UNITED STATES DEPARTMENT OF AGRICULTURE

THE FEDERAL MEDICARE PROGRAM

Talk by John Noble
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It is a pleasure to be here with you today to discuss the Federal medicare program -- past, present, and prospective.

The launching of Title XVIII -- popularly known as Medicare -- on July 1, 1966 was preceded by more man-hours of planning and implementation than any other peacetime operation in the history of our country.

One of the primary tasks of the Social Security Administration, of course, was to develop a wide range of policies and procedures to govern the operation of the program. In this process, we felt that we had an essential responsibility to insure that the continuing advice and counsel of the health community, the insurance industry, and other interested parties would be reflected.

Medicare's administration required that many new interrelationships be established by the Federal government with a variety of groups and organizations. These included State health and welfare agencies, the nation's hospital system, extended care facilities, home health agencies, independent laboratories, and some 250,000 practicing physicians.

Named as fiscal intermediaries were the Blue Cross Association with its 74 Blue Cross Plans, in addition to 11 commercial insurance companies and one independent insurer. Carriers selected include 33 Blue Shield Plans, 15 commercial insurance companies, an independent insurer, and a State agency. There are also 67 group practice prepayment plans which participate.

In very brief form, this will give you some idea of the depth and scope of the planning that went into Medicare before the first claim could be paid.

Let me turn now to some of the accomplishments of Medicare. We believe Medicare has gotten off to a very good start in its goal of financing high-quality medical care for our older citizens within the framework of the existing health care system. Medicare has proved that it can work within that framework -- and month by month the number of people that it has helped continues to mount. At the same time, the claims processing operation across the nation has improved rapidly from the standpoint of both speed and efficiency as carriers, beneficiaries, and physicians have become more familiar with the program.

I would like to discuss the status of Medicare in connection with the beneficiaries of the program -- those 19 million Americans age 65 and over who are covered under the hospital insurance part and the 17.7 million older citizens who have enrolled in the voluntary medical insurance part.

There is no question that Medicare already has served this age group to a substantial degree. During the first year, $2.5 billion was paid for hospital insurance benefits and an additional $669 million was paid for medical insurance benefits.

There were 5 million hospital admissions for inpatient care. When this figure is adjusted for readmissions, we would estimate that about 4.0 million beneficiaries received inpatient hospital services during the first year of Medicare. What is probably more significant than these numbers is the fact that many of these persons were receiving care for the first time as insured patients. Many who formerly would have been ward patients have a new status -- that of semiprivate patients who, if they wish, can have services performed by physicians of their own choice. And -- perhaps of equal importance -- many have gained a peace of mind which cannot be measured, in the knowledge that medical expenses will not result in serious depletion of savings or require heavy financial assistance from children.

In respect to medical care, carriers paid over 14 million bills for services performed by physicians, independent laboratories, and other providers of benefits. Of these, over 90 percent were for physicians' services. It should be noted that medical insurance under Medicare includes not only inhospital doctors' services, but also provides reimbursement for the cost of such services in the patient's home or the doctor's office.

These are, of course, the two major coverages under Medicare -- inpatient hospital services and physicians' services. It is difficult to measure, at this point, either the full impact of services that have already been received or the effect of the assurance that future necessary services will largely be paid for. For one thing, I think that more of the elderly will secure needed health services earlier in an illness than before, because the cost factor is no longer such an overriding consideration. I think this means that fewer of the elderly, in the future, will progress so far in the degenerative diseases before they receive medical attention, and that fewer will deteriorate into chronic care patients. We have talked so long about the importance of early medical care, and yet we have watched many of the elderly -- decade after decade -- receive medical care too late. I consider Medicare to be the beginning of the end of most such tragic events.

Medicare, of course, is not the full answer to this problem, but Medicare has placed the vast majority of the elderly in the position of being able to afford the care they need. As a group, they simply did not have that ability prior to Medicare. In all frankness, even though most physicians and the health community were willing to render free care, it cannot be ignored that

the patient also had to consent to charity. Pride is a widespread trait in the elderly and I think that many of our older citizens -- for that reason -- refrained from accepting charity care at the expense of their health.

In respect to services provided to beneficiaries by home health agencies, we received 228,000 "start of care" notices, about 70 percent under the medical insurance program and 30 percent under the hospital insurance program. During the year, 450,000 bills for home health services were paid.

From January 1, 1967, when the extended care benefit became effective, to June 30, there were 199,000 admissions to extended care facilities. In the six-month period, 330,000 bills for extended care services were paid.

These two types of benefits -- home health care and extended care -- exemplify the ways in which Medicare is stimulating the growth of new concepts in health care. It is true that these services have existed in the past in some communities, but they have often been underutilized despite their acknowledged medical merit. A major reason was that few private insurance programs included coverage for such benefits. Another reason was that neither level of service had received full recognition among the professional community prior to the present efforts being made to upgrade facilities, improve the professional status of their personnel, and bring to the attention of physicians the full scope of their services. We all recognize that there is a tremendous need for these services, because they are often better-suited, both medically and psychologically, to the health care requirements of patients at successive stages of illness. Moreover, they can play a major role in the future in relieving hospitals of the unnecessary burden of expanding staff and facilities to care for persons who do not need the intense, multi-faceted care that hospitals are designed and equipped to provide.

Of course, hospital services to outpatients are another important device for relieving pressure on inpatient facilities, and 1.2 million bills for outpatient hospital services were paid during the first year. Admittedly, this has been a complex and difficult benefit to administer because of some of the provisions written into the present law. However, certain legislative changes, we hope, will result in a simplified outpatient hospital benefit and a more manageable claims process in this area. I will discuss these and other possible legislative changes later.

Let me turn now to another aspect of the status of Medicare -- its status in respect to the health community.

I think it can fairly be said that Medicare has already had a profound influence on the general health community. Most dramatic has been the process of certifying facilities for participation and what it has accomplished. As you know, in order for a hospital, extended care facility, home health agency, or independent laboratory to participate in the program as a reimbursable provider of health services, it must meet conditions of participation designed to assure that the facility can render quality care, both in terms of its

physical environment and in the adequacy and professional qualifications of its staff. The conditions are set at a very high level, and the fact that they have been fully met -- or met substantially enough for temporary approval -- by 6,800 hospitals, over 4,000 extended care facilities, more than 1,800 home health agencies, and nearly 2,400 independent laboratories is a notable achievement. Let us look at one specific example. Until July 1, 1966, home health agencies in most communities furnished only visiting nurses' services. One of the conditions of participation for home health agencies was the requirement that they must provide at least one additional health service beyond visiting nurses' care. As a result, all of the 1,800 participating home health agencies -- virtually the entire number of such agencies in the nation -- now provide at least one additional service. Nearly two-thirds provide two or more services in addition to nursing care. It should be noted that this expanded capacity in the services of home health agencies is not restricted to Medicare beneficiaries; thus, this is a dramatic example of the important influence of Medicare on the nation's health care system. In one substantial step, the entire home health care area has been elevated to a far higher level of capacity to meet health needs of our citizens.

Let me give you another example -- utilization review. We usually think of utilization review as having a single purpose -- through review of long-stay cases, to assure that institutional care is not excessively utilized under the program when alternative levels of care are medically indicated. However, on a long-range basis, there may be an even more important result of this provision. In its sample review of all long-stay institutional cases under Medicare -- in analyzing admission patterns, lengths of stay and treatment modes by diagnostic or other classifications -- the utilization review function can in time produce a large body of valuable information which will make an important contribution to improvements in medical aspects of institutional care. It is the educational potential of such data -- maintained and used locally by the institution's own medical staff -- which deserves fully as much attention as the individual case review function of the utilization review committee. I am not implying that the advent of Medicare and utilization review were simultaneous; on the contrary, many hospitals had formal or informal utilization review committees prior to Medicare. Medicare's role, however, was to extend to all participating institutions the requirement that they establish formal review mechanisms to fulfill what is essentially a function of the organized staff. In this provision lies the firm assurance that patient care policies and practices will remain in the hands of the profession itself. While considerable latitude is permitted in the methods of utilization review, I think this is another dramatic example of how, with the advent of Medicare, a significant change took place in the entire health care system. And these kinds of changes, I think, are permanent landmarks.

Another very important relationship between Medicare and the health community lies in our reimbursement approach. We are statutorily committed to paying "reasonable costs" for institutional services and "reasonable charges" for physicians' services. The program did not have to take this direction.

If we were to have followed the usual pattern in the health insurance field, institutional reimbursement could have been based upon a fixed fee schedule, which is a common practice among many insurers. The program chose, however, to reimburse the health community at a level that would represent, as nearly as possible, the actual costs and the "going rate" of health services. That decision will have profound consequences for the health community, for other government programs which reimburse providers of health services, and for other third-party payers in the private insurance sector. The consequence that is intended, of course, is that if we pay a fair price for quality care, our beneficiaries will receive quality care. I should note that if the reimbursement principles we have adopted have the effect of inflating the price of care without elevating the quality of care, that would be a deplorable consequence, since it might curtail the great potential for the health community which lies within the principles we have adopted. I think it goes virtually without saying that the financial support that Medicare reimbursement will provide to the health community on a long-term predictable basis will go far in encouraging their own long-range planning for the improvement of their health care capacity.

Turning specifically to the physician sector, medical insurance under Medicare bases reimbursement for a physician's services on his customary charges and on prevailing charges within his area of practice. The reasonable charge approach, as opposed to fee schedules, is the more complex way for us but the fairer way from the standpoint of the physician. Through payment of reasonable charges, physicians will finally be assured of fair and equitable reimbursement for the many elderly patients who were treated on a reduced-fee or no-fee basis in the past. Under Medicare, there no longer is any reason why Medicare beneficiaries should not be charged a physician's usual and customary fee, nor is there any reason why they should not have the full status of all other paying patients.

I would like to call your attention to one other aspect of the Medicare program which, I believe, cannot fail to have a beneficial long-range effect on the medical care picture in this nation.

In addition to its contribution to the upgrading of care -- both on a short-range and long-range basis -- and its direct impact in assuring protection to the elderly against most of their health care costs, I think Medicare will have still another far-reaching consequence. That consequence will be its establishment of a standard, in relation to its broad spectrum of benefits, against which persons under age 65 will measure the adequacy of their own health insurance coverage. Medicare's incorporation of outpatient coverage, extended care, home health care, and physicians' home and office services into a single comprehensive package of protection will have a powerful influence in determining what the public will consider adequate health care coverage in the future -- and the direction which the delivery of services by the health community will be expected to take.

In closing, I would like to briefly outline some probably legislative changes which will affect Medicare.

1. A new optional method for payment of physicians' bills will permit payment to be made on the basis of an itemized, but unreceipted, bill in lieu of an assignment.

2. Outpatient hospital diagnostic services will be transferred from hospital insurance to medical insurance. Pathology and radiology services performed for hospital inpatients will be exempt from the deductible and coinsurance provisions of the medical insurance program.

3. Podiatrist's services will be covered, with the exception of routine foot care.

4. The initial certification requirement by physicians for hospital admissions and outpatient hospital services will be eliminated, except for admissions to psychiatric and tuberculosis institutions. Physician certification of extended-stay cases will be retained.

5. There will be an additional 30 days of coverage for inpatient hospital services in each spell of illness, bringing the total days to 120. The coinsurance for each of the 30 additional days will be one-half the inpatient hospital deductible.

6. The Secretary of Health, Education, and Welfare will be authorized to experiment in reimbursing a limited number of organizations and institutions on a basis other than that of reasonable costs. The purpose would be to increase the efficiency and economy of providing health services while maintaining quality of care.

7. An advisory council will be appointed next year to study the feasibility of providing health insurance protection for the disabled under Title XVIII, and will report its findings no later than January 1, 1969.

In this short discussion, I have tried to give you an overall picture of Medicare -- past, present, and prospective. I would like to emphasize one additional point.

I believe Medicare has already demonstrated that the Government and the health community can work together well in common recognition that our purposes and goals are not really in conflict. I think the law's administration has affirmed Medicare's basic reason for being -- to provide a financing mechanism for a broad spectrum of services without altering the primacy of the [illegible] medical judgment [illegible]

physician's medical judgment in medical matters. I think the health community is becoming increasingly reassured -- through our continuing dialogue with them and through the program's performance itself -- that we have no intention of encroaching on their professional relationships and every intention of reimbursing their services in the fairest and most equitable manner possible. I think, in the final analysis, this growing confidence and rapport between Government and the health community may be one of Medicare's most fundamental achievements.