COST AND FINANCING OF HEALTH CARE FOR THE AGED**

I. Needs and Resources


Information contained in this volume is based on a survey of 2,809 families conducted in July 1953. It deals with families in general, but the data are broken down by age groups. Among the data on persons aged 65 and over not readily available elsewhere are the level of charges for physicians' services, hospitalization, and medicines. Other information categorized by age groups includes possession of insurance, hospital admission rates, length of hospital stays, surgical procedures, and medical and dental consultations.


Along with a statement of principles, this report by the Commission on Financing Hospital Care summarizes the problems the aged and other low-income groups pose for hospital care financing. It includes information on hospital utilization by the aged and existing sources of payment, a summary of proposals on hospital care financing advanced by various organizations, and the Commission's own recommendations.

Brewster, Agnes W. "Care in nursing homes through prepayment hospital plans." *Research and Statistics Note* (U.S. Social Security Administration, Division of Program Research, Washington 25), No. 41, November 25, 1958. 6 pp. On request.


In recent years nursing homes have acquired an increasingly important

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** Items from this list should be ordered directly from the publisher. Addresses are given in connection with each reference.
role among medical-care institutions for the aged population. These two publications summarize the availability, costs, and methods of financing nursing home care. Private insurance in this area is still in the experimental stage, leaving public funds a major source of financing.


The data relating to ownership of hospitalization insurance, receipt of hospital care, and payment of hospital bills contained in this survey by the Bureau of the Census provide a useful benchmark for comparison with developments since then.


Based on a national survey of the resources of aged beneficiaries in 1951, this article shows that at that time only 1 out of every 4 or 5 beneficiaries had some form of hospitalization insurance. Other data, on the nature of the insurance protection and sources of income, provide a basis for evaluating recent improvements in these areas.


The author argues that the widely accepted notion that only a little over one-third of those aged 65 and over have hospital insurance is misleading because it understates the actual amount of available or desired health protection. He emphasizes the "wide variety of medical care programs for public assistance recipients," other Federally supported programs, and the fact that many people decide against insurance on religious or other grounds even when they can afford it.


In 1957, 43 percent of the aged beneficiaries had hospital insurance, but only 28.5 percent were also covered for surgery. Of those not covered, 39 percent said they could not afford it, 37 percent had not thought about it, and 23 percent had to discontinue their policies. Presents comparative data on hospital admission rates and length of stay for 1951 and 1957.

Among the highly interesting data contained in this preliminary report are information on the distribution of medical costs and hospitalization costs by income groups and on the extent to which insurance and other means meet the costs.


This volume is mainly a collection of essays oriented toward the availability, cost, and financing of health care. It includes also a statistical appendix containing the most important data then available. The health-care section includes discussions of trends in commercial health insurance programs and other health plans. The section on hospital care includes an analysis of the operation of the Hill-Burton Act in relation to the needs of older people.


This report summarizes all the major aspects bearing on the hospitalization problems of the aged. It "presents information on the characteristics of the aged population, current levels of use of hospitals and expenditures for medical care by aged persons, factors influencing trends in cost of medical care, and present methods of financing hospital care for the aged. It also presents estimates on the costs and discusses the administrative implications of providing hospital and nursing home, care insurance through the OASDI mechanism. The report also discusses several alternative methods of helping the aged meet these costs."


Section I deals with "The health of the aged and aging" and Section III with "Income maintenance and financing of medical care." They contain statements by leading experts on a wide range of questions in these areas and draw on practical experience to illustrate some of the major problems.

Based on continuing nationwide household interviews, these reports present information classified by age and otherwise on such aspects as incidence of illness and disability, length and frequency of hospitalization, number of restricted-activity and bed-days per year, and number of visits to dentists and physicians.


"The volume assembles in one place data from a variety of sources, much of which has not been readily available or generally known." The great variety of data on the socio-economic characteristics of the aged and on their health status and means of financing health services makes this publication extremely useful.

2. Voluntary Methods


Of the estimated six million persons 65 and older with hospitalization insurance, 3.5 million are covered by Blue Cross. In addition to enrollment figures, this article presents information on how enrollment was obtained, conditions of enrollment, coverage for pre-existing conditions, and change in benefits and premiums for those who converted from group enrollment.


A report on a study by the National Industrial Conference Board which includes 30 companies extending medical insurance to all or some of their retired employees. It shows how costs can be reduced and their predictability increased by various types of ceilings and elimination of certain benefits available to active employees. Methods of payment range from no payment by the retiree, to partial, to complete payment.


Lists the major types of private health insurance plans available to the aged. The major problems encountered by the insurer are underwrit-
ing and financing. The low income of the aged suggests a paid-up policy approach, but then benefits must be fairly specific to make costs predictable. Increase in comprehensiveness of benefits increases unpredictability of costs.


A survey of major importance covering extent of hospital, surgical, and medical insurance, underwriting practices, actuarial and cost analyses, and legislative recommendations. It estimates that about 65 percent of persons 65 years of age and older had no hospital insurance in 1956. Of those covered by group contract prior to retirement or other termination of employment, only about 22 percent had the right of conversion to individual policies, but at substantially higher rates and usually with a reduction in benefits. The findings on individual health insurance policies were that "little more than one percent . . . are non-cancellable or guaranteed renewable for life."


Contains information on conversion, cancellation, and non-renewal practices of eleven leading insurance companies and the non-profit pre-payment plans of New York. Termination of commercial policies for age and ill health was found to be a major problem in insuring the aged. Illustrative cases, an extensive bibliography, and New York insurance bills of 1957 are included.


"A 'typical' Blue Shield plan offers continuation of benefits to members regardless of age. Premiums for the group conversion and nongroup contracts under which older people continue their membership are, however, 15-20 percent higher than those for group contracts. Age limits on initial enrollment and restrictions on provision of benefits for pre-existing conditions under nongroup contracts may bar the enrollment or restrict the available benefits of older persons seeking to enroll."


A very important finding of the study of HIP experience is that "despite conversion privilege most of those who must decide whether to convert or to terminate coverage drop their insurance," even though individual premium rates are only slightly higher than group rates. The study also provides information on health services furnished to
aged enrollees and considers the possible consequences of an increase in the proportion of aged beneficiaries.


The characteristics of 300 selected plans, covering approximately 5 million workers, are examined in this study. It contains comparative information on hospital, surgical, and medical benefits available to active, old and young, and retired workers and their dependents. Most plans maintain benefits unchanged for active older workers, except when hired at an advanced age. A large number, however, eliminate or reduce benefits for retirees and their dependents. Sometimes retirees may continue participation in group insurance with no or only partial employer financing. A similar survey of 300 plans for late 1958 is contained in Bulletin No. 1250, now in press. Another digest of 100 plans for early 1958 is published as Bulletin No. 1236 (available from the Government Printing Office for $1.25). It does not permit strict comparison with the survey for late 1955, but seems to indicate a trend toward liberalization of these benefit plans.

3. ROLE OF GOVERNMENT


A well-rounded discussion presenting the role of the Federal Government, the public welfare implications, and the viewpoints of organized medicine, the hospitals, and voluntary insurance. All recognize the fundamental responsibilities of the Government in the health field, but emphasize the possibilities and desirability of the voluntary approach. The limitations of this approach, recent advances in both governmental and voluntary health protection measures, and the need and nature of further improvements in them are also noted. Authors of articles are Franz Goldman, Mary S. Weaver, Henry A. Holle, James P. Dixon, and J. F. Follman, Jr.


The first of these two monographs describes the type of medical care that is available in the continental United States to recipients of federally subsidized old-age assistance and to beneficiaries of other categorical assistance programs. It presents on a state by state basis methods of administration, scope of programs, financial provisions, and relationships with professional groups, insofar as this information was
obtainable through a questionnaire. The second deals with some of the basic principles and problems of these programs in the areas of assumption of responsibility, forms and administration of programs, and quality and quantity of care.


This article examines the initiation and early experience of Federal participation following the amendments to the Social Security Act in 1950. It stresses the limited impact of the law.

Public Health Economics (Bureau of Public Health Economics, School of Public Health, University of Michigan), November, 1957. "State to start paying medical bills for half million October 1." pp. 529-531. $4.50 yearly.


These brief articles summarize the experience of two states with new plans of public assistance medical care. Both maintain free choice of physician, but under the California plan the doctor is paid directly by the state according to a schedule of fees set up by the state, while in Colorado the program is administered for the state by the Colorado Blue Cross-Blue Shield. California imposes no specific dollar limit on the amount of care an eligible person may receive but requires special approval for care that goes beyond specified limits. In Colorado "the benefits follow the pattern of benefits provided by the full semiprivate Blue Cross certificate and the Blue Shield benefit program," which includes full coverage for hospitalization, surgical and in-hospital care, in addition to nursing home care following acute hospitalization and medical care in nursing homes. The implementation of the Colorado program has been considerably more successful than the California plan.

4. The Forand Bill


"Doctors can't beat the Forand Bill." By Harold J. Peggs. pp. 199-202. 60 cents.

The discussion in these four articles centers around the possibility of taking positive steps to prevent compulsory Federal health insurance of the type envisaged by the Forand Bill. Dr. Jaworski believes in the feasibility of a paid-up-at-65 Blue Shield-Blue Cross program, but overlooks the thorny problems relating to inflation, adverse selectivity, and financial management brought out by Goldberg. Goldberg considers the idea unworkable at present. Lois Chevalier reports on an alternative approach, introduced in Iowa, under which doctors sponsor Blue Shield contracts "providing service coverage on the basis of fees that average 40 percent of most doctors' charges." Dr. Peggs considers such lowering of fees for the aged neither workable nor capable of forestalling Federal legislation.


These abstracts of scattered publications and press releases summarize the attitudes toward Federal health insurance legislation for the aged of organized medicine, hospitals, and labor, and include a summary of the general arguments for and against Federal action. The AMA warns against hasty action and announces its "strong opposition" to the "revolutionary proposal." The AHA believes the Forand Bill to be unsuitable but takes a more compromising stand. Labor finds against existing commercial insurance arrangements and for the Forand Bill.

U. S. Congress, 86th, 1st session. House of Representatives. H.R. 4700. A bill to amend the Social Security Act and the Internal Revenue Code so as to provide insurance against the costs of hospital, nursing home, and surgical service for persons eligible for old-age and survivors insurance benefits, and for other purposes. Introduced by Mr. Forand. Washington 25. February 18, 1959. 22 pp. On request.

This 1959 version of the Forand Bill, like its 1957 predecessor, provides up to 60 days of free hospital care yearly, up to 120 days a year of free nursing home services (120 days is the combined maximum of hospital and nursing home days), and full payment for the cost of surgical services. Hearings on the Bill were held during the week of July 13, 1959.