PREVIEW OF THE SSA's STATISTICAL PROGRAM ON HEALTH CARE OF THE AGED

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Both statisticians and health care specialists can look forward with anticipation to the fund of data that will come from the new program of health insurance for the aged established by the 1965 Amendments to the Social Security Act. For many years, we have used what scraps of information were available to estimate the medical care needs, the hospital utilization, the medical expenditures and the aggregate resources devoted to health care of the aged population. By this time next year, we shall have not only a surer basis for estimate and a new situation that will make us struggle to interpret trend lines, but also the beginnings of an unprecedented volume and kind of information on the patterns of health care of aged individuals. I would stress the phrase patterns of health care, for the new program gives us a unique opportunity for measurement of individual by individual receipt of health services over a year or many years, from record data.

What I shall give you today is definitely a preview of the statistical program that will become possible as a result of HIB. It is a preview in that this is the first public summary of our research and statistical plans; a preview, also, in that we are in the early stages of planning. Furthermore, the SSA is still in the process of discussion and negotiation with potential administrative agents and carriers. The system or systems through which data will be generated are not yet fixed. We do, however, have sufficiently clear notions as to the kinds of data that will become available to sketch in a general picture.

First it might be well for me to describe briefly the major features of the health insurance program. As I am sure you all know, the so-called Medicare program establishes two related health insurance programs for aged persons. A basic plan (Part A) provides protection for all persons aged 65 and over against the costs of inpatient hospital care, post-hospital extended care services, post-hospital home health services, and outpatient hospital diagnostic services. These benefits are automatically available to OASDI and railroad retirement beneficiaries. The cost will be paid through a separate payroll tax and trust fund. Uninsured persons now aged 65 or over are also eligible for these benefits, with the cost paid from general revenues. An intensive effort is being made to register all such persons. This activity has already gotten under way and a major informational campaign will be carried on throughout the fall in an attempt to reach all old people.

I might say parenthetically that as statisticians we are looking forward with some curiosity to see what is the total count of aged under the program at the end of this campaign as compared with population estimates. We in SSA are also planning to use the opportunity to survey the characteristics of the uninsured group--particularly those under 70 or 75--to settle some questions about the nature of the gaps in OASDI coverage.

The second part of the health insurance program (Part B) is a voluntary plan providing payments for physicians and for other medical and health services not covered by the basic plan and financed through monthly premiums of $3 (until 1968, when the amount may go up) matched by an equal amount from the general revenues of the Federal Government. All aged persons are eligible to enroll in the plan and it is anticipated that between 80 and 95 percent will do so. The way was smoothed for social security beneficiaries by an increase in cash benefits amounting to at least $4 a month for a retired worker and $6 for a couple.

Benefits under both parts will become payable beginning July 1, 1966, except for post-hospital extended care benefits which start on January 1, 1967.

Not all medical services are covered under the program. Among the important omissions are drugs and dentistry. We shall be studying the effect of such omissions and the problems and costs involved in their coverage. But protection is also limited for types of services that are covered. The patient (or someone on his behalf) must pay the first $40 of hospital costs, and for days of care beyond 60 and up to the maximum of 90 in a spell of illness, he pays $10 a day. There is also a deductible of $20 for outpatient hospital diagnostic services received in each 20-day period--after which the program pays 80 percent of the charge. This deductible, however, counts as an expense under the supplementary medical insurance program, which pays 80 percent of the reasonable costs or charges for covered services above the first $50 in a calendar year. There is a lifetime limit of 190 days for inpatient psychiatric hospital services. And there is a limit of 100 days of post-hospital extended care services during any spell of illness, with the patient paying $5 a day after the 20th day.

If you are thinking that this a complicated program, you are right; but there is one more detail I want to add. A spell of illness, which sets the bounds on eligibility for hospital and post-hospital care, begins with the first day of hospitalization. It ends when the individual has been out of a hospital or extended care facility for 60 consecutive days. A person may be discharged and readmitted several times during a spell until he uses up his 90 days, but a new spell does not begin until he has been out for 60 days. The reason I mention this detail is that it means that for administrative reasons--to determine individual eligibility--we must know the total period of hospital or

institutional care, not just the covered period. As statisticians we are going to make use of this circumstance--that is to say we plan to get information at the time of hospital discharge even though this comes well after 90 days.

In the case of skilled nursing home or other extended care facilities the problem of collecting meaningful data is a bit more complicated. The average stay in such institutions is about two years and it may well be that we should be satisfied with current reports on covered days only and get information on uncovered days by special sample studies or daily census type inquiries. These latter studies might be carried out by some group or groups other than SSA.

This may be a good point at which to note that the DHEW has announced the assignment of specific operating functions under the 1965 Amendments to constituent units. The SSA is responsible for the general management and operation of the two health insurance programs. The Welfare Administration is responsible for standards for the State programs of medical assistance and for administration of the new project grants for health programs for school and pre-school children that were established by the 1965 Amendments. Both will work closely with the Public Health Service which is assigned principal responsibility for the professional aspects of the hospital and medical insurance programs.

Under the law, the Secretary is required to use State public health agencies or other appropriate State agencies in determining which hospitals and other institutional providers of service meet the standards and conditions for participation. The State agencies will resurvey all providers under Part A periodically. They may also provide consultation to providers of service to help them meet established standards.

In the administration of Part A benefits, the bill provides that associations or groups of providers of service (hospitals, extended care facilities, and home health agencies) may nominate certain organizations, public or private, to serve as intermediaries between them and the Federal Government. Individual providers may, however, elect to deal directly with the Secretary. Under the supplemental voluntary insurance plan, public agencies and private organizations will also act as administrative agents, but they will not be selected by the nomination process. Instead, the Secretary is required, to the extent possible, to enter into agreements with interested and qualified agencies and organizations which he believes are capable of doing the job.

Hospitals and other institutional providers of service are to be paid on a reasonable cost basis. The formula for determining reasonable cost will be worked out in consultation with providers and the Health Insurance Benefits Advisory Council. Since this Council has not yet been appointed, you will understand why I cannot now tell you in any detail just what information relating to hospital costs will become available. I might observe that the first day deductible of $40, like the premium for the Part B benefits, is fixed only through 1968. Thereafter the amount is determined each year by the Secretary in relation to changes in average per diem hospital costs. We shall certainly be watching closely the components of costs and variations among hospitals in this respect.

Payments to physicians will be made by carriers. The carrier is obligated to see that the charges of physicians (and other noninstitutional providers) are reasonable and not higher than charges for comparable services to the carrier's other policy holders or subscribers. In determining reasonable charges, the carriers will consider the customary charges for similar services generally made by the physician or other person or organization furnishing the covered services and also the prevailing charges in the locality for similar services. Payment by a carrier for physicians' services will be made on the basis of a receipted bill or an assignment under which the reasonable charge will be full charge for the service.

As I said at the outset, final decisions have not yet been reached as to the precise role to be played by the various administrative agents. It is clear, however, that there are strong administrative--as well as research and statistical--considerations pointing toward central record keeping. For Part A the most efficient system would appear to be one in which hospital admission and discharge reports for all aged persons (and similar reports from extended care facilities, hospital outpatient departments and home health agencies) flow directly to the SSA central record keeping and central computer facilities. No matter how frequently aged persons move or where they get their hospital care, it would thus be possible to maintain a current record of eligibility for additional services. For Part B benefits the problems are more complicated, but we are hopeful that information on covered services and payments can be incorporated in the master beneficiary utilization tape. Since the deductible for hospital outpatient services counts towards the deductible or coinsurance amounts under Part B, there is an administrative tie-in. More importantly, we are stressing the value for research purposes of the linkage of information on the hospital and medical services received by aged individuals. This value is recognized by those primarily concerned with the administration of the program, and by potential carriers and administrative agents with whom we have talked.

We anticipate, therefore, that we shall have the basis not only for cross-sectional analyses of hospital and health service utilization, but also for longitudinal studies of the patterns of covered services received by individuals from age 65 or the start of the program until death. In the case of hospital care, we should have almost complete reporting of all episodes. For the other services, we shall have in the records only those services for which the program pays at least in part. For example, there will be aged

persons who spend less than the deductible for physicians or other services covered under Part B and probably others who spend more than $50 in the year but fail to realize that they could get reimbursement. Neither the carriers nor SSA will know about these services and expenditures. It may seem somewhat niggling to mention the gaps when the data potentially available are so much more extensive than we have ever had before. I do it to keep some balance.

In addition to utilization data, the basic statistics will include data on costs and on charges--total and covered--and of course on characteristics of all covered persons and providers. The potentialities for combining these several kinds of information open new vistas for analysis and research.

We are currently in the midst of specifying the essential statistical input of the system, developing detailed tabulation plans for data that should be currently available, and beginning to outline some of the special studies that should be undertaken at an early date. For this audience it might be of interest if I mention some of the statistical problems we are now debating.

What population base should we use to derive annual utilization rates? The usual procedure is to use mid-year population figures, but in this age group where the death rate is high the use of a mid-year figure will distort the rates. An alternative we are exploring is to add monthly eligible population data and divide by 12 to obtain average person-years of exposure. This method may have particular advantages when one is dealing with subgroups of changing composition, such as public assistance recipients, or the population of geographic areas.

We are still discussing the desirable geographic detail. We have also recognized that for some purposes we shall want data by residence of the beneficiary and for others by location of the provider. Utilization rates, which represent the probability of persons in a given area being hospitalized (or receiving some other service) should use the population resident in an area as the base, with a breakdown between those receiving services in and outside the area. Studies concerned with the adequacy of existing facilities or the organization of health care will call for counts of the characteristics, including usual place of residence, of all aged persons served in a specified time period.

One troublesome problem has to do with information as to race. For analysis of utilization and patterns of care this is an item of obvious importance. Unfortunately in the past few years, SSA records have developed rather sizable gaps as a result of the fact that such information was not obtained for persons assigned social security account numbers under the Internal Revenue Service registration project. In the years up to 1961, about one-half percent of the social security numbers issued did not have the race item filled in on the social security account number application form. From April 1962 through March 1964, 29 percent of the 14 million numbers issued had race unreported. As a result we lack this information for at least 1.2 million persons now aged 65 and over. The SSA does not want to ask a question as to race in connection with applications for benefits, since the purpose could easily be misunderstood. The special Internal Revenue Service form is no longer in use, and the SSA is again asking for and tightening up on procedures to get the information on new account number applications. But the problem of correcting for past omissions is more difficult and we shall probably be able to solve it only in part.

There are obviously a great variety of special studies that will become possible and desirable once the Medicare program has been in operation for a year or two. Indeed, I am sure, we will be trying to answer certain kinds of questions after the first months, or even weeks. There will be special analyses relating to the program itself--utilization experience of different groups, where people receive services, various aspects of costs and financing under the program. There will be important methodological studies both before and after the program goes into operation. We are, for example, presently looking into the form which a system of classification of medical procedures might take. We shall be concerned with such problems as improved methods of reporting of deaths, improved classification systems for services, alternative sampling and analytical techniques for longitudinal studies, studies of the lag between receipt of services and the receipt of the bill. There will be a whole range of studies of the impact of the program on hospitals and the organization of medical services, on medical manpower and medical prices, on voluntary insurance, on the remaining medical expenditures of aged persons and on their levels of living and--tentatively, since no one really knows how to measure this--on the quality of medical care.

We shall be giving particular attention to the studies called for by Congress, specifically studies and recommendations concerning the adequacy of existing health personnel and facilities, forms of health care alternative to inpatient hospital care, and the effects of the deductibles and coinsurance provisions upon beneficiaries, persons who provide health services, and the financing of the program.

Many of these studies will be carried out by the SSA. For others, particularly those relating to medical manpower and facilities or the organization of medical services, primary responsibility will rest with the PHS. Studies of the services received by public assistance recipients will be of joint concern to SSA and the WA. And we hope to encourage and support special studies by research groups outside the government. There are many aspects of the impact of the program that can best be evaluated in local communities, and many special problems or issues

that should receive critical attention from statisticians and researchers in a variety of agencies.

What are we doing now to make possible valid before and after studies? We seriously considered the possibility of mounting a special survey of the medical expenditures of aged persons this coming January or February; but it was simply not possible to marshall the necessary manpower. We shall have to make do, therefore, with special tabulations and analyses of data collected in earlier surveys by the Health Information Foundation and by the SSA in its 1963 Survey of the Aged. One study we are planning involves tabulation of the first year's experience under the HIB program of the aged persons in our 1963 sample who survive through June 1967. Whether we will decide to resurvey this group to get additional current information on such matters as living arrangements, continuation of voluntary health insurance, etc., or to undertake a new cross-sectional sample survey after the HIB program has been in operation for a few years we have not yet decided.

There are, of course, other ongoing statistical series that will reflect the impact of the program. We have, for example, been talking with staff of the National Center for Health Statistics about the possibility of their expanding as early as next January their collection of information relating to health service utilization of aged persons, particularly physicians' services, and possibly also medical expenditures, in order to provide the basis for more adequate interpretation of later trend data.

As I warned you at the outset, this has necessarily been a very general preview of what statisticians can expect and look forward to having in the way of new data. In conclusion I would say simply that we who are directly involved are excited about the potentialities for statistical analysis and research in this new health insurance program. We are overwhelmed by the size of the job to be done between now and next July 1 and thereafter, but still hopeful that what proves feasible and realizable will not be too far from the ideal.