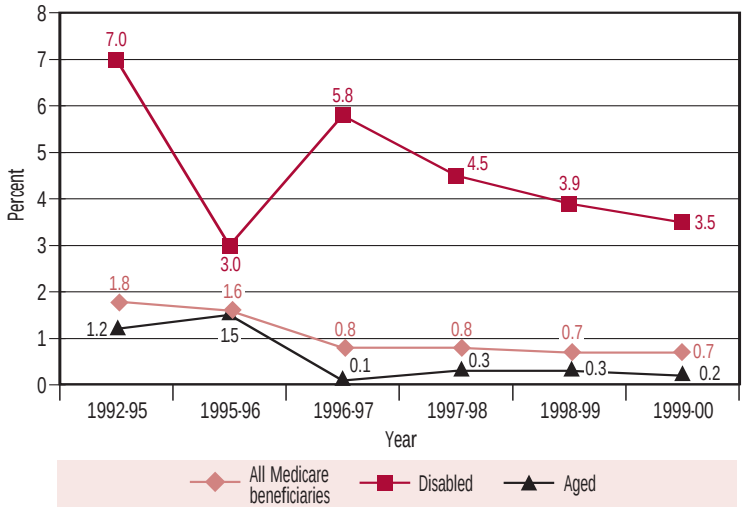
2 TRENDS IN THE MCBS: 1992–2000

THE MEDICARE POPULATION

In 2000, there were an estimated 40.6 million Medicare beneficiaries, a 0.7 percent rise over the previous year. Approximately 5.5 million (13.5 percent) beneficiaries were disabled (below age 65) and 35.1 million (86.5 percent) were aged (age 65 or above). The count of disabled beneficiaries grew by 3.5 percent whereas that of the aged grew by only 0.2 percent, rates that have decelerated relative to the 3 preceding years (Figure 2-1).

Figure 2-1. Annual Growth in Medicare Population by Medicare Status, 1992-2000

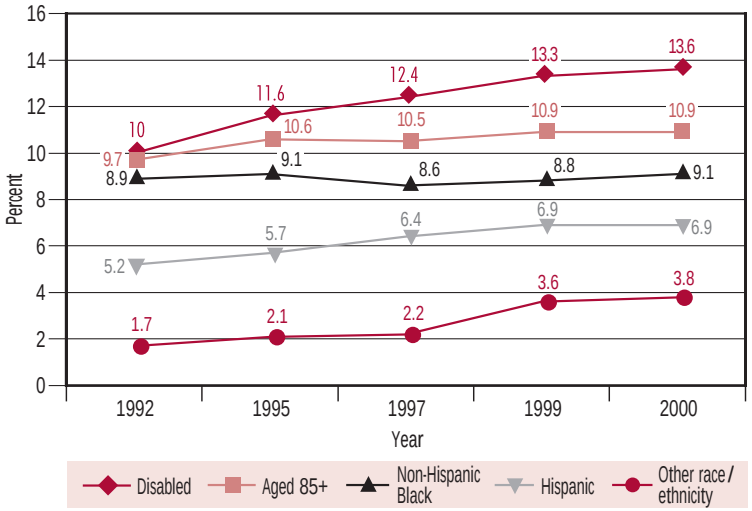


The Medicare population continued to become increasingly diverse in composition, as the representation of some vulnerable subgroups grew more rapidly than the Medicare population as a whole (Liu and Sharma, 2002) (Figure 2-2).

PERSONAL HEALTH CARE EXPENDITURES

Personal health care expenditures (PHCE) represent direct consumption of health care goods and services provided by hospitals, physicians, and other sources of medical care and equipment. The

Figure 2-2. Proportion of Selected Groups in the Medicare Population, 1992-2000



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 (PM).

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.[1] 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

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

valuable frame of reference for policymakers to track trends in the health care industry.

In 2000, the NHE exceeded $1.3 trillion, growing 6.9 percent since 1999. The PHCE share of gross domestic product (GDP) remained approximately 13 percent from 1993 to 2000 (Levit, et. al., 2002).

Figure 2-3. National Personal Health Care Spending, 1992-2000

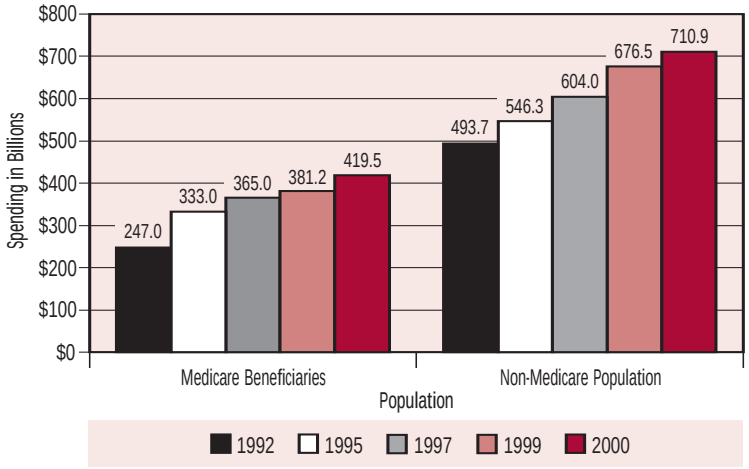
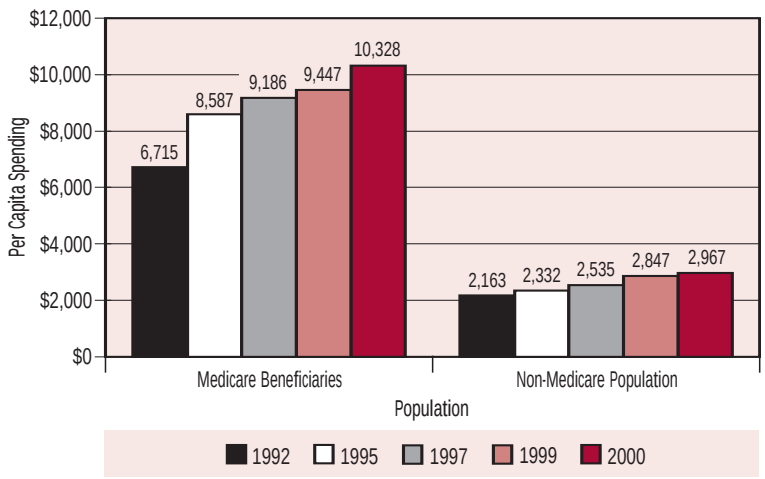


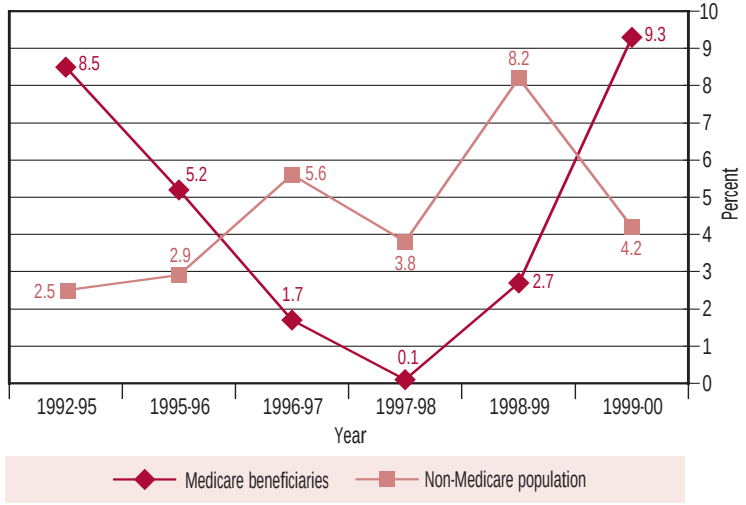
Figure 2-4. Per Capita Spending on Personal Health Care, 1992-2000



In contrast to the period between 1997 through 1999, there was somewhat faster growth in NHE in 2000, primarily as the result of a retreat from tightly managed care and rapid growth in publicly financed care. The same factors also reshuffled the composition of health care spending growth (Strunk, et al., 2001).

PHCE by Medicare beneficiaries amounted to $420 billion in 2000, while the non-Medicare population spent $711 billion (Figure 2-3). Although it composed only 14.5 percent of the total U.S. population, the Medicare population accounted for 37 percent of national personal health care resources. Per capita PHCE for the Medicare population was $10,328 in 2000, whereas for the non-Medicare population, it was $2,967, or less than one-third as much (Figure 2-4). Unlike recent years, Medicare beneficiaries' annual growth in per capita PHCE in 2000 was considerably greater (9.3 percent) than that of the non-Medicare population (4.2 percent) (Figure 2-5). This was attributable to the impact of the Balanced Budget Refinement Act (BBRA), considerable increases in private health insurance (PHI) premiums, and lagging growth in the

Figure 2-5. Annual Growth in Per Capita Spending on Personal Health Care, 1992-2000



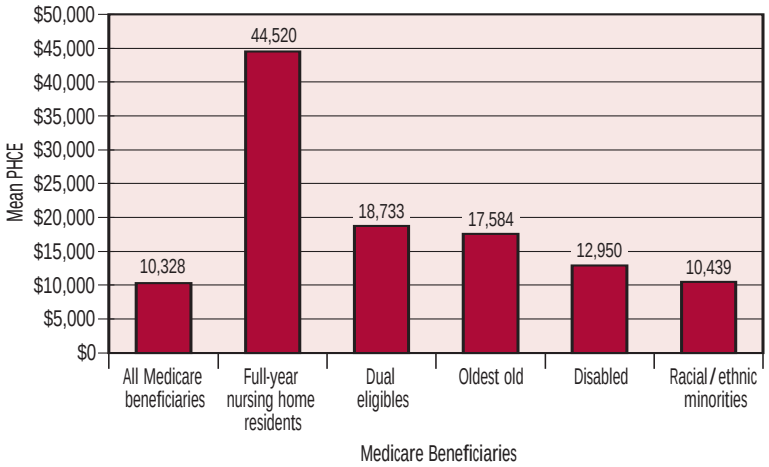
Medicare managed care market, which together served to raise Medicare beneficiaries' health care outlays (Strunk, et al., 2001; Levit, et al., 2002).[2]

Between 1999 and 2000, PHCE by Medicare beneficiaries grew by 10.1 percent, more than 10 times the rate between 1998 and 1999 (0.9 percent) because of several developments. The BBRA served to ease the provider payment reductions mandated by the BBA, thus directly increasing Medicare outlays. In spite of the BBRA, many Medicare managed care providers withdrew or reduced their service agreements primarily to curtail Medicare losses, leading to a virtual standstill in Medicare+Choice (i.e., the Medicare managed care program introduced by the BBA) enrollment. Due to greater provider market consolidation, health care costs increased as insurers were no longer able to negotiate significant price discounts as in previous years (Smith et al., 2001). As a result, to cover higher medical costs and to restore profitability, private insurers imposed significant hikes on premiums including those for Medigap policies.

SPECIAL POPULATIONS

Certain vulnerable populations continued to show markedly above average per capita PHCE in 2000. They included full-year nursing home (NH) residents,[3] the oldest old, the Medicare and Medicaid dually eligibles (DEs), and the disabled (Figure 2-6).[4] These subgroups often overlap. Beneficiaries over age 85 constituted nearly half of full-year nursing homes beneficiaries. Over one-third of the DE population consisted of the nonelderly (under 65) disabled. Similarly, minority beneficiaries composed a disproportionate share (32 percent) of the latter. Although the disabled use Medicare-covered services at a lower rate than the aged, their per capita total health care expenditure was higher, perhaps because they may also qualify for Medicaid or other funding (CMS Data Compedium, 2002). More than one-half of the DE population reported fair or poor health status, suggesting their need for more intensive health

Figure 2-6. Per Capita Personal Health Care Expenditures by Selected Groups of Medicare Beneficiaries, 2000



care interventions. Since some of the subpopulations grew more rapidly than the entire Medicare population, they are likely to spur future growth in all Medicare beneficiary average per capita PHCE.

Some subgroups within the Medicare population indicated high total, as well as Medicare financed, per capita expenditures. They illustrated how healthcare resources are concentrated on the care of relatively few. In 2000, beneficiaries with End Stage Renal Disease (ESRD) spent an average of $58,420 (70 percent of which is paid by Medicare), a sum more than 5 times the average amount spent by beneficiaries who do not have ESRD (for whom Medicare pays about 48 percent). Beneficiaries with an inpatient stay spent $27,258 (65 percent paid by Medicare), nearly 4 times as much as those without an inpatient stay ($7,174, of which 31 percent is paid by Medicare). Likewise, deceased beneficiaries incurred $25,935 (64 percent paid by Medicare) for end-of-life expenses, whereas beneficiaries who survived incurred $10,793 (47 percent paid by Medicare.[5] The occurrence of any of the above (ESRD, inpatient episode, or death) significantly raised both total expenditure and the share financed by Medicare.

[2]Population and national health expenditure estimates for 2000 come from data published by CMS, Office of the Actuary, in 2002, while estimates for 1999 come from data published by the same source in 2001.

[3]Their room and board expenses considerably increased their average PHCE.

[4]The subgroups presented in this figure are not mutually exclusive. The figure also includes beneficiaries from racial / ethnic minorities, whose average spending is not significantly larger than the overall average.

[5]This comparison does not account for the fact that unlike the deceased survivors may continue to expend resources for as long as they live.

According to CY 2000 MCBS data, more than two-thirds of Medicare beneficiaries have two or more of the following chronic conditions: stroke, diabetes, pulmonary disease, heart disease, hypertension, arthritis, osteoporosis or broken hip, Parkinson's disease, and urinary incontinence. Almost one quarter of all beneficiaries have four or more of the above chronic conditions. Moreover, the likelihood of having at least one functional limitation (IADL or ADL) rises as the number of chronic conditions rises. While only 23 percent of beneficiaries without any chronic condition report some functional limitation, 68 percent of those with four or more chronic conditions indicate some. In response to these health challenges, beneficiaries with chronic disease expend significant resources on healthcare services, including those covered by Medicare. Nearly 35 percent of all Medicare program spending is accounted for by the 24 percent of Medicare beneficiaries who report four or more chronic conditions.[6] In fact, many beneficiaries with chronic conditions lack the financial resources to cover their healthcare and other basic living expenses: according to MCBS data for CY2000, almost one in six beneficiaries with two or more chronic conditions has an income at or below $10,000 per year.

FUNDING SOURCES

In 2000, both the non-Medicare and the Medicare populations exhibited funding patterns very similar to those observed in previous years (Figure 2-7).[7] Most of the PHCE by the non-Medicare population was financed by private sources, including PHI (47.7 percent) and out-of-pocket (OOP) payments (15.8 percent).[8] Public funds,[9] mainly Medicaid, financed only 19.2 percent. In contrast, approximately two-thirds of Medicare beneficiaries' PHCE was funded by public sources, a share that has slightly declined in recent years. In 2000, Medicare funded 52.3 percent of Medicare beneficiaries' PHCE and Medicaid funded 12.2 percent. The remainder was covered by OOP payments (19.4 percent), PHI (12.2 percent), and other sources of payment (3.9 percent) (Figure 2-7).

Unlike recent years, public funding for PHCE by Medicare beneficiaries grew quite significantly (9.4 percent) (Figure 2-8). Total Medicare payments in 2000 amounted to $220 billion, a rise of 8.3 percent since 1999. Per capita Medicare payment, $5,406,

Figure 2-7. Sources of Funds for Personal Health Care Expenditures by Medicare Beneficiaries and the Non-Medicare Population, 2000

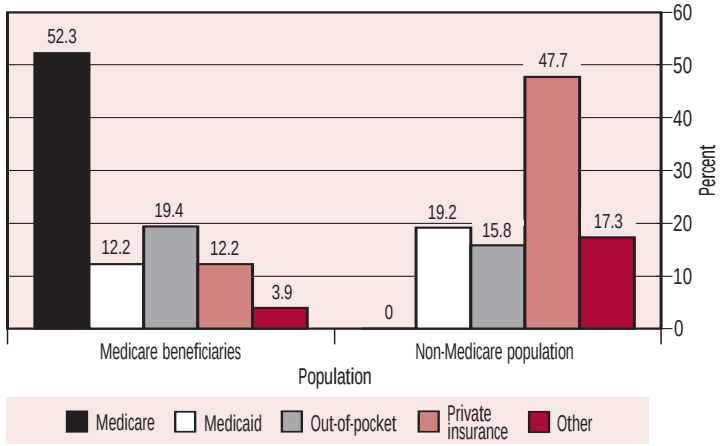
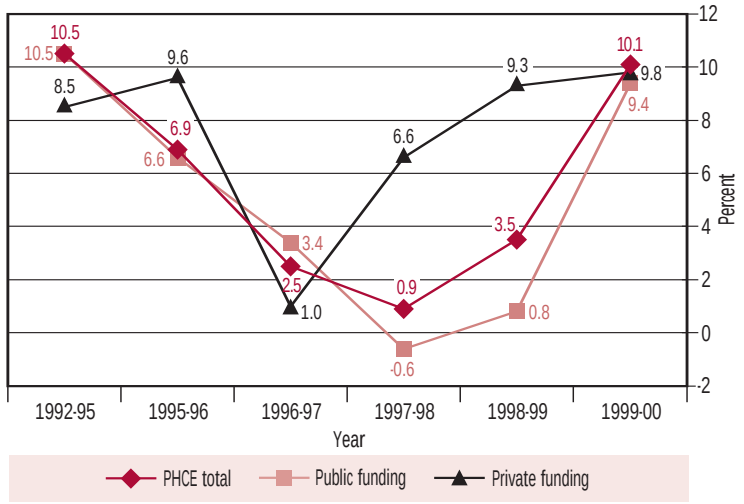


Figure 2-8. Annual Growth Rates of Personal Health Care Expenditures by Medicare Beneficiaries, by Funding Source, 1992-2000



[6]Yet, there is growing recognition that traditional fee-for-service Medicare is not well suited to meet these beneficiaries' needs and, as a result, it is not cost-effective (IOM, 2001). Whereas good chronic care is "continuous, multidisciplinary, accessible, coordinated and patient centered…Medicare beneficiaries typically receive fragmented healthcare from multiple providers and multiple sites of care" which entails high expenses for all stakeholders, including Medicare. Evidently, Medicare policies "discourage a team approach to care and provide little incentive [to providers] to keep the beneficiary well… [They] do not support the coverage for many benefits or services vital to those with chronic conditions, such as outpatient prescription drugs, sensory aids, or custodial care…[As a result] providers often deny care when the beneficiary's condition is stable or when maintenance services are needed." Such policy leads to subsequent expenditure of considerable health care resources for the beneficiaries in question (NHPF, 2003). In response to these concerns, Medicare has initiated a series of demonstration programs (i.e., PACE) that seek to institute "integrative care."

[7]To achieve comparability between the Medicare and non-Medicare populations, other private payments in NHE were collapsed with other public to become payments from other sources.

[8]In this sourcebook, discussions on private sources are limited to PHI and OOP payments.

[9]Discussions on public sources are limited to Medicare and Medicaid payments.

exhibited a 7.4 percent rise from 1999. Along with numerous changes in the Medicare managed care market, the increases may be attributed to the BBRA, enacted in November 1999 to raise (or delay reductions in) payments specified by the BBA. In 2000, two important policy changes also took effect: the hospital outpatient prospective payment system was implemented in July and the home health prospective payment system (PPS) in October. Overall, these resulted in considerable growth in Medicare spending.

Medicare's spending on all major service types increased during this period. Medical provider/supplier services and inpatient hospital services showed the largest increases ($6.2 billion and $6.1 billion respectively). Between 1999 and 2000, inpatient hospital services experienced higher price inflation (relative to the Consumer Price Index for Medical Goods and Services (CPI-M)) and a higher volume, as reflected by the discharge rate (CMS Data Compendium, 2002; Heffler, et al., 2001). Rapid growth of physician and other clinical services may be attributed to growth in imaging procedures, in visits associated with drug prescribing, and less frequent utilization review of these services (Levit et al., 2003).

The observed rise in hospital (inpatient) spending growth may be the outcome of greater Medicare payments via the BBRA.[10] In addition, greater provider bargaining power with respect to health plans led to higher provider fees (Strunk, et al., 2001). A fall in required authorizations for services and more direct access to specialists also may have stimulated demand for hospital (and physician/supplier) services (Strunk, et al., 2001). In recent years an increasing share of Medicare payments for inpatient and outpatient hospital services has been for pharmaceutical products whose costs have been increasing very rapidly (Health Care Financing Review (HCFR) Statistical Supplement, 2003). On the other hand, growth in inpatient spending was somewhat curbed as the average complexity of Medicare inpatient services (associated with changes in hospital coding practices) declined for the third consecutive year (Levit, et al., 2003).

Skilled nursing facility (SNF) and home health services experienced significant Medicare spending growth between 1999 and 2000, 22.1 percent and 13.7 percent respectively. The BBRA raised payments to SNFs for some complex patient conditions and for facilities specializing in the care for AIDs patients (Levit, et al., 2002). As with hospital services, a rising share of Medicare SNF payments were for increasing costly pharmaceutical products (HCFR Statistical Supplement, 2003). In addition, the BBRA delayed BBA-mandated payment reductions to home health care agencies (HHAs) and increased Medicare per beneficiary payment limits for some HHAs (Levit, et al., 2002).

Medicaid funding for the DE population increased from its level of about $44 billion between 1996 and 1999 to $51 billion in 2000. Although average health care spending by the DEs declined from 1997 through 1999, positive growth returned in 2000; i.e., it rose from $16,644 in 1999 to $18,733 in 2000. The CY2000 MCBS data indicated that Medicaid funding rose most significantly for long-term care services ($4.3 billion) and prescription medications ($1.3 billion). Annual growth in Medicaid funding surged for home health services (38.5 percent), medical provider services (38.4 percent), and as in previous years, outpatient prescription medications (29.3 percent). Only SNF services showed a 19.3 percent decline in Medicaid funding, as state Medicaid programs turned to less expensive sources of such care.

Between 1999 and 2000, private funding grew by 9.8 percent, building on momentum evident since 1998 (Figure 2-8). Private health insurance funding growth moderated to 9.0 percent in 2000, from 19.5 percent in 1999. A number of developments appeared to drive the surge in the growth of private insurance spending. Along with greater utilization of health care services by the insured, private insurance benefit expenses increased due to shifts in consumers' choice toward less restrictive forms of managed care. Moreover, greater consolidation among health care providers (particularly hospitals) allowed them more bargaining power to negotiate higher payment from insurers. To

[10]The BBRA reduced BBA-mandated Medicare cuts for graduate medical education (GME) and eased reductions in disproportionate share (DSH) payments for hospitals with a large share of indigent patients. In addition, the BBRA provides for a 1-year payment increase to hospitals that are sole providers in their communities (i.e., rural hospitals), effective October 2000.

cover rapidly rising costs and to restore profitability, the growth of private health insurance premiums accelerated for many beneficiaries (Strunk, et al., 2001). According to CY2000 MCBS data, except for

Figure 2-9. Sources of Funds for Personal Health Care Expenditures by Medicare Beneficiaries, 1992-2000

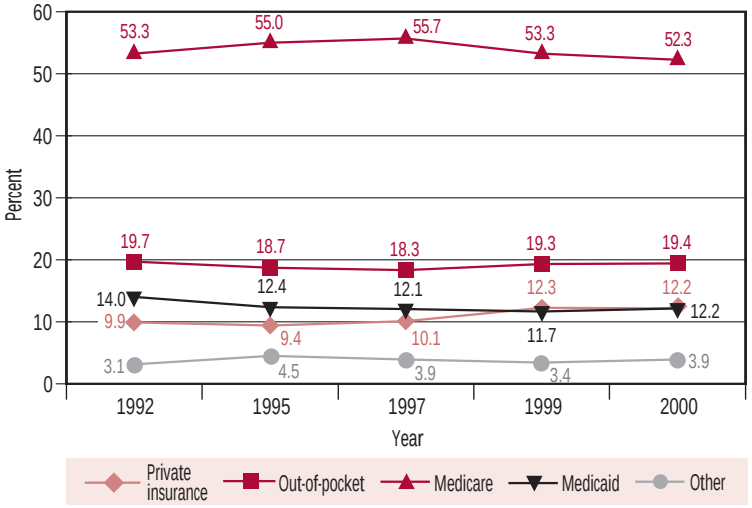
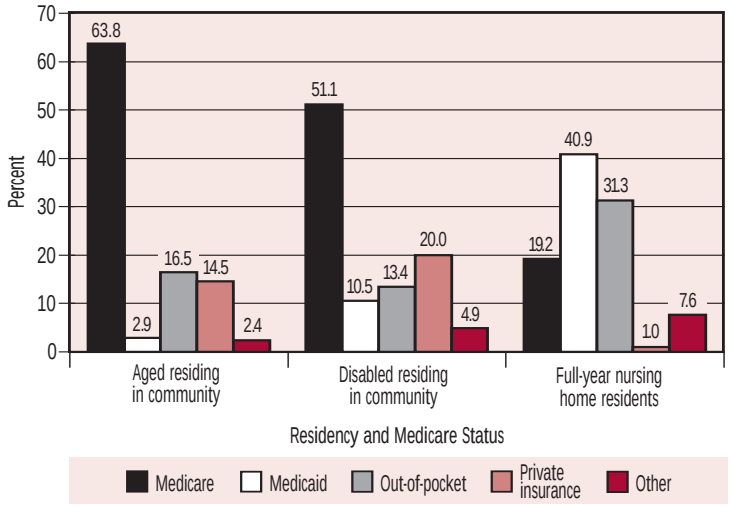


Figure 2-10. Sources of Funds for Personal Health Care Expenditures by Residency and Medicare Status, 2000



home health care, SNF services, and outpatient hospital care (which declined by 58 percent, 23 percent, and 4 percent respectively), PHI funding increased for all other major service types in 2000. Medical provider services and prescription medications showed the most appreciable growth in magnitude, $2.4 billion (20.1 percent) and $2.3 billion (17.8 percent), respectively.

Between 1999 and 2000, OOP funding for the PHCE of Medicare beneficiaries rose by 10.3 percent ($7.6 billion), the highest annual growth rate since 1992. The share of PHCE paid out-of-pocket increased slightly from the previous year, reaching 19.4 percent in 2000 (Figure 2-9).[11] Third-party payers continued to shift an increasing share of higher medical care costs for covered services to Medicare beneficiaries, in spite of the fact that many beneficiaries have limited means. According to MCBS data for CY2000, an estimated 49 percent of elderly households have income less than $20,000. Furthermore, the elderly poor spend a greater proportion of their income out-of-pocket for health care compared with their wealthier counterparts. Much of the increase in OOP outlays was for medical provider/supplier services ($3.1 billion or 22.8 percent of annual growth), followed by prescription medications ($2.2 billion or 14.5 percent), and long-term care services ($2.1 billion or 6.7 percent). Notably, the latter two services were typically not covered either by Medicare or by Medigap (with some exceptions). Spending on inpatient hospital services also grew rapidly ($452 million or 18.0 percent). Only outpatient hospital services witnessed a contraction in OOP funding, by $639 million or 17 percent relative to the previous year.

Aged and disabled community residents had distinctive patterns of funding compared with full-year nursing home residents (Figure 2-10). For aged community residents, Medicare financed 63.8 percent of total PHCE, while OOP (16.5 percent) and PHI (14.5 percent) payments contributed much of the remainder. Disabled community residents also funded their PHCE primarily with Medicare payments (51.1 percent), along with sizeable contributions from PHI (20.0 percent) and OOP payments (13.5 percent). The allocation of

[11] In the MCBS, out-of-pocket payments include direct payments for coinsurance amounts, copayments, deductibles, balance billings and charges for non-Medicare covered services not paid for by public or private sources. Premium payments are not included. However, other data sources indicate that in 1999, among beneficiaries with fee-for-service Medicare, nearly one-third of beneficiary out-of-pocket spending was cost-sharing for Medicare-covered services (17 percent) and Medicare Part B premium payments (15 percent). Another one-fifth (21 percent) was for private health insurance premiums, while less than half the OOP spending was for services not covered by Medicare (CMS Data Compendium, 2002).

funding among payers remained unchanged for the aged and the disabled between 1999 and 2000. Compared with the disabled, the Medicare-funded share of PHCE increased for the aged, while their PHI-funded share decreased. In contrast to community residents, for full-year nursing home residents, Medicaid and OOP payments contributed 40.9 and 31.3 percent respectively for PHCE, whereas Medicare funded 19.2 percent.

PHCE BY SERVICE CATEGORY

In 2000, the significantly higher growth of PHCE manifested as higher spending levels on all major service types except SNF services. Spending levels rose most steeply for physician/supplier services ($12.5 billion), long-term care ($8.6 billion), inpatient hospital services ($7.4 billion), and prescription drugs ($7.1 billion). Annual spending growth was highest for prescription drugs (18.8 percent), followed by physician/supplier services (13.8 percent), home health services (11.7 percent), and long-term care (11.7 percent). In contrast, spending on SNF services declined by $127 million (1 percent), between 1999 and 2000.

Spending for inpatient and ambulatory services continued to account for more than 60 percent of personal health care expenditures by Medicare beneficiaries in 2000 (Figure 2-11). The share of PHCE for inpatient services fell slightly (from 29 percent to 28.1 percent), in spite of its 6.7 percent annual growth (Table 2-1). MCBS data also indicated that though inpatient user rates and episodes per user remained fairly steady, inpatient cost per user increased 6.1 percent between 1999 and 2000, the highest annual rise since 1992. Among the ambulatory services, medical provider/supplier services for noninstitutionalized Medicare beneficiaries showed comparable growth in average visits per user (5.7 percent), but a much greater rise in cost per user (13.1 percent) between 1999 and 2000.

Figure 2-11. Proportion of Personal Health Care Spending by Medicare Beneficiaries, by Selected Type of Service, 1992-2000

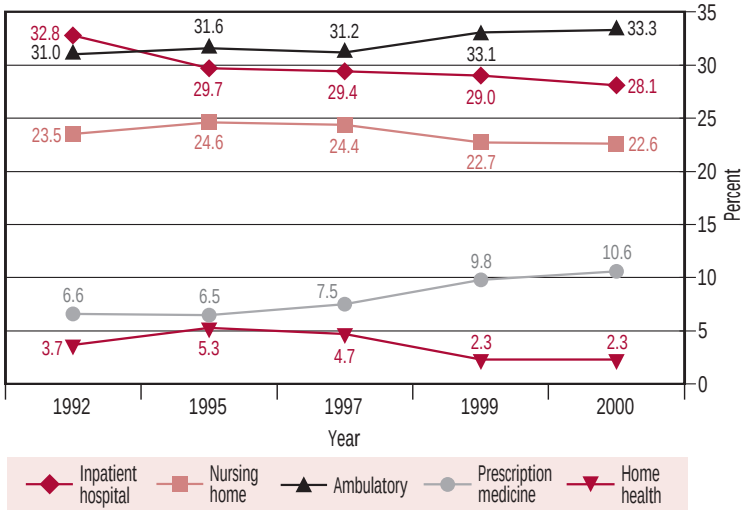


Table 2-1. Annual Growth Rate of Spending by Selected Service Type, 1992-2000

	1992-95 (%)	1995-96 (%)	1996-97 (%)	1997-98 (%)	1998-99 (%)	1999-00 (%)
Inpatient Hospital	6.8	5.0	3.3	-4.1	7.4	6.7
Ambulatory	11.1	4.7	3.4	5.4	-2.6	10.7
Physician/ Supplier	10.4	4.4	1.8	5.5	-1.6	13.8
Outpatient Hospital	13.2	5.5	7.9	5.3	-7.8	2.7
Prescription Medicine	10.0	14.5	10.5	20.6	5.1	18.8
Home Health	24.2	6.7	-8.1	-25.4	4.6	11.7
Nursing Home	12.1	9.0	0.0	-0.5	6.5	9.8
Long-term Care	10.0	5.5	-2.8	1.5	13.9	11.7
Skilled Nursing Facility	34.7	33.9	15.8	-9.8	-32.1	-1.0

In 2000, the annual growth in spending on outpatient prescription medications ranked highest among all service categories listed on Table 2-1 (18.8 percent), even though only three-quarters of all beneficiaries had drug coverage (CMS DC, 2002).[12] In 2000, Medicare beneficiaries' PHCE for PM increased from 9.8 percent to 10.6 percent, a net increase of $7.1 billion. Among the noninstitutionalized, the average prescription cost per user was

[12]Note the spending figure does not include the cost of pharmaceutical products dispensed in hospitals or clinics.

Figure 2-12. Prescription Medicine Utilization by Noninstitutionalized Medicare Beneficiaries, 1992-2000

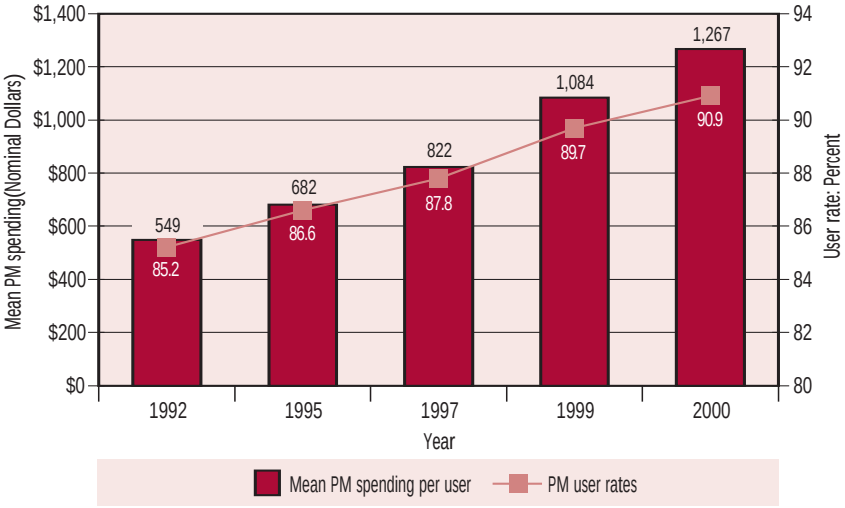
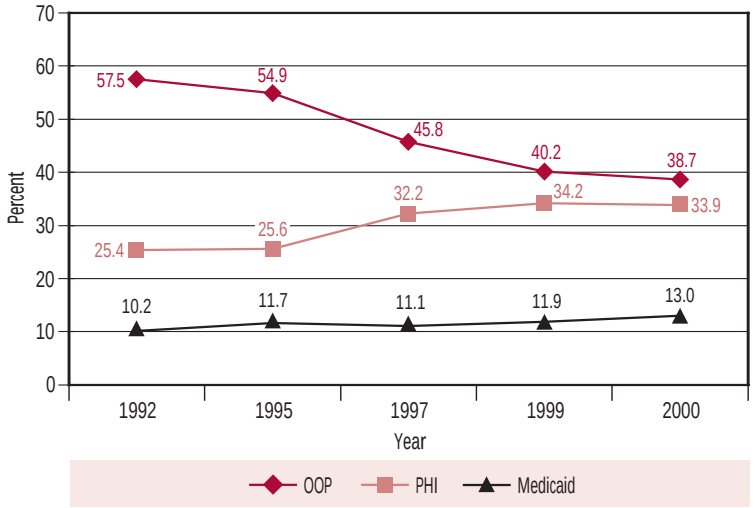


Figure 2-13. Distribution of PM Spending by Major Sources of Payment for Noninstitutionalized Medicare Beneficiaries, 1992-2000



$1,267 in 2000, rising 16.8 percent from 1999 (Figure 2-12). Since prescription drug use increases with age, along with the prevalence of health problems, this trend has raised concern because these rapidly rising drug costs disproportionately impact aged Medicare beneficiaries (Kaiser Family Foundation (KFF), 2003).

Double-digit growth in prescription drug spending, evident since 1994, may be attributed to a number of trends. Greater coverage of prescription drugs through third-party insurers and the resulting reduction in consumer OOP expenses continued to induce greater consumer demand. MCBS data on noninstitutionalized Medicare beneficiaries indicated that from 1992 to 2000, the OOP share of total PM spending declined from 58 percent to 39 percent, whereas the PHI share increased from 25 percent to 34 percent (Figure 2-13). Medicaid's share of PM spending also increased, from 11.7 percent in 1995 to 13.0 percent in 2000, motivating states to curb these costs.

Along with other factors, increased direct-to-consumer advertising led to increased PM user rates and greater intensity of use (Levit, et al., 2003). Based on MCBS data for CY2000 among noninstitutionalized Medicare beneficiaries, the average number of prescriptions per user rose by 8.2 percent between 1999 and 2000, the highest annual rise since 1992.

In response, many third-party payers adopted measures to slow the rapid ascent in drug spending. For example, insurers' use of a three-tiered drug copayment structure grew rapidly, from 36 percent in 1998 to 80 percent in 2000, thus shifting a larger portion of (brand-name) drug costs to consumers (Levit, et al, 2002).[13] Other drug cost containment measures now commonly used include the use of drug formularies, generic drug incentive programs, prior authorization, and drug utilization review.

In contrast to the rapid growth of drug spending, spending on SNF care continued its decline, dropping by 1 percent between 1999 and 2000 (Table 2-1). The decline has moderated from a 10 percent

[13] It remains unclear whether tiered plans have their intended effect on drug spending in the long run.

contraction between 1997 and 1998, just after the passage of the BBA, to a 1 percent fall between 1999 and 2000, largely due to the BBRA. Among noninstitutionalized Medicare beneficiaries, cost per user held steady between 1999 and 2000. However, utilization fell due to a declining user rate (dropping by 15.9 percent) and reduced number of stays per user (decreasing by 1.8 percent).

Greater nursing home spending by Medicare beneficiaries was primarily due to a surge in spending on long-term nursing home care that was slightly offset by a decline in SNF care spending, $8.6 billion and $127 million, respectively. Total Medicare payments on long-term care and SNF care services declined by 4.3 percent in 2000.

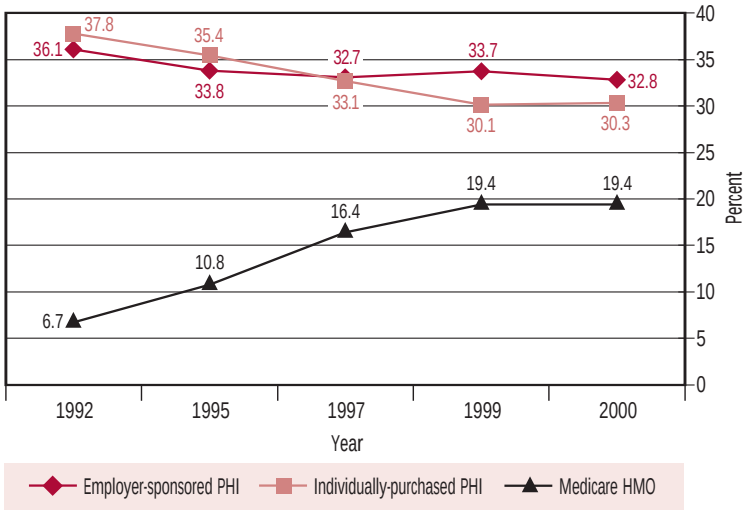
In contrast to its consistent decline since 1996, between 1999 and 2000, home health spending rose by 11.7 percent, an increase of $1.0 billion, on account of the BBRA's easing of home health facility payment restrictions imposed by the BBA. Of noninstitutionalized beneficiaries, the user rate fell slightly between 1999 and 2000 due to greater eligibility restrictions implemented by the BBA, whereas the cost per user rose by 16.4 percent, as the previously mandated reduction of payment amounts was moderated by the BBRA.

INSURANCE STATUS

On account of the continued economic boom in 2000, employer-sponsored PHI expanded its coverage of working adults, including some Medicare beneficiaries. While the rate of employer-sponsored PHI among Medicare beneficiaries apparently halted its downward slide between 1996 and 1999, the slide resumed in 2000 (Figure 2-14). In addition, the percentage of large employers providing retiree health benefits declined by 13 percent between 1996 and 2000 (KFF, 2001).[14]

On the other hand, although individually-purchased PHI declined gradually among Medicare beneficiaries from 1995 to 1999, it

Figure 2-14. Trends of Private Health Insurance and Medicare HMO Coverage for Noninstitutionalized Medicare Beneficiaries, 1992-2000



remained steady between 1999 and 2000 (Figure 2-14). While the rising cost of premiums, greater cost-sharing, and eroding benefits of individually-purchased PHI reduced the number of policyholders, other factors have induced more beneficiaries to keep or acquire PHI policies, including the increasingly higher cost-sharing in Medicare HMOs, limitations in their availability and/or access (in some areas), and fewer (or more restricted) benefits. In response to rapid health care cost increases, private insurance premiums grew faster in 2000 than the average annual growth between 1993 to 1998, thus making private coverage increasingly more expensive (American Association of Retired Persons, 2002).

As in 1999, enrollment in Medicare HMOs was 19.4 percent of the noninstitutionalized Medicare population in 2000. Relatively low annual increases in Medicare payments to managed care organizations (MCOs) stipulated by the BBA, (but modified by the BBRA) prompted some Medicare HMO plans to withdraw from selected service areas or terminate their contracts to avert expected losses (since the meager growth in Medicare revenues did not cover

[14]Because this may affect new retirees who just become eligible for Medicare, the impact on the PHI coverage of the overall Medicare population was slight: 33 percent of noninstitutionalized beneficiaries still had employer-sponsored PHI in 2000, compared with 34 percent in 1996.

rapidly growing costs). For many plans that remained in the market, beneficiary coverage became less comprehensive (i.e., reduced benefits) and some plans have begun either to charge premiums or have raised premiums (Gold and Achman, 2001). Moreover, plan benefit levels vary widely across the country, especially between the urban and rural areas, revealing geographically uneven access. Even though lower costs (33 percent) or better benefits (24 percent) were the most common reasons for joining a Medicare+Choice HMO, recent reversals have led to greater OOP costs for current Medicare+Choice enrollees (CMS DC, 2002; Gold and Achman, 2001). Perhaps as an outcome of these developments, since 1998, the proportion of Medicare beneficiaries without any supplemental insurance (i.e., fee-for-service (FFS) only) for the entire year has been very gradually rising, reaching 9.7 percent of the Medicare population in 2000.[15]

SUMMARY

In 2000, the Medicare population maintained a very modest annual growth trend that began in 1996. Particular subgroups of Medicare beneficiaries, such as the disabled, those aged 85 or above, and racial/ethnic minorities, continued to increase, making the Medicare population more diverse in composition.

Medicare beneficiaries' PHCE growth sharply accelerated in 2000. Accelerated growth was fueled by the BBRA, which relaxed the payment, eligibility, and utilization restrictions mandated by the BBA. These provisions also affected the Medicare managed care market, bringing enrollment to a standstill. Moreover, the expansion of health insurance coverage to more individuals (i.e., the employed) and the retreat from tightly managed care encouraged greater health care utilization, and the resulting escalation in medical expenses led private insurers to increase premiums considerably.

The shares of public (i.e., Medicare and Medicaid) and private funding for Medicare beneficiaries' PHCE held steady in 2000. Both Medicare and Medicaid funding accelerated between 1999 and 2000. In addition, private funding grew briskly during this period, reflecting strong growth of both private insurance and private OOP spending. Greater utilization of healthcare services by the insured, greater medical expenses due to providers' greater bargaining power, and payers' continued shifting of a greater share of medical costs to beneficiaries all contributed to the observed growth in private spending. Among sources of payment, Medicare beneficiaries continued to rely primarily on Medicare and Medicaid.

As in previous years, the distribution of health care services used by Medicare beneficiaries adjusted to new policies and market conditions such as the enactment of the BBRA, changes in the Medicare managed care market, trends in private health insurance markets, and other factors. In 2000, the shares of PHCE of long-term care, physician/supplier services, and PM services increased, whereas the shares of inpatient hospital, outpatient hospital, and SNF care declined.

Because of greater PM coverage, lower OOP cost, and greater utilization of newer and often more expensive medications by Medicare beneficiaries, the growth in PM spending was the highest among all types of major health services. As a result, the PM share of PHCE continued to rise. Increasing third-party payments for PMs (which imply lower out-of-pocket costs), direct-to-consumer advertising, and the introduction of new drugs and/or therapies fueled the rapid growth in PM consumption.

The BBA, the managed care backlash, and the private health insurance market trends were among the numerous forces that shaped the health care cost and utilization patterns of Medicare beneficiaries in recent years. The BBRA, enacted in November 1999, moderated the stringent provisions of the BBA. New prospective payment systems for outpatient hospital and home

[15]Though 9.7 percent beneficiaries go without supplemental coverage for the entire year, an estimated 15 percent of beneficiaries lack supplemental insurance at any point during the year (CMS DC, 2002).

health agency services also were introduced by Medicare in 2000. A retreat from restrictive forms of managed care contributed to greater medical care costs and utilization. To cover increasing benefit costs and to restore profitability, private insurers stipulated a significant rise in premiums. Taken together, these factors helped to spur an acceleration of Medicare beneficiaries' health care expenditure growth and shifted the composition of services.