Hospitalization insurance for OASDI beneficiaries : report submitted to the Committee on Ways and Means by the Secretary of Health, Education, and Welfare in compliance with House Report 2288, 85th Congress.

[COMMITTEE PRINT]

HOSPITALIZATION INSURANCE FOR OASDI BENEFICIARIES

REPORT

SUBMITTED TO THE

COMMITTEE ON WAYS AND MEANS

BY THE

SECRETARY OF HEALTH, EDUCATION, AND WELFARE

In Compliance with House Report 2288, 85th Congress

APRIL 3, 1959

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LETTER OF SUBMITTAL

APRIL 2, 1959.

Hon. WILBUR D. MILLS,
Chairman, Committee on Ways and Means, House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: I have the honor to submit the report on "Hospitalization Insurance for Old-Age, Survivors, and Disability Insurance Beneficiaries."

This report is made in compliance with the request of your committee in its report to accompany H.R. 13549, Social Security Act Amendments of 1958 (85th Cong., 2d sess., H. Rept. 2288).

You will recognize that the enclosed report contains the review and summary of a considerable body of information bearing on the questions posed by your committee. Data from several recent national surveys make possible a current assessment of the medical care problems of older persons and provide a basis for the cost estimates requested by the committee. I am sure you realize that these problems are constantly under study, and that there is considerable activity throughout the country in an effort to develop better hospitalization insurance protection for the aged population.

The report presents information on the characteristics of the aged population, current levels of use of hospitals and expenditures for medical care by aged persons, factors influencing trends in costs of medical care, and present methods of financing hospital care for the aged. It also presents estimates of the costs and discusses the administrative implications of providing hospital and nursing home care insurance through the old-age, survivors, and disability insurance mechanism. The report also discusses several alternative methods of helping the aged meet these costs.

We have attempted to present the most important factual information bearing on this subject in the most objective possible manner.

In addition, the introduction identifies the arguments that are advanced both for and against Federal action in this area. We have not, however, attempted to present conclusions and recommendations based on this discussion. This, we felt, was an undertaking which should be deferred until after the factual information bearing on the subject had been brought together in as complete and objective a manner as possible. That has been our aim in this report. We trust the committee will find that it contains the material necessary for full consideration of the problems which led to its request for the study.

Having completed this compilation, we are now proceeding with an analysis of the policy issues involved with a view to developing specific recommendations.

Sincerely yours,

ARTHUR S. FLEMMING, *Secretary.*

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HOSPITALIZATION INSURANCE FOR OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE BENEFICIARIES

INTRODUCTION

In response to a request from the Ways and Means Committee of the House of Representatives, this report has been prepared to present the results of a study of alternative ways of providing insurance to finance hospital and nursing home care for old-age, survivors, and disability insurance beneficiaries, and of the practicability and costs of the several methods considered.

The primary purpose of this introduction is to identify the arguments that are advanced both for and against Federal action in this area.

There is general agreement that a problem does exist. The rising cost of medical care, and particularly of hospital care, over the past decade has been felt by persons of all ages. Older persons have larger than average medical care needs. As a group they use about two and a half times as much general hospital care as the average for persons under age 65, and they have special need for long-term institutional care. Their incomes are generally considerably lower than those of the rest of the population, and in many cases are either fixed or declining in amount. They have less opportunity than employed persons to spread the cost burden through health insurance. A larger proportion of the aged than of other persons must turn to public assistance for payment of their medical bills or rely on "free" care from hospitals and physicians. Because both the number and proportion of older persons in the population are increasing, a satisfactory solution to the problem of paying for adequate medical care for the aged will become more rather than less important.

In our society the existence of a problem does not necessarily indicate that action by the Federal Government is desirable. The basic question is: Should the Federal Government at this time undertake a new program to help pay the costs of hospital or medical care for the aged, or should it wait and see how effectively private health insurance can be expanded to provide the needed protection for older persons?

Reasons Advanced as to Why the Federal Government Should Not Take Action

Here are some of the reasons that are advanced by those who support the adoption of a "wait and see" position:

1. As recently as early 1952, only about 25 percent of the 12.7 million persons aged 65 and over had any form of health insurance. Today about 40 percent of the 15.3 million persons in this age group have

some type of health insurance. Whereas a decade ago, few insurance plans were open to older persons, many prepayment plans and insurance companies now provide such coverage and others are experimenting with special arrangements to cover the aged.

It is reasonable to expect that the proportion of the aged population covered by voluntary insurance will increase, and perhaps for a time at a faster rate than over the past 6 years. However, as the proportion rises, further increases become relatively more difficult to achieve. If the same average yearly increase in the proportion covered as that during the past few years is maintained, private hospital insurance will reach about 56 percent of the aged population in 1965 and 68 percent in 1970. If the same increase in coverage of OASDI beneficiaries that was recorded between 1951 and 1957 continues, about 70 percent of the aged beneficiary group will have some form of health insurance by 1965.

If recognition is given to the fact that voluntary insurance may never be able to reach certain groups—for example, persons already in long-stay institutions, those with the very lowest incomes and others for whom the premium cost of individually purchased insurance is more than they are able to pay—the present achievement of voluntary insurance in relation to its potential is even greater than the 40-percent coverage of persons 65 and over would suggest. It is recognized, of course, that a part of the problem will remain even after private insurance has reached its maximum development.

2. A compulsory program to provide insurance against the cost of hospital care for OASDI beneficiaries or other aged persons would in large part undercut voluntary efforts to meet this particular need. Some older persons would purchase insurance to cover the cost of types of services not covered by the Government program, such as private room accommodations in the hospital or surgery or physicians' home and office visits. But there would be little opportunity left for private insurance against the cost of those hospital services that were paid for by the Government program. A decision to initiate a compulsory insurance program would be virtually irreversible.

3. Pressures would develop for extending a hospital benefits program to include other components of the medical care bill. The costs of short-term hospitalization on the average represent between 25 and 30 percent of the present medical care bill for the aged. Furthermore, voluntary insurance coverage of medical expenditures other than hospital bills is much less adequate than that for hospital benefits. Thus it would be difficult to limit a Government program to hospital or hospital and nursing home benefits. The eventual cost burden that might result if an initial program of hospital benefits were expanded to include other types of service could be at least two or three times as large as the cost for hospital benefits alone.

4. It is difficult to estimate with any accuracy the future cost of medical care. Many persons are concerned with increases in medical costs beyond those originally anticipated that have occurred in other programs. They believe that the eventual costs of hospital benefits alone may be much more than the estimated cost based on current practices and experience.

5. Pressures would also develop for extending insurance against the cost of hospital and other medical care to the working population and their dependents. Workers who were paying social security taxes

to cover the cost of health benefits in old age might object to waiting until they reached retirement age to get such protection and be willing to pay additional contributions in order to have such insurance for themselves and their dependents immediately. A decision to provide hospital insurance for the aged might thus lead to much more far-reaching Government action.

6. Federal action would result in a diminution of responsiveness to varying individual and local situations, and the attenuation of personal relationships and personal concern which almost inevitably accompanies a displacement of local and private arrangements by centralized governmental programs.

Reasons Advanced as to Why the Federal Government Should Act

Here are some of the reasons advanced by those who believe this problem can only be solved through action by the Federal Government:

1. A decision against Government action at this time would merely postpone an effective solution of the problem of medical costs for many of the aged. The basic difficulty that private insurance faces in its efforts to extend hospital insurance protection to the aged is that they are a high-risk, high-cost group. A premium charge based on the experience and covering the entire cost of a reasonable level of protection for an aged group will be higher than many aged persons can afford to pay. Existing insurance has attempted to meet this situation by scaling down the benefits and protection provided, by spreading part of the cost over younger age groups, or by a combination of these methods. Limited protection leaves a large part of the original problem unsolved. If the higher than average cost of adequate medical care for the aged is accepted as a social cost that should be shared by the entire community, Government is in a better position than private industry to distribute the cost burden broadly and equitably.

2. It is possible that a public program of hospital benefits for the aged—by taking over this special problem—would help assure the continued acceptance of private insurance and prepayment arrangements as the method of handling the costs of medical care for the great majority of the population. A broad spreading of the risk and costs can be much more readily achieved by private insurance for the employed members of the population under 65 and their dependents than for the entire population. Employee benefit plans would also be relieved of the special charge which some of them are now carrying through various methods of continuing health insurance coverage for retired persons, thus removing these costs as a possible deterrent to employment of older workers and lessening the pressures against changes of jobs.

3. A publicly supported program of hospital benefits for the aged could provide more extensive and more adequate protection than has characterized much of the private insurance available to aged persons. There would be no lifetime limits on the total costs that would be covered, no cancellation of the insurance, no exclusion of preexisting conditions, and there could well be a higher maximum than is usual in insurance company policies on the number of days of hospital care that would be paid for during a year, as well as coverage of the cost of all hospital extras.

4. A little over 70 percent of all persons aged 65 and over are now eligible for benefits under the OASDI program. Eventually more than 9 in 10 aged persons will be eligible. The OASDI mechanism provides a ready and equitable method of spreading the cost of hospital care for the aged over the entire working population. A small increase in the present social security taxes would provide immediate protection for those now eligible for benefits. Persons now at work would in turn become entitled to the same protection when they reached retirement age. The individual's contribution toward the cost of medical care in old age would be spread over his working lifetime without breaks in coverage due to change of residence or employment.

5. For any specified level of protection, the cost of hospital insurance under OASDI would be relatively low because of the size of the group, the compulsory coverage resulting in lack of adverse selection and the fact that the collection of contributions and identification of eligible persons would utilize existing tax reports and wage records.

Fears as to rising costs under a public program are often greatly exaggerated. Costs may rise in absolute terms without an increase in costs in relation to the gross national product or in costs as a percent of taxable payrolls. Changes in medical knowledge and practice that no one can foresee may, of course, substantially increase or decrease future medical costs. Such changes would affect the total resources used for medical services no matter what method of paying for care was involved.

The first four chapters of the following report summarize the most recent available data concerning (1) the characteristics of the present OASDI beneficiaries and of the total aged population, (2) the use of hospitals and nursing homes by aged persons and their total medical costs and expenditures, (3) past and possible future trends in the overall cost of hospital and medical care, (4) the existing health insurance coverage of aged persons and the methods that are being used by private insurance in an effort to expand coverage, and current governmental provisions for medical care of older persons.

The fifth chapter discusses the use of the OASDI mechanism to provide insurance for OASDI beneficiaries against the cost of hospital and nursing home care. The final chapter discusses several other methods of helping the aged to meet these costs. Cost estimates are given for each of the methods considered.

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however, there are still considerable numbers of aged persons who had no opportunity to become beneficiaries of the program. The following analysis of the characteristics of the beneficiary population is, therefore, focused against a backdrop that includes all persons 65 and over. It draws upon the findings of the national survey of old-age and survivor insurance beneficiaries conducted late in 1957 (*2*).

Age and sex

Of all persons 65 and over, more than one-third have passed their 75th birthday. Almost one in seven is an octogenarian. Women outnumber men in the population past 65, by a ratio of nearly 120 to 100. The excess of women to men increases with each 5-year age group, reaching 140 to 100 at age 85 and over.

The age distribution of the present OASDI beneficiary population differs significantly from that of the total aged population. Only 28 percent of the beneficiaries—in contrast to 34 percent in the total aged population—are past 75. Fewer than 1 in 10 is an octogenarian. And, among persons 65 and over drawing OASDI benefits, men slightly outnumber women—102 to 100. In the age group of 85 and over, however, the ratio of men to women was 165 to 100 at the end of 1957.

Such a disparity is to be expected in the early years of a social insurance system where the primary basis of eligibility is employment. (The opposite situation is found, of course, under the old-age assistance programs, with 164 aged women for every 100 aged men.)

Several factors account for these differences. The age at which male workers have started drawing old-age benefits has averaged 68–69 years (*3*). As a result, men beneficiaries are somewhat older than the total male population aged 65 and over. Women beneficiaries who are 65 and over, on the other hand, average more than a year younger than all aged women in the population. The population's very oldest women are underrepresented in the beneficiary group (they are found instead among the assistance recipients). Not workers themselves, many of these older women were already widowed when the insurance system began, or were wives (many of whom are now widowed) of men already out of the labor force.

In time, this age difference for the women will be largely eliminated. For the men, however, the difference reflects retirement practice rather than immaturity of the insurance system and can thus be expected to continue. If the "beneficiary population" is thought of as including men who would be eligible for benefits were they not still at work, however, any difference between the age distribution of this group and the total male population 65 and over would probably be negligible.

These age differences color many of the comparisons of the beneficiary population with the total aged population. For men, the differences are accentuated when findings from the beneficiary survey are used—because beneficiaries were included in the survey only if they had been on the rolls for at least a year and thus tended to be older than all beneficiaries.

Marital status

The fact that women live longer than men, combined with a tendency for men to marry women younger than themselves, results in an aged population that contains a great many widows. Of all women 65

and over, more than half (55 percent) are widows. Only one out of every three aged women, but as many as two out of three men, are married and living with the spouse. Of the married couples in the total aged population, almost half include a spouse under 65—with the younger partner almost always the wife.

Men beneficiaries of OASDI are about as likely as other aged men to be married and living with their wives. Women beneficiaries, on the other hand, are more likely than other aged women, being younger, to be married. Indeed, close to half of those in the 1957 survey were married and living with their husband. Of the married couples with one or both members receiving an OASDI benefit, less than three-tenths included one spouse under age 65. Information is not yet available from the survey as to the proportion of all women beneficiaries who were widows, but it is obviously smaller than for the total aged population.

Living arrangements

The vast majority of all aged persons—about eight-tenths of the men and seven-tenths of the women—live with a relative. For the men, this related person is usually the wife; two-thirds of those 65 and over, as previously noted, and more than half of those 75 and over, are living with their wives. Because women tend to outlive their husbands, their living arrangements are different. They are no more likely to be living with their husband than with a son, daughter, or other relative. This is especially true at the older ages. Of the women 75 and over, only 2 in 10 are living with their husbands; between four-tenths and five-tenths live with other relatives, while more than three-tenths live alone or with nonrelatives.

While a relatively small proportion of the total aged population lives in institutions, this proportion rose rapidly between 1940 and 1950. Of all people 65 and over, 3.14 percent were in institutions in 1950 as compared with 2.46 percent in 1940. Over the decade, the largest relative increase in the aged institutional population took place in homes for the aged and in nursing homes, but the number in hospitals for the mentally ill increased almost as rapidly. Information on changes since 1950 will not be available for the total aged population until the 1960 census results become available.

A detailed description of the living arrangements of beneficiaries in 1957, by martial status, can be drawn from the beneficiary survey. Of the couples, three-fourths lived alone; most of the rest who shared living arrangements were in their own home rather than in the home of a relative. Almost three-fifths of the nonmarried retired workers lived alone, and more than one-fifth lived in a relative's home. Of the widows, almost as many lived with others as lived by themselves, probably a reflection of their advanced age. Three percent of the nonmarried retired workers and 4 percent of the widows were living in institutions at the end of the survey year.

Sources and amount of income and assets (*4*)

In June 1958, one in every five persons 65 and over had a paying job. When women who are not themselves earners but are married to earners are included, the proportion of the aged population with some money income from employment is raised to just over one-fourth or almost 4 million people. Fully two-fifths of this group would be

drawing benefits under the OASDI program were it not for employment. Many of the remainder with earnings have only part-time or intermittent work and are at the same time drawing benefits.

The 8.8 million persons over 65 who were drawing benefits in June 1958 under the OASDI program accounted for 58 percent of all aged persons—64 percent of the aged men and 53 percent of the aged women. Substantially all the men were drawing benefits as retired workers. Of the women beneficiaries, 42 percent were receiving benefits on the basis of their own wage record; more than one-third were drawing a wife's benefit and almost all the remaining a widow's benefit.

About 2.5 million persons, or 16 percent of the aged population, received old-age assistance in June 1958. Of these, 1.9 million—about two-thirds of them women—received their major support from assistance. The remainder were receiving assistance payments to supplement insurance benefits that were inadequate for their needs.

Some of the persons not having earnings or income from the basic social insurance or public assistance program could count on income from the railroad retirement program, from Government employees' systems or from veterans' compensation and pension programs. In all there were well over a million aged persons who received benefits in mid-1958 because of the retirement or death of a railroad worker or Government employee and some 900,000 who received veterans' pensions or compensation payments because of previous military service. Some of them also had earnings, OASDI benefits or public assistance; others did not.

Obviously, the aged are a diverse group with respect to sources of income. Except for full-time earnings, however, these sources are, by their very nature, the kind that do not yield large amounts of income. In mid-1958 benefits paid to retired workers under OASDI, for example, were averaging something over $66 a month (roughly $800 a year), and old-age assistance payments, a little over $61 (not quite $750 a year). The 1958 amendments provided an increase of approximately 7 percent in OASDI benefits, effective at the beginning of 1959. Old-age assistance payments averaged $64 in December 1958.

Many of the aged have income from more than one of these sources or from these sources and private pensions and savings. But even in combination, these sources yield relatively low money incomes for the great bulk of the aged population. Thus, both in 1956 and 1957 three-fifths of all people 65 and over had less than $1,000 in money income

and only one-fifth had more than $2,000. Of the men, two in five had less than $1,000 and one in three had $2,000 or more. Of the couples with the husband aged 65 or over who had their own household and did not share it with relatives—generally the most well to do among the aged—almost half had cash incomes of less than $2,000 in 1956 and 15 percent reported incomes of $5,000 or more. Half the aged persons living alone or with nonrelatives (not in institutions) had incomes of $900 or more, half had less. Nonmarried aged persons living with relatives had on the average even less.

A number of the aged have available as an additional source of funds the assets accumulated in earlier years—in fact, their assets tend to be greater than those of younger persons with the same income—but it is likely to be those with relatively high income who have substantial holdings. A survey made for the Federal Reserve Board early in 1957 found that 45 percent of all spending units headed by a person aged 65 or over had financial assets of less than $500 or none at all and 35 percent had $2,000 or more, including 11 percent with holdings of $10,000 or more. Of this latter group, two-fifths had money incomes of at least $5,000 and one-fifth of $3,000 to $5,000, whereas of the aged spending units whose financial assets amounted to less than $1,000, 90 percent had incomes of less than $3,000.

The money income position and asset holdings of aged beneficiaries may be illustrated by data from the beneficiary survey for retired couples in which both husband and wife were entitled to benefits throughout the survey year. The income of single retired workers is roughly half that of the couples and the income of widows is somewhat lower than that of single workers.

The median total money income of retired beneficiary couples in 1957 was $2,190, or $183 a month. The couple characteristically had some income other than benefits, with half having $900 or more of such income for the year. But the source of this additional income was such that it could not reasonably be expected to continue in future years in approximately the same amount as in the survey year. The average couple had no income from an employer or union pension (just over one-fourth had income from this source) or from veterans' compensation and pension payments (fewer than 1 in 20 couples had such payments).

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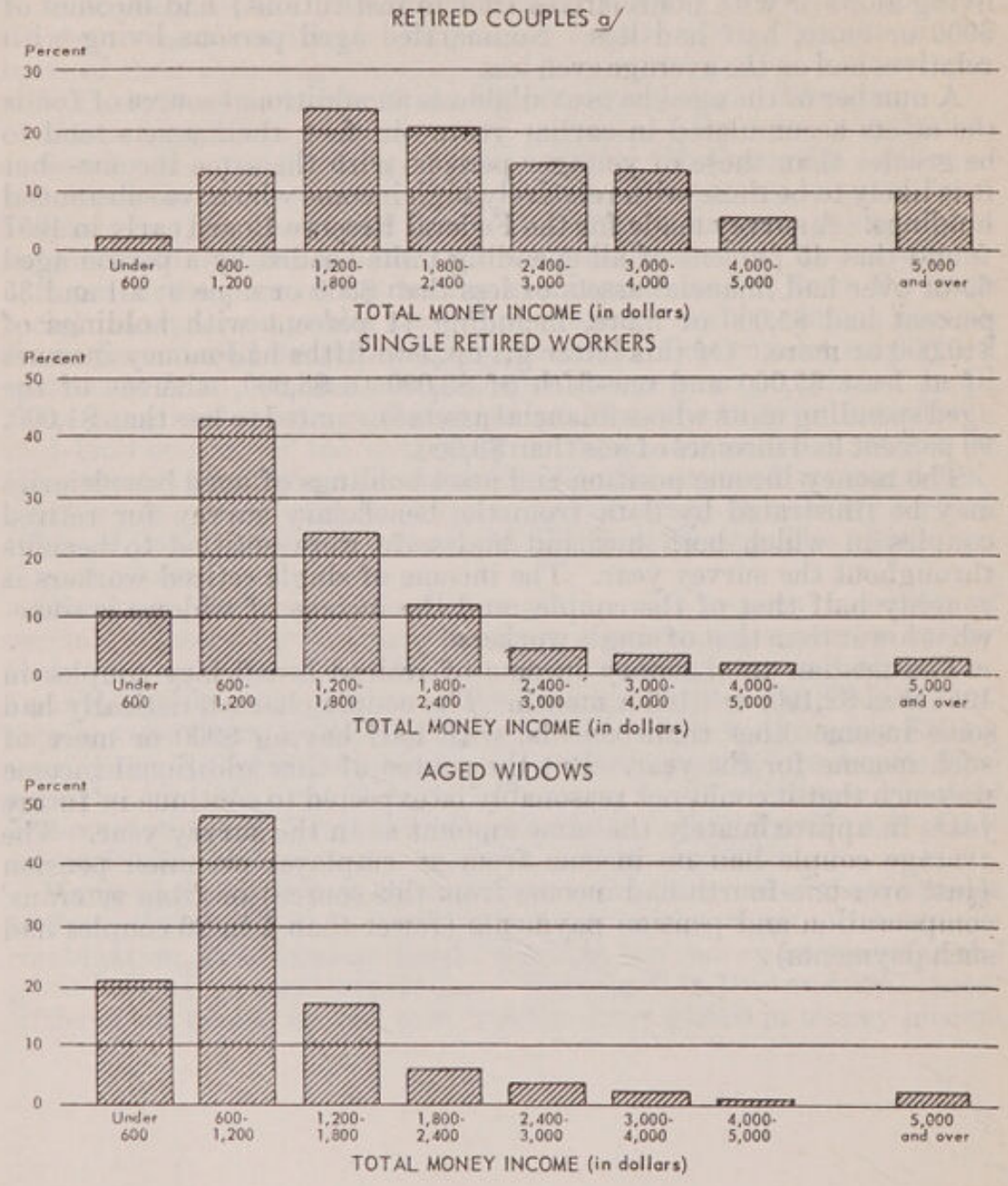
PERCENT DISTRIBUTION OF AGED OASI BENEFICIARIES BY TOTAL MONEY INCOME, 1957



a/ Both husband and wife entitled to benefits all year

SOURCE: BOASI Beneficiary Survey, 1957.

The typical retired couple did not receive income from public assistance, nor did relatives outside the household contribute money to their support. Only 6 and 5 percent, respectively, reported these sources of supplemental income. The majority of the couples had some income from assets—interest, dividends, or rental income; for couples with such income, half had $200 or more for the year. Earnings were not a source of income for the retired worker in most of the couples but of the 37 percent who had earnings, half earned more than $1,030 during the year.

These retired couples had a median net worth of $9,620. Liquid assets, stocks, bonds, and owned mortgages together accounted for a relatively small part of net worth; only half had as much as $1,580 in such assets. An equity in the home was of major importance. Almost three in every four beneficiary couples owned their own homes—most of them free of mortgage—and the median equity in nonfarm homes for the homeowners was $8,360.

The majority of the couples (7 out of 10) carried some life insurance. For those with life insurance the median face value was $1,810.

Beneficiaries in the Future

With seven-tenths of our aged population now eligible for benefits, it seems reasonable to assume that beneficiaries today are fairly representative of beneficiaries in the years immediately ahead. Increasingly, the beneficiary population will become more nearly synonymous with the total aged population. It is estimated that over three-fourths of the aged population will be eligible for benefits in 1970, and over 80 percent in 1980.

Any assessment of the probable situation of beneficiaries in the future must take account of the fact that persons on the beneficiary rolls are getting progressively older. Of the beneficiaries 65 and over at the end of 1957, there were 28 percent who had passed their 75th birthday. This is in contrast to the situation 10 years earlier when only 20 percent of the aged beneficiaries were of such an advanced age. The aging of the beneficiary rolls can be expected to be accompanied not only by higher medical costs but by the using up of savings and less opportunity to supplement benefits with earnings. Of the retired worker beneficiaries surveyed in 1957, 7 in 10 who were not employed at the end of the year reported themselves not well enough to work. This proportion ranged from about 6 in 10 at the lower ages to about 8 in 10 at the most advanced ages.

Improvement in the cash income position of beneficiaries can reasonably be expected, if for no other reason than that the benefit itself is increasing as a result of higher wage levels. Prior to the effect of the 1958 amendments, the average old-age benefit awarded in a given month was running $9 to $10 higher than the average benefit received by all those in current payment status. The 1958 amendments provided an increase of roughly 7 percent in these benefits in recognition of changes in purchasing power since 1954, and raised the maximum annual earnings base for benefits and contributions from $4,200 to $4,800.

It is not so easy to forecast other changes in the economic situation of aged beneficiaries in the years ahead. Between 1951 and 1957 the average total money income of retired workers on the OASI rolls went up roughly 50 percent, much more than the rise in consumer prices. The net worth of beneficiaries also rose substantially in dollar terms but much of this increase resulted from a higher valuation of the owned home, the most usual asset of aged persons.

Earnings were more important as a supplement to benefits in 1957 tha in 1951, reflecting liberalization of the retirement test and the addition to the benefit rolls of self-employed persons who tend to continue at work longer than wage or salaried employees.

Nevertheless, the proportion of beneficiaries for whom benefits remained practically the sole source of cash income was almost unchanged between 1951 and 1957. In the case of retired couples, for example, while the proportion with as much as $1,500 in addition to benefits increase from 1 in 5 to almost 1 in 3, the proportion with no money income other than their benefit or less than $75 was nearly one-fifth in 1957 as it had been in 1951.

Assumptions as to continued improvement in the income situation of beneficiaries must be tempered by the caution that future beneficiaries will come increasingly from the low-income agricultural areas. The insurance system, originally limited to wage and salary workers in industry and commerce, has gradually been expanded to cover virtually all the gainfully employed, including agricultural and domestic workers, farm operators, and other self-employed persons. The impact of the original coverage was naturally much greater in the industrialized and more prosperous States.

Because of their late start, the rural low-income areas can be expected to account for proportionately more beneficiaries during the years ahead while they are catching up. These are the areas where the total income of beneficiaries—and the benefit itself—can be expected to be relatively low because of low wage levels. Workers qualifying on the basis of agricultural employment and self-employment will also be much less likely to have private pensions or other health and welfare benefits to supplement their OASDI income.

SOURCES

(*1*) These and subsequent population data relating to all aged persons are based on the most recent Census Bureau reports updated and adjusted by the Social Security Administration to include estimates for Alaska, Hawaii, Puerto Rico, and the Virgin Islands.

(*2*) For further detail, see "Income of OASI Beneficiaries: Highlights From Preliminary Data, 1957 Survey," Social Security Bulletin, August 1958; "Assets and Net Worth of OASI Beneficiaries: Highlights From Preliminary Data, 1957 Survey," Social Security Bulletin, January 1959.

(*3*) For further detail see Social Security Bulletin, Annual Statistical Supplement, 1957.

(*4*) Income data for all aged persons are based on "Selected Sources of Money Income for Aged Persons," Social Security Bulletin, December 1958; Bureau of the Census, Current Population Reports, Series P–60, Nos. 27 and 30; and unpublished tabulations prepared (for 1956) by the Bureau of the Census for the Social Security Administration. For further detail on assets, see "Survey of Consumer Finances: The Financial Position of Consumers," Federal Reserve Bulletin, August 1957 and September 1957. Cross-tabulation of asset holders by income is unpublished. The spending unit is defined to include all related persons living in the same dwelling who pool their incomes for major expenses and also persons living alone.

CHAPTER II

CURRENT LEVELS OF USE OF HOSPITALS AND EXPENDITURES FOR HOSPITAL AND MEDICAL CARE BY AGED PERSONS

The success of modern medicine in preventing epidemics and in curing or controlling diseases once usually fatal has brought chronic illness, particularly the illnesses of old age, to the fore as a health problem. In part because of these new developments, older persons have greater need for hospital and other medical services than younger persons. They may require more elaborate types of care than younger persons and their recovery is likely to be slower.

Beyond these general observations, however, there is no adequate basis for judgment as to how much hospital and medical care older persons—or, indeed, the population as a whole—should be receiving. There is some information as to how much they are getting and how their total expenditures for medical care are distributed among different types of service.

Health Status

The National Health Survey is beginning to yield a wealth of new and useful data on the health status of the civilian noninstitutional population and the medical services they receive. Some contrasts in health status between persons aged 65 and over and persons of all ages are evident in the following summary findings based on the first 12 months of the survey (table 1).

Table 1.—*National health survey: Frequency of occurrence of specified health conditions and utilization of services, 1957–58 (1)*

Type of experience [1]	Rate per 100 persons per year		
	Persons aged 65 and over	Persons under age 65	Persons of all ages
Restricted activity days	4,730	1,743	2,000
Bed disability days including hospital days	1,630	697	780
Days in short-stay hospitals	178	76	85
Incidence of acute conditions	163	269	260
Persons with one or more chronic conditions [1]	76	38	41
Persons with activity limited by chronic conditions [1]	42	7	10
Persons injured	25	28	28
Physician visits	680	514	530
Dental visits	80	168	160

[1] Based on first quarter data.

These figures corroborate the findings of earlier studies that the aged spend at least twice as many days per capita in general hospitals as the population as a whole, that acute conditions occur less frequently among the aged and chronic conditions more frequently than

among younger persons. Aged persons, according to this survey, see the dentist at about half the frequency, and physicians more frequently than persons of all ages. Among the chronic diseases in which the case rate for the aged is substantially higher than for younger age groups are: cancer, cerebral hemorrhage, heart diseases, nephritis, high blood pressure and arteriosclerosis, and arthritis and rheumatism.

Another indication that the medical-care needs of older persons are considerably greater than those of the rest of the population is afforded by data on costs of medical care (out-of-pocket expenses, less health insurance premiums, plus health insurance benefits) obtained in a nationwide survey of family medical-care costs (*2*). In the 12-month period July 1952–June 1953 the average cost of medical care per person in the noninstitutional population was $66, but for those aged 65 years or more it was $102, or half again as much. A very rough estimate of the equivalent cost at current prices (using the Consumer Price Index as a basis for adjustment) would be $81 and $125, respectively, per person.

There are also significant differences in the distribution of the medical-care dollar of the aged as compared with the rest of the population. The same study shows that hospital bills [1] and medicines made up considerably larger proportions of the medical care costs for the aged than for the population as a whole, 24 and 21 percent compared with 20 and 15 percent. Because hospital costs have increased more rapidly than other medical costs, the proportion of total medical costs represented by hospital services would be higher today—perhaps 28 percent for the aged—if utilization of the various types of medical services is assumed not to have changed.

Utilization of General Hospitals by Aged Persons

In the past 2 years there have been four surveys from which national data were obtained on the use of hospitals by persons aged 65 and over. As of the time of writing of this report, only preliminary data are available from two of the surveys and the analysis of much of the detailed data from a third has not been completed. However, the data that are in such form as to permit analysis provide substantial information on the current use of hospitals by aged persons and a reasonable basis for estimates of the cost of prepayment of hospital expenses for OASDI beneficiaries.

The four new national surveys are (I) the survey of OASDI beneficiaries made by the Bureau of Old-Age and Survivors Insurance in the fall of 1957 (*3*), (II) the survey carried out in September 1956 by the Bureau of the Census for the Public Health Service as an extension of the monthly current population survey (4), (III) data from the national health survey for the period July 1957–June 1958 (*1*), and (IV) a survey financed by the Health Information Foundation and carried out by the National Opinion Research Center of the University of Chicago in the spring of 1957 (*5*). Considerably more detailed information is at present available from the first two of these studies than from the last two.

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[1] Including expenditures for emergency outpatient care; excluding most payments for care in long-term hospitals because many of the patients in long-term hospitals are not considered part of the noninstitutional population and also excluding the value of free or reduced-rate care in nongovernmental nonprofit hospitals if it was not connected with any form of prepaid medical-care plan or insurance.

Although limited to current beneficiaries, the BOASI survey included beneficiaries residing in institutions. Data presented here from the other three surveys relate to the total noninstitutionalized population. In the fourth study, however, data were not collected relating to a member of the family who was in a hospital on the survey date. Household surveys generally miss some days of hospital experience, because they fail to enumerate persons who live alone and are in the hospital on the survey date, members of families that break up at least temporarily because of major illness, and persons who have died during the survey year. The last omission is the most important quantitatively. There are a few studies which provide some basis for an adjustment to take account of these missing days of hospital care. The adjustment is larger for the older age groups because of the higher proportion of deaths in these groups than in the population under 65. For the cost estimates presented in Chapter V, a substantial allowance (in the neighborhood of 20 to 25 percent for the entire group aged 65 and over) was made for this factor. The available data permit nothing more than a rough overall correction, however, and the analysis of hospital utilization which follows relates to the information reported in the surveys.[2]

The most important overall measures of the extent of hospital use by all persons aged 65 and over included in the four surveys are summarized in table 2.

TABLE 2.—*Use of hospitals by persons aged 65 and over, 4 national surveys, 1956–58*

Annual rate	BOASI, 1957	Census-PHS, 1956	NHS, 1957–58	NORC-HIF, 1957
Persons hospitalized per 100	11.1	9.9	[1] 12.1	10.4
Average days of care per person hospitalized	21.2	17.6	[2] 14.8	15.4
Days of hospital care per 100 persons in population, total	236.0	175.0	178.0	160.0
Excluding days:				
Beyond 30	158.0	125.0	[3] 144.0	(4)
Beyond 60	192.0	149.0	(4)	152.0
Beyond 90	204.0	160.0	[3] 172.0	(4)

[1] Number of discharges.
[2] Days per discharge.
[3] Exclusion based on days per discharge.
[4] Not available.

These data all relate to care in general and short-term special hospitals (excluding care in mental institutions, tuberculosis sanitoriums, nursing homes, and similar institutions). The data from the national health survey that have been tabulated as of this time relate to hospital discharges, rather than number of persons hospitalized. Since some persons are hospitalized more than once during a year the number of admissions or discharges is larger than the number of persons hospitalized. In the BOASI survey, for instance, the annual rate of admissions was 13.6 as compared with the rate of 11.1 persons hospitalized per 100 persons. The Census-PHS 1956 survey also showed

[2] Data collected in the BOASI survey on hospital utilization of a beneficiary's spouse who died during the year were excluded from the analysis because similar data were not obtained for old-age beneficiaries who died during the survey period, and data available from hospital records for use in making the correction for decedents apply to all deceased persons regardless of family status.

about 25 percent more admissions than persons hospitalized during the year. A count of the number of perons hospitalized from the national health survey will probably show between 10 and 11 persons per 100. The proportion of aged persons found to be hospitalized during a year was thus very similar in all four studies.

The average days per admission or per discharge are of course less than the average days per person hospitalized. The total days of hospital care per hundred persons in a survey population are the same whether based on a count of admissions or of persons hospitalized. The data from the four surveys on this item are thus directly comparable.

The number of OASDI beneficiaries entering hospitals was somewhat larger than that shown by the surveys for the aged population as a whole and their average stay was significantly longer. Beneficiaries thus had more days of hospitalization per capita per annum.

The special characteristics of the beneficiary group suggest some reasons for this difference. Retired persons are more likely to need hospitalization than those still at work and for the most part the BOASI survey excludes persons who are not substantially retired. Moreover, many of the beneficiaries, particularly among the men aged 65–69, probably retired because of poor health.

Persons in the institutional population are more likely than others to be in poor health and the BOASI survey is the only one to include the institutional population. Furthermore, the beneficiary data include persons who are hospitalized during the entire survey year; such cases were omitted entirely in one of the other surveys and may have been underenumerated in the other two insofar as the individuals were not counted as members of the surveyed household. The beneficiary group includes somewhat more persons with hospital insurance (43 percent) than the aged population as a whole, and fewer recipients of public assistance or others with very low income.

Some of the factors which influence the extent of hospital utilization can be identified from the more detailed information that is available from some of the surveys.

Personal characteristics

Age, sex, and marital status all affect the amount of time spent in hospitals. Household surveys show that aged men are admitted more frequently and stay longer in hospitals than aged women. The differences found are much greater in some surveys than in others and, perhaps because of sampling variations, are not consistent for all age and other subgroups. The very limited information that is available relating to persons who die in hospitals suggests that women decedents have somewhat more days of hospitalization than men decedents.

In general, the amount of time spent in the hospital for every 100 persons in the population increases with age. In the Census-PHS survey there were 176 days of hospitalization in a year for every 100 persons aged 65–69 and 207 days for every 100 persons aged 75 and over.

Marital status and the interrelated factor of living arrangements also affect the need for hospital care. A person living alone may have to be hospitalized for an illness which could be treated at home if other people were present to provide care. Married men and widows—many of the latter live with their children—have in gen-

eral lower rates of hospitalization than single persons; married women have almost as high rates as single women, perhaps because aged husbands are less able to care for their wives than women for their husbands.

Income

In the main the probability of a beneficiary entering a hospital during the year, as indicated by BOASI survey data, bears no systematic relationship to his income (or, in the case of married beneficiaries, to the income of the couple). At each income level, however, those beneficiaries with some health insurance tend to have a higher hospital admission rate than beneficiaries with no insurance.

Insurance status

Persons who have health insurance enter hospitals more frequently, but have more short-duration stays than those who are uninsured. For the BOASI and the Census-PHS surveys, the experience of those aged 65 and over with and without insurance in the 12-month period is shown in table 3.

TABLE 3.—*Use of hospitals by persons aged 65 and over, by hospital insurance coverage status, BOASI, 1957, and Census-PHS, 1956, surveys*

	BOASI, 1957		Census-PHS, 1956	
	Insured	Uninsured	Insured	Uninsured
Persons hospitalized per 100 persons	14.2	8.8	12.4	8.5
Average days of care per person hosptalizied	17.4	25.7	15.0	19.8
Total days hospital care per 100 persons	248.0	226.0	186.0	168.0

The reasons for these differences are fairly clear. Persons with insurance are more likely to go to the hospital early in the course of an illness or for essentially diagnostic purposes and thus stay a relatively short time. The uninsured group includes a larger proportion of "impaired risks" who cannot purchase insurance, of older persons with more serious medical needs, and probably of persons who because of fear of the costs postpone getting medical and hospital care until the need is overwhelming.

The type of health insurance found among a particular group may itself affect the extent of hospitalization. It is generally assumed by those working in the field that utilization will be higher the more nearly complete the protection provided for a particular risk. This is one of the reasons given for use of coinsurance; it is also one of the reasons advanced by the insurance industry for assuming a very large increase in utilization beyond that now found for persons having cash indemnity insurance if a program of hospital service benefits were made available to most of the aged population. There is little factual basis for measuring the magnitude of such differences.

Another factor of some significance would appear to be the extent to which insurance or prepayment applies to the total medical bill and not just to a part, such as hospitalization or hospital and surgical care. One recent carefully designed comparative study showed significantly (about 20 percent) lower hospital admission rates for the members of a large prepayment plan that provides almost all medical

services outside as well as in the hospital than for a comparable group who had hospital or hospital-surgical insurance only. For persons admitted to the hospital the average duration of stay was much the same in the two groups. As a result the average annual number of days of care per 100 persons in the comprehensive prepayment plan was about 85 percent of that for the other group. In the case of persons aged 65 and over the differences were less than for those in younger ages. The overall utilization rate for persons aged 65 and over in the prepayment plan was 159.5 days as compared with 168.1 days for the group with more limited insurance coverage (*6*).

Type of hospital

As was indicated earlier, the hospital care that is measured in all the data cited was received in general and special short-stay hospitals. As might be expected, the average duration of stay in Veterans' Administration general hospitals, which treat short-term and long-term patients, is considerably higher than that for patients treated in private, short-term hospitals.

The 1956 Census-PHS survey found that veterans of wars other than World War II spent 34 days, on the average, when hospitalized in a Federal (predominently VA) hospital and only 10 days when hospitalized in a non-Federal short-term general hospital.

Preliminary data from the recent National Health Survey show similar differentials in length of hospital stay between veterans treated in Veterans' Administration general hospitals and persons discharged from private and public general hospitals.

In the main, these differences are accounted for by the fact that more than 35 percent of all patients in VA general hospitals are in fact neuropsychiatric or tuberculosis patients and another 20 percent are patients treated for either a neoplastic, a chronically disabling respiratory or cardiovascular disability (*7*). Utilization rates derived from stays in all general hospitals are thus likely to be higher than would be found for non-Federal hospitals only.

Changes in Hospital Utilization Since 1951

The utilization rates derived from two of the current national surveys can be compared with data obtained in two 1951 surveys: a Census-SSA survey similar to the Census-PHS 1956 survey and the 1951 BOASI beneficiary survey.

The same general relationships between utilization rates for the aged and for the total population, and for those with and those without insurance were found in the earlier studies as in the comparable 1956 or 1957 experience. During the period, there was an increase both in the proportion of persons aged 65 and over and in the proportion of aged beneficiaries with insurance. The total days of care per 100 aged persons also increased, but very much less than the increase insurance coverage.

The 1951 Census-SSA survey showed 26 percent of the persons 65 and over having hospitalization insurance while hospital utilization for the entire 65 and over group was 165 days of general hospital care per 100 persons in the population (*8*). The comparable figures from the Census-PHS 1956 survey were 36 percent with hospital insurance and a utilization rate of 175 per 100 persons aged 65 and over. The

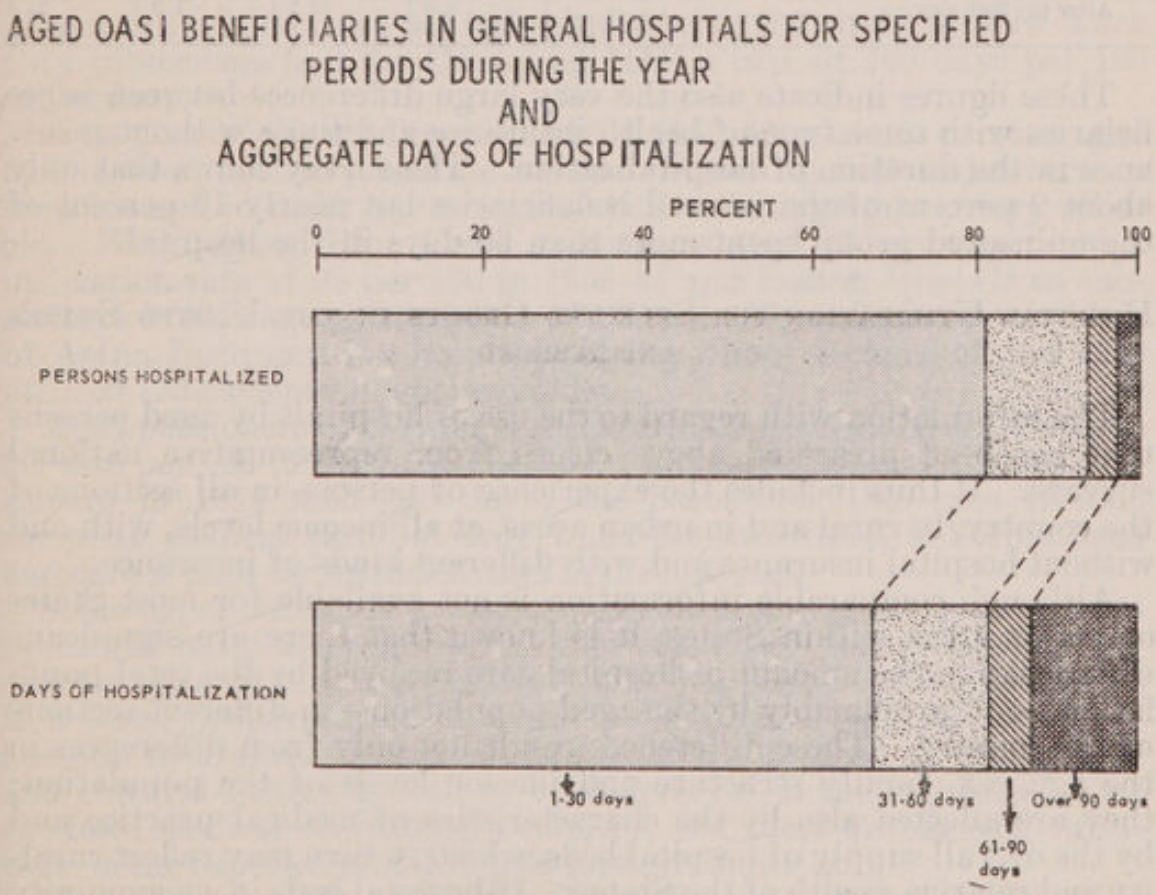
1951 beneficiary survey showed 23 percent with hospitalization insurance and a utilization rate of 225 days per 100 aged beneficiaries (*9*), as compared with 43 percent with insurance and a utilization rate of 236 per 100 in the 1957 beneficiary survey.

Duration of General Hospital Stays

For persons aged 65 and over the four recent national surveys show from 15 to 22 days of hospitalization per year per person hospitalized in general hospitals. These averages include many short and some very long stays. The relative number of aged persons hospitalized for different periods of time during a year in the two surveys for which such information is now available is shown in table 4.

Table 4.—*Percent of persons aged 65 and over hospitalized for specified periods of time during the year, Census-PHS, 1956, and BOASI, 1957, surveys*

Days hospitalized	Census-PHS, 1956	BOASI, 1957
1 to 30 days	71.5	81.9
31 to 60 days	18.5	12.4
61 to 90 days	5.2	3.2
91 days and over	4.8	2.5



SOURCE: BOASI Beneficiary Survey, 1957. Data for persons aged 65 and over

Although a larger proportion of the aged beneficiaries than of all aged persons included in the Census-PHS survey had less than 31 days and a smaller proportion had more than 60 days of hospitalization during the year, the very long stays of a relatively few beneficiaries, as well as the somewhat higher rates of persons hospitalized, resulted in considerably more days of hospitalization for the entire beneficiary group.

The total days of hospital care per 100 persons in the population, excluding days beyond 30, beyond 60, and beyond 90, were shown on page 15 above. The percent of all days accounted for by periods of hospitalization of different duration during a year were as follows:

TABLE 5.—*Persons aged 65 and over: Days of general hospital care per 100 persons per year and percent of days in periods of specified duration during year, Census-PHS, 1956, and BOASI, 1957, surveys*

	Census-PHS 1956	BOASI, 1957		
		Total	With health insurance	Without health insurance
Days of general hospital care per 100 persons per year	175	236	248	226
Percent of days accounted for by days—				
Before the 31st	71.8	67.3	83.2	54.0
Between the 31st and 60th	13.8	14.5	13.3	15.5
Between the 61st and 90th	6.4	5.0	2.3	7.3
After the 90th day	8.0	13.2	1.2	23.1

These figures indicate also the very large differences between beneficiaries with some type of health insurance and those without insurance in the duration of hospitalization. The survey shows that only about 2 percent of the insured beneficiaries but nearly 10 percent of the uninsured group spent more than 60 days in the hospital.

HOSPITAL UTILIZATION FOR SELECTED GROUPS IN THE UNITED STATES AND ABROAD

The information with regard to the use of hospitals by aged persons that has been presented above comes from representative national surveys. It thus includes the experience of persons in all sections of the country, in rural and in urban areas, at all income levels, with and without hospital insurance and with different kinds of insurance.

Although comparable information is not available for most States or major areas within States, it is known that there are significant differences in the amount of hospital care received by the total population—and presumably by the aged population—in different sections of the country. These differences result not only from differences in the age, sex, family structure and income levels of the population; they are affected also by the characteristics of medical practice and by the overall supply of hospital beds, which in turn may reflect rurality and relative wealth of the States. If hospital beds in a community are in short supply, the acutely ill will have first call on the available beds, and hospital stays will on the average be shorter than if beds are plentiful.

The Nation's hospital plant today provides 3.5 hospital beds per 1,000 population in non-Federal short-term general and special hos-

pitals and 4.2 per 1,000 in all general (short- and long-term, including Federal) and all short-term special hospitals (*10*). It is of some significance that these proportions are almost exactly the same as in 1946, in spite of the postwar program of hospital construction and the sizable growth during the period in the use of voluntary health insurance to prepay the costs of hospitalization. Acceptable non-Federal general hospital beds, according to Public Health Service data for July 1, 1958, are somewhat more evenly distributed in relation to population today than in 1946, but even in 1958, the number of beds per 1,000 population varied from 2.49 in South Carolina and 2.58 in Indiana to 5.07 in Montana (*11*).

Scattered information with regard to hospital utilization is available from a considerable number of local surveys or surveys based on the experience of particular population groups or insured plans. As would be expected, the utilization rates derived from such special experiences show a very wide range (*12*).

For example, a New York City study made in 1951 showed an annual rate of 94 days of general hospital care per 100 persons aged 65 and over. The California Health Survey of 1954–55, on the other hand, found 190 days of hospitalization for each 100 persons aged 65 and over. These two studies included both insured and uninsured aged persons.

There are more studies that relate to an insured population only. A 1954 study of Blue Cross-Blue Shield subscribers in New York City gave a rate of 168 days per 100 members; a 1955 study of New York City subscribers to Blue Cross and HIP a rate of 160 days per 100 subscribers.

A number of the studies made about 1950–52 relate to persons aged 55 and over, probably because too few persons aged 65 and over were then insured to make any sample data for that age group very reliable. Birmingham Blue Cross subscribers aged 55 and over had a utilization rate of 98 per 100 in 1952–53 and Boston Blue Cross subscribers in this age group a rate of 162 per 100, while Boston holders of Aetna Insurance Co. hospital policies who were aged 55 and over utilized 123 days per 100 policyholders.

Aged pensioners of the General Electric Co. used 226 days of hospital care per 100 in the years 1948–51. Missouri Pacific Railroad pensioners in 1954 used 550 days; the benefits in this plan include complete medical care but only when the individual is hospitalized and care is paid for up to 365 days in the hospital.

Some experience data are also available from certain government-sponsored hospital programs in other countries. These data are frequently cited as indicative of what may happen in the United States if a large proportion of the aged population should come to have hospital insurance. Hospital utilization is influenced by many social and cultural factors as well as by differences in the organization of the total medical services of a country, and there are marked variations in the experience of different foreign countries.

Most of the readily available information as to hospital utilization in other countries relates to the total population and not to the aged population. Data specifically for persons aged 65 and over are available from several of the provinces of Canada. Attention is usually directed to those provinces that have publicly supported hospital programs, and particularly to Saskatchewan.

Hospital utilization rates both for the aged and for the entire population are much higher in Saskatchewan than those found in the United States. In 1957 the rate for the entire population of the province was 228 days per 100 persons and for persons 65 and over it was 687 days per 100. The underlying reasons are fairly clear. Saskatchewan is a poor, highly rural province. The province has deliberately provided a hospital bed capacity considerably larger than that ordinarily regarded as necessary or desirable. In 1957, it had 7.4 general hospital beds per 1,000 population (as compared with 4.2 in the United States). An air ambulance service brings persons from remote areas to hospitals for all kinds of care.

The Saskatchewan public hospital service program has no restrictions as to age, kind of disease or duration of care provided. A substantial proportion of the persons hospitalized, and particularly of those 65 and over, are hospitalized for chronic conditions (60 percent of those 65 and over according to a recent Public Health Service study (*13*)), and the proportion of long-stay cases—some as long as 5 years—is comparatively high.

About 27 percent of all persons receiving hospital service in Saskatchewan are public-assistance recipients who are entitled also to care by private physicians paid from public funds. Physicians' visits to these cases are found to be mainly in the hospital, a saving in physician time that is particularly significant in a Province where so large a part of the population lives in remote areas. From the point of view of the patient, and his family also, hospitalization may be dictated by social as well as strictly medical considerations.

In effect, the Saskatchewan hospital program has operated as an institutional-care program. The Province is now starting a program for construction of nursing homes and other special types of facilities that in time may somewhat alter this general picture.

In British Columbia—where a system of public hospital care has also been in existence for a number of years, but where hospital bed capacity is lower, and hospital benefits, though unlimited in duration, are available only for acute illnesses—the hospital utilization rate for for persons 65 and over is about half that in Saskatchewan.

Utilization of Nursing Homes and Other Facilities

There is much less information with regard to the extent of utilization of nursing homes and other types of medical facilities by aged persons. Most population surveys relate primarily, if not exclusively, to persons who are not living in institutions. Surveys of the institutional population have been infrequent and have provided little information as to rates of admission, length of stay, or similar factors.

The BOASI survey not only included beneficiaries who were resiing in institutions at the time of the survey, but also obtained information on the total time spent in institutions during the survey year. As compared with 11 in every 100 aged beneficiaries who spent some time in a general hospital during the survey year, there were 2.3 per 100 who spent some time in long-stay institutions—1.0 in mental hospitals, tuberculosis, sanatoriums, or other types of chronic disease hospitals, and 1.3 persons in nursing homes.

The total days spent in these chronic-care institutions aggregated considerably more than the total days in general hospitals—448 days of institutional care as compared to 236 days of hospital care per 100 beneficiaries. There were 172 days of care in mental, tuberculosis, and other chronic disease hospitals, and 276 days of care in nursing homes per 100 beneficiaries. It was not practicable to get from the beneficiaries who were surveyed sufficient information to classify the nursing homes even roughly into those that provided primarily residential and custodial care and those that gave skilled nursing and medical care.

Sixty-seven percent of all the recorded stays in nursing homes were for more than 60 days, and many were for a full year. Only 13 percent of the aged beneficiaries who had been in nursing homes during the survey year had spent less than 30 days in the home. A third of the nursing-home cases spent some time in a hospital during the survey year, almost always a general hospital.

There are perhaps 450,000 beds in nursing homes of all types in the United States. A recent national conference on nursing homes and homes for the aged suggested that such homes be classified according to the kind of service they provide as residential facilities, personal care facilities, nursing care facilities and multiple service facilities.

The latter two categories would encompass what earlier Public Health Servise studies had called skilled nursing homes. To meet this definition a home must provide skiled nursing care and related medical services for 24 hours a day. As of January 1958, the States reported (under the Hill-Burton medical facilities construction program) a total of 221,435 skilled nursing home beds. Of these, 108,416 were considered unacceptable because of fire hazards or health reasons. In the aggregate the States considered that they needed 436,000 skilled nursing home beds.

About three-fourths of all skilled nursing homes, with a little less than two-thirds of the beds, are proprietary institutions. In July 1956, the latest date for which detailed figures are available, 5 percent of the homes with about 15 percent of the beds were publicly owned and operated; the remainder were nonprofit homes or of unknown ownership (*14*).

A 1953–54 survey of nursing homes in 13 States found that 90 percent of the patients in proprietary nursing homes (including all types and not just skilled nursing homes) were aged 65 and over. Two-thirds of the aged patients were women. Only one-half could walk alone and one-fifth were completely bedfast. Eighteen percent of the patients had been in their present home for 3 years or more. Public assistance financed, entirely or in part, the cost of care of one-half of all patients in proprietary nursing homes (*15*).

There are a few other scattered studies which give some indication of the characteristics of persons in nursing homes. For example, a 1958 study of 530 residents of five Jewish homes for the aged which provide nursing-home type care found that half of the persons in the homes were 80 years or age or over and widows constituted the largest group. In the four homes in the United States (one of the homes studied was in Canada) almost one-half the residents were supported primarily by public assistance. At the time of the study

3 in every 10 residents had been living in the home 5 years or longer. Some nursing service was required by all but a small fraction of the residents and many required extensive medical services as well (*16*).

Medical Care Costs

It is well known that the aged, like other predominantly low-income groups, are likely to find the financing of their medical needs a heavy burden. Sometimes they forego necessary medical care entirely or defer it much longer than is desirable. In other instances they get the care they need, but must relay on others to help pay for it. The degree to which they fail to obtain an adequate amount of medical care can only be inferred. However, the degree to which older persons encounter difficulty in paying for the medical care they receive—as well as the amount of their costs—can be illustrated by preliminary findings from the 1957 survey of OASDI beneficiaries.

The statistics presented above on hospital utilization relate to all individuals or all beneficiaries aged 65 and over. The analysis of medical care costs that follows is presented separately for nonmarried beneficiaries aged 65 and over and for beneficiary couples (some of which include a spouse under age 65) because for married persons, an analysis of medical care costs, their relationship to resources, and the means of meeting them, are much more meaningful when related to couples than to the individuals making up the couples.

Since total medical costs include household medicine chest items as well as prescription medicines and the services rendered by hospitals, physicians, and others, it is to be expected that few beneficiary groups would have no costs during a period of a year. Of the married couples in the survey sample, for instance, only 3 percent reported incurring no medical costs during the survey year. Another 6 percent reported that some (or all) of their care was furnished "free," i.e., without direct charge to anyone.[3] Nine percent had known costs totaling $800 or more (table 6).

Table 6.—*Medical costs: Percent distribution of aged OASI beneficiaries by amount incurred during year, 1957*

Total medical cost	Beneficiary couples	Nonmarried beneficiaries
Total	100	100
None incurred	3	8
$1 to $99	28	42
$100 to $199	17	17
$200 to $299	13	8
$300 to $399	9	4
$400 to $499	6	3
$500 to $599	4	1
$600 to $799	3	2
$800 to $999	2	1
$1,000 or over	7	4
Some free care	6	8
Unknown	2	2

[3] Beneficiaries were not necessarily classified as receiving "free" care because they themselves or their relatives did not pay for it. They were classified as receiving "free" care whenever care was supplied by a hospital or doctor and no bill was rendered to anyone, or when a public assistance or other agency made payment directly to the hospital or doctor, or other vendor and the beneficiary did not know the amount of such payment. The dollar value of the medical care for which there was a charge was not tabulated if some care was received "free."

For those beneficiaries reporting medical costs of known amount (including zero) and having no item furnished "free," the median expense incurred was about $190 for the married couples, a little more than twice the figure of $90 for the nonmarried beneficiaries. Because, as shown below, beneficiaries with some "free" care or costs of unknown amount had hospitalization more often than other beneficiaries, the cost of their care, if known, would probably have raised the medians above these levels.

On the whole, there appears but little systematic relationship between the amount of medical costs and the amount of cash income. This is consistent with the finding that there is no systematic relationship between the size of income and the number of persons hospitalized per 100 beneficiaries. The distribution of nonmarried beneficiaries at different income levels by amount of medical cost, presented by way of illustration, is shown in table 7.

TABLE 7.—*Medical costs and income: Percent distribution of aged nonmarried OASI beneficiaries with specified incomes, by amount incurred during year, 1957*

Money income	Total medical cost					
	Total	None or less than $100	$100 and under $500	$500 and over	Some free care	Unknown
All incomes	100	50	32	8	8	2
Under $600	100	51	35	7	5	2
$600 to $1,199	100	54	28	7	9	2
$1,200 to $1,799	100	48	34	7	10	1
$1,800 to $2,399	100	45	36	10	7	2
$2,400 to $2,999	100	51	34	8	5	2
$3,000 and over	100	42	35	16	4	3

Medical costs and hospitalization

Total medical costs during a year are of course likely to be much larger when there is a period of hospitalization or nursing home care than when there is not. The median costs, for example, for those couples reporting at least one episode of hospitalization [4] for either member (excluding those receiving any "free" service or with unknown costs) was about $700 compared with only $140 for those couples whose medical costs for the year included no hospitalization.

[4] The data in this section cover cost of stays not only in general hospitals but also those in mental, tuberculosis, and other long-stay hospitals and in nursing homes, and the term "hospitalization" is used to relate to all such care, unless otherwise specified.

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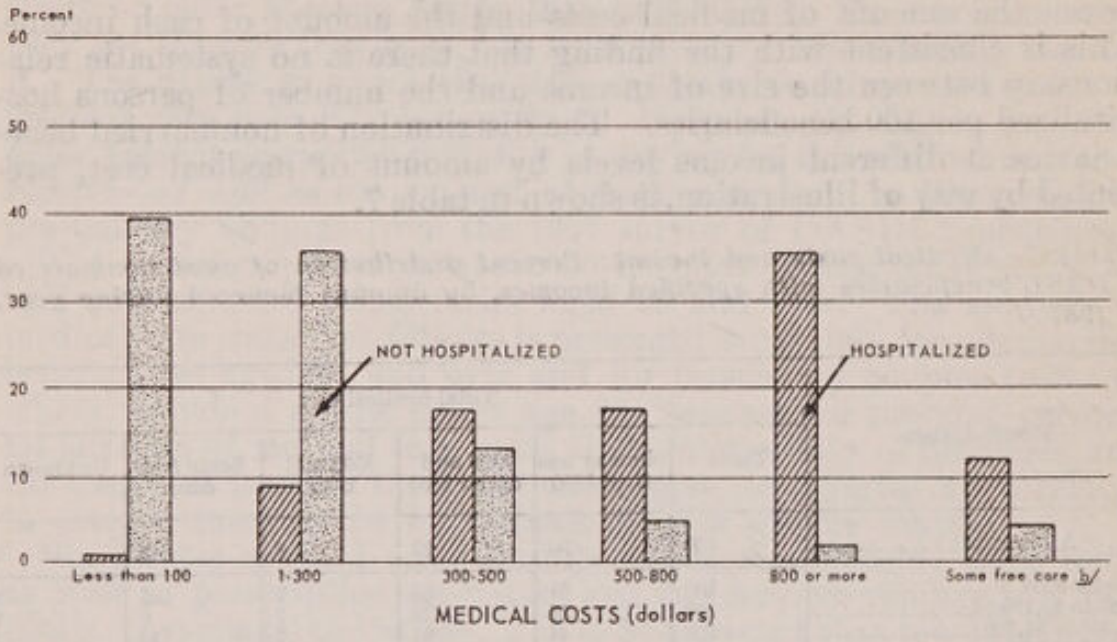
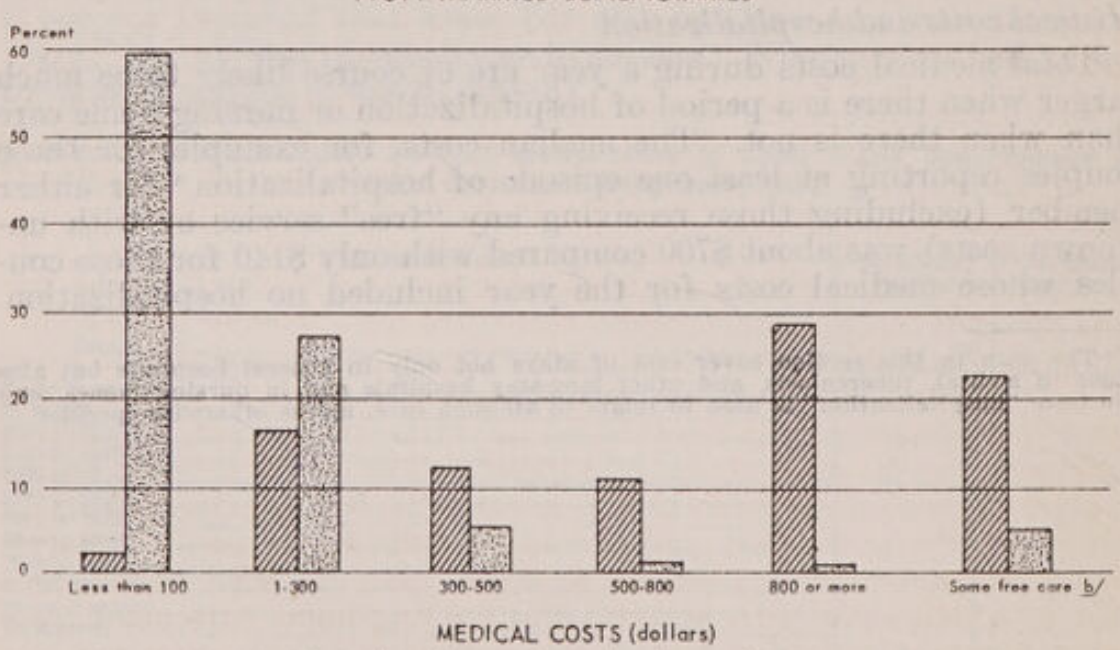
TOTAL MEDICAL COSTS FOR AGED OASI BENEFICIARIES: PERCENT DISTRIBUTION FOR THOSE HOSPITALIZED a/ AND NOT HOSPITALIZED DURING YEAR.

BENEFICIARY COUPLES



NON-MARRIED BENEFICIARIES



a/ Hospitalized in general hospitals and long-stay hospitals and nursing homes. For couples, hospitalized cases include those with either or both members hospitalized. Cases with unknown costs not shown.

b/ See text for definition of "free" care.

SOURCE: BOASI Beneficiary Survey, 1957.

Corresponding figures for nonmarried beneficiaries are about $625 and $75, respectively. Moreover, 12 percent of the couples and 23 percent of the nonmarried beneficiaries with care in a hospital or nursing home had some "free" care. The figures in table 8 give the percentage within each cost group that had one or more admissions to any type of hospital or nursing home during the year and the proportion with at least one stay in a general hospital during the year.

TABLE 8.—*Percent of aged OASI beneficiaries who were hospitalized during year, by amount of total medical cost, 1957*

Total medical cost	Beneficiary couples hospitalized [1]		Nonmarried beneficiaries hospitalized	
	Total	In general hospital	Total	In general hospital
Total	21	20	16	13
$1 to $99	1	1	1	1
$100 to $199	4	4	8	8
$200 to $299	9	9	14	13
$300 to $399	21	20	24	22
$400 to $499	34	33	40	37
$500 to $599	45	45	57	57
$600 to $799	55	53	69	64
$800 to $999	74	74	83	52
$1,000 or over	89	84	85	52
Some free care	44	34	46	35
Unknown	66	64	57	50

[1] 1 or both members.

Not only does the proportion of beneficiary couples or nonmarried persons with at least one period of hospitalization or nursing-home care rise sharply from only 1 percent among those reporting costs of less than $100 to more than 80 percent of those reporting costs of $1,000 or more, but it is significant also that nearly half the beneficiary groups receiving some medical care free had had a period of hospitalization. Almost all the beneficiary couples with high medical costs and a period of hospitalization received care in general hospitals. On the other hand a substantial proportion of the nonmarried hospitalized beneficiaries with high costs were in long term hospitals or nursing homes.

The effect of a period of hospitalization on the size of the total medical bill can be demonstrated more directly. Among those couples having hospitalization of one or both the members and able to report their total medical costs, the costs associated with such episodes averaged 64 percent of their total medical bills for the year, 41 percent representing charges made by a general hospital, 4 percent charges of chronic care institutions and 19 percent the fees for the surgeon and in-hospital doctor's care. As would be expected because nonmarried beneficiaries are older, on the average, than married beneficiaries, the cost associated with hospital and nursing-home care made up an even greater portion of total medical costs for them than for beneficiary couples—77 percent versus 64 percent—with nursing-home

charges alone representing 22 percent of their total medical bills and general hospital fees 33 percent.[5]

Costs associated with hospital and nursing-home care accounted for 37 percent of the aggregate costs of all beneficiaries able to report their total medical costs. General hospital fees alone represented 20 percent, nursing-home charges 5 percent, charges in other long-stay institutions 3 percent. Surgeons' and in-hospital doctors' fees made up the remaining 9 percent.

Means of meeting medical costs

Since large bills necessarily create more of a financial problem than small bills and a hospital stay is likely to result in large bills, it would be useful to find out how elderly beneficiaries pay for necessary hospitalization. This is not possible because of the difficulty of separating available resources used to pay for hospitalization from those used to pay associated costs. Information is available, however, from the 1957 survey on the means by which beneficiaries met their total medical costs in the survey year.

More than four-fifths of all beneficiary groups incurring medical costs assumed responsibility themselves for all the medical costs they incurred during the year. Relatively few—14 percent of the couples and 9 percent of the nonmarried beneficiaries—had any of their expenses covered by insurance. Among the insured, as would be expected (because the usual form of health insurance provides protection against hospitalization costs), beneficiaries who were hospitalized had a higher portion of their medical costs met by health insurance than those who were not, as shown in table 9.

TABLE 9.—*Percent of aged OASI beneficiaries with hospitalization insurance having specified proportion of medical costs met by such insurance, 1957*

Percent of total medical cost met by insurance	Insured beneficiary couples		Insured nonmarried beneficiaries	
	Hospitalized [1]	Not hospitalized	Hospitalized	Not hospitalized
Total	100	100	100	100
None covered	16	92	13	96
1 to 24	28	4	19	2
25 to 49	29	2	36	
50 to 69	15	1	13	1
70 or more	7		12	
Unknown	5	1	8	1

[1] 1 or both members hospitalized.

More than 8 percent of all couples and 11 percent of all nonmarried beneficiaries had some of their costs met by a public or private health or welfare agency. For 6 percent of the couples and twice as large a proportion of the nonmarried persons, relatives were called upon to foot all or part of the medical bills; 6 percent of the couples and 3

[5] The fact that beneficiaries were classified by marital status at the end of the year and that the medical costs of a spouse who died during the year were included with those of the survivor results in a slight inflation of the importance of hospitalization costs for nonmarried persons. As shown below, the hospitalization rate was high for deceased spouses. However, beneficiaries whose spouse had died comprised only 1.6 percent of beneficiaries classified as nonmarried and their total costs accounted for 5 percent of the aggregate costs of nonmarried beneficiaries.

percent of the nonmarried persons had larger unpaid medical bills at the end of the year than at the beginning.

In the case of beneficiaries with relatively high costs the situation was somewhat different. (For purposes of this analysis, the married couples with medical costs of $800 or more and nonmarried individuals having costs of $500 or more were singled out as having relatively high costs.) Such beneficiaries—a considerable number of whom had a period of hospitalization, namely 85 percent of the couples and 79 percent of the nonmarried—were more likely than others to have some medical costs covered by insurance. They were somewhat less likely than other beneficiaries to assume sole responsibility for costs not covered by insurance, and more likely to have relatives pay some bills, to draw on their own assets, or to increase their outstanding medical debt. These differences are illustrated by the proportions of all beneficiaries as compared with those incurring relatively high costs who used selected means of meeting some of their costs (table 10).

TABLE 10.—*How medical costs were met by all aged OASI beneficiaries and by those having relatively high costs, 1957*

[Percent]

Selected means of meeting medical costs [1]	Beneficiary couples		Nonmarried beneficiaries	
	All	Having costs of $800 or more	All	Having costs of $500 or more
Insurance covered some costs	14	53	9	38
Beneficiary assumed entire responsibility [2]	86	84	79	61
Relatives assumed some responsibility	6	15	12	31
Health or welfare agency assumed some responsibility	8	2	11	12
Medical debt increased	6	25	3	10

[1] Items not mutually exclusive since beneficiaries frequently used more than 1 means to meet medical costs.

[2] Exclusive of any portion covered by insurance. May include payments from assets as well as from current income and any portion as yet unpaid.

The seeming paradox that beneficiaries incurring high costs were no more likely than others—and in the case of married couples actually less likely—to have a public or private health or welfare agency responsible for some of their costs is accounted for by the fact that many of the beneficiaries needing medical care that was relatively high in cost obtained some of it without charge because of limited ability to pay; medical costs were not aggregated for beneficiaries having some care "free."

As indicated above, 6 percent of all beneficiary couples and 8 percent of all nonmarried persons were classified as receiving some medical item or service "free." About half of these cases involved hospitalization. It is highly likely that if the costs of such hospital care could be approximated, the number of beneficiaries with large total medical costs would be considerably greater. Only 9 percent of the married couples or nonmarried beneficiaries classified as receiving some "free" care had any medical costs covered by insurance. A hospital or other health or welfare agency assumed at least some responsibility for medical costs in most of these cases of "free" care, and relatives contributed a share for 14 percent of the couples and 28 percent of the nonmarried persons.

As would be expected, those receiving some "free" medical care were considerably more likely than others to be on public assistance rolls during all or part of the year (table 11).

TABLE 11.—*Percent of aged OASI beneficiaries with specified medical costs receiving public assistance during year, 1957*

	Beneficiary couples	Nonmarried beneficiaries
All beneficiaries	7	13
Some free care	27	37
High medical costs [1]	5	14
Low or intermediate medical costs	7	10
Cost unknown	2	14
No medical costs	2	10

[1] $800 or more for couples, $500 or more for nonmarried individuals.

It is not possible to determine how many beneficiaries (in addition to those receiving some medical care entirely free) were charged reduced rates for some service because of limited ability to pay.

Costs of terminal illness

In one important respect the beneficiary survey data are incomplete: They include no information on medical costs incurred by old-age or widow beneficiaries who died during the survey year.

However, data obtained for persons who died leaving a surviving spouse drawing a retired worker's benefit give some indication of the cost of terminal illness. Such cases comprised less than 1 percent of all the beneficiary groups studied and the data therefore must be used with care. In almost all of these cases the survivor was the husband, because the sample design did not include women drawing widows' benefits unless their husband had died before the beginning of the survey year.

Total medical costs for the couples where one of the partners died averaged much higher than where both survived, because the costs incurred by the dying spouse were high. They were also more likely to receive some "free" care. This came about in part because the spouses who died were quite likely to have had some hospitalization during the year and, as shown earlier, an episode of hospitalization is likely to be associated with high medical costs or need for "free" care. The following figures compare the experience of the deceased spouses with that of all nonmarried beneficiaries:

	Average medical costs [1]	Percent receiving some free care	Percent hospitalized
Spouses dying during survey year	$550	14	54
All nonmarried beneficiaries	209	8	16

[1] Based on those with known costs and not receiving any item "free."

The survivors of these deceased spouses also tended to have above-average medical costs—with more than a fourth requiring some hospitalization themselves—so that total expenses for the couple averaged

higher than where both partners survived the entire survey year, as illustrated by the following:

	Average medical costs [1]	Percent receiving some free care	Percent with one or both members hospitalized
Beneficiary couples with spouse dying during year	$783	19	65
Other beneficiary couples	339	6	21

[1] Based on those with known costs and not receiving any item "free."

As might be expected, the high costs associated with the death of a spouse meant that the survivors had greater difficulty in meeting their total medical costs than other beneficiaries. Insurance covered some of the costs in only one-fourth of the cases where one of the partners had died. Nearly one-third received some help from relatives, and a fourth still had medical bills remaining unpaid at the end of the survey year.

To the extent that old-age beneficiaries who died during the survey year (and were, therefore, not included in the survey) incurred greater expenses than those who survived, the survey statistics understate average medical costs for all beneficiaries; and to the extent that some of those dying left insufficient funds to cover all their bills, the statistics understate the volume of medical costs which must be assumed by others.

SOURCES

(*1*) Public Health Service, Health Statistics from the U.S. National Health Survey, Publication No. 584: Series B–4, "Disability"; B–5, "Selected Survey Topics"; and B–7, "Hospitalization: Patients Discharged." Data are for July 1957 to June 1958 except as noted.

(*2*) Data for the general population from Odin W. Anderson and Jacob J. Feldman, "Family Medical Costs and Voluntary Health Insurance: A Nationwide Survey," 1956. Corresponding data for those aged 65 and over from "Financing Health Costs for the Aged," New York State Conference, 1956, pages 67–72.

(*3*) Data on hospital utilization of beneficiaries from "Aged Beneficiaries of OASDI: Highlights on Health Insurance and Hospital Utilization, 1957 Survey," Social Security Bulletin, December 1958, and unpublished tabulations. Data on medical costs of beneficiaries based on unpublished tabulations.

(*4*) "Use of General Hospitals," Public Health Reports, May 1957, and unpublished data from the Bureau of the Census-Public Health Service current population survey of September 1956.

(*5*) Unpublished data from Health Information Foundation-National Opinion Research Center survey in the spring of 1957.

(*6*) American Hospital Association, "Prepaid Medical Care and Hospital Utilization," Hospital Monograph Series No. 3, 1958. Data are as of 1955.

(*7*) Letter from the Veterans' Administration.

(*8*) Social Security Administration, "Hospitalization and Insurance Among Aged Persons: A Study Based on a Census Survey in March 1952," Bureau Report No. 18, April 1953.

(*9*) "Incapacity and Hospital Care of Aged Beneficiaries of Old-Age and Survivors Insurance," Social Security Bulletin, April 1955.

(*10*) American Hospital Association, "Hospitals: Guide Issue," August 1, 1957, text table B, page 348. See also Public Health Service, "Hospital and Medical Facilities in the United States as of January 1, 1959."

(*11*) Unpublished data from Public Health Service, Division of Hospital and Medical Facilities.

(*12*) Social Security Administration, Division of Program Research, preliminary staff memorandum, "Basic Cost Calculations Relating to Proposals To Provide Hospitalization and Other Medical Care Services to OASDI Beneficiaries," January 20, 1958.

(*13*) Marcus S. Goldstein, "Morbidity Experience of Saskatchewan General Hospitals, 1951: Frequency and Duration of Hospitalization by Primary Diagnosis," October 1958.

(*14*) "Nursing Homes: Public and Private Financing of Care Today," Social Security Bulletin, May 1958.

(*15*) Public Health Service, "Nursing Homes, Their Patients and Their Care," Public Health Monograph No. 46, 1957.

(*16*) Franz Goldmann, "Residents of Homes for the Aged: Their Health Conditions and Health Needs," 1959.

CHAPTER III

FACTORS INFLUENCING TRENDS IN COSTS OF HOSPITAL AND MEDICAL CARE

In the United States and in many other countries, complaints about the rising cost of medical care, and above all hospital costs, have been increasingly heard during the last decade. The medical care component of the Bureau of Labor Statistics' Consumer Price Index reflects the rising price trends in the United States. The "price" of medical care began to climb in 1941 and has increased over the last decade nearly twice as much as the average "price" for all the goods and services used by families, and shows the greatest increase of any of the eight major groups of items.

Percent increase in Consumer Price Index, 1948–58

	Percent
All items	20
Food	16
Apparel	3
Housing	26
Transportation	39
Medical care	43
Personal care	27
Reading and recreation	16
Other goods and services	27

Over a longer period, from 1938 to 1958, the "price" of medical care as measured by the Consumer Price Index, increased only slightly more than the average for all goods and services. The price of hospital care, however, rose almost 300 percent as compared to 105 percent for the entire index (*1*). Although a multiplicity of factors have entered into the rising costs of hospital care, the two principal factors are the change in the character of the hospital itself, and the greater demand and utilization of hospital care brought on by the growth of health insurance and the rising standard of living of the American consumer.

Changing Character of Hospitals

The hospital of today is as unlike the hospital of 20 or 30 years ago as the 1958 model automobile is unlike the Model T. You pay more but also get more. The hospital of today stands for the oxygen tent, the blood bank, the operating room, and the other instruments through which modern medicine demonstrates its ability to save life. It is also where the laboratory and radiographic procedures and radioactive elements are available for diagnostic procedures. It is a complicated organization of services most of which must be available for use on a moment's notice.

Hospital wages and salaries

With the change in character has come the need for a larger proportion of skilled workers of all kinds, plus an attempt to bring hospital salaries into line with the general wage level. The increased number of employees in the hospital can be attributed to the reduction of the workweek as well as the expansion of hospital services. With the advent of the 40-hour week, three employees were needed to cover each position where two had been before—since hospital work is an around-the-clock operation and is likely to remain so. In 1946, payroll accounted for a little more than one-half of the average total expense per patient day and by 1955 it was 62 percent.

Despite the fact that payroll dropped back to 60½ percent in 1957, it seems reasonable to assume that further attempts will have to be made to bring hospital salaries into line with the general wage level. For example, the average annual earnings for all short-term and general hospital employees increased by 122 percent between 1946 and 1957, as compared to only 79 percent for all employees in industry. This faster increase—one that occurred in services generally during this period—was in large part a reflection of the catching up with the more rapid increases that occurred in earnings in manufacturing during the war. Nonetheless, in 1957 the average full-time hospital employee earned only $2,717 per year, or about two-thirds as much as a full-time worker in industry (*2*).

There has been and continues to be a serious shortage not only of physicians but also of all other types of health personnel—nurses, occupational and physical therapists, medical and psychiatric social workers, medical technologists, dieticians, and also practical nurses, aids, technicians, and homemakers. To meet the needs for hospital and other health personnel, salaries had to be raised rapidly in recent years, and they will undoubtedly exceed their present levels. Whether the earnings of health personnel will in the future rise much faster than general wage levels is a different question. It is reasonable to assume some further relative improvement, however.

Unlike industry, hospitals are hard put to cushion wage increases with greater productivity. Hospitals may be able to improve their productivity slightly by having less skilled persons take over some of the dutes requiring lesser skills now performed by professionals, but this will hardly be enough to completely absorb a round of wage increases.

Technical equipment

Advances in scientific medicine have been accompanied by the need for expensive equipment and highly trained technicians. Not all hospitals have as yet been able to take advantage of some of the advances in modern medical practice because of the cost of some of the equipment and the space needed for its installation. There has, however, been a significant increase in the proportion of hospitals offering

the more important specialized services, as indicated in the following data from the American Hospital Association (*3*):

Service	Percentage of general and allied special hospitals with specified services	
	1946	1957
Diagnostic X-ray	86	96
Clinical laboratory	76	94
Metabolism apparatus	69	90
Electrocardiograph	53	92
Blood bank	23	59
Physical therapy	33	38
X-ray therapy	33	36
Electroencephalograph	6	12
Outpatient department	43	55
Number of hospitals	4,702	5,309

It is to be expected that the trend toward more complete availability of a wide range of technical equipment will continue, but that there will also be more communitywide pooling of expensive equipment such as the electroencephalograph.

Length of stay

With the change in medical technology and the wide use of new and expensive drugs, there has been a notable decrease in the average length of stay in hospitals over the past decade—from 9.1 days in 1946 to 7.6 days in 1957. However, there has been a large increase in persons going into hospitals, and, consequently, the total days of hospital care per 100 persons in the population actually changed very little over the period—it was 89 per 100 in 1946 and 93 per 100 in 1957.

Because more service is usually required the first few days, the shorter stay has resulted in a heavier concentration of services per patient day, and, therefore, a higher per-patient-day cost. Since for persons over 65, the average stay in the hospital is more than half again as long as for the population as a whole, their per-patient-day cost may be lower.

Thus, the changing character of the hospital has been a major factor in bringing about the rising cost of hospital care over the past one or two decades. Further changes of this nature are to be expected, and they will likewise probably result in a continued rise in the unit costs of hospital care for all age groups. If overall costs are to be held down in the face of these rising prices, it will probably have to be through a reduction in utilization and average length of stay. One way in which this might occur would be through improved diagnostic and other out-of-hospital services (see below), although it is also possible that such developments would increase overall demand for medical care.

Increasing Effective Demand

The improved methods of paying for hospital services through voluntary insurance (discussed in ch. IV), and the general rise in incomes in recent years have led to an increase in medical expenditures as well as in hospital utilization. Medical care spending actually has increased proportionately more than personal income in recent decades. It is a more important part of the family budget than ever before. Allowing for population growth, per capita medical care and health insurance expenditures by consumers from 1948 to 1958 went from $52 to $88, an increase of 69 percent. Private spending for hospital care, both in gross and per capita terms, has been gaining steadily. On a per capita basis the change has been from $13 in 1948 to $26 in 1957 (*4*).

Of course, spending for medical care is still influenced by the amount of income. The survey of family expenditures in 1950, conducted by the Bureau of Labor Statistics, shows that urban families with income less than $2,000 spent over 7½ percent of their income—after taxes—for the year on medical care, an average of about $50 a person. At the other end of the income scale, the families with income of $7,500 or more spent 3½ percent of their year's income for medical care, or about $104 a person. Thus the upper-income families, using only half as large a share of their funds as the low-income group, were able to spend an average of twice as much for medical care per family member (*5*).

The greater effective demand for hospital care brought about by a rising standard of living and the growth of health insurance has played a major role in the increasing cost of hospital care reflected over the last two decades. The continued rising standard of living and growth of health insurance will probably continue to influence the cost of hospital care in the future.

Other Factors Affecting Future Trends in Medical Costs

The cost of medical care in the years ahead will be affected not only by future trends in the two factors which have been identified as of major significance in the past decade, but also by other factors whose effects can only partially be measured or predicted at this time. In projecting overall hospital and medical-care costs, the inter-relationship of all the various factors must be considered.

On the one hand, there is the probability of rising daily costs of hospital care and of increased utilization of hospitals due to prepayment or to new medical procedures, and to the economy in physician time which hospitalization of his patients makes possible. On the other hand, there are the improved diagnostic and other services that will keep more persons out of hospitals. There are also the changes in the organization of hospital and other types of medical care that will shift more days of care from the most expensive facilities to fully adequate but less costly types of institutional care or to supervised medical services in the home. And beyond these, there is the unpredictable effect of medical research. Some of the ways by which unit and overall costs may be affected are discussed below.

Organization of Health Services

The extent to which future health services will be associated with hospitals will be affected by many factors. Some can be identified at this time, but how they will react on one another is an open question.

The growth of private hospital insurance has undoubtedly contributed to the increasing use of hospital services. Removal of financial barriers to care is one purpose of hospital insurance. Questions are increasingly being raised, however, as to whether the availability of partial prepayment of hospital bills, in the absence of similar insurance for all medical bills, has not resulted in some medically unnecessary hospital stays. Hospital administrators, Blue Cross plans, the insurance industry and insurance commissioners in a number of States are showing increasing interest in a reexamination of current practices.

These pressures may have a perceptible effect on future trends, for example, it may be possible to cut down unnecessary use of inhospital care for diagnostic purposes by altering the patterns of insurance coverage, as well as methods of medical practice. However, the more complex the equipment and related requirements needed for accurate diagnosis, the more will efficiency of operation suggest the hospital for these purposes.

Over half the general hospitals in the United States have outpatient clinics but the kind and quality of services offered vary greatly and a large part of the population still thinks of them as charity clinics (*6*). With a change in emphasis and in public attitudes, hospital outpatient clinics could provide a broad range of services of high quality for paying patients. If such outpatient care were covered by health insurance, this might have a significant effect on hospital utilization.

Considerable experimentation is going forward on new organizational arrangements for the health care of older people. Experiments are concerned with ways to decrease the use of hospitals and of the most expensive hospital beds, and at the same time to adapt health services and facilities to meet more fully the needs of the elderly patients.

In-hospital care

Experimentation with reorganization of arrangements for inpatient hospital care is underway in several hospitals. The Public Health Service is carrying on research on staffing requirements and costs of an organization of services tailored to meet the needs of the individual patient. This system of care has been termed progressive patient care. Designed to provide a high level of patient care at the lowest possible cost to the patient, while making the best use of scarce medical and nursing personnel, this pattern of hospital organization includes (1) intensive care, (2) intermediate care, (3) self-care, (4) long-term care, and (5) home care.

Of those patients of all ages who are in general hospitals today only about 10 percent are critically ill and require constant nursing care and the ready accessibility of lifesaving drugs and equipment. A special hospital unit for intensive care would meet the needs of these patients. About one-half of the patients in a general hospital

require intermediate care provided in a special unit where patients are ambulatory for short periods and can begin to care for themselves. While most patients are discharged to their homes from this unit, there are others who require convalescent care.

The needs of these convalescent patients, as well as of ambulatory patients requiring diagnostic facilities only, can be met in hotel-type accommodations where nursing care is minimal and self-help care emphasized. It has been estimated that about one in each five patients now in general hospitals would benefit from care in this type of unit and at the same time costs of their care could be lowered.

Home care

Home care may provide the services of a visiting nurse to carry out the orders of the physician or be an extension of hospital services. Patients in the home-care program of the latter type—referred from hospitals—are seen at regular intervals by physicians and nurses from the hospital. Should readmission be necessary it is accomplished without the difficulties usually associated with hospital admission. This type of care is particularly appropriate for the long-term illnesses of the elderly—heart disease, cancer, arthritis, etc. For some it reduces the length of stay and the number of readmissions to the hospital, and for others, the need for custodial institutional care.

A home-care program may be a way of saving in terms of general hospital bed utilization. Many factors, such as the admission and discharge policies of the hospital and home-care program, will determine to what extent it is a saving.

Preventive care

More extensive application of known preventive and early diagnostic techniques offers promise of reduction in the subsequent need for hospital care for the individual patient with a prolonged illness. While primary preventive measures are not known for the vast majority of chronic diseases to which older people are subject, early diagnosis of conditions leading to chronic and progressive impairment would reduce the subsequent costs of care in many cases. For example, increasing emphasis is being placed on rehabilitation of the disabled, so that they may return to a normal life or be able to care for themselves at least in some measure. Only a beginning has been made, however, on investigation of the potentialities and techniques of rehabilitation of the chronically impaired.

Group practice

In recent years there has been a rapid increase in medical group practice until today there are about 1,000 groups in operation. With greater specialization in the practice of medicine, group practice is considered an efficient means for bringing together the diverse skills and achievements of modern medicine. Having specialists' care so readily available may do much to encourage early hospitalization. On the other hand, the preventive aspects of this type of practice and the grouping of out-of-hospital diagnostic services may reduce the need for hospitalization. The experience of some of the prepaid group plans indicates some reduction in the length of hospital stays may be expected where prepayment covers a broad range of out-of-

hospital as well as hospital costs (7). The net influence of group practice, however, can hardly be determined in such an early stage of its growth.

Skilled nursing home care

Nursing home care has grown phenomenally within a relatively short span of years. Increasing attention is being directed to differentiation of nursing homes in accordance with the service requirements of patients, to improved licensure and regulation of nursing homes, and to the quality of care provided. With the continued growth and improvement of nursing homes, with their greater asociation with the mainstream of medical care, and with increased coverage under health insurance, pressure will be brought to build more and upgrade those already in existence. (See ch. II.)

In a few communities nursing homes have been made an integral part of a hospital, thus facilitating the interchange of patients between nursing home and hospital and the supervision of the nursing home operations by trained hospital staffs. There is a discussion of broadening existing home care programs of hospitals to provide or supervise services to patients in nursing homes and also to facilitate the training of nursing home personnel.

Medical research

While it is reasonable to assume that the increasing support of medical research will result in new and dramatic discoveries, it is obviously impossible to foretell their impact. Some can be expected to have effects similar to the use of antibiotics for the treatment of pneumonia and the substantial reduction in hospital care that followed. Others will be similar in effect to new methods of cardiac surgery, saving lives but at the cost of elaborate equipment and the time of highly skilled personnel.

It is much too early to be able to forecast the net effect on hospital and other institutional care of the research going forward on the progressive aging process, on cell physiology and chemistry, on the nervous system, on metabolism, on the endocrine system, on the neuromuscular system as well as of the research on chronic diseases to which the aged are especially subject. However, even though new discoveries may lead to control of disease, it is not unlikely—if we judge from the impact of research on medical care in the past—that the net effect will be a greater demand for medical services among the population generally. Substantial progress in increasing the lifespan of those 65 and over is likely to increase the incidence of degenerative diseases and of care required for these diseases. The trend may be expected to be toward higher health-service requirements in the future.

It seems doubtful that changes in medical practice and organization of services will hold down the overall cost of medical care for the aged. The cost will probably continue to rise despite any of these changes. Hopefully, however, the availability of more and better out-of-hospital facilities will help to keep costs from going as high as they might, were current practices maintained. There is not sufficient information, due to lack of experience, to predict to what extent hospital utilization will be affected by improved out-of-hospital services.

Overall Medical Costs

Public and private expenditures for medical services, medical research, construction of medical facilities, and public health activities in 1957 took 4.7 percent of the Nation's total output. In 1929, all such health expenditures amounted to about 3.5 percent of the gross national product. Whether the proportion of the national output going into health services in the next decade or two will change significantly depends both upon developments in the medical field and upon the rate of growth of total output. If productivity continues to increase as it has in the past, more real resources will be available for health purposes without any increase in the share. On the other hand, if a larger share can be used effectively for health, the public would in all probability support such use.

The way in which the total amounts spent for health are divided among research, prevention, and different types of service will be of growing importance. In this respect, we may be approaching a crossroad. It is possible that the factors leading to increased use of in-hospital care and those leading to relatively more use of out-of-hospital services are coming into a new balance.

It is not unreasonable to anticipate that increasing emphasis on preventive measures, improved organization of methods of care, and the results of continuing research will make possible further improvements in medical services without substantial increases in the overall costs of hospital care as a proportion of a national output that we may assume will continue to expand.

SOURCES

(*1*) "Medical Care in the Consumer Price Index, 1936–56," Monthly Labor Review, September 1957; Bureau of Labor Statistics, Consumer Price Index, December 1958.

(*2*) American Hospital Association, Hospitals: Guide Issue, June 1951, August 1958; Department of Commerce, "U.S. Income and Output, Supplement to Survey of Current Business," 1959.

(*3*) American Hospital Association, "American Hospital Directory," 1947; Hospitals: Guide Issue, August 1958.

(*4*) "Voluntary Health Insurance and Medical Care Expenditures: A 10-Year Review," Social Security Bulletin, December 1958.

(*5*) Wharton School of Finance and Commerce in cooperation with Bureau of Labor Staticstics, "Study of Consumer Expenditures, Incomes and Savings," vol. XVIII, University of Pennsylvania, 1957.

(*6*) For data on utilization by age and income levels, see "Factors in Outpatient Visits," Public Health Reports, June 1957.

(*7*) American Hospital Association, "Prepaid Medical Care and Hospital Utilization," Hospital Monograph Series No. 3, 1958; Group Health Association (District of Columbia) News, January–February 1959; "1957 Annual Report of Group Health Cooperative of Puget Sound"; Cooperative Health Federation of America, "Proceedings of the Annual Group Health Institute," August 1956.

CHAPTER IV

ORGANIZED METHODS OF FINANCING HOSPITAL CARE FOR THE AGED

Voluntary prepayment of hospital and medical costs has won wide and increasing acceptance among both consumers and providers of medical service. The scope and types of prepayment arrangements available vary greatly for different groups and in different areas. The cost of the insurance to the individual is equally varied.

About 121 million persons—72 percent of the total population—were covered by some form of hospitalization insurance as of the end of 1957. Preliminary estimates for December 1958, show just over 121 million or 70 percent of the population at the end of that year, having hospital insurance. Ten years earlier, in December 1947, the 53 million persons with such protection had represented 37 percent of the total population. Insurance against the costs of hospital care is the most widely held type of health insurance. Most, but not all, persons having such coverage also have insurance against some other medical costs. At the end of 1957, 109 million persons—65 percent of the population—carried surgical care insurance. At the end of 1947, only 18 percent had surgical insurance.

Regular medical expense insurance, covering the costs of physicians' services other than surgical care and certain other benefits, increased even more sharply, from 6 percent at the end of 1947 to 43 percent of the population in 1957. Much of this form of insurance applies only to physicians' visits to hospitalized patients. The 72 million persons with regular medical expense insurance in 1957 included approximately 13 million with major medical expense policies, a form of insurance unknown a decade ago.

This new form of insurance—designed to provide partial protection against the costs of "catastrophic" or prolonged illness—covers a wide range of types of care both in and out of the hospital but insures only amounts over a specified sum (the deductible amount which may be covered by basic coverage or paid by the insured himself) and usually only a stated portion (75–80 percent) of the remaining medical bills up to a maximum which may be as high as $5,000 or $10,000. The 72 million persons include also about 5 million persons enrolled in community and other independent plans providing quite comprehensive medical services of all types (*1*).

The proportion of the total private medical bill paid by insurance has also increased over the past decade. Voluntary health insurance benefits covered about 57 percent of private expenditures for hospital services in 1957; they had covered 27 percent in 1948. About 31 percent of private expenditures for physicians' services were reimbursed by insurance in 1957; only 6 percent had been covered in 1948. Pri-

vate insurance benefits represented 24 percent of all private expenditures for hospitalization and medical care in 1957, as against 8 percent in 1948 (*2*).

The growth of private health insurance has been markedly stimulated by the inclusion of health benefits in collectively bargained employee benefit plans. It is estimated that close to three-fourths of the health insurance coverage now in effect—including coverage of both employees and their dependents—derives from employee benefit plans under collective-bargaining arrangements or established unilaterally by the employer (*3*). This factor, combined with the greater accessibility of hospitals and other types of medical care in urban areas, has resulted in an uneven spread of insurance coverage. The approximately 30 percent of the population without any health insurance includes a disproportionate number of persons in rural areas, in small establishments or self-employed, and retired persons and other low-income groups.

The extent of coverage also varies greatly from State to State. In eight States, of which all but one (Vermont) were highly urban and industrialized, more than 80 percent of the population is estimated to have had some type of health insurance at the end of 1957; in Connecticut and Ohio the proportion was over 90 percent. In six States, on the other hand, less than 50 percent of the population was covered, ranging down to about 40 percent in Mississippi and Louisiana (*1*).

Persons aged 65 and over are perhaps the most important of the groups with less than average protection under existing voluntary insurance. Several recent studies suggest that approximately 40 percent of the population in these ages now has some form of health insurance coverage.

A nationwide survey carried out by the Bureau of the Census for the Social Security Administration in March 1952 showed 26 percent of the persons aged 65 and over, as compared with 59 percent of those under 65, having some form of health insurance (*4*). These are the earliest figures available for the 65 and over group. In September 1956, a similar nationwide survey was carried out by the Bureau of the Census for the Public Health Service. This study showed 36

percent of the group aged 65 and over (as compared with 64 percent of the total population and 66 percent of those under age 65) having health insurance (*5*).

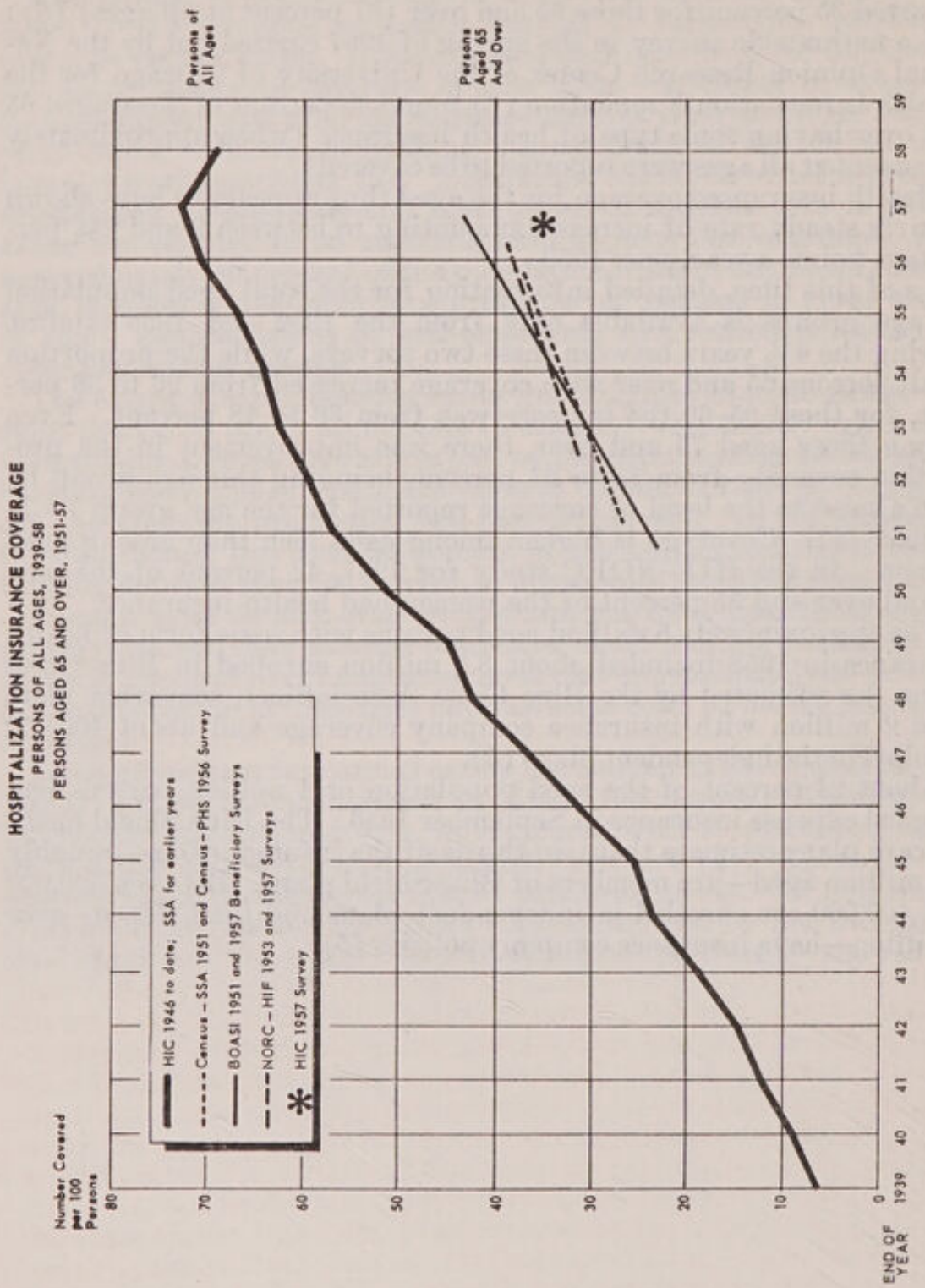
A special study made for the Health Insurance Council in late 1957 reported 35 percent for those 65 and over (67 percent at all ages) (*6*); and a nationwide survey in the spring of 1957 carried out by the National Opinion Research Center of the University of Chicago for the Health Information Foundation (*7*) found 39 percent of those aged 65 and over having some type of health insurance (when approximately 70 percent at all ages were reported to be covered).

Health insurance coverage for the aged thus appears to have shown a fairly steady rate of increase, amounting to between 2 and 2½ percentage points a year, since 1952.

As of this time, detailed information for the total aged population by age groups is available only from the 1952 and 1956 studies. During the 4½ years between these two surveys, while the proportion of all persons 65 and over with coverage increased from 26 to 36 percent, for those 65–69 the increase was from 36 to 48 percent. Even among those aged 75 and over, there was improvement in the proportion covered—from 15 to 24 percent, bringing this age group by 1956 almost to the level of coverage reported for the age group 70–74 in 1952 (*5*). Coverage is higher among aged men than among aged women. In the HIF–NORC study for 1957, 42 percent of the men 65 and over and 35 percent of the women had health insurance.

The approximately 6 million aged persons with some form of health insurance in 1958 included about 3.5 million enrolled in Blue Cross plans (as estimated by the Blue Cross Association), somewhat more than 2 million with insurance company coverage and about 400,000 enrolled in the independent plans (*5*).

About 24 percent of the aged population or 4 million persons had surgical expense insurance in September 1956. The Blue Shield medical care plans estimate that two-thirds of the insured group—roughly 2½ million aged—are members of Blue Shield plans. Between 300,000 and 400,000 are enrolled in independent plans and the balance—over 1 million—have insurance company policies (*5*).


HOSPITALIZATION INSURANCE COVERAGE
PERSONS OF ALL AGES, 1939-58
PERSONS AGED 65 AND OVER, 1951-57
Number Covered per 100 Persons
Persons of All Ages
Persons Aged 65 And Over
HIC 1946 to date; SSA for earlier years
Census – SSA 1951 and Census – PHS 1956 Survey
BOASI 1951 and 1957 Beneficiary Surveys
NORC – HIF 1953 and 1957 Surveys
HIC 1957 Survey
END OF YEAR
1939 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59
0 10 20 30 40 50 60 70 80

The OASDI beneficiary survey found that 60 percent of the insured nonmarried beneficiaries and 50 percent of the insured couples were enrolled in Blue Cross. Some of this group also had insurance company policies. Some 36 percent of the nonmarried insured beneficiaries and 42 percent of the insured couples had as their single form of insurance an insurance company policy. About 7 percent had other forms of coverage alone, or in combination with Blue Cross or an insurance company policy. In 15 percent of the insured couples, only one of the two partners was covered by the insurance.

The Health Insurance Council found that the vast majority of the insured aged were enrolled as individuals (nongroup) though there are a few notable exceptions such as pensioners of certain large unions. Only one in three insured person aged 65 and over had group coverage; two-thirds of the insured persons between ages 60 and 64 years on the other hand were enrolled through a group. (*6*)

Hospitalization and other forms of health insurance are most easily obtained and most widely held by those among the aged who are still employed—particularly those employed in large industries where group contracts are prevalent. The Census-PHS survey found that half of the aged population still in the labor force had hospitalization insurance while only about a third of the aged not in the labor force were insured.

It is understandable then that the older the age group the smaller is the proportion of persons with health insurance. This difference results in part but not entirely from the newness of the prepayment mechanisms. More persons now reach age 65 with insurance coverage for themselves and their spouses that they can carry forward than was true a few years ago, but even for this group, limitations on total lifetime benefits and cancellation of policies after periods of illness, as well as reduced ability to pay the premiums, cut down on the extent of coverage among the older age groups.

The HIF–NORC study showed that of those persons aged 65 and over having health insurance in 1957, about 56 percent (64 percent of the men) first obtained their insurance through a place of employment. About a fourth of the insured group had carried health insurance for less than 5 years, about 7 percent had had such insurance for 25 years or more. This survey also found that about one-sixth (16 percent) of the persons surveyed had been covered in the past but were uninsured at the time of the survey. The reasons given for termination of coverage included inability to continue payments for almost one-third of the group, and retirement from work for about one-fourth. Six in 10 aged persons had no form of health insurance at the time of the survey. Two in 10 reported that they could not afford it. An additional 1 in 10 had been refused insurance or had had a policy canceled. Thus, of those without insurance, half, in their own opinion, either could not afford or could not buy a policy. The others said they had never thought about health insurance or didn't want it.

Even more than in the case of younger persons, hospitalization insurance is the most frequent type of coverage among the aged. Of those with any form of health insurance in 1956, about 23 percent of those aged 65 and over as compared with 13 percent of those under 65 had prepaid hospitalization as their only form of health insurance (*5*). In the HIF–NORC study about a fourth (26 percent) of the aged

had insurance covering all or part of their doctor bills in the hospital and 8 percent had insurance covering office and home visits, as compared with nearly 39 percent with some type of health insurance.

Some 43 percent of the aged beneficiaries on the OASDI rolls at the end of 1957 reported that they had hospitalization insurance (*8*). Half of those aged 65–69 but only 37 percent of the 75–79 age group and 27 percent of those 80 and over had hospitalization insurance. Less than 1 in 3 beneficiaries had insurance against surgical expense. Those without health insurance usually gave 1 of 2 reasons for not having it: 39 percent said they could not afford it, and 37 percent said they had never had the opportunity to purchase it, had not thought much about it or the like. The remaining 23 percent were not insured because the policy had been canceled, could not be continued after retirement, and so forth. The first two reasons were cited by a larger proportion of the beneficiaries who came on the rolls in the 1940's than of those who retired more recently.

There was a definite relation between ownership of hospitalization or surgical insurance and the income of the beneficiary group. In the case of married couples, the proportion with hospitalization insurance was more than 3 times as high when the couple's income was $5,000 or over as when it was under $1,200 a year. The percent of married beneficiaries 65 and over with hospitalization and with surgical (including in some cases other medical) insurance was as follows:

Money income of couple	Percent of married beneficiaries with—	
	Hospitalization insurance	Surgical (or medical) insurance
Total	45.9	32.3
Under $1,200	20.5	15.7
$1,200 to $1,799	34.8	22.8
$1,800 to $2,399	43.9	27.2
$2,400 to $2,999	55.3	40.0
$3,000 to $4,999	60.7	42.9
$5,000 and over	65.0	54.0

A similar relationships between income and insurance ownership occurred among single beneficiaries, 39 percent of whom had hospitalization insurance. Of those with total annual money income of less than $600, there were only 26 percent who had hospital insurance as compared with 67 percent in the case of those with incomes of $3,000 and over.

The beneficiary survey also provides some information on the extent to which aged persons who had hospitalization insurance received help from their insurance in meeting the costs of care in general hospitals. For the insured beneficiaries who received care in a general hospital during the year, who knew the net cost of this care, and who had some of this cost met by insurance, the average cost associated with hospitalization was about $590. Of this amount, about $425 represented the hospital's bill and $165 charges by surgeons and other private physicians. About two-thirds of the hospital charges and one-fifth of the physicians' bills were met by insurance.

Unfortunately it is not possible to estimate what proportion of the aggregate medical bill or of the aggregate private medical expenditure of all persons aged 65 and over is covered by insurance.

Existing Voluntary Health Insurance Mechanisms

The mechanisms by which persons past 65 originally obtained voluntary health insurance are identical in most respects to those applicable to the younger population. At least 1,150 different organizations provide today's voluntary health insurance to the 121 million persons enrolled, including the 6 million aged who have health insurance.

These 1,150 different organizations are generally referred to as if they fell into five clearly differentiated categories of underwriters: (1) Blue Cross hospitalization plans, (2) Blue Shield surgical-medical plans, (3) group insurance companies, (4) accident and health companies, and (5) independent plans.

In actuality the classification is not so simple. In some localities combined Blue Cross hospitalization and Blue Shield surgical-medical plans are found; Blue Cross plans in several States sell surgical-medical expense policies while Blue Shield plans in the West cover hospitalization. Some insurance companies limit their sales to either group or individual hospital, surgical and medical expense policies but some sell both group and individual policies. The independent plans are, if anything, more diverse in the kinds of benefits they offer (*9*).

The differences between the health insurance coverage of the aged and that of the younger population lie mainly in the area of (1) benefits available; (2) premium costs; and (3) sources of financing. These differences are interrelated since the level of benefits affects premium costs and premium costs may determine the benefits included under the terms of the policy. Where an employer is paying part or all of the premium for his employees, the cost to the individual may be low while the scope of the benefits can be as broad as the financial participation of all parties will permit. Conversely, where only the insured is bearing the premium cost, financial considerations may call for a ceiling on the premium if the policy is to find a market and hence limitations on the benefits offered under the policy's terms are usual.

The public, including those aged 65 and over, has obtained health insurance through three main avenues although a fourth avenue is of some significance, especially with respect to the aged. Community plans, chiefly Blue Cross and Blue Shield but also including a variety of organizations unaffiliated with these plans, sell hospitalization insurance (and insurance covering other medical services) with premiums based on the whole community's experience (community rated).

Group insurance companies, as their name implies, sell hospitalization and other kinds of policies to various types of groups, with the premiums largely established by the particular group's experience (experience rated). The Blue Cross and Blue Shield plans also enter into some experience-rated contracts; these contracts generally provide for some modification of the benefits available under their community-rated policies.

Individually purchased (nongroup) coverage is provided by Blue Cross and Blue Shield plans, by accident and health insurance companies, and by other organizations. The fourth category under which existing health insurance is obtained—by a small percentage of the population—includes self-insuring employee benefit plans and union health and welfare funds. Insurance company premiums are established for classes of persons, with rates varying by age at issue.

The significance of community rating, experience rating and self-insurance to above-average insurance risks such as the aged will become clear as the different forms of premiums and health insurance benefits are described. Although actual figures on enrollment of the aged through each avenue are not available, the order of presentation indicates the relative importance of each major type and, within these types, of the available alternatives.

COMMUNITY-RATED PREMIUMS

Premiums are determined in community plans from the experience of the entire group of enrollees, including lower-than-average, average, and above-average risks. The additional cost of the above-average risk is spread over the entire group and raises the premium for all participants slightly. To illustrate in very simple terms:

Total group	100 persons.
Under age 65	92 persons.
Over age 65	8 persons.
Normal cost per person under age 65	1 unit.
Normal cost per person over age 65	2½ units.
Cost for 100 persons:	
92×1 unit	92 units.
8×2½ units	20 units.
Total cost	112 units.

In this example the per capita community rate would be 1.12 units. The increase in premium for each of the younger persons would be 12 percent and the reduction in premium for each of the aged would be from 2½ units to 1.12 units. If the cost for persons 65 and over in the example were 3 units, cost for each person under 65 would be increased by 16 percent. If the aged represented only 5 percent of the whole group instead of 8 percent, costs would be increased by 7.5 percent (at 2½ units per aged person) or 10 percent (at 3 units per aged person).

To avoid this excess cost by reason of including the aged, some community-rated arrangements lower the benefits available to the aged to bring their unit cost to the approximate level of the average cost of the younger plan members. Other plans charge persons aged 65 and over a larger premium, one more nearly equal to their expected unit cost. Some plans use a combination of these methods.

Most (but not all) Blue Cross and Blue Shield contracts spread the risk of the aged over all their enrollees and set their premiums at a level reflecting the experience of all their members.

In a few localities aged persons are able to obtain not only hospitalization insurance but comprehensive medical care through such community plans as Group Health Association of Washington, D.C., the Kaiser Health Plans, Ross-Loos Medical Group and a few others. Persons who have been members of these plans prior to age 65 can

continue their membership at the rate for all participants. In none of these plans can persons enroll initially after age 65 without substantial limitations on the benefits.

Group conversion

Existing enrollment in community-rated plans originates chiefly through coverage of employed groups. Persons 65 and over still actively at work are normally included as regular members of the group plan covering all employees. Some of the existing coverage of the aged comes from these arrangements. Since this chapter focuses primarily on special arrangements for the retired aged, such coverage is not discussed in any detail.

When members leave employed groups to retire from work they are usually given an option; they may convert to a type of membership by which they pay the premiums directly to the plan, instead of through the group, or they may drop their insurance. If they elect to continue, their membership is known variously as "left-employ," "group-conversion" or "left-group" coverage. Much of the existing enrollment of the aged in Blue Cross, Blue Shield and similar community-rated plans is of this type.

The enrollee may have the same benefits as before he left the group, and at the same premium, or his benefits and/or his premium may be altered to avoid an impact on the group rate. The retiring enrollee seldom has a choice as to future benefits or premiums; employer participation in paying premium costs ends when the policy is converted to a "left-employ" contract. Premiums are usually paid quarterly, semiannually or annually rather than on a monthly basis. Since the Blue Cross policies are not in practice canceled except for nonpayment of premiums, the premium rates also reflect a use rate based on noncancelability.

Widows and dependent children of insured persons in community-rated plans are also offered the option of continuing coverage as "left-group" members of the plan.

Continued group participation after retirement

To avoid the handicaps of the typical group conversion policy (which may include higher premiums, lower benefits, and no employer contribution), employers are more and more often making arrangements for their pensioned employees (and frequently their dependents) to continue to participate in the health insurance program covering their active employees. Deductions for the premium, corresponding to payroll deductions, may be made from the retiree's pension or the employer may pay the retiree's premiums himself. The entire group continues to be charged the community rate and the retiree receives the same range of benefits available to all participants in the plan's group contract. Although this is a rapidly growing practice, its impact is not yet large. It is effective primarily for workers who remain with a single employer for a considerable period before retirement.

EXPERIENCE-RATED GROUP PREMIUMS

Insurance company rates are related to the anticipated experience of the particular group purchasing the policy. (As noted above, some Blue Cross plans also offer experience-rated contracts to some groups.)

Using the example on page 48, the premium quoted might be less than 1 unit if the group were youthful or slightly above 1 unit if the employees were middle aged. If the subsequent experience proves better than this initial estimate, an adjustment (dividend or rate credit) is made; if worse, premiums are raised at the time the contract is renewed.

Experience-rated group plans including retired persons

Until recently, only active employees and their dependents were accepted as participants in group plans. The active employees could include persons past 65, as long as they were still at work. When they retired, however, many older persons lost their coverage. Widows of employees were also ineligible for coverage after the death of their husbands. Since their age at retirement was usually a barrier to obtaining any substitute form of health insurance, numerous retired persons—now in the upper age brackets of those past age 65—have had no health insurance since they withdrew from the labor market.

More and more, group policies are providing for continuation of the retiree under the group plan. In essence, this is little different from the continued group participation after retirement already described in connection with community-rated premiums. In any plan in which persons regardless of their age pay the same rate, the cost with respect to the active employees will be increased over the rate for them alone. An increase in the premiums paid by active employees may be avoided if the retiree's benefits are reduced or his contribution, or the contribution of the employer on his behalf, is raised above that required for the active employee.

The increase in the overall premium would be small in the early years of such contracts, for few such arrangements in their initial stages include the already retired pensioners. If the ratio of retired to active employees in the group should become sizable, there could eventually be a decided effect on the premium rate. For this reason, active employee groups frequently resist inclusion of retired employees in their group, unless the employer absorbs the entire excess cost of the retired workers. In some long-established plans the employment ranks have shrunk and pensioners have come to represent as many as 25 of each 100 persons enrolled in the plan. A more usual ratio would be much lower—say 5 to 10 pensioners per 100 persons—when the program became stabilized (*10*).

Not generally appreciated is the fact that the workers who receive this form of retirement benefit must in nearly every instance qualify as pensioners. Length of employment with the particular employer governs eligibility for a company pension and this may be 5, 10, or even 20 years with the company (*11*). One reason for the tie-in of the health insurance program with the pension program arises from the possibility of deductions from the pension check to pay the pensioners' share of the premium. Another reason derives from the fact that the pensioned employees form a definable group.

One device used in experience-rated plans to hold the line on rising costs is to place a "lifetime limit" on the benefits the retiree can receive under the policy. If the retiree exhausts his "lifetime limit" (usually $1,000–$2,500, depending on the plan) soon after retirement, his coverage under this policy is terminated.

Conversion of group to individual policies

In recent years, some group insurance company contracts have stipulated that retiring employees shall be given an option to convert their group policy to an individual policy with the insurance company writing the group coverage. Unlike the usual individual policy, described later, no health statement is required. In other respects the policies offered are drawn from among the nongroup policies of the particular company. Some insurance companies are not currently licensed to offer nongroup policies so are unable to offer this option.

Groups confined to retired persons

One of the difficulties in providing health insurance coverage to persons who are no longer employed, or self-employed, or who are living as widows on pensions, lies in the need to establish a central mechanism for group collection of premiums and payment of claims, both of which produce savings in administrative costs as well as limiting the element of adverse selection. Organizations of retired persons have, within the last year or so, been used as such instruments. Interest in this approach is mounting among Golden Age Clubs, housing colonies for retired persons, and the like. A relatively short period is usually fixed in which membership in the retiree organization can be established and the member may then sign up for the insurance. Where the enrollment group relates to the residents of a housing development or members of a club, the insurance—as in the case of group insurance in general—usually does not go into effect until a high percentage of all the residents or members have signed up to participate, another device intended to reduce adverse selection.

Initial premiums are established as for other forms of group plans by appropriate weighting for the sex and age of the particular retired group. Since the bulk of the membership is no longer young, rates are naturally higher than for younger groups. Using the original example as a reference point, in a group composed entirely of 100 persons aged 65 and over, the normal cost becomes 2.5 units per capita compared to slightly more than 1 unit when the cost for the same benefits is spread over a group of all ages. Subsequent experience governs future premium rates. Some of these organizations have developed primarily because membership in the association affords an opportunity to enroll in the organization's health insurance plan. In some States insurance regulations do not permit this form of group underwriting.

A modified version of this approach was adopted by the Federal Reserve Bank System. Annuitants of this agency were originally enrolled as "group-conversion" members of Blue Cross plans throughout the country. Benefits varied from plan to plan. Each annuitant paid his own premiums. The System developed a group out of these persons and one Blue Cross plan now covers all of them; premiums are deducted from the annuitants' pension checks and forwarded in a lump sum to the one Blue Cross plan, in similar fashion to the procedure used by other groups composed entirely of retirees.

Special forms of group policies—paid-up-at-retirement

Discussions of health insurance protection of the aged generally contain references to paid-up-at-retirement coverage. Interest in this approach stems from recognition of the limited incomes of the aged

that inhibit their ability to purchase from a retirement income the forms of insurance already described.

In actuality, one form of paid-up policy has already been described—that under which the retired person is continued as part of the group but makes no premium contribution; the former employer (with or without contributions from the actively employed) may finance the retirees' benefits on a pay-as-you-go basis each year.

In its pure form, the so-called paid-up-at-retirement policy provides the employee on retirement with the equivalent of an annuity; his contract guarantees that a specified set of health insurance benefits will be available to him during the remainder of his life. The benefits are on a cash indemnity basis (a specified number of dollars for up to a specified number of days of care, plus an allowance for hospital extras). It would be very difficult for an insurance company to estimate the future cost of a service benefit (guaranteeing up to a specified number of days of care). This is a very new approach and very little of this type of coverage has been sold. If the policy is not purchased until the date of retirement, the initial costs are high ($700 to $1,300 per individual). Similarly, even if purchased prior to retirement, the annual payments required for persons already approaching retirement would be substantial.

If the costs were spread over the full working life of the individual, the annual payments would be small. As a practical barrier to this approach, however, few persons spend their entire working life with one employer. Aside from the uncertainty as to whether they will still be with the same employer when they retire, there are other factors that could make workers reluctant to participate in purchasing this form of insurance. They may anticipate that their existing health insurance coverage will continue after retirement or they may fear that a specified set of cash indemnity health benefits may prove inadequate if the trend of rising medical costs continues.

PREMIUMS THAT ARE INDIVIDUALLY SET—NONGROUP INSURANCE

Second only to group conversions as the main source of existing health insurance among the retired aged is the continuation of a nongroup policy purchased when the person was younger and maintained after reaching age 65. Increasingly aged persons are, however, also able to obtain policies after the 65th milestone. In either case these policies are financed by the individual. The vast majority are cancelable at the option of the insurer though an increasing proportion are noncancelable or guaranteed renewable up to a specified age. The latter two types call for higher premiums than is the case with the cancelable policies. Premiums may be raised from time to time, if the company changes the premium for all policies of similar form or class.

Nongroup policies of insurance companies

Up until a few years ago individual or family policies (so-called to distinguish them from group policies) were sold only to persons who had not yet achieved age 55 or 60. Now these policies are made available by a number of companies to persons in the higher ages. A check

on the highest age at which a group of 104 insurance companies would issue individual policies, showed the following (*12*) :

Highest age at issue	Number of companies	Percent
Total	104	100.0
55 and under	6	
59 and 60	27	48.1
64 and 65	17	
69 and 70	10	
74 and 75	14	
79 and 80	17	51.9
84, 85, 90 (1 each)	3	
No maximum	10	

Restrictions on the benefits provided and relatively high costs reflect the expectation of adverse selection in a transaction in which the purchaser of the insurance is electing to obtain it. A health statement is required in applying for the policy and the application may be rejected on the basis of an existing physical condition or recent illness. The health statement also serves as a basis for cancellation of the policy by the company if a claim is made for expenses for a condition not mentioned by the applicant but antedating the writing of the policy (*13*).

Individually purchased paid-up-at-retirement policies

In addition to the nongroup policies already described some companies sell policies (providing cash indemnity benefits) to persons prior to retirement that are paid up at retirement and not cancelable thereafter. The highest age at issue has been 59.

An example of this type of coverage is a policy providing given amounts a day for hospital room and board expenses. The insured is entitled to 365 days of hospitalization up to age 65 and 90 days after his 65th birthday. Under this policy premium rates for miscellaneous hospital expenses and for surgical expense vary by (1) amounts selected by the insured as maximums, (2) age at issue, and (3) sex.

Nongroup policies of community-rated plans

Most Blue Cross, Blue Shield, and other nonprofit plans using community-rating to set group premiums also enroll persons on an individual basis. The age limit for such enrollment is usually 65 though 11 of the 79 Blue Cross plans have no age limit, and in 12 plans an age limit of age 60 or lower is found. Five Blue Cross plans do not provide for nongroup enrollment (*14*). Like all forms of Blue Cross-Blue Shield coverage, technically the policies are cancelable but the plans reportedly seldom exercise this legal right. The various plans have different mechanisms for enrollment of nongroup members including (1) "community enrollment drives," in which enrollment is opened to all members of a given community for a specific period; (2) open enrollment for a specific period, usually 2 weeks twice a year; (3) continuous open enrollment.

A health statement is usually a requirement and persons may be rejected on the basis of this report. Waiting periods before certain benefits become available are usual; certain conditions may never be

covered or may not be covered until the member has been enrolled for 6 months or a year.

Depending on the insurance laws of the States and on plan practices, the premiums for nongroup coverage may be established in one of three ways: (1) on the same basis as the group or group conversion premium; (2) slightly above the group rate, to take into account higher administrative costs associated with nongroup enrollment; (3) on the basis of the experience of the entire nongroup class of enrollees. Modifications in the benefits provided under the group contracts are frequently introduced to offset the likelihood of adverse selection. These usually take the form of reductions in the benefit days per year or in the per diem room allowances.

INDEPENDENT PLANS

In addition to the plans and policies already described there is another category of prepayment for hospital and medical care derived from arrangements usually referred to as "independent plans." Some of these plans fall into the category of community-rated or experience-rated plans, already described, while others provide benefits through quite a different approach—namely some form of self-insurance. The entire membership in these latter plans is composed of employees—both active employees and pensioners—of a common employer, or members of a trade union. Contributions from the members and/or the employer go into a health and welfare fund or employee hospital association or mutual benefit association from which the benefits are paid or covered services are furnished or purchased.

Out of 175 industrial plans, some 80 reported that they were covering retired workers in 1957; 40 of them also provided benefits to dependents of retirees. Nearly 315,000 retirees and their dependents were eligible for benefits in these 80 plans, which had a combined enrollment of about 3 million active employees. Among the 80 plans, 27 reduced the retired worker's benefits below those of the active worker (these were small plans). In 11 of these 27 plans and in 13 plans where there was no reduction in benefits the retired worker paid the entire premium. In the remaining 56 plans the retiree contributed part of the premium cost in 21 plans, while in the other 35 all of the retirees' costs were paid by the active workers and/or the employer.

A number of these plans operate their own hospitals or health centers and employ staff physicians. The cost of pensioners is absorbed into the overall cost of operating the hospital or clinic. The railway hospital plans are notable examples of plans that have covered pensioners for many years. Examples can also be found in other industries. Length of employment prior to retirement frequently governs the extent to which pensioners are entitled to continue their health insurance protection (*9*) (*15*).

Premium Charges and Benefit Provisions of Health Insurance Policies Applicable to the Aged

There is a wide variation both in benefits and in premium charges for insurance policies covering the aged. Some of the major reasons for these variations have already been discussed. The extent to which

the risk is spread among all age groups or concentrated on the aged as a separate group and the extent to which costs are insured through broad benefits or left to be met at the time illness occurs are basic factors in premium rates. Noncancelable or guaranteed renewable policies may sell for more than policies that can be canceled by the insurance carrier. In addition, the selling (acquisition) and administrative costs vary for different classes of policies. In pricing a given set of benefits a company necessarily adds to the expected claims cost the costs of selling the insurance, as well as premium taxes and the cost of billing and collecting premiums. Some of these items are necessarily more expensive per person insured on an individual basis than when the insured is under a group policy.

It is therefore difficult to summarize, in any meaningful way, the current expenditure required for one aged person to purchase hospitalization insurance. Nevertheless, some general indication can be given.

COMMUNITY-RATED PLANS

While information is available for the Blue Cross community-rated plans on premiums and on the benefits a given premium will provide, summarizing the benefits and premiums simultaneously is next to impossible because of the differences in the plans and in the costs of hospital care in different parts of the country. Considering first the benefits afforded by the 79 plans, under group conversion contracts as of late 1958 the number of days of basic benefit (per stay in most cases, per year in a few) ranged from 21 to 365. Thirteen plans provided 21 days of care, 23 provided 30–35 days, and 28 provided 70–75 days. Six covered 120 days and 1 covered 365 days of care. Other variations appeared for the nine remaining plans. In addition, 23 plans provided further days of partial reimbursement. The number of additional days covered ranged from 30 to 295 and tended to be greater the lower the number of days of full benefit provided (*14*).

The plans varied in the type of room and board coverage provided such as semiprivate (30 plans), ward (12), or an allowance toward the room charge. Equally varied was the extent to which charges for the operating room, anesthesia, X-ray, laboratory services, and drugs and medicines were covered although the majority provided quite complete benefits.

The annual premiums for these benefits varied from $19 to $88 for a single person and from $52 to $203 for a family. The annual premiums under approximately comparable group, group conversion and nongroup contracts in the fall of 1958 were as follows (*16*):

	Number of Blue Cross plans	Annual premium	
		Median	Range
Group contract	79		
1 person		$30.00	$16.20–$70.80
Family		73.20	43.80–162.60
Group conversion contract	79		
1 person		42.20	19.20– 87.00
Family		84.70	51.00–202.80
Nongroup contract	74		
1 person		42.00	22.08– 87.80
Family		84.00	51.60–202.80

The additional annual cost of group conversion over group contracts was as follows:

	Number of Blue Cross plans	Additional annual premium	
		Median	Range
Plans not reducing benefits	57		
1 person	[1] 56	$9.60	$0–$55.56
Family	[1] 56	10.44	0–115.92
Plans reducing benefits	22		
1 person	22	7.80	1.20–18.60
Family	[2] 21	7.20	1.80–40.20

[1] Group conversion rates not available for 1 plan in which the group conversion rates vary by locality.
[2] 1 plan omitted because group family rate is higher than group conversion family rate. Benefits are not comparable since group conversion members are subject to an 80/20 deductible clause and reduced maternity benefits.

Many Blue Cross plans offer group contracts with additional or broader benefits and of course, higher premiums than those offered under the contracts analyzed here. Such additional benefits are ordinarily not available to group conversion and/or nongroup enrollees.

Blue Shield premiums and benefit provisions vary even more widely than those of Blue Cross.

Those relatively few aged persons who are enrolled in community plans providing prepayment for most types of medical care ordinarily pay a single premium covering hospital care, surgical services, physicians' services in hospital, office and home and laboratory services and the like. The annual premium cost of the benefits was $100 per person or less in several of these plans in early 1958.

GROUP INSURANCE POLICIES

Because experience-rated plans are frequently tailored to the particular group, it is not possible to summarize in the same way as for Blue Cross plans the benefits provided or premiums charged. As has been indicated, the benefits under insurance company policies are on a cash indemnity basis. Illustrative benefit combinations available to aged persons are cited below. A general idea of the annual premiums for group coverage for specified benefits can be obtained from examining the premium rates for an initial period for a standard group of all ages. (These rates would be subject to rate credits or dividends in subsequent years.)

For a policy providing reimbursement of up to $10 a day for up to 70 days of hospital care with 10 times the daily rate (i. e., $100) for

hospital "extras," such rates for a standard group with 21–31 percent females would be:

	Annual premium for a standard group (without maternity or obstetrical benefits)	
For hospitalization coverage ($10 a day for up to 70 days and up to $100 for extras):		
Employee only	$20.28	
Family, combined rate	61.57	
Husband and wife	48.36	
For surgical policy	*$200 fee Schedule*	*$300 fee Schedule*
Employee only	$6.84	$10.27
Family, combined rate	22.47	33.71
Husband and wife	16.55	24.84

Since the premiums shown are those applicable initially to a so-called standard group, they would ordinarily be increased through subsequent adjustments where the group encompassed sizable numbers of aged persons.

Insurance on a group of persons aged 65 and over

Two examples of policies limited to groups of retired persons will serve to illustrate the amount of premiums and kinds of benefits that go with this relatively new form of coverage.

1. A group plan for an association of retired persons: The annual premium per individual is $72. The plan pays $10 a day for 31 days per illness, 50 percent of miscellaneous hospital expenses or of emergency outpatient hospital care for accidents up to a total payment of $125. Surgical expenses with a $200 maximum fee schedule are payable. Hospital care for any condition for which the insured was hospitalized in the 12 months preceding membership in the group is not covered. Six months must elapse before claims are again paid for the same or a related illness.

2. A group plan for an association of retired college professors: The annual premium per individual is $96. The policy pays $15 a day for the first 31 days and $7.50 a day for the next 90 days of hospitalization. Rehospitalizations for the same or related causes must be separated by 6 months. Hospital care in the first year of the contract for conditions which required hospitalization in the previous 12 months is not covered. This policy also pays 50 percent of miscellaneous hospital expenses or emergency outpatient care for accidents up to a payment of $120 (i.e., $240 of expense incurred). It includes surgical expense coverage with a $200 maximum fee schedule and $3 a day for 31 days for physicians' nonsurgical calls when the patient is in the hospital (*17*).

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A paid-up-on-retirement policy

Only one such policy—available to employees of one company—has been described in the literature. It provides annually for 31 days of hospital care at $14 a day and for up to $210 for hospital extras. It includes a surgical expense policy with a $300 maximum fee schedule. At age 65 this policy costs $1,200 per individual or $2,400 for a couple.

Under the existing plan the employer's contribution varies according to the employee's length of service with the company, reaching 100 percent with respect to both the employee and his spouse after 20 years' service. The company has a profit-sharing plan in which the employee can accumulate the amounts required for his share of the payments made on his retirement.

INDIVIDUALLY PURCHASED INSURANCE

The myriads of policies offered by insurance companies on a nongroup basis make it impossible to select a typical policy or an average premium, because premiums vary with the age of the policyholder and by reason of all the other cost factors already mentioned.

A noncancelable policy

For illustrative purposes, it may be useful to describe very briefly one new and much discussed noncancelable policy that became available in late 1958. This "lifetime renewable safeguard policy" is available to persons aged 65 to 75. A health statement is required with the application. The purchaser of the policy can put together from a series of riders a package that meets the requirements of his pocketbook. None of the available riders pays for nonsurgical physicians' attendance or for outpatient diagnostic services. Ordinarily noncancelable policies carry higher premiums than cancelable policies; the premiums for this contract however appear to include little if any loading for the lifetime renewable feature.

A typical package under this policy might include for each period of illness separated by 6 months, $10 a day for up to 30 days of hospital care; hospital extras of up to $50 for medicines and appliances, up to $25 each for operating room, surgical dressings and costs, blood transfusions and oxygen, up to $20 for X-ray and for anesthetic and up to $15 for laboratory service; and surgical expense under a $200 fee schedule—such a package would cost $89.40 per person per year. With $15 a day for hospital room and board, a $375 surgical fee schedule and more generous hospital extras, the premium for the package would be $153.80 a person a year. A very minimal package, including only $8 a day for hospital care, a $150 surgical fee schedule and very limited hospital extras subject to deduction and coinsurance (the insurance paying 80 percent of the amount spent above $250 but no more than $1,000) the annual premium would be $58.72 per person (*17*).

A paid-up-at-retirement policy

Paid-up-at-retirement policies taken out prior to age 59 and requiring no premiums after age 65 may cost 4 to 4.5 times as much at age 59 as at age 21 for the daily room and board benefit and 3 to 4 times as much at age 59 as at age 21 for the miscellaneous hospital

expenses and surgical benefits (the rate for females is higher than for males, accounting for the range).

Under one recently issued policy, a $10 a day benefit for 365 days of hospital care up to age 65 and 90 days after the 65th birthday would cost a male $102.50 annually if issued at age 59 (twice as much if it paid $20 a day), as compared with $22.80 at age 21. The addition of miscellaneous hospital extras up to $150 would add $78 annually to the premium if issued at age 59 (compared to $18 if issued at age 21). Surgical benefits up to $200 would cost annually $42 if issued at age 59 ($10 at age 21). The three types of coverage if initially obtained at age 59 would come to $223 annually for males at the $10 a day room and board rate or $325 a year if the policy paid $20 a day for room and board (*17*).

INDEPENDENT PLANS

Neither premiums nor benefits in these plans lend themselves to statistical analysis zecause the sources of founds and the scope of benefits vary so much that no two plans are alike. Some independent plans provide only cash indemnities for specified periods of hospital care plus limited amounts for hospital extras and in some cases for surgical and in-hospital physicians' care. Others provide service benefits (sometimes with coinsurance) and include home and office as well as hospital care. Of 60 independent plants owning their own hospitals, a recent survey showed that 41 provided 365 days of hospital care and only 4 provided 35 or fewer days. Thirty-seven additional plans operating clinics contracted with a community hospital for hospital care for their members; 27 of them also provided 365 days of hospital care (*9*).

Hospital and Medical Care Provided Through Public Programs and Philanthropic Sources

There is considerable variation in the extent to which hospital and medical care is now directly available to aged persons and others, through public programs or through private arrangements supported in part by philanthropy.

PUBLIC PROGRAMS

A number of special groups can obtain hospital and medical care under public programs without regard to income or ability to pay. Most important are veterans with service-connected disabilities, active and retired military personnel and their dependents, Members of Congress and certain other Government officials, Indians, and merchant seamen.

For many years, the major part of the care for tuberculosis, mental illness, and leprosy has been provided in public hospitals. Such care is free for very low income groups, but those able to pay all or part of the costs are usually expected to do so. Publicly administered general hospitals in many localities also provide care without charge or with charges related to income for persons who cannot afford to pay in full.

Still other programs are open only to "needy" persons. Prominent among these are the public assistance medical care programs and the

services provided to veterans with non-service-connected disabilities. Some State and local governments also provide hospital and nursing home care for the medically indigent through financial arrangements with private institutions as well as directly through public facilities.

About 19 percent of all patients in privately controlled general hospitals are aged 65 and over. But in general hospitals under the auspices of State and local governments, patients aged 65 and over are nearly 26 percent of the patient population (*18*).

Veterans' programs

Out of a total of 22,560,000 veterans in 1957, there were 1,034,000 who were 65 and over. By 1976, the total veteran population is expected to drop to 18,758,000 but the number who will be 65 and over is expected to rise to 2,307,000.

Generally speaking, care in VA hospitals may be secured by veterans for service-connected disabilities incurred or aggravated during a period of war, or for any other disability when the veteran is unable to defray the expenses of necessary hospital care. In practice, a veteran's inability to meet the cost of care for a non-service-connected disability is generally established through the veteran's declaration to that effect.

About a fifth of all patients in VA general hospitals are aged 65 or over. The Veterans' Administration estimates that as of June 1957, for veterans of all ages, VA general hospitals were providing 45.1 percent of the care for medical, surgical, and neurological patients whose disabilities were non-service-connected. But for veterans who were 65 and over, the VA was providing 56.6 percent of the general hospital care for such patients.

The Veterans' Administration assumes in its estimates that in the case of service-connected disabilities requiring general hospital care all such care is received under VA auspices. Although there now are about 2 million veterans with service-connected disabilities who receive compensation, the number who will receive general hospital care specifically for service-connected disabilities is expected to decline steadily in the future. In contrast, because of the aging of the veteran population, the number of veterans 65 and over who will be receiving care in VA general hospitals for non-service-connected disabilities is expected to increase (*19*).

Public assistance

Public assistance provides for the basic maintenance of persons whose income and resources are inadequate to meet their needs as determined by State and local welfare agencies. At present about 5.7 million persons receive assistance under the four federally aided programs. An additional 1.1 million persons receive assistance under general assistance programs financed entirely from State and/or local funds. A large proportion of the public assistance caseload is made up of persons with unusually heavy medical needs resulting from disability, chronic illness, or the infirmities of old age. Some are forced to seek assistance primarily because of the need for medical care.

Because the demands for medical care have been very great, a serious problem of financing has arisen in many States. Public assistance agencies must decide how much money from limited appropriations should be spent for medical care. The public assistance program has primary responsibility for providing money for basic maintenance of

people—food, clothing, and shelter. However, medical care may also be a necessity of life and some medical care must be provided to those eligible for assistance if no other program can meet emergency need. The decision as to the content and amount of medical care to be provided under the public assistance program rests with the State agency and there are wide differences among States with respect to the types and quantities of medical care provided.

As of January 1958, some medical care was provided under 1 or more of the special types of public assistance in all but 2 of the 53 States and Territories. The type of care covered most frequently under plan provisions for the three adult programs—old-age assistance, aid to the blind, and aid to the permanently and totally disabled—was nursing-convalescent home care. Among the other types of care covered most frequently under the adult programs were drugs, hospitalization, and practitioners' services. In old-age assistance, 49 of the 53 States had specific provisions for nursing-convalescent home care, 39 for drugs, and 35 each for hospitalization and practitioners' services (*20*).

The determination of what constitutes eligibility for medical care under the public assistance programs is made by the States. This determination is usually made by considering the needs and resources of the individual and the availability of medical services from some other source. Most recipients of medical care under the public assistance programs also get payments to meet their maintenance needs, but some get payments only for their medical care.

Information regarding the volume of vendor payments (made directly to the suppliers) for medical care is regularly available. But information regarding the amount of money made available to recipients to enable them to purchase medical care themselves is not regularly available. During the fiscal year ended June 30, 1958, vendor medical payments under the four federally aided categories totaled $236.1 million. The amount spent under each of the federally aided programs was as follows: old-age assistance, $159.1 million; aid to the blind, $5.1 million; aid to the permanently and totally disabled, $28.6 million; and aid to dependent children, $43.2 million. These payments constituted the following proportions of total assistance payments: old-age assistance, 8.8 percent; aid to the blind, 6 percent; aid to the permanently and totally disabled, 13.5 percent; and aid to dependent children, 5.3 percent.

Vendor payments under the old-age assistance program constituted about two-thirds of all vendor payments under the four federally aided types of public assistance. Hospitalization was the type of service for which the largest amount of vendor payments was made in old-age assistance: that expenditure was 39.5 percent of total vendor payments according to State reports covering nine-tenths of such payments in old-age assistance.

A smaller proportion of the vendor payments, 26.3 percent, was made for nursing and convalescent home care, although more State plans included provision for such services. The proportions of total vendor payments for drugs and supplies and for practitioners' services were 14.7, and 10.8 percent, respectively. In the other adult programs, aid to the blind and aid to the permanently and totally disabled, expenditures for hospitalization also ranked first, and those for nursing and convalescent home care ranked second.

The most comprehensive information relating to amounts for medical care included in money payments is for a selected month January–March 1957. For the 25 States that reported information of this type, the proportion of cases having an amount for medical care included in requirements varied widely.

In States having maximums or other limitations on payments the inclusion of an amount for medical care in requirements may result in payment to the recipient of the full amount of medical care costs, only a part of the amount, or nothing over and above other requirements.

On an annual basis, the money payments in the reporting States that represented amounts for medical care would have totaled more than $73 million at the January–March 1957 rate (*20*). The reporting States may not be entirely representative of other States; the total increase in money payments for the country as a whole that resulted from the inclusion of medical needs in requirements probably amounted to about $100 million a year.

General assistance is financed entirely from State and/or local funds. There are wide differences among States, and even among local jurisdictions within a State, with respect to the types and amounts of assistance provided under the program.

During the fiscal year ended June 30, 1958, vendor payments for medical care under State and local general assistance programs totaled $83.8 million. These payments constituted 24.7 percent of all general assistance reported. While all vendor payments for medical care under general assistance were made from State and/or local funds without Federal participation, an unknown, though probably substantial, amount was spent in behalf of recipients of the four special types of public assistance. It is in many cases administratively simpler for States to make such payments under their general assistance programs and they are likely to do so when the amounts needed by recipients under one of the special categories exceed the maximum that can be matched by Federal funds.

Special interest attaches to the amounts spent for nursing or convalescent home care under the public assistance programs. This type of care is particularly important in aid to the permanently and totally disabled and is becoming increasingly important in the old-age assistance program as the average age of recipients increases and as old-age, survivors, and disability insurance provides the basic income for more of the aged who do not have special needs. Unfortunately, information is not available as to how much of such care is in skilled nursing homes and how much in domiciliary-type institutions. The maximum amounts paid from public assistance funds for nursing home care vary greatly from State to State, as does the adequacy of the care made available. In the States reporting information for a selected month January–March 1957, total monthly assistance payments to and in behalf of nursing home cases averaged $113.73 in old-age assistance (24 States) and $128.17 in aid to the permanently and totally disabled (20 States) (*20*).

In a study covering 13 States in 1953–54, it was found that payment for care for about 51 percent of all patients in proprietary nursing homes was fully or in part from public assistance. In no State was the proportion less than 25 percent and in a few States the proportion

was as high as 70 percent. Similarly, in a sampling of voluntary and public nursing homes in 11 of these States, the same study found that 50 percent of patients in these homes were also dependent in whole or in part upon public assistance support (*21*).

NONGOVERNMENTAL PROGRAMS

Nongovernmental hospitals traditionally provide some free medical care to the needy and medically needy and finance this care from such resources as endowment income and philanthropic contributions. The furnishing of free care by hospitals has been financed, in part, within hospital budgets through payments that are higher than true costs by self-supporting patients or by their third-party carriers. Increasingly, nongovernmental hospitals have been paid for services to needy persons through various public programs and public grants.

As a group, nonprofit general and allied special short-term hospitals have had small surpluses of total receipts (including philanthropic contributions, endowment income, governmental grants, etc.) over expenses in recent years. In 1957, for example, the aggregate surplus for all these hospitals was about 3.4 percent of income (*22*). Some hospitals, of course, continue to have deficits. A nationwide study of 1,400 hospitals made in 1954 showed that one-fourth of the hospitals studied had overall deficits, amounting generally to less than 10 percent of expenditures. The remaining three-quarters of the hospitals were able to finance current operations out of current income, typically with small surpluses (*23*).

In spite of the apparent fiscal balance of many hospitals, there is still the problem in many States of providing the financial resources to cover the cost of free and part-paid care for patients limited in their ability to pay. Within the last 4 to 5 years some of these States have conducted studies of the impact of this problem upon their hospitals.

These studies examined the financial resources of the hospitals which enabled them to cover their free and part-paid care. Special note was made of the extent to which resort was made to increased charges to paying patients, limitations on hospital services, inadequate allowances for depreciation and maintenance, etc.

Among the States reporting studies are some in which the financial problem of hospitals is aggravated because public assistance or the other public programs pay none or only part of the cost of hospital care for the needy and medically needy. Data from a few of the more recent studies indicate the magnitudes of the "losses" by hospitals in recent years for free and part-paid care:

In Missouri, a study covering 1953–54 indicated that 1,496 medically needy patients received care costing $246,234 from 8 urban hospitals and 20 in smaller communities. Only about 22 percent of the total bill was paid; 78 percent of the amount of these bills remained unpaid from any sourcee (*24*).

A Georgia study showed that, in 1955, 51,479 out of 215,357 patients (23.9 percent) admitted to 28 general hospitals were indigent or medically indigent. The total estimated loss for this care was nearly $4 million. This loss was mainly absorbed through surpluses from paying patients (*25*).

A study was made by the Alabama Hospital Association covering 87 percent of the general hospital beds in that State. The study showed that in 1955, out of a total cost of $7¼ million for inpatient and outpatient care of the indigent and medically indigent, only $4 million was received as reimbursement. Thus, an unpaid balance of $3¼ million had to be absorbed by the hospitals (*26*).

In Mississippi, reports from 75 hospitals in a study of indigent hospital care in 1956, showed that the cost of that care was slightly more than $4½ million. Considerably less than half of the days of care provided was compensated by public payments, but even these days were compensated at only about one-third of the cost (*27*).

A study in Pennsylvania showed that, in 1954–55, 178 State-aided hospitals incurred a deficit of $12¾ million over and beyond State-aid payments for free and part-paid inpatient care. Overall, this deficit together with the deficit on outpatient care absorbed nearly all the funds available to the hospitals other than payments by or on behalf of patients (*28*).

There can be no doubt that to the extent that public assistance and other public programs have approached making full payments for the cost of providing hospital care to the needy and medically needy, one of the most troublesome elements in hospital financing is being overcome. This situation increasingly prevails particularly among the wealthier States. But in other States, mainly those with lower levels of per capita income, adequate financing of indigent hospital care persists as a disturbing problem.

SOURCES

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(*3*) "Growth in Employee-Benefit Plans," Social Security Bulletin, March 1958.

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(*6*) Albert Hermalin, "Health Insurance—The Public's View" (report of a special survey made by the Health Insurance Council), May 13, 1958.

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(*10*) Ibid. and unpublished data.

(*11*) Based on Employee Benefit Plan Review Research Reports for situations current as of December 1958.

(*12*) From "Who Writes What in Life, Accident and Sickness" (published by the National Underwriter), 1957 edition.

(*13*) Much of the material in this and the next section was drawn from "Voluntary Health Insurance and the Senior Citizen: A Report on the Problems of Continuation of Medical Care Benefits for the Aged in New York State," State of New York Insurance Department, 1958.

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CHAPTER V

METHODS OF PROVIDING OASDI BENEFICIARIES WITH HOSPITAL AND NURSING HOME BENEFITS UNDER TITLE II OF THE SOCIAL SECURITY ACT

The present chapter explores the methods that might be used and the probable costs involved in providing hospital and nursing home benefits for OASDI beneficiaries under title II of the Social Security Act.

This approach would make use of the existing OASDI administrative setup for the collection of contributions and the identification of eligible persons. Contributions could be deposited in the OASI and DI trust funds or, following the practice when disability benefits were added, a separate trust fund could be established.

Ninety percent of all employed persons in the United States are now paying, with the help of contributions from employers, toward the cost of retirement, disability, and survivor benefits for themselves and their dependents. They could similarly pay toward the cost of hospital and nursing home benefits in retirement or for their survivors, through an additional contribution for this purpose that would be collected as part of an increased total social security contribution. Such prepayment would assure that more than 9 out of 10 persons reaching retirement age some years in the future would have hospital insurance coverage. It could also assure such protection immediately for 7 out of 10 of those already age 65 or over.

The addition to the program of a new type of benefit would necessitate policy decisions on a number of questions relating to the groups eligible for benefit, the scope and character of the benefits, and the method of administration—more specifically, the method of reaching agreements with and making payments to hospitals and nursing homes.

Groups Eligible for Benefits

In order to make the social security program effective within a reasonable period of time, the law has from the beginning provided that workers already approaching retirement age when they first had an opportunity to be covered could become insured on the basis of very brief periods of covered employment. And as the benefit provisions have been changed to take account of changing price and wage levels, the benefit amounts of those on the rolls have also been raised. A social insurance system can use current contribution income to pay full-rate benefits to this generation of aged because it can safely assume that successive generations of workers will continue to pay contributions, to acquire rights and to draw on those rights when they reach retirement age, or become disabled or leave surviving widows and children.

If the same principle were followed, funds derived from current social security contributions for hospital benefits would be used to provide such benefits immediately to persons now eligible for cash benefits.

A decision would have to be made as to the treatment of persons eligible for but not currently receiving cash benefits. In mid-1958, there were about 1.8 million persons beyond retirement age who were fully insured but not drawing benefits, including 1.6 million who had never filed a claim for benefits and 200,000 whose benefits were suspended. Such persons, and in many cases their wives (some 600,000 in mid-1958), could at any time receive cash benefits if they retired. There are also at any time some eligible younger persons not drawing benefits, primarily widowed mothers who are at work.

In principle, there are strong arguments for restricting eligibility for hospital benefits to those who have retired. Persons still employed have much more opportunity to get group health coverage, and those who are self-employed or employed in small establishments at least have a more adequate income with which to purchase individual insurance and are more likely than retired persons to be in sufficiently good health so that they can buy insurance. In addition, it is thought by some persons that to base eligibility for the hospital benefits on the attainment of any specified age, rather than on retirement, would weaken the rationale for special treatment of the aged as compared with the rest of the population.

The problem is to find a satisfactory test of retirement. In the case of the cash benefits, the present retirement test which defines substantial retirement primarily in terms of annual earnings below a specified amount is workable and equitable in relation to employed and self-employed persons. With the retirement test on an annual basis, however, it is not always possible to determine in advance whether an individual should be receiving cash benefits for a particular month, and the required suspension of benefits may occur after rather than during the time when he was earning more than the minimum allowed. To restrict the eligibility for hospital benefits to those who are actually receiving cash benefits would result in serious difficulties and anomalies. It would also result in considerable pressure on many individuals to retire as soon as possible in order to have the hospital benefit protection.

Difficulties of a different kind would arise if there were a special test of retirement for eligibility for hospitalization benefits, such as receipt of cash benefits for a certain number of months—probably 12 months if employed and self-employed persons are to be treated equitably—within a specified time. If hospital benefits were available only on this basis, there would be a substantial waiting period after retirement before hospitalization benefits could be paid. Particularly for those who are forced to retire because of illness, this delay in obtaining protection could be serious. Such a provision might increase the existing pressures to abolish the retirement test entirely.

Identifying eligible persons

If all persons who could be eligible for cash benefits were entitled to the hospital benefits, eligibility, once established, would be on a lifetime basis for old-age beneficiaries. Men 65 and over and women 62 and over and also younger beneficiaries and eligibles could receive

some form of document certifying to their eligibility for the hospitalization benefits with recertification at appropriate intervals for those who did not have lifetime eligibility. When the individual was admitted to a hospital, presentation of the card or document would establish a presumption or evidence of eligibility under the program. From the point of view of both the individual and the hospital the procedure would be essentially the same as that under most Blue Cross plans, which commonly use an identification card to establish at least provisional eligibility.

With a limit on the number of days of hospital care provided as a benefit, the hospital would need a check on whether the patient had already exhausted his benefits for the current year. The medical history taken in the hospital would provide the necessary information in the great majority of cases, since readmission occurring within any 12-month period would frequently be in the same hospital. In cases where the patient had changed residence or for an unconscious patient, verification of the amount of care which would be paid for by the OASDI system would be necessary. Prompt identification of eligible individuals is of importance both to the hospital and to the person and his family. The necessary checks would presumably be handled through the local and area offices of the Bureau of Old-Age and Survivors Insurance.

SCOPE AND NATURE OF THE BENEFITS

Assuming a primary decision had been made that the benefits to be provided should relate to the cost of hospital, or of hospital and nursing home care, subsidiary questions as to the scope of the services to be paid for would have to be answered.

It should perhaps be noted explicitly that the hospital, or nursing home, service which any beneficiary receives can only be that which is available in a hospital, or nursing home, to which a physician recommends admission. An insurance system does not provide hospital services; it provides an assurance that the cost of specified services received by beneficiaries will be paid from insurance funds. Hospital insurance for OASDI beneficiaries would not directly affect existing variations in the number of hospital beds in relation to the total population of different communities or sections of the country, nor would it result in uniformly high standards of care in all hospitals. It could encourage high standards and help assure more adequate operating income for all hospitals meeting such standards. It might also result in pressures for expansion of facilities in some areas.

Because of the more limited development of nursing home facilities, the lack of professionally accepted standards as to the care provided in such homes and the greater variability and lack of stability in the current methods of financing nursing home care, a nursing home benefit might affect many fewer beneficiaries at the outset than a hospital benefit. The benefit could also be expected to have a greater impact on the future development of nursing home care and indeed of convalescent and chronic care facilities and arrangements generally.

Service or indemnity benefits

Existing voluntary insurance follows two different practices with regard to the costs that are covered. Most Blue Cross plans insure

the member against the costs of specified services. The insured person in effect is guaranteed a stated number of days of care in a semiprivate room (or ward) and certain specialized services such as use of the operating room, anesthesia, and so forth. This is a so-called service benefit. Most insurance company policies guarantee to reimburse the beneficiary a stated number of dollars per day of hospitalization with stated allowances towards the costs of other hospital charges. This type of coverage is called cash indemnity.

Since hospital costs and charges vary greatly not only in different parts of the country but also within local communities, the extent and character of the protection provided may be quite different under the two types of benefit. In most circumstances, the individual—and the hospital—cannot know in advance what part of the total hospital bill will actually be covered by a benefit that is guaranteed in dollar terms. With a service benefit, both the beneficiary and the hospital know for what kinds of services payment is assured. Furthermore, the beneficiary knows that when he receives such services their cost (for the specified number of days of care) will be paid for in full no matter to which of the participating hospitals his doctor chooses to send him.

A service benefit—providing as nearly uniform protection as possible for all beneficiaries—would seem the most appropriate type of benefit under a compulsory social insurance program. It is also the only type of benefit which could guarantee hospitals full payment for the cost of specified hospital service for aged persons. On the other hand, it does require a type of negotiation and agreement with hospitals that could be avoided with a cash indemnity benefit.

Some groups have suggested that even though the hospital benefits should in general be service benefits, the beneficiary should be required to pay out-of-pocket some initial charge. The intended purpose of such a deductible amount not covered by insurance is to discourage overutilization of hospital services, as well as to place some of the cost burden directly on the individual receiving hospitalization.

The actual effect of such an out-of-pocket charge would obviously depend on the amount. Opinion among physicians and other qualified persons differs as to what constitutes overutilization of hospital services. A question to which no clear answer can be given is whether an out-of-pocket charge that would not place undesirable barriers in the way of needed hospital care would have much effect on admissions.

The detailed cost estimates presented below relate to a full service benefit. Figures are also given to indicate the costs of a cash indemnity benefit on specified assumptions as to the amount of the indemnity payment.

Hospital services to be paid for

The services that would be paid for through the insurance program would presumably include all those services normally provided by hospitals and included in the usual hospital bill. In addition to room, board, and nursing care, these would include use of the operating room, oxygen, certain drugs and therapies, and so forth.

It is assumed that the benefit would cover semiprivate accommodations with more expensive accommodations paid for by the insurance system only when required for medical reasons. Beneficiaries would also presumably have the option of using ward accommodations. If

they elected to use private rooms, the difference in cost would be borne out-of-pocket.

There are differences in practice among hospitals as to whether certain services—in particular those of anesthesiologists, radiologists, and pathologists—are included as hospital services. As a result the scope of the services paid for by Blue Cross plans varies in different plans and in different parts of the country.

If hospital benefits were provided under OASDI a difficult decision would have to be made as to whether the services that would be paid for from the trust fund would include for each hospital those services usually included in its bills. This would result in variations in the scope of the benefit for different beneficiaries. Alternatively, if the types of services that would be paid for were spelled out in some detail and applied uniformly for all hospitals providing such services, it might be necessary to develop several different systems of payment to hospitals depending on their own accounting practices.

Some of the legislative proposals for hospital benefits have provided that any institution licensed as a hospital under State law would be eligible to enter into an agreement to receive payment for services provided to beneficiaries. Alternatively, this privilege might be extended only to hospitals accredited by the Joint Commission on Accreditation of Hospitals in which the American Medical Association, the American Hospital Association and the American College of Surgeons participate, or by other appropriate accrediting agencies, thus assuring that certain standards of care would be met.

Duration of hospital benefits

Information was given in chapter II on the duration of general hospital stays for aged persons. Under present practices, it would appear that about three-fourths of the persons aged 65 and over who are hospitalized in general and special short-term hospitals spend less than 30 days, 90 percent less than 60 days and more than 95 percent less than 90 days in the hospital in the course of a year. These ratios would be affected by increased admissions, changes in the age, sex, and living arrangements of those admitted and other factors. They give a general idea, however, of the proportion of beneficiaries who would have practically all of their general hospital costs paid for by an insurance benefit limited to 30, 60 or 90 days of care in general hospitals.

Mental and other long-term hospitals

A decision would need to be made as to whether care in mental and tuberculosis hospitals should be paid for from social-security contributions. Such hospitals are now largely supported by State and local revenues, and the care which they provide is generally of a long-term character. The social insurance program would be taking on an entirely different kind of burden if it undertook to pay for such care than if the benefits covered only relatively short-term illnesses.

The many senile old persons who now occupy beds in mental hospitals might be better cared for if there were suitable nursing home care and other chronic care accommodations available. Movement of older persons out of mental hospitals could well be discouraged if insurance contributions were available to cover the cost of their care in such hospitals but not in nursing homes generally. For purposes

of the cost estimates, it has been assumed that the hospital benefit would not cover the cost of care in mental or tuberculosis hospitals.

Relation to other public hospital benefits

A related question arises concerning the cost of services now paid for through other Federal programs, though in this case the issue relates primarily to source of financing. It may be assumed that some persons eligible under OASDI and also under another program would choose to receive their care in Veterans Administration, Public Health Service or other Federal general hospitals. Whether the trust fund should pay for such services is a debatable question. (It presumably would not in any case pay, as part of the hospital benefit, the cost of the physicians' services which these hospitals provide for all patients.)

Similarly, hospital services that would be paid for under the insurance benefit could either include or exclude the cost of care covered under a workmen's compensation program.

It is assumed that the insurance benefit would pay for care in State and local public general hospitals. The OASDI system would, of course, take over the cost of public and private hospital services for beneficiaries whose care is now paid for by the public assistance program because no other resource is available.

Nursing home care

The Ways and Means Committee request is not clear as to the kind of nursing home care that is contemplated. Earlier proposals have related to skilled care of a kind that can appropriately take the place of hospital care at certain stages of illness, primarily during convalescence. The problems and costs involved in such a limited nursing home benefit are discussed. But in view of the possibility that the committee had in mind a much broader provision and that there would be pressures to expand the scope of a limited benefit once adopted, attention is given also to the problems and costs of a more general nursing home benefit.

There is at present a serious shortage of high quality nursing home beds of all types—not only those providing skilled nursing care but also those providing primarily residential and custodial type care (*1*). State laws with regard to licensure of nursing homes are much newer and standards far more variable than the laws and regulations relating to licensure of hospitals. There is no recognized national accrediting agency. If nursing home benefits were provided, therefore, the insurance system might, at least at the outset, have to establish its own standards as to the care for which it would pay.

Considering first the possibility of a limited skilled nursing home benefit, it may be noted that such benefits are now provided by a few Blue Cross and other plans. The benefits may apply to care in a chronic disease or convalescent hospital as well as in a nursing home. In some plans the benefits are payable only on discharge from a hospital and for periods of varying duration (30 days in a lifetime at one extreme, 2 years at the other) (*2*). Relatively few persons have up to the present been covered under such provisions.

While the number of skilled nursing homes in the United States is increasing, the availability of beds in such homes varies greatly from one community to another. Payment for the costs of such care under OASDI even for limited periods could be expected to stimulate

the development of more such facilities. For the time being, beneficiaries would have markedly unequal opportunities to get such care and therefore to have such care paid for from the trust fund. On the other hand, for the beneficiary the alternative to prepaid care in a skilled nursing home would, in many cases, be continued prepaid care in a hospital (for just how many days would depend on whether the hospital benefit covered 30, 60, 90 or more days of care in a year).

One of the issues with regard to skilled nursing home benefits, if they are provided, is whether the prepayment should apply only for illness in which the patient is discharged to the nursing home from a hospital. Such a restriction would emphasize care in a skilled nursing home as an alternative to the final stages of hospital care once the acute period of illness has passed. Increasingly, however, modern medical practice is making possible and desirable the treatment of many illnesses—such as pneumonia, certain types of heart attack, etc.—without the need for a period of hospitalization. The judgment of the physician must determine whether a patient is cared for in the hospital or elsewhere. It would be unfortunate, however, to adopt benefit requirements that would encourage hospitalization of persons who could be equally well cared for in a skilled nursing home throughout the entire period of illness.

A limited skilled nursing home benefit would not, and would not be designed to, meet the problem of the long-term chronically ill. Nor would it meet the problems of those many older persons who need residential care without continuous medical or nursing services. Both problems are serious and of increasing magnitude. The cost of long-continued institutional care is beyond the ability of most individuals or families to finance. The payment for nursing home care is placing an increasing burden on public assistance funds, while the level of assistance payments to nursing homes in all but a few States is so low as to make high quality care difficult if not impossible to achieve.

Because of the increasing need for good nursing home care, and the difficulties of drawing a sharp line between skilled nursing home care and other types of care, it might prove difficult to limit a nursing home benefit under OASDI to short-term convalescent care.

Whether the cost of long-continued care in nursing home or other chronic care facilities should be financed from social insurance contributions of employees, employers, and self-employed persons or whether it should be a charge on general revenues presents a major issue of social policy.

Methods of Handling the Benefit Arrangements

The necessary arrangements with hospitals and nursing homes to permit payment for specified services provided to OASDI beneficiaries could follow one of several different patterns.

Payments to hospitals and nursing homes

If the benefits took the form of a cash indemnity payment, it would not be necessary for the insurance system to enter into any negotiations with hospitals or nursing homes as to the amount to be paid. On evidence that the services were rendered, the hospital could be paid directly or through a third party for the specified amounts of cash indemnification. It would also be possible to pay these amounts to

the beneficiary or for the beneficiary to assign his benefits directly to the hospital. In any case, the hospital would bill the beneficiary and collect from him—or from him and from relatives or welfare or other agencies—for amounts not covered by the indemnity payments.

With a service benefit, the insurance system would pay to the hospital, directly or through an agent, agreed upon amounts per day of care rendered to beneficiaries. Hospitals are now reimbursed under a number of governmental programs—maternal and child health, crippled children, veterans, vocational rehabilitation—on the basis of a formula which is intended to approximate the actual costs incurred in providing the services. Many Blue Cross plans use similar formulas in arriving at the rates they pay hospitals. The amount paid per day of care thus varies from one hospital to another, but an attempt is made to assure that all hospitals receive a fair reimbursement of their costs.[1] In the case of insurance covering primarily aged persons, a reasonable cost formula should probably take some account of the lower daily cost of long-term stays. A number of Blue Cross plans pay a higher amount per patient day for the first few days than for subsequent days in a hospital stay. Other methods of adjusting payments to the level of care received could obviously be devised. The exact method to be used would of necessity be left to the administering agency to determine, after consultation with representatives of hospitals and other appropriate groups.

Nursing homes could be paid on the same basis as hospitals—that is, a per diem or perhaps a weekly rate that reflects actual costs. There has, however, not been the same kind of experience with such payment for nursing home care. Whether the accounting procedures of most nursing homes are adequate for accurate cost determinations may be questioned. Hospitals did not generally keep accounts in the necessary detail before payments from public funds and from Blue Cross became of some importance. It is probable that for nursing home services negotiated rates based on approximations of actual costs would have to be used at the outset.

Neither in the case of hospitals nor nursing homes would it appear desirable for the trust fund to pay customary charges for a service benefit. Such charges bear no uniform relation to actual costs; payments on this basis could be inequitable to either the provider of service or the fund.

Hospitals could submit individual bills for each beneficiary or consolidated billings at stated periods. Under the Medicare program, for instance, hospital bills are submitted primarily on a consolidated basis to Blue Cross plans and on an individual basis for the patients whose bills are handled by Mutual of Omaha (*3*).

Purchase of insurance

It was suggested in the request of the Ways and Means Committee that the OASDI system might "buy insurance * * * from private and nonprofit health insurance organizations." Under such an arrangement, bids would be invited from insurance companies and health plans as to the premiums they would charge for insuring the benefits speci-

[1] Excessively high costs resulting from expensive location and surroundings or other luxury features may be excluded from the amounts entering into the reimbursable cost formula or other negotiated rate.

fied in the social security legislation (and according to standards of care or other matters spelled out in regulations).

The problem faced by an individual insurance carrier in determining a fixed-bid rate for such share of the business as it wished to carry is of an entirely different character than the problem of estimating average costs for the OASDI system as a whole. Thus private insurance carriers would have difficulty in determining premium rates for this special coverage group and might be reluctant to make bids that from the point of view of the trust fund—and the contributors to the system—could be considered reasonable.

The State public welfare agencies that have tried to purchase hospital insurance covering public assistance recipients have found either that no carrier was willing to write a policy or that the rates were so much above the cost of self-insuring that there was no justification for such use of public funds. The one State (Colorado) that uses Blue Cross to handle the costs of hospitalization has been able to purchase such insurance for younger assistance recipients only; for old-age assistance recipients it has had to pay for the service on a cost-plus basis (cost of services plus cost of administration).

It is possible that a consortium of insurance carriers might be found to bid on the benefits for the entire group, somewhat as was done by the life insurance carriers under the Government employee life insurance program. In that program, there is no assignment of a policy to a particular company until the individual retires or dies. In the case of a hospital benefit, a method of assignment would have to be found that would let both the beneficiary and—unless the benefit was a cash indemnity—the hospital, know in advance what company was carrying his policy. Except for the extra costs that would be involved in such assignments, if the OASDI system received the appropriate rate credits and dividends, such a consortium would tend to become essentially an agent group paid on a cost-plus basis.

Use of private insurance carrier as agent

The OASDI system might underwrite directly the cost of the benefits, but use a private insurance carrier or carriers as its agents in negotiating agreements with hospitals and nursing homes and in handling claims from them and making payments to them. The insurance carrier would receive a reasonable payment for its administrative services.

For hospital benefits the trust fund might contract with a single national agent, such as the national Blue Cross Association. It is possible that this association might be willing to act also as agent in negotiations with and payments to nursing homes. Alternatively, there could be several agents selected on geographic or other bases.

Use of State agencies as agents

Another possible alternative would be to utilize appropriate State health or welfare agencies, in those States that were willing to enter into such an agreement, to handle the relations with hospitals and nursing homes. As in the case of private carriers serving as agents, the State's administrative costs for the program as well as the amounts it paid to hospitals and nursing homes would be reimbursed—or advanced on an estimated basis and later adjusted—from the trust fund. Some States might not choose to participate or be in

a position to do so immediately and the Secretary of Health, Education, and Welfare would need authority to administer the program directly in any State that did not enter into an agreement to act as agent. A similar reserved power should be available to him under any other agency arrangement.

Direct administration by the Department of Health, Education, and Welfare

It would also be possible for the Department of Health, Education, and Welfare, through the Bureau of Old-Age and Survivors Insurance, the Public Health Service, or a special unit set up for the purpose, to handle directly the arrangements with and payment of hospitals and nursing homes. There are fewer than 7,000 general and special hospitals in the country that would be providing the hospital services guaranteed as benefits. Practically all of them are familiar with the general basis for cost determination and the payment procedures that would be used no matter what agency handled the arrangements. Arrangements with nursing homes would present a more difficult but not insuperable problem. If the Secretary of Health, Education, and Welfare were given responsibility for administering the benefit payment provisions, it would be desirable for him to have the option of working through appropriate voluntary insurance plans or representatives of the providers of service.

Administrative Review Arrangements

None of the methods of handling payments to hospitals would involve completely new types of recordkeeping or reporting for hospitals. Unless a flat per diem basis of payment were adopted, some hospitals that are now paid by Blue Cross on the basis of billings would have to make changes in their accounting and recordkeeping procedures. Some statistical checks by the insurance system would, of course, be necessary. There is virtually universal agreement that there should be no interference with the internal administration of hospitals or with the authority of the physician in medical matters. Nevertheless, the use of public funds for social programs always implies some public concern not only with the proper handling of funds but also with the quality of the benefits received.

It is inevitable that if insurance—private or public—is available to cover the costs of some but not all types of services, there will be pressures from patients and doctors alike for maximum use of those services for which payment is guaranteed. One procedure the system could adopt to encourage proper utilization of hospital services would be to maintain an adequate statistical check on the services for which it is paying. What appear to be questionable practices could then be discussed with the appropriate agency or provider of services. Relatively simple checks might prove quite helpful. Some Blue Cross plans, for instance, have found a routine notification to the doctor that his patient has been in the hospital for 30 days results in a significant number of discharges. Other plans and some hospitals are experimenting with such procedures as the review by a medical committee of all hospital admissions and of stays beyond a certain duration (*4*).

Whether the payment arrangements were handled directly by HEW or through an agent, HEW would presumably be responsible for establishing requirements for fiscal and statistical controls and for analyses of experience data. The method of using any insights gained from such analyses as well as other kinds of checks on quality of service would vary somewhat depending on the administrative pattern adopted.

Extent of Coverage

A program of hospital benefits for persons eligible for old-age, survivors, and disability insurance would protect a little over 70 percent of the aged population in 1960. By 1970 it would reach an estimated 76 percent and in 1980 a little over 80 percent of the persons then aged 65 or over. It is likely that there would be pressure to provide similar benefits for the remaining groups of aged persons.

While there would be a number of problems involved, it would be possible to provide the same benefits to some additional aged persons by permitting other public retirement programs to buy into the system on behalf of their beneficiaries. In effect the OASDI system would serve as administrative agent for these other programs.

A policy question would also arise as to whether public welfare agencies should be given the option of carrying their responsibility for hospital care for old-age assistance recipients through arrangements with and appropriate payments to the OASDI system. The funds would presumably come as at present from the general revenues of the Federal and of State and local governments.

Alternatively, the Federal Government might pay from general revenues into the hospital insurance account of the OASDI system an amount sufficient to cover the cost of hospital benefits for all aged persons who are not eligible under OASDI or any public retirement system. The size of any such supplementary program of hospital insurance would diminish in the future as an increasing proportion of all aged persons become eligible for OASDI benefits.

Cost Estimates

HOSPITAL BENEFIT COSTS

It is more difficult to estimate the future costs of any type of medical benefit than it is to estimate the long-term costs of specified cash benefits. For both types of benefit, future costs will be affected by changes in the age and sex composition of the beneficiary group, in the average span of life, and similar factors—some of which can be predicted with a reasonable degree of certainty, others only within a wide range of assumptions. The long-range cost of hospital or other medical benefits will in addition be affected by changes in the organization of medical practice and new developments in scientific knowledge as well as by changes in labor costs and other charges. The kinds of change in medical practice that have occurred in recent years and the further changes which are in sight were reviewed briefly in chapter III. It must always be recognized, however, that a major breakthrough—in cancer research, for instance—could quite suddenly change the picture, and in an unpredictable direction. Thus, while for planning purposes it is essential to have long-range actuarial

estimates of the possible costs of hospital or nursing home benefits, considerable weight should be given to the near future in evaluating the cost burden of a proposed program.

Estimates are presented below of the current and long-range cost of hospital service benefits on two assumptions as to the maximum number of days in a year that would be insured—one a maximum of 30 days, the other of 60 days. While detailed computations were not made for a benefit of up to 90 days, the data on hospital utilization rates that were given in chapter II indicate that an extension of the days covered from 60 to 90 would add in the neighborhood of 10 percent to the total cost.

The detailed long-range estimates have been prepared also on the basis of two sets of assumptions as to the other medical cost factors, thus suggesting a reasonable range within which costs could fall. The general effect on costs of an additional set of assumptions is also indicated. In all the long-range estimates, the figures used for the number of beneficiaries and eligible persons and the taxable payroll for selected years are those developed by the Division of the Actuary of the Social Security Administration for the actuarial cost estimates for the present OASDI program (*5*). In order to minimize the number of different estimates shown, the demographic and other assumptions used in the year-by-year estimates are those appropriate to an intermediate-cost estimate for the present cash benefits. The variable assumptions relate to hospital utilization and costs.

Hospital utilization

Both the low and the high cost estimates use as their base the experience reported in the BOASI beneficiary survey. Total days of hospital care including days up to 30, and up to 60, in a year were computed on the assumptions summarized below for separate sex and age groups (65–69, 70–74, and 75 and over). The rates for each group were then adjusted upward to allow for the days of hospital care received during the survey year by beneficiaries who had died prior to the time of enumeration, using age-sex specific death rates and estimated hospital utilization experience for decedents. Similar but somewhat less complex methods were used to derive the utilization rates for the younger beneficiary groups.

Age-sex specific rates incorporate directly into the long-range cost estimates all the appropriate adjustments for the changing composition of the beneficiary population in the future. That is to say, the estimates reflect both the gradual aging of that population and the increasing proportion of women beneficiaries that are to be expected.

The major assumptions underlying the calculations of days of care per capita were as follows: For both low and high cost estimates the proportion of persons hospitalized and the days of hospital care per person per year reported for aged beneficiaries having health insurance were used for this portion of the eligible group. For the high cost estimate, it was assumed that if hospital benefits became generally available, the persons hospitalized among the presently uninsured proportion of the aged would jump to the present rate for insured beneficiaries, e.g., from 8.8 to 14.2 per 100 per year. (See ch. II, table 3.) It was further assumed that the average days per hospitalized person per year for this presently uninsured portion would remain at the rate reported in the survey rather than falling to the rate for the

presently insured group (for all age-sex groups the rate was 25.7 days among the uninsured and 17.4 days among the insured before the cutoff after 30 or after 60 days).

It can be expected that persons now uninsured, since they include many of the poorer health risks, would have somewhat longer stays than the present insured groups even after availability of benefits removes the cost barrier to early admission to a hospital. The combination of the admission rate of the insured and the duration rate of the uninsured, however, appears to be a generous assumption under present conditions of medical and hospital practice.

For the low cost estimate, it was assumed that those presently uninsured would increase their utilization only up to the average experience of the total aged beneficiary group, or 236 days per 100 before any cutoff. For the near future this is as rapid an increase in utilization as could reasonably be expected. In projecting this rate to the long-term future, the low estimate gives some weight to the probable success of current efforts to encourage progressive patient care, the reduction in hospital admissions that could result from development of outpatient diagnostic facilities, and similar trends in medical practice. The low cost estimate includes an adjustment of the hospital utilization rates for ages below 70 to reflect the fact that hospital utilization is substantially lower among employed than among retired aged persons (*6*). The low cost estimate also uses a lower average number of days of hospital care for decedents.

Both sets of estimates include safety factors in addition to those inherent in the assumptions already described. In neither estimate was any correction made to take account of stays in Veterans' Administration general hospitals (such days are included in the beneficiary utilization rates, but might not be paid for by the OASDI program) or for the fact that the existing beneficiary population from which the utilization rates were derived is more largely urban than the future beneficiary population and would thus tend to make more use of hospitals. Because the estimated average hospital stay assigned to decedents was rough,[2] no adjustment was made in the high cost estimate to take account of the 60-day cutoff in days covered, and the adjustment used for the 30-day benefit specifications excluded only days between the 30th and 60th, leaving the excess days over 60 as a safety factor in both cases. The high cost estimate also assigns to the group eligible but still at work the same utilization rate as that for the retired beneficiaries. In neither estimate is allowance made for the fact that the increase from the present to the assumed ultimate level of utilization would occur gradually, thus resulting in a lower level premium cost than that calculated.

The utilization rates for the younger beneficiary groups were based on data from the Census-PHS September 1956 survey, the National Health Survey and other sources. For young widows, the rate used in the 60-day benefit high cost estimate, for example, was 1 per day per capita per annum; for children, 0.5 days. The September 1956

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[2] Very little information on this specific rate is available. The estimates used were based primarily on sex but not age specific data for persons aged 65 and over from a special survey in San Jose County, Calif. See Siegel, Beth M., Belloc, Nedra B., and Hesse, Frank F. "Household Surveys for Hospital Planning Adjusted for Decedents Missed," Public Health Reports, vol. 72, No. 11, November 1957. Data from insured experiences such as those of Blue Cross or insurance companies include decedents.

survey showed a rate including maternity stays of 0.9 for persons 14–64 and 1.2 for insured persons in these ages and a rate of 0.3 for persons under 14 (the total group and those insured)—in all cases without any cutoff for days above 60. For women 62–64, an assumed rate of 1.6 days was used and for the disabled, a rate based on the high utilization rate for the aged (2.8 days with a 60-day benefit).

The low and high cost (age-sex specific) utilization rates when applied to the 1960 eligible aged population result in average utilization of 2.3–2.8 days per eligible person per year with hospital benefits up to 60 days in a year. (For eligibles aged 65 and over the comparable rates are 2.4–3.) These figures are higher than the preliminary estimates developed by the SSA last year, which showed utilization rates, with a 60-day cutoff, or 2–2.5 days per eligible person aged 62 and over in 1957 (7). At the time the earlier estimates were prepared, the data from the BOASI beneficiary survey—from which the rates used in this study are largely derived—were not available.

Future experience with hospitalization of aged persons will depend on many different kinds of factors, the more important of which have been discussed earlier. Actual utilization rates in the long term future could well be either higher or lower than the 2.3–2.8 day range used in the estimates prepared by the Department. On balance, however, that range would appear reasonable under foreseeable conditions.

Cost per day of hospital care

The estimated cost of a day of care was calculated in relation to average daily costs in general and special hospitals, starting with 1956 data (the most recent year for which all the relevant figures are available) and projecting to 1960 the trend according to rates of increase that had been found for the past decade. In 1956, total expense in all non-Federal short-term general and special hospitals was $24.15 a day. When this figure is reduced by the estimated cost of outpatient departments and research included in the total, the resultant figure is about $22.50.

For the aged, some further reduction is appropriate because their longer stays result in a lower per diem cost, that would presumably be reflected in some manner in payments to hospitals. Care in non-Federal long-term general and special hospitals, which presumably could be used in the program, was $10.20 a day in 1956; no allowance, however, was made for such lower rate. The average reimbursable cost formula used by many Federal Government agencies was $20.50 for 1956; it represents the average daily cost in 1,958 general hospitals. Taking into account these various figures, it was decided to use as a basis for the projections a cost of $21 a day for the aged and disabled, and $23 a day for younger widows and children as of 1956. The resulting figures for 1960 were $27 a day for the aged and $29 a day for younger beneficiaries.

For the long-term estimates a further adjustment in these figures was made to reflect the fact that the earnings level used in the most recent actuarial cost estimates is based on 1956 earnings. (See appendix A.)

In effect, the long-range cost estimates postulate that hospital per diem costs will continue to rise at a more rapid rate than general

wage levels until the early 1960's but thereafter will increase at the same rate as wage levels and the expansion of the economy in general. In evaluating this assumption, it should be kept in mind that the per diem rates used do not include nearly as large an allowance as might be justified for the reduced costs of long stays in short-term hospitals, and do not include any allowance for the lower average per diem costs that would result from an increase in appropriate facilities for chronic care. These cost-reducing factors would have a more significant effect on the estimates relating to a 60-day benefit than those relating to a 30-day benefit.

It could also be assumed that hospital costs will continue to rise more rapidly than general wage levels until say 1970, but with the difference in the two rates of increase becoming gradually less over the course of the decade. On this assumption, year-by-year costs for 1970 and after might be about 15–20 percent higher and the level-premium costs about 12–15 percent higher than those shown in table 2.

It would also be reasonable, however, to assume with respect to cost estimates for the very long term future, that average per diem costs would decline relatively, due to changes in institutional patterns and other factors. If the combined effect of such changes and of potentially lower utilization rates than those used are considered, it would be reasonable to have another set of cost estimates showing level premium costs 12–15 percent lower than those shown.

Early year hospital benefit costs

The estimated costs of hospital service benefits for persons who will be eligible for OASDI in 1960 are shown in table 1. With a hospital benefit of up to 60 days a year, hospital benefit costs in 1960 would probably be about $900 million, or a little over 0.4 percent of taxable payroll. With a 30-day limit the cost would be somewhat under $800 million and somewhat less than 0.4 percent of taxable payroll. The major part of the cost would be incurred for aged beneficiaries. If the benefit covered 90 days of hospital care in a year, the cost in 1960 would be about $990 million.

Estimates for a year in the immediate future can reasonably be made using a single set of assumptions. The 1960 estimates are based on the low-cost assumption as to days of hospital care described above. They thus allow for an immediate substantial increase in hospital utilization by persons now without hospital insurance—although not as large an increase as is postulated in the high-cost estimates for future years when the program could have been in effect long enough for such further expansion to occur. The per diem costs used in the 1960 estimate reflect the rising trend in hospital costs over the past decade projected to 1960.

TABLE 1.—*Estimated costs in 1960 of hospital service benefits for persons eligible for OASDI* [1]

	Benefit costs (millions)	Benefit costs as percent of taxable payroll [2]
Hospitalization up to—		
60 days in a year:		
Total	$895.4	0.428
Aged [3]	826.3	.395
Disabled workers and their dependents	33.6	.016
Mothers and children [4]	35.5	.017
30 days in a year:		
Total	771.3	.368
Aged [3]	713.1	.340
Disabled workers and their dependents	28.4	.014
Mothers and children [4]	29.8	.014

[1] Exclusive of administrative costs, see text.
[2] Taxable earnings limit of $4,800 per year.
[3] Includes women aged 62–64.
[4] Surviving children and their mothers and children of retired workers and their mothers.

Long-range costs

The estimated long-range future costs of hospital service benefits on low cost and high cost assumptions are shown in table 2. Costs as a percent of taxable payroll for selected years to the year 2050 and the calculated level-premium cost into perpetuity are indicated. Over 90 percent of the total cost represents benefits for the aged group of eligibles. It would appear that, at least through 1970, hospital benefits of up to 60 days in a year might involve costs equal to about 0.5 percent of taxable payroll. Thereafter, assuming no change in medical practices or the other factors underlying these estimates, costs would become somewhat larger. The decline in costs as a percent of taxable payroll around the year 2000 occurs also in the estimated cost of the present system. It results from the fact that the aged population then will consist primarily of surviving persons from among the relatively low number of births during the 1930's while the labor force will reflect the high birth rates of the 1940's and later years. As a consequence, it is not until almost 2025 that the 60-day hospital benefit, on an intermediate cost basis, would involve expenditures of as much as 0.75 percent of taxable payroll on the assumptions used.

TABLE 2.—*Estimated long-range costs of hospital service benefits for persons eligible for OACDI, as a percent of taxable payroll (low cost and high cost assumptions for hospital cost factors, intermediate cost assumptions for all other factors)* [1]

Calendar year	Hospitalization up to 60 days in a year		Hospitalization up to 30 days in a year	
	Low cost hospital factors	High cost hospital factors	Low cost hospital factors	High cost hospital factors
1965	0.42	0.53	0.36	0.43
1970	.46	.58	.39	.47
1975	.49	.62	.42	.50
1980	.53	.67	.45	.54
1990	.59	.74	.50	.60
2000	.57	.73	.49	.58
2025	.68	.87	.59	.70
2050	.83	1.05	.70	.84
Level-premium cost [2] [3]	.58	.74	.49	.59

[1] Exclusive of administrative costs, see text. Taxable earnings limit of $4,800 per year. See also table in appendix A.
[2] At 3 percent interest.
[3] If the hospital low cost factors are combined with other low cost factors and the hospital high cost with other high cost factors, the resulting level-premium costs for the 60-day benefit are 0.50 and 0.86, respectively.

These estimates assume a continuation of the present maximum taxable earnings limit of $4,800 a year, or its equivalent. If the taxable base were raised so that a larger portion of total payrolls were taxed, the costs as a percent of taxable payroll would, of course, be lower than those shown. With a taxable wage base of $6,000, for example, costs as a percent of taxable payroll would be about 6 percent below the percent of payroll figures in table 2.

As pointed out above, changes in medical knowledge and practice could result in somewhat different experience in the long-term future. These long-term projections serve to indicate, however, the general magnitude of the cost burden that the system would be assuming on the basis of present knowledge and practices.

Administrative costs

The estimates in tables 1 and 2 relate to benefit costs only. The added cost of administration might amount to 5 percent of the benefit costs, with some variation depending on how the arrangements with, and payments to, hospitals were handled. No new costs would be involved in collection of the contributions, and relatively minor costs in identification of eligibles. The administrative costs of the agents for the medicare program amounted to less than 2 percent of the medical service expenditures in the first year of operation (*8*).

Cost estimates for a cash indemnity hospital benefit

In order to illustrate the possible cost of a cash indemnity hospital benefit, an estimate was made assuming an indemnity payment of $10 a day for up to 30 days and for up to 60 days, plus the cost of hospital "extras" up to $100 and up to $150 a year. Although hospital utilization would probably be somewhat lower with this more limited protection, the estimates are based on the same utilization rates used in the estimates for the 1960 cost of a service benefit. It was assumed that with a 30-day benefit and $100 allowance for hospital "extras" the reimbursement for the extra services might amount to $90 on the average

in respect to each hospitalized aged or disabled person and $80 in respect to mothers or children. For the 60-day benefit and $150 allowance, the corresponding amounts for hospital "extras" used were $135 for the aged and disabled, $100 for mothers and $80 for children (*9*).

On these assumptions, the 1960 cost would be about $500 million for the 30-day—$100 cash indemnity benefit and about $640 million for the 60-day—$150 cash indemnity benefit. As a percent of taxable payroll, the costs would be 0.24 percent and 0.30 percent, respectively.

NURSING HOME BENEFIT COSTS

There is very little experience on which to base an estimate of the cost of a nursing home service benefit, whether such a benefit were limited to skilled nursing home care as a substitute for hospital care or applied broadly to nursing home care of all types. Furthermore the need for additional nursing home beds and the possible expansion that might occur if a method of paying for care were to become available are so great that it is not possible to develop the same kind of credible long-range cost estimates as were given for the general hospital benefits. The general magnitude of the potential costs can, however, be suggested.

Most nursing homes currently keep a minimum of records, and consequently no generally accepted accounting practices have yet developed. A survey carried out jointly by the Public Health Service and the Commission on Chronic Illness in 13 States in 1953–54, provides some information on nursing home charges. The median monthly charge for private paying patients was $175 in proprietary homes and, in 10 of these States, the median charge in voluntary nonprofit and public homes was $116 (*10*). Larger homes and homes with more trained nurses had higher charges. A special study of the costs of "acceptable" care that was made in Florida in 1955 suggested a cost level of $156.50 a month for "care with adequate diet and nursing care in nursing homes for the average patient"; the cost level suggested for "care for an acutely ill person" was $176.39 a month (*11*).

An estimate relating to a very limited skilled nursing home benefit might build upon the experience of the few Blue Cross plans having such a benefit. The available data suggest that a skilled nursing home benefit of say 90 or 120 days less any days in a hospital (up to 30 or 60 days) might involve 8 or 9 days of such care per 100 aged eligibles in a year. If a rate of 10 days per 100 aged beneficiaries were used for the aged (and 20 days for the disabled), together with a daily cost of $10 (or about $300 a month), the 1960 cost of this benefit would be about $14 million or 0.007 percent of payroll. Since this kind of nursing home benefit would substitute nursing home care for much more expensive days of hospital care, the net cost of such a benefit would be negligible at the outset. It would become larger as the number of beds in skilled nursing homes increases. Just how much larger might depend in considerable part on the extent to which it was possible in practice to keep the benefit within the intended limits of short-term convalescent care. There is some question whether any such limitation could be effectively enforced.

If, on the other hand, a nursing home benefit covering long-term care in all types of nursing homes is proposed, the costs would be of a very different order of magnitude. The BOASI beneficiary survey data cited in chapter II provide a basis for rough estimates for the aged.

For every 100 aged beneficiaries there were 276 days of care in nursing homes during the year. This included homes of all types. Assuming that all of the homes would qualify for payments from the OASDI system and therefore applying this rate to the 1960 eligible aged population, and allowing an average of $10 a day for the cost, the annual cost in 1960 would be about $363 million.

If a nursing home benefit of this kind were available, some persons now in mental hospitals and chronic care facilities, and some now cared for at home, might well enter nursing homes. (And some existing mental and other hospitals might develop associated nursing home facilities.) Any large shift would require an expansion in nursing home facilities and might therefore take some time. The shortage of nurses imposes a major limitation on rapid expansion of skilled nursing homes and of high quality homes of all types.

For the near future an outside limit on utilization and costs might rest on the following assumptions. The aged beneficiary group spent 448 days per 100 per year in all long-term facilities—mental, tuberculosis, and chronic care hospitals and nursing homes. This rate is higher than could be reached in the near future for nursing home care only. If nevertheless this rate is assumed, the annual cost of a nursing home benefit for the 1960 eligible aged group would be $590 million assuming an average daily cost of $10 and $885 million if the daily cost were as high as $15.

A very broad nursing home benefit might thus cost from about half as much as a general hospital benefit of 30 days in a year to as much as a 60-day general hospital benefit. It should be noted that a nursing home benefit of this kind could well result in some decrease in the estimated cost of hospitalization benefits particularly if a 60 or 90 day benefit were contemplated.

Another kind of offset against the nursing home benefit might also be considered. If the insurance system were to pay for long-continuing institutional care, it would be reasonable to reduce the cash benefit payable to the individual receiving such care, leaving him with some minimal amount for personal needs not taken care of by the institution. In the case of a married person the reduction should take into account the fact that a wife's benefit is only half the worker's benefit and that the couple's normal living arrangements are built upon their combined benefits. Any reduction in the total cash benefits of a beneficiary couple, one of whom was receiving long-term institutional care paid for by the insurance system might therefore be such as to leave not only the personal needs allowance but the full amount of the retired worker's benefit for the spouse at home. If persons receiving nursing home benefits had their cash benefits reduced to $25 a month, for example, with the special adjustment suggested in the case of married couples, the cost offset might be in the neighborhood of $40 million against the lower figure ($363 million) cited above and $65 million against the higher figures ($590 and $885 million). A similar reduction would, of course, not be appropriate in the case of a short-term general hospital or nursing home benefit.

OTHER COST ESTIMATES

In considering the cost estimates prepared by the Social Security Administration, it may be helpful to see how they compare with estimates from two other sources. One set, prepared by the Health Insurance Association of America and presented in testimony before the House Ways and Means Committee in 1958, relates specifically to the cost of a program for OASDI beneficiaries (*12*).

The other estimates were prepared by the New York State Insuraance Department (*13*) to provide insurance underwriters and health service plans in that State with a sound actuarial basis for writing health insurance policies, particularly policies covering persons aged 65 and over. The Insurance Department also used the figures in estimating the potential cost of a broad extension of hospital (and surgical) insurance to the entire population of the State. While the New York study did not, of course, include cost estimates relating to a program for OASDI beneficiaries, the utilization rates derived in that study are pertinent to a consideration of both the SSA and the HIAA cost estimates.

In 1957, the New York State Insurance Department undertook a comprehensive study of the coverage and characteristics of voluntary health insurance in the State. In the course of this study, the department obtained information with regard to hospital utilization, classified by age and sex, from a number of companies selling health and accident insurance, two Blue Cross plans and one Blue Shield plan, and the Health Insurance Plan of Greater New York. The insurance companies submitted information for their total U.S. business. Only a few of these companies or plans, however, had usable experience data for the group aged 65 and over. The hospital data "include care for all sickness and injury, including such long-term disabilities as tuberculosis and mental or nervous disorders whether in a general or special hospital." (*13*).

An actuarial committee was then set up by the New York State Insurance Department to develop utilization and cost estimates. In constructing its hospital utilization table, the actuarial committee studied not only the rather limited amount of experience data for the aged furnished the department as a result of its special inquiry, but also related published data. The appendix of the report issued by the department includes, for instance, tabular data from the Census-PHS 1956 survey; the AMA 1953 one-day hospital census; the Census-SSA 1951 survey; the California 1954–55 health survey; and the Annual Report of the Saskatchewan Hospital Service Plan for 1956. Experience data from most of these surveys are presented in chapter II above.

The hospital utilization tables that were prepared in the New York study thus represent the best judgment of a group of actuaries as to rates that are appropriate and safe for use by private insurance carriers and health service plans. The rates are presented by single years of age from 18 to 99. When weighted to reflect the estimated 1960 age-sex composition of the OASDI eligible aged population (women 62+, men 65+), the average overall rates are 2.3 days per person per year with a 31-day benefit and 3.3 days per person per year with a 120-day benefit. For eligibles aged 65 and over, the rates

are 2.4 and 3.4 days, respectively. These utilization rates are identical with the higher of the two rates developed by the SSA for the 30-day benefit and consistent with the SSA estimate for a 60-day benefit.

In calculating the annual cost of hospital care for the New York population, the study used an average cost of $30 a day including the hospital charges for ancillary services as well as basic room rates. The same amount is used for all age groups. A reimbursable cost figure would take some account of the probably lower average daily costs for the aged resulting from their longer stays. In 1956, hospital daily room rates for semiprivate rooms in New York were about 25 percent higher than the average for the United States as a whole. After adjusting to take into account these various factors, application of New York study data to the OASDI beneficiary group would result in overall cost estimates of about the same magnitude as those prepared by the SSA and presented above.

The HIAA estimates of last year, on the other hand, are significantly higher than the SSA estimates. The hospital utilization rates used by the HIAA were based on the estimates prepared by the actuarial committee of the New York State Insurance Department study, with very slight modifications for some ages, but with the utilization rates adjusted to apply to a 60-day benefit. When applied to the 1960 OASDI eligibles, the aggregate rate derived from the basic utilization figures presented by the HIAA is 2.9 days per person per year for the total group (women 62+ and men 65+) and 3.0 days for eligibles aged 65 and over. These rates were, however, increased by 25 percent for the HIAA initial-year cost estimates and by an additional 36 percent for 1979 and thereafter, resulting in rates of 3.6 and 4.9 days for the initial and long-term estimates.

The HIAA justifies this upward adjustment of the basic estimates on the ground that a Government-run program will result in a higher utilization rate than private insurance and cites particularly the experience under the Saskatchewan Hospital Service program. Data for the Saskatchewan plan were presented in chapter II, and a number of reasons were given for questioning the applicability of this experience to a program providing general hospital benefits for up to 60 days in a year for OASDI beneficaries.

When cost estimates are based on the experience of a group including persons without health insurance, some upward adjustment in computed rates is appropriate to take account of the higher utilization found for persons having health insurance. It may be noted, however, that the 2.9 day rate on which the HIAA estimates are based is itself a derived, judgmental estimate of the utilization to be expected for a population all of whom have insurance under service benefit as well as cash indemnity benefit plans.

In calculating annual costs, the HIAA used a figure of $27 as the per diem charge in 1959. This is not significantly different than the figures used by the SSA for 1960 ($27 a day for the aged and $29 a day for younger beneficiaries). The HIAA assumes that the cost of administration of a program for OASDI beneficiaries would be 10 percent of benefit disbursements rather than the 5 percent used by the SSA as the additional administrative cost.

Combining these various factors, the HIAA estimated that the cost of a 60-day hospital benefit for aged, and mother and child eligibles

in 1959 would be $1,370.3 million or 0.67 percent of taxable payrolls (table 3). The SSA estimate of the 1960 benefit cost for these two groups—$861.8 million—increased by 5 percent for the cost of administration, is $904.9, or 0.43 percent of taxable payroll.

For the long-term future, the HIAA estimates, as was pointed out above, assume a further 36 percent increase in utilization rates by 1979. They also assume that, by 1979, daily hospital costs will rise about 20 percent more than any increase in general wage levels over the period. As indicated earlier, some further increase in hospital wages and other costs, relative to general wage and price levels, may occur in the next decade or two, although the catching-up process would appear to be largely past. It is possible also that new techniques or new drugs may push up real costs per day of care. Past experience would suggest, however, that if this occurs, there will be an accompanying drop—not an increase—in average length of stay and hence of days per capita. The HIAA long-term utilization rate, on the other hand, would imply either a very sharp increase in rates of admission to hospitals or a marked reversal of the trend toward shorter duration stays, or both.

The 1979 utilization and cost figures developed by the HIAA when used in combination with the intermediate long-range cost estimates of the Division of the Actuary of the SSA, assuming a 2.6 percent interest rate and a $4,200 taxable wage limit (the applicable amount in 1958), resulted in an estimated level-premium cost for a 60-day hospital benefit for aged and young survivor eligible groups of 1.655 percent of taxable payroll. If adjusted to the present $4,800 taxable payroll base and a 3-percent interest rate, the level-premium cost would be 1.50 percent of payroll.[3] The comparable SSA estimate (for aged and mothers and children, intermediate hospital cost factors, 5 percent administrative costs) is 0.66 percent of taxable payroll.

TABLE 3.—*Health Insurance Association of America estimates of costs of hospital benefits for OASDI eligibles (aged and mothers and children)*

HIAA estimated costs	Aged and mothers and children	Aged	Mothers and children
1959 costs:			
Amount (in millions)	$1,370.3	$1,319.8	$50.5
Percent of taxable payroll [1]	.67	.65	.02
Level premium costs as percent of taxable payroll:			
Published estimate [2]	1.655	1.620	.035
Adjusted estimate [3]	1.50	1.47	.032

[1] Computed by SSA.
[2] Using a $4,200 taxable payroll base and 2.6 percent interest.
[3] Using a $4,800 taxable base payroll and 3 percent interest, computed by SSA, see text.

Source: HIAA estimates from Hearings on Social Security Legislation Before Committee on Ways and Means, 85th Cong., 2d sess., June 1958, pp. 612–630.

The HIAA also presented estimates of the cost of a limited, skilled nursing home benefit. The estimates are given as relating to a benefit of 120 days of care a year less the days of care spent in a general hospital (up to 60) before transfer to a skilled nursing home. The

[3] The level-premium cost estimate presented by the HIAA was developed, on its request, by the Division of the Actuary of the SSA, using hospital cost factors specified by the HIAA. The Actuary took no responsibility for the reasonableness of these factors.

method of estimate and the resulting figures, however, are those appropriate to a general nursing home benefit not tied to a hospital stay.

The HIAA estimate of the 1959 cost of a nursing home benefit starts with the total number of skilled nursing home beds now in existence, computes the percent occupied by aged persons and the percent of aged persons who are OASDI eligibles and allows for 100 percent occupancy of that proportion of beds by persons entitled to the nursing home benefit, or in other words persons who have not used up the 120 days of benefit. The HIAA points out that its estimate allows for only 1½ percent of the aged eligibles to be occupying nursing home beds at any one time. This would be true, however, only if most beneficiaries stayed no more than 120 days. The HIAA estimate of the 1959 cost of a nursing home benefit was $513.9 million.

For the future, the HIAA postulated that most unskilled nursing home beds would be converted to skilled beds and that new facilities would be developed. It was assumed, therefore, that the cost of a nursing home benefit would triple in 10 years. The HIAA points out that this projection implies that less than 5 percent of the aged OASDI beneficiaries will be in skilled nursing homes at any one time. If applied to a benefit of 120-day duration, this estimate means that at least 15 percent—and if many beneficiaries stay more than 120 days, a considerably larger percent—of all aged beneficiaries would be in a nursing home at some time during the year.

Even if there were no limit on the duration of the nursing home benefit a fivefold increase in the proportion of beneficiaries in nursing homes would imply a significant decrease in hospital utilization by aged persons, a marked movement of aged persons out of their own homes and into institutions, or both. If the former were the major factor the HIAA estimate of the long-term cost of a nursing home benefit would appear inconsistent with the assumptions underlying its estimate of the long-term cost of a hospital benefit.

The computed level-premium cost of a nursing home benefit as presented by the HIAA was 1.16 percent of taxable payroll. This is lower than the lowest of the SSA estimates of the cost of a general nursing home benefit in 1960 expressed as a percent of taxable payroll (1.7 percent). The HIAA used a daily cost of $7, while the SSA assumed an average cost of $10 a day as the probable immediate rate and $15 for an outside estimate. The SSA estimate of the cost of a limited skilled nursing home benefit (payable only to persons discharged to the nursing home from a hospital) is very much lower (0.007 percent of taxable payroll in 1960).

SOURCES

(*1*) "Inventory of Nursing Homes and Related Facilities," Public Health reports, December 1954.

(*2*) J. F. Follmann, Jr., "Nursing Home Care," Best's Insurance News, July 1958.

(*3*) Maj. Gen. Paul I. Robinson, "Medicare: Uniformed Services Program for Dependents," Social Security Bulletin, July 1957.

(*4*) Adjudication of Francis R. Smith, insurance commissioner of the Commonwealth of Pennsylvania in the matter of filing of Hospital Service Association of Western Pennsylvania, made September 30, 1957.

(5) Eighteenth Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund, 85th Congress, 2d session, House Document 401.

(6) Hospital experience data of the Blue Cross Insurance Plan in St. Louis, Mo., suggest that for persons 65 and over the rate is at least 25 percent lower for those employed than for retired aged persons (communication from the plan).

(7) See Social Security Administration, Division of Program Research, preliminary staff memorandum, "Basic Cost Calculations Relating to Proposals to Provide Hospitalization and Other Medical Care Services to OASDI Beneficiaries," January 20, 1958.

(8) U.S. Department of Defense, Office for Dependents' Medical Care, "Dependents' Medical Care Program, First Annual Report," June 1958.

(9) Based on data in table B1–a pages 142–143, of source cited in item (13) below, with an allowance for increased costs since 1957.

(10) Public Health Service, "Nursing Homes, Their Patients and Their Care," Public Health Monograph No. 46, 1957.

(11) F. H. Britt and M. H. Jacks, "Cost of Care of Aged and Infirm Residents in Florida Nursing and Boarding Homes," Public Health Reports, August 1956.

(12) See appendix by E. J. Faulkner, Health Insurance Association of America, in "Hearings on Social Security Legislation Before Committee on Ways and Means," 85th Congress, 2d session, June 1958, pages 612–630.

(13) "Voluntary Health Insurance and the Senior Citizen: A Report on the Problem of Continuation of Medical Care Benefits for the Aged in New York State," State of New York Insurance Department, New York, 1958.

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CHAPTER VI

METHODS OF PROVIDING HOSPITAL BENEFITS OTHER THAN THROUGH USE OF THE OASDI MECHANISM

The alternative methods of assuring OASDI beneficiaries protection against the costs of hospital and nursing home care that are explored in this chapter are: (1) stimulation of voluntary health insurance through pooling, reinsurance, regulation, or checkoff of premiums for OASDI beneficiaries; (2) Federal subsidies to private carriers to cover above-average risks or to supplement premiums from persons of low income; and (3) Federal grants to the States for medical care for the indigent and medically indigent. Summaries of legislative proposals along these lines that have been introduced in earlier congressional sessions are included in appendix B.

The alternatives considered in this chapter are based primarily on previous legislative proposals. There are, however, other possibilities for Federal action. However, time has not permitted any of them to be developed and evaluated in adequate detail for this report. For example, it would theoretically be possible to develop a program of hospitalization insurance for the aged along the lines of a Federal tax-offset for State insurance programs. There is, also, the possibility of developing a program that would be limited to coverage of the catastrophic costs of sickness among the aged, either under the OASDI mechanism or through Federal-State matching grants.

The alternatives considered in this chapter would not apply specifically to the beneficiary group except for the proposal of stimulation through a checkoff against benefits. In the other proposals, OASDI beneficiaries would receive protection, not as beneficiaries, but as members of the aged population, as persons with low incomes, or as part of the total population.

An earlier chapter indicated that some persons now receive hospitalization and medical services without charge in publicly administered hospitals and institutions. It has been assumed for purposes of this report that whatever expansion in public medical facilities and services may occur in the future, a system of public hospitals need not be seriously considered as the primary method of assuring hospital and nursing home care for OASDI beneficiaries. Hence, no attempt has been made to estimate the cost or to analyze the administrative implications of such a method.

Stimulation of Voluntary Insurance

As noted earlier, the proportion of the population aged 65 and over reported as having some insurance against the costs of hospital care increased from 26 percent to 36 percent between March 1952 and September 1956 and by 1958 to about 40 percent. In terms of num-

bers of persons, about 3.5 million persons aged 65 and over had some form of hospital insurance in 1952 and 9.2 million did not. Today with a larger total aged population, there are probably somewhat more than 6 million aged persons with hospital insurance and about 9 million without. Unfortunately, there is no source of information on the number of permanently disabled persons who have hospital or other types of medical insurance, and information for young widows and their children is limited to those included in the beneficiary survey (56 percent of these widows had health insurance).

The experimentation with new methods of covering the aged under voluntary insurance that has been described in chapter IV should result in further increases in hospital insurance coverage among persons already past 65. It is difficult to predict how rapid an expansion is likely to occur with no Government action or with governmental encouragement short of subsidy. If the same average yearly increment in the proportion covered that occurred between 1952 and 1957 were maintained, private hospital insurance would reach about 56 percent of the aged population in 1965 and 68 percent in 1970. If the increase in health insurance coverage of OASDI beneficiaries as reported in 1951 and 1957 were maintained, about 70 percent of the beneficiary group would have such coverage in 1965.

These projections take no account of the drop in the proportion of the total population covered by health insurance that occurred between 1957 and 1958 and that may have been paralleled in the experience of the aged. As the proportion of any population group that is covered rises, further increases become relatively more difficult to achieve, since more of the employed groups, those with higher incomes, and the favorable risks come in first. In the case of the beneficiaries, the increasing proportion of farmers and other self-employed persons—who would have had less opportunity to get coverage prior to retirement—will tend to slow down increases in coverage.

Expanded protection would require an improvement in the benefits available as well as in the number of persons covered. All such changes involve problems of costs of the insurance and of how the premium structure can distribute the additional costs for the aged.

A number of proposals have been made in the past as to ways in which Government might encourage and stimulate such developments without direct subsidy.

Pooling

One method of encouraging and assisting experimentation with coverage of the aged would be to create a mechanism for two or more carriers to pool their accumulated experience, specialized personnel and other resources to experiment with improved methods of coverage. Existing antitrust laws constitute an obstacle to such joint action on the part of private carriers otherwise in competition with each other. Legislation has been proposed in the past to permit agreements among private carriers to take collective action under specified conditions. Such voluntary pools could facilitate the development and testing of new and broadened types of insurance for the aged. They would not, however, meet the problem of the financial barriers to purchase of insurance by the aged.

Reinsurance

A Federal program to reinsure health insurance carriers against abnormal losses has also been proposed as a method of strengthening and improving voluntary health insurance. Some of these proposals have been designed to emphasize experimentation with coverage for the aged. All proposals of this type have contemplated that the Government would make an initial advance to get such a fund underway, that the cost of the reinsurance would be paid by the participating carriers, and that the fund would ultimately be self-supporting. Participation would be entirely voluntary on the part of individual carriers.

As in the case of pooling arrangements, reinsurance per se would not improve the ability of low income persons to purchase health insurance. Rather, it would help protect carriers against losses incurred through experimentation with new and improved types of coverage.

Regulation

There has been considerable interest in a number of States in the possibility of bringing about improvements in voluntary health insurance through regulation of the form that policies may take (*1*). Requirements that policies be noncancelable, except for nonpayment of premiums, have been considered in a number of States, and similar requirements with respect to insurance sold interstate have been included in bills introduced in Congress. There has also been some interest in legislation requiring that insurance carriers accept impaired risks and all persons regardless of age. None of the proposals deals with the problems of the effect of such requirements on the size of the premiums or on the marketability of the policies.

Regulation of insurance has been established as a State function. In view of the problems of interstate competition and other difficulties, it seems unlikely that there will be very rapid action along these lines in many States.

Voluntary checkoff of premiums

Another type of proposal would have the Government operate a check-off system, similar to a payroll deduction, on a voluntary basis for persons receiving OASDI cash benefits. Beneficiaries could authorize the SSA to deduct from their monthly checks the amount of the premium for a private hospital insurance policy. A single policy might be developed that would be designed to meet the needs of the majority of beneficiaries, or there could be several different policies from among which beneficiaries could choose. In either case, since participation would be voluntary and the entire cost would be borne by the beneficiary group, there is no reason for thinking that the premiums could be much lower than those now charged by group plans covering the aged.

To illustrate the difficulties that would face such a plan, it may be noted that one of the newest group policies available to aged persons provides benefits of $10 a day for up to 31 days of hospital care per illness, 50 percent of hospital extras for a maximum payment of $125 (50 percent of $250), and surgical care with a $200 maximum fee schedule, for an annual premium of $72. The benefits under the policy would on the average cover less than a fourth, probably less than a

fifth, of the total medical costs an aged person might expect to incur. The premium, however, would represent more than 7 percent of a $1,000 a year income, and the premium for a couple more than 7 percent of a $2,000 a year income. In 1957 almost half of the nonmarried beneficiaries had incomes of less than $1,000, and more than two-fifths of the couples had less than $2,000.

Subsidy of premium payments

A variant of the premium checkoff proposal would have the Government subsidize the cost of health insurance bought by OASDI beneficiaries through a matching payment for amounts deducted from the monthly benefit, thus reducing the premium charge carried directly by the beneficiary. If the purchase of insurance was voluntary, such matching payments would presumably come from general revenues. Unless the subsidy represented a substantial portion of the premium, it is probable that not many more beneficiaries would participate in the plan than in a voluntary checkoff without subsidy.

A compulsory checkoff, which has also been suggested, would raise serious questions as to the adequacy of the reduced cash benefit and the justification for such a policy. A compulsory checkoff accompanied by an equivalent increase in benefit amounts—in other words, a 100 percent subsidy of the premium charge—would hardly seem feasible unless a single type of policy were prescribed. If the benefit specifications were legislatively determined, the plan would forego all the advantages of flexibility and individual choice that are among the major arguments for private insurance. The arrangement would become somewhat similar to one of the alternatives discussed in chapter V—purchase of hospital insurance from private insurance companies by the OASDI trust fund—although with perhaps less public control over the costs of the program.

Costs

The proposals relating to pooling, reinsurance, or regulation would involve no significant cost to the Government. A voluntary checkoff plan would involve relatively small but not insignificant administrative costs for the OASDI system. A subsidy of all or part of the premiums could involve costs ranging from relatively small amounts up to amounts equal to or more than those estimated for hospital benefits provided through the OASDI mechanism (i.e., upwards of $900 million in an early year).

Subsidies to Private Carriers

The difficulties of providing hospitalization and health insurance coverage for the aged stem primarily from the fact that they require above-average amounts of care and in general have below-average incomes. Any large expansion of protection for the aged thus seems unlikely without some way of covering the costs by spreading them over other segments of the population and throughout the lifetime of the individual. Voluntary insurance has succeeded in doing this to a limited extent through community-rated premiums and inclusion of the retired aged in employed groups. There is a question, however, of how far voluntary effort and private industry can go in developing the kind of distribution of costs that would be needed to assure adequate protection to all or the great majority of the aged.

One proposal that has been made in the past is that the Government should provide subsidies to private insurance carriers to absorb the excess cost of above-average risks and also to pay part of the premium for persons with low income. Under this arrangement, voluntary insurance would continue to offer policies with varying benefit and premium provisions, with a Government subsidy coming into play when the policy covered aged persons, disabled persons or other above-average risks and when it was bought by families with incomes below specified amounts.

The major bills that have embodied this type of plan have called for Federal grants to the States, with State administration and with the actual scope of the plan varying locally. Of the various proposals of this type, the Flanders-Ives bill was developed in the most detail and is used here for illustrative purposes. (See also appendix B.)

Under this approach subscribers to nonprofit plans would pay charges scaled to their incomes, with Federal-State money making up the difference between these charges and the particular plan's "reasonable cost" of providing the services to its beneficiaries. In order to determine the actual percentage of income that the subscribers would pay for any specific policy, the legislative proposal set forth a "yardstick." This yardstick was in the form of a rather complete package of personal health services for which the subscriber would pay 3 percent of his adjusted gross income up to $5,000. Beyond this income level, the subsidy did not apply.

The yardstick pricing was recognized as pragmatic, with the particular percentage chosen for the purpose of not being too high—"people would not subscribe"—or too low—"the voluntary character of the program would be vitiated." The benefits which a particular plan guaranteed to provide, through a contract between the plan and the regional health authority, were to be compared with this yardstick in order to set the actual percentage of income that the subscriber would pay. The reasonable cost of this particular package was then to be determined on the basis of established cost norms in order to arrive at the amount of the public subsidy.

In relation to the yardstick proposed by the bill, it was roughly estimated that the proportion of the cost that would be met by Federal-State funds would be 25–35 percent of the total. This ratio does not serve, however, as a basis for estimating the proportion of subsidization that might be required under a proposal covering only the aged or limited to beneficiaries of OASDI, and relating only to hospitalization insurance.

Whatever the benefit provisions contemplated under such an approach, it would be necessary to establish some kind of cost-norm or basic premium structure that would apply to all participating plans. And even though the proposal for Federal or Federal-State subsidization were limited to high-risk or low-income groups, such norms would need to apply to all policies in order to assure that there would not be a loading of costs on subsidized policies.

When such requirements are recognized and spelled out in detail, it becomes apparent that the degree of regulation of voluntary health insurance that would be involved would probably be unacceptable and that such a program would be complicated and costly to administer. Subsidy of private insurance without reasonable requirements as to

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who are primarily dependent on public assistance) could afford to pay 2 percent of their incomes for reasonably adequate hospital benefits. (On the average, low income families spend 6 to 7 percent of their incomes for all medical care.)

In 1957, about 80 percent of persons aged 65 and over reported total money income of less than $2,000. The 2 percent of income that the entire group might pay for hospital insurance could be estimated to amount to $20 per person per year. In relation to the hypothetical premium cost of $72 suggested above, this would mean a subsidy of $52 per aged person who obtained insurance.

The subsidy in 1960 would amount to at least $520 million if such insurance were purchased by virtually all of the 10 million aged estimated to have incomes under $2,000 and not primarily dependent on old-age assistance. If three-fourths of those to whom the subsidy was available insured themselves, the total cost to the Government would be about $390 million.

Other variations could be assumed—for example, the subsidization of costs above a specified percentage of income for persons with incomes below $2,000 (or some lower amount) coupled with subsidization of only the "excess cost" for aged persons with higher incomes—and the range of possible costs to the Government would vary accordingly.

If the program were handled on a Federal-State basis, with the States expected to pick up a substantial share of the subsidy, total Government costs could be expected to be less than indicated in these examples since the requirement of State financing would presumably be accompanied by some flexibility as to the level of the subsidy.

Federal Assistance to the Medically Indigent

Tax revenues of Federal, State, and local governments are now used to pay all or part of the cost of hospital and other medical care for needy persons. (See ch. IV.) Such direct support might be increased, both through an expansion of the medical services provided under public assistance and through an extension of aid under a special program for the medically indigent with a somewhat more liberal test of need. A special program for the medically indigent would presumably operate through Federal matching grants to the States, and might be administered through either the State public welfare or health departments.

Under the present public assistance programs, the Federal Government will match State and local expenditure for medical care for persons who are receiving help towards the payment of medical costs only. The latter are persons whose income from other sources is sufficient to provide them with the food, shelter, and clothing included in the assistance standards, but who do not have money to meet necessary medical bills.

There is a large and indeterminate number of persons with income and resources somewhat above the existing levels of assistance standards who nevertheless have great difficulty in paying for medical care. To them a hospital stay or prolonged illness outside the hospital can mean the exhaustion of savings, heavy burdens on younger members of the family, and eventually the necessity of turning to public assist-

ance for the basic means of subsistence. Many of them have no real opportunity to purchase hospital or medical care insurance. For others, the premiums they would have to pay are beyond their means, particularly in view of the medical services that would not be covered by any insurance they can buy.

Various definitions of the medically indigent are possible and the definition chosen would in turn govern the cost of a specific proposal. Legislative proposals for the medically indigent which were introduced in the period 1946–49 were geared to families with relatively low incomes. For example, the Taft proposal of 1949 was thought of as one which might reach 20 percent—or possibly 25 percent—of all families. The Taft proposals were based on the premise that a large part of the medical bill for the needy was already being met through such devices as care in county hospitals, as well as free care by private physicians. The $300 million annually which was to be spent in Federal funds (and matched in State funds) was not to replace existing efforts, and the bill specifically provided that total contributions from the State and from local governments could not be less than their expenditures for medical services to the covered group prior to the initiation of the program. (See appendix B.)

No major proposal for a Federal-State program for the medically indigent has been put forward since 1949. This may be due, at least in part, to the fact that the 1950 Amendments to the Social Security Act provided for Federal sharing in the direct payments made by States to doctors, hospitals, or other persons furnishing medical care to assistance recipients in the four federally aided categories. In the subsequent period, there have been significant advances in State programs for medical care for public assistance recipients.

If all States had assistance standards as adequate as those now used in some States, a part of the problem of the medically indigent would be met. Under present programs, however, this would require not only additional State and local funds for medical care but substantially increased funds for cash assistance—a result of more liberal eligibility standards that would include persons who do not meet the more stringent tests of need. For this reason, it is not realistic to think of meeting the medical needs of all medically indigent persons—or of aged persons—through the existing public assistance programs.

A new program of assistance, specifically for medical expenses and with its own test of need, could take one of several alternative forms. A decision would have to be made as to whether the program would apply only to persons aged 65 and over or to medically indigent persons in all age groups.

A second issue would relate to the types of medical services to be paid for. If the Government were to provide funds to pay for medical services for individuals and families meeting some test of need, should this assistance extend only to the costs of hospital care? When a needs test is involved there are substantial reasons for covering all types of care. The test of need could well vary with the size of the medical costs involved. In other words, assistance could be extended to families of considerably higher income levels when large and continuing medical needs existed than when the family's medical costs were lower.

A basic question with regard to such a program would be whether there should be uniform nationwide standards as to the test of need and the medical services to be paid for. Even though the program were a Federal-State program, the offer of Federal financial assistance could relate to a specified list of services to be paid for and could specify the needs test to be used in determining eligibility for assistance. With Federal standards of this kind, the Federal aid might take the form of a grant sufficient to cover a high proportion of the cost of a minimum program, with the States required to provide the remainder and free to provide as much more as they wanted to achieve a more adequate program.

Alternatively, the special medical assistance program could be developed on the same principles as the existing Federal-State public assistance programs, with each State establishing its own test of need and determining the types of services for which it would pay.

A program with uniform nationwide standards as to coverage and need might specify also the standards to be met by hospitals and nursing homes and the basis for payments to them (e.g., full cost). If standards of need were left to the individual States, it is probable that they would also be responsible for standards as to relationships with hospitals or other providers of service.

Costs

The possible costs of a program of public assistance specifically for medical expense cannot be gaged except in relation to the broadest of assumptions as to standards used in determining medical indigency. Of all people 65 and over, three-fifths had no money income or less than $1,000 in 1957 and another fifth had between $1,000 and $2,000.

It is conceivable that three out of every four aged persons could prove need in relation to hospital costs (or at least those costs which exceeded any protection they might have through private health insurance). Thus, expenditures for hospital care for the aged under a program of medical assistance assuring uniform nationwide protection might be of the same order of magnitude as the costs of providing hospital insurance for aged OASDI beneficiaries—roughly $750 million in 1960 for persons aged 65 and over.

On the other hand, if a program of assistance for the medically indigent were developed on the same principles as the existing public assistance programs, with the definition of need left to the individual States, there would undoubtedly be considerable variation in standards from State to State. The size of existing State old-age assistance loads reflects great variations in assistance standards as well as in the extent of need.

There are few States which are now doing so nearly complete a job of providing medical care through old-age assistance that they might not have an equal number of aged persons who are medically indigent. In States that provide very little medical care through the old-age assistance program, much larger proportions of the aged could qualify as medically indigent under a program with a uniform definition of need. With the definition left to the States, however, it is doubtful that these gaps would be closed and much the same interstate variation might be expected to persist in a special assistance program.

For illustrative purposes, then, it might be assumed for the country as a whole that additional aged persons equal in number to those already receiving old-age assistance would have their hospital costs paid through a special assistance program. This would amount to some 2½ million persons. They could be expected to represent a high cost group since they would include persons who were medically indigent by virtue of serious illness and heavy medical expenses. If it were assumed that they would receive on the average 3 days, or alternatively 4 days, of hospital care per person per year, and if daily payments to hospitals were the same as those assumed for 1960 in the cost estimates in chapter V ($27 a day), total annual expenditures for hospital care would run in the neighborhood of $200 million or $270 million with the higher utilization.

These estimates are appropriate in relation to a benefit limited to 60 days of hospitalization in a year. Under an assistance program, such a limitation on the number of benefit days is less justifiable than under an insurance program. On the other hand, it is probable that average daily payments to hospitals under a Federal-State assistance program would be lower than those used in these calculations.

The costs of nursing homes care, if provided on a uniform national basis under a program for the medically indigent, would probably be of about the same magnitude as the costs suggested in chapter V for a broad nursing home benefit, although it is assumed that the lower of the two daily rates of payment to nursing homes used in that chapter is the one that would obtain under an assistance program. The range of annual costs for this kind of nursing home provision in 1960 might thus be in the neighborhood of $320 million to $520 million for persons aged 65 or over. For a program with standards set by the individual States, the costs would again be less.

All the costs cited above apply to a program of medical assistance for the aged only. If assistance were extended to other medically indigent persons or if all types of medical service and not only hospital and nursing home care were covered, the costs would be very much larger.

The proposals considered in this chapter thus run the gamut from almost no cost to the Federal Government to costs of many millions of dollars. The provisions suggested likewise range from those that would assist small or large segments of the aged with all or only a part of their medical costs. The great variation in the potential impact of these proposals illustrates the complexity of the problem with which this study has attempted to deal.

SOURCES

(*1*) Examples are the following bills introduced in the Senate of the State of New York in 1957 and 1958:

On January 22, 1957, S. Int. 551—No. 552 (re insuring preexisting conditions); S. Int. 624—Nos. 640, 2116 (re noncancelability); and S. Int. 623—No. 639 (re provision for conversion from group to nongroup insurance) were introduced.

On March 5, 1958, S. Int. 3648—Nos. 4161, 4383; S. Int. 3649—Nos. 4162, 4384 and S. Int. 3650—Nos. 4633, 4385 relating to conversion and cancellation were introduced. S. Int. 3647—Nos. 4160, 4382 of March 5, 1958, provided for clear printing on insurance contracts of the provisions relating to age limits, policy cancellation and renewal dates, grace periods and the like.

(*2*) U.S. Senate, 81st Congress, 1st session, "Hearings Before a Subcommittee of the Committee on Labor and Public Welfare on S. 1106, S. 1456, S. 1581, and S. 1679," part I, pages 165–166.

APPENDIXES

APPENDIX A

Estimated number of persons eligible for monthly benefits under the OASDI program, Jan. 1, 1960

[In thousands]

Type of beneficiary and age	Total	Men	Women
The aged	13,159	5,890	7,269
Persons aged 65 years and over	11,591	5,890	5,701
65 to 69 years	4,858	2,390	2,468
70 to 74 years	3,655	1,824	1,831
75 years and over	3,078	1,676	1,402
Persons 62 to 64 years	1,568	----	1,568
Disabled workers aged 50 to 64 years	430	----	----
Young survivors and dependents	2,625	----	----
Mothers:			
Widows and young wives of retired workers	640	----	----
Wives of disabled workers	85	----	----
Children: [1]			
Surviving children and children of retired workers	1,775	----	----
Children of disabled workers	125	----	----
Total	16,214	----	----

[1] Includes dependent disabled children aged 18 and over whose disability began before age 18.

Hospital utilization rates: Average days of general hospital care per person per year, used in developing cost estimates for hospitalization benefits for OASDI beneficiaries

OASDI beneficiary type	Hospitalization up to 60 days in a year		Hospitalization up to 30 days in a year	
	Low cost hospital factors	High cost hospital factors	Low cost hospital factors	High cost hospital factors
All aged [1]	2.3	2.8	2.0	2.3
Aged 65 and over [1]	2.4	3.0	2.1	2.4
Male:				
65 to 69	1.9	2.6	1.6	2.1
70 to 74	2.1	2.4	2.1	2.2
75 and over	3.4	4.6	2.8	3.4
Female:				
62 to 64	1.5	1.6	1.3	1.4
65 to 69	1.8	2.0	1.6	1.7
70 to 74	2.7	3.0	2.3	2.5
75 and over	3.3	4.1	2.7	3.1
Children	.4	.5	.3	.4
Mothers (young widows)	.8	1.0	.7	.9
Disabled	2.6	2.8	2.2	2.4

[1] Calculated from the age-sex specific utilization rates weighted by the estimated number eligible for OASDI as of January 1960. The long-range cost estimates use the age-sex specific rates applied to the estimated population in the specified years.

Summary of estimated 1960 costs of alternative programs [1] *(exclusive of costs of administration)*

Type of program	Number of persons protected (in millions)	Costs	
		Millions of dollars	Percent of taxable payroll
OASDI program:			
Hospital service benefits, 60 days:			
All OASDI beneficiary groups	16.2	895.4	0.427
Aged eligible persons (women 62+, men 65+) [2]	13.2	826.3	.395
Limited skilled nursing home benefit (aged and disabled)	13.6	14.0	.007
General nursing home benefit (aged and disabled)	13.6	363–885	.2–4
Subsidy to private carriers:			
Part of premium to offset excess hospital costs of aged:			
If three-fourths of all aged 65 or over participate	11.8	520	----
If one-half of all aged 65 or over participate	7.8	350	----
Part of premium for low income aged not on public assistance:			
All with incomes of less than $2,000	10.0	520	----
Three-fourths of those with incomes of less than $2,000	7.5	390	----
Federal assistance to medically indigent:			
Hospital care for persons aged 65 and over:			
Uniform Federal standards	11.6	750	----
Federal-State program, State standards	2.5	200–270	----
Nursing home care for persons aged 65 and over: Uniform Federal standards	11.6	320–520	----

[1] For basis of estimates see ch. V and VI.
[2] For comparison with programs relating only to persons aged 65 and over, the OASDI eligibles aged 65 and over number 11.6 million and hospital benefit costs for this group would be $762.8 million.

Estimated long-range costs of hospital service benefits for persons eligible for OASDI, as a percent of taxable payroll (low cost and high cost assumptions for hospital cost factors, intermediate cost assumptions for all other factors) for benefits up to 60 days in a year, by beneficiary type, selected years 1965–2050 [1]

Year	Hospitalization up to 60 days in a year			
	All beneficiary types	Aged [2]	Mothers and children [3]	Disabled workers and their dependents
	Low cost hospital factors			
1965	0.42	0.38	0.01	0.02
1970	.46	.42	.01	.03
1975	.49	.45	.01	.03
1980	.53	.49	.01	.03
1990	.59	.55	.01	.03
2000	.57	.54	.01	.03
2025	.68	.65	.01	.03
2050	.83	.78	.01	.03
Level premium cost [4]	.58	.54	.01	.03
	High cost hospital factors			
1965	0.53	0.48	0.02	0.03
1970	.58	.53	.02	.03
1975	.62	.57	.02	.03
1980	.67	.62	.02	.03
1990	.74	.70	.01	.03
2000	.73	.69	.01	.03
2025	.87	.83	.01	.04
2050	1.05	1.01	.01	.04
Level premium cost [4]	.74	.69	.01	.03

[1] Excludes administrative costs. Taxable earnings limit of $4,800 a year. For assumptions as to hospital cost factors see ch. v.
[2] Includes women aged 62–64.
[3] Survivor children and their mothers and children of retired workers and their mothers under age 62, including disabled children aged 18 and over whose disability began before age 18.
[4] At 3 percent interest.

Estimated long-range costs of hospital service benefits for persons eligible for OASDI, as a percent of taxable payroll (low cost and high cost assumptions for hospital cost factors, intermediate cost assumptions for all other factors) for benefits up to 30 days in a year, by beneficiary type, selected years 1965–2050 [1]

Year	Hospitalization up to 30 days in a year			
	All beneficiary types	Aged [2]	Mothers and children [3]	Disabled workers and their dependents
	Low cost hospital factors			
1965	0.36	0.33	0.01	0.02
1970	.39	.35	.01	.02
1975	.42	.38	.01	.03
1980	.45	.42	.01	.03
1990	.50	.47	.01	.02
2000	.49	.46	.01	.02
2025	.59	.55	.01	.03
2050	.70	.67	.01	.03
Level premium cost [4]	.49	.46	.01	.02
	High cost hospital factors			
1965	0.43	0.39	0.02	0.02
1970	.47	.43	.01	.03
1975	.50	.46	.01	.03
1980	.54	.50	.01	.03
1990	.60	.56	.01	.03
2000	.58	.55	.01	.03
2025	.70	.66	.01	.03
2050	.84	.80	.01	.03
Level premium cost [4]	.59	.55	.01	.03

[1] Excludes administrative costs. Taxable earnings limit of $4,800 a year. For assumptions as to hospital cost factors see ch. v.
[2] Includes women aged 62–64.
[3] Survivor children and their mothers and children of retired workers and their mothers under age 62, including disabled children aged 18 and over whose disability began before age 18.
[4] At 3 percent interest.

Derivation of Hospital Cost Factors for Long-Range Cost Estimates

The hospital utilization rates used and the method by which they were derived were described in chapter V. The per diem hospital cost figures used in the long-range cost estimates were $24 for the aged and disabled and $26 for younger eligibles. These figures are 14 percent above the estimated 1956 hospital per diem cost figures described in chapter V.

The actuarial cost estimates for the OASDI system are calculated on the assumption that earnings levels will remain stable into the future. The yearly costs expressed as a percent of taxable payroll that result from use of this hypothetical basis are identical with those that would result if benefit levels (and all elements entering into the determination of cash benefits, including the taxable earnings limit) were increased proportionately with any increase in earnings levels. In relation to the cost of hospital service benefits, this method of calculation allows for future increases in hospital costs equal to any increase in the general earnings level. The earnings level used in the most recent actuarial cost estimates is based on 1956 earnings. The assumed 14 percent increase above the 1956 level in the hospital per diem costs used in the long-range cost estimates represents the difference between the projected increase in hospital per diem costs and the projected increase in general earnings levels between 1956 and the early 1960's.

Appendix B

Major Legislative Proposals in Earlier Congresses

Over the years, many and varied proposals have been made for Federal legislation to provide health insurance, to stimulate the spread of voluntary health insurance, and to support State medical-care programs. This appendix summarizes the major proposals made in bills introduced in U.S. Congresses beginning with the late 1930's that are relevant to this study.

The summary is not limited to proposals specifically designed to provide insurance against the cost of hospitalization, or hospital and nursing home care, for the beneficiaries of old-age, survivors, and disability insurance. It is limited, however, to approaches that could be used for this purpose. It omits, therefore, proposals in which the primary basis for selecting the population group to be protected is not only unrelated to age but is one not likely to encompass many aged people. Thus excluded are such proposals as exemptions or credits on Federal income taxes for amounts paid as health insurance premiums, or special programs for farm families and agricultural migrants, and for temporarily unemployed persons. Also omitted, even though they may affect substantial numbers of aged persons, are proposals limited to public-assistance recipients.

Some proposals express their coverage in terms of "low-income families" or "medically indigent persons" wherever found in the total population. Most aged persons and other beneficiaries of the old-age, survivors, and disability insurance program could come within their scope, especially if broadly defined. These proposals are therefore included, along with proposals that are either specifically designed for all aged persons or for beneficiaries, or that have such comprehensive coverage that these groups are included.

This summary of proposals indicates those on which hearings have been held.

A. Reinsurance, pooling, and regulation

These proposals are designed to encourage the growth of voluntary health insurance without requiring any permanent form of Federal subsidy or tax. They therefore hold Federal subsidization to a minimum, involving only direct Federal expenditures for costs of administration and for sums needed to launch the proposed reinsurance corporation. They are intended to encourage expansion of the availability of voluntary insurance coverage (1) through legislation waiving the antitrust laws so as to permit insurance carriers to pool their resources in developing policies and methods for extending insurance to substandard health risks, (2) through Federal participation in the reinsurance, and (3) through Federal regulation of interstate insurance.

1. Reinsurance and pooling

Existing antitrust laws constitute a barrier to collective efforts of groups of private insurance carriers who might wish to pool their experience and technical know-how and their financial resources in

the development of new policies to cover unusual risks. Amendment of the antitrust laws has been suggested by the Secretary of Health, Education, and Welfare.

A bill whose purpose was "to encourage the extension and improvement of voluntary health prepayment plans or policies" was introduced in the 2d session of the 84th Congress. It authorizes the Secretary of Health, Education, and Welfare, after consultation with the Federal Trade Commission and approval by the Attorney General, to approve voluntary agreements between certain private insurance organizations to make available new or improved types of insurance coverage.[1]

While the population groups affected were not spelled out, proponents of the proposal believed carriers might be more willing to experiment with coverage of substandard risks such as the aged or those with disabling conditions if they were able to take collective action to develop such policies. Experiments in coverage of rural and low income families might also be undertaken.

Improvements in benefits could be tried, such as the sale of more noncancellable policies, extension of existing benefits, major medical expense policies, and the like.

No Federal funds were involved in this proposal. The insurance carriers would fix their own premiums.

The following congressional bills embodied this proposal:

Year	Congress	Session	Bill No.	Sponsors
1956	84th	2d	H.R. 12153	Priest.
1956	84th	2d	H.R. 12140	Thompson.
1956	84th	2d	S. 4172	Hill and Smith.
1957	85th	1st	H.R. 489	Thompson.
1957	85th	1st	S. 1750	Hill and Smith.
1957	85th	1st	H.R. 6506	Harris.
1957	85th	1st	H.R. 6507	Wolverton.

2. Federal Reinsurance Corporation

These proposals contemplate the formation of a federally operated reinsurance fund to which the Federal Government would make an initial contribution and to which insurance carriers would contribute a small percentage of their premium income. The fund would provide partial indemnification to the companies for extraordinary losses experienced under those health insurance contracts which were reinsured.

As first roughly outlined in a proposal made by Mr. Harold Stassen in 1950 the reinsurance fund would have repaid insurance carriers for a portion of any hospitalization claims exceeding a maximum such as $1,000 and for medical-surgical bills above a certain maximum. Bills actually introduced in Congress have taken three forms.

(*a*) *The 1950 Wolverton reinsurance proposal.*—Congressman Wolverton's proposal embodied the Stassen suggestions with some additional features. It contemplated a Federal Health Reinsurance Corporation. Nonprofit organizations could reinsure their health service contracts with this corporation for a premium if these contracts met

[1] Also the 1957 proposal applied only to nonprofit plans and to the smaller commercial companies (defined as companies paying out less than 1 percent of all health insurance benefits or having less than 0.5 percent of the assets of all health insurance companies and plans in the United States).

some specific criteria as to population groups covered and benefits offered. Separate funds to reinsure hospitalization and medical care were to be established. The reinsurance could be invoked and the corporation become liable for 66⅔ percent of each claim in excess of $1,000 for any 12-month period for any one individual.

Subscription charges for the contracts were to be related to subscribers' incomes, to encourage participation of low income families.

The benefits contemplated were as follows: Six months of hospital care per year with the subcriber himself to pay 5 percent or $1 a day whichever was less as coinsurance; 95 percent of physicians' charges in hospitalized cases; 12 visits with a doctor in his office or at home with the subscriber paying out-of-pocket 25 percent. The scale of charges to be paid by the insurer was to be fixed; the doctors were to agree not to make an additional charge of more than the 25 percent the subscriber was to pay directly. The plan did not cover the first visit to the doctor.

The sources of financing the reinsurance corporation proposed were $50 million from Federal general revenues divided equally into the hospital and the medical care funds, and 2 percent of gross premiums received for health service contracts.

The following bills embodied this proposal:

Year	Congress	Session	Bill No.	Sponsors
1950	81st	2d	H. R. 8746	Wolverton.
1954	83d	2d	H. R. 6949	Do.
1955	84th	1st	H. R. 400	Do.
1955	84th	1st	H. R. 401	Do.

(*b*) *The 1954 administration proposal.*—The administration's proposal for reinsurance departed from the earlier concept of repaying insurance carriers a portion of an individual's large claims and dealt with a carrier's average losses which resulted when the plan paid out more than it received in premiums. Both nonprofit and commercial insurance companies could participate.

Encouragement of underwriting major medical expense was anticipated as well as broadening of basic benefits, noncancelable insurance, etc. The 1954 proposal would have established a reinsurance fund which would pay 75 percent of a plan's losses on reinsured contracts that exceeded the premium income of the contracts less 87.5 percent of the administrative expenses predetermined for the contract. The Federal Government would lend the fund $25 million which would eventually be refunded from reinsurance premiums. Premiums of unspecified size (but 2 percent of reinsured premium income was discussed) would be paid by the carriers to the fund.

The 1954 administration proposal was introduced in the following bills:

Year	Congress	Session	Bill No.	Sponsors
1954	83d	2d	H.R. 8356	Wolverton.
1954	83d	2d	S. 3114	Ives, Flanders, Purtell, Cooper, Upton, Ferguson, Bush, and Saltonstall.
1955	84th	1st	H.R. 2533	Wolverton.

There were hearings on H.R. 8356 in March, April, and May 1954 and on S. 3114 in April 1954. The House Committee on Interstate and Foreign Commerce reported out H.R. 8356, but it failed to carry and was referred back to the committee, which took no further action.

(*c*) *The 1955 administration proposal.*—A revised version of the reinsurance proposal of the 83d Congress was included as title I of an omnibus health bill introduced in 1955. The reinsurance fund was divided into four parts and each separate fund was to receive an initial $25 million in Federal money to launch it. The four funds dealt with: (1) plans for low and average income families, (2) major medical expense contracts, (3) plans specifically designed for rural areas, and (4) certain other plans.

Other features, including the terms of the reinsurance premiums and the claims formula, were the same as in the earlier administration proposal.

A type of contract providing a wide range of benefits but with coinsurance features was included for low income families.

Under the 1955 proposal, the Federal Government would contribute up to $100 million which would eventually be paid back. Participating insurance companies were to pay the fund an unspecified percentage of their premium income as reinsurance premiums.

The following bills embodied the proposal:

Year	Congress	Session	Bill No.	Title or part of bill	Sponsor
1955	84th	1st	H.R. 3458	Title I	Priest.
1955	84th	1st	H.R. 3720	do	Wolverton.
1955	84th	1st	S. 886	do	Smith and others.
1957	85th	1st	S. 1750		Hill and Smith.
1957	85th	1st	H.R. 6506		Harris.
1957	85th	1st	H.R. 6507		Wolverton.

3. Federal regulation

In 1956 and 1957 three bills were introduced in the House of Representatives whose purpose was to encourage improvements in available voluntary health insurance policies, and thus indirectly to promote the spread of such protection. The method proposed was to prohibit the issuance of health insurance policies which could be canceled after a stated period for any reason other than nonpayment of premiums. The prohibition would apply to insurers engaged in interstate business.

Though applicable both to group and individual policies, the prohibition would be most meaningful in relation to individually purchased policies. Such policies are frequently the only ones older persons, rural residents, widows and the self-employed can purchase.

(Bills of similar intent have been introduced into several State legislatures, notably New York and Oklahoma.)

Bills introduced in sessions of the U.S. Congress were as follows:

Year	Congress	Session	Bill No.	Sponsors
1956	84th	2d	H.R. 8216	Christopher.
1957	85th	1st	H.R. 116	Do.
1957	85th	1st	H.R. 5041	Rhodes.
1957	85th	1st	H.R. 7087	Christopher.

B. FEDERAL SUBSIDIES TO PRIVATE CARRIERS

In recognition of the problem to low-income groups, including the aged, of financing their own voluntary health insurance premiums, there have been a variety of proposals whose aim is to provide a form of Federal subsidy for either part of their premiums or the excessive cost of the care they will require, or both.

The purpose of these proposals is to make possible the inclusion under voluntary health insurance of groups inadequately represented in the existing enrollment without excessive financial burdens on those with low incomes and without either a differential premium on high cost risks or higher premium rates for the entire enrollment.

1. Flanders-Ives proposal

This proposal, incorporated in a series of bills introduced during the period 1949–55, would have built on existing nonprofit plans subsidizing them from Federal funds indirectly through State plans.

Among its more important features were (1) scaling of premiums to income; (2) encouragement of expansion of coverage and improvement in the scope of benefits by subsidizing premiums of low-income families and losses incurred from above average risks; (3) recognition of the fact that existing prepayment plans vary widely in the scope of the benefits they provide—the program was designed to be adaptable to the existing level of voluntary health insurance benefits; (4) costs reflecting local scales of payment to hospitals and providers of services; (5) State operation and control of the program; (6) development of health service areas.

The bill did not attempt to secure uniformity of prepaid protection throughout the Nation, or even within a given State, leaving the scope of benefits to be determined locally in relation to those locally available.

Any resident of a State having an approved State plan would be eligible for participation. Eligible persons could request payroll deductions for premiums. Premiums could be paid on behalf of welfare clients.

The bill spelled out a rather complete list of personal health services which might be provided including hospital room and board, services of physicians, dentists, nurses, and other auxiliary personnel, and related drugs, appliances, and ambulance service.

The regional health authority was to determine for its locality which of the benefits spelled out above might be included in contracts with prepayment plans in their local area. The regional health authority and each local prepayment plan would then enter into a contract for specific benefits selected from among these. The premiums established under these contracts were to be determined by the relationship of the benefits afforded to a so-called cost norm, priced to provide fairly complete coverage of physicians' services and 30 days of hospital care per person per year.

Financing the costs of the benefits agreed on would involve funds from three sources—subscriber premiums which would be related to family income as well as benefits insured; State and local subsidies to bring actual premium income up to an "allowed cost"; and Federal grants to the States, varying according to the State's per capita income,

to share one-third to three-fourths of the subsidies paid to the prepayment plans.

Under the Flanders-Ives proposal, the local prepayment plan could provide either service benefits or cash indemnification of the claimant.

The following bills embodied this proposal:

Year	Congress	Session	Bill No.	Sponsors
1949	81st	1st	S. 1970	Flanders and Ives.
1949	81st	1st	H.R. 4918 through H.R. 4924.	Case of New Jersey, Fulton, Hale, Herter, Javits, Morton, and Nixon.
1949	81st	1st	H.R. 5087	Auchincloss.
1951	82d	1st	H.R. 146	Do.
1953	83d	1st	S. 1153	Flanders and Ives.
1953	83d	1st	H.R. 3582	Hale.
1953	83d	1st	H.R. 3586	Javits.
1953	83d	1st	H.R. 4128	Scott.
1955	84th	1st	S. 434	Case of New Jersey, Flanders, and Ives.
1955	84th	1st	H.R. 481	Scott.

Hearings held in June 1949 included testimony on S. 1970; hearings were held on H.R. 4918 and other identical bills in July 1949.

2. Hill-Aiken proposal

These bills (1949–53) were intended to provide voluntary health insurance for persons unable to pay part or all of the usual premium. Each State was to establish a State agency which would administer the means test. It would collect the portion of the premium from persons able to pay part of the cost, and pay the insurance plan the entire premium with respect to all such insured persons. The State agency would reimburse the plan for payments made to hospitals, etc., for care of persons certified as eligible for State payment (i.e., unable to pay any of the cost).

The plan contemplated service benefits covering 60 days of hospital care per year; surgical, obstetrical and medical services in the hospital; and diagnostic and outpatient services in hospitals or diagnostic clinics.

Of the public outlays for low income groups paying none of their costs or only part of their premiums, the Federal Government would provide from one-third to three-fourths (depending on the State's financial ability) and States and localities would share equally the remainder.

It was specifically provided that persons eligible for State payment were to be issued "membership cards," indistinguishable from those of regular members.

This proposal was introduced in the following bills:

Year	Congress	Session	Bill No.	Sponsors
1949	81st	1st	S. 1456	Hill, O'Connor, Withers, Aiken, and Morse.
1951	82d	1st	S. 2171	Hill and Aiken.
1953	83d	1st	S. 93	Do.

Hearings were held on S. 1456 in May and June 1949.

C. FEDERAL GRANTS FOR STATE HEALTH PROGRAMS

Proposals for Federal grants to State-operated medical care programs lay out only broad outlines of the type of program envisaged, leaving to the States the specific provisions.

1. The Wagner proposal of 1939

The coverage of the Wagner proposal of 1939 was in terms of all persons included in benefits of those State plans approved by the Social Security Board "for extending and improving medical care"; persons living in rural areas and those in greatest need were specifically mentioned. Similarly, the benefits contemplated were to be determined by the States in plans approved by the Social Security Board and could include "all services and supplies necessary for the prevention, diagnosis, and treatment of illness and disability."

State funds were to be provided according to a variable matching formula, but no Federal matching was allowed for so much of the State expenditure as was in excess of $20 a year per individual eligible for medical care.

The method of paying the providers of services was left to the State.

This proposal was included in S. 1620 (76th Cong., 1st sess.) introduced by Senator Wagner in 1939. There were hearings on this bill in the period, April to July 1939.

2. The Capper bills (1939–41)

The Capper bills were designed to foster State programs of medical care for lower income workers with coverage, for most of them, on a compulsory basis. The population groups to be covered were to be determined by the State, with workers' contributions related to their income and with Federal financial participation limited to persons with lower earnings.

Minimum benefits to be provided in approved State plans were specified. Details differed in various versions of the proposal but, in general, these included general practitioners' services in the home, office, and hospital, most dental services, home nursing care, maternity care, and, if prescribed, hospital and specialists' and laboratory services and care.

Contributions would be made to a health insurance fund in each State by the Federal and State Governments, by compulsorily covered workers and their employers and by other workers requesting voluntary coverage. While details differed, each of the bills introduced by Senator Capper (S. 658 in 1939; S. 3660 in 1940; and S. 429 in 1941) provided that the amounts of workers' contributions would vary directly with their incomes, with compensating increases for the lowest income workers from either employer or State-Federal contributions.

The method of paying the providers of care would be determined by the States or by local areas within the States.

3. The Taft bills (1946–49)

Another proposal in which Federal grants would be used for State-operated programs was embodied in the Taft bills of 1946–49. In these proposals it was recognized that the State-operated programs might utilize voluntary health insurance in the provision of service.

The Taft proposals would have covered all those families and individuals in the State unable to pay the whole cost of needed medical and dental services.

Federal grants would be made to each State, on the basis of State population, to carry out surveys of existing medical, hospital, and dental services and to formulate "in detail" a 5-year plan for extending such services to persons unable to pay. The Federal share was to be matched by each State.

Federal matching grants for carrying out approved State plans would be made on a variable matching basis, varying between 33⅓ and 75 percent inversely with each State's per capita income.

Total contributions from the State and from local governments could not be less than their expenditures for medical services to the covered groups prior to initiating the program and not less than the difference between the Federal grant and the cost of the approved State plan. Contributions from private institutions were allowed.

Collection of part of the costs of services from those patients or their families able to pay part of such costs could be provided for in the State plan.

Each State might choose any one (or a combination) of several ways to provide and to pay for services to eligible recipients. Use of nonprofit prepayment plans as insurers or agents and the reimbursement of local governments and private, nonprofit organizations for services rendered to eligible recipients were mentioned.

This proposal was embodied in the following bills:

Year	Congress	Session	Bill No.	Sponsors
1946	79th	2d	S. 2143	Taft, Smith of New Jersey, and Ball.
1947	80th	1st	S. 545	Taft, Smith of New Jersey, Ball, and Donnell.
1949	81st	1st	S. 1581	Taft, Smith of New Jersey, and Donnell.

There were hearings on S. 545 in May, June, and July 1947 and January, February, May, and June 1948. Hearings on S. 1581 were held in May and June 1949.

4. The Lodge bills (1940–49)

This proposal restricted the subsidization to certain high-cost drugs and medical services and would not have covered hospitalization costs.

The population group affected was described in terms of "such persons as may require 'X-ray services, laboratory diagnostic services, respirators, and the drugs useful in treating or preventing the listed diseases' and such other infectious or chronic diseases as the Surgeon General may from time to time prescribe."

Federal grants to each State would constitute one-half of all funds spent under the State's plan. Conditions under which recipients would pay for part of these services, while not mentioned in the proposal, could presumably be specified in State plans and could include use of voluntary health insurance plans.

Senator Lodge introduced the proposal in 1940 (S. 3630), 1947 (S. 678), and 1949 (S. 1106). There were hearings on S. 678 in April 1948 and on S. 1106 in May and June 1949.

D. NATIONAL COMPULSORY INSURANCE WITH STATE OPERATION

A series of proposals for a national compulsory system of health benefits was introduced by Senators Wagner and Murray and Congressman Dingell during the period 1943–57. These proposals provided for the setting up of a separate account in the U.S. Treasury and for payments to this account computed as a percent of the taxable earnings of insured persons.

The compulsory coverage of the proposals included almost all employees and self-employed in private pursuits, Federal civilian employees and annuitants, and persons entitled to OASDI benefits, and their dependents. Groups not compulsorily covered, such as recipients of public assistance, the unemployed, and certain persons in temporary employment (and their dependents) could be insured for any periods for which payments were made by or for them or for which guarantees of payment were made by any local, State, or Federal agency.

The benefits proposed included almost all physicians', dental, and home nursing services; hospital services for periods up to 60 days per beneficiary per year; prescribed auxiliary services and appliances and usually expensive drugs. All benefits except general practitioner and dental services would be available only be referral or prescription.

Since the Wagner-Murray-Dingell proposal was introduced as a health rather than a tax measure, the exact methods of raising Federal revenues to finance the benefits were not specified in the bill itself. However, the bill was so drafted as to make it clear that revenues would come, in the main, from payroll taxes.

The proposals contemplated administration by the States as agents. Any State could assume responsibility for administering the specified benefits within its boundaries by submitting to the National Insurance Board a plan which complied with listed provisions in the bill. The National Insurance Board could itself administer the program in States without approved plans.

Federal authorities would divide funds among the States on the basis of population, availability of health resources, and differing costs of services in various areas. State administrative agencies would contract with providers of care and fix rates of payments for services; State agencies would pay providers' bills or might utilize local health region officials or nonprofit voluntary prepayment plans as agents for making such payments. Physicians would select the manner in which they would be reimbursed, whether by fee-for-service, capitation, or salary.

This proposal was included in the following bills:

Year	Congress	Session	Bill number	Sponsors
1943	78th	1st	S. 1161 [1]	Wagner and Murray.
1943	78th	1st	H.R. 2861 [1]	Dingell.
1945	79th	1st	H.R. 395	Do.
1945	79th	1st	S. 1050	Wagner and Murray.
1945	79th	1st	S. 1606	Do.
1945	79th	1st	H.R. 4730	Dingell.
1947	80th	1st	S. 1320	Wagner, Murray, Pepper, Chavez, Taylor, and McGrata.
1947	80th	1st	H.R. 3548	Dingell.
1947	80th	1st	H.R. 3579	Celler.
1949	81st	1st	S. 5	Wagner, Murray, Pepper, Chavez, Taylor, and McGrath.
1949	81st	1st	H.R. 345	Celler.
1949	81st	1st	H.R. 783	Dingell.
1949	81st	1st	S. 1679	Wagner, Murray, Pepper, Chavez, Taylor, McGrath, Thomas, and Humphrey.
1949	81st	1st	H.R. 4312	Biemiller.
1949	81st	1st	H.R. 4313	Dingell.
1950	81st	2d	H.R. 6766	Bosone.
1951	82d	1st	H.R. 27	Celler.
1951	82d	1st	H.R. 54	Dingell.
1953	83d	1st	H.R. 1817	Do.
1955	84th	1st	H.R. 95	Do.
1957	85th	1st	S. 844	Murray.
1957	85th	1st	H.R. 3764	Dingell.

[1] These 1943 bills called for Federal administration rather than through a State plan.

There were hearings on S. 1606 in April-July 1946; on S. 1320 in May-July 1947 and January, February, May, and June, 1948; on S. 1679 in May and June 1949; and on H.R. 4312 and H.R. 4313 in July 1949.

E. FEDERALLY OPERATED HEALTH INSURANCE

Various proposals have been made over the years for national health insurance operated by the Federal Government. These include a proposal for voluntary insurance, one which combines compulsory coverage for workers with low earnings with voluntary coverage for others, a proposal for compulsory hospital insurance for persons covered by old-age, survivors, and disability insurance and one for beneficiaries of that system.

1. National Voluntary Health Insurance

As proposed by Senator Hunt in 1950 in S. 2940 (81st Cong. 2d sess.), any individual who, with his dependents, had an annual income of $5,000 per year or less, who applied for the insurance, and who paid the prescribed premiums would be covered along with his dependents.

The benefits contemplated included medical, surgical, and dental services regardless of location; home nursing care; hospital care and related services for up to 60 days per person per year; such auxiliary

services as laboratory tests, X-ray, diagnosis or treatment, optometrists' services, appliances, unusually expensive drugs, and so forth.

The program would be administered by a National Health Insurance Board with the Surgeon General as chairman and four additional appointive members, within a proposed Cabinet-level Department of Health.

Insured persons would be free to select and change physicians, dentists, hospitals, and so forth.

It was proposed that a Personal Health Insurance Account be created in the U.S. Treasury. All premiums, as set by the National Health Insurance Board, would be paid into this account. Reserves in the account could be invested in the same manner as those of the Federal old-age and survivors trust fund. Congress was authorized to appropriate additional money to the account when needed to carry out the program. No participation by State or local governments or private organizations is indicated in this proposal.

Payments to the providers of medical care benefits were to be made directly from the personal health insurance account under regulations promulgated by the National Health Insurance Board.

2. National health insurance combining compulsory and voluntary coverage

In 1938, Congressman Treadway introduced this proposal in H.R. 9847 (75th Cong., 2d sess.). Compulsory coverage was proposed for almost all employees (including dependents) earning $1,800 per year or less (agricultural employees excepted), with voluntary coverage for all other persons.

The proposed benefits included almost all physicians' services; hospital services up to 10 consecutive weeks per illness per person; "necessary" drugs and laboratory and diagnostic services. Services for diagnosis and treatment of any disability or disease for which public care was available "free" or "at nominal charges" or for which some agency or other person was required to pay would not be included.

Each employee covered compulsorily would contribute 2 percent of his remuneration, but not less than 35 cents per week nor more than 70 cents per week or $36 per year. His employer would contribute 1 percent of such employee's remuneration, but not less than 20 cents per week nor more than 35 cents per week or $18 per year.

All voluntarily covered persons would make sufficient contributions, as determined by Federal authorities, to pay benefit and administrative costs for such persons.

Moneys would become part of a "health insurance fund" operated by a "Health Insurance Commission" set up as a public corporation to administer the plan.

The Commission could pay physicians on a salary, a capitation, or a fee-for-service basis, except that, if fees were paid, maximum amounts, based on the number of patients, would be set and fees prorated accordingly.

Workers in any industry having a private medical services insurance plan would be excepted from compulsory coverage if the private benefits were at least equal to those under the public plan.

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self-employed. The amount of the additional payroll tax would, of course, depend on the exact benefits proposed. The level premium cost of the Forand proposal for hospitalization, nursing home and surgical benefits was estimated at one-half of 1 percent of covered payrolls.

The earliest proposals contemplated that the program would utilize the States, and preferably the State public health agencies, as administrative agents. Only in a State which did not effect an agreement to administer the program would the overall administrative functions be performed federally. (Necessary regulations relating to the program in general and determinations as to an individual's insured status would, of course, be made at the Federal level.) As a result of the post-1952 development of national Blue Cross contracts and the implementation of Medicare, more recent proposals have contemplated national administration of the hospitalization benefits.

The following bills have embodied this proposal:

Year	Congress	Session	Bill Number	Sponsor
1952	82d	2d	S. 3001	Murray.
1952	82d	2d	H.R. 7484	Dingell.
1952	82d	2d	H.R. 7485	Celler.
1953	83d	1st	H.R. 8	Dingell.
1953	83d	1st	H.R. 390	Celler.
1953	83d	1st	S. 1966 [1]	Murray, Humphrey, and Lehman.
1955	84th	1st	H.R. 638	Celler.
1955	84th	1st	H.R. 2384	Dingell.
1956	84th	2d	H.R. 9868	Do.
1956	84th	2d	H.R. 9980	Metcalf.
1957	85th	1st	H.R. 1092	Celler.
1957	85th	1st	H.R. 4765	Dingell.
1957	85th	1st	H.R. 9448	Roberts.
1957	85th	1st	H.R. 9467 [2]	Forand.

[1] Includes provisions permitting States to extend hospitalization coverage to noninsured aged persons.
[2] Includes nursing home benefits and surgery.

Hearings before the House Committee on Ways and Means on all titles of the Social Security Act, in June 1958, included testimony on H.R. 9467.

Appendix C

From report of House Ways and Means Committee to accompany H.R. 13549, Social Security Act Amendments of 1958 (85th Cong., 2d sess., H. Rept. 2288, pp. 6 and 7):

Your committee is very much aware of the problems faced by the aged in paying for hospital services and nursing home services. A number of bills introduced in the 85th Congress would broaden the old-age, survivors, and disability insurance program to provide for payment of the cost of hospitalization and nursing home services for beneficiaries under this program. In the recent public hearings that your committee held on social security, a number of witnesses testified on these proposals.

There was considerable testimony to the effect that, under existing arrangements, insurance against the cost of needed hospital and nursing home services is out of reach of many older people. There appears to be a need for making this protection available to older people. Your committee believes, however, that more information on the practicability and the costs of providing this kind of protection through various methods should be available before it entertains

any recommendation for legislation on the subject. A study of alternative ways of providing insurance against the cost of hospital and nursing home care for old-age, survivors, and disability insurance beneficiaries should be made.

The alternatives explored should include among other proposals: A prepayment plan under which persons would, during their working years, pay additional social-security contributions which would be used to buy this type of insurance (to take effect when the individual becomes an old-age, survivors, and disability insurance beneficiary) from private and nonprofit health insurance organizations; other methods of providing insurance against the cost of hospital and nursing home care under title II; and any other method which offers reasonable prospects for protecting old-age, survivors, and disability insurance beneficiaries against the cost of needed hospital and nursing home care. The study would include, for each of the several alternatives, an evaluation of (1) cost of the benefits and (2) administrative implications.

Your committee has asked the Secretary of Health, Education, and Welfare to conduct such a study and to report the results on or before February 1, 1959. With the results of such a study available, the Congress will be in a better position to decide what legislative measures, if any, should then be taken to meet the problem.

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