Health Insurance for the Aged: Claims Reimbursed For Hospital and Medical Services*

CLAIMS FOR reimbursement of part of the cost of hospital and medical services under the health insurance program for the aged are recorded in the central records of the Social Security Administration. The data on these claims provide a means of measuring the extent of utilization of covered services, as well as information on the total charges and amounts reimbursed for these services.

The January 1967 issue of the BULLETIN presented data on inpatient hospital claims for the first 3 months of the operation of the health insurance program for the aged. More complete inpatient claims data covering the first 6 months of the program's operation are now available and are presented here. Also included are the first available figures on the bills reimbursed and recorded in the Social Security Administration central records during the first 8 months of the medical insurance program.

INPATIENT HOSPITAL CLAIMS

For July–December 1966, approximately 1.7 million inpatient hospital claims were reported by intermediaries as approved for payment under the hospital insurance program as of February 24, 1967. Claims approved are reported in table 1 according to the specific month of intermediary approval and include those recorded in the central utilization record as of the February date.

Because of lags in the reporting and processing of claims under the hospital insurance program, the number of monthly claims reported here probably do not represent all the claims for services approved in any given month. As more time elapses, claims data for the earlier months will became more nearly complete. For example, claims approved for payment during the first 3 months of the program and recorded in the Social Security Administration tape record as of February 24, 1967, totaled 629,833, or about three-fifths more than the number recorded for the same period 4 months earlier.[1]

The number of claims approved by intermediaries and recorded in the tape record each month only partially reflects actual inpatient hospital utilization under the program. Delays in submission of claims by hospitals, in claims processing by intermediaries, and in recording the data in the central utilization record result in understating the number of cases receiving inpatient hospital care during the month.

Distribution of the 1.7 million claims by month approved shows only 2 percent recorded in July, a sharp increase in the following month, a continued monthly upward trend to a peak of 381,355 in November, followed by an 8-percent drop in December. The small number reported for July reflects the delay in transmittal of forms and claims at the beginning of the program. The drop in December from the previous month may be the result of the lag in reporting and recording the data as of February 24, 1967, the date of summarization.

The 1.7 million claims account for 21.8 million days of care covered under the hospital insurance program, or an average of 12.6 days per claim. A claim is defined here as the submission of a bill requesting reimbursement for inpatient hospital care. Claims are generally submitted after a person is discharged from the hospital. Interim bills or claims requesting payment for part of an inpatient hospital stay may, however, be submitted. The average length of stay per claim is therefore less than the average per discharge, especially for long-stay hospitals, which are more likely to submit interim bills when the stay covers an extended period.

The average number of days of covered care increased monthly from 7.0 days in July to 13.6

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[1] See Howard West, "Health Insurance for the Aged: The Statistical Program," *Social Security Bulletin*, January 1967, page 13, table 6.

TABLE 1.—Hospital insurance: Number of claims approved for payment, covered days of inpatient care, total charges and reimbursed amount, by month claim was approved and type of hospital, as of February 24, 1967 [1]

Month claim approved [2]	Approved claims			Hospital charges				
	Number	Covered days of care [3]		Total (in thousands)	Per claim	Per day	Amount reimbursed	
		Total	Average per claim				Total (in thousands)	Percent of total
	All hospitals							
Total [4]	1,734,853	21,843,398	12.6	$939,753	$542	$43	$748,700	79.7
July	40,475	284,676	7.0	11,264	278	40	8,364	74.3
August	268,640	2,776,155	10.3	116,057	432	42	90,878	78.3
September	320,718	3,977,478	12.4	167,758	523	42	133,525	79.6
October	372,227	4,909,498	13.2	208,796	561	43	167,442	80.2
November	381,355	5,103,484	13.4	223,470	586	44	179,250	80.2
December	351,438	4,792,107	13.6	212,408	604	44	169,240	79.7
	Short-stay hospitals [5]							
Total	1,708,936	21,057,538	12.3	$921,710	$539	$44	$733,474	79.6
July	40,354	283,463	7.0	11,229	278	40	8,336	74.2
August	265,757	2,712,427	10.2	114,332	430	42	89,336	78.1
September	316,696	3,864,869	12.2	164,810	520	43	130,928	79.4
October	365,266	4,699,714	12.9	204,229	559	43	163,550	80.1
November	375,353	4,913,395	13.1	219,159	584	45	175,764	80.2
December	345,510	4,583,670	13.3	207,951	602	45	165,560	79.6
	Long-stay hospitals [6]							
Total	21,613	738,900	34.2	$16,297	$754	$22	$13,993	85.9
July	116	1,150	9.9	33	286	29	26	79.7
August	2,880	63,715	22.1	1,725	599	27	1,542	89.4
September	3,613	108,792	30.1	2,797	774	26	2,489	89.0
October	5,655	195,807	34.6	4,039	714	21	3,518	87.1
November	4,649	175,395	37.7	3,756	808	21	3,091	82.3
December	4,700	194,041	41.3	3,948	840	20	3,326	84.2

[1] Includes only those claims approved and recorded in the Social Security Administration central utilization record *before* February 24, 1967.
[2] Month in which the intermediary approved the claim for payment.
[3] Includes covered days of care after June 30, 1966 (not exceeding 90 days in a spell of illness).
[4] Includes 4,302 claims with type of hospital unknown.
[5] General and special hospitals reporting average stays of less than 30 days.
[6] General and special hospitals reporting average stays of 30 days or more; tuberculosis, psychiatric, and chronic disease hospitals; and Christian Science sanitoria.

in December. Claims approved and processed during the early months included a considerable number of stays for persons who were in hospitals on July 1 so that only the part of these stays after June 30 is reflected in the number of days that were covered under the program and for which reimbursement was requested.

Only a small percentage of claims—about 1 percent—is for care in long-stay hospitals. The average number of days per long-stay hospital claim is nearly three times that of the short-stay hospital claim—34 days compared with 12 days. The long-stay hospital claims include only the days of care covered under the program—up to 90 days of care in a "spell of illness." Inpatient hospital care beyond the maximum covered is not reported here. Although the data presented cover the first 183 days of the program's operation, the period is not long enough to reflect many long stays. Thus, the average length of stay will probably continue to increase monthly as the program progresses, especially for long-stay hospitals.

Total charges for the 1.7 million tabulated claims amounted to approximately $940 million, representing $542 per claim and $43 per day. Distribution of the claims by type of hospital shows that the total charges per claim are almost 30 percent less in short-stay hospitals than in long-stay hospitals but the daily charges for the former are double those for the latter. Total charges averaged $22 per day in long-stay hospitals and $44 per day in short-stay hospitals.

Approximately four-fifths of the $940 million in total charges was reimbursed under the hospital insurance program. The amounts reimbursed during these early months of the health insurance program are based on interim per diem rates that will be adjusted in the future on the basis of reasonable costs of operation of the hospital. Deductible and coinsurance payments by beneficiaries and noncovered services are, of course, excluded from the amounts reimbursed.

The proportion of total charges reimbursed under the program varies with the type of hospital—79.6 percent in short-stay hospitals compared with 85.9 percent in long-stay hospitals. This difference is a function of the variation in length of stay. When the stay is short, the $40 deductible and any noncovered items (private rooms, if not medically indicated, and other luxury services) account for a larger proportion of the total bill. Conversely, when the hospital stay is long, the deductibles and noncovered items represent a relatively smaller part of the charges. For stays beyond 60 days and up to 90 days in a spell of illness, the eligible beneficiary pays a coinsurance amount of $10 per day. For these very long stays, the proportion of total charges reimbursed will decline.

SUPPLEMENTARY MEDICAL INSURANCE CLAIMS

The data on inpatient hospital claims presented above are obtained from the bill form approved for payment by the intermediary and forwarded to the Social Security Administration for re-

cording in the central record. The data on medical insurance claims (excluding home health and outpatient hospital services) are based on a payment record consisting of tape, punched card, or other machine-readable records of each bill paid by the intermediary to a physician, beneficiary, or supplier of service under the program.[2] Thus the payment record provides a rapid method for summarizing data on the number of bills paid and recorded in the Social Security Administration central records, type of service provided, total reasonable charges, and amounts reimbursed under the medical insurance program. For home health and outpatient hospital services, claims data are based on bills approved for payment by the intermediary and forwarded to the Social Security Administration.

Reasonable charges are determined by intermediaries on the basis of customary charges for similar services generally made by the physician or other supplier of covered services and on prevailing charges in the locality for similar services. They cannot be higher than the charges applicable for the intermediary's own policyholder for comparable services under comparable circumstances. Reimbursed amounts are payments by intermediaries after the $50 deductible has been met and excluding the 20-percent coinsurance.

Data are presented for almost all of the first 8 months of the operation of the program, divided into four specified periods based on the date of record summarization: July 1–October 14, 1966; October 15–December 2, 1966; December 3, 1966–January 20, 1967; and January 21–February 23, 1967. All the payment records processed during these periods are now included so that, unlike the claims reports in the hospital insurance program, future monthly reports of payment records data under the medical insurance program will not provide additional data for the earlier months. The payment record is intended to provide fairly current data on bills paid by carriers.

These data, however, should not be construed as current information on the utilization of services under the program. Nor should the average charge per bill be construed as that for the average enrollee. For example, a patient receiving services in a specific month may possibly wait to submit all his bills at the end of the year or, if his physician accepts assignment, the latter may accumulate bills for periods of several months. Current data on the utilization of services under the medical insurance program are being collected by means of the Current Medicare Survey.[3]

By February 24, 1967, almost 2.6 million bills had been reimbursed by intermediaries under the medical insurance program and were transmitted to and recorded in the Social Security Administration central utilization record. A bill is defined here as a request for payment from or in behalf of a beneficiary as a result of services provided by a single physician or supplier. The bill may cover one or more covered services provided to an eligible beneficiary on the same or different dates. Thus, one bill may cover an office visit to a surgeon before an operation that includes diagnostic procedures, the inhospital surgical procedure, and several postoperative visits in and out of the hospital.

Of the 2.6 million bills for physicans' and related services, 70 percent were classified as

TABLE 2.—Medical insurance: Number of reimbursed bills for physicians' and related medical services, total reasonable charges, and reimbursed amount, by type of bill and period recorded, as of February 24, 1967 [1]

Type of bill and period recorded	Number of bills	Reasonable charges			
		Total (in thousands)	Per bill	Amount reimbursed	
				Total (in thousands)	Percent of total
All bills [2]	2,582,207	$217,871	$84	$146,765	67.4
July 1–Oct. 14, 1966	138,035	16,433	119	10,449	63.6
Oct. 15–Dec. 2, 1966	328,082	32,785	100	21,482	65.5
Dec. 3, 1966–Jan. 20, 1967	893,765	76,811	86	51,782	67.4
Jan. 21–Feb. 23, 1967	1,222,325	91,842	75	63,052	68.7
Surgical bills	516,373	98,416	191	70,527	71.7
July 1–Oct. 14, 1966	44,715	9,419	211	6,486	68.9
Oct. 15–Dec. 2, 1966	84,628	16,846	199	11,834	70.2
Dec. 3, 1966–Jan. 20, 1967	183,210	35,048	191	25,115	71.7
Jan. 21–Feb. 23, 1967	203,820	37,103	182	27,091	73.0
Medical bills	1,812,577	111,051	61	70,951	63.9
July 1–Oct. 14, 1966	89,654	6,774	76	3,812	56.3
Oct. 15–Dec. 2, 1966	229,300	15,155	66	9,198	60.7
Dec. 3, 1966–Jan. 20, 1967	636,850	38,919	61	24,902	64.0
Jan. 21–Feb. 23, 1967	856,773	50,203	59	33,039	65.8

[1] Includes only those bills for which reimbursement was made by the intermediary and which were recorded in the Social Security Administration central utilization record *before* February 24, 1967.

[2] Includes 253,257 bills for medical services other than physicians' services, such as home health, outpatient hospital, independent laboratory, and other services covered under the program.

[2] For a more complete description of the payment record and other basic records, see Howard West, *op. cit.*, pages 5–8.

[3] For a complete description and first findings, see Jack C. Scharff, "Current Medicare Survey: The Medical Insurance Sample," *Social Security Bulletin*, April 1967, pages 4–9.

medical services and 20 percent as surgical services, and the remaining 10 percent were for other services covered under the medical insurance program (table 2). When a physician includes charges on a single bill for both a surgical procedure and a nonsurgical procedure, the highest-priced service is the determining factor in classifying a bill as surgical or medical.

Total reasonable charges for the 2.6 million bills amounted to approximately $218 million, or an average of $84 per bill. Total charges include the entire amount of the individual's bill, including the deductible and coinsurance, where no previous bills for covered services had been submitted and the bill is more than the $50 deductible. Medical bills totaling less than $50 are submitted to the intermediary but not included here as these are used only to satisfy the deductible and are not reimbursable. Where the beneficiary had previously incurred bills of less than $50, the part of the last bill that was used to meet the deductible is included in the total charges shown.

Although the number of recorded medical bills outnumbered the surgical bills by more than 3 to 1, the total reasonable charges for surgical bills almost equalled the total for medical bills—$98 million for surgical bills and $111 million for medical bills. The average charge for surgical bills is, of course, significantly larger than that for medical bills—$191 compared with $61 per bill. As indicated previously, one bill for medical services may and, in fact, often does include more than one covered service provided to an enrollee.

The supplementary medical insurance program provides payment for 80 percent of the reasonable charges for physicians and other covered services following payment by the patient of the first $50 of such charges. Thus, in the early months of the program, relatively large medical expenditures were required in order to be reimbursed. It is likely that the first bills were mainly for illnesses requiring hospital care where the outlays are high. This assumption is supported by the fact that about half the amount reimbursed in the first period was for surgical bills, for which total reasonable charges averaged $211.

Average charges per bill, as shown on table 2, decreased from $119 in the first reporting period (July 1–October 14, 1966) to $75 in the last period (January 21–February 23, 1967). This decreasing average charge per bill during successive months is undoubtedly the result of the application of the deductible provision to payments for covered services at the beginning of the program. Many of those who had met the deductible in the first months of the program may have used some covered services during succeeding months, for which the charges were relatively small. In addition, some persons may have partially met the deductible in the early months of the program and the bill used later for meeting the deductible may be relatively small.

Of the aggregate total reasonable charges of $218 million for physicians and related medical services, $147 million or more than two-thirds was reimbursed through payments made by inter-

TABLE 3.—Medical insurance: Number of reimbursed bills for physicians' and related medical services, total reasonable charges, and amount per bill, by type of service and period recorded, as of February 24, 1967 [1]

Type of service	Total	July 1–Oct. 14, 1966	Oct. 15–Dec. 2, 1966	Dec. 3, 1966–Jan. 20, 1967	Jan. 21–Feb. 23, 1967
	Number of bills				
All services [2]	2,582,207	138,035	328,082	893,765	1,222,325
Physician services	2,328,950	134,369	313,928	820,060	1,060,593
Surgical	516,373	44,715	84,628	183,210	203,820
Medical	1,812,577	89,654	229,300	636,850	856,773
Home health services	38,939	([3])	2,518	13,821	22,600
Outpatient hospital services	141,606	433	2,671	35,610	102,892
Independent laboratory services	30,429	1,320	3,586	9,172	16,351
All other services [4]	38,001	1,821	4,635	13,573	17,972
	Total reasonable charges (in thousands)				
All services [2]	$217,871	$16,433	$32,785	$76,811	$91,842
Physician services	209,467	16,193	32,001	73,967	87,306
Surgical	98,416	9,419	16,846	35,048	37,103
Medical	111,051	6,774	15,155	38,919	50,203
Home health services	2,373	([3])	202	883	1,288
Outpatient hospital services	2,683	16	112	867	1,688
Independent laboratory services	983	55	133	297	498
All other services [4]	1,992	159	270	660	903
	Amount per bill				
All services [2]	$84	$119	$100	$86	$75
Physician services	90	121	102	90	82
Surgical	191	211	199	191	182
Medical	61	76	66	61	59
Home health services	61	([3])	80	64	57
Outpatient hospital services	19	36	42	24	16
Independent laboratory services	32	42	37	32	30
All other services [4]	52	87	58	49	50

[1] See footnote 1, table 2.
[2] Includes 4,281 bills, $371,480 in total reasonable charges, and $87 in amount per bill for which type of service is unknown.
[3] Fewer than 50 bills.
[4] Includes rental of durable medical equipment, ambulance service, internal and external prosthetic devices and appliances, and supplies.

mediaries. The percentage reimbursed is higher for surgical bills than for medical bills (72 percent compared with 64 percent) because the amount paid by the patient ($50 deductible and 20-percent coinsurance) constitutes a relatively smaller proportion of the total when it is applied to the larger surgical bill.

The proportion of total reasonable charges reimbursed rises slightly in successive periods from 64 percent for bills reimbursed July 1–October 14, 1966, to 69 percent in January 21–February 23, 1967. This increasing trend in the later months probably reflects the increasing number of persons who had met the deductible in previous months and, consequently, only needed to pay the coinsurance amounts on all subsequent bills for medical services incurred during the year. Nearly all the recorded payments for the first 2 months of 1967 probably reflect utilization of services in 1966.

Table 3 presents a more detailed distribution of the bills, by type of service, their total reasonable charges, and the amount per bill. Of the 253,000 paid bills for services other than physician services, the majority are for outpatient hospital services. The average charges per bill per outpatient hospital service are considerably smaller than for any other type of service, and amount to $19. Bills for home health and independent laboratory services averaged $61 and $32, respectively. Included in the latter group are only those charges for laboratory services billed directly by independent laboratories. Where the bill for physicians' services includes charges for laboratory services, these are classified as physicians' services.

Approximately 38,000 bills are classified as other medical services. These include rental of durable medical equipment, ambulance service, internal and external prosthetic devices, and appliances, and supplies. The average charge per bill reimbursed during the period July 1, 1966, to February 23, 1967, for these other medical services amounted to $52.

The distribution, by type of service, of the bills reimbursed during each of the four periods shows an increasing number of bills for other than physician services in the later periods. At the beginning of the program, there were relatively few bills for these other services, perhaps because procedures for reimbursement for the new benefits were developed somewhat more slowly than for other medical services. In addition, many beneficiaries may not have been fully aware of the coverage for these services early in the program. Finally, these are relatively inexpensive services and, without a large physician's bill, require a cumulation of several bills to meet the $50 deductible before reimbursement of the claim is made.

Data have been presented that relate to inpatient hospital claims for the first 6 months of the program and to medical insurance claims reimbursed in the program's first 8 months. Similar data will be published in the BULLETIN in its regular series of tables.