THE FIRST 100 days OF MEDICARE

Under Secretary WILBUR J. COHEN

SINCE 1963 we have witnessed a significant array of health measures passed by the Congress. More health legislation has been passed in the past 2 years than ever before in the nation's history. This legislation covers a broad spectrum of our health needs—from increased nursing home construction to community mental health centers, from training professional health workers to research facilities for the mentally retarded, from health services to crippled children to health insurance for the aged.

The new programs enacted by the Congress and, particularly, Medicare provide the potential for providing comprehensive, high-quality care and for enabling people to obtain this kind of care when and where they need it. It is not possible to describe briefly the impact of the Medicare program on the millions of older Americans it will directly affect and on the health community and the voluntary insurance field. The potential effects of this vast program are so profound that no one can truly predict all of its benefits. But I think that it is safe to say that no single legislative act of the Federal Government will have a more beneficial effect upon the capacity of this country to provide high-quality health care to its citizens.

The first 100 days of Medicare have been a truly remarkable achievement. I am proud to say that the most far-reaching medical program enacted in the past 100 years has gone successfully into effect in the past 100 days. Almost 1½ million older Americans have entered hospitals for treatment under Medicare and have had most of their hospital expenses paid by Medicare.

Mr. Cohen, Under Secretary of the Department of Health, Education, and Welfare, delivered the address on which this paper is based to the American Society for Public Administration, Washington, D.C., October 19, 1966.

About 300,000 bills for physicians' services have been paid under the medical insurance part of the Medicare program, and about 62,000 people have received health services at home after their hospital stay.

Despite some dire predictions before July 1, older people have not rushed to the hospitals for treatment. There are not any long lines of people waiting for admission to hospitals, but, as it should be, more older people than before are getting the hospital care they need, particularly those who did not have health insurance before Medicare and those who had inadequate coverage.

Participants

Medicare, its provisions and the relationships under it, has many ramifications. However, all who have been concerned with implementation and operation of the program have done a splendid job in getting the program started. Some 6,750 hospitals and their staffs are involved, 250,000 physicians, the staffs of 1,300 participating home health agencies, 74 Blue Cross organizations, 33 Blue Shield plans, 15 insurance companies, and 1 independent health insurer. More than 100 group practice prepayment plans and scores of agencies acting as fiscal intermediaries or dealing directly have an important role. Medicare involves Federal and State employees. It involves some 19½ million older people and their families. The successful launching of the program has resulted from the understanding and the cooperative participation of many diverse groups, institutions, and individual persons.

Many of those involved have had to modify some of their procedures. Some 6,616 hospitals, accounting for 98 percent of the short-term general care hospital beds in the nation, are participating in the program. The certification of these hospitals has been accomplished in a way that is upgrading the level of health care available to all. For example, about 550 hospitals were certified on a conditional basis pending correction of various deficiencies. They are now working to correct these deficiencies so that they can continue to participate in the program. In addition, many of the 280 hospitals that were rejected because they could not meet the requirements for even conditional certification are also striving to come up to standards. The entire community will benefit from the upgrading that follows from this process.

There is still cause for concern, however, about the situation in some communities in the South where between 150 and 200 facilities have not yet taken the steps necessary to provide services on a nondiscriminatory basis. But, taken as a whole, progress toward the complete elimination of discrimination in the provision of hospital care has been very good.

We are also encouraged by the number of home health agencies that are being certified. About 1,300 such agencies are already participating in the program and another 400, mostly new ones, are currently developing the services necessary for certification.

Extended Care Facilities

With the deadline date of January 1, 1967, rapidly approaching, we are moving ahead to certify eligible extended care facilities. About 12,400 nursing homes have been sent applications. For some time now they have had information about the conditions and standards of participation so that they could be preparing for participation. They have also been given guidelines that explain the application of Title VI of the Civil Rights Act to extended care facilities.

Unfortunately, conditions in many of the so-called nursing homes are scandalous. President Lyndon B. Johnson, so appalled by the conditions he has seen in some of these homes around the country, has established a special task force to develop a modern, improved nursing home program for the nation. He is calling on creative architects and other experts to make plans for nursing homes that no longer serve simply as human warehouses but will help restore older people to creative and useful lives.

Many of the nursing homes that received applications to participate in the Medicare program, of course, will not meet the high-quality standards of the program. The extended care benefit under Medicare is a special kind of benefit for skilled nursing homes. It is designed primarily for the recently hospitalized patient who continues to need full-time skilled nursing care for a relatively short time rather than the

patient who needs custodial care. Some people need continuing skilled nursing care for the same condition for which they were treated in the hospital, and this care can be provided just as satisfactorily and at less cost in a high-quality extended care facility as in a hospital. Of course, there is also great need for good custodial care and for residential homes for the relatively able-bodied, but the extended care benefit under Medicare is not directed at either of these kinds of care. Under Medicare, physicians' services and a number of other medical and health services are covered for persons living in custodial or residential institutions as well as persons in their own homes, but room and board charges are not covered.

Although it is not necessary that all the nursing homes of the country or that even most of them qualify under the Medicare program in order to have a sufficient number of participating facilities, it is important that a sufficient number of high-quality homes are located in the right places. Because of the special nature and relatively short duration of this benefit, we do not expect that Medicare will be paying for more than 20 to 25 percent of the nursing home beds in the country at any one time. However, a much larger proportion will continue to be reimbursed under the public assistance programs and under the title XIX medical assistance programs.

We are particularly concerned that people fully understand the extended care benefit. Qualifying extended care facilities will be connected with hospitals through an agreement involving arrangements for a timely transfer of patients and an interchange of records. We hope that this connection will upgrade the medical care given in extended care facilities. We also hope that, increasingly, the hospitals of the country will acquire their own extended care facilities, for this would be an additional guarantee of the medical quality of the institution and of the use of efficient alternatives to acute hospital care.

Unfortunately, there may be many people who believe that the extended care benefit is intended to deal with custodial nursing home care. This impression must be corrected. There is a very special problem in this regard at the beginning of the program. The provision covering certain people who will be in extended care facilities when the benefit goes into effect on January 1, 1967, is designed to cover patients who are in extended care facilities at the beginning of the program under the same conditions that will apply to patients entering such facilities after the program is in effect. But, if people think that the intention was to cover nursing home care generally they will view the exclusions as arbitrary and be tempted to circumvent them.

Under the law a person in a participating extended care facility on January 1, 1967, will have his bills paid under Medicare if he entered the extended care facility after a hospital stay and if he is not a long-term patient. Specifically, the persons already in extended care facilities on January 1, 1967, who will receive the coverage are those who had a hospital stay of at least 3 days ending after June 30, 1966, and had entered the extended care facility within 14 days of discharge from the hospital and are still in need of continuing skilled nursing care. All other patients in extended care facilities will by definition not qualify for extended care benefits.

We hope to prevent hospital admissions designed solely to qualify people for extended care benefits. We need the help of hospitals, extended care facility personnel, physicians and their staffs, and the public at large to prevent any such unnecessary hospitalization.

Policy Revisions

Especially good progress has been made in developing regulations to cover all of the important policies which will govern program operations. The development of principles has been largely accomplished and practically all of them have been published for the purpose of obtaining comments—and I might say that a great deal of comment has been received, comment not only from the health field, but from organizations representing the consumer of health services and from various congressional sources. All the regulations were developed after widespread consultation among a great variety of expert and knowledgeable people, and in many instances out of intensive and detailed negotiations with representatives of the groups most intimately involved.

We are still working on revised reimbursement policies for hospitals and extended care facilities. We have received a great deal of advice on this regulation. We are considering all the suggestions. We hope to be able to announce our revised policies soon.

Let me assure you that even when regulations are issued in what are considered "final form," they—and indeed the law itself—can be modified in the future on the basis of experience with the program. For example, Secretary John W. Gardner has assured the officers of the American Hospital Association that the hospital reimbursement principles will be re-evaluated promptly as experience under the program develops. We may expect, then, a great deal of continuing attention to the results of the reimbursement formula.

Supplementary Medical Insurance

My discussion thus far has been mostly about where we stand in relation to hospital insurance. Now I should like to discuss the other part of the Medicare program—the supplementary medical insurance plan. Because of the time required to meet the $50 deductible under medical insurance, claims under this part of the program lag behind those for hospital insurance. However, about 1.1 million eligibility inquiries have been received from intermediaries. About 55 percent of the claims paid so far for reimbursement of physicians' services were received on assignment.

Some 17.4 million persons (more than 90 percent of those aged 65 and over) signed up for the voluntary medical insurance plan and agreed to pay the $3 a month premium in the largest voluntary effort ever carried out in this country.

Even more impressive, has been that after a single premium notice was mailed, a quarterly premium was collected from all but about 10 percent of the 2½ million people who had to be billed directly because they were not cash beneficiaries. A second notice was mailed to the 10 percent who had not yet paid, reminding them that September 30 was the end of the grace period for payment. A personal followup was made of nonrespondents to insure that they understood exactly what their situation was before they dropped out of the program. Voluntary programs call for individual action, of course, and there are always a few persons who do not take that action within given time limits for one reason or another. This was true under the Medicare program.

Evaluation and Improvement

The extensive planning that took place before July 1 has paid off in valuable dividends. This gigantic enterprise is working well. But we are not yet completely satisfied. We very much want to improve procedures and forms and systems, and we have already taken many steps to be sure that we will do better.

There always seem to be inevitable differences between the best designed product and its final form after field testing. And this was true in the Medicare program. Despite literally hundreds of consultations with expert professional and technical advisors before July 1, one of the first tasks performed when the program started was an evaluation of the forms, procedures, and policies as they were actually working.

In addition to on-the-spot visits to hospitals, work groups representing intermediaries and hospitals are evaluating the experience of these visits. As a result several steps have been taken to smooth out and speed up operations.

- The outpatient billing requirement on the itemization of diagnostic tests was altered to permit grouping under descriptive categories instead of listing the tests individually.
- The requirement of detailed information about specific laboratory and X-ray procedures on the physician's billing form was eliminated for hospitals and physicians who have agreed to use the optional percentage method of determining professional charges.
- To speed up the payment of hospital costs, the hospital is permitted to transmit the inpatient billing form even though the physician's billing form has not been completed.
- Optional procedures were authorized which will permit hospitals and home health agencies to eliminate multiple patient signatures and which will make one signature serve for all Medicare forms during one hospital stay.
- Intermediaries may permit alternatives in the presentation of machine billings, which will

eliminate for many hospitals the requirements for detailed charge information on the inpatient billing form.

• Intensive study of the possibilities for combining hospital forms and simplifying outpatient billing is underway.

Just as we have been making changes under the hospital insurance part of the program, we are also considering changes to smooth out operations under the voluntary medical insurance part of the program. And in making any changes we work closely with the groups involved.

One of the biggest jobs we have is to broaden the knowledge and understanding of the many different groups who need to know about Medicare. Informing people about their rights and responsibilities is always a continuing job. Knowledge of a program always falls short of what we would consider desirable. It is, of course, no more realistic to expect people to have memorized the main features of the Medicare handbook ahead of time than it is to expect them to understand all the details of a private insurance or Blue Cross policy. It is important, however, that as many people as possible know the broad outlines and know where to turn for additional help and information when they need it. It is particularly important that people have the kind of information they need to plan for supplementary insurance and to plan other ways of taking care of the deductible and co-insurance.

We are, of course, engaged in a continual effort to improve understanding of the program. Every effort is being made to inform beneficiaries that they should have their Medicare cards with them when they go to a hospital or a doctor's office and to inform people as they near age 65 to contact their social security district office during the 3 months before their 65th birthday. Every effort is also being made to let beneficiaries know that there are deductibles and co-insurance and certain limitations in the coverage of the program, and we are trying very hard to get across the nature of the extended care facility benefit.

The Department of Health, Education, and Welfare, under the direction of the Assistant Secretary for Program Coordination William Gorham, has undertaken a major study of rising medical costs. We expect to have the findings of the study soon. We all know that medical costs have been rising sharply—of course, this was true even before Medicare.

We wish to do everything possible to curtail unnecessary increases in cost, while at the same time our policies will be designed to support improvements in the quality of care and compensation adequate to attract an increasing number of highly qualified health personnel.

I am convinced that Medicare represents one of those truly tremendous forward steps that has marked the growth and strength of our great nation. Like social security itself—Medicare is becoming a part of American life, and I think it will not be long before people will look back and find it difficult to visualize a society in which no such provision for assuring access to quality health care for older citizens had existed.

President Johnson, in his recent speech in Baltimore, recommended that the Medicare program be expanded to cover disabled persons receiving social security benefits. About 1 million persons are in this group. They are retired because of disability and, in general, are in the same circumstances as a retired person over age 65.

The President has also recommended an increase in social security benefits of at least an average of 10 percent for the 22 million beneficiaries of the program.

Both these recommendations would greatly strengthen and improve the protection provided by the program. We are also continuing our studies of other improvements that could be made in the entire social security program. We expect that the President will make further recommendations to the Congress next year.

The first 100 days of Medicare—truly momentous days—mark a milestone along the road to better health care for the American people. Many new opportunities are arising and we are on the threshold of a bright new era in the field of health care. We are on the threshold of readily available, improved medical care for our citizens. "Good health for every citizen to the limits of our country to provide it," as set forth by President Johnson, can be attained

through the application of modern medical miracles that are rapidly being uncovered and through new developments in the organization and delivery of services.

Future Needs

This is an era of revolutionary changes in the field of medicine. The explosion of scientific knowledge has led to rapid advancements in medical technology which is being directed to the improvement of the nation's health. We are faced with an exciting challenge of bringing the past and present miracles of modern medicine, the continuing and future miracles of modern medicine, and services to all men, women, and children—regardless of race, color, or any other factor other than medical needs.

President Johnson is particularly concerned about what is being done both within and outside the Federal Government to prevent and control disease and to make high-quality medical care more readily available. This is of utmost importance because in the years to come we will uncover new knowledge for saving lives, preventing disease, easing pain, and improving man's total well-being. We must be sure that this new lifesaving knowledge is brought forth as quickly as possible to the people whose lives depend on it.

We have seen remarkable progress in medical and health care within our generation. We have eliminated many of the frightening diseases of childhood. Some surgery that once was precarious has now become routine because of the development of new surgical techniques. We have made great advances in the treatment of mental illness and mental retardation.

We have made great strides. But we must still go much further.

- An all-out effort must be made to reduce infant mortality rates.
- Mortality and morbidity differentials which now exist between whites and nonwhites must be wiped out.
- Every expectant mother must be assured high-quality prenatal and postnatal care if we are to reduce the crushing burden of mental retardation and mental illness.
- We must eliminate the scourge of the many communicable diseases—viral, bacterial, and parasitic.
- We must, and we shall, cut the toll of the major killer diseases—heart disease, cancer, and stroke.
- We must provide highly specialized lifesaving equipment, services, and treatment for people who need artificial hearts, kidneys, or organ transplants.
- We must provide preventive health care throughout every community.

The new Medicare program embodies principles and methods which I believe will help us solve some of the most pressing health care problems which presently confront us. We are just beginning a new venture that is designed to remove the threat of economic ruin resulting from the high cost of illness among older people, and all of us have an important stake in its success. We welcome the opportunity to consider jointly the problems as well as the great potential for progress which is afforded by this program and the other programs which are now underway or being developed.