98th Congress
2d Session

COMMITTEE PRINT

S. PRT.
98-172

BACKGROUND MATERIAL RELATED TO MEDICARE FINANCING ISSUES

PREPARED BY THE STAFF FOR THE USE OF THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ROBERT J. DOLE, *Chairman*

APRIL 1984

Printed for the use of the Committee on Finance

U.S. GOVERNMENT PRINTING OFFICE

31-294 O

WASHINGTON : 1984

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I. BACKGROUND

The Medicare Program (authorized under title XVIII of the Social Security Act) provides health insurance to nearly 30 million eligible beneficiaries including most individuals age 65 and over, persons under 65 who have been entitled for a period of 24 months to Social Security or Railroad Retirement benefits because of disability, and certain workers and their dependents who need kidney transplantation or dialysis. Medicare is a Federal program with uniform eligibility and benefits throughout the United States. Protection is available to insured persons without regard to their income or assets. Medicare is the largest health care financing program in the United States and, except for Social Security, is the largest entitlement program in the Federal budget. Program spending accounts for more than 25 percent of national health spending for hospital care and for more than 17 percent of all such spending for physicians' services. In the absence of new legislation or other changes, program spending will increase from $66.3 billion in FY 1984 to an estimated $76.8 billion in FY 1985 or 15.8 percent.

A. Program Eligibility and Benefits

Medicare consists of two parts: Part A or the Hospital Insurance (HI) program and Part B or the Supplementary Medical Insurance (SMI) program.

HI entitlement and benefits

Hospital Insurance helps pay the costs of inpatient hospital services, skilled nursing facility services, home health care and hospice care. The vast majority of persons reaching age 65 are automatically enrolled and entitled to protection under Part A of the program. Those over 65 not entitled to protection may voluntarily obtain protection by paying the full actuarial cost of such coverage (currently $155 a month).

During each benefit period (which begins when an insured individual enters a hospital and ends when he or she has not been in a hospital or skilled nursing facility for 60 days), Hospital Insurance will pay for:

(1) 90 days of inpatient hospital care subject to a deductible [1] (currently $356) to be paid by the beneficiary; a daily copayment (currently $89) is required of the beneficiary from the 61st through the 90th day. An additional lifetime reserve of 60 days, subject to a daily copayment (currently $178) may be drawn upon, if a beneficiary is hospitalized longer than 90 days during a benefit period.

[1] The amount of the deductible is updated annually to reflect changes in the average cost of inpatient hospital care. Hospital and skilled nursing facility copayments are fixed percentages of the inpatient deductible and are therefore also updated annually.

(2) Up to 100 days in a medicare-approved skilled nursing facility for persons in need of skilled nursing care and/or rehabilitation services on a daily basis. After the first 20 days, beneficiaries must pay a daily copayment amount (currently $44.50).

(3) Home health services are provided without an overall limitation on the number of visits. No deductibles or coinsurance payments are required.

Individuals entitled to hospital insurance benefits who are terminally ill may elect to receive covered hospice services (in lieu of most other Medicare benefits) for up to two periods of 90 days each, plus an additional 30 days.

SMI enrollment and benefits

Supplementary Medical Insurance (Part B) helps pay for the services of independent practitioners (primarily physicians), outpatient hospital services, laboratory services, and other medical and related services. An individual who is entitled to HI benefits will be automatically enrolled in the SMI program, but he may decline coverage. Other persons 65 and older, who are not eligible for HI benefits, can enroll in SMI at certain designated times provided they also enroll in Part A of the program. Virtually all persons age 65 and older and all persons covered by Hospital Insurance may elect to enroll in the Supplementary Medical Insurance program by paying a monthly premium (currently $14.60 per month).

Supplementary Medical Insurance (with certain exceptions) pays 80 percent of the "reasonable charges", after the enrollee meets an annual deductible of $75, for: physicians' services; limited services of chiropractors, podiatrists and dentists; laboratory and other diagnostic tests; X-ray and radiation therapy; home dialysis supplies and equipment; medical devices other than dental and most eyeglasses; physical and speech therapy; ambulance services; and certain other services.

Current enrollment and program expenditures

During FY 1984, an estimated 30 million people including 27 million aged and 3 million disabled persons will be entitled to benefits under the Hospital Insurance portion of the Medicare program. Approximately 7.5 million (or one in four) of the persons protected by the program will receive covered services during the year. Hospital Insurance expenditures during FY 1984 will amount to an estimated $45.1 billion.

During FY 1984, an estimated 29.2 million persons will be enrolled under Part B. Of these, about 20.3 million persons (70%) are expected to receive covered services during the year, accounting for program expenditures of approximately $21.3 billion.

Estimates for FY 1983 through FY 1985 are summarized in Table 1:

TABLE 1.—HOSPITAL INSURANCE (HI) AND SUPPLEMENTARY MEDICAL INSURANCE (SMI) PROGRAM DATA [1]

	Fiscal years		
	1983 (estimate)	1984 (estimate)	1985 (estimate)
Persons Entitled or Enrolled (in millions) [2]			
HI	29.1	29.7	30.2
Aged	26.2	26.8	27.3
Disabled	2.9	2.9	2.9
SMI	28.7	29.2	29.8
Aged	26.0	26.6	27.2
Disabled	2.7	2.6	2.6
Persons Receiving Services (in millions) [2]			
HI	7.3	7.5	7.7
Aged	6.5	6.7	7.0
Disabled	0.8	0.8	0.8
SMI	19.6	20.3	21.1
Aged	17.8	18.5	19.2
Disabled	1.8	1.8	1.8
Program Outlays (in billions) [3]			
Total	$56.9	$66.3	$76.8
HI	38.6	45.1	52.1
SMI	18.3	21.3	24.7

[1] Numbers may not add due to rounding.
[2] Source: Health Care Financing Administration.
[3] Source: President's FY 1985 Budget.

B. Historical and Projected Trends in Program Expenditures

Relative importance and rate of increase by type of service

Table 2 shows the estimated relative importance and average annual growth rate of program expenditures for each type of service covered under Part A and Part B, during the period 1975 to 1985. Hospital inpatient services account for almost all benefit expenditures under Part A, but home health services are growing nearly twice as fast. Under Part B, physicians services account for the majority of benefit payments while payments for hospital outpatient services have been growing most rapidly. Overall, Part A accounts for more than two-thirds of total benefits in the Medicare program as a whole, but its share is declining since Part B payments have been increasing more rapidly.

TABLE 2—BENEFIT PAYMENTS BY SERVICE UNDER PART A AND PART B, FISCAL YEARS 1975 and 1985

[Dollars in millions]

	1975 payments (actual)		1985 payments (estimate)		Projected average annual growth (1975-85) percent
	Amount	Percent	Amount	Percent	
Part A					
For hospital inpatient services	$9,947	96.1	$48,177	94.2	17.1
For skilled nursing facility services	273	2.6	573	1.1	7.7
For home health services	133	1.3	2,154	4.2	32.1
For hospice services			240	0.5	
Total benefit payments	$10,353	100.0	$51,144	100.0	17.3
Part B					
For physician services	$2,861	76.0	$17,745	75.9	20.0
For radiology and pathology services	199	5.3	552	2.3	10.7
For hospital outpatient services	540	14.3	4,581	19.3	23.8
For other medical and health services	165	4.4	820	3.5	17.4
Total benefit payments	$3,765	100.0	$23,698	100.0	20.2
Part A	$10,353	73.3	$51,144	68.3	17.3
Part B	3,765	26.7	23,698	31.6	20.2
Total	$14,118	100.0	$74,842	100.0	18.2

Source: Health Care Financing Administration.

Sources of increases in benefit expenditures

Historical and projected increases in expenditures for hospital inpatient services under Medicare may be broken down into three components: (1) increases due to changes in the prices of labor and other goods and services that hospitals purchase in order to produce inpatient care as measured by the market basket index; (2) increases due to changes in the quantity and mix of services per inpatient discharge (e.g., more tests and procedures or relatively more of the costly tests and procedures), called unit input intensity or service intensity and; (3) increases due to changes in the volume of Medicare patients treated (e.g., increased enrollment and higher admission rates per enrollee). Table 3 shows annual rates of increase for historical periods and expected increases for the period 1983 to 1995 for each of these components as well as data on changes in general wage and price levels for comparison.

Historically, increases in the prices that hospitals pay for goods and services, as measured by the market basket index, have accounted for slightly more than one-half of the rate of increase in total HI inpatient expenditures and about two-thirds of the increase in expenditures per enrollee. The remainder of the increase,

with substantial variations from year to year, is attributable in roughly equal shares to changes in service intensity, increased enrollment and changes in the number of admissions per enrollee.

TABLE 3.—HISTORICAL AND PROJECTED ESTIMATES OF RATES OF INCREASE (PERCENT) IN MEDICARE EXPENDITURES FOR HOSPITAL INPATIENT CARE, BY SOURCE, 1972–95

	General wages and prices		Hospital prices			Unit input intensity (service intensity) [1]	Volume growth		HI inpatient costs overall rate of increase
	Covered wages	CPI	Wages	Prices	Market basket index		HI enrollment	Admission incidence	
Historical rates:									
1972	7.3	3.3	6.8	4.5	5.9	0.1	1.6	3.0	10.9
1973	6.9	6.2	5.5	8.0	6.5	5.5	6.2	2.4	16.4
1974	7.4	11.0	7.7	14.2	10.4	-3.2	6.6	8.7	23.6
1975	6.6	9.1	9.9	12.2	10.9	5.6	3.2	1.4	22.5
1976	8.2	5.8	8.2	8.3	8.2	6.1	2.9	0.8	19.0
1977	8.0	6.5	7.1	7.9	7.4	4.6	3.0	1.4	17.3
1978	8.2	7.6	8.4	7.9	8.2	2.2	2.7	1.2	14.8
1979	8.8	11.1	8.4	11.1	9.6	1.8	2.7	1.7	16.4
1980	8.6	13.5	10.6	12.8	11.6	0.9	2.1	4.7	20.3
1981	8.8	10.2	12.3	11.1	11.8	3.8	1.8	3.0	21.6
1982	5.6	6.0	11.0	7.0	9.3	3.2	2.0	2.3	17.6
Projected rates: [2]									
1983	4.6	3.1	7.6	4.5	6.3	3.7	1.4	1.3	13.2
1984	4.6	4.4	7.5	6.3	7.0	2.3	2.0	0.9	12.6
1985	5.5	5.3	8.0	6.7	7.5	1.6	1.8	1.1	12.4
1986	5.6	4.8	7.7	6.2	7.1	1.0	1.9	1.1	11.4
1987	5.7	4.4	7.8	5.7	6.9	1.0	2.0	1.0	11.2
1988	5.4	4.1	7.5	5.3	6.6	1.0	1.9	1.1	10.9
1989	5.4	4.0	7.0	5.2	6.3	1.0	1.8	1.2	10.5
1990	5.6	4.0	7.2	5.2	6.4	1.0	1.8	1.2	10.6
1995	5.5	4.0	6.6	5.0	6.0	1.0	1.2	1.3	9.7

[1] A residual category including increases due to "other sources", the part of annual increases in hospital inpatient cost per discharge not accounted for by increases in the market basket index or volume growth

[2] Based on Alternative II-B assumptions (pessimistic intermediate)

Source: 1983 Annual Report of Board of Trustees of the Federal Hospital Insurance Trust Fund

As shown in Table 4, increases in expenditures for physician services under Part B may be broken down similarly into: (1) increases in recognized (reasonable) charges per physician visit, (2) increases in physician visits per enrollee per year (including increases due to provision of relatively more complex services) and (3) increases in SMI enrollment. While increases in reasonable charges per visit have generally accounted for more than one-half of the rate of increase in expenditures, the relative importance of this component is expected to decrease in the near future as the rate of increase in physicians' fees declines and visits per enrollee and other volume factors increase more rapidly.

TABLE 4.—HISTORICAL AND PROJECTED ESTIMATES OF RATES OF INCREASE (PERCENT) IN MEDICARE EXPENDITURES FOR PHYSICIAN SERVICES BY SOURCE, 1972–86.[1]

	Increases due to prices		Increases due to volume		Overall rate of increase
	Physician fee component of CPI	Reasonable charges per visit	Visits per enrollee[2]	Enrollment	
Historical rates:					
1972	5.2	4.0	2.6	1.9	8.7
1973	2.6	2.1	5.1	1.9	9.3
1974	5.0	3.4	5.5	2.7	12.0
1975	12.8	9.2	3.5	2.5	15.8
1976	11.4	8.5	3.0	2.7	14.8
1977	10.2	9.2	3.4	2.3	15.5
1978	8.9	9.4	3.9	2.3	16.3
1979	8.6	8.0	3.5	2.4	14.5
1980	11.5	9.1	6.9	2.5	19.5
1981	11 1	8.4	7.8	2.2	19.4
Projected rates:[3]					
1982	11.7	10.8	11.9	2.2	26.7
1983	10.6	9.6	8.8	2.1	21.9
1984	8.8	6.9	7.7	2.1	17.5
1985	7.4	5.7	7.3	2.2	15.9
1986	6.2	5.8	6.2	2.3	14.9

[1] Aged enrollees only; excludes disabled and ESRD enrollees.
[2] Includes the effects of changes in the mix of physician services toward more complex and expensive services per visit.
[3] Based on Alternative II-B (pessimistic intermediate) assumptions.

Source: 1983 Annual Report of the Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund.

C. Impact of Recent Legislation

Amendments to the Social Security Act that will affect Medicare program revenues or outlays have been enacted in each of the last three years in Public Law 97-35, the Omnibus Budget Reconciliation Act of 1981 (OBRA); Public Law 97-248, the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA); and Public Law 98-21, the Social Security Amendments of 1983. Although the most recent savings and revenue estimates prepared by the Congressional Budget Office (CBO) for each of these laws are not strictly comparable, it is possible to examine the distribution of projected changes in program revenues and outlays by type of change within each law.[3] Table 5 shows the percentage distribution of estimated program savings (including revenue increases) for each of these laws.

More than 60 percent of total estimated savings under OBRA and more than 75 percent of the total under TEFRA is due to reductions in program outlays under Part A. Most of the projected

[3] The estimates for each law were made at different times, for different periods of time, using different economic assumptions; and some provisions overlap. Thus, absolute comparisons cannot be made.

reductions in outlays in both cases are expected to result from changes in provider reimbursement methods, primarily involving payments for inpatient hospital services. In fact, over one-half of projected total savings under TEFRA is attributable to the extension of the hospital per diem routine operating cost limits to cover total operating costs per discharge and the three-year rate of increase limit imposed on Medicare reimbursements to hospitals.

Almost all of the projected changes in program outlays and revenues under the Social Security Amendments of 1983 are expected to result from increases in HI tax revenues. Although the adoption of a prospective payment system for hospital payments under Medicare creates incentives for hospitals to reduce their costs and, thus, has the potential for large long-term savings, the projected impact of this provision was not estimated by CBO.

Moreover, in considering the projected savings due to the Social Security Amendments of 1983, it must be noted that the prospective payment system (PPS) for hospitals was to be budget neutral—i.e., to yield no additional savings for fiscal years 1984 and 1985 beyond those achieved through the TEFRA legislation of 1982. However, the budget neutrality provision expires at the end of fiscal year 1985 and control over PPS rates passes to the Secretary of HHS beginning in fiscal year 1986. Depending upon decisions yet to be made by the Secretary, the ultimate impact of the PPS on the budget could be either favorable, adverse, or even neutral.

TABLE 5.—PERCENTAGE DISTRIBUTION OF ESTIMATED MEDICARE SAVINGS BY CATEGORY OF CHANGE FOR LEGISLATION ENACTED SINCE 1981 [1]

[Percent]

Category of change	OBRA—1981 [2]	TEFRA—1982 [3]	SS Amend.—1983 [4]
1. Provisions affecting HI trust fund revenues:			
A. Changes in HI tax provisions	0	0	55.53
B. Other tax changes (other sources)	0	0	25.26
C. Changes in covered employment	0	3.69	17.22
2. Provisions affecting HI trust fund outlays:			
A. Changes in eligibility	0	6.70	0
B. Changes in covered services	1.87	0.23	0
C. Changes in patient cost-sharing	20.24	0	0
D. Changes in provider payments	36.67	66.48	2.43[6]
E. Changes in program administration	1.34	3.14	−0.11
3. Provisions affecting SMI trust fund revenues:			
A. Changes in enrollee premiums	0	9.00	4.53
4. Provisions affecting SMI trust fund outlays:			
A. Changes in eligibility	10.87	3.11	0
B. Changes in covered services	0	0	0
C. Changes in patient cost-sharing	17.00	5.20	0
D. Changes in provider payments	10.52	2.45	0

TABLE 5.—PERCENTAGE DISTRIBUTION OF ESTIMATED MEDICARE SAVINGS BY CATEGORY OF CHANGE FOR LEGISLATION ENACTED SINCE 1981 [1]—Continued

[Percent]

Category of change	OBRA—1981 [2]	TEFRA—1982 [3]	SS Amend.—1983 [4]
E. Changes in program administration	0.49	0	0
Total	100.0	100.0	100.0

[1] Estimated savings figures obtained from varius Congressional Budget Office documents.
[2] Estimated savings computed for fiscal years 1982 through 1984.
[3] Estimated savings computed for fiscal years 1983 through 1987.
[4] Estimated savings computed for fiscal years 1983 through 1988.
[5] Provisions have been grouped on the basis of their direct effects which may differ from the final impact, e.g., reductions in provider payments may ultimately result in higher beneficiary costs.
[6] Estimate does not include budgetary impact of the Prospective Payment System beyond 1985 as the effect of decisions by the Secretary of HHS could either increase or decrease aggregate medicare outlays.

II. CURRENT PROGRAM FINANCING

A. Basis of Social Security Financing

The Constitution provides that "no money shall be drawn from the Treasury, but in consequence of appropriations made by law." For most Federal programs, funding is made out of general revenues on an annual basis in one of the several departmental appropriations acts. Social security operates on a totally different basis. The Social Security Act provides for an appropriation out of the Treasury and into specified trust funds of amounts exactly equal to the amount of social security taxes imposed on employers and employees and on self-employed persons and, under the SS Ams of 1983 (P.L. 98-21), amounts collected through the taxation of S.S. benefits. This is a permanent appropriation and transfers to the trust funds are made on a daily basis consistent with the pattern of tax collections. In addition, a relatively small amount of revenue flows into the trust funds from general revenue reimbursements and from interest on investments.

Once moneys have been transferred to each of the trust funds, they are available to be expended to meet benefit costs without any further action on the part of the Congress. (Trust fund moneys are also available for administrative costs, but may be expended for that purpose only up to limits established in annual appropriations acts.) If benefit costs should exceed the available balances in the trust funds, there is no statutory authority to meet the deficit from general revenue appropriations.

Three social security programs OASI, DI and HI are designed to operate on this self-sustaining basis.

For each of these programs there is a separate trust fund which receives its share of social security tax. The proportion of the tax each year that is allocated to each trust fund is specified by law.

Interfund borrowing

Prior to legislation enacted in 1981 (P.L. 97-123), each social security program had to meet its benefit obligations through the balances in its own trust fund. That is, the financial operations of the OASI, DI, and HI programs were completely independent. The 1981 legislation authorized "interfund borrowing" whereby on a temporary basis the surplus balances in any one trust fund may be used to help finance benefits paid out of the other trust funds.

The Old-Age and Survivors Trust Fund has borrowed $12.4 billion from the HI trust fund. The Social Security Amendments of 1983 (Public Law 98-21) extended the interfund borrowing authority from 1982 through 1987.

Under the law, loans are required to be repaid at the earliest possible date, but not later than 1989. Interest would be paid monthly to HI on any outstanding loans to OASDI. OASDI could not borrow from HI in any month in which the HI trust fund ratio is under 10 percent. In 1983 and 1987, OASDI would repay loans from HI whenever the OASDI fund ratio at the end of the year exceeded 15 percent. In 1988 through 1989, OASDI would repay HI, in 24 equal monthly installments, the loan balance outstanding at the end of 1987 plus outstanding interest.

B. Hospital Insurance

The HI program is financed primarily from amounts appropriated to the Hospital Insurance Trust Fund under a permanent appropriation of taxes paid by workers, their employers, and by individuals with self-employment income, in work covered by the Hospital Insurance payroll tax. In general, covered employment is the same as that covered by the Old Age and Survivors and Disability Insurance (OASDI) and Railroad Retirement cash benefit programs. Beginning in 1983, employment with the Federal Government, except in very limited instances, is also covered by, and subject to Hospital Insurance payroll taxes (but not to other Social Security taxes). An individual's HI contributions are computed on annual wages and/or self-employment income, up to a specific maximum annual amount. The HI rates applicable to taxable earnings in each of the calendar years 1966-1984 are shown in Table 6. The maximum amounts of annual taxable earnings and HI contribution in each of these years is also shown.

TABLE 6.—HOSPITAL INSURANCE TAX RATES AND MAXIMUM TAXABLE AMOUNT OF ANNUAL EARNINGS

Calendar year	Maximum taxable earnings	HI tax rate [1] (percent)	Maximum HI contribution
1966	$6,600	0.35	$23.10
1967	6,600	0.50	33.00
1968-71	7,800	0.60	46.80
1972	9,000	0.60	54.00
1973	10,800	1.00	108.00

TABLE 6.—HOSPITAL INSURANCE TAX RATES AND MAXIMUM TAXABLE AMOUNT OF ANNUAL EARNINGS—Continued

Calendar year	Maximum taxable earnings	HI tax rate [1] (percent)	Maximum HI contribution
1974	13,200	0.90	118.80
1975	14,100	0.90	126.90
1976	15,300	0.90	137.70
1977	16,500	0.90	148.50
1978	17,700	1.00	177.00
1979	22,900	1.05	240.45
1980	25,900	1.05	271.95
1981	29,700	1.30	386.10
1982	32,400	1.30	421.20
1983	35,700	1.30	464.10
1984	37,800	1.30	491.40

[1] Rates on employee and employer, each as a percentage of taxable earnings (payroll). Beginning in 1984, the rate on self-employed individuals is double the employee/employer rate.

For 1985 and thereafter, the rates shown in Table 7 are the rates scheduled under provisions of present law. Beginning in 1975 the maximum taxable earnings amount is adjusted automatically by law each year to reflect changes in the general level of wages in employment subject to social security taxes, which include the HI tax.

TABLE 7.—HOSPITAL INSURANCE TAX RATES SCHEDULED UNDER PRESENT LAW

Calendar years	Maximum taxable earnings	Scheduled HI tax rate (percent) [1]
1985	Subject to automatic increase	1.35
1986 and later	Subject to automatic increase	1.45

[1] Rates on employee and employer, each as a percentage of taxable earnings (payroll).

Note: Rates on self-employed individuals are double the employee/employer rates

In general, the principles employed in financing the Hospital Insurance portion of Medicare are similar to those employed in the Social Security cash benefit programs. That is, benefit outlays and administrative expenses are intended to be sustained, over the long-run, by the HI taxes. To meet this objective, the Board of Trustees [2] has adopted the general principle that annual income should be equal to annual outlays plus an amount sufficient to maintain a permanent trust fund balance equal to one-half year's program expenditures. This principle reflects the view that a contingency fund (50 percent reserve) is needed to cover the risk that

[2] The Board of Trustees of the HI trust fund consists of the Secretaries of Health and Human Services, Labor, and Treasury.

future revenues and outlays may differ from projected levels. It also reflects the judgment that full funding of future benefits, as workers accrue the rights to those benefits, is unnecessary and impractical. Further, investment of the surplus assets of the fund (the 50 percent reserve) provides income, in the form of interest earnings and net capital gains, to support program expenditures.

There are two exceptions to these principles. One exception concerns the coverage of a small number of individuals entitled, but not insured. These individuals were grandfathered early in the program and their costs are financed out of general revenues. In addition, these are the voluntarily enrolled persons whose costs are financed from the premiums that they pay.

C. Supplementary Medical Insurance

Supplementary Medical Insurance (SMI), unlike HI, is not compulsory. This program receives no proceeds from social security taxes and is now heavily supported by the general fund of the Treasury.

The SMI program is financed by monthly enrollee premiums (currently $14.60 per month) and appropriations from general revenues of the Treasury. The original Medicare legislation required the Secretary of Health and Human Services to set the Part B monthly premium amount annually so that aggregate premium income would equal one-half of SMI program expenses for aged enrollees projected for the forthcoming year plus a contingency reserve to cover projection errors and unanticipated events. The remaining one-half of Part B revenues was paid from general revenues.

Subsequent legislation (P.L. 92-603) limited increases in the Part B monthly premium to the percentage increase in cash benefit payments under the Old Age and Survivors, and Disability Insurance programs since the last increase in the Part B premium. Under the law, when aggregate premium income is insufficient to cover one-half of SMI program expenses, the difference is made up by additional appropriations of general revenues. Since then, increases in program expenses have significantly out-paced increases in OASDI cash benefits so that, by 1983, premiums accounted for less than 25 percent of program expenses for aged enrollees instead of the 50 percent originally envisioned. (See table 8.)

Provisions of the Tax Equity and Fiscal Responsibility Act of 1982 (P.L. 97-248) and the Social Security Amendments of 1983 (P.L. 98-21) first temporarily suspended the limitation on SMI premium increases for two 1-year periods and then delayed the suspension for six months. Under current law, SMI premiums beginning in January 1984 will be allowed to increase to a level sufficient to produce premium income equal to 25 percent of projected SMI costs for aged enrollees. The earlier limitation on premium increases will apply again for periods beginning on or after January 1, 1986.

TABLE 8.—MEDICARE SUPPLEMENTARY MEDICAL INSURANCE PREMIUM AMOUNTS

	Monthly premium amounts		
	For enrollee (aged and disabled)	Government amounts	
		For aged	For disabled
July 1966 to March 1968	$3.00	$3.00	.....
April 1968 to June 1970	4.00	4.00	.....
12-Month period ending June 30 of:			
1971	5.30	5.30	.....
1972	5.60	5.60	.....
1973	5.80	5.80	.....
1974 [1]	6.30	6.30	$22.70
1975	6.70	6.70	29.30
1976	6.70	6.30	30.30
1977	7.20	14.20	30.80
1978	7.70	16.90	42.30
1979	8.20	18.60	41.80
1980	8.70	18.10	41.30
1981	9.60	23.00	41.00
1982	11.00	34.20	62.20
1983	12.20	37.00	72.00
July 1 to Dec. 31, 1983	12.20	41.80	80.00
Calendar year:			
1984	14.70	44.10	94.70
1985 [2]	16.60	49.80	107.60
1986 [2]	17.30	57.50	124.30
1987 [2]	18.10	65.90	141.30
1988 [2]	18.90	75.10	159.10

[1] In accordance with limitation on the costs of health care imposed under Phase II of Economic Stabilization program, the standard premium rate for July and August 1973 was set at $5.80 and $6.10, respectively. Effective September 1973, the rate increased to $6.30.

[2] Estimates.

III. FINANCIAL PROSPECTS OF THE MEDICARE TRUST FUNDS

A. Hospital Insurance (HI) Trust Fund

The adequacy of the financing of the HI program, under present law can be evaluated by several different measures. One measure is provided by comparing on a year-to-year basis the actual tax rates specified by law with the projected total costs of the program, expressed as a percentage of taxable payroll. If these two items were exactly equal and all projection assumptions were realized, tax revenues together with interest income would be sufficient to pay for benefits and administrative expenses for insured persons in each year of the projection period. In practice, Congress has approved an HI tax schedule with rate changes occurring at intervals of several years, rather than yearly increases to match exactly with projected cost increases. Thus, a second useful indicator of the actuarial status (balance) of the Hospital Insurance program is pro-

vided by measuring the difference between the *average* tax rate and the *average* cost of the program (over the whole projection period), expressed as a percentage of taxable payroll over the same period.

Program actuaries make long-range (25-year) estimates of average costs as a percentage of taxable payroll for Hospital Insurance every year in order to show the relationship of projected trends in program costs to projected trends in program revenues. These annual estimates include four sets of projections based on economic assumptions ranging from pessimistic (Alternative III) to relatively optimistic assumptions (Alternative I). Intermediate assumptions are incorporated in Alternatives II-A and II-B. Unless otherwise noted, the actuaries' estimates shown in this report are based on Alternative II-B (pessimistic intermediate) assumptions.

Since its inception in 1965, annual projections of the financial condition of the Hospital Insurance program have generally been unfavorable. The Trustees of the Hospital Insurance Trust Fund have reported in 14 of the last 15 years that the HI program would be in deficit condition (see Table 9).

TABLE 9.—PAST LONG-RANGE FORECASTS OF THE HOSPITAL INSURANCE PROGRAM

25-year estimate made in calendar year	Average cost [1]	Average scheduled tax rate [1]	Difference
1966	1.23	1.23	.....
1967	1.23	1.23	.....
1968	1.38	1.41	0.03
1969	1.79	1.50	—.29
1970	2.04	1.56	—.48
1971	2.20	1.58	—.62
1972	2.21	1.60	—.61
1973	2.67	2.63	—.04
1974	2.63	2.65	.02
1975	2.86	2.70	—.16
1976	3.39	2.75	—.64
1977	3.96	2.80	—1.16
1978	3.86	2.74	—1.12
1979	3.82	2.78	—1.04
1980	3.80	2.81	—0.99
1981	4.28	2.84	—1.44
1982	4.93	2.86	—2.07
1983	4.11	2.87	—1.24

[1] Average (as a percentage of taxable payroll) for the 25-year period, using intermediate range economic assumptions (II-B).

Source: Annual Reports of the Board of Trustees of the Federal Hospital Insurance Trust Fund.

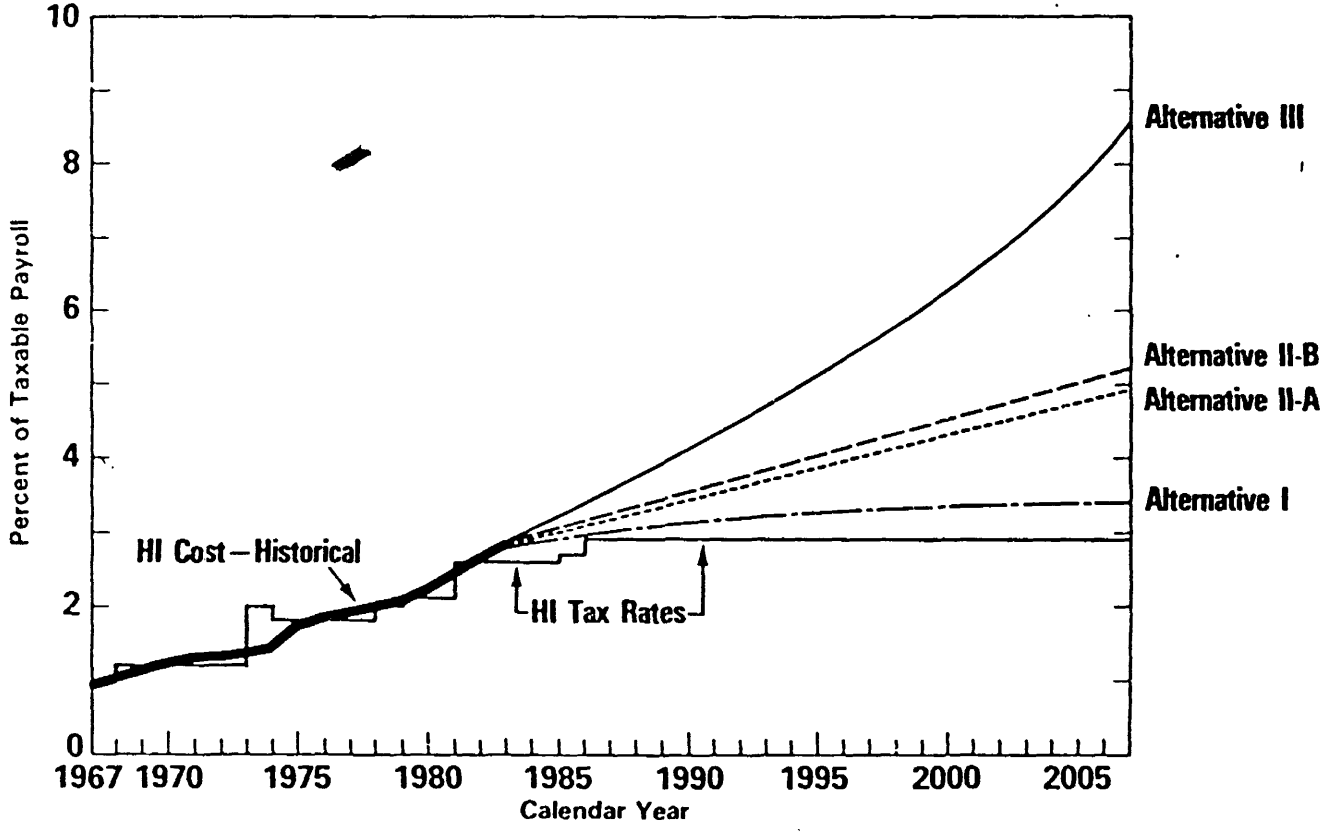
Long-range projections reported in the 1983 Trustees Report indicate that the size of the trust fund deficit (actuarial status) will grow steadily worse over the next 25 years as indicated in Chart 1. Over the whole 25 year period from 1983 to 2007, the average deficit is estimated at −1.24 percent of taxable payroll.

In other words, HI tax rates scheduled under current law would have to be increased on average by 43 percent from 2.87 percent of taxable payroll (average combined tax rate on employees and employers) to 4.11 percent over the whole 25 year period in order to bring the trust fund into actuarial balance. Alternatively, if scheduled tax rates were not increased, program expenditures would have to be reduced by an average of 30 percent over the period to eliminate the financing problem.

It should be noted that all actuarial estimates contained in the 1983 Trustees Report reflect the recent effects of legislation described earlier as well as assumptions about future behavior where administrative discretion exists. For example, the 1983 estimates are based on the assumption that the Secretary of HHS will limit increases in the hospital payment rates under the Medicare prospective payment system in fiscal year 1986 and later to the market basket rate plus 1 percentage point.

CHART 1

Estimated HI Cost and Tax Rates



Even a valuation period as long as 25 years may fail to present fully future contingencies that may be expected as the result of certain demographic changes. The Trustees also note, however, that the degree of uncertainty concerning future hospital costs, relative to the remainder of the economy, is sufficiently great to limit the usefulness of projections beyond 25 years. Nevertheless, it might be noted that over a 75-year period, the actuaries' projections suggest a pattern of ever increasing trust fund deficits reaching very high levels around the middle of the next century. Table 10 shows projections of program costs, income and trust fund balances, as a percentage of taxable payroll, over the period from 1983 to 2057. Similar figures for the Old Age and Survivors, and Disability Insurance (OASDI) trust funds combined, and the combined balance for the three trust funds (OASDI, DI and HI) are shown for comparison. As noted, however, the reliability of estimates for periods beyond 25 years is substantially diminished because of the increased uncertainty associated with very distant trends in hospital costs.

TABLE 10.—COST RATES, INCOME RATES AND TRUST FUND BALANCES AS A PERCENTAGE OF TAXABLE PAYROLL FOR OASDI AND HI PROGRAMS UNDER INTERMEDIATE (II-B) ECONOMIC ASSUMPTIONS, CALENDAR YEARS 1983-2057

Calendar year	OASDI			HI [1]			OASDHI balance
	Cost rate	Income rate	Balance	Cost rate [2]	Income rate	Balance	
1983	+11.49	+11.24	−0.24	+2.70	+2.73	+0.03	−0.22
1985	+11.33	+11.85	+0 25	+2.88	+2.70	−0.18	+0.07
1990	+11.27	+12.71	+1.44	+3.46	+2.90	−0.56	+0.88
1995	+10.65	+12.79	+2.14	+4.05	+2.90	−1.15	+0.99
2000	+10.08	+12.78	+2.71	+4.58	+2.90	−1.68	+1.03
2005	+9.90	+12.79	+2.89	+5.13	+2.90	−2.23	+0.66
2010	+10.31	+12.82	+2.51	+5.61	+2.90	−2.71	−0.20
2015	+11.43	+12.88	+1.45	+6.22	+2.90	−3.32	−1.87
2020	+12.76	+12.95	+0.19	+7.00	+2.90	−4.10	−3.91
2025	+13.96	+13.03	−0.93	+7.89	+2.90	−4.99	−5.92
2030	+14.73	+13.08	−1.65	+8.65	+2.90	−5.75	−7.40
2035	+15.16	+13.12	−2.04	+9.10	+2.90	−6.20	−8.24
2040	+15.17	+13.14	−2.03	+9.29	+2.90	−6.39	−8.43
2045	+15.17	+13.16	−2.01	+9.32	+2.90	−6.42	−8.43
2050	+15.27	+13.16	−2.11	+9.35	+2.90	−6.45	−8.55
2055	+15.40	+13.17	−2.23	+9.37	+2.90	−6.47	−8.69
25-year avg.:							
1983-2007	+10.66	+12.50	+1.83	+4.02	+2.87	−1.15	+0.68
2008-2032	+12.64	+12.95	+0.32	+7.08	+2.90	−4.18	−3.86
2033-2057	+15.23	+13.15	−2.08	+9.29	+2.90	−6.39	−8.47
75-year avg.:							
1983-2057	+12.84	+12.87	+0.02	6.79	+2.89	−3.90	−3.88

[1] HI numbers differ from 1983 HI Trustees Report due to treatment of lump-sum transfers for deemed military service wage credits.

[2] HI cost rates exclude amounts required for building or maintaining the level of trust fund assets.

Source: 1983 Reports of the Boards of Trustees of the Federal Old Age, Survivors and Disability Insurance Program and of the Federal Hospital Insurance Program.

The near-term financing situation for the Hospital Insurance program is also severe. Estimated operations of the HI Trust Fund in the near-term are shown in Table 11. These estimates indicate that program outlays will exceed income this year and, except for 1986, annual deficits will grow rapidly throughout the remainder of this decade.

TABLE 11.—ESTIMATED NEAR TERM OPERATIONS OF THE HI TRUST FUND, CALENDAR YEARS 1982-90

[In billions of dollars]

Year	Income	Outgo	Difference	Interfund borrowing [1]	Net increase in fund	Fund at year end	Assets (percent) [2]
1982	$38.0	$36.1	$2.7	—$12.4	—$10.6	$8.2	52
1983	44.7	41.2	3.5	.....	3.5	11.7	20
1984	45.6	46.6	—1.0	.5	—.5	11.2	25
1985	51.3	52.3	—1.0	.....	—1.0	10.2	21
1986	58.4	58.0	.4	1.1	1.5	11.8	18
1987	62.5	64.1	—1.6	2.4	.8	12.6	18
1988	66.0	71.0	—5.0	8.4	3.5	16.1	18
1989	70.0	78.4	—8.4	.....	—8.4	7.8	21
1990	73.9	86.6	—12.7	.....	—12.6	.....	9

[1] The negative amount shown for 1982 was a loan made from the HI Trust Fund to the social security old age and survivors' program in that year. The positive amounts represent repayment of the loan principal to the HI Trust Fund in the amounts and years indicated.

[2] Fund assets (in dollars) at beginning of year as a percentage of estimated dollar outgo during year

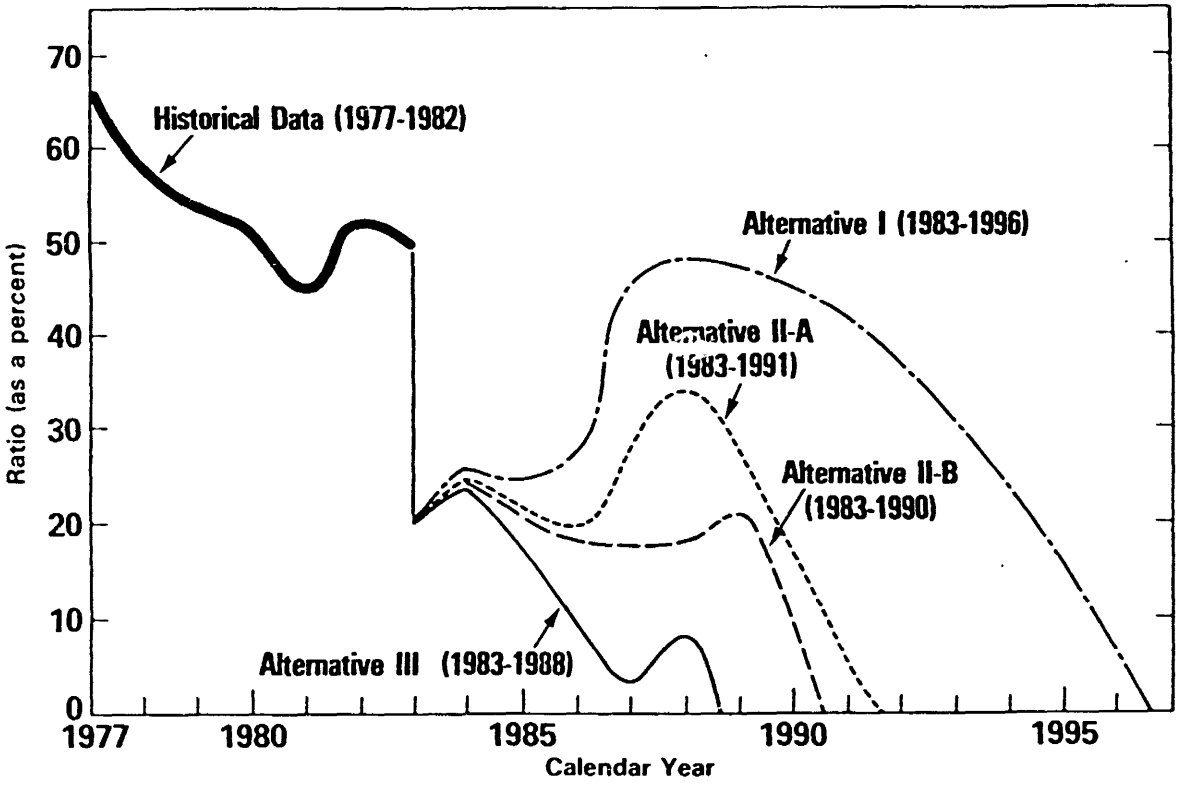
Source: 1983 Annual Report of the HI Board of Trustees

The short-term financial adequacy of the trust fund also can be measured by the ratio of assets at the beginning of the year to projected outlays during the year, expressed as a percentage. The Trustees have adopted the principle that the asset ratio should not fall below 50 percent; if it falls below 10 percent there would be a significant likelihood that the fund would be exhausted sometime during the year. The pattern of projected asset ratios (shown in the last column of Table 11 and graphically illustrated in Chart 2) is distorted by the decline in assets associated with the loan of $12.4 billion to the OASI program in 1982 and by loan repayments expected in 1986, 1987 and 1988. Nevertheless, it is clear that the assets of the fund will be inadequate to support benefit payments as early as 1990.

Based on these estimates, the Trustees concluded that the tax rates currently specified in the law (including the scheduled 1985 and 1986 increases) would be sufficient, along with interest earnings and assets in the HI Trust Fund, to support program expenditures only for the next six or seven years.

CHART 2

Short Term HI Trust Fund Ratios



Note: The trust fund ratio is defined as the ratio of assets in the trust fund at the beginning of the year to disbursements during the year.

Congressional Budget Office estimates

Estimates of the near-term financial condition of the HI Trust Fund made in early 1983 by the Congressional Budget Office (CBO) were somewhat more pessimistic than those made by the trust fund actuaries. Prior to enactment of the Social Security Amendments of 1983 (P.L. 98-21), CBO projected that the Fund could be exhausted as early as 1987. Projections made after passage of the 1983 legislation indicate that the infusion of additional income to the Fund (resulting from certain tax changes in the 1983 Act) delays depletion by a little more than one year, from 1987 to 1988, while savings from the changes in hospital payment policies included in the legislation defer depletion by about another year until late 1989 or early 1990. CBO's estimates were based on the assumption that future hospital payment rates (for fiscal year 1986 and later) would increase by the market basket rate plus 2½ percentage points.

In November 1983, CBO projected depletion of the HI Trust Fund by the end of the decade (1990 was the most probable year) unless further policy changes are made in the Medicare Hospital Insurance program. The year-end balances in the Trust Fund were projected to decline each year as annual outlays exceed annual income. Deficits would be small at first, but then increase rapidly. By 1995, the annual deficit is projected to be over $60 billion and the cumulative deficit will total more than $250 billion. (See Table 12.)

TABLE 12.—CBO PROJECTIONS OF HOSPITAL INSURANCE TRUST FUND INCOME, OUTLAYS, AND BALANCES UNDER THE ASSUMPTION THAT HOSPITAL PAYMENT RATES AFTER FISCAL YEAR 1985 INCREASE BY THE MARKET BASKET RATE PLUS 2½ PERCENTAGE POINTS

[In billions of dollars]

Calendar years	Income [1]	Outlays	Annual surplus (excluding any negative interest)	Year-end balance
1981	$35.7	$30.7	$5.0	$18.8
1982	25.6	36.1	−10.6	8.2
1983	43.8	40.6	3.1	11.3
1984	46.3	46.5	−0.2	11.1
1985	53.4	51.2	2.2	13.3
1986	66.4	57.3	9.1	22.4
1987	66.7	64.5	2.2	24.6
1988	66.8	72.5	−5.7	18.9
1989	70.7	81.5	−10.8	8.1
1990	74.5	91.7	−17.2	−9.1
1991	77.9	103.1	−23.8	−34.3
1992	81.1	115.8	−31.1	−69.0

TABLE 12.—CBO PROJECTIONS OF HOSPITAL INSURANCE TRUST FUND INCOME, OUTLAYS, AND BALANCES UNDER THE ASSUMPTION THAT HOSPITAL PAYMENT RATES AFTER FISCAL YEAR 1985 INCREASE BY THE MARKET BASKET RATE PLUS 2½ PERCENTAGE POINTS—Continued

[In billions of dollars]

Calendar years	Income [1]	Outlays	Annual surplus (excluding any negative interest)	Year-end balance
1993	83.9	130.1	−39.7	−115.1
1994	86.3	146.2	−49.5	−175.1
1995	87.7	164.5	−60.9	−251.8

[1] Income to the trust funds is budget authority. It includes payroll tax receipts, interest on balances, and certain general fund transfers. When year end balances are negative, income includes negative interest, which is the amount that would be paid by the trust fund on hypothetical borrowing required to continue benefit payments. Income in 1982 reflects $12.4 billion in interfund transfer from the HI trust fund to the OASI trust fund. The estimates assume that the interfund transfer will be repaid by 1987.

Note: Minus signs denote deficits.

Source: CBO estimates as of November 1983 based on February 1983 assumptions, but updated to reflect the Social Security Amendments of 1983 (P.L. 98-21).

The CBO also pointed out, however, that the rate of depletion of the HI trust fund depends heavily on future rates of increase in payments to hospitals under the Medicare hospital prospective payment system established in P.L. 98-21.

Beginning in FY 86, the Secretary of Health and Human Services is given considerable discretion under present law to set hospital payment rates under the HI program. If the Secretary decides to permit such payments on a per case basis to increase by one percentage point more than the annual rate of increase in the hospital market basket then CBO projects a delay in the date of the Trust Fund's depletion to sometime in 1992. Large deficits in the Fund would still occur, but in smaller annual and cumulative amounts.

TABLE 13.—CBO PROJECTIONS OF HOSPITAL INSURANCE TRUST FUND INCOME, OUTLAYS, AND BALANCES UNDER ASSUMPTION OF MORE STRINGENT PAYMENT RATES AFTER 1985 [1]

[In billions of dollars]

Calendar years	Income [2]	Outlays	Annual surplus (excluding any negative interest)	Year-end balance
1986	$66.4	$57.3	$9.1	$22.4
1987	66.9	62.1	4.8	27.2
1988	67.1	68.3	−1.2	26.0
1989	71.5	75.1	−3.6	22.4
1990	75.9	82.6	−6 8	15.7

TABLE 13.—CBO PROJECTIONS OF HOSPITAL INSURANCE TRUST FUND INCOME, OUTLAYS, AND BALANCES UNDER ASSUMPTION OF MORE STRINGENT PAYMENT RATES AFTER 1985 [1]—Continued

[In billions of dollars]

Calendar years	Income [2]	Outlays	Annual surplus (excluding any negative interest)	Year-end balance
1991	80.1	90.9	−10.7	4.9
1992	84.6	99.9	−15.2	−10.4
1993	89.1	109.8	−19.4	−31.2
1994	93.6	120.8	−24.1	−58.4
1995	98.0	133.0	−29.5	−93.4

[1] Assumes payment rates are increased one percentage point per year faster than the increase in the hospital market basket.

[2] Income to the trust funds is budget authority. It includes payroll tax receipts, interest on balances, and certain general fund transfers. In years when balances are negative, income includes negative interest, which is the amount that would be paid by the trust fund on hypothetical borrowing required to continue benefit payments. Income in 1982 reflects $12.4 billion in interfund transfers from the HI trust fund to the OASI trust fund. The estimates assume that the interfund transfer will be repaid by 1987.

Note: Minus signs denote deficits.

Source: CBO estimates as of November 1983 based on February 1983 assumptions, but updated to reflect the Social Security Amendments of 1983 (P.L. 98-21).

Reasons for HI financing problems

To the extent that program costs as a percentage of taxable payroll have exceeded or will exceed the scheduled HI tax rates, those rates must be increased or benefits reduced in order to adequately finance Hospital Insurance on a "pay as you go" basis. Since inpatient hospital services account for 95 percent of HI benefit expenditures, the program's financial experience is determined almost entirely by what happens in the hospital sector.

Trends in program costs can be broadly separated into (1) increases in aggregate expenditures by hospitals in providing covered services and (2) changes in the share of such expenditures that are borne by the HI program. Increases in aggregate inpatient hospital costs reflect increases in unit input prices, such as higher wages for labor and higher prices for things hospitals buy, changes in the volume or mix of services provided and changes in unit input intensity (e.g., increases in the numbers of hospital employees and in the amount of supplies and equipment to produce a unit of service) and changes in the volume of inpatient admissions. Changes in the program's share of aggregate hospital costs also result from changes in the proportion of the population covered (including changes due to legislation), changes in the relative number and value of services received by beneficiaries and the effects of reimbursement policies on the level of program payments.

Although changes have occurred in the program's share of aggregate hospital costs, the most important cause of financial problems

for the Hospital Insurance program has been that aggregate hospital costs for all patients, including Medicare patients, have increased substantially faster than increases in average wages and prices in the general economy.

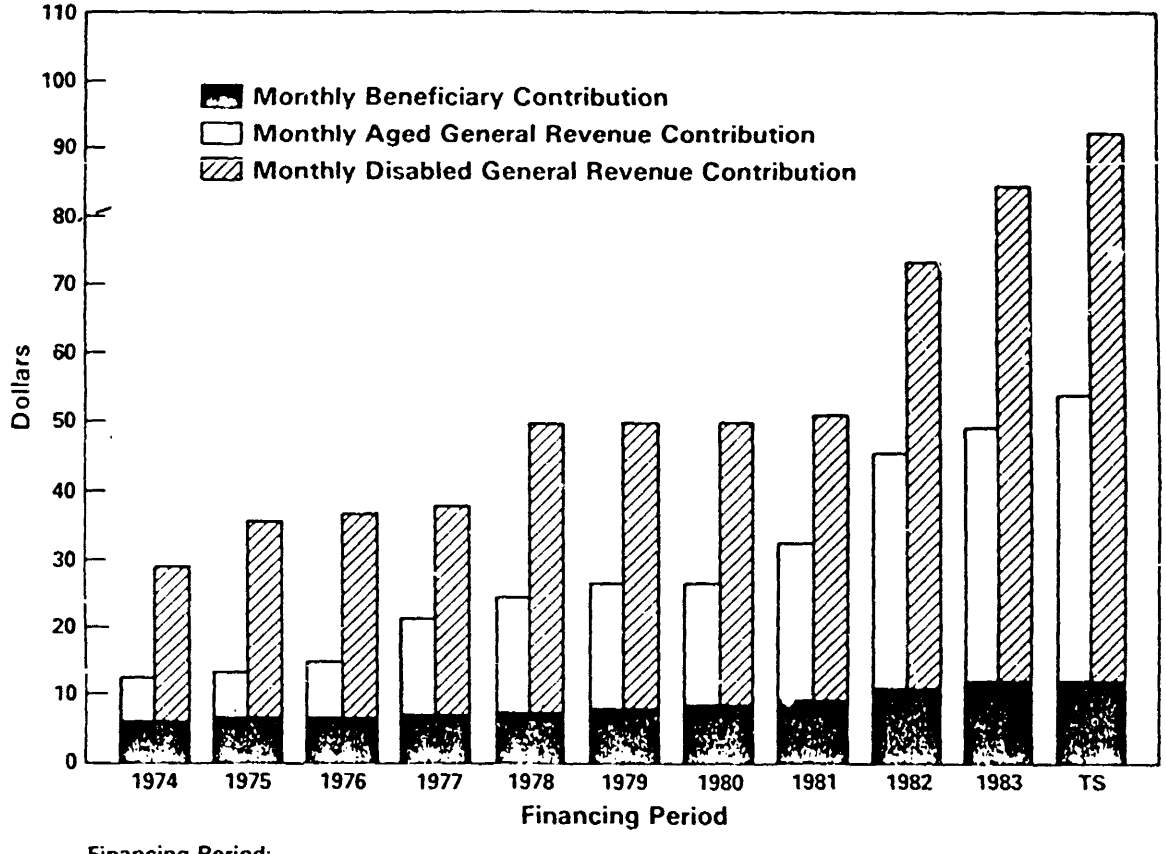
Until October 1, 1983 the Hospital Insurance program reimbursed institutions for inpatient hospital services on the basis of the share of total inpatient hospital costs attributable to providing services to Medicare beneficiaries. In their 1983 report, however, the Trustees of the HI fund express the view that the recent changes in hospital payment policies under Medicare—from retrospective cost-based reimbursement to prospectively determined payments based on individual patient diagnoses—will make future outlays under the program "potentially less vulnerable to excess rates of growth in the hospital industry." Thus, the Trustees note, past trends in aggregate HI inpatient hospital costs may have little relation to projected payment levels anticipated in future years. On the basis of intermediate range (II-B) assumptions, the Trustees estimate that annual increases in HI inpatient costs will decline from 13.3 percent for 1983 to 8.6 percent by the end of the 25-year period.

B. Supplementary Medical Insurance Trust Fund

Financing for the Supplementary Medical Insurance program is established annually on the basis of the standard monthly premium rate (paid by or on behalf of all enrollees) and monthly actuarial rates determined separately for aged and disabled beneficiaries. The monthly actuarial rates are set equal to one-half the monthly amounts estimated to be necessary to finance the SMI program over the next one year period. These rates determine the amount to be contributed from general revenues on behalf of each enrollee. Since July 1973 annual increases in the standard monthly premium rate have been limited to the rate of increase in OASDI cash benefits. As a result, premium amounts are currently much lower than the amount that would be needed to cover the remaining half of annual outlays. Based on the formula in the law, however, additional government contributions effectively make up the difference between the sum of the monthly premium rate, the actuarial rates and the full cost of the program. Chart 3 presents these values for financing periods since 1974. The extent to which general revenue financing is becoming the major source of income for the program is clearly indicated in this chart, and in table 8.

CHART 3

SMI Monthly Per Capita Income



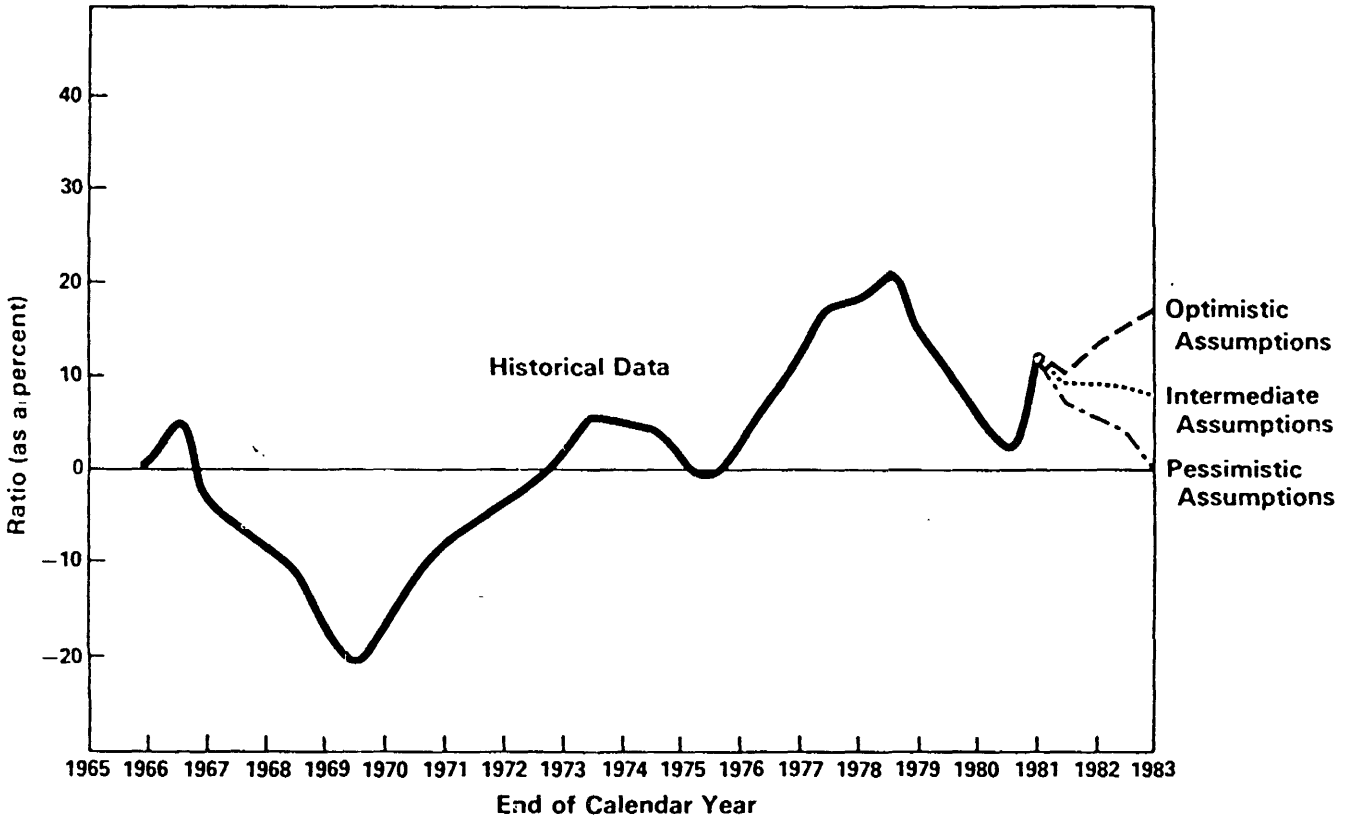
Financing Period:
For periods 1983 and earlier, the financing period is July 1 through June 30.
For the transitional semester (TS), the financing period is July 1, 1983 through Dec. 31, 1983

Because the standard monthly premium amount and the Federal general revenues contribution amounts are reset each year, concern about the financing of the SMI trust fund tends to focus on the question of whether or not the amounts established for the current year will provide trust fund revenues sufficient to meet the projected benefit outlays and administrative expenses incurred during the year. A second test of actuarial soundness concerns the extent to which trust fund assets available at the end of the period will be sufficient to cover both projected benefit liabilities incurred but not paid yet and any discrepancies between projected and actual benefit expenditures during the year (i.e., projection errors).

Tests for actuarial soundness and trust fund adequacy can be based on a direct examination of projected absolute dollar levels of revenues and expenditures. In testing the adequacy of trust fund assets, however, a relative measure is more useful. The relative measure or ratio used for this purpose is the ratio of the projected net surplus or deficit at the end of one year to the following year's projected expenditures. Chart 4 shows this ratio for historical years and for projected years under the intermediate assumptions (Alternatives II-A and II-B), as well as more pessimistic and fairly optimistic assumptions.

CHART 4

Actuarial Status of the SMI Trust Fund



Note: The actuarial status of the SMI trust fund is measured by the ratio of the end of year surplus or deficit to the following year's incurred expenditures.

Annual financing of SMI benefits tends to obscure long term trends in program cost. Part B benefit expenditures have increased rapidly in the past and this trend is expected to continue for the foreseeable future. Recent CBO estimates suggest that SMI expenditures will increase at an annual rate of more than 15 percent over the period 1985 to 1989.

The projected rapid growth in SMI raises concern over its impact on the Federal budget deficit. By law, appropriations from general revenues to SMI must be sufficient to guarantee solvency of the trust fund. Thus, concern arises because the projected growth of SMI is so much faster than the growth of the general revenues from which it draws support. According to CBO, outlays under SMI are projected to increase by almost 16 percent per year through 1988. To finance this increase, general revenue contributions will have to rise even faster—averaging about 17 percent per year because enrollee premiums are scheduled to grow at a slower rate after 1985 when premium increases will again be limited by the rate of growth in the Social Security cost-of-living increase. Consequently, the share of general revenues needed to finance the SMI trust fund will rise from 3.1 to 5.7 percent between 1982 and 1988. If the share of general revenues contributed to the SMI trust fund were not allowed to rise, outlays would have to be reduced or premiums increased by almost $27 billion over the 1984-88 period, an amount representing about 19 percent of all SMI expenditures for the period.

Projections of SMI growth beyond 1988 are difficult, but CBO has outlined two possible scenarios to indicate the demands that SMI could place on Federal revenues. First, if the growth of both revenues and SMI outlays were to continue at the same annual rates now projected through 1988, SMI would require about 12 percent of general revenues in 1995. Alternatively, if the growth of SMI outlays decelerated to an annual rate of less than 12 percent and general revenues rose by 8 percent annually, the share of such revenues necessary to fund SMI would rise to over 7 percent in 1995.

IV. THE 1982 ADVISORY COUNCIL ON SOCIAL SECURITY

Section 706 of Title VII of the Social Security Act requires the Secretary of Health and Human Services to appoint an Advisory Council on Social Security every four years to review the status of each of the four Federal insurance trust funds established under the Act. These include the Federal Old-Age and Survivors Insurance and the Federal Disability Insurance trust funds established under Title II, and the Federal Hospital Insurance (Part A) and the Federal Supplementary Medical Insurance (Part B) trust funds established under Title XVIII of the Act.

Under the law, the Advisory Council is required to review the financial status of the trust funds in relation to the long-term commitments of the old-age, survivors and disability insurance programs and the hospital and supplementary medical insurance programs and to review the scope of coverage, the adequacy of benefits and all other aspects of these programs, including their impacts on the public assistance programs authorized in the Social Security Act.

The law also requires the Advisory Council to submit reports of its findings and recommendations to the Secretary of Health and Human Services for transmittal to the Congress and to the Board of Trustees of each of the trust funds. The term of appointment expires with the submission to the Congress of the Council's reports.

The recent Advisory Council on Social Security, appointed in September 1982, was asked to focus its attention on the Federal Hospital Insurance (HI) and the Federal Supplementary Medical Insurance (SMI) programs. Because of the serious financial problems projected for the HI trust fund, the Council's attention was focused principally on the Part A hospital insurance program. The Council's recommendations are described in the next section. The report of the Advisory Council, submitted to the Congress in 1984, is contained in Appendix B. The Council members are:

Chairperson

Otis R. Bowen, M.D., Department of Family Medicine, Long Hospital, Indianapolis, Indiana.

Members

Richard W. Rahn, Ph.D., Vice President, U.S. Chamber of Commerce.

James D. McKevitt, Director of Federal Legislation, National Federation of Independent Business.

Linda H. Aiken, R.N., Ph.D., Vice President, Robert Wood Johnson Foundation.

Karl D. Bays, Chairman, Chief Executive Officer and Director, American Hospital Supply Corporation.

Kenneth McCaffree, Ph.D., Hansville, Washington.

David W. Christopher, Price Waterhouse Company.

Samuel Howard, Vice President and Treasurer, Hospital Corporation of America.

Stanford D. Arnold, Secretary-Treasurer, Michigan Building & Construction Trades Council.

Alvin E. Heaps, President, Retail, Wholesale & Department Store Unions.

C. Joseph Stetler, LL.B., Attorney at Law, Dickstein, Shapiro & Morin.

James Balog, Senior Executive Vice President, Drexel Burnham Lambert.

Rose (Leone) M. Zamaria, Lake Worth, Florida.

V. POLICY OPTIONS CONSIDERED BY THE ADVISORY COUNCIL

A. Summary of the Options

Over the past 15 months, the Council reviewed the Medicare program and the status of the trust funds. The Council's deliberations were based on a projected cumulative deficit by 1995 of $200 to $300 billion in the Hospital Insurance (HI) Trust fund. Table 14 summarizes the policy options identified by the Advisory Council and their recommendations regarding each option.

TABLE 14.—MEDICARE FINANCING POLICY OPTIONS CONSIDERED BY THE 1982 ADVISORY COUNCIL ON SOCIAL SECURITY

Policy options	Council recommendation	Policy option effects on			
		HI trust fund		SMI trust fund	
		Revenues	Outlays	Revenues	Outlays
Increase reliance on general revenues.	Rejected	✓			
Increase scheduled payroll taxes	Rejected	✓			
Interfund borrowing	Approved [1]	✓			
Reallocate OASDI tax rates to HI	Approved	✓			
Tax on health insurance fringe benefits.	Approved	✓			
Excise taxes on alcohol and tobacco.	Approved	✓			
Changes in covered employment	Approved [2]	✓			
Index annual deductible	Approved				✓
Increase age of eligibility	Approved		✓	✓	✓
Apply means test	Rejected		✓		
Extend coverage for specific diseases or treatments.	Rejected		✓		
Restructure HI	Approved	✓	✓		
Optional part A benefit improvements.	Approved	✓	✓		
Optional part B benefit improvements.	Approved			✓	✓
Targeted long-term care benefits	Study				
Preventive services benefits	Study				
Voluntary vouchers	Approved		✓		✓
Annual adjustment to hospital payment rates.	Approved		✓		✓
Medical education costs	Approved		✓		
Fee schedules for physicians	Approved				✓

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TABLE 14.—MEDICARE FINANCING POLICY OPTIONS CONSIDERED BY THE 1982 ADVISORY COUNCIL ON SOCIAL SECURITY—Continued

Policy options	Council recommendation	Policy option effects on HI trust fund		Policy option effects on SMI trust fund	
		Revenues	Outlays	Revenues	Outlays
Assignment incentives	Approved				✓
Encourage new technology	Approved		✓		✓
Promote living wills	Approved		✓		✓
Improve management of medicare.	Approved		✓		✓
Develop health care IRAs	Study				
Improved information to beneficiaries.	Approved		✓		✓
Expand medicare as secondary payor.	Approved		✓		✓

[1] Authorized by P.L. 97-248, the "Tax Equity and Fiscal Responsibility Act of 1982" and extended by P.L. 98-21, the "Social Security Amendments of 1983."
[2] Required by provisions of P.L. 98-21.

B. Advisory Council Recommendations

The Advisory Council on Social Security offered 27 policy recommendations intended to respond to the projected trust fund deficit of $200 to $300 billion by 1995. The recommendations are described below.

1. Options that affect trust fund revenues

a. *Increase reliance on general revenues.*—The Council opposes any increase in the use of general revenues to finance the Medicare Hospital Insurance trust fund. The Council questions the soundness of any policy which relies upon general revenues to finance the HI program. In an era when the Government is experiencing substantial annual deficits, reliance on general revenues would only serve to exacerbate the problem of increasing deficits.

b. *Increase scheduled payroll taxes.*—The Advisory Council opposes any further increase in scheduled HI payroll taxes. A substantial majority of Council members opposed raising revenues through an increase in payroll taxes because of the potentially adverse effects such taxes would have on employment and business activity. The Council believed that a tax which is not progressive unduly burdens middle and low income workers. The current payroll tax already imposes a substantial burden on such workers and should not be increased.

c. *Interfund borrowing.*—The Council believes that the individuality of the Old Age and Survivors Insurance (OASI), Disability Insurance (DI) and Hospital Insurance (HI) programs should be preserved and that each program should be funded at a level sufficient to meet its continuing needs. Where short-term interfund borrowing among the trust funds is deemed necessary, such borrowing

should be subject to appropriate safeguards which include specific repayment schedules and prohibition against reducing the lending fund's assets below an actuarially acceptable level. The Council recognizes that interfund borrowing has been used in the past and now has been reauthorized through 1987. However, the Council was pleased that legislation enacted in 1983 that reauthorized such interfund borrowing included provisions that address the Council's concerns.

d. *Reallocate OASDI tax rates to HI.*—The Council recommends that, if needed, consideration be given to a reallocation of payroll tax rates between OASDI and HI in order to transfer sufficient OASDI surplus revenues to HI during the period 1985 through 1995 to maintain the financial viability of the HI trust fund. The Council believes that the diversion of projected surplus OASDI revenues by a reallocation of contribution rates among the OASI, DI and HI trust funds is a viable method for alleviating a substantial portion of the short-term projected HI deficit. However, the Council recognizes that both long- and short-range considerations must govern any specific reallocation proposal. Reallocation should only be considered if the integrity of all three trust funds will be preserved.

e. *Tax on health insurance fringe benefits.*—The Council endorses the Administration's proposal to consider any employer's contribution to an employee's health benefit plan that exceeds $70 a month for an individual and $175 a month for a family as income to the employee and subject to Federal, in the same manner as wages. The Council also recommends that consideration should be given to earmarking an appropriate portion of the incremental revenues that would be realized from the proposed tax to Medicare's Hospital Insurance trust fund.

A substantial majority of Council members believes that the principal benefit to be derived from this tax-exemption limitation is that it will bring about a change in consumer health care purchasing patterns by increasing consumer cost consciousness and provider competitiveness that will slow the increase in health care costs. Removing the current complete tax exemption of these benefits will make employees more conscious of and concerned about the cost of health care and the cost effectiveness of the services they receive. Revenue raising possibilities under this recommendation were a secondary consideration.

f. *Excise taxes on alcohol and tobacco.*—The Council recommends that Federal excise taxes on alcohol and tobacco be increased, with the increased revenue to be earmarked to the HI trust fund. The Council does not specify the amount to be raised and earmarked to the HI trust fund, but suggests that the amount be determined by the Congress.

Although the Advisory Council generally viewed increased taxes as an undesireable alternative for resolving the financial problem facing the Hospital Insurance trust fund, the projected substantial deficit precluded a resolution based solely on a reduction of expenditures. A majority of Council members recommended an increase in the Federal excise tax on alcohol and tobacco products based on the demonstrated correlation between the use of these products and increased health care costs.

g. *Extend covered employment.*—The Council concurs with the recommendations of the National Commission on Social Security Reform and with subsequently enacted provisions of Public Law 98-21, that (1) mandate Old-Age, Survivors, Disability and Hospital Insurance (OASDHI) coverage be extended to employees of nonprofit organizations, and (2) preclude State and local government units which have elected OASDHI coverage for their employees from terminating such coverage in the future, including termination actions underway but not completed by the date of enactment of Public Law 98-21.

The Council concluded that coverage under Medicare of all persons in paid employment is a desirable objective that would contribute to the fiscal stability of the OASI, DI and HI programs. Therefore, the Council believes that the recent enactment of provisions mandating coverage for all employees of nonprofit organizations and precluding terminations of coverage by State and local employees, along with prior legislative action covering all current and future Federal workers under the HI program, has contributed to this objective.

2. Options that affect program outlays

a. *Index annual deductible.*—The Council recommends that the current Supplementary Medical Insurance (Part B) deductible be indexed to the Consumer Price Index (CPI) to keep pace with inflation and with increases in beneficiary income. The indexing should begin as soon as feasible.

Unlike the inpatient deductible under the Part A Hospital Insurance program, which is indexed to the cost of hospital care, increases in the Part B deductible are adjusted periodically by Congress. The Council believes that increases that have been legislated have failed to keep pace with either the increasing cost of Part B services or the increasing income available to the elderly.

Given their historically greater rate of increase, the Council acknowledges that indexing the deductible to medical costs could produce a disparity between income increases and deductible increases over time. The Council, therefore, recommends that the Part B deductible be indexed to the slow-rising Consumer Price Index as soon as feasible to insure a more reasonable ratio between beneficiary income and Part B cost sharing.

b. *Increase age of eligibility.*—The Council recommends an increase in the age of eligibility for Medicare benefits from age 65 to 67. This recommendation provides for the age of eligibility to be increased by three-month increments per year beginning on January 1, 1985. Beginning on January 1, 1989, the rate of increase will escalate to six-month increments, achieving full implementation of the age 67 eligibility on January 1, 1990. The Council further recommends that, subsequently, the age of eligibility for Medicare benefits should be indexed to increases in life expectancy.

A majority of the Council members concluded that the age of 65 as the initial age of eligibility was rooted more in custom than an assessment of health care needs. The age of eligibility for unreduced monthly social security retirement benefits has been increased to age 67 although full implementation of the new age will not occur until the third decade of the 21st century. However,

there is no inherent linkage between eligibility for monthly retirement benefits and Medicare. Today more than 50 percent of those eligible for Social Security elect reduced old age benefits up to 3 years prior to the age at which they become eligible for Medicare.

Recognizing the increase in life expectancy since 1966, the year of Medicare's enactment, and the increased cost of health care services to those of advancing years, the Council believes it is necessary to assure that Medicare's resources are focused on the population most in need of Medicare protection. A substantial majority of the Council concluded that there is a need to adjust the age of eligibility to reflect the changes in life expectancy that have already occurred and to accomplish this adjustment by the end of the decade. With respect to the future, the Council recommends periodic adjustments to reflect changes in life expectancy.

c. *Apply means test.*—The Council opposes any effort to tie entitlement to Medicare benefits to a beneficiary's financial status. The Council rejects the concept of "means testing", believing that Medicare should remain an entitlement program where individual income or wealth is not a factor considered in determining one's eligibility for benefits.

d. *Extend coverage for specific diseases and treatments.*—The Council opposes any further extension of Medicare coverage to individuals (not otherwise eligible based on age or disability status) on the basis of medical diagnosis or the medical necessity for a particular form of treatment. Should specific categories of disease be considered in the future for Federal financial assistance, such assistance should be provided through a special program with separate allocation of funds to pay for the required treatment.

The Council acknowledges the success of the End Stage Renal Disease (ESRD) provisions of Medicare enacted in 1972 in providing financial assistance to those in need of this expensive treatment. However, the Council believes that in the future, the Medicare program's eligibility requirements be restricted to existing beneficiary categories i.e., aged and disabled, and any special disease categories requiring financial assistance should be separately funded.

3. Options that affect revenues or outlays through benefit restructuring

a. *Restructure HI.*—The Council recommends a restructuring of the Medicare Part A Hospital Insurance program to provide:

Unlimited hospital inpatient days per calendar year.

A per admission deductible, as currently computed, but limited to two hospital admissions per calendar year.

A daily coinsurance, equal to 3 percent of the hospital inpatient deductible, for each inpatient day except the initial day of any stay, when the inpatient deductible applies.

A skilled nursing facility benefit of 100 days per calendar year with no coinsurance on days 1 through 20 and a 12.5 percent coinsurance on days 21-100.

Retention of the currently available home health benefits under Medicare Part A.

The current hospice benefit.

b. *Optional Part A benefit improvements.*—The Council recommends an enhanced Part A Hospital Insurance benefit be offered to

beneficiaries as an integral part of their Part B (SMI) election that provides for:

Elimination of the 3 percent daily coinsurance on hospital inpatient days.

Elimination of the 12.5 percent daily coinsurance on days 21-100 of skilled nursing facility stay benefits.

A beneficiary who elects to take Medicare's Part B coverage would automatically elect the Part A enhanced benefit. The enhanced Part A benefit would be financed with an actuarially sound premium. This premium would include an additional amount for the purpose of providing additional revenues necessary to help to resolve the current disparity between beneficiary contributions to the HI trust fund and the value of benefits received.

The Council concluded that while the hospital insurance program of Medicare, Part A, provides adequate coverage for most beneficiaries, it does not provide adequate protection in the event of catastrophic illness. The Council believes that financing an improved benefit package for all Medicare beneficiaries through increased coinsurances on shorter hospital stays would place the financial burden only on those who were ill and required inpatient care. In the Council's opinion, the establishment of a premium to finance improved benefits and to generate additional revenues to help insure the fiscal soundness of the program is a more equitable means of sharing additional beneficiary costs. The Council believes that the changes it is recommending will also facilitate beneficiary understanding of their benefits under Medicare and simplify administration of the program.

c. *Optional Part B benefit improvements.*—The Council also recommends an enhanced Part B benefit to be offered on an optional basis, i.e., not as an integral part of the beneficiary's Part B election. The enhanced benefit would provide a yearly limit on Part B out-of-pocket expenses, which would be indexed annually to recognize increases in per capita Part B program expenditures. The Part B option would also be financed by a premium which would be added to the current Part B premium for those electing this option.

Recognizing beneficiary concerns regarding increasing cost-sharing liability under the part B supplementary medical insurance program, the Council concluded that offering, on an optional basis, the opportunity to limit cost-sharing liability for Part B services to an annual dollar amount would improve the protection available and preclude or reduce the need to purchase private supplemental (Medigap) insurance.

Although the Council recognizes that the recommended restructure will increase beneficiary contributions under the Medicare program the benefits offered will be improved and at less cost than comparable Medicare/Medigap protection.

d. *Targeted long term care benefits.*—The Council recommends that the Secretary of Health and Human Services, in developing a comprehensive long term care program, seek guidance from those studies which have suggested the targeting of groups who will benefit from these services. The Council recognizes the problems faced by the Medicare population due to the fragmentation among several programs of services offered to beneficiaries who need on-

going chronic care. As the Medicare population ages, the Council believes that the need for long term care services will increase.

The Council believes that more conclusive information regarding the long term care needs of the elderly is needed. Recognizing the potentially high cost of such care, any expansion of long term care benefits under the Medicare program, especially at a time when the program is experiencing serious fiscal problems, would not be appropriate. A piecemeal attack on the critical problem of financing long term care will not work. Development of a comprehensive program is necessary. Any long term care program should target those who are eligible for conventional long term care and provide alternative care as a substitute for more expensive conventional care.

e. *Preventive services benefits.*—The Council believes, in general, that the elderly can benefit from prevention-oriented programs and screening procedures. The Council suggests that a comprehensive review of the Health Care Financing Administration's demonstration projects to assess the economy and efficacy of expanding Medicare coverage to include preventive services be undertaken prior to any change in the law.

The Council viewed as inconclusive the evidence concerning the cost-effectiveness of preventive services. The offering of such services may improve health and mobility of the elderly and produce long-term program savings. However, while there was agreement that there must be preventive services that could be shown to be cost-effective, a comprehensive study should be undertaken to identify those particular services before expansion of Medicare's coverage of preventive care.

f. *Voluntary vouchers.*—The Council recommends the use of a voluntary voucher in the Medicare program. The voucher would provide beneficiaries with an alternative to the current method of reimbursing medical services. The voucher would also promote the development of more efficient ways of delivering services by health care providers.

The Council was in general agreement that a voucher system represents one means for the promotion of competition in the health industry and that such a system would increase incentives for beneficiaries to be more sensitive to the cost of health care services. Although the Council expressed opposition to any mandatory voucher system, a substantial majority supported a voluntary system provided beneficiaries are given adequate assistance in the process of choosing an alternative health care plan.

4. Options that affect program outlays through changes in provider reimbursement

a. *Annual adjustment to hospital payment rates.*—The Council endorses the principle of prospective payment for Medicare inpatient hospital services. The Council supports a prospective payment system based on diagnosis provided it is equitable for all hospitals, encourages efficiency of operations and maintains accessibility and quality of care for Medicare beneficiaries.

The Council recognizes that the allowed rate of increase in the DRG rates will have a significant impact upon the costs of the Medicare hospital insurance program. Therefore, the Council urges

the Secretary of HHS to exert care to limit any annual rate of growth in the DRG rates that is above the annual rate of change in the hospital input price index.

b. *Medical education costs.*—The Council believes that it is inappropriate for the Medicare program, which is designed to pay for medical services provided to the elderly, to underwrite the cost of training medical personnel and recommends that such support be withdrawn as alternative funding sources are identified. The Council believes that medical education is an appropriate area for governmental support and recommends that the Department of Health and Human Services undertake a study to identify and develop other Federal, State and local funding sources.

c. *Fee schedules for physicians.*—The Council believes that Medicare's statutorily mandated reasonable charge method of reimbursement has not been effective in controlling expenditures or encouraging utilization of cost effective services. As a step toward reform of the system, the Council recommends a statutory revision to authorize reimbursement based on fee schedules adjusted initially and periodically for differences in cost of living and/or maintaining a practice. The Council urges that development of the schedules be undertaken with due concern for all interested parties, direct input from the medical profession, and with maintenance of support for the capitation system.

The Council believes that the current reasonable charge system has failed to curb inflation in medical care costs and, in fact, has probably contributed to that inflation. The current system has also helped to perpetuate significant payment differentials among geographic areas and medical specialties. The Council views fee schedules as the initial step in reform of the system and encourages the medical profession and other third party payors to cooperate in experimenting with and developing alternative methods of reimbursement.

d. *Assignment incentives.*—The Council recommends a statutory revision to the current medicare assignment system. The revision would establish a physician participation agreement system under which physicians would annually elect whether they would "participate", i.e., accept assignment on all services to Medicare patients. Notice of intent to participate, or to withdraw from participation, would be made six months in advance. Claims for reimbursement for services furnished by physicians who decided not to participate would always be made to the patient who would be responsible for the physician's entire bill including any amount that exceeds Medicare's reasonable charge.

The Council recommends the following incentives for physicians to participate:

Competition: The Medicare program would publish annually a directory of participating physicians. The directory would be published on a local basis, e.g., city, county or Standard Metropolitan Statistical Area (SMSA), as appropriate.

Billing: Participating physicians could take advantage of streamlined billing and payment procedures. Such incentives could include provisions for multiple-list claims, automated or electronic billing with the program providing some of the nec-

essary equipment and an electronic funds transfer (EFT) process.

5. Additional Options

a. *Encourage medical technology.*—The Council recommends that it should be fundamental policy of the Department of Health and Human Services to promote the development of medical technology. Criteria used to evaluate new technology should stress the efficacy of new procedures as well as their cost. The Council believes that the development of new medical technology and procedures should be encouraged. At the same time the Council believes that greater attention must be given to the criteria used to evaluate new technology. The initial cost of new technology is one criterion for assessment. Lower cost, brought about by economies of scale, is another criterion. Value, however, is a criterion of no less importance. It must be measured by the benefit that new technology brings to medicine itself, to international competitiveness for the United States and, most of all, to the healthful lives of the American people.

b. *Promote living wills.*—The Council supports the concept of voluntary advanced directives as a means of appropriate decisionmaking about life-sustaining treatment for incapacitated patients. Also, recognizing that this is an individual State determination, the Council encourages a voluntary program in the 14 States where advanced directives are legal and encourages the other 36 State legislatures to enact such legislation. In the States where this is legal, the Council suggests that a person be offered a living will when signing up for Medicare.

The Council further suggests that the guidelines employed for this voluntary program be those found in the report on "Deciding To Forego Life-Sustaining Treatment" by the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavorial Research.

The Council recommends that HCFA undertake a comparative study to assess what the impacts (financial and otherwise) have been in those 14 States that have living wills compared to those States without them.

c. *Improve medicare management.*—The Council recommends that the Health Care Financing Administration continue its efforts to improve the management of the Medicare program. As part of this effort, HCFA should review the recommendations of the President's Private Sector Survey on Cost Control and the Office of the Inspector General of the Department of Health and Human Services.

The Council believes that if the American people are to be asked to make sacrifices to preserve the financial viability of the Medicare program, they must be assured that program managers are striving to contain the cost of the Medicare program and assure that it will carry out its mission to make first class health care available to the elderly and disabled of this country.

d. *Develop health care IRA's.*—The Council urges that further study be given to proposals for long term restructure of the Medicare program to encourage individuals to save during their work-

ing years for the purpose of purchasing health care coverage in retirement years. Such proposals could further encourage individuals to save by establishing individual tax deductible "health credit accounts", similar to individual retirement accounts (IRAs). Medicare would be modified to complement individual spending during retirement years.

e. *Improved information to beneficiaries.*—An effort to improve Medicare's current program of information and assistance to beneficiaries should be a joint undertaking between the Health Care Financing Administration and the Social Security Administration.

f. *Expand medicare as secondary payor.*—The Council suggests an effort to identify additional areas where Medicare could serve as a secondary payor to group health insurance for the working aged or their spouses. The study would include evaluation of the implementation of current provisions and consideration of appropriate areas in which to expand the concept.

TABLE 15.—ESTIMATED IMPACT OF THE FINAL RECOMMENDATIONS OF THE ADVISORY COUNCIL ON THE HOSPITAL INSURANCE (HI) PROGRAM

[In millions of dollars]

Recommendation	Effective date	Calendar year—											
		1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	Total, 1985–95
Items affecting HI Income:													
Taxation of employer-provided health insurance	1/1/84	254	300	344	406	482	569	669	784	918	1,071	1,249	7,046
Restructuring HI	1/1/84	1,270	1,425	1,600	1,795	1,980	2,200	2,425	2,660	2,915	3,205	3,500	24,975
Total impact on HI Income [1]		1,504	1,680	1,869	2,096	2,292	2,494	2,764	3,049	3,373	3,721	4,124	28,966
Items affecting HI outlays:													
Advancing age of eligibility for medicare benefits	1/1/85	−550	−1,275	−2,130	−3,165	−4,965	−7,115	−8,540	−9,790	−10,935	−12,385	−13,815	−74,665
Restructuring of HI	1/1/85	−645	−725	−810	−905	−1,010	−1,125	−1,245	−1,370	−1,510	−1,665	−1,820	−12,830
Prospective payment-limit increases to market basket + 0 percent	1/1/88	0	0	0	−570	−1,315	−2,205	−3,240	−4,455	−5,865	−7,495	−9,375	−34,520
Eliminate medicare funding of medical education expenses	1/1/87	0	0	−2,800	−3,300	−3,600	−4,000	−4,400	−4,900	−5,400	−5,900	−6,500	−40,800
Total impact on HI outlays [1]		−1,185	−1,985	−5,585	−7,650	−10,395	−13,670	−16,390	−19,195	−22,095	−25,470	−29,130	−152,750

[1] Total impact figures do not equal the sum of the appropriate items due to the interaction of the recommendations. Total impact on income does not include changes in interest income to the fund.

Note: Items not included in chart are statements of the Advisory Council and have no cost or savings impact. Proposals involving tax rate changes have not been specified at this time.

Source: Department of Health and Human Services.

TABLE 16.—ESTIMATED IMPACT OF THE FINAL RECOMMENDATIONS OF THE ADVISORY COUNCIL ON THE SUPPLEMENTARY MEDICAL INSURANCE (SMI) PROGRAM

[In millions of dollars]

Recommendation	Effective date	Fiscal year—				
		1985	1986	1987	1988	1989
Net effect on SMI income:						
Change in premium income		−40	−135	−250	−370	−580
Change in general revenue		−165	−435	−745	−1,225	−1,990
Net effect on SMI outlays:						
Raise age of eligibility to medicare benefits	1/1/85	−155	−455	−845	−1,310	−2,125
Index part B deductible to CPI-W all items	1/1/85	−25	−65	−125	−195	−270
Participating physician	10/1/84	30	45	50	60	65
Total impact on SMI outlays		−150	−475	−920	−1,445	−2,330

Source. Department of Health and Human Services.

TABLE 17.—ESTIMATED OPERATIONS OF THE HOSPITAL INSURANCE TRUST FUND WITH AND WITHOUT THE ESTIMATED EFFECTS OF THE RECOMMENDATIONS OF THE ADVISORY COUNCIL, CALENDAR YEARS 1984–95

[Dollar amounts in billions]

Calendar year	Total income [1]		Total outgo		Net increase in fund		Fund at end of year		Ratio [4] (percent)	
	Without recommendations [2]	With recommendations [3]	Without recommendations [2]	With recommendations [3]	Without recommendations [2]	With recommendations [3]	Without recommendations [2]	With recommendations [3]	Without recommendations [2]	With recommendations [3]
1984	$46.1	$46.1	$46.6	$46.6	−$0.5	−$0.5	$11.2	$11.2	25	25
1985	51.3	52.9	52.3	51.1	−1.0	1.8	10.2	13.0	21	22
1986	59.5	61.5	58.0	56.0	1.5	5.5	11.8	18.5	18	23
1987	64.9	67.5	64.1	58.5	0.8	9.0	12.6	27.5	18	32
1988	74.5	77.9	71.0	63.3	3.5	14.6	16.1	42.1	18	44
1989	70.0	74.4	78.4	68.0	−8.4	6.4	7.8	48.5	21	62
1990	73.9	79.6	86.6	72.9	−12.6	6.7	−4.9	55.2	9	67
1991	77.8	85.0	95.1	78.7	−17.3	6.3	−22.2	61.4	−5	70
1992	81.8	90.8	104.5	85.3	−22.7	5.5	−44.9	67.0	−21	72
1993	85.5	96.7	114.7	92.6	−29.2	4.1	−74.0	71.1	−39	72
1994	89.0	102.8	125.8	100.3	−36.8	2.4	−110.8	73.5	−59	71
1995	92.4	109.1	137.9	108.7	−45.5	0.3	−156.3	73.9	−80	68

[1] Includes the loan repayments from the Old Age and Survivors Insurance Trust Fund to the Hospital Insurance Trust Fund as reported in the 1983 Trustees' Report.
[2] Based on 1983 Trustee's Report Alternative II–B assumptions updated January 6, 1984.
[3] Includes the loan repayments from the Old Age and Survivors Insurance Trust Fund to the Hospital Insurance Trust Fund as reported in the 1983 Trustees' Report.
[4] Ratio of assets at the beginning of the year to outgo during the year.

Source: Department of Health and Human Services.

APPENDIX A

TABLE A-1.—CBO REVISED PROJECTIONS OF SPENDING REDUCTIONS FOR LEGISLATIVE CHANGES MADE IN CALENDAR YEAR 1981 (OMNIBUS BUDGET RECONCILIATION ACT OF 1981), JANUARY 1982 ESTIMATES [1]

[Dollar amounts in millions]

Category of change	Fiscal year			3-year total	Percent [2]
	1982	1983	1984		
1. Provisions affecting HI revenues	0	0	0	0	0
2. Provisions affecting HI outlays				−$2,643	$61.1
A. Changes in eligibility	0	0	0	0	0
B. Changes in covered services				−81	1.9
Elimination of need for occupational therapy as a basis for entitlement to home health services	−$23	−$27	−$31	−81	1.9
Eliminate reimbursement for free-standing alcohol detoxification facilities	([3])	([3])	([3])	0	0
C. Changes in patient cost-sharing				−875	20.2
Making part A deductible and coinsurance more current	−185	−305	−360	−850	19.7
Making part A coinsurance current with the year in which services are furnished	−5	−10	−10	−25	0.6
D. Changes in provider payments				−1,629	36.7
Repeal of temporary delay in periodic interim payments	−692	0	0	−692	16.0
Set section 223 limits on reimbursements to hospitals at 108 percent	−75	−105	−125	−305	7.1
Limit nursing differential to 5 percent	−95	−105	−130	−330	7.6
Elimination of occupancy test for hospital long-term care	−70	−80	−90	−260	6.0
Set section 223 limits on reimbursement to home health agencies at 45th percentile	−12	−23	−27	−62	1.4
E. Changes in program administration				−58	1.3
Less frequent SNF surveys [4]	−4	−4	−4	−12	0.3
PSRO modifications	−5	−8	−5	−18	0.4
Payments to promote closing and conversion of underutilized facilities [4]	−2	−7	−19	−28	0.6
3. Provisions affecting SMI revenues	0	0	0	0	0
4. Provisions affecting SMI outlays				−1,681	38.9
A. Changes in eligibility				−470	10.9
Medicare payments secondary in cases of end-stage renal disease (revenue increase)	−95	−165	−180	−440	10.2
Elimination of unlimited open enrollment	−9	−10	−11	−30	0.7
B. Changes in covered services	0	0	0	0	0
C. Changes in patient cost-sharing				−735	17.0
Increase in part B deductible and elimination of carryover from previous year	−175	−265	−295	−735	17.0
D. Changes in provider payments				−455	10.5
Limitation on reasonable charge for outpatient services	−15	−23	−27	−65	1.5
Incentive reimbursement rate for renal dialysis services [5]	−105	−130	−155	−390	9.0
E. Changes in program administration				−21	0.5
Civil money penalties	−7	−7	−7	−21	0.5

TABLE A-1.—CBO REVISED PROJECTIONS OF SPENDING REDUCTIONS FOR LEGISLATIVE CHANGES MADE IN CALENDAR YEAR 1981 (OMNIBUS BUDGET RECONCILIATION ACT OF 1981), JANUARY 1982 ESTIMATES [1]—Continued

[Dollar amounts in millions]

Category of change	Fiscal year			3-year total	Percent [2]
	1982	1983	1984		
Total HI and SMI	−1,574	−1,274	−1,476	−4,324	100.0

[1] This table reflects estimates from the Congressional Budget Office which show the impact of the legislative changes enacted during 1981. The numbers are not extremely sensitive to economic conditions. Thus any changes to the numbers from earlier estimates represent different assumptions.

[2] Totals may not add due to rounding.

[3] Negligible.

[4] As of January 1, 1984, the provision had not been implemented.

[5] CBO and Administration estimate that was used during the 1981 reconciliation process.

Note.—Minus (−) indicates an expenditure reduction or revenue increase, plus (+) indicates an expenditure increase or revenue decrease.

Source: Congressional Budget Office.

TABLE A-2.—CBO REVISED PROJECTIONS OF SPENDING REDUCTIONS FOR LEGISLATIVE CHANGES MADE IN CALENDAR YEAR 1982 (TAX EQUITY AND FISCAL RESPONSIBILITY ACT OF 1982), JANUARY 1983 ESTIMATES [1]

[Dollar amounts in millions]

Category of change [2]	Fiscal year					5-year total	Percent [3]
	1983	1984	1985	1986	1987		
1. Provisions affecting HI revenues						−$852	3.7
C. Changes in covered employment						−852	3.7
HI tax for Federal employees (outlay savings)	−$116	−$160	−$174	−$195	−$207	−852	3.7
2. Provisions affecting HI outlays						−17,699	76.5
A. Changes in eligibility						−1,546	6.7
Medicare secondary for older workers [4]	−60	−181	−308	−464	−533	−1,546	6.7
B. Changes in covered services						−54	0.2
Hospice care	1	1	−16	−40	0	−54	0.2
C. Changes in patient cost-sharing	0	0	0	0	0	0	0
D. Changes in provider payments						−15,344	66.5
Elimination of nursing differential	−95	−110	−125	−145	−165	−640	2.8
Hospital-based physicians	−6	−40	−75	−110	−125	−356	1.5
Hospital reimbursement changes [5] (medicaid savings of $460 million)	−895	−2,380	−4,610	−3,060	−1,740	−12,685	55.0
Elimination of private room subsidy	−35	−75	−80	−85	−90	−365	1.6
Single reimbursement limit for skilled nursing facilities and home health agencies	−20	−53	−62	−69	−77	−281	1.2
Elimination of duplicate payments for outpatient services	−75	−135	−175	−210	−255	−850	3.7
Temporary delay in periodic interim payments	−750	−100	870	0	0	+20	−0.0
Percentage arrangements (not for hospital-based physicians)	0	−17	−20	−23	−26	−86	0.4
Prohibit payment for Hill-Burton care	−15	−17	−20	−23	−26	−101	0.4
E. Changes in program administration						−725	3.1
Audit and medical claims review	−85	−215	−215	−130	0	−645	2.8
Subtitle C—Utilization and quality control peer review	0	−15	−20	−20	−25	−80	0.3
3. Provisions affecting SMI revenues						−2,075	9.0
A. Changes in enrollee premiums						−2,075	9.0
Part B premium as a constant percentage of costs (medicaid cost of $155 million)	−35	−240	−550	−600	−650	−2,075	9.0
4. Provisions affecting SMI outlays						−2,483	10.7
A. Changes in eligibility						−718	3.1
Medicare secondary for older workers [4]	−28	−84	−143	−216	−247	−718	3.1
B. Changes in covered services	0	0	0	0	0	0	0
C. Changes in patient cost-sharing						−1,200	5.2

TABLE A-2.—CBO REVISED PROJECTIONS OF SPENDING REDUCTIONS FOR LEGISLATIVE CHANGES MADE IN CALENDAR YEAR 1982 (TAX EQUITY AND FISCAL RESPONSIBILITY ACT OF 1982), JANUARY 1983 ESTIMATES [1]—Continued

[Dollar amounts in millions]

Category of change [2]	Fiscal year					5-year total	Percent [3]
	1983	1984	1985	1986	1987		
80 percent radiologist/pathologist (medicaid cost of $90 million)	−150	−210	−245	−280	−315	−1,200	5.2
D. Changes in provider payments						−565	2.4
Reimbursement of assistants at surgery	−24	−63	−113	−170	−195	−565	2.4
E. Changes in program administration	0	0	0	0	0	0	0
Total medicare provisions	−2,388	−4,094	−6,081	−5,840	−4,676	−23,079	100.0

[1] This table reflects estimates from the Congressional Budget Office
[2] Provisions with no, or negligible, budgetary impact are excluded from table
[3] Totals may not add due to rounding
[4] Savings split between HI (68.3%) and SMI (31.7%) according to relative size of part A and part B programs in 1985.
[5] Assumes the "target" reimbursement system is not extended after 3 years

Source: Congressional Budget Office

TABLE A-3.—CBO PROJECTIONS OF SPENDING REDUCTIONS FOR LEGISLATIVE CHANGES MADE IN CALENDAR YEAR 1983 (THE SOCIAL SECURITY AMENDMENTS OF 1983) [1]

[Dollar amounts in millions]

Category of change	Fiscal years						6-year total	Percent [2]
	1983	1984	1985	1986	1987	1988		
1. Provisions affecting HI revenues							$11,522	98.0
A. Changes in HI tax provisions							−6,528	55.5
SECA tax increase	−0	−$377	−$1,262	−$1,434	−$1,605	−$1,670	−6,348	54.0
State speedup	0	−140	−10	−10	−10	−10	−180	1.5
B. Other tax changes (other sources)							−2,970	25.3
Military transfer credits	−$3,290	+70	+70	+60	+60	+60	−2,970	25.3
C. Changes in covered employment							−2,024	17.2
Cover nonprofit organizations	0	−216	−326	−397	−480	−605	−2,024	17.2
2. Provisions affecting HI outlays							+299	−2.5
D. Changes in provider payments							+286	−2.4
Pass through mandatory FICA	0	150	224	150	38	7	+569	−4.8
Prospective payment system	0	0	0	([3])	([3])	([3])	0	0
Delay SNF reimbursement limit	20	22	5	3	3	4	+57	−0.5
Lower return on equity capital	−10	−90	−100	−100	−40	0	−340	2.9
E. Changes in program administration							+13	−0.1
DRG Commission	0	[4] 1	[4] 3	[4] 3	[4] 3	[4] 3	+13	−0.1
3. Provisions Affecting SMI revenues							−533	4.5
A. Medicare premium delay: SMI	113	63	−90	−202	−206	−211	−533	4.5
4. Provisions affecting SMI outlays	0	0	0	0	0	0	0	0
Total							11,756	100.0

[1] CBO estimates based on January 1983 economic assumptions

[2] Totals may not add due to rounding.

[3] The budgetary impact cannot be estimated because the law allows the Secretary of HHS, as advised by a panel of experts, nearly unlimited discretion in setting payment rates for inpatient hospital services. Those rates could be set such that aggregate medicare outlays would increase or decrease.

[4] This provision is subject to appropriation. For fiscal year 1984, the appropriation was $1.5 million.

Source: Congressional Budget Office

APPENDIX B

MEDICARE
Benefits and Financing

REPORT OF THE 1982 ADVISORY COUNCIL ON SOCIAL SECURITY

ADVISORY COUNCIL ON SOCIAL SECURITY

200 INDEPENDENCE AVE., S.W.
WASHINGTON, D.C. 20201

Otis R. Bowen, M.D.
Chairperson

Thomas R. Burke
Executive Director

FEB 21 1991

The Honorable Margaret M. Heckler
Secretary of Health and Human Services
Washington, D.C. 20201

Dear Madam Secretary:

As required by section 706 of the Social Security Act, I herewith enclose for transmittal to the Congress and to the Boards of Trustees of the Federal Old Age and Survivors Insurance, Disability Insurance, Hospital Insurance and Supplementary Medical Insurance Trust Funds the reports of the Advisory Council on Social Security which was appointed in September 1982. As directed by its Charter, the Council's major findings and recommendations concern the Hospital Insurance and Supplementary Medical Insurance programs. Also included are findings and recommendations with respect to the Old Age and Survivors Insurance and Disability Insurance programs.

Sincerely,

Otis R. Bowen, M.D.
Chairperson

Enclosure

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

MAR 8

The Honorable Thomas P. O'Neill, Jr.
The Speaker of the House of Representatives
Washington, D.C. 20515

Dear Mr. Speaker:

The provisions of Section 706 of the Social Security Act require the appointment of an Advisory Council on Social Security every four years. When my immediate predecessor, Secretary Schweiker, made his appointments to this Advisory Council in September of 1982, the Council was charged with reviewing the complex financial structure of the Medicare program.

Chaired by the distinguished former Governor of Indiana, Otis Bowen, the 13 members of the Advisory Council from the private sector have submitted their report and findings to me as Secretary of Health and Human Services. This report represents a sincere effort and significant personal commitment by Members of the Advisory Council to contribute to the national dialogue and debate on this difficult issue.

Pursuant to the mandate of the statute, I hereby transmit their Report and findings to you. I have made an identical transmission to President of the Senate and the Secretary of the Treasury in his capacity as Managing Trustee of the Boards of Trustees of the Old Age and Survivors Insurance, Disability Insurance, Hospital Insurance and Supplementary Medical Insurance Trust Funds.

These recommendations should be added to the many proposals already under discussion and those yet to be advanced by other interested groups as we seek a just and equitable solution to the future financing of the Medicare system.

No one feels more deeply than I the responsibility to maintain faith with and the trust of the elderly Americans who rely so much on our leadership to preserve a secure Medicare system. I look forward to working closely with you to this end.

Sincerely,

Margaret M. Heckler

Margaret M. Heckler
Secretary

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

MAR 8

The Honorable George Bush
President of the Senate
Washington, D.C. 20510

Dear Mr. President:

The provisions of Section 706 of the Social Security Act require the appointment of an Advisory Council on Social Security every four years. When my immediate predecessor, Secretary Schweiker, made his appointments to this Advisory Council in September of 1982, the Council was charged with reviewing the complex financial structure of the Medicare program.

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Pursuant to the mandate of the statute, I hereby transmit their Report and findings to you. I have made an identical transmission to the Speaker of the House of Representatives and the Secretary of the Treasury in his capacity as Managing Trustee of the Boards of Trustees of the Old Age and Survivors Insurance, Disability Insurance, Hospital Insurance and Supplementary Medical Insurance Trust Funds.

These recommendations should be added to the many proposals already under discussion and those yet to be advanced by other interested groups as we seek a just and equitable solution to the future financing of the Medicare system.

No one feels more deeply than I the responsibility to maintain faith with and the trust of the elderly Americans who rely so much on our leadership to preserve a secure Medicare system. I look forward to working closely with you to this end.

Sincerely,

Margaret M. Heckler

Margaret M. Heckler
Secretary

December 31, 1983

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PREFACE

Medicare is the nation's largest federally financed health insurance program serving approximately 30 million elderly and disabled Americans. It is one of the most successful social programs. It has provided basic protection against the costs of health care for a significant portion of the population. However, the continued escalation of health care costs and an increasing elderly population has placed extraordinary demands on the program and its resources that were not anticipated when the program began in 1966. If we are to insure that Medicare will continue to meet the needs of our elderly and disabled citizens prompt action is required to restore its financial position.

When the Advisory Council on Social Security was appointed by the Secretary of Health and Human Services, it was directed by its charter to place particular emphasis on a review of the Medicare program. The Council took its charter very seriously and after more than a year of intensive deliberations, including meetings and public hearings held throughout the United States, has developed a series of recommendations designed both to alleviate the financial problems currently confronting the program and improve its responsiveness to the needs of program beneficiaries.

This is the first Advisory Council on Social Security to address itself primarily to Medicare. Prior Councils gave minimal attention to Medicare. Instead they devoted most of their considerations to the Old Age, Survivors and Disability Insurance programs. In a sense then, this Council has had a unique mission to fulfill.

When the Council was appointed, estimates of an imminent financing crisis in the Hospital Insurance trust fund were just beginning to receive wide public attention. Thus, in addition to having to tackle complex program issues and politically sensitive and occasionally unpopular policy issues, the Council was faced with having to develop a plan to rescue a program with a projected multi-billion dollar deficit. The final Council recommendations attempt to balance the needs and interests of all interested parties - beneficiaries, providers of care, taxpayers, legislators and administrators - while assuring the continued viability of the program.

Throughout our deliberations the Council has received excellent staff support. I would especially commend Thomas R. Burke, Executive Director of the Council, for his dynamic leadership and responsiveness to the needs of the Council.

I hope this report will be given serious attention by all interested parties, particularly the legislators and administrators who have the most direct responsibility for designing and implementing solutions to Medicare's financial problems and other improvements in the programs. Obviously, there are sections of the report that are controversial and which many people may have difficulty endorsing. While it is not expected that the full range of recommendations provided in this report will be adopted, I sincerely believe that the Council has set the agenda for the debate which must begin quickly if the elderly and disabled of America are to continue to have access to the highest quality health care in the world.

Otis R. Bowen
Chairman

1982 ADVISORY COUNCIL ON SOCIAL SECURITY

MEMBERSHIP

1.	Otis R. Bowen, M.D. Chairman	Former Governor of Indiana; Professor of Family Medicine, Indiana University School of Medicine. (Public representation)
2.	Richard W. Rahn, Ph.D.	Vice President and Chief Economist, Chamber of Commerce of the United States. (Employer organization representation)
3.	James D. (Mike) McKevitt	Director of Federal Legislation, National Federation of Independent Business. (Employer organization representation and representation of self-employed)
4.	Stanford D. Arnold	Secretary-Treasurer, Michigan Building and Construction Trades Council (AFL-CIO). (Employee organization representation)
5.	Carlos J. Arboleya (Resigned, May 1983)	President, Chief Operating Officer and Director, Consolidated Barnett Banks of Miami. (Public representation)
6.	Karl D. Bays	Chairman, Chief Executive Officer and Director, American Hospital Supply Corporation. (Public representation)
7.	Kenneth M. McCaffree, Ph.D.	Arbitrator; Professor Emeritus, Economics and Health Services, University of Washington. (Public representation)
8.	Samuel H. Howard	Vice President and Treasurer of the Hospital Corporation of America; Former Vice President for Planning for Hospital Affiliate International; Former Vice President of Finance and Business, Meharry Medical School. (Public representation)

9. Linda H. Aiken, R.N., Ph.D.	Vice President, The Robert Wood Johnson Foundation. Directs the Teaching Nursing Home and the Hospice Evaluation Projects of the Foundation. (Public representation)
10. David W. Christopher	Partner in charge of Pittsburgh Office, Price Waterhouse. (Public representation)
11. C. Joseph Stetler, LL.B.	Member, Dickstein, Shapiro, and Morin, attorneys-at-law, Washington, D.C.; former President, Pharmaceutical Manufacturers Association. (Public representation)
12. James Balog	Senior Executive Vice President, Drexel Burnham Lambert. (Public representation)
13. Alvin E. Heaps	President, Retail, Wholesale and Department Store Unions. (Employee representation)
14. Mrs. Rose (Leone) Zamaria*	Retired. Twenty-six years of Congressional service, for at least nine different members of Congress from five states. (Public representation)

*Appointed 9-28-83 to fill the vacancy created by Carlos Arboleya's resignation in May 1983.

STAFF MEMBERS OF THE ADVISORY COUNCIL ON SOCIAL SECURITY

Executive Director	Thomas R. Burke*
Professional Staff	Steven L. Finlayson* Elizabeth D. Flynn Audrey A. Giarratano Virginia K. Gray* Philip M. Jos* Judith R. Peres Eugene Scanzera Steven H. Siegel Will Wolstein* Jeanette A. Younes
Support Staff	Ruthie Amoyal Martha L. Dixon Julia E. Lee* Virginia Linsky Marjorie B. McGlone Morris L. Talton Rolanda N. Wade
Student Aides	Laura Siff Wendy Suslak

* Served for the duration of the Council

EXECUTIVE SUMMARY OF RECOMMENDATIONS

The Advisory Council on Social Security, appointed in September of 1982, was requested to focus its attention on Title XVIII of the Social Security Act, the Federal Hospital Insurance (HI) and the Federal Supplementary Medical Insurance (SMI) programs. The appointment of the National Commission on Social Security Reform to address the fiscal problems of the Old Age and Survivors Insurance (OASI) and Disability Insurance (DI)programs precluded the need for this Council to undertake an indepth review of those programs.

Over the past 15 months, the Council reviewed both the HI (Part A) and SMI (Part B) programs of Medicare and the status of their respective trust funds. Because of the serious financial problems projected for the Hospital Insurance Trust Fund, principal attention was devoted to the Part A. The majority of the Council's recommendations address this part of Medicare.

The Council's recommendations were designed to accomplish two objectives: first, to provide a means for maintaining the fiscal integrity of the Hospital Insurance Trust Fund through 1995; and second, to provide improvements in the manner in which health care is financed and delivered which will alleviate some of the financial pressures on the trust fund in the future.

The Council adopted the following summary resolution:

> The Council acknowledges a probable deficit in the Hospital Insurance trust fund in 1995 by an amount between $200 and $300 billion, depending upon the optimistic or pessimistic view of the price changes in the medical industry and the economy generally in the next few years. The Council believes that the savings identified in its recommendations concerning Medicare eligibility, reimbursement, and benefit structure will account for a substantial portion of this anticipated deficit. The Council further believes the recommendations on anticipated sources of revenues from taxation of a portion of employer-provided health benefits, the alcohol and tobacco taxes, and if required, the reallocation of payroll taxes to the HI trust fund, will be sufficient to cover additional funding needs through 1995.1/

1/ The most recent estimates of the HCFA Actuary, information received subsequent to the Council's concluding meeting, reflect that if moderate economic assumptions, i.e., Alternative IIB, prevail the 1995 deficit, considering only the amount that expenditures will exceed revenues, will be $156.3 billion. When a reserve equal to 50 percent of expected expenditures is included, the total shortfall in the trust fund will be $225 to $235 billion. (The Board of Trustees of the HI trust fund has adopted the general financing principle that there should be a reserve in the trust fund equal to one-half of a year's disbursements.) Obviously, if the more pessimistic assumptions materialize this deficit figure will be greater. All Council votes and recommendations were predicated on cumulative deficit and reserve requirements of up to $300 billion in 1995.

The Council's recommendations addressed issues of program financing, eligibility, benefit structure, reimbursement and several issues considered general in nature.

PROGRAM FINANCING RECOMMENDATIONS:

- The Advisory Council on Social Security believes that the most critical problem facing the Medicare program--in both the short- and long-range--is the projected insolvency of the Hospital Insurance trust fund. Anticipated outlays in excess of income are expected to deplete this fund before the end of the 1980s.* The Council recommends that planning for the financial stability of the Hospital Insurance trust fund should recognize the likelihood of a $200 to $300 billion deficit in this fund by the year 1995. (Chapter II, A.)

- The Advisory Council on Social Security opposes any increase in the use of general revenues to finance the Medicare Hospital Insurance trust fund.

  The Council questions the soundness of any policy which relies upon general revenues to finance the HI program. In an era when the government is experiencing substantial annual deficits, reliance on general revenues would only serve to exacerbate the problem of increasing deficits. (Chapter II, B.)

- The Advisory Council opposes any further increase in scheduled HI payroll taxes.

  A substantial majority of Council members oppose raising revenues through an increase in payroll taxes because of the potentially adverse effects such taxes would have on employment and business activity. The Council believed that a tax which is not progressive unduly burdens middle and low income workers. The current payroll tax already imposes a substantial burden on such workers and should not be increased. (Chapter II, C.)

- The Council believes that the individuality of the Old Age and Survivors Insurance, Disability Insurance and Hospital Insurance programs should be maintained, and that each program should be funded at a level sufficient to meet its continuing needs. Where short-term interfund borrowing among the trust funds is deemed necessary, such borrowing should be subject to appropriate safeguards which include authority for each fund to

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*Predicated on present law, funding and expenditure control policies, beneficiary entitlement changes and other policies.

borrow from the others, specific repayment schedules and prohibition against reducing the lending fund's assets below an actuarially acceptable level.

The Council recognizes that interfund borrowing has been used in the past and now has been reauthorized through 1987. However, the Council was pleased that legislation enacted in 1983 that reauthorized such interfund borrowing included provisions that address the Council's concerns. (Chapter II, D.)

- o The Council recommends that, if needed, consideration be given to a reallocation of payroll tax rates between OASDI and HI in order to transfer sufficient OASDI surplus revenues to HI during the period 1985 through 1995 to maintain the financial viability of the HI trust fund.

The Council believes that the diversion of projected surplus OASDI revenues by a reallocation of contribution rates among the OASI, DI and HI trust funds is a viable method for alleviating a substantial portion of the short-term projected HI deficit. However, the Council recognizes that both long- and short-range considerations must govern any specific reallocation proposal. Reallocation should only be considered if the integrity of all three trust funds will be preserved. (Chapter II, E.)

- o The Council endorses the Administration's proposal to consider any employer's contribution to an employee's health benefit plan that exceeds $70 a month for an individual and $175 a month for a family as income to the employee and subject to Federal, State and local taxes in the same manner as wages.

The Council also recommends that consideration should be given to earmarking an appropriate portion of the incremental revenues that would be realized from the proposed tax to Medicare's Hospital Insurance trust fund.

A substantial majority of Council members believes that the principal benefit to be derived from this tax exempt limitation is that it will bring about a change in consumer health care purchasing patterns by increasing consumer cost consciousness and provider competitiveness that will slow the increase in health care costs. Removing the current complete tax exemption of these benefits will make employees more conscious of and concerned about the cost of health care and the cost effectiveness of the services they receive.

Revenue raising possibilities under this recommendation were a secondary consideration. (Chapter II, F.)

o The Council recommends that Federal excise taxes on alcohol and tobacco be increased, with the increased revenue to be earmarked to the HI trust fund. The Council does not specify the amount to be raised and earmarked, but suggests that the amount be determined by the Congress.

Although the Advisory Council generally views increased taxes as an undesirable alternative for resolving the financial problem facing the hospital insurance trust fund, the projected substantial deficit precludes a resolution based solely on a reduction of expenditures. A majority of Council members recommend an increase in the Federal excise tax on alcohol and tobacco products based on the demonstrated correlation between the use of these products and increased health care costs. (Chapter II, G).

PROGRAM ELIGIBILITY RECOMMENDATIONS:

o The Council recommends an increase in the age of eligibility for Medicare benefits from age 65 to 67. This recommendation provides for the age of eligibility to be increased by three-month increments per year beginning on January 1, 1985. Beginning on January 1, 1989, the rate of increase will escalate to six-month increments, achieving full implementation of the age 67 eligibility on January 1, 1990. The Council further recommends that, subsequently, the age of eligibility for Medicare benefits should be indexed to increases in life expectancy.

A majority of the Council members concluded that the age of 65 as the initial age of eligibility was rooted more in custom than on assessment of health care needs. The age of eligibility for unreduced monthly social security retirement benefits has been increased to age 67 although full implementation of the new age will not occur until the third decade of the 21st century. However, there is no inherent linkage between eligibility for monthly retirement benefits and Medicare as today more than 50 percent of those eligible for social security elect reduced old age benefits up to 3 years prior to the age at which they may first become eligible for Medicare.

Recognizing the increase in life expectancy since 1966, the year of Medicare's enactment, and the increased cost of health care services to those of advancing years, the Council believes it is necessary to assure that Medicare's resources are focused on the population most in need of Medicare protection. A substantial majority of the Council conclude that there is a need to adjust the age of eligibility to reflect the changes in life expectancy that have already occurred and to accomplish

this adjustment by the end of the decade. With respect to the future, the Council recommends periodic adjustments to reflect changes in life expectancy. (Chapter III, A.)

o The Council concurs with the recommendations of the National Commission on Social Security Reform and with subsequently enacted provisions of Public Law 98-21, that provide (1) that Old Age, Survivors, Disability and Hospital Insurance (OASDHI) coverage be extended on a mandatory basis to employees of nonprofit organizations, and (2) that State and local government units which have elected OASDHI coverage for their employees be precluded from terminating such coverage in the future, including termination actions underway but not completed by the April 20, 1983 date of enactment of Public Law 98-21.

  The Council concludes that coverage under Medicare of all persons in paid employment is a desirable objective that would contribute to the fiscal stability of the OASI, DI and HI programs. Therefore, the Council believes that the recent enactment of provisions mandating coverage for all employees of nonprofit organizations and precluding terminations of coverage by State and local employees along with prior legislative action covering all current and future Federal workers under the HI program has contributed to this objective. (Chapter II, B.)

o The Council opposes any further extension of Medicare coverage to individuals (not otherwise eligible based on age or disability status) on the basis of medical diagnosis or the medical necessity for a particular form of treatment. Should specific categories of disease be considered in the future for Federal financial assistance, such assistance should be provided through a special program with separate allocation of funds to pay for the required treatment.

  The Council acknowledges the success of the End Stage Renal Disease (ESRD) provisions of Medicare, enacted in 1972, in providing financial assistance to those in need of this expensive treatment. However, the Council believes that in the future, the Medicare program's eligibility requirement should be restricted to existing beneficiary categories i.e., aged and disabled, and any special disease categories requiring financial assistance should be separately funded. (Chapter III, C.)

BENEFIT STRUCTURE RECOMMENDATIONS:

o The Council recommends a restructuring of the Medicare Part A Hospital Insurance program to provide:

1. Unlimited hospital inpatient days per calendar year.

2. A per admission deductible, as currently computed, but limited to two hospital admissions per calendar year.

3. A daily coinsurance, equal to 3 percent of the hospital inpatient deductible, for all inpatient days except the initial day of any stay where an inpatient deductible applies.

4. A skilled nursing facility benefit of 100 days per calendar year with no coinsurance on days 1 through 20 and a 12.5 percent coinsurance on days 21-100.

5. The current home health benefit.

6. The current hospice benefit.

The Council recommends an enhanced Part A Hospital Insurance benefit be offered to beneficiaries as an integral part of their Part B (SMI) election that provides for:

1. Elimination of the 3 percent daily coinsurance on hospital inpatient days.

2. Elimination of the 12.5 percent daily coinsurance on days 21-100 of skilled nursing facility stay benefits.

If a beneficiary elects to take Medicare's Part B coverage he/she automatically elects the Part A enhanced benefit. The enhanced Part A benefit would be financed with an actuarially sound premium. This premium would include an additional amount for the purpose of providing additional revenues necessary to help to resolve the current disparity between beneficiary contributions to the HI trust fund and the value of benefits received.

The Council also recommends an enhanced Part B benefit to be offered on an optional basis, i.e., not as an integral part of the beneficiary's Part B election. The enhanced benefit would provide a yearly limit on Part B out-of-pocket expenses, which would be indexed annually to recognize increases in per capita Part B program expenditures. The Part B option would also be financed by a premium which would be added to the current Part B premium for those electing this option. (See recommendation #16.)

The Council concludes that while the hospital insurance program of Medicare, Part A, provides adequate coverage for most beneficiaries, it does not provide adequate protection in the

event of catastrophic illness. The Council believes that financing an improved benefit package for all Medicare beneficiaries through increased coinsurances on shorter hospital stays would place the financial burden only on those who were ill and required inpatient care. The establishment of a premium to finance improved benefits and to generate additional revenues to help insure the fiscal soundness of the program is a more equitable means of sharing additional beneficiary costs.

The Council believes that the changes it is recommending will also facilitate beneficiary understanding of their benefits under Medicare and simplify administration of the program.

Recognizing beneficiary concerns regarding increasing cost-sharing liability under the Part B supplementary medical insurance program, the Council concludes that offering, on an optional basis, the opportunity to limit cost-sharing liability for Part B services to an annual dollar amount would improve the protection available and preclude or reduce the need to purchase private supplemental insurance.

Although the Council recognizes that the recommended restructured benefit package will increase beneficiary contributions under the Medicare program the benefits offered will be improved and at less cost than comparable Medicare/Medigap protection. (Chapter IV, A.)

o The Council recommends that the Secretary of Health and Human Services, in developing a comprehensive long term care program, seek guidance from those studies which have suggested the targeting of groups who will benefit from these services.

The Council recognizes the problems faced by the Medicare population due to the fragmentation among several programs of services offered to beneficiaries who need ongoing chronic care. As the Medicare population ages, the Council believes that the need for long term care services will increase.

The Council believes that more conclusive information regarding the long term care needs of the elderly is needed. Recognizing the potentially high cost of such care, any expansion of long term care benefits under the Medicare program, especially at a time when the program is experiencing serious fiscal problems, would not be appropriate. A piecemeal attack on the critical problem of financing long term care will not work. Development of a comprehensive program is necessary. Any long term care program should target those who are eligible for conventional long term care and provide alternative care as a substitute for more expensive conventional care. (Chapter IV, B.)

o The Council believes, in general, that the elderly can benefit from prevention-oriented programs and screening procedures. The Council suggests that a comprehensive review of the Health Care Financing Administration's demonstration projects to assess the economy and efficacy of expanding Medicare coverage to include preventive services be undertaken prior to any change in the law.

The Council views as inconclusive the evidence concerning the cost-effectiveness of preventive services. The offering of such services may improve health and mobility of the elderly and produce long-term program savings. However, while there was agreement that there must be preventive services that could be shown to be cost-effective, a comprehensive study should be undertaken to identify those particular services before expansion of Medicare's coverage of preventive care. (Chapter IV, C.)

o The Council recommends the use of a voluntary voucher in the Medicare program. The voucher would provide beneficiaries with an alternative to the current method of reimbursing medical services. The voucher would also promote the development of more efficient ways of delivering services by health care providers.

The Council is in general agreement that a voucher system represents one means for the promotion of competition in the health industry and that such a system would increase incentives for beneficiaries to be more sensitive to the cost of health care services. Although the Council opposes any mandatory voucher system, a substantial majority support a voluntary system provided beneficiaries are given adequate assistance in the process of choosing an alternative health care plan. (Chapter IV, D.)

o The Council recommends that the current Supplementary Medical Insurance (Part B) deductible be indexed to the Consumer Price Index (CPI) to keep pace with inflation and with increases in beneficiary income. The indexing should begin as soon as feasible.

Unlike the inpatient deductible under the Part A Hospital Insurance program which is indexed to the cost of hospital care, increases in the Part B supplementary medical insurance deductible are adjusted periodically by Congress. The Council believes that increases that have been legislated have failed to keep pace with either the increasing cost of Part B services or the increasing income available to the elderly.

Given the historic greater increase in the cost of medical services, the Council acknowledges that indexing the deductible to medical costs could produce a disparity between income

increases and deductible increases over time. The Council, therefore, recommends that the Part B deductible be indexed to the Consumer Price index as soon as feasible to insure a more reasonable ratio between beneficiary income and Part B cost sharing. (Chapter IV, E.)

PROGRAM REIMBURSEMENT RECOMMENDATIONS:

- The Council endorses the principle of prospective payment for Medicare inpatient hospital services. The Council supports a prospective payment system based on diagnosis provided it is equitable for all hospitals, encourages efficiency of operations and maintains accessibility and quality of care for Medicare beneficiaries.

  The Council recognizes that the allowed rate of increase in the DRG rates will have a significant impact upon the costs of the Medicare hospital insurance program. Therefore, the Council urges the Secretary of HHS to exert care to limit any annual rate of growth in the DRG rates that is above the annual rate of change in the hospital input price index. (Chapter V, A.)

- The Council believes that it is inappropriate for the Medicare program, which is designed to pay for medical services provided to the elderly, to underwrite the cost of training medical personnel and recommends that such support be withdrawn as alternative funding sources are identified. The Council believes that medical education is an appropriate area for governmental support and recommends that the Department of Health and Human Services undertake a study to identify and develop other Federal, State and local funding sources. (Chapter V, B.)

- The Council believes that Medicare's statutorily mandated reasonable charge method of reimbursement has not been effective in controlling expenditures or encouraging utilization of cost effective services. As a step toward reform of the system, the Council recommends a statutory revision to authorize reimbursement based on fee schedules adjusted initially and periodically for differences in cost of living and/or maintaining a practice. The Council urges that development of the schedules be undertaken with due concern for all interested parties, direct input from the medical profession, and with maintenance of support for the capitation system.

  The Council believes that the current reasonable charge system has failed to curb inflation in medical care costs and, in fact, has probably contributed to that inflation. The current system has also helped to perpetuate significant payment

differentials among geographic areas and medical specialties. The Council views fee schedules as the initial step in reform of the system and encourages the medical profession and other third party payors to cooperate in experimenting with and developing alternative methods of reimbursement. (Chapter V, C.)

o The Council recommends a statutory revision to the current Medicare assignment system. The revision would establish a physician participation agreement system under which physicians would annually elect whether they would "participate", i.e., accept assignment on all services to Medicare patients. Notice of intent to participate, or to withdraw from participation, would be made six months in advance. Claims for reimbursement for services furnished by physicians who decided not to participate would always be unassigned, and program payment would always be made to the patient who would be responsible for the physician's entire bill including any amount that exceeds Medicare's reasonable charge.

The Council recommends the following incentives for physicians to participate:

- Competition: The Medicare program would publish annually a directory of participating physicians. The directory would be published on a local basis, e.g., city, county or Standard Metropolitan Statistical Area (SMSA), as appropriate.

- Billing: Participating physicians could take advantage of streamlined billing and payment procedures. Such incentives could include provisions for multiple-list claims, automated or electronic billing with the program providing some of the necessary equipment and an electronic funds transfer (EFT) process. (Chapter V, D.)

GENERAL RECOMMENDATIONS:

o The Council recommends that it should be a fundamental policy of the Department of Health and Human Services to promote the development of medical technology. Criteria used to evaluate new technology should stress the efficacy of new procedures as well as their cost.

The Council believes that the development of new medical technology and procedures should be encouraged. At the same time the Council believes that greater attention must be given to the criteria used to evaluate new technology. The initial cost of new technology is one criterion for assessment. Lower cost, brought about by economies of scale, is another

criterion. Value, however, is a criterion of no less importance. It must be measured by the benefit that new technology brings to medicine itself, to international competitiveness for the United States and, most of all, to the healthful lives of the American people. (Chapter VI, A.)

o The Council supports the concept of voluntary advance directives as a means of appropriate decision-making about life-sustaining treatment for incapacitated patients. Also, recognizing that this is an individual State determination, the Council encourages a voluntary program in the 14 States where advanced directives are legal and encourages the other 36 State legislatures to enact such legislation. In the States where this is legal, the Council suggests that a person be offered a living will when he/she applies for Medicare.

The Council further suggests that the guidelines employed for this voluntary program be those found in the report on "Deciding to Forego Life-Sustaining Treatment" by the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research.

The Council recommends HCFA undertake a comparative study to assess what the impacts (financial and otherwise) have been in those 14 States that have living wills compared to those States without them. (Chapter VI, B.)

o The Council recommends that the Health Care Financing Administration continue its efforts to improve the management of the Medicare program. As part of this effort, HCFA should review the recommendations of the President's Private Sector Survey on Cost Control and the Office of the Inspector General of the Department of Health and Human Services.

The Council believes that if the American people are to be asked to make sacrifices to preserve the financial viability of the Medicare program, they must be assured that program managers are striving to contain the cost of the Medicare program and assure that it will carry out its mission to make first class health care available to the elderly and disabled of this country. (Chapter VI, C.)

o The Council opposes any effort to tie entitlement to Medicare benefits to a beneficiary's financial status.

The Council rejects the concept of "means testing", believing that Medicare should remain an entitlement program where individual income or wealth is not a factor considered in determining one's eligibility for benefits. (Chapter VI, D.)

The Council recommends further study of three additional program issues:

1. Proposals for long term restructure of the Medicare program which encourage individuals to save during working years for the purpose of purchasing health care coverage in retirement years. Such proposals could establish universal individual "health credit accounts" and further encourage savings through tax deductible accounts similar to individual retirement accounts (IRAs). Medicare would be modified to complement individual spending during retirement years. (Chapter VII A and B.)

2. Improvement of Medicare's current program of information and assistance to beneficiaries. This effort should be a joint undertaking between the Health Care Financing Administration and the Social Security Administration. (Chapter VII, C.)

3. Identification of additional areas where Medicare could serve as a secondary payor to the group health insurance for the working aged or their spouses. The study would include evaluation of implementation of current provisions and consideration of appropriate areas in which to expand the concept. (Chapter VII, D.)

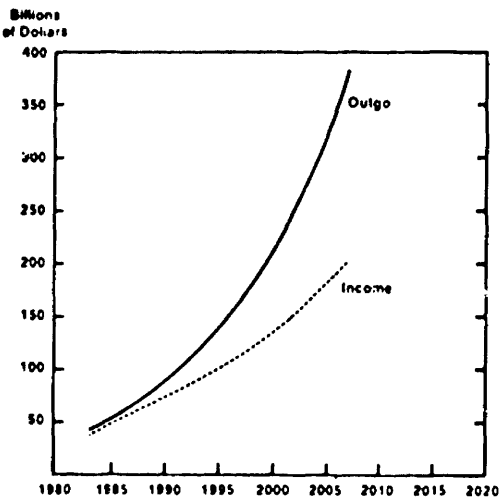
The Council views these issues, particularly the long range restructure concept, as deserving of further study and evaluation.

CHAPTER I - INTRODUCTION AND SUMMARY OF COUNCIL'S ACTIVITIES

Section 706 of Title VII of the Social Security Act mandates the establishment every four years (beginning in 1969) of an Advisory Council on Social Security to review the status of the Federal Old Age and Survivors Insurance Trust Fund, the Federal Disability Insurance Trust Fund, the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, and to review the scope of coverage and adequacy of benefits, as well as all other aspects of these programs. (See Appendix A.) The current Council was appointed in September 1982 by the Secretary of Health and Human Services (HHS) and consists of a Chairperson and 12 other persons. Inasmuch as previous Councils gave limited attention to Medicare and since the National Commission on Social Security Reform was addressing the fiscal crisis facing the Old Age, Survivors and Disability Insurance programs, the current Advisory Council was charged to concentrate on Medicare and to submit a report to the Secretary for transmittal to Congress. (See Appendix B.)

The Council was confronted with the serious financial problems facing Medicare. Estimates indicated depletion of the Hospital Insurance Trust Fund by the end of the decade, and rapidly growing cumulative deficits after that. (See chart below, "Income and Outgo of HI Trust Fund, 1983-2007.") While the Supplementary Medical

Income And Outgo Of HI Trust Fund 1983 - 2007



(Source: Actuarial Note #117, October 1983, Social Security Administration Publication No. 11-11500)

Insurance Trust Fund does not face the prospect of depletion because of automatic transfers from general revenues, these transfers are large and growing rapidly. Moreover, these transfers increase the size of the Federal deficit. The full range of issues explored by the Council during its year of deliberations can be classified into five general subject areas: increasing trust fund revenues; amending eligibility requirements; modifying the Medicare benefit structure; revising cost-sharing provisions; and revising Medicare reimbursement policy. These were further refined into the topical areas represented by each substantive chapter of this report. Some issues defied categorizing into the principal chapters of the report. These can be found in Chapter VI. Other issues were surfaced by members but there was insufficient time to address them in any detail. These are contained in Chapter VII.

The Council met for the first time on November 7-8, 1982, and met monthly thereafter in two day sessions for a total of 14 meetings. All meetings but one were held in Washington, D.C. and all were open to the public in accordance with the Federal Advisory Committee Act (P.L. 92-463, October 1972). Total public attendance at the Council meetings numbered 600. The Council was briefed on various aspects of the Medicare program by officials of the Health Care Financing Administration (HCFA), the Social Security Administration (SSA), the Public Health Service, and by other components of the Department of Health and Human Services, as well as by staff of the Department of the Treasury, Department of Defense, and the Executive Office of Management and Budget. It has heard from experts in health economics and in health care, as well as from researchers and academicians, both individually and in panel presentations, on the strengths and weaknesses of the Medicare program, and suggested directions for the future. Several members of Congress personally appeared before the Council to offer their views. (Appendix C is a list of individuals who made presentations to the members at Council meetings.)

The Council also solicited advice, comments, suggestions, and recommendations from interested individuals, organizations and the public-at-large by conducting eight public hearings. (See Appendix D.) Four were held in Washington, D.C. and the others in San Francisco, Calif.; St. Petersburg, Fla.; Evanston, Ill.; and New Brunswick, N.J. Six of these hearings invited testimony on any and all aspects of Medicare, while two were more focused, one on physician assignment, the other on raising revenue for the Hospital Insurance Trust Fund through taxation. In all, 132 witnesses testified, with public attendance approximating 265. In these public hearings the Council heard from hospitals, physicians, other providers, organizations representing the elderly, the health insurance, tobacco, and alcohol industries, business, labor, State government, as well as from private citizens. The public's views were also conveyed to the Council in thousands of letters.

Staff papers provided the vehicle by which Council members discussed the issues. The work of the Council's own staff was supplemented by assistance from SSA's Office of the Actuary and by the extensive support of HCFA's Office of Financial and Actuarial Analysis staff. Other HCFA and HHS units provided data when needed.

Frank Sloan, Director of the Health Policy Center at Vanderbilt University, served as a Consultant/Advisor to the Advisory Council on Social Security throughout its deliberations.

II. FINANCING

INTRODUCTION

The Medicare program includes two separate health insurance programs; Part A Hospital Insurance and Part B Supplemental Medical Insurance. The Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) programs have separate and distinct trust funds from which benefits are paid.

The HI trust fund is financed primarily by payroll contributions paid by employers, employees, and the self-employed. Over 90 percent of revenues come from this source. Other sources of revenue include small general revenue contributions to cover special situation costs, premiums paid by persons not otherwise eligible who elect to pay the full cost of their coverage, transfers from the Railroad Retirement Fund and interest on trust fund assets.

Projected increases in program expenditures far in excess of increases in revenues indicate that the HI trust fund will be depleted within a decade. Developing methods to deal with this impending fiscal crisis was a primary focus of this Council's activities.

The SMI program is financed primarily by premiums paid by enrollees and general revenue contributions to the trust fund. In fiscal year 1982, premium payments provided over 20 percent and general revenues accounted for 75 percent of SMI trust fund revenues.

Projections in the 1983 Annual Report of the Medicare Board of Trustees show the SMI trust fund actuarially sound at least through fiscal year 1985. Council deliberations with respect to the SMI program did not specifically address measures to increase revenues but, instead, focused on long range cost containment and improved administration of the program.

CHAPTER II - FINANCING

A. Funding Crisis of the Hospital Insurance Trust Fund

Background

The principal concern of this Council has been the fiscal crisis facing the Hospital Insurance trust fund. Assessing the magnitude of the problem is essential to provide an orderly framework for developing solutions.

For 1983, the combined payroll tax for the HI trust fund, paid by employees and employers, was 2.60 percent of payroll. For this same year expenditures under Part A were expected to equal 2.77 percent of total payroll. Based upon current economic projections the disparity between revenue and expenditures is expected to grow until, by the year 2055, expenditures will be 9.37 percent of payroll. The projected disparity will be the result of health care costs continuing to escalate faster than income and the increasing elderly population in the United States, not the result of expanding program benefits.

In the past, the Board of Trustees of the Hospital Insurance trust fund adopted the general financial principle that annual income to the trust fund should be approximately equal to annual outlays of the program plus an amount to maintain a balance equal to one-half year's disbursement. The ratio of assets to disbursements reached a high of .79 in 1975. The ratio has steadly declined until it was .52 in 1982. For 1983 the ratio is expected to decline to .20. This decline is the result of the disparity between payroll taxes and expenditures and a loan of $12.4 billion to the Old Age and Survivors Insurance trust fund.

Discussion

The Advisory Council on Social Security believes that there will be significant changes made in the manner in which health care services are financed and delivered throughout the remainder of this century. Some of these changes are discussed in this report. However, because of difficulty in estimating the impact of these changes and the uncertainty of any long-range economic projections the Council chose to limit its examination of the HI trust fund to

the eleven year period ending in 1995. By then actuarial estimates indicate that the Trust Fund will be $200 to $400 billion in debt, depending upon whether intermediate or pessimistic assumptions are used.

The Council consulted with actuaries from the Health Care Financing Administration and reviewed other estimates of the projected deficit, including those of the Congressional Budget Office. The Council concluded that, as a working assumption, it would assume a deficit of $200 to $300 billion in 1995.1/ Therefore, the Council's recommendations are designed to accomplish two goals: first, to provide a means for maintaining the fiscal integrity of the Hospital Insurance trust fund through 1995; and second, to promote changes in the manner in which health care is financed and delivered which will alleviate some of the financial pressure on the HI trust fund in the future.

Recommendation

The Council unanimously approved the following recommendation:

The Advisory Council on Social Security recognizes that one of the most critical problems facing the Medicare program--in both the short- and long-range--is the projected insolvency of the Hospital Insurance trust fund. Anticipated outlays in excess of income are expected to fully deplete that fund by the beginning of the next decade. Over the longer run, the Council recognizes that at least $200-$300 billion in additional income or decreased outlays will be required to keep the trust fund solvent through 1995. Any recommendations for eliminating this deficit should include long term revisions that assure that savings and increased revenues continue in the out-years.

1/Table number 3 appearing in Appendix H of this report reflects the most recent information from the HCFA Actuary, information provided subsequent to the Council's action on this policy statement. Under Alternative IIB economic assumptions the deficit in 1995 is estimated to be $156.3 billion. However, this includes no reserve. When a reserve equal to 50 percent of expenditures is included (approximately $70 to $80 billion in 1995), the total shortfall in 1995 is estimated to be $225 billion.

Estimated Balance of Hospital Insurance Trust Fund at End of Year
(In Billions of Dollars)

Year	HI Trustees Alternatives[1] I (Most Optimistic)	IIA	IIB (Moderate)	III (Pessimistic)	CBO Estimate[2]
1983	11.8	11.7	11.7	11.4	-
1984	12.6	11.6	11.2	9.1	-
1985	15.2	11.2	10.2	5.5	6.0
1986	27.6	17.1	11.8	1.8	5.4
1987	31.4	23.2	12.6	6.3	1.4
1988	33.5	20.3	16.1	- 7.5[4]	- 7.0
1989	34.6	14.3	7.8	- 28.5	- 20.8
1990	34.2	4.7	- 4.9[4]	- 58.1	- 41.8
1991	32.6	- 9.3[4]	- 22.2	- 97.7	- 70.3
1992	29.5	- 28.2	- 44.9	-148.9	-109.3
1993	23.9	-[5]	- 73.9	-[5]	-160.3
1994	16.3	-	-110.1	-	-226.3
1995	5.5[3]	-	-155.6[6]	-	-310.3

1/ U. S. Department of Health and Human Services, 1983 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund, p. 46.

2/ U.S. Congress. Congressional Budget Office, Changing the Structure of Medicare Benefits: Issues and Options, March 1983, p. 66.

3/ Under this assumption the Trust Fund is depleted in 1996.

4/ Unpublished estimates by HCFA's Office of Financial and Actuarial Analysis. Amounts include interest payments on borrowed funds.

5/ No estimates available.

6/ HCFA actuaries believe that to be financially sound, there should be a $70-80 billion reserve. Thus, the II-B shortfall in 1995 is an estimated $225.6 - 235.6 billion.

CHAPTER II - FINANCING

B. General Revenue Contributions to the Hospital Insurance Trust Fund

Background

Medicare's Hospital Insurance program was originally established as a part of the payroll tax-funded social security programs to supplement the monthly benefits which would be available to elderly individuals entitled to Social Security Old Age and Survivors Insurance benefits. Subsequently, it was expanded to include the long term disabled who are receiving monthly social security benefits. Extension of coverage in 1972 to patients with end stage renal disease did not include a requirement of eligibility for monthly benefits but did require participation in the social security system by the patient or a family member on whom the patient was dependent.

Discussion

In reviewing possible ways to reduce the projected deficit in the HI trust fund, the Council considered the possibility of recommending an annual allocation of general revenues to the fund. Such general revenues would supplement the already-legislated payroll contributions.

General revenues are income to the Treasury, for use in operating the Federal government without specification as to the type of program to be supported. Proponents of general revenue contributions to the HI trust fund note that income taxes, which provide a major portion of general revenues, are more progressive than the social security payroll taxes and, therefore, would be proportionately less onerous for low and middle income workers than an increase in payroll taxes. Also, there is precedent for the use of general revenues in financing a health insurance program since, currently, over 75 percent of Supplementary Medical Insurance trust fund income is from general revenues.

In contrast to social security monthly benefits which are related to the amount contributed to the system by the worker, there is no direct financial relationship between contributions to the HI trust fund and the amount of benefits received by an individual beneficiary. Medical needs determine the amount of services received. When the same benefits are available to all, the contributions-to-benefits relationship becomes blurred.

Several members of the Council questioned the soundness of a fiscal policy which relies on general revenues to finance the HI program. In an era when the Government is incurring substantial annual deficits, reliance on so-called general revenues would only serve to increase that deficit. Also, infusion of substantial general revenues into the HI program could require expansion of the program to persons other than social security contributors and their dependents, further increasing program costs. Among the groups primarily affected would be current Federal retirees and State and local employees and retirees who remain outside the social security system; both of these groups generally have protection available to them through their private retirement system.

After consideration of both sides of this issue the Council determined that use of additional general revenues to finance the HI trust fund would be inappropriate.

Recommendation

A substantial majority of Council members approved the following recommendation:

The Advisory Council on Social Security opposes any increase in the use of general revenues to finance the Medicare Hospital Insurance trust fund.

Dollar Impact on HI Trust Fund

None.

CHAPTER II - FINANCING

C. Hospital Insurance Payroll Tax Increases

Background

The Hospital Insurance program is financed primarily through payroll taxes paid by employers, employees and the self-employed. In 1983, the tax rate is 2.6 percent of employee wages, half (1.3 percent) paid by the employer and half by the employee. The 1983 rate for self-employed persons is 1.3 percent of net earnings; beginning in 1984, the self-employed will pay the same rate as the combined employer-employee rate. Taxes are paid on a maximum of $35,700 pre-tax income in 1983; the maximum is subject to automatic yearly increases. The tax rate for 1984 continues at 2.6 percent; increases are scheduled in 1985 and 1986 to 2.7 percent and 2.9 percent respectively.

Discussion

In view of the projected deficit in the HI trust fund, the Council considered the possibility of raising additional revenue through increased payroll taxes. Four options were reviewed: move scheduled increases forward one year; move scheduled increases forward one year and increase the rate one-tenth of one percent beginning in 1986; move scheduled increases forward one year and increase the rate three-tenths of one percent in 1985 and one-tenth of one percent beginning in 1986; or eliminate the ceiling on covered wages and self-employment.

Council deliberations on the issue revealed a general reluctance to raise payroll taxes at all. Some members noted that the latest census figures show current workers, those most likely to be burdened by an increased payroll tax, are less wealthy than the elderly population who would benefit from such a tax. This was particularly apparent when assets as well as income were considered. The Council also reached a consensus that further payroll tax increases could have adverse effects on employment and business activity.

Given the fiscal burden which FICA taxes already place on the working population, the Council viewed any increase in the scheduled payroll taxes as an inappropriate means for raising additional trust fund revenues.

Recommendation

A substantial majority of Council members approved the following recommendation:

The Advisory Council on Social Security opposes any further increase in scheduled Hospital Insurance payroll taxes.

Dollar Impact on HI Trust Fund

None.

CHAPTER II - FINANCING

D. Interfund Borrowing

Background

In 1982, Congress authorized interfund borrowing among the Old Age and Survivors Insurance, Disability Insurance and Hospital Insurance trust funds. General requirements for payment of interest and repayment of principal were also included. While any fund could borrow from any other fund, the primary purpose of the legislation was to permit the OASI trust fund to borrow from the DI and HI trust funds to meet its monthly benefit obligations through June 1983. As a result of this legislation, the OASI trust fund borrowed a total of $12.4 billion from the HI trust fund in 1982. Authority for such borrowing terminated December 31, 1982.

In April 1983, Congress extended the authority for interfund borrowing through 1987. The law includes specific requirements for payment of monthly interest on loans and specifies minimum levels of reserves for the lending fund and for the fund making repayment. All repayment must be completed by January 1, 1990.

Discussion

Early in its deliberations, the Council expressed concern that the long term funding crisis of the HI trust fund not be exacerbated by any actions to meet the short term needs of the OASI trust fund. At the time the OASI trust fund borrowed $12.4 billion, actuaries of the Health Care Financing Administration had already projected that the HI trust fund would be depleted within a decade. The initial interest payment due on the loan was not paid. The possibility of reauthorization of a virtually open-ended authority by other social security trust funds to borrow from the HI trust fund, without assurance of timely repayment, threatened to undermine the Council's efforts to forecast the availability of funds and stabilize the program.

The OASI, DI, HI programs are funded by legislatively established trust funds. The Council endorsed this concept of separate funding as a means of assuring fiscal accountability of each program. Each program must live within the income made available to it. The Council recognized that the recent short term fiscal crisis in the OASI program necessitated extreme measures, including interfund borrowing, to assure continued payment of monthly benefits.

The Council determined that, if interfund borrowing were to be reauthorized, the fiscal viability of all trust funds should be adequately protected. Each trust fund should have authority to borrow from the others. Appropriate provisions for payment of interest and repayment of principal, which protect the fiscal integrity of both borrowing and lending fund, should be included. The Council is gratified that the legislation enacted in 1983 to reauthorize interfund borrowing included provisions to address the Council's concerns.

Recommendation

The Council unanimously approved the following recommendation:

The Advisory Council on Social Security in general believes that the individuality of the Old Age and Survivors Insurance, Disability Insurance and Hospital Insurance programs should be maintained, and that each program should be funded at a level sufficient to meet its continuing needs.

The Council recognizes that interfund borrowing has been employed in the past and that it has been reauthorized through 1987 as a means of alleviating short-term deficits in the social security trust funds. The Council strongly urges that certain safeguards be incorporated in the procedure to assure the fiscal stability of both the borrowing and lending trust funds. At a minimum, such safeguards should include:

1. Authorization of any trust fund financed by FICA taxes to borrow from the others;

2. A requirement that, at the time any borrowing occurs, the trustees establish a specific schedule for repayment of principal and interest; and

3. A prohibition against the lending trust fund reducing its assets below an actuarially acceptable level.

Dollar Impact on HI Trust Fund

The Council's estimate of the trust fund deficit considers the impact of this provision.

CHAPTER II - FINANCING

E. Reallocation of Tax Rates Between the Hospital Insurance Trust Fund and the Old Age and Survivors Insurance and Disability Insurance Trust Funds

Background

While the Hospital Insurance trust fund will be running a deficit over the next twenty-five years, the Old Age and Survivors Insurance and Disability Insurance trust funds will be accumulating a projected surplus (see table I). The expected OASDI surplus could adequately cover projected deficits in the HI trust fund during that twenty-five year period.

Discussion

When reviewing options for reducing the expected deficit in the HI trust fund, the Council searched for ways to distribute evenly the burden of an increasingly expensive Medicare system, while looking for ways to control that growth without endangering beneficiary access to quality care. The Council also reviewed options focused on increasing flexibility to the program to meet any eventuality (see for example, Chapter II, D "Interfund Borrowing", and II, G "Federal Excise Taxes on Alcohol and Tobacco Products").

The Council generally limited its considerations to relatively short-term financing issues. From that perspective, diversion of projected surplus OASDI revenues by reallocating contribution rates among the three trust funds without increasing the combined rate appeared to be a potentially desirable method to alleviate a substantial portion of the projected HI deficit. The Council recognized, however, that both long and short-range considerations must govern any specific reallocation proposal. Therefore, the Council believed that such reallocation should only be considered as long as the integrity of all three trust funds is preserved.

Recommendation

The Council unanimously approved the following recommendation:

The Advisory Council on Social Security recommends that, if needed, consideration be give to a reallocation of existing payroll tax rates between OASDI and HI in order to transfer sufficient OASDI surplus revenue to HI during the period 1985 through 1995 to maintain the financial viability of the HI trust fund.

Dollar Impact on HI Trust Fund

Varies depending on rate reallocated.

TABLE I

Income and Outgo of HI and OASDI Trust Funds 1983-2007

Calendar year	OASDI		HI		Total	
	Tax Income	Outgo	Tax Income	Outgo	Tax Income	Outgo
1983.....	$163.4	$169.5	$ 38.3	$ 40.8	$201.7	$210.3
1984.....	179.8	180.3	42.9	45.7	222.7	226.0
1985.....	197.4	193.8	48.2	51.4	245.6	245.2
1986.....	212.9	209.9	55.5	57.3	268.4	267.2
1987.....	229.1	225.2	59.5	63.6	288.6	288.8
1988.....	260.3	240.8	63.6	70.6	323.9	311.4
1989.....	280.4	256.5	68.0	78.1	348.4	334.6
1990.....	307.0	272.7	72.4	86.4	379.4	359.1
1991.....	329.1	289.8	77.4	95.2	406.5	385.0
1992.....	353.0	307.7	82.6	104.9	435.6	412.6
1993.....	376.4	322.6	87.9	115.2	464.3	437.8
1994.....	400.2	338.4	93.3	126.1	493.5	464.5
1995.....	425.6	355.2	99.0	138.3	524.6	493.5
1996.....	452.9	372.9	105.4	151.6	558.3	524.5
1997.....	482.1	391.7	112.2	165.2	594.3	556.9
1998.....	513.1	413.0	119.4	180.3	632.5	593.3
1999.....	546.4	435.6	127.1	196.4	673.5	632.0
2000.....	581.8	459.7	135.3	213.7	717.1	673.4
2001.....	618.5	485.2	143.7	232.5	762.2	717.7
2002.....	657.0	512.7	152.6	252.0	809.6	764.7
2003.....	698.3	543.0	162.0	273.7	860.3	816.7
2004.....	742.2	575.8	171.9	297.1	914.1	872.9
2005.....	788.5	611.5	182.4	322.7	970.9	934.2
2006.....	836.6	650.5	193.4	350.2	1,030.0	1,000.7
2007.....	886.8	693.3	204.8	380.7	1,091.6	1,074.0

Source: Social Security Administration, Office of the Actuary and Health Care Financing Administration, Office of Financial and Actuarial Analysis

CHAPTER II - FINANCING

F. Taxation of Employer-Provided Health Insurance

Background

Under current law an employer's contribution to an employee's health plan is a tax-free fringe benefit. The employer may, of course, deduct the contribution as a business expense but the employee is not required to report it as income for income tax purposes. Over 90 percent of all subscribers to employment-related group health insurance receive some employer contribution to their premiums. An estimated $20+ billion in additional Federal income taxes would be collected in 1983 if employer health plan contributions were treated as taxable income. Social Security (FICA) taxes would also increase substantially.1/

On several occasions in the past, proposals have been made to treat all or part of the employer's contribution to an employee's health plan as income to the employee and subject to Federal, State and local taxes in the same manner as wages. Some of the proposals, such as one made by the Administration in connection with the 1984 budget process, would add the increased tax revenues to the general fund of the Treasury. Others would earmark the added revenues for a specific purpose, usually a health related purpose such as Medicare, Medicaid or health research activities.

Discussion

The Council reviewed the issue of taxation of employer-provided health insurance from two perspectives: 1) whether removal of tax exempt status on all or a portion of the employer contribution would be effective in controlling increases in health care costs; and 2) whether additional revenues raised in such a manner could appropriately be earmarked for the Medicare program.

Proponents of proposals to treat employer contributions to employee health plans as taxable income point out that this type of increase is progressive. The current exemption from taxation is

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1/ Taylor, Amy K. and Wilensky, Gail R., Tax Expenditures and the Demand for Private Health Insurance, U.S. Department of Health and Human Services, Public Health Service, National Center for Health Services Research, 1982.

disproportionately advantageous to high income taxpayers. The marginal income tax rates of these taxpayers are higher. Also, employers of higher income employees usually make larger contributions to employee health plans than do employers of low income employees.

According to proponents, a potentially greater advantage to removal of the exemption is a slowing of health care cost increases generally. Since employer sponsored health insurance is, tax-wise, advantageous to employees, employers tend to "overinsure" and provide generous benefits. In turn, this additional insurance insulates employees against the true costs of their health care services and encourages utilization and lack of concern for the cost-effectiveness of services received. The end result may be a higher rate of health care cost inflation than would occur if the users of health care were more cost conscious. If employees were required to purchase their health insurance with after-tax dollars, they would become more price-conscious and seek ways to hold down costs. The resulting constraints on cost increases would benefit all health care consumers, including Medicare beneficiaries.

Opponents of proposals to tax employer contributions to employee health plans question whether any of the projected beneficial results will actually occur. While such taxation would fall more heavily on higher income employees, a single limit would fall more harshly on certain higher risk groups, such as older workers and workers in hazardous occupations, and fails to recognize regional differences in health care costs. Employers could shift payments to other types of fringe benefits, negating any revenue increase from taxed health benefits. Finally, it is not certain that any significant behavioral changes to slow escalating costs will actually occur.

The Council recognized that the proposal to tax employer-provided health insurance as wages was both controversial and uncertain of results. However, after consideration of all sides and views on the matter, a consensus developed that such taxation would most likely bring about a change in health care purchasing behavior and would lead to a slowing of increases in health care costs. The revenue-raising possibilities were generally viewed as secondary. The Council agreed, however, that some portion of the employer contribution should remain tax free in order to encourage continued employer contributions and to assure availability of basic health care coverage to workers. The Council endorsed the Administration's proposal to declare all employer contributions in excess of $70 per month for an individual and $175 a month for a family to be taxable income to the employee. The exempt amounts would be redetermined annually in accordance with changes in the Consumer Price Index (CPI).

The possibility of earmarking the increased taxes to the Hospital Insurance trust fund caused considerable debate regarding both the appropriateness of such earmarking and the complexity of its administration. Several members questioned whether a sufficient link existed between Medicare and private health insurance to justify benefiting that program over other health care programs. The logistics of separately identifying income and revenues related to the taxation of employer contributions appeared substantial. The Council supported the concept of earmarking but deferred any recommendation regarding amounts to be earmarked, leaving such a decision to the Congress.

Recommendation

A substantial majority of Council members approved the following recommendation:

The Advisory Council on Social Security endorses the Administration's proposal to consider any employer's contribution to an employee's health benefit plan that exceeds $70 per month for an individual and $175 per month for a family, as income to the employee and subject to Federal, State and local taxes in the same manner as wages. The Council bases its recommendation on the beneficial effect it believes the proposal will have on reducing health care costs through encouraging behavior changes with respect to the utilization of health services. The Council recommends that consideration should be given to earmarking an appropriate portion of the incremental revenues that would be realized from the proposed tax to Medicare's hospital insurance trust fund.

Dollar Impact on HI Trust Fund

The Council decided not to project any specific revenue increases that would be derived from earmarking the incremental revenues. However, since the proposed treatment of employer contributions would increase the wages subject to FICA taxes, the projected increase in HI tax receipts would serve to reduce the projected deficit. If implemented in 1984, increased HI tax receipts would total nearly $7.2 billion through 1995. (See Appendix H, Table 1.)

CHAPTER II - FINANCING

G. Federal Excise Taxes on Alcohol and Tobacco Products

Background

Throughout its discussions concerning ways to make the Hospital Insurance trust fund fiscally sound, the Council was reluctant to consider increases in taxes. However, the size of the anticipated deficit indicated that additional new revenue sources would probably be needed. While discussing alternative sources of revenues, the Council noted some precedent for the transfer of general revenues from specific taxes to trust funds. "In some cases, amounts equivalent to certain excise tax revenues are transferred from general revenues to a trust fund in order to finance specified trust fund expenditures. The general intent of such trust fund excise taxes is to place the tax burden on persons whose activities may have necessitated the expenditures."[1/]

With respect to specific types of excise taxes, the Council found that the Federal excise tax rates were last increased on distilled spirits in 1951 and the taxes on wine and beer in 1955. The Federal excise tax rate on cigarettes, which had not been changed since 1951, was doubled to 16¢ a pack for two years under the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). However, State taxes on these products have been increased considerably over the past five years, with wide variation in tax rates between States. Total revenue raised by all States on alcohol beverages in 1982 was $2.7 billion, or 3.4 percent of total State revenues. Total revenues raised by all States on tobacco products in 1982 was $3.95 billion, or 5 percent of total State revenues.[2/]

Discussion

The Council held a public hearing on the issue of increasing Federal alcohol and tobacco taxes. Testimony was delivered that represented the views of some Members of Congress, the industries involved, academicians, economists, practicing physicians, State officials, public interest groups and interested individuals. The points of view expressed at the hearing precipitated extensive discussion on

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1/ Background and Description of Present Federal Excise Taxes: Prepared by: Joint Committee on Taxation; June, 1982, p. 4.

2/ National Association of State Budget Officers.

a number of related issues:

-- Probable impact on States should the Federal excise tax on alcohol and tobacco be increased.

-- Elasticity of demand for these products.

-- Possible relationship between use of these products and increased health care costs.

-- Probable effect on the industries and their employees.

-- The equity of such a tax.

The Council reviewed several options concerning alcohol and tobacco taxes, including the option to take no action on the question. One option, which would impose additional taxes, provided for an increase of 25, 50 or 100 percent of the current Federal excise tax on both products to be earmarked to the HI Trust Fund. Also included were options to continue the current TEFRA tax on cigarettes to be earmarked to the HI Trust Fund; to allow the TEFRA sunset provision to occur, but increase the tobacco tax by 25, 50 or 100 percent to be earmarked; and/or to increase the alcohol tax by 25, 50 or 100 percent and earmark the increase to the HI fund. Other options suggested equalizing the Federal beer and wine tax with that of the Federal distilled spirits tax and adjusting the tax to reflect inflation since 1951, or to adjust current Federal excise taxes to reflect inflation since 1951. In addition, the Council examined an option to change the Federal excise tax on alcohol and tobacco to an ad valorem tax providing for an automatic annual adjustment for the effect of inflation.

Although a majority of Council members generally viewed increased taxes as an undesirable alternative, members who supported an increase in the Federal excise tax on alcohol and tobacco products cited two primary factors. First, the medical evidence of the incidence of alcohol and tobacco related diseases among users of these product demonstrates the correlation between use of these products and increased health care costs. Therefore, an increased and earmarked Federal excise tax on these products could be justified as an attempt to tax the users for the resulting excess health care costs which they impose on the HI Trust Fund. Second, recognizing the need to find alternative sources of revenue, this tax appeared to be the most fair and equitable and more importantly the "least objectionable" of all the tax alternatives considered.

Those Council members who opposed the increased alcohol and tobacco taxes based their opposition on several factors. 1) There are other products that adversely affect health and it is unfair to single out

the alcohol and tobacco industries for additional taxes to support the Medicare program. 2) Additional Federal excise taxes on these products can adversely affect State governments who rely on State excise taxes on these products. 3) Additional Federal excise taxes will adversely affect demand for these products with resulting detrimental effects on the employment situation in these industries and the economy in general.

As a result of the above deliberations, the Council voted to recommend an increase in the Federal excise tax on alcohol and tobacco and earmark the increase to the HI Trust Fund. The Council did not specify a particular methodology or dollar amount, choosing to let the Congress determine how much revenue might be needed and how best to implement the recommendation.

Recommendation

A majority of Council members approved the following recommendation:

The Advisory Council on Social Security recommends that Federal excise taxes on alcohol and tobacco be increased, with the increased revenue to be earmarked to the HI trust fund. The Council does not specify the amount to be raised and earmarked, but suggests that the amount be determined by the Congress.

Dollar Impact on HI Trust Fund

Unknown

III ELIGIBILITY

Introduction

The Medicare Part A Hospital Insurance program and the Part B Supplementary Medical Insurance program have different eligibility requirements.

Under the original Medicare HI program, eligibility was limited to persons age 65 and over who were eligible for monthly benefits under the Social Security Old Age and Survivors Insurance program. The 1972 Social Security amendments expanded eligibility to include persons who have been receiving Social Security Disability Insurance benefits for at least two years and to persons with end-stage renal disease who are workers or dependents of workers having a recent connection with the Social Security system. Most persons age 65 and over who do not otherwise meet eligibility requirements may secure HI coverage by paying a premium equal to the full actuarial value of the coverage.

Virtually all individuals age 65 and over are eligible to enroll in the SMI program. The 1972 Social Security Amendments expanded eligibility to include persons eligible for HI on the basis of disability or end-stage renal disease.

In addressing Medicare eligiblity issues, the Council's chief concerns related to the projected increase in beneficiary population as a result of increases in life expectancy at a time when fiscal constraint is vital to maintaining the solvency of the program.

CHAPTER III - ELIGIBILITY

A. Advancing the Age of Eligibility for Medicare

Background

Under current law, eligibility for Medicare as an aged individual is contingent on the attainment of age 65.[1] No change in this age requirement has occurred since the Medicare program began in 1966. Until recently, Medicare age of eligibility coincided with the age at which individuals who met the required insured status provisions became eligible for unreduced monthly social security Old Age Insurance benefits. As a result, a perception of an historical relationship between the age of eligibility under the two programs occurred.

While the age of eligibility for the monthly benefit programs may have influenced the eligibility age that was originally selected for Medicare, that relationship has become increasingly less significant over the 17 year Medicare history. Since 1966, an increasing number of individuals have elected to receive reduced benefits, with more than half of those entitled now retiring between age 62 and 65. Therefore, eligibility for Medicare has occurred for most beneficiaries following their retirement and receipt of Social Security benefits.

Public Law 98-21, the Social Security Amendments of 1983, provided for an increase in the age of eligibility for unreduced monthly benefits from 65 to 67 on a gradual phase-in schedule beginning in the year 2000 with full implementation occurring in the year 2027. The law made no changes with respect to Medicare eligibility. Assuming no subsequent changes, Medicare eligibility will eventually precede eligibility for unreduced Social Security benefits.

Since the Medicare program began, the average life span has increased more than 3 years. In 1966, the life expectancy for males was 66.7 and for females 73.9 years. By 1980, life expectancy for males had increased to 69.8 and for females to 77.5 years.[2]

1/ There are no specific age requirements for Medicare eligibility for the disabled or those with end stage renal disease.

2/ Faber, Joseph F., Life Tables for the United States: 1900 - 2050. Actuarial Study #87, Table #5: Published by United States Department of Health and Human Services, September, 1982.

This increasing life expectancy and its impact on the ratio of retirees to workers was a principal consideration in the Congress's recent change in the age of eligibility for Social Security benefits. Similar concerns apply to the increasing Medicare population relative to workers contributing to the program. Additionally, as the principal health insuror of the aged, Medicare may face even greater fiscal problems since, historically, the cost of health care increases with age. With increasing longevity, an expanding aged Medicare population will place even greater fiscal burdens on the program.

Discussion

The Council generally approached the issue of age of eligibility from the perspective of assuring that the program covers those persons most in need of its services. After discussing the increase in life expectancy, the Council reached a consensus that age 65 as the initial age of eligibility was rooted more in custom than in an assessment of health care needs. Considering the need to conserve scarce program resources, the Council reviewed the eligibility issue in terms of overall program goals.

In early discussions, the Council agreed that the age of Medicare eligibility should be increased. Major deliberations centered on what the age increase should be and the rapidity with which it should be implemented. The Council decided that the traditional linkage to age of eligibillty for unreduced Social Security retirement benefits was not necessary. Members did express some concern about alternative sources of health insurance coverage for persons 65 and over. While little hard data exist concerning the types of health insurance currently purchased by early retirees, the fact that a substantial number do retire before the current age of Medicare eligibility indicates that protection is available in the marketplace. The final decision regarding the age of eligibility increase and its implementation was a function of the fiscal needs of the program balanced against selection of a reasonable length of time for future beneficiaries to adjust to the revised age.

The Council concluded that in order to maintain the period of Medicare entitlement at a constant average period, over the long range the age of eligibility should be adjusted periodically to reflect changes in life expectancy. In addition, the age of eligibility should be adjusted by the end of this decade to recognize at least a portion of the changes in life expectancy which have occurred since the program began.

After consideration of a range of options, the Council determined that the age of eligibility should be increased to age 67 by 1990. To accomplish the transition, the age of eligibility would be increased annually by 3 month increments beginning in 1985 and by 6 month increments in 1989 and 1990. Thereafter, increases in age of eligibility would be indexed to increases in life expectancy.

Recommendation

A substantial majority of Council members approved the following recommendation:

The Council recommends an increase in the age of eligibility for Medicare benefits from age 65 to 67. This recommendation provides for the age of eligibility to be increased by three month increments per year beginning on January 1, 1985. Beginning on January 1, 1989, the rate of increase will escalate to six month increments, achieving full implementation of the age 67 eligibility on January 1, 1990. The Council further recommends that subsequently the age of eligibility for Medicare benefits should be indexed to increased life expectancy.

Dollar Impact on HI and SMI Trust Funds

If implemented as recommended, the increase in age of eligibility would produce $74.665 billion savings to the HI trust fund through 1995 and $4.89 billion savings to the SMI trust fund through 1989. (See Appendix H, tables 1 and 2.)

CHAPTER III - ELIGIBILITY

B. Universal Social Security Coverage

Background

At the time the Council initially considered this issue three employee groups were not covered by the social security cash benefit programs: nearly all Federal employees; employees of State and local governments who had not voluntarily elected coverage for their employees; and employees of non-profit organizations who had not voluntarily elected coverage. With respect to Medicare Hospital Insurance coverage, Federal employees were covered on a mandatory basis effective January 1, 1983 as a result of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). However, many State and local government employees and employees of nonprofit organizations remained uncovered by Medicare.

Discussion

When reviewing the scope of the working population covered by the HI program, the Council took the position that under Medicare coverage of all persons who are in paid employment was a desirable goal. Such universal coverage would also contribute to the fiscal stability of the program.

The Council acknowledged that non-profit organizations traditionally had tax-exempt status. Nevertheless, the majority of such organizations had voluntarily elected coverage. The Council found no compelling reasons to continue the voluntary nature of such coverage and took the position that mandatory coverage for all employees of nonprofit organizations furthered the objective of covering all persons in paid employment.

With respect to employees of State and local governments, the Council acknowledged the existence of constitutional questions concerning mandatory coverage. As with non-profit organizations, many State and local governments had elected coverage. However, an increasing number of such entities were electing to terminate such coverage. In view of this trend the Council took the position that, with respect to State and local government employees, action should be limited to preventing termination of those employees already covered.

The Council recognized and concurred with the recommendation made by the National Commission on Social Security Reform that Old Age, Survivors, and Disability Insurance and Hospital Insurance coverage should be extended on a mandatory basis to all employees of non profit organizations. Further, State and local governments which had elected coverage for their employees under the OASDI and HI programs should not be permitted to terminate such coverage in the future. Specifically, termination notices pending would be invalid if the termination process was not completed by the enactment of any new legislation.

The Advisory Council notes that these recommendations became law with the enactment of Public Law 98-21 on April 20, 1983.

Recommendation

The Council unanimously approved the following recommendation:

The Advisory Council on Social Security concurs with the recommendations of the National Commission on Social Security Reform and acknowledges subsequently enacted provisions of Public Law 98-21, that provide (1) that Old Age, Survivors, Disability and Hospital Insurance (OASDHI) coverage be extended on a mandatory basis to employees of non-profit organizations, and (2) that State and local government units which have elected OASDHI coverage for their employees be precluded from terminating such coverage in the future, including termination actions underway but not completed by the April 20, 1983 date of enactment of Public Law 98-21.

Dollar Impact on HI Trust Fund

Because the recommended changes were enacted with Public Law 98-21, the projected savings realized have already been accounted for in the Council's estimate of projected HI trust fund deficits.

CHAPTER III - ELIGIBILITY

C. Diagnosis and Treatment-Related Coverage

Background

The Social Security Amendments of 1972, Public Law 92-603, extended basic Medicare coverage to two additional groups: persons who had been receiving social security disability benefits for at least two years and persons with end-stage renal disease (ESRD) requiring either dialysis or renal transplantation who met or were dependent on someone who met the fully insured or currently insured requirements under Social Security. The ESRD provision was not unique from the standpoint of extending coverage to those under age 65. However, this provision did extend coverage to those in a disease category as opposed to those in a social security monthly benefit category. No other disease category is similarly covered under the Medicare program.

The substantial cost of the ESRD program has generated increasing concern regarding its impact on the Medicare program. Currently, Medicare protects approximately 93 percent of the people receiving any ESRD services. Program expenditures have grown much faster than were originally projected with 1982 costs for ESRD patients about $2 billion. This amount is about 4 percent of total Medicare expenditures although the ESRD population represents only one quarter of one percent of Medicare beneficiaries.

Recent changes in HCFA's methodology for reimbursing dialysis and transplantation are expected to improve the cost-effectiveness of this program. However, the basic criticism that has prevailed since the program's enactment has been directed at the selection of a single category of disease for special treatment under the Medicare program.

Discussion

The Council acknowledged the beneficial results of the ESRD program in terms of the financial assistance it has provided to many thousands of patients with end-stage renal disease over the past 10 years. Clearly it has permitted treatment that would otherwise have been unaffordable to most patients. Additionally, financial support has promoted the development of treatment facilities and thereby provided access to care.

Notwithstanding these beneficial results the Council believed that Medicare was not and is not the appropriate program for providing such diagnosis or disease-related coverage. Proponents of the ESRD program contend that ESRD is a disease category for which an effective therapy that would sustain life was available but for

which access was denied to most patients because of its prohibitive costs. It was financially infeasible for the majority of those afflicted, and providing funding would save lives. However, with the advance of technology other disease categories demonstrate similar characteristics and equally compelling arguments for coverage under Medicare could be made if this were the primary consideration. The Council agreed that in the future where there are compelling arguments in favor of extending financial protection or support to a specific group of individuals with a specific disease, such support should be offered through a specially designed program which is funded through special appropriations.

Initially, the Medicare program was intended to provide protection to individuals in specific social security benefit categories: those over age 65 and, subsequently, persons receiving disability benefits. Should an individual with a particular chronic disease qualify for entitlement based on a social security benefit category, payment for an approved treatment is appropriate. However, the view of the Council was that eligibility for Medicare coverage should not be based upon the existence of a specific disease or medical condition.

During its deliberations on this issue, the Council considered the advisability of a future transfer of health insurance protection for ESRD patients not otherwise eligible for Medicare to a separately funded program. However, the Council determined that since the Medicare program has been the principle health insuror for patients with end-stage renal disease for over 10 years, any change as significant as this could severely impact the treatment delivery system now in place. Also the Council acknowledged that approximately 60 percent of the current ESRD population are eligible for Medicare under either the Old Age and Survivors Insurance or Disability Insurance benefit provisions. To cover only a portion of the future population under a separate program could introduce substantial administrative complexity. In view of these considerations, the Council recommended no changes with respect to the Medicare ESRD program.

Recommendation

The Council unanimously approved the following recommendation:

The Advisory Council on Social Security opposes any further extension of Medicare coverage to individuals (not otherwise eligible based on age or disability status) on the basis of a medical diagnosis or the medical necessity for a particular form of medical treatment. Notwithstanding the beneficial results of the End-Stage Renal Disease Program in terms of the financial assistance it has provided to patients with ESRD, often permitting treatment

that would not otherwise have been affordable for the patient, the Council believes that Medicare is not the appropriate program for providing diagnosis related coverage.

It is the Council's recommendation that, should other categories of disease be considered for Federal financial assistance, such assistance should be provided through a special health care program with separate allocation of funds to pay for required medical treatment. The original intent of the Medicare program--to insure categories of beneficiaries against the financial risk of illness or injury--should be maintained.

Dollar Impact on HI Trust Fund

None.

IV - BENEFIT STRUCTURE

Introduction

The benefits provided under Medicare's Part A Hospital Insurance program and Part B Supplementary Medical Insurance program complement each other to cover a wide range of services provided in the acute care environment.

The HI program covers inpatient hospital services, skilled nursing facility services and home health services. During the period November 1983 through September 1986, HI also provides a hospice benefit which may be elected in lieu of other HI benefits and most SMI benefits.

The SMI program covers physicians' services, including surgery, home, office and institutional visits. Other services covered under SMI include outpatient hospital and rural health clinic services, diagnostic services, ambulance services, outpatient physical therapy and speech pathology, additional home health services and other medical supplies, appliances and equipment.

The Council reviewed the adequacy of the benefit structure and methods to make it more responsive to the needs of its beneficiaries while encouraging cost-effective use of those services.

CHAPTER IV - BENEFIT STRUCTURE

A. Restructure of Medicare Benefit Package

Background

Part A: Currently, Medicare's Part A Hospital Insurance program[1/] covers:

- o Inpatient hospital care for up to 90 days in a benefit period plus a one-time reserve of 60 days.
- o Skilled nursing facility care for up to 100 days in a benefit period.
- o Unlimited home health visits.
- o Hospice care, as an alternative to other Part A benefits and certain Part B benefits.

Certain features of the Part A program have stirred debate and concern among patients, providers, administrators of the program and the public. Three of the issues involve: 1) the "benefit period" concept; 2) cost-sharing provisions; and 3) lack of catastrophic coverage. Any comprehensive plan to reduce costs or increase revenues to ameliorate projected program deficits should include consideration of these issues.

Availability of inpatient hospital benefits and skilled nursing facility benefits is not tied to a specific time period but rather to a variable period depending on the institutional status of the beneficiary. A "spell-of-illness"--the benefit period--generally begins when a patient is admitted to a hospital and ends after the patient has been out of a hospital or facility which provides skilled nursing or rehabilitation services for sixty consecutive days.

As long as the individual remains entitled to Part A hospital insurance there is no limit on the number of benefit periods he or she may have. On the other hand, an individual may be discharged from and readmitted to a hospital or skilled nursing facility several times and continue to be in the same benefit period if 60 days have not elapsed between the previous discharge and the new admission.

1/ See Appendix F for a detailed description of the evolution of current program.

Administration of the benefit period system is both complex and costly. The Department of Health and Human Services (HHS) must maintain a detailed master record on each Medicare beneficiary in order to insure that those providers treating the beneficiary are aware of prior utilization that affects the benefits currently available. Although administrative costs are still relatively small in relation to program benefits, any modification which substantially reduces the data collection and management requirements would produce significant savings for all concerned, HHS, intermediaries and the providers of care.

The benefit period system also presents difficulties for most beneficiaries. Many have a significant problem understanding the complicated "spell-of-illness" concept, especially the majority of beneficiaries who had health insurance prior to age 65 that generally was based on a uniform time period, usually a calendar year.

The Part A cost-sharing provisions, which are also linked to the benefit period system, raise additional concerns. Upon entering a hospital and beginning a benefit period, the patient is liable for:

- An initial deductible based on the average cost of a day of hospitalization.
- Daily coinsurance equal to 1/4 of the deductible for hospital days 61-90 in a benefit period.
- Daily coinsurance equal to 1/2 of the deductible for each lifetime reserve day.
- Daily coinsurance equal to 1/8 of the deductible for skilled nursing facility days 21-100.

The deductible, which is updated annually, is $304 in 1983 and rises to $356 in 1984. There is no limit on the total amount of deductibles and coinsurance that may be imposed in a year other than the limit resulting from the benefit period rules.

The significant increases in hospital utilization and costs and the changing health care needs of the elderly have generated increasing criticism of the cost sharing features of the current system. Some view this sharing as too high, others as inadequate. Still others believe the configuration of the cost sharing provides incentives to overutilize services since there is no cost sharing beyond the deductible for short stays which account for the majority of all hospital admissions. Further, the coinsurance structure requires that those who are very sick and need extended hospitalization subsidize the average beneficiary, since the average length of stay is less than 12 days.

A third problem with the Part A benefit structure is the reality that there are clear limits on the days of protection provided. Utilization in excess of the days available or even of days on which coinsurance is assessed, is unlikely. Less than 25 percent of eligible beneficiaries use hospital inpatient services in a year and of those using such services, the subtantial majority use less than 30 days of care and thus for covered inpatient services, pay only the deductible. Nevertheless, the recognition that exhaustion of benefits is possible produces significant anxiety for many beneficiaries. The fact that over 65 percent (some data indicate over 75 percent) of Medicare beneficiaries secure private supplementary coverage for hospital care indicates that concern about inadequate catastrophic protection is prevalent.

Part B: Currently, Medicare's Part B Supplementary Medical Insurance program covers:

- o Physicians' services, including surgery and home, office and institutional visits.
- o Outpatient hospital services and rural health clinic services.
- o Outpatient physical therapy and speech pathology services.
- o Diagnostic laboratory, diagnostic and therapeutic radiology and other diagnostic services.
- o Ambulance services.
- o Unlimited home health visits.
- o Certain prosthetic devices and other medical supplies, appliances and equipment.

For most covered services, 1/ Medicare pays 80 percent of approved changes after the beneficiary has met a $75 annual deductible. The beneficiary pays a monthly premium - $12.20 in 1983 - equal to about 1/4 of the value of the protection for the aged.

A major concern to many beneficiaries is the lack of a limit on total out-of-pocket expenses that can be incurred under Part B. As long as covered services are used, the coinsurance continues to apply, thus placing the largest burden on the sickest patients.

1/ There are special rules for home health services, outpatient psychiatric services and certain other services.

Discussion

After review of the problems with the current program, the Council reached agreement on the need to restructure the current Part A benefit to accomplish the following objectives:

1. Provide for improved protection against catastrophic illness.

2. Simplify the benefit package to make it understandable to the beneficiary and easier to administer for the Health Care Financing Administration and its contractors.

3. Incorporate reasonable cost-sharing by beneficiaries in a manner that discourages overutilization of services.

4. Spread the risk and cost of health care among all beneficiaries using the traditional health insurance framework rather than placing a financial burden on only those who actually use covered services.

5. Identify ways to alleviate the Part A financial crisis through a combination of expenditure reductions and revenue increases while assuring an adequate benefit structure.

Part A

The Council evaluated a variety of alternatives for accomplishing the above objectives through a redesign of the Part A benefit, to be financed through a modification of current cost-sharing provisions, i.e., deductibles and coinsurance. Several alternatives provided for an improved and simplified benefit package and also addressed the catastrophic protection issue. The Council expressed concern that, if improvements were financed solely through additional copayments, the burden would be borne only by the minority of beneficiaries who actually used covered services.

A preferable alternative would finance benefit improvements and raise additional revenue through a premium. The premium approach would insure that all beneficiaries who are eligible for Part A and any additional catastrophic protection would share equally in the increased cost-sharing.

The Council considered recommending a restructured Part A benefit for which eligibility would be based on both FICA tax contributions and premium payments after retirement. However, the Council believed that making entitlement to Part A contingent on the payment of premiums would be inappropriate since this program has been and should continue to be funded primarily through tax contributions made during working years. To deny Part A protection because of the failure or inability to pay a premium after a worker has contributed would violate a basic principle of the program. Consequently, the

Council developed a recommendation that would restructure the basic Part A Hospital Insurance benefit available to all individuals meeting current eligibility requirements.

The restructured Part A package would eliminate the benefit period provisions of current law and provide catastrophic protection. The revised benefits would be:

- o Unlimited inpatient hospital days with:
  - -- A deductible, computed under current rules, applied to the first two admissions per year, and
  - -- A 3 percent daily coinsurance for each non-deductible day.
- o 100 days of skilled nursing facility benefits per year with:
  - -- Coinsurance on days 21 to 100 equal to 1/8 of the hospital deductible.
- o Current home health and hospice benefits.

The Council proposed an enhanced benefit package to supplement the restructured Part A benefit. The enhanced benefit would be financed by an annual premium paid by beneficiaries electing this coverage.

The enhanced benefit would:

- o Eliminate the 3 percent inpatient hospital coinsurance in the basic Part A plan.
- o Eliminate the coinsurance (1/8 of deductible) that applies to days 21 through 100 of skilled nursing facility services.

In effect beneficiary cost-sharing would be limited to the inpatient deductible that would apply to no more than two admissions per calendar year.

HCFA actuaries estimated that the actuarially sound annual premium necessary to finance the enhanced Part A benefit would be $56.50 in 1985. The premium would be adjusted annually to reflect the cost of covering hospital and skilled nursing facility coinsurance.

The Council also recommended that $42 per year be added to the enhanced benefit premium to generate additional revenue for the HI trust fund. This additional base premium amount would be indexed, in future years, to any increase in the hospital deductible. The additional amount recognizes the disparity between worker contributions to the trust fund and the value of benefits received.

The enhanced Part A benefit, including the additional base amount, would be offered as an integral part of the beneficiary's voluntary Part B election. Therefore, beneficiaries who elected Part B would automatically receive the enhanced benefit package. By merging the enhanced Part A benefit package with the basic Part B coverage, the Council sought to preclude adverse selection. If offered separately, the potential exists that only beneficiaries in poor health would elect the enhanced coverage. To insure that the estimated premium would be both reasonable and reliable the Council concluded that election by the substantial majority of Medicare beneficiaries would be essential.

Part B

The Council also addressed beneficiary concerns that out-of-pocket costs under the Part B Supplementary Medical Insurance program are onerous and unpredictable. Part of the problem relates to additional costs for non-approved charges of physicians who do not accept assignment. The Council addressed the physician assignment question separately. (See Chapter V, D.) Additionally, the open-ended nature of the 20 percent coinsurance requirements can produce financial hardship when the beneficiary incurs extraordinary medical expenses.

To address this problem, the Council recommended an optional enhanced Part B benefit. The proposed option makes no change in the basic benefits offered under Part B but does provide for a cap on Part B out-of-pocket expenses incurred for covered services in a calendar year. Assuming implementation in 1985, a $227 annual cap would apply to out-of-pocket expenditures. The dollar cap would be indexed to the rise in per capita Part B expenses in subsequent years. Once payment toward the deductible and 20 percent coinsurance on approved Medicare charges totaled the applicable dollar limit, the Medicare program would reimburse 100 percent of aproved charges.

The Part B enhancement would also be financed by a premium. No portion of the premium for the optional Part B package would be subsidized by general revenues. 1/ Assuming a substantial majority of beneficiaries elect this option, the actuarially sound premium, based on current cost-sharing rules, would be approximately $150 per year in 1985. A separate Council recommendation to index the Part B deductible to annual increases in the CPI would increase this estimate.

The Council acknowledged that making the Part B enhancement optional might make adverse selection a problem. Considering the coverage and premium costs of typical "Medigap" insurance policies, the

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1/ Currently, general revenues represent approximately 75 percent of the Part B trust fund income.

Council believed the recommended enhancement would be competitive and assumed that a significant portion of the Medicare population would choose to purchase this protection. Those beneficiaries who elect both the Part A and Part B enhanced benefits would pay approximately $250 per year in additional Part B premiums. For beneficiaries who choose not to elect the Part B optional package, but only elect basic Part B insurance with the enhanced Part A benefits, the additional premium is estimated to be approximately $100 per year in 1985. In providing estimates of the premium for the optional Part B supplement, HCFA actuaries emphasized that the actual amount could vary if enrollment estimates are not met.

Comparable coverage purchased through private "Medigap" insurance would generally be more costly. Typical costs for "Medigap" coverage range between $300 and $600 per year. Because such policies often cover the Part A deductible, individuals who use inpatient services could incur, in the year the services were received, slightly higher out-of-pocket expenses under the proposed enhanced package as opposed to a Medicare/Medigap combined plan. However, for the approximate 75 percent who use no inpatient services, yearly out-of-pocket costs would generally be less under this proposal.

The Council noted five major strengths of the total proposed restructured Medicare benefit package:

1. The Part A benefit structure would be more understandable for beneficiaries and easier to administer.

2. For the first time beneficiaries would have protection against catastrophic costs of acute or prolonged illness or injury.

3. Use of a premium to finance the improved coverage would spread the cost among all beneficiaries and avoid placing additional tax burdens on workers.

4. Overall out-of-pocket expenses of beneficiaries should be reduced due to decrease spending for Medigap coverage.

5. Additional revenues and reductions in basic Part A outlays would serve to reduce the projected deficit of the Part A trust fund.

Recommendation

A substantial majority of Council members approved the following recommendation:

The Advisory Council on Social Security recommends that the Medicare Part A Hospital Insurance benefit be revised to provide the following coverage:

1. Unlimited inpatient hospital days per calendar year.

2. A per admission deductible, as currently computed, but limited to two hospital admissions per calendar year.

3. A daily coinsurance, equal to 3 percent of the hospital inpatient deductible, for all inpatient days except the initial day of any stay where an inpatient deductible applies.

4. A skilled nursing facility benefit of 100 days per calendar year with no coinsurance on days 1 through 20 and a 12.5 percent coinsurance (1/8 of the deductible) on days 21 through 100.

5. The current home health benefit.

6. The current hospice benefit.

The Council recommends an enhanced Part A benefit be offered as an integral part of a beneficiary's Part B election that provides for:

1. Elimination of the 3 percent daily coinsurance on inpatient hospital days.

2. Elimination of the 12.5 percent daily coinsurance on days 21-100 of skilled nursing facility benefits.

If a beneficiary elects to take Medicare's Part B coverage he/she automatically elects the Part A enhanced benefit.

The Part A enhanced benefit will be financed by an actuarially sound premium that will include an additional base amount to provide additional program revenues necessary to contribute to reducing the projected trust fund deficits expected to occur by the end of this decade.

The Council also recommends an enhanced Part B benefit to be offered on an optional basis, i.e., not as an integral part of the beneficiary's Part B election. The enhanced benefit would provide a yearly dollar limit on Part B out-of-pocket expenses, which would be indexed annually to recognize increases in per capita Part B program expenditures. The enhanced Part B option would also be financed by a premium which would be added to the current Part B premium for those electing this option.

Dollar Impact on HI Trust Fund

The recommended restructure plan would result in $12.83 billion in Part A program savings and $24.975 billion in additional revenues during the period 1985-1995. (See Appendix H, Table 1.)

CHAPTER IV - BENEFIT STRUCTURE

B. Long Term Care

Background

Medicare was designed to provide long term care services--skilled nursing facility and home health services--with the intent of providing for acute care services in less intensive and, therefore, less expensive settings. The Medicare program was not designed to respond specifically to chronic care needs over a sustained period of time. It is important to bear in mind that Medicare has historically been considered a health insurance program. Questions have been raised concerning the appropriateness of Medicare becoming involved in what is sometimes considered the social component of long term care.

The inclusion under Medicare of coverage for care provided in extended care facilities (subsequently designated skilled nursing facilities (SNFs)), was intended primarily as a cost-saving measure. The idea was to pay for the skilled nursing care required by patients who no longer needed services of an acute care hospital, but who were still too sick to go home. Thus, coverage was limited to persons recovering from an acute illness who need skilled nursing care or skilled rehabilitative care on a daily basis. Coverage is limited to no more than 100 days of care in a participating SNF in a benefit period. Patient cost sharing begins after the 20th day. The Medicare program will not pay for care if the beneficiary is in the SNF for custodial care or needs skilled nursing services or rehabilitative care on less than a daily basis.

Medicare's home health benefit is also designed primarily for the patient who is recovering from an acute medical episode. Eligibility is limited to those who are homebound and whose primary need is for either skilled nursing care on an intermittent basis, or physical therapy, or speech therapy. In implementing these definitions, Medicare has emphasized the rehabilitation and short term nature of the program. The definition of skilled nursing has been interpreted to mean care that only a licensed nurse can provide. Therapy services must require the skills of a trained therapist in order to assure the safety of the patient and effective treatment. A limited number of additional services--occupational therapy, medical social services, home health aide services and certain supplies and equipment--are also covered for

patients who meet the basic coverage requirements. There is no patient cost sharing and no limit on the number of available visits. Home maintenance and meal services are excluded.

Discussion

During deliberations on long term care the Council recognized the magnitude of the problems faced by an aging population, given the fragmentation of services offered to beneficiaries needing ongoing or chronic care of a somewhat less than acute nature. The members acknowledged that as the Medicare population ages the need for chronic long term care services can be expected to increase.

One member suggested the possibility of developing a "Part C" for the Medicare program. The plan would establish a separate trust fund for long term care benefits. It would require that the population aged 55-65 contribute to the fund or show that they had provided a comparable plan of care for themselves. General interest was expressed in the concept. Several members suggested that the idea deserved full development, but given time constraints, this Council could not undertake that development.

The Council summarized the problems of long term care delivery by agreeing that, in principle, a comprehensive range of long term care services is covered by Federal programs. In practice, however, the actual coverage is determined by the level of funding and program design features. Since no single program funds a comprehensive array of long term care services, the effectiveness of coordination across programs (e.g. Medicare/Medicaid/ Administration on Aging) should be evaluated.

The Council believed that, absent more conclusive information regarding the long term care needs of the elderly, and the potentially high cost of such care, the expansion of long term care benefits in the Medicare program would be inappropriate, especially at a time when it is experiencing serious financial problems. Furthermore a piecemeal attack on the overall problem of financing long term care would not work.

Development of a comprehensive program appeared to be a more desirable approach. In that approach, it would be essential that the program target those who are eligible and who would be receiving conventional long term care to receive less expensive alternative care. Most importantly, any new development in alternative care should not be used as an additional service but rather be employed as a substitute to more expensive conventional care. This concern was highlighted in testimony given by the Department of Health and Human Services before the Senate Finance Committee after the close of Council deliberations. In that

statement the Department witness testified that, "other studies conducted by HCFA and the General Accounting Office indicate that an expansion of home health services can be more costly than nursing home care if there is a lack of targeting, that is, if the individuals served are not truly at risk of institutionalization."

Recommendation

The Council unanimously approved the following recommendation:

The growing cost of hospital and nursing home care has prompted studies of the costs and cost-effectiveness of care delivered in alternative settings by both the public and private sectors. Some studies have shown that targeting the population offered home care services as an alternative to institutionalization is a more efficient and appropriate way to deliver care. The Advisory Council on Social Security suggests that in developing a comprehensive long term care program, the Secretary of Health and Human Services be guided by the results of these studies.

Dollar Impact on HI Trust Fund

Unknown.

CHAPTER IV - BENEFIT STRUCTURE

C. Preventive Services

Background

Preventive services are generally discussed in terms of three levels of prevention. Primary prevention reduces the likelihood of the development of a disease or disorder; secondary prevention interrupts, prevents or minimizes progression of a disease or irreversible damage from a disease at an early stage, and comprises the early detection and treatment of disease before irreversible damage has occurred; tertiary prevention focuses on the progression of damage in a disease where such damage has already occurred irreversibly, with emphasis on measures to alleviate disability and to slow progression of established diseases or disorders.

In general, Medicare coverage is limited to care that is reasonable and necessary for the treatment of an illness or injury. With the exception of a specific statutory authorization to cover pneumococcal pneumonia immunization, Medicare does not cover primary preventive services.

Medicare coverage guidelines require that if (secondary or tertiary) ambulatory preventive services are furnished, they are covered only if they are furnished as an integral part of the physician's personal professional services in the course of treatment of an illness or injury. Services of providers, other than physicians, may also be covered only when furnished under a physician's order and direct supervision. Therefore, preventive services given in patient education programs are not covered unless they are furnished by a provider of services (i.e., a hospital, skilled nursing facility, or an entity providing outpatient treatment) and are part of covered services that are necessary for the treatment of an individual's illness or injury.

Information collected over several years from studies by researchers indicates that a specific group of clinical services can be arranged in a manner that is both potentially cost-effective and medically efficacious. Generally, these researchers, such as Breslow and Sommers and the Canadian Task Force,[1/] base their recommendations on expert opinion rather than specific evidence resulting from clinical trials. Most third-party payers do not cover these

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1/Breslow, Lester and Sommers, Anne, New England Journal of Medicine (Vol. 296 pp. 601-08, March 1977).
Canadian Task Force on the Periodic Health Examination.

services because of the lack of convincing scientific studies that attest to the cost-effectiveness of preventive services. Clinical preventive services include procedures such as: breast examination, digital rectal examination, blood pressure screening, history and physical examination, influenza immunization, and papanicolaou smear. Medical literature suggests that the frequency of these procedures ranges from annually to every two years. Some vary by age category with the over 75 population requiring most procedures annually.

Discussion

Through public hearings and panel discussions, the Council heard support for offering preventive services to Medicare beneficiaries. While the literature and research concerning the cost-effectiveness of offering such services is inconclusive, it is possible that offering such services may improve health and mobility in the elderly population, resulting in a long-term cost savings.

Council members noted that the Health Care Financing Administration's recently initiated demonstration projects may provide better guidance in formulating policy for preventive services.

It was also noted, however, that to identify preventive services as a separate reimbursable item could potentially cost more since often these services are rendered as part of a routine office visit (e.g., blood pressure check) with no separate, additional charge.

Members generally agreed that there must certainly be services that could be shown to be cost-effective, but that a comprehensive study should be undertaken to identify those particular services before consideration is given to any expansion of Medicare's coverage of preventive care services.

Recommendation

A substantial majority of the Council approved the following recommendation:

The Advisory Council on Social Security in general believes that the elderly can benefit from prevention-oriented programs and screening procedures. The Council suggests that a comprehensive review of the Health Care Financing Administration's demonstration projects to assess the economy and efficacy of expanding Medicare coverage to include preventive services be undertaken prior to any change in the law.

Dollar Impact on HI Trust Fund

None.

CHAPTER IV - BENEFIT STRUCTURE

D. Voluntary Vouchers

Background

There is a growing consensus that supports the restructuring of the Medicare program to offer options that would introduce a greater degree of competition in the health care delivery system. Vouchers are designed to control costs and promote competition by providing each beneficiary with a predetermined amount of purchasing power for health care services. Beneficiaries could enroll in federally qualified health care delivery systems. These systems would receive a predetermined amount for providing care and would have an incentive to control costs in an effort to attract beneficiaries.

Under a voucher system a Medicare beneficiary would be provided with a credit to purchase health care services from a federally qualified health care delivery system. The voucher's value would be equal to some percentage of the historical cost of providing services to beneficiaries with the same actuarially determined characteristics. (This calculation is referred to as the adjusted average per capita cost, AAPCC). Setting the voucher value below the AAPCC would encourage beneficiaries to become cost conscious and, possibly, result in an immediate savings for the Medicare program.

A federally administered voucher system could require participating health care delivery systems to offer a minimum benefit package at least equivalent to regular Medicare coverage to all voucher recipients. Beneficiaries could change systems, or return to the current Medicare program, during annual open enrollment periods. Delivery systems could not refuse to enroll a voucher recipient because of a preexisting medical condition.

A Medicare voucher system could function like the current Federal Employees Health Benefits system. The Federal government could act as a conduit for making regular premium payments to health care delivery systems which provide services to Medicare beneficiaries. Voucher recipients choosing plans with premiums greater than the value of the vouchers would have to pay the difference. Recipients would remain free to purchase supplemental coverage.

Discussion

The Council heard several presentations on the use of a voucher system as part of the Medicare program. There was general agreement that a voucher system represents one means for the Medicare program

to promote competition in the health care industry. Health care delivery systems and beneficiaries would be given greater incentives to use cost-effective services.

The Council did express concern that beneficiaries be provided adequate assistance in the process of choosing alternative health care plans. Also the Council made clear its opposition to any proposal which would make beneficiary participation mandatory. The Council opposed any proposal which would require beneficiaries to enroll in a voucher system as a prerequisite for Medicare reimbursement. This position also included any proposal which would not permit beneficiaries the opportunity to discontinue participation in a voucher system after enrollment for a stipulated period of time.

The Council was aware that there were many questions regarding the details of a voucher system which its policy statement does not address. These questions will best be resolved through the drafting of legislation and regulations implementing a voucher system.

Recommendation

A substantial majority of Council members approved the following policy statement:

The Advisory Council on Social Security recommends that the Medicare statute be amended to provide Medicare beneficiaries with the option of purchasing their health care services through a voluntary voucher system. All beneficiaries should be given the choice of obtaining the full range of Medicare benefits through either the current reimbursement system or through means of a voucher.

The Council recommends that, in developing a voluntary voucher system for reimbursing health care delivery systems, it is essential that steps be taken to assure that all beneficiaries, whether or not they choose a voucher, receive the full range of Medicare benefits. A voluntary voucher should provide beneficiaries with a reasonable degree of certainty as to their out-of-pocket expenses for Medicare covered services. Beneficiaries should also have an annual opportunity to withdraw from the voluntary voucher system and return to the traditional Medicare program without any penalty. The Council believes that the Department of Health and Human Services and the Health Care Financing Administration should actively administer this program to assure that beneficiaries are adequately protected.

The Advisory Council on Social Security views a voluntary voucher system for the Medicare program as an important step in the development of competition within the health care industry.

Beneficiaries should have the widest possible choice of alternatives for receiving health care services. Physicians and providers should have an incentive to develop more efficient and cost-effective health care delivery systems. Competition within this industry can be an important and effective way to control the growth of health care expenditures. The policies of the Department of Health and Human Services and the Health Care Financing Administration should foster the development of competition within the health care industry.

Impact on Medicare Trust Funds

Initial start-up costs of $50 million.

CHAPTER IV - BENEFIT STRUCTURE

E. Indexing Supplementary Medical Insurance Deductible

Background

For most services covered under Medicare's Part B Supplementary Medical Insurance program beneficiaries are responsible for the payment of an annual deductible, currently $75 1/ Since the beginning of the program in 1966, the SMI deductible amount has been specified in the law. Originally, the deductible was $50. In 1973, it was raised to $60. The most recent increase to $75 occurred in 1982. Specific Congressional action is required to change the amount of the deductible.

The relatively static SMI deductible differs from the Hospital Insurance deductible which is adjusted annually to reflect increases in the costs of hospital care. The fixed annual SMI deductible was modeled after the traditional indemnity-type health insurance which covered non-institutional services. The two increases which have been legislated recognized that rapidly escalating medical costs had eroded the value of the deductible as a deterrent to unnecessary utilization.

Discussion

In spite of two prior increases, the SMI deductible has not kept pace with either medical care cost inflation or the amount of beneficiary income. The 1982 increase to $75 provided a total increase of fifty percent since 1966. In contrast, medical care prices have increased nearly four-fold since 1967. Mean beneficiary income, which was under $2000 for non-institutionalized elderly in 1966, had more than doubled to $4212 in 1973 when the deductible was raised by 20 percent. When the deductible was raised to $75 in 1982, the non-institutionalized elderly's mean income had risen to $9704, nearly four times the average in 1966.

The Advisory Council was aware that proposals have been made to provide automatic increases in the SMI deductible to reflect changes in the costs of medical care. Proponents of such proposals cited the need to adjust the deductible in order to maintain its relative proportion to costs of covered services and to preserve its usefulness as a deterrent to unnecessary utilization of services.

1/ There is no deductible on home health services and pneumococcal vaccine.

Opponents have noted that beneficiary overall out-of-pocket liability for covered services has risen considerably more than the deductible increases due to the widening gap between Medicare's reasonable charge and the physician's actual charge, which must be borne by beneficiaries on unassigned claims. Also, a low SMI deductible in relation to the inpatient hospital deductible (currently $304) may encourage greater use of more cost effective outpatient services.

The Council took the position that increases in the Part B deductible have not kept pace with the escalation in retirees' income that has resulted from the indexing of retirement benefits to the Consumer Price Index (CPI) since 1974. The increasing cost of medical services under Part B without a commensurate increase in the deductible has resulted in an increased cost burden on the SMI trust fund. Since approximately 75 percent of the SMI program revenues are derived from general revenues, this eventually translates into increased income taxes for younger workers. In effect, there is an intergenerational shift in costs from the retired population to the working population.

Periodic adjustments in the deductible provisions of the Medicare statute have not kept pace with the growth in beneficiary income increases resulting from cost of living increases in their retirement benefit.

The Council discussed indexing the deductible to a medical component of the CPI since that would more appropriately reflect the relationship between the deductible and the cost of medical services. However, concern was expressed that with the historically higher increase in the medical component as opposed to the general CPI, beneficiary out-of-pocket cost for the deductible could eventually substantially exceed increases in their income. Consequently, indexing the deductible to the general CPI was endorsed by the Council.

The Council considered the possibility of recommending an increase in the deductible, effective in 1985, but with the initial computation reflecting increases that should have been applied had the Part B deductible been indexed since 1974. After considering the significant increase in the deductible that would result from that methodology ($75 to $134), the Council recommended instead that automatic indexing of the Part B deductible to the CPI should be implemented as soon as feasible.

Policy

A substantial majority of the Council members adopted the following policy:

The Advisory Council on Social Security recommends that the current Supplementary Medical Insurance (Part B) deductible be indexed to the Consumer Price Index (CPI) to keep pace with inflation and with increases in beneficiary income. The indexing should begin as soon as feasible.

Dollar Impact on SMI Trust Fund

If implemented beginning in calendar year 1985, there would be reduced SMI outlays of $680 million for the period 1985-1989. (See Appendix H, Table 2.)

V REIMBURSEMENT

Introduction

Medicare's reimbursement methods were originally designed to follow rather than influence traditional market forces. As the program has steadily increased its share of the health care marketplace, revisions have been made to encourage greater fiscal responsibility on the part of providers of services.

Originally, Medicare reimbursement for institutional services was based on the reasonable cost of those services, retroactively determined on the basis of actual costs incurred. In recent years, some limits on these costs and limits on cost increases were added. Beginning in October 1983, Medicare is phasing in a prospective payment system for hospitals, based on diagnosis-related groups.

Reimbursement for physicians' services and other suppliers of services is generally based on a reasonable charge which takes into account customary and prevailing charges in the local area. Since the mid-1970s increases in physicians' reasonable charges have been limited by an index reflecting increases in overhead and general earnings levels.

Recognizing that the Medicare program should become more proactive to influence charging patterns and encourage cost-effectiveness, the Council reviewed current reimbursement policies for ways to achieve these goals.

CHAPTER V - REIMBURSEMENT

A. Prospective Payment

Background

Costs of the Medicare program are rising at rates far exceeding the costs of most other goods and services. Since 1979, the cost of this program has nearly doubled. Both the manner in which services are provided and the method of reimbursement for those services have contributed to this escalation of expenditures. Critics point out that the third party reimbursement system insulates beneficiaries from the cost of services. Providers and physicians have no incentive to control either the number or the cost of their services.

There have been a number of statutory attempts to control the growth of Medicare expenditures. Efforts to control capital expenditures, utilization and reimbursement in this manner have met with only limited success. The most recent initiative, a prospective payment system for hospitals based on diagnosis-related groups (DRG's), shows some promise of curbing the rate of increase in institutional care costs.

Under the original Medicare law hospitals and other institutional providers of services were to be paid on a retrospective cost reimbursement basis. In effect, hospitals were paid by Medicare for whatever reasonable costs they incurred in providing care to Medicare beneficiaries. That approach was justifiable in 1965, because it followed generally accepted accounting principles. Also there was little Federal experience with hospital reimbursement. However, the extraordinary inflation in hospital costs over the past decade has been attributed, in part, to the traditional Medicare retrospective cost reimbursement system which provides incentives for hospitals to increase, not to constrain costs.

While recognizing the need for major structural reform to eliminate the inflationary spiral in hospital expenditures, Congress also provided interim changes in reimbursement, P.L. 97-248, The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). TEFRA extended the scope of the limits on allowable costs paid to hospitals for the care of Medicare patients. The cost limits apply to total Medicare inpatient operating costs. In establishing the limits, each hospital's cost is adjusted using a case-mix index based on Diagnosis Related Groups (DRGs). Previous limits applied only to routine hospital costs and did not include the cost of

ancillary services. In addition to the new cost limits, the TEFRA provisions established target rates which limit the amount by which a hospital's reimbursement can be increased each year.

The provisions in TEFRA laid the groundwork for the development of a nationwide prospective payment system. As requested by Congress, the Department of Health and Human Services developed a prospective payment proposal and submitted the report on December 28, 1982. The proposal was cost neutral, that is, the overall expenditures would be the same as those projected under the TEFRA legislation. Congress subsequently enacted prospective payment legislation which included the Department's five basic elements:

1. Hospitals will be paid on a per discharge basis, based on diagnosis.

2. Hospitals in a geographic area will be paid the same rate for the same services.

3. Payment rates will cover all operating costs; initially, capital and medical education will be paid separately. These items will be "passed through" the cost report, that is, not subjected to DRG rate limitations.

4. Special provisions will be made for cases with extraordinary lengths of stay (outliers).

5. The system will cover short-term general hospitals.

The prospective payment system is being phased in over a three year period beginning October 1, 1983.

Discussion

The Council discussion on the topic of prospective payment brought to the forefront some important issues related to the prospective payment legislation then pending in Congress. The Council considered, but did not act on, a proposal to go further than merely supporting the legislation mandating prospective payment for Medicare to support an "all-payors" system encompassing the entire health care delivery system. The sensitivity of the Council to the need to control costs during implementation of a major new payment system was evident in discussions regarding the possibility of supporting efforts to dovetail prospective payment with a target rate of increase and the 223 cost limits[1/].

1/Limits set by Section 223 of Public Law 92-603.

In early deliberations the Council unanimously adopted a policy supporting the principle of a Medicare prospective payment system. The Council elaborated on two important aspects of the prospective payment system in its final deliberations.

The first concerned limiting increases in payment per admission (the DRG rate) to a rate equal to or less than the annual increase in the Hospital Input Price Index (HIPI). The Council discussed the policy, currently in effect, of increasing DRG rates by the HIPI plus one percent, and the savings which might accrue from a lower limit. The one percent add-on is described as allowing for technological advances. The Council endorsed a policy urging the Secretary of Health and Human Services to "exert care to limit any annual rate of growth in the DRG rates that is above the annual rate of change in the hospital input price index".

A second issue involved the treatment of capital cost under prospective payment. Present policy allows such costs to be "passed through", that is, not subjected to DRG rate limitations. In preliminary discussion Council members expressed concern that capital be given immediate attention. The consensus supported a Congressionally mandated 18 month study of capital by the Department of Health and Human Services. No formal recommendation on capital was issued by the Council.

Recommendation

The Council unanimously approved the following recommendation:

The Advisory Council on Social Security supports the principle of providing prospective payment rates under Medicare for inpatient hospital services. Furthermore, the Council recommends that the Secretary of Health and Human Services exert care to limit any annual rate of increase in the DRG rates that is above the annual rate of change in the hospital input price index.

Dollar Impact on HI Trust Fund

Substantial savings are projected if annual increases in DRG rates are held to the level of increase in the Hospital Input Price Index (HIPI). If implemented in 1988, savings from this limitation will be $34.52 billion through 1995. (See Appendix H, Table 1.)

CHAPTER V - REIMBURSEMENT

B. Medical Education Expenses

Background

The Medicare program reimburses hospitals for a share of the costs of training residents, nurses and other health care personnel. Medicare's share is based on the proportion of total charges accounted for by Medicare patients. In this manner, Medicare funds help support the advanced clinical training of medical school graduates to prepare them for unsupervised practice in the community.

In its Report to Congress on the Hospital Prospective Payment System, which was subsequently enacted, the Department of Health and Human Services recognized that teaching hospitals incur additional costs over those of community hospitals because of the severity of illness in patients treated, the more intensive care provided and the greater consumption of resources. In the Social Security Reform Act of 1983, the Congress chose to adjust payments to teaching hospitals to account for these factors based upon the number of residents per bed as an operational measure of the complexity of care.

In 1980, the Hospital Insurance trust fund spent an estimated $1.4 billion for the direct and indirect cost of medical education programs. In 1983, these expenditures are expected to be $1.8 billion, a 28.6 percent increase. With the implementation of prospective payment for hospitals the cost of medical education programs will continue to grow. This is due to a provision in the prospective payment legislation which doubled the allowance providers receive for indirect educational expenses.

Discussion

Because of its concern about rising Medicare costs, the Council reviewed current reimbursement policies relating to the education and training of health professionals. Questions were raised about the appropriateness of the public policy to make expenditures from the HI trust fund for these purposes.

Historically, expenditures for the education and training of health professionals have represented between 4 and 6 percent of annual HI trust fund expenditures. If Medicare funding for these programs is withdrawn in 1987, the total program savings through 1995 could eliminate up to 20 percent of the projected deficit. The exact amount cannot be predicted because residents provide substantial

medical service during their training. Removal of the indirect medical education costs could be transferred to the level of payment under DRGs, since they might represent real costs of rendering services to critically ill patients.

Recommendation

A substantial majority of the Council approved the following recommendation:

In view of the financial crisis facing the Medicare program and the expanding supply of physicians and other health care professionals, the Advisory Council on Social Security believes that there is a serious question concerning the use of the Medicare Hospital Insurance trust fund for the training of physicians, nurses, and other health care professionals. The Council recognizes that the Medicare program has had a significant impact upon the supply of health professionals by subsidizing the expenses of training and medical education for these groups. However, the Council thinks that the involvement of the Medicare program in underwriting these costs is inappropriate since the program is designed to pay for medical services for the elderly, rather than to underwrite the costs of training and medical education.

The Council recognizes that the extent of public support for medical education and training health professionals is a complex and difficult matter to determine and implement. The abrupt discontinuance of the use of the Medicare Hospital Insurance trust fund for medical education without an analysis of the impact upon training institutions and a concomitant search for alternative public funding sources would be a disservice to the training and medical education institutions in the country and the training of prospective health care professionals. The Council believes that a study on the restructuring of medical education financing should be undertaken immediately in order to recommend another source for training support that is now being provided under the Medicare program. The Council does not intend to suggest that governmental funding for medical education is inappropriate. This study should be completed within three years under the direction of the Department of Health and Human Services.

Dollar Impact on the HI Trust Fund

If Medicare support for medical education expenses is withdrawn beginning in 1987, savings to the HI trust fund would be $40.8 billion through 1995. (See Appendix H, Table 1.)

CHAPTER V - REIMBURSEMENT

C. Reimbursement for Physicians' Services

Background

Since the beginning of the program, Medicare has determined the amount of reimbursement for physicians' services on the basis of a statutorily defined "reasonable charge" formula. Under this formula, the Medicare-allowed reasonable charge is generally the lowest of: (1) the physician's actual charge for the service; (2) the physician's customary charge for the service; or (3) the prevailing charge for that service in the community. Program payment is 80 percent of the reasonable charge after the patient has met a $75 annual deductible.

Medicare contractors maintain profiles of customary charges for each physician which are updated July 1 of each year to reflect the physician's actual charges in the preceding calendar year. Prevailing charges are updated at the same time and are set at the 75th percentile of customary charges in the locality. Since the mid-1970s, the increase in prevailing charges has been limited to the lesser of the actual increase or the increase in an "economic index" reflecting increases in costs of maintaining an office practice and general earnings in the labor force. When a claim is filed, a comparison is made of the actual charge, the physician's customary charge and the prevailing charge, and payment is based on the lowest of these charges.

The Medicare reimbursement mechanism for physicians' and other services covered under the Supplementary Medical Insurance program was designed to assure adequate access to care for program beneficiaries and to provide uniform protection against the costs of that care. Basing the payment amount on actual established charging patterns assured that Medicare followed the private marketplace. This posture avoided the appearance of Federal intrusion into the practice of medicine which might impede access to care. The 80 percent reimbursement rate provided payment for a uniform proportion of covered medical expenses in keeping with indemnity insurance principles although actual expenses varied in accordance with local charging patterns.

Discussion

In reviewing the operations of the Supplementary Medical Insurance program, the Council identified several problems with the current reasonable charge reimbursement system. As structured, the

system fails to curb excessive inflation in medical costs and, in fact, contributes to that inflation. By following previously established charging patterns, the reasonable charge system helps to perpetuate payment differentials among geographic areas and medical specialties which cannot be attributed solely to differences in the economic climate. Payments in urban areas average 23 percent higher than payment for similar services in rural areas and there are similar disparities between specialists and general practitioners in the same area. Other payment imbalances exist between so-called "technical" and "cognitive" services, with the former, including high technology, diagnostic, laboratory, radiology and surgery compensated at higher rates than ambulatory and primary care. Because it has risen at a slower rate than actual and customary charges, the economic index assures continuation of these payment imbalances.

The Council reached a consensus that the concern over access to care, which led to the current reasonable charge system, is no longer an overriding concern. The Medicare reimbursement formula should be altered to promote more actively payment equity and utilization of cost-effective types of care. Where reimbursement is to continue on a fee-for-service basis, the Council recognized a need to achieve at least some payment reforms in the near future. Most members agreed that fee schedules are a desirable means of accomplishing this goal.

The Council reached general agreement that fee schedules should be as uniform as possible, with adjustments made initially and periodically for differences in cost of living and/or costs of maintaining a practice. The schedules should be designed with sufficient specificity to discourage any tendency to fragment billing. Fee schedules should be particularly effective in controlling overall costs of physicians' services with regard to those treatments and procedures in which Medicare beneficiaries are a significant portion of the total patient load.

Since fee schedules would be a major revision to the current reimbursement system, the Council reasoned that development and implementation of the schedules should take account of the interests and concerns of all parties, i.e., physicians, patients and payors. The medical profession should be involved in development of the schedules. Implementation could be phased in--similar to the phase-in of hospital DRG payments--in order to prevent serious disruption to established charging patterns. Once the schedules are established, a mechanism for adjusting them to meet changing economic conditions and practice patterns should be developed. Again the interests and concerns of all parties should be taken into account.

Fee schedules could be used to slow the rate of increase in Medicare payments for physicians' services. However, another Council goal was to encourage payment equity and cost-effective use of services. Overall cost control was a longer range goal.

Congress has directed the Secretary of Health and Human Services to undertake a study of the viability of extending the diagnosis-related group payment system for reimbursing inpatient hospital services to include reimbursement for associated physicians' inpatient services. The Council generally supported the carrying out of such a study. However, the Council recognized that, if the DRG extension to physicians was found feasible, it would be a longer range payment reform which could not be implemented until after the DRG payment system for hospitals is completely in place and functioning effectively. Also the Council concluded that, when feasible, the study should be expanded to include DRG-type payments for services furnished in hospital outpatient departments.

In expressing the desire to move to fee schedules, the Council did not wish to be interpreted as opposing the use, development of and/or experimentation with other alternative forms of reimbursement. Capitation reimbursement, which has proven cost-effective in HMOs, should continue to be encouraged. Global fees which cover a package of services rather than individual procedures might be a desirable refinement of the basic fee schedule system. Other alternative methods of reimbursement which should be considered include, but are not limited to: capitation payments to individual physicians; preferred provider organizations (PPOs); and individually negotiated fees. The Council concluded that these alternatives need further stuuy and should be addressed in a separate forum. The Council urged cooperation among third party payors and the physician community in developing viable alternative reimbursement methods.

Recommendation

A substantial majority of Council members approved the following recommendation:

The Advisory Council on Social Security believes that Medicare's statutorily mandated reasonable charge method of reimbursement has not been effective in controlling expenditures or encouraging utilization of cost effective services. As a step toward reform of the system, the Council recommends a statutory revision to authorize reimbursement based on fee schedules, adjusted initially and periodically for differences in cost of living and/or maintaining a practice. The Council urges that development of the schedules be undertaken with due concern for all interested parties, direct input from the medical profession, and maintenance of support for capitation reimbursement.

Dollar Impact on SMI Trust Fund

Potential long range savings--not quantified.

CHAPTER V - REIMBURSEMENT

D. Assignment of Benefits for Physicians' Services

Background

Payment for physicians' services under Medicare is carried out in one of two ways. First, the beneficiary may assign his right to be reimbursed directly by the Medicare program to the physician. If the physician "accepts assignment" of the benefit, he or she submits the bill directly to the Medicare carrier and agrees to accept the Medicare-determined reasonable charge as full compensation for that service. In this case, by law, the physician may bill the beneficiary only for applicable cost-sharing amounts; i.e., $75 annual deductible and coinsurance equal to 20 percent of the reasonable charge. The physician may not bill for the difference between the billed charge and what Medicare recognizes as reasonable. Alternatively, the physician may directly bill the Medicare beneficiary who in turn receives the Medicare reasonable charge (minus applicable deductible and coinsurance) from the carrier. The beneficiary pays the physician and is responsible for the cost-sharing as well as the entire difference between what Medicare pays and what the physician bills.

The major advantage to the physician of accepting assignment is the assurance of receiving the Medicare payment directly. Although he or she must still bill and collect the applicable deductible and/or coinsurance amount from the patient he is effectively guaranteed the Medicare payment (assuming the service is a covered service) i.e., there is no risk of non-collection of the Medicare portion from the patient.

The principal disadvantage to the physician of accepting assignments is that the beneficiary may not be charged more than the copayments applicable to the charge determined reasonable by Medicare. Additionally, since the reasonable charge amount is not usually known in advance, the physician must wait for the Medicare payment before billing the patient. Where the current customary charge exceeds Medicare's reasonable charge determination the physician may consider that the loss of the option to collect the additional charge outweighs the convenience and assurance of direct payment from Medicare.

For Medicare beneficiaries the principal advantage of securing medical services from a physician who agrees to accept assignment is the increased predictability of the amount of cost sharing for which they will be responsible. Additionally, the patient is relieved of the burden of submitting a claim to Medicare for the service. (Some physicians will agree to process the bill for the beneficiary

even where they refuse to accept assignment although an additional charge may be made for such service.)

Currently, physicians and suppliers accept assignment of benefits on approximately 50 percent of Medicare claims. The rate is not uniform throughout the country, however, ranging on a statewide basis from less than 20 percent to over 80 percent. The 50 percent Medicare assignment rate average may be misleading because this figure includes services provided to beneficiaries of both Medicare and Medicaid--usually referred to as "crossover claims"--which are required to be assigned. When crossover claims are excluded, the actual assignment rate is estimated to be in the 30-35 percent range.

While the assignment rate has remained relatively stable over the last 8 years, the amount by which Medicare claims have been reduced has increased. In 1981, on average, each Medicare claim was reduced by more than 23 percent (i.e. the Medicare allowance was 23 percent less than the amount billed). Total beneficiary out-of-pocket costs for physicians' charges in excess of reasonable charges were approximately $1.4 billion in 1982.1/

Discussion

Early in its deliberations, the Council recognized the controversy surrounding the current physician assignment system and devoted considerable review and discussion to the issues. A special hearing was held at which physician, beneficiary and insurer viewpoints were aired.

Critics of the current claim-by-claim assignment system charge that it fails to provide adequate financial protection for beneficiaries. Since physicians are free to charge more than Medicare's reasonable charge whenever they wish, patients may at any time become responsible for an unknown and potentially large payment above what Medicare pays. Such uncertainty impedes effective financial planning by beneficiaries and can lead to excessive worry and possible over-insurance with supplemental policies. Overall cost containment efforts are hampered by allowing physicians to shift additional costs to beneficiaries.

Physicians generally prefer the claim-by-claim assignment system over any system which would require the physician to decide for a specified future period whether or not to accept assignment. Many view retention of the current system as critical to assuring beneficiaries' access to physicians' services. Reasons for not accepting assignment range from inadequacy of reasonable charge

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1/Source of statistics - Unpublished data from the Health Care Financing Administration.

reimbursement rates and paperwork burdens to the desire to make financial issues a private matter between the physician and patient.

On the other hand, beneficiaries tend to resent suggestions that physicians make assignment decisions based on perceived ability to pay, noting that such decisions amount to a type of means test. Also, the assignment and reasonable charge systems are difficult to explain and create confusion for beneficiaries. Simplification of these systems could alleviate much of the uncertainty and permit the system to function more efficiently for both beneficiaries and physicians.

The Council discussed six possible recommendations with respect to the physician assignment system:

1. Medicare reimburses only those services furnished under assignment.

2. Physicians always or never accept assignment on a patient-by-patient basis.

3. Physicians always or never accept assignment for all patients.

4. As a condition of participation in Medicare, hospitals must require physicians to accept assignment for Medicare inpatients before being granted admitting privileges.

5. Establish two sets of physician providers--those who always accept assignment (under periodic agreements) and those who may accept assignment on a case-by-case basis. Provide incentives to encourage agreements.

6. Maintain the current system.

After extensive review of the options, the Council approved option 3, to require physicians always to accept or never to accept assignment on all patients. Agreement to participate would be on an annual basis and a change of election would be made 6 months in advance. The factors persuading the Council to this decision included: 1) the need to make liability more predictable for beneficiaries; 2) the increasing number of beneficiaries makes them a larger portion of patients so that physicians would be less prone to refuse to accept patients; and 3) the increasing supply of physicians should encourage competition for all patients, including Medicare patients.

The Council also decided that incentives for physicians to participate should be included in the recommendations. Billing incentives such as multiple-list claims, automated or electronic

billing with the program providing some of the necessary equipment and an electronic funds transfer (EFT) payment process were suggested. In addition, the Council recommended annual publication of a directory of participating physicians, to be available on a local basis.

The Advisory Council on Social Security considered the possibility of providing fiscal incentives in the form of higher payments for services furnished by participating physicians than for services of nonparticipating physicians. After review of the financial implications, the Council decided not to recommend any payment differentials. The persuading factor was the probability of cost shifing to patients of nonparticipating physicians.

Recommendation

A substantial majority of the Council approved the following recommendation:

The Advisory Council on Social Security recommends a statutory revision to the current Medicare assignment system. The revision would establish a physician participation agreement system under which physicians would annually elect whether they would "participate", i.e., accept assignment on all services to Medicare patients. Notice of intent to participate, or to withdraw from participation, would be made 6 months in advance. Claims for reimbursement for services furnished by physicians who decided not to participate would always be unassigned, and program payment would always be made to the patient who would be responsible for the physician's entire bill including any amount that exceeds Medicare's reasonable charge.

The Council recommends the following incentives for physicians to participate:

- Competition: The Medicare program would publish annually a directory of participating physicians. The directory would be published on a local basis, e.g., city, county or Standard Metropolitan Statistical Area (SMSA), as appropriate.

- Billing: Participating physicians could take advantage of streamlined billing and payment procedures. Such incentives could include provision for multiple-list claims, automated or electronic billing with the program providing some of the necessary equipment and an electronic funds transfer (EFT) payment system.

Dollar Impact on SMI Trust Fund

The Council viewed the proposed assignment system as cost-neutral since no revision in amounts payable was recommended. However, HCFA's Office of Financial and Actuarial Analysis believes that some increase in amount of services delivered will occur as participating physicians who previously did not accept assignment on all claims seek to maintain the same level of income from the program. The actuaries estimate increases in SMI outlays of $30 million in FY 1985 rising to $65 million in FY 1989. (See Appendix H, Table 2.)

CHAPTER VI - GENERAL

Introduction

In the course of their deliberations other issues were brought to the attention of the Council, by members, by presenters at Council meetings, or by witnesses at the public hearings. Since some of these had the potential for influencing future directions of the programs the members believed they were worthy of discussion. This chapter addresses four such issues ranging from internal operating procedures to general health market place trends which might affect Medicare.

CHAPTER VI - GENERAL

A. Medical Technology

Background

The increased growth and use of new technology procedures is often perceived as the major contributor to the rapid growth in health care expenditures. In fact, the intensity of hospital inpatient services, a measurement of various factors of which new technology is only one element, accounted for only 20.8 percent of the growth in hospital expenditures during the period 1970-1981.[1/] Frequently, new procedures reduce the total cost of treatment. They also permit treatment with greater effectiveness and reduce discomfort for the patient.

The Health Care Financing Administration makes an independent decision whether or not to reimburse each new procedure. HCFA receives an evaluation of each procedure from the National Center for Health Services Research. The decision whether or not to reimburse a procedure affects not only the care given to beneficiaries but, because of Medicare's market power, the entire health care industry.

Discussion

The Council heard testimony from the Director of the National Center for Health Services Research concerning their procedure for evaluating new procedures for HCFA. The Council agreed that the focus of these inquiries should be on the medical efficacy of new procedures. HCFA should reimburse technology which improves the medical care of the elderly and disabled who benefit from the Medicare program.

The Council agreed that the development of new medical technology and procedures should be encouraged. The United States has, over many years, achieved world leadership in technology applied to medicine. In a time of need for greater competitiveness in international commerce, health technology provides one area where United States leadership can be advanced further.

At the same time, the Council believed that greater attention should be paid to the question of reimbursement amounts. Initial reimbursement should be set at a level which will permit developers to recover the cost of their innovation in a reasonable

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1/Freeland, Marks, and Carol Ellen Schendler, "National Health Expenditures Growth in the 1980's: An Aging Population, New Technologies and Increasing Competition", Health Care Financing Review, March 1983, Vol. 4 No. 5.

amount of time. However, as a procedure becomes more widely used and the cost of each individual use declines, Medicare should adjust its reimbursement rate. Medicare should benefit from all of the cost savings which are the result of new technology and procedures.

Recommendation

The Council unanimously approved the following recommendation:

The Advisory Council on Social Security believes it should be the fundamental policy of the Department of Health and Human Services to promote the continuing development of medical technology.

The initial cost of a new technology is one criterion for assessment. Lower cost, brought by economies of scale, is another criterion. Value, however, is a criterion of no less importance. It must be measured by the benefit that new technology brings to medicine itself, to international competitiveness for the United States and, most of all, to the healthful lives of the American people.

Dollar Impact on Medicare Trust Funds

Unknown.

B. "Advance Directives" or Living Wills"

Background

The high cost of terminal illness is attracting increasing attention as all facets of health services are being scrutinized in these times of fiscal constraint. Medicare is extensively involved in paying for services provided to beneficiaries whose illnesses result in death. Seventy percent of all persons who died in the United States in 1978 were Medicare enrollees, and they accounted for 28.2 percent of total program expenditures.

The Medicare benefit is designed around acute, episodic illness, leaving gaps in coverage for patients with chronic or terminal illnesses. The Medicare benefit structure also gives the terminally ill little flexibility to select the level and type of care that is appropriate not only to their medical needs, but to their own and their families' emotional and psychological needs.

In an effort to minimize out-of-pocket financial risk, patients often use those services for which they have the most adequate insurance coverage--frequently acute inpatient hospital care--bypassing less costly alternatives. The result can be a substantial increase in total Medicare costs.

The high cost of terminal illness and the difficulty of decision-making during a medical crisis, have stimulated public interest in "advance directives". An "advance directive" lets people anticipate that they may be unable to participate in future decisions about their own health care. It can specify the types of care a person wants (or does not want) to receive. The directive may specify a surrogate who could make such decisions if the person is ever unable to do so.

"Advance directives" are not confined to decisions to forego life-sustaining treatment but may be drafted for use in any health care situtation in which people anticipate they will lack capacity to make decisions for themselves. However, the best known type of directive, formulated pursuant to a "natural death" act, does deal with decisions to forego life-sustaining treatment. Beginning with the passage in 1976 of the California Natural Death Act, 14 States and the District of Columbia have enacted statutory authorization for the formulation of advance directives to forego life-sustaining treatment.

The President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavorial Research supported the concept of advance directives.

Concerns about a loss of ability to direct care at the end of life have led various educational, religious and professional groups to promulgate documents, usually referred to as "living wills", by which individuals can indicate their preference not to be given "heroic" or "extraordinary" treatments. Living wills are one form of advance directive. Living wills were initially developed as documents without any binding legal effects. The intent behind the original "natural death" act was simply to give legal recognition to living wills drafted according to certain established requirements.

Discussion

The Council discussion of living wills centered on questions of the legality of offering such documents to Medicare beneficiaries. Some felt that if the opportunity to complete a living will was given to the beneficiary at the time of registration for Medicare, on a purely voluntary basis, there would be no legality issue. The documents themselves would be valid only in States with a "natural death" act or some similar legislation in effect.

Council members called for a statement which encourages States with existing legislation to offer a living will to enrolling Medicare beneficiaries and urging other States to enact legislation recognizing living wills. A sample copy of a living will appears at the end of this section.

Recommendation

The Council unanimously approved the following recommendation:

The Advisory Council on Social Security supports the concept of voluntary advance directives as a means of appropriate decision-making about life-sustaining treatment for incapacitated patients. Also, recognizing that this is an individual State determination, the Council encourages a voluntary program in the 14 States where advance directives are legal and encourages the other 36 State legislatures to enact such legislation. In the States where this is legal the Council suggests that a person be offered a living will when he/she applies for Medicare.

The Council further suggests that the guidelines employed for this voluntary program be those found in the report on "Deciding to Forego Life Sustaining Treatment" by the President's

Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavorial Research. The Commission also concluded that choices of patients, their families and health care providers may legitimately be limited in certain ways on grounds of public policy, professional judgment and consideration of resource scarcity.

The Council encourages HCFA to undertake a comparative study to assess what the impacts (financial and other) have been in those 14 States that have living wills compared to those States without them.

Dollar Impact on HI Trust Fund

Unknown.

DECLARATION

Declaration made this _____day of _____ (month, year). I, _____, being of sound mind, willfully and voluntarily make known my desire that my dying shall not be artificially prolonged under the circumstances set forth below, do hereby declare:

If at anytime I should have an incurable injury, disease, or illness certified to be a terminal condition by two physicians who have personally examined me, one of whom shall be my attending physician, and the physicians have determined that my death will occur whether or not life-sustaining procedures are utilized and where the application of life-sustaining procedures would serve only to artificially prolong the dying process, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care.

In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this declaration shall be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from such refusal.

I understand the full import of this declaration and I am emotionally and mentally competent to make this declaration.

Signed _____

City, County and State Residence

_____

The declarant has been personally known to me and I believe him or her to be of sound mind.

Witness _____

Witness _____

CHAPTER VI - GENERAL

C. Management of the Medicare Program

Background

The Health Care Financing Administration has responsibility for administering the Medicare program. This responsibility includes assuring that the funds are spent in the most cost efficient manner possible. Medicare beneficiaries and the American public in general have a right to expect that these programs are run without fraud, abuse or waste.

HCFA's duty in this regard becomes even more important in view of the projected funding crisis in the Hospital Insurance trust fund. The Council could not, in good conscience, recommend measures to raise revenues and reduce program expenditures without emphasizing the need for management controls.

Discussion

The Council heard presentations from the Office of the Inspector General of the Department of Health and Human Services and the President's Private Sector Survey on Cost Control (the Grace Commission) on ways to strengthen the management of the Medicare program. Although a few of the suggestions ran counter to positions taken by the Council, many of their ideas were incorporated in Council recommendations. The point to be emphasized is that these groups have worked, and continue to work, to find ways to contain the cost of the Medicare program and assure that it will carry out its mission of making quality health care available to the elderly and disabled in this country. The American people as a whole cannot be asked to make sacrifices to finance this program unless they are sure that program managers are striving to achieve this goal.

Recommendation

The Council unanimously approved the following recommendation:

The Advisory Council on Social Security believes the present effort should be encouraged to (1) improve the cash management of funds, (2) improve the operational management of the Medicare program, and (3) eliminate fraud, abuse and waste. Further, the Council urges careful review and analysis by HCFA of the recommendations of the President's Private Sector Survey on Cost Control (Grace Commission) and of the findings and recommendations of the Offfice of the Inspector General without its specific endorsement of any recommendation therein.

In addition, the Advisory Council takes note that the office of the present Inspector General has substantially increased the time and effort expended to minimize fraud, abuse and waste in the Medicare program and the Council urges that this increased emphasis continue.

Dollar Impact on Medicare Trust Funds

Unknown.

CHAPTER VI - GENERAL

D. Income-Related Premiums

Background

Eligibility for Medicare benefits is, generally, a question of each individual's entitlement status. The criteria do not include an individual's income or wealth as factors. Medicare, like the social security Old Age, Survivors and Disability Insurance programs, is a social insurance not a welfare program. This feature, that beneficiaries earn the right to benefits, is one of the cornerstones of the program.

Discussion

In seeking a means for resolving the fiscal crisis in the Hospital Insurance program, the Council discussed a variety of alternatives for reducing costs or raising additional rvenues. One alternative was to determine each person's eligibility for benefits or level of premium payments based upon his or her financial need.

This approach, generically referred to as "means testing", was rejected. The Council believes that Medicare should remain an entitlement program. This program represents a commitment by the American people to a fundamental social policy to assure that all members, including the elderly and disabled, have adequate access to health care.

Recommendation

The Council unanimously approved the following recommendation:

The Advisory Council on Social Security opposes any type of financial criteria in determining an individual's eligibility for Medicare benefits.

Dollar Impact on HI Trust Fund

None.

CHAPTER VII - ISSUES DESERVING FURTHER STUDY

Introduction

This chapter is devoted to identifying issues which the Council considered but, for lack of time, was unable to address in any substantive way. This is not to imply that the chapter reflects the only topics the Council considers worthy of study. Many ideas were raised in both meetings and public hearings that undoubtedly deserve more scrutiny. These are three subjects that generated considerable discussion and that the members believe should be pursued. If the Council remained active for a longer period many more issues would have been included in this chapter. The Council acknowledges the many thoughtful suggestions submitted from a wide variety of sources.

CHAPTER VII - ISSUES DESERVING FURTHER STUDY

A. Long Term Proposal for Restructuring Medicare[1/]

Public policy should be to expect the elderly to provide for a larger portion of the growth in their medical expenses rather than increasing taxes on the less affluent working age population. However, if the elderly are going to be expected to pay more of their own medical care costs, they also should be provided the means by which to increase their savings during their working years to meet the additional expenses after retirement. The following proposal, recommended for additional study, is one alternative for achieving the goal of increased savings to meet subsequent health care expenses.

The Proposal

This proposal is designed to allow an orderly process of restructuring the Medicare system that will both require and enable individuals to make provisions to pay for the bulk of their own medical care bills other than those attributable to catastrophic expenditures. The system is designed to be phased in over a thirty-year period. It is also designed to reduce the anxiety our senior citizens have about the possibility of being confronted with medical expenditures beyond their means to pay for them. The system would involve the following components:

The current Medicare tax for both employers and employees would be frozen at present levels.

A universal "health credit account" would be established for all working Americans including their non-working spouses for the purpose of providing an amount of money for the purchase of basic expected medical care during a normal retirement period. In addition, working Americans would be encouraged to set up a tax deductible health bank IRA which would allow them to set aside funds in addition to the government established "health credit account" up to a specified dollar level each year. The IRS would send a statement annually to all taxpayers which would specify the value of their "health credit account". The value will be equal to accumulated yearly credits which would be specified by Congress, plus the average government "T" bill rate compounded, in effect, an implicit interest payment. No actual funds will be set aside. It will be an accounting entry only. Upon age 59-1/2 or any year thereafter, the participant would be able to draw upon the balance of the "health credit account" for the purchase of medical insurance or actual medical care.

1/ This section was prepared by Council member Richard W. Rahn.

Those who choose to establish their own IRA health bank account in addition to the "health credit account" would be able to withdraw funds at age 59-1/2 for medical insurance or medical care, or continue to allow them to grow and begin withdrawals any year thereafter. Individuals would be encouraged to establish IRA accounts in order to purchase more medical care during retirement years, with less financial hardship and to offset possible hardships occurring because of unanticipated extended illness periods.

The current Medicare tax will be used to provide benefits for current beneficiaries and for those who retire in the next few years, and over time it will be used increasingly to fund the "health credit accounts".

Beginning in 1986, deductibles for Medicare payments will be gradually increased over a thirty-year period, until Medicare pays for only catastrophic care, which would be defined on an individual basis, such as costs that exceed "X percent" of after-tax yearly income. The actual level will depend upon the growth in value of the "health credit account", and the rise in the cost of medical care. However, even the catastrophic care would be coupled with some minimal co-payment, such as 10 percent, to ensure continued cost sensitivity on the part of the patient and the patient's family. This should reduce over-utilization of "heroic" medicine and encourage use of living wills. The cost of the current medical care program will fall, and the resulting revenue, after the catastrophic program costs, will be applied to the health credit funds.

Financial Effect

The "health credit account" will have no immediate financial effect on federal budget outlays and the deficit. However, over time it will increase government liabilities and will affect, depending on the "health credit" account level, actual outlays which would be funded by the existing HI payroll tax and perhaps additionally by expenditure reduction or some increase in other taxes.

The health bank IRA tax deduction will cause a reduction in federal tax revenues, depending upon the amount of the allowable deduction and the utilization rate. Hence, the deficit will be enlarged, but at the same time, private saving will be increased. This increase in national saving is likely to more than offset the revenue loss thus reducing rather than increasing "crowding out".

Provisions could be made to enable holders of health bank IRAs to make deductions for medical insurance or medical care during a period of unemployment. Like the existing IRA accounts, holders of these accounts would be able to withdraw them for other purposes provided they paid the tax penalty.

Benefits of the Proposal

1. It would, for the most part, solve both the short and long term financing problems of Medicare.

2. Over the long run, workers would be able to get coverage under the new system for substantially less than under the current system. Under current law, the HI tax rate will probably have to climb over 10 percent. But the new system could avoid this tax increase. These savings arise primarily because workers under the new system receive the benefit of the increased production and full market returns generated by their health bank IRA investments.

3. Further substantial cost reductions should be realized because the new system allows far wider scope for the operaton of private market incentives:

(a) It would increase competition in the medical sector by allowing private insurers and providers to compete for coverage of retirees. This competitive pressure would likely lead to the development and adoption of institutions with better cost controls, such as HMOs. The competition would increase pressure for development of lower cost medical procedures.

(b) Workers who choose to pay medical expenses directly out of funds accrued in their health banks would have a powerful incentive to conserve medical resources, because they personally will retain the savings. Such conservation would also lead to reductions in medical prices and costs because of reduced unnecessary demand. Workers will also have an increased financial incentive to maintain good health habits.

4. The new system will also sharply increase workers' control and choice over their medical coverage. The system would be diverse and flexible, allowing workers to choose from a myriad of options in the private marketplace the coverage best suited to each of them individually. Workers could choose the mix of institutional coverage and personal financial responsibility they desire. They would also have increased freedom to choose their retirement age, with earlier retirement allowed, and no penalties for later retirement.

5. The new system would provide essential government aid that people need -- catastrophic coverage for the elderly to protect against highly expensive long-term incidents and supplements for those without sufficient resources to pay for needed medical services. But the new system would at the same time maximize the role for the private sector within a framework enabling people to develop the resources to pay for private sector services.

6. The new system would also reduce the anticipated growth in government medical spending over the long run, with most elderly medical coverage provided through the private sector, in a much less expensive fashion.

7. As a side benefit, the reform is likely to increase national savings substantially, due to the funds stored away in the health bank IRAs. This will result in increased capital investments, jobs and economic growth.

In return for these benefits, the costs of the reform seem well worth it.

CHAPTER VII - ISSUES DESERVING FURTHER STUDY

B. Alternative Long Term Proposal for Restructuring Medicare[1/]

An alternative to the Long Term Proposal for Restructuring Medicare would retain some of the basic concepts included in the initial proposal but the IMA purchased by individuals would provide for catastrophic coverage, with Medicare continuing to cover basic health care needs. The current Medicare benefits would be maintained, but Part A and Part B would be combined with all such expenses financed, as Part A is at present, by a payroll tax paid during one's working life. However, the basic cost-sharing under Medicare would be modified to provide for a flat percent coinsurance on all medical expenses an individual incurred during a given year up to a catastrophic cap.

To insure against catastrophic expenses every individual, at age 52 or 55, who would be potentially eligible for Medicare, would be required to begin paying into an Individual Medical Account (IMA) which would be maintained by the Government. All contributions to the IMA would be deductible from gross income for income tax purposes.

For married couples, the IMA could be a joint account with a composite rate for married couples where both are employed and an individual rate for a single family wage earner. The amount to be contributed could be a specified flat amount or varied according to income.

When an individual became eligible for Medicare, the IMA would be available to cover catastrophic expenses arising from payment of the coinsurance. Catastrophic expenses would be defined along the lines outlined in the initial proposal, namely, a cap at 15 to 20 percent of one's after-tax income in any given year. The IMA would then be available to pay medical expenses that exceeded that cap.

By making the catastrophic coverage a function of one's income, the proposal would automatically reflect income differentials among the population at large. Once an individual had incurred catastrophic expenses, i.e. had incurred medical expenses equal to the determined percentage of their income, he or she would draw on the fund in his or her IMA to pay for these catastrophic expenses. If an individual did not incur substantial catastrophic expenses during his/her retirement years then upon death the contribution remaining in the account that he or she had made to the IMA, less interest, would

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1/ This section was prepared by Thomas R. Burke, the Council's Executive Director.

accrue to his/her estate. Any interest that had accrued from his/her remaining contribution would be transferred to a government "catastrophic health care bank". This health care bank would fund the catastrophic expenses of those individuals whose medical care costs exceeded the amount they had accumulated in their individual medical accounts. For example, a low income individuals with a small retirement income may incur catastrophic expenses that exceeded the value of his or her IMA. To protect such individuals once they had drawn down their Individual Medical Account the government health care bank would fund those expenses in excess of their IMA.

Under this proposal persons who do not fully exhaust the IMA would obtain a tax break during their high earning years in return for the foregone interest in their retirement years. In most instances the tax credit would exceed the interest income foregone during retirement years.

This would be an equitable approach. Individuals with very high income in retirement would have catastrophic expenses paid for from the IMA only when a higher dollar limit had been reached. Low income individuals, on the other hand, would be eligible for catastrophic coverage when a smaller proportion of medical expenses had been incurred since catastrophic would be defined as expenses in excess of a designated percentage of one's after tax income. As with the initial proposal, this proposal would have to be phased in and it would be several years before it would become fully operational.

Although this approach does introduce the concept of means-testing in the Medicare program, it is an approach which is not in anyway unique and does not depart from the current income tax structure. It would insure that elderly Americans who have adequate financial means to pay for a greater portion of their health care expenses would do so without unreasonable hardship. Those with lesser means would pay a lesser share of their costs; both would be protected, through their IMA and the government health bank, against catastrophic illness costs.

To be successful this would have to be a mandatory program where all elderly Americans who have attained a designated aged would be required to contribute to an IMA. In effect they would be required to invest some portion of their income during their working years to provide protection against catastrophic health care expenses they may incur in their retirement years. In a sense, they are purchasing a health insurance policy, but for which their investment less interest earned is refundable if not used.

Although this proposal does not alter the responsibility of Medicare to pay for basic health care needs of the elderly it does remove from Medicare a significant portion of the costs currently incurred, mainly catastrophic expenses.

This proposal is offered as a suggested area for further exploration for a long term alternative to the current Medicare program.

Benefits of the Alternative Proposal

1. Although under this proposal only catastrophic expenses would be funded by the IMA and Medicare would continue to cover basic health care costs, it would still remove a substantial portion of the current Medicare costs. The flat percentage coinsurance on all Medicare services would produce these savings. The more excessive health care expenditures would be shifted from the Medicare trust fund to the individual IMA and if that was exhausted to the health care bank.

2. This alternative would continue to instill cost-consciousness on the part of the health care consumer since the individual would be liable for a specific percentage of covered medical expenses he/she incurred until out-of-pocket expenses exceeded the designated percentage of the total retirement income.

3. The Medicare benefit package could be adjusted in the future depending on actuarial experience. Should the Medicare trust fund, which would be supported by FICA taxes paid over one's working years begin to accumulate a large surplus, the benefit package could be expanded or the taxes reduced until some actuarially sound level were reached. In effect, the removal of liability for catastrophic care costs from Medicare could allow for broader or additional coverage of needed health care services.

4. The use of "living wills" would be encouraged since beneficiaries would realize that if extraordinary measures were taken on their behalf, the cost of such measures would be paid from their IMA account resulting in the depletion of the estate eventually payable to their survivors.

5. Many of the benefits identified with respect to the initial proposal would also apply under this alternative.

CHAPTER VII - ISSUES DESERVING FURTHER STUDY

C. Enhancing Assistance to Consumers/Beneficiaries

The Council has not explored in any depth the matter of whether there should be a stronger role for consumers and beneficiaries in the Medicare program, and if so, what form or forms that role should take. However, the Council has heard from a variety of sources urging that, at the very least, information and assistance services to consumers and beneficiaries should be strengthened. In seven of the eight public hearings conducted by the Council, beneficiaries, organizations representing the elderly, even physicians and insurance companies, complained about beneficiaries receiving inadequate information, complicated instructions, and incomprehensible materials. They held the general but pervasive view that insufficient efforts are being directed to helping beneficiaries understand their rights as well as their responsibilities. In addition, the results of two studies commissioned by the Council support this perception.

The Council finds these sentiments persuasive; therefore, it urges the appropriate Federal agencies to strengthen their current program of services to beneficiaries and consumers, involving representative outside organizations and individuals wherever possible. In developing an enhanced program, the following elements should be considered and incorporated:

1. Devote more attention to the preparation of readable and comprehensible information for beneficiaries/consumers. Language should shun bureaucratic and programmatic jargon, and should be written with the reader's perspective in mind.

2. Define and implement a strengthened role for beneficiary/consumer interaction with the administering agency and its agents at the local as well as national level. Consideration should be given to the feasibility of establishing advisory committees to the Health Care Financing Administration (HCFA) and the Social Security Administration (SSA), as well as to the insurance companies who act as carriers and intermediaries for HCFA. These advisory committees might function at the District Office, Regional Office, and headquarters levels of the Federal agencies.

3. Develop and institute a comprehensive and extensive program of educating beneficiaries/consumers to features of the Medicare program. These might include printed

materials, the use of the broadcast media, seminars and workshops, and individual and group counseling. The Council very strongly recommends the use of volunteers to the fullest extent possible.

4. Clarify and define roles and responsibilities in this area between the Health Care Financing Administration, the Social Security Administration, and the carriers and intermediaries.

5. Provide ongoing, regular training to staff in SSA district offices so that they may better respond to inquiries from beneficiaries regarding Medicare.

6. Undertake an ongoing effort to evaluate the effectiveness of all aspects of the administering agency's services to beneficiaries/consumers.

7. Utilize the evaluation results in a continuous effort to improve those services.

CHAPTER VII - ISSUES DESERVING FURTHER STUDY

D. Limitations on Payment for Services Furnished to Employed Aged and Their Spouses

The Advisory Council on Social Security, during its appraisal of Medicare eligibility provisions, reviewed the question of coordination of health insurance benefits of beneficiaries who continue to be employed beyond the age of eligibility under Medicare. The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) provides that effective January 1, 1983 employers of 20 or more employees must offer, to their Medicare eligible workers, the option to select as their primary health insurance the group plan the employer offers to other employees. Where the Medicare eligible employee elects the employer's group insurance plan the Medicare program becomes the secondary payor on health claims.

The Council believes that this provision addresses their concern that whenever an individual continues to work beyond the age of Medicare entitlement and other insurance is available by reason of that employment, Medicare should not serve as the primary payor of their health insurance claims.

The Council does believes that a more extensive evaluation of the appropriate coordination of Medicare and employer-offered group health insurance is necessary with respect to the spouses of employed Medicare-entitled workers. Currently, when the Medicare-entitled worker elects the employer's group plan to be the primary payor and that plan covers his or her dependents, any Medicare-eligible spouse will also receive primary health benefits from the group plan rather than Medicare. However, it is noted that this provision applies only to spouses aged 65 through 69. It would appear that the provision could apply to Medicare-entitled spouses of any age.

Additionally, there are other situations where the worker is not yet eligible for Medicare but his or her spouse is eligible. Although the worker's group health insurance covers dependents Medicare will be the primary payor for the Medicare-entitled spouse. There may be circumstances where such spouses should receive their primary health insurance coverage from the worker's plan with Medicare serving only as a secondary payor. However, the Council acknowledged that more information and more extensive evaluation of the impact of such changes on employer costs, health insurance premium costs for all workers, employment opportunity for workers with older spouses, etc. is necessary before any recommendations could be made. The Council believes that the coordination of benefits for spouses of workers is an area deserving further consideration.

CHAPTER VIII - OLD AGE, SURVIVORS AND DISABILITY INSURANCE PROGRAMS

The Advisory Council on Social Security was charged with focusing its attention on the Medicare program as indicated in the opening chapter of this report. This charge was given because of the significant complexity of the program and the substantial fiscal problems projected for the Hospital Insurance (HI) trust fund.

At the time of this Council's appointment, the National Commission on Social Security Reform, appointed by the President, was considering the particular problems of the Social Security cash benefit programs, i.e., Old Age, Survivors and Disability Insurance (OASDI) trust funds. The Commission was charged with reviewing the financial condition of these trust funds, identifying and analyzing the problems threatening the solvency of these funds, and recommending appropriate solutions to the Secretary of Health and Human Services, the President and the Congress. Subsequent to submission of the Commission's report the Congress passed the Social Security Amendments of 1983 (P.L. 98-21) which incorporated many of the Commission's recommendations. (See Attachment I, Summary of Recommendations of the National Commission on Social Security Reform.) The Commission did not address the financing problems of the Hospital Insurance (HI) trust fund.

The Commission made several recommendations which have an impact on the Medicare program in general and the HI trust fund in particular. In some instances the Council made recommendations which corresponded to those of the Commission. Other recommendations reflected a similar approach to that taken by the Commission. There were, also, certain issues on which the two groups disagreed.

Both the Council and the Commission believed that the fundamental principle underlying both the Social Security monthly benefit program and the Medicare Hospital Insurance program, entitlement earned through contributions made during one's working years, should be retained. The Commission unanimously adopted a recommendation to this effect (Recommendation #1 of the Commission's final report). The Advisory Council expressed support for this same position in its disposition of income-related premiums (see Chapter VI, D).

The Advisory Council concurred with the recommendations made by the National Commission relating to universal social security coverage:

- that OASDHI coverage be extended to employees of nonprofit organizations on a mandatory basis as of January 1, 1984, and

- that State and local governments which cover their employees under OASDHI not be permitted to

terminate such coverage if the termination process is not completed by the enactment date of the new legislation.

The nonprofit organization proposal applies to small nonprofit organizations previously not covered and also requires all nonprofit organizations, including hospitals, that have withdrawn from coverage to again be covered by OASDHI. The proposal does not require mandatory OASDHI coverage for State and local government employees due to constitutional considerations. However, once States or local governments have voluntarily elected coverage, they would be prohibited from withdrawing. The Council believes coverage under OASDHI of all persons in paid employment is a desirable goal in contributing to the fiscal stability of all three trust funds.

One of the themes underlying findings of both groups was recognition that any solution to program financing problems must include provisions for a reasonable increase in the financial responsibility of individual beneficiaries. The Commission addressed this theme by recommending that social security beneficiaries whose income exceeds certain limits pay Federal income tax on a portion of those benefits (Recommendation #7). The Advisory Council has recommended a restructure that will improve the current Medicare Part A hospital insurance benefit but will also require additional cost sharing by beneficiaries through an annual premium. Additionally, the Advisory Council believes that a major part of the solution to the Medicare funding crisis is to bring about a change in the health care purchasing behavior of all Americans by making them more responsible for the cost of their health care services. For this reason, the Council recommended that a cap be placed on tax exempt employer-paid health insurance premiums (see Chapter II, F).

Public Law 98-21 included a provision for gradually raising the age of eligibility for social security benefits. The Council believes that the age of eligibility for Medicare benefits should also be raised, but over a much shorter time span. The Council believes that an increased age of eligibility is reasonable in view of increases in longevity since the implementation of both the Medicare and Social Security programs.

Social security benefit payments are designed to assure beneficiaries equivalent purchasing power throughout their retirement years. The Commission and Congress retained cost-of-living adjustments for social security benefit payments. In light of this fact, the Council believes that it is appropriate to index the Supplementary Medical Insurance Part B deductible to the Consumer Price Index (Chapter IV, E). Social security has provided

a mechanism to assure its beneficiaries do not lose purchasing power over time. An equivalent mechanism for adjusting the Part B deductible will insure that increases in the beneficiary's share of the cost of their health care services will keep pace with increases in their income.

In Public Law 98-21, Congress adopted a Commission recommendation authorizing OASDI to borrow from the HI trust fund (Recommendation #13) and expanded upon that recommendation to authorize borrowing among all three trust funds. Certain safeguards to assure repayment and protect the fiscal integrity of each fund were also included. Assuming safeguards are maintained, the Council agrees with the recommendation as modified by Congress (Chapter II, D).

There are several issues on which the Council takes a different position from that taken by the Commission. Both OASDI and HI are financed through payroll taxes. The Commission recommended advancing the date of implementing scheduled OASDI payroll tax increases (Recommendation #10). However, with respect to the HI program the Advisory Council has specifically rejected this, or any other approach, which would raise additional revenue through the payroll tax mechansism (Chapter II, C).

The Commission recommended that consideration be given to using general revenues as a "fail-safe" means of assuring the financial stability of the OASDI Trust Funds (Recommendation #18). Within the Commission, there was disagreement concerning this recommendation. In contrast, the Council, by a substantial majority, opposes the introduction of general revenues into the financing of the HI Trust Fund (Chapter II, B). The Council believes that public policies designed to increase both competition and sensitivity to the cost of health care services, in conjunction with the established funding mechanisms, will provide the means for assuring the financial stability of the HI trust fund.

The Council made two recommendations which have an impact on the Social Security programs. First, recognizing the anticipated surplus in the OASDI trust funds during the latter part of the century, the Council recommends that if there is a need for additional HI trust fund revenues and if the financial viability of all trust funds is assured, consideration should be given to reallocating payroll tax rates between OASDI and HI during the period 1985-1995 (Chapter II, E).

Second, the Council supports increased consumer awareness and participation in all facets of the Social Security and Medicare programs. To encourage participation, the Council urges greater attention to preparation and dissemination of information to beneficiaries. Emphasis should be placed on training Social

Security District Office staff so that they may better educate beneficiaries. Most importantly, the process of informing and educating should be evaluated and improved on an ongoing basis (Chapter VII, C).

The Council also considered a recommendation by its 1979 predecessor "that the mandate of future Advisory Councils be limited to the Social Security cash benefits program and that a separate Advisory Council be established periodically to review the Medicare and Medicaid programs".1/ The Council discussed this recommendation briefly and concluded that the current advisory procedure is adequate for reviewing all of these programs.

1/ Recommendation #10, 1979 Advisory Council on Social Security Report, p. 193.

ATTACHMENT I

SUMMARY OF RECOMMENDATIONS OF THE NATIONAL COMMISSION ON SOCIAL SECURITY REFORM

1. Do not alter the fundamental structure of the program or undermine its fundamental principles.

2. For purposes of considering the short-range status of the OASDI Trust Funds, $150-200 billion in either additional income or in decreased outgo, or both, should be provided for the OASDI Trust Funds in calendar years 1983-89.

3. For purposes of considering the long-range financial status of the OASDI Trust Funds, its actuarial imbalance of the 75-year valuation period is an average of 1.80 percent of taxable payroll.

4 Coverage under the OASDI program should be extended on a mandatory basis, as of January 1, 1984, to all newly hired civilian employees of the Federal government as well as employees of nonprofit organizations.

5. State and local governments which have elected coverage for their employees under the OASDI-HI program should not be permitted to terminate such coverage in the future.

6. Method of computing benefits should be revised for persons who first become eligible for pensions from non-covered employment, after 1983, so as to eliminate "windfall" benefits.

7. Beginning with 1984, 50 percent of OASDI benefits should be considered as taxable income for income-tax purposes for persons with Adjusted Gross Income (before including therein any OASDI benefits) of $20,000 if single and $25,000 if married, such proceeds to be credited to the OASDI Trust Funds under a permanent appropriation.

8. The automatic cost-of-living adjustments of OASDI benefits should, beginning in 1983, be made applicable to the December benefit checks rather than being first applicable to the June payments. Also, that the amount of the disregard of OASDI benefits for purposes of determining Supplemental Security Income payment levels should be increased from $20 a month to $50.

9. The following changes in benefit provisions which affect mainly women should be made:

   - while present law permits continuation of benefits for surviving spouses who remarry after age 60, also applicable to disabled surviving spouses age 50-59; disabled divorced surviving spouses aged 50-59 and divorced surviving spouses aged 60 and over.

   - spouse benefits for divorced spouses would be payable at age 62 or over.

   - deferred surviving-spouse benefits would continue to be indexed as under present law, except that it would be based on the increases in wages after the death of the worker.

   - benefit rate for disabled widows and widowers aged 50-59 at disablement would be the same as that for non-disabled widows and widowers first claiming benefits at age 60.

10. The OASDI tax schedule should be revised so that the 1985 rate would be moved to 1984, the 1985-87 rates would remain as scheduled under present law, part of the 1990 rate would be moved to 1988, and the rate for 1990 and after would remain unchanged. The HI tax rate for all years would remain unchanged.

11. The OASDI tax rates for self-employed persons should, beginning in 1984, be equal to the combined employer-employee rates. One-half of the OASDI taxes paid by self-employed persons should then be considered as a business expense for income-tax purposes (but not for purposes of determining the OASDI-HI tax).

12. The proposed OASDI tax rates should be allocated between the OASI and DI Trust Funds in a manner different from present law, in order that both funds will have about the same fund ratios.

13. Authority for interfund borrowing by OASDI Trust Funds from the HI Trust Fund should be authorized for 1983-87.

14. A lump-sum payment should be made to the OASDI Trust Funds from the General Fund of the Treasury for the following items:

   - the present value of the estimated additional benefits arising from the gratuitious military service wage credits for service before 1957

- the amount of the combined employer-employee OASDI taxes on the gratuitous military service wage credits for service after 1956 and before 1983

- the amount of uncashed OASDI checks issued in the past estimated at about $300-400 million

15. Beginning with 1988, if the fund ratio of the combined OASDI Trust Funds as of the beginning of a year is less than 20.0 percent, the automatic cost-of-living adjustment of OASDI benefits should be based on the lower of the CPI increase or the increase in wages. If the fund ratio is 32.0 percent or more at the beginning of a year, payments will be made during the following year as supplements to monthly benefits owthrwise payable to make up to individuals for any use of wage increases instead of CPI increases in the past, but only to the extent that sufficient funds are available over those needed to maintain a fund ratio of 32.0 percent.

16. The Delayed-Retirement Credit should be increased from the present 3 percent (for persons who attained age 65 after 1981) to 8 percent, to be phased in over the period 1990-2010.

17. In the case of salary-reduction plans qualifying under Section 401(k) of the Internal Revenue Code, any salary reduction thereunder shall not be treated as a reduction in wages subject to OASDI-HI taxes.

18. In addition to the stabilizing mechanism of Recommendation #15, a fail-safe mechanism is necessary so that benefits could continue to be paid on time despite unexpectedly adverse conditions which occur with little advance notice.

19. The investment procedures of the OASI, DI, HI and SMI Trust Funds should be revised so that, among other things, all future special issues would be invested on a month-to-month basis.

20. Two public members should be added to the Board of Trustees of the OASDI Trust Funds to be nominated by the President and confirmed by the Senate. No more than one public member could be from any particular political party.

21. The operations of the OASI, DI, HI and SMI Trust Funds should be removed from the unified budget.

22. It would be logical to have the Social Security Administration be a separate independent agency and a study should be made as to the feasibility of this recommendation.

SUPPLEMENTARY STATEMENTS BY INDIVIDUAL MEMBERS

Several members of the Council expressed a desire to submit supplemental information or opposing statements regarding the Council recommendations. These supplementary statements appear in this section.

PROPOSAL FOR RE-EVALUATION OF WAGE-INDEXED AND PRICE INDEXED BENEFIT FORMULAS

Submitted by: David Christopher, James D. McKevitt and Richard W. Rahn

A long term solution for the financial difficulties of social security and Medicare requires that we re-examine the purposes of these programs. The retirement system, OASDI, is promising dramatic increases in real, inflation-adjusted benefits to future retirees. In 1981 dollars, an average couple retiring in 1990 can expect to receive roughly $9,000 to $10,000 in annual benefits, depending on economic assumptions (1981 Trustee's Report alternatives II-B and II-A, respectively). For a couple retiring in 2050, benefits are scheduled to double or tripple to roughly $19,000 to $30,000; for a high wage couple, real benefits will rise from roughly $12,000 to $13,000 in 1990 to $30,000 to $47,000 in 2050.

This promised level of support will carry social security beyond its original purpose of being a basic income floor. OASI may threaten the traditional roles played by private savings and pension plans. OASI taxes will rise sharply, reducing employment and living standards of future workers, and pre-empting revenues which will be needed to finance the Hospital Insurance program, unless the latter is scaled back sharply.

The rapid escalation of real benefits is the result of formulas contained in the 1977 Social Security Amendments. These benefit formulas determine the first benefit received by a worker upon retirement, based on a worker's earnings history and certain replacement factors, which are higher for low-wage than high-wage workers. These formulas and the worker's earnings history are indexed over time by the growth of wages, rather than the growth of prices, as a sort of adjustment for inflation. Since wages grow more rapidly than prices over time, benefits grow sharply in real terms as real wages rise. This is the source of the unaffordable doubling or tripling of projected real benefits.

In 1975, the Senate Finance and House Ways and Means Committees commissioned a panel, headed by Professor William Haiao of Harvard, to study the proper design of the formulas and indexes in the benefit structure. The panel produced an important report*, in

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*Report of the Consultant Panel on Social Security to the Congressional Research Service, Prepared for the Use of the Committee on Finance of the U.S. Senate and the Committee on Ways and Means of the U.S. House of Representatives, U.S. Government Printing Office, August 1976.

which it recommended the use of price indexes, rather than wage indexes, for adjusting initial benefit levels for future retirees. Under price indexing, real benefits would rise to roughly $12,500 to $17,000 for an average couple and $21,000 to $31,000 for a high wage couple over time, less than doubling, rather than doubling or tripling as in current law.

It is disquieting to think of what the budget impact would have been if the retirement and disability programs had been paying out in 1983 at the same percent of payroll they are projected to reach after the baby boom retires. Instead of 11.5 percent of payroll, they would have paid out 15.4 percent (the 2055 cost rate). Instead of yearly outgo of about $170 billion in 1983, OASDI would have spent $228 billion, or $58 billion more.

For the combined OASDHI system, the figures are even worse. Instead of the current 14.19 percent of payroll, the system would have paid out 24.77 percent. Instead of yearly outgo of about $211 billion in 1983, OASDHI would have spent $368 billion or $157 billion more.

Despite the recent Social Security Amendments both OASDI and HI continue to be out of balance over the long run. The apparent balance of OASDI over a 75 year average is misleading; OASDI begins to run substantial permanent deficits soon after the turn of the century, which will eventually exhaust the trust funds. At the same time, HI will face rising deficits.

The entire social security system, OASDI and HI, should be revamped in order to prevent undesirable economic consequence. The economy cannot sustain an increase in the payroll tax to the 24 to 25 percent of payroll levels (or higher under what some consider more realistic demographic assumptions) implicit in the OASDI program as currently constituted. Slowing the growth in real cash benefits (namely, OASDI), would free-up tax revenues to help finance Medicare while still providing a generous basic pension. For example, price-indexing could produce savings of 4 to 6 percent of taxable payroll on OASDI that could be used to reduce the HI deficit.

We believe that Congress needs to re-convene the Consultant Panel which investigated the Social Security benefit formulas and receive from them an updated report on the relative costs of wage and price-indexed benefit formulas, and of alternative formulas with various replacement factors. The report should provide information on the real dollar value per retiree or retired couple of the various formulas considered, not merely the percent of income "replaced" by each formula.

We believe that a slower rate of growth of real retirement benefits over time is inevitable. It can be done gradually, with years of warning to those who will retire in the future to enable them to

increase their savings if they desire, or it can be done abruptly, a year or two before each succeeding crisis. Two things are clear: one, the public has been ill-served by the quick fixes and half measures embodied in Social Security and Medicare legislation from 1977 to 1983; and two, the problem has not been solved and will not go away by itself.

The Additional Views of Stanford Arnold And Alvin Heaps

We would like to take this opportunity to comment on the recommendations issued by the Social Security Advisory Council and, for the record, restate our views on whether the members of the Council truly represented the individuals who are the most directly affected by the looming financial crisis in the Medicare system, namely the 26 million elderly and the 3 million disabled Medicare beneficiaries.

We have had reservations about the composition of the Council from the beginning when it became evident that beneficiary groups were denied official representation. We cannot be sure that the recommendations of the Advisory Council on Social Security would have been different had representatives of the elderly and disabled Medicare beneficiaries been members of the Council. But we do know that the concerns of these citizens would have been of far greater significance throughout all of the Council's deliberations.

Beneficiary groups had a single opportunity to present testimony to the Council expressing their concerns about the adequacy of Medicare benefits and their thoughts on how to reduce program expenditures to avoid bankruptcy in the system. It would have been extremely helpful, however, had the input of Medicare beneficiaries gone beyond public hearings and throughout the last year been an integral part of the give and take of the Council members.

In addition to our thoughts on the composition of the Advisory Council on Social Security, we have a number of concerns about its final report. Principally, we believe that the recommendations contained therein, if implemented, will do nothing to stem the rising tide of health care inflation, which is the major cause of the threatened insolvency of the Medicare program. The proposals supported by the majority of Council members hold harmless the primary decision makers in the health care system, namely doctors and hospitals, while squarely placing the financial burden of corrective action on those who are the least responsible for rising costs and the least able to withstand increases in out-of-pocket payments, elderly and disabled Medicare beneficiaries.

The following statement briefly outlines our thoughts on some of the key provisions of the Advisory Council report. It includes our recommendations for more equitable and cost-effective alternatives, which we hope Congress and the Executive branch will consider in developing prpoosals for placing Medicare on a financially stable basis and preserving the health and financial security of beneficiaries.

We agree that the Medicare trust fund is facing a crisis which may be more severe and also quite different than that which was experienced by the Old Age, Survivors and Disability Funds (OASDI). We also agree that the changes Congress made in Social Security last

spring will keep the OASDI funds solvent until well into the next century. Therefore, we joined with the majority of Council members in recommending that borrowing ought to be permitted among the funds as long as minimum reserve requirements are met and provisions are established for repaying such loans.

We support the majority's recommendation that priority be given to studying the question of including cost-effective preventive care and long-term care in the Medicare benefit package.

We agree that medical education should not be financed out of the Medicare trust fund and that funds for teaching and training medical students should come out of a separate, Federal categorical program.

We support the recommendation that physicians be given incentives to accept assignment. We would have preferred that the majority had taken the additional step necessary to require that all physicians participating in Medicare accept assignment. In addition, at the very least, we believe payment to physicians should be included in the Medicare DRG prospective reimbursement system. However, we believe the best way to bring the rapid increases in physician fees under control is through a comprehensive, across-the-board all payors cost containment system covering physicians' fees as well as hospital care.

We supported the majority's recommendation that once the DRG system is fully implemented for hospitals participating in Medicare, the Secretary consider limiting the annual rate of growth in DRG payments to increases in the hospital market basket. However, we repeat that the only way to achieve real cost containment in Medicare and throughout the entire health care system is for Congress to immediately enact legislation creating a cost containment system for all payors and all providers.

We also agree that whatever steps can be taken to improve the management of the Medicare program ought to be expeditiously put in place, although it should be noted that administrative costs for the Medicare program have been consistently at levels for below the industry average for private health insurance programs.

As a final note, we fully support the majority's recommendations that eligibility for Medicare benefits not be contingent on income. We believe any change in this longstanding policy would violate the very essence of the Medicare program and for beneficiaries would act as a cruel and unnecessary barrier to timely and appropriate treatment. Moreover, we recommend that income not be used to determine cost-sharing levels.

We would like to commend the hard work of Dr. Bowen and our colleagues on the Social Security Advisory Council and their dedication to developing a solution to the Medicare funding crisis. We would also like to acknowledge the work of the Executive Director, Tom Burke, and his competent and dedicated staff. By expressing our minority views on the Council's recommendations we do not in any way intend to undermine their efforts. We do, however, believe it is necessary to explain our dissent on a number of key Council votes.

First, we did not support the view held by the majority of Council members that general revenues ought not to be used to fund the Medicare program. The so-called "Medicare problem" exists in large measure because of the Federal government's unwillingness to take the steps necessary to pass a comprehensive cost containment program to control rising health care costs. We are proposing four recommendations to limit total health care spending, which will be described later in this paper. However, if our recommendations are not implemented in time to save the $200 billion plus necessary to prevent bankruptcy of Medicare, general revenue contributions should be used to preserve the program and protect its beneficiaries. Our position on general revenue financing is consitent with the recommendations of previous Social Security Advisory Councils. The alternative, which we believe is politically unacceptable, would be to drastically cut benefits and/or reduce eligibility.

Second, we opposed placing limits on tax free employer contributions to health insurance to fund the deficit in the Medicare program. Under the majority's proposal, any contribution over this amount would be taxable as income to employees. Proponent of this plan, including the Administration, have claimed that the employee health tax proposal is designed to make workers more "cost conscious." In reality it would result in drastic reductions in coverage for preventive care, outpatient diagnostic services, and other benefits which save money. It would leave intact coverage for hospital and surgical benefits which have been the chief source of health-cost inflation and costly overutilization, over which patients have little control. The health tax proposal would also penalize older workers, workers living in high cost areas and those who select more comprehensive benefits plans, such as health maintenance organizations (HMOs). It would be an unprecedented intrusion into the collective bargaining process and would turn back the clock on decades of progress workers have made in winning comprehensive health care protection, while increasing taxes for a single group: workers with high health care costs. In short, we view this proposal as simply robbing Peter to pay Paul. No real reform will be possible in the Medicare system until the real decision makers, namely providers and suppliers of services, have incentives to control costs.

Third, we opposed increasing taxes on alcohol and tobacco to increase revenue for Medicare. These are regressive taxes which would disproportionately impact the low-income population and unfairly single out particular industries. We believe that such a proposal cannot be viewed from the standpoint of Medicare alone and that there are a number of negative economic and social effects of such a decision to which the Council has not given sufficient consideration.

Fourth, we reject the idea of automatically increasing the Medicare Part B deductible at a rate which corresponds to the annual increase in the Consumer Price Index (CPI). We also opposed levying a surcharge of $41 per year on beneficiaries to help finance the deficit in the Part A trust fund. Both proposals would shift to the elderly and disabled a larger share of the burden of rising Medicare costs, without doing anything to change the behavior of the true health care decision makers.

Fifth, we voted against the proposal to restructure the financing of Part A benefits. As of January 1, 1984, Medicare beneficiaries will pay a deductible of $357 every time they enter the hospital. They pay no other charges from the second to the sixtieth day, after which they begin meeting certain coinsurance requirements. In addition, beneficiaries are entitled to 100 days of skilled nursing care per year and are required to pay coinsurance of 12.5 percent per day for the 21st through the 100th day. The majority's proposal would entitle beneficiaries to an unlimited number of hospital days. In exchange, however, they would be required to pay out-of-pocket a daily coinsurance rate of 3 percent of the deductible for each day except the first. We recognize that under the majority's proposal senior citizens and the disabled will have the option of being relieved of any new cost-sharing requirement for inpatient services and the present cost-sharing requirement for skilled nursing care, if they agreed to purchase Part B coverage at a cost over and above their present Part B contribution. We favor including under Medicare coverage for catastrophic expenditures but we oppose requiring the beneficiaries to bear the brunt of this cost. We also oppose the all-or-nothing arrangement which has been endorsed by the Council where, if beneficiaries cannot afford to increase their Part B payment, they will be forced to pay more out-of-pocket for hospital care and will lose their eligibility for Part B medical care services.

Sixth, we also voted against raising the age of eligibility for Medicare from 65 to 67, beginning in 1985. The majority's proposal is inconsistent with the recently enacted Social Security amendments, which gradually begin raising the age of eligibility for Social Security benefits after the year 2000. In addition, we believe that there is little evidence to judge the impact of such an immediate change in eligibility. Only a relatively few individuals

over age 65 will be employed in jobs with good health insurance coverage. The rest will be unable to afford to purchase health care coverage on their own. This was amply demonstrated before Medicare was enacted. Indeed, it was the inability of the elderly to obtain affordable health insurance that led to the enactment of Medicare. We do not believe the simple fact that more people are living longer provides adequate justification for such a change. A number of individuals approaching retirement age have spent years in the workforce doing very strenuous manual labor which frequently leads to debilitating conditions. When they retire at age 65, they are very much in need of Medicare protection.

Seventh, we voted against the voluntary voucher proposal. We are concerned that with the voucher plan elderly and disabled citizens would have to do a great deal of shopping and comparing of plans to determine which insurance policy is right for them. We do not believe beneficiaries would have access to enough information to make such a choice. Furthermore, private insurers have stated publicly that the Medicare benefit package would be almost impossible to duplicate. Insurers would undoubtedly focus their marketing efforts on healthier beneficiaries leaving Medicare with the highest costs and the worst risks, potentially increasing program costs.

To summarize, we believe the recommendations from the majority of the members of the Social Security Advisory Council are designed to spread to Medicare beneficiaries the financial risk of rising program expenditures. Instead, what is urgently needed is across-the-board payment reform which we believe is absolutely necessary to control the costs and perserve the system.

We are proposing, therefore, that Congress consider the following four point alternative program to reduce rising Medicare costs without reducing benefits or beneficiaries.

1. Enact immediately a comprehensive, across-the-board cost containment system for all payors, public and private.

2. Include in the cost containment program a mechanism for limiting physicians' fees.

3. Include in the cost containment program mechanisms to prevent providers from increasing admissions and to limit the rate of growth in capital expenditures.

4. Add to the Medicare program a number of initiatives that have been developed in the private sector by labor and management to control the rate of increase in costs without reducing benefits.

We also urge the Department of Health and Human Services (HHS) to release regulations governing the implementation of the provisions of the Tax Equity and Fiscal Responsibility Act (TEFRA), which allow Medicare beneficiaries to join HMOs with appropriate reimbursement to the HMO.

It is our understanding that shortly after Congress returns in January, Senator Edward M. Kennedy and Congressman Richard Gephardt intend to introduce legislation which would fulfill the first three objectives of our four point plan.

The legislation is based on the premise that Medicare's financial problems cannot be solved simply by reducing Federal outlays. The only permanent solution to this catastrophic problem is to provide strong incentives for providers of care to behave in a more cost-efficient manner. The centerpiece of the Kennedy-Gephardt bill will be an all payors cost containment program to control the rate of increase in hospital costs and physician fees. It limits reimbursement to providers from all payors, public and private, and strongly encourages States to establish their own cost containment plans within Federal goudelines. Wages and benefits on non-supervisory personnel would be protected and special assistance is given to financially threatened inner city and public hospitals which disproprotionately serve the poor and the elderly.

The legislation would impose immediate Federal controls on the rate of growth in hospital costs and physician fees. There would be adjustments for necessary changes in the number and types of admissions; renovation or expansion, which has the prior approval of the State planning agency; and higher costs incurred by a hospital providing a disproportionate percentage of its services to low-income patients in comparison with facilities of similar size and location.

Federal controls on revenues would stabilize the rate of increase in hospital costs until states could develop their own cost containment plans. States with cost containment programs already approved by the Department of HHS would be exempt from the Federal rquirements. The legislation would also establish Federal limits on the rate of growth in payments by all payors to physicians. To have an approved cost containment plan, States would have to set up a system to negotiate reimbursement with physicians and other providers. This requirement is consistent with a recommendation by the Grace Commission that the current method of reimbursing physicians ought to be dropped and a "fixed fee prospective system" ought to be established for providers participating in Medicare.

The Kennedy-Gephardt proposal would also end the Medicare pass-through for capital expenditures and, as part of the new payment system, control the rate of growth in such spending. There would

also be strong financial penalties for hospitals which unnecessarily increased admissions to hold down any unexpected increase in hospital utilization.

Doctors participating in Medicare who provide services to inpatients will be paid through the hospital or the medical staff, based on a predetermined amount for services rendered in connection with each DRG. Reimbursement for physicians treating non-institutional Medicare patients will be phased in gradually. Reimbursement controls over private physicians will also be phased in.

The Kennedy-Gephardt program has been costed-out by actuaries who have estimated that, if the legislation is passed in FY 1985 and assuming no increase in payroll taxes, there will be a surplus in the Medicare trust fund until 2005. Comparison of these estimates demonstrate how Medicare costs can be effectively controlled. It is clear that the time for Congress to act is now.

We would also like to recommend that Congress consider improving the efficiency and quality of care associated with the Medicare program by adopting some of the changes which have been implemented by labor and management in collective bargaining to reduce rising health care costs without reducing benefits.

The following is a list of only a few such procedures and estimates of how much they can reduce insurance premiums:

Proposal	Potential Reduction in Health Insurance Premium Cost
Preadmission testing	0.8 percent
Ambulatory surgery	1.9 percent
Precertification of hospital care	1.0 percent
Second opinions	0.7 percent
Concurrent review	4.1 percent
Retrospective review	1.5 percent
Fee negotiation	3.4 percent
Hospice care	1.1 percent
Coordination of benefits	7.3 percent
Alternative delivery systems	8.5 percent
Total	30.3 percent

Taken together these initiatives can reduce health insurance premiums by 30 percent and play a major role in restraining the rate of increase in health care costs. We do not have estimates to determine how much these initiatives could reduce Medicare program cost but, based on the expenditures in the private sector, we are confident these programs could reduce the rate of increase in Medicare costs and significantly improve the quality of care.

It has been known for some time that HMOs provide incentives for participating physicians to reduce unnecessary inpatient and outpatient provider utilization. Organized labor has strongly encouraged its members to join group practice plans and other cost-effective delivery systems. Last fall Congress passed legislation paving the way for large numbers of Medicare beneficiaries to join HMOs. Unfortunately, the Department of Health and Human Services (HHS) has yet to finalize the regulations which would implement this law. We urge members of Congress use their influence to assure that HHS implements this law so that Medicare beneficiaries will have the opportunity to enter cost-effective delivery systems.

We believe our recommendations offer members of Congress and the Executive branch a practical and equitable approach for improving the efficiency of the Medicare program and substantially reducing program expenditures without harming beneficiaries. Unlike the majority recommendations, our proposals provide strong financial incentives for the providers and suppliers of health care services to reduce unnecessary costs. In sharp contrast with the majority's recommendations, our proposals do not increase the already heavy financial burden on elderly and disabled Medicare beneficiaries, many who have been the chief victims of health care inflation.

We hope our proposals will be fully considered by the Congress and we will be pleased to make ourselves available to provide whatever assistance we can to assure that our country maintains a healthy and viable Medicare program.

APPENDICES

Sec. 706(a) 276

Advisory Council on Social Security

Sec. 706. (a) During 1969 (but not before February 1, 1969) and every fourth year thereafter (but not before February 1 of such fourth year), the Secretary shall appoint an Advisory Council on Social Security for the purpose of reviewing the status of the Federal Old-Age and Survivors Insurance Trust Fund, the Federal Disability Insurance Trust Fund, the Federal Hospital Insurance Trust Fund, and the Federal Supplementary Medical Insurance Trust Fund in relation to the long-term commitments of the old-age, survivors, and disability insurance program and the programs under parts A and B of title XVIII, and of reviewing the scope of coverage and the adequacy of benefits under, and all other aspects of, these programs, including their impact on the public assistance programs under this Act.

(b) Each such Council shall consist of a Chairman and 12 other persons, appointed by the Secretary without regard to the provisions of title 5, United States Code, governing appointments in the competitive service. The appointed members shall, to the extent possible, represent organizations of employers and employees in equal numbers and represent self-employed persons and the public.

(c)(1) Any Council appointed hereunder is authorized to engage such technical assistance, including actuarial services, as may be required to carry out its functions, and the Secretary shall, in addition, make available to such Council such secretarial, clerical, and other assistance and such actuarial and other pertinent data prepared by the Department of Health, Education, and Welfare as it may require to carry out such functions.

(2) Appointed members of any such Council, while serving on business of the Council (inclusive of travel time) shall receive compensation at rates fixed by the Secretary, but not exceeding $100 per day and, while so serving away from their homes or regular places of business, they may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5703 of title 5, United States Code, for persons in the Government employed intermittently.

(d) Each such Council shall submit reports (including any interim reports such Council may have issued) of its findings and recommendations to the Secretary not later than January 1 of the second year after the year in which it is appointed, and such reports and recommendations shall thereupon be transmitted to the Congress and to the Board of Trustees of each of the Trust Funds. The reports required by this subsection shall include—

(1) a separate report with respect to the old-age, survivors, and disability insurance program under title II and of the taxes imposed under sections 1401(a), 3101(a), and 3111(a) of the Internal Revenue Code of 1954,

(2) a separate report with respect to the hospital insurance program under part A of title XVIII and of the taxes imposed by sections 1401(b), 3101(b), and 3111(b) of the Internal Revenue Code of 1954, and

(3) a separate report with respect to the supplementary medical insurance program established by part B of title XVIII and of the financing thereof.

After the date of the transmittal to the Congress of the reports required by this subsection, the Council shall cease to exist.[1]

Grants for Expansion and Development of Undergraduate and Graduate Programs

Sec. 707. (a) There is authorized to be appropriated $5,000,000 for the fiscal year ending June 30, 1969, and $5,000,000 for each of the three succeeding fiscal years, for grants by the Secretary to public or nonprofit private colleges and universities and to accredited graduate schools of social work or an association of such schools to meet part of the costs of development, expansion, or improvement of (respectively) undergraduate programs in social work and programs for the graduate training of professional social work personnel, including the costs of compensation of additional faculty and administrative personnel and minor improvements of existing facilities. Not less than one-half of the sums appropriated for any fiscal year under the authority of this subsection shall be used by the Secretary for grants with respect to undergraduate programs.

(b) In considering applications for grants under this section, the Secretary shall take into account the relative need in the States for personnel trained in social work and the effect of the grants thereon.

(c) Payment of grants under this section may be made (after necessary adjustments on account of previously made overpayments or underpayments) in advance or by way of reimbursement, and on such terms and conditions and in such installments, as the Secretary may determine.

(d) For purposes of this section—

(1) the term "graduate school of social work" means a department, school, division, or other administrative unit, in a public or nonprofit private college or university, which provides, primarily or exclusively, a program of education in social work and allied subjects leading to a graduate degree in social work;

(2) the term "accredited" as applied to a graduate school of social work refers to a school which is accredited by a body or

[1] See also sec. 373 of P.L. 95-216.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CHARTER

1982 Advisory Council on Social Security

Purpose

Title VII, section 706 of the Social Security Act (title 42, United States Code, section 907) requires the Secretary of Health and Human Services to appoint an Advisory Council on Social Security every four years for the purpose of reviewing the status of the Federal Old-Age and Survivors Insurance Trust Fund, the Federal Disability Insurance Trust Fund, the Federal Hospital Insurance Trust Fund, and the Federal Supplementary Medical Insurance Trust Fund in relation to the long-term commitments of the old-age, survivors, and disability insurance program and the programs under Parts A and B of title XVIII, and for the purpose of reviewing the scope of coverage and the adequacy of benefits under, and all other aspects of these programs, including their impact on the public assistance programs under the Social Security Act.

Authority

The Advisory Council is established by title VII, section 706 of the Social Security Act (title 42, United States Code, section 907).

Function

The Advisory Council on Social Security shall conduct the reviews required by title VII, section 706 of the Social Security Act (title 42, United States Code, section 907) with particular emphasis to be placed on a review of the programs under Parts A and B of title XVIII, and prepare and submit reports on their findings and recommendations.

Structure

The Council shall consist of a Chairman and 12 other persons, appointed by the Secretary, without regard to the provisions of title 5, United States Code, governing appointments in the competitive service. The appointed members shall, to the extent possible, represent organizations of employers and employees in equal numbers and represent self-employed persons and the public and shall serve for the duration of the Council.

Staff support, analytical services, and the designated Federal official to perform such functions as are required by the Federal Advisory Committee Act will be provided to the Council by the Department of Health and Human Services. The chairman may by law make such other staff appointments as he considers necessary to carry out the mission of the Council.

Meetings

Meetings shall be held at the call of, or the advance approval of, the designated officer or employee of the Department of Health and Human Services, who shall also approve the agenda. No meeting shall be conducted in absence of the designated officer or employee of the Department of Health and Human Services.

Meetings shall be open to the public except as determined otherwise by the Secretary pursuant to section 522b(c) of title 5, United States Code. Notice of all meetings shall be given to the public.

Meetings shall be conducted, and records of the proceedings kept, as required by applicable law and Departmental regulations.

Compensation

Appointed members of the Council, while serving on business of the Council (inclusive of travel time), shall receive compensation at rates fixed by the Secretary, but not exceeding $100 per day, and while so serving away from their homes or regular places of business, they may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5703 of title 5, United States Code, for persons in the Government employed intermittently.

Annual Cost Estimate

Estimated average annual cost for operating the Council including compensation, and travel expenses for members but excluding staff support is $172,000. Estimate of staff support required is 7.50 staff years at an estimated average annual cost of $183,000.

Reports

Reports of the 1982 Advisory Council's findings and recommendations (including any interim reports the Council may have issued) shall be submitted to the Secretary not later than July 1, 1983, and such reports shall thereafter be transmitted to the Congress and to the Board of Trustees of each of the Trust Funds. The reports shall include a list of members, the Council's functions, dates, and places of meetings, and a summary of the Council's activities and recommndations made during the duration of the Council. The reports shall also include, as reguird by law, (1) a separate report with respect to the old-age, survivors, and disability insurance program under title II of the Social Security Act and of the taxes imposed under section 1401(a), 3101(a), and 3111(a) of the Internal Revenue Code of 1954, (2) a separate report with respect to the hospital insurance program under Part A of title XVIII of the Social Security Act and of the taxes imposed by sections 1401(b), 3101(b), and 3111(b) of the Internal Revenue Code of 1954, and (3) a separate report with respect to the supplementary medical insurance program established by Part B of title XVIII of the Social Security Act and of the financing thereof. A copy of the reports shall be provided to the Department Committee Management Officer.

Termination Date

The Council shall cease to exist after the date of the transmittal to the Congress of the Council's reports.

Approve:

Richard S. Schweiker

Date

Secretary

APPENDIX C

List of Individuals Making Presentations at Council Meetings

Richard S. Schweiker, Secretary, Department of Health and Human Services[1/]

John A. Svahn, Commissioner of Social Security[1/]

Carolyne K. Davis, Administrator, Health Care Financing Administration

Judith Moore, Director, Office of Legislation, Office of Legislation and Policy, Health Care Financing Administration

Roland E. King, Director, Office of Financial and Actuarial Analysis, Bureau of Data Management and Strategy, Health Care Financing Administration

Robert J. Myers, Executive Director, National Commission on Social Security Reform[1/]

John Wilkin, Actuary, Economic and Demographic Estimates, Social Security Administration

Bryan R. Luce, Ph.D., Director, Office of Research and Demonstrations, Health Care Financing Administration

Joseph Newhouse, Ph.D., Project Director, Health Insurance Study, Rand Corporation

Anne R. Somers, Professor of Community Medicine, New Jersey-Rutgers Medical School

Jack A. Meyer, Ph.D., Director, Center for American Policy Research, American Enterprise Institute

Patrice H. Feinstein, Associate Administrator for Policy, Health Care Financing Administration

Roger O. Egeberg, M.D., Director, Office of Professional and Scientific Affairs, Health Care Financing Administration[1/]

Richard P. Kusserow, Inspector General, Department of Health and Human Services

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1/ The position held at the time of presentation.

Frank A. Sloan, Ph.D., Director, Health Policy Center, Institute for Public Policy Studies, Vanderbilt University

The Honorable William Archer (R-Tex), U.S. House of Representatives

David Winston, Executive Director, National Committee for Quality Health Care

Jeffrey Merrill, Director, Center for Health Policy Studies, Georgetown University

Lynn Etheredge, Scholar-in-Residence, Center for Health Policy Studies, Georgetown University

E. William Dinkelacker, Ph.D., Executive Office of Management and Budget

Philip J. Cook, Ph.D., Institute of Policy Sciences, Duke University

Eugene Lewit, Ph.D., Associate Professor of Medicine, University of Medicine and Dentistry of N.J.

Glenn Hackbarth, Ph.D., Special Assistant to Assistant Secretary for Planning and Evaluation/Health, Department of Health and Human Services

Richard Foster, Office of the Actuary, Social Security Administration

Bruce Schobel, Office of the Actuary, Social Security Administration

Keith Powell, Office of Financial and Actuarial Analysis, Health Care Financing Administration

Robert J. Rubin, M.D., Assistant Secretary for Planning and Evaluation, Department of Health and Human Services

Carl J. Schramm, Ph.D., J.D., Director, Center for Hospital Finance and Management, Johns Hopkins University

George Schieber, Ph.D., Director, Office of Policy Analysis, Office of Legislation and Policy, Health Care Financing Administration

Allen Dobson, Ph.D., Acting Director, Office of Research, Office of Research and Demonstrations, Health Care Financing Administration

William R. Johnson, Senior Vice President for Marketing, Blue Cross and Blue Shield Association

Robert Shapland, Associate Actuary, Mutual of Omaha (representing Health Insurance Association of America)

Randy Freudig, President, National Association of Health Underwriters

John B. O'Day, President - Managing Director, Insurance Economics Society of America

Gerard Anderson, Ph.D., Associate Director, Center for Hospital Finance and Management, John Hopkins University

Michael Maher, Director, Office of Reimbursement Policy, Bureau of Eligibility, Reimbursement and Coverage

John E. Marshall, Ph.D., Director, National Center for Health Services Research, Public Health Service, Department of Health and Human Services

Robert J. McEwen, S.J., Ph.D., Professor of Economics, Boston College

Stephen F. Gibbens, Director, Office of Long Term Care, Health and Welfare Agency of California

Cynthia D. Coale, Executive Director, Multi-Purpose Senior Services Program, Ukiah, California

John A.D. Cooper, M.D., Ph.D., President, American Association of Medical Colleges

Robert M. Heyssel, M.D., President, Johns Hopkins Hospital and Chairman-Elect, American Association of Medical Colleges

Richard Knapp, Director of Department of Teaching Hospitals, American Association of Medical Colleges

William G. Onsted, President, Private Sector Council

Hazel Strothers, Office of the Assistant Secretary for Management and Budget, Department of Health and Human Services

Joseph Ingram, Office of the Inspector General, Department of Health and Human Services

The Honorable Wendell H. Ford (D-Ky), United States Senate

John Wilkins, Director, Office of Tax Analysis, Department of the Treasury

Thomas Vasquez, Deputy Director, Office of Tax Analysis, Department of the Treasury

The Honorable David Durenberger (R-Minn), United States Senate

APPENDIX D

Report on Public Hearings

The members of the Advisory Council on Social Security recognized early the need to conduct public hearings. The intent of the public hearings, as stated by the chairperson, was to provide individuals and organizations a forum for recommending changes in the Medicare program, to identify the major concerns of the public regarding Medicare, and to gather expert testimony on particular issues. The Council held six public hearings on open topics and two public hearings that addressed specific issues. A report of each hearing follows immediately after this summary.

The six public hearings were scheduled at central locations in various regions of the nation. Cities were selected on the basis of accessibility to individuals and groups. The cities chosen were Washington, D.C. (two hearings), San Francisco, California (West), St. Petersburg, Florida (South), Evanston, Illinois (Midwest), and New Brunswick, New Jersey (Northeast). A total of 132 witnesses presented testimony to the Council. Groups represented were beneficiary organizations, advocacy organizations, provider organizations, the insurance industry, the health care industry, the alcohol and tobacco industries, business, labor, and State government. Private citizens also testified. The presentations covered such diverse areas as: the composition of the Advisory Council, reimbursement issues, revenue generation, expanding benefits, controlling hospital costs, reducing program abuse, deductibles and coinsurances, and increases in premiums.

The public hearings proved to be a valuable resource in the subsequent Council deliberations. For example, while addressing physician assignment, the Council gave significant consideration to concerns expressed at several hearings about the increasing uncertainty of costs for physician services. Additionally, the Council carefully considered testimony which had been presented at the public hearings in their development of recommendations for restructuring the Medicare benefit package and alternatives to inpatient care. Two special hearings were held to gather information concerning specific program issues addressed by the Council.

When addressing the physician assignment issue, the Council quickly concluded that there was little hard data on which to base a recommendation. To gather information on the effects of the various options available, the Council conducted a public hearing in

Washington, D.C., dedicated to the subject of the assignment provisions of the Medicare program. Thirteen organizations testified and four submitted written statements for the record. The presenters represented physicians associations, insurance groups, and beneficiary advocacy organizations. The information presented a focal point for the subsequent deliberations and final recommendation regarding the Medicare physician assignment policy.

At the March 1983 meeting, the Council considered alternate sources of revenue for the Hospital Insurance Trust Fund. The divergence of opinion on using taxes as a source of revenues motivated the Chairperson to schedule a public hearing in Washington, D. C., on the subject of raising revenues through taxation. Twenty representatives of organizations presented testimony. The majority of the speakers were representing either the industries or individuals who would bear the brunt of any economic impact from increased taxes or individuals from various public interest groups. Several speakers opposed increases in the excise taxes on alcohol and tobacco because of the economic affects on jobs, state revenues, and income taxes. Additionally, they thought this type of tax was discriminatory and poor tax policy. Other speakers favored those two taxes as a means of reducing consumption and also helping to pay for the long term adverse effects on health and the increased health care costs which they generate. The representatives of the older American associations favored increased payroll taxes which were generally opposed by all the other speakers.

In addition to the public hearings the Council received input from the public in the form of thousands of pieces of correspondence. The overwhelming majority of the correspondence was from beneficiaries of the Medicare program. The correspondence in the main reflected opinions and concerns similar to those raised during the public hearings. Areas of particular concern were the complexity of the program, lack of adequate information on program benefits and reimbursement, and need for additional coverage or improved benefits. During the deliberations the Council received representative samples of correspondence and briefings on the various concerns of the correspondents. All inquiries to the Council received appropriate and timely responses.

ADVISORY COUNCIL ON SOCIAL SECURITY
PUBLIC HEARINGS REPORTS

Hearing No. 1

City: Washington, D.C.

Date: December 13, 1982

Location: Holiday Inn, Capital Mall Area, 550 C. Street

Time: 8:00 a.m. - 12:00 noon

Advisory Council Members Present:

Dr. Otis R. Bowen, Chairman
Ms. L. Aiken
Mr. S. Arnold
Mr. J. Balog
Mr. K. Bays
Mr. D. Christopher
Mr. A. Heaps
Mr. S. Howard
Mr. K. McCaffree
Mr. R. Rahn
Mr. C. Stetler

Council Staff Present:

Mr. Thomas R. Burke, Executive Director
Ms. R. Amoyal
Mr. S. Finlayson
Ms. V. Gray
Mr. P. Jos
Ms. J. Lee
Ms. J. Peres
Mr. E. Scanzera
Mr. W. Wolstein

Other Federal Staff:

Mr. G. Duff, Office of Beneficiary Services
Health Care Financing Administration

Ms. E. Gutman, Office of Beneficiary Services
Health Care Financing Administration

Organizations and Individuals Making Oral Presentations:

1. National Council of Health Centers
   Mr. Jack MacDonald
   Executive Vice President
   Ms. Donna Barnako
   NCHC Representative
2. The American Association of Retired Persons
   Mr. Jim Hacking
   Assistant Legislative Counsel
   Mr. Jeff Christy
   Legislative Representative
3. National Multiple Sclerosis Society
   Mr Harry Hall
   Washington Representative
4. National Union of Hospital and Health Care Employees, AFL-CIO
   Mr. Henry Nicholas
   President
5. Leadership Council of Aging Organizations
   Mr. Jacob Clayman
   Chairman
   Ms. Janet Mayder
   Deputy Director of Research
   National Council of Senior Citizens
6. Save Our Security (SOS) Coalition
   Mr. Arthur Fleming
   Advisory Committee Chairman
   (Former Secretary Department of Health Education and Welfare)
7. Older Women's League
   Ms. Alice Quinlan
   Washington Representative
8. Health Security Action Council
   Mr. Melvin A. Glasser
   Director
9. AFL-CIO (Social Security Department)
   Ms. Karen Ignani
   Assistant Director
10. Gray Panthers
    Ms. Frances Klafter
    Chairwoman, National Health Task Force
11. National Association of Manufacturers
    Ms. Sharon Kanner
    Analyst, Social Security and Health Care
12. National Council of Senior Citizens
    Mr. William R. Hutton
    Executive Director
13. National Conference of Catholic Charities
    Father Tom Harvey
    Executive Director

Summary of Testimony and Discussion:

National Council of Health Centers (NCHC)

Jack MacDonald, Executive Vice President, accompanied by Donna Barnaka, represented NCHC, a voluntary association of proprietary health agencies furnishing a broad spectrum of inpatient and home care. His prepared statement covered 4 basic areas of concern to NCHC: catastrophic health coverage, Medicare definition of skilled care, prospective payment for skilled nursing facilities, and addition of a Part C long-term care benefit to Medicare.

NCHC endorses the concept of catastrophic coverage for Medicare beneficiaries, but notes that the existing benefit structure would not respond to the catastrophic expenses of prolonged nursing care. NCHC recommends provision for an additional 100 days of nursing home care (with cost sharing) for persons reaching the catastrophic limit; approximately 55 percent of beneficiaries entering nursing homes would be helped.

Closely allied to the proposed catastrophic coverage is a proposal to redefine Medicare's skilled care definition. NCHC believes the current benefit is too narrowly defined, noting that the average covered stay is only 24 days, although 100 days are available and less than 1-1/2 percent of Medicare expenditures are for skilled nursing facility care. A costly result of the strict interpretation is the backup of Medicare patients in hospitals awaiting non-existent Medicare nursing beds.

NCHC endorses the concept of prospective payment for Skilled Nursing Facilities (SNFs), but applauds the decision of Department of Health and Human Services to move slowly in developing a specific plan. Cooperation with the nursing home industry on this endeavor is essential. Any prospective payment system must: recognize quality levels of service; encourage and reward efficiency; encourage orderly growth; reward use of cost-effective providers; simplify administration. The development of the system cannot be unduly delayed since the use of DRG reimbursement for hospitals, if enacted, would increase demand for SNF care.

NCHC also recommends the addition of a new Medicare long-term care program - Part C. Part C would subsume the current Medicare SNF and home health benefits and Medicaid long-term care benefits for the elderly and would offer a variety of institutional and noninstitutional services. States would contribute toward cost sharing for low-income beneficiaries. Copayments would be related to income up to 40 percent of costs. Supplemental private coverage could be purchased. This approach is recommended because it establishes a basic long-term care benefit responsive to the needs of the elderly and insures dignity of the individual by eliminating the Medicaid provision that requires patients to dispose of most of their assets before receiving assistance.

NCHC will be happy to participate in further discussions of these issues.

In response to questions by Dr. Bowen, Mr. Howard and Mr. Arnold, Mr. MacDonald and Ms. Barnaka expanded upon the NCHC Part C proposal and its concept of a comprehensive long-term care benefit. Financing for the proposed Part C would be derived from several sources: lowered hospital costs because of swifter movement to long-term care, State contributions toward care of low income patients and cost sharing. The benefits would be means tested. NCHC estimates that based on current demographics, nearly 300,000 new nursing home beds will be needed by 1990. By covering a wider range of noninstitutional care, some of this costly capital investment can be avoided and per unit costs would decrease, although overall costs might not be due to larger number of patients served.

The possibility of a higher eligibility age for Part C is worthwhile to explore; initial eligibility at age 70- would still cover 99% of the LTC needs of the over 65. Mr. MacDonald noted that that attitude toward long-term care has now come full circle -- from covering terminal illness as an SNF benefit at the beginning of Medicare, subsequently narrowing the skilled nursing definition to exclude most palliative care and now introducing a hospice benefit.

American Association of Retired Persons (AARP)

Mr. Jim Hacking and Mr. Jeff Christy presented the views of the American Association of Retired Persons (AARP), a mass membership organization with approximately 13,500,000 members who are age 55 or older.

They submitted the Association's written statement and proceeded to summarize it. The Association believes that the solutions to Medicare's problems require changes in the means of delivering and paying for the services. Many factors were pointed to as fueling the growth of the health sector of the economy. But, the Association represented that government subsidies have stimulated both the demand and supply side of this growth; the government's tax laws being responsible for the growth of private and third-party payments on the demand side, with the hospital expansion stimulated by such things as the Hill-Burton program and the tax-exempt status of hospital construction bonds on the supply side. They stated that the current system rewards providers with more income for giving more care than is necessary or beneficial. AARP took the position that hard economic times and runaway hospital inflation are eroding our basic commitment to health care for the elderly and disabled. Sustaining the commitment to accessible and affordable health care for the elderly and disabled is the fundamental responsibility of the Advisory Council on Social Security. AARP believes that finding affective ways to control the rate of escalation of health care costs, especially in hospital costs in both the short and long run should be the Council's focus.

When asked if AARP would support cost sharing at the front end of Medicare coverage in trade for something like coverage for catastrophic illness, Mr. Hacking responded no. AARP believes the program gains from that sort of a trade, and not the beneficiaries. The amounts talked about for catastrophic coverage are about $2500 to $3,000 - there is really no benefit to the vast majority of Medicare beneficiaries.

National Multiple Sclerosis Society (NMSS)

Mr. Harry Hall advised the Council that he was representing the National Multiple Sclerosis Society, an organization which attempts to promote the interests of Multiple Sclerosis patients and also to promote a cure for this disease which effects approximately 250,000 people in the United States and several million in the world. The organization has a strong interest in Social Security and Medicare because the people they represent become disabled at an early age in adult life, usually after establishing a work record, and therefore, have eligibility for Social Security after the required two-year waiting period for Medicare.

NMSS believes that a reduction in health care costs is probably necessary, but they are concerned that such a reduction would not mean reducing health care services. Any reduction of health care services will be very costly to the Multiple Sclerosis patient. One of the major problems faced by such patients is the need to treat secondary problems as soon as they occur.

With respect to voucher systems, NMSS is concerned because they would not like to see employed individuals during their working years encouraged by health care which does not adequately take care of, or anticipate the kind of health care needs that may have to be faced if one becomes disabled.

With respect to increased cost sharing, Mr. Hall pointed out that most of the patients he represents are at the point of a financial crisis already and further cost sharing would only aggrevate this. Also, incentives not to use health care where it is needed presents a particular problem to the Multiple Sclerosis patient.

Finally, with respect to catastrophic protection, Mr. Hall emphasized the particular needs of the disabled who faced extraordinary costs year in and year out, sometimes for decades. He urged the Council to keep those needs in mind when considering the appropriateness of providing catastrophic insurance under Medicaid and Medicare.

In response to Council members' questions regarding the effect of potential increases in cost sharing on the Multiple Sclerosis patient,

Mr. Hall emphasized that anything that would cause an individual to forego seeking health care early would have particularly detrimental affect on the MS patient. The MS patient faces a significant number of secondary symptoms of the disease itself, e.g. blatter infections. If you fail to treat them early enough, then you have a potentially very costly problem to face later. Thus, it is really unwise to discourage people from using health care that they may need at the earliest point in time in which they need it.

National Union of Hospital and Health Care Employees

Taking the position that Social Security be maintained with fiscal i tegrity, Mr. Henry Nicholas, representing the National Union of Hospital a d Health Care Employees, stated that Social Security is a social co ntract to allow the elderly the dignity of caring for themselves. Mr. Nicholas opposes any reduction or changes in this commitment and believes that Medicare should be expanded to include: out-patient services, prescription drugs, dental services, eyeglasses, community health care centers, and long-term care. Opposing increases in cost sharing, Mr. Nicholas suggests the Council investigate the purposes, benefits and results of the Medicare program, along with national health insurance. No questions were received from Council members.

Leadership Council of Aging Organizations

In his prepared remarks, Mr. Jacob Clayman indicated that the Council needed among other perspectives that of the beneficiary, but noted that official beneficiary representation on the Advisory Council was lacking. Consequently, he offered the knowledge and experience of his organization.

He spoke of the value of the Medicare program: improved financial access to health care, as well as a positive contribution to the quality of life for millions of older persons. But, it has had limitations, too, making beneficiaries the victims of its reimbursement system and of Federal budget policy.

Mr. Clayman spoke of the health care needs of the elderly, concluding that a broad spectrum of health care services were required, including a health insurance system to meet their needs, which Medicare is not. He proceeded to identify costs not covered by Medicare, which he said also reflect the elderly's health needs. He noted the spiraling of program costs, the absence of cost-savings incentives, and predicted that recent Medicare reductions will not control costs. He believes that the elderly beneficiary is already cost-conscious and not able to absorb any further financial burden. He reminded the Council that Medicare pays no more than 44 percent of the health costs of senior citizens, while acknowledging that cost-saving provisions are required. Nevertheless, liberalization of

the program is needed, not further reductions. His Leadership Council would be pleased to discuss cost-savings proposals with the Advisory Council. Mr. Clayman concluded by offering the help and assistance of its Leadership Council to solve Medicare's problems. He can send "...a stream of information," and would also like to present the case more thoroughly.

At the conclusion of his statement, Dr. Bowen accepted Mr. Clayman's offer, inviting him to send anything relevant. Then followed questions and comments from the Council, with members asking for specific suggestions from Mr. Clayman and Ms. Janet Mayder, Deputy Director of Research for the National Council of Senior Citizens, who accompanied Mr. Clayman. Mr. Clayman's responses to various questions by members included agreement that cost-consciousness is necessary, but that benefits should not be cut. He also attributed responsibility for rising costs to hospitals and physicians. Furthermore, he is opposed to any redefinition of eligibility which would raise the eligibility age, or which would impose a means test.

Save Our Security (SOS)

Arthur Fleming, former Secretary of HEW presented the remarks of the Coalition to Protect Social Security popularly known as "Save Our Security."

He believes that in approaching Medicare, it is very important to keep in mind that it is a part of the Social Security system and that it is an insurance program. As such, the benefit structure that has been built into Medicare constitutes a contract between the government and those who have contributed through payroll taxes. To view the program as above should preclude one from considering a means test. To introduce a means test would constitute a violation of the contract between the government and those who have been contributing payroll taxes. Also, the problem should not be addressed through additional cost sharing.

He believes that the problem which confronts Medicare must be faced from the standpoint of cost containment. Organizations comprising SOS have not focused on any one program for cost containment -- but he offered that if the Council felt it would be of assistance, they could try to see what agreement they could get on an approach to cost containment. Also, he offered assistance in analyzing cost containment proposals from the standpoint of the impact that they might have on the quality of care.

He suggested that the Council look at the suggestions that the 1971 Advisory Council made regarding the financing of Medicare. That suggestion was to consider combining Part A (Hospital Insurance) and Part

B (Supplementary Medical Insurance) and that it then be financed through contributions from the worker, employer and government (1/3 each). This has the effect of introducing general revenues into the financing of Medicare.

He believes that this is also the time to address Medicare's inadequacies in providing for long-term care. Medicare's emphasis on institutional care has resulted in home care suffering. Recent amendments in the Tax Reform bill allowing Medicare to reimburse for hospice care has alleviated the problem to some extent. However, in considering strengthening Medicare's participation, he suggests that the Council should view long-term care being comprised of at least three components - an assessment program to determine the capacity of the older persons and the most appropriate services that might be needed by an older person and determine the availability of home care or skilled nursing facility services. Medicare should not enter into long-term care services just simply by adding nursing home benefits, an assessment program and home care services as alternatives to institutionalization are necessary.

In response to questioning, Mr. Fleming indicated he is not against cost sharing already contained in the law, it is the additional proposals he objects to. He sees cost sharing for the second to the sixtieth day as a violation of the contract.

With regard to the trade-off of some level of cost sharing from the second to the sixtieth day in exchange for catastrophic coverage, Mr. Fleming reiterated his objection. There are not a large number of older persons who require hospital care beyond sixty days. For the majority who do use hospital care from the second to the sixtieth day, he believes we should continue to make that available without charge. This is why he believes it is desirable to improve the system and shift to less costly delivery such as home care.

Mr. Fleming acknowledged that cost containment was not a major issue at the time the Medicare law was passed. The cost controls that existed were contained in the definitions of reasonable charges and costs. It was not a period of high inflation.

While not pointing the finger at any particular provider group, he believes that some provider groups have been responsible for the extraordinary costs and rise in health care costs. This was evidenced by the all out opposition to cost containment efforts from provider groups. He believes that the opposition groups should have made an effort to help develop a cost containment effort that everybody could have lived with.

Mr. Fleming agreed that the Council couldn't really address the problems in the economy as a whole. However, he views participation on the Advisory Council as a great opportunity to take a fresh look at the whole Medicare program. He believes that the Advisory Council has the

ability to make recommendations for long-term as well as short-term solutions. Perhaps look down the road and point to the direction of the way the program should be so that those working in the field have an objective to work toward.

He reiterated his belief that it is very important to provide incentives for older persons to participate in preventive programs which is why he is vehemently opposed to the cost sharing allowed in the new tax reform legislation for preventive programs in Medicaid.

He also believes strongly that it is appropriate to fund Social Security and Medicare with a 1/3 contribution from general revenues. He indicated that the leadership in the 1930s thought that ultimately general revenues would play a part in funding the programs for the elderly. He doesn't have any philosophical difficulties in the Federal government being involved in caring for the elderly. Many other nations have come to that point and he believes that it represents a good investment of tax payer's money.

He closed by acknowledging the good work on behalf of the elderly Indiana accomplished under the leadership of Dr. Bowen as Governor.

Older Women's League

Ms. Alice Quinlan, Washington representative of the Older Women's League, presented a summary of the League's concerns on Medicare about current inadequacies and the impact of policies under consideration on women 65 and older.

Ms. Quinlan stated that women constitute 60% of the population over 65 and for this group, the median income (1981) is $4,757.00. Based on these figures, Ms. Quinlan expressed the belief that women have inadequate access to health care and in the case of Supplementary Medical Insurance, the cost would be one-third of the median income. Another problem mentioned was that low assignment rates add an additional burden by absorbing more of the elderly's limited income.

Ms. Quinlan felt that a voucher system for elderly women would make them vulnerable to unscrupulous marketing techniques. Additionally, Ms. Quinlan is concerned about prospective reimbursement leading to two classes of patients and services. Based on the median income figures, Ms. Quinlan views a catastrophic cap and additional co-payments as an unfair burden which elderly women would be unable to bear.

Ms. Quinlan stated that a change in Medicare from an orientation toward acute care to an orientation based on prevention, maintenance of wellness, and assistance to care givers would improve the lives of the elderly and lead to reduced costs.

Health Security Action Council (HSAC)

Melvin A. Glasser, Director, presented the recommendations of the HSAC, a coalition of labor, business, professional, senior citizen, farm, civil rights and youth organizations representing health care consumers. HSAC presented proposals in three areas: revision of Medicare benefit structure; achieving equitable cost-sharing; and cost containment.

Since they have greater health care needs and a high percentage are low-income individuals, the elderly should have a more comprehensive package of benefits. Additional benefits needed include: reduction in escalation of coinsurance; coverage of prescription drugs; and additional long-term care benefits.

There is a desperate need to find ways to control costs, rather than simply shifting them out of the Federal budget onto others. Increases in beneficiary cost-sharing and cost-shifting to the private sector and State and local governments merely conceal the Federal budget problem without improving the overall economic situation.

Solutions to cost escalation can be found in HSAC's newly developed HALT (Health Action to Limit Takeaways) program. The program has 5 features: (1) concurrent containment of public and private costs; (2) involve all providers in the health care system; (3) halt all price increases for 2 years, except for inflationary increases in market basket costs; (4) develop prospective budgeting for institutional providers with state-by-state ceilings; and (5) arrange negotiated reimbursement rates on a state-by-state basis with professional providers.

HSAC would be glad to submit the HALT program in more detail if the Council wishes.

Dr. Bowen requested that HSAC submit the details of the HALT plan to the Council. In response to questions from Mr. McCaffree and Mr. Bays, Mr. Glasser expanded on the HALT reimbursement proposals, which are based on the premise that the current reimbursement system is the principle problem of health care cost escalation. Professional fees would be negotiated between the profession and a state commission composed of Medicare contractors, consumers and insurers. Rates could be set on a time, per service, capitation or other basis and would be adjusted annually, subject to an overall cap related to market basket increases. On the institutional side, the proposal would build on current statewide cost control systems which have achieved an average 4% annual decrease from what costs would have otherwise have been. The proposed cap would be on statewide costs so that payments to individual hospitals could be adjusted as needed for casemix, mix-of-services and similar changes.

AFL-CIO (Social Security Department)

Ms. Karen Ignani presented testimony on behalf of Mr. Burt Seidman, the Director of the Department of Social Security, AFL-CIO. Ms. Ignani began by emphasizing that the costs of getting sick and the expenses of getting well are very much on the minds of the elderly and disabled Americans and that the concern was certainly not unwarranted.

Elderly people are highly susceptible to chronic conditions and although their life expectancy has increased in recent years, their health status is not a great deal better than it once was. It was emphasized that most Americans have relatively comprehensive hospital care and Major Medical insurance during their work lives and anticipate similar coverage when they retire and they become eligible for Medicare. However, workers then find that Medicare generally falls far short of meeting their health care needs.

Despite the financial investment that has been made in Medicare, many senior citizens remain unable to afford essential medical treatment. Medicare requires a sizeable amount of patient cost sharing; provides no protection against catastrophic illness; and does not cover services that the elderly most frequently need, such as preventive services, long-term care, prescription drugs, foot care, dental care and eyeglasses.

Under Medicare, the sicker you are, the more you pay. Unless eligible for Medicaid, many older and disabled persons are forced to go without essential health care services, because they cannot afford the high cost of treatment. Some are postponing treatment unless hospital care is warranted, which is even more expensive for the program, but generally cheaper for the beneficiary.

As a percent of their income, elderly people are spending as much for health care now as they were prior to the passage of the Medicare program. Since the elderly themselves are not much better off today than they were before the passage of Medicare, the AFL-CIO believes that it is appropriate for this Council to consider who, if not the elderly, are benefitting and what can be done to make the program more responsive to health care needs of those it was designed to serve.

Ms. Ignani cautioned the Council to be skeptical of those who claim that we can solve the so-called "Medicare problem" by cutting benefits. "Patients are not responsible for escalating health costs. It is the providers and the suppliers of health care services who decide who needs health care, when they need it and how much they need."

Two-thirds of the rise in Medicare expenditures has been attributed to inflation. Those run-away costs, in the view of the AFL-CIO, can be attributed to the unwillingness of the Congress to make Medicare anything more than an open ended program, encouraging hospital expansion and

excessive utilization of services. Until serious efforts are made to change the way the providers are reimbursed, their is no relief in sight for the Federal government, or for the financially over burdened beneficiary.

With respect to reimbursing hospitals and physicians on a prospective basis, although the AFL-CIO has long advocated such forms of reimbursement, they urge that the Administration's proposal be carefully evaluated. Basing payments on diagnostic-related groups (DRG's) could, rather than reduce Medicare costs, actually result in more hospitalization, more surgery, and higher health care costs for those covered under private insurance. The Council was urged to take an active role in this redesign of the Medicare reimbursement system.

Further, it is the hope of the AFL-CIO that the Council would take a strong stand in support of Medicare beneficiaries, and not support the Administration plans to further slash current services and protections.

The AFL-CIO believes that the Administration's proposals to cut back Medicare costs only provide stronger financial incentives to turn away Medicare beneficiaries and for employers to lay off older workers, rather than pay more for their health insurance. The proposals under consideration for next year would require patients to pay 10% of their per diem costs for the second to the sixteenth hospital day. This would produce a minimum cost of $600 for the typical ten-day hospital stay and equate to two months of benefits for the average widow on Social Security. With respect to voucher systems, the AFL-CIO is concerned that financial gimmicks would be used to lure individuals on fixed incomes to abandon Medicare for lower-grade coverage, which might result in an earlier death for some and unnecessary suffering for many who will be unable to afford doctor visits that are no longer covered by insurance.

In summary, the AFL-CIO urged the Council to recommend that the Secretary take the lead within the Administration to develop a comprehensive across-the-board cost containment system that would reduce Medicare inflation and slow the rate of growth in all Medicare programs. Savings that would be produced, could then be used to solve the short-term crisis that we face in Medicare at the end of the decade. Additionally, they would give the Council flexibility to recommend expansion of Medicare benefits to cover prescription drugs, foot care, eyeglasses, etc. What we have done in the past is taken an evolutionary approach to the problems that exist and it was suggested that this Council ought to consider taking a revolutionary approach. The problems of the total health care industry must be looked at comprehensively, rather than just telescoping the Medicare program.

There were a number of questions from the Council subsequent to Ms. Ignani's presentation. With respect to the issue of vouchers, Ms. Ignani clarified that their major concern was with the fact that elderly people

need to reduce their expenses and therefore, there would clearly be an incentive to buy a cheaper plan of health insurance and in effect, the beneficiaries would be playing Russian roulette. Since the system is probably going to have to end up paying for their care in any event, we may find that vouchers are more expensive in the long run than in the short run.

In answer to questions concerning the use of DRG's in any prospective payment system, Ms. Ignani expressed the concern that there could be a shifting of services to the outpatient setting without appropriate controls, problems in defining diagnosis, which would provide incentives to "kick up" the DRG category used by providing additional services such as surgery. The use of DRG's may well be a good starting point in some areas, but the jury is still out on determining their validity and so there is continued skepticism as to how we will be able to predict expenditures in the future. The Council should examine other ways and not just look at DRG's.

With regard to where the Council should focus its attention to bring the cost of the program under control, Ms. Ignani suggested strongly that while it is necessary to take a comprehensive view of the whole program instead of focusing on the buyers, i.e. the beneficiaries, the Council ought to take a close look at the providers, those who have profitted from the Medicare system. This system as designed provides no incentive to contain costs, but rather, often encourages escalation of costs.

With respect to perceived failures in the Medicare program, Ms. Ignani emphasized that while the Medicare program has done a good job with respect to improving access to care under the Part A side of the program, the Part B side, as more physicians have opted out of the program of assignment, has presented increasing financial barriers to the elderly. The program really provides nothing to encourage primary care or to cover the kinds of things that elderly people desperately need, such as dentures, eyeglasses, and other items that would prevent the onset of more critical illness. In general, we have been penny wise and pound foolish in the program and if this continues, we face both serious fiscal and health problems in the future.

At present, we have a never ending spiral of higher costs resulting in higher insurance premiums for people to pay. It is time in Ms. Ignani's view, to take a look at what we're buying for those dollars.

Gray Panthers

Representing the Gray Panthers, Ms. Frances Klafter explained that her "grass roots" organization senses the Medicare beneficiaries' frustration with the program. Ms. Klafter claims that the current Administration's policies toward the elderly have not been fair. The Gray Panthers do not want the Council to dismantle Medicare, but to expand it to include:

long-term care; dental care; eyeglasses; and preventive care. All of these new services could be met, according to Ms. Klafter, by "leashing" health care provider charges.

Ms. Klafter holds that Part B is the beneficiaries' entry point into the system and that the elderly do not know in advance what are going to be the charges for the health care services they receive. To change this, the Gray Panthers have published, "How to Organize a Medicare Assignment Program." This is a "how-to" booklet for communities to list which local physicians accept Medicare assignment for beneficiaries seeking low-cost health care. No questions were received from Council members.

National Association of Manufacturers (NAM)

The following statement, provided by the National Association of Manufacturers, summarizes the prepared remarks. The presentation by NAM which was given on December 12, 1982 was delivered by Ms. Sharon Canner, a staff member.

> In 1981, business and industry paid an estimated $74 billion for group health insurance or 25 percent of this nation's $287 billion for health. With the addition of business taxes for Medicare and Medicaid and other related health costs, the employer's share exceeds 50 percent of this $287 billion. Given the organization of our health care system, the private sector's health costs are closely intertwined with the public sector's, each sector having a significant impact on the other. Thus, a financially sound Medicare program is part of NAM's overall strategy to manage high and rapidly rising health costs. Internally, NAM companies are conducting claims and utilization review, and they are working in their communities with other groups concerned about costs.
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> Assuring the long-term financial integrity of Medicare is no easy task in view of overall inflation, price increases in the health care marketplace, and high unemployment with reduced tax collections. Given these factors, the NAM recommends that: (1) Medicare continue to encourage local initiatives in controlling health costs; (2) Federal support be continued for utilization review with regulations that encourage the private sector to use these services; (3) Medicare benefits foster consumer cost-consciousness; (4) use of alternative delivery systems which promote cost savings be encouraged; (5) the Federal government continue to improve its position as a prudent buyer of health services; and (6) the prospective budgeting system now under development by the Health Care Financing Administration assure that costs are not shifted to private patients.

National Council of Senior Citizens (NCSC)

William R. Hutton, Executive Director, presented the statement of the NCSC. In prepared remarks, Mr. Hutton traced the role of NCSC in getting the original Medicare law enacted and in serving as an advocate of beneficiary interests. NCSC urges the Council to recognize the extraordinary health care needs of the elderly, not totally met by Medicare, to carefully evaluate the impact on the beneficiary of any proposed changes, and to seek changes beneficial to all age groups by attacking the basic problems of the health care system.

Mr. Hutton endorsed the remarks made earlier by NCSC President, Jacob Clayman, representing the Leadership Council of Aging Organizations and noted that the elderly cannot absorb any further out-of-pocket costs for health care, nor can they afford benefit cuts. Increases in cost sharing do not affect Medicare or total system costs. Physicians, not patients, make most utilization decisions. Beneficiaries are the victims of health cost inflation; providers are the cause.

NCSC recommends that the Council focus on larger health systems issues and endorses 3 areas of study recommended by the 1979 Council: (1) consumer problems in meeting out-of-pocket costs and securing high quality services; (2) overall problems in organization and delivery of care at affordable prices; and (3) developing less costly alternatives to inpatient hospital care and controlling hospital costs. NCSC opposes a voucher system, additional early copayments with catastrophic coverage or means test as solutions to the problems.

NCSC recommends several additional areas of study. Retrospective cost and fee-for-service reimbursement need revision; if a prospective payment system is developed, it should be universal. Recognize that providers are the major cause of inflation and direct cost-cutting efforts accordingly. Examine specific causes of Medicare cost increases, particularly the effect of rapidly escalating hospital costs. Evaluate proposals on basis of their impact on the health care system and on the beneficiary, not just on program savings.

In summary, NCSC urges the Council to keep the beneficiary's interests at the forefront of the deliberations. Do not impose on the elderly and disabled the burdens and responsibilities which rightly should be placed on the entire health industry.

In response to questions from Mr. Balog, Mr. Hutton reiterated the NCSC position that any prospective reimbursement plan should be applied system-wide, not just to Medicare. In dialogue with Mr. McCaffrey, he described the special vulnerability of the elderly to "ripoff artists" as a major reason for NCSC opposition to a voucher system.

National Council on Catholic Charities (NCCC)

Reverend Harvey, the Executive Director of the National Council on Catholic Charities, acknowledged that the Council had a special mandate to fulfill in reviewing the fiscal condition of the Medicare program and also in examining the equity and adequacy of the current program structure. Father Harvey advised the Council that he wished to limit his remarks to the need to examine a variety of concerns regarding equity and adequacy of the current Medicare program. In particular, Father Harvey said that he wished to raise a voice on behalf of those in the society most threatened by the cost of health care.

Father Harvey is concerned that we be most sensitive to the fact that some 15.7% of people aged 65 and over have incomes below the official poverty line; were we to include the near poor, that figure would be substantially higher. For one out of four people, Social Security represents 90% of their income and clearly, this is not a picture of prosperity.

Under the Medicare program, the elderly are now responsible for some 50% of their health care costs, and for many, this constitutes a serious hardship, and for some, a personal catastrophe. The study suggests that dependency on Medicare is highest for those with a low income and it increases with age. Therefore, any across-the-board benefit reductions or cost sharing increases would be disproportionately borne by the poorest and oldest members of the population. Care must be taken by the Council to avoid options which would reduce much needed access to health care. Even under the current program, too many must choose among food, heat and health.

The Catholic Charities' position is in opposition to changes in coinsurance and deductible features, which would further restrict access to care by the elderly and especially the needy elderly. Additionally, the NCCC are strongly committed to the social insurance nature of the Medicare program and oppose any segregation of the needy elderly into some means tested program. The poor, so often voiceless and without advocates in our society need and deserve the protection of being in a program universe along with others of their age.

With respect to voucher programs in health care the NCCC registers its strong opposition to the concept, because they believe it will lead toward class stratification in health care delivery and do so to the detriment to those most in need and least able to bargain and pay for decent care.

Father Harvey voiced concern that while a universal social insurance system of paying and providing for health care may not solve all of the problems, they are convinced that none of the major delivery or finance problems can be properly dealt with until some form of national health insurance comes about. With respect to who is at fault for the increasing

escalation in health care costs, there is a familiar pattern of blaming the elderly for seeking too costly care, often unnecessarily. Such reasoning, in Father Harvey's view, reinforces the so-called "generation gap conflict" which has been much discussed with reference to Social Security.

Father Harvey then quoted a recent statement by Mr. Lane Kirkland, President of the AFL-CIO, which in summary, stated that most human beings accept the proposition that they have some responsibility to their parents that might otherwise be a burden and might diminish their capacity to meet other responsibilities such as the education of their children. It is not unreasonable to say that the proper place to put the costs of caring for the elderly is on those who have a job and can work, those who are healthy and have a long life ahead of them, as opposed to imposing those burdens on those who have already done their work and have made their contribution to society.

In Father Harvey's view to the extent that added revenues are needed to preserve and expand Medicare coverage, the National Council on Catholic Charities believes that those resources should be sought from those who are in the best position to accept that responsibility. They consider it unconscionable for our society to provide less or to exact more from the elderly who may be willing, but who are unable to give any more.

ADVISORY COUNCIL ON SOCIAL SECURITY
PUBLIC HEARINGS REPORTS

Hearing No. 2

City: Washington, D.C.

Date: January 17, 1983

Location: Holiday Inn, Capital Mall Area, 550 C Street

Time: 8:00 a.m. - 12:00 noon

Advisory Council Members Present:

Dr. Otis R. Bowen, Chairman
Ms. Linda Aiken
Mr. Stanford Arnold
Mr. James Balog
Mr. Alvin Heaps
Mr. Samuel Howard
Mr. Kenneth McCaffree
Mr. James McKevitt
Mr. C. Joseph Stetler

Council Staff Present:

Mr. Thomas R. Burke, Executive Director
Mr. Steve Finlayson
Ms. Virginia Gray
Mr. Phil Jos
Ms. Julia Lee
Ms. Jean Morris
Ms. Judith Peres
Mr. Eugene Scanzera
Mr. Will Wolstein

Other Federal Staff:

Mr. George Duff, Office of Beneficiary Services
Health Care Financing Administration

Ms. Elaine Gutman, Office of Beneficiary Services
Health Care Financing Administration

Organizations and Individuals Making Oral Presentations:

1. Blue Cross and Blue Shield Association — Lawrence Morris

2. Health Insurance Association of America — Richard Mellman
Vice President, Actuary
Prudential Insurance Company

3.	Group Health Association of America	Erling Hansen General Counsel
4.	American Hospital Association	Jack Owens Executive Vice President
5.	Federation of American Hospitals	Michael Bromberg Executive Director Al Baker Deputy Director
6.	American Society of Internal Medicine	Monte Malach President N. Thomas Connally Trustee
7.	Home Health Services and Staffing Association	Frank Samuels
8.	National Mental Health Association	Robert Vondivier Director for Public Policy
9.	Amy Neustein, Ph.D.	Medical Sociologist
10.	Ms. Audrey Koch	Private Citizen
11.	Mrs. Rosa Hines	Private Citizen
12.	Volunteer Trustees of Not-For-Profit Hospitals	Benjamin Sturges Member Board of Governors
13.	American Nurses Association	Ada Jacox First Vice President
14.	American Association of Homes for the Aging	Laurence Lane Director of Public Policy

Summary of Discussion:

1. Blue Cross and Blue Shield Association. Mr. Lawrence Morris represented the Blue Cross and Blue Shield Association. Mr. Morris had three major points to make. First, there is no single solution to the problem facing the Medicare program. Second, the major emphasis of legislation and administration change in a short term would have to be on cost containment, because dramatic reductions in benefits or eligibility or alternatively increases in taxes are not realistic. Third, in the cost containment area, radical changes in payment or other program features would have to be subjected to careful evaluation and phased in to permit adjustment and implementation.

In the area of cost containment, Mr. Morris addressed two issues, audit and provider payments. Mr. Morris recommended that the Health Care Financing Administration abandon its previous policy of reducing administrative costs and put more money into audits, which could return, in certain instances, up to 26:1 in savings. It is his position that any introduction of a new payment system should be carefully phased in and should be experimented with, along with other means of payment. One example is the target rate program where hospitals will be able to keep any savings from operating below the target rate.

Several Council members asked questions on the association's position on prospective reimbursement. The association is not opposed to prospective reimbursement but feels that it should be implemented in phases to allow for adjustment. He felt that the incentive in prospective reimbursement probably would encourage a greater amount of efficiency.

2. Health Insurance Association of America. Mr. Richard Mellman represented the Health Insurance Association of America. Mr. Mellman's statement covered two points. The first point was why insurance companies are concerned about containing medical costs. The second point, why the larger system of changes is necessary.

In response to high costs, the insurance companies have come up with several methods of cost containment. Among those methods are initiatives for the cost effective plan design, benefit provisions and other programs, such as second opinion surgical program, promotion of HMOs, preferred provider plan, and more rational use of cost sharing provisions. More importantly, though, they feel it is necessary that there be a fundamental change in the overall reimbursement system. The current system for reimbursement holds few incentives for providers to practice cost effective care. His organization came out in favor of prospective hospital pricing on a DRG basis.

Mr. Mellman's group has been carefully monitoring the New Jersey DRG system, and although it may be premature, they believe that the system offers great promise for achieving meaningful economies without compromising quality of medical care. He encouraged the Council to consider system-wide, all payer reform. If the all payer system is not put in place, then there would be cost shifting of an aggregate amount to the private health insurance companies.

Mr. Heaps and Mr. Balog asked about Medigap insurance coverage. Mr. Mellman informed the Council that one-third of the Medicare population has Medigap insurance at an average cost of $150 per year. The insurance covers 50% - 60% of the benefits.

Mr. Arnold questioned the effectiveness of the DRG system for cost containment. Mr. Mellman liked the DRG concept as a cost effective method to increase productivity. He felt it would be premature to be more definitive.

Ms. Aiken asked for clarification on implementing the volunteer system state by state. Mr. Mellman felt that it could be implemented through pressure from federal legislation.

3. Group Health Association of America. Mr. Erling Hansen represented the Group Health Association of America. Mr. Hansen's presentation focused on highlighting the important role that health maintenance organizations could play in providing comprehensive medical and hospital benefits for the Medicare beneficiary. He concentrated on the significance of the recent amendment to Section 1876 of the Social Security Act which permitted a true prospective payment to HMOs for Medicare benefits.

Mr. Hansen continued on the importance this has to the Medicare beneficiaries who live on a fixed income. They would be able to receive all treatment necessary from a single source and have confidence in knowing that there would only be a single constant prepayment. Among the many benefits of this type of arrangement are no worry for acceptance of assignment for any service delivered, no paperwork burden, and an assured predictable annual medical cost.

Citing New Jersey as an example, Mr. Hansen expressed concern about the impact of prospective payment on HMOs unless they are given a special status within the prospective payment program. In New Jersey, the HMOs had experienced an increase of 20% - 30% in hospital costs attributable to the DRG program. The New Jersey DRGs do not take into account the efficiencies of the HMO hospital system.

In response to questions from the Council, the GHAA representative reviewed the reasons for the 30% higher cost under DRGs in New Jersey. He attributed lower costs for HMOs to the way HMOs practice medicine, specifically, the way they go about running tests, the way they enter people into the hospital and review them, and the way they treat people in the community. To a large degree, it centers around the HMOs utilization controls which are different from other medical groups in the community. One difference is the HMO patient population is not reflective of the community, or the Medicare population. Mr. Hansen is encouraged by Secretary Schweiker's commitment to a modified reimburement rate for HMOs.

4. American Hospital Association. Mr. Jack Owens represented the American Hospital Association. Mr. Owens outlined the AHA's position on several problems in the Social Security and Medicare programs. He came out against interfund borrowing. He emphasized that increased costs for hospital care was not strictly related to higher costs in the hospital, but to increased demand by a larger population which is older. Another area of increase is in the kind of treatments being given to the elderly.

One problem is the need for predictability both in what the government is going to pay out and what revenues needed to be paid in. That problem could be solved by going to a prospective payment system and he favors the DRG system. The second problem he focused on was the lack of incentive within the system to reduce utilization. He believed that this lack of incentive is due to the per diem basis of payment. A reasonable solution to this problem is a cost-per-case approach. He cautioned about going to an all-payer system. Medicare would end up paying for patients who could not pay for their own care because they are unemployed or not covered by insurance.

He next emphasized the lack of incentive for patients to restrain costs. His solution to this type of problem is some sort of patient requirement to pay part of the bill and in return, the patient would receive some form of tax deduction based on an income limit.

In his discussion after his presentation, Mr. Owens reemphasized AHA's support for the DRG form of prospective reimbursement. He did indicate that the AHA proposed system varied from the Health Care Financing Administration's proposal. Mr. Owen discounted the California experiment for contracting out to hospitals as being unworkable for Medicare. He also sees extensive revenue shifting in response to Medicare prospective reimbursement.

5. Federation of American Hospitals.

Executive Director Michael D. Bromberg and Deputy Director Al Baker represented the Federation of American Hospitals. The Federation of American Hospitals supported the Council's actions on interfund borrowing. Mr. Bromberg called for a clarification or a reaffirmation of the government's commitment to help care for the elderly. He believes that a restoration of cost consciousness in providers and patients is intrinsic to any solution to rising in health costs. Without price awareness, the demand is infinite.

The FHA is supportive of prospective payment for hospitals and is supportive of the Administration's approach in general, although it will have amendments which it is going to propose. They are against the $305 deductible, which they feel is too high. They are in favor of a small copayment during the first 30 or 60 days of hospitalization with a catastrophic lever on the other end. They also support a voluntary Medicare private insurance option, otherwise known as a voluntary voucher. They believe an important step was taken in that direction with a 95% reimbursement for HMOs. They also favor a change in the tax law which would put a ceiling on the amount of health insurance in the private sector which is tax free to the employee. It is FHA's position that this will place a burden equally on all parties to be cost conscious.

In reply to Council questions, Mr. Bromberg acknowledged that it is the physician not the patient that makes most of the decisions regarding health care utilization. In support of increased cost sharing, FHA believes that if physicians are aware that the patient will have a substantial liability for the services he provides, or orders, the physician will think twice and control utilization. All parts of the system, i.e. patients, hospitals insurers, as well as physicians share the blame for current problems. Any reform plan should include incentives for all groups, not just hospitals.

With respect to the potential problem of lower quality of care resulting from utilization controls, Mr. Bromberg believes that physicians will not cut corners, simply because of the payment mechanism. Savings can be achieved through such actions as elimination of unnecessary week-end hospital stays, preadmission testing, and increased peer review. He cited HMOs as one example of cost effective high quality care and urged that many of the incentives offered to HMOs be provided to other types of health care providers in order to stimulate competition.

For beneficiary cost sharing, Mr. Bromberg suggested eliminating the Part A deductible and instituting a level, per diem cost sharing designed to achieve the same overall result. He noted that about half of the Medicare beneficiaries (those with less than average length of stay) might benefit from such a change. He also indicated support for eliminating the current bias for inpatient services by equalizing cost sharing between inpatient and outpatient services.

6. American Society of Internal Medicine. Dr. Monte Malach and Dr. Thomas Connally represented the American Society of Internal Medicine. Dr. Malach is President of the American Society of Internal Medicine and Dr. Connally is on the Board of Trustees. According to Dr. Malach, it is ASIM's position that an effective strategy must be developed to address the current reimbursement incentives that often have perverse results. Dr. Connally followed up by outlining specific programs for change. The first is to eliminate the current bias in favor of technology intensive procedures and against cognitive services. Dr. Connally quoted a Health Care Financing Administration study that showed that cognitive services were under valued in comparison to surgical procedures. His second point was that Medicare should provide incentives for providing services in ambulatory settings instead of more expensive in hospital settings. ASIM is strongly in favor of regulations which would permit Medicare reimbursement for any covered procedure, regardless of the setting in which this is provided as long as the setting is medically appropriate. Dr. Connally's third point was that patients should pay cost sharing for the first 60 days of hospitalization. This should be combined with a catastrophic coverage, in addition to varying coinsurance rates with income.

In response to questioning by the Council, Dr. Malach stated that his group is in opposition to mandatory assignments. In his opinion, forced assignment disrupts communication with the patient and results in a breakdown in the quality of care. Additionally, the expected future increase in the number of physicians will not reduce costs but will start a dramatic shift in patients competing for physicians.

7. Home Health Services and Staffing Association. Mr. Frank Samuels represented the Home Health Services and Staffing Association. Mr. Samuels stated his organization's position that the present reimbursement system ignores the preventative and curative care which is available through home health services.

Mr. Samuel's recommendations to the Council were two-fold. First, that home care become the first line of defense in health care and not a minor appendage, and secondly that there be a gradual expansion of home care coverage that will avoid over utilization and achieve savings from substitution for institutional costs. Home care costs would increase, but Mr. Samuel's sees a need for careful integration of home health care into the total health care system.

In the discussion following his presentation, Mr. Samuel expressed the opinion that home care was not fully utilized due to institutional biases and a lack of data on overall cost savings.

8. National Mental Health Association. Mr. Robert Vondivier, Director for Public Policy represented the National Mental Health Association. He was accompanied by John Ambrose, the Associate Director for Public Policy.

Mr. Vandivier emphasized the lack of adequate mental health treatment for the elderly. One of the primary reasons for this lack of treatment is in the diagnosis of mental illness as an inevitable consequence of growing old. Despite the need, his organization feels that Medicare regulations severely limit reimbursement for mental health treatment, particularly, in the outpatient services area, where mentally ill people could be treated most effectively. This is the result of the historic Medicare bias to hospital reimbursement.

Medicare should be changed to move toward reimbursement of various sorts of out-of-hospital treatments available now, which were not available when Medicare was first enacted. Community health centers, day treatment programs and new psychiatric drugs are examples of things that have been developed over the last 15 years. These would help the seriously mentally ill patient who lives in the community. These issues should be addressed in the context of cost containment. Changes should be made to Medicare which expand out of hospital care significantly.

Mr. Vandivier suggested that such changes could include in the benefit package a trade-off arrangement between hospital and out-of-hospital care. Yearly limitations on the extent of reimbursement for general hospital, mental health treatment might also be applied and the resulting savings used to finance out-of-hospital care. They are strongly against increasing beneficiary payments through increases in premiums for deductibles.

9. Medical Sociologist, Amy Neustein, Ph.D. Ms. Neustein gave a presentation on a program that she developed known as Prospective Payment Adaptation Program (PPAP). The PPAP program was designed to reduce cost of care to be equal to or less than an amount of fixed reimbursement under a prospective payment system. Ms. Neustein advocated a two-year moratorium on introduction for prospective payment in hospitals which adopted the PPAP program.

PPAP focuses on procedures for procuring diagnostic information during patient interviews. Through the method that she recommends, she feels it would help eliminate unnecessary tests and procedures. Another area that PPAP addresses concerns terminal cases in the last stages of illness, where many physicians use desperate measures for prolongation instead of using caring measures. This calls for a shift to pain stabilization and symptom control and away from life prolongation technology.

Mr. Heaps questioned whether a patient knows enough to discuss treatment with a physician. Dr. Neustein indicated that using proper linguistic technology, the physician can guide the patient to a more accurate description of symptoms, also noting that these techniques are not deterred by language barriers. To a question on whether hospital costs will increase even if the DRG system is legislated, Dr. Neustein responded in the affirmative, citing cost shifts and other complications.

10. Private Citizen, Ms. Audrey Koch. Ms. Koch was a former rehabilitation teacher of the blind, employed by the Columbia Lighthouse for the Blind. Ms. Koch advocated an expansion of benefits to cover services to the blind. Ms. Koch thought rehabilitation of the handicapped blind and disabled would remove them from the expensive nursing home setting and put them into a productive and independent status. She quoted as an example people who were being reimbursed for rehabilitation for strokes and other disabling diseases, which did not cover the elderly blind. She cited specific cases from the work that she had done over the past three years as to the benefits of rehabilitation.

11. Private Citizen, Mrs. Rosa Hines. Mrs. Hines testified on the benefits of rehabilitation services for the blind. She had been under the care of Ms. Koch. Mrs. Hines reviewed her situation — how rehabilitation had enabled her to get out of a nursing home which had been expensive and establish herself in an environment where she was independent and productive to the community. It is her feeling that Medicare should pay for these services, because in the long run, they would be cheaper for the program.

12. Volunteer Trustees of Not-for-Profit Hospitals. Mr. Ben Sturges, a member of the Board of Governors and Linda Miller who is the Executive Director of Volunteer Trustees represented the Volunteer Trustees of Not-for-Profit Hospitals.

Mr. Sturges had suggestions concerning improving the financing of the trust funds. He advocated moving from a flat structure of premium and deductible payments to one based on ability to pay. Under the current system, the middle and lower income beneficiaries contribute a significantly higher proportion of their expendable income to their Medicare insurance costs than wealthier patients.

The proposed alternative is to index the beneficiary's costs to his or her ability to pay. This should generate billions of dollars to the trust funds. It has a significant precedent in the progressive income tax. It is his feeling that this is equitable and puts no pressure on providers to cut back on health care services to the elderly. He addressed the argument that the Medicare program is an insurance program and that indexing based on income would violate the insurance principle. He argues that Medicare beneficiaries and those who have paid into Medicare have never ever paid the full cost of the program. In addition, times are desperate and measures must be taken to protect the Medicare beneficiaries and the elderly who should not have to suffer from reduced benefits or increased taxes.

There was further discussion on Mr. Sturges' proposal to index the deductible and copayments to income. Savings resulting from this proposal were estimated at two billion dollars. Mr. McCaffree suggested an alternative approach which would be to give tax credits based on income up to a cap. Mr. McCaffree's suggestion, it was pointed out, would require transferring funds from general revenues.

13. American Nurses Association. Ms. Ada Jacox, First Vice President and Director for the Center for Nursing Research at the University of Maryland and Ms. Cynthia Ditmyer, a staff member, represented the American Nurses Association.

Ms. Jacox felt that after 18 years of experience with the Medicare program, it was time to consider some major structural changes. Her group does not feel that minor adjustments would suffice. She expressed the view that Medicare had reached the point where its greatest benefits were to providers, hospitals and physicians, rather than to the elderly population, which it was designed to care for.

Despite increases in copayments and deductibles and reducing benefits across the board for the Medicare population, costs continue to rise, while access of elderly low income people to health care has been eroded. Ms. Jacox advocated a change from encouraging hospitalization to a more flexible use of alternative, more cost effective health care settings and providers.

She favored prospective reimbursement as a means of encouraging providers to control costs. She described the health care delivery system as a large black box characterized by excessive profit making and inefficiency. She also feels that Medicare does not address the long-term needs of the elderly, particularly the chronically ill.

Ms. Jacox strongly advocated removing the financial incentives for costly care, expanding the focus to include a broader range of alternative health care providers and settings, and maintaining a federal commitment to health care planning.

In the discussion following Ms. Jacox's remarks, there was a question as to the reasons for the increasing profits in the medical industry during recessionary periods. Ms. Jacox thought that the explanation was due to the high profit margin on medical products. Ms. Jacox also stated that one of the greatest inefficiencies was the provision of services by over prepared costly providers. Mr. McKevitt requested that ANA submit any papers available on that subject.

In response to additional questions from the Council Ms. Jacox explained that the percentage decrease of nurses over the past 20 years was due to the cap on salaries, burn out, and dissatisfaction with limits on authority. Ms. Jacox continued by explaining the lack of nurses and practitioners in nursing homes was due to the lack of emphasis within the nursing home industry on funding nursing care. A large part of the problem is due to reimbursement methods and legal constraints on what nurses can do. Ms. Jacox attributed a large amount of the inefficiencies to the overlap in functional responsibilities in the hospital.

14. American Association of Homes for the Aging. Mr. Laurence Lane, Director of Public Policy, represented the American Association of Homes for the Aging. Mr. Lane had several points to make on restructuring the Medicare benefit package. The most basic change his group advocates is modifications to the provision of long-term care services. He requested the Council carefully consider the impact on delays in cost of living adjustments on any additional cost sharing which may be advocated by the Advisory Council. He also felt that the shift in the Medicare focus to preventative long-term care services should accompany any significant changes in cost sharing.

Mr. Lane also requested that the Council consider the recommendation brought forth by the Federal Council on Aging that a secondary benefit package under Medicare be provided for the frail elderly. Catastrophic coverage would be one means of providing this type of secondary care.

Mr. Lane also felt that there would be problems with prospective reimbursement if it were applied to skilled nursing facilities. It would

increase the backlog of administrative hospital days. His final point was that his association believes there is a need for developing a social entitlement approach to long-term care. One means of doing this would be the development of Medicare Part C. Another possibility would be developing in coordination with private insurance some consolidation of certain Medicare and Medicaid features.

ADVISORY COUNCIL ON SOCIAL SECURITY
PUBLIC HEARINGS REPORTS

HEARING NO. 3

City: San Francisco, California

Date: February 24, 1983

Location: Auditorium, San Francisco Department of Public Health
101 Grove Street

Time: 9:00 a.m. - 3:30 p.m.

Advisory Council Members Present:

Dr. Kenneth McCaffree, Chairman
Dr. Linda Aiken
Dr. Richard Rahn

Council Staff Present:

Mr. Thomas R. Burke, Executive Director
Mr. Steven Finlayson
Ms. Virginia Gray
Ms. Julia Lee

Organizations and Individuals Making Oral Presentations:

1.	Occupational Therapy Association of California	Gary Powell
2.	Congress of California Seniors, Inc.	Carl Jones Executive Director
3.	Western Gerontological Society	Charlene Harrington
4.	Marin Area Agency on Aging	Miriam Wallace
5.	California Commission on Aging	Mercia Leton Kahn
6.	American Chiropractic Association	Lee R. Selby President
7.	Chinese American Citizens Alliance	George Suey Executive Director
8.	Federation of Retired Union Members, AFL-CIO	Joseph Lynch President
9.	California Association for Adult Day Health Services	Linda Crossman Vice President

10.	Senior Opportunity Service Programs of Stanislaus County	John L. Martin Executive Director
11.	San Francisco Home Health Service	Hadley Dale Hall Executive Director
12.	Long Term Care Demonstration Project of North San Diego County	L borah Hill Project Director
13.	Multipurpose Senior Service Project, San Diego Site	Evelyn Giet
14.	Department of Geriatric Services, Mt. Zion Hospital and Medical Center	Barbara Sklar Director
15.	Private Citizen	Margaret S. McGee
16.	Private Citizen	Sherman Welden
17.	On Lok Senior Health Services	Maria-Louise Ansak Executive Director
18.	California Seniors Coalition	Frank Freeland Vice Chairman
19.	Occupational Therapist	Beverly Gehri
20.	California Legislation Council for Older Americans	Ruth Davidow
21.	Gray Panthers of San Francisco	Caroljean Wisnieski
22.	Economic Opportunity Council	Goldie Korman
23.	Gray Panthers of Oakland-Emeryville	Eugene Sharee
24.	Gray Panthers of Oakland	Rose Dellamonica
25.	Department Store Employees Union, Local 1100	William Silverstein
26.	Private Citizen	Laing Sibbet

Summary of Discussion:

1. Occupational Therapy Association of California. Mr. Gary Powell represented the Occupational Therapy Association. Mr. Powell advocated an expansion of the current rehabilitative services provided by occupational therapists under Parts A and B. It is their position that this will lower long run cost by reducing the reoccurrence of hospitalization for discharged people whose disabilities are only partially covered by Part B. This is a logical extension of the treatment provided under Part A in the hospital

setting. Progress can be made to improve the condition of the elderly by completing therapy begun in the hospital in a community setting under part B. They strongly support the Boggs' Amendment to Title XVIII of the Social Security Act which would provide this type of coverage. In subsequent questioning by Council members, Mr. Powell stated his belief that the Boggs' amendment would actually decrease the cost to the Medicare program. This would occur by shifting from professional physical therapists and speech therapists to occupational therapists in the home at lower cost. Mr. Powell agreed to submit cost figures on potential savings to the Advisory Council.

2. Congress of California Seniors, Inc. Mr. Carl Jones, Legislative Director, represented the Congress of California Seniors which is a state-wide organization affiliated with the National Council of Senior Citizens. Mr. Jones' association believes that Medicare and Medicaid should be modified to cover both social services and the medical needs of the elderly. It should be changed to avoid the loss of resources the elderly suffer in order to qualify for outpatient benefits. In his opinion the current medical model on which our health delivery system is based treats only the acute illness and emphasizes utilization of high technology medicine which results in unnecessary expenditures of money and human resources. This should be reoriented to wellness programs and long term care. The programs should be changed nationally to expand Medicare/Medicaid medical reimbursement to include preventive health care and health maintenance services that include outpatient prescription drugs, eye examinations and prescription glasses, routine physical examinations, routine dental care, dental prosthetics and hearing aids. Changes should include methods to encourage the use of non institutional long term care whenever medically appropriate including home health care, day care centers, congregate housing and community based arrangements. To pay for these added costs, the Congress of California Seniors recommends mandatory prospective reimbursement for hospital services; hospital rate review commissions; negotiated fee schedules for physicians, hospital services and other providers; limiting the annual growth of hospital expenditures; expanding Medicare/Medicaid coverage to encourage development of the use of less expensive non-institutional services; providing easier access to HMOs; supporting the continuation of state and local health planning efforts; strengthening state efforts to control fraud and abuse; and mandating physician assignment under part B. Mr. Jones was against current legislation by the administration which would reduce benefits, increase cost sharing or delay eligibility for Medicare. Dr. McCaffree asked how Mr. Jones' recommendation for physician assignment would be implemented. Mr. Jones said that his organization had not worked out a complete proposal and there were a lot of questions yet to be answered, such as would all physicians have to accept assignment or would it be an individual choice by physician to accept assignment. In response to further questioning, Mr. Jones stated that it was his opinion that expansion of long term care would reduce costs by shifting treatment from institutional care to nursing homes. For other outpatient types of treatment, Dr. Aiken questioned whether beneficiaries would actually shift from physicians who do not take assignment to physicians who do take assignment if assignment became mandatory. Would this create competitive incentive for more physicians to accept assignment. Mr. Jones had no definitive information.

3. Western Gerontological Society. Ms. Charlene Harrington represented the Western Gerontological Society, an advocacy group for the aged. Western Gerontological Society spoke out against increases in copayments and deductibles and the possibility of means testing. They recommend that cost containment be achieved by making fundamental changes in reimbursement policy for Medicare. Specifically, they favor controlling rates for all payers rather than just Medicare. The association supports the Secretary on prospective reimbursement but recommends that the proposal be extended to cover all payers. They advocated a strong push for social health maintenance organizations similar to the current HCFA demonstration. Social health maintenance organizations were described as similar to the HMO model with capitated rates but including a full range of long term care services in addition to hospital and physician services. They believe this proposal will control cost at the same time as developing an integrated delivery system for the aged including a full range of acute chronic care services.

4. Marin Area Agency on Aging. Ms. Miriam Wallace spoke for the Marin County Commission on Aging. Ms. Wallace expressed her agency's concern about the emphasis being placed on cutting Medicare expenses by making the beneficiary pay a larger share of the costs. It is their position that it is incorrect to think patients can influence doctors in hospitals to deliver care at lower costs. Additionally, increasing costs to the beneficiary may discourage early treatment. The outcome is self-defeating. It will increase hospital utilization and result in more severe cases requiring acute care. Patients are not in a position to control utilization. Patients cannot control visits by non-primary care physicians while in the hospital. Only containment and control of hospital cost structures will reduce those costs. Ms. Wallace expressed opposition to the proposed cap saying that financial cost up to $2,500 are still more than many elderly can bear.

They are also opposed to the proposed voucher system. The elderly may shop around for less expensive health insurance and end up with less extensive health care. This would result in a two tier medical care system. One for those who can afford out-of-pocket expenses of any amount and one for those whose income is threatened by erosion due to increased gaps in costs in medical coverage. In response to a question from Dr. McCaffree, Ms. Wallace stated that her organization did not have any fiscal data on costs or a system that would replace the current deductibles and copayments.

5. California Commission on Aging. The speaker was Ms. Mercia Ieton Kahn, Commissioner for the California Commission on Aging. Ms. Kahn reported that her commission has had hearings throughout California on health care. There was a clear indication among California's 4.1 million older citizens that they wanted a secure, adequate and stable income in old age and accessible, affordable, and high quality health care. She is opposed to the voucher system since it opens up the door to unscrupulous insurance companies to provide less service and/or inappropriate services. It adds another profit layer which may not add to cost effectiveness. Concern with freezing reimbursement rates and cutting provider reimbursement without controlling

total provider rates will result in cost shifts to beneficiaries. The Commission strongly favors prospective reimbursement. They do not support the concomitant cutbacks in service, increased copayments and share of costs which are creating severe financial hardship for the state's poor, and discouraging them from seeking needed health care. Ms. Kahn reported that 10 years ago the State of California made access to health care for the poor more difficult by increasing their share of cost. The end result was delayed health care for the poor until problems became very acute. What the state saved in outpatient care, it more than paid for in inpatient care.

Dr. Aiken questioned how one could control cost shifting in the Part B program. Ms. Kahn thought that one possibility was in assignments. She mentioned experiments in Orange County and San Diego County where a list of doctors who accepted assignment is being published. As a result, the number of doctors accepting assignment in California is increasing. She advocated that assignment experiments be tried by the administration. Vouchers had some potential if first adequately tested. Dr. McCaffree asked for any suggestions for changing the structure of incentives that induce the decision maker to reconsider hospitalization. Specifically, incentives to physicians or the hospital in the role of decision maker on what services are to be used. Ms. Kahn felt that one key area to look into would be malpractice, as this results in a lot of unnecessary tests. Another area is physicians giving in to patients when patients request to stay an additional day. Education in that area would be beneficial.

6. American Chiropractic Association. Dr. Lee R. Selby represented the American Chiropractic Association. It is the position of the American Chiropractic Society that health care delivery in the United States is geared to a monopoly by the highest price provider groups. They want this to change to recognize the full resources of all lower cost alternative health care providers such as dentists, podiatrists, optometrists, and chiropractors. They recommend the use of tax incentives for health care competition to encourage the use of lower cost alternative health care providers. They call for a shift in emphasis from acute care to programs of wellness, as it is much more efficient and less costly system for preventing disease. Dr. Rahn asked for specific tax incentive recommendations. Dr. Selby said his organization did not have specifics. Dr. Aiken questioned whether there would actually be substitution for current practices or expansion to include other providers which would result in supplemental treatment. She wondered how this could be controlled. In Dr. Selby's opinion, lower cost providers actually treat the same ailments as physicians it is just that they use different approaches which are much less costly. Dr. Aiken wondered what would prevent the lower cost providers from increasing their fees to match the higher cost rather than having a drop in the physician cost. Dr. Selby replied that was not something that can be guaranteeed although it should reduce the prices under competition.

7. Chinese American Citizens Alliance. Mr. George Suey is the National Executive Director of the Chinese American Citizens Alliance. Mr. Suey expressed opposition to increases in costs to Medicare beneficiaries. Any increases in costs will impact mainly on elderly females who have few savings

since they have spent their lives raising families and supporting their homes. The only way to reduce cost and save the system is through cost containment. The legislature has been at the mercy of the medical industry and providers which has led to a great deal of tampering with Medicare to the detriment of the elderly beneficiaries and the poor. He wants the Council to advise the legislature on the negative impact that changes in the system will have on the poor beneficiaries of our nation. The poor are particularly vulnerable because they cannot afford to buy additional coverage through Medigap insurance to cover the costs passed on to the beneficiary. In response to questions from the Council members, Mr. Suey stated that many of the elderly Asian women are widows. They are outliving their husbands by 5-10 years. Their income is the bare minimum Social Security benefit of a $180-200. A $45.00 Medicare increase would be a substantial portion of their income.

8. Federation of Retired Union Members, AFL-CIO. The speaker was Joseph Lynch, President of the San Francisco Federation of Retired Union Members. The position of Mr. Lynch's organization is that Medicare has not significantly improved the status of health care for the elderly in this country. Medicare requires a sizeable amount of patient cost sharing and provides no protection for catastrophic illness and other services needed most by the elderly, such as preventive health care, long term care, prescription drugs, foot care, dental care, and eyeglasses. Since the out-of-pocket beneficiary costs have not changed and Medicare is increasing its percentage of the total health care cost at 19 percent per year, obviously the benefits are going to groups other than the beneficiaries. Specifically, the increases are going to hospitals and providers. The solution cannot be found in cutting benefits. His group favors prospective reimbursement but cautions against the diagnosis related groups (DRG) approach. He urged the Council to take a strong role in proposing a comprehensive program to reduce overall health care costs across the board and not strictly for Medicare. He was against current administration proposals to increase beneficiary cost sharing and vouchers. He sees both options as a tax on the current benefit status of the elderly, particularly women, by increasing the portion that would have to be paid for health care out of fixed incomes.

9. California Association for Adult Day Health Services. Linda Crossman, Director of the Adult Day Care program in Marin County, represented the Association For Adult Day Health Services. The Association advocates inclusion of adult day health care as a Medicare benefit. Adult day health care is a comprehensive package of therapuetic and health care services provided to the elderly in group settings in either free standing or institutional based facilities. It is a method of delivering health care services to disabled elderly while allowing them to remain in their homes. The program has expanded to 800 centers in the last 5 years despite the lack of a stable source of funding. The association's position is that adult day health care promotes an optimal level of functioning for disabled older persons which can reduce the incidence of further disability, acute episodic illness and hospitalization and the need for nursing home placement. This

should reduce health care cost for this population. The association presented a fact sheet that showed that a person in an adult day health service instead of a nursing home saves the state of California from $90.00 a month for people who are in intermediate care level to $312.00 a month for those who are at the skilled nursing facility. In a recent California study with approximately 300 clients, the reduction based on the number of eligibles for skilled nursing facilities resulted in a savings of $292,000 and for those eligible for intermediate level care there was a savings of $117,000. The health center delivers approximately 23 hours a month in individual nursing, physical, speech and occupational therapy. The package costs approximately $455.00. The same package delivered at home would be $1,500.00 The association supports the development of comprehensive community based and long term care programs of which adult day health care would be only one component of a range of needed services. Dr. Aiken questioned whether any study had been done of such a program being implemented with cost sharing, particularly a large copayment. Ms Crossman replied that her group is looking into that in conjunction with a health maintenance organization for the elderly with a heavy emphasis on long term care. Ms. Crossman stated that the plan would be actuarially sound. Based on a question from Dr. McCaffree, Ms. Crossman explained that it would be necessary to have a gate keeping mechanism for each client that would provide a complete assessment of the individual need.

10. Senior Opportunity Service Programs of Stanislaus County. The speaker for this group was John L. Martin, Executive Director of Senior Opportunity Service Program of Stanislaus County, Inc. The Senior Opportunity Service Program is a non-profit agency for providing services to elderly residents of Stanislaus County. Mr. Martin was specifically speaking for the group within his organization living on a fixed income that could not afford to purchase supplemental insurance coverage. It is this group that he feels would be most affected by any decrease in benefits or increase in cost sharing. He cited cases of people in the group who were doing without urgently needed medical attention because of a lack of funds. His response to the problems of the trust fund was to urge the panel to recommend that additional cost containment measures be placed on hospitals and physicians. He favored simplifying the Medicare program billing forms. In response to a question from Dr. Aiken, Mr. Martin stated his opinion that very few people in his group had any kind of catastrophic coverage. The cost of Medigap insurance is prohibitive people for that live on a fixed income of $5,000-10,000 a year.

11. San Francisco Home Health Service. Mr. Hadley Dale Hall represented the San Francisco Home Health Service. Mr. Hall characterized the problems in the home health care area as being divided into two major groups, fragmentation and abuse. Fragmentation is the result of reimbursement being spread out among the various titles of the Social Security Act. Also, there is a fragmentation in eligibility, management and definition. Abuse centers around the abuse of patients and is well documented. Abuses will not be contained until standards are revised. There were no questions by the Council.

12. Long Term Care Demonstration Project of North San Diego County. The project was represented by the Director, Deborah Hill. Ms. Hill explained that this project is a Medicare funded demonstration of community based long term care. The project is measuring the possibility of eliminating the revolving door syndrome that has developed in the acute care model by providing long term care. They are studying a group of people who are receiving benefits under Medicare that are gradually spending down their resources. These beneficiaries are going in and out of acute care hospitals when they really need treatment in a less intense setting. Costs are escalating as a result of this. Eventually, the costs are transferred to the Medicaid system and imposed upon the taxpayer. Ms. Hill wants the Advisory Council to recommend development of a national policy for long term care which would provide a continuum of health care. She emphasized the need for home health services and an interdisciplinary approach over the long term. The project is attempting to demonstrate that this approach is successful in cost containment. The preliminary findings indicate that the project is succeeding. The experimental group is utilizing 25 percent less hospitalization than the control group and the utilization of the skilled nursing facility and nursing home has decreased by 40 percent.

13. Multipurpose Senior Service Project, San Diego Site. The project was represented by Evelyn Giet. It is a Health Care Financing Administration funded project in the state of California providing information on cost effective ways of delivering health care to seniors without institutionalization. Ms. Giet emphasized the high cost burden and cost sharing that individuals must pay for home health services and long term care in the community based setting. The demonstration is showing a marked decrease in cost of about 20 percent. This is accomplished by removing individuals from inhospital service to an outpatient setting and from a skilled nursing facility into the community. For about 1,900 clients, there was a savings of $4.5 million a year. She recommends developing a very sophisticated method of eligibility screening which would identify individuals for treatment in this type of program. The screening would make it possible to make informed decisions about the appropriate level of care and how long term care can meet the needs of the clients. The information and system necessary to set up these screens are available today. This program would require major modifcation to sources of reimbursement. As long as reimbursement is fragmented, there will be no indepth look at how to provide cost effective health care.

14. Department of Geriatric Services, Mt. Zion Hospital and Medical Center. Barbara Sklar, Director of Geriatric Services spoke for the Mt. Zion Hospital and Medical Center. She briefed the panel on projects she had directed which dealt with coordinating hospital based service delivery programs in urban settings. They were long term care programs designed to provide alternatives to the existing fragmented health care delivery system. Services are tailored around individual needs and not upon reimbursement methods. An individual is offered an incentive community-based service in which individual needs are

assessed, appropriate home care services are provided, and independence is promoted. One model has a lead agency take administrative responsibility for coordinating a group of agencies to provide a comprehensive array of services to the elderly in a designated community. The lead agency is responsible for planning, developing and implementing the system. The services are purchased from existing providers. Where none exist new service programs are developed. These are all designed to prevent people from falling through cracks. Mt. Zion assists each individual through a standardized case management system. The clients are given comprehensive functional assessments and the results are presented to a multidisciplinary team. A social worker, nurse, physician and where necessary a physical therapist, occupational therapist, speech therapist or mental health professional, work together to develop a service plan. The plan is negotiated with the client and with family or friends as needed. After agreement, implementation of the plan is monitored by the service coordinator. Service funding combines existing programs, title 3 of the Older Americans Act, titles, XVIII, XIX and XX of the Social Security Act, with a group of waivered services under contract with Medicare for Project Open and under Medi-Cal for the San Francisco Multi-Service Senior Program. The ultimate goal is to demonstrate that quality, coordinated care is less expensive than institutional care. Preliminary data from the project indicates there are savings in the area of a 17 percent reduction in overall health expenses. A major savings is the result of decreased acute hospital utilization. The average length of stay for the experimental patient is 7.6 days and for the control patient 12 days. A similar pattern was observed in the skilled nursing facility. Ms. Sklar strongly advocates federal leadership in proposing legislation which would permit the merging of funds to allow for more flexibility in the delivery of health care.

15. Margaret S. McGee, Private Citizen. Ms. McGee spoke as a user of Medicare benefits. She addressed the question of possible cutbacks in the benefit allowed for hospital admissions. She felt that increased cost sharing would guarantee that many people will not be permitted to enter a hospital. It would be a return to the old practice of hospitals refusing to admit a patient without a substantial down payment in cash. This would result in people dying, and a practice of euthanasia under the mask of fiscal responsibility. Additionally, Ms. McGee spoke out against the high profits that hospitals are making. Hospitals should not be making profits since they are a public service. Another problem mentioned by Ms. McGee was the difficulty Medicare patients are having finding doctors who will accept assignment. She thought that this was due to low usual and customary fees. In response to questioning by Dr. McCaffree, Ms. McGee cited several examples that she knew of where hospitals were fraudulently billing for tests that had not been provided.

16. Dr. Sherman Welden, Neuropsychologist, Private Citizen. Dr. Sherman Welden was speaking as a private citizen. He is a neuropsychologist working with a multi-disciplinary group attempting to understand Alzheimer's disease. Dr. Welden spoke on the inadequacy in

Medicare benefits which precludes psychological testing as part of a diagnosis. As a result of this deficiency many of the elderly are misdiagnosed. There have been instances where his team has tested people and determined the proper diagnosis, and then been unable to receive Medicare reimbursement. He claims that there is an effort on the part of Blue Shield to eliminate neuropsychological testing as a benefit for older people. Dr. McCaffree questioned whether neuropsychological testing would be provided more often if it were prescribed by physicians. Dr. Welden felt that the physicians did not have sufficient experience in that area to make such recommendations.

17. On Lok Senior Health Services. The spokesman for the On Lok Health Services was the Executive Director, Maria-Louise Ansak. On Lok is a community-based long term care organization which provides alternatives to nursing home care. Their goal is to provide a health care delivery system which contains costs, provides quality care, and is targeted to the sick or elderly, specifically, those persons eligible for either intermediate or skilled nursing care. On Lok is similar to health maintenance organizations except that it provides health and social services to participants through staff or by contract with providers such as acute care hospitals and nursing homes. Since 1979, Medicare has funded the On Lok community care organization for dependent adults with the objective of applying the management reimbursement principles of HMOs to the problem of long term care. Contrary to Medicare, whose reimbursement methodology fosters dependency and encourages the use of high cost services, their program attempts to keep the individual as independent as possible and provide the lowest cost service first. Long term care providers often use the highest cost service since alternatives are not available. As an example, elderly patients are frequently placed in acute hospitals on a short term basis since there is no one available to see them through a crisis in their homes. On Lok is attempting to find alternatives and the result has been cost savings. The cost for taking care of On Lok patients was 21 percent lower than that of a match control group in the community. There have been major changes in service utilization patterns, particularly in inpatient to outpatient services. The acute hospitalization rate for the very frail On Lok patient is lower than that of the healthier average population. Freedom over the use of resources has led to creativeness. Low rates have been negotiated for service contracts and lower cost services have been substituted for high cost services. One of the keys to success has been the use of multidisciplinary teams to access service delivery and reassess participants, and the involvement of the community to ensure a check for the delivery of high quality care. According to On Lok, HCFA has not taken advantage of their findings or those of other similar long term care demonstrations which have been run throughout the country. Higher priority has been given to hospital cost containment, even though hospital costs will never be reduced significantly until there has been development of alternatives to common unnecessary hospitalization. The current approach by HCFA is not going to solve the problem of long term care for a population with multiple diagnoses and many related social problems. In their opinion HCFA needs to look at the totality of health and social care for the elderly; otherwise, its attempts at cost containment are going to be futile.

18. California Seniors Coalition. Frank Freeland, Vice Chairman of the California Seniors Coalition represented this group. Mr. Freeland spoke on the inadequacy of a Medicare program which requires additional coverage through Medigap. Additionally, he claimed that Medigap supplemental policies are inadequate and the costs exorbitant. He recommended solving this problem by expanding and improving the Medicare program. Mr. Freeland requested that there be rollbacks in the increases in the copayments and deductibles which have taken place since 1982. He favors establishing a part C optional insurance program. In response to Mr. Rahn's question on where the additional money would come from to finance the losses from the rollbacks, Mr. Freeland stated that the money could be obtained through health care cost containment and reduction of the cost increases for the hospitals and doctors.

19. Beverly Gehri, Occupational Therapist. Beverly Gehri is a private practice occupational therapist speaking as a private citizen. Ms. Gehri spoke on the financial benefits of utilizing occupational therapy in a private practice setting. Ms. Gehri reported that the occupational therapist in a private practice had lower overhead and operating costs. This meant that they could treat patients for less than if the individual was in an acute care facility or a skilled nursing facility. She was against capping the occupational therapy benefit at $500.00. This type of cap results in beneficiaries being transferred to an acute care fully covered setting as soon as the $500.00 benefit is reached. A person is taken from an inexpensive setting and put into a more expensive one with a higher cost to Medicare. Ms. Gehri advocated covering occupational therapy under Part B, particularly in the skilled nursing facility where there would be a high return for this type of treatment in removing people from the nursing facility which would reduce the number of readmissions to the acute hospital setting.

20. California Legislative Council for Older Americans. Ms. Ruth Davidow represented the California Legislative Council for Older Americans. Ms. Davidow spoke out against additional copayments. She advocated increasing benefits to cover preventive and educational type services. She is in favor of a planned health care system which would provide for needed services for the elderly and disabled in the home and community. In her opinion this would reduce the number of acutely ill being institutionalized at greater cost. Ms. Davidow is in favor of containing provider cost to pay for additional benefits and coverage for the elderly. The biggest expense to Medicare is the fact that it is part of an unplanned, unwieldy large non-system.

21. Gray Panthers of San Francisco. Ms. Caroljean Wisnieski represented the Gray Panthers of San Francisco. Ms. Wisnieski stated that it is the experience of the Gray Panthers, based on 3 1/2 years of health insurance counseling of the elderly, that most of the elderly are suffering from inflated out-of-pocket costs due to the inadequacies of Medicare as it was originally legislated. These inadequacies result in actual benefit payments amounting only to 38 percent of covered medical bills. They see the crux of the problem as being the unbridled license given to hospitals to inflate health care costs. They recommend that the government impose a ceiling on hospital bills. They advocate passage of the Medicare Physician Reimbursement Reform Act of 1982 (H.R. 7254). This legislation would provide positive incentive for more physicians to accept Medicare assignment. In response to

questions from Dr. McCaffree, Ms. Wisnieski stated that in her opinion she did not think physicians would accept assignment if they were locked into a position of accepting all or none. She is in favor of a case-by-case approach on accepting assignment.

22. Economic Opportunity Council. Ms. Goldie Korman represented the Economic Opportunity Council. Ms. Korman was against any increase in cost sharing copayment or deductible in Medicare. Ms. Korman sees the constant turmoil in the health insurance area as having tremendous impact on the health of the elderly. They cannot stand the pressure and the fear of constant changes.

23. Gray Panthers of Oakland-Emeryville. Mr. Eugene Sharee spoke for the Oakland-Emeryville, Gray Panthers. Mr. Sharee's group opposes to further increases in the Medicare premium, deductible and coinsurance payment. His group proposes that for the long run, a comprehensive national health services plan as proposed by Ron Dellums be enacted. He recommended reductions in the military budget to cover the additional funding necessary for health care. He sees it as a question of the country changing priorities on where it is going to use its resources. Mr. Sharee favored adult day health service programs which provide care to the elderly in their homes at lower rates than the cost of placing the individual in a nursing home or acute care hospital.

24. Gray Panthers of Oakland. Ms. Rose Dellamonica spoke for the Oakland Gray Panthers. It was Ms. Dellamonica's opinion that Medicare coverage has been decreasing every since it was originally passed in 1965. She thinks that the legislative intent of Medicare has been changed through regulation to reduce and eliminate services that were originally covered. She questioned the advisability of the revamping of regulations to eliminate home services in 1969. She sees as the direct result of the elimination of those services a rise in the nursing home industry with increased cost to Medicare. As a result of the increase in nursing homes, people have lost their independence and their dignity.

25. Department Store Employees Union, Local 1100. Mr. William Silverstein, a member of the Department Store Employees Union retiree group spoke. Mr. Silverstein was in favor of cost containment as a method of reducing hospital costs.

26. Private Citizen, Mr. Laing Sibbet. Mr. Sibbet was the former coordinator for the Department of Senior Services for the County of Shasta. Mr. Sibbet was in favor of changing the Medicare benefit package to include home services. Right now, these services are being covered by local municipalities and counties. When the local government cannot cover the cost of the service, they pass the patient onto the federal government who has to pay the increased cost for treatment in an institutional setting. It was his opinion that it would be cost effective if one agency covered a continuum of services instead of having it spread out among many agencies.

ADVISORY COUNCIL ON SOCIAL SECURITY
PUBLIC HEARINGS REPORTS

HEARING NO. 4

City: St. Petersburg, Florida

Date: March 1, 1983

Location: St. Petersburg Public Library, 3745 Ninth Avenue, North

Time: 9:00 a.m. - 10:50 a.m.

Advisory Council Members Present:

Dr. Richard W. Rahn, Chairman
Mr. Carlos J. Arboleya

Council Staff Present:

Mr. Philip Jos
Mr. Steven Finlayson
Ms. Ruthie Amoyal

Other Federal Staff:

Ms. Jane Westcott, Director, Office of Public Affairs, Atlanta Region

Mr. James Willis, Chief, Office of Beneficiary Services Atlanta Region

Organizations and Individuals Making Oral Presentation

1.	Florida Hospital Association	Kenneth McGee Vice President
2.	CAC Health Plan	Jeffrey Prussin Executive Vice President
3.	St. Petersburg Free Clinic	Sister Margaret Freeman
4.	Private Citizen	Emily Rogers Coeyman
5.	Private Citizen	Barry Walter
6.	Private Citizen	Sister Mary Georgia Rush
7.	Private Citizen	Ann Schumaker
8.	Private Citizen	E. H. Talbert
9.	Private Citizen	Walter Treichel

Summary of Discussion:

1. Florida Hospital Association, Inc. Mr. Kenneth McGee, Vice President of the Florida Hospital Association was the spokesman. Mr. McGee's association is strongly in favor of prospective reimbursement to lower the rate of increase in hospital costs. They view it as a method for the Hospital Insurance Trust Fund to predict outlays and allow hospitals to improve their financial planning. They are concerned about the method of change to the payment system which might cause massive shortfalls in Medicare payments to specific hospitals, particularly in communities such as Miami or St. Petersburg where there are large concentrations of elderly citizens. The Association recommends that the Health Care Financing Administration be required to make data available to the hospital association so an analysis can be made of the impact of the new prospective payment system. While this is being done, they are in favor of a cautious phasing in of the program.

2. CAC Health Plan, Inc. The speaker for the CAC Health Plan was Mr. Jeffrey Prussin, the Executive Vice President. CAC is a Health Maintenance Organization in Florida which has been serving Medicare beneficiaries under a prepaid Medicare demonstration project since November 1, 1982. The CAC plan for Medicare beneficiaries requires no premium and has virtually no cost sharing for the Medicare beneficiary. They provide unlimited hospital and skilled nursing facility days. Other benefits included in their package are preventive care, outpatient prescription drugs, comprehensive dental care with copayments, eyeglasses, podiatry, immunization, and transportation for routine appointments. They permit beneficiaries a free choice of physician although, if a beneficiary selects a physician that is not part of a CAC plan, then CAC only reimburses the physician 80 percent of the usual, customary, and reasonable charge and imposes a $100.00 per year deductible on the beneficiary. Under the demonstration project, CAC receives 95 percent of the Medicare adjusted area per capita cost. CAC claims that they are saving considerable money in administrative costs for the Health Care Financing Administration. CAC believes that they save in other areas by eliminating the need for supplemental insurance and the roll over into Medicaid from the Medicare program. Additionally, in their opinion, they reduce the rate of inflation and hospital costs.

3. St. Petersburg Free Clinic. The speaker was Sister Margaret Freeman, Executive Director of the St. Petersburg Free Clinic. The St. Petersburg Free Clinic provides service to people who do not have supplemental coverage for outpatient Medicare or Medicaid services. Sister Freeman spoke out against any increase in the cost of Medicare to the beneficiary. She favors institution of a system of appropriate care. She defined this as a national system of primary health care with an entry level of health care which would be available to all people at a reasonable cost. This system should include payment to physician extenders such as certified nurse midwives, nurse clinicians, and physician assistants. These groups can provide services for lower reimbursement rates than physicians.

4. Emily Rogers Coeyman, Private Citizen. Ms. Emily Rogers Coeyman spoke as a private citizen on her own behalf. Ms. Coeyman was against including federal employees in the Social Security system. In her opinion this would cost the federal government and the tax payer more than it would by leaving the retirement system the way it is currently structured. She advocated freezing any increases in Medicare until the cost-of-living increase is restored.

5. Barry Walter, Private Citizen. Mr. Barry Walter spoke on his own behalf. Mr. Walter was against the need for individuals on low fixed incomes to spend down their savings in order to qualify for Medicaid to obtain services which are not covered by Medicare. Particularly, he was concerned that many people on fixed incomes could not afford additional Medigap insurance. He related his personal problems with finding coverage for his wife who required institutional long term care.

6. Sister Mary Gregoria Rush, Private Citizen. Sister Mary Gregoria Rush spoke on her own behalf as a private citizen. Sister Rush was against the current high cost of Medicare. One of the biggest problems in the system is that it allows users and providers of medical services to ignore costs due to third party billing. Those unable to afford third party insurance are forced to do without health care. To resolve this problem, she made 11 recommendations:

1. Reorganize the system of health care delivery.

2. Let the government set up a decentralized network of clinics staffed by salaried doctors and other health care workers with a focus on preventive measures and wellness.

3. Pay hospitals a flat rate based on set prices for the more than 45 different categories of illnesses.

4. Give incentives for cost efficiencies. For example, if the hospital can cover the cost for less than the flat rate it receives, let it keep the difference. If it exceeds the cost, then the hospital receives nothing more from Medicare. This would lead to approximately $18 billion in savings for Medicare over the next 3 years.

5. Put a ceiling on reimbursement to hospitals and physicians for patient care.

6. Tax federal employees who are eligible for Medicare benefits but who do not pay Social Security taxes.

7. Allow tax breaks or offer incentives by subsidizing community care for the elderly to keep people from being institutionalized.

8. Increase the retirement age to 70.

9. Get a handle on fraud.

10. Put the nation's 10 million unemployed back to work so more dollars will be paid into the system.

11. Take a look at other countries, especially Japan, for solutions to Medicare problems.

7. Ann Schumaker, Private Citizen. Ann Schumaker spoke on her own behalf as a private citizen. Ms. Schumaker spoke on the draining cost hospital care has on the elderly, particularly women. It strips them of their dignity and takes away what few savings they have. The problem is related to the lack of control on hospital and physician medical costs. She related several personal experiences which involved abuses by both hospitals and doctors. She believes doctors are preying upon the elderly who do not understand the system. Doctors force patients into accepting unnecessary tests and admittances which drain them of what little money they have.

8. E. H. Talbert, Private Citizen. Mr. Talbert spoke on his own behalf as a private citizen. Mr. Talbert expressed his low opinion of the Health Care Financing Administration. The Health Care Financing Administration is doing nothing constructive to hold down medical costs. As a result of their negligence, Congress is being forced to shift a large share of medical expenses to the elderly. Among HCFA's specific failures is its inability to solve the problem of medical cost containment. He recommends that the federal government spend more money on policing the medical profession. HCFA should do this as one of its primary missions. He urges increased competition within the medical profession and that people caught cheating or fraudulently abusing the system have their licenses removed and be jailed.

9. Walter Treichel, Private Citizen. Mr. Walter Treichel spoke on his own behalf as a private citizen. Mr. Treichel spoke on fraud in the Medicare program. He advocates increased prosecution for fraud of doctors who are abusing Medicare to make money. He complained that beneficiaries report fraud and nothing is done. The cases are not investigated. He recommended increasing the premium and providing 100 percent coverage of all services to protect low income beneficiaries who cannot afford supplemental insurance.

ADVISORY COUNCIL ON SOCIAL SECURITY
PUBLIC HEARINGS REPORTS

HEARING NO. 5

City: Evanston, Illinois

Date: March 9, 1983

Location: Third Floor Auditorium, 1 American Plaza

Time: 9:00 a.m. - 2:30 p.m.

Advisory Council Members Present:

Mr. C. Joseph Stetler, Chairman
Mr. David W. Christopher
Mr. Karl D. Bays
Mr. Richard W. Rahn
Mr. James Balog

Council Staff Present:

Mr. Thomas R. Burke, Executive Director
Mr. Steven Finlayson
Ms. Julia Lee
Mr. Eugene Scanzera

Other Federal Staff:

Mr. Wayne Stanton, Regional Director, Chicago Regional Office
Ms. Jill Black, Director, Office of Public Affairs,
Chicago Regional Office

Organizations and Individuals Making Oral Presentations:

1.	Action Committee to Implement the Mental Health Recommendations of the 1981 White House Conference on Aging	Bernice Neugarten
2.	Private Citizen	Martin Tater
3.	Society for Hospital Social Work Directors	Maria Davis
4.	American Medical Peer Review Association	Howard Strawcutter, M.D. President
5.	American Medical Association	Jerald Schenken, M.D. Vice Chairman
6.	Ancilla Domini Health Services	Richard Batt Vice President

7.	St. Mary's Hospital, East St. Louis	James C. Bell Director
8.	American Federation of Home Health Agencies	Karen Linnell President
9.	Legal Assistance to Medicare Patients	William A. Dombi Attorney
10.	Kansas Association of Home Health Agencies	Yvonne Olsen President
11.	Renal Physician's Association	Alan Kanter
12.	American Health Care Association	C. Robert Norman President
13.	Visiting Nurse Association of Evanston	Catherine B. Carey Executive Director
14.	Evanston Commission on Aging	Roselle Hart Secretary
15.	Illinois Department of Aging	Albert Neely Special Assistant
16.	Private Citizen	Jennie J. Wolf
17.	American Pathology Foundation	Perry A. Lambird, M.D. President
18.	Suburban Cook County Area Agency on Aging	Jonathan Lavin Executive Director
19.	Illinois Nurses Association	Joann Page President
20.	Gray Panthers	Agnes Ranseen
21.	National Council of Senior Citizens	Loretta Simmons
22.	Academy of Certified Social Workers	Sandra Johnson
23.	Private Citizen	William Griffith
24.	North Shore Senior Center	Pat Taylor Executive Director
25.	Wilmette Housing Commission	Jean R. Cleland Chairperson
26.	Aid for Independent Living	Phyllis Upshaw

Summary of Discussion:

1. Action Committee to Implement the Mental Health Recommendations of the 1981 White Conference on Aging. Bernice Neugarten represented the Action Committee. The Action Committee is concerned with the issues related to the financing, organization, and delivery of mental health services to older Americans. It is the belief of the Action Committee, based on findings of the 1981 White House Conference on Aging and studies by other organizations, that mental health care concentrated on an inpatient physical health oriented treatment model is often less effective than outpatient treatment for the majority of emotional behavioral difficulties that are experienced by older people. Despite this, Medicare coverage for outpatient mental health care is restricted to $250 per year with a coinsurance. In their opinion, as a result of these policies, thousands of older Americans are foregoing treatment for psychological problems or are receiving inappropriate intensive and expensive inpatient mental health care. The committee feels that the problems of the elderly in many cases can be treated through relatively short term therapy which usually can be administered on an outpatient basis. Specific changes recommended by the Action Committee are first, the annual limit for outpatient care should be expanded to $1,000 per year, which would allow between 15-20 sessions of therapy. Second, coinsurance requirements should be decreased to 20 percent to be equal to coinsurance requirements for physical health care. Third, the Medicare program should cover services by non-physician mental health providers such as psychologists, social workers and psychiatric nurses as well as physician services provided through the community health centers and medical centers. This would expand the availability of services and stimulate providers to more generally recognize and treat older persons. In response to a question from Mr. Stetler, Ms. Neugarten informed the Council that there was no specific action going on at this time in Congress to implement their recommendations on mental health.

2. Private Citizen, Martin Tater. Martin Tater represented himself as a private citizen. Mr. Tater advocated separating Social Security from Medicare. He wants Social Security to be set up as a separate administration with funding strictly from Social Security revenue sources currently in place. He recommended that Medicare be set up as a separate administration with benefits financed strictly from general revenues. He favors restricting Social Security and Medicare benefits to citizens of the United States. Mr. Tater felt that this had to be done in order to provide security for future generations.

3. Society for Hospital Social Work Directors. The speaker for the Society for Hospital Social Work Directors was Maria Davis. Ms. Davis was against any changes in the reimbursement formula for Medicare which would place an additional burden on the elderly. Any increase in copayments would place a heavy burden on the elderly population. The result of this type of burden would make preventive medicine unaffordable to the elderly. People coming into the hospital would have more severe illnesses and would need more major medical intervention with hospital stays which are

significantly longer. She mentioned home health care, adult day care, foster care and outpatient mental health care as systems designed to prevent the elderly from having to be committed to hospitals or institutions at higher rates.

4. American Medical Peer Review Association. The American Medical Peer Review Association was represented by their President, Howard Strawcutter, M.D. Dr. Strawcutter described several problems that might occur under recent changes to the Medicare laws in TEFRA and the proposed prospective payment system. Some of the impacts resulting from TEFRA might be inappropriate admission of patients who should be cared for on an outpatient basis, favoring admission of patients within each DRG group whose costs are comparatively low; allowing bias to affect the selection of principle diagnosis for patients with multiple diagnoses in order to obtain higher payments; withholding clinical services; substituting less expensive services; and delaying the use of new technology in order to reduce the cost which would encourage greater overall use of services in subsequent stages. Dr. Strawcutter emphasized that the administration has not focused any attention on quality and appropriateness of medical care. It is his group's feeling that true utilization review can only be conducted by skilled professionals. Only medical review at the local level will protect the cost effectiveness of care in the aggregate by reducing unnecessary readmissions or preventing unacceptable levels of care. He believes that an effective utilization and quality review system must continue to operate to monitor hospital admission practices, quality of care, the documentation necessary to conduct evaluations of patient care and to indicate corrective action as necessary. In response to a question from the Council, Dr. Strawcutter clarified that he thought that abuses in the admittance patterns would be more likely in for-profit hospitals since they can more easily avoid admitting the sickest types of patients. Dr. Strawcutter mentioned the probability of the admission of beneficiaries who had previously been treated on an outpatient basis. Dr. Strawcutter was asked what the reasoning was behind the administration attempt to eliminate peer review. He responded that he thought it was a move on the administration's part to eliminate what they perceive as a regulatory function and to open medicine up to the free market forces.

5. American Medical Association. Gerald R. Schenken, M.D., Vice Chairman of the American Medical Association Council on Legislation spoke for the AMA. He outlined how recent technological breakthroughs in medicine had driven the cost of medical care higher. To control increasing cost two approaches have been recognized. The first, which has been used over the last few years was to reduce the demand on the Part A trust fund by changing the laws governing the scope and operation of the program. The second approach is to increase the FICA tax which goes to support the Hospital Insurance Trust Fund. The AMA does not support any increases in the program or major restructuring unless there are adequate assurances that there will be continued appropriate high quality care available to all beneficiaries. If this cannot be done then Congress must recognize the problem and inform the American public that they are reducing the earlier promises of the Medicare program. It is their position that the experience with Medicare shows the need for integrated short and long term national health policy. The AMA has undertaken such a program involving all sectors of the American public including physicians, federal

government, business, hospital associations and beneficiaries. They expect the first results from this project later this year. In regards to the administration proposals the AMA is opposed to immediate adoption of the prospective payment program. They would rather see a demonstration of the proposal. They are opposed to the elimination of the one percent add-on to hospital target rates which allows for increases in intensity of care. They do not support the Medicare voucher system but would rather see demonstrations and experimentation with diverse approaches to vouchers. The AMA supports catastrophic coverage for Medicare beneficiaries with copayments during early hospitalization, but they are concerned about the amount of copayment that has been proposed and the timing of the implementation. They are opposed to the proposed 1 year freeze on physician reimbursement under the Medicare reasonable charge system. They want Congress to ensure that the Medicare Trust Fund will be restored after it has been weakened by interfund borrowing. They are in favor of increasing the HI portion of the FICA tax on employees and employers. Mr. Rahn questioned Dr. Schenken as to whether the AMA realizes the impact of increasing payroll taxes on the unemployment rate. Dr. Schenken reply that they did but the impact on unemployment had to be weighed against the promises that had been made to the elderly. Mr. Bays asked Dr. Schenken to comment on physician assignment. Mr. Schenken did not think the AMA has taken an indepth survey on physician attitudes toward assignment. Mr. Balog questioned why assignment rates vary by age, geographic region and medical specialty. Dr. Schenken did not know. Dr. Schenken thought that any type of mandatory assignment would not necessarily deny the Medicare beneficiary treatment but it would surely deny the beneficiary some access to care. It would downgrade the importance of the dialogue between the doctor and the patient on ways to use resources available. In the end, it would be punitive to the beneficiary. In response to a question on defensive medicine and the feasibility of medical malpractice pool insurance, Dr. Scheken did not think that the physician should be immune to the risk for poor practice. In response to a question on the extent of defensive medicine, he felt that approximately four percent of medical practice was defensive.

6. Ancilla Domini Health Services, Inc. Mr. Richard A. Batt, Vice President of Ancilla Domini Health Services represented that organization. Mr. Batt advised the Council members that the country is moving toward a two tier health care system. One tier is composed of high quality service for those who are employed and the other tier covers the poor and the elderly who have been treated previously through titles XVIII and XIX. His organization advocates a national dialogue on whether American society should have a national health policy which provides a general level of quality basic services to persons of all socio-economic means or whether to continue to permit the two tier health system to develop. Additionally, this group advocates a basic structural reform of the health care system. They are for spending less money on hospitals and more money on ambulatory care, home health services, day care, homemaker services and preventive services. Mr. Batt emphasized the importance of the long term financial health of the Social Security program. He favors mandatory and universal coverage. His final recommendations were for development of a long term strategy for long term health care to prevent the random development of policy at high cost, as high technology advances are made to prolong the life of individuals.

7. St. Mary's Hospital, East St Louis, Illinois. Mr. James C. Bell, director of community relations represented St. Mary's Hospital. St. Mary's is a private not-for-profit hospital. Mr. Bell addressed the problems resulting from the Tax Equity and Fiscal Responsibility Act of 1982. Under the changes to Medicare, high quality, high efficiency hospitals such as St. Mary's will be penalized for having been cost effective. This is due to cost increases being restricted to eight percent for 1983, even though St. Mary's rate per discharge is 36 percent below the norm for the region. This clearly demonstrates that the target rate limits place a greater penalty on institutions which have been cost effective in the past. Under the proposed prospective payment system using DRG's, if the rates are set on historic cost and not regional or national basis then the efficient hospital will be treated the same as the inefficient. This will be unfair and damaging to the most efficient providers.

8. American Federation of Home Health Agencies, Inc. The Federation president, Karen Linnell was the speaker. Ms. Linnell was present to advocate expansion of home health care services as a cost effective and more humane treatment modality for large numbers of elderly Americans. She bases this on the changes that have taken place in society which have reduced the family ability to assist the elderly person. The most significant factor that has changed has been the increase in working women. Additionally, the health care needs of the elderly have changed dramatically since 1965 when Medicare was enacted. No longer is acute illness the problem that it was at that time. This change means that more of the elderly are surviving the acute phases of their illness and face a relatively long period of chronic illness with debilitating conditions. Most of the elderly are unable to meet the stringent Medicare requirements for home health care. As a result they are institutionalized which dramatically increases medical expenses. Ms. Linnell made the following recommendations:

1. Modify the present definition of intermittent skilled nursing and home health aide services to permit up to 60 daily visits of each for each illness.

2. Remove the requirement that a patient be confined to his residence to receive home health services under Medicare.

3. Cover drugs and biologicals in the home setting for patients under a home health plan of treatment.

4. Cover home health aide and homemaker services without the prerequisite that patients require skilled nursing, physical or speech therapy so the provision of home health aide and homemaker services would prevent institutionalization.

5. Provide for added incentives for home care, including adoption of patient assessment and referral mechanisms for all elective institutional admissions, tax credits for people who care for elderly family members at home and reduce Medicare institutional reimbursement for those diagnoses that can be treated by home health services.

In response to a question from the Council on the potential for exploitation and abuse of the program, Ms. Linnell replied that in the state of Michigan home health agencies are closely monitored by both the Department of Public Health and Blue Cross/Blue Shield of Michigan, the Medicare intermediary.

9. Legal Assistance to Medicare Patients. This group was represented by an attorney, Mr. William A. Dombi. This is a legal advocacy group representing Medicare beneficiaries. Mr. Dombi spoke against the administration proposals for copayments and freezing physicians reimbursement as a method of controlling utilization. In his opinion, the system controls utilization and there is no overutilization of services at this point. He views the additional copayments and freezes as a means of reducing Medicare expenditures and reducing utilization not controlling a nonexistent overutilization. They will have an adverse impact on the health care of the elderly by keeping the beneficiaries away from the services they require. Mr. Dombi advocates a total restructuring of the Medicare program which will replace the current restrictions on beneficiary access to care. Part of this restructuring would be to use the economic power of the Medicare program to force physicians to accept assignment. Another area of reform would be to shift the emphasis toward preventive medicine particularly in the early stage of diagnosis. This would include reconsideration of the needs of the chronically ill individual. In Mr. Dombi's opinion there is misadministration of the program through the denying of benefits to individuals who should be covered, according to the intent of Congress. The administration is arbitrarily withholding benefits through denial and redefinition. In response to a question from the Council, Mr. Dombi expressed the opinion that if there were more skilled nursing facilities their utilization would reduce the hospital stays of beneficiaries.

10. Kansas Association of Home Health Agencies. The speaker, Yvonne Olsen is President of the Kansas Association of Home Health Agencies. The Kansas Association advocaces home care as a means of reducing Medicare cost. They are against the proposals to increase the deductible and copayments. Ms. Olsen thinks the result of any increases will be in discouraging utilization of medical services by the aging who simply cannot afford increased out-of-pocket expenses. They are strongly in favor of hospice coverage as defined in the Tax Equity and Fiscal Responsibility Act of 1982. In the area of vouchers they do not recommend that a system be immediately implemented. They would prefer to see a pilot study done first. She questioned the advisability of vouchers, since the profit incentive would add to the administrative costs on the premiums of any voucher program.

11. Renal Physicians Association. Dr. Alan Kanter represented the Renal Physicians Association. Dr. Kanter described the End Stage Renal Disease program as a very unique $1 billion a year operation being run by the Health Care Financing Administration. The program has been cost effective. One example is the fact that dialysis today costs less than dialysis did in 1967. In Dr. Kanter's opinion, one of the problems of maintaining continuing cost efficiency in this program is the lack of continuity in the Health Care Financing Administration's senior management. The changes in management within HCFA prevent any continuity in the promulgation of rules and regulations. Also, the changes in management create delays and protract decision making which adds cost to the program.

12. American Health Care Association. C. Robert Norman, President of the Indiana Health Care Association spoke for the American Health Care Association which represents long term health care facilities. This association makes recommendations for the financing and coverage of extended care services under Medicare. He described the misunderstanding of the elderly that Medicare coverage is comprehensive. In particular he spoke about the restrictive medical eligibility criteria for skilled nursing facility care. Medicare currently pays less than two percent of the nation's nursing home costs. As a result, nursing home patients and their families are stuck with 42 percent of the over $20 billion cost. Specific recommendations by the association were:

1. Implement a prospective reimbursement system for skilled nursing facilities. Currently, over 2/3 of the state Medicaid programs have successfully employed prospective payment systems for nursing homes.

2. Set a reasonable fixed coinsurance amount for skilled nursing facilities. They recommend disconnecting the artifical linkage between the percentage of the SNF payment rate and the inflationary hospital cost.

3. Redefine the allowable coverage for skilled nursing care to permit a broader range of nursing home services, particularly intermediate care. These should provide more economic and appropriate services to the Medicare beneficiary.

4. Implement the Congressional directive to eliminiate the minimum 3 day prior hospitalization requirement for skilled nursing facility coverage.

5. Redefine of the spell of illness to eliminate inconsistencies. The spell should end when the beneficiary is neither under Medicare inpatient treatment or skilled nursing facility treatment.

6. Reimburse for services performed by physician assistants and nurse practitioners under the supervision of a physician, acting within the scope of their license to conduct Medicare required visits and recertificiation.

These combined recommendations should conserve program spending, improve service to the beneficiary, and enhance the provision of long term care. In response to a question from the Council, Mr. Norman described their proposals as being cost neutral. Initially there would be a shift in cost from inpatient care to the skilled nursing facility, but it is their position that it is a long run opportunity for reduction in total program cost through the shift in care.

13. Visiting Nurses Association of Evanston. The presenter was Kate Carey, Executive Director of the Visiting Nurses Association of Evanston. Ms. Carey was also speaking for the Illinois Council of Home Health Services. Ms. Carey described the beneficial effects Medicare has had on the elderly to date. She then described the shortcomings of the Medicare program. Specifically, she

addressed the problem of lack of coverage for mundane every day needs, particularly, chronic care for the elderly. In her opinion, the focus of Medicare needs to be shifted to include an expanded role for home care. She described home care as being less expensive than hospital care and more supportive of independence. She cited the hospice program as being a step in the right direction. Ms. Carey recommended prudent use of homemakers, more thoughtful use of home health aides and strengthening the use of social service assistance for the individual. Her position is to focus on a shift from the high cost setting, where 74 percent of the dollars go, to the lower cost more humane setting where the people are. Another recommendation was that the Council examine the bonanza that Medicare has been for hospitals, physicians, and intermediaries, and that be the area that the Council look for economies. Copayments and deductibles were described as punitive measures against the elderly who are already beleagured.

14. Evanston Commission on Aging. The Evanston Commission on Aging was represented by the secretary, Roselle Hart. Ms. Hart addressed four points that are considered vital by her organization to any future plan for Medicare.

1. Medicare should remain an insurance program which makes means testing unacceptable.

2. Cost savings should be accomplished through hospital cost containment rather than beneficiary deductibles and coinsurance.

3. Home based health services should be expanded to enable a person to continue living in their home.

4. Medicare should be expanded to provide an array of services to the chronically ill who cannot remain in their homes. This should include nursing homes and other institutions.

15. Illinois Department of Aging. Mr. Albert Neely spoke for the Illinois Department of Aging. Mr. Neely spoke about the problems facing minority Medicare beneficiaries, particularly the female elderly who comprise a disproportionate share of the population below the proverty line. Mr. Neely's department had several recommendations to make to Medicare to correct the problems of the poor elderly. Specifically, he referred to a program administered by the state of Illinois which provides community care and support services to reduce incidence of institutionalization of people over age 60. Approximately 11,000 people are currently utilizing the services. Another recommendation of his department is to provide tax credits to families who provide care to older people in their own homes. One area that he is concerned with is putting constraints on the constant rise in deductibles and coinsurance cost being borne by the beneficiaries. In addition to this, they would like to see more emphasis placed on promotion of wellness programs and a preventive care concept. Mr. Neely recommended the Council look into a means of improving the rate of acceptance of assignment by physicians. He concluded his comments by emphasizing that techniques needed to be developed which would not place the sole burden of cost containment on the consumer but rather on the health system itself which has the prime responsibility for determining utilization.

16. Jennie J. Wolf, Private Citizen. Ms. Wolf spoke as a private citizen about her views on Medicare. Ms. Wolf favored taking Medicare out of Social Security. She was against having to pay Medicare taxes after age 65 even though the person may be working.

17. American Pathology Foundation. Dr. Perry A. Lambird, president, American Pathology Foundation, was the speaker. Dr. Lambird's association presented seven approaches to revising Medicare.

1. His organization believes that through financing, the amount of services for Medicare are actually rationed. This includes rationing of quality of services and rationing of innovation. It is his feeling that hospitals, doctors, and the federal government should be removed from decision-making based on rationing. The patient should be the one to determine what quality and what level of care would be received.

2. In the area of payments for medical and hospital services, his group recommends the establishment of an indemnity payment system or individual IRA trust fund which would pay bonuses to individuals based on controlling expenditures. Under the IRA concept, there would be no Medicare payroll tax. The bonuses would encourage people to control utilization which would result in a decrease in medical cost. This would provide a psychological incentive to the patient to control services at the time they are rendered. The system would include catastrophic health coverage and provide first dollar coverage in excess of what is available currently.

3. The Medicare program should have any associated welfare benefits cut out from the medical hospital benefits which are covered under the program. Specifically, End Stage Renal Disease programs should be removed from Medicare coverage.

4. Dr. Lambird recommends that the Department of Health and Human Services increase the number of experiments in hospital reimbursement techniques.

5. The foundation recommends that the Council propose the reinstitution of the Health Insurance Benefits Advisory Council in the Department of Health and Human Services. It is his opinion that this would eliminate the advisary relationship between the Medicare administrators and the providers.

6. Dr. Lambird recommends that the Advisory Council obtain the American Medical Association health policy agenda, study it and follow its guidelines.

7. He recommends that the Council support the continuation of basic research and technological development in medicine. In his opinion the recent administrations have been anti-technology and have attempted to block the continuing development of medicine.

In response to a question from the Council on different methods of handling physician assignment, Mr. Lambird felt that the main problem with assignment is the cap on the usual prevailing, and, customary fees that Medicare pays. The rate Medicare pays is well below the inflation rate of treatment provided by the physician. As a result, the physicians are not interested in assignment. If assignment is mandated, then it is his opinion there will develop a two class medical system for the beneficiary. The Council asked for Dr. Lambird's opinion on the extent of the problem of practicing defensive medicine and if a possible solution might not be a Medicare administered insurance program. Dr. Lambird thought that the problem of defensive medicine is not as significant as is touted. He does not believe that the government could effectively manage an insurance program and that this should be left in the hands of the free market system and private sector.

18. Suburban Cook County Area Agency on Aging. Johnathan Lavin, Executive Director, Suburban Cook County Area Agency on Aging, was the speaker. Mr. Lavin related the problems older Americans have in obtaining affordable health care. Over the past 3 years, the cost to the individual for medical treatment has increased at an accelerated rate. Shifting of these increases to the elderly is becoming oppressive to the point where the elderly are having to make budgeting decisions which may force an older person to neglect medical care for more urgent needs until the medical condition has become truly chronic. Mr. Lavin was against the negative approaches that are being pursued to control cost. For example, one method is denying more claims which results in shifting the payment to the beneficiary and increasing the beneficiary portion of cost. He recommends a prospective payment system for controlling cost. He is in favor of a total system of long term care which should be community based. In response to a question from the Council on how to fund the proposed total system for health care, Mr. Lavin felt that at this point, the funding for the elderly was broken into several categories. If you were a worker at some point, then Medicare was willing to pay for your acute care, but if you were not a worker or you were impoverished, then Medicaid would pay for your long term needs.

19. Illinois Nurses Association. The president of the Illinois Nurses Association, Joann Page, spoke. Ms. Page described the inadequacies and the gaps in coverage in the benefits in the Medicare program. She was concerned about the lack of attention to the long term needs of the elderly. Because of the lack of an alternative to institutional care, many older Americans must either live in a skilled nursing home, where the level of care is often higher than they need, or try to remain in their own homes where care may be inadequate or non-existent and insurance rarely covers needed health services. Additionally, her group is against increased copayments or deductibles which will impose a growing financial burden on the Medicare beneficiaries who are least able to absorb increasing costs. They recommended several changes to Medicare to compensate for the problems that they foresee.

1. Study and design a prospective payment system.

2. Look at a variety of alternatives for financing and providing health care, such as a preferred provider organization.

3. Shift the emphasis of Medicare from cost of institutional health care to a broader focus on more cost effective alternative providers of health care outside of institutions.

4. Modify the continued physician control of patient access to health care by giving a greater role to alternative providers and health services.

5. Insure cost efficiency by the government renewing its commitment and support for Medicare by approving and strengthening health care planning. Based on the past experience deregulation results in a proliferation of costs.

20. Gray Panthers. Agnes Ranseen represented the Gray Panters. The Gray Panthers were in favor of enlarging health care benefits and making it more accessible to people in need. She spoke about the detrimental effect of increasing copayments and deductibles for individuals who are on fixed pensions. Ms. Ranseen does not want the elderly to have to make the choice between food or health care.

21. Edna Summers, Private Citizen. Edna Summers spoke on her own behalf as a private citizen. She was formerly an alderman from Evanston. Ms. Summers spoke about the advantages, both financial and moral, to the elderly of expanding home health services and home care for the disabled. When it comes to budget cutting, she recommended looking at the duplication of expensive equipment and the increases in hospital costs as areas for controlling the rise of expensive health care. She was against anything which would deprive the elderly, who have contributed to the community, of their dignity such as a means test. She was strongly in favor of retaining the insurance concept of Medicare.

22. National Council of Senior Citizens. Ms. Loretta Simmons is an advisor to the Northwest Council Senior Citizens. Ms. Simmons claims that many senior citizens, after 16 years of Medicare, still do not have the services that the program was designed to provide. She maintains that the public, particularly the elderly, want better access to health care and not the limits and the reductions in benefits which are being proposed in Wasnington. Ms. Simmons was against the increases in deductibles and additional copayments being proposed. She was against any kind of a means test. Another point of concern was the lack of representation of elderly on the Advisory Council. The Council was weighted in favor of the business community. Nothing was being done to curtail the profits in medical care whereas much is being done to curtial the benefits. In response to questions from the Council, Ms. Simmons said she favored using general revenues by cutting the military budget to finance expansion of benefits and access for the elderly.

23. Sandra Johnson, Private Citizen. Sandra Johnson, a social worker, spoke on her own behalf. Ms. Johnson reported that among the elderly, their major concern was the skyrocketing cost of Medicare. Four specific areas that she addressed as being problems for the elderly were:

1. The process of filing for Part B Medicare benefits.

2. The question of non-coverage of preventive health visits.

3. The fact that mental health outpatient care is limited to $250.00 per calendar year.

4. Home health care proprietary agencies versus voluntary agencies.

She cited HMOs as an example of how preventive health care can reduce health care expenses. She was against the special privileges which permit proprietary home health care coverage to exceed the coverage which could be provided by voluntary agencies.

24. William Griffith, Private Citizen. Mr. Griffith spoke on his own behalf. Mr. Griffith was against the voucher plan. As a former insurance salesman, he feels that private insurance companies are offering inadequate coverage compared to Medicare. In his opinion, a voucher plan would lead to serious insecurity on the part of the elderly as to their future health care. The current Medicare system on the other hand does leave a degree of confidence and stability in the minds of senior citizens. It is his opinion that it would be better to continue reviewing the Medicare program and improving it than creating a competitive voucher plan. Another area that Mr. Griffith recommended for change was improving and increasing the number of audits on physician and hospital bills. One way to do this would be to offer a bonus or commission to claim processors. The money would come from the Medicare system from recoveries from excessive billings by doctor and hospital. Mr. Griffith urged the Council to look at methods to increase the assignment rate among physicians. He favors catastrohpic coverage. He sees the fear of long term debilitating illness as being a primary factor of insecurity in the elderly. He recommends inclusion of catastrophic coverage in Medicare. His final recommendation was to develop a system of preventive medicine for Medicare. This, in his opinion, would reduce the long term cost to the program. He specifically recommended HMOs as a means of doing this.

25. North Shore Senior Center. Pat Taylor, Executive Director of the North Shore Senior Center spoke on behalf of the senior citizens at her center. Ms. Taylor was part of the 1981 White House Conference on Aging and spoke on the resolutions that resulted from that conference. Particularly, she spoke about the charges that the Conference made to Congress and the President to develop a national health policy which would assure full comprehensive health services to all Americans. In her opinion we cannot expect a tax on the diminishing number of workers to finance a health system where cost are double the inflation rate. She sees the crisis in Medicare as only part of the problem the whole nation is facing. It is a problem where steadily increasing costs are increasing the expense to the worker and to the user of the system. This crisis is due to a patchwork quilt of self-defeating policies. She is not in favor of spending any more money trying to repair a system which is not working and probably has never worked as it was intended. She sees the country as needing a fundamental change. We have a national responsibility for health care and the Council must develop a plan to provide this to the citizens.

26. Wilmette Housing Commission. Jean R. Cleland represented the Wilmette Housing Commission. Ms. Cleland is a community service worker with the elderly in Wilmette. She spoke about the daily problems people have with the Medicare system. To them it is complicated and confusing. They feel that in many cases, coverage is both inadequate and generous. The beneficiaries are unfamiliar with what is covered and what is not covered. Nor are they aware of the changes that occur from time to time. As a result, they do not know how to make claims. In some cases they do not even apply because they are cynical and do not believe Medicare would pay for anything. They have difficulty keeping track of the claims and reimbursements. As a result, they are over-insured with medigap insurance even when they cannot afford it. They are strongly in favor of preventive health coverage so they will not have to put off seeing a doctor for precautionary care when they cannot afford it. Her solution to some of these problems is in encouraging assignment and developing the health maintenance organization method of providing health care.

27. Aid for Independent Living. The spokesperson for Aid to Independent Living was Phyllis Upshaw. Aid for Independent Living provides home services. This group is in favor of extending Medicare coverage to non-medical home services as a means of improving health prevention and reducing the cost of institutional care. Ms. Upshaw felt that this would reduce admissions to hospitals and costs to the Medicare program. Also, mental and physical problems could be identified earlier before they have a chance to become severe. She cited several examples of cases where the independent living worker determined a problem existed and referred the case for further development.

ADVISORY COUNCIL ON SOCIAL SECURITY
PUBLIC HEARING REPORTS

HEARING NO. 6

City: New Brunswick, New Jersey

Date: March 22, 1983

Location: The Labor Education Center

Time: 9:00 A.M. - 5:00 P.M.

Advisory Council Members Present:

Linda H. Aiken - Chairperson
James Balog
Alvin E. Heaps

Council Staff Present:

Thomas R. Burke, Executive Director
Steven Finlayson
Julia Lee
Judith Peres
Eugene Scanzera

Organizations and Individuals Making Oral Presentations:

1.	Brookdale Center on Aging	Daniel G. Fish
2.	Rutgers Community Health Plan	Roger Birnbaum
3.	American Jewish Congress	Martin Hochbaum
4.	The New Jersey State Society of Anesthesiologists	Arganey L. Lucas
5.	The New York State Office of Aging	Craig Polhemus
6.	New Jersey Psychological Association	Bart Rossi
7.	The New Jersey Federation of Senior Citizens	John E. Kelly
8.	The Medical Society of New Jersey	Howard Slobodian
9.	The John F. Kennedy Medical Center	Joseph Sherber
10.	The Action Alliance of Senior Citizens of Greater Philadelphia	Jack Zucker
11.	The Senior Adult Council of the Jewish Y's and Centers of Greater Philadelphia	Seymour Kornblum

12. The Archdiocese of Philadelphia Senior Citizens Council	John Boyle
13. The Rutgers University College of Nursing	Lucille Joel
14. The National Committee on Nursing	Ernest May
15. The New Jersey State Nurses Association	Suzanne Hawes
16. The Essex County Division on Aging	Joseph Bernstein
17. The New Jersey State Department of Health	Faith Goldschmidt
18. The Home Health Agency Assembly	Winifred Livengood
19. The Loeb Center for Nursing and Rehabilitation, Montefiore Hospital	Genrose Alfano
20. Private citizen	Eline McGriff
21. Private citizen	Miriam Dinerman
22. Private citizen	Suzie Mundhenk
23. Private citizen	Lucille Mahn
24. Private citizen	Shirley Dozier

Summary of Discussion:

1. Brookdale Center on Aging. Mr. Daniel G. Fish represented the Brookdale Center on Aging. The Center objected to both means testing Medicare, and catastrophic coverage. In the area of regulatory restrictions, it was suggested that the Health Care Financing Administration relax its restrictions on home health care services and skilled nursing facility care, in order to reduce the costs of unnecessary institutionalizations and prolonged hospital stays.

   In conclusion, Mr. Fish acknowledged the need to contain costs, but favored initiatives which did not shift the cost burden to beneficiaries. He gave the hospice program as an example of such an alternative. In response to a question on catastrophic coverage, he explained that the Center is not opposed to the principle of the program, but to an increase in costs for so many beneficiaries with benefits for so few. Finally, he commented on the lack of representation of Medicare beneficiaries on the Council.

2. Rutgers Community Health Plan. Mr. Roger Birnbaum represented the Rutgers Community Health Plan and addressed proposed legislation that would change Medicare reimbursement to hospitals to a prospective per case basis, and the implications of this change for HMOs.

   First, Mr. Birnbaum stated that HMOs believe in prospective reimbursement, but pointed out several problems which arise due to this system. These include: the negative consequences of an all payer system, the neutralization and reversal of HMO incentives to reduce length of stay, and the hesitation of HMOs to enter into risk based Medicare contracts.

   Mr. Bernbaum concluded that movement toward an all payer per case reimbursement system should include provisions to ensure the negotiating flexibility of HMOs. In response to questions, he stated that recent legislation seems to address the major concerns of HMOs. He offered to submit data comparing the utilization patterns and length of stay of beneficiaries in the Rutgers Plan to those in general.

3. The American Jewish Congress, (AJC). Mr. Martin Hochbaum represented the American Jewish Congress. Mr. Hochbaum summarized several concerns of the AJC. These included an increase in the deductible, which would amount to over $1,000 in some cases as well as postponement of much needed medical care, and the voucher proposal, in that it would not guard against decreasing benefits to the elderly. Mr. Hochbaum urged the Advisory Council to oppose the continued existence of the prior hospitalization requirement for skilled nursing facilities, on the grounds that it leads to the placement of patients into hospitals for the sole purpose of establishing eligibility. He expressed the desire for expansion of the $250 limit on psychiatric coverage under Medicare, since the amount of benefits and services that can be received from this sum are minimal. He also stated the need to expand custodial care and to include preventive care provisions under Medicare.

   When questioned on whether or not the AJC had given thought to financing increased benefits, Mr. Hochbaum alluded to increasing taxes, the need for changes in legislation and gaps in coverage.

4. The New Jersey State Society of Anesthesiologists (NJSSA). Mr. Arganey L. Lucas represented the NJSSA. Mr. Lucas requested that the Council reconsider the new regulations concerning anesthesiologists in the provision of care to Medicare patients. He then mentioned possible solutions to these problems.

   Mr. Lucas first discussed the unsatisfactory nature of recovery room regulations. He indicated that it would require the abandonment of the anesthesized patient in the recovery room, where 8% of

post-operative mortality occurs. This would pose major problems for patients as well as anesthesiologists, who would be exposed to malpractice claims. Mr. Lucas pointed out that several inconsistencies in the regulations could lead to the possible abandonment of the life-saving role of floating anesthesiologists on cardiac arrest teams. Mr. Lucas offered several suggestions for the improvement of regulations concerning operating and recovery rooms.

In response to questions, Mr. Lucas stated that the malpractice insurance for New Jersey anesthesiologists was an annual premium of $17,000. He also stated that the Medicare program should not do anything about defensive medicine.

5. New York State Office of Aging (NYSOA). Mr. Craig Polhemus represented the NYSOA. Mr. Polhemus stated that three major pending administration proposals should be shelved. These included the proposals to index the Part B deductible, to alter the rate of increase for the Part B premium, and to restructure hospital cost sharing. After summarizing the proposals statistically and analytically, he explained that they unjustly shifted costs to more than 17 million Medicare recipients. He suggested that in their place, the Council might consider developing a bipartisan proposal for Medicare, which would balance reasonable cost constraints with a rational funding base that does not penalize the elderly.

   During questioning, Mr. Polhemus suggested prospective budgeting for hospitals as an example of an initiative which would balance reasonable cost constraints without imposing unjust penalties. He suggested as a funding base, general revenue financing and changes in payroll taxes, but added that the State of New York could not endorse such suggestions at this time. He also stated that he would submit for the record, estimates as to the burden on the State Medicaid Program of hospital cost sharing.

6. New Jersey Psychological Association (NJPA). Mr. Bart Rossi represented the NJPA. Mr. Rossi spoke on the lack of coverage for mental health benefits under Medicare and the increased costs resulting from this deficiency. He illustrated this with several examples of cases in which psychologists prevented unnecessary hospitalizations, but were not adequately reimbursed for their services. Mr. Rossi also criticized aspects of non-competition, stating that it prevented qualified psychologists from making referrals. In conclusion, Mr. Rossi suggested that mental health coverage be provided in the form of a specific ceiling for reimbursement. He also suggested the institution of the 80-20 copayment rate that is used for all other services under Medicare.

7. The New Jersey Federation of Senior Citizens (NJFSC). Mr. John E. Kelley represented the NJFSC. Mr. Kelly stated that the problems with escalating medical costs are a result of provisions in the law which prohibit Medicare from negotiating fees with providers. This, combined with the emasculation of Parts A and B has benefited providers and harmed beneficiaries.

   After questions and discussion on incentives to encourage assignment, Mr. Kelly suggested that the initial disbursement method of the Medicare law be changed so that the Government could negotiate fees.

8. The Medical Society of New Jersey (MSNJ). Dr. Howard Slobodien represented the MSNJ and summarized three problems with the Administration's prospective payment proposals. His first criticism pertained to the unproven effectiveness of the DRG system. Secondly, he pointed to the lack of information as to the true costs of the program; and lastly, to the lack of data on physician involvement in the program. While the untested nature of the program could lead to a number of complications, such as rewarding institutions with rapid turnovers, the problems related to costs include cost-shifting to beneficiaries. Additionally, lack of data on physician involvement might cause the breakdown of the program.

   With respect to financing, Mr. Slobodien stated the desire of the MSNJ for both long and short-term solutions for Medicare and Social Security. As a final item, he criticized the redefinition of the term physician in that it would remove responsibility from those with full plenary licenses.

   In response to questions, Mr. Slobodien stated that fee structures should be made to be reflective of current costs in order to get more physicians to accept assignment. Problems of defensive practice and physician cost control were also discussed.

9. The John F. Kennedy Medical Center. Mr. Joseph Sherber represented the John F. Kennedy Medical Center. Mr. Sherber stated his view of two specific reforms necessary in the Medicare system, i.e. the unification of the reimbursement systems for hospitals and doctors, and the making of out-patient treatment and home care programs viable alternatives to unnecessary hospitalizations, by allowing reimbursement for both types of services at the same time. His response to a question concerning the combination of home health and out-patient services was to include them under Part A.

10. The Action Alliance of Senior Citizens of Greater Philadelphia. Mr. Jack Zucker represented the Action Alliance of Senior Citizens of Greater Philadelphia. Mr. Zucker began by stating his dismay that no Medicare beneficiaries were represented on the Council. He also stated that the hearings should be more widely publicized.

The Action Alliance of Senior Citizens is opposed to increased cost sharing for Parts A and B of Medicare, the Administration's voucher system proposal, and added copayments for catastrophic insurance. They supported prospective reimbursement to reduce hospital costs and demanded that Medicare beneficiaries be given access to names of doctors who accept assignment.

In conclusion, Mr. Zucker expressed the need to expand contributions from general revenues to Medicare, and for a national health service program.

11. The Senior Adult Council of the Jewish Y's and Centers of Greater Philadelphia. Mr. Seymour Kornblum represented the Senior Adult Council. Mr. Kornblum commented on the absence of Medicare beneficiaries on the Advisory Council. He stated that his organization was troubled by the Administration's proposed changes in the health care system and by their failure to address the need for long-term care and preventive care. Mr. Kornblum stated that his organization was opposed to transferring costs to beneficiaries, increased deductibles, vouchers, and means tests and to increased cost containment. They supported a universal national insurance system, but until its inception, urged the following: (1) requiring all physicians to accept assignment, with the provision of a more rational base for establishing fees, (2) installing the prospective payment plan with the provision of a monitoring structure to ensure quality of care, (3) liberalizing medical eligibility to provide for the unemployed, and (4) ensuring competition between insurance plans.

12. The Archdiocese of Philadelphia Senior Citizens Council. Mr. John Boyle represented the Archdiocese of Philadelphia Senior Citizens Council. Mr. Boyle stated that his organization was opposed to cost sharing for Medicare beneficiaries. He argued that what is needed is a comprehensive cost containment program for all sectors of the health care field, and in the long-term, a national heath insurance program. In conclusion, Mr. Boyle stated that Medicare problems should not be solved by benefit cuts, but by an infusion of general funds.

13. The Rutgers University College of Nursing. Dr. Lucille Joel represented the Rugters University College of Nursing. Dr. Joel offered three recommendations for curtailing health care costs: formalization of nurse's rights to serve as a substitute for more costly provider professionals (including reimbursement for their services); providing alternative services to costly institutionalization; and incorporating a methodology into rate setting and reimbursement which maximizes regulatory control of Medicare dollars.

During questioning, Dr. Joel stated that direct reimbursement has been provided for nurses certified in the psychiatric mental health nursing practice (through CHAMPUS), commercial programs on the state level, and for nurse mid-wives (through a new provision under Medicaid).

14. The National Committee on Nursing (NCN). Dr. Ernest May represented NCN and suggested two basic recommendations to the Council, that all types of nursing education programs be continued in order to provide enough nurses to staff hospitals, nursing homes, health care agencies, industry schools, and defense forces; and that some support be shifted from medical clinical teaching to nursing clinical teaching in hospitals. The purpose of this is to allow colleges to work more closely with hospitals to bridge the gap between nursing education and nursing service, and thus provide more and better nursing education.

15. New Jersey State Nurses Association (NJSNA). Dr. Suzanne Hawes represented the NJSNA. Dr. Hawes summarized her organization's views in three major areas of health care, the recommendation that nurses services be substituted for those of more costly providers; that reimbursement be expanded to cover home care services; and that reimbursement cover community nursing centers. Dr. Hawes stated the organization's opposition to increased beneficiary copayments, and support of prospective payment under the condition that nursing intensity resource use be addressed as a separate cost unit.

During questioning, Dr. Hawes stated that nursing care would occupy an even greater role in health care if there were a voucher system since quality of care can be delivered at low cost.

16. The Essex County Division on Aging. Mr. Joseph Bernstein represented the Essex County Division on Aging. Mr. Bernstein stated his disappointment in the lack of representation of retirees on the Council and the lack of publicity of the hearings. He stated his organization's opposition to groups such as the AMA and the AHA which he described as "out to protect their members." He stated that changes in Medicare should be directed toward these groups, not beneficiaries. In particular, Mr. Bernstein mentioned that rapidly rising doctor's fees must be controlled and requested that the Government do its best to protect beneficiaries from costs which are increasing to levels beyond their ability to pay.

17. The New Jersey State Department of Health. Ms. Faith Goldschmidt represented the New Jersey State Department of Health. Ms. Goldschmidt stated several benefits of the DRG system, i.e. equitable allocation of resources, efficient usage of resources, equity across all payers (no massive cost shifting), and the encouragement of quality of care to all patients regardless of socio-economic status. She also mentioned the need for an outlier policy for atypical resource use, as well as the need for extensive computer capability, a phasing-in period and a system of education, if the system is

instituted nationwide. She also mentioned the need for an independent monitoring system (to ensure quality of care), new technology, and flexibility for states to implement their own systems.

In conclusion, Ms. Goldschmidt stated that the DRG system has been successful in containing health care costs in New Jersey. During questioning, Ms. Goldschmidt mentioned an increase in bulk buying among hospitals as a cost saving measure. There were also several questions pertaining to teaching hospitals and to the handling of capital. In response, Ms. Goldschmidt offered to submit further informational material.

18. Home Health Agency Assembly (HHAA). Winifred S. Livengood represented HHAA. Ms. Livengood stated that home health care should occupy a key position in the health care delivery system because it provides a less costly alternative of long-term care and is necessary to assist those elderly who are severely impaired due to strokes, heart attacks, etc. Also, policies which limit reimbursement to skilled care only should be reformed. Ms. Livengood stated that the HHAA supported an organized program of health maintenace monitoring to aid those with less severe chronic disabilities.

    In conclusion, Ms. Livengood stated that if these measures are taken into account, the health of the elderly would improve and medical costs would decline.

19. Loeb Center for Nursing and Rehabilitation, Montefiore Hospital. Ms. Genrose Alfano represented the Loeb Center for Nursing and Rehabilitation. Ms. Alfano suggested that a special level of hospital-based extended care, catering to the needs of the disabled or minimally functional, be formulated. This level of care would fall between acute and nursing home care and would encourage the achievement of maximum functional independence during patient recuperation. Ms. Alfano cited studies which indicated that the readmission rate of patients discharged from Loeb Center was 3%, while that of patients discharged to home care programs was 15%. Studies also indicated that Loeb Center patients fared better and at less overall costs than other patients. Thus, although this category of extended care is a costly one, it would cut down on the frequency of readmissions to acute hospitals and admissions to nursing homes.

20. Dr. Erline McGriff (private citizen). Speaking as a nursing educator, Dr. McGriff stated that Medicare should not subsidize hospitals for nursing education costs, and that nursing as a learned profession belongs in colleges and universities.

21. Miriam Dinerman (private citizen). Ms. Dinerman expressed her concern over the lack of support and disincentives for family care and the lack of adequate home based alternatives in Medicare which result in

costly and unnecessary hospital stays and institutionalizations. She also expressed concern over the lack of social workers in nursing homes resulting in a great deal of inefficiency. Finally, she stated that community health centers should be reimbursed for treatment of alcoholics in order to avoid increased costs resulting from unnecessary hospitalizations.

22. Suzie Mundhenk (private citizen). Ms. Mundhenk pointed out gaps in Medicare services, resulting from the lack of alternatives for home care. Included were personal care services, medical day care and RESPIT care services.

23. Lucille Mahn (private citizen). Ms. Mahn pointed out the benefits of extended family care provided by the West Hudson Extended Care Facility. For example, it decreases length of hospital stay, allowing patients to return to their homes. She stated that education concerning Medicare must be provided to the great number of senior citizens who do not understand the system.

24. Shirley Dozier (private citizen). Ms. Dozier presented a breakdown of doctor's fees and visits to nursing homes, and a breakdown of fees for home health care.

ADVISORY COUNCIL ON SOCIAL SECURITY
PUBLIC HEARINGS REPORTS

HEARING NO. 7

City: Washington, D. C.

Date: April 6, 1983

Location: Hubert H. Humphrey Building
200 Independence Avenue, S.W.

Advisory Council Members Present:

Dr. Otis R. Bowen, Chairman
Mr. James Balog
Mr. Samuel Howard
Mr. James D. McKevitt

Council Staff Present:

Mr. Thomas R. Burke, Executive Director
Mr. Steven Finlayson
Ms. Virginia Gray
Mr. Phil Jos
Ms. Judith Peres
Mr. Stephen Siegel
Ms. Wendy Susiak
Mr. Will Wolstein
Ms. Julia Lee

The purpose of this hearing was to obtain input from various members of the public regarding the assignment provisions of the Medicare program.

1. American Society of Internal Medicine - N. Thomas Connally, M.D. The American Society of Internal Medicine presented its view that based on a survey of its membership, it believes that the individual assignment option is in the best interest of the Medicare patient and the physician. It should be retained in its current form. The Society based its support of this position on a survey of its 18,000 members to which over 1,100 members responded. Their survey data also indicates that the members of the society are more likely to accept assignment than they have been in the past. A survey done in 1977 indicated that 38.5 percent of the members accepted assignment on Medicare claims, while in 1982, the rate was 45.9 percent.

In response to questions concerning assignment, Dr. Connally said that if the assignment option was eliminated ASIM would encourage physicians to discuss their fees with patients, and if necessary, lower their fees. Another option would be for physicians to recommend qualified surgeons who are willing to

accept assignment over those who are not. He also stated that physicians would prefer a system of annual assignment to one of mandatory assignment if faced with such a choice.

Dr. Connally also stated that ASIM supported prospective hospital reimbursement, but mentioned two specific problems with the DRG system. First, the complications caused by multiple diagnoses, and secondly, the lack of any type of home health care. He stated that he would not object to making physician fees public knowledge. His stand on defensive medicine was that it played a major role in increasing costs. He thought that physicians would welcome a system of insurance coverage provided by Medicare.

2. National Council of Senior Citizens - Richard Shoemaker. The National Council of Senior Citizens took the position that physician choice under the assignment provision is a major reason for the elderly out-of-pocket expenses. They believe that assignment should be made a mandatory portion of the Medicare program. Mr. Shoemaker pointed out that at one time the Council used HCFA data to publish lists of physicians who accepted assignment. That data is no longer available. Mr. Shoemaker also stated that the National Council of Senior Citizens supports the idea of promoting the use of prepaid or capitation rates for physician services.

In response to questions, Mr. Shoemaker stated that the National Council supports a national health insurance program for all payers. He also stated that mandatory assignment would eliminate part of the financial barrier to access to health care and that the focal point for shifting costs should be physicians, not beneficiaries.

3. National Health Task Force, Gray Panthers - Frances Klafter, Chairperson. Ms. Klafter reviewed the National Health Task Force's efforts to organize a national Medicare assignment campaign. They used HCFA data to publish lists of physicians in various areas, including Washington, D. C., who would accept assignment. She stated that this effort had been very successful until HCFA decided not to provide the information to the public any longer. Ms. Klafter and the National Health Task Force of the Gray Panthers believe that the current assignment provisions impose an unfair burden on the elderly in requiring them to take out-of-pocket payments to physicians without knowledge of whether or not they accept assignments.

4. American Urological Association - Paul J. Schildt, M.D., President. The American Urological Association supports the principle of voluntary physician assignment. The association believes that voluntariness provides flexibility, which benefits both patients and physicians. They are opposed to the idea of a mandatory assignment provision. Dr. Schildt indicated that he was not opposed to the idea of publishing a list of physicians in the area who accept assignment.

During questioning, Dr. Schildt was questioned about his assertion that mandatory assignment was unacceptable to both doctors and beneficiaries. Dr. Schildt had no objection to publishing lists of physician names and their assignment rates. He stated that the association had no

position on how to bring Medicare costs down, but that he thought that efforts to do so should be concentrated on hospitals not physicians.

5. American Medical Association - William R. Felts, M.D. Since the inception of the Medicare program, efforts have been made to reduce the level of reimbursement made to physicians. Initially, the Medicare program set the reasonable charge at the 83rd percentile of the prevailing charge. That was reduced to 75th percentile and further limited by the Medicare Economic Index. Additional problems resulted because of the time lag which exists in calculating updated reasonable charges and the fact that the Medicare Economic Index is based on 1971 data. The American Medical Association believes that the current voluntary assignment provision permits the physician to decide on whether or not to accept assignment, and permits the beneficiary the opportunity to decide whether or not to use a particular physician. Citing 1979 data, the American Medical Association pointed out that nationally, 51.1 percent of all claims were assigned. This represented 50.7 percent of all charges. Their data also indicates that the higher the charges on the claims, the greater the likelihood that the physician will accept assignment. Dr. Felts suggested that if the Council recommends that the Medicare program adopt a mandatory assignment provision, it should also recommend provisions to assure that the reasonable charge determinations are updated and maintained at an equitable level for physicians.

In response to questions, Dr. Felts stated that the AMA has not yet determined its position on the publishing of lists of physician names and their assignment rates. He also stated that he would not object to the institution of the DRG system for physicians as long as it was done on an experimental basis. Dr. Felts also objected to getting fees directly from a hospital for hospital inpatients since physicians would lose their ability to direct patient care. Finally, he stated that even if allowable charges were fair and reasonable, he would still object to mandatory assignment.

6. Blue Shield of Pennsylvania - Leroy K. Mann, President. In 1982, the assignment rate in Pennsylvania was above 70 percent whereas the national assignment rate was approximately 50 percent. Mr. Mann felt that there were a number of factors which affected each carrier's assignment rate, one of the most important being physician participation in the Blue Shield Plan's private business. He felt that the higher the assignment rate, the greater the benefit to beneficiaries in reducing their out-of-pocket expenses, and relieving them of the difficult burden of attempting to fill out complicated forms for submission to insurance programs. He suggested a number of steps to promote further growth of the assignment rates. Carriers and HCFA need to maintain communication and cooperation with the physician community, assure that their claims are accurately and promptly processed and also assure that reasonable reimbursement rates are adequate. Second, Mr. Mann stated that it is very important that the beneficiaries be educated about assignment, since they do not fully understand what the provision means.

7. Blue Shield of Massachusetts - John Larkin Thompson, President. Massachusetts Blue Shield is unique in that it is the only Blue Shield in the nation

which a physician is required under state law to participate in the plan's private business. If he does not, the plan will pay neither the physician or his patient for services rendered. Ninety five percent of all physicians in Massachusetts have a contract to participate in the Blue Shield private business plans. Currently, there is litigation concerning the possible anti-trust implications of this statute. Although Massachusetts Blue Shield's overall assignment rate for Medicare is 78.1 percent (well above the national average), it varies significantly from 53 percent in the Cape Cod area, to over 80 percent in the Boston area. In addition, there is significant variation within various specialties. Mr. Thompson pointed out that one of the most significant factors as to whether the assignment rate is high or low seems to be the concentration of physicians of a given specialty in a given geographic area. He felt that whether or not the Council recommends that the assignment provision be made mandatory, it is imperative that the beneficiary be removed from the process of filing Medicare claims. He suggested that both the carriers and HCFA need to further educate beneficiaries on the meaning and the implications of the decision to accept assignment. He also believes that it would be beneficial to make available to the public, lists of physicians indicating those who generally do or do not accept assignment in a given area.

3. Blue Cross/Blue Shield of Florida - Bill Long, Director of Medicare & Communications. Florida Blue Shield expects to process 16 million Part B claims in 1983. It has an assignment rate of approximately 47 percent. Mr. Long reviewed several reasons why physicians do not accept assignment including the fact the Medicare reasonable charge determinations are significantly less than the submitted charges, a lack of understanding of the Medicare reasonable charge determinations, the long delay in receiving payments, and other inadequate incentives for accepting assignment. He believes that Florida Blue Shield's implementation of electronic medium claims processing has made physicians more inclined to accept assignment since they are able to receive faster payment. He suggested several possible ways for the Council to deal with the problem of lower assignment rates. The Council may consider requiring physicians to accept assignment. A restructuring of the current reimbursement mechanism may also encourage physicians to accept assignment.

The Council questioned all three Blue Shield plans [illegible].

All of the plans agreed that the idea of return to use permit for the Medicare program was a good one.

During the question and answer period for these groups, the difference between the Massachusetts fee schedule for the three of the Medicare program for the same procedures was discussed. The difference was attributed to the use of the Consumer Price Index without the use of the health care component in Massachusetts. Incentives for the high rate of physician assignment in Pennsylvania involve a combination of good performance by the carrier, traditional relationships with private business, good communication, a fair review of claims, etc., were discussed. Mr. Thompson, Blue Shield of Massachusetts,

suggested negotiations between physicians and beneficiaries as a means of determining an acceptable level of fees in the area as an incentive for physicians to accept assignment. There was further discussion on the advantages of an assignment for all for a fixed period of time.

9. American College of Physicians - Helen L. Smits, M.D., F.A.C.P., Chairperson, Health Care Financing Subcommittee. The current assignment provisions reflect a dilemma in the delivery of health care. On the one hand, there is the belief that it is unacceptable to fail to provide health services to anyone on the basis of inability to pay. On the other side, it appears to be a consensus that the financial reality precludes providing services to all patients irrespective of their needs. What has happened is that the physician is forced to make the choice, on a case-by-case basis, as to the degree of financial risk he is willing to take in providing services. The current Medicare Economic Index fails to fully take into account the facts that are involved in the practice of medicine in 1983. The problem with the index that it locks in the reimbursement disparities between geographic areas without recognizing changes in the costs of practicing in different areas of the country. Another serious problem physicians are faced with is the administrative cost and paperwork burden of filling out Medicare claims. Without dealing with these structural problems, the American College of Physicians believes that physicians will not be any more inclined to accept assignment in the future than they have been in the past.

10. Nationwide Mutual Insurance Company - Michael J. Schaub, Associate Vice President, Medicare Operations. Nationwide is the carrier for the state of Ohio. They have an assignment rate of 38.7 percent for 1983. This is an increase over the assignment rate for 1973, which was 28 percent. Nationwide anticipates that its assignment rate will decline as the TEFRA provision concerning reimbursment for inhospital radiology and pathology services take effect. In Ohio, more than 50 percent of all assigned claims are for beneficiaries who are either Medicare/Medicaid eligible or receive inpatient or outpatient diagnostic radiology and pathology services. The carrier has been able to overcome physicians' philosophical resistance accepting assignment. Physicians who are still reluctant to accept assignment point to the reduction in their charges which occur when they do so as one of the main obstacles. Whether or not the carrier is able to increase its assignment rate, Mr. Schaub felt that it was very important that the physicians rather than the beneficiaries fill out claims. By doing so, the claims which are received by carriers are more complete, easier to process, and provide more accurate information, thereby, saving administrative costs to the Medicare program.

In response to questions, Mr. Schaub stated that the office manager, billing manager, the secretary, or the physician himself often make the decision to accept assignment. The decision is based on a credit interview with the patient. When questioned as to why there should be direct payment to a physician from Medicare if he accepts assignment, Mr. Schaub responded that in this way, physicians can decide on whether to charge the full fee, accept the Medicare allowance, or charge the difference between allowance and payment. He also suggested that there should be changes in the legislation to allow for negotiated fee schedules. It was his opinion that if the message

[illegible] would have a great difference in terms of increasing acceptance of assignment.

11. [illegible] Help, Inc. - Ms. Doris Fullerton, President. Here to Help, Inc. is a private medical billing agent which assists physicians and individuals in preparing claims to be submitted to the Medicare program. Ms. Fullerton explained that physicians feel that the Medicare reimbursement rates are unrealistic reimbursing 38-42 percent of what their actual charges are. Mrs. Fullerton believes that it is important for HCFA and the carriers to conduct a concentrated educational campaign to advise both beneficiaries and physicians as to the meaning and importance of the assignment provisions.

12. American Academy of Family Physicians - Gerald R. Gheringer, M.D. The greatest factor which deters physicians from accepting assignment, is that the reasonable charge determination often bears no relationship to what a physician charges his non-Medicare patients. Physicians find it difficult to understand why they should accept less from the Medicare program than from their private patients. The Medicare Economic Index placed a cap on the amount which the Medicare program will reimburse physicians and, therefore, further erodes their willingness to accept assignment. The increase in the Medicare Economic Index has been significantly less than all other economic indicators. Another problem in having physicians accept assignment is the delay in updating profiles. Physicians are reimbursed based on profiles that are any where from 1+ to 2+ years old. In addition, the Medicare program reimburses physicians based on their specialties. Family physicians tend to be reimbursed at a lower rate than other specialties. This makes family physicians even less inclined to accept assignment. Dr. Gheringer maintains that until the current reimbursement practices are changed family physicians will continue to remain reluctant to accept assignment.

During questioning, Dr. Gheringer stated that even if fee schedules were adjusted, physicians would not approve of "mandatory" assignment, the term inspires resistance. However, he did state that there would be markedly less reluctance to accept assignment. Dr. Gheringer also mentioned that there should be an incentive for physicians to practice in rural areas.

13. American College of Radiology - M. Pinson Neal, M.D. Historically, the American College of Radiology has encouraged its members to accept assignment. However, Dr. Neal felt that the new reimbursement provisions of TEFRA, which limit hospital radiology reimbursement to 60 percent of the prevailing charge for that same service if performed in an office, will cause physicians to be increasingly reluctant to accept assignment. Other factors making physicians reluctant to accept assignment are the delay in receiving reimbursement from carriers, and the messages printed on the Explanation of Benefits which beneficiaries receive indicating that the charges were reduced because they were not reasonable. Dr. Neal warned that the administrative and reimbursement problems now imposed upon radiologists could provide further disincentive for their accepting assignment.

Questions dealt with the legislative history behind diagnostic radiologists and radiation oncologists receiving 100 percent reimbursement.

In addition to the testimony presented at the hearing, the Advisory Council received written statements from four groups.

1. American College of Surgeons - C. Rollins Hanlon, M.D., F.A.C.S. The American College of Surgeons believes that each physician should have the opportunity to decide whether or not to accept assignment from Medicare patients on a case-by-case basis. Such physician decisions take into account a variety of factors that have an important bearing on the physician-patient relationship. The College would oppose mandatory assignment for physicians.

2. American Osteopathic Association. The American Osteopathic Association supports the current freedom of choice provision of the Medicare assignment provision.

3. Michigan Senior Advocate Council - Keith McCall, Vice Chairperson. The Michigan Senior Advocate Council believes that HCFA should promote the acceptance of assignment by physicians and that the assigned payment should be accepted as payment in full.

4. Comments from a Private Anonymous Citizen. Physicians abuse their assignment agreements and seek to obtain additional reimbursement from beneficiaries. One possible way to improve assignment acceptance is through a system of tax incentives for physicians who accept assignment. Increased assignment of claims will reduce administrative expenses by making the processing of claims easier.

ADVISORY COUNCIL ON SOCIAL SECURITY

Public Hearings Reports
Hearing No. 8

City: Washington, D.C.

Date: July 18-19, 1983

Location: Hubert H. Humphrey Building
200 Independence Avenue, S.W.

Advisory Council Members Present

Dr. Linda H. Aiken
Mr. James Balog
Mr. David W. Christopher
Mr. Alvin E. Heaps
Mr. Samuel H. Howard
Mr. James D. McKevitt
Dr. Richard W. Rahn
Mr. C. Joseph Stetler

Council Staff Present:

Mr. Thomas R. Burke, Executive Director
Mr. Steven Finlayson
Ms. Elizabeth Flynn
Ms. Virginia Gray
Mr. Philip Jos
Ms. Julia Lee
Ms. Judith Peres
Mr. Stephen Siegel
Mr. Will Wolstein

The purpose of this hearing was to obtain input from various members of the public regarding raising revenues through taxation for Medicare program.

1. Georgetown University, Center for Strategic and International Studies - Dr. Paul C. Roberts indicated that the Center is of the opinion that hospital insurance must be dealt with within the framework of the entire OASD/HI and Supplementary Medical Insurance systems. This will return OASI to its original intent as a basic retirement floor supplemented by private pensions and savings. Dr. Roberts referred to the tables contained in his formal testimony showing the cost rate, total income rate and the

surplus of debits that this system faces. He stated that if you were to make a change from wage to price indexes, the basic problem would be solved. Dr. Roberts cited examples of growth in benefits under wage indexing and then summarized his recommendations as follows: (1) approach the problem in terms of the combined system, transferring current OASDI surpluses to HI by reallocating the tax rates across the trust funds; (2) slow the growth of outyear OASDI benefits by switching wage indexation to price indexation; (3) gradually increase HI premiums; and (4) compensate current and future workers for the slower growth of outyear benefits by expanding IRAs over time.

2. National Federation of Independent Business - The speaker was Mr. William Dennis, Director of Research. The Federation is a trade association representing owners of small and independent businesses. Mr. Dennis recommended that the Council not impose additional payroll taxes to finance any projected revenue shortfalls. His opinion as an economist is that the long-term burden for paying the entire tax ultimately falls on the employee. Further, that the "contexts" which allegedly require maintenance of the payroll tax are irrelevant, and that payroll tax increases are no longer a viable means to raise revenue.

3. The Cigar Association of America - Mr. Norman F. Sharp, President, presented the views of the Association. He stated that the industry is economically-depressed and that any price increases, whether from increased costs of labor and materials or from higher taxes would act to depress sales. Mr. Sharp testified that the cigar industry is only a marginally profitable industry. It is recovering from prior depressions but is faced with an onslaught of tax increase proposals. The user tax that is being considered would be punitive and would further depress sales, escalate the decline of the industry and increase unemployment. Mr. Sharp urged the Council to use a cost/benefit approach which would take into consideration the small amount of revenue raised versus the disastrous impact on an already depressed industry.

4. The Honorable Walter D. Huddleston - U.S. Senator from Kentucky. Senator Huddleston urged rejecting solutions such as raising and/or earmarking existing beverage and tobacco excise taxes for Medicare. He believes that such revenues would provide only a small part of the funds, they are an unstable source of funding, and they would preempt an important source of State and local revenues. Senator Huddleston presented three arguments against such a move: use of excise taxes for Medicare reduces one deficit (Medicare) and increases another (the general budget deficit); you can either raise revenues substantially, or reduce consumption substantially, but not both; and any gain in Federal excise revenues from higher taxes on tobacco and alcohol must be offset against State excise tax losses.

5. Representative Andrew Jacobs - House of Representatives. Congressman Jacobs stated that taxpayers pay a regressive Social Security tax and are entitled to protection from those who might be higher risks for the insurance program. An excise tax on alcohol and tobacco which increase costs to the program is a method of placing the burden on the group at risk. He did not think that an excise tax would have any effect on depressing the alcohol and cigarette industries.

6. Tobacco Institute - Mr. William B. Prendergast, Consultant, presented testimony on behalf of Mr. Samuel C. Chilcote, Jr., President of the Tobacco Institute. Mr. Prendergast expressed the Institute's position that the payroll tax and excises on tobacco and alcohol are already being fully exploited. Their present magnitude makes them oppressively burdensome on business, labor and the consumer and a drag on the general economy. Mr. Prendergast stated that to earmark these excise taxes for the HI trust fund would eliminate them as a funding source for other health programs, including Medicare Part B and Medicaid. Such a change would add rigidity to the Federal fiscal system discipline and establish irrational budgetary priorities. Mr. Prendergast suggested that if the Council decides to recommend specific tax increases for Medicare, careful scrutiny should be given to a far broader range of revenue raising alternatives than it has so far considered. A further suggestion was offered by Mr. Prendergast that controlling health costs be the Council's first priority.

7. Brimmer and Company, Inc. - a firm engaged in research and advising clients concerning developmental effects in financial institutions, trends in economic activity, and interest and money in capital markets. Mr. Andrew F. Brimmer, President, addressed his comments to the following issue: Should the present Federal excise tax on alcoholic beverages be increased, and the proceeds earmarked for the health insurance trust fund? Mr. Brimmer did not think that this is an efficient means of raising revenue. Additionally, excise taxes in general do not satisfy the basic criteria of a good tax which are efficiency, equity, cost-effectiveness and revenue potential. Excise taxes violate the efficiency criteria because of their adverse price effects. It alters relative prices in a selective and distorted manner. Taxes which reduce the spendable income of the poor, detract from equity issue.

   Mr. Brimmer's conclusion were based on a study, "Excise Taxes and the Demand for Distilled Spirits" done by his company. Their study found strong evidence of an adverse equity impact if the Federal excise tax on distilled spirits were doubled. In addition, any assessment of taxes must take into account macro-economic and long-run growth objectives. In general, excise

taxes are not helpful fiscal instruments because they aggravate the fluctuation in output that are inherent in a market economy. Mr.Brimmer summarized his arguments stating an increase in the excise tax would have a severely adverse effect on consumption. It would distort the already inequitable distribution of the tax burden. The burden would fall substantially on low-income groups. The higher price that would result from a substantial increase in the tax would lead to a decline in consumption and a reduction in the level of output and employment in the industry. The end result would not generate enough revenue to contribute to the solution to the health care financing problem.

8. Distilled Spirits Council of the U.S., Inc. - Mr. Frederick A. Meister, President, spoke on behalf of his company. He stated that excise taxes are regressive, and that there would be no benefit from imposing an excise tax upon the hundred million moderate consumers of distilled spirits. Earmarking excise taxes for Medicare does not address the real, long-term problems underlying Medicare deficits. It will provide insignificant revenues toward this end. States now depend on excise taxes for an average of 4 percent of their revenues. Any major Federal increase would cost the States greatly in lost current revenues, reduced capacity to make any further State tax increases, as well as contribute to unemployment.

9. National Beer Wholesalers Association of America - Mr. Robert W. Sullivan, Executive Vice President, represented the Association. He thought that putting a tax on beer as opposed to other so-called luxury taxes would be extremely regressive. Those who think an increase in excise taxes would decrease health problems and raise revenues are not addressing all of the facts. This option as a funding policy, Mr. Sullivan went on to say, is punitive and raises serious questions of fairness and equity. It would be ineffective and not a viable alternative for increasing trust fund revenues.

10. National Alcohol Tax Coalition - was represented by Mr. George Hacker, Association Director for Alcohol Policies at the Center for Science in the Public Interest. The coalition is comprised of 95 diverse national, State and local organizations who share a common interest in increasing Federal alcohol excise taxes. They support the proposed option. They believe that raising the excise tax makes good sense and represents sound governmental policy. Mr. Hacker suggested that present tax rates be doubled and that a move be made towards a system of taxation that imposes fair and rational levies on all forms of alcohol. Further, to avoid any fiscal absurdity, alcohol excise taxes should be raised gradually to catch up with inflation since the last tax increase and that

future increases be indexed to the Consumer Price Index, or to increases in health care costs. Mr. Hacker urged a significant portion of the revenues be allocated to rehabilitation, prevention and research programs which would thereby reduce overall health care costs and save lives.

11. Massachusetts Alcohol Service Association - Mr. Jack Donahue, Executive Director, represented the Association. He stated to the Council that he has tried to be fair and objective when presenting his concerns on alcohol users and abusers to the news media and government committees. He does not believe that these two sources have the same attitude. He cites the toxic waste disposal as an example. Since the damage done by the use and abuse of alcohol is far greater, why not make the liquor industry responsible for any resultant problems. He noted that no increase in public taxes on alcohol has beer made since 1952 in spite of the rise in the cost of alcohol. Mr. Donahue believes that the American taxpayers subsidize the liquor industry because the industry is allowed a tax deduction for marketing and advertising and they purchase surplus grain to convert to alcohol. Because of the tremendous amount of money spent on advertising by the liquor industry, the legislation introduced in the past has not been passed. Killing the proposed tax increases is a demonstration of the power and influence of the liquor industry. Massachusetts spends $19 million of State tax revenues for alcoholic programs. Alcoholism treatment is only partially covered by Medicare and in Massachusetts. Mr. Sullivan stated that every program the Federal government has reduced has resulted in an increase in various taxes in Massachusetts. Mr. Sullivan offered his assistance in implementing the inclusion of treatment for alcoholism in the program when it is initiated.

12. The National Council on Alcoholism - is dedicated to the alleviation of the disease of alcoholism and the attendant problems. Mr. Jay Lewis, Director for the Policy Office, indicated that NCA supports higher Federal taxes on alcoholic beverages to bolster the Medicare Trust Fund. They are convinced that such a move would reduce consumption and the level of alcohol problems in this nation. Although reduction in consumption would tend to diminish the actual dollar gains to Medicare, such an eventuality offers promise of a payoff to the Medicare system itself incalculably greater than reflected in the short term balance. Mr. Lewis further stated NCA's position that the taxes on beer and wine be equal to the tax on distilled spirits and that the taxes be adjusted for inflation since the last tax increase in 1951.

13. Comprehensive Care Corporation - Mr. Harley Dirks, Washington Representative, testified for the Corporation, a company that provides alcoholism, psychiatric and behavioral medicine care to 35,000 Americans each year. Mr. Dirks stated that revision and

eligibility requirements, increasing premiums, etc., offer only a partial solution to the funding problems. New sources of revenue need to be explored. The Corporation recommends amending the Internal Revenue Code of 1954 to increase Federal excise tax on alcoholic beverages. This would provide revenues from the additional tax and could be deposited in the Health Insurance Trust Fund under the Social Security Act and a portion earmarked for alcoholism treatment. Mr. Dirks indicated this increase would be logical and fair because it is primarily a user tax. Mr. Dirks cited various statistics in support of their recommendation.

14. New Jersey Division of Alcoholism, State Department of Health - Mr. Riley Regan, Director, a former alcoholic, does not believe that increasing the alcohol beverage tax will have any impact on an individual's consumption. Mr. Regan feels that the Medicare system has to become aware that alcoholism is the number one public health problem and urges considering the allocation of funds for treatment in the Medicare program. He would not like to see the alcoholic beverage tax increased simply as a means of paying for Medicare shortfalls.

15. Harvard Medical School - Dr. Francis D. Moore, President of the Massachusetts Health Data Consortium. Dr. Moore's presentation focused on increasing revenues to pay public expenditures for medical care of certain diseases suffered by all age groups and especially the elderly, by means of cause and user taxes. Such taxes have a double function. First, to increase revenue to pay for the public costs of those illnesses, and second, to act as a disincentive to the overuse of these products. Dr. Moore thought there would be three arguments against such taxes. Why should a careful driver or occasional smoker pay for the imprudent? Will these funds be used just to subsidize the cost of illness and, therefore, the habit? Will this be a dangerous precedent that would be applied to all other things in our society?

    Dr. Moore went to say that cause and user taxes would perform the function of defraying the public cost of misuse of alcohol and tobacco and would act as a mild disincentive to overuse.

16. Michigan Department of Public Health - Mr. Kenneth Eden, presenting for Dr. Robert Brook, Administrator, Office of Substance Abuse Services. The Department believes it is appropriate for the Council to consider increases in Federal excise taxes on alcohol as a source of revenue for Medicare. Judicious alcohol excise tax increases could yield a dual benefit--vitally needed revenues on one hand for health care services, and reduction in the levels of alcohol-related

casualties that afflict not only these citizens but everyone. Mr. Eden suggested the need to examine cost-savings options and to address the current Medicare reimbursement policies bearing on alcoholism treatment. They recommend progressive policies in the Medicare reimbursement program.

17. Dr. Henry Thomassen - Economic Adviser to the Governor of the State of Georgia, spoke on behalf of himself. Dr. Thomassen thinks that the Council should begin by looking at broader participation measures, such as the payroll tax, rather than narrower levies. States fear narrower levies would tend to introduce a series of inequities and offer a series of economic distortions that are not readily foreseen. He presented the following arguments against imposing additional excise taxes at this time. Curbs and cuts in the last two years have left States with a feeling of increased responsibility for its citizens. With the recent recession, Dr. Thomassen says, the State revenue gains are far weaker and too feeble to cover extended functions. State governments derive a considerable amount of revenue from the excises levied on alcohol and tobacco. If the government were to raise such excises, States believe the impact would fall inequitably on the States. When increases in excises are imposed, volatility is introduced into these revenue sources. States are concerned that increases in the taxes may prove counterproductive to promoting economic development. If current prices are pushed up, the gap between the illegal and legal price will widen. Further, to establish a connection through taxes between smoking, drinking and Medicare may very well introduce a backlash. While the evidence is not wrong, nor unacceptable, the public has not yet come to believe it. In closing, Mr. Thomassen said that if the cost of hospital insurance programs are rising at anything close to the 13% that CBO has projected, then to attempt a baleout using excise taxes, which grow very slowly, is probably to impose a burden that excise taxes alone cannot bear.

18. John Hopkins University - Dr. Harvey Brenner, Professor of Operations Research and Behavioral Sciences, School of Hygiene and Public Health. Dr. Brenner stated that his testimony is based on his current belief that there is insufficient scientific information to back legislation that would cut back on overall alcohol use.

    Dr. Brenner directed his testimony to the two propositions under consideration by the Council: 1) that health care costs attributable to alcohol consumption are high, and 2) taxation of alcohol consumption is an equitable alternative to ease the current economic plight of Medicare by relieving the non-drinking public of some of the burden of subsidizing those who do drink. The first proposition implies the incorrect assumption that

alcohol consumption is a risk to health and health care. Dr. Benner felt that only heavy alcohol consumption and not consumption per se is a risk to health; therefore, it is not true that non-drinkers are subsidizing the health care of drinkers. Clinical and epidemiological evidence shows clearly that moderate drinkers are at a lower risk for cardiovascular disease. Cardiovascular disease accounts for the majority of mortaility disease and acute hospital care. It is likely that moderate drinkers are actually subsidizing the health care of non-drinkers. Dr. Brenner's own studies have shown that spirits consumption per capita is a significant risk in cardiovascular mortality. He stated that these findings on a national level should not necessarily be interpreted to mean spirits consumption at the individual level is inherently more pathological than beer or wine. To the extent that the second proposition is false, taxation of alcohol consumption is likely to decrease beer consumption. Since beer consumption is less related to addicted drinking, and more sensitive to price change, it is possible taxation could depress consumption of beer and result in increased cardiovascular illness and related health care expenditures.

Dr. Brenner concluded that it is logical to ask whether the Advisory Council would recommend taxation of frequently used dietary items which he feels are a considerably greater risk to health and hospital costs than the average use of alcohol. His final statement was that cigarette consumption is clearly more damaging to health than alcohol, animal fats, or salt and, in contrast to these dietary items, does not appear to show offsetting health or other social benefits.

19 American Association of Retired Persons - Mr. James Hacking, Legislative Counsel. The Association represents 14.7 million members who are concerned that the need for solutions will result in Medicare proposals that ignore the existing flaws in the health care delivery and financing system.

Mr. Hacking testified that double digit cost escalation is not unique to Medicare and if the solutions focus on Medicare alone, only two options will be considered--reductions in benefits, and/or increases in taxes. Neither option is likely to solve any hospital-based escalation problems. AARP has urged the Council to examine the health care marketplace and the cost-escalating economic incentives inherent in the market and make recommendations across the board. The objective of any proposed solution should be a drastic constriction of the flow of resources from tax and premium dollars to hospitals and channeling more resources into less costly alternatives including means to stimulate competition in the delivery of health care services.

Mr. Hacking believes substantial increases in tax revenues for the Medicare program would be shortsighted and probably damaging to the economy if allocated to the current system. AARP prefers progressive tax revenue sources which would tend to have lesser adverse economic effect. He agrees with the economists who suggest that the short term effects of payroll tax increases add to inflation and unemployment. A general revenue increase would be considerably less damaging to employment levels. He further stated that excise taxes are a regressive source of revenue relative to income tax, and since they are not so broadly based tend to be less regressive than more broadly-based sales taxes or value-added tax.

In closing, Mr. Hacking stated that if we are unable to initiate these reforms in the near future, the eventual tax and premium cost burdens required to sustain not just public programs like Medicare and Medicaid, but also the private health insurance will become so great that benefit protections will be reduced and financial access to basic health care protection for all will rapidly decline.

20. Boston Elderly Commission - Mrs. Helane Goldstein, Director, Washington Office of Boston Commission on Affairs of the Elderly. Mrs. Goldstein testified that although the scope of the hearing is limited to the question of additional tax revenue for Medicare, there are a number of policy changes which could result in savings for the Medicare program without damaging the quality or availability of health and long term care. The Commission recommends the elimination of the cap on the payroll tax. They feel this places a greater burden on low- and middle-income wage earners. They support Federal excise taxes on alcohol and tobacco as these drugs cause disproportionate health burden for the general population.

Mrs. Goldstein urged the Council to consider increased taxes at the Federal level on luxury items, i.e., furs, jewelry, automobiles. Mrs. Goldstein suggested if additional revenue is necessary, then reinstitution of the 70% tax bracket would be appropriate. She concluded that the Elderly Commission feels the foregoing proposals are equitable and would help guarantee the access to health care.

Summary of the 1983 Annual Reports of the Medicare Board of Trustees

Prepared by the Health Care Financing Administration
Bureau of Data Management and Strategy
June, 1983

INTRODUCTION

This summary presents an overview of the information contained in the annual reports of the trustees required under Title XVIII of the Social Security Act - Health Insurance for the Aged and Disabled, commonly known as Medicare. There are two basic programs under Medicare:

(1) Hospital Insurance (HI) which pays for inpatient hospital care and other related care of those aged 65 and over and of the long-term disabled, and

(2) Supplementary Medical Insurance (SMI) which pays for physicians' services, outpatient hospital services and other medical expenses of those aged 65 and over and of the long-term disabled.

The HI program is financed primarily by payroll taxes, with the taxes paid by current workers used to pay benefits to current beneficiaries. However, the HI program maintains a trust fund that provides a small reserve against fluctuations. This type of financing is generally known as pay-as-you-go financing. By contrast, the SMI program is financed on an accrual basis with a contingency margin. This means that the SMI trust fund should always be somewhat greater than the claims that have been incurred by enrollees but not yet paid by the program. The trust funds hold all of the income not currently needed to pay benefits and related expenses. The assets of the funds may not be used for any other purpose; however, they may be invested in certain interest-bearing obligations of the U.S. Government.

The Secretaries of Treasury, Labor, and Health and Human Services serve as trustees of the HI and SMI trust funds. The Secretary of Treasury is the managing trustee. The Administrator of the Health Care Financing Administration, the agency charged with administering the Medicare program, is the Secretary of the Board of Trustees.

Copies of the complete 1983 HI and SMI annual reports can be obtained from the Health Care Financing Administration, Office of Public Affairs, Room 658 East High Rise, 6325 Security Boulevard, Baltimore, Maryland, 21235.

HOSPITAL INSURANCE TRUST FUND

As mentioned in the introduction, the HI trust fund is financed primarily by payroll taxes. The HI contribution rates applicable to taxable earnings in each of the calendar years 1981 and later are shown in Table 1. The maximum taxable amounts of annual earnings are shown for 1981 through 1983. After 1983, the automatic increase provisions in section 230 of the Social Security Act determine the maximum taxable amount.

TABLE 1.--CONTRIBUTION RATES AND MAXIMUM TAXABLE AMOUNT OF ANNUAL EARNINGS

Calendar year	Maximum taxable amount of annual earnings	Contribution rate (Percent of taxable earnings) Employees and employers, each	Self-Employed
1981	$29,700	1.30	1.30
1982	32,400	1.30	1.30
1983	35,700	1.30	1.30
Changes scheduled in present law:			
1984	Subject to	1.30	2.60
1985	automatic	1.35	2.70
1986 & later	increase	1.45	2.90

The Social Security Act was amended during 1982 by the Tax Equity and Fiscal Responsibility Act (TEFRA) and during 1983 by the Social Security Admendments of 1983 (Public Law 98-21). The major provisions among the many affecting the HI program were:

(1) TEFRA changed the method by which Medicare reimburses hospitals by replacing the previous per diem limits on routine inpatient

costs by limits on total inpatient costs per admission and limits on increases in total inpatient costs per admission. These limits are effective for cost reporting periods beginning on or after October 1, 1982. The limits on increases in total inpatient costs per admission expire for cost reporting periods beginning on or after October 1, 1985.

(2) Medicare coverage is extended to Federal employees, who are required to pay the hospital insurance portion of the FICA tax as of January 1, 1983.

(3) Medicare will temporarily cover hospice care for beneficiaries having a life expectancy of six months or less. This provision is effective November 1, 1983, and expires October 1, 1986.

(4) Public Law 98-21 changes the method by which Medicare makes payments to hospitals. Hospitals will no longer be reimbursed on a reasonable cost basis for their inpatient operating costs. Hospitals will be paid a prospectively determined price per discharge using diagnosis related groups. This provision is effective for hospital fiscal years beginning on or after October 1, 1983.

(5) Social Security coverage is mandated for employees of non-profit organizations. Terminations of coverage are not permitted as of March 31, 1983. Also, no terminations of coverage by State and local governments or entities will be permitted after April 20, 1983. Such entities now outside the system will be permitted to rejoin. This provision is effective upon enactment.

(6) Interfund borrowing among the OASI, DI and HI trust funds (authorized in 1981) is extended through 1987 with repayment to be made during 1988-1989 in 24 equal monthly payments. Beginning June 1983, loans would be repayable when the fund ratio of the borrowing fund exceeds 15 percent.

Operations of the HI Program

At the end of 1982, 26 million people over age 65 and 3 million disabled people under age 65 were covered under HI, financed primarily by the contributions of 116 million workers through payroll taxes. Payroll taxes during 1982 amounted to $34.6 billion, accounting for 90.9% of all HI income. About 2.7% of all income resulted from reimbursements from the general fund of the Treasury for military service credit and benefits for certain uninsured persons. Interest payments to the HI fund amounted to 5.4% of all HI income for 1982. The remaining 1.0% was contributed through premiums paid by voluntary enrollees and taxes collected from railroad workers. Of the $36.1 billion in HI disbursements, $35.6 billion was for benefit payments while the remaining $0.5 billion was spent for administrative expenses. HI administrative expenses were 1.4% of total disbursements.

Table 2 displays the HI fund operations for calendar years 1970-1982. In most years, the HI fund has increased. However, the fund ratio (the fund at the beginning of the year divided by disbursements during the year) has declined every year from its peak of 79 percent in 1975 to

45 percent in 1981. The fund ratio increased slightly at the beginning of 1982 primarily due to the increase in the contribution rate in 1981.

TABLE 2.--HI FUND OPERATIONS
CALENDAR YEARS 1970-1982
(Amounts in Billions)

Calendar year	Total income	Total disbursements	Interfund Borrowing Transfers	Net increase in fund	Fund at end of year	Ratio at beginning of year
1970	$ 6.0	$ 5.3		$ 0.7	$ 3.2	47%
1971	5.7	5.9		-0.2	3.0	54
1972	6.4	6.5		-0.1	2.9	47
1973	10.8	7.3		3.5	6.5	40
1974	12.0	9.4		2.7	9.1	69
1975	13.0	11.6		1.4	10.5	79
1976	13.8	13.7		0.1	10.6	77
1977	15.9	16.0		-0.2	10.4	66
1978	19.2	18.2		1.0	11.5	57
1979	22.8	21.1		1.8	13.2	54
1980	26.1	25.6		0.5	13.7	52
1981	35.7	30.7		5.0	18.7	45
1982	38.0	36.1	$-12.4	-10.5	8.2	52

NOTE: Components may not add to totals due to rounding.

Actuarial Status of the Trust Fund

The Board of Trustees has adopted the general financing principle that annual income to the hospital insurance program should be approximately equal to annual outlays of the program plus an amount to maintain a balance in the trust fund equal to one-half year's disbursements. Due to the $12.4 billion loan to the OASI fund at the end of 1982, the trust fund was far below this desired level. Projections were made under four alternative sets of assumptions: optimistic, two intermediate sets (alternatives

II-A and II-B), and pessimistic. Under both sets of intermediate assumptions, the trust fund ratio is projected to remain around 20 to 30 percent in most years until the late 1980's and then decline rapidly with complete exhaustion of the fund around 1990.

Under the more optimistic set of assumptions (alternative I), the trust fund is projected to grow until about 1988, then to decline steadily until the fund is completely exhausted in 1996. Under the more pessimistic set of assumptions (alternative III), the trust fund is projected to decrease steadily with complete exhaustion of the fund by 1988.

Table 3 summarizes the estimated operations of the HI trust fund under the four alternative sets of assumptions. Figure 1 shows historic trust fund ratios for recent years and projected ratios under the four sets of assumptions.

The adequacy of the financing of the HI program on a long-range basis is measured by comparing on a year-by-year basis the actual tax rates specified by law with the corresponding total costs of the program, expressed as percentages of taxable payroll. The actuarial balance is defined to be the excess of the average tax for the 25-year valuation period (1983-2007) over the average cost of the program expressed as a percent of taxable payroll. The average tax rate for the 25-year period

TABLE 3.--ESTIMATED OPERATIONS OF THE HOSPITAL INSURANCE TRUST FUND DURING CALENDAR YEARS 1982-96, UNDER ALTERNATIVE SETS OF ASSUMPTIONS
(Dollar amounts in billions)

Calendar Year	Total Income	Total disbursements	Interfund borrowing transfers 1/	Net increase in fund	Fund at end of year	Ratio of assets to disbursements 2/ (percent)
			ALTERNATIVE I (Optimistic)			
1982 3/	$38.0	$ 36.1	$-12.4	$-10.6	$ 8.2	52%
1983	44.8	41.2		3.6	11.8	20
1984	46.0	46.2	1.0	0.9	12.6	26
1985	52.0	51.1	1.6	2.5	15.2	25
1986	59.1	55.7	9.1	12.5	27.6	27
1987	63.6	60.5	0.7	3.8	31.4	45
1988	68.0	65.9		2.1	33.5	48
1989	71.9	70.8		1.1	34.6	47
1990	76.8	77.1		-0.4	34.2	45
1991	80.8	82.4		-1.6	32.6	42
1992	86.1	89.1		-3.1	29.5	37
1993	90.1	95.8		-5.7	23.9	31
1994	95.3	102.8		-7.6	16.3	23
1995	99.4	110.2		-10.8	5.5	15
1996	104.5	117.6		-13.2	4/	5
			ALTERNATIVE II-A (Intermediate)			
1982 3/	38.0	36.1	-12.4	-10.6	8.2	52
1983	44.7	41.2		3.6	11.7	20
1984	45.8	46.5	0.6	-0.1	11.6	25
1985	51.3	51.8		-0.5	11.2	22
1986	56.2	57.1	4.8	5.9	17.1	30
1987	61.9	62.6	6.8	6.1	23.2	37
1988	65.7	68.9	0.2	-3.0	20.3	34
			ALTERNATIVE II-B (Intermediate)			
1982 3/	38.5	36.1	-12.4	-10.6	8.2	52
1983	44.7	41.2		3.5	11.7	20
1984	45.6	46.6	0.5	-0.5	11.2	25
1985	51.3	52.3		-1.0	10.2	21
1986	58.4	56.0	1.1	1.5	11.8	18
1987	62.5	64.1	2.4	0.8	12.6	18
1988	66.0	71.0	5.4	3.5	16.1	18
1989	70.0	78.4		-8.4	7.8	21
1990	73.9	86.6		-12.6	6/	9
			ALTERNATIVE III (Pessimistic)			
1982 3/	38.0	36.1	-12.4	-10.6	8.2	52
1983	44.4	41.2		3.2	11.4	20
1984	44.5	46.8		-2.3	9.1	24
1985	50.5	54.1		-3.6	5.5	17
1986	58.2	61.9		-3.7	1.8	9
1987	62.6	70.5	12.4	4.5	6.3	3
1988	66.5	80.4		-13.9	7/	8

1/ A loan to the OASI trust fund would still be an asset of the HI trust fund. However, since these assets are not immediately available for payment of HI benefits, they are subtracted from the HI fund balance. A negative amount is a loan to the OASI trust fund. A positive amount is a repayment of principal to the HI trust fund.

2/ Ratio of assets in the trust fund at the beginning of the year to disbursements during the year.

3/ Figures for 1982 represent actual experience.

4/ Trust fund depleted in calendar year 1996.

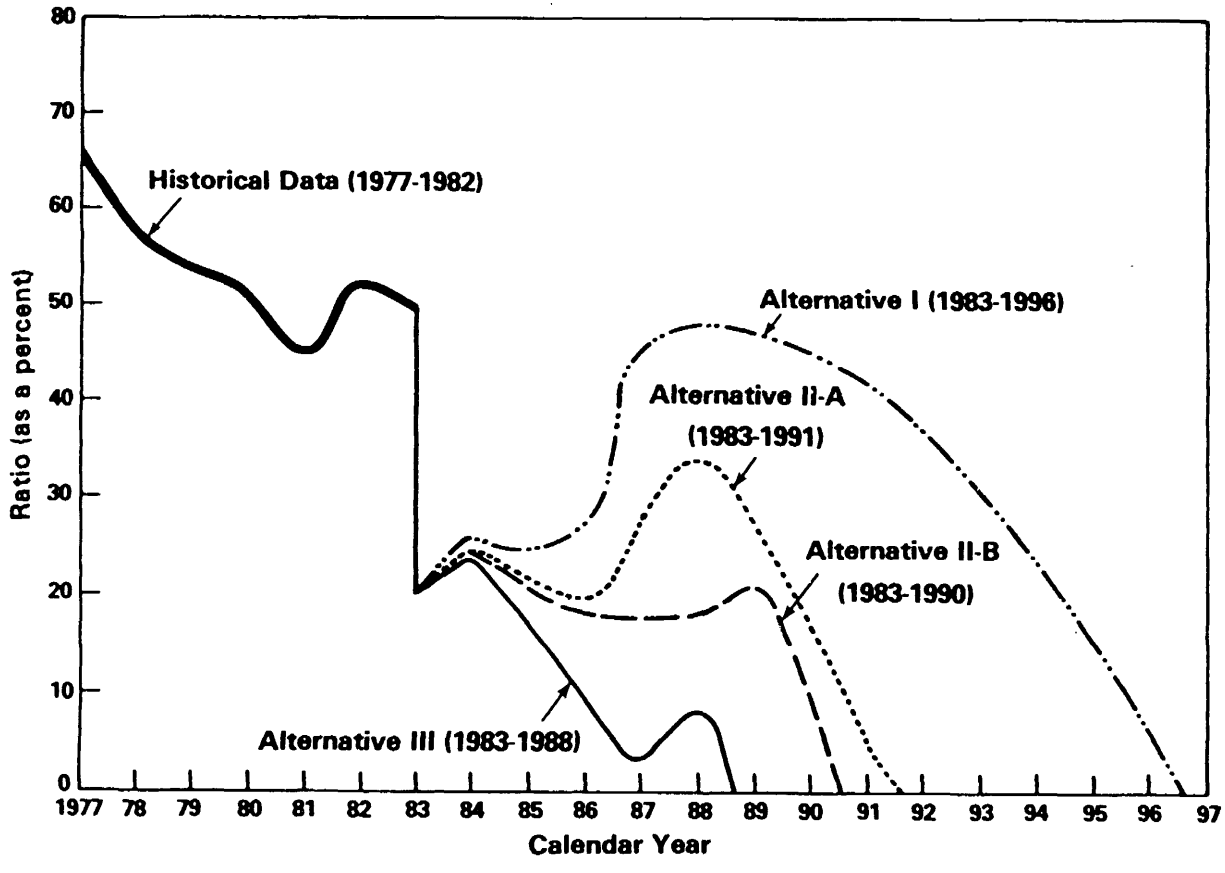
5/ Trust fund depleted in calendar year 1991.

6/ Trust fund depleted in calendar year 1990.

7/ Trust fund depleted in calendar year 1988.

NOTE: Totals do not necessarily equal the sum of rounded components.

Figure 1
Short Term HI Trust Fund Ratios



Note: The trust fund ratio is defined as the ratio of assets in the trust fund at the beginning of the year to disbursements during the year.

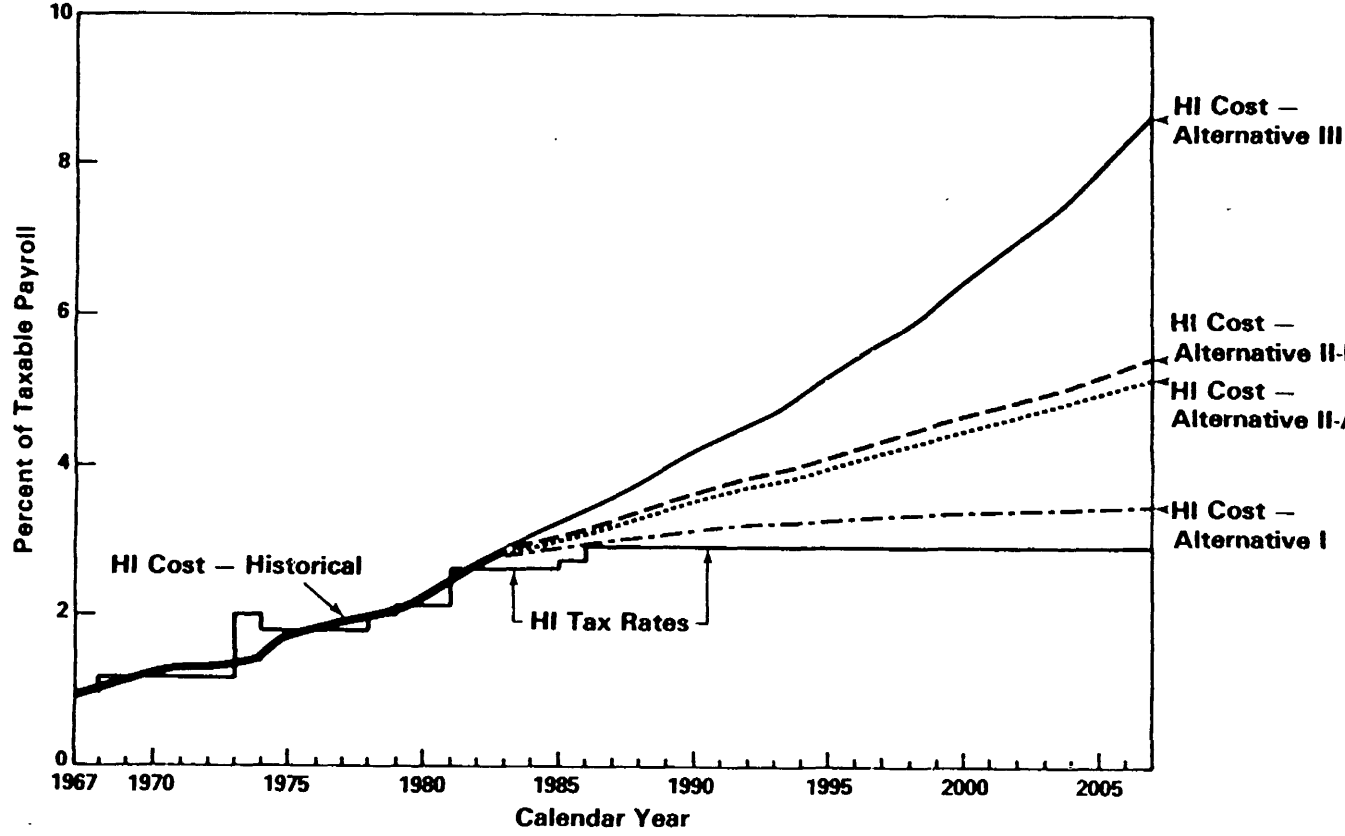
1983-2007 is 2.87 percent. The average cost of the program under alternatives II-A and II-B is 3.97 and 4.11 percent of taxable payroll, respectively. Table 4 compares the actuarial balance under each of the four sets of assumptions. Figure 2 shows the year-by-year costs as a percent of taxable payroll for each of the four sets of assumptions, as well as the scheduled tax rates. The cost figures in Table 4 and Figure 2 include amounts for building and maintaining the trust fund at the level of a half year's disbursements as recommended by the Board of Trustees. Figure 2 emphasizes the inadequacy of the financing of the HI program by illustrating the divergence of the program costs and scheduled tax rates under each set of assumptions.

TABLE 4.--ACTUARIAL BALANCE OF THE HOSPITAL INSURANCE PROGRAM, UNDER ALTERNATIVE SETS OF ASSUMPTIONS

	Alternative			
	I	II-A	II-B	III
Average contribution rate, scheduled under present law 1/	2.87%	2.87%	2.87%	2.87%
Average cost of the program, for expenditures and for trust fund building and maintenance 2/	3.21	3.97	4.11	5.38
Actuarial balance 3/	-0.34	-1.10	-1.24	-2.51

1/ Average for the 25-year period 1983-2007.
2/ Average for the 25-year period 1983-2007, expressed as a percent of taxable payroll. Taxable payroll is adjusted to take into account the lower contribution rates on self-employment income in 1983, on tips, and on multiple-employer "excess wages" as compared with the combined employer-employee rate.
3/ The actuarial balance of the hospital insurance program is defined to be the excess of the average tax rate for the 25-year valuation period over the average cost of the program, expressed as a percent of taxable payroll, for the same period.

Figure 2
Estimated HI Cost and Tax Rates



It is noteworthy that under all four sets of assumptions used in the 1983 report, the outlook for the hospital insurance trust fund is slightly more optimistic than it was in the 1982 report. This is primarily the result of the major legislation during 1982 and 1983 which will help curtail the rapid increase in hospital costs. Table 5 below presents a comparison of the projected experience in the 1982 and 1983 reports.

TABLE 5.--STATUS OF THE HOSPITAL INSURANCE TRUST FUND

	Year in which the trust fund is exhausted as published in the		Actuarial Balance of the HI program 1/ as published in the	
Alternative Assumptions	1982 Report	1983 Report	1982 Report	1983 Report
I (Optimistic)	1991	1996	-0.86	-0.34
II-A (Intermediate)	1989	1991	-1.63	-1.10
II-B (Intermediate)	1987	1990	-2.07	-1.24
III (Pessimistic)	1986	1988	-3.73	-2.51

1/The actuarial balance of the hospital insurance program is defined to be the excess of the average tax rate for the 25-year valuation period over the average cost of the program, expressed as a percent of taxable payroll, for the same period.

Conclusion

The present financing schedule for the hospital insurance program is barely adequate to ensure the payment of benefits through the end of this decade if the assumptions underlying the estimates are realized. The trust fund is exhausted in 1991 and 1990 under alternatives II-A and II-B, respectively. Under the more pessimistic assumptions, the fund is exhausted in 1988. Even under the more optimistic alternative I, the present financing schedule will result in the fund being exhausted in 1996. In order to bring the hospital insurance program into close actuarial balance, either disbursements of the program will have to be reduced by 30 percent or financing will have to be increased by 43 percent. Despite the short-term uncertainties, the enactment of TEFRA in 1982 and Public Law 98-21 in 1983 has substantially reduced the long range deficit of the HI fund. More importantly, the prospective payments provisions of Public Law 98-21 have made the outlays of the HI program potentially less vulnerable to excessive rates of growth in the hospital industry by providing the Secretary of Health and Human Services with some discretion over the level of payments to hospitals.

The quadrennial Advisory Council on Social Security, appointed by the Secretary, will be addressing the financial status of the hospital insurance trust fund. The council's report is due by the end of 1983. The Board recommends that Congress study carefully the advisory council's recommendations as it takes further action to curtail the rapid growth in the cost of the hospital insurance program which has occurred in recent years and which is anticipated in the future.

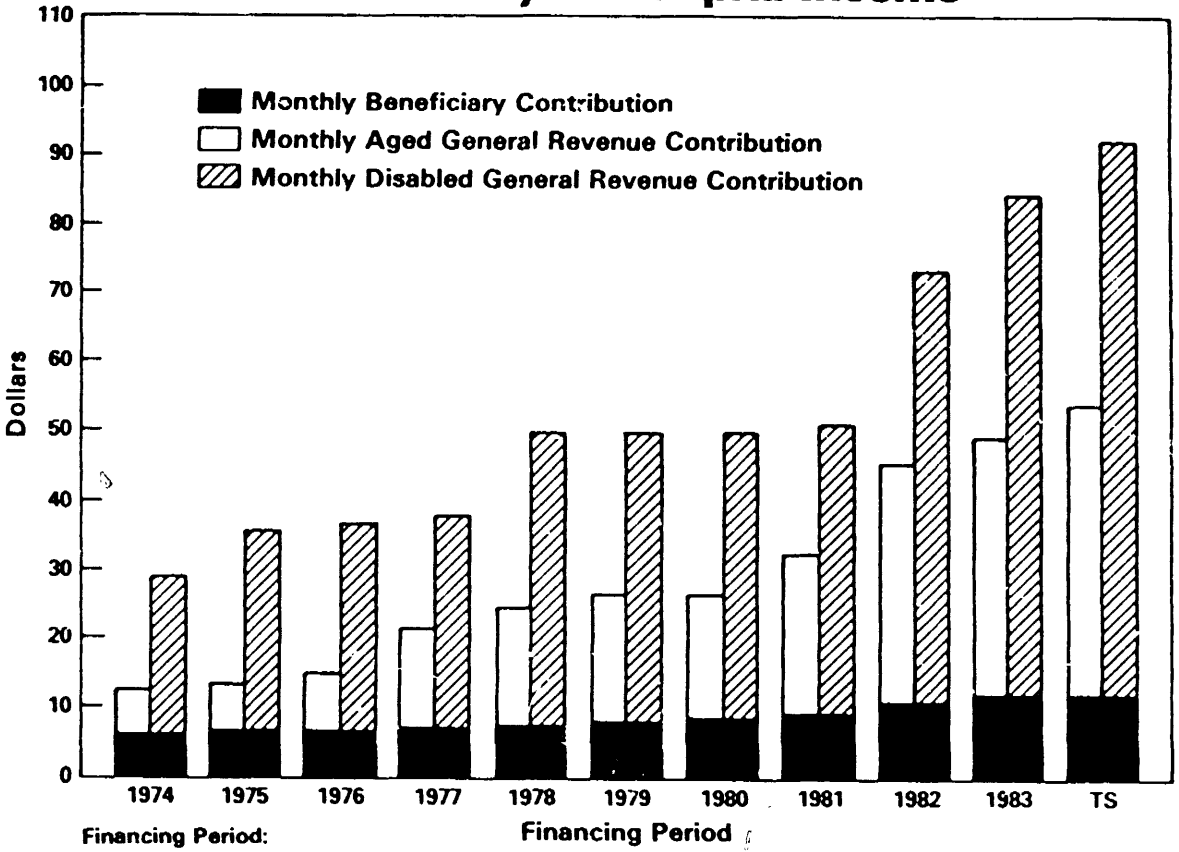
SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND

Financing for the supplementary medical insurance program is established annually on the basis of standard monthly premium rates (paid by or on behalf of all participants) and monthly actuarial rates determined separately for aged and disabled beneficiaries (on which general revenue contributions are based). Prior to the 6-month transition period (July 1, 1983 through December 31, 1983) these rates were applicable to the 12-month periods ending June 30. Beginning January 1, 1984, the annual basis will change to the 12-month periods ending December 31. Monthly actuarial rates are equal to one-half the monthly amounts necessary to finance the SMI program. These rates determine the amount to be contributed from general revenues on behalf of each enrollee. Based on the formula in the law, the government contribution effectively makes up the difference between twice the monthly actuarial rates and the standard monthly premium rate. Figure 3 presents these values for financing periods since 1974. The extent to which general revenue financing is becoming the major source of income for the program is clearly indicated in this figure.

Standard monthly premium rates and monthly actuarial rates have been announced for periods through December 31, 1983. For the 6-month period ending December 31, 1983 (transitional semester (TS)), the standard monthly premium rate is $12.20, and the monthly actuarial rates are $27.00 and $46.10 for the aged and disabled, respectively.

The Social Security Act was amended during 1982 and 1983. The major provisions among the many affecting the SMI program were:

Figure 3
SMI Monthly Per Capita Income



Financing Period:
For periods 1983 and earlier, the financing period is July 1 through June 30.
For the transitional semester (TS), the financing period is July 1, 1983 through December 31, 1983

(1) The premium rate applicable July 1, 1983 through December 31, 1983 is frozen at the rate which applied June 1983. Some general revenues shall be added from July through December to compensate for keeping the smaller June 1983 premium for that period. From January 1984 through December 1985, the monthly SMI premium is set at one-half of the actuarial rate for aged enrollees. After December 1985 the determination of the premium rate will revert to the method used before enactment of this provision and future increases shall apply on a calendar year basis.

(2) Medicare becomes the secondary payor for employees aged 65 through 69 (and their spouses of the same age) who are covered by health plan benefits of an employer.

(3) The basis upon which provider-based physicians are reimbursed are to be prescribed in regulations which distinguish between (a) professional component, and (b) provider component.

Operations of the SMI Program

In fiscal year 1982, 28.2 million people were covered under SMI. General revenue contributions during 1982 amounted to $13.3 billion, accounting for 75.6% of all SMI income. About 21.7% of all income resulted from the premiums paid by the participants, with interest payments to the SMI fund accounting for the remaining 2.7%. Of the $15.6 billion in SMI disbursements, $14.8 billion was for benefit payments while the remaining $0.8 billion was spent for administrative expenses. SMI administrative expenses were 4.8% of total disbursements. The historical operations of

the SMI trust fund since fiscal year 1977, as well as the projected operations of the fund for fiscal years through 1985, for both alternative II-A and alternative II-B are shown in table 6. As can be seen, income has exceeded disbursements for most of the historical years and the trust fund balance is projected to continue to increase through fiscal year 1985. However, as the report notes, the financial status of the program depends on both the total net assets and liabilities. It is, therefore, necessary to examine the incurred experience of the program since it is this experience which is used to determine the actuarial rates discussed above and which forms the basis of the concept of actuarial soundness as it relates to the SMI program.

TABLE 6.--SMI FUND OPERATIONS
FISCAL YEARS 1977-1985
(In Billions)

Fiscal Year	Total income	Total disbursements	Net increase in fund	Fund at end of year
1977	$ 7.4	$ 6.3	$ 1.0	$2.3
1978	9.0	7.4	1.7	4.0
1979	9.8	8.8	1.0	5.0
1980	10.3	10.7	-0.5	4.5
1981	12.4	13.2	-0.8	3.7
1982	17.6	15.6	2.1	5.8
Alternative II-A:				
1983	19.1	18.3	0.7	6.5
1984	22.4	21.3	1.1	7.6
1985	25.3	24.5	0.8	8.5
Alternative II-B:				
1983	19.1	18.3	0.7	6.5
1984	22.4	21.3	1.1	7.6
1985	25.5	24.6	0.9	8.5

Note: Components may not add to totals due to rounding.

Actuarial Soundness of the SMI Program

The concept of actuarial soundness, as it applies to the supplementary medical insurance program, is closely related to the concept as it applies to private group insurance. The supplementary medical insurance program is essentially yearly renewable term insurance intended to be self-supporting from premium income paid by the enrollees and from income contributed from general revenue in proportion to premium payments.

In testing the actuarial soundness of the supplementary insurance program, it is not appropriate to look beyond the period for which the enrollee premium rate and level of general revenue financing have been established. The primary tests of actuarial soundness, then, are that (1) income for years for which financing has been established be sufficient to meet the projected benefits and associated administrative expenses incurred for that period and (2) assets be sufficient to cover projected liabilities which will have been incurred by the end of that time but will not have been paid yet. Even if these tests of actuarial soundness are not met, the program can continue to operate if the trust fund remains at a level adequate to permit the payment of claims as presented. However, to protect against the possibility that cost increases under the program will be higher than assumed, assets should be sufficient to cover the impact of a moderate degree of projection error.

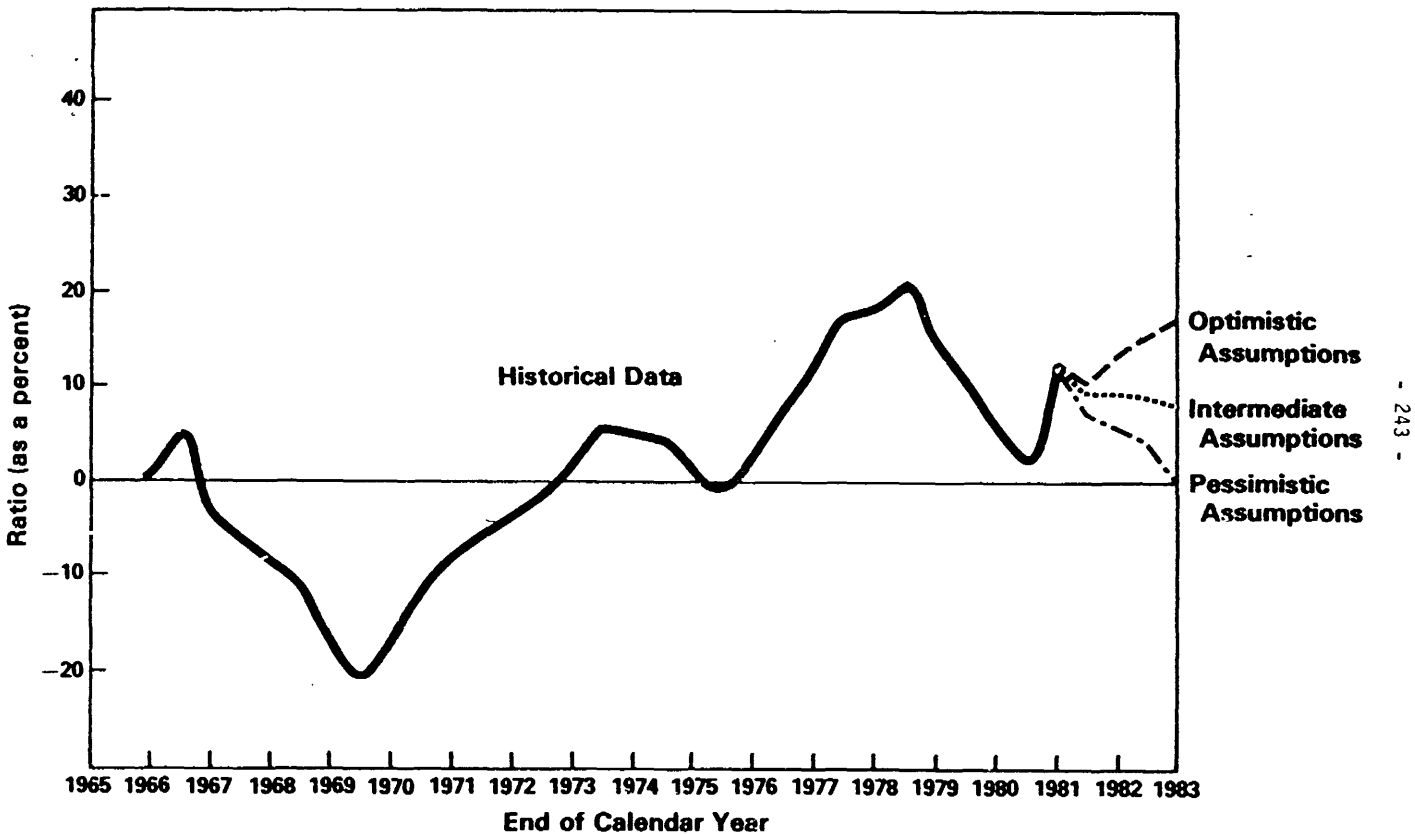
The initial tests for actuarial soundness and trust fund adequacy can be viewed by direct examination of absolute dollar levels. In providing an appropriate contingency or margin for error, however, there must

be some relative measure. The relative measure or ratio used for this purpose is the ratio of net surplus or deficit to the following year's incurred expenditures. Figure 4 shows this ratio for historical years and for projected years under the intermediate assumptions (alternative II-B), as well as high and low cost sensitivity scenarios.

Financing for the 12-month period ending June 30, 1983 was established to maintain assets at the same level relative to program expenditures which existed prior to June 30, 1982. The resulting excess of assets over liabilities as of June 30, 1983 represents 9.4% of the projected incurred expenditures for the following 12-month period.

The actuarial rates for the 6-month period ending December 31, 1983, as implemented, will reduce this excess to a more appropriate level. Under more pessimistic assumptions as to cost increases, assets based on financing already established will be insufficient to cover outstanding liabilities. However, the trust fund would remain positive allowing claims to be paid.

Figure 4
Actuarial Status of the SMI Trust Fund



Note: The actuarial status of the SMI trust fund is measured by the ratio of the end of year surplus or deficit to the following year's incurred expenditures.

Conclusion

The financing established through December 1983 is sufficient to cover projected benefit and administrative costs incurred through that time period and to build a level of trust fund assets which is adequate to cover the impact of a moderate degree of projection error. Thus, the SMI program can be said to be actuarially sound.

APPENDIX F

A REPORT ON THE HISTORY OF THE MEDICARE PROGRAM*

Medicare, the national health insurance program for the aged and disabled, is a success story that is currently encountering problems because of its accomplishments. Its success lies in the protection against the high costs of illness it offers to more than 26 million persons aged 65 and over and to approximately three million disabled persons under age 65. Its problems spring from the ever-increasing costs of reimbursing for services rendered to program beneficiaries, from the distribution of these reimbursements among the population served, and from the types of services needed by the elderly that are not covered by Medicare. The following statistics highlight some of the program successes.

- o The number of aged enrollees in the Medicare program increased from 19.1 million in 1966 to 26.8 million in 1983.1/
- o The number of disabled enrollees rose from 1.7 million in 1973 to 3.1 million in 1983.2/
- o Services covered under Medicare have extended the lives of many of the disabled and improved the quality of life of many of the elderly.

The problems that are currently casting a long shadow on these successes include the following.

- o The Hospital Insurance trust fund, from which reimbursements for Part A services are made, is expected to be depleted by 1989 or sooner and to experience a $200 to $300 billion deficit by 1995.3/
- o Reimbursements for covered services increased from $4.6 billion in 1967 to $43.5 billion in 1981 and are expected to reach $58 billion in 1983.4/
- o The distribution of reimbursements for services to the aged are heavily skewed, with a small portion of the aged population (8 percent) accounting for 66 percent of total reimbursements in 1981.5/ The major portion of these reimbursements (30%) paid for services rendered in the last year of life.
- o Many services needed by the elderly, especially those age 75 and over, are not covered by Medicare.6/

*Prepared under contract for the Advisory Council on Social Security by MAXIMUS, Incorporated, 6723 Whittier Avenue, McLean, Virginia

The following section discusses the current status of the Medicare program, including some of the financial problems that are expected to have an impact on the program in the future.

In reviewing this information, it is important to keep in mind several factors that have contributed and will continue to contribute to the demands made on the program. These factors include demographic changes, the increase in life expectancy, the changing needs of the elderly population, and the advances in medical technology. A few salient features of these factors are presented below.

- o Demographic Changes: In 1981, the over 25 million Americans age 65 and over represented 11 percent of the total population. Moreover, between 1960 and 1970, the population age 65 and over increased in number by 21 percent while the population under 65 increased by 13 percent. Between 1970 and 1979, the population age 65 and over increased by 23.5 percent compared with only a 6.3 percent increase in the population under 65.[7] In addition, between 1980 and 2030, the total population is expected to grow by 40 percent whereas the elderly population will more than double.[8] The growth in the number of elderly and the proportion of the population they represent will clearly have implications for the Medicare program in the future.

- o Increases in Life Expectancy: Since 1954, there has been a 5.7 percent increase in life expectancy at birth in the United States, with average remaining years of life rising from 70 years in 1954 to 74 years in 1981. The increase in life expectancy at birth results to a large extent from wiping out diseases that contributed to high infant and child mortality rates. Since the mid-century, there has also been a slight increase in life expectancy in the upper age groups.[9] In 1978, women age 65 could expect to live an average of 18.4 additional years whereas men age 65 could expect to live 14 more years. By 2050, women age 65 are projected to average 23 additional years of life and men 17 additional years.[10]

- o Changes in Health Care Needs: The elderly have more health problems and use more health services than the general population. Moreover, as people age, chronic diseases and conditions increase, frequently resulting in limitations in the activities of daily living. This is particularly evident among people age 75 and over, the fastest growing portion of the elderly population. The functionally disabled are at risk for needing a wide range of long-term health and social services. Those with most severe functional impairment may require care in an institutional setting. Others may be able to continue to live independently in the community, provided that

services such as home health care, personal care, homemaker and chore services, monitoring services, adult day care, or home and congregate meals are available. At present, only medically oriented home health care is covered under Medicare. Other needed services are available under a variety of federal, state, and local programs, each with its own eligibility and cost-sharing requirements. For example, although less intensive care is available in intermediate care facilities and reimbursed under Title XIX of the Social Security Act (Medicaid), to be eligible for care in these facilities individuals must have economic assets below state-established ceilings.

Many believe that the lack of coordination in long-term care services delivery results in a significant level of unmet need among the elderly population. However, it is difficult to measure the need for formal, government-sponsored services because the availability and willingness of family and friends to provide informal care cannot be accurately gauged. The following estimates suggest the magnitude of unmet need.

- In 1978, an HEW Task Force estimated that 3.6 to 7.8 million disabled adults received no formal long term care services, although evidence suggested that many received care from family or friends. (HEW, 1978, Appendix 10, Table 1)

- 4.4 million persons suffer some activity limitation and live alone. NCHS, NHIS (1977), unpublished. How many need services and how many currently receive formal services is unknown.

- Almost 1.6 million noninstitutionalized persons need assistance in basic activities such as bathing, dressing, eating, and going to the toilet. However, depending on the activity, 88.4 to 96.5 percent report that they do receive the needed assistance most of the time. NCHS, NHIS (1977), unpublished; NCHS, 1978, table 23.

- Of persons needing assistance in at least one of the activities of daily living, 166,000 live alone and 51,000 more live with nonrelatives. NCHS, NHIS (1977), unpublished.[11/]

Should Medicare become the vehicle for providing the type of long term care services that are currently needed, there would be a significant increase in program expenditures. This would result in a significant shift from Medicare's traditional role of providing acute care treatment.

- o Technological Advances in Medicare: The past fifteen years have been characterized by tremendous advances in medical technology. High technology diagnostic procedures, such as Computerized Axial Tomography (CAT) scanning and ultrasound, have reduced the need for other less reliable, more costly, and more painful diagnostic procedures (e.g., exploratory surgery). However, they sometimes have also partially contributed to the rate of increase in health care costs and to the increase in expenditures for publicly funded health care programs. In like manner, advances in therapeutic procedures such as coronary bypass surgery and organ transplants have had a similar effect on costs and expenditures. In examining the costs and expenditures of the Medicare program, it is important to keep in mind what has been purchased by these advances. Both types of advances have led to improved quality of care, reduction in complications and human suffering, improved quality of life, and perhaps, to an increase in life expectancy.

In addition to the recent dramatic changes for the elderly in demographics and their health profile, there has been substantial change in the economic position of the elderly. In a comparison between the younger adult population and the elderly (age 65 and over) population, the elderly have had a higher percentage increase in median income over the last two decades.[12] Since 1972, when the elderly received a substantial social security 20 percent "catchup" increase, their median income has grown at twice the rate of younger adults. For elderly males, median income has increased 34.9 percent between 1966 and 1981 and for females during the same period 56.4 percent as measured in constant 1981 dollars. The dilemma of high inflation rates has had little impact on the majority of the elderly whose real median income remained about constant in 1980-1981, while the younger population dropped a few percent from the 1980 level.[13]

Louis Harris and Associates conducted a survey in 1981 for the National Council on the Aging which indicated that 66 percent of those 65 and over own their houses free and clear.[14] Additionally, two-thirds of all homes owned free and clear are owned by the elderly.[15] In another measure of real wealth, the percent of income saved by the elderly is approximately the same as the general population.

The overall economic condition of the elderly poor has improved. In 1982, 27.1 percent of the Federal budget went to programs for the elderly. Federal, state and local assistance has considerably decreased the plight of the elderly poor. The under 65 living in poverty has increased from 11.3 percent in

1970 to 13.9 percent in 1981, while during the same period the over 65 living in poverty has decreased from 24.6% percent to 15.3 percent.[16]

The first four factors discussed in the foregoing give some indication of why Medicare program expenditures have risen beyond any of the original projections about the costs of providing care to the elderly. The brief discussion of these issues is intended to serve as a background to the remaining sections of this report. These sections summarize the current status of the Medicare trust funds, describe the legislative climate that preceded enactment of Medicare, review subsequent legislative changes to the program, and highlight the impact of these changes on the program and its beneficiaries.

I. THE CURRENT STATUS OF THE MEDICARE TRUST FUNDS

Medicare consists of two separate but complementary types of insurance. Hospital insurance (Part A) or the basic program helps pay for inpatient hospital care, medically necessary inpatient care in skilled nursing facilities, and home health care services. Supplementary medical insurance (Part B) provides coverage for physicians' services, outpatient hospital care, outpatient physical and speech therapy, home health care services, and certain other medical services and supplies.

Two separate trust funds have been establish from which all reimbursement for benefits and administrative expenses are made. Proceeds from the tax on a portion of current earnings in employment, the principal source of funding for hospital insurance, as well as monies collected from the railroad retirement system, limited general revenues to cover costs of certain "grandfathered" beneficiaries, and premiums paid by those who voluntarily enroll in the hospital program, are deposited in the Hospital Insurance (HI) trust fund. Premiums paid by those who enroll in the supplementary program and the matching contributions made by the Federal government from general revenues are deposited in the Supplementary Medical Insurance (SMI) trust fund.

Reimbursements for covered services from both trust funds have risen dramatically since 1967, the first year of full program implementation. In 1967, slightly more than $3 billion in HI benefits and $1 billion in SMI benefits were paid by the respective trust funds. The respective Boards of Trustees of the two trust funds estimate that, in 1983, benefit payments for hospital insurance will reach approximately $40.6 billion and that those for the supplementary program will be more than $17.5 billion.[17]

The 1983 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund provides estimates of the operations of the Hospital Insurance Trust Fund during calendar years 1982-1996. Under the most optimistic of the alternatives (Alternative I), the HI trust fund is projected to grow until about 1988 and then to decline steadily until the fund is exhausted in 1996. Under the most pessimistic projections (Alternative III), the trust fund is projected to be completely depleted by 1988.

The two intermediate estimates (Alternatives II-A and II-B) assume that the ratio of assets to disbursements will remain around 20 to 30 percent until the late 1980s and then decline rapidly. Under these assumptions, the trust fund is projected to be exhausted by 1990 or 1991.

Exhibit I-1 presents the projections of the Board of Trustees of the Federal Hospital Insurance trust fund under the two intermediate alternatives.

Factors contributing to the projected deficit include the increase in hospital costs in excess of earnings taxed to generate revenue for the HI trust fund and the increase in the number of persons age 65 and over who will be eligible for benefits. With respect to the first of these factors, estimates are that hospital costs attributable to Medicare beneficiaries will increase by 13.2 percent annually between 1982 and 1995 whereas covered earnings will only rise at an annual rate of 6.8 percent. 18/

Although reimbursements for benefits under SMI are also expected to continue to rise, no long-range projections are made for this trust fund. Its financing is established annually on the basis of standard monthly premium rates and actuarial rates, and its cost-sharing provisions are not automatically adjusted for changing economic conditions as are many of the HI provisions. It is estimated that financing assets will exceed liabilities by $1,655 million at the end of June 1982. This excess is projected to increase to approximately $1.9 billion at the end of June 1983.19/ The actuarial status of the SMI trust funds is satisfactory both on a cash basis and an accrual basis.20/ Exhibit I-2 summarizes the projections on income, disbursements, and year end balance for this trust fund.

Exhibit I-1

ESTIMATED OPERATIONS OF THE HOSPITAL INSURANCE TRUST FUND 1982-1991, UNDER SELECTED ALTERNATIVE SETS OF ASSUMPTIONS

(Dollar Amounts in Billions)

ALTERNATIVE II-A

	1982 (Actual)	1983	1984	1985	1986	1987	1988	1989	1990	1991
Total Disbursements	$36.1	$41.2	$46.5	$51.8	$57.1	$62.6	$68.9	$75.8	$83.5	$91.5
Total Income	$38.0	$44.7	$45.8	$51.3	$58.2	$61.9	$65.7	$69.8	$73.9	$77.5
Fund at End of Year	$ 8.2	$11.7	$11.6	$11.2	$17.1	$23.2	$20.3	$14.3	$ 4.7	1/
Ratio of Assets to Disbursements (Percent)	52%	20%	25%	22%	20%	27%	34%	27%	17%	5%

1/ Trust Fund depleted in calendar year 1991

ALTERNATIVE II-B

	1982 (Actual)	1983	1984	1985	1986	1987	1988	1989	1990
Total Disbursements	$36.1	$41.2	$46.6	$52.3	$58.0	$64.1	$71.0	$78.4	$86.6
Total Income	$38.0	$44.7	$45.6	$51.3	$58.4	$62.5	$66.0	$70.0	$73.9
Fund at End of Year	$ 8.2	$11.7	$11.2	$10.2	$11.8	$12.6	$16.1	$ 7.8	2/
Ratio of Assets to Disbursements (Percent)	52%	20%	25%	21%	18%	18%	18%	21%	9%

2/ Trust Fund depleted in calendar year 1990

Source: 1983 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund, p. 44.

Exhibit I-2
ESTIMATED PROGRESS OF SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND (CASH BASIS) CALENDAR YEARS 1983-1995*
(In Millions)

	1982 Actual	1983		1984		1985	
		A	B	A	B	A	B
Total Income	$16,580	$19,584	$19,584	$22,849	$22,866	$26,166	$26,328
Total Disbursements	$16,227	$19,043	$19,047	$22,060	$22,083	$25,392	$25,497
Balance in Fund at End of Year	$ 6,230	$ 6,771	$ 6,767	$ 7,560	$ 7,550	$ 8,334	$ 8,381

*The projections shown in the exhibit are based on two sets of economic assumptions: Alternative A and Alternative B. These alternatives reflect two different levels of expectation of future performance of the economy.

Source: 1983 Annual Report of the Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund, p. 24.

The preceding section emphasizes the financial problems that the Advisory Council on Social Security considered in its evaluation of the Medicare program and its recommendations. The following section summarizes the issues which predominated prior to enactment of the legislation that established the program (P.L. 89-97) and highlights those factors which influenced the provisions and structure of Medicare.

II. HISTORY OF THE ORIGINAL MEDICARE LEGISLATION[21]/

Before a national health insurance program to protect the elderly against the costs of medical care became an issue, the Congress had engaged in a series of debates that addressed broader questions related to health insurance. From 1933 to 1949, the focus of the debate shifted from the issue of medical

insurance as a viable means of sharing the risk of illness to the issue of who should sponsor and operate a nationwide health insurance system. In the 1950s, proposed legislation began to emphasize the need to protect the elderly against the risk of incurring medical expenses that could result in impoverishment.

A. THE PRE-MEDICARE DEBATE

In 1959, the Forand Bill (H.R. 4700), introduced during the sessions of the 86th Congress, called for coverage of persons age 65 and over who were eligible for OASI benefits, even if employed, and excluded coverage of persons receiving Old Age Assistance (OAA). The proposed benefit package included 60 days per year of hospital coverage, 120 days/year of nursing home care available only after transfer from a hospital, full payment of surgeons' fees, and full payment of inpatient hospital diagnostic services and drugs. Financing was based on an additional social security tax (.25% on the first $4,800 of wages) to be paid in equal amounts by the employer and employee.

Opposition to the bill--from the Administration and from national associations representing physicians, dentists, hospitals, and nursing homes--was based on a rejection of the compulsory social insurance method of financing, as well as of any federal action whatsoever in the area of medical insurance. Although Congress postponed action on the bill until 1960, its opponents organized efforts to block its passage in committee.

1. The Public Assistance Approach to Financing Medical Care for the Elderly

As a first alternative to the social security tax financing approach, the public assistance approach was introduced as the Kerr-Mills Bill in 1960. This bill called for federal-state matching funds to support medical care for the needy elderly and the medically indigent and was endorsed by the medical profession. Kerr-Mills was passed as P.L. 86-778 in 1960 and was viewed as a means of liberalizing federal participation in state old-age assistance programs.

Beneficiaries under Kerr-Mills included the two and a quarter million elderly (approximately 13% of the elderly population) who were receiving Old Age Assistance (OAA) and elderly people who were deemed medically indigent, i.e., persons not receiving OAA benefits whose resources and income were insufficient to meet the costs of necessary medical services. The OAA portion of the Act provided federal funds of up to $12/month per OAA recipient for medical care in addition to the maximum of

$65/month that the federal government was paying to the states for each recipient. The Medical Assistance to the Aged (MAA) program provided federal repayment to the states of a portion of state expenditures for medical care of the medically indigent. The federal share of MAA to individual states would vary according to the state's per capita income. It was the latter portion of the Act (MAA) that became the focus of much of the debate that ensued over legislation based on the social security financing method for health insurance to the elderly.

2. The Public Assistance vs. Social Security Financing Debate

In 1961 the King-Anderson Bill (H.R. 4222 and S. 909) was introduced. A variation of the Forand Bill in that it was based on social security financing, King-Anderson differed from the Forand bill by including railroad retirement beneficiaries, changing the period of insurance from year to "benefit period," increasing the number of covered days of hospital and nursing home services, including home health care services, and excluding surgeons' fees. King-Anderson also incorporated deductibles for certain types of services and increased the taxable earnings base to $5,000.

Opponents of King-Anderson, including the American Medical Association, pointed to Kerr-Mills as the preferable way of providing insurance for the elderly. They maintained that Kerr-Mills, and other state and local programs, allowed for the natural development and implementation of the community's responsibility for its members and ensured that the medical services offered would be determined by resources available in the community. They also maintained that passage of King-Anderson would have a deleterious effect on already existing state and local programs such as Kerr-Mills.

Supporters of King-Anderson maintained that Kerr-Mills was a desirable supplementary method for meeting the medical care costs of the needy elderly but inadequate as the principal means of doing so. The effectiveness of the MAA approach in Kerr-Mills was questioned because of the variations from state to state in the types of services covered, in definitions of medical indigence, and in resources available to implement the program. In addition, states were free to choose not to participate in the program, thus making it possible to leave some elderly people unprotected.

3. The Private vs. Compulsory Insurance Debate

Arguments for and against Kerr-Mills, brought forth to oppose or support the social security financing approach, broadened the scope of the debate to include arguments over private

versus compulsory insurance as the most desirable and effective means of meeting the health care costs of the elderly. At hearings on Health Services for the Aged under the Social Security Insurance System held by the Committee on Ways and Means in 1961, the American Medical Association testified in favor of private insurance, maintaining that the amount of private health insurance owned by the aged was growing at a faster rate than that owned by the population as a whole. Statistics presented to support the concept of private insurance included the following:

- o only 26 percent of the population age 65 or older were covered by health insurance of any kind in 1952 whereas more than 50 percent of that population owned some kind of coverage in mid-1961;
- o the number of elderly covered in 1951 was 3.4 million persons while the number covered in 1961 represented 8 million people;
- o 25 to 30 percent of the aged were not in the market for health insurance because their medical care needs were met by OAA;
- o approximately 240 voluntary health insuring organizations, including Blue Cross and Blue Shield, were issuing hospital or surgical policies to the elderly; and
- o Blue Cross alone had increased its membership to 56,063,125 persons in 1960 - a gain of 1,041,382 over the previous years.22/

The AMA concluded its testimony by asserting that voluntary health insurance had made remarkable progress in its brief history and was capable of steadily increasing the percentage of the population covered, that voluntary health insurance allowed freedom of choice to individuals, and that passage of King-Anderson would impose a rigid, inadequate pattern of benefits on the elderly as well as destroy their freedom of choice.

As Congress took no action on medical insurance for the elderly in 1961, the debate over H.R. 4222 continued in 1962. During the 1962 hearings, supporters of federal compulsory insurance presented other statistics showing that, in 1961:

- o 28 percent of 49 million people were not covered by voluntary health insurance because they were poor, elderly, or poor health risks;

- o only 14 percent of couples and 9 percent of non-married persons had any of their total medical care expenses covered by insurance;

- o only 33 percent of the poor, 42 percent of retirees, and 30 percent of the elderly who were unable to work or keep house were covered by insurance; and

- o only 3 percent of elderly couples and 8 percent of non-married elderly had incurred no medical costs in that year.23/

Furthermore, they asserted that the level of coverage for the elderly was less than that provided for younger members of the population; that it did not include many services needed by the elderly such as nursing home and home health care, outpatient diagnostic services, physicians' home and office visits, and drugs; and that even the level of hospital coverage was inadequate. With regard to hospital coverage, they pointed out that Blue Cross plans covered only 31 days of care, with a limited allowance for room and board, and required deductibles and coinsurance. Finally, in response to the AMA's contention that private insurance allowed greater freedom of choice, the proponents of compulsory insurance stated that the choices of the elderly were limited by what they could afford.

Despite the continued opposition of the American Medical Association, support for compulsory insurance financed by a social security tax emerged from other sectors. For example, in 1961, the Income Maintenance Section of the White House Conference on Aging, which had a large number of physicians and health insurance representatives as members, endorsed the social security mechanism as the basic means of financing health care for the aged. In 1962, the American Hospital Association (AHA) withdrew its opposition to social security financing stating that the means of financing was not its concern so long as the federal government did not administer the program. As an alternative, AHA proposed that program operation be placed in the hands of a private organization such as Blue Cross.

The AHA compromise (i.e., social security financing with private organizations administering the program) led to an amendment to the public welfare bill, introduced in the Senate as a means of enacting Medicare legislation. This amendment specified that a national health insurance program for the elderly would:

- o use private organizations to administer the program,

- o establish a special Hospital Insurance trust fund, and

- o assure against federal control over providers of medical services.

Although the Senate amendment was dropped when it became apparent that there was little likelihood of passage, when the 1963 King-Anderson Bill (H.R. 3920 and S. 880) was reintroduced, it retained the three provisions mentioned above.

In fact, from 1963 onward, the proposed bills included the following administrative and financing requirements.

- o Conditions prescribed by the Secretary of HEW for hospital participation could not be stricter than those required for accreditation by the Joint Commission on the Accreditation for Hospitals (JCAH).
- o The Secretary of HEW was required to assist providers, carriers, and other private and public organizations to develop plans to make supplementary private insurance available to the elderly.
- o Providers were authorized to designate organizations of their choice to act as fiscal intermediaries with the federal government.
- o A separate Hospital Insurance trust fund was to be created.
- o The federal government would share costs incurred by state agencies in planning and coordinating the program.
- o Progressive increases would be allowed in the wage base and tax rates to be shared equally by employees and employers.

Other approaches to providing health care insurance to the elderly were subsequently proposed, but no legislation was passed.

King-Anderson (H.R. 1 and S.1) was reintroduced in 1965. This bill called for a benefits package similar to those of earlier bills, allocated a specified portion of the social security tax to a separate hospital insurance trust fund, and authorized private insurance carriers to create programs to make low-cost supplementary health insurance available to the elderly. At this juncture, the AMA "eldercare" alternative was introduced. Eldercare would allow the elderly to purchase private health insurance at premium rates based on income, the federal government would subsidize premiums for the needy elderly, and the program would be administered by the states.

Committee hearings on King-Anderson began in January 1965. From the content of these hearings, it is apparent that the debate had finally moved away from the ideological issues of the earlier years and had focused on technical aspects of administering and financing a Medicare program.

Exhibit II-1

SUMMARY OF ELIGIBILITY AND BENEFITS OF PROPOSED LEGISLATION, 1959-1965

	FORAND BILL (1959)	KING-ANDERSON (1961)	KING-ANDERSON (1963)	KING-ANDERSON (1965)
ELIGIBILITY	OASI beneficiaries age 65 and over except OAA beneficiaries	As in 1959 and Railroad Retirement Beneficiaries	As in 1961 and Non-eligible OASI or RR beneficiaries with 3 quarters OASI coverage	As in 1963
BENEFITS: • Hospital	60 days/year	90 days/benefit period. Deductible $10/day for first 9 days	As in 1961 or 45 days/benefit period. Deductible: None or 180 days/benefit period. Deductible: Avg. cost of 2½ days care	60 days/benefit period. Deductible: Avg. cost of 1 day care
• Nursing Home	120 days/year or 2 days for each unused hospital day, on discharge from hospital	As in 1959 with 180 day maximum	180 days/year	60 days/benefit period
• Home Health	None	240 visits/year	As in 1961	As in 1961
• Surgeons' Fees	Full payment	None	As in 1961	As in 1961
• Laboratory and X-Ray	Full payment inpatient only	As in 1959 and outpatient with $20 deductible/diagnostic study	As in 1959 and outpatient with $20 deductible/30 day period	As in 1963 with deductible set at ½ average cost of 1 day of hospital care
• Drugs	Full payment inpatient only	As in 1959	As in 1959	As in 1959

Shortly after hearings began, a bill was introduced to support a voluntary program, two-thirds of which would be paid from federal general revenues and the remainder financed by monthly premiums. The Mills bill (H.R. 6675) was proposed as a compromise between King-Anderson and the voluntary program. This bill (H.R. 6675) became the vehicle for the final Medicare legislation.

Exhibit II-1 summarizes the provisions of the bills introduced between 1959 and 1965. As is evident from this summary, the proposed legislation differed principally in the extent of the institutional-focused benefits intended to protect the elderly from the high costs associated with care for acute-diseases or acute episodes of chronic conditions.

The proposed taxable earnings base and the social security tax rate provided in bills introduced between 1959 and 1965, excluding the Mills Bill, are displayed in Exhibit II-2.

Exhibit II-2

PROPOSED EARNINGS BASE AND TAX RATES FOR SOCIAL SECURITY FINANCING OF MEDICARE, SELECTED BILLS, 1959-1965

	WAGE BASE	TAX RATES		
		EMPLOYER	EMPLOYEE	SELF-EMPLOYED
Forand (1959)	$4,800	.25%	.25%	.375%
King-Anderson (1961)	5,000	.25%	.25%	.375%
King-Javits (1962)	5,200	.25%	.25%	.375%
King-Anderson (1963)	5,200	.25%	.25%	.375%
King-Anderson (1965)	5,600	.30%	.30%	.45% (1966
	5,600	.38%	.38%	.57% (1967-68,
	5,600	.45%	.45%	.675% (1969

B. THE SOCIAL SECURITY ACT OF 1965: MEDICARE ENACTED

The Mills bill (H.R. 6675) was similar in its basic program (Part A) to King-Anderson, though somewhat less extensive. The most unexpected feature of the bill was the inclusion of a supplementary medical insurance program (Part B) to pay for 80 percent of physicians' services and a variety of other services. Enrollment in this portion of the Medicare

program would be voluntary and subject to an annual deductible for services used ($50). It would also require a monthly premium ($3) paid by the enrollee and matched by an equal sum from general revenues. The Mills Bill also included an improved Kerr-Mills program (Title XIX or Medicaid).

The House Report on H.R. 6675 (March 29, 1965)[24/] stated that:

- o Kerr-Mills did not adequately meet the overall national goal to provide adequate medical care for the elderly because of the failure of some states to implement the program as anticipated;
- o the provision that the program be operated by private organizations was intended to take advantage of the experience of private agencies so that rates of payment would be fair for institutional providers, contributors to the Hospital Insurance trust fund, and other patients; and
- o utilization review committees in hospitals and extended care facilities were required for institutional participation in the Medicare program, even though the bill gave ultimate authority in determining utilization of services to physicians.

The report also expressed the Committee's belief that the program would be totally self-supporting on the basis of contributions from employees and employers and the self-employed.

In the Senate Finance Committee hearings on H.R. 6675, two major issues were debated: a) transfer of payment for certain hospital-based specialists (e.g., radiologists, anesthesiologists, pathologists, and psychiatrists) to the basic program (Part A) rather than including these payments in the supplementary program (Part B) as proposed in the Mills bill; and b) an alternative plan which would change the focus from limited benefits for all the elderly to a program primarily concerned with protection against catastrophic illness. The Senate Finance Committee approved the amendment to pay specialists' services under the basic plan and adopted a modified version of the catastrophic plan by adding an additional 60 days of hospital care, provided patients paid a portion of the costs.

The Conference Committee agreed to retain part of the additional benefits proposed by the Senate Finance Committee

but rejected the transfer of payments for hospital-based specialists to the basic plan. Conference committee estimates,[25] based on actuarial data, were that the costs of benefits and administration of the two portions of the Medicare programs for the first year of operation would be as follows.

	Trust Fund	General Revenue	Total
	($ millions)		
Hospital Insurance	$2210	$290	= $2,500
Supplementary Medical Insurance	$ 600	$600	= $1,200

The Medicare bill was signed into law as P.L. 89-97 on July 30, 1965. The actual provisions of P.L. 89-97 in terms of benefits, and coverage are presented below.

MEDICARE PART A: THE BASIC PROGRAM

- o Inpatient Hospital: 90 days per spell of illness, including tuberculosis and psychiatric hospitals with a lifetime limit of 190 days on inpatient psychiatric hospital services.
- o Skilled Nursing Facility: Up to 100 days per spell of illness after a three-day hospital stay.
- o Outpatient Hospital: Diagnostic services furnished by a hospital during a 20-day period (subject to $20 deductible and 20 percent co-payment).
- o Home Health Services: Up to 100 visits per spell of illness for condition treated in hospital or SNF, after three-day hospital stay or SNF stay to include intermittent nursing care, therapy, or home health aide service.

MEDICARE PART B: THE SUPPLEMENTARY PROGRAM

- o Physician and Other: Physician and surgeons' services furnished in home, hospital, clinic, or elsewhere.
- o Outpatient Hospital: Diagnostic X-Ray, lab and other tests; X-Ray, radium, and isotope therapy.
- o Home Health Service: Up to 100 visits per year to include nursing care and/or therapy and/or home health aide, with no prior hospitalization requirement.

- o Medical Supplies and Equipment: Surgical dressings, splints, casts, and other devices for fractures, rental of durable medical equipment, prosthetic devices to replace internal body organs, artificial limbs, etc.

It is important to note that the final legislation was a political synthesis intended to lessen the opposition of providers and insurers.[26] As enacted, Medicare had the following characteristics.

- o Its benefit structure was closely modeled on that of existing private insurance plans.
- o The mode of reimbursement--cost reimbursement for institutional providers and usual, customary, and reasonable charges for physicians--were developed to ensure the program followed existing patterns.
- o The types of services covered focused on acute care for specific diseases and conditions with little attention given to chronic care and the nonmedical support service needs of the elderly.

There were advantages to using private organizations as fiscal intermediaries. For example, it allowed for almost immediate implementation of the program, and it eliminated the need for a separate government administrative bureaucracy which, if created, could add substantially to program costs.

The disadvantage of using fiscal intermediaries to administer the program was that it reduced the federal government's control of program costs.[27]

In basing reimbursement procedures on "reasonable costs and charges," the Congress also facilitated program implementation. However, this reimbursement methodology, as time has shown, contains no incentives for providers to control costs. It appears that in its desire to ensure access to care, the Congress gave little consideration to the issue of costs in the original legislation, and this issue became the focus of many subsequent attempts to improve the program. Concern with access and quality soon gave way to legislative efforts to control program costs with a concomitant effect on the Medicare program and its beneficiaries.

III. CHANGES IN MEDICARE LEGISLATION

There have been several amendments to Title XVIII of the Social Security Act that created the Medicare Program, since its enactment in 1965. This section will discuss the modifications

and additions that resulted from the 1972 Social Security Amendments (P.L. 92-603), the 1978 Amendments to the End Stage Renal Disease Program (P.L. 95-292), the Omnibus Reconciliation Act of 1980 (P.L. 96-499), the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35), and the Tax Equity and Fiscal Responsibility Act of 1982 (P.L. 97-248). The impact of the 1975 Health Planning Act (P.L. 93-641) and certain changes contained in the Social Security Act of 1983 (P.L. 98-21) will also be addressed.

The provisions of these legislative acts appear to parallel the major health policy concerns of the 1970s and the early 1980s. Certain provisions of the 1972 Amendments and of the 1975 Health Planning Act reflect the intent to prepare the health care system for some form of national health insurance. By necessity this meant attempting to control costs to some extent as well as ensuring access and quality. By 1977, national health insurance was no longer a viable political issue. Instead, the major focus in health policy was on containing hospital costs. In keeping with the current Administration's emphasis on reducing Federal expenditures, the most recent legislation reflects the continued effort to reduce the rate of increase in program costs.

These broad issues affected some of the specific legislative changes in Medicare in the areas of expanding coverage to needy populations other than the elderly; authorizing quality, utilization, and cost control programs; and adjusting certain facets of the program to reduce costs.

A. The SOCIAL SECURITY AMENDMENTS OF 1972 (P.L. 92-603)

The Social Security Amendments of 1972 expanded eligibility for Medicare, established a utilization review program, and authorized development of regulations to control increases in physicians' fees and capital expenditures. These provisions and congressional intent in adopting them are described in the following sections.

1. Expansion in Eligibility for Medicare

The Social Security Amendments of 1972 (P.L. 92-603) extended Medicare benefits to two groups of people under age 65:

- o disabled persons who had been receiving Social Security cash benefits because of disability for not less than 24 consecutive months and disabled Railroad Retirement annuitants; and

- o chronic kidney disease patients who required renal dialysis or kidney transplants, with eligibility beginning four months after a course of renal dialysis had been initiated and ending twelve months after renal transplantation had occurred or dialysis had been terminated.

In including disabled persons under age 65 as Medicare beneficiaries, the Congress sought to provide protection to a group of people who were at risk of incurring high medical care costs. The Senate Report on H.R. 1[28] noted that, like the elderly, disabled persons:

- o are frequently characterized by low income and high medical expenses;
- o use a greater proportion of health services than the population at large (e.g., 7 times more hospital services and 3 times more physician services); and
- o are unable to obtain private health insurance because they are poor health risks.

The amendment to include End Stage Renal Disease patients was proposed on the Senate floor by Senator Vance Hartke. In advocating coverage for this population, Senator Hartke stated that:

- o 8,000 Americans would die as a result of kidney disease in 1972 who could have been saved had they been able to afford renal dialysis or kidney transplants;
- o the indirect costs of mortality--in lost future income--was approximately $1.5 billion annually;
- o there were eight thousand new kidney disease patients in the United States each year; and
- o the annual costs of care for this population was more than $1 billion a year.[29]

The Conference Committee estimated that expansion of eligibility to include the disabled and those deemed disabled because of kidney disease would increase program costs by approximately $1.9 billion.

Exhibit III-1 shows how these costs would be allocated between the two trust funds.

Exhibit III-1

CONFERENCE COMMITTEE ESTIMATES OF COSTS OF COVERAGE FOR THE DISABLED AND CHRONIC KIDNEY DISEASE PATIENTS IN 1974

Eligibility	Hospital Insurance	Supplementary Medical Insurance	Total
	(In Millions)		
Disabled	$1,412	$365	$1,777
Chronic Kidney Disease	75	52	127

Enactment of this provision would provide coverage to approximately 1.7 million disabled beneficiaries and some 18,000 chronic kidney disease patients.

Medicare coverage for these groups became effective on July 1, 1973, subject to the same cost-sharing and other requirements as for other beneficiaries. However, for chronic kidney disease patients, the law specified that reimbursement would be limited to kidney dialysis treatment centers that met requirements to be developed by the Department of Health, Education and Welfare (DHEW, now DHHS).

2. Modification to Skilled Nursing and Home Health Services

Benefits under both Parts A and B of Medicare were primarily designed to respond to the need for acute health care services associated with treatment of specific diseases or acute episodes of chronic conditions. P.L. 92-603 made certain changes to the skilled nursing and home health services components of the program in response to confusion about the types of services covered and the increase in utilization of these benefits. These changes are described in the following sections.

a. Skilled Nursing Services

Implementation of the extended care benefit was delayed until 1967 because of the need to develop guidelines for a new type of benefit and to establish certification criteria for extended

care facilities. Congress had expressly stated that this benefit did not apply to "custodial care;" this and less intensive care in nursing homes was covered by Medicaid, for those persons eligible under the requirements of the Medicaid program. The legislation (P.L. 89-97) specified that the extended care benefit applied to skilled nursing care or rehabilitative services provided on a daily basis and to other services of a kind that would be covered if furnished to a patient in a hospital.

Despite this expressly-stated restriction, there was considerable confusion over what constituted an extended care level of services. Therefore, between 1967 and 1969, the proportion of persons reimbursed for extended care services increased by 11 percent (from 18 to 20 persons per 1,000 enrollees). The total number of persons served also rose from 354,000 to 394,000.

In 1969, HEW issued guidelines which defined more precisely the types of services that would be covered. As a result, both the proportion and total number of beneficiaries served decreased to 12 persons/1,000 enrollees and 239,000 beneficiaries respectively.

In 1972, the term "skilled nursing facility" replaced that of "extended care facility" in the law, and Congress specified that for both Medicare and Medicaid this term applied to institutions providing skilled nursing or rehabilitative services on a daily basis. However, at the same time, Congress relaxed the level of care requirements set forth in the 1969 guidelines, and also waived both beneficiary and provider liability in certain cases where claims had been disallowed for services not medically necessary or not provided at a covered level of care.

In 1973, both the number of beneficiaries served and the amounts reimbursed for SNF services increased slightly, although not to 1969 levels.

Because HEW has imposed regulations and standards to ensure that the skilled nursing benefit complies with the original legislative intent, the portion of Medicare expenditures for nursing home services has always represented a small proportion of total Medicare expenditures (1.3% in 1979).

b. Home Health Agency (HHA) Services

The original Medicare law covered home health care under both the basic program (Part A) and the supplementary program (Part B). The purpose of the hospital insurance home health agency

benefit was to meet the needs of patients discharged from a hospital or extended care facility after a minimum 3-day stay. The services covered under Part B required no prior hospitalization.

Home health care under both programs covered:

- o part-time or intermittent nursing care, and physical, occupational, and speech therapy;
- o medical social services; and
- o part-time or intermittent services from a home health aide.

Coverage of medical supplies (other than drugs and biologicals) and appliances was also authorized by the law.

Between 1967 and 1969, the number of persons using home health agency services under HI increased from 126,00 (7 per 1,000 enrolled) to 190,000 (10 per 1,000 enrolled). Under SMI, persons receiving services increased from 118,000 (7 per 1,000 enrolled) to 145,000 (8 per 1,000 enrolled). Reimbursements under HI rose from $26 million to $50 million between 1967 and 1969, and under SMI from $17 million to $26 million.30/

Guidelines defining more precisely when home health services covered under Medicare would be reimbursed were issued by HEW in 1969. By 1971, usage and reimbursement had dropped significantly--to 167,000 persons served under HI and to 8[illegible],000 under SMI. Payments for home health agency's services fell to $42 million under HI and $13 million under SMI.

P.L. 92-603, the 1972 Social Security Amendments, modified the home health agency benefit as follows.

- o It eliminated the 20 percent copayment for HHA services under SMI.
- o It authorized a limited number of posthospital home health visits for designated medical conditions during which a person would be presumed eligible.
- o It instituted a waiver of liability similar to that for SNF services.

The Conference Committee estimated that elimination of the 20 percent copayment for home health care under SMI would result in an $8 million dollar increase in program costs in the first full year of implementation.31/

In 1975, HCFA data showed that the number of persons receiving reimbursed HHA services under HI had increased to 329,000 (15 per 1,000 enrolled) with reimbursement equal to $136 million. Under SMI persons receiving reimbursed services increased to 161,000 (7 per 1,000 enrolled) with reimbursements equalling $56 million.32/

3. Modifications to Control Program Costs and Utilization

Reimbursement under the HI program was originally based on retrospective payment of "reasonable costs" incurred for provider services. The House Report on H.R. 6675 (P.L. 89-97) shows that the Congress intended that "reasonable costs" meet actual costs of care, however widely they may vary, and that these costs include appropriate payments for depreciation on buildings and equipment, proper interest on capital indebtedness, and a portion of medical education costs.

Unfortunately, the enactment of Medicare coincided with a period of inflation in health care costs. These costs nearly doubled between 1955 and 1965 and they have continued to rise at an annual rate of about 13 percent. As early as 1969, the Secretary of HEW was calling for measures to arrest health care cost inflation.

Under the provisions of P.L. 92-603 (1972 Social Security Amendments), Congress's first response to the problem with rising health care costs and their effect on Medicare included:

- o establishment of Professional Standards Review Organizations (PSROs) to ensure that reimbursed services were medically necessary, provided according to professional standards, and rendered at the appropriate level of institutional care (Section 249F);
- o establishment of limits on reasonable costs (section 223); and
- o establishment of limits on reimbursement for unnecessary capital expenditures (section 1122).

The following sections will summarize briefly these provisions.

a. Establishment of Professional Standards Review Organization

In 1970, legislation (H.R. 17550) was introduced in the House Ways and Means Committee authorizing the Secretary to set limits on reasonable cost determinations, on increases in

physicians' fees, and on reimbursement for capital expenditures for facility or service expansion not approved by state and local planning agencies.

The Senate Finance Committee accepted the House bill with minor modifications and added a Bennett Amendment to establish Professional Standards Review Organizations (PSROs). This Bennett Amendment was an outgrowth of the Medicredit Plan developed by the American Medical Association, which proposed that state medical societies develop peer review organizations as a mechanism for cost control.

In 1971, H.R. 1, which was similar to the 1970 bill, was introduced and passed in the House. In 1972, the Senate Finance Committee passed H.R. 1, with the amendment to establish PSROs. Under the provisions of the Act, PSROs were to ensure that reimbursed services were medically necessary, provided according to professional standards, and rendered at an appropriate level of care if provided in institutional settings. The 1972 Amendments stipulated that the PSROs should consist of susbstantial number of practicing physicians in a local area whose primary responsibility would be to provide comprehensive and ongoing review of services covered under Medicare, Medicaid, and the Maternal and Child Health programs.

The PSROs were authorized to undertake professional inquiries before and/or after the provision of services, to examine pertinent records, and to inspect physical facilities. No Medicare or Medicaid claim was to be paid if disapproved by a PSRO after a review had been conducted.

The PSRO program was implemented in 1974, and by 1980 there were 47 fully designated and 140 conditionally designated PSROs in operation. The major focus of PSRO review was on inpatient services, and the 1978 evaluation of the services of the program indicated that the PSROs had contributed to the reduction in lengths-of-stay (LOS).

b. Limits on "Reasonable Costs"

Section 223 of P.L. 92-603 authorized the Secretary of HEW to establish methods for determining "reasonable costs" of health services that take into account "various types or classes of institutions, agencies, and services." The Senate Finance Committee report, in its discussions of this amendment, stated "that costs can and do vary from one institution to another as a result of differences in size, in the nature and scope of services provided, the type of patient treated, the location of the institution, and various other factors affecting the efficient delivery of services."[33]/

In compliance with the law, an Interim Schedule of Limits on Hospital Inpatient General Routine Services Costs was developed by HEW and published in the Federal Register on June 6, 1974. Revisions to the Interim Schedule were likewise published on April 17, 1975. In comments received during the 30 day period required by law, objections were voiced because of methods used in developing the classification system; the adverse effects of the regulations on teaching hospitals; the absence of consideration given to patient mix, scope of service, lower average length-of-stay, or higher capital and interest costs among newer facilities; and the methods used to group SMSAs (Standard Metropolitan Statistical Areas) and non SMSAs.34/

The Secretary responded to these objections at the time the final regulations, which were to take effect on July 1, 1975, were promulgated. Subsequent revisions to Section 223 were issued annually although opposition continued. Those objecting to the regulations viewed them as a method of imposing mandatory cost controls on approximately one-fifth of the nation's hospitals and a means of meeting budgetary goals rather than screening for inefficient hospitals.

c. Limits on Reimbursement for Capital Expenditures

When Medicare was created, the nation faced a shortage of hospital and nursing home beds. Therefore, to promote access to care by making facilities available, the Congress reimbursed hospitals and extended care facilities (ECFs) for new equipment and construction. The Congress also stipulated that for-profit ECFs were to be paid additional sums for return-on-equity to offset the tax exempt status of nonprofit ECFs. This return-on-equity was extended by regulation to other cost-reimbursed providers, including hospitals.

Section 1122 of the 1972 Amendments gave the states the option of designating a state agency to review and approve proposed health facility capital investments to determine eligibility for Medicare and Medicaid reimbursements for depreciation, interest, return-on-equity capital, and related costs. The purpose of this provision, as stated in the law, was to assure that federal funds appropriated under Title V, XVIII and XIX would not be used to support unnecessary capital expenditures. Under the law, the Secretary was authorized to withhold or reduce reimbursement to those providers whose capital expenditures were inconsistent with state or local health facility plans. However, if it was determined that disallowance of capital expenditures would discourage the operation or expansion of organizations that had demonstrated the capability of providing comprehensive health services, the Secretary was authorized to approve such expenses.

In reality, disapproval by state agencies did not mean that capital expenditures were not reimbursed.

d. Limits on Reimbursements to Physicians

The Supplementary Medical Insurance Program is a voluntary program financed by monthly premiums of enrollees and contributions from general revenues. Beneficiaries share in the costs of services provided by paying a deductible and 20 percent of reasonable charges.

The Secretary of HHS enters into contracts with carriers whose principal functions are to determine whether the charges submitted are allowable (reasonable) and to make payment. The reasonable charge for a specific service, in the absence of unusual medical complications, or certain other circumstances, is the lowest of the physician's "customary charge" for the service, the "prevailing charge" for that service in the area, or the physician's actual charge. Further, the "reasonable charge" for a service may not exceed the charge applicable for a comparable service under comparable circumstances to the policyholders or subscribers of the "carriers" which administer the Part B program.

Limits on Increase in Physicians' Fees: The 1972 Amendments authorized the Secretary of HEW to develop an economic index for use in determining the amount of increase in prevailing charges that would be recognized for reimbursement purposes. The Congress included this amendment in response to inflation in fees for physician services that had occurred since the passage of Medicare. (See Exhibit III-2)

Exhibit III-2

TOTAL HEALTH CARE EXPENDITURES
(in billions)

	FY 1966	FY 1968	INCREASE
Physician Services			
For persons 65 and over	$1.66	$2.34	41%
For persons under 65	7.21	8.39	16%
Hospitals			
For persons 65 and over	3.29	5.40	64%
For persons under 65	10.95	14.00	28%

Source: Social Security Administration data on annual expenditures. Cited in Rethinking Medicare to Meet Future Needs. Issues Book. Washington, D.C., The Government Research Corporation, 1982, p.30.

The Congress instructed HEW to create an index that would measure the increase in physician practice costs (e.g., rental of office space, wages of non-physician labor) and permit an annual increase in income derived from Medicare payments that would be commensurate with the general rise in earnings in the United States. The intent was to limit increases in prevailing charges recognized by the Medicare program "to rates that economic data indicate would be fair to all concerned and follow rather than lead inflationary trends."35/

Payments for Services of Teaching Physicians: Section 227 of P.L. 92-603 provided that teaching physicians be reimbursed on a cost basis (under Part A rather than Part B) for services to patients, with certain exceptions.

The original legislation (P.L. 89-97) specified that all hospital services of physicians, except for residents and interns, would be reimbursed under Part B of the Medicare program. To implement this policy, the Bureau of Health Insurance (BHI) issued various rulings from 1967-1972 which provided guidelines for teaching physicians in submitting bills for professional services rendered to Medicare patients. The 1967 rulings specified that, for the teaching physician to bill Medicare patients under Part B, the physician must be the patient's attending physician and provide personal care or personal and identifiable direction to residents and interns participating in care. The 1969 guidelines further clarified these regulations, stating that physician services other than direct patient care were to be reimbursed as provider (hospital) costs under the basic plan (Part A). In 1970, staff of the Senate Finance Committee prepared an analysis of payments to medical staffs of teaching hospitals. This analysis became the basis for the Section 227 limits on payments to teaching physicians included in the 1972 Amendments.

According to P.L. 92-603, services of a teaching physician would be reimbursed on a cost basis (under Part A) unless the patient was the physician's bona fide patient or unless the hospital had routinely charged all patients and collected (in a majority of cases) on a fee-for-service basis since January 1, 1965.

B. THE HEALTH PLANNING ACT OF 1975 (P.L. 93-641)

In 1974, Congress passed P.L. 93-641 (S. 2994), the National Health Planning and Resources Development Act, which was signed into law in January 1975. The Act established area-wide health planning agencies whose functions were to increase access,

quality, and acceptability of services; restrain increases in costs; and prevent unnecessary duplication of services. These agencies were to develop long-and short-range plans; to approve or disapprove use of federal funds for grants, loans, contracts, or loan guarantees; and to submit their recommendations to State Planning Agencies.

However, the provisions of P.L. 93-641 did not apply to facilities subject to review under Section 1122 of the Social Security Act of 1972 nor to those subject to Certificate of Need (CON) programs. Review of these facilities remained the responsibility of the State Planning Agencies. The CON program applied to new institutional health services proposed to be offered or developed within a state, and its effect was to require prior approval of new institutional health facilities or services. The State Planning Agency's decision was to be made on the basis of a set of criteria which included , but was not restricted, to a determination of "need."[36]

The major purpose of P.L. 93-641, as is evident from the Congressional Record,[37] was to improve health planning by correcting the deficiencies of the three planning functions authorized by the Public Health Services Act--Regional Medical Planning, Comprehensive Health Planning, and Hill Burton. As Senator Edward Kennedy stated in introducing the bill, this improvement in health planning was a necessary mechanism to ensure that national health insurance, which he believed would be implemented, could meet its goal of providing access to health care in underserved areas.

C. 1978 AMENDMENTS TO THE ESRD PROGRAM (P.L. 97-292)

Congress had underestimated the costs to the Medicare program of providing coverage to ESRD patients. Conference committee estimates of program costs for 1974 were $127 million; actual costs for that year were $193 million. In 1977, Congress acknowledged that despite the program's success in meeting patients' needs, there were a number of serious problems to be addressed. Among these were the impact of the Medicare reimbursed services on the care patterns of chronic kidney disease patients and the effect of these patterns of care on program costs.

In 1972, when the amendment was passed to cover renal dialysis in approved facilities, 40 percent of chronic kidney disease patients were using home dialysis. By 1975, this percentage had decreased to 25 percent, and by 1977 less than 10 percent were using home dialysis. In addition only 10 percent of patients were electing to undergo kidney transplants (down from 16 percent in 1975).[38]

In the 1977 committee report accompanying the proposed legislation, it was pointed out that the costs of home dialysis ranged from $8,000 to $12,000 per patient per year whereas dialysis at the renal dialysis centers approved for reimbursement under Medicare ranged from $15,000 to $30,000 per patient per year. The difference in costs was attributed to costs incurred for capital expenditures and maintenance at the dialysis facilities.39/

The objectives of the legislation proposed by Congress in 1977 were to:

- o provide incentives for lower cost, medically appropriate self-dialysis;
- o eliminate program disincentives to use of kidney transplantation;
- o provide for incentive reimbursement methods;
- o develop long-range national objectives with regard to the most effective use of resources for treating ESRD; and
- o provide for studies of alternative ways to improve the program.

To meet these objectives the provisions of the legislation, enacted in 1978 as P.L. 95-292, included the following:

- o waiver of the three-month waiting period for people entering self-care training programs prior to the end of the third month after the month in which renal dialysis begins,
- o coverage of disposable supplies and of periodic supportive services such as dialysis equipment maintenance,
- o coverage of self-care dialysis units in renal dialysis facilities,
- o full reimbursement to facilities for dialysis equipment purchased for exclusive home dialysis use,
- o immediate coverage of hospitalization for transplant patients,
- o extension of coverage for transplant patients from 12 to 36 months,

- o immediate resumption of hospital coverage if the kidney transplant fails, and
- o coverage of donor expenses for hospital services and aftercare.

P.L. 95-292 also authorized the development and use of an incentive reimbursement system with respect to payment for dialysis services provided to patients treated in facility settings.

D. THE OMNIBUS RECONCILIATION ACT OF 1980 (P.L. 96-499)

Public Law 95-142, the Medicare/Medicaid Anti-Fraud and Abuse Amendments of 1977, required HEW to conduct a review of home health and other in-home services provided under Titles XVIII, XIX, and XX of the Social Security Act and make recommendations for change. In 1979, HEW submitted its report to the Congress.

Several problems were identified including: lack of coordination among the multiple programs; variations in eligibility, coverage, and benefits across states; reimbursement policies which discouraged use of home health benefits; inconsistencies in claims administration; inadequate supply and distribution of home health services across the country; and inadequate quality assurance for home health care.

Among the recommendations for changes submitted in the report were:

- o elimination of the 3-day prior institutionalization requirement under Part A;
- o inclusion of occupational therapy as one of the primary skilled service needs to establish eligibility for home health services;
- o reimbursement for physician's assistants and nurse practitioners, under the general supervision of a physician, to review and approve home health care plans; and
- o conduct of a demonstration to develop utilization review for home health agencies.

In 1980, a number of amendments to expand the home health program were signed into law as part of the Omnibus Reconciliation Act of 1980 (P.L. 96-499). Effective on July 1, 1981, the provisions included:

- o elimination of the 3-day prior hospitalization requirement under Part A;
- o elimination of the requirement that covered services be for the same condition for which the beneficiary was treated in the hospital;
- o inclusion of occupational therapy as a basis for initial entitlement to services;
- o removal of statutory limitations on the number of home health visits allowed under Parts A and B; and
- o removal of the requirements for beneficiary payment of the $60 deductible per year under Part B.

The Senate Special Committee on Aging, in its report on 1980 developments in aging, noted that the change in the hospital requirement under Part A would grant access to home health services to approximately 1.1 million Medicare beneficiaries not covered under Part B. The report also stated that this change "is expected to correct the potential for physicians to place a Medicare beneficiary in an acute-care hospital in order to qualify the beneficiary for the home health care benefit, thereby increasing the overall Medicare costs for treatment of illness."[40]

With regard to the removal of the limits on the number of home health visits (100 visits/spell of illness under Part A and 100 visits/calendar year under Part B), the Senate Special Committee indicated that this change was advocated to encourage more reliance on home health care as an alternative to other, more expensive forms of health care.

The Special Committee report also stated that the utilization of Medicare home health services, intended to meet the needs of thousands of homebound elderly suffering from illness and disability, had risen dramatically. Citing HCFA data, the report showed that total Medicare reimbursement for home health services increased from $217 million in 1975 to $912 million in 1981, with almost 16 million home health visits made to the aged and disabled in 1977. The report also noted that the number of Medicare-certified home health agencies had increased from 2,250 in 1975 to about 3,000 in 1980.[41]

Reasons given for the increase included the growing proportion of older persons in the population, heightened awareness of the desirability of home health care as the appropriate mode of care for patients, and the increase in the number of Medicare-certified home health agencies.

Home health care within the Medicare program has received little attention to date because home health care expenditures represent a small portion of total Medicare expenditures (less than 2 percent). Despite this, the Senate Committee report recommended a number of amendments focusing on abuses within the program, which were enacted in the 1980 Omnibus Reconciliation Act. These included authorizing the Secretary of HEW to establish bonding and escrow requirements for HHA's having little or no funds other than those received for Medicare payments, requiring the Secretary of HEW to establish regional intermediaries for home health agencies, and specifying the nature of cost caps to be set by the Secretary on home health agency per visit costs.

E. THE OMNIBUS BUDGET RECONCILIATION ACT OF 1981[42/]

Recent legislation related to the End Stage Renal Disease Program has as its objective reduction in program costs. Under the provisions of the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35), Medicare will become the secondary payor for the first 12 months after an individual has been determined eligible for Medicare ESRD benefits, but only to the extent that the patient has private insurance coverage. Beginning with the thirteenth month following the month in which entitlement to ESRD benefits is established, Medicare will become the primary payor. This change does not apply to persons entitled to program coverage on the basis of age or disability.

P.L. 97-35 also required the Secretary to prescribe in regulations a method (or methods) for prospectively determining the amounts of payments to be made for renal dialysis services. Separate composite weighted formulas were to be calculated for hospital-based and for other renal dialysis facilities, with both formulas taking into account the proportions of patients dialyzing in a facility and those dialyzing at home and the relative costs of providing services in such settings. The legislation authorized the Secretary to use a different prospective reimbursment method or methods, if it was determined after detailed analysis, that such a method (or methods) would both more effectively encourage the efficient delivery of services and provide greater incentives for use of home dialysis.

P.L. 97-35 also contained a number of other amendments to the Medicare program. For example, reimbursement changes reduced the inpatient hospital routine nursing cost differential from 8.5 percent to 5 percent; reduced the reimbursement limits established for inpatient general routine hospital operating costs and home health agency costs; required establishment of incentive reimbursement rates for renal dialysis services; adjusted payments with respect to inappropriate hospital services; and provided payments to promote the closing and conversion of underutilized facilities.

P.L. 97-35 included a number of changes in cost-sharing requirements for Medicare beneficiaries. It increased the Part B deductible to $75, eliminated the carryover provision in determining whether an individual has met the Part B deductible, and provided for making the calculation of the Part A deductible on a more current basis, thereby increasing beneficiary liability. The law also deleted occupational therapy as an initial qualifying criterion for home health benefits.

Finally, P.L. 97-35 made modifications to, but did not repeal, the PSRO program. Rather, it required the Secretary to assess the relative performance of each PSRO and authorized the Secretary to terminate up to 30 percent of current PSROs by the end of FY 82. The legislation did not include deletion of the utilization review requirements of the law.43/

F. THE TAX EQUITY AND FISCAL RESPONSIBILITY ACT OF 1982 (P.L. 97-248)

The Tax Equity and Fiscal Responsibility Act of 1982 (P.L. 97-248) made several amendments to Medicare. For example, this act authorized the Secretary of HHS "to eliminate the 3-day prior hospital stay requirement for skilled nursing facility coverage at such time as, through reimbursement changes or other adjustments, (he) the Secretary determines that such action will not lead to an increase in program costs and that it will not alter the acute nature of the benefits."44/

This Act also added a new benefit category to the Medicare hospital insurance program, that of hospice services. Hospice care, which focuses on palliative rather than curative care for the terminally ill, can be provided in a number of different settings. Traditionally, Medicare has not covered hospice care, although certain services may be reimbursed when provided by hospitals, physicians, or other covered care givers.

Under the provisions of P.L. 97-248,45/ coverage of hospice care is authorized for a terminally ill beneficiary with a life expectancy of six months or less. A beneficiary may elect to receive hospice care in lieu of most other benefits except those of the attending physician (if not employed by the hospice). The hospice benefit period would consist of two periods of 90 days and one period of 30 days. Benefits provided would include nursing care, therapies, medical social services, homemaker-home health aide services, physicians' services, short-term inpatient care, and outpatient drugs for pain relief. Hospices would be established as a separate provider category under Medicare. Reimbursement would be based on reasonable costs subject to a limit equal to 40 percent of the average Medicare per capita expenditure during the last six months of life for beneficiaries dying of cancer.

According to the provisions of the law, the hospice program must have an interdisciplinary group of personnel which includes at least one physician, one registered professional nurse, and one social worker employed by the hospice, plus at least one pastoral or other counselor. Other requirements that a hospice must meet include:

- o maintenance of central clinical records on all patients;
- o use of volunteers in the provision of services in accordance with standards set by the Secretary to assure a continuing level of effort to use volunteers;
- o licensure in accordance with any applicable state or local law;
- o agreement not to discontinue care to a patient because of the inability of the patient to pay for such care; and
- o meeting other health and safety standards set by the Secretary.

The hospice must be certified to participate in Medicare as a separate provider category in accordance with requirements established by the Secretary. However, the Secretary is authorized to eliminate duplication where any hospice provider requirements are the same as requirements already met by the provider under other agreements with the Secretary, such as a home health agency, skilled nursing facility, or hospital certified to participate in Medicare.

There is no reimbursement under Part B for an individual's attending physician who is employed by the hospice; counseling would be included as a core service; and noncore services could be provided, under arrangements, by others.

A 5 percent copayment on respite care services and a 5 percent copayment on drugs covered are required under the provision.

The Law authorized coverage for hospice services for the period November 1, 1983 to October 1, 1986, with the Secretary required to issue implementing regulations by September 1, 1983.

CBO estimated that this provision will increase Medicare expenditures by $1 million in Fiscal Year 1983 and $1 million in Fiscal Year 1984. It was estimated that, during Fiscal Year 1985, $16 million would be saved. This estimate assumes an average per capita saving of $235.

Public Law 97-248 added Health Maintenance Organizations (HMOs) as a source of services. The HMOs would be reimbursed at 95 percent of the adjusted average per capita cost. To be eligible for reimbursement, HMOs have to meet existing Federal and State guidelines.

Other changes enacted as part of Public Law 97-248 included repeal of the existing PSRO program and establishment of the Utilization and Quality Control Peer Review Organization (UQCPRO) program. The new PROs were defined as either an entity composed of a substantial number of licensed physicians practicing in an area or an entity which has sufficient physicians available to conduct adequate peer review of medical services. Under the provisions of this act, the review may include professional activities of physicians, other practitioners, and institutional and noninstitutional providers to determine necessity and reasonableness of care, quality of care, and appropriateness of setting. The determinations of the PROs would ordinarily be binding with regard to payment of benefits. CBO estimates were that the new program would result in savings to Medicare of $15 and $20 million for fiscal years 1984 and 1985 respectively.46/

Despite the difficulties of using regulations as a means of controlling costs, this legislation also authorized the Secretary to set limits and ceilings on certain portions of the program expenditures for inpatient services, or rescinded previous provisions that allowed providers to be reimbursed at higher levels. For example, the 8.5 percent nursing salary differential, established by regulation in 1969 to cover the more intensive nursing care presumed to be required by elderly patients, was reduced to 5 percent by law in 1981 and rescinded in 1982.

In addition, the provisions of the Tax Equity and Fiscal Responsibility Act (TEFRA) modified existing 223 limits by extending them to ancillary services and special care unit operating costs. CBO estimated that savings to the Medicare program resulting from TEFRA's expansion of section 223 limits would be $25 million in 1983, $510 million in 1984, $1,110 million in 1985, and $1,490 million in 1986.

G. THE SOCIAL SECURITY AMENDMENTS OF 1983 (P.L. 98-21)

Other changes to the Medicare legislation were contained in certain provisions of the Social Security Amendments of 1983. The most important of these provisions, and the one expected to have the most far-reaching effect on future costs of the program, was that which altered the form of reimbursement to inpatient hospitals.

TEFRA (P.L. 97-248) had included a provision requiring the Secretary of Health and Human Services (HHS) to develop a legislative proposal for Medicare payment to hospitals, skilled nursing facilities, and to the extent feasible, other providers, on a prospective basis. The Secretary's Report on Hospital Prospective Payment to Medicare was submitted to Congress in December 1982.

P.L. 98-21, enacted on July 20, 1983, authorized prospective reimbursement to inpatient hospitals to be implemented as follows.[47]

Beginning with hospital accounting years starting on or after October 1, 1983, hospitals (except for psychiatric, rehabilitative, long-term care and children's hospitals) will no longer be reimbursed on a reasonable cost basis. Hospitals will be paid a prospectively determined amount per discharge based upon diagnosis related groups (DRGs).

Separate payment rates will apply to urban and rural areas. For the first three years, separate rates will be determined for each of the nine census regions, and there will be a blend of national and regional DRG rates in each hospital's cost base. The cost of capital and the direct cost of medical education will continue to be reimbursed on the basis of reasonable costs. The adjustment under the law, prior to amendment for indirect costs of medical education, will be doubled. The rate of return on equity for proprietary hospitals will be reduced by one-third. The Secretary will provide additional payments for outlier cases.

Payment for non-physician service provided to hospital inpatients must be made under Part A except that the Secretary may waive these restrictions during the transition period for hospitals that have billed extensively under SMI. Medicare payments must be made under a state system if the system meets certain statutory requirements. Upon request of the state of New York and/or Massachusetts, or the parties to their demonstration agreements, the Secretary of Health and Human Services would be required to modify the terms of their demonstration agreement so the States would not be required to maintain a rate of increase in their Medicare hospital costs below the national rate of increase in such costs.44/

The decision to change from a retrospective to prospective reimbursement system for inpatient services was not lightly taken. Since 1972, the Department of Health and Human Services, in response to Congressional interest in prospective payment, has funded a number of demonstration projects in this area and evaluated their results. From their experience with these demonstrations, the Health Care Financing Administration (HCFA) has been able to make some generalizations, including the following:

- o prospectivity itself seems to be effective in holding down rates of increase in hospital costs;
- o all prospective systems seem to require a consideration of hospital case-mix;
- o small, rural hospitals frequently require exceptions unless case-mix is explicitly recognized in the payment process; and
- o successful systems require a firm legal basis, strict enforcement, and a lack of escape mechanisms.45/

Other modifications contained in this legislation, which will affect the status of the Medicare Hospital Insurance Trust Fund, include:

- o mandating social security coverage for employees of non-profit organizations;
- o disallowing withdrawal from Social Security by state and local government or entities;
- o increasing the hospital insurance tax rate for the self-employed to equal the combined employer-employee tax rate; and

- o eliminating Medicare payment for a new capital expenditure project unless the state has established a Section 1122 approval process and approved the expenditures under this mechanism.

As the preceding review of legislation shows, Congressional focus has shifted from access to care to reduction in program expenditures. In the following section, the changes in the Medicare program resulting from the legislation and from regulations developed by HCFA will be described.

IV. CHANGES IN THE MEDICARE PROGRAM

As would be expected, the legislative changes to the Medicare program had a significant impact on the program and its beneficiaries. A brief discussion of the components of the program and these impacts follows.

A. ELIGIBILITY

Currently, persons age 65 and over who are eligible for social security or railroad retirement benefits, disabled persons under 65 who have been entitled to disability benefits for at least 24 months, covered workers and their dependents with chronic kidney disease requiring dialysis or kidney transplants, and federal employees who are employed as of January 1, 1983 are automatically entitled to hospital insurance (HI) coverage without cost. Persons age 65 and over who are not entitled to social security or railroad retirement benefits may voluntarily enroll in the hospital program and must pay a monthly premium.

Persons automatically entitled to benefits under the hospital insurance program may participate voluntarily in the Supplementary Medical Insurance (SMI) program. Most other persons age 65 and over may participate in SMI even though they have not previously paid into Social Security. However, only those age 65 and over may enroll in the SMI program without being eligible for the hospital insurance program; this option is not available to disabled persons under age 65 who are not eligible for hospital insurance. Those who choose to participate in SMI pay a monthly premium and are subject to deductibles and copayments for services received.

In fiscal year 1983, approximately 26.8 million people age 65 and over and 3.1 million disabled persons had protection under Part A of the Medicare program. In the same year, 26.0 million elderly persons and 2.7 million disabled were enrolled in Part B.[49]

From 1967 to 1981, the number of aged enrollees in the Hospital Insurance program increased from 19.49 million to 25.9 million, and the aged enrolled in Supplementary Medical Insurance rose from 17.89 million to 25.4 million.[50]

From 1974 to 1981, the number of disabled Medicare enrollees in the HI program under age 65 rose from 1.93 to 3.0 million, and those disabled enrolled in the SMI program increased from 1.74 to 2.7 million.

Enrollment of End Stage Renal Disease patients under age 65 who were "deemed disabled" for purposes of coverage increased from 6.4 to 18.3 thousand in the HI program between 1973 and 1978, and enrollment in the SMI program rose from 6.3 to 17.2 thousand.

Exhibit IV-1 summarizes data on Medicare enrollees by type of coverage, age and type of enrollees for the period between July 1, 1966 through 1978. Published data, broken out into the categories presented in Exhibit IV-1, are not currently available for later years.

B. COVERAGE

As was noted earlier, there have been few changes to the coverage offered under Medicare. The only category added to the hospital insurance package has been that of hospice services.

Exhibit IV-2 summarizes the changes in coverage that have occurred since enactment of Medicare.

C. REIMBURSEMENT AND UTILIZATION

Expansion to include the disabled and those deemed disabled had three major effects on the Medicare program. It increased total costs beyond that projected by the Conference Committee, particularly for End Stage Renal Disease patients served; it shifted the patterns of services somewhat among the three groups of users; and the per capita reimbursement for each group differed significantly.

Exhibit IV-3 provides information on total Medicare reimbursements for all services from 1966 to 1981. Exhibit IV-4 shows benefit payments by type of services and beneficiaries for the Fiscal Year 1982.

Exhibit IV-1

NUMBER OF AGED MEDICARE ENROLLEES BY TYPE OF COVERAGE AND AGE, JULY 1, 1966-1978

(Thousands)

	HOSPITAL INSURANCE			SUPPLEMENTARY MEDICAL INSURANCE		
		AGE			AGE	
YEAR	TOTAL	65-74	75+	TOTAL	65-74	75+
1966	19,082	11,990	7,092	17,736	11,186	6,550
1967	19,494	12,116	7,378	17,893	11,114	6,779
1968	17,770	12,158	7,611	18,805	11,561	7,244
1969	20,014	12,195	7,819	19,195	11,705	7,490
1970	20,361	12,316	8,045	19,584	11,873	7,711
1971	20,742	12,462	8,280	19,975	12,050	7,924
1972	21,115	12,641	8,474	20,351	12,248	8,104
1973	21,571	12,911	8,660	20,921	12,586	8,334
1974	21,996	13,182	8,814	21,422	12,925	8,496
1975	22,472	13,426	9,046	21,945	13,215	8,730
1976	22,920	13,691	9,229	22,446	13,529	8,917
1977	23,475	13,986	9,488	22,991	13,830	9,161
1978	23,984	14,259	9,725	23,531	14,119	9,412
ACRG (%)	1.9	1.5	2.7	2.4	2.0	3.1

Exhibit IV-1

(continued)

YEAR	ALL DISABLED									
	HOSPITAL INSURANCE					SUPPLEMENTARY MEDICAL INSURANCE				
	TOTAL	AGE				TOTAL	AGE			
		35	35-44	45-54	55-64		35	35-44	45-54	55-64
1973	1,730.5	192.4	218.0	438.8	881.4	1,569.9	174.9	194.7	390.2	810.0
1974	1,928.1	220.2	237.6	481.4	988.9	1,745.0	194.0	211.0	428.0	912.0
1975	2,168 4	254.3	261.7	530.0	1,122.4	1,959.2	225.8	232.3	469.2	1,032.0
1976	2,392.2	288.3	285.8	574.0	1,244.1	2,168.5	258.3	255.7	510.2	1,144.3
1977	2,619.4	322.6	310.6	617.3	1,368.9	2,372.6	290.0	278.8	548.7	1,255.2
1978	2,793.2	344.8	335.4	646.5	1,466.5	2,543.2	311.9	303.1	579.2	1,349.0
ACRG(%)	9.6	11.7	8.6	7.8	10.2	9.6	11.6	8.9	7.9	10.2
DISABLED - END-STAGE RENAL DISEASE ONLY										
1973	6.4	2.2	1.4	1.7	1.1	6.3	2.1	1.3	1.7	1.1
1974	10.1	3.4	2.1	2.7	1.9	9.6	3.2	2.0	2.6	1.8
1975	12.7	4.3	2.4	3.3	2.6	12.1	4.1	2.3	3.2	2.6
1976	14.7	4.8	2.8	3.9	3.3	14.0	4.5	2.6	3.7	3.2
1977	16.5	5.1	3.0	4.4	3.9	15.5	4.8	2.8	4.2	3.7
1978	18.3	5.6	3.3	4.8	4.6	17.2	5.2	3.1	4.5	4.3
ACRG(%)	21.0	18.7	17.1	20.8	28.6	20.4	18.1	17.4	19.5	27.3

ACRG = Annual compound rate of growth.

SOURCE: Health Care Financing Administration, Kathryn Barrett, "Medicare: Persons Enrolled in the Health Insurance Program, 1977-1978." HCFA Program Statistics Report, in preparation.

Cited in the Medicare and Medicaid Data Book, 1981, pp. 16-17.

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Exhibit IV-2

BENEFITS AND COVERAGE UNDER HI AND SMI: ORIGINAL BENEFITS AND SELECTED MODIFICATIONS

ORIGINAL HOSPITAL INSURANCE BENEFITS (PART A)		
INPATIENT HOSPITAL	SKILLED NURSING FACILITY	HOME HEALTH AGENCY
• Up to 90 days/benefit period for room and board in semiprivate accommodations, nursing services, except private duty nursing, drugs and biologicals, and other services ordinarily furnished by a hospital to its patients • Full payment of first 60 days less a deductible equal to the average cost of one day of care per benefit period • Payment for next 30 days shared by beneficiary in the amount of one-fourth of the deductible for each day of hospital care • Covers tuberculosis and psychiatric hospitals with a lifetime limit of 190 days of psychiatric inpatient care	• Up to 100 days/benefit period for nursing care; room and board, physical, occupational, or speech therapy, drugs, and biologicals; and medical services of an intern or resident-in-training • Benefits payable only after discharge from a hospital after a stay of 3 or more consecutive days • Full payment for the first 20 days • Payment for remaining 80 days shared by beneficiary in the amount equal to one-eighth of the inpatient hospital deductible for each remaining day	• Up to 100 visits per spell of illness for part-time or intermittent nursing care, physical, occupational, or speech therapy, part-time or intermittent services of a home health aide, medical supplies other than drugs and biologicals, and use of medical appliances • Benefits payable only after discharge from a hospital or SNF after a stay of 3 or more consecutive days • No deductible and no coinsurance
SELECTED MODIFICATIONS		
• In 1968, a 60-day nonrenewable lifetime reserve was added to be used at the beneficiary's option when 90 days in a benefit period were exhausted, subject to copayment of one-half the inpatient deductible for each day of care • After 1972, dentists were permitted to determine need for hospitalization for severe dental impairments, and services of podiatric residents and interns were covered • After 1978, kidney donor inpatient services were covered	• After 1982, the 3-day prior hospitalization requirement was eliminated	• After 1980, the 3-day prior institutionalization requirement was eliminated

NOTES • For the period November 1, 1983 to October 1, 1986, Part A of Medicare will pay, on a reasonable cost basis or other basis, for hospice care. The description of this new benefit is found in Section III-F of this report

• Outpatient hospital services originally covered under Part A were transferred to Part B in 1968

Exhibit IV-2

BENEFITS AND COVERAGE UNDER HI AND SMI: ORIGINAL BENEFITS AND SELECTED MODIFICATIONS

(continued)

ORIGINAL SUPPLEMENTARY MEDICAL INSURANCE BENEFITS (PART B)*			
PHYSICIAN AND OTHER MEDICAL SERVICES	OUTPATIENT HOSPITAL	HOME HEALTH	MEDICAL SUPPLIES AND EQUIPMENT
• Physician and surgeon services furnished in hospital, home, clinic, office or elsewhere -- not including routine physical exam • Diagnostic tests, X-rays, radium and radioactive isotope therapy	• Services incident to physicians' services rendered to outpatients and outpatient speech and physical therapy	• Up to 100 visits per year for nursing care and/or therapy, and/or home health aide services • No prior hospitalization was required	• Surgical dressings • Splints, casts, and other devices for fractures • Rental of durable medical equipment • Prosthetic devices to replace internal body organs, artificial limbs, etc
MODIFICATIONS			
• After 1972, certain chiropractic services for specified conditions were covered as were office-based physical therapist services, with a $100/year limit • After 1980, the limit on office-based physical therapy services was raised to $500/year	• Outpatient services originally covered under Part A were transferred to Part B after 1966	• 20 percent copayment was eliminated after 1972 • After 1980, limit on number of visits was removed and the Part B deductible no longer applied to these services	• After 1978, disposable supplies for ESRD home dialysis and supportive services such as maintenance of dialysis equipment in home were covered

*These benefits are subject to an annual deductible and 20 percent copayment by beneficiaries. However, to preclude a beneficiary's having to meet a deductible twice in a short period of time, a carry-over provision was applied. Covered expenses incurred in the last quarter of a year and applied to the deductible in that year were also credited toward the deductible for the following year. After 1981, this carry-over provisions was no longer applicable.

D. FINANCING/COST-SHARING

The rate of increase in hospital costs has continued to surpass that of the taxable earnings wage base since the Medicare program was enacted. Most recent estimates are that between 1982 and 1995 hospital costs attributable to Medicare

Exhibit IV-3

MEDICARE BENEFIT PAYMENTS, CALENDAR YEARS 1966-1981
(In Billions)

YEAR	MEDICARE
1966	$ 1.0
1967	4.6
1968	5.7
1969	6.6
1970	7.1
1971	7.9
1972	8.6
1973	9.6
1974	12.4
1975	15.6
1976	18.4
1977	21.8
1978	24.9
1979	29.3
1980	35.7
1981	43.5
1982	49.1

NOTE: Beginning July 1, 1973, Medicare payments include the disabled and persons with end-stage renal disease.

Source: Health Care Financing Administration, Bureau of Data Management and Strategy. Executive Data Compendium, May 1983, Table III-1, Table IV-1, and Table IV-3.

will increase by 13.2 percent annually while the taxable earnings base will rise at a rate of 6.8 percent per year.

1. Increases in Tax Rate and Wage Base for Hospital Insurance Financing

Congress has made several adjustments to the tax rate and earnings base to correct for inflation in hospital costs. As a result the tax rates and earnings base have increased substantially, as can be seen in Exhibit IV-5.

Exhibit IV-5

HOSPITAL INSURANCE FINANCING: SELECTED TAX TABLE AND WAGE BASE INCREASES (1966-1983)

	Wage Base	%/Contribution Rate (Employer/Employee Each) and Self-Employed
1966	$ 6,600	.35
1970	7,800	.60
1974	13,200	.90
1978	17,700	1.00
1979	22,900	1.05
1981	29,700	1.30
1982	32,400	1.30
1983	35,700	1.30

Source: U.S. House Committee on Ways and Means. Background Material and Data on Major Programs Within the Jurisdiction of the Committee on Ways and Means (EMCP-3) February 8, 1983, p. 154.

After 1983, the automatic increase provisions in Section 230 of the Social Security Act will determine the maximum taxable amount. The contribution rate for the self-employed will also change. These changes will be as follows.

- o The maximum taxable amount of annual earnings will be subject to automatic increases.
- o The contribution rate for employers and employees, each, will increase from 1.30 percent of taxable earnings in 1984 to 1.35 percent in 1985 and to 1.45 percent in 1986 and later.
- o The contribution rate for the self-employed will rise to 2.60 percent of taxable earnings in 1984, to 2.70 percent in 1985, and to 2.90 percent in 1986 and later.52/

2. Reduction in Rate of Increase of "Reasonable Charges" under Part B

Establishment of the Medical Economic Index (MEI) authorized by P.L. 92-603 has effectively controlled the rate of increase in physician charges under Part B. However, the amount of increase in "allowed" charges has consistently fallen behind the Consumer Price Index (CPI) for all services and the CPI for

Exhibit IV-4

MEDICARE HOSPITAL INSURANCE AND SUPPLEMENTARY MEDICAL INSURANCE BENEFIT PAYMENTS BY TYPE OF SERVICE FOR AGED AND DISABLED BENEFICIARIES, FISCAL YEAR 1982

(In Millions)

HOSPITAL INSURANCE		SUPPLEMENTARY MEDICAL INSURANCE	
TYPE OF SERVICE AND BENEFICIARY	BENEFIT PAYMENTS	TYPE OF SERVICE AND BENEFICIARY	BENEFIT PAYMENTS
TOTAL	$ 34,344	TOTAL	$ 14,806
Aged[1]	30,343	Aged	12,290
Disabled	4,001	Disabled	2,516
Inpatient Hospital Services[2]	32,685	Physician and Other Suppliers	10,721
Aged	28,791	Aged	9,424
Disabled	3,894	Disabled	1,297
Skilled Nursing Facility Services	464	Radiology and Pathology[3]	648
Aged	447	Aged	581
Disabled	17	Disabled	67
Home Health Services	1,195	Outpatient Hospital	2,882
Aged	1,105	Aged	1,774
Disabled	90		1,108
		Home Health Services	73
		Aged	67
		Disabled	6
		Group-Practice Prepayment Plans	316
		Aged	298
		Disabled	18
		Independent Laboratory Services	166
		Aged	146
		Disabled	20

[1]Benefit payments for aged beneficiaries are 88 percent of the total.
[2]Benefit payments for inpatient hospital services are 95 percent of the total.
[3]Reimbursement for services by radiologists and pathologists received as an inpatient in a hospital.

NOTE: Distributions by type of service and beneficiary are estimated.

SOURCE: OMB. Cited in Health Care Financing Administration, Bureau of Management and Strategy. Executive Data Compendium, May 1983, Tables IV-2 and IV-3.

physician services since the MEI was implemented. That is, increase in fees for physician services has surpassed the percent increase allowable under MEI. The result has been a substantial increase in the number of claims for which the physician receives a reduced payment because his/her bill is greater than the reasonable charge determination made by the carrier.

The impact of the MEI on the reduced reasonable charge rate can be seen from the following.[53]

- o In the third quarter of 1969 about one in five approved assigned claims resulted in a payment to a physician of an amount less than the billed charges (i.e., a reasonable charge reduction rate of 22 percent).
- o By 1981, about four of every five assigned claims resulted in reduced payments for billed charges (i.e., a reasonable charge reduction rate of 82.8 percent).
- o During calendar year 1981, the reasonable charge reduction rate for unassigned claims, excluding those of hospital-based physicians, was 85.8 percent; the average amount reduced per claim was $25.78.

3. Decline in Assignment Rates and Impact on Beneficiary Cost-Sharing

Physicians and other providers may choose on a bill-by-bill basis whether or not to accept "assignment" which will bind them to accept the reimbursement policies established by the program. If the physician accepts assignment, the physician bills the program directly and is paid Medicare's charge less any deductible and the coinsurance. The physician may not charge the beneficiary (nor collect from another party such as a private insurer) more than the applicable deductible and coinsurance amounts.

If the physician does not accept assignment, payment is made directly to the beneficiary on the basis of an itemized bill, whether paid or unpaid. The beneficiary is then liable for the physician's full charge, including any amount by which the physician's actual charge exceeds the Medicare-determined reasonable charge.

Some researchers have maintained that the MEI had an adverse affect on physician's willingness to accept assignment. However, this is more difficult to assert with any conviction because the net assignment rate had already begun to decline in 1971, as can be in Exhibit IV-6. This exhibit does not show

some of the variations that exist in assignment rates. For example, assignment rates are lower for the aged than for disabled beneficiaries (47 percent and 62 percent, respectively, for all physicians' charges), and they vary considerably by area of the country (from a low of 20 percent in South Dakota to a high of 82 percent in Rhode Island).

Exhibit IV-6

NET ASSIGNMENT RATES, BY YEAR, 1968-81
(In percent)

Calendar Year	Net Assignment Rate
1968	59.0
1969	61.5
1970	60.8
1971	58.5
1972	54.9
1973	52.7
1974	51.9
1975	51.8
1976	50.5
1977	50.5
1978	50.6
1979	51.3
1980	51.5
1981	52.3

Sources: Ferry, Thomas P., et al. "Physicians Charges Under Medicare: Assignment Rates and Beneficiary Eligibility," Health Care Financing Review, Winter 1980, p. 50; and Department of Health and Human Services, Health Care Financing Administration, Bureau of Program Operations, Part B Carrier Workload Report; June 1982; August 1982.

The level of assignment rates does have an impact on beneficiary out-of-pocket costs, since beneficiaries are responsible for the difference between the reimbursed rate and the charge on unassigned claims. In 1982, the difference was estimated at $25.78 per unassigned claim. The low assignment rate (52.3 percent in 1981) means that a large proportion of the elderly and disabled are paying this amount out-of-pocket.

4. Other Increases in Beneficiary Cost-Sharing

The continuing escalation in medical care costs has had its effect on beneficiaries' out-of-pocket expenditures, as can be seen from Exhibit IV-7, which compares the deductibles, coinsurance, and premiums under Medicare for 1966 and 1983.

Exhibit IV-7
DEDUCTIBLES, COINSURANCE, AND PREMIUMS UNDER MEDICARE:
1966, 1983

HOSPITAL INSURANCE

	Deductible		Coinsurance	
	1966	1983	1966	1983
Inpatient Hospital				
(Days 1 - 60)	$40	$304	N/A	N/A
(Days 61 - 90)	N/A	N/A	$10/day	$76/day
(60 day lifetime reserve)	N/A	N/A	N/A	$152/day
Skilled Nursing Facility				
(Days 1 - 20)	N/A	N/A	N/A	N/A
(Days 21 - 100)	N/A	N/A	$5/day	$38/day

SUPPLEMENTARY MEDICAL INSURANCE

	Deductible		Coinsurance		Premium	
	1966	1983	1966	1983	1966	1983[2]
Benefit Package (Physician Services, Outpatient diagnostic, home health,[1] other)	$50	$75	20% of Reasonable Charges		$3	$12.20

[1]Deductible and coinsurance for home health services were eliminated under provisions of P.L. 96-499 and P.L. 92-603, respectively.

[2]Under limits established in P.L. 92-603, the monthly premium would have been $13.10. Under provisions of P.L. 98-21, which authorized premium increases on a calendar year basis rather than on July 1, the premium was frozen at the 1982 rate for the period from 1 July 1983 to 31 December 1983. The premium will rise to $14.20 in January 1984.

In general, the amount of health care costs paid by the elderly out-of-pocket has been rising. For example, as a proportion of total income, per capita expenditures not paid by Medicare has risen from 16.8 percent in 1970 to 19.1 percent in 1980. This proportion is fast approaching the pre-Medicare level of 20.4 percent.53/

One of the factors contributing to the increase in out-of-pocket expenditures for health care among the elderly is the purchase of private insurance to supplement Medicare. Concerned about the ability of Medicare to offer adequate protection against the high cost of illness and about needed services not covered by Medicare, the elderly are turning to other types of supplemental insurance including:

- o Medicare supplement policies designed to fill the gaps in Medicare coverage, which often pay some or all of Medicare's deductible and coinsurance requirements and a percentage of actual charges unmet by Medicare;
- o indemnity policies, which pay a fixed amount for each day of hospitalization; and
- o specified disease policies, which limit coverage to certain "dread diseases" such as cancer.

Although these forms of insurance offer a wider range of options, they frequently are limited in scope. Nevertheless, in 1978, about two-thirds of the Medicare population purchased some form of health insurance to supplement Medicare at a cost of approximately $4 billion for 19 million policies.54/

V. CURRENT ISSUES

Among the major issues that must be addressed in future efforts to reform and improve Medicare are cost containment, financing, and the adequacy of the benefit package. The first of these issues has been a concern for the past several years, with legislative efforts shifting from authorizing regulations to control costs to enacting provisions to reduce expenditures.

A. COST CONTAINMENT

Most of the current proposals directed toward reducing expenditures focus on restraining the growth in health care costs by introducing competition into the health care system.

Some proponents of the competition approach believe that alternative health plans, particularly prepaid plans such as Health Maintenance Organizations (HMOs), offer a viable, cost-effective alternative to the fee-for-service system.

Recent reports show that these prepaid plans are able to provide services more efficiently than the loosely structured fee-for-service system, principally by controlling inpatient utilization and length-of-stay. In addition, they offer preventive care including routine physical exams and patient education--services not covered by Medicare.

Since 1972, a number of demonstration projects have been implemented to allow enrollment of Medicare beneficiaries in Group Practice Prepayment Plans (GPPPs) and Health Maintenance Organizations (HMOs). The GPPPs provide physician services and other related medical services for predetermined premiums rather than on a per unit or per service schedule. HMOs, provide inpatient and outpatient services, either directly or through contract with others, on the basis of a fixed payment without regard to the frequency or extent of services provided to a given enrollee. In 1982, the Congress legislated in TEFRA inclusion of HMOs as a source of services at 95 percent of the Average Annual Per Capita Cost (AAPCC).

Medicare beneficiaries who participate in these plans pay a supplementary premium to cover the Medicare deductible and coinsurance as well as any benefits or services not covered by Medicare. Covered services are reimbursed by Medicare according to the type of arrangement the plan has with the Medicare program.

As of March 1981, almost two percent of Medicare beneficiaries (575,188 individuals) were enrolled in the 75 prepaid plans that were contracting with Medicare.57/

Other suggested approaches to cost containment include providing Medicare beneficiaries with vouchers to be used in enrolling in government-approved HMO or other selected provider plans, such as Preferred Provider Organizations (PPOs), and combining Part A and B of Medicare without changing the services covered. Under the second of these approaches, the deductible would be decreased with a cap on cost-sharing to some level that would cover catastrophic illness.

The most promising approach is the prospective reimbursement system that has been adopted for Medicare inpatient hospital services as a result of the Social Security Amendments of 1983. In addition, the Congress has mandated studies on reimbursement for capital and medical education expenses.

B. FINANCING

Current estimates are that to keep the Hospital Insurance trust fund solvent over the next 25 years, revenues must be increased by 70 percent or expenditures reduced by 40 percent. Among the

options suggested for increasing revenues are: levying excise taxes on cigarettes and alcohol; increasing payroll taxes beyond those already scheduled; increasing income taxes; and taxing health benefits provided by employers to employees.[56] None of these options has been adopted to date.

C. BENEFITS

Even the strongest supporters of the Medicare program acknowledge that the benefits now covered do not address the changing needs of the elderly. As life expectancy has increased and health status improved, the number of people living beyond age 75 has also increased. This portion of the population is most frequently characterized by aloneness and multiple chronic conditions that affect their ability to perform the normal activities of daily living. In short, this age group constitutes those most in need of long-term care services or preventive services which are not covered by Medicare.

In addition, these elderly people represent the population most at risk for admission into nursing homes. Currently, as was seen in the previous discussion of skilled nursing benefits, nursing home stays not associated with acute conditions and not requiring skilled nursing care are not covered under Medicare. Although Medicaid does cover these services for those meeting the "means test," there are a number of elderly people who must deplete their resources or whose resources are exhausted because of extended care in skilled nursing facilities in order to be eligible for the type of nonskilled or supportive care that they need.

It is obvious from the discussion of the financing problems of the Medicare program that additional benefits as part of the Medicare package have ceased to be an option. However, to respond to the needs of the elderly, consideration should be given to establishing programs specifically directed to long-term care or to providing resources to make community-based supportive or preventive services available. The Department of Health and Human Services is conducting a variety of demonstrations in this area some of which include Medicare.

VI. SUMMARY

Most health policy analysts acknowledge that Medicare is a successful program. It pays for fully 45 percent of the cost

of care received by the nation's elderly. It has contributed to major progress in life expectancy for the elderly and disabled. For example:

- o the death rate has dropped at an annual average rate of 1.5 percent between 1968 and 1978;
- o between 1960 and 1978, life expectancy at age 65 has increased by two years;
- o chances for survival among people with ESRD have improved, since without dialysis the annual death rate for such patients is estimated to be about 98 percent whereas with dialysis it varies from 8 to 20 percent; and
- o the quality of life for some of the chronically disabled, such as those now able to afford surgery for the removal of cataracts, has improved.58/

The history of Medicare brings to light the evolutionary character of this program in the sense that the original design, though never altered, has been refined and modified to respond to the major health policy issues facing the nation at different points in time. The original concern with providing access to needed care produced a program that covered the most costly forms of care--hospital and skilled nursing services--and provided funds to support hospital and facility expansion. The desire to protect other vulnerable members of our society--the disabled and those afflicted with chronic kidney disease--resulted in an expansion of the eligibility requirements.

The increasing costs of health care services and the proportion of those costs borne by the federal government led to legislative efforts to control costs through regulations limiting reimbursements to providers and physicians.

The current deficits in the federal budget have produced new efforts to achieve savings or reduce expenditures by a combination of provisions that include increased cost-sharing among beneficiaries, risk sharing on the part of providers, cuts in the proportion of capital expenditures paid by the federal government, and adoption of a DRG-based prospective reimbursement system for inpatient hospital services.

The awareness that the acute-care, disease-oriented nature of the benefit package does not meet some of the most pressing needs of the elderly resulted in minor changes in the home health care benefit. The desire to provide a less costly and more appropriate form of care to the terminally ill added the hospice benefit to the Medicare program.

However, despite these changes, the financing, cost containment, and appropriate benefit issues remain as the most pressing problems for the future. It is on these issues that the Advisory Council has directed its attention, and it is to their resolution that the Council recommendations are directed.

1/Health Care Financing Administration, Bureau of Data Management and Strategy. Health Care Financing Administration Statistics, September 1982, p. 6.

2/Health Care Financing Administration, Bureau of Data Management and Strategy. Executive Data Compendium. May 1983, p. I-1.

3/The Board of Trustees, Federal Hospital Insurance Trust Fund. 1983 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund. June 1983, p. 46.

4/The Health Care Financing Administration, Bureau of Data Management and Strategy, op. cit., pp. III-1 and IV-4.

5/Ibid., p. IV-9.

6/Somers, Anne R. "Rethinking Medicare to Meet Future Needs." Washington, D.C.: The Government Research Corporation, p. 3.

7/U.S. Senate. A Report of the Special Committee on Aging. Part I, Developments in Aging: 1980. Report #97-62. Washington, D.C.: U.S. Government Printing Office, 1981, p. xiii.

8/U.S. Department of Health and Human Services, Health Care Financing Administration. Long Term Care: Background and Future Directions. (HCFA 81-20047). Washington, D.C.: Health Care Financing Administration, 1981, p. 1.

9/U.S. Senate. A Report of the Special Committee on Aging. Volume I, Developments in Aging: 1982. Report #98-13. Washington, D.C.: U.S. Government Printing Office, 1983, pp. 7-8.

10/Ibid., pp. 7-8.

11/U.S. Department of Health and Human Services, Health Care Financing Administration. Long Term Care, pp. 27-28.

12/U.S. Senate. A Report of the Special Committee on Aging. Volume I, Developments in Aging: 1982. Report #98-13. Washington, D.C.: U.S. Government Printing Office, 1983, p. 2.

13/Ibid., pp. 12 and 13.

14/Ibid., p. 243.

15/Ibid., p. 40.

16/Ibid., p. 19.

17/The Board of Trustees, Federal Hospital Insurance Trust Fund. op. cit., p. 31, and the Board of Trustees, Federal Supplementary Insurance Trust Fund. 1983 Annual Report of the Board of Trustees of the Supplementary Medical Insurance Trust Fund. June 1983, p. 28.

18/The New York Times, February 21, 1983, pp. 1A, B7.

19/The Board of Trustees, Federal Supplementary Medical Insurance Trust Fund. op. cit. pp. 22 and 29.

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VOTES BY MEMBERS BY ISSUE

(Y-In Favor; N-Against; A-Absent)

Issue	Bowen	Aiken	Arnold	Balog	Bays	Christopher	Heaps	Howard	McCaffree	McKevitt	Rahn	Stetler	Zamaria	Tally
Chapter II-A Funding Crisis of the HI Trust Fund	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y-13 N-0
Chapter II-B General Revenue Contributions to HI Trust Fund	Y	N	N	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y-10 N-3
Chapter II-C Raising Additional Revenue through Payroll Tax Increase-Against	Y	N	Y	Y	Y	Y	Y	Y	N	Y	Y	N	Y	Y-10 N-3

Issue	Bowen	Aiken	Arnold	Balog	Bays	Christopher	Hears	Howard	McCaffree	McKevitt	Rahn	Stetler	Zamaria	Tally
Chapter II-D Interfund Borrowing	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y-13 N-0
Chapter II-E Reallocation of Tax Rates between HI and OASDI	Y	Y	A	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y-12, A-1 N-0
Chapter II-F Taxation of Employer-Provided Health Insurance	Y	Y	N	Y	Y	Y	N	Y	Y	Y	N	Y	Y	Y-10 N-3

Issue	Bowen	Aiken	Arnold	Balog	Bays	Christopher	Heaps	Howard	McCaffree	McKevitt	Rahn	Stetler	Zamaria	Tally
Chapter II-G Increased & Earmarked Federal Excise Taxes on Alcohol and Tobacco Products	Y	Y	N	Y	Y	N	N	Y	Y	N	N	N	Y	Y-7 N-6
Chapter III-A Advancing the Age of Eligibility	Y	N	N	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y-10 N-3
Chapter III-B Universal Social Security Coverage	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y-13 N-0

Issue	Bowen	Aiken	Arnold	Balog	Bays	Christopher	Heaps	Howard	McCaffree	McKevitt	Rahn	Stetler	Zamaria	Tally
Chapter III-C Diagnosis and Treatment Related Coverage Under Medicare	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y-13 N-0
Chapter IV-A Restructure of Medicare Part A HI and Enhanced Part A and B Benefits	Y	Y	N	Y	Y	Y	N	Y	Y	A	Y	Y	Y	Y-10, A-1 N-2
Chapter IV-B Long Term Care	Y	Y	A	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y-12, A-1 N-0

Issue	Bowen	Aiken	Arnold	Balog	Bays	Christopher	Heags	Howard	McCaffrey	McKernan	Rann	Stetler	Zamaria	Tally
Chapter IV-C Preventive Services	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y-12 N-1
Chapter IV-D Voluntary Vouchers	Y	Y	N	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y-11 N-2
Chapter IV-E Indexing SMI Deductible	Y	N	N	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y-10 N-3
Chapter V-A Prospective Payment	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y-13 N-0

Issue	Bowen	Aiken	Arnold	Balog	Bays	Christopher	Heaps	Howard	McCaffree	McKevitt	Rahn	Stetler	Zamaria	Tally
Chapter V-B Medicare Medical Education Expenses	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y-12 N-1
Chapter V-C Medicare Reimbursement for Physicians' Services	Y	Y	A	Y	Y	Y	Y	Y	N	Y	N	Y	N	Y-9, A-1 N-3
Chapter V-D Assignment of Medicare for Physicians' Services	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y-12 N-1

Issue	Bowen	Aiken	Arnold	Baley	Bays	Christopher	Deaps	Howard	McCaffree	McEwen	Rann	Stelter	Zamaria	Tally
Chapter VI-A Medical Technology	Y	Y	A	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y-12, A-1 N-0
Chapter VI-B "Advance Directives" or "Living Wills"	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y-13 N-0
Chapter VI-C Management of the Medicare Program	Y	Y	A	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y-12, A-1 N-0

Issue	Chapter VI-D Income Related Premiums-Against	Executive Summary General Statement
Bowen	Y	Y
Aiken	Y	Y
Arnold	Y	Y
Balog	Y	Y
Bays	Y	Y
Christopher	Y	Y
Heaps	Y	Y
Howard	Y	Y
McCaffree	Y	Y
McKevitt	Y	Y
Rahn	Y	Y
Stetler	Y	Y
Tamaria	Y	Y
Tally	Y-13 N-0	Y-12, A-1 N-0

APPENDIX E

ACTUARIAL ANALYSIS OF THE FINAL RECOMMENDATIONS OF THE ADVISORY COUNCIL ON SOCIAL SECURITY

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

- 306 -

Memorandum

January 6, 1984

Guy King, Director
Office of Financial and Actuarial Analysis, BOMS

Cost Estimates of the Final Recommendations of the Advisory Council--INFORMATION

Phil Jos, Deputy Executive Director
Advisory Council on Social Security

Attached are four tables showing the estimated effects on the Medicare program of the final recommendations of the Advisory Council. Tables 1 and 2 show the estimated impact of the recommendations on the HI and SMI trust funds, while Tables 3 and 4 present the estimated operations of the HI trust fund with and without the effects of the recommendations. These estimates may differ from previous estimates due to modifications made by the Advisory Council. The estimates are based on 1983 Trustees' Report Alternative II-B assumptions.

TABLE 1

Estimated Impact of the Final Recommendations of the Advisory Council on the Hospital Insurance (HI) Program
(In Millions of Dollars)

Item No.	Recommendation	Eff. Date	CY 1985	CY 1986	CY 1987	CY 1988	CY 1989	CY 1990	CY 1991	CY 1992	CY 1993	CY 1994	CY 1995	Total, CY 1985-1995
Items effecting HI income.														
4	Taxation of Employer-Provided Health Insurance	1/1/84	254	300	344	406	482	569	669	784	918	1,071	1,249	7,046
11	Restructuring of HI	1/1/85	1,270	1,425	1,660	1,795	1,980	2,200	2,425	2,660	2,915	3,205	3,500	24,975
Total Impact on HI Income 1/			1,504	1,680	1,860	2,096	2,292	2,494	2,764	3,049	3,373	3,721	4,124	28,966
Items effecting HI Outlays.														
8	Advancing Age of Eligibility for Medicare Benefits	1/1/85	- 550	-1,275	-2,130	-3,165	- 4,965	- 7,115	- 8,540	- 9,790	-11,935	-12,385	-13,815	- 74,665
11	Restructuring of HI	1/1/85	- 685	- 725	- 810	- 905	- 1,010	- 1,125	- 1,245	- 1,370	- 1,510	- 1,665	- 1,820	- 12,830
16	Prospective Payment-Limit Increases to Market Basket + 0%	1/1/88	0	0	0	- 570	- 1,315	- 2,205	- 3,240	- 4,455	- 5,865	- 7,495	- 9,375	- 34,520
17	Eliminate Medicare Funding of Medical Education Expenses	1/1/87	0	0	-2,800	-3,300	- 3,600	- 4,000	- 4,400	- 4,900	- 5,400	- 5,900	- 6,500	- 40,800
Total Impact on HI Outlays 1/			-1,185	-1,985	-5,585	-7,650	-10,395	-13,670	-16,390	-19,195	-22,095	-25,470	-29,130	-152,750

1/ Total impact figures do not equal the sum of the appropriate items due to the interaction of the recommendations. Total impact on income does not include changes in interest income to the fund.

NOTE: Items 1-3, 6, 9, 10, 12, 13, and 20-23, are statements of the Advisory Council and have no cost or savings impact. Items 5 and 7 involve tax rate changes which have not been specified at this time. Item 14 has undetermined cost. Items 15, 18, and 19, affect the Medicare SMI program but have no impact on HI.

Bureau of Data Management and Strategy
Office of Financial and Actuarial Analysis
January 6, 1984

TABLE 2

Estimated Impact of the Final Recommendations of the Advisory Council on the Supplementary Medical Insurance (SMI) Program (In Millions of Dollars)

Item No.	Recommendation	Eff. Date	FY'85	FY'86	FY'87	FY'88	FY'89
Net effect on SMI Income:							
	Change in Premium Income		- 40	-135	-250	- 370	- 580
	Change in General Revenue		-165	-435	-745	-1,225	-1,990
Net effect on SMI Outlays:							
8	Raise Age of Eligibility to Medicare Benefits	1/1/85	-155	-455	-845	-1,310	-2,125
15	Index Part B Deductible to CPI-W all items	1/1/85	- 25	- 65	-125	- 195	- 270
19	Participating Physician	10/1/84	30	45	50	60	65
Total Impact on SMI Outlays			-150	-475	-920	-1,445	-2,330

Bureau of Data Management and Strategy
Office of Financial and Actuarial Analysis
January 6, 1984

TABLE 3

Estimated Operations of the Hospital Insurance Trust Fund During CY 1984-1995 1/
(Dollar Amounts in Billions)

Calendar Year	Total Income 2/	Total Outgo	Net Increase in Fund	Fund at End of Year	Ratio 3/ (Percent)
1984	$46.1	$ 46.6	$- 0.5	$ 11.2	25%
1985	51.3	52.3	- 1.0	10.2	21
1986	59.5	58.0	1.5	11.8	18
1987	64.9	64.1	0.8	12.6	18
1988	74.5	71.0	3.5	16.1	18
1989	70.0	78.4	- 8.4	7.8	21
1990	73.9	86.6	-12.6	- 4.9	9
1991	77.8	95.1	-17.3	- 22.2	-5
1992	81.8	104.5	-22.7	- 44.9	-21
1993	85.5	114.7	-29.2	- 74.0	-39
1994	89.0	125.8	-36.8	-110.8	-59
1995	92.4	137.9	-45.5	-156.3	-80

1/ Based on 1983 Trustees' Report Alternative II-B assumptions.
2/ Includes the loan repayments from the Old Age and Survivors Insurance Trust Fund to the Hospital Insurance Trust Fund as reported in the 1983 Trustees' Report.
3/ Ratio of assets at the beginning of the year to outgo during the year.

Bureau of Data Management and Strategy
Office of Financial and Actuarial Analysis
January 6, 1984

TABLE 4

Estimated Operations of the Hospital Insurance Trust Fund During CY 1984-1995 with the Estimated Effects of the Final Recommendations of the Advisory Council 1/
(Dollar Amounts in Billions)

Calendar Year	Total Income 2/	Total Outgo	Net Increase in Fund	Fund at End of Year	Ratio 3/ (Percent)
1984	$ 46.1	$ 46.6	$-0.5	$11.2	25%
1985	52.9	51.1	1.8	13.0	22
1986	61.5	56.0	5.5	18.5	23
1987	67.5	58.5	9.0	27.5	32
1988	77.9	63.3	14.6	42.1	44
1989	74.4	68.0	6.4	48.5	62
1990	79.6	72.9	6.7	55.2	67
1991	85.0	78.7	6.3	61.4	70
1992	90.8	85.3	5.5	67.0	72
1993	96.7	92.6	4.1	71.1	72
1994	102.8	100.3	2.4	73.5	71
1995	109.1	108.7	0.3	73.9	68

1/ Based on 1983 Trustees' Report Alternative II-B assumptions adjusted to include the estimated effects of the final recommendations of the Advisory Council.

2/ Includes the loan [redacted]ments from the Old Age and Survivors Insurance Trust Fund to the Hospital Insurance Trust Fund as reported in the 1983 Trustees' Report.

3/ Ratio of assets at the beginning of the year to outgo during the year.

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January 6, 1984

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