

# EBRI ISSUE BRIEF

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January 1984

#26

## MEDICARE REFORM: SUMMARY RECOMMENDATIONS OF THE ADVISORY COUNCIL ON SOCIAL SECURITY

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### ABSTRACT

The Medicare program is now the single largest purchaser of health care services in the United States. Most observers agree that Medicare will be bankrupt by the end of this decade, unless Congress undertakes major reforms to either increase the financing, or control the growth of benefits, or both. Yet most observers also agree that current Medicare coverage for physician and preventive care, and for catastrophic health expenditures is inadequate.

Congress' decisions on Medicare reform will have significant implications for workers and employers in terms of higher payroll tax rates, the current cost of employee benefits and workers' protection against the risk of high health care expenses in retirement. If Congress mandates an even greater role for employers than that which was mandated under the Tax Equity and Fiscal Responsibility Act (TEFRA), it could increase employer health care costs for elderly and retired workers--at a time when the Financial Accounting Standards Board (FASB) is considering reporting changes that would effectively require that such health care commitments be treated as a corporate liability. Resolution of Medicare's problems will directly affect private employee benefit decision making and corporate finance.

Medicare changes outside of the federal budget process are unlikely to occur in the 1984 election year. But the next Congress will certainly have to address this issue comprehensively--and preparatory work is underway.

This issue brief discusses: (1) the factors behind the growth of the Medicare program, including the legislative changes since its enactment; and (2) the Summary Recommendations of the Advisory Council on Social Security. The Advisory Council's recommendations are highly controversial and have provoked wide differences of opinion both within and outside the Advisory Council. They are among the proposals that will be considered in reforming Medicare.

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## PROGRAM DESCRIPTION

Medicare has two parts: Part A--Hospital Insurance (HI) and Part B--Supplementary Medical Insurance (SMI). Generally, HI provides insurance coverage for three types of health care services: (1) up to ninety days of inpatient hospital care during each benefit period (plus a sixty day lifetime reserve);<sup>1/</sup> (2) up to one hundred days of extended care in a skilled nursing facility during each benefit period after discharge from a hospital;<sup>2/</sup> and (3) home health services. Medicare HI is financed by a trust fund that is supported by a payroll tax in the same way as Social Security's Old-Age, Survivors and Disability Insurance (OASDI) trust funds.

SMI covers physicians' and surgeons' services, some ancillary services and equipment, hospital or clinic outpatient services, and other noninstitutional care. Unlike HI, participation in SMI is voluntary and requires a premium payment by the enrollee.<sup>3/</sup> The SMI premium is subsidized from general revenues. In 1982, \$12.3 billion (approximately 76 percent of SMI's total program cost) was financed from general revenues.

## RISING COST OF MEDICARE

HI and SMI were enacted in 1965 as Title XVIII of the Social Security Act. Since the programs were implemented in 1966, enrollment and expenditures have risen steadily. The number of persons enrolled in HI has increased by more than 52 percent--an average annual growth rate of 2.5 percent. In 1982, 29.1 million persons--12.5 percent of the total population--were enrolled in the HI program; 28.4 million persons participated in SMI. Levels and growth of HI and SMI enrollment since 1966 are presented in table 1.

Despite the relatively modest average annual growth of Medicare enrollment, total Medicare spending, and spending per enrollee, have grown rapidly. Since 1967, the cost of HI has grown at an average annual rate of 17 percent; the cost per enrollee has grown at an average annual rate of nearly 14 percent. HI and SMI program cost, net of enrollee premiums, is presented in table 2. At the historical rate of growth, the cost of HI--and the payroll tax burden of HI--doubles about every five years.

The cost of the SMI program net of enrollee premiums is borne by taxpayers. The cost of SMI has risen even faster than that of the HI program. Since

<sup>1/</sup> A Medicare benefit period begins with the first day of inpatient care in a participating hospital or skilled nursing facility. The benefit period ends after the beneficiary has left inpatient care for sixty consecutive days.

<sup>2/</sup> Medicare's restriction on skilled nursing facility use in a single benefit period severely limits coverage for long-term care. In 1982, Medicare paid for less than 2 percent of the elderly's long-term care.

<sup>3/</sup> It should be noted that in some instances individuals are required to pay a premium for HI coverage. This occurs when an individual has insufficient work history in covered employment. These persons represent a very small percentage of total enrollment in the HI program.

1967, the cost of SMI has risen at an average annual rate of 21.6 percent; per enrollee, the taxpayer cost of SMI has risen at an 18 percent average annual rate. At these rates, the net SMI program cost, net of enrollee premiums, doubles about every four years.

The real cost of these programs--i.e., net of increases in the Consumer Price Index (CPI)--has also risen. Since 1967, the real cost of HI has risen by 9.1 percent; the real cost of SMI has risen by more than 13 percent. The cost of these programs is projected to continue rising along with the number of elderly entitled to Medicare coverage, the projected life expectancy of the elderly, and continued inflation in health care costs.

Both the Social Security Administration and the Congressional Budget Office (CBO) have made long-term projections of HI's trust fund status. Differences

TABLE 1

Number and Growth of Persons Enrolled in Medicare Hospital Insurance (HI) and Supplementary Medical Insurance (SMI), 1966-1982 a/

YEAR	HI	SMI
(Persons in millions)		
1966	19.1	17.7
1967	19.5	17.9
1970	20.4	19.6
1975	24.6	23.9
1980	25.3	27.4
1981	28.6	27.9
1982	29.1	28.4
(Percents)		
Total Growth, 1966-1982	52.4	60.5
Average Annual Growth, 1966-1982	2.5	2.8

Source: U.S. Department of Health and Human Services, Social Security Administration, Social Security Bulletin Annual Statistical Supplement, 1982 (Washington, D.C., 1983), pp. 202-206; U.S. Department of Health and Human Services, Health Care Financing Administration, The Medicare and Medicaid Data Book, 1981 (Washington, D.C., 1982), pp. 16-17; and unpublished data from the U.S. Department of Health and Human Services, Social Security Administration.

a/ Persons enrolled as of July 1.

TABLE 2

Total Program Cost and Average Cost Per Enrollee, Hospital Insurance (HI) and Supplementary Medical Insurance (SMI): Current and Real Dollars, 1967-1982

Year	Total Program Cost a/ (millions)	Cost per Enrollee	Total Program Cost a/ (millions)	Cost per Enrollee
	<u>Current Dollars</u>		<u>Real Dollars b/</u>	
<u>HI</u>				
1967	3,430	176	3,430	176
1970	5,215	256	4,484	220
1975	11,574	470	9,960	404
1980	25,558	1,010	10,356	409
1981	30,704	1,074	11,272	394
1982	36,120	1,241	12,581	432
Average Annual Growth, 1967-1982 (percents)	17.0	13.9	9.1	6.2
<u>SMI</u>				
1967	667	37	667	37
1970	1,116	57	960	49
1975	2,819	118	2,426	102
1980	8,234	301	3,336	122
1981	10,306	369	3,783	135
1982	12,530	441	4,364	154
Average Annual Growth, 1967-1982 (percents)	21.6	18.0	13.3	10.0

Source: U.S. Department of Health and Human Services, Social Security Administration, Social Security Bulletin Annual Statistical Supplement, 1982 (Washington, D.C., 1983), pp. 200-201.

a/ Total program expenditures for health care services and administrative expenses, net of enrollee premiums, as of December 31.

b/ Current dollars adjusted for inflation by the CPI (base year=1967).

between the projections are generally attributable to differences in economic and program assumptions. Recent Social Security estimates, based on assumptions of improving economic conditions and lower program outlays, indicate that the HI trust fund might be solvent until 1991 or 1992. Preliminary CBO estimates are slightly less optimistic and project HI insolvency by 1990 or 1991. Current projections indicate that HI's cumulative trust fund deficit may range as high as \$250 billion by 1995.<sup>4/</sup>

#### LEGISLATIVE CHANGES TO THE MEDICARE PROGRAM

Congress has made many changes to the 1965 legislation in an effort to: (1) rectify perceived inequities in Medicare entitlement; (2) slow the growth of Medicare spending; and (3) expand Medicare's revenue base. The major changes in Medicare entitlement, benefits, financing and administration are summarized below.

#### Entitlement

In 1972, Congress extended Medicare coverage to three groups of persons: (1) disabled persons; (2) persons with end-stage renal disease; and (3) elderly persons who were enrolled in the SMI program, but were not otherwise entitled to HI coverage.

- o Disabled persons. Persons under age sixty-five who receive monthly Social Security disability benefits were given entitlement to Medicare coverage. Disabled persons qualify for Medicare coverage, however, only after they have received disability benefits for a period of twenty-four consecutive months. This waiting period, combined with the required five-month waiting period for disability benefits, means that disabled persons become eligible for Medicare benefits no sooner than twenty-nine months after the onset of disability.
- o Persons with end-stage renal disease. Persons under age sixty-five with end-stage renal disease who require a kidney transplant or a regular course of renal dialysis and who are insured by Social Security, or who are the spouse or dependent of an insured person, were given entitlement to Medicare coverage. Such persons may begin receiving benefits the third month after the month in which the person begins a regular course of renal dialysis. (Based on specific circumstances the benefit periods may vary.)
- o SMI enrollees. All persons over age sixty-five who are enrolled in SMI were given eligibility, upon application, for HI coverage. Elderly persons enrolled in SMI who do not otherwise

<sup>4/</sup> Paul B. Ginsburg and Marilyn Moon, "An Introduction to the Medicare Financing Problem," in the proceedings of the Conference on the Future of Medicare, U.S. House of Representatives Committee on Ways and Means (Washington, D.C., 1983).

qualify for HI coverage participate in HI voluntarily and pay a premium for HI coverage.

In 1980, Congress modified the 1972 legislation and further expanded Medicare entitlement. Most importantly:

- o Persons who are entitled to retirement or disability benefits from Social Security or Railroad Retirement, but do not actually receive monthly benefits, were made eligible for Medicare coverage. If disability cash benefits stop because the person is working but he or she has not recovered from the disability, medicare coverage may continue for thirty-six months after cash benefits stop.

In 1982, Congress made two major changes to Medicare's entitlement rules--contracting eligibility for Medicare-financed health care services and, in effect, expanding the payroll tax base that finances Medicare.

Elderly employees aged sixty-five to sixty-nine who are otherwise entitled to Medicare coverage are required to use Medicare as a secondary payer, if they choose to participate in a basic or major medical employer group health insurance plan. However, if they reject the employer's health plan, Medicare will be the primary health insurance payer.

- o Employers with twenty or more employees who offer group health insurance as an employee benefit are required to offer the same coverage to elderly employees (aged sixty-five to sixty-nine) that they offer to younger employees. Employer plans may no longer provide Medicare "carve-out" coverage for these employees.
- o Federal employees were made eligible for Medicare entitlement based on their current employment and, at the same time, were required to pay the Medicare portion of the Social Security payroll tax.

### Benefits

Medicare benefits have also expanded. In 1967--after only one year of program operation--Congress expanded inpatient hospital benefits by establishing a lifetime reserve for inpatient care.

- o Persons entitled to Medicare coverage were given a lifetime reserve of sixty days of inpatient hospital care to use after they have exhausted Medicare's per episode limit on inpatient hospital days.

Congress also expanded coverage for services of providers not recognized in the original legislation. The expanded HI coverage includes: (1) services provided by interns and residents in podiatry training (1972); (2) home health care services (1980); (3) hospice care (1982, effective through October 1, 1986); and (4) institutional care services provided by health maintenance organizations (1982).

Congress expanded SMI coverage to include: (1) the purchase of durable medical equipment (1967); (2) physical therapy services, some chiropractor services, outpatient speech pathology services, and some optometrist services (1972); (3) services provided by rural health clinics (1977); (4) home health care services, some procedures performed in freestanding ambulatory surgical centers, and the services of comprehensive outpatient rehabilitation facilities (1980); and (5) medical care services provided by health maintenance organizations (1982).

The cumulative effects on total cost of some of the changes are apparent. For example, in fiscal year 1980, 10.4 percent of Medicare enrollees were under age sixty-five, and qualified for Medicare because of disability or end-stage renal disease. These persons represented 13.3 percent of total Medicare spending. In 1981, Medicare HI paid \$666 million for home health care services; SMI paid an additional \$13 million for home health care; these amounts totaled about 2.1 percent of all Medicare spending in 1981. The increased coverage authorized by Congress since Medicare's initial legislation has been an important factor in the program's projected financial crisis.

### Financing

Responding to the rising cost of Medicare and the OASI financing problems, Congress expanded the general revenue financing of the SMI program and authorized borrowing among the HI, OASI, and DI trust funds. In 1972, the Congress authorized general revenue financing for all SMI costs not met by enrollee premiums, liberalizing the federal matching of SMI premiums. Congress also limited the rate of enrollee premium increases to the rate of increases in OASDI cash benefits. In 1983, Congress froze SMI enrollee premiums for the balance of the calendar year, and reset SMI premiums through the end of 1985 at one-half the aged actuarial rate.

In 1981, Congress authorized interfund borrowing among Social Security's OASI, DI, and HI trust funds through the end of 1982 with no schedule for repayment. In 1983, Congress extended interfund borrowing authority through 1987; set a floor on the lending fund's trust fund balance, and scheduled repayment of the principal and interest on past and future loans.

Interfund borrowing has also affected Medicare's HI trust fund. In 1983, OASI borrowed, on two occasions, a total of \$12.4 billion from the HI trust fund, reducing the year-end balance of HI's trust fund by about 5 percent. Full repayment of the loan is included in Social Security's projections of the HI trust fund status through 1990.

### Administration

Congress has made several recent changes in the way that Medicare pays for health care services. Two of these changes are particularly important in terms of HI's projected outlays for hospital care.

In 1982, Congress capped the annual increase in hospital costs that Medicare will reimburse as part of hospital room and board charges. The cap is set at the annual rate of increase in the prices paid by hospitals for supplies and services, plus 1 percentage point. The cap expires September 30, 1985.

In its 1983 amendments to the Social Security Act, Congress authorized major reform of the way Medicare calculates its payments for inpatient hospital care. Reimbursable amounts are to be calculated based on 468 diagnosis-related groups (DRGs). The calculation of DRGs is based on the patient's diagnosis rather than on the actual hospital services provided to the patient, or the length of the patient's hospital stay.<sup>5/</sup> Medicare DRG-based reimbursement is being phased in gradually between 1984 and 1986.

#### IMPLICATIONS OF MEDICARE REFORM FOR THE PRIVATE SECTOR

The decisions ultimately made by Congress may have significant implications for workers and employers in terms of higher payroll taxes and workers' protection against health risks in retirement. If Congress mandates an even greater role for employers than that which was mandated under the Tax Equity and Fiscal Responsibility Act (TEFRA), it could increase employer health care costs for both elderly and retired workers. At the same time, the Financial Accounting Standards Board is considering reporting changes that would effectively require that employer commitments for post-retirement health insurance benefits be treated as a corporate liability. Thus, resolution of Medicare's problems may directly affect both private employee benefit decision making and corporate finance.

Public expectations about the role of Medicare as a social insurance program have been, in part, nurtured by Medicare's expansionist history. These expectations may prove to be the most difficult obstacle faced by Congress in its task of trimming Medicare entitlement, benefits, and program costs.

Medicare changes outside of the federal budget process are unlikely to occur in the 1984 election year. But the next Congress will have to address comprehensive Medicare reform--and preparatory work is underway. The House Ways and Means Committee, for example, recently sponsored a two-day conference on Medicare, designed to solicit the opinions and discussion of leading experts in the field.<sup>6/</sup>

#### ADVISORY COUNCIL PROPOSALS FOR REFORMING MEDICARE

Under the Social Security Act, the Secretary of Health and Human Services appoints an Advisory Council on Social Security every four years for the

<sup>5/</sup> See: Employee Benefit Research Institute, "Medicare Moves to Prospective Pricing for Hospital Care," EBRI Notes vol. 4, no. 2 (Washington, D.C., March/April 1983), pp. 1-4.

<sup>6/</sup> U.S. Congress, House Committee on Ways and Means, Committee Print 98-20: Conference on the Future of Medicare: Conference Schedule and Preliminary Papers. Sponsored by Committee on Ways and Means, Congressional Budget Office and Congressional Research Service, 98th Cong., November 29-30, 1983.



purpose of reviewing the status of the Social Security trust funds. To avoid duplicating the work of the National Commission on Social Security Reform, and recognizing the importance of the Medicare funding "crisis," the latest Advisory Council on Social Security focused on Medicare. Its members were appointed by Secretary Schweiker in 1983. The Advisory Council has released its Summary Recommendations. Its final report is expected to follow closely the Summary Recommendations, and it will be delivered to HHS Secretary Margaret Heckler by March 1984.

The Summary Recommendations of the Advisory Council on Social Security are highly controversial and have provoked wide differences of opinion both within and outside the Advisory Council. Congress is not likely to enact these recommendations en bloc, without considering a host of other options put forth by individual members of Congress, and health care experts in academia and in the private sector. But, the Advisory Council proposals warrant significant attention, nonetheless. These proposals may be organized into four categories: (1) financing; (2) eligibility; (3) benefits; and (4) administration.

### Financing

Proposals to change the financing of Medicare fall into three categories:

- (1) Expanding the tax base. The tax base could be expanded in several ways. The Advisory Council on Social Security recommended:
  - o imposing a "cap" on the amount of employer contributions to health insurance that are tax-exempt;<sup>7/</sup> and
  - o increasing the federal excise tax on alcohol and cigarettes.

The Advisory Council recommended that all or a portion of the increment in general revenues that would result from either measure be earmarked to Medicare's HI trust fund.<sup>8/</sup>

<sup>7/</sup> The Advisory Council has endorsed a cap of \$70 per month for individual coverage, and \$175 per month for family coverage; the Council report presents no opinion on indexing the cap. For a full discussion of this type of proposal, see EBRI's Issue Brief, "Revising the Federal Tax Treatment of Employer Contributions to Health Insurance: A Continuing Debate," no. 21 (August 1983).

<sup>8/</sup> As proposed by the Administration, employer contributions to health insurance above the cap would be taxed as earnings. Excess employer contributions would, therefore, be taxed by Social Security (FICA). Earmarking a portion of the cap's general revenue yield raises the incremental revenue that the HI trust fund would normally receive from FICA taxation of employer contributions above the cap.

These particular revenue sources have received attention for different reasons. A tax cap on employer contributions to health insurance has been advocated by the Administration and others as a way to control health care cost inflation, although existing research has not established the relationship between the tax status of employer contributions to health insurance and rising health care costs.<sup>9/</sup> Taxing alcohol and cigarettes is seen as a user tax, since consumption of these products is perceived as ultimately increasing health care costs among the elderly. The burden of either tax, however, would be regressive.<sup>10/</sup>

- (2) Reallocating the payroll tax. The Advisory Council on Social Security recommended consideration of reallocating the payroll tax between OASDI and HI during the period 1985-1995, in order to transfer projected OASDI revenue surpluses to HI. This proposal bypasses interfund borrowing, as well as the scheduled repayment of funds that would be diverted from OASDI. Projections of the minimum balances that OASDI would require to meet its obligations rely on economic assumptions that are subject to substantial error. Reallocating the payroll tax, therefore, could have adverse financial effects on OASDI.
- (3) Eligibility. The Advisory Council also recommended raising the age of eligibility for Medicare benefits to age sixty-seven. This would be accomplished by raising the age of eligibility by three months each year in 1985 through 1988 and by six months in 1989 and 1990. On this schedule, the shift to age sixty-seven would be fully implemented by January 1, 1990. Thereafter, the age for Medicare eligibility would automatically increase with increases in life expectancy among the elderly.

### Benefits

The Advisory Council's proposals to restructure Medicare benefits fall into two general categories:

- (1) Proposals to change the scope of benefits covered by Medicare generally aim to provide catastrophic coverage under Medicare and reduce the elderly's risk of financially devastating health

<sup>9/</sup> A review of the literature in this area is provided in: Deborah Chollet, Employer-Provided Health Benefits: Coverage, Provisions and Policy Issues (Washington, D.C.: Employee Benefit Research Institute, 1984).

<sup>10/</sup> A regressive tax is one that takes an increasing share of total family income at lower levels of income. Conversely, a progressive tax takes an increasing share of total family income at higher income levels. For a discussion of the equity implications of these proposals, see: Chollet, Employer-Provided Health Benefits; and Stephen Long, "Alternative Financing Sources," in the proceedings of the Conference on the Future of Medicare, Committee on Ways and Means.

care expenses. It also may reduce Medicaid's spending for the elderly. Alternatively, these proposals are intended to reduce the elderly's need for Medigap insurance (private insurance that supplements Medicare coverage). All else being equal, these proposals would raise Medicare spending.

The Advisory Council on Social Security has endorsed several proposals that would improve HI coverage for catastrophic health care needs. These include:

- o Expanding coverage to include unlimited inpatient hospital days per calendar year.
  - o Expanding coverage to include up to one hundred days of skilled nursing home care per calendar year, with no coinsurance on the first twenty days of care and a coinsurance rate of 12.5 percent on subsequent days of care.
  - o Providing enhanced HI coverage as a mandatory addition to SMI coverage. This enhanced coverage would pay the daily coinsurance amount for inpatient hospital care and for skilled nursing care required by the basic HI plan. SMI enrollees would be required to pay the actuarial value of the additional benefits in their SMI premium, plus an additional amount to offset the difference between their accumulated contributions to HI and the value of benefits currently received.
  - o Offering an optional SMI supplement to finance an annual limit on Part B out-of-pocket expenses. The SMI supplemental benefit would be financed by an increment to enrollees' SMI premium.
- (2) Proposals to reform the structure of Medicare cost sharing aim to reduce Medicare spending net of the elderly's premiums and accumulated contributions. This would be accomplished, in part, by increasing the elderly's awareness of health care costs.

The Advisory Council has also endorsed several changes in cost sharing for current benefits under HI and SMI. These include:

- o Limiting payment of HI's per-admission deductible for inpatient hospital care to payment for two admissions per calendar year.
- o Establishing a hospital coinsurance rate under HI equal to 3 percent of the inpatient hospital deductible per day. This coinsurance rate would apply only to hospital days beyond those which are included in computation of the deductible.

- o Indexing the SMI deductible to the CPI. SMI's deductible has been increased only twice since the program began. The current deductible is 50 percent greater than that in effect in 1966 (\$75 per year). Over the same period, however, median family income among the elderly rose by about 172 percent, and the CPI rose by 187 percent. Although some elderly may be able to pay a higher SMI deductible, closer analysis of the changing distribution of income among the elderly--and the ability of near-poor elderly to pay a higher SMI deductible--should be considered seriously before raising the SMI deductible.

Others have suggested that growth of SMI per-capita reimbursements might be an appropriate basis for indexing the SMI deductible.<sup>11/</sup> Since 1966, SMI reimbursements per beneficiary have risen 328 percent.

### Administration

Proposals that relate to the administration of Medicare generally address Medicare's practice of reimbursing health care providers. The Advisory Council on Social Security has endorsed several proposals affecting Medicare reimbursement.

- (1) Payment for medical education. Currently, Medicare pays a share of medical education expenses in their payment for hospital room and board. The Advisory Council opposed this practice and recommended that federal support for medical education be provided outside the Medicare program.
- (2) Prospective payment of physicians. Currently, Medicare pays "reasonable" charges for physician services. This translates to payment of physician charges up to the seventy-fifth percentile of all physician charges in the same geographic area for the same service. This standard, however, is without meaning (since all physician charges include higher charges to non-Medicare patients). Further, a number of factors unrelated to physician costs can cause the seventy-fifth percentile charge to rise. The Advisory Council recommended that Medicare pay physicians based on a fee schedule, adjusted periodically for changes in the CPI or in practice costs.
- (3) Mandatory assignment. Currently, physicians may refuse to accept Medicare reimbursement as payment in full for the services provided to Medicare patients on a case by case basis. Physicians who refuse assignment bill the Medicare patient directly. Medicare then reimburses the patient for "reasonable" charges. Physician charges in excess of Medicare

<sup>11/</sup> U.S. Congress, Congressional Budget Office, "Changing the Structure of Medicare Benefits: Issues and Options" (Washington, D.C., March 1983).

reimbursement are paid directly by Medicare beneficiaries, either out-of-pocket or through private insurance. Data from 1977 indicate that less than 50 percent of physician charges are paid on an assignment basis. Nonassigned charges in excess of Medicare reimbursement, consequently, have become a major part of the cost of Medicare-covered services paid by beneficiaries.

The Advisory Council recommended that physicians who elect to participate in Medicare be required to accept assignment on all services to Medicare patients. Physicians would be required to notify Medicare six months before initiating or withdrawing from program participation.

Another proposal endorsed by the Advisory Council on Social Security addresses the ethical and cost issues of life-sustaining treatment for incapacitated Medicare patients. Currently, fourteen states recognize "voluntary advanced directives" (i.e., establishing a "living will" that states the general course of medical treatment to be followed if the individual becomes incapacitated). The Advisory Council recommended that, in these states, the elderly be offered a living will at the time they enroll in Medicare. In this way, the elderly could elect to limit life-sustaining treatment and, consequently, Medicare cost.

In addition to these major proposals to reform Medicare the Advisory Council on Social Security has forwarded two general recommendations to the Secretary of HHS of particular interest to workers:

- o First, the Advisory Council recommended further study of ways to encourage individuals to save during their working years for the purpose of purchasing health insurance coverage in retirement. This recommendation was forwarded as a first step in major long-term reform of the Medicare program.
- o Second, the Council recommended review of the current-law provision that Medicare serve as second payer for the health care of elderly workers and their spouses, in order to identify ways in which the legislation or its implementing regulations might be made more effective in limiting Medicare expenditures for elderly workers.

## CONCLUSION

Medicare's history has been characterized by expanding entitlement, benefits and cost. Today, Medicare is one of the largest and fastest-growing components of the federal budget, and the single largest purchaser of health care services in the United States. The HI costs are projected to grow faster than the program's payroll tax revenues. Most observers agree that the program will be bankrupt by the end of the decade. Yet most observers also agree that Medicare's current coverage for physician care, preventive care, and catastrophic health care expenditures is inadequate.

Recent Medicare legislation has capped increases in HI spending over the next several years and radically reformed the way that Medicare calculates its payment for inpatient hospital care. To ensure Medicare's future, however, Congress must soon consider more fundamental reforms of Medicare.

It is unlikely that Congress will complete a major reform of the Medicare system in the 1984 election year. Any Medicare legislation considered this year will most likely be directed toward reducing the short-term federal budget deficit rather than the long-term changes needed to keep Medicare solvent.<sup>12/</sup>

The recommendations of the Advisory Council on Social Security represent some of the options that Congress will consider--along with many options proposed by health care experts in Congress, in universities and in the private sector. Two themes stand out from the Advisory Council's recommendations: (1) an increased emphasis on competition; and (2) a greater encouragement of the individual's role in anticipating and meeting health care needs. It remains to be seen what place these two themes will be given within the final legislative solution to reforming Medicare.

<sup>12/</sup> For the President's fiscal year 1985 Budget Proposals, see EBRI's Issue Brief no. 27 (February 1984).

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