to the
fund, more than offsetting savings from benefits changes for the next five years. The bill doubled the coal tax until the time the trust fund fully repaid the government for monies paid from general revenues. The change in eligibility standards was even more striking: 1) it ended the presumption that miners with 10 years experience who died from a respiratory disease died as a result of black lung, 2) it ended the presumption that miners with 15 years in the mines who were totally disabled due to respiratory impairment were disabled from black lung disease and 3) it allowed the Labor Department to seek a second opinion in determining whether an X-ray shows pneumoconiosis. (43)

Benefits were also restricted by limiting survivor benefits to cases in which the miner died specifically to black lung benefits for those who were earning above the Social Security excess earning limit. (44)

Assessment of Black Lung as an Entitlement

The black lung program is a classical case of an intended temporary benefit transformed into an ongoing, autonomous entitlement that obligated Federal monies into the 21st century. The crisis that precipitated the benefit - the Farmington disaster - blinded policymakers to the long range implications of their actions. What compounded the problem is the
enactment of a "temporary" administrative system that 1) assumed the financial burden instead of the responsible companies and 2) got hopelessly bogged down assessing claims and fighting appeals from both miners and operators. Both of these factors engendered the liberalization of eligibility standards to just improve processing time and to create a trust fund that was woefully inadequate to sustain itself. The ongoing obligations of the trust fund in effect made the entitlement permanent because extending revenue apparatus often extends the existence of the benefits.

The Reagan Administration came the closest to aligning the black lung entitlement to the original intentions, but it failed to adequately resolve the moral and ideological dilemma of Federal financing of medical entitlement programs. The program still fails to assign ultimate responsibility for social and medical insurance upon interest groups. The dissolution of the adversarial nature of workmen's compensation in favor of federal acceptance of financial obligations enhances political compromise, but extends the ideological conflict into the future, only to be resolved with even higher costs to the interested parties and to society.
Chapter Three: The Roots of Entitlement Growth

Both the End Stage Renal Dialysis and Black Lung programs represented special medical entitlements because of their unusual growth and eligibility requirements. Both programs became established as "temporary" arrangements to sustain stricken individuals until new technology or a new payor emerged. The key assumption made in starting the ESRD entitlement was the future development of new dialysis technology and immunosuppressant drugs that would lessen the necessity of institutional dialysis or surgical operations. Black lung policymakers assumed that the "ultimate responsibility" for the coal miners' disability would one day be borne by the mining companies, the union, or even the coal miners themselves. Federal participation was considered a temporary, but necessary, arrangement in order to assist the miners while the political and economic debate raged on.

What was clearly unintended in both programs was the open-ended, long-term financial involvement committing billions of dollars to a small and specialized beneficiary group. Once it became clear that the old assumptions were wrong, why did it become nearly impossible for the government to scale down or to eliminate these programs? Are the reasons specific to these very specialized medical programs, or are they common to all entitlements? The answer is a complex one, but a careful examination of the patterns of entitlement development and their political dynamics among both medical
and nonmedical programs can yield useful insights concerning the key stages of expansion. Such an inquiry establishes important implications for future efforts in entitlement control and fiscal responsibility.

In reviewing recent studies of both medical and nonmedical entitlements, this paper describes and evaluates several key characteristics that instigate uncontrollable spending. These characteristics also encumber efforts at controlling rates of growth and absolute expenditures. The following types of entitlements will be discussed and analyzed:

- "Crisis" entitlements - those programs which arise from an actual or perceived danger to a specified group of people. They may include programs designed to fulfill some "critical" human need that has gone unrectified.

- "Automatic" entitlements - those programs dependent upon a declared policy objective, such as nutrition levels, or a demographic characteristic such as age or poverty. Programs incorporating these "automatic forces" are essentially uncontrollable by direct government policy.

- "Participatory" entitlements - those programs that incorporate incentives for a designated group of providers or administrators to provide or disseminate services. Such incentives may include decentralized control of spending, regulations, or eligibility determination.

- "Symbiotic" entitlements - those programs that are within another entitlement framework, or whose rules allow overlapping of eligibility for related benefits in a different entitlement.
It should be recognized that programs can incorporate more than one of the above characteristics. Such a classification facilitates analysis and highlights certain political and budgetary phenomena.

Crisis Entitlements: Compelling the Benefits

Both ESRD and black lung entitlements were forged in a perception of crisis: urgent action was seen as necessary to save lives and to rectify deplorable working conditions. While each program had different medical characteristics and epidemiological proclivities, both incorporated liberal eligibility standards and generous benefits.

In ESRD, the random nature of the disease, the suddenness of disability and death, and the availability of life sustaining technology propelled the heretofore small program onto the entitlement ledger. The personal plight of the kidney patients added a dramatic flair to the policymaking process and created a moral imperative to "do something fast right now". Consequently, erroneous assumptions about the effectiveness of future medical technology and the number of new kidney patients were made without adequate debate.

In essence, the prevailing political attitude was to do something quickly. Eligibility standards were deliberately made lax to allow anyone with kidney disease access to their due benefits. Anyone with ESRD was eligible for benefits, regardless of their age or amount contributed to Social Security. Copious benefits were provided to ensure utilization
and widespread availability. No time limit was set for dialysis benefits and provisions were made for multiple treatment modalities such as transplantation and home or institutional dialysis. The idea was not to skimp and to avail all patients to a wide array of necessary treatment regimens. Costs and long term obligations clearly were secondary to the desire to save lives.

The black lung entitlement was also conceived in the crucible of crisis. For years long-standing safety deficiencies and deplorable working conditions smoldered beneath public and political attention. It was the Farmington disaster in 1968 and the attendant media coverage that compelled Federal action. In the midst of conflicting claims between the miners and the coal companies, pressure was brought to bear upon the Federal government by the miners' union to make some commitment towards mine safety and black lung disease.

The government adopted the black lung entitlement as a means of conflict resolution. Benefits were conferred upon the miners before the ultimate responsibility for their plight could be resolved. In the meantime, miners were satisfied by the presence of benefits and the companies were relieved of the financial burden.

The maxim in black lung eligibility: don't quibble with details. The prevailing attitude regarded black lung disease as a chronic, progressive, debilitating disease without a cure. Entitlement was meant as compensation for past and future suffering, rather than a therapeutic endeavor. The tenet of
presumptive eligibility for black lung benefits according to the length of work in the mines allowed for the rapid and efficient inclusion of those "objectively" qualified for benefits. However, the rule was also permissive enough to allow some miners with the prerequisite seniority, but without demonstrable pneumoconiosis, to garner benefits. Nonqualified and qualified miners, in effect, vied for the same benefit packages and the resulting deluge of claims dramatically lengthened administrative processing of legitimate claims. Further expensive liberalization of benefits became necessary just to relieve the backlog.

Undernutrition in America is a chronic problem which also has been framed in terms of a "crisis" needing immediate, vigorous Federal action. Interest group pressure and intense media attention highlighted the severity of the problem and tended to emphasize the social neglect of basic human needs. Ted Lascher's analysis of the food stamp program underscores the importance of media and research organization studies in influencing the creation of food entitlements. The root of the studies' power was their proclamation of serious deficiencies in a basic human need understood by everyone. "(A)rguments about the need to attack inadequate nutrition have been salable to a broad cross-section of society, including a cross-section of elites, than arguments used for a great many other social programs. This is probably due to the fact that people recognize that a minimum diet is needed to maintain health, that the signs of inadequate nutrition are
relatively clear, and that the long-term effects of food deprivation are well-documented. Furthermore, American social welfare programs ... have been oriented toward 'meeting people's basic needs,' and providing an adequate diet is certainly consistent with that orientation. The result of this perspective is that new evidence of domestic hunger is likely to be seen by a great many as a problem to be addressed." (1)

Lascher describes how a 1968 Field Foundation report identifying 256 "hunger counties" and a CBS documentary illustrating domestic malnutrition fomented tremendous political pressure upon the President and the Congress to "do something." (2) The generation of a crisis atmosphere contributed to significant expansion of new benefits and liberalization of existing eligibility standards during the first Nixon Administration. The food stamp program became an open-ended entitlement with lowered purchase requirements and increased stamp allotments. Benefits were indexed to sustain real gains for future years and the USDA began developing nationwide eligibility standards in place of the hodge-podge of widely varying standards in local counties. (3)

What can be implied about entitlements forged in the fire of crisis? Some conclusions are clear: crisis compels immediate action by Congress and the President to establish an "answer", preferably liberally funded. Eligibility standards are deliberately lax to accommodate all of the target beneficiaries and benefits are liberalized to ameliorate criticisms of "not doing enough". Crisis engenders a
willingness to accept unproven or dubious assumptions about future spending or the level of beneficiary participation. What is created is a powerful framework for expenditure expansion as loose standards allow increased numbers of new beneficiaries and liberal provisions permit quick escalations of costs. Events assumed to materialize in the future and reduce spending, for example, new medical technology in ESRD or delegation of responsibility in black lung, often fail to coalesce, leaving the government with unanticipated long-term financial commitment. Crisis can motivate positive action but it can also blind government to the follies of unscrutinized assumptions.

Automatic Entitlements: Elements of Uncontrollability

Federal spending programs are not random: they are specifically designed to attain a policy objective or to influence political, social, or economic forces in a desired manner. In particular, entitlements acknowledge that deficiencies in some attribute such as health, wealth, or caloric intake are not distributed randomly but have affinities for certain socioeconomic conditions. In order to rectify such deficiencies, entitlements recognize the particular problems of a certain group as both legitimate and solvable. For instance, the problem of persistent malnutrition among poor children is perceived as morally reprehensible in an "affluent society" but eradicable by providing their families with cheaper food and higher incomes.
In crafting entitlements to fill perceived deficiencies two fundamental assumptions are usually made about 1) the desirable outcome and 2) the current status of the beneficiary group. Both of these assumptions involve independent variables and represent automatic forces beyond direct control by the government. When assumptions of desirable outcome and current status are incorporated into the rules of eligibility and benefit packages, spending becomes dependent not upon government action but upon dynamic changes in independent variables such as the economy, demographics, or health levels. Government becomes a passive spending power, unable or unwilling to control the number of beneficiaries or the amount of benefits dispensed.

Desirable outcomes involve specified policy objectives and are dependent upon the definition of the outcome and the costs required to attain the outcome. The declared goal of an entitlement can be quite specific - saving and sustaining kidney disease patients, or rather vague - providing "access" and "adequate" health care for the elderly. Unfortunately, specificity of an objective does not imply specificity of spending. As described previously, sustaining kidney patients and coal miners with pneumoconiosis require long-term commitment and involve intensive medical attention. Costs incurred in trying to achieve these policy goals are open-ended: no spending limit is established as long as there are eligible beneficiaries and progress towards the desirable outcome.
Desirable outcomes can also involve helping a beneficiary group attain some economic good such as food stamps, housing, or indexation of benefits. In these cases the prices of the goods are subject to an endless array of exogenous marketplace forces, such as price levels, interest rates, or unemployment, which are not directly controllable by an entitlement program except as part of a general fiscal policy. Dynamics of the economy, therefore, make the costs of entitlements benefits as desirable outcomes rather unpredictable and uncontrollable.

The "current status" of a beneficiary group involves automatic forces in eligibility criteria and the benefit packages. By "current status", one considers the major demographic characteristics of the group and the amount of a benefit already possessed. Demographic characteristics include age, race, sex, family size, occupation, and so forth. Benefits include income, health, food, housing, and so forth.

Changes in beneficiary status escalate uncontrollable costs through major increases in the numbers of people entering a demographic characteristic (e.g. the number of 65-year olds eligible for Medicare) covered by an entitlement or through a decline in the eligibles' resource base (e.g. income in recently unemployed working families).

Maureen Young's analysis of Federal housing programs describes two basic goals, or desirable outcomes, of the entitlements: "(a) Ensuring the availability of adequate and affordable housing, especially for low-income households, and
(b) encouraging home ownership." (4) The first primary goal of securing housing for poor families necessitated the incorporation of demographic factors of income, age, disability, and race (to promote equal housing opportunities). (5) It was assumed low income families were "priced out" of the housing market because of meager resources and high entry costs such as deposits and down-payments.

A key entitlement program utilized rent supplements by which the government contributed the difference between the current rental value of an apartment and 25% of a tenant's income (15% for very poor families and those with heavy medical expenses). (6) Such a program tied spending to the uncontrollable variables of local rent levels, tenant preferences, and income levels of families. Variations in any of these factors, invariably upward in terms of rent and usually downward in terms of income, impose unanticipated additional costs that quickly escalate to very high levels. By fiscal year 1981 the rent supplement program cost over $7.5 billion. (7)

To achieve the desired outcome of more home ownership, the government employed incentive strategies designed to ameliorate two important costs in buying a home - interest of mortgages and property taxes. The programmatic tools used to subsidize these costs can be extensive, almost labyrinthine: guaranteed long-term fixed payment mortgages, increased credit supply through Federally supported mortgage associations, tax expenditures favoring savings and loans, interest ceilings,
on deposits sustaining mortgage lending, and tax deductions for current homeowners. (8) This plethora of programs for the middle and upper classes, like those supporting poor families, incur unpredictable, variable costs when economic forces change prevailing interest rates, lengths of mortgages, consumer preferences, and aggregate income levels. Although the mechanism of home subsidies are distinct from rent supplements, the financial physiology is the same: quickly escalating costs derived on automatic, uncontrollable forces. In fiscal year 1982, tax expenditures accorded to homeowners alone cost the government $35.5 billion in foregone income. (9)

The California State Teachers' Retirement System is another automatic entitlement incorporating elements of uncontrollability. Patricia Miller's analysis of the program identified the liberalization of pension benefits as an incentive to increase the supply of teachers in a growing California. Like the Social Security system, pensions of retired teachers were financed with contributions from currently employed teachers. Teacher contributions to the pension fund were linked to a percentage of the teacher's salary based on the individual's sex and age. During times of economic growth, this pay-as-you-go funding was possible and allowed benefit liberalization. (10)

Economic recession and slower population growth resulted in a surplus of teachers and lower incomes from which the pension could draw new contributions. Increases in obligations for teachers nearing retirement and for the large cohort of
teachers hired in the growth years added to the problem of unfunded liability. Miller notes the doubling of unfunded liability within the past six fiscal years has been the result of: 1) accrued benefits being driven higher by unanticipated inflation, 2) improvements in life expectancy increasing total lifetime benefit liability, and 3) trends towards earlier retirement also increasing the average retirement lifetime. (11) Continued growth in unfunded liability will be derived from uncontrollable political factors such as:

a) The legislature's unpredictable behavior in appropriating state contributions to the pension fund.

b) Erratic economic growth and unpredictable levels of teachers' contributions.

c) New benefits covering disability and cost-of-living adjustments.

d) School districts' negotiated bargaining agreements or hiring practices. (12)

The tremendous expansion of pension obligations will result in expenditures exceeding contributions by the year 2000 and exceeding assets by 2075. Total exhaustion of pension assets is predicted by 2078. (13)

Financial distress of the pension system could very well discourage recruitment of new teachers: "For three decades, (pension) benefits were tailored to draw teachers to the State. In the years ahead, when the next shortage of teachers is predicted, (the pension) is not as likely to be valued and trusted as an incentive by prospective teachers. It will be much more difficult for the state to continue the existing
benefits at the current levels, and the legislature will find that enhancing benefits as a wage replacement is likely to be impossible." (14)

In assessing automatic entitlements, the escalation of desirable outcomes and changes in beneficiary status, each with its own set of dynamic automatic forces, can coalesce and generate enormous uncontrollable costs in a short period of time. The problem of automatic entitlements not only involves cost unpredictability but difficulty in controlling the terms of the entitlement and discerning the key elements of uncontrollability within a given program. The causes of uncontrollability within any program can be complex and elusive, involving peculiar and collaborative combinations of automatic forces. Even if the root of the problem were to be exposed, political pressures from beneficiary groups complicate efforts at meaningful constraint.

Participatory Entitlements: Proliferation of Decentralization

In a "traditional" entitlement, benefits are conferred directly from the government to the eligibles. Monthly social security payments are a prime example of a direct relationship between the beneficiary and the government. Through direct entitlements, the government itself assumes responsibility to administer and regulate the program. Control over eligibility standards and benefit levels is centralized within the appropriate administrative agency, such as the Social Security
Administration. Direct entitlements, therefore, afford the government a relatively high degree of autonomy and control over the terms of the program. Centralized responsibility by itself is no guarantee of expenditure amelioration, but lines of accountability are clearer and more responsive to efforts at controlling costs.

For some types of benefits, the government pledges a good for which it is unable or unwilling to provide. These goods are conferred by a third party or independent provider group and are usually subsidized or guaranteed by the government. To elicit adequate participation from outside parties, government extends a wide array of incentives including subsidy payments or revenue sharing schemes. More importantly, government often decentralizes its authority over the entitlement to the provider groups. Determination of eligibility, level of service, and types of benefits delivered often become the responsibility of local authorities or provider groups.

By vesting control outside of itself, government recruits provider groups as a key participant in entitlement administration. One would expect to witness a wide variability of standards and benefit packages when third parties exercise their power to determine eligibility and expenditures. While this may result in a distribution of goods more reflective of local conditions and preferences, local exercise of spending rights in the framework of lax or vague guidelines, can become a prime source of uncontrollable
expenditures. Spending becomes dependent upon the idiosyncracies of the provider group - its political ideology, perceptions of the entitlement's purpose, and orientation to the beneficiary group. Any desired changes in the terms of the entitlement would most likely conflict with the ethos of the providers. The political physiology would favor inertia, particularly if authority over the provisions of the program is decentralized over a wide array of providers. Imposition of new terms would very likely encounter stiff resistance and noncompliance.

Another key implication concerning participatory entitlements is that the providers become dependent upon the incentives and come to view payments or revenue shares as "just" income. Provider incentives become entitlements in themselves and thus a new dependency relationship becomes established between the government and the third party. Once again, any alteration of terms affecting the beneficiary group invariably involves conflict with the provider's incentives. The interposition of vested third-parties between the government and the beneficiaries encumbers expenditure control because liberalization of participatory incentives is often required to sustain the entitlement.

Like the ESRD incentives to renal physicians and proprietary dialysis centers, the Medicare and Medicaid programs involved decentralized control of fees, services, and eligibility requirements to the physicians or the state governments.
The autonomy of physician control over both fees and services were effectively highlighted in Walter Wong's analysis of Medicare's spending rules. Medicare's reimbursement policy was deliberately liberalized during the program's formulation to pay what the physician or a designated intermediary determined to be "reasonable and customary" charges. These terms were incentives for physicians to accept Medicare assignment and thereby allow a greater choice of doctors for the eligibles. But the incentives were not accompanied by rules or guidelines over the level of utilization, producing almost immediate cost escalation. (15)

Wong cites a Senate Finance Committee staff report stating the consequences of lax controls: "No one can say for certain how much money has been overpaid as a result of the failure to apply the statutory limitation on 'reasonable charges'. Compared with the Blue Shield payments for similar services under their most widely held contracts, however, it is safe to say that Medicare has spent many hundreds of millions of dollars more than would otherwise have been required had those same Blue Shield schedules served to limit reimbursement." (16)

The problem is one of perspective: what is a financial hemorrhage to the government can represent pecuniary lifeblood to physicians and hospitals. Later attempts to stem the bleeding (infusions) instigated "a battle between administrators trying to control rules which had been intentionally made liberal, and providers who were intent on
receiving the highest reimbursements possible." (17)

Determined Federal efforts to tighten provider rules and thereby lower spending floundered in the face of physicians' control over their services. If doctors found the incentives unpalatable they simply refused to participate or reduced the level or quality of services rendered to the patients. Nonparticipation can also mean higher costs for beneficiaries: "When a provider refuses to accept assignment, he bills the patient directly. The charge is generally higher than that recognized under Medicare. Medicare reimburses the patient for the 'reasonable' charge, leaving the patient with the remainder of the bill - including the difference between the total bill and 'reasonable' charges defined by Medicare. As a result, provider charges become uncontrolled, Medicare benefits rise (because they are based on prevailing provider fees), and the proportion of costs paid by beneficiaries rises." (emphasis mine) (18)

Wong provides the following illustrative example: "Most physicians prefer that the senior citizen pay them their fee, say $25 for an office visit. The senior must then fill out the Medicare forms and seek repayment from Medicare. The fact that Medicare determines that the reasonable charge in this case was $12 and pays 80 percent thereof or $9.60 means that the senior must pay the remaining $15.40 out of his own pocket." (19)

As Wong astutely observed, "The problem with provider rules is that they place responsibility for and control of
spending decisions in the hands of providers." (20) The power of the physicians to 1) raise beneficiaries' costs and 2) raise government spending by mere nonparticipation generated political pressure from the patients to force liberalization of reimbursement policy and relieve the patients' added financial burden. Reimbursement policy reinforced the physicians' self-anointed power to control services and to charge the highest fees possible with little interference from the government in determining how the fees were established.

Medicaid's provider incentives for physician and hospitals were quite similar: it allowed "reasonable" cost reimbursement and encouraged states to set physician payments high enough to encourage participation. What made Medicaid more complex than Medicare from the standpoint of provider incentives is its Federal-State composition. The Federal government shared the states' cost of administering health services to the poor. The Federal government set basic standards on minimum services but delegated to the states responsibility for administration and distribution of benefits. The states were free to determine eligibility standards and benefit packages.

Federal control became two steps removed from the intended beneficiaries - the states controlled day to day administration and the physicians garnered autonomy over fees and services. Decentralization of authority limited the extent to which Washington could control costs or predict
future expenditures. According to Pamela Arbuckle's study, "Because of the open-ended 'entitlement' nature of the Medicaid program, new fiscal controls cannot be applied directly through budget limits and administrative directives... The Federal Government asserts fiscal control indirectly by enacting laws and producing regulations that increase or restrict States' options in designing and administering their programs." (21) Federal control was thereby circumscribed to altering States' incentives without affecting such uncontrollable factors as the number of beneficiaries or total state spending.

Washington used matching funds as its key participatory incentive. States, in turn, were encouraged to liberalize benefits for eligibles and reimbursements for health care providers. The strategy was to subsidize proliferation of offered services and provider participation to ensure widespread availability of basic Medicaid benefits in all fifty states. States had an incentive to add optional services or to expand existing ones because the federal subsidy cheapened the states' procurement costs. Pennsylvania, for example, could make available $1,000,000 worth of nursing home care for only $500,000 of its own money. Washington would provide the rest. Through this matching mechanism, state spending decisions controlled total Federal Medicaid expenditures.

Federal efforts to control costs included President Reagan's 1981 proposal to cap Federal monies at a specified
level so that costs in expanding services would be borne entirely by the states. Vigorous lobbying by the states defeated the idea, but Congress acted to increase state autonomy over Medicaid by allowing the states to drop or deemphasize various services. Congress did not alter Federal matching funds, an action which actually discouraged pruning of services. In surrendering $1,000,000 worth of benefits, a state loses $500,000 in Federal funds but saves only $500,000 of its own money. Matching funds not only subsidized spending but it also sustained state inaction in cutting expensive services.

In Medicaid, the proliferation of decentralized control over spending and benefits to the fifty states promoted expensive incentives for provider participation and established a powerful mechanism for uncontrollable Federal expenditures.

Another Federal-State endeavor that deserves a brief discussion as a participatory entitlement is the Revenue Sharing program. It is an unusual entitlement in that the beneficiaries are not individuals but units of government. It is also unusual in that the funds distributed to state and local governments had no strings attached to their use. Designed to replace a plethora of categorical grant-in-aid programs for social services, revenue sharing was intended to give state and local governments maximum flexibility in fiscal decision-making. While overall Federal contributions were reasonably controlled by the regular appropriations process, decisions as to where and for what the funds were devoted to
were uncontrollable by Washington.

As described by Carol Lazzarotto's analysis of the program, aggregate Federal payments were relatively predictable and controllable by basing a locale's share on formulae which included the area's population, relative income, level of urbanization, and state tax revenues. Such formulae assured reasonable stability of Federal funding levels and reassured local governments of a steady flow of money from year to year. It was feared that unstability or unreliability would result in waste or inefficiency: "If the continuation of Revenue Sharing is uncertain, or there are wide fluctuations in the amounts received, local officials will be more inclined to spend their funds on one-time capital expenditures. This distortion is generally deemed undesirable." (22)

By voluntarily decentralizing decision-making into the hands of local officials, Washington lent itself to instances of "bad allocations", including inefficient use of funds or their flagrant abuse. Furthermore, political credit for projects funded by revenue sharing accrued to local officials instead of the area's Congressman. Political jealousy aside, the delegation of spending authority to local officials created a strong dependence on Federal monies for their own political successes. Local officials grew accustomed to the regularity of the money and viewed their shares of the Federal till as an inviolable entitlement. As locales started long-term projects, the goal became to finish the endeavor with revenue shares. Should the costs of the
project rise, localities learned to seek additional money from Washington. "Grantsmanship" was replaced by "sharesman-
ship" as cities, states, and regions competed and cooperated to cajole larger portions of the fiscal pie.

In retrospect, the strategic premise of Federal participatory entitlements is to encourage smaller government units or independent service providers to deliver goods, funds, or other specified benefits. The incentives employed to elicit support for these programs devolved authority and control over the terms of the benefits to those groups that stood to gain financially from these arrangements. Decentralized control weakened Federal efforts at containing escalating expenditures by establishing a proliferation of eligibility criteria, benefit packages, and reimbursement rates across the spectrum of providers. Uncontrollability of entitlement costs was derived not only from the rules of the program but also from the perogative of providers to defend and promote their own interests.

Symbiotic Entitlements: the Political Ecology of Rising Costs

With the growth of Federal programs covering a wide spectrum of social services, it is inevitable that there would be considerable overlapping of similar beneficiaries and benefits. Some entitlements, for administrative and political purposes, are within another entitlement program. Others make allowances for its beneficiaries to obtain benefits from different entitlements. Such arrangements make it possible
for duplication of Federal payments or, in the case of entitlements-within-entitlements, for expenditure growth of a smaller program under the protective shield of the larger program. Thus, expenditure control is hampered for two reasons: 1) reductions in benefits in an outside program can cause increasing benefits for eligibles in a given entitlement; 2) efforts at substantial cost-cutting focus quickly on large, "big ticket" programs, sparing smaller entitlements that often have higher rates of growth.

As described earlier, end-stage renal dialysis was incorporated into the Medicare program on the coat-tails of a larger legislative initiative with minimal scrutiny of its cost-generating potential. The rapid growth of spending after ESRD's enactment forced government to attempt to hold down costs without excluding beneficiaries.

Medicare, in turn, benefited from its symbiotic relationship with Social Security by having Medicare's taxes included within a taxpayer's Social Security deductions. As Wong asserted, the Social Security "shield" for Medicare financing focused political opposition to the larger Social Security program and away from Medicare: "(I)ndividuals tend to identify the payroll tax as 'the Social Security tax' and many are not acutely aware of the portion being taken to finance Medicare. The relative attention which is paid to each of these programs is exhibited at higher levels as well. Recent Congressional behavior ... considered action to address Social Security funding problems to be much more important than Medicare's woes, typifies this relationship." (23)
Medicare's power to raise large amounts of revenue through Social Security enhanced its ability to fund expanded benefit packages with minimal political opposition. Such assuredness of funds allows Medicare's administrators to advance liberal provisions under the unrefutable logic of: "If I can get the money, why not spend it?"

Another framework for expansion is what can be termed "cross-benefits" - similar goods or services provided by different entitlements. Since most social service programs consider a beneficiary's resource base as including benefits from other programs, changes in the provisions of one program can significantly raise costs for another. Lascher's examination of the Federal food stamp program highlights its dynamic linkage to another anti-poverty program: "(A)tempts to reduce expenditures in a program such as Aid to Families with Dependent Children will actually lead to increased food stamp expenditures. It has been estimated that roughly 75% of AFDC households receive food stamps, and that for these people approximately one-third of any cut in AFDC benefits will be offset by increased food stamp benefits. The result is that attempts to reduce entitlement outlays are even technically more complicated than may initially be believed."

(24)

Similarly, the dynamic of cross-benefits between the retirement pensions of California teachers and Social Security pensions also generates higher than anticipated costs for Washington. According to Miller's analysis of the California
teacher pension system, teachers can "double dip" into Social Security if a spouse or the teacher him(her)self is eligible for and contributed to Social Security. Double-dipping allows an individual to have two pension plans - one (Social Security) indexed to the Consumer Price Index and the other (the state pension) assured of annual 2% increases. (25)

The added cost to the Federal government involves a subtle but powerful cost escalator. According to Miller, Department of Treasury regulations are designed to equalize the percentage of combined pension benefits of highly paid double-dippers (the teachers) with that of the lower paid double-dippers (clericals). The objective of the regulations was to lower, by reducing the Social Security payment, the combined pension paid to the teachers down to the level conferred to the clerical workers. In a shrewd move made by state officials, school districts created an entirely separate pension system for the lower paid employees to be coordinated with Social Security. (26) This created two classes of double-dippers that were "unequalizable" by Treasury regulations. The combined pension benefits of the lower paid rose to the approximate level enjoyed by the teachers. Federal expenditures increased because 1) the teachers' Social Security pensions were not cut to reduce their combined benefits to the level of the clericals, and 2) Social Security payments to the clericals increased from the state severing the linkage between the clericals' and teachers' pensions.
The presence of symbiotic entitlements creates interminable problems for Federal cost control. The dynamics of entitlements-within-entitlements and cross-benefits elude direct efforts by the governments in changing the terms of spending through regulations and legislation. The implications for budget controllers are clear: entitlements can be closely related to one another, necessitating comprehensive and coordinated strategies that account for intrinsic compensating mechanisms within a given program. Furthermore, the scalpel of the "budget surgeon" must penetrate deep enough to reveal heretofore hidden entitlements protected by more visible programs. Failure to do so allows smaller programs to grow at high rates of expansion and to sustain the financial hemorrhage.

Controlling Entitlements: A Sisyphean Endeavor?

Government entitlements are powerful instruments of change: they create new arrays of benefits, incentives, and guarantees which radically alter expectations of government action. Past arrangements are broken and new relationships between government, beneficiaries, and providers are cemented. For people with kidney disease prior to the advent of dialysis and transplantation, the absence of Federal financing programs or guaranteed health services meant certain death. For coal miners, the absence of government safety regulations and disability payments meant progressive pneumoconiosis and
extremely hazardous working conditions. Government intervention in these diseases has sustained life for thousands of people. It would be difficult to imagine any other institution empowered or financially able to underwrite the costs of such a humanitarian endeavor.

As new sets of political and economic dependencies develop and become established over a period of time, the status quo becomes comfortable and reassuring: entitlements become legitimate arrangements, valued for its efficacy and convenience. Robert Behn and Kim Sperduto, in their analysis of Federal medical school capitation payments, describe the melding power of entitlements: "If a relationship has existed for a long while, everyone comes to assume that it is a proper one. Even if no vows of fidelity are exchanged, the mere passage of years cements everyone's expectations and establishes a sense of legitimacy. The configuration of dependencies comes to look like a correct and just arrangement - the 'natural' way of doing things." (27)

It therefore becomes increasingly difficult for budget control groups in Congress or in the White House to change the terms of the entitlement without incurring the wrath of both the beneficiaries and the providers. Conflict is often resolved by inaction or liberalization because of the political risks involved in being identified with cutting benefits. Debate becomes focused upon the dependency of the beneficiaries to their entitlement and the consequences of severing the pecuniary umbilical cord. Behn and Sperduto
asserts, "The question ... is not whether some hypothetical program should be ended, but whether some specific, identifiable individuals should lose their benefits. It focuses on people and their losses. Regardless of the reasons for initiating the program or the legitimacy of the pressures used to maintain it, its termination would hurt people - and it is hard not care about their plights." (28)

What to do? Given: 1) the political difficulty in securing an effective coalition of budget control groups, 2) the inevitable public outcry at cutting benefits, and 3) complicated financial physiology involving vague standards, numerous incentive mechanisms, cross-benefits, and uncontrol- lable automatic factors, are entitlements immune from all efforts at cost control, or are there ways to establish prudent policies concerning eligibility, benefits, and providers?

Actions to clarify and to lessen dependency relationships should include steps to set very specific standards in creating eligibility and benefits. This holds particular value for new programs established in response to a perceived crisis. As described in kidney dialysis and black lung, the pressure to "do something" suspends careful investigation of advocates' assumptions concerning the number of future eligibles and the cost of their benefits.

Exclusion criteria should be incorporated in regulations to make it clear for whom the program is not intended. While exclusion criteria may seem draconian, they stem the
the natural inclination in expanding the beneficiary base to include people of a similar occupation or health status, who otherwise are ineligible for benefits, but who have symptoms congruent to a covered disease.

While precedent programs with their initial small enrollment and nascent budgetary appetite are accommodated with ease, their uninhibited growth encumbers future efforts to serve additional claims. For example, the rise of ESRD costs has made Congress less willing to subsidize other medical-surgical interventions like liver transplantation or artificial heart implantation. Concurrently, the escalation of black lung costs and its administrative fiasco stiffened Congressional resistance against funding similar occupational respiratory diseases such as talcosis, beryllinosis, and asbestosis.

Policies regarding entitlements with automatic, uncontrollable factors should set realistic expectations of desirable outcomes and, as much as possible, ameliorate the impact of changes in demographics and the economy upon cost escalation. Explicit provisions should be made to dis-enroll beneficiaries or lower their benefits if their resource base enlarges to a point well beyond their need for government aid. Such "scale-down" provisions helps to counterbalance additional expenditures incurred by automatic cost escalators, although the administrative feasibility of these proposals remains to be researched.

Policymakers and administrators of participatory
entitlements should acknowledge the power of incentives. Reimbursement policy should regard provider groups as bona fide interest groups with an economic and political interest in sustaining and expanding an entitlement. The implication of these viewpoints is that policy should establish incentives that motivate cost savings while preserving, as much as possible, delivery of adequate and effective services. MediCal (Medicaid) reform in California and Medicare's new Diagnosis-Related Group payment system for hospital services are pioneering examples of provider competition and prospective savings being employed to constrain service utilization.

The decentralization of control over payment and services by provider groups and smaller government units entail more difficult and sophisticated methods to promote accountability. Standards in delivery of services and responsible utilization should be promoted among appropriate provider organizations. Such standards can be easily sidestepped so that regulations and legislation may be necessary to enforce reasonable control over the providers' terms of the entitlement.

Symbiotic entitlements require a comprehensive strategy that recognizes the effects of "entitlement shielding" and cross-benefits between programs. Singular efforts focused upon only one program or one class of beneficiary may neglect counterbalancing cost increases in similar programs. Whether a particular program's administration takes cost-shifting to other programs into account is problematical. Coordination requires a coordinator, preferably with resources extensive
enough to research eligibility criteria and benefit packages, and with enough political independence to promote clear and substantial changes.

This thesis, in describing the key factors of entitlement expansion, establishes important implications for contemporary and prospective policymaking in the budgeting of Federal medical and social programs. Recommendations by themselves cannot instigate positive action - they must be accompanied by the willingness to use them prudently and compassionately in face of escalating political opposition. The objective of these proposals is to lay the foundation towards a new public philosophy which allocates resources in a realistic manner and adopts eligible beneficiaries with a sense of justice. Such an endeavor will become increasingly important in an era of huge budget deficits and demands for responsive and effective government.
Chapter One Notes


6. Ibid. p.207


8. Ibid. p.215.

9. Ibid. p.216.

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13.Ibid.p.216.


15.Ibid. p.220.


Chapter Two Notes


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11. Derickson, p.34.


15. Popick, p.335.


17. Popick, p.337.
18. Popick, p.337.
23. Kerr, p.57.
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27. CQA, p.495.(1975)
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32. 1976 Congressional Quarterly Almanac, p.375.
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35. 1977 CQA, p.175.
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43. Ibid., p. 2569.

44. Ibid., p. 2569.
Chapter Three Notes


2. Lascher, p.17.


5. Young, p.11.

6. Young, p.22.

7. Young, p.29.


13. Miller, Appendix B.

14. Miller, p.46.


16. Wong, p.16.

17. Wong, p.20.

18. Wong, p.23.


20. Wong, p.22.


27. Behn R.D. and Sperduto K. "Medical Schools and the 'Entitlement Ethic'," The Public Interest, No 57, Fall 1979, p.55.