

# COLORADO'S MEDICAL CARE PROGRAM FOR THE AGED

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**HIF Perspectives number a2**

1960

## FOREWORD

In Colorado all recipients of old age assistance enjoy a medical care plan that permits them free choice of hospital and physician. Their program, most of which is under the administration of Colorado Hospital Service (Blue Cross) and Colorado Medical Service (Blue Shield), provides essentially the same benefits as these plans' usual contracts, as well as several others (*e.g.*, limited home and office calls) the plans do not normally offer.

This unique program developed as the result of an unusual situation in Colorado, but its provisions and administration may hold important answers for people concerned with the health needs of the aged in other parts of the country. Certainly the utilization of services and the costs of care within this program will interest those in states expanding their present programs or instituting new ones in response to the new Congressional appropriations for medical care for recipients of public assistance. Perhaps most worthy of study in the Colorado program for the aged is the acceptance it has secured among pensioners, physicians, welfare officials, hospital administrators, and virtually every other group in the state.

The Colorado program is not unknown today. Blue Cross and Blue Shield in Colorado and the department of public welfare receive queries about it almost daily, and the officials of these organizations are called on to speak before groups around the country on its administration. This short study, it is hoped, will supplement their efforts, presenting a survey of the Colorado experience in developing the medical care plan, a review of the program itself, a brief analysis of utilization and costs it has experienced, and a summary of the attitudes toward it by those close to its operation. This report was sponsored and financed by Health Information Foundation.

## **Acknowledgments**

The assistance of the many physicians and hospital administrators in Colorado who willingly contributed their time to the preparation of this report is gratefully acknowledged.

Special acknowledgment is also made to the following directors and staff members of organizations principally concerned with the administration of the Colorado program:

Mr. Guy R. Justis, Director of the Colorado State Department of Public Welfare;

Mr. Thomas M. Tierney, Executive Vice President of Colorado Blue Cross (Colorado Hospital Service);

Mr. John J. Vance, Executive Vice President of Colorado Blue Shield (Colorado Medical Service).

The thoughtful assistance and guidance of Mr. Richard P. MacLeish, Executive Director of the Colorado Hospital Association, Mr. Charles E. Bloedorn, Executive Director of the National Annuity League, and Miss Charline J. Birkins, Director of the Denver Department of Welfare, are gratefully acknowledged.

**I**N 1936 THE VOTERS OF COLORADO WERE ASKED to approve an amendment to the state constitution creating a pension fund and a state-wide pension system. The amendment provided that all needy persons over 60 who met residence requirements set by the legislature would receive a minimum pension (less other income) of \$45 a month and as much above \$45 as the pension fund could pay. To finance these pensions the amendment assigned to a pension fund 85 per cent of all proceeds from state sales, use and liquor taxes, as well as all revenue from a special levy on inheritance taxes and corporation license fees, and 85 per cent of the revenue from all city and town beer and liquor licenses. The fund was also assigned 85 per cent of all *future* excise taxes that the state might levy. No provision was made for any carry-over from one year to the next of money in the fund. Whatever accumulated during the year above the amount paid out monthly was to be distributed in a year-end bonus or "jackpot" to the pensioners.

Although the 1936 amendment has been termed in retrospect an "inordinately generous" acceptance of responsibility for the aging pioneers of the state, its provisions seem to have been intended to satisfy the minimum needs of older people. The sum selected and the provision that other income of any kind was to be subtracted from the pension payment seem to have been related to old-age insurance payments anticipated under the Federal Social Security Act passed the previous year. Both political parties in Colorado endorsed the state pension amendment, as did the voting public. The amendment was approved, and the Colorado electorate repeatedly defeated later efforts to repeal or modify it (in 1938, 1940, 1946 and 1948).

The old-age pension program established by the amendment became operative in September, 1937. About 30,000 persons were immediately

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eligible for its benefits. This number increased to 40,000 by 1940 and to 50,000 by 1950. The increase was held down somewhat by the adoption in 1941 of a special residence requirement for pensioners between 60 and 64. To be eligible for the pension, persons in this age group had to have resided in the state since 1906 (changed in 1949 to a flat 35 years). The residence requirement for those 65 and over remained at five years. In 1943 the limit to a pensioner's assets for continued eligibility was set at \$750 (raised to \$1,000 in 1957).

The "fatal weakness" in the provisions of the 1936 amendment did not become evident until after World War II, when Colorado found itself in a difficult financial situation. The state was limited by the 1936 amendment to 15 per cent of excise tax income for all non-pension expenditures at a time of great population growth and need for public programs. New taxes at this point would have served little purpose since the state would have been limited by the 1936 amendment to only 15 per cent of these funds too. From the 85 per cent of excise revenues available to the pension fund, pension payments had grown from the original \$45 monthly payment to \$76 in 1950 and to over \$100 in 1955. While this amount was not widely regarded as excessive, projected tax revenues would soon have made it so.

The problem, of course, was that since the pension allocation had been established by an amendment to the state constitution, it could be altered only by a new amendment voted by the electorate. And that electorate included the pensioners themselves, who could be expected to vote to preserve their program, and their relatives, who might, under a less liberal program, have to assume some of the cost of their support.

During the same post-war period, particularly since 1950, national attention focused to an increasing degree on the problems of the aged. Surveys of the aged themselves showed prime concern with their health needs and the problems they had in financing their health care. In Colorado consideration of the problems of the aged led in January, 1955, to the appointment of a Governor's Commission on the Aged to study the problems of "geriatrics, housing, recreation, employment, medical care, and the other special impacts which face aging persons." In announcing the Commission the Governor noted that Colorado voters had consistently defeated "ill-considered proposals" to amend the pension system. "If progress is to be made in this field," he wrote, "it will be

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achieved through enlightened awareness and understanding of the whole problem, and not by those who for one reason or another seek to change the basic tax structure of the state."

However, the needs of Colorado's aged and the state's financial problems were inextricably linked. The Commission's first report, made in April, 1956, recommended revisions of the 1936 pension law bearing on both problems. The constitutional amendment placed before the voters in November, 1956, included these basic provisions:

1. Assured payment of \$100 per month (less any other income) for all eligible state pensioners, with increases if the cost of living rose.
2. Establishment of a \$5 million stabilization fund to assure full pension payments at all times.
3. Establishment of a \$10 million a year fund from tax revenue to finance a health and medical program for pensioners, to be defined and administered by the state department of public welfare.
4. All tax revenue above that needed each year for pension payments and the health care program to revert to the state general fund for other public expenditures.

Colorado voters approved the new amendment by close to a two-to-one vote, and it became effective on January 1, 1957. The new medical care fund that had been voted accumulated during 1957.

While the amendment specified the amount that was to be spent for the medical care program, it said nothing about what *kind* of program was to be instituted. This decision was left to the state welfare department, which was charged under the new law with general administration of the program. The welfare department promptly organized a Medical Advisory Committee to help guide it in implementing the program. The broad scope of the Medical Advisory Committee is indicated by the organizations represented on it. These included the state medical

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society, osteopathic association, pharmacal association, hospital association, and dental association, the state department of public health, the state association of county commissioners, the National Annuity League, the state Chamber of Commerce, League of Women Voters, and county welfare directors association.

The welfare department and the committee considered many alternatives. It was suggested, for example, that the welfare department administer the program directly by contracting with physicians and hospitals for their services to pensioners. This would have required the department to establish fee schedules for physicians, payment formulas for hospitals, and regulations governing the quantity and quality of service pensioners would receive. The welfare department believed that the desired results could be achieved more economically and efficiently by working with existing medical agencies.

It was also suggested that the entire medical care fund be prorated among the counties, so that each county welfare department could administer its own health care program. Since Colorado counties vary greatly in their health care facilities (7 have no physician, about 20 have no hospital), this alternative could not have provided a uniform statewide program. This arrangement would also have resulted in high administrative costs, because it would have required duplicate health-care administrative organizations in each county.

Still another proposal was that the state employ panels of physicians to care for pensioners and even construct and operate special hospitals for the aged. This suggestion was rejected because it denied free choice of physician and hospital for the pensioner, an important consideration for both the department and advisory committee.

A suggestion which gained strong support was that the state welfare department purchase Blue Cross and Blue Shield health insurance for all pensioners. Since these plans already covered close to 40 per cent of the state's population, their use could free the welfare department of all direct administrative responsibility and of all but final fiscal responsibility and review.

There were several objections to this proposal: First, the standard contracts of Blue Cross and Blue Shield would not suit the needs of pensioners without modification; second, and probably most important, the

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use that pensioners would make of a health care program defied estimate, so that premiums could not be fixed with any accuracy.

The welfare department selected a close alternative to this proposal. It contracted with the Blue Cross and Blue Shield plans for their administration of a program of hospital care and in-hospital medical services, paying them their costs plus a fixed fee per claim. The department elected at the same time to administer directly a program of financing nursing home care for pensioners. The medical care program for pensioners began January 20, 1958, with payments by the welfare department for nursing home care and transportation of pensioners to and from nursing homes and hospitals. The administration of hospital care and physicians' services by Blue Cross-Blue Shield began on February 1, 1958, less than three months after the welfare department's decision was made.

## THE PROGRAM

The essential provisions of hospital care, in-hospital physicians' services, and nursing home care with which the medical program started are still its mainstays. However, the program has been expanded and modified during the past 34 months, as experience indicated and the fixed \$10 million medical care fund allowed. It will probably continue to change, as it should. Some changes that have been suggested already are covered later in this study.

Those eligible for the benefits of the medical care program include all persons who receive any state pension payment, no matter how little. (Some 25 Colorado pensioners collect less than \$1 per month, having other income that is subtracted from the present maximum pension payment of \$107; these people are eligible for the medical care program.) The pensioner case load was 53,168 at the end of 1959. This number included 47,691 Class A pensioners (those aged 65 and over), 3,807 Class B pensioners (those between 60 and 64), and 1,670 Class C pensioners (aged 60 and over and institutionalized). Class C pensioners (most of whom are in the state's mental hospitals) do not actually participate in the medical care program. The case load of pensioners 65 and over includes approximately one-third of those in this age-group in the state.

**Hospitalization** The agreement between the Colorado Hospital Service (Blue Cross) and the state department of public welfare made

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available to pensioners the benefits of the Blue Cross comprehensive certificate then in effect, with some modifications. Essentially, the benefits for pensioners were these: Coverage for the full cost of hospital care in a semi-private room in any general hospital in the state, from the first day of hospitalization through the thirtieth day per admission. Full coverage could be extended beyond the thirtieth day if requested by the attending physician and approved by the welfare department. Waiting periods for pre-existing conditions were waived. Hospitalization for tuberculosis or psychotic conditions was excluded (patients with these conditions became Class C pensioners), but the cost of hospitalization was covered until the end of the month in which the diagnosis was made of a hospitalized patient. Under the contract Blue Cross agreed to pay hospitals its usual cost reimbursement for providing these benefits to pensioners. The state welfare department agreed to repay Blue Cross the full amount it paid out (subject to audit adjustments) plus a fee of \$2 for each hospital case.

During the almost-three years since the original agreement was signed (January, 1958) very few changes have been found necessary in the hospitalization contract. The major change occurred during 1960 when expenditures under the program neared the \$10 million maximum allowed by the law. Beginning September 15, 1960, the hospital benefit was reduced from 30 days to 21 days per admission, and readmissions within 30 days of discharge were excluded from coverage. As earlier, the attending physician can still request extension of the 21-day limit or a readmission within 30 days of discharge.

These changes in the hospital benefit were made for several reasons: Although pensioners hospitalized for over 30 days were only 6 per cent of all hospital admissions during 1959 and the first six months of 1960, they accounted for about 22 per cent of the total cost of hospital care used under the program. The lower limit was not intended to deny needed medical care but to force closer attention by physicians and hospitals to long-staying patients. The restriction on readmissions was needed to enforce the limit to the length of stay allowed, for without such a restriction a patient could be discharged at the end of the covered length of stay and immediately readmitted.

**Physicians' Services** The medical care benefits for pensioners agreed to by the welfare department and Blue Shield were essentially those of the standard Blue Shield contract then in effect on a "service"

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basis for low-income subscribers. As revised for pensioners, the contract provided complete coverage for in-hospital surgical and medical care, as well as accident and emergency care in or out of the hospital, by any Blue Shield participating physician or any Colorado physician eligible to be a participating physician. As in the Blue Cross agreement, waiting periods for pre-existing conditions were waived for pensioners. Radiation therapy for malignancies was included as a benefit. The 30-day hospitalization limit applied to medical as well as hospital coverage, with the same provision that extensions could be requested by the attending physician. Medical care for tuberculosis and mental diseases was excluded. Blue Shield agreed to administer the medical program for a fee of \$2 for each physician's bill. Colorado physicians agreed to accept their standard fee schedule as payment in full for pensioner patients.

A number of changes—several of them major—were made in medical care benefits and in other provisions for physicians' services after the medical care program was initiated:

1. Effective December 1, 1958, physicians' services were extended to pensioners in nursing homes. Under the provisions of this extension patients in nursing homes each could receive up to two physician's calls per month for routine care. Two additional calls during the month were permitted if necessitated by an acute illness. Physicians agreed to accept as payment in full the fees set for visits to pensioners in nursing homes: up to \$5 per call, except that when the physician saw more than one patient during the same visit to the nursing home, he would receive up to \$2 for each additional patient seen. The physician could be paid for only one call per day to a home, except in emergencies. An allowance of up to \$7 was made for night calls to nursing homes.

2. Also effective December 1, 1958, coverage for consultations and the services of assistant surgeons was included in the medical program.

3. Effective July 1, 1959, limited benefits for physicians' home and office calls were added to the program. Each pensioner could receive a maximum of two home or office calls in each calendar quarter (not cumulative). The allowances set for these calls, which were specified to be partial indemnity rather than payment in full, were \$3 for office calls, \$5 for home calls. Physicians may bill pensioners for the difference

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between the allowance and their usual fee. (Office calls in Colorado are often \$4-\$5 and home calls \$7-\$8.) Blue Shield agreed to administer this part of the medical care program for a flat monthly fee of \$4,500 (later reduced, when the volume of office calls proved to be lower than anticipated).

4. On January 1, 1960, a new physicians' fee schedule was made the basis of payments for services to pensioners. The new schedule, called the Standard "A" Plan fee schedule, had been developed over a two-year period by the state medical society's 48-member Blue Shield Fee Schedule Advisory Committee to form a new minimum Blue Shield schedule for low-income subscribers. The new schedule, which raised fees between a third and a half for most procedures, satisfied many of the objections physicians raised to the financial aspects of the medical care program when pensions rose beyond \$100 per month.

5. The change in the hospitalization limit from 30 to 21 days, effective September 15, 1960, affected in-hospital medical care as well as hospital care.

**Nursing Home Care** The state welfare department contracted directly with the state's nursing homes to provide nursing home care for pensioners. The pensioner entering a nursing home agreed to pay the home \$100 from his pension or other income, retaining only a small amount of his pension (originally \$5, now \$7) for clothing and incidentals. The welfare department agreed to supplement the pensioner's payment by an amount dependent jointly upon the services available in the home and the amount of care required by the patient.

To determine these payments all licensed nursing homes in the state were placed in one of four categories. Homes placed in Group I, to which the welfare department would make no supplementary payments, were those lacking the staff qualifications of homes in Groups II, III, and IV. Homes which employed a fulltime licensed registered or practical nurse in charge of nursing care, had a nurse on duty around the clock, and provided an average of 1.5 hours of nursing care per patient in each 24 hours were placed in Group II. These homes received a maximum additional payment of \$20 per month from the welfare department for each of their pensioner patients. Homes placed in Group III had nursing staffs of the same quality as Group II homes, but enough nursing staff to

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provide two hours of patient care per patient in each 24 hours. Group III homes received a maximum of \$35 per pensioner. Homes placed in Group IV were those with a fulltime professional nurse in charge of nursing care, a professional nurse on duty at all times, and two hours of nursing care per patient. Group IV homes received a maximum of \$45 per month for each pensioner.

Pensioner patients were similarly classified according to the amount of nursing care they required. Pensioners in Classification I were ambulant and had no special nursing needs beyond medication and help with their bath or personal care. The welfare department made no additional payment for Classification I patients. Patients in Classification II included those who were semi-ambulatory or semi-bed patients and those requiring special food preparations. The nursing home was paid a maximum of \$25 for each of these patients. Patients in Classification III included complete feeder or bedfast patients, severe diabetics who needed insulin and/or special foods regularly, senile or confused patients who needed supervision for their personal safety, and any others whose care required an unusual degree or amount of skilled nursing care. Additional payments for these patients was made to a maximum of \$50.

The maximum amount which the welfare department pays a nursing home is, therefore, \$95 per month (to a Group IV home for a Classification III patient) above the pensioner's payment of \$100. Vendor payments by the welfare department actually amounted to an average of \$67 per patient per month during the first six months of 1960. The pensioner's family or friends may make additional payments to the nursing home above the \$100 from his own pension and the payment by welfare. However, nursing homes contracting with the state are not permitted to collect more than a total of \$250 for any pension recipient.

The provisions for nursing home care have not been modified substantially since the program was begun. At the present time (December, 1960), however, the state welfare department is trying to gain acceptance by the state's nursing homes of new criteria for allocating its payments for pensioners. Under the proposed system, payments would be based more closely on the quality and amount of care provided by the home. It is not known when this schedule, which would have the effect of raising the payments to homes which provide more services, will be put into effect.

**Other Medical Care: Drugs and Transportation** Drugs are provided pensioners only in hospitals and nursing homes. Prescribed drugs for hospital patients are covered in the Blue Cross hospitalization part of the program. These include any medicines the physician prescribes for a hospitalized pensioner and are paid for within the Blue Cross formula for reimbursing hospitals. Coverage for drugs prescribed for patients in nursing homes was initiated directly by the welfare department in December, 1958. The department agreed to pay for any prescribed drugs except cortisone and cortisone component drugs, common household remedies, personal care items, and dietary foods or food supplements. It limits amounts and refills. Payment for medical supplies is limited to such items as insulin hypodermic needles and syringes, bandages and dressings, catheters, and colostomy bags. The welfare department pays for these drugs and supplies according to a schedule it sets; all drug bills are reviewed by the state pharmacal association for conformity to the policies of the department.

The welfare department pays the cost of public transportation needed by pensioners to reach hospitals or nursing homes. This provision was necessitated by the long distances patients are often required to travel in Colorado to reach health facilities.

## ADMINISTRATIVE PROCEDURES

As mentioned earlier, Blue Cross and Blue Shield were selected to administer the bulk of the old-age pension medical care program partly because they already had the administrative mechanisms to do the job. This promised low-cost administration and, equally important, the least added burden of paperwork and detail on the suppliers of services. This section will review very briefly the administrative involvement of each participant in the program: the pensioner, the hospital, the physician, the nursing home, Blue Cross and Blue Shield, and the state and county departments of public welfare. Some of the forms used in the program are reproduced in the appendix.

**The Pensioner** At the inception of the medical care program (or when he joined the pension rolls) every pensioner received a letter from his county welfare department outlining the program, with an identification card enclosed. The pensioner presents this card, which resembles cards commonly used by Blue Cross plans, to be admitted to a hospital

or to receive out-of-hospital medical care. Presenting his card completes the pensioner's share of the administrative routine.

**The Hospital** For the hospital to which the pensioner seeks admittance the administrative procedures are identical to those it would follow in admitting a Blue Cross member. The hospital must contact Blue Cross to confirm the pensioner's eligibility for care (despite his identification card, the pensioner may not currently be on the pension rolls). When the pensioner is discharged, the hospital must inform Blue Cross what services he received, either attaching its bill to a short form or listing the services on a form. The hospital also notifies the patient's county welfare department, by postcard, of his discharge.

**The Physician** The physician whose pensioner-patient is admitted to a hospital normally has one form to complete: a standard statement of services rendered the patient, which the physician sends to Blue Shield. If his pensioner-patient will require more than the 21 days of hospitalization normally provided in the program, the physician must complete a second form, requesting whatever additional days seem to be needed. This must be sent to the director of medical services of the state welfare department by the patient's fourteenth day of hospitalization.

Pensioner home and office visits, since these are not usual Blue Shield benefits, require a special form, which the physician sends to Blue Shield after each call. Physicians' visits to patients in nursing homes also require a "non-Blue Shield" form. This form is submitted to Blue Shield every three months for all nursing home services the physician provided during the quarter.

**The Nursing Home** Nursing homes submit a single form each month to their county department of public welfare. This form, sent in with voucher attached, lists all pensioner-patients in the home, the patients' classifications (Class I if ambulatory, etc.), the dates on which they were being cared for, the home's monthly rate, the total amount due for each patient, the amount paid by the patient, and the balance due for each patient from the welfare department.

**Blue Cross and Blue Shield** Blue Cross shares with the welfare department the largest part of the program's administrative detail. Blue Cross must, first, keep an up-to-date record of all pensioners eligible for care (as it does also with its members) to confirm their eligibility



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when they apply for admission to a hospital. Blue Cross must also notify county welfare departments weekly of any pensioners from the county who have been admitted to a hospital during the week (this information is sent on IBM cards).

The remainder of Blue Cross-Blue Shield routine consists of processing physicians' claims, making hospital payments, and obtaining reimbursement from the state for these payments, plus an administrative fee. Blue Shield pays physicians monthly according to the agreed fee schedule for the services they have reported. Blue Cross pays hospitals three times monthly according to its regular cost formula agreement, subject to semiannual audit adjustments. Three times a month, Blue Cross bills the state welfare department for the payments it has made to hospitals and its administrative fee, attaching an IBM card for each pensioner-patient and a list of all payments made. Blue Shield submits similar invoices and supporting IBM cards for patients given medical care, separating home and office call cases from others since its administration fee is different for these cases.

**State and County Welfare Departments** At the start of the medical care program in 1958 the state welfare department furnished Blue Cross a complete list of pensioners eligible for care. Since then, responsibility for keeping the list current has fallen to each county welfare department, which sends Blue Cross monthly additions to and deletions from the pension group in the county.

For pensioners who are hospitalized, the county departments (notified by Blue Cross) may have additional responsibilities (planning with the pensioner's family toward his release, etc.). The state welfare department is administratively involved with those patients for whom an extension of stay or readmission within 30 days is requested. The director of medical services must approve or disapprove the extension or readmission and notify the hospital, as well as Blue Cross, the attending physician, and the county department. Payment to Blue Cross and Blue Shield for the services they administer is made directly by the state department from the health program fund. A copy of the month's billing for its pensioners is sent to each county department.

The state and county welfare departments are additionally involved with those parts of the medical care program they administer directly:

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nursing home care, including drugs prescribed for patients in nursing homes, and transportation to and from health facilities. For all of these, responsibility for determining eligibility and authorizing payment is placed on the county welfare department. Each county department submits to the state department a monthly "medical care payroll" and statement of expenditures for nursing home patients in the county, as well as a "control of payments" for estimating the medical care payroll for the coming month. All drug bills are independently sent to the state department, where, as noted earlier, they are reviewed for the department by the state pharmacal association.

## EXPERIENCE: USE AND COSTS

### A. Utilization

Pensioners' use of health services has increased steadily since the inception of the medical care program. This increased use has resulted from the systematic expansion of the program to provide more needed health services for pensioners and from their greater utilization of covered services. Naturally, the program is too young—some of its provisions having been added or modified only in recent months—to fix its exact pattern of use or of shifts in use. Nevertheless, a body of data does exist concerning the health care utilization of the Colorado pensioners which, coupled with data on cost, tells generally what can be expected under a program of this kind.

The characteristics of the 58,393 persons who were recipients of old age assistance during 1959 (Class A or Class B)\* can only be stated generally here. Perhaps the most surprising characteristic is their sex distribution: Almost three-fourths were women (73.7 per cent). The average age of the pensioners (including the Class B pensioners between 60 and 64) was 72, about three years higher than the average 20 years earlier. The economic characteristics of the pension group can be summarized readily: None had an income over \$107 per month from all sources, but all had that amount unless they were residents of nursing homes; none had assets over \$1,000; none had transferred assets to relatives within the past five years. All pensioners were United States citizens and residents of the State of Colorado for at least five years (35 years in the case of the Class B pensioners).

\*This was the total number who received some pension payment during the year, not the average monthly case load.

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During 1959, 56 per cent of the pensioners used one or more of the different medical services provided under the program. A quarter of them (24.4 per cent) were hospitalized at least once during the year; 8.4 per cent used nursing home care, and at least a quarter used the home and office call provisions that were available during the last six months of the year. Utilization of all phases of the program ranged widely among the state's 60-odd counties; the differences were apparently due more to the presence or lack of health care facilities in various counties than to any other factor. For example, long-stay hospitalizations were associated with pensioners coming from counties without hospitals or physicians.

**Hospitalization** The 14,236 pensioners who required hospitalization during 1959 had a total of 22,113 hospital admissions, a rate of 424 admissions per 1,000 pensioners (Table 3). Of the total number of admissions, 8,591 (39 per cent) were men and 13,522 (61 per cent) women. Since only a fourth of the pensioners were men, the rate of hospital admissions for men (624 per 1,000) was far higher than for women (356 per 1,000). The overall admission rate in 1959 was slightly higher than that in the first eleven months of the program (February-December, 1958); the admission rate during the first six months of 1960 continued the slow rise. Because readmissions accounted for a high proportion of hospital admissions (about a third of all admissions in 1959 were readmissions), the recently imposed restriction in the program on readmissions within 30 days of discharge may have a marked effect on admission rates, but no data are yet available.

The average length of stay per hospital admission during 1959 was 11.8 days. This was an increase over the first year of the program, when the average hospital stay was 11.4 days. For the first six months of 1960 the average hospital stay was 12.0 days. The distribution of admissions by the number of days hospitalized is shown in Table 1. As this table shows, 94 per cent of all hospital admissions in 1959 were for periods of 30 days or less. This percentage was maintained during the first six months of 1960. It would be interesting to know whether the provision of nursing home care in the program reduced the proportion of long-stay hospitalizations among pensioners, but no data are available.

Hospital admissions of pensioners were more often for medical care than for surgery. Diseases of the circulatory system caused about 22 per cent of all admissions in 1959. Diseases of the digestive system resulted

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Table 1  
Hospital Admissions by Number of Days Hospitalized  
1959

Number of days hospitalized	Admissions		Expenditures	
	Number	Per cent of total	In dollars*	Per cent of total
1-10	13,272	60	1,486,824.	27
11-20	5,027	23	1,523,852.	28
21-30	2,526	11	1,276,866.	24
31-40	628	3	461,412.	8
41-50	370	2	326,331.	6
51 and over	290	1	362,760.	7
Total	22,113	100	(5,438,047.)**	100

\*Expenditures before audit adjustment.

\*\*Totals do not add up precisely because of rounding.

Source: Table III, "Progress Report on Colorado's Old Age Pension Health & Medical Care Program," January through December, 1959. Colorado State Department of Welfare.

Table 2  
Hospital Admissions by Diagnosis  
1959

Diagnosis	Admissions		Total Days		Expenditures	
	Number	Per cent of total	Number	Per cent of total	In dollars*	Per cent of total
Diseases of circulatory system	4,768	22	63,259	24	1,267,386.	23
Diseases of digestive system	3,465	16	37,749	14	884,162.	16
Accidents, poisonings and violence	2,835	13	30,079	12	582,375.	11
Diseases of the respiratory system	2,341	11	27,092	10	552,020.	10
Neoplasms	1,765	8	23,928	9	537,146.	10
Diseases of genitourinary system	1,714	8	21,440	8	483,077.	9
Diseases of nervous system and sense organs	2,096	9	24,129	9	465,231.	9
All others	3,129	14	33,652	13	666,647.	12
Total	22,113	(100)**	261,328	(100)**	(5,438,047.)†	100

\*Expenditures before audit adjustment.

\*\*Percentages do not total exactly 100 per cent because of rounding.

†Totals do not add up precisely because of rounding.

Source: Table V, "Progress on Colorado's Old Age Pension Health & Medical Care Program," January through December, 1959. Colorado State Department of Welfare.

in 16 per cent of admissions. Accidents, poisonings, and violence constituted the third largest cause of hospital admissions, accounting for 13 per cent of admissions. Diseases of the respiratory system resulted in 11 per cent of admissions, and neoplasms accounted for 8 per cent of admissions (Table 2).

**Physicians' Services** During 1959 physicians submitted bills for 33,565 separate services for hospitalized pensioners. About 42 per cent of these were for medical care and 31 per cent were for surgery. The remainder covered anesthesia, surgery assistance, x-rays, consultations, and laboratory services. The proportion of services used by men and women (37 and 63 per cent) was comparable to their proportion of admissions. As would be expected from the reasons for admissions, diseases of the circulatory system required a large percentage of the medical services performed (28 per cent). Diseases of the digestive system (17 per cent) and diseases of the respiratory system (15 per cent) required the next largest number of medical services. The largest number of surgical services was necessitated by conditions of the skin, such as moles, warts, polyps; these accounted for close to a fourth of all surgery (a large proportion of it minor surgery). The next largest diagnostic categories for surgical services were conditions of the musculoskeletal system and digestive system. These three categories necessitated about 70 per cent of all surgical procedure.

Pensioners' use of physicians' home and office calls, covered in the medical care program only after mid-1959, can only be estimated. By the end of 1959 physicians had submitted bills for 39,111 calls. During the first part of 1960 the rate of home and office calls under the program was about 30,000 calls per quarter, 80 per cent of them office calls and and 20 per cent home calls.

**Nursing Home Care** While 4,907 pensioners used nursing home care during 1959, the average monthly caseload was 2,318. Of this average, 321 (14 per cent) were ambulatory patients who needed no special services; 1,013 (44 per cent) were semi-ambulatory, semi-bedfast, or in need of some special diet or care; and 984 (42 per cent) were completely bedfast or needed substantial special care. During the first five months of 1960 the average number of pensioners in nursing homes rose slightly, to 2,520, or almost 5 per cent of the average monthly pensioner case load. At the same time, the proportion of patients needing no special

Table 3  
Utilization Rates for Selected Services  
1959\*

Type of service	Number of admissions and surgical procedures	Rate per 1,000
Hospitals	22,113	424
Nursing homes	4,907	95
Surgical procedures	10,498	203

\*Calculated from average monthly caseload of 51,760 Old Age Pension recipients.

Table 4  
Expenditures for All Services by Type of Service and Per Person  
1959

Type of care	Expenditures	Per person	Percentage
Hospitalization	\$5,209,851.	\$100.	59.8%
Nursing home	1,804,724.*	35.	20.7
Physicians' services:			
Home & office calls	\$ 133,240.	28.	16.8
Nursing home calls	63,497.		
In-hospital services	1,265,129.		
	1,461,866.		
Drugs for patients in nursing homes	182,943. }	5. }	2.1
Transportation	59,145. }		.7
Total	\$8,718,529.	\$168.	(100%)**

\*This was the amount paid by the state. An additional \$2.8 million was paid by the pensioners directly, and an unknown amount was paid by their families. Pensioner payments increase the known expenditures for nursing homes from \$1.8 to \$4.6 million, and from \$35 to \$89 per pensioner. Per capita expenditures for all services rise from \$168 to \$222. The per cent of total expenditures spent for nursing homes increases from 20.7 to 40.

\*\*Percentages do not total exactly 100 per cent because of rounding.

care or only limited special care dropped slightly (to 12 and 42 per cent of the nursing-home caseload), while the proportion of patients needing maximum care rose to 46 per cent.

Nursing home patients are generally long-stay patients. The pension medical care program has not been in effect long enough to provide state-wide data on pensioners' length of stay in nursing homes. In large Denver County, however, the welfare department's experience over the years with pensioners in nursing homes indicates that the average length of stay is about 23 months. The average age of this county's nursing-home pensioner-patients is 82. Of 368 pensioners leaving Denver County nursing homes in 1959, 60 per cent died, 25 per cent went home, and the remainder were transferred to other facilities.

## B. Costs

A major task of the 1955 Governor's Commission on the Aged was to estimate the probable cost of an old-age pension medical care program. The sum fixed in the proposed constitutional amendment for a pension fund had to be both acceptable to the electorate and adequate for a full health care program. As noted already, a maximum of \$10 million per year was the amount set and then fixed into law in 1956. This was believed adequate for the program, but the state welfare department chose additionally to begin the program with only fundamental—in-hospital and nursing-home—coverage and then expand it after cost experience accumulated.

Like utilization, the cost of the medical care program has risen steadily since the program's inception, but at a higher rate. The increased costs stem from three factors: the increased benefits offered in the expanding health program, the increased use of covered services by pensioners, and the rising costs of health care. In the first eleven months of the program (Feb.-Dec., 1958) its total costs were \$5.7 million. In 1959 total expenditures reached \$8.7 million, or \$168 per pensioner. During the first six months of 1960 they exceeded \$5 million, so that despite efforts to reduce utilization and cost during the latter part of this year, costs should reach or exceed the present \$10 million limit by the end of the year.

The following discussion views costs principally in terms of the expenditure needed for each major part of the medical care program. It

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also seeks to estimate how far the program goes in meeting the total health care costs faced by pensioners. A third viewpoint of the cost of the program might be what share of all of Colorado's health care expenses the program pays. Of this, a few statistics must suffice: Payment to hospitals for pensioner care represents 12 to 15 per cent of total hospital costs in Colorado. For nursing homes, the program is still more important. Well over half—perhaps 60 per cent—of the income of the state's 347 nursing homes comes from pensioners or is paid for them.

**Hospitalization** In 1959 hospitalization accounted for \$5.2 million or 60 per cent of the total expenditures for the medical care program (Table 4). On a per capita basis, hospitalization cost \$100 per pensioner on the rolls. The average cost for each day of hospitalization was \$21; the average cost per admission \$243. During the first six months of 1960 the average cost per day was \$23; the average cost per admission was \$274.

The recent lowering of the covered hospital stay from 30 to 21 days, with a required 30 days between admissions, may be reflected in hospital costs for the latter half of 1960. While hospital stays over 30 days accounted for only 6 per cent of all admissions during 1959 and the first half of 1960, they accounted for over 20 per cent of hospital costs during these periods.

**Physicians' Services** Physicians' services cost \$1.5 million in 1959 or \$28 per pensioner, accounting for 17 per cent of the cost of the program. The bulk of the cost of physicians' services (86 per cent) was for care to in-patients in hospitals. The balance (9 and 5 per cent) was for home and office calls and for visits to patients in nursing homes. The cost of physicians' services in 1959 was substantially higher than in 1958 when, limited to in-hospital care, it amounted to \$697 thousand for eleven months. The cost of physicians' services should rise sharply again for the full year 1960, reflecting a full year of home and office calls and the adoption of the new Standard "A" fee schedule for physician payments on January 1.

The average charge for physicians' services in the hospital was \$33 per billing in 1959. The average charge for in-hospital surgery was \$40, for medical services \$38. The low average surgical billing resulted in part from minor surgery for conditions of the integumentary system (*e.g.*, removal of cysts, warts, and lesions) and conditions of the urinary system.

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The average surgical charge without these two diagnostic categories was slightly over \$50.

The average payment for home or office calls during 1959 was \$3.40, reflecting the 80/20 ratio of these calls, which are paid for at \$3 per office call and \$5 per home call.

**Nursing Home Care** The total of \$1.8 million paid to nursing homes by the state in 1959 (\$35 per pensioner) represented only a part of the payment they received for pensioner care. The pensioners themselves paid \$2.8 million directly, and their families paid an indeterminable—but substantial—amount supplementing both the state payments and those of the pensioners. Such payments were made for an estimated 35 per cent of the pensioners in nursing homes. The average monthly payment by the welfare department was \$65 for each pensioner-patient. During the first five months of 1960 the average payment rose slightly, to \$67 per month. Including both public and private sources of nursing-home payments, known expenditures in 1959 totalled \$89 per pensioner and accounted for 40 per cent of total expenditures for all services.

**Other Medical Services** Payments of \$183 thousand were made for prescribed drugs and medical supplies for pensioners in nursing homes during 1959, an average of less than \$40 for each pensioner in a nursing home during the year and only about \$3.50 per pensioner in the average case load. \$59 thousand was paid for public transportation (essentially ambulance service) to enable pensioners to obtain necessary medical care.

**Pensioners' Health Care Costs** No study exists—and none has been attempted here—of pensioners' total health care costs or of what proportion of these costs the program covers. A number of pensioners were interviewed, however, and the following is based on their mention of expenditures for health care and comments by physicians and hospital personnel.

It seems certain that for many pensioners, whatever hospital care or physicians' services are not paid for by the program are simply not paid for, being either deliberately donated care or uncollectible billing. Since hospital and physicians' care are provided broadly under the program, however, the amount of "free" care pensioners receive is probably not great.

Of those pensioners interviewed who had been hospitalized (and most of those seen had been at some time since the program began), none reported having to pay more than a relatively small amount when discharged. Most said they had been charged nothing at all. Those who said they had to pay something mentioned such items and costs as "*transfusions, \$10;*" "*telephone, \$1.50;*" "*special nurse, \$13.50.*" Obviously, some of these services were charged for at sharply reduced rates.

The home and office calls appear to be used more for physicians' management of chronic conditions than for temporary acute illnesses. For many pensioners payment for these visits by the program replaced expenditures that they previously had to make for regularly received treatment ("*blood tests every two weeks,*" "*'shots' every six weeks,*" "*every two months for my heart.*"). Since the program includes home and office calls only on an indemnity basis, it would be interesting to know what proportion of physicians *do* bill their pensioner-patients for an additional amount, and what the collection record is for these bills. No data are available on this, but relatively few pensioners mentioned any significant payments to physicians.

The major expenses that remain for a number of pensioners are for drugs and appliances. Physicians interviewed reported that their pensioner patients often made wide use of non-prescription medicines and preparations—chiefly laxatives, nutritional supplements, and analgesics. A majority of the pensioners interviewed, however, mentioned prescribed drugs when asked about medicines they "*had to buy themselves.*" These included "*medicine for high blood-pressure,*" "*medicine for my heart,*" "*medicine for my feet,*" "*digitalis,*" etc., the average cost of which was \$4 to \$5 per month (the range, from \$.50 to \$12). Fewer pensioners had costs for health goods—chiefly dentures, eye-glasses, and hearing aids—among those interviewed, but some spent substantial sums for these appliances, including an 85-year old who had just contracted to pay \$20 a month for a \$400 hearing aid. More typical were "*an examination and glasses for \$27*" and "*glasses for a couple of dollars.*"

### C. Use and Cost: Comparative Data

No data exist on the use of services or expenditures for care by the non-pensioner aged in Colorado. Thousands of people over 65 are members of Colorado Blue Cross (perhaps as many as 60,000), but that plan

began recording the age of its new subscribers and their dependents only in the past few years, so that it cannot isolate its aged members for special study. The use and costs of health care by the aged nationwide and in the few other states in which data have been collected provide the only bases for comparison with the Colorado program. Additionally, because hospitalization rates and costs vary in different parts of the country, those of Colorado Blue Cross members furnish a guide to the particular pattern of hospitalization and health care costs in Colorado.

**Colorado Blue Cross Members** The rate of hospital admissions among Colorado Blue Cross members was 163 per 1,000 in 1959, appreciably above the nationwide rate for insured persons of 130 per 1,000 reported in a study in 1958 by Health Information Foundation and National Opinion Research Center. (The admission rate for old-age pensioners, 424 per 1,000, was 2½ times that of Colorado Blue Cross members.) The average length of stay for Blue Cross members was 7.0 days (11.8 days among hospitalized pensioners). The average cost per day was comparable: \$24 for Blue Cross members, \$21 for pensioners. But their shorter length of stay gave Blue Cross members a substantially lower average cost per admission (\$167) than pensioners (\$243). And in terms of the total hospital bill, Blue Cross paid hospitals \$17.3 million for in-hospital care of its 640,321 members, while the pensioner group, fewer than one-tenth the number, cost \$5.2 million for in-hospital care, or almost one-fourth of the total Blue Cross disbursements.

**Nationwide Insured, Over-65** Colorado seems to have a higher hospital utilization rate than the nation as a whole, as the Colorado Blue Cross data suggest. The hospital utilization rates for Colorado's old-age pensioners are also substantially higher than the utilization rates for the nationwide insured population 65 years of age and over. While the admission rate for Colorado pensioners was 424 per 1,000, the rate for insured persons 65 and over throughout the country was 180 in 1958, as reported by the HIF-NORC study.

**Indiana Blue Cross Members** In 1956 the Blue Cross Plan of Indiana provided detailed data on its hospital utilization by age which showed an admission rate of 220 per 1,000 among its members 65 and over. The number of hospital days per 1,000 was 3,250 for this group, compared to over 5,000 days per 1,000 for Colorado pensioners.

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**Saskatchewan** The utilization rate in the Colorado program approaches the rate in a government-sponsored insurance plan in Saskatchewan, Canada. In this province-wide plan the admission rate for those 65 years of age and over is 390 and the number of days per 1,000 is over 7,200.

What accounts for these wide variations? No answer is known at this time, although the different patterns of hospital care are becoming clearer as more data are collected. One obvious reason for the differences in utilization between Colorado pensioners and Indiana Blue Cross members and nationwide insured persons is that the Colorado pensioners are older on the average. Also, Colorado's pensioners fall entirely within the lower income level, associated with lower health status, while the other two groups do not.

Cost comparisons are also of interest. In the 1958 study by HIF-NORC the per capital annual expenditures for insured people 65 and over were \$214, not including expenditures for nursing homes. Excluding all nursing home expenditures from the Colorado figure gives a cost of \$133. Services paid for by the pensioner or received free are not known. A closer comparison can be made by comparing expenditures for hospital care, since the Colorado program appears to pay virtually all of pensioners' expenditures for hospitalization. The expenditures per person for general hospital care for insured persons 65 and over in the country were \$65 in 1958, compared with \$100 in Colorado in 1959. For physicians' services expenditures were \$63 and \$28 respectively. Fully one-half of the nationwide expenditure of \$63 was for home and office calls, a type of service only partially covered in Colorado (and covered for only part of the year).

## LOCAL EVALUATION OF THE PROGRAM

One generalization must be made first in reviewing attitudes toward the old-age pension medical care program: Every one of about a hundred physicians, hospital administrators, welfare officials, pensioners, and Blue Cross-Blue Shield executives interviewed agreed that the Colorado program has worked well. Going beyond the approval of these individuals, virtually every organized group concerned with health care for the aged in Colorado has also endorsed the program, including the state Chamber of Commerce, labor council, League of Women Voters, medical so-

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ciety, and National Annuity League (the state's largest pensioner organization). Details of the program may be criticized, problems may be cited that it has created or contributed to, and many many suggestions are made for improving it—but all of these are offered the researcher within the clear context of approval of the way the program is meeting the needs of the aged it covers.

Which particular feature of the program is singled out for approval is likely to depend on the special interest of the commentator, except that the selection of Blue Cross and Blue Shield to administer most of the program is universally credited with its wide acceptance and smoothness of operation.

*"With Blue Cross administering the program," a county welfare director explains, "we have no problems with hospitals—no difficulty about admissions and no time-consuming conferences about charges or the like."*

An orthopedic surgeon says, similarly, *"physicians' acceptance of this program was largely due to its use of Blue Shield. If the same program had been set up through a state bureau, we would have had a completely different reaction to it."*

A state welfare department official agrees that *"by using the existing channels—Blue Shield and Blue Cross—we avoided any conflict with physicians and hospitals and held down our paperwork too."*

A hospital administrator holds that *"existing Blue Cross and Blue Shield controls have held abuse to a minimum in this program—far less than would be found in a government program."*

Even a physician who believes the old-age pension health program should have been opposed as *"socialistic"* (no group did oppose the program when it was instituted, nor has any since) still agrees that it has been *"well accepted"* by other physicians and that *"using Blue Cross and Blue Shield was probably a good idea."*

A few of the secondary features of the program singled out for special approval were these:

1. The pensioner can now have a doctor to whom he can go regularly for treatment, one who knows his problems.

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2. Pensioners can go to whatever hospital they want—saving many of them a long trip to the state's Colorado General Hospital in Denver.
3. Hospitals and physicians can now collect some payment for patients they formerly cared for free or at greatly reduced charges.
4. Nursing homes throughout the state have improved to qualify for maximum payment under the plan.

Different statistics were cited as evidence of the program's success:

1. 98 per cent of the physicians in the state voluntarily take part in the program (95 per cent participate in Blue Shield).
2. Only 2 per cent of the total cost of the program goes for administration, generally agreed to be far less than some proposed arrangements for pensioner care would have cost.
3. No gross abuse of the program has been reported. Despite their advanced age and the availability of paid-for care, almost half of the pensioners made no use at all last year of the program's services.

What about the pensioners themselves? Those interviewed (as well as a much larger number who expressed their views to their physicians) seemed entirely favorable toward the program and grateful for it. Besides free choice of hospital and physician and the assurance that care was readily available—both already mentioned—the pensioners interviewed spoke most often about the high quality of care they thought they received from physicians and hospital personnel. Many seemed to view this care in terms of their pensioner status: *"It made no difference to anyone at the hospital; they treated me wonderfully,"* or even, *"the Queen of England couldn't have gotten better care."*

The means test for participation in the pension program does not appear to be an issue in Colorado. Pensioners apparently consider the eligibility requirements relatively generous and believe that they are applied impersonally and objectively. Further, the climate of opinion

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in the state is such that old-age pensioners are not regarded as paupers or low-grade citizens.

Pensioners' suggestions for additional coverage are reviewed below, but the limited cost data available and their own views show that the program meets the major needs that pensioners see. Similarly, the director of the pensioners' National Annuity League, while advocating broader scope for the program, has called it *"perhaps the most workable of any in the nation."*

**Problem Areas in the Program** *"Any health program for old people is going to have problems. These people are more likely to be sick than younger people. They go to the hospital more often, and they stay longer."* So a Denver surgeon summed up the major problem area for the Colorado program. When analyzed, most of the flaws or problems that local observers find in the program are related to pensioners' utilization of services.

The earliest problem created by the medical care plan derived from this utilization and from the program's free-choice-of-hospital provision. Pensioners formerly could receive "free" care or have the cost paid by the local welfare department only in county hospitals or the Colorado General Hospital in Denver. At the advent of the program, most hospitals in giant Denver county, which has virtually half of the state's population, and in some other counties were already operating at high rates of occupancy. With pensioners covered for care in any general hospital in the state and with increased hospital utilization following coverage under the new program, an added burden was placed on these hospitals. At the same time, county hospitals—in particular, Denver General Hospital—experienced a sharp drop in pensioner patients. While this has been mitigated somewhat—Colorado General, for example, which experienced an immediate 10 per cent drop, later found its patient load returning to normal—some disparity still exists.

Perhaps the most obvious problem created partly by pensioner utilization of services is that the cost of the program has risen to—or above—the \$10 million limit fixed by state law. The view is widely held that the pension fund should have been created with an "escalator" clause to absorb at least the rising cost of hospital care. (The increase in hospitalization expenditures from 1959 to 1960 is actually divided



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almost equally between a 10 per cent rise in hospital admissions among pensioners and an 11.5 per cent increase in per diem hospital costs.) In defense of the original creation of a fixed fund in a time of rising medical care costs, it was thought then that Federal benefits for the aged would broaden to reduce the state's pension rolls, thus counterbalancing the rising costs of care. While no change is possible now without another constitutional amendment, it does appear likely that Federal funds becoming available will be allowed to augment the \$10 million fund.

The principal effort that has been made to hold costs under the \$10 million limit was, as discussed earlier, the reduction in days of hospitalization allowed and the added requirement that 30 days elapse between admissions. Some believe that these provisions may lead to the first significant friction between the state welfare department and physicians. Although the department has been reviewing physician requests for extending pensioners' hospital stay since the program began (denying about 25 per cent of them), the number of these requests has been small. Under the changed program the number is rising sharply and, it is suggested, some physicians will resent the review "from behind a desk" of their medical judgment.

Of all the benefits in the medical care program, the home and office call allowances are questioned most often by physicians and others concerned with the program. The stated objections are these:

1. The indemnity aspect of the allowance involves the doctor in billing the pensioner for one or two dollars above the cost paid by the plan, and at the same time leaves the pensioner an amount to pay out of a pension designed mainly for food, clothing and shelter.
2. The number of calls allowed is not enough to provide care in case of real illness, and the lack of a "carry-over" privilege from one quarter to the next encourages the pensioner to use his two calls "whether he really needs them or not," whereas he might save them for a time of sickness if he were allowed to credit unused calls toward later use.
3. Any close administration of home and office calls would cost as much as the benefit itself. As a result, this part of

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the program is almost uncontrolled, no check being made of the actual number of calls used by each pensioner.

4. The need for help in paying for home and office calls is much less than the need pensioners have for other services to be covered (a home-care program is usually mentioned as an alternative).

**Suggestions for Changes** The changes most often suggested for the medical care program are of two kinds: new benefits or administrative modifications (some of which would reduce benefits). One administrative change that has been suggested is that home and office calls should be provided under a coupon arrangement. Each pensioner would receive a year's supply of coupons, which he would exchange for physicians' services when he needed them. The coupons would provide the needed check on his use of calls. Another proposal is that committees of physicians in every hospital should assume the task of reviewing pensioner hospital stays and requesting additional days when needed. This, it is said, would satisfy the welfare department that every request had medical validity and avoid denied requests that create confusion in the hospital and resentment by individual doctors.

A more fundamental suggestion for altering the program is that indemnity provisions should be added to all benefits, so that the patient would pay for part of every day hospitalized and every physician's service. Its proponents hold that this change would reduce utilization and cost greatly. (Opponents of the idea say that pensioners could not possibly assume any substantial part of the financial burden from their pension payments, so that only a rise in the proportion of unpaid bills would result.)

Another suggested program change calls for this inclusion of nursing home care under Blue Cross administration, like hospital care. (Opponents of this proposal—including Blue Cross officials—feel that, since Blue Cross has had no special experience with nursing homes as it has with hospitals, it could do no better than the welfare department in the administration of this part of the program.) Nursing homes and nursing home care certainly represent one of the biggest problem areas for the program at the present time, as they undoubtedly would regardless of which agency administered these benefits. Nursing home stand-

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ards have apparently improved greatly over the past few years, and a number of new homes have opened. But what standards and what additional nursing home facilities are now needed are hotly debated questions. In addition, nursing home operators are pressing for increased payments to offset their rising costs.

According to figures developed by the National Annuity League, the state needs twice the number of nursing home beds it now has. The League maintains that if these beds were available, close to 2,000 patients in general hospitals could be moved to them, reducing health care costs greatly for these patients (per diem cost in nursing homes is about \$5.50, while that in general hospitals is over \$20). To raise standards in the present homes, the state welfare department has developed a new payment formula that would pay more than at present to homes with higher quality of care. Nursing home operators and their association strongly oppose the new standards. Certainly needed at the present time are full cost data on nursing home operation, which most homes in Colorado have not developed.

The new benefits proposed for the medical care program include virtually every health care cost that people face. It should be noted, though, that a large percentage of people interviewed (pensioners as well as welfare department officials and physicians) held that the present benefits are adequate and that the program needs no expansion (even if additional funds were available to it). Among those who favored expanding the program, the needs mentioned most often were these:

1. Drugs and appliances (hearing aids, eyeglasses, and dentures). These were suggested most often by the pensioners themselves.
2. Blood and blood plasma. The physicians suggesting this added benefit noted that the aged as a group were least able to make replacement (or obtain replacement) for blood used.
3. Diagnostic services in physicians' offices, as an extension of the present home and office call program. Advocates of adding these services claim that hospitalization would be reduced as a result; pensioners now being hospitalized

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so that the program covers their diagnosis would be cared for by the physician in his office. They point out that almost a fourth of all hospitalization under the program is for one to three days—much of that being diagnosis rather than treatment, they believe. Critics of the idea of covering office diagnostic services note, however, that the experience of other states (Maryland is cited) does not bear out the belief that hospital use will be lowered. They add that, particularly with the aged, diagnostic services would simply bring to light more conditions for treatment, resulting in *more* hospitalization.

4. A home-care and homemaker program, combining calls by a housekeeper, public nurse, and physician. Such a program might enable pensioners to remain at home who otherwise must enter nursing homes, reducing the cost of their care and relieving the pressure for nursing home beds. Along with diagnostic services (and less controversially), this proposed benefit is suggested more often than any other as a real need.

## OBSERVATIONS AND IMPLICATIONS

Because of its organization, the medical care program for the recipients of old age assistance in Colorado provides an important medical care laboratory for other states to study. One large unknown in providing medical care for the aged has been what the cost of that care would be. Another has been what range, quantity, and types of services are needed by the aged. The Colorado program is particularly valuable for study because its financing has been generous and pensioners' use of covered services has not been unduly restricted.

Several observations can be drawn from the Colorado experience. *First, a program of this type requires more generous financing than is generally supplied for public medical care programs.* No criteria exist for determining whether or not pensioners' utilization of services is at a "proper" level or properly balanced between types of services (hospital care, nursing home care, physicians' services, etc.). However, since the program gives pensioners the same access as the rest of the population to services it covers, the use and quality of these services under the pro-

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gram are likely to approximate those of segments of the general insured population with the same sex, age, and other characteristics. If this is true, then the cost of medical care under a program of this kind should also approximate that of the comparable part of the general population.

A second observation is that nursing homes have assumed a very important role in health care for the aged, stimulated by the presence of public money and the obvious need for this type of facility for the aged. *In Colorado the expenditure per pensioner for nursing homes approaches that for general hospitals.* Critics may say that both the general hospital and the nursing homes would not assume the importance they do in Colorado if more attention were paid to physicians' office services and home care of various kinds. This may be so, but Colorado shows what happens in a medical program for the aged with institution-based services and limited physicians' home and office calls. If additional physicians' and home-call services are included later, it should be possible to measure the impact of these additions upon the use of services already covered.

Some of the specific decisions made in this program deserve mention. The decision to contract for services with Blue Cross and Blue Shield reveals substantial confidence and understanding between the state welfare department, the Blue Cross and Blue Shield plans, the hospitals and the medical profession, and citizens' groups *before* the medical care program for the aged was inaugurated. This rapport enabled the state to take advantage of the existing administrative organizations and place a full-scale program in operation in three months.

Government contracting out for goods and services for which it is responsible has many precedents in this country. However, some hold that government delegates too much responsibility when it contracts out for services to people who are its direct charge instead of providing the services with its own personnel. This view represents a philosophical difference but it falls within the range of acceptable alternatives in our country. Certainly the government should, as in Colorado, be able to account for the cost, quantity, and quality of services provided.

The waiving of waiting periods for pre-existing conditions when the program was established recognized that underwriting principles which may be equitable for other segments of the population can be

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inequitable for the indigent aged. A related decision established administration of the program under a "cost-plus" arrangement. As a general principle of administration "cost-plus" is not usually favored because it is assumed not to provide an incentive for efficient, economical operation. Whether this is true or not in medical care administration can be debated, but in Colorado the program has been administered at extremely low cost (less than 0.8 of 1 per cent for the Blue Cross portion of the program). And it would be a bold Blue Cross or Blue Shield administrator who would set a fixed contract price on medical care for the aged.

In Colorado, the state retains ultimate responsibility for financing and overseeing the general operation of the program, while using the administrative framework of Blue Cross-Blue Shield and the controls already operating in those plans. This arrangement would not prevent the state welfare department from imposing further controls on the program if these seemed desirable. One control already exercised was cutting back the days of hospital care from 30 to 21. So far the program is as liberally administered as its funds permit. At present all parties in the program are reasonably content, certainly a primary criterion in medical care administration. The program should, of course, receive continuing review and evaluation. In a day-to-day sense this is already being done, but the existing data on the experience of the program could undoubtedly be exploited more fully and new data could be assembled. These would give increased knowledge for guidance of the program (for example, the seemingly high hospital readmission rate should be analyzed closely, but present records yield little data on this).

There are several long-term considerations that deserve mention in the Colorado experience. The decision to work with existing prepayment plans in turn presumed working with the existing structure of the medical establishment. Some may feel that limiting the program to the existing insurance and medical establishment makes it difficult to bring in innovations. These critics might challenge the absence in Colorado of a program in physical rehabilitation or the lack of extensive preventive services. Philosophic differences on how to organize and provide medical care are closely related to differing concepts of adequacy for public health care programs.

Finally, can the Colorado program be applied in other states? The

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answer is generally yes, if there is a mandate from the state government, statewide Blue Cross and Blue Shield plans that are functioning well, relatively generous financing, cooperative hospital and medical associations, and a favorable climate of public opinion. This has been the combination of circumstances in Colorado so far. The added and exceedingly necessary ingredient in Colorado has been a willingness to try, to watch and to learn. ■

## Appendix

The following are some of the forms used in the medical care program, as described on pages 10 and 11. These show the extent of reporting required of the suppliers of services under the program.

COLORADO OLD AGE PENSION MEDICAL PLAN PARTICIPANT	
H. H. NO. NAME	
GROUP NO.	RECIPIENT'S SIGNATURE
ADMINISTERED BY COLORADO BLUE CROSS - BLUE SHIELD	

PENSIONER IDENTIFICATION CARD

SUBSCRIBER NO		GROUP NO	
PATIENT'S NAME (LAST FIRST MIDDLE INITIAL)			
S & S	DATE OF BIRTH	RELATIONSHIP	
ADMISSION DATE		HOUR OF ADMISSION	
DIAGNOSIS		DOCTOR'S NAME & ADDRESS	
DOCTOR NO		FULL NAME & ADDRESS OF OUT OF STATE B C PLAN	
SUBSCRIBER'S NAME & ADDRESS		CONFIRMATION	
CONTRACT CODE		B C EFF DATE	
FULL DATES		TYPE OF DRUG	
INVEST		REJ	
PD TO			

**EXPLANATION OF CODES**  
**SEX & STATUS**  
 1 MALE ADULT  
 2 FEMALE ADULT  
 3 MALE CHILD  
 4 FEMALE CHILD  
 5 INFANT  
 6 DECEASED  
**INVESTIGATION**  
 1 NECESSARY TO OBTAIN ADDITIONAL INFORMATION  
 2 NECESSARY TO ESTABLISH UTILIZATION IN OTHER HOSP.  
 3 CONTRACT NOT IN ORDER TO DATE  
 4 INVESTIGATED & APPROVED  
**REJECTION CODE**  
 1 INELIGIBLE FOR MATERNITY CARE  
 2 PRE-EXISTING CONDITION  
 3 DIAGNOSTIC CONDITION  
 4 USED ALL TIME AVAILABLE  
 5 INELIGIBLE OUTPATIENT SERVICE  
 6 DEPENDENT INELIGIBLE FOR BENEFIT  
 7 ADMISSION PRIOR TO EFFECTIVE DATE OR CONTRACT CANCELLED  
 8 BENEFIT DENIED - SEE LETTER OF REJECTION

SUBSCRIBER NO		GROUP NO	
PATIENT'S NAME (LAST FIRST MIDDLE INITIAL)			
S & S	DATE OF BIRTH	RELATIONSHIP	
ADMISSION DATE		HOUR OF ADMISSION	
DIAGNOSIS		DOCTOR'S NAME & ADDRESS	
DOCTOR NO		FULL NAME & ADDRESS OF OUT OF STATE B C PLAN	
SUBSCRIBER'S NAME & ADDRESS		CONFIRMATION	
CONTRACT CODE		B C EFF DATE	
FULL DATES		TYPE OF DRUG	
INVEST		REJ	
PD TO			

**COLORADO HOSPITAL SERVICE**  
 244 UNIVERSITY BOULEVARD  
 DENVER 6, COLORADO

TWO PARTS OF HOSPITAL ADMISSION NOTICE  
(TO BE ATTACHED TO STATEMENT OF ACCOUNT)

## Attach Completed Admission Notice

Here

Complete Lower Portion  
As Outlined  
And Forward Immediately To  
Colorado Hospital Service

SPECIMEN

**CHECK TYPE OF BLUE CROSS CERTIFICATE HELD BY SUBSCRIBER HERE:** Series: A-5 ☐ 7 ☐ 9 ☐ 12 ☐ 14 ☐ Comp. ☐

**Itemized Statement of All Hospital Charges for Services Rendered**

**LIST OF SERVICES**  
NOTE: Compute 80% Benefits in Same Columns (A-5 series only)

TOTAL CHARGES FOR HOSPITAL RECORDS	DISTRIBUTION OF CHARGES			
	1.	2.	3.	4.
Days @ \$ _____ per day				
Days @ \$ _____ per day				
Days @ \$ _____ per day				
Operating or Delivery Room				
Care or Ophthalmic Room				
Dressings				
Drugs and Solutions				
Oxygen Therapy and Inhalations				
Physical Therapy				
Radiation Laboratory				
Surgical Laboratory				
"				
"				
X-Ray				
"				
Anesthetic Administration				
Other Charges				
TOTALS	1.	2.	3.	4.

**AMOUNT DUE HOSPITAL FROM PATIENT** **A**

**DISPOSITION OF CASE:** Cont. Care ☐ Discharged ☐ Expired ☐

**Final Diagnosis:** \_\_\_\_\_

**LENGTH OF STAY AND ACCOMMODATIONS OCCUPIED**  
 WHOLE BENEFIT DAYS ☐ HALF BENEFIT DAYS ☐  
 Days in Private Room \_\_\_\_\_  
 Days in 2 Bed Room \_\_\_\_\_  
 Days in 3 or more Bed Room \_\_\_\_\_  
 Admission Date \_\_\_\_\_ Hour \_\_\_\_\_ A.M./P.M.  
 Discharge Date \_\_\_\_\_ Hour \_\_\_\_\_ A.M./P.M.  
 Remarks: (List Surgery, if performed, time and type of anesthesia here.) \_\_\_\_\_  
 Date Billed \_\_\_\_\_ By \_\_\_\_\_

**FOR BLUE CROSS OFFICE USE**

B.C. Diagnosis \_\_\_\_\_ Accommodations \_\_\_\_\_  
 Type Case \_\_\_\_\_ Private Room Days \_\_\_\_\_  
 Full Benefit Days \_\_\_\_\_ Total Benefit Days \_\_\_\_\_  
 Rider Benefits ☐

**TOTAL BILL** \_\_\_\_\_

**B. C. PLAN BENEFITS** \_\_\_\_\_

**NON CONTRACT CHARGE TO SUBSCRIBER** \_\_\_\_\_

**B. C. PAYMENTS**

Blue Shield Benefits	TYPE SERVICE	DIAGNOSIS CODE	AMOUNT PAID
Anesthesia	2		
Laboratory	3		
X-Ray	4		

☐ Check if 80% Benefits are included. The sum of the totals in columns 2, 3 and 4, must equal total of column 1.

FORM 100-750-0007 11-5-66 11-66

BILLING COPY

BLUE CROSS STATEMENT OF ACCOUNT, LONG FORM

Attach Completed  
Teletype Admission Notice  
Here

Complete Lower Left Portion  
As Outlined.

Attach Hospital Statement  
And Forward Immediately To  
Colorado Hospital Service

SPECIMEN

TO BE COMPLETED BY HOSPITAL	FOR BLUE CROSS OFFICE USE												
Disposition of Case: Continued Care <input type="checkbox"/> Discharged <input type="checkbox"/> Expired <input type="checkbox"/>													
Final Diagnosis _____													
LENGTH OF STAY AND ACCOMMODATIONS OCCUPIED	Type Case _____ B. C. Diagnosis _____												
Days in Private Room @ \$ _____ per day	Accommodations _____ Private Room Days _____												
Days in 2 Bed Room @ \$ _____ per day	Full Benefit Days _____ Total Benefit Days _____												
Days in 3 or more Bed Room @ \$ _____ per day													
Admission Date _____ Hour _____ A.M./P.M.	<b>TOTAL BILL</b> _____												
Discharge Date _____ Hour _____ A.M./P.M.	<b>B. C. PLAN BENEFITS</b> _____												
Remarks: Type Surgery (if performed) _____	<b>NON CONTRACT CHARGE TO SUBSCRIBER</b> _____												
	<b>B. C. PAYMENT</b> _____												
	Blue Shield Benefits: <table border="1"> <thead> <tr> <th>TYPE SERVICE</th> <th>DIAGNOSIS CODE</th> <th>AMOUNT PAID</th> </tr> </thead> <tbody> <tr> <td>Anesthesia</td> <td>2</td> <td></td> </tr> <tr> <td>Laboratory</td> <td>3</td> <td></td> </tr> <tr> <td>X-Ray</td> <td>4</td> <td></td> </tr> </tbody> </table>	TYPE SERVICE	DIAGNOSIS CODE	AMOUNT PAID	Anesthesia	2		Laboratory	3		X-Ray	4	
TYPE SERVICE	DIAGNOSIS CODE	AMOUNT PAID											
Anesthesia	2												
Laboratory	3												
X-Ray	4												
Total Charges _____ \$													
Blue Cross Allowances _____ \$													
Amount Due from Patient _____ \$													
Date Billed _____ By _____													

10-21-66 10-66-200

BLUE CROSS STATEMENT OF ACCOUNT, SHORT FORM  
(FOR HOSPITALS USING MACHINE BILLING)

# HIF Perspectives

MED-7 (Rev. 1-60)

## COLORADO STATE DEPARTMENT OF PUBLIC WELFARE

### REQUEST FOR EXTENSION OF HOSPITAL CARE BEYOND 21-DAY PERIOD

\_\_\_\_\_  
Hospital  
\_\_\_\_\_  
Address  
\_\_\_\_\_  
Colorado

TO: ATTENDING PHYSICIAN

DR. \_\_\_\_\_ Date Form Completed \_\_\_\_\_  
County of \_\_\_\_\_  
Address \_\_\_\_\_ Residence \_\_\_\_\_  
Date Admitted \_\_\_\_\_  
Age \_\_\_\_\_

Name \_\_\_\_\_ HH# \_\_\_\_\_ S \_\_\_\_\_  
is hospitalized and under your care. Before authorization for payment for hospitalization or physician's services beyond 21 days can be obtained from the Colorado State Department of Public Welfare it is necessary for you to supply us with the information listed below. Please complete and return this form to this hospital immediately if hospitalization will extend beyond 21 days. This report will be forwarded to the Colorado State Department of Public Welfare by this hospital.

Completed by the Attending Physician

1. Estimated need for hospitalization beyond 21 days is \_\_\_\_\_ days.
  2. Diagnosis \_\_\_\_\_
  3. Complications \_\_\_\_\_
  4. Prognosis \_\_\_\_\_
  5. Comments \_\_\_\_\_
- Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_

### EXTENDED HOSPITAL CARE AUTHORIZATION (Used by Colorado State Dept. of Public Welfare)

The request to extend hospitalization for the patient named above has been:

- ☐ Extended Until \_\_\_\_\_  
☐ Extension Denied \_\_\_\_\_

\_\_\_\_\_  
Director of Medical Services

\_\_\_\_\_  
Date

REQUEST FOR EXTENSION OF HOSPITAL CARE

# Colorado's program for the aged

PHYSICIAN'S SERVICE STATEMENT		COLORADO MEDICAL SERVICE, INC. 244 UNIVERSITY BLVD. DENVER 8, COLO.		ALL BENEFITS MUST BE BILLED BY THE PHYSICIAN RENDERING SERVICE.	
PATIENT AND SUBSCRIBER IDENTIFICATION					
SUBSCRIBER'S NUMBER		GROUP NUMBER		FULL NAME OF PATIENT	
PATIENT IS		SUBSCRIBER'S SPOUSE		PATIENT'S DATE OF BIRTH	
FULL NAME OF SUBSCRIBER		SUBSCRIBER'S ADDRESS			
GENERAL INFORMATION					
ATTENDING PHYSICIAN		DATE FIRST SEEN FOR THIS CONDITION		PROBABLE DATE OF ONSET OF BASIC PATHOLOGY	
WAS THIS AN ACCIDENT?		IF YES DATE OF ACCIDENT		WAS THIS AN ACCIDENT?	
SERVICES WERE RENDERED IN		PHYSICIAN'S OFFICE		HOSPITAL	
YOUR FINAL DIAGNOSIS					
SERVICES RENDERED					
TYPE OF SERVICE	DATE OF SERVICE	PLEASE GIVE PROCEDURE CODE FROM PARTICIPATING PHYSICIAN'S MANUAL WHENEVER POSSIBLE. OR DESCRIBE SERVICE IN DETAIL		YOUR TOTAL CHARGE	FOR BLUE SHIELD USE ONLY
SURGERY					LOC LDC HCR SS MS SSB-R
ANESTHESIA		LENGTH OF TIME			
LABORATORY					
DIAGNOSTIC X-RAY					
RADIATION THERAPY					
MEDICAL CARE	FROM	ADMISSION DATE	DISCHARGE DATE	NUMBER OF CALLS	
	TO	WAS SURGERY PERFORMED DURING THIS ADMISSION?	YES BY	NO BY	
OBSTETRICAL		SURGICAL PROCEDURE		DATE OF SURGERY	
CONSULTATION		REQUESTED BY DR.			
ASSISTANT SURGEON		DIAGNOSIS OF CONDITION REQUIRING CONSULTATION			
		PROCEDURE CODE		LENGTH OF TIME	
DATE OF THIS STATEMENT					TOTAL \$
PHYSICIAN SUBMITTING STATEMENT					SSR MSB BL CR BL SN SS RT
PHYSICIAN'S ADDRESS					CONF. CONF. PASC. PASC.
PHYSICIAN'S SIGNATURE					BL CR EFF. BL SN EFF.
REMARKS TO BLUE SHIELD (USE REVERSE SIDE IF NECESSARY)					CONF. EFF. SS. EFF.
DOCTOR'S ACCOUNT NUMBER					

PHYSICIAN'S SERVICE STATEMENT FOR SERVICES  
RENDERED IN HOSPITAL OR OFFICE

# HIF Perspectives

**SPECIAL REPORT  
OLD AGE PENSION MEDICAL PLAN  
NURSING HOME CASES**

This report should be completed quarterly at the end of March, June, September and December for all services rendered during the preceding quarter, and mailed to COLORADO MEDICAL SERVICE, INC., 244 UNIVERSITY BLVD., DENVER 6, COLORADO.

An Old Age Pension recipient in a currently licensed nursing home is eligible for physician services to the extent of two (2) calls per month for care of chronic or continued illness. If additional calls are necessary for care of acute illness or an acute manifestation of a chronic illness, payment may be made for up to two (2) additional calls in any one month upon appropriate explanation by the attending physician.\* Night calls (between the hours of 11:00 PM and 7:00 AM) should be designated by the initials "N.C." after the date.

PERIOD COVERED BY THIS REPORT: Quarter ending ☐ March 31; ☐ June 30; ☐ September 30; ☐ December 31, 19\_\_\_\_

**NURSING HOME VISITS  
(To be used by the attending physician only for reporting all calls\*)**

NAME OF PATIENT	GROUP NO.	H.J.L. NUMBER	NAME OF NURSING HOME	DATES OF ALL VISITS MONTH DAYS	FOR BLUE SHIELD OFFICE USE
SPECIMEN					

**NURSING HOME CONSULTATIONS  
(To be used by consulting physicians only for reporting consultation services requested by the attending physician\*)**

NAME OF PATIENT	GROUP NO.	H.J.L. NUMBER	NAME OF NURSING HOME	ATTENDING PHYSICIAN	DATE OF SERVICE	FOR BLUE SHIELD OFFICE USE

DATE OF THIS REPORT: \_\_\_\_\_  
 PHYSICIAN SUBMITTING REPORT: \_\_\_\_\_  
 PHYSICIAN'S ADDRESS: \_\_\_\_\_  
 PHYSICIAN'S SIGNATURE: \_\_\_\_\_

DOCTOR'S ACCOUNT NUMBER \_\_\_\_\_

\*USE REVERSE SIDE FOR EXPLANATION OF ADDITIONAL VISITS, REASONS FOR CONSULTATION, AND/OR FOR REPORTING MILEAGE

PHYSICIAN'S BILLING FORM FOR NURSING HOME CARE

# Colorado's program for the aged

## COLORADO OLD AGE PENSION MEDICAL CARE PROGRAM BILLING FORM FOR HOME AND OFFICE CALLS

This report should be completed by the physician at the time of the home or office call and submitted IMMEDIATELY to: COLORADO MEDICAL SERVICE, INC., 244 UNIVERSITY BOULEVARD, DENVER 6, COLORADO

BILLINGS RECEIVED MORE THAN SIX MONTHS AFTER THE SERVICE DATE CANNOT BE HONORED FOR PAYMENT.

H. H. NUMBER	GROUP NUMBER	NAME OF PATIENT	TYPE CALL		DATE OF CALL			CHARGE
			HOME	OFFICE	MO.	DAY	YEAR	
								\$

REASON FOR CALL OR DIAGNOSIS: \_\_\_\_\_

DOCTOR: The OAP Medical Program provides each pensioner with an allowance for only two professional calls per calendar quarter at the rate of up to \$3.00 for office calls or \$5.00 for home calls. In signing and submitting this statement for reimbursement, the doctor certifies that he has not billed the OAP Medical Program for more than two professional visits to the pensioner named herein in the calendar quarter concerned. Additional calls should be billed directly to the pensioner.

Doctor's Account No. (Blue Shield) \_\_\_\_\_

SPECIMEN

FOR BLUE SHIELD USE ONLY

Physician Submitting Statement \_\_\_\_\_ (PLEASE PRINT OR TYPE)

PHYSICIAN'S SIGNATURE \_\_\_\_\_

These forms may be obtained from Colorado Medical Service, Inc.

928.0000 9004 1-60 (M489 70)

PHYSICIAN'S BILLING FORM FOR HOME AND OFFICE CALLS

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