Current Data From the Medicare Program

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Medicare's Effects on Medical Care

DURING the first year of Medicare, the Social Security Administration paid out $2.5 billion in hospital insurance benefits under part A of the program and about $700 million in supplementary medical insurance benefits under part B. Medicare payments during the period July 1966–June 1967 resulted in the largest absolute and relative annual increases in government expenditures for health and medical care since World War II, when expenditures almost doubled in a 1-year period as a result of the medical requirements of the military services. Expenditures for personal health care in fiscal year 1967 are estimated at $41.5 billion, of which $12.6 billion, or 30 percent, comprised public funds. In fiscal 1966, public funds accounted for only 22 percent of the $36.8 billion expended for personal health care. Medicare largely accounts for this shift to public financing of a greater share of personal health care expenditures.

Much of the statistical effort of the Division of Health Insurance Studies of the Social Security Administration during the first year of Medicare was directed to the further development, testing, and refinement of the data collection system. Although not thoroughly refined, the system nevertheless has provided some output on the operation and effectiveness of the program. I present only a few highlights here, making no attempt to cover all aspects of the program or all the available data. Recent issues of the *Social Security Bulletin* contain several articles describing various aspects of Medicare (*1–6*).

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Highlights of First Year of Medicare

About $3.2 billion were expended for hospital and medical benefits during the first year of Medicare (July 1966–June 1967). There were 5 million admissions of enrollees to the more than 6,800 certified hospitals in the United States and its outlying areas. This figure amounts to 263 admissions to short term and long term hospitals for every 1,000 aged persons enrolled under the program. The distribution of hospital admissions per 1,000 enrollees showed considerable variation among the States, ranging from a low of 196 in each of the three States of Delaware, Maryland, and New Jersey to a high of 398 in North Dakota. On the basis of U.S. Census divisions, admission rates were lowest in the Middle Atlantic States and highest in the West North Central States (table 1).

Admissions to extended care facilities during the first 6 months of calendar year 1967, when this benefit first became available, amounted to almost 200,000, or a rate of 10.5 per 1,000 enrollees during the 6-month period. We assume hospital admissions were divided equally between the first and second 6 months of fiscal 1967, about one of every 12 admissions to a hospital was of an enrollee who was later admitted to an extended care facility. Admis-

Table 1. Number of hospital insurance enrollees admitted to hospitals and extended care facilities and to home health care, and rates per 1,000 by region, census division, and State, July 1, 1966–June 30, 1967

Region, census division, and State	Enrollment (in thousands) [1]	Inpatient hospital admissions		Extended care facility admissions [2]		Home health care starts [3]	
		Number (in thousands)	Per 1,000 enrollees	Number (in thousands)	Per 1,000 enrollees	Number (in thousands)	Per 1,000 enrollees
United States and territories	18, 898. 6	4, 967. 0	263	198. 6	10. 5	228. 0	12. 1
United States total [4]	18, 754. 9	4, 952. 6	264	198. 6	10. 6	228. 0	12. 2
Northeastern	**5, 013. 2**	**1, 154. 8**	**230**	**47. 7**	**9. 3**	**92. 4**	**18. 1**
New England	1, 229. 9	319. 2	260	16. 2	13. 2	27. 0	22. 0
Maine	115. 5	31. 2	270	1. 3	11. 3	1. 1	9. 5
New Hampshire	76. 7	21. 3	278	. 4	5. 2	2. 0	26. 1
Vermont	47. 5	14. 7	309	. 2	4. 2	. 7	14. 7
Massachusetts	617. 9	168. 5	273	7. 3	11. 8	11. 8	19. 1
Rhode Island	99. 7	22. 1	222	. 7	7. 0	3. 6	36. 1
Connecticut	272. 6	61. 4	225	6. 3	23. 1	7. 8	28. 6
Middle Atlantic	3, 783. 3	835. 6	221	31. 5	8. 3	65. 4	17. 3
New York	1, 905. 2	417. 8	219	14. 6	7. 7	29. 7	15. 6
New Jersey	652. 1	127. 6	196	6. 2	9. 5	13. 9	21. 3
Pennsylvania	1, 226. 0	290. 2	237	10. 8	8. 8	21. 8	17. 8
North Central	**5, 541. 0**	**1, 568. 2**	**283**	**45. 7**	**8. 2**	**57. 2**	**10. 3**
East North Central	3, 682. 2	967. 0	263	31. 2	8. 5	42. 5	11. 5
Ohio	961. 0	227. 5	237	8. 4	8. 7	12. 2	12. 7
Indiana	476. 3	110. 1	231	2. 8	5. 9	2. 3	4. 8
Illinois	1, 064. 6	283. 3	266	9. 0	8. 5	11. 1	10. 4
Michigan	727. 4	193. 2	266	5. 8	8. 0	9. 1	12. 5
Wisconsin	452. 9	152. 9	338	5. 2	11. 5	7. 8	17. 2
West North Central	1, 858. 8	601. 2	323	14. 5	7. 8	14. 7	7. 9
Minnesota	396. 1	156. 1	394	4. 4	11. 1	4. 3	10. 9
Iowa	346. 7	110. 3	318	2. 9	8. 4	4. 3	12. 4
Missouri	537. 5	151. 9	283	3. 5	6. 5	3. 4	6. 3
North Dakota	64. 5	25. 7	398	. 6	9. 3	. 2	3. 1
South Dakota	78. 3	28. 0	358	. 3	3. 8	. 9	11. 5
Nebraska	177. 6	51. 1	288	1. 1	6. 2	. 7	3. 9
Kansas	258. 1	78. 1	303	1. 7	6. 6	. 9	3. 5

[1] As of January 1, 1967.
[2] From January 1 to June 30, 1967.
[3] Includes home health start of care notices under both hospital insurance (part A) and medical insurance (part B).
[4] Includes unknown.
[5] Less than 50.

SOURCE: These preliminary data are based on the notices which are transmitted to the Social Security Administration upon admission of a hospital insurance program enrollee to a hospital or extended care facility or upon his start of home health care. Only notices received by the Administration by June 30, 1967, are included.

sion rates for extended care facilities ranged from 3.4 per 1,000 enrollees in Wyoming and 3.8 per 1,000 in South Dakota and Mississippi to a high of 26.7 per 1,000 in the State of Washington. The availability of certified beds in a State is clearly a major factor in the rate of admissions to extended care facilities. There are 29 beds for every 1,000 Medicare enrollees in Washington compared with three beds per 1,000 enrollees in South Dakota and Mississippi and seven beds per 1,000 in Wyoming (*5*).

Medicare's first year saw 228,000 notices for start of home health care services under both the hospital and medical insurance programs—about 12 notices per 1,000 enrollees. Here, too, there is considerable variation among the States, ranging from three notices per 1,000 enrollees in the four States of Kentucky, North Carolina, North Dakota, and South Carolina to 36 in Rhode Island.

Per capita benefit payments during the first year amounted to about $135 under the hospital insurance program and about $40 under the supplementary medical insurance program. Benefit payments reflect bills received, processed, and paid; many bills for incurred services are still

Table 1. Number of hospital insurance enrollees admitted to hospitals and extended care facilities and to home health care, and rates per 1,000 by region, census division, and State, July 1, 1966–June 30, 1967—Continued

Region, census division, and State	Enrollment (in thousands) [1]	Inpatient hospital admissions		Extended care facility admissions [2]		Home health care starts [3]	
		Number (in thousands)	Per 1,000 enrollees	Number (in thousands)	Per 1,000 enrollees	Number (in thousands)	Per 1,000 enrollees
South	**5,391.7**	**1,463.0**	**271**	**44.3**	**8.2**	**34.9**	**6.5**
South Atlantic	2,526.6	636.4	252	23.7	9.4	20.8	8.2
Delaware	41.8	8.2	196	.5	12.0	1.1	26.3
Maryland	262.2	51.4	196	2.8	10.7	1.7	6.5
District of Columbia	67.0	19.1	285	.3	4.5	1.9	28.4
Virginia	331.3	78.6	237	2.5	7.5	2.3	6.9
West Virginia	190.5	56.2	295	.9	4.7	.9	4.7
North Carolina	375.5	105.1	280	1.8	4.8	1.2	3.2
South Carolina	175.2	38.7	221	1.5	8.6	.6	3.4
Georgia	334.9	84.4	252	2.1	6.3	2.1	6.3
Florida	748.2	194.7	260	11.3	15.1	9.0	12.0
East South Central	1,190.5	312.3	262	7.4	6.2	6.5	5.5
Kentucky	323.1	90.0	279	2.6	8.0	1.1	3.4
Tennessee	357.5	104.2	291	2.2	6.2	2.8	7.8
Alabama	299.9	72.4	241	1.8	6.0	2.2	7.3
Mississippi	210.0	45.7	218	.8	3.8	.4	1.9
West South Central	1,674.6	514.3	307	13.2	7.9	7.6	4.5
Arkansas	221.1	66.6	301	1.0	4.5	1.0	4.5
Louisiana	279.9	65.5	234	2.0	7.1	1.0	3.6
Oklahoma	278.1	87.2	314	1.3	4.7	2.0	7.2
Texas	895.5	295.0	329	8.9	9.9	3.6	4.0
West	**2,809.0**	**760.2**	**271**	**60.9**	**21.7**	**43.3**	**15.4**
Mountain	621.6	193.5	311	10.3	16.6	8.7	14.0
Montana	67.3	25.2	374	1.2	17.8	.4	5.9
Idaho	64.5	17.9	278	1.1	17.1	1.1	17.1
Wyoming	29.4	7.5	255	.1	3.4	.2	6.8
Colorado	176.7	62.4	353	3.4	19.2	3.3	18.7
New Mexico	63.2	17.4	275	.5	7.9	.6	9.5
Arizona	126.2	38.3	303	2.4	19.0	2.1	16.6
Utah	69.3	18.0	260	1.1	15.9	.6	8.7
Nevada	25.0	6.8	272	.5	20.0	.4	16.0
Pacific	2,187.4	566.7	259	50.6	23.1	34.6	15.8
Washington	303.4	85.6	282	8.1	26.7	4.1	13.5
Oregon	208.2	55.3	266	4.0	19.2	2.3	11.0
California	1,632.0	413.6	253	37.7	23.1	28.0	17.2
Alaska	5.6	1.5	268	[5]	[5]	[5]	[5]
Hawaii	38.2	10.7	280	.9	23.6	.2	5.2
Outlying areas	143.7	14.4	100	[5]	[5]	[5]	[5]
Unknown		6.4		.1		.2	

outstanding. Benefit payments do not include administrative costs (7).

Part A claims that have been approved for payment and processed by the Social Security Administration provide a description of the type and scope of services used. Of the 5.1 million hospital insurance claims recorded as of August 4, 1967, 86 percent were for inpatient hospital services, 6 percent were for outpatient hospital diagnostic services, 5 percent were for extended care services, and the remaining 3 percent were for home health services (table 2). Hospital claims approved for payment and processed by the Social Security Administration include those for persons discharged from hospitals and those for persons still in the hospital for whom an interim claim has been made. For the latter group, the number of claims will exceed the number of admissions.

The bulk of the payments under the hospital insurance program is for inpatient hospital care. The 5.1 million claims recorded through August 4, 1967, included $2.2 billion in payments to the various providers of services, of which 96 percent was for inpatient hospital care. Reimbursements averaged $481 per recorded inpa-

tient hospital claim, $12 per outpatient hospital diagnostic claim, $62 per home health care claim, and $300 per claim for post-hospital extended care services. In the instances in which the type of hospital was known, 98 percent of the recorded claims, 95 percent of the days of care, and 98 percent of the amount of reimbursement were for care in short-stay hospitals (table 3).

Covered days of hospital care per recorded claim averaged 13.3 days in all hospitals, 12.9 days in short-stay hospitals, and 36.4 days in long-stay hospitals. The average daily charge for total recorded claims was $45. It was $46 in short-stay hospitals and $19 in long-stay hospitals.

Under part B, the carriers submit a payment record to the Social Security Administration for each bill they have paid. By August 4, 1967, a

Table 2. Number and percentage distribution of hospital insurance claims approved for payment and amounts reimbursed, by type of benefit, July 1, 1966–June 30, 1967

Type of benefit	Approved claims		Amount reimbursed [1]		
	Number	Percent distribution	Total (in thousands)	Percent distribution	Per claim
Total	5, 127, 608	100. 0	$2, 212, 248	100. 0	--------
Inpatient hospital	4, 403, 797	85. 9	2, 119, 918	95. 8	$481
Outpatient diagnostic	305, 687	6. 0	3, 646	. 2	12
Extended care facility	263, 499	5. 1	79, 050	3. 6	300
Home health care	154, 625	3. 0	9, 634	. 4	62

[1] Amounts paid to the providers for covered services, based on an interim rate. Payments exclude deductibles, coinsurance amounts, and noncovered services as specified by law. The amounts paid to providers are adjusted at the end of each provider's operating year on the basis of audited reasonable costs of operation.

SOURCE: Only claims for payment under the hospital insurance program which had been approved by intermediaries and recorded in the central records of the Social Security Administration before August 4, 1967.

Table 3. Number and percentage distribution of hospital insurance claims approved for payment for inpatient hospital care, covered days, and total charges with amounts reimbursed, by type of hospital, July 1, 1966–June 30, 1967

Claims, covered days, and charges	All hospitals [1]	Short-stay hospitals	Long-stay hospitals [2]
Approved inpatient hospital claims:			
Number	4, 403, 797	4, 317, 115	70, 695
Percent distribution	100. 0	98. 0	1. 6
Covered days of care: [3]			
Total (in thousands)	58, 566, 577	55, 814, 044	2, 572, 468
Percent distribution	100. 0	95. 3	4. 4
Average days per claim	13. 3	12. 9	36. 4
Charges:			
Total (in thousands)	$2, 639, 940	$2, 583, 851	$49, 285
Percent distribution	100. 0	97. 9	1. 9
Per claim	$599	$599	$697
Per day	$45	$46	$19
Amount reimbursed: [4]			
Total (in thousands)	$2, 119, 918	$2, 072, 572	$42, 527
Percent distribution	100. 0	97. 8	2. 0
Percent of total charges	80. 3	80. 2	86. 3

[1] Includes 15,987 claims with type of hospital unknown.

[2] General and special hospitals reporting average stays of 30 days or more; tuberculosis, psychiatric, and chronic disease hospitals and Christian Science sanatoriums.

[3] Covered days of care after June 30, 1966 (not including days in excess of 90 in a spell of illness).

[4] See footnote 1, table 2.

SOURCE: See table 2.

Table 4. Number of reimbursed supplementary medical insurance bills for physicians' and related medical services and total reasonable charges with amount per bill, by type of service, as of August 4, 1967

Type of service	Bills		Reasonable charges [1]		
	Number	Percent distribution	Total (in thousands)	Percent distribution	Amount per bill
All services [1]	12, 720, 568	100. 0	$897, 325	100. 0	$71
Physicians	10, 880, 236	85. 5	840, 219	93. 6	77
Home health care	194, 791	1. 5	11, 489	1. 3	59
Outpatient hospital	1, 037, 197	8. 2	15, 942	1. 8	15
Independent laboratory	179, 625	1. 4	4, 837	. 5	27
All other	307, 296	2. 4	15, 675	1. 7	51

[1] Includes 121,423 bills and $9,161,264 total charges for which type of service is unknown.

SOURCE: Only payment records on bills which had been submitted and reimbursed by the intermediaries under the supplementary medical insurance program and recorded in the central records of the Social Security Administration before August 4, 1967.

total of 12.7 million medical insurance bills had been paid by the carriers and recorded in the SSA central records. Of this total, 86 percent was for physicians' services, 8 percent for outpatient hospital therapeutic services, and the remaining 5 percent for home health, independent laboratory, and other medical services (table 4).

Total reasonable charges for the 12.7 million recorded medical insurance bills amounted to $897 million, an average of $71 per bill. Reasonable charges are determined by the carriers on the basis of the customary charges for similar services generally made by the physician or supplier for the covered services and on the prevailing charges in the locality for similar services. A charge cannot be higher than that applicable for the carrier's own policyholders for comparable services under comparable circumstances.

Reasonable charges per recorded bill averaged $77 for physicians' services, $15 for outpatient therapeutic services, $59 for home health services, $27 for independent laboratory services, and $51 for all other services. Of the 10.9 million recorded bills for physicians' services, 17 percent were surgical bills and 83 percent were medical bills. Reasonable charges for surgical bills amounted to $333 million and averaged $180 per bill; for medical bills, they amounted to more than $500 million and averaged $56 (table 5).

For the 12.7 million part B bills paid by carriers and recorded in the SSA central records, 70 percent of the reasonable charges for all covered medical services were reimbursed. The proportion of physicians' surgical bills that was reimbursed was 74 percent; for the physicians' medical bills, the proportion was 68 percent. A larger percentage of the surgical bill was reimbursed because the total charges on the average surgical bill are higher than on the average medical bill, and hence the $50 deductible represents a smaller proportion of the total.

Extent of Hospital Insurance Protection

The figures just cited are aggregate data reflecting the magnitude and scope of the Medicare program. These data and others obtained from the claims process provide some measure of the extent to which the program has met its objective of providing adequate hospital and medical insurance protection to the aged during its first year of operation.

Of the 19 million persons aged 65 and over enrolled in the program, an estimated 4 million, or about 1 of every 5 enrollees, received hospital care during the first year of Medicare. Included are the persons admitted to short-stay general and special hospitals and a relatively small percent admitted to long term hospitals. The total days of inpatient hospital care rendered to aged persons during the year are estimated at 66.5 million (5 million admissions multiplied by 13.3 days per recorded claim). Applying the total days of inpatient hospital care to the number

of persons admitted (rather than to the number of admissions), the average aged person hospitalized during the first year of Medicare spent almost 2½ weeks in the hospital, or an average of almost 17 days. At $46 per day—the amount reported on our hospital claims—the total charges during the year for the average hospitalized aged person were estimated to be approximately $750. If we assume the beneficiary paid the $40 deductible and another $10 for noncovered items, Medicare paid about $700, or 93 percent of the average $750 annual bill.

Averages can be both interesting and meaningful for many purposes. In the area of medical costs, especially of hospital costs, in which the incidence of very heavy expenditures is uneven, the range of incurred costs is especially significant. A large proportion of the 4 million hospitalized aged were confined for long periods. For these persons, the amount of costs reimbursed under the hospital insurance program obviously was much larger than for the average enrollee. To obtain an accurate picture of the distribution of hospitalized persons by duration of stay and information on the cause of hospitalization and of the procedures performed, we must wait until all the claims incurred for the first year of Medicare are filed and recorded in our data collection system. Because there is no cutoff period for submission of bills, we were still receiving bills in June 1967 for services incurred under the hospital insurance program in its first month of operation—July 1966. One percent of the inpatient hospital bills for July 1966 that have been recorded in our files were not received and recorded until June 1967. We plan, however, by the end of 1968, to tabulate the program data for the first 6 months of the hospital insurance program so that we can better assess its full impact on persons using part A services.

Physicians' and Related Medical Services

For hospitalized persons, payment of the major share of costs incurred during the hospital stay is only part of the picture. That a hospital illness is often associated with higher than average medical costs is clear. But what is the range of medical care costs for those aged persons who are not hospitalized? To what extent do these enrollees use physicians' and other medical services? Finally, what portion of these medical costs are covered under the supplementary medical insurance program, for which the beneficiary paid a monthly premium of $3?

The answers are not readily available from the claims data. Considerable delays in the statistical reporting of current information under the supplementary medical insurance program are inherent in the procedure for receipt and payment of bills by carriers. Several factors contribute to these delays. Physicians

Table 5. Number of reimbursed supplementary medical insurance bills for physicians' and related medical services and total reasonable charges with amounts reimbursed, by type of bill, as of August 4, 1967

Bills and charges	All bills [1]	Physicians' services	
		Surgical	Medical
Bills			
Total number	12, 720, 568	1, 848, 910	9, 031, 326
Percent distribution	100. 0	14. 5	71. 0
Reasonable charges			
Total (in thousands)	$897, 325	$332, 953	$507, 266
Percent distribution	100. 0	37. 1	56. 5
Per bill	$71	$180	$56
Amount reimbursed: [2]			
Total (in thousands)	$625, 146	$244, 775	$342, 384
Percent distribution	100. 0	39. 2	54. 8
Percent of total charges	69. 7	73. 5	67. 5

[1] Includes 1,718,909 bills for home health, outpatient hospital, independent laboratory, and other services covered under the medical insurance program, not shown separately. Also includes 121,423 bills for which type of service is unknown.

[2] Represents 80 percent of the reasonable charges for covered services each year after the beneficiary has paid the first $50 of such charges.

SOURCE: See table 4.

Table 6. Cumulative number and percentage distribution of medical insurance enrollees and charges for covered medical services, by use of covered service and deductible status, for 6 months ending December 1966 and June 1967

Use of services and charges	July–December 1966		January–June 1967	
	Number	Percent distribution	Number	Percent distribution
Total enrollees (in thousands) [1]	17, 938	100. 0	17, 949	100. 0
Using no services	6, 085	33. 9	5, 900	32. 9
Using covered services [2]	11, 854	66. 1	12, 049	67. 1
Deductible not met	7, 439	41. 5	6, 289	35. 0
Deductible met	4, 058	22. 6	5, 297	29. 5
Total charges (in thousands)	$963, 542	100. 0	$1, 005, 916	100. 0
Deductible not met	$145, 030	15. 1	$109, 652	10. 9
Deductible met	$818, 512	84. 9	$896, 264	89. 1
Potentially reimbursable	$494, 197	51. 3	$578, 612	57. 5
Average charges [3]	$84		$87	
Deductible not met	$19		$17	
Deductible met, total	$202		$169	
Potentially reimbursable	$122		$109	
Percent of total reimbursable [4]	60. 4		64. 5	

[1] All persons enrolled in the supplementary medical insurance program who were exposed to risk at any time during the 6-month period. Included are all persons reaching age 65 and enrolling in the second or later months and all persons who died or terminated enrollment during this period, regardless of the month of occurrence.

[2] Includes persons using services for which a bill is not expected.

[3] Based on the number of enrollees using covered services, excluding persons for whom a bill is not expected.

[4] Represents the amount reimbursable as a percent of total charges for persons who have met the deductible by the end of the period.

SOURCE: Current Medicare Survey.

may be slow in sending their bills to patients, and the beneficiaries are instructed to accumulate their bills until charges exceed the $50 deductible. This process is difficult for many of the aged to understand. Finally, the deadline for submission of bills for services incurred during the period July 1–September 30, 1966, is April 1, 1968; for services received October 1, 1966–September 30, 1967, the deadline is December 31, 1968.

To shorten the delays and provide more current information on the volume of medical services used under the program and the resulting charges incurred against the Medical Insurance Trust Fund, we initiated the Current Medicare Survey (CMS). The medical insurance sample of this survey is based on periodic interviews with persons enrolled in the supplementary medical insurance program. (References 3 and 8 provide a more complete description of the survey and the data collected through July 1967.)

Information on the use of, and charges for, covered medical services has been collected for the first 12 months of Medicare's operation. We are presenting these data, however, for two periods in order to compare the first 6 months with the second. The use of, and charges for, services are figured by the calendar year; the payment of 80 percent of the reasonable charges for physicians' services and other covered services follows the payment by the patient of the first $50 of such charges during a calendar year. The important qualification is that any expenses incurred by an enrollee in the last 3 months of a calendar year and applied to his deductible for that year may be carried over and applied to his deductible for the next calendar year.

Comparison of the use of covered medical services for the last 6 months of 1966 with the use for the first 6 months of 1967 indicates no startling increases. During each period, about 12 million persons, or two-thirds of all medical insurance enrollees exposed to risk, used covered medical services. The population at risk represents the persons enrolled at any time during a period covered by the data. If the period is 1 month, this population is the same as the enrolled population. If the period is 2 or more months, it includes persons who have been enrolled for any part of the period—for example, persons reaching age 65 and enrolling in the

second or later months, persons who died in the interval, and persons who terminated their insurance at any time during the period. Among this user group, a significantly larger proportion received sufficient services during the second 6-month period to meet the $50 deductible requirement than during the first 6-month period (table 6). During the first 6 months that Medicare was in effect, approximately 4 million persons, or about 34 percent of the enrollees receiving medical services, incurred charges in excess of $50. By contrast, more than 5 million aged persons, or 44 percent, fell into this category by the end of June 1967.

The increase from one period to the next is partly due to the effect of the carryover provision previously mentioned. It reflects also, however, the rise in medical care prices, a rise that probably resulted in an increasing number of patients reaching the $50 deductible even though the same number of persons used similar services during the two periods.

Comparison of the average charges per person using covered services in the two periods reveals an increase during the second period. If we assume that there were no major changes in the types of sevices used, the increased average charges resulted from higher physicians' fees. The Bureau of Labor Statistics reported an increase of 3.3 percent in the physicians' fees component of the medical care price index from December 1966 to June 1967. Charges per person using covered medical services averaged $84 during the first 6 months of Medicare and increased to $87, a 3.6 percent rise during the second 6-month period—about the same rate of increase as in the price index for physicians' fees. Until we can analyze further the kind and frequency of services used during these periods, we cannot be certain whether the increase in average charges is actually due to the rise in physicians' fees or is merely a coincidence.

For persons who had not met the deductible by the end of each of the 6-month periods, charges averaged less than $20. For persons who had met the deductible, the average charges were about $200 during the latter half of 1966 and $170 during the first half of 1967.

Total charges of almost $2 billion were incurred under the medical insurance program during the first year of Medicare. If we assume that all these charges will be classified as reasonable by the carriers, more than $1 billion of the almost $2 billion are potentially reimbursable. Potentially reimbursable charges represent charges that are determined by carriers for the supplementary medical insurance program on the basis of customary charges for similar services made by physicians or other suppliers of covered services and on prevailing charges in the locality for similar services. A reasonable charge cannot be higher than that applicable for the carrier's own policyholders for comparable services under comparable circumstances. When the $1 billion potentially reimbursable is compared with the $700 million actually paid out in benefits during the first year, a clear picture emerges of the extent of lags in the claims process under this part of Medicare.

Use of, and charges for, medical services among the aged differ to some extent by age and sex. The Current Medicare Survey provides some evidence that the proportion of enrollees using covered medical services has increased with age—from 66 percent for persons aged 65–74 to 74 percent for persons aged 85 and over (*8*). In addition, the average charges have also increased with age—from $83 per enrollee in the youngest age group to $109 in the oldest. A somewhat larger proportion of aged women (71 percent) than of aged men (62 percent) used medical services. The average charges for women, however, were lower.

The proportion of total enrollees who used covered medical services and met the deductible varied substantially by region, ranging from 27 percent in the South to 37 percent in the West. Regional differences in the proportion who met the deductible resulted partly from variations in the cost of medical services and partly from variations in the extent of their use.

Monthly Variations in Data

In addition to the cumulative data available from the Current Medicare Survey, information is provided also on a monthly basis. These monthly data have greater statistical variances than the cumulative data. Nevertheless, they provide an insight into month-to-month fluctuations in the extent of medical services used by

this large population group (tables 7 and 8). During each of the first 12 months of Medicare, about one-third of the medical insurance enrollees used covered medical services under the program. The proportion ranged from a low of 30.4 percent in December 1967 to a high of 35.1 percent in May 1967. In aggregate terms, the number ranged from 5.3 million persons in December to 6.2 million in May.

A comparison of the number and proportion of persons meeting the deductible during the first month of the new calendar year (January 1967) with the corresponding figures for the first month of Medicare's operation shows clearly the effect of the carryover provision. By the end of January 1967, a total of 1.3 million persons had met the deductible, or more than twice the number who had done so in the first month of the program. Since the proportion using covered medical services did not vary substantially, the difference can be traced to the effect of the carryover provision.

During each succeeding month in 1966 and 1967, the proportion of enrollees using medical services who had met the $50 deductible increased significantly. By the end of December 1966, about one-half of those using services had met the deductible; this proportion increased to three-fifths by the end of June 1967.

Of special interest is the distribution of persons using medical services by the amount of the deductible they used monthly (table 9). For example, 22 percent of the enrollees using medical services in January 1967 had incurred charges of less than $10 by the end of the month. An equal proportion incurred charges of $10–$20. By the end of June, however, only 6 percent of the enrollees using services during that month had incurred charges of less than $10, and the charges for an additional 10 percent

Table 7. Estimated number and percentage distribution of medical insurance enrollees by month and use of covered medical services, July 1966–June 1967

Month	Estimated monthly enrollment [1]	Enrollees using no services	Enrollees using covered services		
			Total [2]	Deductible not met	Deductible met
Number in 1966 (in thousands):					
July	17, 507	11, 872	5, 635	4, 697	607
August	17, 533	11, 958	5, 575	4, 248	1, 079
September	17, 561	11, 964	5, 597	3, 761	1, 538
October	17, 497	11, 648	5, 849	3, 451	1, 935
November	17, 510	12, 052	5, 458	2, 720	2, 278
December	17, 523	12, 197	5, 326	2, 446	2, 423
Number in 1967 (in thousands):					
January	17, 504	11, 596	5, 908	4, 204	1, 312
February	17, 501	11, 835	5, 666	3, 530	1, 767
March	17, 513	11, 495	6, 018	3, 299	2, 422
April	17, 555	11, 458	6, 097	2, 871	2, 879
May	17, 611	11, 418	6, 193	2, 506	3, 296
June	17, 678	11, 689	5, 989	2, 138	3, 454
Percentage distribution in 1966:					
July	100. 0	67. 8	32. 2	26. 8	3. 5
August	100. 0	68. 1	31. 8	24. 3	6. 1
September	100. 0	68. 1	31. 9	21. 4	8. 8
October	100. 0	66. 6	33. 4	19. 7	11. 1
November	100. 0	68. 8	31. 1	15. 5	13. 0
December	100. 0	69. 6	30. 4	14. 0	13. 8
Percentage distribution in 1967:					
January	100. 0	66. 2	33. 8	24. 0	7. 5
February	100. 0	67. 6	32. 4	20. 2	10. 1
March	100. 0	65. 6	34. 3	18. 8	13. 8
April	100. 0	65. 3	34. 8	16. 4	16. 4
May	100. 0	64. 8	35. 1	14. 2	18. 7
June	100. 0	66. 1	33. 8	12. 1	19. 5

[1] Number of enrollees at the beginning of each month as estimated by adjusting the July 1, 1966, and the January 1, 1967, tabulated enrollment for increments of persons reaching age 65 and for decrements of persons who died or terminated enrollment.

[2] See footnote 2, table 6.

SOURCE: Current Medicare Survey.

reached $10–$20. These data indicate that a large number of aged persons use medical services continually throughout the year and eventually meet or approach the $50 deductible. This continual use is not surprising because aged persons are more prone than younger persons to suffer chronic illnesses that require continuing medical care.

While the Current Medicare Survey has already proved to be an important instrument for measuring the effectiveness of the medical insurance program, it also has been used effectively in evaluating policy. Determination on a current basis of the utilization of, and charges for, services incurred and of the Government's obligations under part B provided the basic information for increasing the premium rate from $3 to $4 per month effective April 1, 1968.

Table 8. Estimated total and average charges for medical insurance enrollees using covered medical services, by month and deductible status, July 1966–June 1967

Month	Total	Deductible not met	Deductible met	
			Total	Potentially reimbursable
1966 total (in thousands):				
July	$166, 867	$56, 983	$109, 884	$63, 629
August	167, 367	45, 457	121, 910	80, 275
September	164, 993	39, 230	125, 763	82, 857
October	170, 144	34, 945	135, 199	91, 363
November	158, 841	24, 635	134, 206	96, 171
December	139, 638	22, 267	117, 371	83, 861
1967 total (in thousands):				
January	154, 855	46, 162	108, 693	65, 309
February	138, 216	35, 133	103, 083	70, 245
March	173, 577	32, 653	140, 924	97, 975
April	189, 149	26, 068	163, 081	118, 782
May	191, 450	23, 919	167, 531	122, 252
June	159, 330	17, 637	141, 693	104, 732
1966 average charge: [1]				
July	31	12	181	105
August	31	11	113	74
September	31	10	82	54
October	32	10	70	47
November	32	9	59	42
December	29	9	48	35
1967 average charge: [1]				
January	28	11	83	50
February	26	10	58	40
March	30	10	58	40
April	33	9	57	41
May	33	10	51	37
June	28	8	41	30
1966 percentage distribution: [2]				
July	100. 0	34. 1	65. 9	57. 9
August	100. 0	27. 2	72. 8	65. 8
September	100. 0	23. 8	76. 2	65. 9
October	100. 0	20. 5	79. 5	67. 6
November	100. 0	15. 5	84. 5	71. 7
December	100. 0	15. 9	84. 1	71. 4
1967 percentage distribution: [2]				
January	100. 0	29. 8	70. 2	60. 1
February	100. 0	25. 4	74. 6	68. 1
March	100. 0	18. 8	81. 2	69. 5
April	100. 0	13. 8	86. 2	72. 8
May	100. 0	12. 5	87. 5	73. 0
June	100. 0	11. 1	88. 9	73. 9

[1] Based on the number of enrollees using covered services excluding persons for whom a bill is not expected.

[2] The "potentially reimbursable" part represents the amount reimbursable as a percent of total charges for persons who have met the deductible by the end of each month.

SOURCE: Current Medicare Survey.

Table 9. Estimated number and percentage distribution of medical insurance enrollees using covered medical services, by amount of deductible used by the end of each month, January–June 1967

Amount used	January	February	March	April	May	June
Total enrollees [1]	5, 908	5, 666	6, 018	6, 097	6, 193	5, 989
Number (in thousands) using:						
Under $10	1, 311	805	697	467	452	331
$10–$19	1, 299	1, 054	946	746	576	575
$20–$29	914	842	778	831	625	591
$30–$39	592	547	591	545	626	496
$40–$49	416	556	518	508	511	376
$50 and over [2]	1, 375	1, 862	2, 487	3, 002	3, 403	3, 619
Percentage distribution:						
Under $10	22. 2	14. 2	11. 6	7. 7	7. 3	5. 5
$10–$19	22. 0	18. 6	15. 7	12. 2	9. 3	9. 6
$20–$29	15. 5	14. 9	12. 9	13. 6	10. 1	9. 9
$30–$39	10. 0	9. 7	9. 8	8. 9	10. 1	8. 3
$40–$49	7. 0	9. 8	8. 6	8. 3	8. 3	6. 3
$50 and over [2]	23. 3	32. 9	41. 3	49. 2	54. 9	60. 4

[1] Estimated number of enrollees using covered medical services, including persons for whom a bill is not expected.

[2] The number of persons shown who used services and met the deductible each month is greater than the number in table 8 because the number here includes those who received free services during the month but had incurred charges in previous months.

SOURCE: Current Medicare Survey.

Future Reporting

In addition to several articles in the *Social Security Bulletin* describing the statistical program of Medicare and presenting the first provider and claims data (*1–6*), a new report entitled "Health Insurance Statistics," presenting results of the Current Medicare Survey, has been sent initially to a large mailing list. As additional data become available, they will be released in this report as well as in the *Bulletin*.

A population base permits the calculation and presentation of a wide variety of utilization rates for population subgroups. When utilization data are combined and cross-classified by the characteristics of the beneficiaries and the providers of services, these data offer many possibilities for analysis and study of the variations in the patterns of use of hospital and medical services and of the factors affecting that use (*9*).

Plans are well underway to initiate a comprehensive series of reports linking the characteristics of the providers of services, the various services used under the program, and the demographic characteristics of the enrollees. The major obstacle we have encountered has been the lag in reporting by providers, patients, and intermediaries.

Because we recognize that lags in reporting and recording claims may be considerable, our current plans call for tabulation of the data on the use of hospital and medical services in the first 6 months of Medicare. Presentation of these data will also enable us, subsequently, to make the transition to reporting by the calendar year. Hereafter, as the data become available for the different types of services and the two parts of the program, they will be released and published.

In addition to statistical reporting of the use and costs of hospital and medical services, the Social Security Administration has undertaken a broad research program in order to measure the impacts of Medicare on both public and private medical care programs, to identify and define program gaps and unmet needs, and to examine and evaluate the economic consequences of Medicare.

Summary

During the first year of Medicare (July 1966–June 1967), the Social Security Administration paid out about $3.2 billion in benefits—$2.5 billion in hospital insurance benefits under part A and $700 million in supplementary medical insurance benefits under part B. For each enrollee aged 65 and over, part A benefit payments

averaged $135 and part B payments averaged $40.

Most of the part A payments were for hospital care. Of the 19 million persons aged 65 and over enrolled in the program, about one in every five received hospital care during the first year of Medicare and stayed an average of 2½ weeks in the hospital. About one of 12 of these hospitalized persons went on to an extended care facility. Under part B, about one-third of the enrollees used covered services during each of the first 12 months of Medicare. The end of the first 6 months of 1967 found about 5 million enrollees, 44 percent, with sufficient charges incurred to meet the deductible and be eligible for benefits.

Other data available on the first year of Medicare include the following: (*a*) admission rates for hospitals and extended care facilities and rates for start of care for home health services, reported by State; (*b*) the number of claims approved for payment and the amounts reimbursed for each type of part A service and the number of reimbursed bills and reasonable charges for each type of part B service; and (*c*) utilization and charges data from the part B sample of the Current Medicare Survey, reported for each month and summarized for the two 6-month periods. The utilization and charges information includes the number of enrollees using services and the number meeting the $50 deductible, as well as the total charges and the amounts potentially reimbursable.

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Aid in Diagnosis of Leprosy

The Division of Direct Health Services, Public Health Service, has available for free distribution to any tissue laboratory requesting it, material that will aid in the tissue diagnosis of leprosy.

The material consists of wet tissue that is positive for *Mycobacterium leprae* when stained with the Fite acid-fast stain. The free distribution also includes a copy of the Fite acid-fast stain procedure in use at the Public Health Service Hospital in Carville, La., and a representative slide from similar material, which is stained for *M. leprae* by this technique.

Requests for the material from interested laboratories should be directed to Dr. Richard E. Mansfield, Chief, Laboratory Branch, U.S. Public Health Service Hospital, Carville, La. 70721.