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1ST ANNUAL REPORT ON MEDICARE

LETTER

FROM

THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE

TRANSMITTING

THE FIRST ANNUAL REPORT ON THE MEDICARE PROGRAM, PURSUANT TO SECTION 1875(b) OF THE SOCIAL SECURITY ACT

JUNE 24, 1968.—Referred to the Committee on Ways and Means and ordered to be printed with illustrations

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LETTER OF SUBMITTAL

THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE,
Washington, D.C., June 14, 1968.

Hon. JOHN W. McCORMACK,
Speaker of the House of Representatives,
Washington, D.C.

DEAR MR. SPEAKER: Pursuant to section 1875(b) of the Social Security Act, I submit to you herewith the first annual report on the medicare program.

Medicare has brought invaluable benefits to millions of individual Americans. Virtually all of the Nation's aged are protected by this comprehensive health insurance program. In the words of President Johnson, they are "able to receive the medical care they need without suffering crushing economic burdens." Thus they now enjoy greatly increased personal security.

Aged Americans are indeed receiving more and better health care, because of medicare, than ever before in history. For the first time in their lives, many have access to the full health resources of their communities and many have received hospital care as private patients. And many have received surgical or corrective therapy that, without medicare, would have been delayed or not undertaken at all. Thus, the full results of the medicare program cannot be measured in statistics alone. They can only be seen when one examines its effect upon the individual beneficiary, when one sees the increased physical well-being, the greater vitality, and the heightened personal fulfillment now enjoyed by millions of aged Americans because of medicare.

These benefits alone prove the great worth of medicare. But the program has produced additional results of benefit to all Americans, not just our aged.

The program's quality standards for participating hospitals, extended care facilities, home health agencies, and independent laboratories have resulted in a substantial improvement of health facilities throughout the Nation, and this improvement is continuing. Moreover, medicare has demonstrated how effective utilization review can improve health care practices.

Medicare pioneered new pathways in health insurance through insured alternatives to hospital care: hospital outpatient services, posthospital extended care, home health care, and the provision of physician's services at home and in the office. The program's success with insured alternatives to hospital care has established a desirable pattern for the Nation's health insurance industry.

The application of the requirements of the Civil Rights Act, in the implementation of medicare, has resulted in minority group access to high quality care for the first time in many communities.

Medicare's accomplishments are impressive. However, it should be noted that medicare is and will continue to be affected by the basic problems of our health care system such as the shortage of health manpower and facilities and the rising costs of hospital and medical care. Adequate solutions to these problems cannot be devised by any single program, no matter how large. They will be achieved only through a cooperative national effort, involving many diverse groups, organizations, and individuals who are interested in and affected by our health system.

We intend to consolidate the gains made by medicare in its first year, and we intend to refine, simplify, and improve its administration. At the same time, we look forward to taking part in the crucial effort to develop and support promising solutions to the problems now facing our national health care system.

Respectfully,

WILBUR J. COHEN,
Secretary.

MEDICARE

IMPLEMENTATION

(JULY 30, 1965–JUNE 30, 1966)

OPERATION

(JULY 1, 1966–JUNE 30, 1967)

"The success of the medicare program in its first year has surpassed even the expectations of some of its staunchest supporters. The program is fulfilling the promise that older Americans and their families will be free of major financial hardship because of illness."

{ President Johnson, July 1, 1967, the first anniversary of Medicare }

Summary of first year's operations (July 1, 1966—June 30, 1967)

Enrollment (at end of period):	
Hospital insurance	19, 400, 000
Medical insurance	17, 900, 000
Inpatient admissions and plans for home health services:	
Inpatient hospital admissions	5, 000, 000
Extended care facility admissions	199, 000
Home health plans initiated	228, 000
Health insurance bills paid:	
Inpatient hospital	4, 700, 000
Outpatient hospital	1, 200, 000
Extended care	330, 000
Home health	450, 000
Physicians' and other medical services	13, 700, 000
Benefits paid:	
Hospital insurance	$2, 525, 000, 000
Medical insurance	$669, 000, 000
Participating providers of services (at end of period):	
Hospitals	6, 831
Extended care facilities	4, 089
Home health agencies	1, 808
Independent laboratories	2, 380
Intermediaries and carriers (at end of period):	
Hospital insurance	13
Blue Cross Association (involving 74 plans)	1
Commercials	9
Independent	2
State agency	1
Medical insurance	50
Blue Shield	33
Commercials	15
Independent	1
State welfare department	1
Group practice prepayment plans (at end of period):	
Direct dealing	24
Carrier dealing	42
Administrative expenses: [1]	
Hospital insurance	$89, 000, 000
Medical insurance	$134, 000, 000

[1] Includes some administrative expenses incurred in fiscal year ending June 30, 1966.

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FIRST ANNUAL REPORT ON THE MEDICARE PROGRAM

Introduction

The Health Insurance for the Aged Act, which provided for the establishment of the medicare program, was enacted on July 30, 1965, as part of the Social Security Amendments of 1965. This act provided for the establishment of two separate health insurance programs for older people—a hospital insurance program covering almost all people age 65 and over, and a supplementary medical insurance program covering those people age 65 and over who voluntarily enroll and pay the required premiums. The assumption of the basic administrative responsibility for these vast new programs presented an unprecedented challenge to the organization and staff of the Social Security Administration on a local, regional, and national level. The response of the Social Security Administration and the other Government and non-Government agencies, organizations, and institutions involved in the administration of the medicare program is reported in the following pages.

While this report is limited to the implementation of medicare under title XVIII of the Social Security Act, it is important to note that the 1965 amendments also provided for major improvements in the cash benefits provided under the social security program that had to be implemented along with the medicare program. These improvements included a general increase in benefits and substantial liberalizations in the old-age, survivors, and disability insurance coverage and benefit provisions that enabled millions of additional people to meet the eligibility requirements of the program. Implementing major changes in the old-age, survivors, and disability insurance program provided for under title II of the Social Security Act, along with the vast new medicare programs created under title XVIII of the act taxed the resources available for every aspect of the administration's responsibilities. For example, in addition to processing the applications required to establish hospital insurance eligibility for about 3.5 million people not receiving social security or railroad retirement benefits, the Social Security Administration processed an estimated 5 million claims for cash benefits during the year following the 1965 amendments. The overall effect was an increase from 3.5 million claims in fiscal year 1965 to 8.5 million claims in fiscal year 1966, more than doubling the claims load. At the same time, the Social Security Administration was processing an estimated 22 million applications for enrollment in the supplementary medical insurance program.

It is also important to note that the Social Security Administration was assisted in implementing the medicare program by the Public Health Service and other components of the Federal Government, State agencies, Blue Cross, Blue Shield, private insurance organizations, virtually every major organization and association in the health

care field and innumerable individual experts. The successful implementation of the medicare program was an outstanding example of cooperation for the common good in which every American can take justifiable pride.

This first annual report covers both the preparations in the 11–month period preceding July 1, 1966, when the program became operative, and the operations of the program during the first full year of benefit payment. The highlights of each of these periods are presented in the first chapter of the report. The organization for the administration of the program is described in the second chapter of the report. The third chapter covers activities carried out to establish the eligibility of aged people for protection under the program. The fourth chapter covers the establishment of the eligibility of health-care institutions to participate in the program. The fifth chapter of the report deals with claims and provider reimbursement under the hospital insurance part of the program. The sixth chapter deals with claims and payment for services under the medical insurance part of the program.

CHAPTER I

Highlights and Summary

PREPARATION

(JULY 30, 1965—JUNE 30, 1966)

During the 11-month period between enactment of the Social Security Amendments of 1965 and the start of operations, the administrative design for operation of the new program was established. The Social Security Administration and other components of the Department reorganized, recruited, and retrained personnel, and reprogramed systems and operations to accommodate their broadened responsibilities; regulations, policies, procedures, and systems were developed for the medicare program; contracts were negotiated with State agencies, intermediaries, and carriers, covering the role each would play in the administration of the program; eligible people were enrolled in the program; thousands of hospitals and other health care institutions were surveyed and certified to participate as providers of services under the program; and public information programs were launched to inform affected individuals of their rights and responsibilities under the new program.

Establishing the beneficiary rolls

One of the largest and most important tasks involved in implementing medicare was to inform people age 65 and over of their rights under the hospital insurance part of the program and their eligibility for coverage under the medical insurance part of the program and to arrange for them to submit the necessary application forms. The hospital insurance part of the program automatically covered almost all people age 65 and over. However, approximately 3½ million people who were not on the benefit rolls of either the social security or railroad retirement programs had to file applications in order to establish their entitlement. Coverage under the medical insurance part of the program required voluntary enrollment in every case.

To assure that no one was disadvantaged by lack of information or lack of opportunity to enroll, the Social Security Administration mounted a public information campaign through all available media, followed up by direct contact and, where necessary, recontact with virtually all of the 19 million people aged 65 or over in the Nation.

Of the 19.1 million people who would be 65 by July 1, 1966, 15½ million were reached through social security and railroad retirement cash benefit rolls, 1 million were reached through the State welfare rolls, 1 million through Internal Revenue Service records and 300,000 through the civil service retirement benefit rolls. The remaining aged were reached through a variety of approaches such as mailing of information about the program to the administrators of homes for the

aged and skilled nursing homes, and special projects such as "Medicare Alert," under which older people were employed to help inform the aged who were homebound or for other reasons were especially difficult to reach. Throughout this effort, excellent cooperation was obtained from television and radio stations, the press, employers, unions, senior citizen organizations, insurance companies, Blue Cross and Blue Shield organizations, and various citizen groups.

By July 1, 1966, entitlement to hospital insurance had been established for 18.9 million people—almost all those potentially entitled. Over 90 percent of those potentially entitled—17.6 million people—had been signed up for the medical insurance coverage.

Bringing providers of service into the program

Another major task involved in implementing the medicare program was informing hospitals, extended care facilities, home health agencies, and independent laboratories of the conditions under which their services might be covered under the program and establishing whether institutions wishing to participate met these conditions. The law provides that hospitals which meet the accreditation standards of the Joint Commission on Accreditation of Hospitals are automatically eligible to participate, provided they have established the utilization review procedures required under the law and are in compliance with title VI of the Civil Rights Act. However, the 4,000 hospitals not accredited by the JCAH, the nearly 6,000 institutions applying to be designated as extended care facilities, the more than 1,300 home health agencies, and the nearly 3,000 independent laboratories wishing to provide covered services under the program had to be surveyed to determine whether they were in compliance with the conditions set forth in the statute and the health and safety conditions promulgated by the Secretary. This huge task was accomplished through a cooperative effort involving State agencies in every jurisdiction—which performed the actual survey of health facilities and certified to their compliance with the conditions of participation—and the U.S. Public Health Service, which worked with the Social Security Administration in developing the conditions of participation in the program and determining compliance with the civil rights requirements.

By July 1, 1966, 6,200 hospitals, representing about 97 percent of the short-term general hospital beds in the country, were participating in the program, having met both the quality standards for participation and those of title VI of the Civil Rights Act. After an intensive drive to stimulate the establishment of new home health agencies and the expansion and strengthening of existing ones, 1,200 [1] agencies were able to qualify to participate by July 1 when the program became operational. By January 1, 1967, when extended care benefits first became payable, 2,800 extended care facilities, representing about 210,000 beds, had qualified for participation in the program. The services of independent laboratories were covered under interim guidelines until December 16, 1966, at which time the final conditions for coverage of such services became effective. By that date, some 2,100 laboratories had been approved for coverage.

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[1] Does not count some 250 subunits of 7 State health departments. When the program began, only the 7 departments were certified; the individual subunits were later certified to participate as separate agencies.

Efforts to assist health facilities to eliminate deficiencies and to bring additional facilities into compliance with the civil rights requirements are continuing, particularly in areas where there are shortages of participating facilities. By January 31, 1968, 6,862 hospitals, 4,421 extended care facilities, 1,898 home health agencies, and 2,406 independent laboratories were participating in the program.

Contracting with insurance organizations

While providers were being brought into the program and entitlement to benefits was being established, arrangements were being made—as provided by law—with insurance organizations to handle the processing of claims and certain other administrative functions under the medicare program. Hospitals, extended care facilities, and home health agencies, working through their associations or groups, have the right to nominate the fiscal intermediaries through which they are reimbursed, or they may elect to obtain reimbursement directly from the Social Security Administration. Under the medical insurance part of the program, the Government selects carrier organizations to perform the major administrative functions connected with the payment of bills from physicians and suppliers of other types of covered services or equipment.

Many organizations were nominated to serve as intermediaries. Their capacity to do the job had to be evaluated in the light of criteria developed by the Social Security Administration. A similar evaluation procedure had to be followed in selecting from among the large number of organizations which sought to serve as carriers. By July 1, 1966, agreements had been executed with the Blue Cross Association (acting as prime contractor on behalf of 74 individual Blue Cross plans), as well as with nine commercial insurance companies, two independent plans, and one State agency, to act as fiscal intermediaries for providers under the hospital insurance part of the program.

To act as carriers for the medical insurance part of the program, 33 Blue Shield plans, 15 commercial insurance companies, one independent health insurance plan, and one State welfare department were selected. Special contractual arrangements were also made with a number of group practice prepayment plans.

The Social Security Administration prepared manuals, guidelines, and other instructional and training material covering (1) the policies and procedures to be followed by the intermediaries and carriers in carrying out their functions, and (2) the administrative activities—such as budgeting, procurement, and reporting—which they would be required to carry out. In addition, the Administration provided these organizations with assistance, as needed, in tooling up for their new operations.

Intradepartmental administrative response

Planning within the Department to accommodate the new responsibilities to be assumed under the 1965 amendments began before enactment of the medicare law. While areas involving standards for professional personnel and institutions and civil rights requirements were assigned to the Public Health Service and certain consulting responsibilities were assigned to the Welfare Administration,[2] the responsibilities for organizational and systems development and for imple-

[2] Now assigned to the Social and Rehabilitation Service.

mentation of all aspects of medicare were assigned to the Social Security Administration. Partly in response to new workloads under medicare, and partly in response to expanded workloads under the cash benefits program, the Social Security Administration had opened some 100 new social security offices throughout the country and had increased its staff by 5,000 people before July 1, 1966, when medicare became operative, and by an additional 4,000 people in the first year of operation. The Bureau of Health Insurance, which was organized within the Social Security Administration to assume primary responsibility for medicare administration, had 600 people on duty by the time the program became operative and added 300 more by the end of the first year of operation.

At the same time, the Social Security Administration's data processing systems for the health insurance program were being designed; and well before July 1, 1966, the systems were ready to operate. These systems were set up centrally under both parts of the health insurance program so that information would be readily available to intermediaries and carriers wherever the beneficiary received services. Included are systems for maintaining the individual enrollee's eligibility status, his medical insurance premium account, utilization records and deductible status, as well as systems for recording the participation of providers of services and independent laboratories. The intermediaries and carriers quickly developed claims processing operations which tied in with the Social Security Administration's system. An extensive statistical program was also developed to provide the information needed for evaluating the new health insurance program.

In consultation with representatives of providers of health services, professional groups, and the insurance industry, billing and reporting forms were developed and procedures formulated with a view to ease of understanding and use. For the most part, the forms were less complex than those used in other major public and private plans. However, certain provisions of the medicare law required somewhat different information than that required by private insurers. When the program was initiated, immediate attention was given to the problems created by these differences, and a combination of informational activities and form modifications was quickly employed where necessary. Analysis and reappraisal of forms and procedures to improve and simplify design is a continuing activity.

Developing policy for the administration of the program

It was recognized that implementation of the statutory provisions of medicare would have important effects on the health care industry, welfare programs, and private insurance systems. For this reason, as well as to assure sound administration, elaborations of the statutory provisions through the development of program policies were made only after full consultation with appropriate professional groups and associations throughout the country.

As the first step, the staff of the Department of Health, Education, and Welfare engaged in an intensive study of important policy areas. Then there was extensive consultation on all important policy issues with many professional groups, with outside consultants, and with groups representing employees contributing to the program. The American Hospital Association and the American Medical Association, for example, each established special committees to work directly

with the Government on policy matters. A number of technical work groups were convened, representing in each case the appropriate professional and institutional groups in the health care industry. These technical groups helped develop and refine positions and alternatives in the most critical areas of policy development. The recommendations of these groups were fully considered in policy formulation and the preparation of regulations.

All of this activity was preliminary to consideration of proposed policy and administrative processes by the Health Insurance Benefits Advisory Council. As provided under the medicare law, the Council is made up of experts in the delivery and financing of health care and representatives of the general public. Under the chairmanship of Kermit Gordon, the Council reviewed all significant policies and procedures for the administration of the program.[3]

IMPACT

(JULY 1, 1966–JUNE 30, 1967)

The extensive planning and consultation in preparation for program operation were rewarded in the months that followed July 1, 1966, as it became apparent that, although almost unprecedented in magnitude as a peacetime undertaking and although many aspects of its coverage and administration were new and untried, the program was working well. Some idea of the magnitude of medicare's operations in its first full year is indicated in the table on the inside cover of this report, which shows benefits paid and the number of people and institutions participating, and in charts below, which show the proportions of the expenditures for hospital and physicians' services for the aged met through the program.

During the first year of operation, the older people of the Nation received from 15 to 20 percent more inpatient hospital services than in previous years; and they received these services without the overcrowding of facilities which some people had predicted. The lives of many elderly people have been improved, and often prolonged, because of these services. Almost as important, many who would have received hospital care as charity patients, received such care instead as private patients and on the orders of their own private physicians. For many, the choice of health services has been broadened for the first time to include the full range of quality health care available in the community.

The program has made available insured alternatives to hospital care; that is, hospital outpatient services when appropriate for diagnosis or treatment; posthospital extended care when further hospitalization is not the most appropriate level of care; home health care when that is the most appropriate medical response; and the coverage of physicians' services for home and office visits as well as in an institution. Through the breadth of its coverage, medicare has facilitated the physician's choice of the most appropriate level of care for the medicare patient.

In addition, all older people covered by the program have the security that comes from knowing that serious illness is much less likely to be a major financial problem for them or require them to seek financial

[3] A list of Council members appears in app. A, exhibit 3.

Figure 1--Expenditures for Hospital Care for the Aged, by Source of Funds, Fiscal Year 1967

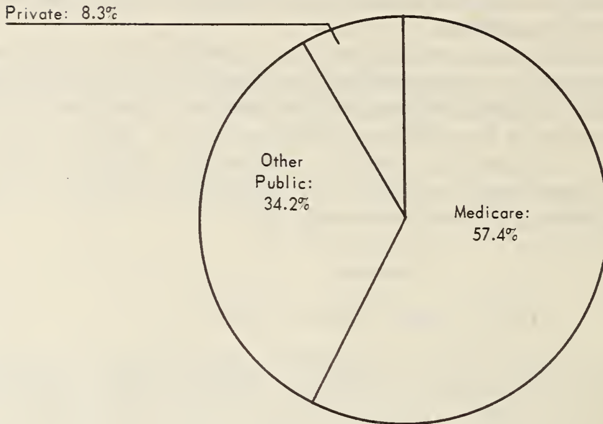
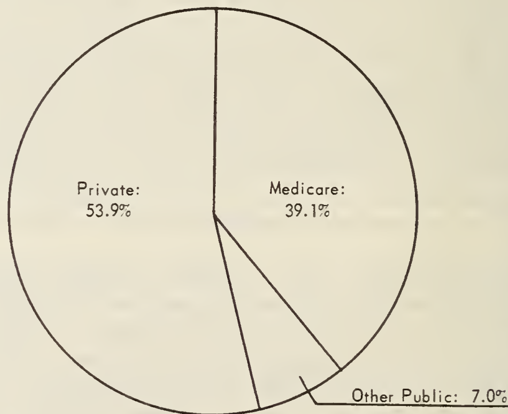


Figure 2--Expenditures for Physicians' Services for the Aged, by Source of Funds, Fiscal Year 1967



help from their children. This is particularly true for the older people who had no health insurance prior to medicare, but is also true of the large number of aged people who had some insurance but much less comprehensive protection than is provided by the medicare program.

Another accomplishment of medicare—one which affects not only the elderly, but patients of all ages—was the upgrading of health care that took place as the result of the quality standards established under

medicare. A substantial upgrading has already taken place in many institutions and independent laboratories, and further upgrading is underway in many facilities as a condition of continued participation in the program. Moreover, the requirement of conformity with title VI of the Civil Rights Act of 1964 by participating institutions has resulted, in many communities, in minority group access to high quality care for the first time.

PROGRAM EVALUATION AND SIMPLIFICATION

Program evaluation and simplification were carried out on an ongoing basis throughout the period of preparation and initial operation. Many problems were anticipated and avoided; other problems were revealed by initial operations and were met by policy or administrative changes and in some instances by changes in the law.

A major goal of program administration has been to reimburse providers currently to avoid the serious financial problems they would face if working capital were tied up in medicare accounts receivable. Months before the program went into effect, the preparation of procedures designed to assure timely payment to providers was well underway. These procedures are being continually reviewed and modified in the light of program experience.

Under procedures in effect from the start of program operations, interim payments approximating a provider's actual costs are made by intermediaries at least monthly, and in most cases weekly, as bills for covered services are submitted. In addition to the basic procedure of making interim reimbursement after bills have been submitted, payments may also be made, upon request by the provider, on a basis designed to reimburse currently for services furnished to beneficiaries.

In the early months of operation, some hospitals experienced financial difficulty because they were unable to complete their medicare billings promptly, or because intermediaries were unable to pay the bills as quickly as desired. Intermediaries were authorized to make accelerated payments on account if the provider was able to demonstrate that its working capital position was being impaired as a result of billing or processing delays and that it would have difficulty in meeting current financial obligations. In addition to these procedures, the Social Security Administration made available an entirely new approach to interim reimbursement for hospital services in January 1968. This new approach should not only reduce the amount of paperwork to a minimum and assure a steady flow of funds to hospitals under medicare, but also, perhaps, become a prototype for payment procedures under other large-scale hospital insurance operations. The new interim payment procedure provides fixed periodic interim payments based on the hospital's prior medicare cost experience, adjusted for changes in medicare utilization, price and wage levels, new or expanded services, and other significant factors. Final settlement will be made at the end of the accounting year, based on actual costs.

In adopting its policies and procedures with respect to outpatient hospital services, the Social Security Administration made every effort to simplify the distinctions that had to be made because of the split coverage of such services under the two parts of the program. However, the administrative costs and difficulties encountered by hospitals in preparing outpatient bills was disproportionate to the small bills

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involved. In addition, hospitals were often unable to determine the patient's deductible status at the time the service was rendered and, once the patient had left the hospital, it was difficult to collect the small amounts due. In response to these problems, the Department sought, and the Congress enacted under the 1967 amendments, a change in the law consolidating all coverage of outpatient hospital services under the medical insurance part of the program and eliminating the special $20 outpatient diagnostic deductible.[4] This change, along with an additional provision of the 1967 amendments allowing hospitals to collect from medicare patients the full amount of patient charges of $50 or less, will simplify the hospitals' billing procedures, and facilitate beneficiary understanding of the program.

The Department developed comprehensive principles for the reimbursement of hospital-based physicians in consultation with all interested parties and the Health Insurance Benefits Advisory Council. Copies of these principles were distributed to intermediaries, carriers, hospitals, and professional groups, and—after taking account of pertinent comments—they were published as final regulations on October 18, 1966. The regulations are designed to be responsive to, but not interfere with, the arrangements adopted by hospitals and hospital-based physicians. However, the regulations required agreement between hospitals and physicians for the identification of compensation to the physician for services to individual patients as a basis for the reasonable charge determinations to be made under the law. By the end of the first year of operation, acceptable agreements had been reached by most participating hospitals and the hospital-based physicians. Nevertheless, throughout the first year of operation, continuing difficulty was experienced with the split billing required under medicare for services of radiologists and pathologists that normally would have been billed by hospitals on a consolidated basis. To permit administrative simplification of the reimbursement procedures involved, and to bring medicare coverage into line with the coverage provided under most other health insurance programs, the 1967 amendments to the Social Security Act eliminated the medical insurance deductible and coinsurance amounts for certain inpatient radiological and pathological services.

Difficulties of another kind were encountered with the requirement that a physician certify to the need for outpatient hospital services or inpatient hospital admission. While the procedures adopted for such certifications applied the legislative requirement as flexibly and simply as possible, and the vast majority of hospitals and physicians offered no objections to the implementation of such procedures, there were physicians who considered these procedures unnecessary and objectionable on the ground that the act of admitting a patient to a hospital was almost always an adequate indication of the need for admission. Experience in the first year of operation indicated that physician certifications of the need for outpatient hospital services or of the need for inpatient hospital services at the time of admission were of little practical value in avoiding unneeded utilization. Consequently, as part of the 1967 amendments, the Congress enacted a change in the law eliminating the requirements for physician certification of the need

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[4] For the effective date and other details of this provision and the other principal provisions of the 1967 amendments, see app. E.

for most outpatient hospital services and for physician certification at the time of admission of the need for inpatient services in hospitals other than psychiatric and tuberculosis hospitals. (The requirement for certification of medical necessity at the time of admission was retained for psychiatric hospitals, tuberculosis hospitals, and extended care facilities, and at the initiation of home health services since special conditions, as well as the specific need for the services provided by these institutions and agencies, are attached to payment for their services.)

Also related to the objectives of avoiding payment for unneeded care is another provision to which considerable attention has been given: utilization review. This requirement for participation in the program applies to both hospitals and extended care facilities. It is intended to promote the most efficient use of available services and facilities through (1) the review of admissions, length of stay, and the professional services furnished, on a sample or other basis, and (2) the review of each case of extended duration. This review is conducted by a staff committee of the institution or an outside group, whose membership includes at least two physicians (and may include other professional personnel). Since the health care professions had recognized for some time the need for mechanisms which would assure quality care of patients and sound utilization of institutional facilities and professional services, the concept of utilization review as a function of the medical community had been receiving increasingly widespread support. Before medicare, however, only about 1,000 hospitals had utilization review committees. Now, all of the almost 7,000 hospitals and 4,500 extended care facilities participating in the program have utilization review committees. Much remains to be done, however, to assure the proper functioning of these committees, and this is an area that will need constant attention in the years ahead.

During the first year of operation, there were 26½ million bills submitted for physicians' and other medical services under the medical insurance program. To meet the difficulties experienced in many parts of the country in coping with the resulting workloads, the Social Security Administration worked closely with the carrier organizations in training personnel, developing electronic processing capability, and in refining administrative procedures and processes. These efforts reduced the carriers' average pending workloads from a peak equivalent of 7.9 weeks' work on hand at the end of August 1966 to 2.7 weeks' work by the end of June 1967.

At the same time, intensive efforts were made to improve coordination between medicare and medicaid programs by furnishing medicare claims information to the State plans administering medicaid programs under title XIX of the Social Security Act, and through the development of common claims forms, cost report forms, and audits.

Careful evaluation was made from the outset of program operations of the effects of the provision of law requiring the patient to pay medical bills before claiming payment under the program if the physician or supplier would not accept an assignment of benefits. Where physicians were unwilling to accept assignments, many beneficiaries experienced financial hardships in paying medical expenses from their limited funds, and some even had to borrow to do so. The Department sought legislation to relieve these hardships and relief was granted

by the Congress under the 1967 amendments by a provision permitting payment to a beneficiary under the medical insurance program based on unpaid and unassigned bills for medical services.

The responses described above are illustrative of the administrative and legislative actions that have been taken to improve the program, simplify its administration, and meet specific problems as experience developed during implementation and initial operations. This work is continuing.

LOOKING FORWARD

While the medicare program has been successfully launched and substantial progress has been made in meeting initial operating problems, much remains to be accomplished. For example:

A continuing effort will be needed to improve beneficiary understanding of the program.

The utilization review committees that have been established by hospitals and extended care facilities to meet the requirements of medicare must be brought to their potential level of effectiveness in assuring appropriate utilization of health facilities.

Intermediary and carrier claims processes will require careful attention to assure that adequate safeguards exist to prevent improper payment under the program and to assure that the amounts paid are reasonable.

Efforts must continue to assure that providers maintain and continue to upgrade the quality of their facilities in line with the conditions of participation in medicare and that the conditions themselves remain responsive to contemporary standards in the health care field.

Provider compliance with the Civil Rights Act and intermediary and carrier compliance with equal employment opportunity requirements must be enforced with unceasing vigor.

Aside from its own policies and procedures, medicare will continue to be affected by trends in the delivery and financing of health care. For example, the rising cost and utilization of medical care were major factors underlying the increase in medical insurance premium rates that went into effect in April 1968,[5] and the increase in the cost of inpatient hospital services from 1966 to 1967 will determine the hospital insurance deductible and coinsurance amounts that will be promulgated for 1969.

Although medicare did not create the problems of rising cost and the other fundamental problems that have existed in the delivery and financing of health care for many years, it has helped bring them to public attention, and the Department is very much involved in the general responsibility to contribute to their solutions. Intensive efforts are underway in many segments of the Federal Government, State governments, and by private organizations and experts to find new and better approaches in the development of high quality health manpower and facilities, the effective and efficient use of health resources, and the equitable and economical financing of all forms of health care.

The Department is giving its full support to these efforts. One of the steps the Department is taking is to review carefully the experi-

[5] For the actuarial assumptions and bases for this rate increase, see app. F.

ence with medicare cost reimbursement to hospitals and other health care institutions, and medicare payments to physicians and other suppliers of medical services, with a view to making or recommending such administrative or legislative changes as seem warranted by developing experience. In support of this review, and in accordance with the provisions of the 1967 amendments to the Social Security Act, the Department will engage in experiments with various methods of reimbursement to institutions and payment to physicians providing services covered under medicare, medicaid, and the maternal and child health programs to develop additional incentives to efficiency and economy while supporting or improving the quality of the services.

The Department has placed high priority on meeting the problems of inadequate health manpower and facilities, and rising hospital and medical costs. Medicare will play an important role in the overall effort to develop and support promising approaches. However, the ultimate resolution of the problems faced in providing and financing health care will require a cooperative effort involving Government and community action at all levels and every component of the health care field.

CHAPTER II

Organization for Administration

Overall responsibility for administration of the medicare program is vested by law in the Secretary of Health, Education, and Welfare. The statute also provides for participation in the administration of the program by private organizations and by public agencies at the State level. In addition, the Secretary, in developing administrative policies and procedures, has sought the advice of leaders of organizations affected by the program and of other individuals who are experts in the delivery and financing of health care.

Within the Department of Health, Education, and Welfare, the Secretary delegated major policy and administrative responsibilities to the Social Security Administration, certain responsibilities in the areas of implementation of title VI of the Civil Rights Act of 1964 and of professional standards to the Public Health Service,[1] and certain consultative responsibilities concerning the interrelationships of the health insurance program, public assistance, and State medical assistance programs to the Welfare Administration (now to the Social and Rehabilitation Service).

Role of the Social Security Administration

Under its delegated responsibility for the formulation of policy and the general management of the health insurance program, the Social Security Administration negotiates and administers agreements with the intermediaries and carriers which perform the payment function; with the State agencies which certify health facilities for participation in the program; and with hospitals and other institutions which provide services for which the program makes reimbursement. The Administration also develops the principles for the reimbursement of institutions and agencies which provide services covered by the program; participates with the Public Health Service in the formulation of the conditions of participation; formulates medicare regulations; develops program policy and procedural instructions; performs the recordkeeping and data processing functions required for administration of the program; collects and analyzes a variety of cost and utilization data; and prepares estimates of future program costs.[2]

Within the Administration, the Bureau of Health Insurance—established shortly after the enactment of the program—has primary responsibility for the formulation of policies and procedures and for the overall administration of the health insurance program.[3]

In addition to the Bureau of Health Insurance, many other Administration components have substantial program responsibilities. The

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[1] Responsibility for establishing compliance of providers with title VI of the Civil Rights Act has since been assumed by the DHEW Office of Civil Rights.

[2] A chart showing the organization of the Social Security Administration appears in app. A, exhibit 1.

[3] A chart showing the organization of the Bureau of Health Insurance appears in app. A, exhibit 2.

Administration's field organization—composed of the various regional offices, district and branch offices, and contact stations throughout the country—carries out enrollment activities and serves as a continuing source of basic program information and direct service to beneficiaries and to the general public.

A Division of Health Insurance Studies has been established in the Administration's Office of Research and Statistics to collect data on program operations and to carry out analytical studies designed to evaluate the program and measure its performance.

The Office of the Actuary has responsibility for the actuarial evaluation of the hospital insurance and medical insurance programs, including the preparation of the actuarial estimates used in setting the medical insurance premium and hospital insurance deductible and coinsurance amounts.[4]

The Office of Information, which has primary responsibility for developing and coordinating the Administration's informational activities, prepares exhibits, films, visual aids, booklets, and other informational materials required to inform the public as well as special professional audiences of their rights and responsibilities under the program.[5]

The Bureau of Data Processing and Accounts expanded its electronic data processing capabilities to maintain the millions of records on beneficiary eligibility, utilization of covered services, and deductible status for the health insurance program. The Bureau also sends premium notices to, and maintains records on the payment of medical insurance premiums by, the approximately 2½ million enrollees who make direct payments or for whom premium payment is made through private retirement groups or similar organizations.

An insurance compliance staff was established in the Office of Administration of the Social Security Administration to assure that insurance companies, Blue Cross and Blue Shield plans, and other organizations performing on insurance contracts with the Federal Government—including the fiscal intermediaries and carriers assisting in the administration of medicare—fully comply with the equal employment opportunity requirements of Executive Order 11246. Since the Social Security Administration's equal employment opportunity activities got underway, substantial progress has been made by the insurance industry. Between December 1965 and November 1967, total employment of medicare carriers and intermediaries increased by 11.9 percent, of which nearly 35 percent represented hirings of members of minority groups. Perhaps more important in the long run, there have been significant changes in attitudes, promotional policies, and other personnel practices which are certain to result in continuing improvement. Examples include the abolition of tests which previously barred minority group members from employment, and an uptrend in hiring of minority group employees for white collar, technical, and sales positions.

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[4] The actuarial assumptions and bases employed in arriving at the medical insurance premium for the period April 1, 1968, through June 30, 1969, are set out in app. F. The first annual promulgation of the hospital insurance deductible is to be made between July 1 and October 1, 1968, and will be effective for calendar year 1969.

[5] A list of selected informational publications on medicare appears in app. G.

Role of the Public Health Service

Within the Public Health Service, the Division of Medical Care Administration provides primary support for professional health aspects of the medicare program, calling on other units of the Service for special consultation as needed. The ongoing activities of the Division of Medical Care Administration which are directly related to medicare include: Participating with the Social Security Administration in formulating the conditions of participation for providers of services, developing policies on the role of State agencies, providing assistance to the State agencies in carrying out their medicare responsibilities, supporting and evaluating experimental approaches to utilization review, and providing professional advice on the many technical and medical questions that arise.

Other activities of the Public Health Service, such as its participation in the assessment of the adequacy of existing health resources and in the development of additional needed resources, although not specifically related to the implementation of medicare, are of great importance to the success of the program. In addition, the Public Health Service had the lead responsibility for establishing the compliance of providers with title VI of the Civil Rights Act [6]—an effort that initially involved heavy staff commitments by both the Public Health Service and the Social Security Administration.

Role of the Social and Rehabilitation Service

The Social and Rehabilitation Service collaborates with the Social Security Administration and the Public Health Service in those aspects of program planning, coordination, and evaluation involving the interrelationships of the health insurance program with public assistance and State medical assistance programs. In addition, the Social and Rehabilitation Service provides consultation and general and technical assistance to State agencies administering medical assistance programs and coordinates these plans with medicare.

Health Insurance Benefits Advisory Council

The law provides for the establishment of a Health Insurance Benefits Advisory Council to advise the Secretary on matters of general policy in the administration of the health insurance program.[7] The initial appointments to the Council, which, as required by law, included leaders in the health care field and representatives of the general public, were announced by President Johnson on November 11, 1965. Kermit Gordon, former Director of the Bureau of the Budget and now President of the Brookings Institution, was named chairman.[8]

From its establishment through June 30, 1967, the Council met 16 times, usually for periods of 2 to 3 days, to consider and offer recommendations on all major aspects of medicare administration. In all, the Council adopted resolutions constituting formal advice to the Secretary on more than 100 policy issues, including the conditions of par-

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[6] Responsibility for establishing compliance of providers with title VI of the Civil Rights Act has since been assumed by the DHEW Office of Civil Rights.

[7] The Social Security Amendments of 1967 increased the membership of the Council from 16 to 19 members and broadened the scope of the Council's responsibility to include study of the utilization of hospital and other medical care and services for which payment may be made under title XVIII with a view to recommending any changes which may seem desirable in the way in which such care and services are utilized, in the administration of the programs established by title XVIII, or in the provisions of title XVIII.

[8] Council members as of June 30, 1967, and as of the date of this report, are listed in app. A, exhibit 3.

ticipation for hospitals, extended care facilities, home health agencies, and independent laboratories; the principles of reimbursement for provider costs and for physicians' services; and on the policies governing physician certification and recertification of the need for medical services. Virtually all of the Council's recommendations are embodied in existing policy and regulations. There were few instances in which there was any significant difference between recommendations of the Council and the policies adopted, and there was no instance in which the policies adopted were unacceptable to the Council. In addition, the Council has made numerous decisions constituting informal advice to the staff in developing policy and regulations and requests for staff development or research on alternative policies for consideration.

Other consultation

In addition to the Health Insurance Benefits Advisory Council, the Administration established nine technical work groups. These groups included representatives of medical associations, hospital associations, nursing associations, dental associations, nursing home associations, commercial insurance companies, Blue Cross, Blue Shield, public health organizations, specialty organizations, as well as consumers, independent experts, and others. The groups studied and offered recommendations on such issues as the conditions of participation, the requirements for physician certification and recertification of the need for services, and the principles of reimbursement for provider costs. Their recommendations were considered in the formulation of the program policies and regulations submitted to the Health Insurance Benefits Advisory Council. Intermediary and carrier consultation groups were also established to allow a continuous flow of information on claims payment procedures and to facilitate the resolution of difficulties encountered by the intermediaries and carriers in the performance of their duties.

Role of the State agencies

The law requires that, wherever possible, the Secretary use the services of appropriate State or local health agencies or other appropriate State or local agencies in determining whether providers of medical services and independent laboratories meet the conditions for participation in the medicare program. Shortly after enactment, upon invitation from the Secretary, the Governor or Chief Executive of all 55 jurisdictions (including the District of Columbia, Puerto Rico, the Virgin Islands, Guam, and America Samoa) had designated agencies—in most instances State health agencies—to perform this function, and agreements were negotiated with all of the States by the end of January 1966.[9]

In carrying out their responsibilities under the health insurance program, the State agencies conduct field surveys of institutions and agencies to determine the extent to which these facilities meet the applicable conditions of participation, undertake periodic resurveys of participating facilities to determine whether they continue to meet such conditions, provide consultative services to facilities experiencing difficulties in meeting the participation requirements,[10] identify non-

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[9] A list of participating State agencies appears in appendix A, exhibit 4.

[10] The consultative function is now fully financed by medicare. However, under the 1967 amendments, it will be financed instead from Federal and State matching funds under the medicaid program beginning July 1, 1969.

participating hospitals which can be reimbursed under the program for emergency services, and coordinate activities under the health insurance program with activities conducted under medical assistance programs. The State agencies are reimbursed for the costs of activities they perform in the program including related costs of administrative overhead and staff.

Role of the intermediaries

Under the medicare law, hospitals, extended care facilities, and home health agencies participating in the program may deal either through a fiscal intermediary of their choice for reimbursement of the costs of services rendered to medicare beneficiaries or directly with the Government. The Secretary is authorized to enter into agreements under which the intermediary assumes responsibility for determining the reasonable costs of services provided to beneficiaries and reimburses the providers for these costs on behalf of the program. In addition, the agreements authorize the intermediary to provide consultative services to providers, make audits of provider records, and perform related functions.

To be selected as a fiscal intermediary, an organization must first be nominated by an association or group of providers. Then the Social Security Administration must determine that the selection of the nominee is consistent with effective and efficient administration. Hospitals and other providers of services may choose a fiscal intermediary other than their group or association nominee under certain circumstances, or deal directly with the Social Security Administration. In evaluating intermediaries nominated by providers the Social Security Administration considered the organization's size, experience, demonstrated capability and capacity for paying claims, the effectiveness of its ongoing professional and institutional relationships, and its compliance with the equal employment opportunity requirements of Executive Order No. 11246. An additional consideration in the selection of intermediaries was the need to provide, through the participation of a variety of health insurance organizations, a basis for the comparison of relative performances in accordance with the intent of Congress.

Twenty agencies and organizations were nominated by provider associations or groups of hospitals. The American Hospital Association, representing about 85 percent of the Nation's hospitals, nominated the Blue Cross Association as the intermediary for its member hospitals. By July 1, 1966, when the program went into operation, agreements with the Blue Cross Association and 12 commercial health insurers had been established.[11]

The same procedure was followed in the selection of intermediaries for extended care facilities and home health agencies. Except for variations in geographic locations and the addition of one commercial health insurer—in the case of extended care facilities—and one State department of health—in the cases of home health agencies—intermediaries were the same as those chosen by hospitals across the Nation. By January 1, 1967, all of the extended care facility intermediaries had signed agreements and were ready to accept claims.[12]

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[11] A list of all hospital intermediaries, together with their service areas, appears in appendix A, exhibit 5.

[12] A list of all extended care facility and home health agency intermediaries and their respective service areas appears in appendix A, exhibit 5.

Role of the carriers

The Secretary is required by law to contract with organizations engaged in providing, paying for, or reimbursing the cost of, health services under group insurance policies to serve as carriers under the medical insurance program. Under the terms of these contracts, carriers are required to determine the amounts to be paid to physicians and to suppliers for services rendered under the program and to make payments for such services on behalf of the program, to assist in the application of safeguards against the unnecessary utilization of services, and to serve as a channel of communication for information relating to the administration of the program.

In the selection of carriers, consideration was given to such matters as the organization's financial responsibility and experience; its capacity to absorb the additional workload that would accrue from the medicare program; its ability to maintain effective professional relations within its service area; its compliance with the equal employment opportunity requirements of Executive Order No. 11246; and the need to provide, through the participation of a variety of health insurance organizations, a basis for the comparison of relative performance. Organizations wishing to serve as carriers were asked to indicate their willingness to do so in writing along with a statement of their qualifications. Approximately 140 such organizations submitted proposals. Following intensive review of the qualifications of potential carriers, which included onsite reviews of their operations by staff of the Social Security Administration, 33 Blue Shield plans, 15 insurance companies, and one independent health insurer were selected to serve as carriers.[13]

Supervision of intermediary and carrier performance

Shortly after the selections of carriers and intermediaries were completed, the Administration began the dissemination of manuals and other instructional materials to assist them in discharging their program responsibilities. Training sessions, including a series of technical workshops for carrier and intermediary staffs, were conducted throughout the country. Budgets were set up, funds were allocated to finance their medicare operations, and the procurement of needed equipment and space was closely monitored by the Administration to assure that by July 1, 1966, intermediaries and carriers would be as prepared as possible to perform the functions assigned to them.

Financial management.—Intermediaries and carriers operate under cost contracts with the Government under which they are expected to have neither profit nor loss as a result of their medicare operations. Guidelines were issued to enable intermediaries and carriers to determine what costs are reimbursable if incurred in the performance of medicare responsibilities. Two means of controlling carrier financial activities were instituted—a budget system and a cost reporting system.

Under the budget system, annual and quarterly claims workload estimates form the core of the budgeting process. In addition to the costs involved in claims processing, intermediaries and carriers have costs related to their other responsibilities which do not lend themselves so readily to precise measurement. These include provider and

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[13] A list of all carriers for the medical insurance program appears in appendix A, exhibit 6.

professional relations, utilization review, beneficiary services, and, most important from a cost standpoint, audits of providers. Provider audits are generally done by independent accounting firms under subcontract with the intermediaries.

Intermediaries and carriers are required to submit detailed justifications with their annual budget estimates which sufficiently explain the proposed use of funds requested. Items of possible expenditure must be explained fully and are considered in light of estimated workloads and productivity.

When budget analysis is completed, intermediaries and carriers are granted annual budget approvals which are apportioned on a quarterly basis. They are required to plan their operations within these annual and quarterly allocations and are not permitted to incur expenses in excess of them without written authorization.

Under the cost reporting system, each intermediary and carrier is required to submit quarterly cost statements and final annual cost reports based on its accounting year. The quarterly reports reflect actual administrative costs distributed functionally. In addition, they report total benefits paid and workloads processed during the period. These are reviewed in relation to such factors as manpower use, productivity, cost per claim, and the ratio of administrative costs to benefit payments. Significant deviations of incurred cost from the approved budget must be explained.

Final cost reports form the basis for audit and final cost settlement each year and are, therefore, submitted in greater detail. All of the information contained in the quarterly reports is included in these annual reports and, in addition, a detailed justification of proposed expenditures much like that required for budget estimates must be submitted. All pertinent information which has been accumulated about each intermediary and carrier becomes part of the contract reporting and monitoring system used to coordinate the entire system.

Contract reporting and monitoring system.—The various workload and financial reports which intermediaries and carriers are required to submit for a reporting period permit the evaluation of their operations and cost required for those operations. Workload reports reflect not only the quantity of work being done but also the timeliness of performance. Quantity of production is measured in terms of units received and units cleared. Currency of performance is measured in terms of claims awaiting action and the time required to complete them. Promptness is also measured in terms of the number and proportion of cases awaiting action for an atypical period (e.g., over 30 days) in relation to total pending. Complexity of workload is indicated by the distribution of claims by type, and the number of cases which must be returned for additional information or documentation before payment may be made. The monitoring system provides pertinent data for each intermediary and carrier and permits the computation of national averages for comparison purposes. When significant disparities between individual performance and national averages are identified, necessary corrective action is undertaken.

Audits of intermediaries and carriers.—The DHEW Audit Agency examines intermediary and carrier medicare operations. Although the primary purpose of the audits conducted by the audit agency is to review and approve administrative costs, the scope of these audits

is not limited to financial considerations. In addition to verifying financial transactions, auditors verify that funds were spent according to law, regulations, and procedures, and they consider whether policies, plans, and procedures are adequate for effective operations.

Contract performance review.—Teams from the Social Security Administration visit intermediaries and carriers to review their performance. The review team spends 3 to 5 days with the intermediary or carrier, observing and analyzing operating procedures, examining records, and interviewing personnel at all levels. The teams make a detailed examination of organization for performance of medicare functions, staffing of medicare positions, personnel, and management practices, and claims processing techniques. The team also assesses the effectiveness of the application of reimbursement principles, professional relations, beneficiary services, training, as well as the adequacy of space and equipment. Other aspects of performance are also included as may be considered appropriate in the particular situation.

Establishing the claims process

A major task in implementing the medicare program was the establishment of a nationwide system for obtaining uniform and reliable program information from organizations and individuals—providers, physicians, suppliers, intermediaries, and carriers—with widely differing recordkeeping systems and reporting capabilities. Such a system is basic to sound claims administration and management of the program and had to be operative at the outset of program operations. Design of the claims process for the health insurance program was begun before the medicare legislation was enacted. Methods and forms utilized by other programs were scrutinized for possible adaptation to medicare's needs. For example, the medical insurance claims form (Form SSA–1490, Request for Payment) was developed after extensive consultation with representatives of the health insurance industry and the medical profession.

Each step in the claims process was considered, researched, and analyzed with the help of representatives of the health professions and insurers and individual experts both in and out of Government. The planning and consultation required for developing the claims review, data processing, and recordkeeping systems went into full-scale operation after enactment. As a result of these efforts, when medicare went into effect, the program was prepared to receive, record, and adjudicate claims and to make benefit payments.

The systems for recording and updating each health insurance beneficiary's eligibility status, his medical insurance premium account, his utilization of covered services, and his deductible status, as well as systems for recording the participation of institutional providers of services and independent laboratories, were set up centrally within the Social Security Administration. One of the important issues considered during the preliminary consultation with various groups on the basic design of the claims processing and recordkeeping systems was whether the medicare eligibility records should be maintained centrally or on a decentralized basis by the fiscal intermediaries and the carriers. The existence, predating medicare, of a master eligibility record on all social security beneficiaries and the Administration's ready access—through the premium collection process, long-established beneficiary reporting procedures and the ongoing enrollment

process—to information on accretions to, and deletions from, the eligibility records were persuasive arguments for a centralized system. Moreover, the maintenance of such records by individual intermediaries and carriers would have required the development of a system of communications among them to disseminate eligibility information that would have substantially increased administrative costs.

The master eligibility record maintained at social security headquarters in Baltimore indicates whether aged individuals are entitled to hospital insurance benefits, to medical insurance benefits, or to both. The master eligibility file was established by combining data from the preexisting social security and railroad retirement beneficiary records with the records obtained from applications of uninsured people applying to establish eligibility under the health insurance program. The same sources are used to keep the eligibility records current—to add those reaching 65, and drop those who die or (in the case of the medical insurance program) who withdraw. The record also contains information on the extent to which individuals have used the benefits available in each spell of illness (now generally referred to as a benefit period) and on how much of the $50 medical insurance deductible has been met.

Each time a medicare beneficiary is admitted to a participating hospital or extended care facility, or begins a plan of care from a home health agency, the intermediary receives an admission or start-of-care notice. The intermediary sends identifying information and the date of admission or start of care to the Social Security Administration's central record system, which replies giving the patient's entitlement and deductible status, and remaining eligibility for benefits. The intermediary then advises the provider of the patient's eligibility for further benefits and his deductible status. Admission and start-of-care notices are sent to the Social Security Administration by teletype or, in some instances, on magnetic tape, or by direct magnetic-tape to magnetic-tape transmission over high-speed wires. Replies can usually be sent to the intermediary on the second working day after a request for eligibility information has been made.

During the course of treatment, or after the beneficiary is discharged from the hospital or extended care facility or completes a course of home health treatments, the provider submits either an interim or final bill to the intermediary for payment, subject to final settlement at the end of the accounting period. Utilization data are forwarded to the Social Security Administration so that the central records may be updated to provide accurate information in replying to subsequent notices of admission or starts of home health care.

Claims for payment of medical insurance benefits are submitted to the carrier by the beneficiary, or by the physician or supplier if they have agreed to accept an assignment of benefits. The carrier teletypes essential identifying information and the amount determined to be the reasonable charge for the services to the Social Security Administration. When the Administration receives the message, it informs the carrier of the amount of the deductible remaining to be satisfied and updates the deductible records. (Once a carrier has been advised that the deductible has been met, no further query on that beneficiary need be made for the remainder of that calendar year.) The carrier then

makes the appropriate payment to the patient, or physician or supplier. A record of the payment is sent to the Social Security Administration.

As a byproduct of the claims process, data are gathered which permit careful evaluation of the operations and impact of medicare. Before being finally adopted, medicare's statistical program was reviewed by a special Advisory Committee on Health Insurance Benefits Research and Statistics, composed of people prominent in the fields of health and medical research and statistics.

Coordination of medicare and State medical assistance programs

The intent and language of the medicare law and the principles of sound administration require coordination of medicare and State medical assistance programs and the adoption of complementary procedures wherever it is practical.

Most State welfare agencies need medicare billing information to determine the liability of welfare programs to medical vendors for services they provide to medicare beneficiaries who are also assistance recipients. The specific information needed is dependent upon the characteristics and provisions of the particular State medical assistance program. All State medical assistance programs participate to some extent in the payment of some combination of medicare deductibles, coinsurance amounts, or health care expenses not covered by medicare.

To facilitate welfare medical payments which supplement medicare coverage, a claims process was adopted which called for the flow of claims from the provider, physician, or other supplier to the medicare intermediary or carrier, and from there to the medical assistance agency. Even closer coordination can be achieved where the same organization serves in an administrative capacity for both programs. For the most part, mutually satisfactory arrangements have been reached between the intermediaries and the State agencies, but some difficulties have occurred in arranging for coordinated payment for services covered under the medical insurance program and State medical assistance programs. Procedures have been developed to overcome these and other administrative problems involving coordination of medicare and medical assistance programs. For example, common medicare and medical assistance claims forms have been developed, common carriers for both the medicare and medical assistance programs are authorized to issue combined checks covering payment under both programs, and common provider cost report forms and audits are under development.

Medical insurance enrollment and premium payments for assistance recipients under agreements with States are discussed in the following chapter.

CHAPTER III

Establishing Beneficiary Entitlement

In implementing the medicare program, an intensive effort was made to assure that everyone potentially eligible for benefits was informed of his rights under the program and of the action necessary on his part to obtain the protection it offers. Hospital insurance protection is provided for people aged 65 and over who are entitled to monthly social security or railroad retirement benefits. In addition, people now 65 or over who are not insured under either the social security or the railroad retirement programs are eligible for hospital insurance benefits under special transitional provisions of the law.[1] Voluntary supplementary medical insurance protection is available to virtually all people 65 and over, provided they enroll in this part of the program and pay the required premiums.

To inform people 65 or over of their right to enroll for medical insurance protection and to inform the 3½ million people who were not on the social security or railroad retirement benefit rolls of their need to apply to establish entitlement for hospital insurance, a public information campaign was mounted, followed up by direct contact and, when necessary, recontact, with virtually all of the 19 million people aged 65 or over in the country. This was a matter of considerable urgency since the original enrollment period under the medical insurance program was scheduled to end on March 31, 1966,[2] for people who would be 65 before January 1, 1966; those who did not sign up by the deadline would not, under the original law, have another opportunity to enroll until 2 years later and would be required to pay higher monthly premiums.

Initial enrollment activities

Before expiration of the March 31 deadline, the Social Security Administration had reached, with information and application forms, just about all of the 19.1 million people who would be 65 or over on July 1, 1966. In the fall of 1965, an application for medical insurance protection, prepunched and preprinted with the individual's name and social security account number, was mailed, together with an informational pamphlet, to the 15½ million people on the social security and railroad retirement benefit rolls, who were automatically covered for hospital insurance but had to apply for medical insurance coverage. Returns came in from over two-thirds of this group on the first mailing, with 9 out of 10 electing to enroll for medical insurance coverage. This initial contact was followed by subsequent mailings to inform those who had not responded and those who had declined enrollment that they could enroll as late as March 31. Personal contacts were made

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[1] The 1967 amendments to these provisions are outlined in app. E.
[2] Public Law 89–384 extended this deadline to May 31, 1966.

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where necessary through social security district offices and by older people hired for this purpose by the Office of Economic Opportunity.

The 3½ million people 65 and over who were not receiving social security or railroad retirement benefits had to file for both hospital insurance and medical insurance protection. Somewhat over a million people in this group were reached individually through joint projects with State and local welfare agencies. With the cooperation of the Internal Revenue Service, a simplified punchcard application was mailed to another million people over 65 who were not beneficiaries. The majority of those who received this mailing were insured under social security but were not eligible to receive cash benefits because they were still working full time. They were entitled to medicare, however, even though they continued to work.

The Civil Service Commission and the Social Security Administration mailed information to the 300,000 civil service annuitants over 65 who were not social security beneficiaries. This group is eligible for medical insurance protection and some are entitled to hospital insurance protection as well.

In addition to the various projects resulting in direct contact with most people 65 or over, the Social Security Administration mailed information about the program to the administrators of homes for the aged and skilled nursing homes, indicating that social security district office personnel would be glad to go to these homes to take applications from their residents. Excellent cooperation was also obtained from television and radio stations, the press, employers, unions, senior citizen organizations, insurance companies, Blue Cross and Blue Shield organizations, and various citizen groups. Hundreds of meetings were held with the cooperation of mayors and other local officials and organizations and, as a result, hundreds of thousands of people who would not otherwise have been reached were brought in contact with social security representatives.

The Office of Economic Opportunity, in a special project called "Medicare Alert," approved grants to 463 community action programs throughout the Nation to employ older people on a part-time basis to help contact those among the aged who were most difficult to reach. The Medicare Alert projects worked closely with the social security district offices in their respective service areas. Community meetings and programs of direct personal contacts were organized to be sure that the hard-to-reach groups in the community—particularly the uneducated and foreign-language groups—were given an opportunity to make an informed decision about enrolling.

Assistance was received from many other Government agencies including the Post Office Department—which made special efforts in behalf of the medicare enrollment operation even during the 1966 Christmas rush—and the Department of Agriculture—which helped reach people in rural areas, and, through rangers in its Forest Service, helped reach people in remote areas. And, to stress the importance of signing up for medical insurance, the President proclaimed the month of March 1966 as National Medicare Enrollment Month.

About 88 percent, or 16.8 million, of the 19.1 million people who would be eligible for medical insurance coverage on July 1 had en-

rolled by March 31. When the extended deadline was reached on May 31, 17.2 million (90 percent) had enrolled.

By July 1, 1966, when the health insurance program went into effect, 18.9 million people had established entitlement under the hospital insurance program and 17.6 million, 92 percent of those eligible, were enrolled in the medical insurance program.[3]

Ongoing enrollment activities

Every month about 120,000 people reach age 65 and are offered the opportunity to enroll in the medical insurance program. About half of them are already on the social security cash benefit rolls. These beneficiaries are identified electronically as they enter their enrollment period and are advised by mail of their right to enroll in the medical insurance program. In addition to those who may enroll upon attainment of age 65, there is an annual general enrollment period (from January 1 through March 31)[4] for certain people who either could have enrolled previously and did not, or who previously disenrolled.

A number of the methods devised during the initial enrollment period to identify potential beneficiaries who were not entitled to monthly benefits are now being used on an ongoing basis. From combined social security and Internal Revenue Service sources, about 30,000 people who are not eligible for cash benefits can be identified each month as they enter their enrollment period. Programs have also been established with hundreds of large institutions and employers throughout the country through which people are identified as they reach 65. In addition, public information messages emphasize the importance of the decision on enrollment for those approaching age 65.

By July 1, 1967, 19.4 million people were entitled to hospital insurance benefits and 17.9 million people, 92 percent of those eligible, were enrolled in the medical insurance program. In the 6-month enrollment period from October 1, 1967, through March 31, 1968, some 700,000 people were added to the medical insurance rolls in addition to those who enrolled as they reached age 65. About 19.4 million people are currently entitled to hospital insurance benefits, with 95 percent of those eligible enrolled for medical insurance protection.

Medical insurance premium payments

The medical insurance program is financed through monthly premiums paid by those who enroll in the program; equivalent matching payments are made from the general revenues of the Federal Government. The premium rate through March 1968 was $3 per month.[5]

The premiums of people receiving social security cash benefits or railroad retirement or Federal civil service annuities are deducted from their monthly benefit checks. People not receiving monthly benefits are billed quarterly for premiums by the Social Security Administration or Railroad Retirement Board. Premiums may be paid for

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[3] A State and regional distribution of enrollments as of July 1, 1966, and July 1, 1967, appears in app. B, exhibits 1 and 2, respectively.

[4] Prior to the enactment of the 1967 amendments, general enrollment periods were to occur in the last 3 months of each odd-numbered year.

[5] On December 30, 1967, the Secretary announced a $1 increase to $4 per month, beginning April, 1968. For a statement of the actuarial assumptions and bases employed in arriving at the amount of the new premium rate, see app. F.

as long as a year in advance, and for individuals financially unable to make quarterly payments, arrangements can be made for monthly payments.

The Social Security Administration now has group billing arrangements with approximately 125 organizations to pay premiums on behalf of groups of enrollees. The primary advantage of these group premium payment arrangements is that they make possible better integration of the group medical insurance plans with medicare. Some organizations are required by collective bargaining contracts to pay premiums for members of the group; others provide medical care for their members and use medical insurance reimbursement to reduce the cost of such care to their members.

Enrollment and premium payment under State agreements

Under the medicare law, States were permitted to enter into agreements with the Secretary, based on a request made before January 1, 1968, to buy in—that is, to enroll and pay the medical insurance premiums—for public assistance recipients aged 65 or over who were receiving money payments under an approved public assistance plan.[6] The State may limit the agreement to cover only individuals who are not entitled to social security or railroad retirement benefits or it may include those entitled to such benefits as well as those who are not.

As of June 30, 1967, 25 States had signed agreements enrolling approximately 1 million public assistance money payment recipients in the medical insurance program.[7] Largely as a result of a provision in the law requiring States that buy in to make available to all public assistance recipients at least the same benefits as are covered under the medical insurance program,[8] a number of States decided instead to pay cash assistance recipients an additional $3 monthly to cover the premium. Undoubtedly, many people would have been unable to afford their medical insurance protection without the action of the States that "bought in" or assisted welfare recipients in paying the required premiums.

Before entering into a buy-in agreement, the States screened their records to determine the correct social security numbers for public assistance recipents who were to be included under the agreements. They also determined if those recipients had previously enrolled for medical insurance or were eligible for monthly social security or railroad retirement benefits. The initial buy-in enrollment files were then furnished to the Social Security Administration before the effective date of the agreement. Accretions and deletions to this file are reported to the Administration monthly. A major task stemming from buy-in agreements is to assure that premiums are not deducted from the social security or railroad retirement benefits of people covered by these agreements. Social security or railroad retirement beneficiaries who are dropped from buy-in agreements have 3 months after such action in which to withdraw from medical insurance enrollment. If they do not withdraw, premium amounts are deducted from their monthly cash benefit payments.

[6] Under the 1967 amendments, the Jan. 1, 1968, deadline was changed to Jan. 1, 1970, and States may also buy in for all aged people eligible to receive medical assistance under an approved title XIX plan.

[7] A list of these States and the estimated number of recipients for whom they were paying medical insurance premiums appears in app. B, exhibit 3.

[8] Repealed by the 1967 amendments.

Enrollment withdrawals

Relatively few people have expressed regrets about having enrolled in the medical insurance program or any desire to withdraw from the program. People whose premiums are deducted from social security, railroad retirement, or Federal civil service retirement benefit checks— the vast majority of enrollees— had their first opportunity to withdraw from the program during the 6-month general enrollment period that began on October 1, 1967.[9] There were only about 35,000 disenrollments [10] in the general enrollment period—a minor fraction of 1 percent of those who could disenroll—and, as previously noted, during the same period an additional 700,000 people who had failed to take advantage of their first opportunity to enroll enrolled in the program.

In the first year of the program, a monthly average of 1.7 million people were billed directly for their premiums. (The aggregate number was higher because of additions to and deletions from the direct-billing lists from month to month.) During the year, there were 170,000 terminations for nonpayment of premiums. However, not all of these terminations can be ascribed to dissatisfaction with the program. Terminations of enrollment for nonpayment of premiums also were due to inability to afford the premiums; some people in this category were later reenrolled when their State public assistance programs entered into buy-in agreements for welfare recipients.

[9] Under the 1967 amendments, beneficiaries may give notice of withdrawal at any time, effective with the close of the following calendar quarter.

[10] Excludes about 5,000 disenrollments of foreign residents who had enrolled erroneously.

CHAPTER IV

Providers of Services

In establishing health and safety standards for participating providers under the provisions of the law and in applying these standards, the Department took into account both the nature and extent of health services available to beneficiaries in various parts of the country and the need to support contemporary standards of quality and provide maximum impetus to the upgrading of these standards. Excessively high standards would limit beneficiary access to needed care. However, relatively low standards could not have been accepted under a program of so vast a scope as medicare without undesirable effects on the quality of health services provided to people of all ages throughout the country.

Conditions of participation

The formulation of the conditions of participation for hospitals, extended care facilities, home health agencies, and independent laboratories was begun by a joint task force drawn from the Public Health Service, the Social Security Administration, and the Social and Rehabilitation Service (formerly the Welfare Administration). This task force studied State licensing requirements for health institutions and, where they existed, standards in use by national organizations such as the American Hospital Association, Joint Commission on Accreditation of Hospitals, American Osteopathic Association, and the National Council for the Accreditation of Nursing Homes. The task force consulted with organizations and experts in medicine, nursing, and related fields.

Based on its own studies and consultation with interested organizations, the task force developed draft conditions of participation for hospitals, extended care facilities, home health agencies, and for the coverage of the services of independent laboratories, and submitted each set of draft conditions to a special work group of non-government consultants convened to offer expert advice. The consultant work groups included representatives of the American Medical Association, the American Hospital Association, the American Nurses' Association, the American Nursing Home Association, Blue Cross and other insurers, the Joint Commission on Accreditation of Hospitals, State health and welfare administrators, and directors of various extended care facilities and hospitals. The comments of these groups were reviewed by the task force and carefully considered in the preparation of the draft conditions of participation which were submitted to the Health Insurance Benefits Advisory Council for review.

Following review and approval by the Health Insurance Benefits Advisory Council, the draft conditions were published in booklet form and distributed to all institutions identified as possible participants and to the State agencies which would survey facilities applying to

determine if they met the conditions of participation. The release of the draft conditions permitted institutions wishing to participate to consider whether changes would have to be made in their physical plants, staffing patterns, and so forth, in order to participate.

Proposed regulations incorporating the conditions of participation for hospitals were published in the Federal Register on February 15, 1966, and for home health agencies and extended care facilities on May 14, 1966. Proposed regulations covering conditions for coverage of independent laboratories' services were published on June 22, 1966.

Comments were made by many interested organizations, institutions, and individuals. Many of the suggestions went to very basic questions which required thorough analysis before they could be properly resolved. In many instances, a series of communications with the commentators was required to satisfactorily resolve the issues raised. A number of meetings were also held with representatives of the health care industry to discuss these issues. Every effort was made to give full and careful consideration to all comments.

The conditions of participation for hospitals were published as final regulations on October 18, 1966. The conditions for coverage of services of independent laboratories were published as final regulations on December 16, 1966. The conditions of participation for extended care facilities—whose services were covered starting January 1, 1967—were published as final regulations on October 28, 1967. The conditions of participation for home health agencies will be published as final regulations in the near future. These regulations are based on careful evaluation and reevaluation by all interested parties and represent the best professional and administrative judgments about the conditions that should appropriately be required of institutions seeking to participate in the medicare program.

Certification as providers

Health facilities are certified to participate in medicare if they are in "substantial compliance" with the conditions of participation—that is, if they can be found to meet all of the specific statutory requirements, and if they are operating in accordance with all other health and safety conditions of participation without any serious deficiencies. Hospitals accredited by the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association are deemed to meet all of the conditions of participation, except for the utilization review requirement.[1] Hospitals not so accredited, extended care facilities, home health agencies, and independent laboratories must be found to meet the conditions by the State agencies that survey such facilities on behalf of the program.

Providers of services which have deficiencies in one or more of the conditions of participation may nevertheless be found to be in substantial compliance if the deficiency (1) does not involve failure to meet a specific statutory requirement, (2) does not interfere with adequate patient care, (3) does not represent a hazard to patient health or safety, and (4) is one which the institution is making reasonable plans

[1] By statute, a hospital accredited by the JCAH is automatically eligible to participate if it meets the utilization review requirement. The law also provides that, if the Secretary finds that accreditation by the American Osteopathic Association or any other national accreditation body gives reasonable assurance that any or all of the conditions of participation are met, he may treat any institution or agency so accredited as meeting those conditions of participation. The Secretary has, by regulation, recognized the AOA accreditation program for hospitals surveyed after March 1966, or under new standards which the AOA released in November 1965.

and efforts to correct. Consultative services are made available by the State agencies to help providers complete their plans for correcting all deficiencies.

The regulations provide that the initial certifications of hospitals and home health agencies found to be in substantial compliance are for a period of 2 years. If deficiencies in one or more of the conditions are found on initial survey, a resurvey must be made by the State agency within 18 months, or earlier, depending on the nature of the deficiencies. The regulations provide that extended care facilities and independent laboratories must be recertified after a period of 1 year, or, if deficiencies were detected on the initial survey, within 9 months.

If a provider is surveyed or resurveyed and is determined not to be in compliance, or no longer in compliance with the conditions of participation, the State agency will inform the Social Security Administration of this fact. The Social Security Administration, in turn, will act on the State agency's finding—terminating the provider's contract, if appropriate. If the provider disagrees with the Administration's decision, it may request a review of the decision, and will be afforded an administrative review of the determination by the Social Security Administration.

Where denial of participation to providers would seriously limit the access of beneficiaries to needed services because of such factors as isolated location or the absence of sufficient facilities in an area, the institution may, upon recommendation of the State agency, be approved as a provider of services. Such approvals are granted only where the institution has no deficiencies which would jeopardize the health and safety of patients and is making the best use of existing resources to improve its services. Such special certification was not extended to tuberculosis or psychiatric hospitals or to independent laboratories.[2]

Hospitals and home health agencies with these special certifications are resurveyed within 12 months, or sooner if the State agency believes it appropriate. If, on resurvey, it is determined that the provider has not corrected serious deficiencies and that the factor of limited access no longer applies, the provider's participation is terminated. Most of the institutions which were granted such special certifications have been cooperating with State agencies to effect needed improvements in their services and have made considerable progress toward eliminating the problems which stood in the way of their being found in substantial compliance with the conditions of participation.

Certification of hospitals

The process of bringing hospitals into the program began with the mailing of a general informational pamphlet and a question and answer booklet to 10,000 institutions. By January 1966 the State agencies had narrowed the number of institutions which might meet the statutory definition of a hospital to about 8,000 institutions. In February, applications were sent through the State agencies to these 8,000 institutions for their use in requesting participation in the hospital insurance part of the program. Over 90 percent of these institutions applied for participation and the State agencies, working closely

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[2] For discussion of the conditions under which extended care facilities were granted conditional certification, see pp. 34 and 35.

with the social security regional offices and the Public Health Service, began the intensive effort that was required to determine hospital eligibility for participation in the program. This involved reviewing applications, conducting onsite surveys, and consulting with many institutions to help them take corrective action necessary to meet the conditions of participation. It also required the evaluation of more than 7,000 utilization review plans submitted by hospitals, including the approximately 3,800 hospitals accredited by either the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association.

By July 1, 1966, over 6,200 hospitals had been certified as eligible to participate in the program. By the end of the first year of operations, an additional 600 hospitals had been certified to participate in the program, bringing the total to well over 6,800 hospitals, representing approximately 1.2 million beds. While the 6,400 participating general hospitals constitute about 93 percent of the total, their 811,000 beds are only 69 percent of the total in hospitals certified to participate in medicare. The other 7 percent of the participating hospitals are psychiatric and tuberculosis institutions, having a combined total of 346,000 beds.[3] Approximately 2,400 hospitals were certified with deficiencies; of these, about 600 were granted special certification to assure beneficiary access and require special attention by the State agencies to insure that the hospitals correct deficiencies.

As of July 31, 1967, an additional 260 hospitals, though not participating in the program on a regular basis, met special requirements for coverage of emergency services.

Certification of extended care facilities

To assure that interested institutions would have an opportunity to qualify for participation by the January 1967 effective date for the coverage of extended care services, State agencies mailed applications to over 13,000 nursing homes in mid-1966. They began immediately to make followup contact to provide advice and assistance to facilities which needed help in meeting the conditions of participation. By December 1966, nearly 6,000 facilities had filed applications, onsite surveys were being completed, and the other steps in the certification process were well underway.

Many nursing homes had to make substantial changes and improvements in order to be in position to provide the relatively intensive, short-term services covered under medicare. Most nursing homes, for example, had to develop written patient care policies; almost all had to negotiate transfer agreements with hospitals and to develop utilization review plans. Frequently, these facilities also lacked professional direction of one or more of the services offered by the institution, and arrangements had to be made for regular consultation by qualified dietitians, pharmacists, social workers, and others. The shortage of nursing personnel posed problems for many institutions. For that reason, the guidelines for certification permitted, in some instances, temporary conditional certification of facilities which were found to be deficient in meeting the requirement that they have at least one

[3] A table showing the number of participating hospitals and beds in each State appears in app. C, exhibit 1.

registered professional nurse or qualified licensed practical nurse (a graduate of a State-approved school of practical nursing) on duty at all times and in charge of nursing activities during each tour of duty.[4]

By January 1, 1967, when the extended care benefit provisions went into effect, approximately 2,800 facilities were in substantial compliance with the conditions of participation; and over the Nation the number of participating extended care facilities was reasonably adequate. However, there were States and geographical areas within States where extended care beds were in short supply. State agencies turned their attention to identifying areas with such shortages and assisting institutions which had the potential for meeting medicare standards to upgrade their facilities and services. By July 31, 1967, as a result of the assistance provided by the State agencies, an additional 1,400 facilities had been approved for participation. This brought the total number of participating extended care facilities to 4,160.[5]

Certification of home health agencies

In 1965, when the medicare law was enacted, it seemed unlikely that the existing home health services in the country would be adequate to assure the availability of covered services. Agencies providing nursing service in the home were concentrated in large metropolitan areas, and a large number of these were not providing one therapeutic service in addition to nursing, as required by the medicine law.

Assisted by Public Health Service special grant funds and consultation, State health departments launched an intensive drive to stimulate the establishment of new agencies and the expansion and strengthening of existing ones. Through this effort, approximately 1,200 agencies were able to qualify for participation by July 1, 1966. Continued efforts by State agencies after July 1 led to the certification of some 700 additional agencies[6] by July 31, 1967, bringing the total to 1,849, about 60 to 65 percent of which are subdivisions of local public health departments.[7] Some areas are still not served by a participating home health agency. Available home health services have been underutilized in other areas and, in those areas, participating agencies have experienced financial difficulties. State agencies and the Department of Health, Education, and Welfare have assisted such agencies financially and by disseminating information on the availability of their services.

Certification of independent laboratories

The proposed regulations embodying the conditions for coverage of the services of independent laboratories were published on June 22, 1966. However, it was not considered desirable to finally certify laboratories until the regulations had been issued. Therefore, an interim arrangement was established to permit payment for services rendered

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[4] Such conditional certification of extended care facilities expired on Apr. 1, 1968. Of the 250 facilities granted such conditional certification, over 200 now meet the requirements for regular certification; others have withdrawn as providers or have had their participation terminated.

[5] A table showing the distribution of participating extended care facilities by State, appears in app. C, exhibit 2.

[6] Includes some 250 subunits of seven State health departments which had not previously been certified as separate agencies.

[7] A table showing the distribution of participating home health agencies, by State, appears in app. C, exhibit 2.

until May 15, 1967, by apparently qualified laboratories. When formal certification activities began in December 1966, State agencies had to survey more than 2,700 laboratories which had submitted applications. By July 1967, almost 2,400 of these had been approved for participation.[8]

Following completion of most of the initial certifications, State agencies, along with the Social Security Administration and the National Communicable Disease Center of the Public Health Service, began addressing themselves to the question of the eligibility of the approximately 400 laboratories whose directors did not have the educational requirements specified in the regulations. Under the regulations, these laboratories had an interim approval until July 31, 1967. After that date, they could qualify only by substituting, for specified education requirements, successful participation by the director in a Public Health Service approved examination. By the end of the first year of operation, these examinations were being administered throughout the country.[9]

Utilization review of hospital and extended care services

The purpose of medicare's utilization review requirement for hospitals and extended care facilities is to promote the most efficient use of available services and facilities.

To participate in medicare, a hospital or extended care facility must have in effect a utilization review plan which provides for (1) the review, on a sample or other basis, of the medical necessity for inpatient admissions, the length of stay, and the professional services furnished and (2) the review of each long-stay case (that is, a case of continuous extended duration) within a week of the last day of the period of extended duration by a staff committee of the institution, or an outside group, whose membership includes at least two physicians and may include other professional personnel.

The health care professions had recognized for some time the need for mechanisms which would assure quality care to patients through sound utilization of institutional facilities and professional services. As a result, the concept of utilization review as a function of the professional medical community has received increasingly widespread support over the years. Before medicare, however, only about 1,000 hospitals had utilization review committees. Today, all of the almost 7,000 hospitals and 4,500 extended care facilities participating in the program have utilization review committees.

While the establishment of these utilization review committees is, in itself, an important impetus to efficient and appropriate utilization of health facilities, much remains to be done in assuring that the full potential of utilization review is realized. Recognizing the inexperience of many providers in the area of utilization review, the Social Security Administration has undertaken a number of projects to promote understanding of the objectives of utilization review and uniformity in its application. Instructions have been issued to all State agencies and fiscal intermediaries outlining their respective roles in

[8] Their distribution by State is reflected in app. C, exhibit 3.

[9] Regulations provide for continued approval of directors who lack the specified educational requirements, based upon successful participation by their laboratories in State-operated or State-approved programs of proficiency testing.

assessing the effectiveness of utilization review activities in participating providers. In April 1967, officials of the State agencies were brought to Baltimore to attend a conference, part of which was devoted to a discussion of State agency utilization review activities. Similiar discussions were held with hospital insurance intermediaries at Social Security Administration regional offices last fall. Since that time, the Social Security Administration has continued to work closely with State agencies and intermediaries to assure effective utilization review in participating hospitals and extended care facilities. As part of this effort, the State agencies are to obtain detailed information about the composition and functioning of utilization review committees and the positive effects the committees have on utilization of services.

Applicability of title VI of the Civil Rights Act

In addition to meeting the quality standards established under the health insurance legislation, hospitals, extended care facilities, and home health agencies wishing to participate in the medicare program must be in compliance with title VI of the Civil Rights Act of 1964. In its application to medicare, the Civil Rights Act requires that hospitals, nursing homes, and other institutions participating in the program must provide access to their services and facilities without regard to the race, color, or national origin of a patient; that ancillary services and facilities be equally available to all people, and that the staff be recruited and employed in a nondiscriminatory manner. To meet these requirements of law, an institution must engage in no discrimination, separation, or other distinction on the basis of race, color, or national origin in providing services, facilities, or any other activities which influence the admission, care, or treatment of patients.

Every effort, including enlisting the aid of professional groups and other organizations, has been made by the Department of Health, Education, and Welfare to secure voluntary compliance of institutions with the civil rights requirements. Almost all of the hospitals and extended care facilities which applied to participate are now in compliance with the civil rights requirements. As of July 31, 1967, approximately 55 hospitals that had been determined to meet the other conditions of participation were not participating because they did not have clearance under title VI of the Civil Rights Act. Roughly 100 additional hospitals that probably could meet medicare standards had not applied for participation due to the civil rights requirements. By June 30, 1967, fewer than 20 extended care facilities that had submitted complete applications to participate were not participating in the program because of failure to comply with the civil rights requirements. Eighty additional facilities had not yet submitted all of the information asked of applying institutions, so that determinations of their civil rights status were still pending.

A number of extended care facilities meeting the conditions of participation have not applied for various reasons. In some cases, they are filled and have long waiting lists of patients seeking admission so that there is little inducement for them to participate if they think reimbursement under medicare is more restrictive than the reimbursement they might otherwise obtain. And, of course, still other potentially eligible extended care facilities have not applied because of reser-

vations about the civil rights requirements. Because there are such varied reasons for extended care facilities not having applied for participation in the program, it is difficult to determine what effect the civil rights requirements have had on the decision of otherwise eligible facilities to decline participation in the medicare program.

There have been no indications that the civil rights requirements had a significant effect on the participation of home health agencies in the medicare program.

CHAPTER V

Hospital Insurance Operations

Along with the establishment of the administrative organization for the program, the beneficiary rolls, and provider participation, the principles of reimbursement for provider costs were formulated and a nationwide system for the payment of hospitals and other providers was designed and implemented. As with many other aspects of program implementation, the experience of existing public and private programs could be used as a basis for planning. At the same time, there were a number of factors arising from the nature, provisions and the very scope of the medicare program that created policy and administrative problems requiring unique solutions. The goals sought for the reimbursement system were (1) that the intent of the law be carried out as simply and efficiently as possible, and (2) that reimbursement be equitable for beneficiaries, providers, and the social security contributors and general taxpayers who support the hospital insurance program.

Principles of reimbursement

The principles of reimbursement for provider costs are designed to assure that the program will meet all of the costs, but only the costs, of providing covered services to medicare beneficiaries. All necessary and proper provider expenses related to the care furnished beneficiaries are recognized—including educational costs, normal standby costs, bad debts arising from beneficiary failure to meet deductible and coinsurance amounts, interest on borrowed operational funds and capital, straight line or accelerated depreciation on buildings and equipment, and allowance in lieu of costs not otherwise specifically recognized and, in the case of proprietary institutions, a return on equity capital.[1] The methods for determining the share of allowable costs to be borne by the program are designed to provide a more precise apportionment of costs between beneficiaries and nonbeneficiaries than could be obtained by the average per diem cost method commonly used in hospital cost reimbursement. This is in line with the statutory directive that the cost of covered services to beneficiaries not be passed on to nonbeneficiaries, nor the cost of services to nonbeneficiaries borne by the program.

In developing the medicare reimbursement principles—which, to a considerable degree, are based on the American Hospital Association principles of payment for hospital care as they existed at the time the law was enacted—the Social Security Administration conducted an intensive program of research and consultation with national organizations and established prepayment organizations which had developed comparable reimbursement principles in the past. Those consulted included the American Hospital Association, the Blue Cross

[1] The law was amended to provide for a return on equity capital for proprietary institutions by section 7 of Public Law 89–713, enacted November 2, 1966.

Association, the American Medical Association, the American Association of Hospital Accountants, individual Blue Cross plans, State and Federal agencies which purchase health services, individual hospital directors and comptrollers, and nationally recognized authorities in the field of health care costs. No aspect of the program was more carefully considered by the Administration or by the Health Insurance Benefits Advisory Council, which endorsed the principles at each stage of development and promulgation. And, in addition, the Senate Committee on Finance reviewed the proposed principles in executive session in May 1966.

Nonetheless, the principles were the subject of intense controversy throughout their development, promulgation, and implementation. On the one hand, the principles were criticized by some as overly liberal in allowing depreciation on assets financed by public funds—an allowance required by statutory direction that medicare meet the full cost of services to its beneficiaries—and in providing an allowance in lieu of specific recognition of other costs—an allowance considered necessary in view of the lack of precision in hospital cost finding. On the other hand, the principles were criticized by others on the grounds that they make insufficient contribution to the capital needed to replace, expand, and improve health facilities and because they do not contribute to costs of services provided to nonbeneficiaries and which are not fully reimbursed.

The Department is concerned by the unanswered questions in hospital financing that are the underlying basis for criticism of the medicare principles of reimbursement. The problems faced by some hospitals in financing needed improvements in their facilities require solution. The question of how these needs should be met involves the development of public policy regarding the respective roles of the Federal Government, State and local governments, community action, private philanthropy and patient income in hospital financing, and legislation to implement this policy. Federal support may be furnished through grant or loan programs or through programs that pay for patient care, and these alternative approaches must be considered in the context of the need for comprehensive planning to improve and expand our health resources.

The Department is engaged in an intensive effort to find solutions to problems in the delivery and financing of health care services by bringing leading experts in the health care field together to exchange views at a number of general conferences, and to develop specific recommendations through special advisory groups. One example is the National Advisory Commission on Health Facilities, which is studying the problem of meeting and financing the Nation's long- and short-range needs for hospitals and other health care facilities.

The Department is, however, especially mindful of the impact that reimbursement under medicare has on hospital financing, not only because payment for the services of so large a proportion of the patient population is being made under the program, but also through the influence that its principles of reimbursement will have on the reimbursement approaches adopted by other public and private programs. For this reason, the Department is conducting a careful review of all aspects of medicare's principles of reimbursement in light of the impact of medicare on the financial condition of hospitals.

At the same time, the Department is giving high priority to the provision of the 1967 amendments authorizing experimentation with various methods of reimbursement with a view to the creation of additional incentives to efficiency and economy while supporting high-quality services. The overall objective sought by this review and experimentation is to assure that the health care paid for under the program will be of high quality, be provided as efficiently and economically as possible, and be paid for in the most equitable way that can be devised.

Provider payment

A major goal of program administration has been to provide interim reimbursement to providers on a current basis to avoid the serious financial problems that providers would face if working capital were tied up in medicare accounts receivable. Months before the program went into effect, procedures were being designed to assure timely payment to providers. These procedures are continually reviewed and modified in the light of program experience.

Under the procedures in effect from the start of program operations, interim payments approximating a provider's actual costs are made, at least monthly, and in most cases weekly, by intermediaries as bills for covered services are submitted. Intermediaries make appropriate adjustments in the interim rate of payment and lump-sum payments to bring past payments in line with costs during the reporting period. A retroactive adjustment based on the actual costs is made at the end of the provider's reporting period.

In addition to the basic procedure of making interim reimbursement after bills have been submitted, payments may also be made, upon request by the provider, to reimburse currently as services are furnished to beneficiaries prior to the submission of bills. The amount of payment is based on the average costs incurred by the provider in rendering covered services as estimated from data derived from provider and intermediary records and adjusted periodically to reflect the provider's most current experience under the program.

In response to reports that some hospitals were experiencing financial difficulty because medicare billings were being delayed for various reasons, intermediaries are authorized to make accelerated payments on account if the provider is able to demonstrate that its working capital position is being impaired as a result of hospital billing or intermediary processing delays and that it would have difficulty in meeting current financial obligations. The amount of the payment is a percentage of the cost of covered services rendered to beneficiaries for which billings have not been submitted or are pending in the intermediary's office, less the applicable deductibles and coinsurance amounts.

In addition to the procedures discussed above, the Social Security Administration has made available an entirely new approach to interim reimbursement for hospital services. This new approach will not only eliminate the need for itemization of charges on individual bills and assure a steady flow of medicare funds to hospitals, but may also become a prototype for payment procedures under other large scale hospital and insurance operations. The new interim payment procedure provides fixed periodic interim payments on the basis of the hospital's medicare cost experience, adjusted for changes in medicare

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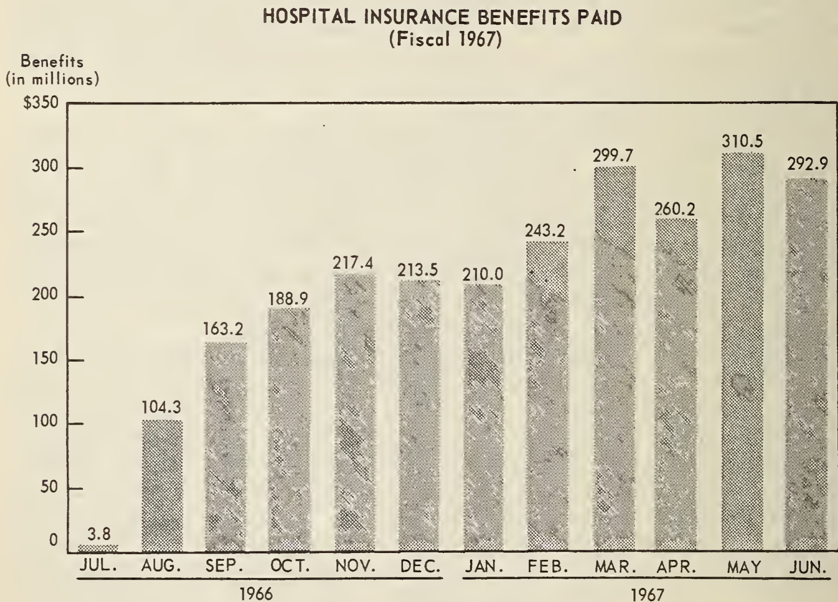
utilization, price and wage levels, new or expanded services, and other significant factors rather than on the basis of individual bills. Interim payments under this procedure are generally on a weekly basis and are made without regard to medicare utilization during the particular payment period. The hospital is required to submit the necessary utilization information and interim payments are, of course, subject to adjustment based on actual costs during the reporting period.

Claims experience

During the first year of medicare, over $2.5 billion was paid out under the hospital insurance program. (This amounted to $132 per covered individual.) The $2.5 billion represents amounts drawn from the Federal Hospital Insurance Trust Fund for hospital insurance benefit payments in the year ending June 30, 1967, and does not include amounts withdrawn later for services rendered through that date.

The gradual increase in monthly benefit payments—from a low of $3.8 million in the first full month of operations, to $210 million in January 1967 and $292.9 million in June 1967—is shown in the following chart.[2]



Total hospital insurance benefit payments during fiscal 1967 ($2.508 billion)[3] exceeded by $170 million the $2.338 billion in benefits estimated for the first year of operation. This 7 percent difference was caused primarily by a more rapid increase in hospital costs than had been anticipated in the original estimates. However, net contribution

[2] A distribution of total hospital insurance benefit payments, by State, in the year ending June 30, 1967, appears in app. D, exhibit 1.

[3] Excludes $17 million of intermediary benefit payments in fiscal year 1967, which had not cleared through the Treasury before July 1, 1967.

income of $2.689 billion was $304 million more than estimated (due to increases in earnings greater than had been assumed). As a result, the excess of contributions over benefits was $134 million more than expected. The trust fund ended the year with a balance of $1.3 billion.

Of the 5.4 million claims approved for payment under the hospital insurance program and recorded in the Social Security Administration's records for the year ending June 30, 1967, 85 percent were for inpatient hospital care, 6 percent were for outpatient hospital diagnostic services, 6 percent were for extended care services (which had been in effect only for the last half of the fiscal year), and 3 percent were for posthospital home health care.[4] Average reimbursement per claim was also greatest for hospital inpatient claims, averaging $485 per claim, compared to $296 per claim for posthospital extended care services, $63 per home health claim, and $12 per outpatient hospital diagnostic claim.[5]

Inpatient hospital services

There were nearly 5 million covered hospital admissions under medicare from July 1, 1966, through June 30, 1967. An estimated 1 million of these admissions represent second or subsequent admissions so that about 4 million medicare beneficiaries—or about 1 out of every 5 beneficiaries—received covered hospital services during the year. There were 263 admissions to either short- or long-term hospitals for every 1,000 people covered. The distribution of hospital admissions by State showed considerable variation, ranging from a low of 196 per 1,000 people covered in three States—Delaware, Maryland, and New Jersey—to a high of 398 per 1,000 in North Dakota. Admissions were lowest in the Middle Atlantic States and highest in the Northwest.[6]

Ninety-eight percent of the approved inpatient hospital claims, 95 percent of the covered days of inpatient care, and 98 percent of the amount reimbursed for inpatient hospital care were for the care of beneficiaries in short-term hospitals. Covered days of hospital care per recorded claim averaged 13.4 days in all hospitals, 13 days in short-term hospitals, and 36 days in long-term hospitals.[7] Beneficiaries who received covered hospital services used an average of 17 days of hospital care during the year.

Payment to hospitals for inpatient care is being made on a current basis. During the first year of the program, hospitals were paid over $2.2 billion for inpatient hospital services.[8] The average daily hospital *charge* for total recorded approved claims for the first year was $45: $46 in short-term hospitals and $19 in long-term hospitals.[9] These charges do not, of course, represent the amounts paid by the program since hospitals are reimbursed for the reasonable cost of services they provide, less deductible and coinsurance amounts.

Data from a number of sources indicate that the aged are now receiving more inpatient hospital services than they did before medicare.

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[4] See app. D, exhibit 2.

[5] Data on admissions are determined from the inquiries made to central office records regarding the entitlement of people found to be covered. The number of claims exceeds the number of admissions because more than 1 claim (for instance, for interim payments) sometimes results from an admission. Figures on reimbursement are limited to amounts paid to providers on an interim basis. Final figures cannot be determined until postaudit and adjustment have been made and recorded.

[6] See app. D, exhibit 4.

[7] See app. D, exhibit 3.

[8] See app. D, exihibit 2.

[9] See app. D, exhibit 3.

Although the amount of this increase cannot be estimated precisely, the Administration's projection before the program began of a maximum increase of 20 percent in the use of inpatient hospital services by beneficiaries appears to have been fairly close. There have been isolated instances of hospital crowding, but this also occurred before medicare. There has been some decline in the use of hospitals previously devoted to indigent patients and a compensating increase in the use of other hospitals.

Outpatient hospital diagnostic services

While outpatient hospital therapeutic services are covered under the medical insurance part of the program, outpatient hospital diagnostic services were originally covered under the hospital insurance part of the program.[10] The program paid 80 percent of the reasonable cost of the services after application of a $20 deductible for each 20-day diagnostic study period. The small average medicare payment ($12) for the 325,000 recorded bills [11] probably would have been even less if some hospitals had not felt that, for small bills, the difficulty in separating charges for the two parts of the program and billing the program was not warranted by the reimbursement they would receive. Of course, the $12 figure does not reflect the total protection given by this benefit since amounts not paid under the hospital insurance program were credited to the medical insurance deductible and were reimbursable if that deductible had been satisfied for the year.

Extended care services

For the 6-month period beginning January 1, 1967, when coverage of extended care services began, 199,000 extended care facility admission notices were received for beneficiaries. This is a rate of about 10.5 admissions per 1,000 people covered during the 6-month period. In that period, about 1 out of every 12 beneficiaries admitted to a hospital was subsequently admitted to an extended care facility. The total of 318,000 claims received for extended care services during the fiscal year included many partial payments for patients whose stays were continuing. Admission rates ranged from lows of 3.4 per 1,000 people covered in Wyoming and 3.8 per 1,000 in South Dakota and Mississippi to a high of 26.7 per 1,000 people covered in the State of Washington.[12] The availability of beds in participating facilities is clearly a major factor in extended care facility admission rates. In Washington, there were over 32 beds for every 1,000 people covered by the program compared with 5 beds per 1,000 for South Dakota, less than 4 per 1,000 in Mississippi, and 11 beds per 1,000 in Wyoming, in July 1967.

Home health services

The Social Security Administration received about 228,000 home health start-of-care notices by June 30, 1967, under both the hospital and medical insurance programs. These represented about 12 notices per 1,000 people covered at the end of the fiscal year. There was considerable variation among the States, ranging from just over 3 notices

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[10] Beginning Apr. 1, 1968, outpatient hospital diagnostic services are covered under the medical insurance, rather than hospital insurance, part of the program.
[11] See app. D, exhibit 2.
[12] See app. D, exhibit 4.

per 1,000 in four States (Kentucky, North Carolina, North Dakota, and South Carolina) to about 36 in Rhode Island.[13]

Fiscal intermediary performance in processing hospital insurance bills

As was expected, the receipt of medicare hospital bills began slowly in July 1966, when only 109,300 bills were received, but rose steadily and sharply throughout the fiscal year. During January 1967, intermediaries received 939,000 bills. In June 1967, the number had risen to 1,212,800—almost 1.3 times as many as were received in January and more than 11 times the number received during the first month of the program.

On the whole, intermediary processing of hospital insurance bills kept pace with the increase in receipts. Until December 1966, the number of bills cleared lagged behind the number received, though not by any substantial amount. In January 1967, however, the processing rate exceeded receipts for the first time and remained ahead or close to the break-even point for the rest of the fiscal year. During June 1967, 1,285,300 bills were cleared compared to 1,212,800 received. The result of the improved processing rate during the second half of the year was a gradual reduction of the number of pending bills (that is, bills received but not yet cleared), so that by the fiscal year's end, only 352,800 bills were pending, representing approximately 1.2 weeks of work. The building up, peaking, and relative stabilization of fiscal intermediary workloads is reflected in the following table:

HOSPITAL INSURANCE INTERMEDIARY WORKLOADS (JULY 1966 TO JUNE 1967)

Month	Bills received	Bills cleared	Bills pending
July 1966	109, 300	60, 000	49, 300
August	532, 100	417, 200	164, 200
September	638, 400	551, 400	251, 200
October	745, 200	693, 400	303, 000
November	784, 900	746, 900	341, 000
December	845, 500	808, 500	378, 000
January 1967	939, 600	941, 500	376, 100
February	973, 000	945, 400	403, 700
March	1, 164, 800	1, 172, 200	396, 300
April	1, 144, 000	1, 120, 700	419, 600
May	1, 274, 500	1, 268, 800	425, 300
June	1, 212, 800	1, 285, 300	352, 800

The following table depicts three additional indexes of intermediary performance in fiscal year 1967: (1) Ratio of bills cleared during the month to bills received during the month; (2) the number of weeks of work pending at the end of each month; and (3) the percentage of total bills pending which were pending over 30 days at the end of each month.

[13] See app. D, exhibit 4.

PERFORMANCE INDICATORS FOR HOSPITAL INSURANCE INTERMEDIARIES (JULY 1966 TO JUNE 1967)

Month	Ratio of clearances to receipts (percent)	Weeks of work pending	Percentage of pending bills pending over 30 days
July 1966	54.9	3.3	----------
August	78.4	1.8	5.9
September	86.4	1.9	17.2
October	93.0	1.7	18.2
November	95.2	1.9	24.0
December	95.6	2.0	27.7
January 1967	100.2	1.7	23.8
February	97.2	1.6	24.8
March	100.6	1.6	19.4
April	98.0	1.5	20.0
May	99.6	1.4	14.2
June	106.0	1.2	12.3

This table shows that almost from the beginning, fiscal intermediaries were able to handle their workloads without too much difficulty. From the second month of the program's operation they had 2 weeks of work or less on hand. The ratio of clearances to receipts was closely in balance after the third month, and remained close to 100 percent for the rest of the year.

Since billings involving inpatient radiologists' and pathologists' services and outpatient hospital services have represented a substantial proportion of bills pending over 30 days, the percentage of bills pending over 30 days should diminish as a result of the simplifications made possible by the 1967 amendments.[14]

Delays in submitting bills and delays in receiving payments from some intermediaries resulted in a shortage of operating capital for some providers early in the program. Accelerated payments on account (discussed earlier in this chapter) were quickly made and alleviated much of this problem. In addition, action was taken so that intermediaries made interim payments at more frequent intervals than they had prior to medicare.

Overall, there have been relatively few problems in the query-response part of the electronic data processing system; that is, the system through which providers obtain information on the extent to which individual patients are eligible to receive services covered under medicare. There have been few mechanical malfunctions and clerical errors. Intermediaries undertook continuous educational efforts with providers' billing staffs in an effort to reduce errors in submitting queries, and these efforts were very effective.

In summation, following minor operating adjustments, fiscal intermediaries have been handling their medicare workloads quite well. Many have shown considerable skill in early detection of problems and have worked well with providers and the Government to find and implement solutions.

Administrative costs of intermediary operations

Data derived from intermediary cost reports reveal that, during the first year of program operations, the ratio of intermediary administrative costs to benefit payments was reasonable, despite the high first-year expenses incurred in recruiting and training new employees, refining

[14] Discussed in chapter I.

procedures to meet medicare requirements, and the other one-time costs incident to establishment of the claims process. By December 31, 1966, intermediary administrative costs were 1.5 percent of intermediary benefit payments and, for the entire fiscal year, intermediary administrative costs were 1.3 percent of benefit payments.

There were, to be sure, substantial variations in the ratio of administrative costs to benefit payments among intermediaries. Some of the reasons for these variations were differences in local wage scales and the technical sophistication of the organizations' medicare operations. Experience to date indicates that greater use of sophisticated data processing equipment generally produces a lower ratio of administrative costs to benefit payments. Also, the type of bills processed affects the ratio; for example, the ratio of administrative costs to benefit payments was generally higher for intermediaries with relatively large extended care facility workloads and for those servicing areas which include large outpatient centers.

Providers dealing with the Social Security Administration

Hospitals and other providers of services which do not wish to be served by a fiscal intermediary may deal directly with the Social Security Administration. Although the vast majority of providers chose to use intermediaries, a significant number chose to deal directly with the Government. As of June 30, 1967, 191 hospitals with 175,000 beds, 32 extended care facilities, 30 home health agencies, and 27 group practice prepayment plans had elected to do so; in subsequent months, 29 additional hospitals were added to the roster of direct-dealing institutions. The intermediary functions for all direct-dealing providers are performed by a component of the Bureau of Health Insurance.

During the first year of operations, notices of admission from direct-dealing hospitals and extended care facilities and start-of-care notices from home health agencies averaged about 3,000 per week. The number of bills submitted by these providers increased steadily during the year, from an average of 1,000 per week in September 1966 to 5,700 during the months of May and June 1967. By June 30, 1967, payments of approximately $37.9 million covering approximately 116,000 bills had been made to direct-dealing providers. Current financing payments totaling $1.9 million were made during the same period to 23 providers, and approximately $285,000 was paid to 12 providers as accelerated payments on account. In addition, under the medical insurance program, the 27 direct-dealing group practice prepayment plans received $13.7 million in interim payments for estimated costs through June 1967.

Reimbursement for emergency services

Generally, hospital benefits are paid only for care furnished to patients by hospitals participating in the program. However, the law also provides for the payment of benefits, subject to the applicable deductible and coinsurance amounts, for inpatient hospital services and outpatient hospital diagnostic services furnished to patients who are brought to a nonparticipating hospital in an emergency.[15] To

[15] Emergency services are outpatient hospital diagnostic services and inpatient hospital services which are necessary to prevent the death or serious impairment of the health of the individual and which, because of the threat to the life or health of the individual, necessitate the use of the most accessible hospital available which is equipped to furnish such services.

qualify for payment for emergency services, a nonparticipating hospital is required to meet certain standards specified in the law concerning clinical records, medical staff bylaws, and nursing services.[16] In addition, the hospital's claim for payment must be accompanied by the attending physician's statement describing the nature of the emergency, furnishing relevant clinical information about the patient's condition, and certifying that the services rendered were required as emergency services. Claims for payment for emergency services furnished by nonparticipating hospitals are reviewed in the Social Security Administration regional offices, with necessary professional consultation provided by Public Health Service regional medical consultants. These claims are submitted to and paid by an intermediary designated to handle emergency claims by the Social Security Administration. During the first year of operations, there were 20,610 emergency admissions to nonparticipating hospitals.[17] Of the 19,229 bills submitted and processed for these services, 18,008 were allowed, 400 were denied in part; and 821 denied entirely.

[16] For changes in the law with respect to payment for services in nonparticipating hospitals, see app. E.

[17] State-by-State emergency admission figures and claims data are in app. D, exhibit 5.

CHAPTER VI

Medical Insurance Operations

The medical insurance program is an indemnity program designed to reimburse the beneficiary, or pay on his behalf, reasonable charges incurred for physicians' services and certain other medical services, and the reasonable costs for certain provider services, subject to applicable deductible and coinsurance amounts.[1] Proper payment involves the determination that the service for which a charge is incurred is covered under the program and medically necessary and that the charge (or cost where applicable) for the service is reasonable.

The statute provides for the use of private insurance carriers in the administration of this part of the program. In selecting carriers to pay claims on behalf of the program, the administration considered the experience and the capability of the applying organization to administer claims under the program and the need to provide a sufficient variety of organizations to afford a basis for comparison of performance.[2]

While the carrier organizations are responsible under the statute and their contracts for the proper payment of claims, the final responsibility for the proper administration of the program rests with the Department. To carry out this responsibility, the Department has issued regulations and guidelines for the administration of medical insurance claims that are designed to assure that the administration of the program will be prudent, economical, and consistent with the statute and the intent of Congress. In addition, the Department conducts audits and performance reviews to assess the quality of carrier performance.

DETERMINATION OF REASONABLE CHARGES

The law does not contemplate establishment of a general fee schedule applicable to all physicians and suppliers of covered medical services nor that the beneficiary's income will be taken into consideration in determining the amount of the payment that is made for services furnished to him. Rather, the law calls for individual determinations by the carrier which take into account the customary charges of the physician, and the prevailing charges in the locality for similar services. In addition, carriers are required to assure that the charges determined to be reasonable for medicare beneficiaries are not higher than the charges applicable for comparable services under comparable circumstances to their own policyholders and subscribers. In effect, payment is to be made on the basis of the lowest of the following: (1)

[1] Provider services paid on the basis of reasonable costs include up to 100 home health visits in addition to, and without the prior hospitalization requirement applicable to, the home health services covered under the hospital insurance part of the program. Provider services also include other medical or health services (other than physicians' services unless furnished by a resident or an intern under an approved training program) furnished by or through a hospital, extended care facility, or home health agency.

[2] Organizations serving as carriers are listed in app. A, exhibit 6.

actual charge made by the physician, (2) the charge he customarily makes for similar services, (3) the prevailing charges in the locality for similar services, or (4) the charge applicable for similar services under comparable circumstances under the carrier's own policies.

To provide for consistency among carriers in the application of the reasonable charge criteria in the statute and to establish the standards against which carrier performance would be evaluated, the Department formulated and promulgated guidelines to clarify and interpret the reasonable charge criteria set forth in the law, and to suggest methods for implementing these criteria. These guidelines were subsequently published as proposed regulations in the Federal Register of February 8, 1967, and as final regulations on August 31, 1967.

The process of making reasonable charge determinations involves a review by the carrier of each bill. While the sequence of procedures followed may vary from carrier to carrier, the overall process involves checking each bill against data previously compiled on the physician's customary charges and the prevailing level of charges in the locality in which the physician practices. A number of carriers have already computerized or are in the process of computerizing this phase of the process. Charges for services involving unusual medical complications or which otherwise pose special questions are referred for review by physicians or specially trained personnel on the carrier's staff and, where appropriate, consultations are held with the physician or supplier involved and medical society review committees.

MEDICAL INSURANCE COVERAGE IN THE HOSPITAL SETTING

Some of the most complex problems in the administration of the program resulted from the need to identify and determine the reasonable charges for services that, while rendered in a hospital setting, are excluded under the hospital insurance part of the program and covered under the medical insurance part of the program. Such services include all physicians' services (except for the services of residents and interns under approved training programs) and outpatient therapeutic services. (Outpatient diagnostic services were covered until April 1, 1968 under the hospital insurance part of the program). To determine the respective liabilities of the two parts of the program and to determine the patient's liabilities under the differing but interacting deductible and coinsurance provisions of the two parts of the program, it was necessary to break down specific services into components—identifiable services to individual patients by physicians as opposed to supporting hospital services and outpatient therapeutic services as opposed to outpatient diagnostic services—solely for medicare purposes. While an effort was made to apply the law as simply as possible, the result was serious recordkeeping and billing problems for hospitals and misunderstanding among beneficiaries. To alleviate these difficulties, the Department sought changes in the law that would permit simplification of the procedures involved; such changes were enacted under the 1967 amendments to the Social Security Act.

Hospital-based physicians

The Department developed comprehensive principles for the reimbursement of hospital-based physicians in consultation with all interested parties and the Health Insurance Benefits Advisory Council.

These principles were distributed to intermediaries, carriers, hospitals, and professional groups in January 1966, published as proposed regulations on June 28, 1966, and as final regulations on October 18, 1966. The regulations are designed to be responsive to, but not interfere with, the arrangements adopted by hospitals and hospital-based physicians. However, these regulations did require agreement between hospitals and physicians for the identification of compensation to the physician for services to individual patients as a basis for the reasonable charge determinations to be made under the law.

By the end of the 1st year of operation, acceptable agreements had been reached by most participating hospitals and the hospital-based physicians. Continuing difficulty was nonetheless experienced throughout the 1st year of operation with respect to the split billing required under medicare for radiologists' and pathologists' services that would normally be billed by the hospital on a consolidated basis. To permit administrative simplification and to bring medicare coverage into line with most other health insurance programs, the 1967 amendments to the Social Security Act eliminated the medical insurance deductible and coinsurance amounts with respect to radiological and pathological services.

Outpatient services

In adopting policies and procedures the Social Security Administration made every effort to simplify the distinctions that had to be made between identifiable physicians' services to individual patients and other hospital services, and between diagnostic services and therapeutic services, in billing for outpatient services under medicare. However, the administrative costs and difficulty encountered by hospitals in preparing outpatient bills was disproportionate to the small amounts involved. In addition, hospitals were often unable to determine the patient's deductible status at the time the service was rendered and, once the patient had left the hospital premises, it was difficult to collect the small amounts involved.

In response to these problems, the Department sought, and the Congress enacted, under the 1967 amendments, a change in the law consolidating all coverage of outpatient hospital services under the medical insurance part of the program and eliminating the $20 deductible for outpatient diagnostic services. This change, along with an additional provision allowing hospitals to bill medicare patients directly for small outpatient charges, will simplify administration, reduce hospital recordkeeping and billing problems, and facilitate beneficiary understanding of the program.

Physicians' services rendered in a teaching setting

Another area that required special attention was payment for physicians' services rendered in a teaching setting. Services rendered in a teaching setting often involve both the services of residents and interns under approved graduate medical education programs, which are covered under the hospital insurance part of the program on a cost basis, and services of attending physicians, which are covered under the medical insurance part of the program on a charge basis. The Department developed and promulgated regulations for determining reasonable charges in a teaching setting that clarify the con-

ditions under which payment is to be made for services by the attending physician. These regulations specify that a charge should be recognized under the medical insurance program for the services of an attending physician who involves residents and interns in the care of his patient only if his services to the patient are of the same character, in terms of the responsibilities to the patient that are assumed and fulfilled, as the services he renders to his other paying patients.

BILLING PROCEDURES

Under the law as originally enacted, and during the 1st year of operation, payment for the services of physicians and suppliers could be made in one of two ways. Under one of these methods, the physician or supplier billed the patient directly, and, after having paid the bill, the patient submitted the itemized receipted bill to the carrier for payment. Under the other method, the physician or supplier accepts an assignment of the patient's claim and requests payment directly from the carrier. In accepting an assignment under the program, the physician or supplier agrees to accept as full charge for the services the amount that the carrier determines to be the reasonable charge, and to bill the patient for no more than the unmet portion of the annual $50 deductible amount plus the applicable coinsurance amount (20 percent of the reasonable charge).

In the year ending June 30, 1967, nearly 54 percent of all medical insurance bills were paid on an assignment basis. This figure includes the bills of hospital-based physicians, who are usually paid under the assignment method. Excluding bills of hospital-based physicians, nearly 46 percent of the medical insurance bills paid in the 1st year of the program were paid on the basis of assignments. As the year progressed, there was a decrease in the proportion of physicians providing services under the program who never accepted assignments, and a substantial decrease in the proportion of bills paid that were paid for services of physicians who never accepted assignments. Special tabulations of payment records received and processed through the middle of November 1966 indicated that about 58 percent of physicians providing services under the program never accepted assignments, and that about 40 percent of the bills paid were for services of physicians who never accepted assignments. Similar tabulations for payment records received and processed through February 1967 indicated that about 54 percent of physicians providing services under the program never accepted assignments and about 30 percent of the bills paid were paid for services of physicians who never accepted assignments. Significantly, the proportion of bills paid by assignment varied directly with the size of the bill; that is, the larger the bill, the greater the probability that the physician would accept payment on an assignment basis. The proportion of bills paid by assignment also varied considerably by State.

Although many physicians were accepting assignments at least part of the time, there were instances where a physician preferred not to accept assignment, even though the beneficiary was not in a position to pay the bill. In recognition of the hardship imposed on medicare patients or their families in such cases, the 1967 amendments removed the requirement of a receipted bill as a basis for reimbursement where

the physician is unwilling to accept assignment of medical insurance benefits. Thus, payment now may be made either to the patient on the basis of an itemized bill—paid or unpaid—or to the physician under the assignment method.

DETERMINATION OF COVERAGE AND APPROPRIATE UTILIZATION OF SERVICES

As previously mentioned, the determination of whether the service for which the charge is rendered is covered and medically necessary is the responsibility of the carriers under the provisions of the law and the terms of their contracts with the Government. To carry out its basic responsibility for the overall administration of the program, the Social Security Administration has issued instructions explaining and interpreting the coverage provisions and exclusions set forth in the law. However, the application of the criteria involved requires judgment and experience in dealing with the medical profession.

The carriers have been required to develop methods for identifying claims involving possible unnecessary utilization of services and to resolve these claims through review by medical consultants, the physicians involved, and, where appropriate, local medical societies. The effectiveness of these methods is considered in audits of carrier operations.

REIMBURSEMENT OF GROUP PRACTICE PREPAYMENT PLANS

Most services covered by the medical insurance program are rendered on a fee-for-service basis. However, services furnished under group practice prepayment plans are normally rendered in return for predetermined premium payments. In recognition of the need for special adaptation of the medicare payment procedures for services rendered by group practice prepayment plans, the law provides that an organization which furnishes medical and other health services (or arranges for their availability) on a prepayment basis, may elect to be paid 80 percent of the reasonable cost of services in lieu of 80 percent of the reasonable charge for such services.

Great care was exercised in developing and refining guidelines for the reimbursement of the 24 group practice prepayment plans that are being reimbursed directly by the Social Security Administration on a reasonable cost basis and the 42 group practice prepayment plans that are reimbursed through carriers on a reasonable charge basis. This included careful and ongoing consultation with the plans themselves to assure that the methods were as responsive as possible to the variety of group practice prepayment plan arrangements in existence throughout the country.

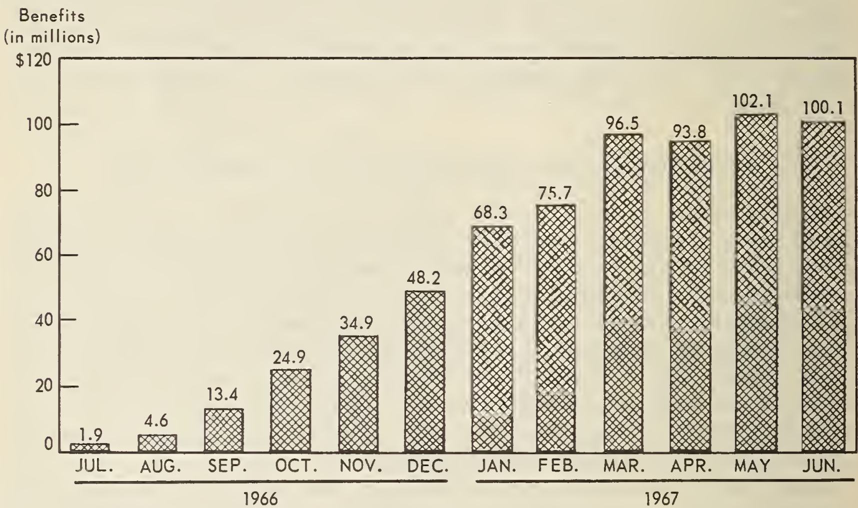
In spite of the care taken in developing the methods for reimbursing group practice prepayment plans and the continuing efforts to refine and adapt these methods as experience developed, it has not been possible to accommodate all of the plans in every respect. Many plans believe that, to fully realize the incentives for efficiency and economy in the utilization of health care services under their methods of operation, medicare would have to reimburse them for services under both the hospital and medical insurance parts of the program on the basis of prospectively determined capitation payments, rather than on the basis

of the cost of services actually rendered to medicare beneficiaries. While such an approach is not possible under present law, the Department is giving high priority to testing various methods of reimbursing group practice prepayment plans under the authority to experiment with alternative bases for reimbursement granted by the 1967 amendments to the Social Security Act.

EXPERIENCE UNDER THE MEDICAL INSURANCE PROGRAM

During the first year of the program, $664 million[3] was paid in supplementary medical insurance benefits. Payments began at a relatively low level but grew steadily, so that they had reached $48.2 million in December 1966, and more than double that amount, $100.1 million, in June 1967. This growth in benefit payments is shown in the following chart.[4]

MEDICAL INSURANCE BENEFITS PAID
(Fiscal 1967)



A total of 10.2 million medical insurance bills were approved for payment and recorded in the Social Security Administration's records for the year ending June 30, 1967.[5] Of this total, 86 percent were for physicians' services, 8 percent for outpatient hospital therapeutic services, and the remaining 6 percent for home health, independent laboratory, and other medical services. Total reasonable charges for the 10.2 million bills amounted to $740 million.[6]

Of the 8.8 million recorded bills for physicians' services, 18 percent were for surgical and 82 percent were for other medical bills. Reason-

[3] Excludes $5,000,000 of carrier benefit payments which had not cleared through the Treasury before July 1, 1967.

[4] A distribution of medical insurance benefit payments, by State, in the year ending June 30, 1967, appears in app. D, exhibit 1.

[5] Recorded in social security central records as of Mar. 8, 1968. A number of bills for services rendered during the year ending June 30, 1967, have yet to be recorded.

[6] The program pays 80 percent of the reasonable charges for covered services each year after the beneficiary has incurred $50 of such charges during the year. Also, see app. D, exhibit 6.

able charges for surgical bills amounted to $280 million and averaged $182 per bill. Reasonable charges for other medical bills amounted to $415 million and averaged $57 per bill.[7]

Use of current medicare survey to obtain current medical insurance utilization data

Utilization data based on medical insurance claims paid and recorded cannot provide current information because of the inherent lapse of time between the incidence and reporting of covered services. Physicians may put off sending bills to patients. Beneficiaries are instructed to accumulate bills until charges exceed the $50 deductible, and some hold bills until after the close of the year in which the services were rendered. Because of the time lapse, it was anticipated that the data derived from recorded experience would be inadequate for current needs.

To provide current information on the incidence of covered services under the medical insurance program and the resulting charges incurred against the Federal supplementary medical insurance trust fund, the current medicare survey (CMS) was developed. Data are obtained through periodic interviews with a scientifically selected sample of people enrolled in the medical insurance program. The interviews are conducted so as to provide these data about 3 months after the reference period, considerably in advance of the time adequate data could become available from recorded experience.[8]

Current medicare survey data on the use of, and charges for, covered medical services have been collected for the first 12 months of the program's operation. Because these data need to be analyzed on both a fiscal and calendar year basis, they are divided into two parts. The first covers the period July through December 1966, the first 6 months the program was in effect. The second covers the first 6 months of calendar year 1967; the two periods together comprise fiscal year 1967.

Use of and charges for medical services

Comparison of data for the two periods indicates no startling difference in use of services. During each period, about 12 million people, or two-thirds of all medical insurance enrollees exposed to risk, used covered medical services.[9] Among the group using covered services, a significantly larger proportion used sufficient services during the second 6-month period to meet the $50 deductible requirement. During the first 6 months the program was in effect, approximately 4 million

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[7] See app. D, exhibit 7.

[8] The CMS design calls for monthly personal interviews of nearly 4,000 people selected from the primary 5-percent statistical sample of those enrolled in the medical insurance program. The sample represents the 17,500,000 people residing in the 50 States and the District of Columbia who were enrolled for medical insurance benefits as of July 1, 1966. People selected in July remained in the sample through the end of December 1966. A second sample was selected for interviews starting in October 1966. This group will remain in the survey for 15 months. In addition, there is a small incremental sample representing people who "age into" the universe each month. Experienced field interviewers contact beneficiaries individually to obtain information about the use of medical care and related services during the preceding month. A careful editing and screening process identifies those items not covered by the program. Charges are accumulated so that the total covered charges for an individual may be located along a continuum from any point below the deductible to any point above.

[9] Population at risk represents people enrolled at any time during a period covered by the data. If the period is 1 month, this population is the same as the enrolled population. If the period is 2 or more months, it includes those who may have been enrolled for any part of the period; for example, people reaching age 65 and enrolling in the second or later months, people who died in the interval, and people who terminated their insurance at any time during the period.

people, or about 34 percent of those using medical services, incurred charges in excess of $50. By contrast, more than 5 million aged persons, or 44 percent, fell into this category during the 6 months ending June 1967.[10] This increase is partly due to the effect of the provision permitting the carryover of expenses incurred in meeting the $50 deductible during the last quarter of a calendar year (October to December) as a credit toward the deductible for the next calendar year. It also reflects the rise in medical care costs, and may reflect some seasonal effects—possibly greater use of services in the first than in the second half of the calendar year. Thus, a significantly higher proportion of patients reached the $50 deductible during the second 6-month period, even though approximately the same number of people used covered medical services during the two periods.

Average charges per person for covered services increased during the second 6 months of the program. During the first 6 months, charges averaged $84; during the second 6 months, they averaged $87, a 3.6-percent increase. For people who had not met the deductible by the end of each of the 6-month periods, charges averaged less than $20. For those who had met the deductible, average aggregate charges were about $200 for the latter half of 1966 and $170 for the next 6-month period. This drop in average charges for the latter period among people who had met the deductible probably resulted from the carryover provision, which permitted them to meet the deductible for 1967 with less than $50 in charges during 1967 whereas the minimum in 1966 was $50.

Use of and charges for medical services among the aged differed to some extent by age and sex. The proportion of enrollees using covered medical services increased with age—from 66 percent for people aged 65 to 74 to 74 percent for people aged 85 and over. A somewhat larger proportion of aged women used medical services than did aged men—71 and 62 percent, respectively.[11] In addition, average charges increased with age—from $83 per enrollee in the youngest age group to $109 in the oldest age group. Average charges for women, however were lower.[12]

The proportion of enrollees who used covered medical services and met the $50 deductible varied by region, ranging from less than 27 percent in the South to nearly 37 percent in the West. Average charges also varied considerably by region—from $80 per enrollee in the South to $109 in the West. This difference in average charge was apparently due in substantial part to the higher proportions of beneficiaries using services. The difference in charges for those who met the deductible was much smaller proportionately, $171 in the South and $184 in the West.

Monthly variations

In addition to the cumulative data it provides, the CMS provides information on a monthly basis. These monthly data are subject to greater sampling variances than the cumulative data, of course, but they provide an insight into the month-to-month fluctuations in the extent of medical services used by a large population group. During each of the first 12 months of medicare, about one-third of the medical insurance enrollees used covered medical services under the program. The

[10] See app. D, exhibit 8.
[11] See app. D, exhibit 9.
[12] See app. D, exhibit 10.

proportion ranged from a low of 30.4 percent in December 1966, to a high of 35.1 percent in May 1967. In aggregate terms, the number ranged from 5.3 million people in December to 6.2 million in May.[13]

The effect of the deductible carryover provision may be seen clearly by comparing the number and proportion of people who used services meeting the deductible during the first month of the new calendar year (January 1967) with the corresponding figures for the first month of medicare's operation. By the end of January 1967, 1.3 million people had met the deductible, more than twice the number who did so in the first month of the program.

Since the proportion using covered medical services did not vary substantially and the rise in physicians' charges was not large enough to account for the difference, the difference can be traced to the effect of the carryover provision.

As would be expected, the proportion of enrollees using medical services who met the $50 deductible increased significantly as the year progressed. By the end of December 1966, about one-half of those using services had met the deductible; the proportion had increased to three-fifths by the end of June 1967.

CARRIER PERFORMANCE IN PROCESSING MEDICAL INSURANCE BILLS

Receipt of medical insurance bills began slowly, but increased dramatically as the fiscal year progressed and more and more beneficiaries met the $50 deductible and submitted bills for payment. At first, carriers experienced difficulty in processing medical insurance claims in the quantities in which they were received. As illustrated by the following table, clearances fell substantially behind receipts, and by the end of January 1967, an accumulation of almost 2.8 million bills was pending disposition in carrier offices across the country.

MEDICAL INSURANCE CARRIER WORKLOADS (JULY 1966 TO JUNE 1967)

Month	Bills received	Bills cleared	Bills pending disposition
July 1966	72,400	32,700	39,700
August	640,700	250,300	430,100
September	1,232,900	712,500	950,500
October	1,647,100	1,036,600	1,561,000
November	1,702,900	1,484,400	1,779,500
December	2,356,800	1,918,600	2,217,700
January 1967	2,968,600	2,388,000	2,798,300
February	2,824,700	2,837,800	2,785,200
March	3,251,700	3,424,700	2,612,200
April	2,962,300	3,358,000	2,216,500
May	3,298,900	3,522,000	1,993,400
June	3,499,100	3,400,500	2,092,000

Beginning with February and continuing through May 1967, clearances exceeded receipts. By June, the pending load had been reduced by over 706,000 bills from the maximum reached in January, and the number of weeks of work on hand had dropped from an August 1966 high of 7.9 weeks to 2.7 weeks at the end of June. Paralleling this improvement was a substantial reduction in the percentage of pending bills which were pending over 30 days; these dropped from a November high of 30.1 percent to 15.2 percent by the end of the following June.

[13] See app. D, exhibit 11.

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The following table illustrates these changes.

PERFORMANCE INDICATORS FOR MEDICAL INSURANCE CARRIERS (JULY 1966 TO JUNE 1967)

Month	Ratio of clearances to receipts (percent)	Weeks of work pending	Percentage of pending bills pending over 30 days
July, 1966	45.2	4.9	----------
August	39.1	7.9	3.5
September	57.8	5.6	16.5
October	62.9	6.3	24.3
November	87.2	5.0	30.1
December	81.4	4.9	23.4
January, 1967	80.4	4.9	24.7
February	100.5	3.5	22.9
March	105.3	3.3	23.8
April	113.4	2.6	21.2
May	106.8	2.5	19.6
June	97.2	2.7	15.2

A number of factors caused the development of larger than desirable backlogs in the operations of several carriers. Coverage of physicians' services in their offices with only a $50 deductible was relatively unusual in insurance, and the processing of a very large number of small bills was not a task with which carriers had much familiarity. Furthermore, the payment of bills under the reasonable charge concept proved to be more complex than many carriers had anticipated. Consequently, initial staffing had to be adjusted, and some carriers in tight labor areas had difficulty in recruiting additional staff.

Some carriers encountered difficulty in obtaining equipment and in integrating relatively complex program requirements with other EDP systems. Furthermore, many incomplete claims were submitted during the early months of the program's operations, and had to be returned for additional information. The majority of the returned claims were those sent in by older people whose physicians chose to bill them directly. Claims sent in by physicians were more often complete.

A wide and varied range of actions were initiated by carriers and the Administration to simplify operations, overcome operational problems, and expedite claims processing. Individual arrangements were made between almost every carrier and its counterpart Social Security Administration district office for district office assistance in perfecting claims which contained incomplete or incorrect information. The statistical reporting requirements for carriers were substantially reduced temporarily to free their staffs for the more critical claims processing activities. Carriers made appropriate use of overtime where staffing problems existed. And, in some instances, personnel from Social Security Administration district offices, payment centers, and central office were detailed to carriers for brief periods to help meet emergency situations.

The results of these combined efforts were reflected in the dramatic increase in carrier productivity and in the marked decrease in the number of bills pending. Performance indicators reflected a remarkable improvement in carrier claims processing by the end of the first fiscal year.

As the administrative design of the program took shape it was found, as had been anticipated, that there was no industrywide agreement on the approach to reasonable charge determinations and that many carriers would need to modify their approach to charge determinations considerably to meet the intent of the medicare law. In this climate it was clear that uniform application of the reasonable charge provisions of the law would require the promulgation of guidelines interpreting the reasonable charge provisions and setting forth the standards against which carrier performance would be judged. And, as noted earlier, such guidelines were developed, promulgated, and finally published as regulations.

At the same time, it was recognized that simply publishing guidelines setting forth the intent of the law and suggesting methods of implementation would not, in itself, create the capacity to take into account the physicians' customary charges and the prevailing charges in the locality for similar services where neither the basic data nor the systems for making such determinations existed. These guidelines, however, do provide common understanding of the data and systems that are required for acceptable reasonable charge determinations under the medical insurance program and furnish a common yardstick for measuring carrier performance of this function.

The Social Security Administration has worked closely with carriers in their efforts to refine all aspects of claims processing, including the determination of reasonable charges. Moreover, the effectiveness with which customary and prevailing charges are taken into account in making reasonable charge determinations has been given heavy emphasis in carrier performance reviews. Reviews are conducted at the actual work stations to ascertain and evaluate the guides and screens being used for reasonable charge, coverage, medical necessity, and appropriate utilization determinations. Deficiencies and necessary corrective actions are discussed with technical staff as well as top management and followed up by central office and regional office staff of the Social Security Administration.

Administrative costs of carrier operations

Partly because the flow of bills to the medical insurance carriers started at a relatively slow pace, the ratio of administrative expenses to benefit payments was relatively high at the start of the program. However, with the flow of medical insurance claims increased and carrier productivity improved as employees became more familiar with medicare requirements, the ratio declined from 16.4 percent for the 6 months ending December 31, 1966, to 11.1 percent for the 9 months ending March 31, 1967; and for the entire year the ratio of carrier administrative costs to benefit payments was 9.4 percent.

Despite anticipated increases in wages, rents, supplies, and other operating costs, the ratio of costs to benefit payments is expected to be lower for many organizations in fiscal year 1968 than in fiscal year 1967. This reduction is anticipated as a result of improved employee productivity, increased mechanization of the claims process, and the likelihood of a relatively stable flow of medical insurance claims throughout the year.

APPENDIXES

Appendix A. Organization for Administration

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7. Group practice prepayment plans reimbursed directly by SSA on reasonable cost basis 66
8. Group practice prepayment plans reimbursed through carriers on reasonable charge basis 67

Exhibit 1

Social Security Administration Organization Chart

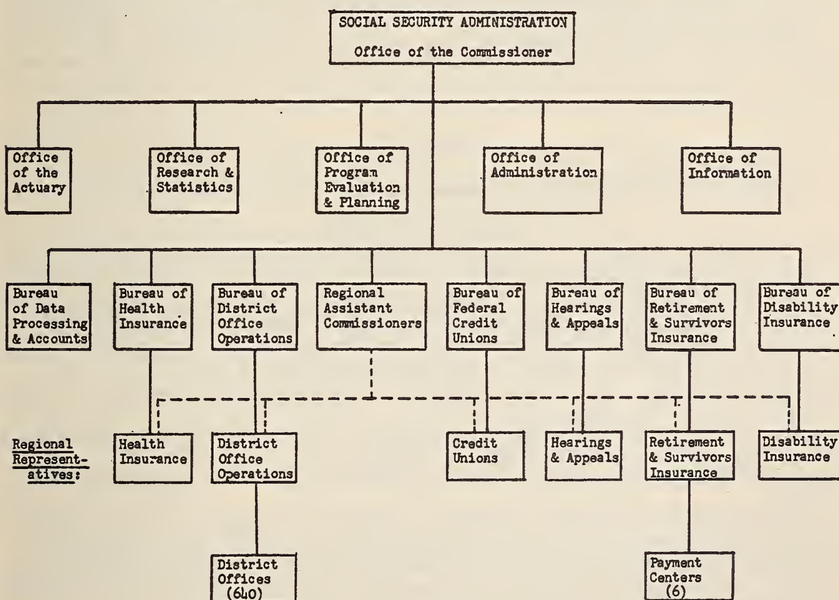

EXHIBIT 2

BUREAU OF HEALTH INSURANCE ORGANIZATION CHART

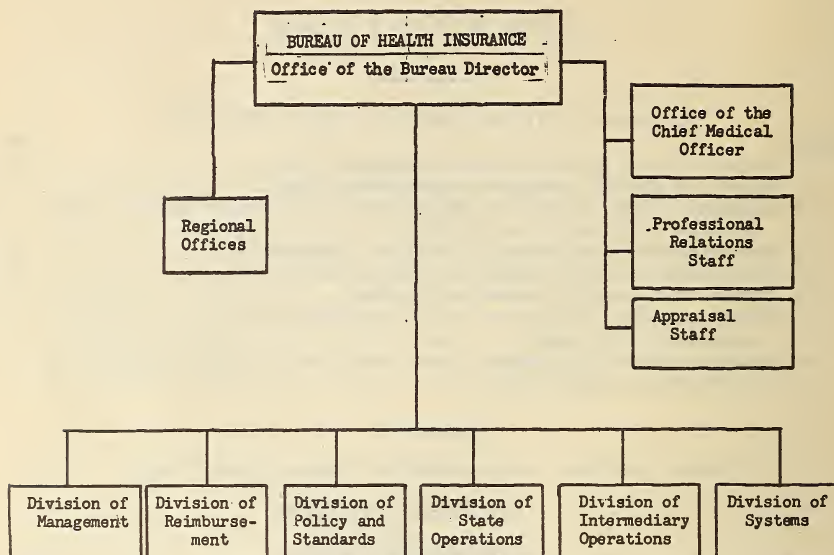

EXHIBIT 3

MEMBERS OF THE HEALTH INSURANCE BENEFITS ADVISORY COUNCIL

(As of June 30 1967)

Kermit Gordon, Chairman, president, Brookings Institution; former Director of the Bureau of the Budget.

William E. Beaumont, Jr., past president of the American Nursing Home Association; owner-administrator, Beaumont Nursing Homes, Little Rock, Ark.

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

Kenneth W. Clement, M.D., past president, National Medical Association; practicing surgeon, Cleveland, Ohio.

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

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

C. Manton Eddy, past president, Health Insurance Association of America, director, Aetna Insurance Co.; director, Connecticut General Life Insurance Co.

Caldwell B. Esselstyn, M.D., executive director of the Community Health Association, Detroit, Mich.; former chairman and presently a member of the board of the Group Health Association of America.

Jose A. Garcia, M.D., practicing physician, Corpus Christi, Tex.; former vice president general, League of United Latin-American Citizens (LULAC).

The Very Reverend Monsignor Harrold A. Murray, director, Bureau of Health and Hospitals, United States Catholic Conference.

Russell A. Nelson, M.D., president, The Johns Hopkins Hospital, Baltimore, Md.; past president, American Hospital Association.

Howard P. Rome, M.D., councillor and past president, American Psychiatric Association; senior consultant in psychiatry, Mayo Clinic, Rochester, Minn.; professor of psychiatry, Mayo Graduate School of Medicine, University of Minnesota.

Samuel R. Sherman, M.D., chairman, Council on Legislative Activities, American Medical Association; planning officer, Mount Zion Hospital, San Francisco, Calif.

Nathan J. Stark, group vice president of operations, Hallmark Cards; president, Kansas City General Hospital and Medical Center Corp.

Ray E. Trussell, M.D., director, School of Public Health and Administrative Medicine, Columbia University; former commissioner of hospitals for New York City.

Carroll L. Witten, M.D., past president, American Academy of General Practice; practicing physician, Louisville, Ky.

MEMBERS OF THE HEALTH INSURANCE BENEFITS ADVISORY COUNCIL

(As of June 14, 1968)

Charles L. Schultze, Chairman, professor of economics, University of Maryland; senior fellow, Brookings Institution; former Director of the Bureau of the Budget.

Bernard Bucove, M.D., Health Services Administrator of New York City; former director, Washington State Health Department; past president and former member of the executive committee of the Association of State and Territorial Health Officers.

Kenneth W. Clement, M.D., past president, National Medical Association; practicing surgeon, Cleveland, Ohio.

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

Margaret B. Dolan, professor and head, Department of Public Health Nursing, University of North Carolina School of Public Health; past president of the American Nurses' Association.

C. Manton Eddy, past president, Health Insurance Association of America; director, Aetna Insurance Co.; director, Connecticut General Life Insurance Co.

Caldwell B. Esselstyn, M.D., associate program coordinator, New York Metropolitan Regional Medical Program, Associated Medical Schools of New York; former chairman and presently a member of the board of the Group Health Association of America; former executive director of the Community Health Association, Detroit, Mich.

Merrill O. Hines, M.D., medical director and chairman of the Board of Management, Ochsner Clinic; professor of clinical surgery, Tulane Medical School.

William R. Hutton, executive director and director of information, National Council of Senior Citizens, Inc.; editor, Senior Citizens News.

The Very Reverend Monsignor Harrold A. Murray, director, Bureau of Health and Hospitals, United States Catholic Conference.

Russell A. Nelson, M.D., president, The Johns Hopkins Hospital, Baltimore, Md.; past president, American Hospital Association.

Howard P. Rome, M.D., senior consultant in psychiatry, Mayo Clinic, Rochester, Minn.; councillor and past president, American Psychiatric Association; professor of psychiatry, Mayo Graduate School of Medicine, University of Minnesota.

Syble H. Scott, practicing attorney; nursing home operator; faculty member, School of Continuing Education, University of Oklahoma.

Samuel R. Sherman, M.D., former chairman, Council on Legislative Activities, American Medical Association; planning officer, Mount Zion Hospital, San Francisco, Calif.

Herman M. Somers, Ph. D., professor of politics and public affairs, Princeton University; past member of the Advisory Council on Social Security; consultant to many governmental and private agencies in the fields of administration and health services.

Nathan J. Stark, group vice president of operations, Hallmark Cards; president, Kansas City General Hospital and Medical Center Corp.

Ray E. Trussell, M.D., director, School of Public Health and Administrative Medicine, Columbia University; former commissioner of hospitals for New York City.

Adolfo Urrutia, M.D., practicing surgeon; past president of staff, Santa Rosa Medical Center, San Antonio, Tex.; fellow of the American College of Surgeons.

Carroll L. Witten, M.D., past president, American Academy of General Practice; practicing physician, Louisville, Ky.

Exhibit 4

State Agencies Administering Provider Certification

Alabama: State Department of Public Health, Montgomery, Ala.
Alaska: Alaska Department of Health and Welfare, Juneau, Alaska.
Arizona: State Department of Health, Phoenix, Ariz.
Arkansas: State Board of Health, Little Rock, Ark.
California: State Department of Public Health, Berkeley, Calif.
Colorado: State Department of Public Health, Denver, Colo.
Connecticut: State Department of Health, Hartford, Conn.
Delaware: State Board of Health, Dover, Del.
District of Columbia: District of Columbia Health Department, Washington, D.C.
Florida: State Board of Health, Jacksonville, Fla.
Georgia: Georgia Department of Public Health, Atlanta, Ga.
Guam: Department of Public Health and Welfare, Agana, Guam.
Hawaii: Hawaii Department of Health, Honolulu, Hawaii.
Idaho: Idaho Department of Health, Boise, Idaho.
Illinois: Illinois Department of Public Health, Springfield, Ill.
Indiana: State Board of Health, Indianapolis, Ind.
Iowa: State Department of Health, Des Moines, Iowa.
Kansas: State Department of Health, Topeka, Kans.
Kentucky: Commonwealth of Kentucky Department of Health, Frankfort, Ky.
Louisiana: Louisiana Department of Hospitals, Baton Rouge, La.
Maine: Maine Department of Health and Welfare, Augusta, Maine.
Maryland: State Department of Health, Baltimore, Md.
Massachusetts: Massachusetts Department of Public Health, Boston, Mass.
Michigan: Michigan Department of Health, Lansing, Mich.
Minnesota: State Department of Health, Minneapolis, Minn.
Mississippi: Mississippi State Board of Health, Jackson, Miss.
Missouri: Division of Health, Jefferson City, Mo.
Montana: State Board of Health, Helena, Mont.
Nebraska: State Department of Health, Lincoln, Neb.
Nevada: Division of Health, Carson City, Nev.
New Hampshire: New Hampshire Division of Public Health, Concord, N.H.
New Jersey: State Department of Health, Trenton, N.J.
New Mexico: New Mexico Department of Public Health, Sante Fe, N. Mex.
New York: New York State Department of Health, Albany, N.Y.
North Carolina: State Board of Health, Raleigh, N.C.
North Dakota: State Department of Health, Bismarck, N. Dak.
Ohio: Ohio Department of Health, Columbus, Ohio.
Oklahoma: State Department of Health, Oklahoma City, Okla.
Oregon: State Board of Health, Portland, Oreg.
Pennsylvania: Department of Health, Harrisburg, Pa.
Puerto Rico: Puerto Rico Department of Health, San Juan, P.R.
Rhode Island (except extended care facilities): Rhode Island Department of Health, Providence, R.I.
Rhode Island (extended care facilities only): Rhode Island Department of Social Welfare, Providence, R.I.
South Carolina: State Board of Health, Columbia, S.C.
South Dakota: State Department of Health, Pierre, S. Dak.
Tennessee: Tennessee Department of Public Health, Nashville, Tenn.
Texas: State Department of Health, Austin, Tex.
Utah: State Department of Health, Salt Lake City, Utah.
Vermont: Vermont Department of Health, Burlington, Vt.
Virgin Islands: Virgin Islands Department of Health, St. Thomas, V.I.
Virginia: State Department of Health, Richmond, Va.
Washington: State Department of Health, Olympia, Wash.
West Virginia: State Department of Health, Charleston, W. Va.
Wisconsin: State Board of Health, Madison, Wis.
Wyoming: State Department of Public Health, Cheyenne, Wyo.

Note.—The government of American Samoa, the sole operator of medical facilities in that territory, has appointed an administrative officer to confer with DHEW with regard to the medicare program.

Exhibit 5

Intermediaries for Hospital Insurance Program and States in Which They Service Providers

Aetna Life & Casualty: California, Connecticut, Florida, Illinois, Massachusetts, Nevada, New York, Tennessee, Virginia, and Washington.
Blue Cross Association (through 74 Blue Cross plans): All States except Hawaii and Nevada and the Virgin Islands.
Community Health Association (CHA): Michigan.
Cooperativa de Salud de Puerto Rico: Puerto Rico.
Hamilton Life Insurance Co.: New York (extended care facilities only)[1]
Hawaii Medical Services Association: Hawaii.
Inter-County Hospitalization Plan, Inc.: Pennsylvania.
Kaiser Foundation Health Plan, Inc.: California, Hawaii, and Oregon (Kaiser Foundation providers only).
Mutual of Omaha: Alabama, California, Colorado, District of Columbia, Idaho, Iowa, Kansas, Kentucky, Maryland, Minnesota, Mississippi, Missouri, Montana, Nebraska, Oklahoma, Oregon, South Dakota, Texas, Virginia, Virgin Islands, Washington, West Virginia, and Wisconsin.
Nationwide Mutual Insurance Co.: Ohio.
New York State Department of Health: New York (home health agencies only).
Prudential Insurance Co.: New Jersey.
Travelers Insurance Co.: California, Connecticut, Florida, Georgia, Maine, Massachusetts, Michigan, Minnesota, New Hampshire, New Mexico, New York, Pennsylvania, Rhode Island, and Vermont.

[1] Effective May 1968, Travelers Insurance Co. became the intermediary for New York extended care facilities.

Exhibit 6

Carriers for Medical Insurance Program

Alabama: Blue Cross-Blue Shield of Alabama.[1]
Alaska: Aetna Life & Casualty.
Arizona: Aetna Life & Casualty.
Arkansas: Arkansas Blue Cross & Blue Shield, Inc.[1]
California:
- California Blue Shield.[1]
- Occidental Life Insurance Co. of California.

Colorado: Colorado Medical Service, Inc.[1]
Connecticut: Connecticut General Life Insurance Co.
Delaware: Blue Cross & Blue Shield of Delaware, Inc.[1]
District of Columbia: Medical Service of the District of Columbia.[1]
Florida: Blue Shield of Florida, Inc.[1]
Georgia: John Hancock Mutual Life Insurance Co.
Hawaii: Aetna Life & Casualty.
Idaho: The Equitable Life Assurance Society of the United States.
Illinois:
- Continental Casualty Co.
- Illinois Medical Service.[1]

Indiana: Mutual Medical Insurance, Inc.[1]
Iowa: Iowa Medical Service.[1]
Kansas: Blue Cross-Blue Shield of Kansas.[1]
Kentucky: Metropolitan Life Insurance Co.
Louisiana: Pan-American Life Insurance Co.
Maine: Union Mutual Life Insurance Co.
Maryland: Maryland Medical Service, Inc.[1]
Massachusetts. Massachusetts Medical Service.[1]
Michigan: Michigan Medical Service.[1]
Minnesota:
- Blue Shield of Minnesota.[1]
- The Travelers Insurance Co.

Mississippi: The Travelers Insurance Co.
Missouri:
- General American Life Insurance Co.
- Surgical Care, Inc.[1]

Montana: Montana Physician's Service.[1]

Footnote p. 66.

Nebraska[2]: Mutual of Omaha Insurance Co.
Nevada: Aetna Life & Casualty.
New Hampshire: New Hampshire-Vermont Physician Service.[1]
New Jersey: The Prudential Insurance Co. of America.
New Mexico: The Equitable Life Assurance Society of the United States.
New York:
- Blue Shield of Western New York, Inc.[1]
- Genessee Valley Medical Care.[1]
- Group Health Insurance, Inc.
- Metropolitan Life Insurance Co.
- United Medical Service, Inc.[1]

North Carolina: Pilot Life Incurance Co.
North Dakota: North Dakota Physicians Service.[1]
Ohio:
- Medical Mutual of Cleveland, Inc.[1]
- Nationwide Mutual Insurance Co.

Oklahoma:[3] Aetna Life and Casualty.
Oregon: Aetna Life and Casualty.
Pennsylvania: Pennsylvania Blue Shield.[1]
Puerto Rico: Seguros de Servicio de Salud de Puerto Rico, Inc.
Rhode Island: Rhode Island Medical Society Physicians Service.[1]
South Carolina: Blue Cross—Blue Shield of South Carolina.[1]
South Dakota: South Dakota Blue Shield.[1]
Tennessee: The Equitable Life Assurance Society of the United States.
Texas: Group Medical and Surgical Service.[1]
Utah: Medical Service Bureau.[1]
Vermont: New Hampshire-Vermont Physician Service.[1]
Virgin Islands: Mutual of Omaha Insurance Co.
Virginia:
- Medical Service of the District of Columbia.[1]
- The Travelers Insurance Co.

Washington: Washington Physicians Service.[1]
West Virginia: Nationwide Mutual Insurance Co.
Wisconsin:
- Medical Society of Milwaukee County.[1]
- Wisconsin Physicians Service.[1]

Wyoming: The Equitable Life Assurance Society of the United States.

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[1] Blue Shield Plan.
[2] The Nebraska State Department of Public Welfare was among the initial carrier selections. However, the agreement was terminated by mutual consent effective May 5, 1967, following a request by the Department of Public Welfare.
[3] As of July 1, 1967, the Oklahoma Department of Public Welfare assumed the carrier role for those individuals included in the "buy-in" agreement.

Exhibit 7

Group Practice Prepayment Plans Reimbursed Directly by SSA on Reasonable Cost Basis

Atcheson, Topeka, and Santa Fe Hospital Association, Topeka, Kans.
Boro Medical Center, New York, N.Y.
Community Health Association, Detroit, Mich.
Community Health Foundation, Cleveland, Ohio
Family Health Program of Southern California, Long Beach, Calif.
Group Health Cooperative of Puget Sound, Seattle, Wash.
Group Health Plan, Inc., St. Paul, Minn.
Health Insurance Plan of Greater New York, New York, N.Y.
Kaiser Foundation Health Plan, Inc., Oakland, Calif.
Kansas City Southern Employees Hospital Association,[1] Kansas City, Mo.
La Societe Francaise de Bienfaisance Mutuelle, San Francisco, Calif.
Louisiana and Arkansas Railway Employees Hospital Association,[1] Shreveport, La.
Local 1205 Health Center, Brooklyn, N.Y.
Medical Institute of Local 88, St. Louis, Mo.
NYSA–ILA Coordinating Committee, New York, N.Y.
NYSA–PWU Welfare Fund, New York, N.Y.
Philadelphia AFL–CIO Hospital Association, Philadelphia, Pa.

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Police and Firemen's Medical Association, Philadelphia, Pa.
Santa Fe Coast Lines Hospital Association, Los Angeles, Calif.
Southern Pacific Employees Hospital Association, San Francisco, Calif.
St. Louis Labor Health Institute, St. Louis, Mo.
St. Louis Southwestern Railway Hospital Trust,[2] Texarkana, Ark.
Union Family Medical Fund of the Hotel Industry of NYC, New York, N.Y.
United Mine Workers of America Retirement and Welfare Fund, Washington, D.C.
Wabash Memorial Hospital Association, Decatur, Ill.
Western Clinic, Tacoma, Wash.

[1] Plan terminated operations on Mar. 31, 1967.
[2] Effective July 1, 1967, this plan ceased operations.

Exhibit 8

Group Practice Prepayment Plans Reimbursed Through Carriers on Reasonable Charge Basis

United Medical Service, New York, N.Y.:
- Amalgamated Laundry Workers Health Center, New York, N.Y.
- Building Service Employees Local 32B, New York, N.Y.
- Health Center—Local 1111, New York, N.Y.
- Provision Salesmen and Distributors Union Welfare Trust Fund, New York, N.Y.
- Hebrew Butcher Workers Union Local 234, New York, N.Y.
- Sidney Hillman Health Center, New York, N.Y.
- United Wire Metal and Machine Health and Welfare Fund, New York, N.Y.
- Max Bleicher, M.D., Diagnostic Clinic, New York, N.Y.

Group Health Insurance, Inc., New York, N.Y.:
- Medical and Dental Plan of the Electrical Manufacturing and Supply Industry, Flushing, N.Y.

Blue Cross and Blue Shield of Delaware, Inc., Wilmington, Del.:
- Electra Arms Medical Center, Wilmington, Del.

Pennsylvania Blue Shield, Camp Hill, Pa.:
- A. F. of L. Medical Service Plan of Philadelphia, Philadelphia, Pa.
- Sidney Hillman Medical Center, Philadelphia, Pa.

Medical Service of the District of Columbia, Washington, D.C.:
- Group Health Association, Washington, D.C.

Seguros de Servicio de Salud de Puerto Rico, Hato Rey, P.R.:
- Association de Maestros de Puerto Rico, Hato Rey, P.R.
- Fondo de Bienestas ILA–PRSSA, San Juan, P.R.

Blue Shield of Florida, Inc., Jacksonville, Fla.:
- Centro Espanol de Tampa, Tampa, Fla.
- Circulo Cubano de Tampa, Tampa, Fla.
- La Benefica Espanola, Tampa, Fla.

Travelers Insurance Co., Hartford, Conn.:
- Taborian Hospital, Mound Bayou, Miss.

Illinois Medical Service, Chicago, Ill.:
- Civic Medical Center, Chicago, Ill.
- Medical Center—Beef Boners and Sausage Makers, Chicago, Ill.
- Sidney Hillman Health Center, Chicago, Ill.
- Union Health Service, Inc., Chicago, Ill.

General American Life Insurance Co., St. Louis, Mo.:
- Transit Services Corporation of Metropolitan St. Louis, St. Louis, Mo.

South Dakota Medical Service, Inc., Sioux Falls, S.D.:
- Homestake Mining Co., Lead, S.D.

Pan American Life Insurance Co., New Orleans, La.:
- Stanocola Medical Clinic, Baton Rouge, La.

Colorado Medical Service, Denver, Colo.:
- Employees Mutual Aid Association of Public Service Company of Colorado, Denver, Colo.

Aetna Life Insurance Co., Phoenix, Ariz.:
- Phelps Dodge Corporation Hospital-Medical-Surgical Plan, Douglas, Ariz.

Occidental Life Insurance Co., Los Angeles, Calif.:
- Ross Loos Medical Group, Los Angeles, Calif.
- Transportation Hospital Association, Los Angeles, Calif.

Washington Physician Service, Seattle, Wash.: Community Medical Service, Inc., Seattle, Wash.

United Medical Service, Inc., New York, N.Y.:
- Union Health Center, International Ladies' Garment Workers' Union, New York, N.Y.

Massachusetts Medical Service, Boston, Mass.:
- Union Health Center, International Ladies' Garment Workers' Union, Boston, Mass.
- Union Health Center, International Ladies' Garment Workers' Union, Fall River, Mass.

Prudential Insurance Co., Millville, N.J.:
- Union Health Center, International Ladies' Garment Workers' Union, Newark, N.J.

Pennsylvania Blue Shield, Camp Hill, Pa.:
- Union Health Center, International Ladies' Garment Workers' Union, Philadelphia, Pa.
- Tri District Health Center, International Ladies' Garment Workers' Union, Wilkes-Barre, Pa.
- Union Health Center, International Ladies' Garment Workers' Union, Allentown, Pa.

Illinois Medical Service, Chicago, Ill.:
- Chicago Health Center, International Ladies' Garment Workers' Union, Chicago, Ill.

Blue Cross-Blue Shield of Kansas, Topeka, Kans.:
- Kansas City Garment Industry Health Center, Kansas City, Kans.

General American Life Insurance Co., St. Louis, Mo.:
- Garment Industry Health Center, St. Louis, Mo.

Occidental Life Insurance Co. of California, Los Angeles, Calif.:
- Union Health Center, International Ladies' Garment Workers' Union, Los Angeles, Calif.

Appendix B. Enrollment for Hospital and Medical Insurance

Exhibit:

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1. Enrollment for hospital and medical insurance by type of entitlement, geographic division, and State, as of July 1, 1966	70
2. Enrollment for hospital and medical insurance, by type of entitlement, geographic division, and State, as of July 1, 1967	72
3. States with "buy-in" agreements for medical insurance coverage of public assistance cash recipients, June 30, 1967	74

EXHIBIT 1

HEALTH INSURANCE FOR THE AGED: ENROLLMENT FOR HOSPITAL AND MEDICAL INSURANCE, BY TYPE OF ENTITLEMENT, GEOGRAPHIC DIVISION, AND STATE, AS OF JULY 1, 1966[1]

Geographic division and State	All persons enrolled			Entitled to social security benefits[2]		Entitled to railroad retirement benefits[2]		Other enrolled persons		
	Hospital insurance	Medical insurance	Hospital and medical	Hospital insurance	Medical insurance	Hospital insurance	Medical insurance	Hospital insurance	Medical insurance	Hospital and medical
Total	18,858,569	17,611,587	17,581,837	15,856,260	14,882,057	821,254	761,483	2,445,810	2,221,611	2,191,861
New England	1,224,031	1,175,764	1,173,236	1,066,452	1,029,144	29,510	27,817	138,867	129,264	126,736
Connecticut	270,576	262,470	262,288	241,566	234,884	5,246	4,976	25,598	24,400	24,218
Maine	115,527	110,904	110,639	99,958	96,022	4,644	4,401	12,608	12,113	11,848
Massachusetts	614,947	592,881	591,237	528,215	511,721	13,553	12,758	78,079	73,151	71,507
New Hampshire	76,421	69,952	69,772	67,651	62,863	2,371	2,179	7,417	5,883	5,703
Rhode Island	99,179	94,300	94,129	88,631	84,748	1,464	1,367	9,612	8,695	8,524
Vermont	47,381	45,257	45,171	40,431	38,906	2,232	2,136	5,553	5,022	4,936
Middle Atlantic	3,765,627	3,593,585	3,589,293	3,305,813	3,165,175	153,502	144,342	353,542	329,648	325,356
New Jersey	648,099	625,003	624,233	576,242	557,844	22,593	21,449	56,501	52,764	51,994
New York	1,896,392	1,816,071	1,813,826	1,679,693	1,615,829	55,749	52,529	180,990	167,136	164,891
Pennsylvania	1,221,136	1,152,511	1,151,234	1,049,878	991,502	75,160	70,364	116,051	109,748	108,471
East North Central	3,671,529	3,461,972	3,458,865	3,183,339	3,011,242	172,571	161,419	371,976	343,397	340,290
Illinois	1,061,043	1,000,026	998,976	907,880	859,717	60,679	56,460	112,293	102,829	101,779
Indiana	474,760	442,057	441,768	419,556	392,026	26,381	24,565	38,771	34,952	34,663
Michigan	725,670	691,345	690,751	643,693	612,601	20,026	18,844	68,576	66,294	65,700
Ohio	958,899	901,187	900,340	816,564	769,594	48,583	45,511	108,068	99,813	98,966
Wisconsin	451,157	427,357	427,030	395,646	377,304	16,902	16,039	44,268	39,509	39,182
West North Central	1,847,884	1,709,226	1,706,856	1,547,343	1,445,809	104,305	97,368	230,487	198,859	196,489
Iowa	345,531	328,132	327,772	295,955	281,953	16,648	15,741	38,803	36,120	35,760
Kansas	256,512	224,578	224,317	214,405	194,676	18,275	16,897	29,834	18,734	18,473
Minnesota	393,280	371,121	370,399	327,876	313,095	24,220	23,048	48,781	42,379	41,657
Missouri	534,468	490,410	489,805	437,323	403,574	29,244	26,819	77,347	68,926	68,321
Nebraska	176,012	162,532	162,319	150,272	138,658	10,770	10,042	18,584	17,280	17,067
North Dakota	64,266	59,367	59,293	54,440	50,880	2,916	2,727	7,771	6,578	6,504
South Dakota	77,815	73,086	72,951	67,072	62,973	2,232	2,094	9,367	8,842	8,707
South Atlantic	2,469,160	2,306,915	2,298,710	2,019,296	1,892,603	113,832	105,913	370,528	341,424	333,219
Delaware	41,514	39,728	39,692	35,958	34,399	2,733	2,626	3,730	3,591	3,555
District of Columbia	66,832	61,862	59,736	51,674	46,725	1,919	1,714	13,828	13,971	11,845
Florida	711,896	679,919	678,902	608,151	582,429	30,976	29,254	83,698	78,819	77,802
Georgia	330,223	301,760	301,155	244,083	225,257	13,878	12,690	76,513	67,843	67,238
Maryland	258,288	235,981	234,118	215,269	198,381	13,552	12,653	33,178	28,492	26,629

North Carolina	370,796	345,893	345,496	306,106	286,121	10,430	9,696	57,612	53,285	52,888
South Carolina	172,917	159,275	159,037	135,486	125,188	4,989	4,491	33,951	31,007	30,769
Virginia	326,647	302,543	300,780	267,510	247,042	21,808	20,062	43,476	41,288	39,525
West Virginia	190,047	179,954	179,794	155,059	147,061	13,547	12,727	24,542	23,128	22,968
East South Central	1,178,143	1,097,600	1,096,039	905,946	845,625	56,141	51,798	232,727	216,078	214,517
Alabama	296,379	279,856	279,430	220,636	207,888	11,312	10,436	67,836	64,794	64,368
Kentucky	321,183	302,694	302,321	256,181	240,508	19,505	18,165	51,123	49,391	49,018
Mississippi	208,122	184,342	184,068	153,726	138,970	7,317	6,593	49,406	40,963	40,689
Tennessee	352,459	330,708	330,220	275,403	258,259	18,007	16,604	64,362	60,930	60,442
West South Central	1,642,484	1,549,302	1,546,758	1,241,521	1,166,222	63,328	58,475	357,076	343,049	340,505
Arkansas	216,643	201,252	201,031	164,625	152,516	9,750	8,902	45,352	42,740	42,519
Louisiana	276,127	256,029	255,696	189,543	175,087	9,839	8,942	79,523	74,585	74,252
Oklahoma	272,687	254,837	254,432	208,561	195,091	8,032	7,365	58,789	54,925	54,520
Texas	877,027	837,184	835,599	678,792	643,528	35,707	33,266	173,412	170,799	169,214
Mountain	611,072	575,612	574,396	505,790	477,300	41,111	38,813	78,464	73,309	72,093
Arizona	120,746	113,115	112,898	102,180	95,859	6,780	6,307	14,282	13,350	13,133
Colorado	175,092	166,739	166,393	139,710	133,558	10,734	10,187	28,295	26,518	26,172
Idaho	63,685	59,209	59,152	55,755	51,989	3,552	3,384	5,771	5,172	5,115
Montana	67,180	63,780	63,691	56,871	53,820	5,700	5,427	6,547	6,421	6,332
Nevada	24,230	22,775	22,702	20,607	19,272	1,778	1,683	2,484	2,437	2,364
New Mexico	62,181	57,188	56,991	47,631	43,811	3,925	3,574	11,729	10,852	10,655
Utah	68,613	65,383	65,180	58,570	55,968	5,602	5,354	6,518	6,093	5,890
Wyoming	29,345	27,423	27,389	24,466	23,023	3,040	2,897	2,838	2,466	2,432
Pacific	2,159,291	2,029,853	2,026,006	1,840,617	1,755,475	79,297	74,655	269,730	229,066	225,219
Alaska	5,589	4,505	4,484	4,739	3,979	68	53	821	503	482
California	1,608,277	1,513,524	1,510,696	1,358,706	1,299,723	56,439	53,132	214,277	181,133	178,305
Hawaii	37,307	35,888	35,752	32,091	30,801	333	302	5,050	4,948	4,812
Oregon	206,214	191,850	191,602	183,658	172,660	9,750	9,174	17,053	14,102	13,854
Washington	301,904	284,086	283,472	261,423	248,312	12,707	11,994	32,529	28,380	27,766
Other areas	141,731	94,637	94,588	104,845	81,525	149	14	36,745	13,105	13,056
American Samoa	181	39	39	90	23	0	0	91	16	16
Guam	1,124	694	692	146	123	0	0	978	571	569
Puerto Rico	137,864	92,315	92,269	103,026	80,070	12	11	34,832	12,240	12,194
Virgin Islands	2,267	1,523	1,522	1,427	1,249	3	2	837	272	271
Other territories	295	66	66	156	60	134	1	7	6	6
Foreign countries	133,269	10,361	10,359	132,703	10,256	1,331	128	82	64	62
Canada	19,485	2,097	2,097	19,017	2,045	544	55	38	20	20
Mexico	4,496	915	915	4,457	907	134	16	2	2	2
All others	109,288	7,349	7,347	109,229	7,304	653	57	42	42	40
Unknown State	14,348	6,760	6,731	2,595	1,681	6,177	741	5,586	4,348	4,319

[1] Based on data recorded as of Dec. 3, 1966.

[2] Includes 264,000 people entitled to both social security and railroad retirement benefits on the basis of earnings under both programs.

EXHIBIT 2

HEALTH INSURANCE FOR THE AGED: ENROLLMENT FOR HOSPITAL AND MEDICAL INSURANCE, BY TYPE OF ENTITLEMENT, GEOGRAPHIC DIVISION, AND STATE, AS OF JULY 1, 1967.[1]

Geographic division and State	All persons enrolled			Entitled to social security benefits [2]		Entitled to railroad retirement benefits [2]		Other enrolled persons		
	Hospital insurance	Medical insurance	Hospital and medical insurance	Hospital insurance	Medical insurance	Hospital insurance	Medical insurance	Hospital insurance	Medical insurance	Hospital and medical insurance
Total, all areas	19,358,102	17,869,376	17,840,666	17,280,796	16,102,331	845,800	772,315	1,503,196	1,255,648	1,226,938
United States	19,047,997	17,753,224	17,724,626	17,021,537	15,999,358	835,753	769,692	1,461,480	1,244,893	1,216,295
New England	1,243,083	1,189,209	1,186,805	1,148,848	1,102,707	29,983	27,843	75,207	69,322	66,918
Maine	116,599	111,562	111,308	105,755	101,295	4,707	4,401	7,845	7,529	7,275
New Hampshire	78,011	72,508	72,357	72,743	67,892	2,384	2,164	3,909	3,438	3,287
Vermont	47,922	45,853	45,763	43,627	41,806	2,257	2,145	2,874	2,713	2,623
Massachusetts	623,686	598,257	596,680	569,942	548,640	13,641	12,686	45,043	41,744	40,167
Rhode Island	100,786	95,013	94,864	95,091	90,187	1,460	1,349	4,767	3,997	3,848
Connecticut	276,079	266,016	265,833	261,690	252,887	5,534	5,098	10,769	9,901	9,718
Middle Atlantic	3,827,097	3,619,945	3,615,812	3,565,113	3,387,365	155,334	144,017	154,495	134,862	130,729
New York	1,926,520	1,828,331	1,826,175	1,812,891	1,728,422	56,727	52,450	77,243	67,220	65,064
New Jersey	661,734	635,046	634,278	623,430	599,981	22,910	21,395	22,736	20,846	20,078
Pennsylvania	1,238,843	1,156,568	1,155,359	1,128,792	1,058,962	75,697	70,172	54,516	46,796	45,587
East North Central	3,723,350	3,469,737	3,466,685	3,418,319	3,210,467	175,443	161,640	186,778	152,662	149,610
Ohio	972,489	899,735	898,906	872,873	815,683	49,446	45,699	64,686	52,311	51,482
Indiana	481,245	445,211	444,935	446,744	415,134	26,616	24,437	17,875	15,184	14,903
Illinois	1,074,725	998,618	997,566	979,677	919,462	61,957	56,642	53,273	41,927	40,375
Michigan	736,465	693,036	692,461	689,830	652,978	20,370	18,876	33,006	27,697	27,122
Wisconsin	458,426	433,137	432,817	429,195	407,210	17,054	15,986	17,938	15,543	15,223
West North Central	1,879,846	1,724,386	1,722,321	1,686,201	1,563,583	106,354	97,938	122,126	96,341	94,276
Minnesota	400,499	379,157	378,634	359,110	340,655	24,359	22,912	24,661	23,043	22,520
Iowa	349,136	329,924	329,574	319,748	302,695	16,821	15,692	18,488	17,273	16,923
Missouri	544,912	489,484	488,922	476,096	435,016	30,029	27,111	48,512	36,571	36,009
North Dakota	65,359	59,517	59,456	59,395	54,913	3,005	2,762	3,844	2,680	2,619
South Dakota	79,318	73,625	73,515	73,582	68,468	2,250	2,087	4,343	3,897	3,787
Nebraska	179,496	164,862	164,661	164,845	151,551	11,067	10,193	7,263	6,635	6,434
Kansas	261,126	227,817	227,559	233,425	210,285	18,823	17,181	15,015	6,242	5,984
South Atlantic	2,593,911	2,374,721	2,366,674	2,265,645	2,100,339	119,151	109,087	245,435	200,101	192,054
Delaware	42,589	40,123	40,090	39,037	37,039	2,853	2,678	1,616	1,306	1,273
Maryland	269,277	241,848	239,970	241,278	218,210	14,012	12,879	17,800	14,404	12,526
District of Columbia	67,703	61,016	58,873	56,229	49,469	2,020	1,733	10,051	10,368	8,225
Virginia	338,946	308,296	306,609	300,993	274,107	22,473	20,359	21,849	19,899	18,212
West Virginia	192,959	179,703	179,548	168,264	158,163	13,837	12,814	14,063	11,784	11,629

North Carolina	383,901	347,394	347,046	340,983	314,939	10,749	9,837	35,633	25,922	25,574
South Carolina	178,877	162,790	162,581	151,412	138,077	5,140	4,545	23,887	21,627	21,418
Georgia	342,681	295,356	294,787	269,898	245,118	14,444	12,952	62,803	41,512	40,943
Florida	776,978	738,195	737,170	697,551	665,217	33,623	31,290	57,733	53,279	52,254
East South Central	1,211,576	1,095,358	1,093,916	993,656	917,294	57,937	52,582	177,278	141,957	140,515
Kentucky	328,116	303,261	302,896	277,302	258,250	20,120	18,473	36,539	32,121	31,756
Tennessee	363,250	336,991	336,509	308,658	287,437	18,506	16,819	41,613	38,026	37,544
Alabama	306,300	279,888	279,528	240,683	224,242	11,838	10,716	57,312	48,309	47,949
Mississippi	213,910	175,218	174,983	167,013	147,365	7,473	6,574	41,814	23,501	23,266
West South Central	1,704,316	1,579,383	1,577,032	1,373,332	1,279,536	66,331	60,351	284,967	258,830	256,479
Arkansas	224,739	207,529	207,327	181,031	166,747	10,266	9,226	36,632	34,577	34,375
Louisiana	286,294	250,471	250,160	212,321	192,896	10,207	9,107	66,657	51,149	50,838
Oklahoma	281,734	263,744	263,370	228,843	213,171	8,247	7,521	47,410	45,684	45,310
Texas	911,549	857,639	856,175	751,137	706,722	37,611	34,497	134,268	127,420	125,956
Mountain	635,279	591,308	590,019	558,618	523,312	42,888	39,883	48,557	42,439	41,150
Montana	67,979	63,861	63,769	61,183	57,638	5,762	5,410	2,963	2,690	2,598
Idaho	65,294	59,956	59,896	60,305	55,809	3,668	3,443	2,741	2,079	2,019
Wyoming	29,748	27,769	27,735	26,261	24,564	3,135	2,940	1,377	1,252	1,218
Colorado	179,668	171,058	170,727	154,481	146,925	11,182	10,483	17,758	17,287	16,956
New Mexico	64,879	56,810	56,619	53,402	48,492	4,066	3,683	8,562	5,736	5,545
Arizona	130,892	121,706	121,349	116,508	108,629	7,311	6,693	9,729	8,950	8,593
Utah	70,831	66,128	65,972	63,268	59,779	5,875	5,469	3,871	3,020	2,864
Nevada	25,988	24,020	23,952	23,210	21,476	1,889	1,762	1,556	1,425	1,357
Pacific	2,229,539	2,109,177	2,105,362	2,011,805	1,914,755	82,332	76,351	166,637	148,379	144,564
Washington	307,466	287,659	287,102	281,601	265,840	12,974	12,053	17,767	14,490	13,933
Oregon	211,723	195,177	194,941	197,841	184,694	10,126	9,374	8,089	5,291	5,055
California	1,665,167	1,584,480	1,581,597	1,490,286	1,424,717	58,696	54,481	137,991	126,476	123,593
Alaska	5,872	4,501	4,483	5,031	4,176	186	128	648	231	213
Hawaii	39,311	37,360	37,239	36,996	35,328	350	315	2,142	1,891	1,770
Other areas	150,922	92,019	91,971	112,739	83,674	173	32	38,034	8,335	8,287
Puerto Rico	146,781	89,794	89,751	110,686	82,067	23	19	36,086	7,722	7,679
Virgin Islands	2,460	1,542	1,541	1,605	1,373	12	10	852	167	166
American Samoa	211	34	34	117	26	0	0	94	8	8
Guam	1,180	586	583	183	15	20	0	997	434	431
Other territories	290	63	62	148	56	138	3	5	4	3
Foreign countries	140,668	15,412	15,411	140,190	15,314	1,220	147	99	80	79
Canada	20,720	3,041	3,041	20,348	2,992	448	40	45	37	37
Mexico	5,122	1,266	1,266	5,074	1,253	138	21	7	7	7
All others	114,826	11,105	11,104	114,768	11,069	634	86	47	36	35
Unknown	18,515	8,721	8,658	6,330	3,985	8,654	2,444	3,583	2,340	2,277

[1] Based on data recorded as of Dec. 29, 1967.

[2] Includes 271,700 people entitled to both social security and railroad retirement benefits on the basis of earnings under both programs.

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EXHIBIT 3

STATES WITH "BUY-IN" AGREEMENTS FOR MEDICAL INSURANCE COVERAGE OF PUBLIC ASSISTANCE CASH RECIPIENTS, JUNE 30, 1967

State	Estimated coverage	
	Number of enrollees	Percent of total enrollees in State
Total	1,154,000	[1] 11
Arizona	13,500	11
Arkansas	65,000	31
California	311,000	20
Colorado	42,000	25
Connecticut	8,000	3
Florida	79,000	11
Indiana	20,000	4
Iowa	24,000	7
Maine	11,500	10
Massachusetts [2]	16,400	3
Minnesota	27,500	7
Montana	4,300	7
Nebraska	13,000	8
New Hampshire	4,400	6
New Jersey	13,500	2
New York	68,000	4
Oklahoma	81,500	31
South Carolina	23,000	14
South Dakota	5,600	8
Tennessee	46,400	14
Texas	230,000	27
Vermont	4,300	9
Virginia	11,000	4
Wisconsin [2]	8,000	2
Wyoming	23,000	83

[1] Based on total number of medical insurance enrollees in the 25 "buy-in" States; 6 percent of all medical insurance enrollees were covered under buy-in agreements on July 1, 1967.

[2] Buy-in agreement limited to assistance recipients not entitled to social security or railroad retirement cash benefits.

Appendix C. Providers of Services

Exhibit:

1. Table 1: Number of participating hospitals and number of adult beds by type of hospital, geographic division, and State, July 1967 ..... Page 75
2. Table 2: Number of participating extended care facilities and home health agencies, by geographic division and State, July 1967 76
3. Table 3: Number of participating independent laboratories, by geographic division and State, July 1967 78

EXHIBIT 1

TABLE 1.—NUMBER OF PARTICIPATING HOSPITALS, ADULT BEDS, AND BEDS PER 1,000 HOSPITAL INSURANCE ENROLLEES, BY TYPE OF HOSPITAL, GEOGRAPHIC DIVISION, AND STATE, JULY 1967

Area	Total[1]		General[2]			Psychiatric.		Tuberculosis	
	Hospitals	Beds	Hospitals	Beds	Beds per 1,000 enrollees[3]	Hospitals	Beds[4]	Hospitals	Beds[4]
Total	6,857	1,157,603	6,406	811,243	42.4	331	322,886	120	23,474
New England	383	86,755	344	59,320	47.8	31	26,285	8	1,150
Maine	62	4,896	60	4,296	36.9	1	485	1	115
New Hampshire	35	3,140	33	2,658	34.3	1	400	1	82
Vermont	25	3,738	22	1,813	37.9	2	1,850	1	75
Massachusetts	189	47,941	169	35,477	57.0	16	11,886	4	578
Rhode Island	21	7,352	17	4,821	48.0	3	2,231	1	300
Connecticut	51	19,688	43	10,255	37.4	8	9,433	0	0
Middle Atlantic	818	279,317	741	158,442	41.6	69	119,403	8	1,472
New York	405	156,888	366	79,844	41.7	34	76,322	5	722
New Jersey	121	42,389	111	24,249	36.9	8	17,450	2	690
Pennsylvania	292	80,040	264	54,349	44.1	27	25,631	1	60
East North Central	1,169	221,075	1,047	163,385	44.1	74	50,272	48	7,418
Ohio	266	48,085	230	41,093	42.5	19	4,782	17	2,210
Indiana	138	24,401	124	17,840	37.2	9	5,969	5	592
Illinois	297	69,891	269	47,628	44.6	19	20,102	9	2,161
Michigan	282	54,636	257	37,484	51.2	16	15,258	9	1,894
Wisconsin	186	24,062	167	19,340	42.5	11	4,161	8	561
West North Central	919	101,206	879	80,205	42.9	32	20,033	8	968
Minnesota	197	25,348	186	18,590	46.7	7	6,414	4	344
Iowa	146	14,223	141	13,495	38.8	4	472	1	256
Missouri	171	28,623	161	22,345	41.3	10	6,278	0	0
North Dakota	63	5,327	61	3,552	54.7	2	1,775	0	0
South Dakota	63	4,804	62	3,204	40.8	1	1,600	0	0
Nebraska	109	7,598	105	6,887	38.6	3	581	1	130
Kansas	170	15,283	163	12,132	46.8	5	2,913	2	238
South Atlantic	811	136,664	763	101,204	40.0	35	30,410	13	5,050
Delaware	9	2,764	7	1,588	37.8	1	1,001	1	175
Maryland	61	23,553	50	11,960	45.2	10	11,193	1	400
District of Columbia	15	12,017	13	5,312	78.7	2	6,705	0	0
Virginia	106	14,530	102	13,895	41.6	2	181	2	454
West Virginia	86	9,668	80	8,377	43.8	5	901	1	390
North Carolina	150	21,388	144	17,641	46.7	2	2,253	4	1,494
South Carolina	71	12,440	68	7,000	39.7	3	5,440	0	0
Georgia	136	14,165	131	13,275	39.4	4	209	1	681
Florida	177	26,139	168	22,156	30.0	6	2,527	3	1,456
East South Central	481	47,367	459	42,766	35.8	9	2,468	13	2,133
Kentucky	132	13,791	120	10,956	33.7	5	1,894	7	941
Tennessee	156	17,644	148	16,090	44.9	3	515	5	1,039
Alabama	117	10,817	115	10,605	35.2	1	59	1	153
Mississippi	76	5,115	76	5,115	24.2	0	0	0	0

See footnotes at end of table.

EXHIBIT 1—Continued

TABLE 1.—NUMBER OF PARTICIPATING HOSPITALS, ADULT BEDS, AND BEDS PER 1,000 HOSPITAL INSURANCE ENROLLEES, BY TYPE OF HOSPITAL, GEOGRAPHIC DIVISION, AND STATE, JULY 1967—Continued

Area	Total[1]		General[2]			Psychiatric		Tuberculosis	
	Hospitals	Beds	Hospitals	Beds	Beds per 1,000 enrollees[3]	Hospitals	Beds[4]	Hospitals	Beds[4]
West South Central	919	88,394	899	71,317	42.5	15	14,659	5	2,418
Arkansas	106	9,670	103	7,670	34.7	2	1,428	1	572
Louisiana	109	13,818	106	12,409	44.0	3	1,409	0	0
Oklahoma	150	15,024	147	10,056	36.2	3	4,968	0	0
Texas	554	49,882	543	41,182	45.9	7	6,854	4	1,846
Mountain	404	35,643	387	29,799	47.8	13	5,358	4	486
Montana	67	3,917	64	3,482	51.4	1	140	2	295
Idaho	50	2,409	49	2,359	36.5	0	0	1	50
Wyoming	30	2,054	29	1,494	50.4	1	560	0	0
Colorado	91	13,145	86	9,259	52.1	5	3,886	0	0
New Mexico	47	3,338	45	3,071	48.3	2	267	0	0
Arizona	62	5,824	58	5,365	42.8	3	318	1	141
Utah	37	3,333	36	3,146	45.1	1	187	0	0
Nevada	20	1,623	20	1,623	64.7	0	0	0	0
Pacific	846	150,332	788	97,702	44.5	50	51,604	8	1,026
Washington	122	14,718	114	9,686	31.7	6	4,608	2	424
Oregon	89	13,651	84	10,173	48.6	4	3,299	1	179
California	590	117,581	548	74,405	45.4	38	42,785	4	391
Alaska	18	831	16	574	101.5	1	225	1	32
Hawaii	27	3,551	26	2,864	74.6	1	687	0	0
Other areas	107	10,850	99	7,103	48.6	3	2,394	5	1,353
American Samoa	1	145	1	145	728.6	0	0	0	0
Guam	1	199	1	199	172.3	0	0	0	0
Puerto Rico	100	10,300	92	6,553	46.1	3	2,394	5	1,353
Virgin Islands	5	206	5	206	86.0	0	0	0	0

[1] Includes 4 Federal hospitals; excludes 17 Christian Science sanatoriums.
[2] Short-stay and long-stay hospitals. Includes separately certified medical and surgical units and beds of psychiatric and tuberculosis hospitals not accredited by the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association.
[3] Based on number of persons enrolled in hospital insurance program as of Jan. 1, 1967.
[4] Includes only active-care beds for psychiatric and tuberculosis hospitals accredited by the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association.

EXHIBIT 2

TABLE 2.—NUMBER OF PARTICIPATING EXTENDED CARE FACILITIES, NURSING BEDS, BEDS PER 1,000 HOSPITAL INSURANCE ENROLLEES, AND PARTICIPATING HOME HEALTH AGENCIES, BY GEOGRAPHIC DIVISION AND STATE, JULY 1967

Area	Extended care facilities			Home health agencies
	Facilities	Beds[1]	Beds per 1,000 enrollees[2]	
Total	4,160	291,307	15.2	1,849
New England	366	23,172	18.7	358
Maine	21	814	7.0	21
New Hampshire	7	324	4.2	29
Vermont	9	336	7.0	9
Massachusetts	130	9,803	15.8	171
Rhode Island	14	740	7.4	25
Connecticut	185	11,155	40.7	103
Middle Atlantic	482	45,678	12.0	313
New York	220	24,638	12.9	138
New Jersey	66	6,561	10.0	55
Pennsylvania	196	14,479	11.7	[3] 120

See footnotes at end of table.

EXHIBIT 2—Continued

TABLE 2.—NUMBER OF PARTICIPATING EXTENDED-CARE FACILITIES, NURSING BEDS, BEDS PER 1,000 HOSPITAL INSURANCE ENROLLEES, AND PARTICIPATING HOME HEALTH AGENCIES, BY GEOGRAPHIC DIVISION AND STATE, JULY 1967—Continued

Area	Extended care facilities			Home health agencies
	Facilities	Beds [1]	Beds per 1,000 enrollees [2]	
East North Central	655	49,090	13.3	314
Ohio	159	10,907	11.3	102
Indiana	51	3,837	8.0	24
Illinois	148	11,152	10.4	83
Michigan	125	11,035	15.1	49
Wisconsin	172	12,159	26.7	56
West North Central	372	20,806	11.1	122
Minnesota	127	7,702	19.3	41
Iowa	58	3,216	9.2	17
Missouri	62	4,292	7.9	20
North Dakota	23	1,089	16.8	6
South Dakota	9	396	5.0	5
Nebraska	26	2,086	11.7	5
Kansas	67	2,025	7.8	28
South Atlantic	415	31,877	12.6	195
Delaware	8	488	11.6	5
Maryland	47	4,571	17.3	26
District of Columbia	6	1,537	22.8	2
Virginia	46	3,364	10.1	[3] 32
West Virginia	21	1,010	5.3	21
North Carolina	38	2,607	6.9	15
South Carolina	50	2,887	16.4	[3] 22
Georgia	56	4,172	12.4	11
Florida	143	11,241	15.2	61
East South Central	184	11,385	9.5	154
Kentucky	44	2,903	8.9	12
Tennessee	43	2,778	7.8	75
Alabama	80	4,922	16.3	[3] 36
Mississippi	17	782	3.7	31
West South Central	423	25,557	15.2	169
Arkansas	33	2,018	9.1	[3] 67
Louisiana	118	6,601	23.4	[3] 38
Oklahoma	28	1,274	4.6	[3] 40
Texas	244	15,664	17.5	24
Mountain	262	16,301	26.1	70
Montana	34	1,535	22.7	13
Idaho	36	2,212	34.2	10
Wyoming	7	342	11.5	8
Colorado	89	6,864	38.6	15
New Mexico	16	1,011	15.9	4
Arizona	40	2,339	18.7	9
Utah	27	1,459	20.9	8
Nevada	13	539	21.5	3
Pacific	995	67,027	30.5	151
Washington	162	9,893	32.4	27
Oregon	74	4,137	19.8	29
California	739	51,728	31.6	92
Alaska	6	153	27.1	1
Hawaii	14	1,116	29.1	2
Other areas	6	414	2.8	3
American Samoa	0	0	0	0
Guam	0	0	0	1
Puerto Rico	6	414	2.9	1
Virgin Islands	0	0	0	1

[1] Includes skilled nursing beds only.
[2] Based on number of persons enrolled in hospital insurance program as of Jan. 1, 1967.
[3] County and other local units of State health departments certified on a statewide basis counted separately.

EXHIBIT 3

TABLE 3.—*Number of participating independent laboratories, by geographic division and State, July 1967*

	Independent laboratories		Independent laboratories
Total, all areas	2,136	East South Central	51
New England	156	Kentucky	20
Maine	2	Tennessee	20
New Hampshire	1	Alabama	11
Vermont	2	Mississippi	0
Massachusetts	80	West South Central	134
Rhode Island	19	Arkansas	0
Connecticut	52	Louisiana	0
Middle Atlantic	473	Oklahoma	0
New York	228	Texas	134
New Jersey	124	Mountain	117
Pennsylvania	121	Montana	8
East North Central	293	Idaho	0
Ohio	83	Wyoming	3
Indiana	26	Colorado	29
Illinois	117	New Mexico	0
Michigan	57	Arizona	53
Wisconsin	10	Utah	12
West North Central	136	Nevada	12
Minnesota	9	Pacific	663
Iowa	16	Washington	62
Missouri	55	Oregon	29
North Dakota	8	California	554
South Dakota	4	Alaska	2
Nebraska	18	Hawaii	16
Kansas	26	Other areas	50
South Atlantic	63	Puerto Rico	49
Delaware	4	Virgin Islands	1
Maryland	30	American Samoa	0
District of Columbia	5	Guam	0
Virginia	17		
West Virginia	7		
North Carolina	0		
South Carolina	0		
Georgia	0		
Florida	0		

Appendix D. Experience Under the Hospital Insurance and Medical Insurance Programs

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EXHIBIT 1

HEALTH INSURANCE BENEFIT PAYMENTS, FISCAL YEAR ENDING JUNE 30, 1967

[in thousands]

	Hospital insurance	Medical insurance		Hospital insurance	Medical insurance
United States	[1] $2,525,818	[2] $669,832	Montana	9,745	2,208
			Nebraska	20,663	5,573
Alabama	26,868	6,490	Nevada	4,802	923
Alaska	483	105	New Hampshire	10,197	2,005
Arizona	21,552	6,858	New Jersey	78,317	28,135
Arkansas	21,071	5,138	New Mexico	7,460	2,332
California	286,290	111,857	New York	303,521	81,220
Colorado	30,555	9,146	North Carolina	34,565	10,342
Connecticut	48,900	10,961	North Dakota	10,182	2,169
Delaware	5,322	1,441	Ohio	124,220	23,451
District of Columbia	9,820	2,954	Oklahoma	33,351	10,543
Florida	103,558	36,220	Oregon	28,322	6,799
Georgia	29,339	8,036	Pennsylvania	149,467	36,270
Hawaii	5,196	1,746	Puerto Rico	4,468	1,803
Idaho	6,774	2,258	Rhode Island	14,457	3,639
Illinois	159,439	27,643	South Carolina	14,169	3,830
Indiana	53,850	11,146	South Dakota	10,583	2,223
Iowa	41,426	8,099	Tennessee	40,382	10,121
Kansas	31,381	6,782	Texas	103,762	33,233
Kentucky	32,615	7,187	Utah	7,719	2,120
Louisiana	23,544	6,627	Vermont	5,071	1,332
Maine	14,621	3,032	Virginia	32,107	11,152
Maryland	32,401	5,949	Virgin Islands	211	15
Massachusetts	105,916	22,842	Washington	44,836	12,198
Michigan	108,028	19,852	West Virginia	19,206	5,846
Minnesota	66,882	15,814	Wisconsin	63,995	11,974
Mississippi	13,904	4,217	Wyoming	3,191	982
Missouri	67,114	14,994			

[1] Includes $17,000,000 in benefits paid by intermediaries which did not clear through the Treasury before July 1967.
[2] Includes $5,000,000 in benefits paid by carriers which did not clear through the Treasury before July 1967.

EXHIBIT 2

HOSPITAL INSURANCE PROGRAM: NUMBER AND PERCENTAGE DISTRIBUTION OF CLAIMS APPROVED FOR PAYMENT AND AMOUNTS REIMBURSED, BY TYPE OF BENEFIT, JULY 1, 1966 TO JUNE 30, 1967 [1]

Type of benefit	Approved claims		Amount reimbursed [2]		
	Number	Percent distribution	Total (in thousands)	Percent distribution	Average per claim
Total	5,361,644	100.0	$2,313,868	100.0	
Inpatient hospital	4,546,051	84.8	2,205,028	95.3	$485
Outpatient diagnostic	325,469	6.1	3,894	.2	12
Extended care facility	317,718	5.9	94,113	4.0	296
Home health	172,406	3.2	10,833	.5	63

[1] Only claims approved and recorded in the Social Security Administration central records before Apr. 19, 1968.
[2] Amounts paid to providers for covered services during the year are based on interim rates to be adjusted after audit of provider costs and exclude deductibles, coinsurance amounts, and noncovered services as specified by law.

EXHIBIT 3

HOSPITAL INSURANCE PROGRAM: NUMBER AND PERCENTAGE DISTRIBUTION OF CLAIMS FOR INPATIENT HOSPITAL CARE APPROVED FOR PAYMENT, COVERED DAYS, TOTAL CHARGES AND AMOUNTS REIMBURSED, BY TYPE OF HOSPITAL, JULY 1, 1966 TO JUNE 30, 1967[1]

Item	All hospitals[2]	Short stay	Long stay[3]
Approved inpatient hospital claims:			
Number	4,546,051	4,451,434	77,650
Percent distribution	100.0	97.9	1.7
Covered days of care:[4]			
Total	60,812,051	57,820,169	2,799,093
Percent distribution	100.0	95.1	4.6
Average per claim	13.4	13.0	36.0
Charges:			
Total (in thousands)	$2,744,144	$2,682,802	$54,066
Percent distribution	100.0	97.8	2.0
Average per claim	$604	$603	$696
Average per day	$45	$46	$19
Amount reimbursed:[5]			
Total (in thousands)	$2,205,028	$2,153,285	$46,504
Percent distribution	100.0	97.7	2.1
Percent of total charges	80.4	80.3	86.0
Average per claim	$485	$484	$599

[1] Only claims approved and recorded in the Social Security Administration central records before Apr. 19, 1968.
[2] Includes 16,967 claims with type of hospital unknown.
[3] General and special hospitals reporting average stays of 30 days or more; tuberculosis, psychiatric, and chronic disease hospitals, and Christian Science sanatoriums.
[4] Covered days of care after June 30, 1966 (not including days in excess of 90 in a spell of illness).
[5] Amounts paid to providers for covered services during the year are based on interim rates subject to adjustment after audit of provider costs and exclude deductibles, coinsurance amounts, and noncovered services as specified by law.

EXHIBIT 4

HEALTH INSURANCE PROGRAM: NUMBER OF INPATIENT HOSPITAL ADMISSIONS, EXTENDED CARE FACILITY ADMISSIONS, AND HOME HEALTH START OF CARE NOTICES, AND RATES PER 1,000 ENROLLEES, BY REGION, CENSUS DIVISION, AND STATE, JULY 1, 1966 TO JUNE 30, 1967[1]

Region, census division, and State	Inpatient hospital admissions		Extended care facility admissions[3]		Home health start of care[4]	
	Number (in thousands)	Per 1,000 enrollees[2]	Number (in thousands)	Per 1,000 enrollees[2]	Number (in thousands)	Per 1,000 enrollees[2]
United States and territories	4,967.0	263	198.6	10.5	228.0	12.1
U.S. total[5]	4,952.6	264	198.6	10.6	228.0	12.2
Region:[6]						
Northeastern	1,154.8	226	47.7	9.3	92.4	18.1
North Central	1,568.2	283	45.7	8.2	57.2	10.3
South	1,463.0	271	44.3	8.2	34.9	6.5
West	760.2	271	60.9	21.7	43.3	15.4
New England	319.2	260	16.2	13.2	27.0	22.0
Maine	31.2	270	1.3	11.3	1.1	9.5
New Hampshire	21.3	278	.4	5.2	2.0	26.1
Vermont	14.7	309	.2	4.2	.7	14.7
Massachusetts	168.5	273	7.3	11.8	11.8	19.1
Rhode Island	22.1	222	.7	7.0	3.6	36.1
Connecticut	61.4	225	6.3	23.1	7.8	28.6
Middle Atlantic	835.6	221	31.5	8.3	65.4	17.3
New York	417.8	219	14.6	7.7	29.7	15.6
New Jersey	127.6	196	6.2	9.5	13.9	21.3
Pennsylvania	290.2	237	10.8	8.8	21.8	17.8
East North Central	967.0	263	31.2	8.5	42.5	11.5
Ohio	227.5	237	8.4	8.7	12.2	12.7
Indiana	110.1	231	2.8	5.9	2.3	4.8
Illinois	283.3	266	9.0	8.5	11.1	10.4
Michigan	193.2	266	5.8	8.0	9.1	12.5
Wisconsin	152.9	338	5.2	11.5	7.8	17.2
West North Central	601.2	323	14.5	7.8	14.7	7.9
Minnesota	156.1	394	4.4	11.1	4.3	10.9
Iowa	110.3	318	2.9	8.4	4.3	12.4
Missouri	151.9	283	3.5	6.5	3.4	6.3
North Dakota	25.7	398	.6	9.3	.2	3.1

See footnotes at end of table.

EXHIBIT 4—Continued

HEALTH INSURANCE PROGRAM: NUMBER OF INPATIENT HOSPITAL ADMISSIONS, EXTENDED CARE FACILITY ADMISSIONS, AND HOME HEALTH START OF CARE NOTICES, AND RATES PER 1,000 ENROLLEES, BY REGION CENSUS DIVISION, AND STATE, JULY 1, 1966 TO JUNE 30, 1967 [1]—Continued

Region, census division, and State	Inpatient hospital admissions		Extended care facility admissions [3]		Home health start of care [4]	
	Number (in thousands)	Per 1,000 enrollees [2]	Number (in thousands)	Per 1,000 enrollees [2]	Number (in thousands)	Per 1,000 enrollees [2]
West North Central—Con.						
South Dakota	28.0	358	0.3	3.8	0.9	11.5
Nebraska	51.1	288	1.1	6.2	.7	3.9
Kansas	78.1	303	1.7	6.6	.9	3.5
South Atlantic	636.4	252	23.7	9.4	20.8	8.2
Delaware	8.2	196	.5	12.0	1.1	26.3
Maryland	51.4	196	2.8	10.7	1.7	6.5
District of Columbia	19.1	285	.3	4.5	1.9	28.4
Virginia	78.6	237	2.5	7.5	2.3	6.9
West Virginia	56.2	295	.9	4.7	.9	4.7
North Carolina	105.1	280	1.8	4.8	1.2	3.2
South Carolina	38.7	221	1.5	8.6	.6	3.4
Georgia	84.4	252	2.1	6.3	2.1	6.3
Florida	194.7	260	11.3	15.1	9.0	12.0
East South Central	312.3	262	7.4	6.2	6.5	5.5
Kentucky	90.0	279	2.6	8.0	1.1	3.4
Tennessee	104.2	291	2.2	6.2	2.8	7.8
Alabama	72.4	241	1.8	6.0	2.2	7.3
Mississippi	45.7	218	.8	3.8	.4	1.9
West South Central	514.3	307	13.2	7.9	7.6	4.5
Arkansas	66.6	301	1.0	4.5	1.0	4.5
Louisiana	65.5	234	2.0	7.1	1.0	3.6
Oklahoma	87.2	314	1.3	4.7	2.0	7.2
Texas	295.0	329	8.9	9.9	3.6	4.0
Mountain	193.5	311	10.3	16.6	8.7	14.0
Montana	25.2	374	1.2	17.8	.4	5.9
Idaho	17.9	278	1.1	17.1	1.1	17.1
Wyoming	7.5	255	.1	3.4	.2	6.8
Colorado	62.4	353	3.4	19.2	3.3	18.7
New Mexico	17.4	275	.5	7.9	.6	9.5
Arizona	38.3	303	2.4	19.0	2.1	16.6
Utah	18.0	260	1.1	15.9	.6	8.7
Nevada	6.8	272	.5	20.0	.4	16.0
Pacific	566.7	259	50.6	23.1	34.6	15.8
Washington	85.6	282	8.1	26.7	4.1	13.5
Oregon	55.3	266	4.0	19.2	2.3	11.0
California	413.6	253	37.7	23.1	28.0	17.2
Alaska	1.5	268	(7)	(7)	(7)	(7)
Hawaii	10.7	280	.9	23.6	.2	5.2
Outlying areas	14.4	100	(7)	(7)	(7)	(7)
Unknown	6.4		.1		.2	

[1] Data based on notices received by June 30, 1967.
[2] Based on enrollment data for the hospital insurance program, as of Jan. 1, 1967.
[3] Extended care facility admissions from Jan. 1, 1967, to June 30, 1967; rates are for the 6-month period.
[4] Includes home health start of care notices under both hospital insurance and medical insurance.
[5] Includes unknown.
[6] Northeastern includes New England and Middle Atlantic States; North Central includes East North Central and West North Central States; South includes South Atlantic, East South Central and West South Central States; and West includes Mountain and Pacific States.
[7] Less than 50.

EXHIBIT 5

INPATIENT EMERGENCY HOSPITAL SERVICES IN NONPARTICIPATING HOSPITALS, BY SOCIAL SECURITY ADMINISTRATION REGION AND STATE, FISCAL YEAR 1967

Social Security Administration, region and State	Total claims received	Total processed	Allowed	Denied in part	Denied
United States	20,610	19,229	18,008	400	821
Region I:					
Connecticut					
Maine	130	127	85	22	20
Massachusetts					
New Hampshire					
Rhode Island	5	4	2	1	1
Vermont	38	24	13	5	6
Total	173	155	100	28	27

EXHIBIT 5—Continued

IMPATIENT EMERGENCY HOSPITAL SERVICES IN NONPARTICIPATING HOSPITALS, BY SOCIAL SECURITY ADMINISTRATION REGION AND STATE, FISCAL YEAR 1967—Continuep

Social Security Administration, region and State	Total claims received	Total processed	Allowed	Denied in part	Denied
Region II:					
Delaware					
New Jersey	118	118	61	6	51
New York	1,104	1,007	676	59	272
Total	1,222	1,125	737	65	323
Region III:					
District of Columbia					
Kentucky	238	192	178	1	13
Maryland	8	8	8		
Pennsylvania	45	42	42		
Puerto Rico	4	3	2		1
Virginia	217	212	186	9	17
Virgin Islands					
West Virginia	50	45	43		2
Total	562	502	459	10	33
Region IV:					
Alabama	2,689	2,577	2,538	12	27
Florida	486	465	464		1
Georgia	1,980	1,863	1,841	3	19
Mississippi	6,756	6,136	5,968	34	134
North Carolina	209	189	187	1	1
South Carolina	1,525	1,365	1,327	4	34
Tennessee	304	274	268		6
Total	13,949	12,869	12,593	54	222
Region V:					
Illinois	11	11	1	2	8
Indiana					
Michigan					
Ohio	4	4	1		3
Wisconsin	46	44	26	8	10
Total	61	59	28	10	21
Region VI:					
Iowa	46	42	12	17	13
Kansas	1	1		1	
Minnesota	29	26	12	10	4
Missouri	90	89	1	51	37
Nebraska	106	103	25	43	35
North Dakota	32	32	6	18	8
South Dakota					
Total	304	293	56	140	97
Region VII:					
Arkanass	167	166	157	7	2
Louisiana	2,130	2,081	2,044	19	18
New Mexico	99	95	90	1	4
Oklahoma	156	154	150	3	1
Texas	1,195	1,154	1,095	34	25
Total	3,747	3,650	3,536	64	50
Region VIII:					
Colorado	29	27	25		2
Idaho	79	79	47	17	15
Montana	28	27	16	10	1
Utah	4	3	3		
Wyoming	16	15	15		
Total	156	151	106	27	18
Region IX:					
Alaska					
American Samoa					
Arizona	19	18	18		
California	171	163	154		9
Guam					
Hawaii					
Nevada					
Oregon	113	112	102	1	9
Washington	133	132	119	1	12
Total	436	425	393	2	30

EXHIBIT 6

MEDICAL INSURANCE PROGRAM: NUMBER OF REIMBURSED BILLS FOR PHYSICIANS' AND RELATED MEDICAL SERVICES, TOTAL REASONABLE CHARGES, AND AVERAGE AMOUNT PER BILL, BY TYPE OF SERVICE, JULY 1, 1966 TO JUNE 30, 1967 [1]

Type of service	Bills		Charges [2]		
	Number	Percent distribution	Total (in thousands)	Percent distribution	Average amount per bill
All services [3]	10,189,810	100.0	$739,994	100.0	$73
Physicians	8,784,283	86.2	695,485	94.0	79
Home health	153,131	1.5	9,136	1.2	60
Outpatient hospital	788,467	7.7	12,507	1.7	16
Independent laboratory	143,657	1.4	3,995	.5	28
All other	234,363	2.3	12,420	1.7	53

[1] Only bills for which reimbursements were made by the carriers and which were recorded in the Social Security Administration central records before Mar. 8, 1968.

[2] Reasonable charges as determined by the carriers on the basis of customary charges for similar service generally made by the physician or supplier of covered services and on prevailing charges in the locality for similar services. A charge cannot be higher than that applicable for the carrier's own policyholder for comparable services under comparable circumstances.

[3] Includes 85,909 bills and $6,451,000 total reasonable charges for which type of service is unclassified in the data.

EXHIBIT 7

MEDICAL INSURANCE PROGRAM: NUMBER OF REIMBURSED BILLS FOR PHYSICIANS' AND RELATED MEDICAL SERVICES, TOTAL REASONABLE CHARGES, AND REIMBURSED AMOUNT, BY TYPE OF BILLS, JULY 1, 1966 TO JUNE 30, 1967 [1]

Item	All bills [2]	Physicians' services	
		Surgical	Medical
Bills:			
Total number	10,189,810	1,538,761	7,245,522
Percent distribution	100.0	15.1	71.1
Charges: [3]			
Total (in thousands)	$739,994	$280,253	$415,232
Percent distribution	100.0	37.9	56.1
Average bill	$73	$182	$57
Amount reimbursed: [4]			
Total (in thousands)	$513,272	$205,436	$278,631
Percent distribution	100.0	40.0	54.3
Percent of total charges	69.4	73.3	67.1
Average per bill	$50	$134	$38

[1] Only bills for which reimbursements were made by the carriers and which were recorded in the Social Security Administration central records before Mar. 8, 1968.

[2] Includes 1,319,618 bills for home health, outpatient hospital, independent laboratory, and other services covered under the medical insurance program not shown separately. Also includes 85,909 bills for which type of service is unclassified in the data.

[3] Reasonable charges as determined by the carriers on the basis of customary charges for similar services generally made by the physician or supplier of covered services and on prevailing charges in the locality for similar services. A charge cannot be higher than that applicable for the carrier's own policyholder for comparable services under comparable circumstances.

[4] Represents 80 percent of reasonable charges for covered services each year after the beneficiary has paid the first $50 of such charges during the year.

EXHIBIT 8

CURRENT MEDICARE SURVEY: CUMULATIVE NUMBER AND PERCENTAGE DISTRIBUTION OF MEDICAL INSURANCE ENROLLEES AND CHARGES FOR COVERED MEDICAL SERVICES, BY USE OF COVERED SERVICE AND DEDUCTIBLE STATUS, 6 MONTHS ENDING DECEMBER 1966 AND JUNE 1967

Item	July–December 1966		January–June 1967	
	Number	Percent distribution	Number	Percent distribution
NUMBER OF ENROLLEES (IN THOUSANDS)				
Total [1]	17,938	100.0	17,949	100.0
Using no services	6,085	33.9	5,900	32.9
Using covered services, total [2]	11,854	66.1	12,049	67.1
Deductible not met	7,439	41.5	6,289	35.0
Deductible met	4,058	22.6	5,297	29.5
CHARGES (IN THOUSANDS)				
Total	$963,542	100.0	$1,005,916	100.0
Deductible not met	145,030	15.1	109,652	10.9
Deductible met, total	818,512	84.9	896,264	89.1
Potentially reimbursable	494,197	51.3	578,612	57.5
AVERAGE CHARGES				
Total [3]	$84		$87	
Deductible not met	19		17	
Deductible met, total	202		169	
Potentially reimbursable	122		109	
Percent reimbursable of total [4]	60		64	

[1] Represents all people enrolled in the supplementary medical insurance program and exposed to risk at any time during the 6-month period. Included are all people aging into the program, and all deaths and terminations during this period, regardless of the month of occurrence.

[2] Includes people using services for which a bill is not expected.

[3] Based on number of enrollees using covered services, excluding those for whom a bill is not expected.

[4] Represents amount reimbursable as a percent of total charges for people who have met the deductible by the end of the period.

EXHIBIT 9

CURRENT MEDICARE SURVEY: ESTIMATED 6-MONTH CUMULATIVE NUMBER AND PERCENTAGE DISTRIBUTION OF MEDICAL INSURANCE ENROLLEES, BY SELECTED CHARACTERISTICS AND USE OF COVERED MEDICAL SERVICES, JANUARY–JUNE 1967 [1]

	Total	Enrollees not using services	Enrollees using covered services		
			Total [2]	$50 deductible not met	$50 deductible met
Total number (in thousands) [3]	17,949	5,900	12,049	6,289	5,297
PERCENTAGE DISTRIBUTION					
All persons	100.0	32.9	67.1	35.0	29.5
65 to 74	100.0	34.2	65.7	34.4	28.6
75 to 84	100.0	31.1	68.8	36.5	29.9
85 and over	100.0	26.6	73.5	33.8	37.6
Men	100.0	37.8	62.2	30.0	28.9
65 to 74	100.0	40.0	60.0	28.8	27.8
75 to 84	100.0	35.1	64.9	32.5	29.0
85 and over	100.0	25.8	74.2	29.2	42.7
Women	100.0	29.1	70.9	38.9	30.0
65 to 74	100.0	29.7	70.3	38.8	29.3
75 to 84	100.0	28.1	71.9	39.6	30.6
85 and over	100.0	27.0	73.0	36.5	34.5
Census region:					
Northeast	100.0	30.9	69.1	35.5	30.8
North Central	100.0	36.7	63.2	34.1	27.5
South	100.0	33.0	67.0	37.5	26.6
West	100.0	28.2	71.8	31.4	36.8

[1] Represents the status of medical insurance enrollees by the end of the 6-month period January–June 1967, with respect to their use of covered medical services and meeting the $50 deductible.

[2] Includes people using services for which a bill is not expected.

[3] Represents all people enrolled in the supplementary medical insurance program and exposed to risk at any time during the 6-month period. Included are all people aging into the program, and all deaths and terminations during this period, regardless of the month of occurrence.

EXHIBIT 10

CURRENT MEDICARE SURVEY: ESTIMATED 6-MONTH TOTAL AND AVERAGE CHARGES PER MEDICAL INSURANCE ENROLLEE USING COVERED MEDICAL SERVICES,[1] BY SELECTED CHARACTERISTICS AND DEDUCTIBLE STATUS, JANUARY TO JUNE 1967[2]

Characteristic	Total	$50 deductible not met	$50 deductible met	
			Total	Potentially reimbursable
Total charges (in thousands)[3]	$1,005,916	$109,652	$896,264	$578,612
All persons	87	17	169	109
65 to 74	83	17	162	103
75 to 84	90	17	178	117
85 and over	109	18	190	127
Men	94	18	172	112
65 to 74	91	18	167	107
75 to 84	93	17	177	117
85 and over	126	16	201	135
Women	82	17	167	107
65 to 74	78	17	159	101
75 to 84	88	17	179	117
85 and over	98	20	182	121
Census region:				
Northeast	89	17	171	110
North Central	80	17	158	101
South	80	16	171	111
West	109	21	184	120

[1] Based on number of enrollees using covered services, excluding those for whom a bill is not expected.
[2] Charges reflect the experience of medical insurance enrollees by the end of the 6-month period, Jan. 1 to June 30, 1967, with respect to their use of covered medical services and meeting the $50 deductible.
[3] Represents charges for all people enrolled in the medical insurance program and exposed to risk at any time during the 6-month period. Included are charges for all people aging into the program, and all deaths and terminations during this period, regardless of month of occurrence.

EXHIBIT 11

CURRENT MEDICARE SURVEY: ESTIMATED NUMBER AND PERCENTAGE DISTRIBUTION OF MEDICAL INSURANCE ENROLLEES, BY USE OF COVERED MEDICAL SERVICES, JULY 1966 TO JUNE 1967

Month	Estimated monthly enrollment [1]	Enrollees using no services	Enrollees using covered services		
			Total [2]	Deductible not met	Deductible met
	Numbers (in thousands)				
1966:					
July	17,507	11,872	5,635	4,697	607
August	17,533	11,958	5,575	4,248	1,079
September	17,561	11,964	5,597	3,761	1,538
October	17,497	11,648	5,849	3,451	1,935
November	17,510	12,052	5,458	2,720	2,278
December	17,523	12,197	5,326	2,446	2,423
1967:					
January	17,504	11,596	5,908	4,204	1,312
February	17,501	11,835	5,666	3,530	1,767
March	17,513	11,495	6,018	3,299	2,422
April	17,555	11,458	6,097	2,871	2,879
May	17,611	11,418	6,193	2,506	3,296
June	17,678	11,689	5,989	2,138	3,454
	Percentage distribution				
1966:					
July	100.	67.8	32.2	26.8	3.5
August	100	68.1	31.8	24.3	6.1
September	100	68.1	31.9	21.4	8.8
October	100	66.6	33.4	19.7	11.1
November	100	68.8	31.1	15.5	13.0
December	100	69.6	30.4	14.0	13.8
1967:					
January	100	66.2	33.8	24.0	7.5
February	100	67.6	32.4	20.2	10.1
March	100	65.6	34.3	18.8	13.8
April	100	65.3	34.8	16.4	16.4
May	100	64.8	35.1	14.2	18.7
June	100	66.1	33.8	12.1	19.5

[1] Represents number of enrollees at the beginning of each month and estimated by adjusting the July 1, 1966, and the Jan. 1, 1967, tabulated enrollment for increments of people reaching age 65 and for decrements of people who died or terminated enrollment.
[2] Includes people using services for which a bill is not expected.

EXHIBIT 12

CURRENT MEDICARE SURVEY: ESTIMATED NUMBER AND PERCENTAGE DISTRIBUTION OF MEDICAL INSURANCE ENROLLEES USING COVERED MEDICAL SERVICES, BY MONTH AND AMOUNT OF DEDUCTIBLE USED BY THE END OF EACH MONTH, JANUARY-JUNE 1967

Amount	January	February	March	April	May	June
	Number (in thousands)					
Total enrollees [1]	5,908	5,666	6,018	6,097	6,193	5,989
Under $10	1,311	805	697	467	452	331
$10 to $19	1,299	1,054	946	746	576	575
$20 to $29	914	842	778	831	625	591
$30 to $39	592	547	591	545	626	496
$40 to $49	416	556	518	508	511	376
$50 and over [2]	1,375	1,862	2,487	3,002	3,403	3,619
	Percentage distribution					
Total enrollees [1]	100.0	100.0	100.0	100.0	100.0	100.0
Under $10	22.2	14.2	11.6	7.7	7.3	5.5
$10 to $19	22.0	18.6	15.7	12.2	9.3	9.6
$20 to $29	15.5	14.9	12.9	13.6	10.1	9.9
$30 to $39	10.0	9.7	9.8	8.9	10.1	8.3
$40 to $49	7.0	9.8	8.6	8.3	8.3	6.3
$50 and over [2]	23.3	32.9	41.3	49.2	54.9	60.4

[1] Represents estimated number of enrollees using covered medical services, including people for whom a bill is not expected.

[2] The number of people shown here, who used services and met the deductible each month, is greater than the number shown in exhibit 11 because the number in this table includes those with free services during the month but with incurred charges in previous months.

Appendix E. Principal Changes in Medicare Made by the 1967 Amendments

PAYMENT FOR PHYSICIANS' AND OTHER SERVICES MAY BE MADE ON UNPAID BILLS

If no assignment is taken, medical insurance payments may now be made directly to the patient on the basis of an itemized bill—even though it has not been paid. There is no change in the assignment method under which physicians and suppliers may have payment made directly to them. This new provision applies to all bills received or processed by carriers on or after January 2, 1968 (the date of enactment) even though the services were rendered before that date.

TIME LIMIT FOR FILING MEDICAL INSURANCE BILLS (PAID OR UNPAID)

In order for payment to be made on a bill it must be submitted before December 31 of the year following the year in which services are received. For purposes of this rule, services received in the last 3 months of a calendar year are counted as received in the following year; thus, bills for such services may be submitted until December 31 of the second year after the year in which services were actually received.

A special extension permits bills for covered services received in July, August, or September 1966, to be submitted until March 31, 1968.

ELIMINATION OF CERTAIN PHYSICIAN CERTIFICATIONS

Physician certification of medical necessity for virtually all outpatient hospital services and admissions to general hospitals has been eliminated. The provision applies to admissions and to outpatient services furnished on and after January 2, 1968. The first certification for inpatient services in a general hospital will now be required as of the 14th day of services. Certification on admission is still required for admissions to psychiatric and tuberculosis hospitals and to extended care facilities.

ADDITIONAL INPATIENT HOSPITAL BENEFIT DAYS (EFFECTIVE JANUARY 1, 1968)

Each hospital insurance beneficiary will have a "lifetime reserve" of 60 additional days of inpatient hospital coverage. These additional days can be used at the patient's option whenever the 90 days covered in a "spell of illness" have been exhausted, and are subject to $20 a day coinsurance. This benefit is not renewable; the number of days in a beneficiary's "lifetime reserve" is permanently reduced by the number of days used.

NOTE: If the beneficiary is an inpatient of a participating hospital on January 1, 1968, and has previously exhausted his inpatient hospital benefits, the lifetime reserve days can be drawn on immediately.

FULL REIMBURSEMENT OF RADIOLOGY AND PATHOLOGY SERVICES TO HOSPITAL INPATIENTS (EFFECTIVE APRIL 1, 1968)

Payment of the full reasonable charges may be made under medical insurance for radiology and pathology services furnished by physicians to inpatients of participating hospitals. The $50 annual deductible does not have to be met. Thus, because there will rarely be any patient liability for these services, medicare reimbursement procedures can be greatly facilitated and the patient can frequently be left out of the process completely.

Under this provision, it will also be possible to pay for radiology and pathology services to hospital inpatients in a manner that is more consistent with the usual billing procedures of many hospitals and the manner in which these services are reimbursed by most other health insurance programs. Where the hospital customarily bills for both the hospital's services and the services of the pathologists and radiologists, the absence of the medical insurance deductible and coinsurance will now make it unnecessary to break down the bill on a patient-by-patient basis into the parts covered under the hospital insurance and medical insurance programs, since this can be done on an aggregate basis. Thus, where the total services are billed through the hospital, the provision would provide opportunities for the development of hospital billing procedures that will greatly reduce paperwork and facilitate administration.

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INCLUSION OF ALL OUTPATIENT HOSPITAL BENEFITS UNDER MEDICAL INSURANCE (EFFECTIVE APRIL 1, 1968)

This provision consolidates all covered outpatient hospital services under the medical insurance program. Thus, there will be only a single deductible and coinsurance applied to *all* covered outpatient hospital services (the $50 annual medical insurance deductible and 20 percent coinsurance), and no need to separate diagnostic from therapeutic services as in the past, for allocation of costs and charges to different parts of the medicare program.

Also, effective April 1, 1968, hospitals may, in situations to be described in forthcoming regulations, collect an outpatient charge of $50 or less from the beneficiary. This provision will simplify hospital collection processes in situations where the hospital cannot readily determine whether the patient has met the deductible, and he is able to pay the bill at the time services are rendered. Where such collections are made, the beneficiary would ordinarily receive the medical insurance reimbursement on the basis of a claim prepared on his behalf by the hospital. Payments to the hospital will be periodically adjusted to assure that total hospital reimbursement for outpatient services does not exceed what the hospital would have received if it had submitted all bills on a cost reimbursement basis.

PAYMENT FOR ADDITIONAL OUTPATIENT PHYSICAL THERAPY SERVICES (EFFECTIVE JULY 1, 1968)

At present, physical therapy services are covered when furnished under the direct supervision of a physician or to homebound patients under a home health plan. Effective July 1, 1968, physical therapy services will also be covered under the medical insurance program when furnished by qualified providers of services or others under arrangements with, and under the supervision of, such providers. For purposes of this additional coverage, the term "providers of services" includes approved clinics, rehabilitation agencies and public health agencies. In order for payment to be made for such services, a physician must certify that the patient requires physical therapy services on an outpatient basis, and is under a plan of treatment established and periodically reviewed by a physician which prescribes the type, amount, and duration of the services. The patient does not need to be confined to his home.

PAYMENT UNDER MEDICAL INSURANCE FOR CERTAIN ANCILLARY SERVICES NOT PAYABLE UNDER HOSPITAL INSURANCE (EFFECTIVE APRIL 1, 1968)

Under this provision, payment can be made under medical insurance for certain ancillary services furnished by a hospital or extended care facility for which no payment can be made under hospital insurance. This provision would apply, for example, where a patient has exhausted his hospital insurance eligibility or where an extended care facility patient has not met the prior hospitalization requirement. These benefits are subject to the $50 deductible and 20 percent coinsurance.

INCLUSION OF CERTAIN PODIATRISTS' SERVICES AND GENERAL EXCLUSION OF SPECIFIED FOOT CARE SERVICES (EFFECTIVE JANUARY 1, 1968)

Services of doctors of podiatry or surgical chiropody are covered under the medical insurance program as physicians' services, but only with respect to functions which they are authorized to perform by the State where they practice. However, certain specified foot care services will now be excluded whether performed by a podiatrist or medical doctor. These exclusions include treatment of flat foot conditions, the prescription of supportive devices for such conditions, treatment of subluxations of the foot, and routine foot care (including cutting or removal of corns, warts or callouses, trimming of nails and other routine hygienic care).

SPECIFIC EXCLUSION OF EYE REFRACTIONS

All procedures performed during any eye examination on and after January 2, 1968, to determine the refractive state of the eyes (even in connection with furnishing prosthetic lenses) are now excluded from coverage. The exclusion applies whether the refractions are performed by ophthalmologists, other physicians, or optometrists, and even though the total examination is for the treatment or diagnosis of eye disease or injury.

PAYMENT FOR PURCHASE OF DURABLE MEDICAL EQUIPMENT (EFFECTIVE JANUARY 1, 1968)

In addition to payment for rental, payment can also be made for purchase of durable medical equipment by or for an individual. Except for inexpensive items, payment will be made periodically in the same amount as if the equipment were rented, but only for the period of time that the equipment is medically necessary or until the purchase price has been met, whichever occurs first.

PAYMENT FOR PORTABLE X-RAY SERVICES (EFFECTIVE JANUARY 1, 1968)

Payment will be made for diagnostic X-ray services furnished in the patient's home or other place of residence. These services will be covered under medical insurance if they are provided under the general supervision of a physician and if they meet health and safety regulations.

BLOOD DEDUCTIBLES (EFFECTIVE JANUARY 1, 1968)

Under this provision, the definition of "blood" is broadened to include packed red blood cells as well as whole blood. A 3-pint blood deductible will now also apply to the medical insurance program for blood furnished during a calendar year in connection with services covered by that program. This deductible is separate from the 3-pint blood deductible for each "spell of illness" in the hospital insurance program, and neither can be used to meet the other.

PAYMENT FOR SERVICES FURNISHED TO INPATIENTS OF NONPARTICIPATING HOSPITALS

Under this provision, partial payment may be made for inpatient emergency or nonemergency services furnished by certain nonparticipating hospitals between July 1, 1966, and January 1, 1968, and for emergency inpatient services furnished by certain nonparticipating hospitals in respect to admissions on or after January 1, 1968. A facility is considered a hospital under this provision if it is licensed as a hospital, has a full-time nursing service, and is primarily engaged in furnishing medical care under the supervision of a doctor of medicine or osteopathy. Hospital insurance will pay 60 percent of the room and board charges and 80 percent of other charges for covered services after the usual deductibles are met. These benefits are limited to 20 days if the hospital does not qualify to take part in medicare, but if the hospital begins to participate in medicare before January 1, 1969, and applies its utilization review plan to the services rendered, the full duration of hospital insurance benefits can apply.

INCENTIVE REIMBURSEMENT EXPERIMENTATION

The Secretary of Health, Education, and Welfare is authorized to experiment with alternative methods of reimbursement to organizations and physicians under the medicare, medicaid, and child health programs. The experiments would test various incentives for increasing the efficiency and economy of health services without adversely affecting the quality of care. Experiments may involve only those physicians, institutions, and organizations that agree to participate and may not be initiated until the Secretary obtains the advice and recommendations of specialists competent to evaluate the possibility of securing productive results.

ADVISORY COUNCIL STUDY OF HEALTH INSURANCE FOR THE DISABLED

An advisory council, to be appointed in 1968, will study the question of providing health insurance protection for the disabled under title XVIII. The council will make its recommendations to the Secretary not later than January 1, 1969.

CHANGES IN REDUCTION OF BENEFIT DAYS FOR PSYCHIATRIC AND TUBERCULOSIS TREATMENT (EFFECTIVE JANUARY 1, 1968)

Any inpatient days in a psychiatric or tuberculosis hospital in the 90-day period before his hospital insurance coverage began have previously counted against a beneficiary's days of coverage during his first "spell of illness." This provision has been modified as follows:

1. The reduction will not apply to tuberculosis hospitals.

2. The provision no longer prevents payment for inpatient services in a general hospital unless the services are primarily for the diagnosis or treatment of mental illness and the spell of illness began in a psychiatric hospital.

3. The applicable period prior to hospital insurance eligibility has been extended from 90 to 150 days to reflect the new lifetime reserve of 60 additional inpatient hospital days.

HEALTH INSURANCE BENEFITS ADVISORY COUNCIL

The 1967 admendments expand the responsibilities of the Health Insurance Benefits Advisory Council to include reviewing the utilization of services under medicare and making recommendations for program changes.

STUDY OF DRUG PROPOSALS

The Secretary will study a proposal to establish quality and cost standards for drugs for which payment is made under the Social Security Act, and a proposal to cover drugs under the medical insurance program. He is required to report his findings and recommendations to the President and the Congress by January 1, 1969.

COVERAGE OF SERVICES OF ADDITIONAL HEALTH PRACTITIONERS

The Secretary will study the need for extension of coverage under the medical insurance program to the services of additional types of licensed practitioners performing health services in independent practice. He will make recommendations to the Congress prior to January 1, 1969.

HOSPITAL INSURANCE ELIGIBILITY

Individuals reaching age 65 prior to 1968 were eligible for hospital insurance benefits, under a "transitional insured status" provision, even though they did not have any social security work credits. Under the new law, people who reach 65 in 1968 and are not entitled to monthly social security or railroad retirement benefits will need three calendar quarters—about three-fourths of a year—of social security work credits, in order to be eligible for hospital insurance.

For people who reach 65 after 1968, the amount of work credits needed increases by three quarters each year—six quarters will be needed by those who reach 65 in 1969, nine by those who reach 65 in 1970, and so on. Eventually, the amount of work required for hospital insurance protection will be the same as that required for monthly cash benefits.

However, a person who qualifies for monthly benefits as the dependent or survivor of an insured worker will not need any work credits.

MEDICAL INSURANCE ENROLLMENT

Changes were also made in the provisions for medical insurance enrollment. A person who is not enrolled for medical insurance may enroll during the first 3 months of any year, provided this period begins within 3 years after he had his first opportunity to enroll. People already 65 or older who do not have medical insurance may enroll through April 1, 1968; if they do not enroll by that date, they will have to wait until 1969 for another opportunity to do so.

A person who is enrolled for medical insurance may give notice of his intention to drop the insurance at any time. The notice is effective at the end of the next calendar quarter (except for notices received on or before April 1, 1968, which are effective on that date). He may re-enroll during the first 3 months of any year, but only if he does so within 3 years after his coverage is terminated.

FINANCING HOSPITAL INSURANCE

The favorable actuarial balance of 0.74 percent of payroll that the social security program has is sufficient to finance a substantial part of the cost of the cash benefit provisions in the new law. The remaining cost of the cash benefit increases and the income required to assure an adequate financing base for the hospital insurance program will be secured through: (1) an increase in the contribution and benefit base from $6,600 to $7,800 (effective January 1, 1968), and (2) revised contribution rate schedules for the cash benefits and hospital insurance parts of the program. There will be no increase in the total contribution rate for 1968. The ultimate contribution rate for cash benefits will be in-

creased from 4.85 percent to 5 percent beginning in 1973 and the ultimate rate for hospital insurance will be increased from 0.80 percent to 0.90 percent beginning in 1987.

The tables below compare the contribution rates under the old and the new law. For each they show the percentage for retirement, survivors, and disability insurance and the percentage for hospital insurance:

EMPLOYER-EMPLOYEE (EACH)

Period	Old law			New law		
	RSDI	HI	Total	RSDI	HI	Total
1968	3.9	0.5	4.4	3.8	0.6	4.4
1969–70	4.4	.5	4.9	4.2	.6	4.8
1971–72	4.4	.5	4.9	4.6	.6	5.2
1973–75	4.85	.55	5.4	5.0	.65	5.65
1976–79	4.85	.6	5.45	5.0	.7	5.7
1980–86	4.85	.7	5.55	5.0	.8	5.8
1987 and after	4.85	.8	5.65	5.0	.9	5.9

SELF-EMPLOYED PEOPLE

Period	Old law			New law		
	RSDI	HI	Total	RSDI	HI	Total
1968	5.9	0.5	6.4	5.8	0.6	6.4
1969–70	6.6	.5	7.1	6.3	.6	6.9
1971–72	6.6	.5	7.1	6.9	.6	7.5
1973–75	7.0	.55	7.55	7.0	.65	7.65
1976–79	7.0	.6	7.6	7.0	.7	7.7
1980–86	7.0	.7	7.7	7.0	.8	7.8
1987 and after	7.0	.8	7.8	7.0	.9	7.9

Appendix F. Statement of Actuarial Assumptions and Bases Employed in Arriving at the Amount of the Standard Premium Rate for the Supplementary Medical Insurance Program Beginning April 1968

There follows a statement of actuarial assumptions and bases employed in arriving at the amount of the standard premium rate for the supplementary medical insurance program beginning April 1968. The standard premium rate is that rate which is payable by those who enroll in their initial enrollment period and by those who enroll in a general enrollment period that terminates less than 12 months after the close of their initial enrollment period.

The actuarial determination has been made on the basis of both the actual operating experience under the program and the results of a current continuing sample survey of beneficiaries (which gives certain information more promptly than do the aggregate operations of the program). Because of the time lag in the submission of bills in this program, complete figures for the 6 months of 1966 are not yet available, and the processed data for the first 10 months of 1967 are rather incomplete.

There are current figures for cash expenditures under the program, but these figures taken alone are misleading because they do not take into account the liabilities arising from the natural delay in benefit payments until well after the date that services were received. Such delay is due to the tendency of enrollees to accumulate a number of bills before submitting a claim, the inherent delays by physicians and enrollees in making requests for payment, and the time required by the carriers to adjudicate and pay claims. There was a balance of $394 million in the supplementary medical insurance trust fund at the end of October 1967 (a decline from a peak of $570 million at the end of March 1967), but there were at that time substantial outstanding liabilities incurred for services rendered during the first 16 months of the program.

On the basis of claims and administrative expenses paid (cash basis), the average monthly per capita expenditures of the program for the 6 months of 1966 were $1.93; for the first 10 months of 1967, the average was $6.06. However, these figures need to be adjusted for the estimated increase in liability that took place during the period for benefits that will be paid for services rendered during the period but had not been paid at the end of the period; that is, the premium rate must be set on an accrual basis, rather than a cash basis.

Figures on an accrual basis for the 6 months of 1966 are, of course, much more complete than for 1967. On the basis of the 1966 accrual figures, it is now estimated that, for this 6-month period, benefits and administrative expenses per capita exceeded the income from premiums and matching Government contributions by 30 cents per month (that is, 15 cents each). It is further estimated that the liability of the system for the entire 1½ year period, July 1966 to December 1967, will be about 7-percent higher than the income from the premiums and the matching Government contribution. In other words, it is expected that the $3 premium for the entire period will be lower than half the cost for benefits and administrative expenses by about 20 cents. About 12 cents of this 20 cents is accounted for by the fact that apparently physicians' fees were higher during this period than had been assumed in setting the premium; the remaining 8 cents arises from the fact that there has apparently been a somewhat greater utilization of services under the program than had been anticipated. Projecting costs of the program for the 15-month period following March 1968 at the level of operation in 1966–67 thus would require an additional 20 cents in the premium rate. These estimates are based upon incomplete data for past periods and upon projections thereof and may be somewhat more or less when the final accounts are in.

In estimating the cost of the program for April 1968 through June 1969, it is necessary to provide for the long-term trend toward greater utilization of medical services (including the effects of the discovery and more frequent use of new, highly expensive medical techniques) and the long-range upward trend of the general earnings levels, which will be reflected in higher physicians' fees and administrative expenses.

It is assumed that, in 1968–69, physicians' fees will increase at an annual rate of 5 percent and utilization of medical services by enrollees will increase at an annual rate of 2 percent. Administrative expenses are assumed to represent 9½ percent of the benefit payments; this figure is based on the actual operating

results in 1967, when the average per capita administrative expenses of $0.56 per month represented 9.5 percent of the average per capita benefit costs on an incurred basis. (The administrative expenses, on a paid basis, represented an average monthly per capita amount of $0.70 for the 6 months of 1966. The 1966 average was relatively high because of the necessary one-time startup costs.) The average interest rate on the invested assets of the trust is assumed to be 4¾ percent (the rate applicable to virtually the entire portfolio as of October 31, 1967).

It is estimated that the monthly per capita cost on a calendar-year basis would be $7.61 for 1968 and $8.28 for 1969 if the provisions of the 1967 amendments were in effect for this entire period. The cost for the 15-month period beginning April 1968 would average out at $7.89 a month (half of which is $3.95). Thus, a standard premium rate of $4 per month for the period April 1968 through June 1969 would allow a margin for contingencies, as required by law.

In addition, the interest earnings of the trust fund are available as a margin for contingencies and, if not needed to pay benefits and administrative expenses in the current period, will reduce the unfunded liability for the past deficiency in the premium rate. Interest earnings are the equivalent of another 10 cents per capita in available income.

The explanation of the $1 increase in the monthly premium rate for the new premium period can be summarized in the following manner:

(*a*) The cost of the protection under the program as in effect in 1966–67 is estimated to have exceeded the income from premiums and Government matching contribution by about 7 percent—an increase of about 20 cents.

(*b*) The cost of the program in 1966–67 was abnormally low as a result of the fact that in the 6 months of operation in 1966 the full $50 deductible was applicable, and it had a much stronger effect in reducing benefit costs than will be the case in later years; in other words, with all other things being the same, the program cost is higher for future years, in which the $50 deductible is usually applicable for 12-month periods, than for the initial period—an increase of about 3 cents.

(*c*) The $50 deductible represents a smaller proportion of the total covered medical charges when these increase as a result of either higher physician fees or higher utilization—an increase of about 11 cents.

(*d*) The utilization of medical services is assumed to be higher in the new premium period than in 1966–67, and so the program cost is higher—an increase of about 11 cents.

(*e*) The level of physicians' fees is assumed to be higher in the new premium period than in 1966–67, and so the program cost is higher—an increase of about 27 cents.

(*f*) The increased benefit protection arising from the provisions of the 1967 amendments must be taken into account—an increase of about 23 cents.

(*g*) The promulgated rate includes an amount to provide a margin for contingencies—an increase of 5 cents.

As indicated previously, the program has more than ample funds, on a cash basis, to meet its expected obligations for benefit payments and administrative expenses now and in the period to which the promulgated premium rate applies.

Appendix G. Publications Relating to Medicare

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1. Selected medicare publications ---- 96
2. Medicare Regulations ---- 97
3. Publications relating to the financing of the health insurance program ---- 98
4. Social Security Bulletin articles ---- 98
5. Miscellaneous publications ---- 99

Exhibit 1

Selected Medicare Publications

Recent Improvements in "Your Social Security" (SSI–1967–1): Outline of changes made by 1967 amendments to the old-age, survivors, disability, hospital, and medical insurance programs.

1967 Social Security Amendments (SSI–1967–6): A discussion of how the amendments affect almost all Americans, whether working or retired.

Your Medicare Handbook (SSI–50): The primary informational vehicle to communicate medicare provisions to beneficiaries. Reflects changes made by 1967 amendments. A copy was mailed to each beneficiary.

An Important Announcement to the Health Care Community About the 1967 Changes in Medicare (SSI–1967–8): Information for physicians, hospital administrators, and members of professional health care organizations on major changes in medicare.

A Brief Explanation of Medicare, "Health Insurance for People 65 or Older" (SSI–43): Brief explanation of major benefits of medicare. Includes 1967 amendment changes.

Recent Improvements in Medicare (SSI–1967–2): Brief explanation of 1967 changes in medicare. (Also available in Spanish—SSI–1967–2SP.)

When You Enter a Hospital "How Does Medicare Help" (OASI–892): Generally, explains medicare benefits for inpatients. (Being revised to include 1967 changes.)

How Much Does Medicare Pay for "Outpatient Hospital Services" (OASI–891): Explains benefits and methods of payment for outpatient services. (Being revised to reflect signfiicant changes made by 1967 amendments in transferring all outpatient services to medical insurance part of medicare.)

Extended Care Benefits After Hospitalization Under the Medicare Program (OASI–890): Facts on extended care and requirements for coverage of such services. (Being revised to take account of 1967 changes.)

Medicare and the Extended Care Facility—"What It Means to You" (OASI–893): General explanation of extended care benefits. (Being revised to emphasize that program does not pay for custodial care.)

How Medicare Helps to Pay a Home Health Agency for Providing Your "Home Health Benefits" (OASI–896): Discusses home health benefits. (Being revised to include discussion of coverage of physical therapy.)

How to Claim Benefits Under Medical Insurance (SSI–37): Explanation of methods of payment for medical expenses and how benefits are determined. Includes the 1967 changes.

Your First $50 of Medical Insurance Expenses Under Medicare Meets the Calendar Year Deductible (OASI–894): Explanation of deductible provisions. (Being revised to emphasize elimination of deductible for radiologists' and pathologists' services, time limit for filing medical insurance claims, and the deductible carryover provisions.)

Your Health Insurance (SSI–14): Explanation of medicare for social security beneficiaries who will soon be age 65.

Almost 65? (OASI–877c): Urges people approaching age 65 to investigate medicare benefits.

Eight Reasons Why You Should Have "Doctor-Bill Insurance" (SSI–1967–5a): Letter from Commissioner of Social Security urging hospital insurance beneficiaries to elect medical insurance benefits.

Letter to Social Security Beneficiaries (SSI–28): Initial notice to beneficiaries approaching age 65 to sign up for medical insurance protection.

Letter to Social Security Beneficiaries (SSI–30): Follow-up notice to SSI–28.

A Brief Outline of "Medical Insurance Benefits" (Doctor-Bill Insurance) under Medicare (SSI–1967–5): To be enclosed with SSI–1967–5a, SSI–28, and the SSI–30. (Also printed in Spanish—SSI–1967–5SP).

Letter to Medicare Beneficiaries (SSI–6): Accompanies mailing of beneficiaries' health insurance cards, asks them to check it, and tells how to use it.

Medical Insurance, Record of Medical Expenses (OASI–881c): Folder provided to beneficiaries to record medical expenses and bills until they submit them for payment.

Your Medical Insurance Premium (SSI–1967–1), (Premium Stuffer): Notified beneficiaries of increase in medical insurance premiums effective April 1968.

Special Message About Medicare for Railroad Retirement Beneficiaries Who Receive Social Security Payments (OASI–881e): Explanation of how medical insurance premiums are deducted for railroad annuitants and where they should send their claims.

A Special Message to Medical Insurance Beneficiaries Who Are Members of Group Practice Prepayment Plans (OASI–881l): Explanation of special methods of deductible computation for GPPP's. Also informs that it is not necessary to file medicare claims for plan services.

For Physicians, A Reference Guide to Health Insurance Under Social Security (OASI–876): Comprehensive explanation of medicare for physicians. (Being revised to include the 1967 changes.)

Notes for the Office Assistant (SSI–18): Short explanation of medicare payment provisions under medical insurance. Also outlines what is necessary for properly filed claims.

Financing Your Social Security Benefits (SSI–36): Facts on program financing and how old-age and survivors, disability, hospital, and medical insurance trust funds are kept in actuarial balance.

Individual copies of all pamphlets listed are available from social security district and branch offices througout the country or from the Social Security Administration, Baltimore, Md., 21235. Bulk orders are sold at rates which vary with each publication. Inquiries about bulk orders should be addressed to the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C., 20402.

Exhibit 2

Federal Health Insurance for the Aged (20 C.F.R. 405) Regulations Published in the Federal Register

Subpart and title:

A. Hospital Insurance Benefits.
B. Supplementary Medical Insurance Benefits.
C. Exclusions; Recovery of Overpayment; and Liability of a Certifying Officer.
D. Principles of Reimbursement for Provider Costs; and for Services by Hospital-Based Physicians.
E. Criteria for Determination of Reasonable Charges; Reimbursement for Services of Hospital Interns, Residents, and Supervising Physicians.
F. Agreements With and Functions of Providers, Intermediaries, Carriers and State Agencies.[1]
H. Review and Hearing Under the Supplementary Medical Insurance Program.
I. Premiums for Supplementary Medical Insurance Benefits.[1]
J. Conditions of Participation; Hospitals.
K. Conditions of Participation; Extended Care Facilities.
L. Conditions of Participation; Home Health Agencies.[1]
M. Conditions for Coverage of Services of Independent Laboratories.
O. Providers of Services and Independent Laboratories; Determinations and Appeals Procedures.
P. Certification and Recertification.

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[1] Published as proposed regulations in the Federal Register.

Exhibit 3

Publications Relating to the Financing of the Health Insurance Program

TRUST FUND REPORTS

Board of Trustees of the Federal Hospital Insurance Trust Fund annual reports issued as follows:

1966 (for fiscal year ending June 30, 1965), House Document No. 393, 89th Congress, second session; February 28, 1966.

1967 (for fiscal year ending June 30, 1966), House Document No. 64, 90th Congress, first session; February 28, 1967.

1968 (for fiscal year ending June 30, 1967), House Document No. 290, 90th Congress, second session; March 27, 1968.

Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund annual reports issued as follows:

1966 (for fiscal year ending June 30, 1965), House Document No. 394, 89th Congress, second session; February 28, 1966.

1967 (for fiscal year ending June 30, 1966), House Document No. 66, 90th Congress, first session; February 28, 1967.

1968 (for fiscal year ending June 30, 1967), House Document No. 291, 90th Congress, second session; March 27, 1968.

ACTUARIAL COST ESTIMATES

Actuarial cost estimates and summary of provisions of the old-age, survivors, and disability insurance system as modified by the Social Security Amendments of 1965, and actuarial cost estimates and summary of provisions of the hospital insurance and supplementary medical insurance systems established by such act. Committee print, Committee on Ways and Means, House of Representatives, 89th Congress, first session; July 30, 1965.

Actuarial cost estimates for the old-age, survivors, disability, and health insurance system as modified by the Social Security Amendments of 1967. Committee print, Committee on Ways and Means, House of Representatives, 90th Congress, first session; December 11, 1967.

ACTUARIAL STUDIES

Myers, Robert J., "Actuarial Cost Estimates for Hospital Insurance Act of 1965 and Social Security Amendments of 1965." Actuarial study No. 59, U.S. Department of Health, Education, and Welfare, Social Security Administration, Division of the Actuary; January 1965.

Myers, Robert J., and Baughman, Charles B., "History of Cost Estimates for Hospital Insurance." Actuarial study No. 61, U.S. Department of Health, Education, and Welfare, Social Security Administration, Office of the Actuary; December 1966.

Bayo, Francisco, "U.S. Population Projections for OASDHI Cost Estimates." Actuarial study No. 62, U.S. Department of Health, Education, and Welfare, Social Security Administration, Office of the Actuary; December 1966.

MISCELLANEOUS

"Statement of Actuarial Assumptions and Bases Employed in Arriving at the Amount of the Standard Premium Rate for the Supplementary Medical Insurance Program for the Period April 1968 Through June 1969."

Note.—This statement appears as appendix F in this report.

Exhibit 4

Articles Relating to Medicare Published in the "Social Security Bulletin"

Cohen, Wilbur J. and Ball, Robert M., "Social Security Amendments of 1967: Summary and Legislative History" (February 1968).

Myers, Robert J. and Bayo, Francisco, "Financing Basis of Old-Age, Survivors, and Disability Insurance and Health Insurance Under the 1967 Amendments" (February 1968).

Horowitz, Loucele A., "Medical Care Price Changes in Medicare's First Year" (January 1968).

Allen, David, "Health Insurance for the Aged: Participating Home Health Agencies" (September 1967).
Reed, Louis S. and Myers, Kathleen, "Health Insurance Coverage Complementary to Medicare" (August 1967).
Ball, Robert M., "Medicare's First Year" (July 1967).
Hess, Arthur E., "Medicare's Early Months: A Program Round-up" (July 1967).
Stewart, William H., M.D., "The Impact of Medicare on the Nation's Health Care Systems" (July 1967).
Rice, Dorothy P. and Horowitz, Loucele A., "Trends in Medical Care Prices" (July 1967).
Allen, David, "Health Insurance for the Aged: Participating Extended-Care Facilities" (June 1967).
Division of Health Insurance Studies, Office of Research and Statistics, "Health Insurance for the Aged: Claims Reimbursed for Hospital and Medical Services" (May 1967).
Scharff, Jack, "Current Medicare Survey: The Medical Insurance Sample" (April 1967).
Division of Health Insurance Studies, Office of Research and Statistics, "Enrollment in the Health Insurance Program for the Aged" (March 1967).
West, Howard, "Health Insurance for the Aged: The Statistical Program" (January 1967).
Ball, Robert M., "Health Insurance for People Aged 65 and Over: First Steps in Administration" (February 1966).
Myers, Robert J. and Bayo, Francisco, "Health Insurance, Supplementary Medical Insurance, and Old-Age, Survivors, and Disability Insurance: Financing Basis Under the 1965 Amendments" (October 1965).
Cohen, Wilbur J, and Ball, Robert M., "Social Security Amendments of 1965: Summary and Legislative History" (September 1965).

The Social Security Bulletin is the official monthly publication of the Social Security Administration. A subscription to the Bulletin may be purchased from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. Price: $2.75 a year in the United States, Canada, and Mexico; $3.50 in all other countries; single copies $.25.

Exhibit 5

Miscellaneous Publications

U.S. Social Security Administration, Office of Research and Statistics: Health Insurance Statistics, health insurance series—"Health Insurance for the Aged: Number of Participating Health Facilities, July 1967, by State," April 8, 1968 (HI–6).
U.S. Social Security Administration, Office of Research and Statistics: Health Insurance Statistics, health Insurance series—"Enrollment of Aged Public Assistance Recipients in the Medical Insurance Program Under Social Security," March 11, 1968 (HI–5).
U.S. Social Security Administration, Office of Research and Statistics: Health Insurance Statistics, health insurance series—"Medicare and Care of Mental Illness," March 7, 1968 (HI–4).
U.S. Social Security Administration, Office of Research and Statistics: Health Insurance Statistics, health insurance series—"Number of Persons Using Medicare Services, July 1, 1966 to June 30, 1967," February 5, 1968 (HI–3).
U.S. Social Security Administration, Office of Research and Statistics: Health Insurance Statistics, current medicare survey series—"Current Medicare Survey Report," January 26, 1968 (CMS–3).
U.S. Social Security Administration, Bureau of Health Insurance: "Directory of Providers of Services," No. 1, hospitals, No. 2, extended-care facilities, No. 3, home health agencies, No. 4, independent laboratories, 1968.
U.S. Social Security Administration, Office of Research and Statistics: Health Insurance Statistics, health insurance series—"Blood Utilization by Inpatients Under Medicare," November 30, 1967 (HI–2).
U.S. Social Security Administration, Office of Research and Statistics: Health Insurance Statistics, health insurance series—"Current Data From the Medicare Program," November 20, 1967 (HI–1).

U.S. Social Security Administration, Office of Research and Statistics: Health Insurance Statistics, current medicare survey series—"Current Medicare Survey Report," July 28, 1967 (CMS–1).

U.S. Social Security Administration, Office of Research and Statistics: "Health Insurance Enrollment Under Social Security," number of persons by State and County, July 1, 1966.

U.S. Social Security Administration, Bureau of Health Insurance: "Qualification Criteria for Prospective Fiscal Intermediaries and Carriers," 1965.

Recent highlights

Enrollment (as of Apr. 1, 1968):	
Hospital insurance	19, 400, 000
Medical insurance	18, 600, 000
Inpatient admissions and plans for home health services (cumulative through April 1968):	
Inpatient hospital admissions	9, 600, 000
Extended care facility admissions	562, 000
Home health plans initiated	440, 000
Health insurance bills paid (cumulative through April 1968):	
Inpatient hospital	9, 600, 000
Outpatient hospital	3, 800, 000
Extended care	1, 200, 000
Home health	1, 200, 000
Physicians' and other medical services	39, 000, 000
Benefits paid (cumulative through April 1968):	
Hospital insurance	$5, 600, 000, 000
Medical insurance	$1, 800, 000, 000
Participating providers of services (as of April 1968):	
Hospitals	6, 847
Extended care facilities	4, 510
Home health agencies	2, 036
Independent laboratories	2, 490

Open enrollment period for medical insurance:

700,000 new enrollees sign up—about 95 percent of all eligibles now enrolled—only 35,000 drop coverage.

Premium adjustment:

Utilization and cost of services increase—protection expanded—monthly premiums increase from $3 to $4 beginning April 1968. (Government still matches premium payment dollar for dollar.)

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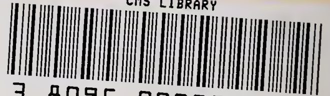
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