



# 1 INTRODUCTION AND HIGHLIGHTS OF FINDINGS

*Health and Health Care of the Medicare Population: Data from the 1994 Medicare Current Beneficiary Survey* is the third in a series of Medicare beneficiary sourcebooks. The data are from the Medicare Current Beneficiary Survey (MCBS), a rotating panel survey of a nationally representative sample of aged and disabled Medicare beneficiaries. The MCBS is sponsored by the Health Care Financing Administration (HCFA), under the general direction of its Office of Strategic Planning. During the first 10 years of the survey, data are being collected through contracts with Westat, a survey research organization with offices in Rockville, Maryland.

The MCBS is a comprehensive source of information on the health status, health care use and expenditures, health insurance coverage, and socioeconomic and demographic characteristics of aged and disabled Medicare beneficiaries. Survey data are collected three times a year over 4 years regardless of whether the beneficiary lives in a household or a long-term care facility. The data are used to create annual public use files (PUFs) containing a cross-section of all persons entitled to Medicare during the year. The 1994 MCBS, for example, includes beneficiaries who were entitled to Medicare for all or part of the year, as well as beneficiaries who died in 1994. These data can be used for cross-sectional analyses, or linked to PUFs from previous years for longitudinal analyses of the Medicare population.

One of the strengths of the MCBS is the scope of data that is collected on personal health care utilization and expenditures by Medicare beneficiaries. Sample persons are asked about expenditures on Medicare-covered services and health services not typically covered by the Medicare program. Noncovered services include purchases of prescription medicines, dental care, hearing aids, eyeglasses, and long-term care facility services. To determine who finances the expenditures, the MCBS also collects data on out-of-pocket payments, third party payers, and programs such as the VA. This information is used in conjunction with Medicare claims data

to determine the amounts paid by Medicare, Medicaid, other public programs, private insurance, and households for each medical service reported by a beneficiary.

Annual data from the MCBS are released to the public in two different PUFs. Access to Care PUFs—available for calendar years 1991 through 1996—contain information on beneficiary access to medical providers, satisfaction with health care, health status and functioning, and demographic and financial characteristics. The files also include Medicare claims for beneficiaries who were enrolled in Medicare for the entire calendar year and living in a community setting. They provide a snapshot of the “always enrolled” Medicare population, and can be used to analyze characteristics of beneficiaries who were potential or actual users of Medicare-covered services during the entire 12-month period.

Cost and Use PUFs—available for calendar years 1992 through 1995—are more comprehensive than the Access to Care PUFs. The files include information on services not covered by Medicare, and the samples are chosen to represent all beneficiaries who were ever enrolled in Medicare during a calendar year. Cost and Use files also contain detailed information on health insurance coverage, as well as health status and functioning data from the Access to Care PUFs. The data can be used to analyze total and per capita health care spending by the entire Medicare population, including part-year enrollees and persons who died during the year.

The MCBS sourcebooks include data from both sets of PUFs. This sourcebook also uses time series data from previous PUFs to highlight change in health and health care utilization between 1992 and 1994. Chapter 2 contains information on emerging trends and patterns in the 1992-1994 data. It has sections on growth in personal health care spending by Medicare beneficiaries, income inequality in the Medicare population, the correlation between health and socioeconomic status, access to care, and satisfaction with health

care. Chapter 3 contains the same set of the cross-sectional data from the Access to Care and Cost and Use PUFs as previous sourcebooks. It also has a new set of time series data for the years 1992-1994, with detailed tables on the characteristics of Medicare beneficiaries; health status and functioning; use, cost, and sources of payment for health care services; and access to and satisfaction with care.

Appendix A has a description of the sample design, survey operations, response rates, and structure of the MCBS public use files. It also includes a discussion of procedures to calculate standard errors for cross-sectional statistics and estimates of net change over time. Appendix B contains a glossary of terms and variables used in the detailed tables.

## HIGHLIGHTS OF FINDINGS

### Personal health care expenditures

■ Health care expenditures by Medicare beneficiaries expanded from \$247.0 billion to \$303.7 billion between 1992 and 1994. The 10.9 percent annual rate of growth in health care spending by Medicare beneficiaries was approximately three times that of the non-Medicare population, which saw its expenditures rise from \$492.8 billion in 1992 to \$528.0 billion in 1994.

■ Per capita spending increased at a slower annual rate than total spending because the Medicare and non-Medicare populations grew 4 percent and 1.7 percent, respectively, between 1992 and 1994. The average expenditure by Medicare beneficiaries increased from \$6,716 to \$7,936, an annual growth rate of 8.7 percent. In contrast, the average expenditure in the non-Medicare population increased from \$2,159 to \$2,274, an annual growth rate of 2.6 percent.

■ Spending on health care varies widely within the Medicare population. In 1994, the average personal health care expenditure was \$5,615 for aged community residents, \$6,484 for disabled community residents, and \$36,519 for long-term care facility residents. Between 1992 and 1994, the average expenditure by disabled community residents grew at an annual rate of 1.0 percent, whereas spending by aged community residents and long-term care facility residents grew at annual rates of 6.9 and 10.2 percent, respectively.

■ Funding of health care for aged and disabled persons was remarkably stable over the 3-year period. The main payers were Medicare (53%), households (19%), Medicaid (14%), and private insurance (9%). The share paid by Medicare may be slightly overstated relative to other payers because the MCBS uses Medicare claims to supplement household-reported information on health care utilization and expenditures. Comparable information is not available for services not covered by Medicare.

### Medicare beneficiary income

■ The proportion of elderly beneficiaries living in poverty has declined significantly since the early 1960s, and income standards continued to improve between 1992 and 1994. The median annual income of aged beneficiaries living in communities grew 8.8 percent, from \$14,400 to \$15,660. On the other hand, the average annual consumer price index increased 5.6 percent, suggesting a gain of about 3.2 percent in real income during this period.

■ Financial gains by elderly community residents disguise a substantial degree of income inequality within the Medicare population. Beneficiaries in the highest income quartile had 56 percent of the total income reported by Medicare beneficiaries, while the lowest income quartile had 7 percent of the total. These income distributions were relatively constant between 1992 and 1994, although beneficiaries in the lowest income quartile did show a slight increase in their share of the total.

■ Among community residents, race and education appear to have a strong influence on income. Non-Hispanic whites had significantly more income than non-Hispanic blacks or Hispanics, and their income was more stable than that of other racial and ethnic groups during the period 1992-1994. Education has a significant effect on the financial well being of beneficiaries, as the best-educated beneficiaries reported more than twice the income of their less educated counterparts.

■ Low-income beneficiaries account for a disproportionate share of total health care spending by the Medicare population. Between 1992 and 1994, health care spending by beneficiaries in the lowest income quartile increased from 33 percent to 36 percent of total spending. The proportion of low-income beneficiaries in long-term care facilities explains some, but not all, of the difference in spending by income quartile. In 1994, for example, the gap in average spending by community-only residents in the lowest and highest income quartiles was 27 percent (\$6,470 versus \$5,110).

### Health and socioeconomic status

■ Although the relationship between health and socioeconomic status is complex, low-income beneficiaries living in communities are more likely to have health problems than their high-income counterparts. Over 50 percent of beneficiaries in the lowest income quartile, compared to approximately 23 percent in the highest quartile, reported that they were in poor or fair health. Beneficiaries with at least one functional limitation were twice as likely to be in the lowest income quartile as opposed to the highest income quartile.

■ The relationship between health and socioeconomic status also is reflected in the prevalence of disease reported by beneficiaries in different income groups. In 1994, beneficiaries in the lowest income quartile nearly always ranked highest among the four income groups in the prevalence of major diseases such as

Alzheimer's disease, diabetes, heart disease, mental illness, osteoporosis, and stroke.

■ Health care spending by Medicare beneficiaries is highly skewed toward persons in poor health. In 1994, beneficiaries with three to five limitations in activities of daily living (ADLs) accounted for more than one-third of all beneficiary spending on personal health care, even though they consisted of only 11 percent of the Medicare population. Beneficiaries with one to two limitations in ADLs were responsible for another 20 percent of total spending, while they made up 14 percent of the population.

■ On average, beneficiaries with three to five limitations in ADLs spent six to seven times as much on health care as beneficiaries with no functional limitations. Moreover, the difference in total spending by beneficiaries in the two groups grew more than 5 percentage points between 1992 and 1994. In 1994, beneficiaries with no functional limitations accounted for about 24 percent of total spending, while beneficiaries with three to five functional limitations accounted for 37 percent of the total.

### Access to care

■ Access to care does not appear to be 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. Beneficiaries also reported a decline in barriers to care between 1992 and 1994, although some segments of the Medicare population had more than average difficulty obtaining medical care.

■ Vulnerable populations such as low income beneficiaries and disabled beneficiaries, racial and ethnic minorities, and beneficiaries without supplemental insurance (i.e., fee-for-service only beneficiaries) face higher than average barriers to care. Disabled and fee-for-service only beneficiaries consistently had more access problems

than other vulnerable groups. However, access may have become more equitable in recent years, as vulnerable populations made better than average gains in access to care between 1992 and 1994.

- Disabled beneficiaries were the only group to experience a decline in access to a usual source of care. Between 1992 and 1994, the proportion of disabled beneficiaries that used a particular medical person or place for health care fell from 88.5 percent to 87.7 percent. On the other hand, the proportion of disabled beneficiaries using office-based physicians as their usual source of care increased from 70.0 percent in 1992 to 72.0 percent in 1994.

- Beneficiaries with no supplemental insurance were least likely to have access to a usual source of care even though their use of a particular medical person or place for health care increased from 80.8 percent in 1992 to 83.9 percent in 1994. These beneficiaries consistently reported more access problems, such as delays in care due to cost and difficulty in obtaining care, than other groups.

- In 1994, a significantly larger proportion of beneficiaries in the lowest income quartile (10%) did not have a usual source of care compared to beneficiaries in the highest income quartile (6%). Beneficiaries with the lowest mean income were more likely than other groups to use an emergency room or hospital outpatient department for health care. However, differences in access to care by beneficiaries in the four income quartiles narrowed between 1992 and 1994.

## Service utilization patterns

- The proportion of Medicare beneficiaries using selected services increased between 1992 and 1994. Low-income beneficiaries living in communities, for example, were more likely to use inpatient and outpatient hospital services, physician/supplier services, and prescription drugs in 1994 than they were in 1992. User rates increased the most for outpatient hospital services, as nearly 60 per-

cent of beneficiaries in the lowest income quartile had at least one outpatient hospital department visit in 1994.

- Use of long-term care facilities also appears to be increasing. In 1992, 7.7 percent of the Medicare population had at least one long-term care facility stay. By 1994, the proportion had grown to 8.9 percent, or approximately 3.4 million beneficiaries. Low-income beneficiaries had the largest increase in the use of long-term care facilities, with user rates rising from 15.5 percent in 1992 to 17.4 percent in 1994.

- Low- and high-income beneficiaries have substantially different patterns of service utilization. In 1994, high-income beneficiaries were more likely to use outpatient, physician/supplier, and prescription medicine services; whereas low-income beneficiaries were more likely to use inpatient hospital and long-term facility care services. For beneficiaries living in communities, the largest difference was in the use of inpatient hospital services (21.6 percent for low-income beneficiaries versus 15.1 percent for their high-income counterparts in 1994).

- Vulnerable populations, such as the disabled, non-white beneficiaries, and fee-for-service only beneficiaries, had relatively stable utilization rates during the years 1992-1994. However, fee-for-service only beneficiaries living in communities did show a 2.4 percentage point decline in the use of prescription medicines, with user rates decreasing from 76.6 percent in 1992 to 74.2 percent in 1994.

## Satisfaction with care

- Most Medicare beneficiaries appear to be relatively satisfied with the quality of their general health care. Between 1992 and 1994, the proportion of community-only beneficiaries who were satisfied or very satisfied with their general health care increased from 88.2 percent to 90.4 percent. Satisfaction rates are even high-

er when beneficiaries who did not see a doctor during the year in question are excluded from the comparisons. Then the proportion of beneficiaries satisfied or very satisfied with their general health care rises from 95.2 percent in 1992 to 96.0 percent in 1994.

■ Vulnerable segments of the Medicare population expressed below average satisfaction with their health care. Although not mutually exclusive, the groups least satisfied with their health care include the disabled and Medicare fee-for-service only beneficiaries. Both groups reported a gain over 1992, but 8.5 percent of the disabled and 6.9 percent of the fee-for-service only beneficiaries remained unsatisfied with their general health care in 1994.

■ Vulnerable populations also are less satisfied than the typical beneficiary with such dimensions of their health care as availability of care at night and on weekends, ease of getting to a doctor, and cost of care. The disabled were usually least satisfied, followed by

fee-for-service only beneficiaries, the low-income beneficiaries, and non-white beneficiaries. However, the proportion of beneficiaries in vulnerable populations expressing satisfaction with various dimensions of their health care generally increased between 1992 and 1994.

■ Out-of-pocket cost is the least satisfactory dimension of health care, with 15.0 percent of all community-only residents reporting that they were unsatisfied with their share of health care costs in 1994. Fee-for-service only beneficiaries were least satisfied with cost, primarily because they face higher out-of-pocket expenses than other groups. Disabled beneficiaries were nearly as dissatisfied as fee-for service beneficiaries with cost, but satisfaction with cost increased significantly in both groups between 1992 and 1994. The proportion of beneficiaries satisfied with cost increased by 11 percentage points in the fee-for-service only group and 7 percentage points in the disabled group.