ANALYSIS PLAN

MEDICARE CURRENT BENEFICIARY SURVEY

OVERVIEW

As health care costs mount and America's population ages, the Medicare program becomes an increasingly pivotal issue in national politics.

Certainly this is the case regarding the Federal budget. Much is made of the impending insolvency of the Part A trust fund, but there is a more immediate budget issue in the form of general revenue going to Part B. In Federal fiscal year (FY) 1970, 0.5 percent of Federal on-budget receipts was spent on SMI – about a tenth of the 5.4-percent on-budget deficit that year. In FY 2002 SMI outlays consumed 5.4 percent of receipts, almost a third of the 18.3-percent deficit. And in FY 2007, projections show SMI outlays to be 5.5 percent of receipts, almost three quarters of the 7.3-percent deficit.

Medicare is also a pivotal issue in terms of the number of people touched by the program. The size of the elderly population in the United States is growing, in number and in its share of the total population. Over the past half century, the elderly U.S. population (those aged 65 years and older) increased in numbers, from 12.3 million people in 1950 to 35.0 million in the year 2000. During that same time period, elderly people increased as a proportion of the population, from 8.2 percent of all Americans to 12.4 percent. Government projections of the population growth put the number of elderly Americans at 82.0 million in the year 2050 — 20.3 percent of the total population. And for each elderly person affected by the Medicare program there are likely to be several children concerned about their parent's health and financial well-being.

From a public policy perspective, then, it is essential to understand how and how well Medicare is meeting the needs of its population. It is equally important to be able to speculate reliably on the economic consequences of changes to the program, both for the Federal government and for Medicare beneficiaries.

The Medicare Current Beneficiary Survey (MCBS) is the ideal survey to provide this information. It is specifically designed to produce the data needed to assess the feasibility, impact, and costs of proposals to change Medicare, and to monitor the impact of broader health care changes on Medicare beneficiaries. It provides a unique analytical data set for use by analysts who seek to understand how Medicare interacts with the social, economic, and demographic life factors of its beneficiaries. Unlike other health services research surveys, the MCBS is focused on the Medicare population, resulting in data that can be used to detect and to simulate broader changes than can be done with smaller data sets.

The Medicare Current Beneficiary Survey is also an ideal vehicle to monitor the impact of health reforms over time. Being continuously in the field with a stable instrument, it provides data to examine the effects of health care reform through pre- and post-reform comparisons. MCBS users can detect changes in health insurance coverage, beneficiary satisfaction with care, health status, use of services and public and private expenditures for health care very rapidly. The analytical power of the data is enhanced by a routine oversample of disabled enrollees and the oldest old – groups of particular policy interest.

USES OF MCBS INFORMATION

Tracking performance

As an indication of its usefulness for program evaluation, CMS is using MCBS data to measure five of the Performance Goals in its FY2004 Government Performance and Results Act (GPRA) Annual Performance Plan. These goals involve:

- Influenza and pneumococcal vaccination,
- Use of mammography services,
- Effectiveness of dissemination of Medicare information to beneficiaries,

- Beneficiary understanding of basic features of the Medicare program, and
- Awareness of opportunities to enroll in Medicare Savings Programs.

Baseline cost estimates

The CMS Office of the Actuary is regularly required to make cost estimates for proposed changes in the Medicare program. These estimates are prepared for CMS leadership, for the Department, OMB, and the White House; and for the Congress. Accurate cost estimates depend upon current and reliable data on the patterns of health service use and expense of the Medicare population. Person-based use and expense data, which the MCBS provides, are particularly valuable in estimating costs. They permit analytic differentiation between persons with and without certain characteristics, such as secondary insurance coverage, or across variables that are graduated or scaled, like income.

Typically it is difficult or impossible to produce cost estimates for Medicare program expansions solely from Medicare administrative data. Proposals usually affect subpopulations of enrollees along income lines, supplementary insurance characteristics, and the like – information not collected by the program. A prime example was provided by the debate over the cost of prescription drug coverage under the Medicare Catastrophic Coverage Act (1988) .In order to obtain baseline data on the current cost of drugs for the Medicare population, the Office of the Actuary had to rely on external data sources that were outdated and not completely suited for the task. This resulted in an inability to produce a generally accepted set of cost estimates for the drug benefit until after the legislation was enacted. Without the MCBS, similar problems can be expected in obtaining baseline data for the cost of program restructuring or expansions. The MCBS addresses this problem by providing a complete picture of the use of all health services by the Medicare population, most particularly those services not covered under Medicare for which administrative records are not available.

A recurring question that arises in estimating costs of program expansions is the size of "induced demand." This factor, also called the “insurance effect,” reflects the increase in use and expenditure that occurs when Medicare coverage is extended to a previously uncovered service. Induction can occur in the short term and in the long term, and there is considerable uncertainty over its size in the Medicare population. By providing utilization rates for services not covered by Medicare, distributed by secondary insurance coverage status and health status, the MCBS assists estimation of the magnitude of the induction factor.

After the fact, the longitudinal nature of the MCBS provides the capability to compare cost estimates to actual experience. This provides a feedback mechanism to validate and improve cost estimation techniques. Empirical verification of the cost associated with induced demand should greatly support the actuaries' estimation and incorporation of this phenomenon in subsequent cost estimates.

Analysis of supplementary health insurance

A primary information need when evaluating changes to Medicare is the extent and type of supplementary health insurance coverage among the Medicare population. Program changes intended to promote more cost-effective choices by Medicare beneficiaries, if they are to achieve their ends, depend on accurate knowledge of the extent of supplemental health insurance coverage, and its effect on point-of-service beneficiary liabilities, deductibles and coinsurance.

The MCBS continuously collects detailed information on the number and type of additional policies owned by beneficiaries. It also documents any shifts in coverage by health insurance policies. Information is available on supplemental insurance expenditures for all type of services--including those, which Medicare does not cover, such as prescription drugs and long term nursing care.

In addition to aiding in estimates of the cost of potential new benefits, information on the distribution of secondary insurance coverage of services facilitates analysis of who is likely to be affected by proposed changes. The MCBS collects a wide variety of person-level socioeconomic and demographic data, allowing an evaluation of which sub-populations will be most helped by Medicare program expansions.

Analysis of alternatives to fee-for-service Medicare

The relatively rapid rise (and collapse) of the Medicare+Choice (M+C) program has focused attention on how managed care and other alternatives to fee-for-service (FFS) benefits work or could work in the Medicare program. The MCBS has been used—and continues to be used—to compare experience of enrollees in M+C and FFS, especially as utilization patterns of M+C enrollees are not recorded in the administrative data systems. The ability to oversample in geographic areas heavily served by M+C plans was used for several years to boost the number of survey participants enrolled in those plans, providing information about the differences in life factors, program knowledge, and program satisfaction in the M+C and FFS populations.

Monitoring and evaluating the effects of program changes

The Medicare Current Beneficiary Survey is the best vehicle to monitor and evaluate the impact of Medicare changes over time. Because it is continuously in the field with a stable panel of beneficiaries, it can be used to examine the effects of Medicare program changes through pre- and post-reform comparisons. Using the MCBS, analysts can detect changes in secondary health insurance coverage, health status, satisfaction with care, use of Medicare services and out-of packet expenditures for health care. The analytical power of the data is enhanced by a routine oversample of disabled enrollees and of the oldest old, and by periodic oversamples of other populations of policy interest.

Access to care

An example of the value of the MCBS for monitoring and evaluating program changes is the issue of access to care. The reconciliation acts of 1989 and 1990 changed the way in which Medicare pays physicians. In the face of widespread concern that physician payment reform might have the unintended consequence of decreasing the Medicare population's access to physician care, Congress mandated that CMS and PPRC monitor access and prepare annual reports to Congress on their findings. Both CMS and PPRC relied on the MCBS as the primary data source in their analyses of the impact of physician payment reform on access to physician care.

Correlates of health care

Health services research has demonstrated that health and health care use do not operate in a vacuum. There are intricate and little-understood connections between health and health care and social, economic, and demographic life factors. MCBS data have been used to examine the effects of:

Income and wealth on access and health status,

Access to nursing homes, access to transitional care, and the relationship of housing characteristics, residential patterns, and social context (within the family, among friends and neighbors) on use and access to health services,

Other public insurance, such as the Qualified Medicare Beneficiary (QMB) program, on use of services (a special supplement was added to the MCBS to evaluate the extent to which the benefit is being used, and to determine the best means to reach eligible persons), and

Medicaid spend-down on use patterns for both community and institutionalized individuals.

Institutional and long term care facilities, and other living arrangements

The past decade has been witness to rapid growth of retirement communities and other forms of living arrangements between the tradition single-family dwelling and the traditional nursing home. What is not well understood is how people in those various settings perceive and need Medicare. Through the MCBS, information is available on the array of services available to enrollees who live in different settings, and on the characteristics of those enrollees. The MCBS can be used to identify patterns that predict institutionalization and compare the characteristics that lead to this over time, including living arrangements, age and degree of disability or dependence as measured by ADLs and IADLs.

MCBS data are being used to study long term home health care and transitional (post acute) care and long-term care rendered by providers such as hospitals and rehabilitation

facilities. The MCBS provides detailed information on the financing of all forms of long term care and sources of payment for these services including third party payments and out of pocket or family expenditures.

Analysis of the balance between institutional and noninstitutional services, availability, cost and living arrangements can be examined by comparing information collected by both the community and the facility components. Extensive information is collected on home health- care in the community component, thus facilitating comparisons of the two groups (institutionalized and non-institutionalized) by functional status, selected demographic characteristics and patterns and cost of utilization over time.

Variations in Medicare need and use among subgroups of enrollees

Many older studies of the Medicare population focused upon the elderly as a homogenous group, primarily because of sample size concerns. The MCBS is a rich data base focused on the elderly and the disabled, which allows analysis of a variety of subgroups that are of particular interest to policy makers, such as the dually eligible enrollees, near-poor elderly enrollees, disabled enrollees, the oldest old, people living alone, the working elderly and people living in rural areas. It is an ideal data set for use in policy studies that increasingly focus on subsets of the Medicare population.

The MCBS collects detailed information on persons who have dual, or crossover, coverage for Medicaid and Medicare. Most proposals for health care system reform pay close attention to this group of low-income elderly persons. The data collected permit detailed comparisons of differences in demographic and socioeconomic characteristics for dual-eligible persons compared to those with Medicare-only entitlement, as well as comparisons of use rates and expenditure differences for these two populations. This information improves our understanding of how the dually-eligible enrollees contribute to the expenditure growth of both programs. It also provides an information base for evaluating the person and expenditure impacts of changes to either Medicare or Medicaid that have feedback or transfer payment effects on the other program.

The MCBS collects detailed data on income and assets, allowing analysis of the near poor elderly who are of particular policy interest. This type of analysis is of particular interest at the present, as Congress debates legislation offering subsidies for drug insurance to low-income enrollees: do they use prescription drugs in different patterns? Do they have other forms of drug insurance?

MCBS will provide a rich data source for the analysis of the health care use and expenditure patterns of non-elderly Medicare beneficiaries. Crosscutting person level data are available about this subgroup, including demographic characteristics, initial reasons for eligibility, utilization patterns and access to health care. Analysts can examine the effects of any health care reform initiatives on disabled beneficiaries' financial liability and access to care.

The continuous nature of the survey shows trends in the type and distribution of services by the Medicare population over time. For example, analysts can track the effects of the aging of the elderly population on use of services and health expenses. Because of its structure, the MCBS can be used to separate cohort effects from secular effects in Medicare trends.

Information about the nation's health dollar

CMS is responsible for maintaining the U.S. National Health Accounts. These accounts comprise estimates of the nation's total annual expenditures for health care, by type of service and channel of payment. Figures are estimated not only for past years, but for future years as well. The National Health Accounts are the official federal government estimates of health care spending; as such, they are the essential information for understanding the current system of financing health care.

Capture all personal health care expenditures for the Medicare population, the MCBS provides a complete picture of more than 40 percent of the nation's health expenditures. Used in connection with other data, this information will strengthen the accuracy of the National Health Accounts, making them a better tracking tool for the financial effects of health care reform on the total health system. This is an important contribution to improving the data that is widely used to form the nation's picture of the directions, progress and problems of its health sector.

SUMMARY: SHAPING THE FUTURE HEALTH CARE SYSTEM FOR THE ELDERLY

The MCBS is a continuous information system to monitor emerging structural changes in the U. S. health care financing and delivery system. Linking survey collected information with the CMS administrative files further expands the power of the data to provide not only a continuous service use record, but to allow prospective estimates to be made.

The MCBS provides a rich information base about trends and changes in the types of care received, the settings for care, and more general changes in the patterns of medical practice. This information will allow us to identify and report on significant trends and changes as they are occurring. It will also provide detailed information on beneficiaries' health status and history, their ability to perform activities of daily living, their insurance and financial position, and their family circumstances and support systems. This information will be essential to evaluating the financial, social, administrative, and political feasibility of proposals intended to expand current alternatives in order to meet the needs of the growing elderly population of the U.S.