The COMMONWEALTH FUND

MEDICARE AT 50 YEARS

# MEDICARE

## *50 Years of Ensuring Coverage and Care*

Karen Davis, Cathy Schoen, and Farhan Bandeali

April 2015

**The Commonwealth Fund** is a private foundation that promotes a high performance health care system providing better access, improved quality, and greater efficiency. The Fund's work focuses particularly on society's most vulnerable, including low-income people, the uninsured, minority Americans, young children, and elderly adults.

The Fund carries out this mandate by supporting independent research on health care issues and making grants to improve health care practice and policy. An international program in health policy is designed to stimulate innovative policies and practices in the United States and other industrialized countries.

The COMMONWEALTH FUND

# MEDICARE

## 50 Years of Ensuring Coverage and Care

**Karen Davis, Cathy Schoen, and Farhan Bandeali**

**April 2015**

**ABSTRACT**

For 50 years, Medicare has accomplished its two key goals: ensure access to health care for its elderly and disabled beneficiaries, and protect them against the financial hardship of health care costs. As the single largest source of health insurance in the United States, with 55 million covered through the program, Medicare has both shaped the U.S. health system and responded as needs have demanded. But rising costs, affecting the federal budget and beneficiaries, are an ongoing challenge that will need to be addressed. As the Medicare population continues to age, better strategies also are required to serve the increasing number of beneficiaries with complex care needs and chronic conditions. To control Medicare's costs while enhancing the quality of its coverage and care, policymakers must continue to identify and spread promising payment and delivery system reforms that can help the program achieve success over the next 50 years.

*This report is the first in a series that traces the evolution of Medicare and its major accomplishments over the past 50 years; examines the Affordable Care Act's reforms to Medicare and the challenges facing policymakers going forward; and lays out policy options to ensure Medicare's viability and effectiveness for future beneficiaries.*

Support for this research was provided by The Commonwealth Fund. The views presented here are those of the authors and not necessarily those of The Commonwealth Fund or its directors, officers, or staff. To learn more about new publications when they become available, visit the Fund's website and register to receive email alerts. Commonwealth Fund pub. no. 1812.


MEDICA
AT
50
YEARS

# CONTENTS



# LIST OF EXHIBITS

## ABOUT THE AUTHORS

**Karen Davis, Ph.D.,** is currently the Eugene and Mildred Lipitz Professor in the department of Health Policy and Management and director of the Roger C. Lipitz Center for Integrated Health Care at the Bloomberg School of Public Health at Johns Hopkins University. Dr. Davis has served as president of The Commonwealth Fund, chairman of the department of Health Policy and Management at The Johns Hopkins Bloomberg School of Public Health, and deputy assistant secretary for Health Policy in the department of Health and Human Services. She also serves on the board of directors of the Geisinger Health System and Geisinger Health Plan. She received her doctoral degree in economics from Rice University.

**Cathy Schoen, M.S.,** is the executive director of The Commonwealth Fund Council of Economic Advisors. She is the former senior vice president for Policy, Research, and Evaluation at The Commonwealth Fund, as well as the former research director of the Fund's Commission on a High Performance Health System. Previously, Ms. Schoen was on the research faculty of the University of Massachusetts School of Public Health and directed special projects at the UMass Labor Relations and Research Center. During the 1980s, she directed the Service Employees International Union's research and policy department. Earlier, she served as staff to President Carter's national health insurance task force. Prior to federal service, she was a research fellow at the Brookings Institution. She has authored numerous publications on health policy and insurance issues, and coauthored the book *Health and the War on Poverty.* She holds an undergraduate degree in economics from Smith College and a graduate degree in economics from Boston College.

**Farhan Bandeali, M.S.P.H.,** is a senior research program coordinator II at the Roger C. Lipitz Center for Integrated Health Care at the Bloomberg School of Public Health at Johns Hopkins University. His areas of interest include comprehensive health policy reform, comparative health systems' analysis, and health systems payment reform. Mr. Bandeali is motivated to bring about a primary-care-centered approach to boost quality, generate savings, and protect the health of our most vulnerable Americans. He graduated Summa Cum Laude and Phi Beta Kappa from Florida International University and then went on to study health systems at the Johns Hopkins Bloomberg School of Public Health. Previously, he helped lead the implementation of a nationwide evaluation of the government- and NGO-implemented health system in Afghanistan.

---

*Editorial support was provided by Ann B. Gordon and Chris Hollander.*

# EXECUTIVE SUMMARY

As Medicare prepares to mark its 50th anniversary in July 2015, there is a lot to celebrate. For 50 years, Medicare has accomplished its two key goals: ensure access to health care for its elderly and disabled beneficiaries, and protect them against the financial hardship of health care costs. Before Medicare, 48 percent of Americans 65 and older had no insurance; today, that figure is just 2 percent. Today, older Americans pay 13 percent of their health care expenses directly out-of-pocket, compared with 56 percent in 1966. By ensuring access to care, Medicare has contributed to a five-year increase in life expectancy at age 65. Medicare covers 55 million Americans, about 17 percent of the U.S. population. Its beneficiaries are the nation's oldest, sickest, and most disabled citizens. Three-quarters of them have one or more chronic conditions, and one-quarter rate their health as fair or poor. Today nearly 30 percent of beneficiaries are either over age 85 or disabled and under age 65.

As the single largest source of health insurance coverage, Medicare has both shaped the U.S. health care system and responded as needs have demanded. In 1972, coverage was added for people of any age with end-stage renal disease and those who are disabled for two years or more. In 1997, Medicare Part C—which has evolved into Medicare Advantage—was created to enable beneficiaries to choose an HMO-style Medicare plan instead of traditional Medicare. Prescription drug benefits were introduced in 2003, and preventive services without copayments were added under the Affordable Care Act in 2010.

Medicare performs well compared with private insurance coverage. Medicare beneficiaries are less likely to report not getting needed care, less likely to experience burdensome medical bills, and less likely to report negative insurance experiences than those under age 65 insured by employer plans or individual insurance.

Rising costs, affecting both the federal budget and beneficiaries, are an ongoing challenge. The average beneficiary spends 15 percent of income on health care, compared with just 5 percent for those under age 65. And because Medicare covers only a portion of medical expenses, most beneficiaries supplement Medicare with other coverage, adding to complexity and administrative cost.

Additional challenges facing Medicare include the need for more comprehensive benefits in traditional Medicare, improved financial protection for low- and modest-income beneficiaries, and reduced complexity in coverage. Better strategies also are needed to serve the expanding number of beneficiaries with complex care needs and multiple chronic conditions—symptoms of an aging population.

To control Medicare's costs while enhancing the quality of its care, policymakers must continue to identify and spread promising payment and delivery system reforms—many of which are now being tested by the new Center for Medicare and Medicaid Innovation. The success of these changes will be critical to ensuring that beneficiaries will continue to reap the benefits modern medicine has to offer.

# MEDICARE: 50 YEARS OF ENSURING COVERAGE AND CARE

On July 30, 1965, President Lyndon Johnson signed into law the nation's first comprehensive government-sponsored program to provide health insurance for older Americans. Called Medicare, the program had been about 20 years in the making. After signing the Medicare bill into law, Johnson presented the first Medicare card to the former president who had first championed the idea: Harry S Truman, then 81 years old.

As Medicare prepares to mark its 50th anniversary, there is a lot to celebrate. In its first 50 years Medicare has unquestionably achieved its two basic goals: to ensure that Americans 65 and older have access to health care, and to protect them and their families from severe financial hardship from medical bills. In 1972, coverage was added for people with certain disabilities and those with end-stage renal disease. Along the way, Medicare also has helped to change medical technology and the health care delivery system. It has helped accelerate progress by indirectly financing medical education and teaching hospitals, and has ensured access for its beneficiaries to the latest medical advances.

## Medicare: Meeting Important National Goals

For five decades, Medicare has met a growing number of important goals for the nation. Today, it serves 55 million Americans in a number of important ways.

### *Providing Health Insurance Coverage*

When Medicare was established, 48 percent of Americans 65 and older were uninsured.[1] Many people lost their health insurance when they retired, and private insurance companies, concerned about adverse risk, were reluctant to write comprehensive policies for older adults. Policies that were available often limited coverage, exempted pre-existing conditions, and offered inadequate protection (Exhibit 1).[2]

After Medicare was enacted, the number of uninsured Americans plummeted from 71 million in 1953 to 23 million in 1976. Today only 2 percent of adults 65 and older are uninsured.[3]

**EXHIBIT 1. MEDICARE COVERAGE AND CARE, THEN AND NOW**

| | 1970 | 2012 |
|---|---|---|
| **Beneficiaries (millions)** | 20 | 55.7 (2015) |
| Percent disabled under age 65 | 7.4% (1973) | 17% |
| Beneficiaries as share of U.S. population | 9.8% | 16% |
| Uninsured age 65 and older | 48% (1963) | 2% |
| **Life expectancy at age 65** | | |
| Men | 77.8 (1960) | 82.7 (2010) |
| Women | 80.8 (1960) | 85.3 (2010) |

Sources: Centers for Disease Control and Prevention, www.cdc.gov/nchs/data/hus/hus13.pdf; U.S. Social Security Administration, www.ssa.gov/history/lifeexpect.html; National Center for Health Statistics National Nursing Home Survey, 2004; and K. Davis and C. Schoen, *Health and the War on Poverty: A Ten-Year Appraisal* (Washington D.C.: Brookings Institution, 1978).

### *Reducing Financial Risk*

Prior to Medicare, older people and their adult children faced a high risk of financial burden because of medical bills. In 1966, older Americans paid 56 percent of their medical expenses directly out-of-pocket.[4] Medicare was designed to eliminate this financial pressure and ensure access to needed care.[5,6] Today, older Americans pay just 13 percent of their health care expenses directly.[7]

### *Improving Access*

The enactment of Medicare had an immediate and dramatic impact on access to health care services for beneficiaries.[8] Reduced financial barriers resulted in increased demand and use of services. From 1963 to 1970, the hospital admission rate for older Americans increased from 18 percent to 21 percent. Additionally, the proportion of elderly Americans seeing a physician rose from 68 percent to 76 percent.[9]

### *Reducing Disparities*

In its early years, Medicare was a major force for the racial desegregation of health care facilities, dramatically reducing disparities in access to care by making vigorous enforcement of the Civil Rights Act a condition of hospital participation in the program. Hospitals integrated their medical staffs, waiting rooms, and hospital floors in a period of less than four months.[10] Between 1961 and 1968, hospitalization rates for whites age 65 and older rose 38 percent, while rates for blacks 65 and older jumped 61 percent.[11] As a result, disparities in access to hospital services for people of all ages narrowed, with the difference in hospitalization rates between whites and blacks falling from 30 percent in 1961 to 17 percent by 1968.[12]

## Supporting Advances in Care and Delivery

Medicare has given beneficiaries access to the latest advances in medical research and has helped finance medical progress through its indirect support of graduate medical education and payments to teaching hospitals.[13] Gains in life expectancy at age 65 accelerated after enactment, increasing by 15 percent between 1965 and 1984, compared with 5 percent between 1950 and 1965.[14] Life expectancy of Medicare beneficiaries is now five years longer than it was when Medicare started. Annual death rates of those age 85 and older dropped by 18 percent between 1960 and 1970, compared with just 2 percent between 1950 and 1960.[15] While these gains undoubtedly owe much to advances in clinical care and medical research, Medicare ensured access to high-quality care for its beneficiaries.[16] Medicare has been both a leader and an innovator, helping to set quality standards and supporting both medical advances and innovation in health services delivery.[17]

### *Providing Peace of Mind*

Among voters of all ages, Medicare is one of the most widely supported government programs. Medicare beneficiaries are more satisfied with their Medicare coverage than adults under age 65 are with private health insurance.[18]

## Medicare's Enrollment and Benefits Have Continuously Expanded

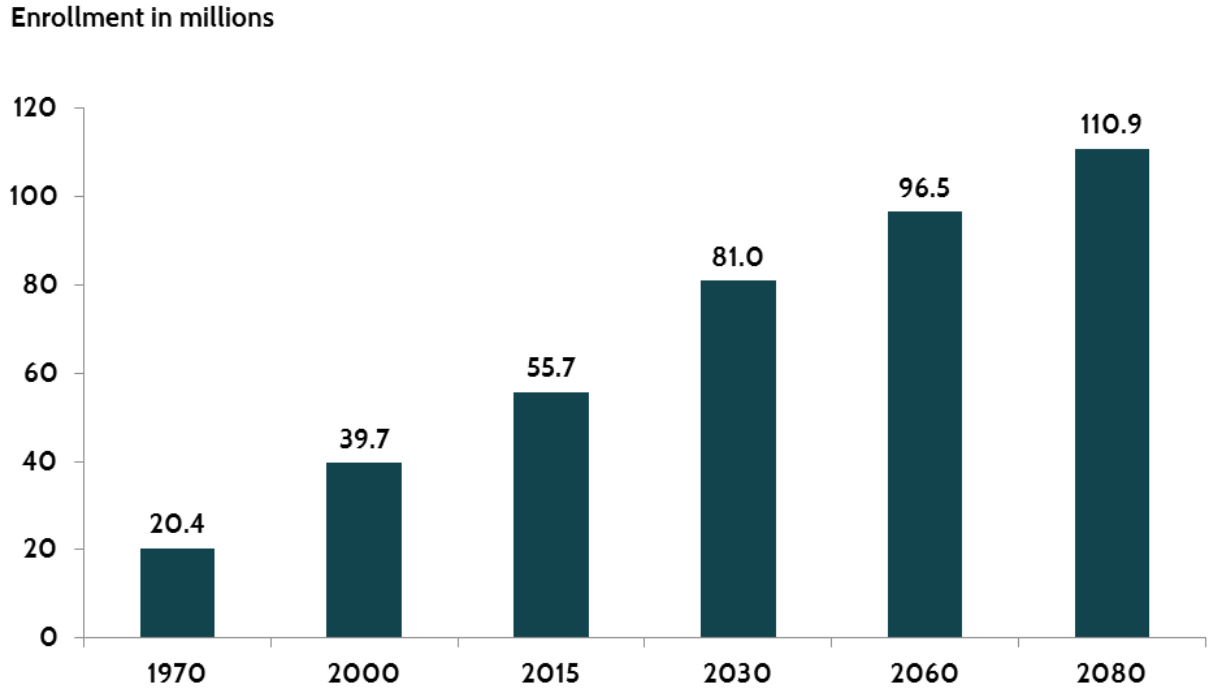
When Medicare was launched, it covered 20 million people. In 2015, Medicare covers 55 million people, or 17 percent of the U.S. population.[19] Eighty percent of beneficiaries are age 65 or older (and eligible for Social Security); the remaining 20 percent comprise individuals with serious disability (and covered by Social Security Disability Insurance) or end-stage renal disease.[20]

Expanding Medicare's benefits over the years has been a challenge. In 1988, prescription drug coverage was added through the Medicare Catastrophic Coverage Act (MCCA), as well as limits on beneficiaries' out-of-pocket expenses. The higher premiums necessitated by these reforms, however, were unpopular, and in 1989 Congress repealed its actions. Nevertheless, the will to increase benefits persisted, and in 2003 a voluntary prescription drug benefit was introduced as part of the Medicare Modernization Act. In 2013, Medicare Part D drug coverage provided benefits to 39.1 million beneficiaries.[21]

In 1997, Medicare Part C—now called Medicare Advantage—was created to give beneficiaries the option of choosing an HMO-style Medicare plan instead of traditional Medicare. Currently, about 30 percent of beneficiaries have opted for this program.

Medicare enrollment is expected to grow rapidly as members of the baby boom generation, born after World War II, become eligible. An estimated 81 million people will be enrolled by 2030, after which enrollment is projected to increase more slowly, reaching 111 million by 2080 (Exhibit 2).

### Exhibit 2. Medicare Enrollment, 1970–2080




Source: Centers for Medicare and Medicaid Services, *2013 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds* (Washington, D.C.: CMS, 2013).

## Demographics of the Medicare Population

Medicare covers the oldest and most disabled portion of the population. Today, 30 percent of beneficiaries are age 85 and older or disabled under age 65 (Exhibit 3). The majority of enrollees are women (55%). About one-fourth (23%) have less than a high school education, and less than half (47%) have some college or more. About half (49%) live with a spouse; 29 percent live alone; 5 percent live in institutions (primarily nursing homes); and 18 percent report other housing arrangements (such as living with a family member).

Incomes of Medicare beneficiaries are lower than those of working families. Social Security provides a base income that keeps most elderly out of poverty. Poverty rates for Medicare beneficiaries (14%) are lower than for children (22%). Forty-two percent of Medicare's beneficiaries 65 and older have incomes at 200 percent of the poverty level or below. Only one-fourth (27%) have incomes over four times the poverty level.

Modest incomes combined with a greater need for medical care put beneficiaries at financial risk of burdensome medical bills. Even with Medicare, some beneficiaries are faced with substantial out-of-pocket costs.[22]

### EXHIBIT 3. CHARACTERISTICS OF MEDICARE BENEFICIARIES, 2010

| Characteristic | Percent of the Medicare Population | Characteristic | Percent of the Medicare Population |
|---|---|---|---|
| Total population = 48.4 million | 100% | **Living arrangement** | |
| **Sex** | | Institution | 5 |
| Male | 45 | Alone | 29 |
| Female | 55 | Spouse | 49 |
| **Race/ethnicity** | | Other | 18 |
| White, non-Hispanic | 77 | **Education** | |
| African American, non-Hispanic | 10 | No high school diploma | 23 |
| Hispanic | 9 | High school diploma only | 29 |
| Other | 5 | Some college or more | 47 |
| **Age** | | **Income status** | |
| <65 | 16 | Below poverty | 14 |
| 65–74 | 44 | 100%–125% of poverty | 9 |
| 75–84 | 27 | 125%–200% of poverty | 19 |
| 85+ | 13 | 200%–400% of poverty | 31 |
| **Health status** | | Over 400% of poverty | 27 |
| Excellent or very good | 43 | **Supplemental insurance status** | |
| Good or fair | 48 | Medicare only | 10 |
| Poor | 8 | Managed care | 24 |
| **Residence** | | Employer-sponsored insurance | 29 |
| Urban | 77 | Medigap | 18 |
| Rural | 23 | Medigap with employer-sponsored insurance | 4 |
| | | Medicaid | 14 |
| | | Other | 1 |

Sources: Medicare Payment Advisory Commission, *A Data Book: Health Care Spending and the Medicare Program* (Washington, D.C.: MedPAC, June 2014).

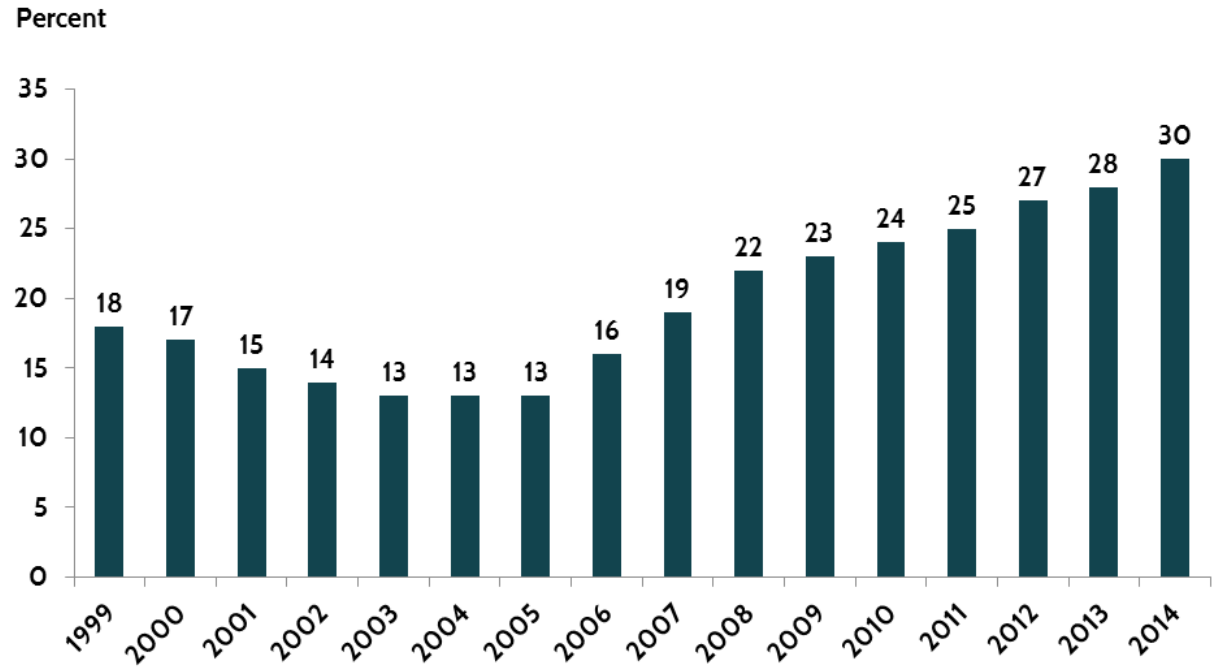
## Medicare Financing: Sharing the Load with Beneficiaries

At the heart of Medicare's design, and known as traditional Medicare, are Part A, Hospital Insurance, and Part B, Supplementary Medical Insurance. Part A includes coverage for hospital care, skilled nursing facility services, other institutional care, some home health care, and hospice care. It is financed primarily by a payroll tax of 1.45 percent each on employers and workers. Part B covers services from physicians and other professionals, ambulatory surgical centers, outpatient dialysis, home health, and other ambulatory services. It is financed approximately three-fourths from general tax revenue and one-fourth by beneficiary premiums. Higher-income beneficiaries now pay higher Part B premiums.

Part C, Medicare Advantage, enables beneficiaries to choose an integrated benefit package under private plans that contract with Medicare to deliver Part A and Part B health services. Enrollment in private plans has grown rapidly since 2003, when the Medicare Modernization Act, which covered prescription drugs, also liberalized payment to private Medicare managed care plans, allowing them to provide preventive health services and other added benefits at little or no extra cost to the patient (Exhibit 4).

Part D covers prescription drugs under private drug plans. It is financed approximately three-fourths from general tax revenues, with the remainder split between beneficiary premiums and state government contributions. Higher-income beneficiaries pay an additional premium. About 63

**Exhibit 4. Percent of Medicare Beneficiaries Enrolled in Medicare Advantage Plans, 1999–2014**




Source: Analysis of Medicare Advantage enrollment files by the Henry J. Kaiser Family Foundation.

percent of Medicare beneficiaries have a private drug plan either as standalone coverage or in connection with Medicare Advantage plans. About 15 percent have retiree drug coverage. Eleven percent of Medicare beneficiaries had other sources of coverage (such as Medicaid, military, or veterans drug coverage). Twelve percent, or 6 million, continue to have no prescription drug coverage or coverage that is not on par with the Part D standard benefit.[23]

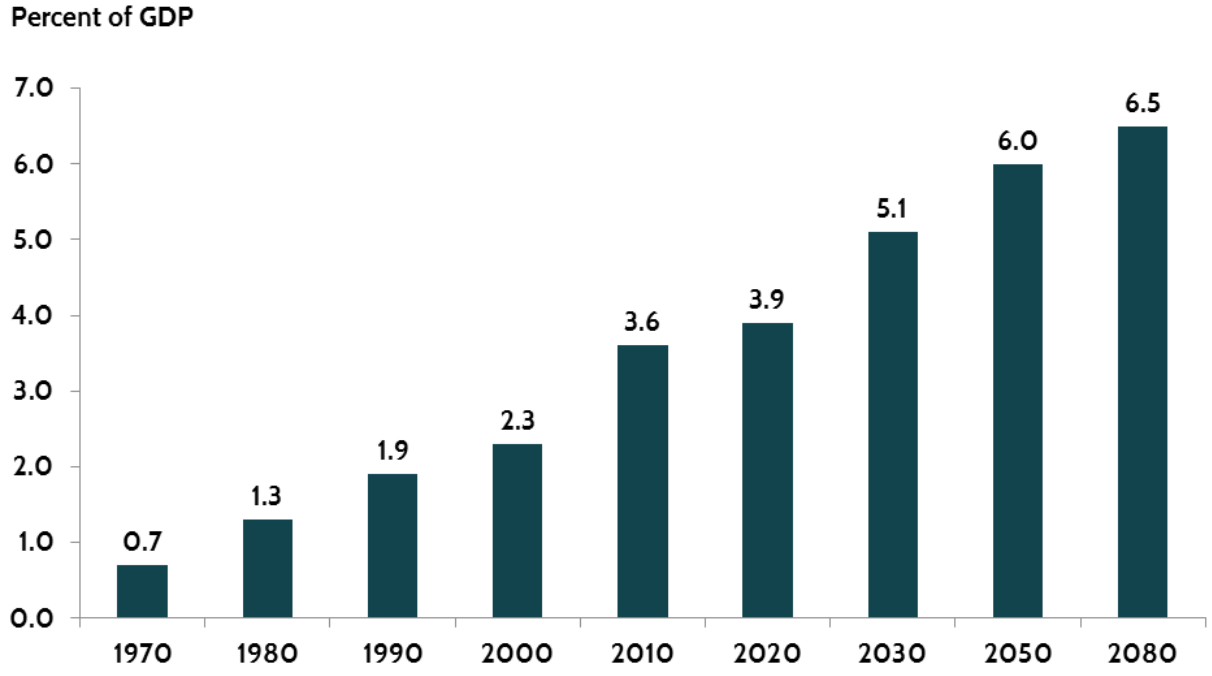
### *Medicare Covers Two-Thirds of Beneficiaries' Costs*

Spending per Medicare beneficiary increased 500 percent cumulatively between 1970 and 2013, from $385 to $12,210, or 0.7 to 3.5 percent of GDP.[24] Total Medicare spending in 2013 was $583 billion, making Medicare one of the largest purchasers of health care in the U.S., accounting for nearly one-fourth (23%) of total personal health care expenditures. Current projections predict that Medicare spending will make up 5.1 percent of GDP by 2030 (Exhibit 5).

Medicare accounts for 23 percent of spending on physician and clinical services; 23 percent of spending on nursing home care; 27 percent of hospital spending; 43 percent of home health spending; and 26 percent of spending on prescription drugs (Exhibit 6).

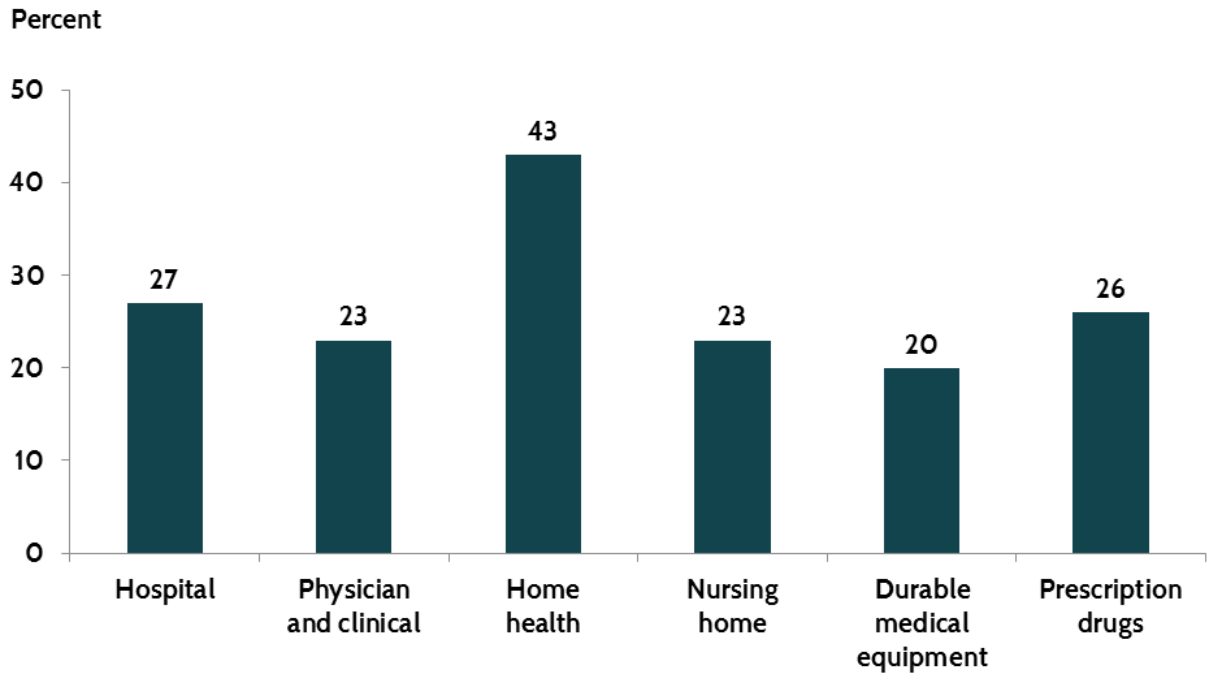
Older beneficiaries cost more because of their greater need for health services to address a higher number of chronic conditions. There is a twofold difference in spending between those ages 65 to 84 and those 85 and older. Per capita spending on women is nearly 25 percent higher than on

**Exhibit 5. Medicare Spending as Percentage of U.S. Gross Domestic Product, 1970–2080**




Source: Medicare Payment Advisory Commission, *Health Care Spending and the Medicare Program*, Data Book (Washington, D.C.: MedPAC, 2014).

## Exhibit 6. Medicare's Share of Spending by Type of Service, 2012




Source: Medicare Payment Advisory Commission, *Health Care Spending and the Medicare Program*, Data Book (Washington, D.C.: MedPAC, 2014).

men in 2010. However, spending levels between women and men ages 65 to 84 are virtually identical; the difference emerges primarily in adults age 85 and older.

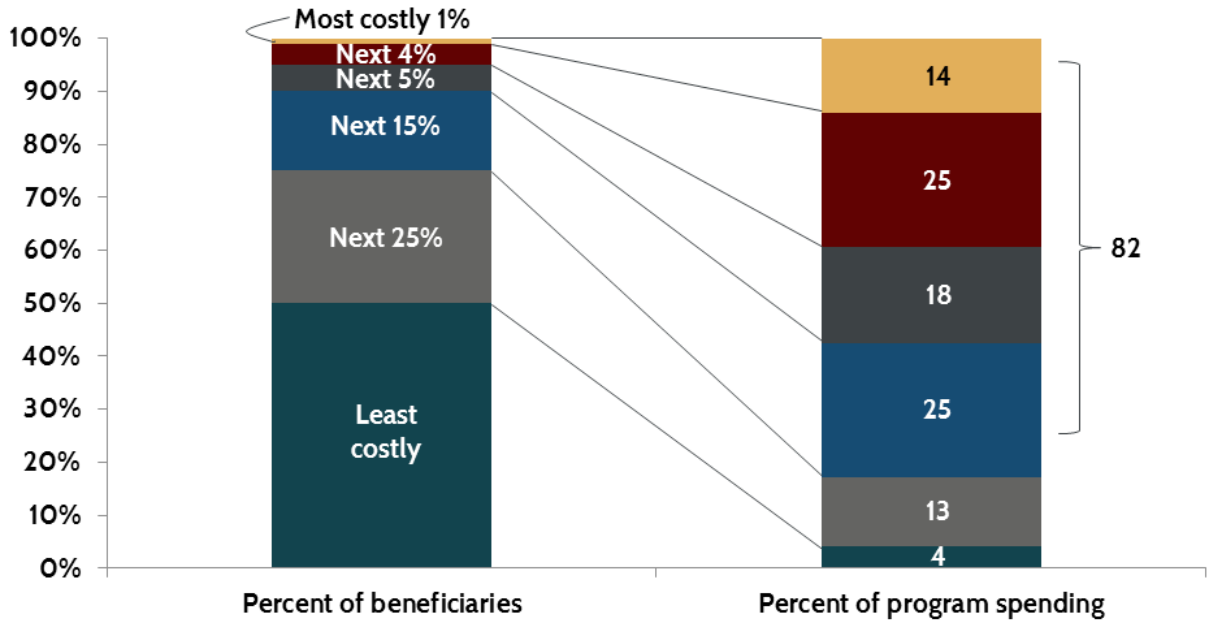
In the aggregate, Medicare pays two-thirds of the health care costs of its beneficiaries. Patients pay 13 percent directly out-of-pocket, while private supplemental coverage, including employer-sponsored retiree plans and private MediGap plans, pay 15 percent. Medicaid and other public sources of coverage reimburse the remaining 5 percent of costs.[25]

Not surprisingly, Medicare outlays are concentrated on those beneficiaries who are the sickest and have the most complex care needs. Five percent of beneficiaries account for 25 percent of Medicare spending, and the quarter of beneficiaries with the highest costs account for 82 percent of all Medicare outlays (Exhibit 7). By contrast, the half of beneficiaries with the lowest expenditures account for only 4 percent of outlays.

### *Beneficiaries Pay Out-of-Pocket for Deductibles, Supplemental Coverage*

Even with Medicare, the cost to beneficiaries of premiums and cost-sharing can be quite significant, especially for those with extensive health care needs. Part A includes a deductible based on the average cost of one day of hospital care ($1,260 in 2015) for a given benefit period. There is no further cost-sharing for the first 60 days. For hospital days 61 through 90 in a single benefit period, a coinsurance payment of $315 per day is required; for days 91 and beyond, this rises to $630 per each "lifetime reserve" day (up to 60 days over the beneficiary's lifetime). The Part B premium is typically

## Exhibit 7. Spending in Traditional Medicare Is Highly Concentrated in Small Group of Beneficiaries, 2010




Note: All data are fee-for-service and for calendar year 2010. Analysis excludes beneficiaries with any group health enrollment during the year. "Percent of program spending" total may not sum to 100 percent because of rounding.
Source: Medicare Payment Advisory Commission, analysis of 2010 Medicare Current Beneficiary Survey Cost and Use files (Washington, D.C.: MedPAC).

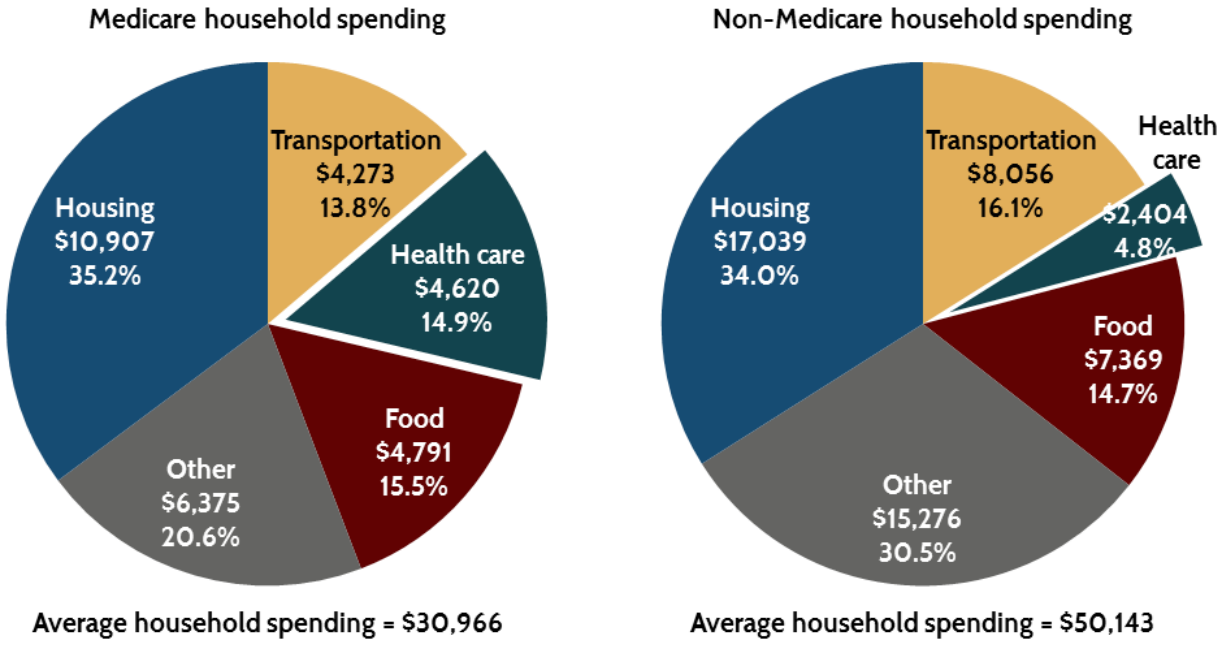
$104.90 in 2015, with a $147 deductible. Part C and Part D plan premiums and cost-sharing vary by plan. These out-of-pocket costs, in addition to the cost of noncovered services, leave beneficiaries paying an average of 15 percent of income on health care, compared with 5 percent for those under age 65 (Exhibit 8).

Higher-income beneficiaries—those reporting more than $85,000 on an individual tax return, or $170,000 on a joint return—pay higher premiums under Part B and Part D. The amount of the premium corresponds with their income level. For example, an individual with income above $214,000, the top tier, would pay a Part B premium of $335.70 per month and an extra Part D premium of $70.80 a month, over and above the Part D premium charged by their private drug plan.[26]

The high out-of-pocket costs lead many beneficiaries to obtain supplemental coverage (Exhibit 9). In 2010, almost 30 percent of beneficiaries had employer-sponsored insurance, typically retiree health coverage from former employers; 24 percent had a private Medicare Advantage managed care plan; and 22 percent had a private Medicare supplemental insurance policy known as Medigap. Fourteen percent were covered by Medicaid; approximately 10 percent of Medicare beneficiaries had no supplemental coverage.

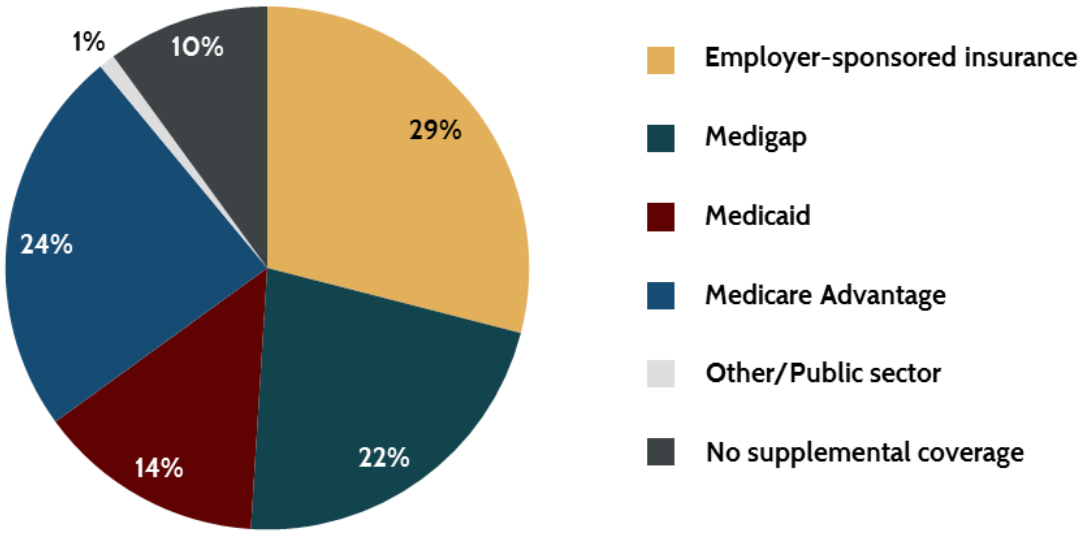
The extent and type of supplemental coverage varies by beneficiary income and health status. Medicaid is an important form of supplemental coverage for low-income Medicare beneficiaries,

## Exhibit 8. Many Medicare Beneficiaries Do Not Have Sufficient Savings to Cover Health and Long-Term Care Expenditures as They Age, 2009




Source: J. Cubanski, C. Swoope, A. Damico et al., "Health Care on a Budget: The Financial Burden of Health Spending by Medicare Households," analysis of the Bureau of Labor Statistics Consumer Expenditure Survey Interview and Expense Files, 2009 (Menlo Park, Calif.: Henry J. Kaiser Family Foundation, June 2011).

## Exhibit 9. Sources of Supplemental Coverage Among Noninstitutionalized Medicare Beneficiaries




Source: Medicare Payment Advisory Commission, analysis of 2010 Medicare Current Beneficiary Survey Cost and Use files (Washington, D.C.: MedPAC).

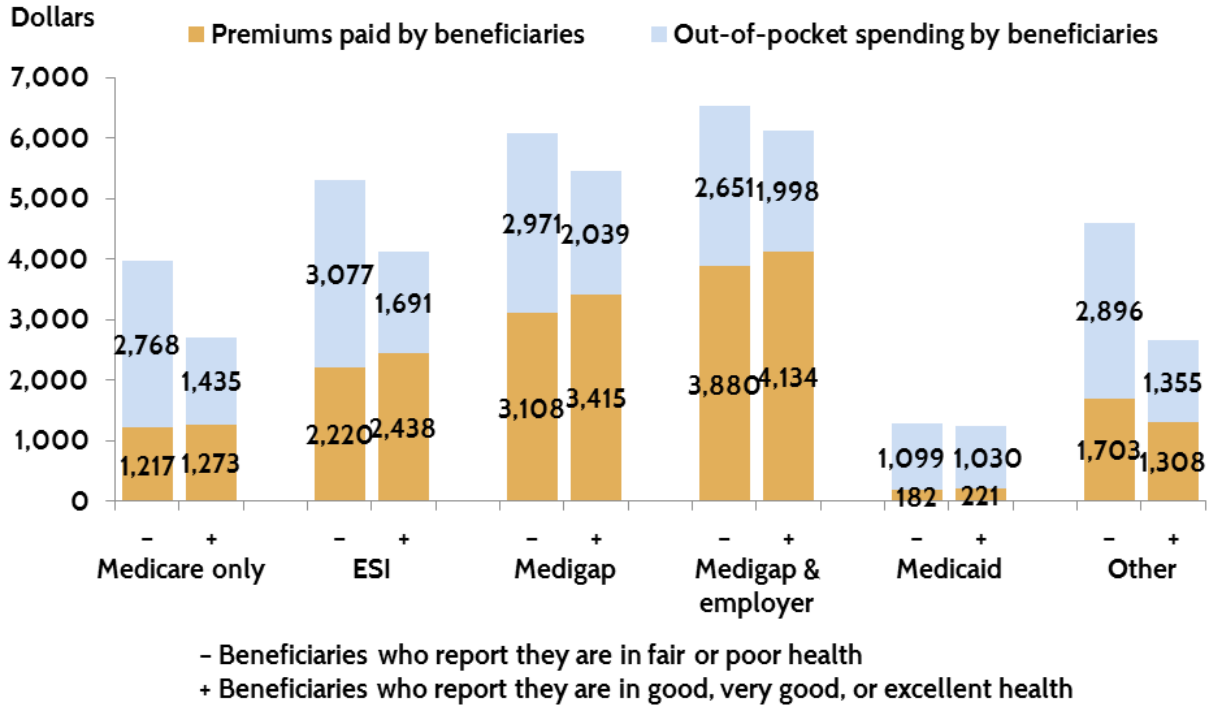
helping to pay for premiums and cost-sharing, as well as covering services not covered by Medicare, such as long-term nursing home care. For those with incomes under $10,000, 57 percent receive supplemental coverage through Medicaid.

Nearly half of Medicare enrollees with incomes above $80,000 receive coverage from employer-sponsored insurance; another quarter purchase Medigap coverage; and a fifth purchase Medicare Advantage private plan coverage. For those with modest incomes between $10,000 and $20,000, 15 percent have no supplemental coverage, while 21 percent are covered by Medicaid, and only 17 percent have employer-sponsored coverage.

Similarly, those who report their health as excellent or very good are more likely than those in poor health to have employer-sponsored coverage (34% vs. 18%), more likely to purchase Medigap coverage (24% vs. 16%), and more likely to be covered under private Medicare Advantage plans (25% vs. 18%). Those in poor health are more likely to have Medicaid (31%) than those in better health (7%), and also more likely to be without any form of supplemental insurance (15% vs. 10%).

Total out-of-pocket costs also vary by health status, with those self-reporting as being in fair or poor health paying almost 50 percent higher out-of-pocket payments than those reporting to be in better health (Exhibit 10). High out-of-pocket costs place a particular burden on Medicare beneficiaries whose income levels are less than 200 percent of the poverty level.

**Exhibit 10. Out-of-Pocket Spending for Premiums and Health Services per Medicare Beneficiary, by Insurance and Health Status, 2010**

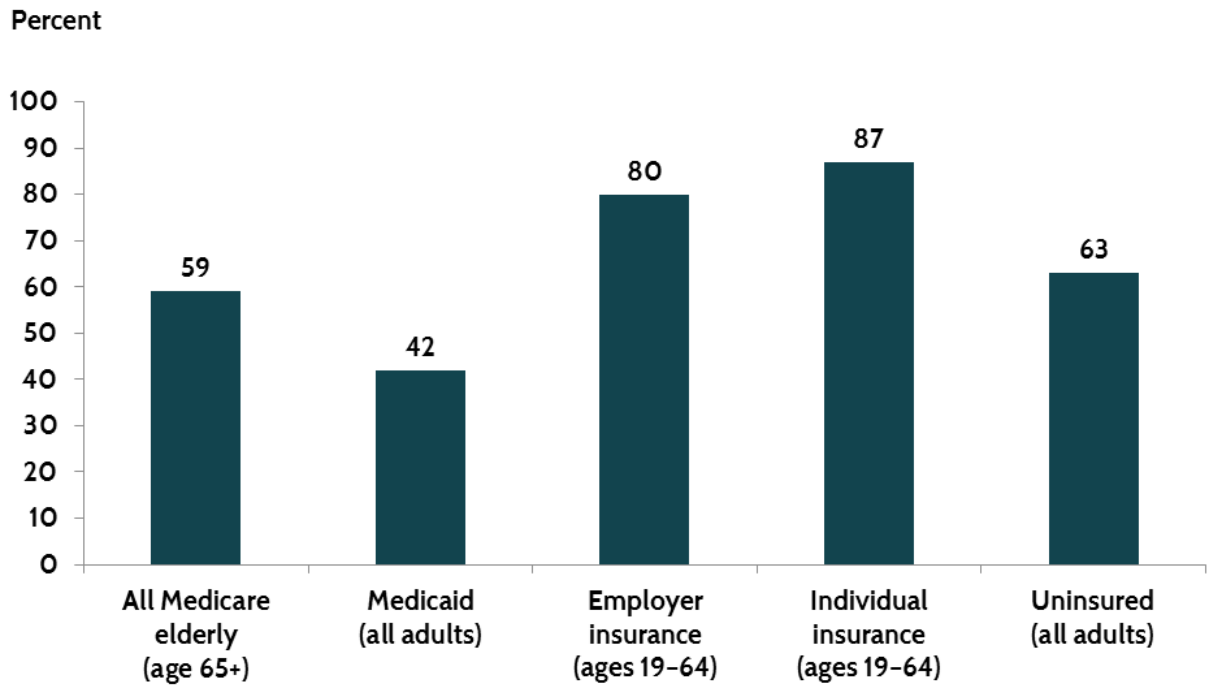



Note: ESI = employer-sponsored supplemental insurance.
Source: Medicare Payment Advisory Commission, analysis of 2010 Medicare Current Beneficiary Survey Cost and Use files (Washington, D.C.: MedPAC).

### *Financial Burdens Are Lightest for Medicare Beneficiaries*

In 2012, about 60 percent of Medicare beneficiaries reported total family out-of-pocket costs and premiums in excess of $1,000, compared with 80 percent or more for adults with employer-based insurance (Exhibit 11). This finding is especially striking given the lower income and poorer health reported by Medicare beneficiaries. Similar rates of out-of-pocket costs were reported by traditional Medicare and Medicare Advantage beneficiaries. Thirty-one percent of all Medicare elderly, 38 percent with employer insurance, and 49 percent with individually purchased insurance reported costs to be 10 percent or more of income.

**Exhibit 11. Total Out-of-Pocket Costs of $1,000 or More, 2012**




Source: The Commonwealth Fund Biennial Health Insurance Survey (2012).

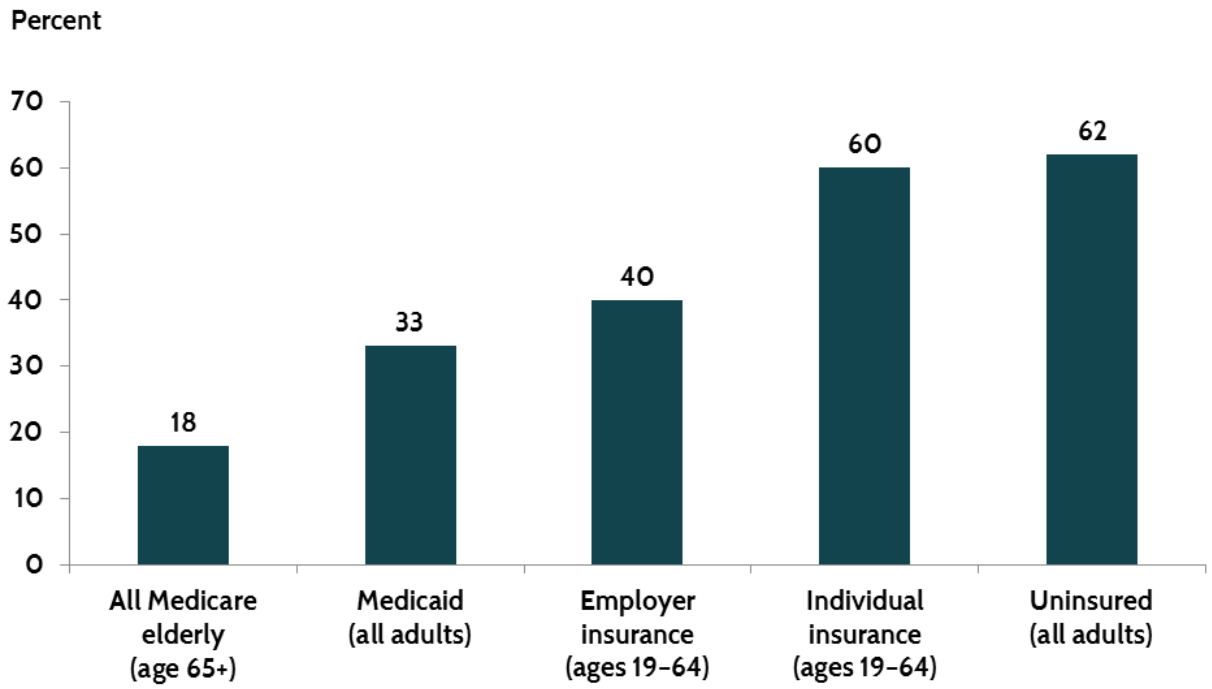
While Medicare requires substantial cost-sharing, elderly Medicare beneficiaries report fewer problems paying bills than those under age 65. The Commonwealth Fund's 2012 Biennial Health Insurance Survey found that only 14 percent of elderly Medicare beneficiaries reported problems paying medical bills, compared with 33 percent of individuals with employer-based insurance, 45 percent with individual coverage, and 50 percent of the uninsured. Among those with employer-based insurance, the share reporting financial problems caused by medical bills was double that for Medicare patients (34% and 16%, respectively).

## Ensuring Access and Promoting Quality

### *Providing Access to Care*

Medicare beneficiaries report having fewer cost-related barriers to care than people with other sources of coverage. Adjusted for race, poverty status, health status, and number of chronic conditions, findings from the Biennial Health Insurance Survey indicate only 18 percent of elderly Medicare beneficiaries had cost-related access problems, compared with 40 percent of adults with employer-sponsored insurance and 62 percent of the uninsured (Exhibit 12). Nonetheless, international comparisons show that adults 65 and older in the U.S. are much more likely to face problems with access to care than their counterparts in other countries.

**Exhibit 12. Any Access Problem Because of Cost, 2012**

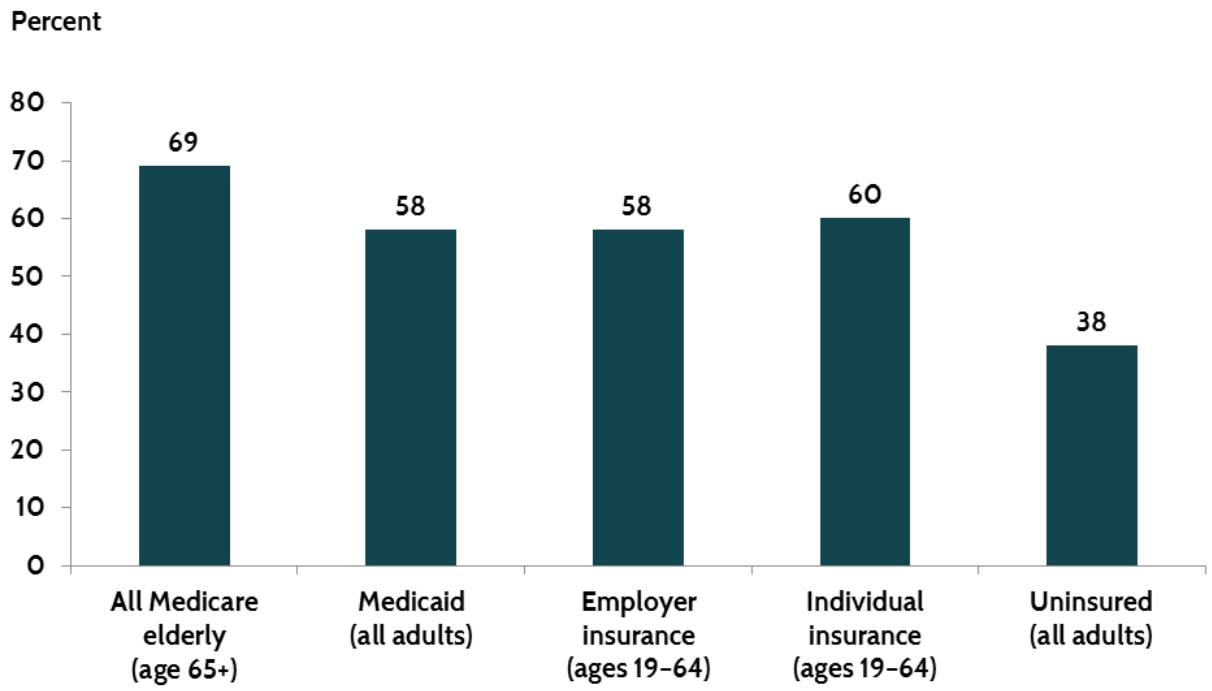



Source: The Commonwealth Fund Biennial Health Insurance Survey (2012).

### *Promoting the Medical Home Model, Preventive Care, Quality of Care*

Medicare beneficiaries 65 and older report care experiences that are similar to or better than that of individuals under age 65. Nearly 70 percent of elderly Medicare beneficiaries report having a regular doctor or place of care that is accessible, knows them and coordinates their care (a medical home), compared to 58 percent of individuals with employer-based insurance (Exhibit 13). The uninsured

## Exhibit 13. U.S. Adults Who Have a Medical Home, 2012




Source: The Commonwealth Fund Biennial Health Insurance Survey (2012).

were the least likely to have access to a medical home, with only 38 percent reporting such care experience. Concerning the ease of getting after-hours care without going to the emergency department, no significant differences were found between those with employer-based insurance and Medicare. Those most likely to report difficulty getting care had Medicaid or no insurance.

More Medicare beneficiaries 65 and older with chronic conditions (65%) reported receiving all recommended preventive care services than those with employer-based insurance (43%), or those with no insurance (18%). Traditional Medicare and Medicare Advantage enrollees reported similar rates for all preventive care services.

Thirty-five percent of elderly Medicare beneficiaries rated their quality of care to be excellent or very good compared with 21 percent of people with employer-based insurance and 28 percent of adults with individual insurance. Medicaid patients were significantly more likely to rate their care excellent or very good than those in employer groups; the uninsured were less likely to report better care.

### *Traditional Medicare vs. Medicare Advantage*

One of the key issues Medicare has faced throughout its history is whether market-based private insurance would yield greater value for the money spent. The pressure for privatization of Medicare has led to a gradual expansion of private Medicare Advantage plans offered through the program,

and further steps toward private provision of insurance for Medicare beneficiaries promises to be a central question in future Medicare reforms.

Proponents of Medicare as social insurance make a number of points. Medicare, they note, covers the oldest, sickest, and most disabled individuals, as well as some of the poorest, while private insurers tend to prefer those who are relatively younger, healthier, and financially more secure. Because of the highly skewed nature of health expenditures, with a few individuals accounting for a disproportionately large share of spending, natural market forces cause private insurers to avoid those at highest risk. And, in fact, research has shown that Medicare Advantage plan enrollees tend to be healthier.[27] The healthier enrollment of private plans can be explained in part by the imperfect risk adjustment mechanism used by the Centers for Medicare and Medicaid Services to set payment for Medicare Advantage plans—that is, plans continue to find that it pays for them to seek out the best risks.

Some argue that private plans are more responsive to beneficiary preferences. Yet survey research shows Medicare compares favorably to private insurance on measures of performance such as access to care and protection from financial burdens, with no significant differences on these dimensions between Medicare Advantage and traditional Medicare.[28] Other research shows that disparities tend to be greater in Medicare Advantage than in traditional Medicare for those who have lower incomes, or are female, black, in fair or poor health, or less educated.[29]

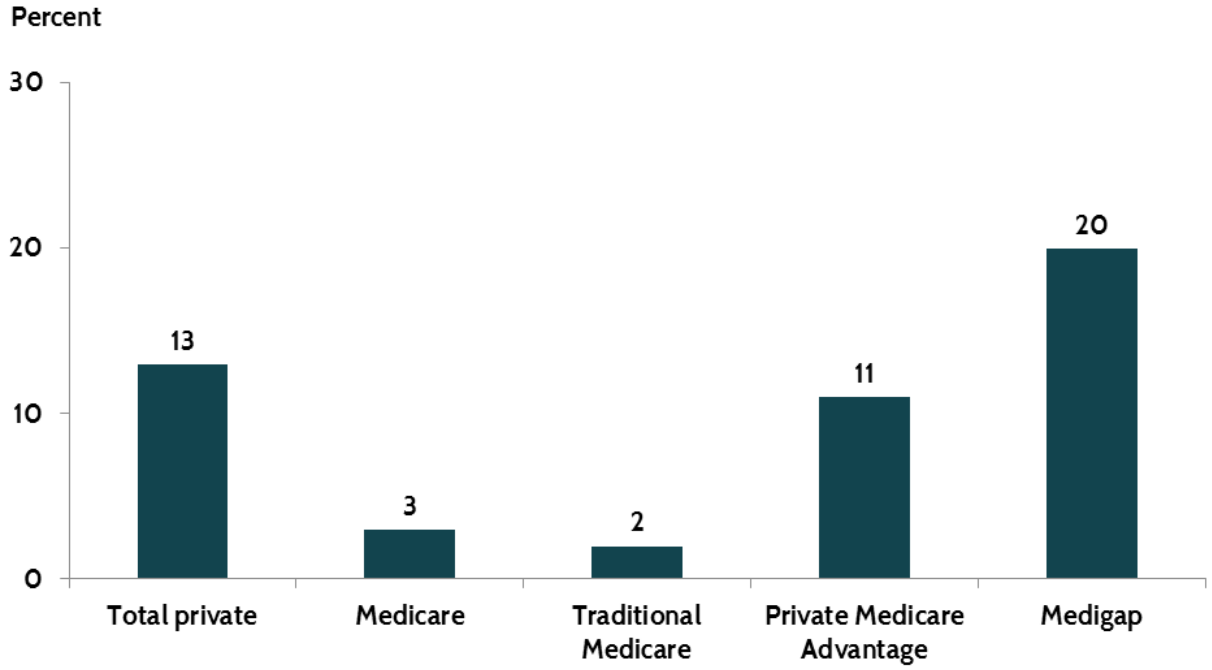
Medicare beneficiaries for the most part are pleased with their health insurance coverage. Elderly Medicare beneficiaries are significantly less likely than those with employer-based coverage to report having negative insurance experiences, such as receiving expensive medical bills for uncovered services, being charged more than insurance would pay, or not having their insurance accepted. Individually insured adults are more likely to have a negative experience. Forty-six percent of Medicare Advantage beneficiaries reported negative insurance experiences, compared with 33 percent of traditional Medicare beneficiaries.

Satisfaction with insurance coverage is significantly higher among Medicare beneficiaries. Only 7 percent of traditional Medicare beneficiaries and 11 percent of Medicare Advantage enrollees rate their insurance as fair or poor, compared with 21 percent of adults with employer-based insurance. Adults with individual coverage were the most dissatisfied, with 45 percent rating their insurance as fair or poor.

Finally, administrative costs in traditional Medicare, which average 2 percent to 3 percent, are much lower than those in Medicare Advantage (11%) or private supplemental Medigap plans (20%) (Exhibit 14).

The Affordable Care Act includes provisions designed to improve the value provided by Medicare Advantage plans. These include phasing out the federal government's overpayments to Medicare Advantage plans, which have been reimbursed an average of 13 percent above the amount it would have cost to care for the same beneficiaries under traditional Medicare. The ACA also limits administrative overhead in Medicare Advantage plans to no more than 20 percent of premiums

## Exhibit 14. Administrative Costs of Private Coverage Are High




Sources: Commonwealth Fund Commission on a High Performance Health System, *The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way* (New York: The Commonwealth Fund, Feb. 2009); Congressional Budget Office, *Designing a Premium Support System for Medicare* (Washington, D.C.: CBO, 2006); and S. Sheingold, A. Shartzer, and D. Ly, *Variation and Trends in Medigap Premiums* (Washington, D.C.: U.S. Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, Dec. 2011).

collected.[30] Moreover, enrollees now have access to plan quality "star ratings," which appears to have led to some shift in enrollment toward 4- and 5-star plans.[31]

One of the major rationales for the Medicare Advantage program has been the belief that participating plans would use disease management and care coordination tools to reduce the need for hospitalization and to otherwise control use of health services.[32] In fact, only a portion of Medicare Advantage plans are based on integrated delivery system models; others amount to no more than discounted fee-for-service plans, offering open access to all providers willing to participate. To ensure that Medicare, in all its forms, is providing good value to beneficiaries, it will be important to monitor the relative performance of traditional Medicare and the array of private plans available through the Medicare Advantage program.

### Challenges Ahead: Serving Boomers, Controlling Costs

Medicare faces enormous challenges as members of the baby boom generation, now in their late 50s and 60s, become eligible for coverage. Beginning in 2011, and continuing for the next 20 years, roughly 10,000 Americans will turn 65 every day.[33] As more and more reach the age of Medicare eligibility and enroll, total Medicare expenditures are projected to rise faster than growth in the overall economy. This accelerating rise in enrollment in coming years is fueling concerns about the future impact on the federal budget and the solvency of the Medicare Hospital Insurance Trust Fund.

There are other challenges as well. Medicare's insufficient benefit package compels many beneficiaries to seek supplementary private coverage. While the addition of prescription drug coverage in 2003 and elimination of cost-sharing for preventive care have had beneficial effects, Part B and Medigap premiums and the cost of noncovered services add to beneficiaries' financial burdens.[34] The aging of the population and the high prevalence of chronic disease among older adults also call for better strategies to serve beneficiaries with complex care needs and control the high costs associated with their care.

To date, policy leaders have followed a prudent course. Spurred by the Affordable Care Act, Medicare is currently testing promising innovations in health care delivery and payment, some of which have produced encouraging early results.[35] Over the coming years, it may even be possible to achieve significant savings by spreading the most successful of these new payment policies and delivery system models.

The ACA's reforms alone will not be enough, however, to address all of Medicare's challenges. In addition to addressing the stark fiscal realities that face the program, a future reform agenda also must seek to: improve financial protection for low- and modest-income beneficiaries; modernize Medicare's benefit package; reduce complexity in traditional Medicare's coverage; deliver more effective care to complex beneficiaries with high needs and high costs; and accelerate the program's move toward value-based payment.

There have been numerous proposals to transform Medicare. One of these, "Medicare Essential" (discussed in one of the forthcoming papers in our *Medicare at 50 Years* series) would create a comprehensive Medicare benefit financed by beneficiary premiums.[36] Because Medicare has substantially lower administrative costs than those in private supplemental insurance plans, beneficiaries would save on premiums. Beneficiaries would also have incentives to seek care from higher-value, lower-cost providers, such as patient-centered medical homes and accountable care organizations. Under another proposal, known as "premium support," beneficiaries would receive a payment that they would use to buy health insurance on their own, whether private coverage or traditional Medicare.[37] If the premium of the plan they choose exceeds the premium-support allowance, beneficiaries would pay the difference or enroll in a plan with lower premiums but higher deductibles and fewer benefits. But with so many beneficiaries already spending a sizable portion of their incomes on health services, it may not be possible to ask that they bear even greater out-of-pocket costs.

Perhaps the best course may involve building on the comparative advantages of both public and private insurance and promoting healthy competition between the two. Traditional Medicare has the advantage of lower administrative costs and participation by nearly all hospitals and physicians despite lower provider payment rates. Private plans have more flexibility to contract with lower-cost providers and to set restrictions on use of services (such as prior authorization of hospitalization). With its lower administration costs and lower provider payment rates, traditional Medicare in particular may offer important advantages that can be used to improve coverage options

for those under age 65, particularly those nearing retirement, by reducing costs to enrollees and improving the stability of coverage as older adults age into Medicare.

Upcoming papers in the *Medicare at 50 Years* series examine the Affordable Care Act's reforms to Medicare and the challenges ahead and analyze policy options to ensure Medicare's viability and effectiveness for future beneficiaries.

## NOTES

[1] R. Andersen, J. Lion, and O. W. Anderson, *Two Decades of Health Services: Social Survey Trends in Use and Expenditure* (Cambridge, Mass: Ballinger Publishing Company, 1976).

[2] K. Davis and C. Schoen, *Health and the War on Poverty: A Ten-Year Appraisal* (Washington, D.C.: Brookings Institution, 1978); K. Davis and D. Rowland, *Medicare Policy: New Directions for Health and LongTerm Care* (Baltimore: Johns Hopkins University Press, 1986).

[3] National Center for Health Statistics, *Health, United States, 2013* (Washington D.C.: U.S. Department of Health and Human Services, May 2014).

[4] Note that implementation of Medicare did not begin until July 1966. B. S. Cooper and N. L. Worthington, "Age Differences in Medical Care Spending, Fiscal Year 1972," *Social Security Bulletin,* May 1973 36(5):1–15.

[5] R. M. Ball, "Perspectives on Medicare: What Medicare's Architects Had in Mind," *Health Affairs,* Nov. 1995 14(4):462–72.

[6] L. B. Johnson, "Statement by the President on the Inauguration of the Medicare Program, 1966," accessed Dec. 15, 2015, at http://www.presidency.ucsb.edu/ws/?pid=27692.

[7] Medicare Payment Advisory Commission, *A Data Book: Health Care Spending and the Medicare Program* (Washington, D.C.: MedPAC, June 2014).

[8] Davis and Schoen, *Health and the War on Poverty*, 1978.

[9] Andersen, Lion, and Anderson, *Two Decades of Health Services,* 1976.

[10] D. B. Smith, *Health Care Divided: Race and Healing a Nation* (Ann Arbor, Mich.: University of Michigan Press, 1999).

[11] K. Davis, "Equal Treatment and Unequal Benefits: the Medicare Program," *Milbank Quarterly. Health and Society,* Autumn 1975 53(4):449–88.

[12] Institute of Medicine, *Graduate Medical Education That Meets the Nation's Health Needs* (Washington, D.C.: National Academies Press, Sept. 2014).

[13] Ibid.

[14] D. Blumenthal, M. Schlesinger, and P. B. Drumheller, *Renewing the Promise: Medicare and Its Reform* (New York: Oxford University Press, 1988).

[15] National Center for Health Statistics, *Health, United States,* 2014.

[16] B. A. Weisbrod, "The Health Care Quadrilemma: an Essay on Technological Change, Insurance, Quality of Care, and Cost Containment," *Journal of Economic Literature,* June 1991 29(2):523–52.

[17] D. McCanne, Innovation Leader—Medicare or Private Insurance?, available at http://pnhp.org/blog/2012/06/22/innovation-leader-medicare-or-private-insurance/.

[18] K. Davis, C. Schoen, M. Doty, and K. Tenney, "Medicare Versus Private Insurance: Rhetoric and Reality," *Health Affairs,* published online Oct. 2002.

[19] *2014 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds,* p. 198.

[20] Centers for Medicare and Medicaid Services, *Medicare Enrollment—Disabled Beneficiaries* (Washington D.C.: U.S. Department of Health and Human Services, 2011), accessed Dec. 5, 2014, at http://cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareEnrpts/Downloads/12All.pdf.

[21] Blumenthal, Schlesinger, and Drumheller, *Renewing the Promise*, 1988.

[22] J. Cubanski, C. Swoope, A. Damico et al., *How Much Is Enough? Out-of-Pocket Spending Among Medicare Beneficiaries: A Chartbook* (Washington, D.C.: The Kaiser Family Foundation: July 2014).

[23] Medicare Payment Advisory Commission, *A Data Book, 2014* (Washington, D.C.: MedPAC, June 2014).

[24] Blumenthal, Schlesinger, and Drumheller, *Renewing the Promise*, 1988.

[25] Medicare Payment Advisory Commission, *A Data Book, 2014,* Chart 3-3.

[26] K. Lankford, "What You'll Pay for Medicare in 2015," *Kiplinger*, accessed Dec. 5, 2014, at http://www.kiplinger.com/article/retirement/T039-C001-S003-what-you-ll-pay-for-medicare-in-2015.html.

[27] J. H. Ng, J. D. Kasper, C. B. Forrest et al., "Predictors of Voluntary Disenrollment from Medicare Managed Care," *Medical Care,* June 2007 45(6):513–20.

[28] Commonwealth Fund 2012 Biennial Health Insurance Survey, available at http://www.commonwealthfund.org/publications/surveys/2013/biennial-health-insurance-survey.

[29] M. N. Elliott, A. M. Haviland, N. Orr et al., "How Do the Experiences of Medicare Beneficiary Subgroups Differ Between Managed Care and Original Medicare?" *Health Services Research,* Aug. 2011 46(4):1039–58.

[30] Centers for Medicare and Medicaid Services, *80/20 Rule Delivers More Value to Consumers in 2012,* accessed Dec. 5, 2014, at http://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/2012-medical-loss-ratio-report.pdf.

[31] R. O. Reid, P. Deb, B. L. Howell et al., "Association Between Medicare Advantage Plan Star Ratings and Enrollment," *Journal of the American Medical Association,* Jan. 16, 2013 309(3):267–74.

[32] N. Pourat, M. Kagawa-Singer, and S. P. Wallace, "Are Managed Care Medicare Beneficiaries with Chronic Conditions Satisfied with Their Care?" *Journal of Aging and Health,* Feb. 2006 18(1):70–90.

[33] Centers for Disease Control and Prevention, *The State of Aging & Health in America 2013* (Atlanta: CDC, U.S. Dept of Health and Human Services, 2013), available at www.cdc.gov/aging.

[34] Centers for Medicare and Medicaid Services, *The Affordable Care Act: Strengthening Medicare in 2011* (Washington D.C.: U.S. Department of Health and Human Services, 2011), accessed Dec. 5, 2014, at http://www.cms.gov/apps/files/medicarereport2011.pdf.

[35] Centers for Medicare and Medicaid Services, "Innovation Models," 2013, accessed Dec. 4, 2014, http://innovation.cms.gov/initiatives/index.html#views=models. For a summary of the ACA's health care delivery system reform initiatives, see The Commonwealth Fund's online Health Reform Resource Center. For evidence of the reforms' early impact, see D. Blumenthal, M. K. Abrams, and R. Nuzum, "The Affordable Care Act at Five," Health Policy Report, *New England Journal of Medicine,* forthcoming May 6, 2015, and M. K. Abrams, R. Nuzum, M. Zezza, J. Ryan, J. Kiszla, and S. Guterman, *The Affordable Care Act's Reforms to Health Care Delivery and Payment: A Progress Report at Five Years* (New York: The Commonwealth Fund, forthcoming May 2015).

[36] K. Davis, C. Schoen, and S. Guterman, "Medicare Essential: An Option to Promote Better Care and Curb Spending Growth," *Health Affairs,* May 2013 32(5):900–9.

[37] Website of U.S. Representative Paul Ryan, http://paulryan.house.gov/issues/issue/?IssueID=9969#.VTaBcZO2o-I.

The
COMMONWEALTH
FUND

1 East 75th Street · New York, NY 10021
Tel: 212.606.3800

1150 17th Street NW · Suite 600 · Washington, DC 20036
Tel: 202.292.6700

www.commonwealthfund.org

Affordable, quality health care. For everyone.