

Centers for Medicare & Medicaid Services Releases 2011 MCBS *Access to Care* Research Files

Introduction

The Medicare Current Beneficiary Survey (MCBS) *Access to Care* research files are designed to provide quick access to MCBS data and related findings to users. With over 20 years of continuous data collection, the MCBS is the preeminent source of information related to Medicare beneficiary access to and satisfaction with care, health status, health care cost and use, and source of payment. The survey represents the total Medicare population, whether aged or disabled, living in the community or a facility, or served by managed care or fee-for-service (FFS) and as such provides unique insight into the Medicare program, its operations, and the people it serves.

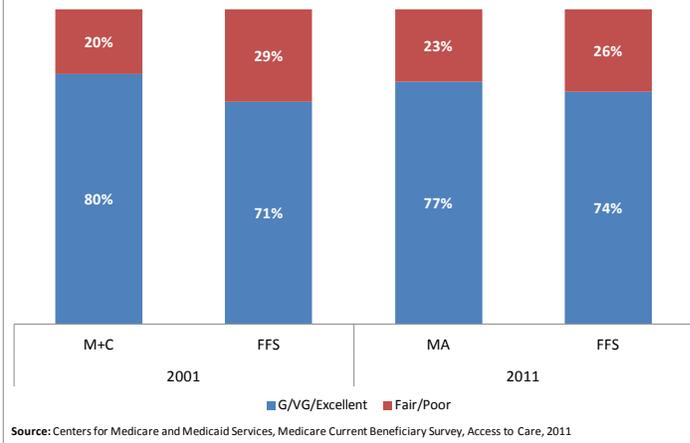
In a reflection of the commitment the Centers for Medicare & Medicaid Services (CMS) has to greater transparency and timeliness, the 2011 *Access to Care* files are being released three months earlier than the 2010 files and less than year after interviews were conducted in the field.

This data brief provides a snapshot of the approximately 42.5 million Medicare beneficiaries that lived in the community, were alive for the Fall 2011 interview, became eligible for Medicare before 2011, and lived in the 50 states and the District of Columbia.¹ The brief highlights selected estimates for key areas of the MCBS *Access to Care* files:

- Comparisons between beneficiaries enrolled in private Medicare Advantage health plans (MA) and those enrolled in traditional FFS
- Racial and ethnic disparities in health care utilization and health outcomes
- Beneficiary satisfaction with and access to care

¹ MCBS sample participants living in Puerto Rico were excluded as the provision of health care is different than in the 50 states and the District of Columbia. The exclusion of respondents from Puerto Rico reduced the overall Hispanic population examined in this data brief.

Figure 1: Self-Reported Beneficiary Health Status, by Medicare Delivery System: 2001 and 2011



Source: Centers for Medicare and Medicaid Services, Medicare Current Beneficiary Survey, Access to Care, 2011

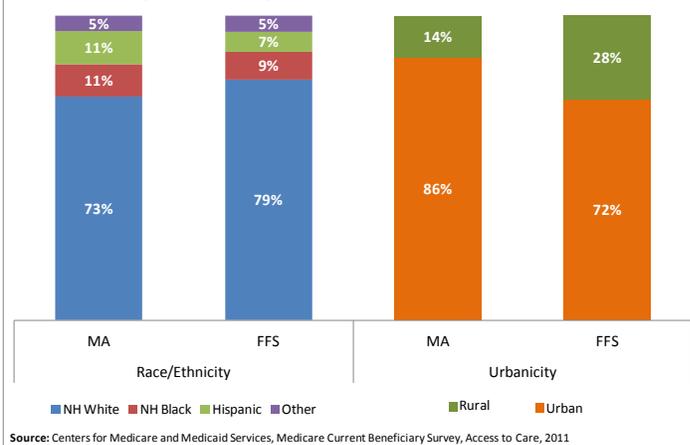
Highlights

Characteristics of Medicare Beneficiaries by Delivery System

The MCBS allows for direct comparisons between beneficiaries enrolled in private Medicare health plans (M+C and MA) and those enrolled in traditional FFS.² The proportion of Medicare beneficiaries choosing to enroll in a private Medicare plan versus FFS has increased significantly between 2001 and 2011. In 2001, 17 percent of Medicare beneficiaries were enrolled in M+C, compared to 28 percent enrolled in MA in 2011.

Beneficiaries enrolled in FFS have traditionally had worse health status compared to those in MA. In 2001, almost 30 percent of FFS beneficiaries rated their health as fair or poor, compared to 20 percent of M+C beneficiaries. While the gap in health status between beneficiaries in MA

Figure 2: Characteristics of Beneficiaries, by Medicare Delivery System, Race and Ethnicity, and Urbanicity: 2011



Source: Centers for Medicare and Medicaid Services, Medicare Current Beneficiary Survey, Access to Care, 2011

and FFS narrowed in 2011, beneficiaries in FFS were still more likely to report worse health status than those in MA. (Figure 1)

One of the major advantages of the MCBS is that it collects self-reported race and ethnicity from beneficiaries. Because self-reported race and ethnicity are more reliable than CMS administrative data, this allows for the examination of health care utilization and health outcomes of traditionally underserved populations. For example, self-identified Non-Hispanic White beneficiaries were more likely to be enrolled in FFS than in MA in 2011, while Non-Hispanic Black and Hispanic beneficiaries were more likely to be enrolled in MA than in FFS. (Figure 2)

² The Medicare Modernization Act of 2003 (MMA) changed certain aspects of Medicare Part C (coverage through private health plans), including how private plans are referenced. Prior to the MMA, these plans were referred to as Medicare+Choice (M+C) plans. Currently, these organizations are referred to as Medicare Advantage health plans or Medicare Advantage Organizations.

In addition to race and ethnicity, MA/FFS differences can be examined across a number of other dimensions, including urbanicity. Beneficiaries living in rural areas accounted for a much smaller share of the MA population than they did of the FFS population in 2011. This may be due in part to the greater difficulties MA plans face in constructing adequate networks in rural areas.

Health Disparities among Medicare Beneficiaries

The MCBS is a critical source of information on health disparities among Medicare beneficiaries. The 2011 data show that Non-Hispanic White beneficiaries were less likely than Non-Hispanic Black and Hispanic beneficiaries to rate their health as fair or poor, be obese, or have at least one functional limitation. (Figure 3)

Non-Hispanic Black beneficiaries reported some of the poorest health outcomes with over one-third in fair or poor health, 40 percent obese, and 56 percent reporting at least one functional limitation.

Beneficiaries also varied by race and ethnicity in their use of preventive services in 2011. Non-Hispanic White beneficiaries were more likely to report receiving a flu shot and a PSA blood test (for males) in the past year than were Non-Hispanic Black or Hispanic beneficiaries. There was no difference by race or ethnicity in the percentage of female beneficiaries that reported getting a mammogram in the past year. (Figure 4)

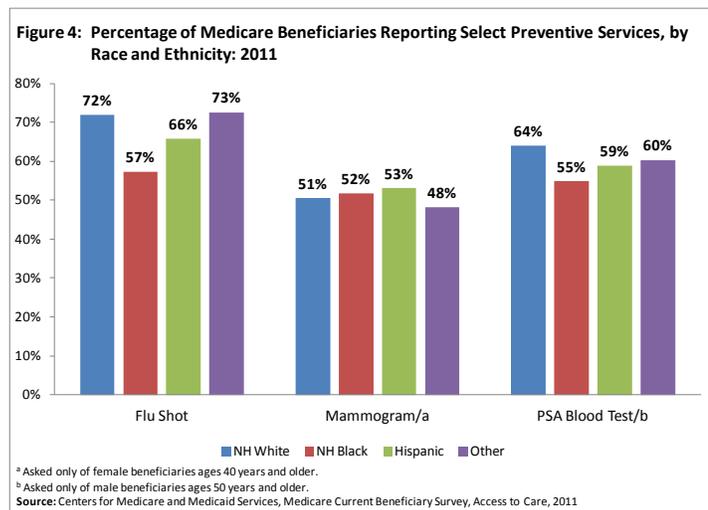
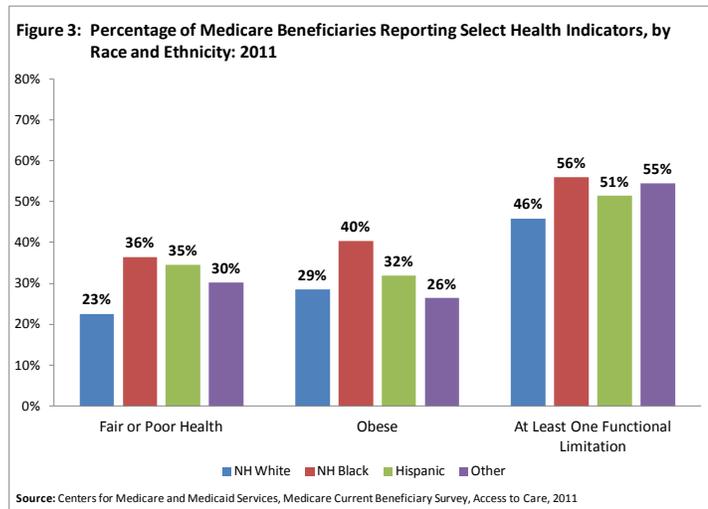


Table 1: Percentage of Medicare Beneficiaries Satisfied with the Quality of Medical Care Received, by Delivery System and Year: 2001, 2006, 2011

Delivery system	2001		2006		2011	
	Est	SE	Est	SE	Est	SE
All beneficiaries	95.6%	0.2	96.3%	0.2	96.4%	0.2
FFS	95.7%	0.2	96.3%	0.2	96.3%	0.2
MAO	95.1%	0.5	96.1%	0.6	96.7%	0.3

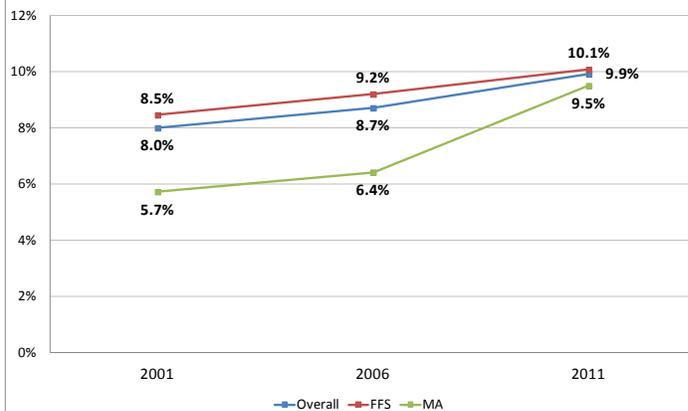
Source: Centers for Medicare and Medicaid Services, Medicare Current Beneficiary Survey, Access to Care, 2011.

Table 2: Percentage of Medicare Beneficiaries Reporting Difficulty with Access to Care, by Type of Difficulty: 2011

Type of Difficulty	Est	SE
Trouble getting needed health care	5.2%	0.3
Delayed health care due to cost	9.9%	0.4
Decided not to get a prescription due to cost	8.6%	0.3

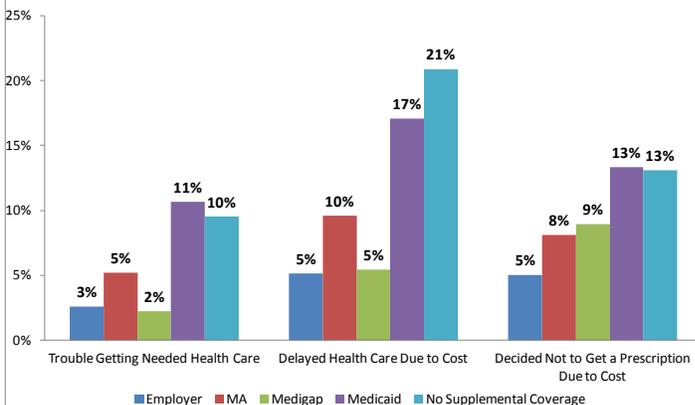
Source: Centers for Medicare and Medicaid Services, Medicare Current Beneficiary Survey, Access to Care, 2011.

Figure 5: Percentage of Medicare Beneficiaries Delaying Care Due to Cost, by Medicare Delivery System: 2011



Source: Centers for Medicare and Medicaid Services, Medicare Current Beneficiary Survey, Access to Care, 2011

Figure 6: Percentage of Medicare Beneficiaries Reporting Difficulty with Access to Care, by Type of Supplemental Insurance: 2011



Source: Centers for Medicare and Medicaid Services, Medicare Current Beneficiary Survey, Access to Care, 2011

Medicare Beneficiary Satisfaction with and Access to Care

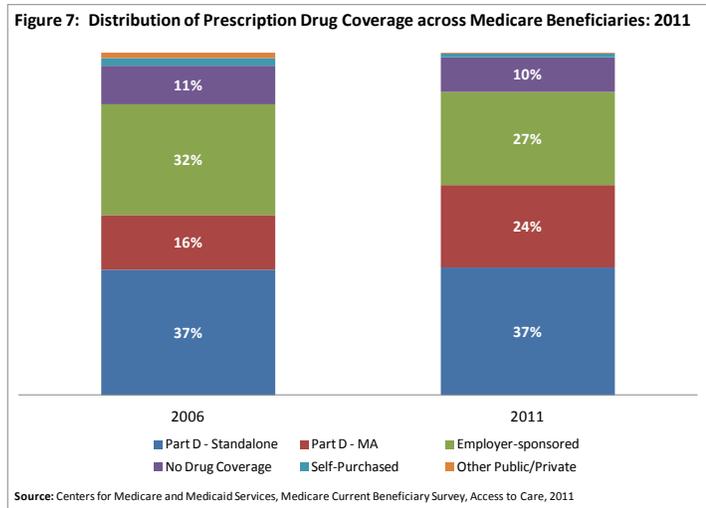
The MCBS is a valuable tool for gaining insight into Medicare beneficiary satisfaction with and access to health care. Coupled with other information on beneficiary characteristics and insurance coverage (e.g., delivery system, supplemental insurance, drug coverage, etc.), the MCBS allows for a variety of comparisons to be made concerning these important topics. For example, 96 percent of beneficiaries reported that they were satisfied with the quality of the medical care they received in 2011. This did not vary by delivery system (MA vs. FFS) and remained consistently high over time. (Table 1)

In 2011, just 5 percent of beneficiaries reported trouble getting needed health care. However, almost 1 in 10 beneficiaries reported that they delayed health care or decided not to get a prescription due to cost. (Table 2)

Ten percent of beneficiaries reported delaying care due to cost in 2011, with similar rates for those enrolled in MA vs. FFS. Between 2001 and 2011, beneficiaries in private plans reported an increase in delaying care due to cost, from 6 percent to about 10 percent. (Figure 5)

Access to care varied widely by type (and existence) of supplemental

insurance coverage. Beneficiaries eligible for Medicaid and beneficiaries with no supplemental coverage were more likely to report trouble getting needed health care than were beneficiaries with employer sponsored supplemental plans, MA, or Medigap. Beneficiaries eligible for Medicaid and beneficiaries with no supplemental coverage were also more likely to report delaying health care due to cost and not getting a prescription due to cost. (Figure 6)



Prescription Drugs

In 2011, about 90 percent of Medicare beneficiaries had some type of prescription drug coverage, with little change from 2006 to 2011. However, the distribution of beneficiaries by source of coverage changed. Between 2006 and 2011, there was an increase in beneficiary enrollment in MA Part D drug plans, from 16 percent to 24 percent. Over the same period, there was a decrease in beneficiaries reporting employer-sponsored drug coverage, from 32 percent to 27 percent. (Figure 7)

Table 3. Percentage of Medicare Beneficiaries Delaying a Prescription Due to Cost, by Type of Prescription Drug Plan and Year: 2006, 2011

PD plan type	2006		2011	
	Est	SE	Est	SE
All plans	8.6%	0.3	7.5%	0.3
Part D - Standalone	11.3%	0.5	9.5%	0.5
Part D - MA	10.2%	0.9	8.9%	0.7
Employer-sponsored	4.7%	0.3	3.7%	0.4

Note: Too few beneficiaries in the following plans reported delaying a prescription due to cost for a reliable estimate: self-purchased plans, other public/private plans, and no prescription drug coverage.

Source: Centers for Medicare and Medicaid Services, Medicare Current Beneficiary Survey, Access to Care, 2011.

The percentage of beneficiaries reporting that they delayed filling a prescription due to cost dropped between 2006 and 2011. In both years, beneficiaries enrolled in Part D standalone and MA Part D plans were most likely to report delaying a prescription due to cost; however, this may be attributable to socioeconomic factors more than type of drug coverage. (Table 3)

This data brief was written by staff from CMS's Office of Information Products and Data Analytics (OIPDA). To learn about OIPDA, visit www.cms.gov/Research-Statistics-Data-and-Systems/Research/ResearchGenInfo/OIPDA.html. For more information about the MCBS, visit www.cms.hhs.gov/mCBS. To purchase MCBS files, contact the Research Data Assistance Center (ResDAC) at www.resdac.org or (888) 973-7322.

Technical Notes

Data

The MCBS *Access to Care* research files are designed to be released within one year of the end of data collection. Expedited release of MCBS data is accomplished by focusing the *Access to Care* files on cross-sectional data captured in the Fall round interviews only (as opposed to including all three interviews in the year) and omitting survey-reported utilization and expenditure data (which are captured in the MCBS *Cost and Use* files).

The content of the *Access to Care* Public Use File is governed by what can be released in an expedited manner. In addition to questions from the interview supplement concerning access to care, satisfaction with care, and usual source of care, the file contains demographic and health insurance data as well as data on health status and functioning. To facilitate analysis while still allowing for expedited release, *Access to Care* files are enhanced with available CMS administrative data and accompanied with Medicare claims data for survey participants who received services through traditional (FFS) Medicare.

Survey Design

The MCBS is an in-person, longitudinal panel survey. Respondents are interviewed three times a year over a period of four years to form a continuous profile of their health care experience. Two types of interviews are conducted in the MCBS, a community interview done in the home and an institutional interview of knowledgeable staff on behalf beneficiaries in a facility setting. In 2011, there were 14,120 community interviews and 907 institutional interviews.

Population

The 2011 *Access to Care* file is designed to represent a point-in-time snapshot of the Medicare population and for this reason is not representative of the entire Medicare population in 2011. In essence, the 2011 *Access to Care* file captures the “always-enrolled” Medicare population, or those Medicare beneficiaries that became eligible before January 1, 2011, continued to be enrolled in 2011, and were still alive for their Round 61 (Fall 2011) MCBS interview. The MCBS estimate of this always-enrolled population for 2011 is 45,825,140. Two groups of individuals were not included in the 2011 “always-enrolled” estimates and are worth noting: beneficiaries who first became eligible for Medicare after the start of the 2011 calendar year and beneficiaries who died prior to receiving a Fall 2011 interview. Based on CMS administrative data, these two groups accounted for approximately 5,300,000 beneficiaries in 2011.

Weighting

The 2011 *Access to Care* file contains a cross-sectional weight for each of the 15,027 beneficiaries that were surveyed and responded to the Round 61 interview. These weights reflect the overall selection probability of each sample person. This includes adjustments for survey non-responses and post-stratification to control totals based on when beneficiaries became eligible for Medicare, age, sex, race, region, and metropolitan area status. The weights inflate the sample to the 2011 always-enrolled national Medicare population. Longitudinal weights are also provided for users interested in analyzing data over time.

Sampling Error

Sampling error refers to the expected squared difference between a population value (a parameter) and an estimate derived from a sample of the population (a statistic). Because the MCBS samples Medicare beneficiaries, statistics derived from the sample are subject to sampling error. The error reflects chance differences between estimates of a population parameter that would be derived from different samples of the Medicare population. Sampling error will affect nearly any MCBS estimate of a population parameter (e.g., a percentage, mean, ratio, or count of persons or events).

Standard errors that take into account the complex, multi-stage design of the MCBS were calculated for all statistics reported in this data brief to assess the impact of sampling variability on the accuracy of estimates. For example, Table 2 indicates that 5.2 percent of beneficiaries reported trouble getting needed health care. The standard error of this estimate (0.3 percent) can be used to assess its statistical reliability by constructing a confidence interval that would contain the true value of the population parameter with some given level of confidence, such as 95 percent.

Another measure of statistical reliability is the relative standard error (RSE) of an estimate. The RSE of an estimate x is calculated by dividing the standard error of the estimate, $SE(x)$, by the estimate, and expressing the quantity as a percent of the estimate, i.e.,

$$RSE = 100 \left(\frac{SE(x)}{x} \right)$$

Using data from the needed care example, the RSE of the estimated proportion of beneficiaries reporting trouble getting needed health care in 2011 is $(100 \times (0.3/5.2)) = 5.8$ percent. An RSE of this magnitude would suggest that the estimate is statistically reliable. Statistical reliability of an estimate decreases as the RSE increases. All estimates presented in the current publication have an RSE of less than 30 percent.

Other MCBS Data Products

The MCBS *Cost and Use* files capture survey-reported data for an entire year (up to three interviews per survey participant), include utilization and cost information (regardless of payer), and link Medicare claims data to survey-reported data. As such, the MCBS *Cost and Use* files can support a broader range of research and policy analyses on the Medicare population than would be possible using either survey data or administrative claims data alone. The *Cost and Use* files are typically released two years following the fielding of the survey.