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DataWatch

Three Decades Of Medicare: What The Numbers Tell Us

by Margaret H. Davis and Sally T. Burner

Abstract: The Medicare program was first implemented to meet a critical need in American society, and over its thirty-year history it has evolved into an integral part of the U.S. health care system. This DataWatch provides a broad overview of the program, outlining both historical and current trends in coverage, financing, payment mechanisms, beneficiary status, benefits, and spending.

For three decades Medicare has provided millions of Americans with the security that they will be able to get important health care services when they need them. The program also has undergone many changes and has grown in ways its original designers never imagined. In this DataWatch we describe the evolution of the Medicare program.

Structure And Financing Of The Medicare Program

Coverage. When Medicare was enacted in 1965, the benefit package was patterned after the products most commonly sold by private insurance companies. Thus, Medicare is made up of two separate, complementary insurance programs, Hospital Insurance (HI, also called Part A) and Supplementary Medical Insurance (SMI, also called Part B). Part A covers inpatient hospital services, skilled nursing facility care, home health care, and hospice care for terminally ill beneficiaries (a benefit added in 1982). Part B covers physician services, durable medical equipment, outpatient medical services such as lab tests, physical and occupational therapy, and ambulance transportation. Recently, Part B coverage was extended to certain preventive services, including hepatitis B, flu, and pneumococcal pneumonia vaccines; Pap smears; and screening mammography.

Medicare does not offer coverage in a number of areas, including dental services, outpatient prescription drugs, hearing aids, most eyeglasses, and long-term nursing home care. The Medicare Catastrophic Coverage Act of 1988 would have provided for the most significant expansion of benefits

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since the program's inception, including coverage for most outpatient prescription drugs. However, the act was repealed in 1989.

Part A financing. Persons age sixty-five and older who are eligible for any type of Social Security benefits are automatically entitled to Part A, as are some disabled persons and persons with end-stage renal disease (ESRD). Other elderly persons who are not automatically entitled may purchase Part A with a monthly premium (\$261 in 1995). Under Part A, beneficiaries must pay a deductible and daily coinsurance for inpatient hospital services and coinsurance for skilled nursing facility (SNF) services. The deductible is updated each year, based on the weighted average of factors used for updating payments to hospitals. In 1966 the inpatient hospital deductible was \$40 per benefit period; by 1995 the deductible had grown to \$716. Coinsurance increases are tied to the increase in the hospital deductible.

Part A benefits and administrative expenses are paid from a trust fund that is financed primarily through payroll taxes on employees, employers, and self-employed persons. When Medicare began in 1966, the maximum taxable amount of annual earnings was \$6,600, and the contribution rate for employers, employees, and the self-employed was 0.35 percent. Today employers and employees each contribute 1.45 percent of maximum taxable annual earnings, and the self-employed contribute 2.9 percent. The Omnibus Budget Reconciliation Act (OBRA) of 1993 eliminated the maximum taxable earnings base for 1994 and later, so that now all earnings in covered employment are subject to the contribution rate.

Part B financing. Part B is voluntary and open to all Part A enrollees and most Americans age sixty-five and older. Part B beneficiaries pay an annual deductible, which has increased only three times during Medicare's thirty-year history: In 1966 the deductible was \$50; \$60 in 1973; \$75 in 1982; and \$100 in 1991. The deductible has not kept pace with program costs. If the deductible had increased at the same rate as covered charges, it would be more than \$1,000 in 1995.¹ Part B copayments have remained at 20 percent of allowed charges since the program's inception.

Part B benefits and administrative costs also are paid from a trust fund. However, this fund receives most of its income from general federal revenues and premiums. When Medicare began in 1966, beneficiaries paid \$3 a month for Part B coverage. Until 1976 the premium rate was set by law to cover 50 percent of program costs for aged enrollees. From 1976 to 1983 the percentage increase in the premium rate was limited to the percentage increase in Social Security benefits. However, because costs were rising faster than increases in Social Security benefits, the portion of program costs covered by the premium decreased greatly, to approximately 25 percent by 1983. Beginning in 1984 Congress legislated specific premium rates, intending to cover 25 percent of program costs. Because growth rates

slowed in 1992, the premium is now paying a higher proportion of costs. In 1995 the monthly premium of \$46.10 per beneficiary covered 31.5 percent of actual program costs. The premium will decrease in 1996, to \$42.10.

Medicare payment changes. In the first years of the program, Medicare payment mechanisms looked like those of the major private insurers of the late 1960s. Institutional providers were paid based on costs incurred. Physicians were paid based on “allowed charges,” which were determined by actual customary and prevailing charges. As program expenses grew, limitations such as fee screens began to be put on reimbursements. However, payments still remained tied to charges.

Perhaps the most significant changes in the Medicare program during the past thirty years have been the ways providers are compensated. These changes were prompted by concerns about trust fund solvency and about equity in compensation. Beginning in 1984 payment for hospital inpatient services was changed from a retrospective to a prospective basis. At the center of the new prospective payment system (PPS) was a classification of discharges into about 470 diagnosis-related groups (DRGs). Hospitals were paid a set amount for each patient according to the patient’s DRG classification; special exceptions were made for unusual cases (“outliers”), and expenses such as interest and depreciation continued to be paid on the basis of costs. Affecting some 80 percent of total Medicare inpatient hospital benefits, PPS has had a profound effect on trends in inpatient and outpatient use, as we describe below.

Changes were made to payments for physician services in 1992. Legislators and policy analysts were concerned that general practitioners were being paid too little and specialists too much, considering the time, supplies, and educational investment that went into those services. Accordingly, a resource-based relative value scale (RBRVS) was constructed to rationalize the relative payments for services provided. To prevent practitioners from “gaming” the system, a volume performance standard (VPS) also was instituted; if the volume of services exceeded a target established by historical patterns, payment per service would be reduced.

Managed care. At the time Medicare was enacted, the concept of managed care was not well known. However, from the outset Medicare legislation allowed for reimbursement to prepaid medical plans. Real growth in managed care in the private sector began during the 1970s. Growth in Medicare managed care during the 1970s and 1980s lagged behind that in the private sector: Not until 1985, when the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) was implemented, did Medicare develop prepaid risk contracts, and Medicare health maintenance organization (HMO) enrollment began to increase.

Medicare enrollment in managed care plans, while still small, has grown

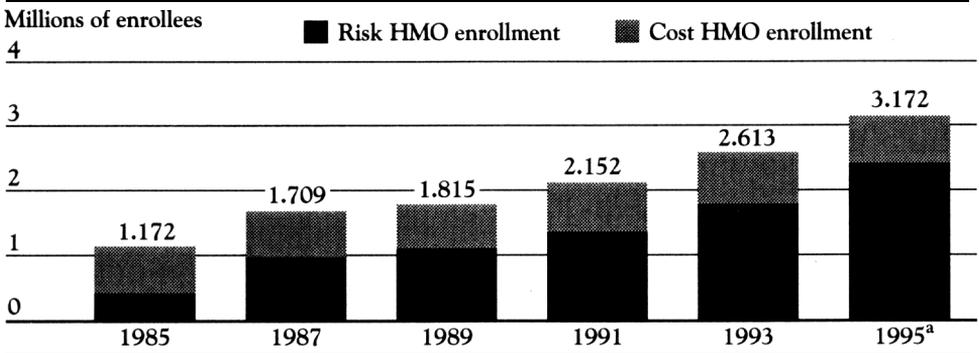
rapidly in recent years. Nearly three-quarters of all beneficiaries live in areas served by at least one Medicare managed care plan. In 1979 only sixty-four HMOs had Medicare contracts. As of June 1995 the number of contracting plans had risen to 250, enrolling 3.2 million Medicare members—about 9 percent of all beneficiaries (Exhibit 1). In fact, since 1989 the rate of growth of Medicare risk HMO enrollment has exceeded the rate of growth in HMO enrollment in the private sector; from December 1993 to December 1994 growth in Medicare risk HMO enrollment was 25 percent; enrollment growth among all privately insured HMO enrollees (excluding those in Medicare and Medicaid) was about 6 percent.²

Who Are The Medicare Beneficiaries?

Aged beneficiaries. Medicare was created as a health insurance program for the nation's elderly citizens and remains largely so today. When the program was enacted in 1965, only half of the elderly population was covered by health insurance.³ By 1967 nearly all of the aged population had gained access to health insurance coverage. Today some thirty-three million elderly persons (98 percent of the nation's elderly) are enrolled. Over the past thirty years the elderly have accounted for a continuously increasing share of the total population: 9 percent in 1966; 13 percent by 1995; and a projected 20 percent by 2030.⁴ In addition, the Medicare population has aged: In 1966 just 17 percent of beneficiaries were age eighty or older, compared with 24 percent today.

Disabled beneficiaries. Congress expanded Medicare in 1972 to cover disabled persons and persons with ESRD. In doing so, it made insurance accessible to a vulnerable population who had very limited access, if any, to

Exhibit 1
Medicare HMO Enrollment, 1985-1995



Source: Health Care Financing Administration, Office of Managed Care, 1995.

Note: HMO is health maintenance organization.

^aAs of June 1995.

insurance coverage. Disabled and ESRD beneficiaries made up almost 8 percent of the Medicare population in 1974 and have grown rapidly to 12 percent in 1994 and a projected 17 percent by 2010. The fastest rate of enrollment growth has been among the ESRD population. Between 1975 and 1982 the number of ESRD enrollees increased at an average annual rate of 13.7 percent, compared with 2.3 percent for all disabled persons (including ESRD) and 2.4 percent for aged beneficiaries. Between 1982 and 1992 the ESRD-only population grew an average of 10.1 percent per year, compared with 4 percent per year for all disabled persons and 1.9 percent per year for the elderly.

Beneficiary income. The economic status of the elderly as a group has improved during the past thirty years, although many elderly persons continue to live in precarious financial conditions. In 1966 nearly 29 percent of the elderly lived in poverty, compared with 12 percent now.⁵ Yet in 1992 nearly 80 percent of Medicare beneficiaries reported total gross income of less than \$25,000, and 35 percent reported less than \$10,000.⁶ Also, more elderly have had to rely on Social Security benefits as their major source of income. In 1992 nearly one-third of the aged relied on Social Security for 80 percent or more of their income, compared with one-quarter in 1971.

Health status and access to care. It is difficult to estimate the exact impact Medicare has had on health status, but over the past thirty years there have been some some major improvements in key health status indicators, such as greater longevity for the elderly.⁷ Self-reported health status also has improved over time: In 1993, 28 percent of elderly persons reported their health to be fair or poor, compared with 31 percent in 1976.⁸

Access to physician services also has improved. In 1993 the elderly averaged 10.9 physician contacts per year, compared with 6.7 contacts per year in 1964.⁹ Fears that Medicare's new physician payment system would degrade access to care were unfounded; since the fee schedule was introduced in 1992, physician visits actually have increased. In addition, claims data show that the total volume of services per beneficiary continued to grow after the fee schedule was introduced.¹⁰ In 1993 just 7.4 percent of the elderly reported not seeing a doctor in the past two or more years, compared with 21 percent in 1964.¹¹ As further evidence of financial access to care, in 1995 a record 75 percent of physicians and suppliers signed a participation agreement to accept assignment on all Medicare-covered services and to accept the Medicare-allowed charge as payment in full. Although access has improved over time, disparities still exist in access among different vulnerable groups, including African Americans, Hispanics, disabled persons, dual eligibles (those who qualify for both Medicare and Medicaid), the very old, and those without supplemental insurance coverage.

Use of services. Hospital use has changed dramatically since the early

years of the program, In 1972 Medicare beneficiaries had 302 discharges per thousand enrollees, with an average length-of-stay of 12.1 days (Exhibit 2). Between 1983 and 1993, after implementation of PPS, discharges per thousand decreased 2.2 percent per year and days by 4.2 percent per year.

SNF care is a small, rapidly growing Medicare benefit. Although it is still small, the number of persons per thousand beneficiaries receiving covered SNF care more than doubled between 1987 and 1993, from nine to twenty-five. Clarification of coverage criteria resulted in tremendous growth in SNF use between 1991 and 1993: Days of care increased by 45 percent over the two-year period. Health Care Financing Administration (HCFA) actuaries anticipate that growth in SNF use will moderate in the future.

Home health care has been one of the fastest-growing segments of the Medicare program. The number of beneficiaries receiving home health services increased from forty-nine persons per thousand enrollees in 1987 to seventy-one in 1992. The 1989 revisions of Medicare coverage guidelines resulted in significant growth rates. There were three and one-half times as many visits in 1993 as in 1989, an increase of about 36 percent per year. Exhibit 3 presents trends in the use of SNF and home health services.

The elderly's health care bill. Medicare pays for a substantial part of the health care bill of the nation's elderly population. In 1967 Medicare

Exhibit 2

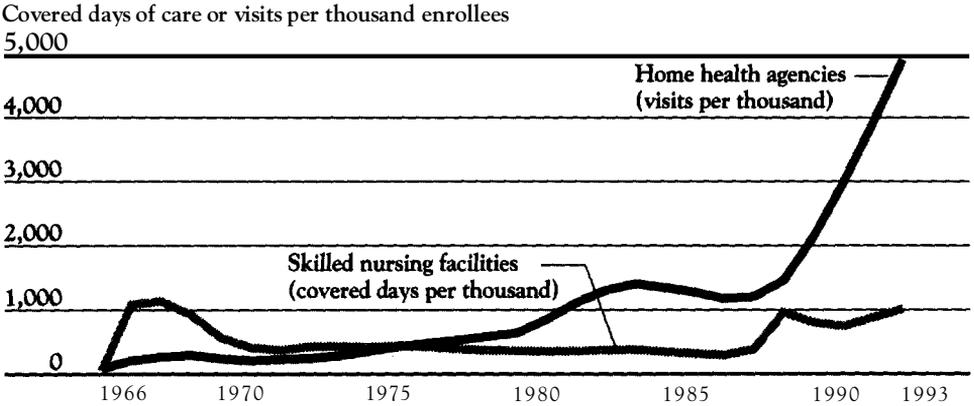
Short-Stay Hospital Discharges And Days Of Care, Calendar Years 1972-1993

Calendar year	Discharges		Days of care		
	Number (thousands)	Per 1,000 enrollees	Number (thousands)	Per 1,000 enrollees	Per discharge
1972	6,380	302	77,198	3,656	12.1
1975	8,001	325	89,275	3,623	11.2
1980	10,279	366	109,175	3,890	10.6
1985	10,027	328	86,339	2,822	8.6
1986	10,044	322	86,910	2,784	8.7
1987	10,110	317	89,651	2,815	8.9
1988	10,256	316	90,873	2,804	8.9
1989	10,148	307	89,902	2,721	8.9
1990	10,522	312	92,135	2,749	8.8
1991	10,896	316	93,936	2,728	8.6
1992	11,111	316	92,900	2,642	8.4
1993	11,158	311	88,671	2,474	8.0
Average annual rate of change					
1972-83	5.4%	2.3%	3.4%	0.3%	-1.9%
1983-93	-0.2	-2.2	-2.3	-4.2	-2.0
1972-93	2.7	0.1	0.7	-1.8	-2.0

Source: Health Care Financing Administration, Bureau of Data Management and Strategy, data from the Medicare Decision Support System; data development by the Office of Research and Demonstrations.

Exhibit 3

Medicare Use Of Skilled Nursing Facilities And Home Health Agencies, Covered Days Of Care Or Visits Per Thousand Enrollees. Calendar Years 1966-1993



Source: Health Care Financing Administration, Office of the Actuary, Office of National Health Statistics

payments accounted for 32 percent of that bill; by 1969 the proportion had increased to 45 percent and remained fairly constant through 1987.¹² However, Medicare is a negligible source of payments for long-term nursing home care, a large expense for many elderly persons, especially those age eighty-five or older. In 1987 nursing home care accounted for 20 percent of total spending by persons age sixty-five and older, and Medicare paid for less than 2 percent of those costs. When long-term care expenses are excluded from the elderly's spending, the proportion of expenses paid by Medicare increases to 55 percent.

While the Medicare share of the elderly's bill has remained stable, there has been a significant change among other sources of payment. In 1969 private sources (private premiums and patient copayments) paid for 31 percent of personal health care expenditures for the aged; other public sources (including Medicaid) paid for 24 percent.¹³ By 1987 the private share had increased to 37 percent, and the other public share had decreased to 18 percent.¹⁴ Eighty-nine percent of beneficiaries have some form of supplemental coverage that pays for part or all of Medicare copayments and other health expenses. This coverage may be employer-sponsored or self-purchased Medigap plans, Medicaid, or other governmental programs.

As with other large insurance programs, there is tremendous variation in the distribution of Medicare payments per enrollee. In 1992, 10 percent of enrollees accounted for almost 70 percent of payments. The small proportion of beneficiaries with high program costs has remained stable over time. The three groups of high-cost users are beneficiaries with ESRD, those who die during the year, and those who have an inpatient hospital stay. About

22 percent of enrollees had no payment made on their behalf, and an additional 33 percent incurred payments of less than \$500.

Medicare And The U.S. Health Care System

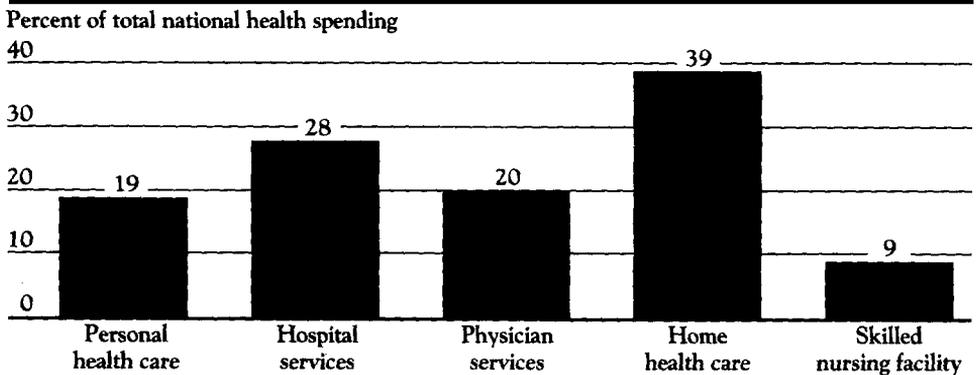
Medicare has contributed significantly to the U.S. health care system's structure and has served as a support system for critical providers and institutions. This influence can be seen in the growth in Medicare's share of total national health spending, expenditures for graduate medical education, payments to hospitals serving a disproportionate share of low-income persons, and payments to sole community providers in rural communities.

National health spending. Medicare grew from about 11 percent of total personal health care spending in 1967 to almost 20 percent by 1993 (Exhibit 4). It is a major source of payments for many of the categories of personal health care spending, although it pays less than 10 percent of the total nursing home bill and virtually none of the nation's dental services or prescription drugs.

Graduate medical education. In 1995 Medicare payments to hospitals for direct graduate medical education (GME) are estimated to be nearly \$2.2 billion. Medicare also makes payments to teaching hospitals to support the increased costs associated with operating intern and resident programs; in 1995 it will spend nearly \$4.5 billion for indirect GME.⁵

Disproportionate-share and sole community provider status. Through the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Congress authorized Medicare to include in its rates an adjust-

Exhibit 4
Medicare's Share Of Spending For Selected Categories, 1993



Source: Health Care Financing Administration, Office of the Actuary, 1994.

Notes: There is no "prescription drug" category in the trustees' report. The minimal amount that is spent for renal dialysis and drugs used in hospitals is included under "hospital services." Also, long-term care spending is incorporated into the categories "home health care" and "skilled nursing facility."

ment that provides additional payments to hospitals that serve a disproportionately large share of low-income patients. Without Medicare's support, many of these "safety-net" hospitals, particularly in inner-city and rural areas, would be forced to close, leaving beneficiaries and uninsured persons without access to health care. The amount Medicare has contributed to these hospitals has grown substantially over the past five years, from \$1.7 billion in 1990 to a projected \$4.2 billion in 1995.¹⁶

Medicare also makes supplemental payments to hospitals that are the only source of inpatient hospital services reasonably available to Medicare beneficiaries in a geographic area. Today, 728 hospitals qualify as sole community providers, receiving a total of about \$2.6 billion from Medicare.¹⁷ Again, without these supplemental payments, many of these hospitals would have to close their doors.

Administrative costs. Medicare's administrative costs have always been minimal and have decreased over time as a share of total program spending. Recently they have averaged less than 2 percent of program spending. Private-sector administrative costs are much higher: 5.5 percent in the large-group market and 25 percent in the small-group market.¹⁸

Medicare contracts with "fiscal intermediaries" to process Part A claims and with "carriers" to process Part B claims. These contractors include Blue Cross/Blue Shield plans or other private insurance companies. In the first years of the program Medicare had agreements with approximately 136 contractors, which processed nearly twenty-eight million claims per year. Over the years the number of contractors has gradually declined, to about seventy-four today. However, the number of claims processed has skyrocketed. In 1995 the Medicare program will handle nearly 785 million claims for Part A and Part B services.

Figures on net cost per claim illustrate the increasing efficiency of the program. In 1975 the average cost per claim for Part A (intermediaries) was \$3.84 and for Part B (carriers) was \$2.90; by 1994 those costs had decreased to \$1.51 and \$1.21 per claim, respectively—nearly a 60 percent reduction. The use of electronic submissions of claims is the largest contributor to contractor unit cost efficiencies. HCFA has ambitious goals to standardize and automate claims processing and continues to promote the submission of electronic claims. In fiscal year 1995, 95 percent of all Part A bills and 75 percent of all Part B claims were received electronically.

Medicare Spending: Benefit Growth Trends

Overall Medicare spending has grown rapidly during the past thirty years (Exhibit 5). By 1993 Medicare spending reached \$154 billion, growing at an average annual rate of 14.1 percent. The rate of growth has not been

Exhibit 5

Medicare Expenditures, By Type Of Service, Selected Years, 1966-1993

Calendar year	Total	Hospital care	Physician services	Home health care	Other services ^a	Nursing home care	Program administration
1966	\$ 1,823 ^b	\$ 1,233 ^b	\$ 446 ^b	\$ 5 ^b	\$ 15 ^b	\$ 0 ^b	\$ 1206
1970	7,700	5,268	1,656	60	74	244	398
1975	16,396	11,490	3,370	192	322	293	729
1980	37,521	26,339	7,983	653	1,003	411	1,131
1981	44,884	31,580	9,457	849	1,233	452	1,313
1982	52,466	36,756	11,271	1,092	1,572	491	1,284
1983	59,762	41,190	13,299	1,340	1,992	521	1,421
1984	66,465	45,680	14,788	1,576	2,307	560	1,554
1985	72,190	48,898	16,546	1,598	2,651	579	1,918
1986	76,929	50,910	18,925	1,528	3,115	578	1,873
1987	82,304	52,963	21,819	1,466	3,567	624	1,865
1988	89,361	56,345	24,290	1,587	3,953	938	2,247
1989	102,606	62,822	27,250	1,978	4,622	3,450	2,485
1990	112,064	68,521	29,952	3,010	5,702	2,414	2,466
1991	123,291	74,906	31,380	4,255	7,097	2,859	2,794
1992	138,281	84,197	32,351	5,914	8,428	4,525	2,865
1993	154,202	92,700	34,817	8,072	9,388	6,124	3,101
Average annual percent growth							
1967-93	14.1%	13.9%	13.7%	21.7%	23.0%	12.1%	11.3%
1967-76	16.6	18.0	13.8	21.2	28.8	1.0	18.4
1976-84	16.4	16.0	18.0	24.2	23.8	6.3	7.3
1984-93	19.8	17.2	14.3	37.7	13.0	46.4	:::

Source: Health Care Financing Administration, Office of the Actuary, Office of National Health Statistics.

^a Combines the categories "medical durables" and "other professional services."

^b Millions of dollars.

constant, however, as general economic conditions, payment innovations, and coverage expansions all have affected growth. From 1967 to 1984 the program grew at an average annual rate of 16.5 percent. Implementation of PPS in 1984 curbed inpatient use dramatically, and growth slowed to 9.2 percent per year between 1984 and 1991. Then, in 1991-1993, with the rapid growth in home health and SNF care, Medicare spending again reached double-digit growth rates—1.8 percent per year on average.

Hospital payments (both inpatient and outpatient) account for more than 60 percent of total spending and thus have a big impact on the growth of overall spending. Prior to PPS, hospital payments were growing at 17.1 percent per year. The impact of PPS was dramatic: During the first six years of PPS the growth in inpatient hospital spending slowed to 5.7 percent per year, followed by a slight acceleration in growth through 1993. While

inpatient spending was slowing, outpatient payments increased at an average annual rate of 13.9 percent between 1984 and 1993.

Physician services are the second-largest component of spending, accounting for almost a quarter of total program payments. Between 1967 and 1993 physician payments grew at an average annual rate of 13.7 percent (Exhibit 5). The recent RBRVS program appears to be successful in restraining cost increases, however. Growth in Medicare physician payments slowed to an average annual rate of 5.3 percent between 1991 and 1993.

In recent years home health and SNF services have been the fastest-growing components of Medicare spending. Home health spending grew at an average rate of 18 percent per year between 1967 and 1989, and at an average rate of 34 percent per year between 1989 and 1993, after major eligibility expansions. Even with this phenomenal growth, home health still only accounts for about 5 percent of total Medicare spending. However, Medicare is the primary payer for all home health services, paying slightly less than 40 percent in 1993.

The recent acceleration of SNF spending is more dramatic. Prior to 1989 spending for SNF services was the slowest-growing component of Medicare spending, averaging only 5.4 percent per year between 1967 and 1988. There was a huge jump of 268 percent in SNF spending in 1989 as a result of the implementation of the Medicare Catastrophic Coverage Act. With the repeal of that act in 1989, SNF payments decreased by 30 percent. But as with home health, clarification of coverage regulations caused SNF payments to grow almost 40 percent per year between 1991 and 1993. Unlike home health, Medicare is not a major source of payment for SNF services; it paid for only about 9 percent of total SNF expenses in 1993.

Benefit growth compared with the private sector. It is not very useful to compare recent changes in Medicare spending and private insurance spending on an aggregate basis, since Medicare enrollment has been growing at about 2 percent per year, while the number of persons with private health insurance has been declining.¹⁹ On a per enrollee basis, the growth comparison shows mixed results. The growth rate of Medicare spending averaged 7.1 percent per year between 1984 and 1991, less than the annual growth in private health insurance benefits per insured person during the same period (Exhibit 6).²⁰ Beginning in 1992 the situation reversed, with the private sector growing more slowly than Medicare. This slower growth is primarily due to private-sector shifts from high-cost fee-for-service plans to lower-cost managed care plans, at a rate much more rapid than for Medicare enrollees.²¹ There also is evidence that employers are reducing benefits and increasing cost sharing for their employees and retirees, while the benefit package for Medicare enrollees is unchanged.²²

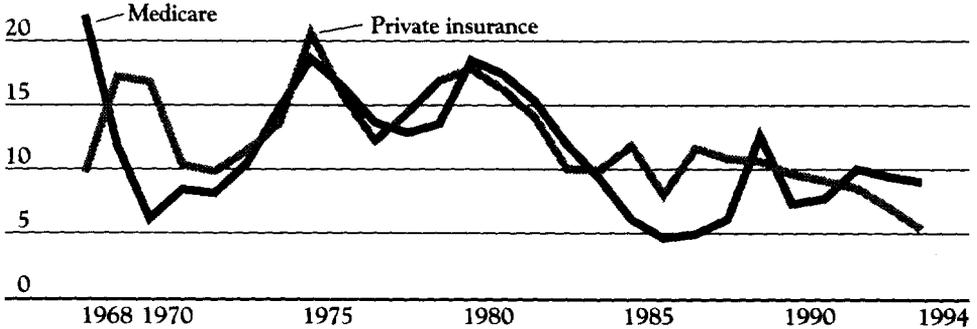
In a recent analysis, Urban Institute researchers attempted to put Medi-

Exhibit 6

Growth In Expenditures Per Enrollee, Medicare Versus Private Insurance, Calendar Years 1968-1994

Annual percent increase

25



Source: Health Care Financing Administration, Office of the Actuary, 1995.

care and private spending on a more comparable basis, by removing home health and SNF benefits from Medicare spending and prescription drugs from private health insurance benefits.²³ On this adjusted basis, Medicare grew more slowly than private spending each year between 1985 and 1992 and only exceeded private growth by 0.3 percent in 1993.

Conclusion

As Congress and the nation debate the future of Medicare, it is useful to examine the program's history, goals, and trends. Medicare has achieved its most basic goal: expanded access and health care benefits for millions of elderly and disabled Americans. The vast majority of beneficiaries today report high satisfaction with the quality of medical care they receive.²⁴ The elderly also report feeling "peace of mind" because of Medicare.²⁵

Medicare has pioneered new methods of provider payment and has played a central role in the development of new models of health care delivery. Medicare also has remained committed to strengthening and preserving essential institutions in thousands of communities throughout the country. As we move toward the twenty-first century, Medicare must evolve to meet the challenges of a more complex and rapidly changing health care system, while maintaining its commitment to assure equal access to the best health care available.

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