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Report to the Congress; by Elmer B. Staats, Comptroller General.

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Medicare was established to protect the elderly against the costs of inpatient hospital care. The proposed Comprehensive Health Insurance Act of 1974 (CHIP) would combine parts A and B of Medicare and would modify Medicare's cost-sharing formulas and limit beneficiaries' liability based on income. The proposed National Health Insurance Act of 1974 (Kennedy-Mills proposal) would leave the Medicare cost-sharing formula essentially the same but would limit the beneficiaries' liability based on income. The proposed Catastrophic Health Insurance and Medical Assistance Reform Act (Long-Ribicoff proposal) would, essentially, supplement Medicare's existing benefits by covering catastrophic illnesses. Both the CHIP and the Kennedy-Mills proposal would use credit cards (program payments would be made in full to participating providers, such as hospitals, on behalf of beneficiaries). Findings/Conclusions: Of the various proposals, eliminating the limits on inpatient hospital days and substituting a flat, daily coinsurance charge for the existing inpatient deductible and coinsurance seem most attractive, since they would simplify administration. Introducing a modified benefit structure based on individual or family income would greatly increase costs, particularly if strictly enforced and monitored to maintain the integrity of the system, and could have only a limited impact on total program benefits. Introducing a credit card system would simplify administration and reduce costs for providers, but would increase administrative costs to the Government. Recommendations: The Social Security Administration should test the feasibility and

utility of a credit card system in a national health insurance scheme. Congress should explore whether the benefits of an income test would justify the resultant added administrative problems and costs. If cost sharing for inpatient services is desirable, Congress should provide for a fixed, daily copayment. (DJM)

00505

REPORT TO THE CONGRESS

BY THE COMPTROLLER GENERAL OF THE UNITED STATES

Potential Effects Of National Health Insurance Proposals On Medicare Beneficiaries

Medicare has protected the elderly against the costs of hospitalization, but its complicated benefit structure has created administrative problems. Some national health insurance proposals would change the benefit structure. GAO recommends that

--the Congress in its deliberations of national health insurance proposals carefully explore whether the benefits of introducing an income test would justify the resultant added administrative problems and costs, and

--a credit card system be tested under Medicare to determine its feasiblity for use under national health insurance.

HRD-76-129

FEB. 24, 1977

COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON, D.C. 20548

B-164031(4)

To the President of the Senate and the
Speaker of the House of Representatives

This report describes Medicare's coverage of the costs of hospitalized beneficiaries and compares Medicare coverage with the coverage under selected national health insurance proposals. It also discusses administrative problems connected with Medicare's benefit structure and points out potential administrative problems in selected national health insurance proposals.

The review was made to determine (1) whether Medicare was meeting its basic legislative intent of protecting the elderly against the costs of inpatient hospital care and (2) the potential effect of selected national health insurance proposals in this regard.

Our review was made pursuant to the Budget and Accounting Act, 1921 (31 U.S.C. 53), and the Accounting and Auditing Act of 1950 (31 U.S.C. 67).

We are sending copies of this report to the Director of the Office of Management and Budget; and to the Secretary of Health, Education, and Welfare.

Comptroller General
of the United States

Contents

ABBREVIATIONS

BCA	Blue Cross Association
CHIP	the proposed Comprehensive Health Insurance Act of 1974
GAO	General Accounting Office
HEW	Department of Health, Education, and Welfare
SSA	Social Security Administration
SSI	Supplemental Security Income for the Aged, Blind, and Disabled

COMPTROLLER GENERAL'S REPORT TO THE CONGRESS

POTENTIAL EFFECTS OF NATIONAL HEALTH INSURANCE PROPOSALS ON MEDICARE BENEFICIARIES
Department of Health, Education, and Welfare

D I G E S T

Medicare is intended to protect the elderly against the costs of inpatient hospital care. About 1 in 5 of the over 20 million aged Medicare beneficiaries use inpatient hospital benefits annually. Medicare pays over 90 percent of their hospital bills.

Many national health insurance proposals introduced in the Congress would affect Medicare's methods of reimbursing beneficiaries for their costs of medical care. This report looks at several prominent health insurance proposals and analyzes features of each and how they would affect Medicare's methods of reimbursement. GAO also analyzes the effect of each proposal on a number of beneficiaries. (See p. 16.)

For example, the proposed Comprehensive Health Insurance Act of 1974, would

--introduce cost-sharing limitations based on beneficiaries' incomes,

--remove the limit on the number of days of hospital care covered by Medicare, and

--impose as much as 20 percent cost sharing (coinsurance) with the first day of hospitalization. Under this proposal, beneficiaries with annual incomes less than $3,500 would usually pay less than they would under Medicare, and beneficiaries exceeding $3,500 would usually pay more. (See p. 17.)

The proposed Medicare Improvements of 1976 introduced in the 94th Congress would

--change Medicare's cost-sharing system,

--supplement Medicare's existing benefits to cover catastrophic illnesses, and

--limit increases in Medicare reimbursements for costs and charges in fiscal years 1977 and 1978.

The coverage for catastrophic illnesses would affect only about 4 percent of the Medicare beneficiaries who use hospital benefits in a year. The remaining hospitalized beneficiaries would pay an average of about $180 more than they would under the existing program. (See p. 23.)

The proposed Comprehensive National Health Insurance Act of 1974 would remove Medicare's limitations on the number of days of hospital care covered and limit beneficiaries' cost sharing based on income. No beneficiary would pay more than would have been paid under Medicare; some lower income beneficiaries would pay less. (See p. 25.)

The proposed Catastrophic Health Insurance and Medical Assistance Reform Act would supplement Medicare. The coverage for catastrophic illnesses would begin after 60 hospital days, which would affect about 3 percent of the Medicare beneficiaries who use hospital benefits in a year. This would provide full inpatient hospital coverage with no cost sharing. (See p. 27.)

Medicare's benefit structure is complicated. Beneficiaries do not understand it. Medicare's inpatient hospital benefits are based upon a benefit period or "spell of illness" which begins when a beneficiary is admitted to a hospital, and ends when the beneficiary has been out of a hospital or skilled nursing facility for 60 consecutive days.

Medicare's hospital cost-sharing charges, which begin with the 61st day of hospitalization, and limitations on covered days, have

had a negligible effect on discouraging hospital use. Only about 2 percent of the hospitalized beneficiaries used more than 60 days in a benefit period. Less than 1 percent used more than 90 days. (See p. 10.)

The system has created administrative problems--for the Government, for intermediaries (such as the Blue Cross Association), and for hospitals because of the need to determine the days used in a benefit period and when hospitals should charge for deductible amounts and cost sharing. (See p. 31.)

Provisions of various national health insurance proposals which would simplify the program include:

--Eliminating the inpatient hospital day limitations.

--Using credit cards. Providers would be paid by Medicare on behalf of beneficiaries. Medicare would collect the beneficiaries' share of costs.

--Replacing the present inpatient deductible and cost sharing amounts with a fixed, daily charge to the hospitalized beneficiary. (See p. 33.)

Proposals which would increase administrative problems and related costs include:

--Introducing various levels of cost sharing based on income.

--Using credit cards to pay physicians and other professionals.

If Medicare cost sharing were based on individual or family income, then that income would have to be determined individually. The cost to make these determinations could be substantial. (See p. 33.)

Using credit cards for Medicare inpatient hospital services would involve about 6,900 hospitals and 8 million transactions. The accounting and collecting of the cost sharing for other services would involve over 400,000 physicians and other professionals, and 100 million transactions. Bad debts, under such an arrangement, could be substantial. (See p. 35.)

The Social Security Administration should expand its current efforts in testing the use of credit cards under Medicare to determine the feasibility of their use under national health insurance proposals. (See p. 38.)

In its deliberations on national health insurance proposals for changing Medicare's benefit structure, we recommend that the Congress carefully explore whether the benefits of introducing an income test would justify the resultant added administrative problems and related costs. If cost sharing for inpatient hospital services is believed desirable, we recommend that the Congress provide for a fixed, daily copayment for inpatient hospital services.

CHAPTER 1

INTRODUCTION

The Social Security Amendments of 1965 added two titles to the Social Security Act, administered by the Department of Health, Education, and Welfare (HEW). These titles dramatically increased the Government's involvement in paying for health care.

Title XVIII, Health Insurance for the Aged, established a program popularly known as Medicare, in which the Government pays for most of the health care for eligible persons aged 65 and older. Medicare became effective on July 1, 1966. The Social Security Amendments of 1972 extended Medicare protection to (1) persons under age 65 who were entitled to social security or railroad retirement benefits because of a disability for at least 24 months and (2) insured individuals and members of their families under age 65 with chronic kidney disease. Medicare is administered by the Social Security Administration (SSA) of HEW.

Title XIX, Grants to States for Medical Assistance Programs, established a Federal-State program popularly known as Medicaid, in which the Government pays 50 percent or more of a State's costs for medical care given to certain people unable to pay for such care. Medicaid became effective in January 1966. It is administered by the Social and Rehabilitation Service of HEW.

Medicare has two parts. Part A--Hospital Insurance Benefits for the Aged and Disabled--covers inpatient hospital services and post-hospital care in a skilled nursing facility 1/ or in a patient's home. Part A is principally financed by taxes on earnings paid by employers, employees, and self-employed persons. In 1976 about 22 million aged and about 2.3 million disabled people (including those with chronic kidney disease) were eligible for part A benefits. For fiscal year 1967, the first full year of Medicare, part A benefit payments were about $2.5 billion. For fiscal year 1976 they were about $12.2 billion; about 96 percent was for inpatient hospital services.

1/A skilled nursing facility is a specially qualified facility which has the staff and equipment to provide skilled nursing care or rehabilitation services as well as other related health services.

Part B of Medicare--Supplementary Medical Insurance Benefits for the Aged and Disabled--generally covers 80 percent of the reasonable costs of physician services, outpatient hospital services, home health services, and various other medical and health services, subject to an annual $60 deductible. Enrollment in part B is voluntary. Part B is financed by monthly premium payments and appropriations from the general revenues of the U.S. Treasury. In 1976 about 21.9 million aged and about 2 million disabled people were enrolled for part B benefits. For fiscal year 1967, part B benefit payments were about $644 million. Fiscal year 1976 payments were about $4.7 billion. About 77 percent was for physicians' services; about 19 percent for outpatient hospital services.

Under Medicaid, the Government pays from 50 to 78 percent of the costs States incur in providing medical services to certain low-income people. Title XIX requires that States participating in Medicaid provide benefits for inpatient and outpatient hospital services; laboratory and X-ray services; skilled nursing facility services for individuals age 21 and older; early and periodic screening, diagnosis, and treatment of people under age 21; home health services; family-planning services; and physicians' services. Additional services such as dental care and prescribed drugs may be included under a Medicaid program if a State chooses. As of November 1976, 49 States and 4 jurisdictions 1/ were participating in Medicaid.

Generally, persons receiving public assistance under the Aid to Families with Dependent Children Program 2/ and Supplemental Security Income for the Aged, Blind, and Disabled (SSI) 3/ are eligible for Medicaid. These persons are generally referred to as categorically needy.

Aged, blind, or disabled people or persons with dependent children who have too much money or resources to qualify for public assistance, but not enough to meet the costs of necessary medical care, may also be entitled to Medicaid benefits if the State chooses. These people are referred to as medically needy. As of November 1976, 32 States and jurisdictions had elected to cover the medically needy.

1/The District of Columbia, Puerto Rico, the Virgin Islands, and Guam.

2/Title IV part A, Social Security Act.

3/Title XVI, Social Security Act.

Some people can receive both Medicare and Medicaid benefits. For the estimated 2.2 million categorically needy aged people, Medicaid pays the Medicare cost-sharing, as well as Medicare's part B premiums.

For fiscal year 1967 the Government paid about $1.2 billion. For fiscal year 1976 the Government paid about $7.8 billion for about 23.2 million people.

MEDICARE INPATIENT HOSPITAL BENEFITS

Of the health care benefits discussed, the most costly has been the part A inpatient hospital benefits for the aged.

Administering part A benefits

SSA administers part A benefits with the assistance of intermediaries. The principal intermediary is the Blue Cross Association (BCA), which subcontracts most of its work to 72 Blue Cross plans throughout the United States. On July 1, 1975, BCA was the intermediary for about 90 percent of the 6,904 hospitals participating in Medicare. The other participating hospitals deal directly with SSA or with nine commercial intermediaries.

Intermediaries pay hospitals and other providers for their services to Medicare beneficiaries and transmit information and instructions between SSA and the hospitals. Intermediaries (including SSA) spent about $114 million in fiscal year 1976 for part A administrative costs under Medicare.

Part A benefit structure

Under Medicare, hospital insurance benefits are structured around a benefit period or "spell of illness." A benefit period begins when a beneficiary is admitted to a hospital and ends when the beneficiary has been out of a hospital or skilled nursing facility for 60 consecutive days. A beneficiary can have as many benefit periods as needed.

Medicare provides coverage for inpatient hospital care up to 90 days in each benefit period. 1/ For the first 60 days during a benefit period, Medicare pays for virtually

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1/A beneficiary can use no more than 190 days for inpatient care in a psychiatric hospital.

all covered services, 1/ except for a deductible which is generally related to the cost of a day of inpatient care and is charged to the beneficiary. Medicare pays for all covered services from the 61st-90th days of inpatient hospital care in a benefit period, except a daily coinsurance amount paid by the beneficiary. The coinsurance equals one-fourth of the deductible amount. Since January 1968, Medicare has also covered an additional 60 reserve days of inpatient hospital care. These can be used as elected by the beneficiary, but they can be used only once. Daily coinsurance for the reserve days is one-half the deductible amount.

For post-hospital care, Medicare provides coverage for care in a skilled nursing facility up to 100 days in each benefit period. Medicare pays for all covered services for the first 20 days. For the next 80 days the patient must pay a daily coinsurance charge based on one-eighth of the inpatient deductible. For home health care, Medicare part A pays up to 100 home visits in each benefit period, provided that such visits are used within a year from the beneficiary's most recent discharge from a hospital or skilled nursing facility. The beneficiary does not pay a coinsurance charge for home health visits.

Since the inception of Medicare, part A inpatient deductible amounts pertaining to hospital care have steadily increased, which reflects a general rise in hospital costs since 1966.

Part A Deductible and Coinsurance Amounts

Effective date	Inpatient hospitals		
	First 60 days (deductible)	61st-90th day	60 reserve days
		(coinsurance per day)	
July 1966	$ 40	$10	not covered
Jan. 1968	40	10	$20
Jan. 1969	44	11	22
Jan. 1970	52	13	26
Jan. 1971	60	15	30
Jan. 1972	68	17	34
Jan. 1973	72	18	36
Jan. 1974	84	21	42
Jan. 1975	92	23	46
Jan. 1976	104	26	52

1/The beneficiary pays for the first three pints of blood furnished in a benefit period.

The "query system" and how it works

The status of benefits must be determined each time a patient is admitted for inpatient care. SSA has a system to provide information on eligibility and benefits and to maintain current individual records.

Hospitals and skilled nursing facilities submit queries through the intermediary to SSA each time a beneficiary is admitted. Notices of admission usually accompany the queries. These notices provide information on the beneficiary including the date of admission, the admitting hospital, and other related medical information.

When SSA receives the notice of admission, the beginning of hospitalization is recorded in the beneficiary's master record by creating an "open item" on the SSA automatic data processing record. This open item is closed when the corresponding final hospital bill is paid by the intermediary and is processed by SSA. 1/

Within the Blue Cross system, an intermediary transmits data on the notice of admission to BCA over the telecommunications system, a computer-controlled communications network between BCA and the Blue Cross plans. The BCA in Chicago regulates the data transmission to and from the individual plans. BCA transmits the notices of admission to SSA.

SSA responds to each query through BCA to the intermediary, usually within 2 working days. The SSA reply shows the remaining benefit days and the deductible status after adjustments based on the last bill. However, SSA instructs the intermediaries to develop the replies to determine the days actually available as of the date of admission and whether a new benefit period has begun, before sending the information to the hospital. This development may include contacting other intermediaries, hospitals, and skilled nursing facilities concerning information reported earlier on the notice of admission and/or on any open items which the SSA reply shows.

During 1974, SSA received about 8.2 million part A queries through BCA. An admission or start-of-care notice was transmitted for 7.4 million queries. SSA sent out

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1/The query system is also used for deleting open items, obtaining benefit status information without creating an open item, or resubmitting queries or notices of admission because no reply had been received from SSA within 7 days.

8 million replies through BCA concerning eligibility for hospital and skilled nursing facilities benefits.

NATIONAL HEALTH INSURANCE PROPOSALS

During the 93d and 94th Congresses, various proposals for national health insurance were introduced which, wholly or in part, would extend to nearly everyone the protection provided to the aged, poor, and disabled.

A July 1974 SSA analysis grouped the national health insurance proposals into the following four categories:

--Combined public and private plans which would feature (1) privately financed and administered plans requiring employers to provide specific benefits for employees and their families and (2) publicly financed protection plans for the aged and low-income groups.

--Mainly public plans which would be financed principally by payroll taxes and Federal general revenues and would be administered by Federal and/or State and local governments.

--Plans which would provide tax credits to be subtracted from personal income taxes (1) to offset the premium cost of qualified private health insurance or (2) when medical expenses exceeded a specific percent of family income. Some plans would also require employers to offer qualified policies to retain favorable tax treatment.

--Plans which generally would protect the public against the cost of catastrophic illness.

Under these proposals, Medicare would either continue or be modified, supplemented, or replaced by a new program.

CHAPTER 2

INPATIENT HOSPITAL CARE FOR THE ELDERLY UNDER MEDICARE

Medicare paid about $32 billion for about 530 million days of inpatient hospital care for the elderly from July 1966 through July 1, 1973, when the disabled were added to the program. Beneficiaries incurred about $2.2 billion in deductible and coinsurance amounts in that period.

According to the analyses and studies discussed on the following pages, the program provided full coverage (excluding the statutory deductible and coinsurance amounts) for covered services to about 99 percent of the beneficiaries requiring inpatient hospital care, and about 97 percent of all inpatient hospital days (excluding psychiatric) used by these beneficiaries. In terms of protecting the elderly against the costs of inpatient hospital care, the program has been successful.

Medicare's coinsurance charges imposed after the 60th and 90th days of hospitalization were intended to prevent abuses of hospital use. About 95 percent of hospital use during a benefit period ended at least 14 days before the coinsurance provisions were to become effective. Further, inpatient hospital coinsurance charges applied to only about 2 percent of the beneficiaries, and about 4 percent of the covered days and represented only about 1 percent of program costs for inpatient hospital care. Because beneficiaries paid only about 20 percent of such charges, the hospital coinsurance feature of Medicare seemingly had a negligible effect on hospital use and program financing.

SOCIAL SECURITY ADMINISTRATION STUDIES BASED ON HOSPITAL LENGTHS OF STAY

The Social Security Administration does not accumulate statistical data on inpatient hospital use on the basis of the benefit period. SSA develops data on the basis of

--the number of beneficiaries using hospital insurance benefits during a year,

--the number of admissions,

--the length of stay for each admission, and

--the number of days hospitalized in a year.

Nevertheless, SSA studies strongly suggest that Medicare provided virtually complete coverage for the inpatient hospital days used by beneficiaries in short-stay hospitals.

For example, SSA's Office of Research and Statistics tabulated a sample of length of stays in short-stay hospitals during 1971 on record as of January 3, 1973. Over half of the hospital stays were less than 10 days, about 93 percent were 30 days or less, and 99 percent were 60 days or less. The average length of stay was 12.4 days. 1/

During 1971, about 4.5 million beneficiaries--about 1 of 5 eligible people--were admitted to hospitals about 6.2 million times, or about 1.4 admissions each. The length of stays for beneficiaries discharged from short-stay hospitals in 1971 is summarized in the following table.

Number of inpatient hospital days	Number of stays in short-stay hospitals	Percent of total stays	Cumulative percent of stays
less than 4	952,695	15.8	15.8
4-6	1,198,775	19.9	35.7
7-9	1,047,840	17.4	53.1
10-12	744,220	12.4	65.5
13-15	542,425	9.0	74.5
16-20	577,270	9.6	84.1
21-25	351,830	5.8	89.9
26-30	208,000	3.4	93.3
31-45	260,965	4.3	97.6
46-60	82,605	1.4	99.0
61-90	44,720	.7	99.7
91-120	9,320	.2	99.9
Over 120	5,615	.1	100.0
Total	6,026,280	100.0	100.0

Because neither the Office of Research and Statistics nor the actuarial sample discussed on the following page provided information on the total inpatient hospital days that Medicare beneficiaries were not covered by their 90-day benefit period or reserve benefit, we asked the American Hospital Association to make a nationwide study of member hospitals to estimate the amount of care provided to

1/A December 1975 Office of Research and Statistics study on hospital use and length of stays by Medicare beneficiaries in short-stay hospitals during 1973 showed similar information, except that the average length of stay was about 11.8 days.

Medicare beneficiaries after their benefits were exhausted. Based on responses from 590 short-stay hospitals, 1/ only about 1.4 percent of all the days of care provided to Medicare patients in short-stay hospitals were not covered by the program. 2/

Through fiscal year 1973, Medicare beneficiaries admitted to short-stay hospitals averaged about 98.5 percent of total hospital admissions by Medicare beneficiaries. These admissions also represent about 96 percent of total covered days.

ANALYSIS OF SSA'S ACTUARIAL SAMPLE

SSA's Office of the Actuary maintains information (including bills) on hospital use and on charges for a continuous sample of approximately 0.1 percent of persons eligible for part A benefits.

During 1971, 4,025 of the sampled beneficiaries (about 1 in 5) were admitted for inpatient hospital care in short- and long-stay hospitals. For 100 beneficiaries, their 1971 admissions continued benefit periods which began in 1970. The remaining 3,925 beneficiaries began new benefit periods with their first admissions in 1971. The 3,925 beneficiaries were admitted 5,423 times, about 1.4 admissions each. 3/

The 3,925 beneficiaries had 4,517 benefit periods during 1971. About 86 percent (3,391 beneficiaries) had 1 benefit period, 12 percent (480 beneficiaries) had 2 benefit periods. The remaining 54 beneficiaries had 3 or 4 benefit periods during the year. Overall, each beneficiary was ad-

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1/The periods covered by these responses generally covered annual reporting periods ending at various dates during 1972 and, thus, included a mixture of 1971 and 1972 data.

2/This estimate of about 1.0 million days in 1971 excludes any days when Medicare denied payments because the care was not medically necessary (i.e., custodial care). Such care was never intended to be paid by the program.

3/As shown in app. I, the length of stays for the sample beneficiaries in 1971 closely coincides with Office of Research and Statistics tabulations of the length of stays for all beneficiaries hospitalized in 1971. Therefore, we believe the actuarial sample represents the entire population from which it was drawn.

mitted about 1.2 times for each benefit period. On the average, then, about 1 out of every 5 beneficiaries using the hospital benefit is readmitted to a hospital within 60 days of the prior discharge.

The following table shows hospital use during the 4,517 benefit periods. The 90-day limitation on Medicare coverage was met or exceeded in less than 1/2 of 1 percent of the 4,517 benefit periods beginning in 1971. 1/

Number of covered inpatient hospital days in benefit period	Number of benefit periods	Percent of total benefit periods	Cumulative percent of benefit periods
less than 4	576	12.7	12.7
4-6	814	18.0	30.7
7-9	721	16.0	46.7
10-12	517	11.4	58.1
13-15	415	9.2	67.3
16-20	476	10.5	77.8
21-25	303	6.7	84.5
26-30	202	4.5	89.0
31-45	278	6.2	95.2
46-60	117	2.6	97.8
61-90	80	1.8	99.6
91-120	12	.3	99.9
121-150	6	.1	100.0
Total	4,517	100.0	100.0

A similar study completed in 1976 by the Office of the Actuary showed 5,066 benefit periods commencing in 1973 for the 0.1 percent sampled beneficiaries. The results of this study did not vary significantly from those shown above. The 90-day limitation also was only exceeded in less than 1/2 of 1 percent of the benefit periods beginning in 1973.

1/About 1.8 million disabled persons became eligible for Medicare in July 1973. A limited Office of Research and Statistics study of hospital and nursing home use by the disabled during fiscal year 1972 showed that although the disabled tend to be admitted to hospitals more often than the elderly during a year, the overall pattern of hospitalization during a benefit period did not vary greatly from hospitalization of the elderly. (See app. II.)

Beneficiaries exhausting 90 days of inpatient hospital care in a benefit period

Of the sample beneficiaries who received inpatient hospital care in 1971, 38 (about 1 percent) used 90 days or more of inpatient care in 1 benefit period. Twenty-five of the 38 patients began the benefit period in 1971, and 13 continued a benefit period which began in 1970. Thirty-three patients exhausted their benefits in short-stay hospitals, and 5 exhausted their benefits in long-stay hospitals.

About 13,000 of the sampled beneficiaries (about 63 percent) received some inpatient hospital care during the 5-1/2 year period from July 1966, when Medicare became effective, through December 1971. Only 321 beneficiaries (2.5 percent) received 90 days or more of inpatient hospital care in 1 or more benefit periods during that period. Since January 1968, when the 60-day reserve benefit became effective, 220 sample beneficiaries exhausted their 90 inpatient hospital days in 1 or more benefit periods. As indicated by the following table, most of these elected to use some of the 60 reserve days, but few used all of the days.

	Year in which benefits were initially exhausted					
	1968	1969	1970	1971	Total	Percent
Beneficiaries using some reserve days	35	51	26	27	139	63.2
Beneficiaries using all reserve days	10	5	4	4	23	10.4
Beneficiaries not using reserve days	22	16	13	7	58	26.4
Number of beneficiaries exhausting 90-day inpatient hospital benefit	67	72	43	38	220	100

According to inpatient bills, the beneficiaries who exhausted their benefits through 1971 often had complications involving a basic chronic illness which required either a series of hospital admissions or long-term hospitalization. Examples follow.

Beneficiary A

Beneficiary A exhausted his inpatient hospital benefits in 1968 and then used his reserve days. In that benefit period he was admitted to a short-stay hospital 8 times for stays from 2 to 54 days. He was admitted for emphysema, malnutrition, heart trouble, acute urinary retention, shoulder and hip contusions, head lacerations, dehydration, and a fractured hip. The intervals between hospital stays ranged from 3 to 49 days--none long enough to establish a new benefit period.

Beneficiary A again exhausted his inpatient hospital benefits in 1969. He was admitted to a long-stay hospital once for chronic bronchitis and pulmonary emphysema during this benefit period.

Beneficiary B

Beneficiary B exhausted her part A inpatient hospital benefits in 1971. Under that benefit period, she was first admitted to the hospital for diabetes, gangrene of the right foot, and a blocked right leg artery. She stayed 30 days. Two weeks later, under the same benefit period, she was readmitted for diabetes and for an amputation of the right foot, which was complicated by an ulcer on the amputation spot. She was discharged after 75 days--15 days were reserve days. Two days later, she was hospitalized again for abnormally low blood sugar, using 3 more reserve days. About 6 weeks later, she was hospitalized for a stroke. She stayed 9 days, again using reserve days because she had not been out of the hospital long enough to establish a new benefit period.

Beneficiary C

Beneficiary C exhausted both her inpatient hospital benefits and lifetime reserve benefits in 1970, being continuously hospitalized for a total of 350 days. This hospitalization consisted of five stays--three in a long-stay hospital and two in a short-stay hospital. She was first admitted to a long-stay hospital for chronic arthritis, blood insufficiency, high blood pressure, and hardening of the arteries. This was followed by gangrene of the left foot and ankle, which resulted in her left leg being amputated at the short-stay hospital. She returned to the long-stay hospital; but shortly thereafter, she contracted gangrene of the right heel, which resulted in a below-the-right-knee amputation again at the short-stay hospital. She was readmitted to the long-stay hospital for a urinary tract infection. After exhausting her 90-day inpatient benefit

and her 60-day reserve, beneficiary C spent an additional 200 noncovered days in the long-stay hospital before being discharged. Since she was a continuous hospital inpatient for 350 days she was unable to qualify for a new benefit period.

Beneficiary D

Beneficiary D exhausted both 90 days of inpatient hospital benefits and 60 days of reserve benefits during a single hospital stay in 1968. The patient was admitted to the hospital with breast cancer and died at the end of the 161-day stay. The last 11 days were not covered by Medicare.

LIMITED EFFECT OF COINSURANCE ON PROGRAM BENEFICIARIES AND COSTS

Although all beneficiaries beginning a benefit period had to pay for the inpatient deductible, relatively few (about 2 percent) were subject to the daily coinsurance charges for the 61st-90th days of care in a benefit period or for the 60-day reserve. As shown by the table on page 10 for about 95 percent of the sample benefit periods, hospitalization ended at least 14 days before the coinsurance provisions were to become effective.

SSA's Office of the Actuary estimated that about 4 percent of the 79 million covered days of care in 1971 were subject to coinsurance--3 percent for the 61st to 90th days hospitalized and 1 percent for reserve days used. On the basis of these estimates, coinsurance charges totaled about $58 million in 1971 or about 1 percent of benefit payments.

The American Hospital Association's study estimated total annual coinsurance charges at $57.2 million; the beneficiaries or their insurers other than Medicare paid about $40.5 million. State Medicaid program paid about $10.6 million, and the Medicare program paid about $6.1 million as Medicare bad debts. 1/

The Health Insurance Institute reported that, of the estimated 21 million persons age 65 and older at the end of 1971, 11 million (52 percent) had private health insurance covering hospital confinements which primarily supple-

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1/Under Medicare's cost reimbursement principles, Medicare will reimburse hospitals for the uncollectable deductible and coinsurance amounts applicable to Medicare patients but not for the bad debts of non-Medicare patients.

mented Medicare. If it is assumed that half of the $57.2 million in Medicare coinsurance was paid by private insurance, the distribution of the payment of coinsurance charges would be as follows.

Source of payment	Amount	Percent
	(millions)	
Complementary insurance	$28.6	50.0
Beneficiaries	11.9	20.8
Medicaid programs	10.6	18.5
Medicare (hospital bad debts)	6.1	10.7
Total	$57.2	100.0

Thus, Medicare beneficiaries paid only about 20 percent of coinsurance charges.

CONCLUSIONS

The Medicare program has been successful in protecting the elderly against the costs of inpatient hospital care. It has provided full coverage (excluding the statutory deductible and coinsurance amounts) to about 99 percent of the beneficiaries requiring inpatient hospital care. Most Medicare beneficiaries requiring hospitalization would be required to pay in any year only the inpatient deductible either once or twice.

Although the incidence of the charge of an initial inpatient deductible would have varied (see page 9), it would have made little difference in overall coverage whether the inpatient hospital benefit was limited to 90 days on the basis of (1) admissions, (2) a calendar year, or (3) the benefit period. Depending on which method is used, in 1971 the following number of deductibles would have been made.

Deducible based on:	Number
Admissions	5,423
Calendar year	3,925
Benefit period	4,517

Legislation intended hospital coinsurance charges to prevent abuses of hospital use. However, the coinsurance features of the inpatient hospital benefit have had a negligible effect on hospital use and program financing.

The following table summarizes the costs of covered inpatient hospital services used by Medicare patients in 1971.

	Amount	Percent
	(000 omitted)	
Program coverage:		
Medicare paid	$5,512	93.7
Beneficiaries' liabilities:		
Inpatient deductible	312	5.3
Coinsurance	58	1.0
Cost of covered days	$5,882	100.0

CHAPTER 3

HOW WILL PROPOSED CHANGES AFFECT MEDICARE'S BENEFIT STRUCTURE?

From January 1973 to July 1974, 22 proposals for national health insurance were introduced in the 93d Congress. From April through July 1974, the House Committee on Ways and Means held extensive public hearings on national health insurance. In May 1974 the Senate Committee on Finance held hearings. In August 1974 the Committee on Ways and Means met to devise a compromise national health insurance bill, but on August 22, 1974, the chairman announced that the committee was setting aside further consideration of it.

The 93d Congress adjourned with no further committee action on the proposals. Most of the 22 proposals were reintroduced in the 94th Congress and contained many of the same features as the previous years's bills.

Several proposals would change Medicare's existing benefit structure and would, therefore, affect the extent of coverage. (See app. III.)

The proposals introduced in the 93d Congress included the following three features which would affect Medicare's benefit structure.

--Combining parts A and B of Medicare.

--Modifying the cost sharing and/or premium payments based in part on an individual's or family's income.

--Introducing coverage to supplement Medicare during a catastrophic illness, which would eliminate the existing inpatient hospital day limitations.

The following three proposals, introduced in the 93d Congress, received prominent mention in the media.

--Senate bill 2970 and House bill 12684 were introduced February 6, 1974. The proposed Comprehensive Health Insurance Act of 1974 (CHIP) would (1) combine parts A and B and (2) modify Medicare's cost-sharing formulas and limit beneficiaries' liability based on income.

--Senate bill 3286 and House bill 13870 were introduced April 2, 1974. The proposed Comprehensive National

Health Insuarnce Act of 1974 (Kennedy-Mills proposal) would leave the Medicare cost-sharing formula essentially the same but would limit the beneficiaries' liability based on income.

--Senate bill 2513 was introduced October 2, 1973. The proposed Catastrophic Health Insurance and Medical Assistance Reform Act (Long-Ribicoff proposal) would, essentially, supplement Medicare's existing benefits by covering catastrophic illnesses.

The effect these bills and the proposed Medicare Improvements of 1976 (H.R. 12082,, introduced February 25, 1976, might have on Medicare's existing inpatient benefit structure is discussed in this chapter.

CHIP

This proposal would establish a three-part national program.

--An employee health care benefit program, under which employers would have to offer private heatlh insurance plans to their employees.

--A federally assisted plan operated by the States for low-income families, which, to some extent, would replace Medicaid. Medicaid would be terminated except for certain services not covered under CHIP: (1) services in intermediate care facilities, (2) services in skilled nursing facilities for persons age 21 and older, (3) care in mental institutions for persons under age 21 or over 65, and (4) home health services.

--A Federal plan for the aged which would replace Medicare with an expanded program.

Each plan provides the same protection against costs related to catastrophic illness and provides the same scope of health services.

In January 1975, the President called for a 1-year moratorium on new spending programs, including national health insurance. CHIP was not reintroduced in the 94th Congress.

Under CHIP, as proposed in 1974, the Federal plan for the aged would cover persons insured under social security or railroad retirement. Under temporary transitional provisions, all resident citizens (or permanent alien residents)

who reached age 65 in the first year of the program would also be covered. Persons age 65 and older not covered under the Federal plan would be eligible for the assisted health care plan. The assisted plan would provide the same health services, but have different premium payments and cost sharing based on annual income. Disabled persons included under Medicare by the Social Security Amendments of 1972 would not be eligible for the Federal plan, but most of them would be covered by the assisted plan.

The Federal plan basically continues the Medicare program. The plan would remove the limitations on days of inpatient hospital services and add some new benefits, such as paying for outpatient prescription drugs.

Unlike Medicare, the Federal plan for the aged would not have separate part A and part B programs. The separate part A and part B deductibles, and the part B premium would be replaced by (1) a single deductible for all covered services, except outpatient drugs which would have a separate deductible and (2) a single premium, estimated at $90 for 1975. All expenses above the deductibles would be coinsured, and a maximum annual liability for both deductibles and coinsurance would be set, based on the beneficiaries' incomes. Everyone, regardless of marital status, would have the same cost-sharing limits.

Income Classes and Cost Sharing Under CHIP's Federal Plan for the Aged

Income class (individuals) (note a)	Income limits (note b)	Deductible		Coinsurance rate	Maximum individual liability	
		Regular	Drug		Percent of income	Amount
				(percent)		
1	under $1,750	$ -	$ -	10	6	$ 0 - under $105
2	$1,750 - under 3,500	50	25	15	9	158 - under 315
3	3,500 - under 5,250	100	50	20	12	420 - under 630
4	5,250 and over	100	50	20	-	750

a/According to information from the Social Security Administration's Office of the Acturay, about 4 percent of the Medicare beneficiaries would be in income class 1; about 51 percent in class 2; about 20 percent in class 3; and about 25 percent in class 4.

b/Income to be determined on the basis of the criteria under the Supplementary Security Income program authorized by Title XVI of the Social Security Act.

Considering the deductible and coinsurance revisions, the additional elderly people to be coverd under the combined program and the added benefits, the Department of Health, Education, and Welfare estimated that CHIP would cost the Government about $1.8 billion more than the existing program.

We sampled 80 beneficiaries who were hospitalized in 1971 to assess the effect of CHIP on Medicare's benefit structure.

On the basis of 1971 data, adjusted for higher 1976 costs and charges, they would have incurred about $249,000 for hospital and medical expenses covered by Medicare. We considered only the "reasonable charges" 1/ for medical services. Where the actual charge exceeds the reasonable charge, the beneficiary may have to pay the difference, depending on whether or not the physician or supplier agrees to accept the reasonable charge as the full charge. Under Medicare's existing benefit structure, about 90 percent of the $249,000 would have been paid by the program and about 10 percent by the beneficiaries, as shown in the following table. 2/

1/Reasonable charges are generally the lowest of

--the physician's or supplier's actual charge for the service,

--the physician's or supplier's customary charge for that service, or

--the prevailing charge made for similar services in the locality.

2/Because our sample was selected from a group of only those beneficiaries that used inpatient hospital benefits (about 1 in 5 Medicare beneficiaries in 1971), the expenses and distribution thereof are not typical of the overall Medicare population. In 1971, about 78 percent of the eligible beneficiaries used some covered part B services and about 43 percent met the $50 deductible and were therefore reimbursed for some portion of the part B services. For those meeting the deductible in 1971 the average covered part B charges, as adjusted for the higher 1976 charges, were about $369, whereas, the average covered part B charges for beneficiaries in our subsample were $657.

Distribution of Covered Expenses Under Existing Medicare Benefit Structure

	Inpatient hospital (part A)		Medical (part B)		Total	
	Amount	Percent	Amount	Percent	Amount	Percent
Program pays	$186,270	94.7	$38,590	73.5	$224,860	90.2
Beneficiary liability:						
Deductible	9,152		4,302		13,454	
Coinsurance	a/1,248		9,647		10,895	
	10,400	5.3	$13,949	26.5	$24,349	9.8
Total	$196,670	100.0	$52,539	100.0	$249,209	100.0

a/Applicable to 2 of the 80 beneficiaries who had been hospitalized more than 60 days in a benefit period.

Coverage under CHIP

Under the proposed benefit structure provided by the Federal plan, the $ 9,209 in inpatient hospital and part B medical expenses applicable to the 80 sampled beneficiaries would have been distributed between the program and the beneficiaries depending on income class as follows. 1/

	Medicare		CHIP					
			Income class 2 ($236 maximum liability) (note a)		Income class 3 ($525 maximum liability) (note a)		Income class 4 ($750 maximum liability)	
	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent
Program pays	$224,860	90.2	$231,664	93.0	$214,701	86.2	$207,534	83.3
Beneficiary liability	24,349	9.8	17,545	7.0	34,508	13.8	41,675	16.7
Total	$249,209	100.0	$249,209	100.0	$249,209	100.0	$249,209	100.0

a/Calculated at the midpoint of the income class.

1/Because only 4 percent of the Medicare beneficiaries would be in income class 1 and their cost-sharing liability would be negligible, the comparisons are not shown.

For income class 2, although 61 of the 80 beneficiaries would have been liable for the assumed maximum of $236, only 33 beneficiaries would have been liable for more under CHIP than Medicare. For income class 3, 67 of the 80 beneficiaries would have been liable for more under CHIP than under Medicare; 41 were liable for the maximum of $525. For income class 4, 74 beneficiaries would have been liable for more under CHIP, but only 24 were liable for the maximum of $750.

This increase in the beneficiaries' share is primarily due to coinsurance being imposed from the first day of hospitalization. Once the $100 regular deductible has been met, the beneficiary would be responsible for 20 percent of hospital expenses--which made up 78.9 percent ($196,670) of total expenses in our sample. Under Medicare, however, a beneficiary would have been responsible only for the $104 deductible in a benefit period, until the 61st day of hospitalization when coinsurance would be applicable.

Examples of how some of the 80 beneficiaries would have fared under Medicare as compared with CHIP follow.

Beneficiary A

This beneficiary was selected from those hospitalized from 4 to 6 days during 1971. Beneficiary A was hospitalized for 6 days at a cost of $852 and also incurred $451 in allowed reasonable charges during 1971 for covered part B medical services.

Under Medicare, the beneficiary would have been liable for $104 of the hospital expenses and $138 of the medical expenses. Under CHIP, beneficiary A would have been liable for the maximum of $236 if in income class 2 or $341 if in class 3 or 4.

Beneficiary B

This beneficiary was selected from those hospitalized from 7 to 9 days during 1971. Beneficiary B was hospitalized for 9 days at a cost of $1,278 and also incurred $215 in allowed reasonable charges during 1971 for covered part B medical services.

Under Medicare, the beneficiary would have been liable for $104 of the hospital expenses and $91 of the medical expenses. Under CHIP, beneficiary B would have been liable for the maximum of $236 if in income class 2 or $379 if in class 3 or 4.

Beneficiary C

This beneficiary was selected from those hospitalized from 10 to 12 days during 1971. Beneficiary C was hospitalized for 11 days at a cost of $1,562 and also incurred $350 in allowed reasonable charges during 1971 for covered part B medical services.

Under Medicare, the beneficiary would have been liable for $104 of the hospital expenses and $118 of the medical expenses. Under CHIP, beneficiary C would have been liable for the maximum of $236 if in income class 2 or $462 if in class 3 or 4.

Beneficiary D

This beneficiary was selected from those hospitalized from 16 to 20 days during 1971. Beneficiary D was hospitalized for 18 days at a cost of $2,556 and also incurred $698 in allowed reasonable charges during 1971 for covered part B medical services.

Under Medicare, the beneficiary would have been liable for $104 of the hospital expenses and $188 of the medical expenses. Under CHIP, beneficiary D would have been liable for the maximums of $236 or $525 under income class 2 or 3 and $731 if in income class 4.

Beneficiary E

This beneficiary was selected from those hospitalized from 31 to 45 days during 1971. Beneficiary E was hospitalized for 44 days during the year, which involved three admissions for stays of 22, 12, and 10 days and two benefit periods at a cost of $6,248. The beneficiary also incurred $2,156 in allowed reasonable charges during 1971 for covered part B medical services.

Because the hospital care involved two benefit periods, under Medicare the beneficiary would have been liable for two inpatient hospital deductibles or $208 and $479 of the medical expenses. Under CHIP, beneficiary E would have been liable for the maximums of $236 or $525 under income class 2 or 3--both less than the $687 under Medicare. If in income class 4, beneficiary E would have been liable for the $750 maximum.

MEDICARE IMPROVEMENTS OF 1976

This proposal would modify the existing Medicare program by

--eliminating the inpatient hospital day limitations,

--including coverage of catastrophic illnesses under parts A and B,

--limiting increases in Medicare reasonable costs and charges, and

--introducing a revised cost-sharing structure to discourage unnecessary hospital use.

Part A beneficiaries would continue to pay the initial deductible when hospitalized. However, the revised cost-sharing provisions would require beneficiaries to pay 10 percent of the charges for hospitalization, skilled nursing care, and home health services, but only up to a maximum annual amount. The maximum would be $500 for the period March through December 1976 and $500 in 1977. The maximum would rise in future years to reflect the cost-of-living increases to social security benefits. Amounts spent by an individual in December would be credited to the limit in the following year.

The part B annual deductible would be increased to $77 for 1977 and would reflect changes in social security benefits for future years. The existing 20-percent cost-sharing provision under part B would remain generally in effect. 1/ However, beginning in 1977, cost sharing would be limited to an annual maximum amount. This maximum would be $250 for 1977 and would also reflect changes in social security benefits. Amounts spent by an individual in December of any year would be credited to the limit in the following year.

This proposal would also limit increases in Medicare reasonable costs and charges for fiscal years 1977 and 1978. Under part A, increases in allowed reasonable costs would be limited to 7 percent more than the reasonable costs in the

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1/For home health and in-hospital pathology and radiology services, Medicare presently pays 100 percent of the reasonable costs or charges. The proposed bill would add a 10-percent cost-sharing requirement for these services.

previous fiscal year. Under part B, increases in reasonable charges would be limited to 4 percent.

On the basis of actual 1971 data, adjusted for higher costs and charges in 1976, the 80 beneficiaires in our sample would have incurred about $249,000 in covered hospital and medical expenses. Under Medicare's existing benefit structure, the beneficiaries would have to pay about 10 percent of the expenses. Under the proposed structure, beneficiaries would have to pay about 15 percent, as shown in the following table. 1/

Covered Expenses Under Medicare Benefit Structure and Under Medicare Improvements of 1976

	Medicare				Medicare Improvements of 1976			
			Total				Total	
	Part A	Part B	Amount	Percent	Part A	Part B	Amount	Percent
Program pays	$186,270	$38,590	$224,860	90.2	$171,474	$40,323	$211,797	85.0
Beneficiary liability:								
Deductible	9,152	4,302	13,454		9,152	5,543	14,695	
Coinsurance	1,248	9,647	10,895		16,044	6,673	22,717	
	10,400	13,949	24,349	9.8	25,196	12,216	37,412	15.0
Total	$196,670	$52,539	$249,209	100.0	$196,670	$52,539	$249,209	100.0

Only three beneficiaries would benefit by the coverage for catastrophic illnesses--only one of these incurred more than $500 in part A expenses. The other 77 beneficiaries would have to pay an average of $182 more than they would under the existing program.

Our analysis considered only the reasonable charges for medical services covered by Medicare. The beneficiaries' total liability may be higher if actual charges are greater than the amounts allowed.

1/Assumes maximum limits on cost sharing under parts A and B to be in effect for all of 1976. Under the proposal only the last 10 months of 1976 have a maximum limit on cost sharing for part A, and part B has no maximum limit until 1977.

THE KENNEDY-MILLS PROPOSAL

This proposed national health insurance program would provide comprehensive health care benefits to all Americans, except those covered under Medicare. All social security cash bereficiaries not eligible for Medicare, such as those between 62 and 65, would be covered under this plan. However, Medicare would continue to cover its existing beneficiaries, and the benefits would be expanded.

This proposal would modify Medicare to include

--a voluntary long-term care program,

--coverage of prescription drugs,

--elimination of the inpatient hospital day limitations,

--coverage of catastrophic illnesses, and

--certain other benefits.

The long-term care program would be voluntary and would cover long-term services, when deemed medically necessary, including care in skilled nursing and intermediate care facilities provided under agreements with community long-term care centers. It would also cover noninstitutional medical and social services. For this program, each person would pay $6 a month. Under the long-term care program, the cost of outpatient prescription drugs would be covered, except for $1 for each prescription.

The limitation on the number of inpatient hospital days under Medicare would be eliminated, but the cost-sharing provisions would remain generally in effect. Due to eliminating the hospital day limiations, the coinsurance rate (one-half the Medicare deductible) would apply after 90 days. Under the national health insurance and the proposed modified Medicare program, cost sharing (deductible and coinsurance amounts) would be limited to $1,000 per calendar year for an individual and other family members. The $1 drug payment would not be included in this amount.

Although not specifically provided for in the bill, according to a statement by Senator Kennedy in May 1974, the sponsors intended to reduce the limit of cost sharing for low-income Medicare beneficiaries--similar to the limitations under the proposed national health insurance plan. For individuals, the limit would be based on 25 percent of income

over $2,400. For a Medicare beneficiary with an annual income of $3,600, the limit on cost sharing would be $300 (25 percent of $1,200).

Assuming the same income classes and the same income midpoints used in the CHIP analyses, the $249,209 for inpatient hospital and part B medical expenses applicable to the 80 sampled beneficiaries would have been distributed between the program and the beneficiaries as follows:

	Medicare (see p. 20)		Medicare as modified by Kennedy-Mills					
			Income class 2 $1,750 under $3,500 ($138 maximum liability) (note a)		Income class 3 $3,500 under $5,250 ($494 maximum liability)		Income class 4 $5,250 and over ($1,000 maximum liability)	
	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent
Program pays	$224,860	90.2	$241,059	96.7	$227,112	91.1	$225,384	90.4
Beneficiary liability	24,349	9.8	8,150	3.3	22,097	8.9	23,825	9.6
Total	$249,209	100.0	$249,209	100.0	$249,209	100.0	$249,209	100.0

a/Calculated at the midpoint of the income class after the $2,400 exclusion, which SSA estimated would apply to about 3 million (about 25 percent) of the 11.4 million beneficiaries in this class. No cost sharing was assumed for 25 percent of the 80 beneficiaries.

The proposal to limit cost sharing would affect mostly the individuals in income class 2, about 51 percent of the aged Medicare beneficiaries. Of the individuals in income class 3 (about 20 percent of the aged Medicare beneficiaries) 11 beneficiaries would have deductible and coinsurance charges above the assumed limit of $494. For individuals in income class 4 (about 25 percent of the aged Medicare beneficiaries) only one beneficiary would incur deductible and coinsurance charges under Medicare above $1,000.

Proposed separate cost-sharing limitations for aged couples

The foregoing analysis applied proposed cost sharing to individuals. Under the Kennedy-Mills formula, the limit on cost sharing for aged couples would be based on 25 percent of income over $3,600. About 50 percent of the people age 65 or older in the United States are married couples. What would happen if proposed limits on cost sharing were applied to them?

In the preceding table the income for a couple was assumed to be divided equally between the man and wife. Under this assumption, about 3.8 million aged beneficiaries (0.8 million in income class 1 and 3 million in income class 2), about 17 percent of the aged population, would have incomes of $2,400 or less. They would not have to pay Medicare deductible and coinsurance amounts. However, because about 50 percent of the people age 65 or older are married couples, apparently only about 1.6 million of the aged beneficiaries, about 7 percent, would not have to pay. Presently, for the estimated 2 million elderly people eligible for cash welfare assistance and covered by both Medicare and Medicaid, Medicaid pays the Medicare deductible and coinsurance amounts.

SSA lacks data on how married couples use Medicare services. SSA estimates indicate that about 75 percent of the aged married couples have incomes over $4,800 and thus would have a liability limitation over $300. Of the 80 sampled beneficiaries, 53 (about 66 percent) had deductible and coinsurance charges less than $300. Unless both spouses used inpatient hospital services, most married Medicare beneficiaries probably would not greatly benefit from the proposed limitation.

THE LONG-RIBICOFF PROPOSAL

This proposal provided for a catastrophic illness insurance plan covering all persons either fully or currently insured 1/ under the Social Security program or entitled to social security benefits, as well as their spouses and dependent children. Persons (and their dependents) with certain specified credits under Social Security, but not enough to meet the regular insured requirements, would also be eligible. The act provided for a medical assistance plan to cover catastrophic and other illnesses of low-income beneficiaries through a uniform national program replacing Medicaid.

1/A person who has social security credit for at least 1-1/2 years (6 quarters) of work within a 3-year period is currently insured. To be fully insured, a person needs 1 quarter of coverage for each calendar year after 1950 (or after the year in which he or she became 21) up to the year he or she became entitled to benefits. A person with 40 quarters of coverage is fully insured for life.

A revised proposal was introduced on October 3, 1975, incorporating (1) a plan covering the catastrophic illnesses of all citizens or permanent residents of the United States and (2) a basic health benefits program for low-income people, which would also replace Medicaid.

Both plans supplement Medicare, since they do not pay (1) hospital benefits until a beneficiary has spent 60 days in a hospital during the year or (2) part B medical benefits until a beneficiary or his or her family has incurred $2,000 for covered medical expenses during the year. Hospital days and medical expenses incurred during the last 3 months of a year, if they are not covered expenses for that year, may be counted toward the 60 days and the $2,000, respectively, for the next year.

Once a person has been hospitalized a total of 60 days in a year, the plans provide benefits for generally an unlimited number of inpatient hospital days. The 1973 proposal calls for a daily coinsurance for these days equal to one-fourth of the Medicare deductible. The 1975 proposal does not provide for any coinsurance after the deductible has been met. Also, because Medicare's benefits would continue, providing 90 days of inpatient hospital care in a benefit period in addition to the 60 day reserve, some stays could be covered under both Medicare and the Long-Ribicoff plans. In these instances, the stays would be reimbursed under the plans.

After the $2,000 of expenses have been incurred, the plans cover physicians' and other miscellaneous health services. Generally, except for a limit per year per person for outpatient psychiatric physicians' services, benefits would not be limited. However, the 1973 proposal did impose 20-percent coinsurance after the $2,000 had been incurred, but combined hospital and medical coinsurance payments under that plan would be limited to $1,000 a year for an individual. Coinsurance was not included in the 1975 proposal.

On the basis of medical expenses and hospital use in 1971, 9 of the 80 sampled beneficiaries would have qualified for benefits in 1976 under the Long-Ribicoff plans--2 of these by meeting the 60-day requirements.

One beneficiary spent 64 days in hospitals during the year. Under Medicare he would have been liable for $104 in coinsurance (4 days at $26). Under the 1975 proposal, the beneficiary would pay nothing since there is no coinsurance. Under the 1975 proposal the second beneficiary, who had 97 inpatient hospital days, would be liable for $1,144 less

than under Medicare. The other seven beneficiaries would have qualified because they had $2,000 of expenses. Under the 1975 proposal, since they would pay no coinsurance in this case, the beneficiaries would pay $559 less under the plan than they would under Medicare. Therefore, the 1975 Long-Ribicoff catastrophic illness proposal would decrease the 80 sampled beneficiaries' liabilities for expenses from $24,349 (9.8 percent) under Medicare to $22,542 (9.0 percent).

The medical assistance plan would be available to persons eligible for Medicaid during January through June 1977 and to low-income individuals and families. Individuals with incomes at or below $2,400 and two-person families with incomes of $3,600 or less would be eligible. For aged persons covered, this plan would pay the Medicare part B premiums and deductibles and coinsurance. This is basically what Medicaid has been paying as of November 1976 for about 2.2 million aged persons who are categorically needy. Except for a copayment of $3 for each of the first 10 outpatient physicians' visits for an individual or family, the medical assistance plan generally has no deductibles or coinsurance.

CONCLUSIONS

Under Medicare's existing benefit structure, the hospital coinsurance features seem to have had a negligible effect on program use and costs, because most beneficiaries were discharged before coinsurance became effective. For those who believe that copayments can and do help reduce excessive or unnecessary use of hospital services, the proposed copayment features for CHIP and the Medicare Improvements of 1976 would be an improvement over the existing Medicare program. Further, by eliminating the existing limit on inpatient hospital days, CHIP or the Medicare Improvements of 1976 would provide additional protection to those beneficiaries--less than 1 percent of those using hospital services in a year--who exhausted their 90-day benefit period.

On the other hand, for those who do not believe that cost sharing reduces hospital use, imposing cost sharing from the first day of hospitalization would merely increase the "out of pocket" costs for many Medicare beneficiaries. Thus, the effectiveness of cost sharing as a means of curbing unnecessary use of hospital services must be clearly established. We believe this is particularly important for CHIP, since SSA estimates indicate that CHIP's proposed changes in cost sharing would redistribute the beneficiaries' liability under Medicare from persons with incomes less than $3,500 to persons with incomes over that amount. Administering cost sharing based on income is a costly process.

The elimination of the limit on inpatient hospital care under the Kennedy-Mills bill would provide additional protection to those relatively few beneficiaries who exhaust their 90-day benefit period. Because the Kennedy-Mills proposal would not change the basic cost-sharing formula for Medicare, no beneficiary would pay more under the proposal than under Medicare. By limiting payments based on income, some beneficiaries would pay less, with the major effect of the reduced cost sharing being applicable to the lower income individuals. Realistically assessing the effect of such limitations is difficult, because of the uncertain effect of the proposed separate cost-sharing limitations for aged couples.

The Long-Ribicoff plans would only slightly affect Medicare's existing benefit structure. The coverage for catastrophic illnesses would not become effective until after 60 days, which would affect about 3 percent of the Medicare beneficiaries using their inpatient hospital benefits in a year. The proposals would virtually negate the benefit period approach by providing full inpatient hospital coverage with no coinsurance.

CHAPTER 4

HOW PROPOSED CHANGES WOULD AFFECT MEDICARE'S PROGRAM ADMINISTRATION

Although Medicare's existing part A benefit structure has caused administrative problems for the Social Security Administration, the intermediaries, and the hospitals, such problems appear relatively minor when compared with the administrative problems possible under certain proposed changes to Medicare's benefit structure:

--Various levels of cost sharing based on beneficiaries' incomes.

--Assuming responsibility for collecting deductible and coinsurance amounts from the beneficiaries for services provided by numerous noninstitutional providers.

ADMINISTRATIVE PROBLEMS WITH PART A BENEFIT STRUCTURE

There have been several problems in administering Medicare's hospital insurance benefits. These problems can be reasonably attributed to the benefit period and the related query system for confirming eligibility and benefit status. (See app. IV.)

--Medicare beneficiaries do not understand their hospital benefits. We interviewed 187 program beneficiaries in 4 SSA district offices to determine their understanding of the part A benefit structure. About 80 percent of the beneficiaries interviewed could not relate any knowledge or understanding of the benefit period. (See p. 48.)

--SSA has historically had problems in keeping its part A master records reasonably current, because notices of admission must be closed by a corresponding bill in the same chronological sequence that the services in a benefit period are provided.

--As a result of the above situation, about 30 percent of SSA's responses to hospital and skilled nursing facility queries regarding the eligibility and benefit status of beneficiares required additional development by the intermediaries.

--The American Hospital Association estimated that, for over half the admissions to short-stay hospitals, Medicare patients were discharged before the hospital received notification of their eligibility and benefit status. Hospital billings for Medicare patients take twice as long to be submitted after discharge as the bills for non-Medicare patients.

--SSA does not systematically obtain information on admissions to approximately 13,000 nonparticipating hospitals and nursing homes where such admissions would break the 60-consecutive-day period required to begin a new benefit period. Thus, complete knowledge and control of when a new benefit period should begin is lacking and would be impractical.

EFFECT OF PROPOSED CHANGES ON PROGRAM ADMINISTRATION

Various features of the proposals for national health insurance would reduce some of the administrative problems discussed above, but also create worse administrative problems.

Simplification of benefit structure

Both the proposed Comprehensive Health Insurance Act of 1974 and the Kennedy-Mills proposal would provide for (1) eliminating the inpatient hospital day limitations (although the latter proposal would retain the benefit period) and (2) using credit cards (program payments would be made in full to participating providers, such as hospitals, on behalf of those beneficiaries not in default on their payments). The beneficiaries' cost-sharing amounts would be charged to their accounts to be collected by the program. Those beneficiaries not paying their cost-sharing amount would be in default. The health card would essentially limit the hospitals' involvement in the query process to identifying beneficiaries in default.

Eliminating the inpatient day limitations and the benefit period should help beneficiaries to understand their benefits. With such changes,

--admissions and related discharges would not need to be recorded chronologically on SSA's master records,

--the query process would be reduced to one of establishing eligibility, and

--a beneficiary would not have to be identified as admitted or not admitted to a nonparticipating institution within 60 days of discharge from a hospital or skilled nursing facility.

Certain other proposals such as the Ullman bill and the Staggers bill (see app. III) while retaining the benefit period with a limit on the number of inpatient hospital days would ultimately introduce a flat $5-a-day copayment for inpatient hospital services. This should help beneficiaries to understand the program and simplify the query process by eliminating the inpatient deductible and coinsurance amounts beginning with the 61st day. Admission notices would not have to be processed in chronological order. Hospitals would know what to charge beneficiaries, except for the few who exhausted their benefits.

A $5-a-day copayment for inpatient hospital services in 1971 would have produced about the same deductible and coinsurance amounts ($385 million) which were actually incurred ($370 million) under Medicare's existing benefit structure. A coinsurance charge of about $7.30 a day would have been required in 1974 to produce the $640 million incurred in that year.

Potential administrative problems

Proposals incorporating income tests for cost sharing and having the program assume responsibility for collecting copayment amounts could create major administrative problems.

Income test for cost sharing

Basing cost sharing on income would require that the income of individuals and families in the Medicare program be determined.

SSA estimated that, for the assisted and Federal plans under the CHIP proposal, over 39 million income determinations would have to be made. Using experience on making income determinations under the Supplemental Security Income (SSI) program which features face-to-face interviews, SSA estimated that income determinations for 39 million filing units could require over 65,000 staff-years and salaries of at least $800 million. After adding personnel fringe benefit costs and other costs such as travel, equipment, rent, and training, SSA estimated that total costs could be at least $1.5 billion, of which at least $700 million would apply to the elderly Medicare population. This approximates the

estimate of $750 million in total Medicare administrative costs in fiscal year 1975.

Although we believe the SSA estimates are too high, 1/ they do indicate how administrative costs would be affected by determining the incomes of Medicare's beneficaries.

In commenting on our draft report, the Department of Health, Education, and Welfare stated that SSA does not assume that the income definition and income determination process used for the SSI program would be used in implementing proposed income-related health care provisions. According to SSA, estimates of the cost of such an approach were developed to illustrate the need to find simpler, less costly alternatives.

Introducing various cost-sharing arrangements based on income would also involve the problems of maintaining the integrity of the system and, particularly under CHIP, of individuals changing from one cost-sharing class to another. For example, under CHIP, a variance of $1 in income (from $3,499 to $3,500) would increase an individual's coinsurance rate from 15 to 20 percent and the maximum cost-sharing liability by $105 (from $315 to $420).

Assuming responsibility for collecting deductible and coinsurance amounts

Introducing various classes of or cost-sharing limitations based on income would virtually require the proposed credit card system because of the difficulties in promptly communicating to providers the beneficiary's income class and/or cost-sharing liability. With credit cards, the program would pay the participating providers--including hospitals--in full. The program would be responsible for collecting the appropriate cost-sharing amounts from the beneficiaries. This would involve

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1/The estimate did not consider married persons (approximately 10.6 million) whose incomes could be determined at the same time as their spouses' incomes. The estimate did not consider the income determinations already required under the Supplemental Security Income and State Aid to Families with Dependent Children program, which could account for about 7 million of the estimated 39 million determinations. Also, an assumed 100 percent addition to personnel salary costs exceeds SSA experienced rates for personnel fringe benefits and support costs which, according to SSA officials, are about 40 percent, excluding administrative costs of the States and Medicare contractors.

--notifying providers of beneficiaries in default,

--accounting for and collecting the beneficiaries' liabilities, and

--assuming the risk of bad debts.

SSA estimated that cost sharing for fiscal year 1975 for the aged under either Medicare or CHIP for the same covered services would be $2.3 billion and $2.4 billion, respectively. Under the existing Medicare benefit structure, about $0.7 billion applied to part A services and about $1.6 billion applied to part B services.

Of the $0.7 billion, about 95 percent represented cost sharing for inpatient hospital services provided by about 6,900 participating hospitals. The $1.6 billion would involve services provided by over 400,000 physicians and other professionals and by independent laboratories, hospitals, and suppliers. The inpatient hospital cost sharing would apply to about 8 million hospital admissions. The part B cost sharing would apply to over 100 million transactions, if the program also assumed the responsibility for collecting the cost of services applied against the part B deductible.

In terms of communicating with providers and accounting for the beneficiaries' liabilities, inpatient hospital services would represent a relatively low volume of both providers and transactions.

Under the CHIP and Kennnedy-Mills proposals, credit cards would be provided to all elderly persons enrolling in the programs. Credit, subject to interest, would be available to each beneficiary to cover cost sharing, unless the account was in default.

Since all beneficiaries would be issued a card initially, bad debt or default rates could be expected to be relatively high until defaulters are identified. According to an SSA analysis, physicians average 88 percent collection on billings. As noted on page 13, although about half the beneficiaries had complementary insurance, the coinsurance bad debts under Medicare for inpatient hospital services were about 10 percent. Of the coinsurance beneficiaries had to pay, which excludes the amounts paid by complementary insurance and Medicaid, the coinsurance bad debts were about 34 percent under Medicare for inpatient hospital services.

Another indicator of possible bad-debt costs under a credit card system is the State experience with the "spend down" liability, or obligation to pay some medical expenses, of the medically needy under Medicaid. The income of the medically needy in excess of the amount needed for basic living expenses must first be used to pay the costs incurred for health insurance premiums, certain related cost-sharing expenses, and the cost of health care not included in the State medical plan and then to pay covered care.

In at least two States, certain providers are paid in full and the beneficiaries' spend down liabilities are handled by the State as money to be collected from the recipient. These States appeared to have a high proportion of bad debts.

A January 1975 SSA planning paper for national health insurance discussed initially limiting the credit card to inpatient hospital services. Some advantages of this are that

--a relatively small number of high cost transactions, where the cost of collection would be relatively small compared to the amount of the benefit, would be involved,

--a limited number of providers would be involved and defaulters and money owed could be identified for providers through existing systems, and

--the collection experience could be used in identifying problems and developing policy and procedures for wider application.

Since hospitals are reimbursed on the basis of reasonable costs, which include the bad debts of Medicare beneficiaries for deductible and coinsurance amounts, the savings to the providers by eliminating bad debts (except for beneficiaries in default) would probably be passed on to the program. The program would benefit if its collection experience is better than the hospital's.

CONCLUSIONS

Medicare's existing benefit structure for inpatient hospital services is complicated and has created administrative problems for SSA, the intermediaries, and the hospitals.

Various national health insurance proposals would change the existing benefit structure. Of these proposals, eliminating the limits on inpatient hospital days and substituting a flat, daily coinsurance charge for the existing inpatient deductible and coinsurance seem most attractive since they would simplify administration.

Introducing a modified benefit structure based on individual or family income would greatly increase administrative costs, particularly if strictly enforced and monitored to maintain the integrity of the system, and could have only a limited impact on total program benefits. Under CHIP, for example, the Federal plan for the aged could be paying as much as $700 million in administrative costs merely to redistribute about $2.4 billion in cost sharing among the program beneficiaries and their complementary insurers.

Introducing a credit card system would simplify program administration and reduce related costs for providers but could be expected to increase the administrative cost to the Government.

Section 222(b) (1) of the Social Security Amendments of 1972 (Public Law 92-603) amended section 402 (a) of the Social Security Amendments of 1967 (42 U.S.C. 1395b-1) to authorize HEW, either directly or through grants and contracts, to develop projects to determine whether changes in methods of payment or reimbursement would have the effect of increasing the efficiency and economy of health programs established by the Social Security Act.

This rather broad authority could be used to implement a project to test the use of a credit card system under Medicare.

AGENCY COMMENTS

In our draft report we proposed that the Secretary direct the Commissioner of Social Security to initiate a project to determine whether paying for inpatient hospital services with credit cards would increase the efficiency and economy of the program. HEW, in commenting on our draft report on October 1, 1976 (see app. V), said it questions the usefulness of a demonstration project limited to inpatient hospital services. According to HEW, a health card approach for part B services has greater potential benefits--the principal one being its effect on having physicians accept Medicare's allowable charge as the full charge, thus, having the potential to reduce costs to beneficiaries.

According to HEW, SSA has considered several possible projects. One project being considered would use a health card system to pay physicians, in accordance with a negotiated fee schedule, for services to Medicare beneficiaries. An ongoing project, which deals with payment for prescription drugs in California, is expected to provide information on various aspects of the health card concept including administrative costs and bad debts.

HEW also said it was considering a health card system experiment to be used primarily for ambulatory care. Such an experiment would include direct cash savings to patients. HEW hopes the experiment would involve agreements by physicians to accept the health card for a large proportion of their patients, thereby demonstrating that a health card can result in real savings to patients and providers.

According to HEW, SSA plans to continue its efforts in examining the feasibility of health card approaches. However, HEW's comments do not demonstrate a strong commitment to the experiments which we believe are very important before any wider adoption of the health card approach is considered under national health insurance. The only definite commitment is an experiment with prescription drugs.

Although we agree that the health card approach for part B services would provide more potential for benefiting the beneficiary by limiting the charges to amounts considered reasonable by Medicare, we still believe that a health card experiment involving inpatient hospital services offers more potential advantages from an administrative standpoint for the various reasons discussed on page 36. If the Government's success as a bill collector is demonstrated on a test basis, it could lead to a wider application, thus eliminating the need for timely determination of Medicare beneficiaries' deductible and coinsurance status. This could result in substituting a relatively simple system for checking credit status, instead of the present query system with its related administrative problems for SSA, its intermediaries, and providers.

In any event, we agree with HEW that various alternative experimental approaches could be used to determine the feasibility of the credit card concept.

RECOMMENDATION TO THE SECRETARY OF HEW

We recommend that the Secretary of HEW direct the Commissioner of Social Security to expand SSA's current efforts in testing the use of credit cards under Medicare and determining the feasibility of their use under national health

insurance proposals. The interested legislative committees should be informed before such a test is undertaken.

RECOMMENDATION TO THE CONGRESS

In its deliberations of national health insurance proposals that would change Medicare's benefit structure, we recommend that the Congress carefully explore whether the benefits of introducing an income test would justify the resultant added administrative problems and costs. If cost sharing for inpatient hospital services is desirable, we recommend that the Congress provide for a fixed, daily copayment for inpatient hospital services.

CHAPTER 5

SCOPE OF REVIEW

This review was made to determine how well inpatient hospital care under Medicare covered the elderly, the effect proposed changes would have on Medicare's existing inpatient benefit structure, and possible administrative problems associated with these changes.

Work was done at the Social Security Administration central office in Baltimore and the SSA district offices in Atlanta, Boston, Chicago, and Los Angeles. Work was also done at the Blue Cross Association in Chicago and four Blue Cross plans--United Hospital Service Association, Atlanta; Massachusetts Blue Cross, Inc., Boston; Hospital Service Corporation, Chicago; and Blue Cross of Southern California, Los `ngeles.

Medicare beneficiaries' hospital use data discussed in this report was obtained by reviewing the hospital claims records for an SSA actuarial sample of 0.1 percent of all beneficiaries eligible for part A hospital insurance benefits. This is a continuing sample of beneficiaries whose social security numbers end with digits 595. We also used data from SSA's Office of Research and Statistics on length of stays in short-stay hospitals by medical beneficiaries in 1971.

We selected calendar year 1971 because it was the latest year for which relatively complete data was available when our review began. As of January 1977, relatively complete data was available for calendar year 1973 from SSA's Office of Research and Statistics and the Office of the Actuary. We compared this data with the 1971 data. Hospital use by sample beneficiaries and projections of sample results to the universe of Medicare beneficiaries were discussed and developed with the cooperation of the Office of the Actuary, SSA.

Information on the amount of inpatient hospital care received by beneficiaries but not covered by Medicare and other information on program administration was obtained from a survey conducted at our request by the American Hospital Association. The association sent questionnaires to about 800 non-Federal, short-term general hospitals of all sizes and locations registered by the association and certified by SSA for use by Medicare patients. About 590 hospitals (74 percent) replied and provided the association the basis for projecting, with a 95-percent assurance, that only about 1 percent of the inpatient hospital days of Medicare

beneficiaries in short-stay hospitals are not covered by Medicare.

We reviewed regulations, directives, and records pertaining to the administration of the query system at the SSA central office, BCA, and four selected Blue Cross plans. We also obtained, with the cooperation of BCA, information on program administration and costs from 69 other Blue Cross plans. We interviewed 187 program beneficiaries in 4 SSA district offices to determine their understanding of the part A benefit structure.

We analyzed how various features of national health insurance proposals introduced in the 93d Congress would affect the Medicare benefit structure and program administration. Our analysis included the use of a stratified subsample of the 0.1 percent sample maintained by the Office of the Actuary, adjusted to allow for higher part B physicians' charges and part A reimbursements in 1976, in order to determine the distribution of covered expenses under the existing Medicare benefit structure and under four major national health insurance proposals.

MEDICARE INPATIENT HOSPITALIZATION IN 1971

Number of inpatient hospital days	Office of Research and Statistics sample data (as of 1/3/73)			Sample data								
				By length of stay			By benefit period			By calendar year		
	Number of stays in short-stay hospitals	Percent of stays	Cumulative percent of stays	Number of stays	Percent of stays	Cumulative percent of stays	Number of benefit periods	Percent of benefit periods	Cumulative percent of benefit periods	Number of beneficiaries with this number of covered days in year	Percent of beneficiaries	Cumulative percent of beneficiaries
less than 4	952,695	15.8	15.8	786	14.5	14.5	576	12.7	12.7	441	11.2	11.2
4-6	1,198,775	19.9	35.7	1,081	19.9	34.4	814	18.0	30.7	611	15.6	26.8
7-9	1,047,840	17.4	53.1	994	18.3	52.7	721	16.0	46.7	562	14.3	41.1
10-12	744,220	12.4	65.5	680	12.5	65.2	517	11.4	58.1	437	11.1	52.2
13-15	542,425	9.0	74.5	480	8.9	74.1	415	9.2	67.3	354	9.0	61.2
16-20	577,270	9.6	84.1	545	10.1	84.2	476	10.5	77.8	415	10.6	71.8
21-25	351,830	5.8	89.9	295	5.4	89.6	303	6.7	84.5	305	7.8	79.6
26-30	208,000	3.4	93.3	200	3.7	93.3	202	4.5	89.0	222	5.7	85.3
31-45	260,965	4.3	97.6	232	4.3	97.6	278	6.2	95.2	311	7.9	93.2
46-60	82,605	1.4	99.0	77	1.4	99.0	117	2.6	97.8	145	3.7	96.9
61-90	44,720	.7	99.7	48	.9	99.9	80	1.8	99.6	93	2.4	99.3
91-120	9,320	.2	99.9	4	.1	100.0	12	.3	99.9	22	.5	99.8
Over 120	5,615	.1	100.0	1	(less than .1)	100.0	6	.1	100.0	7	.2	100.0
Total	6,026,280	100.0		5,423	100.0		4,517	100.0		3,925	100.0	

APPENDIX I

APPENDIX II

INPATIENT HOSPITAL CARE USED BY DISABLED PERSONS

About 1.8 million disabled persons became eligible for Medicare benefits effective July 1, 1973. According to the Social Security Administration's Office of the Actuary, approximately 2.2 million will be covered by the program in fiscal year 1976. About 700,000 (32 percent) will receive reimbursed hospital services as compared to about 23 percent of the aged that will receive inpatient hospital care in fiscal year 1976.

The estimated average number of days of hospitalization for each aged and disabled enrollee is shown below.

Average Number of Days Hospitalized

	FY 1974	FY 1975	FY 1976
Aged	3.9 days	4.0 days	4.1 days
Disabled	4.0 days	4.3 days	4.4 days

On the average, the disabled had more days in the hospital each year. Because the lengths of stay for the disabled for fiscal year 1974 were approximately the same as for the aged (about 11.5 days), the difference in the average days hospitalized is due to (1) a higher percent of the disabled using hospital services and/or (2) a higher number of admissions during the year for the disabled.

An earlier study by SSA's Office of Research and Statistics tends to support the above differences. The office sampled 2,000 disabled persons from those

--between the ages of 20 and 64,

--qualified for SSA disablility benefits for at least 24 months, and

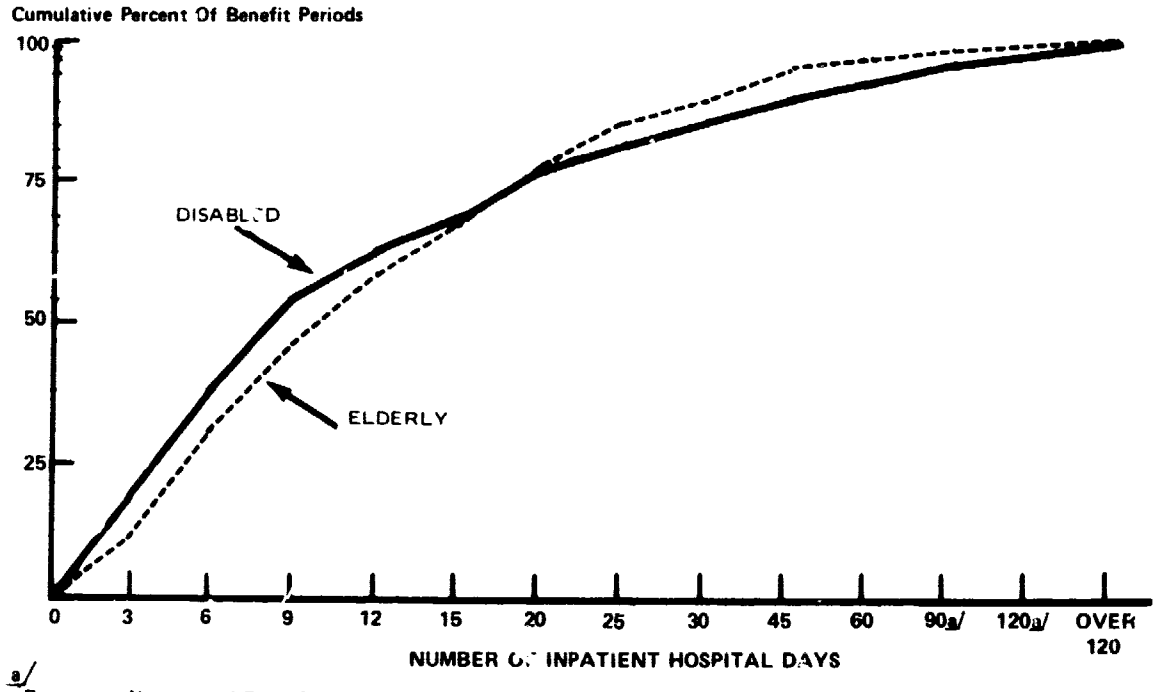
--who would have been eligible for disability benefits for at least 1 month during fiscal year 1972.

Analyses of hospital use for the sample showed that 571 persons (29 percent) received inpatient hospital care during fiscal year 1972. Of these, 372 received inpatient care in one or more short-stay, long-stay, or tuberculosis hospitals, or one of these in combination with psychiatric hospital care. The other 199 generally received inpatient

hospital care in only psychiatric hospitals where Medicare coverage is limited or in military or Veterans Administration hospitals which are not covered by Medicare.

The 372 disabled persons discussed above were admitted for inpatient care an average of 1.8 times during the year, 1/ a rate higher than the 1.4 admissions for the elderly, as discussed in chapter 2. Even with the higher admission rate, a slightly higher percentage of the benefit periods used by these disabled persons were terminated within the first 15 days of inpatient care. However, the use of inpatient hospital care in the benefit period by the 372 disabled in fiscal year 1972 and the elderly in fiscal year 1971 was similar as shown in the following graph.

Benefit Periods of Disabled and Elderly Medicare Beneficiaries Compared



a/ Represents Noncovered Days Or Usage Of Reserve Days.

1/Some pre-fiscal year 1972 admissions were included in the sample. If a person became eligible during a hospital stay in fiscal year 1972 which began before fiscal year 1972, that stay was counted. Also if an already eligible individual was in the hospital at the start of fiscal year 1972, that particular stay was included.

APPENDIX II

In summary, available data support the conclusion that, similar to the aged, very few eligible disabled are likely to exhaust their Medicare hospital benefits under Medicare's existing benefit structure.

APPENDIX III

Major National Health Insurance Proposals Introduced in the 93d Congress

As of April 11, 1974, and Reintroduced in the 94th Congress as of April 22, 1975

Congress	Bill number	Title (date introduced)	Principal sponsors	Relationship to Medicare
93d	H.R. 1	National Health Care Services Reorganization and Financing Act (1/3/73)	Ullman	As the federally financed plan of health insurance for the aged, Medicare parts A and B would be combined and the part B premium eliminated. Coverage for catastrophic illnesses, eliminating the cost sharing and hospital limitation of the Medicare benefits, would be available for low-income aged 6 months after enactment. After 3 years, it would cover all of those aged who meet a specified medical expense limit based on family income. After a 5-year phase in, Medicare would be replaced by comprehensive health care benefits, including 90 days of inpatient hospital services in a benefit period with a $5 a day copayment, 30 days in a skilled nursing facility at $2.50 a day, 90 days in a nursing home at $2.50 a day, $1 copayment on drug prescriptions, and 10 visits a year for outpatient physican services with a $2 copayment per visit.
94th	H.R. 1	National Health Care Services Reorganization and Financing Act (1/14/75)	Ullman	Benefit structure similar to above bill.
93d	H.R. 22 and S.3	The Health Security Act (1/3/73)	Kennedy-Griffiths	Medicare is abolished. A national health insurance plan is established for the entire population with no limits or cost sharing for inpatient general hospital services or physicians' services. The benefit period is kept for skilled nursing facilities where 120 days are covered, and for inpatient psychiatric hospital services where 45 days are covered. Prescription drugs are covered for chronic diseases and other selected conditions or if provided through participating institutions, Health Maintenance Organizations, and professional foundations.
94th	H.R. 21 and S.3	The Health Security Act (1/14/75)	Kennedy-Corman	Benefit structure similar to above bill.
93d	H.R. 1054 and S.587	National Catastrophic Illness Protection Act of 1973 (1/3/73)	Roe-Beall	Medicare continues. Provides for voluntary private health insurance for all U.S. residents. Individual and family medical expenses (as defined in Federal income tax law) would be paid once they reached a certain amount--a deductible based on income and family size. Low income people would have no deductible. Payments made by a third party, including Medicare, can be counted towards the deductible. Premiums, set by the Department of Health, Education, and Welfare according to family size and composition, are paid by the policyholder, but could be subsidized by the goverment.
94th	H.R. 1373	National Catastrophic Illness Protection Act of 1975 (1/14/75)	Roe	Benefit structure similar to above bill.
93d	H.R. 2222 and S.444	Health Care Insurance Act of 1973 ("Medicredit") (1/18/73)	Fulton-Hartke	Medicare continues. Persons 65 and older would remain under Medicare and would not be covered under this proposal. For others, the proposal provides for tax credits against individual income taxes to offset all or part of the premium cost of qualified health insurance policies. It would replace much of the Medicaid program.
94th	H.R. 6222	Comprehensive Health Care Insurance Act of 1975 (4/22/75)	Fulton	Similar in the use of a tax credit mechanism to the above bill. However, this bill provides that (1) employers make insurance available to each employee and (2) the Government participate through tax credits or certificates of entitlement in the premium for qualified supplemental insurance purchased for those unemployed or self-employed persons who have reached 65 or are otherwise eligible for benefits under part A or part B of Medicare. The amount shall be determined on income tax liability. The insurance shall exclude all items and services to the extent they are included as benefits in parts A and B of Medicare and shall not reimburse for deductible and coinsurance imposed under that title. It would allow for 365 days of inpatient hospital care in a policy year less the days covered under Medicare. Benefits provided under this insurance plan would not be subject to any coinsurance or deductible.

APPENDIX III

Congress	Bill number	Title (date introduced)	Principal sponsors	Relationship to Medicare
93d	S. 915	National Health Insurance and Health Services Improvement Act of 1973 (2/20/73)	Javits	Medicare will be absorbed into a national health insurance program that will eventually cover the general population. The benefit period remains for institutional services with a deductible each benefit period and coinsurance after the 60th day. Most services (except institutional) would be subject to the present Medicare part B cost sharing of an annual deductible per person and 20 percent coinsurance. Other benefits are added, such as annual physical checkups and prescription drugs for chronic illnesses. Coverage is automatic unless an individual elects coverage from a private carrier.
93d	H.R 5200 and S.1100	National Health Care Act of 1973 (3/6/73)	Burleson-McIntyre	Medicare continues. Aged enrolled in Medicare part B could be covered under a phased in State plan providing a broad range of medical services through private insurance. Medicare would initially pay for its covered services. The plan would cover 120 days of hospitalization per illness with $5 copayment each day increasing to 300 days per illness in 1979. Cost-sharing limits would be based on family size and income. Any individual incurring $5,000 in 12 consecutive months in medical expenses would be entitled to maximum benefits, despite the phase in schedule. For certain income ranges, the part B premium would count toward the insurance premium under the State plan.
94th	H.R. 5990 and S.1438	National Health Care Act of 1975 (4/15/75)	Burleson-McIntyre	Contains many of the same provisions as the above bill. This plan places no limit on inpatient hospital services, but a deductible and coinsurance feature coupled with a maximum family ability based on family size and income.
93d	S.2513	Catastrophic Health Insurance and Medical Assistance Reform Act (10/2/73)	Long-Ribicoff	Supplements Medicare. It begins paying benefits once a patient has spent 60 days in hospitals in a year or has incurred $2,000 of deductible medical expenses. Unlimited inpatient hospital days are provided and medical services above the deductible are covered but with 20 percent coinsurance. Hospital and medical coinsurance payments are limited to $1,000 each year per individual.
93d	H.R. 11345	The National Comprehensive Health Benefits Act of 1973 (11/8/73)	Staggers	Medicare continues. Program provides for basic health services for aged within 2 years, with Medicare parts A and B continuing. Medicare benefits would be payable to the extent that the benefits are not included in the basic health services under the new program. Within 4 years, coverage for catastrophic illnesses would go into effect, with Medicare continuing. Finally, within 7 years, comprehensive health care benefits would take effect. Comprehensive benefits allow for 60 days of inpatient hospital care each benefit period with a $5 a day copayment. Benefits for catastrophic illnesses go into effect once an expense limit based on income is reached. Under these, there would be no cost sharing or limit on inpatient hospital days or physician services. This program, when fully operating, provides broader benefits than under Medicare.
94th	H.R. 2050	National Comprehensive Health Benefits Act of 1975 (1/23/75)	Staggers	Benefit structure similar to above bill.
93d	H.R. 12684 and S.2970	Comprehensive Health Insurance Act of 1974--the Administration Plan (2/6/74)	Packwood-Mills-Schneebeli	Medicare continues as the Federal Plan for Aged but with some changes. Separate A and B deductibles are replaced with a single $100 deductible, and a separate deductible for drugs. Coinsurance is set at the rate of 20 percent of expenses above the deductible and a $750 maximum individual yearly liability is established. Day limitations on inpatient hospital services are removed. Reduced cost sharing for low income beneficiaries is also provided.
93d	H.R. 13870 and S.3286	Comprehensive National Health Insurance Act of 1974 (4/2/74)	Kennedy-Mills	Medicare amended to include a voluntary long-term care program, coverage of outpatient prescription drugs, a provision limiting copayments to $1,000 per year, and other minor benefits. Eliminates limit on number of inpatient hospital days and the deductible amount for blood.

APPENDIX IV

ADMINISTRATIVE PROBLEMS WITH EXISTING HOSPITAL INSURANCE BENEFIT STRUCTURE AND RELATED QUERY SYSTEM

As noted in chapter 4, several problems in administering the hospital insurance program can be attributed to the present Medicare benefit structure and the related query system for notifying hospitals of beneficiary eligibility and benefit status. These problems are discussed in the following sections.

LACK OF BENEFICIARY UNDERSTANDING OF HOSPITAL INSURANCE BENEFITS

We talked to 187 Medicare beneficiaries visiting Social Security Administration district offices in four major cities (Atlanta, Boston, Chicago, and Los Angeles). Of the 187 beneficiaries interviewed, only 2 could identify all of the following principal features of a benefit period:

--That it begins when a beneficiary is first admitted to a hospital.

--That it ends when a beneficiary has been out of a hospital or a facility primarily providing skilled nursing care for 60 consecutive days.

--That 90 days of inpatient hospital care are covered in each benefit period.

Thirty-one beneficiaries identified 1 or 2 of the above features, but 154 beneficiaries (about 80 percent) did not relate any knowledge or understanding of the benefit period.

Only 23 beneficiaries knew that 60 days of inpatient care during a benefit period were covered in full, except for the deductible; 22 knew that coinsurance was chargeable beginning with the 61st day of inpatient hospital care; and only 3 knew of the 60-day reserve benefit.

Officials at five hospitals visited said most Medicare beneficiaries simply did not understand Medicare's benefit structure and tended to rely on the hospitals for information and guidance.

Beneficiaries may not need to understand the nature and scope of their benefits, because Medicare covers all

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inpatient hospital stays for virtually all patients and because physicians rather than the beneficiaries make most decisions pertaining to hospitalization.

However, one out of every five elderly beneficiaries can be expected to be hospitalized at least once during a year, and simplifying this important and costly benefit could enhance their peace of mind and understanding of the program.

SSA AND INTERMEDIARY PROBLEMS IN ADMINISTERING THE QUERY SYSTEM

We estimate that the administration of the part A inpatient hospital query system costs over $6 million annually for the SSA administrative costs and the reimbursable administrative costs of the Blue Cross Association and its local Blue Cross plan subcontractors, who handle about 90 percent of all part A Medicare claims. These costs include:

--SSA costs of about $.7 million for personnel and data processing of part A queries. Most of these queries relate to inpatient hospital care.

--BCA costs of about $.3 million allocated to Medicare based on the Association's use of its nationwide telecommunications system.

--Subcontractor costs of about $5.2 million for personnel and other costs, such as data processing communications and postage related to receiving and transmitting hospital admission notices over the telecommunications system, processing SSA replies back to the hospitals, and investigating qualified responses.

Although the over $6 million annual cost of the inpatient hospital query system could not be termed large in relation to part A's estimated administrative costs of $322 million in fiscal year 1976, the system has encountered several problems. Administering the query system costs short-term hospitals about $11.5 million annually. (See p. 54.)

Many SSA responses require additional development by intermediaries

SSA processed 8 million responses containing eligibility data to hospital and skilled nursing facility queries through BCA during 1974, of which about 2.3 million (about 30 percent) required additional development by the intermediary. The types of responses processed included:

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Type response	Number of responses	Percent of responses
Unqualified approval for part A benefits	1,869,615	23.3
Qualified approval for part A benefits	5,332,374	66.3
Duplicate responses	339,010	4.2
Informational only	208,720	2.6
Rejections	232,127	2.9
Disallowed (entitled to part B benefits but not part A benefits)	55,035	.7
Total	8,036,881	100.0

SSA gives unqualified approval for benefits only under two circumstances; for a beneficiary who is eligible but has never used part A benefits, and for a beneficiary who has used some part A benefits for which the last recorded discharge data is within 60 days of the current admission but for which no query related open items are on SSA tape records. Of the 1.9 million unqualified approvals in 1974, 1.7 million were for beneficiaries using part A benefits for the first time.

Of the 5.3 million qualified approvals, 3.3 million did not usually require additional development by the intermediaries. The remaining approvals were qualified about 95 percent of the time because SSA had open items on its records. For these, the intermediary must obtain information on the previous use of benefits and compute the remaining benefits before forwarding the reply to the hospital or skilled nursing facility. Often this delays the fowarding of the response to the hospital.

For example, intermediary officials at Blue Cross of Southern California said 12 percent of the SSA responses require manual processing involving correspondence with hospitals and other providers, other intermediaries, and the beneficiaries to determine the current status of benefits. For nearly 40 percent of such cases, this takes over 30 days, and as many as 90 days, to complete.

About 5,000 responses were rejections for ineligibility for either part A or part B benefits, and 227,000 were rejections because the beneficiaries' eligibility had not been established or SSA could not match the patients' names and identificiation on the query with the SSA tape records. The latter rejections usually require some followup and further development by the intermediary or SSA.

APPENDIX IV

SSA problems in keeping records current on part A use

To administer the part A benefit period, open items on SSA tape records must be closed in the order that the services were provided. Open items are closed when SSA receives the corresponding bill and records the amount of benefits used. Whenever SSA does not receive a bill corresponding to an admission or if SSA has to return a bill to an intermediary for corrections or additional information, all subsequent bills for that benefit period cannot be recorded until the outstanding bill is received or, if incomplete, completed, returned to SSA, and recorded on the tape records. These bills are termed "bills in orbit." 1/

SSA formerly retained all bills in orbit until the outstanding bill was cleared. Under this procedure, bills in orbit increased steadily from about 460,000 in July 1970 to 638,000 in March 1972.

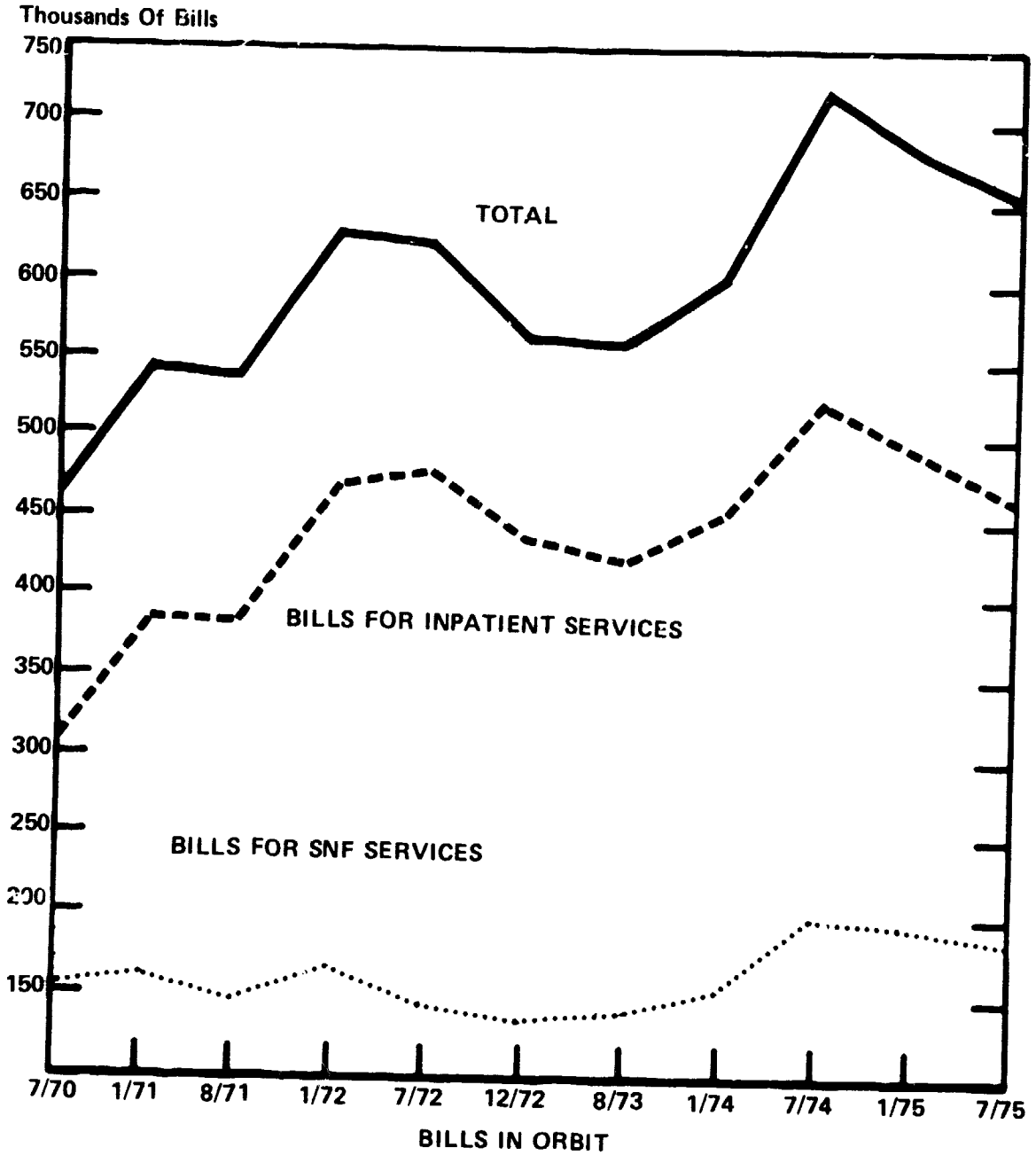
Effective January 1973, SSA implemented a revised procedure which allows SSA to finish processing the bills for each benefit period. Under this procedure, all bills following an outstanding bill need not be retained in orbit. Once a beneficiary is eligible for a new benefit period, any bills received for the new benefit period can be recorded on the tape records, provided no outstanding bills apply to the new benefit period. An SSA official stated that although this revised procedure could somewhat reduce the backlog of bills in orbit, the reduction would not be large because most of the backlog is made up of bills from 1966 through 1968.

The backlog of hospital and skilled nursing facility bills in orbit for the period July 1970 through July 1975 is summarized on the graph on the following page.

In May 1974, SSA sent out notices to the intermediaries in an attempt to close 150,000 open items generally dating before July 1971. Most of these represented bills that had been returned to the intermediaries for correction or additional information. As of July 1975, about 50,000 of these items remained to be cleared.

1/Bills in orbit can be screened for information for responding to queries. They are not, however, recorded on SSA's master records.

APPENDIX IV


Thousands Of Bills
750
700
650
600
550
500
450
400
350
300
250
200
150
TOTAL
BILLS FOR INPATIENT SERVICES
BILLS FOR SNF SERVICES
7/70
1/71
8/71
1/72
7/72
12/72
8/73
1/74
7/74
1/75
7/75
BILLS IN ORBIT

APPENDIX IV

In May 1975, SSA informed the intermediaries that pre-October 1973 open items would be purged from the system unless bills were submitted by October 1975, since the filing time limit had expired. For claims filed after December 1974, SSA has established a time limit for submitting all Medicare claims for payment for services reimbursable on a reasonable cost basis, which is generally December 31 of the calendar year following the year in which the services were furnished.

The large number of open items, with its accompanying large number of bills in orbit, has been a problem at SSA, despite consistent efforts to reduce them. In June 1970 there were 2.4 million hospital and skilled nursing facility open items; in June 1972, 2.8 million. In January 1974, the number had risen to 4.2 million open items, and as of August 1975, 3.3 million open items remained. Coupled with the fact that SSA takes an average of 115 days after a Medicare patient is discharged to receive and record the bills on the master records, open items create a situation that does not respond to the needs of the query system.

Lack of controls over care provided in nonparticipating institutions

Under the existing query system, information on admissions and hospital use, which SSA needs to determine the status of benefits, is not complete. Under the law, a benefit period ends when the beneficiary has been out of a hospital or a facility primarily providing skilled nursing care for 60 consecutive days.

As of July 1975 about 720 hospitals and 11,900 facilities that provided skilled nursing care were not participating in Medicare. Although SSA determined that an admission to one of these facilities would break the 60-consecutive-day period required to start a new benefit period, these nonparticipating institutions are not obligated to report to SSA the admission of Medicare beneficiaries. Therefore, some Medicare beneficiaries, after discharge from a participating hospital or skilled nursing facility, might be admitted to a nonparticipating institution during the 60-day period following the discharge and yet be covered later by Medicare under a new benefit period for which the beneficary is not entitled.

According to SSA officials, this can be controlled in only one way. The participating hospitals usually ask the beneficiaries upon admission whether they have been

institutionalized in the last 60 days. These officials stated that SSA must depend on the participating hospitals to identify and obtain details of any care in nonparticipating institutions. While no studies have been made, SSA officials believe that the frequency with which patients come from a nonparticipating institution to a participating institution claiming a new, but unearned, benefit period is very small. They said SSA cannot require nonparticipating institutions to report such admissions and the effort and costs to establish controls for the potentially few instances of unreported admissions breaking the 60-day waiting period is not warranted.

Although we do not disagree with SSA's assessment, under Medicare's existing part A benefit structure, complete control and enforcement of when a new benefit period should start is simply not practicable.

HOSPITAL PROBLEMS IN ADMINISTERING THE QUERY SYSTEM

Administering the query system is costly to hospitals and in about half the cases does not provide information on the beneficiary's entitlement and benefit status until after the beneficary has left the hospital. The American Hospital Association estimated that short-term hospitals spend about $11.5 million annually to operate the query system for part A inpatient claims.

The minimum time a hospital can expect to receive notification of a Medicare beneficiary's entitlement and status of benefits varies depending on the method used to transmit the query and the amount of verification and development necessary by the intermediary before forwarding the responses to the hospitals. The American Hospital Association estimated that 55 percent of all Medicare patients in short-stay hospitals are discharged by the time the SSA query response is received by the hospital. Under these circumstances the process seems to be of limited use to the hospitals.

Hospitals reported to the Amercian Hospital Association that they normally bill non-Medicare patients about 7 days after discharge. However, because of delays associated with the query system, the bills for the average Medicare patient are made 14 days after discharge. Intermediary officials in Atlanta said overpayments and underpayments to hospitals occur because claims have been paid out of sequence and because coinsurance rates were applied to the wrong claims. In some cases hospitals required the beneficiaries to pay the

deductible more than once in the same benefit period because the patients had been discharged before the hospital received the SSA response on their current benefit status. In these instances, the intermediary must follow up on the claims to (1) insure that hospitals make appropriate refunds to the beneficiaries and (2) adjust for any overpayments and underpayments made to the hospitals.

SUMMARY

A basic problem in administering Medicare's existing benefit structure and related query system is that, generally, admissions and the corresponding bills for a benefit period must be recorded on SSA's master records in chronological sequence to provide accurate information on the beneficiaries' benefit status. Another problem is that determining whether a hospital admission represents the start of a new benefit or the continuation of a previous benefit period is dependent on the date of the latest discharge from a hospital or skilled nursing facility--which for any beneficiaries involved in the 3.3 million open items must usually be determined through further development by the intermediary.

These problems seem to be inherent in the benefit structure as prescribed by the present Medicare law and not susceptible to solution through administrative action.

APPENDIX V

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
OFFICE OF THE SECRETARY
WASHINGTON, D.C. 20201

OCT 1 1976

Mr. Gregory J. Ahart
Director, Human Resources Division
United States General
Accounting Office
Washington, D.C. 20548

Dear Mr. Ahart:

The Secretary asked that I respond to your request for our comments on your draft report entitled, "Impact of Selected National Health Insurance Proposals On Medicare Hospital Insurance." The enclosed comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

We appreciate the opportunity to comment on this draft report before its publication.

Sincerely yours,

John D. Young
Assistant Secretary, Comptroller

Enclosure

APPENDIX V

COMMENTS OF THE DEPARTMENT OF HEALTH, EDUCATION AND WELFARE ON THE GENERAL ACCOUNTING OFFICE DRAFT REPORT ENTITLED "IMPACT OF SELECTED NATIONAL HEALTH INSURANCE PROPOSALS ON MEDICARE HOSPITAL INSURANCE"

GAO Recommendation

That the Secretary direct the Commissioner of Social Security to initiate a demonstration project aimed at (1) determining whether the health card approach for paying for inpatient hospital service would tend to increase the efficiency and economy of the Medicare program, and (2) testing the feasibility of such an approach for possible use under the various national health insurance proposals.

DEPARTMENT COMMENT

We question the usefulness of a demonstration project to test the health card concept limited to inpatient hospital services. With respect to inpatient services, the patient liability under Medicare is quite small and the costs of administering the health card credit and collection system could far outweigh the limited benefits that would accrue to the hospital. In addition, the beneficiary would not benefit from such a system. A health card approach for Part B services, however, has greater potential benefits. Several possible demonstrations have been under consideration by SSA. The principal advantage of the system is its potential impact on the assignment rate (by removing the burden and risk of the physician having to bill the patient for the deductibles and coinsurance).

One project under consideration by SSA's Office of Research and Statistics would utilize a health card system under which physicians would be paid, in accordance with a negotiated fee schedule, for services to Medicare beneficiaries. Thus, the beneficiary would be better informed about his total liability and the physician would be assured of his full fee. However, it is still too early to say whether the project will be implemented.

Another demonstration project initiated by the Office of Research and Statistics--dealing with payment for prescription drugs in the State of California--should yield additional information on the operation of a health card system. Under this project--which was primarily designed to test the effects of cost-sharing on the utilization of prescription drugs--a selected number of Medicare beneficiaries were divided into four groups each with a different drug insurance program. One of the programs, which called for the application of deductibles and coinsurance, provided a payment mechanism through a health card system. While a limited demonstration of this type may not be indicative of experience under a system covering a broad range of services and population groups, it should provide important information on various aspects of the health card including administrative costs and bad debts.

In addition, SSA believes that much could be learned from economic analysis of other credit and collection systems. Simulation of alternative health card models might also reveal comparative costs and administrative feasibility. In this connection, the Department is exploring the possibility of an experiment with a health credit card mechanism to be used primarily in ambulatory care settings for a broadly defined population that would include more than just the beneficiaries of public programs. Such an experiment would build in direct cash savings to patients. The Department hopes it would involve agreements by physicians to accept the health card for a large proportion of their patients thereby providing a valid test of the hypothesis that a health card can result in real savings to patients and providers.

SSA in the future expects to continue its efforts in examining the feasibility of health card approaches.

Other Matters in the Draft Report

The discussion beginning on page 51 of the draft report conveys the impression that SSA assumes that the income definition and income determination process used for the Supplemental Security Income program would be used in implementing proposed income-related health care provisions. This is not the case. Rather, the estimates of the cost of such an approach were developed to illustrate the need to find simpler, less costly alternatives.

APPENDIX VI

PRINCIPAL DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE OFFICIALS RESPONSIBLE FOR ACTIVITIES DISCUSSED IN THIS REPORT

	Tenure of office	
	From	To
SECRETARY OF HEALTH, EDUCATION, AND WELFARE:		
Joseph A. Califano, Jr.	Jan. 1977	Present
David Mathews	Aug. 1975	Jan. 1977
Caspar W. Weinberger	Feb. 1973	Aug. 1975
Frank C. Carlucci (acting)	Jan. 1973	Feb. 1973
Elliot L. Richardson	June 1970	Jan. 1973
Robert H. Finch	Jan. 1969	June 1970
Wilbur J. Cohen	Mar. 1968	Jan. 1969
John W. Gardner	Aug. 1965	Mar. 1968
COMMISSIONER OF SOCIAL SECURITY:		
James B. Cardwell	Sept. 1973	Present
Arthur E. Hess (acting)	Mar. 1973	Sept. 1973
Robert M. Ball	Apr. 1962	Mar. 1973