

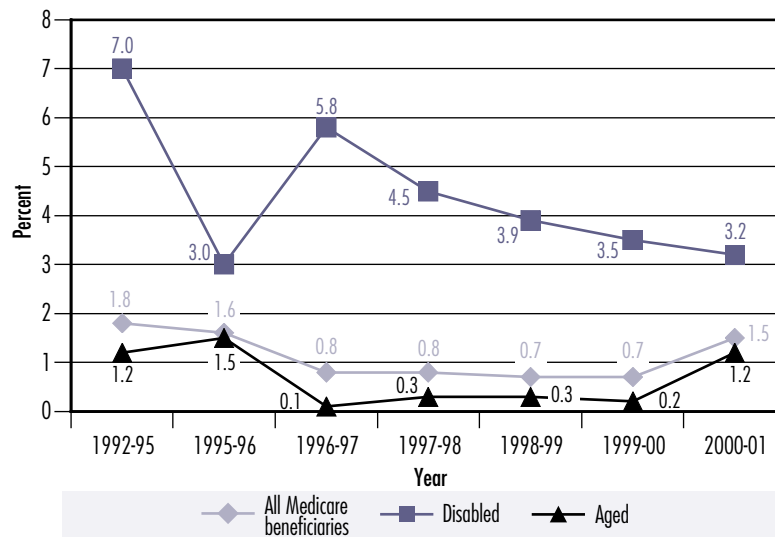


2 TRENDS IN THE MCBS: 1992–2001

The Medicare Population

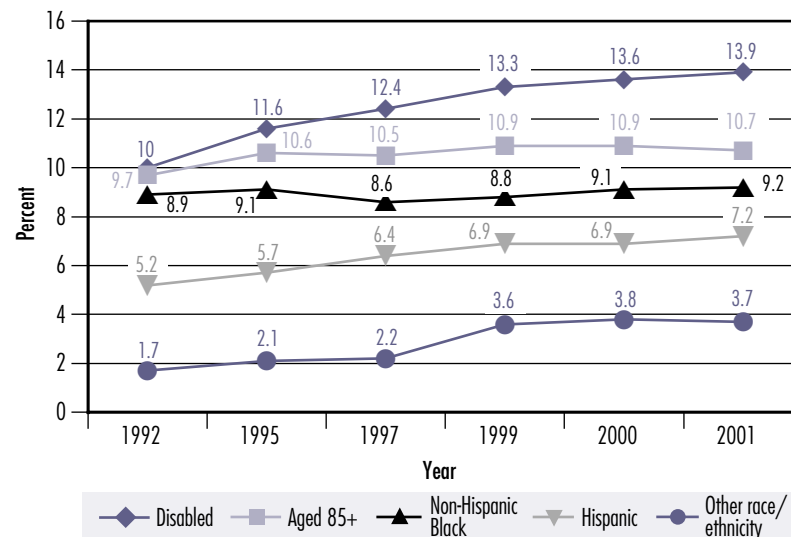
In 2001, the Medicare population grew by 1.5 percent over the previous year (Figure 2-1), reaching an estimated 41.2 million Medicare beneficiaries. Even though the growth rate remained low, it showed an upturn doubling the growth rate of previous years. This growth rate was partly driven by faster growth among aged Medicare beneficiaries (aged 65 or older), compared with the second half of the 1990s. In 2001, aged beneficiaries totaled 35.5 million (86.1 percent). As in previous years, disabled beneficiaries (beneficiaries under age 65) grew more rapidly than aged beneficiaries (i.e., by 3.2 percent and 1.2 percent respectively), reaching approximately 5.7 million (13.9 percent). In addition to disabled beneficiaries, other vulnerable subgroups that grew more rapidly than the Medicare population included Hispanics, non-Hispanic Blacks, and Medicare and Medicaid dually eligibles (DE). Reflecting their relatively faster growth rates, the shares of these subgroups increased slightly (Figure 2-2).

Figure 2-1. Annual Growth in Medicare Population by Medicare Status, 1992-2001



¹ National health expenditures include personal health care expenditures, administrative costs, public health spending, and research/construction expenses.

Figure 2-2. Proportion of Selected Groups in the Medicare Population, 1992-2001



Personal Health Care Expenditures

Personal health care expenditures (PHCE) represent direct consumption of health care goods and services provided by hospitals, physicians, and other sources of medical care and equipment. The Medicare Current Beneficiary Survey (MCBS) provides estimates of expenditures for Medicare-covered services as well as some relatively expensive services not typically covered by Medicare, for example, nursing home (NH) care and prescription medicines (PM). Information on noncovered services fills a large gap in knowledge about beneficiary health care spending. The Centers for Medicare and Medicaid Services (CMS), the primary source of Medicare program data, has claims information for only those services covered under Medicare Part A and Part B.

Estimates of national health expenditures (NHE) are produced annually by CMS.¹ The NHE estimates identify all health care goods and services produced in the U.S. health care market and determine the amount spent on them. The NHE presents a comprehensive picture of

national health care spending and provides information on sources of funding and services consumed by all U.S. residents. Total health care spending by the Medicare population is included in the NHE. The NHE report serves as a valuable frame of reference for policymakers to track trends in the health care industry.

In 2001, the NHE amounted to \$1.4 trillion, marking a growth of 8.7 percent from 2000. This continued the accelerating growth trend of the past 3 years (Levit et al., 2003). As a result, PHCE's share of gross domestic product (GDP) climbed to a new high of 14.1 percent in 2001 from 13.3 percent in 2000. This rise departed from nearly a decade's record of PHCE staying at 13 percent of GDP in the 1990s. Several main factors contributed to fast growth of PHCEs in 2001, including increasing Medicaid spending in the midst of a recession and payment increases to Medicare providers mandated by the Balanced Budget Refinement Act (BBRA) (Levit et al., 2003). Other factors included increases in utilization, reflected by growing quantity, changing mix

Figure 2-3. National Personal Health Care Spending, 1992-2001

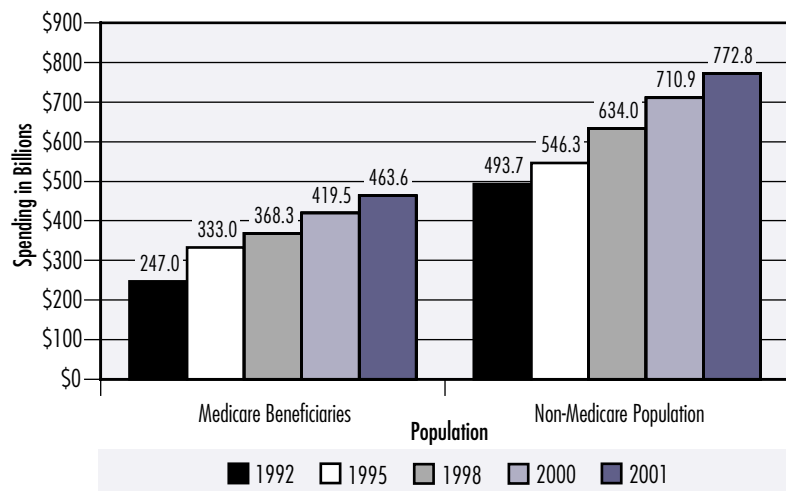
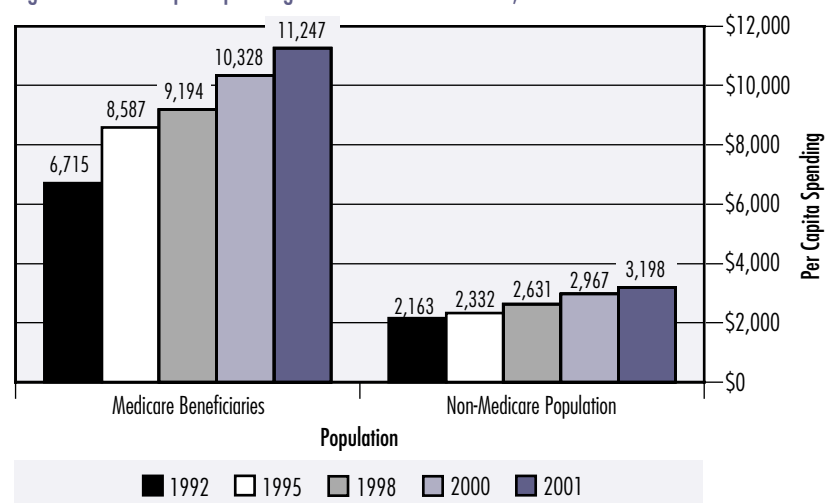


Figure 2-4. Per Capita Spending on Personal Health Care, 1992-2001



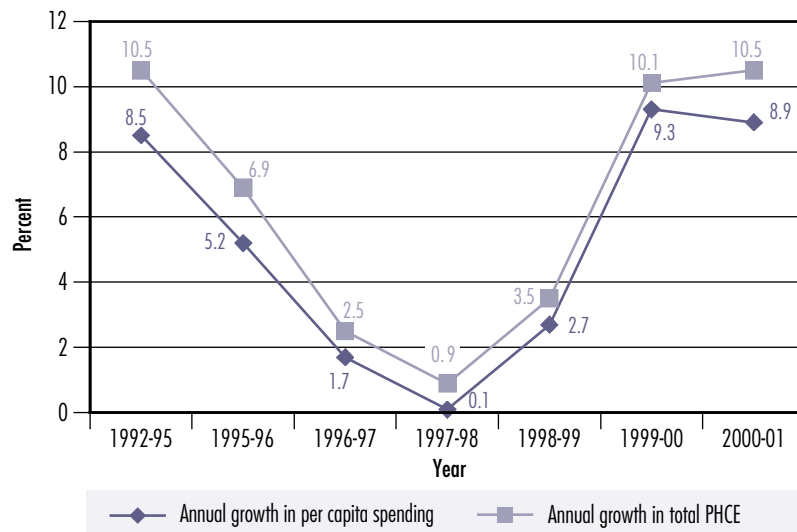
and quality of services, rising medical costs, and introduction of new technology (Cowan et al., 2004).

PHCE by Medicare beneficiaries amounted to \$464 billion in 2001, while the non-Medicare population spent close to \$773 billion (Figure 2-3). Although the Medicare population consisted of 14.6 percent of the total U.S. population, it consumed 37.5 percent of national health care resources. Per capita PHCE for the Medicare population amounted to \$11,247 in 2001, more than 3 times the amount for the non-Medicare population (Figure 2-4).² The annual growth in Medicare beneficiaries' aggregate PHCE and per capita PHCE reversed their low-growth trend in the late 1990s (Figure 2-5). Growth in total PHCE increased to double digits in 2000. CY 2001 maintained this momentum by showing a growth of 10.5 percent. Growth in per capita PHCE also reached a decade's high.

Fast growth in Medicare beneficiaries' health care spending was largely attributable to rising Medicare expenditures as a consequence of the BBRA effects of payment increases to Medicare providers. Other factors

² U.S. population and national health expenditure estimates for 2001 come from data published by CMS, Office of the Actuary, in 2001, while estimates for 2000 come from data published by the same source in 2000.

Figure 2-5. Annual Growth in Aggregate and Per Capita Spending on Personal Health Care by Medicare Beneficiaries, 1992-2001



included large increases in private payments, including payments from private insurance as well as out-of-pocket payments, and declines in Medicare managed care enrollment.

In 2001, most of the vulnerable populations continued to show significantly higher than average per capita PHCE. They included full-year NH residents,³ the oldest old, the DEs, and the disabled (Figure 2-6).⁴ On the other hand, racial and ethnic minorities, Hispanics and non-Hispanic Blacks in particular, were showing lower than average per capita PHCE.

Funding Sources

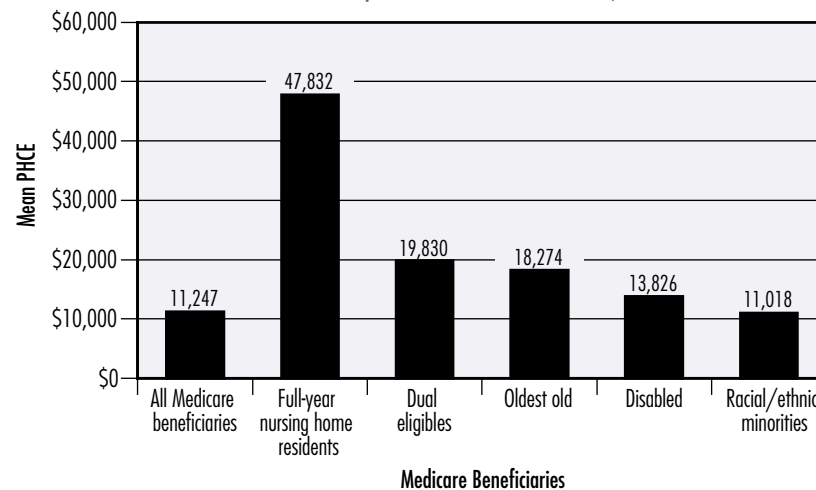
The non-Medicare and the Medicare population exhibited distinctive funding patterns of their PHCE (Figure 2-7).⁵ The bulk of the PHCE by the non-Medicare population was financed by private sources, including primarily private health insurance (PHI) (48.9 percent) and out-of-pocket (OOP) payments (14.9 percent).⁶ Public funds,⁷ mainly from

Medicaid, consisted of 20 percent. In contrast, close to two-thirds of Medicare beneficiaries' PHCE was financed by public sources, even though the share of public funds showed declines over the years (Figure 2-8). In 2001, Medicare funded 52 percent of Medicare beneficiaries' PHCE and Medicaid funded 12 percent. The remainder was covered by OOP payments (19 percent), PHI (13 percent), and other sources (4 percent).

Consistent with trends seen in the NHE accounts (Levit et al., 2003), growth in public as well as private funding for Medicare beneficiaries continued to accelerate (Figure 2-9). Total Medicare payments in 2001 amounted to \$241.8 billion, a two-digit increase of 10.5 percent over 2000. Per capita Medicare payment of \$5,866 also grew 9 percent from 2000. This continued the trend of sharp upturns between 1999 and 2000.

In 2001, high growth rates in Medicare spending were shown in major service types (Table 2-1). Medicare spending on skilled nursing facility (SNF) care increased by 33 percent compared with 2000, showing a net increase of \$3.3 billion. Substantial increases were also observed in Medicare payments on ambulatory care, i.e., physician (12.2 percent)

Figure 2-6. Per Capita Personal Health Care Expenditures (PCHE) by Selected Groups of Medicare Beneficiaries, 2001



³ Their room and board expenses considerably increased their average PHCE

⁴ The subgroups presented in this figure are not mutually exclusive.

⁵ To achieve comparability between the Medicare and non-Medicare populations, the category "other" includes both other private payments in NHE and other public payments.

⁶ In this sourcebook, discussions on private sources are limited to PHI and OOP payments.

⁷ Discussions on public sources are limited to Medicare and Medicaid payments.

and outpatient hospital care (12.5 percent), with respective net increases of \$8.4 and \$2.9 billion. At the same time, sizeable increases were seen in Medicare payments on inpatient care (a net growth of \$6.3 billion).

Figure 2-7. Sources of Funds for Personal Health Care Expenditures by Medicare Beneficiaries and the Non-Medicare Population, 2001

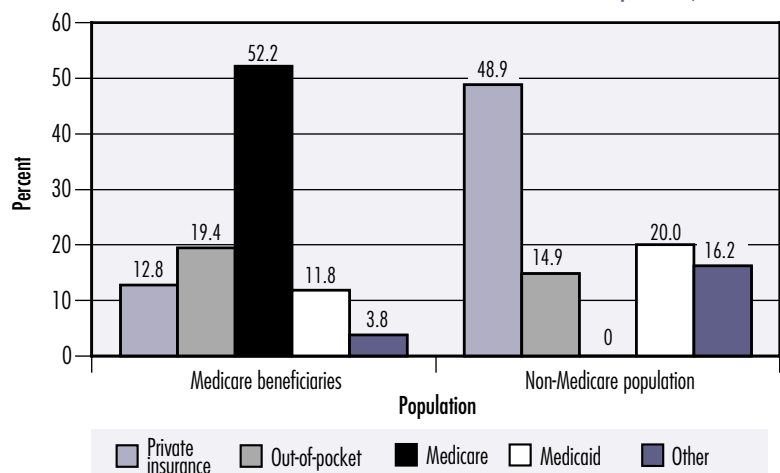


Figure 2-8. Sources of Funds for Personal Health Care Expenditures by Medicare Beneficiaries, 1992-2001

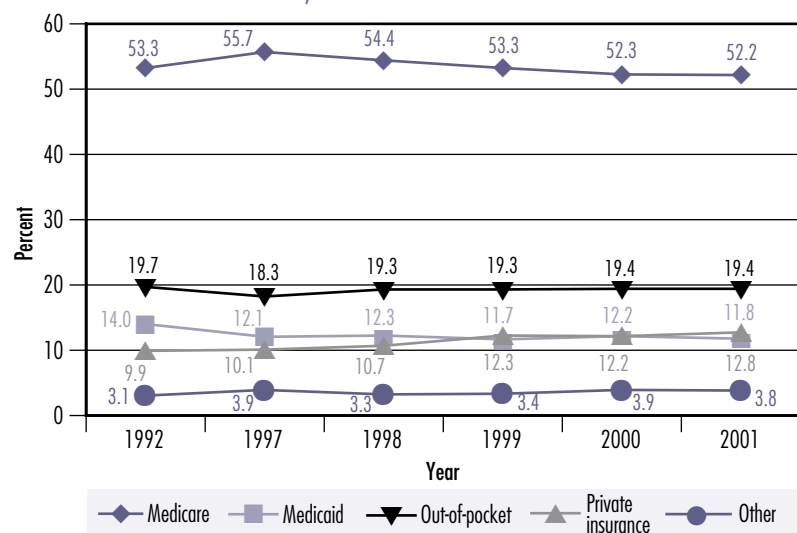


Figure 2-9. Annual Growth Rates of Personal Health Care Expenditures by Medicare Beneficiaries by Funding Source, 1992-2001

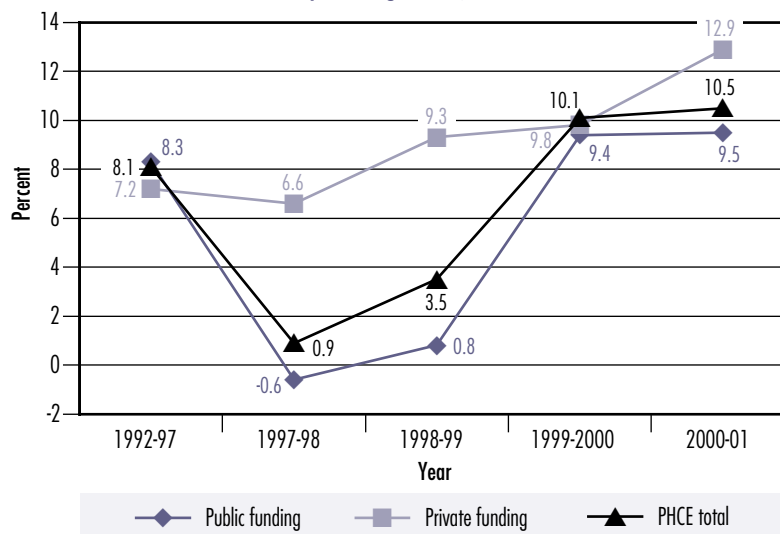


Table 2-1 Annual Growth Rates of Medicare Expenditures by Medicare Beneficiaries by Selected Service Type, 1992-2001

Selected Service Type	1992-95 (%)	1995-96 (%)	1996-97 (%)	1997-98 (%)	1998-99 (%)	1999-00 (%)	2000-01 (%)
Inpatient Hospital	7.5	3.5	2.5	-1.7	4.5	6.4	6.2
Physician/Supplier	11.2	4.0	7.3	3.1	8.0	9.9	12.2
Outpatient Hospital	13.4	6.7	8.7	0.9	2.3	8.0	12.5
Home Health	25.2	7.3	-7.2	-27.2	-32.6	13.7	7.7
Skilled Nursing Facility	38.1	38.8	7.6	-6.1	-8.5	1.8	32.6

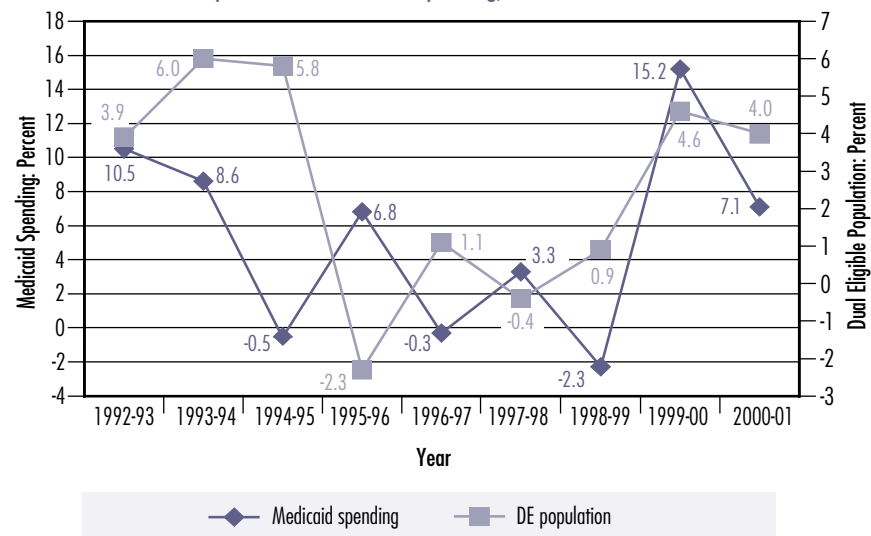
Medicare spending on different service types went through a series of increases and decreases in the past decade (Table 2-1). These sharp up-and-down swings in the annual growth rate reflected responses to changes in the Medicare policies during the decade, in particular, Federal antifraud measures in the mid-1990s, the introduction of the

Balanced Budget Act (BBA) in 1997 and 1998, and the tempering provisions of BBRA and the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) in 2000. “BBA contributed to a rapid deceleration in FFS spending growth from 1997-1999, followed by a rebound as the provisions of BBRA and BIPA were implemented” (Cowan et al., 2004). Large growth seen in CY 2001 in SNE, ambulatory, and inpatient spending were closely tied to BBRA’s provisions, including increasing payments to providers—in particular, hospitals, nursing homes, and home health agencies—and accelerating the reduction of Medicare required coinsurance for outpatient services.

Compared with the non-Medicare population, economy downturns in 2000 and 2001 apparently had a similar yet milder impact on the health care spending pattern of the Medicare population. The recession may have contributed to the increases in the size of the DEs in the Medicare population since 2000. By 2001, the DE population increased to 7.5 million. During the past decade, the DE population showed two growth spurts, one during the first 5 years of the 1990s and the other between 1999 to 2001 (Figure 2-10). During these two periods, the growth rate of the DE population significantly outpaced that of the Medicare population (Figures 2-1 and 2-10). Consequently, the proportion of the DE population also slightly increased to 18.3 percent of Medicare beneficiaries in 2001.

Total Medicaid spending by this population amounted to \$54.8 billion, representing a 7 percent growth from 2000 (Figure 2-10). During the mid-1990s, the annual growth rate of Medicaid spending plummeted to negative numbers and stayed low until the end of the 1990s. The recent upsurge in overall Medicaid spending probably reflected increases in population as well as utilization. The bulk of Medicaid expenditures concentrated on long-term nursing home care (75.4 percent) and PMs (13.1 percent) for the DE population, amounting to \$41.3 billion and \$7.2 billion, respectively. These two expenditures showed net increases of \$1.6 billion and \$1.4 billion dollars, respectively. Medicaid spending

Figure 2-10. Annual Growth Rates of the Medicare and Medicaid Dual Eligible Population and Medicaid Spending, 1992-2001



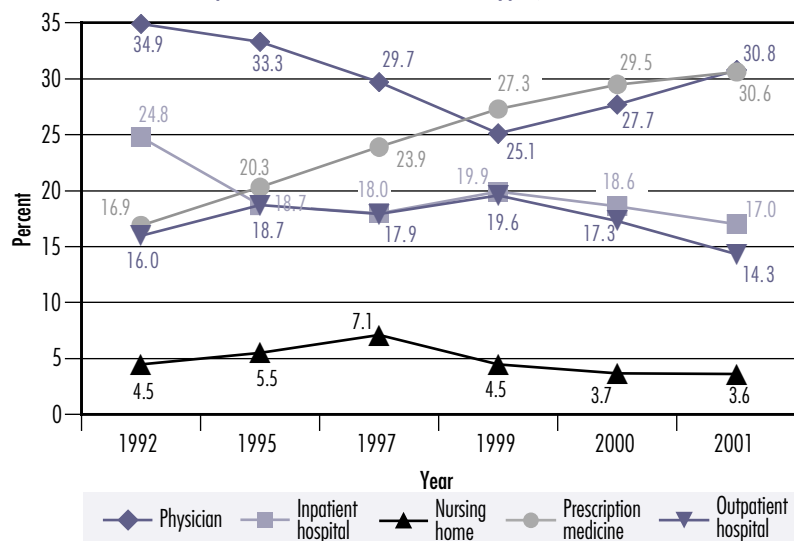
on PMs, in particular, almost tripled in the past 5 years, from \$2.7 billion in 1996 to \$7.2 billion in 2001.

In the private sector, PHI spending by Medicare beneficiaries revealed two trends in recent years: accelerated growth rates and shifting spending patterns. Parallel to the fast-paced growths in the public sector, PHI spending grew briskly during 2001 for the third consecutive year, estimated at \$59.4 billion. The annual growth rate of PHI surged to 16 percent, representing a net increase of \$8.2 billion over 2000. The increases were apparently associated with the rises in PHI coverage among Medicare beneficiaries. Paradoxically, during this time of economic downturn, the coverage rate of PHI among noninstitutionalized Medicare beneficiaries, both employer-sponsored and individually purchased, showed significant increases compared with the flat growth rate of the Medicare population. In CY 2001, beneficiaries reported that both types of PHI coverage, by employers as well as individually-purchased, grew slightly.⁸

⁸ See further discussion in the section “Insurance Status,” page 15.

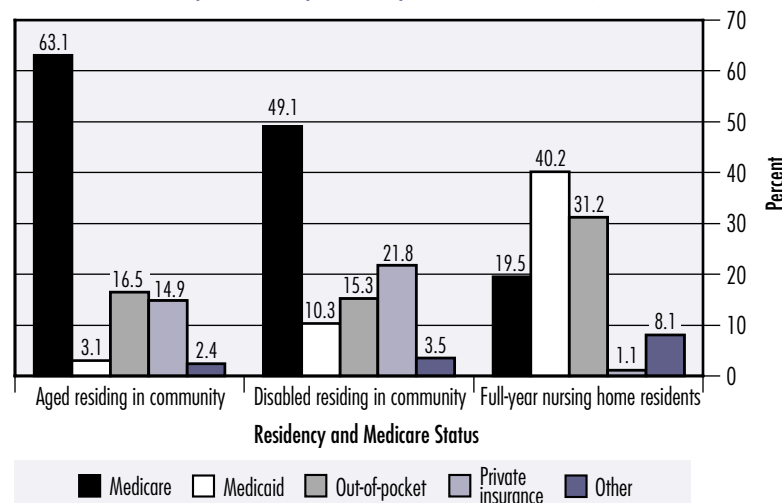
PHI expenditures by Medicare beneficiaries showed shifting spending patterns on major service types in the past decade (Figure 2-11). In 1992, the bulk of PHI money was spent on physician (35 percent) and inpatient care (25 percent). By 2001, spending on PM (\$18.2 billion) gradually climbed up to 31 percent of total PHI, and expenditures on physician care (\$18.3 billion) also increased to 31 percent. On the other hand, spending on inpatient and outpatient care declined to 17 and 14 percent of the total PHI payments respectively. Growth rates of PHI spending on physician care, PM, and SNF care were increasing, respectively, to 29, 21, and 19 percent.

Figure 2-11. Proportion of Medicare Beneficiaries' Private Health Insurance Expenditures on Selected Service Types, 1992-2001



Growth in beneficiaries' OOP payment, the main source of private funding, accelerated at a similar rate (10.9 percent) to total PHCE for the second consecutive year, with a net increase of \$8.8 billion. Per capita OOP was estimated at \$2,185 in 2001. The bulk of OOP payments was spent on SNF or long-term facility care (40 percent). PMs used 21 percent and ambulatory care another 23 percent. Increases of OOP spending spread across major service types, with major spikes

Figure 2-12. Sources of Funds for Medicare Beneficiaries' Personal Health Care Expenditures by Residency and Medicare Status, 2001



in OOP payments on hospital care, both inpatient (45.9 percent) and outpatient (34.1 percent). These spikes were attributable to the rise of Medicare Part A deductible and cost-sharing for inpatient hospital care,⁹ and the gradual upward shifting in inpatient service utilization.

Aged and disabled community residents showed distinctive patterns of funding sources compared with nursing home residents (Figure 2-12). For aged community residents, Medicare financed 63.1 percent of total PHCE, while OOP (16.5 percent) and PHI (14.9 percent) payments contributed much of the remainder. Disabled community residents also funded their PHCE primarily with Medicare payments (49.1 percent), along with sizeable contributions from PHI (21.8 percent) and OOP payments (15.3 percent). The financing structure underlying sources of payment remained basically stable for these two groups compared with previous years. Notably, funding from the private sector inched up in its share of total PHCE for the disabled residing in the community. For full-year nursing home residents, Medicaid and OOP payments financed larger shares of their PHCE, at 40 and 31 percent respectively, whereas Medicare funded 19.5 percent.

⁹ The Medicare Part A deductible for inpatient hospital care rose to \$792 in 2001, a \$16 increase, while in previous years the raises were usually \$8.

PHCE by Service Category

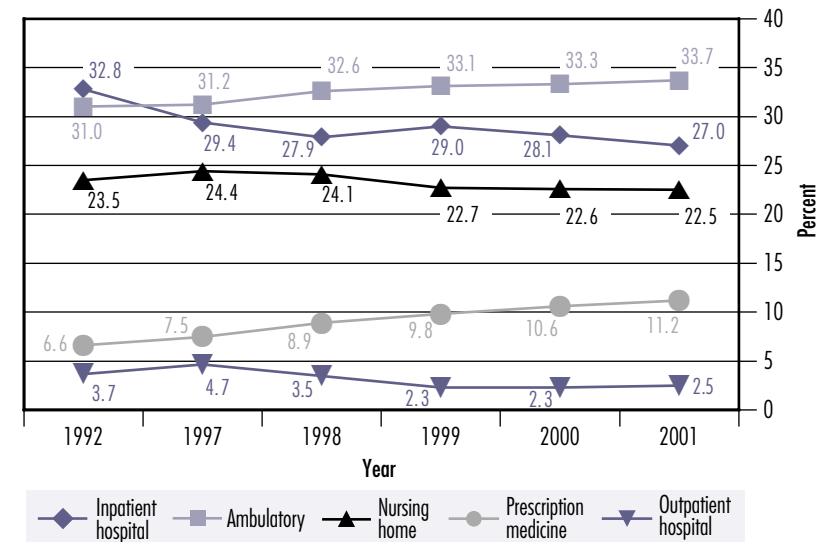
Double-digit growth in PHCE by Medicare beneficiaries was attributable to fast increases across all major service types in 2001 (Table 2-2), although growth rates for different services varied. Annual growth rates for SNF care spiked up by 29.7 percentage points, followed by home health care (17.6 percent) and PM services (16.8 percent). Growth in physician care spending (12.6 percent) also outpaced the overall growth level.

Table 2-2. Annual Growth Rates of Personal Health Care Expenditures by Medicare Beneficiaries by Selected Service Type, 1992-2001

	1992-97 (%)	1997-98 (%)	1998-99 (%)	1999-00 (%)	2000-01 (%)
Inpatient Hospital	5.8	-4.1	7.4	6.7	6.1
Ambulatory	8.2	5.4	5.1	10.7	11.9
Physician/Supplier	7.4	5.5	4.6	13.8	12.6
Outpatient Hospital	10.5	5.3	6.5	2.7	9.8
Prescription Medicine	11.0	20.6	13.9	18.8	16.8
Home Health	13.5	-25.4	-32.1	11.7	17.6
Nursing Home	8.9	-0.5	-2.6	9.8	9.8
Long-term Care	6.4	1.5	-1.6	11.7	6.8
Skilled Nursing Facility	30.5	-9.8	-7.8	-1.0	29.7

Over the past decade, proportions of PHCE by Medicare beneficiaries on major service types underwent gradual shifting (Figure 2-13). Medicare beneficiaries were spending larger shares of PHCE on ambulatory care and prescription medicines, and smaller proportions on inpatient services. In 2001, spending on inpatient and ambulatory services continued to account for more than 60 percent of total PHCE. In spite of gradual declines in the inpatient share of PHCE, the utilization level of inpatient services grew steadily, with a net growth of \$7.5 billion between 2000 and 2001. The user rate of inpatient hospital services also rose slightly to 21.2 percent, exceeding the peak

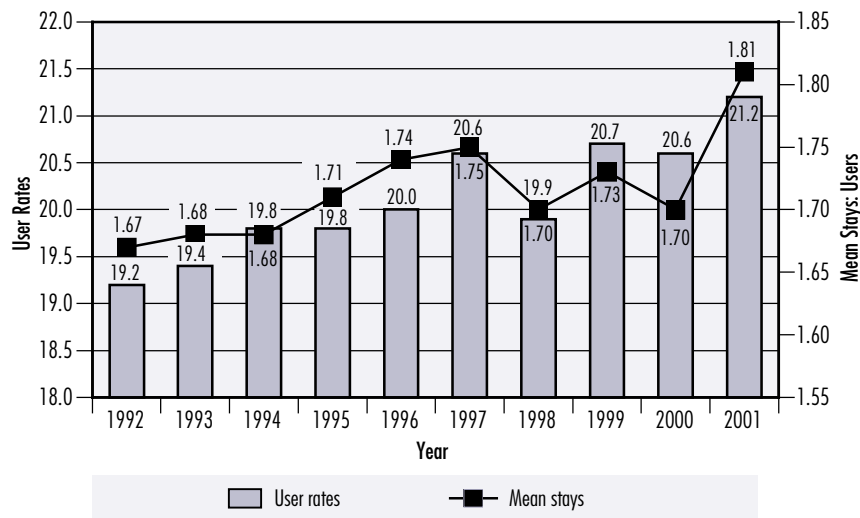
Figure 2-13. Proportion of Personal Health Care Spending by Medicare Beneficiaries by Selected Type of Service, 1992-2001



rate during the past decade (Figure 2-14). Compared with 2000, total inpatient stays by Medicare beneficiaries, estimated at 15.9 million episodes, grew to a historical high by 11.3 percentage points. The mean stays for users also inched up from 1.7 stays to 1.8 stays.

Similarly, increases observed in ambulatory services by Medicare beneficiaries were apparently attributable to increased levels of utilization, reflected by both the rising user rates and more use per user as seen in the U.S. population (Levit et al., 2003). User rates of physician services maintained a steady upward, though modest, trend in the past decade, from 92.6 percent in 1992 to 95.1 percent in 2001 (Figure 2-15). On the other hand, user rates of outpatient care showed a faster increase over the past decade than any other service, from 58.7 percent in 1992 to 70.7 percent in 2001, an increase of 12 percentage points. Increased utilization levels also were reflected in mean visits per user (Figure 2-16), where steady rises were observed in mean physician visits as well as mean outpatient visits. The growth in user rates,

Figure 2-14. Utilization of Inpatient Hospital Service by Medicare Beneficiaries, 1992-2001



compounded with increases in usage per user, led to upsurges in PHCE by beneficiaries. Compared with 2000, net increases in ambulatory care amounted to \$16.6 billion in 2001.

Figure 2-15. User Rates of Ambulatory Services by Medicare Beneficiaries, 1992-2001

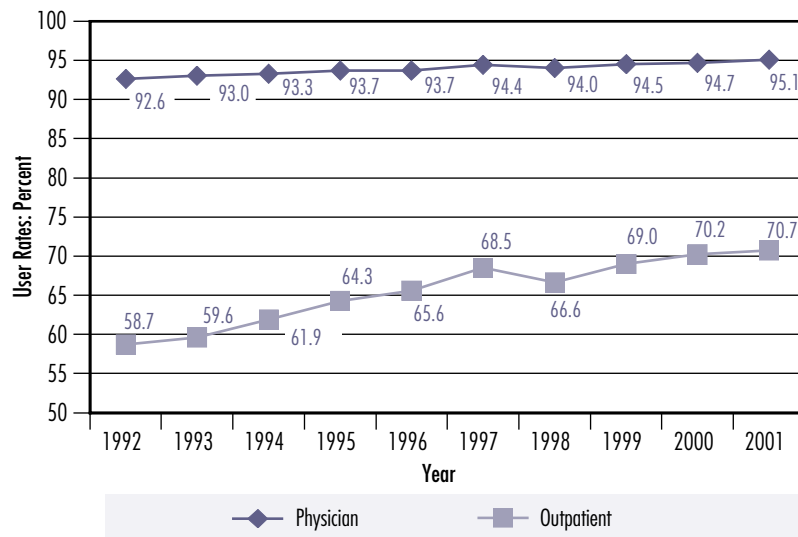
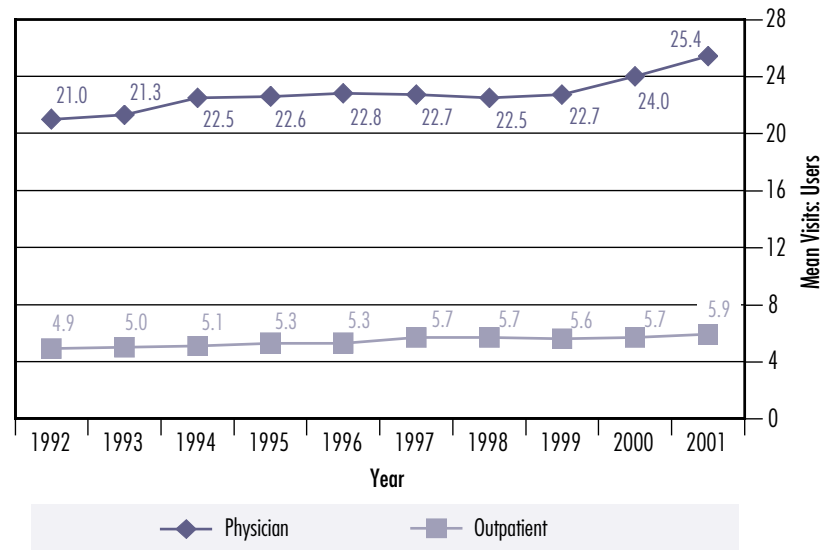


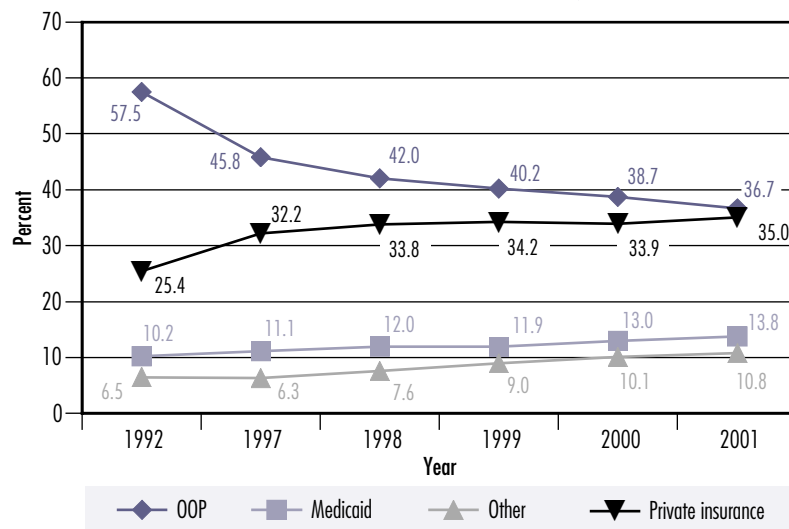
Figure 2-16. Mean Use of Ambulatory Services by Medicare Beneficiaries, 1992-2001



In 2001, spending on prescription medications maintained the fast growth momentum, amounting to \$52 billion (a 17 percent growth and a net increase of \$7.5 billion from 2000). PM's share of Medicare beneficiaries' PHCE increased steadily over the years to 11.2 percent (Figure 2-13).

Double-digit growth in prescription drug spending in the past decade was attributed to a number of trends, such as increased third-party coverage and continued new drug introduction. Since PHI and OOP are the major sources of payment of PM expenditures (covering 75 to 83 percent of PM spending), greater coverage of prescription drugs through third-party insurers and the resulting reduction in consumer OOP expenses served to induce greater consumer demand (Levit et al., 2003). Data on noninstitutionalized Medicare beneficiaries indicated that from 1992 to 2001, OOP's share of total PM spending declined from 58 percent to 37 percent; whereas PHI's share increased from 25 percent to 35 percent. On the other hand, Medicaid's share of PM inched up steadily to 14 percent (Figure 2-17).

Figure 2-17. Major Sources of Payment for Prescription Medicine Expenditures by Noninstitutionalized Medicare Beneficiaries, 1992-2001



Moreover, increased user rates and greater intensity of use also fueled growth (Cowan et al., 2001). PM user rates among noninstitutionalized Medicare beneficiaries increased steadily from 85 percent in 1992 to 91 percent in 2001 (Figure 2-18). Total PMs filled in 2001 reached 1,046 million, nearly doubling the number in 1992. The average number of PMs filled by users also rose from 19.5 in 1992 to 29.2 in 2001. Continuing its rise since 1992, average prescription drug spending per user nearly tripled in the past 10 years, reaching \$1,446 (in nominal dollars) in 2001 (Figure 2-18).

Apparently, changes in Medicare policies are the predominant drivers of the growth curves. Up until 1999, nursing home care, both short and long-term, had been the one sector that experienced the slowest or sometimes negative growth. In 1999, BBA mandated a conversion from a cost-based reimbursement system to a prospectively determined payment system for Medicare SNFs, leading to major declines in Medicare payments to providers. Starting in 2000, BBRA and BIPA modified the BBA limitations with an interim payment system and raised substantially Medicare payments to nursing homes (Levit et al., 2003). Medicare's more generous payments apparently spurred higher levels of utilization of SNF services. Even though user rate of SNF care remained flat in recent years at 4.5 percent, the estimated total number of SNF episodes increased to 3.9 million stays, up by 10.3 percentage points compared with 2000 (Figure 2-19). Medicare payments to providers, alone, jumped up by 32.6 percentage points, with a net increase of \$3.3 billion. Not surprisingly, mean spending per user increased substantially to \$8,952, by 24.2 percent compared with 2000 (Figure 2-19).

Figure 2-18. Prescription Medicine Utilization by Noninstitutionalized Medicare Beneficiaries, 1992-2001

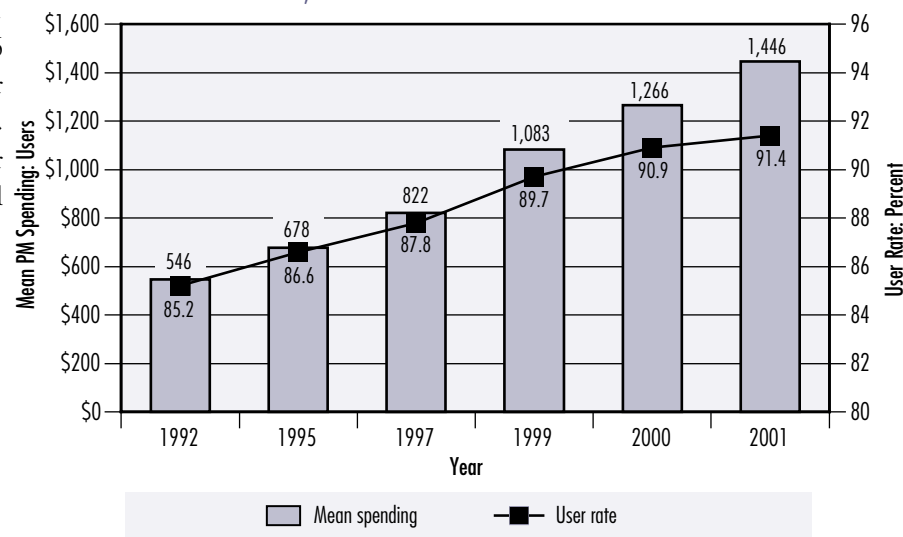
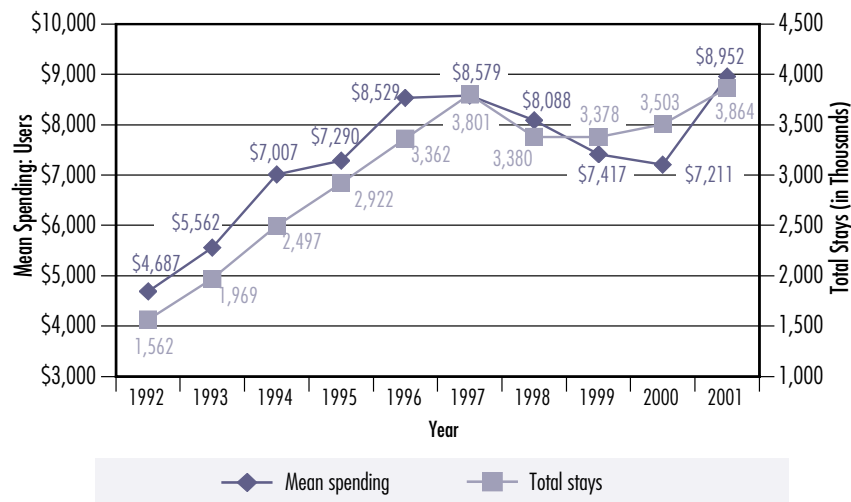
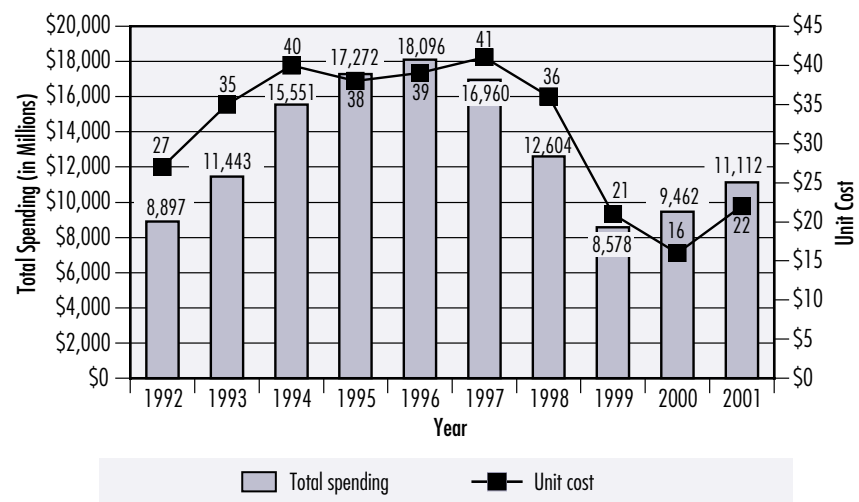


Figure 2-19. Utilization of Skilled Nursing Home Care by Medicare Beneficiaries, 1992-2001



In the past decade, the levels of home health spending swung up and down, reflecting changes in Medicare's home health care policy. Total home health care spending peaked during 1996 and 1997 and then took a sharp downturn between 1997 and 1999, due to BBA's harsh effects. Since 1999, BBRA and BIPA relaxed the payment limitations, increasing Medicare payments to freestanding home health agencies (Levit et al., 2003). Consequently, home health care spending reversed the trend of negative growth and started to show accelerated increases. In 2001, total home health care spending by Medicare beneficiaries residing in the community reached \$11.1 billion, an 18 percent increase compared with 2000 (Figure 2-20). However, these increases were largely attributable to the higher cost factor rather than increased utilization. In 2001, the unit cost of home health care showed a sharp upturn (Figure 2-20).

Figure 2-20. Home Health Care Spending by Noninstitutionalized Medicare Beneficiaries, 1992-2001

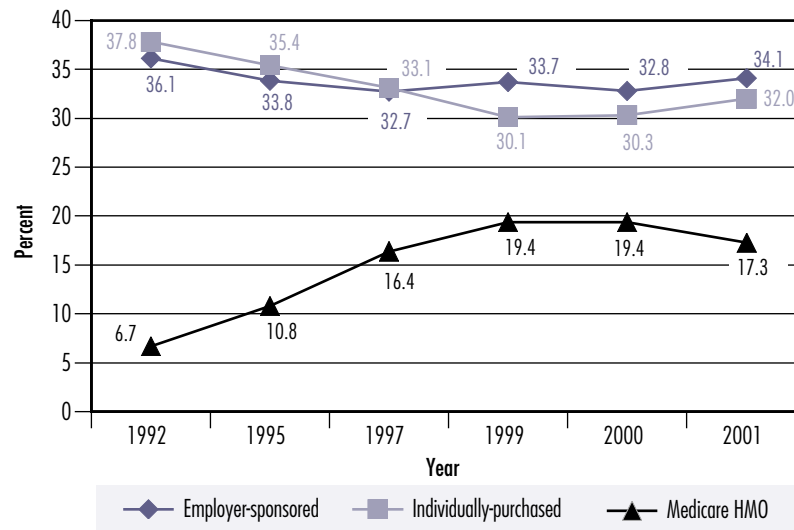


Insurance Status

In 2001, the rate of employer-sponsored PHI coverage among Medicare beneficiaries increased to 34 percent; and the rate of individually-purchased PHI rose to 32 percent. Whereas the rising cost of premiums, greater cost-sharing, and eroding benefits of PHI served to reduce the number of policyholders, the increasingly higher cost-sharing in Medicare HMOs, limitations in their availability in certain areas, and more restricted benefits have induced some beneficiaries to keep or acquire PHI policies. This trend may also reflect the broader national shift from tightly managed, lower cost health maintenance organization plans toward plans that allow greater access to providers, even at a higher expense (Levit et al., 2003). In spite of the greater out-of-pocket expense involved, a rising proportion of Medicare beneficiaries have opted to retain private supplemental policies.

In 2001, enrollment in Medicare HMOs witnessed the first drop since the early 1990s (Figure 2-21). Total number of enrollees consisted of 17.3 percent of the noninstitutionalized Medicare population, a decline of 2 percentage points compared with 2000. Very modest annual increases in Medicare payments to managed care organizations (MCOs), stipulated by the BBA, prompted some Medicare HMO plans to withdraw from selected service areas or to terminate their Medicare contracts entirely. In spite of changes introduced by the BBRA and BIPA to undo the most stringent effects of the BBA, many plans that remained in the market reduced benefits or raised premiums. These recent changes have led to greater OOP cost and reduced benefits for Medicare enrollees (Gold and Achman, 2002).

Figure 2-21. Private Health Insurance and Medicare HMO Coverage for Noninstitutionalized Medicare Beneficiaries, 1992-2001



Summary

In 2001, the growth rate of the Medicare population climbed upward, even though remaining low. Certain vulnerable subgroups, including racial and ethnic minorities, the disabled beneficiaries, and the DEs grew at a faster pace, shifting the composition of the Medicare population.

In CY 2001, both aggregate and per capita PHCE by the Medicare population maintained the fast growing momentum from 2000. Public as well as private funding surged to a historic high. Predominant factors attributing to the double-digit growth, included Medicare policy changes mandated by BBRA and BIPA, inducing higher levels of utilization of selected types of health care services.

Further usages reflecting changes in the Medicare policies included beneficiaries' shifting service mix and using more ambulatory, PM, and SNF care services in the place of inpatient services. The share of PM services in PHCE increased over the years, almost doubling the 1992 PM share. Spending on SNF care also increased by a third.