Statement of
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before the
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Committee on Energy and Commerce
U.S. House of Representatives

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NOTICE

This statement is not available for public release until it is delivered at 10:00 a.m. (EST) Wednesday, March 26, 1986

Mr. Chairman, it is a pleasure to appear before this Subcommittee to discuss the elderly and health care expenditures. Decisions about the design of federal health programs are especially difficult to make now. On the one hand, federal health outlays represent 12 percent of total spending and they have been rising faster than other federal spending, making them visible candidates for change in the current deficit reduction climate. Medicare plays a central role, since it represents 60 percent of federal health spending. On the other hand, there is concern about the financial burdens of health care on program beneficiaries--particularly the elderly. Medicare's premiums and cost sharing are substantial under current law. Moreover, some services are not covered by Medicare and, in the case of long-term care, there are potentially catastrophic financial risks for beneficiaries.

At your request, my testimony today concentrates on two topics:

- The economic status of the elderly, and
- Their expenditures for health care.

THE ECONOMIC STATUS OF THE ELDERLY

Incomes of the elderly have risen substantially in recent years, in large part as a result of growth in Social Security and in public and private retirement benefits. Nonetheless, a large number of older people remain poor, and many more have incomes that place them just above the official poverty thresholds.

Income Overview

The income picture of the elderly has brightened significantly over time. After accounting for inflation, the average cash income of families with elderly members increased by nearly 18 percent during the 15-year period from 1969 to 1984--the latest year for which detailed data are available--while the average income of unrelated elderly individuals rose by 34 percent. 1/ Compared with younger people, the elderly have also made gains, as shown in Table 1. Average before-tax income both of families with elderly members and of unrelated elderly individuals increased as a fraction of comparable nonelderly income--from 68 percent in 1969 to 78 percent in 1984 for families containing elderly people, and from 50 percent to 60 percent for single elderly. In per capita terms, the incomes of the two groups became even more similar, because older families tend to be smaller than younger ones. Finally, because much of their income is not subject to income and payroll taxes, the elderly make further gains in terms of their after-tax income, relative to the younger population. 2/

Economic gains are reflected in the decline in the poverty rate among the elderly, from 25.3 percent in 1969 to 12.4 percent in 1984. 3/ This fall

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1. Only noninstitutionalized people are included in this discussion of the economic status of the elderly.

2. For example, Social Security benefits are partially taxable only if the sum of adjusted gross income, tax-free interest income, and one-half of Social Security benefits exceed $32,000 for couples and $25,000 for single individuals. In addition, payroll taxes only apply to earnings--a relatively small source of income for most elderly.

3. In 1984, the poverty threshold for a one-person household was $4,979 for people age 65 or older, and was $5,400 for people age 15 to 64. For two-person households, the threshold was $6,282 for those headed by an elderly person, and $6,983 for those headed by a nonelderly person.

TABLE 1. AVERAGE INCOMES OF THE ELDERLY AND NONELDERLY, 1969 AND 1984 a/

	Family Income	Family Income Per Capita	Income of Unrelated Individuals
Before Taxes			
1969			
Elderly	7,800	3,000	2,800
Nonelderly	11,500	3,500	5,600
Ratio, Elderly to Nonelderly	0.68	0.87	0.50
1984			
Elderly	26,000	10,900	10,800
Nonelderly	33,300	11,100	18,000
Ratio, Elderly to Nonelderly	0.78	0.99	0.60
After Federal Income and Payroll Taxes			
1984			
Elderly	23,200	9,800	10,100
Nonelderly	27,500	9,100	14,500
Ratio, Elderly to Nonelderly	0.85	1.08	0.70

SOURCE: Congressional Budget Office calculations based on March 1970 and March 1985 Current Population Surveys.

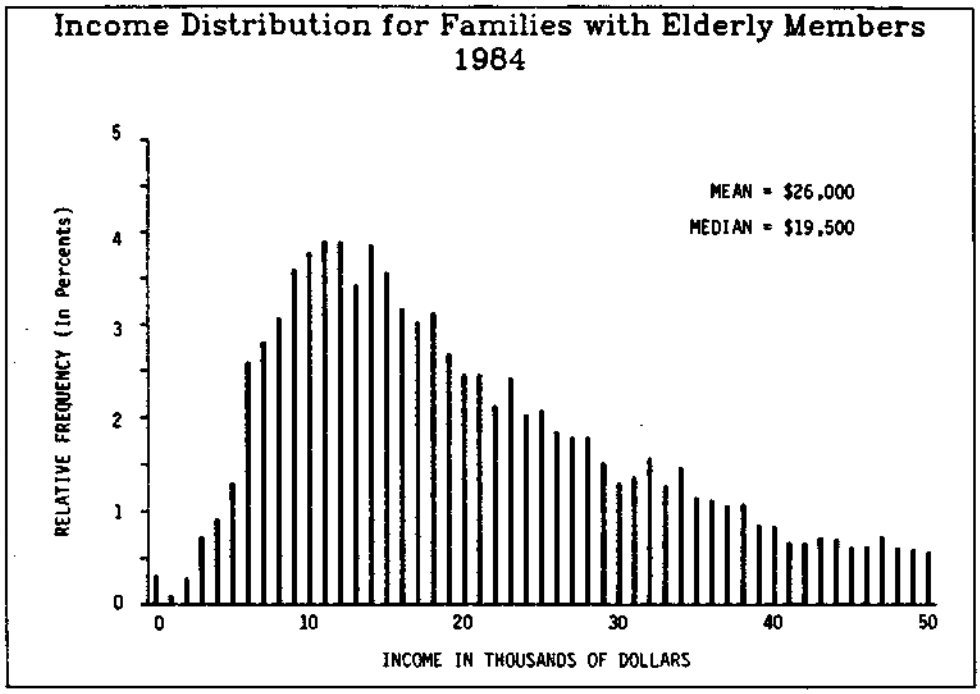
a. In this table, elderly families consist of families with two or more people that include at least one person age 65 or older, while nonelderly families consist of other families headed by people age 25 to 64. Elderly individuals include people age 65 and older who are living alone or with people to whom they are not related. Nonelderly individuals include similar people age 25 to 64.

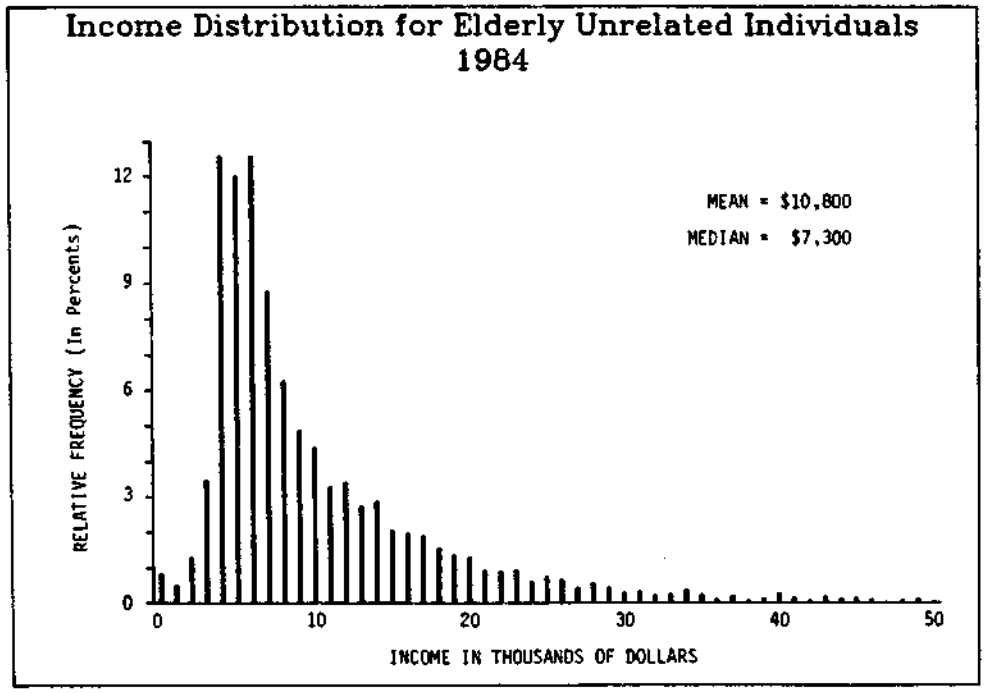
contrasts sharply with the rise in the poverty rate among the younger population that occurred during the same period--increasing from 10.7 percent to 14.7 percent. A large share of elderly had incomes just above the poverty line, however, with 8.8 percent of the elderly--or about 2.4 million people--having incomes between 100 percent and 125 percent of poverty, compared with 4.5 percent of the nonelderly.

The diverse economic condition of the elderly is reflected both in the wide variation in their income levels, and in differences in poverty rates among demographic groups. As seen in Figure 1, the incomes both of families with elderly members and of unrelated elderly individuals are widely distributed, with large numbers of elderly units having incomes considerably above, and considerably below, the "typical" elderly units. Similarly, poverty rates vary considerably among different demographic groups. For example, the poverty rate of elderly men in 1984 was 8.7 percent, compared with a rate of 15 percent for elderly women, and 35.6 percent for elderly black women in that year.

These are incomplete measures of economic well-being, however. They do not include in-kind transfers--from programs such as Medicare and Food Stamps--and they do not account for differences in expenditures on less discretionary items--including housing and health care--that restrict the amount of income that is available for other spending. They also take little account of wealth as a financial resource. For instance, many of the elderly own their homes outright, thus providing them with a valuable asset and freeing them from rent or mortgage payments.

FIGURE 1.





SOURCE: Congressional Budget Office tabulations of the March 1985 Current Population Survey.

NOTE: See footnote a in Table 1 for definitions.

Sources of Income of the Elderly

Let me turn now just to the personal income of elderly couples and individuals. 4/ Four sources--Social Security, pensions, income from assets, and earnings--provide most of the cash income of the elderly today. In addition, some of the poorest elderly receive means-tested cash transfers.

Social Security. Social Security is the largest single source of income for the elderly today, providing over 40 percent of their total cash income. The fraction of the elderly receiving these benefits has expanded steadily. It has risen between 1969 and 1984, for example, from 88 percent to over 95 percent for elderly couples, and from 81 percent to 91 percent for the single elderly, as shown in Figure 2. These gains are attributable in large part to earlier expansions in coverage for workers, which have resulted in an increasing share of the workforce becoming eligible for benefits when they retire.

Average real Social Security benefits--that is, the level of benefits after adjusting for inflation--have also increased. In 1984 the average elderly couple received about $8,900 in benefits, and the average single elderly person about $4,900. These gains occurred for a variety of reasons, including across-the-board benefit increases in the early 1970s and growth in average covered earnings of new retirees, which is a determinant of benefit levels.

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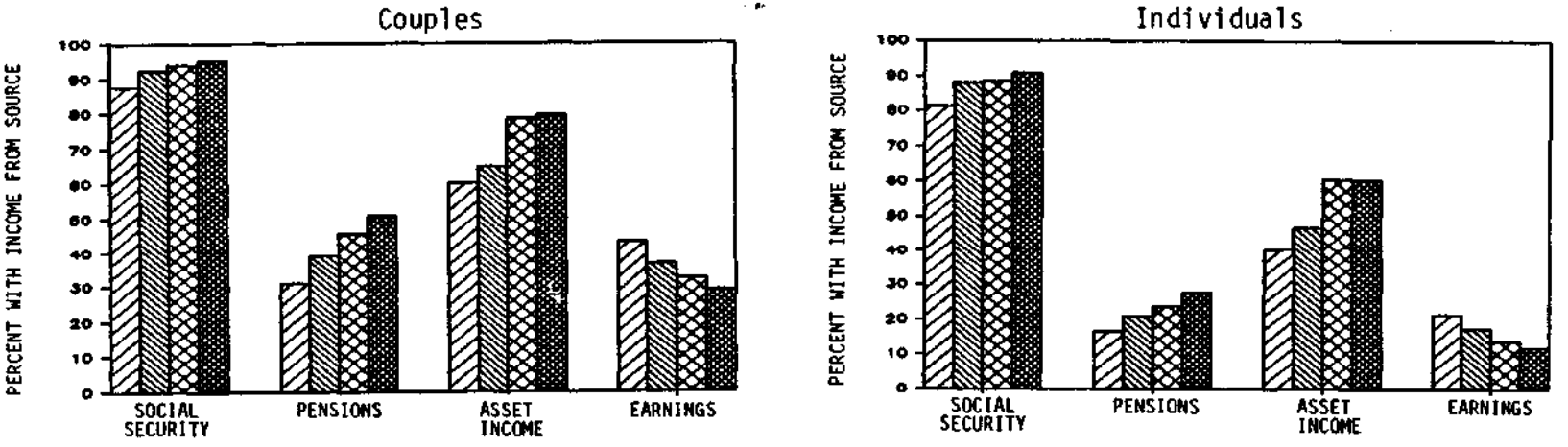
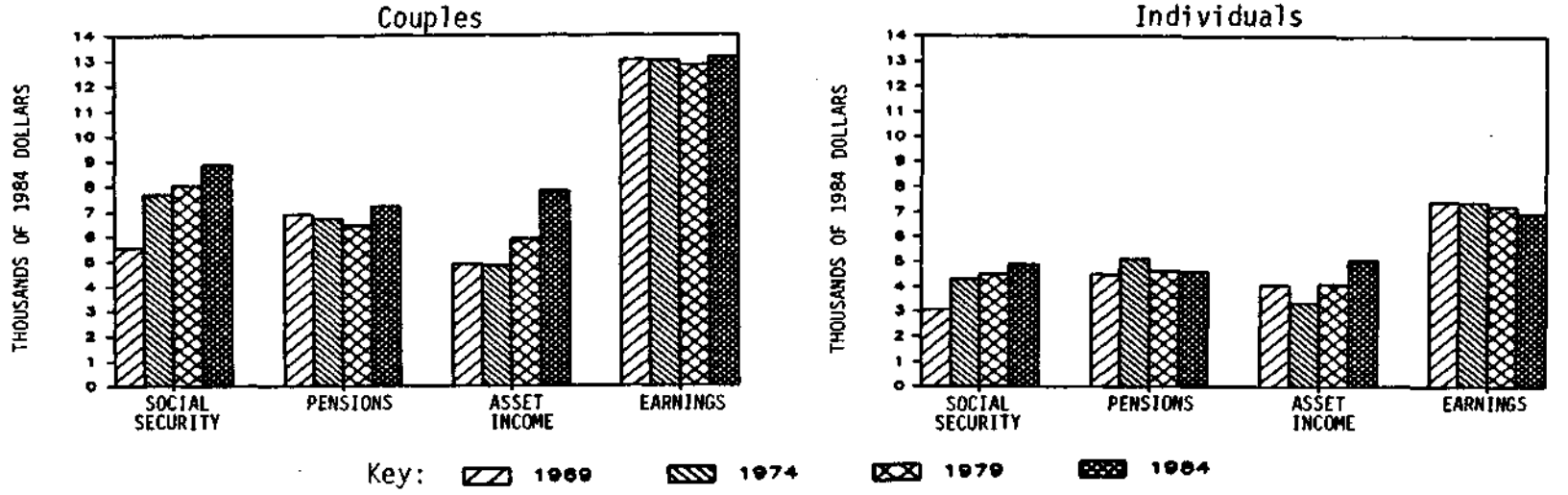
4. Elderly couples include those in which the older spouse is age 65 or older and the younger spouse is age 62 or older. Elderly individuals include all unmarried persons age 65 or older.

FIGURE 2.

PERCENTAGE OF ELDERLY WITH INCOME FROM SOURCE, 1969-1984



AVERAGE INCOME FROM SOURCE FOR RECIPIENTS, 1969-1984



SOURCE: Congressional Budget Office tabulations of the Current Population Surveys done in March 1970, 1975, 1980, and 1985.

Pensions. Private and public employee pensions also have been a growing source of income for the elderly, and today provide roughly 15 percent of their total income. The fraction of the elderly receiving these benefits has grown from 31 percent in 1969 to just over 50 percent in 1984 for couples, and from 16 percent to 27 percent for single elderly, which reflect both past expansions in coverage by private plans and past increases in public employment. The real level of pension benefits for those receiving them has remained relatively constant in recent years--at about $7,000 for elderly couples, and $4,600 for elderly individuals.

Income from Assets. Asset income has similarly risen in importance, and--at about 30 percent of total income--ranks second only to Social Security in its contribution to income of the elderly. Nearly eight out of ten elderly couples, and six out of ten elderly individuals, reported receiving income from assets in 1984. The amount varied dramatically, however, because the level of such income depends both on the rate of return received from the assets--such as the interest rate--and on the amount of assets that provide a cash return. 5/ In 1984, elderly couples with income from assets received an average of $7,800 from that source, while elderly individuals received about $5,100.

Earnings. In contrast to many other sources, earnings of the elderly have decreased dramatically as a share of total income--from 29 percent in 1969 to about 13 percent in 1984. An important explanation is the decline in the

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5. This category of income does not include the value of services provided by owner-occupied housing.

fraction of elderly who are working. The labor force participation rate for elderly men dropped from 27.2 percent in 1969 to 16.3 percent in 1984, and, for elderly women, from 9.9 percent to 7.5 percent. Real annual earnings for those elderly couples who have a worker present remained relatively constant at about $13,000, on average, while they declined slightly to about $6,600 for elderly individuals.

Means-Tested Cash Transfers. Means-tested cash transfers--the largest of which is Supplemental Security Income--are a small component of the total income of the elderly, but provide significant support for many of those with low incomes. The fraction of the elderly receiving income of this type has declined somewhat in recent years, with 3 percent of elderly couples, and 12 percent of elderly individuals, receiving some benefits in 1984. Average real benefit amounts have also fallen for those receiving this income--in part because of the rise in Social Security payments--so that the average elderly couple received about $2,400 in 1984, and the average single elderly person about $1,900 in cash aid.

Other Economic Resources

In addition to cash income, elderly people often have access to other economic resources, including in-kind benefits and wealth.

In-kind benefits are a major determinant of the well-being of the elderly, although they are typically not included in measures of income. Medicare--the largest of these benefits for the elderly--is available regardless of income to all people age 65 or older. Other aid--including food

stamps, Medicaid, and housing assistance--is provided for some low-income elderly. It is difficult to place a specific value on much of this aid, although the cost to the government of providing it is considerable. Medicare expenditures for the elderly in 1985 were about $58 billion, for example, and major means-tested in-kind benefits for the elderly totaled an additional $13.5 billion.

Wealth--that is, the difference between a family's assets and its liabilities--also contributes economic resources both by providing services such as housing and by increasing purchasing power. While we know less about the wealth of the elderly than about their income, some information is available. For today's population, wealth increases with age, on average, reaching its highest levels for families whose heads are between age 55 and age 75. Wealth is also positively related to family income for both the elderly and nonelderly, although the elderly typically have considerably more wealth than do younger families with similar income. Home ownership accounts for a significant share of wealth for the elderly--thereby reducing their cash expenditures for housing--with about 70 percent of elderly families owning their homes, and most of them owning the houses outright. Nonetheless, home equity typically represents a smaller fraction of wealth for the elderly than it does for the nonelderly, presumably because the elderly have larger amounts of financial assets.

Sources of Income of Elderly People in Different Income Groups

The economic well-being of the elderly is also reflected in part by the sources of income on which they rely. As shown in Table 2, Social Security

TABLE 2. PERCENTAGE DISTRIBUTION OF INCOME BY SOURCE FOR ELDERLY IN DIFFERENT INCOME GROUPS, 1984

Income Source	Income Quintiles (In percents) Lowest 20	20 to 39	40 to 59	60 to 79	80 to 100
Elderly Couples a/					
	Income Range (In dollars)				
	All Income Groups	Less than 10,100	10,100-14,449	14,450-20,099	20,100-30,099	30,100 and above
Social Security	37.6	82.2	69.2	55.5	37.4	17.8
Government Pensions	8.5	1.8	4.7	5.7	10.5	10.4
Private Pensions	7.7	2.9	7.7	11.5	9.9	6.2
Income from Assets	27.6	6.1	10.4	17.9	26.7	38.4
Earnings	16.9	2.2	6.0	7.9	14.7	25.7
Means-Tested Cash Transfers	0.3	3.3	0.6	0.1	0.0	0.0
Other Income	1.3	1.5	1.4	1.4	0.8	1.5
Total	100	100	100	100	100	100
Elderly Individuals a/					
	Income Range (In dollars)				
	All Income Groups	Less than 4,200	4,200-5,799	5,800-8,049	8,050-13,699	13,700 and above
Social Security	44.5	75.0	81.6	74.2	52.9	21.7
Government Pensions	7.8	0.6	1.1	3.6	7.9	11.1
Private Pensions	4.7	0.4	1.0	4.2	7.4	5.0
Income from Assets	30.6	3.5	4.7	10.0	21.6	48.5
Earnings	8.1	0.6	1.3	2.5	7.1	12.3
Means-Tested Cash Transfers	2.3	17.8	7.2	3.1	0.2	0.0
Other Income	2.1	2.1	3.1	2.4	2.9	1.4
Total	100	100	100	100	100	100

SOURCE: Congressional Budget Office calculations based on the March 1985 Current Population Survey.

a. Elderly couples include those in which the older spouse is age 65 or older and the younger spouse is age 62 or older. Elderly individuals include all unmarried people age 65 or older.

supplies 75 percent or more of total cash income for low-income elderly; over 85 percent of this group's income comes from the combination of Social Security and means-tested cash transfer programs. In contrast, the better-off elderly receive, on average, a much larger fraction of their total income from earnings and assets. Pensions also provide an increasing share of the total as incomes rise.

HEALTH CARE EXPENDITURES BY THE ELDERLY

The remainder of my statement concerns health care expenditures by the elderly. It begins with an overview of the kinds of health care services consumed by the elderly and how they are financed. Because of its importance in paying for acute care--that is, health services other than long-term care--Medicare is discussed next, with a focus on the payments that must be made by its beneficiaries in order to receive services. 6/ The financial risk posed by these liabilities gives rise to the voluntary purchase of private supplementary insurance by many elderly, so my statement then turns to the characteristics of this insurance and of the elderly who have it. Finally, we present CBO calculations of out-of-pocket payments by the elderly for acute care services that take into account the effects of private insurance and Medicaid.

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6. Because this statement concentrates on people age 65 and older, when public programs are considered, younger groups--such as those with end-stage renal disease who are covered by Medicare and some low-income disabled who are covered by Medicaid--are not discussed.

Overview

Health spending for people age 65 and older is considerable. For example, in 1984, it averaged $4,200 per person--over three times that for the nonelderly. As shown in Figure 3, nearly two-thirds of this spending was financed through government programs. Medicare paid for 45 percent of all services, state and federal Medicaid payments accounted for 13 percent, and other public programs (the largest being those of the Veterans Administration) provided an additional 6 percent. The remaining share--over one-third of the total--was financed by the elderly or their families, either directly through payments to providers of services or indirectly through premiums for insurance. 7/

Medicare's role primarily involves financing acute care services--73 percent of the cost of the elderly's hospital services and 44 percent of the cost of their physicians' services were paid by the program in 1984. About two-thirds of the costs of other acute care services were financed by the elderly themselves; for example, private spending for out-of-hospital prescription drugs averaged about $100 per enrollee that year.

In contrast, Medicaid is the principal source of public financing for nursing home care--paying for 41 percent of total costs--while Medicare accounted for only 2 percent of the total. The remaining costs of long-term care, which are almost all paid by the elderly or their families, represent perhaps the greatest financial risk. Although only about 1 in 20 elderly

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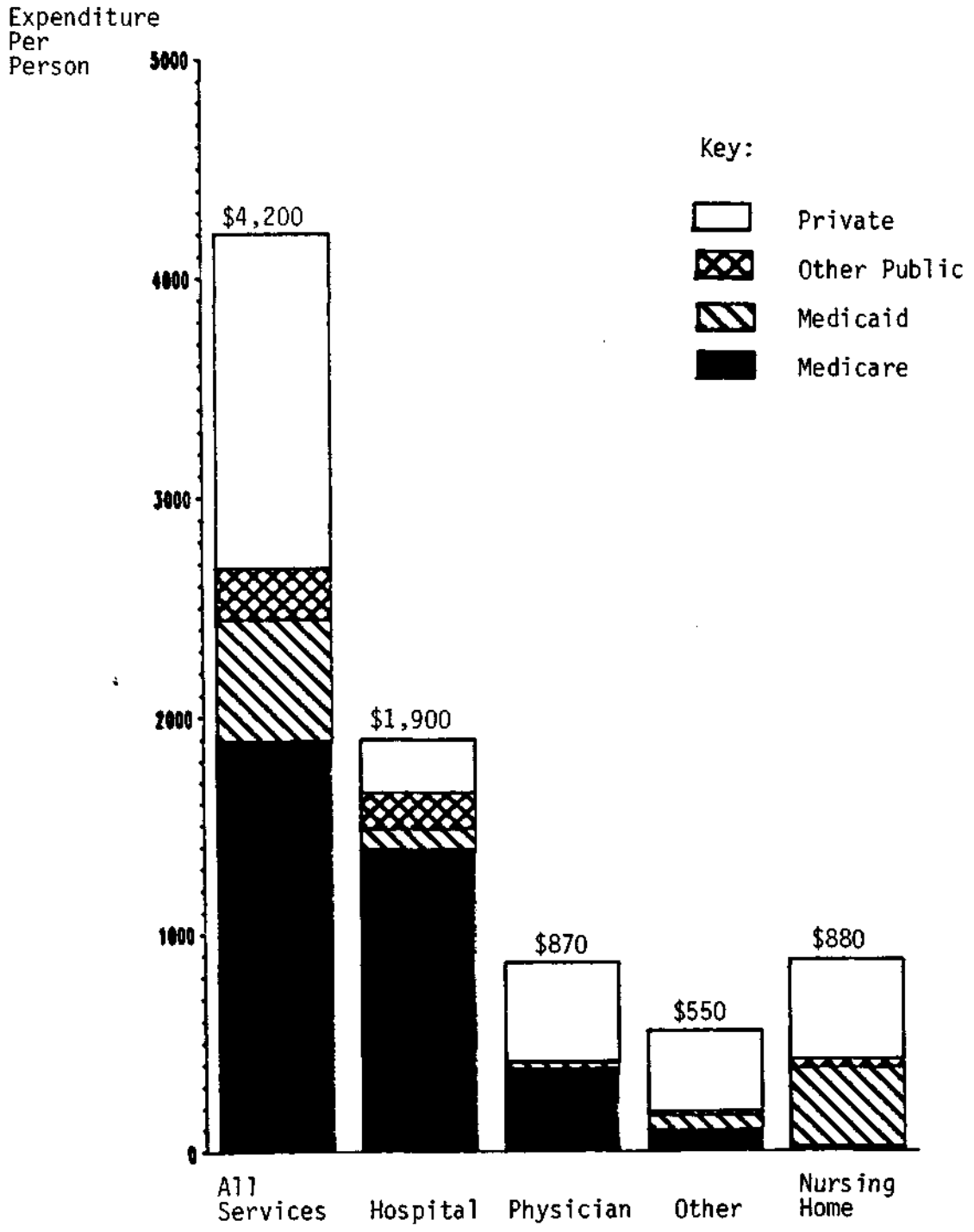
7. In addition to private health insurance premiums, these figures count Supplementary Medical Insurance premiums paid by beneficiaries as private spending. They exclude contributions that cover the administrative costs of private insurance.

FIGURE 3. PER CAPITA HEALTH EXPENDITURES FOR THE ELDERLY, BY SOURCE OF PAYMENT, 1984 (In dollars)



SOURCE: Congressional Budget Office calculations based on D.R. Waldo and Helen C. Lazenby, "Demographic Characteristics and Health Care Use and Expenditures by the Aged in the United States: 1977-1984," Health Care Financing Review, vol. 6, no. 1, pp. 1-29.

resided in a nursing home in 1980--the most recent year for which data are available--over 20 percent of those age 85 and older were institutionalized. For people in this situation, stays tend to be long and the cost per month high. Moreover, there is hardly any private insurance to cover these stays, and public coverage through Medicaid is limited to elderly people with low incomes or those whose spending has exhausted their incomes and assets.

While the problem of financing long-term care is extremely important, its dimensions and possible policy responses are only beginning to be understood and tested. The rest of my remarks today will, therefore, address only spending and insurance coverage for acute care services.

Enrollees' Potential Liabilities Under Medicare

Although Medicare covers most of the costs of serious illness, beneficiaries are responsible for a portion of their health care expenditures. Payment of the Supplementary Medical Insurance (SMI) premium, estimated to be $217 for 1987, will provide enrollees with coverage for physicians' services, although they will still be responsible for a $75 deductible, 20 percent of physicians' allowed charges, and any billings by their physicians over Medicare's allowed amounts. Under the Hospital Insurance (HI) portion of Medicare, beneficiaries who are hospitalized will pay a deductible amount for each spell of illness (estimated to be $572 in 1987), coinsurance of $143 per day for inpatient days 61 through 90, and $286 per day for any of the 60 lifetime reserve inpatient days. 8/

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8. Those beneficiaries discharged to skilled nursing facilities (SNFs) will pay coinsurance of $71.50 per day for days 21 through 100. If the lifetime reserve of hospital days is exhausted, all subsequent charges are paid by the enrollees, as are charges for any SNF days over 100. Few beneficiaries--less than 1 percent--are in these situations, however.

The potential financial risk to enrollees for Medicare-covered services--ignoring for the moment whether they are paid out of pocket, by private insurance, or by Medicaid--will vary substantially around the average of $700 for 1987, depending on the kind and amount of services used by the individual patient. As Figure 4 shows, even when physicians' bills that exceed Medicare's allowed amounts are ignored, beneficiaries' liabilities are estimated to range from $250 for the 34 percent of enrollees who will use no reimbursible services--but who will pay the SMI premium and perhaps some costs that do not exceed the SMI deductible--to $14,270 for the one-fifth of one percent whose hospitalization will be long enough to draw on lifetime reserve days. 9/ For those who are hospitalized--25 percent of the elderly during any year--average cost sharing for SMI and HI combined is expected to be $1,550, but enrollees who have multiple admissions (8 percent of the total) will pay an average of $2,450. Older enrollees are especially likely to face these high liabilities; for example, while 6.4 percent of those age 65 to 74 will have multiple admissions, 11 percent of those 85 and older will use this amount of services.

Private Supplementary Insurance and Medicaid

In 1984, private supplementary insurance--both group and individual policies--and Medicaid protected over 20 million, or 80 percent, of the

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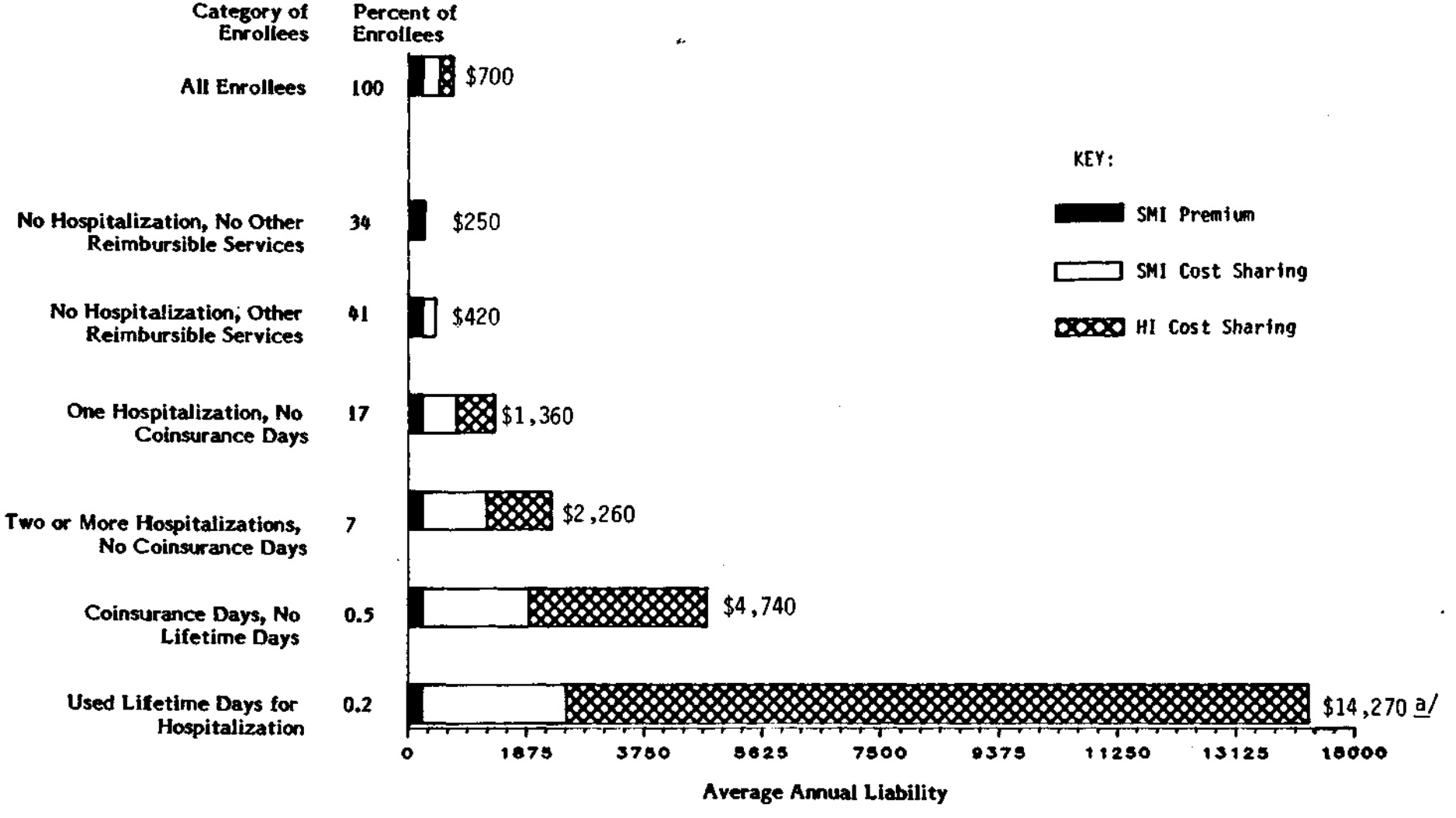
9. These estimates reflect beneficiaries' liabilities for SMI premiums and for cost sharing under both SMI and HI; that is, they exclude payments for services not covered by Medicare and any additional billings by physicians over Medicare's allowed amounts. These additional out-of-pocket expenditures are taken into account below.

FIGURE 4. AVERAGE LIABILITIES OF ENROLLEES IN 1987 FOR PREMIUMS AND COST SHARING UNDER MEDICARE, BY USE OF SERVICES (In dollars)



SOURCE: Congressional Budget Office estimates based on the 1981 Medicare History File.

NOTE: All enrollees will pay the SMI premium of $217 in 1987; cost sharing under both SMI and HI will rise as use of health care services--especially hospitalization--increases.

a. In addition, this group will incur average spending of $7,000 for the hospital costs of some enrollees after they have exhausted their lifetime reserve days.

noninstitutionalized elderly from most of the potential risks described above. 10/

As Figure 5 shows, 18 million--or 72 percent--of the elderly were covered by some form of private supplementary insurance, either as part of a group (generally insured through their current or former employer or union) or under an individual policy. There is considerable variation in the benefits offered under these policies, however--ranging from the conventional employer-provided insurance held by the working aged to hospital indemnity plans that pay only a limited sum for each day of hospitalization. 11/

The most common form is the "Medigap" policy, which is designed to pay part or all of Medicare's deductible amounts and coinsurance. In all but one state, these policies are required to meet minimum standards at least as stringent as those set out under the Baucus Amendment to the 1980 Social Security Disability Act (Public Law 96-265). These standards require coverage of nearly all SMI coinsurance, all HI coinsurance, and 90 percent of

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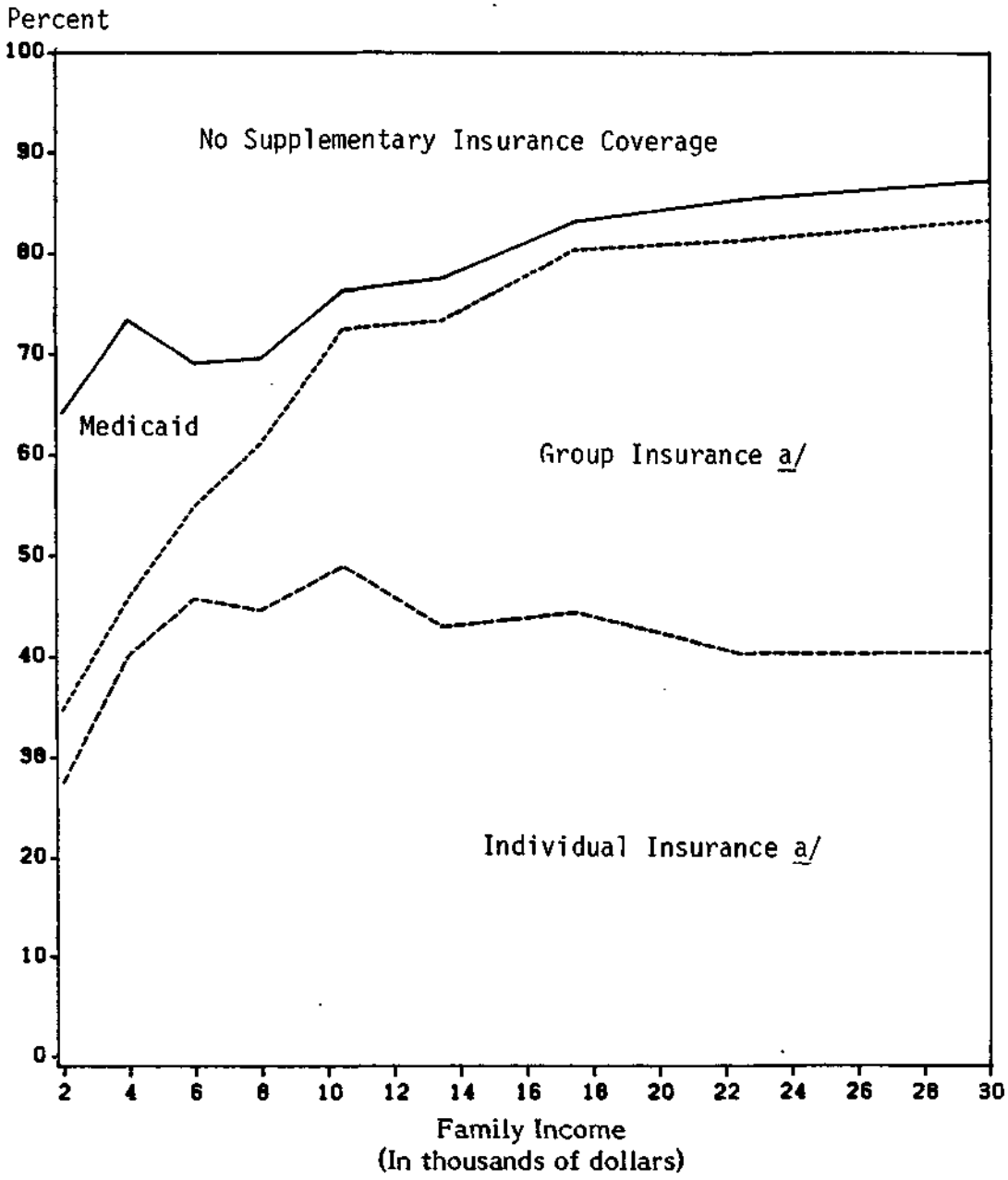
10. Most of the estimates in this section are based on the April 1984 Survey of Income and Program Participation (SIPP), which covers the civilian, noninstitutionalized population of the United States. Therefore, about one million institutionalized elderly, many covered by Medicaid, are excluded from this analysis of supplementary insurance. Individuals who have both private policies and Medicaid eligibility are included in the Medicaid category.

11. The situation differs for those elderly under age 70 who are employed and covered by their employers' health plan, and for spouses under 70 who are covered by plans of workers under age 70. These private insurance plans must pay all bills that they cover, with Medicare serving as a secondary payer. Little is known about these beneficiaries or the characteristics of these plans, however.

FIGURE 5. PERCENT OF ELDERLY MEDICARE ENROLLEES HAVING SUPPLEMENTARY INSURANCE COVERAGE, BY FAMILY INCOME, APRIL 1984



SOURCE: Congressional Budget Office tabulations of Survey of Income and Program Participation (SIPP).

a. The SIPP questionnaire allows for description of only one type of private insurance plan. The first descriptive question asks whether it was an employer or union plan. Therefore, people who were covered under both a group and an individual plan are likely to have been classified above as covered by group insurance.

all hospital expenses for 365 days beyond exhaustion of HI's coverage. Consequently, Medigap policies greatly reduce the risks of high out-of-pocket expenditures associated with Medicare's covered services, although most policies do not cover other costs such as those for prescription drugs.

To obtain Medigap coverage, of course, the elderly (or an employer or union) must pay a premium reflecting the generosity of the benefit package, as well as administrative and marketing costs that ranged from 15 percent to 35 percent of the premium. Annual Medigap premiums averaged roughly $300 to $400 per person in 1984, though as a result of considerable differences in benefits and administrative costs, they ranged from as low as $150 to over $1,000.

The likelihood of an elderly person having private insurance rises with family income. As Figure 5 also shows, 44 percent of those with incomes under $5,000 were covered, compared with 87 percent of those with incomes of $25,000 or more. Group insurance was more likely among those who had higher incomes, were younger, lived with their spouses, or were employed, while ownership of individual policies was more evenly distributed.

An additional 2 million, or 8 percent, of the elderly were eligible for Medicaid in April 1984. Medicaid eligibility, which is closely linked to receipt of SSI cash benefits, is largely concentrated among those with low incomes. In the 38 states with programs for the "medically needy," some elderly with incomes above cash assistance standards may also become

eligible for Medicaid, especially if they have incurred high out-of-pocket expenses relative to their incomes.

Once covered by Medicaid, an elderly person faces little risk of high out-of-pocket expenses--the SMI premium and Medicare's cost sharing requirements are generally paid by Medicaid. Moreover, physicians who treat elderly Medicaid patients may not bill these patients for any additional charges. Finally, many states cover a wide range of additional services as optional benefits that further reduce the risks to these elderly--48 of 50 Medicaid programs covered prescription drugs in 1981, for example.

Despite this widespread supplementary coverage, about 5 million--or 20 percent--of elderly Americans had no protection other than Medicare against health care costs. Moreover, the elderly with lower incomes and with greater health care needs were most likely to lack supplementary insurance, as shown in Table 3. For example, nearly 30 percent of the elderly with family incomes under $9,000 had neither private coverage nor Medicaid eligibility, compared with 10 percent of those with family incomes over $25,000. Although health care needs rise with age, so did the likelihood of being without supplementary insurance--17 percent of those between 65 and 69 lacked coverage, compared with 27 percent of those 80 and older. Finally, lack of supplementary coverage was not related to health status, largely because Medicaid covers many of the elderly who are most likely to have poor health. Among those who were not eligible for Medicaid,

TABLE 3. CHARACTERISTICS OF ELDERLY MEDICARE ENROLLEES, APRIL 1984 a/

Characteristic	Number of Enrollees (in millions)	Percent of Enrollees	Percent Having Neither Private Supplementary Coverage Nor Medicaid Eligiblity
ALL b/	25.6	100	20.1
Family Income			
Under $5,000	3.1	12.2	28.5
$5,000 - $8,999	5.6	21.8	29.9
$9,000 - $14,999	6.2	24.1	20.8
$15,000 - $24,999	5.9	22.9	13.7
$25,000 and Over	4.9	19.1	10.1
Age			
65 - 69	8.6	33.3	17.3
70 - 74	7.2	28.0	19.1
75 - 79	4.9	19.3	20.1
80 and Above	5.0	19.4	26.5
Self-Reported Health Status			
Excellent	6.6	25.6	19.5
Good	9.5	37.1	20.1
Fair	6.4	25.2	20.4
Poor	3.1	12.1	20.8

SOURCE: Congressional Budget Office calculations based on the Survey of Income and Program Participation and the 1980 National Medical Care Utilization and Expenditure Survey.

a. Details may not add to totals because of rounding.

b. These estimates apply to the civilian, noninstitutionalized population age 65 and over enrolled in Medicare.

however, those in poor health were least likely to have private insurance--28 percent were not covered, compared with 20 percent for those whose health was good or excellent. 12/

Out-of-Pocket Spending

In the final analysis, out-of-pocket spending by the elderly for acute care results from the illnesses that befall them, the types of supplementary coverage they have, if any, and their cost.

As shown in Figure 6, out-of-pocket expenditures by those who have neither private supplementary insurance nor Medicaid eligibility will average $710 in 1987. The variation in spending by patients using different kinds and amounts of services will resemble that in Figure 4, except that the cost sharing amounts for Medicare's covered services will be somewhat lower. 13/ This difference will occur because those who must actually pay cost sharing are discouraged from obtaining as much health care as consumed by those who have insurance coverage that "fills in" their deductible and coinsurance liabilities. 14/ In addition, other types of costs--

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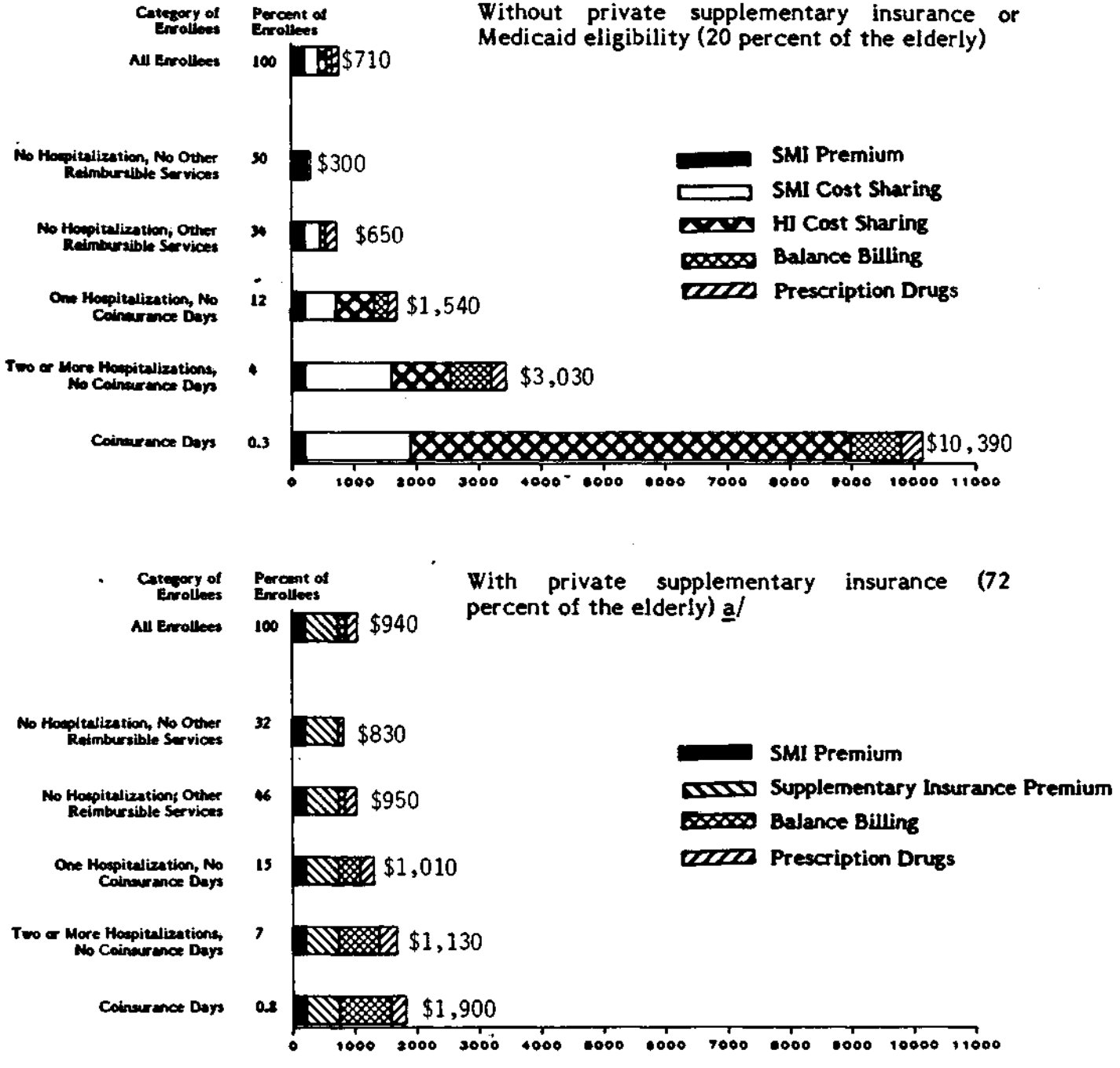
12. Part of the explanation is that the decision to purchase private supplementary insurance is directly related to the ability to pay its premiums and those with greater health care needs typically have lower incomes. Factors that lead to loss of coverage or barriers against acquiring coverage may also be important.

13. Some of the elderly who will use substantial amounts of health care services (such as those who will be hospitalized long enough to use lifetime reserve days) may receive charity care, rather than paying all of their expenses themselves. The estimates in Figure 4 do not account for charity care, however, because there are insufficient data.

14. For example, those with supplementary coverage are about one and one-half times as likely to be hospitalized during the year as those with no additional coverage, a difference that is related to Medicare's sizeable deductible for inpatient hospital care. There is a comparable difference in use of physicians' services.

FIGURE 6. OUT-OF-POCKET SPENDING FOR ACUTE-CARE SERVICES BY INSURANCE STATUS AND BY USE OF SERVICES, 1987 (In dollars)



SOURCE: Congressional Budget Office estimates based upon 1981 Medicare History File and 1980 National Medical Care Utilization and Expenditure Survey. See text for details.

a. The remaining 8 percent of the elderly will have minimal out-of-pocket expenditures once their eligibility for Medicaid is established.

such as physicians' bills that exceed Medicare's allowed amounts and those for prescription drugs--will be lower, on average, because they are also related to the use of Medicare-covered services.

The lower use of health care services by the elderly who do not have supplementary coverage that pays Medicare's cost sharing occurs despite the fact that these beneficiaries are older and sicker. Although it is generally agreed that insurance coverage should impose some economic discipline on enrollees (and their physicians) to encourage careful consumption of services, there is much less agreement on just how strong that discipline should be and, therefore, on what are appropriate levels of use. It is not possible, then, to say whether necessary health care services are forgone because of cost sharing, or whether those with supplementary coverage use some unnecessary services.

In contrast, the elderly with private supplementary insurance will spend an average of $940 out-of-pocket in 1987 for acute care. This amount will exceed payments by those without supplementary insurance for two reasons: their use of medical care will be greater, and they will pay administrative costs for their insurance policies. Their risks of extremely high expenditures will be much lower, however, as indicated by the more even distribution of spending by patients using different kinds and amounts of services--the lowest users will spend about $830, on average, and the highest users about $1,900. 15/

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15. These estimates are based on the provisions of a typical private supplementary policy. While the out-of-pocket expenditures of individual enrollees will depend on the characteristics of their own policies, the variability in their experiences will be far less than for those with neither private supplementary coverage nor Medicaid eligibility.

Finally, out-of-pocket spending after people become eligible for Medicaid is minimal, as a result of the program's generous benefit package and extremely limited cost sharing.

CONCLUSION

In sum, the well-known statistic that the elderly spend 15 percent of their income for all their health care services hides tremendous variability in their individual experiences. Despite substantial federal spending, differences in beneficiaries' out-of-pocket costs for acute care are striking, especially among the 20 percent who have no supplementary coverage. This group is disproportionately likely to have low incomes, though not low enough to be eligible for Medicaid. Moreover, the possibility of having to pay for long-term care means that all the elderly--including those with average and high incomes who generally have excellent Medigap coverage--are exposed to substantial financial risk.