Notes and Brief Reports

Meeting the SMI Deductible Under Medicare, 1966–70*

Twenty-five million persons aged 65 or older were enrolled for supplementary medical insurance (SMI) between July 1, 1966—when the Federal program of health insurance for the aged began—and December 31, 1970. Supplementary medical insurance is the voluntary part of health insurance for the aged, commonly known as Medicare.

Under SMI, which pays for physicians' and related services, benefits begin in any calendar year after the insured person has paid the annual deductible.[1] Charges applied toward the deductible in the last 3 months of the calendar year may be carried over to the next year to be again applied to the annual deductible.

The Social Security Administration records kept to determine eligibility for reimbursement show that 37 percent of all persons ever enrolled in the first 4½ years of the program never met the deductible.

More than half those ever enrolled from 1966 to 1970 had been in the program 4 years or more (table 1). These persons had five opportunities to meet the deductible. Sixty-eight percent had accumulated charges of $50 or more in at least 1 year during this period, and 6 percent met the deductible every year—five times. Those enrolled in the program less than 4 years (43 percent) were persons who aged into the program after July 1, 1966, or who died in the intervals shown in table 1.

The data are from a 5-percent sample of SMI enrollees that contains information as of January 1973 on their SMI deductible status for each year. This information is entered in the file as insurance carriers consult central office records to determine if an enrolled person who has submitted a claim has met the deductible. The carrier inquiry includes the date of the service and the allowed charge. Such information is cumulated on an annual basis for each individual until the records show that he has reached the deductible. If a person filed no claim for reimbursable service, the SMI file will, of course, indicate that he has never met the deductible. There is some evidence that in each year about 6 percent of the enrollees did not file a claim[2] when they were eligible for reimbursement.

The number of persons whose bills are equal to or greater than the deductible in any period is influenced by the demographic characteristics of the persons, the amount of medical services they use, and changes in medical prices over a period of time. Each year from 1967 to 1970 an increasing proportion of the persons enrolled for SMI has met the deductible (table 2). According to the Current Medicare Survey,[3] the percentage of enrollees *using* covered services remained constant and the rise in the proportion meeting the deductible is attributable to the higher average charges for physicians' services. Though the rise in charges may be the major factor, part of the growth may result from greater awareness of the

TABLE 1.—Number and percentage distribution of persons meeting the supplementary medical insurance deductible for specified number of times, by duration of enrollment, July 1966–December 1970, as of January 1973

[Estimated from 5-percent sample of SMI enrollees]

Duration of enrollment (in months)	All enrollees	Enrollees, by number of times deductible met					
		No record	One	Two	Three	Four	Five
	Number (in thousands)						
49–54	14,008	4,467	2,894	2,410	1,807	1,533	896
37–48	2,249	638	508	444	380	237	43
25–36	2,894	1,080	733	644	380	58	----
13–24	2,763	1,229	883	565	86	----	----
Less than 13	2,836	1,865	806	166	----	----	----
	Percentage distribution						
49–54	100.0	31.9	20.7	17.2	12.9	10.9	6.4
37–48	100.0	28.4	22.6	19.7	16.9	10.5	1.9
25–36	100.0	37.3	25.3	22.3	13.1	2.0	----
13–24	100.0	44.5	31.9	20.5	3.1	----	----
Less than 13	100.0	65.8	28.4	5.8	----	----	----

*Prepared in the Division of Health Insurance Studies, Office of Research and Statistics.

[1] Until the end of 1972, the deductible—the amount to be paid by the patient before reimbursement occurs—was the first $50 in the calendar year. See "Provisions of the Law" in *Medicare: Health Insurance for the Aged, 1968, Section 1: Summary*, Social Security Administration, Office of Research and Statistics, pages xxxii–xxxvi.

[2] *Ibid.* See page xiii for a discussion of differences in the proportion of the Medicare population meeting the deductible, as reported in the Current Medicare Survey and as recorded in administrative files.

[3] *Current Medicare Survey Report: Use of Medical Care Under Supplementary Medical Insurance, 1966–70* (Health Insurance Statistics, CMS No. 19), Office of Research and Statistics, 1972.

TABLE 2.—Percent of SMI enrollees meeting the deductible, by age and sex, July 1966–December 1970, as of January 1973

[Estimated from 5-percent sample of SMI enrollees]

Age and sex	July–Dec. 1966	1967	1968	1969	1970
Total	16.8	35.1	37.5	40.5	42.2
65–66	13.0	25.3	27.2	29.6	31.1
67–68	15.4	32.7	34.7	38.0	39.7
69–70	15.7	34.1	36.8	39.7	41.7
71–72	16.5	35.1	38.0	41.0	43.4
73–74	17.4	36.8	39.2	42.0	44.3
75–79	18.6	38.9	41.4	44.5	46.2
80–84	19.8	40.7	43.5	46.3	47.7
85 and over	20.7	42.0	45.0	47.7	49.0
Men	16.3	33.4	35.6	38.5	40.2
65–66	12.5	24.0	26.0	28.5	29.9
67–68	14.9	31.1	33.1	36.1	38.1
69–70	15.0	32.4	35.1	38.0	39.9
71–72	16 0	33.5	36.1	39.1	41.4
73–74	16.9	35.1	36.9	39.9	42.1
75–79	18.2	37.3	39.6	42.7	44.3
80–84	19.8	39.9	42.2	44.8	46.3
85 and over	20.3	42.0	44.4	47.8	48.7
Women	17.3	36.3	39.0	41.9	43.7
65–66	13.3	26.3	28.3	30.5	32.1
67–68	15.8	34.1	36.1	39.5	41.0
69–70	16.3	35.5	38.0	41.0	43.1
71–72	16.8	36.3	39.4	42.4	44.9
73–74	17.8	38.0	40.8	43.5	45.8
75–79	18.9	40.0	42.6	45.7	47.5
80–84	19.8	41.2	44.3	47.3	48.6
85 and over	20.9	41.9	45.4	47.7	49.2

carryover provision and more knowledge of how to file a claim.

Since persons aged 65 and 66 were not in the program for a full year, they had less opportunity to reach the deductible than those in the next age group. The percentage meeting the deductible rose steadily with each age group, and the rise in each year was about the same. For every age group, however, the proportion reaching the deductible was higher from year to year.

Social Security Abroad

No-Fault Accident Compensation in New Zealand*

New Zealand is introducing a Government-operated, no-fault accident insurance program that provides injured workers with a benefit of up to four-fifths of their usual earnings. This is the latest move in the social field by a country that allocates 37 percent of central government spending to welfare and social insurance.

The Accident Compensation Act of 1972—effective April 1, 1974—provides for two interrelated, no-fault accident compensation programs: (a) occupational disease and 24-hour accident coverage for the entire labor force, financed by contributions from employers and the self-employed; and (b) complete motor-vehicle accident coverage for the entire population financed by vehicle drivers and owners.[1]

An agency under the Ministry of Social Security—the Accident Compensation Commission—is to supervise the two programs. The new arrangements replace complicated mechanisms for dealing with compensation for industrial accidents and for highway injuries where negligence can be established. The result is a contributory accident insurance that is not work-related but earnings-related.

The two new programs provide for hospital and medical treatment, rehabilitation, and nontaxable cash compensation covering all the consequences of an accident—that is, loss of income and physical and emotional suffering. Benefits for income loss will be earnings-related, in contrast to the flat-rate benefits of the New Zealand social insurance system. Moreover, liability is being liberalized to cover all injuries to workers regardless of when or where they occur.

The cost of the new system is to fall on employers and the self-employed for the earners' accident compensation program and on motor vehicle drivers and owners for the motor vehicle compensation program. In a sense there is a general revenue component: medical-hospital benefits will continue to be provided by the national health insurance system that is entirely government financed.

The Act of 1972 was the end result of a series of reports starting in 1962, which examined the feasibility of establishing a Government-operated program offering complete coverage for work-accident and occupational disease victims. The

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[1] On March 9, 1973, the Government of New Zealand decided to extend coverage under the Accident Compensation Act to nonworking housewives and other nonearners (that is, students, retired persons, and the unemployed). As a consequence, the implementation date of the schemes was postponed from October 11, 1973, to April 1, 1974. Government sources expect that the appropriate amending legislation will be presented by the end of August 1974.