CHAPTER 2

Medicare beneficiaries' access to quality health care

RECOMMENDATION

2A The Secretary should periodically identify potential problems in beneficiaries' access to care that arise in the evolving Medicare program and should report annually to the Congress on findings from studies undertaken to examine those potential problems.

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The Balanced Budget Act of 1997 changed Medicare payment policies in ways that could affect beneficiaries' access to quality care. Although the Congress increased some payments to providers and lessened their regulatory burden in the Balanced Budget Refinement Act of 1999, whether these steps were needed to ensure continued access is still unclear. Recent studies of access to physician services and post-acute care have generally concluded that Medicare policy changes have not caused access problems for most beneficiaries, and MedPAC's routine monitoring analyses have showed no increase in access problems in the first year following Balanced Budget Act enactment, although certain groups of beneficiaries continue to experience considerably higher rates of problems than do others. Some studies have uncovered new problems, however, that warrant attention. For example, beneficiaries who need medically complex care may face increased difficulty obtaining skilled nursing facility admissions; whether those admitted are now less likely to receive appropriate care is as yet unknown. An increase in the share of beneficiaries who lack supplemental insurance coverage is also a concern, given the importance of this coverage in promoting access to care. MedPAC's analysis of trends in beneficiaries' financial liability for health care and the implications of the Balanced Budget Act does not lead us to expect significant increases in out-of-pocket spending, but does suggest that the liability gap between managed care and traditional program enrollees is likely to shrink. Because continued vigilance is needed as the Act's implementation progresses, the Commission will make access monitoring a continued priority and calls upon the Secretary of Health Human Services to do likewise.

In this chapter

The Balanced Budget Act of 1997 (BBA) made a number of important changes in Medicare policies, some of which could affect beneficiaries' access to care or the quality of care they obtain. Certain reductions in payment levels mandated by the BBA could decrease the willingness or ability of providers to serve beneficiaries, or cause providers to reduce the value of the services they furnish. In addition, some changes in Medicare's provider payment methods mandated in the BBA—notably, shifts to prospective payment systems for certain providers previously reimbursed on a cost basis—could change the availability of certain services by altering incentives for providing them. Significant changes in payments to Medicare+Choice (M+C) plans could affect access to services for enrollees, as well as reduce the extent to which plans offer enriched benefit packages and lower out-of-pocket spending for their enrollees. Other BBA changes could affect some beneficiaries' access to care by affecting the amount of out-of-pocket payments for which they are financially liable.

Assessing the effects of BBA policy changes on beneficiaries' care is challenging in several respects. First, not all changes have yet been fully carried out, and some were rescinded or modified by the Balanced Budget Refinement Act of 1999 (BBRA). In addition, few data are yet available by which to assess changes that have been implemented. Finally, it is difficult to isolate the effects of BBA policy changes from the effects of ongoing changes in the health care delivery system. Despite these limitations, the Medicare Payment Advisory Commission (MedPAC) and others have taken steps to evaluate the extent to which beneficiaries' access to care has changed since new Medicare payment policies took effect and the degree to which the new policies have caused those changes.

MedPAC concludes that as yet, there is little reason to believe that Medicare policy changes enacted by the BBA have posed a significant threat to beneficiaries' access to care, although certain findings warrant additional attention. For example, MedPAC's study of access to physician services found no indication that cuts in physician payment levels changed the willingness or ability of physicians to continue serving Medicare beneficiaries. The Commission's study of beneficiary access to home health care under the interim payment system uncovered evidence of potential problems, although the effects of the new payment system were confounded by other factors. Studies of access to skilled nursing facility (SNF) care have found that some medically complex patients may have increased difficulty obtaining admissions under the new payment system, although no studies have addressed whether the care received by SNF patients has changed.

MedPAC's routine monitoring efforts also do not show increasing access problems for beneficiaries. Findings from an analysis of beneficiary survey data show no changes in access for traditional program and M+C enrollees between 1997 and 1998, although higher rates of problems persist among certain vulnerable populations. Furthermore, an increase in the share of beneficiaries lacking supplemental insurance coverage deserves further study. Data are not yet available to assess beneficiary financial liability—an important determinant of access—in the post-BBA world. MedPAC's analyses of trends in pre-BBA data and of the likely impact of BBA changes do not provide cause for concern in the near future for traditional program beneficiaries, but BBA provisions could lead to increases in financial liability for M+C enrollees.

Although the BBRA reduced the likelihood of certain access problems developing as a result of BBA provisions, continued vigilance is needed to ensure that beneficiary care is not compromised by forthcoming Medicare policy changes. MedPAC will continue to monitor and report on beneficiary access as further changes are instituted and additional data become available. As required by the BBRA, the Commission's future work will address access to quality health care for beneficiaries who live in rural areas. MedPAC will also examine the effects on beneficiary care of shifting to prospective payment for post-acute care, drawing on the work of sponsored research to develop indicators of beneficiaries' use of needed services. Furthermore, MedPAC urges the Secretary to renew her focus on issues of beneficiary access to quality care. The Commission recommends that she periodically identify key access issues that arise in the evolving Medicare program and that she report annually to the Congress on findings from studies undertaken to address those issues.

This chapter begins with an overview of characteristics of the beneficiary population associated with greater likelihood of access problems and an analysis of these characteristics among beneficiaries in the traditional Medicare program and M+C enrollees. Next, it describes key BBA modifications to provider payment methods and amounts that could affect access to care for beneficiaries enrolled in the traditional program, and examines evidence on changes in beneficiary access to care since Medicare policy changes took effect. It then assesses how recent changes in Medicare managed care could affect enrollees and examines how changes have affected coverage or access to services. Following a brief review of current issues relating to Medigap coverage, the chapter continues with an analysis of beneficiaries' out-of-pocket spending for health care that assesses how spending has changed, factors influencing future changes, and resulting implications for access. The chapter concludes with a discussion of the need for future access monitoring and MedPAC's recommendation to the Secretary aimed at meeting this need.

Beneficiary characteristics associated with access and satisfaction

Medicare researchers have found that certain beneficiary characteristics or circumstances are associated with a greater likelihood of experiencing problems in obtaining needed health care

on a timely basis. Efforts to monitor Medicare beneficiary access have often included assessments of the extent to which these vulnerable groups experience problems, compared with others.

The groups of beneficiaries who have been found to be vulnerable to access problems differ somewhat between the traditional program and the managed care option. Vulnerability to access problems in the traditional program appears related to minority status, relative need for care, and ability to pay for care. For example, analyses of the annual Medicare Current Beneficiary Survey (MCBS) have consistently shown that traditional program beneficiaries who are African American, Hispanic, functionally disabled, in poor health, poor, or lacking supplemental insurance coverage are more likely than other beneficiaries to report problems obtaining care (MedPAC 1998).[1] In contrast, Medicare managed care enrollees' access to services has been found to vary based on health, functional, or disability status, rather than on race, ethnicity, or income. For instance, a 1996 study of Medicare managed care enrollees' access found that those who were disabled and younger than 65, older than 85, functionally impaired, in fair or poor health, or in worsening health were more likely than other enrollees to report access problems (Nelson et al. 1997). However, additional analysis revealed that, with the notable exception of the nonelderly disabled population, greater need for care explained much of the difference in rates of reported access problems.[2]

Beneficiaries not enrolled in managed care who lack any form of public or private supplemental coverage are a vulnerable group of particular policy interest because the share of beneficiaries in this group has increased significantly in recent years. MedPAC's analyses of data from the MCBS show that the proportion of noninstitutionalized beneficiaries in the traditional Medicare program lacking any supplemental coverage has increased from 12.2 percent in 1996 to 13.6 percent in 1997 and 14.4 percent in 1998. This reflects a decline in employer-sponsored coverage and Medigap coverage over this period. The percentage of beneficiaries covered by Medicaid remained stable.

The issue of the vulnerability of rural beneficiaries to access problems is a complicated one; MedPAC will focus on this issue in our work over the next 18 months. The notion of rural beneficiary vulnerability stems from concerns about the adequacy and fragility of health care delivery systems in sparsely populated areas. However, evidence on the extent to which Medicare beneficiaries who live in rural areas experience more access problems than others is mixed (MedPAC 1998). For example, analyses of Medicare claims conducted by the Physician Payment Review Commission (PPRC) showed that beneficiaries residing in rural areas were more likely than others to be admitted to the hospital for conditions that could be averted by proper use of ambulatory care, but less likely to be admitted to the hospital through the emergency room (PPRC 1995). The nature and extent of access problems may differ for different types of rural areas; in addition, the issue of rural beneficiaries' vulnerability is complicated by the fact that Medicare includes numerous special payment policies designed to promote access to care for rural beneficiaries. It is likely that more problems with beneficiary access would be evident in the absence of those policies, although their cumulative effects have not been studied.

An analysis of data from the 1998 MCBS shows the proportion of beneficiaries living in a community setting who have characteristics or circumstances that place them at greater risk of experiencing access problems (Table 2-1). Compared with traditional program enrollees, fewer M+C enrollees were in many of the groups viewed as potentially vulnerable to access problems in 1998. Two groups show the largest disparities between M+C and the traditional program: residents of rural areas and beneficiaries eligible for Medicare on the basis of a disability. Because few M+C plans are available in rural areas, only 5.7 percent of M+C enrollees were rural residents, compared with 28.8 percent of traditional program enrollees.[3] Only 6.7 percent of M+C enrollees were disabled and younger than 65, compared with 13.6 percent of beneficiaries enrolled in the traditional program. Health and functional status differences between the two populations are also notable; 21.4 percent of M+C enrollees and 28.6 percent of traditional program enrollees reported fair or poor health, and 10.9 percent of M+C enrollees and 13.9 percent of traditional program enrollees reported needing help with activities of daily living.

Access to care in the traditional Medicare program

Since the BBA's enactment, policymakers and others have raised questions about the extent to which payment changes in Medicare have affected the care received by beneficiaries who obtain care through the traditional program. Changes in Medicare payment levels or methods could reduce providers' willingness to serve beneficiaries or their ability to make certain services available. Such changes could also provide incentives to reduce the intensity or duration of care. A number of studies have assessed whether beneficiary care

1 Regression analyses showed that poor health status (self-reported) and a lack of supplemental insurance coverage were more predictive of access problems than were other factors (PPRC 1997).

2 The researchers controlled for differences between vulnerable groups and other enrollees in relative need for care by computing the percentage of beneficiaries who reported access problems among those defined as having a need for particular services. Enrollees were considered to be in need of a service if they reported either having received a service or not receiving it when they believed it to be necessary.

3 See Chapter 5 for a discussion of Medicare+Choice plan availability in rural areas.

TABLE 2-1

Selected characteristics of noninstitutionalized traditional Medicare and Medicare+Choice enrollees, 1998

Characteristics	All	Traditional Medicare	Medicare+Choice
Race			
African American	9.4%	9.3%	10.0%
White	88.9	89.0	88.1
Other	1.8	1.7	2.0
Ethnicity			
Hispanic	6.8	6.4	8.2
Other	93.3	93.6	91.8
Age			
85+	9.2	9.4	8.6
Under 85	90.8	90.6	91.4
Self-reported health status			
Excellent	14.9	14.2	18.0*
Very good or good	57.9	57.3	60.6
Fair or poor	27.3	28.6	21.4
Help with functional impairment			
Needed	13.3	13.9	10.9*
Not needed	86.7	86.1	89.1
Medicare eligibility status			
Disabled	12.3	13.6	6.7*
Aged	87.7	86.4	93.3
Annual income			
Up to $10,000	25.9	26.9	21.3*
More than $10,000	74.1	73.1	78.7
Place of residence			
Rural	24.7	28.8	5.7*
Urban	75.4	71.2	94.3
Supplemental Insurance			
Private	63.6	73.6	—
Medicaid	10.4	12.0	—
Medicare only	26.1	14.4	—

Note: * Difference between traditional Medicare and Medicare+Choice enrollees in their distribution across categories is statistically significant at a 0.05 level. Percentages do not always total 100 due to rounding.

Source: MedPAC analysis of data from the 1998 Medicare Current Beneficiary Survey Access to Care file.

has changed as a result of BBA payment changes; most have found little discernible, negative impact on beneficiary access to or quality of care. Further study of some potential problems in post-acute care is required, however, and additional studies will be needed to assess policies not yet phased in.

Providers' willingness and ability to serve Medicare beneficiaries

Health care providers may become less willing or able to serve Medicare beneficiaries if the payments they receive from the program are not adequate to cover their costs. Because provisions of the BBA changed many of Medicare's payment levels and methods, it is important to monitor providers' responses to those changes to ensure that beneficiaries continue to have adequate access to quality medical care. This section identifies key BBA payment policy changes relating to ambulatory care, hospital care, and post-acute care, and reviews evidence on the extent to which these changes have affected providers' willingness or ability to serve beneficiaries.

Beneficiary access to ambulatory care

Although the BBA made a number of important changes in payments to hospital outpatient departments (OPDs) and physicians that stand to affect Medicare beneficiaries' access to those services, problems are not yet evident. Because MedPAC is concerned about the magnitude of changes in payments to OPDs, the Commission reiterates its advice to the Secretary of Health and Human Services to monitor beneficiary access to these services as new payment methods are instituted. Although the Commission's own study of physician attitudes and perceptions did not provide an immediate cause for concern about beneficiary access to physician services, MedPAC will continue to track ongoing changes in physician payment policies and their effects on beneficiary care.

Changes in payments to outpatient departments Although the BBA made significant changes in payments to hospital outpatient departments, the key change has yet to occur. The BBA eliminated the so-called formula-driven overpayment, under which Medicare's payments did not correctly account for beneficiaries' cost-sharing, and extended the reduction in payments for services paid on a cost-related basis. That change, which took effect in 1998, reduced payments to hospitals by about 9 percent (MedPAC 1999b). The law also directed the Secretary to establish a prospective payment system (PPS) for services paid at least partially on the basis of incurred costs. The PPS originally was to have gone into effect in January 1999, but now will not be initiated before July 2000. In accordance with provisions in the BBRA, the PPS will be phased in over a transition period—ending, for most hospitals, in 2003—and spending will increase from BBA levels.

Although MedPAC supports the OPD payment reforms made in the BBA, the Commission has also acknowledged that the magnitude of the payment reductions and certain design features of the forthcoming payment system could have negative implications for Medicare beneficiaries' ability to obtain needed ambulatory care (MedPAC 1999b). Therefore, the Commission previously recommended that the Secretary closely monitor hospital outpatient service use following the move to the PPS to ensure that access to appropriate care is not compromised.

Effects of changes in payments to physicians In contrast to changes in OPD payments, many of the most important changes in payments to physicians took effect immediately following the BBA. Their effects were not unidirectional; the effects on beneficiary access might therefore be mixed. The Commission has not, to date, found evidence that beneficiary access to physician services is decreasing. Findings from a MedPAC-sponsored survey of physicians, conducted after key BBA changes, do not raise concerns about physicians' willingness or ability to care for Medicare beneficiaries in the short term. However, the Commission will continue to look for changes in access as additional BBA changes occur.

The BBA made significant changes in physician payments. The law replaced the volume performance standard system used to update physicians' fees with the sustainable growth rate (SGR) system. The SGR replaced the three conversion factors used for surgical services, primary care, and other nonsurgical services with a single factor that reduced payments for some services and increased them for others. The BBA also required a phase-in of a new method for calculating payments to physicians for their practice costs.

Several important changes to Medicare's payments to physicians occurred almost immediately after BBA enactment. The single conversion factor was implemented January 1, 1998, along with changes in practice expense payments for certain services. The Health Care Financing Administration (HCFA) also increased the relative value units for physician work associated with certain surgical services in 1998, to be consistent with previous changes in payments for evaluation and management services. The net effects of these changes were largest for some surgical procedures, such as cataract surgery and some orthopedic procedures, where payment rates fell by 13 percent or more (MedPAC 1998). However, payments for office visits and some diagnostic services increased by at least 7 percent.

To assess whether and how physicians responded to the 1998 changes in Medicare's payments to physicians, MedPAC contracted with Project HOPE and the Gallup Organization to conduct a mail and telephone survey of physicians (Schoenman and Cheng 1999). A total of 1,298 physicians were interviewed between December 1998 and March 1999. The survey provided information comparable to that obtained through a 1994 survey of physicians conducted by PPRC, allowing for assessment of changes over time in physician satisfaction with various components of practice and reimbursement levels. For certain survey questions, physicians were also asked to report the extent to which their practices had changed in the past year.

Survey findings show that, at least in the short term, physicians are still willing and able to care for Medicare beneficiaries:

- Among physicians accepting all or some new patients, more than 95 percent said they were accepting new Medicare fee-for-service (FFS) patients in 1997 (before the Medicare payment policy changes took place) and in early 1999. Consistent with findings from the 1994 PPRC survey, physician acceptance of new Medicare patients was comparable to their acceptance of new privately insured FFS patients.
- Only about 10 percent of physicians reported any change since 1997 in the priority given to Medicare patients seeking an appointment. Of those changing their appointment priorities, the percentage that reported giving Medicare patients a higher priority was almost the same as the percentage that assigned Medicare patients a lower priority.
- Only 4 percent of physicians said it was very difficult to find suitable referrals for their FFS Medicare patients, a finding comparable to the percentage reporting problems in referring their privately insured FFS patients.

Many surveyed physicians expressed concerns about payment levels. About 45 percent said that reimbursement levels for Medicare FFS patients are a very serious problem, compared with 25 percent for private FFS patients.[4] A higher percentage

4 Surgeons were significantly more likely than other physicians to say that fee-for-service Medicare reimbursement levels represented a very serious problem.

of physicians—59 percent—reported that reimbursement levels for FFS Medicaid patients are a very serious problem. Physicians expressed the highest level of concern with the reimbursement levels of health maintenance organizations (HMOs) and other capitated plans: About 66 percent of physicians surveyed said that the reimbursement levels of HMOs are a very serious problem.

Although the immediate impact of BBA changes to physicians appears not to have threatened beneficiary access to care, other BBA-required changes to physician payments that could affect access did not take effect immediately. Of particular interest is the effect of practice expense changes, which will not be completely implemented until 2002 and which may cause significant cuts in payments for certain services. Other effects related to implementation of the SGR are also possible, prompting the Commission to recommend an additional allowance in the SGR for cost increases associated with improvements in medical capabilities and advancements in scientific technologies (MedPAC 1999b).

Beneficiary access to hospital care

Because hospital care is often the consequence of an event beyond the control of an individual or a hospital, access to hospital care is first and foremost measured by the effect of payment provisions on hospitals' abilities to remain open and operational.

With the passage of the BBA, the Congress made several changes in hospital payments that have the potential to affect beneficiary access or reduce the quality of hospital care. These provisions included: no updates to inpatient operating payments for hospitals under the Medicare PPSs in fiscal year (FY) 1998 and limited updates from 1999 to 2002; phased reductions in the per-case adjustments for the indirect costs of medical education (IME); temporary reductions for hospitals serving a disproportionate share (DSH) of low-income patients; and a new transfer policy for 10 high-volume diagnosis related groups (DRGs) that reduces payment rates when hospitals discharge patients in these DRGs to post-acute care facilities following unusually short stays. By themselves, lower updates would have slowed the growth in payment rates but would not have reduced them. However, in FY 1998, the combined effect of the freeze on payment rates and smaller IME and DSH payment adjustments reduced payment rates in absolute terms. Payment rates began to increase again in FY 1999, but slower than they would have in the absence of the BBA.

It is important to consider these payment policy changes in the context of the trend in aggregate Medicare payments to hospitals for inpatient services covered by prospective payment. At the time Congress enacted the BBA, average Medicare inpatient margins had risen from -2 percent to 17 percent over six years. In recommending the freeze on inpatient payments in FY 1998 and supporting the expanded transfer policy, the Prospective Payment Assessment Commission (ProPAC) believed that payments could be modestly reduced, and thereby brought into closer alignment with the costs of care, without compromising quality or access to care (ProPAC 1997).

These provisions, along with the cumulative impact of similar reductions in post-acute care, have raised concerns about the viability of certain hospitals—particularly low-volume hospitals, and especially low-volume hospitals in rural areas. Concerns have been raised over the impact of these provisions on access to care (in both rural and urban settings), but there are insufficient data to draw definitive conclusions. Despite the lack of data, the BBRA contained a number of provisions targeted to rural hospitals, including provisions to strengthen the Critical Access Hospital program (an extension of the Medicare-dependent hospital program) and increased flexibility to provide graduate physician training in rural areas.

The BBRA requires MedPAC to initiate a series of studies that will attempt to answer many of the questions surrounding access to hospital care for Medicare beneficiaries who reside in rural areas. The most significant is an assessment of special payment provisions for rural hospitals and their impacts on access and quality.[5] These studies will enable MedPAC to analyze the impact of the BBA on rural providers and whether and how access to and quality of care have been affected.

Beneficiary access to post-acute care

Systems for paying post-acute care providers—including skilled nursing facilities, home health agencies, long-term hospitals, and rehabilitation facilities—currently are undergoing changes that alter the method and level at which providers are reimbursed. These changes, which generally move reimbursement from cost-based systems to PPSs, may potentially affect providers' ability and willingness to furnish care. Payment systems in the post-acute care arena are at different stages of development or implementation. These changes, occurring over a relatively short period of time, create uncertainty as to whether access to care will be adequately maintained. Therefore, the Commission reiterates the need to monitor beneficiaries' access to quality care as these payment systems are developed and implemented (MedPAC 1999b).

The BBA and the BBRA mandated substantial changes in Medicare payment policy for providers of post-acute care. The BBA required the Secretary to implement a new PPS for rehabilitation facilities and develop a payment proposal for long-term hospitals. The BBRA refined these mandates by requiring the Secretary to implement a discharge-based PPS for rehabilitation facilities and to

5 Other MedPAC reports on rural health mandated in the BBRA include: an evaluation of the impact of the PPS for psychiatric hospitals on access to such services at rural hospitals; a study on the appropriateness of applying the outpatient PPS to certain rural and cancer hospitals; and a study to determine the feasibility and advisability of exempting home health services provided by rural home health agencies from the PPS.

classify patient discharges according to functional-related groups. The BBRA also required the Secretary to develop a patient classification system for long-term hospitals in an effort to move toward a discharge-based PPS.

The BBA also made provisions for developing and implementing a new PPS in the home health care arena. Until HCFA institutes that system on October 1, 2000, Medicare makes payments to home health agencies using an interim payment system (IPS), which limits agencies' cost-based payments. The IPS created controls on agency spending for home health services. However, it also raised concerns about whether agencies could meet the cost of providing services to beneficiaries with extensive needs. Because these beneficiaries require more intensive services, and because the IPS does not adjust payments to account for these costs, providers might fail to provide or prematurely end visits for these patients.

The BBA also changed the payment system for SNFs to a PPS. Under the PPS, Medicare pays facilities a single case-mix adjusted per diem rate for each resident. This rate covers all routine, ancillary, capital-related costs and the cost of Part B services provided during a beneficiary's Part A stay. HCFA began to phase in the PPS for SNFs on or after July 1, 1998, according to their cost reporting periods. The PPS is now in place for all facilities; however, the federal rates are still being phased in.[6] The BBRA adjusted payment rates under the PPS by increasing federal per diem payments by 20 percent for some categories of patients (those believed to have higher non-therapy ancillary costs). Additionally, the BBRA raised federal rates for all categories of patients by 4 percent in FY 2001 and 2002.

Although the PPS is intended to reflect efficient treatment costs associated with the full range of SNF patient types, several studies have found that payments were too high for patients who use relatively few non-therapy ancillary services and too low for those who need relatively high levels of these services (Abt Associates 1998; AHCA 1999; NSCA and AHCA 1999). Inadequate payment rates could potentially result in SNFs denying admission to beneficiaries with medically complex care needs. Although the BBRA made temporary payment increases to the 15 categories of patients considered medically complex, continued monitoring of access for these patients is needed to ensure that the increases are sufficient.

Studies of the impact of payment changes have revealed changes in access to home health care and SNF care for some beneficiaries. Agencies and facilities are asking more detailed questions to assess patients' clinical status and the potential cost of caring for them. Patients requiring the most extensive care face more difficulty in SNF or home health agency placements. However, studies that rely heavily on surveys of hospital discharge planners do not capture the issues facing those beneficiaries who reside in the community and are seeking access to care, nor do they address whether beneficiaries admitted as patients obtain appropriate services of adequate duration and intensity. MedPAC has found that the direct impact of changes in payment systems is difficult to distinguish from other factors that alter the health care delivery environment for Medicare. For example, antifraud initiatives, more stringent review of claims, changes in covered benefits, and market forces may help explain decreases in service use.

Access to home health care Since the IPS took effect, the home health care industry has experienced a number of agency closures and agencies have reduced capacities. Researchers have found that these changes have affected certain beneficiaries' access to care, although most beneficiaries are still able to obtain home health care. The General Accounting Office (GAO) found that access generally has not been impaired, despite the closure of approximately 14 percent of home health agencies since 1997 (GAO 1999b). But interviews with key stakeholders in areas with higher frequencies of closures suggest that home health agencies are asking more detailed information about potential patients, and that patients who require costlier services are facing difficulty in finding an agency willing to provide visits.

The Office of the Inspector General (OIG) also studied the effect of the IPS on access to home health care, with results similar to those of the GAO. About 85 percent of hospital discharge planners surveyed reported that beneficiaries were able to receive care when they needed it, but 15 percent state that care was not always available (OIG 1999b). About 60 percent of all discharge planners also believed that the IPS has made the process of placing Medicare beneficiaries with home health agencies more difficult, due to the burden of providing additional information on prospective patients. Patients who face increased difficulty in placement have chronic, intensive, or higher-cost health care needs.

MedPAC sponsored a survey of home health agencies to examine whether access has been compromised by the IPS (MedPAC 1999a). This research reveals that the broad impact of the IPS did not fulfill "the worst predictions," but has likely negatively affected beneficiaries (Abt Associates 1999). Results indicate that the new payment system has led agencies to exercise cost-cutting measures, including refusing services to Medicare patients who have chronic, long-term conditions, especially diabetes. More than half of agencies surveyed expected to exceed their per-beneficiary limit and said that, as a result of the IPS, they would be more likely to decrease their Medicare caseloads, deny admission to certain types of patients, discharge certain types of patients, or reduce clinical staff or hours.

Access to skilled nursing facility care Recent studies on access to SNF care suggest that the PPS may have contributed

6 The BBRA made allowances for facilities to opt either to be paid through a blend of the federal and facility-level rate or to be paid at a fully federal rate for the SNF PPS during the phase-in period of the federal rates.

to access problems for beneficiaries needing the most complex care.

The OIG released the results of two random-sample surveys that found few access problems for Medicare beneficiaries but noted a potential problem in placing beneficiaries requiring extensive services (OIG 1999a, OIG 1999c). One study surveyed hospital discharge planners, the other nursing home administrators and Minimum Data Set (MDS) coordinators. Most MDS coordinators, who are responsible for assessing residents' status and are aware of the admission process, stated that the new reimbursement system did not cause SNFs to refuse patients. Most discharge planners said they did not have difficulty placing patients in nursing homes. However, nursing home administrators, MDS coordinators, and hospital discharge planners reported that nursing homes were changing their admission practices in response to the new PPS—for example, by focusing on whether patients require costly intravenous medications, lab work, or transportation. One-fifth of hospital discharge planners said that as a result, it has become more difficult to place patients requiring extensive services, but easier to place those needing short-term rehabilitation.

The GAO also studied beneficiaries' access to SNF care by surveying 153 discharge planners in 43 states (GAO 1999a). The agency's results generally concur with those of the OIG, finding that beneficiaries' placement in nursing homes has not been affected by the new PPS. However, about two-thirds of surveyed planners reported that SNFs have become more reluctant to admit higher-cost patients, such as those requiring intravenous antibiotics and infusion therapy. Additionally, the GAO study cited a preference by facilities to admit patients needing short-term care. Despite the change of preferences by SNFs, most discharge planners reported that difficult-to-place patients eventually are placed, though they remain hospitalized longer than similar patients did before the PPS.

Using the Medicare Current Beneficiary Survey to evaluate access

To evaluate access to care from the beneficiary perspective, the Commission analyzed data from the 1997 and 1998 Access to Care files of the Medicare Current Beneficiary Survey (MCBS). Initially fielded in 1991, the MCBS is a longitudinal survey of a nationally representative sample of Medicare beneficiaries administered by the Health Care Financing Administration (HCFA).[7]

Each autumn, HCFA administers the MCBS access to care supplement to noninstitutionalized beneficiaries. The survey includes questions on problems experienced in obtaining care, satisfaction with care, and usual source of care. Since 1996, it has also included questions designed to evaluate Medicare managed care enrollees' access to care and satisfaction with care. Medicare managed care enrollees, those age 85 and over, and disabled beneficiaries under age 65 are oversampled to permit policy researchers to draw conclusions about how these groups fare compared with their counterparts.

In 1997, 17,078 Medicare beneficiaries were interviewed using the access to care supplement; the 1998 Access to Care file includes data from 19,651 respondents. The increase in sample size reflects an increase in the oversample of Medicare+Choice enrollees in 1998. The sample size increase improved the precision with which access and satisfaction can be analyzed for groups within the population enrolled in Medicare+Choice. ■

7 For additional information on the Medicare Current Beneficiary Survey and its history, see Adler 1994.

To date, no study has addressed whether beneficiary use of needed SNF care has changed as a result of the PPS. MedPAC recognizes the need to analyze changes in use within a clinical context to evaluate the effects of changes under the PPS, and is funding work to assess the feasibility of developing clinically meaningful indicators of the use of SNF care that reflect standards of appropriate care and can be used with routinely collected administrative data. If such indicators can be developed, the Commission will sponsor their development and use them to analyze the effects of changes in SNF use. Ultimately, this project should allow MedPAC to evaluate whether any changes in beneficiaries' use of SNF care since PPS implementation are clinically problematic.

Access and satisfaction reported by Medicare beneficiaries enrolled in the traditional program

MedPAC analyses of data from the MCBS reveal that beneficiaries reported no more problems obtaining health care in the first year since BBA enactment than they did in the previous year. Only a small percentage of beneficiaries who obtained care through the traditional program in 1998 experienced problems with access or expressed dissatisfaction with their care, although certain subgroups of the beneficiary population were significantly more likely to do so.

Traditional program enrollees' access to care

The percentage of beneficiaries in the traditional program reporting problems with access to care did not change

TABLE 2-2

Access to care for noninstitutionalized beneficiaries in traditional Medicare, by selected beneficiary characteristics, 1998

Characteristics	Had trouble getting care	Delayed care due to cost	No usual source of care	No office visit this year
All	3.3%	7.6%	10.3%	20.6%
Race				
African American	5.9*	11.2*	17.6*	31.5*
White (R)	2.9	7.0	9.1	18.7
Other	7.1	8.8	13.4	39.1*
Ethnicity				
Hispanic	5.1*	10.3	17.9*	29.8*
Other	3.2	7.4	9.7	19.9
Age				
85+	2.5*	2.6*	7.3*	11.9*
Under 85	3.4	8.1	10.6	21.5
Self-reported health status				
Excellent (R)	1.5	2.9	15.9	29.1
Very good or good	2.1	5.1*	9.2*	18.7*
Fair or poor	6.6*	14.8*	9.6*	20.0*
Help with functional impairment				
Needed	8.0*	13.4*	7.5*	17.4*
Not needed	2.6	6.6	10.7	21.1
Medicare eligibility status				
Disabled	10.2*	21.8*	15.5*	39.0*
Aged	2.3	5.3	9.5	17.7
Annual income				
Up to $10,000	6.0*	13.2*	15.9*	24.9*
More than $10,000	2.4	5.6	8.2	18.9
Place of residence				
Rural	3.0	9.2*	10.2	22.4
Urban	3.5	6.9	10.3	19.9
Supplemental Insurance				
Private	2.0*	4.4*	6.9*	16.0*
Medicaid	6.4	10.2*	14.2*	21.4*
None (R)	7.0	21.0	24.2	43.0

Note: * Difference between subgroups, or between subgroup and reference group (R), is statistically significant at a 0.05 level.

Source: MedPAC analysis of data from the 1998 Medicare Current Beneficiary Survey Access to Care file.

meaningfully from 1997 to 1998. In both years, slightly more than 3 percent of beneficiaries reported trouble getting care, about 8 percent reported delaying care due to its cost, roughly 10 percent reported that they did not have a usual source of care, and about 20 percent had not had an office visit to a physician that year.

Consistent with findings from previous analyses, in 1998 certain groups of beneficiaries were more likely to report access problems (Table 2-2). These groups included beneficiaries who were African American, in fair or poor health, eligible because of disability, earned up to $10,000 per year, or lacked private supplemental insurance coverage.

Beneficiaries needing assistance with activities of daily living (ADLs) because of a functional impairment were more likely to report trouble with getting care and delaying care due to cost, compared with those who did not need assistance. However, they were less likely than other beneficiaries to report that they had no usual source of care or had not had an office visit in the past year.

African-American beneficiaries were more likely than their white counterparts to experience access problems in 1998. Roughly 11 percent of African Americans, and 7 percent of whites, delayed care due to cost. African Americans were twice as likely to report trouble getting care and to have no usual source of care. About 32 percent of African-American beneficiaries had not had a physician's office visit during the year, compared with 19 percent of whites.

Roughly 7 percent of beneficiaries in self-reported fair or poor health—but less than 2 percent of those who reported being in excellent health—said that they had trouble getting care during 1998. About 15 percent of those in fair or poor health—but only about 3 percent of those in excellent health—delayed care due to cost. However, those in excellent health were significantly more likely than those in fair or poor health to have no usual source of care and to have had no office visit in the past year.

Among beneficiaries needing help with ADLs because of a functional impairment, 8 percent had trouble getting care and 13 percent delayed care due to cost. Only 3 percent of those who did not need help experienced trouble getting care, and 7 percent delayed care due to cost. However, the percentage of beneficiaries without a usual source of care was 3 points lower for those needing help, compared with those who did not. The percentage of beneficiaries without an office visit in the past year was about 4 points lower for those who needed help, compared with those who did not.

The percentage of beneficiaries without an office visit in the past year was 21 points higher for disabled-eligible people, compared with age-eligible people. Furthermore, 10 percent of disabled beneficiaries, but only 2 percent of aged beneficiaries, experienced trouble getting care in 1998. More than 20 percent of disabled beneficiaries, but only 5 percent of aged beneficiaries, reported that they had delayed care due to cost. The percentage of beneficiaries without a usual source of care was 6 points higher for disabled-eligible persons, compared with age-eligible persons.

Among beneficiaries with incomes of up to $10,000 per year, 6 percent reported trouble getting care and 13 percent reported delaying care due to cost. Among beneficiaries earning more than $10,000 per year, only 2 percent reported trouble getting care and 6 percent reported delaying care due to cost. Furthermore, the percentage of beneficiaries without a usual source of care was 16 percent for those earning up to $10,000 per year, but only 8 percent for those earning more than $10,000 per year. About 25 percent of beneficiaries with an annual income up to $10,000, but only 19 percent of those with an annual income greater than $10,000, had not had an office visit.

Relatively high levels of access problems among beneficiaries who lack supplemental coverage may be of particular concern, given that Commission analyses show this population is growing as a proportion of noninstitutionalized beneficiaries in the traditional program. In 1998, beneficiaries in the traditional program who lacked supplemental coverage were more than three times as likely as those with private supplemental insurance to report trouble getting care. Beneficiaries without supplemental coverage were nearly five times as likely to have delayed care due to cost, more than three times as likely to lack a usual source of care, and more than two and a half times as likely to have not visited a doctor's office in the past year, compared with those with private supplemental insurance.

Traditional program enrollees' satisfaction with care

There was no meaningful change from 1997 to 1998 in the fraction of beneficiaries enrolled in the traditional program who reported satisfaction with their care. In 1997, about 93 percent of beneficiaries said their physician's examinations were thorough; in 1998, 94 percent did. Roughly 94 percent of beneficiaries had great confidence in their physician in 1997; in 1998, 95 percent did. During 1997 and 1998, about 95 percent of beneficiaries reported satisfaction with the availability of medical care, and roughly 96 percent of beneficiaries reported satisfaction with the overall quality of their care.

Consistent with results from prior Commission analyses, certain groups of beneficiaries were less likely to be satisfied with their care in 1998, although levels of satisfaction were very high even among those groups (Table 2-3). Beneficiaries in fair or poor health and those needing assistance with a functional impairment were less likely to agree that their physician's examinations were thorough, to have great confidence in their physician, or to report satisfaction with the availability and overall quality of medical care, compared with those in better health or those not needing help. Aged beneficiaries and those with either private or Medicaid supplemental insurance were more likely to have great confidence in their physicians and be satisfied with the availability and quality of medical care, compared with disabled beneficiaries and those without supplemental coverage. Hispanic ethnicity, an annual income of up to $10,000, and urban residence were associated with decreased satisfaction with the quality of care received.

Access to care in the Medicare+Choice program

Extensive changes in the Medicare managed care program since the Congress enacted the BBA have implications for

TABLE 2-3

Satisfaction with care for noninstitutionalized beneficiaries in traditional Medicare, by selected beneficiary characteristics, 1998

Characteristics	Strongly agree/ agree with "Physician checks everything"	Strongly agree/ agree with "Great confidence in physician"	Very satisfied/ satisfied with availability of medical care	Very satisfied/ satisfied with overall quality of care
All	94.2%	95.3%	95.0%	96.3%
Race				
African American	94.7	94.5	95.9	96.2
White (R)	94.1	95.4	94.9	96.3
Other	92.5	95.2	92.5	93.3
Ethnicity				
Hispanic	97.0*	95.0	95.2	94.2*
Other	94.0	95.3	95.0	96.4
Age				
85+	94.4	95.2	96.1*	96.7
Under 85	94.2	95.3	94.8	96.2
Self-reported health status				
Excellent (R)	95.3	96.6	96.4	97.8
Very good or good	94.7	96.1	96.0	97.1
Fair or poor	92.8*	93.2*	92.8*	93.9*
Help with functional impairment				
Needed	92.3*	93.4*	90.9*	94.0*
Not needed	94.5	95.6	95.7	96.6
Medicare eligibility status				
Disabled	93.1	91.7*	91.4*	92.7*
Aged	94.4	95.9	95.7	96.8
Annual income				
Up to $10,000	94.6	94.4	94.5	94.5*
More than $10,000	94.1	95.5	95.2	96.8
Place of residence				
Rural	92.7*	95.5	94.9	97.1*
Urban	94.8	95.2	95.0	95.9
Supplemental Insurance				
Private	94.1	95.8*	95.5*	96.9*
Medicaid	95.3	95.0*	95.1*	95.4
None (R)	93.7	92.2	91.7	93.6

Note: * Difference between subgroups, or between subgroup and reference group (R), is statistically significant at a 0.05 level.

Source: MedPAC analysis of data from the 1998 Medicare Current Beneficiary Survey Access to Care file.

beneficiaries who lost their health plan coverage and for plan enrollees.

Policy changes with implications for Medicare managed care enrollees' access

The BBA made two types of changes that could affect beneficiaries' abilities to obtain health care through private health plans participating in the Medicare program. First, it took a number of steps that influenced plans' ability to participate in Medicare and that may also have affected their willingness to do so. Second, it contained provisions that could affect access to care for beneficiaries enrolled in health plans that participate in the program.

The BBA created the M+C program, which broadened eligibility for program participation to health plans other than the health maintenance organizations that previously participated in the Medicare risk program. This change had the potential to increase the availability of private health plans to Medicare beneficiaries, creating more alternatives in terms of benefits packages, cost-sharing arrangements, and administrative designs. However, very few of the newly eligible plans have as yet participated, and a considerable number of plans have partially or completely left the M+C program.[8]

BBA changes in plan payment methods and levels may provide plans with incentives to reduce access to services. The BBA established a system for making payments to plans based on a blend of historic county-level spending and national average costs, adjusted for local price levels. As a result of the new system and low levels of spending growth in traditional Medicare, health plan payment growth in the home counties of more than 90 percent of M+C plan enrollees was limited to 2 percent per year in both 1998 and 1999. This could induce participating plans to increase beneficiary cost-sharing, reduce the scope of benefits provided beyond the basic Medicare package, or reduce access to covered services for enrollees. The BBA also required HCFA to implement a system of risk adjustment, which the agency began to phase in January 1, 2000. This system, which is likely to reduce overpayments to M+C plans in the aggregate, has raised concerns among plans about the levels of future payments.

Effects of health plan withdrawals on beneficiary coverage and care arrangements

When health plans stop participating in Medicare or stop serving enrollees in certain geographic areas, beneficiaries experience changes in their coverage and health care arrangements that could affect access to services. Because of recent health plan decisions to stop participating in the M+C program or to withdraw from particular counties, about 405,000 beneficiaries lost their existing health plan coverage in 1998, and another 329,000 did so in 1999. These beneficiaries had to either change health plans or use the traditional program, with or without a supplemental insurance policy. About 50,000 beneficiaries in 1998 and 79,000 beneficiaries in 1999 were left with no other M+C plan available in their area.

The Kaiser Family Foundation sponsored a survey of 1,830 Medicare beneficiaries who lost their private health plan coverage in late 1998 as a result of market withdrawals or service-area reductions (Laschober et al. 1999). The study found that many affected beneficiaries experienced some disruption or decline in coverage. Two-thirds of all the involuntary disenrollees enrolled in another Medicare managed care plan, 15 percent purchased a Medigap policy to supplement traditional Medicare coverage, 8 percent went without supplemental coverage, 4 percent used employer-sponsored coverage, and 1 percent used Medicaid. Most beneficiaries—80 percent—had another risk plan available to them. Of those who did, three-quarters enrolled in one (or in a Medicare cost plan, demonstration plan, or other health plan participating in Medicare).[9] One-third of respondents experienced a decline in benefits, and 39 percent reported higher monthly premiums. One in seven lost prescription drug coverage and about one in five had to switch to a new primary care physician or specialist. Those with traditional Medicare only, Medigap insurance policyholders, the oldest, and the near-poor experienced the greatest hardship after disenrollment.

Medicare managed care enrollees' access to care

The extensive changes in the Medicare managed care program that have occurred since BBA enactment have had some negative implications for beneficiaries. MedPAC's analyses show that health plans have reduced their benefits packages and increased cost-sharing requirements since the M+C program was initiated.[10] These changes stand to affect beneficiaries' satisfaction and access to care. Even with these benefit retractions, however, the least generous M+C plan still provides benefits and cost-sharing that are more favorable, from the beneficiary standpoint, than those provided under traditional Medicare. And although M+C plans also differ from traditional Medicare in that their care management mechanisms allow for greater restrictions on beneficiary access to services, the extent to which plans have changed their use of such restrictions in recent years is unclear.

8 See Chapter 5 for an analysis of Medicare+Choice plan pullouts.

9 Of those who had no risk plan serving their county, 24 percent joined a managed care plan participating in Medicare on a cost basis, a plan participating in a Medicare demonstration, or another type of plan—other than a risk plan—that the beneficiary reported as a health maintenance organization.

10 See Chapter 5 for details of this analysis.

TABLE 2-4

Access to care for noninstitutionalized beneficiaries enrolled in Medicare+Choice, by selected beneficiary characteristics, 1998

Characteristics	Had trouble getting care	Delayed care due to cost	No usual source of care	Difficulty getting referrals	Plan ever refused to pay for emergency
All	5.1%	4.5%	5.9%	6.2%	2.0%
Race					
African American	4.3	6.4	9.1*	5.9	2.2
White (R)	5.2	4.5	5.3	6.2	1.9
Other	3.0	2.4	9.5	3.0	0.8
Ethnicity					
Hispanic	6.8	3.8	7.6	9.7	2.7
Other	4.9	4.6	5.7	6.0	1.9
Age					
85+	4.8	3.5	4.6	4.9	1.5
Under 85	5.1	4.6	6.0	6.4	2.0
Self-reported health status					
Excellent (R)	3.6	3.4	8.1	4.4	0.9
Very good or good	3.7	3.5	5.6*	5.3	1.9*
Fair or poor	10.2*	8.3*	4.5*	10.2*	3.2*
Help with functional impairment					
Needed	10.4*	7.7*	5.1	8.0	2.8
Not needed	4.4	4.1	6.0	6.0	1.9
Medicare eligibility status					
Disabled	9.9	14.0*	8.0	10.2	1.5
Aged	4.7	3.8	5.7	6.0	2.0
Annual income					
Up to $10,000	4.8	6.8*	8.4*	6.0	1.6
More than $10,000	5.0	3.8	5.0	6.2	2.1
Place of residence					
Rural	3.9	7.0	6.9	8.0	2.0
Urban	5.2	4.4	5.8	6.1	2.0

Note: * Difference between subgroups, or between subgroup and reference group (R), is statistically significant at a 0.05 level.

Source: MedPAC analysis of 1998 Medicare Current Beneficiary Survey Access to Care file.

MedPAC's analysis of data from the MCBS shows no notable change from 1997 to 1998 in the percentage of managed care enrollees reporting problems with access to care. In both 1997 and 1998, about 5 percent of managed care enrollees reported trouble getting care, roughly 4 percent of managed care enrollees reported delaying care due to cost, and 6 percent of enrollees reported that they had no usual source of care. The percentage of managed care enrollees reporting difficulty in obtaining referrals to specialists, of those who tried to obtain a referral, was just under 7 percent in 1997 and just over 6 percent in 1998. In 1997, more than 1 percent of enrollees reported that their plan refused to pay for emergency care; 2 percent did so in 1998.

Analysis of selected beneficiary characteristics indicated that certain groups were more likely to have problems obtaining care in the M+C program in 1998 (Table 2-4). Those in fair or poor health reported more problems across most of the access measures evaluated, although they were more likely to have a usual source of care—perhaps because their health

conditions required them to seek care. The percentage of beneficiaries having trouble getting care or delaying care due to cost was about twice as large for functionally impaired individuals, compared with those who were not impaired. Those with annual incomes up to $10,000 were more likely to delay care due to cost or to have no usual source of care, compared with beneficiaries with annual incomes greater than $10,000. African Americans were more likely than whites to lack a usual source of care. The percentage of beneficiaries delaying care due to cost was roughly three and a half times greater for disability-eligible, versus age-eligible, beneficiaries.

Enrollees' satisfaction with the care they received was similar for 1997 and 1998. In both years, about 93 percent of enrollees reported that their physicians' examinations were thorough, 94 percent had confidence in their physician, 94 percent were satisfied with the availability of medical care, and 95 percent were satisfied with the overall quality of care they received during the past year. The percentage of enrollees reporting they would recommend their health plan to family and friends was 91 percent in 1997 and 90 percent in 1998.

Certain beneficiary characteristics were associated with lower levels of satisfaction in 1998 (Table 2-5). People in fair or poor health were substantially less likely than those in excellent health to be satisfied with their care by all five measures assessed. Although those 85 years of age or older were less likely to have confidence in their physicians, they were more likely to be satisfied with the availability of care, compared with younger enrollees. Poorer enrollees and those needing help with ADLs because of a functional impairment were less likely to be satisfied with the availability and quality of medical care, compared with those who had higher income or did not need help with ADLs, respectively. African Americans, disabled-eligible enrollees, and urban residents were each less satisfied by one of the five measures, compared with their counterparts.

The reasons enrollees joined managed care plans, rather than remaining in traditional Medicare, were also similar in 1997 and 1998. However, in 1998, cost was less of an incentive and better benefits were more of an incentive, compared with 1997. In 1997, 43 percent of enrollees reported joining their managed care plan because of cost; only 36 percent reported this as a consideration in 1998. Slightly less than 19 percent of beneficiaries reported joining a managed care plan because of better benefits in 1997; this figure was 23 percent in 1998.

The share of Medicare managed care enrollees reporting prescription, optical, preventive, and dental coverage did not change meaningfully from 1997 to 1998. In 1997, about 84 percent of enrollees reported prescription coverage, 81 percent optical coverage, 96 percent preventive coverage, and 53 percent dental coverage. The following year, about 87 percent of enrollees reported prescription coverage, 82 percent optical coverage, 97 percent preventive coverage, and 55 percent dental coverage. The number of beneficiaries reporting coverage for nursing home services was slightly more than 25 percent in 1997 and slightly less than 24 percent in 1998.

Medigap insurance and access to care

Given the importance of supplemental insurance for beneficiaries' access to care, information on changes to Medigap regulations and trends in the supplemental insurance market are relevant to Medicare policymaking. As noted above, beneficiaries without supplemental insurance are more likely to report problems obtaining access to care, probably because of the financial burdens of cost sharing under Medicare.

The BBA and the BBRA included provisions that could increase access to care by increasing the availability of Medigap policies. MedPAC reviewed the Medigap provisions of these laws to assess their implications for beneficiary access, compiled information on current Medigap issues, and developed three findings with implications for future work:

- Low use of the Medigap guaranteed issue rights extended by the BBA likely reflects the higher costs and limited benefits provided by the policies, compared with Medicare managed care.
- Limited availability of Medigap policies for certain groups of beneficiaries lacking guaranteed issue rights—including those with end-stage renal disease (ESRD) who are younger than 65, those disabled and younger than 65, and some who voluntarily disenroll from a Medicare+Choice plan—may have implications for these groups' abilities to obtain needed care.
- Rising Medigap premiums, decreased provision of employer-sponsored supplemental insurance coverage, and increasing costs for pharmaceutical drugs are important trends because they tend to affect the desire for Medigap insurance, the ability to purchase it, or both.

Medigap insurance

Beneficiaries generally obtain supplemental coverage through employer-sponsored retiree health benefits, individually purchased Medigap insurance, or Medicaid. Some beneficiaries hold both employer-sponsored and individually purchased supplemental coverage. Analysis of the 1996 MCBS shows that 25 percent of Medicare beneficiaries had Medigap coverage, 31 percent had employer-sponsored coverage, and 4 percent had both. In general, Medigap policies offer fewer benefits at higher cost than do other forms of supplemental insurance or managed care plans (PPRC 1997).

TABLE 2-5

Satisfaction with care for noninstitutionalized beneficiaries enrolled in Medicare+Choice, by selected beneficiary characteristics, 1998

Characteristics	Strongly agree/ agree with "Physician checks everything"	Strongly agree/ agree with "Great confidence in physician"	Very satisfied/ satisfied with availability of medical care	Very satisfied/ satisfied with overall quality of care	Would recommend plan to family/friends
All	93.3%	94.0%	93.8%	95.0%	89.9%
Race					
African American	96.3*	95.2	95.8	96.5	88.2
White (R)	92.9	93.8	93.3	94.8	90.1
Other	94.7	95.9	98.1*	95.9	89.3
Ethnicity					
Hispanic	94.4	94.0	90.0	89.9*	87.0
Other	93.2	94.0	94.1	95.4	90.1
Age					
85+	90.5	90.5*	97.0*	94.9	90.4
Under 85	93.6	94.3	93.5	95.0	89.8
Self-reported health status					
Excellent (R)	93.7	95.7	95.3	97.1	91.2
Very good or good	94.4	94.9	95.6	96.4	92.2
Fair or poor	90.1*	90.1*	88.3*	89.3*	82.4*
Help with functional impairment					
Needed	91.5	93.4	90.5*	91.9*	87.0
Not needed	93.5	94.1	94.2	95.4	90.2
Medicare eligibility status					
Disabled	91.9	93.7	83.8*	92.4	85.3
Aged	93.4	94.0	94.6	95.2	90.2
Annual income					
Up to $10,000	91.9	92.1*	92.4	93.0*	90.6
More than $10,000	93.5	94.5	93.8	95.5	89.7
Place of residence					
Rural	90.0	94.1	91.2	97.9*	90.2
Urban	93.5	94.0	93.9	94.8	89.9

Note: * Difference between subgroups, or between subgroup and reference group (R), is statistically significant at a 0.05 level.

Source: MedPAC analysis of 1998 Medicare Current Beneficiary Survey Access to Care file.

However, decreases in the generosity of benefits offered by M+C plans and employer-sponsored coverage may lead to fewer differences among these sources of supplemental insurance in the future.

Medigap provisions of the Balanced Budget Act and Balanced Budget Refinement Act

Both the BBA and the BBRA extended guaranteed issue rights to additional groups.[11] Under these provisions, insurers who sell Medigap policies must accept all eligible individuals who apply, without regard to health status. By ensuring that beneficiaries can purchase Medigap policies, these provisions should also increase these beneficiaries' access to

11 The BBA also authorized high-deductible options for plans F and J, increased the portability of Medigap insurance in conformance with the Health Insurance Portability and Accountability Act (P.L. 104-191), and prohibited the sale of policies that duplicate Medicare managed care coverage or cover the deductible of a medical savings account.

care. However, the specificity of the guaranteed issue rights still leaves some individuals without guaranteed access to a supplemental policy.

The BBA guaranteed issue of Medigap plans A, B, C, or F, which do not include coverage of prescription drugs, to:

- any enrollee of an M+C plan or other Medicare managed care plan[12] whose plan is terminated, who moves out of the service area, or who terminates enrollment for cause;
- any beneficiary who terminates a Medigap policy to enroll in an M+C plan or other Medicare managed care plan for the first time, and subsequently disenrolls within the first 12 months;[13]
- any beneficiary whose Medigap policy is involuntarily terminated (for example, because of bankruptcy of the issuer) or who terminates a policy for cause;[14] and
- any beneficiary who loses employer-sponsored supplemental coverage.

Beneficiaries who enrolled in an M+C plan when first eligible for the Medicare program at age 65, and who then choose to return to FFS Medicare within the first 12 months of that initial enrollment, may purchase any Medigap plan, including those that cover prescription drugs.

These guaranteed issue rights pertain to beneficiaries ages 65 and older; issue rights for beneficiaries younger than 65 vary by state. Beneficiaries have 63 days from termination to exercise these guaranteed issue rights. During this period, insurers cannot refuse to issue a policy or put conditions on a policy, charge more based on an individual's health status or use of services, or impose a pre-existing condition exclusion.

The BBRA extended guaranteed issue rights parallel to those outlined in the BBA to beneficiaries ages 65 and older in Program of All-Inclusive Care for the Elderly. The legislation also gives beneficiaries whose M+C plans have been terminated the option of exercising their guaranteed issue rights within 63 days of notification of the plan's intent to terminate. They no longer have to wait until the plan has actually terminated, but may do so.

Impact of Balanced Budget Act provisions on access to Medigap and remaining access issues

Limited use of the guaranteed issue rights extended to involuntary disenrollees may reflect the higher costs and limited benefits provided under Medigap compared with Medicare managed care. Recent evidence suggests that among those involuntarily disenrolled from a managed care plan at the end of 1998, only 15 percent purchased Medigap insurance (Laschober et al. 1999). The likelihood of doing so was inversely proportional to the number of alternative managed care plans available; only 2 percent of those with more than five plans available, but 41 percent of those with no plans available, bought a policy. Individuals purchasing Medigap after being disenrolled from Medicare+Choice reported having higher premiums, higher out-of-pocket costs, and fewer benefits than they had previously. Two-thirds stated that they were "more worried now about their ability to pay health care bills."

As benefit packages for M+C plans become less generous the differences in coverage between Medigap and managed care plans may narrow. In addition, Medigap continues to provide supplemental coverage that affords individuals greater access to care than does the Medicare program alone.

The limited availability of Medigap for groups of beneficiaries who lack guaranteed issue rights is likely to influence access for those groups, particularly for those who also lack a managed care option. Voluntary disenrollees from managed care plans make up one such group. In addition to limiting and changing service areas, M+C plans may increase premiums and decrease benefits. If, in response to these changes, beneficiaries voluntarily switch to traditional Medicare, they have guaranteed issue rights only under conditions stipulated in the BBA (for example, disenrolling within 12 months of first-time enrollment in a managed care plan). Individuals with ESRD do not have guaranteed issue rights before their open enrollment period at age 65.[15] Approximately 25 percent of ESRD beneficiaries younger than 65 have no supplemental coverage. Similarly, the nonelderly disabled often lack supplementary insurance. It is estimated that approximately 30 percent of this group has no supplemental coverage.

Three additional trends in the Medigap insurance market may affect beneficiaries' desire for and ability to obtain supplemental coverage, and thus their access to care. Premiums for Medigap policies are increasing. At the same time, a decreasing percentage of employers are providing retirees with supplemental coverage. Finally, while prescription drug costs are increasing faster than costs for other Medicare services, few beneficiaries have Medigap policies that cover drugs, because such policies are either unavailable or expensive.

Premiums are rising and vary markedly across and within markets. Insurance experts estimate that the average premium in 1998–1999 was $1,500, with annual rate increases of 8-10 percent in 1999–2000 (Weller 1999). In addition, more insurers are selling attained-age

12 Other types of managed care plans include Medicare risk or cost HMO, similar demonstration plans, or a Medicare SELECT policy.

13 These beneficiaries may also return to their previous Medigap policy, which may offer drugs if the policy is still available.

14 Unless otherwise stipulated in state law.

15 See Chapter 6 for a discussion of Medicare's ESRD payment policies.

policies, in which premiums rise as a beneficiary ages. States regulate premium ratings and can allow any of three rating methods: attained-age, issue-age (premium set according to the beneficiary's age when the policy is first issued), or community rating (everyone in a market area is charged the same premium).

Fewer employers are offering retiree health plans, which potentially increases demand for Medigap insurance. In general, beneficiaries with employer-sponsored plans have lower out-of-pocket premium costs than do those in Medigap plans. Analysis of the 1996 MCBS indicates that those with employer-sponsored supplemental insurance paid, on average, $500 out-of-pocket for premiums (excluding the employer's share) while those with Medigap paid an average of $1,150. However, recent trends indicate that employers are decreasing retiree health benefits and increasing retiree cost-sharing for those benefits. The percentage of large employers offering supplemental health coverage to retirees 65 and older fell from 40 percent in 1995 to 30 percent in 1998 (EBRI 1999); a further decrease to 28 percent occurred in 1999.

Approximately two-thirds of beneficiaries with Medigap policies do not have drug coverage of any kind (Davis et al. 1999); increasing pharmaceutical costs will affect them disproportionately. Furthermore, most of the guaranteed issue rights included in the BBA (those limited to plans A, B, C, and F) do not include plans with a prescription drug benefit. Employer-sponsored plans, however, are more likely to provide prescription drug coverage. In 1995, only 14 percent of those with employer-sponsored plans had no prescription drug coverage.

Trends in beneficiaries' financial liability over time

Beneficiaries' out-of-pocket spending on health care (including acute health care services and premiums for Medicare and supplemental coverage) can be a large hurdle to access to care. Traditional Medicare has substantial cost-sharing requirements on some medical goods and services and provides no coverage for others, most notably prescription medicines and long-term care. The program also lacks catastrophic coverage, leaving some beneficiaries with significant health care needs at risk for considerable out-of-pocket expenses, which can deter them from obtaining needed health care services. Therefore, it is useful to determine the extent to which beneficiaries face a high degree of

Previous Medigap insurance regulation

Medigap insurance is regulated by both the federal and state governments. Before 1980, there was no regulation of Medigap policies, and many consumers held multiple, often duplicative policies. The "Baucus amendments" (P.L. 96-265) led to prohibitions on selling duplicate policies and provided for voluntary certification standards. To improve the consumer's ability to compare benefits and premiums, the Omnibus Budget Reconciliation Act of 1990 (OBRA-90) (P.L. 101-508) standardized benefit packages to 10 types, labeled A through J. The core benefit package (plan A) covers the coinsurance for Medicare Parts A and B, additional hospital days, and blood products. The remaining packages provide the core benefits plus various combinations of additional benefits. Only three of the policies—H, I, and J—cover prescription drugs. Given the large increment in premiums for Medigap policies with a prescription drug benefit, considerable selection effects are likely to be occurring in these plans. Plan A must be sold in all states; state regulations determine which other plans can be offered by insurers. Three states (Massachusetts, Minnesota, and Wisconsin) have Medigap standards that supercede the OBRA-90 legislation. Policies are guaranteed renewable. Insurers cannot terminate a policy except in certain circumstances, such as nonpayment of premiums. The OBRA-90 regulations apply only to policies sold after July 31, 1992.

An alternative form of Medigap insurance, Medicare SELECT, was also created under OBRA-90 and extended in 1995. This program allows insurers to establish restricted networks and cover only those services obtained through the SELECT network, with the exception of emergency care. Medicare SELECT plans must conform to one of the 10 standard benefit packages and are available in a limited number of states.

OBRA-90 also provided for an open enrollment period for the first six months in which beneficiaries are age 65 or older and enrolled in Part B. During open enrollment, beneficiaries cannot be denied a policy or issued a policy with medical underwriting. Pre-existing condition exclusions were limited to six months. After the open enrollment period, beneficiaries had no guaranteed issue rights to Medigap policies. OBRA-90 did not provide for an open enrollment period for beneficiaries leaving Medicare managed care plans to enroll in fee-for-service Medicare. Nonelderly disabled beneficiaries (including those with end-stage renal disease) also were not covered under the open enrollment provisions, although some states do provide protections for this group. ■

financial liability from health care spending.

MedPAC's analysis of Medicare beneficiaries' financial liability indicates that most beneficiaries do not spend a high percentage of income on health care. However, much of the total out-of-pocket spending is concentrated among a small percentage of beneficiaries.

This phenomenon reflects the lack of a catastrophic limit in the traditional Medicare program, which may or may not represent a shortcoming, depending on the perspective from which the program is viewed. If Medicare is viewed as a transfer program, high out-of-pocket spending by a small percentage of beneficiaries does not necessarily represent a shortcoming of Medicare because the program succeeds in transferring resources from the employed population to supplement the resources beneficiaries have available to pay for health care. If Medicare is considered to be an insurance program, however, the lack of catastrophic protection appears problematic because most private health plans place limits on the liability of their policyholders. The history of the Medicare program reflects these different perspectives. The program was not originally intended to provide catastrophic coverage, but policymakers implemented—and later repealed—annual out-of-pocket limits on hospital inpatient care and Part B services under the Medicare Catastrophic Coverage Act of 1998.

Four other findings from the analysis have important implications regarding beneficiaries' financial liability:

- Beneficiaries' out-of-pocket spending is heavily concentrated in three categories: medical provider services and equipment, prescription medicines, and premiums for supplemental coverage. To reduce beneficiaries' out-of-pocket liabilities and improve access to care, policymakers should focus on those attributes of Medicare coverage that most affect out-of-pocket spending on these categories.
- On average, beneficiaries spend a greater percentage of their budgets on their own health care than do people not eligible for Medicare (primarily those younger than 65).
- Financial liability from out-of-pocket spending on health care may actually be greater than that indicated by our

Cost sharing and uncovered services under Medicare

The traditional Medicare program has two distinct cost sharing systems. One is for services in Part A, which covers hospital inpatient services, care in skilled nursing facilities, some home health services, and hospice care. The other is for services in Part B, which covers physician services, laboratory services, durable medical equipment, hospital outpatient services, home health services not covered under Part A, and other medical services. Also, beneficiaries who choose Part B coverage are responsible for a premium unless they participate in Medicaid, which pays the premium for them. Finally, the traditional program does not cover some products and services at all, most importantly outpatient prescription medicines (with some exceptions), services in long-term care institutions, and long-term home and community-based care.

Medicare+Choice (M+C) enrollees typically face very different cost sharing than do beneficiaries in the traditional program. Under Medicare rules, cost sharing in M+C cannot be greater than cost sharing in traditional Medicare, but it can be less. If an M+C plan has expected Medicare revenues in excess of projected Medicare costs, it must do one of three things: (1) return the surplus to Medicare; (2) pass the surplus through to enrollees in the form of reduced cost sharing for covered services, additional benefits, or reduced premiums for the benefits; or (3) place the surplus in reserve in the Hospital Insurance Trust Fund or the Supplementary Medical Insurance Trust Fund. In nearly all such cases, plans have elected to pass the surplus to enrollees. However, plans cannot use the surplus funds to pay enrollees' Part B premiums. ■

TABLE 2-6 **Percentage of Medicare beneficiaries' income spent on health care, 1992–1996**

	Year				
	1992	1993	1994	1995	1996
Mean	19	17	19	19	18
Median	10	9	9	9	9
90th percentile	33	31	32	32	31

Note: Average annual sample size: 12,392. These results are based on individual, not household, data.

Source: MedPAC analysis of Medicare Current Beneficiary Survey Cost and Use files, 1992–1996.

Methods used for analyzing financial liability

Throughout this analysis, the basis for measuring beneficiaries' financial liability was out-of-pocket spending on health care, defined as the sum of beneficiaries' out-of-pocket spending on medical goods and services, Part B premiums, and premiums for private supplemental coverage and enhanced benefits under managed care.

The databases we used include the Medicare Current Beneficiary Survey (MCBS) Cost and Use files from 1992 through 1996 and the 1996 Consumer Expenditure Survey (CES). Although both the MCBS and CES collected data on health care spending, out-of-pocket spending on health care at the person level was much lower in the CES. In the CES, mean spending on health care by households made up entirely of Medicare beneficiaries was $2,466. The average number of people in these households was 1.4, so mean health care spending at the person level was $1,755 ($2,466 divided by 1.4). At the same time, mean out-of-pocket spending on health care in the MCBS was $1,950. The discrepancy likely was due, at least in part, to the fact that the MCBS cross-referenced traditional beneficiaries' use of services with Medicare claims data, but the CES did not.

As part of our analysis, we used the MCBS to analyze trends from 1992–1996. We adjusted dollars to 1992 levels using the gross domestic product deflator. Also, a measure of financial liability used throughout our analysis was the percentage of income that beneficiaries spent on health care. In the MCBS, income for married beneficiaries was reported as joint income, but health care spending was given at the individual level. Therefore, when we determined the percentage of income spent on health care, we divided each married beneficiary's income by 1.26, the ratio of the poverty line for two-person elderly households to the poverty line for single-person elderly households.

We also used the MCBS to compare the financial liability of beneficiaries enrolled in managed care plans, beneficiaries in the traditional program who had Medigap policies, and traditional program beneficiaries who had no supplemental coverage. We adjusted the results for the managed care enrollees and Medicare-only beneficiaries to represent the out-of-pocket spending on acute care that would occur if those populations had the same age and sex profiles as the population with Medigap. ■

analysis—and analyses by other researchers—because we exclude out-of-pocket spending on long-term care services in institutions. Annually, only about 6 percent of beneficiaries pay out-of-pocket for long-term care, but those that do tend to pay large amounts.

- Managed care enrollees have much less financial liability from health care spending, compared with beneficiaries in traditional Medicare who have Medigap policies. We compared these two groups because beneficiaries often choose between these two types of coverage. Lower financial liability likely indicates that managed care enrollment can improve beneficiaries' access to care. However, most beneficiaries with Medigap coverage could have enrolled in managed care, which suggests that Medigap coverage may have attributes that outweigh its higher cost.

The percentage of income beneficiaries spend on health care

One key way to measure the extent of financial liability is the percentage of income beneficiaries spend on acute health care. For most beneficiaries, this percentage is not extremely high. MCBS data indicate median values (half of all values are greater, the other half are less) of about 9 percent from 1992–1996 (Table 2-6).

However, our results also show a consistently wide range of percentages of income spent on health care. From 1992–1996, the percentages at the 90th percentile (greater than 90 percent of all values) were more than three times higher than those at the median (Table 2-6). There were between 36.7 million and 39.4 million beneficiaries each year from 1992–1996, meaning that 3.7 million to 3.9 million beneficiaries had spending levels above the 90th percentile.

Among low-income beneficiaries, the discrepancy between median and 90th percentile values was even more pronounced (Table 2-7). These differences occurred because about half of these beneficiaries also had Medicaid, which requires no premium payment and pays many health care costs that Medicare does not.[16] Because of the Medicaid coverage, dually eligible beneficiaries typically have little or no out-of-pocket spending, and generally spend small fractions of their incomes on health care. But among the low-income beneficiaries without Medicaid coverage, even relatively low levels of out-of-pocket spending can result in the spending of large shares of income. Therefore, low-income beneficiaries who have Medicaid coverage likely have much better access to care than do those who do not.

These large differences in values of the percentage of income spent on health care illustrate a weakness of Medicare. However, in considering changes to address this weakness, policymakers

16 An exception is the Specified Low-Income Medicare Beneficiaries program, which pays only for the Part B premium.

TABLE 2-7

Percentage of income spent on health care by low-income beneficiaries, 1992–1996

	Year				
	1992	1993	1994	1995	1996
Mean	41	35	43	41	40
Median	14	10	10	10	11
90th percentile	89	68	75	73	71

Note: Average annual sample size: 3,174. Low-income beneficiaries include those who do not live with a spouse and have incomes below the poverty line for a single-person elderly family, as well as those who live with a spouse and have joint incomes below the poverty line for a two-person elderly family. These results are based on individual, not household, data.

Source: MedPAC analysis of Medicare Current Beneficiary Survey Cost and Use files, 1992–1996.

should bear in mind that Medicare provides nearly universal coverage to the elderly, who are generally considered bad risks by private insurance. Further, the program has increased the well being of its covered population by improving its access to care and substantially reducing its financial burden from health care use (Moon 1996). For example, in 1996, Medicare paid about 50 percent of beneficiaries' total medical care expenditures, including long-term care, and paid about 63 percent of beneficiaries' acute care expenditures. Although beneficiaries were responsible for the remaining share of expenses, their financial liability was much less than it would have been in the absence of the program.

Which services contribute the most to out-of-pocket spending?

To the extent that policymakers want to reduce the likelihood that beneficiaries spend large percentages of income on health care, it is useful to know which goods and services account for the highest out-of-pocket spending. Policymakers could target the areas of Medicare cost sharing and uncovered services that contribute the most to high out-of-pocket spending. Also, it is helpful to know if there is a trend in how much beneficiaries spend on each service in relation to other services. Knowing how beneficiaries are changing their patterns of out-of-pocket spending could provide an early warning for policymakers about which services could become more (or less) troublesome in terms of beneficiaries' financial liability.

MCBS data show that from 1992–1996, four categories dominated mean out-of-pocket spending by beneficiaries: supplemental premiums, Part B premiums, medical provider and equipment, and prescription medicines (Table 2-8). However, adjusting all dollars to 1992 levels reveals that mean out-of-pocket spending on prescription medicines actually grew very slowly. Supplemental premiums, when adjusted for inflation, also grew slowly from 1993–1996 (1992 values reflect a different estimation methodology).[17] In contrast, mean out-of-pocket spending on dental services and outpatient hospital care grew much more quickly.[18] However, mean out-of-pocket spending on those services is much smaller in magnitude compared with the four dominant categories, so the dominant categories are likely to maintain that status in the future. Further, the 95th percentile values of out-of-pocket spending on three of the dominant categories—supplemental premiums, medical provider and equipment, and prescription medicines—are much larger than the 95th percentile values for other services. Therefore, policymakers concerned about reducing financial liability for beneficiaries with high out-of-pocket spending should focus on these categories.

Out-of-pocket spending on prescription medicines

Although our analysis shows prescription medicines to be one of the largest categories of out-of-pocket spending, the total effect of prescription medicines on beneficiaries' financial liability is probably even greater than the analysis reveals. Because Medicare does not cover prescription drugs, HCFA cannot cross-reference information supplied by MCBS survey respondents with Medicare claims data. Further, most beneficiaries have supplemental or managed care coverage that pays part or all costs for prescription medicines (Davis et al. 1999). Prescription medicine coverage increases premiums for supplemental coverage, which increases beneficiaries' out-of-pocket liabilities. Therefore, beneficiaries' financial liability has been affected both directly and indirectly by the substantial recent growth in spending—from $452 in 1992 to $581 in 1996, after deflating 1996 dollars to 1992 levels—on prescription medicines by all sources.

Persistence of financial liability

An important factor in determining the severity of financial liability is whether

17 Table 2-8 shows a large drop in out-of-pocket spending on supplemental premiums from 1992–1993, in large part because of a change in the method HCFA used in the MCBS to estimate supplemental premiums for beneficiaries who gave questionable responses. In 1992, HCFA assumed that nearly all beneficiaries who had supplemental coverage through former employers paid an out-of-pocket premium for that coverage. Therefore, HCFA usually estimated a positive premium for beneficiaries who reported they paid no premium for employment-related coverage. After 1992, HCFA assumed most beneficiaries who reported no premium were correct. Hence, average out-of-pocket spending on supplemental premiums appears to have dropped substantially from 1992–1993.

18 The percentage change in mean spending on inpatient hospital services was also quite high from 1992–1996: 34.4 percent. However, the mean level was flat from 1993–1996.

TABLE 2-8 **Out-of-pocket spending on health care by category for all beneficiaries, 1992–1996, adjusted for inflation**

Category	Statistic	Year 1992	1993	1994	1995	1996	Percent change 1992–1996
Supplemental premiums	Average	$620	$480	$473	$488	$498	–19.7%
	95th percentile	$1,616	$1,546	$1,518	$1,540	$1,642	
Part B premiums	Average	309	346	378	409	374	20.9
	95th percentile	382	428	469	515	466	
Medical provider & equipment	Average	277	278	318	331	323	16.5
	95th percentile	993	1,030	1,156	1,162	1,166	
Prescription drugs	Average	254	252	249	255	260	2.6
	95th percentile	1,011	1,038	1,018	1,043	1,033	
Dental	Average	110	113	116	128	141	28.6
	95th percentile	590	592	590	641	706	
Outpatient	Average	50	51	55	62	65	28.2
	95th percentile	230	230	239	258	278	
Inpatient	Average	43	57	63	56	57	34.4
	95th percentile	58	118	189	111	54	
Total and other	Average	1,681	1,601	1,683	1,765	1,758	4.6
	95th percentile	3,901	3,885	4,080	4,275	4,331	

Note: Average annual sample size: 12,424. These results are based on individual, not household, data. "Medical provider and equipment" category includes services by medical doctors and other health care practitioners, laboratory and radiology services, durable medical equipment, and nondurable supplies. Dollars were adjusted to 1992 levels using the gross domestic product deflator.

Source: MedPAC analysis of Medicare Current Beneficiary Survey Cost and Use files, 1992–1996.

that liability is short lived or persists over a number of years. A beneficiary who spends a high percentage of income on health care is less burdened if such spending lasts a short time rather than an extended period.

Our analysis reveals that levels of spending remained fairly consistent over a three-year period. For example, among beneficiaries who were at or above the 90th percentile of income spent on health care in 1994 and who lived through 1996, 41 percent were at or above the 90th percentile in 1995, and 29 percent were in the same range in 1996 (Table 2-9).

Out-of-pocket spending on long-term care in institutions

Medicare is intended to assist beneficiaries in paying for acute care services. The program does not cover long-term care in institutions, though out-of-pocket spending on long-term care substantially increases the financial liability of some beneficiaries. Because out-of-pocket spending on long-term care can drastically affect beneficiaries' financial liability, it can affect their access to care.

In any given year, only about 6 percent of beneficiaries pay out-of-pocket for long-term care. However, among the beneficiaries that do pay out-of-pocket, amounts typically are large. Among all Medicare beneficiaries, the 95th percentile value of out-of-pocket spending on long-term care exceeded $1,350 each year from 1992–1996 (Table 2-10). Compared with spending on acute care services (Table 2-8), such spending ranks among the largest categories. The possibility of facing such high levels of out-of-pocket spending can deter some beneficiaries from seeking long-term care when they need it.

Certain groups of beneficiaries bear particularly large burdens of out-of-pocket spending on long-term care. Over the 1992–1996 period, the 95th percentile values of out-of-pocket spending on long-term care were much higher for beneficiaries ages 85 and older than for the general Medicare population. Also, the 95th percentile values were relatively high for low-income beneficiaries. However, low-income beneficiaries generally had a lesser burden than did older beneficiaries, at least in part because Medicaid pays the long-term care expenses of many low-income beneficiaries.

Out-of-pocket spending by managed care enrollees versus traditional program beneficiaries

Because enrollment in Medicare managed care plans has grown rapidly in recent years, this population has become large enough that analysts have an interest in how its access to care compares with that of beneficiaries in the traditional program. This section examines differences between the two groups' financial liability on health care, which helps to indicate how financial liability affects differences in access to care. Here, "managed care" refers only to health maintenance organizations, because the

TABLE 2-9

Distribution of 1995 and 1996 percentage of beneficiaries' income spent on health care, by level of 1994 percentage of income spent on health care

1994 percentage of income percentile	1995 percentage of income percentile: 0–25	25–50	50–75	75–90	90+	Total*
0–25	64	16	10	6	4	100
25–50	24	46	20	7	4	100
50–75	11	24	44	16	6	100
75–90	7	12	25	41	15	100
90+	5	11	16	28	41	100

1994 percentage of income percentile	1996 percentage of income percentile: 0–25	25–50	50–75	75–90	90+	Total*
0–25	60	18	12	6	4	100
25–50	26	39	21	7	7	100
50–75	11	24	42	15	7	100
75–90	8	14	31	32	15	100
90+	8	10	23	29	29	100

Note: * Sums may not total 100 due to rounding. Sample size: 3,084. Analytic sample includes beneficiaries who were alive from 1994 through 1996 and in traditional Medicare over that period.

Source: MedPAC analysis of Medicare Current Beneficiary Survey Cost and Use files, 1994–1996.

TABLE 2-10

Out-of-pocket spending by beneficiaries on care provided in long-term care institutions, 1992–1996, adjusted for inflation

Population	Statistic	Year: 1992	1993	1994	1995	1996
All beneficiaries	Average	$573	$576	$597	$615	$642
	95th percentile	$2,263	$1,522	$2,074	$1,738	$1,350
Age 85 and older	Average	2,904	2,837	2,965	2,937	3,017
	95th percentile	20,316	20,705	21,169	20,692	21,828
Low income	Average	1,004	1,020	1,033	1,120	1,190
	95th percentile	6,118	6,474	6,613	6,909	7,191

Note: Average annual sample sizes: 12,424 for all beneficiaries; 2,049 for age 85 and older; 3,206 for low income. These results are based on individual, not household, data. Long-term care refers to services provided by nursing homes, retirement homes, mental health facilities, and other long-term care facilities. Dollars were adjusted to 1992 levels using the gross domestic product deflator.

Source: MedPAC analysis of Medicare Current Beneficiary Survey Cost and Use files, 1992–1996.

MCBS data include only that type of managed care.

Medicare managed care enrollees compared with beneficiaries with Medigap

We compare the financial liability of managed care enrollees to that of beneficiaries in traditional Medicare who purchased Medigap policies because many beneficiaries face the choice of these two options. In general, managed care enrollees have less financial liability for health care spending than do beneficiaries with Medigap, implying managed care may help beneficiaries' access to care. For example, from 1992–1996, managed care enrollees, on average, paid a lower percentage of income on health care (Table 2-11). Also, their mean out-of-pocket spending on health care was much lower (Table 2-12). However, the 95th percentiles of out-of-pocket spending for these two populations are more similar than are the mean values, which is due to the catastrophic limits of Medigap coverage. For example, the ratio of mean out-of-pocket spending by beneficiaries with Medigap to mean out-of-pocket spending by managed care enrollees was between 1.65 and 1.98 during the 1992–1996 period. At the same time, the ratio of 95th percentile values for the two groups was between 1.29 and 1.64.

The substantial differences in spending between managed care enrollees and beneficiaries with Medigap should be interpreted with the caveat that the data used precede the BBA. The increased cost sharing and reduced benefit packages that managed care enrollees have faced since the BBA, and the increase in premiums from 1999 to 2000, should narrow the financial liability gap.

Higher financial liability is not a failure of traditional Medicare

Higher out-of-pocket spending by beneficiaries with Medigap does not indicate a failure of the traditional program. Other factors, besides reducing

TABLE 2-11

Percentage of income spent on health care by beneficiaries with different coverage, 1992–1996

	Year				
Population	**1992**	**1993**	**1994**	**1995**	**1996**
Managed care					
Mean	12	14	15	13	18
Median	7	7	8	8	7
90th percentile	25	28	27	25	26
Medigap					
Mean	28	26	25	26	26
Median	17	15	16	15	16
90th percentile	43	40	40	40	39
Medicare only					
Mean	22	19	25	33	23
Median	10	10	11	11	11
90th percentile	31	32	39	47	34

Note: Average annual sample sizes: 992 for managed care; 3,185 for Medigap; 1,381 for Medicare only. These results are based on individual, not household, data. We adjusted the values for the managed care and Medicare-only populations to match values that would occur if those populations had the same age and sex profiles as the Medigap population.

Source: MedPAC analysis of Medicare Current Beneficiary Survey Cost and Use files, 1992–1996.

TABLE 2-12

Out-of-pocket spending on health care by beneficiaries with different coverage, 1992–1996, adjusted for inflation

		Year				
Population	**Statistic**	**1992**	**1993**	**1994**	**1995**	**1996**
Managed care	Average	$1,172	$1,312	$1,409	$1,439	$1,458
	95th percentile	$2,701	$3,198	$3,611	$3,402	$3,336
Medigap	Average	2,325	2,252	2,326	2,377	2,587
	95th percentile	4,451	4,514	4,644	4,589	5,226
Medicare only	Average	1,245	1,269	1,574	1,842	1,438
	95th percentile	3,100	3,128	4,275	5,136	3,818

Note: Average annual sample sizes: 993 for managed care; 3,192 for Medigap; 1,390 for Medicare only. These results are based on individual, not household, data. We adjusted the values for the managed care and Medicare-only populations to match values that would occur if those populations had the same age and sex profiles as the Medigap population. Dollars were adjusted to 1992 levels using the gross domestic product deflator.

Source: MedPAC analysis of Medicare Current Beneficiary Survey Cost and Use files, 1992–1996.

financial liability, affect beneficiaries' decisions to enroll or not enroll in managed care. Many beneficiaries with Medigap coverage could choose managed care, under which they would have less financial liability. They stay in the traditional program presumably because it, combined with Medigap coverage, has attributes that more than offset the additional cost.

Income also may play a role in the willingness of beneficiaries to pay higher out-of-pocket costs for Medigap. Managed care enrollees are more likely to have low incomes than are beneficiaries with Medigap. For example, 19.3 percent of beneficiaries with Medigap who lived in counties with at least one risk plan had incomes of up to $10,000 in 1996; 22.9 percent of managed care enrollees had incomes of up to $10,000. However, the income advantage of the beneficiaries with Medigap appears to be small—differences in the shares of beneficiaries in each of the higher-income categories are not statistically significant (Table 2-13).

Other effects of managed care enrollment on beneficiaries' access to care

In addition to improving beneficiaries' access to care by reducing their out-of-pocket spending, it appears that managed care also improves the access to care of many beneficiaries by improving their coverage. There is evidence that a large percentage of managed care enrollees who were in the traditional program lacked supplemental coverage before enrolling. In 1998, 26 percent of first-year managed care enrollees who changed enrollment from traditional Medicare did not have supplemental coverage in 1997. In contrast, only 13 percent of the beneficiaries who lived in a county with at least one M+C plan and remained in the traditional program in 1998 were without supplemental coverage in 1997 (Table 2-14).

If one examines out-of-pocket spending on health care and the percentage of income spent on health care by Medicare-

TABLE 2-13

Income distribution of managed care enrollees and beneficiaries with Medigap who have access to managed care, 1996

	Insurance category	
Annual income	**Managed care**	**Medigap with risk plan in county**
Up to $10,000	22.9%	19.3%
$10,000–25,000	45.7	47.8
$25,000–40,000	18.9	18.6
$40,000 or more	12.6	14.3

Note: Sample sizes: 1,375 for managed care; 1,683 for Medigap with risk plan in county. Income for single beneficiaries is their individual income. Income for married beneficiaries is their joint income.

Source: MedPAC analysis of Medicare Current Beneficiary Survey Cost and Use file, 1996.

TABLE 2-14

Previous year supplemental insurance for beneficiaries in traditional Medicare and first-year Medicare+Choice enrollees who were in traditional Medicare, noninstitutionalized population

	1998 Medicare+Choice enrollment	
1997 supplemental coverage	**Enrolled in Medicare+Choice**	**Remained in traditional program**
No supplemental	25.7%	12.5%
Private	58.8	70.4
Medicaid	5.0	14.0
Other public	3.4	1.6
Nonrisk health maintenance organization	7.2	1.4

Note: Sample sizes: 283 for enrolled in Medicare+Choice; 6,145 for remained in traditional program. Private coverage includes coverage obtained through former employers and individually purchased plans.

Source: MedPAC analysis of Medicare Current Beneficiary Survey Access to Care files, 1997–1998.

only beneficiaries, it is not clear whether managed care enrollment could improve their access to care. On the one hand, from 1992–1996, the mean percentage of income they spent on health care generally was higher than that of managed care enrollees (Table 2-11).[19] On the other hand, their mean out-of-pocket spending generally was similar to that of managed care enrollees (Table 2-12).

Managed care improves access to care for Medicare-only beneficiaries not because it reduces out-of-pocket spending, but because it provides more comprehensive coverage. Previous analysis indicates that Medicare-only beneficiaries use fewer services than they would if they had better coverage (PPRC 1996). Hence, managed care enrollees who previously were Medicare-only beneficiaries likely respond to the more comprehensive coverage under managed care by substantially increasing their use of services.

Equity in financial liability between beneficiaries and nonbeneficiaries

One of the initial goals of the Medicare program was to eliminate the inequity in access to care between beneficiaries and people not eligible for Medicare (Long and Settle 1984). Because financial liability affects access to care, comparing Medicare beneficiaries' financial liability on health care with the financial liability of individuals not eligible for Medicare (nonbeneficiaries) helps indicate the program's success in meeting this goal, and provides another perspective from which to view beneficiaries' financial liability.

Also, comparing what beneficiaries and nonbeneficiaries forgo to purchase health care provides information about the impact on beneficiaries of out-of-pocket spending. For example, if beneficiaries, on average, spend a relatively large fraction of their budgets on health care, are they able to make up for it by spending a relatively small fraction of their budgets on other essential items, or do they forgo items generally considered more discretionary?

Using the 1996 CES to compare the financial liability of beneficiaries and nonbeneficiaries indicates that Medicare may not have eliminated the access inequity between the two groups. Aggregate spending on health care by households with one or more Medicare beneficiaries was a much larger fraction of spending on all budget items, compared with households with no beneficiaries. Not only did beneficiaries face higher financial liability from health care, they were not able to make up for the difference by spending less on other essential budget items. That is, beneficiaries and nonbeneficiaries spent comparable percentages of their budgets on housing and food (Table 2-15).[20]

19 In 1995, the mean percentage of income spent on health care by Medicare-only beneficiaries was much higher than in other years. This was due, primarily, to an unusually large outlier value. If this value is removed, the mean falls to 24 percent in 1995.

20 These results are based on average household budgets of $18,782 for all-Medicare, $23,029 for some-Medicare, and $33,288 for no-Medicare.

TABLE 2-15

Percentage of aggregate expenditures on various budget items, 1996

	Percentage of aggregate expenditures		
	Households with Medicare beneficiaries		
Budget item	All-Medicare households	Some-Medicare households	No-Medicare households
Health care	13.1	11.1	4.2
Housing	35.2	33.7	31.9
Food	17.5	17.2	16.0
Transportation	17.4	19.0	21.0
Miscellaneous	6.8	7.1	6.0
Entertainment	4.3	4.5	5.5
Clothing	3.0	3.3	4.3
Pensions and payroll taxes	2.5	4.2	11.0

Note: Sample sizes: 3,001 for all-Medicare; 4,521 for some-Medicare; 15,361 for no-Medicare. In all-Medicare households, only Medicare beneficiaries are members. Some-Medicare households contain at least one Medicare beneficiary. No-Medicare households have no Medicare beneficiaries. "Pensions and payroll taxes" category includes life insurance; payroll deductions for Social Security, private pensions, and government pensions; and nonpayroll contributions to individual retirement plans.

Source: MedPAC analysis of Consumer Expenditure Survey data, 1996.

Need for continued monitoring of beneficiary access to quality health care

MedPAC believes that continued, close monitoring is required in a time of ongoing, fundamental change in Medicare program policies. The Commission is therefore concerned about the limited extent to which the Secretary has taken steps to assess and report publicly on the implications of Medicare policy changes for beneficiary access to quality health care. Although the Secretary was required to monitor and report annually to the Congress on beneficiary access to care, she has not issued a report since 1995 and the mandate has now expired. This former mandate, motivated by concerns that the move to a physician fee schedule could have negative implications for beneficiary care, has not been replaced with a comparable requirement to monitor changes in beneficiary access that might occur as a result of BBA-mandated changes in payment methods and amounts. Because many changes now under way in Medicare are comparable in scope to the phase-in of the physician fee schedule, MedPAC believes that a focused effort to identify emerging access issues, evaluate the nature and scope of access problems, and issue findings and recommendations for any needed policy changes is in order.

RECOMMENDATION 2A

The Secretary should periodically identify potential problems in beneficiaries' access to care that arise in the evolving Medicare program and should report annually to the Congress on findings from studies undertaken to examine those potential problems.

Although studies by both HCFA and PPRC have concluded that implementation of the Medicare fee schedule has not worsened existing access problems or caused new ones, continued monitoring is needed because of the nature and magnitude of ongoing changes in the Medicare program that could affect access.[21] To reflect current access issues, such monitoring might appropriately adopt a somewhat different focus and methodology for assessment. For instance, access monitoring efforts now need to account for the growing presence of the M+C program. Monitoring plan enrollees' access to services can provide information on the extent to which Medicare policy changes or other factors result in changes in enrollees' abilities to obtain needed medical care. M+C program growth may also have implications for ongoing efforts to monitor access to care of beneficiaries in the traditional program. For example, managed care growth could result in changes in the characteristics of the population remaining in the traditional program. Any such changes need to be accounted for in analyses of time trends. Such growth could also have a spillover effect on health care practices in the traditional indemnity sector.

Another access issue that must be considered in designing new monitoring systems is the question of how to obtain information on access to types of health care services for which beneficiaries may not be able to assess their own needs. Although monitoring access to physician services specifically, and monitoring access to care generally, can draw upon information from beneficiaries on their experiences and perceptions, beneficiaries may be less able to assess the extent of their own access to post-acute care services. Therefore, a plan for monitoring access to these services will likely need to rely on another source of routinely available data. MedPAC is sponsoring work to determine the feasibility of developing measures of beneficiaries' use of needed SNF care that draw upon routinely generated administrative data; this should provide information on the merit of this approach.

21 See MedPAC's June 1998 Report to the Congress for a summary and findings of previous studies of Medicare beneficiary access to care.

Monitoring access to physician services

The Omnibus Budget Reconciliation Act of 1989 (OBRA-89) established both Medicare physician payment reform and a mandate for the Secretary of Health and Human Services to monitor the effects of reform on beneficiary access to care. OBRA-89 called for the Secretary to monitor and report annually on changes in utilization and access to care by April 15 of each year (beginning in 1991). It also established a requirement that the Physician Payment Review Commission (PPRC) review and comment on the Secretary's report. Despite the OBRA-89 requirement, the Secretary has not issued a report on beneficiary access to care and service utilization since 1995; this may be due in part to the failure of previous studies to uncover changes in access.

The Secretary—like the PPRC—has failed to find any changes in beneficiary access as a result of implementing the Medicare Fee Schedule as a mechanism for paying physicians. Changes in use of services (such as a decline in cataract surgeries) could be explained by changes in medical practice or in the health care needs of the beneficiary population. Furthermore, no changes in the extent to which beneficiaries perceived problems obtaining medical services or in characteristics of beneficiaries more likely to experience problems were found in previous studies. Because the introduction of the fee schedule provided the impetus for the access reporting mandate, the failure to uncover changes in access limited the report's ongoing significance in terms of public policy.

The Secretary is expected to release early this year her final report on beneficiary access to physician services, although the mandate to report annually on beneficiary access expired December 21, 1999, in accordance with the Federal Reports Elimination and Sunset Act of 1995 (P.L. 104-66, Section 3003). According to HCFA staff, the Secretary's forthcoming report will be similar to previous reports in the types of analyses conducted, but will be scaled back from previous studies in terms of analytic scope and depth. The report will include descriptive data on changes in service use, drawing upon claims data from 1997 and earlier years, as well as analyses of beneficiary perceptions and experiences relating to access, drawing upon data from the 1997 Medicare Current Beneficiary Survey.

Upon release of this report to the Congress, MedPAC will issue comments on the Secretary's findings, methodology, and recommendations, if any. In developing its comments, MedPAC will draw on its own work to assess beneficiary access, as well as on the input of a panel of physician experts, as required by law. ■

In the absence of careful evaluations of the effects of new policies on beneficiary care, policymakers must rely on anecdotes and secondary sources of information in deciding how to proceed. Therefore, designing and conducting timely studies of access—and drawing reasonable conclusions and making policy recommendations on the basis of those findings—will remain an important function of MedPAC and should continue to be an important responsibility of the Secretary. ■

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