Health Insurance for People Aged 65 and Over: First Steps in Administration

by ROBERT M. BALL*

AS THIS article goes to press, the new health insurance program providing protection against hospital and medical care costs for the Nation's older men and women has been the law of the land for less than 5 months. During this time the Social Security Administration has taken many of the steps necessary to assure that on July 1, 1966, the promised protection will be available.

The 1965 amendments to the Social Security Act added, as part of the social insurance protection provided under the Act, two coordinated programs of health insurance for the aged—a basic hospital insurance plan and a voluntary supplementary medical insurance plan.[1]

The hospital insurance program will cover up to 90 days' in-patient hospital services in a spell of illness; the first 60 days will be covered essentially in full after a deductible of $40. For each of the remaining 30 covered days in a spell of illness, the patient will pay a $10 coinsurance amount. Outpatient hospital diagnostic services are also covered. The program pays 80 percent of the cost of these diagnostic services after a $20 deductible is applied to diagnostic services furnished to an outpatient of a participating hospital during a 20-day period. This hospital insurance will also cover in-patient care for up to 100 days in a spell of illness for continued treatment in an extended-care facility after transfer from a hospital where the patient stayed 3 or more days. The first 20 days of extended care will be covered in full. For each of the remaining days in a spell of illness the patient will pay $5 coinsurance. Home health services are covered for up to 100 visits during the year for continued care following the patient's discharge from a hospital (after a stay of at least 3 days) or from an extended-care facility. The deductibles will be adjusted from time to time as hospital costs rise.

Generally, the medical insurance program will pay 80 percent of the reasonable charges for covered services, above a $50 annual deductible. The program covers physicians' services regardless of where they are rendered, up to 100 home health visits each year and a variety of other medical and health services, such as diagnostic X-ray and laboratory tests; X-ray, radium, and radioactive isotope therapy; prosthetic devices; and rental of durable medical equipment.

Enrollment in the medical insurance program is voluntary. The program is financed through a premium of $3 monthly paid by the beneficiary and an equal amount paid by the Federal Government out of general revenues.

Benefits under both the hospital insurance program and the medical insurance program will first be payable on July 1, 1966, except for services in extended-care facilities, which will first be covered on January 1, 1967.

One job of top priority has been to get information to the people and to the institutions affected so they can do their part. The 19 million Americans past age 65 must be informed of their rights under the hospital insurance plan, and they also have to be given an opportunity to join the voluntary medical insurance plan. The hospitals and nursing homes, the home health care plans, the physicians, nurses, and other members of the health professions, and the State health agencies—all must be informed how the new program affects them.

PUBLICIZING THE PROGRAM

First, millions of descriptive pamphlets have been distributed to the people affected. The first copies were actually distributed to the press on the plane that accompanied the President to the ceremony marking the signing of the 1965 amendments to the Social Security Act.

Then, on September 1, the Social Security Administration began to distribute materials to

*Commissioner of Social Security.

[1] For a full description of the 1965 amendments, see Wilbur J. Cohen and Robert M. Ball, "Social Security Amendments of 1965: Summary and Legislative History," *Social Security Bulletin*, September 1965.

the 15½ million persons aged 65 and over who are receiving monthly cash benefits under the Social Security Act or the Railroad Retirement Act. The mailings were completed on October 13. Each beneficiary received material describing the two health plans—the basic hospital insurance plan, which gives him protection without any action on his part, and the voluntary, supplementary plan, which covers primarily physicians' services. An application card for supplementary medical insurance was mailed with the material, prepunched with the beneficiary's name and account number. To exercise his option the beneficiary could simply check "yes" or "no," sign his name, and return the card. About two-thirds of these applications had been returned at the time this article went to press, with about 90 percent indicating that the beneficiary wants to participate in the medical insurance program. A followup mailing was begun on January 12.

The first enrollment period for the supplementary medical insurance plan ends March 31, 1966. In general, anyone who has reached age 65 before the first of the year must have enrolled by March 31 or wait 2 more years and then have to pay higher premiums.

We have been able to reach directly about 80 percent of the people aged 65 or over in this way. About one-third of the remainder are receiving old-age assistance payments and will hear directly from State welfare agencies. There are more than a million people past age 65 who are not insured under social security or the railroad retirement program and are not receiving welfare payments. Many of these people are quite old, some are bedridden. Many of them probably do not realize that just about everyone aged 65 or over is covered under the health insurance program, even though he may never have worked under social security. Some of them probably are over age 72 and do not know that they may be eligible also to receive a special cash benefit of $35.00 a month—$17.50 for their wives—because of the new, liberalized eligibility requirements that apply to older people who have had some work under social security or whose husbands have had some covered work. We have been trying to reach these people through television, newspapers, and other public media, as well as through organizations in touch with older people. All homes for the aged and nursing homes have received a special mailing in an attempt to reach all residents of such homes. We have undertaken a joint project with the Office of Economic Opportunity in which they will hire older people to assist in locating shut-ins and arranging group meetings for other hard-to-reach older people. The Rural Community Development Services of the Department of Agriculture is assisting us in reaching people in rural areas.

We have also needed to reach about a million people aged 65 and over who are insured under social security but who have never filed applications because they are working and the retirement test has meant that they would not get any cash benefits. They are, of course, eligible for health insurance, and they should file applications and present proof of age to establish entitlement. Moreover, under the liberalized retirement test that goes into effect in 1966, some of these people may, upon filing an application, become entitled to receive some cash benefits. By the end of 1965, we had identified most of these workers from our records and made a direct mailing to them.

By early February we will be mailing an eligibility card, similar in purpose to a Blue Cross card, to all those who have established their eligibility for both hospital insurance and medical insurance. Before the July effective date we will also be mailing such a card to those who have established eligibility only for hospital insurance.

Not only the aged but also the institutions providing services—hospitals, nursing homes, and home health services—needed to be informed about the new program. Late in August we mailed a special pamphlet and a series of questions and answers to about 10,000 institutions that had identified themselves as "hospitals." The pamphlets were also mailed to nearly 15,000 nursing homes and to about 1,000 home health agencies. Later these institutions were given specific information on their right to select fiscal intermediaries such as Blue Cross or private insurance companies and their right to deal directly with the Social Security Administration if they wish. During the week of January 17 the hospitals were given a statement of the eligibility conditions they must meet to participate in the program and sample forms to use in applying to designated State agencies (usually the health

department) for a determination of eligibility.

After eligibility for participation has been determined the hospital, if it wishes to participate, will be asked to sign a simple agreement providing that it will not charge the patient for any services reimbursed under the plan and agreeing to abide by the nondiscrimination policies of title 6 of the Civil Rights Act. National policies on reimbursement will be issued prior to the mailing of these agreements. The hospital does not obligate itself to participate in the plan until the agreement is signed.

ADDITIONAL STEPS IN ADMINISTRATION

In July, President Johnson announced the reorganization of the Social Security Administration to accommodate the new legislation. Within the Administration a new Bureau of Health Insurance was established that will have primary responsibility for administering the hospital and medical insurance plans, and other major changes were made in both the field and central office organization. A departmental order has been issued that assigns the major policy and administrative responsibility for the program to the Social Security Administration, certain responsibilities in the area of professional standards to the Public Health Service, and certain State consulting responsibilities to the Welfare Administration.

To assure prompt and adequate service to beneficiaries, we are taking steps to establish more than 80 new social security branch and district offices and 21 new temporary service centers. These are in addition to the 622 offices and more than 3,500 regularly scheduled itinerant service points already in existence. We have also redesigned our computer programs so that the enormous power of modern technology will be at the service of recordkeeping for this new program, speeding up the processing, keeping costs down, and making for better and easier service for all involved.

Probably the most important activity has been the series of consultations held with the many organizations and groups that have a vital stake in this program or that have professional or administrative competence to contribute to it. The Social Security Administration has met with—to name a few—the American Hospital Association and executives of State hospital associations, the American Medical Association, the National Medical Association, various specialty organizations, the Blue Cross Association and several individual plans, the National Association of Blue Shield Plans, a task force composed of representatives of many commercial insurance companies, many individual insurance companies, the group health plans, the Joint Commission on Accreditation of Hospitals, representatives of nursing groups, nursing homes, and homes for the aged, and many more. It has been and will continue to be the Administration's policy to adopt rules, regulations, and procedures only after consulting closely with those who have a major interest and technical competence in matters relevant to the program. We have established nine work groups made up of such people to identify, study, and resolve the important issues.

The new legislation provides for the establishment of two formal advisory groups. One is the Health Insurance Benefits Advisory Council, which was appointed by the Secretary of Health, Education, and Welfare on November 11. The 16 members are:

Chairman, Kermit Gordon, vice president, the Brookings Institution, and former Director of the Bureau of the Budget

William E. Beaumont, Jr., president emeritus, American Nursing Home Association

Bernard Bucove, M.D., director, Washington State Health Department, and vice president, Association of State and Territorial Health Officers

Kenneth W. Clement, M.D., past president, National Medical Association

Dorothy A. Cornelius, R.N., executive director, Ohio State Nurses' Association, and vice president, American Nurses' Association

Nelson H. Cruikshank, former director, Department of Social Security, AFL-CIO

C. Manton Eddy, president, Health Insurance Association of America, and senior vice president and director, Connecticut General Life Insurance Company

Caldwell B. Esselstyn, M.D., executive director, Community Health Association, Detroit, and past chairman of the board, Group Health Association of America

José A. Garcia, M.D., former vice president general of the League of United Latin-American Citizens (LULAC)

The Very Rev. Msgr. Harrold A. Murray, director, Bureau of Health and Hospitals, National Catholic Welfare Conference

Russell A. Nelson, M.D., president, the Johns Hopkins Hospital, and past president, American Hospital Association

Howard P. Rome, M.D., president, American Psychiatric Association, and senior consultant in psychiatry, Mayo Clinic

Samuel R. Sherman, M.D., chairman of the American Medical Association's Council on Legislative Activities and Council on Economics of Medical Care, and president, California Medical Association, 1963–64

Nathan J. Stark, vice president, Hallmark Cards, and president, Kansas City General Hospital and Medical Center Corporation

Ray E. Trussell, M.D., director, Columbia University School of Public Health and Administrative Medicine, and Commissioner of Hospitals, New York City, 1961–65

Carroll L. Witten, M.D., president-elect, American Academy of General Practice, and president of the Kentucky Academy of General Practice

The Council has been giving advice on administrative policy and on formulating regulations. As we went to press, the Council had made recommendations concerning reimbursement for the services of hospital-based physicians, the eligibility criteria for hospital participation, and certain of the regulations governing certification and recertification by physicians of the medical necessity of services. The second advisory group is a nine-man National Medical Review Committee, which will come into being somewhat later. It will study the utilization of hospital and other medical care with a view to recommending changes in the way covered care and services are used and in the administration of the hospital and medical insurance plans. The committee will be representative of organizations and associations of professional people. A majority will be physicians.

Quality of Care

The main purpose of the legislation, of course, is to help older people meet the cost of the medical care they receive. The program does not itself provide care. The law, in addition to strictly prohibiting Federal interference in the practice of medicine, contains many other safeguards against undue Government interference in the provision of health services. It is our direct concern, then, to help people meet their bills, not to make changes in the way medical care is given. Congress recognized, however, that the broad scope of the program could have important indirect effects on the quality of medical care. The legislation was carefully framed to make these indirect effects support the efforts of the health profession to improve the quality of medical care for the American people.

The indirect effects of the new program are important if for no other reason than sheer size. The hospital insurance program will underwrite costs for about 15 percent of all general hospital admissions and probably more than 25 percent of the days of general hospital care. In addition, the standards required of the participating institutions, the requirement for utilization review, the reimbursement policies, and many other elements of the program will undoubtedly influence the policies of Blue Cross, other insurers, and public assistance agencies and so affect care for people of all ages.

Full Reimbursement for Reasonable Cost

The element that has the greatest impact on quality of hospital care—the one that stands out above all others—is the direction given in the legislation to pay the full reasonable cost of covered care. By and large, in most fields of life you get only what you pay for. In providing payments to meet the full reasonable cost of care, the legislation provides financial support for the best quality of care that can be delivered.

The principles enunciated in the congressional committee reports on reimbursement are important to everyone interested in the quality of health care. These reports stress that what is intended by the law is not some uniform, flat rate of reimbursement but a payment tailored to the cost of care delivered by the individual institution. This principle of reimbursement recognizes that differences in costs from institution to institution generally reflect differences in the quality and intensity of care they provide. Specifically, payment of the reasonable cost of services is intended to meet actual costs, determined under a national formula, however widely costs may vary from one institution to another—except where a particular institution's costs are substantially out of line with those of other institutions similar in size, scope of services, utilization, and other relevant factors.

The principle of full reimbursement for reasonable costs gives assurance that—as hospitals acquire new equipment, adopt new health practices, and improve their services and techniques—additional operating costs will be reimbursed. This built-in responsiveness to changing practices will give the proper financial underpinning to improvements in care.

It is also clear from the congressional reports that the Social Security Administration is expected to learn from experience gained by private organizations; it is directed to consult with them to assure that payments to hospitals are fair to hospitals, contributors to the program, beneficiaries, and other patients. The congressional reports further state that in paying reasonable costs the policy will be to reimburse a hospital or other provider of services so that an adjustment can be made at the end of each cost period for costs actually incurred. This provision will be especially important when prices rise, since such a policy will provide for reimbursing hospitals in terms of what was actually spent—not just agreed to in advance.

Adequate Financing

The principle of adequate reimbursement is backed up by provision for adequate financing—financing that uses the same method that underlies the social security cash benefits program. In an area like hospital insurance, where costs have risen sharply and will continue to rise, social security financing (financing out of a percentage of earnings) means that income will rise with increases in prices and earnings. Since the income to the social security system automatically rises as earnings levels rise, a significant part of any increase in hospital costs will be automatically met by a concurrent increase in income. Moreover, the cost estimates in the hospital insurance program allow for a continuation of a faster rise in hospital costs than in earnings.

A final conservative factor in the estimates is that they assume no further increase during the next 25 years in the $6,600 maximum wage base, which limits the amount of earnings to which the contribution rate applies. Actually, this maximum wage base is almost certain to be raised—as it has in the past—as earnings rise. Such an increase will provide a still further source of income to the hospital insurance program. Thus, the principle of full reimbursement for reasonable cost is backed by adequate long-range financing.

Conditions for Participation

The legislation, in addition to leaning heavily on the principle of full reimbursement for reasonable cost, recognizes that high-quality health care could be undermined if benefits were permitted to be paid for institutional care of inferior quality. It therefore establishes certain minimum standards that must be met by hospitals, extended-care facilities, and home health agencies that wish to participate in the program. There is thus a double provision supporting quality of care—Government's willingness to pay for a quality job and its insistence on at least minimum standards.

A general hospital that is accredited by the Joint Commission on Accreditation of Hospitals will generally be assumed to meet all but one of the various participation standards. It will automatically qualify to receive payments if it has arrangements for reviewing the utilization of services and meets any State or local health and safety standards that are stricter than the Joint Commission's and that have been established by a State or political subdivision as a condition for payment for medical care under the Federal-State public assistance programs. Hospitals that are not accredited can also participate, but they must demonstrate specifically that they satisfy the standards for participation that were issued by the Department of Health, Education, and Welfare on January 12.

These standards are designed to lend support to what has already been achieved and to support continued upgrading as further progress is made through accreditation and other voluntary or State standard-setting activities.

Utilization Review

An important requirement for participation in the hospital insurance program is provision

for reviewing the utilization of services. Participating institutions must have in effect a utilization review plan applicable to services furnished beneficiaries of the program. What is involved is the review of admissions, lengths of stay, and the medical necessity of services provided, as well as some form of review that addresses itself to the problem of long-stay cases. The hospital will have the option of utilization review by a staff committee of its own, unless the hospital is too small, or it can associate itself with a community-based review plan—one, for example, established or sponsored by a local medical society in cooperation with the hospitals in the area.

The review is directed to self-appraisal by physicians of their practices. Though the practices of the individual physician will be reviewed, the main objective is the promotion of efficient use of available facilities based upon professional responsibility for the judgments of the care needed. The intention of the requirement for professional self-review of utilization is to prevent the need, now and in the future, to have such a function performed by Government.

Although the utilization review is endorsed by the health professions, the Social Security Administration is aware that review procedures are in an early stage of development and require study and experimentation. Much would be lost if innovation were to be stifled. The need for flexibility is recognized, and there seems to be no reason why a wide variety of patterns of utilization review cannot meet the requirements of the law. The regulations for a utilization review plan were issued on January 12 as part of the conditions for participation of hospitals.

Role of State Agencies

As indicated earlier, arrangements are now being made with State agencies, which will operate under agreements with the Secretary to determine if a provider of services meets the conditions for participation in the program. In addition, the State agencies will render consultant services to providers. It is not enough to say a provider does not meet the standards; the institution can be helped to come up to standard. Thus, consultant services can include assistance in establishing and maintaining necessary fiscal records and otherwise meeting the conditions for participation. Assisting an extended-care facility to establish a transfer agreement with a participating hospital is an example of a consultative function a State agency can perform to assist providers to qualify.

State agencies may also be used to render consultant services to providers and medical societies in establishing and testing utilization review procedures. Their work will, of course, be coordinated with any related activities of fiscal intermediaries and medical societies in consultant services that are directed to utilization review. The State may make specific recommendations for additional health and safety requirements, for institutions within its jurisdiction, that it believes to be desirable.

The State agencies will be reimbursed for their program activities. The Federal Government can also pay a share of the cost of State and regional planning for the coordination of an agency's activities under the program with other activities for which the agency is responsible. In authorizing this type of cost sharing, the law recognizes the need for coordinating the new program of health insurance for the aged with programs for those of all ages.

This use of State agencies has one important objective in common with the other provisions described—full reimbursement for reasonable cost plus adequate financing to back up this reimbursement, the requirement that providers of service meet minimum standards, the support given to accreditation standards (and to State standards where they are higher), the provision for paying for consultant services to improve substandard institutions, and provision for financial participation in planning activities. All support the drive of the health professions to improve the quality of care and will have a positive effect over the long run on the quality of care provided not only to the aged but to people of all ages.

Utilization Rates

Perhaps one more thing should be said about the quality of care. Will the legislation result in such crowding of hospitals that the quality

of care will deteriorate? The Social Security Administration does not believe that it will —at least in most places—although recognizing that the shortage of high-quality, extended-care facilities is a major problem and that there are very serious shortages of nurses, doctors, and other health personnel.

One safety factor is that the plan is so timed that hospitals will encounter at the best possible time any backlog of need for hospital care among the aged. July and August, the first months the plan will be paying for care, have hospital utilization rates about 10 percent lower than the peak months of February and March.

On a longer-range basis, since persons over age 65 account for only about one-fourth of all hospital days used, even a large increase in utilization by the aged would not greatly increase the general rate. If, for example, the rate for the elderly were to go up by the unlikely figure of 20 percent, the overall increase would still be only 5 percent. The impact is, of course, uneven, and some hospitals would find any increase in utilization a problem. In the country as a whole, however, utilization is only about 75 percent of bed capacity, whereas it would be administratively practical to achieve 85 percent.

Unnecessary utilization needs to be controlled, and the new program, through its utilization committee requirement and in other ways, will help to control it. The prevention of unnecessary utilization of services is of first-rank importance not only because of the money cost involved but, even more fundamentally, because of the national major shortages of health personnel. As a Nation we are also short of high-quality nursing homes, and there needs to be a very significant expansion of agencies providing the sort of home health services contemplated by the health insurance program. The health personnel shortages, particularly, are likely to last for a long time. It takes 8 years or more to train a doctor after we do all the things necessary to expand the training facilities and induce more young people to undertake medicine as a career. The shortage of nurses is acute. In some places, wings of new hospitals, needed to serve patients, have not been opened because there are not enough nurses.

The program of health insurance for the aged did not create these shortages. However, the shortage situation over the next several years adds to the need for preventing the wasteful and unnecessary use of services. Because something is being paid for that was not paid for before, there is, of course, a tendency for all concerned to use the service more freely. As a matter of social policy we have an obligation to see that services are not wasted.

Where there is crowding or a shortage of facilities or health personnel, obviously the solution is to expand our ability to provide service—not to deny the aged the care they need because they cannot pay for it. Even where facilities are limited, older people should have a right to compete on an equal basis with younger patients.

And the new program—in helping to pay the current operating expenses of hospitals on a full, reasonable cost basis and relieving hospitals of part of their present burden of charity cases—makes the provision of additional hospitals and other health facilities, where needed, more possible.

Role of the Fiscal Intermediary

One of the very large and important roles for private organizations in the administration of the program is that of "fiscal intermediary." The law provides that associations or groups of providers of service (hospitals, extended-care facilities, and home health agencies) may nominate certain organizations, public or private, to serve as intermediaries between them and the Federal Government. Basically a fiscal intermediary, under agreement with the Secretary and using national principles of reimbursement, will determine the amount of payments due upon presentation of bills by hospitals and other providers of service and will make the payments to the providers.

The fiscal intermediaries can, at the option of the Secretary, fill certain additional needs. They can, for example, provide consultative services to providers to enable them to set up and maintain necessary fiscal records and to otherwise qualify as participants, and they can furnish information and instructions received from the Secretary and audit records of providers to ensure that proper payments are made. Certain of these additional functions parallel some of the functions that may be assigned to States. The extent to which they would be performed by States and by private organizations serving as fiscal inter-

mediaries will depend on the readiness and ability of the various agencies to take on the job. Since the Secretary is authorized to delegate consultative and other functions to either State agencies or fiscal intermediaries, he can select the organization that he finds can most capably carry out these functions in the specific situation.

The nomination of agents to perform certain administrative tasks under the basic hospital insurance program is up to the providers of services themselves. These providers may nominate any agent they wish, and the Government is, of course, neutral with respect to which organizations they nominate. Under the law the role of the Federal Government is to make the final decision as to whether the use of the nominated agent will be consistent with effective and efficient administration and whether the agent is able and willing to assist in the application of safeguards against unnecessary utilization of covered services. The American Hospital Association, representing about 85 percent of the hospitals of the country, nominated the Blue Cross Association as the agent for its member hospitals. This nomination was approved by the Secretary of Health, Education, and Welfare on January 11, together with the nomination by a smaller number of hospitals of the Travelers Insurance Company and the Aetna Life Insurance Company.

Nomination by a group or association will not be binding on an individual provider that notifies the Social Security Administration that it does not wish to be bound by the group nomination. Such a provider can, at any time, elect to deal with a different fiscal intermediary, provided the Secretary and the selected intermediary consent. Alternatively, the provider can elect to deal directly with the Social Security Administration rather than with the organization nominated. A provider not belonging to a group or association that has nominated a fiscal intermediary has the same choices available. It can elect to deal through an intermediary nominated by another association, if the intermediary and Secretary consent, or it can elect to deal directly with the Social Security Administration.

Claims Procedures

The procedures for making payment for the health services covered under the hospital insurance program will be familiar to patients, doctors, and institutional providers because they will follow present patterns used by the large prepayment organizations.

The physician will determine for his patients, as he always has, the nature of the services required. And if these services require hospitalization or other institutional services, he will make the same arrangements as he does now for his patient's admission and care. Every beneficiary will display his health insurance benefits card upon admission. At that time, the patient will make appropriate arrangements for the payment of the deductible and any coinsurance amount that he may be called on to pay to the hospital. In brief, he will be admitted under existing hospital procedures.

A procedure has been worked out that will enable hospitals and other providers to promptly verify a patient's eligibility for benefits. The hospital will get all needed eligibility information within a short time of when it makes the request. Such a procedure will mean that the admissions process at a hospital should be of no more concern—and, in fact, of less concern in some instances—than now.

In addition, there is the statutory assurance that payment can be made for as many as 6 days of care where a hospital acts reasonably in assuming the eligibility of an individual who, it turns out, had already used up his benefits for that spell of illness.

Hospitals, and other providers, will be paid at appropriate billing intervals, but not less often than once a month.

MEDICAL INSURANCE PLAN

The law requires the Secretary of Health, Education, and Welfare, to the extent possible, to contract with "carriers" to carry out the major administrative functions of the medical insurance program. A carrier is defined in the law as a voluntary association, corporation, partnership, or other nongovernmental organization lawfully engaged in providing, paying for, or reimbursing the cost of health services under group insurance policies or contracts, or similar group arrangements, in consideration of premiums or other periodic charges payable to the

carrier. The definition would specifically include a group health organization or a health benefits plan sponsored or underwritten by an employee organization. A State welfare agency may act as the carrier for its aged welfare recipients. No contract will be entered into unless the Secretary finds that the carrier will carry out its functions efficiently and effectively and will meet such requirements as to financial responsibility, legal authority, and other matters as are found to be necessary.

The carriers are to be responsible for determining the amounts to be paid for physicians' services and for making the payments. They may also be used in a similar capacity with respect to payments for other kinds of services covered under the medical insurance program. They will also be responsible for auditing records on which payments are based; determining that the institutional providers meet the utilization review requirements; assisting in the application of safeguards against unnecessary utilization of services and in the establishment of review groups; and serving as a channel of communication for information relating to the program's administration. One of the most important results of the assignment of these responsibilities to carriers is that the responsibility for determining reasonable charges for physicians' services will be in the hands of private insurance organizations, group health plans, and other voluntary medical insurance plans with experience in reimbursing physicians for their services.

Carriers will be reimbursed for the costs they incur in participating in the program. In fact, the law provides for advancing funds to them for the purpose of making benefit payments and for use as a working fund to cover the administrative expenses that they incur. The working funds will be paid on the basis of provisionally estimated costs, and payments will then be adjusted at the end of the accounting period to reflect actual costs.

In determining whether a carrier's participation is consistent with the program's efficient and effective administration, some of the elements that will be considered by the Social Security Administration are:

(1) The capability of the agent to make timely and accurate payments for services rendered on the basis provided for in the law;

(2) Ability and willingness to assist in the arrangements with hospitals and other institutional providers of service for utilization review and the application of safeguards against unnecessary utilization;

(3) Willingness to develop interest and participation of hospitals, physicians, and other health organizations and personnel in the program; and

(4) Effective processing of inquiries and complaints from beneficiaries. This matter has particular significance for the agents who handle the medical insurance benefits because the law places full authority with the agent to provide a "fair hearing" when requests for payments are denied, not acted on with reasonable promptness, or the amount of payment is in controversy.

As of press time, 140 organizations had made formal proposals to be selected as carriers under the medical insurance plan.

Reasonable Costs and Charges Under the Medical Insurance Plan

Under the medical insurance plan, institutional providers of service will be reimbursed on the basis of reasonable costs, following the same definition as for the hospital insurance plan. Payments for physicians' services will be made on the basis of reasonable charges. The law provides that in determining the reasonable charge for a service, the customary charges of the physician and the prevailing charges in the community will be taken into account and that the reasonable charge will not be higher than the charges generally paid by the carrier on behalf of its own subscribers or policyholders for comparable services provided under comparable circumstances. Payment by carriers for physicians' services will be made on the basis of a receipted bill or to a physician upon an assignment. Under either method, the carrier (after the deductible has been met) will pay 80 percent of what it determines is the reasonable charge for the services rendered—to the patient if he has sent in the receipted bill or directly to the physician if he has accepted the patient's assignment. If the doctor has agreed to assignment, he must accept the reasonable charge as his full fee.

HEALTH MANPOWER AND HEALTH FACILITIES

Steps have been taken and more will be needed to improve the supply of health manpower and health facilities. This need is independent of the establishment of the insurance program for the aged, and efforts to meet the need must be pursued separately. The Health Professions Educational Assistance Act of 1963 and its 1965 amendments, the Nurse Training Act of 1964, and the 1964 amendments to the Hill-Burton Act, which provided for a marked increase in long-term facilities—all are steps in the right direction.

Grants for the construction of six new medical schools and for the expansion of 18 schools already are providing places for 725 additional first-year medical students each year. The 16 grants to schools of nursing—two for new schools and 14 for the expansion of existing schools—provide teaching facilities for 788 new nurses annually. In addition, the subprofessional training programs of the Manpower and Development Training Act are stepping up the Nation's supply of practical nurses, laboratory technicians, and other paramedical personnel.

These programs are all steps in the right direction, but action must be taken on a community-by-community basis to determine how best to take advantage of the new programs. Statistics on the utilization of health facilities throughout the Nation and the availability of health personnel do not present a meaningful picture of the situation in any given community. Each community must inventory its own resources to determine what is needed within the community in terms of additional hospitals, nursing homes, home health agencies, and health personnel. And each community must organize to make sure that everything possible is being done in the direction of having the needed facilities and personnel available, not only for aged persons but for everyone.

CONCLUSION

The fundamental concepts behind the health insurance program for the aged are quite simple. The idea is to help people pay for the health care they receive. The program does not itself provide care or, for that matter, guarantee that anyone will receive any particular service. The physician will continue to determine whether an individual should be hospitalized or requires other institutional services, and he will make the same arrangements as he does now for the patient's admission and care. The program, like existing private insurance arrangements, will be limited to making payments for part of the cost of the care provided.

A key difference between the hospital plan and the usual private health insurance policy is that the contributions that support the new program are paid while the individual is working, with benefits available at age 65. This special financing arrangement for benefits in old age is desirable because at that time of life incomes tend to decrease sharply and the incidence of costly illness increases. The median income of the aged is only about half that of younger persons with the same family composition, but the elderly use, on the average, almost three times as many days of hospital care.

The net effect of this unhappy combination of high health costs and low incomes is that, if premiums must be paid in old age, adequate health insurance costs more than most older people can afford to pay. The approach that the new hospital insurance program takes in meeting the problem is to apply the same principles of financing as those underlying social security retirement benefits—people pay while at work, when they have income, and have the protection after retirement, without further payment at that time.

This approach is used to finance the most expensive part of the health insurance program—the part covering hospital and related services—which is estimated to be worth about $11 per month per insured person.

Over the long run, protection under the basic plan is limited to those who have contributed toward social security and hospital insurance protection and to their dependents, although in getting the program started there will be general revenue financing for other persons past age 65. The contributory element protects the rights and dignity of the recipients and keeps this program, like the rest of social security, in the tradition of earned rights. Workers can expect that, having

contributed, they will get benefits as an earned right, without undue restrictions and in a manner that safeguards their freedom of action and their privacy.

The supplementary medical plan follows somewhat different principles. But here, too, people will be contributing toward their own protection. Because the Government pays half the cost and because the protection is built on the basic hospital plan, most people will be able to pay the required premium in old age—$3 for $6 worth of protection.

Finally, in planning the overall management, design, and implementation of the two health insurance programs the Social Security Administration is working closely with all interested parties. Administrative policies will be developed in full consultation with the groups immediately involved, as well as with the broad advisory groups required by law to be established. We are determined to avoid red tape. The Social Security Administration is proud of its ability to run a vast Government program of cash benefits paying $1½ billion a month to more than 21 million people efficiently and with a sympathetic individualized concern for each person affected. It will do everything possible to do as well in the health insurance field.

The impact of the program on the product itself—that is, on the quality of health care—will always be an important consideration. The expertise of the Social Security Administration in managing records and in maintaining effective relationships with beneficiaries will be combined with the experience that intermediaries and State agencies have built up in claims administration and in the professional aspects of dealing with hospitals, extended-care facilities, home health agencies, physicians, and others. The Administration is dealing with both prepayment organizations and commercial insurance groups on this basis of division of responsibility—a procedure that will, it is believed, provide not only a significant mutuality of interest but also an assignment of authority and responsibility to the areas where the respective strengths lie.

The objective is broader than efficiency of operations and accurate payment for high-quality health services. The Administration is committed to support the gains that have been made—and will continue to be made—by the great voluntary medical care system in the United States.