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HEALTH CARE EXPENDITURES FOR THE ELDERLY: HOW MUCH PROTECTION DOES MEDICARE PROVIDE?

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PREPARED BY THE STAFF OF THE

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EXECUTIVE SUMMARY

Medicare was designed to serve as the basic protection against the high costs of health care for 26 million older Americans. In recent years, however, rising health care costs and growing Federal deficits have focused attention on the need to constrain the rapid growth in total expenditures of the medicare program. Yet, proposals for reducing expenditures must be evaluated in light of their impact on the program's beneficiaries. An analysis of current medicare coverage and the costs of health care borne directly by the elderly are essential to this evaluation.

Medicare's share of total health care expenditures for those over 65 has increased over time, from 35.3 percent in 1970 to an estimated 45 percent in 1980. For those services medicare was designed to cover, the program improved its share of costs, from 70 percent to 75 percent, during the same decade. However, total per capita health care costs not paid for by medicare have also grown as a percentage of the elderly's income over the past decade, from 16.8 percent of total income in 1970 to 19.1 percent in 1980, to the point where such expenses now approach premedicare levels (20.4 percent).

Of the expenditures not covered by medicare, the major share is paid directly by the beneficiary. In 1977, persons over age 65 paid 29.1 percent of their total health care expenditures directly out-of-pocket. There is little evidence that this percentage has diminished in recent years.

These direct out-of-pocket payments include copayments and charges in excess of payments from medicare as well as services not covered by medicare. They do not include, however, the premiums paid by beneficiaries for medicare ($146 a year) or for private supplemental insurance ($300 to $400 a year for a typical policy).

The primary portion of beneficiaries' direct out-of-pocket expenditures results from nonhospital services. Medicare has increased its original share of hospital expenditures, covering 74 percent of hospital bills in 1970 and 82 percent in 1980. When considered as a percent of the elderly's income, the amount of hospital expenses not covered by medicare has actually declined slightly, from 2.8 percent in 1970 to 2.6 percent in 1980.

Medicare pays a considerably smaller portion of physicians services than it does of hospital services (59 percent). Although that portion has remained essentially constant over time, expenditures for physicians services not paid for by medicare have increased as a percent of total income from 1.9 percent to 2.65 percent from 1970 to 1980.

Although 70 percent of the elderly have some form of supplemental private insurance, these policies primarily cover only the uncovered portion of services already covered by medicare. Private insurance pays only a small portion of the elderly's total health expenditures (6.6 percent). Premium rates for private insurance have been steadily

increasing, some more than doubling over the past decade. Changes to the medicare program in terms of increased copayments or decreased reimbursement rates have added to these increases. For example, increases in medicare deductibles enacted in 1981 accounted for one-quarter of the 24-percent increase in actuarial value for typical new policies written in 1982 by one insurance company.

While medicare has maintained its share of total health expenditures for the elderly, significant gaps in coverage remain. Health expenditures not paid for by medicare are also growing as a percentage of the elderly's income. Proposals enacted in 1981 increased the amount of these expenditures by increasing the part A deductible from $204 to $260, twice the amount of the average annual increase, and increased the part B deductible from $60 to $75, the first such increase in 9 years. In considering new measures to limit medicare expenditures, there must be a concern for the further cost-shifting impact of those proposals.

CONTENTS

HEALTH CARE EXPENDITURES FOR THE ELDERLY: HOW MUCH PROTECTION DOES MEDICARE PROVIDE?

INTRODUCTION

Medicare was enacted in 1965 as a means of providing protection for the elderly from the costs of health care. There is no question that medicare has, in fact, provided this protection to many older Americans and, in doing so, has become the single largest purchaser of health care in the world. From a program spending $3.2 billion in 1967, it will grow to $49.8 billion in 1982.[1]

Nevertheless, in recent years, there has been considerable debate concerning whether medicare is adequately covering the cost of care for the elderly. Some have pointed to the gaps in medicare's coverage and the increasing costs of physician services not paid for by medicare. Others have argued that medicare has not only kept pace with total personal health care expenditures, but its share has grown over time.

The concern over reducing Federal deficits and the large share of outlays that medicare represents in the overall Federal budget has made it important to carefully reexamine medicare's performance. Recent data on medicare provides an overall description of the protection provided by the program, particularly in regard to the health care services it was intended to cover. The adequacy of medicare's coverage, however, must also be examined in light of expenditures by the elderly for services not covered by medicare and the performance of other sources of payments (supplemental insurance and medicaid) in meeting the shortfall between medicare and total health expenditures. This paper examines these three issues.

MEDICARE COVERAGE AND PAYMENT

Although medicare's share of health care costs for individual beneficiaries may vary widely according to services needed and duration of care, aggregate data can provide an overall description of the level of protection medicare currently provides.

Total Personal Health Care Expenditures for the Elderly [2]

As can be seen by table I below, medicare's share of total personal health care expenditures for the elderly has not declined. In fact, it has risen since 1970, though it represents only 45 percent of total health expenditures for persons over the age of 65.

[1] Information provided by the Health Care Financing Administration (HCFA), Department of Health and Human Services.

[2] Total health care expenditures include total payments from all public and private sources for personal health care including physician services, hospital care, nursing home care, drugs and medical sundries, home health services, and other professional services such as dental services, laboratory services, and eyeglasses and other appliances.

TABLE I.—TOTAL PERSONAL HEALTH CARE EXPENDITURES FOR THE AGED [1]

Year	Total (millions)	Medicare (millions)	Medicare percent of total
1965	$8,869	----------	----------
1970	17,270	$6,098	35.3
1976	37,674	16,313	43.3
1977	43,303	19,140	44.2
1978	49,366	21,770	44.1
1980 [2]	68,400	30,800	45.0

[1] Fisher, Charles R., "Differences by Age Groups in Health Care Spending," Health Care Review, vol. 1, No. 4 (spring 1980).
[2] Estimated data supplied by the Health Care Financing Administration.

Despite medicare's increasing share of costs, however, the elderly person's per capita responsibility for his or her total health care bill is also growing, from $503 in 1970 to $1,436 in 1980. As table II shows, this is an increase from 16.8 to 19.1 percent of total income.

TABLE II.—TOTAL PER CAPITA PERSONAL HEALTH CARE EXPENDITURES NOT PAID BY MEDICARE AS A PERCENT OF TOTAL INCOME FOR THE ELDERLY

Year	Total per capita expenditures	Medicare per capita expenditures	Expenditures net of medicare	Personal income	Percent
1965	$472	----------	$472	$2,137	20.4
1970	854	$351	503	2,991	16.8
1976	1,624	703	921	5,147	17.9
1977	1,821	805	1,016	5,592	18.2
1978	2,206	893	1,133	6,161	18.4
1980 [1]	2,638	1,201	1,436	7,512	19.1

[1] Estimates supplied by the Health Care Financing Administration.

Thus, health care expenditures for the elderly not paid by medicare have been increasing over the years between 1970 to 1980 with respect to income and are approaching the same share of income that health care costs consumed in 1965, prior to medicare (20.4 percent).

Health Care Costs Not Paid by Medicare

There are four major sources of health care costs for the elderly not paid by medicare:

(a) *Uncovered services.*—Since medicare's focus is essentially on covering acute care, many services remain outside its scope of benefits. These services range from basic preventive services to long-term care. For example, while the pneumococcal vaccine was recently included as a covered service, other preventive measures, from flu shots to physical exams, are not covered. Further, while there is a limited skilled nursing home benefit (restricted to 100 days), longer term skilled care and lower levels of chronic care are not covered. In addition, the hospital benefit is limited to 150 days. Finally, there is no coverage for outpatient drugs under medicare, nor for basic dental service, or eyeglasses.

(b) *Cost sharing.*—Medicare employs a variety of cost-sharing mechanisms including a deductible for hospital services ($260 in

1982), copayments on hospital and nursing home services,[3] and a $75 per calendar year initial deductible and 20 percent coinsurance on physician and outpatient services. The hospital and nursing home deductible and copayment amounts are automatically increased each year.

(c) *Charges in excess of medicare payments for covered services.*—When physicians bill a medicare patient directly for services ("unassigned claims"), the beneficiary must then pay not only the 20 percent coinsurance but also any amount above what medicare considers "reasonable" for that claim (as determined by law and regulation). Almost 50 percent of all physician claims are unassigned.

(d) *Premiums.*—Although not included in total personal health care expenditures, beneficiaries also pay a monthly premium for medicare coverage for physician services. The premium rises automatically each year and is currently $11 per month.

Evaluating medicare's performance on the basis of its share of total health expenditures is somewhat misleading, however, since personal health care expenditures include nursing home costs (usually covered by medicaid and direct out-of-pocket payments rather than medicare) and other services which medicare was never intended to cover. Considering only medicare-covered services provides a description of more typical coverage for a noninstitutionalized medicare beneficiary and a better picture of how well medicare has done with those services it was specifically intended to cover.

Hospital Expenditures

Hospital expenditures represent the single largest component of the medicare program. Of the $1,201 spent per capita for personal health care under medicare in 1980, $888 (or 74 percent) was for hospital services. Medicare hospital expenditures rose by almost 260 percent between 1970 and 1980.[4]

Table III shows overall and medicare spending for hospital care on a per capita basis between 1967 and 1980:

TABLE III.—OVERALL AND MEDICARE PER CAPITA HOSPITAL EXPENDITURES FOR THE AGED[1]

Year	Total hospital	Medicare hospital	Medicare as percent of total
1967	$219	$151	69
1968	245	179	73
1969	302	223	74
1970	320	237	74
1971	351	265	75
1972	386	291	75
1973	386	291	75
1974	479	362	76
1975	578	451	78
1976	675	520	77
1977	752	578	77
1978	816	673	82
1979	919	774	84
1980	1,083	888	82

[1] Data supplied through the Bureau of Data Management and Strategy (BDMS), HCFA.

[3] Copayments for hospital services are imposed only after 60 days of care and are equal to one-fourth of the hospital deductible for the 61st through 90th day (currently $65 per day) and one-half the deductible for the 91st to 150th day (currently $130 a day). For nursing home care, the copayment is applied only after 20 days of care and is equal to one-eighth the hospital deductible from the 21st through 100th day of care ($32.50 per day).

[4] Health Care Financing Administration, unpublished data, 1982.

Clearly, medicare has more than maintained its original share of hospital expenditures, despite significant increases in the cost of hospital care. When considered as a percent of the elderly's income, the amount not covered by medicare has actually declined from 2.8 percent in 1970 to 2.6 percent in 1980.

This is true largely because of the structure of the current medicare hospital benefit. Medicare pays the full cost of hospital care until the 60th day for most beneficiaries who use hospital services, except for a deductible based on the average national cost of a hospital day. Since only 4 percent of medicare beneficiaries use more than 60 days, total hospital out-of-pocket expenditures are very small.[5]

Physician Expenditures

Medicare's share of charges for physician services has remained virtually the same since 1969, as can be seen in table IV:

TABLE IV.—OVERALL AND MEDICARE PHYSICIAN EXPENDITURES ON A PER CAPITA BASIS FOR THE AGED[1]

Year	Overall	Medicare physician	Medicare percent overall expenditures
1967	$99	$51	52
1968	117	72	62
1969	132	78	59
1970	143	85	59
1971	152	90	59
1972	158	94	59
1973	172	99	58
1974	190	108	57
1975	240	139	58
1976	270	156	58
1977	306	177	58
1978	348	204	59
1979	403	237	59
1980	471	279	59

[1] Data supplied through the Bureau of Data Management and Strategy (BDMS), HCFA.

Medicare pays a considerably smaller portion of physician services than it does of hospital services. Although that portion has remained essentially constant over time, the nonmedicare portion of costs for physicians services in terms of actual expenditures has increased as a percent of total income, from 1.9 percent to 2.65 percent from 1970 to 1980.

The reasons why medicare coverage of physicians services has not been as effective as that of hospital services are complex. First, medicare's 20 percent coinsurance on physicians services means that, under the best circumstances, medicare would only pay 80 percent of costs (less the annual deductible). Second, on an unassigned claim, medicare may pay less than 80 percent of actual charges if the amount billed is deemed not to be "reasonable." Reasonable charges in 1980 constituted 77.3 percent of actual physician charges.[6] According to actu-

[5] Data supplied through the Bureau of Data Management and Strategy (BDMS), HCFA.

[6] "Reasonable," or allowable, charges are based on past billing experience of that doctor and comparisons with other physicians performing the same procedure in the same area. The amount of increase in the allowable charge is constrained year-to-year by an inflation factor called the economic index.

arial estimates, this percentage declined to 75 percent in 1981 and will decline further to 72.4 percent in 1982. Medicare's payment, if reasonable charges were 72.4 percent of total costs, would equal only 58 percent of the total physician bill.[7]

The assignment rate (the percent of claims where the physician will accept medicare payment in full and not bill the beneficiary for more than the 20 percent coinsurance) has remained just above 50 percent since 1974. It was 51.8 percent in 1980. Thus in almost 50 percent of the claims, beneficiaries are responsible for the difference between reasonable charges and actual cost.[8] On average, this difference has risen from 14.4 percent of the total amount of a claim in 1974 to 22.4 percent in 1980.[9] (The difference between reasonable charges and actual cost is also seldom covered under private supplemental insurance or medicaid.)

Trends in Medicare Coverage

Although medicare has slightly increased its share of total personal health care expenditures over the past 5 years, health care costs not paid for by medicare are steadily increasing as a percent of the elderly's income (19.1 percent in 1980) to almost premedicare levels (20.4 percent). Medicare's ability to maintain its share of total costs has been largely due to the structure of the hospital benefit. The elderly remain at risk for the rising costs of those health services which medicare does not cover and also face increasing physician costs. While medicare's share of payments for physician services has remained static, the cost of physician services not paid by medicare is growing faster than the elderly's income, on average.

Trends in medicare coverage for persons over the age of 65 are only available through 1980. However, the 1981 Omnibus Budget Reconciliation Act further added to costs not paid by medicare by increasing the hospital deductible from $204 to $260, twice the average annual increase, and by increasing the part B deductible from $60 to $75, the first such increase in 9 years.

OTHER SOURCES OF PAYMENT

The above discussion focused on the relationship between medicare coverage and total health care expenditures. The total gap between expenditures and coverage is not necessarily absorbed by the beneficiary, however. Over 70 percent of the elderly have some sort of supplemental coverage, including both private insurance and medicaid.[10] Table V below shows the share of payments for health care for the elderly by source of payor. Other than medicare, the major sources of payment are medicaid and private, which includes private insurance and direct out-of-pocket payments.

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[7] Data supplied by the Prudential Insurance Co. of America.
[8] BDMS, op. cit.
[9] HCFA, unpublished data, 1982.
[10] Ibid.

TABLE V.—SHARE OF PAYMENTS FOR HEALTH CARE FOR THE ELDERLY BY SOURCE OF PAYOR[1]

[Source of funds per capita]

Year	Total	Percent private[2]	Percent medicare	Percent medicaid	Percent other public[3]
1965	$472	70.1			29.9
1970	854	38.8	41.1	11.0	9.2
1976	1,624	35.5	43.3	15.0	6.2
1977	1,821	36.1	44.2	13.9	5.9
1978	2,026	36.9	44.1	13.4	5.6

[1] HCFA memorandum from the Director, Office of Legislation and Policy to the Deputy Administrator, Jan. 8, 1981.
[2] Includes direct out-of-pocket expenditures and expenditures covered by private supplemental insurance. HCFA statistics show that in calendar year 1978, of total private expenditures, 37.3 percent was for nursing homes, 19.9 percent for physician services, 15 percent for other health care professionals, and 2.2 percent for eyeglasses and other appliances.
[3] Other public in 1965 included funds paid under the Kerr-Mills program which was a forerunner to medicaid and now includes medical payments under vocational rehabilitation, temporary disability insurance, public health service programs, veterans' and defense health programs, and State and local health expenditures.

Supplemental Insurance

Private insurance's share of total personal health expenditures for the elderly was 6.6 percent in 1977, the most recent year for which data is available.[11] There is little evidence that this share has changed in recent years. Even though a full range of private benefit packages are available to the elderly, the bulk of coverage is primarily designed to cover medicare deductibles and coinsurance amounts. Many policies also provide some coverage for hospital stays beyond the medicare 150-day lifetime limit. Thus, while private insurance can fill some of the gaps in medicare coverage, a large portion of most services to the elderly are not included in the basic supplemental insurance package. Few supplemental policies, for instance, cover long-term care or outpatient drugs, which can represent sizable expenses for many elderly persons.

In addition, the elderly who do have supplemental health insurance have been confronted with increasing premium rates over the years. A typical annual premium rate for an over-65 individual, $180 to $240 in 1965 (prior to medicare), is $300 to $400 in 1982 (only as a supplement to medicare).[12] Data from one State shows increases in premiums of over 250 percent between 1970 and 1980, and there is evidence that premiums for some Blue Cross plans might have been higher had they not been subsidized by the plan's other insurance business.[13]

While more extensive packages covering medicare's uncovered services may be available, the premium costs for these packages can be prohibitive. For example, in Pennsylvania, an out-of-pocket drug benefit alone would cost $10.65 per month.[14] A policy of another company that paid up to 40 percent of the difference between the physician billing amount and medicare payments added approximately $12.95 to monthly premium payments. Rising premium costs may result in the elimination of some forms of coverage. For example, the company offering the benefit described above has decided to discontinue this option after 1982 due to its rising costs.[15]

[11] Fisher, Charles, R. "Differences by Age Groups in Health Care Spending," Health Care Financing Review, vol. 1, No. 4, Spring 1980.
[12] Based upon discussions with Blue Cross of Western Pennsylvania. While these figures only represent one plan's experience, discussions with the Blue Cross Association would indicate that they are not atypical.
[13] Ibid.
[14] Ibid.
[15] Mutual of Omaha, unpublished data, 1982.

Changes in the level of medicare copayments contribute to increasing supplemental insurance premium costs. For example, in January 1982, Prudential offered a new medicare supplemental portfolio. The part A portion of these plans ($10.40 a month) were 27 percent more costly than they would have been in 1981. Twelve percent of this higher cost is the direct result of the increased deductible enacted in the 1981 Omnibus Budget Reconciliation Act.

The cost of a new Prudential supplemental policy covering parts A and B which does not cover the part B deductible (and only picks up the 20 percent coinsurance on reasonable charges) would only be 3 to 5 percent higher if written in 1982. However, the increase of a plan covering the difference between actual costs and medicare payments would be 24 percent higher if written in 1982 ($64 a month).[16] One-quarter of this increase in actuarial value is the result of increased copayments enacted in the 1981 Omnibus Budget Reconciliation Act. The remainder is due to the normal increase in medicare's hospital deductible, higher medical costs, and the declining percentage of total costs designated as reasonable charges.[17]

Blue Cross/Blue Shield medicare supplemental insurance plans (held by over one-half of persons over 65 with any form of supplemental coverage) are experiencing similar rate increases. A BC/BS survey of plans chosen at random, with consideration given to insure good geographic representation by plan size, revealed average rate increases of 24 to 37 percent effective early 1982. While some of these rate increases were stated to be due to previous inadequate rates, at least two of the six medicare supplemental plans had rate increases of 24 and 35 percent which were virtually all due to benefit increases and higher medicare copayments. A forthcoming survey of plans underwriting the majority of medicare supplemental coverage for Blue Cross/Blue Shield suggests even higher rate increases.[18]

Medicaid

While medicaid covers over 13 percent of the health care costs to the elderly, this figure can be put in clearer perspective. The vast majority of these expenditures is for a small percentage of the population using the long-term care benefit. Because medicaid is a means-tested program for low-income individuals only, it does not provide any protection at all for most elderly (about 80 to 85 percent of medicare beneficiaries do not participate in medicaid).[19] Therefore, although medicaid does fill an important gap, particularly in terms of services for the poorest elderly and for needed long-term care, its impact is limited or nonexistent for the majority of medicare beneficiaries.

Direct Out-of-Pocket Payments

The major source of payment for health expenditures not paid by medicare is direct out-of-pocket payment by the beneficiary. The elderly were responsible for 29.1 percent of their total personal health care expenditures in calendar year 1977.[20] This would equal $525 per

[16] Such a plan includes coverage for the part B deductible, part A hospital and 100 percent private duty nursing benefits, and 50 percent of drug costs.
[17] Data supplied by the Prudential Insurance Co. of America.
[18] Data supplied by Blue Cross/Blue Shield.
[19] BDMS, op. cit.
[20] Fisher, op. cit.

capita in 1977 and approximately $768 in 1980. There is no evidence that this share has changed in recent years. Further, these direct out-of-pocket costs do not include the part B premium costs paid by the beneficiary (currently $132 a year, increasing to $146.40 in July 1982), nor the cost of supplemental medical insurance premiums.

CONCLUSION

For those services which medicare covers, the program has slightly increased its share of costs, from 70 percent of the total cost of medicare-covered services in 1970 to 75 percent in 1980.[21] This is mainly a result of medicare's increased share of hospital expenditures for the elderly, 74 percent in 1970 to 82 percent in 1980. Medicare's share of physician expenditures, on the other hand, has remained static at 59 percent.

Even though medicare's coverage as a percentage of total health care expenditures has also increased slightly, rising health care costs have resulted in increasingly burdensome out-of-pocket health costs for persons over 65. Total health costs not paid by medicare are increasing as a percentage of the elderly's income. Further, significant gaps in coverage for the over-65 population clearly remain. There continue to be services uncovered by medicare or private insurance. Thirty percent of persons over 65 have no supplemental insurance to help meet the gaps between what medicare pays and the actual cost of services. In addition, as in the instance of unassigned claims for physician services, even private insurance seldom meets the growing difference between actual cost and what medicare pays for reasonable charges.

Whatever the past performance, there is a certain fragility in medicare's capacity to maintain its share of health care expenditures. Further increases in the costs of health care, changes in patterns of utilization, decreased assignment rates, and actual changes in current law can all significantly alter medicare's contribution. Any increases, for example, in cost sharing for hospital services would significantly increase out-of-pocket expenditures, especially given the expensive nature of such services. Similarly, any reductions in physician reimbursement could be expected to further erode medicare's share of physician costs by decreasing the assignment rate and by increasing the difference between physicians' billing and medicare reimbursement. Private coverage and medicaid may pick up part of this differential, but they can neither account for all of it nor would this be accomplished without marked increases in premium rates for those who do have private insurance.

Thus, in considering new measures to limit medicare expenditures, there must be consideration also for the cost-shifting impact of those proposals. While proposals shifting costs could reduce anticipated medicare expenditures, they would also result in even larger health liabilities for the elderly. The need to restrain the growth of medicare costs must be balanced with the need to protect many of this Nation's most vulnerable citizens from the growing risk of medical pauperization. Ultimately, the tension between these two objectives may only be resolved through consideration of a wider range of alternatives for reform of the existing health care system.

[21] Ibid.

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