

Program Information

*on Medicare, Medicaid, SCHIP,
and other programs of the*

Centers for Medicare & Medicaid Services



Office of Research, Development, and Information

June 2002 Edition



CMS Web-Based Chart Series

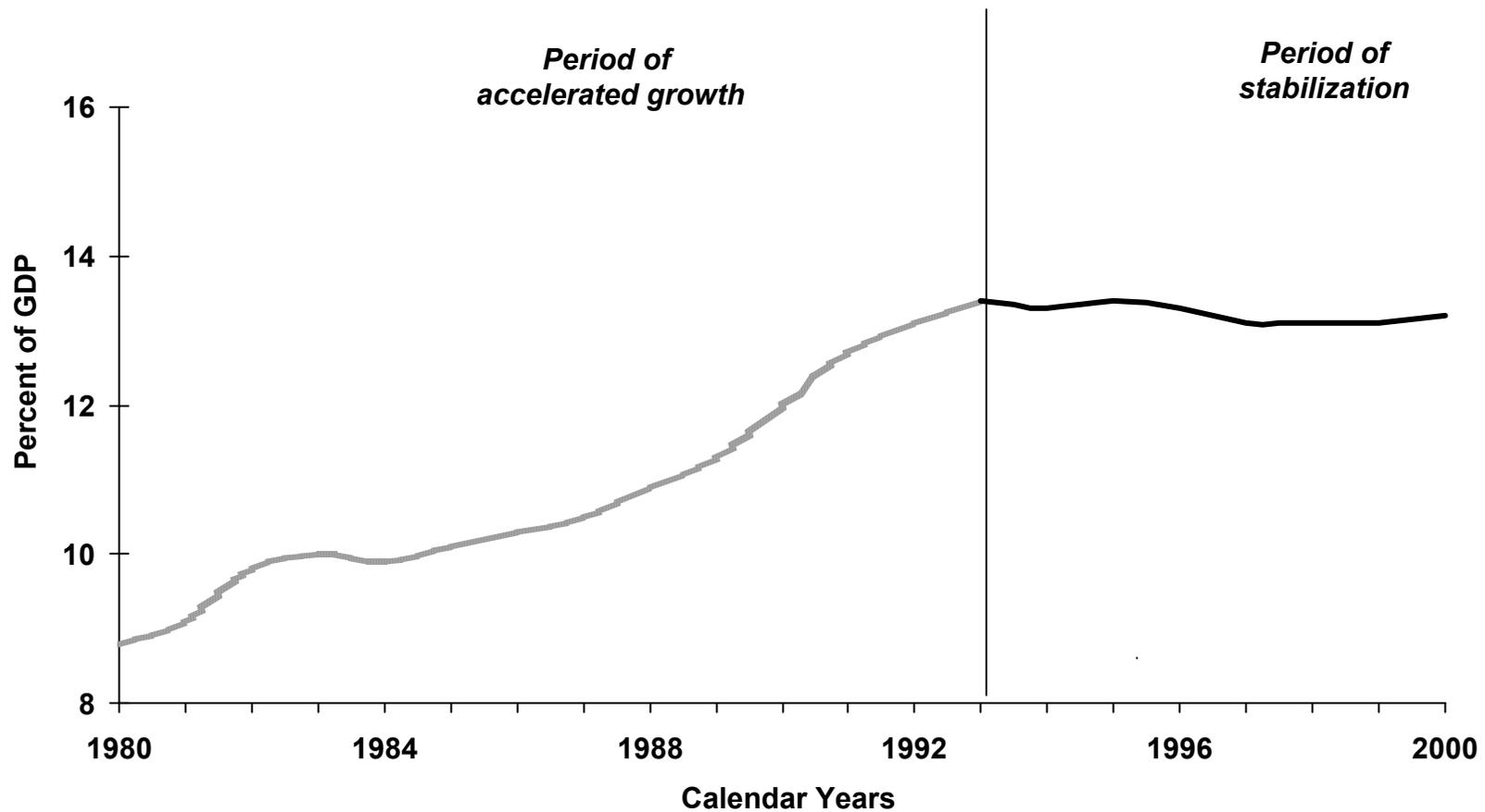
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I. U.S. Health Care System

National Health Expenditures as a Share of Gross Domestic Product (GDP)

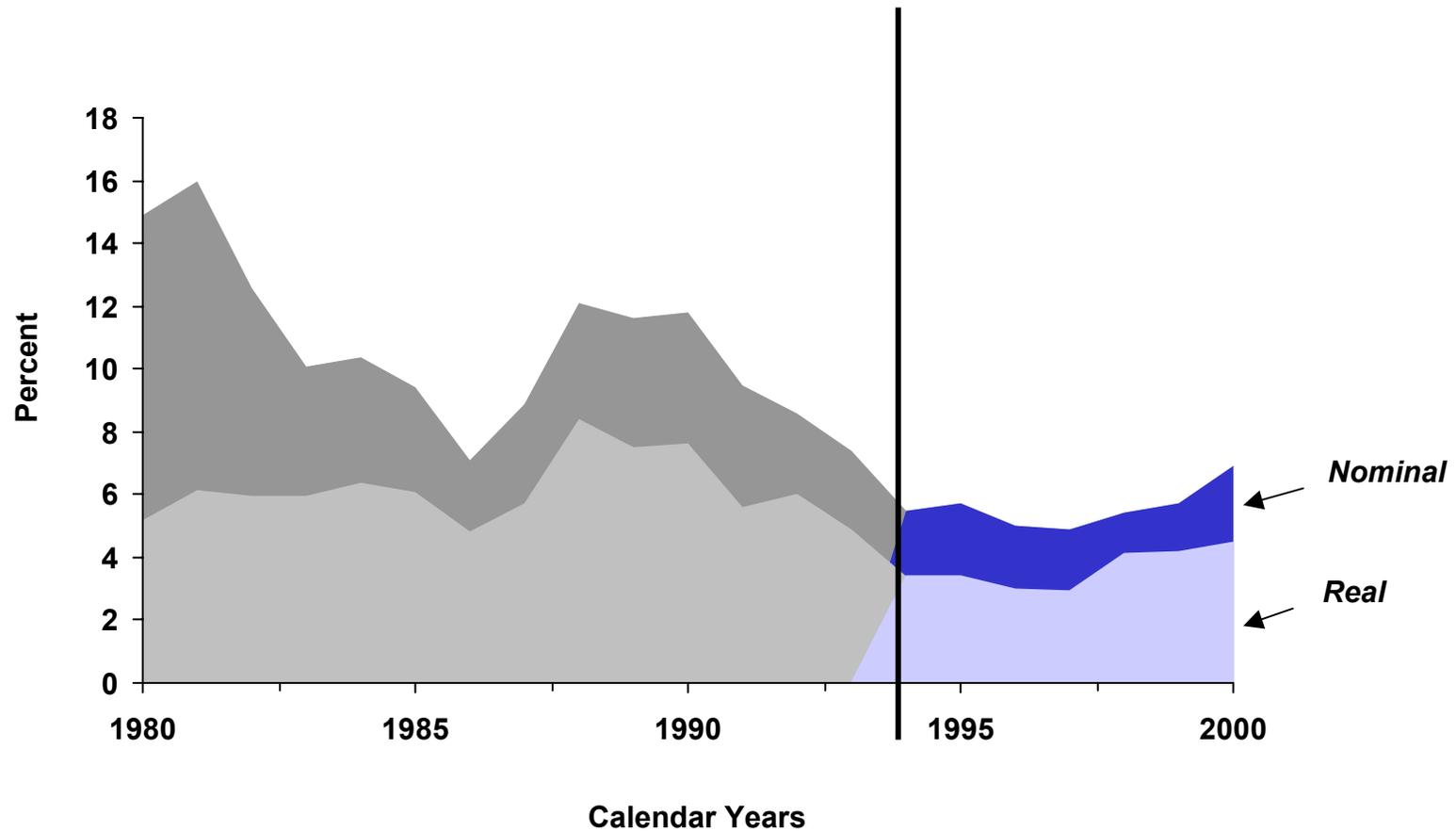
Rapid growth in the health spending share of GDP stabilized beginning in 1993.



Source: CMS, Office of the Actuary, National Health Statistics Group.

Growth in National Health Expenditures

Health spending growth slowed between 1993 and 2000 to an average increase of 5.6 percent, about half the rate of increase between 1980 and 1993.

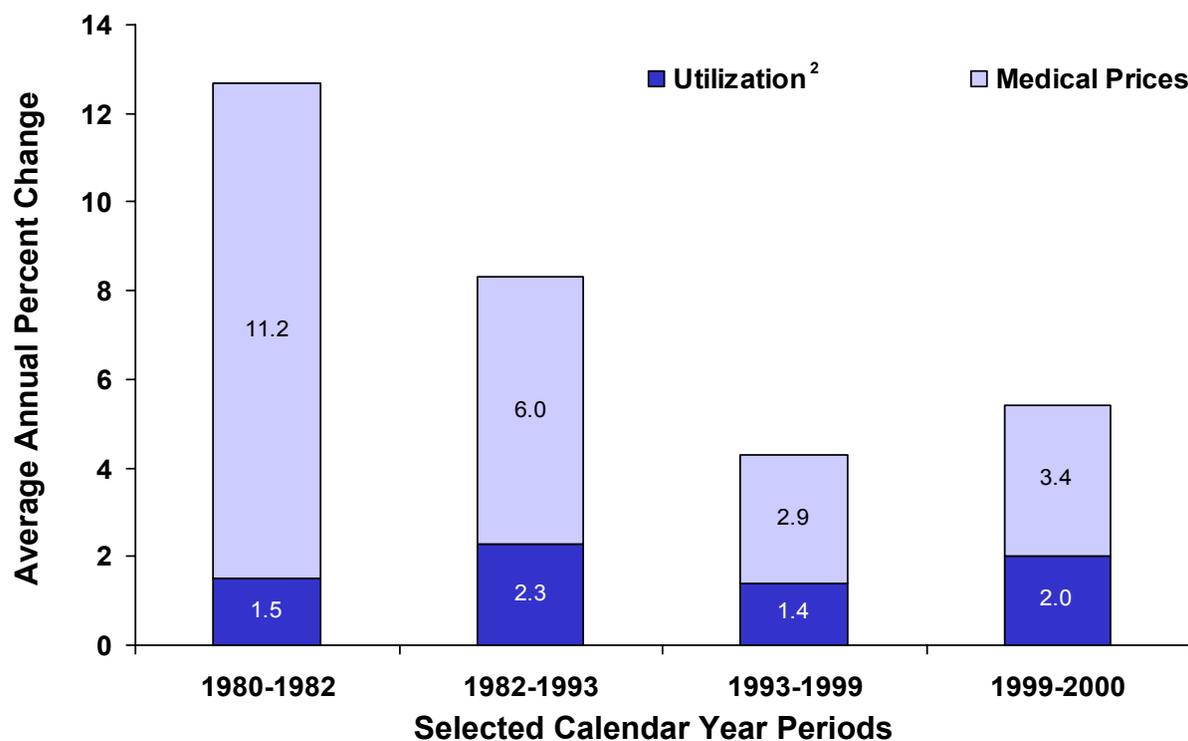


Note: Deflated using the GDP chain weighted price index. Nominal: values expressed in current dollar terms (not adjusted for inflation). Real: values adjusted for economy-wide inflation.

Source: CMS, Office of the Actuary, National Health Statistics Group.

Factors Accounting for Growth in Personal Health Care¹ Expenditures Per Capita

The most important factor accounting for the slowdown in personal health care expenditure growth after 1993 was the decline in medical price growth.



¹ Personal health care spending comprises therapeutic goods or services rendered to treat or prevent a specific disease or condition in a specific person.

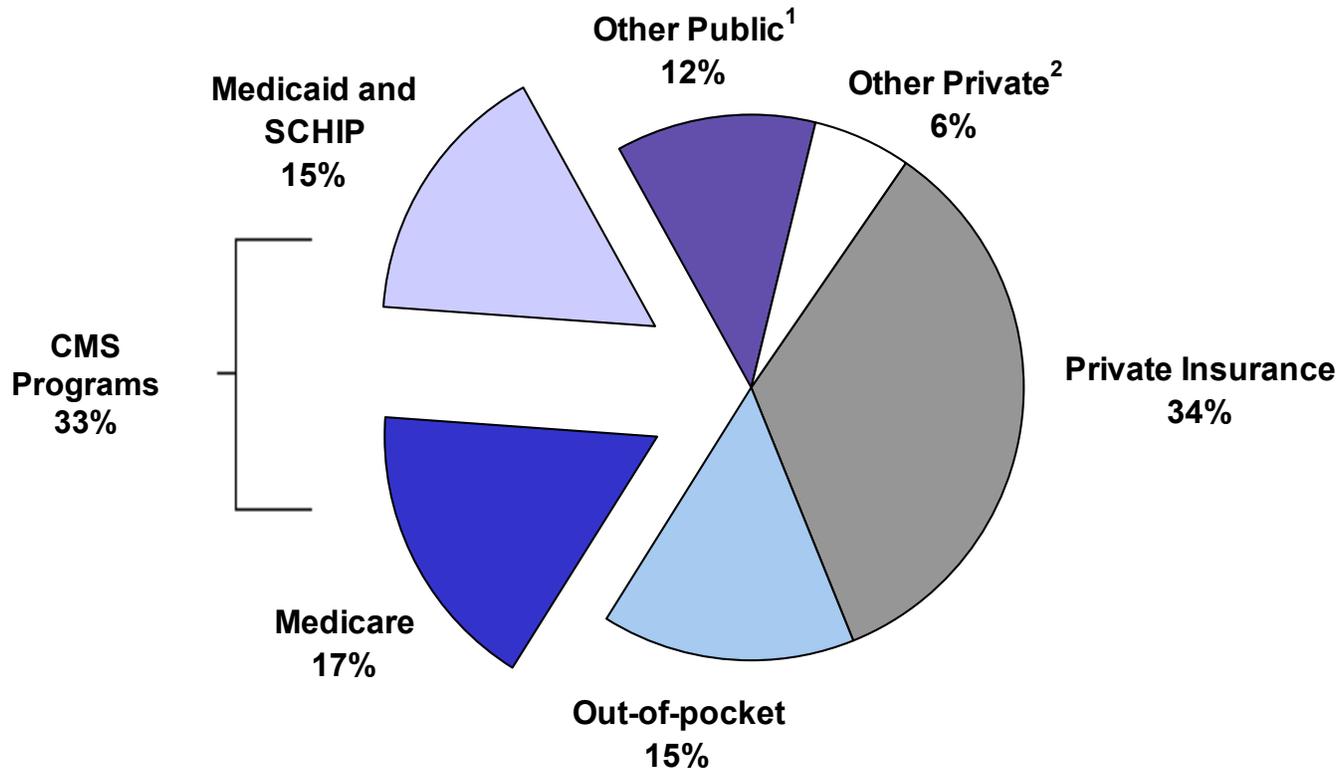
² Utilization includes quantity, quality, and mix of services. As a residual, this factor also includes any errors in measuring prices or total spending.

Note: Medical prices are calculated using the personal health care chain-type index constructed from the producer price index for hospital care, nursing home input price index for nursing home care, and consumer price indexes specific to each of the remaining personal health care components.

Source: CMS, Office of the Actuary, National Health Statistics Group.

The Nation's Health Dollar, CY 2000

Medicare, Medicaid, and SCHIP account for one-third of national health spending.



Total National Health Spending = \$1.3 Trillion

¹ Other public includes programs such as workers' compensation, public health activity, Department of Defense, Department of Veterans Affairs, Indian Health Service, and State and local hospital subsidies and school health.

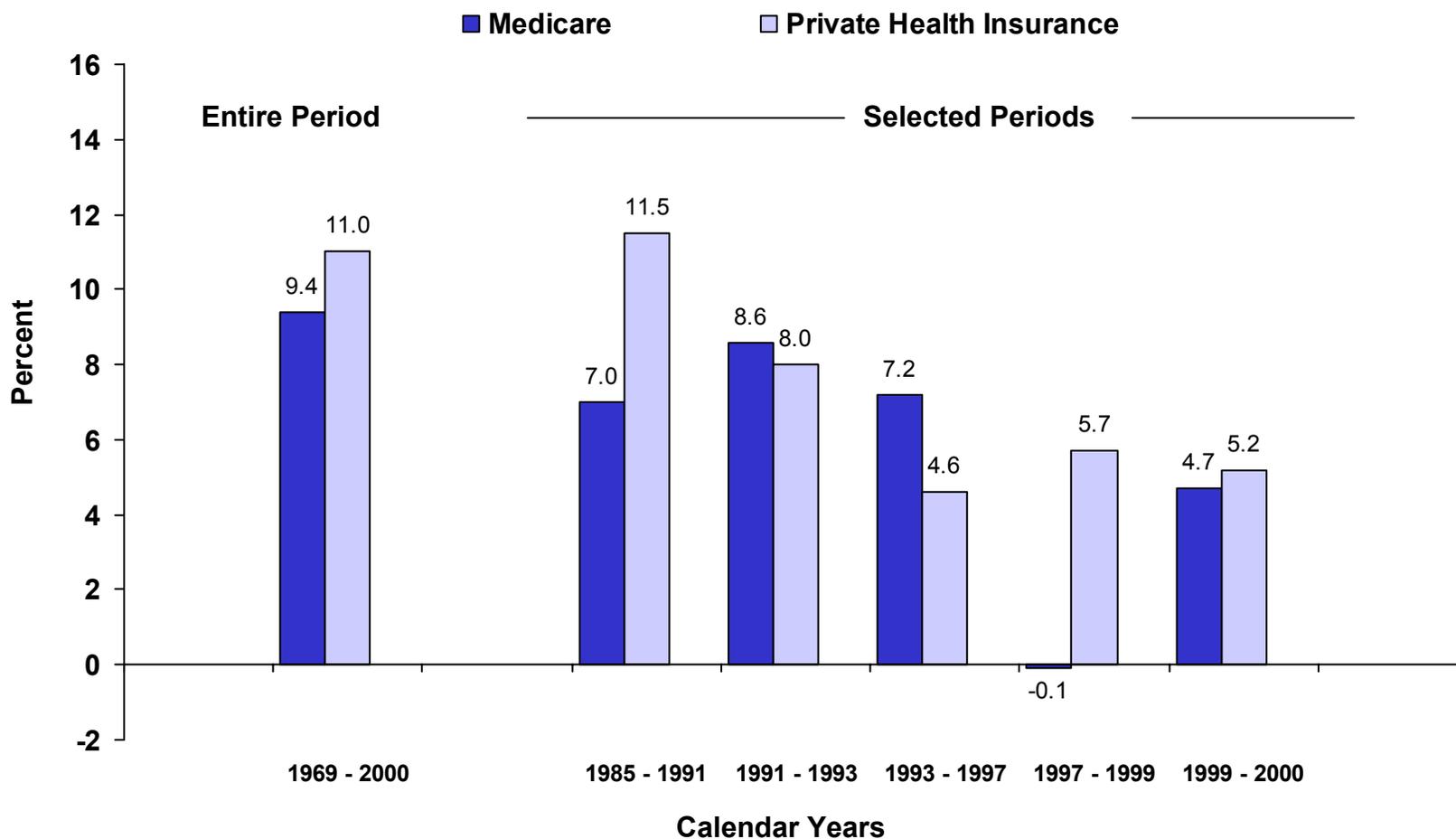
² Other private includes industrial in-plant, privately funded construction, and non-patient revenues, including philanthropy.

Note: Numbers shown may not sum due to rounding.

Source: CMS, Office of the Actuary, National Health Statistics Group.

Average Annual Growth in Per-Enrollee Medicare and Private Health Insurance Benefits

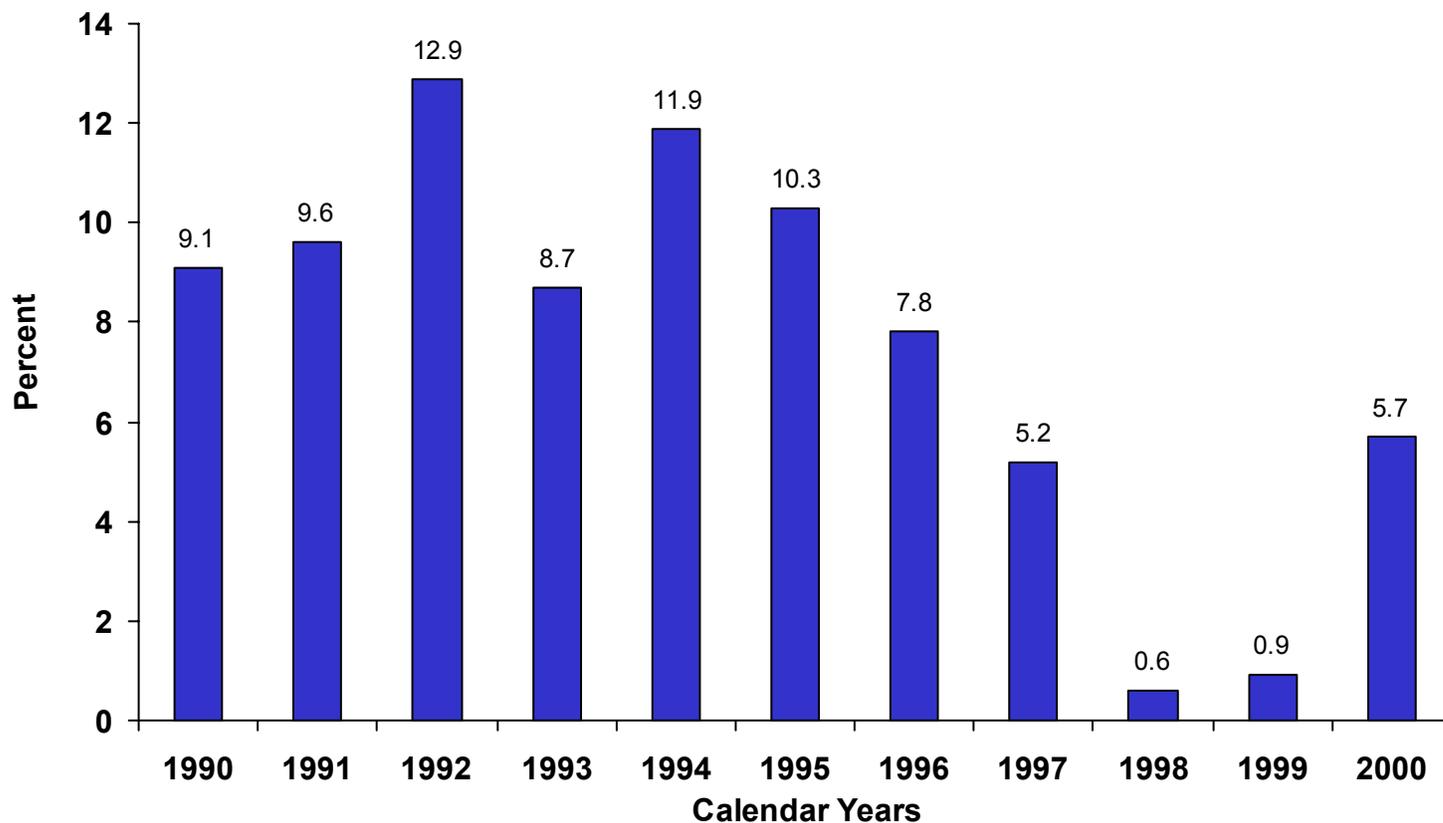
Medicare grew slightly slower than private health insurance over the 30-year period, though growth rates diverged significantly in selected periods.



Source: CMS, Office of the Actuary, National Health Statistics Group.

Growth in Aggregate Medicare Personal Health Care Spending

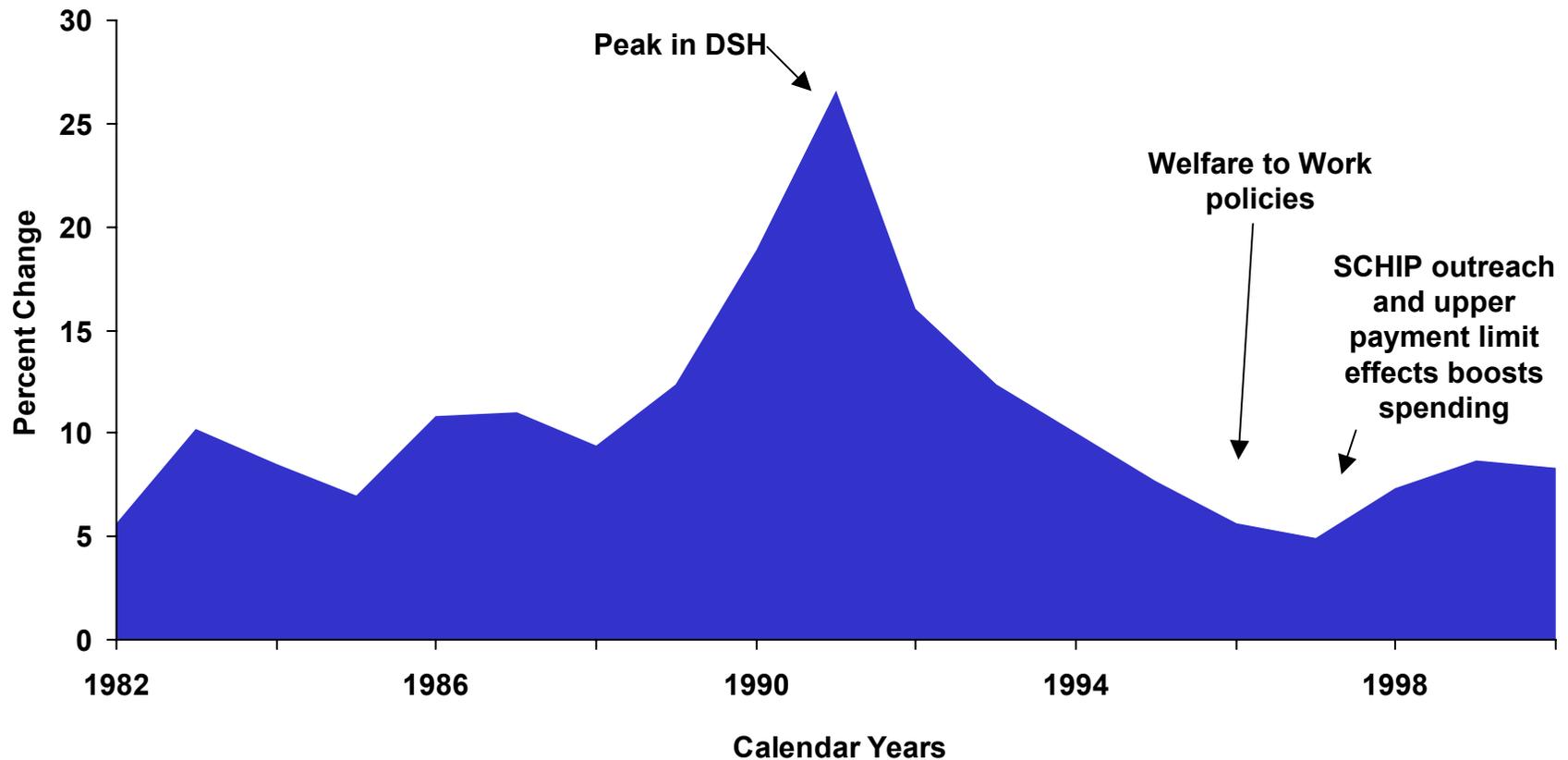
Following rapid growth in expenditures in the early 1990s, the Balanced Budget Act reduced the rate of spending growth between 1997 and 1999. The Balanced Budget Refinement Act contributed to a resurgence of spending in 2000.



Source: CMS, Office of the Actuary, National Health Statistics Group.

Growth in Medicaid Spending

Changing Medicaid eligibility rules and a spillover effect from outreach efforts under SCHIP led to increasing Medicaid spending in 1998 and 1999 followed by stabilization in 2000.

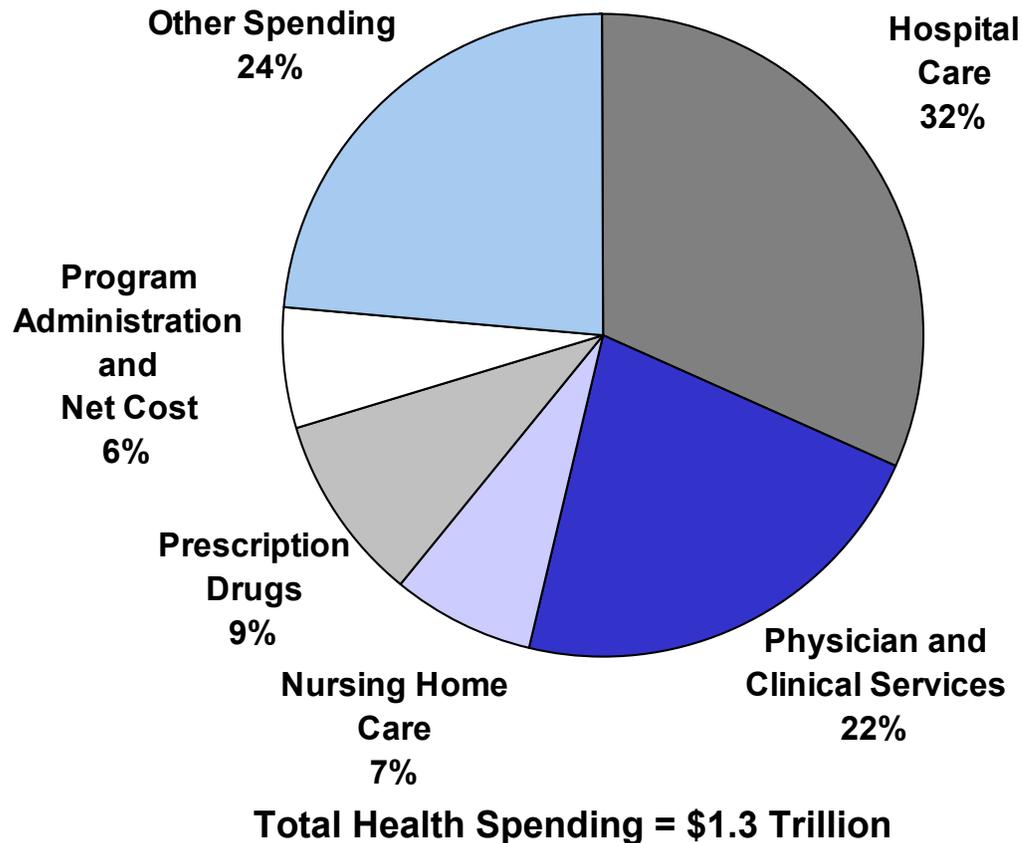


Note: DSH is disproportionate share hospital. SCHIP is the State Children's Health Insurance Program. For a discussion of changing eligibility policies, see K. Levit et al., "Health Spending in 1998: Signals of Change," *Health Affairs* (Jan/Feb 2000): 124-132.

Source: CMS, Office of the Actuary, National Health Statistics Group.

The Nation's Health Dollar, CY 2000

Hospital and physician spending accounts for more than half of all health spending.

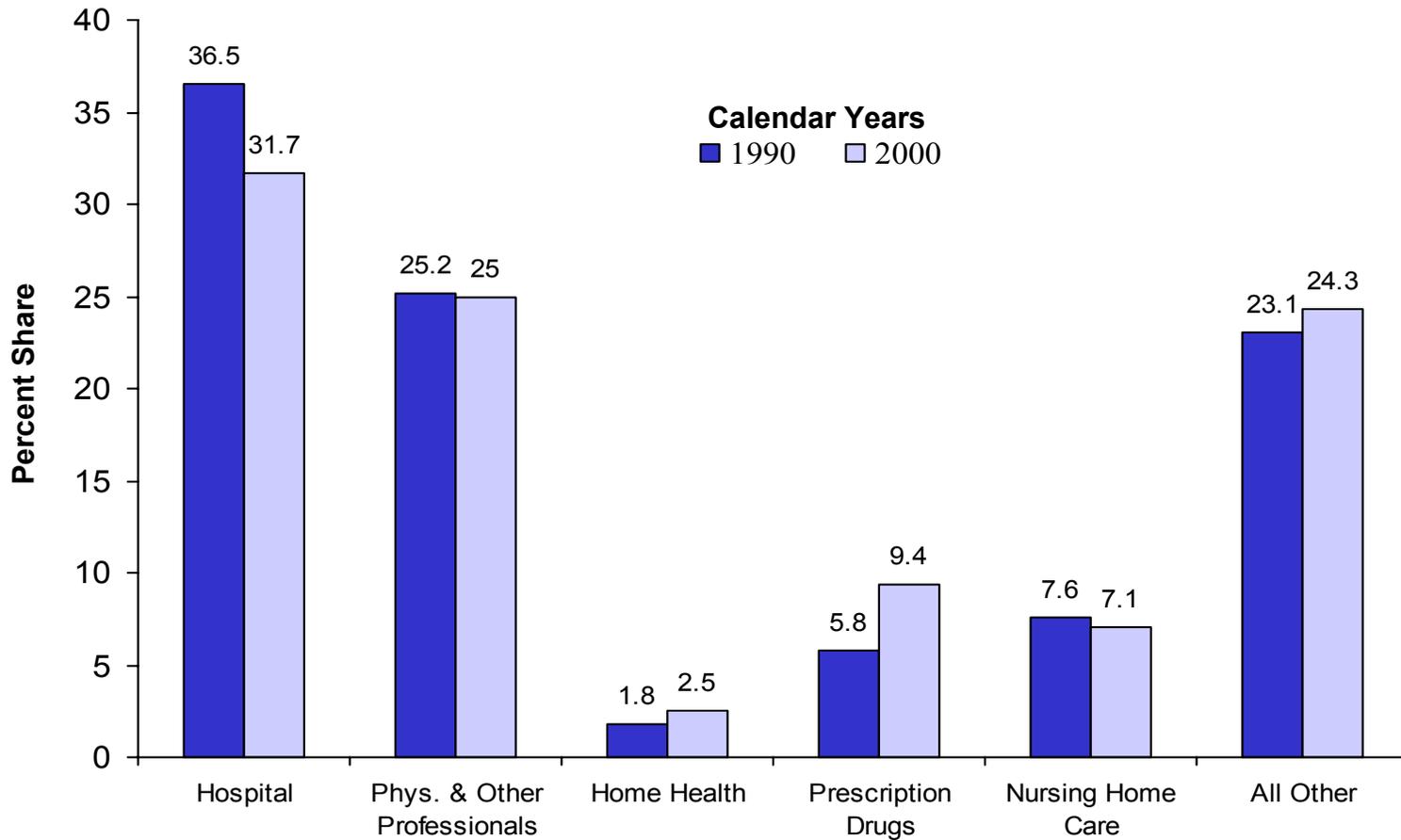


Note: Other spending includes dentist services, other professional services, home health, durable medical products, over-the-counter medicines and sundries, public health, research and construction.

Source: CMS, Office of the Actuary, National Health Statistics Group.

Expenditures for Health Services, by All Payers

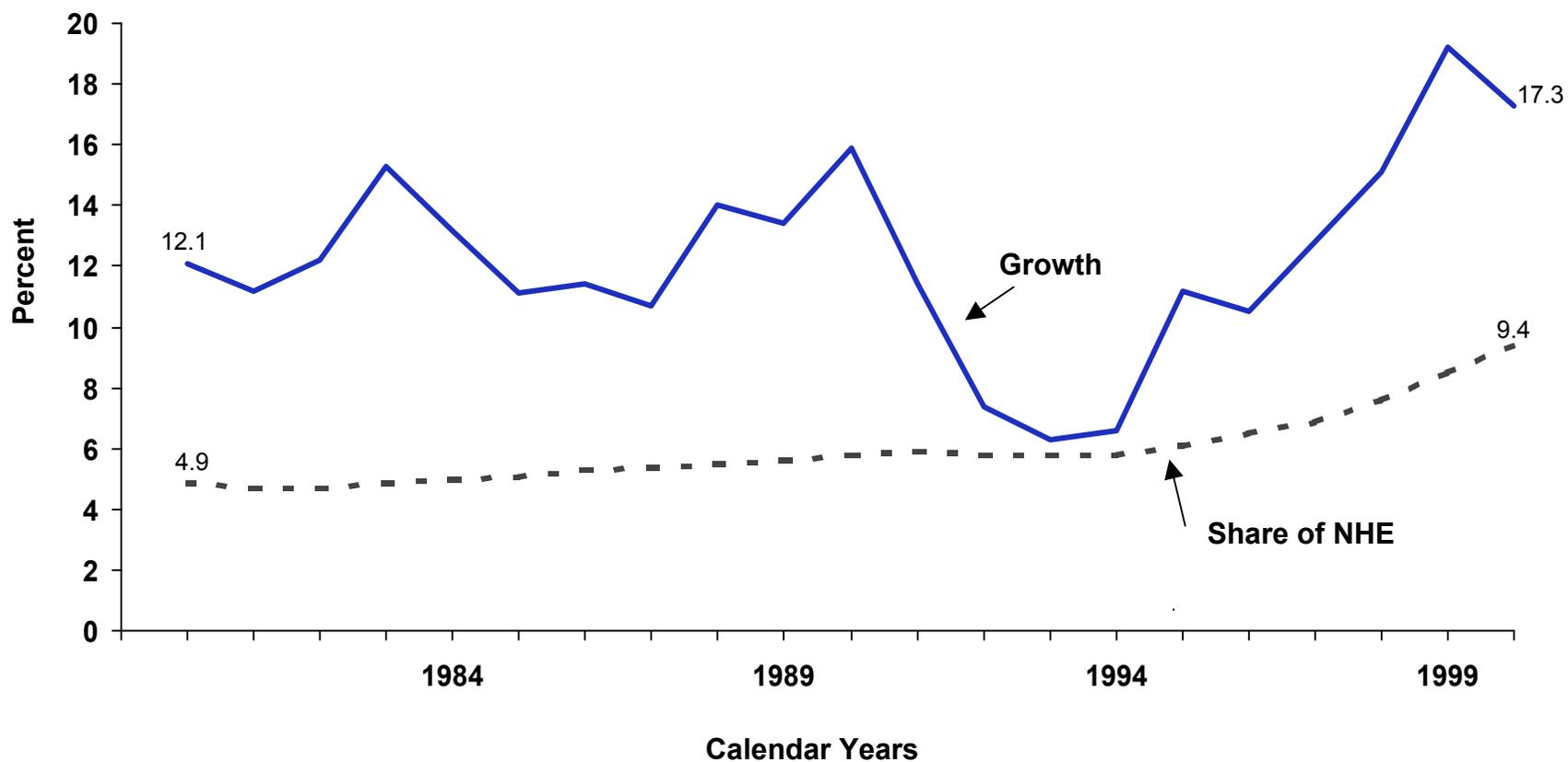
In recent years, the hospital share of total spending has decreased while the prescription drug share has increased.



Source: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group.

Prescription Drug Expenditure Growth and Share of National Health Expenditures

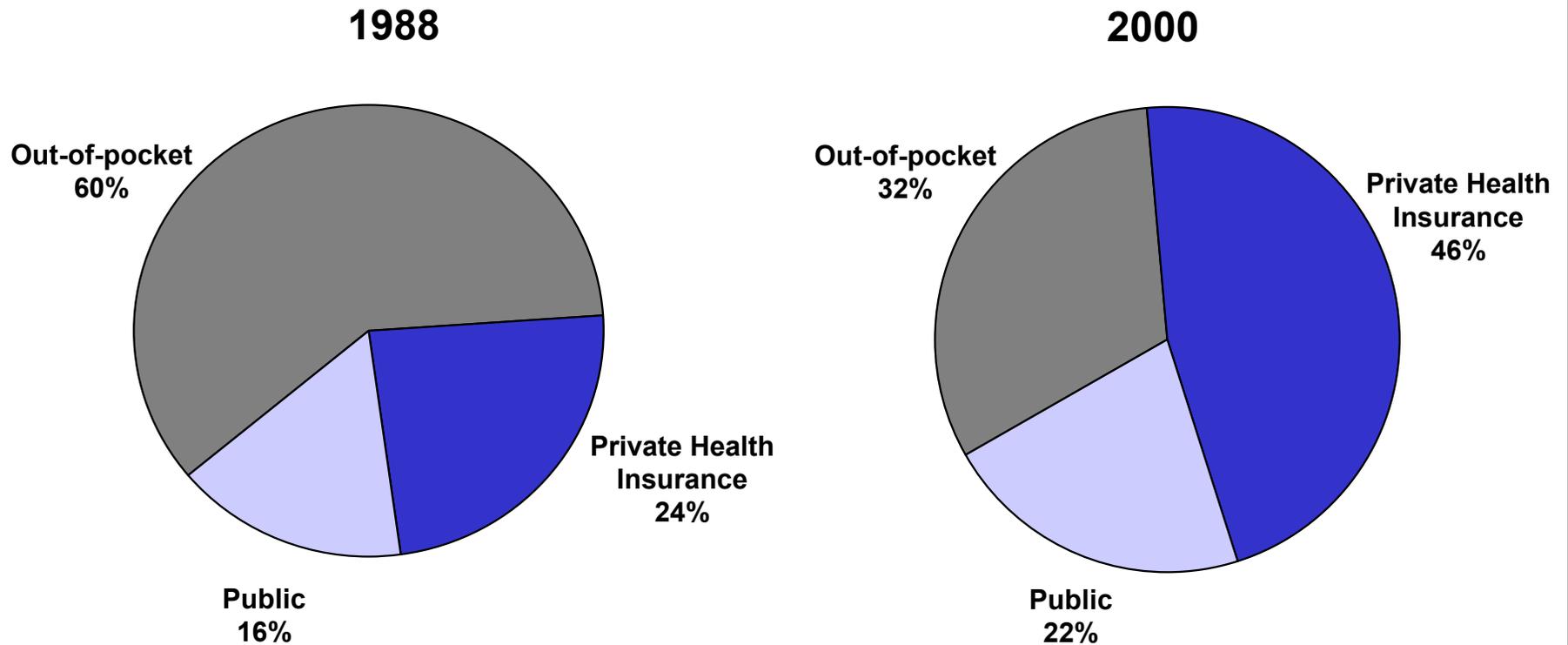
Sharply rising prescription drug expenditure growth nationwide in the mid- to late 1990s caused noticeable growth in prescription drugs as a share of total health spending.



Source: CMS, Office of the Actuary, National Health Statistics Group.

Expenditures for Prescription Drugs, by Source of Funds

The financing of prescription drug expenditures has rapidly shifted from consumer out-of-pocket spending to private health insurance.

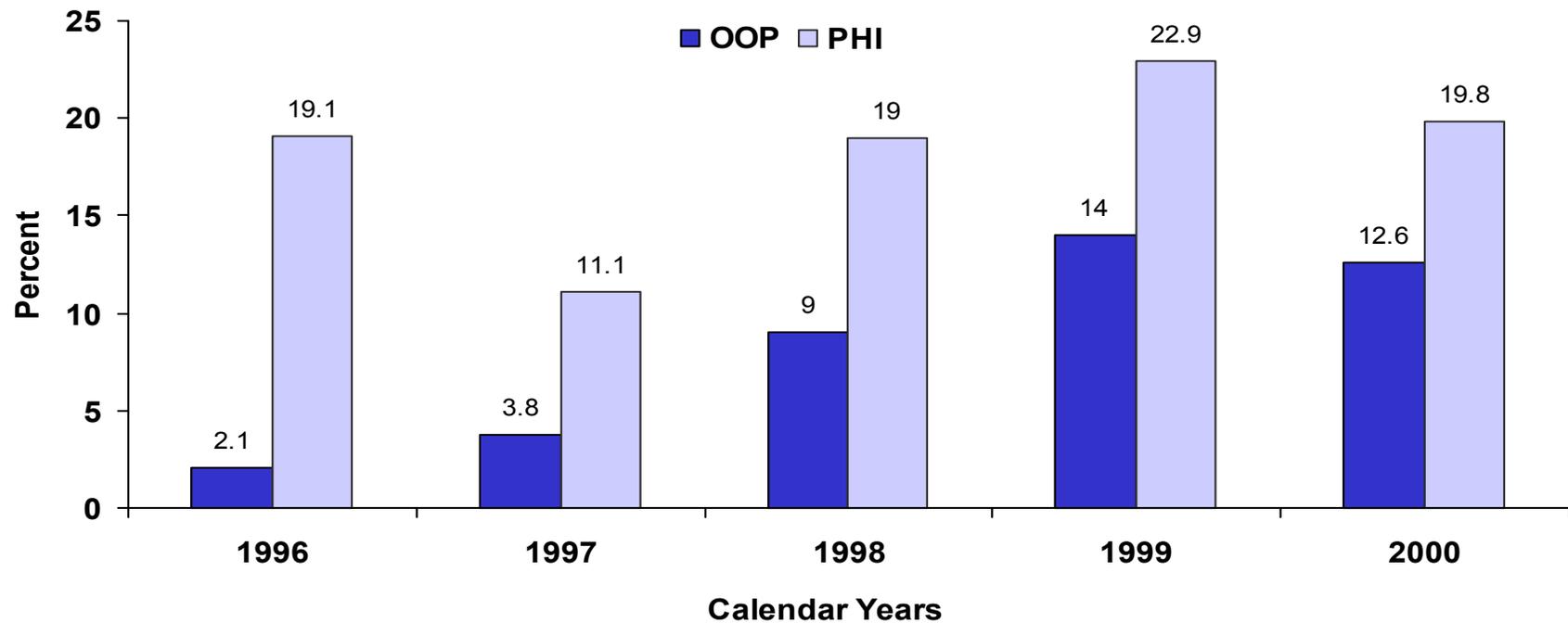


Note: Data are Calendar Year.

Source: CMS, Office of the Actuary, National Health Statistics Group.

Growth in Prescription Drug Out-of-Pocket and Private Health Insurance Spending

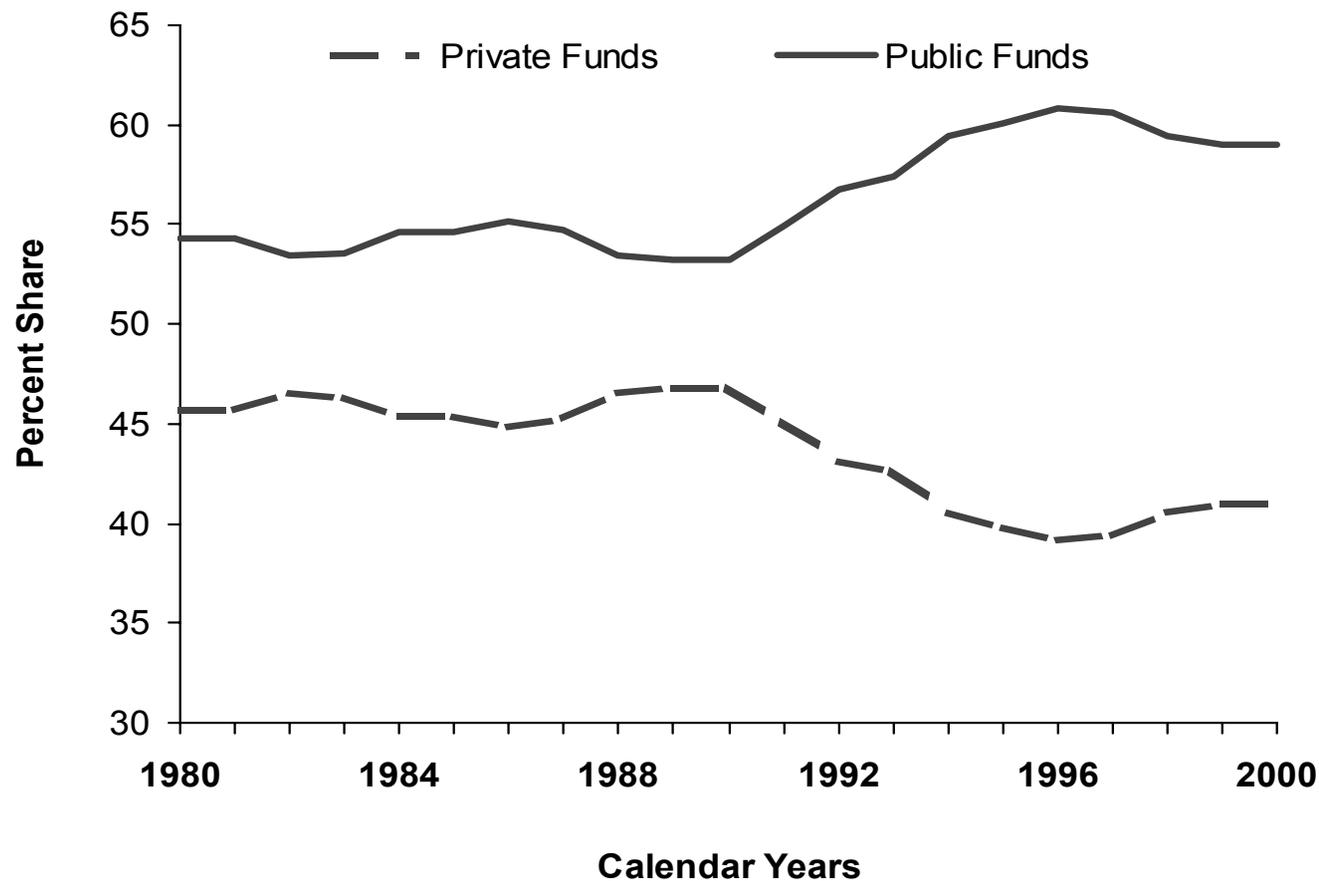
In an effort to control rising drug spending, insurers implemented tiered co-pays that shifted part of spending growth back to consumers. This contributed to a smaller gap between the rate of out-of-pocket and private health insurance spending growth in recent years.



Source: CMS, Office of the Actuary, National Health Statistics Group.

Expenditures for Hospital Services by Source of Funds

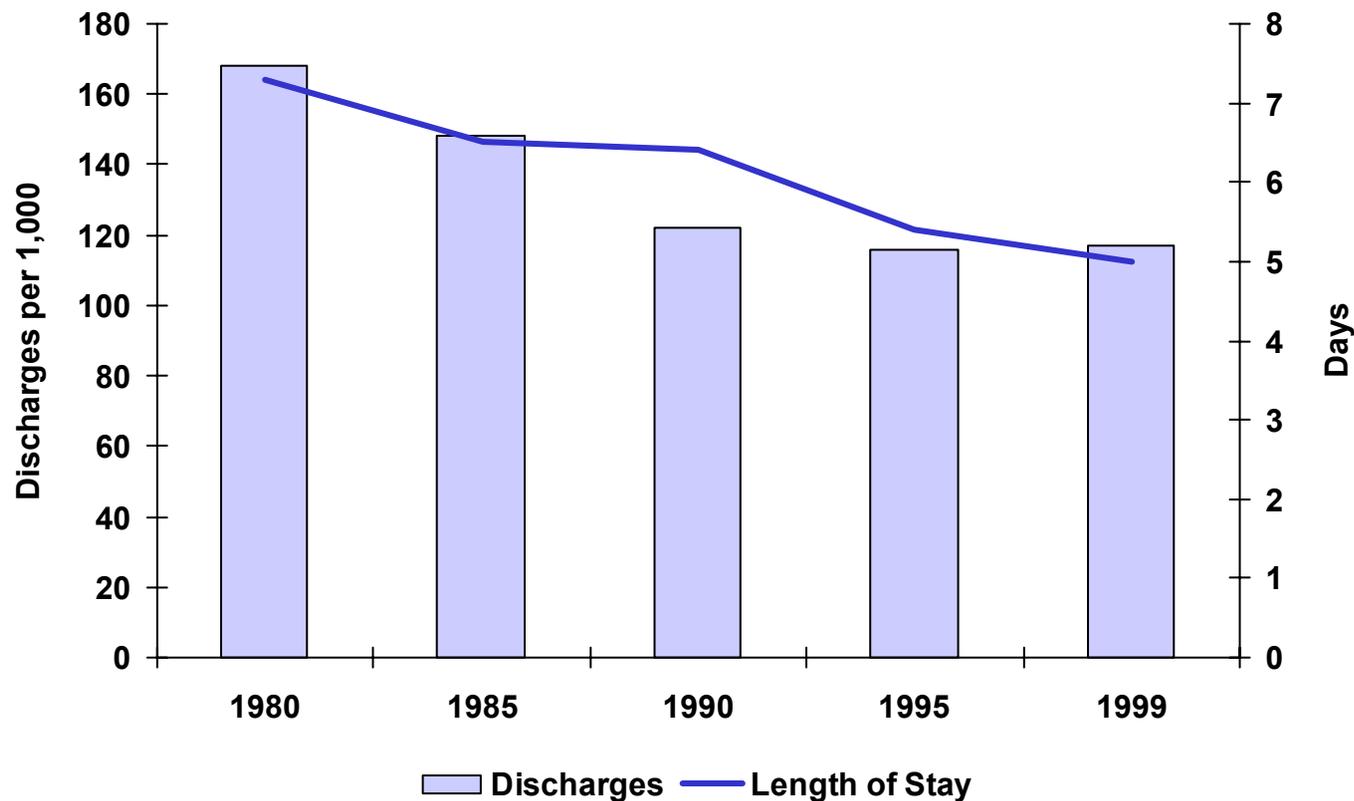
Higher public payments have offset lower private payments in the past decade.



Source: CMS, Office of the Actuary, National Health Statistics Group.

Short-Stay Hospitals: Discharges and Length of Stay for All Payers

The implementation of the Medicare prospective payment system and the rise of managed care have contributed to a noticeable decline in both discharges and average length of stay.

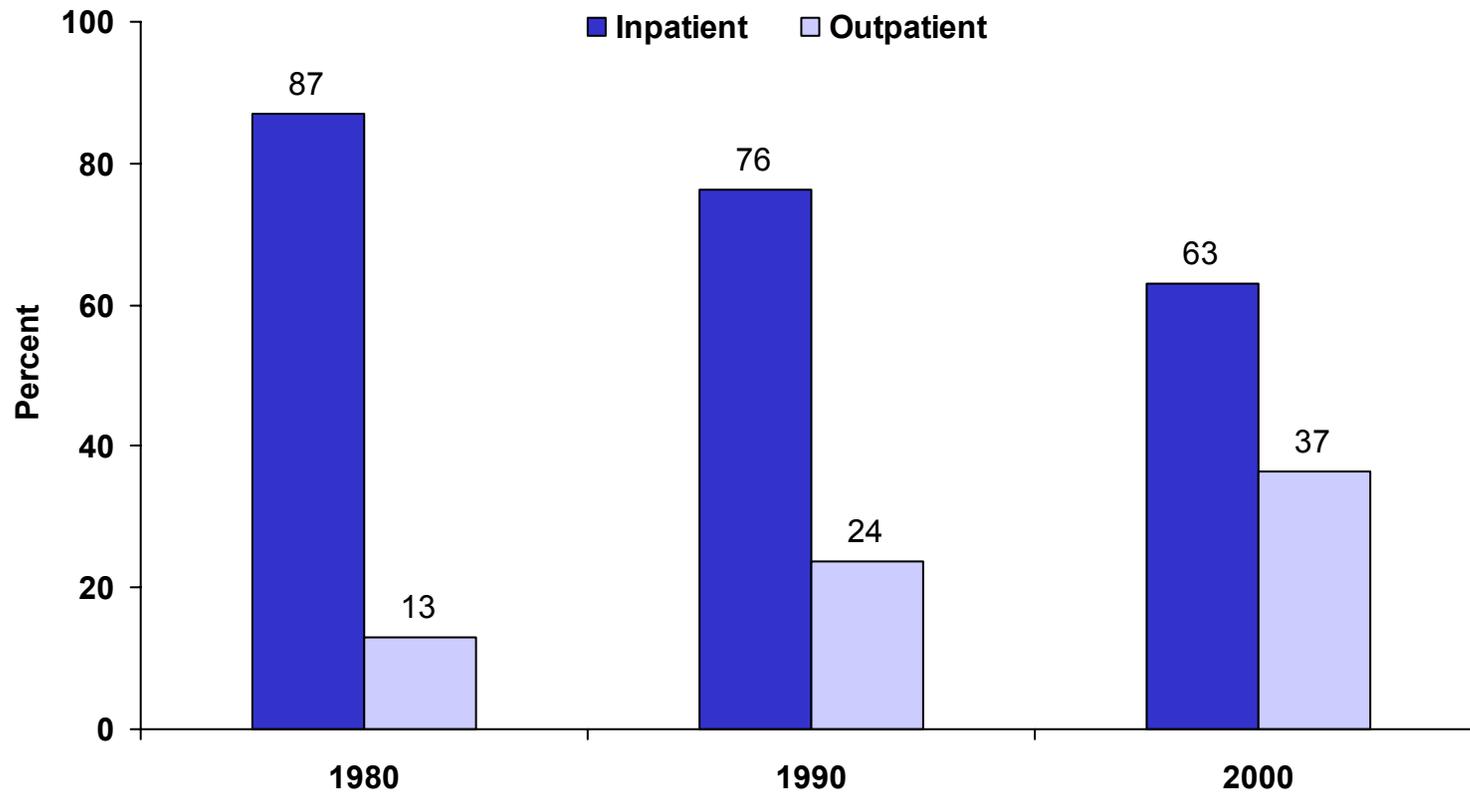


Note: This chart captures discharges and length of stay for all patients of all payers in non-federal hospitals with average lengths of stays of less than 30 days.

Source: U.S National Center for Health Statistics, *Vital and Health Statistics*, Series 13.

Community Hospital Expenditures: Inpatient and Outpatient Shares for All Payers

Over the last 20 years there has been a significant shift in the composition of health services as more treatments are performed in the outpatient setting.

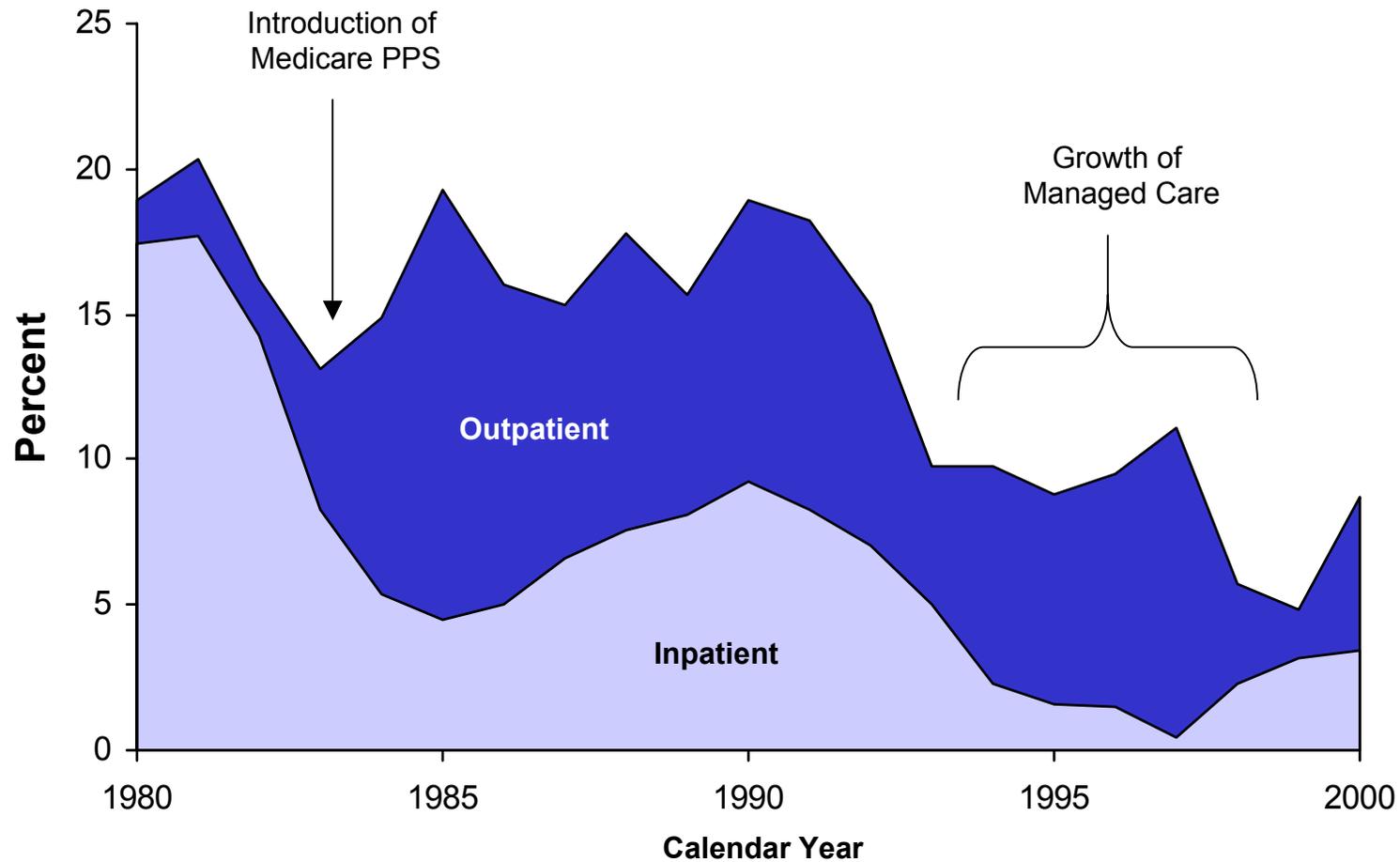


Note: Community hospitals are all non-federal, short-term general, and special hospitals whose activities are available to the public.

Source: CMS, Office of the Actuary, National Health Statistics Group.

Growth in Inpatient and Outpatient Expenditures in Community Hospitals for All Payers, 1980-2000

Managed care contributed to the slower pace in inpatient expenditure growth and the continued move of services to outpatient settings that began with the introduction of Medicare PPS.

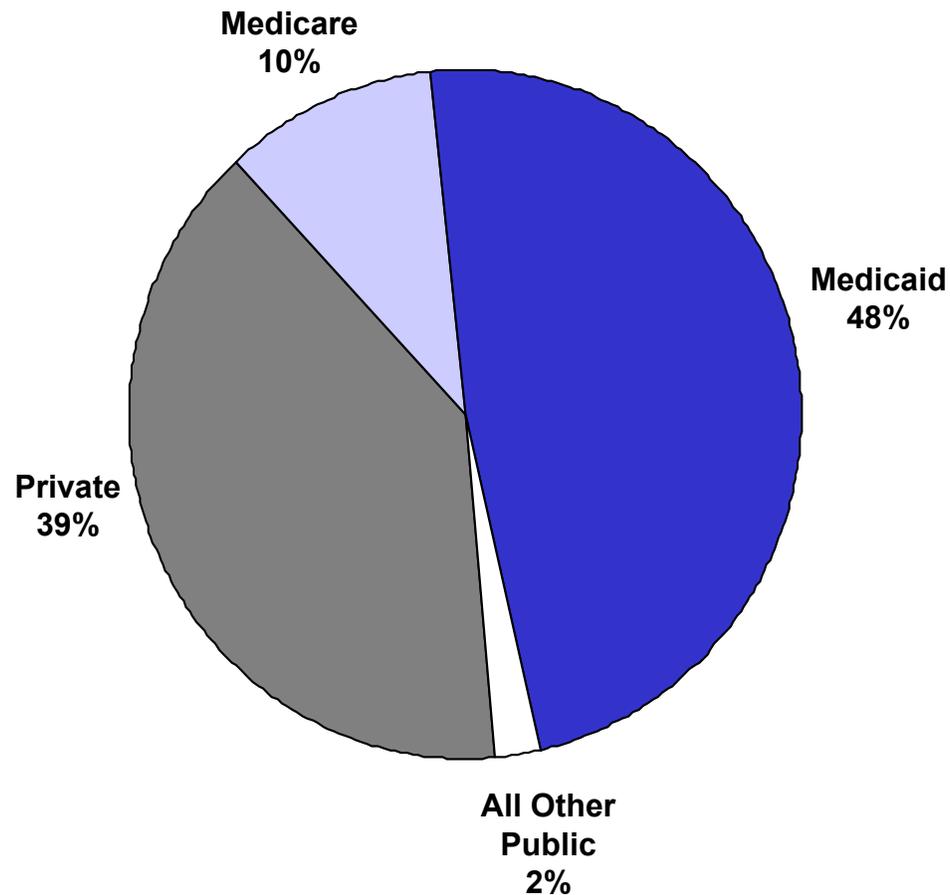


Note: Community hospitals are all non-federal, short-term general and special hospitals whose facilities are available to the public.

Source: CMS, Office of the Actuary, National Health Statistics Group.

Distribution of Funding for Freestanding Nursing Home Expenditures for All Payers, CY 2000

Medicaid remains the largest single payer of nursing home care.

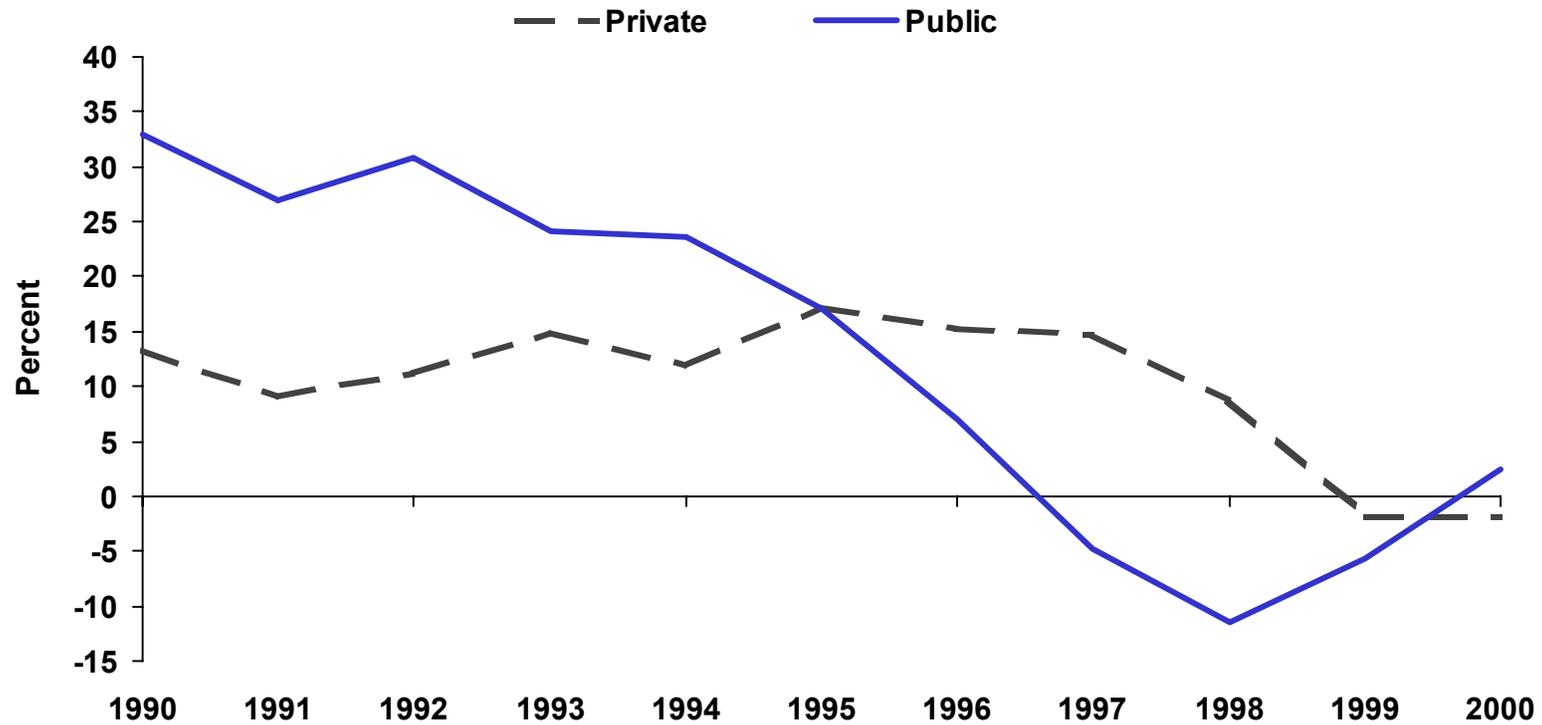


Note: Hospital-based Skilled Nursing Facilities are excluded.

Source: CMS, Office of the Actuary, National Health Statistics Group.

Annual Growth in Public and Private Sources of Home Health Spending: CY 1990-2000

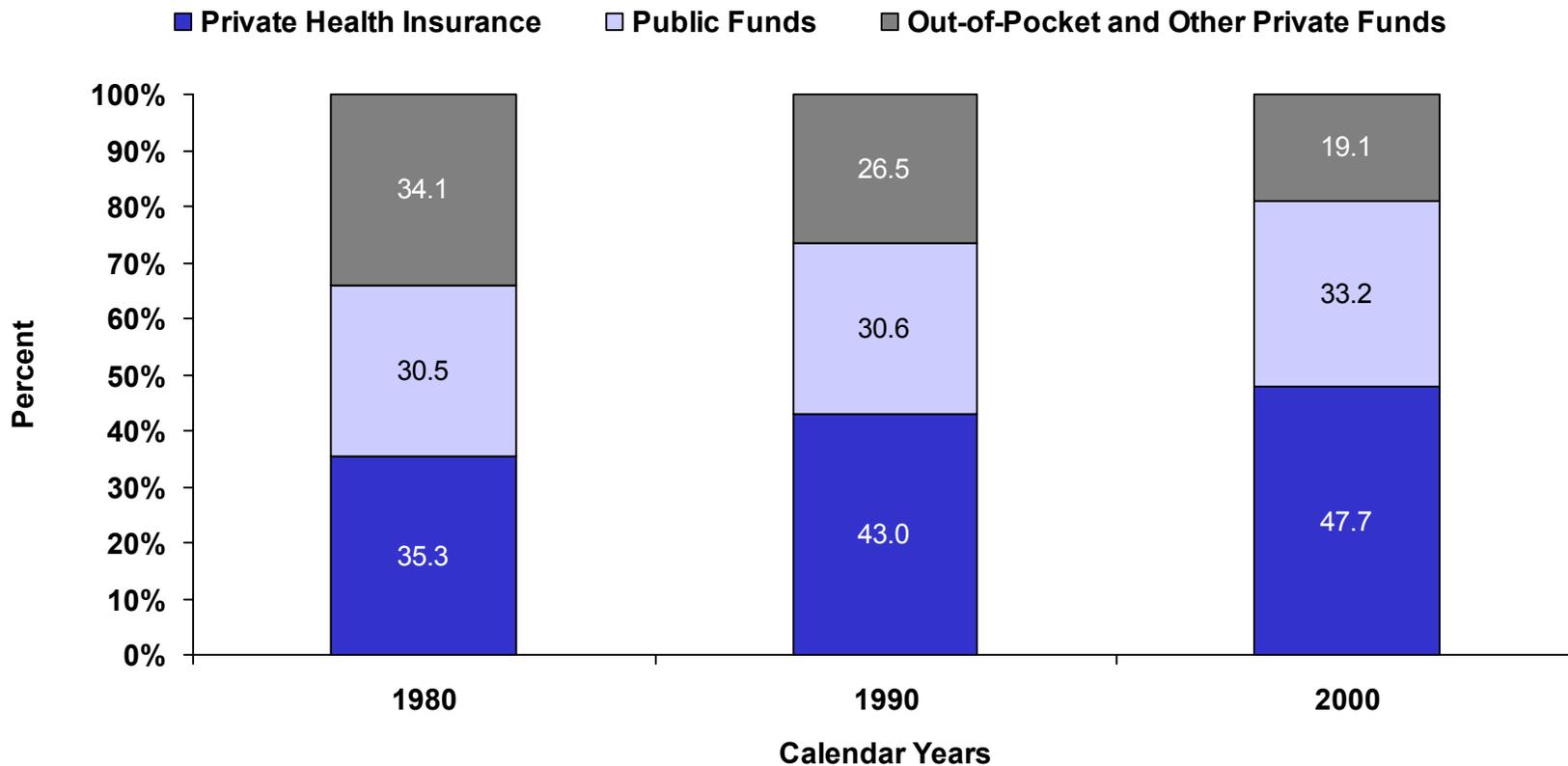
Rapid growth in public spending for home health ceased in the late 1990s with the BBA's interim payment system plus increased fraud and abuse efforts under Medicare.



Source: CMS, Office of the Actuary, National Health Statistics Group. Note: BBA indicates the Balanced Budget Act of 1997.

Share of Expenditures for Physician and Clinical Services, by Source of Funds

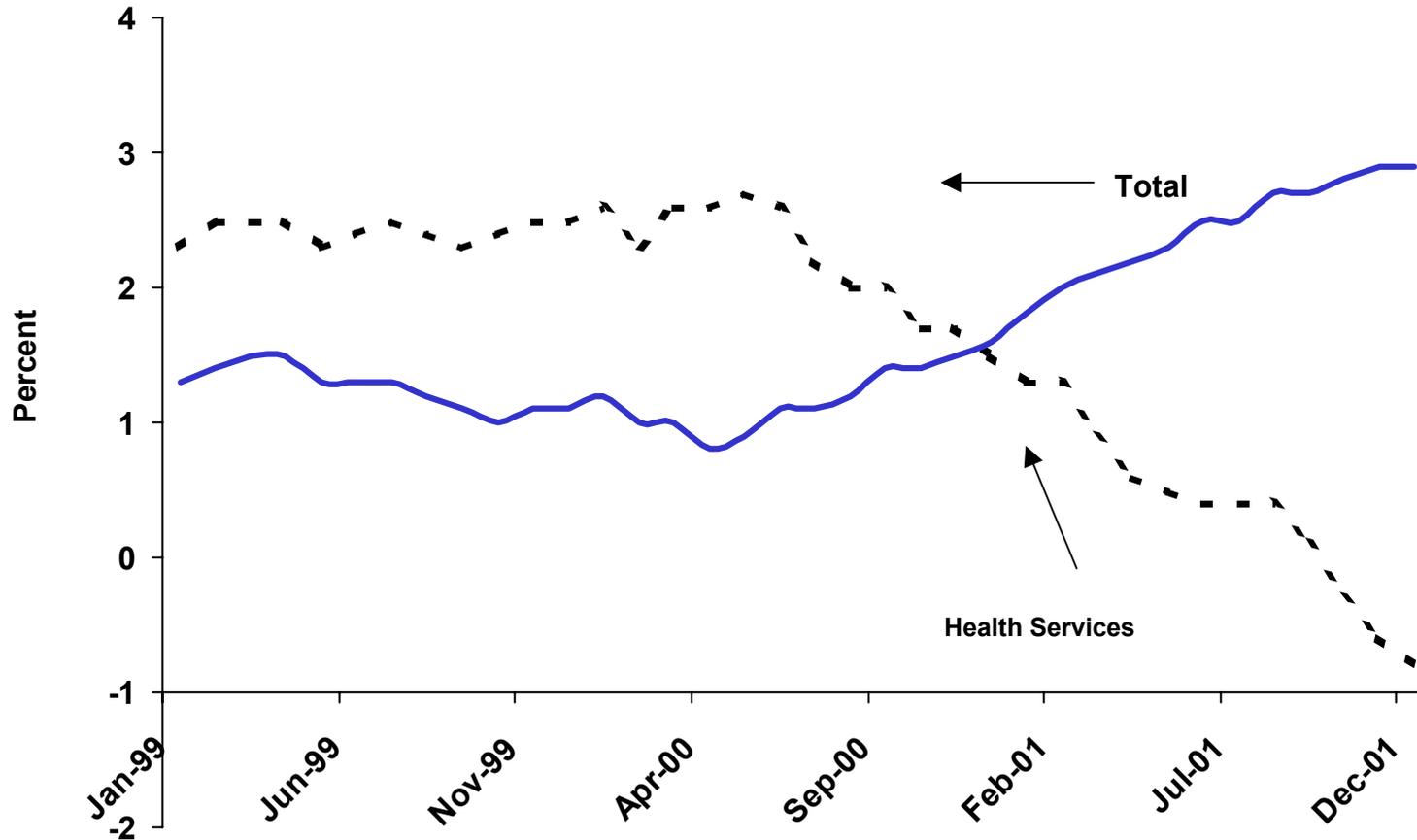
Over the decade, out-of-pocket payments declined while private insurance payments increased.



Source: CMS, Office of the Actuary, National Health Statistics Group.

Growth in Total and Health Services Employment

The upturn in health spending in 2000 is expected to continue in 2001, as reflected in employment statistics; health care employment continues to increase while employment in the overall economy falls.

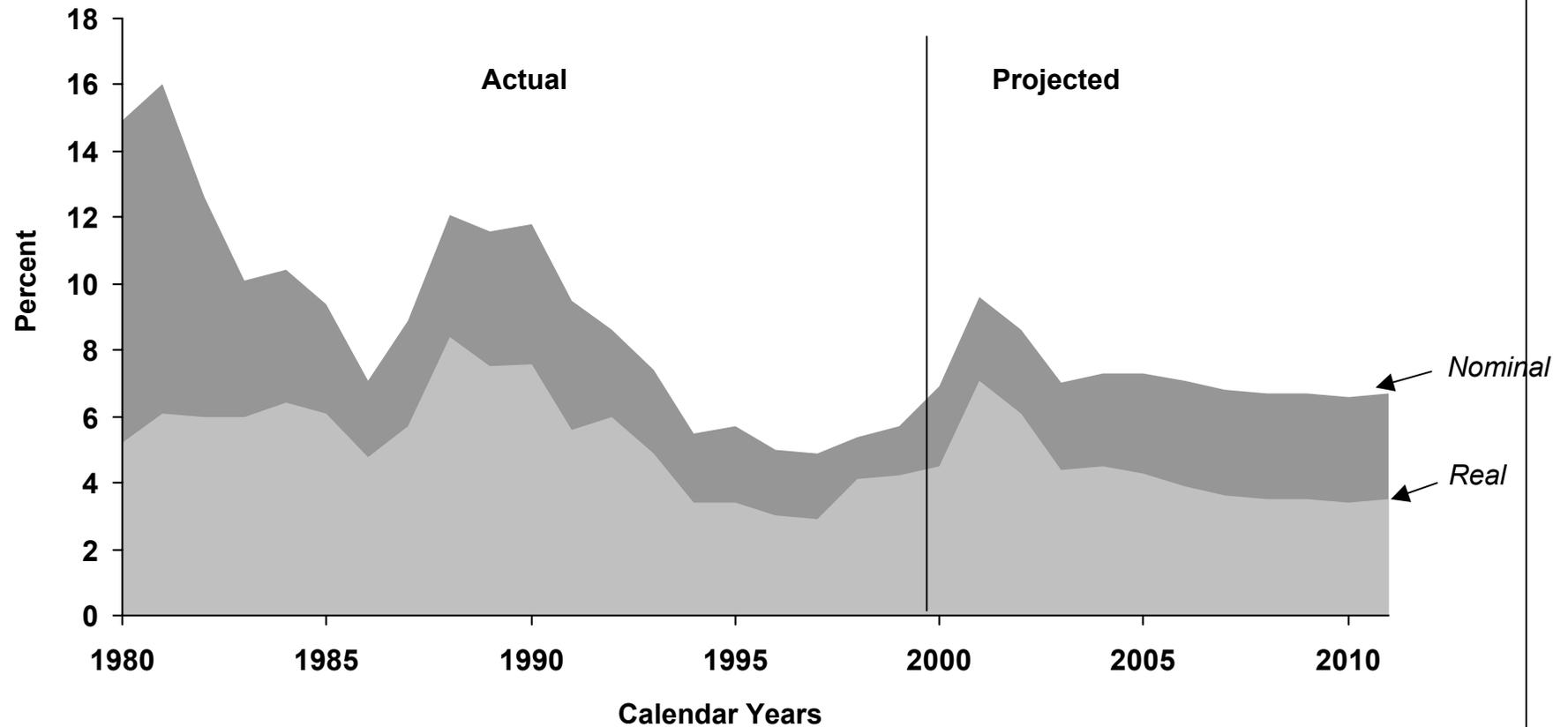


Note: Percent change from the same period of previous year.

Source: U.S. Department of Labor, Bureau of Labor Statistics.

Growth in National Health Expenditures

Nominal health expenditure growth is projected to exceed the growth of the mid- to late 1990s, but fall short of the growth experienced in the late 1980s.

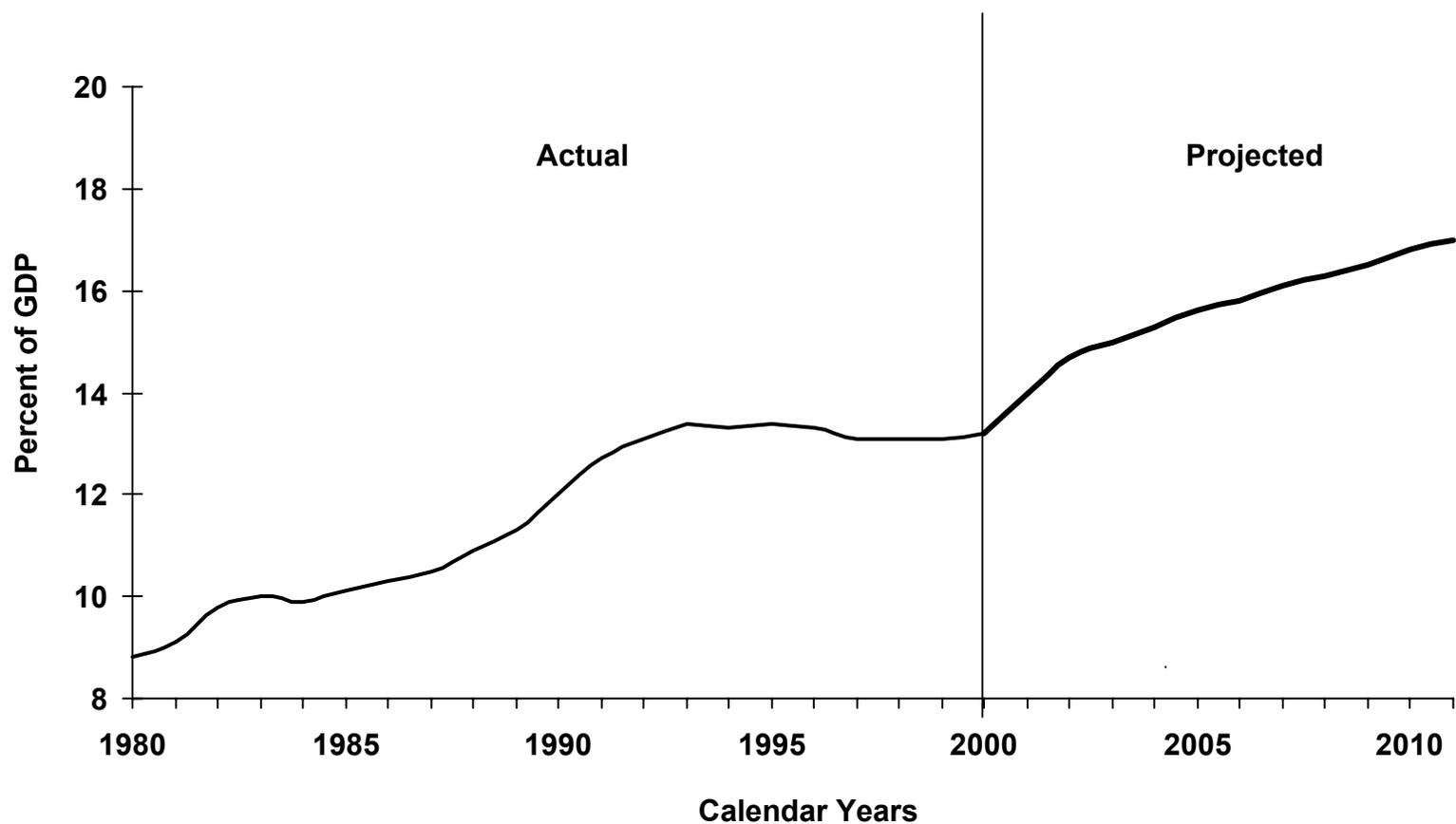


Note: Nominal: values expressed in current dollar terms (not adjusted for inflation). Real: values deflated by the GDP chain-weighted price index.

Source: CMS, Office of the Actuary, National Health Statistics Group.

National Health Expenditures as a Share of Gross Domestic Product (GDP)

Between 2001 and 2011, health spending is projected to grow 2.5 percent per year faster than GDP, so that by 2011 it will constitute 17 percent of GDP.

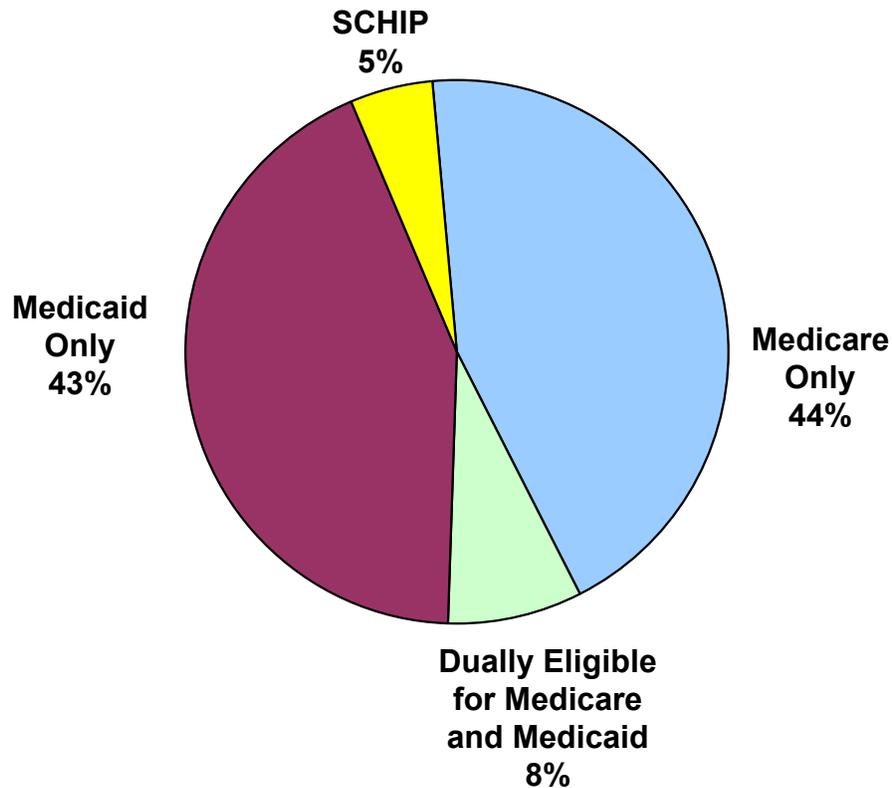


Source: CMS, Office of the Actuary, National Health Statistics Group.

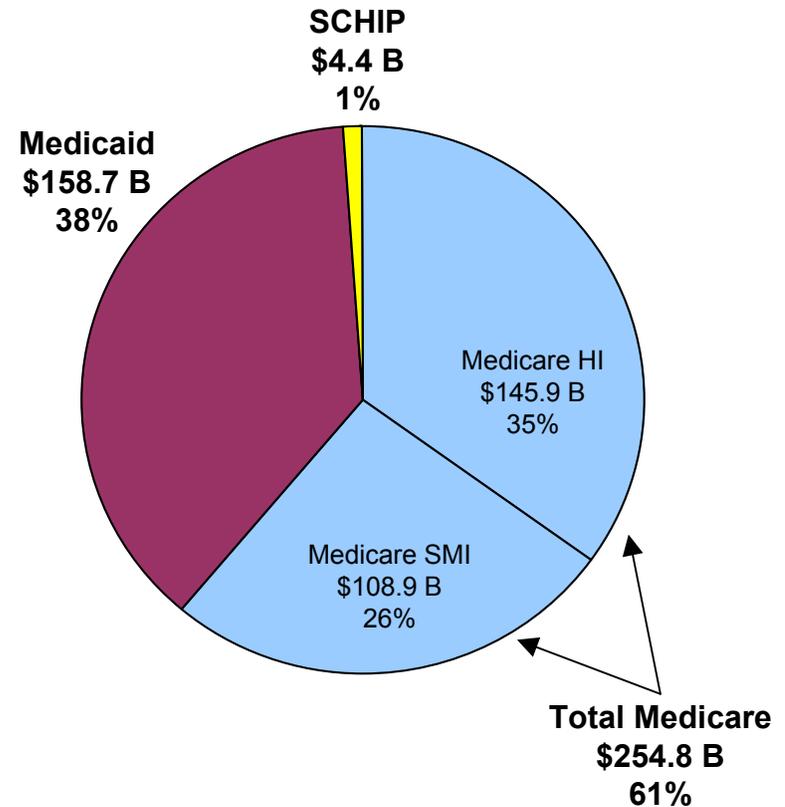
II. CMS Program Operations

CMS Beneficiaries and Program Spending

**Beneficiaries
(79.3 million)**



**Federal Entitlement Outlays
(\$417.8 billion)**

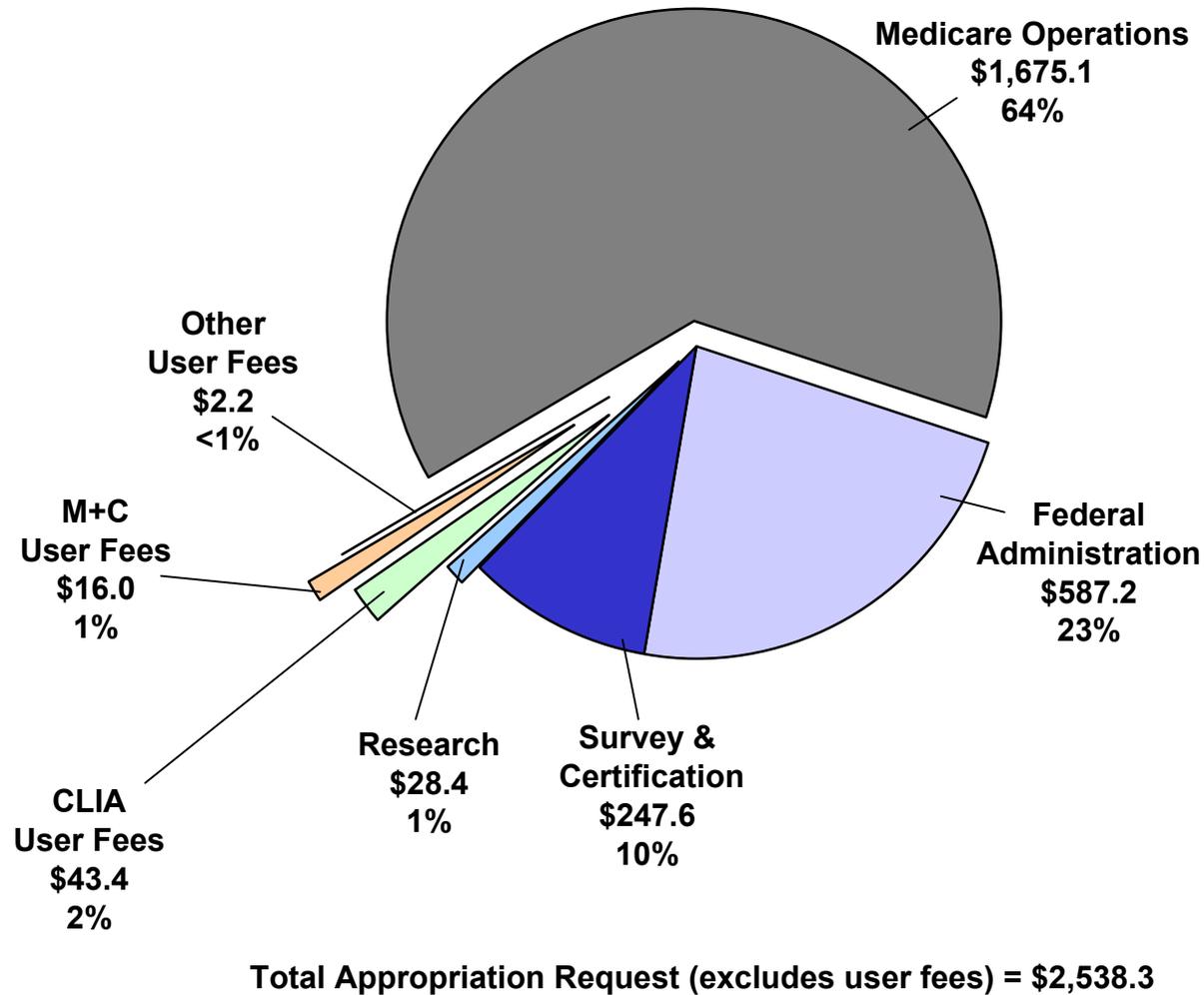


Notes: 1) Data are current law estimates for FY 2003; 2) Data may not sum due to rounding; 3) The number of beneficiaries was calculated on an average enrollment basis (e.g. person-years of enrollment); 4) Medicare spending does not include administrative costs; 5) Federal Medicaid spending includes administrative costs and Vaccines for Children Program; 6) The \$4.4 billion for SCHIP does not include a transfer to Medicaid; 7) The additional State share for Medicaid in FY 2003 is an estimated \$121.2 billion, and for SCHIP is \$1.8 billion; 8) Dually eligible beneficiaries are eligible for both Medicare and Medicaid during some point in the year. The number of Medicare beneficiaries, including dually eligible persons is 40.7 million. The number of Medicaid beneficiaries, including dually eligible persons is 40.4 million.

Source: FY 2003 President's Budget.

The CMS Budget: Program Management Account

(dollars in millions)

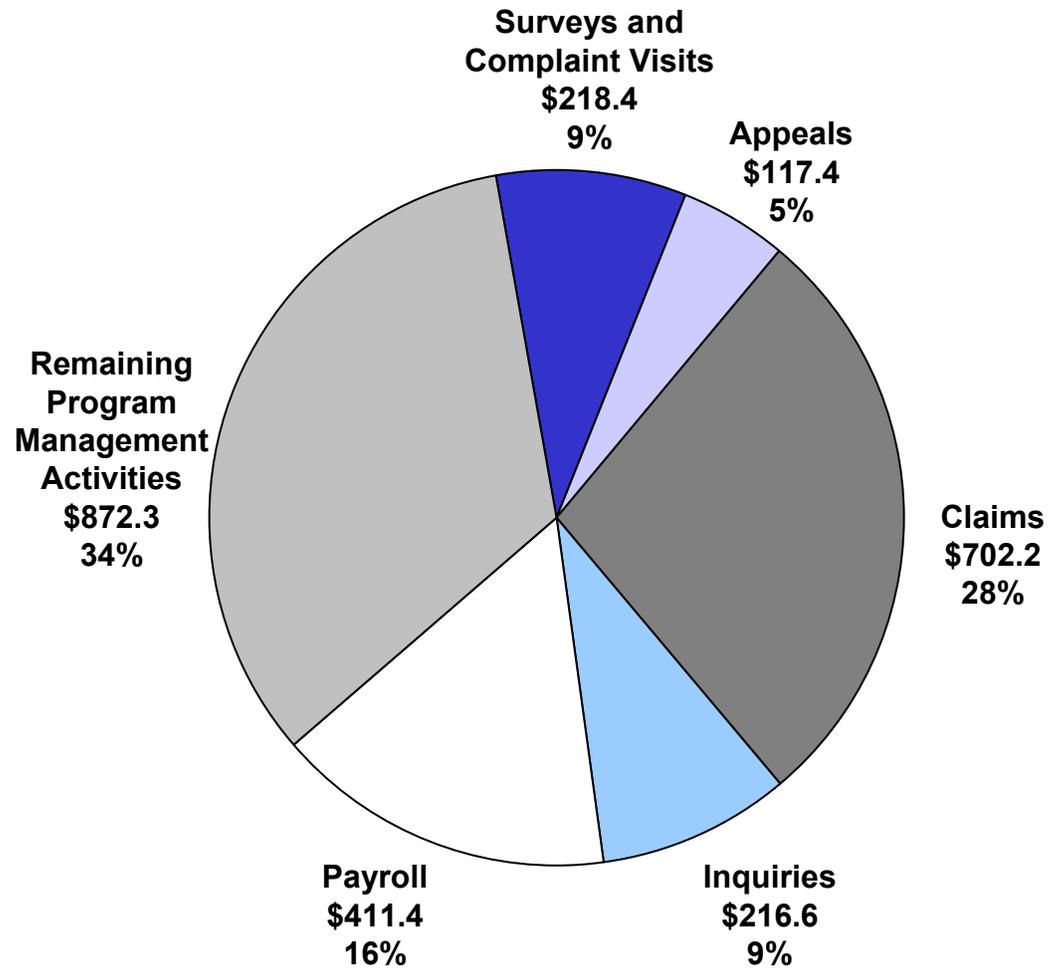


Note: The data used to compute this chart are based on CMS's FY 2003 current law program level request, totaling \$2,599.9 billion.

Source: FY 2003 President's Budget.

The CMS Budget: Breakout of Program Management Activities

(dollars in millions)



Total Appropriation Request = \$2,538.3

Note: This chart is a workload display of our FY 2003 current law program management appropriation request.

Source: FY 2003 President's Budget.

Serving Beneficiaries

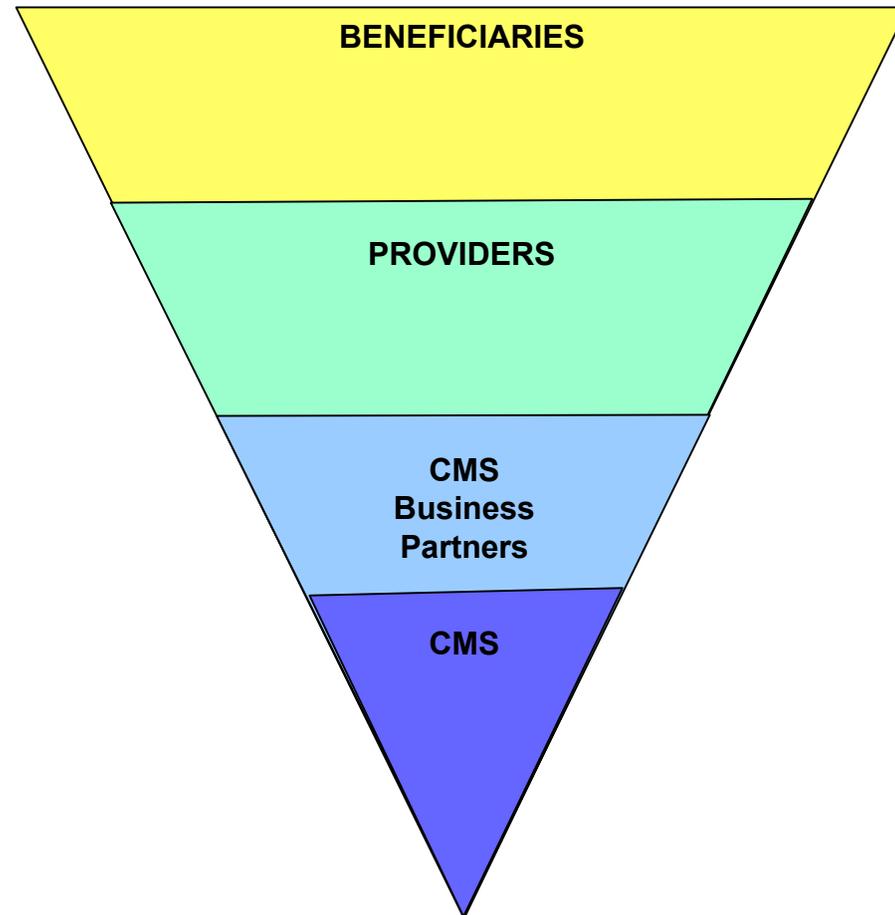
CMS works with many others to serve beneficiaries.

Medicare, Medicaid & SCHIP Beneficiaries **74 Million**^{1,2}

Hospitals	6,000
HMO's, LTC Facilities & Other	41,700
Physicians & Practitioners	885,500
Labs	173,800
Total Providers	1,107,000

State Medicaid / SCHIP Staffing	34,000
State Surveyor Staffing	6,200
Medicare Contractor Staffing	22,400
PRO Staffing	2,600
Total Business Partners	65,200

Central Office Personnel	2,939
Regional Office Personnel	1,561
Total CMS Personnel	4,500



¹ The number of beneficiaries was calculated on an average enrollment basis (e.g. person-years of enrollment).

² These data are FY 2001.

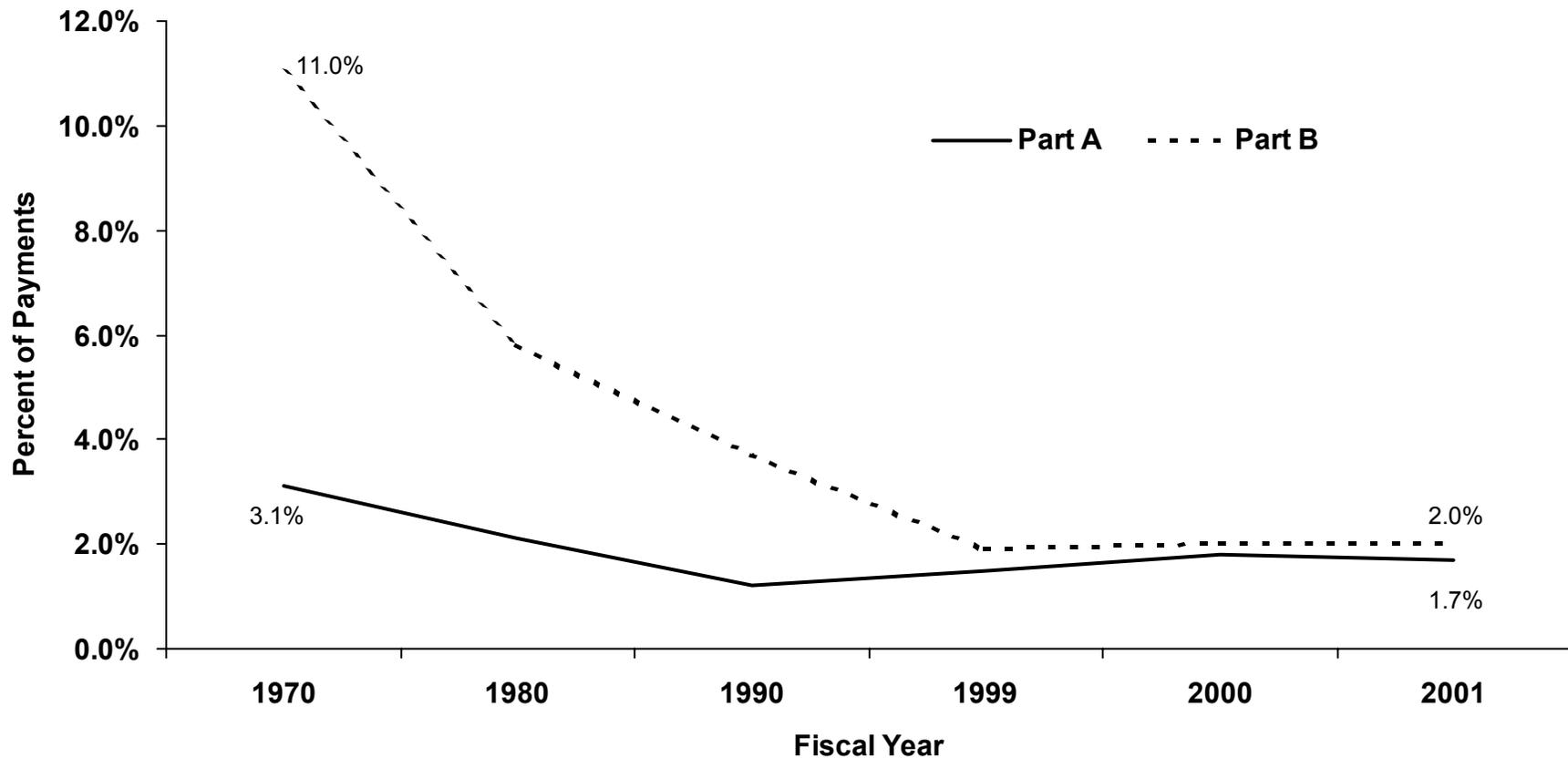
³ These counts are based on Medicare data.

⁴ These data are as of December 2001.

Source: Provider counts from CMS's Office of Research, Development, and Information; Beneficiary and business partner counts from CMS's Office of Financial Management.

Medicare Administrative Expenses as a Percent of Benefit Payments

Over the past two decades, Medicare's administrative costs declined as a percentage of total program spending.

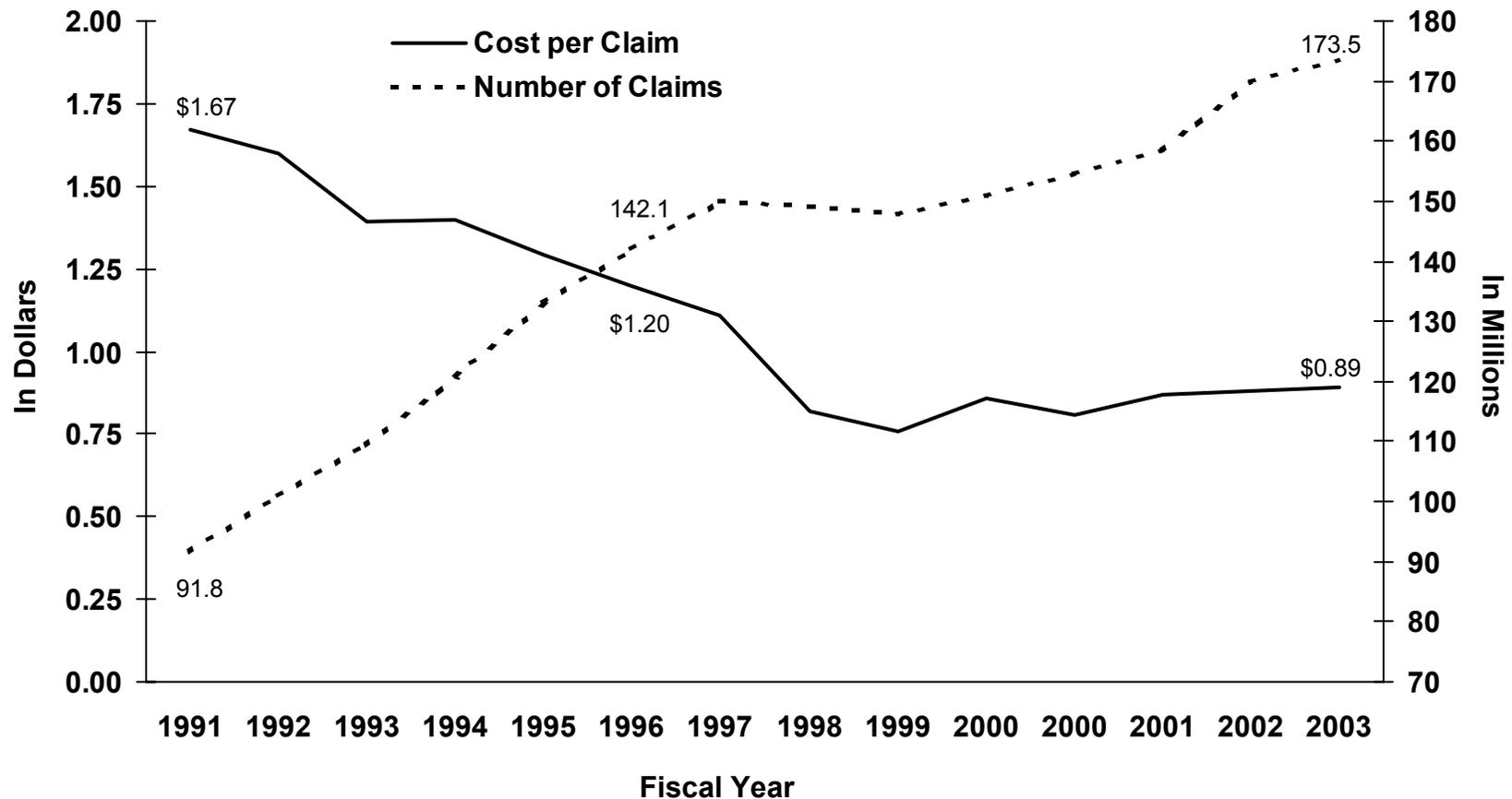


Note: Data are reported for community-dwelling beneficiaries only.

Source: CMS, Office of the Actuary.

Medicare Part A Cost per Claim and Number of Claims

Over the last decade, the number of Part A claims nearly doubled while the cost of processing each claim steadily declined.

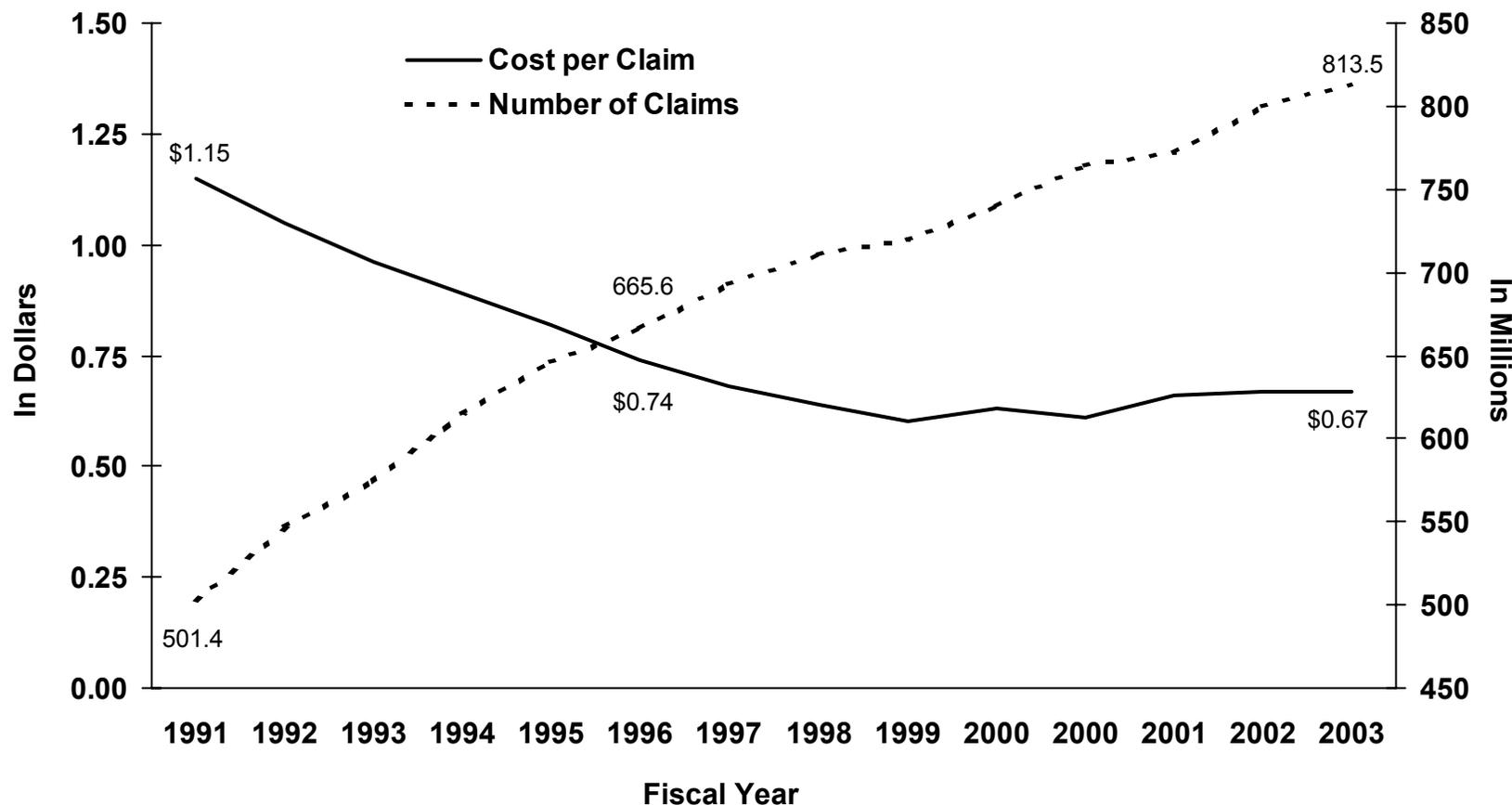


Notes: 1) FY 1997 and prior years include Part A inquiries, Part A provider education and training (PET), and shared systems maintenance costs. 2) The 2002 and 2003 data are preliminary estimates. 3) Cost per claim is in current dollars.

Source: CMS, Office of Financial Management.

Medicare Part B Cost per Claim and Number of Claims

Over the last decade, the number of Part B claims grew considerably while the cost of processing each claim steadily declined.

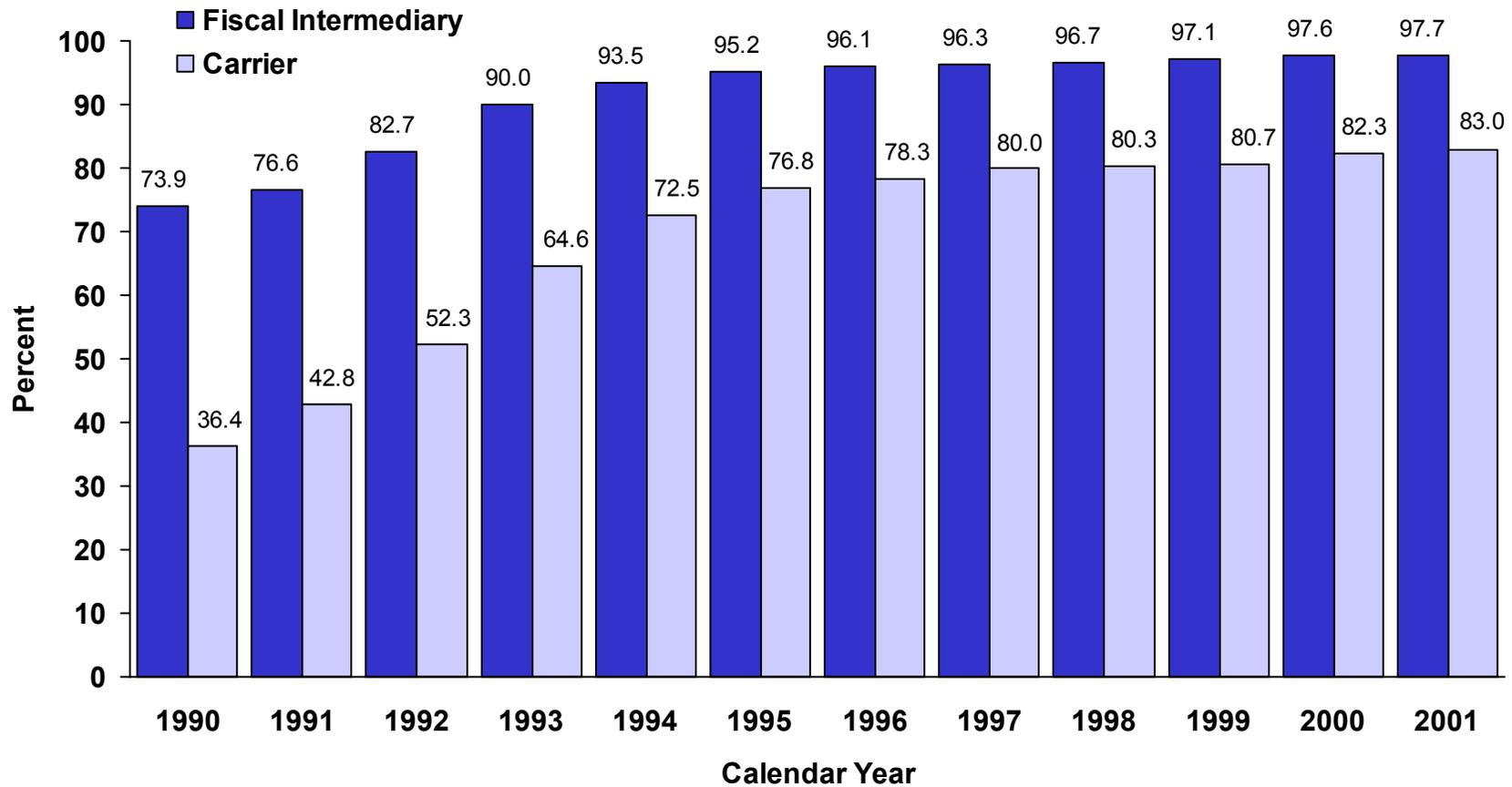


Notes: 1) The 2002 and 2003 data are preliminary estimates. 2) Cost per claim is in current dollars.

Source: CMS, Office of Financial Management.

Electronic Claims

The rate of electronic submission of Medicare claims grew considerably over the last decade.



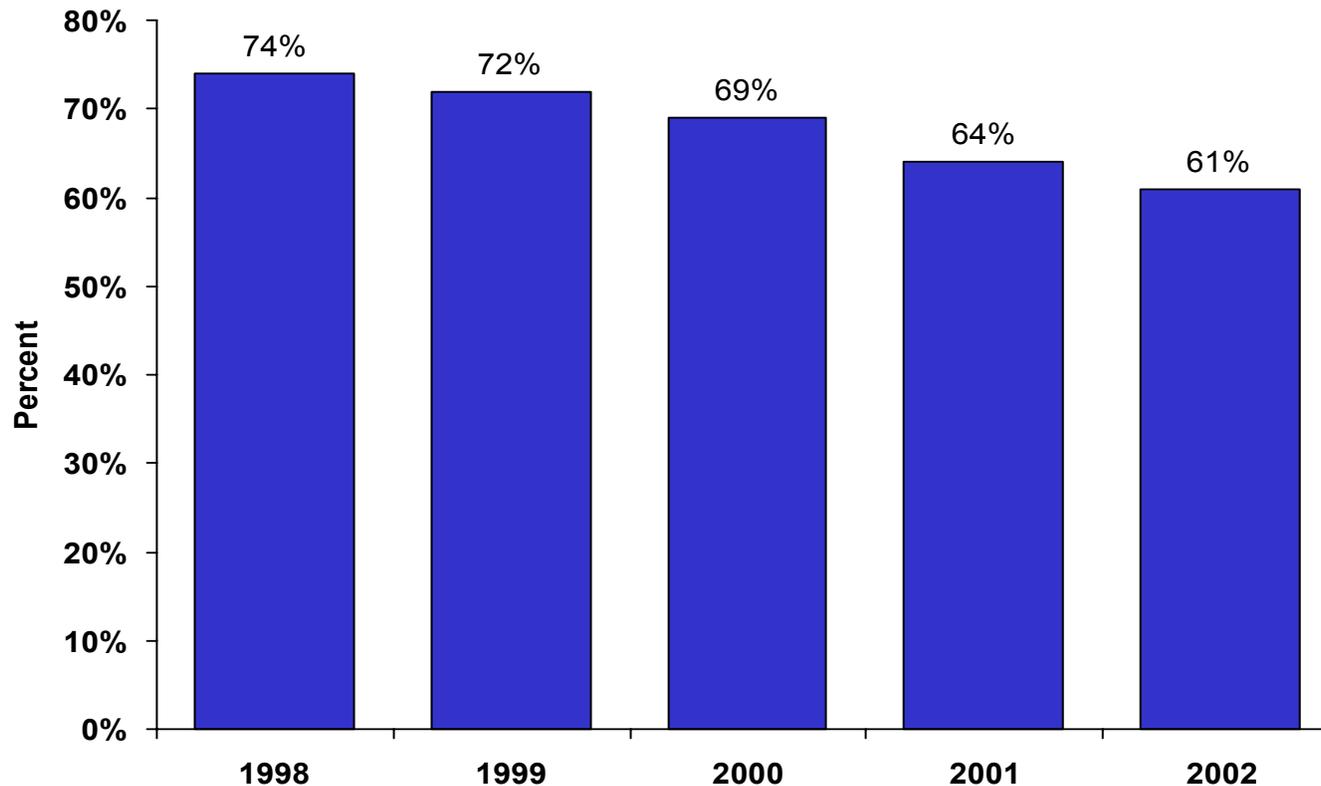
Source: CMS, Center for Medicare Management and Office of Financial Management.

III. Medicare Program Information

A. Medicare+Choice

Percent of Medicare Population with Access to at Least One Medicare+Choice Coordinated Care Plan

Access to Medicare+Choice Coordinated Care Plans declined as plans withdrew in 2001 and 2002.

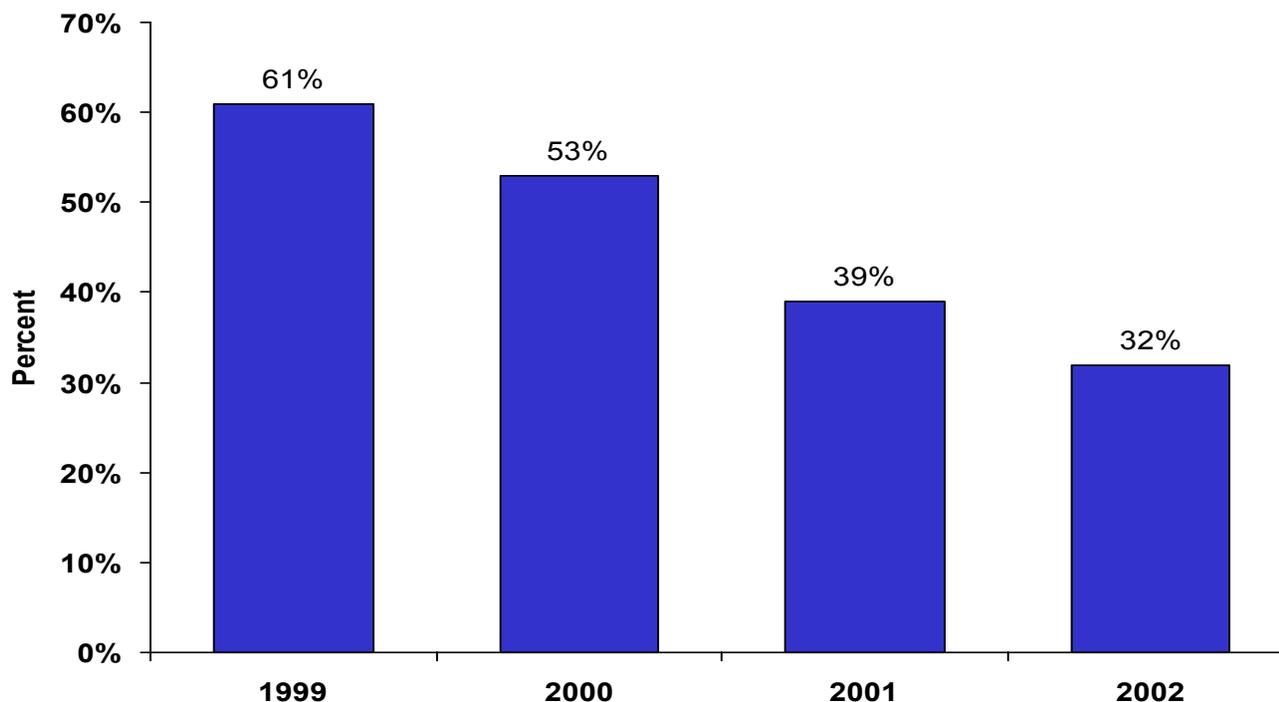


Notes: 1) Medicare+Choice Coordinated Care Plans are private managed care plans, such as health maintenance organizations, that enter into contracts with CMS to enroll Medicare beneficiaries and which are responsible for providing the full range of Medicare-covered services to their enrollees. 2) In 2001, an additional 18% of the Medicare population had access to Medicare+Choice through Sterling, the private fee-for-service plan. In 2002, an additional 16% have access to Sterling as the only available Medicare+Choice plan. 3) Data reflect the overall Medicare population.

Source: CMS, Office of Research, Development, and Information analysis of data from Medicare Compare and the CMS Plan Information Control System.

Percent of Medicare Population with Access to Zero Premium Medicare+Choice Coordinated Care Plans

Access to zero premium plans declined in 2002, continuing a pattern of significant decline.

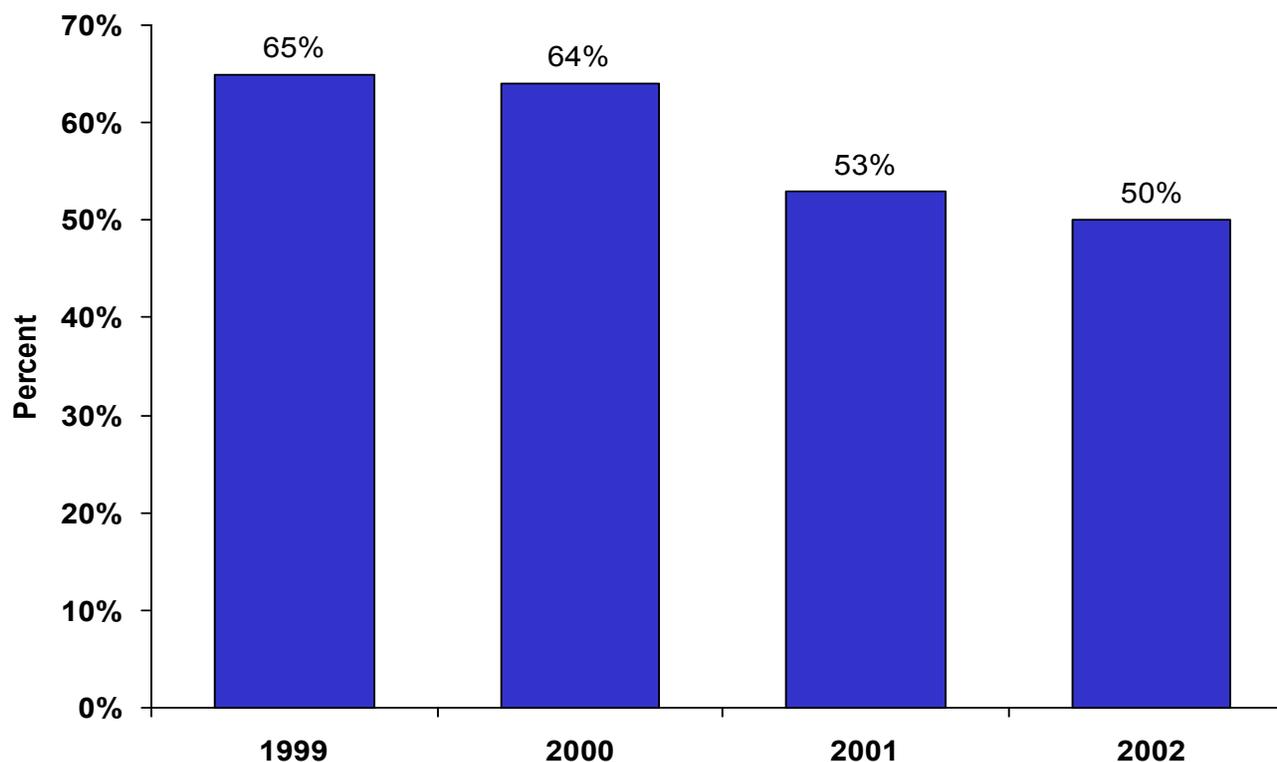


Notes: 1) Medicare+Choice Coordinated Care Plans are private managed care plans, such as health maintenance organizations, that enter into contracts with CMS to enroll Medicare beneficiaries and which are responsible for providing the full range of Medicare-covered services to their enrollees. 2) Zero premium plans are M+C plans that have no premium charge for beneficiaries who wish to enroll in the plan. M+C plans that do charge a premium may include, as part of the premium, charges for services not covered by Medicare, as well as charges for the cost sharing of traditional Medicare (e.g., the 20% cost sharing for physician services, which is not included in the Medicare program's payment to the M+C plan on behalf of the enrollee). Note that in order to enroll in an M+C plan, beneficiaries must continue to pay their Medicare Part B premiums. 3) For 2001, 46% of Medicare+Choice Coordinated Care Plan enrollees (including both those affected by a non-renewal and affected enrollees) were in zero premium plans. 4) Data reflect the overall Medicare population.

Source: CMS, Office of Research, Development, and Information analysis of data from Medicare Compare.

Percent of Medicare Population with Access to Any Medicare+Choice Plan with Drug Coverage

In 2002, access to any Medicare+Choice plans with drug coverage continued to decline.

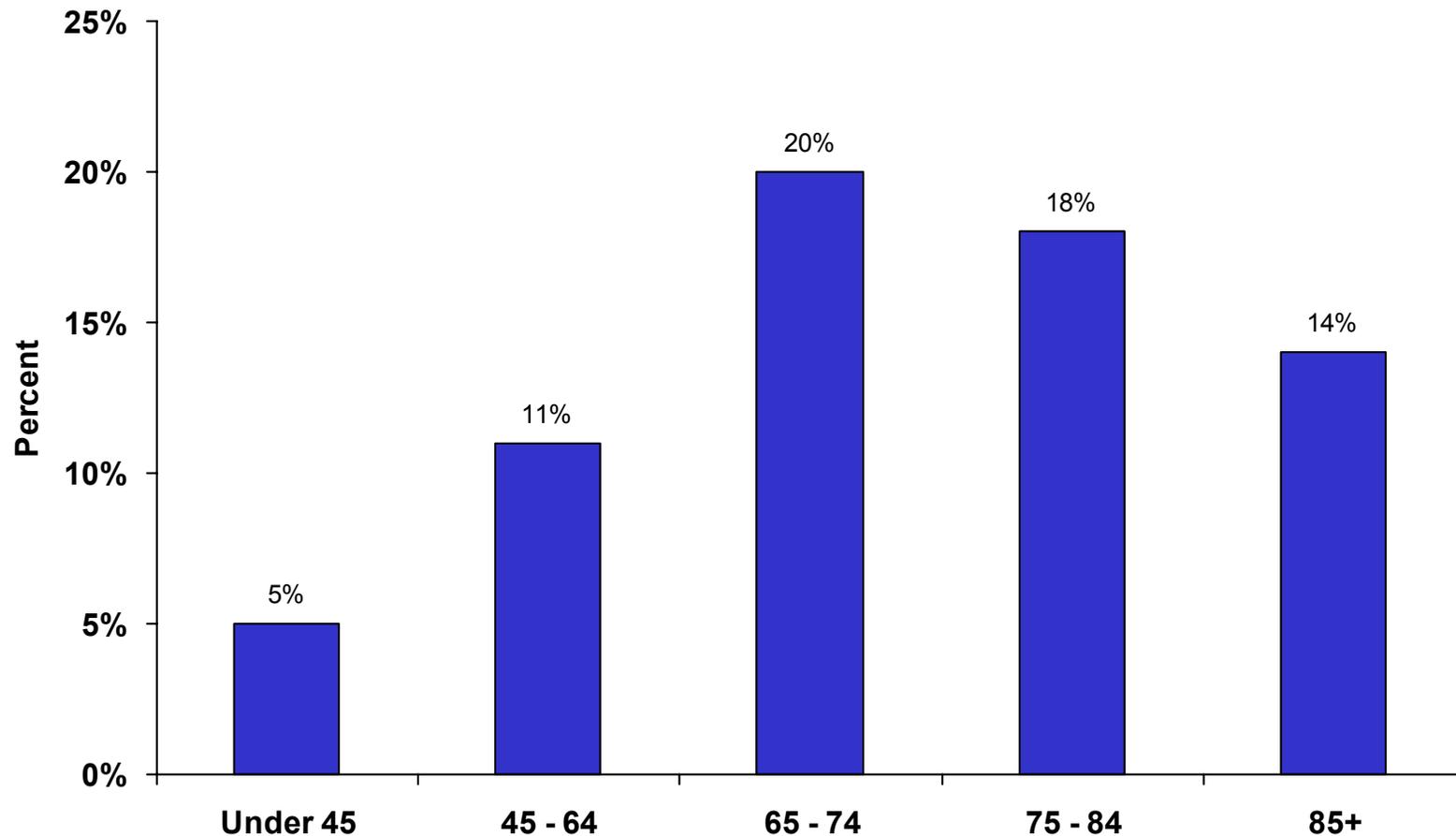


Notes: 1) Medicare+Choice Coordinated Care Plans are private managed care plans, such as health maintenance organizations, that enter into contracts with CMS to enroll Medicare beneficiaries and which are responsible for providing the full range of Medicare-covered services to their enrollees. 2) Data reflect the total Medicare population. 3) Access means the availability of any plan with drug coverage.

Source: CMS, Office of Research, Development, and Information analysis of data from Medicare Compare for 2001 and 2002. The Medicare Payment Advisory Commission (MedPAC) for 1999 and 2000.

Percent of Beneficiaries Joining Risk HMOs, by Age Group, 2000

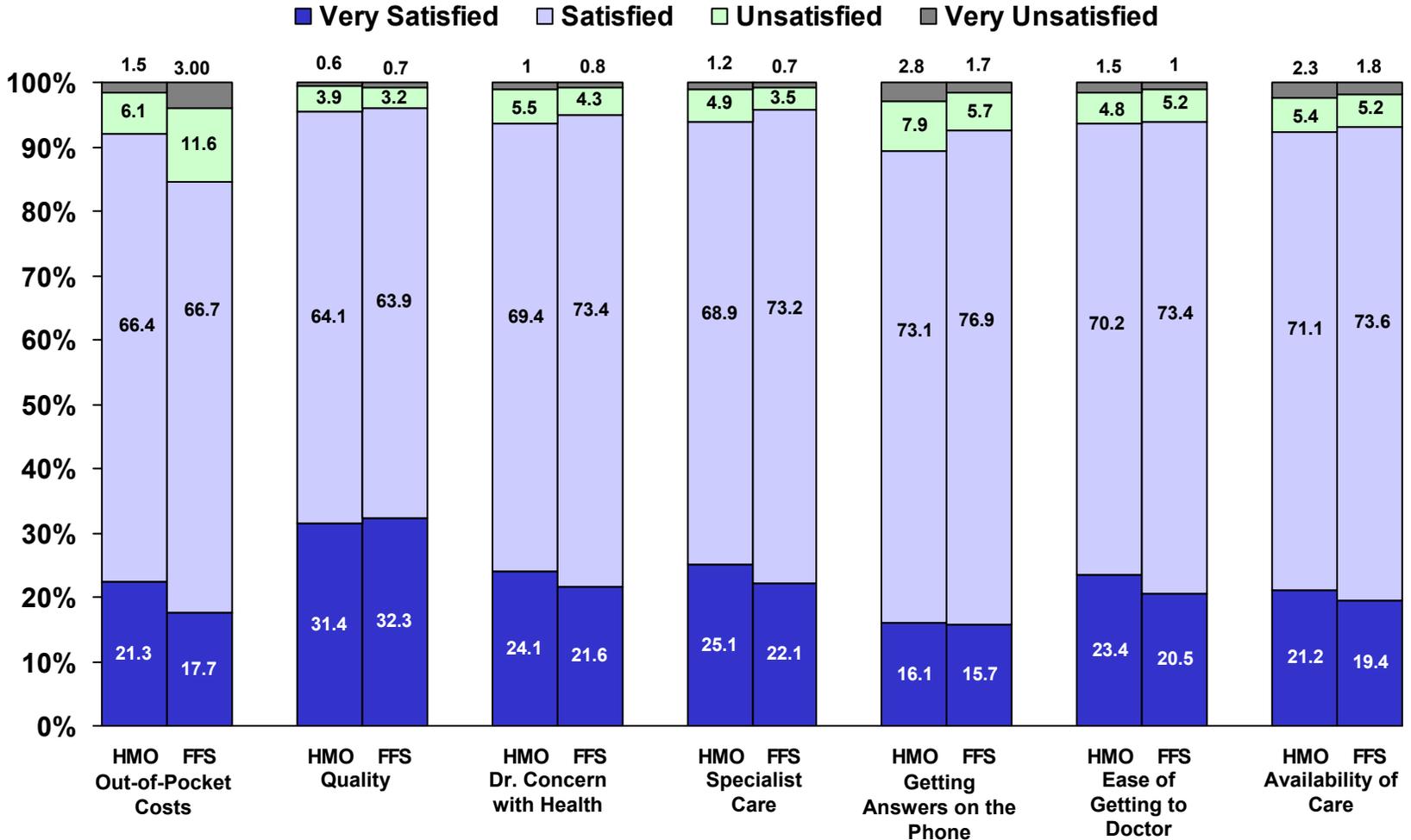
Beneficiaries between the ages of 65 and 84 are more likely to join HMOs than are the disabled.



Source: CMS, Office of Research, Development, and Information: Data from Medicare Current Beneficiary Survey (MCBS) 2000 Access to Care File.

Beneficiary Attitudes Toward HMOs and Fee-for-Service, 2000

Medicare beneficiaries in managed care and fee-for-service have high levels of satisfaction with their health care.

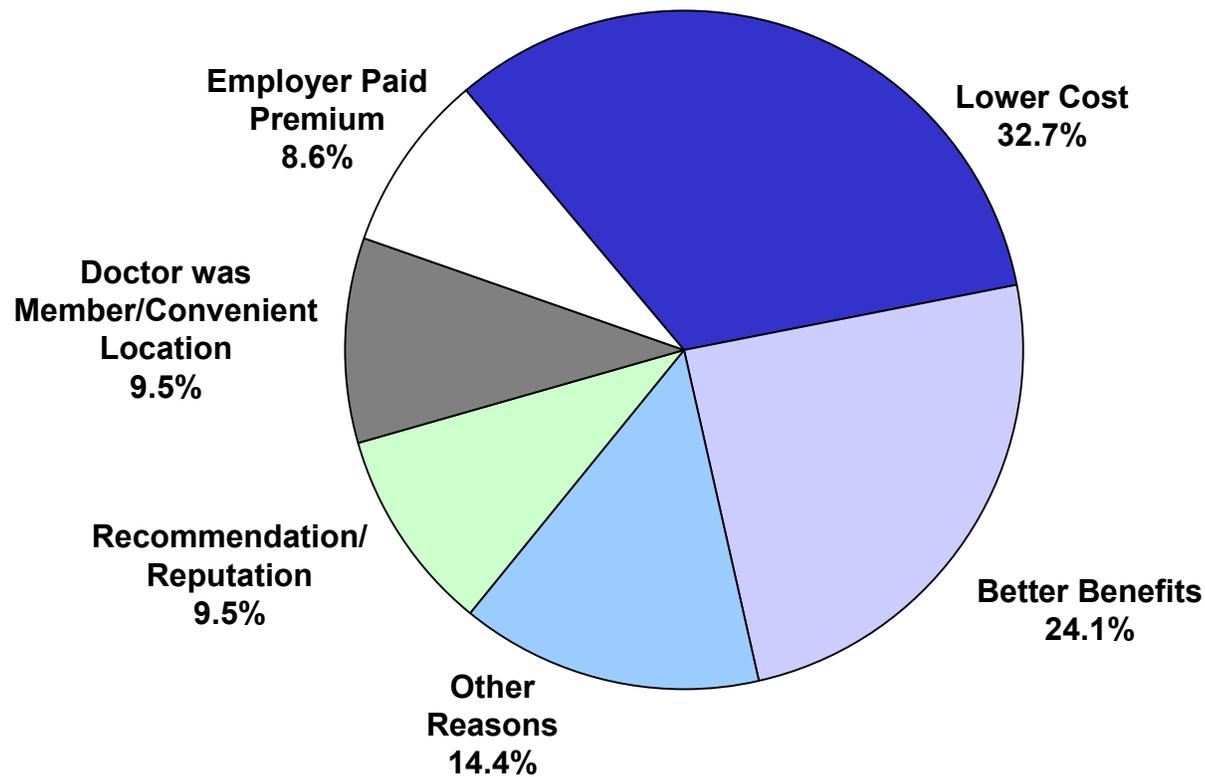


Note: Does not include beneficiaries in facility care.

Source: CMS, Office of Research, Development, and Information: Data from the Medicare Current Beneficiary Survey (MCBS) 2000 Access to Care File.

Primary Reason a Beneficiary Joined a Medicare Risk HMO, 2000

Lower costs or better benefits were the most common reasons for joining a Medicare Risk HMO.

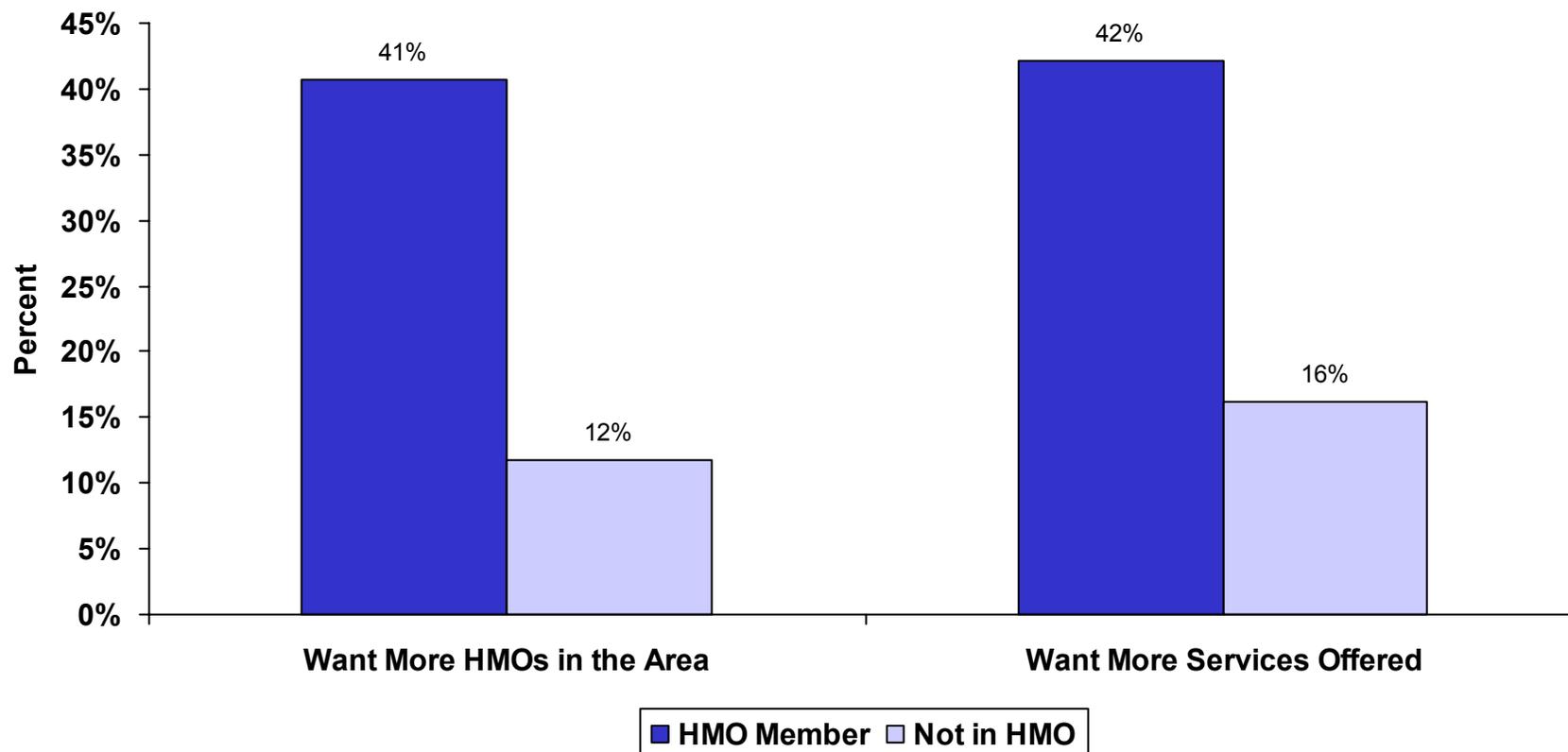


Note: Does not include beneficiaries in facility care.

Source: CMS, Office of Research, Development, and Information: Data from the Medicare Current Beneficiary Survey (MCBS) 2000 Access to Care File.

Beneficiary Desire for Additional Medicare Risk HMOs and Additional Services, by HMO Status, 2000

Beneficiaries in Medicare managed care plans expressed greater desire for additional plans in the area and more services to be offered by those plans.



Note: Does not include beneficiaries in facility care.

Source: CMS, Office of Research, Development, and Information: Data from the Medicare Current Beneficiary Survey (MCBS) 2000 Access to Care File.

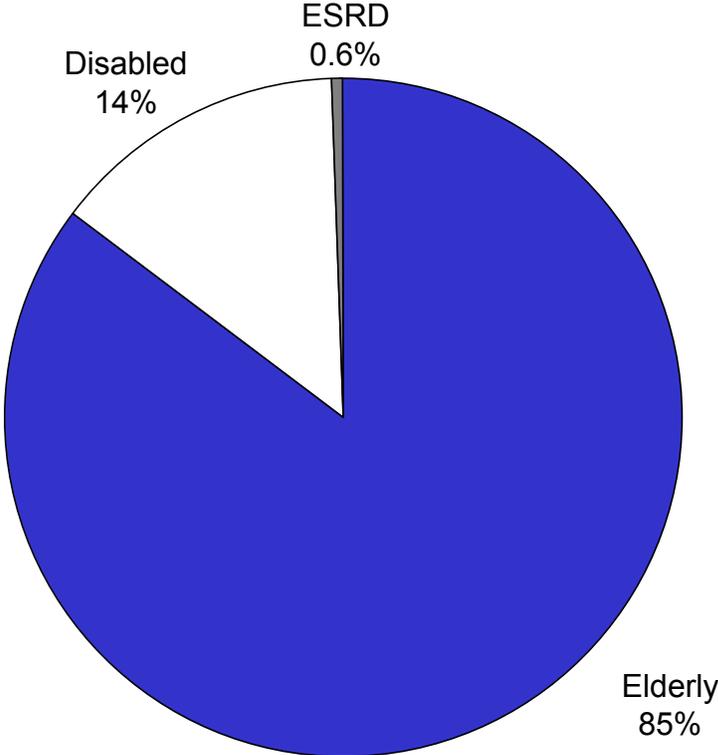
III. Medicare Program Information

B. Profile of Medicare Beneficiaries

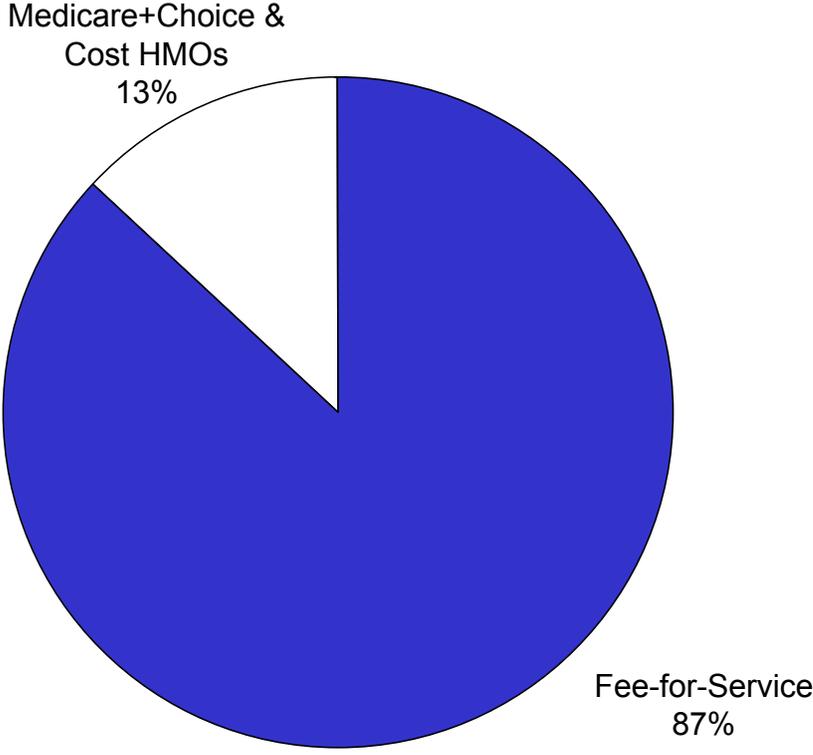
1. Beneficiary Demographic Information

Medicare Beneficiaries: Source of Eligibility and Coverage, 2002

Source of Eligibility



Source of Coverage



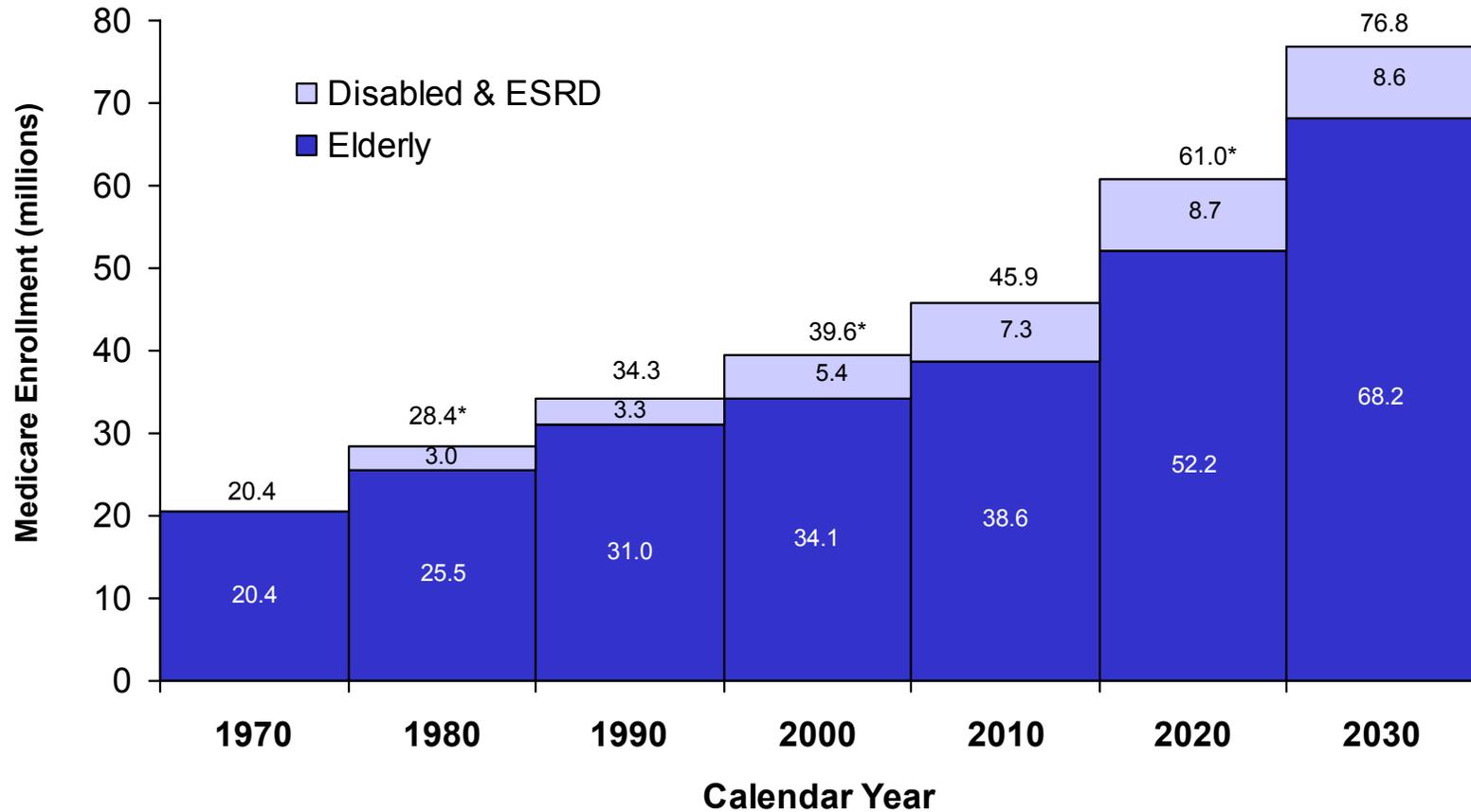
Beneficiaries = 40 million

Notes: 1) Totals may not sum due to rounding; 2) ESRD refers to beneficiaries under age 65 with End-Stage Renal Disease; 3) the Disabled category refers to beneficiaries under age 65 without ESRD.

Source: Elderly, disabled, and ESRD data from CMS's Office of the Actuary; Medicare+Choice and cost plan data from CMS's Medicare Managed Care Contract Report, March 2002.

Number of Medicare Beneficiaries

The number of people Medicare serves will nearly double by 2030.

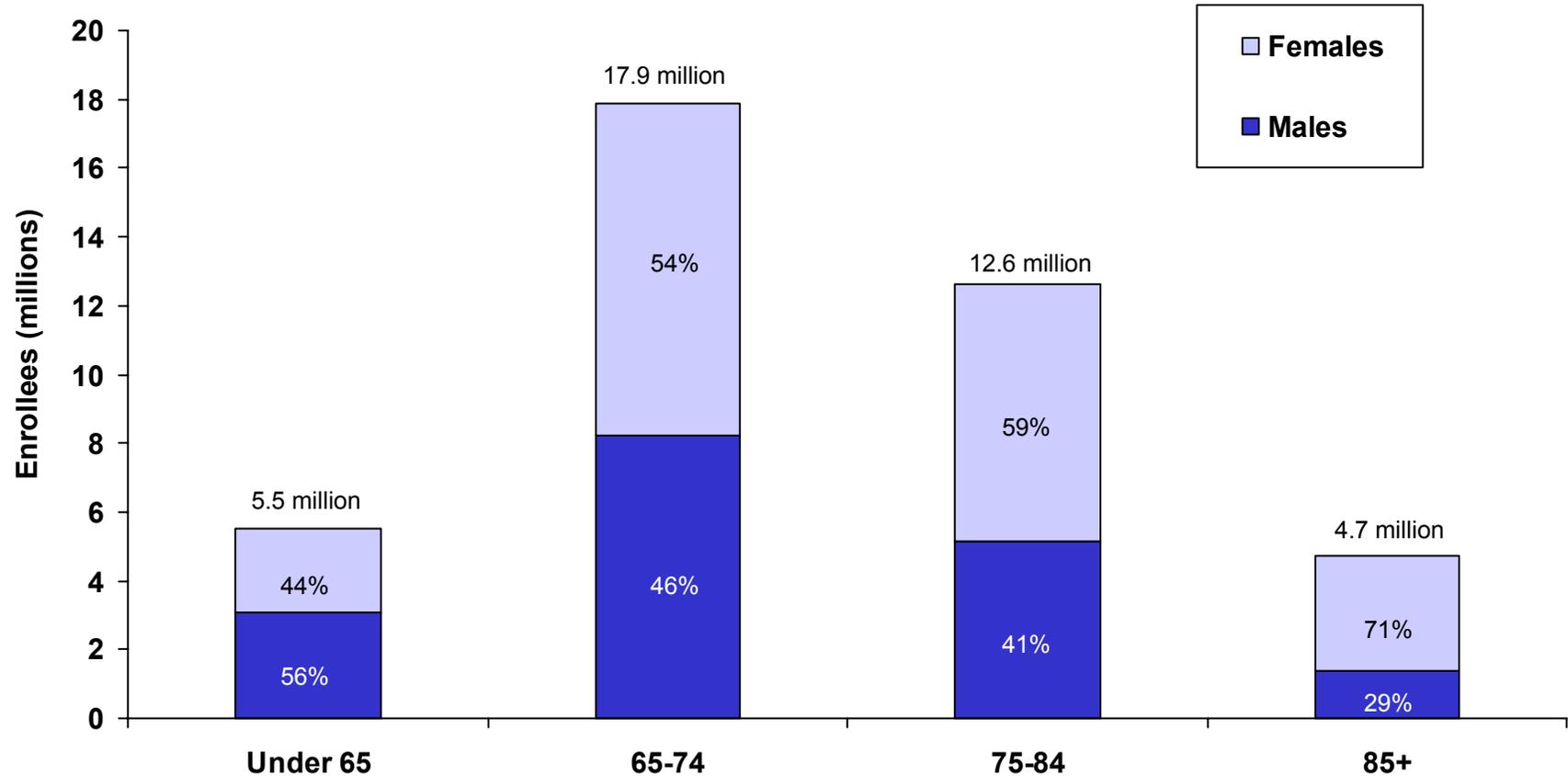


* Numbers may not sum due to rounding.

Source: CMS, Office of the Actuary.

Age and Gender of the Medicare Population, 2000

The proportion of women increases as the population grows older.

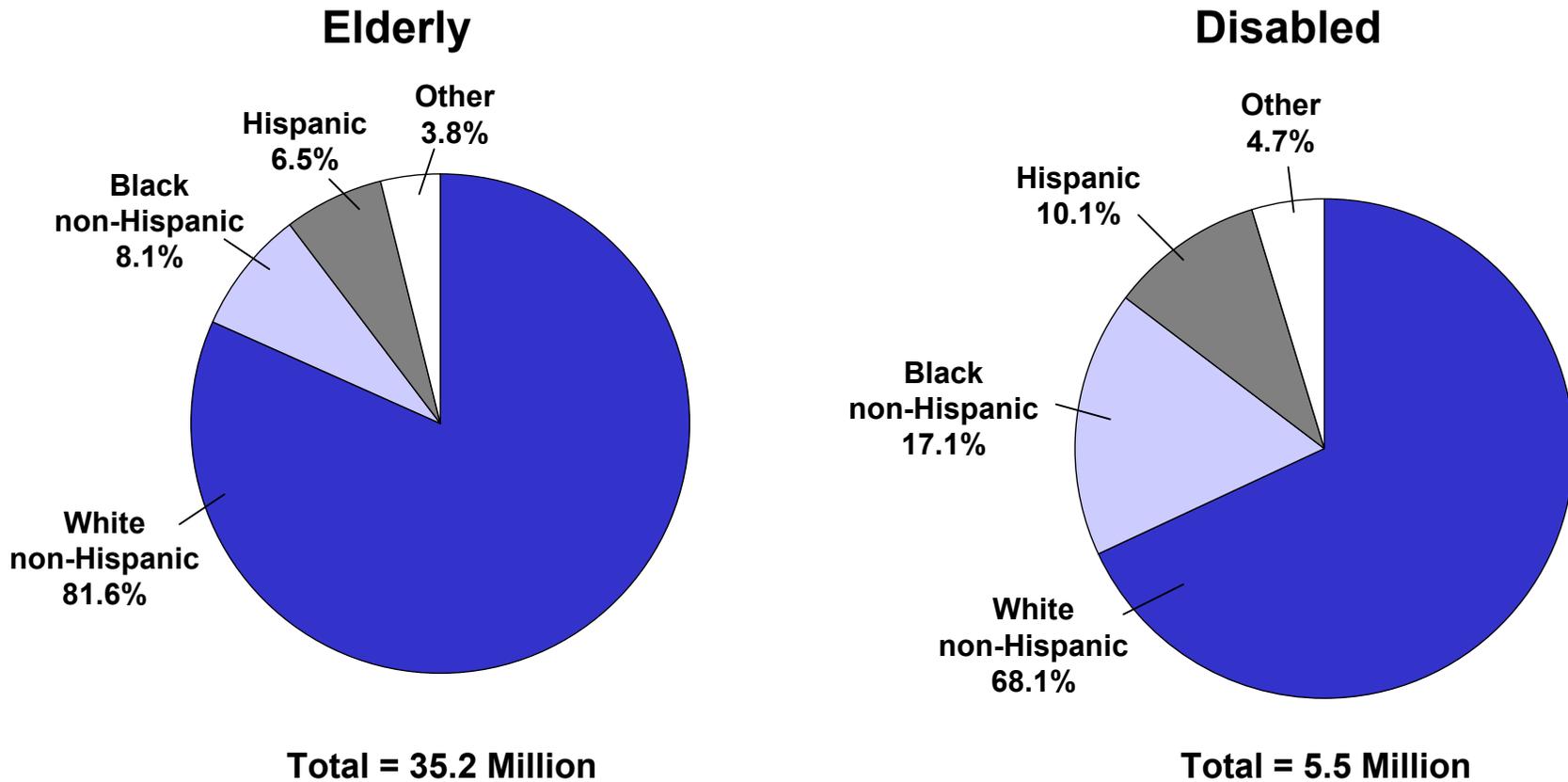


Note: Fifty-six percent (23 million) of all Medicare beneficiaries are female; 44% (18 million) are males. Data reflect Medicare beneficiaries ever enrolled in the program during the year.

Source: CMS, Office of Research, Development, and Information: data from the Medicare Current Beneficiary Survey (MCBS) 2000 Access to Care File.

Race/Ethnicity Distribution of Medicare Beneficiaries, 2000

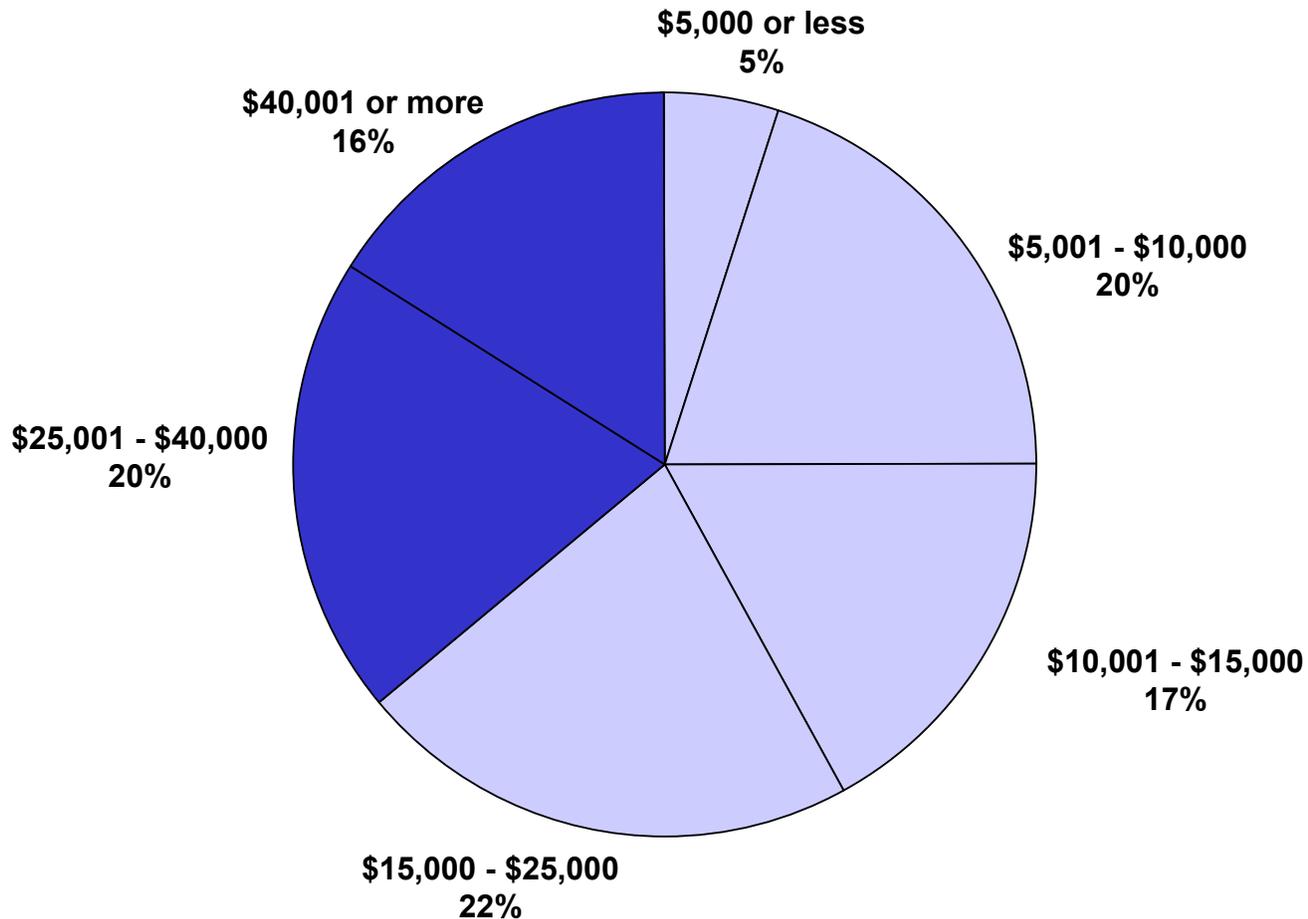
Minority beneficiaries are disproportionately represented among the disabled.



Source: CMS, Office of Research, Development, and Information: Data from the Medicare Current Beneficiary Survey (MCBS) 2000 Access to Care Files.

Income Distribution of Medicare Beneficiaries, 2000

Nearly 65 percent of Medicare beneficiaries have annual incomes below \$25,000.

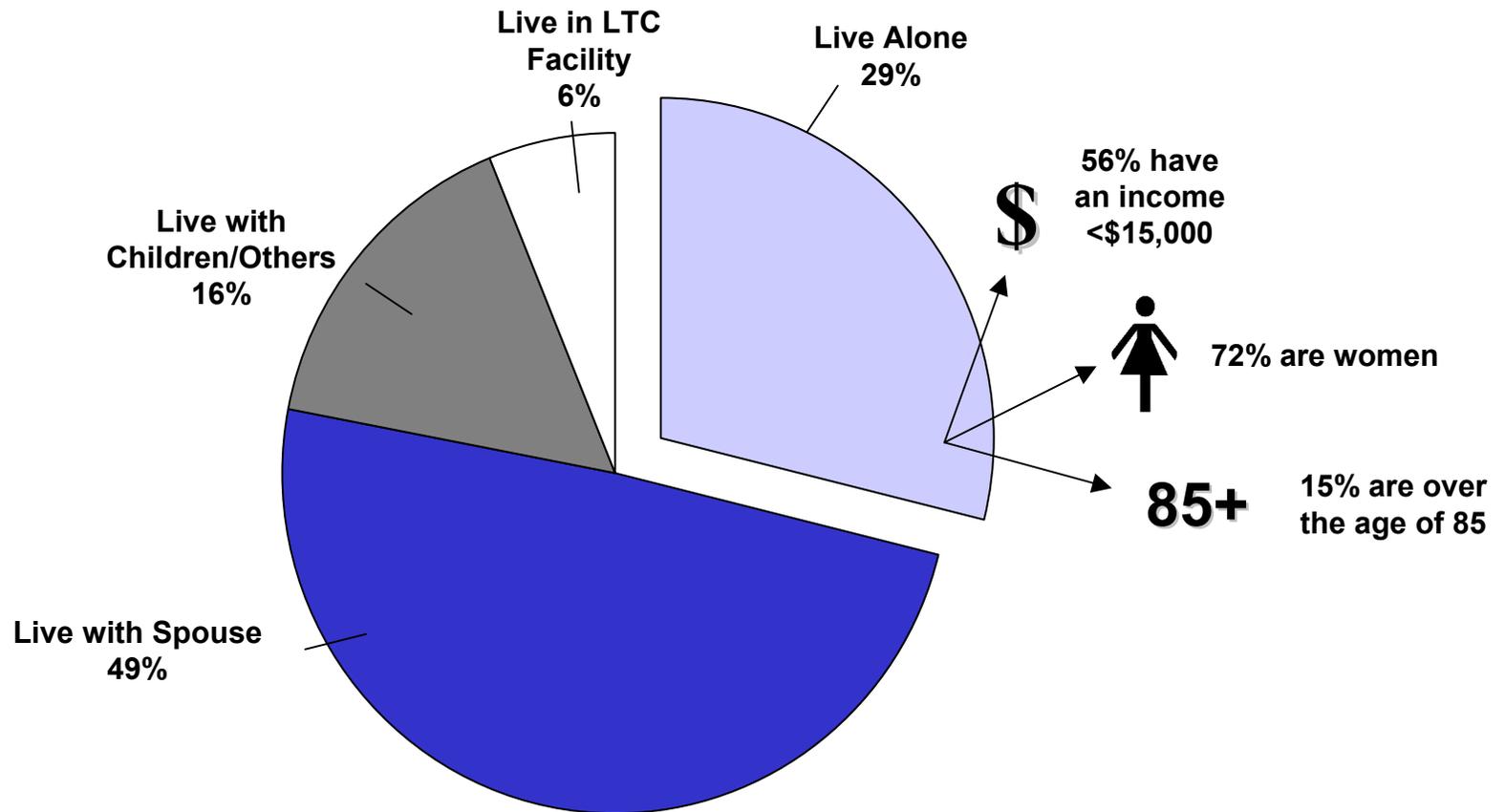


Notes: 1) Numbers may not sum due to rounding; 2) annual income figures are for calendar year 2000.

Source: CMS, Office of Research, Development, and Information: Data from the Medicare Current Beneficiary Survey (MCBS) 2000 Access to Care File.

Living Arrangements of Medicare Beneficiaries, 2000

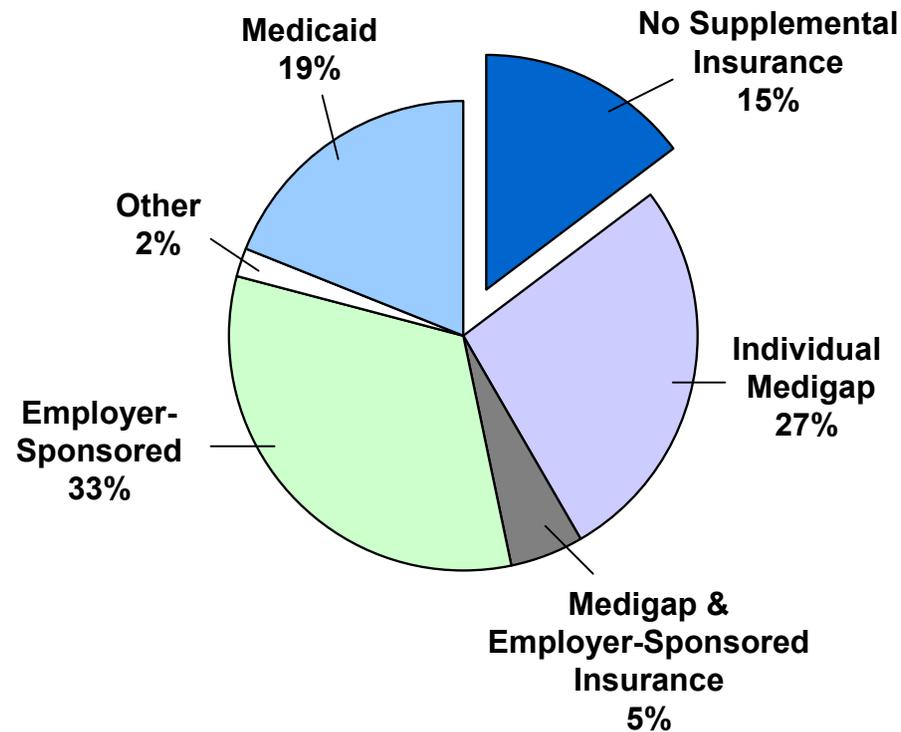
Among the nearly 30 percent of beneficiaries living alone, a large proportion are women and have low incomes.



Source: CMS, Office of Research, Development, and Information: Data from the Medicare Current Beneficiary Survey (MCBS) 2000 Access to Care File.

Types of Supplemental Health Insurance Held by Fee-for-Service Medicare Beneficiaries, 2000

Most beneficiaries using fee-for-service Medicare have private, supplemental health plans.



Note: Medicaid (shown above) includes both Qualified Medicare Beneficiaries (QMBs) and Specified Low-Income Medicare Beneficiaries (SLMBs).

Source: CMS, Office of Research, Development, and Information: Data From the Medicare Current Beneficiary Survey (MCBS) 2000 Access to Care File.

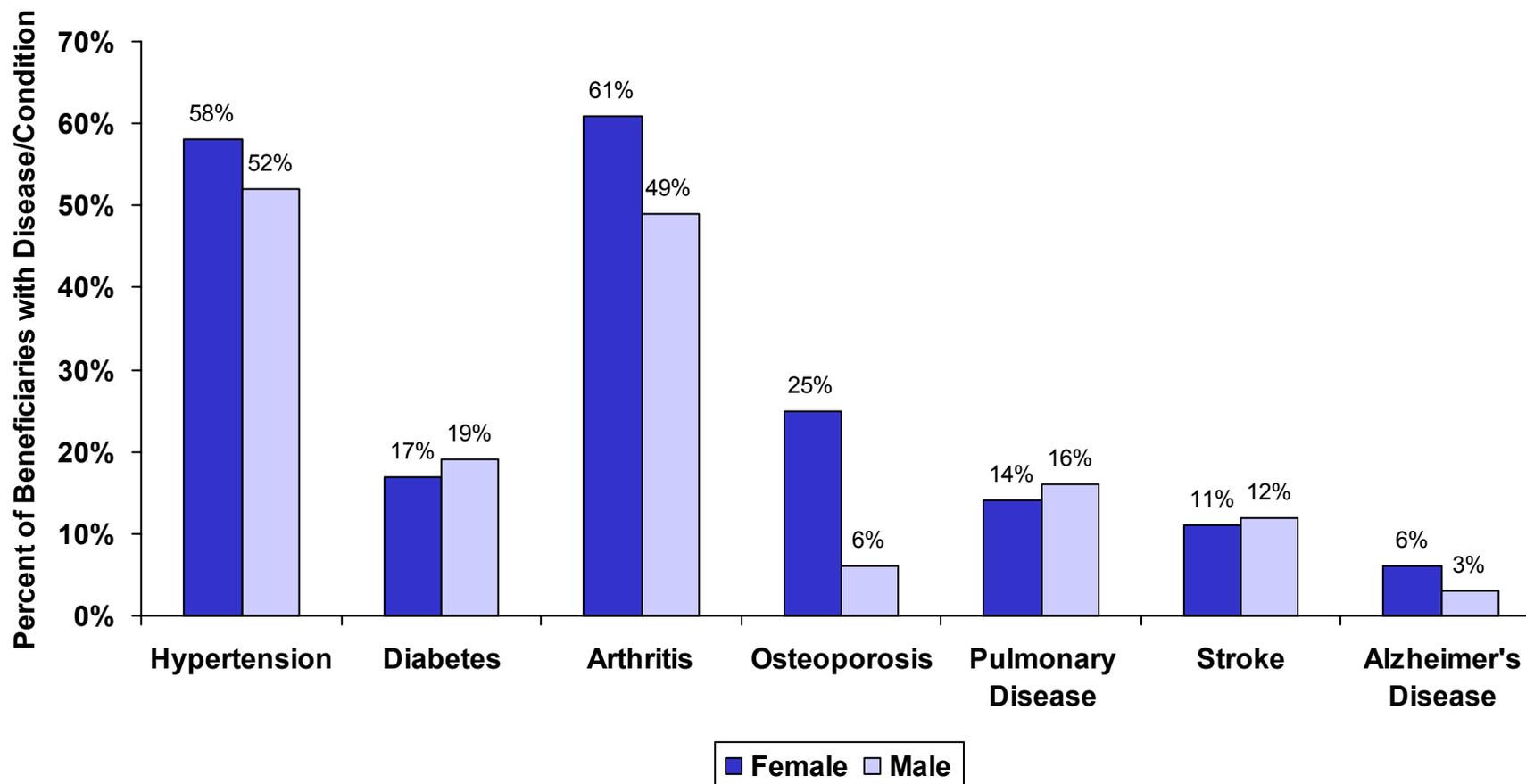
III. Medicare Program Information

B. Profile of Medicare Beneficiaries

2. Beneficiary Health Status/Functional Limitations

Medicare Beneficiaries' Self-Reported Diseases and Chronic Conditions, by Gender, 2000

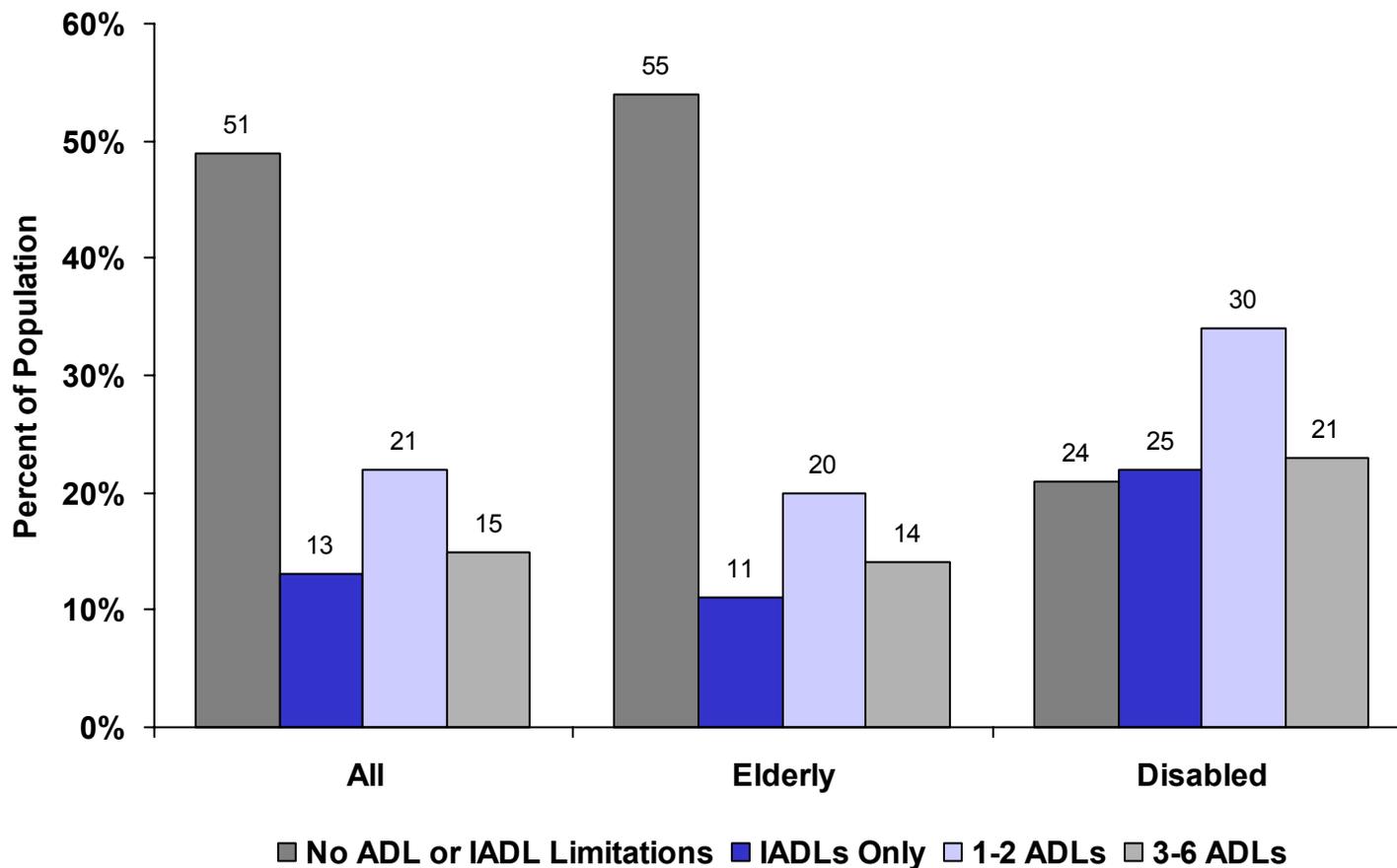
Female beneficiaries are more likely to have hypertension, arthritis, osteoporosis, and Alzheimer's disease.



Source: CMS, Office of Research, Development, and Information: Data from the Medicare Current Beneficiary Survey (MCBS) 2000 Access to Care File.

Distribution of Medicare Enrollees, by Functional Status, 2000

More than one-third of the Medicare population needs assistance with at least one “activity of daily living.”

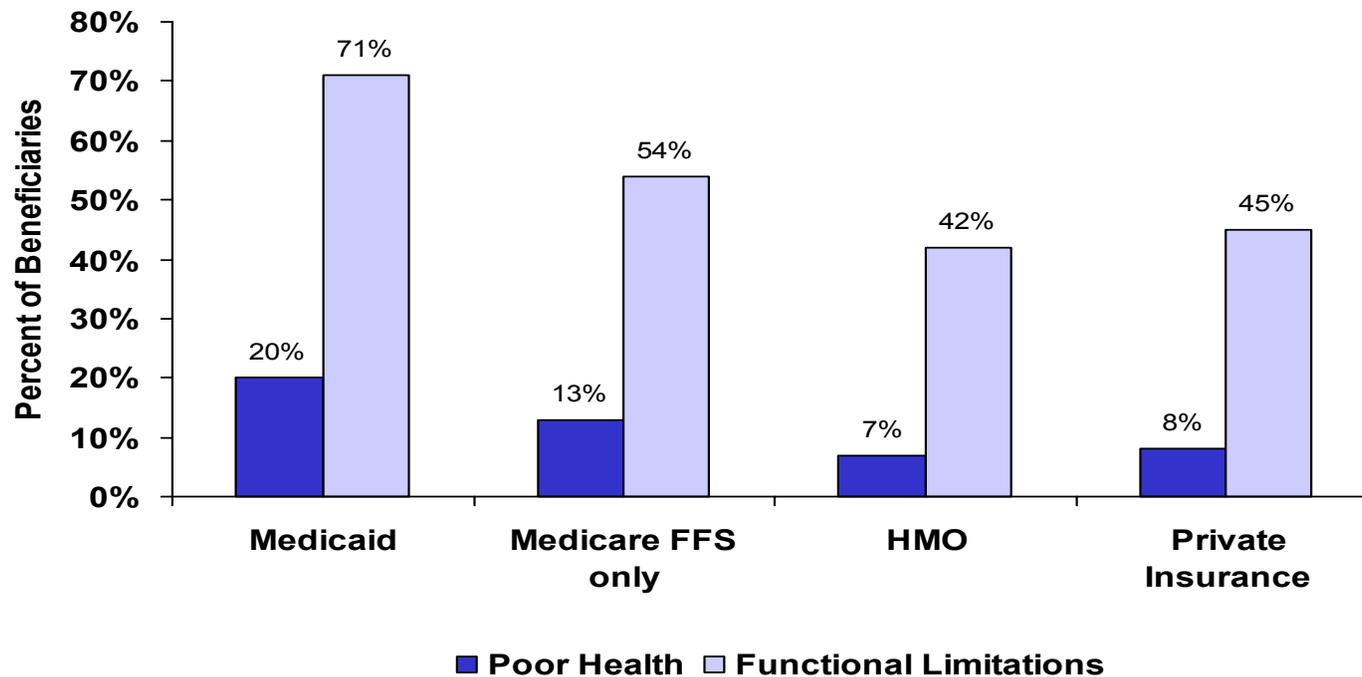


Note: ADLs are activities of daily living (e.g., eating, bathing); IADLs are instrumental activities of daily living (e.g., shopping, use of phone, cleaning).

Source: CMS, Office of Research, Development, and Information: Data from Medicare Current Beneficiary Survey (MCBS) 2000 Access to Care File.

Beneficiaries with Poor Health and Functional Limitations, by Insurance Status, 2000

Medicare beneficiaries in poor health or with functional limitations are more likely to receive Medicaid assistance or to have no supplemental insurance.



Source: CMS, Office of Research, Development, and Information: Data from the Medicare Current Beneficiary Survey (MCBS) 2000 Access to Care File.

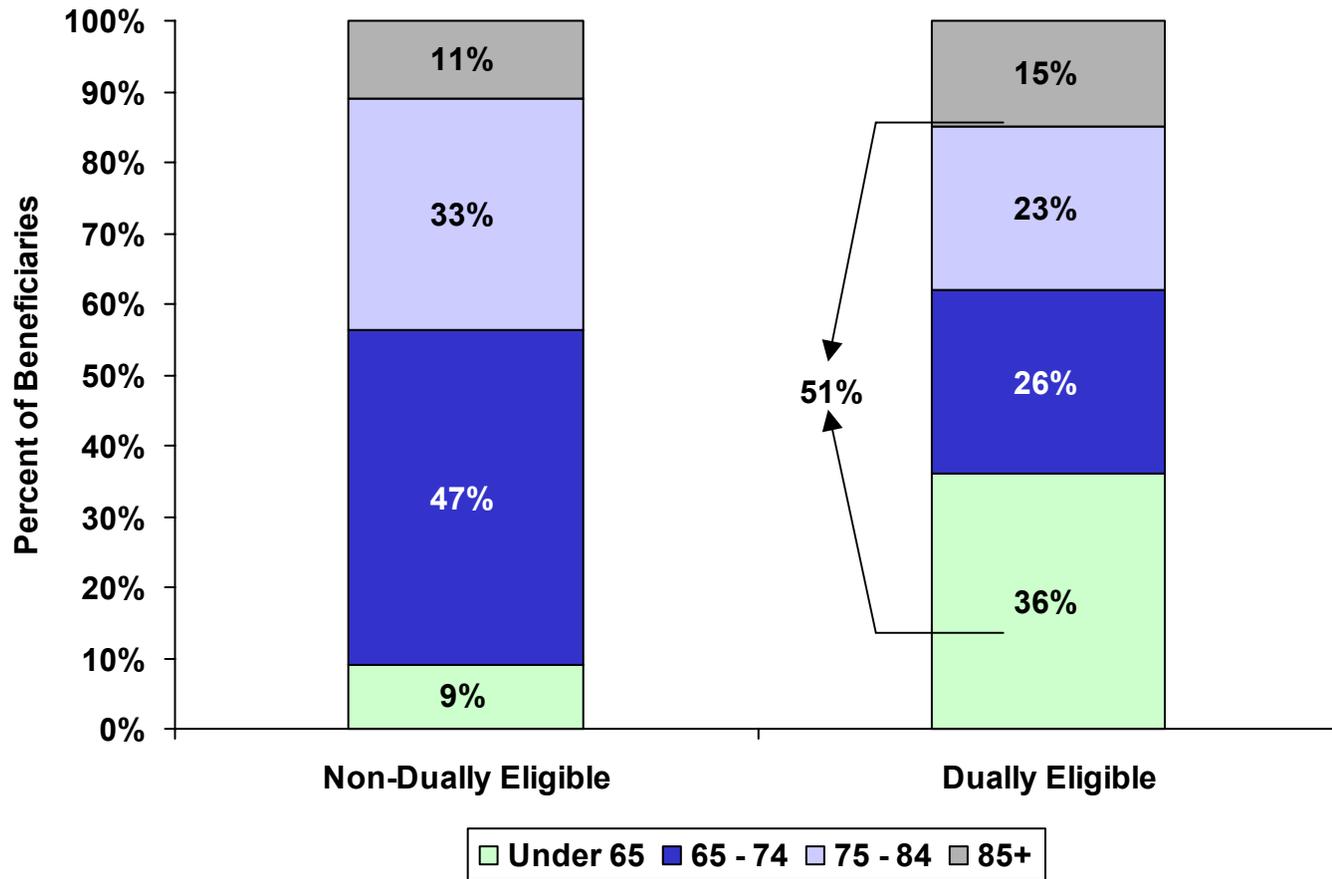
III. Medicare Program Information

B. Profile of Medicare Beneficiaries

3. Dually Eligible Beneficiaries

Proportion of Medicare Dually Eligible and Non-Dually Eligible Beneficiaries, by Age, 2000

Over half of the dually eligible population are under age 65 or over 85.

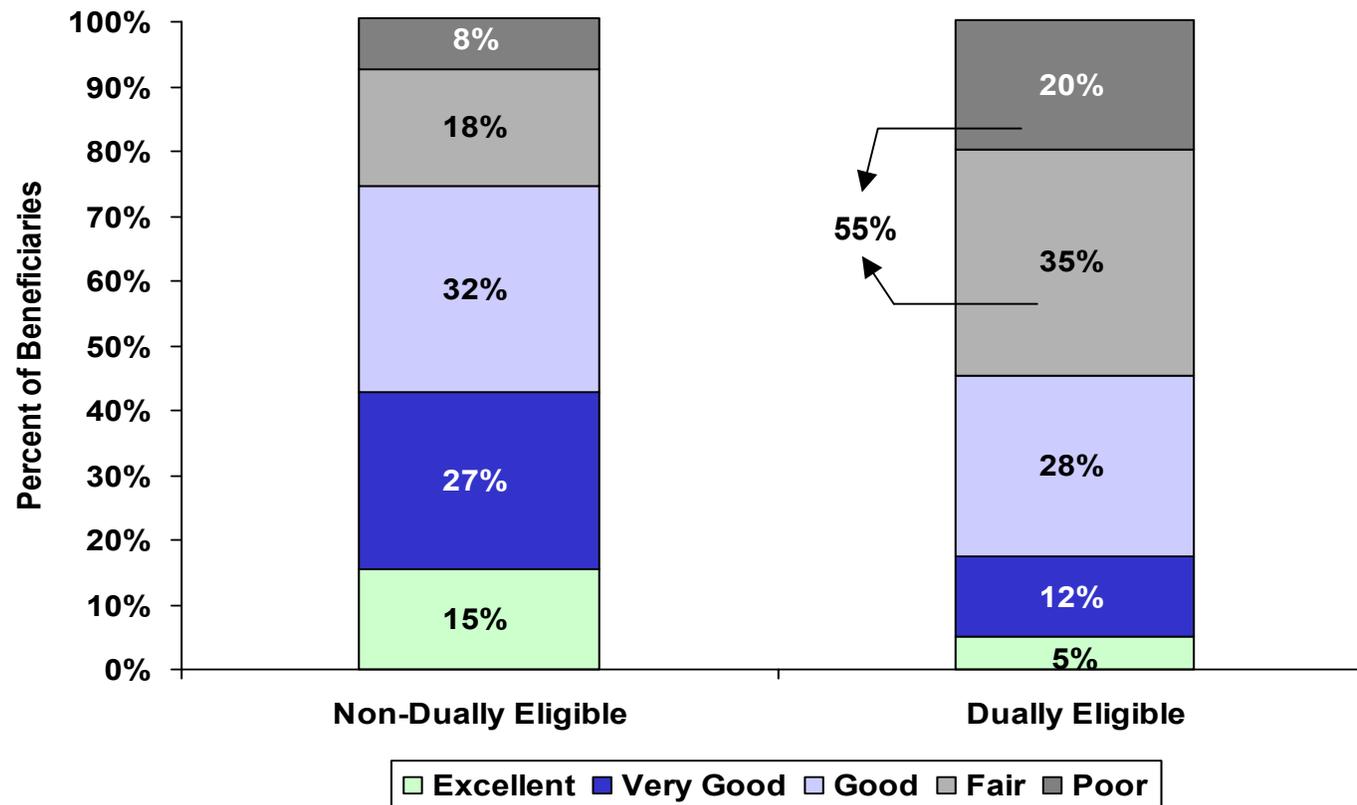


Note: Dually eligible beneficiaries are Medicare beneficiaries that also receive Medicaid coverage.

Source: CMS, Office of Research, Development, Information: Data from the Medicare Current Beneficiary Survey (MCBS) 2000 Access to Care File.

Self-Reported Health Status of Dually Eligible and Non-Dually Eligible Beneficiaries, 2000

Over half of the dually eligible population is in poor or fair health.

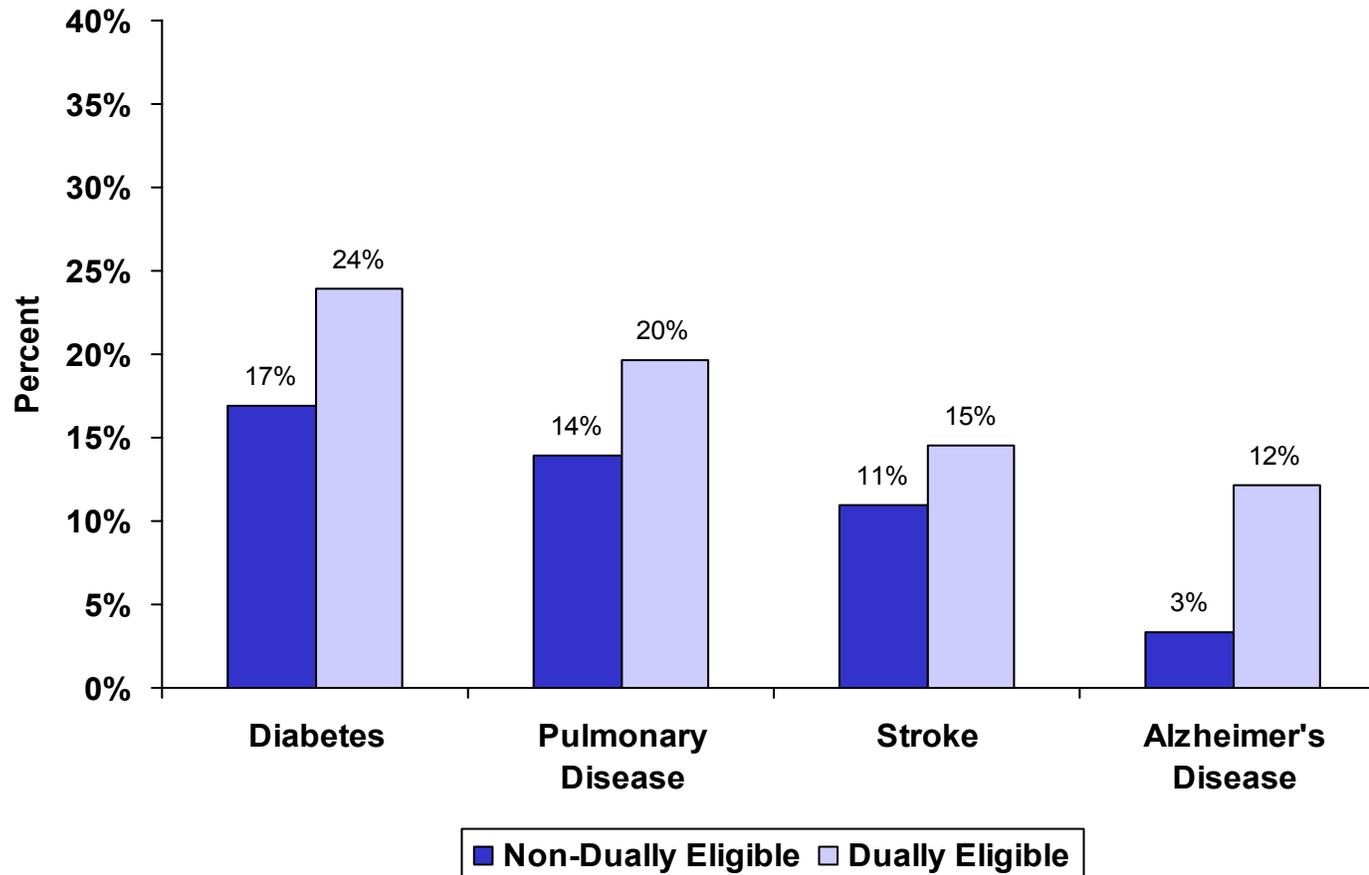


Note: Dually eligible beneficiaries are Medicare beneficiaries that also receive Medicaid coverage.

Source: CMS, Office of Research, Development, Information: Data from the Medicare Current Beneficiary Survey (MCBS) 2000 Access to Care File.

Percent of Non-Dually Eligible and Dually Eligible Beneficiaries with Selected Diseases and Chronic Conditions, 2000

The dually eligible population has higher rates of debilitating diseases and conditions such as pulmonary disorders and Alzheimer's disease.

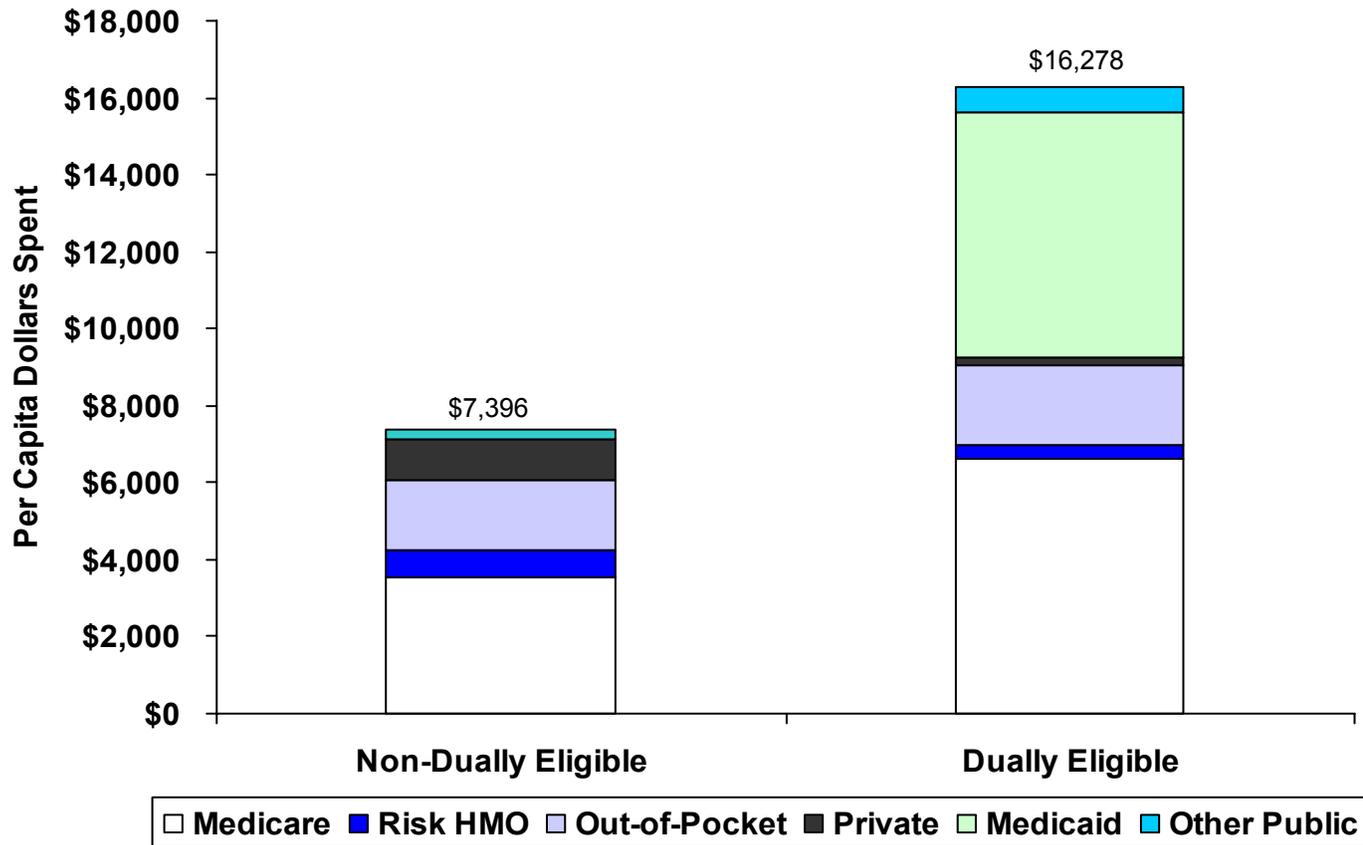


Note: Dually eligible beneficiaries are Medicare beneficiaries that also receive Medicaid coverage.

Source: CMS, Office of Research, Development, Information: Data from the Medicare Current Beneficiary Survey (MCBS) 2000 Access to Care File.

Total Health Expenditures by Payer for Dually Eligible and Non-Dually Eligible Beneficiaries, 1999

Health expenditures for the dually eligible population were more than double that of the non-dually eligible.



Note: Out-of-Pocket does not include premium payments. Payers will not sum to total due to some small categories being omitted. "Other Public" includes VA, DOD, and state-based pharmaceutical assistance programs.

Source: CMS, Office of Research, Development, and Information: Data from the Medicare Current Beneficiary Survey (MCBS) 1999 Cost and UseFile.

III. Medicare Program Information

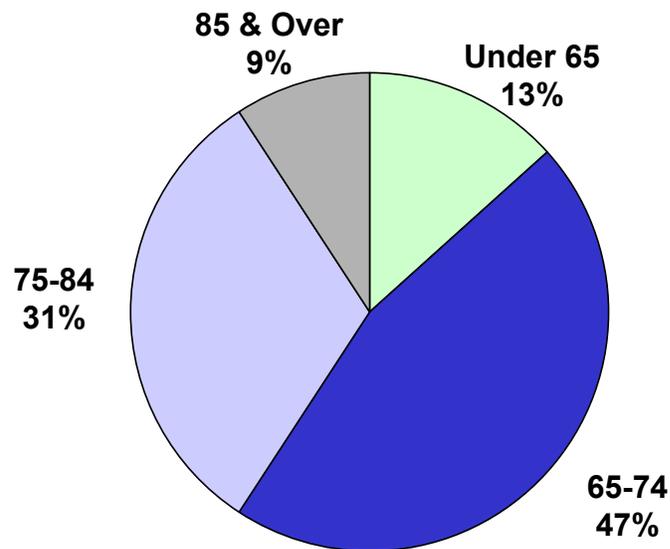
B. Profile of Medicare Beneficiaries

4. Beneficiaries Living in Long-Term Care Facilities

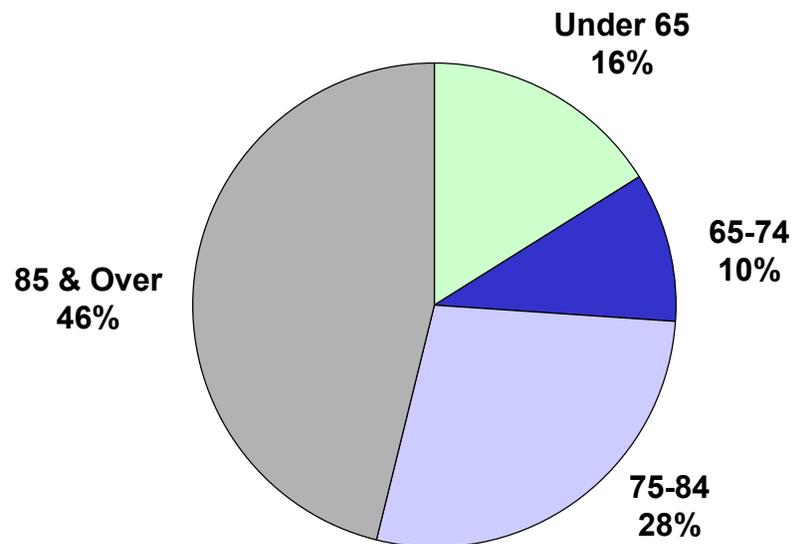
Age of Medicare Beneficiaries Living in the Community and Long-Term Care Facilities, 2000

Beneficiaries over age 85 make up nearly half of beneficiaries in long-term care facilities.

Beneficiaries Living in the Community



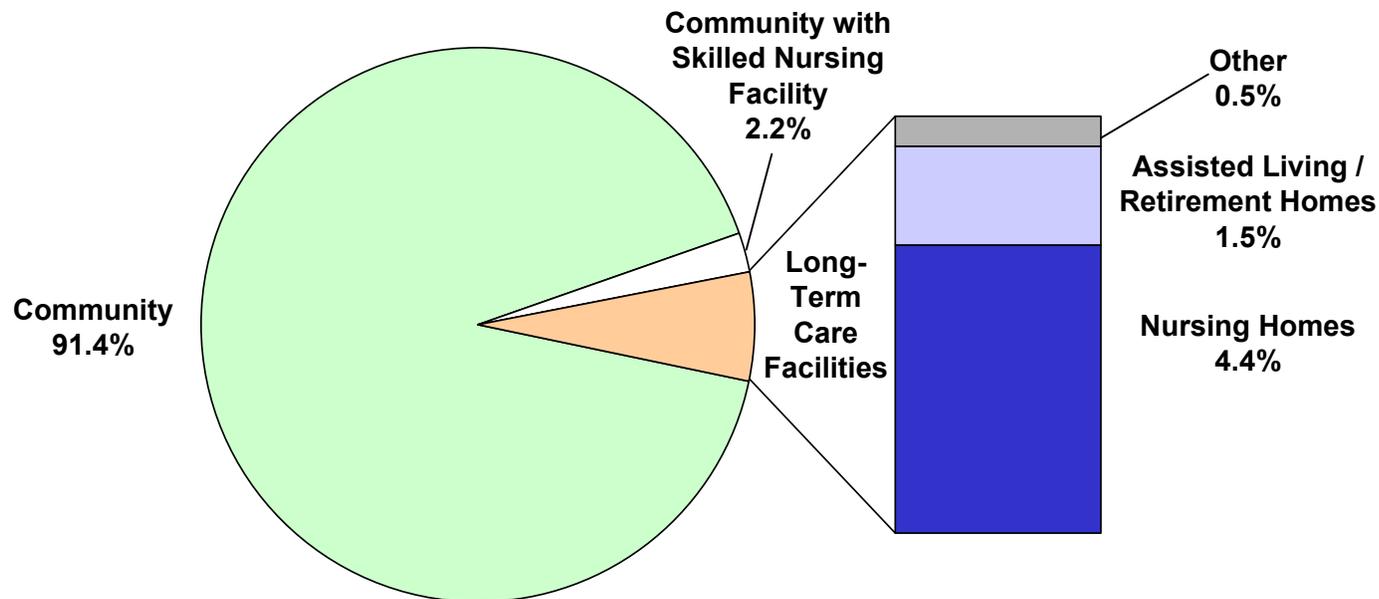
Beneficiaries in Long-Term Care Facilities



Source: CMS, Office of Research, Development, and Information: Data from the Medicare Current Beneficiary Survey (MCBS) 2000 Access to Care File.

Medicare Beneficiaries Living in the Community and in Long-Term Care Facilities, 1999

For the six percent of beneficiaries living in long-term care facilities, most live in nursing homes but some live in assisted living/retirement homes or other facilities.

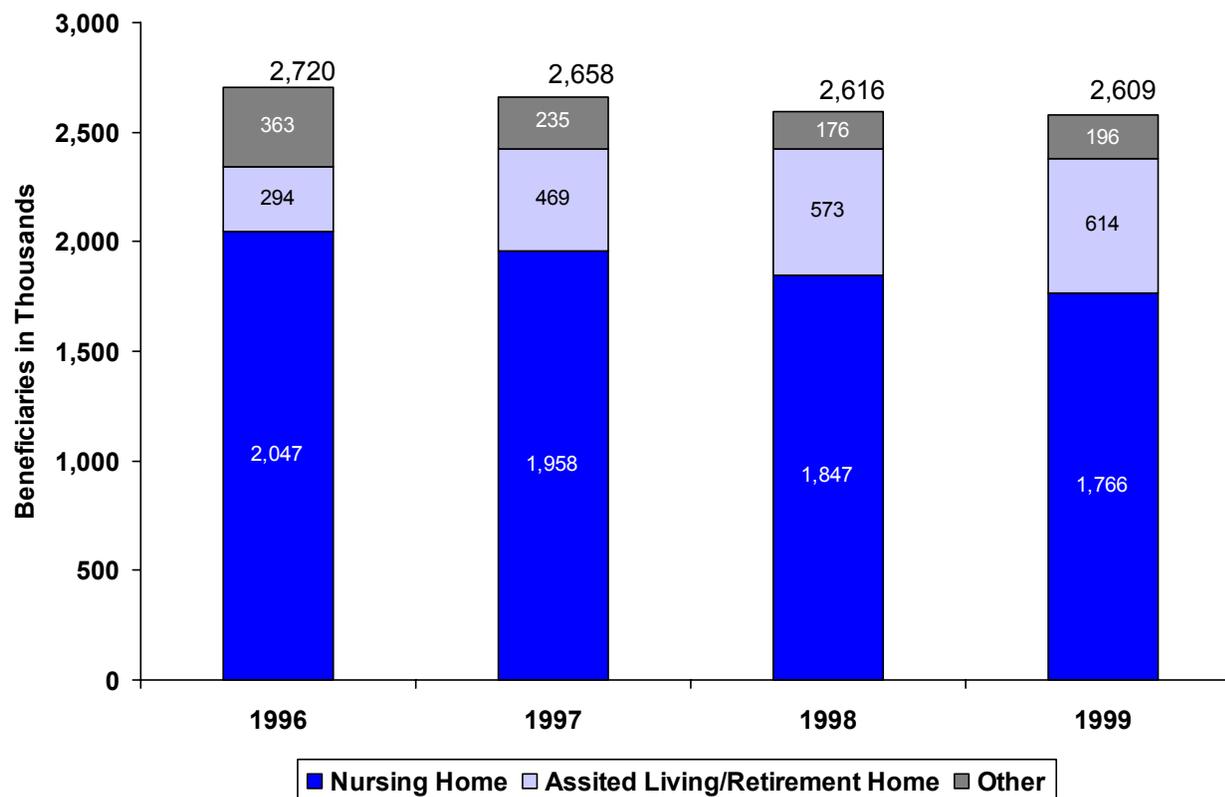


Note: Assisted Living/Retirement Home also includes Domiciliary Care Homes, Board and Care Homes, and Independent Living Units. All of these arrangements offer some level of assistance to the beneficiary. "Other" includes mental health facilities, mentally retarded/mentally disabled facilities and other unclassified facilities.

Source: CMS, Office of Research, Development, and Information: Data from the Medicare Current Beneficiary Survey (MCBS) 1999 Cost and Use File.

Beneficiaries Living in Long-Term Care Facilities, by Type of Facility, 1999

Since 1996, the number of beneficiaries living in traditional nursing homes and other facilities has declined, while use of other types of assisted living arrangements has increased.

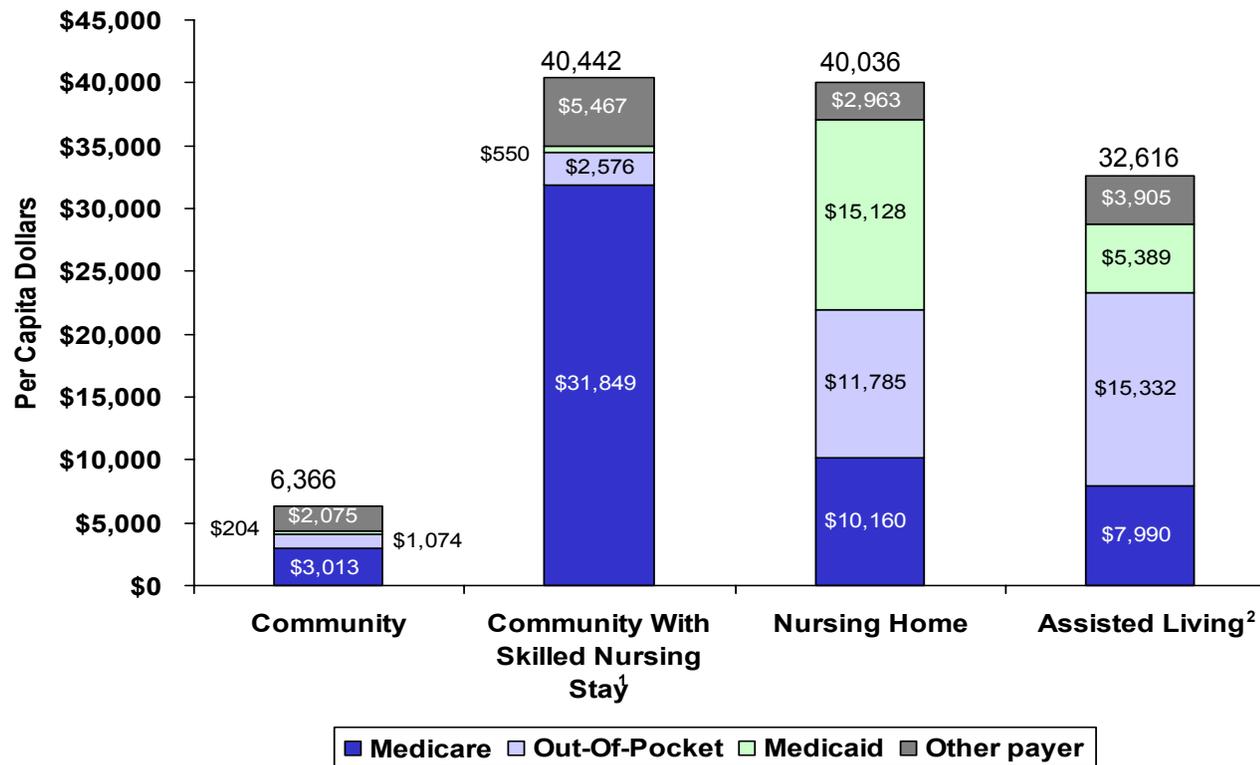


Note: Assisted Living/Retirement Home also includes Domiciliary Care Homes, Board and Care Homes, and Independent Living Units. All of these arrangements offer some level of assistance to the beneficiary. "Other" includes mental health facilities, mentally retarded/mentally disabled facilities and other unclassified facilities.

Source: CMS, Office of Research, Development, and Information: Data from the Medicare Current Beneficiary Survey (MCBS) 1996-1999 Cost and Use Files.

Per Capita Total Health Care Expenses, by Payer, for Beneficiaries Living in Long-Term Care Facilities and the Community, 1999

Beneficiaries in assisted living facilities have lower total expenses than those in nursing homes, but higher out-of-pocket costs.

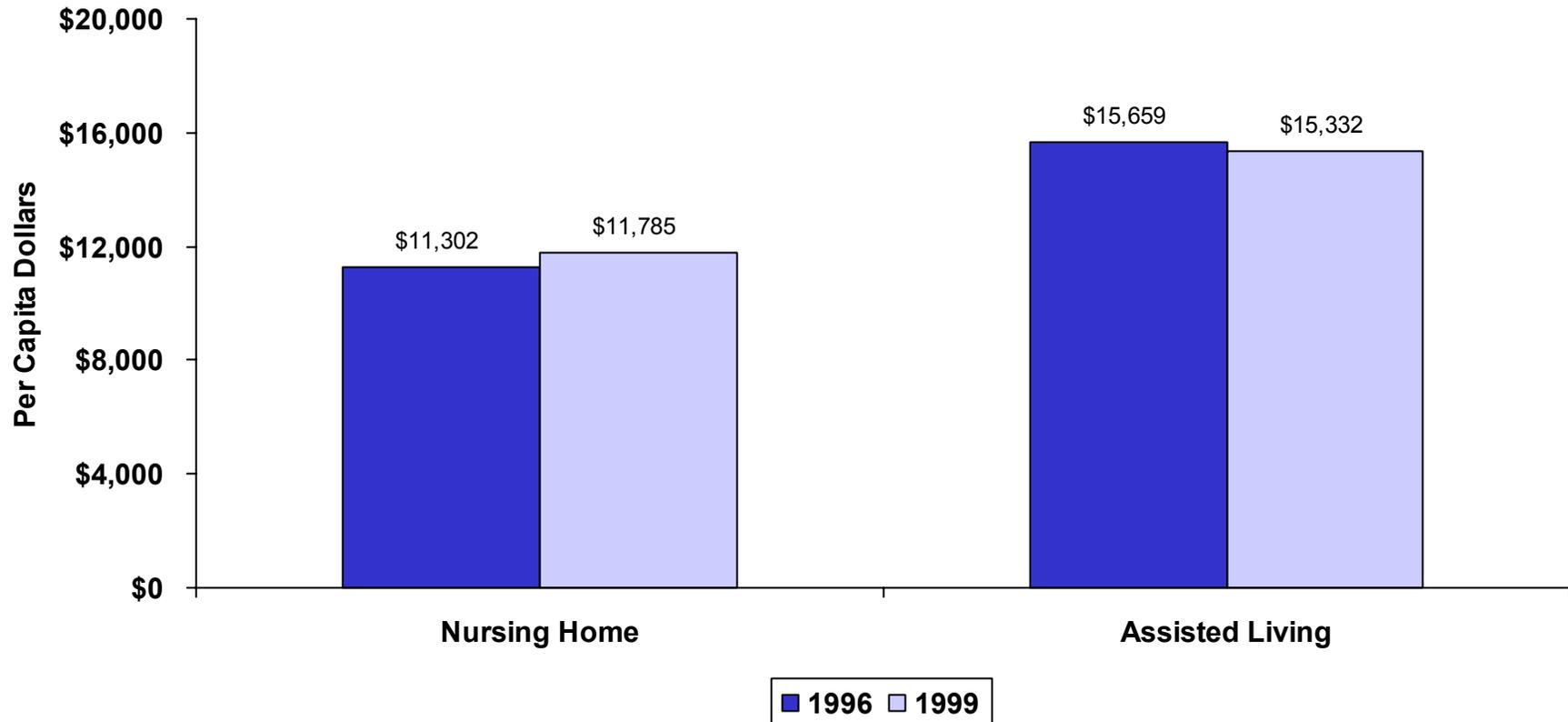


Notes: 1) Because a Skilled Nursing Facility stay is a Medicare covered benefit, Medicare covers a large portion of the expenses for beneficiaries in this group. 2) Assisted Living/Retirement Home also includes Domiciliary Care Homes, Board and Care Homes, and Independent Living Units. All of these arrangements offer some level of assistance to the beneficiary.

Source: CMS, Office of Research, Development, and Information: Data from the Medicare Current Beneficiary Survey (MCBS) 1999 Cost and Use File.

Per Capita Out-of-Pocket Expenses for Beneficiaries Living in Long-Term Care Facilities, 1996 and 1999

Out-of-pocket expenses remained relatively flat between 1996 and 1999.



Note: Assisted Living/Retirement Home also includes Domiciliary Care Homes, Board and Care Homes, and Independent Living Units. All of these arrangements offer some level of assistance to the beneficiary.

Source: CMS, Office of Research, Development, and Information: Data from the Medicare Current Beneficiary Survey (MCBS) 1996 and 1999 Cost and Use Files.

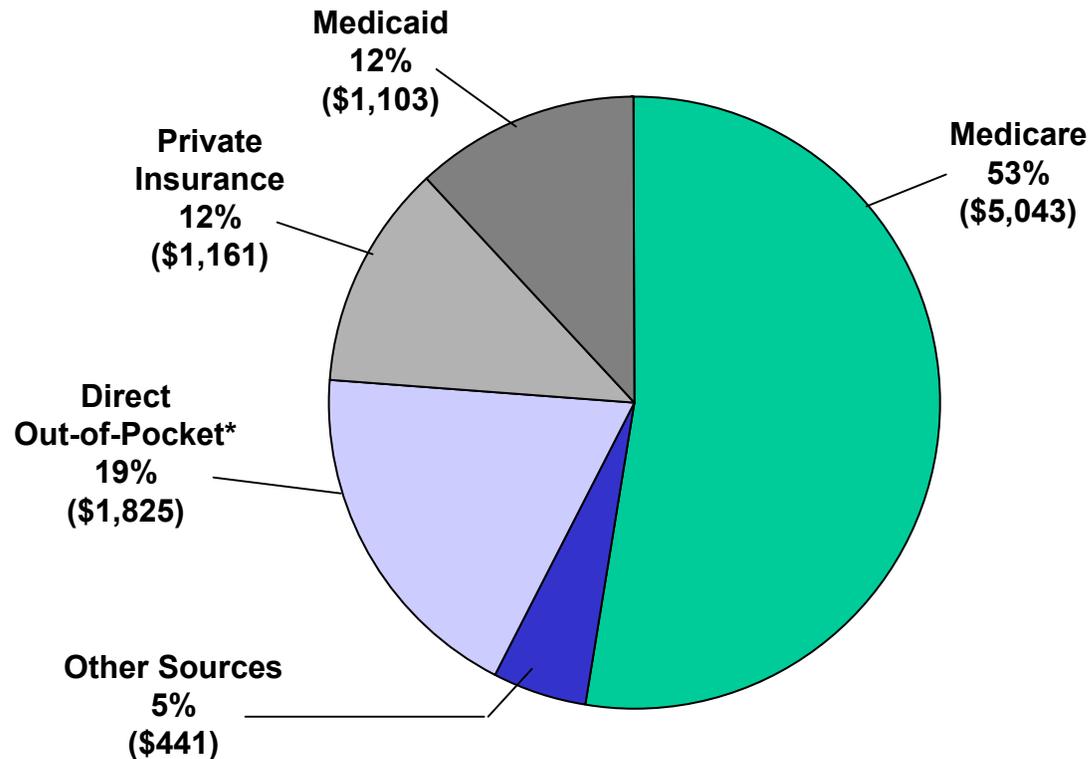
III. Medicare Program Information

B. Profile of Medicare Beneficiaries

5. Beneficiary Health Spending

Sources of Payment for Medicare Beneficiaries' Medical Services, 1999

Medicare pays a little more than half of the total cost of beneficiaries' medical care.



Overall Medical Expenses per Medicare Beneficiary = \$9,573

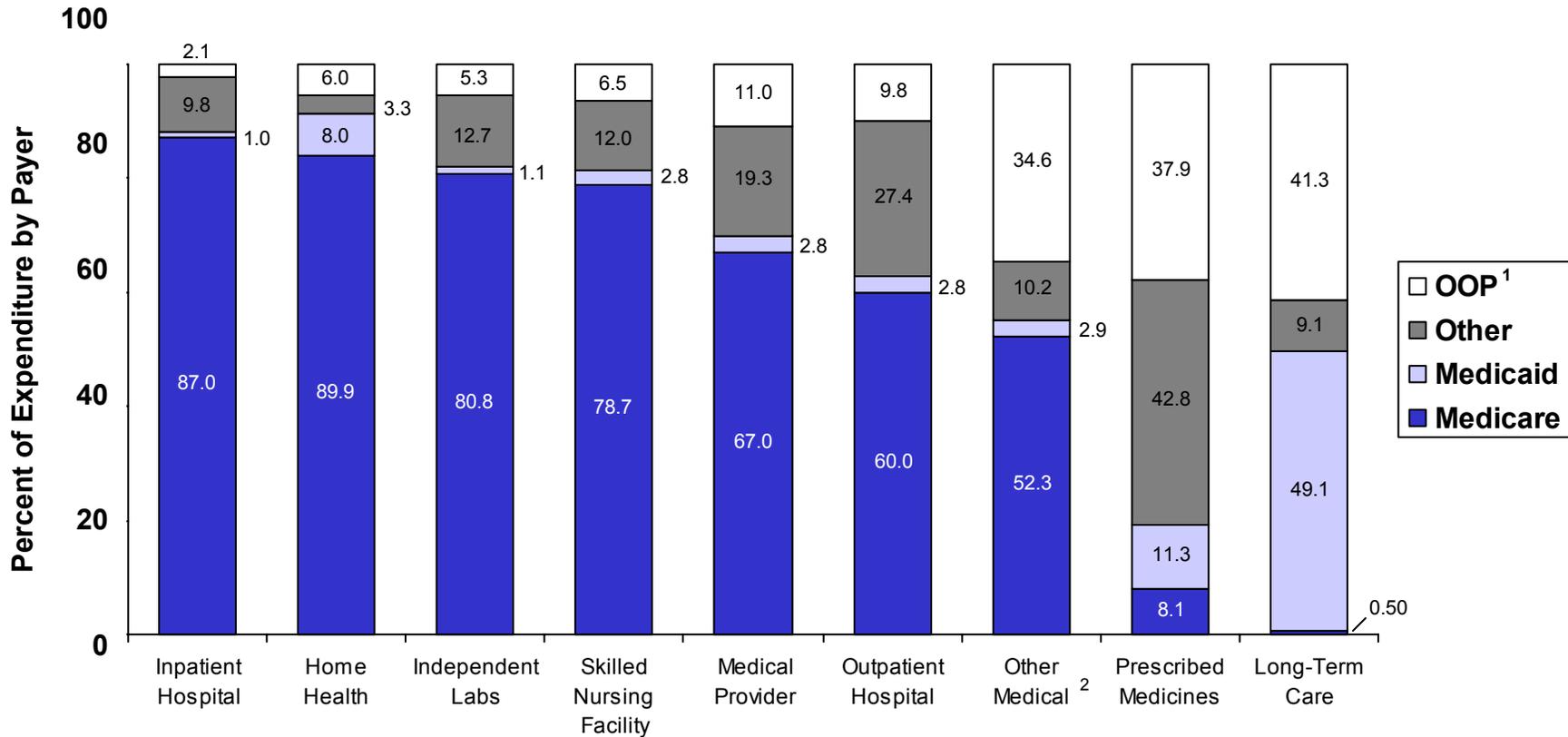
*Beneficiary out-of-pocket spending does not include their payments for Medicare Part B premiums, private insurance premiums, or HMO premiums.

Note: Data are for all beneficiaries, both fee-for-service and Medicare+Choice enrollees.

Source: CMS, Office of Research, Development, and Information: Data From the Medicare Current Beneficiary Survey (MCBS) 1999 Cost and Use File.

Sources of Payment for Medicare Beneficiaries, by Type of Service, 1999

Medicare pays a large proportion of the total expenses of services it covers.



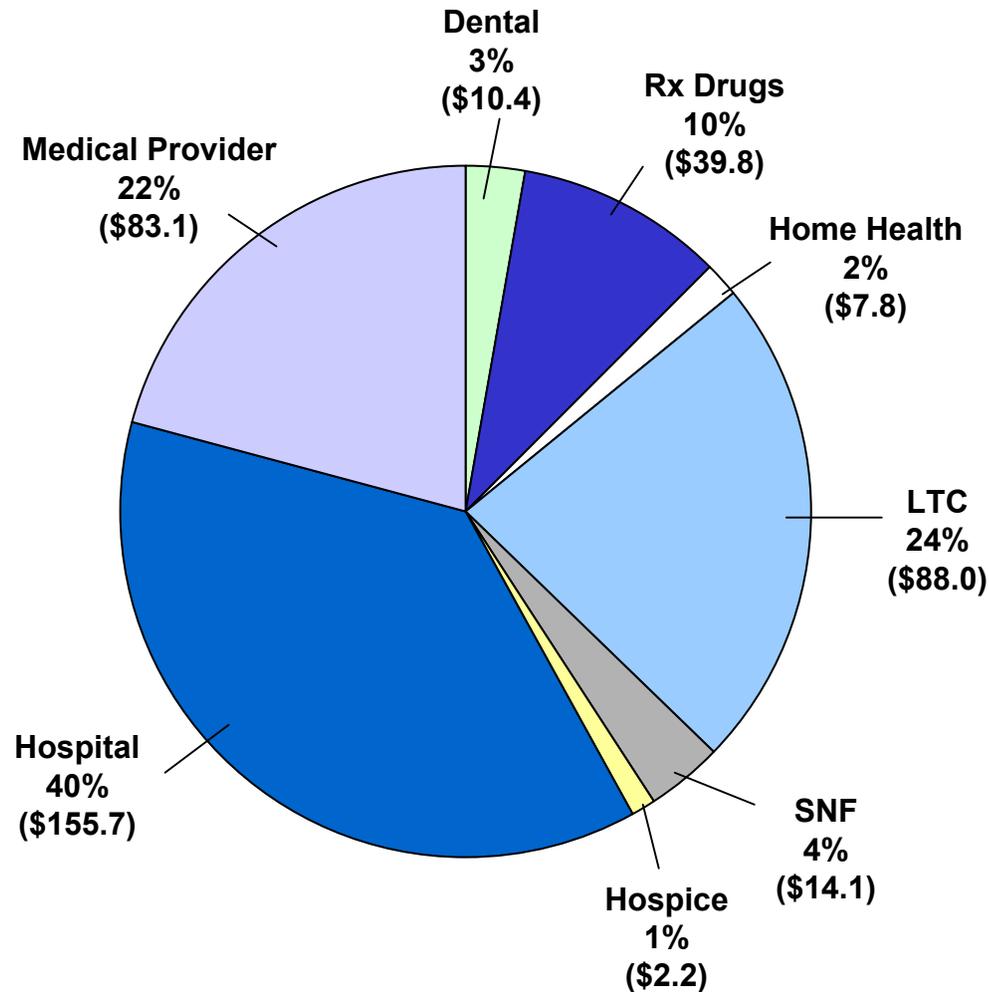
¹ OOP is out-of-pocket.

² Other Medical includes things such as hospice and durable medical equipment.

Source: CMS, Office of Research, Development, and Information: Data from the Medicare Current Beneficiary Survey (MCBS), 1999 Cost and Use File.

Total Health Care Expenditures for Medicare Beneficiaries, 1999

Total Health Care Expenditures = \$385.2 Billion

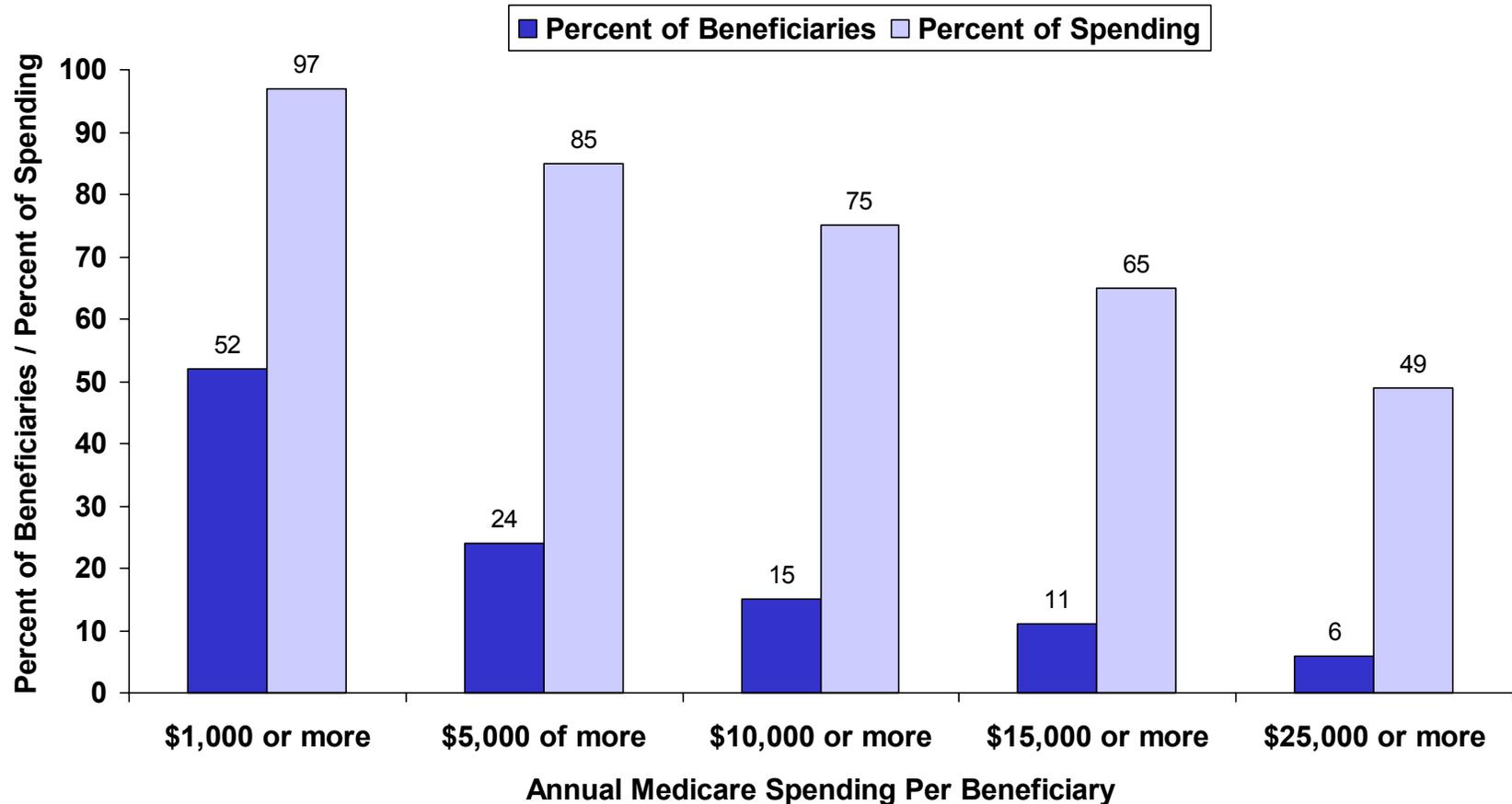


Note: Premium payments are excluded. LTC is long-term care. SNF is skilled nursing facility.

Source: CMS, Office of Research, Development, and Information: Data from the Medicare Current Beneficiary Survey (MCBS) 1999 Cost and Use File.

Cumulative Distribution of Medicare Spending for Fee-for-Service Beneficiaries, 1999

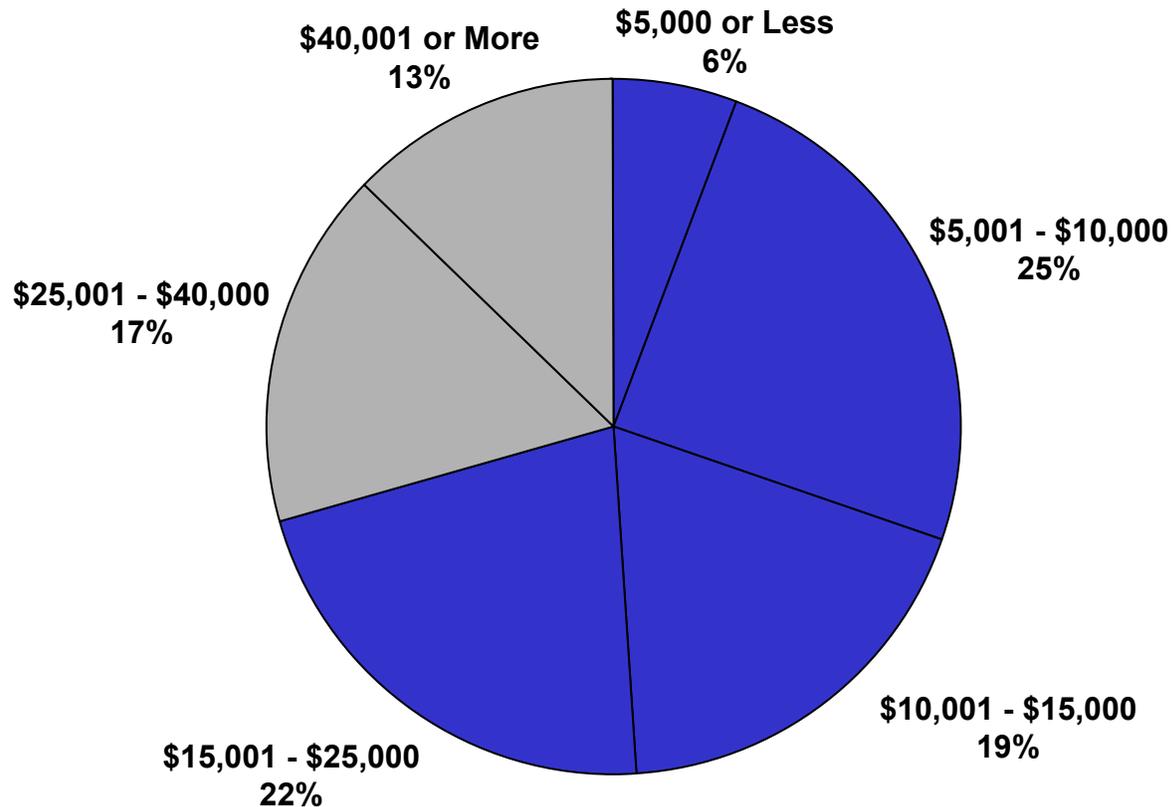
Six percent of beneficiaries account for nearly fifty percent of program spending.



Source: CMS, Office of Information Services: Data from the Medicare Decision Support Access Facility; data development by the Office of Strategic Planning.

Medicare Spending for Fee-for-Service Beneficiaries, by Income, 2000

About seventy percent of Medicare expenditures are on behalf of individuals with annual incomes of \$25,000 or less.

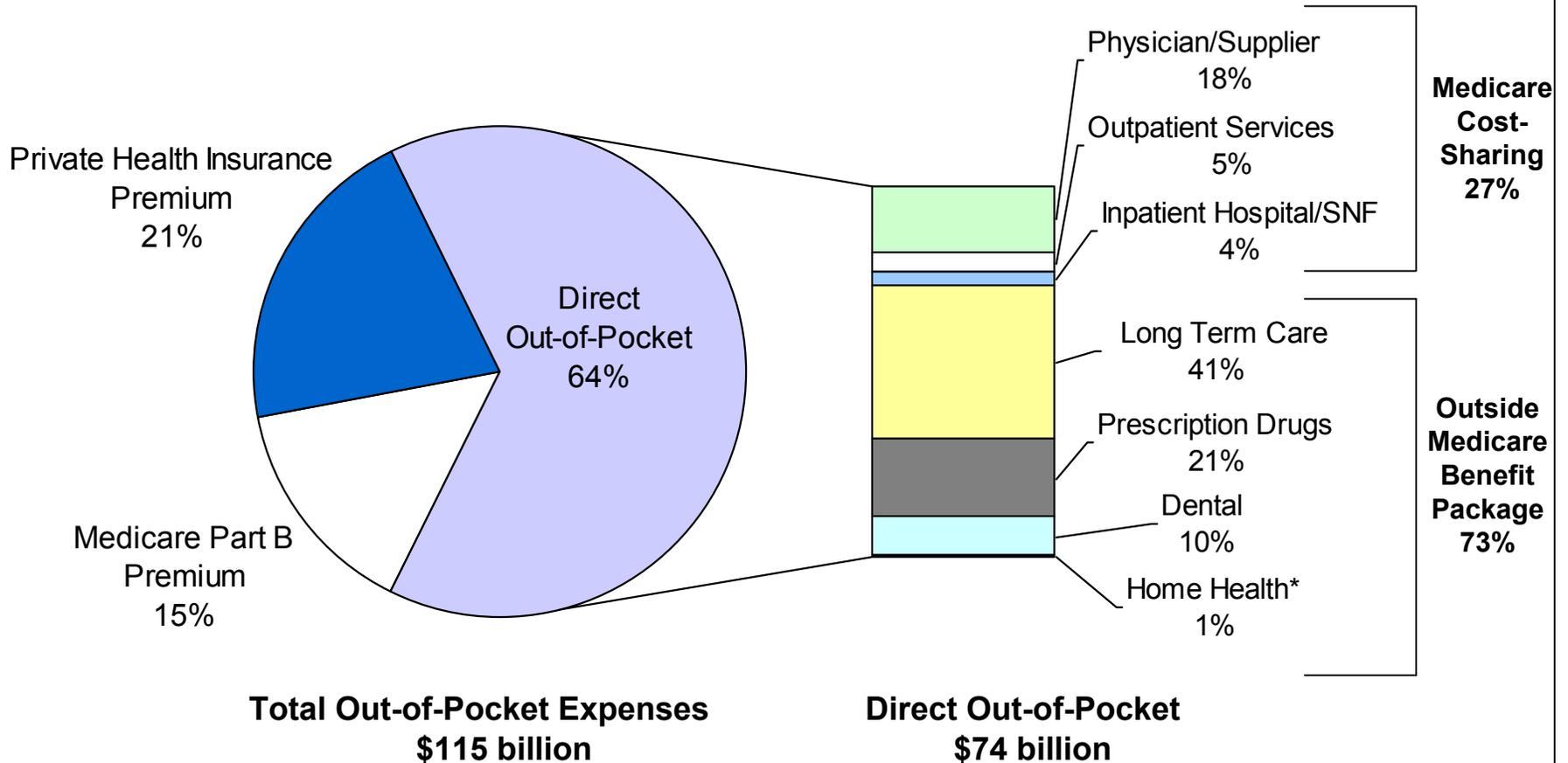


Note: Data may not sum due to rounding.

Source: CMS, Office of Research, Development, and Information: Data From the Medicare Current Beneficiary Survey (MCBS) 2000 Access to Care File.

Medicare Beneficiary Out-of-Pocket Spending, 1999

The majority of beneficiary out-of-pocket spending is for Medicare cost-sharing and payment for non-covered services.



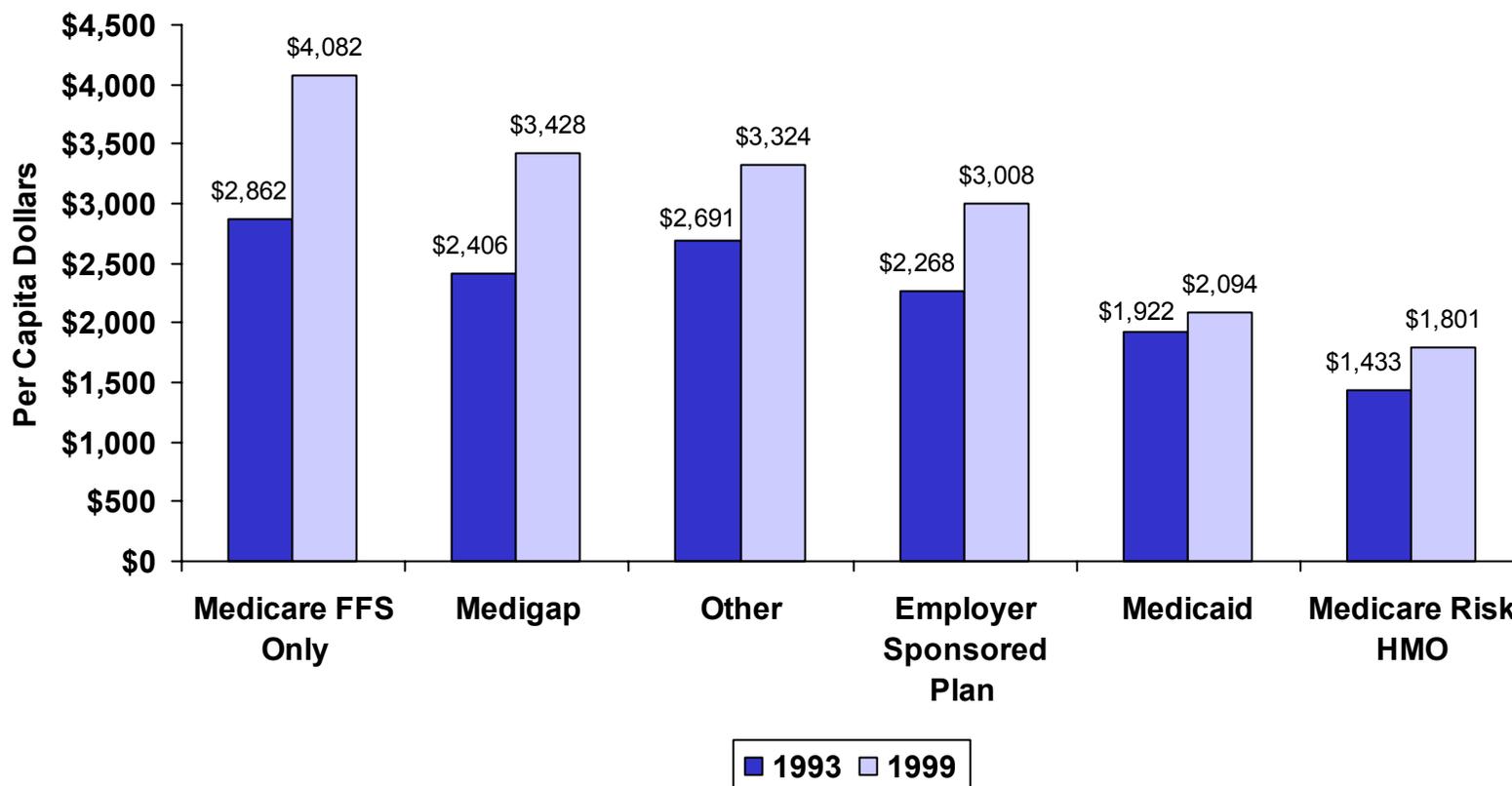
*These are for home health services not covered by Medicare.

Note: 1) Data are for all beneficiaries, both fee-for-service and Medicare+Choice enrollees. 2) Total per capita direct out-of-pocket spending is \$1,825.

Source: CMS, Research, Development, and Income, Medicare Current Beneficiary Survey (MCBS) 1999 Cost and Use File.

Per Capita Out-of-Pocket Expenses for Medicare Beneficiaries, by Type of Insurance Coverage

Beneficiaries without supplemental insurance and those with Medigap coverage had the largest increase in per capita out-of-pocket spending between 1993 and 1999.



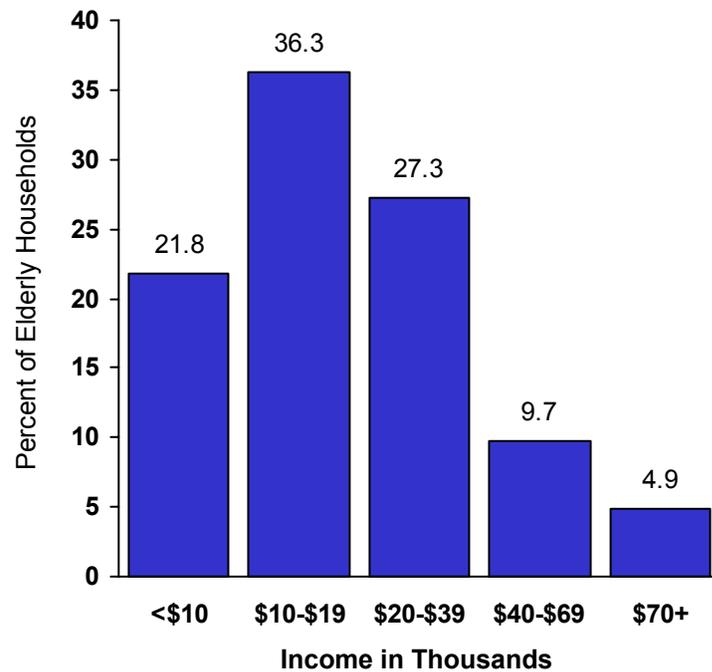
Note: Premium payments are included.

Source: CMS, Office of Research, Development, and Information: Data from the Medicare Current Beneficiary Survey (MCBS), 1993 and 1999 Cost and Use Files.

Elderly Health Spending as a Percentage of Income, 2000

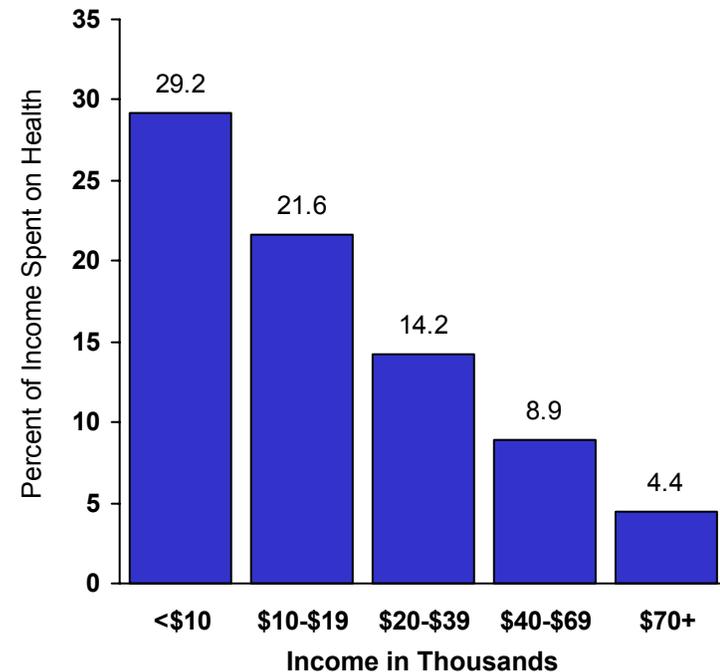
Most elderly households have incomes below \$40,000 and spend a high percentage of their income on health care.

Percent of Elderly Households by Income



Most Elderly Households Have Incomes Below \$40,000

Elderly Households' Health Spending as a Percentage of Income



The Elderly Poor Spend a Greater Portion of Their Income on Health

Source: CMS, Office of the Actuary: data from the Bureau of Labor Statistics, Consumer Expenditure Survey, 1999-2000.

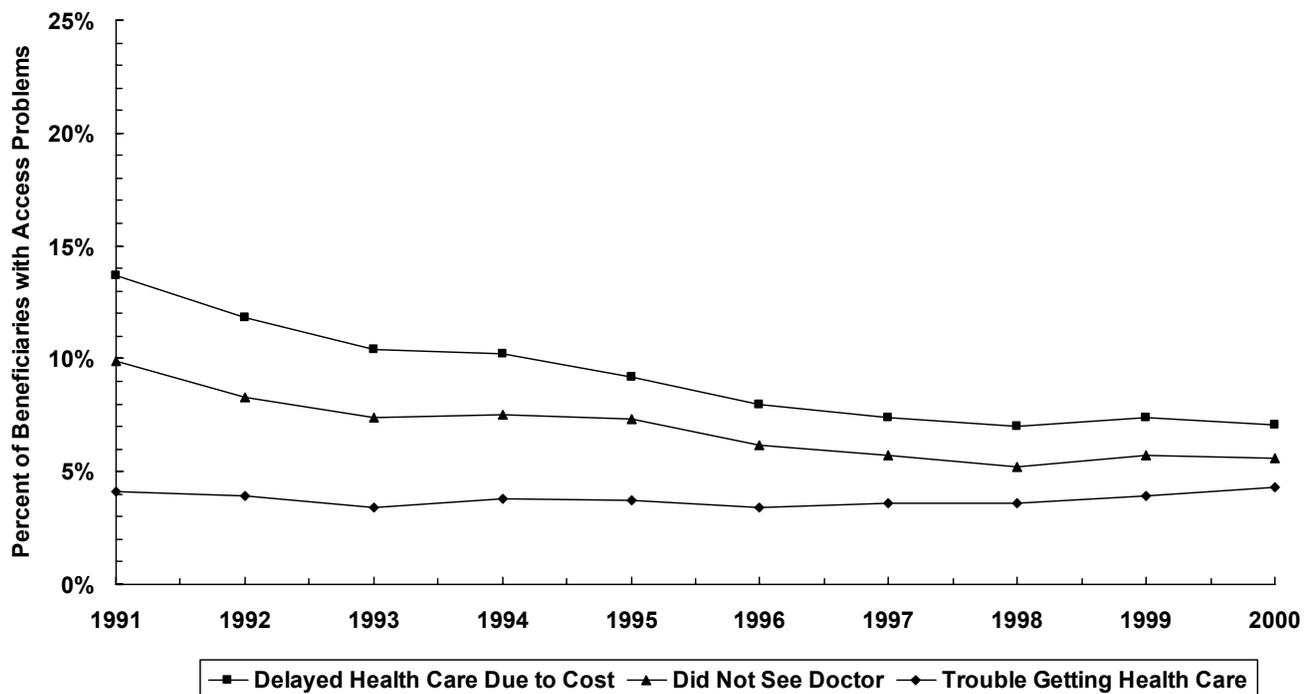
III. Medicare Program Information

B. Profile of Medicare Beneficiaries

6. Beneficiary Access to Care and Satisfaction

Reported Trouble Getting Health Care, Delaying Health Care, or Not Seeing a Doctor for a Medical Condition, 1991-2000

The percent of beneficiaries delaying care due to cost or not seeing a doctor declined between 1991 and 2000.

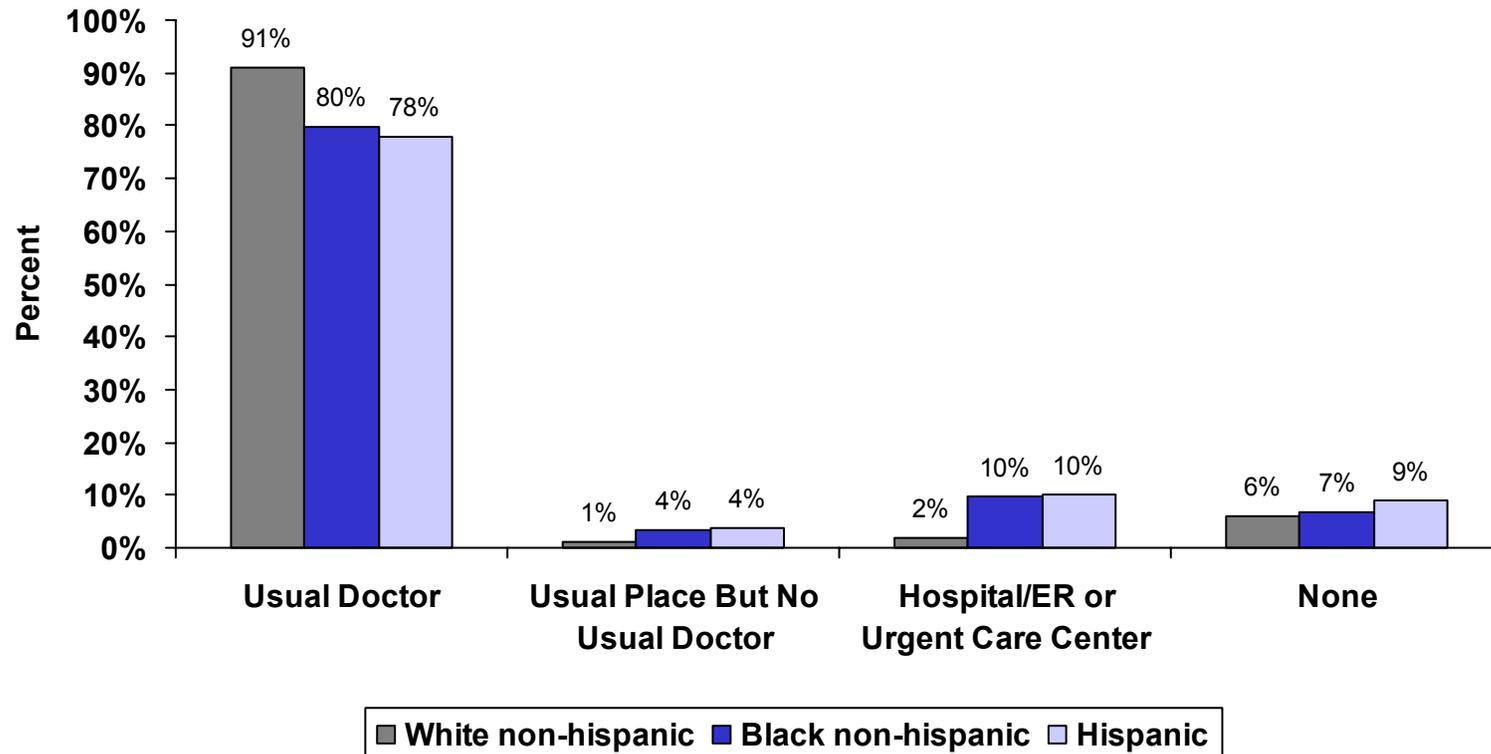


Note: Does not include beneficiaries in facility care.

Source: CMS, Office of Research, Development, and Information: Data from the Medicare Current Beneficiary Survey (MCBS) 1991-2000 Access to Care Files.

Beneficiary Usual Source of Care, by Race, 2000

Minority beneficiaries were less likely to have a usual doctor for their care; however, the majority of beneficiaries have a usual doctor.

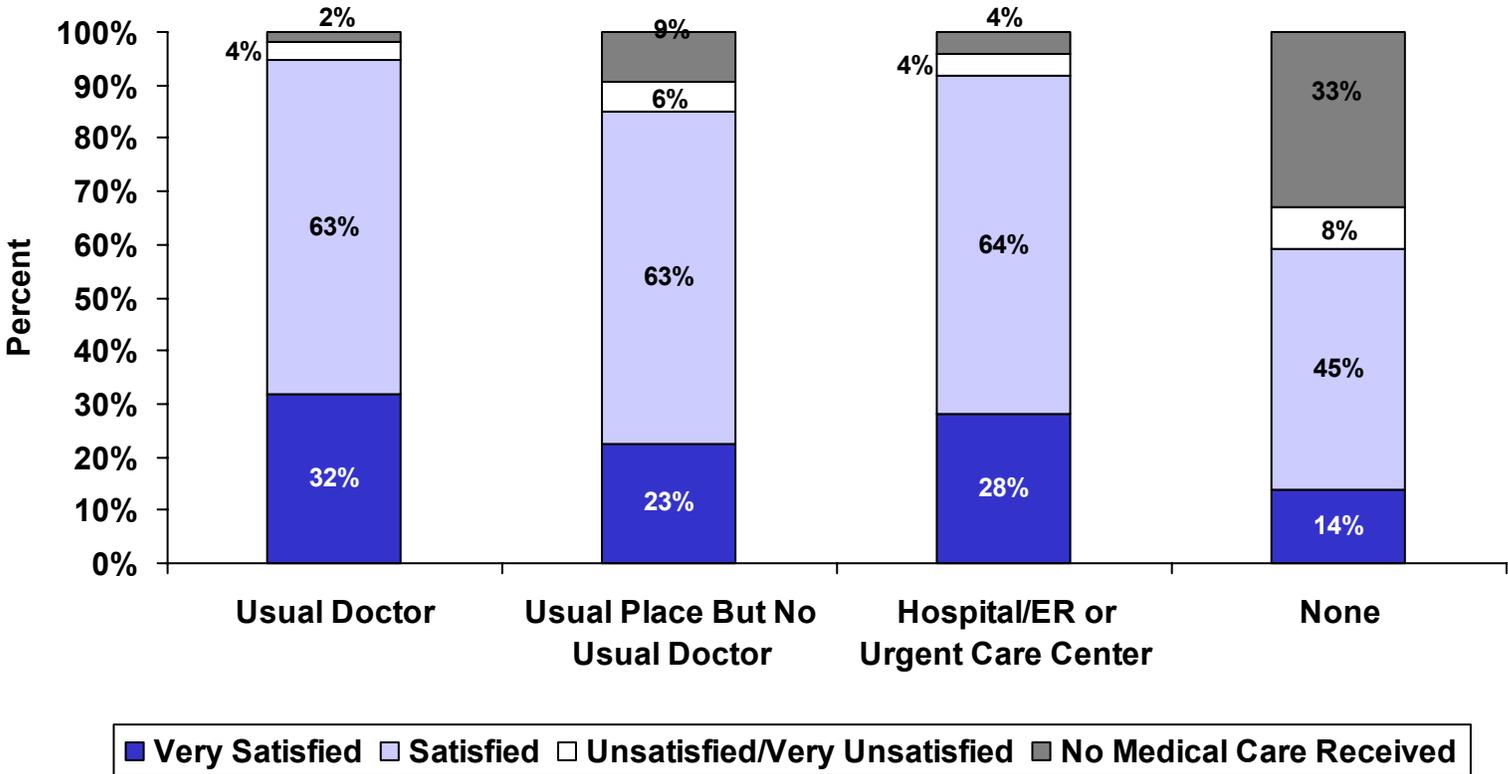


Note: Does not include beneficiaries in facility care.

Source: CMS, Office of Research, Development, and Information: Data from the Medicare Current Beneficiary Survey (MCBS) 2000 Access to Care File.

Beneficiary Satisfaction with Medical Care, by Usual Source of Care, 2000

Beneficiaries with a usual source of care were more satisfied with the quality of their care than were those without any usual source of care.



Note: Does not include beneficiaries in facility care.

Source: CMS, Office of Research, Development, and Information: Data from the Medicare Current Beneficiary Survey (MCBS) 2000 Access to Care File.

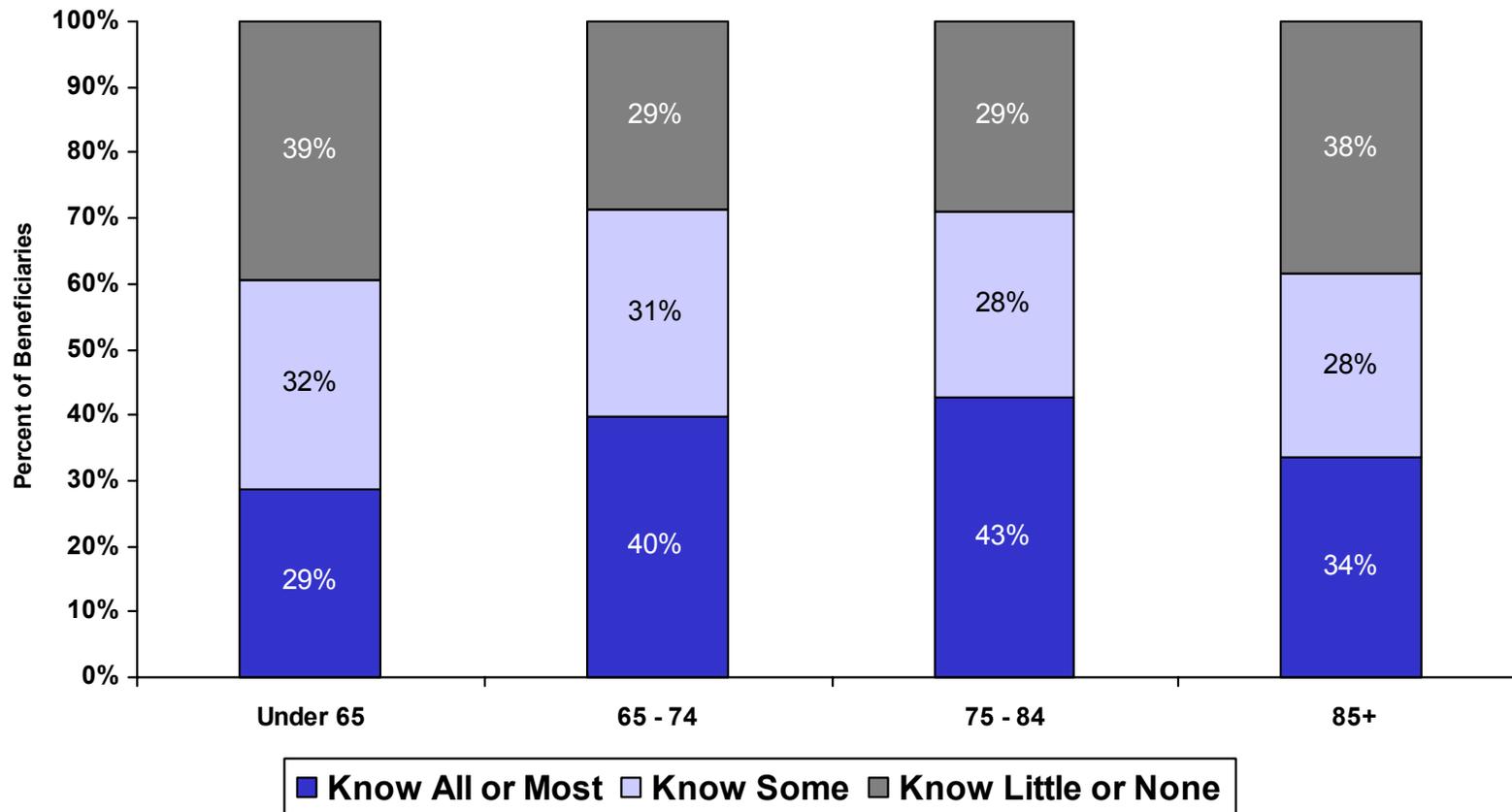
III. Medicare Program Information

B. Profile of Medicare Beneficiaries

7. Beneficiary Knowledge

Beneficiary Knowledge About the Medicare Program, by Age, 2000

Beneficiaries under age 65 and over 85 reported the biggest knowledge gap about Medicare-covered services.

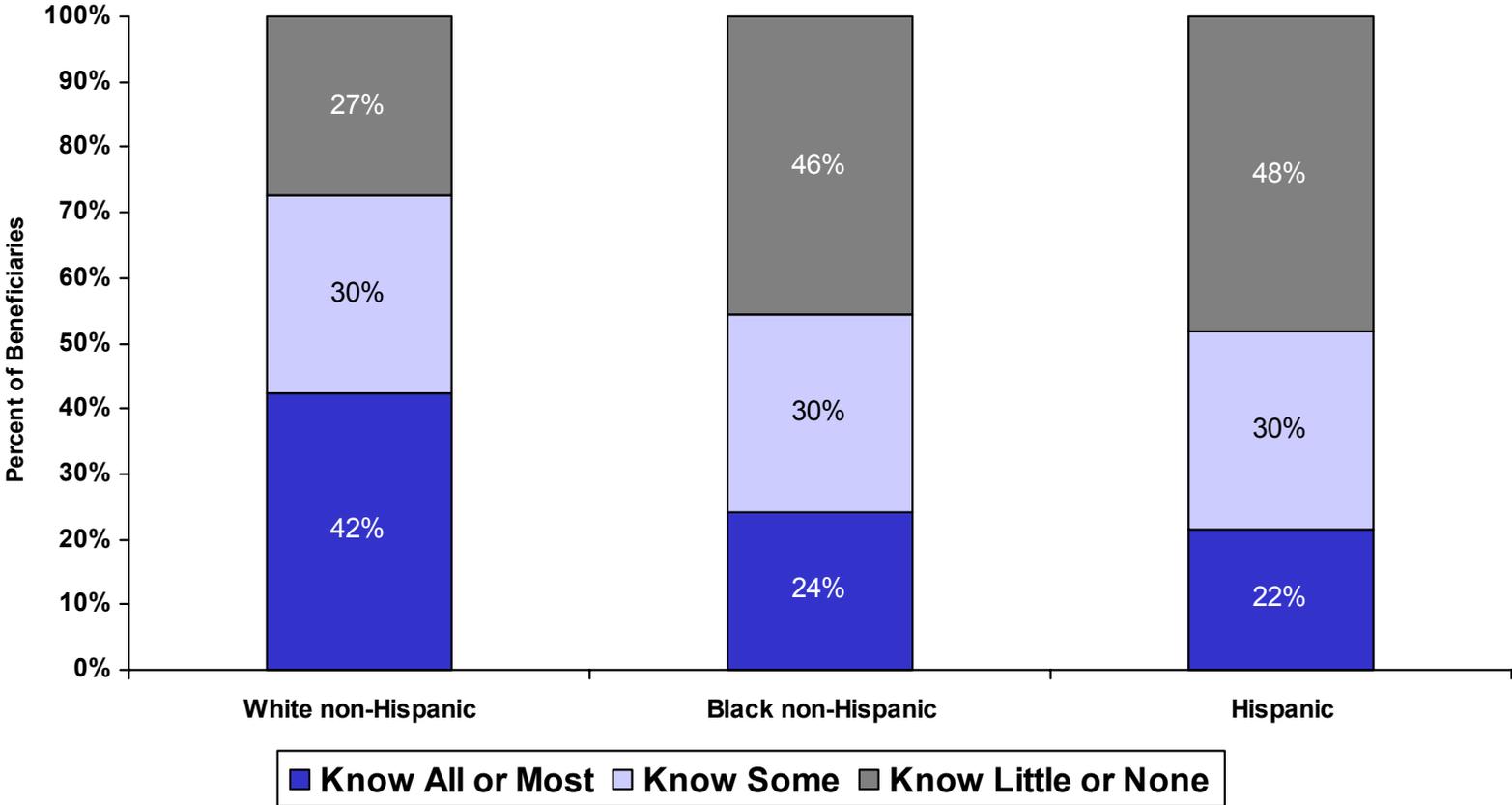


Note: Does not include beneficiaries in facility care.

Source: CMS, Office of Research, Development, and Information: Data from the Medicare Current Beneficiary Survey (MCBS) 2000 Access to Care File.

Beneficiary Knowledge About the Medicare Program, by Race, 2000

Minority beneficiaries are more likely than white beneficiaries to report knowledge gaps about the Medicare program.

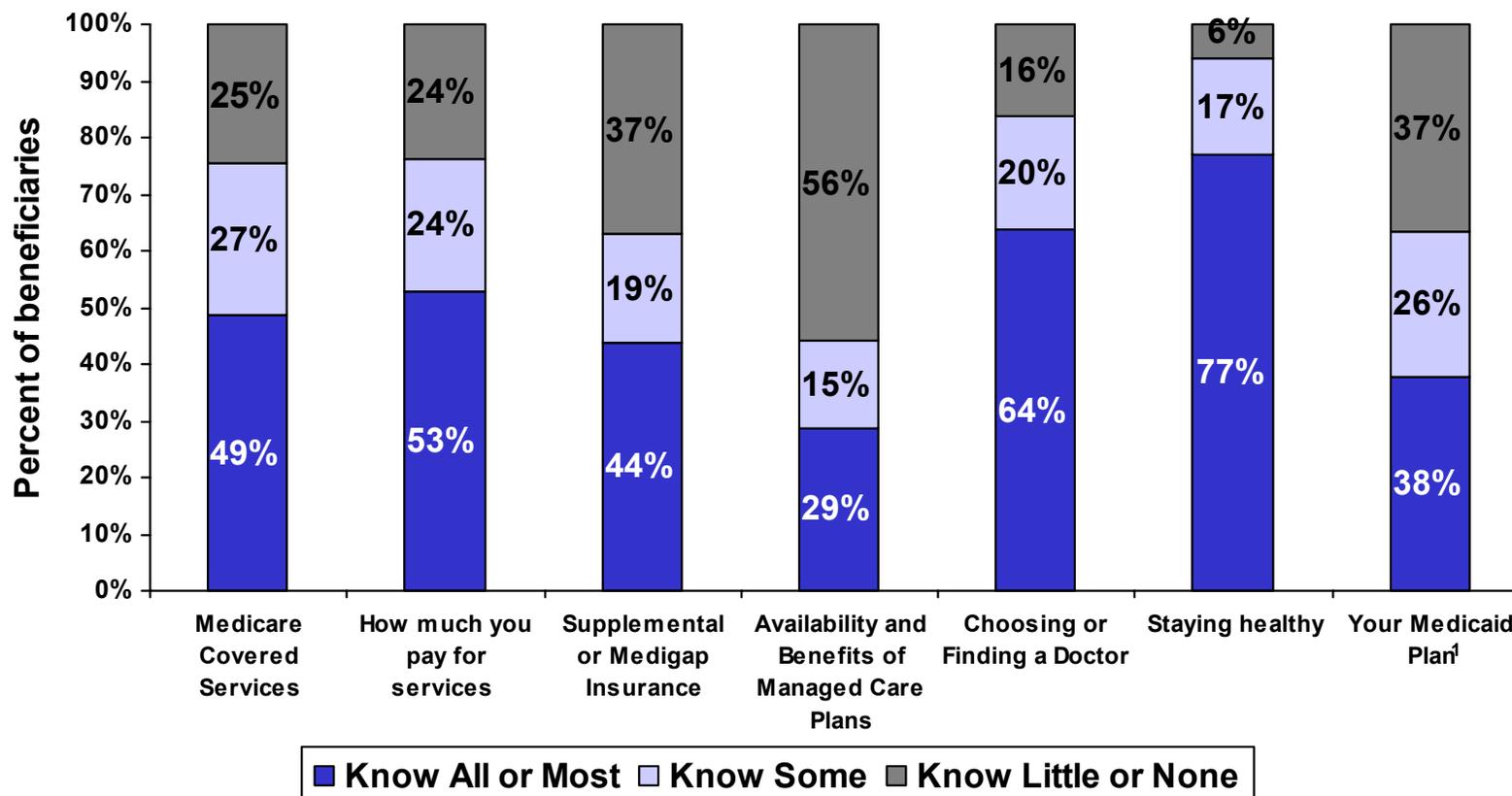


Note: Does not include beneficiaries in facility care.

Source: CMS, Office of Research, Development, and Information: Data from the Medicare Current Beneficiary Survey (MCBS) 2000 Access to Care File.

Beneficiaries' Self-Reported Knowledge of the Medicare Program and Other Health Care Issues, 2000

Beneficiaries reported being less knowledgeable about availability and benefits of managed care plans.

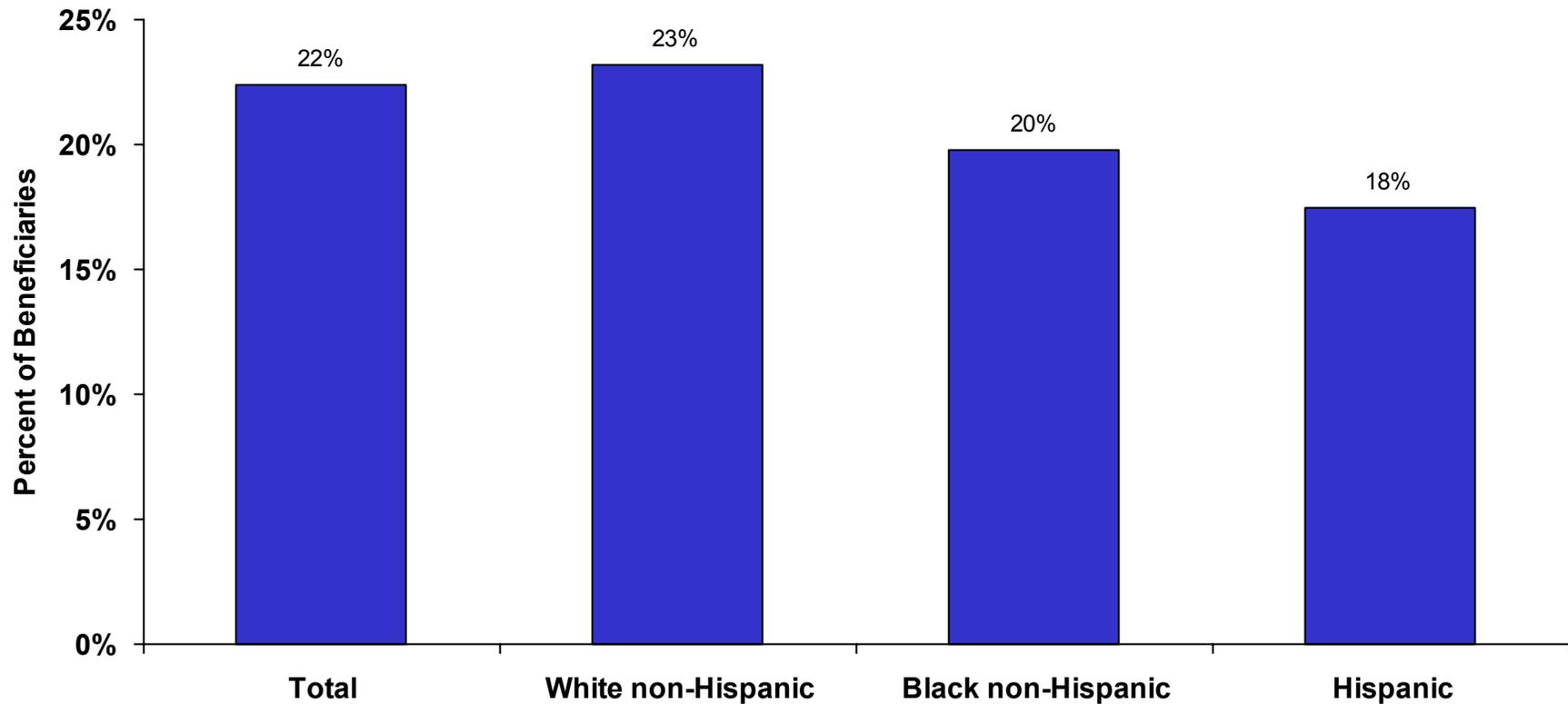


Notes: 1) Asked only of Medicaid beneficiaries. 2) Does not include beneficiaries in facility care.

Source: CMS, Office of Research, Development, and Information: Data from the Medicare Current Beneficiary Survey (MCBS) 2000 Access to Care File.

Percent of Medicare Beneficiaries Seeking Medicare/Health Insurance Information, by Race, 2000

Less than one-quarter of beneficiaries reported seeking information relating to the program.

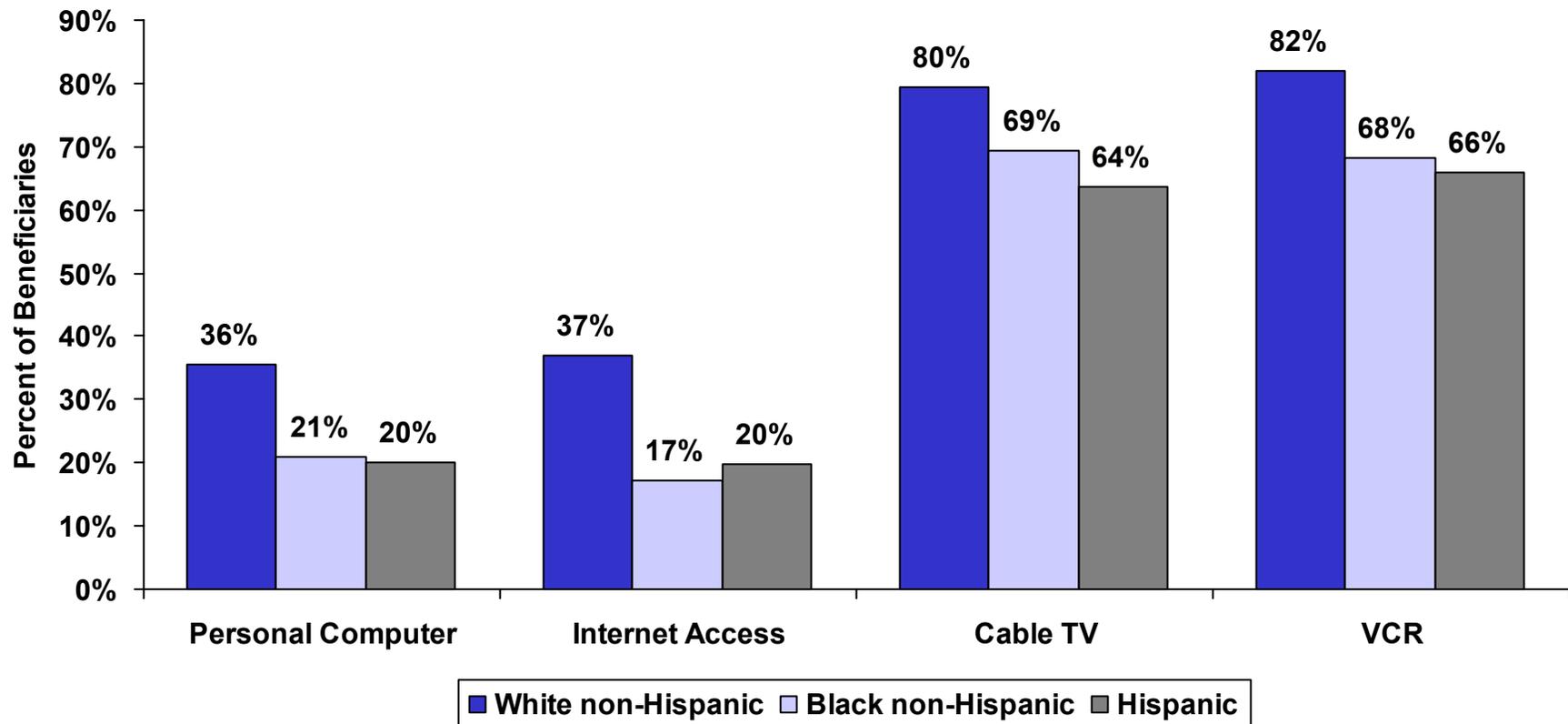


Note: Does not include beneficiaries in facility care.

Source: CMS, Research, Development, and Information: Data from the Medicare Current Beneficiary Survey (MCBS) 2000 Access to Care File.

Technologies Beneficiaries Have Available in Their Homes, by Race, 2000

The majority of beneficiaries have cable television and a VCR in their home. In early 2001 less than one-third have PCs or Internet access.

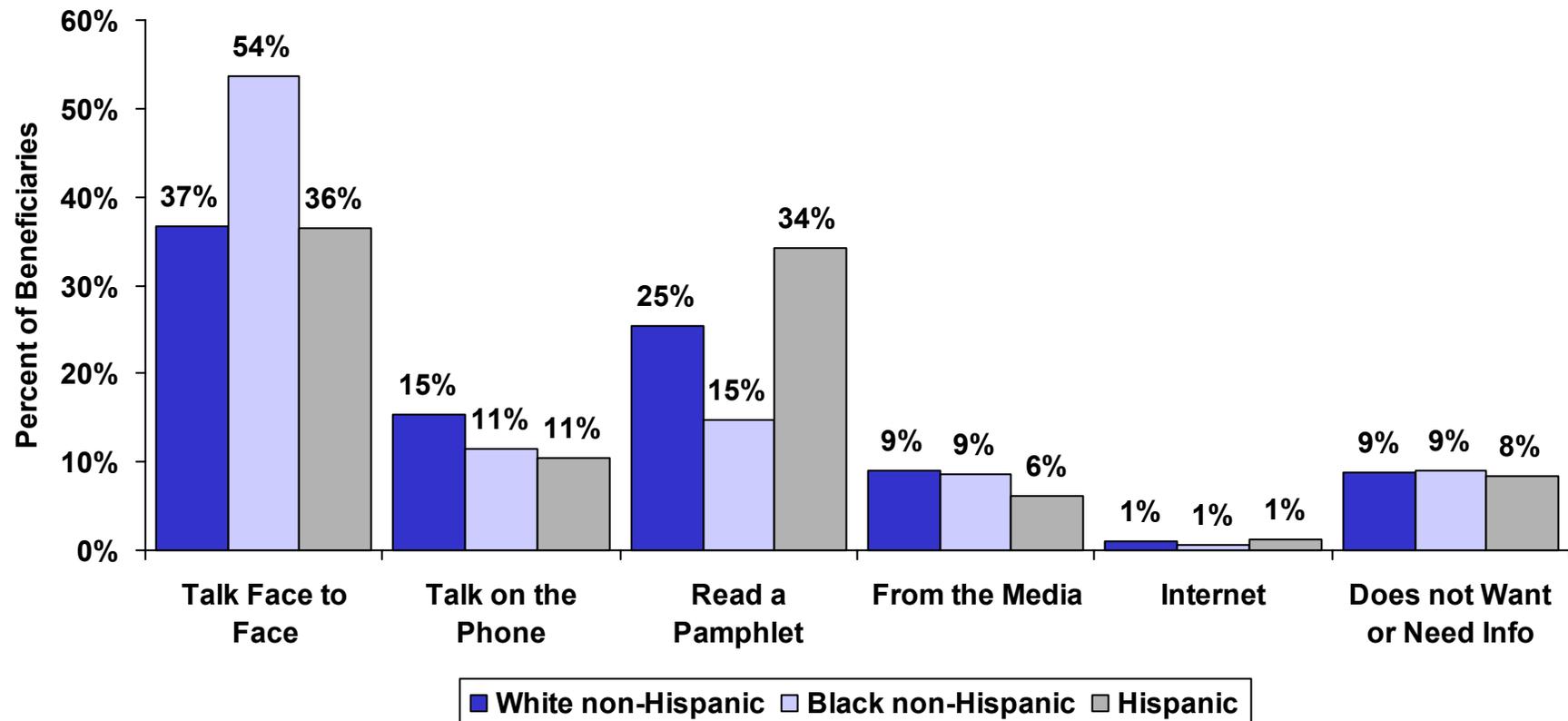


Note: Does not include beneficiaries in facility care. Beneficiaries were asked this question between January and April 2001.

Source: CMS, Office of Research, Development, and Information: Data from the Medicare Current Beneficiary Survey (MCBS) 2000 Access to Care File.

Beneficiary Preferences for Keeping Up With Program Changes, by Race, 2000

The preferred way of receiving Medicare information is by talking with someone face to face.



Note: Does not include beneficiaries in facility care.

Source: CMS, Office of Research, Development, and Information: Data from the Medicare Current Beneficiary Survey (MCBS) 2000 Access to Care File.

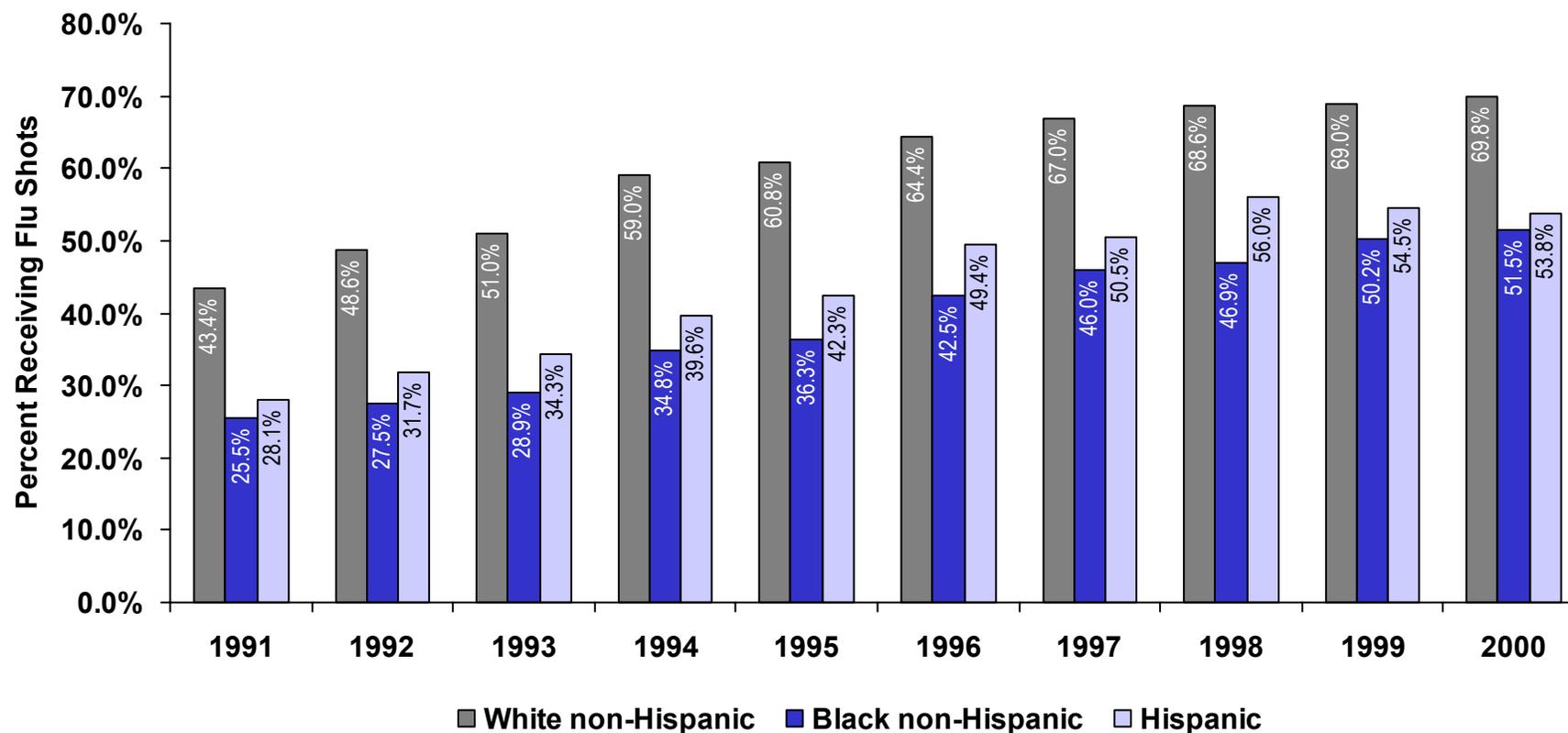
III. Medicare Program Information

B. Profile of Medicare Beneficiaries

8. Prevention

Medicare Beneficiaries Who Received Flu Shots, by Race

Utilization of flu shots was higher for white non-Hispanic beneficiaries than other racial groups, but rates for all groups increased over the decade.

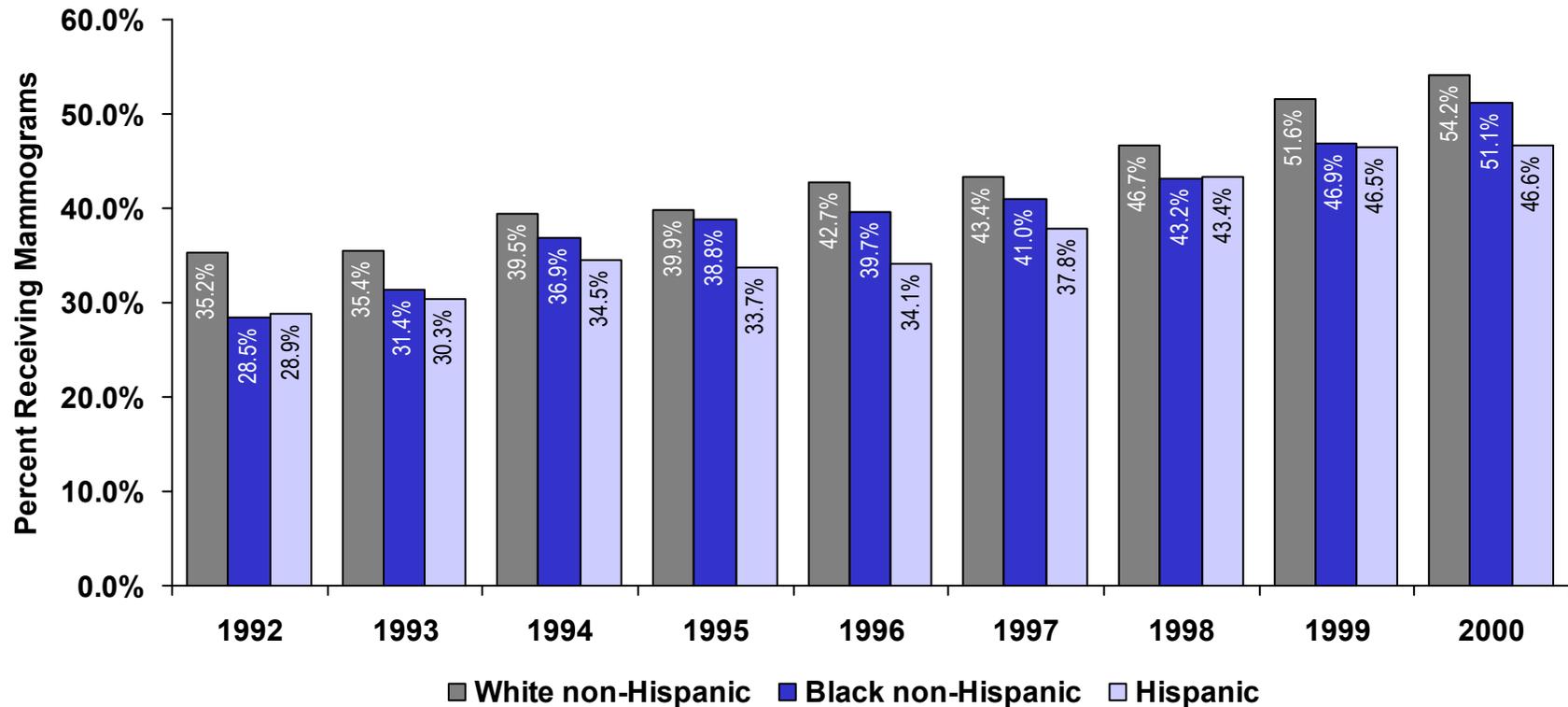


Note: Data reflect beneficiaries who report receiving flu shots. MCBS survey includes fee-for-service and managed care enrollees as well as aged and disabled beneficiaries. Does not include beneficiaries in facility care.

Source: CMS, Office of Research, Development, and Information: Data from Medicare Current Beneficiary Survey (MCBS) 1991-2000 Access to Care Files.

Female Medicare Beneficiaries Who Received Mammograms, by Race

Mammograms were more common for white non-Hispanic beneficiaries than other racial groups, but rates for all groups increased over the decade.

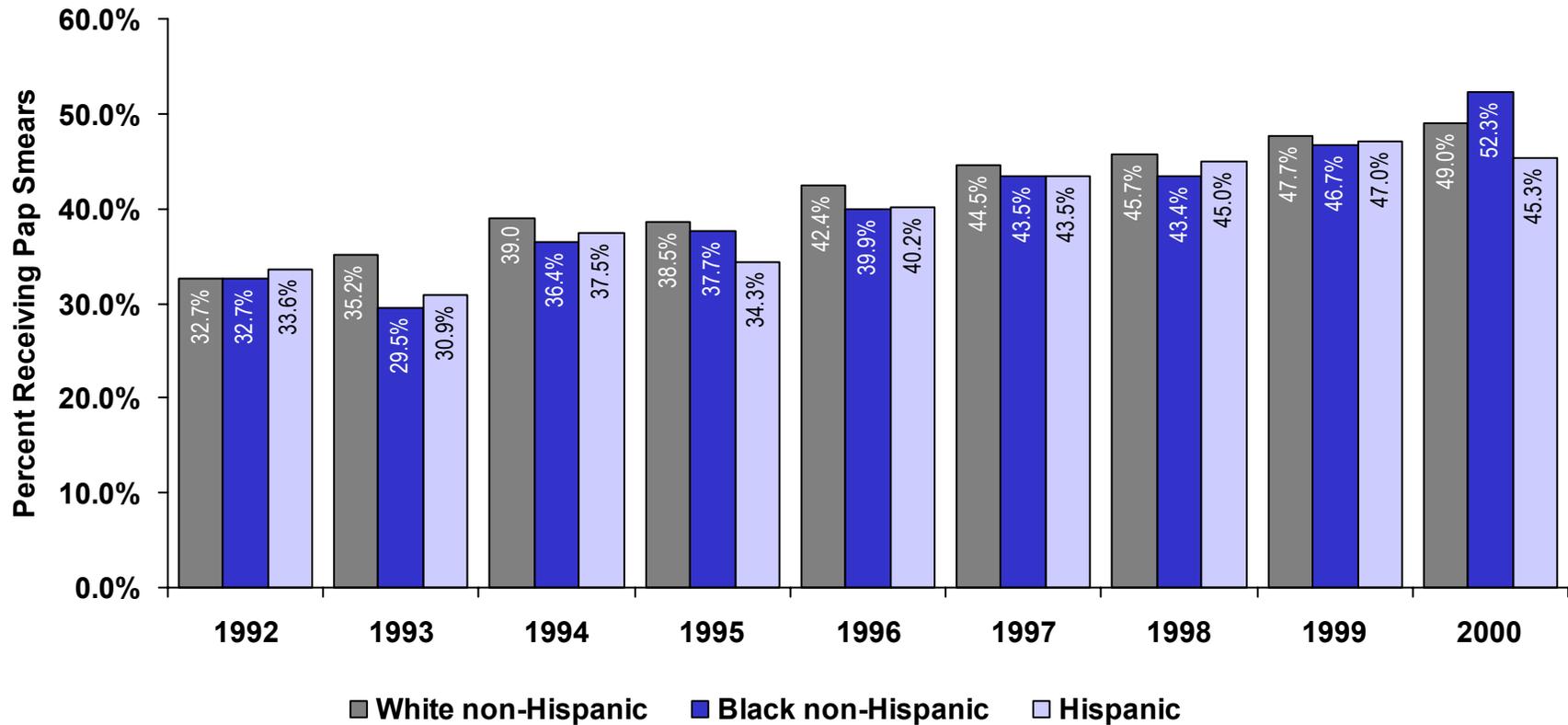


Note: Data reflect female beneficiaries who reported receiving mammograms in the past year, and include both preventive and diagnostic services. MCBS survey includes fee-for-service and managed care enrollees as well as aged and disabled beneficiaries. Does not include beneficiaries in facility care.

Source: CMS, Office of Research, Development, and Information: Data from Medicare Current Beneficiary Survey (MCBS) 1992-2000 Access to Care Files.

Female Medicare Beneficiaries Who Received Pap Smears, by Race

Utilization of Pap smears has increased over the decade.

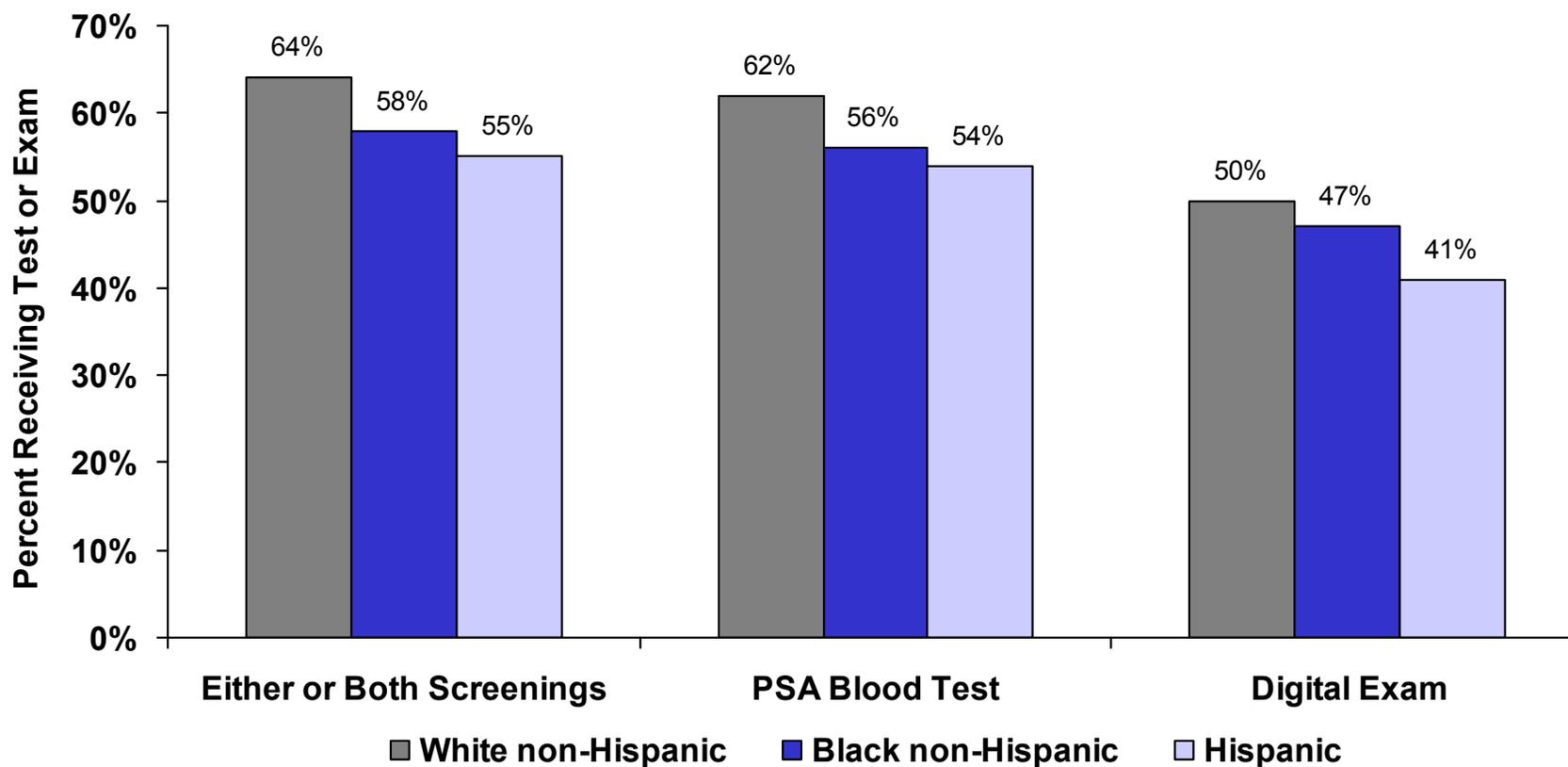


Note: Data reflect female beneficiaries who reported receiving a Pap smear in the past year. The MCBS Survey includes fee-for-service and managed care enrollees as well as aged and disabled beneficiaries. Does not include beneficiaries in facility care.

Source: CMS, Office of Research, Development, and Information: Data from Medicare Current Beneficiary Survey (MCBS) 1992-2000 Access to Care Files.

Male Medicare Beneficiaries Screened for Prostate Cancer, by Race, 2000

Hispanic male beneficiaries were least likely to receive either type of screening.



Note: Data reflect male beneficiaries who reported receiving prostate screenings.

Source: CMS, Office of Research, Development, and Information: Data from Medicare Current Beneficiary Survey (MCBS) 2000 Access to Care File.

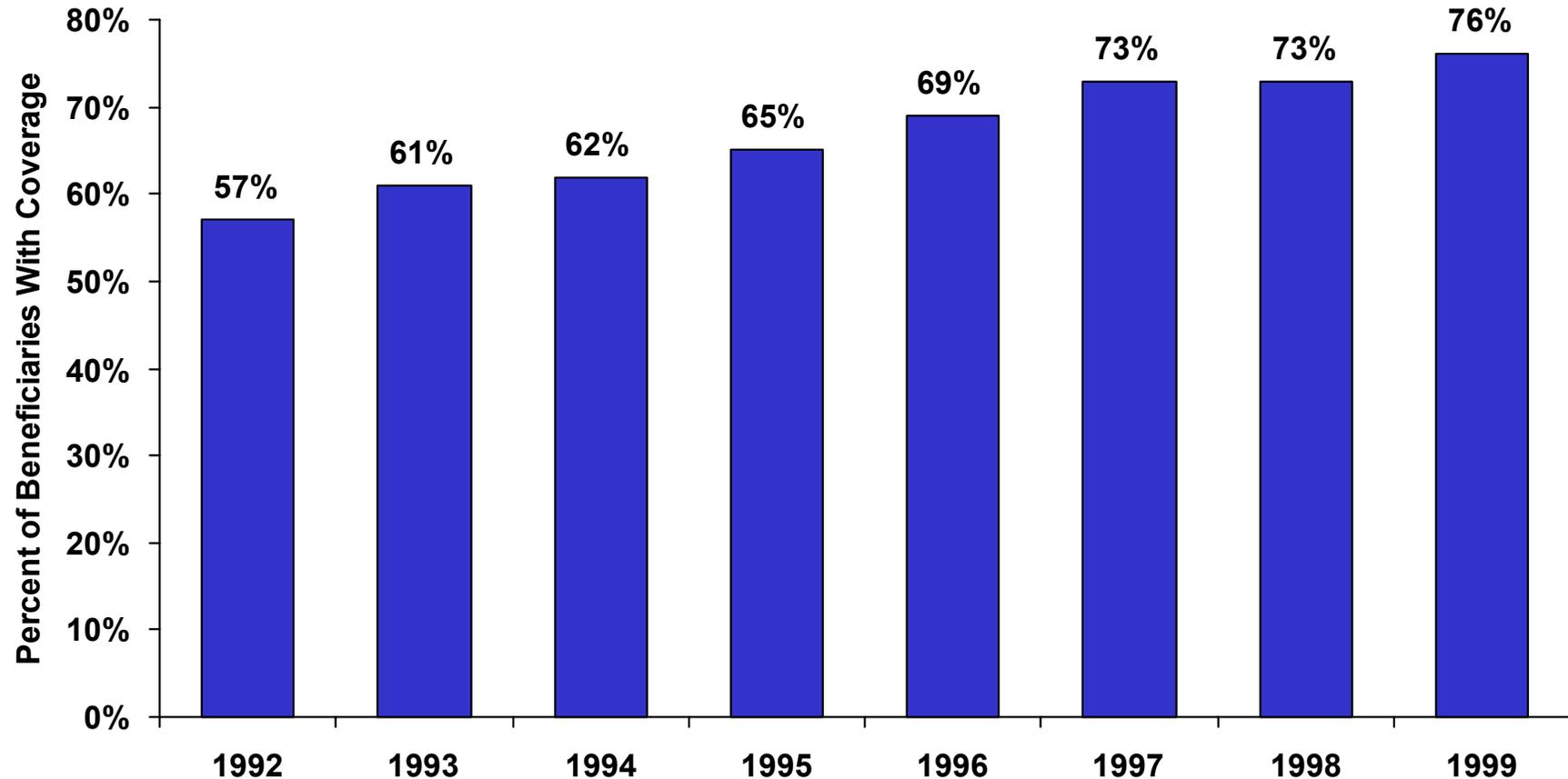
III. Medicare Program Information

B. Profile of Medicare Beneficiaries

9. Prescription Drug Coverage

Percent of Medicare Beneficiaries with Prescription Drug Coverage, 1992-1999

About three-quarters of Medicare beneficiaries had prescription drug coverage at some point in 1999.

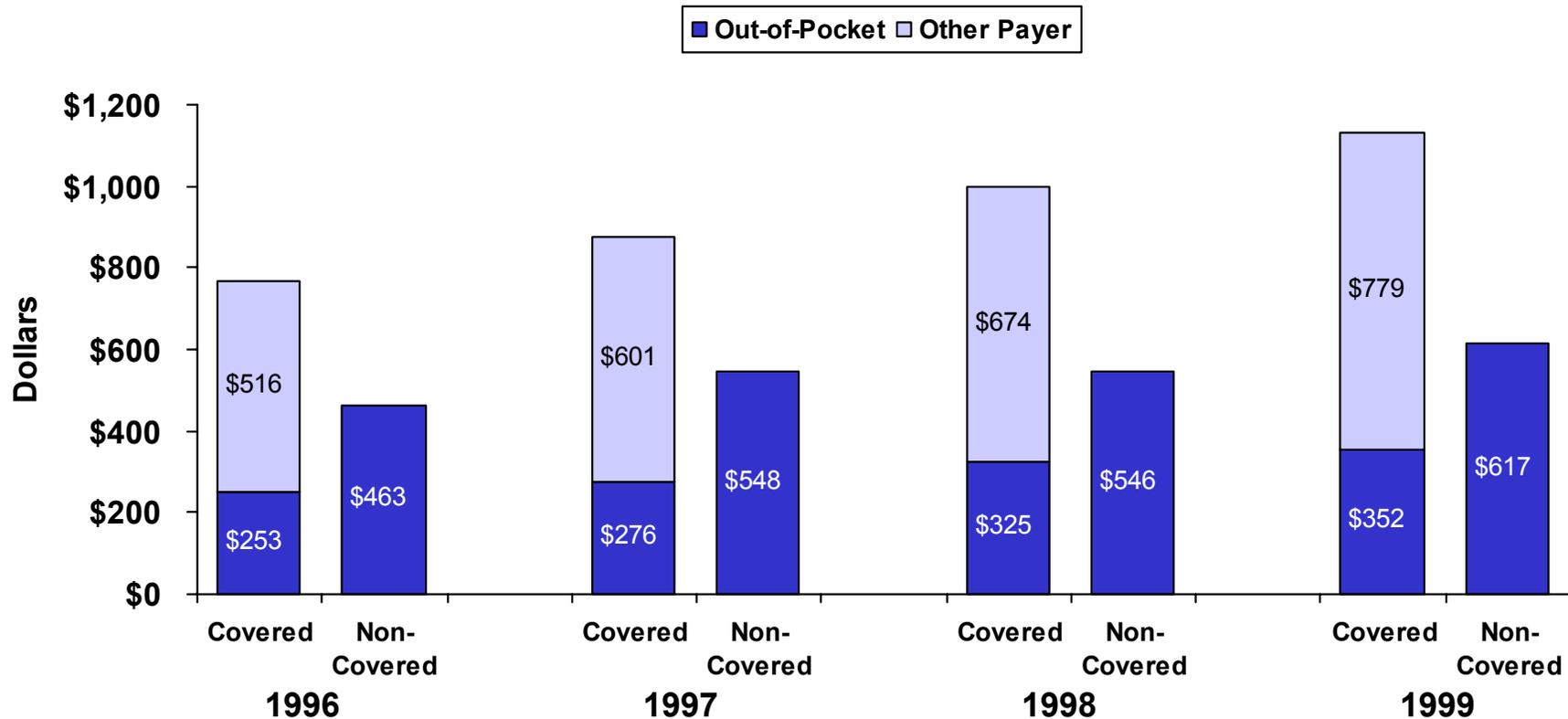


Note: This includes beneficiaries who had some type of drug coverage at any point during the year. Does not include beneficiaries in facility care.

Source: CMS, Office of Research, Development, and Information: Data from the Medicare Current Beneficiary Survey (MCBS) 1992-1999 Cost and Use Files.

Total Spending for Prescription Drugs for All Medicare Beneficiaries, 1996-1999

Total spending for drugs was higher for beneficiaries with drug coverage than without; however, non-covered beneficiaries pay substantially more out-of-pocket costs.

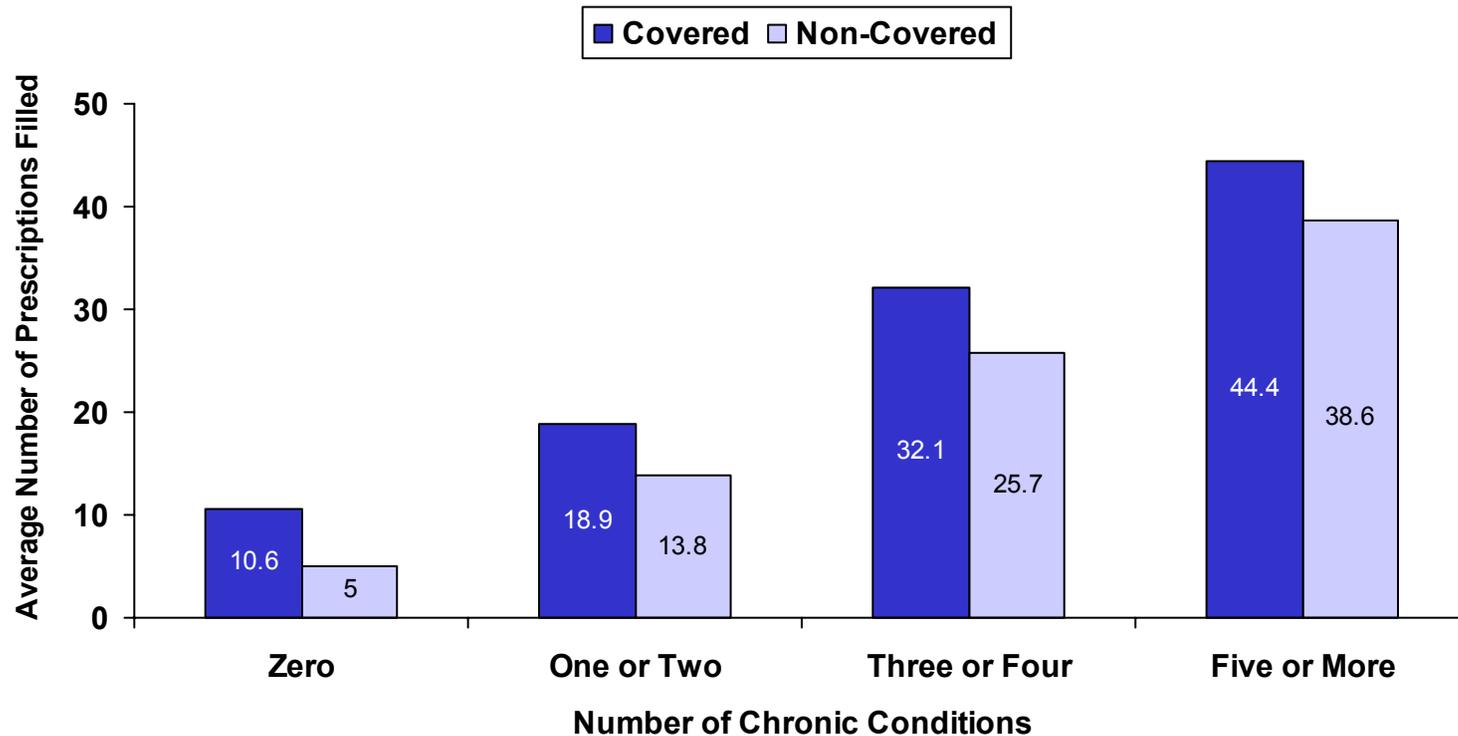


Note: Does not include beneficiaries in facility care. Does not adjust for underreporting of prescription drugs.

Source: CMS, Office of Research, Development, and Information: Data from the Medicare Current Beneficiary Survey (MCBS) 1996-1999 Cost and Use Files.

Average Number of Prescriptions Filled for Beneficiaries With and Without Drug Coverage, by Number of Chronic Conditions, 1999

Beneficiaries with prescription drug coverage fill more prescriptions than those without drug coverage, regardless of the number of chronic conditions they have.

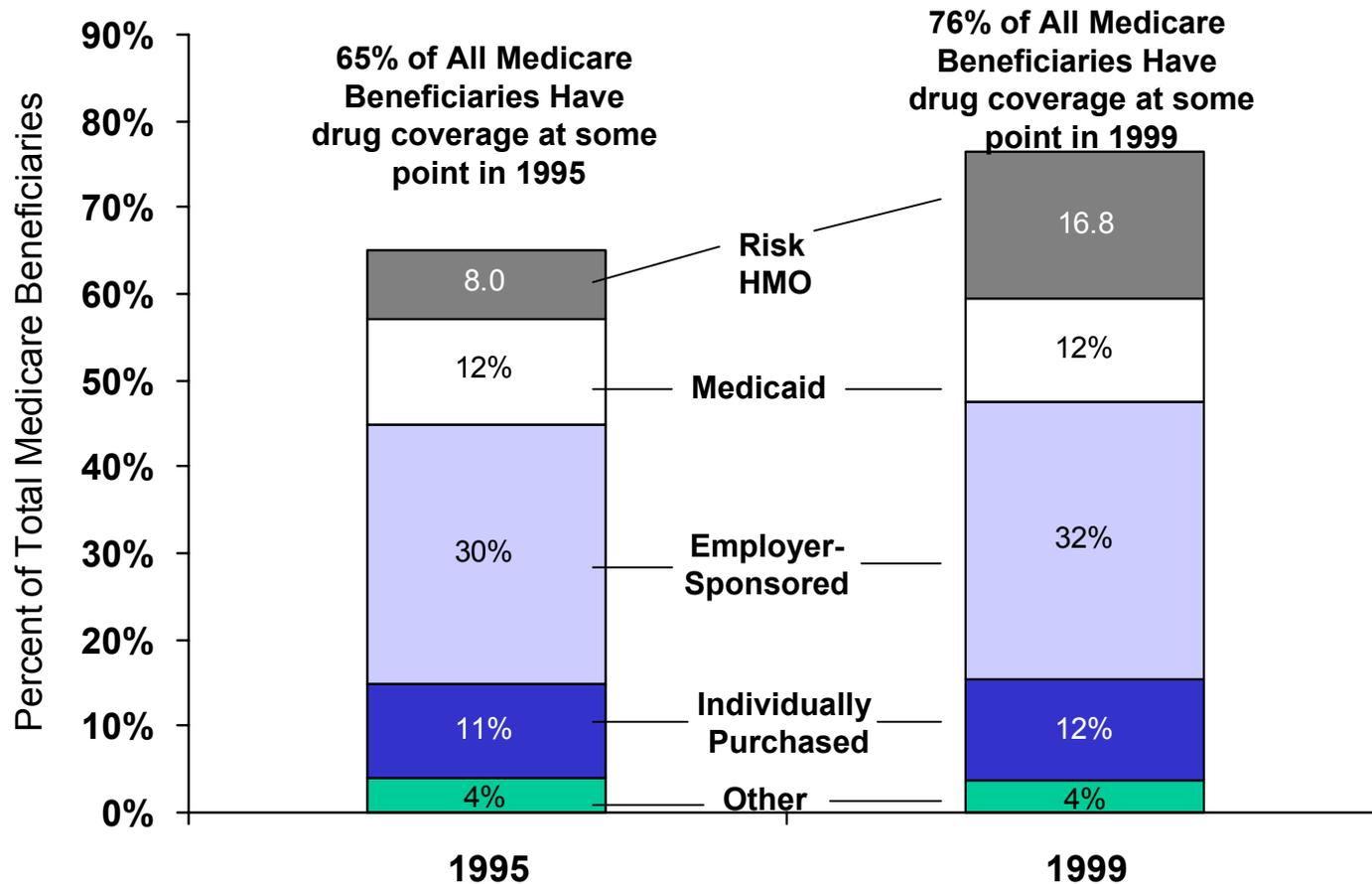


Note: There were 2.4 million covered and 1.1 million non-covered beneficiaries with no chronic conditions. There were 13.4 million covered and 4.5 million non-covered beneficiaries with 1 or 2 chronic conditions. There were 11.3 million covered and 2.9 million non-covered beneficiaries with 3 or 4 chronic conditions. There were 2.0 million covered and 0.4 million non-covered beneficiaries with 5 or more chronic conditions. Does not include beneficiaries in facility care. Does not adjust for underreporting of prescription drugs.

Source: CMS, Office of Research, Development, and Information: Data from the Medicare Current Beneficiary Survey (MCBS) 1999 Cost and Use File.

Medicare Beneficiaries With Drug Coverage, by Primary Source of Supplemental Coverage, 1995 and 1998

A larger proportion of beneficiaries obtained supplemental drug coverage from a managed care plan between 1995 and 1999.



Note: Does not include beneficiaries in facility care. Percentages shown in bars are Medicare beneficiaries with drug coverage as a percent of total Medicare beneficiaries. Beneficiaries do not necessarily get drug coverage from their primary sources of supplemental insurance.

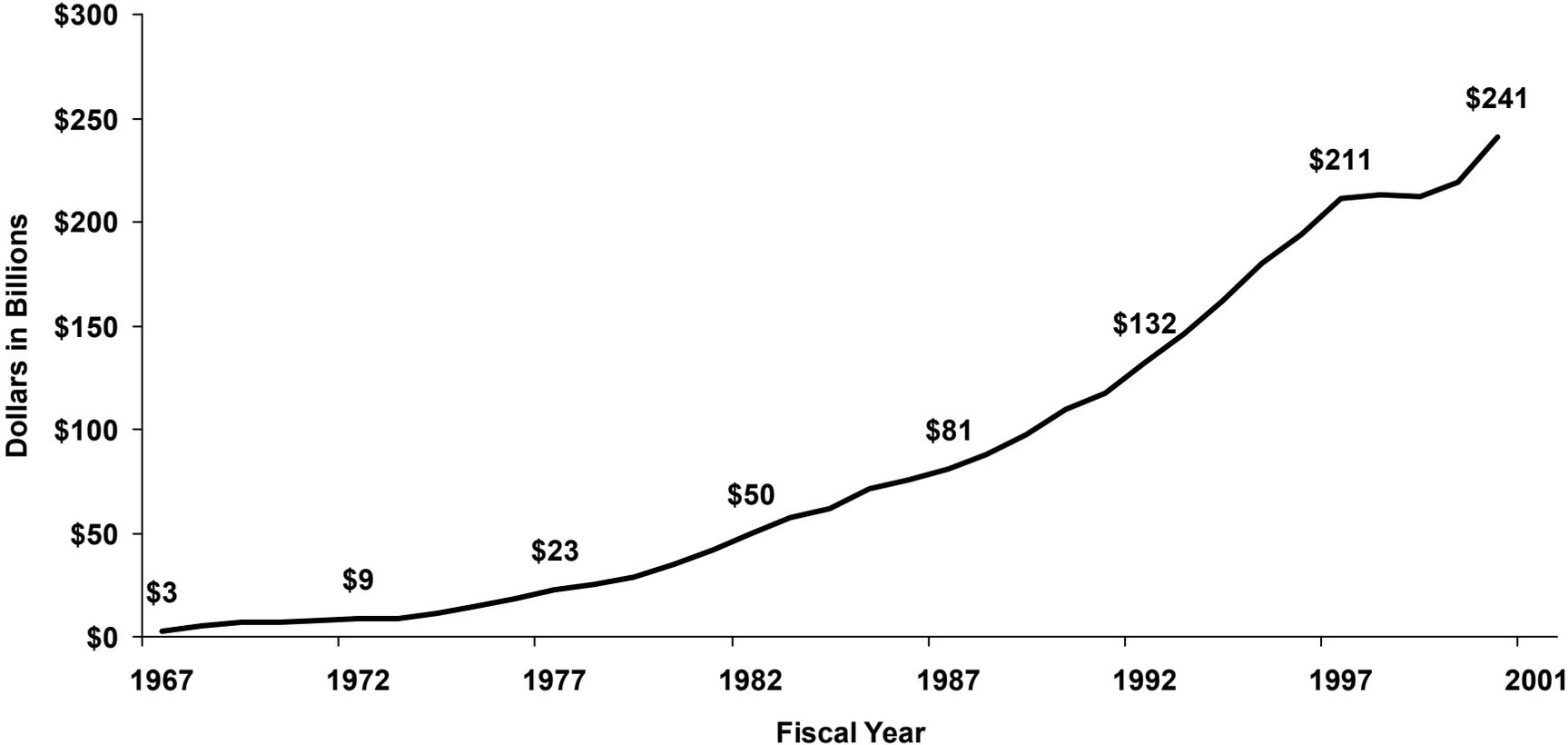
Source: CMS, Office of Research, Development, and Information. Data are from the Medicare Current Beneficiary Survey (MCBS) 1995 and 1999 Cost and Use Files.

III. Medicare Program Information

C. Medicare Program Spending

Medicare Spending

Overall Medicare spending grew from \$3.3 billion in 1967 to nearly \$241 billion in 2001.

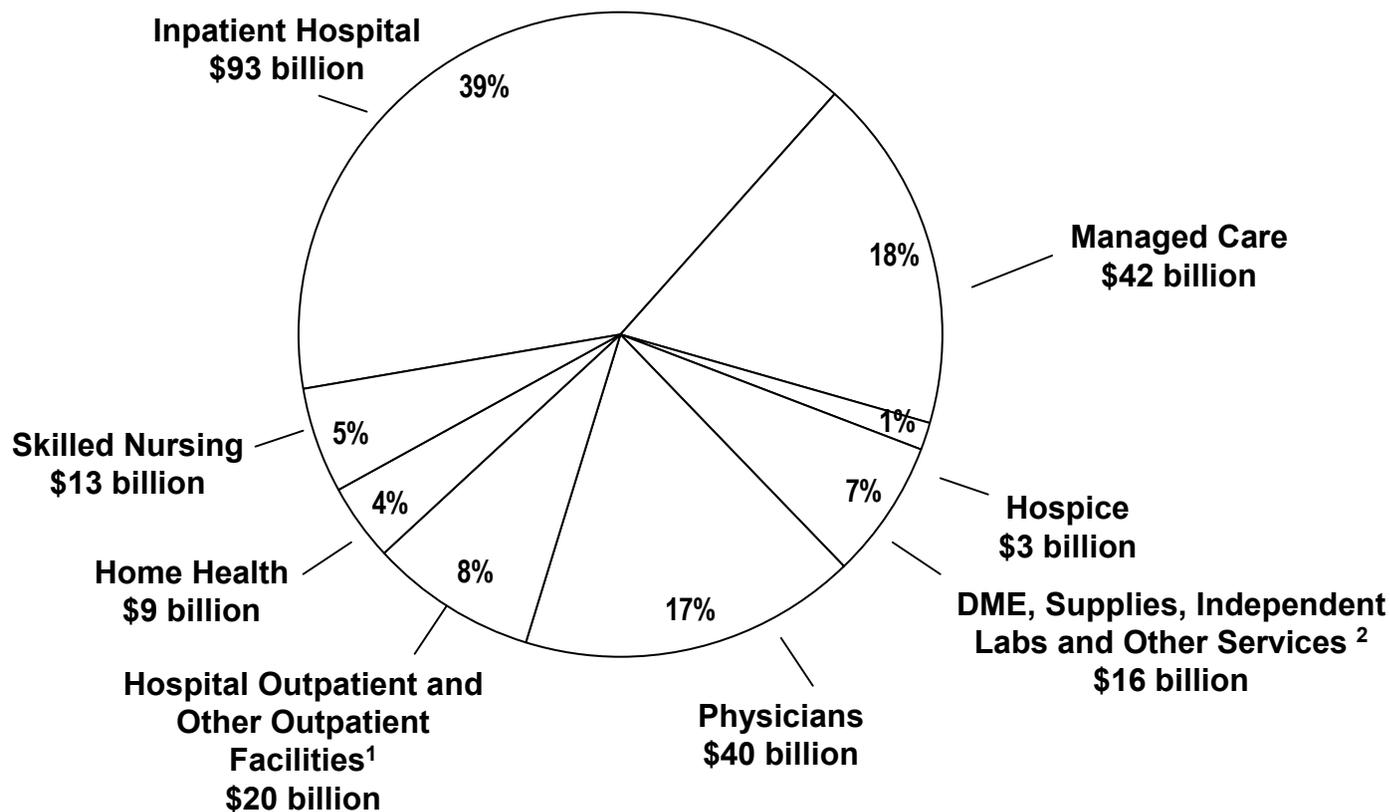


Note: Overall spending includes benefit dollars, administrative costs, and program integrity costs. Represents Federal spending only.

Source: CMS, Office of the Actuary.

Where the Medicare Claims Dollar Went, FY 2001

Total = \$236 billion



¹ Other outpatient facilities include ESRD freestanding dialysis facilities, RHCs, outpatient rehabilitation facilities, and federally qualified health centers.

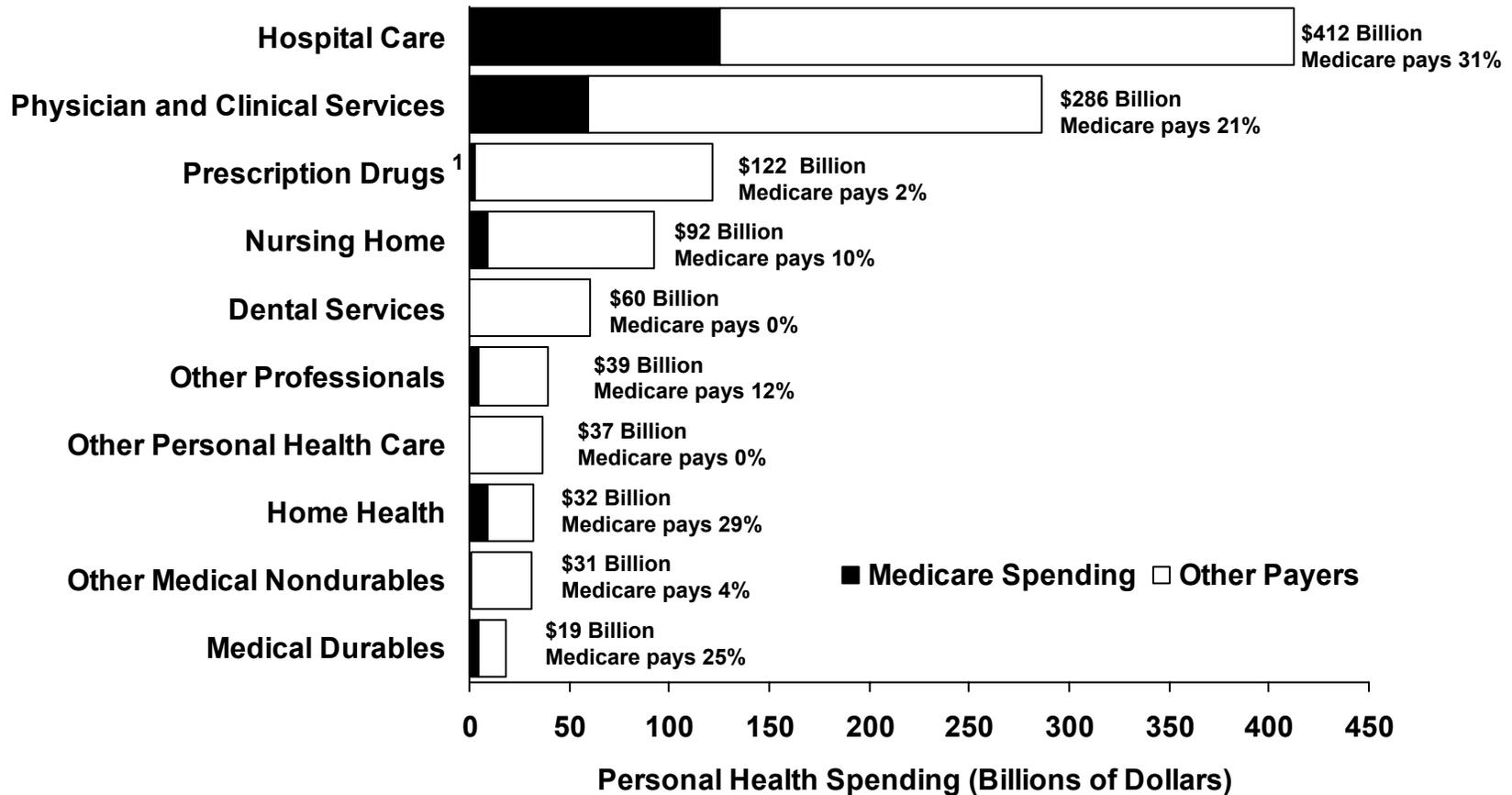
² Other services include ambulatory surgical center facility costs and ambulance services.

Note: Spending includes benefit dollars only. Data do not sum due to rounding.

Source: CMS, Office of the Actuary

National Personal Health Care Expenditures, by Type of Service and Percent Medicare Paid, CY 2000

*Total national personal health care spending in CY 2000 was \$1.1 trillion;
Medicare accounted for 19 percent.*



¹ Medicare payments are from managed care plans only, since fee-for-service Medicare does not generally cover outpatient prescription drugs.

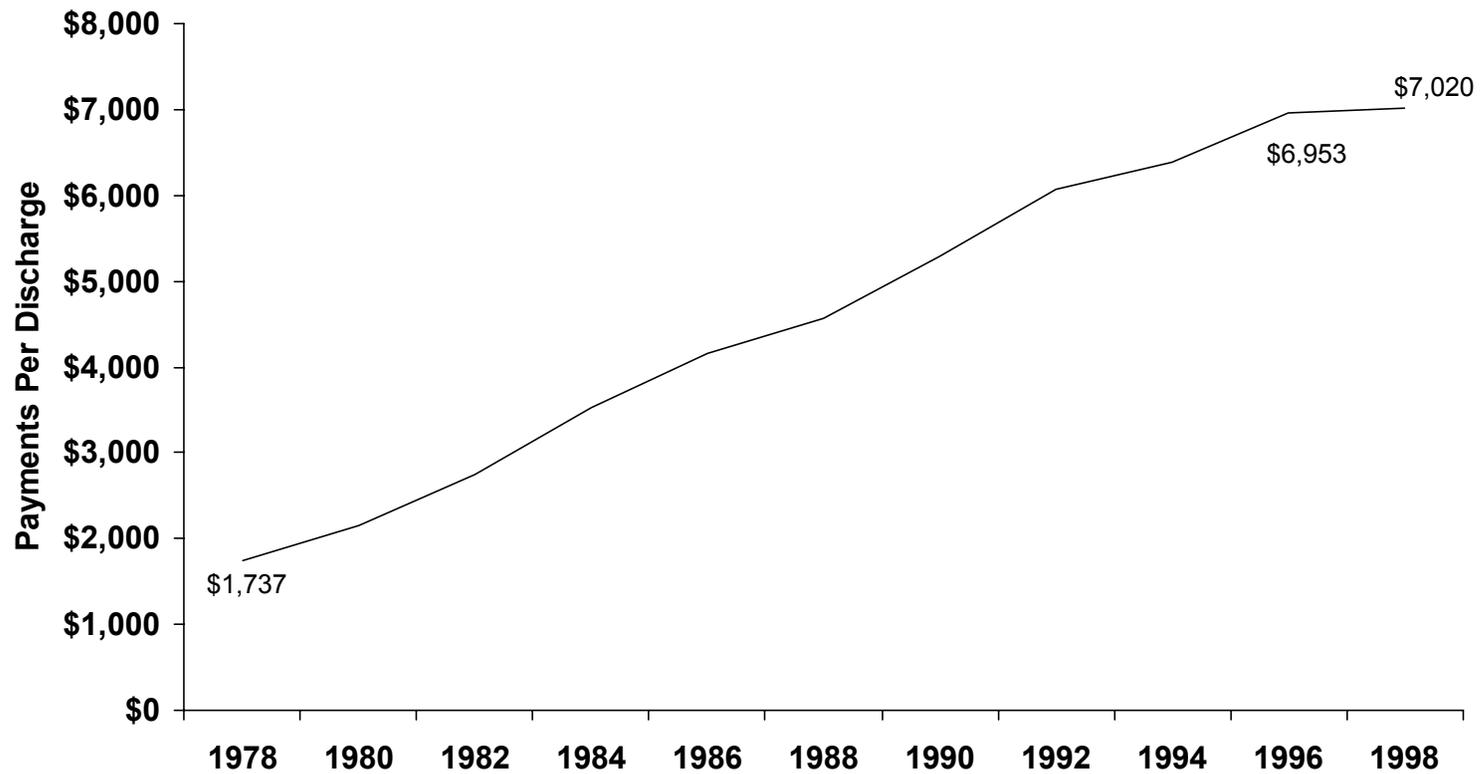
Source: CMS, Office of the Actuary, National Health Statistics Group

III. Medicare Program Information

D. Medicare Spending and Utilization by Service Sector

Average Program Payment per Medicare Beneficiary Discharge for Short-Stay Hospitals

After steadily rising for two decades, average program payments per discharge stabilized somewhat between 1996 and 1998.

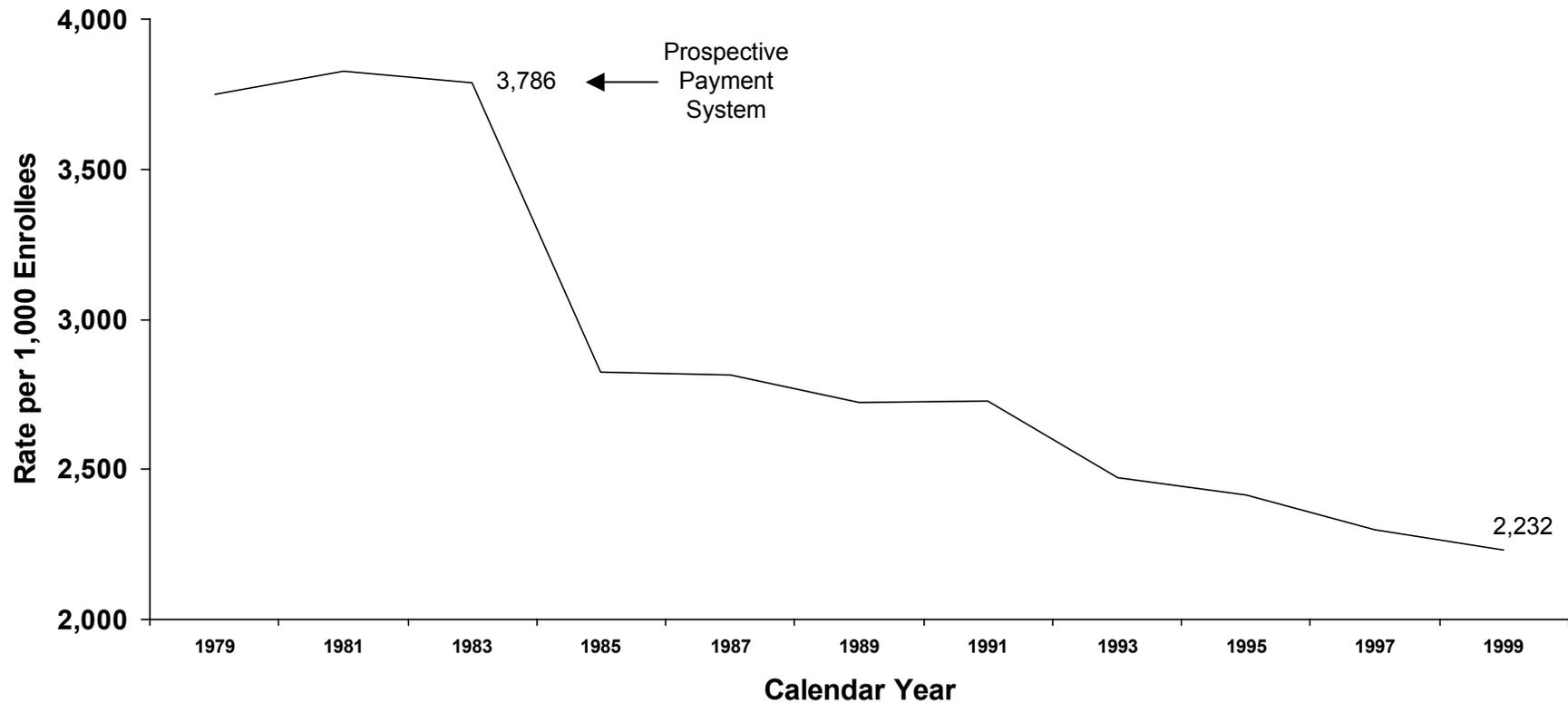


Note: Medicare program payments represent fee-for-service only.

Source: CMS, Office of Information Services: Data from the Medicare Support Access Facility; data development by the Office of Research, Development, and Information.

Total Days of Care of Medicare Beneficiary Stays in Short-Stay Hospitals

Total days of care per 1,000 Medicare beneficiaries continued a historical downward trend started in 1983.

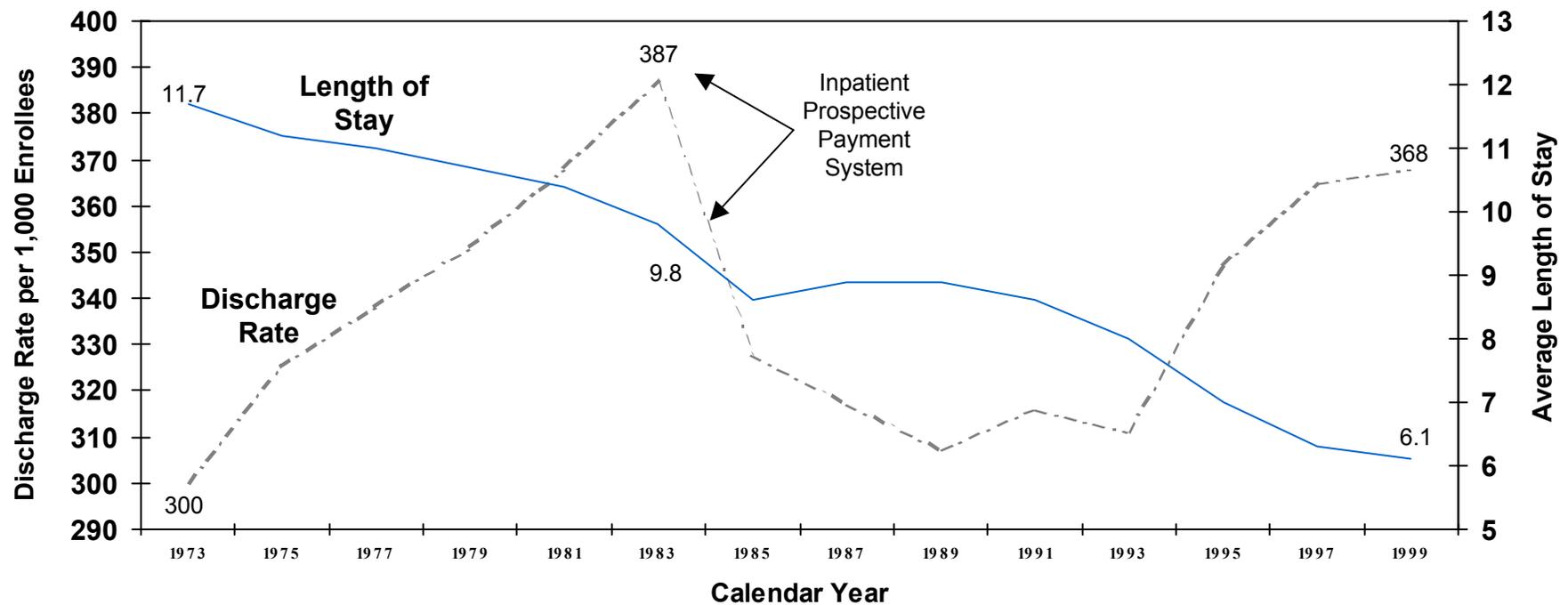


Note: Beginning with 1994 data, the utilization statistics do not reflect managed care enrollment.

Source: CMS, Office of Information Services: Data from the Medicare Support Access Facility; data development by the Office of Research, Development, and Information.

Discharge Rate and Average Length of Stay of Medicare Beneficiary Stays in Short-Stay Hospitals

Although discharge rates and average length of stays both fell between 1983 and 1993, discharge rates have risen sharply since 1993.

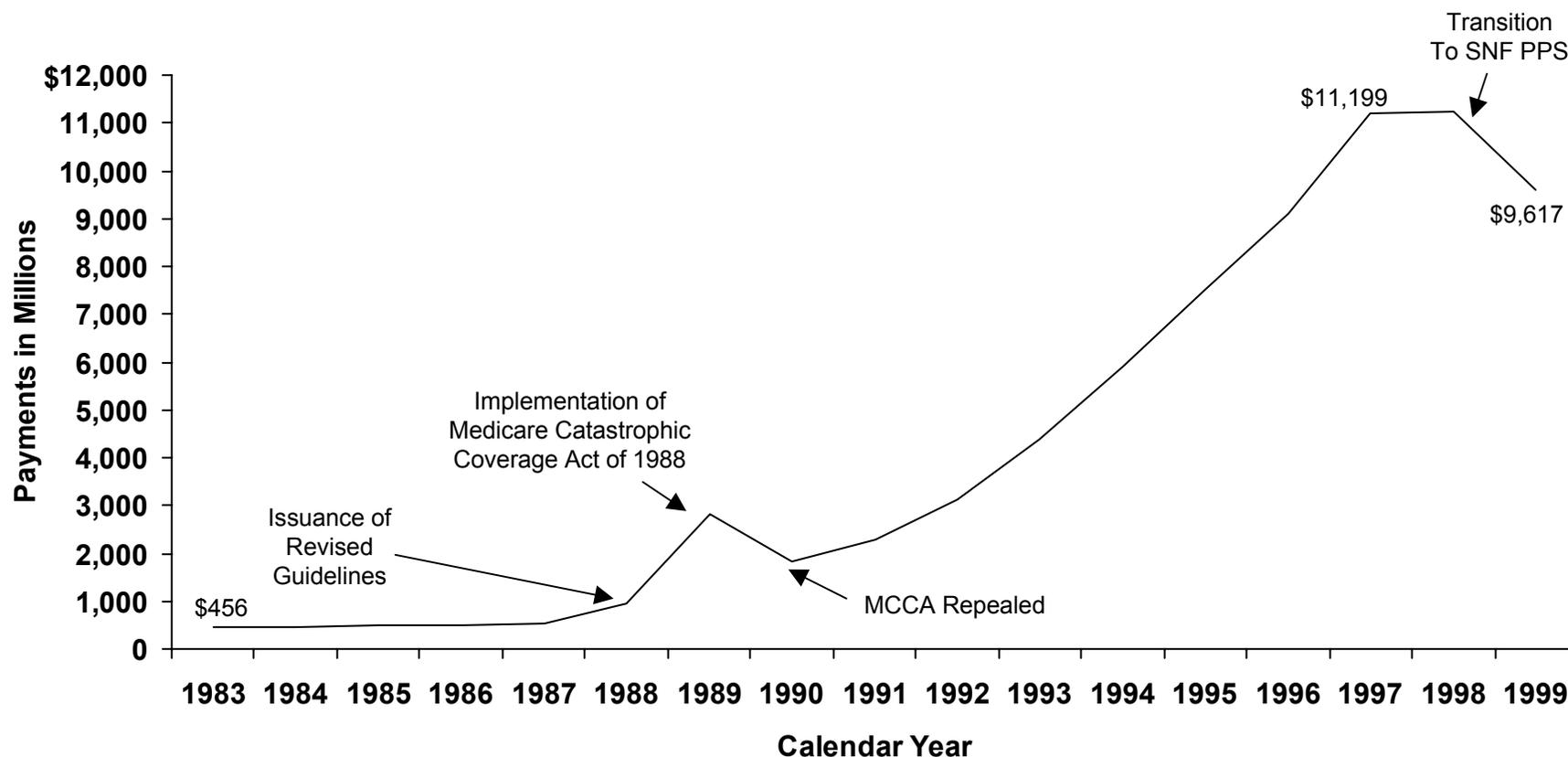


Note: Beginning with 1994 data, the utilization statistics do not reflect managed care enrollment.

Source: CMS, Office of Information Services: Data from the Medicare Support Access Facility; data development by the Office of Research, Development, and Information.

Growth in Medicare Skilled Nursing Facility Program Payments

After rising rapidly during the 1990s, payments to skilled nursing facilities fell for the first time in 1999.

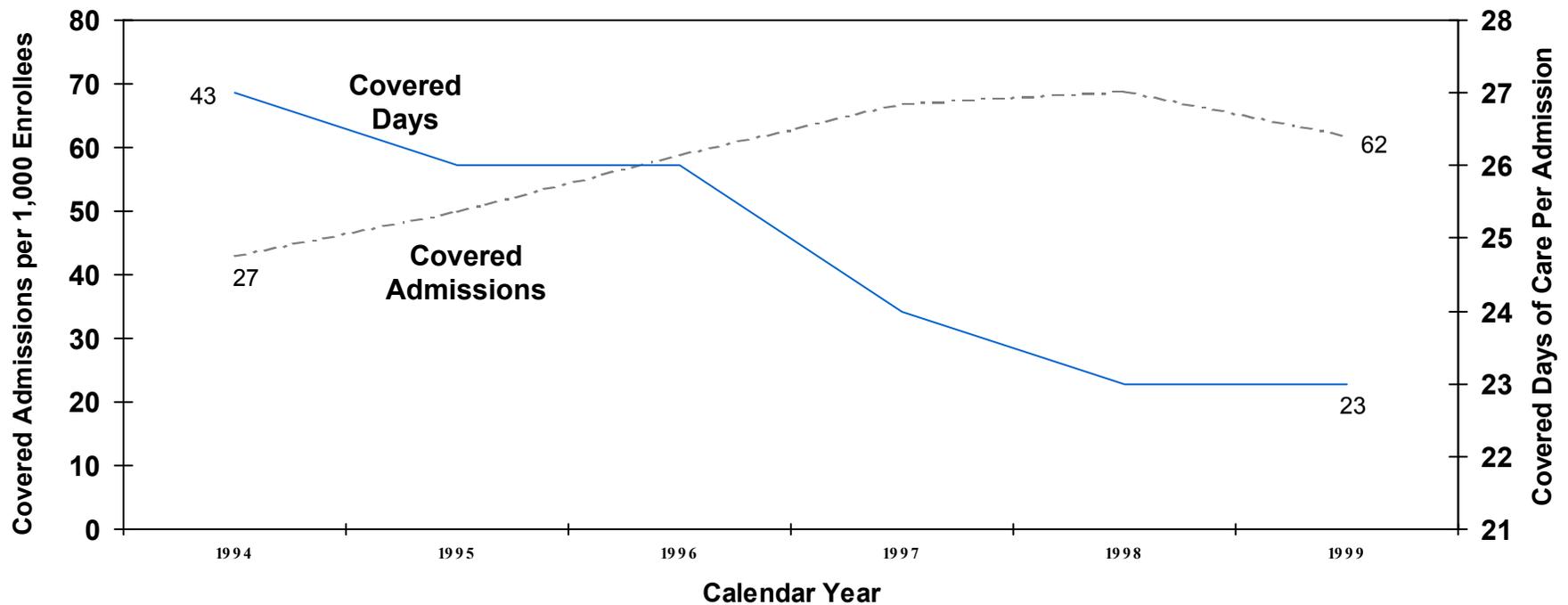


Note: Medicare program payments represent fee-for-service only. MCCA is the Medicare Catastrophic Coverage Act of 1988. SNF PPS is the skilled nursing facility prospective payment system.

Source: CMS, Office of Information Services: Data from the Medicare Support Access Facility; data development by the Office of Research, Development, and Information.

Skilled Nursing Facility Covered Admissions and Covered Days of Care for Medicare Beneficiaries

From 1994 to 1999, skilled nursing admissions increased while the average number of days per stay decreased.

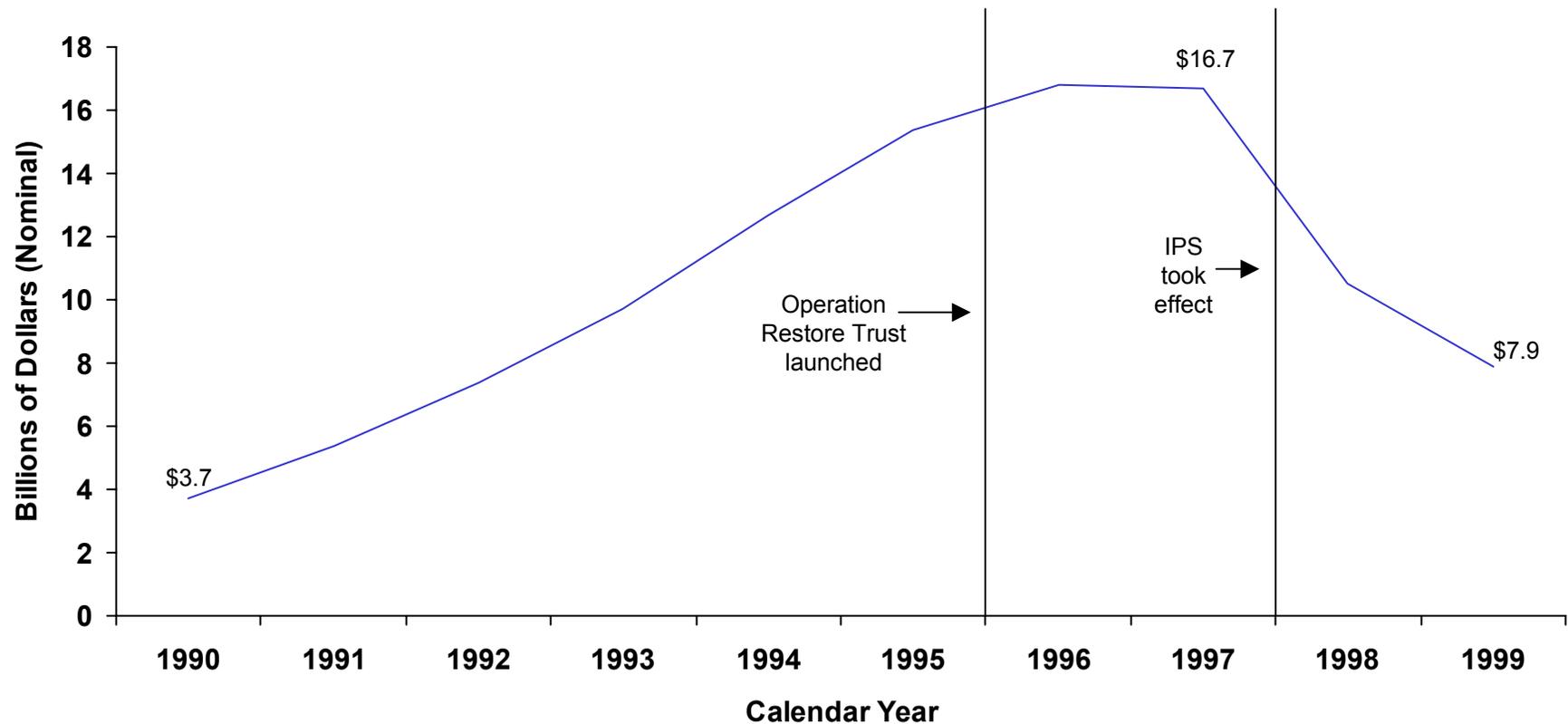


Note: Beginning with 1994 data, the utilization statistics do not reflect managed care enrollment.

Source: CMS, Office of Information Services: Data from the Medicare Support Access Facility; data development by the Office of Research, Development, and Information.

Medicare Fee-for-Service Home Health Expenditures

After rising rapidly for most of the decade, total home health spending fell 37 percent in 1998.

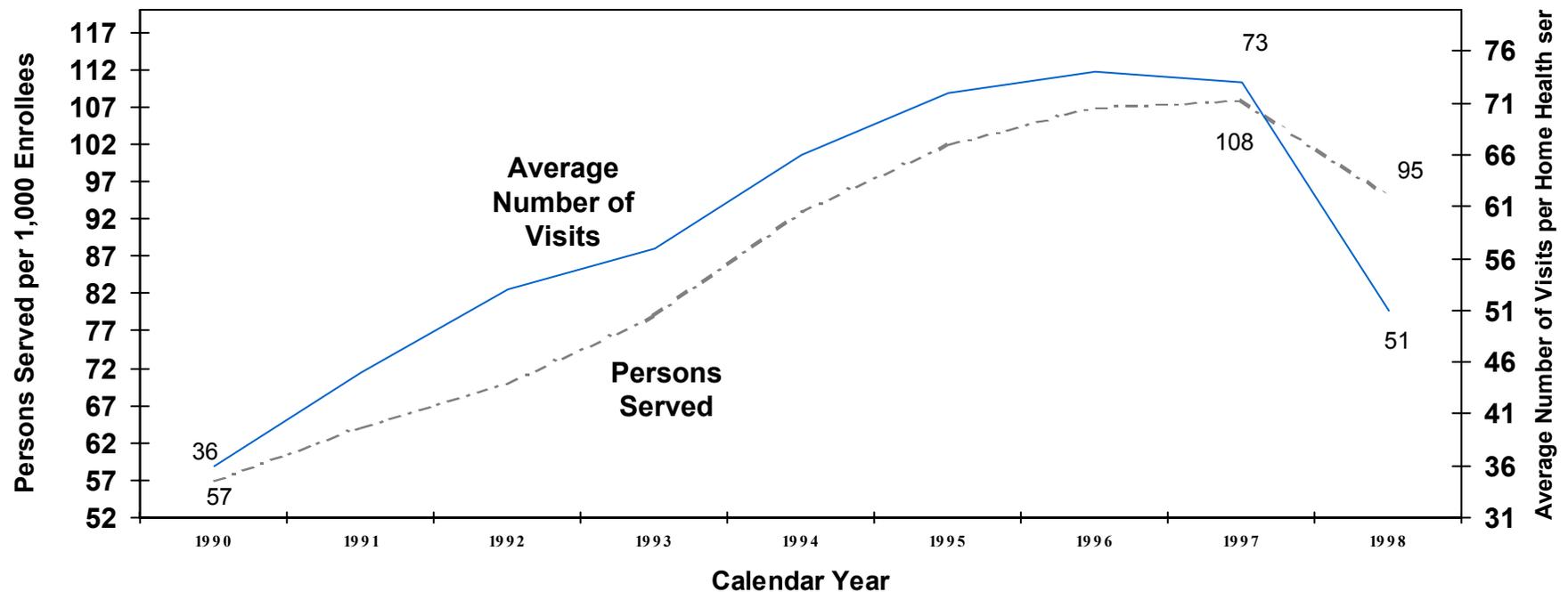


Note: Medicare program payments represent fee-for-service only. IPS is the interim payment system created by Congress in the Balanced Budget Act of 1997. Operation Restore Trust was a comprehensive anti-fraud initiative sponsored by HHS.

Source: CMS, Office of Information Services: Data from the Standard Analytical File; data development by the Office of Research, Development, and Information.

Persons Served and Average Number of Visits by Home Health Agencies

After sharply rising for most of the 1990s, both the number of persons served and average number of visits declined beginning in 1997.

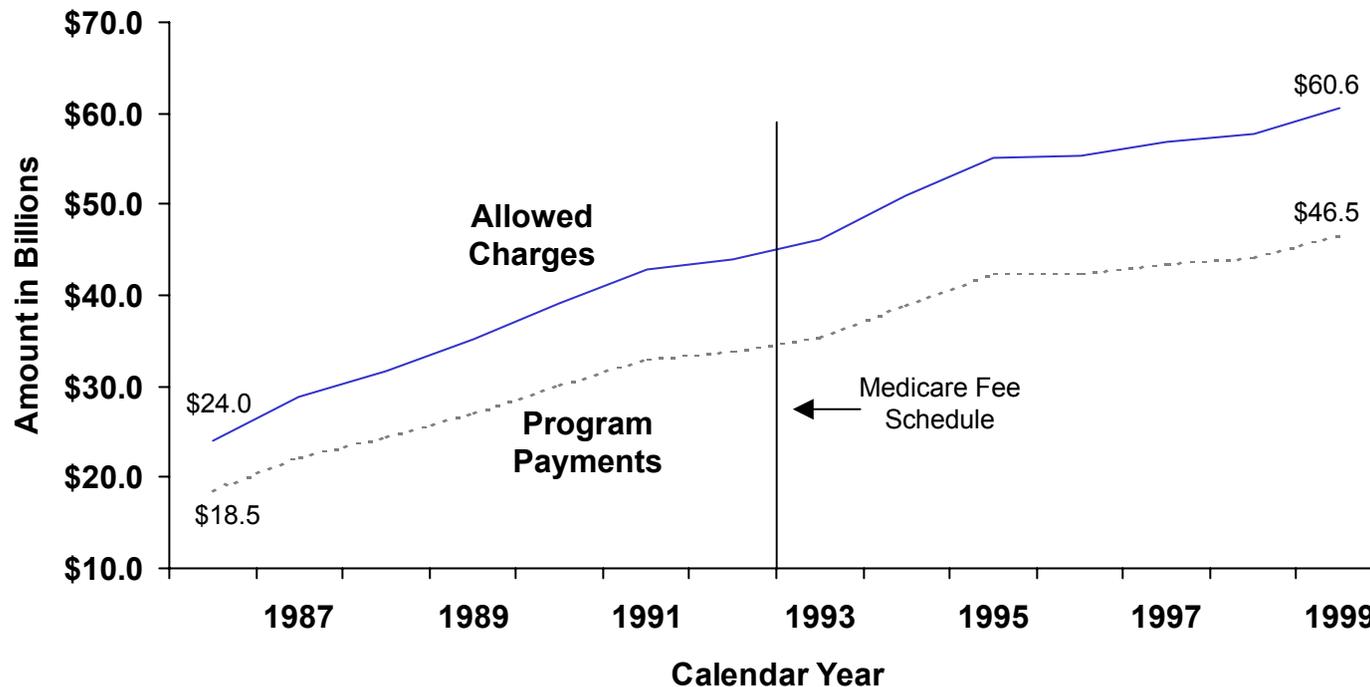


Note: Beginning with 1994 data, the utilization statistics do not reflect managed care enrollment.

Source: CMS, Office of Information Services: Data from the Medicare Support Access Facility; data development by the Office of Research, Development, and Information.

Trends in Medicare Physician and Supplier Allowed Charges and Program Payments

From 1987 to 1999, Medicare-allowed charges for physician and supplier services increased and total program payments rose.

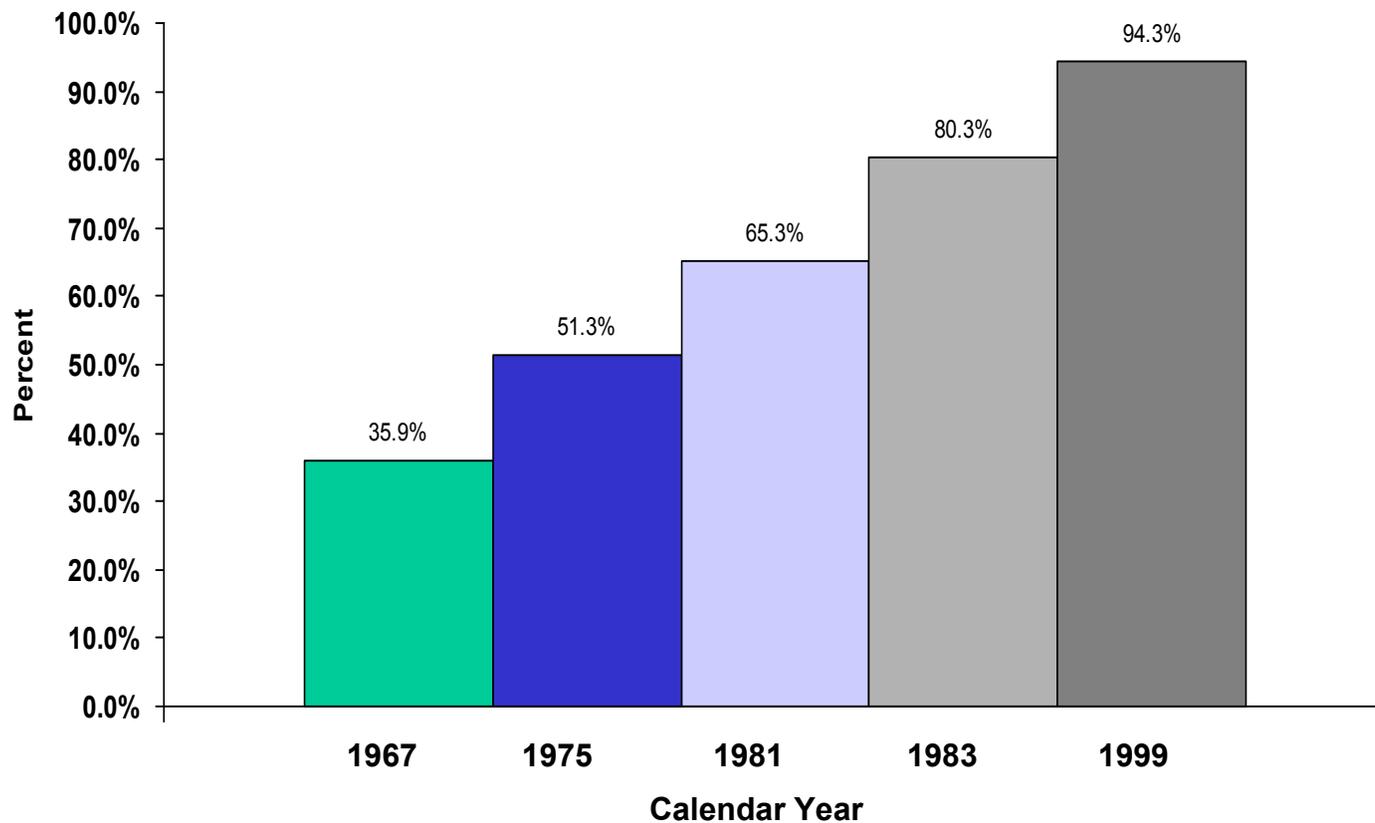


Note: The difference in the amount of these two cost measures is due primarily to cost sharing. Medicare program charges and payments represent fee-for-service only.

Source: CMS, Office of Information Services: Data from the Medicare Decision Support Access Facility; data development by the Office of Research, Development, and Information.

Medicare Beneficiaries Receiving a Reimbursed Physician or Other Medical Service

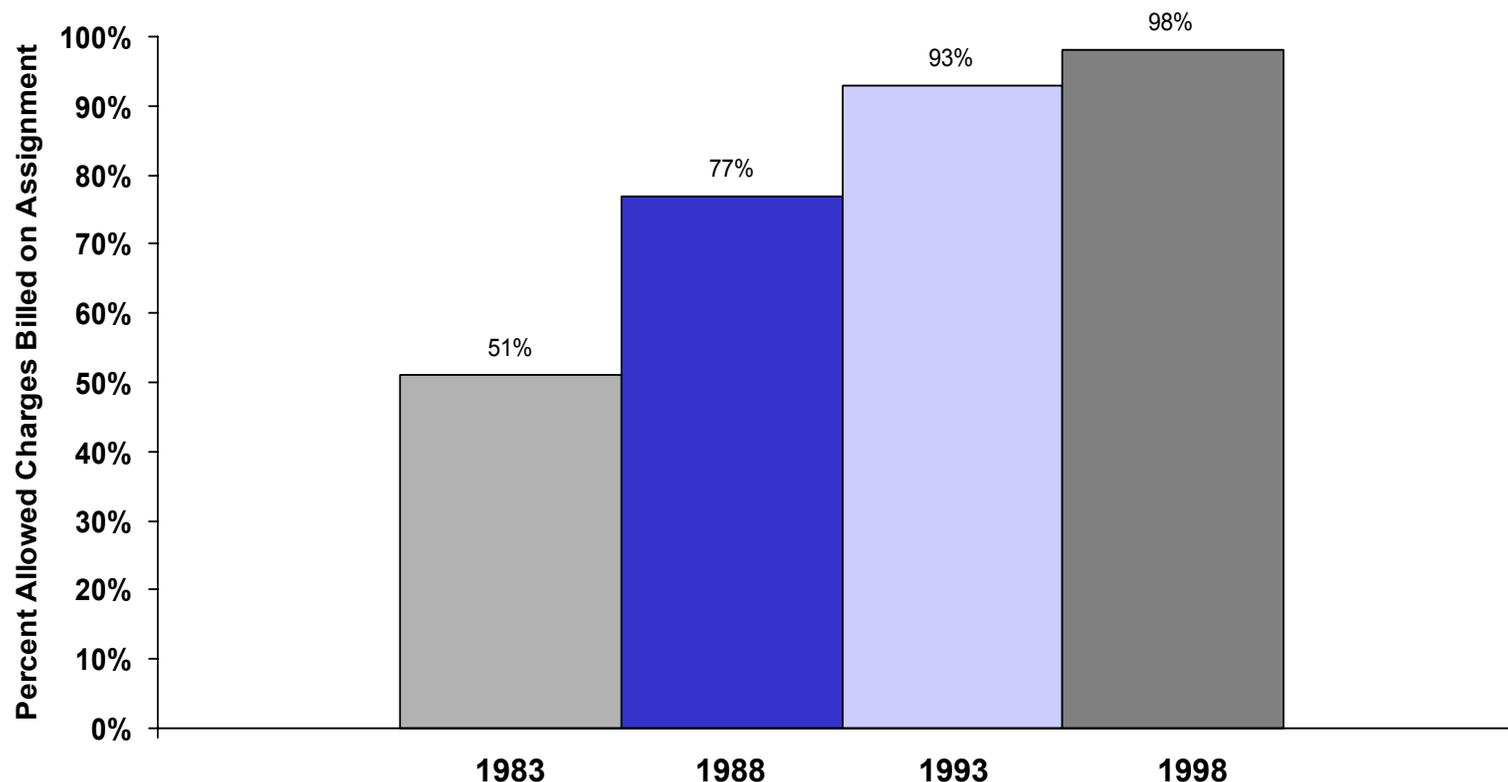
The proportion of beneficiaries receiving Medicare-reimbursed physician or other medical service grew substantially from 1967 to 1999.



Source: CMS, Office of Information Service: Data from the Medicare Support Access Facility; data development by the Office of Research, Development, and Information.

Medicare Assignment Rate for Physicians' Services

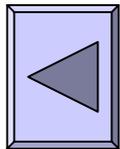
The percent of Medicare-allowed charges for physicians' services billed on assignment increased substantially over the decade.



Note: Assignment rates are calculated based on the ratio of assigned allowed charges to total allowed charges (which reflects both assigned and unassigned allowed charges) for all physician services. Supplier services are excluded.

Source: CMS, Office of Information Service: Data from the Medicare Support Access Facility; data development by the Office of Research, Development, and Information.

End of Presentation



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