1988

Serving the Elderly: Need Versus Policy

Wornie L. Reed
University of Massachusetts Boston

TROTTER INSTITUTE

Serving the Elderly: Need Versus Policy

Wornie L. Reed

OCCASIONAL PAPER

WILLIAM MONROE TROTTER INSTITUTE
UNIVERSITY OF MASSACHUSETTS AT BOSTON
BOSTON, MASSACHUSETTS 02125-3393

Occasional Paper No. 15

Serving the Elderly: Need Versus Policy

Wornie L. Reed

Director, William Monroe Trotter Institute

Presented at the Annual Meeting of the Society for the Study of Social Problems, August 23, 1988 in Atlanta, GA.

Director, William Monroe Trotter Institute
University of Massachusetts at Boston

Medicare was established in 1965 under Title XVIII of the Social Security Act. It was originally meant to eliminate the financial barriers to medical care for the aged. It has been called a form of national health insurance for persons age 65 and over. But it was deliberately designed in a manner to avoid modification of the fee-for-services system that is the basis of American Medical Care (Estes, 1979). As a result, inflation in the cost of care has seriously reduced financial benefits to the beneficiaries and in turn limited the access to medical care by the elderly.

Background

Medicare covers all elderly persons regardless of income. On the other hand, Medicaid eligibility is determined by income, rather than age; low income persons are covered by Medicaid. While Medicare requires co-insurance and deductible payments by the beneficiary, Medicaid provides comprehensive coverage for health care services for the poor. The need for (and dependency on) Medicare is most pronounced among the low-income elderly who can least afford private health insurance. Even with Medicare, however, older persons are required to pay part of the costs for some services out of their own pockets.

As general health care costs increase, there are also increases in the share that the older person must pay. Thus the older person is not entirely freed by Medicare from the financial burdens of hospital and medical costs. To some extent, the additional costs that are not covered by Medicare may be paid by Medicaid, where available, in the state where the older person lives.

Medicaid is a public-welfare program for low-income persons of all ages. However, the elderly poor are the primary users and beneficiaries of Medicaid (U.S. DHEW, 1978). Moreover, Medicaid has been the fastest growing budgetary item in state welfare programs since 1975 (U.S. DHEW-OHDS, 1985).

The costs of Medicaid are paid with matching federal and state funds. Further, Medicaid permits each state to determine its own eligibility requirements for applicants who seek services through its programs. Generally, persons who are eligible for benefits under Supplemental Social Insurance (SSI) and under Aid to Families with dependent Children (AFDC) are also eligible for Medicaid (Coalition on Women and the Budget, 1983). Of special importance to the elderly infirm is the provision of unlimited nursing-home care without requiring previous hospitalization (Kart, et al., 1978). The current mood against welfare for the poor in the United States suggests that as poverty increases, or becomes protracted, as for example, among members of the permanent underclass, the greater will be the demands for "out-of-pocket" resources, and "third party liability." Third party liability – primarily through private health insurance – is the major alternative to Medicare and Medicaid for covering health care costs (HCFA, 1985).

Although, in 1981, the median income of elderly persons was high enough to keep most of its members above the poverty level, many live below the poverty level. And when the "near" poverty level is considered, some 30 percent live in poverty or near poverty (Huttman, 1985). Among the black elderly, over one-third live below the poverty level.

What this means is that, despite Medicare, a large segment of the elderly do not have access to medical care or have no means to pay for it. Furthermore, it cannot be assumed that Medicaid finances health care services for all of the poor. Many elderly persons do not qualify for Medicaid because of various state eligibility policies. For example, owning a home makes one ineligible for Medicaid. As a result of the restrictions on Medicaid coverage, about 60 percent of the poor (of all ages) are not covered by Medicaid (Davis and Rowland, 1986).

During the past four years, Medicare premiums, deductibles, co-payments, and other fees to be paid by patients have increased. Ceilings have been imposed on

what doctors and hospitals can charge the government under Medicare, but in many cases the excess charges have been passed on to the patient, or services have been reduced. Today, nationwide, Medicare pays for about 49 percent of the total health care costs of older citizens, and Medicaid pays about 13 percent. The rest is paid out-of-pocket, either directly or through private insurance plans; those who can not afford these costs may not go to the doctor or purchase prescribed medicines.

With the rapid rise in health care costs, Medicare protection is gradually being eroded. In 1980, older Americans (65 and over) paid, on the average, $327 out of their pockets for health care services. This figure, which includes insurance costs, means that the elderly pay 18.5 percent of their medical care costs.

Medicare neither provides comprehensive coverage for all health care services nor completely pays for those services it does cover. Cost-sharing mechanisms, such as co-insurances and deductibles, reduce the benefit levels, such that only 74 percent of the total costs incurred for hospital care and 55 percent of costs for physician services were paid by Medicare.

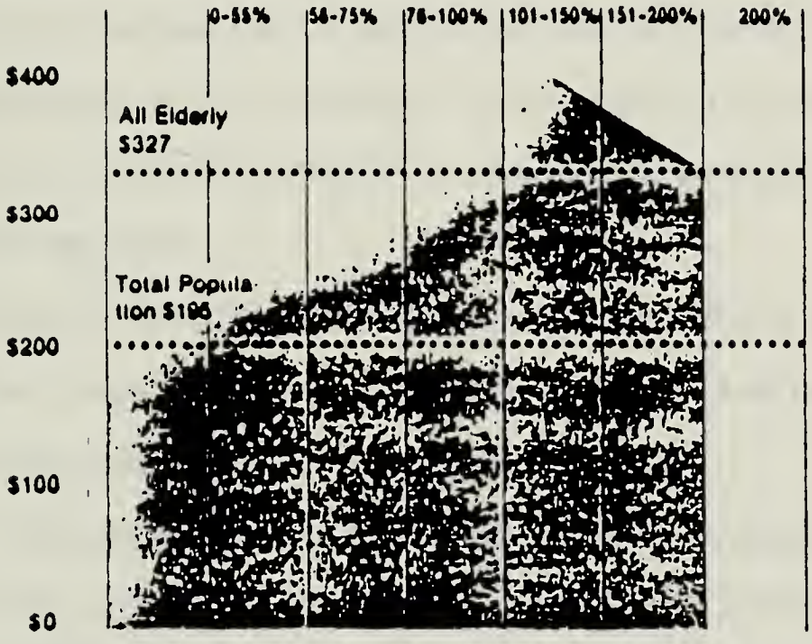
It is the near-poor elderly who bear the brunt of out-of-pocket costs, as the elderly who were between 101 and 150 percent of the poverty level in 1980, paid more out-of-pocket medical expenses ($391.85) than any other poverty level grouping. (See Figure 2).

Health and Medical Care of the Poor Elderly

Table 1 shows an analysis of the health and medical care characteristics of poor and near-poor elderly. The data used in this analysis were derived from the 1977 National Medical Care Expenditure Survey (NMCES), which provided detailed national estimates of the use of health services, health expenditures, and health insurance coverage. This table examines the role of public insurance programs for

Figure 1

Mean per capita out-of-pocket expenses of the elderly, by poverty level, 1980.



Source. Unpublished draft, Deliverable. No. 305F, Health Care Financing Administration, February 28, 1983. Howell, E., Corder, L., and Dobson, A., Out-of-Pocket health expenses for Medicaid and other poor and near poor persons in 1980

the elderly whose incomes were less than 125% of the poverty line (Berk and Wilensky, 1984).

For the purpose of this analysis these poor elderly were divided into three groups. The first group consisted of the approximately 1.4 million Medicare beneficiaries who lacked private health insurance and did not receive Medicaid assistance. The second group was the 1.5 million Medicare beneficiaries who also had Medicaid but lacked any private coverage. The third group included over 3 million poor elderly who had private or other coverage to supplement their government financed insurance.

Race. More than one-half of the poor elderly blacks (54.9%) have either Medicare and no other insurance or they qualify for Medicaid. And only 5.4 percent of the blacks had private supplemental insurance.

Health Status. The population with both Medicare and Medicaid was in poorer health than the population with private insurance or with Medicare only. On the other hand, the Medicare only group and the private and other group did not differ very much by health status.

Utilization. The medical care utilization data (physician visits) in Table 1 demonstrates that the absence of supplemental insurance such as Medicaid or private coverage has a major impact on the use of Medical services by the poor elderly since they do not have the resources to purchase services out of their pockets. Those poor elderly with Medicare and Medicaid, who are the sickest, have the largest mean number of physician visits per year. However, those who had Medicare only had fewer visits than those with private or other insurance despite the fact that they tend to be in slightly worse health.

Out-of Pocket Expenses. The elderly with Medicare and Medicaid coverage but no private insurance – the poorest group – had a relatively low out-of-pocket per capita expense; however, the next group on an SES scale would be those

Table 1

Health and Medical Care Characteristics of the Poor Elderly, 1977

Type of Coverage	Total Population	Percentage Non-White	Percentage with Fair or Poor Perceived Health Status	Mean number of Physician Visits	Mean Out-of-Pocket Expense
Medicare Only	1,364,000	21.0	37.4	4.2	$290
Medicare and Medicaid	1,484,000	33.9	50.5	7.0	$97
Private and Other	3,031,000	5.4	33.0	6.5	$329

Source: National Medical Care Expenditure Survey, National Center for Health Services Research (cited in Berk and Wilensky, 1984).

persons with Medicare only, who had an out-of-pocket expense level close to the most "well-off" of these poor and near poor elderly. Undoubtedly, this contributed to the low utilization rate of this group.

Table 2 shows the per capita spending and sources of funds for personal health care expenditures for persons 65 years of age and older in 1984. Out of a total average yearly expenditure of $4,202, two-thirds of the costs are paid by government sources and one-third by private sources, mostly the beneficiary (32.4%), as 25.2 percent was paid for medical care and 7.2 percent was spent for insurance coverage.

Out-of-pocket Costs By Health Status and Income

In a recent experimental study on beneficiary-oriented cost containment we analyzed out-of-pocket costs by health status and by income (Reed, 1988).

Methods

In this study actuarial calculations were used to provide estimates of future average annual medical costs for persons not on Medicaid who are just turning 65 years of age, and an estimate of who would be the payers of those costs depending on the actions of the individual in selecting insurance coverages and seeking out medical care providers who accept Medicare assignment (Accepting assignment means accepting the government's fee schedule). Medical care costs were restricted to those services covered (at least in part) by Medicare plus prescription drugs.

A range of estimates was prepared depending on the recent medical history of the individual. The average annual costs were taken to mean a weighted average of costs in the next five years, the weights being the probability of survival to that year times a discount factor for time value of money. Costs were adjusted for inflation only to the extent that medical care costs are expected to exceed the general inflation rate.

Table 2

Per capita spending and sources of funds for personal health care expenditures for persons 65 years of age and older-1984.

Payer	Total	Hospital Care	Physicians' Services	Nursing Home Care	Other Care
Total	$4,202	$1,900	$868	$880	$554
Private	32.8	11.4	39.7	51.9	65.3
Consumer	32.4	11.0	39.6	51.2	64.8
Out-of-pocket	25.2	3.1	26.1	50.1	59.9
Insurance	7.2	7.9	13.5	1.1	4.9
Other	0.4	0.4	.0	0.7	0.5
Government	67.2	88.6	60.3	48.1	34.7
Medicare	48.8	74.8	57.8	2.1	19.9
Medicaid	12.8	4.8	1.9	41,5	11.4
Other	5.6	9.1	0.7	4.4	3.4

Source: U. S. Health Care Financing Administration, Bureau of Data Management and Strategy. HCFA Statistics. Washington, D.C.: Government Printing Office, 1984, P.21

The resulting rates represent the average cost for all Medicare enrollees. They were adjusted to reflect the average experience of non-institutional, non-welfare Medicare eligibles age 65-69. Seven health statuses were defined based on an individual's recent medical experience. The definitions were dictated largely by the availability of a data base in which the future costs of a cohort could be followed after a medical event. This data base is the Medicare History File which contains the Medicare bills of 5% of eligibles for the years 1975 to 1978. Tabulations for these estimates were prepared by the Bureau of Data Management and Strategy at the Health Care Financing Administration (HCFA).

The tabulations divided the sample of eligibles into seven cohorts depending on their medical experience in 1975. The seven cohorts were defined as follows:

(1) Those hospitalized for heart disease or neoplasms of certain internal organs in 1975

(2) Those hospitalized for diabetes, arthropathy, or ulcers in 1975

(3) Those hospitalized with other diagnoses for over 20 days in 1975

(4) Those hospitalized with other diagnoses for 6-20 days in 1975

(5) Those hospitalized for less than 6 days in 1975

(6) Those not hospitalized in 1975, but with enough Medicare outpatient expenses to meet the part B Deductible

(7) Those with no Medicare reimbursement in 1975 (i.e., those who had medical expeditures less than the $75 deductible)

The per capita Medicare reimbursement was calculated for each of those seven cohorts and for the total of all seven in 1975, 1976, 1977, 1978.

The average annual cost as just described for each of the seven health status cohorts was then divided among four payers: Medicare, self, private insurer supplementing Medicare, and physicians' foregone fees when assignment is accepted. The division of such costs depends on the choices of the beneficiary of

which supplemental insurances to buy and whether or not to seek out physicians who accept assignment.

Findings

Seven options are illustrated in this table which shows the average expected distribution of costs for a male in our best broad health status group:

1. Medicare Part A only (beneficiary refuses Part B)
2. Medicare Parts A and B only
3. Medicare A & B and use a primary physician who takes assignment
4. Medicare A & B and use all physicians who take assignment
5. Medicare A & B and a typical HMO option
6. Medicare A & B and a typical Medigap policy
7. Medicare A & B, a typical Medigap policy and use of only physicians who take assignment.

For background, Tables 3 and 4 are provided. They show the expected out-of-pocket cost calculations (in 1986 dollars) of a sample of new Medicare enrollees in the Rochester, New York area. Table 3 shows these distributions for a male in the best health status category (no hospitalization, 3 or fewer physician visits). Table 4 shows the expected distribution of costs by payer for a female in the worst health status (a perosn hospitalized for heart disease or neoplasms of certain internal organs); Table 5 shows the out-of-pocket costs by health status organized into three broad groupings: poor health, fair health, and good health. In addition to the great differences in out-of-pocket payments by health status there are also great differences by provider practice and insurance coverage.

Of particular interest here is the distribution of the elderly in this cost breakdown. The bottom of Table 5 shows that of this sample of 800 new Medicare enrollees some 88 percent had HMO or private supplemental insurance, a proportion that is higher than the average of all persons over 65 years of age.

TABLE 3

Monroe County - Average Annual Cost of Medical Care
Male Health Status 7 - Ages 65 to 69

Payer	No Assignment		Medicare Parts A & B		Medicare with Supplemental Ins.		
	Part A Only	Parts A & B	Primary Assign	All Assign	HMO	Medigap no Assign	Medigap all Assign
Medicare	$ 772	$ 986	$ 986	$ 986	$1591	$ 986	$ 986
Physician	0	0	73	98	0	0	98
Supplemental	0	0	0	0	-679	-87	-87
Beneficiary	$ 797	$ 583	$ 510	$ 485	$ 711	$ 707	$ 609
Total	$1569	$1569	$1569	$1569	$1623	$1607	$1607

TABLE 4

Monroe County - Average Annual Cost of Medical Care
Female Health Status 1 - Ages 65 to 69

Payer	No Assignment		Medicare Parts A & B		Medicare with Supplemental Ins.		
	Part A Only	Parts A & B	Primary Assign	All Assign	HMO	Medigap no Assign	Medigap all Assign
Medicare	$3241	$4292	$4292	$4292	$1345	$4292	$4292
Physician	0	0	65	286	0	0	286
Supplemental	0	0	0	0	3542	292	292
Beneficiary	$2407	$1356	$1291	$1070	$ 815	$1101	$ 816
Total	$5648	$5648	$5648	$5648	$5702	$5686	$5686

Table 5

Average Annual Direct Cost of All Care (Premiums, Copays, etc.)
Ages 65-69

	No Assignment		Medicare A & B		Medicare with Supplemental		
	Part A Only	Parts A&B	Primary Assign	All Assign	HMO	Medigap no Assign	Medigap all Assign
HEALTH STATUS							
Poor Health[1] (High Cost)	$2253	$1310	$1252	$1050	$709	$1028	$768
Fair Health[2] (Medium Cost)	$1471	$927	$857	$750	$657	$839	$662
Good Health[3] (Low Cost)	$840	$611	$537	$510	$607	$666	$565

1. Generally indicates major health problem (example, heart disease) with long annual hospital stay.
2. Generally indicates chronic health problem (example ulcers) with a short hospital stay.
3. Generally indicates good health with regular check-ups, minor chronic problems.

(Percent by Income)

INCOME							
≥24,000	5.1	–	1.1	–	5.9	1.2	25.1
20,001 -24,000	1.7	–	0.2	–	2.6	0.4	15.0
$15,000 -20,000	1.1	0.2	0.2	–	2.8	0.4	16.0
$10,000 -15,000	0.7	–	0.7	–	1.7	0.2	10.5
≤$10,000	0.4	–	1.0	–	0.5	0.4	5.2
Totals (100%)	9.0		3.1		13.6	2.4	71.8

On the other hand there were still 12 percent who did not have supplemental insurance and 9 percent who had only Part A of Medicare – which means they would be expected to pay, on the average, between $840 and $2,253 out of their pockets for health care depending on their health condition.

Table 6 shows the out-of-pocket costs by sex and income for a specific health status category – health status 6, a "fair" health status: persons not hospitalized, but with more than three physician visits, during the preceding year. Over 6 percent of these persons had no Part B coverage, no supplemental insurance, physicians who did not accept assignment, and the potential liability of $1,600 or $1,300 out-of-pocket costs per year for males and females, respectively. And few of them could afford such costs.

Conclusion

What these data indicate are quite simply the fact that we have a policy that does not fit the need – or the promise. Despite the originally expressed intentions of the medicare program, the acquisition of medical care is still a function of personal finances.

Table 6

Monroe County - Average Annual Out-of-Pocket Costs of Medical Care by Sex, Income
Health Status 6 - Ages 65 to 69

Characteristics	No Assignment		Medicare Parts A & B		Medicare with Supplemental Ins.		
	Part A Only	Parts A & B	Primary Assign	All Assign	HMO	Medigap no Assign	Medigap all Assign
Sex							
Males	$1,614	$953	$826	$747	$771	$932	$726
Females	1,321	819	717	653	749	849	683
Income			(Percent)				
≥$24,000	1.3	–	1.3		7.8	1.0	24.7
$20,001 - 24,000	2.6	–	–		0.7	–	16.9
$15,001 - 20,000	0.7	–	–		2.6	0.7	14.3
$10,001 - 15,000	0.7	–	0.7		1.3	–	11.0
≤$10,000	0.7	–	2.0		2.0	0.7	6.5
Totals 100 =	6.1		4.0		14.4	2.4	73.4

References

Coalition on Women and the Budget. (1983). Inequality of Sacrifice: The Impact of the Reagan Budget on Work. Washington, D.C.: National Women's Law Center.

Davis, K., and D. Rowland. (1983). "Uninsured and Underserved: Inequities in Health Care in the United States." Millbank Memorial Fund Quarterly, 53 (Fall): 449-88.

Estes, C.L. (1979) The Aging Enterprise. San Francisco: Jossey-Bass Publishers.

Health Care Financing Administration (HCFA) (1985). Third Party Liability in the Medicaid Program: A Guide to Successful State Aging Practices. Washington, D.C.: United States Government Printing Office.

Huttman, E.D. (1985). Social Services for the Elderly. New York: Free Press.

Kart, C.S., E.S. Metress, and J.F. Metress. (1978). Aging and Health: Biologies and Social Perspectives. Mentre Park, CA: Addison-Wesley.

Reed, W.L. (1988). A Test of the Value of Expected Out-of Pocket Cost Savings as an Incentive for Changing Beneficiary Choice Behavior. Final Report and Executive Summary, August 1988. Grant No. 17-C-98392.

U.S. Department of Health and Human Services (U.S. DHEW). (1978) Health United States. PHS No. 78-1232. Public Health Service, National Center for Health Statistics. Washington, D.C.: Government Printing Office.

U.S. Department of Health and Human Services, OHDS (U.S. DHHS OHDS) (1985). Social Services In the Year 2000: Proceedings of a Symposium. (DHHS Publication Number OHDS, 85-10012). Washington, D.C.: U.S. Government Printing Office.