

This paper examines the effects of two potential changes in Medicare's benefit structure: increased cost-sharing on the one hand, and improved protection against catastrophic amounts of medical expenditures by beneficiaries on the other. A variety of options will be considered with emphasis on their impact on individual enrollees, particularly the elderly.

ISSUES AND STRATEGIES FOR CONTROLLING MEDICARE OUTLAYS

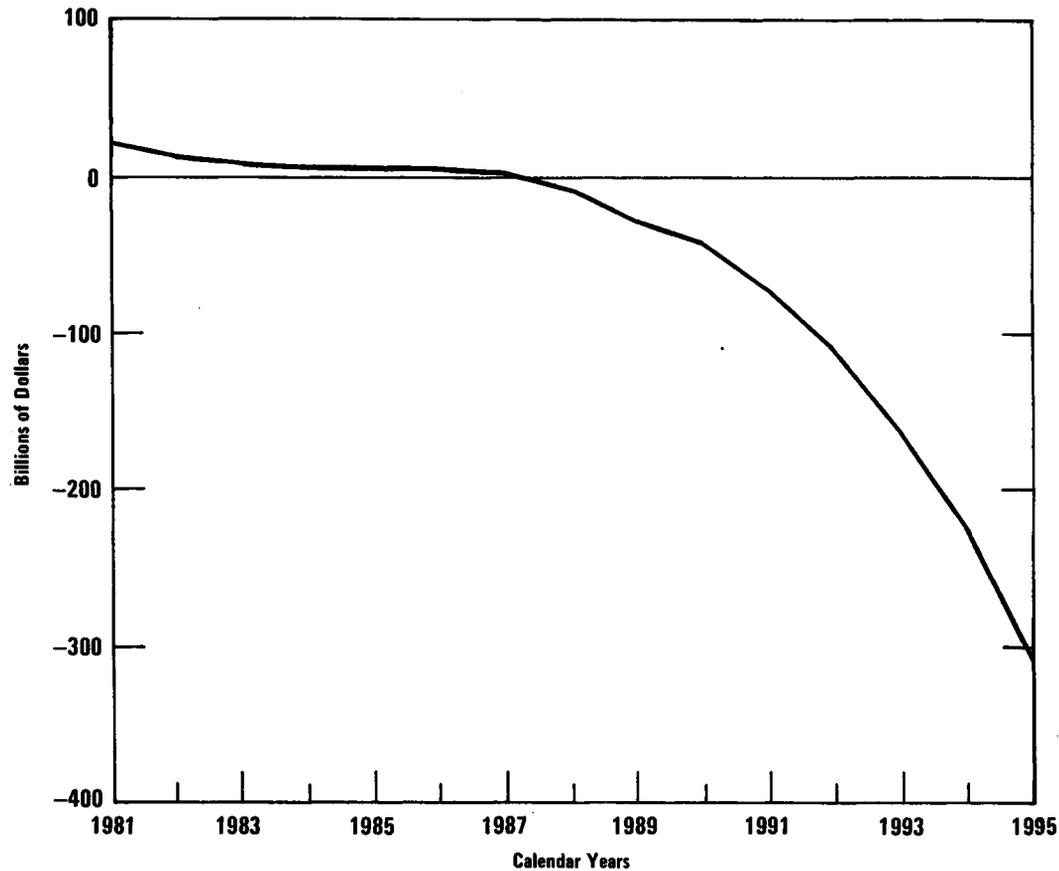
The Medicare program of health insurance for the aged and disabled constitutes one of the largest and most rapidly growing areas of the federal budget. Medicare alone accounted for about 7 percent of federal outlays in fiscal year 1982. Between 1970 and 1982, Medicare outlays increased at an annual rate of 17.7 percent, reflecting the effects of expanded eligibility to include the disabled, the increased use of services by existing beneficiaries, and the rising costs of medical care. Even after the changes enacted in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), Medicare outlays are projected to reach \$112 billion by 1988--increasing at an average annual rate of 14.4 percent from 1983 through 1988. If there are no further policy changes, Medicare's share of total federal outlays will rise to 10 percent by 1988.

In addition to concern over the size of the federal deficit, the solvency of the Medicare Hospital Insurance trust fund is also at issue. The HI portion of Medicare is funded primarily by payroll taxes paid by employers and employees. Since 1966, these taxes have been assessed in conjunction with Social Security payroll taxes and the revenues placed in the HI trust fund. Benefits are then paid out of that trust fund. (Supplementary Medical Insurance, on the other hand, is supported jointly by general revenue funds and enrollees' contributions in the form of monthly premiums.)

The projected future growth in the HI portion of Medicare will result in outlays exceeding trust fund revenues in every year and a deficit in the year-end balance by calendar year 1987 or 1988.² Since, under current law, benefit payments must be made from the trust fund, concern about the size of Medicare reflects financing problems as well as the broader issue of controlling federal spending (see Figure 1 and Appendix A).

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2. These figures assume that the other Social Security trust funds do no further borrowing from the HI fund. If the reimbursement changes enacted in TEFRA for hospitals are extended at their 1985 degree of stringency, a deficit in the HI trust fund would be postponed until 1988.

Figure 1.
End-of-Year Balances in the Hospital Insurance Trust Fund



SOURCE: Preliminary CBO estimates.

NOTE: The figures presented here assume that the hospital reimbursement payment rates created under the Social Security Amendments of 1983 will be updated yearly so as to maintain the same level of stringency as would have occurred if the Tax Equity and Fiscal Responsibility Act of 1982 had been extended. See Appendix A for additional information.

The benefit structure of Medicare could be changed in a number of ways to increase enrollee cost-sharing, thereby lowering Medicare outlays. Often, this would involve increased patient liability for some portion of the charge for each medical event. For example, coinsurance (a flat percentage of the charge) or higher copayments (a set dollar amount per event) could be

assessed for each day in the hospital.³ Enrollees might also be made liable for some portion of the costs in the form of higher deductible amounts before Medicare begins reimbursement for services. Finally, the introduction of an HI premium or an increase in the SMI premium might also be considered a form of increased cost-sharing.

Changes in the benefit structure alone--unless they were very large--would not be sufficient to solve the HI financing problems that will arise over the next decade. Indeed, the options considered here would only delay the onset of the deficit in the HI trust fund. They might, however, represent one part of a more comprehensive package to address the HI financing problem. Other elements might include, for example, restricting reimbursements to providers or replacing the current program with a system of vouchers, both of which are analyzed elsewhere.⁴

ISSUES AND STRATEGIES FOR EXPANDING MEDICARE BENEFITS

Less than half of the health care expenditures of the elderly are reimbursed through Medicare. Even for covered services, no protection is offered to limit extraordinary out-of-pocket costs. For example, hospital insurance covers only 90 days per benefit period--defined as a spell of illness in which hospital stays are separated by less than 60 days--although a lifetime reserve of 60 days can also be applied when needed.⁵ After the first 60 days of a stay, patients must share a portion of costs.

The benefit structure of Medicare could be changed so as to provide more comprehensive protection for extended hospital stays or other extraordinary use of covered services. One major approach would be to introduce a limit on beneficiaries' cost-sharing liability for Medicare-covered services.

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3. The term "coinsurance" generally refers to the percentage of the cost of care paid by beneficiaries. As currently used for HI services, however, coinsurance is expressed as a percentage of the hospital deductible amount.
 4. These broad financing issues are discussed in Special Committee on Aging, U.S. Senate, Prospects for Medicare's Hospital Insurance Trust Fund, 98:1 (March 1983). For a discussion of proposals for the use of vouchers in Medicare, see Congressional Budget Office, Containing Medical Care Costs Through Market Forces (May 1982), Chapter IV.
 5. The lifetime reserve is limited to a total of 60 days over the entire lifetime of a beneficiary.

Such limits would increase outlays or reduce net savings if introduced in combination with additional cost-sharing.

EXAMINING CHANGES IN THE BENEFIT STRUCTURE

Each of the options discussed in this paper will be analyzed in terms of the following three questions:

- o How would changes in the benefit structure be distributed among the elderly and disabled?
- o How would beneficiaries' use of medical care change?
- o What would be the impact on federal spending?

The distributional effects of some of the options would depend on whether enrollees have other sources of funds. Thus the ability of the aged and disabled to absorb the costs of medical care varies with income. The actual burden borne by Medicare enrollees also depends on their access to public sources of support. For example, the Medicaid program--which provides medical care for some low-income persons--might absorb any additional cost-sharing for those covered by both programs. Finally, since medical problems may extend over time, the distribution of costs over periods other than a calendar year is likely to be of interest.

Increased cost-sharing is generally believed to lead to lower use of health care services, although most studies supporting this argument have not focused specifically on the elderly or disabled. Even so, the desirability of these cost-sharing options would also depend on the extent to which reduced services would affect the health of beneficiaries.

The impact of increased cost-sharing on the level of federal spending would depend on two factors: the per capita costs paid by enrollees and the extent to which cost-sharing reduced the use of health care services. Together with any offsetting changes in benefits from other programs, these two factors would determine the size of reductions in expenditures by the federal government.

PLAN OF THE PAPER

Chapter II of this paper describes the current structure of Medicare benefits. It discusses the growth in those benefits, particularly in the areas that would be affected by changes in cost-sharing. The current pattern of health expenditures by the elderly is analyzed in Chapter III. Included are

estimates of per capita Medicare benefits and enrollees' health care liabilities by income, age, and existence of other health coverage. Chapter IV discusses broad issues concerning increased cost-sharing and expanded catastrophic protection, with a particular emphasis on their likely effects on Medicare outlays. Finally, specific options for changing the benefit structure are analyzed and compared in Chapter V.

CHAPTER II. THE STRUCTURE AND GROWTH OF MEDICARE BENEFITS

Since its introduction in 1966, Medicare has played a large and growing role in supporting acute medical care for aged and disabled persons. This chapter describes current eligibility rules, the benefit structure, and sources of growth in Medicare benefits.

THE ELIGIBLE POPULATION

Those eligible for Medicare include persons 65 and over, disabled persons entitled to Social Security cash benefits for 24 consecutive months, and most persons with end-stage renal disease. In practice, however, participation varies between Part A and Part B.

Part A Hospital Insurance (HI) is available without charge to those eligible, including more than 95 percent of all elderly persons. In addition, persons 65 or over ineligible for automatic participation may purchase HI coverage—currently at a rate of \$113 per month. Among the Social Security disability population, a smaller proportion receive Medicare HI coverage because of the two-year waiting period.

Part B Supplementary Medical Insurance (SMI) is available to the disabled who are eligible for HI and to almost all persons 65 or over. Participants must pay a monthly premium, however—or have it paid on their behalf by others. The monthly premium is currently \$12.20. Not all persons who participate in HI purchase SMI coverage, however. In 1982, 99 percent of elderly HI participants were also enrolled in SMI, but only 92 percent of the disabled.

SERVICES COVERED BY MEDICARE

The Medicare program is largely confined to medical services that meet acute health care needs. HI covers short-term hospitalization, skilled nursing care, and home health services. SMI focuses on ambulatory care, including physician services, some laboratory fees, home health services, and outpatient hospital care.

HI Services

HI covers primarily hospital inpatient care. Beyond a required deductible--\$304 in 1983--the first 60 days of hospitalization for a spell of illness are covered in full. Medicare directly reimburses hospitals (and other HI providers) according to the costs incurred for treatment of the Medicare enrollee. For each hospital day after that through day 90, a coinsurance payment of one-fourth of the deductible amount is charged. That is, in 1983, beneficiaries pay \$76 per day for days 61 through 90. After 90 days of hospitalization, a beneficiary may draw on a one-time reserve of 60 days with a required payment of one-half the deductible amount for each such day.

In addition to short-stay hospitalization, HI also covers up to 100 post-hospital days in a skilled nursing facility (SNF). The beneficiary is liable for a coinsurance payment after 20 days of care, equal to 12.5 percent of the hospital deductible. To qualify for reimbursement, the beneficiary must have acute care needs.¹

The last category of services covered by HI is home health care. Coverage is not subject to coinsurance but may only be provided by approved home health agencies. Relaxation on July 1, 1981, of some of the requirements for home health care is likely to result in an expansion in these agencies, and therefore in more use of these services over time.

SMI Services

After beneficiaries meet a \$75 annual deductible, SMI pays 80 percent of "reasonable" charges for medical and health-related services and supplies, including payments to physicians, hospital outpatient facilities, and home health agencies.² Beneficiaries may, however, be liable for amounts in excess of 20 percent of allowed charges if physicians or suppliers refuse to

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1. The Tax Equity and Fiscal Responsibility Act of 1982 authorizes the Secretary of Health and Human Services to eliminate the three-day prior hospital stay requirement for SNFs at such time as he determines that such action will not lead to an increase in program costs, and will not change the acute care nature of the benefit.
 2. "Reasonable" charges are the lowest of (1) the service provider's customary charge for the service, (2) the prevailing charge in the locality for similar services, or (3) the charge applicable for comparable services of the provider.

accept assignment--that is, refuse to accept the reasonable (allowed) charge amount as payment in full.³

Physician services (for care both in and out of hospitals) account for nearly three-fourths of all SMI outlays for benefits. Levels of allowed charges vary by specialty of physician, procedure performed, and locality.⁴

The next largest category--about 19 percent--of SMI reimbursements is for outpatient hospital care. Other medical services covered include medical supplies, drugs that cannot be self-administered, ambulance services, some therapy services, and home health care.

The mix of services for both HI and SMI varies considerably between aged and disabled enrollees. For example, the disabled population uses 28 percent more outpatient hospital services per capita than enrollees aged 65 and over. If end-stage renal disease beneficiaries were included as disabled, that figure would be even higher.

SERVICES NOT COVERED BY MEDICARE

The Medicare program is designed to cover the acute care needs of the elderly and disabled rather than provide a fully comprehensive range of medical services.⁵ Consequently, a large portion of medical expenditures--particularly those made by the elderly--are outside the scope of Medicare. Altogether, Medicare paid 69 percent of the hospital and physician expenses of the elderly but only 44 percent of their total health expenditures in 1978.

3. Refusal to accept assignment means that the provider bills the patient directly, at a level which may exceed the reasonable charge for that service. The beneficiary will then be reimbursed by Medicare at 80 percent of the allowed charge. Although such refusal allows physicians to bill patients for additional amounts, physicians may simply not wish to deal directly with Medicare. In calendar year 1981, these allowed charges were only 77 percent of the size of submitted charges on average.
4. Pathologists and radiologists who accepted assignment were reimbursed at 100 percent of the allowable charge between 1967 and 1982. That special treatment was repealed by the Tax Equity and Fiscal Responsibility Act of 1982.
5. Studies of total health care spending have not been conducted for the disabled. The disabled are probably less likely to be institutionalized than the elderly, but they may have similar drug and dental expenses.

Medicare reimbursement paid only 3 percent of all the elderly's nursing home care expenses, since this care is largely directed at long-term chronic illness and Medicare's skilled nursing benefit is restricted to acute care needs.⁶ This is an important exclusion, since in 1978 nursing home care accounted for one-fourth of total health care expenditures on the elderly.

Outpatient drugs and dental services are also largely excluded from Medicare coverage. These two areas represented 9.3 percent of the elderly's total medical care expenditures in 1978, almost none of which was financed by Medicare.

THE SIZE AND GROWTH OF MEDICARE OUTLAYS

Reimbursements for all Medicare services totaled \$49.2 billion in fiscal year 1982. HI, the larger program, accounted for \$34.3 billion in reimbursements. Although SMI represented 30 percent of all Medicare reimbursements in 1982 (see Table 1), enrollees paid approximately one-fourth of the costs of SMI with their premiums. Taking these contributions into account would implicitly lower the net reimbursement figure for Medicare to \$45.4 billion in 1982 and cause the share of net reimbursements accounted for by SMI to drop to \$11.2 billion, which represents 25 percent of net total reimbursements.

The Medicare program has grown rapidly since fiscal year 1967 when total outlays were \$3.4 billion (see Figure 2). Outlays for 1983 are expected to total \$57.4 billion, and CBO projects that by 1988 they will be \$112 billion.⁷

Factors contributing to this growth include:

- o Rapid increases in the price of medical care;
- o Expansion in the volume of services provided; and
- o Increases in the number of enrollees.

6. This does not imply, however, that the balance was paid by individuals. Medicaid, the health care program for low-income persons, paid for nearly 39 percent of such care.

7. The 1988 projection assumes no further changes in coverage of medical services.

TABLE 1. DISTRIBUTION OF MEDICARE BENEFITS BY SERVICES COVERED, FISCAL YEAR 1982

	Benefits (billions of dollars)	Percent of Total Benefits
Hospital Insurance	34.3	70
Inpatient hospital	32.7	67
Skilled nursing care	0.5	1
Home health care	1.2	2
Supplementary Medical Insurance	14.8	30
Physician services	10.7	22
Outpatient services	2.9	6
Radiology and pathology	0.6	1
Other medical services	0.6	1
Total Medicare Benefits	49.2	100

SOURCE: Budget of the U.S. Government, Appendix, 1984.

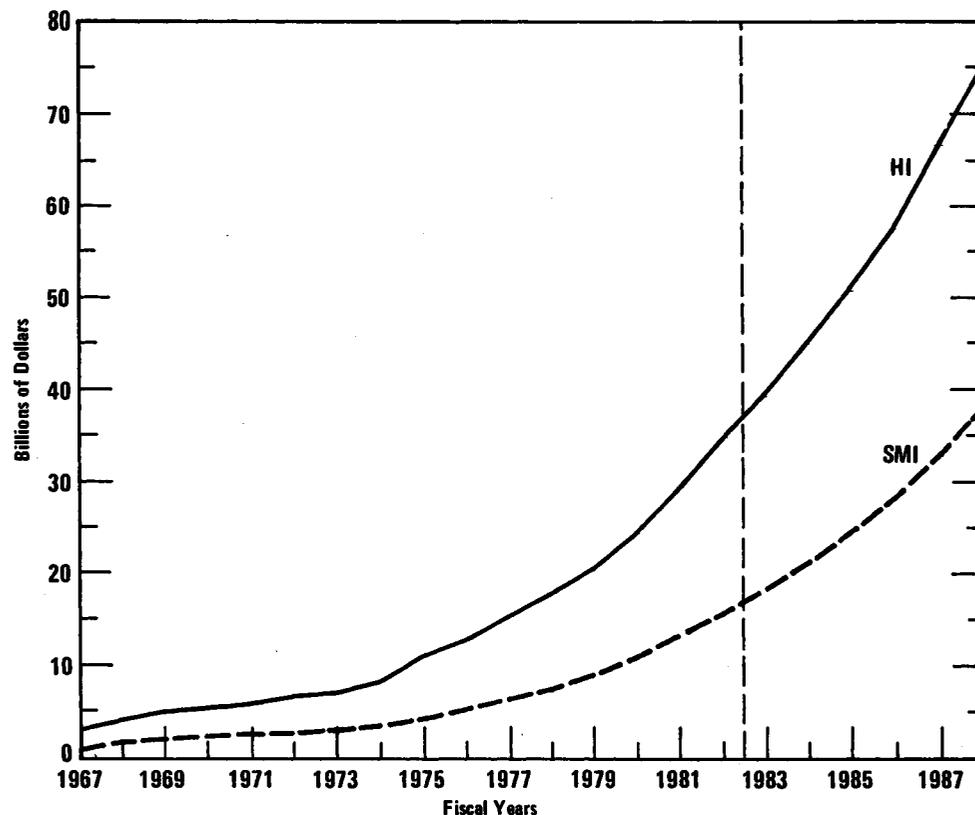
The most rapid component of growth has been in benefits per user, reflecting the combined effect of the first two factors. Moreover, both the number of services used and the price of medical care are likely to be affected by changes in the benefit structure of Medicare. It is important, therefore, to separate these two factors from the share of growth attributable to increases in the size of the enrollee population. Table 2 summarizes the average annual compound rates of growth of benefits and of the number of enrollees between 1978 and 1982.

Growth in Enrollees

The number of enrollees has expanded as the number of elderly has grown and as a result of adding disabled persons to the eligible population, although only a small part of total benefit growth is attributable to growth in enrollees. The number of elderly enrollees under both HI and SMI has increased at a rate of about 2.2 percent per year. Even more important has been the inclusion of disabled persons, beginning in fiscal year 1974. By

Figure 2.

Medicare Outlays for Hospital Insurance (HI) and Supplementary Medical Insurance (SMI)



SOURCES: Office of Management and Budget and Congressional Budget Office.

NOTE: Numbers for 1967-1982 are actual totals, whereas those for 1983-1988 are CBO estimates. Beginning with 1983, figures include the effects of the Tax Equity and Fiscal Responsibility Act of 1982 but assume no further changes in legislation through 1988.

1981, the number of disabled enrollees under HI had risen to over 3 million or 11 percent of all Medicare enrollees. Although disabled enrollees increased at an annual rate of 1.7 percent between 1978 and 1982, the number fell below 3 million in 1982 and is projected to remain fairly stable through 1988. Enrollee growth for the disabled under SMI has been higher.⁸

8. This increase in SMI participation may have been stimulated by the lower relative contributions to the cost of care from SMI premiums, which have declined from 50 to 25 percent of the cost of SMI

TABLE 2. AVERAGE ANNUAL COMPOUND RATES OF GROWTH OF BENEFITS AND ENROLLEES, FISCAL YEARS 1978-1982 (In percent)

	Aged Enrollees	Disabled Enrollees ^a	All Enrollees
Hospital Insurance			
Total benefits	18.4	19.3	18.5
Number of enrollees	2.3	1.7	2.2
Proportion of enrollees receiving reimbursement	2.1	1.1	2.0
Benefits per user	13.4	16.1	13.7
Supplementary Medical Insurance			
Total benefits	20.7	24.0	21.2
Number of enrollees	2.3	2.2	2.2
Proportion of enrollees receiving reimbursement	2.9	2.0	2.9
Benefits per user	14.7	19.0	15.3

SOURCE: Budget of the U.S. Government, Appendix, 1979 and 1984.

a. These growth rates include persons with end-stage renal disease.

Growth in the Use of Services

Changes in the volume of medical services used by enrollees arise from several sources. Part of this increased use is attributable to the aging of the population. In 1966, 37 percent of elderly enrollees were 75 or older. That figure had increased to 41 percent by 1979. Older individuals progressively receive more Medicare services of all types, particularly

coverage. This decline in contributions by enrollees has also resulted in an even more rapid increase in federal contributions than is indicated in Table 2, which shows gross rather than net reimbursements for SMI.

hospital and skilled nursing care.⁹ Even within each age category, however, the volume of services has been increasing. For example, for persons aged 65 to 66, rates of hospital discharge per 1,000 enrollees increased by 27 percent between 1967 and 1976. Finally, methods of treatment have changed, expanding the complexity or intensity of care so that enrollees of all ages receive additional medical services for many illnesses. This may result from use of more sophisticated procedures or simply from increased frequency of tests or physician visits, for example.

One indicator of increased use by enrollees is the percentage who receive reimbursed services in any year. In HI, this proportion has grown for elderly enrollees at an average rate of 2.1 percent per year since 1978. Use of HI services by disabled enrollees has grown by about half that rate. For inpatient hospital care, the number of all Medicare enrollees with a hospital stay increased from 19 percent in 1967 to 23 percent in 1978. Overall, the growth in the number of enrollees using SMI has been at a rate of 2.9 percent per year. Such growth may in part reflect the decline in the size of the deductible for SMI relative to medical care prices. That is, enrollees are now more likely to exceed the deductible, thereby qualifying for Medicare reimbursement.

Growth in Per Capita Costs

In general, costs of medical care have increased faster than the general rise in medical care prices, largely due to increases in intensity of care.¹⁰ For example, between 1970 and 1982, hospital inpatient expenses increased at an average annual rate of 15 percent, 9 percentage points of which reflected increased input prices, 2 percentage points increases in admissions, and 3 percentage points increases in net intensity of care. To the extent that these findings would be similar for Medicare, increases in per capita benefits reflect both price increases and changes in the quantity of services consumed.

Quantity of care received is even more difficult to identify for SMI services, which have grown at an annual per capita rate of 18 percent

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9. A more comprehensive discussion of differences in Medicare use by age groups can be found in Chapter III.
 10. Intensity represents a residual category of expenditures not accounted for by changes in input prices or--in the case of hospitals--admissions factors. Along with additional resources applied to patients' care, it may include changes in productivity, changing patterns of use, and errors in the measurement of input prices.

between 1974 and 1980. Since information on the number of specific types of services used is generally not available, it is difficult to determine the extent to which use has changed. Among the types of services provided, growth in outpatient hospital care has been particularly high. For example, the annual average compound rate of growth between 1974 and 1980 was 26 percent (see Table 3). For physician services for elderly enrollees, the rate of growth over the same period has averaged 16 percent.

TABLE 3. AVERAGE ANNUAL COMPOUND RATES OF GROWTH IN EXPENDITURES PER ENROLLEE BY TYPE OF MEDICARE SERVICES, 1974-1980 (In percent)

Type of Service	Annual Rate of Growth
Hospital Insurance	15.1
Inpatient hospital	15.2
Home health	27.3
Skilled nursing	4.0
Supplementary Medical Insurance	18.2
Physician services	15.6
Outpatient hospital	25.7
Independent laboratory	25.0
Home health	25.9
Other ^a	34.4
All Medicare	16.1

SOURCES: Health Care Financing Review (September 1982) and The Social Security Bulletin, Annual Statistical Supplement, 1981.

- a. This category includes ancillary services, renal dialysis by limited care facilities, hospital-based physicians services, and other suppliers.

When considering options for revising the structure of benefits under Medicare, the question of how increased burdens would be spread across the enrolled population is particularly important since many of the enrollees have limited incomes. This chapter first examines who among the elderly spends how much for what medical services, and then focuses on Medicare-covered services to provide insight into how various options for revising the structure of benefits could be formulated to control the size of the added burden and its distribution.¹

By 1984, it is projected that medical care expenditures for both Medicare-covered and noncovered services will total over 14 percent of the incomes of the noninstitutionalized elderly. Individuals are liable for about 37 percent of all these expenditures and for about 29 percent of the costs of Medicare-covered services. The pattern of these overall expenditures highlights both the absolute size of burdens on the elderly and the relative impact of changes in cost-sharing liability. These issues are analyzed in the first half of the chapter.

Medicare-related individual costs are currently more evenly distributed among all enrollees than are the reimbursement amounts for Medicare-covered services, largely because most costly hospital visits do not require substantial beneficiary cost-sharing. Even so, about 11 percent of elderly enrollees pay 36 percent of all Medicare-related individual costs and account for 78 percent of total reimbursements. If cost-sharing was to be increased proportionately in the same areas now subject to cost-sharing, the impact would reflect current patterns of beneficiary liability. It may be more instructive to examine how beneficiaries would be affected if reimbursement patterns were to change--that is, by adding cost-sharing for services for which the costs are now almost fully reimbursed, such as short hospital stays. Consequently, the second half of this chapter focuses both on current patterns of Medicare reimbursement and on Medicare-related

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1. This chapter concentrates on the elderly rather than the disabled. Information is more readily available for the elderly, who represent 90 percent of Medicare enrollees. Appendix C contains a more detailed discussion of the patterns of health care use by the elderly. When patterns of expenditure vary substantially between these two groups, the differences are discussed in this chapter. Otherwise, specific results for the disabled are summarized in Appendix D.

enrollee costs in order to examine the potential impact of changes in the benefit structure.

The most recent data available for this analysis are from 1977 and 1978;² for purposes of illustration, however, the information presented will be expressed in 1984 dollars. Such adjustments are made because policy changes affecting the Medicare benefit structure are not likely to be implemented until fiscal year 1984 and because medical care prices have risen so rapidly since 1977. The results presented here, however, are only adjusted to reflect price and income changes, and thus implicitly assume that no change occurs in the structure of benefits and of medical expenditures between 1977 and 1984.³

OVERALL HEALTH CARE EXPENDITURES

Although Medicare plays an extremely important role in covering health care expenses for its elderly beneficiaries, reimbursements nonetheless account for less than half of the costs of their medical care. This is because of the large share of medical expenditures concentrated on non-acute care such as nursing home care.⁴ In 1978, for example, Medicare paid

2. It is difficult to provide a comprehensive picture of the health patterns of Medicare enrollees from any one source of data. Consequently two sources of data have been used here. The first, the Medicare History Sample, represents a summary of actual Medicare bill information. This large data source is longitudinal--allowing analysis of a five-year history of individual records--and is of sufficient size to focus on the larger users of Medicare services who constitute only a small proportion of all enrollees. On the other hand, it can only indirectly supply information about out-of-pocket expenses and has no information on incomes. The second data source, the National Medical Care Expenditure Survey, helps to fill these gaps. Its sample size is considerably smaller, but information is available for the entire range of medical expenditures, other sources of support for expenses, income, and other demographic information.
3. A more detailed description of these adjustments and some discussion of their limitations can be found in Appendix B.
4. Nursing homes in these estimates refer to all facilities that provide some level of nursing care. Homes certified by Medicare and Medicaid to provide skilled or intermediate care dominate the category, but a small proportion of homes providing only minimal nursing services are also included.

an estimated 44 percent of all health expenditures for the elderly. Medicaid contributed 14 percent and other public sources--such as Veterans Health Care--accounted for 6 percent.⁵ Private sources, representing the remaining 36 percent, include individual out-of-pocket payments, private health insurance, and aid from charitable organizations. A more specific breakdown of private and public funding sources by type of care is shown in Table 4.

TABLE 4. DISTRIBUTION OF PER CAPITA HEALTH EXPENDITURES FOR THE ELDERLY BY TYPE OF EXPENDITURE AND SOURCE OF FUNDS, 1978

Type of Expenditure	Total in 1984 Dollars ^a	Percentage Distribution by Source of Funds		
		Private	Medicare	Other Public
Hospital Care	2,007	12	75	13
Physicians' Services	845	41	56	4
Nursing Home Care	1,197	54	3	43
Dentists' Services	131	97	--b	3
Drugs and Sundries	306	84	--b	16
Eyeglasses and Appliances	57	67	31	2
Other Health Services	137	46	31	23
Total	4,680	37	44	19

SOURCE: Charles R. Fisher, "Differences by Age Groups in Health Care Spending," Health Care Financing Review (Spring 1980), pp. 65-90.

a. These figures have been inflated to 1984 dollars based on projections of Medicare per capita outlays through 1984. Since the share of expenditures by type of service and source of payment remained relatively constant between 1970 and 1978, it was assumed that an inflator based on Medicare-covered services would reasonably approximate the increases in overall expenditures.

b. Less than 0.5 percent.

5. Preliminary figures for 1980 indicate that these proportions have remained relatively constant.

Medicare's contribution arises largely from hospital and physician reimbursements since its focus is on acute care. Medicare pays 69 percent of total expenditures in these two areas.⁶ Only 3 percent of nursing home expenses are covered under Medicare, whereas Medicaid pays for nearly 40 percent of them. If nursing home care is excluded from the total estimate, Medicare pays for 58 percent of all other medical expenditures.

The introduction of Medicare substantially increased the share of expenses covered by the federal government, but it has not led to a major shift in the pattern of use of health care services by the elderly. Moreover, since its introduction, the federal government's share of financing for care has shifted very little. In 1965, before the introduction of Medicare and Medicaid, the share of expenditures paid from private sources was 70 percent. After dropping to 39 percent in 1970, the private share of such expenditures declined only slightly to about 37 percent in 1978. The composition of expenditures has also remained stable, with small increases in the proportion for hospital care (largely covered by Medicare) and for nursing home care (where the private contribution is greater than half).⁷

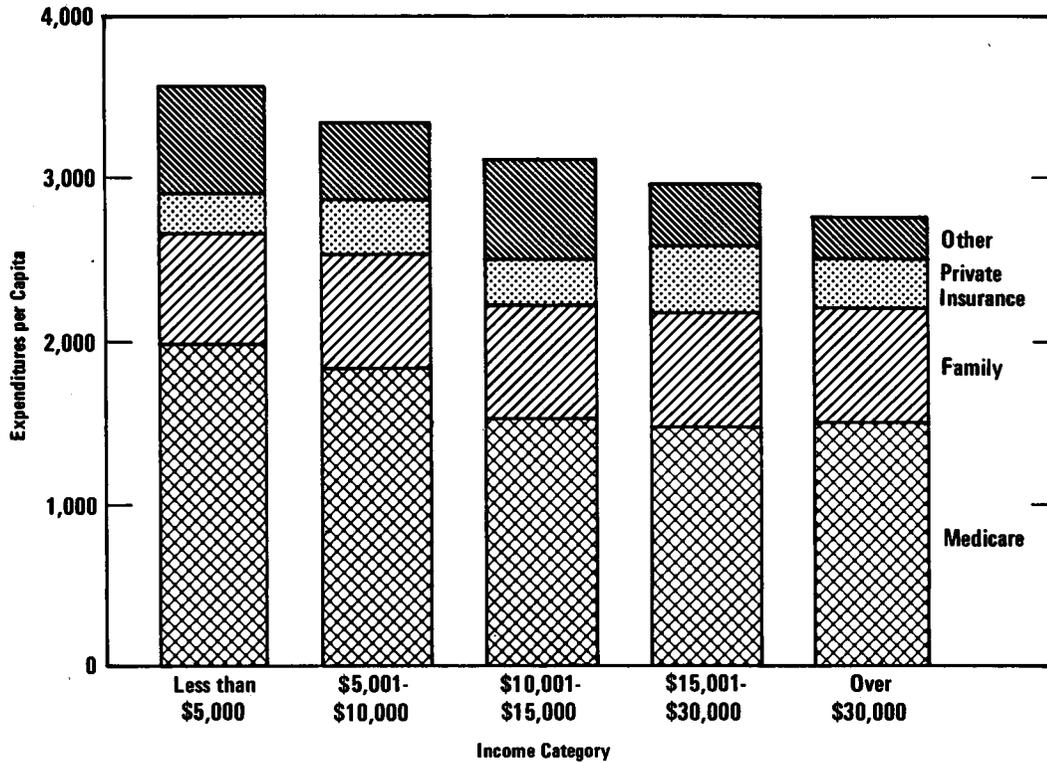
Differences in Health Expenditures by Income

Per capita expenditures for elderly Medicare enrollees from all sources vary among income classes. Figure 3 shows average per capita medical expenditures from all sources for noninstitutionalized elderly Medicare enrollees by income and Table 5 summarizes the distribution of income of the elderly.⁸ Total expenditures generally decline as income increases.

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6. This figure could be contrasted with employer-provided coverage to private-sector workers in which over 80 percent of the cost of hospital care and physician services is covered on average. See Congressional Budget Office, Protection from Catastrophic Medical Expenses: The Effects of Limiting Family Liability Under Existing Employee Insurance Programs (August 1981).
 7. If these trends continue, the share of expenditures paid by Medicare is not likely to go up.
 8. It is important to note that a large portion of the elderly's medical expenses--the costs of nursing home care--is not captured in these data. Per capita expenditures are contrasted with family income. In families with more than one elderly individual, the total amount of health expenditures would be even higher.

Figure 3.

Annual per Capita Medical Expenditures for Elderly Noninstitutionalized Medicare Enrollees, by Source of Payment and Income (In 1984 dollars)



SOURCE: National Medical Care Expenditure Survey.

NOTE: The amounts shown here indicate payments for health care services. Consequently, the private insurance category consists of payments to providers from insurance companies and does not include premiums paid to insurance companies.

If expressed as a percentage of average income, the differences in medical expenditures would be even more pronounced. It is projected that by 1984 noninstitutionalized persons with household incomes under \$5,000 will have medical expenditures totalling 97 percent of their \$3,659 average income, 18 percent of which they must pay out-of-pocket. Those in the highest income category are expected to have expenditures representing less than 5 percent of their projected average income of \$58,306 and will pay just over 1 percent out-of-pocket. Dollar amounts of Medicare reimbursement decline as income increases, except for those in the highest income group, mainly because of falling total expenditures. Private

expenditures (paid either by the family out-of-pocket or by private insurance) as a percentage of total medical expenses increase with income, from a low of 26 percent in the bottom income class to more than 36 percent in the top two income categories. In absolute terms, however, this trend is less pronounced since there is a decline in total outlays as income increases. The "other payer" category is most important at lower income levels and is dominated by Medicaid reimbursements that cover about 10 percent of (the noninstitutional) medical expenses for those in the lowest income group.

TABLE 5. DISTRIBUTION OF NONINSTITUTIONALIZED ELDERLY ENROLLEES AND THEIR INCOME BY FAMILY INCOME CATEGORY, 1977 (In 1984 dollars)

Family Income Category	Percentage of Enrollees	Average Family Income
\$5,000 and Less	12.6	3,659
\$5,001 - \$10,000	22.0	7,312
\$10,001 - \$15,000	19.4	12,334
\$15,001 - \$20,000	11.9	17,412
\$20,001 - \$30,000	14.7	24,503
\$30,001 and Above	19.4	58,306
All Noninstitutionalized Elderly Enrollees	100.0	21,358

SOURCE: National Medical Care Expenditure Survey.

Individual Liability for Health Care Costs

To calculate a person's liability for health care, a somewhat different set of expenditures focusing on direct out-of-pocket health care costs and insurance premiums is relevant. Direct out-of-pocket costs are shown as family contributions in Figure 3. Individual liability also includes medical insurance premiums, since persons who use no medical care in a given year may still face considerable personal liability for the costs of insurance. Where a portion of such insurance is borne by another payer--