

REPORTS ON TOPICS OF CURRENT INTEREST

MEDICARE

I know you want to hear mostly about the prospects for the Medicare bill and its potential impact on private health insurance plans, but I thought it would be more sensible first to go over some of the provisions of the bill briefly so that we will all start from the same point.

The bill, which was passed by the House and is now before the Senate Finance Committee, is an omnibus bill covering a host of Social Security matters. It is entitled "Social Security Amendments of 1965" and is commonly referred to as the Mills Bill, or simply H.R. 6675. The provisions of most importance to private insurance plans can be considered under three headings, those relating to health insurance, the increases in cash benefits, and the disability amendments.

The health care provisions aptly referred to by members of the House Ways and Means Committee as the three-layer benefit cake are as follows.

The first part, the hospital insurance plan or the basic plan, is essentially the long-standing King-Anderson proposal. It is built primarily around a 60-day semiprivate benefit for bed care, with a \$40.00 deductible. It also provides diagnostic benefits in a hospital out-patient department prior to hospital confinement and two types of post-hospital benefits—namely services in extended care or nursing home facilities and home health services, both of which are intended to make it possible to substitute less expensive care for in-patient care during convalescence. The hospital insurance plan is to be financed as a part of the Social Security payroll tax.

The second layer of health insurance was completely unexpected and came about through the political pressures engendered by the Republican proposals and the opposition of the American Medical Association. Both tended to focus on the limited hospital only nature and, thus, inadequacy of the King-Anderson proposal for those who really need help with their medical care bills. The reaction of the Chairman, Mills, and the Ways and Means Committee was to broaden the administration's bill by the addition of a voluntary supplementary benefit plan. This is in the form of a major medical plan with a \$50 calendar year deductible and 80 per cent reimbursement thereafter. It covers principally physicians' services but also includes diagnostic tests, radiology, ambulance services, dress-

ings, home health services, and hospital care for mental conditions. The financing is to be different from that of the hospital benefits. A \$3-a-month premium is to be paid by each individual electing to be covered at his own option in much the same way as under a private plan; a matching amount is to be paid by the federal government from general revenues. The departure from payroll-tax financing in this way introduces a new element into Social Security funding, other than for assistance programs, which in turn may lead to greater reliance on general revenues to finance future liberalizations.

The third layer of health care protection is a proposed strengthening of the public assistance for the aged provisions of the earlier Kerr-Mills Bill. This is to be financed from general revenues, as are the hospital insurance benefits for those not under Social Security.

Coming now to the cash benefits, old-age and survivors and disability payments to those drawing benefits are to be raised by 7 per cent retroactively to January 1, 1965. In addition, the bill builds in sizable future increases, the extent of which can best be illustrated in terms of the maximum benefit allowance. The maximum monthly allowance for a single person is now \$127. This will go up proportionately with the 7 per cent change as of January 1, 1965, then to \$150 by reason of an increase in the maximum wage base proposed from \$4,800 to \$5,600 as of January 1, 1966, and to \$168 on January 1, 1971, through a further increase in the maximum wage base to \$6,600. Maximum family benefits are scheduled to increase in a similar way. Another new principle is involved here in that Congress has never before authorized such an automatic escalation of the wage base and corresponding old age and survivors and disability benefits.

The proposed disability amendments would liberalize the definition of disability and also reduce the elimination period for which benefits are not payable. The concept underlying the present definition was that of early retirement and complete withdrawal from the labor market because of disability of indefinite duration which could be expected to result in death. This is to be replaced by the less severe requirement that the nature of the disability be such as to bring about the inability to work at gainful employment.

At the same time the initial period of disability for which no benefits are payable would be reduced by one month from six and a half months on the average to five and a half months. If this passes, an overlap of benefits will be created with many existing temporary disability benefits plans, namely, those under which benefits are paid for 26 weeks or more.

To finance the expanded old-age and survivors and disability benefits

and the hospital insurance plan, Social Security taxes are to be increased substantially. As mentioned above, the maximum wage base is to be raised to \$5,600 in 1966 and then to \$6,600 in 1971. The contribution percentages schedules are also to be increased, with the ultimate employer/employee combined rate going from $9\frac{1}{4}$ per cent to 11.2 per cent of covered wages.

The maximum tax, employer and employee each, is \$174 at present. This will go up to \$244 in 1966 and in steps to an ultimate level of \$370 in 1987. By comparison, the present wage base and tax schedule develops a maximum employer and employee tax of \$199 in 1966 and \$222 in 1987.

The provisions of the bill with respect to the administration of the health care benefits are of interest. An intermediary between the government on the one hand and claimants and the providers of services on the other is contemplated for both the hospital insurance and voluntary supplementary plans. For the hospital insurance plan the providers are to designate a fiscal agent of their choosing, and it is assumed that for the most part the hospitals will select the Blue Cross for this role.

For the administration of the voluntary supplementary benefits the Secretary of Health, Education, and Welfare is to contract with existing carriers to the maximum extent possible. This leaves the way open for insurance companies and other health insurers to participate in carrying out the program. The arrangement, however, contemplates the provision of claims and related services for the government alone, entirely without the assumption of risk.

With this backdrop, we can now talk about the prospects for the bill and its likely impact on existing health care plans.

It seems certain that H.R. 6675 will pass possibly by early July, although the final bill may be modified by reason of the deliberations in the Senate. The voluntary supplementary plan now scheduled to become effective July 1, 1966, may be delayed, for example.

Supposing H.R. 6675 is adopted about as outlined, what will be its impact on private health insurance? We have made rough estimates of the portion of the total medical care bill for those over 65, which will be covered by the benefits proposed, and an analysis of the remaining uncovered expenses.

It appears that the basic hospital plan will pay for about 40 per cent of the aggregate medical bills of those age 65 and over and that the voluntary supplementary part will add another 20 per cent or so to the government's sphere of activity. In other words, under these two plans government will be assuming about 60 per cent of the cost of hospital and medical care for those 65 and over. Since it will be undesirable to

duplicate the federal benefits, possible future supplementation of coverage through private plans will be limited to the remaining 40 per cent.

The major areas of medical care in the uncovered 40 per cent and the proportions of the total cost represented by each are about as follows: Optional private room charges, i.e., where private-room accommodations are not medically necessary but are at the instance of the patient—2 per cent; hospital stays beyond 60 days—5 per cent; private duty nursing at home or in the hospital—7 per cent; prescribed drugs outside of the hospital—11 per cent; and, last, the value of the deductible and co-insurance provisions in the governmental plans—15 per cent.

More directly, the passage of Medicare will bring on a tremendous upheaval among health insurance plans of all kinds, insurance company policies and plans, Blue Cross-Blue Shield programs, the group practice plans, union welfare plans, and any other private programs. It may be helpful to consider separately the situation presented upon the enactment of Medicare, that during the period before the benefits actually become effective, and then what the longer future holds.

Considerable confusion and misunderstanding are likely on the enactment of Medicare. Despite the abundant publicity surrounding this question over so long a period, few people have much sense of what is contemplated or when it is likely to become effective. Consequently, the first problem will be that of communications. It will be most important to emphasize that Medicare cannot become effective for more than a year, before July 1, 1966, as presently proposed, and, therefore, that persons who have retirement health coverage should maintain it in force. What's more, those who do not have such benefits still have the same need to seek protection during the interim.

The second stage, the retooling necessary after enactment and before July 1, 1966, will be an enormous undertaking. Preliminary review shows that in most cases the nonduplication provisions in existing plans will not be sufficient to prevent overlap with the expected federal benefits. Hence practically all plans will require amendment.

The breakup of family coverage presents additional problems. A man age 65 or over will be eligible for the government benefits, whereas his wife, if she is under age 65, and any dependent children will not. In the reverse situation, the wife may be over 65 and eligible for the federal plans but her husband, if under 65, will not be. Premiums and employee contributions will call for modification to correspond with changes in the policy provisions. Exceptional problems are presented by individual lifetime guaranteed renewable policies which may not be changed unilaterally by the insurers.

What sort of benefit plans and policies are to be offered for sale in the future? This, too, is a more involved question for individual policies than the group plans.

I might mention that the Health Insurance Association of America hopes to be of help to its member companies in the resolution of these many transition problems. The Association has appointed a special *ad hoc* committee to study the impact of Medicare which will consider the problems of the various segments of the business, namely, individual policies, group insurance, mass enrolment plans and the State 65 plans.

Steps are also under way through the Association to alert the insurance commissioners to what they will have ahead of them in terms of the multiplicity of policy form submissions and related matters. It is likely that this subject will be broached to the commissioners at the forthcoming meeting of the NAIC in New York in June. A first approach of this kind was made at a zone meeting in Dallas several weeks ago which was reported to have been well received.

Turning now to the longer-range prospects and leaving aside speculation about whether or how soon Medicare may expand into other areas, it is clear that the new program will exercise a strong influence on private health insurance of all types as well as on the future provision of hospital and medical care in this country.

For one thing, the benefits are substantially broader than those which many policies and plans now provide for persons under 65. For instance, the benefits of the hospital insurance plan are at the semi-private level. Doctors' home, office, and hospital visits are included in the voluntary supplementary plan and the cost of doctors' services is expressed in terms of the physicians' reasonable and customary charges as opposed to a schedule of maximum allowances for the different procedures. Also, new coverages like nursing home protection and home health services are included.

These provisions will likely lead to the broadening of health plans for persons under 65. Perhaps, there will also be a trend to the adoption of the governmental benefit formulae for under 65 coverage in order to minimize differences from the coverage provided by government for those over 65 which would otherwise be apparent.

While the uncovered areas present underwriting problems, some supplementary private coverage over age 65 will be stimulated, particularly for the cost of drugs. This will be easier to do under group plans than individual policies.

Another major influence of the Medicare program will stem from the various cost and quality controls written into the bill. For example, a

hospital will be required to have a functioning utilization committee if it is to be eligible for reimbursement from the government for services rendered to those over 65. Comparable doctor review committees will be required in connection with the voluntary supplementary plan. In addition, a wealth of statistical information will likely be forthcoming in time against which to compare utilization, costs, and charges. These measures will undoubtedly spill over and have an important effect on the health care of those under 65. Hopefully, the introduction of the government as an overseer in this way will act as a restraining force on rising medical care costs generally.

Finally, a question of particular interest to insurance companies is the effect that Medicare may have on the competitive position of the Blue Cross organizations. Apart from their probable choice as the principal administrator for the hospital insurance plan, Blue Cross will be relieved of significant costs for benefits they are providing now for persons over 65. A Blue Cross spokesman stated recently that the reduction in premiums would of course vary from plan to plan and would average about 5 per cent nationwide.

On the other hand, the basis set forth in the Medicare bill for reimbursing hospitals comes closer to meeting the cost of all items in full than do some Blue Cross reimbursement formulas, which operate in certain areas to give sizable discounts to the Blue Cross plans. Pressure on these preferential pricing practices as they continue to apply to the care and insurance of those under 65 can be expected to follow from the new standard of hospital reimbursement established for Medicare. To the extent that this brings about more equal payment of hospital costs for Blue Cross subscribers under 65, some offset to the competitive advantage flowing from the reduction in Blue Cross premiums mentioned above will be produced.

These comments must be regarded as tentative since changes in H.R. 6675 will undoubtedly be made in the Senate.

MORTON D. MILLER

MR. GILBERT W. FITZHUGH: The hasty addition of the voluntary supplementary surgical and medical benefits plan to the Medicare package is a matter of concern to many persons in Washington. The proposed program was expanded in this way in the House Ways and Means Committee after only a few days of consideration and without public hearings in depth, by contrast with the long period of years during which the hospital insurance plan had been under study and discussion.

It seems to me this matter should be of concern to us more because of its future impact on the standards of medical care and the health and welfare of the people than because of its impact on our business, important as that is. It would seem advisable to defer action on the supplemental benefits until the matter can receive the careful study it deserves.

MR. CHARLES V. SCHALLER-KELLY: The Medicare proposals meet an important social need and should be supported; in fact the proposals of H.R. 6675 should be broadened to cover an even larger proportion of the hospital and medical bills for persons age 65 and over. There could be a more rounded discussion if the views of a spokesman for Blue Cross or a proponent of Medicare were presented in detail.

MR. GARY K. DROWN: The substantially higher employee Social Security tax rates and bases necessary to finance the expanded program may prove to be a significant burden in the future, even heavier than federal income taxes, assuming standard deduction, for a taxpayer with five or more dependents and earnings less than or equal to the Social Security tax base.

MR. JOHN S. MOYSE: The quality of health care in the United States may in time become impaired by reason of the government's undertaking of Medicare. Based on a personal experience while my wife and I were traveling in England, doctors in hospitals operating under the British National Health Service are able to spend little time with their patients because of the pressure of their work.

MR. ANDREW C. WEBSTER presented the report on American Academy of Actuaries previously presented at the New York Regional meeting by Henry F. Rood and reported in *TSA*, XVII, 81.

MR. HUDSON J. STOWE presented the report on Accreditation—Canadian Developments previously presented at the New York Regional meeting by E. Sydney Jackson and reported in *TSA*, XVII, 83.

MR. VICTOR E. HENNINGSSEN presented, as he did at the Denver Regional meeting, reported in *TSA*, XVI, 94, a summary of the discussions and considerations regarding the Proposed Rules Governing Valuation of Securities and Mandatory Securities Valuation Reserve, which have been under study by a Joint Committee of the American Life Convention and the Life Insurance Association of America.

MR. HENNINGSEN also summarized the memorandum submitted to the Treasury Department by the ALC-LIAA suggesting the immediate need for updating the table of Uniform One-Year Term Premiums set forth in Revenue Ruling 55-747 (PS 58) for determining reportable costs under individual life insurance policies used in pension plans and split-dollar plans.

MR. JOHN H. MILLER presented the report on Committee To Study Pension Plan Problems which he had previously presented at the New York Regional meeting, as reported in *TSA*, XVII, 85.