Health Insurance Coverage Complementary to Medicare

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MORE THAN 10 million aged persons are covered under policies or contracts of private health insurance organizations for benefits that complement the benefits under the Federal program of health insurance for the aged (Medicare). This article describes the coverage offered by the various types of health insurance organizations.

BLUE CROSS AND BLUE SHIELD PLANS

Before the establishment of Medicare, the Blue Cross and Blue Shield plans together covered approximately 6 million aged persons for hospital care and a slightly smaller number for surgery and in-hospital physician visits. About 60 percent of those covered came under nongroup contracts, and 40 percent were under group contracts.

As of January 1, 1967—6 months after Medicare began operations—these plans covered nearly 5 million aged persons for hospital care and at least 4.5 million for physician services, two-thirds of them under nongroup contracts and the rest under group contracts.[1]

All Blue Cross and Blue Shield plans have offered benefits complementary to Medicare on a group basis and virtually all on a nongroup basis. Benefits under the two types of contracts are similar.

Nongroup Contracts

The following analysis of nongroup contracts is based upon copies of contracts of the individual plans supplied to the Office of Research and Statistics by the Blue Cross Association and the National Association of Blue Shield Plans. It relates to contracts received as of January 1, 1967, and includes all but two of the 75 Blue Cross plans in the United States and all but eight of the 73 Blue Shield plans in this country. The other plans either had not issued contracts by this date or had not sent copies of these contracts to the central organizations.

Of the 135 nongroup contracts included in the analysis, 49 were issued separately by Blue Cross plans, 38 separately by Blue Shield plans, and 48 jointly by cooperating or paired Blue Cross and Blue Shield plans. Eighty-one of the 106 plans or pairs of plans offering contracts issued only one contract, 22 issued two contracts, 2 offered three contracts, and 1 issued four contracts.

Where a Blue Cross plan has offered a contract independently, the benefits generally complement the hospital insurance program (Part A of Medicare). Where a Blue Shield plan has issued a contract independently, the benefits complement the supplementary medical insurance program (Part B). Contracts issued jointly by cooperating or paired Blue Cross and Blue Shield plans complement both Part A and Part B. Also offering contracts that supplement both parts of the program are those Blue Cross plans not affiliated with a Blue Shield plan and those Blue Shield plans not affiliated with a Blue Cross plan that offer both hospital and medical benefits to their subscribers. The distribution of the 135 contracts by the part of Medicare complemented is as follows:

Type of plan	Total number of contracts	Contracts complementing—		
		Mainly Part A	Mainly Part B	Parts A and B
All plans	135	43	25	67
Blue Cross	49	39	----	10
Blue Shield	38	----	24	14
Blue Cross-Blue Shield	48	4	1	43

In general, the contracts tend to fall into two groups—those that provide a basic "first dollar" coverage and those that use a "major medical" approach and cover a certain percentage of illness expense above a deductible amount. Of the total,

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[1] These figures include a small number of the aged who retained their regular health insurance coverage because they wanted protection for dependents under age 65.

112 are in the first group; 13 provide both basic and supplementary major medical benefits; and 10 are the comprehensive major medical type.

Contracts complementary to Part A of Medicare.—In all, 110 contracts complement in some way the hospital insurance provisions of Medicare. Ten of these are of the comprehensive major medical type and one provides a stipulated amount for each day of hospital confinement.

Medicare's $40 in-hospital deductible is covered in full by 95 of the 99 contracts providing basic benefits; two other contracts cover the deductible in part. All but two contracts pay the $10 per day coinsurance amount for the 61st to the 90th day of hospital care. Fifty-three contracts provide additional days of hospital care, generally 30 days, beyond the 90 provided under Medicare. Two plans—those for Massachusetts and Delaware—provide 275 additional days of hospital care under the more comprehensive of their contracts.

Part A of Medicare covers hospital outpatient care for diagnostic studies but not for treatment. Virtually all the basic benefit contracts provide some outpatient benefits for care of accidental injury. Most of them stipulate that such care must be given within a certain number of hours (commonly 72) of the accident. Forty-two provide outpatient care for emergency illness such as a stroke, sunstroke, heart attack, or diabetic coma. Eighty-six contracts cover outpatient care for minor surgery—that is, charges for use of the operating room.

Forty-two contracts provide some benefits for one or more types of therapy on an outpatient basis. Radiation therapy is most commonly provided, and physical therapy is next in frequency. A few contracts cover shock therapy or cobalt therapy. Twelve contracts cover all types of therapy that the hospital is equipped to provide on an outpatient basis. These benefits are usually limited to continued care of the condition for which the patient had been hospitalized.

Fifty-nine of the basic benefit contracts provide for full payment of Medicare's $20 deductible for outpatient diagnostic studies, and three more pay part of this deductible. Fifty-five contracts cover the 20-percent coinsurance.

Benefits in extended-care facilities are provided by 41 contracts. Of these contracts, 35 pay the $5 a day for the 21st to the 100th day of care and 13 pay all or part of the cost of additional days of care beyond 100. Most of these 13 contracts provide a dollar allowance ($5–$12) against the cost of care for a specified number of days (30–260). A few pay the full cost of care for an additional 20 or 60 days, and some provide additional days but require the patient to pay $5 a day toward the cost.

Prescribed drugs outside the hospital are covered to some extent under nine of the basic benefit contracts, all of which pay 80 percent of the charges incurred for drugs above a deductible of $10 to $25, within a specified period after discharge from the hospital. Under most contracts the drug must have been prescribed in connection with the condition for which the patient was hospitalized.

Private-duty nursing is covered to some extent under five of the 99 contracts. The benefit provided is 80 percent of the charges incurred up to specified maximums in terms of dollars, hours of nursing, or both.

Most of the 13 contracts that offer both basic and supplementary benefits provide additional coverage of hospital care and some care in extended-care facilities by paying a specified portion of the cost (usually 80 percent) above a deductible—typically, $100.

Contracts complementary to Part B of Medicare.—Ninety-two contracts provide some coverage that complements the medical benefits under Medicare. Of these, 22 that cover physician services only on a major medical basis are discussed later. Eight other contracts provide only an indemnity allowance ($3, $4, or $5) for each day of care while the person was in the hospital. The remaining 62 contracts pay all or part of the $50 deductible for medical insurance and all or part of the coinsurance amount for surgery and in-hospital physician visits. Thirty-three of these contracts provide full coverage of both the deductible and coinsurance amounts, 21 cover fully only the coinsurance amount, five cover fully only the deductible, and the rest pay part of one or the other or both.

Thirty-one of the 62 contracts also pay the deductible or coinsurance amounts for X-ray diagnosis and radiation therapy in the office and/or hospital outpatient department. Some of these

contracts also cover the deductible and coinsurance on emergency care charges for visits either to a hospital outpatient department or to a physician's office or for both types of visits. Twelve contracts cover all types of physician services, including office and home calls. Of these, four pay both the deductible and coinsurance amounts; five pay just the coinsurance; the rest pay some part of either the deductible or coinsurance or both.

Contracts using a "major medical" approach.—A major medical approach is used in part or in whole by 23 contracts, one of which covers only hospital care. Twelve of the remaining 22 provide some basic benefits complementary to Part A of Medicare—that is, they pay all or part of the $40 deductible and the 20-percent coinsurance amount; they then cover expense for additional hospital care and charges for physician services and appliances on a major medical basis, paying 80 percent of the charges above a deductible (generally $100). The payment that the insured person makes out of pocket for the deductible and coinsurance amounts under Part B of Medicare is included as reimbursable expense. Thus, after the deductibles are taken care of, Medicare and the complementary coverage together would pay 96 percent of physicians' reasonable charges —80 percent through Medicare and 80 percent of the remaining 20 percent through the complementary coverage.

Ten contracts provide all their benefits on a major medical basis, paying 80 percent (in one case, 75 percent) of covered expense above a deductible of $100 (in a few cases, $50). Covered expense includes expenses not paid or reimbursed by Medicare for hospital care, physician services, and, to some extent, drugs (six plans), appliances (six plans), private-duty nursing (six plans), and care in extended-care facilities (four plans). Maximum lifetime benefits under these plans, as well as under the supplementary major medical plans, are in most cases $10,000.

Coverage outside the United States.—Most contracts provide for some coverage of medical care expenses outside the United States. Medicare does not cover these expenses at all. Ninety-eight of the 135 contracts provide at least some coverage, and 31 of these provide less coverage outside the United States than they do within the country by paying only a specified percent of covered charges or by imposing limits on the number of days of hospital care or the aggregate dollar amount of benefits. A few stipulate that benefits will not be furnished if the subscriber has been out of the United States for more than a specified period, say 6 months.

Exclusions and limitations.—Almost half (59) of the 135 contracts exclude benefits for preexisting conditions until after a certain number of months of enrollment. Under the majority of these contracts this waiting period is 6 months; under the others, 3, 10, 11, or 12 months. A few contracts impose a waiting period for benefits for other specified conditions, notably care for hemorrhoids, hernias, and diseases not common to both sexes. Probably most of the holders of these nongroup complementary contracts had Blue Cross-Blue Shield coverage before Medicare and they would not be affected by such restrictions.

Many contracts limit benefit days for care of mental illness or for care in psychiatric hospitals to fewer than the number provided for general illness. Fifteen contracts exclude all benefits for care in mental and tuberculosis hospitals.

Subscription charges.—Most contracts issued singly by Blue Cross, mainly complementing Part A of Medicare, cost between $2 and $3 a month. This is also the most frequent charge for the separate Blue Shield contracts complementing Part B. Most contracts written jointly by Blue Cross and Blue Shield plans and complementing both parts of Medicare cost between $4 and $6 a month.

The following tabulation shows the monthly nongroup subscription charges for these contracts:

Monthly cost	Contracts complementing—		
	Mainly Part A	Mainly Part B	Parts A and B
Total number of contracts	43	25	67
$1.00–1.99	7	7	0
2.00–2.99	25	10	6
3.00–3.99	5	5	7
4.00–4.99	4	2	22
5.00–5.99	1	0	19
6.00–6.99		1	9
7.00–7.99			4
Unknown [1]	1		

[1] Information on cost not available; contract subsequently withdrawn.

Many aged persons with Blue Cross-Blue Shield complementary coverage complain that they are paying for these contracts almost as much as they were paying for their Blue Cross-Blue Shield coverage before Medicare. In some cases, this is true. The explanation is probably not that these complementary contracts are overpriced, but that before Medicare the aged members of Blue Cross and Blue Shield plans were being heavily subsidized by the younger members. The 40 percent of all aged members of these plans who had group coverage in many cases had been paying only one-third to one-half the cost of the care utilized. Aged persons who were formerly covered under group conversion contracts, on which the plans generally lost money, were also being heavily subsidized by the younger members. Under the present complementary contracts the aged, for the first time, are being asked to pay their own way.

The subscription charges for the complementary contracts are distinctly lower than the rates at which the Blue Cross-Blue Shield plans offered initial nongroup enrollment to older persons before Medicare. In 1962–63 the Blue Cross-Blue Shield plans made a national effort to offer a good level of protection to older people. Under the initial nongroup enrollment programs offered, the combined Blue Cross-Blue Shield charges ranged from $6.00 to over $16.00 per month, with a majority costing between $8.00 and $14.50 per month.[2] Financial experience alone can measure whether the present nongroup complementary contracts are fairly priced.

Group Contracts

The complementary benefits made available to aged persons under group contracts are similar to those under nongroup contracts. Blue Cross and Blue Shield plans tailor their contracts to provide what groups, especially large groups, desire.

Generally, the employer or union wants to provide identical benefits for all members of the group. Where the group's benefits were broader than benefits under Medicare in important respects—for example, full hospital care for 180 or 365 days and service benefits (at least for those under a specified income level) for surgery and in-hospital physician visits—the general practice, the Blue Cross Association reports, has been for the group to provide the same benefits to older employees and covered annuitants, with Medicare benefits "carved out." Under this arrangement, Medicare is in effect the primary carrier for aged members, and the group plan simply pays for the benefits not paid for by Medicare. Under this arrangement in large experience-rated groups, no price is put upon the complementary coverage provided to older members. The experience on them is simply melded into that for the group as a whole.

Where the group's coverage was generally less extensive than that of Medicare, some employers terminated coverage for older members, and the plan then made its nongroup complementary coverage available to these persons on a direct-payment basis.

In other cases, particularly in moderate or smaller groups with benefits not markedly greater than those under Medicare, the employer or union continued its former coverage for the younger members and provided to the older members, on a group basis, benefits identical with the plan's nongroup complementary coverage, described above. In such a case, the subscription rate for the older person was generally somewhat less than the plan's nongroup rate.

Summary

In general, the Blue Cross and Blue Shield complementary coverage mainly fills in the gaps between Medicare and the usual Blue Cross-Blue Shield coverage. Only to a moderate degree do the plans offer benefits that go beyond those that had been previously offered.

Blue Cross and Blue Shield plans have moved steadily toward the provision of more comprehensive benefits—X-ray and laboratory service outside the hospital, physician's office and home visits, visiting-nurse service, nursing-home care, and drugs. In some cases this broadening of benefits has been accomplished by extension of

[2] Louis S. Reed, *Blue Cross-Blue Shield Nongroup Coverage for Older People*, Research Report No. 4, Office of Research and Statistics, Social Security Administration, 1963.

basic benefits, in other cases through extended-benefit or supplementary major medical programs. The complementary coverage shows a cautious continuation of this trend.

Although most of the contracts do not depart from familiar territory, a few do go far toward providing comprehensive health coverage. Notable in this respect is the most comprehensive of the three contracts offered jointly by the Massachusetts Blue Cross and Blue Shield plans. This contract provides—in addition to paying the deductible and coinsurance amounts under Part A of Medicare and for surgery, in-hospital physician visits, and continued physician care in the office and in the home after hospitalization—275 added days of hospital care, an allowance of $8 a day for 265 additional days' care in extended-care facilities, and some coverage of charges for drugs and private-duty nursing and for care outside the United States.

One feature of these complementary contracts requires additional comment—their complexity. Many aged persons would find it difficult to understand what the contracts offer. Contracts that must exclude Medicare benefits, fill in gaps, or extend additional benefits probably cannot fail to be complex.

INSURANCE COMPANIES

Before Medicare, insurance companies covered approximately 6.2 million persons aged 65 and over for hospital expense—about one-third of them under group policies and two-thirds under individual policies, with some having both types.[3] On the basis of its 1967 surveys of insurance companies, the Health Insurance Association of America estimates that at the end of 1966, 4.9 million aged persons had hospital expense protection from insurance companies—2 million under group policies and 2.9 million under individual policies. The Association concludes tentatively that few aged persons have both group and individual coverage or more than one individual policy.

[3] The Health Insurance Association of America has estimated that, at the end of 1963, 2.6 million aged persons were insured under group policies and 4.4 million under individual policies. Adjustment for persons holding more than one policy brought the net number of different persons covered to 6.2 million.

Individual Policies

Most of the larger writers of individual health insurance policies have continued to offer some coverage to older persons. One very large company has offered such coverage only to persons who were previously insured by it whose coverage was reduced or terminated with the introduction of Medicare. Insurance companies have liquidated the cooperative programs (the "State 65" plans) that they had in a few States for offering coverage to older persons before Medicare. These plans had about 250,000 aged persons enrolled on the eve of Medicare.[4]

A recently published report of the Health Insurance Institute describes new individual health insurance policies made available, as of July 1966, to persons aged 65 and over.[5] The report lists 59 companies that have offered "hospital-patient income plans." The common feature of these plans is that they pay the insured person a stated amount for each day of a hospital confinement, which "may be used to pay for hospital services not covered by Medicare or to take care of the many personal expenses of a hospitalization."

Typical benefit amounts are $5 or $10 a day, $50 to $100 a week, and $100 to $500 a month. Most of the plans provide benefits for up to a year, a few for 6 months or 90 days. A number of companies, in recognition of the coinsurance under Medicare after 60 days of hospitalization, pay a smaller amount for 1–60 days of hospitalization and then a larger amount for each day thereafter. A few plans pay the $40 deductible. Most commonly, the plans pay a flat amount per day or week for each day of hospitalization.

More than half of the companies provide, under one policy or another, additional benefits that are generally optional at a higher rate. Most common are benefits for nursing-home care, for which benefits of $5.00 or $7.50 a day for 60 or 90 days are frequently paid. A number of companies offer other benefits—reimbursement of surgical expense, for example, and, less frequently, benefits for outpatient care or private-duty nursing.

[4] *Blue Cross and Other Private Health Insurance for the Elderly, Hearings before the Subcommittee on Health of the Elderly of the Special Committee on Aging, U. S. Senate* (part 4A, appendix B), 1964.

[5] *Report on New Health Insurance Policies of Insurance Companies Available to Those 65 and Over—as of July 1, 1966.*

About half the companies have no age limits for applicants for insurance; others have an entrance age limit of 70, 75, or 80. In general, only aged persons considered to be in reasonably good health would be accepted or known health conditions would be waived. Some policies are guaranteed renewable for life; some are renewable at the option of the company; others are continuable unless terminated for all residents of the State.

Nine companies are listed as providing "medical expense reimbursement plans (while in-or-out of the hospital)." These plans provide a stated dollar amount for each day of hospital care or a stated percentage of hospital expense during the hospital stay, with benefits arranged so that the plan does not pay charges covered by Medicare. Most of the plans provide fairly comprehensive benefits, generally on a major medical basis and pay 80 percent of covered expense above the Medicare deductibles plus a $50 or $100 deductible. After the deductibles are satisfied, these plans together with Medicare would pay 96 percent of the reasonable charges for physician services, for example.

The principal offerings of three of the largest writers of individual accident and health insurance—Mutual of Omaha, Bankers Life and Casualty, and Continental Casualty—are described in some detail below.

Company A's principal plan provides a benefit of $100 a week for 26 weeks at an annual premium of $111.60 ($9.30 a month), $122.40, or $133.32, depending on State of residence. Riders changing the benefits to $50 or $150 a week are available at equivalent rates. Preexisting conditions are covered after one year. The policy is offered to all aged persons irrespective of state of health, and the company may not refuse to renew the policy or may not change the premium unless like action is taken for all persons of the same classification in the State.

Another policy, available at a cost of $57 a year, pays the first $40 of hospital expense; $10 a day for the 61st to the 90th day; $25 a day for hospital room and board and 80 percent of expense for ancillary services for care after the 90th day; $5 a day for care in extended-care facilities from the 21st to 100th day; and the first $20 and 20 percent of subsequent charges for outpatient hospital diagnostic services.

Company B insures the majority of its aged policyholders under a policy that pays for each hospital confinement in a general hospital the first $40 of hospital expense, $10 a day of covered expense for the 61st through 90th day, and 80 percent of covered expense from the 91st through 365th day—all subject to a lifetime benefit maximum of $10,000 per insured person. Covered expenses are hospital board and room up to $25 a day and other necessary hospital services, not including services of physicians. Before Medicare became effective, this policy was originally offered to all aged policyholders, who were urged to change over to it. The charge is $3 a month for persons aged 65–69, $3.50 for those aged 70–74, and $4 a month for those aged 75 and over. The policy is guaranteed renewable at rates that apply to all persons of specified aged groups in the State of residence.

Other featured policies pay $50 a week or $100 a week during hospitalization. Preexisting and a few specified conditions, including mental illness and heart disease, are excluded. Standard risks between age 65 and age 69 pay a premium of $8.80 a month, and the premium goes up $1 a month for each next older 5-year age group. Persons with known health conditions—overweight, diabetes, heart trouble, and the like—may be accepted at higher premiums.

Company C has two principal plans, one of which pays $70 a week for 52 weeks at a cost of $8 per month and another that pays $110 a week for 52 weeks at a cost of $12.50 per month. The insured is covered immediately for accident or sickness, but for preexisting conditions there is a 6-month waiting period. Hospital care for mental illness is excluded except for the first 13 weeks of confinement with a 26-week lifetime maximum. Benefits for out-of-hospital drugs, out-of-hospital private-duty nursing, and nursing-home care are available at an additional cost.

Policies paying a stipulated amount per day of hospitalization have the advantage of administrative simplicity—the company need not find out what Medicare has paid or will pay. Such policies are also readily understood by the prospective purchaser or policyholder. They have the drawback that under some circumstances they may encourage excessive hospital utilization, since the insured person gets a specified amount for each day he stays in the hospital.

Group Coverage

All or virtually all companies writing group health insurance are offering coverage complementary to Medicare. They must offer such coverage if insured groups are to be retained or new groups to be acquired.

Under group insurance a company will write virtually any plan that a large employer or union welfare fund desires. In general the employer or union wants to provide benefits to aged active employees and their dependents (and to retired aged employees and their dependents, if that is desired) that will usually equal those available to younger employees. It is generally felt that aged covered persons should not suffer, because of Medicare, any loss of benefits formerly available to them under the general program. Thus, where the group's coverage is broader than that of Medicare in significant respects, the employer or welfare fund will wish to supplement Medicare benefits to bring them up to the level of those for active employees. Naturally the form of this supplementation tends to depend on the general nature of the group's plan—that is, whether it provides basic (first dollar) benefits, comprehensive major medical benefits, or some combination of basic plus supplementary major medical benefits.

Where the group's overall coverage is less extensive than that of Medicare and the employer does not wish to "beef it up" to make it more or less comparable with Medicare, the employer will usually terminate coverage for aged persons.

Most companies have developed coverage of a more or less standard pattern, supplementing either their basic or their major medical plans. One large company offers, to groups having a 70-day basic hospital plan, coverage supplementing the hospital benefits of Medicare that pays the $40 deductible and the coinsurance amount for the 61st to 70th day; the initial premium for this coverage is 91 cents a month. A 120-day hospital plan can be supplemented by coverage that pays the deductible, $10 for the 61st to 90th day, and a daily benefit in amounts ranging from $10 to $35 for the 91st to 120th day; the initial charge varies from $1.18 to $1.39 a month depending on the amount of the daily benefit. In both cases, as is the general practice for large groups, after, the cost for this coverage would be experienced-rated with that for the group as a whole.

For groups with a basic surgical coverage, coverage complementary to the medical benefits of Medicare is available that pays 30 percent of the scheduled amount under the present surgical schedule; the initial premium varies from 24 cents a month for a $150 surgical schedule to 52 cents a month for a $500 schedule.

For groups having a comprehensive major medical expense plan (but no basic coverage), the standard complementary coverage offered pays 80 percent of covered expenses, after an initial deductible of $50, $100, or $150 for private-duty registered nurses, out-of-hospital prescribed drugs, and the first three pints of blood. The initial premium ranges from $3.78 to $2.65 per month depending upon the deductible. The assumption here, clearly, is that Medicare coverage of all other types of expense is good enough and requires no supplementation. It will be noted that claims under all these plans can be administered without reference to what the aged person has received or will receive under Medicare.

Another large company usually recommends a major medical type of coverage that pays 75 or 80 percent of covered expenses beyond those paid by Medicare and a calendar-year deductible of perhaps $100. Covered medical expenses include nursing, drug, hospital, and physician charges. There is a lifetime benefit maximum of $5,000, subject to restoration on the basis of proof of insurability. Prices vary with the geographical area, but a typical first-year premium is about $7 a month.

One major company's standard Medicare supplement pays 80 percent of covered medical expenses above a $50 deductible in any calendar year and up to a maximum benefit of $5,000. Covered medical expenses include essentially all inpatient hospital expenses not covered by Medicare, charges for private-duty nurses, and expenses for drugs and medicine. Optional, more comprehensive benefit features available include coverage of physician charges, to the extent that such charges are not paid by Medicare because of application of the medical benefit deductible; 20-percent coinsurance charges for physician services under the medical insurance part of Medicare; actual hospital charges for outpatient services; coverage of private-room charges up to certain amounts. The charges for the standard

Medicare supplement begin at about $2.69 in the lowest-cost area with a $100 deductible and go as high as $13.80 in the highest-cost area, with a $10,000 benefit maximum and the most comprehensive benefit features available.

All companies will also provide complementary coverage on a "benefit offset" formula, under which expenses paid by Medicare are deducted from similar benefits payable under the group's regular health insurance plan. The insurance companies have not encouraged this approach because it presents difficult claims administration problems. Many companies have bought this approach, however, because of their bargaining agreements or other reasons.

Another approach followed by some policyholders is to continue existing benefit plans without change for persons aged 65 and over. These policyholders rely on the application of the "government exclusion" clauses or "coordination with other benefits" provisions to integrate the benefits of their existing plans with those provided by Medicare. In plans with a "government exclusion" clause, the described benefits of the plan apply to all expenses not paid for by Medicare. When a plan relies on the "coordination" provision the regular benefits that would have been payable in the absence of Medicare are reduced only to the extent necessary to prevent the individual from collecting more than 100 percent of all medical expenses covered either by Medicare or the policyholder's plan. Both these arrangements are rather liberal and result in a combined plan (Medicare and the policyholder's) that provides benefits at a level approaching 100-percent reimbursement of most medical expenses.

INDEPENDENT PLANS

Before Medicare, the "independent" health insurance plans (all plans other than Blue Cross, Blue Shield, and insurance companies) covered at least 435,000 persons aged 65 and over for hospital care and about 500,000 for one or more types of physician services.[6]

Preliminary data from the 1967 survey of the larger independent plans indicate that the number of aged persons covered at the end of 1966 was smaller by 10–20 percent. About one-third of those covered are members of community plans, and about two-thirds belong to employer-employee-union plans.

Community Group-Practice Plans

About 75 percent of the total enrollment in the community plans is in eight large group-practice plans—the Kaiser Health Plans of Northern and Southern California, Oregon, and Hawaii; the Health Insurance Plan of Greater New York; Group Health Cooperative of Puget Sound (Seattle, Washington); Community Health Association (Detroit); and Group Health Association (Washington, D. C.).

All these plans provide comprehensive coverage of hospital care and physician service.[7] Some also provide (to all or some of their subscribers) other benefits—visiting-nurse service, for example, drugs, and private-duty nursing in the hospital. In general, these plans offer to aged persons their regular benefits with the Medicare benefits "carved out," usually at rates lower than those paid by other subscribers, and the plans are reimbursed by Medicare for their estimated costs in providing those services for which Medicare assumes responsibility.

The Northern California Kaiser plan provides to aged subscribers entitled to hospital and medical benefits under Medicare, with the subscriber paying the $3 monthly supplementary medical insurance charge: (a) all necessary physician services at a charge of $1 for each office visit and a charge for each home visit equal to 20 percent of the prevailing rates; (b) all necessary hospital care for up to 111 days of care in each spell of illness; (c) physicial checkups, hearing tests, and eye examinations for glasses at a charge of $1 per visit; (d) out-of-hospital prescribed drugs at reduced charges; (e) immunizations at no charge; (f) prescribed private-duty nursing during covered hospitalization; (g) post-hospital care in extended-care facilities at no charge for 50 days (with the plan paying the $5 a day for the

[6] These estimates are based on the 1966 survey of the larger independent plans, made by the Office of Research and Statistics, in which the plans were asked to report the number of persons aged 65 and over who were covered at the end of 1965.

[7] One plan—the Health Insurance Plan of Greater New York—does not provide hospital care, but subscribers are required to have this coverage from other sources.

21st–50th days) and at $5 a day for the remaining 50 days; (h) 200 home health services at no charge; and (i) 80 percent of charges for appliances and rental of durable medical equipment.

The plan is reimbursed by Medicare for its estimated costs in furnishing that part of these services to which the subscriber is entitled under Medicare. The charge of this complementary coverage is $5.60 a month for group subscribers —slightly more for individual subscribers. The other Kaiser plans have roughly similar arrangements.

The Health Insurance Plan of Greater New York provides complete physician service to its subscribers, including service in extended-care facilities, physical checkups, immunizations, and eye examinations. Aged persons who are covered for both parts of Medicare and have complementary coverage are entitled to the same services, for which the charge is $1.50 a month for group enrollees, $5.45 per quarter for direct-payment enrollees who enrolled before Medicare, and $9.95 per quarter for individuals who enrolled after the start of Medicare.

Group Health Cooperative of Puget Sound provides its regular benefits to persons aged 65 and over. These benefits include complete hospital care for 180 days; complete physician services in the hospital, clinic, home, and extended-care facility; all out-of-hospital prescription drugs; special-duty nursing in the hospital; and authorized ambulance service in the area. The charge for the complementary coverage is $6 a month to Cooperative members and $6.75 to others. The plan's regular subscription charges for adult members are $9 a month, and its charges to persons aged 65 and over who are not covered by both parts of Medicare are $13.50 a month.

Community Individual Practice Plans

There is only one large plan of this nature—Group Health Insurance, Inc. (New York City). Its most popular types of coverage are the "semiprivate" and "family doctor" plans. The first covers surgery, in-hospital medical visits, diagnostic X-ray and laboratory examinations in the office, home, and hospital, and visiting-nurse service. Participating physicians (almost 10,000 in the metropolitan area) agree to accept the plan's payments as full payment if, in case of hospitalization, the subscriber uses ward or semiprivate accommodations. The family doctor plan provides the same services plus physician's office and home visits, including preventive care. Participating "family doctors" (usually general practitioners) accept the plan's payments for office and home calls ($4 and $6, respectively) as full payment for their services; other physicians may charge extra. The regular rate for the individual subscriber is $1.65 a month for the semiprivate plan and $3.90 for the family doctor plan. Both plans are offered on a group basis, and groups of more than 100 members are experience-rated after the first year.

Groups may elect to have their aged members who are eligible for both parts of Medicare receive complementary coverage—in effect, the benefits described above with relevant Medicare benefits "carved out." In the first year, the group's rates are reduced by 1 percent if the aged persons are covered at the so-called "Medicare reasonable charge" level and by 1½ percent if aged persons are covered at the plan level of payment; after the first year, the rates are based on the experience of the group as a whole.

Employer-Employee-Union Plans

About 500 plans are operated by employers, union-management welfare funds, employee benefit associations, and unions. Some 20 of the larger plans have about one-half the total enrollment. The complementary programs of a few of the larger ones are described here.

The United Mine Workers Welfare and Retirement Fund provides, in combination with Medicare, fairly comprehensive medical care to aged beneficiaries. The beneficiaries must have enrolled for Medicare's medical benefits in order to receive any UMW health benefits, which include unlimited care in hospitals and nursing homes, physician services in the office, home, and hospital (including routine physical examinations and immunizations), outpatient diagnostic service, out-of-hospital prescription drugs, and eyeglasses for cataract cases. These benefits are considerably broader than those furnished to beneficiaries under age 65 by the plan. The plan is considered by Medicare to be a group-practice plan and is reimbursed for its costs in providing Part B benefits to aged beneficiaries.

The Health Plan of the National Association of Letter Carriers—serving about 24,000 aged persons—is one of the employee organization plans providing benefits under the Federal employees health benefits plan. Most of the aged persons served are not eligible for hospital care under Medicare; some have enrolled for medical benefits under the program and some have not. This plan pays the first $3,000 of hospital charges for room and board, the first $1,000 of other hospital charges, and 80 percent of all subsequent charges. It pays actual charges up to specified scheduled allowances for surgery ($400 maximum) and, after the member has paid the next $200 of the surgical charge, 80 percent of the balance of any additional customary and reasonable charges. For all other medical expense (physicians' charges for other types of services, prescribed drugs, private-duty nursing, artificial limbs, etc.) it pays, in each calendar year, 80 percent of charges above a $50 deductible, up to a maximum of $15,000.

Aged persons, notwithstanding eligibility for Medicare benefits, pay the same rates as younger members and receive the same benefits. (Under the Federal Employees Health Benefits Act, approved plans may offer benefits at only two rates—one for the employee or annuitant alone and another for the employee or annuitant and family. Special contracts at special rates for those enrolled under either or both parts of Medicare therefore cannot be offered by any plan.) In general, the plan totals all expenses of an illness, subtracts the amounts that Medicare will pay, and pays the lesser of the balance or what it would have to pay if it were not for Medicare.

The plan of a large tire and rubber company (like that of three other large companies in the industry, which also self-insure for hospital, surgical, and in-hospital medical benefits) provides that benefits covered by both Medicare and the company's hospitalization plan will be paid by Medicare. Benefits payable under the company plan but not provided by Medicare continue to be paid under the company plan, so that, as the company explains to the plan members, "under no circumstances will the total benefits from Medicare and the company plan be less than the benefits you (the retired employee) would have received under the company plan without Medicare." The same provision is made with respect to surgical and in-hospital medical benefits. The company encourages employees to enroll for Part B of Medicare to take advantage of the extra benefits provided by it.

A similar pattern is followed by various other large company plans or union self-insured programs that provide physician services on a fee-for-service basis. They "carve out" or fill in and add to the Medicare benefits so that the benefits for the aged enrollees are never less than those for younger employees.

The pattern under the various employer-employee-union plans that provide benefits through group practice (such as those of the railroad associations) is similar to the community group-practice plans previously described. In general, the aged person is entitled to the plan's regular benefits and the plan is reimbursed for its costs in providing that share of the benefits for which Medicare is responsible.

FEDERAL EMPLOYEE HEALTH BENEFIT PROGRAMS

This account of complementary coverage to Medicare would not be complete without some discussion of the complementary coverage provided under the health benefit programs of the Federal Government for its active or retired employees. Special problems exist in such coverage because Medicare does not cover certain Federal employees and annuitants and their dependents[8] and because the provisions of the Federal employee programs are established through legislation.

Under the Federal Employees Health Benefits Act that covers active employees and those who have retired since the inauguration of the plan in 1960 (almost 7.5 million persons), employees have a choice among 36 approved plans: A Government-wide service benefit plan offered by Blue Cross-Blue Shield, a Government-wide indemnity plan offered by a large group of insurance companies and managed by the Aetna Life Insurance Company, 15 plans of employee organizations,

[8] Hospital insurance under Medicare covers all persons aged 65 and over who are or would be eligible for old-age benefits and transitionally all other aged persons except those enrolled in a health benefits plan under the Federal Employees Health Benefits Act or who were so enrolled on February 16, 1965, or could have enrolled at that time or subsequently.

12 local group-practice plans, and 7 local individual practice plans. The existing legislation authorizes the Civil Service Commission to permit each approved plan to offer two levels of benefits (a high option and a low option) on a dual rate basis—that is, a rate for the employee (or annuitant) alone and a rate for the employee (or annuitant) and dependents.

As Medicare began operations, there were about 125,000 employees or annuitants covered under this Federal employees' program who were aged 65 and over, many of whose spouses had also reached that age. About 40 percent of these persons, the Civil Service Commission estimates, were eligible for hospital benefits under Medicare because of private employment and 60 percent were not eligible; all could enroll for medical benefits under Part B of Medicare.

Under the Act, the Civil Service Commission could not permit approved plans to offer separate benefit packages to those aged 65 and over. To assist aged annuitants in determining what action they should take with respect to Medicare—that is, whether they should enroll for Part B of Medicare, continue their coverage under the Federal employees' program, or drop that coverage—the Commission informed annuitants of the considerations to be kept in mind in making their decisions: Whether the annuitant was eligible for Part A of Medicare; whether he had dependents under age 65 for whom he wished to retain the coverage of the Federal employees' program; and the relative costs and scope of his Federal employee plan in comparison with those of the two parts of Medicare.

Medicare pays its benefits irrespective of other coverage and is thus always the primary carrier. The Commission contracted with approved plans that, in settling claims for persons eligible for Medicare, they were to pay expenses not covered by Medicare up to the limits of their benefit coverage but not more than 100 percent of covered expenses.

Under the retired Federal employees health benefits program (the program for employee annuitants who had retired before the Federal Employees Health Benefits Act was passed and their survivor annuitants) approximately 300,000 persons were covered before Medicare. The great majority of these annuitants were over age 65 and eligible for hospital benefits under Medicare and eligible to enroll for medical benefits under that program.

Within the program for retired Federal employees, eligible annuitants have a choice between a "uniform plan" and any private health insurance plan that they elect. Toward the cost of either plan the Government contributes $3.50 a month for a person enrolling for himself alone and $7 for a person enrolling for himself and his dependents.

Under the "uniform plan" enrollees are offered a choice of three specific contracts: a "basic coverage" only (providing very limited indemnity payments for hospital care and surgery); a "major medical" coverage that excludes benefits payable under the basic coverage; and a "basic plus major medical benefit" coverage. The cost of the basic coverage for a single person is $7.50; for the major medical coverage, it is $7; and for both contracts the cost is $14.50 a month.

The Civil Service Commission also wrote to annuitants under this program, suggesting that they enroll in both parts of Medicare. The annuitants' attention was drawn to the considerations they should take into account in deciding whether to drop the uniform plan, drop their private plan, or switch from the uniform plan to a private plan (or vice versa). Most annuitants under this program who had private plans had Blue Cross and Blue Shield coverage and could advantageously, in most cases, change to a nongroup complementary coverage. For those who remained with the uniform plan, there could, of course, be no change in benefits, but the Civil Service Commission contracted, as for the plans under the health benefits program for active Federal employees, that the plan would reimburse covered persons for covered expenses beyond those paid for by Medicare up to the limit of what the plan would have paid out if Medicare had not existed, but not more than 100 percent of covered expenses.

Under the contractual arrangements, both the plans for active Federal employees and those for the retired Federal employees complement the Medicare coverage (up to 100 percent of allowable expense), regardless of whether the employee is enrolled under only one or both parts of Medicare and regardless of whether he has a spouse or other dependent who is under age 65 and therefore not eligible for Medicare.

The problems of optimum coordination of Medicare benefits and benefits available under the Federal employee health benefit programs cannot be solved without legislative changes in the acts governing the Federal employee programs or Medicare, or both. The Civil Service Commission has proposed legislation for changes in the Federal employee health benefit programs that would aid in the achievement of this objective.

SUMMARY AND CONCLUSIONS

Most private health insurance organizations have offered contracts to the aged that complement Medicare. This complementary coverage has been widely purchased or otherwise obtained by older persons. Blue Cross-Blue Shield plans now have about 87 percent as many aged persons enrolled as they had before Medicare. Insurance companies had about 80 percent as many aged persons enrolled at the end of 1966 as were enrolled before Medicare. The number of persons aged 65 and over that are covered by the independent plans is between 80 percent and 90 percent of that before Medicare.

Probably more than 10 million aged persons now have some type of private complementary health insurance. It may be assumed that most of these had private insurance coverage before Medicare. In addition to those covered under private programs a considerable number of aged persons have or soon will have some protection complementary to Medicare under public programs.

Some 2.1 million needy aged persons are recipients of old-age assistance and thus eligible for the medical care that is available to them in their States. Additional numbers of aged persons with low incomes are eligible for medical care under the 29 State medical assistance programs now in operation (as of May 10, 1967); others will become eligible as additional States establish these programs. Through private health insurance or public programs, therefore, well over 60 percent of all aged persons now have or soon will have some provision for medical costs in addition to that which they have under Medicare.

In general, Blue Cross and Blue Shield have offered complementary coverage to aged persons that fills in and adds on to the Medicare coverage to bring it closer to the level of protection offered to younger persons. A few plans have made available to aged persons a fairly comprehensive health coverage, but most have not ventured beyond familiar areas.

Insurance companies under their individual business have sold many policies providing stipulated payments for each day of hospital confinement. Such policies can be easily administered, but in some situations they may encourage overutilization of hospital care.

Insurance companies under group policies have filled in or added on to the benefits provided under Medicare in various ways—by providing types of benefits not covered, by making the Medicare deductible and coinsurance amounts reimbursable expenses under major medical policies, or by "carving out" Medicare benefits from the regular group coverage.

The independent plans have generally complemented Medicare by providing their regular benefits with benefits under Medicare "carved out." Plans that provide comprehensive coverage of physician services through group practice have continued this coverage for older persons and generally are reimbursed by Medicare on a cost basis for their expenses in providing that share of the services for which Medicare would be responsible.

In large degree these complementary contracts are filling in the deductibles and coinsurance amounts that the covered person has to pay under Medicare. One reason for the presence of these deductible and coinsurance features in the Medicare program was that they would reduce the cost of the program to the Government. Undoubtedly, another reason was the belief of some legislators that these features would be helpful in protecting the program against unnecessary utilization and excessive charges—that they would deter unnecessary hospital admissions, shorten hospital stays, and give covered persons an interest in obtaining physician services at reasonable costs.

The growth of coverage complementary to health insurance for the aged under the Social Security Act, the extent to which the supplements alter hospital utilization or other costs, and the implications of the developments for the program itself call for continuing study.