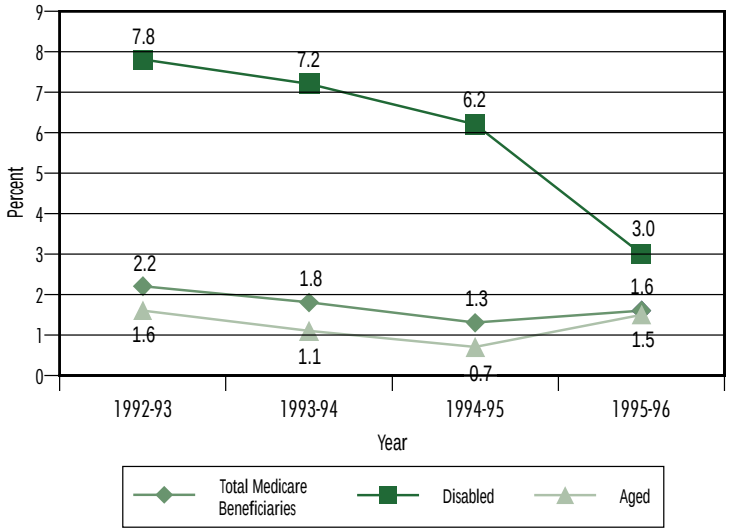
2 TRENDS IN THE MCBS: 1992–1996

In 1996, the number of Medicare beneficiaries grew to an ever-enrolled population of 39.4 million, representing an increase of 2.6 million since 1992.[1] Of the 36.6 million beneficiaries residing in the community, 32.3 million were age 65 or older (also referred to as "aged beneficiaries" in this sourcebook), and 4.3 million were disabled beneficiaries under the age of 65. Another 2.8 million aged and disabled beneficiaries lived all or part of the year in long-term care facilities.

Between 1992 and 1995, the annual growth rate of the Medicare population declined gradually from 2.2 percent to 1.3 percent, and then increased to 1.6 percent in 1996 (Figure 2-1). The growth pattern of aged Medicare beneficiaries differed from that of the disabled. The growth rate of aged beneficiaries declined between 1992 and 1995 and then increased between 1995 and 1996. Disabled beneficiaries were one of the fastest growing Medicare-entitled populations, with an average annual growth rate of 7 percent since the inception of Medicare and Medicaid eligibility for people with disabilities in 1973 (Master and Taniguchi, 1996). In the early 1990s, growth of disabled beneficiaries remained four times as high as that of aged beneficiaries. By 1996, the growth slowed down to 3 percent, but still doubled that of the aged. The fast expansion of disabled Medicare beneficiaries changed the face of the Medicare population slightly. Disabled beneficiaries increased from 10 percent of the Medicare population in 1992 to 12 percent in 1996. Overall, this increase amounts to a net growth of 971,000 beneficiaries.

Figure 2-1 Annual Growth in Medicare Population by Medicare Status, 1992–1996



Health Care Expenditures

Personal health care expenditures (PHCE) by aged and disabled beneficiaries represent direct consumption of health care goods and services provided by hospitals, physicians, and other suppliers of medical care and equipment. The Medicare Current Beneficiary Survey (MCBS) provides estimates on expenditures for Medicare-covered services as well as for some relatively expensive services not typically covered by Medicare (e.g., long-term facility care and prescription medicines). Information on the noncovered services fills a large gap in our knowledge about beneficiary health care spending. The Health Care Financing Administration (HCFA), the primary source of the Medicare program data, has claims information for only those services covered under Medicare Part A and Part B. The Medicare-covered expenditures represent slightly more than one-half of the cost of medical goods and services consumed by aged and disabled beneficiaries.[2]

Estimates of national health expenditures (NHE) are produced annually by HCFA for the U.S. Department of Health and Human Services (DHHS). The annual NHE estimates identify all health care goods and services, and determine the amount spent on them. The NHE presents a comprehensive picture of national health care spending, and provides information on sources of funding and services consumed by all U.S. residents. Total health care spending by

[1] See the Section "The Sample" in Appendix A for a detailed explanation on the concept of "ever-enrolled" Medicare population.

[2] According to the MCBS, Medicare financed about 55% of the health care of aged and disabled beneficiaries in 1996. The survey uses Medicare claims to supplement information reported by sample persons on the use of Medicare-covered services. Since sample persons do not have a corresponding mechanism to help them remember noncovered service utilization, expenditures on these services are probably underreported relative to Medicare-covered services.

aged and disabled beneficiaries is included in the NHE. The NHE report serves as a valuable frame of reference for policymakers to track emerging trends in the health care industry.

Since 1960, total health care spending has grown dramatically, increasing from 5.1 percent (in 1960) to 13.6 percent of the gross domestic product (GDP) in 1996. However, the proportion of health care spending in GDP has remained unchanged since 1992. Total health care spending, nevertheless, has been increasing (Levit et al., 1998b). In 1996, national health care expenditures totalled $1,042.5 billion. More than 88 percent of NHE ($924 billion) was spent on personal health care goods and services purchased directly by the resident population.[3]

Figure 2-2 presents data on personal health care spending by Medicare beneficiaries and the rest of the nation between 1992 and 1996. During this period, growth in NHE for the non-Medicare population remained at around 3-4 percent, the smallest increase in more than 30 years (Levit et al., 1998a). However, PHCE for Medicare beneficiaries increased rapidly between 1992 and 1995, with annual growth rates ranging from 9.6 to 11.0 percent. Growth of PHCE for Medicare beneficiaries outpaced the growth of GDP by 3.5 to 4.9 percent per year in recent decades (Fuchs, 1999).[4] However, these divergent trends shifted in 1996. For the first time in the decade, growths in Medicare beneficiaries' PHCE slowed substantially, declining from a two-digit annual growth rate in previous years to 6.9 percent.

Per capita PHCE showed similar trends for the non-Medicare and the Medicare population (Figure 2-3). Per capita PHCE for the non-Medicare population grew slowly between 1992 and 1995, compared to faster growth among Medicare beneficiaries. This growth translated to an increase of $2,317 for Medicare beneficiaries and $238 for nonbeneficiaries during this period. However, in 1995-1996, growth in per capita spending on health care by

Figure 2-2 National Spending on Personal Health Care, 1992-1996

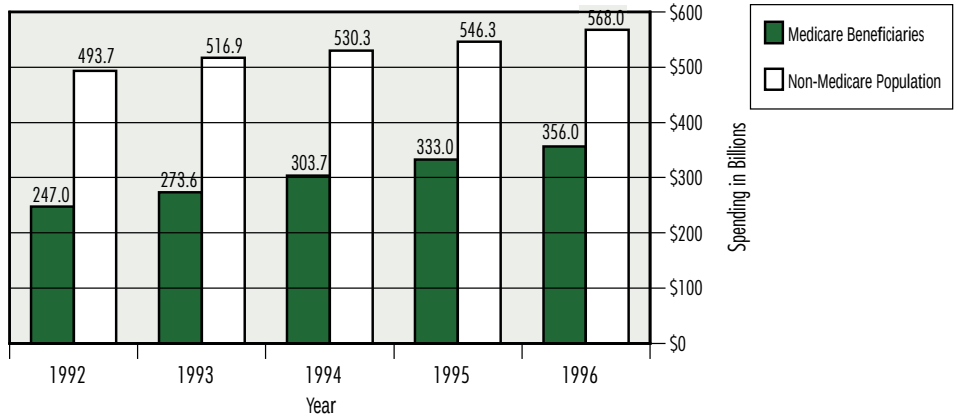
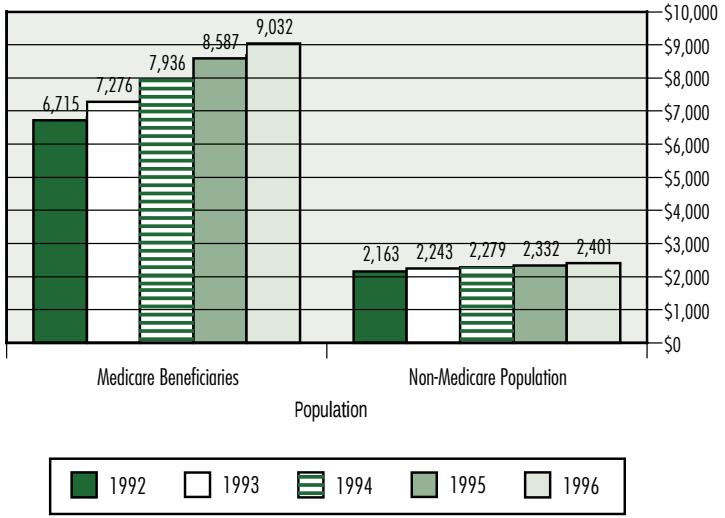


Figure 2-3 Per Capita Spending on Personal Health Care, 1992-1996

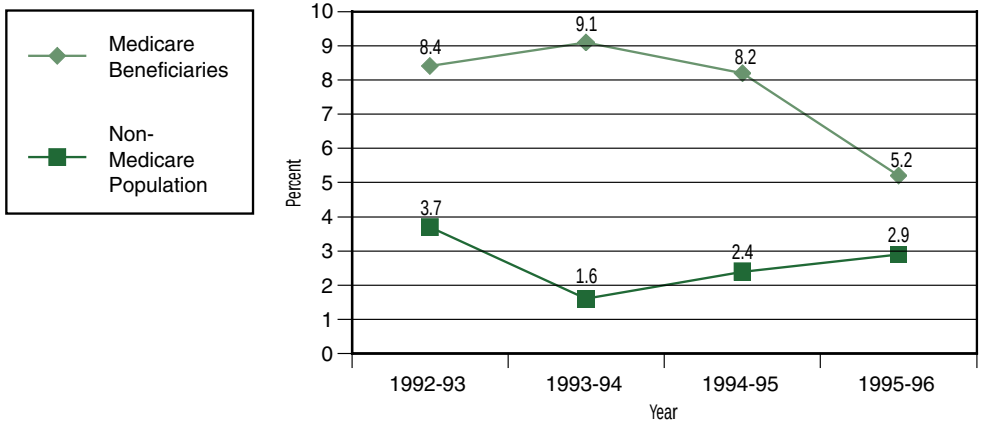


[3] The national health expenditures include personal health care expenditures, plus public program administration costs, the net cost of private health insurance, research by nonprofit groups and government entities, and the value of new construction put in place for hospitals and nursing homes. In 1996, expenditures for services other than personal health care were $118.5 billion.

[4] GDP increased by 5.4 percent between 1995 and 1996.

Medicare beneficiaries declined, expanding by only 5.2 percent, compared to 8-9 percent between 1992 and 1995 (Figure 2-4).

Figure 2-4 Annual Growth in Per Capita Spending on Personal Health Care, 1992-1996



Until 1995, growth in spending by Medicare beneficiaries had been mirroring growth patterns in the public sector of NHE, i.e., high rates of growth in contrast with dramatic downward trends in the private sector. Smith et al. (1998) predicted that a similar declining trend will emerge in health spending in the public sector in the late 1990s. Expenditure data on Medicare beneficiaries may serve as the harbinger of such a trend.

The deceleration of PHCE by Medicare beneficiaries reflects a combination of factors. A series of policy and administrative changes affecting Medicare were effective in controlling public spending (Braden, 1998; Levit et al., 1998a and 1998b). These changes included measures mandated by Congress that restrained the growth in Medicare payments to providers, and penalties in the form of stricter limits on the growth in physician fees imposed on physicians for exceeding the Medicare volume performance standards (VPS) in 1994 and 1995. These changes may have contributed to slowdowns in growth in expensive services such as home health care and skilled nursing facility (SNF) care, and stable growth in other services, such as inpatient hospital care. For instance, HCFA implemented a series of administrative measures in reaction to dramatic increases in home health care spending, particularly concerning home health providers and their reimbursement. These measures served as effective, although temporary, "cost controls" over skyrocketing home health expenses in the mid- and late-1990s.[5] The home health interim payment system mandated by the Balanced Budget Act (BBA) of 1997 implemented a number of changes in the way Medicare pays for home health services, further curtailing growth in spending.

The acceleration in Medicare HMO enrollment and other managed care plans also contributed to curbing growth in public spending. Between 1992 and 1996, enrollment in Medicare HMOs doubled from 6.7 percent of Medicare beneficiaries to 12.8 percent. In addition, capitated Medicare payments to managed care plans increased, from 4.8 percent of total Medicare expenditures in 1990 to 10.5 percent in 1996. Health maintenance organizations attracted Medicare beneficiaries by offering more comprehensive benefits at low premiums and lower out-of-pocket expenses. Expansions in Medicare HMO enrollment also left an impact on the mix of health care spending. Whether Medicare saves or loses money over healthy HMO enrollees is controversial (Moon, 1999). However, researchers agree that recent slowdowns in Medicare spending were partially attributed to cost savings from the change to managed care (Levit et al., 1998a and 1998b; Wilensky and Newhouse, 1999; Iglehart, 1999). These savings are considered one-time gains (Wilensky and Newhouse, 1999). Researchers doubt, therefore, that these gains will continue very far into the new century, although they may continue for several more years.

Other factors contributing to declines in growth of health care spending by Medicare beneficiaries include slowing in medical prices, excess health system capacity, a deceleration in the growth

[5] These administrative measures include tightening controls over home health agencies (HHAs), such as revising the Medicare Conditions of Participation (CoPs) for HHAs, requiring that HHAs collect information relating to an Outcomes and Assessment Standard Information Set (OASIS), revising the HHA Manual, and increasing physician and beneficiary outreach in the monitoring of home health care services.

of the Medicare population, and the administration's and providers' reactions to fraud and abuse (Braden et al., 1998; Levit et al., 1998a).[6]

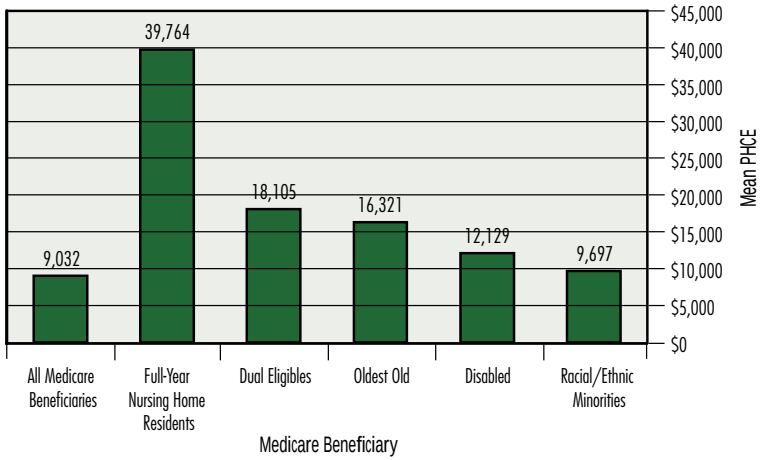
Despite the fact that growth in health care expenditures began to decelerate for Medicare beneficiaries in 1996, they still incurred significantly higher costs than the non-Medicare population. In 1996, PHCE by Medicare beneficiaries ($356 billion) constituted 38.5 percent of national health care spending, even though this population composes only 14 percent of the U.S. population. Per capita spending on health care by Medicare beneficiaries was almost four times as high as that of the non-Medicare population, averaging $9,032 in 1996.

High cost in PHCE by Medicare beneficiaries was partially driven by certain segments of the Medicare population, because of their health care needs. These segments included the oldest old (age 85 and over), the disabled, those dually eligible for Medicaid and Medicare, and nursing home residents. Figure 2-5 shows per capita health care spending by these groups in 1996.[7] Consistent with patterns seen in previous years, full-year nursing home residents incurred the highest cost, followed by dual eligibles, the oldest old, disabled, and racial and/or ethnic minorities.

Funding Sources

Personal health care was funded by both private and public resources.[8] Private resources include funds paid directly by consumers or their private health insurance (PHI), as well as from other sources such as charitable foundations. Public resources consist mostly of payments by Federal, state, and local government through universal entitlement programs such as Medicare, or means-tested programs such as Medicaid. These payment sources played very different roles in the financing of health care for the non-Medicare and Medicare populations (Figure 2-6). In 1996, private funds consisting mostly of PHI and out-of-pocket payments

Figure 2-5 Per Capita Personal Health Care Expenditures: Selected Groups of Medicare Beneficiaries, 1996



accounted for 66 percent of PHCE by the non-Medicare population (Braden et al., 1998); whereas for Medicare beneficiaries, they accounted for 29 percent. This difference mainly stemmed from the role of PHI in financing health care for the two populations (46 percent for the non-Medicare and 10 percent for the Medicare population). Private health insurance was not the primary payer for most health services consumed by Medicare beneficiaries, although 68 percent had private insurance in 1996. The share of out-of-pocket payments by Medicare beneficiaries (19 percent) was comparable to that of the non-Medicare population (20 percent). Nevertheless, average out-of-pocket payments by Medicare beneficiaries were almost four times as much, due to their much higher PHCE. In 1996, per capita out-of-pocket payments by Medicare beneficiaries were $1,674, compared with $474 for the non-Medicare population.

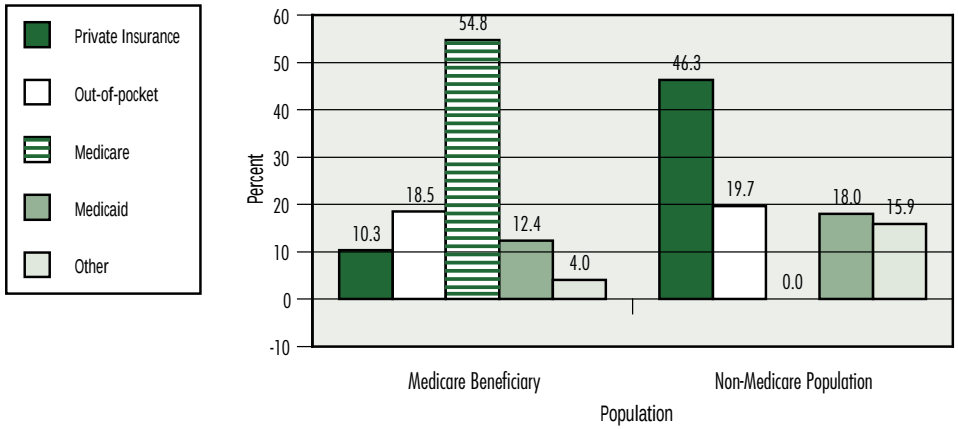
Public resources played a significantly less important role in health care financing for the non-Medicare population than they did for Medicare beneficiaries. Medicaid, the main public payer for the non-Medicare population's health care, financed 18 percent of their

[6] In May 1995, Operation Restore Trust (ORT) was launched by the administration to improve efforts at detecting and eliminating Medicare and Medicaid fraud, waste, and abuse. ORT is targeting four areas of high spending growth, including home health care, in the five states that compose more than one-third of all Medicare and Medicaid beneficiaries—New York, Florida, Illinois, Texas, and California. For instance, home health care provided to Medicare beneficiaries was under scrutiny by the Department of Health and Human Services' Office of Inspector General (OIG), because of high utilization growth.

[7] The categories of beneficiaries presented in this figure are not mutually exclusive.

[8] To achieve comparability between the Medicare and non-Medicare population, "other private payments" in NHE were collapsed with "other public."

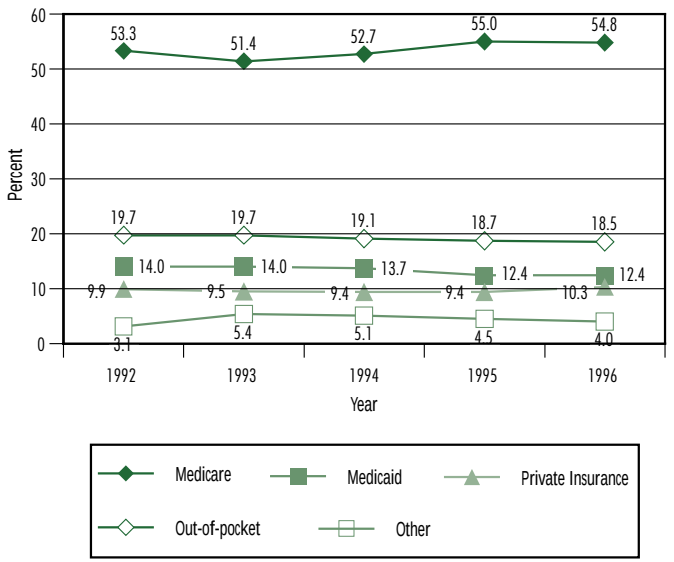
Figure 2-6 Sources of Funds for Personal Health Care Expenditures: Medicare Beneficiaries and the Non-Medicare Population, 1996



PHCE. By comparison, public funds, mostly Medicare and Medicaid, covered 67 percent of PHCE incurred by Medicare beneficiaries. Medicare, through the hospital insurance and supplementary medical insurance programs, was by far the predominant payer (55 percent). Total Medicare expenditures on PHCE amounted to $195 billion in 1996, representing a 6.5 percent increase from the previous year. Per capita Medicare payment grew 4.8 percent between 1995 and 1996, averaging $4,948 in 1996. Medicaid, acting as a supplemental health insurance as well as the primary payer for noncovered services for eligible beneficiaries, paid another 12 percent of PHCE. The financing pattern of PHCE for the Medicare population remained stable between 1992 and 1996, with slight increases in the shares by Medicare and reductions in the shares by Medicaid and household payments (Figure 2-7).

In 1996, total out-of-pocket (OOP) payment for Medicare beneficiaries amounted to $66 billion, 18.5 percent of total PHCE. Similar to the non-Medicare population (Levit et al., 1998a), OOP spending by Medicare beneficiaries declined slightly yet consistently for the fifth consecutive year, from 19.7 percent of PCHE in 1992

Figure 2-7 Sources of Funds for Personal Health Care Expenditures: Medicare Beneficiaries, 1992–1996



to 18.5 percent in 1996. The annual growth rate of OOP for Medicare beneficiaries also declined from 11 percent in 1993 to 6 percent in 1996. The decline in the growth of OOP was largely attributed to the expansion of managed care, "which generally requires more limited co-payments on insured services and smaller deductibles than indemnity insurance requires" (Levit et al., 1998a). Per capita OOP varied dramatically among groups of Medicare beneficiaries. In 1996, per capita OOP for aged community residents amounted to $1,058, compared with $1,202 for disabled community residents, and $11,934 for full-year nursing home residents.

Figure 2-8 presents sources of funding for aged and disabled Medicare beneficiaries residing in communities for part or all of 1996, and for full-year nursing home residents. Aged and disabled beneficiaries exhibit similar patterns in payer source. Medicare

finances more care for the aged (68 percent) than for the disabled (58 percent); whereas Medicaid paid a larger share of health care for disabled beneficiaries than for the aged (9 percent vs. 3 percent, respectively). Funding sources for full-year nursing home residents were different than for community residents. Medicaid was the primary funding source (40 percent) for nursing home residents. Almost another third was financed by OOP payments. Medicare was the third largest payer (19 percent). Although approximately 12 percent of full-year nursing home residents were covered by PHI, its share in their health care was negligible (1 percent).

PHCE by Service Category

The distribution of personal health care expenditures by type of service has changed little since 1992 (Figure 2-9). The largest share of PHCEs has been for inpatient and long-term care. Increasing enrollment in managed care caused a reallocation of Medicare expenditures away from inpatient care and toward ambulatory services (Smith et al., 1998; Levit et al., 1998a).[9] Data from the MCBS somewhat support this finding. From 1992 to 1996, the share of inpatient hospital services gradually declined from 33 to 29 percent of PHCE. During this time, combined ambulatory services saw a slight increase from 29 percent in 1993 and 1994 to 31 percent in 1996. After a drop between 1992 and 1993, spending for these services increased until 1995, and then declined slightly in 1996. Combined ambulatory services had become the largest share of PHCE by Medicare beneficiaries since 1995. These changes are often explained by the expanding role of managed care and the resulting changes of shifting from more costly inpatient care to less expensive ambulatory care (Levit et al., 1998a; Smith et al., 1998).

Annual growth rates in spending for various services varied tremendously (Table 2-1). The most notable trends included fast growth in prescription medicine (PM) expenditures, and slowdowns in growth in inpatient hospital and home health care expenditures. In the early 1990s, Medicare beneficiary PM expenditures grew at a rate comparable to that of total PHCE. However, in 1995, the growth in PM spending accelerated. In 1996, the PM growth rate doubled that of PHCE. Increases in PM expenditures were probably driven by increasing numbers of PMs dispensed and medicine

Figure 2-8 Sources of Funds for Personal Health Care Expenditures: Residency and Medicare Status, 1996

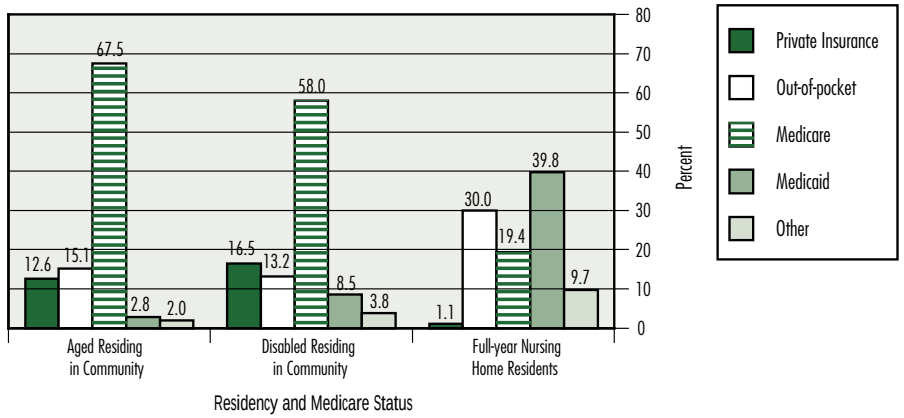
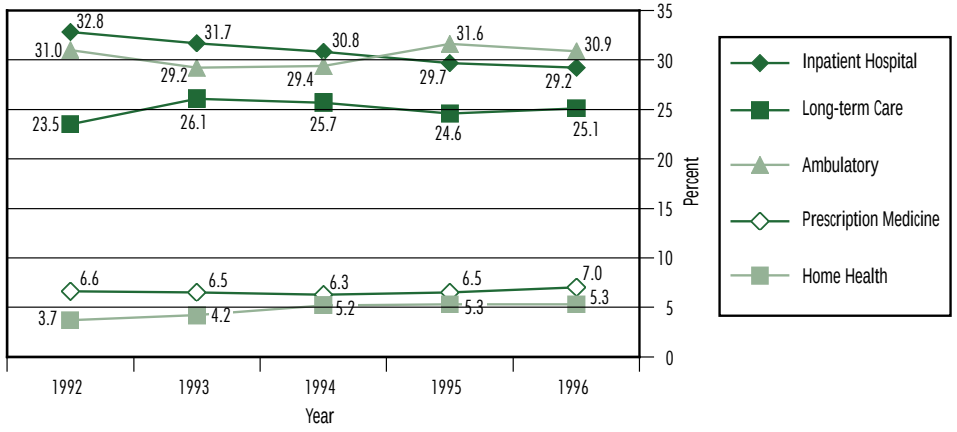


Figure 2-9 Distribution of Personal Health Care Spending by Medicare Beneficiaries: Type of Service, 1992–1996



[9] Ambulatory services include physician/supplier services and outpatient hospital services.

price hikes (Levit et al., 1998a; Soumerai and Ross-Degnan, 1999). A recent study found that 86 percent of Medicare beneficiaries living in the community used at least one prescription medicine during 1995, and the average such beneficiary used 18.5 prescriptions in 1995 (Davis et al., 1999).

Table 2-1 Annual Growth Rate by Selected Service Type, 1992-1996

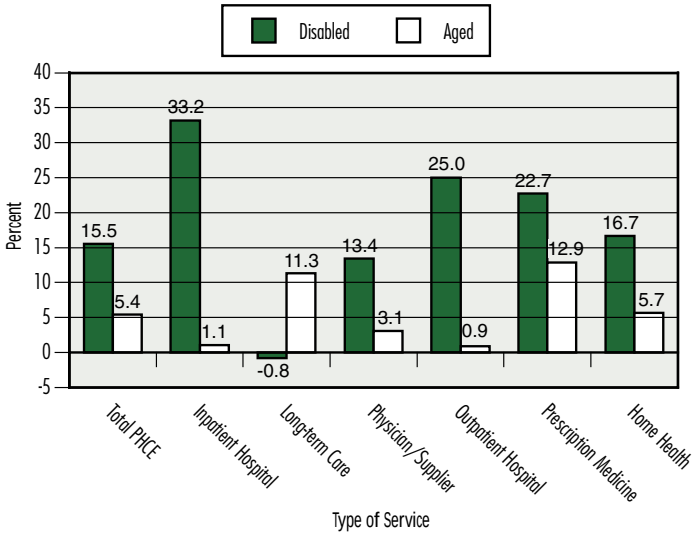
	1992–93	1993–94	1994–95	1995–96
Inpatient hospital	6.9%	8.0%	5.7%	5.0%
Long-term care	22.6%	9.7%	4.7%	9.0%
Ambulatory	4.5%	11.6%	17.6%	4.7%
Prescription Medicine	9.9%	6.5%	14.2%	14.5%
Home health	26.3%	35.8%	11.7%	6.7%

Table 2-1 also illustrates declining growth of inpatient hospital services and home health care. Growth in inpatient hospital spending declined from 6.9 percent between 1992-1993 to 5 percent between 1995-1996. Annual spending growth for home health care decelerated from its height of 36 percent growth in 1993-1994 to 7 percent growth in 1995-1996. The declines in home health spending reflected effective administrative cost controls discussed earlier,[10] and government and providers' reactions to fraud and abuse.[11]

On the other hand, the mid-1990s were also characterized by more rapid increases in ambulatory patient care. The growth rates for ambulatory services increased into the mid-1990s but then decreased in 1996 (Table 2-1).

Overall, for most service types, PHCE for disabled Medicare beneficiaries grew faster than did those for aged beneficiaries. Figure 2-10 indicates that in 1996, total PHCE increased 15.5 percent for disabled beneficiaries, compared with 5.4 percent for aged beneficiaries. In addition, PHCE growth rates illustrate that spending by disabled beneficiaries grew at a much faster pace than for aged beneficiaries for almost all major services except for long-term care.

Figure 2-10 Annual Growth Rate of PHCE: Medicare Status by Selected Type of Service, 1995–1996



Medicare Beneficiary Income

After the 1990-1991 recession, the U.S. economy saw a period of prosperity characterized by low unemployment rates, low inflation, and rising income. In 1996, U.S. households experienced an annual increase in their real median income for the second consecutive year (U.S. Bureau of the Census, 1997).

MCBS data can be used to assess income trends for the entire Medicare population, including the disabled under the age of 65 and those beneficiaries living in long-term care facilities.[12] In general, Medicare beneficiaries' incomes reflected this trend of rising incomes.[13] In 1996, the economic status of aged beneficiaries living in communities showed substantial improvement compared

[10] See Footnote 5.

[11] See Footnote 6.

[12] Income statistics from the MCBS may not be completely comparable to data from other sources such as the Current Population Survey (CPS) or the Survey of Income and Program Participation (SIPP). Definitions of income are not consistent among different sources. Furthermore, the CPS and SIPP collect information on the income of all family members living in a household. The MCBS, on the other hand, limits income data to the beneficiary, and spouse if married, regardless of whether other family members are present in the household.

[13] MCBS estimates of Medicare beneficiary income should not be compared to incomes reported for other segments of the population without considering such factors as taxes, government subsidies, and other benefits. Elderly people typically pay low taxes, have an implicit return on equity in their homes, and receive payments in kind that are not available to other groups. Much of their income, moreover, is from sources that are often underreported by survey respondents.

with their status in the early 1990s. In the early 1990s, Medicare beneficiaries' real income showed little improvement (Olin and Liu, 1998).

Figure 2-11 presents median incomes for three groups of Medicare beneficiaries between 1992 and 1996. Nominal income increased for long-term facility residents and disabled beneficiaries residing in communities over 5 years. However, after adjusting for inflation in the average annual consumer price index, the increases in real income of 1.1 and 0.7 percent, respectively, are negligible. On the other hand, median income increased 25.7 percent for aged beneficiaries residing in communities, which represents a growth of 13 percent in constant dollars.

The MCBS data also suggest substantial income inequality among Medicare beneficiaries. Aged beneficiaries living in communities had both more income and greater increases in income than disabled beneficiaries or those residing in long-term care facilities. Aged beneficiaries had more than twice the income of long-term care facility residents, and 80 percent more income than disabled beneficiaries living in communities (Figure 2-11).

Medicare beneficiary income is highly concentrated among a relatively small proportion of the population. In 1996, beneficiaries in the highest income quartile controlled 57 percent of the total, while the share received by beneficiaries in the lowest income quartile was 7 percent.[14] Between 1992 and 1996, the gap between the lowest and the highest income quartiles increased, with slightly more income controlled by the top quartile. Figure 2-12 further illustrates the degree of income inequality among Medicare community residents. Beneficiaries in the highest income quartile had nine times the average income of beneficiaries in the lowest income quartile, and more than twice the average income of beneficiaries in the second highest income quartile. Between 1994 and 1996, the wealthiest beneficiaries increased their incomes faster relative to the other beneficiaries. The trends and income dispersions

Figure 2-11 Median Income of Medicare Beneficiaries, 1992–1996

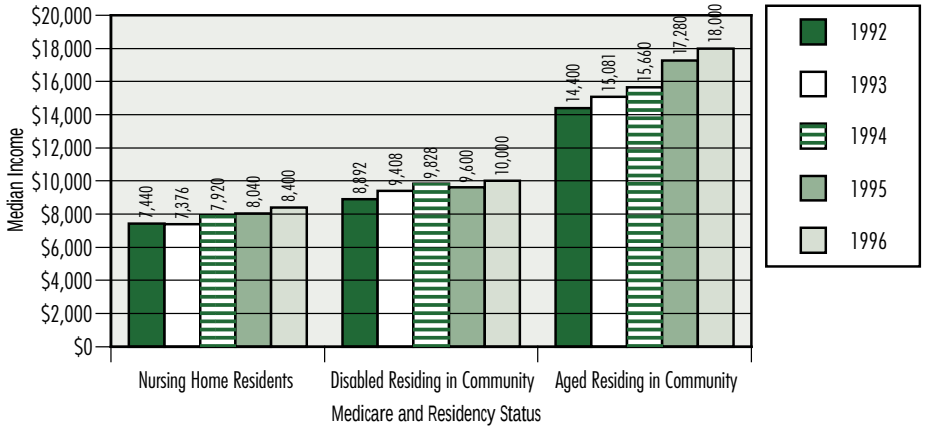
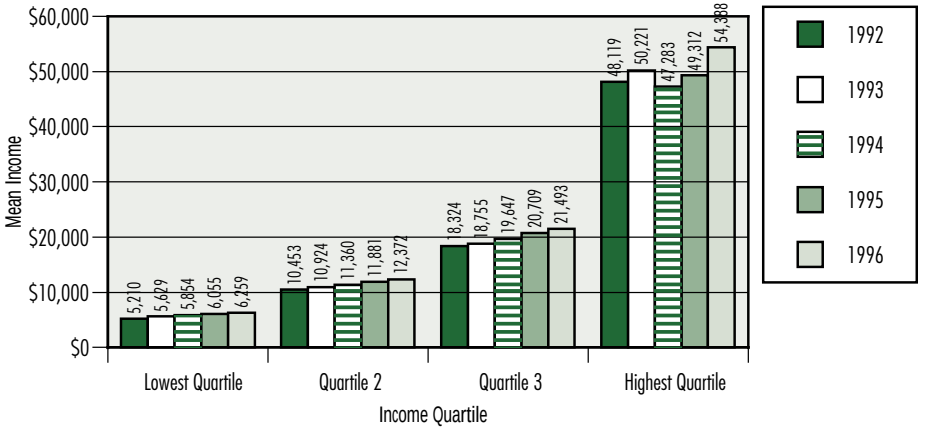


Figure 2-12 Mean Income of Medicare Beneficiaries Residing in the Community: Income Quartile, 1992–1996



reported in the MCBS are consistent with Current Population Survey (CPS) data collected by the U.S. Bureau of the Census. According to the 1996 CPS statistics, for example, proportions of elderly households (headed by people aged 65 and over) with high

[14] See Table 6.1 in Chapter 3 of this sourcebook.

relative incomes have increased substantially since 1969 (McNeil, 1998).

Income inequality within the Medicare population has been linked to factors such as age, disability, gender, race, marital status, and educational attainment (U.S. Bureau of the Census, 1996; Rowland and Lyons, 1998; Master and Taniguchi, 1996; Davis and O'Brien, 1996). It is also related to health status and residence (i.e., community or facility). For instance, long-term facility care residents have larger health care expenditures, and are more likely to deplete their savings and income-producing assets faster than community residents. Figure 2-13 illustrates differences in reported income by race and ethnicity for married beneficiaries living in communities.[15] Non-Hispanic whites had the highest and Hispanics had the lowest mean income between 1992 and 1996. The average income of non-Hispanic white beneficiaries was consistently higher than incomes reported by other groups during the years 1992-1996. Moreover, between 1993 and 1996, the income of non-Hispanic blacks was below its 1992 level. By comparison, the income of non-Hispanic whites and Hispanics increased in the mid-1990s.

[15] Mean incomes were calculated only for beneficiaries who lived the entire year in communities, because the difference in income reported by full- and part-year community residents is significant.

[16] The Federal Government produces annual poverty thresholds in order to assess change over time in the economic well being of persons and families in the U.S. In 1996, the poverty threshold for a person age 65 or older was $7,525. For a two-person family headed by a householder age 65 or older, the threshold was $9,484.

Figure 2-13 Mean Income of Married Medicare Beneficiaries Residing in the Community: Race and Ethnicity, 1992–1996

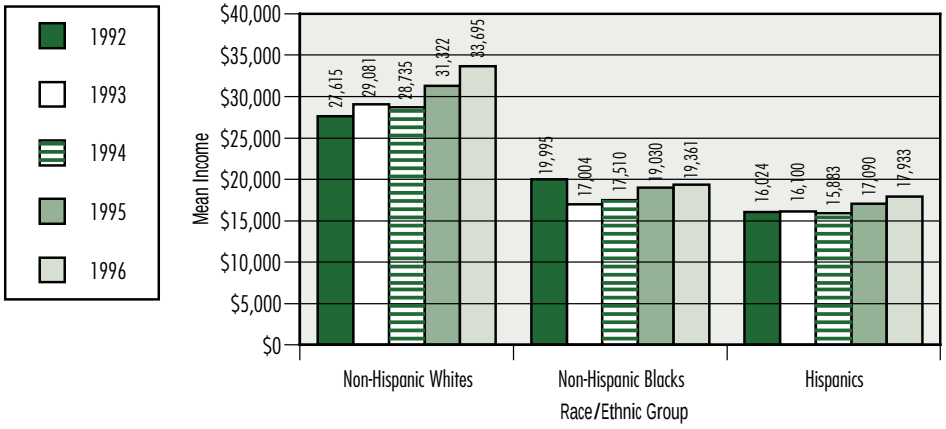
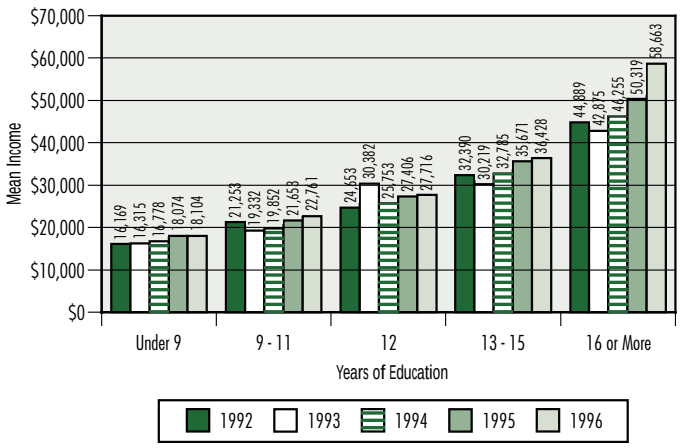


Figure 2-14 shows the effects of another factor on the distribution of income among Medicare beneficiaries—the link between education and income. Education had a dramatic impact on the income of a Medicare beneficiary. In 1996, the average income reported by married beneficiaries living in communities ranged from $18,100 for beneficiaries with fewer than 9 years of education to $58,700 for those with at least 16 years of education. These differences had remained largely unchanged. However, a notable exception was the large increase of income between 1994 and 1996 experienced by those with at least 16 years of education.

Figure 2-14 Mean Income of Married Medicare Beneficiaries Residing in the Community: Education Level, 1992–1996



In 1996, a significant proportion of Medicare beneficiaries lived in poverty or near poverty, i.e., with incomes between 100 and 125 percent of the poverty threshold.[16] Because of the dramatic improvement in economic status of aged beneficiaries living in communities, the proportion of elderly households under the poverty threshhold was smaller than that for all persons (10.8 percent vs. 13.7 percent, respectively). However, elderly households were more likely than nonelderly to have incomes just over the poverty threshold. The CPS data indicate that a larger proportion of the

elderly than nonelderly were classified as "near poor" (7.6 percent vs. 4.4 percent respectively; Lamison-White, 1997).

Health and Socioeconomic Status

The degree of income inequality observed among Medicare beneficiaries is an important concern because socioeconomic status is a powerful, although not well-understood, determinant of health. Studies of nonelderly people have shown that poor and poorly educated populations have higher mortality rates and greater morbidity than wealthier or better educated populations (Pappas et al., 1993; Angell, 1993). Other studies have shown that education is more important than race in predicting mortality from coronary disease and in determining the life expectancy of older persons (Keil et al., 1993; Guralnik et al., 1993).

Among Medicare beneficiaries, health and socioeconomic status are clearly correlated. Beneficiaries in the lowest income quartile are more likely to report poor or fair health, one or more limitation in activities of daily living (ADLs), and higher prevalence rates for major diseases. Figure 2-15, for instance, illustrates significant differences in self-reported health status by lower and higher income beneficiaries.[17] Nearly 38 percent of beneficiaries in the lowest income quartile, compared to approximately 15 percent in the highest income quartile, reported that they were in poor or fair health.

Self-reported data on limitations in ADLs are another measure of health status. Activities of Daily Living are those related to personal care, including eating, bathing, and dressing.[18] These activities have the same relationship to income as do self-assessed health status for elderly and disabled beneficiaries living in communities. Figure 2-16 illustrates that a beneficiary with at least one such limitation was more than twice as likely to be in the lowest income quartile as opposed to the highest income quartile (29 percent vs. 12 percent respectively).

Figure 2-15 Percent of Medicare Beneficiaries Living in the Community Reporting Poor or Fair Health: Income Quartile, 1992–1996

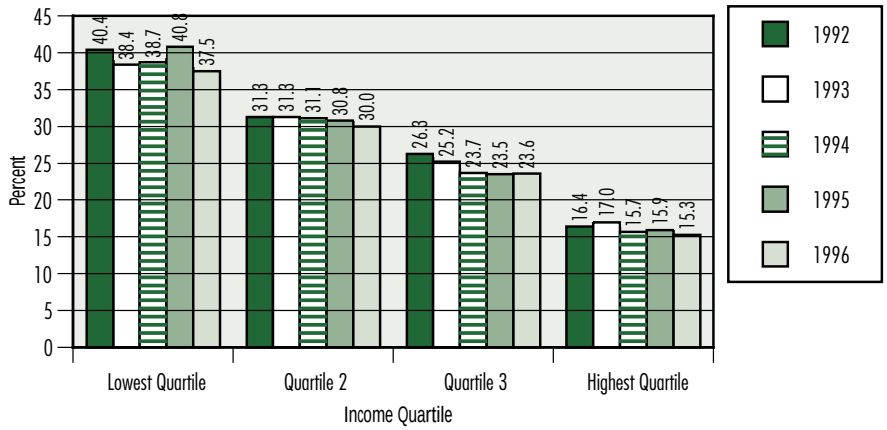
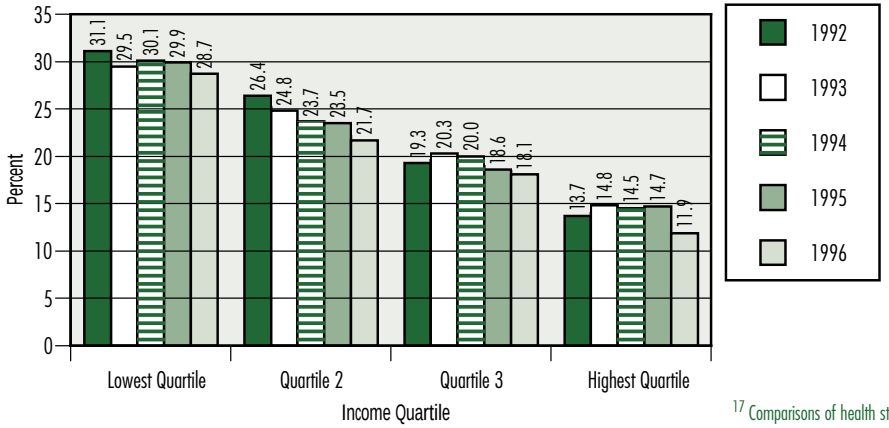


Figure 2-16 Percent of Medicare Beneficiaries Living in the Community with at Least One Limitation in Activities of Daily Living: Income Quartile, 1992–1996

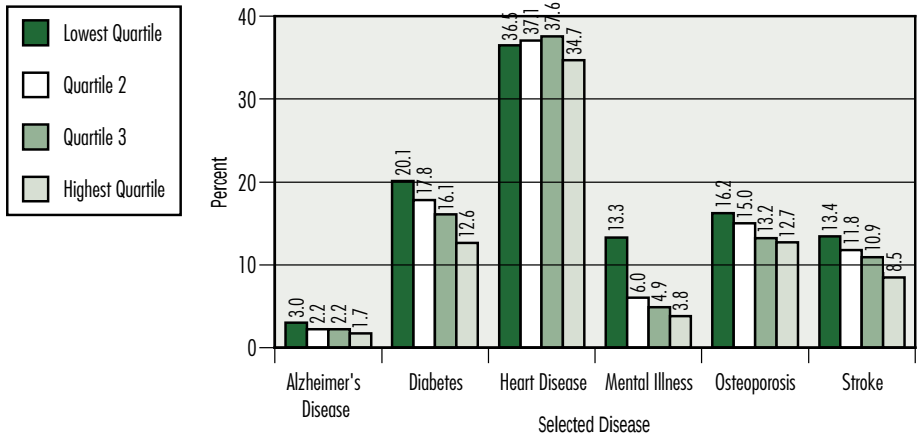


[17] Comparisons of health status were restricted to beneficiaries living in the community for the entire or part year.

[18] See Definitions of Terms and Variables in Appendix B for a complete list of ADLs.

Further evidence of the relationship between health and socioeconomic status can be seen in Figure 2-17. Beneficiaries in the lowest income quartile nearly always ranked highest among the four income groups in the prevalence of major diseases such as Alzheimer's disease, diabetes, mental illness, osteoporosis, and stroke. Among beneficiaries living in communities, heart disease was the only category in which the lowest income quartile did not have the highest prevalence. Conversely, beneficiaries in the highest income quartile always had the lowest prevalence rates for the selected diseases.

Figure 2-17 Percent of Medicare Beneficiaries Living in the Community with Selected Diseases: Income Quartile, 1996

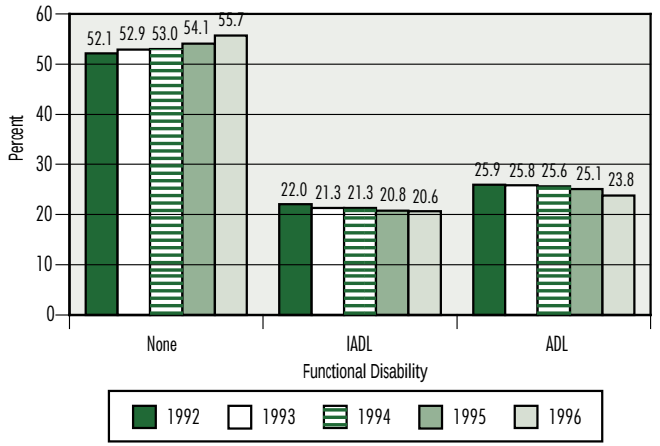


Trends in Health Status

Trends in health and functional status of the Medicare population between 1992 and 1996 are complex. Some findings suggest that overall, Medicare beneficiaries were experiencing improved health. Figure 2-15 indicates that the proportion of beneficiaries in each income quartile reporting poor or fair health declined gradually yet steadily between 1992 and 1996. Beneficiaries in the lowest income quartile experienced the largest decrease (2.9 percent) in persons reporting poor or fair health.

Between 1992 and 1996, Medicare beneficiaries reported fewer functional limitations (Figure 2-18). Both the proportions of beneficiaries with limitations in ADLs and Instrumental Activities of Daily Living (IADLs) decreased during this time. Instrumental Activities of Daily Living are related to independent living, including preparing meals, managing money, and shopping, among other activities.[19] Conversely, beneficiaries who did not report any functional limitations increased steadily from 52 percent to 56 percent.

Figure 2-18 Functional Disabilities of Medicare Beneficiaries, 1992–1996



As the population lives longer, beneficiaries seem to be able to delay the onset of moderate functional disabilities.[20] Even though proportions of severe functional disabilities (i.e., 3-5 functional limitations) remained largely unchanged since 1992, the rate of moderate functional disabilities continued to decrease, especially between ages 65-74 and 75-84 (Figure 2-19). These data suggest that overall, the health status of the younger segment of aged beneficiaries was improving. Younger beneficiaries who qualified for

[19] See Definitions of Terms and Variables in Appendix B for a complete list of IADLs.

[20] Moderate functional disability refers to IADL or 1-2 ADLs.

Figure 2-19 Medicare Beneficiaries with Moderate Functional Disabilities by Age Group, 1992–1996

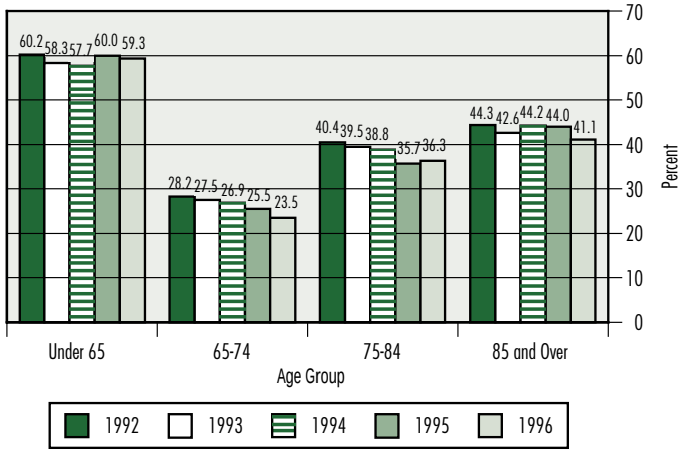
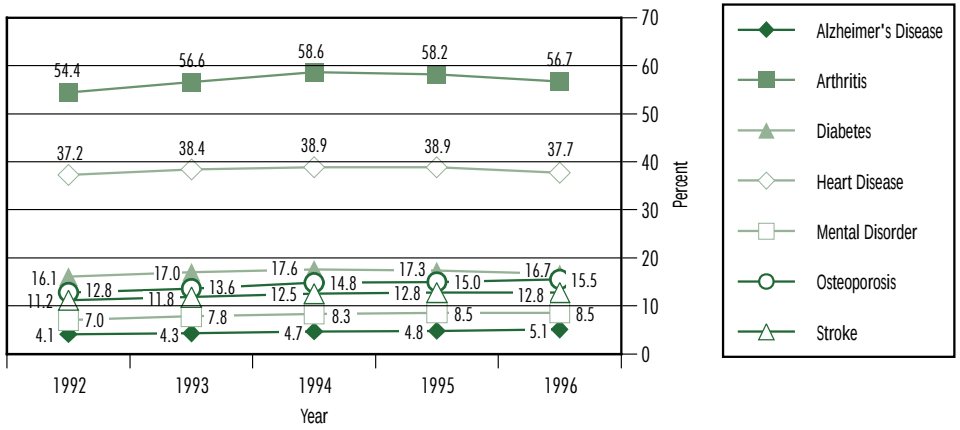


Figure 2-20 Prevalence of Selected Diseases of Medicare Beneficiaries, 1992–1996



Medicare because of their age were more likely to report better health and fewer limitations in ADLs and IADLs.

Between 1992 and 1996, the prevalence of major diseases afflicting Medicare beneficiaries rose slightly (Figure 2-20). For instance, the prevalence of Alzheimer's disease, mental disorder, osteoporosis, and stroke increased perceptibly, from 1-3 percent. Higher prevalence of these diseases may be partially attributed to prolonged life span of the population. Since most of these diseases are not easily curable but can be treated or controlled, their prevalence will be on the rise as this population ages and lives longer.[21]

Health Insurance

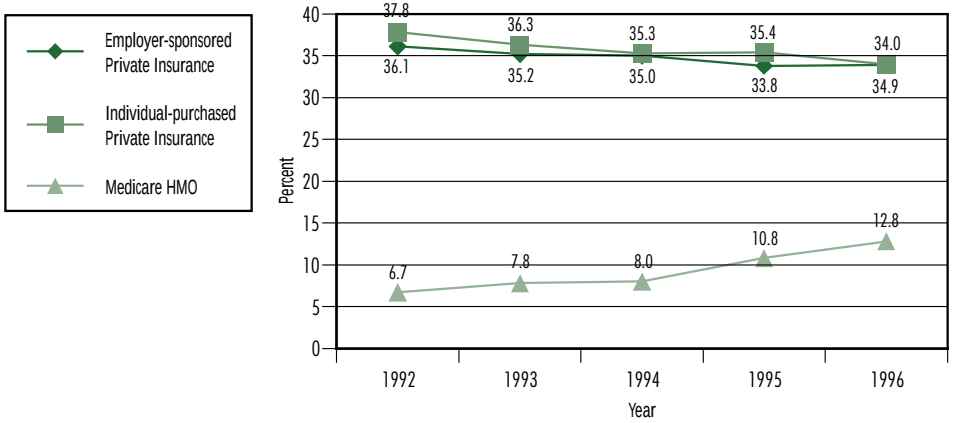
The MCBS collects data on health insurance for Medicare beneficiaries. Between 1992 and 1996, steady increases in Medicare HMO enrollment coincided with continuous declines in private health insurance (Figure 2-21). Rapid expansions of managed care in the private sector in the early 1990s spurred the growth of Medicare HMOs. Enrollment of Medicare HMOs jumped from 6.7 percent in 1992 to 12.8 percent in 1996, a two-fold increase in 5 years.[22] Conversely, as observed by many, both employer-sponsored and individually-purchased private health insurance were declining over the years (Glied and Stabile, 1999). The MCBS data indicated that employer-sponsored health insurance dropped from 36.1 percent in 1992 to 33.9 percent in 1996, and individually-purchased insurance showed an even steeper decline, from 37.8 percent in 1992 to 34 percent in 1996. Declines in private health insurance were caused partly by employers' further entrenchment from providing private health insurance because of financial constraints such as increasing fiscal liabilities (Shea and Stewart, 1994; Kuttner, 1999). These declines might also be explained by the expansion of Medicare HMOs, which provided more comprehensive coverage for beneficiaries and reduced their need for supplemental health insurance.

Disabled beneficiaries were more likely than other beneficiaries to have fee-for-service coverage with no supplemental insurance. Twenty-six percent of disabled beneficiaries had fee-for-service only

[21] The slight decline in the prevalence of some of the major diseases in 1996 might reflect changes in the sample design in that year rather than real change in disease trends. The original MCBS followed a longitudinal design until 1994 when the rotating panel design was fielded. The year 1995 was the first year when approximately one third of the original sample was retired. (See Appendix A for a detailed explanation.) The change of the design obviously had an effect on some of the trend data.

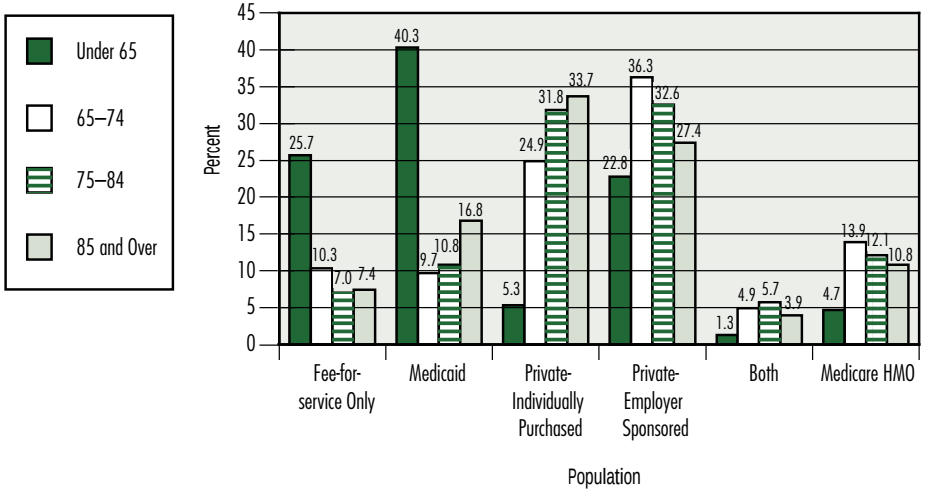
[22] Numbers presented in this chart differ slightly from those presented in data tables in Chapter 3, because groups here do not represent mutually exclusive categories.

Figure 2-21 Trends of Private Health Insurance and Medicare HMO Coverage for Medicare Beneficiaries, 1992–1996



coverage, compared to 8.9 percent of aged beneficiaries (Figure 2-22). Aged beneficiaries were more likely than the disabled to have

Figure 2-22 Health Insurance Coverage of Noninstitutionalized Medicare Beneficiaries by Age Group, 1996



had some form of supplemental insurance, such as individually-purchased or employer-sponsored private health insurance, or to be enrolled in a Medicare HMO. The lack of supplemental insurance placed proportionally more beneficiaries in a precarious position regarding prescription medicine and other uncovered services.

Access to Care

Findings from the MCBS and other sources have suggested that compared with the general U.S. population, Medicare beneficiaries continued to have fewer barriers to health care (Olin, Liu, and Merriman, 1999; Olin and Liu, 1998). Access to health care is often measured by sources of health care and factors affecting the use of medical services. Presence or absence of a usual source of care, for example, is a frequently cited indicator of an individual's ability to gain access to general health care. Between 1992 and 1996, the proportion of beneficiaries living in communities who said they had a usual source of care increased from 90.5 percent in 1992 to 92.8 percent in 1996. These beneficiaries reported that their usual source of care was a doctor's office or clinic, HMO, hospital emergency or outpatient department, or some other specific place. The remaining beneficiaries are considered vulnerable to access problems because they did not use a particular medical person or place for their health care.

Temporary concerns caused by the introduction of the Medicare Fee Schedule (MFS) for physicians in 1992 dissipated as research concluded that Medicare beneficiaries' access to care as measured by service utilization and expenditures did not decline (Trude and Colby, 1997; Rosenbach et al., 1995; Physician Payment Review Commission, 1996). However, although improvement in access to care holds true for the Medicare population in general, certain subgroups, such as racial and ethnic minorities, low-income beneficiaries, and those without supplemental health insurance continued to experience more than average barriers in access to health care.

The increased likelihood that a beneficiary had a usual source of care is important, since it is considered as one of the more important measures of access to health care (Sox et al., 1998; Lee and Kasper, 1998). In addition, the overall trend toward more beneficiaries having a usual source of care may understate the extent to which access improved between 1992 and 1996. During this period, the proportion of beneficiaries using office-based physicians (i.e., doctors' offices or clinics, or HMOs), as opposed to hospitals or other medical facilities, for their health care increased by more than 3 percentage points (Figure 2-23). These data suggest that more beneficiaries were establishing a usual source of care, and the source was increasingly likely to be an office-based physician rather than a hospital or other facility.

Figure 2-23 also displays the trend between 1992 and 1996 toward increased use of office-based physicians by disabled beneficiaries, racial and ethnic minorities, and low-income beneficiaries. Disabled beneficiaries reported the largest gain in their use of office-based physicians as their usual source of care. The only subgroup not increasing its use of office-based physicians during this time period were those fee-for-service only beneficiaries. However, the more vulnerable Medicare beneficiaries were still less likely than all beneficiaries to use office-based physicians as their usual source of care.

Between 1992 and 1996, fewer beneficiaries reported difficulty in getting care (Figure 2-24). Most beneficiaries living in communities did not appear to have difficulty in getting care, as the proportion reporting difficulty declined from 4.1 percent in 1992 to 3.3 percent in 1996. While vulnerable segments of the population experience considerably more than the average degree of difficulty in getting care, access appeared to be improving for these beneficiaries. Between 1992 and 1996, the drop in the proportion of vulnerable populations reporting difficulty in getting care ranged from 1.8 percentage points for low-income beneficiaries to 3.4 percentage points for disabled beneficiaries. fee-for-service only beneficiaries were the only group to experience increased difficulty in getting care in some of these years.

Figure 2-23 Proportion of Community Residents Using Office-Based Physicians as Their Usual Source of Care, 1992–1996

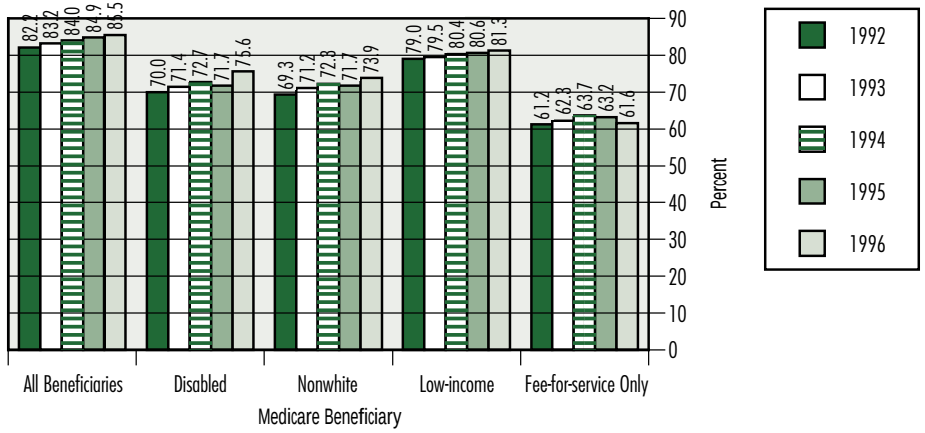
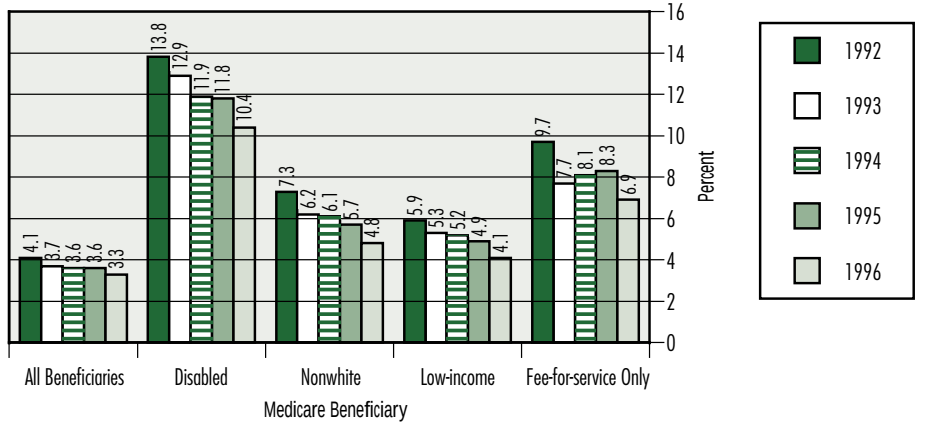
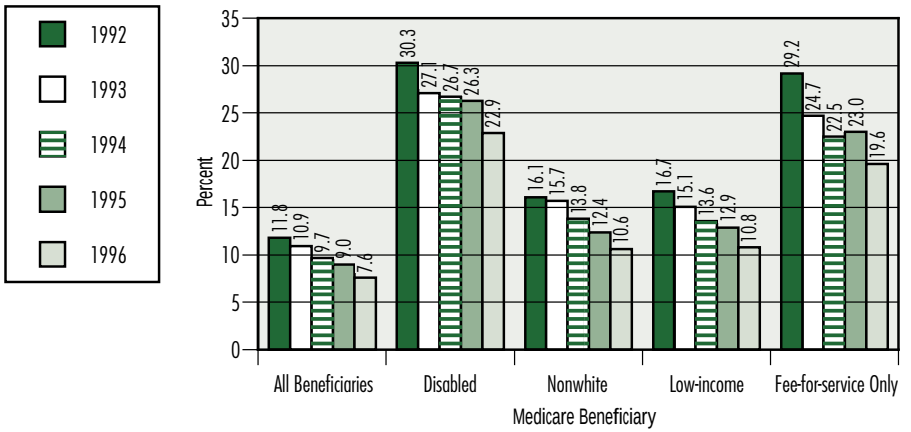


Figure 2-24 Proportion of Community Residents Reporting Difficulty in Obtaining Care, 1992–1996



Cost-related barriers to care also declined substantially for all segments of the Medicare population. The proportion of beneficiaries who reported that they delayed care due to cost declined from 11.8 percent in 1992 to 7.6 percent in 1996 (Figure 2-25). Vulnerable segments of the population benefited the most during this period. For example, the likelihood that a Medicare fee-for-service only beneficiary would delay care because of cost considerations fell by 9.6 percentage points, from 29.2 percent in 1992 to 19.6 percent in 1996. Gains of this magnitude are encouraging because they suggest that barriers to care were becoming less an issue for vulnerable populations, although cost clearly remained an important consideration in decisions by vulnerable populations to delay care.

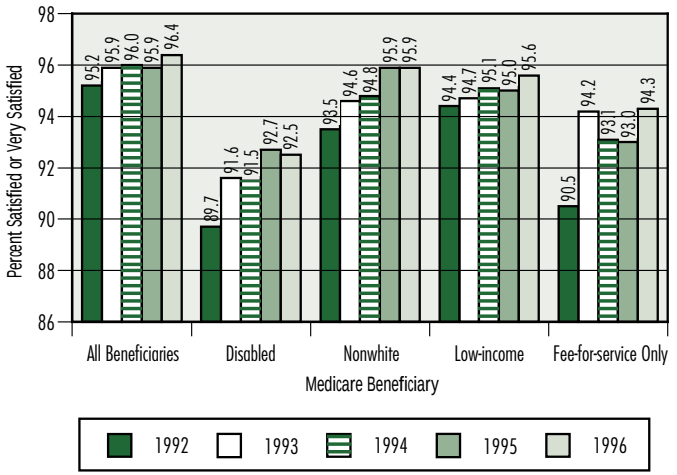
Figure 2-25 Proportion of Community Residents Who Delayed Care Due to Cost, 1992–1996



Satisfaction with Care

Most Medicare beneficiaries expressed high levels of satisfaction with the overall quality of their health care. More than 96 percent of all elderly and disabled beneficiaries living in communities said they were satisfied or very satisfied with the quality of their care in 1996, up by 1.2 percent since 1992 (Figure 2-26).[23] The more vulnerable subgroups of Medicare beneficiaries reported slightly lower levels of satisfaction with their health care, but overall the proportion of dissatisfied beneficiaries was surprisingly small. All subgroups were more satisfied with their overall health care in 1996 than they were in 1992. Disabled beneficiaries were the least satisfied with their health care, but 92.5 percent reported being satisfied or very satisfied. That Medicare beneficiaries were reporting increased satisfaction with the overall quality of their general health care might not be particularly surprising. Satisfaction with health care was highly correlated with the presence of a usual source of care (Lee and Kasper, 1998), and more beneficiaries had established a usual source of care in recent years.

Figure 2-26 Proportion of Community Residents Satisfied with the Quality of Their Medical Care, 1992–1996

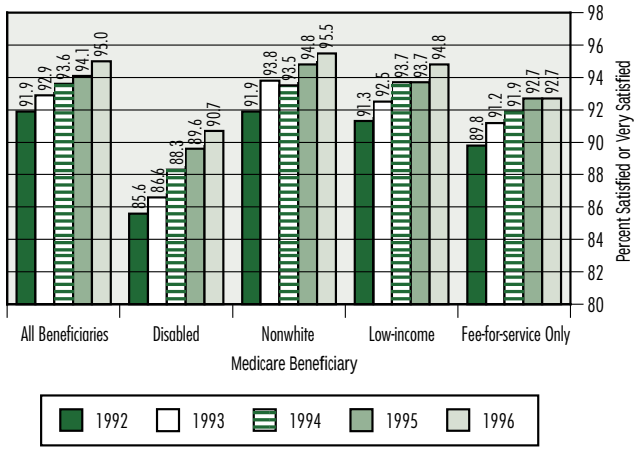


Another dimension of satisfaction with health care is the availability of health care at nights and on weekends (Figure 2-27). Beneficiaries who had experience with this dimension of their health care also reported high levels of satisfaction with their ability to get care at night and on weekends. Among the more vulnerable subgroups, disabled beneficiaries were least satisfied with this dimension of their health care, but they also expressed the largest

[23] These percentages differ from those presented in Table 6.15 because the denominator used in calculating the percentage of beneficiaries satisfied or very satisfied with their health care excludes beneficiaries who reported no experience with the dimension of health care in question.

increase in satisfaction between 1992 and 1996 (5.1 percentage points). Overall, though, the more vulnerable subgroups largely were satisfied with their availability of care at nights and on weekends.

Figure 2-27 Proportion of Community Residents Satisfied with the Availability of Care at Night and on the Weekend, 1992–1996



Ease and convenience of getting to a doctor is another dimension of patient satisfaction. Well over 90 percent of all beneficiaries were satisfied or very satisfied with this aspect of their health care (Figure 2-28). Disabled beneficiaries expressed the least satisfaction with ease of getting care, but the responses may have been more a reflection of their mobility than the availability of their transportation options. As with other measures of satisfaction, the proportion of positive responses increased for all subgroups between 1992 and 1996.

Not surprisingly, Medicare beneficiaries expressed the least satisfaction with the out-of-pocket cost of health care compared to other dimensions of their health care (Figure 2-29). Among the vulnerable populations, the proportion of beneficiaries satisfied with cost

Figure 2-28 Proportion of Community Residents Satisfied with Their Ease of Getting Care, 1992–1996

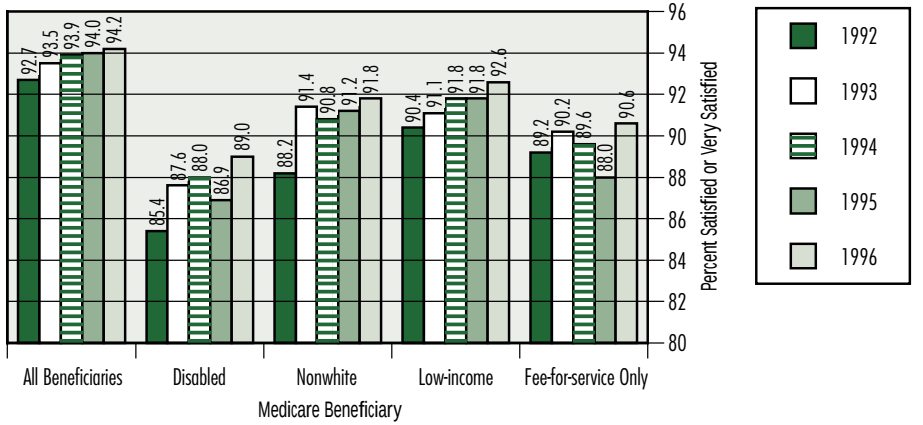
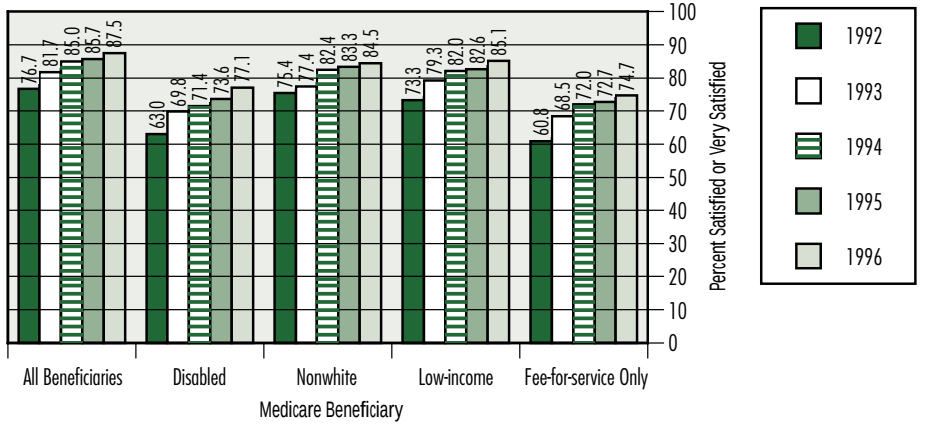


Figure 2-29 Proportion of Community Residents Satisfied with the Cost of Their Care, 1992–1996



ranged from 75 percent by Medicare fee-for-service only beneficiaries to 85 percent by low-income beneficiaries in 1996. However, responses to the question about satisfaction with out-of-pocket

costs of health care yielded some interesting results. First, two vulnerable group —nonwhite beneficiaries and low-income beneficiaries—were nearly as satisfied as the average beneficiary with their out-of-pocket costs. Second, the proportion of beneficiaries satisfied with their out-of-pocket costs increased significantly between 1992 and 1996. fee-for-service only beneficiaries—the group facing the highest out-of-pocket expenditures for health care—and disabled beneficiaries both increased 14 percent in satisfaction with cost. All groups made a gain of more than 9 percentage points. These responses are strong evidence that beneficiaries benefited from the introduction of a new fee schedule for physicians in 1992. In addition, findings suggest that among vulnerable populations, disparities in access to care may be declining.

Summary

This chapter points to new findings from the 1996 MCBS and highlights ongoing trends among Medicare beneficiaries. Most notably, cost control measures have contained spending increases in a dramatic way. In the early and mid-1990s, health care spending by Medicare beneficiaries was characterized by double-digit growth. A major slowdown in the rapid growth of health care spending by Medicare beneficiaries occurred for the first time in the decade in 1996. Major factors responsible for controlling costs include policy and administrative measures to reduce public spending, expansions in Medicare HMO enrollment, and the administration and providers' reaction to fraud and abuse.

Coincident with these trends in spending, total expenditures on ambulatory services accounted for a larger share of PHCE than did inpatient services in 1996. Spending for prescription medications grew the fastest among all major types of services. Medicare HMO coverage continued to increase, although employer-sponsored and individually purchased health insurance declined in 1996 for the Medicare population.

Medicare beneficiaries generally found health care to be accessible, and were overwhelmingly satisfied with the care that they received. Almost 93 percent of beneficiaries reported that they had a usual source of care and 86 percent reported that their usual source of care was in a doctor's office. Throughout the mid-1990s, increasing numbers of Medicare beneficiaries reported that they were satisfied with their ease of getting care and with the availability of care on nights and weekends. Finally, cost-related barriers to care have been declining throughout the mid-1990s. Fewer beneficiaries reported delaying care because of the cost and more were satisfied with the cost of their health care.

Despite the achievements in satisfaction with and access to health care, certain subgroups of the Medicare population were still experiencing barriers to access. The disabled, in particular, reported ongoing problems in access and were less satisfied with care than the majority of beneficiaries. In 1996, less than 5 percent of disabled beneficiaries were enrolled in a Medicare HMO, compared with 13 percent enrollment rates for aged beneficiaries. In spite of their large proportion of Medicaid coverage (40 percent), disabled beneficiaries were more likely to have Medicare fee-for-service coverage with no supplemental health insurance. Almost 23 percent of disabled beneficiaries reported delaying care because of cost, compared to 8 percent of all beneficiaries. While disabled beneficiaries reported increasing satisfaction with and access to care in the mid-1990s, they still were confronted with significant barriers.

Medicare beneficiaries with fee-for-service only coverage reported significantly lower satisfaction with the quality of their medical care and more barriers to accessing that care. These beneficiaries were least likely to report using an office-based physician as their usual source of care. In 1996, almost 20 percent of beneficiaries with fee-for-service only coverage delayed care due to its cost. The rapid growth of spending for prescription medications will pose increasing burdens for those beneficiaries with fee-for service-only coverage.

Low-income beneficiaries and those who are ethnic and racial minority group members also continued to experience more barriers to care and less satisfaction with care than do the majority of Medicare beneficiaries. Nonwhite beneficiaries were less likely than other beneficiaries to use office-based physicians as their usual source of care, and more likely to report difficulty in obtaining care and delayed care due to cost.

The income of Medicare beneficiaries continued to improve in 1996. Most of the income gains were to aged beneficiaries residing in communities, compared to disabled beneficiaries or beneficiaries in long-term care facilities. In addition, beneficiaries of racial and ethnic minority groups saw smaller income gains. Although smaller proportions of Medicare beneficiaries were living in poverty in 1996, there were still significant numbers of elderly households near the poverty threshhold. Lower income beneficiaries were more likely to report poorer health and functional limitations than were those beneficiaries with higher incomes.

Overall, findings from the 1996 MCBS suggest that the declines in PHCE growth, increasing access to and satisfaction with health care, increasing incomes, and diminishing functional disabilities indicate better health for the Medicare program's beneficiaries. These findings also suggest the continuing need to address the barriers to health care encountered by vulnerable beneficiaries. These vulnerable beneficiaries, including disabled, racial and ethnic minorities, low-income, and those with fee-for-service only coverage, still face problems accessing health care and should be the focus of additional vigilance to ensure their access to health care.