Health Care Financing Note

Use and cost of hospital outpatient services under Medicare, 1985

by Charles Helbing and Viola B. Latta

Presented in this article are program data on the use and cost of hospital outpatient (HOP) services rendered to aged and disabled Medicare beneficiaries during calendar year 1985. Trend data are also presented for calendar years 1974-85. The data shown in this article focus on charges, reimbursements, and reimbursements per enrollee as a means of measuring the cost of HOP services. The data provide information to help identify trends and patterns of care for monitoring the Medicare HOP benefit and for evaluating the impact of the inpatient hospital prospective payment system (PPS) on the use and cost of HOP services.

Introduction

Among the health care services covered by Medicare, reimbursements for HOP services have shown the largest rate of growth since the inception of the program. From 1974, the first full year of coverage for disabled Medicare enrollees, through 1983, HOP reimbursements rose from $0.3 billion to $2.7 billion, an average annual rate of increase of 26 percent. Similarly, during the same period, all Medicare expenditures showed an average annual rate of growth of about 20 percent. With the advent of the Medicare PPS in October 1983, HOP expenditures continued to grow at a rapid pace. From 1983 through 1985, HOP expenditures rose to $4.1 billion, an average annual rate of increase of 23 percent. During the same period, all Medicare expenditures showed an average annual growth rate of about 12 percent.

PPS legislation restructured the payment system by which short-stay hospitals are reimbursed for inpatient services rendered to Medicare beneficiaries. The new system gives short-stay hospitals the incentive to hold costs down because they earn a profit when their costs fall below the prospective payment or absorb a loss when their costs exceed the prospective payment. As a result, health care decisions being made in response to PPS are expected to have a profound impact on other providers of health care, especially hospital outpatient facilities. For example, the Physicians' Practice Costs and Income Survey (Health Care Financing Administration, 1983-85) indicates that physicians treating Medicare patients are being encouraged to shorten lengths of hospital stays, reduce ancillary services, and foster outpatient testing.

Preliminary findings from studies on the impact of the PPS suggest these reasons for HOP services being the fastest growing segment of the health care industry:

- There are direct financial incentives for hospitals to shift care to ambulatory settings when it is clinically appropriate and cost efficient.
- Surgical and diagnostic technological innovations have enabled hospitals to perform more procedures on an ambulatory basis.
- Utilization review policies have influenced the Medicare patient case mix in hospitals. For example, preadmission review for medical necessity, appropriateness, and quality of care encourage treatment in the safest and most cost-effective setting.
- The addition of ambulatory surgical benefits under Medicare and the repeal of the Part B deductible for home health agency services have encouraged the use of outpatient services (Omnibus Budget Reconciliation Act, 1980, Public Law 96-499).
- The shift of patient care to an outpatient setting has reduced the risk of nosocomial infections.

Selected data highlights

Trends in the number of supplementary medical insurance enrollees and the amounts of covered charges and reimbursements for the years 1974 through 1985 are shown in Table 1.

- From 1974 to 1983, reimbursements for HOP services to Medicare beneficiaries increased from $0.3 billion to $2.7 billion (Figure 1), an average annual rate of growth (AARG) of about 26 percent. For all Medicare reimbursements during this period, the AARG was 20 percent.
- From 1983 through 1985, reflecting the first 2 full years of the Medicare prospective payment system, HOP reimbursements rose from $2.7 billion to $4.1 billion, an AARG of about 23 percent. For all Medicare expenditures, the AARG slowed to an estimated 12 percent.
- The average HOP reimbursement per enrollee grew from $14 in 1974 to $92 in 1983, and then rose to $136 in 1985. The AARG was about 23 percent for both periods.

The use of hospital outpatient services under Medicare is shown in Table 2 for 1985, displaying covered charges, percent distribution, and average charge per enrollee, by type of service, sex, race, and type of enrollment.

Table 1

Hospital outpatient charges and reimbursements under Medicare, by type of enrollment and year service was incurred: 1974-85

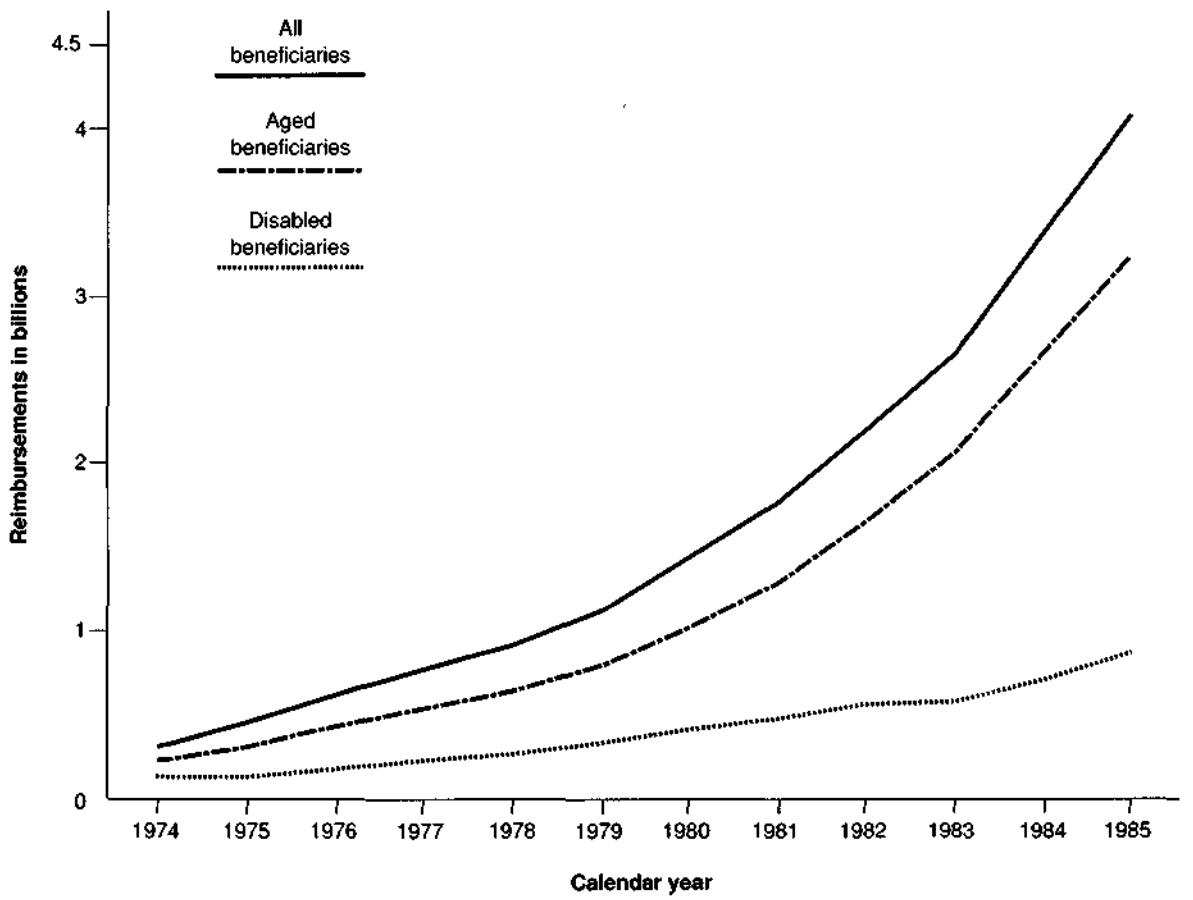
Type of enrollment and year service incurred	Number of SMI[1] enrollees	Covered charges in thousands	Reimbursements		
			Amount in thousands	Per enrollee	As percent of charges
All beneficiaries					
1974	23,166,570	$535,296	$323,383	$13.96	60.4
1975	23,904,551	747,518	469,875	19.66	63.0
1976	24,614,402	974,708	630,323	25.61	64.7
1977	25,363,468	1,175,878	773,490	30.50	65.8
1978	26,074,085	1,384,067	923,658	35.42	66.7
1979	26,757,329	1,660,363	1,132,202	42.31	68.2
1980	27,399,658	2,076,396	1,441,986	51.75	69.4
1981	27,941,227	2,521,191	1,777,255	63.61	70.4
1982	28,412,282	3,164,530	2,203,260	77.55	69.6
1983	28,974,535	3,813,118	2,661,394	91.85	69.8
1984	29,415,397	5,129,210	3,387,146	115.15	66.0
1985	29,988,763	6,480,777	4,082,303	136.13	63.0
Average annual rate of growth	2.4	25.4	25.9	23.0	—
Aged					
1974	21,421,545	394,680	220,742	10.30	55.9
1975	21,945,301	546,095	323,563	14.74	59.3
1976	22,445,911	704,569	432,971	19.29	61.5
1977	22,990,826	855,412	540,040	23.49	63.1
1978	23,530,893	1,005,467	648,249	27.55	64.5
1979	24,098,491	1,203,048	797,442	33.09	66.2
1980	24,680,432	1,517,183	1,030,896	41.77	69.9
1981	25,181,731	1,874,136	1,300,040	51.63	69.3
1982	25,706,792	2,402,462	1,645,064	63.99	68.5
1983	26,292,124	2,995,784	2,066,207	78.59	69.0
1984	26,764,150	4,122,859	2,679,571	100.12	65.0
1985	27,310,894	5,210,762	3,211,744	117.60	61.6
Average annual rate of growth	2.2	26.5	27.6	24.8	—
Disabled					
1974	1,745,019	140,617	102,641	57.07	70.8
1975	1,959,248	201,423	146,312	74.69	72.6
1976	2,168,467	270,139	197,352	91.03	73.1
1977	2,372,594	320,466	233,450	98.38	72.8
1978	2,543,162	378,600	275,409	108.29	72.7
1979	2,658,838	457,315	334,760	125.90	73.2
1980	2,719,226	559,213	411,090	151.55	73.5
1981	2,759,496	647,054	477,215	172.94	73.7
1982	2,705,490	762,068	558,195	206.32	73.2
1983	2,682,411	817,335	595,187	221.89	72.8
1984	2,651,247	1,006,351	707,575	266.88	70.3
1985	2,677,869	1,270,015	870,560	325.09	68.5
Average annual rate of growth	4.0	22.1	21.3	17.1	—

[1]Supplementary medical insurance.

SOURCE: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Medicare Statistical System.

- Nearly one-half of all Medicare HOP charges ($6.5 billion) were for three services—radiology ($1.4 billion or 22.2 percent), end stage renal disease (ESRD) ($0.9 billion or 13.2 percent), and laboratory ($0.8 billion or 12.9 percent) (Figure 2).
- HOP charges for operating room services ($0.4 billion) accounted for about 7 percent of all HOP charges for Medicare beneficiaries, reflecting the increasing number and variety of surgical procedures performed in an outpatient setting.
- There were substantial differences by race and type of entitlement in the charge per enrollee for HOP services. The total charge per enrollee for persons of races other than white ($338) was 66 percent higher than that for persons of the white race ($203). The total charge per disabled enrollee ($474) was 149 percent higher than that for the aged ($191). This difference was reflected, for the most part, in the use of ESRD services that accounted for 44 percent of all HOP charges among the disabled, but only 6 percent among the aged. Charges for ESRD services represented 34 percent of all charges for persons of races other than white compared with 9 percent for white persons.

Figure 1
Medicare reimbusements for hospital outpatient services used by aged and disabled beneficiaries: 1974-85



SOURCE: Health Care Financing Administration, Office of Research and Demonstrations: Data from the Division of Program Studies.

Hospital outpatient clinic and emergency room visits and charges for 1985 under Medicare (Table 3), are shown by sex, race, and type of enrollment.

- Users of HOP services in 1985 made 5.7 million visits to clinics and almost 7.0 million visits to emergency rooms.
- Although data are not shown in the tables, the rate of use of clinic services by Medicare beneficiaries declined about 7 percent from 1983 (204 visits per 1,000 enrollees) to 1985 (190 visits per 1,000 enrollees). This finding is contrary to the expected shift in hospital services from the inpatient to the outpatient setting.
- The rate of emergency room services, however, showed a moderate increase of about 13 percent from 1983 (206 visits per 1,000 enrollees) to 1985 (232 visits per 1,000 enrollees).
- The average charge per visit in 1985 was slightly higher for emergency room services ($43) than for clinic services ($41).
- Substantial differences exist in the rate of use (visits per 1,000 enrollees) of clinic and emergency room services by race and type of entitlement. Persons of races other than white used clinic and emergency room services 4.6 times and 1.5 times more, respectively, than did white persons. Disabled beneficiaries used clinic and emergency room services 2.6 times and 2.2 times more, respectively, than did aged beneficiaries.

For aged Medicare beneficiaries (Table 4), hospital outpatient covered charges and reimbursements are shown for 1985, by area of residence.

- The average HOP reimbursement per aged enrollee in the United States was $118.
- By region, the average HOP reimbursement per enrollee was highest in the Northeast ($131) and lowest in the South ($102), a difference of 28 percent.

Table 2

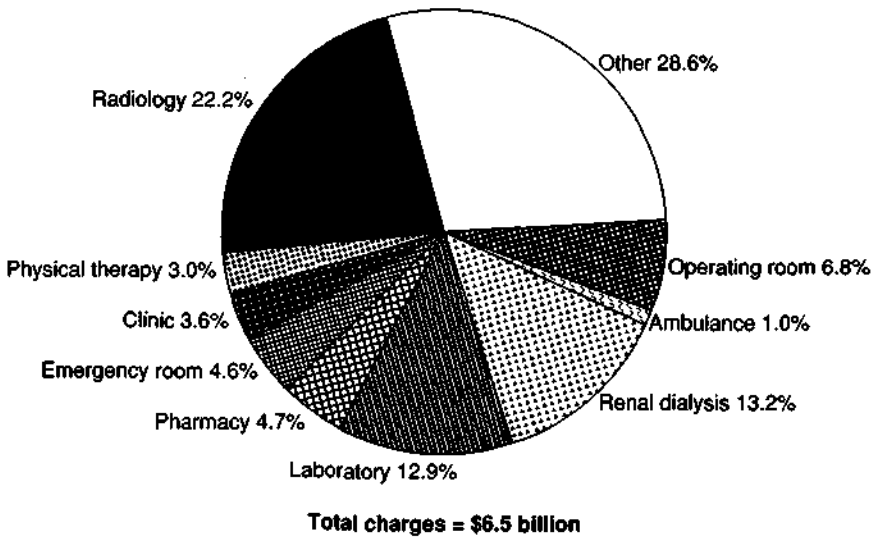
Covered charges, percent distribution, and average charge per enrollee for hospital outpatient services under Medicare, by type of service, sex, race, and type of enrollment: 1985

Sex, race, and type of enrollment	Total	Clinic	Emergency room	Laboratory	Radiology	Pharmacy	Physical therapy	Ambulance	Operating room	End stage renal disease[1]	Other[2]
					Covered charges in thousands						
Total	$6,480,777	$231,427	$300,599	$837,768	$1,439,819	$302,280	$194,612	$63,217	$443,281	$853,624	$1,856,015
Sex											
Male	2,853,571	90,075	133,776	352,557	625,039	135,562	70,956	28,960	178,046	449,905	810,234
Female	3,627,205	141,352	166,823	485,211	814,779	166,717	123,655	34,256	265,235	403,719	1,045,780
Race											
White	5,315,580	141,936	246,970	705,424	1,267,277	262,953	170,811	55,115	400,730	495,502	1,598,539
All other	984,968	83,731	46,191	109,685	131,939	31,357	18,203	6,285	30,479	330,691	207,642
Unknown	180,228	5,760	7,438	22,658	40,602	7,969	5,597	1,817	12,072	27,430	49,833
Type of enrollment											
Aged	5,210,761	181,576	247,373	705,850	1,308,441	264,629	170,223	56,629	417,872	300,367	1,588,107
Disabled	1,270,015	49,851	53,226	131,918	131,378	37,651	24,388	6,588	25,408	553,257	267,907
					Percent distribution						
Total	100.0	3.6	4.6	12.9	22.2	4.7	3.0	1.0	6.8	13.2	28.6
Sex											
Male	100.0	3.2	4.7	12.4	21.9	4.8	2.5	1.0	6.2	15.8	28.4
Female	100.0	3.9	4.6	13.4	22.5	4.6	3.4	0.9	7.3	11.1	28.8
Race											
White	100.0	2.7	4.6	13.3	23.8	4.9	3.2	1.0	7.5	9.3	30.1
All other	100.0	8.5	4.7	11.1	13.4	3.2	1.8	0.6	3.1	33.6	21.1
Unknown	100.0	3.2	4.1	12.6	22.5	4.4	3.1	1.0	6.7	15.2	27.7
Type of enrollment											
Aged	100.0	3.5	4.7	13.5	25.1	5.1	3.3	1.1	8.0	5.8	30.5
Disabled	100.0	3.9	4.2	10.4	10.3	3.0	1.9	0.5	2.0	43.6	21.1
					Charges per enrollee						
Total	$216.11	$7.72	$10.02	$27.94	$48.01	$10.08	$6.49	$2.11	$14.78	$28.47	$61.89
Sex											
Male	227.65	7.19	10.67	28.13	49.86	10.81	5.66	2.31	14.20	35.89	64.64
Female	207.82	8.10	9.56	27.80	46.68	9.55	7.08	1.96	15.20	23.13	59.92
Race											
White	202.82	5.42	9.42	26.92	48.35	10.03	6.52	2.10	15.29	18.91	60.99
All other	337.66	28.70	15.84	37.60	45.23	10.75	6.24	2.15	10.45	113.37	71.18
Unknown	208.60	6.67	8.61	26.23	46.99	9.22	6.48	2.10	13.97	31.75	57.68
Type of enrollment											
Aged	190.79	6.65	9.06	25.84	47.91	9.69	6.23	2.07	15.30	11.00	58.15
Disabled	474.24	18.62	19.88	49.26	49.06	14.06	9.11	2.46	9.49	206.59	100.04

[1]Services to end stage renal disease patients consist primarily of renal dialysis.
[2]Includes charges for computerized axial tomography, durable medical equipment, blood, etc.

SOURCES: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Medicare Statistical System; Office of Research and Demonstrations: Data from the Division of Program Studies.

Figure 2
Percent distribution of hospital outpatient charges under Medicare, by type of service: 1985



SOURCE: Health Care Financing Administration, Office of Research and Demonstrations: Data from the Division of Program Studies.

Table 3
Hospital outpatient clinic and emergency room visits and charges under Medicare, by sex, race, and type of enrollment: 1985

Sex, race, and type of enrollment	Clinic				Emergency room			
	Visits		Charges		Visits		Charges	
	Number in thousands	Per 1,000 enrollees	Amount in thousands	Per visit	Number in thousands	Per 1,000 enrollees	Amount in thousands	Per visit
Total	5,705	190	$231,427	$40.57	6,959	232	$300,599	$43.20
Sex								
Male	2,254	180	90,075	39.96	3,065	245	133,776	43.65
Female	3,451	198	141,352	40.96	3,895	223	166,823	42.83
Race								
White	3,667	140	141,936	38.71	5,829	222	246,970	42.37
All other	1,882	645	83,731	44.49	959	329	46,191	48.17
Unknown	156	181	5,760	36.93	171	198	7,438	43.50
Type of enrollment								
Aged	4,546	166	181,576	39.94	5,715	209	247,373	43.28
Disabled	1,159	433	49,851	43.01	1,244	465	53,226	42.79

SOURCES: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Medicare Statistical System; Office of Research and Demonstrations: Data from the Division of Program Studies.

- By State, Massachusetts had the highest average reimbursement per enrollee ($217) and South Dakota the lowest ($66), a difference of 229 percent (Figure 3).

Presented in Table 5 are hospital outpatient covered charges and reimbursements for disabled Medicare beneficiaries, excluding those for end stage renal disease.

- The average Medicare HOP reimbursement per disabled enrollee in the United States, excluding enrollees with ESRD, was $132. This figure was 12 percent higher than the average for aged enrollees ($118).
- By region, the average reimbursement per disabled enrollee was highest in the Northeast ($165) and lowest in the South ($105), a difference of 57 percent.
- By State, the average reimbursement per enrollee ranged from $288 in the District of Columbia to $73 in Alabama, a difference of 295 percent (Figure 4).

For Medicare beneficiaries receiving hospital outpatient services in 1985, the 10 leading (most frequently reported) principal diagnoses are displayed in Table 6. Data include the number of bills, covered charges, reimbursements, and average charges and reimbursements per bill.

- Among all Medicare beneficiaries using HOP services, the 10 leading principal diagnoses accounted for 8.9 million bills or 27 percent of all HOP bills (33.6 million).
- Similarly, the 10 leading principal diagnoses accounted for 26 percent ($1.1 billion) of all Medicare HOP reimbursements ($4.1 billion).
- Diabetes was the most frequently reported diagnosis, comprising 18 percent (1.6 million) of all bills for HOP services (Figure 5).
- Cataract was the most costly leading principal diagnosis, accounting for 14 percent ($0.6 billion) of all HOP reimbursements. The average reimbursement per bill for cataract was $728, or six times higher than the average HOP bill ($121).

For 1985, Table 7 presents the leading (most frequently reported) surgical procedures performed on Medicare beneficiaries in hospital outpatient departments. Utilization is measured by the number of bills, covered charges, and average charges and reimbursements per bill.

- Among all aged and disabled beneficiaries, the 10 leading HOP surgical procedures accounted for 43 percent (1.3 million) of all HOP surgical procedures (2.9 million).
- The 10 leading HOP surgical procedures accounted for about two-thirds ($0.6 billion) of all Medicare reimbursements for HOP surgery ($0.9 billion).
- The average reimbursement per bill for the 10 leading surgical procedures ($489) was 53 percent higher than the average reimbursement for all bills for surgical procedures ($317).
- The most frequent surgical procedure was operation on lens (0.45 million), which accounted for 15 percent of all HOP surgical procedures (2.9 million).
- The highest average charge per bill ($1,521) was for operations on lens (Figure 6).
- The average HOP reimbursement per bill was highest for operations on lens ($966), more than three times higher than the average for all surgical procedures ($317). The next highest average reimbursement per procedure was for operations on the breast ($437).

Definition of terms

Disabled Medicare enrollees—Disabled enrollees are separated into two groups. In the first group are persons entitled to cash disability benefits for at least 24 months; some of these enrollees have end stage renal disease (ESRD). The second group of disabled persons has not been entitled to cash disability benefits for 24 months. These enrollees are entitled to Medicare because they have ESRD and meet certain social security insured status requirements. Eligibility for Medicare coverage begins with the third month after the beginning of a course of renal dialysis.

Hospital outpatient services—Major hospital outpatient services covered by supplementary medical insurance include services in an emergency room or outpatient clinic, laboratory tests billed by the hospital, X-rays and other radiology services billed by the hospital, medical supplies such as splints and casts, drugs and biologicals that cannot be self-administered, and blood transfusions. Surgical and anesthesiology services are also covered. Physical therapy services must be furnished under a plan set up and reviewed periodically by a physician. For outpatient speech pathology services, a speech pathologist can establish the plan of treatment.

Source and limitations of data

The hospital outpatient data are derived from a 5-percent sample of bills for services performed in hospital outpatient departments during 1985. The bills were tabulated by the Health Care Financing Administration's central records as of December 1986. It is estimated that these bills represent about 98 percent of the eventual reimbursements for hospital outpatient services in 1985. Data for the years 1974-85 are based on bills recorded 12 months following the year of service. Sample counts are multiplied by a factor of 20 to estimate population totals. Therefore, the data are subject to sampling variability.

Payments for hospital outpatient services are based on interim rates that may be adjusted after the end of the hospital's accounting year, calculated on reasonable costs of operation. The hospital outpatient figures in this report reflect bills for covered services whether or not a reimbursement was made by the Medicare program.

Table 4

Covered charges and reimbursements for hospital outpatient services used by aged Medicare beneficiaries, by area of residence: 1985

Area of residence	Covered charges in thousands	Total reimbursements		
		Amount in thousands	Per enrollee[1]	As percent of charges
All areas	$5,210,762	$3,211,744	$117.60	61.6
United States[2]	5,192,232	3,199,736	118.32	61.6
Northeast	1,364,572	826,081	130.98	60.5
North Central	1,342,588	864,455	122.95	64.4
South	1,502,151	918,221	102.41	61.1
West	982,920	590,979	124.70	60.1
New England	397,114	280,456	175.74	70.6
Connecticut	75,810	53,893	135.37	71.1
Maine	41,357	24,392	161.60	59.0
Massachusetts	223,094	160,682	217.10	72.0
New Hampshire	21,788	16,646	148.16	76.4
Rhode Island	24,641	16,893	127.41	68.6
Vermont	10,423	7,950	128.66	76.3
Middle Atlantic	967,459	545,625	115.82	56.4
New Jersey	136,361	98,175	106.25	72.0
New York	370,560	203,389	94.39	54.9
Pennsylvania	460,538	244,061	148.41	53.0
East North Central	954,680	623,931	130.95	65.4
Illinois	252,996	173,749	133.67	68.7
Indiana	110,524	79,128	127.71	71.6
Michigan	281,372	174,630	175.43	62.1
Ohio	196,106	119,788	96.10	61.1
Wisconsin	113,682	76,636	127.03	67.4
West North Central	387,908	240,523	106.13	62.0
Iowa	72,397	45,812	114.39	63.3
Kansas	62,132	43,186	137.21	69.5
Minnesota	85,278	52,721	104.32	61.8
Missouri	113,355	64,739	98.71	57.1
Nebraska	29,138	19,707	93.99	67.6
North Dakota	14,440	8,067	94.49	55.9
South Dakota	11,169	6,290	66.36	56.3
South Atlantic	856,773	535,991	113.44	62.6
Delaware	15,188	8,281	122.42	54.5
District of Columbia	17,416	12,387	186.18	71.1
Florida	324,362	217,334	118.80	67.0
Georgia	108,859	61,225	110.36	56.2
Maryland	83,002	54,991	129.69	66.3
North Carolina	114,975	61,816	92.25	53.8
South Carolina	48,357	27,720	86.53	57.3
Virginia	98,092	68,230	124.58	69.6
West Virginia	46,521	24,007	98.21	51.6
East South Central	248,027	141,709	82.79	57.1
Alabama	73,415	40,128	87.80	54.7
Kentucky	52,926	32,732	77.74	61.8
Mississippi	43,552	25,786	88.95	59.2
Tennessee	78,133	43,063	79.19	55.1
West South Central	397,352	240,521	95.10	60.5
Arkansas	47,173	33,713	106.03	71.5
Louisiana	68,150	41,396	104.20	60.7
Oklahoma	54,755	34,497	91.80	63.0
Texas	227,274	130,916	91.03	57.6
Mountain	223,505	149,107	122.71	66.7
Arizona	57,423	40,681	112.44	70.8
Colorado	61,840	36,833	135.99	59.6
Idaho	20,648	15,246	143.90	73.8
Montana	13,807	10,489	110.88	76.0
Nevada	17,658	10,102	115.10	57.2
New Mexico	26,269	16,441	125.76	62.6
Utah	19,496	14,755	120.45	75.7
Wyoming	6,364	4,559	111.62	71.6

See footnotes at end of table.

Table 4—Continued

Covered charges and reimbursements for hospital outpatient services used by aged Medicare beneficiaries, by area of residence: 1985

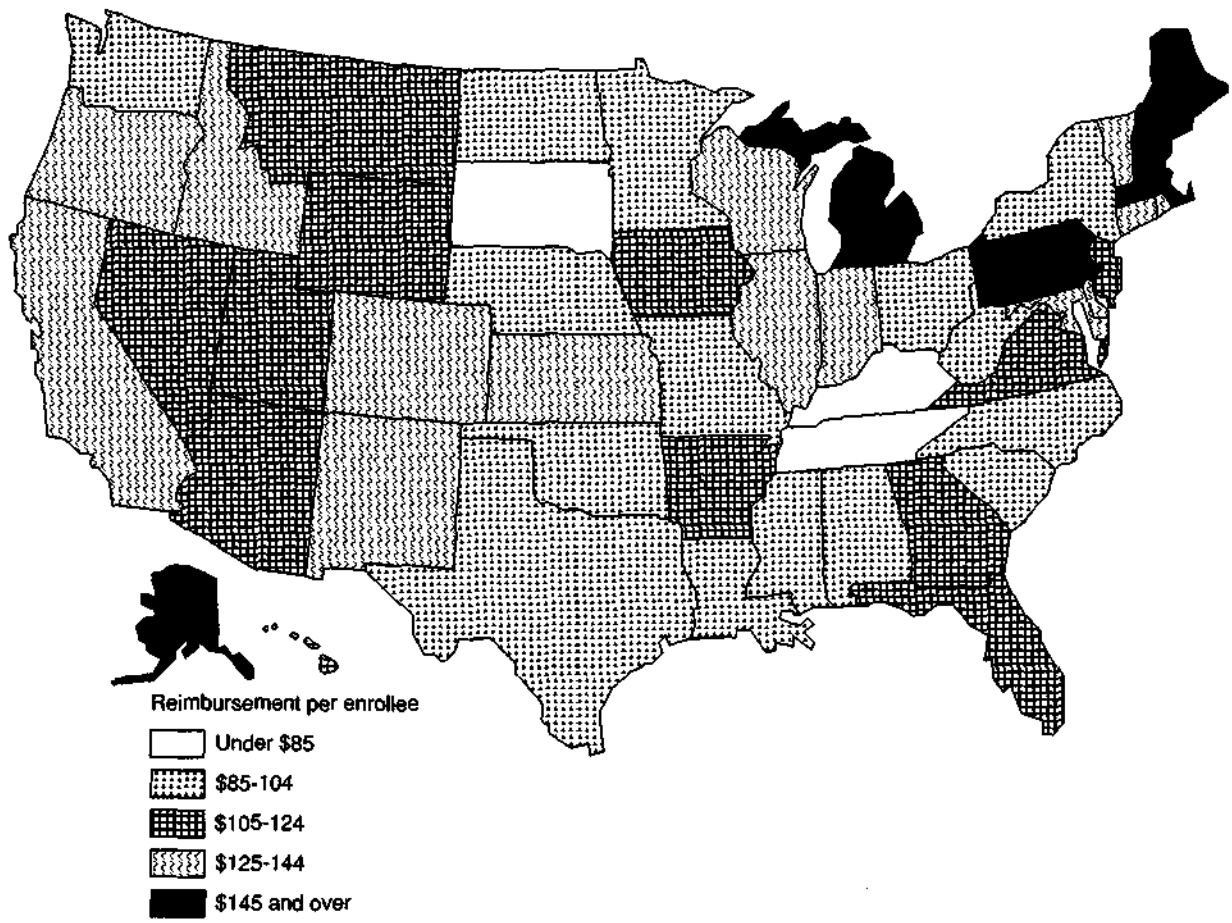
Area of residence	Covered charges in thousands	Total reimbursements		
		Amount in thousands	Per enrollee[1]	As percent of charges
Pacific	759,415	441,873	125.38	58.2
Alaska	3,773	2,366	162.63	62.7
California	599,776	334,459	128.48	55.8
Hawaii	16,758	10,649	116.95	63.6
Oregon	60,532	44,626	132.77	73.7
Washington	78,576	49,771	103.84	63.3
Outlying areas[3]	18,530	12,007	45.91	64.8

[1]Based on supplementary medical insurance enrollment as of July 1, 1985.
[2]Consists of 50 States and the District of Columbia.
[3]Consists of Puerto Rico, Virgin Islands, Guam, other areas, and residence unknown.

SOURCES: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Medicare Statistical System; Office of Research and Demonstrations: Data from the Division of Program Studies.

Figure 3

Average hospital outpatient reimbursement per aged Medicare enrollee, by State of residence: 1985



SOURCE: Health Care Financing Administration, Office of Research and Demonstrations: Data from the Division of Program Studies.

Table 5

Covered charges and reimbursements for hospital outpatient services used by disabled Medicare beneficiaries, excluding those with end stage renal disease (ESRD)[1], by area of residence: 1985

Area of residence	Covered charges in thousands	Total reimbursements		
		Amount in thousands	Per enrollee[2]	As percent of charges
All areas	$552,287	$333,859	$129.54	60.5
United States[3]	549,878	332,355	131.63	60.4
Northeast	151,523	89,175	164.73	58.9
North Central	125,801	79,598	132.14	63.3
South	167,951	100,634	104.62	59.9
West	104,602	62,947	150.13	60.2
New England	38,630	26,940	220.99	69.7
Connecticut	8,267	5,635	211.60	68.2
Maine	3,900	2,329	159.89	59.7
Massachusetts	21,486	15,424	282.93	71.8
New Hampshire	1,874	1,385	164.57	73.9
Rhode Island	2,311	1,572	131.98	68.0
Vermont	792	596	101.44	75.2
Middle Atlantic	112,893	62,235	148.37	55.1
New Jersey	14,291	10,002	126.89	70.0
New York	56,926	30,900	155.76	54.3
Pennsylvania	41,676	21,333	149.98	51.2
East North Central	94,078	60,163	136.97	64.0
Illinois	21,454	14,379	141.31	67.0
Indiana	11,260	7,927	134.65	70.4
Michigan	30,414	18,381	169.31	60.4
Ohio	20,049	12,176	99.40	60.7
Wisconsin	10,902	7,300	153.54	67.0
West North Central	31,723	19,435	119.14	61.3
Iowa	5,509	3,630	135.55	65.9
Kansas	4,139	2,789	139.93	67.4
Minnesota	6,112	3,814	121.73	62.4
Missouri	12,276	7,028	114.90	57.3
Nebraska	1,715	1,089	87.90	63.5
North Dakota	1,136	623	116.81	54.9
South Dakota	838	462	74.46	55.1
South Atlantic	95,977	58,133	118.38	60.6
Delaware	1,330	678	100.92	51.0
District of Columbia	2,365	1,653	287.71	69.9
Florida	22,169	14,526	111.14	65.5
Georgia	17,551	9,604	120.93	54.7
Maryland	11,148	7,773	209.37	69.7
North Carolina	14,402	8,010	96.25	55.6
South Carolina	7,463	3,831	81.28	51.3
Virginia	13,017	8,809	139.95	67.7
West Virginia	6,533	3,248	85.33	49.7
East South Central	34,826	19,917	86.40	57.2
Alabama	8,339	4,334	72.98	52.0
Kentucky	7,737	4,812	81.19	62.2
Mississippi	5,675	3,368	78.68	59.4
Tennessee	13,075	7,402	107.21	56.6
West South Central	37,148	22,584	93.98	60.8
Arkansas	4,918	3,373	86.30	68.6
Louisiana	7,897	4,806	89.00	60.9
Oklahoma	5,135	3,284	104.44	64.0
Texas	19,198	11,121	96.04	57.9
Mountain	19,794	13,051	127.07	65.9
Arizona	5,212	3,579	112.53	68.7
Colorado	5,320	3,296	147.08	61.9
Idaho	1,396	1,000	126.37	71.6
Montana	1,319	1,038	127.53	78.7
Nevada	1,842	1,014	121.75	55.1
New Mexico	3,076	1,896	138.88	61.6
Utah	1,218	940	118.61	77.2
Wyoming	412	288	112.05	69.9

See footnotes at end of table.

Table 5—Continued

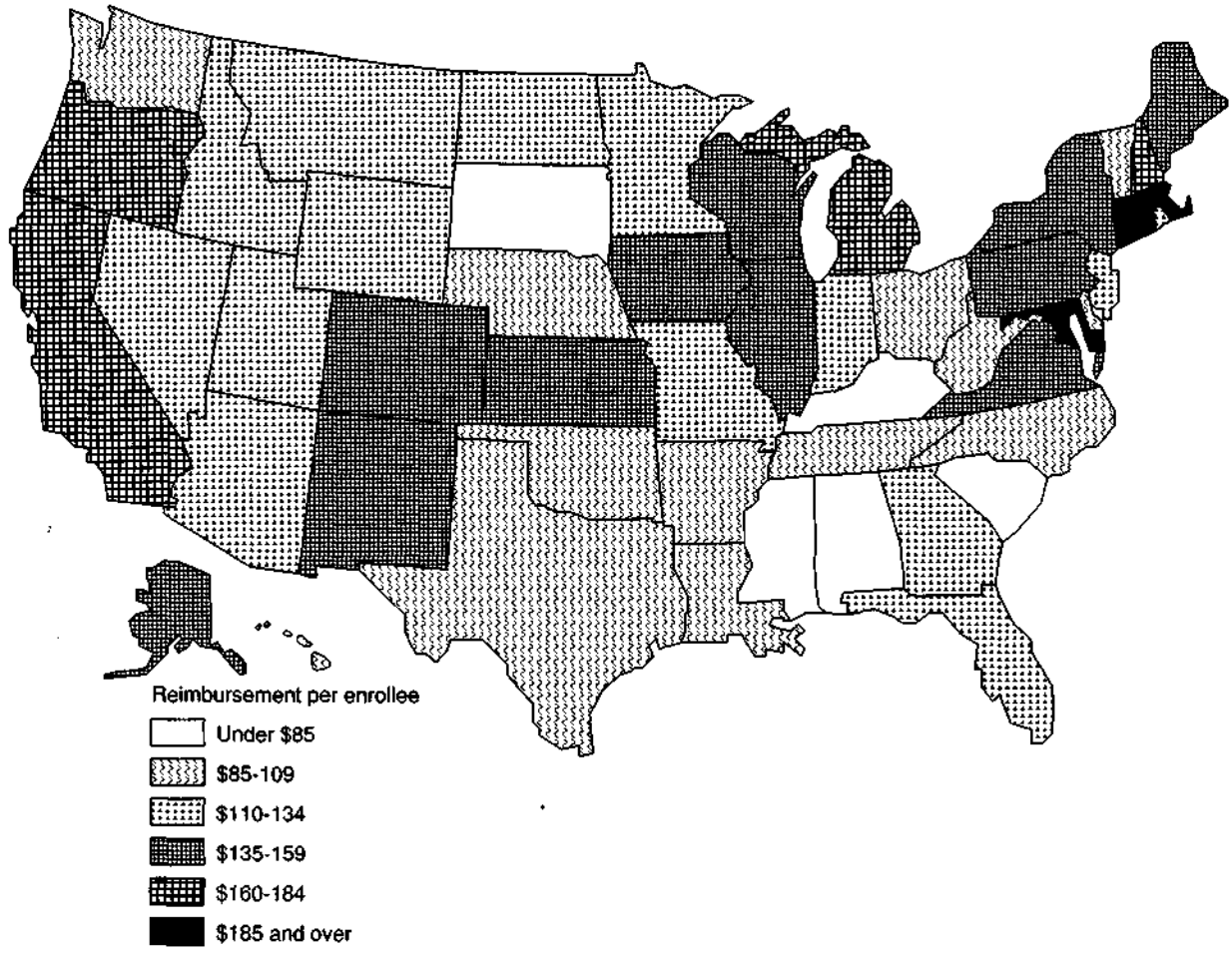
Covered charges and reimbursements for hospital outpatient services used by disabled Medicare beneficiaries, excluding those with end stage renal disease (ESRD)[1], by area of residence: 1985

Area of residence	Covered charges in thousands	Total reimbursements		
		Amount in thousands	Per enrollee[2]	As percent of charges
Pacific	84,808	49,896	157.61	58.8
Alaska	381	255	145.72	67.1
California	70,694	40,446	166.49	57.2
Hawaii	1,074	610	91.20	56.8
Oregon	6,490	4,655	173.68	71.7
Washington	6,169	3,930	102.34	63.7
Outlying areas[4]	2,409	1,504	29.26	62.4

[1]Excludes ESRD data because larger reimbursements for a relatively few disabled ESRD-only enrollees would significantly distort the State reimbursement per enrollee.
[2]Based on supplementary medical insurance enrollment as of July 1, 1985.
[3]Consists of 50 States and the District of Columbia.
[4]Consists of Puerto Rico, Virgin Islands, Guam, other areas, and residence unknown.

SOURCES: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Medicare Statistical System; Office of Research and Demonstrations: Data from the Division of Program Studies.

Figure 4
Average Medicare reimbursement for hospital outpatient services per disabled enrollee, by State of residence: 1985



SOURCE: Health Care Financing Administration, Office of Research and Demonstrations: Data from the Division of Program Studies.

Table 6

Number of hospital outpatient bills, covered charges, and reimbursements under Medicare, by principal diagnosis: 1985

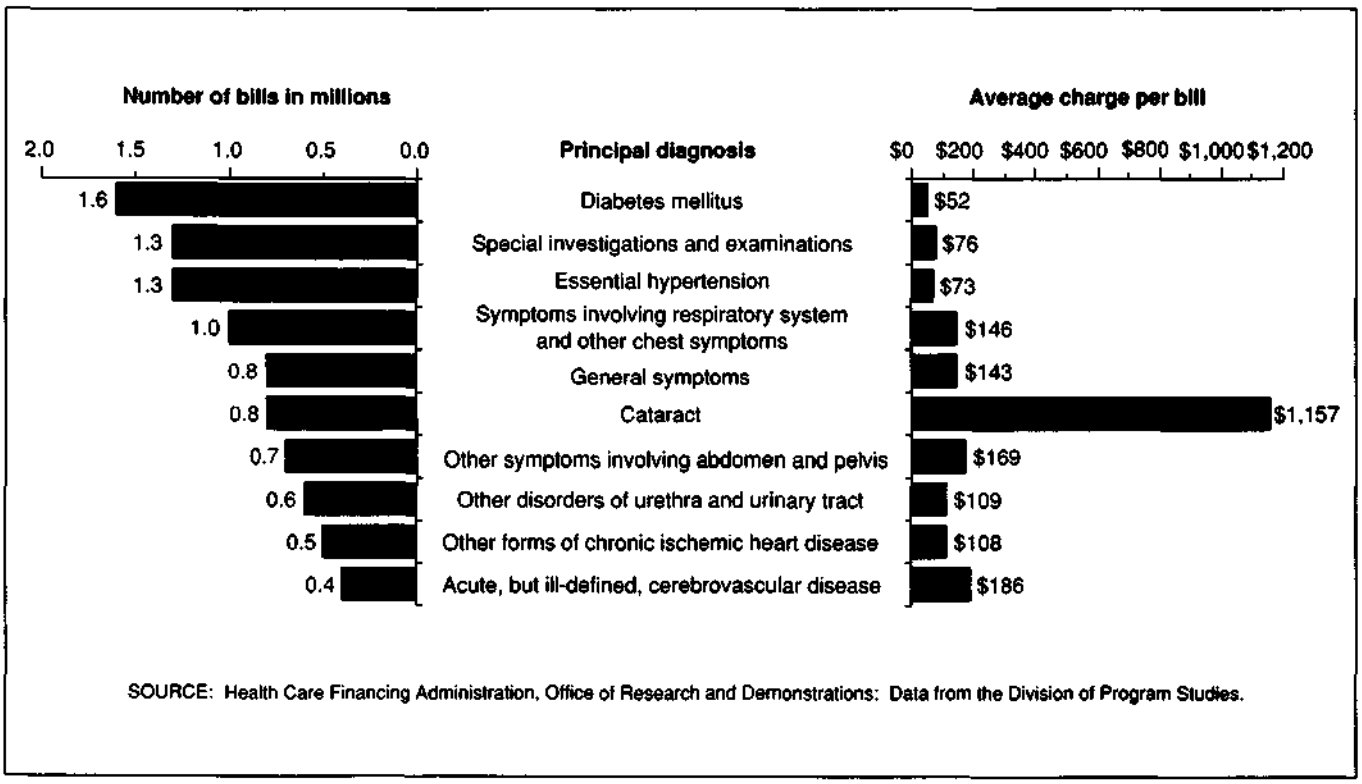
Principal diagnosis	ICD-9-CM code[1]	Number of bills	Covered charges in thousands	Reimbursements in thousands	Average charge per bill	Average reimbursement per bill
Total, all diagnoses	—	33,621,380	$6,480,777	$4,082,303	$192.76	$121.42
Leading diagnoses	—	8,926,740	1,746,799	1,059,961	195.68	118.74
Diabetes mellitus	250	1,578,520	82,646	48,163	52.36	30.51
Special investigations and examinations	V72	1,285,640	97,501	58,422	75.84	45.44
Essential hypertension	401	1,263,600	92,702	52,533	73.36	41.57
Symptoms involving respiratory system and other chest symptoms	786	957,100	140,046	79,906	146.32	83.49
General symptoms	780	825,780	118,330	68,716	143.29	83.21
Cataract	366	780,080	902,726	567,814	1,157.22	727.89
Other symptoms involving abdomen and pelvis	789	709,560	119,896	70,411	168.97	99.23
Other disorders of urethra and urinary tract	599	643,100	70,275	39,405	109.27	61.27
Other forms of chronic ischemic heart disease	414	532,760	57,343	34,147	107.63	64.10
Acute, but ill-defined, cerebrovascular disease	436	350,600	65,336	40,445	186.35	115.36
All other diagnoses	—	24,694,640	4,733,978	3,022,342	191.70	122.39

[1]Principal diagnosis from the *International Classification of Diseases, 9th Revision, Clinical Modification*, Volume 1.

SOURCES: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Medicare Statistical System; Office of Research and Demonstrations: Data from the Division of Program Studies.

Figure 5

Number of bills and average charges for hospital outpatient services under Medicare, by leading principal diagnosis: 1985



SOURCE: Health Care Financing Administration, Office of Research and Demonstrations: Data from the Division of Program Studies.

Table 7

Number of hospital outpatient bills, covered charges, and reimbursements under Medicare, by principal surgical procedure: 1985

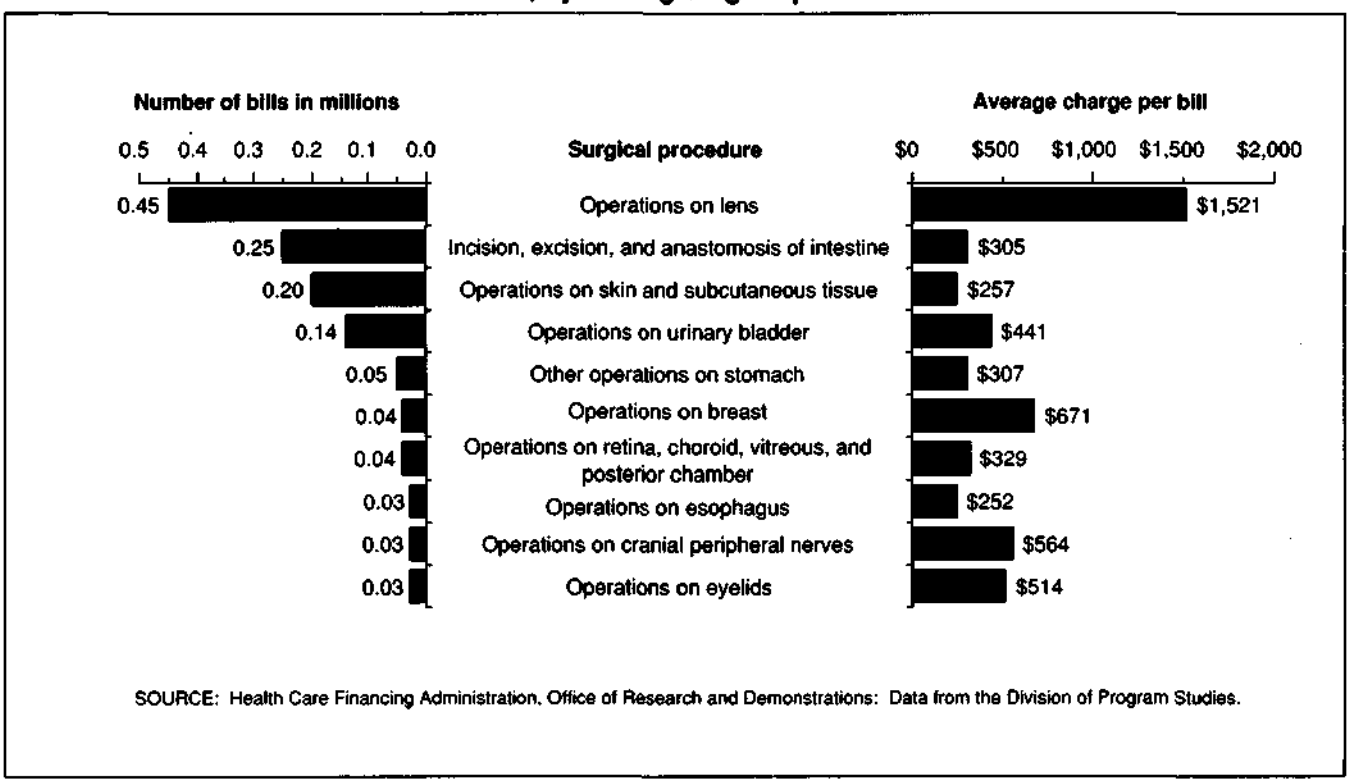
Principal surgical procedure	ICD-9-CM code[1]	Number of bills	Covered charges in thousands	Reimbursements in thousands	Average charge per bill	Average reimbursement per bill
Total, all procedures	—	2,935,920	$1,476,699	$931,999	$502.98	$317.45
Leading procedures	—	1,271,200	979,296	621,667	770.37	489.04
Operations on lens	13	454,240	690,688	438,875	1,520.53	966.17
Incision, excision, and anastomosis of intestine	45	251,480	76,642	48,384	304.76	192.40
Operations on skin and subcutaneous tissue	86	200,220	51,507	31,614	257.25	157.90
Operations on urinary bladder	57	142,960	63,105	40,672	441.42	284.50
Other operations on stomach	44	46,540	14,288	9,098	307.00	195.49
Operations on the breast	85	40,640	27,271	17,748	671.04	436.70
Operations on retina, choroid, vitreous and posterior chamber	14	36,000	11,831	7,283	328.64	202.30
Operations on esophagus	42	33,020	8,328	5,286	252.21	160.09
Operations on cranial and peripheral nerves	04	33,180	18,730	12,128	564.49	365.51
Operations on eyelids	08	32,920	16,905	10,580	513.53	321.37
All other procedures	—	1,664,720	497,404	310,333	298.79	186.42

[1]Principal surgical procedure from the *International Classification of Diseases, 9th Revision, Clinical Modification*, Volume 3.

SOURCES: Health Care Financing Administration, Bureau of Data Management and Strategy: Data from the Medicare Statistical System; Office of Research and Demonstrations: Data from the Division of Program Studies.

Figure 6

Number of bills and average charge for hospital outpatient services under Medicare, by leading surgical procedure: 1985



SOURCE: Health Care Financing Administration, Office of Research and Demonstrations: Data from the Division of Program Studies.

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