2 TRENDS IN THE MCBS: 1992-1994

Health and Health Care of the Medicare Population is an annual sourcebook illustrating data from the most recent Cost and Use File, as well as information on access to and satisfaction with care that was collected in the fall of the same year.[1] In addition to the topics presented in the two previous sourcebooks, the 1994 sourcebook includes a new set of tables that are designed to highlight the usefulness of time series data produced by the MCBS. The new tables, which are in Section 6 of the sourcebook, contain information on selected characteristics of Medicare beneficiaries and their health care expenditures for the years 1992-1994.

The "trends" presented in this chapter draw heavily from data in Section 6. We use the information to illustrate one of the strengths of the MCBS—its ability to track change in the health and health care of the Medicare population. The data can be used alone or in combination with information from other sources to analyze a wide range of issues related to the cost, delivery, and financing of health care for Medicare beneficiaries. The obvious caveat in using the data to assess change over time, however, is that three data points provide limited evidence of a trend.

Health care expenditures

In 1994, the MCBS represented 38.3 million persons who were eligible for Medicare for all or part of the year. Of the 35.5 million beneficiaries living in community settings (i.e., those who did not live in long-term care facilities during any part of 1994), 31.6 million were age 65 or older (aged beneficiaries), and 3.9 million were disabled beneficiaries under the age of 65.[2] Another 2.8 million aged and disabled beneficiaries lived all or part of the year in long-term care facilities. The MCBS provides estimates of total health care spending by these people, as well as detailed information on their demographic and socioeconomic characteristics.

Personal health care spending by aged and disabled beneficiaries represents direct consumption of health care goods and services provided by hospitals, physicians, and other suppliers of medical care and equipment. The MCBS estimates include expenditures on Medicare-covered services as well as relatively expensive services not typically covered by Medicare (e.g., long-term facility care and prescription drugs). Information on the noncovered services fills a large gap in our knowledge about health care spending by beneficiaries because HCFA, the primary source of Medicare program data, has claims for only those services covered under Medicare Part A and Part B. The Medicare-covered expenditures represent approximately one-half of the cost of medical goods and services consumed by aged and disabled beneficiaries.[3] Other health care expenditures by Medicare beneficiaries would be difficult to estimate without data from the MCBS.

Total health care spending by aged and disabled beneficiaries is included, but not shown separately, in the National Health Expenditures report (NHE) produced annually by HCFA for the U.S. Department of Health and Human Services (DHHS). The NHE provides a comprehensive picture of national health care spending, with information on sources of funding and services consumed by all U.S. residents. Policymakers follow the NHE because the share of gross domestic product spent on health care has been growing over time. Between 1960 and 1996, total health care spending grew from 5.1 percent to 13.6 percent of the gross domestic product of the United States (Levit et al., 1997). These expenditures represent the value of foregone opportunities to purchase other goods and services.

In 1994, national spending on health care reached $949.4 billion, including $831.7 billion in health care goods and services purchased directly by the resident population.[4] The average personal health care expenditure was $3,075 for a population of 270.5 million (Levit et al., 1996), but it masks significant variation in health care spending by individuals and groups. The 38.3 million aged and disabled beneficiaries represented in the 1994 MCBS Cost and Use File, for example, constituted 14 percent of the population, but they

1 See Appendix A for a discussion of the MCBS public use files on Cost and Use and Access to Care.

2 Beneficiaries who did not live in long-term care facilities are referred to as community residents in the sourcebook.

3 According to the MCBS, Medicare financed about 54% of the health care of aged and disabled beneficiaries in 1994. However, the survey uses Medicare claims to supplement information reported by sample persons on the use of Medicare-covered services. Since households do not have a corresponding mechanism to help them remember noncovered service utilization, expenditures on these services are probably underreported relative to Medicare-covered services.

4 The national health expenditures include personal health care expenditures plus public program administration costs, the net cost of private health insurance, research by nonprofit groups and government entities, and the value of new construction put in place for hospitals and nursing homes. In 1994, expenditures for services other than personal health care were $117.7 billion.

accounted for 36.5 percent of the $831.7 billion spent on health care in that year. This group, which includes all beneficiaries who were enrolled in Medicare at any time during the year, had an average health care expenditure of $7,936 in 1994.

Recent growth in personal health care spending by Medicare beneficiaries and the non-Medicare population is highlighted in Figure 1. Between 1992 and 1994, national expenditures on personal health care increased from $739.8 billion to $831.7 billion, or slightly more than 6 percent annually. Much of the growth was fueled by Medicare beneficiaries' demand for health care. Expenditures by aged and disabled beneficiaries expanded from $247.0 billion to $303.7 billion, a 10.9 percent annual rate of growth.[5] Expenditures by the non-Medicare population, on the other hand, expanded from $492.8 billion to $528.0 billion, a 3.5 percent annual rate of growth.

Nominal growth in national health care spending can be explained in terms of population growth, economy-wide inflation, medical inflation in excess of economy-wide inflation, and a residual that includes change in the volume and intensity of care provided to patients (Levit et al., 1996). The effects of inflation and change in health care utilization can be seen in Figure 2, which shows per capita expenditures by Medicare beneficiaries and the non-Medicare population for the years 1992-1994. Per capita spending increased at a slower rate than total spending because the Medicare and non-Medicare populations grew by 4 percent and 1.7 percent, respectively, between 1992 and 1994. Nonetheless, spending by Medicare beneficiaries continued to grow significantly faster than that of the non-Medicare population. The average expenditure by Medicare beneficiaries increased at an annual rate of 8.7 percent, from $6,716 to $7,936. The average expenditure by the non-Medicare population increased at an annual rate of 2.6 percent, from $2,159 to $2,274.

Figure 1 National Spending on Personal Health Care, 1992-1994

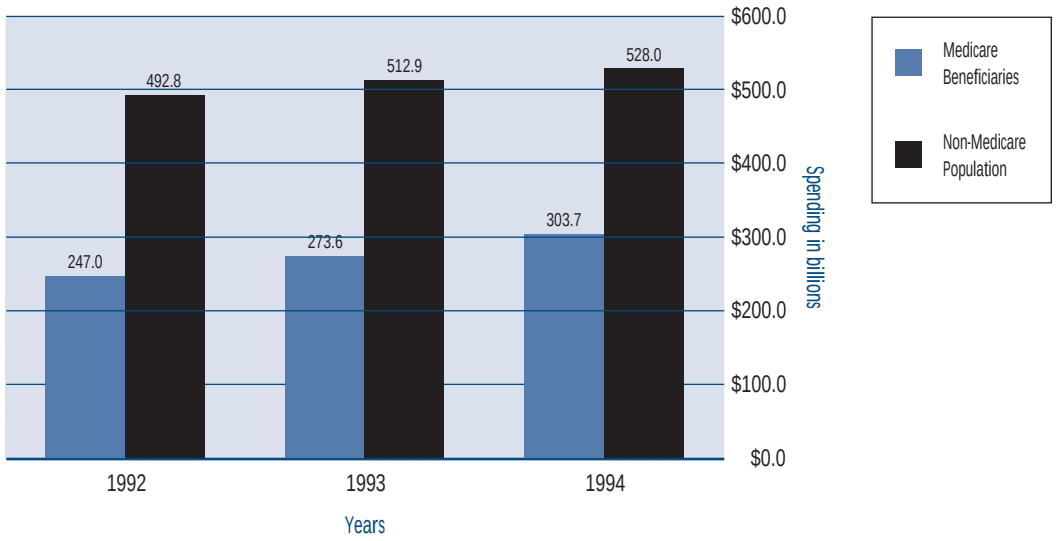
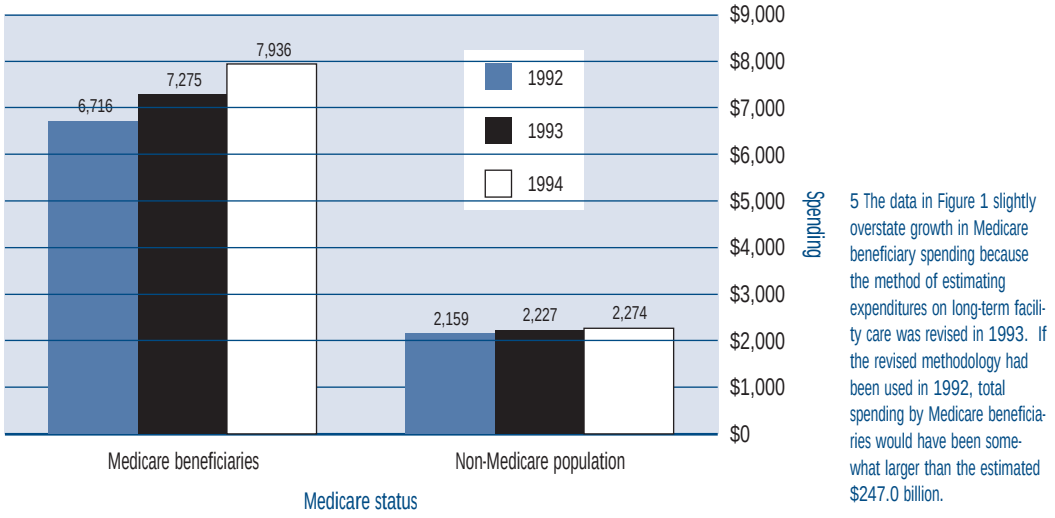
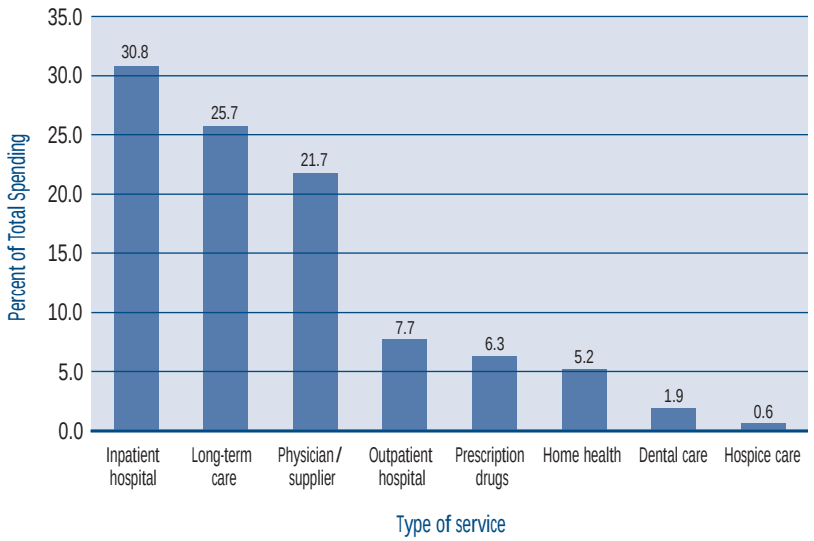


Figure 2 Per Capita Spending on Personal Health Care, 1992-1994



5 The data in Figure 1 slightly overstate growth in Medicare beneficiary spending because the method of estimating expenditures on long-term facility care was revised in 1993. If the revised methodology had been used in 1992, total spending by Medicare beneficiaries would have been somewhat larger than the estimated $247.0 billion.

Figure 3 Distribution of Personal Health Care Spending by Medicare Beneficiaries, by Type of Service, 1994

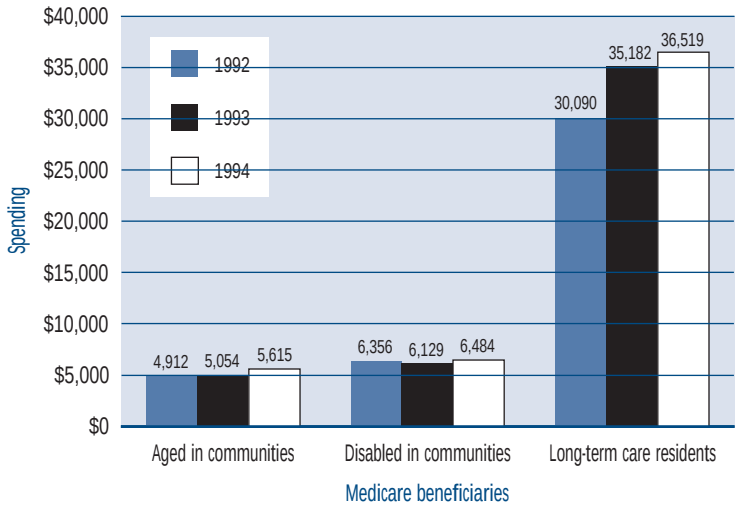


The difference in per capita spending by Medicare beneficiaries and the non-Medicare population reflects individual demand for health care, the impact of managed care on premiums and benefits in the employer-sponsored insurance market, and other factors such as the role of the Federal government in setting Medicare fees for physicians. These factors also may be contributing to the growing gap in per capita spending by the two groups. In 1992, per capita spending by Medicare beneficiaries was $3.1 for every dollar spent by the average person not on Medicare. By 1994, the average expenditure by aged and disabled beneficiaries had increased to $3.5 for every dollar spent by the average person not on Medicare.

Personal health care expenditures are shown for eight categories of care in the sourcebook: inpatient hospital, outpatient hospital, physician/supplier, home health care, hospice care, dental care, long-term facility care, and prescription drugs. The mix of health care services consumed by all Medicare beneficiaries in 1994 can be seen in Figure 3. Hospital care is the largest category of expenditures by aged and disabled beneficiaries. Combined expenditures on inpatient and outpatient hospital services accounted for 38.5 percent of the total health care expenditure in 1994, down slightly from 40.6 percent in 1992. Expenditures on long-term facility care and physician/supplier services are the other two large expenditure categories, capturing 25.7 percent and 21.7 percent of the health care dollar.[6] Other notable expenditure categories are prescription drugs and home health care, which accounted for 6.3 percent and 5.2 percent of the total.

Spending on personal health care is highly concentrated among a small percentage of the Medicare population. In 1992, 10 percent of the Medicare population accounted for 53 percent of the total health care spending by aged and disabled beneficiaries (Laschober and Olin, 1996). While the level of health care spending by an individual Medicare beneficiary is difficult to predict, some groups of beneficiaries are likely to spend more on health care than others. The data in Figure 4, for example, show the average expenditure by

Figure 4 Per Capita Health Care Spending by Community and Long-Term Care Residents, 1992-1994



6 Long-term facility care expenditures in the sourcebook include custodial care provided in licensed nursing homes and other long-term care facilities, as well as skilled nursing facility expenses that are covered by Medicare.

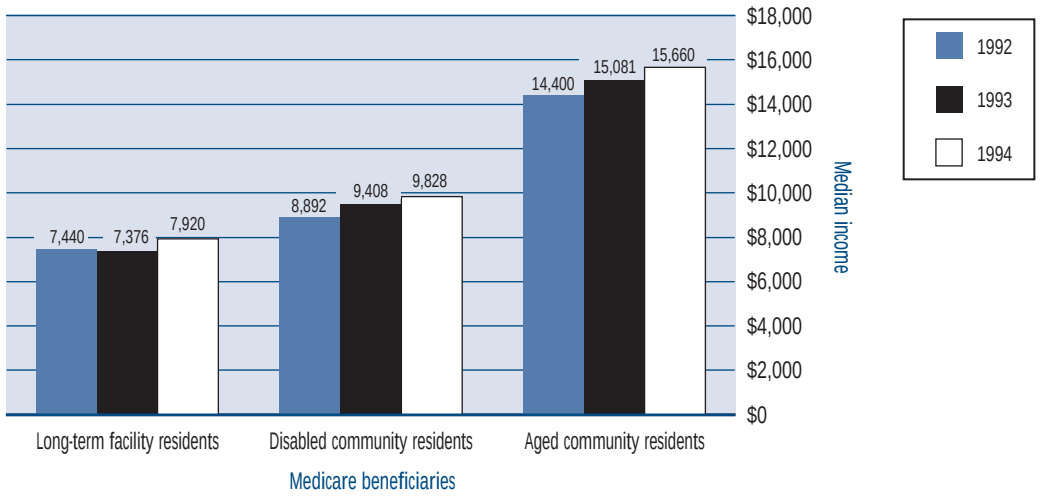
aged community residents, disabled community residents, and aged and disabled beneficiaries who spent all or part of the year in long-term care facilities. In 1994, the average expenditure on health care by aged and disabled community residents was $5,615 and $6,484, respectively. In contrast, the average expenditure by long-term facility care residents was $36,519.

Per capita expenditures by the three groups have grown at significantly different rates in recent years. Between 1992 and 1994, the average expenditure by disabled community residents grew at an annual rate of 1.0 percent. This growth was considerably lower than the rate of inflation, and it may indicate that the average disabled community resident consumed less health care in 1994 than he or she did in 1992. Spending by aged community residents and long-term facility care residents, on the other hand, grew at annual rates of 6.9 percent and 10.2 percent, which suggests an increase in the volume and intensity of care received by beneficiaries in these groups between 1992 and 1994.

Medicare beneficiary income

The economic status of aged beneficiaries living in communities has improved dramatically since the early 1960s, with the number of elderly people living in poverty falling from 26.4 percent to 11.0 percent between 1966 and 1991 (U.S. Bureau of the Census, 1995).[7] In the 1980s, this trend was reflected by relatively constant annual growth in the real personal income of households headed by elderly persons. Between 1979 and 1989, the real median income of elderly households increased by 19.5 percent, while the proportion of elderly persons in poverty fell from 15.2 percent to 11.4 percent (U.S. Bureau of the Census, 1992). However, the 1990-1991 recession at least temporarily halted this trend. Median nominal income of households headed by elderly people was $17,135 in 1992, $17,751 in 1993, and $18,095 in 1994 (U.S. Bureau of the Census, 1996). After adjusting for inflation in the average annual consumer price index, median real income for elderly households was essentially unchanged between 1992 and 1994.[8]

Figure 5 Median Income of Medicare Beneficiaries, 1992-1994



MCBS data can be used to assess income trends for the entire Medicare population including disabled beneficiaries under the age of 65 and beneficiaries living in long-term care facilities.[9] The data in Figure 5, for example, show median income for all three groups of beneficiaries in 1992-1994. Nominal income increased slightly for disabled and aged beneficiaries residing in communities, and remained flat for long-term facility care residents. These findings are consistent with Bureau of the Census data showing little or no growth in real income in households headed by elderly people during the early 1990s. Moreover, the MCBS data also suggest substantial income inequality among Medicare beneficiaries. Aged beneficiaries living in communities had nearly twice the income of long-term care facility residents, and about 60 percent more income than disabled beneficiaries living in communities.

7 The Federal Government produces annual poverty thresholds in order to assess change over time in the economic well-being of persons and families in the U.S. In 1994, the poverty threshold for a person age 65 or older was $7,108. For a two-person family headed by a householder age 65 or older, the threshold was $8,958.

8 The consumer price index (CPI-U) was 140.3 in 1992, 144.5 in 1993, and 148.2 in 1994, using 1982-1984 = 100 as the base.

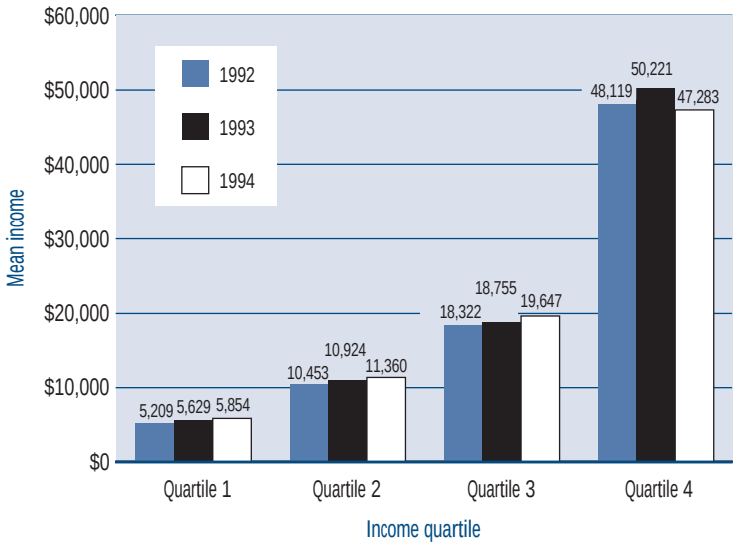
9 Income statistics from the MCBS may not be completely comparable to data from other sources such as the Current Population Survey (CPS) or the Survey of Income and Program Participation (SIPP). The CPS and SIPP collect information on the income of all family members living in a household. The MCBS, on the other hand, limits income data to the beneficiary, and spouse if married, regardless of whether other family members are present in the household.

The degree of income inequality among Medicare beneficiaries can be assessed by calculating the share of aggregate income received by beneficiaries in each quartile of the Medicare population. These data are presented in Table 6.1 of the sourcebook. They were created by ranking beneficiaries according to their income, and dividing them into four equal groups (i.e., the quartiles). If income were distributed equally among all Medicare beneficiaries, each quartile would contain approximately 25 percent of the total income reported by elderly and disabled beneficiaries.[10] Medicare beneficiary income is, however, highly concentrated among a relatively small proportion of the population. Beneficiaries in the highest income quartile controlled approximately 56 percent of the total, while the share controlled by beneficiaries in the lowest income quartile was 7 percent. The combined share of income reported by beneficiaries in the bottom two income quartiles is approximately 20 percent of the total.

Some income inequality should be expected among aged and disabled beneficiaries because age, health, and other factors can affect income. For example, long-term facility care residents have large health care expenditures, and are more likely to deplete their savings and income-producing assets faster than community residents. However, the degree of income inequality within the Medicare population is driven by more than the cost of long-term facility care. The data in Figure 6, which shows the mean income of aged and disabled community residents ranked by quartile, illustrates the degree of income inequality in Medicare households. Beneficiaries in the highest income quartile had more than 9 times the average income of beneficiaries in the lowest income quartile, and twice the average income of beneficiaries in the second highest income quartile.

MCBS estimates of Medicare beneficiary income should not be compared to incomes reported for other segments of the population without considering such factors as taxes, government subsidies, and other benefits. Elderly people typically pay low taxes, have an implicit return on equity in their homes, and receive payments in kind that are not available to other groups. Much of their income, moreover, is from sources that are often underreported by survey respondents. Nonetheless, the trends and distributions of income reported in the MCBS are consistent with Current Population Survey (CPS) data collected by the U.S. Bureau of the Census. Both sources show a lack of income growth between 1992 and 1994, and the degree of income inequality reported by elderly households in the CPS is comparable to MCBS data. According to 1989 CPS statistics, for example, the lowest income quintile of elderly households had 4.1 percent of the total income reported by elderly households, while the highest income quintile accounted for 46.8 percent of the total (U.S. Bureau of the Census, 1992).

Figure 6 Mean Income of Medicare Beneficiaries Residing in Communities, by Income Quartile, 1992-1994



Income inequality within the Medicare population has been linked to factors such as age and disability, gender, race, marital status, living arrangement, and educational attainment (U.S. Bureau of the

10 The share of income held by beneficiaries in each quartile could differ somewhat if the proportion of married and single beneficiaries varied across quartiles.

Census, 1996; Rowland and Lyons, 1998; Master and Taniguchi, 1996; Davis and O'Brien, 1996). The data in Figure 7 illustrate differences in income reported by race and ethnicity for married beneficiaries living in communities.[11] Hispanics had the lowest mean income, and non-Hispanic whites had the highest mean income in 1994 ($16,000 versus $28,000). The average income of non-Hispanic white beneficiaries was 60 to 80 percent more than incomes reported by other groups during the years 1992-1994. Moreover, non-Hispanic blacks lost ground relative to the other groups between 1992 and 1994. Their average income fell approximately 20 percent between 1992 and 1994, while income for non-Hispanic whites and Hispanics remained roughly the same in all 3 years.

Figure 8 shows the effects of another factor on the distribution of income among Medicare beneficiaries—the link between education and income. Education has a dramatic impact on the income of a Medicare beneficiary. The average income reported by married beneficiaries living in communities ranged from $16,000 for beneficiaries with fewer than 9 years of education to $45,000 for beneficiaries with at least 16 years of education. Income rises for beneficiaries with more than 9 years of education, but the difference in incomes reported by each group of beneficiaries has remained essentially unchanged between 1992 and 1994.

Figure 7 Mean Income of Married Medicare Beneficiaries Residing in Communities, by Race and Ethnicity, 1992-1994

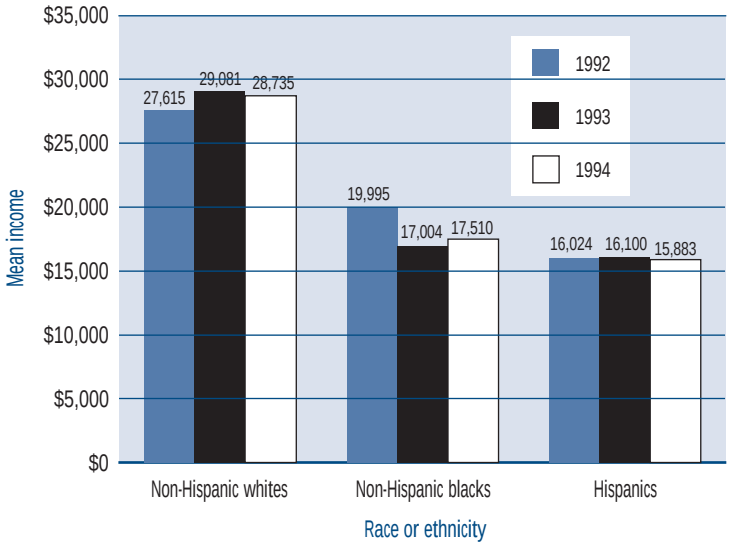
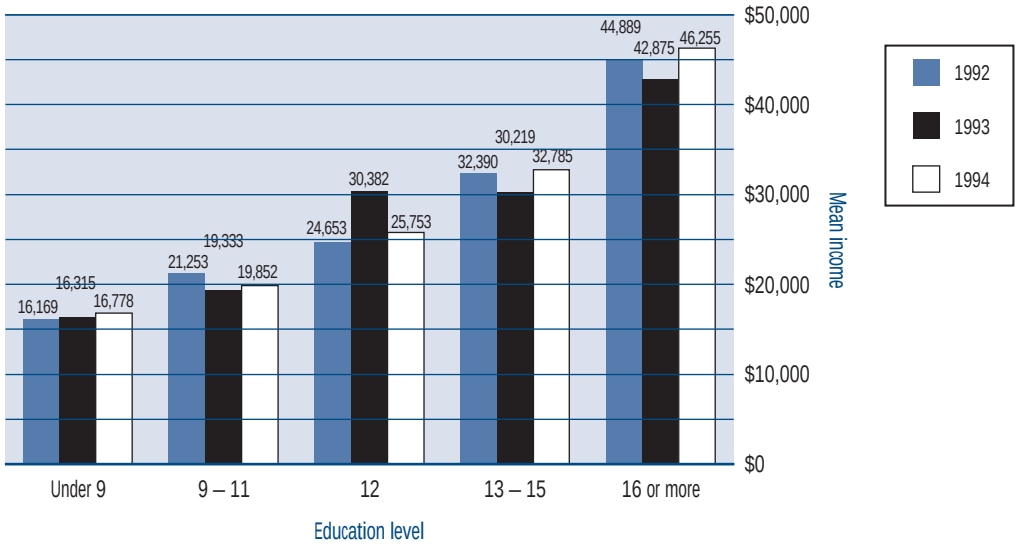


Figure 8 Mean Income of Married Medicare Beneficiaries Residing in Communities, by Education Level, 1992-1994



Health and socioeconomic status

The degree of income inequality observed in the Medicare population is an issue because socioeconomic status is a powerful, although not well understood, determinant of health. Studies of nonelderly people have shown that poor and poorly educated populations have higher mortality rates and greater morbidity than wealthier or better educated populations (Pappas et al., 1993; Angell, 1993). Other studies have shown that education is more important than race in

11 Mean incomes were calculated for only the beneficiaries who lived the entire year in communities because the difference in income reported by full- and part-year community residents is significant.

predicting mortality from coronary disease, and in determining the life expectancy of older persons (Keil et al., 1993; Guralnik et al. 1993).

The correlation between health and socioeconomic status can be seen clearly in the Medicare population. Beneficiaries in the lowest income quartile are more likely to report poor or fair health, one or more limitation in activities of daily living, and higher prevalence rates for major diseases.[12] The data in Figure 9, for instance, show significant differences in self-reported health status by beneficiaries in the lower income quartiles. Over 50 percent of beneficiaries in the lowest income quartile, compared to approximately 23 percent in the highest income quartile, reported that they were in poor or fair health relative to other persons the same age. Moreover, the proportion of beneficiaries in each income quartile reporting poor or fair health remained constant between 1992 and 1994.

Self-reported information on limitations in activities of daily living (ADLs) is another measure of health status. ADLs, which are used to assess the need for assistance in everyday activities, such as eating, bathing, or dressing, have the same correlation with income as self-assessed health status for elderly and disabled beneficiaries living in communities.[13] The data in Figure 10, for example, indicate that a beneficiary with at least one functional limitation was twice as likely to be in the lowest income quartile as opposed to the highest income quartile (29% versus 14 %).

Further evidence of the relationship between health and socioeconomic status can be seen in Figure 11. Beneficiaries in the lowest

Figure 9 Percent of Medicare Beneficiaries in Poor or Fair Health Living in Communities, by Income Quartile, 1992-1994

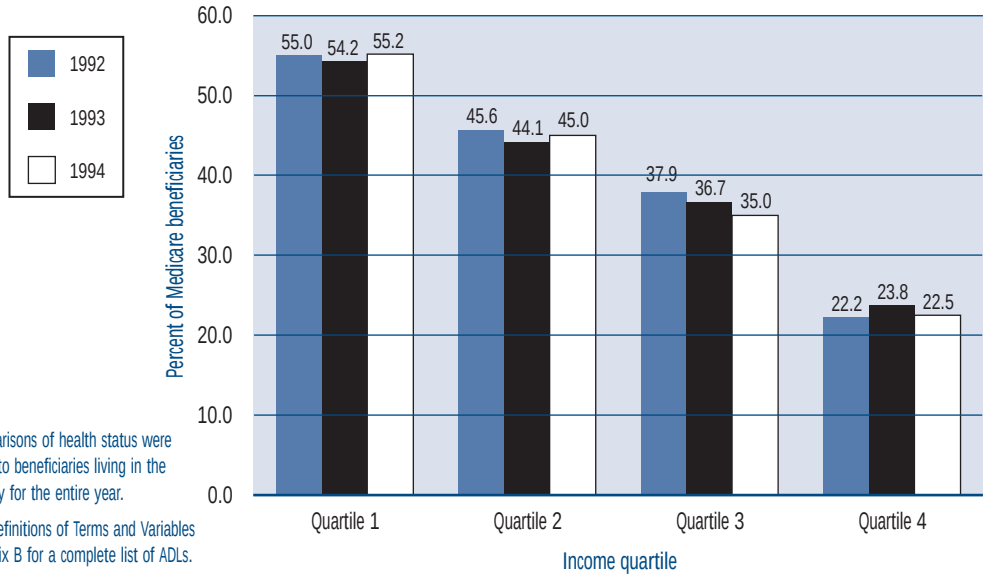
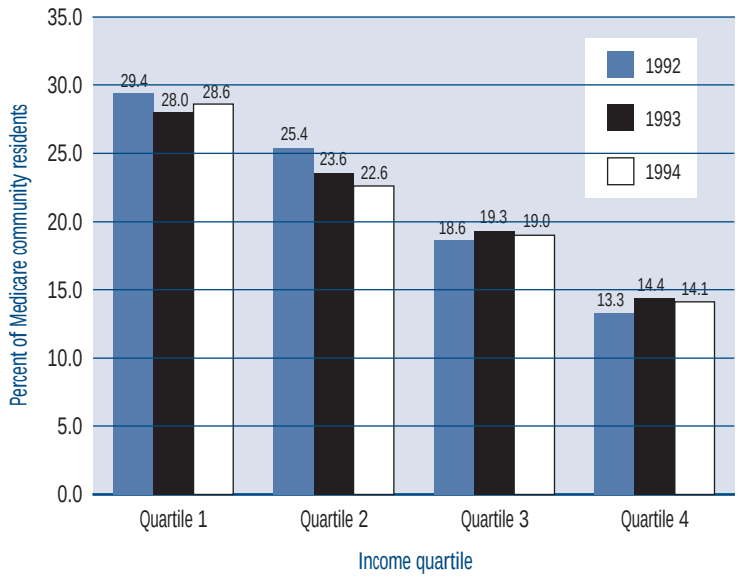


Figure 10 Percent of Medicare Community Residents with at Least One Limitation in Activities of Daily Living, by Income Quartile, 1992-1994



12 Comparisons of health status were restricted to beneficiaries living in the community for the entire year.

13 See Definitions of Terms and Variables in Appendix B for a complete list of ADLs.

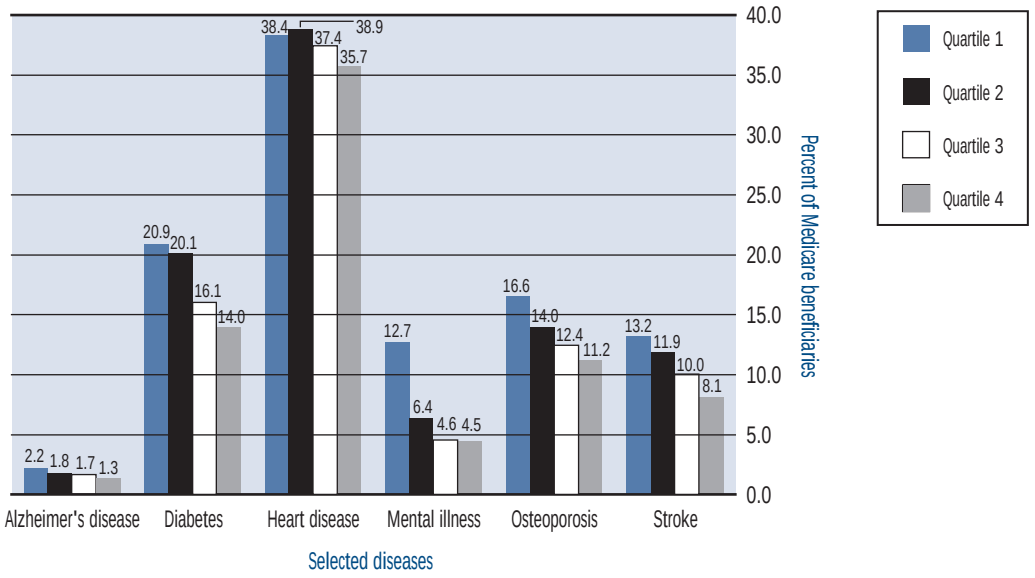
income quartile nearly always ranked first among the four income groups in the prevalence of major diseases such as Alzheimer's disease, diabetes, heart disease, mental illness, osteoporosis, and stroke. Among beneficiaries living in communities, heart disease was the only category in which the lowest income quartile did not have the highest prevalence of disease. Conversely, beneficiaries in the highest income quartile always had the lowest prevalence rates for the selected diseases.

Access to care

Access, which may be defined in terms of an individual's ability to obtain needed medical care, has been a longstanding issue for elderly and disabled persons. It provided impetus for the legislation that created Medicare in 1965, and has been the center of numerous health care debates concerning the general population and Medicare beneficiaries. While Medicare beneficiaries have better access to health care than the general population, the shift to a Medicare Fee Schedule (MFS) for physicians in 1992 raised questions about the effects on some segments of the Medicare population (Physician Payment Review Commission, 1994). To address these concerns, a number of researchers analyzed trends in Medicare-covered service utilization and expenditures following implementation of the MFS, and concluded that access to care by the Medicare population did not decline (Trude and Colby, 1997; Rosenbach et al., 1995; Physician Payment Review Commission, 1996). However, the studies did find that well-known disparities in access to care by vulnerable populations, such as racial and ethnic minorities, low income beneficiaries, and beneficiaries without supplemental health insurance, have continued to persist over time.

Support for these findings can be drawn from MCBS data on trends in sources of care and factors affecting the use of medical services. Presence or absence of a usual source of care, for example, is a frequently cited indicator of an individual's ability to gain access to general health care. Between 1992 and 1994, the proportion of

Figure 11 Percent of Medicare Beneficiaries Living in Communities with Selected Diseases, by Income Quartile, 1994



beneficiaries living in communities who said they had a usual source of care increased from 91 percent in 1992 to 92 percent in 1994. These beneficiaries reported their usual source of care was a doctor's office or clinic, an HMO, a hospital emergency room or outpatient department, or some other specific place. The remaining beneficiaries are considered vulnerable to access problems because they do not use a particular medical person or place for their health care.

The increase in probability that a beneficiary has a usual source of care, although not large, is important because the presence or absence of a usual source of care is considered one of the more important measures of access to health care (Sox et al., 1998; Lee and Kasper, 1998).[14] In addition, the overall trend toward more beneficiaries having a usual source of care may understate the

14 Only 82 percent of the general population had a usual source of care in 1996 (Weinick and Drilea 1998).

extent to which access improved between 1992 and 1994. During this period, the proportion of beneficiaries using office-based physicians (i.e., doctors' offices or clinics, or HMOs), as opposed to hospitals or other medical facilities, for their health care increased by nearly 2 percentage points (Figure 12). These data suggest that more beneficiaries were establishing a usual source of care, and the source was increasingly likely to be an office-based physician rather than a hospital or other facility.

The trend toward increased use of office-based physicians by elderly and disabled beneficiaries also may be a sign that barriers to care are falling for vulnerable populations such as disabled beneficiaries, racial and ethnic minorities, low-income beneficiaries, and Medicare fee-for-service only beneficiaries. Beneficiaries in these categories are less likely than other segments of the Medicare population to have a usual source of care, but they share the same tendency as other beneficiaries to use office-based physicians as their usual source of care. Moreover, the proportion of vulnerable populations with a usual source of care increased between 1992 and 1994.

Further evidence of improved access to care can be inferred from trends in the proportion of beneficiaries reporting difficulty in getting care during the previous year (Figure 13). Most beneficiaries living in communities do not appear to have difficulty in getting care, as the proportion reporting difficulty declined from 4.1 percent in 1992 to 3.6 percent in 1994. While vulnerable segments of the population experience considerably more than the average degree of difficulty in getting care, access appears to be improving for these beneficiaries. Between 1992 and 1994, the drop in the

Figure 12 Proportion of Community Residents Using Office-Based Physicians as Their Usual Source of Care, 1992-1994

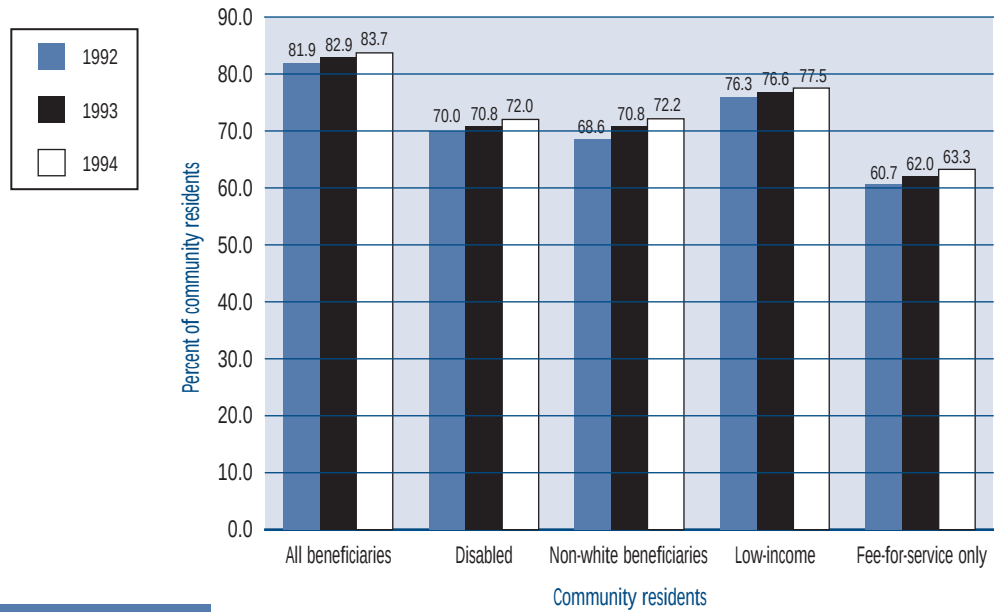
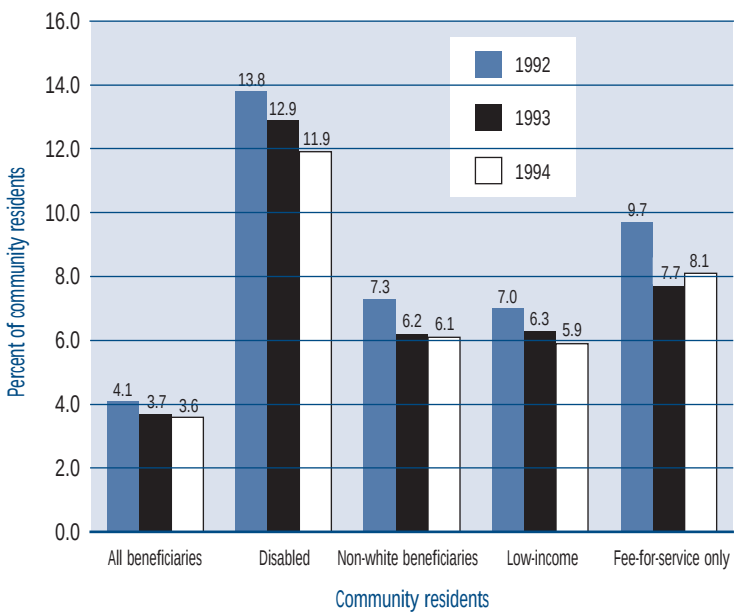


Figure 13 Proportion of Community Residents Reporting Difficulty in Getting Care During the Last Year, 1992-1994



proportion of vulnerable populations reporting difficulty in getting care ranged from 1.1 percentage points for low-income beneficiaries to 1.9 percentage points for disabled beneficiaries. Fee-for-service only beneficiaries were the only group to experience increased difficulty in getting care in any of these years.

Cost-related barriers to care also appear to be declining for all segments of the Medicare population. The proportion of beneficiaries who reported that they delayed care due to cost declined from 11.8 percent in 1992 to 9.7 percent in 1994 (Figure 14). Vulnerable segments of the population benefited the most during this period. For example, the likelihood that a Medicare fee-for-service only beneficiary would delay care because of cost considerations fell by 6.7 percentage points, from 29.2 percent in 1992 to 22.5 percent in 1994. Gains of this magnitude are encouraging because they suggest that barriers to care are becoming less an issue for vulnerable populations, although cost is clearly an important consideration in decisions by vulnerable populations to delay care.

Trends in per capita spending provide additional evidence that beneficiaries in vulnerable groups may be gaining better access to health care. Between 1992 and 1994, per capita health care spending by community residents in the lowest income quartile increased by 28 percent in nominal terms (Figure 15). The growth would be less if adjusted for inflation, but it still represents a significant increase in the volume and intensity of care received by the average low-income beneficiary. If expenditures are viewed as a measure of realized access to care, the growth in spending is consistent with other indicators of declining barriers to care within the Medicare population.

Figure 14 Proportion of Medicare Beneficiaries, Residing in Communities, Who Delayed Care Due to Cost During the Last Year, 1992-1994

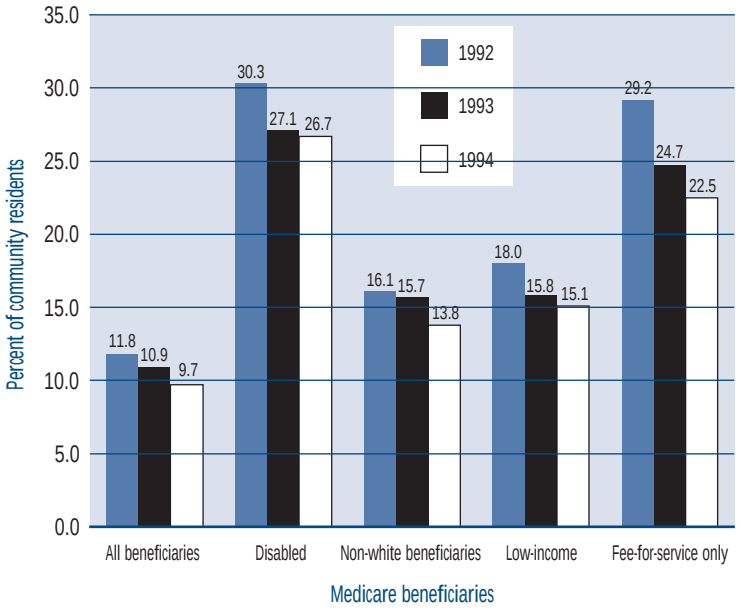
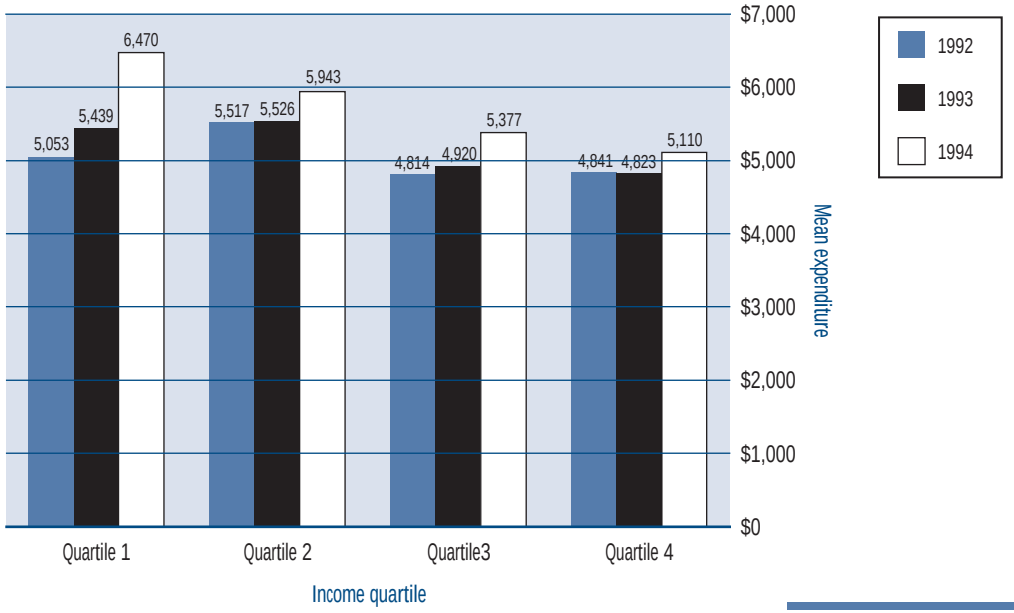


Figure 15 Mean Personal Health Expenditure for Medicare Community Residents, by Income Quartile, 1992-1994



Satisfaction with care

Medicare beneficiaries express high levels of satisfaction with the overall quality of their health care. Over 95 percent of all elderly and disabled beneficiaries living in communities said they were satisfied or very satisfied with the quality of their care in 1992 (Figure 16).[15] Vulnerable populations reported lower levels of satisfaction with their health care, but the proportion of dissatisfied beneficiaries was surprisingly small. Only disabled beneficiaries expressed notably higher than average levels of dissatisfaction with their overall health care, and all groups except low-income beneficiaries were more satisfied with their overall health care in 1994 than they were in 1992.

That Medicare beneficiaries are reporting increased satisfaction with the overall quality of their general health care may not be particularly surprising. Satisfaction with health care is highly correlated with the presence of a regular source of care (Lee and Kasper, 1998), and more beneficiaries have established a usual source of care in recent years. Nonetheless, quality is just one of several factors affecting satisfaction with care. Another dimension of satisfaction with health care is the availability of health care at nights and on weekends (Figure 17). Beneficiaries who had experience with this dimension of their health care also reported high levels of satisfaction with their ability to get care at nights and on weekends. Among the vulnerable groups, disabled beneficiaries were least satisfied with this dimension of their health care, but they also expressed the largest increase in satisfaction between 1992 and 1994 (2.7 percentage points).

Ease and convenience of getting to a doctor is another dimension of health care. Well over 90 percent of all beneficiaries were satisfied or very satisfied with this aspect of their health care (Figure 18).

Figure 16 Proportion of Medicare Community Residents Who Were Satisfied with the Quality of Their Medical Care, 1992-1994

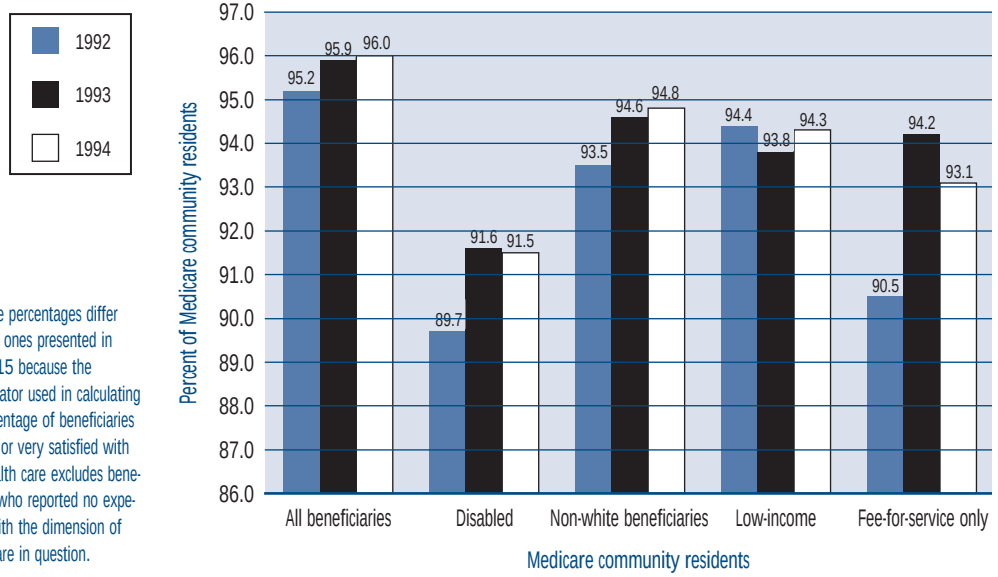
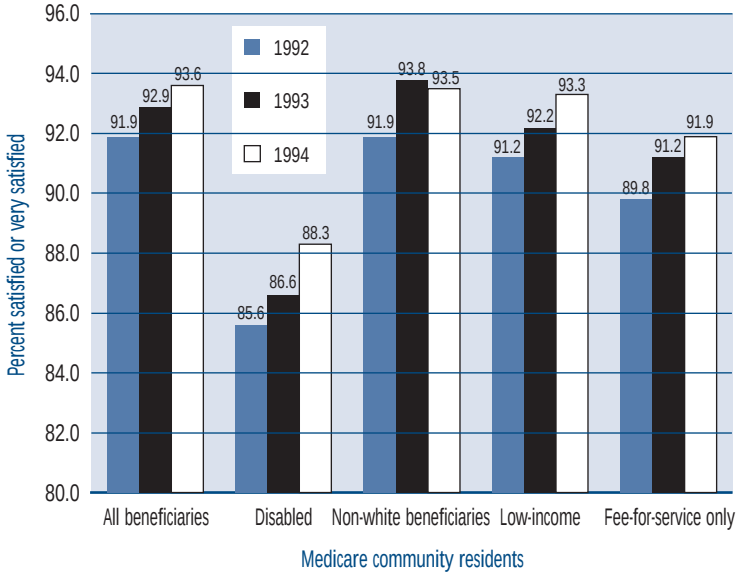


Figure 17 Proportion of Medicare Community Residents Who Were Satisfied with the Availability of Care, 1992-1994



15 These percentages differ from the ones presented in Table 6.15 because the denominator used in calculating the percentage of beneficiaries satisfied or very satisfied with their health care excludes beneficiaries who reported no experience with the dimension of health care in question.

Figure 18 Proportion of Medicare Community Residents Satisfied with Ease of Getting Care, 1992-1994

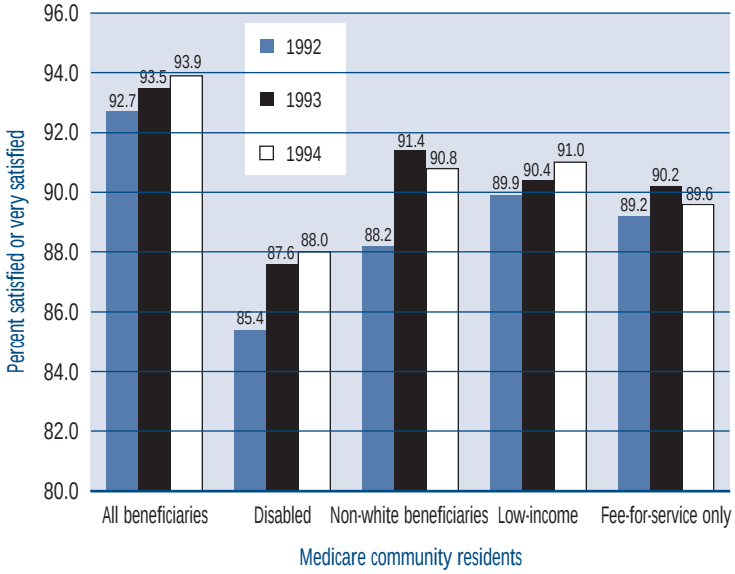
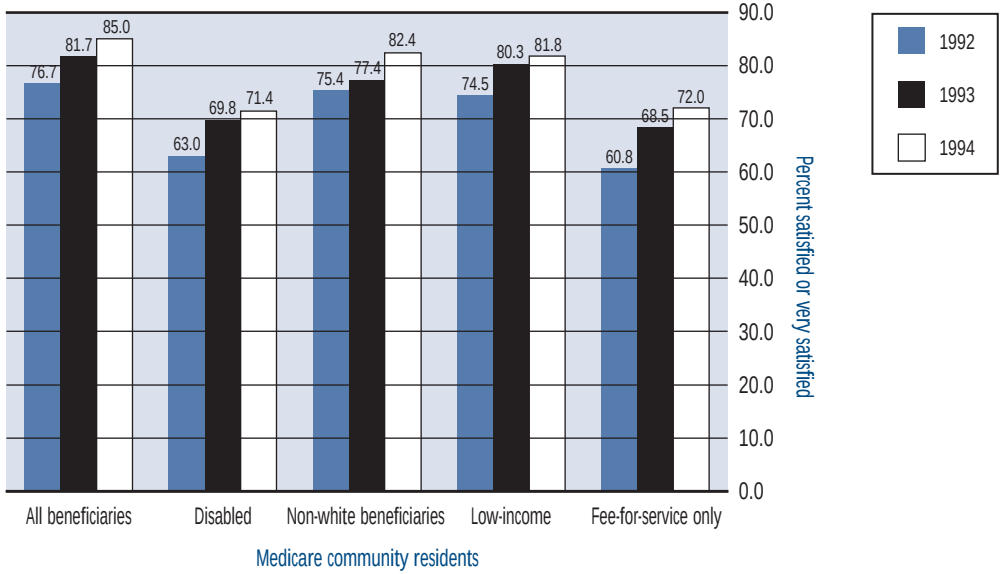


Figure 19 Proportion of Medicare Community Residents Satisfied with the Cost of Care, 1992-1994



Disabled beneficiaries expressed the least satisfaction with ease of getting care, but the responses may be more a reflection of their mobility than the availability of health care in local communities. As with other measures of satisfaction, the proportion of positive responses increased across the board between 1992 and 1994.

Not surprisingly, Medicare beneficiaries expressed less satisfaction with the out-of-pocket cost of health care than other dimensions of their health care (Figure 19). Among the vulnerable populations, the proportion of beneficiaries satisfied with cost ranged from 71 percent by disabled beneficiaries to 82 percent by racial and ethnic minorities in 1994. However, responses to the question about satisfaction with out-of-pocket costs of health care yield some interesting results. First, two vulnerable groups—non-white beneficiaries and low-income beneficiaries—were nearly as satisfied with cost as the average beneficiary. Second, the proportion of beneficiaries satisfied with their out-of-pocket costs increased significantly between 1992 and 1994. Fee-for-service only beneficiaries-the group facing the highest out-of-pocket expenditures for health care-had more than an 11 percentage point gain in satisfaction with cost. No group had a gain of less than 7 percentage points. These responses are strong evidence that beneficiaries benefited from the introduction of a new fee schedule for physicians in 1992, and that disparities in access to care by vulnerable population may be declining.

Summary

Aged and disabled beneficiaries account for about 36 percent of the Nation's spending on personal health care even though they constitute slightly more than 14 percent of the general population. These expenditures are a source of concern for two very different reasons. On the one hand, policymakers are concerned about the economic implications because spending on personal health care reduces the amount of national income that can be invested or

spent on other goods and services. In recent years, national health care expenditures have stabilized at slightly more than 13 percent of the gross domestic product, but the question is whether this stability can be sustained in the future. Between 1992 and 1994, personal health care spending by Medicare beneficiaries grew at an annual rate of nearly 11 percent, as compared to an annual growth rate of 3.5 percent by the non-Medicare population. An increase in personal health care spending by either segment of the population could divert more of the Nation's resources from other uses. Hence, the concerns about the level of health care spending in the United States.

On the other hand, utilization of health care goods and services by the Medicare population must be monitored because some elderly and disabled beneficiaries may not receive adequate care despite the overall level of health care spending. The concern about access is primarily focused on the health care needs of vulnerable segments of the population, such as low-income and disabled beneficiaries, racial and ethnic minorities, and others who may face barriers to care. Beneficiaries in these groups could have problems with access to care. Approximately one-half of all Medicare beneficiaries had an average annual income of less than $10,000 in 1994; and these beneficiaries are in poorer health and have more functional limitations than their wealthier counterparts. Whether poor health and limited financial resources combine with other factors to limit their access to needed care is as important an issue as overall spending on health care.

The data in this sourcebook support three conclusions about the ability of elderly and disabled beneficiaries to get access to health care. First, access to care is not a problem for the typical Medicare beneficiary. Most beneficiaries have a usual source of care, report no difficulty in getting care, and do not delay care due to cost. A vast majority of these beneficiaries are satisfied with the quality of their care and their ability to see a doctor. Out-of-pocket cost is the least satisfactory aspect of their health care, but only 15 percent of all beneficiaries living in communities reported that they were unsatisfied with their share of the cost in 1994.

Second, although overall access to care by the Medicare population is high, not all beneficiaries have equal access to care. Vulnerable populations such as disabled beneficiaries, racial and ethnic minorities, the low-income, and beneficiaries without supplemental insurance (i.e., fee-for-service only beneficiaries) face higher than average barriers to care. These groups are not mutually exclusive, but beneficiaries in these categories are uniformly more likely than the average beneficiary to respond negatively to questions about access to and satisfaction with care. Two groups—disabled beneficiaries and fee-for-service only beneficiaries—stand out in these comparisons because they consistently report more access problems than other vulnerable groups. The differences in access and satisfaction were most obvious in beneficiaries' responses to questions about delays in care due to cost and satisfaction with their share of the cost.

Third, concerns about the impact of the MFS on access to care appear unfounded, at least in the short-term. Between 1992 and 1994, barriers to care declined and satisfaction with care improved for all Medicare beneficiaries including vulnerable populations. Several indicators of access and satisfaction show vulnerable populations making greater than average gains in access to care during this period, which would suggest that access is becoming more equitable over time. Perhaps the most telling indicator of improved access is the gain in beneficiary satisfaction with out-of-pocket health care costs. By 1994, 85 percent of all beneficiaries living in communities said they were satisfied with their out-of-pocket cost of health care, an increase of 8 percentage points from 1992. Vulnerable populations also had large gains in satisfaction with cost. The 11 percentage point jump in satisfaction by fee-for-service only beneficiaries is particularly impressive given that health care expenditures rose substantially while beneficiary income stagnated between 1992 and 1994.