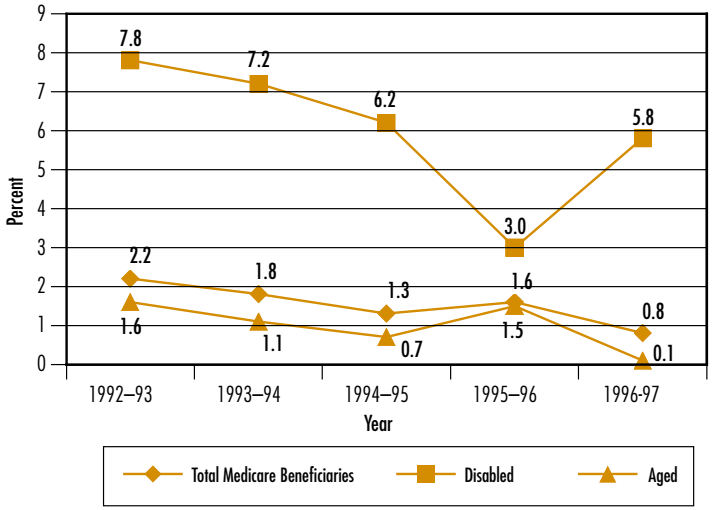
2 TRENDS IN THE MCBS: 1992–1997

THE MEDICARE POPULATION

In 1997, the number of Medicare beneficiaries who were ever enrolled in Medicare at any time during the calendar year grew to 39.7 million, which is 14.3 percent of the total U.S. population.[1] Of all beneficiaries, 5.3 percent were full-year nursing home residents, while 94.7 percent resided in the community for at least part of the year. Beneficiaries aged 65 or over composed 87.6 percent of the Medicare population, and the remaining 12.4 percent consisted of disabled persons.[2]

The annual growth rate of the Medicare population slowed from 1.6 percent in 1995-1996 to 0.8 percent in 1996 and 1997 (Figure 2-1). This reduction was due to the almost zero growth of the sizeable aged population, which more than offset the comparatively rapid growth of the disabled population. At the same time, the proportion of disabled beneficiaries in the Medicare population reached 12.4 percent in 1997, up from 11.8 percent in 1996.

Figure 2-1 Annual Growth in Medicare Population by Medicare Status, 1992–1997



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

[2] In the following discussion, Medicare beneficiaries are divided into two mutually exclusive groups, distinguished by age: all beneficiaries under 65 years old are referred to as *disabled*, while all beneficiaries 65 years old or older are referred to as *aged*. Of course, many who are referred to as *aged* may also be disabled in the conventional sense, but are not included in the *disabled* group in this discussion.

[3] National health expenditures include personal health care expenditures, administrative costs, public health spending, and research/construction expenses.

HEALTH CARE EXPENDITURES

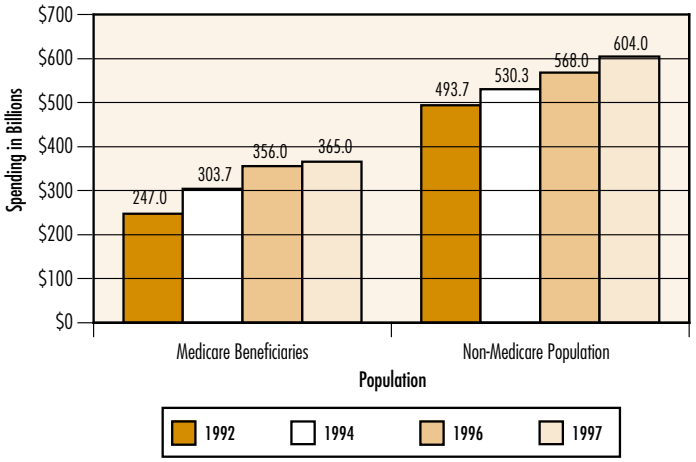
Personal health care expenditures (PHCE) by Medicare beneficiaries represent direct consumption of health care goods and services provided by hospitals, physicians, and other suppliers of medical care and equipment. The Medicare Current Beneficiary Survey (MCBS) provides estimates of expenditures for Medicare-covered services as well as some relatively expensive services not typically covered by Medicare, for example, nursing home care and prescription medicines. Information on noncovered services fills a large gap in knowledge about beneficiary health care spending. The Centers for Medicare and Medicaid Services (CMS), the primary source of Medicare program data, has claims information for only those services covered under Medicare Part A and Part B.

Estimates of national health expenditures (NHE) are produced annually by CMS.[3] The NHE estimates identify all health care goods and services produced in the U.S. health care market 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 the Medicare population is included in the NHE. The NHE report serves as a valuable frame of reference for policymakers to track trends in the health care industry.

In 1997, NHE amounted to $1,092.4 billion, 13.5 percent of the Gross Domestic Product (GDP), of which $969 billion (88.7 percent) was for PHCE (Levit et al., 1998). Between 1996 and 1997, national PHCE grew from $924 billion to $969 billion, at an annual rate of 4.9 percent, the lowest rate in decades. The Medicare population spent $365 billion on PHCE (37.7 percent of national PHCE), while the non-Medicare population spent $604 billion (62.3 percent of national PHCE). Even though the Medicare population composed only one-seventh of the U.S. population, Medicare beneficiaries consumed more than one-third of national

PHCE. While the level of spending continued to rise for both groups (Figure 2-2), the *growth* rate of PHCE declined for the Medicare population. For Medicare beneficiaries, PHCE increased from $356 billion to $365 billion, or 2.5 percent between 1996 and 1997. This relatively low growth rate is a remarkable contrast to the double-digit growth rates recorded as recently as 1994, but consistent with a declining growth trend that has been evident since then.

Figure 2-2 National Personal Health Care Spending, 1992–1997



Much of the rapid growth in health care spending prior to 1995 has been attributed to advances in technology that made it feasible to perform more services for patients, particularly the elderly and the disabled (Fuchs, 1999; Smith et al., 1998). That is, the medical care system delivered more and improved services to patients, and encouraged the usage of available medical services by more people, such as new drugs, MRI, angioplasties, hip replacements, and many other costly services. In contrast to the health care spending trends of the early 1990s, spending growth slowed down considerably after 1995. Although many factors may have led to the observed slowdown, the key factors included greater enrollment in managed care, which facilitated the slowdown in the use of health services, and relatively low price inflation.[4]

Some researchers suggest that the dominant factor behind the slow growth in national health care spending since 1993 was a decline in growth of the quantity (both use and intensity) of services, perhaps due to increased participation in managed care and the utilization review procedures it commonly implements (Smith et al., 1998). To maintain low premiums, managed care organizations negotiated price discounts with providers, and gave incentives to providers to alter their patterns of service delivery to contain cost growth. This, in turn, led to changes in the quantity and mix of health care services for all consumers, including Medicare beneficiaries (Levit et al., 1998). Since enrollment in Medicare managed care grew rapidly in the mid-1990s, reaching 15.8 percent of the Medicare population in 1997, the above scenario was increasingly applicable to the Medicare population. Although total health care costs per enrollee were expected to drop because of the increasing enrollment in managed care, there was lack of consensus among researchers about whether managed care could sustain a reduction in cost growth.[5]

In addition to the modest growth of the quantity of services, both economy-wide and medical-specific inflation rates were relatively low during the mid-1990s.[6] Excess capacity among some health service providers (such as community hospitals) may have boosted competition among providers and drove down prices in the private sector. Revised payment incentives in managed care and in public programs such as Medicare may also have deterred price increases. As a result, growth in real health spending, i.e., economy-wide inflation adjusted growth, decelerated as well (Levit et al., 1998).[7]

Per capita PHCE continued to increase between 1996 and 1997. For the non-Medicare population, per capita PHCE climbed to $2,535, an increase of 5.6 percent from the previous year, while per capita spending for the Medicare population reached $9,186, representing an annual growth rate of 1.7 percent from 1996 (Figure 2-

[4] Most of the rationales provided for the national trends carry over to the Medicare population as well. When possible, rationales specific to the Medicare population are provided.

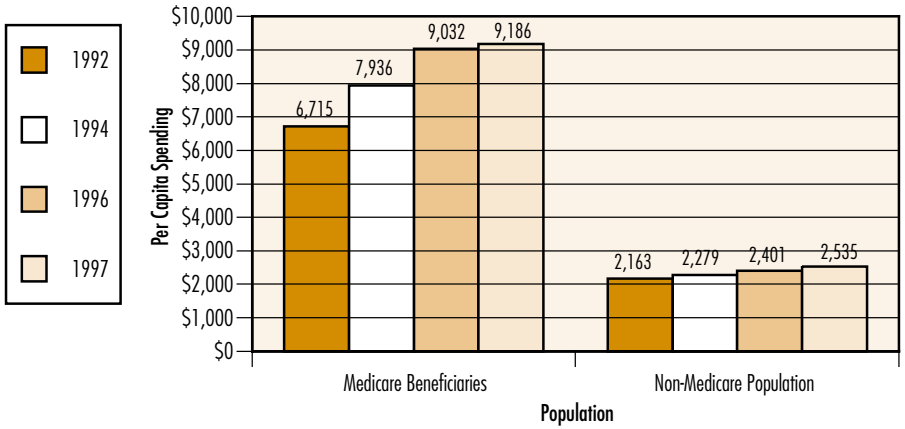
[5] Some researchers believe that continued evolution within managed care may curb growth in health spending in the long run, while others question whether managed care can reduce a key source of cost growth: the diffusion and utilization of new medical technology (Smith et al., 1999; Chernew et al., 1997).

[6] Medical-specific inflation is defined as the amount of price inflation specific to the medical sector of the economy that is over and above general (economy-wide) inflation.

[7] Real growth of health care spending is the product of quantity and intensity of health care services purchased and changes in medical price inflation in excess of economy-wide inflation. That is: Real PHCE=(Excess Medical Price Inflation)*(Quantity and Intensity of Health Care Services). Real growth in PHCE is computed as follows: using the chain-type GDP deflator with 1992 base year as the general inflation index (from US Department of Commerce, Bureau of Economic Analysis), current year dollars are converted into real (1992) dollars by dividing current year dollars by the price index value for the same year. The annual percent growth, using the prior year as the reference year, may then be calculated using real dollars.

3). Since the elderly and the disabled tended to consume more health care services than the rest of the population, it is not surprising that, per capita, PHCE by the Medicare population was more than 3 times as high as that of the non-Medicare population (Fuchs, 1999).

Figure 2-3 Per Capita Spending on Personal Health Care, 1992-1997

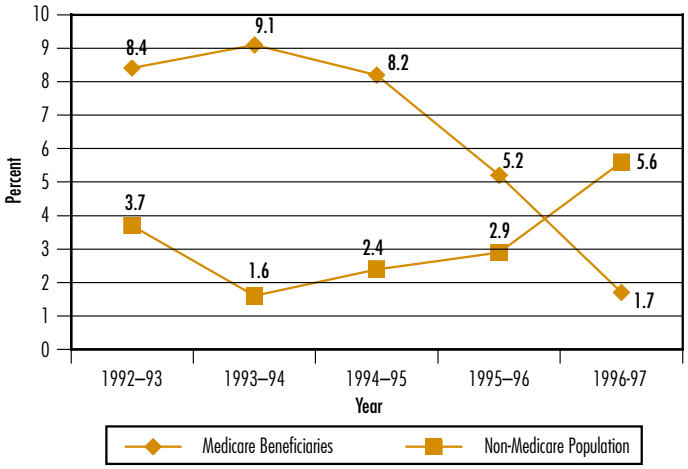


For the first time in recent years, however, the *growth* in per capita spending for the Medicare population fell below that of the non-Medicare population, after consistently declining since 1994 (Figure 2-4). This decline reflected the slowdown in both population and PHCE growth of Medicare beneficiaries observed since 1993. Real growth in per capita PHCE for the Medicare population also decelerated since 1994. Between 1996 and 1997, it declined by –0.2 percent, the first year real growth was negative since the MCBS was initiated in 1992.

HIGH-COST USERS

Medicare high-cost users are those beneficiaries who consume a disproportionate amount of health care resources. The more vulnerable groups of Medicare beneficiaries continued to show above

Figure 2-4 Annual Growth in Per Capita Spending on Personal Health Care, 1992–1997



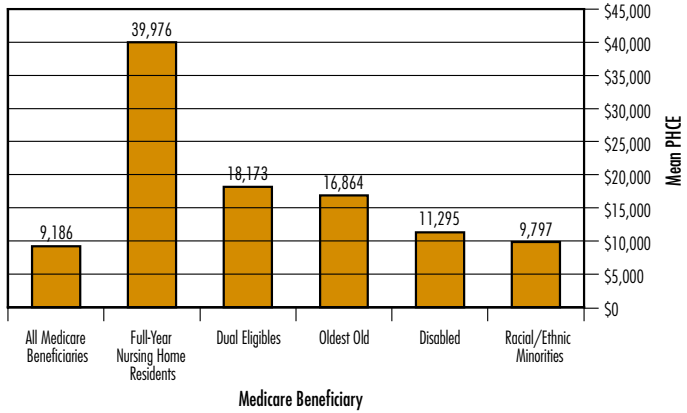
average per capita PHCE in 1997 (Figure 2-5). Full-year nursing home residents had the highest average PHCE, followed by those dually eligible for both Medicare and Medicaid, the oldest old (aged 85 or above), the disabled, and racial/ethnic minorities.[8]

Some interesting patterns are evident upon a closer look at the characteristics of Medicare beneficiaries whose total PHCE was at the 99th percentile or above in 1997 (Table 2-1). Several socioeconomic characteristics distinguished high-cost users from the overall Medicare population. They were more likely to be disabled, male, non-Hispanic black, urban residents, never married, and with an income less than $10,000. High-cost users were much more likely to reside in a nursing home for at least part of the year. In fact, more than 30 percent were full-year nursing home residents, compared with 5.3 percent of the general Medicare population.

Beneficiaries who were severely ill with acute or chronic conditions tended to incur high health care costs. Except for arthritis and hypertension, high-cost beneficiaries had significantly higher

[8] These groups are not mutually exclusive.

Figure 2-5 Per Capita Personal Health Care Expenditures: Selected Groups of Medicare Beneficiaries, 1997



prevalence of all specific health conditions listed, particularly end-stage renal disease (ESRD). Two or more chronic conditions were reported by almost three-fourths of the high-cost group, as compared with two-thirds of all Medicare beneficiaries. Moreover, the presence of at least one functional limitation was also much more prevalent among high-cost users.

In response to their typically poor medical condition, high-cost beneficiaries tended to consume intensive and large quantities of health services. Specifically, the incidence of a hospital inpatient stay, a nursing home stay, or a home health service among high-cost users was many times higher than the corresponding rate for all Medicare beneficiaries. As a result, high-cost users devoted a much larger portion of PHCE to inpatient and nursing home services. Moreover, nearly all major types of health services were consumed in greater quantities on average by high-cost beneficiaries. However, in spite of significantly greater use of health care services, a large proportion of high-cost users did not survive.

Table 2-1 Selected Characteristics of High-Cost Beneficiaries, 1997

Demographics		
Disabled	28.2	12.4
Aged 65–74	30.3	47.2
Male	58.0	43.7
Non-Hispanic Black	22.8	8.7
Income less than $10,000	43.8	26.5
Married	31.8	52.3
Never married	21.5	7.2
Urban residence	85.8	74.3
Lives in community with spouse	44.3	53.5
Lives in community with others	14.4	7.6
Full or part-year nursing home resident	52.3	6.8
Health Condition		
Alzheimer's	20.0	4.9
Arthritis	32.5	55.6
Diabetes	28.7	16.0
Heart Disease	45.9	37.3
Mental Disorder	20.9	9.6
Parkinson's	9.0	1.8
Stroke	21.3	11.4
ESRD	14.4	0.9
Two or more chronic conditions	74.6	66.9
At least 1 functional limitation (IADL)	89.4	43.9
Perceived health status fair or poor	75.9	29.6
Death Rate	23.1	4.7
Use of Health Services		
At least 1 inpatient stay	85.8	20.6
At least 1 nursing home stay	74.8	9.6
At least 1 outpatient visit	95.0	68.5
At least 1 home health event	47.1	13.2

FUNDING SOURCES

Most Medicare beneficiaries finance their health care expenses using other sources besides Medicare, because Medicare does not cover certain services and it requires considerable beneficiary cost-sharing for many covered benefits. A large fraction of beneficiaries have supplemental coverage—either by PHI or Medicaid, while others are eligible for funding from other (third-party) sources. Usually, for expenses that are not covered by third-party sources, payments are made out-of-pocket (OOP). Between 1996 and 1997, all sources of payment indicated either a drop in spending level or a slowdown in spending growth for PHCE. The observed slowdown across all sources may have reflected the accelerating structural change in markets for health care and health insurance, particularly in the way health care was delivered.

Private Funding

Private funds, including both OOP payments and PHI, accounted for 66 percent of PHCE by the non-Medicare population in 1997 (Braden et al., 1998). For Medicare beneficiaries, however, private sources accounted for only 28 percent (Figure 2-6).

In 1997, total OOP payments by Medicare beneficiaries amounted to $66.8 billion, 18.3 percent of total PHCE by the Medicare population.[9] The share of OOP spending by Medicare beneficiaries slightly decreased from 1993 to 1997. In contrast, the non-Medicare population spent $120.8 billion as OOP payments, 20 percent of its total PHCE. Whereas OOP spending grew by 6.2 percent for the entire U.S. population, for Medicare beneficiaries, it grew by 1.2 percent, a rate significantly lower than the rates observed in previous years. Nevertheless, the average OOP payment for Medicare beneficiaries in 1997 was more than 3 times as much as that for the non-Medicare population ($1,681 versus $507), largely spent on items not covered or partially covered by Medicare, such as nursing home services (44 percent), prescription medicines (18.7 percent), and medical provider services (18.5 percent). For full-year nursing home residents, however, the OOP share of their PHCE amounted to 31 percent. Clearly, institutionalized beneficiaries commonly financed out of their own pocket a larger portion of their PHCE.

PHI funding, the second major component of private funding, accounted for 10 percent ($36.7 billion) of total PHCE by Medicare beneficiaries in 1997. Growth of PHI funding for the Medicare population sharply declined to 1 percent. The bulk of PHI funding was for medical provider care (29.7 percent) and prescription medicines (23.9 percent), followed by inpatient (18 percent) and outpatient services (17.9 percent). That almost a quarter of all PHI payments were for prescription medicines was quite understandable since Medicare did not typically cover them. The significant share of PHI payments for medical provider, inpatient, and outpatient services may have reflected services not covered by Medicare and Medicare's cost-sharing provisions or cases where PHI functioned as the primary health insurance (Braden et al., 1998).

Slower growth in PHI spending in the United States mainly reflected the migration of employers and employees into managed care plans and insurers' attempts to expand market share by constraining premium growth. In particular, some research suggests that employers may have been offering less health insurance coverage, reducing current benefits, or increasing cost-sharing, thus reducing the rate of employer-sponsored PHI among new and current Medicare beneficiaries (Glied and Stabile, 1999). Similarly, employers may have required their employees/retirees to enroll in managed care plans. In recent years, the number of individually-purchased PHI policies dropped as well, especially those held by Medicare beneficiaries. The apparent reduction in the extent of funding provided by both types of PHI to Medicare beneficiaries may have reflected less availability and/or the greater OOP costs that these policies required. Lower or less comprehensive PHI cov-

[9] OOP spending includes coinsurance expenses, deductibles required by insurers, and any direct payments for services not covered by an insurer.

erage may also have slowed down health care utilization and intensity, which in turn curbed the growth in PHI spending. Since the rapid growth of enrollment in Medicare HMOs coincided with these trends, some Medicare beneficiaries may have dropped supplemental PHI coverage when they enrolled in Medicare managed care.

Public Funding

As in 1996, public resources provided a significantly smaller share of health care financing for the non-Medicare population than for the Medicare population in 1997 (Figure 2-6). Medicaid, the main public source of funds for the non-Medicare population, financed 18 percent of their PHCE. In contrast, public funds, mostly Medicare and Medicaid, covered 68 percent of PHCE incurred by Medicare beneficiaries.

The Medicare program paid $203.3 billion in 1997 for beneficiaries' health care services, an increase of 4.3 percent from 1996 ($195 billion). Compared with the 8.3 percent growth recorded for 1995-1996, growth clearly decelerated in 1996 and 1997. Medicare financed about 55.7 percent of PHCE by Medicare beneficiaries in 1997, which represented an increase of 0.9 percent from 1996 (Figure 2-7). In 1997, most of Medicare funds were used to pay for inpatient (45.9 percent) and ambulatory care (37.6 percent). However, the share of inpatient care showed a consistent decline in recent years while the share of ambulatory care appeared to be rising. Whereas Medicaid spending on dual eligibles grew by 6.4 percent in 1995-1996, it showed virtually no change in 1996 and 1997. In 1997, most of these funds were spent on nursing home services (83.7 percent) and prescription medicines (6.9 percent).

Medicaid spending growth may have declined because of several developments in 1996-1997: the drop in Medicaid enrollment, the slower growth in the number of Medicaid-eligibles due to revised welfare to work requirements under Temporary Assistance to Needy

Figure 2-6 Sources of Funds for Personal Health Care Expenditures: Medicare Beneficiaries and the Non-Medicare Population, 1997

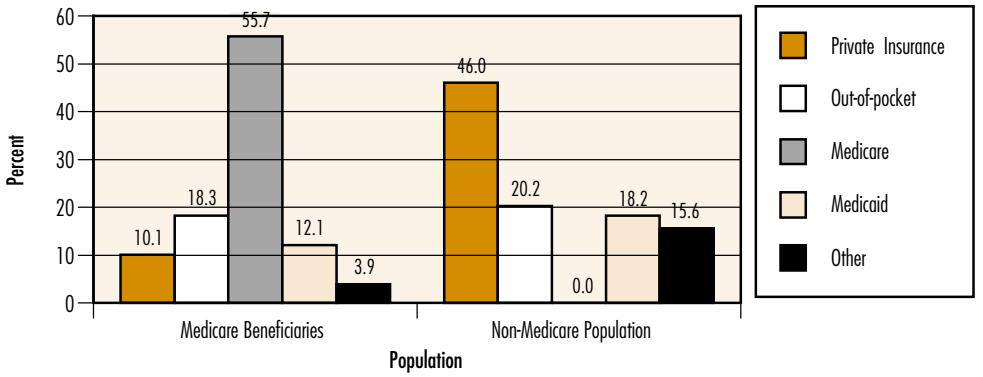
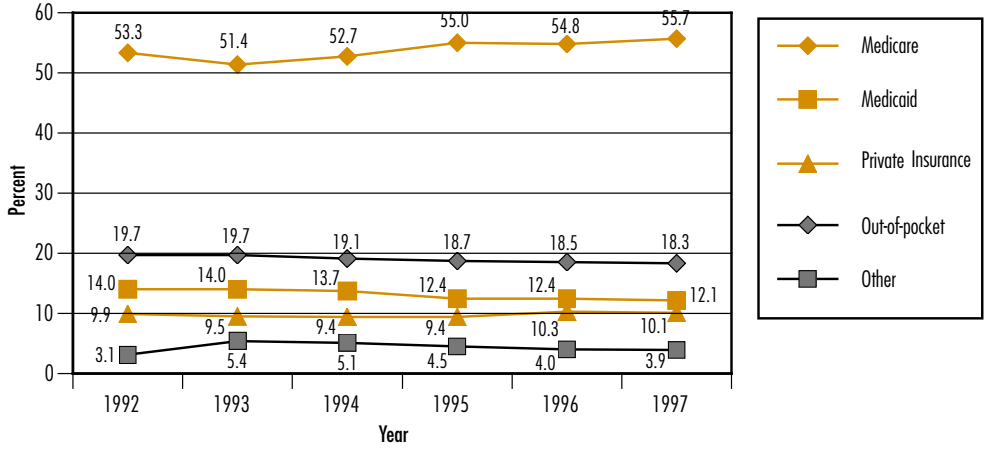


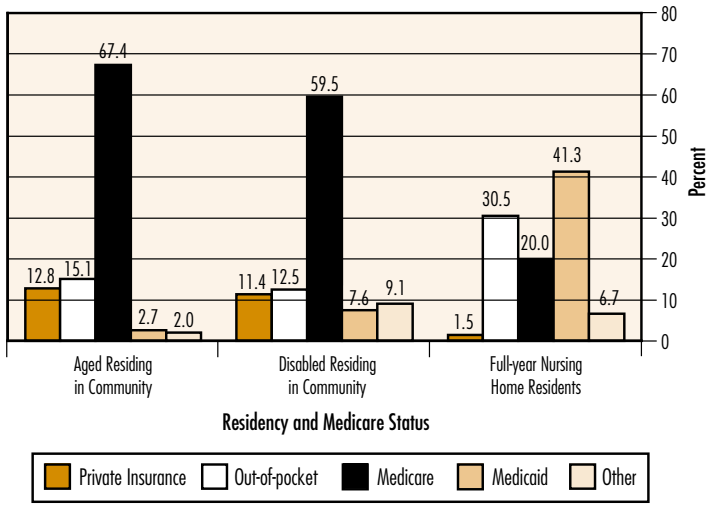
Figure 2-7 Sources of Funds for Personal Health Care Expenditures: Medicare Beneficiaries, 1992–1997



Families, and slower growth in nominal spending per enrollee because of increased managed care enrollment by Medicaid recipients. On the other hand, the slowdown in Medicare spending may have been the result of legislation that restrained growth in Medicare payments to providers, such as the Balanced Budget Act (BBA),[10] Medicare policy changes mandating stricter limits on the growth in physician fees, and providers' reaction to fraud and abuse detection activities. The slight but steady deceleration in the Medicare population growth may also have contributed to curb spending growth (Levit et al., 1998).

Although the shares of various funding sources for PHCE were quite similar for aged and disabled Medicare beneficiaries who live in the community, they were markedly different for full-year nursing home residents and community residents. The relative contributions of each source of payment were compared for three categories of beneficiaries, i.e., full-year nursing home residents, disabled community residents, and aged community residents (Figure 2-8). As in previous years, among community residents, the distributions for the aged and disabled showed many common features. Most of the funding for both groups was provided by Medicare, followed by OOP payments and PHI. However, the disabled derived a significantly larger share of their funding from Medicaid and from other sources as compared with the aged. In contrast, the largest share of PHCE financing for full-year nursing home residents was provided by Medicaid (41.3 percent), followed by the OOP share (30.5 percent). Medicare accounted for only 20 percent of the financing for nursing home residents, roughly one-third the Medicare share for the other two groups. While most of the relative shares of the funding sources remained stable since 1996, the proportion of financing provided by PHI for disabled community-residents declined considerably from 1996 to 1997, perhaps reflecting a switch to Medicare managed care by some of these beneficiaries.

Figure 2-8 Sources of Funds for Personal Health Care Expenditures: Residency and Medicare Status, 1997



PHCE BY SERVICE CATEGORY

In response to different needs across a range of illness and disability, many kinds of health services are used by the Medicare population. Compared with the general U.S. population, the prevalence of chronic and disabling conditions is significantly higher among the Medicare population. In fact, the proportion of the elderly population with limiting chronic conditions increases with age. At any given time, about half of the aged population has multiple chronic conditions (Rice, 1996). In addition to medical care for acute, chronic, and disabling conditions, many disabled and elderly who have lost some capacity for self-care require a wide range of social, personal, and supportive services, often referred to as long-term care.[11] As a result, the elderly/disabled consume an entire spectrum of health services in amounts disproportionate to their numbers in the population.

[10] The BBA, which became effective as of October 1, 1997, incorporates four principal types of change to Medicare: (a) introduction of prospective payment across a wide range of services; (b) cutbacks in payment formulas where rates were perceived to be overly generous; (c) increased private insurance options for Medicare beneficiaries; and (d) alterations in regional payment patterns to encourage the availability of Medicare HMOs (Smith et al., 1998).

[11] Long-term care is defined as physical care over a prolonged period for those persons incapable of sustaining themselves without such care (Rice, 1996).

Medicare beneficiaries' distribution of PHCE by type of service changed only slightly from 1992 to 1997 (Figure 2-9). Over this 6-year period, the largest shares of PHCE were for ambulatory care, inpatient hospital, and nursing home care. These shares remained relatively stable since 1995. The stability of the ambulatory care share masked a slight drop in the share for physician/supplier services that was countered by an increase in the share of outpatient hospital services.[12] In contrast, the share of prescription medicine spending continued to rise since 1994, reaching 7.5 percent of aggregate PHCE in 1997. The share of home health care spending, on the other hand, declined from 5.3 percent to 4.7 percent during this time period.

Between 1995 and 1997, there was a slowdown in the spending growth for all types of services provided to Medicare beneficiaries (Table 2-2). Spending levels, however, continued to rise for all services except nursing home and home health care. The amount of spending on nursing home care remained roughly constant ($89.2 billion), although real growth was –1.9 percent. Expenditures on home health, however, declined from $18.8 billion to $17.3 billion, a real growth rate of –9.8 percent.[13] Growth of inpatient hospital spending for Medicare beneficiaries also continued to decline, at a rate comparable to that of ambulatory care. In contrast to the relatively high growth from 1993 through 1996, prescription medicine spending growth slowed over 1996 and 1997, but remained the highest growth level of all service types.

The slowdown in inpatient hospital care expenditures was primarily accounted for by the decelerated spending for inpatient services at community hospitals due to revised payment incentives, the greater role of managed care such as inpatient utilization review, and site-of-care substitution. The growth in Medicare short-stay inpatient hospital program payments fell to 2.8 percent in 1997, among the lowest rates since 1994 (HCFA, 1999). The observed slowdown may have been in anticipation of the BBA's 1-year freeze on Prospective Payment System rates for inpatient services. Rapid growth in Medicare managed care enrollment during this period may also have contributed. Among fee-for-service-only Medicare beneficiaries, both average length of stay and days of care in short-stay hospitals declined from 1993 to 1997. The resulting inpatient excess capacity gave leverage to managed care organizations, including Medicare HMOs and private HMOs with Medicare beneficiaries as members, in negotiating lower prices for services (Levit et al., 2000).

Figure 2-9 Distribution of Personal Health Care Spending by Medicare Beneficiaries: Type of Service, 1992–1997

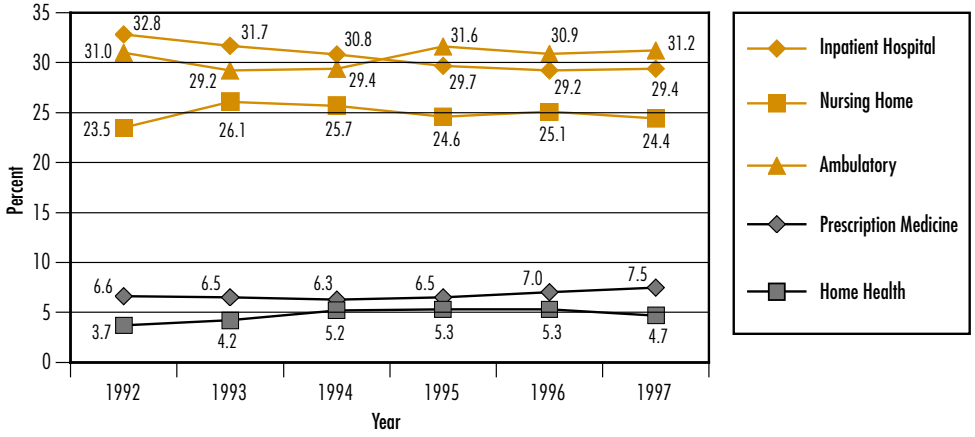


Table 2-2 Annual Growth Rate by Selected Service Type, 1992-1997

	–93	1993–94	1994–95	1995–96	1996–97
Inpatient Hospital	6.9%	8.0%	5.7%	5.0%	3.3%
Nursing Home	22.6%	9.7%	4.7%	9.0%	0.0%
Ambulatory	4.5%	11.6%	17.6%	4.7%	3.4%
Prescription Medicine	9.2%	8.7%	12.2%	14.5%	10.5%
Home Health	26.3%	35.8%	11.7%	6.7%	-8.1%

[12] Ambulatory care services include physician\supplier services, outpatient hospital services, and care provided in ambulatory surgical centers and all other outpatient sites of care.

[13] In the MCBS, home health expenditures include spending for all providers of home health services, including freestanding home health agencies (HHAs) and hospital-based home health facilities. Nursing home expenditures in the MCBS also include all providers of nursing home care, including both freestanding nursing homes and hospital-based facilities. These expenditure classes used in the MCBS for Medicare beneficiaries are to be distinguished from corresponding classes for national spending, in that the latter include only spending at freestanding facilities.

As physicians' involvement with managed care increased over the past few years, growth of spending for physicians' services (1.8 percent) by Medicare beneficiaries has slowed in 1997. Greater prevalence of managed care contracts appears to have restrained revenue growth of physician practices due to discounts for services and to capitated reimbursement. Since a relatively small fraction of the Medicare population was enrolled in Medicare HMOs in 1997, managed care does not appear to have been the main driver of the slowdown in physician spending observed for Medicare beneficiaries. Instead, changes in the payment rate regulations under the Medicare Fee Schedule's Resource Based Relative Values Scale (RBRVS) may have been responsible.

On the other hand, Medicare beneficiaries' hospital outpatient spending grew by 7.9 percent in 1997. The relatively high growth may have arisen from new technological developments and revised provider incentives that transfer more services or procedures to outpatient settings. It may also reflect the fact that hospital outpatient departments were offering many services besides emergency and clinic visits, such as outpatient surgical procedures, imaging, testing, dialysis, and rehabilitation services (Welch, 1998). For Medicare beneficiaries, the shift from inpatient to outpatient hospital care is not surprising since Medicare payment for inpatient services was based on the prospective rate. Thus, a hospital could increase revenues by reducing inpatient stays and discharging the patient to a hospital-based skilled nursing facility (SNF), where payment was cost-based (Levit et al., 1998).[14]

Home health services experienced a wide swing in growth in recent years, beginning from an annual growth of 35.8 percent in 1993-1994 to –8.1 percent in 1996 and 1997.[15] The rapid growth of home health spending in the early 1990s was largely due to changes in Medicare policy intended to facilitate inpatient hospital discharge, i.e., liberalized eligibility criteria and fewer restrictions on the number of home visits per beneficiary (Langa et al., 2001). As a result, overall and Medicare spending on home health care increased dramatically. The sharp deceleration in spending observed since 1994-1995 was primarily a response to the Federal Government's steps to control Medicare home health care expenditures. One step consisted of policy changes, such as restrictions on the growth in per visit payments. Effective October 1997, the BBA changed Medicare payment rates by reducing Medicare per visit cost limits and by revising how payment was determined. It also restricted access to services and redefined visit coverage criteria. Finally, it introduced an interim payment system for home health care until a prospective payment system for it was implemented. Another step consisted of intensified fraud and abuse detection activities, and greater medical review efforts (Levit et al., 1998).

Spending on nursing homes by the Medicare population also slowed during that period, registering zero growth for 1997. Nursing home services were primarily used by the elderly and disabled who needed assistance to function in their daily lives (as assessed by functional limitations) either temporarily or permanently. Because Medicaid was the major payer of nursing home care, financing about one-half of annual nursing home expenditures, changes in State Medicaid payment and coverage policies affected spending for all nursing home care. Part of the slowdown may have been due to efforts by the states to encourage greater use of lower cost treatment settings, such as home health, assisted living facilities, and community-based day care, instead of more costly full-year institutional care.

In response to the brisk growth in Medicare SNF spending for short-term postacute care provided by nursing homes and other facilities between 1991 and 1996, the BBA made several changes to curb rising Medicare payments to SNFs. For instance, the BBA mandated a prospectively determined per diem Medicare payment rate rather than reasonable cost-based payment. It also required all services furnished by the SNF be bundled into a single per diem payment. During a 3-year phase-in period, Medicare payments to

[14] Under the BBA of 1997, the reimbursement for SNF services transitioned to a prospective payment system.

[15] Research indicates that among Medicare beneficiaries, the typical home health care user was older, more limited in activities of daily living (ADLs), more likely to be enrolled in Medicaid, and carried a larger burden of OOP expenses for all health care (Foley et al., 1998). To avoid being institutionalized, many of these beneficiaries, particularly dual eligibles, required home health services to remain in the community.

SNFs were to be based on a changing blend of facility-specific and national per diem amounts. These changes may have contributed to the slowdown in nursing home spending for short-term stays by the Medicare population in 1997.

During this period, prescription medicine (PM) spending grew faster than any other types of health care spending. Several factors were responsible for this rapid growth. Specifically, payment for PMs shifted away from OOP sources and toward third-party payment sources. Previous research showed that the existence of third-party coverage of PMs raises the likelihood that patients will fill prescriptions (Poisal et al., 1999). The switch to managed care, which offers relatively low OOP costs and first-dollar coverage, further increased demand for PMs. Moreover, compared with historical rates, utilization rates of PMs increased since 1995 (as measured by the growth in the number of prescriptions dispensed). This may be the outcome of the large number of new drugs introduced during this period, and increased direct-to-consumer advertising by pharmaceutical manufacturers (Levit et al., 1998).

Nearly two-thirds of Medicare beneficiaries have some insurance coverage for PMs through some form of supplemental insurance, thus boosting demand. The average noninstitutionalized Medicare beneficiary (with or without drug coverage) paid about half of PM cost out of pocket. Moreover, among the aged, the total amount of PM spending varied widely by health status, the presence of functional limitations, and the disability status of the beneficiary (Crystal et al., 2000; Mueller et al., 1997).

INCOME

Data from the MCBS indicate that the median income of all Medicare beneficiaries grew at an annual rate of 6 percent between 1992 and 1997.[16] However, the variability of the income distribution (as measured by the interquartile range) increased over this period, and the skewed nature of the distribution persisted in 1997, i.e., 25 percent of beneficiaries had incomes at or below $9,600 whereas 75 percent had incomes at or below $30,000. Median income for all aged beneficiaries, individuals, and married couples grew 8.3 percent between 1996 and 1997. Thus, Medicare beneficiaries, particularly the aged, appeared to be doing well in terms of income growth.[17] Nonetheless, there was significant variation in income across particular subgroups.

In 1997, median income continued to be the lowest for full-year nursing home residents, higher for disabled community-only residents, and highest for aged community-only residents (Figure 2-10). Between 1992 and 1997, the average annual rate of growth of median income for the three groups was 4 percent, 3 percent, and 6 percent respectively. The low-income status of full-year nursing home residents is not surprising since a relatively large proportion of them spent down their assets and have limited income sources, such as social security only. Insofar as functional limitations and chronic conditions of disabled community residents preclude them from employment and thereby establish other income sources, their relatively low income is also understandable. Figure 2-11 further illustrates the degree of income inequality among Medicare community residents.[18] Beneficiaries in the highest income quartile had more than 8 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. Moreover, income growth was higher during this time period for beneficiaries in the two highest income quartiles.

Poverty or near-poverty is quite prevalent among the Medicare population, especially among certain subgroups (Figure 2-12).[19] For instance, an estimated 12 percent of aged community-only residents lived in poverty in 1997.[20] Almost 32 percent of the disabled lived at or below the poverty level. Nursing home residents were the most likely of all Medicare beneficiaries to live in poverty. Forty-three percent reported incomes at or below poverty, a much

[16] 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.

[17] MCBS estimates of level of 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 on 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. However, recent research indicates that the effects of underreporting in the MCBS income data are modest, when benchmarked to a comparable income definition from the CPS (Alecxih et al., 2001).

[18] To obtain a more representative mean value of income within each quartile, income outliers were excluded from selected quartiles, particularly the highest quartile.

[19] The Historical Poverty Tables produced by the U.S. Census Bureau indicate that in 1997, the poverty threshold for unmarried individuals aged 65 or older was $7,698, whereas for a householder aged 65 or older living with spouse it was $9,712.

[20] Beneficiaries who lived with children were excluded, since there was not sufficient information on their household income, such as whether there were intrafamily transfers of income.

larger proportion than community residents. At the same time, a large proportion of the Medicare population lived in near-poverty.

Figure 2-10 Median Income of Medicare Beneficiaries by Medicare Status and Residence, 1992–1997

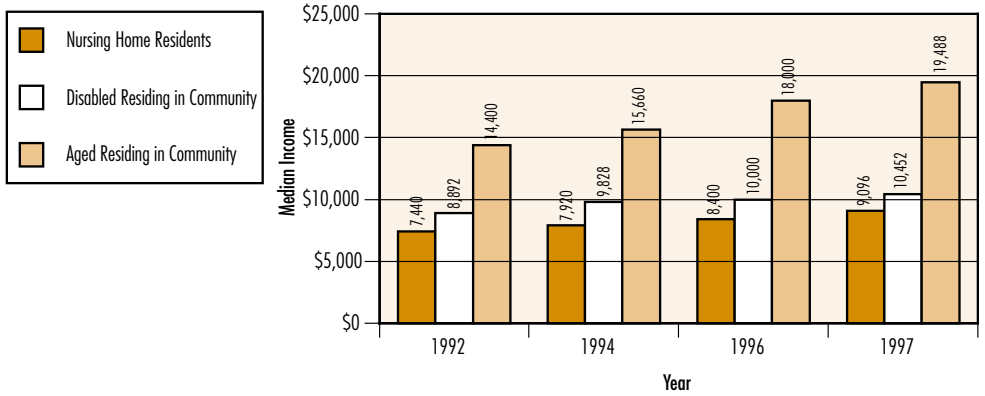


Figure 2-11 Mean Income of Medicare Beneficiaries Residing in the Community: Income Quartile, 1992–1997

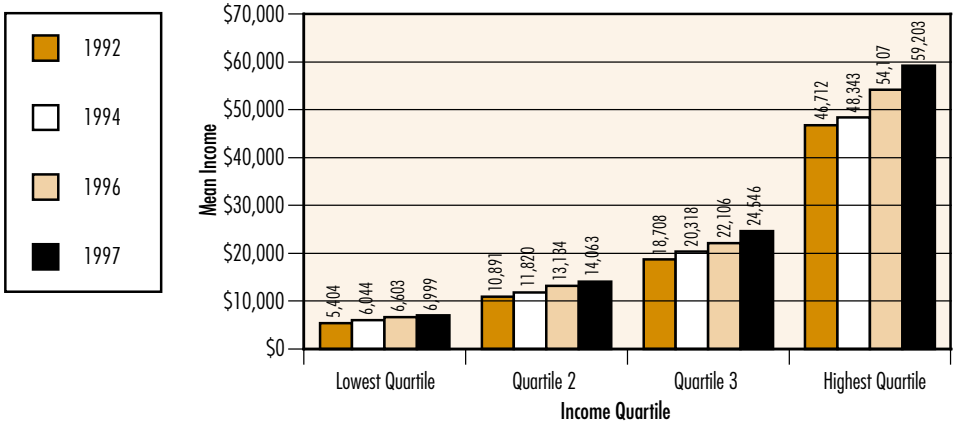
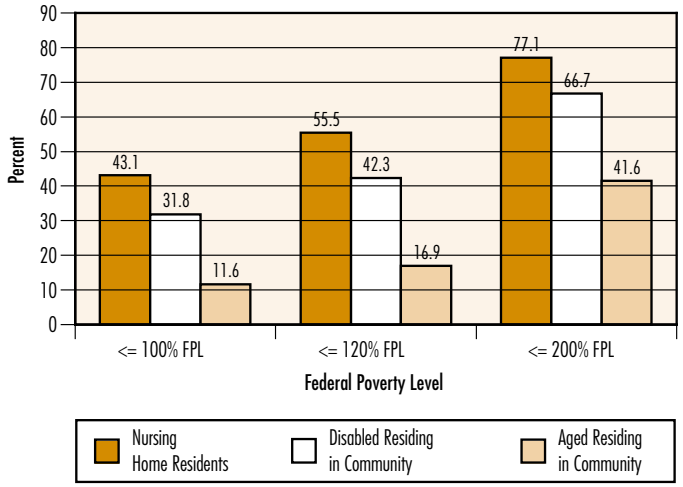


Figure 2-12 Proportion of Medicare Beneficiaries Living Below/Near Federal Poverty Level (FPL), 1997



HEALTH AND SOCIOECONOMIC STATUS

Socioeconomic status is strongly linked to health. For people of low income, poor access to care, inability to afford nutritious food, and risk factors in life style all account for poor health (Stamler, 1985; Haan et al., 1987; Williams, 1990). Data from the MCBS substantiate the relationships between health and income (Liu et al., 2000). Low-income beneficiaries are more likely to report poor health, chronic conditions, and functional limitations.

The disparity of perceived health status between the high- and low-income Medicare beneficiaries persisted in 1997. Among community-only residents, the percentage of those reporting poor or fair health decreased as their income level increased (Figure 2-13). In particular, more than 40 percent of the Medicare beneficiaries in the lowest income quartile reported poor or fair health, compared with 17 percent in the highest income quartile.

The relationship between self-reported health status and income held true across racial background. Higher-income whites were healthier than their lower-income counterparts. Only 16.3 percent of the white beneficiaries in the highest income quartile reported poor or fair health, compared to 36.5 percent of their counterparts in the lowest income quartile. At the same time, the more affluent nonwhites reported better health than the less affluent nonwhites. Less than 25 percent of the nonwhite beneficiaries in the highest income quartile stated their health was poor or fair, while 47.3 percent of their counterparts in the lowest income quartile did. At the same time, within each income level, the racial gap was evident. White beneficiaries in general were healthier than nonwhite beneficiaries.

The relationship between income and self-reported health status held up across all age groups among the aged beneficiaries in 1997. Those who had higher income enjoyed better health than their low-income counterparts, regardless of age. More importantly, among the beneficiaries in the lowest income quartile, the proportion of those between 65 and 74 reporting poor or fair health (36.7 percent) was similar to that of 85 and older (35 percent). In comparison, among those in the highest income quartile, the proportion of beneficiaries between 65 and 74 experiencing poor or fair health (11.4 percent) was significantly smaller than that of beneficiaries 85 and older (25.1 percent). This is consistent with findings on the relationship between health, income, and age (House et al., 1992). In particular, the effect of aging on health may not be seen until later in life, depending on socioeconomic status. Beneficiaries in the lowest income quartile tend to experience poorer health at earlier ages; whereas for beneficiaries in the highest income quartile, the decline in health is more likely to be reported later in life.

Income is also linked to the prevalence of chronic diseases (House et al., 1992). People with lower income reported higher rates of chronic conditions, such as heart disease, diabetes, mental illness, osteoporosis, stroke, and Alzheimer's disease (Figure 2-14). The

Figure 2-13 Distribution of Community-only Residents Reporting Poor or Fair Health: Income Quartile, 1992–1997

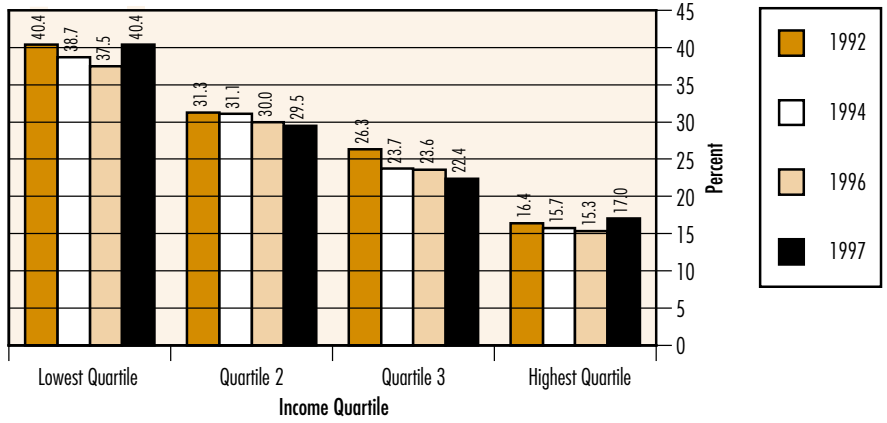
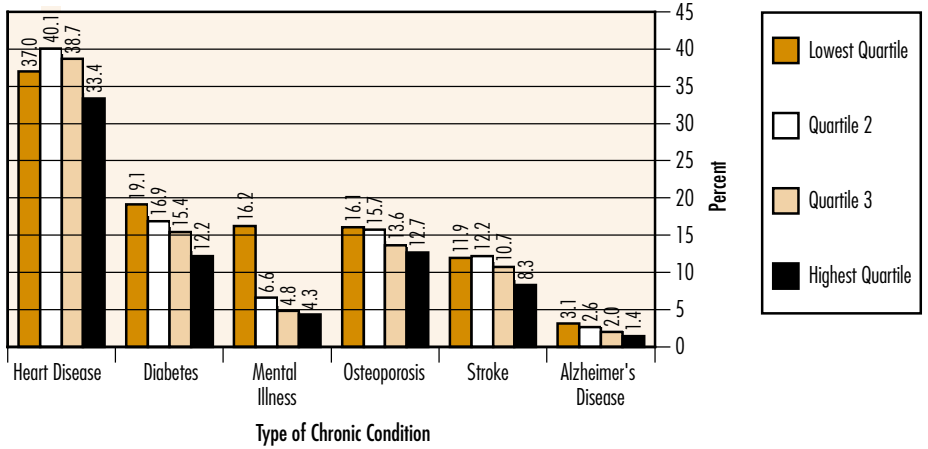


Figure 2-14 Distribution of Types of Chronic Conditions among Community-only Residents: Income Quartile, 1997



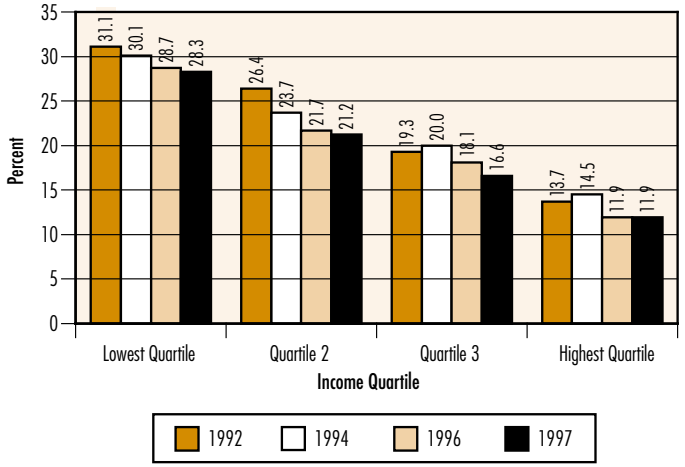
income gap was especially evident among those who had mental illness and diabetes. In particular, more beneficiaries in the lowest income quartile reported mental illness than did beneficiaries in other income groups. While 16.2 percent of the beneficiaries in the lowest income quartile reported mental illness, only 4.3 percent of their highest income counterparts did. At the same time, 19.1 percent of the beneficiaries in the lowest income quartile reported diabetes, compared with 12.2 percent of those in the highest income quartile.

Income was also found highly correlated with functional limitations (Katz et al., 1983; Mor et al., 1989; Guralnik and Kaplan, 1989).[21] Among Medicare beneficiaries living in the community, low-income beneficiaries were more likely to report functional limitations than high-income beneficiaries (Figure 2-15). In 1997, more than 28 percent of the beneficiaries in the lowest income quartile reported at least one functional limitation, compared to 11.9 percent of their most affluent counterparts. The proportion of the beneficiaries in the lowest income quartile reporting at least one functional limitation declined between 1992 and 1997. However, the percentage of this group was still significantly higher than that of other income quartiles in 1997.

The relationship between functional limitations and income was also consistent across age groups. In 1997, beneficiaries in the highest income quartile were the least likely to report functional limitations, regardless of age. Moreover, the gap in the risk of functional limitations was more evident among those aged 65 to 74 across income levels. Specifically, beneficiaries between the ages of 65 and 74 in the lowest income quartile were almost 3 times as likely as their counterparts in the highest income quartile to have functional limitations (17.7 percent versus 6.6 percent). Similarly, beneficiaries between the ages of 75 and 84 were more than twice as likely as their counterparts in the highest income quartile to suffer from functional limitations (32.7 percent versus 14.8 percent).

[21] Functional limitation includes limitations in instrumental activities of daily living (IADLs) or activities of daily living (ADLs). IADLs refer to activities related to independent living. A person has IADLs if he or she has problem preparing meals, performing light or heavy household tasks, and using a telephone by himself or herself. ADLs include activities related to personal care. A person has ADLs if he or she has difficulty bathing or showering, dressing, getting in and out of bed or a chair, using the toilet, and eating (see Appendix B for detailed definitions).

Figure 2-15 Distribution of Community Residents Reporting at Least One Limitation in Activities of Daily Living: Income Quartile, 1992–1997

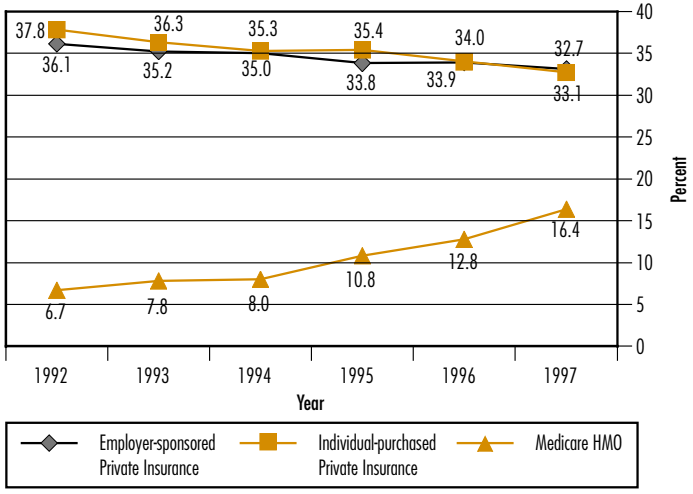


INSURANCE STATUS

Many Medicare beneficiaries have a supplemental insurance policy that provides benefits not covered by Medicare. As mentioned earlier, the presence of supplemental insurance tends to increase utilization rates and total spending on health services. For example, even after controlling for health status variations, beneficiaries with supplemental coverage are more likely to incur health care costs and have higher costs than beneficiaries without coverage (Poisal et al., 1999; Khandker and McCormack, 1999). Moreover, some Medicare beneficiaries hold more than one type of supplemental insurance. These beneficiaries apparently attempt to cobble together the best insurance package they can by using all possibilities available to them. For instance, if a beneficiary lacks prescription medicine coverage through his primary supplemental coverage, some drug coverage may be obtained from another source of health insurance (Davis et al., 1999).

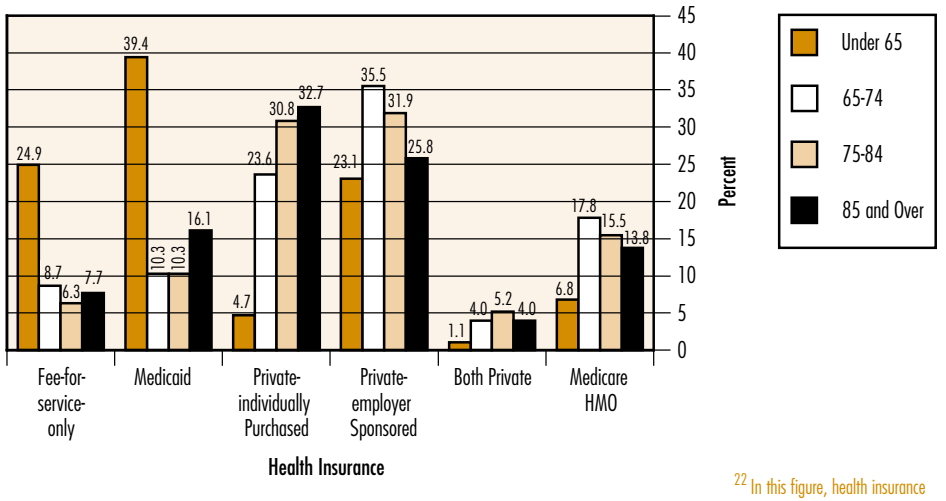
Data trends between 1992 and 1997 suggest a shift by Medicare beneficiaries away from PHI and toward managed care (Figure 2-16). The proportion of Medicare community-residents with PHI declined between 1992 and 1997. In fact, over this period, the average annual rate of decline was greater for individually-purchased PHI (–2.8 percent) as compared with employer-sponsored PHI (–1.7 percent). This may reflect a response to the rising OOP costs and limited benefits that accompany standard indemnity PHI coverage, especially for individually-purchased policies. In contrast, there was greater participation in managed care by the Medicare population. The share of the population covered by Medicare HMO consistently increased at an average annual rate of 20 percent since 1992. Specifically, between 1996 and 1997, the fraction of the noninstitutionalized Medicare population enrolled with a Medicare HMO reached 16.4 percent of the population, with the disabled indicating an increase of 44 percent, while the aged showed an increase of 27 percent.

Figure 2-16 Trends of Private Health Insurance and Medicare HMO Coverage for Noninstitutionalized Medicare Beneficiaries, 1992–1997



Health insurance coverage of noninstitutionalized Medicare beneficiaries varied with age. Among the aged, participation in Medicare HMO and employer-provided PHI declined as age increased. For the oldest old (age 85 and over), the perceived costs of a switch from an established relationship with a fee-for-service provider to an unfamiliar managed care provider may have outweighed any benefits associated with HMO participation. On the other hand, Medicaid participation was the highest for the oldest old among the aged (Figure 2-17).[22]

Figure 2-17 Health Insurance Coverage of Noninstitutionalized Medicare Beneficiaries by Age Group, 1997



In addition, Medicare fee-for-service-only coverage and dual Medicare/Medicaid coverage were significantly more prevalent among the disabled (25 and 40 percent respectively) than the overall aged population (8 and 12 percent respectively). On the other hand, PHI coverage from any source and HMO enrollment were much more common among the aged than the disabled.

[22] In this figure, health insurance coverage is classified into several mutually exclusive categories. They are prioritized so that each beneficiary is assigned to only one category. Medicaid coverage at any point during 1997 (for beneficiaries that are eligible for Medicare FFS and Medicaid) had the highest priority, followed by enrollment in a Medicare HMO. This is followed by four mutually exclusive groups of Medicare fee-for-service-only coverage, individually-purchased PHI, employer-sponsored PHI, and both types of PHI.

ACCESS TO CARE

Access refers to a patient's ability to obtain needed medical care (Physician Payment Review Commission, 1996). Ideally, services should be rendered on the basis of need rather than as a result of structural or individual factors, such as distribution of physicians in an area, income, or race (National Research Council, 1988). However, Medicare beneficiaries who were disabled, nonwhite, with low income, and without supplemental insurance were often confronted with more problems accessing medical care than others. For instance, disabled beneficiaries waited longer than aged beneficiaries before they could make an appointment or be seen by a doctor (Hogan et al., 1995). Beneficiaries with ADLs were also less likely to receive care than those without ADLs (Black et al., 1997). Nonwhite and low-income beneficiaries tended to receive fewer preventive procedures (Rosenbach, 1995; Rosenbach et al., 1995; Miller et al., 1997) and have higher rates of avoidable outcomes (Asch et al., 2000). Lack of supplemental insurance could also reduce access to care. Beneficiaries without supplemental insurance tended to receive less preventive procedures, and were less likely to use Medicare-covered services than beneficiaries with supplemental insurance (Prospective Payment Assessment Commission, 1994; Rowland and Lyons, 1996; Grana and Stuart, 1996/1997; Chan et al., 1999).

Data from the MCBS show that since 1992, access to medical care has improved for all Medicare beneficiaries, including the more vulnerable segments of the Medicare population (Liu et al., 2000). Moreover, the introduction of the Medicare Fee Schedule (MFS) in 1992 did not further reduce access to care among the vulnerable groups, contrary to the concerns among some policymakers and researchers. Although some nonwhite, low-income, and fee-for-service-only beneficiaries still experienced more barriers in access (Physician Payment Review Commission, 1996), access to care among the vulnerable Medicare beneficiaries became more comparable, for the most part, to that of the Medicare population in general. Utilization of health services also increased among the vulnerable subgroups such as the dual eligibles, nonwhites, and the oldest old, as a result of the MFS (Mitchell and Cromwell, 1995; Trude and Colby, 1997).

Access to care is often measured by sources of health care and factors affecting the use of medical services. Having a usual source of care is commonly viewed as an indicator of having access to medical care (Rowland and Lyons, 1996). Lacking a regular physician contact is a strong predictor of poor access to care (Sox et al., 1998). In 1997, 93.7 percent of the Medicare beneficiaries residing in communities reported having a usual source of care, a 3.2 percent increase from 1992. Moreover, more Medicare beneficiaries living in communities reported using office-based physicians as their usual source of care in 1997 than in the early 1990s (Figure 2-18). This upward trend was evident among the Medicare population in general, and also among the more vulnerable groups of the Medicare population. However, compared with the general Medicare population, the more vulnerable subgroups still reported significantly lower rates of using office-based physicians as their usual source of care. For instance, only 65 percent of the fee-for-service-only beneficiaries reported using office-based physicians in 1997, compared with 87 percent of the general Medicare population.

The percentage of Medicare beneficiaries reporting difficulty in obtaining care continued to decrease both in general and also among the vulnerable groups (Figure 2-19). Overall, only about 3 percent of the beneficiaries reported problems getting care in 1997. Similarly, less than 5 percent of the nonwhite and low-income population reported difficulty in getting care, down from 7.3 percent and 5.8 percent respectively, in 1992. The decrease in difficulty in getting care was also evident among the fee-for-service-only beneficiaries. Less than 6 percent of the fee-for-service-only beneficiaries reported problems in getting care, compared to 9.7 percent in 1992. Although the disabled encountered more difficulty obtaining care than other beneficiaries, the extent of improvement in access since

1992 was larger among the disabled (5.2 percent) than among the nonwhites (2.9 percent), the low-income beneficiaries (1.8 percent), and the fee-for-service-only beneficiaries (4.1 percent).

Delaying care because of cost often indicates the presence of financial barriers to health care (Rowland and Lyons, 1996). In fact, cost has been the most cited problem by Medicare beneficiaries who reported difficulty getting care (Physician Payment Review Commission, 1996). However, since 1992, fewer beneficiaries reported delaying care due to cost (Figure 2-20). In 1997, less than 7 percent of all Medicare beneficiaries and less then 10 percent of the nonwhites and the low-income cited cost as a factor for delaying medical care. The disabled and the fee-for-service-only beneficiaries were more likely than other beneficiaries to report delaying care because of cost. However, the proportion of the disabled and fee-for-service-only beneficiaries who reported cost as a factor in delaying care showed a larger decrease since 1992.

SATISFACTION WITH CARE

Medicare has been the major focus of the Federal Government's health care quality assurance efforts (Wilensky, 1997). Level of satisfaction has been increasingly used by health policymakers to evaluate performance of the health care system, especially as a result of increased competition in the Medicare market. Beneficiaries' satisfaction with care has important implications for delivering services efficiently and serving the needs of the beneficiaries (Lee and Kasper, 1998). This source book examines both the general population and the vulnerable population's satisfaction with care.

Most Medicare beneficiaries reported a relatively high degree of satisfaction with their care in the early and mid-1990s (Liu et al., 2000). In 1997, they continued to enjoy a high level of satisfaction with the overall quality of their health care (Figure 2-21). More

Figure 2-18 Proportion of Community-only Residents Using Office-based Physicians as Their Usual Source of Care, 1992–1997

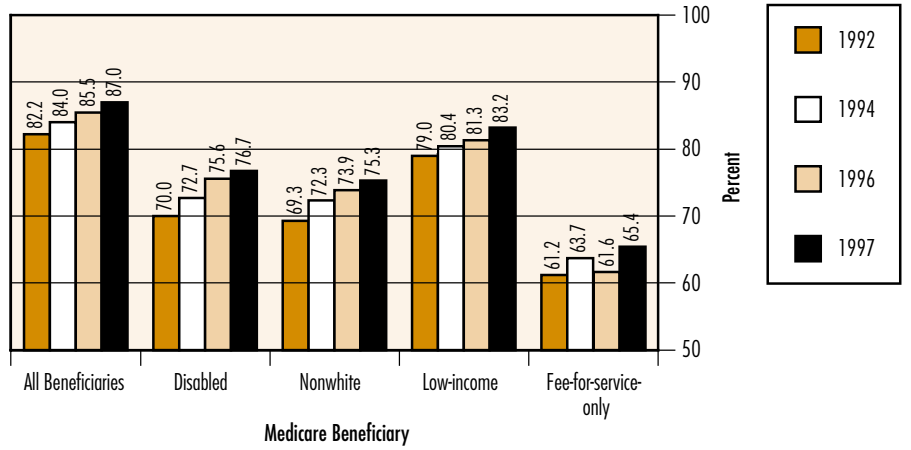


Figure 2-19 Proportion of Community-only Residents Reporting Difficulty in Obtaining Care, 1992–1997

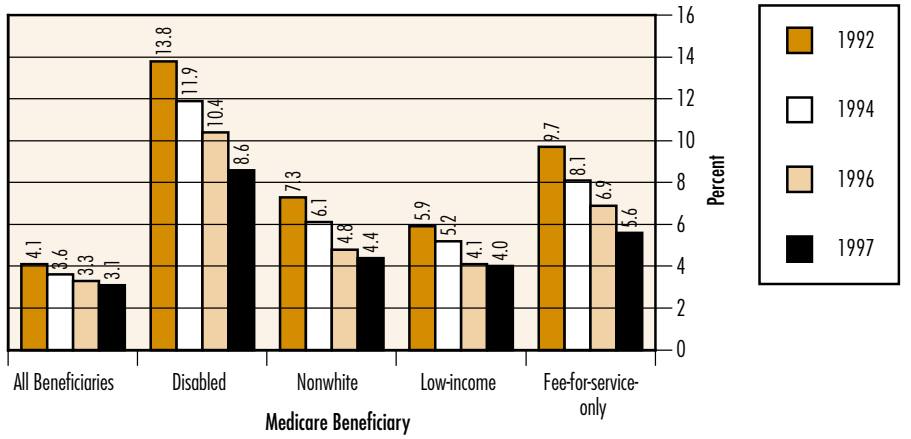


Figure 2-20 Proportion of Community-only Residents Who Delayed Care Due to Cost, 1992–1997

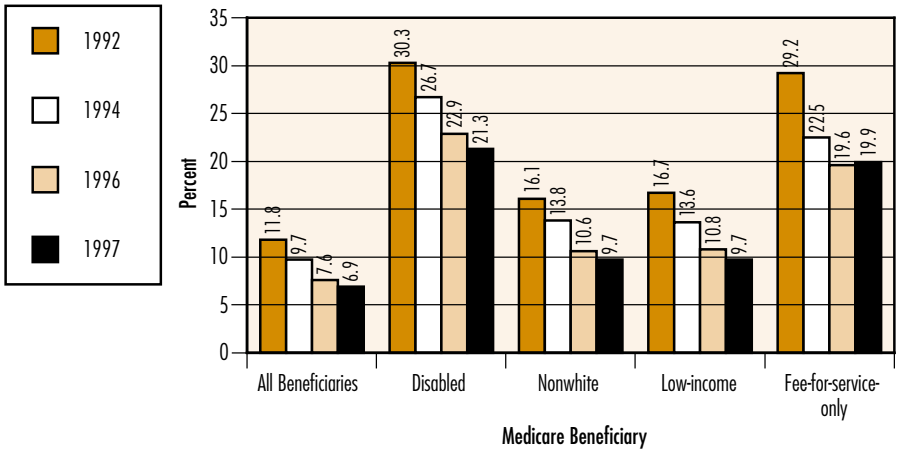
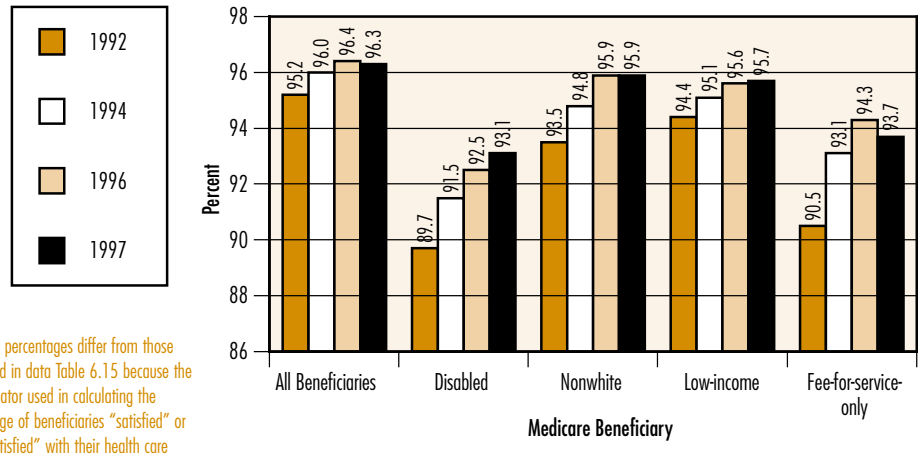


Figure 2-21 Proportion of Community-only Residents Satisfied with the Quality of Their Medical Care, 1992–1997



[23] These percentages differ from those presented in data 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.

than 96 percent of Medicare beneficiaries reported that they were either satisfied or very satisfied with the quality of care.[23] The proportion of dissatisfied beneficiaries remained small, even among the vulnerable segments of the Medicare population. More than 95 percent of nonwhite and low-income beneficiaries were satisfied with the quality of their medical care. At the same time, the percentages of almost all the vulnerable groups satisfied with the quality of care had increased steadily from 1992 to 1997. In particular, the percentage of disabled beneficiaries satisfied with the quality of care grew 3.4 percent from 1992, the largest increase among the four vulnerable groups. Nonetheless, disabled and fee-for-service-only beneficiaries were less satisfied with the overall quality of their medical care, compared with other beneficiaries. These vulnerable groups were more likely to report satisfaction with care because they remained more at risk of inadequate access to needed medical care (Rosenbach et al., 1995; Aharony and Strasser, 1993; Jackson and George, 1998; Pascoe, 1983; Lee and Kasper, 1998; Laschober and Olin, 1996).

The percentage of beneficiaries satisfied or very satisfied with the availability of care at night and weekends also remained high in general in 1997 (94.9 percent), showing a 3 percent increase from 1992 (Figure 2-22). The percentage of disabled beneficiaries reporting satisfaction with the availability of care (90 percent) was the lowest among the four vulnerable groups. The fee-for-service-only beneficiaries also were less satisfied with the availability of care at nights and on weekends than other beneficiaries.

Medicare beneficiaries have been highly satisfied with their ease of getting to a doctor since 1992 (Liu et al., 2000). The percentage of beneficiaries reporting that they were satisfied or very satisfied with their ease and convenience of getting care continued to grow in 1997 (Figure 2-23). In particular, 95 percent of Medicare beneficiaries expressed satisfaction with this aspect of medical care. Moreover, the percentages of beneficiaries of all four vulnerable groups who expressed satisfaction increased steadily from 1992 to

1997. On the other hand, the disabled continued to report the lowest levels (90 percent) of satisfaction with the ease of getting care.

Medicare beneficiaries expressed the lowest levels of satisfaction with the costs, compared to other aspects of their health care. However, beneficiaries' satisfaction with OOP costs continued to increase in the general Medicare population as well as among the vulnerable subgroups (Figure 2-24). The fee-for-service-only beneficiaries continued to be the least satisfied (75 percent) with the costs of care, probably because they tended to incur significant OOP cost for their care due to their lack of supplemental health insurance coverage. The largest increases in satisfaction with costs occurred between 1992 and 1994, suggesting that Medicare beneficiaries benefited from the introduction of a new fee schedule for physicians in 1992.

SUMMARY

Consistent with the slowdown observed in 1996, PHCE by the Medicare population grew at the lowest rate (less than 3 percent) seen in recent years in 1997, while per capita PHCE grew by 1.7 percent between 1996 and 1997. Several factors may have accounted for the slowdown: rapid growth in managed care enrollment, an apparent slowdown in the growth in volume and intensity of services, relatively mild inflation, and modest growth in the Medicare population.

As in previous years, several groups of beneficiaries continued to incur relatively high average PHCE in 1997, consuming a disproportionate share of health care resources within the Medicare population: nursing home residents, dual eligibles, the oldest old, the disabled, and racial/ethnic minorities. Specifically, beneficiaries who suffered from severe illnesses or disabling conditions, as well as the poor (living in or near poverty), tended to incur significantly higher expenses than the general Medicare population.

Figure 2-22 Proportion of Community-only Residents Satisfied with the Availability of Care at Night and on the Weekend, 1992–1997

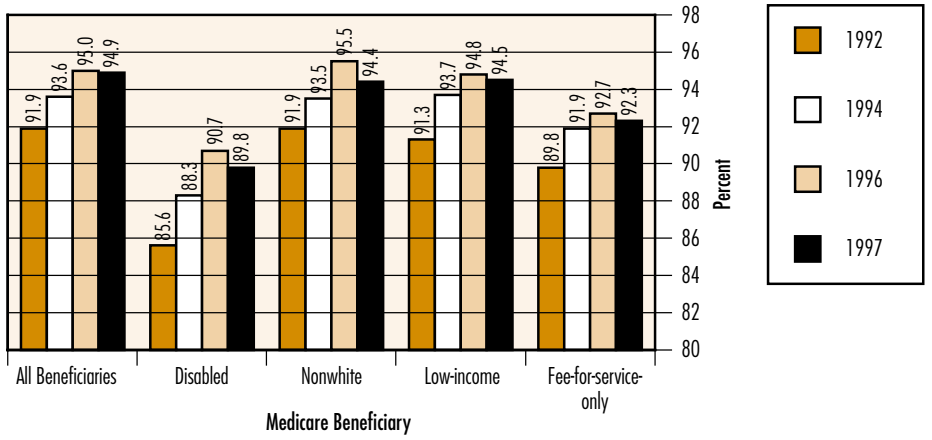


Figure 2-23 Proportion of Community-only Residents Satisfied with Their Ease of Getting Care, 1992–1997

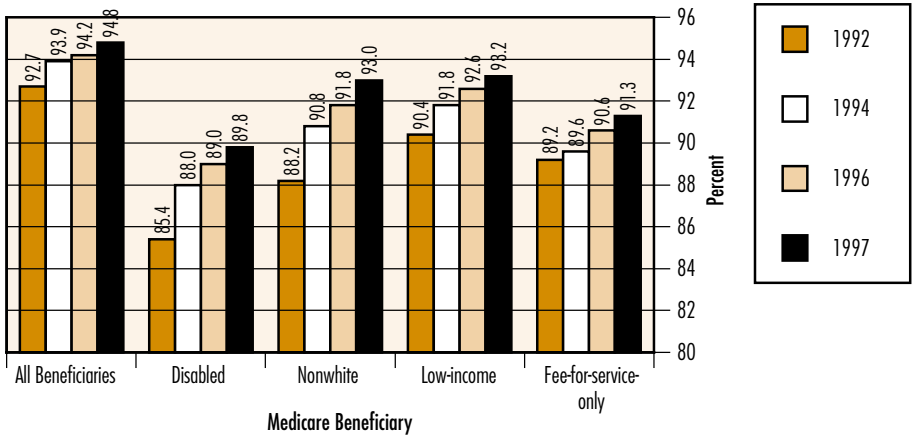
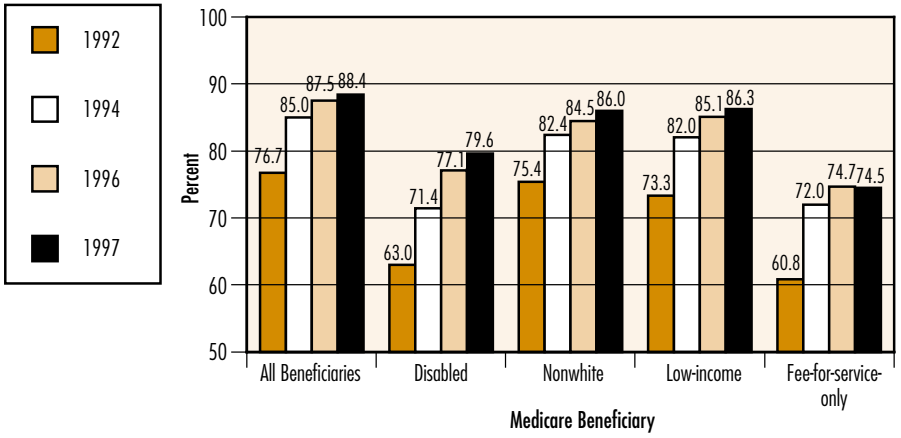


Figure 2-24 Proportion of Community-only Residents Satisfied with the Cost of Their Care, 1992–1997



All sources of payment for PHCE by the Medicare population indicated either a drop in spending level or a slowdown in spending growth. The private share, i.e., portion of OOP payments and PHI funding, of PHCE declined to 28 percent in 1997, whereas public funds, i.e., Medicare and Medicaid, rose to 68 percent of PHCE. Between 1996 and 1997, OOP and PHI spending grew at a rate of about 1 percent respectively. In comparison, Medicare spending grew by 4 percent during that time. Medicaid spending remained the same. As a result, the public share of spending increased more rapidly than the private share. In light of the BBA's revision of Medicare policies, Medicare spending growth was expected to decelerate for several years after 1997, thus keeping Medicare's share of PHCE and spending growth in check. However, while the decline in the Medicare population with PHI coverage would curb PHI cost growth, it could lead to increased public cost growth as more beneficiaries shift to Medicare managed care, or rely on Medicare fee-for-service-only.

Reflecting structural changes in health care and health insurance markets, numerous factors accounted for the trends in the distribution of PHCE by source of payment. The apparent migration by certain beneficiaries from PHI (and perhaps other funding sources) to Medicare managed care could lead to slower growth in OOP and PHI spending. Significant Medicare policy changes and intensified government fraud and abuse detection activities were primarily responsible for the observed slowdown for Medicare spending. Fewer Medicaid enrollees as well as increased managed care enrollment by Medicaid enrollees may have helped to keep Medicaid spending constant.

Distribution of PHCE by Medicare beneficiaries by type of service changed very little between 1992 and 1997, with the exception of the shares of prescription medicine and home health care. Total spending on prescription medicine has reached 8 percent of PHCE; whereas the share of home health spending declined to 4.7 percent. Spending growth decelerated for all service types, largely because of changes in Medicare and Medicaid programs, the increased enrollment in managed care, and other changes in the health care market. Recent efforts by the states to encourage greater use of alternative treatment settings by Medicaid enrollees, as well as the BBA's new regulations for care provided by SNF to Medicare beneficiaries, helped to explain why nursing home spending remained constant. Spending on home health care, however, declined sharply on account of the Federal Government's measures to control the rapid growth of Medicare home health payments, particularly with the implementation of BBA. As a result, the growth of both nursing home and home health care expenditures were likely to slow down over the next several years. Although indicating the highest level of growth of all service types, prescription medicine spending growth slowed to 11 percent in 1997. This relatively high level of growth was caused by several factors: greater PM coverage by third-party sources, rapid growth of prescription drugs on the market, use of direct-to-consumer advertising, and the accelerated growth in managed care enrollment, which usually entails low OOP

costs and first dollar coverage. The extent to which these forces continued to fuel growth in PM spending after 1997 is unclear.

Between 1992 and 1997, Medicare beneficiaries experienced appreciable income growth. The median income of all Medicare beneficiaries grew at an annual rate of 6 percent. However, there was significant variation across particular subgroups: median income was lowest for full-year nursing home residents, higher for disabled community-only residents, and highest for aged community-only residents. Moreover, a sizeable proportion of the Medicare population lived in poverty or had low income. Compared with community residents, the prevalence of poverty was higher for full-year nursing home residents. Likewise, poverty or near-poverty was more common among disabled than aged community-residents. Moreover, low-income beneficiaries living in the community were more likely to report more health conditions, such as chronic diseases and functional limitations, than their higher income counterparts. Persons most in need of health care services often had the least resources to pay for them.

Access to and satisfaction with care remained quite high in 1997, and continued to show improvement among Medicare beneficiaries living in the community. Nearly 87 percent of beneficiaries reported access to office-based physicians as their usual source of care in 1997. However, disabled beneficiaries and Medicare fee-for-service-only beneficiaries reported more difficulty obtaining care and were more likely to delay care due to cost, than other beneficiaries. Similarly, Medicare beneficiaries residing in the community remained highly satisfied with the quality of their health care in 1997. Not surprisingly, disabled beneficiaries were the least satisfied with the quality of their medical care because of access problems. Fee-for-service-only beneficiaries were also less satisfied with the quality of medical care, particularly with the cost of care. Evidently, disparities in access to and satisfaction with care persisted across various vulnerable subgroups. These groups merit careful scrutiny when considering the impact of any proposed policy change affecting the Medicare population.