THE IMPACT OF MEDICARE ON DEMOGRAPHY

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RESUMEN

El así llamado programa Medicare, promulgado en 1965 en la Enmienda al Acta de Seguridad Social, tendrá un significante impacto sobre los estudios demográficos en vista de la vasta cantidad de datos previamente inobtenibles que ahora serán disponibles. No solo habrá una extensa información acerca de costos de hospitalización y otros cuidados médicos para personas de 65 y más años de edad (con adecuadas divisiones por sexo y edad), sino que también se producirán datos muy útiles acerca del verdadero tamaño de la población de 65 y más años.

La razón para este último resultado es que virtualmente todas las personas del país, de 65 y más años llegarán a ser elegibles para seguro hospitalario aún cuando ellas no hayan sido cubiertas anteriormente, o hayan sido sobrevivientes de personas cubiertas bajo los sistemas de ancianos, sobrevivientes o incapacitados. Como resultado de lo anterior, no solamente habrá datos más exactos (lo que es menos probable en los censos, dónde la enumeración necesariamente es incompleta), sino también, una verificación de la edad, desde que ello es necesario de acuerdo a las demandas del procedimiento.

SUMMARY

The so-called Medicare program enacted by the 1965 Amendments to the Social Security Act will have a significant impact on demographic studies, in view of the vast amount of previously unobtainable data that will be made available. Not only will there be extensive information in regard to hospitalization and other medical-care costs for persons aged 65 and over (with adequate subdivisions by age and sex) but also reliable data in regard to the true size of the population aged 65 and over will be produced.

The reason for this latter result is that virtually all persons aged 65 and over in the country will become eligible for hospital insurance, even though they may not have been previously covered, or have been survivors of persons covered, under the Old-Age, Survivors, and Disability Insurance System. As a result, not only will there be an accurate count (unlike the census, where the enumeration necessarily is not complete), but also there will be a verification of age, since this is necessary under the claims process.

The enactment of the so-called Medicare program under the Social Security Act in 1965 should open up new vistas to demographers. Traditionally, and properly, demographers have taken an interest in almost all aspects of our social and economic life. However, up to the present, demographers have made very few studies in the field of sickness and morbidity, probably because information on this subject has, in the past, been rather sparse.[1]

This paper will set forth briefly some of the opportunities for health-care studies that will be made available as a result of the operations of the Medicare program. There will also be indicated the great lack of data in the past in regard to the medical-care experience of persons who will be covered by the new program, namely, persons aged 65 and over.

PREVIOUSLY AVAILABLE DATA

For the past fifteen years, proposals have been made for the establishment of a system of hospitalization and related benefits under the Social Security Act; these came to fruition with the 1965 Amendments. Furthermore, the legislative developments in 1965 resulted in an even broader array of benefits by including provisions for benefits with respect to physician services. In making the cost analyses for these proposals, unfortunately, relatively few data were available. The various insuring organizations—Blue Cross and insurance companies—had not

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[1] For a more complete discussion of this subject, including a description of the United States National Health Survey and its origins, see Forrest E. Linder, "Health as a Demographic Variable," *Proceedings, International Population Conference*, Vienna, 1959.

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made many detailed studies by age but rather generally had only aggregate results. These, of course, were not very useful because of the greatly varying hospital utilization by age. There were available, however, results of a number of survey investigations, but these have limitations because of faulty or inaccurate recall on the part of the respondents and because of the omission of persons who died in the period covered by the survey.

Thus, unlike the situation in establishing an old age pension plan or a survivor benefits system, in which case adequate mortality data are generally available from reliable national sources, there was no firm set of data for hospital-utilization rates that would be applicable to the legislative proposals. Instead, the results of the various surveys had to be used, after what were thought to be appropriate adjustments. The results were also considered in relation to such insurance experience as was available.[2]

THE MEDICARE PROGRAM IN BRIEF

The Medicare program, with benefit operations starting July 1, 1966, relates only to persons aged 65 or over. The hospital insurance portion (HI) provides a maximum of 90 days of hospitalization during a spell of illness (which is defined as ending only after there has been a 60-day consecutive period during which the individual was not hospitalized or in an extended-care facility) after payment of a $40 initial deductible and after payment of $10 coinsurance for each day of hospitalization after 60 days. The magnitude of the deductible and coinsurance is subject to increase if hospitalization costs rise in the future. The HI program also provides certain additional, related benefits—outpatient diagnostic benefits (with a $20 initial deductible and 20 percent coinsurance), posthospital extended-care-facility benefits (maximum of 100 days, with $5 coinsurance for each day after 20 days), and posthospital home-health-services benefits (maximum of 100 visits). The HI program is financed by payroll taxes payable by all active workers who are covered under the old age, survivors, and disability insurance program or the railroad retirement program.

The supplementary medical insurance program (SMI) is not a social insurance system like HI and OASDI, but rather it is an individual, voluntary insurance program with government subsidy. The benefits provided relate primarily to physician services, regardless of whether in home, office, or hospital; they also include certain additional services, such as ambulance, medical supplies and equipment, laboratory tests, and home-health services. The SMI program has a deductible of $50 per year and then 20 percent coinsurance on the part of the beneficiary. SMI is financed by monthly premium payments from the insured person (which initially will be $3) and equal matching amounts from general revenues.

STATISTICS AVAILABLE UNDER THE MEDICARE PROGRAM

Perhaps one reason that so few generalized statistics subdivided by age have been available in regard to the operation of health insurance programs before the advent of Medicare was the great diversity of plans and provisions. Now that a single, uniform program is available for the 19 million persons aged 65 or over, it may be possible to do much more in the field of collection of medical-care statistics and analysis thereof than was formerly possible. Such a wealth of data will become available on a centralized basis that it may be difficult to know how much to seek to obtain in an expeditious manner. Certainly, as a minimum, it should be possible to obtain hospitalization-incidence rates (by age and sex) and duration-of-hospitalization distributions by age and

[2] For more details regarding survey investigations and problems encountered in obtaining and utilizing data for cost-estimating purposes for legislative proposals, see Robert J. Myers, "Actuarial Cost Estimates for Hospital Insurance Act of 1965 and Social Security Amendments of 1965," *Actuarial Study No. 59* (Washington, D.C.: Social Security Administration, 1965).

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sex for those aged 65 and over. Or, combining these two factors, we would have hospital utilization per covered person, by age and sex. More detailed analysis could yield interesting results as to geographical variations, differences resulting from various diagnoses, and so forth.

Then, too, it may be possible to co-ordinate the Medicare hospitalization data with that available from supplementary private insurance plans which tend to "fill in" the deductibles and the coinsurance. Students of the subject of hospitalization experience differ greatly on the question of whether a moderate deductible affects utilization. Perhaps studies can be made in regard to cases where these are "filled in" as against cases where they are not.

Any study and analysis of the various benefits provided under SMI in connection with physician services and other items covered will be somewhat more difficult than the analysis of hospitalization experience. The elements involved are not nearly as clean-cut as is the case for hospitalization, where the concepts of admissions and days of care are reasonably precise. Nonetheless, interesting and valuable studies of the covered medical-care costs will be possible, and this will throw much light on a subject that is currently of such importance, but about which so few data are presently available.

The Social Security Administration is planning a number of continuing studies of the Medicare experience through the use of selected random samples. An actuarial sample of 0.1 percent is to be maintained so as to obtain basic cost data as promptly as possible. More detailed data are to be obtained from a 5 percent statistical sample. An Advisory Committee on Health Insurance Research and Statistics will make continuing recommendations, which will very likely result in the availability of further data related to demographic characteristics.

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