1 INTRODUCTION AND HIGHLIGHTS OF FINDINGS

Health and Health Care of the Medicare Population: Data from the 1999 Medicare Current Beneficiary Survey is the eighth in a series of Medicare beneficiary sourcebooks. The information presented here is drawn from the Medicare Current Beneficiary Survey (MCBS), a rotating panel survey of a nationally representative sample of aged and disabled Medicare beneficiaries. The MCBS is sponsored by the Centers for Medicare and Medicaid Services (CMS), under the general direction of its Office of Research, Development, and Information. Westat, a survey research organization with offices in Rockville, Maryland, has been collecting and disseminating data for more than 10 years of the survey.

The MCBS is a comprehensive source of information on the health status, health care service use and expenditures, health insurance coverage, and socioeconomic and demographic characteristics of aged and disabled Medicare beneficiaries. Survey data are collected three times each year over 4 years, regardless of whether the beneficiary lives in a household or a long-term care facility. The resulting data are disseminated in annual public use files (PUFs) that contain a cross-section of all persons entitled to Medicare during the year. The 1999 MCBS, for example, includes beneficiaries who were entitled to Medicare for all or part of the year, as well as beneficiaries who died in 1999. These data can be used for cross-sectional analyses, or linked to PUFs from previous years for longitudinal analyses of the Medicare population.

One of the strengths of the MCBS is its scope of information on personal health care utilization and expenditures. Respondents are asked about expenditures on Medicare-covered services and health services not typically covered by the Medicare program. Those services typically not covered by Medicare include purchases of prescription medicines, dental care, hearing aids, eyeglasses, and long-term care facility services. The MCBS also collects information on out-of-pocket (OOP) payments, third party payers, and use of health care services provided by such agencies as the Veterans Administration to more fully understand the financing of services not covered by Medicare. This information is used in conjunction with Medicare claims data to determine the amounts paid by Medicare, Medicaid, other public programs, private insurance, and households for each medical service reported by a beneficiary.

Annual data from the MCBS are released to the public in two different PUFs. The Access to Care PUFs, available for calendar years 1991 through 2001, contain information on beneficiaries' access to medical providers, satisfaction with health care, health status and functioning, and demographic and financial characteristics. The files include Medicare claims data for beneficiaries who were enrolled in Medicare for the entire calendar year and were community residents.[1] They provide a snapshot of the "always enrolled" Medicare population, and can be used to analyze characteristics of beneficiaries who were potential or actual users of Medicare-covered services during the entire 12-month period.

The Cost and Use PUFs, available for calendar years 1992 through 2000, are more comprehensive than the Access to Care PUFs. The Cost and Use PUFs include information on services not covered by Medicare, and the samples are chosen to represent all beneficiaries who were ever enrolled in Medicare at any time during a calendar year. The Cost and Use PUFs also contain detailed information on health insurance coverage, as well as health status and functional capacity. The data can be used to analyze total and per capita health care spending by the entire Medicare population, including part-year enrollees and persons who died during the year.

The MCBS sourcebooks include information from both sets of PUFs. The 1999 sourcebook also uses data from previous PUFs. Chapter 2 contains information on emerging trends and patterns between 1992 and 1999. It has sections on the Medicare population, personal health care expenditures (PHCE) by Medicare beneficiaries, vulnerable populations and the impact of the Balanced Budget Act (BBA), funding sources, PHCE by service category, and health insurance status of the Medicare population.

[1] Beneficiaries who did not live in long-term care facilities for the entire year are referred to as community residents in the sourcebook.

Sections 1-5 in Chapter 3 contain the same set of the cross-sectional data from the Access to Care and Cost and Use PUFs as previous sourcebooks. Section 6 data tables highlight emerging trends in health and health care utilization between 1992 and 1999.

Appendix A provides a description of the sample design, survey operations, response rates, and structure of the MCBS PUFs. It also includes a discussion of procedures to calculate standard errors for cross-sectional statistics and estimates of net change over time. Appendix B contains a glossary of terms and variables used in the detailed tables.

HIGHLIGHTS OF FINDINGS

The Medicare Population

- In 1999, total Medicare beneficiaries grew to an ever-enrolled population of 40.4 million, representing 14.5 percent of the total U.S. population. The annual growth rate for the Medicare population remained low at 0.7 percent between 1998 and 1999.

- The Medicare population became increasingly diverse between 1992 and 1999. By 1999, the proportion of White non-Hispanic beneficiaries decreased to 80.7 percent; and the proportions of the oldest old, Hispanics, other race/ethnicity, and disabled beneficiaries increased, respectively, to 10.9 percent, 6.9 percent, 3.6 percent, and 13.3 percent. The proportion of Black, non-Hispanics remained stable.

Personal Health Care Expenditures (PHCE)

- In 1999, PHCE by Medicare beneficiaries increased from $368.3 billion to $381.2 billion, a growth of 3.5 percent. PHCE by Medicare beneficiaries during this period indicated low overall growth, but the growth has accelerated (compared with 1998).

- Similar to 1998, the primary factors contributing to low growth were the effects from the BBA on Medicare payments, the Federal Government's efforts to combat fraud and abuse, and the continued growth of enrollment in Medicare managed care. The accelerations in the growth rates were widely thought to be fueled by the booming economy in the late 1990s, increased health insurance provided by employers, and rising provider costs in the medical industry.

- The Medicare population consumed health care resources in amounts disproportionate to their numbers in the U.S. population. Medicare beneficiaries, who constitute 14.5 percent of the U.S. population, spent 36 percent of total U.S. PHCE. Per capita PHCE for the Medicare population was $9,447 in 1999, more than three times the amount for the non-Medicare population. Nevertheless, annual growth in per capita PHCE for Medicare beneficiaries was only 2.8 percent in 1999, considerably lower than that of the non-Medicare population.

Vulnerable Populations and the BBA Impact

- Due to their significant health care needs, several segments of the Medicare population continued to incur higher than per capita PHCE in 1999. These groups included full-year nursing home residents, Medicare/Medicaid dual eligibles, the oldest old, and the disabled.

- Vulnerable subgroups of the Medicare population seemed to disproportionately bear the brunt of the BBA impact. In contrast to the growth among the overall Medicare beneficiaries, mean PHCE of all the vulnerable subgroups declined from their 1998 level, except for full-year nursing home residents. Among these groups, Medicare/Medicaid dual eligibles and the disabled appeared to have had the biggest decline in expenditures.

Funding Sources

In 1999, public funding, mainly Medicare and Medicaid payments, covered 65 percent of PHCE by the Medicare population, and private funding covered 31.6 percent. The annual growth rate for public funding began falling gradually in 1994, followed by sharp declines from 1995 to 1999. After a steep decline in 1996, the annual growth rate for private funding has continued to increase through 1999 to 9.3 percent.

In 1999, total Medicare payments amounted to $203 billion, a slight increase of 1.5 percent over 1998. Per capita Medicare payment, $5,034, remained almost unchanged from 1998. Medicare's spending pattern on different service types was mixed. Substantial increases were observed in its payments on inpatient and physician care, with respective increases of $4.1 and $4.6 billion. At the same time, sizeable reductions were seen in its payments on home health, long-term nursing home, and skilled nursing facility (SNF) care, respectively -$3.9, -$2.0, and -$0.9 billion.

Medicaid spending on Medicare beneficiaries showed either low or negative growth between 1996 and 1999. Between 1998 and 1999, total Medicaid expenditures of the dually eligibles amounted to $44.5 billion, representing a 2.1 percent decline. For the consecutive second year, per capita PHCE for the dually eligible population fell, from $18,173 in 1997 to $16,644 in 1999.

While public funding declined for Medicare beneficiaries, the annual growth rates of private funding, private health insurance (PHI) more specifically, surged to 19.5 percent between 1998 and 1999, representing the second consecutive year of fast growth. Increased PHI expenditures spread across all major service types in 1999.

PHCE by Service Category

In 1999, inpatient hospital expenditures increased by $7.7 billion, reflecting a rapid annual growth of 7.4 percent. The surge in inpatient expenditures was mainly attributed to increased users. The user rate of inpatient hospital services rose by close to 1 percent since 1996 and reached a new high at 20.4 percent in 1999, representing over half a million of additional inpatient service users compared with 1996. Total inpatient stays by Medicare beneficiaries were estimated at 13.5 million, also representing a historical high. Increases in inpatient spending were largely paid by Medicare and PHI, respectively $4.1 billion and $2.7 billion.

In 1999, total spending on ambulatory services increased by $6.1 billion, representing a 5.4 percent growth. The increase in ambulatory spending might also be attributed to this new high point of physician and outpatient user rates in 1999 at 94.6 and 68.8 percent, respectively. All the growth in physician spending was absorbed by Medicare payments and all the increase in outpatient spending by PHI.

In 1999, the annual growth rate of prescription medications (PM) ranked at the top, at 13.9 percent. PM's share of Medicare beneficiaries' PHCE increased from 8.9 percent to 9.8 percent, representing a net increase of $4.6 billion. Continuing its rise since 1992, the average prescription cost per user almost doubled in the past 7 years, reaching $1,084 by 1999. PM spending was largely paid by Medicare beneficiaries out-of-pocket (OOP) and by PHI. From 1992 to 1999, OOP's share of total PM spending declined from 58 percent to 40 percent; whereas PHI's share increased from 25 percent to 34 percent.

The observed decrease in nursing home spending by Medicare beneficiaries was due to reductions in both long-term nursing home and SNF care spendings, respectively $1.2 and $1.1 billion. This mainly reflected cuts in Medicare payments to SNF

and other hospital-based services. Total Medicare payments on long-term nursing home and SNF care services declined by 20 percent from 1998, representing $2.9 billion. At the same time, the drop in 1999 was also a consequence of Medicaid's reallocation of funding from institutional care to less costly home and community-based services.

Dramatic declines in home health spending continued in 1999 for the third consecutive year for Medicare beneficiaries. In 1999, home health care spending on Medicare beneficiaries plummeted by more than 32 percent, representing $4.1 billion. The bulk of the contractions, $3.9 billion, was the consequence of Medicare's reductions on home health care payments compared with 1998.

Insurance Status

Medicare HMO enrollment continued its expansion, reaching 19.4 percent of the noninstitutionalized Medicare population in 1999. Nevertheless, the growth in enrollment evidently decelerated in recent years, largely due to instabilities in the managed care market.

Concurrent with increasing enrollment in Medicare managed care from 1992 to 1999, PHI enrollment, in particular individually-purchased PHI, declined steadily among Medicare beneficiaries. The proportion of noninstitutionalized Medicare beneficiaries with individually-purchased PHI decreased from 37.8 percent in 1992 to 30.1 percent in 1999; and beneficiaries with employer-sponsored PHI decreased from 36.1 percent to 33.7 percent.