Medicare, Medicaid, and the Elderly Poor

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INTRODUCTION

One out of every five elderly Americans faces each day on a limited income with little flexibility for extra or unexpected medical expenses. When medical care is needed, these 6 million poor and near-poor elderly Americans depend on Medicare for assistance with their medical bills. The universal coverage of Medicare assures them entry to America's health care system and offers protection from financial catastrophe when illness strikes. However, gaps in the scope of Medicare's benefits and financial obligations for coverage can result in onerous financial burdens.

Low-income elderly people are particularly vulnerable because they are more likely to be experiencing health problems that require medical services than those who are economically better off, but are less able to afford needed care because of their lower incomes. Even routine care, such as physician visits or prescription drugs, can require older and poorer beneficiaries to make hard choices between basic necessities and needed health care services. Medicaid serves as an important complement to Medicare by assisting low-income Medicare beneficiaries with their Medicare premiums and cost-sharing and by providing coverage for prescription drugs and long-term care (LTC) services that are not available through Medicare. Without Medicaid's assistance, the costs of basic medical care can impede access to care and erode financial security for low income elderly people.

This article profiles the economic and health status of the low-income elderly population served by Medicare, assesses the impact of Medicare, and examines the role Medicaid plays as a supplement to Medicare. Particular emphasis is given to the burdens medical expenses impose on low-income elderly people, the extent to which coverage to supplement Medicare can assist in alleviating the impact of financial burdens on access to care, and the implications of potential changes in the scope and structure of Medicare and Medicaid for the elderly low-income population.

POVERTY AND ILLNESS IN THE ELDERLY POPULATION

Despite general improvements in the economic situation of the elderly population over the last 3 decades, many elderly Americans continue to struggle to pay living expenses on low or modest incomes. Forty-one percent of the Nation's 31 million elderly people living in the community have incomes below twice the Federal poverty level (FPL) and 1 in 5 are poor or near-poor (U.S. Bureau of the Census, 1996).

In 1994, the FPL was $7,100 per year in income for a single elderly adult and $9,000 for an elderly couple. Twelve percent of the elderly population-3.7 million people-had incomes below the poverty level and another 7 percent-2.2 million people-were near-poor with incomes between 100 and 125 percent of FPL (Figure 1).[1]

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[1] The figures and tables appear at the end of the article.

Together, these 5.9 million poor and near-poor people comprise Medicare's non-institutionalized low-income elderly population. Another 1.4 million elderly reside in nursing homes and receive assistance from Medicaid (Lyons, Rowland, and Hanson, 1996).

The likelihood of living on a low income is greatest for women, minorities, and the oldest Americans (Figure 2). Poverty rates increase with age, with 23 percent of people 75 years of age or over poor or near-poor, in contrast to 16 percent of those 65-74 years of age. Nearly one-fourth of elderly women are poor or near poor, reflecting their lower wage levels during working years, their increased risk of financial stress from widowhood, and longevity that exceeds savings. Elderly minorities are particularly vulnerable to low incomes. Thirty-seven percent of black elderly people and 36 percent of Hispanic elderly people have incomes below 125 percent of FPL.

Poverty is clearly linked to educational level and highly correlated with marital and living arrangements. Well-educated, married couples are financially better off than those who are less educated, single, and living alone. Educational levels correspond to different job opportunities and careers, with the more highly educated likely to have better retirement benefits and more personal savings from their working years. Among today's elderly population, 42 percent have less than a high school education, but there are significant differences by income. Seventy percent of the poor elderly, compared with 23 percent of the non-poor elderly, are without a high school diploma (Figure 3).

Marital status and living arrangement also differ significantly by income, with 42 percent of the poor compared with 21 percent of the non-poor living alone, and only one-third (31 percent) of the elderly poor are married, in contrast to 72 percent of the non-poor elderly. This reflects the older age composition of the poor elderly (14 percent are over 85 years of age compared with 5 percent of the non-poor), and the toll time, illness, and loss of a spouse can impose on an individual's economic well-being. Yet it also means that the poor elderly are less likely to have family or companions living with them who can assist with medical or financial needs.

Medicare coverage is especially important to low-income elderly people because they are in poorer health than higher income elderly people and have few financial assets to draw on when faced with high medical costs. Poor health status, multiple chronic conditions, and functional limitations are all more prevalent among the low-income elderly population than among those with higher incomes. These conditions increase the need for and utilization of medical services which in turn increases the out-of-pocket expenses for cost-sharing and uncovered medical expenses.

The burden of illness is a serious problem for many poor and near-poor elderly people. Overall, one-fourth (24 percent) of the elderly population reports their health status as fair or poor (Figure 4). Over one-third (36 percent) of the poor and nearly one-third (32 percent) of the near-poor elderly report their health as fair or poor compared with only 17 percent of the non-poor elderly with incomes above 200 percent of FPL. Poor health status has been shown to be highly predictive of the need for medical care (Manning, Newhouse, and Ware, 1981).

Chronic conditions requiring increased contact with the medical care system and ongoing health care costs are more prevalent in the elderly population than in the non-elderly population and can be particularly burdensome for low-income elderly people. All elderly people are at increased risk of chronic illness, but low-income

people are more likely to have chronic health problems than non-poor elderly people (Figure 5). Nearly two-thirds (65 percent) of poor elderly people suffer from arthritis that can impair mobility and result in the need for medication for treatment and pain relief. Similarly, the prevalence of diabetes and hypertension, both illnesses requiring substantial medication costs and ongoing physician supervision, is highest in the low-income cohorts of the elderly population.

Functional disabilities contributing to the need for LTC assistance further compound the medical problems of elderly people (Rowland, 1989). Among non-institutionalized elderly Medicare beneficiaries; 7.8 percent report needing help to perform one or more activities of daily living (ADLs), such as dressing, eating, and toileting, and many more report difficulty in carrying out these activities due to health problems. The rates are higher for the poor and near-poor elderly, with 12.9 percent of the poor and 10.5 percent of the near-poor reporting such limitations (Figure 6). Low-income elderly people are also more likely to have three or more ADLs and increased dependency because of multiple limitations than those with higher incomes. Elderly people with functional limitations are often financially strained by non-medical needs and expenses as well as by the need for additional services and special transportation arrangements to obtain medical care.

In sum, poor and near-poor elderly people are more likely to be experiencing health problems for which they require medical services than elderly people who are economically better off, but they are less able to afford needed care because of their lower incomes. For those who need medical care and incur large out-of-pocket expenditures, medical expenses can lead to impoverishment. The extent to which insurance is available to assist with medical bills becomes a crucial factor.

ROLE OF MEDICARE

With the enactment of Medicare in 1965, basic health insurance protection for hospital care and physician services was extended to nearly all elderly Americans. The universal nature of Medicare coverage means that virtually no elderly person is without insurance. Medicare facilitates access to physician services and guarantees admission to a hospital when needed. It means that coverage for the elderly does not vary by State of residence and does not limit the elderly's choice of providers in the mainstream of American medical care. Over its 30 years of operation, Medicare has provided elderly Americans, and especially poor elderly Americans, with the opportunity to benefit from the many advances of American medical technology, most notably treatment for heart disease and cataract surgery, and to gain improved access to the health care system (Madans and Kleinman, 1980; Davis and Rowland, 1986).

Low-income elderly people have been particularly reliant on Medicare coverage because they are in poorer health than high-income elderly, and therefore, are more likely to use health services. Although Medicare provides basic health insurance to promote access to care, it is not an all-inclusive comprehensive and free medical plan for the elderly poor and near-poor. Financial concerns can still impede access to needed medical care, especially for those who have the most health needs. Medicare beneficiaries in poorer health are more likely to report barriers to care than beneficiaries with better health (Rosenbach, Adamache, and Khandker, 1995).

Some of the financial burdens for care stem from the design and scope of the Medicare benefit package. Modeled after private insurance coverage for the non-elderly population, Medicare has substantial cost sharing requirements and financial obligations for beneficiaries. The hospital insurance (Part A) component provides fairly extensive coverage of short-term hospital care and some coverage of post acute skilled nursing facility and home health services. The supplementary medical insurance (Part B) component of Medicare covers physician care and related ambulatory services and home health visits. Medicare requires beneficiaries to pay a premium for coverage under Part B, a deductible for hospital care under Part A, and a deductible and 20 percent coinsurance for most physician and ambulatory care services under Part B (Table 1).

For many elderly people, Medicare thus provides essential, but incomplete, protection against medical expenses. In addition to the required premiums and cost sharing, Medicare's benefit package does not cover the full range of health services needed by many elderly people. Particularly absent from the Medicare benefit package is coverage of outpatient prescription drugs, vision care, and dental services. In addition, Medicare does not cover chronic LTC needs, most notably nursing home care for the disabled elderly (Feder and Lambrew, 1996).

Out-of-pocket spending on acute care medical services and insurance premiums for both Medicare and private supplemental policies are significant expenses in the budgets of elderly Americans (Moon and Mulvey, 1996). The average dollar amount of out-of-pocket spending increases with income, averaging $1495 in 1994 for non-poor elderly and $913 for poor elderly people (Figure 7). The lower level of spending by low-income elderly people reflects both their limited financial ability to pay substantial amounts and the likelihood that some of the low-income elderly are assisted with their medical expenses and premiums by Medicaid. Although the poor elderly spend a lower dollar amount on out-of-pocket medical expenses than higher income elderly, that spending constitutes a much larger share of the overall income of the poor. Health expenditures for acute care services and premiums by the elderly represent one-third of the family income of poor elderly people compared with 16 percent for non-poor elderly families (Figure 8).

To provide assistance with cost sharing and additional protection, most elderly people have private insurance and/or Medicaid coverage to supplement their Medicare coverage (Figure 9). In 1992, 81 percent of Medicare's elderly beneficiaries had private supplemental insurance, often called medigap insurance, in addition to Medicare. An additional 9 percent of elderly beneficiaries received assistance from Medicaid because of their low incomes. However, 10 percent of Medicare beneficiaries had neither Medicaid nor private insurance to supplement Medicare. For these Medicare-only beneficiaries, any expenses uncovered by Medicare are out-of-pocket liabilities.

The pattern of insurance coverage varies significantly by income. Private insurance to complement Medicare is most common among the elderly non-poor population and less extensive as a form of financing for those with lower incomes (Figure 10). Among the elderly poor, over one-third (36 percent) have Medicaid supplementary coverage, 46 percent have private medigap policies, and 18 percent rely solely on Medicare. For the near-poor elderly, private insurance coverage is more extensive, with 64 percent privately insured. Among the near-poor elderly, 15 percent have

Medicaid coverage and 21 percent rely solely on Medicare, reflecting the lower penetration of Medicaid coverage for the near-poor population.

Affordability of private insurance policies to supplement Medicare is a major barrier to coverage for many low-income elderly beneficiaries. Higher income elderly beneficiaries are much more likely to have retiree benefits that provide health insurance coverage to supplement Medicare. Low-income people are less likely to have had the types of jobs during their working years that offer private health insurance after retirement as a benefit. As a result, higher income elderly are more likely to have employer-sponsored coverage, while low-income elderly are more reliant on medigap coverage.

An individually purchased medigap plan in 1992 averaged over $1,000 (Chulis, Eppig, and Poisal, 1995). The high cost of medigap coverage results in a greater financial burden on low-income beneficiaries compared with more economically advantaged elderly people. For a poor elderly individual living on an annual income of less than about $7,000, spending $1,000 on a medigap policy can substantially strain resources. In recent years, Medicaid has helped to fill this gap by providing assistance with Medicare's financial obligations to low-income elderly Medicare beneficiaries, but the large share of both poor and near-poor elderly people relying solely on Medicare for coverage underscores the limits of Medicaid's reach.

ROLE OF MEDICAID

Medicaid makes Medicare coverage affordable for over 4 million low-income elderly Medicare beneficiaries by serving as their medigap policy. For those who qualify for assistance from the means-tested Medicaid program, Medicaid coverage is an important source of health care financing. Medicaid will pay the Medicare Part B premium for Medicare beneficiaries with incomes below 120 percent of FPL plus the Medicare cost sharing for those with incomes below FPL. Elderly cash assistance recipients and others covered at State option can also receive additional benefits from Medicaid to supplement Medicare, including prescription drugs and LTC coverage.

In recent years, Medicaid coverage of the elderly has been expanded considerably to assist low-income Medicare beneficiaries with the growing cost of Medicare premiums and cost-sharing. Most notably, as part of the Medicare Catastrophic Coverage Act of 1988, States were required by July 1992 to provide Medicaid assistance with the Part B premium and Medicare cost-sharing to all elderly individuals and couples with incomes below FPL and assets of less than $4,000 for individuals and $6,000 for couples. The individuals covered under this provision are referred to as Qualified Medicare Beneficiaries (QMBs). The act also required States to phase in by 1995 assistance with Medicare's Part B premium to individuals with incomes between 100 and 120 percent of FPL. For this group, known as Specified Low-Income Medicare Beneficiaries (SLMBs), assistance is limited to the premium payments. States are not required to provide either group with wrap-around benefits to supplement Medicare.

The over 4 million low-income elderly people on Medicaid qualify for assistance by various routes, as shown in Figure 11. Over one-half of the elderly with Medicaid coverage obtain eligibility as "categorically needy" because they are recipients of cash assistance or eligible for assistance under the Supplemental Security Income program. Other individuals are covered at the option of the State as "medically needy"

eligibles. These individuals, accounting for 20 percent of elderly Medicaid beneficiaries, have incomes above welfare cash assistance levels, but incur expenses for health services that reduce their available income to below the income standard for eligibility.

Both the categorically needy and medically needy groups receive Medicaid benefits to complement Medicare's benefit package as well as assistance with Medicare premiums and cost-sharing. The elderly in nursing homes with Medicaid coverage are included in both the categorical and medically needy groups. The QMB/SLMB beneficiaries with their coverage mainly for Medicare financial obligations represent 13 percent of Medicaid's elderly beneficiaries. The remainder of low-income elderly beneficiaries qualify for coverage under coverage provisions that are at State option.

Despite Medicaid's important role in providing protection for Medicare premium and cost sharing requirements, Medicaid spending on behalf of elderly beneficiaries goes primarily toward coverage of more costly LTC services. In 1993, Medicaid spending totaled $125 billion, of which $34 billion was spent on services for the low-income elderly (Liska et al., 1995). One-fourth of this spending went towards acute care services and Medicare payments, and the remainder was devoted to LTC spending on nursing homes and community-based services (Figure 12). In 1993, Medicaid paid $2.7 billion to the Medicare program on behalf of low-income Medicare beneficiaries for premium and cost-sharing obligations and spent an additional $6 billion to supplement Medicare's coverage of hospital and physician care and to cover other medical services, such as prescription drugs not covered by Medicare. These expenditures for acute care and Medicare premiums accounted for 7 percent of total Medicaid spending.

Medicaid thus plays a critical role in providing financial protection to low-income elderly people. However, the scope of Medicaid's protection remains limited in terms of the share of the poor and near-poor population with coverage. Only one-third of the elderly poor and 15 percent of the near-poor elderly have Medicaid coverage despite the financial benefits of such coverage. Lack of awareness and understanding of the assistance Medicaid provides, complex enrollment processes, limited outreach activities by Federal and State governments, and reluctance to apply for help from a welfare-linked program all contribute to low levels of participation in Medicaid by the poor and near-poor elderly (Neumann et al., 1995).

IMPACT OF INSURANCE ON ACCESS

The level of insurance protection to alleviate financial barriers to care is clearly an important element in securing access to care for the low-income elderly population. Although Medicare coverage is universal, ability to pay for Medicare's cost-sharing requirements varies for elderly people at different income levels and with different levels of insurance supplementation. Lack of supplementary coverage through private insurance or Medicaid to fill gaps in Medicare coverage influences access to health services by elderly people. One-half of the population that relies solely on Medicare are poor or near-poor and likely to experience financial burdens that jeopardize access to care.

Examining utilization of ambulatory care services by income status and insurance status shows that Medicare coverage has helped to reduce differentials in access to

care by income, but differentials still remain when variations in insurance are taken into account. Those with Medicare-only coverage do not have comparable access to those with private or Medicaid coverage to supplement Medicare. Levels of physician services are comparable across income groups and, currently, reveal somewhat higher use rates for the low-income population, reflective of their poorer health status (Figure 13). However, physician visits by insurance status, not controlling for income, show that the Medicare-only population has fewer physician visits than the privately insured and notably fewer visits than those with joint Medicare and Medicaid coverage (Figure 14). The higher rates for the Medicaid population reflect their higher rates of chronic illness and disability.

These statistics, however, combine the effects of income and insurance coverage on utilization. Using Medicare spending as a proxy for health services utilization shows lower levels of access for beneficiaries without supplemental insurance. Low-income beneficiaries who rely solely on Medicare are less likely to use any Medicare covered services over the course of a year. Among poor and near-poor Medicare beneficiaries, 30 percent of those with only Medicare coverage received no Medicare reimbursement for services, compared with 17 percent of those with private supplemental insurance and 11 percent with Medicaid (Figure 15).

When access to care is assessed by insurance status and income level, it is apparent that to be low-income and covered only by Medicare is associated with access problems. Measures of access problems, including no usual source of care, difficulties in obtaining care, and lower satisfaction levels for particular aspects of care, are indicative of problems in gaining entry to the health care system and in using services (Weissman and Epstein, 1993). Having a usual source of care, or a particular place where care is obtained, is commonly viewed as an indicator of access to medical care and an important component of primary care. Low-income Medicare beneficiaries who rely solely on Medicare are over twice as likely as those with additional coverage to be without a usual source of care. Nearly one-fourth (22 percent) of Medicare-only beneficiaries report no usual source of care compared with 8 percent of those with private insurance and 9 percent of those with Medicaid (Figure 16).

Problems in obtaining care, such as delay in seeking care due to cost, provide direct evidence of the impact of financial barriers to care. Problems in obtaining care may compromise health status and result in prolonged suffering and increased morbidity. If care is eventually obtained and the problem has become more severe, it may be more difficult and costly to treat because of the delay. Low-income elderly Medicare beneficiaries who have only Medicare are two times as likely to delay seeking needed medical care as those with additional private insurance or Medicaid. One-fourth of low-income Medicare-only beneficiaries indicate that they delayed seeking medical care in the past year because of worry about the cost (Figure 17). In contrast, only 13 percent of those with Medicaid or private insurance reported such delays due to cost. Having additional coverage substantially lowers the likelihood of problems in gaining entry to the health care system.

Similarly, lower levels of satisfaction with out-of-pocket costs reflects inadequate insurance coverage and can be indicative of access problems. Over one-fourth (27 percent) of low-income elderly Medicare-only beneficiaries report that they are unsatisfied or very unsatisfied with the out-of-pocket costs they paid for medical care

(Figure 18). Those with private supplemental coverage also reported similar levels of dissatisfaction. Highlighting the financial protection Medicaid provides for the low-income population, only 12 percent of beneficiaries who had Medicaid were unsatisfied with out-of-pocket costs.

In sum, Medicare has contributed substantially to the well-being of the elderly by facilitating access to care and reducing financial burdens. The program provides coverage of medical care for virtually all elderly Americans, but Medicare's gaps in coverage and financial obligations are particularly difficult for poor and near-poor elderly people to handle. Medicaid plays an essential role in supplementing Medicare's coverage and makes Medicare work for many low-income Medicare beneficiaries. However, Medicaid's assistance does not extend to all low-income elderly people; those who are left to rely on Medicare alone are at substantial risk for access problems.

IMPLICATIONS FOR THE FUTURE

The three decades of experience with Medicare as a primary insurer and Medicaid as a supplement for the low-income elderly demonstrate the importance of both basic coverage for all elderly people and additional financial assistance for low-income elderly people. For those in the elderly low-income population jointly covered by Medicare and Medicaid, access to care, financial protection, and satisfaction with the cost of medical care are all notably higher than for low-income elderly who depend solely on Medicare. With the universal base of Medicare as a building block for health care coverage, the elderly poor and near-poor with Medicaid supplementation are able to access mainstream medical care without severe financial burden.

The partnership between Medicare and Medicaid has enabled millions of low-income Medicare beneficiaries to realize the full potential of Medicare coverage, but the ability to maintain and expand that partnership to reach more of the low-income elderly population is uncertain. Proposals to increase financial obligations under Medicare or shift the program from a defined benefit to defined contribution approach could result in significant increases in beneficiary costs and undermine the adequacy of protection for the poorest beneficiaries. In the past, Medicaid coverage has been used to fill in and compensate for changes in Medicare coverage. However, proposals to convert Medicaid to a block grant to States with a fixed and potentially reduced federal contribution could restrict Medicaid's ability to serve as a Medicare safety net. Such a shift in Medicaid's structure could also jeopardize the continuation of the current level of coverage Medicaid provides to low income Medicare beneficiaries.

As the future of Medicare and Medicaid are debated, particular attention needs to be given to the elderly poor. One in 10 Medicare beneficiaries count on Medicaid to help with their medical expenses and Medicare financial obligations. Even with Medicaid assistance, the elderly poor devote one-third of their family income to health expenses. Low-income elderly Americans experience more health problems and have greater use of health services with the associated cost for treatment and medication than higher income elderly. The 1 in 5 low-income Medicare beneficiaries without Medicaid to supplement Medicare are particularly at risk. Even with Medicare's basic protection, the cost for premiums, cost-sharing, and uncovered services can compromise access to care.

To assure Medicare's adequacy for coverage in the future, it is important to

maintain assistance with financial obligations and additional benefits that Medicaid provides today. It is critical to either maintain the Medicare-Medicaid partnership for the low-income elderly or to provide direct federal assistance to supplement Medicare for the elderly poor. Without such guarantees, Medicare's notable progress in reducing gaps in service use between poor and non-poor elderly could be undone and millions of low income elderly Americans could have their access to medical care compromised.

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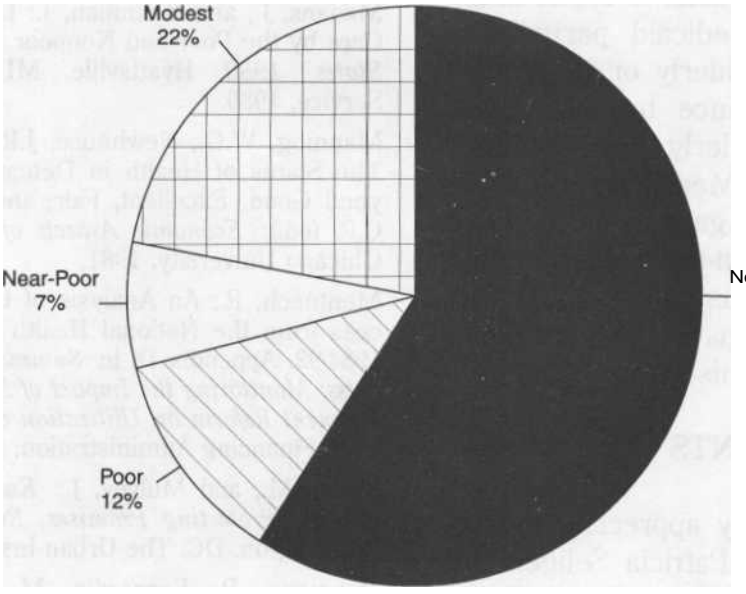
Figure 1

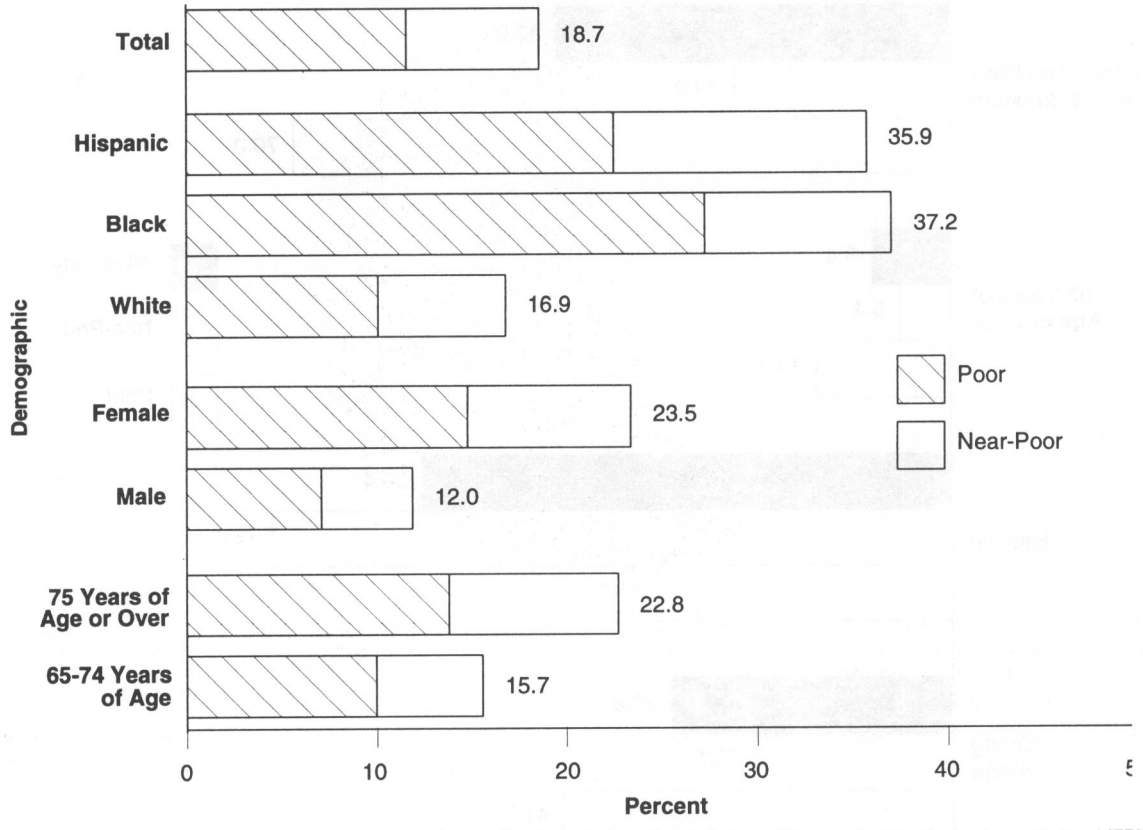
Distribution of Elderly, by Poverty Level: 1994



NOTES: Estimates of non-institutionalized population. The Federal poverty level (FPL) in 1994 was $7,100 for a single individual and $9,000 for a couple. Poor is below 100 percent of FPL. Near-poor is 100-125 percent of FPL. Modest is 125-200 percent of FPL. Non-poor is 200 percent of FPL or greater.

SOURCE: (U.S. Bureau of the Census, 1996).

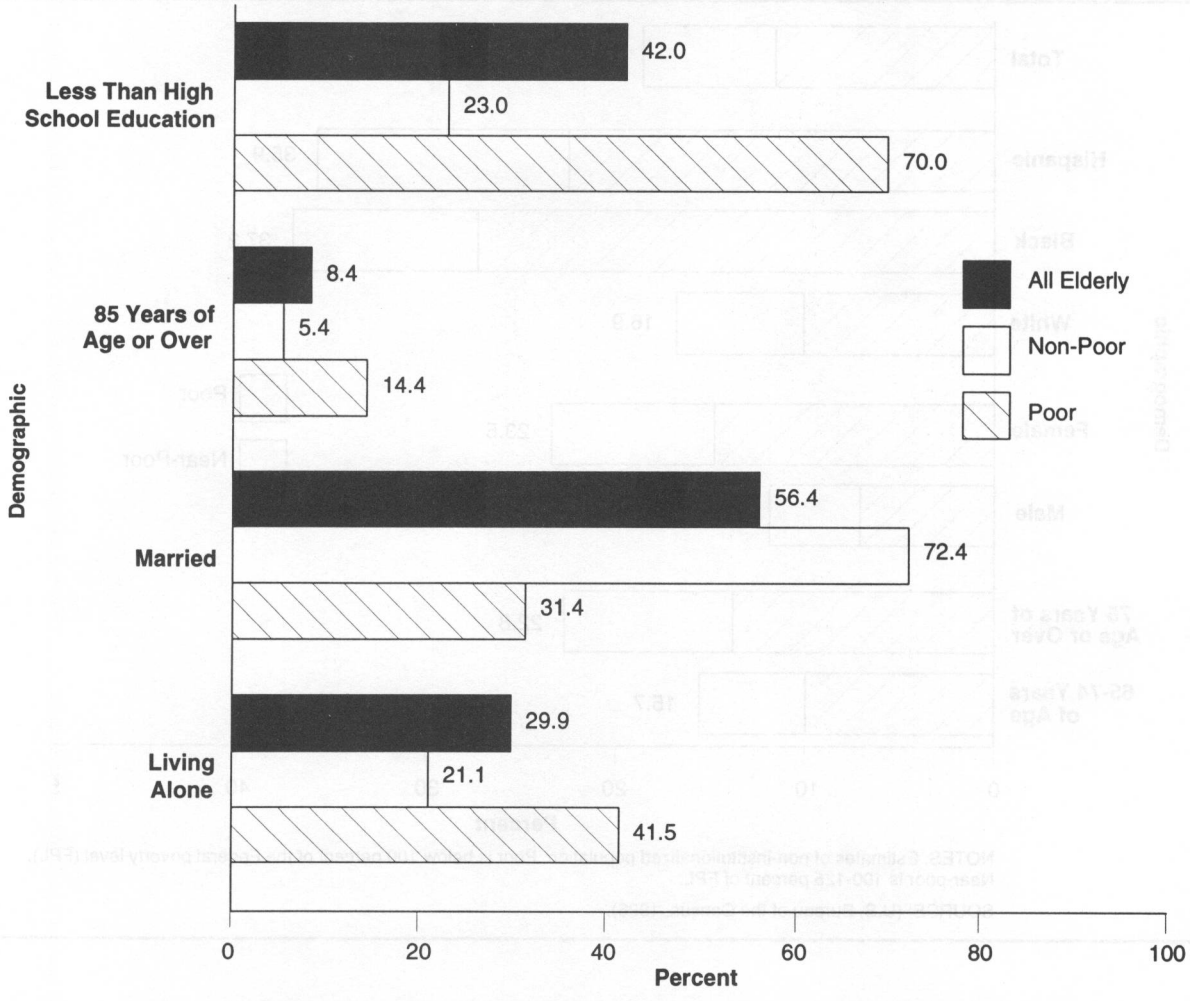
Figure 2
Percent of the Elderly Who Are Low-Income, by Age, Sex, and Race: 1994



NOTES: Estimates of non-institutionalized population. Poor is below 100 percent of the Federal poverty level (FPL). Near-poor is 100-125 percent of FPL.

SOURCE: (U.S. Bureau of the Census, 1996).

Figure 3
Characteristics of Elderly Medicare Beneficiaries: 1992

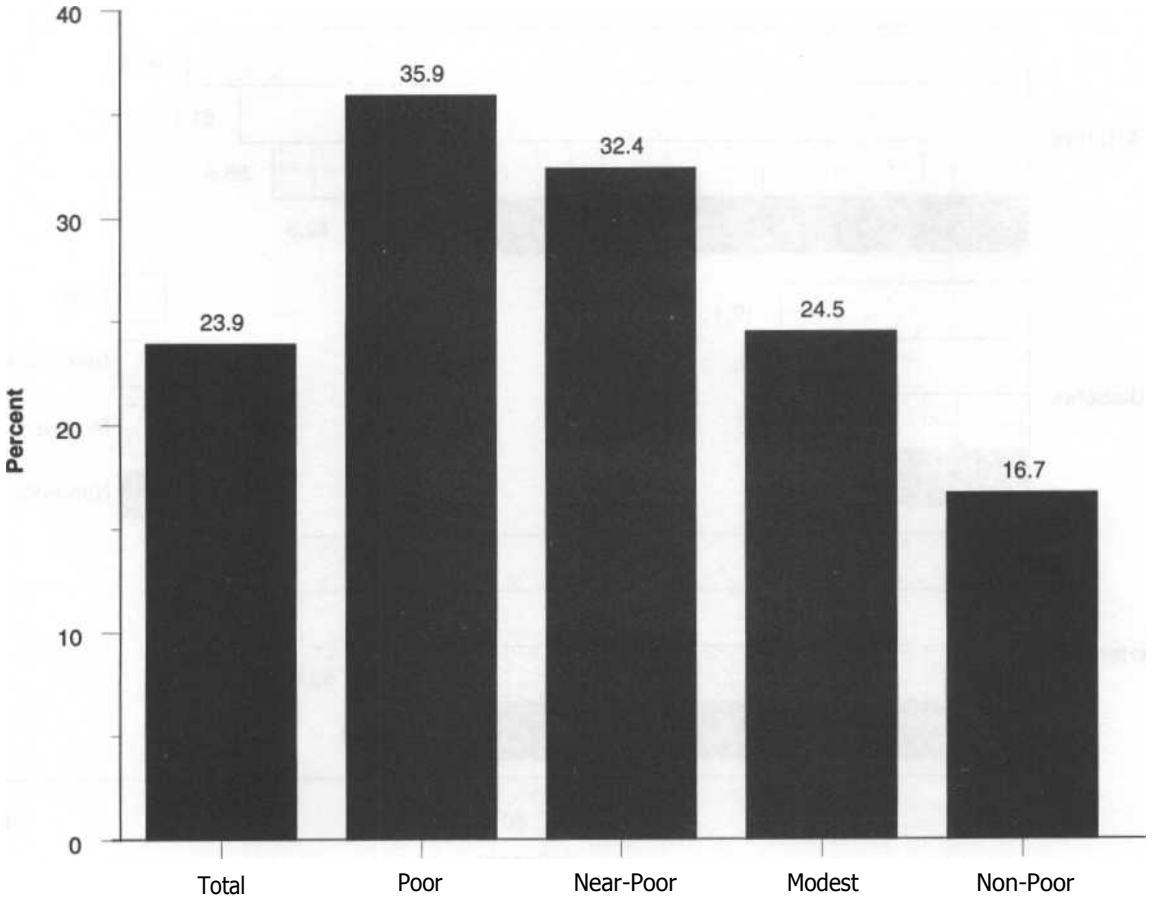


NOTES: Includes non-institutional continuously enrolled beneficiaries. Poor is below 100 percent of the Federal poverty level (FPL). Non-poor is 200 percent of FPL or greater.

SOURCE: Estimates prepared by the authors based on analysis of the 1992 Medicare Current Beneficiary

Figure 4

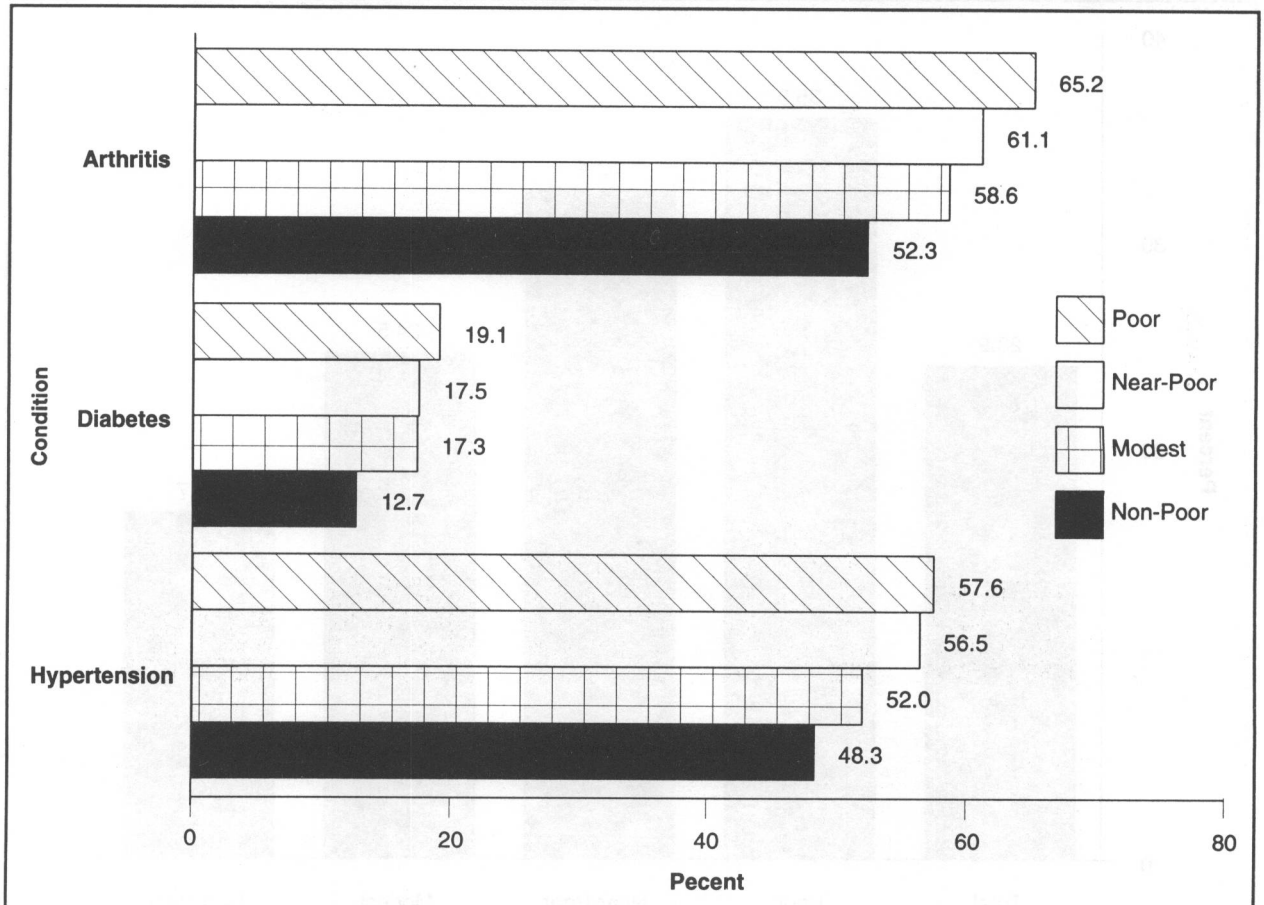
Percent of Elderly Medicare Beneficiaries Reporting Fair or Poor Health: 1992



NOTES: Includes non-institutional continuously enrolled beneficiaries. Poor is below 100 percent of the Federal poverty level (FPL). Near-poor is 100-125 percent of FPL. Modest is 125-200 percent of FPL. Non-poor is 200 percent of FPL or greater.

SOURCE: Estimates prepared by the authors based on analysis of the 1992 Medicare Current Beneficiary Survey.

Figure 5
Percent of Elderly Medicare Beneficiaries With Selected Conditions: 1992

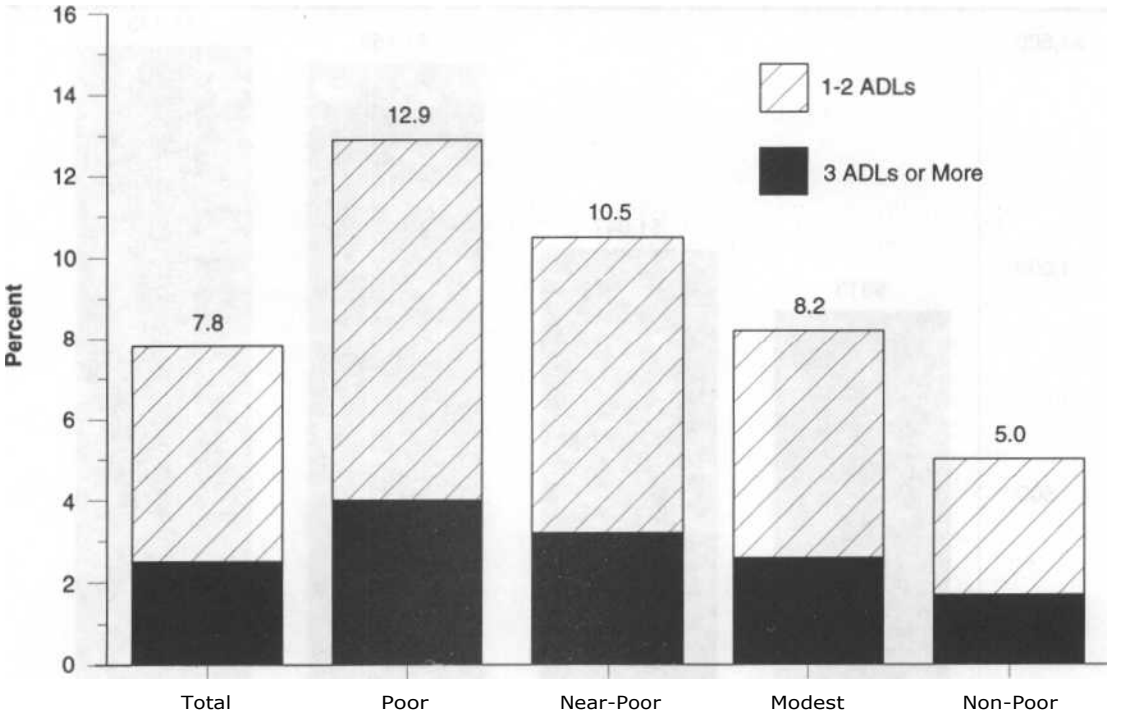


NOTES: Includes non-institutional continuously enrolled beneficiaries. Poor is below 100 percent of the Federal poverty level (FPL). Near-poor is 100-125 percent of FPL. Modest is 125-200 percent of FPL. Non-poor is 200 percent of FPL or greater.

SOURCE: Estimates prepared by the authors based on analysis of the 1992 Medicare Current Beneficiary Survey.

Figure 6

Percent of Elderly Medicare Beneficiaries Needing Help With ADL Limitations: 1992



NOTES: Includes non-institutional continuously enrolled beneficiaries. ADL is activity of daily living. Poor is below 100 percent of the Federal poverty level (FPL). Near-poor is 100-125 percent of FPL. Modest is 125-200 percent of FPL. Non-poor is 200 percent of FPL or greater.

SOURCE: Estimates prepared by the authors based on analysis of the 1992 Medicare Current Beneficiary Survey.

Table 1

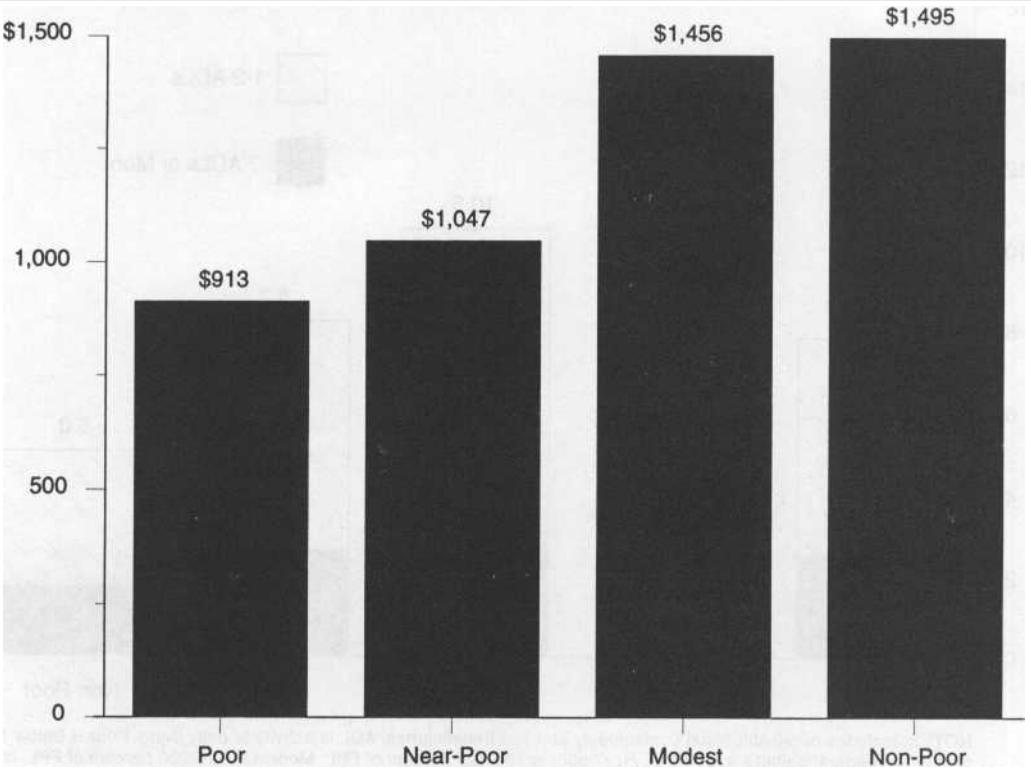
Out-of-Pocket Payments Under Medicare for Hospital and Physician Services'

Hospital Insurance (Part A)	**Coverage for Inpatient Hospital Services**
Hospital Deductible	$736 per Spell of Illness
Coinsurance Days 61-90	$184 per Day
Coinsurance for 60 Lifetime Reserve Days	$368 per Day
Supplemental Medical Insurance (Part B)	**Coverage for Physician and Related Services**
Premium ($42.50 per Month)	$510 per Year
Deductible	$100 per Year
Coinsurance	20 Percent of Medicare Allowable Charges

'Effective January 1, 1996.

SOURCE: Health Care Financing Administration: 1996 Data Compendium. Bureau of Data Management and Strategy. Washington. U.S. Government Printing Office, March 1996.

Figure 7
Out-of-Pocket Health Care Spending by the Elderly: 1994

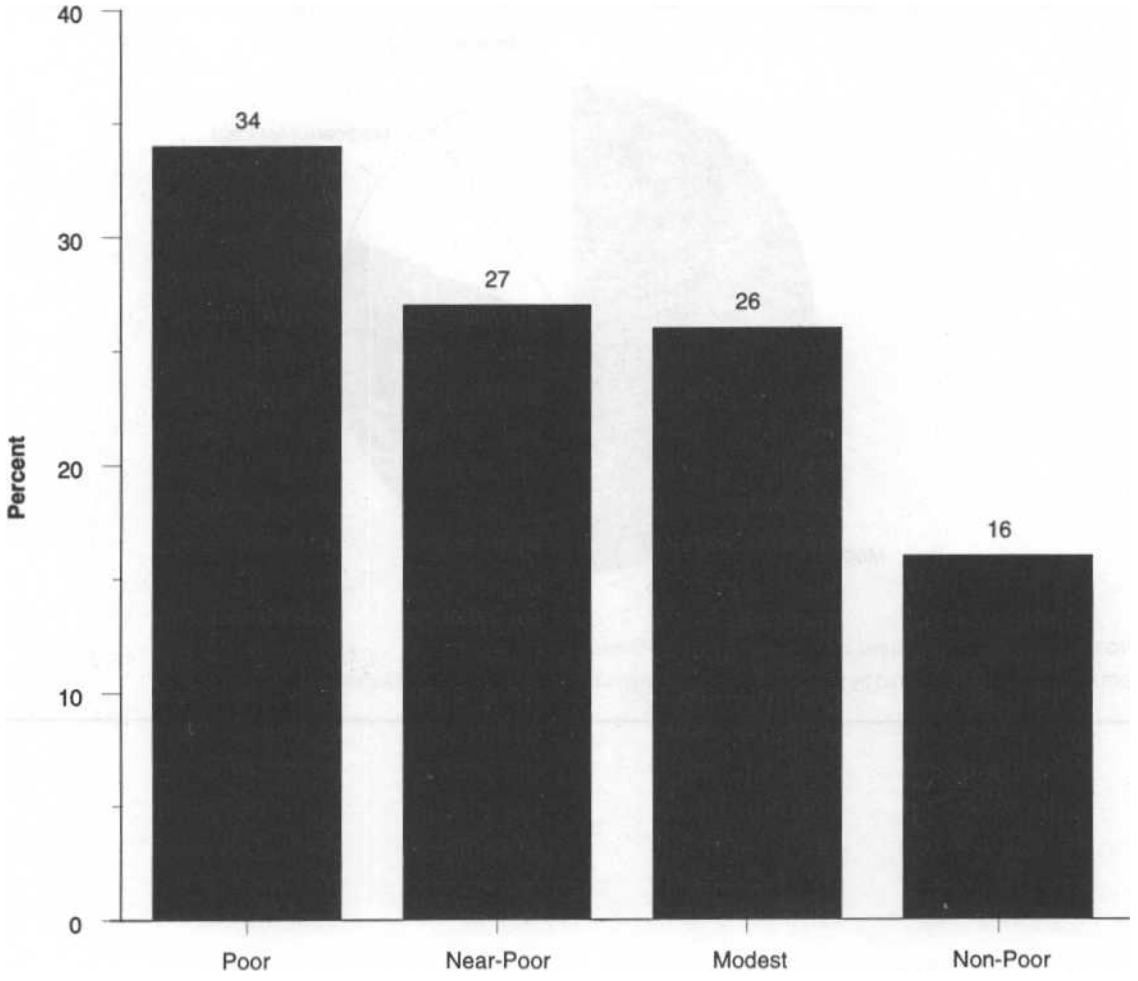


NOTES: Spending includes acute care services and premiums. Poor is below 100 percent of the Federal poverty level (FPL). Near-poor is 100-125 percent of FPL. Modest is 125-200 percent of FPL. Non-poor is 200 percent of FPL or greater.

SOURCE: (Moon and Mulvey, 1996).

Figure 8

Health Expenditures by the Elderly as a Share of Family Income: 1994

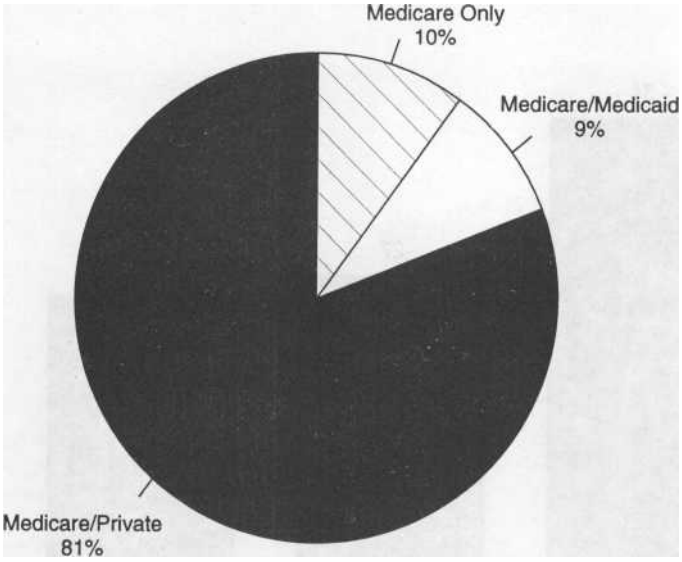


NOTES: Spending includes acute care services and premiums. Poor is below 100 percent of the Federal poverty level (FPL). Near-poor is 100-125 percent of FPL. Modest is 125-200 percent of FPL. Non-poor is 200 percent of FPL or greater.

SOURCE: (Moon and Mulvey, 1996).

Figure 9

Insurance Coverage of Elderly Medicare Beneficiaries: 1992

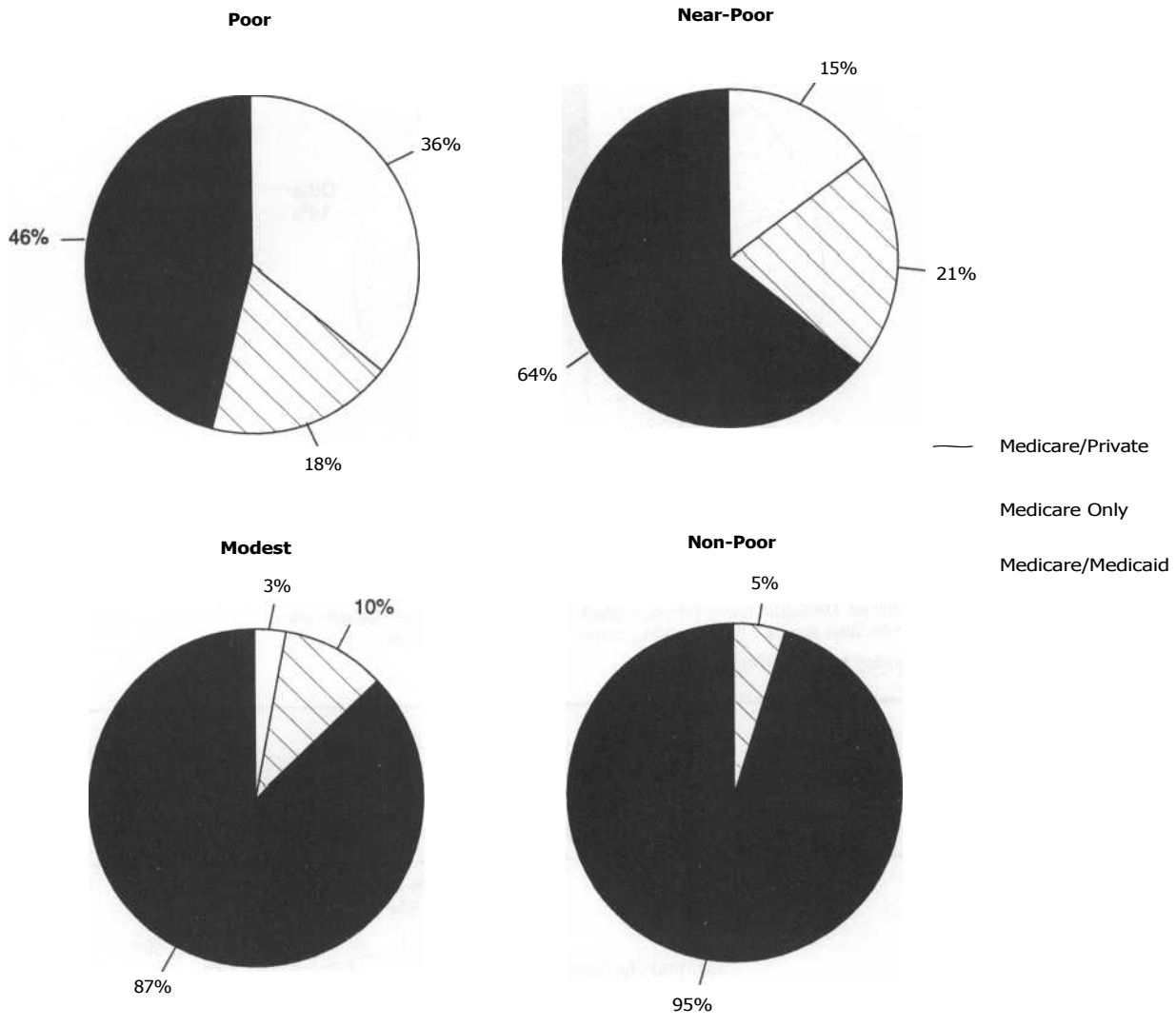


NOTE: Includes non-institutional continuously enrolled beneficiaries.

SOURCE: Estimates prepared by the authors based on analysis of the 1992 Medicare Current Beneficiary Survey.

Figure 10

Insurance Status of Elderly Medicare Beneficiaries, by Poverty Level: 1992

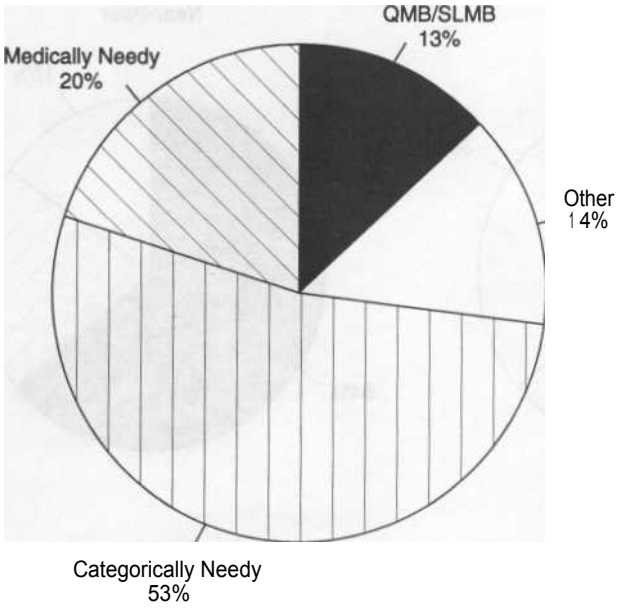


NOTE: Includes non-institutional continuously enrolled beneficiaries.

SOURCE: Estimates prepared by the authors based on analysis of the 1992 Medicare Current Beneficiary Survey.

Figure 11

Distribution of Elderly Medicaid Population, by Eligibility: 1994

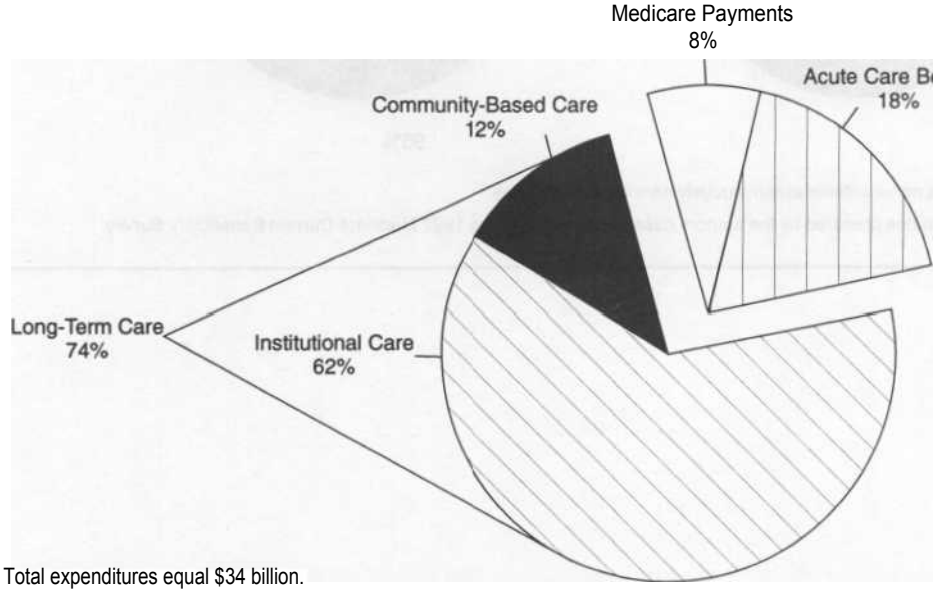


NOTES: QMB/SLMB Is Qualified Medicare Beneficiary/Specified Low-Income Medicare Beneficiaries. Other includes eligibility through legislation prior to 1988. Total equals 4.0 million beneficiaries 65 years of age or over.

SOURCE: (Health Care Financing Administration, 1994).

Figure 12

Medicaid Expenditures for the Elderly: 1993

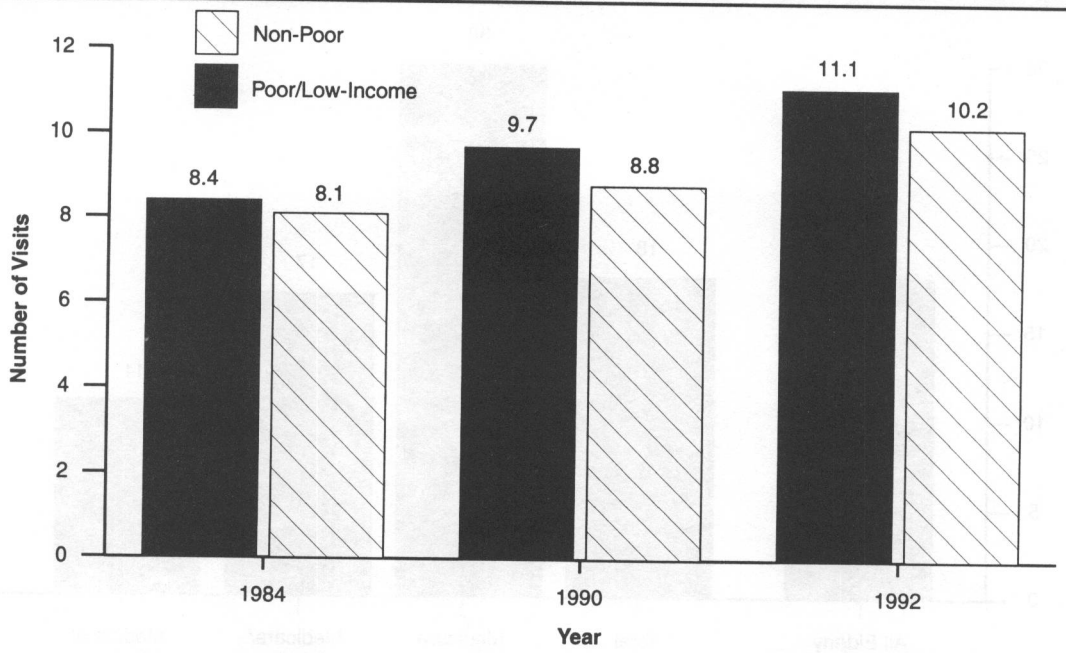


NOTE: Total expenditures equal $34 billion.

SOURCE: (Liska et al., 1995).

Figure 13

Mean Annual Physician Visits for Elderly Medicare Beneficiaries, by Income Status: 1984-92

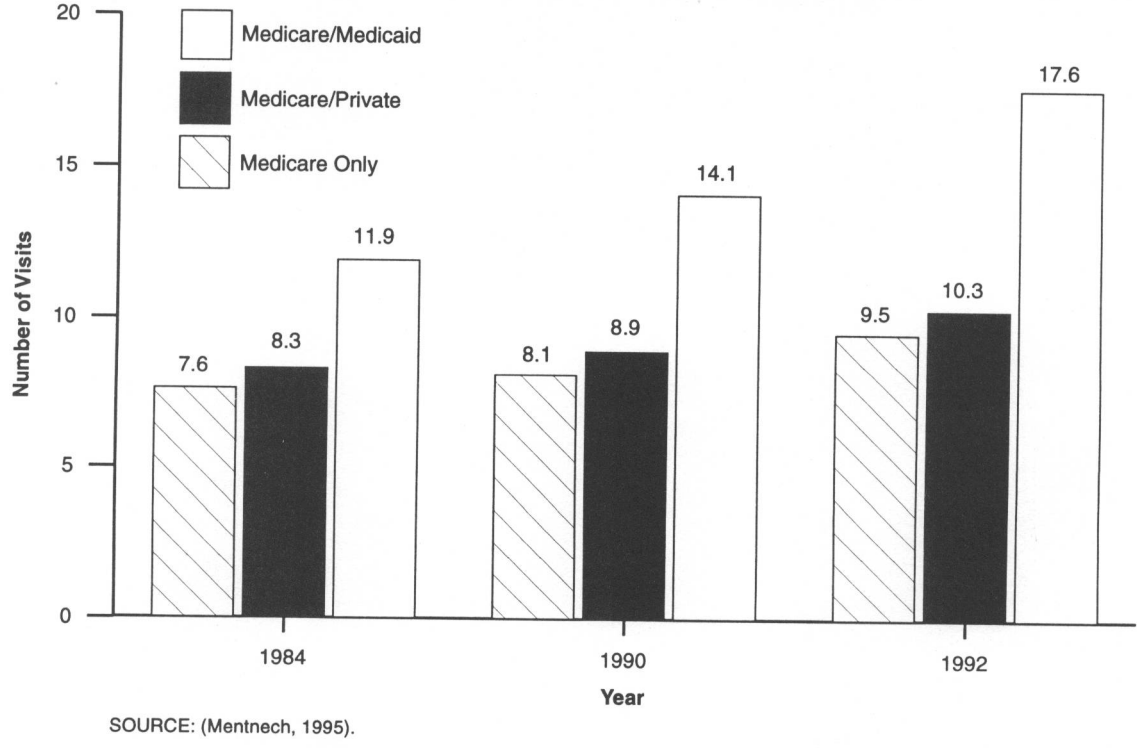


NOTES: Poor is below 100 percent of the Federal poverty level (FPL). Low-income beneficiaries are those with incomes below 125 percent of FPL. Non-poor is 200 percent of FPL or greater.

SOURCE: (Mentnech, 1995).

Figure 14

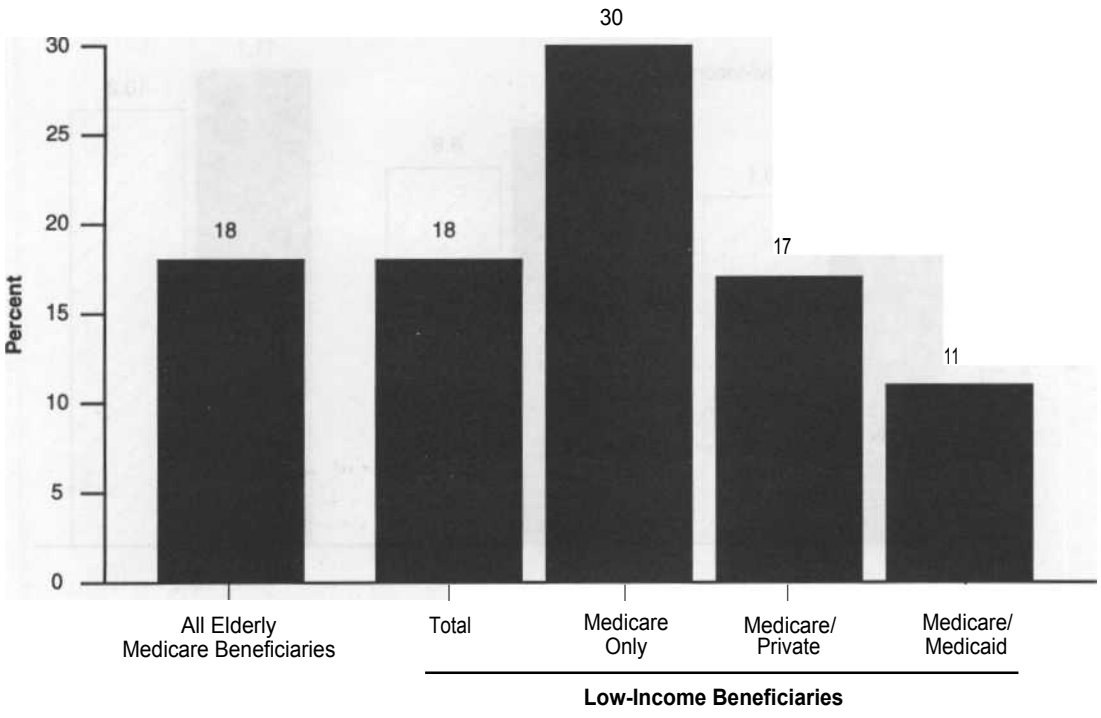
Mean Annual Physician Visits for Elderly Medicare Beneficiaries, by Health Insurance Status: 1984-92



SOURCE: (Mentnech, 1995).

Figure 15

Percent of Elderly Beneficiaries With No Medicare Reimbursement for Services: 1992

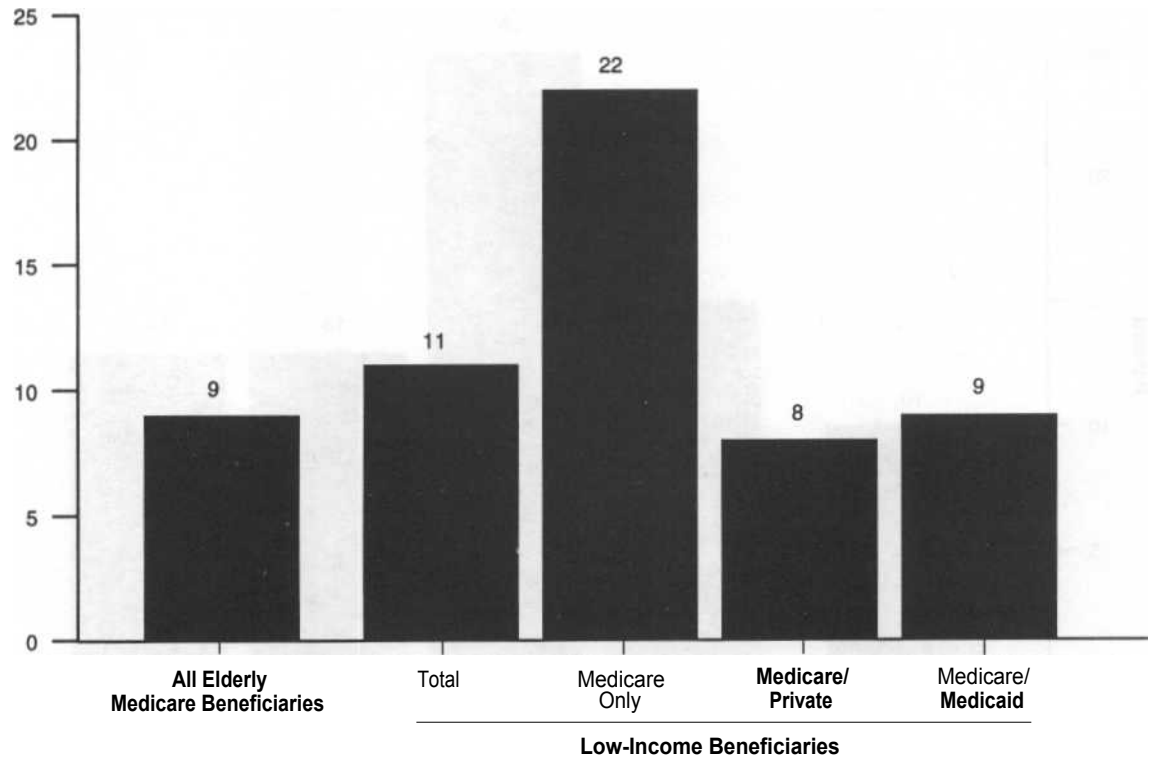


NOTES: Includes non-institutional continuously enrolled beneficiaries. Low-income beneficiaries are those with incomes below 125 percent of the Federal poverty level.

SOURCE: Estimates prepared by the authors based on analysis of the 1992 Medicare Current Beneficiary Survey.

Figure 16

Percent of Elderly Beneficiaries With No Usual Source of Care: 1992

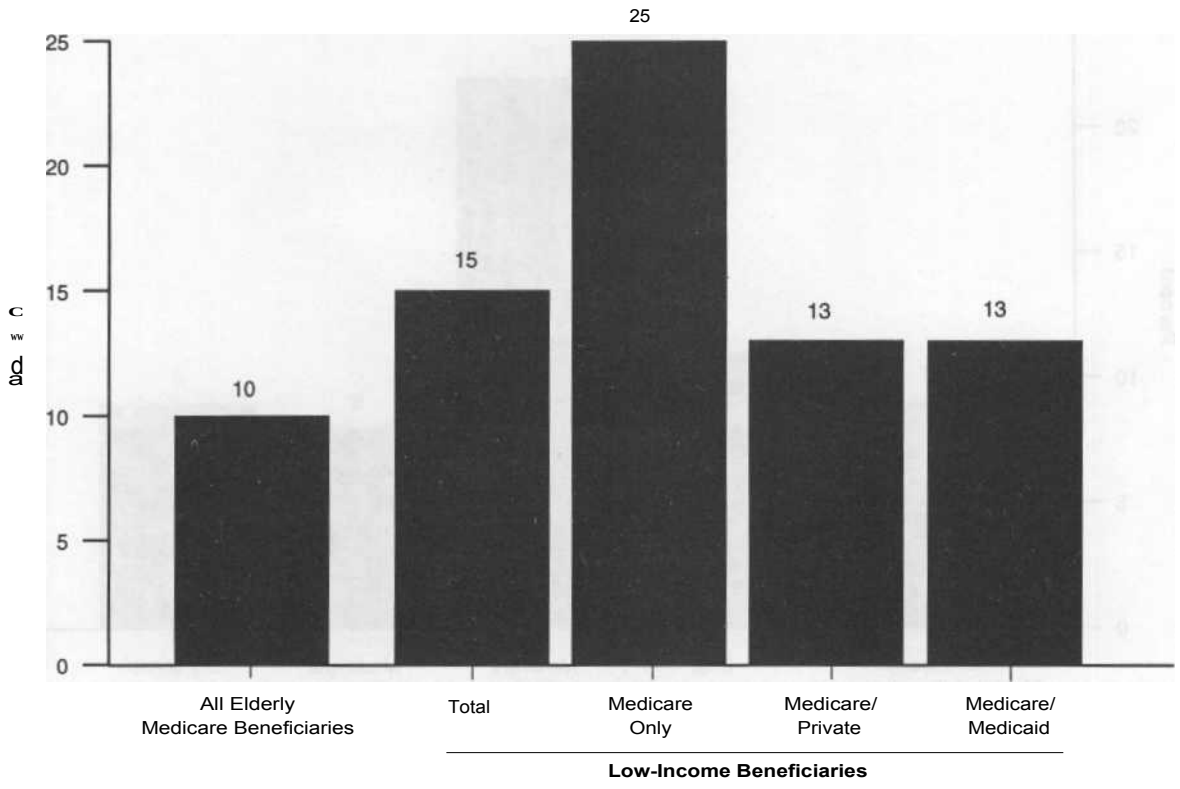


NOTES: Includes non-institutional continuously enrolled beneficiaries. Low-income beneficiaries are those with incomes below 125 percent of the Federal poverty level.

SOURCE: Estimates prepared by the authors based on analysis of the 1992 Medicare Current Beneficiary Survey.

Figure 17

Percent of Elderly Beneficiaries Who Delayed Getting Care Due to Cost: 1992

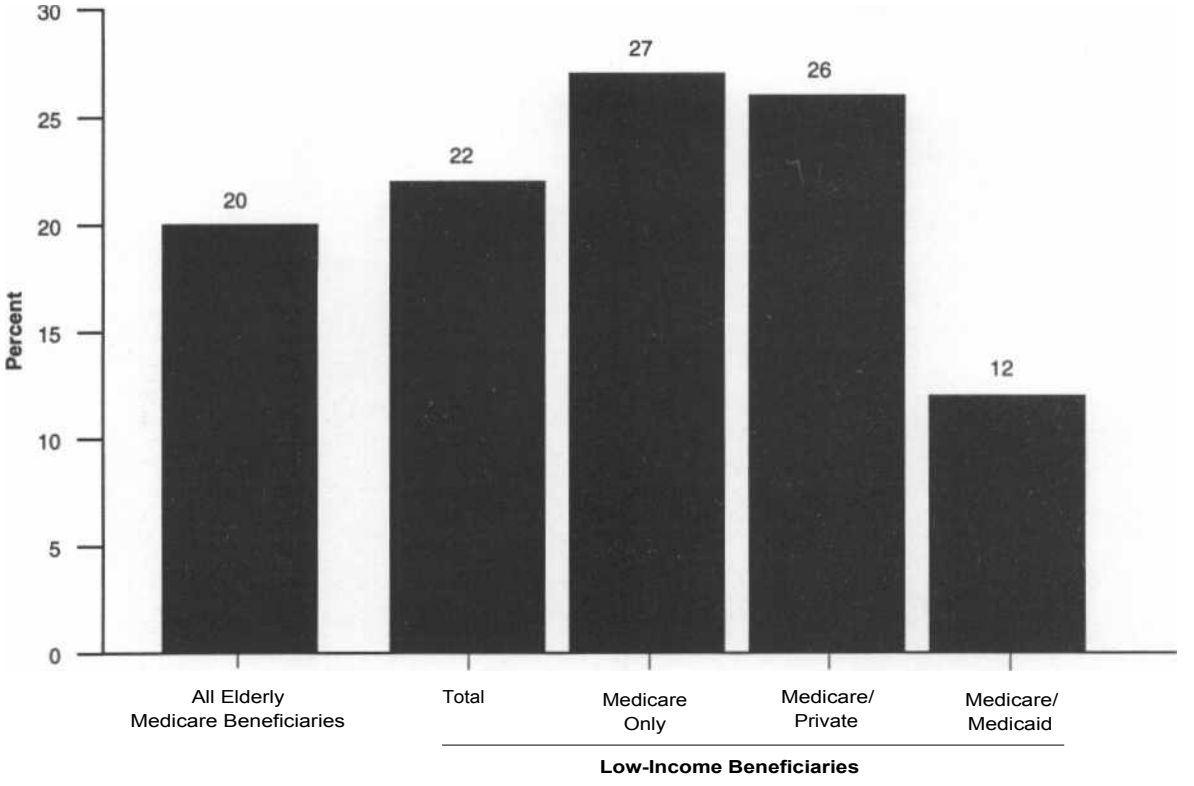


NOTES: Includes non-institutional continuously enrolled beneficiaries. Low-income beneficiaries are those with incomes below 125 percent of the Federal poverty level.

SOURCE: Estimates prepared by the authors based on analysis of the 1992 Medicare Current Beneficiary Survey.

Figure 18

Percent of Elderly Beneficiaries Who Are Unsatisfied With Out-of-Pocket Costs Paid for Medical Care: 1992



NOTES: Includes non-institutional continuously enrolled beneficiaries. Low-income beneficiaries are those with incomes below 125 percent of the Federal poverty level.

SOURCE: Estimates prepared by the authors based on analysis of the 1992 Medicare Current Beneficiary Survey.