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Robert J. Myers

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Chapter 7
Development of the Medicare System

This chapter traces the beginning of the Medicare system from the early efforts at the turn of the century to establish broad government health insurance programs through the battle during 1950–65 to enact Medicare legislation for persons aged 65 and over.[1] Then, the significant amendments made to the Medicare program subsequent to its enactment in 1965 are discussed.

A description is given of the Medicare provisions in legislation passed by both the House and the Senate in 1973 but not finally enacted, because this is a good indication of possible future changes. Also discussed are legislative proposals made in early 1975 by the Advisory Council on Social Security and by President Ford, in late 1979 by the Advisory Council on Social Security, in early 1981 by the National Commission on Social Security, and in early 1984 by the Advisory Council on Social Security. (The National Commission on Social Security Reform, in 1982–83, did not have the Medicare program as part of its assignment.) The chapter concludes with a historical summary of the various promulgated Medicare elements.

Early Legislative Efforts

Germany established a government health insurance program in the 1880s, and several other European countries also did so in the next few years. These were relatively limited plans, and they generally applied only to manual workers and lower-paid salaried employees. Some Americans studied this movement with great interest and approval.

1. For more details on these historical matters, see Robert J. Myers, *Medicare* (Homewood, Ill.: Richard D. Irwin, 1970), chaps. 1–3.

Legislative Proposals before 1935

The first national advocacy of government health insurance in the United States was a plank in the platform of the Socialist Party in the early 1900s. Subsequently, when President Theodore Roosevelt founded the Progressive Party before the 1912 elections, a plank supporting national health insurance was included in its program. The American Association for Labor Legislation (AALL), which ceased operations in the early 1940s, played a most important role in the legislative movement for health insurance, particularly in the period beginning in 1912 and ending somewhat after the termination of World War I.

The AALL, at its inception, was interested primarily in the promotion of state workmen's compensation laws (as they were referred to then). These would provide both medical care and cash payments for workers suffering from industrial injuries or diseases. In this respect, the AALL was extremely successful, because a number of such laws were enacted within a few years, and an irresistible movement was started that eventually resulted in laws in all states.

With this first success as encouragement, the AALL turned its attention to the establishment of separate state programs of medical care and cash benefits on an earnings-related basis similar to workers' compensation but with broader application. The AALL prepared model bills and attempted to get them enacted by state legislatures. Success, however, was minimal. Little more was achieved than bills being introduced and hearings being held. The few instances where the bills came to a vote resulted in rejection. Activity in this area came to a virtual standstill with the advent of World War I, and was not renewed afterward. The opposition to the AALL bills came not only from business and insurance groups but also from the national labor movement. In the beginning, the American Medical Association was favorably inclined, but it soon changed its position.

After World War I, those favoring government health insurance regrouped their forces and made preparations for a new campaign. During the 1920s, their efforts were concentrated on laying the groundwork through studies of the matter, such as those of the Committee on the Costs of Medical Care. Then, in 1934–35, when the Committee on Economic Security (COES), formed by President Franklin D. Roosevelt, was developing the proposals which became the Social Security Act, the proponents of health insurance sought to have it included with old-age insurance and unemployment insurance.

In part because of urgency and in part because of the controversial nature of the subject and the strong opposition involved, no legisla-

tive proposal in the health insurance area was made by the COES or by President Roosevelt in his recommendations to Congress. Also involved was the possibility that any such proposal would be declared unconstitutional and might then even pull down with it the companion old-age benefits and unemployment compensation proposals that were made. Instead, the need for further studies on health insurance was cited by the COES report.

An interesting sidelight of the 1935 legislation that became the Social Security Act was that initially the section that pertained to the duties of the Social Security Board referred to making studies and recommendations in various fields of social insurance, including health insurance. The reference to this controversial subject was stricken out in the course of the legislative action. However, since the final language in regard to studies and recommendations in the social insurance field contained the phrase *related subjects*, the Social Security Board never felt any hesitancy about making extensive studies in the health insurance area.

Even though there was powerful opposition to compulsory health insurance in 1935, one important shift in camps had been made since the 1910s and early 1920s. The American Federation of Labor had, in the meantime, changed its early views of opposition to most forms of social insurance. This position was not revised formally until a few years after the passage of the Social Security Act. In considerable part, this was probably because of the effects of the depression that began in 1930 and the different attitude of AFL President William Green compared with that of his predecessor, Samuel Gompers.

Legislative Proposals between 1935 and 1950

When President Franklin D. Roosevelt signed the Social Security Act in 1935, he made clear his feelings that this legislation was only the cornerstone of a much more extensive program. Under the "study" provisions of the act, the staff of the Social Security Board continued the research and investigation made by the COES on national health insurance.

The Interdepartmental Committee to Coordinate Health and Welfare Activities was established by President Roosevelt directly after the Social Security Act became law. Its recommendations were presented to a National Health Conference in 1938, which brought together a large group of persons who were interested in this subject.

The interdepartmental committee recommended, among other things, social insurance provisions for temporary-disability benefits along the lines of state unemployment insurance programs and for

permanent-disability benefits under the national old-age benefits program. Also, it was proposed that federal grants should be made available to state programs providing medical care for the needy—both those receiving cash public assistance payments and those who were medically indigent. It was also recommended that the states, with federal financial and technical assistance, should establish plans to meet medical costs on a prepayment basis. Such plans would be financed at the state level from general taxes and/or contributions from the covered persons.

The National Health Conference discussed these recommendations in depth. In general, there was complete agreement on the broad principle of improving the nation's health. However, there were differences of opinion on the methods for doing so and especially on how the costs should be financed.

Following the conference, somewhat amended versions of the interdepartmental committee recommendations were embodied in a bill introduced in 1939 by Senator Wagner (Democrat). This was the first major bill outlining a broad federal health program. The bill included, among other major proposals, federal grants-in-aid to the states for medical care programs, whether through insurance, public medical services, or combinations, as the state might decide. The categories of persons to be protected and the services to be covered were described in a very broad and general manner and were not specifically detailed.

Extensive hearings on the Wagner Bill were held. This became the first national legislative sounding on health insurance, bringing to the front the support of major consumer groups and the opposition of the medical profession. A report in favor of the bill was filed, but in view of the opposition the bill was not brought to a vote. The importance of this was twofold: it revived national interest in health insurance, which had been laid aside during the legislative progress of the Social Security Act, and it demonstrated that the compromise of a federal-state grant-in-aid pattern did not result in acceptance.

With the failure of the Wagner Bill to win support for the state-by-state approach (with federal grants), the executive branch gave up this pattern. Instead, encouraged by the successful establishment and operation of the *national* social insurance system of old-age and survivors insurance in 1937–40, the executive branch concentrated thereafter on national proposals for health insurance linked with that system. These proposals became identified as the Wagner-Murray-Dingell Bills (after the two Democratic senators and the Democratic representative who sponsored the legislation). The first of these proposals was made in 1943, and bills along these lines were introduced

at various times in the 1940s and 1950s. These bills closely followed general recommendations made by the executive branch, but they were never endorsed officially by either President Roosevelt or President Truman.

These proposals included programs to provide protection against a considerable part of the expense of hospital and medical services for all workers (including retired workers) and their eligible dependents—not merely for those then covered by the OASI program, but also agricultural and domestic workers, self-employed persons, and the like. President Truman expressed support of the general principles, even though he did not endorse the specific bills.

The Wagner-Murray-Dingell proposal included virtually all medical services, except for drugs (other than unusually expensive prescriptions). Administration would be on a state-by-state basis through state agencies (acting as agents) that would contract with providers of care and fix the rates of payment. Physicians would elect whether they wanted to be reimbursed by fee-for-service, capitation, or salary. However, the total amounts available for reimbursement would be fixed in accordance with what was available through the financing mechanism of the system and would be equivalent in the aggregate, regardless of which method was selected by the physicians individually. The hospitals and other institutional providers of services would be paid on a negotiated cost-reimbursement basis.

The financing provisions of the Wagner-Murray-Dingell proposal were somewhat vague, because the bills were introduced as health measures rather than as tax measures. This legislative procedure apparently was adopted so that the bills would be referred to committees which would be more favorably disposed toward the legislation. The implication was that the financing would be on a percentage-of-payroll basis. A sum equal to 1 percent of taxable wages would be authorized as an initial reserve. A continuing total contribution of 3 percent would be required each year thereafter, plus a further 1 percent (only 0.5 percent for the first three years) for financing dental and home nursing services. Hearings on the Wagner-Murray-Dingell Bills were held for several years, but the legislation never came to the floor of either the House or the Senate for a vote.

An approach taken by a wide variety of bills in the 1940s, mostly introduced by Republican members of Congress, was to encourage voluntary health insurance by giving exemptions or credits for such premiums for federal income-tax purposes.

A completely different approach was taken by Senator Taft—perhaps the leading Republican member of Congress in 1946—as an answer to the Wagner-Murray-Dingell Bills. The Taft Bill would have

provided federal financial support for state programs for the medically indigent. Thus, it might be said that this proposal was the first to establish the format used in the later Medicaid program.

Legislative Action in 1951–1964

The period 1951–64 saw great activity in proposals for medical care benefits under social insurance and public assistance. In the early part of the period, the activity centered on the development and discussion of social insurance proposals, primarily for persons aged 65 and over. Later, in the middle of the period, medical care services under public assistance were significantly expanded, in part because those who opposed the social insurance approach supported public assistance measures as "counterfires." Thus, the Kerr-Mills Act of 1960 (named after the Democratic Senate and House sponsors) establishing the program of Medical Assistance for the Aged (MAA) was enacted and was the first legislation passed in the format that would later emerge as Medicaid.

Beginning in 1960, efforts to enact a social insurance program of hospital benefits were stepped up through a series of bills known as the King-Anderson Bills (named after the Democratic House and Senate sponsors). The subject never came to a vote in the House of Representatives, but rather it was decisively rejected several times by the Ways and Means Committee. On the other hand, several record votes on the matter were held in the Senate, and each time the margin of defeat lessened. The basic natures of the various benefit proposals that were considered over the years were similar, but minor changes were made from time to time in an effort to answer some of the opposition arguments and thus win support.

The proposal of the Johnson administration in 1963 had a unique basis as to the hospital benefits provided. Three options could be elected (irrevocably) by the beneficiary: (1) 90 days of hospital care in a benefit period, with a $10 daily cost-sharing charge for the first 9 days; (2) 45 days with no deductible; or (3) 180 days with a deductible equal to 2½ times the nationwide average daily cost of hospitalization (estimated to total about $100). Although this would have given beneficiaries great flexibility of choice, it would have been very difficult for many of them to understand the options and make a good choice among them.

Finally, in 1964, the Senate passed, by a close vote, an amendment providing hospital insurance benefits for persons aged 65 and over, but the House would not agree to any compromise position, and the

legislation died in conference when the session adjourned for the presidential election.

Over the period, the financing provided in the various proposals was increased significantly—from a combined employer-employee contribution rate of about 0.5 percent of taxable payroll for the earliest proposal to somewhat more than 0.75 percent for the last proposal. This increase was due in part to the continuing rapid increases in hospital costs over the period and in part to the adoption of more conservative assumptions in the underlying cost estimates. In all the proposals, the self-employed rate was 1½ times the employee rate, just as in OASDI.

Enactment of Medicare

The deadlock that occurred in connection with the 1964 legislation left the battle lines clearly drawn in the impending presidential campaign between President Johnson and his Republican opponent, Senator Goldwater. The latter had taken a strong position against the King-Anderson Bill and similar proposals during the 1964 Senate debate. In the actual campaign, however, this issue was not particularly stressed. Rather, others such as the Vietnam War took precedence.

The results of the election changed the complexion of the House of Representatives considerably. It appeared to most political analysts that the temper of the House was clearly to pass some type of legislation providing hospital benefits under Social Security for persons aged 65 and over. And, of course, the Senate, which had favored such a proposal in the 1964 legislative activities, had a composition in 1965 that was even more favorably disposed in this direction.

Administration Proposal in 1965

President Johnson decided to make the Hospital Insurance (HI) proposal his major legislative goal in 1965. It was contained in identical bills introduced by Congressman King (H.R. 1)[2] and Senator Anderson (S. 1).

The King-Anderson Bill of 1965 provided for 60 days of hospital benefits within a benefit period, with a flat deductible equal to approximately the expected nationwide average daily hospital cost under

2. It is interesting that the original bill was not introduced by Chairman Wilbur D. Mills but that the bill approved by the House Ways and Means Committee, with numerous changes, was a "clean" bill and bore his name and had a different number than the "magical" H.R. 1.

the program initially, subject to variation in the future. A maximum of 60 days for the posthospital extended care facility (ECF) benefits was provided. Also included were 240 home health (HH) visits during a calendar year and outpatient diagnostic services during a 30-day period in excess of a deductible equal to 50 percent of the inpatient hospital deductible.

The benefits would be available not only for insured persons aged 65 or over under the OASDI and RR systems but also on a transitional basis for virtually all noninsured persons in the country (excluding only active and retired federal employees eligible for health benefits under their own plan, certain short-residence aliens, and members of subversive organizations). The 1964 Advisory Council on Social Security recommended HI for the disabled, but it was not included.

The financing was at a significantly higher level than the legislative proposals of previous years. In large part, this was the result of the views of Chairman Wilbur D. Mills of the House Ways and Means Committee, because of his concern that the program should be soundly financed, with conservative cost assumptions. The combined tax rate for OASDI and HI would be allocated between the two programs.

The allocation to HI, for the combined employer-employee rate, would be 0.6 percent of taxable payroll for 1966, 0.76 percent for the next two years, and 0.9 percent thereafter. The lower rate for the first year reflected the fact that taxes would be collected for the entire year but that benefits would be paid only for the last six months. The intermediate step for the next two years was established on the grounds that it would be desirable, from an economic standpoint, to have such a graduated basis so that the total tax collections for these years would be as low as possible (and yet meet the program costs), and thereby any fiscal-drag effects would be lessened. The maximum taxable earnings base would be increased to $5,600. Just as in all the previous proposals, the rate for the self-employed was 1½ times the employee rate, as in OASDI.

Other Proposals in 1965

Although the political atmosphere seemed such that it was virtually certain that hospital benefits associated with the OASDI system would be enacted, other proposals were presented to Congress. In part, these were made to show that, although the sponsors had been opposed to the compulsory hospital insurance approach and still were, they nonetheless were interested in solving the problem of health benefits for persons aged 65 and over, but through different means.

One approach was sponsored by Representative John W. Byrnes, the ranking Republican member of the House Ways and Means Committee. His bill provided a full range of health benefits—rather than merely hospital and related benefits, as did the King-Anderson Bill—with certain deductibles and coinsurance. The benefits under this proposal were closely modeled after the high-option indemnity plan of health benefits available for federal employees of all ages (including also the retired). The financing was through individual monthly premium payments from all persons aged 65 and over who elected to be covered.

Although the same benefit protection would have been available for all protected persons under the Byrnes Bill, the premium rate would vary directly with the size of the OASDI or RR monthly benefit that the individual was receiving (or was eligible to receive if not yet retired). Persons not receiving such a benefit (or eligible to do so) would pay the maximum premium possible (i.e., based on the maximum OASDI benefit). Specifically, the monthly premium payment equaled 10 percent of the minimum benefit, plus 5 percent of the amount of the monthly benefit in excess of the minimum benefit (so that it would have varied from approximately $4 to $9 for a single person and from $5 to $12 for a married couple). It was estimated that the premium payments from the beneficiaries would meet about one third of the cost. The remainder would come from general revenues.

Another approach, sponsored by the American Medical Association in its last-ditch fight against the enactment of a health-benefits plan associated with social insurance, was contained in bills introduced by Democratic Representative A. Sidney Herlong and Republican Representative Thomas B. Curtis. This proposal—popularly referred to as Eldercare—essentially would have expanded the federal-state Medical Assistance for the Aged program (MAA). It would have permitted the development of private health insurance that would be fully paid for by MAA for low-income persons and would be on a partial-payment basis for those somewhat above the maximum income limits for "free" coverage. No uniform program of health benefits would have been prescribed or required for the states that wished to participate. This bill also would have liberalized the MAA program in a number of respects, by easing the means-test requirements and by providing increased federal financial participation.

Action of the House of Representatives in 1965

Early in 1965, the House Ways and Means Committee held executive sessions on the various proposals for health benefits for persons aged

65 and over. Chairman Mills had become convinced that the mood of the House of Representatives was such that a bill providing some form of health benefits was called for and that such a bill could be developed on a sound basis. To get a broad base of support, he proposed that the new bill to be written by the committee should incorporate the essential features of all three major pending proposals. This politically logical approach took virtually everybody by surprise, including the sponsors of the three separate approaches.

Actually, many ardent sponsors of health benefits provided through social insurance were greatly pleased by the much broader approach than merely HI, because their real desire was comprehensive medical care through social insurance for persons aged 65 and over—and, in fact, whenever possible for the entire population.[3] The results, therefore, were much more sweeping than the sponsors had ever dreamed possible, although they had some regrets about the voluntary nature of SMI and its being financed in part by the participants, rather than through payroll taxes. On the other hand, some advocates of a national health service viewed the item-by-item approach of Medicare without enthusiasm; they feared that it might inhibit the future growth of comprehensive, unified health services.

The three separate health-benefits proposals were incorporated by the House Ways and Means Committee in the following manner: An HI program would be established with provisions paralleling closely those of the King-Anderson Bill but with significantly different financing provisions. In addition, a supplementary voluntary program covering physicians' services and certain other medical costs would be established. The benefit provisions were similar to those of the Byrnes Bill, except that the hospital and related benefits were carved out (because they were provided in the separate HI system). This new SMI program would be available through individual voluntary election and would be financed by uniform premium rates from the beneficiaries and equal matching contributions from general revenues.

The voluntary nature of SMI, and the requirement that it be administered with a third party (carriers) between physicians and the government, evolved because of the strong views of the American Medical Association (AMA), which were recognized by the committee even though the AMA did not support the proposal. The AMA had

3. In this connection, it is interesting that, when the Johnson administration testified before the House Ways and Means Committee, it pointed out, with approval, the partnership of the federal government handling hospital benefits only, with the private sector having responsibility and opportunities in the area of physician benefits. With the latter being included in the House bill, as SMI, the Johnson administration was completely silent on this point when it testified before the Senate Finance Committee.

always taken a position against any health insurance plan affecting physicians that was financed through payroll taxes and was compulsory for the participants, on the grounds that this involved government control and was socialized medicine. The basis adopted for SMI thus avoided these criticisms.

Finally, as the third part of the combination of the several health-benefits proposals, a medical assistance program (Medicaid) would be established by broadening the existing MAA program to provide more liberal eligibility conditions and federal matching (and also to extend it beyond the aged category to younger persons). These provisions were taken to some extent from the AMA's Eldercare proposal, but they went far beyond it, especially by including younger persons.

The HI-benefit provisions adopted by the committee differed from those of the administration proposal in the following major respects:

1. Posthospital ECF benefits would be available for a maximum of 20 days per spell of illness, plus 2 additional days for each unused day of hospital benefits up to a maximum of 80 additional days. Furthermore, a prior stay of three days in a hospital would be required.
2. The outpatient diagnostic benefits would be changed so that the period to which the deductible applied would be 20 days in the same hospital, rather than 30 days in all hospitals. Furthermore, any deductible paid for this benefit would be credited against the hospital deductible.
3. The HH benefits would be limited to 100 visits and would be available only after hospitalization.
4. The services of certain medical specialists in hospitals (radiologists, anesthesiologists, pathologists, and physiatrists) would be covered under SMI rather than HI.
5. A deductible would be introduced with respect to the first three pints of whole blood furnished in a spell of illness.

HI would be financed by a long-range increasing tax schedule and by an increase of the maximum taxable earnings base to $5,600 for 1966–70 and $6,600 thereafter (compared with the level $5,600 in the administration proposal). The combined employer-employee rate would begin at 0.7 percent in 1966 and would then increase to 1.0 percent in 1967–72, 1.1 percent in 1973–75, 1.2 percent in 1976–79, 1.4 percent in 1980–86, and 1.6 percent thereafter. These rates would be levied on the same earnings base as OASDI.

Unlike any previous proposals, the self-employed would pay only

the employee rate (instead of 1½ times that rate). This was done because of complaints on the part of the self-employed about the rising OASDI tax rate (at the same time, a ceiling of 7 percent was put on that rate, although it was not immediately of any effect). This basis for the self-employed was maintained in all subsequent legislation until the 1983 Act. It should be noted that the self-employed were particularly sensitive to the size of OASDI-HI taxes, because at that time they paid such taxes in one lump sum when the final income tax return was due (now it is paid quarterly on a more or less current basis).

The cost of the benefits for the uninsured group would be borne by general revenues.

SMI would cover physician services, HH services regardless of prior hospitalization (up to a maximum of 100 visits per year), and various other medical and health services, such as diagnostic tests, therapy treatments, ambulance services, surgical dressings, and medical equipment. An annual deductible of $50 and 20-percent coinsurance on the part of the participant would be applicable. (In hindsight, one sees that it was most unfortunate that the initial deductible was not put on a dynamic basis, varying annually with average physician costs—as was done with regard to the HI cost-sharing provisions, relative to hospital costs. Such a logical procedure could probably have been enacted without difficulty and would have held down the increase in the adequate actuarial rates, as well as being equitable to the enrollees by keeping the relative size of the deductible constant.) Special limitations would be provided on outpatient psychiatric care (in essence, 50-percent coinsurance and a maximum reimbursement of $250 per year).

SMI would be financed by premiums of $3 a month from the participants, with equal matching amounts from general revenues. The standard premium rate (for those who enrolled at the earliest possible time or shortly thereafter) would be adjusted in the future (after 1967) as experience indicated. Also, the premium rate would be higher for individuals who did not enter the program when they were first eligible to do so, with strict requirements for such late enrollments and for reenrollments.

The House adopted the provisions of the Ways and Means Committee bill without change.

Action of the Senate in 1965

The Senate Finance Committee approved the provisions for both HI and SMI in substantially the same form as the House bill. The HI-

benefit provisions of the Finance Committee bill differed from those of the House bill in the following major respects:

1. The hospital benefits would be available for an additional 60 days, with coinsurance of $10 per day (automatically adjusted in the future based on changes in hospital costs).
2. The outpatient diagnostic benefits would have 20-percent coinsurance (to parallel the treatment of such services when covered outside of a hospital under SMI).
3. The posthospital ECF benefits would be available for a maximum of 100 days per spell of illness in all cases, but there would be coinsurance of $5 per day (automatically adjusted in the future, based on changes in hospital costs) for each day after 20 days.
4. The HH benefits would have a maximum of 175 visits per year.
5. The services of certain medical specialists in hospitals (discussed previously) would be covered under HI, as in the King-Anderson bill.

The HI program, as modified by the Finance Committee, would be financed by a revised contribution schedule and by an earnings base of $6,600 for all years after 1965. Somewhat higher rates would be provided in the later years of operation than in the House bill, because of the increased cost involved in the benefit changes discussed previously.[4]

The provision for the coverage of railroad workers was changed so that, in essence, the maximum taxable wage base under RR would have to be equivalent to that under OASDI.[5] Otherwise, the HI program would not be administered in any way by the Railroad Retirement Board.

The SMI-benefit provisions of the Finance Committee bill differed from those of the House bill principally in the manner indicated in the previous discussion of the changes in the HI program. The SMI provisions were not changed significantly during the Senate floor debate, but the following important changes were made in the HI provisions:

4. The rates before 1971 would not be increased. The combined employer-employee rates after 1970 would be 0.1 percent higher than those in the House bill.

5. The RR base was then on a monthly basis, so its level was established at one twelfth of the OASDI base. This can, for persons with fluctuating high earnings, result in less tax liability in a year. However, under those circumstances, the RR Account would have to make up the difference to the HI Trust Fund.

TABLE 7.1. Combined Employer-Employee Hospital Insurance Tax Rates under Various Acts

	Combined Employer-Employee Tax Rate					
Period	*1965 Act*	*1967 Act*	*Mid-1972 Act*.*	*End-1972 Act**	*Law Prior to 1977 Act*	*1977 Act*
1966	0.7%	0.7%	0.7%	0.7%	0.7%	0.7%
1967	1.0	1.0	1.0	1.0	1.0	1.0
1968–72	1.0	1.2	1.2	1.2	1.2	1.2
1973	1.1	1.3	1.8	2.0	2.0	2.0
1974–75	1.1	1.3	1.8	2.0	1.8	1.8
1967–77	1.2	1.4	1.8	2.0	1.8	1.8
1978–80†	1.2	1.4	2.0	2.5	2.2	2.1§
1981–85†	1.4	1.6	2.0	2.7	2.7	2.6‖
1986 and after†	1.6	1.8	2.4‡	2.9	3.0	2.9

*The tax schedule in this act never went into effect, being superseded by the schedule in the amendments enacted later in 1972 and by the amendments enacted in 1973, which increased the earnings base from $12,000 to $13,200 (see the next-to-last column).

†For the 1965 and 1967 Acts, these periods are 1978–79, 1980–86, and 1987 and after respectively.

‡2.2 percent for 1986–92.

§But 2.0 percent for 1978.

‖But 2.7 percent for 1985.

1. No limit on the number of hospital days covered (but with coinsurance after 60 days).
2. No requirement of prior hospitalization for HH benefits.
3. Increased tax schedule to finance these changes. The combined employer-employee rates during 1973–86 would be 0.1 percent higher than those under the Finance Committee bill.

Action of the Conference Committee in 1965

The two versions of the bill contained health-benefit provisions that did not differ greatly, so it was relatively simple to obtain agreement. The Senate provisions for HI were followed, except as follows:

1. The maximum number of hospital days per spell of illness would be 90 (with daily coinsurance after 60 days).
2. Prior hospitalization would be required for the HH benefits.
3. The maximum number of HH visits would be 100 in a one-year period.

4. The services of medical specialists would not be covered (but rather would be under SMI).
5. The tax schedule of the House bill was adopted as being sufficient to support the benefit provisions, while the taxable earnings base of $6,600 in all future years in the Senate bill was adopted (see Table 7.1).

Both bodies readily accepted the bill as modified by the conference agreement. President Johnson signed the measure, which was one of the major triumphs in connection with his legislative goals for 1965.

Changes in Medicare since 1965

As might be expected with regard to legislation of the nature and complexity of Medicare, many changes in the original program have been proposed and discussed, and some have been enacted. These changes have occurred in both the HI and SMI provisions, and in the persons covered or eligible for Medicare benefits. Many of the changes were made during the Johnson administration, but they continued through the subsequent administrations.

Considerations and Actions during the Johnson Administration

President Johnson, as indicated, placed great emphasis on healthcare legislation. After the passage of Medicare, this emphasis did not subside, and many changes were proposed by his administration. Substantial revisions were proposed in 1967, and some of these were enacted.

Consideration of Medicare for the Disabled

In 1967, the administration proposed Medicare benefits for disability beneficiaries who were eligible for cash benefits—disabled workers (but not their eligible auxiliaries), disabled-child beneficiaries aged 18 or over (children of retired, disabled, and deceased insured workers), and disabled widows and widowers.

The additional cost to the HI program would be met by increasing the earnings base from $6,600 to $7,800 in 1968–70, $9,000 in 1971–73, and $10,800 in 1974 and after. The SMI benefits for the disabled would be financed by premium payments from the enrollees at the same rate as that paid by those aged 65 and over and by equal matching government contributions.

The bill written by the House Ways and Means Committee did not contain any provisions for extending Medicare to disabled beneficiaries. However, it provided for the establishment of an advisory council to be named by the Secretary of Health, Education, and Welfare to study this subject during 1968 (as did also the final legislation). The administration's proposal in 1967 to include disabled beneficiaries within Medicare was not accepted, primarily because of financing problems and uncertainties.

During the legislative considerations, data became available from a survey of OASDI disabled beneficiaries, and these showed that such persons have hospital and medical costs that are probably about 2½ to 3 times higher on a per capita basis than those of persons aged 65 and over. The use of these new data resulted in a significant increase in the estimated cost of both the HI and SMI benefits for disabled beneficiaries, which would have required a significant rise in the HI tax rates.

Each way that the increased cost of covering the disabled under SMI could be met within the premium-government contribution basis seemed to be unacceptable. If the costs were spread over all beneficiaries (the aged and the disabled), with equal government matching, then it would seem unfair for the aged to pay more than they would have paid if the disabled had not been covered.

If the disabled were charged a special higher premium rate that would be sufficient, together with an equal government contribution (just as for the aged), the rate would be so high that many would not believe themselves able to afford it. More important, because of the diversity of physical conditions among the disabled, the protection for many would not be worth the premium charged. Accordingly, many would not enroll, so that a vicious circle of antiselection and rapidly rising per capita costs would occur.

The only other solution would be to charge the disabled the same premium rates as the aged, but to have a much higher government contribution for the former than for the latter. This procedure would destroy the equal-matching principle (by a considerable amount) and so was unacceptable to the House Ways and Means Committee.

Changes Made by the 1967 Act

As a result, Medicare benefits for the disabled were not included in the 1967 legislation. Other benefit changes were, however, proposed by the administration, and some were adopted by Congress. Also, experience during 1966–67 had indicated that hospital costs had risen

much more rapidly since the enactment of Medicare than had originally been estimated. Accordingly, additional financing seemed necessary. The legislative developments in 1967 are described in Appendix 7-1.

During the Senate debate, Senator Montoya (Democrat) offered an amendment to include an out-of-hospital prescription-drug benefit in SMI. A $25 annual deductible would be applied to charges for drugs. Then, individuals would be reimbursed directly for excess charges, with the reimbursement amount based on the wholesale cost of the least expensive generic equivalent, plus a pharmacist's professional fee (and not on actual charges, unless lower). The latter provision would thus have the effect of producing some cost-sharing, because many purchases would not be on the basis described. The sponsor of the proposal estimated that its cost would be $1 per month (divided equally between the enrollee and the government), while the Social Security Administration estimated the cost at $3.20. The amendment was defeated by a relatively close vote.

The HI changes in the 1967 Act were as follows:

1. The outpatient diagnostic benefits were transferred to SMI.
2. Sixty lifetime-reserve days at daily cost-sharing equal to half the initial deductible were made available.
3. Tax rates for all years after 1967 were increased by 0.1 percent for each party (see Table 7.1).
4. The maximum taxable earnings base was increased from $6,600 to $7,800 (just as for OASDI).

Similarly, the 1967 Act changed the SMI provisions as follows:

1. The outpatient diagnostic benefits were transferred from HI.
2. The cost-sharing provisions with regard to hospital-based physicians for pathology and radiology services were eliminated (but legislation in 1982 restored them in all instances—after legislation in 1980 had done so for nonassignment cases).
3. Physical therapy services outside hospitals were covered on a much broader basis.
4. Enrollment periods are to be held annually (instead of biennially).
5. Enrollees may withdraw at any time (rather than only during a general enrollment period).
6. Premium periods are to be annual (instead of biennial), due to the rapid increases in medical costs that were occurring.

TABLE 7.2. Standard SMI Monthly Premium Rates in Various Periods

Period	*Rate*	*How Determined*
July 1966–December 1967	$ 3.00	1965 Act
January 1968–March 1968	3.00	1967 Act
April 1968–June 1969	4.00	Promulgated
July 1969–June 1970	4.00	Promulgated
July 1970–June 1971	5.30	Promulgated
July 1971–June 1972	5.60	Promulgated
July 1972–June 1973	5.80	Promulgated
July 1973–June 1974	6.30	Promulgated†
July 1974–June 1975	6.70	Promulgated
July 1975–June 1976	6.70*	Promulgated
July 1976–June 1977	7.20	Promulgated
July 1977–June 1978	7.70	Promulgated
July 1978–June 1979	8.20	Promulgated
July 1979–June 1980	8.70	Promulgated
July 1980–June 1981	9.60	Promulgated
July 1981–June 1982	11.00	Promulgated
July 1982–June 1983	12.20	Promulgated
July 1983–December 1983	12.20	1983 Act
January–December 1984	14.60	Promulgated
January–December 1985	15.50	Promulgated
January–December 1986	15.50	Promulgated
January–December 1987	17.90	Promulgated
January–December 1988	24.80	Promulgated
January–December 1989	27.90	Promulgated
January–December 1990	28.60	Promulgated
January–December 1991	29.90	1990 legislation
January–December 1992	31.80	1990 legislation
January–December 1993	36.60	1990 legislation
January–December 1994	41.10	1990 legislation
January–December 1995	46.10	1990 legislation

*The law did not permit an increase because the OASDI cash-benefit level for June 1975 (as known in December 1974) was the same as in June 1974. This resulted from a technical error in the law, as discussed later in this chapter. Legislation in 1975 corrected this error.

†Actually, because of action of the Price Commission, the rate was frozen at $5.80 for July 1973 and $6.10 for August 1973.

Under the initial legislation, the premium rate was established at $3 per month for July 1966 through December 1967 (see Table 7.2). The standard premium rate for persons enrolling in the earliest possible enrollment period was to be promulgated for the succeeding two-year period by the Secretary of Health, Education, and Welfare before October 1967. However, because the 1967 legislation was still pending in September, and there was no possibility of its final enactment then,

and because it contained significant changes in the program, a "quickie" bill was passed to make the promulgation applicable for April 1968 and thereafter (continuing the $3 rate until then).

Advisory Council on Health Insurance for the Disabled

At the end of 1968, the Advisory Council on Health Insurance for the Disabled made a number of sweeping recommendations. First, Medicare coverage would be made available not only to disability beneficiaries but also to insured workers who are disabled for at least three months. The waiting period for cash benefits would not be required, nor would the prognosis of the disability lasting for at least 12 months or until prior death. Furthermore, for persons aged 55 or over, the definition of disability would be more lenient—by requiring disability only such that the person is unable to engage in substantial gainful activity in his or her regular work, rather than for any substantial gainful employment. This would produce an administrative nightmare by having more liberal conditions for short-range Medicare benefits than for the long-range cash benefits.

Second, the council recommended combining HI and SMI for the disabled for financing purposes, with the cost being met half by equal employer-employee contributions (with the self-employed rate continuing to be equal to the employee rate) and half by a government subsidy.

Final Legislative Proposals of the Johnson Administration

Just before going out of office in January 1969, the Johnson administration made a number of sweeping recommendations for legislation to change the Medicare program. These proposals included: (1) extending HI and SMI coverage to disabled beneficiaries, with a liberalized basis of disability eligibility; (2) combining HI and SMI, so that both would be financed by payroll taxes, but with half the cost met by a government subsidy; and (3) including out-of-hospital drug benefits under HI for so-called maintenance drugs (important in the treatment of chronic diseases). No specific recommendations were made on how these expansions would be financed.

Considerations and Actions during the Nixon Administration

The changeover from the Johnson administration to the Nixon administration did not have a substantial impact on the flow of changes

in the Medicare program. The administration continued to recommend legislative changes, and Congress continued to amend the program.

Initial Legislative Proposals of the Nixon Administration

New actuarial cost estimates for HI were made in late 1968 and then again a year later. Each showed significantly higher costs than had previously been estimated. Accordingly, when the Nixon administration made Social Security recommendations in late 1969 (essentially to update the OASDI-benefit provisions), it also made provisions for meeting the financing problems of HI. This would be done in three ways. First, the ultimate combined employer-employee tax rate of 1.8 percent scheduled for 1987 and after (0.9 percent for self-employed persons) would be moved up to 1971 and held level thereafter. Second, the maximum taxable earnings base of $7,800 per year would be increased to $9,000. Third, for 1974 (and each year thereafter), the earnings base would be subject to automatic increase, depending upon changes in the level of earnings in covered employment.

No changes were proposed in the HI-benefit provisions. However, certain legislative changes were recommended in HI (applicable also to the Medicaid program) to achieve more effective cost controls. Such measures would include requirements for better planning of medical facilities and would permit better control of some serious abuses, particularly in the utilization of services.

Legislative Action in 1970–1972

Beginning in 1970, Congress gave thorough consideration to extensive legislation modifying OASDI and Medicare. An omnibus bill containing many important changes in Medicare failed to win enactment in 1970, because insufficient time remained in the session to reconcile the many differences between the House and Senate versions. The various Medicare provisions were carried over into the legislation considered in 1971–72 and enacted in late 1972 (H.R. 1 introduced by Chairman Mills).[6]

While the omnibus bill was being considered in 1971, a "quickie" bill increasing OASDI benefits helped, indirectly, to lessen the long-range financing problems of HI by increasing the earnings base to

6. Unlike what was done in 1965, the "magical" H.R. 1 was retained during the entire legislative procedure, so Chairman Mills could use this to advantage in his sponsorship of the bill.

$9,000 for 1972 and after. Another such "quickie" bill in mid-1972, in addition to increasing cash benefits, remedied the financing problems of HI (at least according to the current actuarial cost estimates) by increasing the earnings base to $10,800 for 1973 and $12,000 for 1974, with automatic adjustments thereafter based on changes in wage levels and by a new tax schedule (see Table 7.1). That schedule, however, never went into effect because it was superseded by the schedule in the omnibus bill enacted later in the year.

The initiative in developing the Medicare provisions in the legislation enacted in 1972 was largely taken by Congress, although the Nixon administration did not object to any of the changes. The administration, however, did propose that SMI should be financed by payroll taxes (as had the Johnson administration), thus indirectly increasing the level of cash benefits for persons aged 65 and over; under this proposal, there would have been no government contribution (whereas the Johnson administration proposal would have increased it over that applicable under SMI). Neither the House nor the Senate gave any support to this approach, and it was not included in any version of the legislation.

The legislation finally enacted in 1972 contained the following major provisions affecting both HI and SMI (with indication of whether the provision originated in the House or the Senate):

1. Coverage of disabled beneficiaries on the roll for at least two years (House).
2. Coverage of insured workers and auxiliaries with chronic kidney disease (Senate).
3. Antiduplication provisions with the Federal Employees Health Benefits program to be effective in 1975, unless that program is changed to be coordinated with Medicare (House); this was repealed later.
4. Extension of coverage to services rendered in Canada and Mexico under certain circumstances (Senate).
5. Special reimbursement provisions for health maintenance organizations (House).
6. Establishment of Professional Standards Review Organizations (Senate).
7. Several changes tightening cost controls and utilization (both bodies).

The 1972 legislation also made the following major changes affecting the HI program only (with indication of which body originated it):

1. Liberalized definition of skilled nursing facility (SNF) services (Senate).
2. Voluntary coverage for persons aged 65 or over, with the full cost to be paid by enrollees (House).
3. Revised tax schedule to meet the long-range imbalance for the previous program and to meet the cost for including the disabled—see Table 7.1 (both bodies).
4. Increase in OASDI-HI taxable earnings base and automatic adjustment thereof in the future in accordance with changes in the level of wages in covered employment (House).
5. Beneficiary relieved of liability when claim previously paid is disallowed if he or she is without fault (i.e., did not know that the services were not covered), and the provider of services was at fault. This will increase the direct cost of the program to some extent, but such higher cost should be more than offset by the closer scrutiny that utilization committees will give so that the liability does not then fall on the institution (Senate).

It is also important to consider the provisions that were adopted by one body but rejected in conference, because these often come up for consideration later. These are described in Appendix 7-2.

The final 1972 legislation contained the following major SMI-only changes (with indication of the originating body):

1. Initial deductible increased from $50 to $60 per year (House).
2. Coverage made automatic for persons newly eligible (if eligible for HI), with the option to elect out (House).
3. Elimination of limitation that persons must enroll within three years of first eligibility (House).
4. Certain chiropractor services covered (Senate).
5. Speech pathologist services covered (Senate).
6. Limited independent physical therapist services covered (House).
7. Coinsurance for HH benefits eliminated (Senate).
8. Premium-rate basis for persons aged 65 and over changed so that the annual increase in the rate cannot exceed the percentage rise in the cash-benefits level (House).
9. Railroad Retirement Board to collect premiums for all persons receiving RR benefits, even though they also receive OASDI benefits (House).
10. More restrictive basis for physician reimbursement—prevailing-charge screen at 75th percentile and adjusted in future by economic index, rather than actual prevailing charges (House).

11. More flexible reimbursement procedures for durable medical equipment to encourage purchase of used items (Senate).

Proposal for Catastrophic Medical Insurance

The Senate bill in the 1970 Social Security legislation which became deadlocked and died at the close of the session contained a provision for a payroll-tax-supported program of catastrophic medical insurance for insured workers and their dependents under age 65. This was sponsored by Chairman Russell B. Long of the Finance Committee. During subsequent periods, and especially in connection with discussions on National Health Insurance, he strongly urged this approach, but it was not debated and voted on in Congress until 1988, when the Medicare Catastrophic Coverage Act of 1988 was enacted (but repealed in 1989), as discussed later. This provision would apply as follows:

1. Hospital costs for days in excess of 60 per year per individual would be covered, with a daily cost-sharing amount equal to one fourth of the HI initial deductible.
2. Benefits would be paid for services covered by SMI after the family expenses in a year had exceeded $2,000, but with 20-percent coinsurance up to that point. The $2,000 limit would be adjusted in future years according to changes in physician-fee levels, based on that component of the CPI.
3. Carry-over deductible under both the medical- and hospital-benefits provisions would apply for expenses incurred or hospital days utilized but not reimbursed in the last calendar quarter of a year.
4. The cost would be met by additional payroll taxes on the earnings covered by OASDI and HI. The combined employer-employee tax rate would be 0.6 percent for the first three years, 0.7 percent for the next five years, and 0.8 percent thereafter, with the self-employed paying half of such rates.

1973 Legislative Proposals of the Nixon Administration

In early 1973, the Nixon administration proposed several changes in the cost-sharing provisions of the Medicare program for the purpose of reducing federal expenditures—and thus increasing individuals' expenditures (except in some long-duration hospital cases). Specifically, the HI cost-sharing would be changed to be an initial deductible of the first day's room-and-board charge in the particular

hospital and then 10-percent coinsurance on all other charges thereafter. Likewise, the SMI cost-sharing would be changed by increasing the initial deductible from $60 to $85 (which was the same, relative to changes in physician fees, as $50 had been in 1966) and increasing the coinsurance rate from 20 percent to 25 percent. These changes would have resulted in cost reductions of $1.3 billion in the first full year of operation.

Although these proposals were, in the author's view, quite reasonable and logical and would have made good sense if they had been adopted originally, they represented a significant deliberalization. Accordingly, they received virtually no support in Congress (in fact, no member would even introduce a bill containing them), and they seemed most unlikely to be adopted. In fact, the Senate added a "sense of the Congress" provision to a bill unrelated to Social Security to the effect that these recommendations of the President should be withdrawn; the provision, however, was deleted in the conference with the House.

The first legislative action taken in 1973 that affected Medicare was in the July amendments, which increased the maximum taxable earnings base for 1974 to $12,600. However, this was overridden by the December amendments, which further increased such base to $13,200 and also readjusted the tax schedule by lowering it in the early years and raising it in the later years (see Table 7.1). Appendix 7-3 describes certain Medicare changes that passed the Senate in 1973 but were not enacted; these may be indicative of future legislative activity.

In 1974, President Nixon proposed a sweeping revision of the Medicare program in conjunction with his proposals for National Health Insurance (see Chapter 9 for details of the general proposal). HI and SMI would be combined, but an enrollee premium would still be required. There would be an annual deductible of $100 per person and 20-percent coinsurance, with the maximum required cost-sharing being $500 per year per person (and $1,000 per family). However, both the deductible and the catastrophic cap would be lower for persons with low incomes.

1975 Legislative Proposals of the Ford Administration

In early 1975, President Ford made several legislative proposals with regard to Medicare. In part, these were made to reduce costs, because of the budgetary problems of the federal government, although they also improved the extent of catastrophic protection. These proposals were somewhat like those made by the Nixon administration in 1973.

Specifically, the cost-sharing provisions under both HI and SMI would be changed.

As to HI, the daily coinsurance for hospital days after the 60th one and for SNF days would be replaced by a straight 10-percent coinsurance on all charges over the initial deductible, but with no limit on the number of days of hospitalization and with maximum cost-sharing of $500 per year. The dollar amount would be adjusted in the future in accordance with changes in the level of OASDI benefits. Based on the 1975 cost-sharing provisions and on an average hospital charge of $100 per day, this proposal would result in higher costs to the beneficiary for stays of 77 days or less, and vice versa.

As for SMI, the deductible would be increased to $77 for 1977 and then from year to year in accordance with increases in OASDI benefits, which would, to a considerable degree, reflect changes in medical costs. (To some extent, this procedure is followed in the determination of the SMI premium rate as a result of the 1972 Act.) Also, a maximum of $250 would be established for the amount of cost-sharing which the beneficiary would be required to pay for any calendar year, with automatic adjustment in the future in accordance with changes in the level of OASDI benefits. With the $77 deductible, this maximum would be operative after recognized charges reach $942 for a year.

As with the proposal of the Nixon administration in 1973, there was considerable logic in this proposal, but its reception by Congress was quite negative. At some point, however, it seems possible that something like the catastrophic-cap portion might be adopted independently.

1975 Advisory Council

As mentioned in Chapter 3, the 1975 Advisory Council on Social Security had an extremely short time to accomplish its assignment.[7] As a result of the financing problems of OASDI, it devoted almost all of its work to that problem and practically none to Medicare. The council also stated that any recommendations that it might make as to the benefit structure of Medicare might soon be outdated by broader modifications of that program which would result if any of the current proposals for national health insurance were enacted.

The council made, indirectly, one important recommendation about

7. It was not appointed until April 1974 (whereas the law required appointment before the end of 1973), and it was supposed to submit its report by January 1, 1975 (but did not do so until March 6, 1975). See page 294.

HI (as described in Chapter 3)—namely, gradually changing its financing from payroll taxes to general revenues. Primarily, this was done to solve the financing problems of OASDI, although it was argued that this would be logical because HI benefits are not related to earnings, as are the HI taxes paid by covered workers. (But note that this runs counter to the arguments about the regressivity of Social Security taxes, because with uniform benefits and percentage-of-earnings taxes, there is much less regressivity than under OASDI, with its earnings-related benefits.)

As mentioned, several council members opposed this change and instead recommended that the financial problems of OASDI be solved by higher tax rates and that the financing of HI be accomplished as under present law by direct payroll taxes. President Ford, too, opposed this shift in the method of financing HI.

One member of the council, a representative from the National Council of Senior Citizens, also opposed the eventual complete financing of HI from general revenues. He took the position that this would destroy the "earned rights" nature of the program. However, he did think that a government subsidy to finance one third of the cost of the program would be desirable.

When dealing with the financing of HI, the council neglected to mention whether its OASDI recommendation that the self-employed should have a tax rate equal to 1½ times the employee rate should also apply to HI, at least as long as the payroll tax was used thereunder.

The council stated its finding that the long-range financing of the HI system and the short-range financing of the SMI system were in an actuarially sound position. The one member of the council who was an actuary dissented with this view for HI on the ground that the council had not investigated this matter sufficiently to make such an unequivocal statement.

Developments in 1975–1980

Relatively little legislative action affecting the Medicare program occurred in 1975–79. Perhaps this was due to the belief by many that national health insurance (NHI) legislation would be shortly forthcoming.

A number of bills dealing with relatively minor aspects of benefit protection were enacted. These included the Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1977 (which tightened up many aspects in this area) and a June 1978 law that related essentially to only the ESRD benefits (providing more incentives for self-dialysis

and having transplants[8] and more cost-effective reimbursement methods with respect to providers).[9]

The 1977 Act dealt with Medicare in only one significant way. As discussed in Chapter 6, the HI tax rates for all future years were reduced slightly to recognize the additional financing that would be derived from the ad hoc increases in the maximum taxable earnings base in 1979–81. The intention was that there should be little net effect on the long-range financial status of HI.

President Carter did not make any specific recommendations for changes in the Medicare program other than urging legislation for hospital cost containment. This would allow the federal government to impose limits on annual increases in each hospital's revenues. Congress did not act on such proposal.

In late 1978 the House passed legislation that would have made some significant changes in the Medicare program, but the Senate did not consider it before the adjournment of Congress. The following are the most important changes included:

1. The limit on the number of HH visits under both HI and SMI would be eliminated, and HH visits would not be subject to a three-day prior-hospitalization requirement under HI and to the $60 deductible under SMI.
2. Disability beneficiaries who recovered but then had a relapse would not be required to serve a new 24-month waiting period for eligibility for Medicare protection.
3. Reciprocal agreements with other countries would be authorized in the Medicare field, so that beneficiaries living or traveling abroad would have hospital- and medical-benefit protection.
4. Services of dentists would be covered under SMI if the same service would be covered if performed by a physician. Also, hospital stays involving major dental procedures (even though not covered under SMI) would be covered under HI.
5. The increase in the SMI premium rate on account of late enrollment would be limited to a maximum of 30 percent, and enrollees who terminated coverage would also be permitted to reenroll

8. This was done by eliminating the three-month waiting period when self-dialysis occurs, by extending the coverage period after transplant from 12 to 36 months, by covering the expenses of the donor of a kidney, and by eliminating the second waiting period for cases where the transplant failed.

9. Certain minor changes were also included—the provision of coverage by physician assistants and nurse practitioners in rural health clinics and coverage for services at Indian Health Service facilities.

no matter how many times they terminated (instead of being allowed to do so only once).

The 1979 Advisory Council on Social Security did not have sufficient time to consider the Medicare program adequately (and, on this account, recommended that a separate advisory council should be established solely for this purpose). To hold down payroll taxes, the advisory council recommended that, in the future, HI should be entirely financed from general revenues, half through earmarked personal income taxes (on income up to the OASDI earnings base) and the remainder through corporation income taxes. The advisory council did not state what would then happen as to the persons to be protected by HI; presumably, all those aged 65 and over in the country would be included, but it is not clear what would be done about disabled persons.

Several laws that were enacted in 1980 dealing primarily with subjects other than Medicare contained provisions affecting HI and SMI. The following were the most important of the changes:

1. HI-benefit protection was made available for DI beneficiaries for 36 months after termination of cash benefits because of substantial gainful activity, although not medically recovered. Also, no second 24-month waiting period for Medicare benefits is applicable to those who recover from disability but then relapse.
2. The 100-visit maximum for home health services under both HI and SMI was eliminated, as was the requirement of prior hospitalization for at least three days under HI. The $60 initial deductible under SMI no longer applied to HH benefits.
3. Application for HI-benefit coverage can be made without also applying for OASDI benefits.
4. SMI enrollment can occur at any time during the year, rather than in a single three-month general enrollment period during a calendar year (legislation in 1981 returned this provision to the original basis). Persons who drop out of SMI can reenter as many times as they wish (formerly, only one reentry was permitted).
5. Independent physical therapy services can be reimbursed up to a maximum of $500 of reasonable charges in a year (instead of $100).
6. Medicare is the secondary payor when automobile or other liability insurance is liable.
7. SNF benefits are available if the transfer from the hospital took place within 30 days (formerly, 14 days).

Recommendations of the National Commission on Social Security

The National Commission on Social Security, which reported early in 1981, made a number of significant recommendations about the Medicare program. The most significant was that HI should, beginning in 1983, be financed to the extent of half its cost coming from general revenues. As a result, the HI payroll-tax rates could be reduced (and, in fact, transferred to bolster the financing of OASDI—see Chapter 3). This recommendation was adopted by a vote of only 5 to 4.

At the same time, the long-range financing of HI was revised so that it would be adequately financed according to the best actuarial cost estimates available. The combined employer-employee rate would be decreased from the presently scheduled 2.6 percent in 1983–84 to 1.3 percent and would then rise to 1.35 percent in 1985, 1.45 percent in 1986, and gradually thereafter to 2.6 percent in 2000 and eventually to 4.15 percent in 2035. The total cost of the program, including the government subsidy, would, of course, be twice these amounts.

To help meet the cost of the general revenues to be provided in the financing of HI, a special 2½-percent surcharge would be added to personal income taxes. This would represent approximately half the general revenues needed, and could be considered as replacing the reduction in the employee HI tax rate. It should be noted that the proceeds from this surcharge would *not* go directly into the HI Trust Fund.

HI coverage would be extended on a mandatory basis, beginning in 1982, to all federal, state, and local government employees and to all employees of nonprofit organizations.

Just as in the case of OASDI, it was recommended that the operations of the HI and SMI Trust Funds should be removed from the unified budget and that interfund borrowing and loans from the General Fund of the Treasury should be applicable to the HI Trust Fund. The recommendation for an independent agency to administer OASDI would also apply to the Medicare program.

The commission also made a number of recommendations for changes in the benefit structure of Medicare, as follows:

1. A catastrophic cap would be provided, such that all out-of-pocket expenses for HI and SMI cost-sharing payments above this amount would be met by Medicare. The cap would be $2,000 for 1982 and would be indexed thereafter by changes in the CPI.
2. The waiting period for disabled beneficiaries before Medicare protection is available would be reduced from 24 months on the roll to 12 months.

3. The age of eligibility for Medicare benefits would be increased from 65 to 68, in the same manner as for OASDI benefits (see Chapter 3).
4. Hospital benefits under HI would be on a calendar-year basis instead of a spell-of-illness basis.
5. Daily cost-sharing amounts for hospital benefits under HI would be changed to 10 percent of the initial deductible for the 51st to 100th days and to 5 percent thereof for the next 50 days (and the lifetime-reserve days would be eliminated).
6. Home health visits would be covered only under SMI (except for those persons under HI but not under SMI).
7. The dollar maximum on outpatient psychiatric services would be updated.
8. Hospital benefits under HI would be payable for hospitalization abroad—at a maximum allowable daily rate equal to 50 percent of the initial deductible.

Legislative Developments in 1980–1984

The Omnibus Budget Reconciliation Act of 1981 made several changes in the Medicare program, as a by-product of efforts to reduce the national budget deficit (because both OASDI and Medicare are included in the unified budget). This "budgetary" procedure also occurred in most subsequent years. In the author's opinion, this is not a desirable way to deal with Social Security legislation, because the changes made are primarily for short-time budget reasons and not for long-range policy reasons—and often are made hurriedly as a small portion of the omnibus bill, without being well thought out.[10] Among the changes made were an ad hoc increase in the HI initial deductible and the related coinsurance provisions, an increase in the SMI annual deductible,[11] the making of Medicare secondary to liability insurance policies (primarily automobile), the making of Medicare secondary to group health insurance during the first year for ESRD

10. Two clear examples of this were the making of Medicare secondary to private group health insurance for active workers aged 65–69 (and for their wives aged 65–69), which involves several anomalies, and rounding OASDI benefits down to the nearest full dime (instead of up) at each step of the benefit computations and then finally down to the next even dollar (which procedure could not be implemented nearly as soon as the law provided).

11. An outstanding example of the weakness of the "budgetary" process of legislating Social Security changes was present in this legislation. One house increased the SMI annual deductible from the existing $60 to $70, with annual automatic-adjustment increases based on the CPI for medical costs. The other house raised the deductible to a static $75. The latter was adopted on the illogical ground that it saved more money immediately (although obviously less over the long run).

cases, and the tightening up of reimbursement provisions relating to providers of services.

Many private health insurance policies contain "carry-over deductible" provisions. These are provided from an equity viewpoint, so as to give fair treatment to persons who had relatively small expenses in most of a year but who had an illness that began toward the close of that year. Before the aforementioned legislation in 1981 eliminated the provision, SMI also did this. The deductible for a particular calendar year was reduced by any expenses incurred in the last three months of the preceding year that were applied toward the deductible then. This change was made both to reduce benefit costs and to simplify administrative procedures.

As an example of how this carry-over provision worked, consider Mr. G who had no SMI medical expenses in the first nine months of 1978 but who then had a serious illness with medical expenses running well beyond $60 in the last three months of the year. Not only would Mr. G have benefits for 1978 of 80 percent of the recognized charges in excess of $60, but also his $60 deductible for 1979 would already be satisfied.[12]

The Tax Equity and Fiscal Responsibility Act of 1982 made several changes in the Medicare program (in addition to dealing with many other programs). This was done through the budget process, rather than the traditional deliberate legislative process (as was the case for the Social Security Amendments of 1983—the 1983 Act). Among these were the following:

1. Compulsory coverage for HI purposes only (not OASDI) of all federal employees, beginning in 1983, including the President, the Vice President, members of Congress, and federal judges,[13] with a transitional provision for those who would retire in the near future before having acquired sufficient QC to become fully insured.
2. Elimination of the three-day prior-hospitalization requirement for SNF benefits if the Secretary of HHS believes that this would reduce costs (never put into effect).

12. As another, more complicated example, assume that Mrs. H had $40 of recognized charges under SMI in January–September 1978 and then another $100 of such charges in October–December. Her SMI benefits for 1978 would be $64 (80 percent of $140, minus $60). The SMI deductible for 1979 would be $40 (the regular $60, minus the amount of the 1978 deductible which was satisfied in the last three months of 1978).

13. Before 1983, temporary civilian employees and members of the armed forces were covered for both OASDI and HI. Beginning in 1984, as a result of the 1983 Act, all new federal civilian hires are covered for both OASDI and HI.

3. Hospice benefits provided—to be effective only in November 1983 to September 1986.
4. Medicare benefits made secondary to group health insurance plans for active workers aged 65–69 (and spouses aged 65–69 of such workers).
5. Setting the standard SMI premium rate at 50 percent of the adequate actuarial rate for July 1983 through June 1985 (as discussed in more detail in Chapter 8); legislation in 1983 changed this to apply to the new calendar-year premium-rate basis for 1984 and 1985, and various subsequent legislation extended this through 1990.
6. Continuation of Medicare benefit protection for persons who appealed disability-benefit termination through the administrative-law-judge stage (if appeal was lost, benefits paid were overpayments).
7. Elimination of the Professional Standards Review Organization program and substitution of the Peer Review Organization program.
8. Several changes that tightened up or restricted reimbursements to providers.

The National Commission on Social Security Reform in 1982–83 decided not to make recommendations about the financing problems of the HI program. It did, however, recognize that HI would very likely have significant problems in the early part of the 1990s (and continuing thereafter)—and possibly even in the late 1980s.

Such action was taken because the OASDI financing problem was of much more immediate urgency and because the statutory Advisory Council on Social Security (which was named in late 1982 and would report in 1983) had been assigned the responsibility for studying the Medicare program. Further, the Medicare program was not specifically within the scope of its assignment.

Some members of the National Commission were concerned about the estimates of large future financing shortfalls under HI. The first major concern was the possibility that any excess of income over outgo of the OASDI Trust Funds occurring during 1990–2010 could be endangered by the sizable additional financing needed by the HI Trust Fund then. The second major concern was that, by ignoring the cost of the HI program, the potential tax burden of the entire Social Security program might not be properly assessed when making reforms in the OASDI portion of the program. Some members believed that the problem of financing the HI program was not simply a matter of providing the funds to meet the costs projected on the basis of

past experience, but rather that first the matter of slowing down the rate of increase in hospital costs generally should be addressed.

The Social Security Amendments of 1983, whose major purpose was to solve the financing problems of OASDI, also included the DRG method of reimbursing hospitals under HI. Also, this law changed the premium-rate period under the SMI and voluntary HI programs, so as to have it conform with the COLA dates under OASDI. Further, provisions were added to permit interfund borrowing from the HI Trust Fund by the OASDI Trust Funds, to require repayment of loans under certain circumstances, to require reporting when the HI and SMI Trust Funds become too low (along with recommendations for remedying the situation), and to provide an immediate lump-sum payment to the HI Trust Fund from the General Fund for the gratuitous military-service wage credits for service rendered in the past and not yet reimbursed. Also, see Appendix 7-4.

The Deficit Reduction Act of 1984 made a number of relatively small changes in the Medicare program, as follows:

1. The standard SMI premium rate is set so as to meet 25 percent of the program's cost for the aged for 1986–87 (just as in 1984–85), except that any increase will not exceed the increase in the individual's OASDI benefit.
2. Medicare is secondary to group health insurance for spouses aged 65–69 for workers under age 65.
3. Outpatient diagnostic laboratory tests by independent laboratories and hospitals are on an assigned basis in all cases, with no cost-sharing by the beneficiary (and at significantly reduced recognized charges than previously). The same procedure is applied for physicians who perform such tests if they accept assignments (otherwise the usual Medicare reimbursement and cost-sharing procedures apply).
4. SMI benefits are payable for the administration of hepatitis B vaccine to high- and intermediate-risk individuals and for blood-clotting factors and necessary supplies for hemophilia cases.

1984 Advisory Council

The 1984 Advisory Council on Social Security, which was supposed to have been appointed in 1981 and to have completed its work in 1982, was not named until mid-1983, and it reported in early 1984. As a complete reversal of the course of action of the preceding two statutory advisory councils (which were supposed to study *both* OASDI and Medicare), this one studied only the Medicare program. In large

part, this was because the National Commission on Social Security Reform was dealing with the OASDI program.

Considering the coming financing problem of the HI program (estimated to occur in about five to eight years), and the general prevailing demand for budgetary reductions, it is surprising that, in the aggregate, the recommendations of the advisory council represented an *expansion* of the Medicare program. Specifically, it made the following findings and recommendations:

1. HI will have a cumulative deficit of $200–300 billion by 1995 (although the actuarial cost estimates which were made in 1985 indicate that this deficit would likely be no more than $235 billion).
2. General revenues should not be used to finance HI.
3. HI and OASDI should continue to be independent of each other, any interfund loans should be strictly limited, and repayments should be on a scheduled basis.
4. Reallocation of the OASDI-HI tax rate, by giving more to HI, should be done when needed to finance HI, if the OASDI Trust Funds are at a sufficiently high level.
5. The proposal of the Reagan administration to subject to personal income taxation any employer contribution to private health insurance in excess of $70 a month for individuals and $175 a month for families should be adopted. A portion of the incremental taxes should go to the HI Trust Fund (not the primary consideration in making this recommendation).
6. Excise taxes on alcohol and tobacco products should be increased (in an unspecified manner), and the proceeds should go to the HI Trust Fund.
7. The minimum age for eligibility for Medicare (other than for the long-term disabled beneficiaries) should be immediately gradually increased so that it would be 67 in 1990. Thereafter, it should be increased in accordance with increases in life expectancy (presumably, at birth—although this was not directly specified).
8. Medicare should not be extended to new categories of persons (such as young survivors or early retirees under OASDI) or to new special disease categories (as is the case for ESRD).
9. HI should provide unlimited days of inpatient hospital care, with the current initial deductible (but to be payable no more than twice in a calendar year) and daily cost-sharing of 3 percent of the initial deductible, but with the latter being elimi-

nated for those who also have SMI coverage (the current daily cost-sharing for SNF benefits would also be eliminated).

10. The SMI initial deductible ($75) should be indexed for changes in the CPI.
11. The SMI premium rate should be increased to recognize the additional HI benefits made available for SMI enrollees (see item 9) and to provide additional revenues to the HI Trust Fund to assist in alleviating its financial problem. The actuarial rate (representing half of the cost of the program and of which the enrollee premium rate is currently one half—i.e., 25 percent of the cost of the program) for 1985 was estimated at $56.50. Thus, the enrollee premium rate would be about $14.10, but to this would be added a surcharge of $3.50 to be diverted to the HI Trust Fund to help to alleviate its financing problem.
12. A so-called enhanced SMI plan should be made available to supplement the regular SMI plan (including the accompanying additional HI benefits therein). The entire cost would be borne by the enrollee and was estimated at $12.50 per month for 1985 (if a substantial majority of the enrollees elect this option, so as to prevent the antiselection which would occur if only a relatively small proportion participated in this option). The benefit provided would be of a catastrophic-cap nature—out-of-pocket expenses of the enrollees for the initial deductible and 20-percent coinsurance would be limited to $227 in 1985. This cap would be adjusted in future years in accordance with changes in per capita SMI expenses. (No explanation is given as to the basis for the $227 figure: it represents the $75 deductible and 20-percent coinsurance on $760 of recognized charges in excess of $75.)
13. A voluntary-voucher system should be established, such that beneficiaries could use the available money to purchase an alternative health-care benefits package in lieu of Medicare benefits. The council believed that this would have the advantages of providing flexibility of choice and competition within the health industry (which, in turn, would promote the development of more efficient ways of delivering services).
14. Several changes in reimbursement-to-providers provisions should be made, such as Medicare not underwriting the cost of training medical personnel and such as requiring physicians to accept assignments either in all cases or not at all.
15. The council opposed any effort to have a means test apply to Medicare benefits.

The author believes that these recommendations, although having many good points, were subject to serious criticism. For those who elect the enhanced SMI benefits, "free" hospitalization without limit would be available after the payment of the initial deductible. This would eliminate the cost-sharing element of cost control and seems a strange thing to recommend for a program with an impending cost crisis in about five years. On the other side of the coin, the increase in the SMI premium rate from a level of about $15 per month to $32 (including an anomalous surcharge of $3.50 to help alleviate the financing problems of HI) is a very sharp increase indeed, and was criticized severely by many. Further, the recommendations as to benefits and financing were not sufficiently precise (e.g., as to how much enrollee premiums would be), and no cost estimates were given to indicate whether the financing problem was solved or to what extent it might still exist. Finally, the recommendation for not using general revenues to finance HI was violated by the recommendation to increase excise taxes on alcohol and tobacco products and to put the proceeds into the HI Trust Fund.

Medicare Catastrophic Coverage Act of 1988

Following the recommendations of the 1984 Advisory Council that catastrophic benefit provisions should be added to the Medicare program, in late 1986 the Reagan administration proposed the following changes:

1. A catastrophic cap on out-of-pocket costs under HI and SMI in excess of $2,000 (indexed in the future) should be established—that is, the beneficiary would not be liable for any cost-sharing amounts which would otherwise have been payable.
2. The SMI premium would be increased initially by $4.92 per month in order to meet the full cost of such new benefit protection.

In addition to the catastrophic benefits under Medicare, the proposal addressed the long-term care problem and gave certain alternatives. One option would be to authorize Individual Medical Accounts for this purpose, which would accumulate with tax-free interest if ultimately used for this purpose. Another alternative would be to provide 50-percent refundable tax credits for premiums for long-term care insurance (up to a maximum of $1,000 per year), which would also receive the same favorable treatment as does life insurance; also,

barriers to prefunding of long-term care benefits provided under employer plans would be removed.

As to the general population, the proposal urged states to require employer plans to offer catastrophic-benefits coverage as an option. Also, states would be encouraged to establish catastrophic "risk pools" for persons whose medical condition makes it difficult or expensive to obtain such coverage. Further, self-employed persons would be given income-tax deductions for health insurance premiums for policies containing catastrophic-benefits provisions.

Not unsurprisingly, the Democratically controlled Congress took the catastrophic-benefits proposal of the "conservative" Republican administration and expanded it significantly. The House and Senate versions, which were passed in 1987, differed considerably, and it took many months until a compromise bill that would be acceptable to both bodies (and to the Reagan administration) could be hammered out.

The final legislation, enacted on July 1, 1988, contained the following provisions:

A. HI Benefits (effective in 1989)
   1. Unlimited days of hospitalization, with only one deductible per year.
   2. 150 days of Skilled Nursing Facility benefits, with daily coinsurance of 20% of average daily SNF recognized costs ($25.50 in 1989) for first 8 days per year (as against daily coinsurance of ⅛ of hospital initial deductible—$67.50 in 1988—for 21st to 100th day in a spell of illness).
   3. Liberalization of definition of "intermittent" in connection with Home Health benefits—so as to define up to 38 days of consecutive care as "intermittent" (instead of, by regulation, no more than 5 days of care per week for 3 consecutive weeks).
   4. Hospice benefits payable beyond previous 210-day limit if recertified as terminally ill.
   5. Blood deductible limited to 3 pints per year (including any under SMI), instead of per spell of illness (and independent of SMI).

B. SMI Benefits (effective in 1990)
   1. Catastrophic cap of $1,370 (adjusted in future years) on out-of-pocket expenses for SMI deductibles and coinsurance (except for coinsurance for respite-care benefits for chronically dependent persons).

2. Mammography screening (varying by age).
3. Respite-care benefits for caretaker of chronically dependent person are provided if either catastrophic cap or drug deductible (see item C) is met.
4. Services and supplies in connection with home intravenous drug therapy.

C. Catastrophic Drug Insurance Benefits (fully effective in 1991)
1. Very limited coverage of prescription drugs taken at home in 1990; full coverage (including also insulin) in 1991.
2. Deductible of $550 in 1990, $600 in 1991, and $652 in 1992 (adjusted in future years).
3. Coinsurance of 50 percent in 1990–91, 40 percent in 1992, and 20 percent in 1993 and after (lower coinsurance in all years for home intravenous drugs).
4. Separate trust fund established for CDI benefits.

D. Financing (effective in 1989)
1. Supplemental Premium (compulsory tax) payable by all persons eligible for HI on an earnings record (whether or not having filed for benefit protection) who are so eligible for more than 6 months in the year and who have a federal income-tax liability of at least $150. The rate is 15 percent of income-tax liability in 1989, rising to 28 percent in 1993 (and may be adjusted upward in future years). The maximum per capita premium is generally $800 in 1989, rising to $1,050 in 1993 (and may be adjusted upward in future years). The premium income is allocated among HI, SMI, and CDI Trust Funds to meet approximately 63 percent of the cost of the new catastrophic benefits.
2. Additional Flat Monthly Premium payable by all persons who elect SMI-CDI. The rate—as an addition to that for pre-1988 law benefits—is $4.00 in 1989, rising to $10.20 in 1993 (adjusted in future years). Different rates for persons covered under SMI-CDI but not HI, and for persons in U.S. territories. The premium income is allocated between the SMI and CDI Trust Funds to meet approximately 37% of the cost of the new catastrophic benefits.

E. Maintenance of Effort by Private Health-Benefits Plans
Postretirement health-benefits plans must provide either additional benefits or cash payments if their benefits duplicate 50% or more of the catastrophic benefits under HI (generally, for 1989 only) and under SMI (generally, for 1990 only).

F. Medicaid Buy-In of Premiums and Cost-Sharing Payments for Low-Income Persons under Medicare

State Medicaid programs would be required, on a phased-in basis, to pay the Medicare monthly premiums, the deductibles, and the coinsurance for Medicare eligibles with incomes below the federal poverty level and with resources of no more than twice the standard under the Supplemental Security Income program. For all but five states, the "100% of poverty" standard would be effective in 1992 (85% in 1989, 90% in 1990, and 95% in 1991); for the five other states, the phasing in begins at 80% and is fully effective in 1993.

G. New Method for Determining Voluntary HI Premium Rate
The voluntary HI premium rate is to be 1/12 of the estimated actuarial value of the benefits and associated administrative expenses for the pertinent year for all persons aged 65 or over who are covered by HI (and not merely for those covered by the voluntary HI program), effective for the 1989 rate.

Immediately after the Medicare Catastrophic Coverage Act (MCCA) legislation was enacted, a storm of protest arose. The principal complaint was about the Supplemental Premium, which would be paid by high-income persons. The amount involved often would be far in excess of the value of the additional benefit protection that would be available (only about $60 in 1989, versus a premium of as much as $800 in many cases). The situation was even further exacerbated for persons in this category who had good postretirement health-benefits coverage from an employer plan and thus had little (or no) net additional coverage.

The situation was really not as unfair as it, at first glance, appears to be. All aged enrollees in SMI in 1989 received, on the average, a tax-free grant from the General Fund of the Treasury amounting to $1,004 (12 times its monthly per capita cost of $83.70—see Table 8.3). Thus, the payment of $800 as the Supplemental Premium merely reduced—but did not eliminate—the government tax-free subsidy to high-income persons under SMI. Of course, it is only natural that persons receiving a subsidy or windfall will object when it is reduced or taken away and will argue strenuously for the former status quo.

The very vocal opposition was essentially from high-income persons and from organizations that represented them, such as associations of retired federal employees and military personnel. The National Committee to Preserve Social Security and Medicare (founded by James Roosevelt) found this to be a good issue to demonstrate its concern for senior citizens and strongly opposed the legislation, urging its repeal. The American Association of Retired Persons, although not liking some of the financing features, did support MCCA and

opposed its repeal—as did also the National Council of Senior Citizens (sponsored by the AFL-CIO).

The congressional supporters of MCCA sought to develop compromises that would salvage portions of the plan, but to no avail. After a lengthy legislative battle, the entire plan was repealed by lopsided margins, in legislation enacted on December 13, 1989, except for the provisions relating to the coordination of blood deductibles under HI and SMI, the new method of determining the voluntary-HI premium rate, and the Medicaid buy-in of premiums and cost-sharing payments under Medicare. Of course, the HI provisions of MCCA that were effective in 1989 and the provision as to maintenance of effort by private health-benefits plans that was applicable to 1989 were operative for that year, but were repealed thereafter (but with certain transitional arrangements).

As will be pointed out later, the hospice and mammography-screening provisions of MCCA were reenacted by legislation dealing with the budget situation that was enacted in late 1990. Also, the additional flat monthly SMI premium of $4 for 1989 under MCCA (for which *no* additional benefits were paid) was in effect then, and the proceeds therefrom were left in the SMI Trust Fund; this premium was, of course, eliminated after 1989.

Legislative Developments after 1984 Other Than MCCA

The several budget-deficit-reduction laws that were enacted after 1984 involved significant changes in the Medicare program. Most of these were reductions in Medicare outlays—especially as to reimbursement procedures for providers of services—but some minor benefit liberalizations also occurred. The following description of these laws will deal only with changes that affect beneficiaries directly and not with the many, frequent changes that reduced reimbursement amounts for providers of services.

The Balanced Budget and Emergency Deficit Control Act of 1985 (commonly referred to as the Gramm-Rudman-Hollings Act, or GRH) permitted reduction of reimbursement to providers of service under both HI and SMI if a sequestration order is required because the budget-reduction target is not met. The same would also apply to SMI benefits. (In actuality, this has occurred several times; for example, SMI benefits for services rendered during October 17, 1989, through March 30, 1990, were reduced by 2.092 percent.)

The Consolidated Omnibus Budget Reconciliation Act of 1985 (enacted in April 1986) made the following changes:

1. The hospice-benefits provision was made permanent.
2. HI coverage is compulsory for all state and local government employees hired after March 1986.
3. The secondary-payor provisions for both HI and SMI are extended, so as to cover all workers aged 65 or over and all spouses aged 65 or over of workers of any age.
4. The extra charge in the voluntary HI premiums for delayed enrollment is limited to 10 percent (beginning for July 1986) and is payable for only twice the period of nonenrollment (instead of having no maximum and being payable for life).

The Omnibus Budget Reconciliation Act of 1986 made the following changes:

1. The HI initial deductible for 1987 was set at $520 (overriding the $572 that had been promulgated under the automatic-adjustment provisions). Future increases in the deductible are to be based on the relative change in the hospital-cost "market-basket" index for the 12-month period ending with September of the year in which the promulgation is made (for the next year) as compared with that for the preceding 12-month period, with adjustment to reflect changes in "real" case mix. Formerly, the adjustment was based on the average per diem cost rate for inpatient hospital services for HI insured persons.
2. The secondary-payor provisions for both HI and SMI were extended, so as to apply to all DI beneficiaries (under the Normal Retirement Age) who are covered under an employer health-benefits plan (of employers with at least 100 employees) as an "active individual" or as a family member of an active employee—to be effective only in 1987–91.
3. Vision-care services provided by an optometrist are covered by SMI if such services would be covered by SMI if performed by a physician (and the optometrist is legally authorized to perform them).
4. Up to $500 of services (per year) of occupational therapists are covered under SMI.
5. SMI carriers are required to pay at least 95 percent of all "clean" claims within 24 days after receipt (17 days for participating physicians).

The Omnibus Budget Reconciliation Act of 1987 made the following changes:

1. Employers are required to pay HI taxes on employee tip income, effective after 1987.
2. Individuals who reestablish entitlement to DI benefits are immediately covered without a further waiting period for HI and SMI, regardless of how long they were off the benefit rolls if their current impairment is the same as (or directly related to) that in their previous period of disability.
3. SMI carriers may *not* make benefit payments before 10 days have elapsed since receipt of claim in July–September 1988, and not before 14 elapsed days in October 1988 through September 1989 (similarly so for HI)—but note item 5 in OBRA of 1986.
4. Physician services provided in ambulatory surgical centers or hospital outpatient departments that take assignment are subject to the SMI cost-sharing provisions (formerly, this was not so).
5. The maximum annual SMI payment for mental-health care services is increased from $250 to $450 for 1988 and to $1,100 thereafter.

The Omnibus Budget Reconciliation Act of 1989 made the following changes:

1. The basis of reimbursement of physician services is changed to the Resource-Based Relative Value Scale method, effective after 1991.
2. The dollar maximum on the annual SMI payment for out-of-hospital mental-health care services is eliminated, effective after 1989.
3. The 50-percent coinsurance on out-of-hospital mental-health care benefits is reduced to 20 percent if provided on a hospital outpatient basis if, in the absence thereof, hospitalization would have been required.
4. Physicians who do not take assignments are required to submit SMI claims for their patients, effective after August 1990.
5. Nonparticipating physicians (those who do not *always* take assignments and whose recognized charges are only 95 percent of those of participating physicians) may not charge the patient more than 125 percent of the recognized charge in 1991 (but 140 percent for "evaluation and management" services, which are essentially for primary care—such as office visits, but not surgery), 120 percent in 1992, and 115 percent thereafter.

The Omnibus Budget Reconciliation Act of 1990 made the following changes:

1. The liberalization of the hospice-benefits provision under HI made by the MCCA, which was repealed, was reenacted.
2. The liberalized mammography-screening benefits under SMI provided under the MCCA, which were repealed, were reenacted (in slightly different form).
3. HI and SMI are the secondary payor, as against private group health insurance, for the 18-month period beginning with the month when first eligible for Medicare ESRD benefits—as against approximately a 9-month period previously.
4. The HI-SMI secondary-payor provisions with respect to DI beneficiaries (which were to expire at the end of 1991) are extended through September 1995.
5. SMI premium rates for each year in 1991–95 are established in the law (instead of being promulgated annually by the Secretary of HHS).
6. Injectable osteoporosis drugs are considered as a covered expense under SMI, effective only in 1991–95.
7. The SMI annual deductible is $100, effective after 1990.
8. The maximum taxable earnings base for HI for 1991 was set at $125,000 (rather than permitting it to be established by the automatic-adjustment provisions that are otherwise applicable to both OASDI and HI, which produced $53,400 for OASDI), with automatic adjustment thereafter.
9. State and local government employees who are not under a retirement system are compulsorily covered by both OASDI and HI, effective beginning July 2, 1991.

1991 Advisory Council

The 1991 Advisory Council on Social Security appointed a Health Technical Panel, whose assignment was to review the assumptions and methodology used in the preparation of the actuarial cost estimates for the Medicare program. The Panel also considered the measures which are used to determine the actuarial status of the program.

The Panel concluded that "The projection work is highly competent" and "Given the limitations of available data, no better models are available." The Panel also recommended that changes should be made in the measures of short-range and long-range actuarial balance for the HI program, so that they would be similar to those used for OASDI (see page 404). These recommendations are presented in Appendix G, and the following discussion shows how they were implemented in the 1991 Trustees Report.

The 1991 Trustees Report adopted the present-value method of

measuring the long-range actuarial balance of the HI program, although the results under the former "modified average-cost" method were also shown. The lack of actuarial balance over the 75-year valuation period is 3.35 percent of taxable payroll under the intermediate estimate (3.79 percent under the former method) and 0.81 percent and 8.03 percent, respectively, under the low-cost and high-cost assumptions. The lack of balance under the intermediate-cost estimate in the 1991 report is 0.09 percent higher than in the 1990 report, due to counterbalancing elements (the same ones that affected OASDI—see pages 439–46—and also the ad hoc increase in the maximum taxable earnings to $125,000 in 1991, as a result of OBRA of 1990, and more conservative assumptions as to hospitalization experience).

The HI Trust Fund is estimated to be exhausted in 2005 under the intermediate assumptions of the 1991 Trustees Report—as against 2003 in the 1990 report (the later time being primarily due to the ad hoc increase in the earnings base in 1991). The corresponding exhaustion years for the low-cost and high-cost estimates in the 1991 report are 2018 and 2001, respectively.

A new test for the short-range financial condition of the HI program is used in the 1991 Trustees Report. To meet this test (which is the same as is used for OASDI—see page 404), the fund ratio (which is the fund balance at the beginning of the year as a percentage of the outgo during the year) must either (a) be at least 100 percent throughout the next 10 years or (b) reach a level of 100 percent within 5 years and remain at that level until the end of the 10-year valuation period. The HI program meets this test under the low-cost estimate and the intermediate-cost estimate, but not under the high-cost estimate. The fund ratio falls below 100 percent for the first time in the following years: intermediate-cost estimate, 2001; low-cost estimate, 2013; and high-cost estimate, 1998.

The ultimate imbalance of the HI program as shown by the 1991 Trustees Report (in 2065, the end of the 75-year valuation period) is 6.40 percent of taxable payroll. This projection is based on a comparison of the ultimate (actually, scheduled to be level in the future) combined employer-employee tax rate of 2.90 percent with the ultimate cost rate of 9.30 percent, which is 3.2 times the tax rate.

The figures from the 1992 Trustees Report which correspond to the foregoing figures as to the actuarial status of HI are presented in Chapter 10.

The 1991 Advisory Council devoted most of its efforts to health-care costs and method of delivery of services rather than to the OASDI program. In fact, its attention was devoted to national problems in this area rather than being limited to the Medicare program.

Because of the great problems involved and the wide variety of views and social philosophies of the members, the Council reached no consensus as to major solutions or sweeping overhauls, despite working for about a year beyond its legal deadline. Instead, it recommended the following incremental and minor changes:

- Creation of a nationwide system of school-based health clinics and school-based health insurance policies for children.
- Expansion of community and migrant health centers and of the national health service corps to provide doctors in ill-served areas.
- Reform of the commercial small-group insurance system to make it easier and cheaper for small businesses to buy good policies for their workers.
- Medical malpractice law reforms.
- Federal expenditure of $3 billion for state experiments on specified total and partial overhaul plans.

Four of the council members dissented, believing that "the Council has ducked the toughest issue"—namely "to devise a coherent, comprehensive response to the urgent need to provide adequate health care for all Americans at a cost that our society can afford." These members stated the following principles:

1. Access to health care should be a universal right.
2. Paying for health care should be a universal obligation.
3. Controlling the cost of health care should be a universal concern.

Certainly, it is difficult to object to these broad, sweeping principles. However, to put them into effect as a specific plan is quite a different matter. It is not clear what these members want—a socialized-medicine plan (under which all suppliers of medical care are government operated), or a Canadian-type plan (under which all suppliers of medical care are strongly controlled financially by the government), or a plan under which *all* employers must provide health insurance with certain minimum (although high) standards, or some other plan? The author also questions the possibility of ever defining, with any detail or precision, what is meant by "affordable, adequate health care."

Promulgated Medicare Elements

Three important elements of the Medicare program that affect the participants are, according to the "permanent" provisions of law, deter-

TABLE 7.3. Hospital Insurance Cost-Sharing Provisions in Various Periods

Period	*Hospital Daily Charge*			*SNF Daily Charge after 20 Days*
	Initial Deductible	*61st to 90th Days*	*Lifetime Reserve*	
July 1966–December 1968*	$ 40	$ 10	$ 20†	$ 5.00‡
1969	44	11	22	5.50
1970	52	13	26	6.50
1971	60	15	30	7.50
1972	68	17	34	8.50
1973§	72	18	36	9.00
1974	84	21	42	10.50
1975	92	23	46	11.50
1976	104	26	52	13.00
1977	124	31	62	15.50
1978	144	36	72	18.00
1979	160	40	80	20.00
1980	180	45	90	22.50
1981	204	51	102	25.50
1982	260	65	130	32.50
1983	304	76	152	38.00
1984	356	89	178	42.50
1985	400	100	200	50.00
1986	492	123	246	61.50
1987	520‖	130	260	65.00
1988	540	135	270	67.50
1989	560	**	**	25.50‡
1990	592	148	296	74.00
1991	628	157	314	78.50
1992	652	163	326	81.50
1993	676	169	338	84.50

*Determined by legislation; all other amounts promulgated by the Secretary of Health, Education, and Welfare (currently Health and Human Services).

†Benefit first available in 1968.

‡Benefit first available in 1967.

§The amounts determined in accordance with the provisions of the law were $76, $19, $38, and $9.50, respectively, but a ruling of the Price Commission prevented these increases and allowed instead the amounts shown here.

‖The actuarially determined rate of $572 was reduced by legislation. If the legislative increase in 1982 and the legislative decrease in 1987 had not been made, the initial deductible in 1987 would have been $508.

**Not applicable for 1989.

‡For first 8 days per calendar year.

TABLE 7.4. Voluntary Hospital Insurance Standard Monthly Premium Rates in Various Periods

Period	*Rate*
July 1973–June 1974*	$ 33
July 1974–June 1975	36
July 1975–June 1976	40
July 1976–June 1977	45
July 1977–June 1978	54
July 1978–June 1979	63
July 1979–June 1980	69
July 1980–June 1981	78
July 1981–June 1982	89
July 1982–June 1983	113
July 1983–December 1983*	113
January–December 1984	155
January–December 1985	174
January–December 1986	214
January–December 1987	226
January–December 1988	234
January–December 1989	156
January–December 1990	175
January–December 1991	177
January–December 1992	192
January–December 1993	221

*Determined by legislation; all other rates promulgated by the Secretary of Health, Education, and Welfare (currently Health and Human Services).

mined by promulgation of the Secretary of Health and Human Services (rather than by congressional action). These are the SMI standard premium rate, the HI initial deductible (upon which all other HI cost-sharing provisions are based), and the HI premium for voluntary enrollees who are not eligible as a result of insured status. Table 7.2 presented the various SMI standard premium rates which have been promulgated in the past. Table 7.3 shows the HI cost-sharing amounts that have been in effect in the past and currently, while Table 7.4 shows the corresponding voluntary HI standard premium rates.

Appendix 7-1

Legislative Development of Medicare Provisions in the 1967 Act

This appendix traces the legislative developments of the HI and SMI provisions in the 1967 Act. It is thus clearly shown how the Johnson

administration wanted to make changes in the original Medicare provisions and how Congress took differing action. The proposals for extending Medicare to disabled beneficiaries are not discussed because these are treated in the text.

HI Legislative Activity

The 1967 administration bill contained a number of changes in HI. The taxable earnings base was changed in the same manner as was proposed for OASDI, as mentioned in Chapter 3. This bill contained the following other important HI provisions:

1. The outpatient diagnostic benefits would be transferred to SMI. The original complicated (but logical) provisions that coordinated this benefit with HI had proved extremely difficult to administer.
2. The cost reimbursement would be reduced if capital expenditures made by the provider of services were contrary to recommendations made by state planning agencies.
3. The professional (i.e., physician) component of pathology and radiology services furnished to hospital inpatients would be transferred from SMI to HI (and would not be subject to cost-sharing, other than the overall HI initial deductible).

The House-passed bill took the following action with regard to HI:

1. The outpatient diagnostic benefits would be transferred to SMI.
2. The maximum duration of hospital benefits in a spell of illness would be increased from 90 days to 120 days, with the additional 30 days being subject to daily cost-sharing equal to half the initial deductible.
3. The tax rate would be increased for all years after 1968 by 0.1 percent for each party (employers, employees, and self-employed).
4. The earnings base would be $7,800 for all future years.

The major changes made by the Senate-passed bill as compared with the House bill were as follows:

1. In lieu of increasing the maximum duration of hospital benefits from 90 days to 120 days (with daily cost-sharing equal to half the initial deductible), a "lifetime reserve" of 60 days, with daily cost-sharing equal to one fourth of the initial deductible, would be provided.
2. The tax rates would be 0.1 percent higher than the rates under

existing law for each party in 1968, the same in 1969–75, and lower in 1976 and after (such decrease being 0.15 percent in 1987 and after). Such decrease would be possible because of the higher earnings bases than those in the House bill (namely, the same as in the administration bill).

The conference committee resolved the differences between the two versions of the bill in the following manner:

1. The additional hospital days in the lifetime reserve were subject to daily cost-sharing equal to half the initial deductible.
2. The tax rates were increased for all years after 1967 by 0.1 percent for each party (see Table 7.1).
3. The earnings base was $7,800 for all future years.

SMI Legislative Action

The 1967 administration bill contained the following changes in the SMI-benefit provisions:

1. HI outpatient diagnostic benefits (relating to the nonprofessional component of such services) would be transferred to SMI (the professional component thereof had always been included in SMI).
2. The professional component of pathology and radiology services furnished to hospital inpatients would be transferred to HI.
3. Certain nonroutine podiatrist services would be covered.

The only significant SMI-benefit changes that were made in the House-passed bill were as follows:

1. Transferring the outpatient diagnostic benefits from HI.
2. Making the cost-sharing provisions inapplicable to the professional component of pathology and radiology services furnished to hospital inpatients.

The Senate-passed bill added the following benefit provisions:

1. Services of chiropractors and certain nonroutine services of optometrists would be covered.
2. Physical therapy benefits furnished outside hospitals would be covered on a much broader basis.
3. Services of clinical psychologists would be covered (even though

not referred by and billed through a physician, with such services being covered under previous law only when billed through a physician).

The final bill followed the provisions of the House bill, except that the physical therapy provision of the Senate bill was retained and a revision of the enrollment and premium-rate procedures added by the Senate Finance Committee was included. Under the final bill, general enrollment periods are to be held annually instead of biennially. Also, enrollees are allowed to withdraw without waiting for an enrollment period.

Appendix 7-2

Changes in the Medicare Program Considered in 1970–1972 but Not Adopted

The legislation that was developed in 1970–72 and enacted in 1972 contained a number of provisions passed by either the House or the Senate but not agreed to by the conference committee. These are described in this appendix, except for the proposal for catastrophic-medical-expense benefits, which is discussed in the text because of its importance in the ongoing discussion of national health insurance.

Such HI provisions were as follows (with an indication of which body passed the provision):

1. Daily cost-sharing for hospital services in the 31st to 60th days equal to one eighth of the initial deductible (House).
2. Increase in lifetime-reserve days from 60 days to 120 days (House).
3. Reduction in daily cost-sharing for lifetime-reserve days from half of the initial deductible to one quarter thereof (Senate).
4. Coverage of specifically named out-of-hospital prescription drugs used for specified chronic conditions, subject to a $1 cost-sharing payment per prescription—to be covered under HI, which seems anomalous (Senate).
5. Voluntary HI coverage for OASDI and RR beneficiaries aged 60–64, financed on a cost basis with no government subsidy (Senate).

Several SMI provisions added by the Senate but not included in the final 1972 legislation were as follows:

1. Voluntary SMI coverage for OASDI and RR beneficiaries aged 60–64, financed on a cost basis, with no government subsidy.
2. Coverage of clinical psychological services when furnished by an independent practitioner.
3. Coverage of outpatient rehabilitation services.

Appendix 7-3

Changes in the Medicare Program Made by Bill Passed by the Senate in 1973 but Not Enacted

As brought out in Chapter 3, significant changes in the Social Security program were contained in legislation that passed the Senate in November 1973 but was not enacted. These proposed changes are of interest in connection with possible future legislative activity.

The only important Medicare provision proposed by the Senate Finance Committee, from a cost standpoint, was the inclusion of outpatient occupational therapy as an SMI benefit, paralleling physical therapy and speech pathology services. However, on the floor of the Senate, the following significant provisions were added:

1. Certain named maintenance drugs for certain specified conditions would be covered under HI, with a cost-sharing payment from the beneficiary of $1 per prescription. The pharmacy would be reimbursed on the basis of the wholesale cost, plus a professional fee, minus the cost-sharing payment, but not in excess of the usual charge, minus the cost-sharing payment.
2. The HI inpatient deductible would continue in 1974 at the 1973 level of $72. Then, increases for 1975 and after would be based on the $72 figure (the deductible actually rose to $84 in 1974).
3. The number of lifetime-reserve days under HI would be increased from 60 to 120 days, and the daily coinsurance therefor would be reduced from 50 percent of the HI initial deductible to 25 percent thereof.
4. The definition of "spell of illness" under HI would be liberalized, so that a spell of illness would end after the individual had been in an SNF for 180 days and had not received skilled nursing care or rehabilitative services. This could provide benefits in a new spell of illness when the individual involved had used up the maximum days of benefits in the previous spell of illness.
5. Coverage under both HI and SMI would be extended to the

disabled spouse under age 65 of an individual who is covered under Medicare as a disability beneficiary.

6. Benefits for HH services under HI would no longer require prior hospitalization and would be paid for a maximum of 100 visits per calendar year (instead of per spell of illness).
7. Coverage under both HI and SMI would be extended on a voluntary basis to persons aged 60–64 who are spouses of individuals covered under Medicare. The cost would be borne entirely by the enrollee under the same conditions as are applicable to voluntary HI enrollees aged 65 or over.
8. Additional financing—an increase in the combined employer-employee HI tax of 0.1 percent—would be provided. Such financing was included with the amendment providing coverage for maintenance drugs and would, on a long-range basis, meet about 70 percent of the estimated cost thereof. No additional financing was provided for the other changes involving increased cost (items 2–6); these had an estimated long-range cost of about 0.1 percent of taxable payroll.

Appendix 7-4

Change in the Medicare Program Made by the Bill Passed by the Senate in 1983 but Not Enacted

The Senate-passed version of the Social Security Amendments of 1983 would have increased the minimum age of eligibility for both HI and SMI benefit protection from 65 to whatever the Normal Retirement Age would be for OASDI (ultimately age 67). This provision would have significantly reduced the long-range cost of the HI program (and thus also its estimated deficit). However, it was dropped in the House-Senate joint conference.