Health Insurance for the Aged: The Statistical Program

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On July 1, 1966, the health insurance program for the aged under the Social Security Act went into effect. This program helps to close a major gap in the economic security of the elderly by providing protection against the high costs of hospital and medical care. The program will have a significant impact on the organization, provision, and financing of health and medical care in the country. Information on the broad scope of benefits and the large population group involved is being incorporated in a comprehensive data-collection system that will provide a means for evaluating the effectiveness of the program.

This article describes briefly the provisions of the health insurance program for the aged, outlines the various components of the statistical system for collection and maintenance of data on the utilization and financing of hospital and medical services and delineates the analytical studies envisioned. State data are presented on the number of hospitals and home health agencies participating under the program. Also presented are 3 months' data on claims paid, based on the bills received from hospitals that have been processed and approved for payment by intermediaries under the hospital insurance program.

Basic Provisions of Law

The 1965 amendments to the Social Security Act added title XVIII to the Act, which provides for two coordinated programs of health insurance for the aged: a basic hospital insurance plan (part A) and a voluntary supplementary medical insurance plan (part B).[1]

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[1] For a full description of the provisions of the health insurance program, see Wilbur J. Cohen and Robert M. Ball, "Social Security Amendments of 1965: Summary and Legislative History," *Social Security Bulletin*, September 1965; see also Robert M. Ball, "Health Insurance for People Aged 65 and Over: First Steps in Administration," the *Bulletin*, February 1966.

BENEFITS

The hospital insurance program provides payment for a large part of the cost of hospital services in a participating hospital for up to 90 days in a "spell of illness" (a period beginning with the first day of hospitalization and ending 60 days after discharge from a hospital or an extended-care facility). The first 60 days of hospitalization are covered essentially in full after a deductible of $40. For each of the remaining 30 covered days in a spell of illness, the patient pays $10 of the daily cost. The program pays 80 percent of the cost of outpatient hospital diagnostic services furnished during a 20-day period, after a deductible of $20.

The program also covers the cost of care up to 100 days during a spell of illness in a participating extended-care facility after transfer from a hospital following a stay of 3 or more days. (This part of the program began January 1, 1967.) The cost of the first 20 days is covered in full; the patient pays $5 of the daily cost for each of the remaining 80 covered days. For the cost of home health services, up to 100 visits during the year are covered, following discharge from a hospital (after a stay of at least 3 days) or from an extended-care facility.

The supplementary medical insurance program provides payment for 80 percent of the reasonable charges for physician services and other covered services following payment by the patient of the first $50 of such charges during the calendar year. The program covers the following services: physician services, regardless of place of service; up to 100 home health visits each year; various other medical and health services, such as diagnostic X-ray and laboratory tests; X-ray, radium, and radioactive isotope therapy; prosthetic devices; and the rental of durable medical equipment.

ELIGIBILITY

The nearly 19 million persons identified as eligible for the hospital insurance benefits as of July 1, 1966, consist of all persons aged 65 or over who

are entitled to monthly cash benefits under the old-age, survivors, and disability insurance (OASDI) or railroad retirement programs and all other aged persons, except retired Federal employees covered under the Federal Employees Health Benefits Act of 1959 and aliens admitted for permanent residence but having less than 5 consecutive years of residence.

As of July 1, 1966, about 17.6 million persons (including retired Federal employees eligible for the supplemental program) had elected to contribute $3 a month to pay their share of the premium for the supplementary medical insurance plan. For approximately 1,000,000 persons receiving public assistance in 25 States, the $3 premium will be paid by the State welfare agencies. About 30,000 retired Federal employees are enrolled in the supplementary medical insurance program but are not eligible to receive hospital insurance benefits.

The March issue of the BULLETIN will carry data on the number, characteristics, and State of residence of persons enrolled in the hospital and medical insurance programs on July 1, 1966.

FINANCING HEALTH INSURANCE BENEFITS

The hospital insurance program is financed on a long-range, self-supporting basis through a separate schedule of increasing tax rates on the first $6,600 of earnings, with the same rate for employees, employers, and self-employed persons. The rate was 0.35 percent in 1966, it rose to 0.50 percent for 1967, and it is scheduled to increase until it is 0.80 percent in 1987 and thereafter. A separate trust fund was established for the hospital insurance program. Included in the law is a special provision to reimburse the hospital insurance trust fund from general tax revenues for the costs of providing hospital insurance coverage for the almost 2.5 million persons not entitled to monthly social security or railroad retirement cash benefits.

The voluntary medical insurance program is financed by $3 monthly premiums from enrollees and a matching payment from general revenues of the Federal Government. A separate trust fund has also been established for this supplementary program.

FISCAL INTERMEDIARIES

Under the hospital insurance program, intermediaries are selected by each hospital to act as the link between the hospitals and the Social Security Administration. A vital role of the intermediaries is to review and pay hospital claims for the costs of providing care to the beneficiaries. The intermediary makes these payments to providers for covered items and services on the basis of reasonable cost determinations and assists in the application of safeguards against unnecessary utilization of covered services.

Under the supplementary medical insurance program, insurance carriers are selected by the Secretary of Health, Education, and Welfare to serve as intermediaries. The principal functions of these carriers are to determine the reasonable charges in their respective areas for each medical care service paid for under the program and to review and pay claims to or in behalf of beneficiaries for the services provided.

The number and types of intermediaries for each of the health insurance programs are summarized below.

Type of intermediary	Hospital insurance	Medical insurance
Total	87	51
Blue Cross-Blue Shield	74	33
Commercial insurance companies	11	15
Other	[1] 2	[2] 3

[1] New York Department of Health and the Social Security Administration, which deal directly with 187 hospitals in 29 States, the District of Columbia, and Puerto Rico.

[2] Group Health Insurance, Inc., Nebraska Department of Public Welfare, and the Social Security Administration, which deal directly with more than 100 group-practice prepayment plans.

The Statistical System

CHARACTERISTICS OF THE SYSTEM

The primary objective of the statistical system of the health insurance program is the provision of data required to measure and evaluate the operations and the effectiveness of the two parts of the program. The benefit payment operations furnish the means of obtaining extensive, systematic, and continuous information about the amount and kind of hospital and medical care services used by the aged, as well as the costs of such

services. The applications of hospitals and of extended-care facilities to participate in the program provide data on the characteristics of such providers of services. The claim number that is assigned to each individual serves as the link between the various services utilized under the program and the demographic characteristics of each individual recorded in the eligibility files.

The data-collection system has two inherent characteristics that determine to a considerable degree the scope, detail, and flexibility of the available data. First, data are collected and maintained on an individual basis so that the beneficiary and his medical experience under the program form the basic unit. Second, records for each bill paid under the hospital insurance program and for a sample of beneficiaries under the medical insurance program are maintained on a centralized basis. Except for intermediary operating statistics such as those relating to workloads, time lags, costs, and the like, all program statistics are centrally prepared.

THE BASIC RECORDS

The statistical system is based on five distinct but related computer-tape record systems: master eligibility record, provider record, hospital insurance (part A) utilization record, medical insurance (part B) payment record, and the record containing a sample of medical insurance bills.

Master Eligibility Record

The master eligibility record identifies each aged person eligible for health insurance benefits and indicates whether he is entitled to hospital benefits, to supplementary medical insurance benefits, or to both. The master eligibility file was established by combining the existing OASDI and railroad retirement beneficiary records with the records created from the applications of uninsured persons aged 65 and over to participate in the health insurance program. The same sources are used to maintain the eligibility records on a current basis—to add the newly aged, eliminate those who die, and identify those who withdraw from the supplementary medical insurance program.

This record was used to create the health insurance card that was sent to each insured person. The card contains the individual's claim number (an adaptation of the number used for OASDI or railroad retirement monthly cash benefit) and indicates the eligibility of the individual for the two parts of the program.

The claim number is the link between the eligibility record and all other records used in the program. The master eligibility record also contains information identifying the State and county of residence, date of birth, sex, and color of each enrolled person. In addition, the record has been further annotated to indicate selected subgroups, such as public assistance recipients whose medical insurance premium is being paid by the State welfare agency, as well as other major groups. The master eligibility record thus provides significant demographic characteristics linked to the utilization and cost data for both parts of the program. Finally, the eligibility record provides the population data for each part of the program and therefore serves as the base for the computation of a variety of utilization rates, limited only by its demographic content.

Provider Record

Every hospital, home health agency, extended-care facility, and independent laboratory must apply for participation in the hospital insurance program in order to be reimbursed for services provided. Each institution or agency must also meet the conditions of participation spelled out in the health insurance provisions of the Social Security Act and by the regulations under the Act. Designated State agencies, operating under agreement with the Department of Health, Education, and Welfare, have the responsibility for determining the extent to which each institution or agency meets these health and safety conditions for participation and for certifying those that satisfactorily do so.[2]

Data included on the application forms used by these institutions (SSA–1514 for hospitals,

[2] For a full description of the conditions, see Social Security Administration, *Conditions for Participation for Hospitals* (HIM–1), *Conditions for . . . Home Health Agencies* (HIM–2), *Conditions for . . . Extended Care Facilities* (HIM–3), and *Conditions for . . . Independent Laboratories* (HIM–4).

SSA–1515 for home health agencies, SSA–1516 for extended-care facilities, and SSA–1517 for independent laboratories) to indicate their desire to participate and to provide needed information have been recorded in the central provider record and will be updated as facilities are recertified periodically, as new ones apply for participation, or as some leave the program.

These application forms are the source for a variety of data on the characteristics of hospitals, home health agencies, extended-care facilities, and independent laboratories participating in the program.

The detailed information about each provider recorded in the statistical tapes includes such items as the State and county in which the institution is located; the number of beds; type of control; the major types of services provided; accreditation status, medical school affiliation, and approved training programs; staff characteristics, including the number of physicians, registered nurses, qualified speech therapists, licensed practical nurses, home health aides, and other skilled medical care personnel; the annual total of adult admissions and discharges; the number of patient days and persons served; and the current reimbursement rate.

When the information in this provider file is combined with utilization data, it serves to relate the characteristics of facilities and agencies that provide care to the kinds and amounts of service used by the aged.

Utilization Record For Hospital Insurance

The administration of the hospital insurance program requires that two items of information be known about each aged person at the time of his admission to a hospital—his eligibility under the program and the extent to which he has used the benefits available to him under the "spell of illness" concept. It is therefore necessary to maintain a master record of the number of days of care received by each aged person in a hospital or extended-care facility and of the number of home health visits received. This central record system is maintained on computer tape by the Social Security Administration.

When the patient is admitted to a hospital, the admission section of the Inpatient Hospital Admission and Billing Form (SSA–1453) is completed by the hospital and forwarded through its intermediary to the Social Security Administration central record. As soon as the record is checked, normally in less than 24 hours, the hospital is informed of the patient's eligibility status and of the number of days remaining during the "spell of illness." At discharge, the hospital completes the billing section of the form and sends it to the intermediary for payment. When approval for payment has been made, the intermediary forwards the claim to the Social Security Administration for recording in the central record. Copies of admission and billing forms are handled in a comparable manner by home health agencies (SSA–1487) and extended-care facilities (SSA–1478). The outpatient diagnostic billing form (SSA–1483) is also transmitted to the Social Security Administration for recording in the central record after the bill is approved for payment by the intermediary.

All the information on utilization experience in hospital and extended-care facilities that is needed to administer the "spell of illness" provision is recorded in the central record. This information includes stays in nonparticipating institutions and days of care not covered or reimbursable under the program.

As a byproduct of the admission and billing procedures a history will be built up for each individual that will permit the summarizing or cumulation of a considerable variety of statistical information. The more important of these items are the dates of admission to and discharge from hospitals and extended-care facilities; length of stay, frequency of use, and discharge status (alive or dead); charge and payment data (including both the covered and noncovered charges, with the former separated with respect to the amount reimbursed and the deductible and coinsurance amounts not reimbursed); the payment source for charges to patients; a report of one or more hospital discharge diagnoses, with the primary diagnosis coded for a 20-percent sample of all beneficiaries; surgical procedures, including the dates of surgery, with the procedure related to the primary discharge diagnosis or the most significant procedure coded for the same 20-percent sample; and diagnostic information coded from all bills from home health agencies and extended-care facilities. For outpatient diagnostic bills,

diagnosis and procedure data are coded for 40 percent of the beneficiaries.

Each admission and billing form contains both the beneficary's claim number and the provider's number, and the resulting tape record can be readily matched to the beneficiary files and the provider files. By this process, a statistical tape record is created that contains all the available information needed for tabulation from the three files.

Payment Record For Medical Insurance

Administration of the supplementary medical insurance program does not require the establishment of a detailed central record of providers since all licensed physicans and osteopaths are eligible to participate in the program. No "spell of illness" concept is involved, and payment or reimbursement is made only after receipt by the carriers of bills having reasonable charges exceeding $50 during a calendar period.[3]

Carriers need to know from a central source only that the deductible has been met; during the remainder of the calendar year, no additional information is required for reimbursement or payment purposes.

For administration and operation of the program, the Social Security Administration must have accurate and complete information on the amounts paid by the carriers for physician services and for other services and supplies under this part of the program. For outpatient psychiatric services, the maximum payment limitation of $250 requires that a cumulative central figure be maintained. To meet these needs, carriers were instructed to furnish a payment record consisting of tape, punched card, or other machine-readable record of each bill paid. A "bill" is defined as a request for payment from or in behalf of a beneficiary as the result of services provided by a single physician or supplier.

The payment record also contains selected items of information needed to provide an efficient basis for drawing samples of the bills. These items provide a sampling frame that will be used to draw additional small samples designed to provide specific information not obtainable from the bills furnished for the basic 5-percent sample of eligible persons under the medical insurance program. (This sample is described in a later section.)

The items in the payment record are:

1. Code number assigned by the carrier to each physician and medical supplier
2. Physician's specialty and board certification
3. Identification of medical degree (M.D., D.O., or D.D.S.)
4. Dollar amount of the reasonable charge as determined by the intermediary for the most expensive procedure itemized on the bill
5. Place (office, home, inpatient hospital, extended-care facility, outpatient hospital, independent laboratory, other) where the most expensive procedure took place
6. Type of service represented by the most expensive procedure (surgery, medical care, consultation, diagnostic X-ray, diagnostic laboratory, radiation therapy, anesthesia, assistance at surgery, other)
7. The number of dates of service shown on the bill
8. The number of dollar charges shown on the bill
9. Indication of payment to beneficiary or to the physician
10. Indication of whether the illness or injury requiring treatment was employment-related.

Sample of Bills Under Medical Insurance

While the payment record provides a rapid method for summarizng payment data and a sampling frame for efficiently drawing additional samples of bills, it does not provide specific data on diagnoses, procedures, and related charges.

Basic statistics on the utilization of physician and other services covered under the supplementary medical insurance program are derived from a continuous sample of the bills paid by intermediaries to or in behalf of 5 percent of all enrolled persons. Intermediaries have been given specific digits of the health insurance claim number to be used in selecting the sample. The payment record for all bills provides the information needed to assure the Social Security Administration that the sample is complete.

The Request for Payment Form (SSA–1490) is designed to provide information on the time and place of each service, the exact procedure carried out or service provided, the condition

[3] In figuring the $50 deductible, reasonable charges for services received between January 1 and December 31 are considered unless the $50 is not met until the last quarter of the year. In such cases, charges for services received in the last 3 months of the year can be used to meet the deductible for the next year.

treated (diagnosis), and the physician's or supplier's charge for the specific service.

For nonsurgical medical services, this information will provide comprehensive and descriptive data on the type of services provided by the physician during each visit. For surgical cases, where the usual practice is to report the surgical procedure, the diagnosis, and the charge without specifying the number of times the patient may have been seen by the surgeon, the statistical unit will be the surgical procedure and not the visit.

As previously indicated, data reflecting physician and other services are based on bills paid. For persons in the 5-percent sample to and for whom payment is made under the program, all their bills, including those used to meet the annual $50 deductible, will be included in the sample and coded. Data will not, however, be available through these procedures for persons in the sample who do not meet the $50 deductible. Such data are being collected by means of the Current Medicare Survey, which will be described in detail in a subsequent issue of the BULLETIN.

For hospital-based physicians who have authorized the provider to collect the fee for their services, Form SSA–1554 (Provider Billing for Patient Services by Physicians) is used. This form is to be completed for each patient. It also includes descriptive information on the date and place of each service, the diagnoses, procedures, and the charges. The same form will be furnished for the 5-percent sample of beneficiaries.

Initial Operating Data

The statistical system outlined above will provide considerable data about the providers of services, the characteristics of the aged persons enrolled, and the utilization and financing of health services under the hospital and medical insurance programs. Basic program operating data will be reported in the BULLETIN and in special reports to be issued by the Office of Research and Statistics as the data become available.

This first report presents State data on the number of participating hospitals and home health agencies as well as selected characteristics of the providers on a national basis. Preliminary data on the number and amount of inpatient hospital claims approved for payment under the hospital insurance program during the first 3 months of operation have also been reported. Because of lags in reporting and recording the data on the statistical tape record, these data are incomplete and will be revised each month in a new series of tables to be published monthly in the BULLETIN, which will also publish a monthly series on claims paid, based on the bills received from physicians or enrollees that have been processed by intermediaries under the supplementary medical insurance program.

PARTICIPATING PROVIDERS

As of September 30, 1966, there were 6,680 hospitals and 1,400 home health agencies certified for participation in the program. Certifications are made by State agencies to the Department of Health, Education, and Welfare indicating that the providers meet the conditions for participation promulgated by the Secretary of Health, Education, and Welfare. A participating provider is a certified institution that has entered into an agreement with the Social Security Administration not to make charges for covered items and services except deductibles and coinsurance amounts; to return any money incorrectly collected; and to provide services on a nondiscriminatory basis in compliance with title VI of the Civil Rights Act of 1964. Approximately 280 hospitals that had applied for participation in the program were not certified, on the basis of noncompliance with the standards. This number does not reflect an unknown number of hospitals that withdrew their applications when it appeared certain that they could not meet the standards and be certified. At the same time, about 175 additional hospitals failed to meet the civil rights requirements.

Hospitals and other providers of service could have been certified for participation under the program if they were found to be in substantial compliance with the conditions for participation, despite the fact that significant deficiencies were found with respect to one or more standards. In order to be certified as being in substantial compliance in the presence of significant deficiencies, the provider must be in general compliance with the initial statement of each condition, must develop an adequate plan to correct the deficiencies, and the deficiencies must not be so serious

as to interfere with adequate care or represent hazards to health and safety. Of the 6,680 hospitals that are now participating under the program, more than 2,000 have significant deficiencies with respect to one or more conditions of participation. A third of these hospitals are reported to have significant deficiencies in six or more conditions of participation, including prob-

TABLE 1.—Health insurance for the aged: Number of participating hospitals and beds, by type of facility, geographic division, and State, as of September 30, 1966 [1]

Geographic division and State	Total [2]		General [3]		Psychiatric		Tuberculosis	
	Hospitals	Beds [4]	Hospitals	Beds [4]	Hospitals	Beds [4]	Hospitals	Beds [4]
United States	6,526	1,201,447	6,111	798,150	305	379,799	110	23,498
New England	374	93,960	335	59,814	31	32,996	8	1,150
Maine	61	4,866	59	4,266	1	485	1	115
New Hampshire	34	5,012	32	2,530	1	2,400	1	82
Vermont	24	3,715	21	1,790	2	1,850	1	75
Massachusetts	186	53,495	166	36,320	16	16,597	4	578
Rhode Island	19	7,202	15	4,671	3	2,231	1	300
Connecticut	50	19,670	42	10,237	8	9,433	0	0
Middle Atlantic	793	284,288	724	155,923	62	126,943	7	1,422
New York	390	154,926	356	78,350	30	75,904	4	672
New Jersey	117	42,621	107	23,799	8	18,132	2	690
Pennsylvania	286	86,741	261	53,774	24	32,907	1	60
East North Central	1,124	246,976	1,010	164,443	69	74,639	45	7,894
Ohio	252	67,748	216	43,007	19	22,271	17	2,470
Indiana	131	23,709	118	17,267	8	5,829	5	613
Illinois	286	72,973	261	45,509	16	25,218	9	2,246
Michigan	278	58,683	252	38,271	18	18,341	8	2,071
Wisconsin	177	23,863	163	20,389	8	2,980	6	494
West North Central	889	111,300	849	78,594	32	31,065	8	1,641
Minnesota	193	25,768	183	18,513	7	6,951	3	304
Iowa	144	15,776	139	13,424	4	2,096	1	256
Missouri	167	34,282	156	21,783	10	11,834	1	665
North Dakota	57	5,157	56	3,462	1	1,695	0	0
South Dakota	62	4,931	61	3,181	1	1,750	0	0
Nebraska	103	9,532	99	6,637	3	2,765	1	130
Kansas	163	15,854	155	11,594	6	3,974	2	286
South Atlantic	765	137,960	723	97,524	30	35,676	12	4,760
Delaware	9	2,764	7	1,588	1	1,001	1	175
Maryland	61	23,695	50	11,960	10	11,235	1	500
District of Columbia	15	12,017	13	5,312	2	6,705	0	0
Virginia	100	14,181	97	13,582	1	145	2	454
West Virginia	84	10,003	80	8,377	4	1,626	0	0
North Carolina	142	18,471	136	16,619	2	358	4	1,494
South Carolina	66	12,038	64	6,633	2	5,405	0	0
Georgia	121	13,286	117	12,408	3	197	1	681
Florida	167	31,505	159	21,045	5	9,004	3	1,456
East South Central	426	46,667	405	39,420	9	5,146	12	2,101
Kentucky	124	16,122	113	10,711	5	4,502	6	909
Tennessee	148	17,061	140	15,437	3	585	5	1,039
Alabama	105	9,880	103	9,668	1	59	1	153
Mississippi	49	3,604	49	3,604	0	0	0	0
West South Central	859	82,794	841	66,988	14	13,960	4	1,846
Arkansas	99	8,883	97	7,455	2	1,428	0	0
Louisiana	87	10,415	85	9,705	2	710	0	0
Oklahoma	144	14,734	141	9,766	3	4,968	0	0
Texas	529	48,762	518	40,062	7	6,854	4	1,846
Mountain	384	38,512	368	32,100	13	5,976	3	436
Montana	65	3,683	62	3,246	1	142	2	295
Idaho	45	2,224	45	2,224	0	0	0	0
Wyoming	29	2,207	27	1,444	2	763	0	0
Colorado	88	16,068	83	12,182	5	3,886	0	0
New Mexico	46	3,318	44	3,051	2	267	0	0
Arizona	58	5,528	55	5,269	2	118	1	141
Utah	33	3,861	32	3,061	1	800	0	0
Nevada	20	1,623	20	1,623	0	0	0	0
Pacific	811	148,614	761	96,419	42	51,004	8	1,191
Washington	120	14,664	113	10,795	5	3,445	2	424
Oregon	86	14,435	81	10,065	4	4,191	1	179
California	560	115,133	525	72,121	31	42,456	4	556
Alaska	18	831	16	574	1	225	1	32
Hawaii	27	3,551	26	2,864	1	687	0	0
Other jurisdictions	101	10,376	95	6,925	3	2,394	3	1,057
American Samoa	1	145	1	145	0	0	0	0
Guam	1	199	1	199	0	0	0	0
Puerto Rico	94	9,826	88	6,375	3	2,934	3	1,057
Virgin Islands	5	206	5	206	0	0	0	0

[1] Excludes approximately 150 hospitals certified for participation, but not recorded in the provider record.
[2] Includes 4 Federal hospitals; excludes 17 Christian Science sanatoria.
[3] Short-stay and long-stay hospitals.
[4] Adult beds only; for psychiatric and tuberculosis institutions not accredited by the Joint Commission on Accreditation of Hospitals, only active care beds are included.

lems with respect to medical staff, pharmacy, nursing services, dietary arrangements, medical records, and physical environment.[4] State agencies are now in the process of assisting hospitals to upgrade their facilities, staff, or services so that their deficiencies will be reduced.

Table 1 gives the number of participating hospitals and beds by type of facility, geographic division, and State. Data are presented for the 6,526 hospitals that were recorded in the provider record as of September 30. The remaining 154 hospitals were certified but not recorded because the data were incomplete. Data on number and type of hospitals do not agree with those reported by the American Hospital Association in their annual guide issue [5] and by other agencies for several reasons. As indicated above, the group of hospitals participating under the Social Security Act excludes those denied and those not applying for certification. The American Hospital Association does not accept hospitals with less than six beds for registration; there is no such limitation for participation under the certification requirements. In addition, the participating hospitals include about 100 general hospitals that are actually distinct parts of psychiatric and tuberculosis hospitals not accredited by the Joint Commission on Accreditation of Hospitals and represent the active-care medical and surgical beds in these facilities. In some instances, active-care psychiatric units of the same hospitals may also be counted here as psychiatric hospitals. At the same time, a number of medical centers are counted as one hospital while, in other cases, different components of the medical centers are counted separately. Finally, only adult-care beds are reported by hospitals participating under the program.

HOSPITALS

The 6,526 hospitals recorded as participating include 1.2 million adult beds. General hospitals comprise 94 percent of the total and include 66 percent of the beds. Only 5 percent of the hospitals and 32 percent of the beds are in participating psychiatric hospitals. The remaining 1 percent of the hospitals and 2 percent of the beds are in tuberculosis hospitals.

Analysis of the hospital data by type of control shows that the vast majority of the general hospitals are nongovernmental and mainly under voluntary control. Of the 6,111 general hospitals participating under the program, 58 percent are voluntary hospitals and include 65 percent of the general hospital beds. Beds in local government general hospitals constitute 21 percent of the total (table 2).

As would be expected, the type of control in participating psychiatric and tuberculosis hospitals is different from that of general hospitals: 9 out of 10 psychiatric hospital beds and 6 out of 10 tuberculosis hospital beds are in State-owned facilities.

Participating psychiatric and tuberculosis hospitals also differ from participating general hospitals in terms of number of beds (table 3). The general hospitals are considerably smaller: about three-fifths have fewer than 100 beds, compared with less than one-fourth for the psychiatric and tuberculosis hospitals. More than half the psychiatric hospitals have 500 beds or over.

Hospital size varies considerably with type of

TABLE 2.—Health insurance for the aged: Number and percentage distribution of participating hospitals and beds, by type of control and type of hospital, as of September 30, 1966

Type of control	Number				Percentage distribution			
	Total [1]	General [2]	Psychiatric	Tuberculosis	Total [1]	General [2]	Psychiatric	Tuberculosis
	Hospitals							
Total	6,526	6,111	305	110	100.0	100.0	100.0	100.0
State [3]	440	192	196	52	6.7	3.1	64.3	47.3
Local	1,535	1,485	5	45	23.5	24.3	1.6	40.9
Voluntary	3,624	3,557	58	9	55.5	58.2	19.0	8.2
Proprietary	927	877	46	4	14.2	14.4	15.1	3.6
	Beds [4]							
Total	1,201,447	798,150	379,799	23,498	100.0	100.0	100.0	100.0
State [3]	428,686	62,168	353,464	13,054	35.7	7.8	93.1	55.6
Local	185,109	170,658	5,444	9,007	15.4	21.4	1.4	38.3
Voluntary	534,161	516,075	17,043	1,043	44.5	64.7	4.5	4.4
Proprietary	53,491	49,249	3,848	394	4.5	6.2	1.0	1.7

[1] Includes 4 Federal hospitals; excludes 17 Christian Science sanatoria.
[2] Short-stay and long-stay hospitals.
[3] Includes 4 Federal hospitals.
[4] Adult beds only; for psychiatric and tuberculosis institutions not accredited by the Joint Commission on Accreditation of Hospitals, only active-care beds are included.

[4] John W. Cashman, *Medicare: Standards of Service in a New Program—Licensure—Certification—Accreditation*, paper presented at the 94th Annual Meeting of the American Public Health Association, San Francisco, California, October 31, 1966.

[5] *Hospitals* (Journal of the American Hospital Association), Guide Issue, August 1, 1966.

TABLE 3.—Health insurance for the aged: Number and percentage distribution of participating hospitals, by size and type of hospital, as of September 30, 1966

Number of beds	Number				Percentage distribution			
	Total [1]	General [2]	Psychiatric	Tuberculosis	Total [1]	General [2]	Psychiatric	Tuberculosis
Total	6,526	6,111	305	110	100.0	100.0	100.0	100.0
Under 24	653	650	2	1	10.0	10.6	.7	.9
25–49	1,562	1,538	21	3	23.9	25.2	6.9	2.7
50–99	1,622	1,547	52	23	24.9	25.3	17.0	20.9
100–199	1,275	1,192	43	40	19.5	19.5	14.1	36.4
200–299	609	575	20	14	9.3	9.4	6.6	12.7
300–399	303	286	4	13	4.6	4.7	1.3	11.8
400–499	150	140	7	3	2.3	2.3	2.3	2.7
500 and over	352	183	156	13	5.4	3.0	51.1	11.8

[1] Includes 4 Federal hospitals; excludes 17 Christian Science sanatoria.

[2] Short-stay and long-stay hospitals.

hospital control (table 4). State hospitals are by far the largest, with 43 percent in the 500-or-over bed category. This category includes no proprietary hospitals and only 4 percent and 3 percent, respectively, of the local and voluntary hospitals. The smallest participating hospitals are proprietary, with 86 percent having fewer than 100 beds and one-fifth with fewer than 25. Local government hospitals are also relatively small, with nearly three-fourths in the less-than-100-bed category.

Home Health Agencies

About 1,400 home health agencies are certified for participation under the program. The provider record is still incomplete so that definitive data are available at this time only for 1,275 agencies, which are shown in table 5 by type of agency, geographic division, and State. Of the 1,275 agencies, 579 or 45 percent are official health agencies. Visiting nursing associations also represent a large proportion of the agencies—about 40 percent. Of the total agencies, "combination government and voluntary" agencies comprise 7 percent, hospital-based programs comprise 6 percent, and the remaining agencies, classified as "other," 2 percent.

Home health agencies must provide skilled nursing services and at least one other therapeutic service. The following tabulation summarizes the number of agencies offering specified therapeutic services.

Type of service	Agencies offering service	
	Number	Percent
Physical therapy	918	72.0
Occupational therapy	190	14.9
Speech therapy	287	22.5
Medical social service	260	20.4
Home health aide	455	35.7

Inpatient Hospital Claims Approved for Payment

Data relating to inpatient hospital claims for the first 3 months of the program, approved for

TABLE 4.—Health insurance for the aged: Number and percentage distribution of participating hospitals, by size and type of control, as of September 30, 1966

Number of beds	Number					Percentage distribution				
	Total [1]	State [2]	Local	Voluntary	Proprietary	Total [1]	State [2]	Local	Voluntary	Proprietary
Total	6,526	440	1,535	3,624	927	100.0	100.0	100.0	100.0	100.0
Under 24	653	41	195	221	196	10.0	9.3	12.7	6.1	21.1
25–49	1,562	12	498	710	342	23.9	2.7	32.4	19.6	36.9
50–99	1,622	44	424	895	259	24.9	10.0	27.6	24.7	27.9
100–199	1,275	70	213	887	105	19.5	15.9	13.9	24.5	11.3
200–299	609	42	79	466	22	9.3	9.5	5.1	12.9	2.4
300–399	303	27	44	230	2	4.6	6.1	2.9	6.3	.2
400–499	150	15	21	113	1	2.3	3.4	1.4	3.1	.1
500 and over	352	189	61	102	----	5.4	43.0	4.0	2.8	----

[1] Includes 4 Federal hospitals; excludes 17 Christian Science sanatoria.

[2] Includes 4 Federal hospitals.

payment as of October 15, 1966, are presented in table 6. Expenditures by the hospital insurance trust fund are reported elsewhere in this issue of the BULLETIN (table M–5, page 36). The amount reimbursed by the hospital insurance program, as shown in table 6, does not coincide with the amount for trust fund expenditures reported by the Treasury Department for the period. There

TABLE 5.—Health insurance for the aged: Number of participating home health agencies, by type of agency, geographic division, and State, as of October 15, 1966 [1]

Geographic division and State	Total	Visiting nurse association	Combination government and voluntary agency	Official health agency	Hospital based program	Other
United States	1,275	506	83	579	81	26
New England	325	243	8	60	12	2
Maine	13	10		3		
New Hampshire	28	23		2	2	1
Vermont	5	5				
Massachusetts	151	100	6	36	8	1
Rhode Island [2]	25	23		1	1	
Connecticut	103	82	2	18	1	
Middle Atlantic	212	107	9	76	19	1
New York	97	30	5	60	2	
New Jersey	52	29	2	14	7	
Pennsylvania [2]	63	48	2	2	10	1
East North Central	225	69	15	124	13	4
Ohio	89	20	8	59	2	
Indiana	17	7	1	7	1	1
Illinois	41	17	3	19	2	
Michigan	36	11	3	19	3	
Wisconsin	42	14		20	5	3
West North Central	87	18	7	46	14	2
Minnesota	25	3	1	18	3	
Iowa	14	10	3	1		
Missouri	13	3		4	4	2
North Dakota	6			5	1	
South Dakota	3			3		
Nebraska	4	1	1		2	
Kansas	22	1	2	15	4	
South Atlantic	124	18	29	70	3	4
Delaware	3	1			1	1
Maryland	25	1		23	1	
District of Columbia	2	1		1		
Virginia [2]	5	4		1		
West Virginia	15	2	1	12		1
North Carolina	12		2	9		
South Carolina [2]	1			1		
Georgia	10	1	2	6		1
Florida	51	8	24	17	1	1
East South Central	100	4		92	3	1
Kentucky	3	1			1	1
Tennessee	74	1		73		
Alabama	3	2		1		
Mississippi	20			18	2	
West South Central	23	5		18		
Arkansas [2]	2	1		1		
Louisiana [2]	2			2		
Oklahoma [2]	2			2		
Texas	17	4		13		
Mountain	44	4	9	24	6	1
Montana	7			5	2	
Idaho	7		2	3	2	
Wyoming [2]	5			5		
Colorado	12	1	6	4		1
New Mexico	1			1		
Arizona	5	2		2	1	
Utah	5	1		3	1	
Nevada	2		1	1		
Pacific	133	38	6	67	11	11
Washington	26	3	4	16	3	
Oregon	28	3		23	1	1
California	77	32	2	27	6	10
Alaska						
Hawaii	2			1	1	
Other	2			2		
American Samoa						
Guam	1			1		
Puerto Rico						
Virgin Islands	1			1		

[1] Excludes about 125 home health agencies certified for participation but not recorded in the provider record.

[2] For these States, approved applications submitted by the State Health Department include 400–500 local (mostly county) departments. Information identifying each of these local subunits is currently being collected.

TABLE 6.—Hospital insurance: Number of claims approved for payment, days of inpatient hospital care, and amount of payments, by month of claim approval and type of hospital, as of October 15, 1966

Month of claim approval [1]	Approved claims			Total hospital charges (in thousands)	Reimbursed by hospital insurance			
	Number	Days of care			Amount (in thousands)	Percent of total charges [2]	Per claim [2]	Per day [2]
		Total	Average per claim					
	Total inpatient hospital services [3]							
Total	387,413	4,015,081	10.4	$166,898	$130,186	78.0	$336	$32
July	33,014	221,508	6.7	8,690	6,409	73.8	194	29
August	221,625	2,234,951	10.1	92,857	72,531	78.1	327	32
September	132,774	1,558,622	11.7	65,351	51,246	78.4	386	33
	Short-stay hospitals [4]							
Total	384,481	3,949,551	10.3	165,017	128,501	77.9	334	33
July	32,927	220,706	6.7	8,666	6,390	73.7	194	29
August	219,555	2,189,480	10.0	91,613	71,407	77.9	325	33
September	131,999	1,539,365	11.7	64,738	50,704	78.3	384	33
	Long-stay hospitals [5]							
Total	2,816	64,694	23.0	1,854	1,667	89.9	592	26
July	84	774	9.2	24	19	80.9	227	25
August	2,068	45,461	22.0	1,243	1,123	90.4	543	25
September	664	18,459	27.8	587	524	89.3	790	28

[1] Month in which the intermediary approved the claim for payment.
[2] Based on unrounded figures.
[3] Includes 116 claims with type of hospital unknown.
[4] General and special hospitals with average stays of less than 30 days.
[5] General and special hospitals with average stays of 30 days or over; tuberculosis, psychiatric, and chronic disease hospitals; and Christian Science sanitoria.

NOTE: Includes only those claims approved and recorded in the Social Security Administration central utilization record before October 15, 1966.

are several reasons for this difference. Trust fund expenditures include—in addition to bills paid by intermediaries—current financing and emergency payments. Current financing is an optional financial arrangement for reimbursement to providers to pay on a current basis for hospital services incurred by beneficiaries. Computation for current financing payments is made quarterly and is based on provider operation experience for the last month of the preceding quarter. Intermediaries may disburse current financing payments up to the amount arrived at through these quarterly computations. Emergency payments represent special advancements to providers to cover cost of services actually provided but for which bills had not yet been processed by the intermediary. When the system has been in operation for a time, such advances should no longer be necessary.

In addition, the data reported in table 6 are based on the month in which the claim is approved by the intermediary and subsequently recorded in the Social Security Administration central utilization record. There is a short lag between the time that the claim is approved and the time of actual payment to the provider of service. Furthermore, not all the claims for the first 3 months had been received and recorded in the statistical tape record as of the time of summarization of the data. Corrected figures will be published later.

The following tabulation compares the monthly amounts reported for trust fund expenditures and for claims approved as of October 15, 1966, under the hospital insurance program.

[In thousands]

Month, 1966	Trust fund expenditures [1]	Inpatient hospital claims approved for payment [2]
Total	$271,389	$130,186
July	3,824	6,409
August	104,339	72,531
September	163,226	51,246

[1] Data from table M-5, page 36 of this issue.
[2] Amounts recorded in Social Security Administration central utilization record, as of Oct. 15, 1966.

Days of care as well as total charges and reimbursement data are reported in table 6. For the

first quarter of the fiscal year 1967, 387,413 inpatient hospital claims had been reported by October 15, 1966, as approved for payment by the intermediary. Almost all of these claims (99 percent) are for reimbursement for care in short-stay hospitals. As would be expected, the average number of days per short-stay hospital claim is considerably less than in the long-stay hospitals: 10.3 days compared with 23.0 days in long-stay hospitals (general and special hospitals with average stays of 30 days or over; tuberculosis, psychiatric, and chronic disease hospitals; and Christian Science sanitoria). As the program continues, average hospital stays will undoubtedly be greater because the claims presented here are only for the first quarter of the program's operation—a period not long enough to reflect many long stays.

Total charges for the 387,413 claims amounted to approximately $167 million. Almost four-fifths—78 percent—of the total hospital charges were paid by the hospital insurance program. The deductibles and noncovered items on the bill account for differences between total charges and reimbursed amounts. The actual amounts reimbursed to hospitals are based on interim per diem rates that will be adjusted in the future on the basis of actual reasonable costs.

The reimbursed amount per claim averaged $334 in short-stay hospitals and almost twice that amount in long-stay hospitals because of the considerably longer stays in the latter. Total charges averaged $29 per day in long-stay hospitals, compared with $42 per day in short-stay hospitals.

Because reimbursement by the hospital insurance program was only for inpatient care beginning July 1, average stays per claim approved in the program's first month were considerably shorter than for the next 2 months. For example, the average length of stay in short-stay general hospitals was only 6.7 days in July, compared with 10.0 days in August and 11.7 days in September. Average stays in long-stay hospitals in each of the 3 months reported show a similar pattern. July claims obviously included a considerable number of stays for aged persons who were in hospitals on July 1, and August claims also included some who were admitted before the effective date of the program.

The small number of inpatient hospital claims for the month of July—8.5 percent of the 3-month total—reflects the delays in transmittal of forms and claims at the beginning of the program rather than a small number of aged persons receiving inpatient hospital care during the month. Likewise, claims approved in September and recorded in the Social Security Administration tape record as of October 15 are 40 percent below the number for August because of the lags in reporting and recording the data. These data will be updated and revised each month and more complete information for the earlier months will be reported in future issues of the BULLETIN.

Analytical Studies

In addition to providing basic data on program operations on a recurrent basis, the statistical system has been designed to provide the basis for a variety of analytical studies to evaluate the program and measure its performance. These studies will be concerned with assessment of program operation and achievements in terms of the program goals: to protect the aged person against the catastrophic costs of hospitalization and illness and to provide quality hospital and medical care in the most efficient and economical manner.

The statistical system has been designed to make possible studies to analyze the utilization experience in relation to the demographic data available from the eligibility records, to the charges and costs of providers, and to carrier operations. Such studies will provide the knowledge necessary for appraising the program's attainment of its purposes and for determining the need for legislative changes to facilitate effective operation.

These studies can be categorized in three main groups: utilization and costs of health services, effectiveness of administration, and questions relating to specific provisions of the law. Several examples of the type of analytical studies to be undertaken are sketched below.

STUDIES OF UTILIZATION AND COSTS OF HEALTH SERVICES

The availability of a population base permits the calculation and presentation of a wide variety of utilization rates for population subgroups. In addition to the utilization data, the basic statistics

include data on total and covered charges for the various types of services. The potentialities for combining and cross-classifying utilization data by characteristics of beneficiaries and providers of services open new vistas for analysis and study of variations in patterns of use for hospital and medical services and the factors affecting such variation, including geographic and certain demographic differences.

The availability of statistical data on utilization of hospital and medical services for each individual beneficiary provides the opportunity for longitudinal studies of the patterns of covered services received by individuals over a period of time. Use of services by specific groups of individuals, beginning at age 65 (or the start of the program), can be followed and studied in terms of the characteristics of the beneficiaries and the type and extent of services received. A tie-in with the basic record system of the Social Security Administration will make possible a unique opportunity for analysis of the medical history after age 65 in relation to the person's work history in covered employment, age at retirement, and benefit status.

The considerable fund of data relating to the characteristics of the providers of service, their reimbursement rates, and the utilization of their services provides the basis for a variety of studies. Geographic differences in reimbursement rates will be analyzed in terms of the providers and the services provided. Studies will be undertaken to determine where beneficiaries in a given geographic area receive their medical services and where hospitalized persons come from.

STUDIES OF EFFECTIVENESS OF ADMINISTRATION

The central statistical system will provide the data required for a variety of studies of the program's administration. Under the hospital insurance plan each group of providers, or association of providers in behalf of their members, has nominated a national, State, or other public or private agency or organization to serve as fiscal intermediaries between themselves and the Federal Government. The intermediary determines the amount of payments due on receipt of bills from hospitals and other institutional providers and makes such payments.

Studies will be undertaken to analyze the operations of the intermediaries with respect to the effective operation of the program. Differences among carriers in their operating costs, methods of payments, procedures for claims review, billing lags, and other administrative responsibilities will be reviewed and analyzed in detail.

Where payment is on the basis of charges for physician services and medical and other health services, the intermediaries or carriers are to take action to assure that the charge on which the reimbursement is based is reasonable and not higher than the charge used for reimbursement in behalf of the carriers' own policyholders or subscribers under comparable circumstances. In determining reasonable charges, the carriers are to consider the customary charges for services generally made by the physician furnishing the covered services, as well as prevailing charges in the locality for similar services.

Analysis will be made of the geographic variation in actual charges for physician services for comparable procedures in relation to their characteristics and those of beneficiaries. The studies will give some clues on the extent to which the carriers are effectively carrying out this important function.

Hospitals and extended-care facilities participating in the hospital insurance program must have a utilization review plan in effect, providing for review, on a sample or other basis, of the following: admissions of beneficiaries of the hospital insurance program to the institution, length of stays, and the medical necessity for services provided. Statistical studies analyzing the variations in institutional stays for comparable diagnostic categories in terms of geographic location and types of institution will assist in evaluation of the utilization review process.

STUDIES RELATING TO SPECIFIC PROVISIONS

The 1965 amendments to the Social Security Act include several special provisions embodying unique concepts in health insurance programs, the effects of which will be studied and analyzed. For example, inpatient hospital and extended-care services within specified limitations are provided under the law for each spell of illness. The term "spell of illness" is defined as beginning the first day (not in a previous spell of illness) in which an individual is furnished covered inpatient hospital or extended-care services and ending with the

last day of the first period of 60 consecutive days during which he was not an inpatient in a hospital or extended-care facility. Studies of the impact of this requirement will be made in terms of the average duration of spells of illness, number of beneficiaries who exhaust benefits during single spells of illness, average duration of time between exhaustion of benefits and beginning of a new spell of illness, and the proportion of total costs of care in hospitals not covered because of the spell-of-illness concept.

Payments to providers of service under the hospital insurance program are made on the basis of reasonable costs for the services furnished. The costs of services in hospitals and extended-care facilities vary widely from one institution to another, reflecting differences in quality and intensity of care. Reimbursement rates and the method for determining reasonable costs will be analyzed in terms of geographic variations, type of facilities, and services provided.

One of the conditions of participation for an extended-care facility is that it must have a transfer agreement with at least one participating hospital (except under special circumstances). A transfer agreement is one that provides, in writing, for the transfer whenever such action is medically appropriate, as determined by the attending physicians. Analysis will be made of the various types of transfer agreements, the implementation of this requirement on a geographic basis, and its effect on patterns of care received under the program.

There is a lifetime limit of 190 days of covered services in psychiatric hospitals. Psychiatric care in general hospitals, however, does not count against the 190-day lifetime limit. Statistical study will be undertaken to determine the number of persons who exhaust these benefits, the number and extent of psychiatric services in general hospitals, and emerging trends in this area.

REPORTING PLANS

Many of the analytical studies described above cannot of course be carried out until the health insurance program for the aged has been in operation for some time. On the extent of services and on charges, the Current Medicare Survey is designed to yield program data on a national basis in advance of the detail to be obtained from the record. Current plans for reporting these survey data as well as basic data on program operations include publication of monthly, quarterly, and annual data in the BULLETIN and in special releases and reports by the Office of Research and Statistics as the data become available and the studies are completed.

The need for statistical data by agencies, organizations, and researchers outside the Social Security Administration will also be taken into account in our tabulation plans. In reporting all program data, the Social Security Administration's general policy relating to confidentiality will be continued. Information will not be released identifying individual beneficiaries and their specific utilization of services under the program.

The health insurance program for the aged will have a significant impact on the entire structure of the organization and financing of health services in the country in addition to its impact on the ability of the aged individual beneficiary to meet the costs of needed hospital and medical care. The broad scope of benefits affecting this large population group and the financing of these benefits will require substantial adjustments in the entire system of health services, involving not only the aged beneficiary but the remainder of the population. In addition to the analytical studies outlined above, a broad research program will be undertaken to measure the impacts on both public and private programs, identify and define program gaps and unmet needs, and examine and evaluate the economic consequences of the program.