

Reports to Congress on OASDHI Studies

AS 1968 drew to a close, several studies called for by the Social Security Amendments of 1967, or requested by the Senate Finance Committee or by the House Committee on Ways and Means, were completed by the Department of Health, Education, and Welfare. Most of these studies dealt with possible changes in the Medicare segment of the social security program. The findings of these studies were included in reports that were sent to Congress or to the President at the beginning of 1969. These findings—and recommendations where they formed a part of the report—are summarized below.

EXTENSION OF MEDICARE TO THE DISABLED

Section 140 of the Social Security Amendments of 1967 called for the establishment of an advisory council, to be appointed by the Secretary of Health, Education, and Welfare, to study "the need for coverage of the disabled under the health insurance program of title XVIII of the Social Security Act." The Council was required to submit a report of its findings not later than January 1, 1969, together with recommendations on the financing of such protection.

On December 31, the Secretary of Health, Education, and Welfare sent to Congress, as directed by law, the report of the Advisory Council on Health Insurance for the Disabled, which recommended extension of Medicare to disability beneficiaries under OASDHI.

The membership of the Advisory Council was as follows:

Chairman Henry Kessler, M.D., Ph.D., Director, Kessler Institute for Rehabilitation.

James Brindle, President, Health Insurance Plan of Greater New York.

James M. Gillen, Director of Personnel Research, General Motors Corporation.

Juanita M. Kreps, Ph.D., Professor of Economics, Duke University.

William O. Kuhl, Ph.D., Director, Research and Education, International Brotherhood of Boilermakers, Iron Ship Builders, Blacksmiths, Forgers, and Helpers.

Leonard W. Larson, M.D., Past President, American Medical Association.

Daniel W. Pettengill, F.S.A., Vice-President, Group Division, Aetna Life and Casualty Company.

Bert Seidman, Director, Department of Social Security, AFL-CIO.

E. A. Vaughn, Vice-President and Controller, Aluminum Company of America.

Anthony G. Weinlein, Ph.D., Executive Assistant to the General President, Service Employees International Union, AFL-CIO.

E. B. Whitten, Executive Director, National Rehabilitation Association.

Alonzo S. Yerby, M.D., Professor and Head, Department of Health Services Administration, School of Public Health, Harvard University.

The Council was charged with examining the extent of the unmet need for health insurance among the disabled, the costs involved in providing them with insurance protection for health and medical services, and the ways of financing this insurance. The Report includes the following summary of the major findings and recommendations:

I. The Council has studied the need for and problems connected with health insurance for the disabled, and finds as follows:

1. Most severely disabled individuals have high health costs and low incomes. Disabled workers who qualify for social security disability benefits use seven times as much hospital care and three times as much physicians' services as does the entire population. Hospital utilization is about $3\frac{1}{4}$ times as great for the disabled as for the aged; utilization of physicians' services is about $2\frac{1}{2}$ times as great for the disabled as for the aged. The median income of disabled worker beneficiaries is less than half that of the nondisabled population.

2. The predominantly high health costs and relatively low incomes of the severely disabled make it unrealistic to expect private voluntary insurance alone to provide the great majority of them with comprehensive protection over the entire period of their disability. In 1966, only 46 percent of the disabled worker beneficiaries under social security had some form of private health insurance; 40 percent had some degree of protection against both hospital costs and the cost of inpatient medical care.

3. It is appropriate, feasible, and desirable to use the social insurance approach to help finance the health costs of the disabled. Through the social insurance mechanism people can make contributions during their working years, when incomes are relatively high, and build protection against hospital and medical costs in the event they become disabled and unable to work. Reliance on the Nation's social insurance system will reduce the need for public assistance and permit Federal-State assistance programs to better fill their role as a backstop to private efforts and social insurance.

II. The Council proposes health insurance protection for the disabled on the following basis:

1. The existing hospital and medical insurance programs under title XVIII of the Social Security Act (Medicare) should be extended to those receiving social security monthly benefits on the basis of their disabilities.

2. Hospital and medical insurance benefits for the present disabled, as well as for those who become disabled in the future, should be financed by contributions from employees, employers, and the self-employed, with a contribution from Federal general revenues equal to one-half the cost of the program.

3. Instead of the 6-month waiting period required in present law for receipt of social security disability benefits, a 3-month waiting period should be required for hospital and medical insurance benefits. The requirement in the cash benefit program that a disability must have lasted or be expected to last at least 12 months or to end in death should not apply in the case of Medicare benefits.

4. Older disabled workers should qualify for Medicare protection on the basis of less severe disability than is required under present law for eligibility for cash benefits. Insured workers aged 55 and over should be eligible for Medicare if they are so disabled that they can no longer engage in substantial gainful activity in their regular work or in any other work in which they have engaged with some regularity in the recent past.

5. Disabled people who qualify for Medicare protection but not for disability benefits should be eligible to receive vocational rehabilitation services financed by the social security program on the same basis as people who qualify for disability benefits.

6. The "level-cost" of the Council's recommendations is estimated at 0.80 percent of taxable payroll. In accordance with Recommendation No. 2 above, half of this cost, or 0.40 percent of taxable payroll, would be met from payroll contributions and the other half from general revenues.

STUDY OF RETIREMENT TEST UNDER OASDI

On January 3, 1969, the Secretary of Health, Education, and Welfare transmitted to the President a report on the retirement test under the social security program, required by section 405 of the Social Security Amendments of 1967. The law directed the Secretary to study "the existing retirement test and proposals for the modification of such test (including proposals for an increase in old-age insurance benefit amounts on account of delayed retirement)."

Social security insures workers and their dependents against the risks of death, disability, and retirement and pays monthly cash benefits to them when loss of income related to one of these risks occurs. The retirement test is the mechanism used to determine if the loss of income from earnings is the result of retirement. The test specifies the amount that a person receiving monthly cash benefits may earn without for-

feiting some or all of his benefit, and the age at which benefits are payable regardless of earnings.

On the basis of the study findings, the Secretary in his letter of transmittal recommended the retirement test be continued but that the following changes in the existing retirement test should be made:

—The annual exempt amount of earnings should be changed from \$1,680 to \$1,800 and the monthly exempt amount (what the beneficiary can earn in a given month, regardless of his annual earnings and still get his benefit for that month) be changed from \$140 to \$150.

—To keep the annual exempt amount of earnings in line with changes in earnings levels, the law should include a provision for automatic adjustment of the amount to be exempted.

—The provision for a two-step reduction in benefits when earnings exceed the annual exempt amount should have no change in the first step of the present provision, under which \$1 of benefits is withheld for each \$2 of earnings for the first \$1,200 above the exempt amount. The second step—for earnings above the first \$1,200 in excess of the exempt amount—should be changed from \$1 of benefits withheld for each \$1 of earnings at that level to \$3 of benefits for each \$4 of earnings.

The study also examined, as directed by Congress, the question of providing higher retirement benefits to those who delay retirement beyond age 65. According to the report, a major factor in considering proposals for delayed retirement credit is its cost and such proposals should have a relatively low priority until benefit levels have been substantively improved.

Cost figures for the various proposals for retirement-test changes and for providing delayed retirement credit are included in the report.

PRESCRIPTION DRUGS UNDER MEDICARE

Coverage of Drugs Under Medicare

Section 405 (a) (3) of the Social Security Amendments of 1967 authorized and directed the Secretary of Health, Education, and Welfare to study "the coverage of drugs under Part B of title XVIII" of the Social Security Act and to transmit to the President and Congress by the beginning of 1969 a report on the findings and recommendations of that study.

On January 13, 1969, the Secretary of Health, Education, and Welfare sent to the President the report of the Task Force on Prescription Drugs established to carry on this study, as well

as others called for by the 1967 amendments.

The report includes the following summary of the study's findings and recommendations:

1. In order to improve the access of the elderly to high quality health care, and to protect them where possible against high drug expenses which they may be unable to meet, there is need for an out-of-hospital drug insurance program under Medicare.
2. Because of the numerous and complex administrative problems and the high program costs involved in providing drug coverage under Medicare, it would be desirable—at least at the outset—to provide the benefit on a less-than-comprehensive basis.
3. While it would be feasible to provide coverage of out-of-hospital prescription drugs under either the hospital insurance (Part A) or medical insurance (Part B) programs of Medicare, there would be significant advantages, in terms of beneficiary eligibility and financing, in providing such coverage under the hospital insurance program.
4. In order to achieve maximum benefits with whatever funds may be available, and to give maximum help to those of the elderly whose drug needs are the most burdensome, particular consideration should be given to providing coverage at the outset mainly for those prescription drugs which are most likely to be essential in the treatment of serious long-term illness.
5. The use of an annual deductible to control costs presents opportunities that warrant further consideration.
6. Restricting benefits to those aged 70, 72 or more would reduce the size and cost of the program, but this is not a preferred approach at this time.
7. It would be preferable for the vendor rather than the beneficiary to have major responsibility for keeping needed records and initiating claims, and to be reimbursed by the program.
8. Because of the large number of claims which would be involved, a suitable automated data processing system could play a vital role in claims processing and other administrative activities, and should be developed and adequately tested.
9. To the extent that appropriate utilization review methods are developed, these should be applied in a Medicare drug program.
10. Reimbursement for product cost, as one element in the total cost of a prescription, may be considered on the basis of (a) "usual and customary" charges, (b) listed wholesale price, (c) actual acquisition cost as verified by audit, or (d) a fixed program payment. Preference would be determined by the nature of the program.
11. Reimbursement for product cost should be based on the cost of the least expensive chemical equivalent of acceptable quality generally available on the market.
12. Since the expressed purpose of the social security program is to provide assistance to beneficiaries, wherever possible, within the framework of the existing health care system, the direct purchase of

drugs by the Federal Government for Medicare beneficiaries is not recommended at this time, but this approach deserves further study.

13. The preferred method of reimbursing for dispensing costs would depend on the nature of the program. If the program provides for a specific dispensing allowance to be paid to the drug vendor, rather than payment to the beneficiary, either a percentage markup or a fixed dispensing fee would be feasible, with a fixed fee approach being preferable.
14. Any drug insurance program instituted under Medicare should include cost-sharing provisions, such as co-payment or co-insurance.
15. Consideration should be given to the use of restrictions on maximum prescription quantities or on maximum prescription prices as additional cost-sharing approaches.
16. Costs of any program would depend on the nature and degree of coverage, the use of deductibles, the use of co-payment, co-insurance and other cost-sharing methods, the type of administrative procedures, the control of program abuse, the appropriate application of utilization review, increases in drug use, changes in prescription prices, and other factors. "High-cost" and "low-cost" estimates for a wide variety of approaches have been developed.

Quality and Cost Standards for Drugs

Section 405 of the Social Security Amendments of 1967 also called for a study of the "quality and cost standards for drugs for which payments are made under the Social Security Act." The Task Force on Prescription Drugs submitted its report on this study on January 10, 1969, to the Secretary of Health, Education, and Welfare. The major findings of the study were summarized as follows:

1. The Task Force finds that the drug quality studies undertaken by the Food and Drug Administration are expected to be adequately if not completely up-to-date by 1971, and thus will provide reasonable assurance of uniform drug quality by that time.
2. There should be uniform standards of quality and efficacy for each product covered in any Federally supported drug program, and it would be inappropriate to provide for differential cost ranges for products sold by proprietary designation.
3. The exclusion of certain combination products, duplicative drugs, and noncritical products from Federal reimbursement would contribute significantly to rational prescribing, and, moreover, it seems reasonable to assume it could yield overall savings of at least 10 percent.
4. Establishing product cost ranges reflecting the cost of drugs generally available by their generic names would save about 5 percent at the retail level.
5. Although the Task Force is convinced that significant program savings could be achieved through the

application of techniques designed to improve the efficiency of vendor operations, it is unable at this time to estimate the extent of these savings.

6. Considerable time would be required to develop all the necessary administrative mechanisms. Therefore full implementation of such provisions as applied to Federal reimbursement for prescribed drugs cannot be assumed in less than two years after enactment of appropriate legislation.

7. Any necessary increases in Federal expenditures for the improvement of drug standards and quality control will have benefits which apply to all users of prescription drugs and should not be attached to the implementation of cost standards for drugs supplied in Federally assisted programs.

8. Establishment of reasonable cost and charge ranges for drugs provided under the Medicare, Medicaid, and Maternal and Child Health programs is feasible, and would reduce the cost of drugs to the Federal and State governments without sacrifice of quality.

PREVENTIVE SERVICES AND HEALTH EDUCATION FOR MEDICARE BENEFICIARIES

The Senate Finance Committee in Senate Report No. 744 of the 90th Congress requested the Secretary of Health, Education, and Welfare "to conduct a study of the possible coverage under Medicare of the cost of comprehensive health screening services and other preventive services designed to contribute to the early detection and prevention of disease in old age, and the feasibility of instituting and conducting informational or educational programs designed to reduce illness among Medicare beneficiaries and to aid them in obtaining needed treatment."

The report—submitted to Congress at the end of December 1968, as required—recommended that

—coverage of comprehensive health screening services and other preventive services not be added to the program at this time.

—clarification of intent in the present law be made by specifying that when an aged individual presents himself with a complaint to his physician, the physician, as part of good patient care management, may perform the tests or examinations he feels are necessary and be able to anticipate reimbursement under the Medicare program.

—a series of well-evaluated, population-based studies be performed to determine the feasibility of including comprehensive health screening and other preventive health services. Specific studies should focus on questions related to validity, reliability, acceptability to patients and physicians, and feasibility in relation to the costs of screening and follow-up. Further studies should examine the effect of elimination of the \$50 deductible for preventive services on utilization of such services.

—a national, cooperative, voluntary effort directed at health education for the aged should be initiated by the Department in cooperation with medical societies, women's auxiliaries, voluntary agencies, advertising groups, consumer groups, senior citizens' organizations, community hospitals and other providers of services, public health agencies, insurance companies, news media and other groups interested in and capable of providing local leadership, initiative and effective action.

—the Social Security Administration expand its activities directed at informing beneficiaries about availability and utilization of services under Medicare, and that wherever possible these activities be coordinated or integrated with general community information and referral services.

COVERAGE OF INDEPENDENT PRACTITIONERS UNDER MEDICARE

Section 141 of the Social Security Amendments of 1967 directed the Secretary of Health, Education, and Welfare to "make a study relating to the inclusion under the supplementary medical insurance program . . . of services of additional types of licensed practitioners performing health services in independent practice." The law called for a report by the beginning of 1969 on the need for and costs of such coverage and on the method of covering these services. The recommendations resulting from the study, as summarized in the letter of December 28, 1968, transmitting the report to Congress, are:

1. The present coverage for services of physical therapists remain as established in the 1967 Social Security Amendments, which extended coverage to outpatient services provided by approved providers, including rehabilitation agencies, clinics, and public health agencies meeting conditions of participation.

2. Coverage be expanded for services of occupational therapists, clinical psychologists, social workers, and speech pathologists provided in organized agencies, centers, or other programs that are not presently eligible for participation and that meet requirements established by the Secretary and designed to promote maximum coordination, continuity, and quality of care, and to which patients are referred by a physician, who establishes a plan for the patient's total care and retains over-all responsibility for patient management. Reimbursement for services would be to the provider agency, center, or program on the basis of reasonable cost.

3. Present coverage for optometric services not be expanded at this time.

4. No changes be made in present coverage for services of audiologists and corrective therapists.

5. No changes be made in coverage in relation to the services of chiropractors.

6. No changes be made in coverage in relation to the services of naturopaths.

SOCIAL SECURITY COVERAGE OF FEDERAL GOVERNMENT EMPLOYEES

The Ways and Means Committee of the House of Representatives and the Senate Finance Committee in their Reports on the Social Security Amendments of 1967 directed the Social Security Administration to make a study of the problems that "have precluded the coverage of governmental employees under social security" and to submit a report of the study, "including positive recommendation for covering Government employees on a basis that is fair to both Government employees and all other workers." The report of the study, submitted to Congress January 17, 1969, recommended that Congress consider "the following related measures as an effective and less costly alternative to direct social security coverage of employment subject to the civil service retirement system."

(a) *Transfer of credits to social security:* Where there is no benefit eligibility under the civil service, foreign service, or Central Intelligence Agency retirement system when a worker dies, becomes disabled, or retires, credits would be transferred from the staff retirement system to social security. The social security trust funds would be reimbursed for the proportionate cost of benefits attributable to the transferred credits with part of this reimbursement financed through withholding by the civil service retirement system of amounts equivalent to social security employee contributions from refunds made to separating employees or their survivors.

(b) *Guaranteed minimum civil service benefits:* Where there is benefit eligibility under the civil service, foreign service, or Central Intelligence Agency retirement system, the staff retirement system benefits (or if social security benefits based on other work are also payable, the staff retirement system and social security benefits together) would be guaranteed to be at least as high as if employment subject to the staff retirement system had been covered by social security.

(c) *Medicare coverage for Federal employment:* Federal workers whose Government employment is not covered under the general social security provisions would have their employment covered under the hospital insurance provisions of social security for purposes of becoming insured for Part A (hospital insurance) Medicare protection when they reach age 63. Those present civil service retirees who are not insured under social security, and their spouses, would at age 65 be deemed insured under Part A of Medicare and could then advantageously enroll under Part B (supplementary medical insurance): the cost of the Part A protection would be borne by the Government, as employer. New health insurance designed to complement Medicare would be available under the FEHB program to Federal retirees and employees who become entitled to Part A protection. This complementary insurance would, together with Part A and Part B protection under Medi-

care, provide health insurance protection at approximately the level provided under the Government-wide high-option FEHB plans.

PERSONNEL QUALIFICATIONS STUDY

In compliance with the request of the Ways and Means Committee of the House of Representatives in its Report on the Social Security Amendments of 1967, the Secretary of Health, Education, and Welfare submitted on December 28, 1968, a report on the quality of personnel needed to provide health services under the Medicare program. The conclusions resulting from the study, which related to five major categories of health services personnel, are:

Physical therapists. In the light of the shortage of physical therapists, efforts should be made to qualify currently disqualified physical therapists for participation under Medicare if they can establish an adequate level of competency. Administrative steps are being taken to develop a proficiency examination which will make this determination possible.

Licensed practical nurse. The charge nurse in an extended care facility is responsible for the total nursing care of all patients during her tour of duty. Because practical nurses licensed by waiver have no standard educational preparation—and often no such preparation at all—the study did not find it appropriate for them to serve as charge nurses, although they may be employed by extended care facilities for general duty nursing. Thus, no change in current requirements will be made. Suggestions are made in the study for actions by State licensing programs and educational institutions, with a view to upgrading waived practical nurses.

Independent laboratory personnel. In view of the potentially crucial value of each laboratory determination made, and the growing complexity of laboratory procedures, it is essential that only well-qualified personnel be entrusted the task of performing laboratory analyses in Medicare-approved laboratories. The study concluded that the current regulations represent the minimal acceptable level of standards to assure safe laboratory performance, and that no change should be made.

Medical record personnel. In light of the acute shortages of medical record personnel, Medicare regulations will be modified to permit accredited record technicians, as well as registered record librarians, to function as hospital medical record department heads under specified conditions.

Corrective therapists. These therapists are not licensed by any State, and their educational programs are not accredited by a specialty accrediting body recognized by the Office of Education or the National Commission on Accrediting. In view of this, the study found that the present Medicare regulations, which require that corrective therapists function under appropriate supervision, should not be changed.