Section 3. Medicare

Medicare is a nationwide health insurance program for the aged and certain disabled persons. The program consists of two parts: the Part A, Hospital Insurance Program and the Part B, Supplementary Medical Insurance Program.

Almost all persons over age 65 are automatically entitled to Medicare Part A. Part A also provides coverage, after a 24-month waiting period, for persons under age 65 who are receiving Social Security cash benefits on the basis of disability. In fiscal year 1997, Part A will cover an estimated 38.1 million aged and disabled persons (including those with chronic kidney disease). Part A provides coverage for inpatient hospital services, up to 100 days of posthospital skilled nursing facility (SNF) care, home health services and hospice care. Medicare Part A is financed primarily through the hospital insurance (HI) payroll tax levied on current workers and their employers. Employers and employees each pay a tax of 1.45% on all earnings. The self-employed pay a single tax of 2.9% on earnings.

Medicare Part B is voluntary. All persons over age 65 and all persons enrolled in Part A may enroll in Part B by paying a monthly premium. In FY1997, Part B will cover an estimated 36.6 million aged and disabled persons. Part B provides coverage for physicians' services, laboratory services, durable medical equipment, outpatient hospital services and other medical services. Part B is financed through a combination of monthly premiums levied on program beneficiaries and federal general revenues. In 1997, the premium was $43.80. Beneficiary premiums have generally represented about 25% of Part B costs. Federal general revenues (that is, tax dollars) account for the remaining 75%.

Th ability of Medcare's current financing mechanism to adequately fund program growth has been of concern for many years. The Part A trust fund is projected to become insolvent in 2001. In that year, revenues coming into the trust fund (primarily payroll taxes), together with any balance carried over from prior years, will be insufficient to cover the payment for Part A benefits in that year.

Contributing to the Part A insolvency issue are two related concerns. First, in the year 2011 the leading edge of the baby boom cohort (persons born between 1945 and 1954) turns age 65. Second, the number of workers whose payroll tax supports Part A benefits is declining. In 1995 there were almost 4 workers per beneficiary, and this number is expected to be about 3 by 2015 and 2 by 2050.

Figure 3.1.
Total Medicare Outlays, FY1967-FY2007

Total Medicare spending increased significantly since the program began; however, the average annual rate of growth has slowed somewhat in recent years. Over the FY1980-FY1990 period, total outlays grew from $35.0 billion to $109.7 billion, for an average annual rate of growth of 12.1%. For the FY1990-FY1996 period, total outlays grew from $109.7 billion to $194.3 billion, for an average annual growth rate of 10.0%. Different trends are recorded for spending on Part A and Part B. The average annual rate of growth in Part A spending increased from 10.6% over the FY1980-FY1990 period to 11.1% over the FY1990-FY1996 period. Conversely, the average annual rate of growth for Part B declined from 14.9% in the FY1980-FY1990 period to 8.2% over the FY1990-FY1996 period.

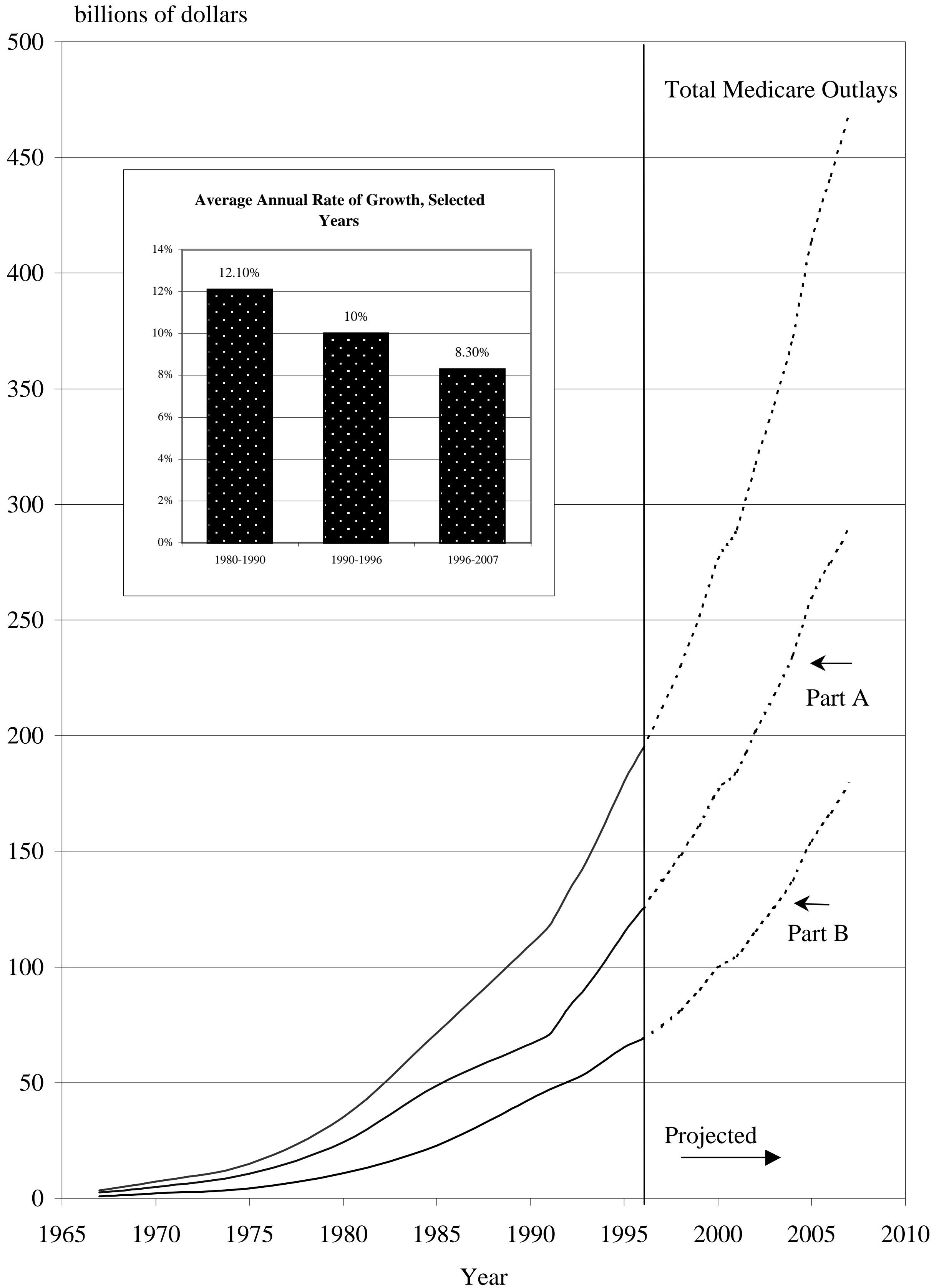
CBO projects that with no changes in funding total Medicare spending will grow from $194.3 billion in FY1996 to $468.7 billion in FY2007. This represents an average annual overall rate of growth of 8.3%. CBO projects that total Part A outlays will increase at an average annual rate of growth of 7.9%, while Part B will increase at an average annual rate of growth of 9.1%.

TABLE 3.1.
Total Medicare Outlays, FY1967-FY2007
(in billions)

Fiscal Year	Part A	Part B	Total Medicare Outlays
1967	$2.6	$0.8	$3.4
1970	5.0	2.2	7.1
1975	10.6	4.2	14.8
1980	24.3	10.7	35.0
1985	48.7	22.7	71.4
1990	66.7	43.0	109.7
1991	70.7	47.0	117.8
1992	82.0	50.3	132.3
1993	91.6	54.3	145.9
1994	102.8	59.7	162.5
1995	114.9	65.2	180.1
1996	125.3	68.9	194.3
1997	137.4	74.6	212.0
1998	148.6	81.5	230.1
1999	161.1	90.3	251.4
2000	176.5	99.8	276.3
2001	184.5	104.7	289.2
2002	201.7	115.7	317.4
2003	217.5	125.7	343.2
2004	234.7	137.6	372.3
2005	259.4	154.6	414.0
2006	275.1	166.9	442.0
2007	289.7	178.9	468.7

NOTE: Data for 1997-2007 are CBO projections. Totals may not add due to rounding. Table prepared by CRS.

Figure 3.1. Total Medicare Outlays, FY1967-FY2007



Source: Figure prepared by CRS based on House Ways and Means, *1996 Green Book,* CBO baseline projections, FY1996-FY-2007.

Figure 3.2.
Total and Net Medicare Outlays, FY1967-FY2007

Net Medicare outlays (after deduction of premiums paid by beneficiaries, primarily for Part B) have also increased significantly since the beginning of the program. The average annual rate of growth has, however, declined in recent years. Over the FY1980-FY1990 period, the average annual rate of growth in *net outlays* was 11.8%; this rate declined to 10.0% for the FY1990-FY1996 period.

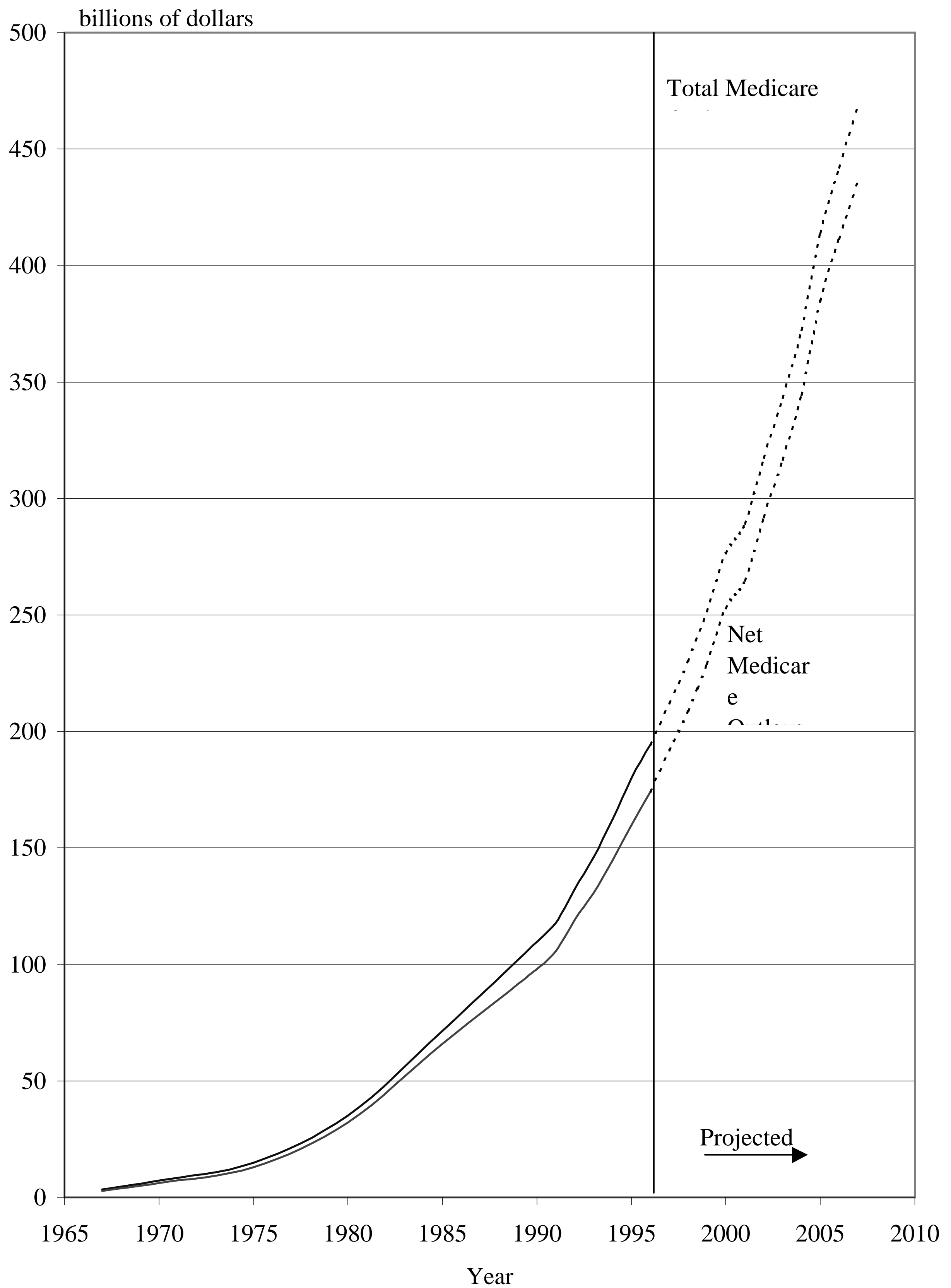
CBO projects that net Medicare outlays will increase from $174.2 billion in FY 1996 to $436.4 billion in FY2007, for an average annual growth rate of 8.7%.

TABLE 3.2.
Total and Net Medicare Outlays, FY1967-FY2007
(in billions)

Fiscal Year	Total Medicare Outlays	Medicare Premium Offset	Net Medicare Outlays
1967	$4.4	$-0.65	$2.7
1970	7.1	-0.94	6.2
1975	14.8	-1.9	12.9
1980	35.0	-2.9	32.1
1985	71.4	-5.6	65.8
1990	109.7	-11.6	98.1
1995	180.1	-20.2	159.9
1996	194.3	-20.1	174.2
1997	212.0	-20.2	191.8
1998	230.0	-21.4	208.6
1999	251.4	-22.5	228.9
2000	276.3	-23.4	252.9
2001	289.2	-24.5	264.7
2002	317.4	-25.6	291.8
2003	343.2	-26.7	316.5
2004	372.3	-28.0	344.3
2005	414.0	-29.3	384.7
2006	442.0	-30.7	411.3
2007	468.7	-32.3	436.4

NOTE: Totals may not add due to rounding. Table prepared by CRS.

Figure 3.2. Total and Net Medicare Outlays, FY1967-FY2007



Source: Figure prepared by CRS based on House Ways and Means, *1996 Green Book* .

Figure 3.3.
Total and Net Medicare Outlays in 1995 Constant Dollars FY1967-FY1996

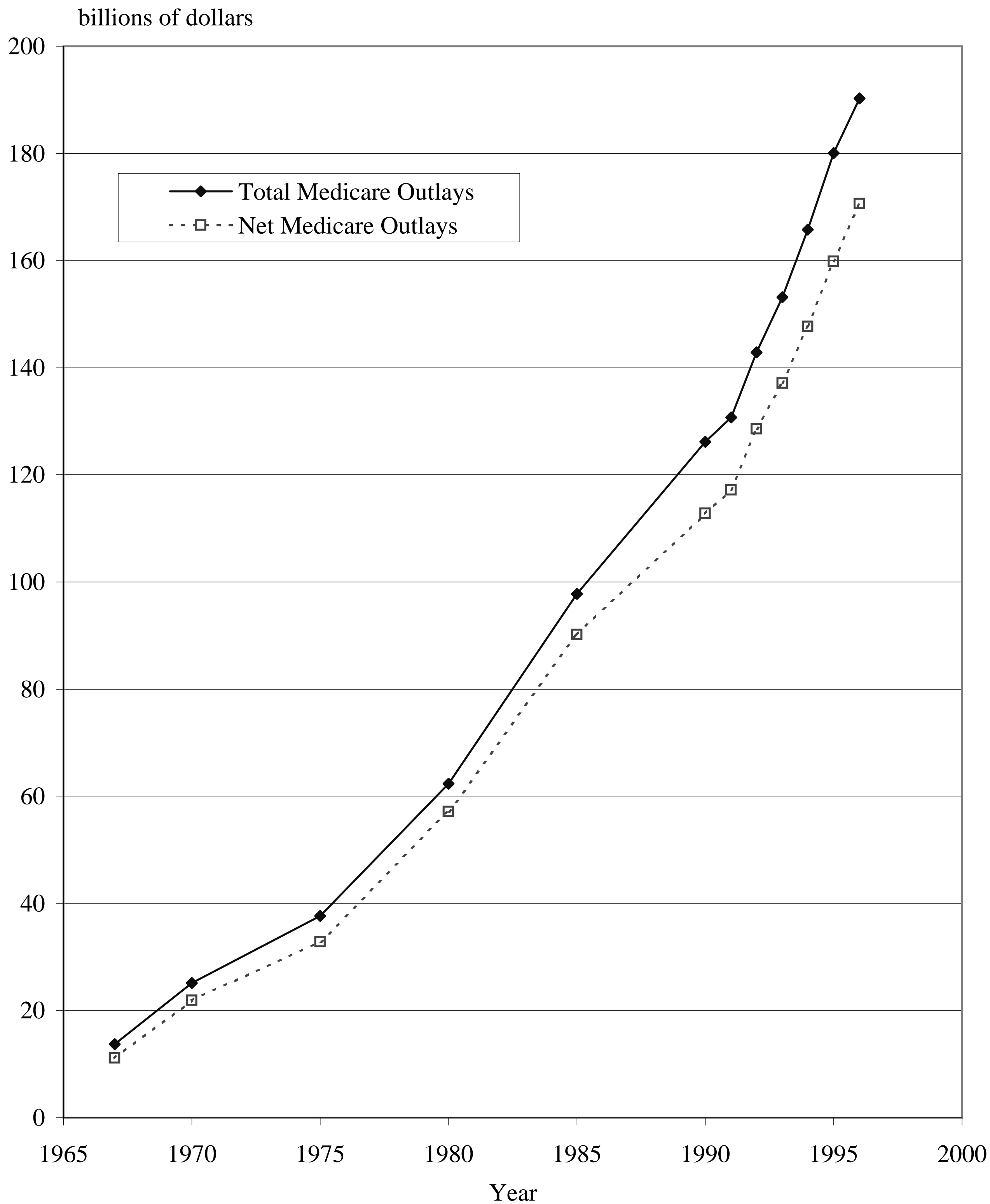
"Real" spending over time is measured in constant, in this case 1995, dollars. Total real Medicare spending increased significantly since the program began. Real spending tripled over the FY1980 to FY1996 period. Over this 16-year period, real total spending (measured in 1995 constant dollars) increased from $62.4 billion to $190.3 billion. This represents an average annual rate of growth of 7.2%. Over the same period, real net Medicare spending increased from $57.1 billion to $170.6 billion. This represents an average annual rate of increase of 7.1%.

TABLE 3.3.
Total and Net Medicare Outlays in 1995 Constant Dollars
FY1967-FY1996
(in billions)

Fiscal Year	Total Medicare Outlays	Medicare Premium Offset	Net Medicare Outlays
1967	$13.8	-$2.6	$11.1
1970	25.2	-3.3	21.9
1975	37.7	-4.9	32.8
1980	62.4	-5.2	57.1
1985	97.8	-7.6	90.2
1990	126.2	-13.3	112.8
1991	130.7	-13.5	117.2
1992	142.8	-14.3	128.5
1993	153.2	-16.1	137.1
1994	165.7	-18.1	147.6
1995	180.1	-20.2	159.9
1996	190.3	-19.7	170.6

NOTE: Table prepared by CRS.

Figure 3.3. Total and Net Medicare Outlays in 1995 Constant Dollars, FY1967-FY1996



Source: Figure prepared by CRS based on House Ways and Means, 1996 Green Book. Constant dollars based on chain-type price index for GDP, Table B-3, Economic Report of the President, Dept of Commerce, BEA.

Figure 3.4.
Age Distribution of Medicare Beneficiaries, 1996

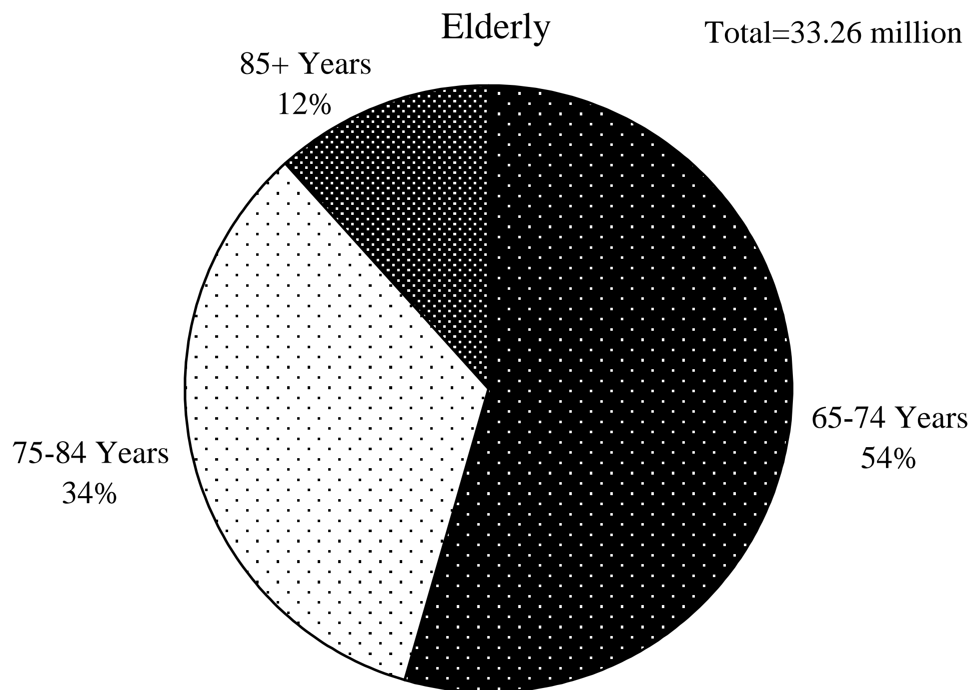
In 1996, 37.8 million persons were enrolled in Medicare. The vast majority of enrollees -- 33.3 million -- were aged. An additional 4.6 million, or 12.1% of the total, were disabled. Over half of the elderly (54%) were under age 75; one-third (34%) were between ages 75 and 84; and the remaining 12% were 85 and over.

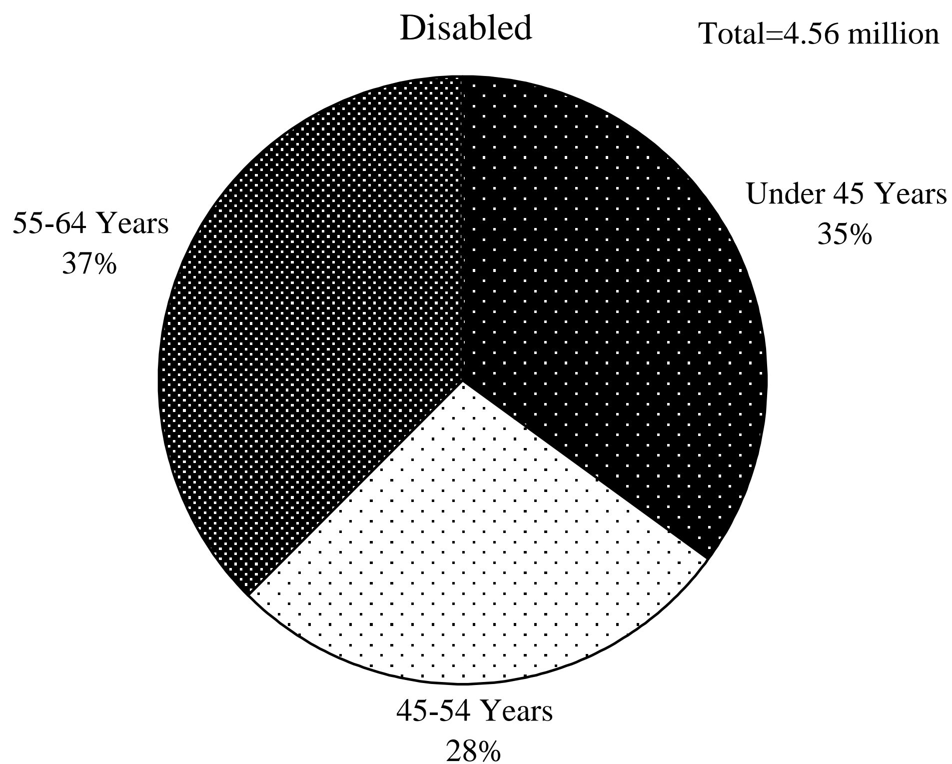
TABLE 3.4.
Age Distribution Medicare of Beneficiaries
1996

	Beneficiaries (in thousands)
Elderly	33,264
65-74 years	18,104
75-84 years	11,255
85+ years	3,905
Disabled	4,565
Under 45 years	1,592
45-54 years	1,266
55-64 years	1,707
All Beneficiaries	37,829

NOTE: Table prepared by CRS.

Figure 3.4. Age Distribution of Medicare Beneficiaries, 1996



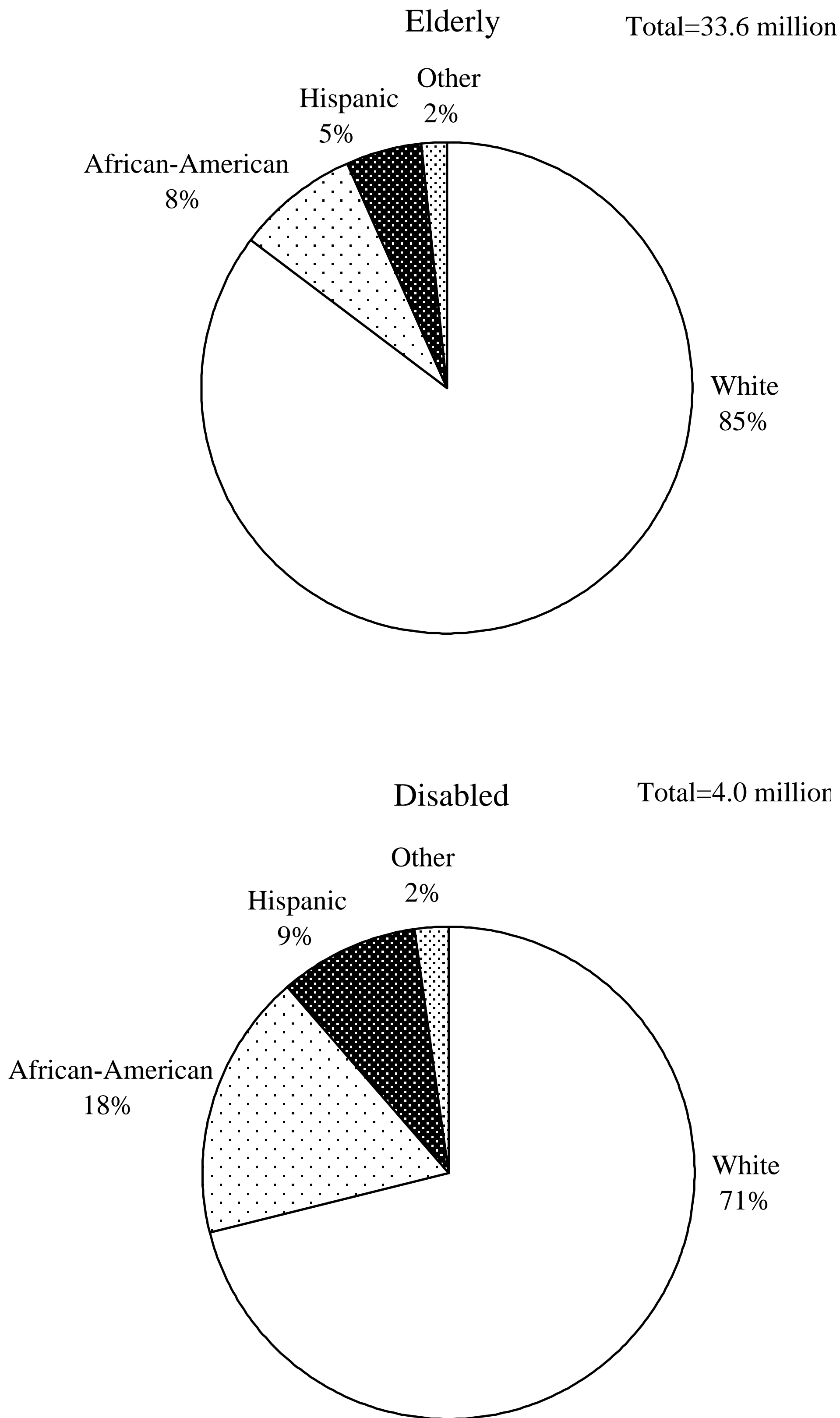


Source: Figure prepared by CRS based on HCFA, *1996 HCFA Statistics.*

Figure 3.5.
Race/Ethnicity Distribution of Medicare Beneficiaries, 1993

The great majority of Medicare beneficiaries are white. Eighty-five percent of the elderly and 71% of the disabled are white. African Americans and Hispanics constitute a larger percentage of the disabled than they do of the elderly population.

Figure 3.5. Race/Ethnicity Distribution of Medicare Beneficiaries, 1993



Source: Figure prepared by CRS based on HCFA, *Profiles of Medicare.*

Figure 3.6.
Medicare Enrollment, 1966-1996

Medicare enrollment grew from 19.1 million persons in 1966 to an estimated 37.8 million persons in 1996. The elderly Medicare population grew from 19.1 million to 33.3 million over the period.

The program began covering the disabled in 1973. The disabled population grew from 2.2 million in 1975 to 4.6 million in 1996.

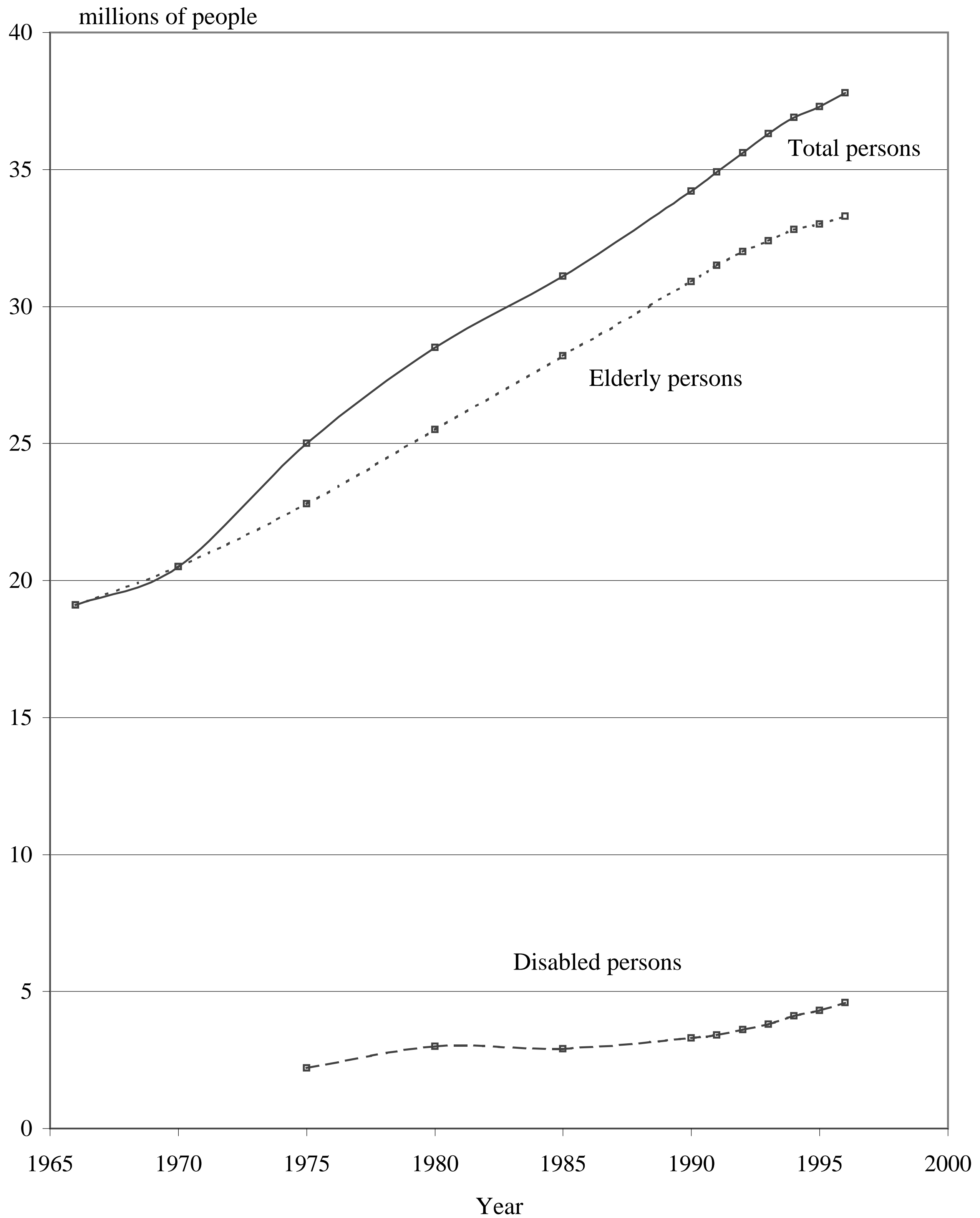
Total Medicare enrollment increased at an average annual rate of 1.8% over the FY1980-FY90 period and 1.7% over the FY1990-FY1996 period. Elderly enrollment increased at an average annual rate of 1.9% for the FY1980-FY1990 period and 1.3% for the FY1990-FY1996 period. Very different trends were recorded for the disabled. While the average annual enrollment rate for the disabled was only 1% for the FY1980-FY1990 period, it climbed to 5.7% for the FY1990-FY1996 period.

TABLE 3.6.
Medicare Enrollment, 1966-1996
(in millions)

Year	Total Persons	Elderly Persons	Disabled Persons
1966	19.1	19.1	--
1970	20.5	20.5	--
1975	25.0	22.8	2.2
1980	28.5	25.5	3.0
1985	31.1	28.2	2.9
1990	34.2	30.9	3.3
1991	34.9	31.5	3.4
1992	35.6	32.0	3.6
1993	36.3	32.4	3.8
1994	36.9	32.8	4.1
1995	37.3	33.0	4.3
1996	37.8	33.3	4.6

NOTE: Medicare coverage was extended to the disabled beginning in 1973. Table prepared by CRS.

Figure 3.6. Medicare Enrollment, 1966-1996



Source: Figure prepared by CRS based on *1996 HCFA Statistics* .

NOTE: Medicare coverage was extended to the disabled in 1973.

Figure 3.7.
Medicare Enrollment: Elderly, Disabled and ESRD
1966-2015

Medicare enrollment is expected to continue to grow. By 2015, the elderly population will have increased to 43.7 million. This projected increase reflects both the fact that the first group of the baby boom population will have reached age 65 as well as the fact that the elderly population is living longer.

The disabled population, including end-stage renal disease (ESRD) beneficiaries, is also expected to grow. It is estimated that this population will grow from 4.7 million in 1996 to 8.3 million in 2015.

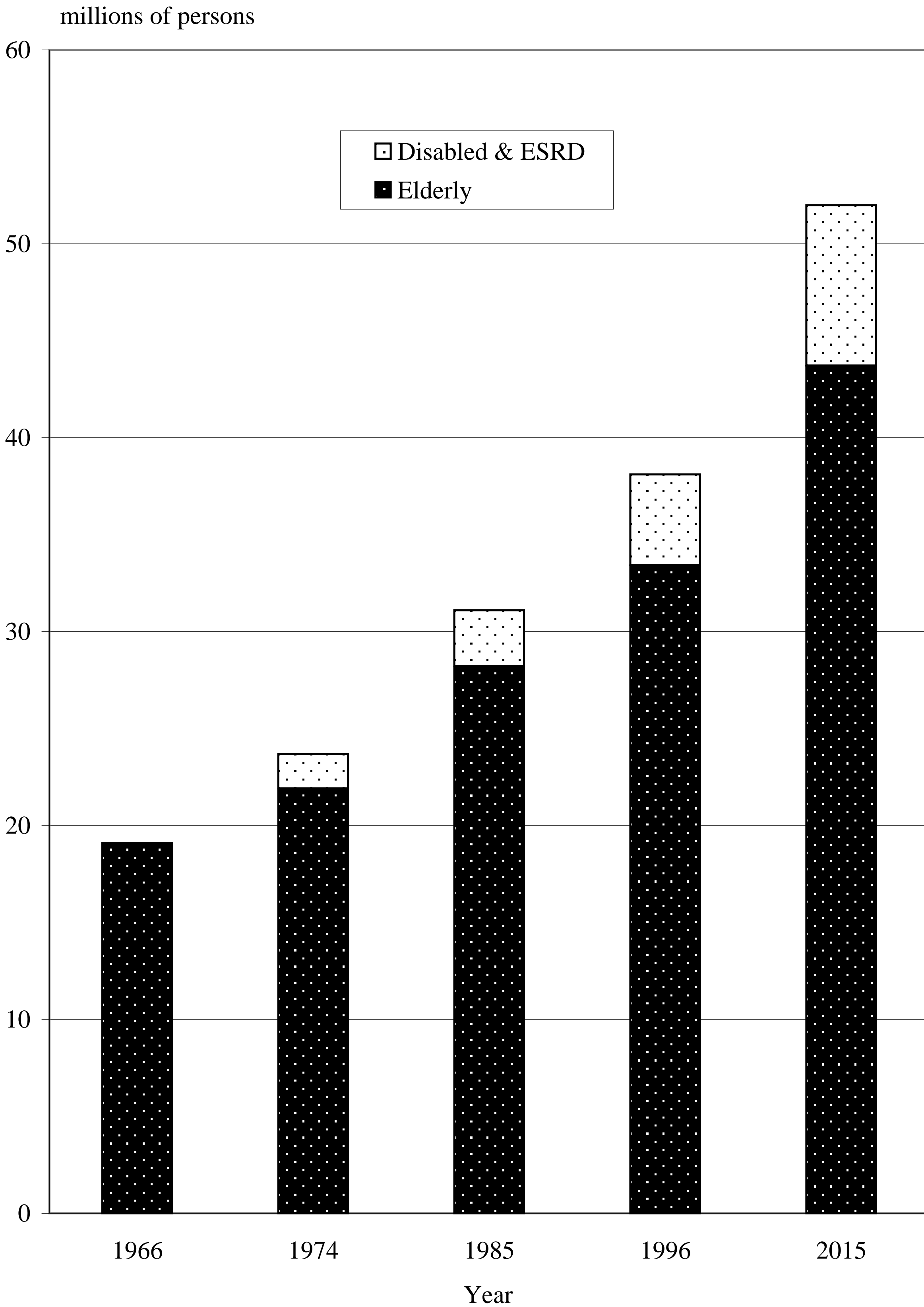
Over the 1996-2015 period, the elderly population is expected to grow by 31%, while the disabled population is expected to increase by 77%.

TABLE 3.7.
Medicare Enrollment:
Elderly, Disabled and ESRD
1966-2015
(in millions)

Year	Elderly	Disabled and ESRD	Total
1966	19.1	--	19.1
1974	21.9	1.8	23.7
1985	28.2	2.9	31.1
1996	33.4	4.7	38.1
2015	43.7	8.3	52.0

NOTE: Table prepared by CRS.

Figure 3.7. Medicare Enrollment: Elderly, Disabled and ESRD, 1966-2015



Source: Figure prepared by CRS based on HCFA, *Profiles of Medicare* , 1996.

Figure 3.8.
The Aging of the U.S. Population, 1960-2030

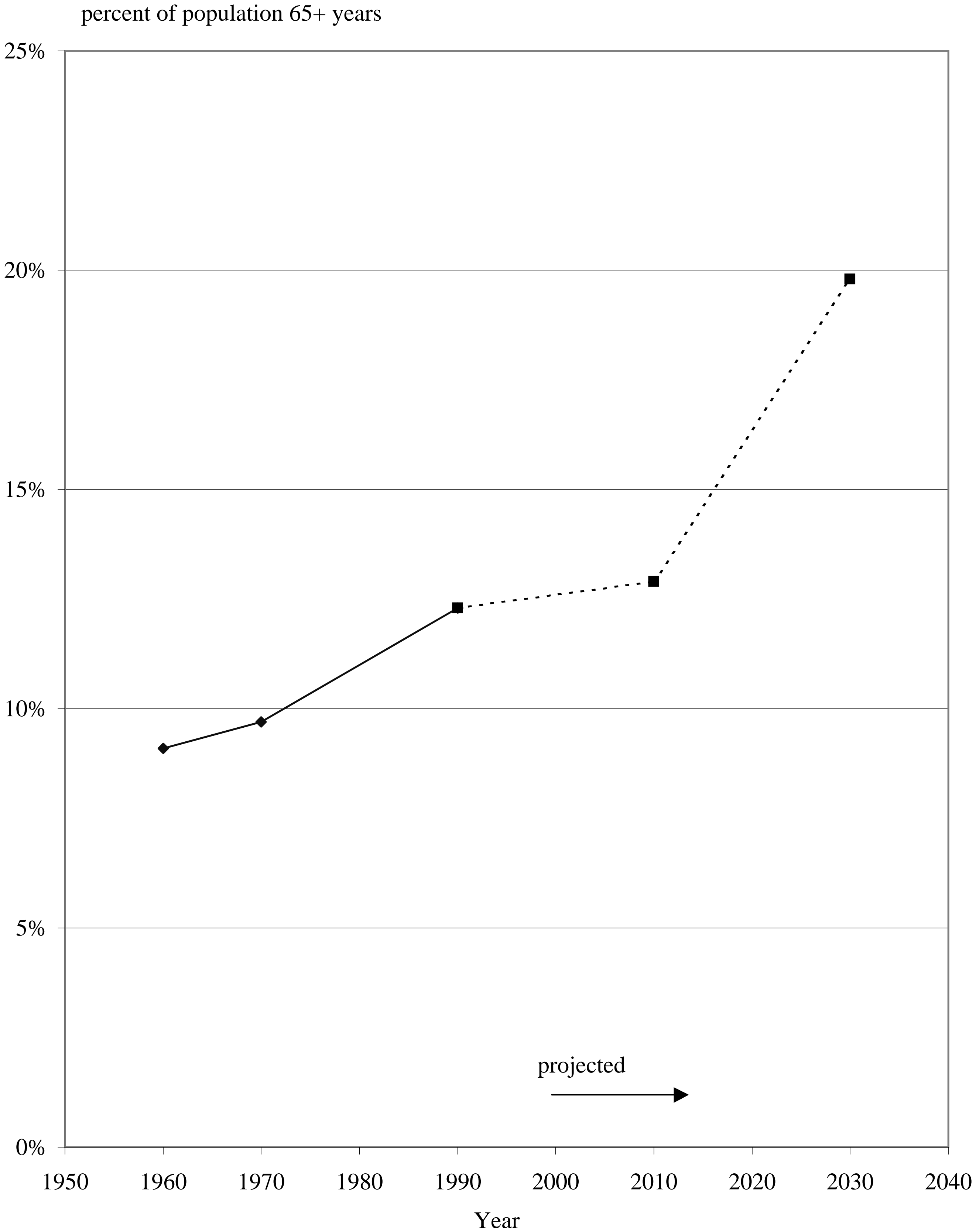
The percentage of the U.S. population over age 65 is growing. In 1960, 9.1% of the population was in this age group. This proportion is expected to double by 2030.

TABLE 3.8.
The Aging of the U.S. Population, 1960-2030

Year	Percent of Population 65+ Years
1960	9.1
1970	9.7
1990	12.3
2010	12.9
2030	19.8

NOTE: Table prepared by CRS.

Figure 3.8. The Aging of the U.S. Population, 1960-2030



Source: Figure prepared by CRS based on HCFA, *Profiles of Medicare, 1996* .

Figure 3.9.
Income Distribution of Elderly and Disabled Medicare Beneficiaries, 1993

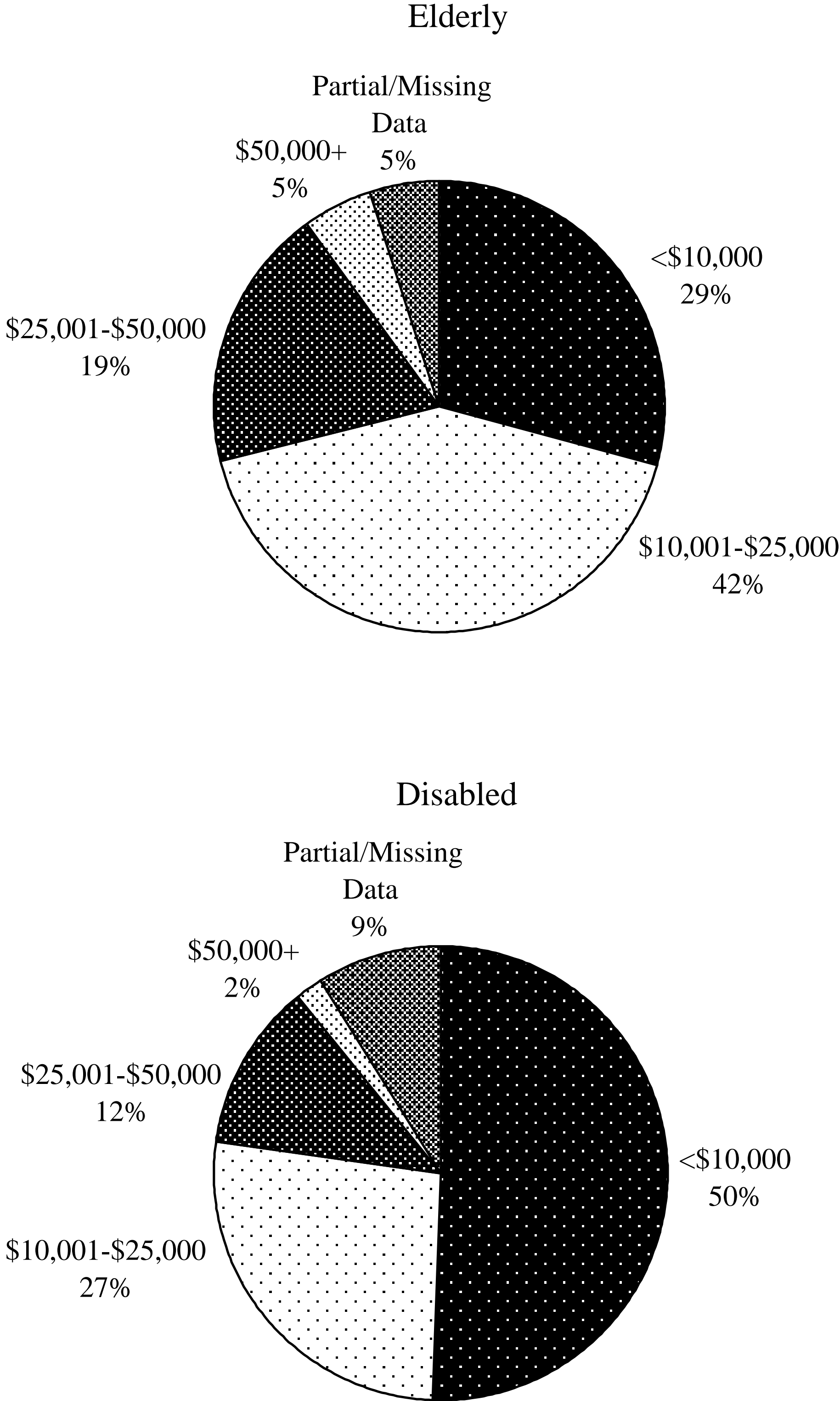
Over 70% of elderly Medicare beneficiaries reported incomes of less than $25,000 in 1993; close to 30% reported incomes of less than $10,000. The disabled generally reported even lower incomes, with over one-half reporting incomes under $10,000, and more than three-quarters reporting incomes under $25,000.

TABLE 3.9.
Income Distribution of Elderly and Disabled Medicare Beneficiaries, 1993
(in percent)

Income	Elderly	Disabled
<$10,000	29	51
$10,001-$25,000	42	27
$25,001-$50,000	19	12
$50,000+	5	2
Partial/missing data	5	9

NOTE: Totals may not add due to rounding. Table prepared by CRS.

Figure 3.9. Income Distribution of Elderly and Disabled Medicare Beneficiaries, 1993



Source: Figure prepared by CRS based on HCFA, *Profiles of Medicare, 1996* .

Figure 3.10.
Percent of Poor Persons in the U.S. Population
1959-1994

From 1959-1994, the percentage of the U.S. population below the poverty line declined from 22.4 to 14.5. An even more dramatic decline was recorded in the poverty rate for the elderly, dropping from 35.2% to 11.7%. A less dramatic decline was recorded for children; the percentage for this group declined from 26.9 to 21.6.

While the rates for both the elderly and children were higher than that for the general population in 1959, the rate for the elderly had dropped below that of the general population by 1994. Conversely, the rate for children in 1994 was considerably above that for the general population and substantially larger than that for the elderly.

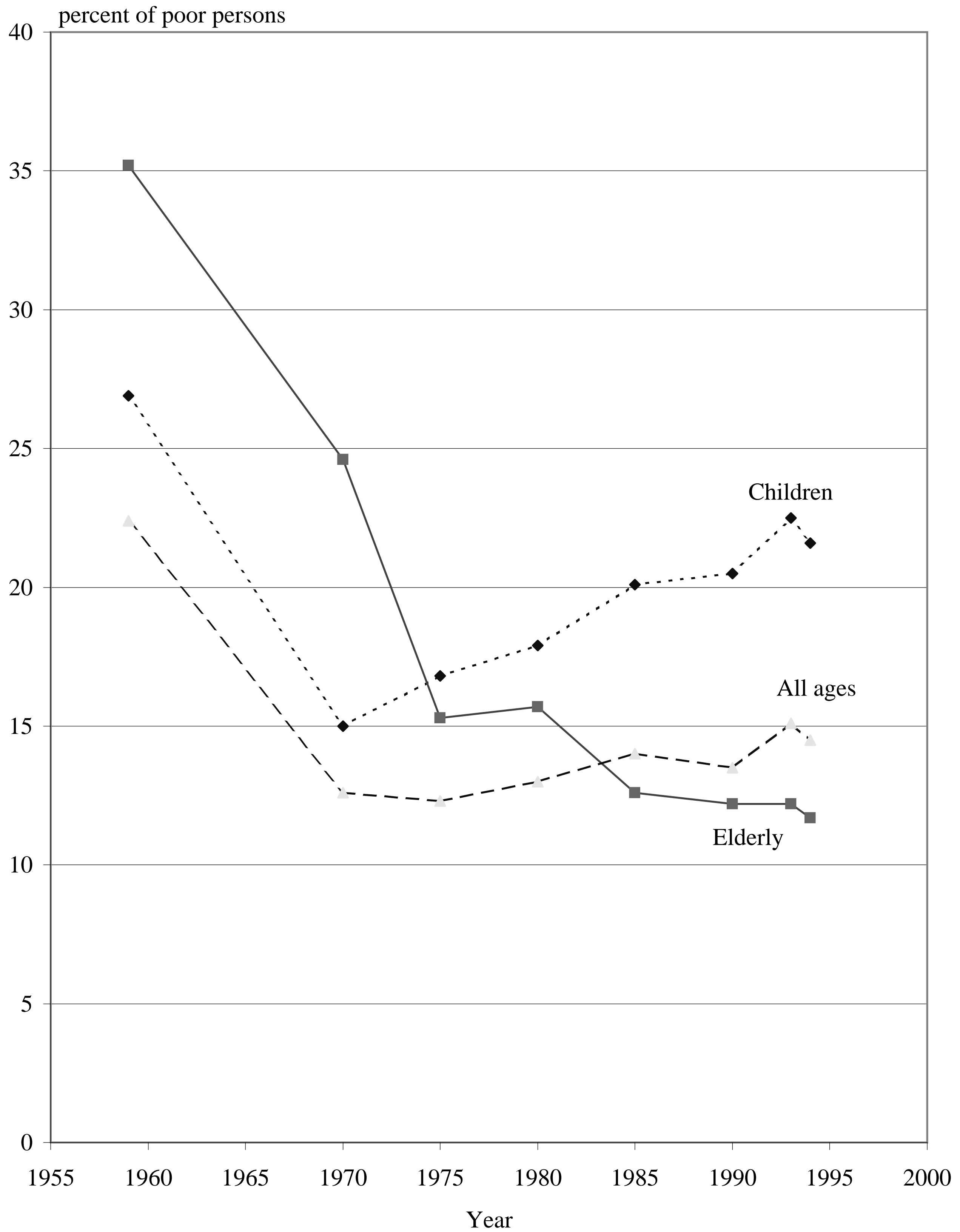
The poverty rate for the elderly has improved over the years, largely as a result of Social Security and a maturing pension system. The aged tend to be more immune to the effects of recession than others.

TABLE 3.10.
Percent of Poor Persons in the U.S. Population
1959-1994

Year	Children	Elderly	All Ages
1959	26.9	35.2	22.4
1970	15.0	24.6	12.6
1975	16.8	15.3	12.3
1980	17.9	15.7	13.0
1985	20.1	12.6	14.0
1990	20.5	12.2	13.5
1993	22.5	12.2	15.1
1994	21.6	11.7	14.5

NOTE: Table prepared by CRS.

Figure 3.10. Percent of Poor Persons in the U.S. Population, 1959-1994



Source: Prepared by CRS based on *Social Security Bulletin, Annual Statistical Supplement*, 1996.

Figure 3.11.
Distribution of Medicare Benefit Payments by Service Category, FY1995

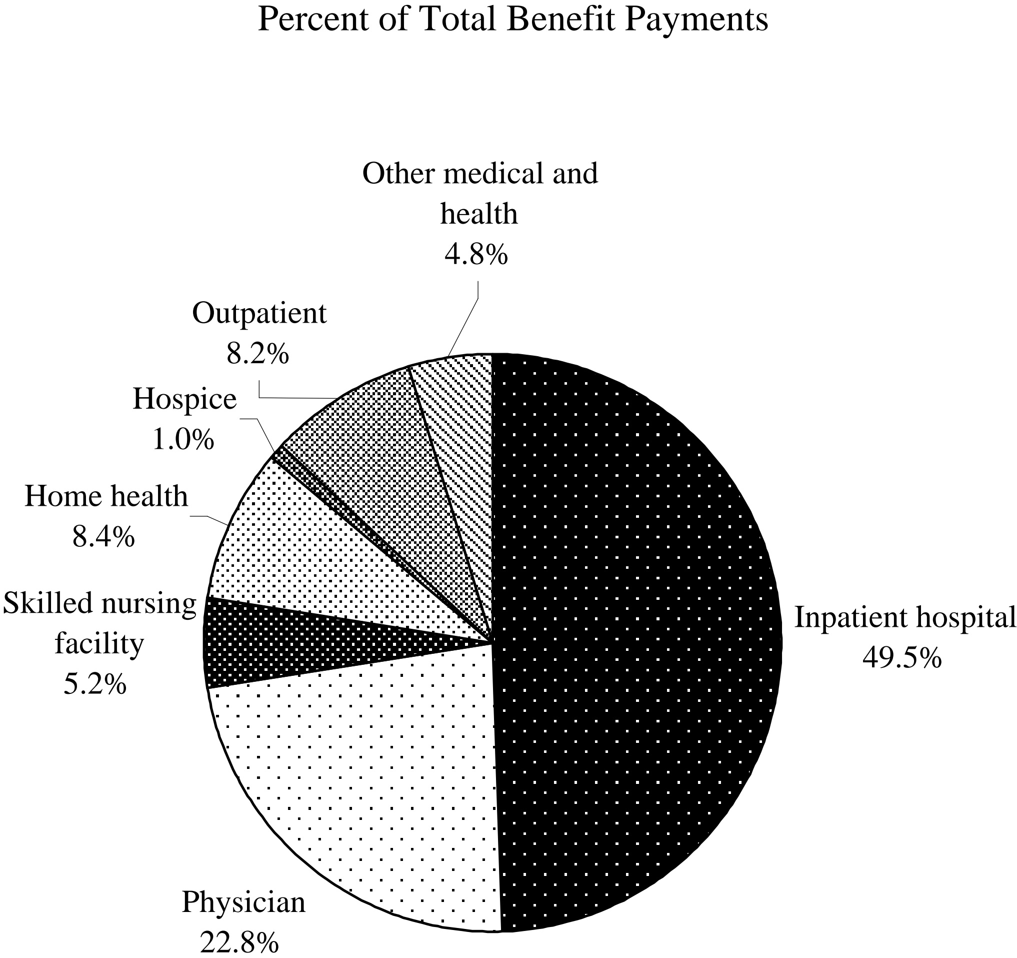
Close to 73% of Medicare benefit payments in FY1995 were for inpatient hospital services and physicians' services. Services provided by skilled nursing facilities and home health agencies accounted for over 13%, while outpatient hospital services accounted for 8% of Medicare benefit payments.

TABLE 3.11.
Distribution of Medicare Benefit Payments by Service Category, FY1995

Service Category	Percent of Total Benefit Payments	Benefit Payments (in billions)
Inpatient hospital	49.5	$87.5
Physician and supplies	22.8	40.4
Skilled nursing facility	5.2	9.1
Home health	8.4	14.9
Hospice	1.0	1.9
Outpatient	8.2	14.6
Other medical and health	4.8	8.5
Total	100	$176.9

NOTE: Table prepared by CRS.

Figure 3.11. Distribution of Medicare Benefit Payments by Service Category, FY1995



Source: Figure prepared by CRS based on House Ways and Means, *1996 Green Book.*

Figure 3.12.
Trends in Distribution of Total Medicare Benefit Payments for Selected Services, FY1980 and FY1995

Payments for inpatient hospital services have represented a declining proportion of total Medicare benefit payments since 1980. The percentage of total payments attributable to skilled nursing facility and home health benefits has increased over the period, while that for physicians services has remained relatively constant.

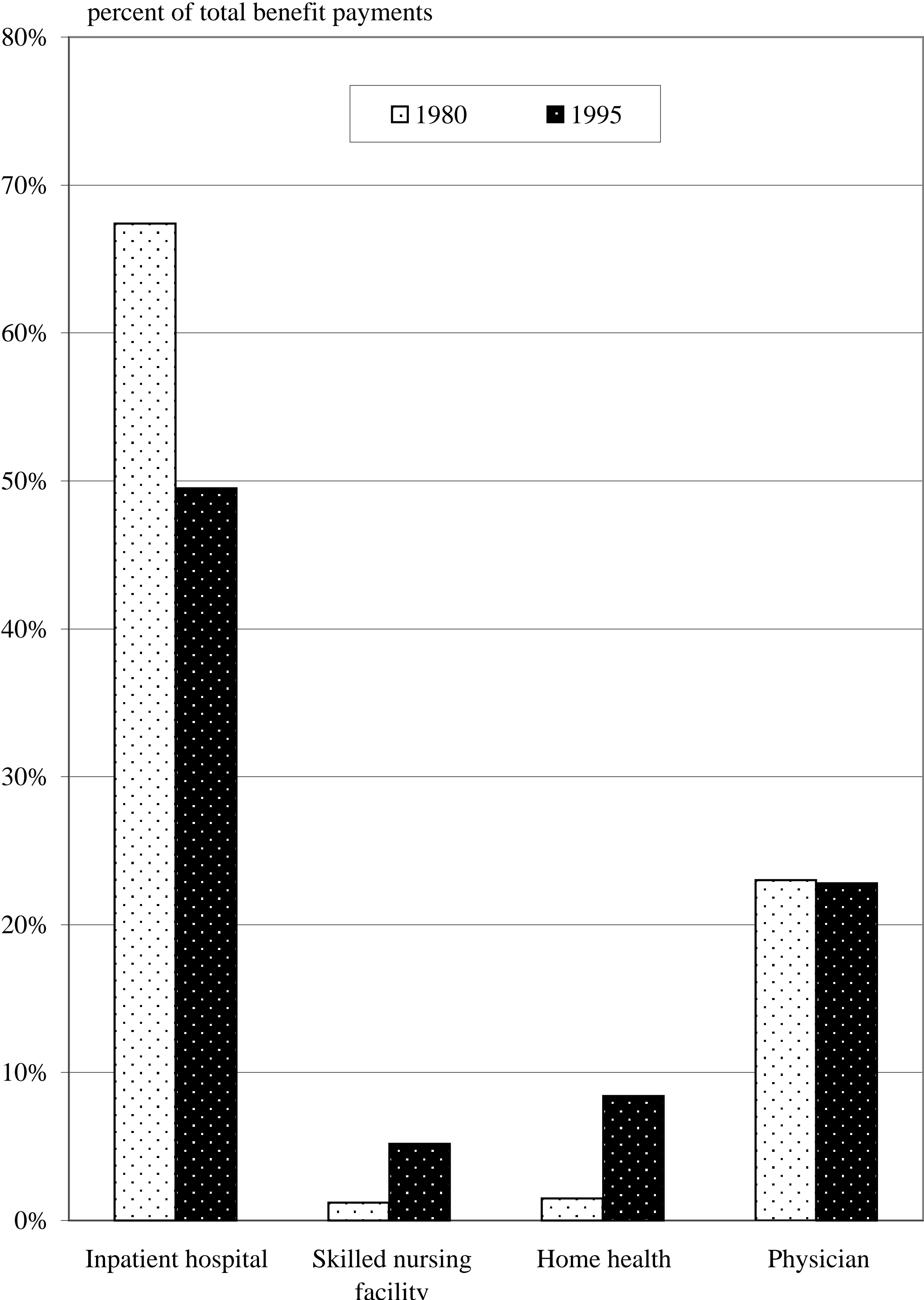
These trends reflect the fact that the growth rates in spending for hospital and physicians services have slowed significantly in response to the introduction of new payment systems (see figure 3.13). In FY1984, Medicare began paying for hospital services under the prospective payment system. In 1992, Medicare began to pay for physicians services on the basis of a fee schedule. In contrast, skilled nursing facility services and home health services continue to be paid on a reasonable cost basis; payments for these services continue to rise at a much faster rate than do those for hospital and physicians services.

TABLE 3.12.
Trends in Distribution of Total Medicare Payments for Selected Services FY1980 and FY1995 (in percent)

Selected Services	1980	1995
Inpatient hospital	67.4	49.5
Physician	23.0	22.8
Skilled nursing facility	1.2	5.2
Home health	1.5	8.4

NOTE: Table prepared by CRS.

Figure 3.12 Trends in Distribution of Total Medicare Payments for Selected Services, FY1980 and FY1995



Source: Figure prepared by CRS based on House Ways and Means, *1996 Green Book.*

Figure 3.13.
Five-Year Average Annual Medicare Growth Rates Selected Years, FY1980-FY1995

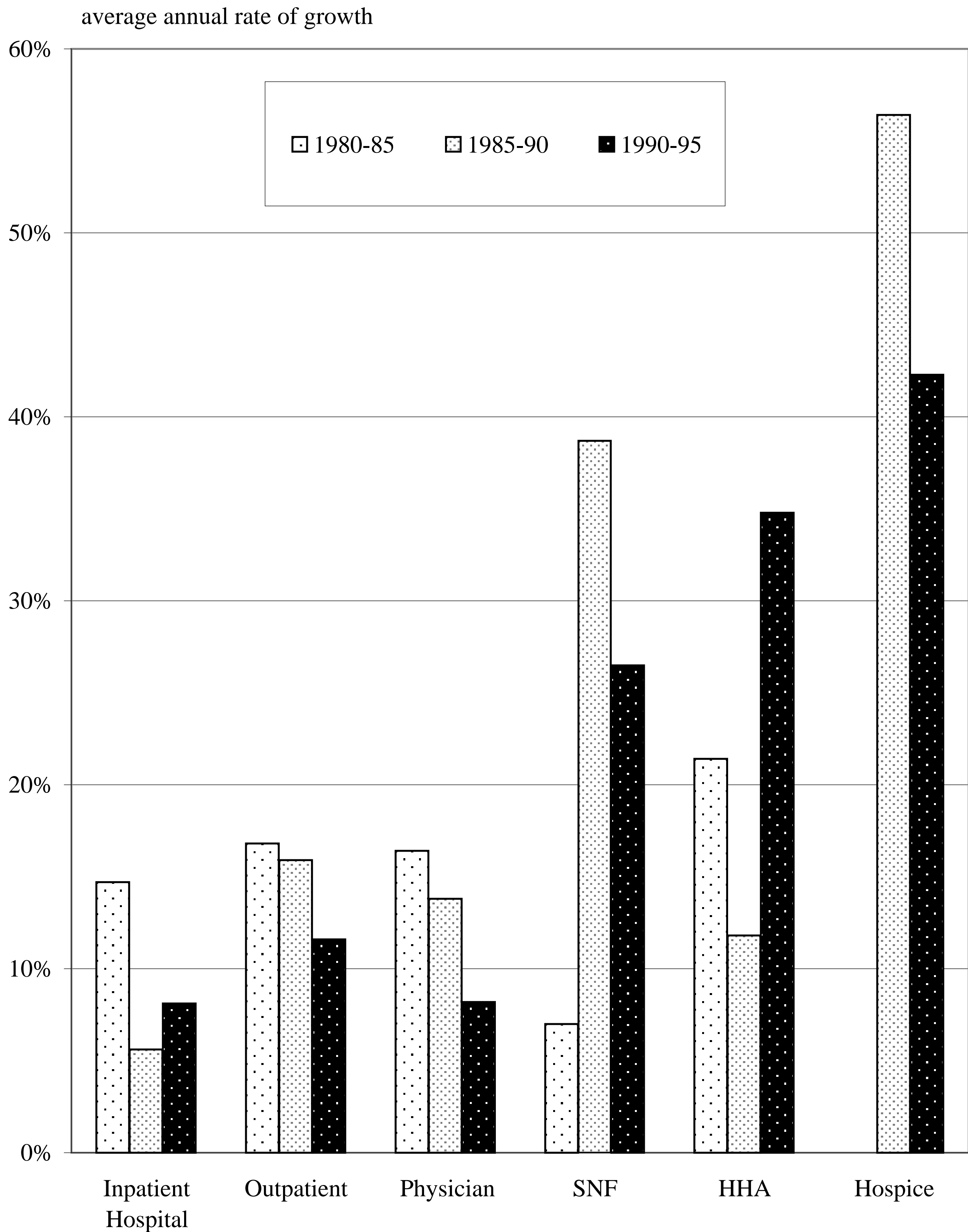
There is wide variation in the average annual growth rates for various service categories. In recent years, the expenditures for skilled nursing facility (SNF) services, home health services, and hospice care have been growing considerably faster than have expenditures for inpatient hospital, outpatient, and physician services.

TABLE 3.13.
Five-Year Average Annual Medicare Growth Rates, Selected Years, FY1980-FY1995
(in percent)

	1980-85	1985-90	1990-95
Inpatient hospital	14.7	5.6	8.1
Outpatient	16.8	15.9	11.6
Physician	16.4	13.8	8.2
Skilled nursing facility	7.0	38.7	26.5
Home health	21.4	11.8	34.8
Hospice	n.a.	56.4	42.3

NOTE: Medicare began covering hospice services in 1983. Table prepared by CRS.

Figure 3.13. Five-Year Average Annual Medicare Growth Rates, Selected Years, FY1980-FY1995



Source: Figure prepared by CRS based on HCFA, *Profiles of Medicare, 1996.*

Figure 3.14.
Medicare Short-Stay Hospital Utilization
Selected Fiscal Years, 1985-1995

Since FY1934 Medicare has paid for acute, or short-stay, hospital care on the basis of a prospective payment system (PPS). Under Medicare's PPS for inpatient care, hospital payment amounts are established in advance of the provision of services on the basis of a patient's diagnosis. The system's fixed prices are determined using a classification system of 487 diagnosis-related groups (DRGs). Each Medicare inpatient case is assigned to one of the 487 DRGs based on the patient's medical condition and diagnosis at admission.

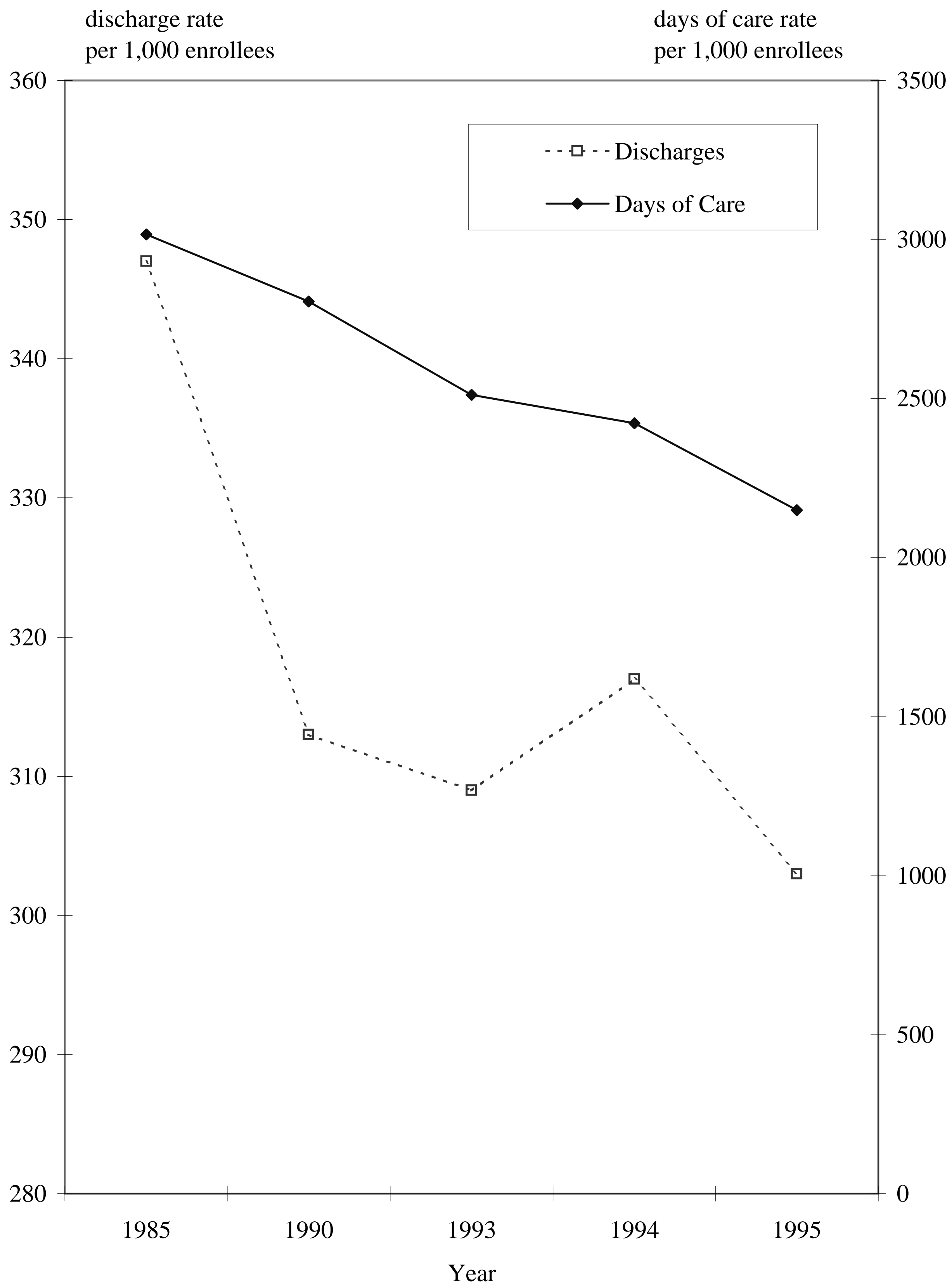
While discharge rates per 1,000 Medicare enrollees remained fairly constant during the 1990s, days of care and average length of stay have decreased significantly over the same period. Between 1990 and 1995, total days of care dropped from 94 million to 79 million, a decrease of almost 19%. Average length of stay also declined from 9.0 days in 1990 to 7.1 days in 1995, a decrease of almost 27%.

TABLE 3.14.
Medicare Short-Stay Hospital Utilization, Selected Fiscal Years 1985-1995

	1985	1990	1993	1994	1995
Discharges					
Total in millions	10.5	10.5	11.1	11.5	11.1
Rate per 1,000 enrollees	347	313	309	317	303
Days of care					
Total, in millions	92	94	91	88	79
Rate per 1,000 enrollees	3,016	2,805	2,512	2,422	2,149
Average length of stay					
All short-stay (in days)	8.7	9.0	8.2	7.6	7.1

NOTE: Table prepared by CRS.

Figure 3.14. Medicare Short-Stay Hospital Utilization, Selected Fiscal Years, 1985-1996



Source: Figure prepared by CRS based on *1996 HCFA Data Compendium* .

Figure 3.15.
Medicare Funding for Graduate Medical Education
1990-1996

Medicare recognizes as reasonable the extra costs of graduate medical education (GME), or medical residency training activities incurred by teaching hospitals. The Medicare program pays for its share of GME costs through two payment mechanisms: the indirect medical education (IME) adjustment, and the direct graduate medical education (direct GME) payment. The IME adjustment is designed to compensate teaching hospitals for their relatively higher costs attributable to the involvement of residents in patient care and the severity of illness of patients requiring specialized services available only in teaching hospitals. The direct GME payment is designed to reimburse teaching hospitals for Medicare's share of the costs of salaries and fringe benefits paid to residents, interns, and teaching faculty, and certain overhead costs relating to teaching activities.

IME payments[1] rose from $2.91 billion in FY1990 to $5.55 billion in FY1996. Total direct GME payments[2] increased from $1.76 billion in FY1990 to $2.86 billion in FY1996.

TABLE 3.15.
Medicare Funding for Graduate Medical Education, 1990-1996
($ in billions)

Year	IME	Direct GME	Total GME
1990	2.91	1.76	4.67
1991	3.21	1.89	5.10
1992	3.67	2.36	6.03
1993	4.09	2.55	6.64
1994	4.50	2.61	7.11
1995	5.10	2.74	7.84
1996	5.55	2.86	8.41

NOTE: Table prepared by CRS.

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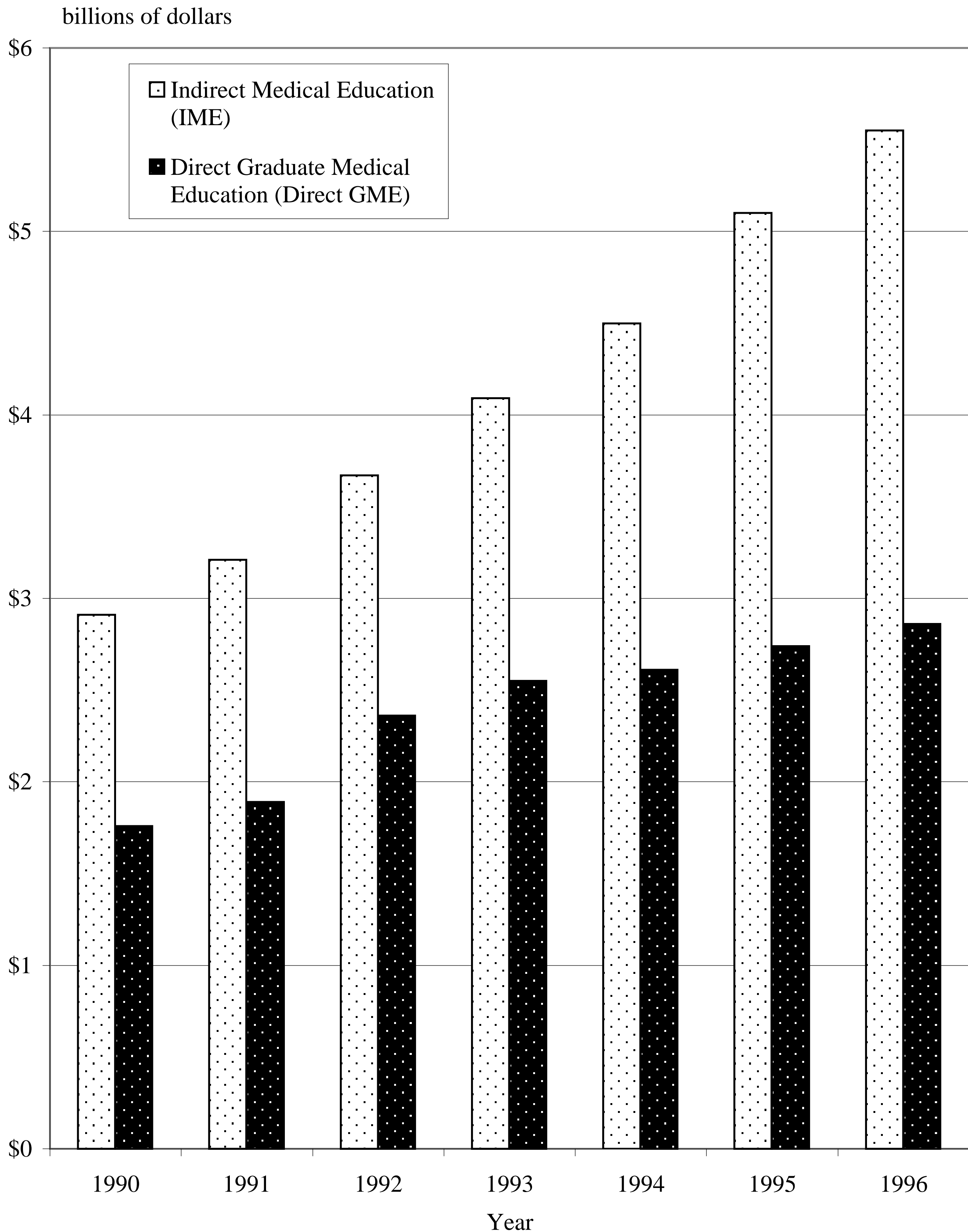
[1] IME amounts include payments for capital costs and payments to managed care plans.

[2] Direct GME amounts include payments for certain hospital-operated nursing and allied health professions education and training programs.

Figure 3.15. Trend in Indirect Medical Education (IME) and Direct Graduate Medical Education (Direct GME) Spending for Medicare, 1990-1996



Source: Figure prepared by CRS based on data provided by HCFA, Office of the Actuary.

Figure 3.16.
Trend in Number of Medical Residents[1]
1990-1996

In the rapidly changing health care market, the supply of physicians and the mix of specialties they practice continue to be of concern to policymakers. An oversupply of physicians and an imbalance in specialty mix can contribute to the growth in health care costs. The growth of managed care has also contributed to the concern about whether or not the correct mix of physician specialties are being trained. Generally, there is concern that too many specialist and not enough primary care physicians are being trained.

Medicare currently pays for residency training without regard to specialty.[2] Some argue that because Medicare is the only explicit payer of graduate medical education costs the program should play a larger role in shaping the physician workforce. Many experts argue that the current Medicare payment methodologies provide incentives for hospitals to increase the number of residents and to focus on specialty and subspecialty training of residents instead of on primary care training.

There is some evidence that the market for physicians is changing slightly in response to general health care market forces. The total number of residents continues to increase each year, although the annual growth rate has dropped from 3.7% in 1990-1991 to 1991-1992, to 0.9% during 1994-1995 to 1995-1996.

TABLE 3.16.
Trend in Number of Medical Residents
1990-1996

School Years	Number of Residents	Annual Growth Rates (in percent)
1990-1991	91,766	--
1991-1992	95,130	3.7
1992-1993	98,573	3.6
1993-1994	102,168	3.6
1994-1995	103,640	1.4
1995-1996	104,609	0.9

NOTE: Table prepared by CRS.

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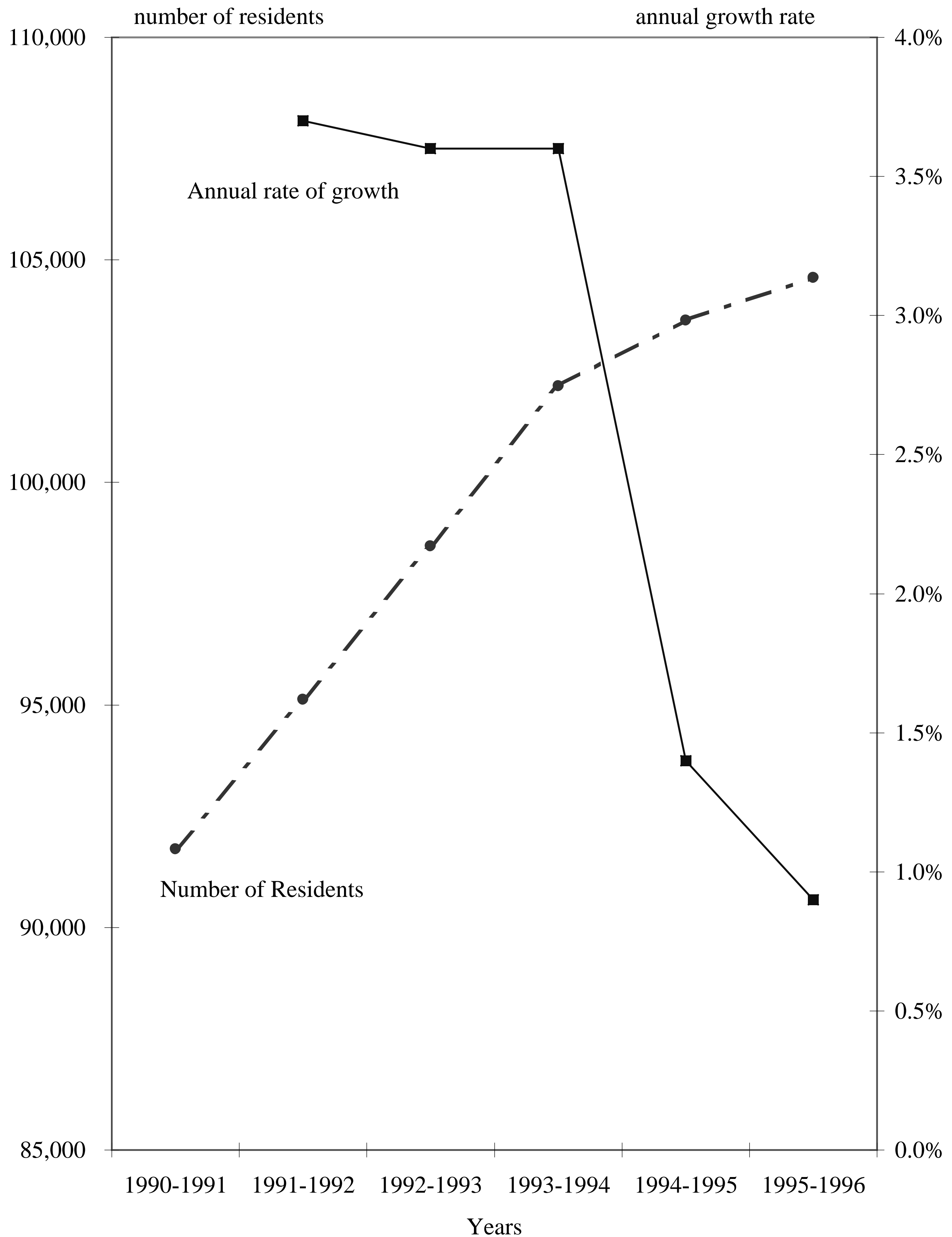
[1]The data presented for medical residents includes residents in allopathic (M.D.) residency programs only.

[2]Medicare pays for its share of the direct cost of GME. For residents in their initial residency period, defined as the minimum number of years required to become board certified and not to exceed 5 years, Medicare counts each full-time-equivalent (FTE) resident as 1.0 FTE. For residents beyond their initial residency period, Medicare counts each resident as 0.5 FTE. There is a special exception for residents in accredited geriatrics training programs that allows these resident to be counted as 1.0 FTE for an additional 2 years.

According to HCFA cost reports for FY1993, approximately 77,585 FTE residents were paid for under Medicare's direct GME payment.

Figure 3.16. Trend in Number of Medical Residents, 1990-1996



Source: Figure prepared by CRS based on data provided by the Association of American Medical Colleges.

Figure 3.17.
Selected Primary Care Residents as a Percent of Total Residents, 1990-1991 and 1995-1996

The specialty mix of residents has been an important concern for GME reform. Many experts look to the specialty choices of medical residents as an indication of the changing health care marketplace and how it will affect the future physician workforce. When considering the number of residents training in primary care, it is important to keep in mind that many residents who undergo training in a primary care specialty may go on to subspecialize and may not practice in primary care once their training is completed.

The number of residents in selected[1] primary care specialties grew from 26,093 in 1990-1991, to 37,369 in 1995-1996, a 43% increase. First-year residents in selected primary care specialties also grew from 10,796 in 1990-1991 to 12,196 in 1995-1996, a 13% increase. When compared to the total number of residents, the proportion of residents in primary care specialties grew from 28.4% in 1990-1991 to 35.7% in 1995-1996.

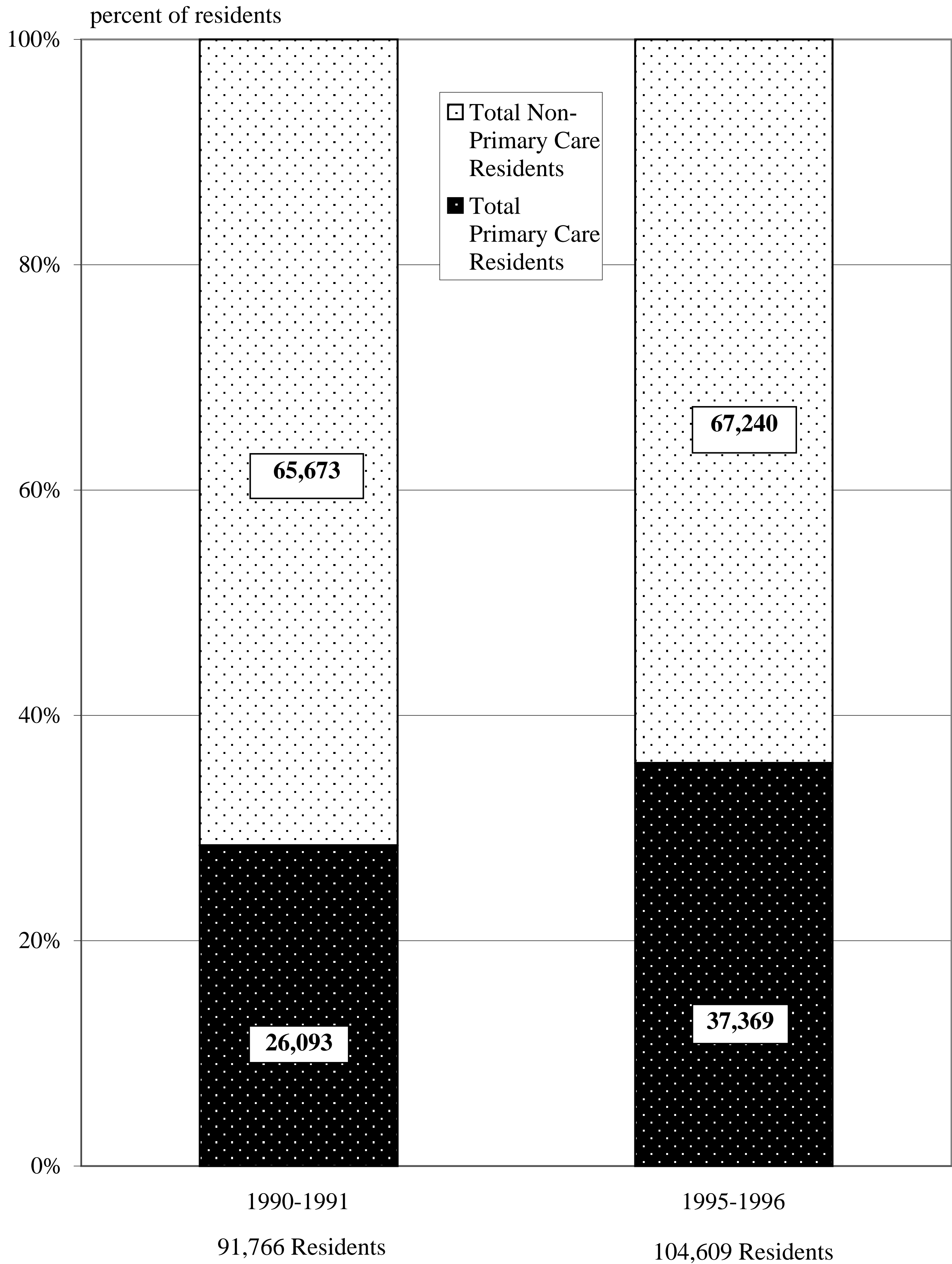
TABLE 3.17.
Selected Primary Care Residents and First-Year Residents
1990-1991 and 1995-1996

Specialty	Primary Care Residents		First-Year Primary Care Residents	
	1990-1991	1995-1996	1990-1991	1995-1996
Family practice	7,183	9,542	2,407	3,231
Family practice -- geriatrics	17	20		
Internal medicine (general)	11,883	19,870	6,070	6,430
Internal medicine -- geriatrics	177	217		
Pediatrics (general)	6,833	7,720	2,319	2,535
Total primary care	26,093	37,369	10,796	12,196

NOTE: Table prepared by CRS.

[1]Selected primary care residency programs include: family practice, family practice -- geriatrics, internal medicine (general), internal medicine -- geriatrics, and pediatrics (general).

Figure 3.17. Selected Primary Care Residents as a Percent of Total Residents, 1990-1991 and 1995-1996



Source: Figure prepared by CRS based on information provided by the Association of American Medical Colleges

Figure 3.18.
Trend in Medicare Payments for Skilled Nursing Facility Care, 1983-1996

Medicare skilled nursing facility (SNF) spending increased dramatically between 1988, when payments were $900 million, and 1989 when payments soared to $3.5 billion. It has increased at an average annual rate of 19% since then, rising to $11.7 billion in 1996.

The initial increase can be traced to two significant changes occurring in the late 1980s. First, HCFA issued new coverage guidelines that became effective in 1988. These guidelines provided SNFs a great deal more information than had previously been available about criteria that must be met for a beneficiary to receive Medicare coverage. A second major, though temporary, change also came in 1988, with the enactment of the Medicare Catastrophic Coverage Act (MCCA). Effective beginning in 1989, this legislation eliminated the SNF benefit's prior hospitalization requirement and made several other changes. The MCCA was repealed in 1989, and the SNF benefits structure assumed its prior form.

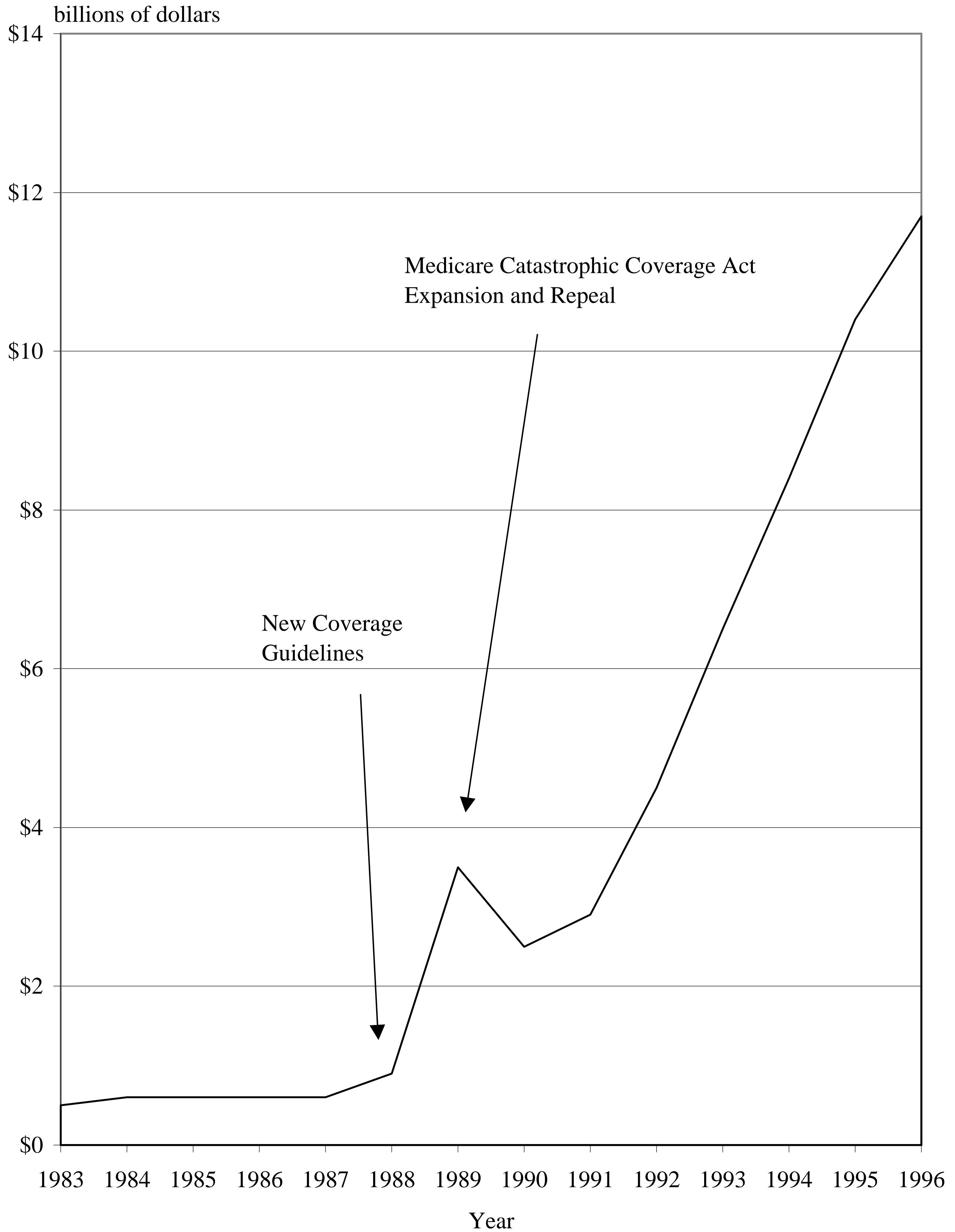
Studies have suggested that the coverage guidelines and the MCCA changes together might have caused a long-run shift in the nursing home industry toward Medicare patients that did not end with the repeal of the MCCA. Between 1989 and 1996, the number of SNFs participating in the program increased from 8,638 to 14,219, or by 65%. In addition, during this same period, an increasing number of persons qualified for SNF care and reimbursements per day of care grew significantly, as explained in the next figure.

TABLE 3.18.
Trend in Medicare Payments for Skilled Nursing Facility Care 1983-1996

Year	Payments (in billions)	Percent Change
1983	$ 0.5	--
1984	0.6	6.9
1985	0.6	2.9
1986	0.6	0.2
1987	0.6	8.8
1988	0.9	47.1
1989	3.5	275.7
1990	2.5	-29.0
1991	2.9	18.4
1992	4.5	55.3
1993	6.5	44.4
1994	8.4	29.2
1995	10.4	23.8
1996	11.7	12.5

NOTE: Total for 1996 is estimated. Rounding in payments may not reflect actual percentage change. Table prepared by CRS.

Figure 3.18. Trend in Medicare Payments for Skilled Nursing Facility (SNF) Care, 1983-1996



Source: Figure prepared by CRS based on data provided by HCFA, Office of the Actuary, and Prospective Payment Assessment Commission Report to Congress, June 1995 and June 1996.

Figure 3.19.
Average Annual Rates of Change for Skilled Nursing Facility Care, by Persons Served, Days Used Per Person Served, and Payment Per Day, 1983-1996

Growth in Medicare skilled nursing facility (SNF) spending can be explained largely by an increasing numbers of persons qualifying for the benefit and increases in reimbursements per day of care. Between 1988 and 1996, persons receiving SNF care increased at an average annual rate of 14.6%, reimbursements per day of covered care increased by 16.3%, and the average number of days per person served increased by 3%.

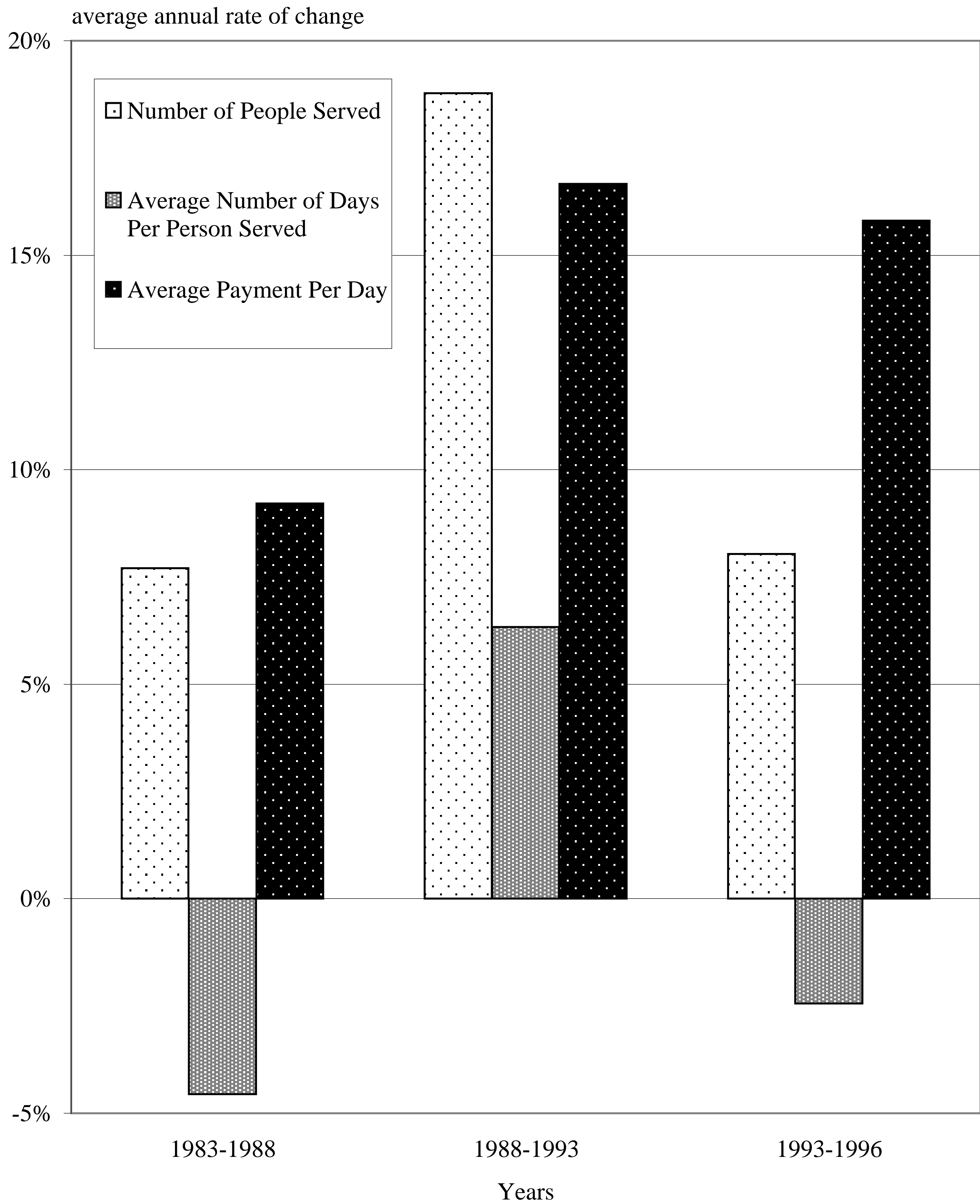
While the growth rate in users, and covered days per person served, has decreased in the period 1993-1996 from the earlier period, 1988-1993, the growth rate for reimbursements per covered day has remained high since 1988. Medicare reimbursement policies explain much of the increase in reimbursements per covered day of care. While routine care costs (nursing, room and board, administrative, and other overhead) are subject to per diem limits, ancillary services (therapies, laboratory services, radiology procedures, supplies and other equipment) are not. In 1990, charges for physical, occupational, speech, and respiratory therapy services were approximately 15% of total Medicare SNF charges. By 1994, these services represented over 30% of charges. Although final payments for therapy and other ancillary services are based on costs rather than charges, these estimates reveal the growth in the relative importance of these services in Medicare program payments for SNF care.

TABLE 3.19.
Average Annual Rates of Change for Skilled Nursing Facility Care, by Persons Served, Days Used Per Person Served, and Payments Per Day, 1983-1996

Year	Number of People Served	Average Number of Days per Person Served	Average Payment per Day (in dollars)
1983	265,000	35.1	$56
1984	299,000	32.2	58
1985	314,000	28.4	65
1986	304,000	26.8	71
1987	293,000	25.4	84
1988	384,000	27.8	87
1989	636,000	46.8	117
1990	638,000	39.5	98
1991	671,000	35.3	123
1992	785,000	36.9	157
1993	908,000	37.8	188
1994	1,068,000	34.7	226
1995	1,110,000	35.1	267
1996	1,145,000	35.1	292

NOTE: Table prepared by CRS.

Figure 3.19. Average Annual Rates of Change for Skilled Nursing Facility Care, by Persons Served, Days Used Per Person Served, and Payment Per Day, 1983-1996



Source: Figure prepared by CRS, based on data provided by HCFA, Office of the Actuary.

Figure 3.20.
Trend in Medicare Payments for Home Health, 1983-1996

Since 1989, Medicare's home health benefit has been the program's fastest growing benefit. Spending increased from $2.6 billion in 1989 to $18.1 billion in 1996, for an average annual rate of growth of 32%.

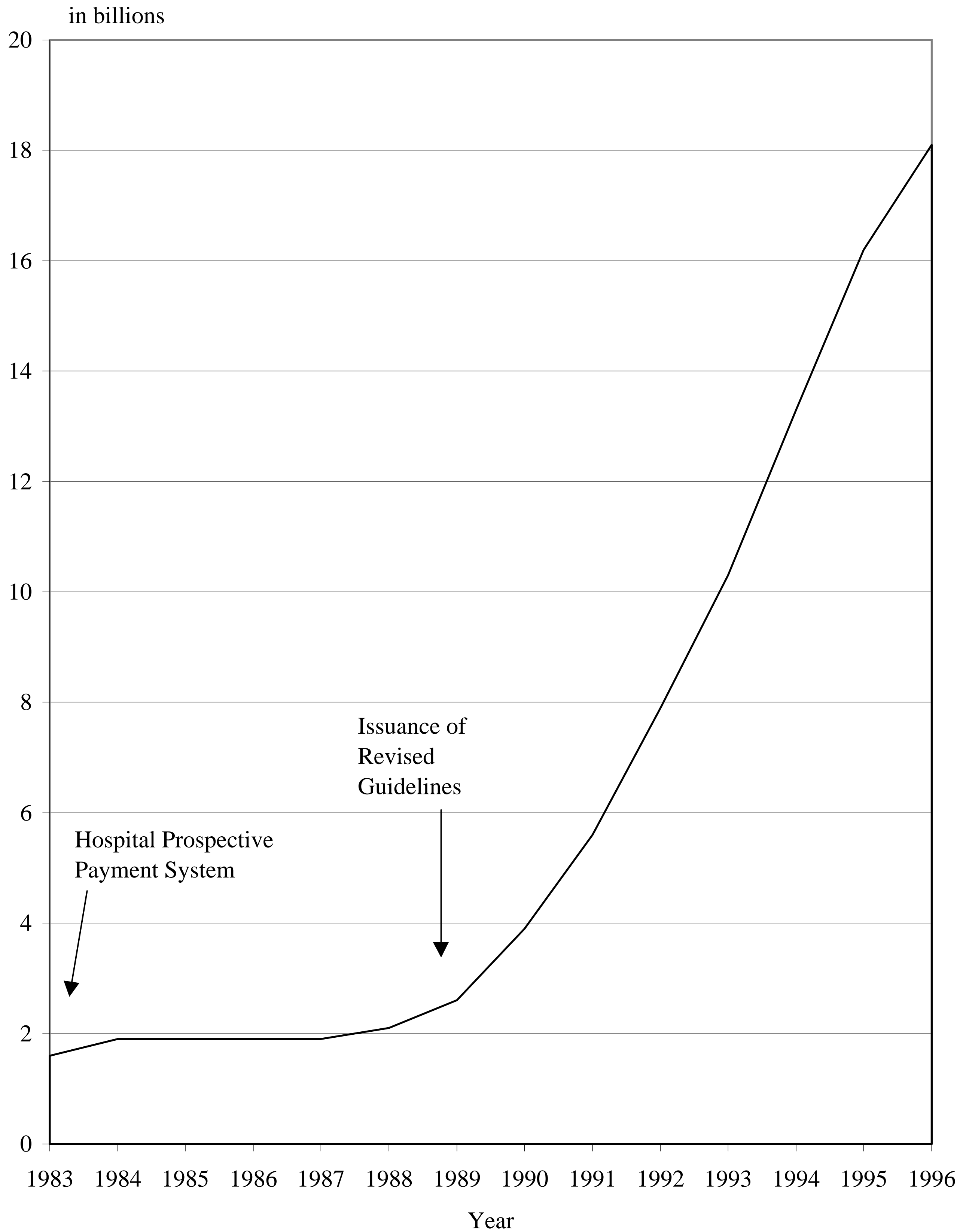
Some portion of this growth may represent a delayed response to an increasing need for home health care resulting from incentives, contained within Medicare's hospital prospective payment system, to discharge patients from hospitals more quickly to other settings. During early years of hospital prospective payment, HCFA implemented medical review and claims processing policies that resulted in high denial rates for home health care. These polices were relaxed by 1989. In addition, revised coverage guidelines that became effective in 1989 are believed to have liberalized coverage policies, increasing the number of eligible persons, the number of allowed visits per week, and the duration of eligibility. Other factors that help explain this growth in spending include aging of the population, technological advances that have made possible a level of care in the home that previously was available only in hospitals and other institutions, and increased supply of services because of the expanding number of agencies participating in Medicare (9,939 in 1996 compared to 5,686 in 1989).

TABLE 3.20.
Trend in Medicare Payments for Home Health
1983-1996

Year	Payments (in billions)	Percent Change
1983	$1.6	--
1984	1.9	17.5
1985	1.9	4.0
1986	1.9	-0.5
1987	1.9	-1.2
1988	2.1	8.6
1989	2.6	23.8
1990	3.9	53.2
1991	5.6	43.6
1992	7.9	41.1
1993	10.3	30.4
1994	13.3	29.1
1995	16.2	21.8
1996	18.1	11.7

NOTE: Total includes both Part A and Part B payments. The total for 1996 is estimated. Rounding in payments may not reflect the actual percentage change. Table prepared by CRS.

Figure 3.20. Trend in Medicare Payments for Home Health, 1983-1996



Source: Figure prepared by CRS based on data provided by HCFA, Office of the Actuary, and Prospective Payment Assessment Commission Report to Congress, June 1995 and June 1996.

Figure 3.21.
Average Annual Rate of Change for Home Health Benefits by People Served, Visits per Person Served, and Payments Per Visit, 1983-1996

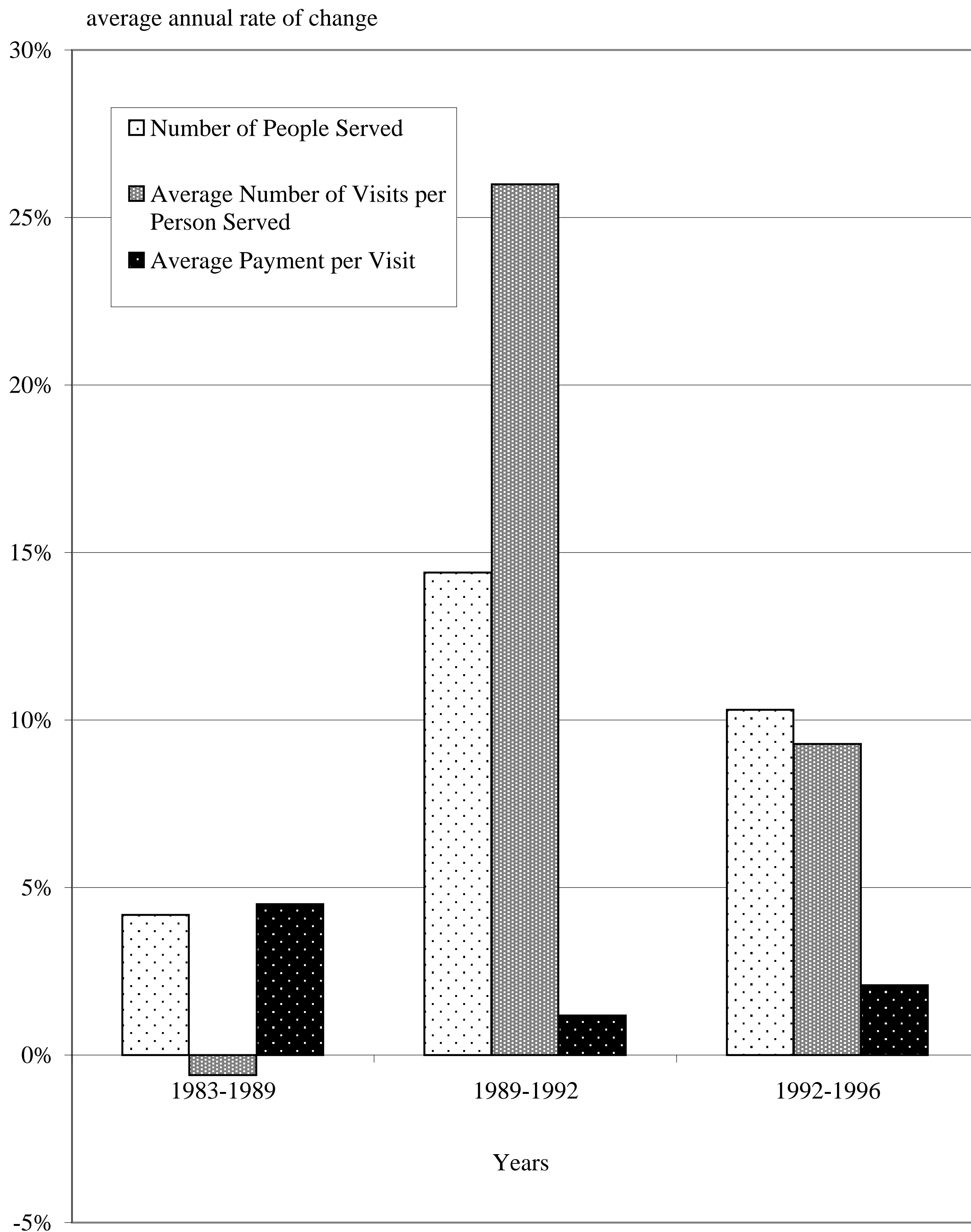
Most of the growth in home health spending can be attributed to an increasing volume of services covered under the program, due to both an increase in the numbers of users and the number of covered visits per user. For the period 1989-1996, the number of users increased at an average annual rate of 12%, and the average number of visits per person served increased at the rate of 16% per year. During this same period, total Medicare enrollment increased by less than 2% per year. Increasing costs for home health services have accounted for comparatively little of the growth in spending. Payments per visit increased at an average annual rate of 1.7% between 1989-1996. Growth in volume of home health services paid for by Medicare was highest in the period 1989-1992, and remains high as compared to growth in payments per visit for the period 1992-1996.

TABLE 3.21.
Trends in Medicare Home Care Utilization and Payments per Visit 1983-1996

Year	Number of People Served	Average Number of Visits per Person Served	Average Payment per Visit (in dollars)
1983	1,318,000	28	$43
1984	1,498,000	27	46
1985	1,549,000	25	49
1986	1,571,000	24	51
1987	1,544,000	23	54
1988	1,582,000	23	56
1989	1,685,000	27	56
1990	1,940,000	36	57
1991	2,223,000	45	56
1992	2,523,000	54	58
1993	2,868,000	59	61
1994	3,175,000	70	60
1995	3,570,000	75	61
1996	3,735,000	77	63

NOTE: Table prepared by CRS.

Figure 3.21. Average Annual Rate of Change for Home Health Benefits, by People Served, Visits Per Person Served, and Payments Per Visit, 1983-1996



Source: Figure prepared by CRS based on data provided by HCFA, Office of the Actuary, and Prospective Payment Assessment Commission Report to Congress, June 1995 and June 1996.ACT.

Figure 3.22.
Medicare Spending for Selected Service Categories, by Major Diagnostic Classification, 1994

The table below shows Medicare spending by major diagnostic classification for four selected service categories: short stay hospital services, skilled nursing facility services, home health services, and physician and supplier services. Taken together, these four service categories accounted for 87.5 % of total Medicare benefit payments for all diagnoses in 1994.

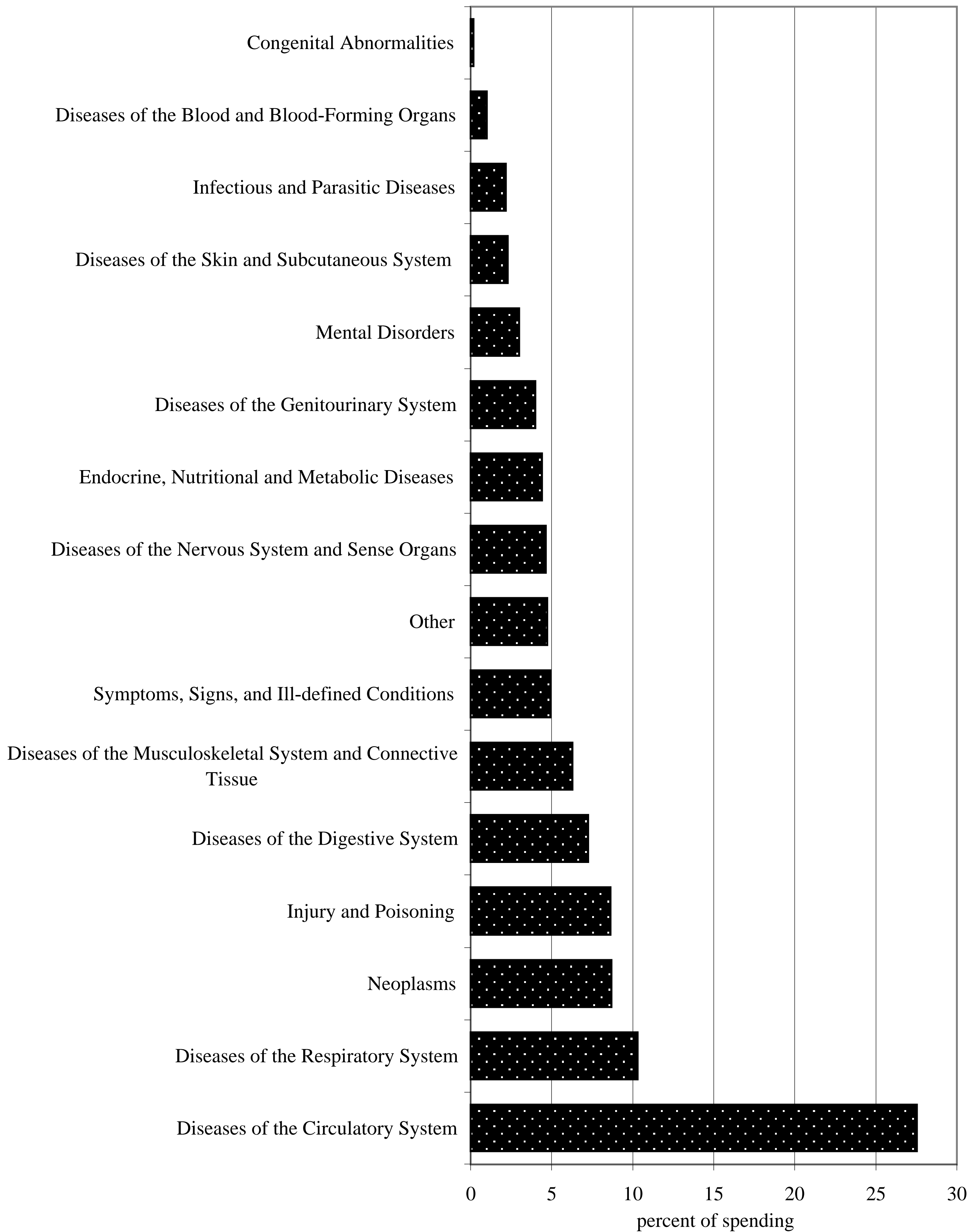
Over one-quarter of Medicare spending in 1994 in these selected service categories was for persons whose diagnosis was a disease of the circulatory system, primarily heart disease. Over 10% of spending was for persons whose diagnosis was a disease of the respiratory system, such as pneumonia and asthma. The categories of neoplasms (cancers), and injury and poisonings, each constituted close to 9% of spending. Other disease categories represented a smaller proportion of the total. For example, endocrine, nutritional and metabolic diseases (including diabetes) jointly represented slightly over 4% of the total.

TABLE 3.22.
Medicare Spending for Selected Service Categories, by Major Diagnostic Classification, 1994
(in thousands)

Major Diagnostic Classifications	Spending	Percent of Grand Total
Infectious and parasitic diseases	$2,795,624	2.1
Neoplasms	11,150,369	8.7
Endocrine, nutritional and metabolic diseases	5,641,492	4.4
Diseases of the blood and blood-forming organs	1,288,862	1.0
Mental disorders	3,821,925	3.0
Diseases of the nervous system and sense organs	5,936,992	4.6
Diseases of the circulatory system	35,322,292	27.5
Diseases of the respiratory system	13,219,977	10.3
Diseases of the digestive system	9,318,279	7.3
Diseases of the genitourinary system	5,117,452	4.0
Diseases of the skin and subcutaneous system	2,937,753	2.3
Diseases of the musculoskeletal system and connective tissue	8,050,947	6.3
Congenital abnormalities	233,107	0.2
Symptoms, signs, and ill-defined conditions	6,315,571	4.9
Injury and poisoning	11,070,884	8.6
Other	6,060,617	4.7
Total, all diagnoses	$128,282,143	100.0

NOTE: Includes Medicare spending for short-stay hospital service, skilled nursing facility service, home health services, and services provided by physicians and suppliers. Together, these accounted for 87.5% of Medicare payments for services in CY1994. Table prepared by CRS.

Figure 3.22. Medicare Spending for Selected Service Categories, by Major Diagnostic Classifications, 1994



Source: Figure prepared by CRS based on HCFA, *Medicare and Medicaid Statistical Supplement*, 1996. See note in table 3.22.

Figure 3.23.
Average Medicare Benefit Payment Per Beneficiary
FY1995

The average annual benefit payment per Medicare enrollee was $4,858 in FY1995. The average for the disabled ($5,283) was 10% higher than that for the aged ($4,808). In part, this reflects the fact that the end stage renal disease population under age 65 is included in the disabled category and has high per capita costs.

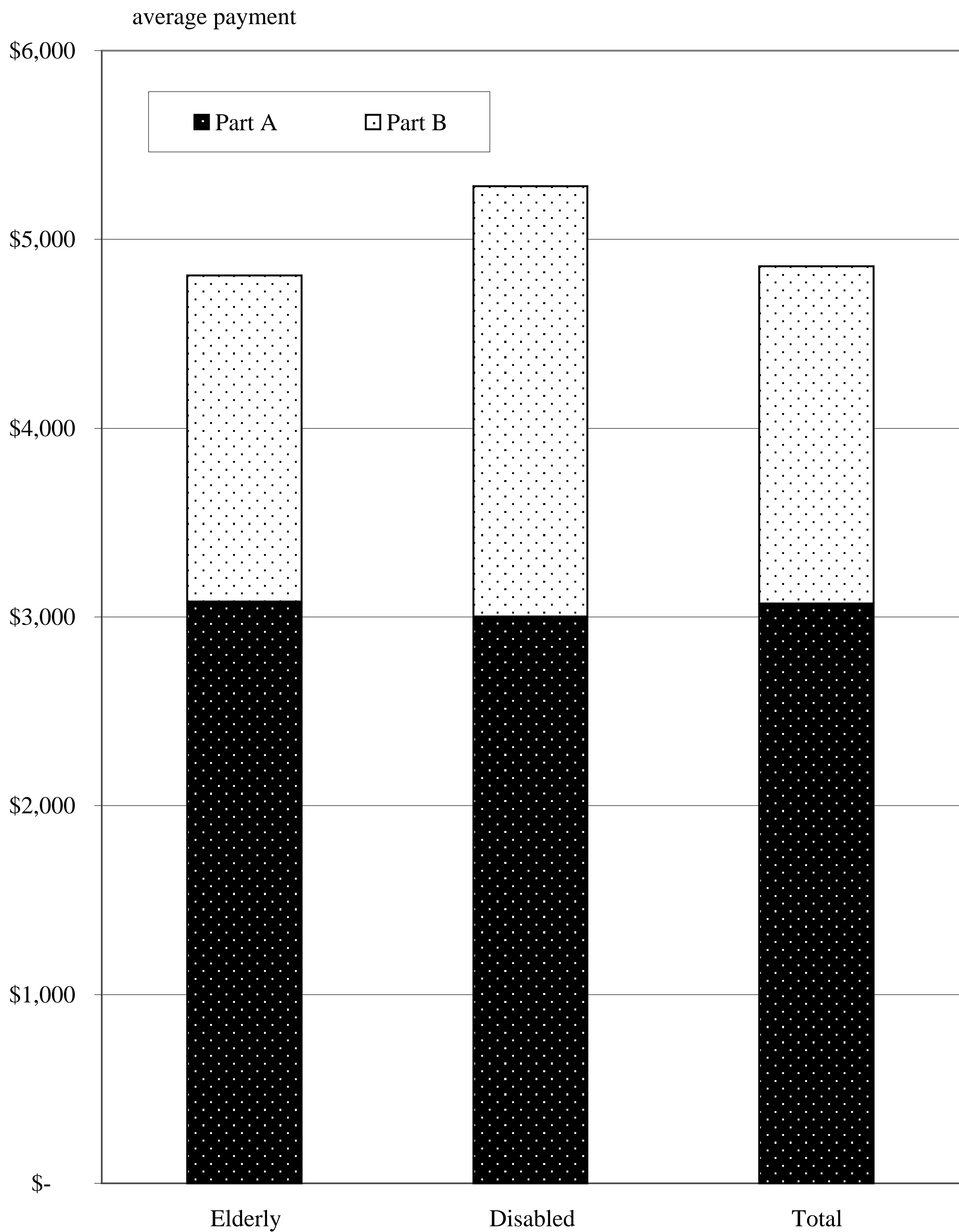
These figures represent average spending for *all* enrollees, even those for whom no Medicare payments were made during the year. In FY1995, only 22% of Part A enrollees had Part A payments made on their behalf, while 84% of Part B enrollees had Part B payments made on their behalf.

TABLE 3.23.
Average Medicare Benefit Payment
Per Beneficiary, FY1995

	Part A	Part B	Total
Elderly	$3,080	1,728	$4,808
Disabled	$3,001	2,282	$5,283
Total	$3,070	1,788	$4,858

NOTE: Table prepared by CRS.

Figure 3.23. Average Medicare Benefit Payment Per Beneficiary, FY1995



Source: Figure prepared by CRS based on the House Ways and Means Committee, *1996 Green Book.*

Figure 3.24.
Distribution of Medicare Spending for Beneficiaries, 1993

Medicare spending is unevenly distributed among beneficiaries. In 1993, 5% of elderly beneficiaries accounted for over one-half of Medicare spending for this population group. At the same time, 10% of beneficiaries accounted for over two-thirds of all spendings for elderly beneficiaries.

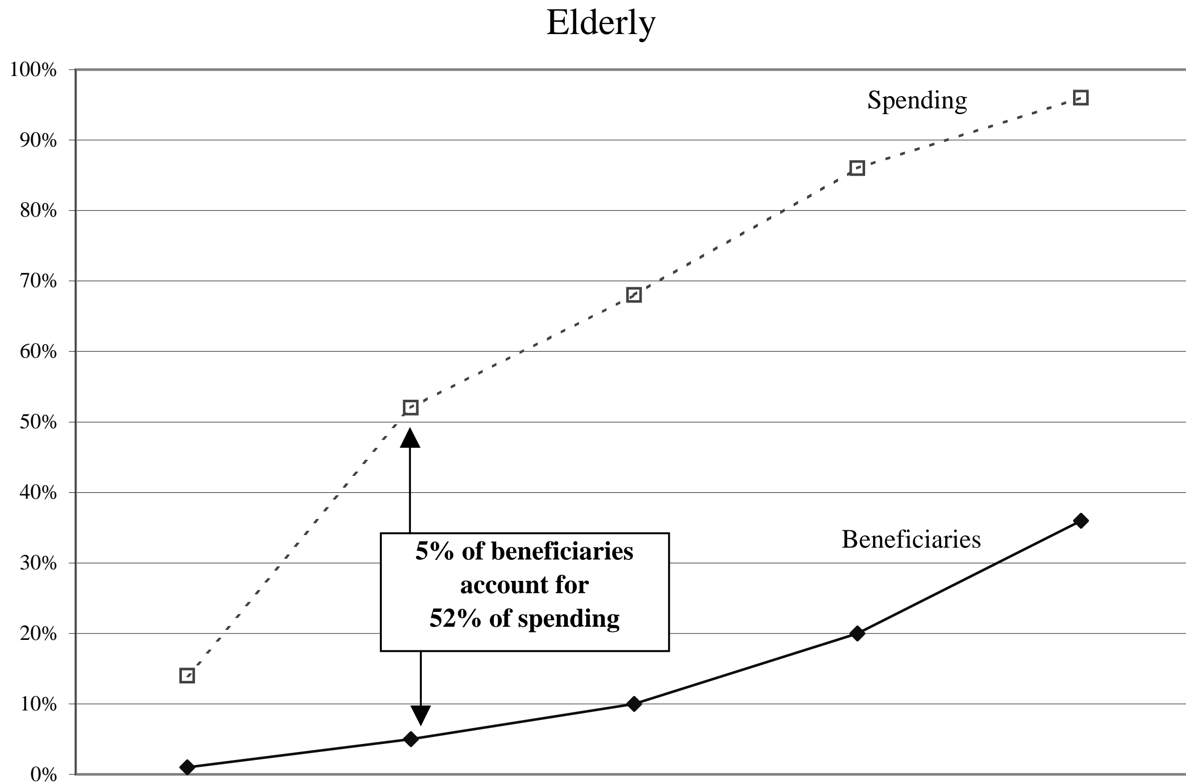
Spending for the disabled was also concentrated among a small proportion of beneficiaries. In 1993, only 1% of beneficiaries accounted for almost one-quarter of spending, 5% accounted for over one-half of spending, and 8% accounted for over two-thirds of all spending for disabled beneficiaries.

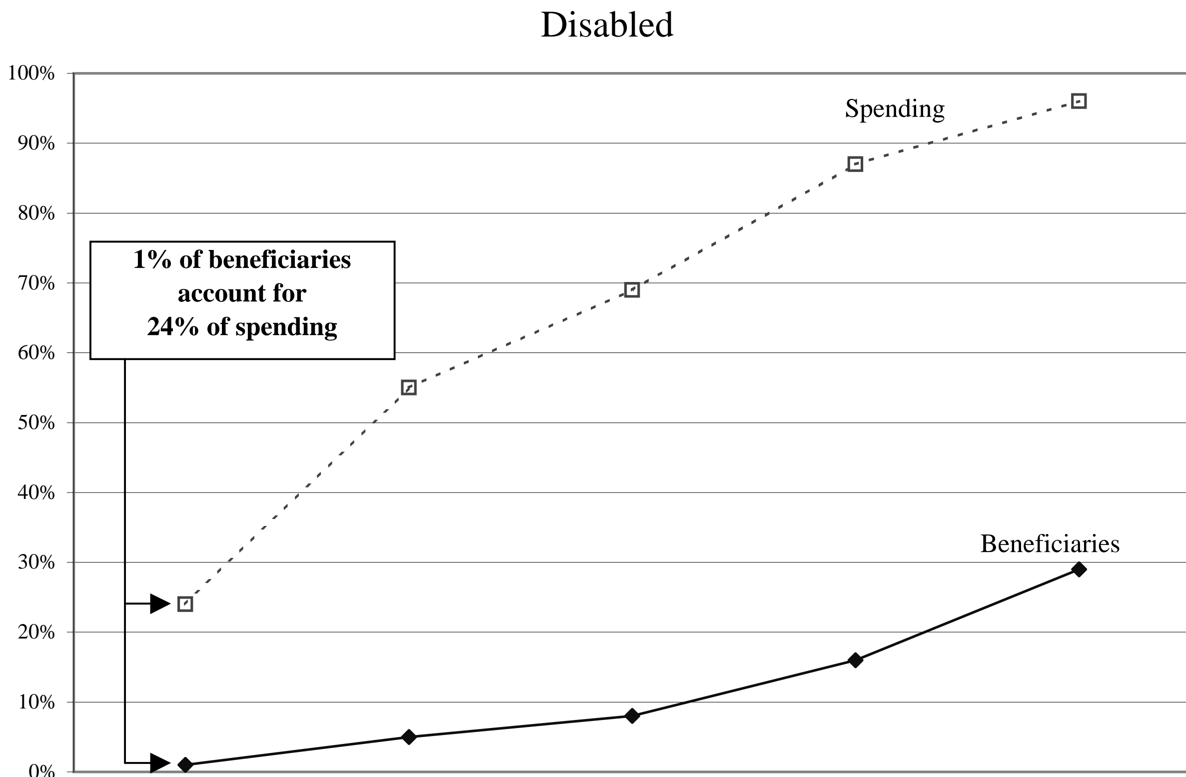
TABLE 3.24.
Distribution of Medicare Spending for Beneficiaries, 1993
(in percent)

Elderly		Disabled	
Percent of Beneficiaries	Percent of Spending	Percent of Beneficiaries	Percent of Spending
1	14	1	24
5	52	5	55
10	68	8	69
20	86	16	87
36	96	29	96

NOTE: Table prepared by CRS.

Figure 3.24. Distribution of Medicare Spending for Beneficiaries, 1993





Source: Figure prepared by CRS based on HCFA, *Profiles of Medicare, 1996.*

Figure 3.25.
Average Medicare Part A and Part B Benefit Payment Per Elderly Enrollee, by Age, 1994

The average annual benefit payment per Medicare elderly enrollee increases by age, reflecting the need for more health care as this population ages. In 1994, the average Part A payment was $1,494 for the 65 to 69 year old population, rising to $4,214 for those 85 and older. Similarly, Part B payments increased from $1,087 for the youngest age group to $1,762 for the oldest group.

TABLE 3.25.
Average Medicare Part A and Part B Benefit Payment Per Elderly Enrollee by Age, 1994

	Part A	Part B
65 and 66 years	$1,494	$1,087
67 and 68 years	1,674	1,215
69 and 70 years	1,852	1,269
71 and 72 years	2,135	1,370
73 and 74 years	2,349	1,468
75-79 years	2,876	1,624
80-84 years	3,547	1,716
85+ years	4,214	1,762

NOTE: Table prepared by CRS.

Figure 3.25. Average Medicare Part A and Part B Benefit Payment Per Elderly Enrollee, by Age, 1994

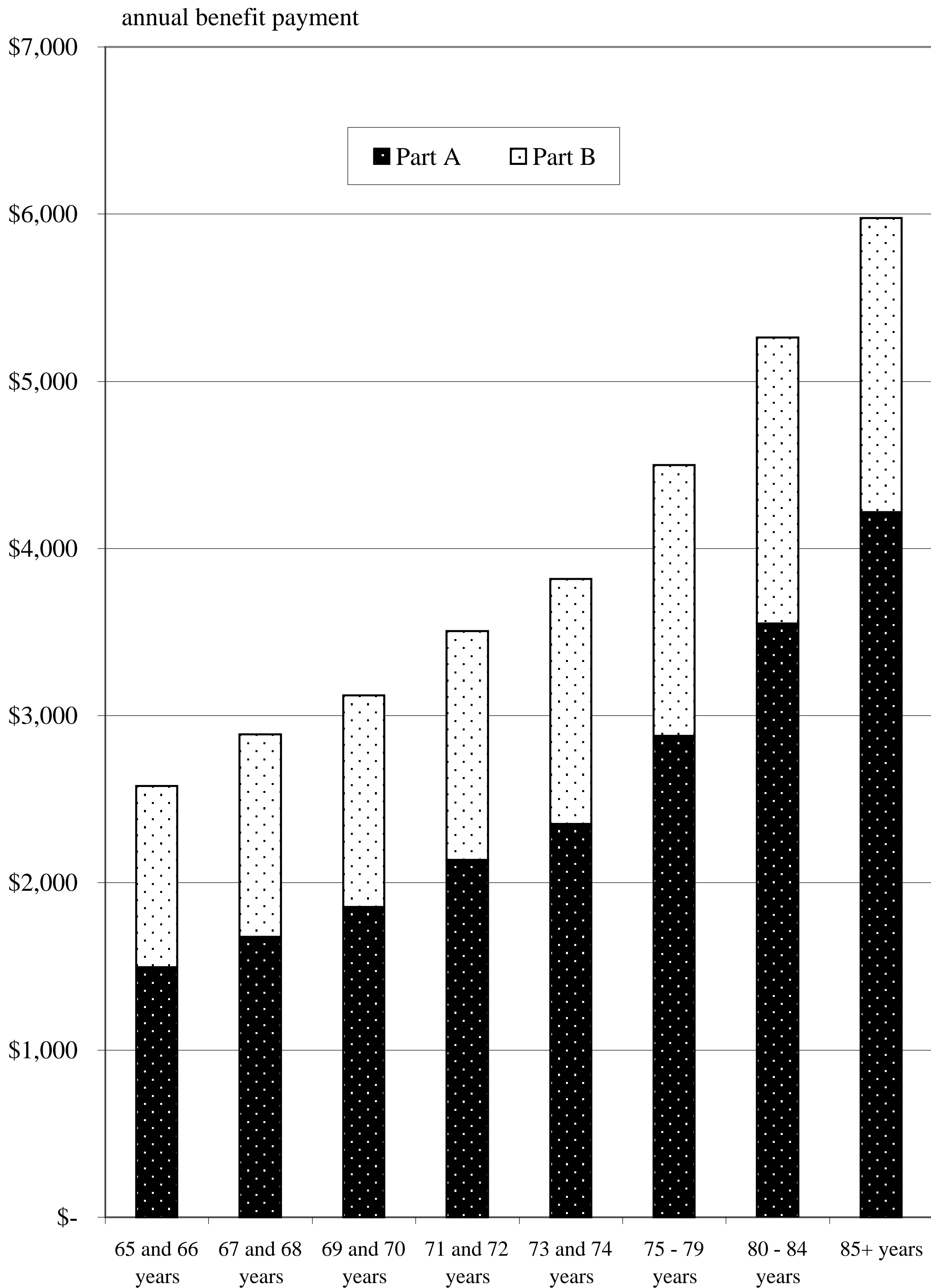


Figure prepared by CRS based on House Ways and Means Committee, *1996 Green Book* .

Figure 3.26.
Average Medicare Benefit Payment Per User of Services by Mortality, ESRD and Hospital Status, 1994

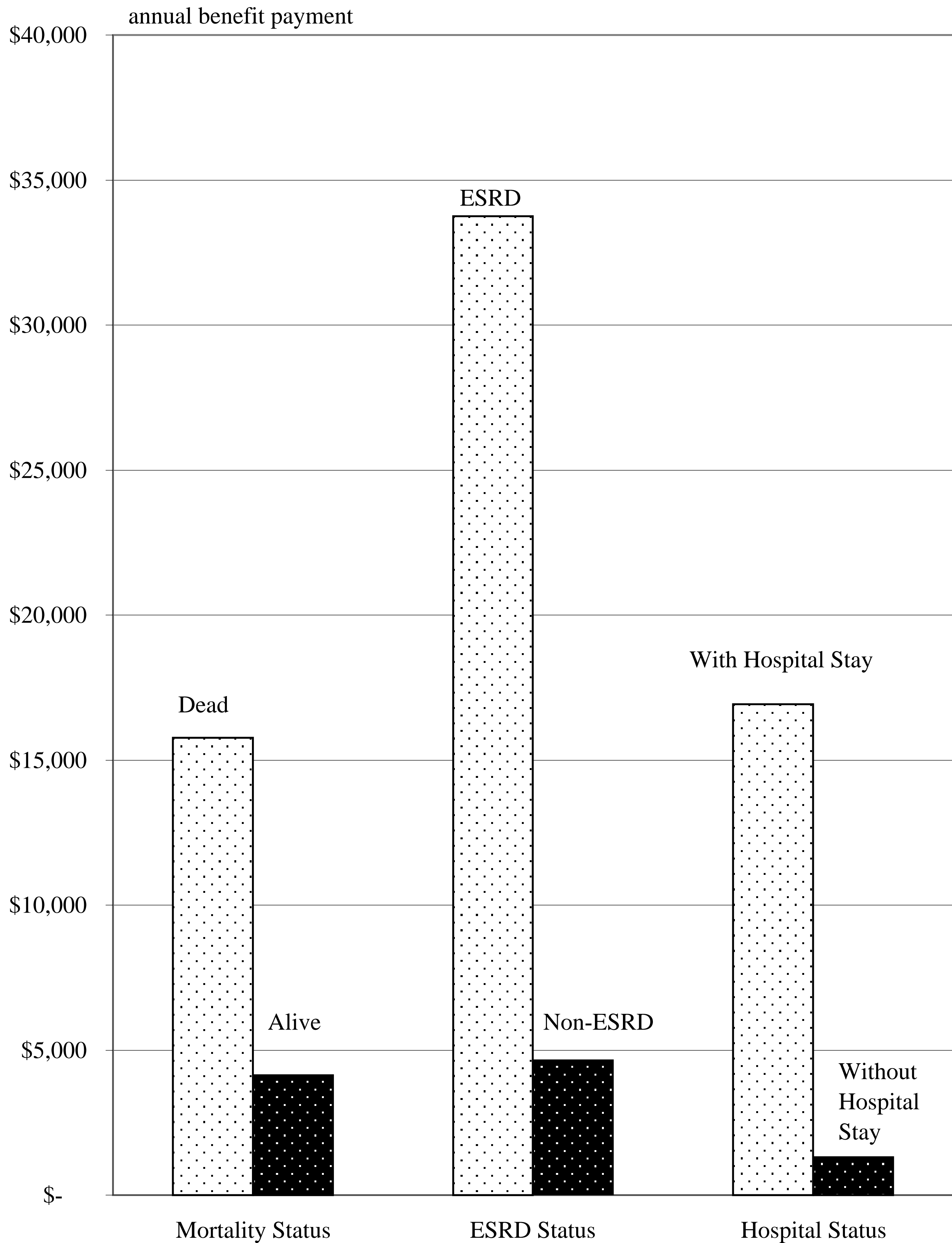
High Medicare spending is frequently associated with specific beneficiary characteristics, namely, whether the person died during the year, whether they were ESRD beneficiaries, or whether they had a hospital stay. In 1994, the average program payment per person for those who died during the year was $15,761, compared to $4,131 for persons who used services but remained alive during the year. In the same year, ESRD beneficiaries averaged $33,745 in payments while non-ESRD beneficiaries who used services averaged $4,637. Persons using hospital services also had higher costs -- $16,925 per person compared to $1,301 for users without a hospital stay.

TABLE 3.26.
Average Medicare Benefit Payment Per User of Services by Mortality, ESRD and Hospital Status: 1994

Type of Service User	Average Benefit Payment
Mortality status: dead	$15,761
Mortality status: alive	4,131
ESRD	33,745
Non-ESRD	4,637
With hospital stay	16,925
Without hospital stay	1,301

NOTE: Excludes persons for whom no Medicare payments were made during the year. Table prepared by CRS.

Figure 3.26. Average Medicare Benefit Payment per User of Services by Mortality, ESRD, and Hospital Status, 1994



Source: Figure prepared by CRS based on *HCFA: Medicare and Medicaid Statiscal Supplement* , 1996. See note in Table 3.26.

Figure 3.27.
Average Medicare Payments Per Enrollee by State and by Region, CY1994

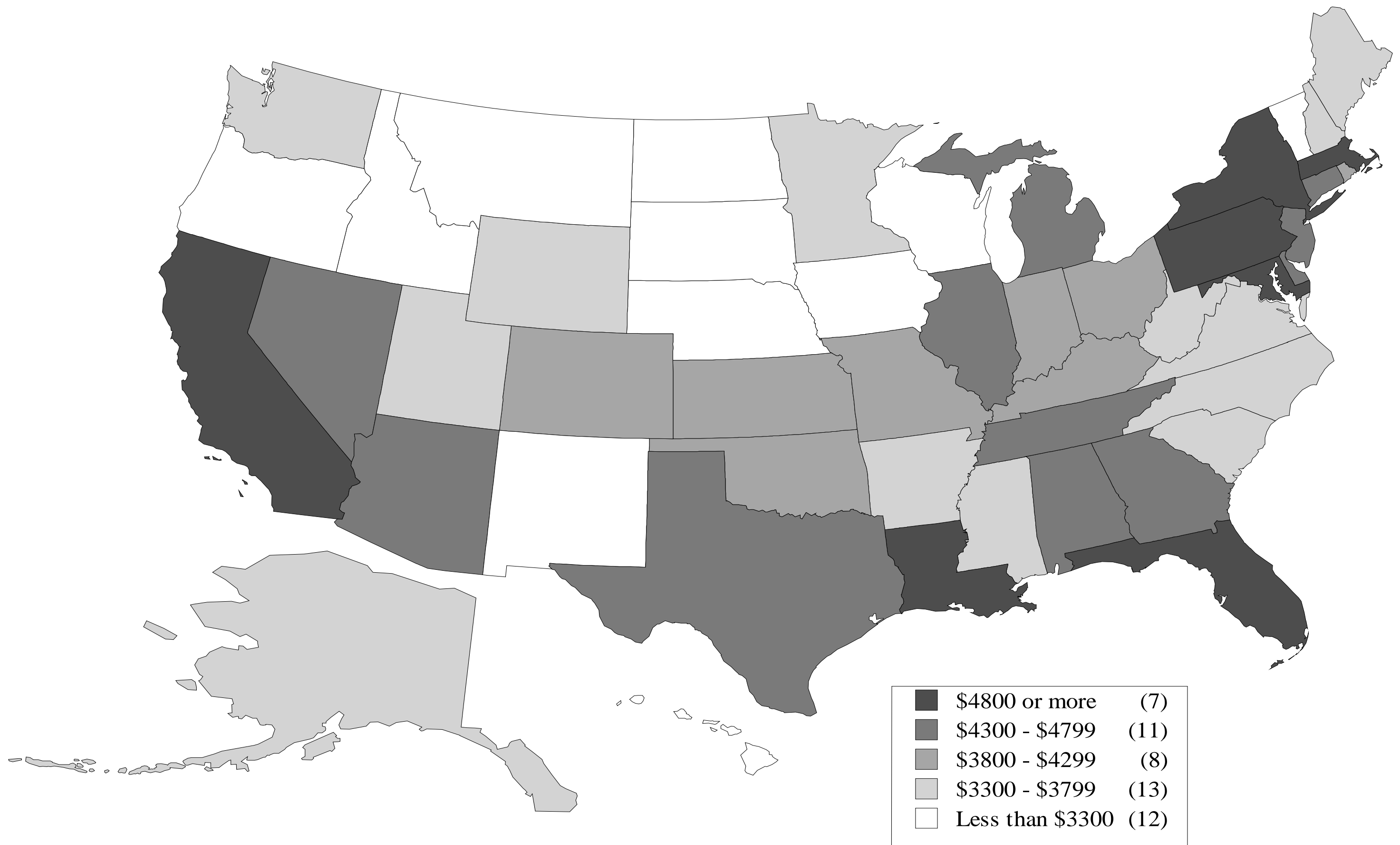
The average Medicare payment per beneficiary varies by state and by geographic region. In 1994, seven States had per enrollee payments over $4,800 -- Louisiana ($5,468), California ($5,219), Pennsylvania ($5,212), Massachusetts ($5,147) Florida ($5,027), Maryland ($4,997), and New York ($4,855). The District of Columbia recorded a per enrollee payment of $5,655 for the same period. The lowest per capita payment was recorded in Nebraska ($2,926). The average payment also varied by geographic region, ranging from $3,578 in the West North Central region to $4,917 in the Middle Atlantic.

TABLE 3.27.
Average Medicare Payments
Per Enrollee by Region and Subregion
CY1994

	Dollars Per Enrollee
United States	$4,375
Region	
Northeast	4,808
Midwest	3,904
South	4,432
West	4,394
Subregion	
New England	4,497
Middle Atlantic	4,917
East North Central	4,045
West North Central	3,578
South Atlantic	4,390
East South Central	4,262
West South Central	4,628
Mountain	3,806
Pacific	4,657

NOTE: Table prepared by CRS.

Figure 3.27. Average Medicare Payments per Enrollee, by State, 1994



SOURCE: Map prepared by CRS based on HCFA, *Medicare and Medicaid Statistical Supplement, 1996.*

Figure 3.28.
Trends in Medicare Part A and Part B Administrative Expenses, 1970-1995

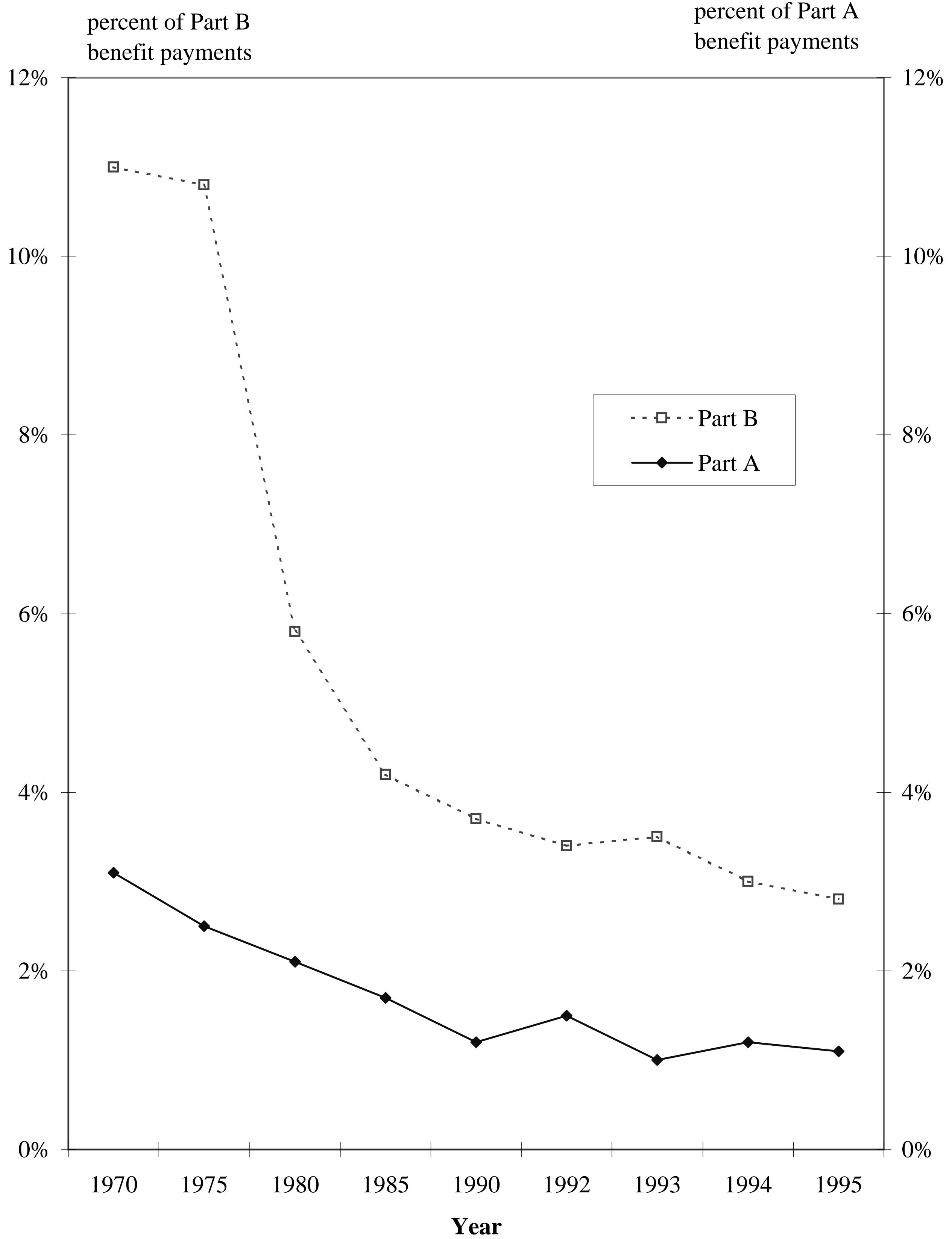
Medicare administrative costs are a small and declining portion of total benefit payments. In 1970, administrative costs represented 3.1% of Part A benefit payments and 11% of Part B benefit payments. By 1995, administrative costs had dropped to 1.1 % of Part A payments and 2.8% of Part B payments. This reflects, in part, technological improvements in automated claims processing. Over 95% of hospital and skilled nursing facility claims are submitted electronically and 75% of physician, laboratory and durable medical equipment claims are submitted electronically.

TABLE 3.28.
Trend in Medicare Part A and Part B Administrative Expenses (as a percent of Part A and Part B benefit payments) 1970-1995

Year	Part A	Part B
1970	3.1	11.0
1975	2.5	10.8
1980	2.1	5.8
1985	1.7	4.2
1990	1.2	3.7
1992	1.5	3.4
1993	1.0	3.5
1994	1.2	3.0
1995	1.1	2.8

NOTE: Table prepared by CRS.

Figure 3.28. Trends in Medicare Part A and Part B Administrative Expenses, 1970-1995



Source: Figure prepared by CRS based on HCFA, *1996 HCFA Statistics.*

Figure 3.29.
Administrative Costs: Medicare Compared to Private Insurance and HMOs, 1993

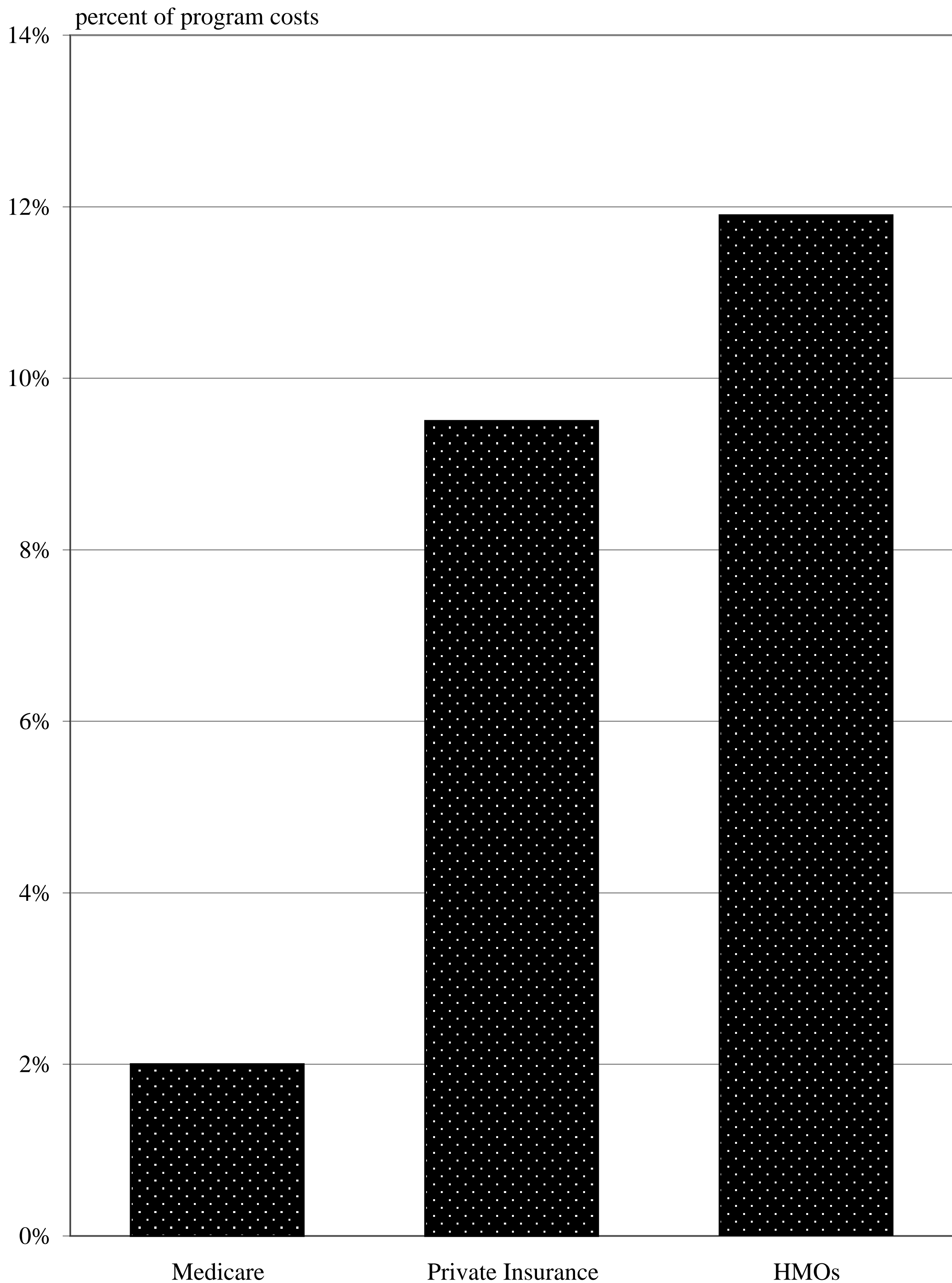
Medicare's administrative costs are substantially lower than those for private insurance. In 1993, Medicare's administrative costs represented about 2% of total program costs, while such costs represented 9.5% of private insurers costs and 11.9% of program costs for health maintenance organizations (HMOs). Private insurance and HMO administrative costs include marketing, profits, and other costs which are not part of Medicare's expenses. Administrative costs for HMOs are higher than for private insurance because HMOs invest more resources into managing the care provided to enrollees.

TABLE 3.29.
Administrative Costs: Medicare Compared to Private Insurance and HMOs, 1993

	Percent of Costs
Medicare	2.0
Private insurance	9.5
HMOs	11.9

NOTE: Table prepared by CRS.

Figure 3.29. Administrative Costs: Medicare Compared to Private Insurance and HMOs, 1993



Source: Figure prepared by CRS based on HCFA, *Profiles of Medicare* , 1996.

Figure 3.30.
Trends in Medicare Claims Volume
1970-1995

The volume of Medicare claims rose from 60.9 million in 1970 to an estimated 784.8 million in 1995. This is close to a thirteen-fold increase. Growth has been greater for Part B claims than for Part A claims.

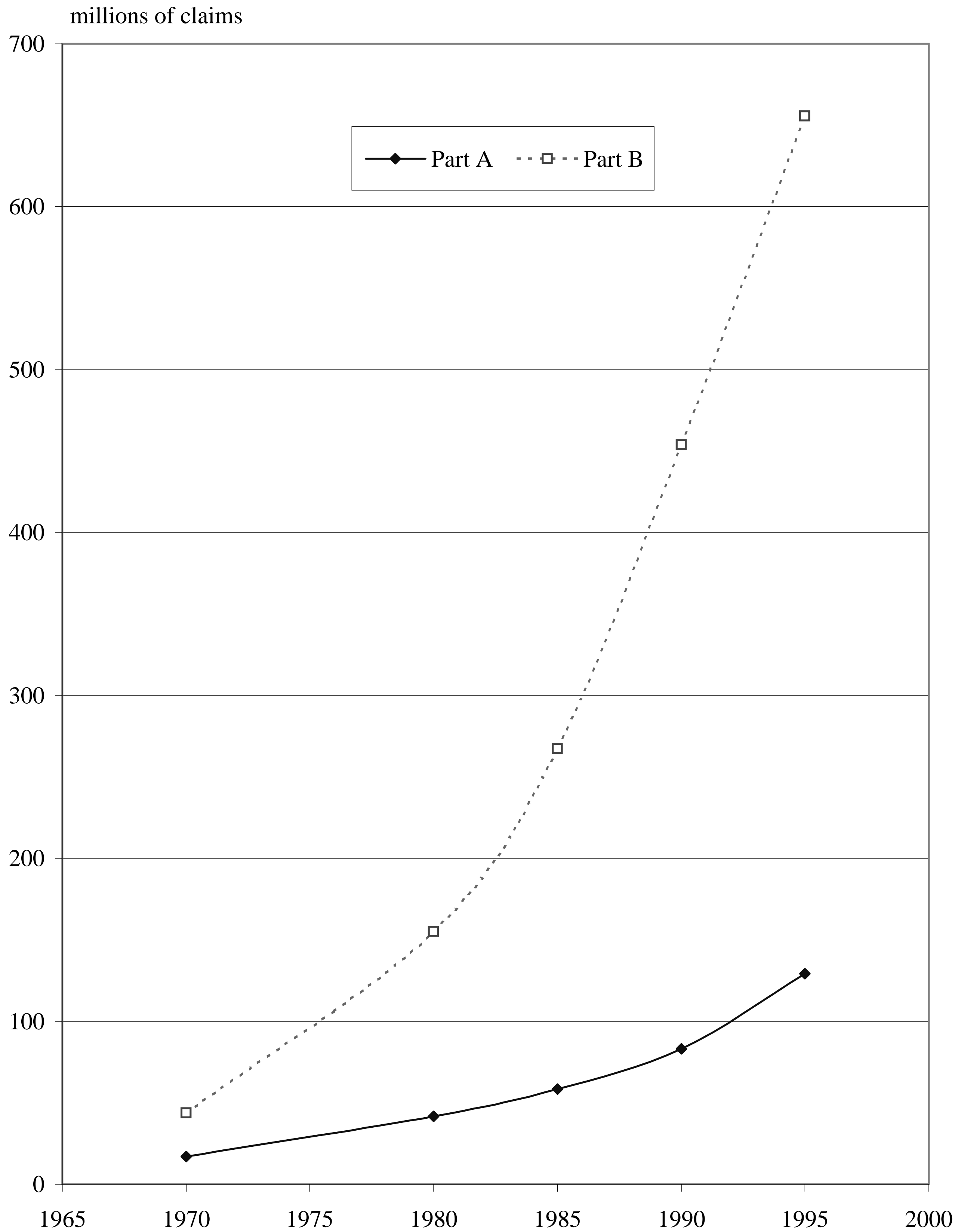
The rapid rise in the volume of claims reflects a number of factors, including increased utilization due to the growing number of beneficiaries, the increasing longevity of the beneficiary population, and advances in medical technology. The higher increase in the number of Part B claims reflects the fact that Part B claims continue to be based on small units of services (e.g., a lab test), while Part A claims now generally represent a larger unit of service, e.g., a hospital admission. (See figure 3.14 for a discussion of DRGs.) The increase in Part B claims also reflects the addition of several service categories, e.g., preventive screenings and flu shots.

TABLE 3.30.
Trends in Medicare Claims Volume, 1967-1995
(in millions)

Year	Part A Claims	Part B Claims	Total Claims
1970	$17.1	$43.8	$60.9
1980	41.8	155.0	196.8
1985	58.5	267.2	325.8
1990	83.2	453.9	537.1
1995	129.2	655.6	784.8

NOTE: Table prepared by CRS.

Figure 3.30. Trends in Medicare Claims Volume, 1970-1995



Source: Figure prepared by CRS, based on HCFA, *Profiles in Medicare,* 1996.

Figure 3.31.
Medicare Part A Trust Fund: Income and Outlays, FY1970-FY2007

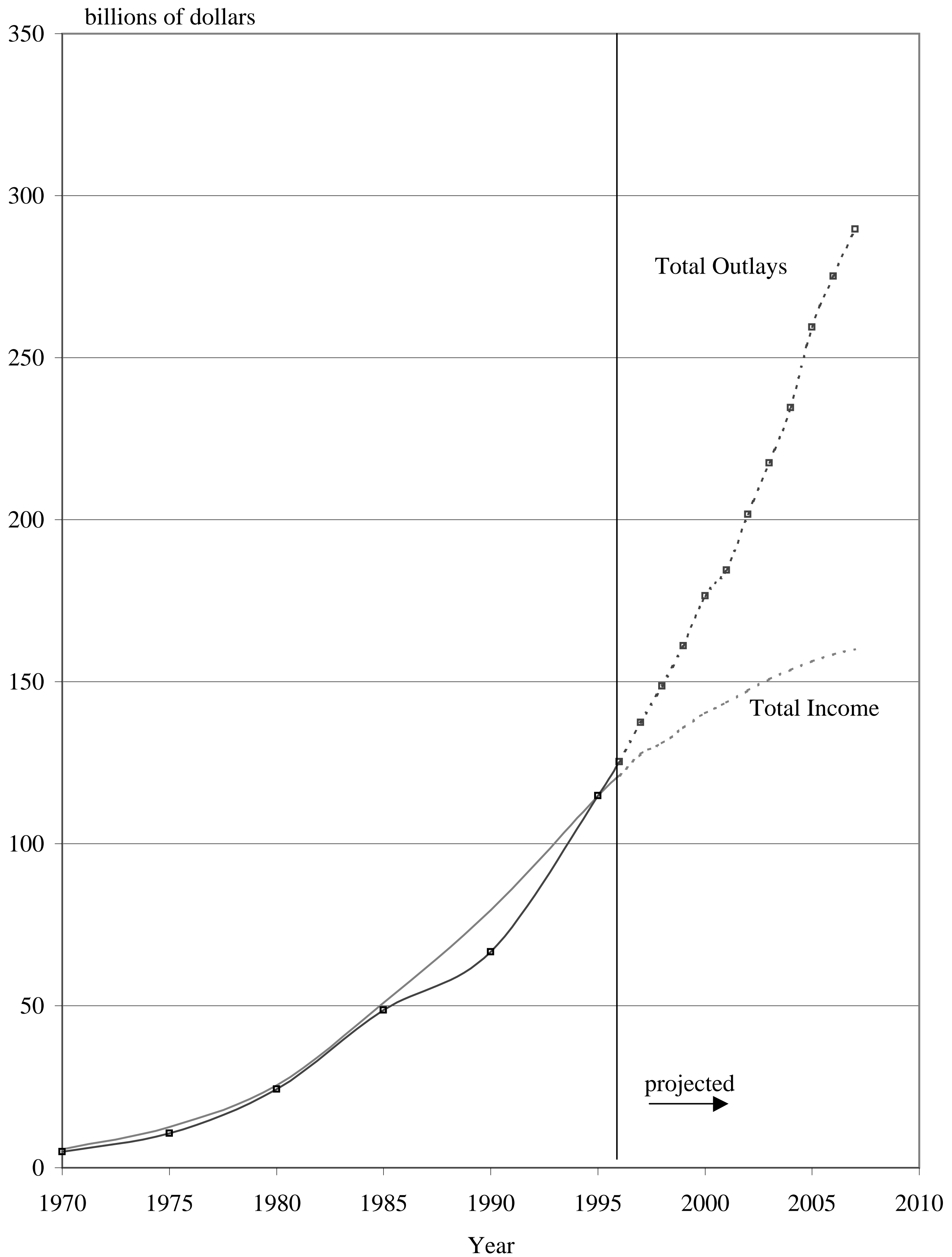
Income to the Medicare Part A Hospital Insurance Trust Fund has traditionally exceeded outlays. However, beginning in FY1995, this pattern was reversed. In that year, the program paid out $36 million more than it took in. CBO estimates that the difference totaled $4.2 billion in FY1996. It is estimated that under current law, the differential will increase rapidly every year. By FY2007, the fund would pay out $289.7 billion, but take in only $160.0 billion in income -- a difference of $129.7 billion.

TABLE 3.31.
Medicare Part A Trust Fund:
Income and Outlays, FY1970-FY2007
(in billions)

Year	Total Income	Total Outlays
1970	$5.6	$5.0
1975	12.6	10.6
1980	25.4	24.3
1985	50.9	48.7
1990	79.6	66.7
1995	114.9	114.9
1996	121.1	125.3
1997	127.7	137.4
1998	131.0	148.6
1999	135.8	161.1
2000	140.2	176.5
2001	143.6	184.5
2002	147.3	201.7
2003	150.7	217.5
2004	153.6	234.6
2005	156.3	259.4
2006	158.4	275.1
2007	160.0	289.7

NOTE: Data for 1997-2007 are CBO projections. Table prepared by CRS.

Figure 3.31. Medicare Part A Trust Fund: Income and Outlays, FY1970-FY2007



Source: Figure prepared by CRS based on *1996 Annual Report of the Board of Trustee of the Federal Hospital Insurance Trust Fund*, (1970-95); CBO, January baseline (1996-2007).

Figure 3.32.
Medicare Part A Trust Fund: End-of-Year Balance
FY1970-FY2007

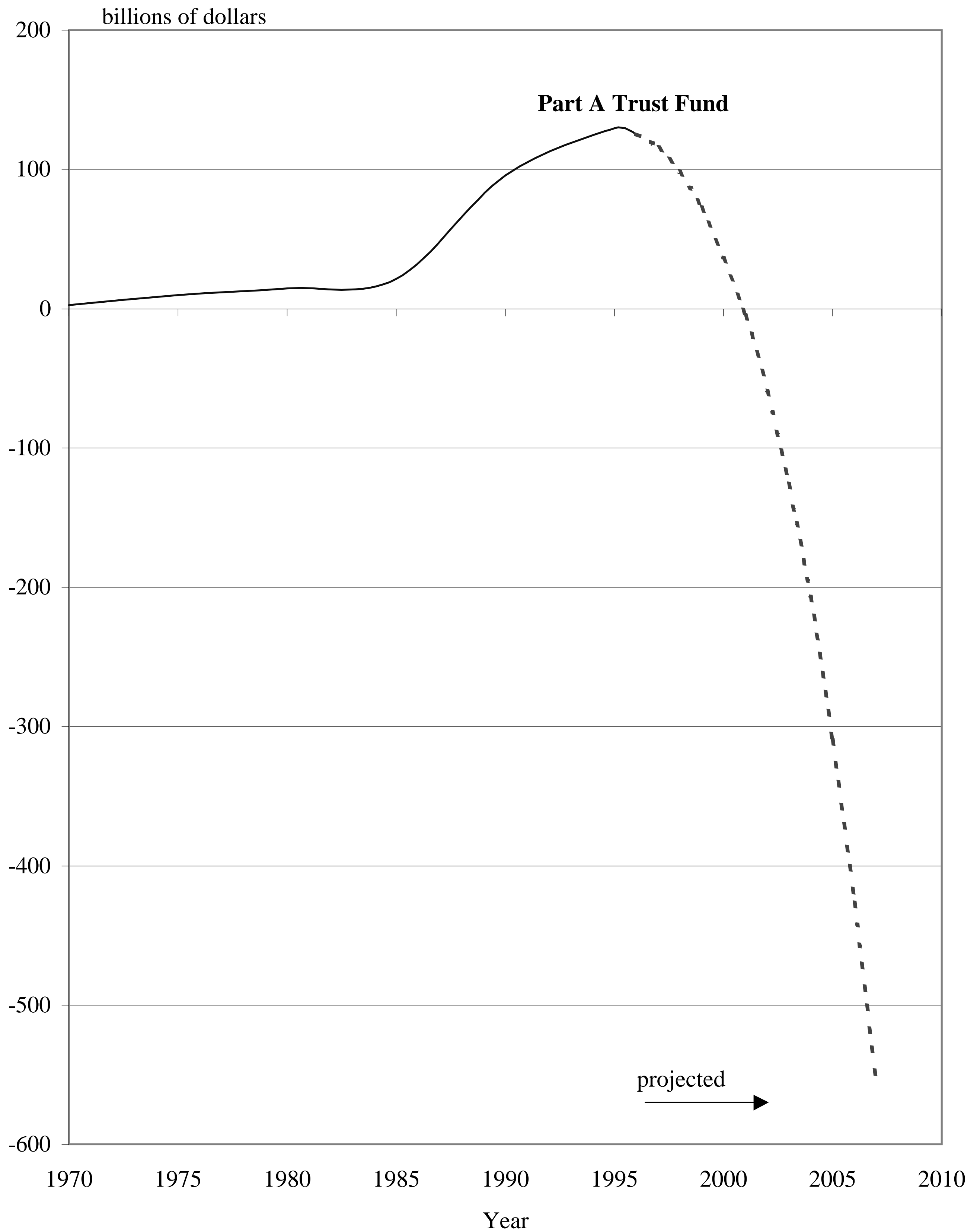
The balance in the Part A Hospital Insurance Trust Fund is rapidly declining. The end-of-year balance began to drop in FY1995. CBO estimates that the balance will fall below zero in FY2001. Given current trends, CBO estimates that the balance would be *minus* $556.3 billion by the end of FY2007.

TABLE 3.32.
Medicare Part A Trust Fund:
End-of-Year Balance, FY1970-FY2007
(in billions)

Year	End-of-Year Balance
1970	$2.7
1975	9.9
1980	14.5
1985	21.3
1990	95.6
1995	129.5
1996	125.3
1997	115.6
1998	98.0
1999	72.8
2000	36.5
2001	-4.5
2002	-58.9
2003	-125.6
2004	-206.7
2005	-309.8
2006	-426.5
2007	-556.3

NOTE: Data for 1997-2007 are CBO projections. Table prepared by CRS.

Figure 3.32. Medicare Part A Trust Fund: End-of-Year Balance, FY1970-FY2007



Source: Figure prepared by CRS based on HHS, 1996 Annual Report of the Board of Trustees of the Federal Hospital Isurance Trust Fund; CBO, January baseline (1996-2007).

Figure 3.33.
Medicare Part A Trust Fund: Projected Income and Cost Rates 1996-2070

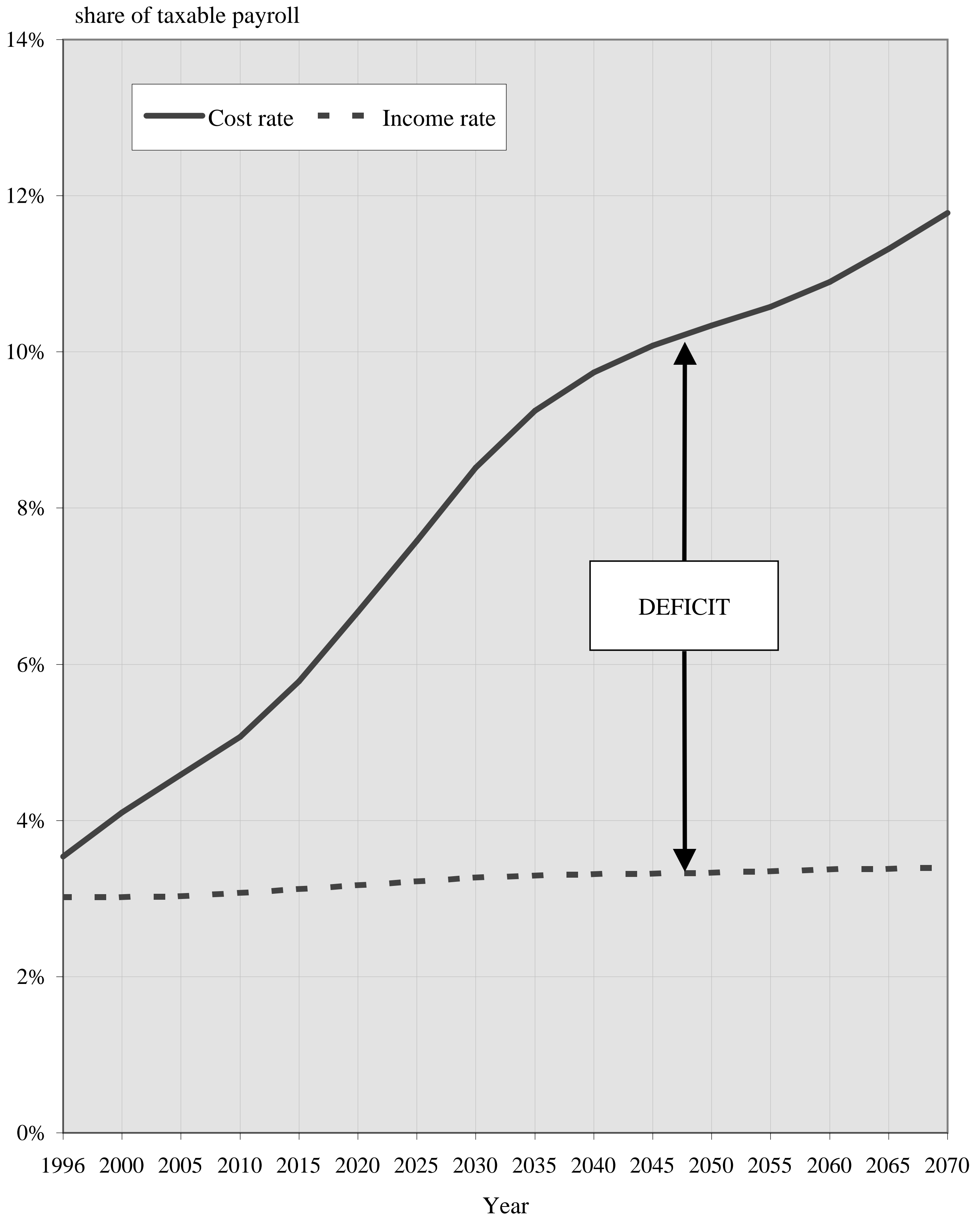
The Medicare trustees measure long-range financial soundness of the hospital insurance (HI) trust fund by comparing: (1) HI tax income (payroll tax and income from taxation of a portion of social security benefits) as a percentage of taxable payroll ("income rate") with (2) HI cost as a percentage of taxable payroll ("cost rate"). There is currently a gap between the two rates. The 1996 estimated cost rate was 3.54% of taxable payroll, whereas the estimated income rate is 3.02%. The gap is thus 0.52% of taxable payroll. Since costs are rising faster than payroll tax receipts, the deficit increases dramatically over the projection period, rising to 2.0 percentage points in 2010 and to 8.38 percentage points by 2070.

TABLE 3.33.
Medicare Part A Trust Fund: Projected Income and Cost Rates, 1996-2070

Year	Income Rate (in percent)	Cost Rate (in percent)	Difference Between Income Rate and Cost Rate
1996	3.02	3.54	-0.52
2000	3.02	4.10	-1.08
2005	3.03	4.59	-1.56
2010	3.07	5.07	-2.00
2015	3.12	5.78	-2.66
2020	3.17	6.67	-3.50
2025	3.22	7.58	-4.36
2030	3.27	8.52	-5.25
2035	3.29	9.25	-5.96
2040	3.31	9.74	-6.43
2045	3.32	10.08	-6.76
2050	3.33	10.34	-7.01
2055	3.35	10.58	-7.23
2060	3.37	10.90	-7.53
2065	3.38	11.32	-7.94
2070	3.40	11.78	-8.38

NOTE: Table prepared by CRS.

Figure 3.33. Medicare Part A Trust Fund: Projected Income and Cost Rates, 1996-2070



Source: Figure prepared by CRS based on HHS, *1996 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund.*

Figure 3.34.
Medicare Part A Trust Fund: Number of Workers Per Beneficiary, 1995, 2010, 2030 and 2060

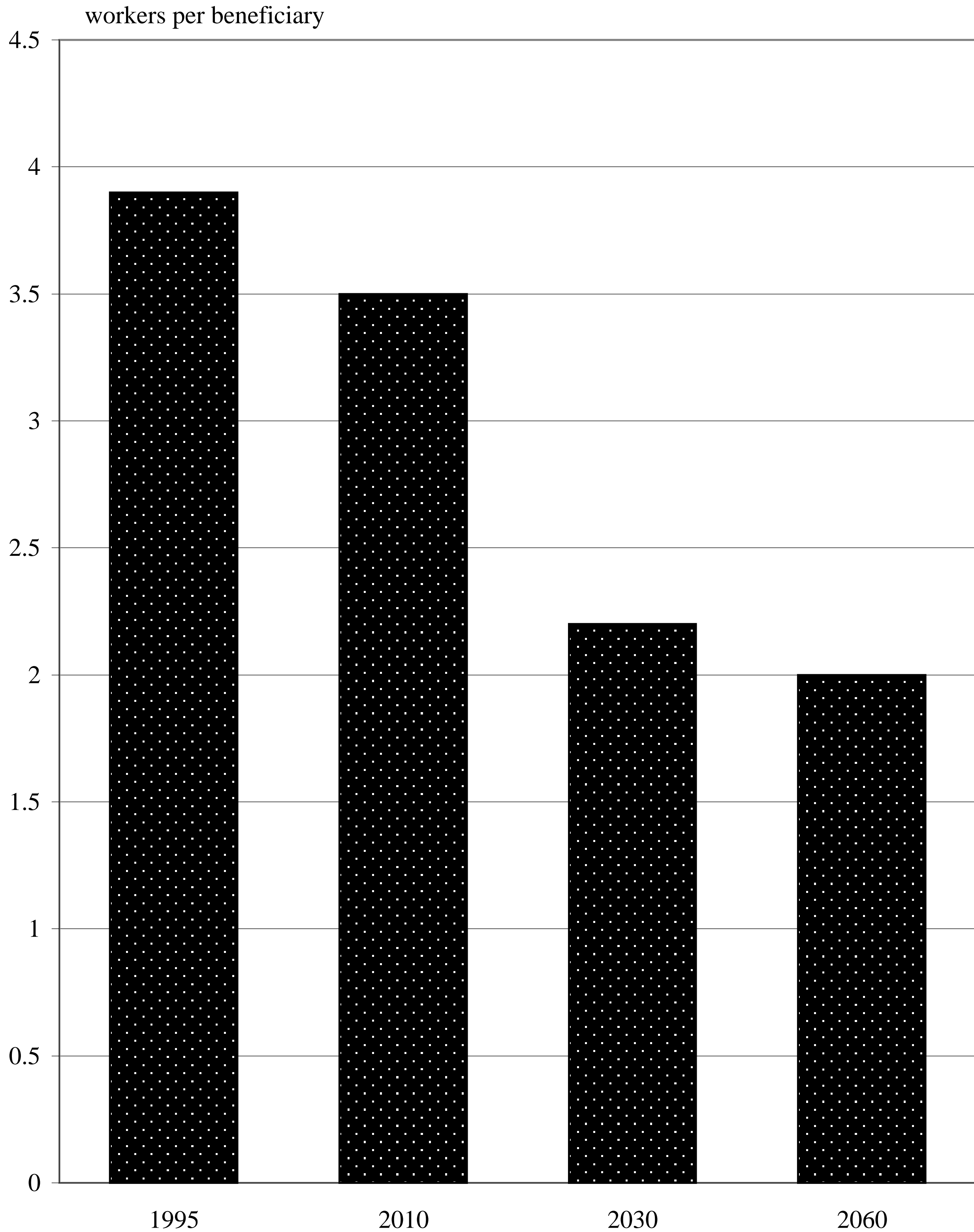
In 1995, there were 3.9 million workers paying a payroll tax for every beneficiary receiving benefits. This number is expected to decline to 3.5 workers per beneficiary when the baby boom generation reaches 65 in 2010. The worker/beneficiary ratio is expected to rapidly decline to 2.2 in 2030 as the last of the "boomers" reaches age 65. The ratio is expected to eventually stabilize at around 2 workers per beneficiary.

TABLE 3.34.
Medicare Part A Trust Fund:
Number of Workers per Beneficiary
1995, 2010, 2030 and 2060

Year	Workers Per Beneficiary
1995	3.9
2010	3.5
2030	2.2
2060	2.0

NOTE: Based on intermediate assumptions. Table prepared by CRS.

Figure 3.34. Medicare Part A Trust Fund: Number of Workers Per Beneficiary, 1995, 2010, 2030, and 2060



Source: Figure prepared by CRS based on *1996 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund*.

Figure 3.35.
Medicare Part B Premium as a Percent of Total Part B Trust Fund Income, FY1970-FY1995

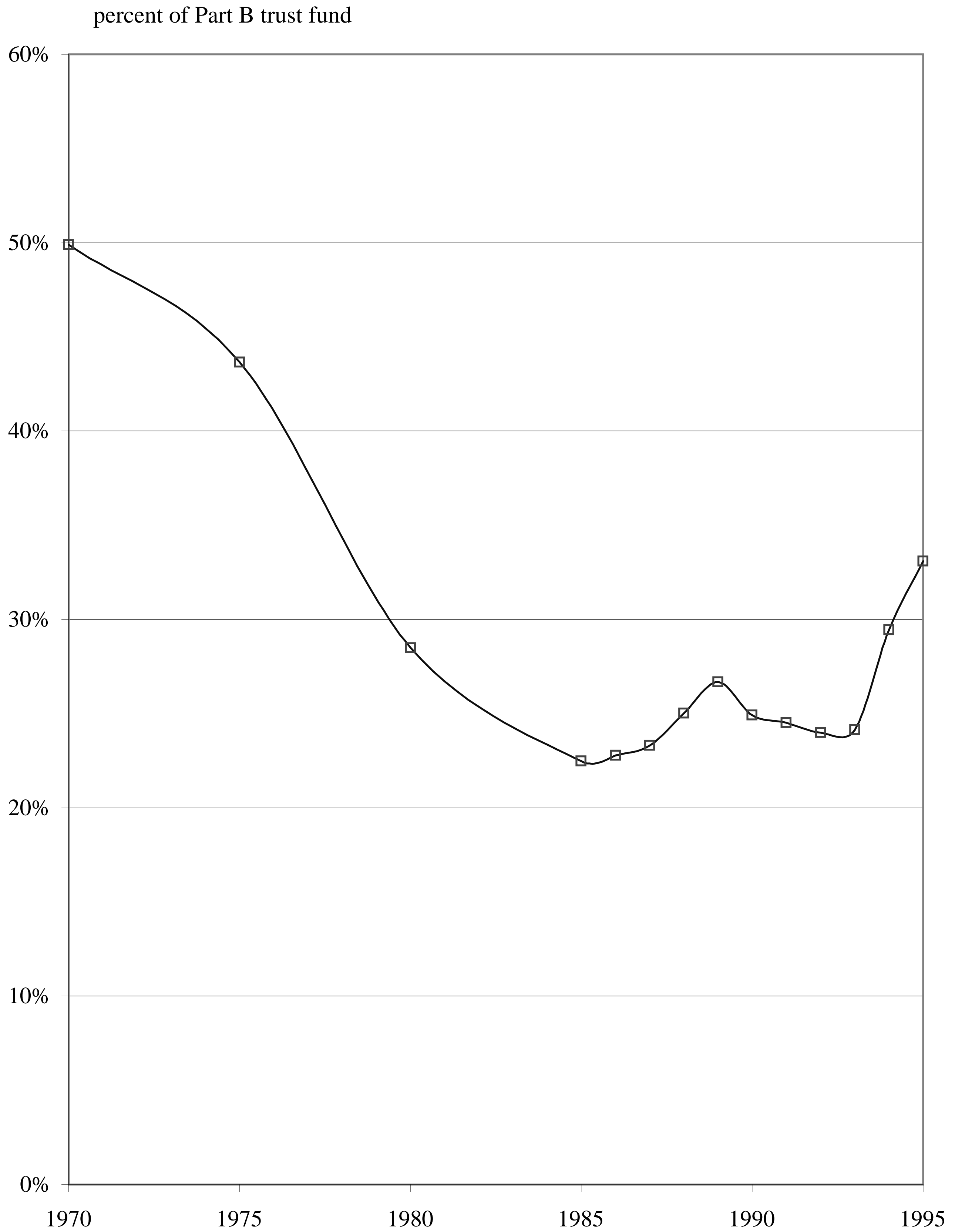
The Part B premium paid by Medicare beneficiaries was originally intended to equal 50% of program costs; general revenues financed the remainder. Legislation enacted in 1972 limited annual increases to the percentage increase in Social Security benefits (the cost-of-living adjustment, or COLA.) As a result, beneficiary contributions dropped to below 25% of program costs by the early 1980s. Since the early 1980s, Congress has regularly voted to set the Part B premium equal to 25% of costs. However, the Omnibus Budget Reconciliation Act of 1990 (OBRA 1990) set specific dollar figures, rather than a percentage, in law for 1991-1995. Because Part B costs rose more slowly than had been anticipated in 1990, the 1995 premium actually represented 31.5% of program costs. The 1996-1998 premiums are again set at 25% of program costs. Under current law, annual increases in 1999 and subsequent years would be subject to the COLA limitation.

TABLE 3.35.
Medicare Part B Premium as a Percent of Total Part B Trust Fund Income FY1970-FY1995

Year	Premium from Employees (in millions)	Total Income (in millions)	Percent of Total
1970	$936	$1,876	49.9
1975	1,887	4,322	43.7
1980	2,928	10,275	28.5
1985	5,524	24,577	22.5
1986	5,699	25,003	22.8
1987	6,480	27,797	23.3
1988	8,756	35,002	25.0
1989	11,548	43,282	26.7
1990	11,494	46,138	24.9
1991	11,807	48,166	24.5
1992	12,748	53,149	24.0
1993	14,683	60,799	24.2
1994	16,895	57,368	29.5
1995	19,244	58,169	33.1

NOTE: Table prepared by CRS.

Figure 3.35. Medicare Premium as a Percent of Total Part B Trust Fund Income, FY1970-FY1995



Source: Figure prepared by CRS based on *1996 Annual Report of the Board of Trustees of the Federal Supplemental Insurance Trust Fund*.

Figure 3.36.
Sources of Payment for Health Care, for All Beneficiaries, Elderly and Disabled, 1992

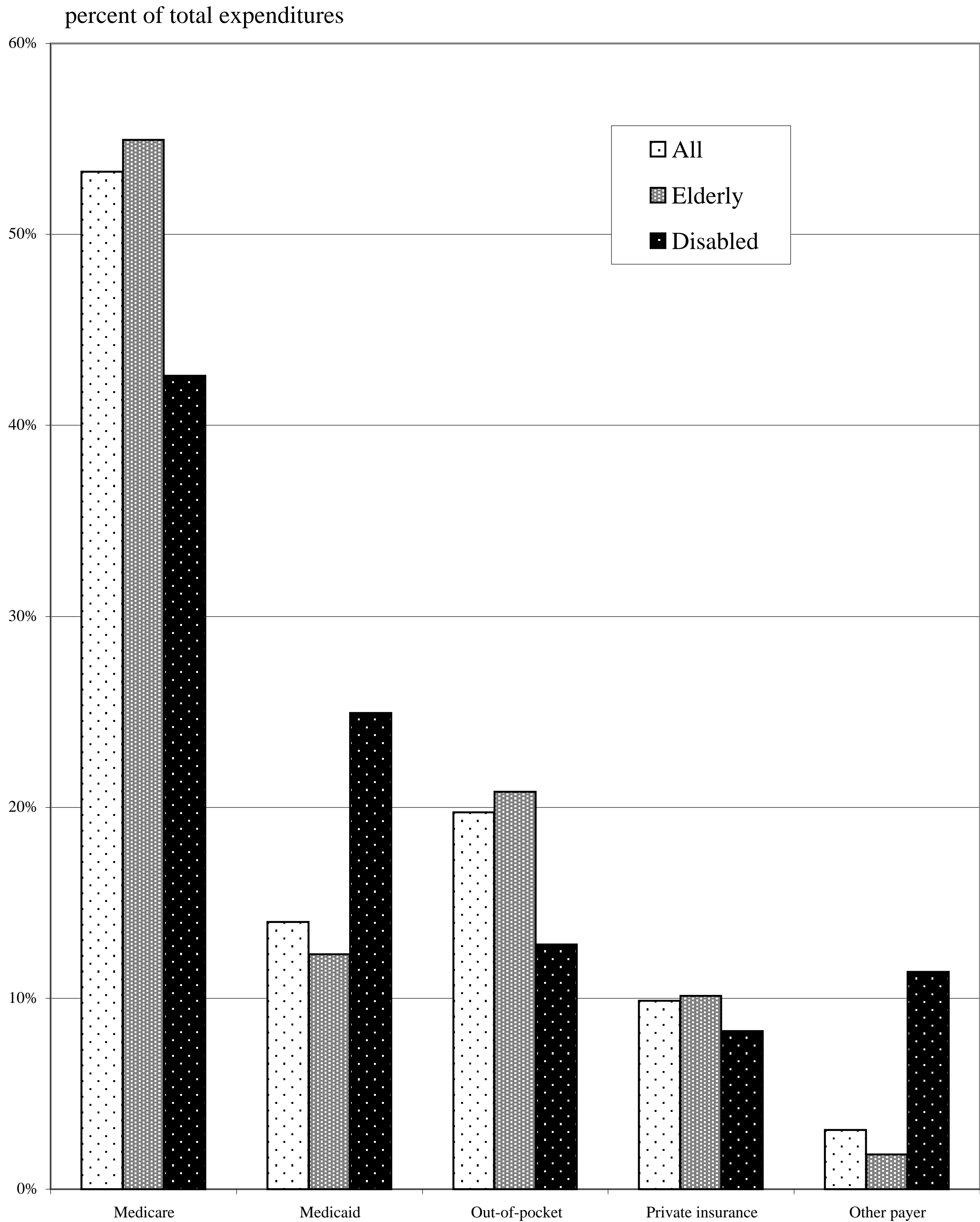
Medicare does not cover all of the health care expenditures for program beneficiaries. Medicare requires cost-sharing for most covered services, provides only limited protection for some services (such as outpatient prescription drugs and long-term care), and includes no protection against the costs of other services. As a result, Medicare financed only 53% of the medical bills for Medicare beneficiaries in 1992. The program covered 55% of the costs for the aged, but only 43% of the costs for the disabled. This difference was almost exactly offset by higher Medicaid payments for the disabled (25% vs.12%). Private insurance covered 10% of medical expenses for the elderly and 8% for the disabled. Both groups paid a portion of their total bill out-of-pocket -- 21% for the aged and 13% for the disabled.

TABLE 3.36
Sources of Payment for Health Care, for all Beneficiaries, Elderly and Disabled, 1992
(in percent)

	Medicare	Medicaid	Private Insurance	Other Payer	Out-of-Pocket
All	53.3	14.0	9.9	3.1	19.7
Elderly	55.0	12.3	10.1	1.8	20.8
Disabled	42.6	24.9	8.3	11.4	12.8

NOTE: Rows may not add to 100% due to rounding. Table prepared by CRS.

Figure 3.36. Sources of Payment for Health Care, for All Beneficiaries, Elderly and Disabled, 1992



Source: U.S. Library of Congress. Congressional Research Service. *Medicare: The Role of Supplemental health Insurance,* by Jennifer O'Sullivan and Jason Lee. Report No. 96-826 EPW, 1996.

Figure 3.37.
Spending for Health as a Percentage of After-Tax Income, Elderly and Nonelderly Households, 1960-1994

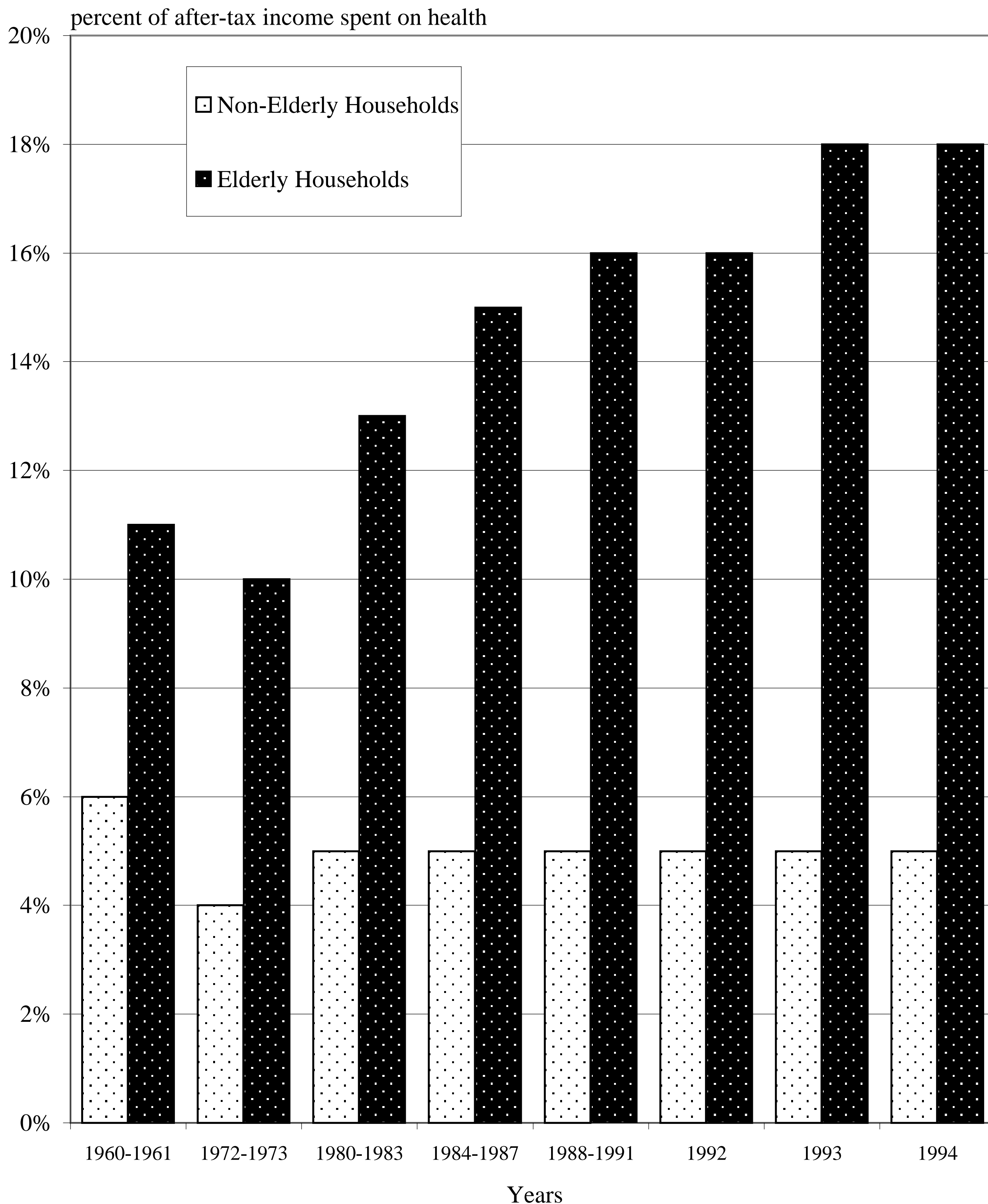
Most persons spend a portion of their incomes out-of-pocket for health care. This spending includes payments for health insurance, medical services, prescription drugs and medical supplies. The percentage of after-tax income that the elderly spend on health care has risen from 11% in the early 1960s to 18% in 1994. In contrast, the percentage spent by nonelderly households has remained relatively constant -- declining from 6% in the early 1960s to 5% in 1994. The higher percentage spent by the elderly reflects several factors, including payments by this population for long-term care services and the premiums paid by those elderly persons who purchase supplemental insurance (i.e., "Medigap") policies.

TABLE 3.37.
Spending for Health as a Percentage of After-Tax Income, Elderly and Nonelderly Households, 1960-1994
(percent of after-tax income)

Year(s)	Nonelderly Households	Elderly Households
1960-1961	6	11
1972-1973	4	10
1980-1983	5	13
1984-1987	5	15
1988-1991	5	16
1992	5	16
1993	5	18
1994	5	18

NOTE: Includes spending for health insurance, medical services, prescription drugs, and medical supplies. Definition of elderly or nonelderly households is based on designation of reference person. Table prepared by CRS.

Figure 3.37. Spending for Health as a Percentage of After-Tax Income, Elderly and Non-Elderly Households, 1960-1994



Source: Figure prepared by CRS based on HCFA, *Profiles of Medicare, 1996.*

NOTE: Includes spending for health insurance, medical services, prescription drugs and medical suppliers.

Figure 3.38.
Sources of Health Insurance for Medicare Beneficiaries, 1994

The majority of Medicare beneficiaries depends on one or more supplemental insurance policies or Medicaid to help pay for services not covered by Medicare and for the program's cost-sharing requirements. In 1994, about 63% of the Medicare population had private supplemental insurance. Private insurance protection may be obtained through a current or former employer. It may also be obtained through an individually-purchased policy (commonly referred to as a "Medigap" policy). In addition, about 16% had Medicaid coverage, while another 3% had supplemental coverage from one of a variety of public sources (such as the military).

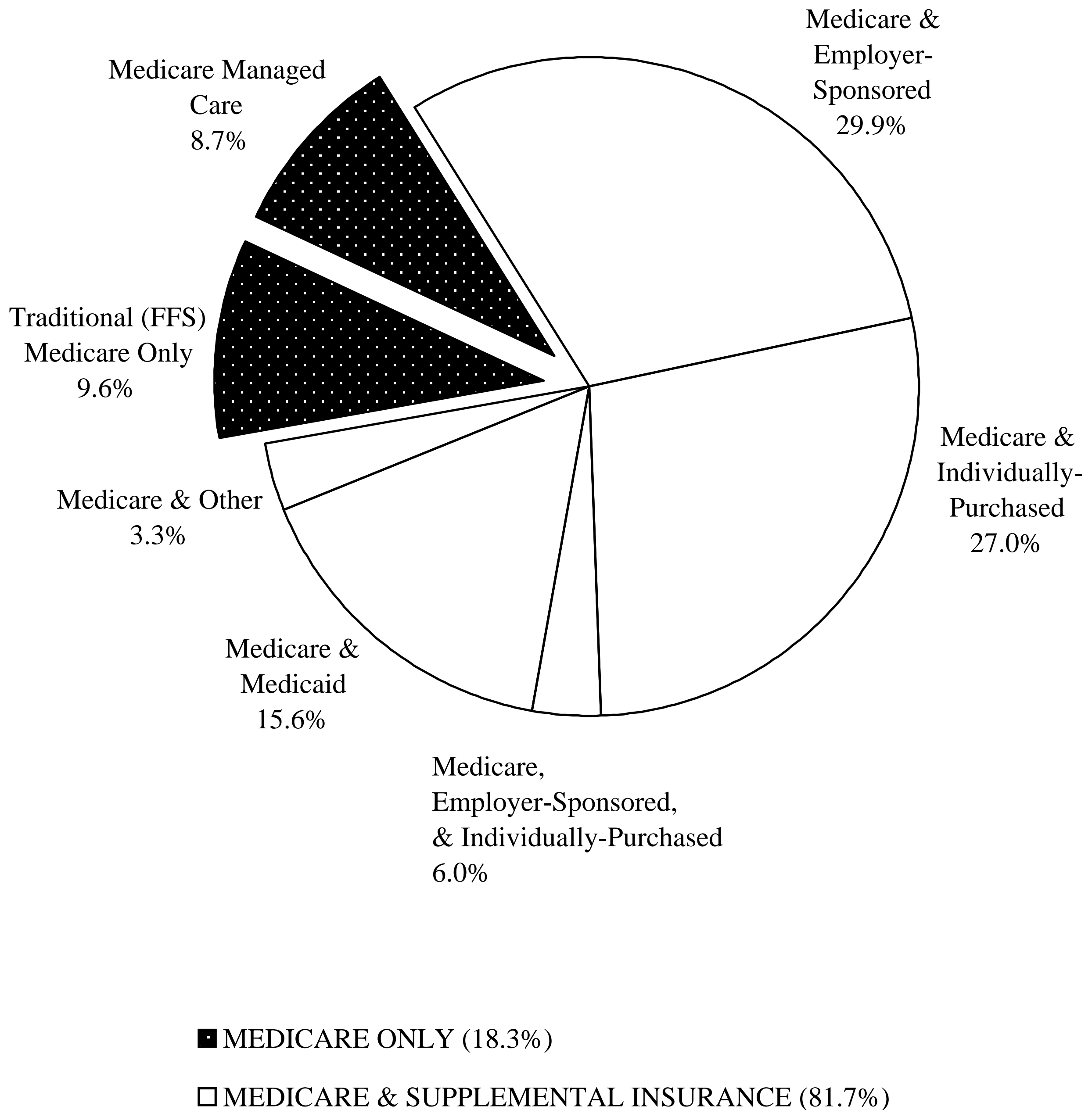
Just under 10% of beneficiaries relied solely on the traditional Medicare program for protection against the costs of health care. In 1994, an additional 9% of beneficiaries were enrolled in managed care organizations; these organizations often provide coverage for services in addition to those covered under the traditional fee-for-service program (see figure 4.17).

TABLE 3.38.
Sources of Health Insurance for Medicare Beneficiaries, 1994

Sources of Health Insurance	Percent of Beneficiaries
Traditional (FFS) Medicare only	9.6
Medicare managed care	8.7
Medicare and employer sponsored	29.9
Medicare and individually purchased	27.0
Medicare and employer-sponsored & individually-purchased	6.0
Medicare and Medicaid	15.6
Medicare and other	3.3

NOTE: Table prepared by CRS.

Figure 3.38. Sources of Health Insurance for Medicare Beneficiaries, 1994



■ MEDICARE ONLY (18.3%)

□ MEDICARE & SUPPLEMENTAL INSURANCE (81.7%)

Source: CRS, U.S. Library of Congress. *Medicare: The Role of Supplemental Health Insurance*, by Jennifer O'Sullivan and Jason Lee. Report No 96-826 EPW. 1996

Figure 3.39.
Sources of Health Insurance, by Medicare Status, 1994

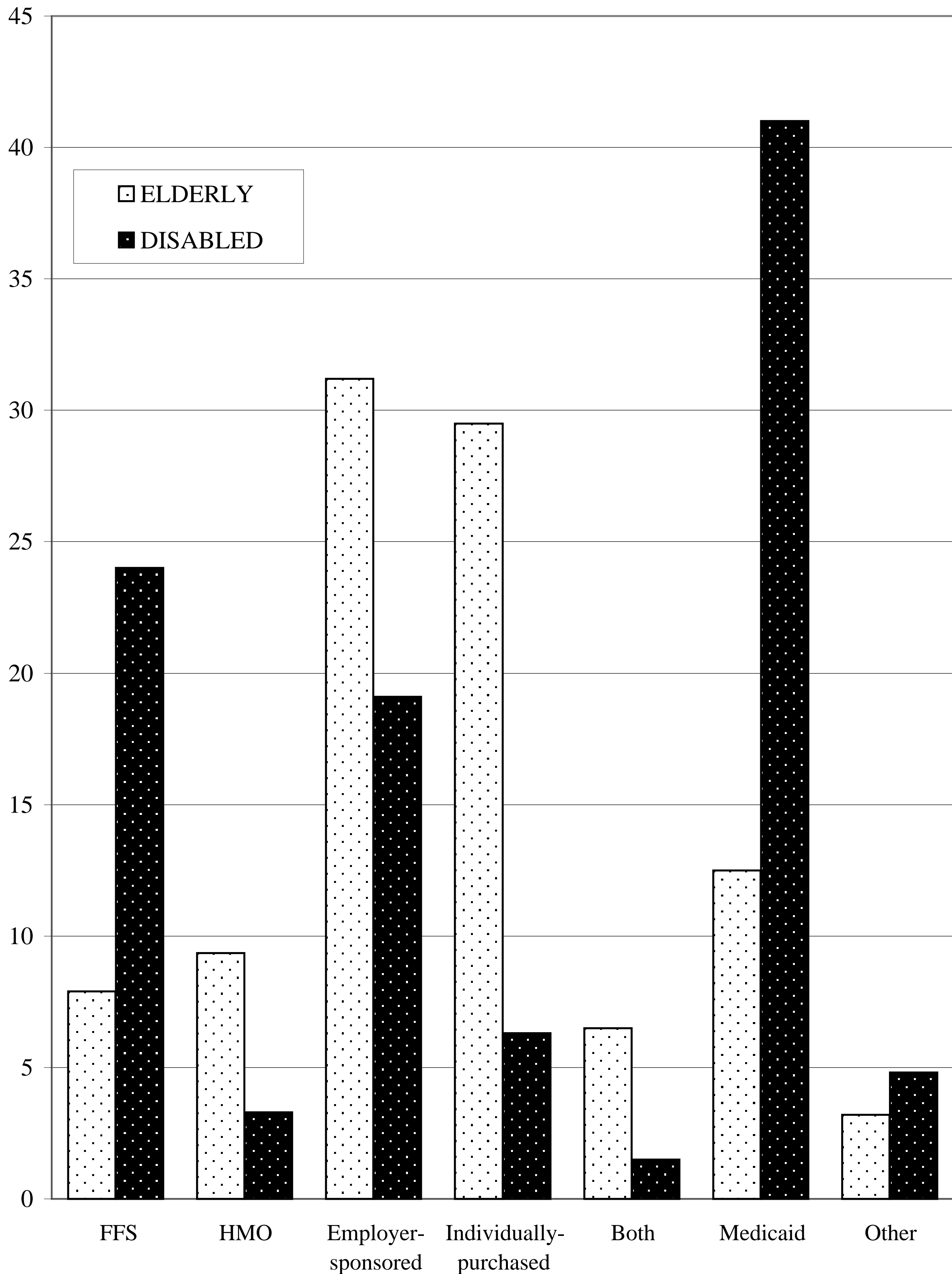
There are considerable differences in the types of supplemental coverage held by the elderly and disabled. Disabled beneficiaries are more likely than the aged to be "dually eligible" for both Medicare and Medicaid (41% vs. 13% in 1994). The disabled are less likely to have either individually-purchased insurance ("Medigap") or employer-sponsored insurance (27% vs. 67% in 1994). Further, a much larger proportion of the disabled than the aged (24% vs. 8%) have no supplemental protection.

TABLE 3.39.
Sources of Health Insurance, by Medicare Status and Age, 1994
(in percent)

	Medicare		Supplemental				Other
	FFS	HMO	Employer-Sponsored	Individually-Purchased	Both	Medicaid	Other
Total	9.6	8.7	29.9	27.0	6.0	15.6	3.3
Elderly	7.9	9.4	31.2	29.5	6.5	12.5	3.2
Disabled	24.0	3.3	19.1	6.3	1.5	41.0	4.8
Elderly							
65-69	10.0	9.3	37.0	25.7	6.5	9.6	1.9
70-74	6.6	9.5	35.4	28.6	7.5	9.6	2.7
75-79	7.1	10.5	30.1	32.1	6.6	10.6	3.0
80-84	6.7	9.3	24.4	34.0	6.2	15.4	4.2
85+	8.9	6.9	18.7	29.7	4.7	25.2	5.8
Disabled							
20-34	18.0	2.6	8.1	1.6	0.8	66.9	1.9
35-54	27.3	2.6	17.1	5.0	0.5	43.0	4.4
55-64	22.2	4.4	25.2	9.4	2.8	29.6	6.4
65+	0.0	0.0	33.7	25.1	0.0	41.2	0.0

NOTE: Table prepared by CRS.

Figure 3.39. Sources of Health Insurance, by Medicare Status, 1994



Source: CRS, U.S. Library of Congress. *Medicare: The Role of Supplemental Health Insurance,* by Jennifer O'Sullivan and Jason Lee. Report No. 96-826 EPW. 1996