SHAPING THE FUTURE OF MEDICARE

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EXECUTIVE SUMMARY

Future projections of Medicare outlays and revenues are sobering. As the baby boom generation reaches retirement, the nation must make tough choices among options to assure the health and economic security of an increasingly older and disabled American population. Congress made a major downpayment on Medicare's future with enactment of the Balanced Budget Act (BBA), which extended the projected solvency of the Part A Trust Fund from the year 2001 to 2010.

The attached testimony makes seven basic points:

The Future Is Unknowable

- Progress in biomedical research and better health behaviors may change the prevalence of disease and disability in future generations of older people.

- The health care system is in the midst of a major transformation that will affect future health costs in ways that are as yet unknown.

- Economic projections are uncertain.

- It may not be sensible to make projections for the coming 25 years; instead, it may be more prudent to project needs for increments of five years and make a series policy changes to address those needs.

Medicare Beneficiaries Already Shoulder a Major Portion of Costs

- While the growth in future Medicare outlays per beneficiary may seem staggering, the health care costs paid by Medicare beneficiaries themselves is high and will grow just as rapidly, if not more rapidly, as program outlays.

- Health care bills are already a major financial burden for a significant number of Medicare beneficiaries. In 1996, beneficiaries spent $2,605 per person, or 21 percent of income, on health care costs.

- Medicare covers only 53 percent of the health expenses of the elderly.

- Medicare is in the bottom decile in generosity of benefits compared with employer health plans; most employer plans, for instance, cover prescription drugs, which Medicare does not.

- Long-term care is a major uncovered expense.

Employers Are Cutting Back on Retiree Health Coverage and Pensions

- Only about 36 percent of Medicare beneficiaries have supplemental health insurance offered by their employers.

- This coverage is likely to decline in future years if current trends continue: in 1988, 44 percent of retirees had retiree health coverage, compared with 30 percent in 1994.

Low Income Medicare Beneficiaries Are Especially at Risk

- Poor and near-poor Medicare beneficiaries spend 30 percent of their income on health care.

- Medicaid does not offer adequate supplemental coverage for poor and near-poor beneficiaries.

The Sickest Beneficiaries Account for a Disproportionate Share of Expenditures

- Medicare outlay averages mask a wide variation in payments: 10 percent of beneficiaries account for 75 percent of outlays.

- The most costly 10 percent of beneficiaries average $37,000 annually in Medicare expenses, and average $8,800 in out-of-pocket expenses.

- Managed care capitated payment rates give plans an enormous incentive to attract healthier patients and to skimp on care for those with serious health problems.

Medicare's Transition to Managed Care Has Unknown Implications

- The BBA is likely to accelerate enrollment in Medicare managed care: the Congressional Budget Office estimates that 39 percent of beneficiaries will be in private plans by 2007.
- Incentives to provide too little care must be balanced with good quality standards, reporting of quality performance, and enforcement of standards.

- Many older beneficiaries may have difficulty understanding and making good choices (e.g., those with dementia, nursing home residents, terminally ill patients, and those with limited education).

- The BBA will require the Health Care Financing Administration to perform major new administrative tasks, but its ability to do so smoothly and effectively with limited resources raises concerns.

Medicare Payment Rates Should Be Comparable to the Private Sector

- Per-person Medicare and private health insurance outlays have grown at comparable rates over the past 25 years.

- It is important that Medicare payments to managed care plans and health care providers be comparable to private sector payments to ensure quality care for beneficiaries.

- The BBA achieved major savings, primarily through prospective payment limits on increases for fee-for-service providers and managed care plans. Whether these limits are too stringent or lax is as yet unclear.

- Prior to passage of the BBA, managed care plans were overpaid approximately 6 percent per beneficiary, in large part because the plans enrolled relatively healthier patients. The BBA will correct the payment system, but to what degree is unclear.

- The managed care industry is fairly concentrated: five national managed care plans account for half of Medicare health maintenance organization enrollment, and two plans typically capture more than 50 percent of states' Medicare markets.

The work of the National Bipartisan Commission on the Future of Medicare could not be more important or timely. The commission can make a major contribution to understanding the options for change and providing the information necessary to make tough choices. With the commission's help, the nation can move toward the goal of assuring that Medicare provides health and economic security for older and disabled Americans in the twenty-first century.

SHAPING THE FUTURE OF MEDICARE

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Future projections of Medicare outlays and revenues are sobering. As the baby boom generation reaches retirement, the nation must make tough choices among options to assure the health and economic security of an increasingly older and disabled American population. Congress made a major downpayment on Medicare's future with enactment of the Balanced Budget Act of 1997 (BBA), which achieved $116 billion in Medicare savings from 1998 to 2002 and $394 billion over the 10-year period from 1998 to 2007. In addition, the act extended the projected solvency of the Part A Trust Fund from the year 2001 to 2010.[1]

One of the important lessons of the BBA is that changes made early on can have major impacts over the longer term. Approximately three-fourths of the 10-year savings the act achieved will come from tightening prospective payment rates to fee-for-service providers and to managed care plans.[2] Extending these payment changes beyond 2002 could make a major difference in future projections.

The Future Is Unknowable

As important as it is to have 10- to 25-year projections of Medicare outlays and revenues, it is equally important to recognize the high degree of uncertainty surrounding such estimates. To an even greater extent than with Social Security, future baseline outlays for Medicare are very difficult to predict accurately. The wisdom of making 75-year projections is questionable.

The first significant unknown is future medical progress. Investment in biomedical research could lead to breakthroughs in preventing or treating conditions that now are very costly to Medicare, including cancer, heart disease, and Alzheimer's disease. Academic health centers and the biotechnology and pharmaceutical industries are currently engaged in research that shows great promise. The prospect of significant advances in the ability to intervene in some of today's major causes of death and disability is encouraging. Current projections in Medicare outlays do not take such possible advances into account.

[1] Congressional Budget Office, *Economic and Budget Outlook: Fiscal Years 1998-2008*, January 1998.

[2] Marilyn Moon, Barbara Gage, and Alison Evans, *An Examination of Key Medicare Provisions in the Balanced Budget Act of 1997*, The Commonwealth Fund, September 1997.

Second, recent evidence suggests that disability rates for older Americans are already declining.[3] An analysis of the rates of chronic disability among people age 65 and older found a decline from 24.9 percent in 1982 to 21.3 percent in 1994, a difference of about 1.2 million people. Since health care expenses are much higher for the disabled, a continuation of this decline could have significant effects on future Medicare outlays.

Third, changes in health habits of older people can affect their health care costs. Tomorrow's elderly will be better educated, less likely to smoke, and more physically and mentally active.[4] A new book entitled *Successful Aging* by Dr. John Rowe and Robert Kahn shows that health is not dictated strictly by genetics.[5] Exercise—even if started later in life—along with vitamins, diet, meaningful activity, and interaction with family and friends can improve functioning and reduce disease and disability in old age.

Fourth, the health care industry is in the midst of a major transformation similar to the corporate downsizing and improved efficiency of the 1980s and 1990s. Health care is being shifted out of hospitals and into doctors' offices and patients' homes. Reliance on specialty care has decreased, and excess capacity is beginning to shrink. Rates of increase in health care expenditures have slowed in recent years, a trend that could be either temporary or permanent. These factors will have a significant, but as yet unknown, effect on Medicare baseline projections and the feasibility of options for tightening Medicare prospective payments to providers.

Finally, economic projections are probably more uncertain than in the past. It is not clear whether productivity is on the rise, whether the retirement age will stop declining and begin to rise, or what future trends in immigration will be. All of these factors could affect future payroll tax revenues. Even small increases in real wages could have a substantial effect.

Given the uncertainty surrounding any future projections, the National Bipartisan Commission on the Future of Medicare is sensible to focus on no longer than 25-year projections. It may also be sensible to make a series of incremental changes in Medicare (e.g., every five years) and gauge their effect before instituting more changes. It is particularly important to assess periodically three effects: 1) the financial burden on beneficiaries from premiums and out-of-pocket expenses and the impact on access to care, 2) the ability of the health sector to absorb Medicare savings without deterioration in the quality

[3] Kenneth G. Manton, Larry Corder, and Eric Stallard, "Chronic Disability Trends in Elderly United States Populations: 1982-1994," proceedings of the National Academy of Sciences, 1997.

[4] Frank B. Hobbs with Bonnie L. Damon, *65+ in the United States*, U.S. Bureau of the Census, P23-190, April 1996.

[5] John W. Rowe, M.D., and Robert L. Kahn, *Successful Aging*, Pantheon Publishing, 1998.

of care, and 3) the extent to which Medicare payment rates for both fee-for-service providers and managed care plans are competitive with the private sector.

Medicare Beneficiaries Already Shoulder a Major Portion of Health Care Costs

While the growth in future Medicare outlays per beneficiary over a 25-year period can seem staggering, the health care costs that Medicare beneficiaries pay themselves is also high and growing just as rapidly. Prescription drugs and long-term care services are among the most rapidly increasing health care expenses, suggesting that growth rates in beneficiary outlays in the future will be even more rapid than for the Medicare program.

Medicare currently "pays" 53 percent of beneficiaries' health care costs, including the portion of Part B financed by beneficiary premiums.[6] The remainder comes from direct out-of-pocket payments, premiums to supplemental private insurance plans, employer contributions to retiree health plans, Medicaid, and other sources.

In 1996, Medicare beneficiaries spent on average of $2,605 per person on their own health care expenses, including premiums, cost-sharing, and noncovered services.[7] About half of this amount was for Medicare and supplemental insurance premiums, one-fourth was for Medicare cost-sharing, and one-fourth was for noncovered services. This cost represents 21 percent of the income of Medicare beneficiaries, compared with 8 percent for the nonelderly.[8]

Health care expenses have risen rapidly since the start of Medicare. Adjusted for inflation, the Part A deductible in 1966 was $193 (in 1997 dollars), compared with $764 today.[9] The Part B deductible is lower today than it was originally—$242 in 1966 and $100 today. The Part B annual premium is also higher—$526 today, compared with $178 in 1966 (in 1997 dollars), and the BBA included a major increase in the Part B premium. The Congressional Budget Office (CBO) estimates that the annual premium will be $1,172 in the year 2006.[10] About one-fifth of 10-year BBA savings came from premium increases.

Medicare's benefits are not generous by today's employer health benefits standards; in fact, they rank in the bottom decile of insurance plans. Most employer plans put a ceiling on out-of-pocket expenses, while Medicare does not. In addition, Medicare does not cover

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[6] U.S. House of Representatives, Committee on Ways and Means, *Medicare and Health Care Chartbook*, February 27, 1997, p. 152.

[7] Marilyn Moon, *Restructuring Medicare's Cost-Sharing*, The Commonwealth Fund, December 1996.

[8] Marilyn Moon, Crystal Kuntz, and Laurie Pounder, *Protecting Low Income Medicare Beneficiaries*, The Commonwealth Fund, December 1996; and American Association of Retired Persons.

[9] Karen Davis, *Medicare Reform: Assuring Health and Economic Security for Beneficiaries*, The Commonwealth Fund, January 1997.

prescription drugs, which are covered by 95 percent of employer plans, and it does not cover most long-term care services. More than three-fourths of Medicare beneficiaries have chronic health problems, and most of them must take prescription drugs over the long term. Out-of-pocket expenses for these drugs are a significant financial burden for beneficiaries with serious illnesses and limited resources, and prescription drug benefits are a major reason for joining Medicare managed care plans.

While Medicare covers some post-acute home health and nursing home services, it accounts for only one in six dollars spent on long-term care services.[11] Medicaid accounts for about two-fifths of long-term care outlays, and most of the remainder is paid directly by beneficiaries. More than half of people age 85 and older require some assistance with everyday activities.[12] Most elderly people who require nursing home care exhaust their savings and must enroll in Medicaid to obtain care. Going on welfare after a lifetime of productive work is demeaning, yet the elderly have few alternatives.

Employers Are Cutting Back on Retiree Health Coverage and Pensions

A popular misperception is that all older people have retiree health coverage to supplement Medicare. This is not the case now, and is likely to be even less true in the future. Currently, 36 percent of Medicare beneficiaries have employer-sponsored health insurance to supplement Medicare.[13] Access to retiree health insurance is available only to those whose previous employer offered coverage and extended this benefit to retirees. The proportion of employers providing retiree health benefits is dropping dramatically, and premium contributions from retirees are rising. In 1988, 44 percent of retirees had health insurance from a previous employer, compared with only 30 percent in 1994.[14] From 1993 to 1994, 30 percent of firms increased retirees' premiums.[15]

The downsizing of American industry has forced more people to retire early, leaving them with more years in old age without earned income and often with responsibility for their own health insurance coverage before Medicare kicks in. A recent survey of the changing American workforce documents a decline in pension coverage, with older women particularly at risk. Without the economic security of income over and above Social Security,

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[10] Congressional Budget Office, *Budgetary Implications of the Balanced Budget Act of 1997*, December 1997.

[11] Harriet L. Komisar, Jeanne M. Lambrew, and Judith Feder, *Medicaid and Long-Term Care for the Elderly: Implications of Restructuring,* The Commonwealth Fund, December 1996.

[12] Hobbs, 1996.

[13] U.S. House of Representatives, February 27, 1997.

[14] U. S. Department of Labor, Pension, and Welfare Benefits Administration, *Retirement Benefits of American Workers: New Findings from the September 1994 Current Population Survey*, Washington, D.C.: U.S. Government Printing Office, 1995.

[15] Foster Higgins, *Highlights: A Monthly Summary of Benefit News*, May 1995.

many older Americans will not be able to absorb health care bills without major financial difficulty.

Low Income Medicare Beneficiaries Are Especially at Risk

Again contrary to popular stereotypes, most Medicare beneficiaries have modest or low incomes. Three-fourths have incomes below $25,000; only 5 percent have incomes above $50,000.[16] About 40 percent of the elderly have incomes below 200 percent of the federal poverty level (in 1997, $7,698 for a single elderly person).[17] Poor, chronically ill beneficiaries are particularly vulnerable; a recent study found that the health of poor diabetics is at risk because they do not have enough to eat.[18] Premiums or out-of-pocket expenses of any magnitude can constitute severe financial problems for even modest income beneficiaries.

Poor and near-poor beneficiaries (below 125 percent of poverty) spend 30 percent of their incomes on health care expenses.[19] Medicaid does not now succeed in protecting even poor Medicare beneficiaries: only about half of this group is enrolled in Medicaid. Almost 16 percent of Medicare beneficiaries either have full Medicaid benefits or subsidies for premiums and cost-sharing.

The Qualified Medicare Beneficiary (QMB) program offers full premium and Medicare cost-sharing subsidies for Medicare beneficiaries with incomes below the federal poverty level, yet only 63 percent of eligible persons participate.[20] The Specified Low Income Medicare Beneficiary (SLMB) program provides premium subsidies for persons living below 120 percent of poverty, yet only 10 percent of those eligible participate.

The BBA increased SLMB eligibility to 133 percent of poverty, but only through 2002. Because funding is capped, the program can offset the full cost of the Part B premium for only about a quarter of the approximately 1.6 million low income people eligible for the improved coverage.[21] More vigorous outreach and adequate ongoing funding are required to assure supplemental coverage for all low income beneficiaries.

As important as QMB and SLMB are, unlike regular Medicaid they do not cover prescription drugs. For those low income beneficiaries with chronic conditions such as arthritis, diabetes, and heart conditions, prescription drug expenses can pose a serious hardship.

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[16] Health Care Financing Administration, *Medicare: A Profile*, February 1995.

[17] E. Baugher and L. Lamison-White, *Poverty in the United States*: *1995*, U.S. Bureau of the Census, P60-194, 1996.

[18] Karin Nelson, Margaret E. Brown, and Nicole Lurie, "Hunger in the Adult Patient Population," *Journal of the American Medical Association* 279 (April 15, 1998):1211-1214.

[19] Moon, Kuntz, and Pounder, December 1996.

[20] Moon, Kuntz, and Pounder, December 1996.

The Sickest Beneficiaries Account for a Disproportionate Share of Expenditures

Averages mask the wide variation in health outlays among Medicare beneficiaries. Both Medicare outlays and out-of-pocket costs are much higher for the sickest 10 percent of beneficiaries: their expenses account for 75 percent of Medicare outlays. In 1996, this 10 percent of beneficiaries averaged $37,000 in Medicare outlays; the healthiest 20 percent incurred no Medicare expenses.[22]

The sickest beneficiaries also spent the most themselves. Their out-of-pocket costs for Medicare-covered services were $5,600; for all health services, their out-of-pocket costs were $8,800. Any increase in cost-sharing would fall disproportionately on these beneficiaries and add to their already considerable financial burden.

The skewed distribution of Medicare outlays is particularly important in terms of Medicare per beneficiary payments to private plans. In 1996, average per beneficiary Medicare spending was $4,754, but four in five beneficiaries incurred less than the average. Managed care capitation payments give plans an enormous incentive to attract healthier patients and to skimp on care for those with serious health problems. Risk adjustment of Medicare capitation payments is important, though state-of-the-art research promises only modest improvements.[23] For example, Medicare outlays within a given condition such as chronic obstructive pulmonary disease are widely skewed as well. It may be necessary to consider a blended approach that combines prospective payments with capitation in order to reduce incentives to deny needed care to the sickest.

Medicare's Transition to Managed Care Has Unknown Implications

The BBA is likely to accelerate enrollment in Medicare managed care plans. The CBO estimates that 39 percent of Medicare beneficiaries will be enrolled in private plans by the year 2007, compared with about 14 percent today.[24] Open enrollment season, to be mounted by the Health Care Financing Administration for the first time in the fall of 1998, will help inform beneficiaries of their options among and within plans. Expansion of the kinds of plans eligible to participate in Medicare may also increase enrollment.

Expanded managed care enrollment is likely to increase Medicare costs, however, rather than reduce them. The best study on the issue finds that the actual cost of serving

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[21] The Commonwealth Fund, *Facts on Medicare and the Balanced Budget Act of 1997*, December 1997.

[22] Marilyn Moon, *Restructuring Medicare's Cost-Sharing*, The Commonwealth Fund, December 1996.

[23] Joseph P. Newhouse, Melinda Beeuwkes, and John D. Chapman, *Risk Adjustment and Medicare,* The Commonwealth Fund, April 1997.

[24] Sandy Christensen, "Memorandum on Medicare+Choice Provisions in the Balanced Budget Act of 1997," Congressional Budget Office, November 12, 1997.

Medicare beneficiaries who opt for health maintenance organization enrollment is 5.7 percent more than Medicare would have paid for these same beneficiaries had they been covered under fee-for-service Medicare coverage. Instead of saving Medicare money, the program loses almost 6 percent for every Medicare managed care enrollee.[25] Managed care plans make money on Medicare beneficiaries by enrolling healthier-than-average patients, yet their administrative costs average 10 to 12 percent, compared with 2 percent for Medicare.[26]

The BBA achieved savings from private plans the same way it achieved savings from prospective payments to fee-for-service providers: by tightening the rate of increase in payments over time. Most plans will receive an annual 2 percent increase. Medicare's payment methods will be modified from 1998 to 2003, including a risk adjustment for health status. The combined effect of the changes will be to reduce Medicare payments to managed care plans about 5 percent relative to Medicare's fee-for-service experience. This adjustment should help correct the historical overpayment of managed care plans, but will also squeeze the availability of supplemental services to Medicare beneficiaries enrolled in managed care plans.

The greater concern with the major changes introduced by the BBA and the projected growth in private plan enrollment, however, is whether private plans will provide quality care to Medicare beneficiaries.[27] Most managed care plans have experience primarily with healthy working families—now it is time for them to become effective at providing quality care to patients with more complex, chronic, and terminal illnesses.

Incentives to provide too little care must be balanced with good quality standards, reporting of quality performance, and enforcement of standards. All of these functions are relatively new responsibilities for the Health Care Financing Administration. The art of quality measurement, reporting, monitoring, and providing clear information to Medicare beneficiaries is rudimentary. Many older beneficiaries may have difficulty understanding and making good choices (e.g., 4 million beneficiaries with Alzheimer's, 1.7 million nursing home patients, 2.4 million terminally ill patients, and 11 million with less than a high school education). Unfortunately, plans have engaged in abuses in marketing products to senior citizens, including during the early years of the Medigap industry, which required strict federal standards, monitoring, and enforcement. Even today, compliance is uneven.[28]

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[25] Kathryn M. Langwell and Laura A. Esslinger, *Medicare Managed Care: Evidence on the Use, Costs, and Quality of Care,* Barents Group, LLC, report to The Commonwealth Fund, May 1997.

[26] U.S. House of Representatives, February 27, 1997.

[27] George Anders, "Medicare's Austerity Eases More Elderly into Frugal HMOs," *The Wall Street Journal*, April 16, 1998.

[28] General Accounting Office, *Medigap Insurance: Insurers' Compliance with Federal Minimum Loss Ratio Standards, 1988-93,* August 12, 1995.

The BBA will require the Health Care Financing Administration to perform major new administrative tasks. Its ability to do so smoothly and effectively with limited resources raises concern.

Medicare Payment Rates Should Be Comparable to the Private Sector

Attention has focused on the slower rate of increase in private sector health outlays in the last few years. It has been assumed that managed care has been the driving force behind the slowdown, which may be the case. But it is also true that the number of privately insured people has declined, and the share of costs paid by workers has increased. Some of the slackening may be attributable to the fact that private coverage is eroding.

Growth in private insurance outlays has also been compared with Medicare outlay growth in recent years. An accurate comparison of the performance of Medicare and private coverage for the working population is difficult, however, because of the age differences in those covered and the variations in benefit packages. Medicare's hospital and physician outlays have grown the most slowly. Home health and nursing home services, rarely covered by private insurance, have grown the most rapidly.

From 1970 to 1995, however, Medicare per beneficiary and private health insurance benefits per capita have grown at comparable rates. From 1993 to 1995, private outlays grew more slowly, but from 1984 to 1991, Medicare grew more slowly.

It is not surprising that private outlays and Medicare outlays—appropriately adjusted for the benefits and people covered—should grow at comparable rates. Over the long term, if Medicare pays less than employers to managed care plans, hospitals, doctors, and other health care providers, beneficiaries cannot expect to receive quality, state-of-the-art care. If Medicare overpays relative to the private sector, it is indirectly subsidizing private employer health plans or leading to windfall provider surpluses.

Rather than continue the somewhat unproductive charges and countercharges about the comparative performance of Medicare and private plans, it is important to monitor closely the relative payments to managed care plans and health care providers. The BBA achieved major savings, primarily from prospective payment limits on fee-for-service providers and private plans. It is not yet clear how these changes will affect provider participation in Medicare, quality of care, and the financial stability of health care providers serving large proportions of Medicare patients.

Medicare prospective payment rates to hospitals and physicians have long been somewhat lower than private sector rates, but without a discernible adverse effect on willingness to participate in Medicare or lower quality services. On the other hand, Medicare

has been overpaying managed care plans by about 6 percent per beneficiary enrolled; therefore, tightening under the BBA should be possible without adverse effects. Some caution has been raised by recent Medicaid managed care experiences: plans have been pulling out or freezing enrollment of Medicaid patients in several states where providers believe they do not receive an adequate payment rate.[29]

Medicare managed care enrollment is heavily concentrated in a few states and in a few managed care plans: five national managed care plans account for half of Medicare HMO enrollment, and two plans typically capture more than 50 percent of states' Medicare market. This dependence of the Medicare program on a limited set of organizations may make it difficult over time to tighten payments without risking access to care for beneficiaries and disrupting important physician-patient relationships.

Conclusion

The work of the commission could not be more important or timely. For more than 30 years, the Medicare program has assured health and economic security for older and disabled Americans. Understanding the strengths of the program and its contributions to improving health outcomes and access to health services is an important foundation on which to build.

Medicare beneficiaries are heterogeneous. Some fit the stereotype of vigorous and well-to-do seniors. But others are older widows living alone, some are in nursing homes, some are terminally ill, and some live on quite modest incomes. These are the faces of Medicare, and they should be kept foremost in mind as new ideas for taking Medicare into the twenty-first century are developed and considered. Modernizing Medicare's benefits—not just looking for savings or shifting costs to beneficiaries—should be an important part of the commission's agenda.

A primary contribution will be helping the American people understand the full range of options available. Accurate projections—not just of Medicare baseline outlays for the next 10 to 25 years but of the effect of changes in benefits, provider payments, and revenues—would be an enormous step forward to clarifying the tough choices ahead. Simulations of how these changes will affect the most vulnerable of Medicare beneficiaries are particularly essential.

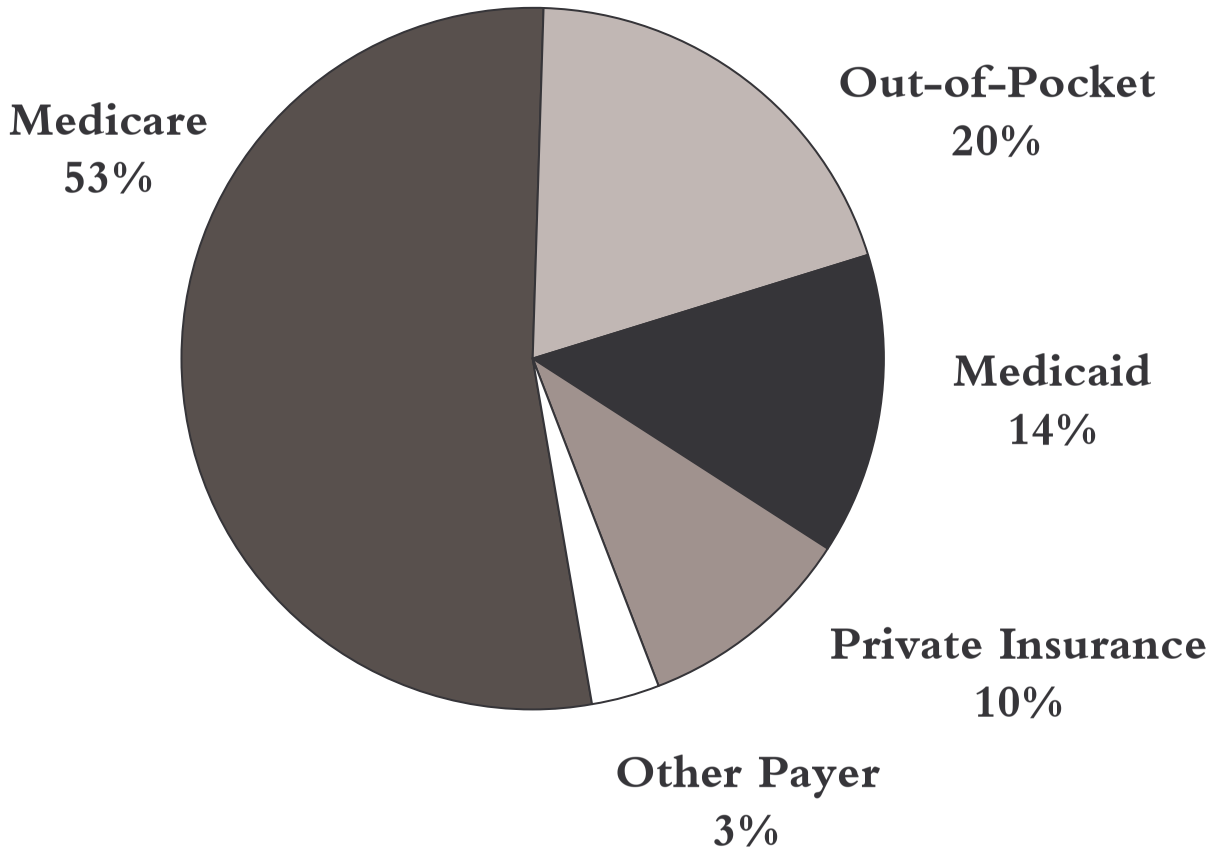
[29] Robert Langreth, "After Seeing Profits from the Poor, Some HMOs Abandon Them," *The Wall Street Journal*, April 7, 1998.

Uncertainty and Medicare Projections

- Biomedical research
- Disability rates declining
- Healthier behavior
- Health system restructuring
- Labor force and productivity trends

THE COMMONWEALTH FUND

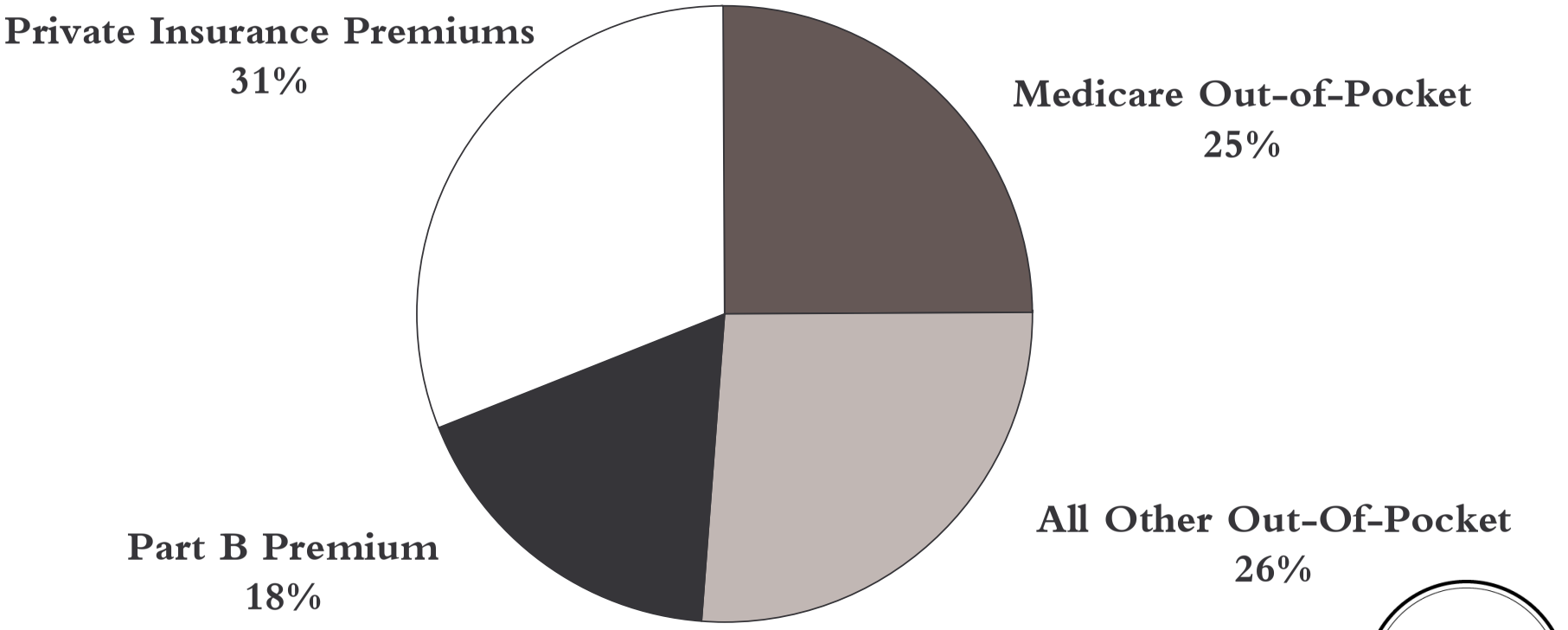
Sources of Payment for Health Care for All Beneficiaries, 1992



Source: Congressional Research Service, 1997.

THE COMMONWEALTH FUND

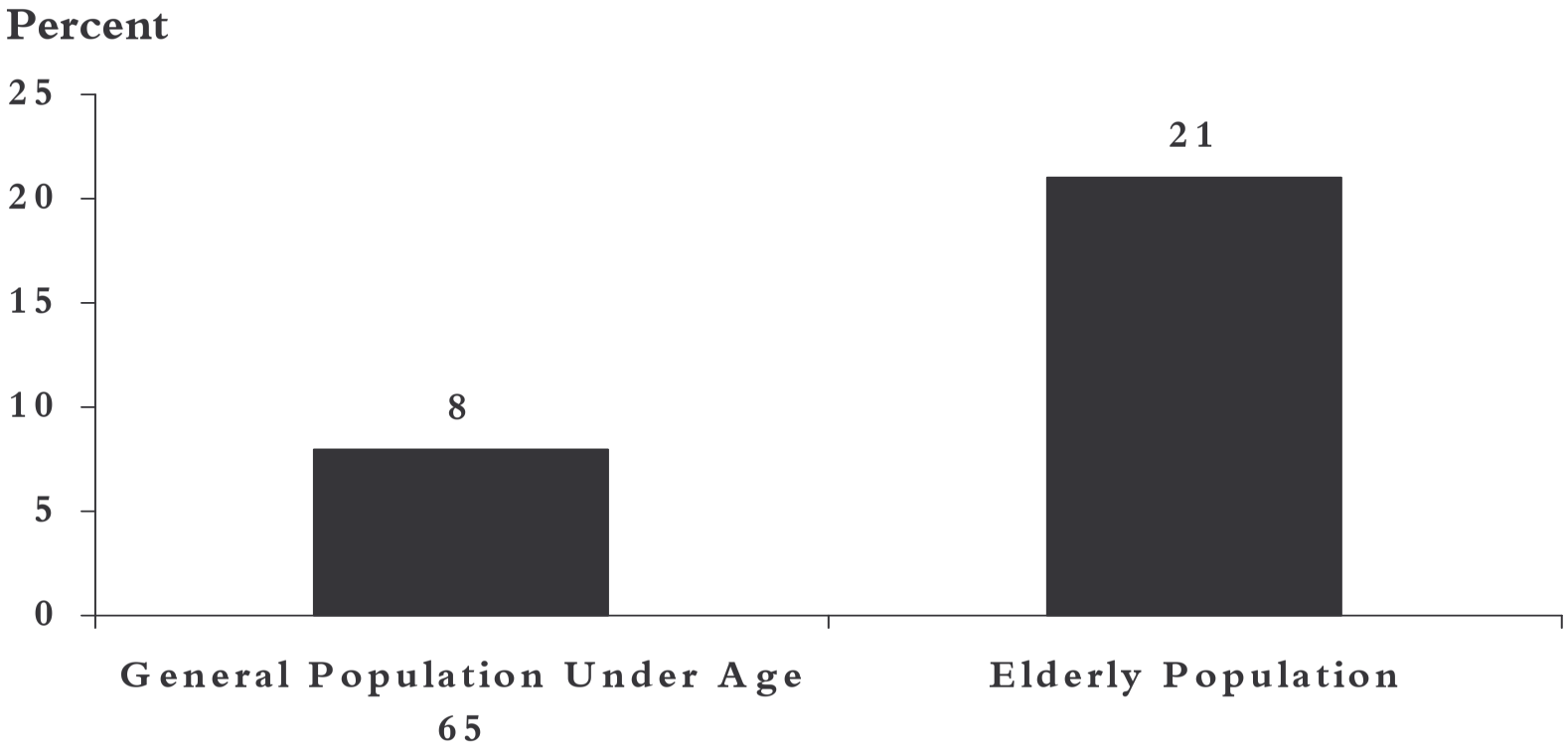
Out-of-Pocket Health Expenditures for the Noninstitutionalized Elderly, 1996
$2,605 per Beneficiary



Source: Marilyn Moon, *Restructuring Medicare's Cost-Sharing*, The Commonwealth Fund, December 1996.

THE COMMONWEALTH FUND

Out-of-Pocket Health Care Spending as a Percentage of Income



Note: Data are for noninstitutionalized population only.

Source: Estimate for population under age 65 is for 1994, based on 1994 data from the American Association of Retired Persons; estimate for elderly from M. Moon, C. Kuntz, and L. Pounder, *Protecting Low-Income Medicare Beneficiaries,* The Commonwealth Fund; November 1996 (based on 1987 data from the National Medical Expenditure Survey, updated to 1996).

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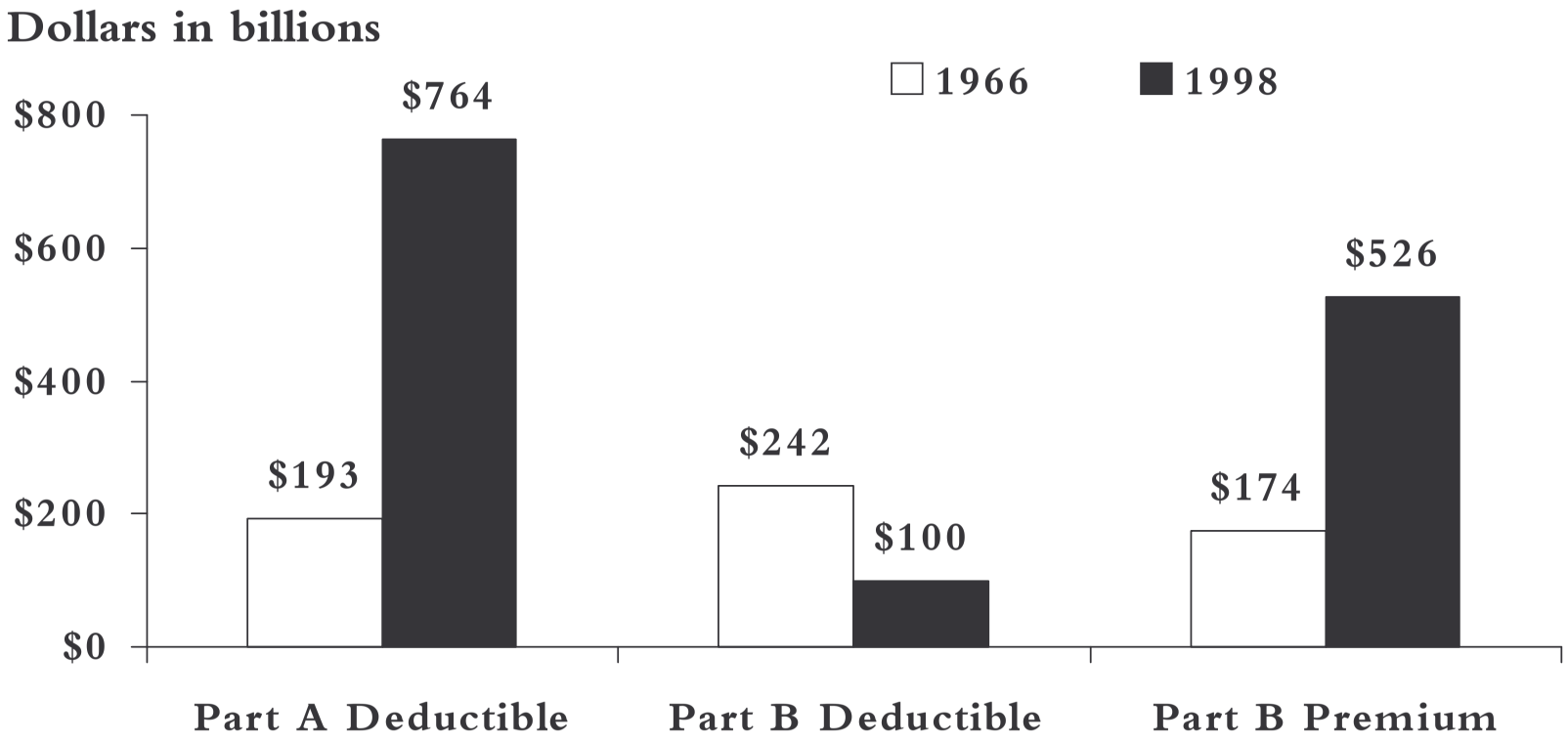
Medicare Cost Sharing, 1966 and 1998 (in 1997 dollars)



Source: Calculated by Karen Davis, based on U.S. House of Representatives, Committee on Ways and Means, *1996 Green Book*.

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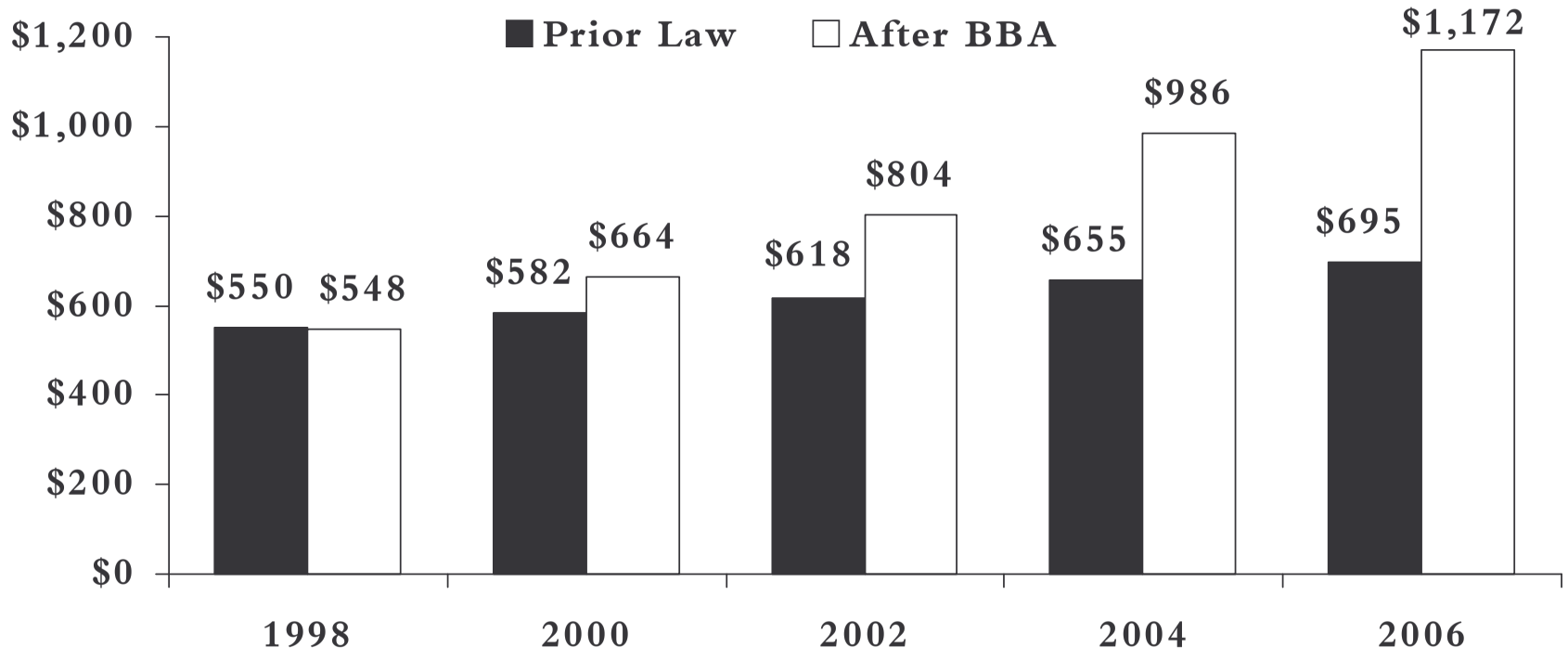
Projected Medicare Part B Yearly Premiums, 1998–2006



Source: Congressional Budget Office, *Budgetary Implications of the Balanced Budget Act of 1997,* December 1997.

THE COMMONWEALTH FUND

Medicare Beneficiaries with Prescription Drug Expenses

- 77% of Medicare beneficiaries take prescription drugs on a regular basis
- 11% of Medicare beneficiaries spend more than $100 a month out-of-pocket on prescription drugs
- Better benefits/lower premiums are a major reason Medicare beneficiaries join HMOs

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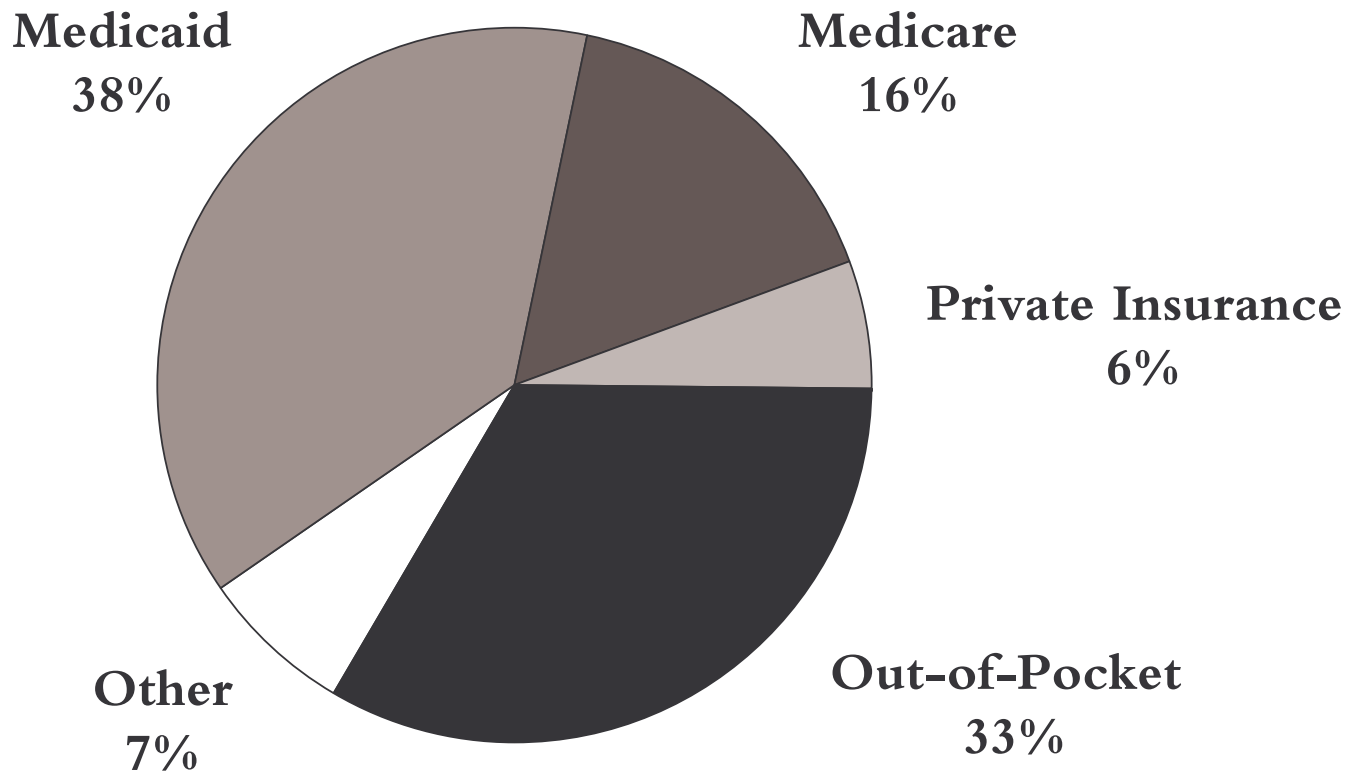
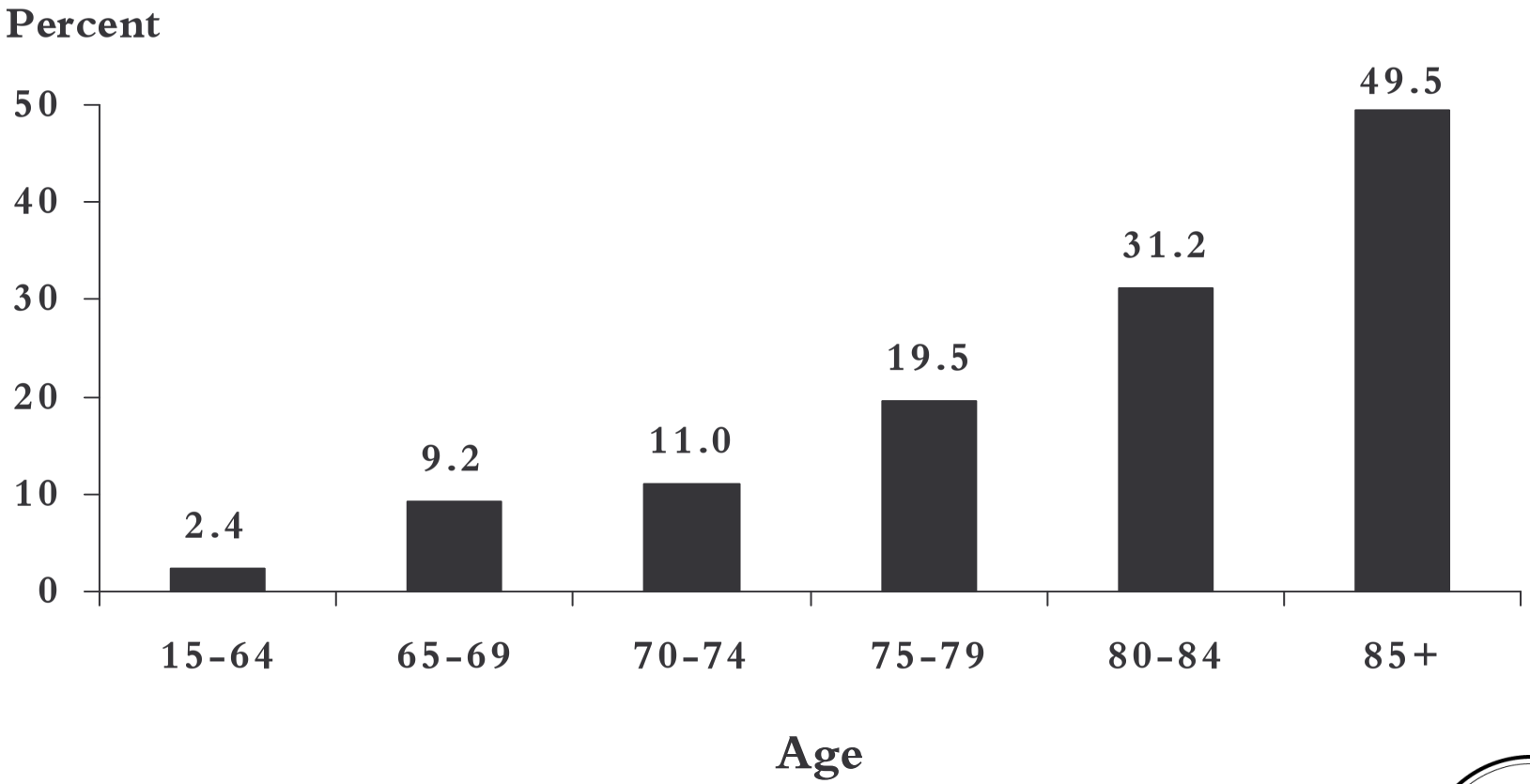
Long-Term Care Expenditures by Payer, 1994



Source: Harriet L. Komisar, Jeanne M. Lambrew, and Judith Feder, *Medicaid and Long-Term Care for the Elderly,* The Commonwealth Fund, December 1996.

THE COMMONWEALTH FUND

Percent of Persons Needing Assistance with Everyday Activities by Age, 1991

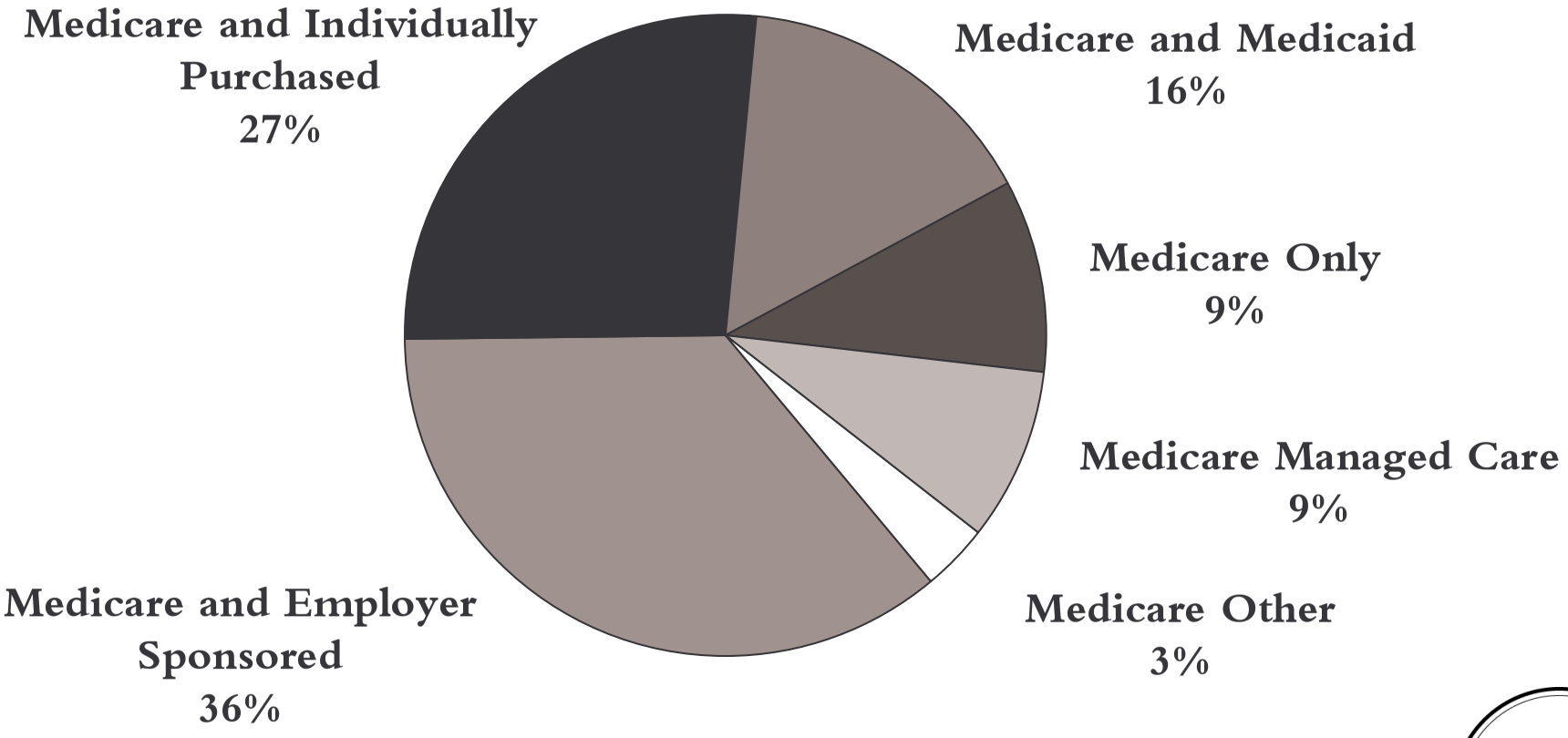


Note: SIPP data is for persons 15 years and older in the civilian, noninstitutional population.

Source: U.S. Bureau of the Census, 1990 and 1991 panels of the Survey of Income and Program Participation (SIPP) files.

THE COMMONWEALTH FUND

Sources of Health Insurance for Medicare Beneficiaries, 1994



Source: Congressional Research Service, 1997.

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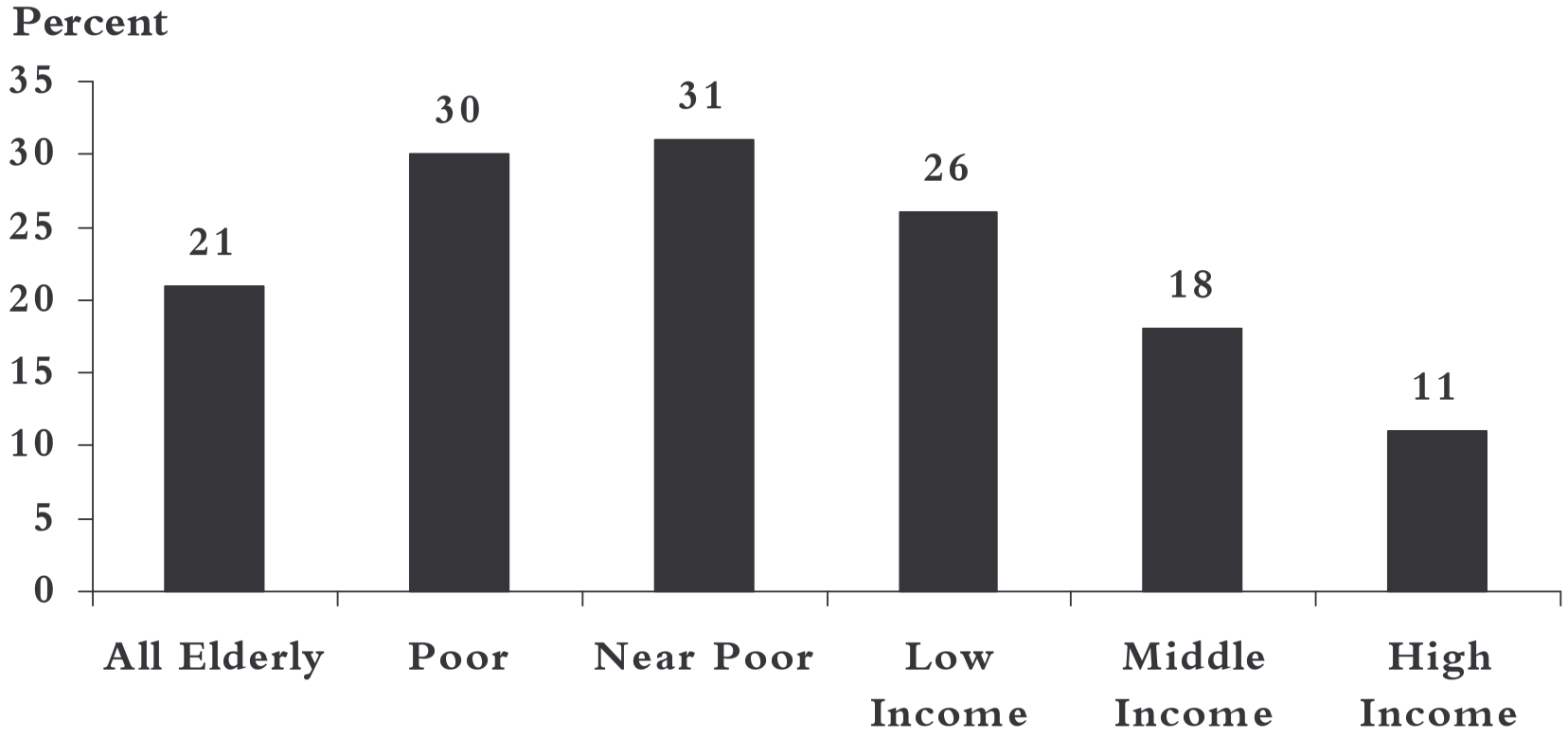
Out-of-Pocket Health Spending by the Noninstitutional Elderly as a Percent of Family Income, 1996



Poverty status definitions: poor = <100% of poverty; near poor = 100%-125%; low income = 125%-200%; middle income = 200%-400%; and high income = 400%+

Source: Marilyn Moon, *Protecting Low-Income Medicare Beneficiaries,* The Commonwealth Fund, December 1996.

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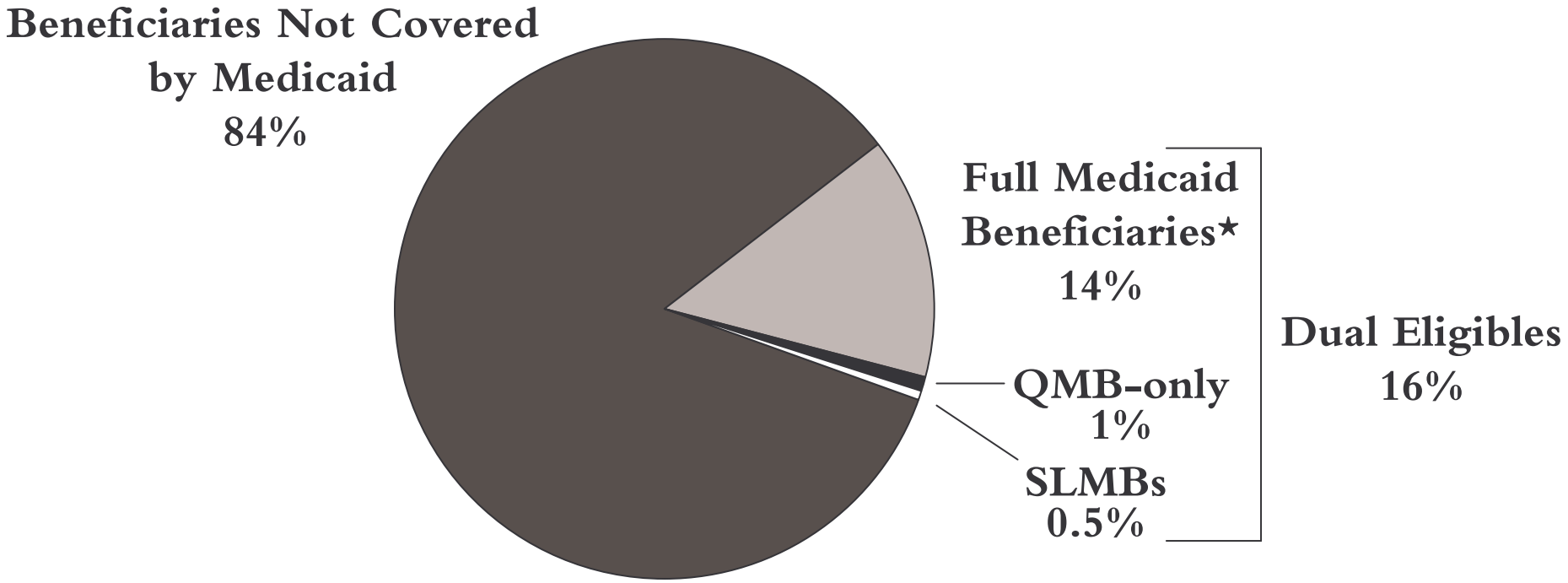
Distribution of Medicare Beneficiaries, by Medicaid Eligibility, 1995



Total Medicare Beneficiaries, 1995 = 37.7 million

*Most full Medicaid beneficiaries are QMBs.
Note: QMBs = Qualified Medicare Beneficiaries; SLMBs = Specified Low-Income Medicare Beneficiaries.
Source: Based on data from Alliance for Health Reform, *Managed Care and Vulnerable Americans: Medicare and Medicaid Dual Eligibles,* March 1997.

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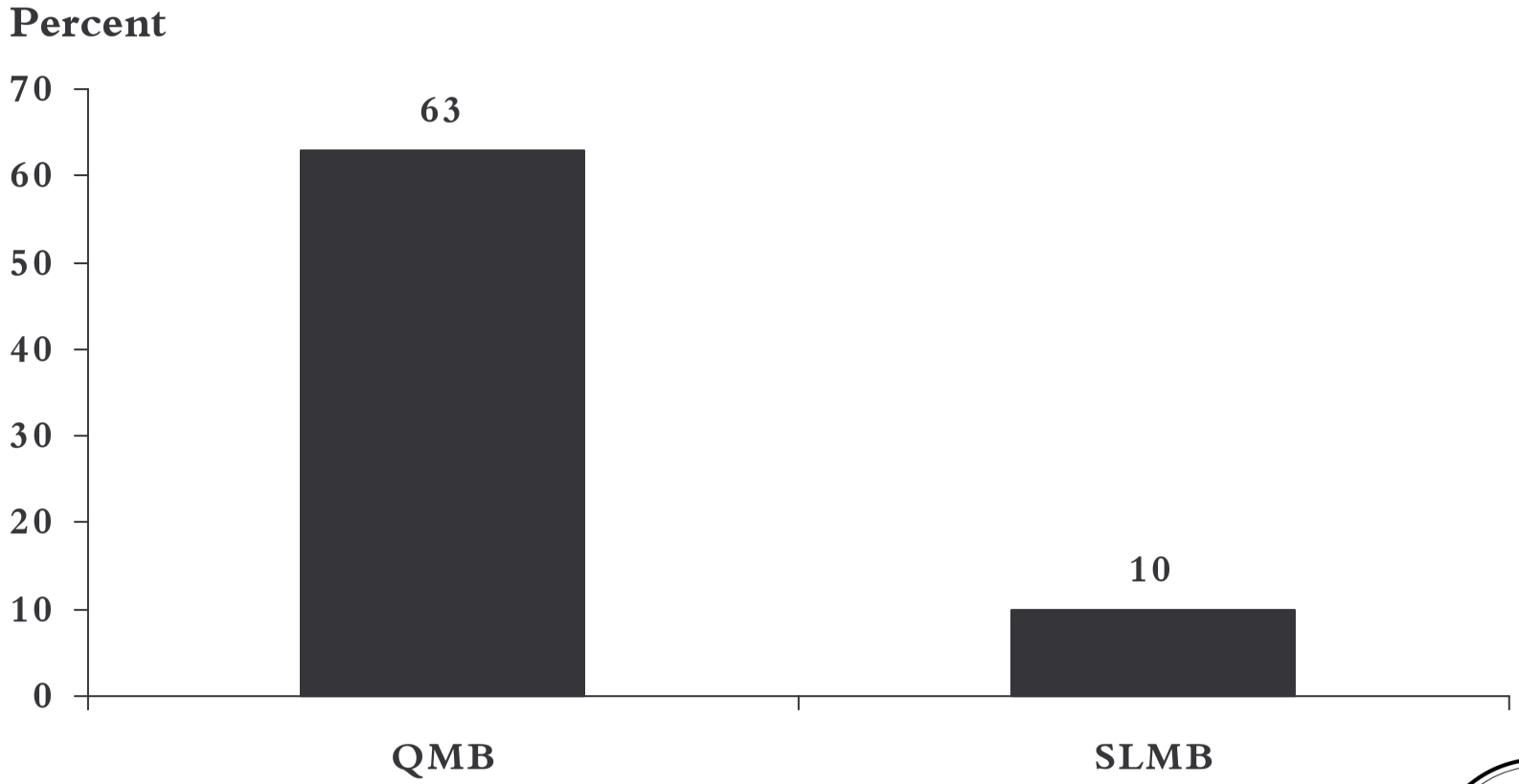
Participation in Qualified Medicare Beneficiary (QMB) and Specified Low-Income Medicare Beneficiary (SLMB) Programs, 1990



Source: Marilyn Moon, *Restructuring Medicare's Cost-Sharing*, The Commonwealth Fund, December 1996.

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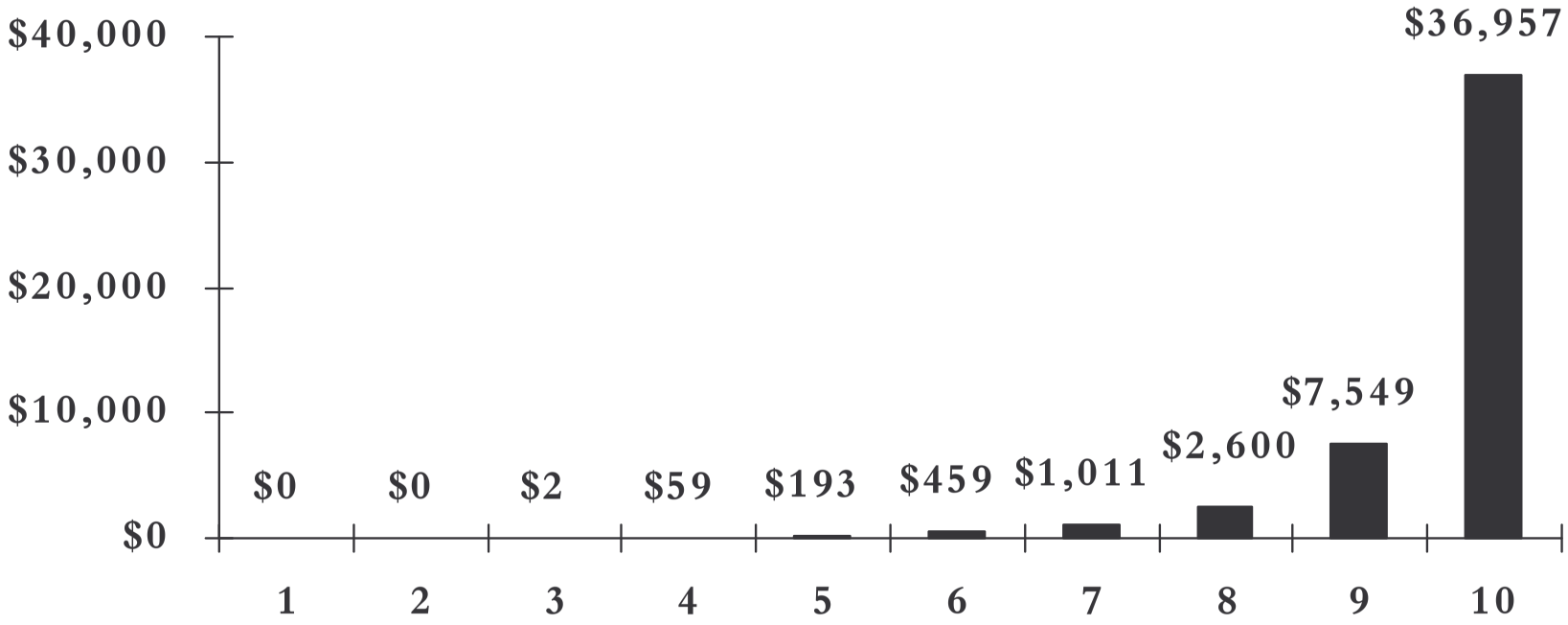
Average Medicare Spending per Beneficiary by Decile, 1996
Four in five beneficiaries incur less than the average $4,753 cost



Source: Marilyn Moon, *Restructuring Medicare's Cost-Sharing,* The Commonwealth Fund, December 1996.

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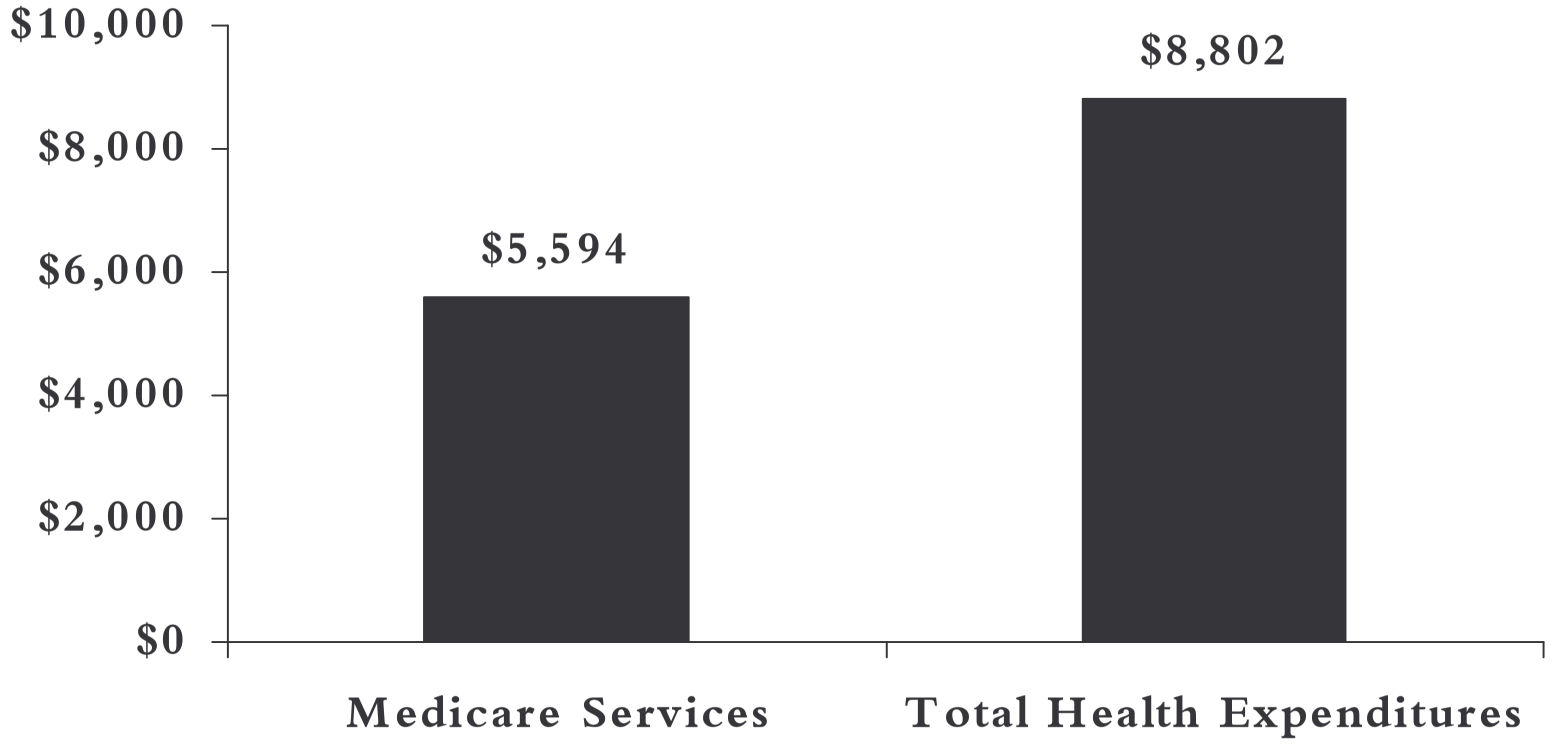
Out-of-Pocket Expenditures per Beneficiary for 10 Percent Most Costly Beneficiaries, 1996



Source: Marilyn Moon, *Restructuring Medicare's Cost-Sharing*, The Commonwealth Fund, December 1996.

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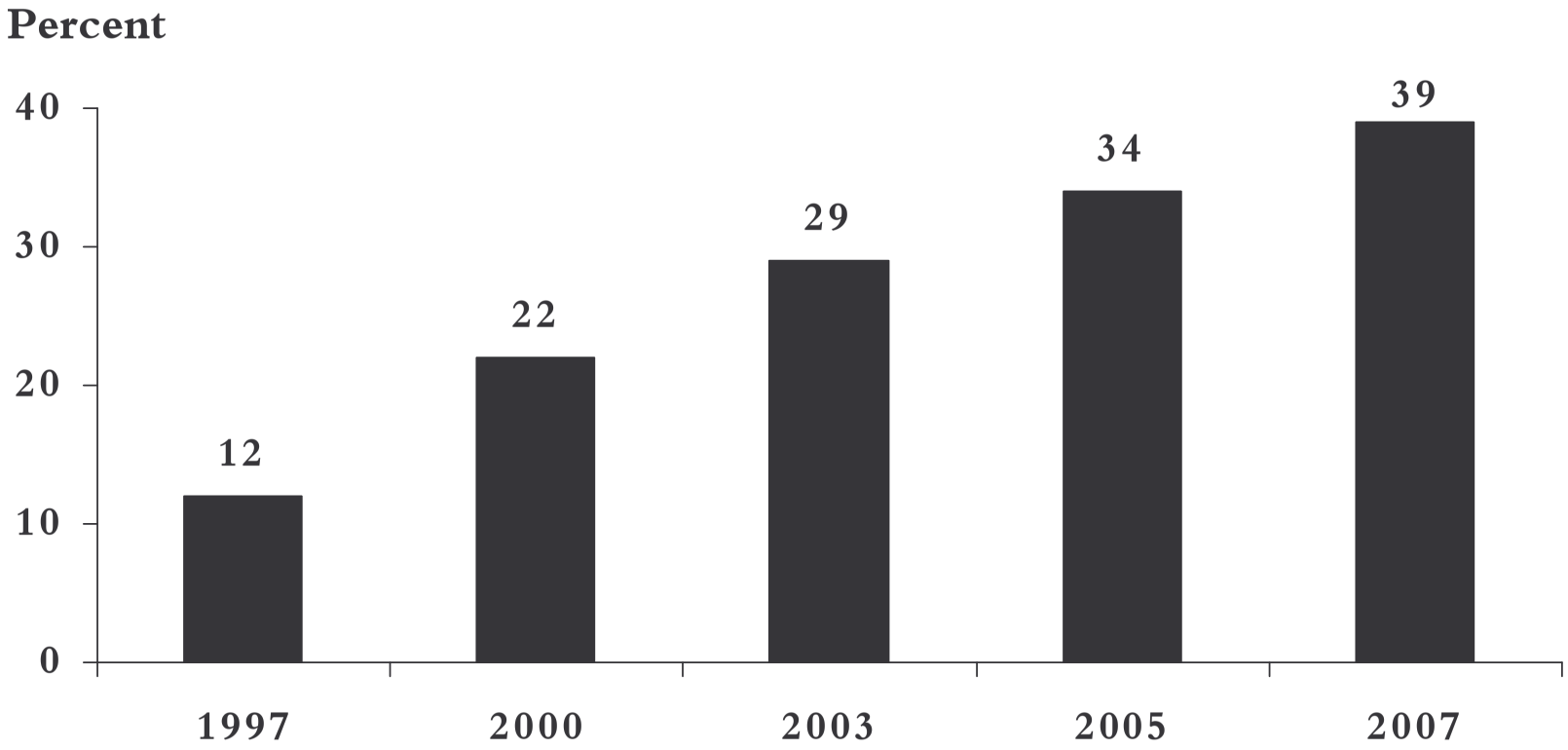
Projected Medicare Private Plan Enrollment, 1997-2007



Source: Sandy Christensen, Memorandum on Medicare+ Choice Provisions in the Balanced Budget Act of 1997, Congressional Budget Office, November 12, 1997.

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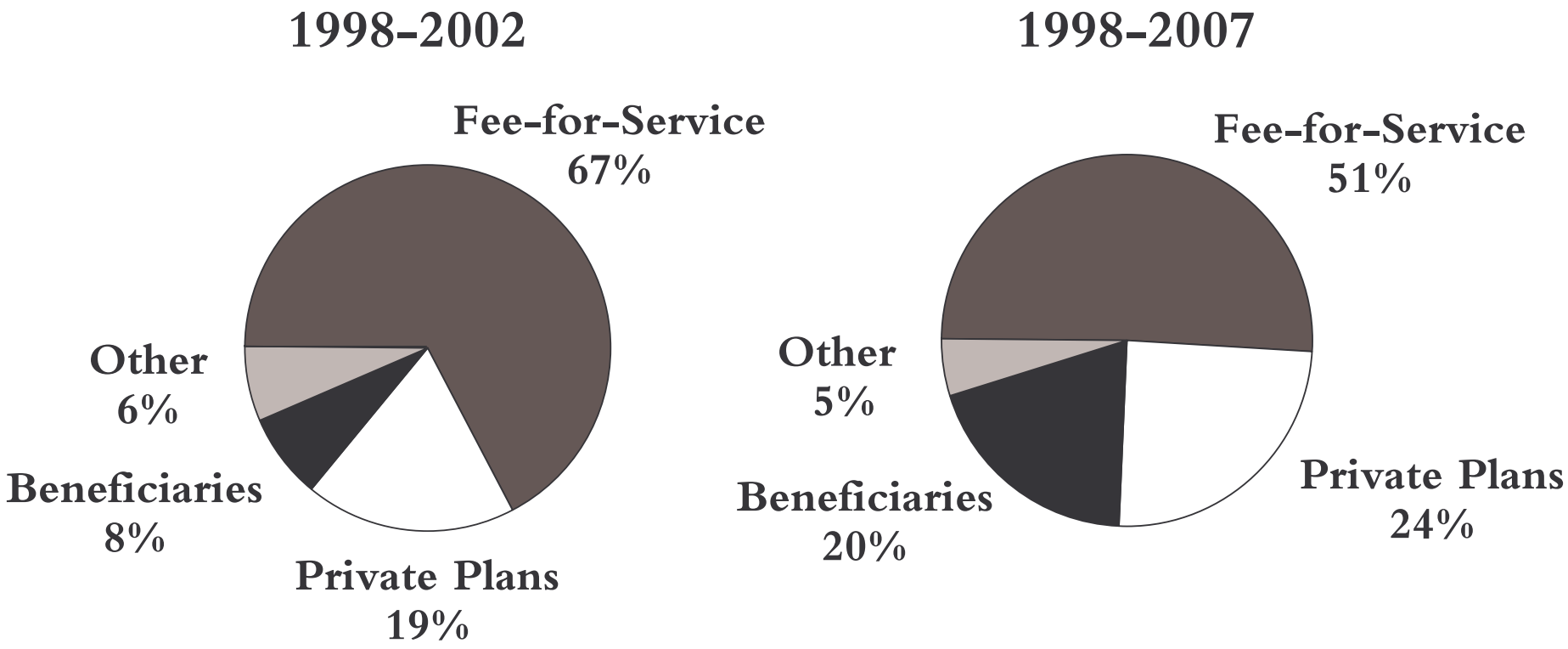
Sources of Medicare Savings, 1998–2002 and 1998–2007



Savings = $116 billion

Savings = $394 billion

Source: Marilyn Moon, et al. *An Examination of Key Medicare Provisions in the Balanced Budget Act of 1997,* The Commonwealth Fund, September 1997.

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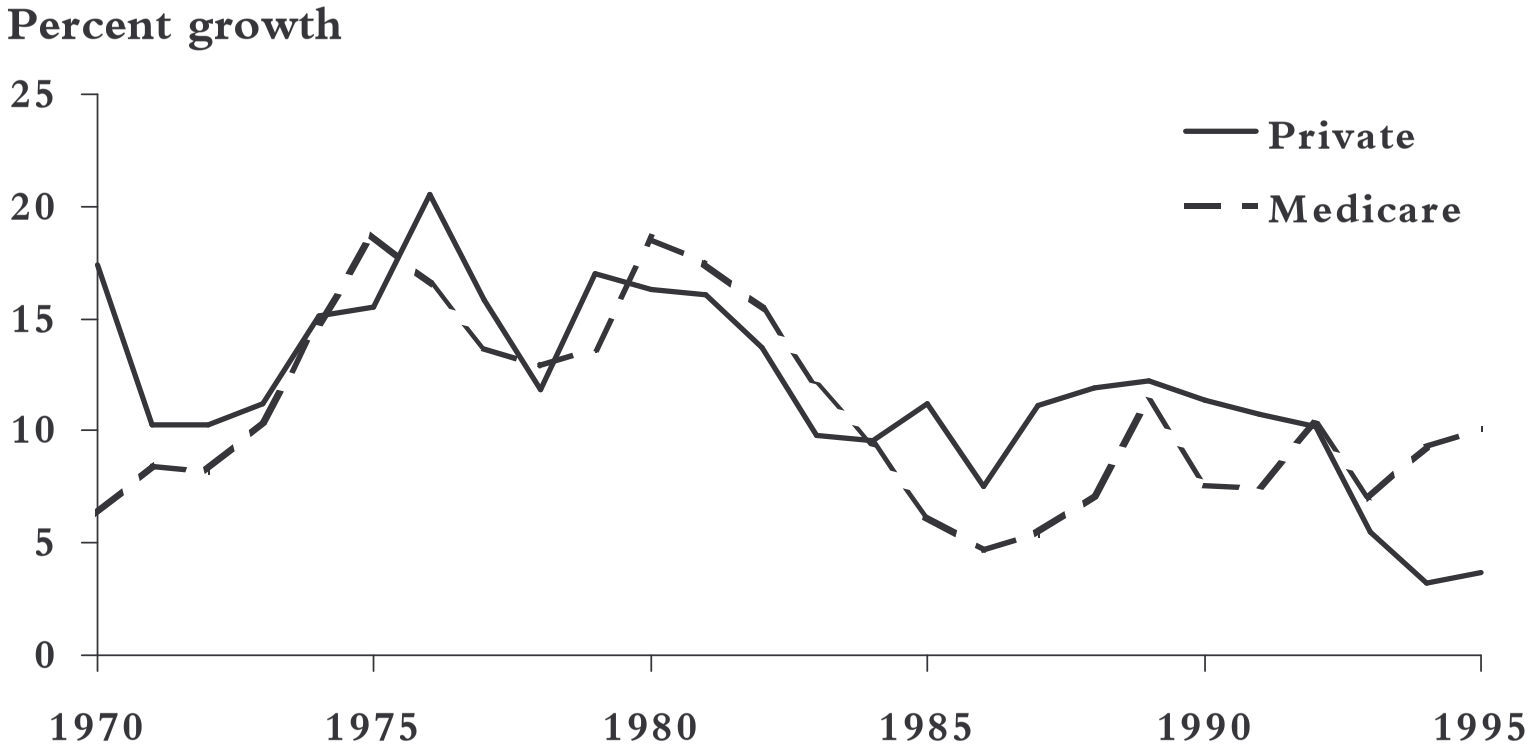
Growth in Medicare and Private Health Insurance Benefits Per Enrollee, Calendar Years 1970–1995



Source: Health Care Financing Administration, Office of the Actuary, data from the Office of National Health Statistics.

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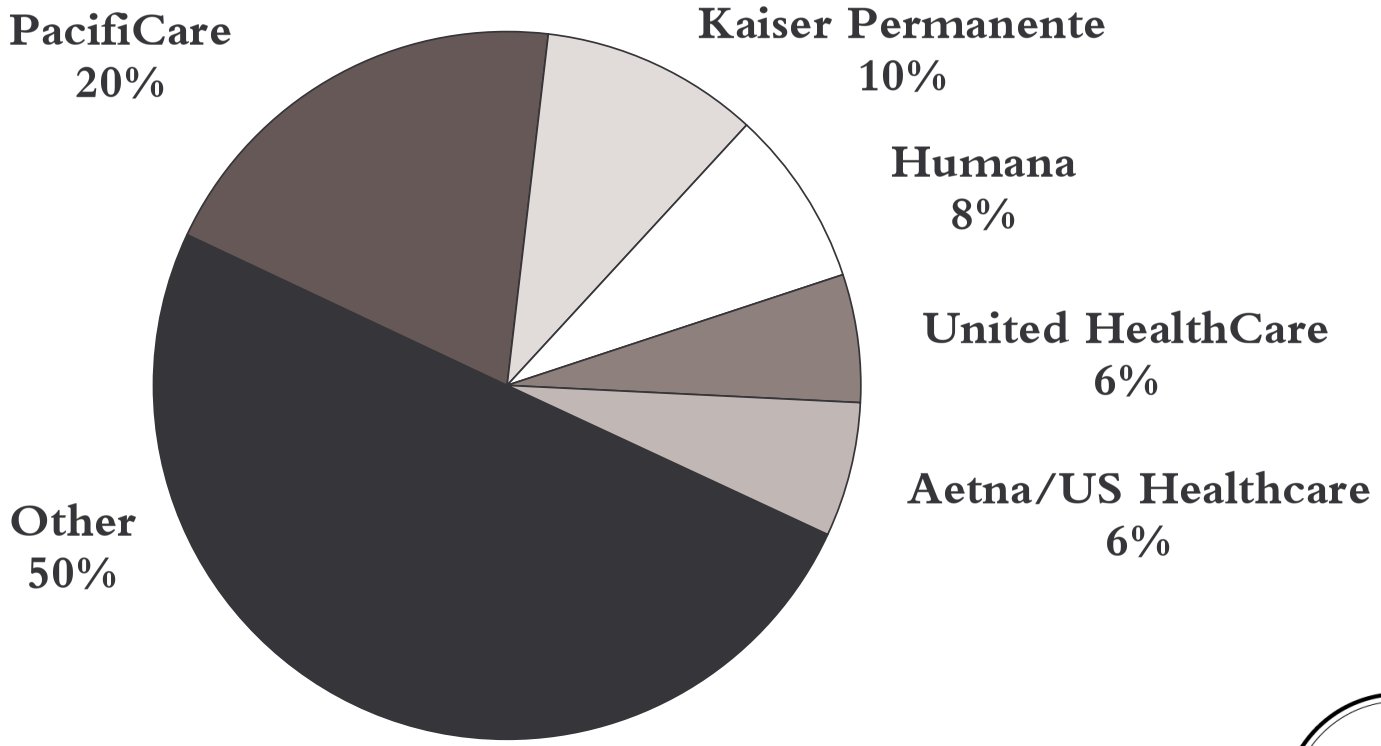
Medicare Risk Enrollment
Half of the Risk Market is Enrolled in the Five Largest Plans, 1997

(Total Risk Enrollment = 5 million)



Source: Health Care Financing Administration, September 1997.

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Medicare: Future Challenges

- **Protecting Medicare's Poor**
- **Need to Improve Benefits**

  --Reduced Beneficiary Cost-Sharing
  --Prescription Drugs
  --Long-Term Care
- **Extending Medicare to Older Adults**
- **Making Managed Care Work for Medicare Beneficiaries**
- **Assuring Medicare's Future Fiscal Solvency**

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