1 INTRODUCTION AND HIGHLIGHTS OF FINDINGS

Health and Health Care of the Medicare Population: Data from the 1995 Medicare Current Beneficiary Survey is the fourth 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 3 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 1995 MCBS, for example, includes beneficiaries who were entitled to Medicare for all or part of the year, as well as beneficiaries who died in 1995. 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 use 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 Veterans Administration. 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 PUFs. Access to Care PUFs—available for calendar years 1991 through 1997—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 1996—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 uses the data to highlight health care access and spending by the entire Medicare population and selected segments of the population. Chapter 2 contains information on national trends and patterns in personal health care spending by Medicare beneficiaries. Chapter 3 highlights groups of community residents who may encounter problems in obtaining access to needed medical care. Chapter 4 contains a snapshot of Medicare beneficiaries who are dually eligible for Medicaid and living in communities. Chapter 5 covers Medicare beneficiaries living in nursing homes. Chapter 6

contains the standard set of cross-sectional data produced in previous sourcebooks, and a set of time series data for the years 1992-1995.

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 billion to $333 billion between 1992 and 1995. The 10.4 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 spending rise from $493.5 billion in 1992 to $545.8 billion in 1995.

- Per capita spending increased at a slower annual rate than total spending because of growth in the Medicare and non-Medicare populations. The average expenditure by Medicare beneficiaries increased from $6,716 to $8,587, an annual growth rate of 8.5 percent. In contrast, the average expenditure in the non-Medicare population increased from $2,161 to $2,330, an annual growth rate of 2.5 percent.

- Spending on health care varies widely within the Medicare population. In 1995, the average personal health care expenditure for a beneficiary was $8,587, but some segments of the Medicare population had much higher than average expenditures. Per capita spending was $38,197 for full-year nursing home residents, $16,850 for dual eligibles, and $16,195 for the oldest old (age 85 or older).

- Medicare and Medicaid fund approximately two-thirds of all health care received by beneficiaries. In 1995, Medicare paid 55 percent of the bill, and Medicaid paid 12 percent. Households were responsible for 19 percent of the total, and private insurance covered another 9 percent.

Vulnerable Populations

- Access to care is not a problem for the typical Medicare beneficiary, but some beneficiaries may encounter more problems and have fewer alternatives in acquiring care than do other beneficiaries. Populations that have been identified as being vulnerable to access problems include the oldest old, racial and ethnic minorities, functionally disabled beneficiaries, low-income beneficiaries, and beneficiaries who do not have supplemental insurance.

- Vulnerable populations living in community settings report more problems in obtaining medical care than the typical beneficiary. These beneficiaries are more likely to indicate that they had difficulty in obtaining care during the previous year, delayed care due to cost, or had a problem but did not see a doctor. They also are less likely than other beneficiaries to have a usual source of care.

- Functionally disabled beneficiaries may be more vulnerable than most other groups. In 1995, the average expenditure by a functionally disabled beneficiary was $15,845, or 250 percent more than the average for all community residents. However, notwithstanding the level of spending, access was more of a problem for the disabled than nearly any other group. The Medicare fee-for-service-only beneficiaries were the only group likely to experience delays in care due to cost and difficulty in obtaining care.

- Beneficiaries who are age 85 or older may not be as vulnerable to access problems as many other beneficiaries. The oldest old were less likely than beneficiaries age 65 to 74 to have access problems, and 96 percent of them were satisfied or very satisfied with the quality of their care.

Dual Eligibles

- Estimates of the number of Medicare beneficiaries who are dually eligible for Medicaid are inconsistent because data from state-specific programs vary in breadth, scope, and quality. The MCBS data indicate that, in 1995, approximately 2.5 million beneficiaries (6.5 percent) received the full range of services offered by state Medicaid programs. In addition, 3 million beneficiaries (7.9 percent) were participating in the Qualified Medicare Beneficiary program for low-income beneficiaries.

- Dual eligibles have relatively high health care expenditures. In 1995, dual eligibles composed 14.4 percent of the Medicare population, but they were responsible for 38 percent of personal health care spending by Medicare beneficiaries. Much of this spending was on nursing home care, as nearly one-third of the dual eligibles spent part or all of the year in a long-term care facility.

- Dual eligibles living in communities have higher-than-average expenditures because they are in worse health and have more comprehensive coverage than most other beneficiaries. Total spending on personal health care is much lower, however, when nursing home residents are excluded from comparisons with other beneficiaries. In 1995, the average expenditure by dual eligibles living in communities was $7,838, compared with $6,081 for beneficiaries who had private supplemental insurance, and $5,011 for Medicare fee-for-service-only beneficiaries.

- Access to care may be a problem for dual eligibles even though they have relatively comprehensive health insurance. In 1995, dual eligibles living in communities were significantly more likely than other beneficiaries to have problems in obtaining care or to delay care due to cost.

Nursing Home Residents

- In 1995, approximately 5 percent of the Medicare population spent the entire year in a long-term care facility. These beneficiaries spent $79.1 billion on personal health care, or one-fourth of total spending by the Medicare population. Approximately $62 billion was for room, board, and nonmedical care services. The balance was primarily for acute care services.

- The typical nursing home resident is an elderly white female with severe functional disability. She is also likely to have limited income and relatively low educational attainment. Seventy-five percent of these beneficiaries receive Medicaid, and they are likely to remain in a long-term facility for the remainder of their lives.

- Per capita health care spending by the nursing home population is high. In 1995, the average expenditure was $35,704 for an aged beneficiary and $52,276 for a disabled beneficiary. These expenditures represent an increase of more than 20 percent since 1992.

- Nursing home care is largely, but not entirely, financed by public sources. In 1995, Medicare and Medicaid paid 60 percent of the personal health care expenses of full-year nursing home residents. Thirty percent was paid out-of-pocket by the beneficiary or family. Per resident out-of-pocket expenditures were $10,185 in 1995.