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DIGEST OF REPORTS ON TOPICS OF CURRENT INTEREST

RECENT DEVELOPMENTS IN HEALTH INSURANCE PROGRAMS IN THE UNITED STATES AND CANADA

MR. MORTON D. MILLER: In giving this report on United States Medicare, I am really pinch-hitting for Dan Pettengill, who has been a very prominent figure in the discussions that took place both before and after the bill was passed. Dan has taken a leadership role in connection with the efforts of the insurance companies to co-operate with the Social Security Administration in developing administrative rules and means of operating in connection with the law. He is greatly respected by Chairman Mills of the House Ways and Means Committee and is often called into consultation by the Social Security Administration. He is also chairman of the Medicare Committee that the insurance companies have set up to co-ordinate their own efforts in this area. I think that it is a great credit to him as an individual and to the Society as a whole that he has assumed so prominent a place in connection with a program of this magnitude.

Turning to Medicare itself, I think that we can say that it is working fairly well, considering the over-all magnitude of the program and the problems involved in getting something this large launched.

As the end of the first year of operation approaches, we can look back and recall that claims were rather slow in coming in following the kickoff on July 1, 1966. There was not the rush to hospitals that had been suggested would take place. Part B claims for payments to doctors were very slow to build up and did not start to occur in any magnitude until September. There were many reasons contributing to this, including the complexity of the program itself, the lack of understanding among beneficiaries and doctors as to what was expected of them, and general uncertainty about what to do. In many cases, we had incomplete or incorrect claim papers and had to return them for resubmission.

Some of this confusion had an effect on the carriers themselves. There was a rapid build-up of claims before the carriers were really ready to take care of them, and they fell a little behind. The carriers also had problems training new staff and working out the bugs in untried systems that had only been on the drawing board up to that point. Of course, they immediately took action to correct these problems, and I am happy to

say that the shakedown period is now at an end. Claims in the carriers' hands are at manageable levels, and many carriers are fully up to date. Further evidence that things are in fairly good shape is the fact that the Social Security Administration has just sent out the renewals of all the carrier contracts for another year.

However, experience to date has revealed certain basic administrative problems that arise from the structure of the law itself. This is perhaps not too surprising in view of the speed with which Part B was added to the basic, underlying hospital portion of the program. The Administration's bill—H.R. 5710—proposes several measures which should help improve administration in the future.

The most important concerns the problem of dual handling of payments to hospital-based physicians, that is, those physicians who carry on their practices within a hospital. The value of services performed by these doctors must be divided into two parts—an institutional part, representing services provided on behalf of the hospital (say, for the supervision of a radiology department), and a personal-service part (say, for reading a specific X-ray plate for a given patient). This problem runs through the whole administration of the plan and is compounded by the interrelationship of deductibles in the plan. We hope that the proposals will simplify this problem. I am glad to say that the carrier administrators took a positive position with respect to the proposals that were advanced.

I would like to add one more thought about program costs, which is a natural question in everybody's mind. I think that, if you have seen the newspaper account of the testimony with respect to H.R. 5710, you will realize that there is a great deal of concern in many quarters in Washington about what the ultimate cost of this program will be. The early indications seem to be that there is more hospital confinement than was anticipated, although, on the counter side, the full effect of extended-care nursing-home-facilities coverage, which began January 1, has not been felt. The designers of the bill hoped that this would feed some patients out of the hospital into less costly nursing-home facilities. We do not know yet whether that is going to take place.

In any event, the cost of the program will be affected by the general rise in hospital costs. The government insurance plan is no more immune to that kind of cost inflation than we are in the private-plan area.

The hospitals continue to be unhappy about the basis of reimbursement of their charges promulgated by the Social Security Administration. This matter is not fully closed, since the Social Security Administration has agreed to consider some improved basis after the year is closed and actual information about hospital costs is available.

It is still too soon to get a clear idea of how Plan B–financing is working out. Perhaps by the end of the year it will be a bit clearer whether the $6 a month that is budgeted for Part B will cover the cost of that part of the program.

I would like to call your attention to the fact that Medicare statistics are being collected. Recent issues of the *Social Security Bulletin*, published monthly by the Social Security Administration, have described the basic statistical program and have given some early data from a sample of claims for doctors' services. Future articles in this *Bulletin* will be interesting to watch, not only for information about Medicare but also for those things that are of interest to our business as a whole.

MR. WILLIAM H. BURLING: This is a continuation of the report on Canadian Medicare prepared by Mr. G. N. Watson and presented at the Spring Regional Meetings in 1966.

The meeting of provincial premiers that was to have been held in June of 1966 was postponed, and a bill was introduced into parliament on July 12 embodying the previously announced federal requirements that Medicare benefits provided by a province would be subsidized from the federal treasury if they were "comprehensive," "portable," "universal," and "administered by a government agency." An effort was made by the Canadian Medical Association to have the subsidy from the federal treasury concentrated on those with low taxable incomes or who were otherwise unable to secure insurance, but their plea was summarily dismissed. The only amendment to the bill made as a result of representations from bodies outside the legislature was one to make it possible for the federal treasury to share the costs of Medicare other than services of M.D.'s.

If newspaper reports are to be believed, there was nevertheless a debate in the cabinet itself, with threats to resign from Mr. MacEachen, the Minister of National Health and Welfare and the sponsor of the bill, if the government retreated to the more modest beginning advocated by the medical profession and businessmen, including the health insurance industry. The simple upshot was a postponement of the "contribution commencement date" to a date later than July 1, 1967, but not later than July 1, 1968. This was announced by the Minister of Finance as a device desired by him to help slow down "inflation." The bill received royal assent in mid-December, 1966, as C-227. Actuaries unfamiliar with the structure of government and political parties in Canada should realize that this bill did not, in itself, bring Medicare into being. The responsibility in Canada for health services belongs clearly in the jurisdiction of the

various separate provinces, and the relationship between a Canadian province and the federal government contains more of an element of independence than does the relationship between a United States state and the federal government. Nation-wide agreement is usually secured by thrashing out differences at conferences of provincial premiers (or provincial ministers responsible for the areas affected) called by the Premier (or corresponding Minister) of Canada. Bill C-227 merely says that "a contribution is payable by Canada to each province . . . in respect of the cost of insured services incurred by the province . . . pursuant to a medical care insurance plan of the province . . . that . . . satisfies the following criteria."

The federal act offers a carrot (an amount then estimated at $35 each year for each person—man, woman, or child in the province) and a goad (the residents of the province must pay the federal tax from which the "contribution" comes, even if the province does not qualify its Medicare plan). The next step was for each province to prepare the posture that it wanted to adopt at the anticipated meeting of all the provinces with "Ottawa." There was room for wide variation in posture because the bill—whether by design or not—is not crystal clear.

In the Maritimes, the governments were content to mark time "studying" the subject and hoping for a system which would help them as "poor" provinces. Quebec also has a commission studying the matter and, in its relations with the federal government in Ottawa, has restricted itself to affirming that it should receive a lump-sum grant with no strings attached. Saskatchewan, which has a law meeting all of Ottawa's criteria, is sitting tight and hoping to recoup half its outlay from the federal treasury. Manitoba has been served for many years by the doctor-sponsored Manitoba Medical Service, which effectively prevented any serious competition by charging rates so low that, for a long period, it had to "discount" its payments to doctors to 75 per cent or so of the fee schedule. The government currently has a bill sitting in the legislature under which it would take over control of Manitoba Medical Service and make it the "public authority" required of Bill C-227. British Columbia already had a government agency selling Medicare to residents and providing for subsidies to those with low taxable incomes when Bill C-227 was passed. No attempt had been made, however, to interfere with the very strong doctor-sponsored plan (Medical Services Association) or with any group insurance written by commercial carriers. In March, 1967, a bill was passed "to establish a Medical Services Commission" to provide the "public authority" demanded by Bill C-227. The

act can now be made effective by the government at will by having it "proclaimed."

Alberta has so far been the lone public proponent of individual responsibility and a multicarrier system with competition and, in order to strengthen its arguments vis-à-vis Ottawa, went ahead with the improvement in its plan outlined last year by Mr. Watson. With no other province following its lead, Alberta too finally decided that it needed a "public authority" and also needed to assume direct responsibility for the subsidized residents. Bill No. 88 was passed in early April, to be effective July 1, 1967. Many of the limitations on payment for medical services in the present Alberta Medical Plan are removed. The "basic benefits" are made wider, notably to include some optometric services, and the extended benefits are completely revised with "deductibles" eliminated. The bill also distinctly spells out the powers of the public authority to use "agents"—presumably the very strong doctor-sponsored plan and the commercial carriers. Ontario went ahead with the plan described last year by Mr. Watson and, in the budget debate this year, the Ontario Minister of Health reported that the plan covered 1,820,000 residents under 700,000 contracts, of which 525,000 were fully subsidized. These figures included some 400,000 fully subsidized contracts covering "welfare" patients.

The long-awaited federal-provincial conference was called for April 17–18 in Ottawa, but it is too early as yet to assess the outcome. Everything hinges on the position that Ontario will adopt, since the federal government needs Ontario in its plan if it is to claim victory. Ontario cannot afford to be too coy, however, because the "goad" in Bill C-227 is a very strong weapon—almost a bludgeon.

The laws in all provinces will probably be adjusted when the Ontario-Ottawa negotiations are completed. The chances are that private carriers will be offered an opportunity to participate in some provinces by administering the "official" provincial benefits as an agent of the provincial public authority on a nonprofit basis.