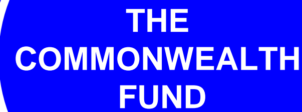

Medicare at 40+: Current Trends and Future Prospects

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Medicare's Accomplishments

- Medicare has improved access to care and financial security for 43 million beneficiaries
  - Before Medicare, about half of all Americans over age 65 had no health insurance
  - Medicare effectively ended racial segregation in hospitals
- Medicare beneficiaries are highly satisfied with their coverage and feel confident in their ability to obtain care

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Profile of Medicare Elderly Beneficiaries and Employer Coverage Nonelderly, by Poverty and Health Problems

Note: Respondents with undesignated poverty were not included; lower income defined as ≤200% of poverty; health problems defined as fair or poor health, any chronic condition (cancer, diabetes, heart attack/disease, and arthritis), or disability .

Source: The Commonwealth Fund Biennial Health Insurance Survey (2003).

Access Problems Because of Cost

Percent of adults who had any of four access problems* in past year due to cost

	Percent
Ages 19–64	39
Ages 65+	17^
Medicare, 65+	15
Employer, 19–64	34^
Individual, 19–64	39^
Medicaid, 19–64	40^
Medicare, 19–64	35^
Uninsured, 19–64	61^

Note: Adjusted percentages based on logistic regression models; age groups controlled for health status and income; insurance status controlled for health status, income, and prescription coverage.

*Did not fill a prescription; did not see a specialist when needed; skipped medical test, treatment, or follow-up; did not see doctor when sick.

^ Significant difference at p≤.01 or better; referent categories are "ages 19–64" and "Medicare 65+".

Source: The Commonwealth Fund Biennial Health Insurance Survey (2003).

Impact of Medicare Coverage on Receipt of Preventive Care

After older adults became eligible for Medicare at age 65, existing disparities in screening between those who were previously insured and those who were previously uninsured were greatly reduced, but not eliminated. Screening increased for tests that are recommended based on evidence for their effectiveness, such as cholesterol testing and mammography, and for services that have not been proven effective at improving health outcomes, such as prostate exams.

Among near-elderly adults ages 60–64 in 1996 who became eligible for Medicare at age 65 in the year 2000, percentage who reported receiving screening tests

		Received test before Medicare eligibility (1996)	Received test after Medicare eligibility (2000)
Uninsured before Medicare*	Cholesterol testing	41	65
	Mammography (women)	46	67
	Prostate exam (men)	29	61
Insured before Medicare*	Cholesterol testing	76	83
	Mammography (women)	76	82
	Prostate exam (men)	74	81

Source: Health and Retirement Study (McWilliams et al. 2003). *Results are shown only for individuals who were continuously uninsured in both 1994 and 1996 or continuously insured in both 1994 and 1996. Results are not shown for those who were intermittently uninsured (uninsured in 1994 or 1996 but not both).

Rating of Current Insurance

Percent of adults who rated their current insurance as “excellent” or “very good”

	Ages 19–64	Ages 65+	Medicare, 65+	Employer, 19–64	Individual, 19–64	Medicaid, 19–64	Medicare, 19–64
Percent	47	64^	68	44^	41^	54^	52^

Note: Adjusted percentages based on logistic regression models; age groups controlled for health status and income; insurance status controlled for health status, income, and prescription coverage.

^ Significant difference at p≤.01 or better; referent categories are “ages 19–64” and “Medicare 65+”.

Source: The Commonwealth Fund Biennial Health Insurance Survey (2003).

Satisfaction With Quality of Care

Percent of adults who were "very" or "somewhat satisfied" with the quality of care they received in the past 12 months

Group	Percent
Ages 19–64	75
Ages 65+	85^
Medicare, 65+	87
Employer, 19–64	81^
Individual, 19–64	79^
Medicaid, 19–64	87
Medicare, 19–64	80
Uninsured, 19–64	48^

Note: Adjusted percentages based on logistic regression models; controlling for health status, income, and prescription coverage.

^ Significant difference at p≤.05 or better; referent categories are "ages 19–64" and "Medicare 65+".

Source: The Commonwealth Fund Biennial Health Insurance Survey (2003).

Confidence in Future Care

Percent of adults who were "very" or "somewhat confident" they will get best medical care available when they need it

	Ages 19–64	Ages 65+	Medicare, 65+	Employer, 19–64	Individual, 19–64	Medicaid, 19–64	Medicare, 19–64	Uninsured, 19–64
Percent	67	77^	80	70^	72	74	74	48^

Note: Adjusted percentages based on logistic regression models; age groups controlled for health status and income; insurance status controlled for health status, income, and prescription coverage.

^ Significant difference at p≤.01 or better; referent categories are "ages 19–64" and "Medicare 65+".

Source: The Commonwealth Fund Biennial Health Insurance Survey (2003).

…Yet Concerns Remain

- Although Medicare spending growth has been about the same as private insurance, it is claiming an increasing share of the federal budget
- Out-of-pocket spending can be burdensome, especially for beneficiaries with lower incomes
- There is wide variation across the country in spending per beneficiary and the quality of care—but not generally in the same direction
- Medicare is oriented toward acute care needs, while an increasing number of beneficiaries have multiple chronic conditions

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Percent Annual Per Enrollee Growth in Medicare Spending and Private Health Insurance and FEHBP Premiums for Common Benefits

Medicare | Private Health Insurance | FEHBP*

Percent

	Medicare	Private Health Insurance	FEHBP*
1969–2003	9.0	10.1	9.6
1999–2003	5.9	8.8	10.7

* FEHBP estimates are for 1969–2002 and 1999–2002 from Levit et al., “Health Spending Rebound Continues in 2002,” *Health Affairs,* Jan/Feb 2004.

Source: Analysis by Office of the Actuary, Centers for Medicare and Medicaid Services, January 2005.

Projections of Federal Expenditures As a Percentage of GDP

Percent of GDP

Social Security | Medicare | Federal Share of Medicaid

30
25
20
15
10
5
0

27.5
5.3
15.9
6.3

22.3
4.0
12.1
6.2

17.4
2.8
8.7
5.9

12.7
2.1
5.7
4.9

9.4
1.6
3.7
4.1

7.7
1.4
2.2
4.1

2002 | 2010 | 2020 | 2030 | 2040 | 2050

Source: Congressional Budget Office (2003), *The Long-Term Budget Outlook (Supplemental Tables)*, Available at http://www.cbo.gov/showdoc.cfm?index=4916&sequence=0 as reported in R. Friedland and L. Summer, *Demography Is Not Destiny, Revisited*, The Commonwealth Fund, March 2005.

Racial and Ethnic Disparities in Chronic Care Management

Among Medicare beneficiaries enrolled in managed care plans, blacks were less likely than whites to receive recommended chronic care services and achieve good outcomes. Hispanics, Asian Americans, and Native Americans were less likely than whites to receive some services but equally or more likely to receive other services or achieve good outcomes.

Percentage of Medicare managed care plan members who received services or achieved outcomes in 1999

	White	Black	Asian	Hispanic	Native American
Beta-blocker after heart attack	89	83	90	88	
Diabetes Hemoglobin A1c testing	80	75	84	79	77
High blood pressure controlled	36	32	42	39	50
Effective acute-phase antidepressant treatment*	60	49	41	58	
Follow-up in 30 days after hospitalization for mental illness	60	42	54	53	

Source: Analysis of HEDIS by Virnig et al. (2002; 2004). Numbers for Native Americans were too small to report for some measures. "Other" race omitted for clarity. *Those newly diagnosed with depression, prescribed an antidepressant, and who continued using an antidepressant during the 12-week acute-treatment phase.

Projected Out-of-Pocket Spending As a Share of Income Among Groups of Medicare Beneficiaries, 2000 and 2005

Out-of-pocket as percent of income

	2000	2025
Beneficiaries age 65+	21.7	29.9
Beneficiaries with physical or cognitive health problems and no other health insurance	44	63.3
Disabled beneficiaries ages 45–65	29.1	41.1
Beneficiaries ages 65–74 with high incomes*	8.9	7.8
Female beneficiaries age 85+ with physical or cognitive health problems and low incomes^	51.6	71.8

* Annual household incomes of $50,000 or more.

^ Annual household incomes of $5,000 to $20,000.

Source: S. Maxwell, M. Moon, and M. Segal, *Growth in Medicare and Out-of-Pocket Spending: Impact on Vulnerable Beneficiaries,* The Commonwealth Fund, January 2001 as reported in R. Friedland and L. Summer, *Demography Is Not Destiny, Revisited*, The Commonwealth Fund, March 2005.

Variation in Annual Total Cost and Quality for Chronic Disease Patients

Quality of Care* and Medicare Spending for Beneficiaries with Three Chronic Conditions, by Hospital Referral Region

Best Practice Curve

Ft. Lauderdale, FL
East Long Island, NY
Orange County, CA
Manhattan, NY
A
Greenville, NC
B
Saginaw, MI
C
Melrose Park, IL
Boston, MA
D
Newark, NJ

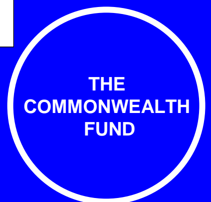
Median Amount Spent per Patient per HRR = $28,694

Average Quality of Care Score: 0.00, 0.20, 0.40, 0.60, 0.80, 1.00, 1.20, 1.40, 1.60

Average Annual Reimbursement per Beneficiary (Wage-Index Adjusted): $-, $10,000, $20,000, $30,000, $40,000, $50,000, $60,000, $70,000, $80,000, $90,000

* Based on percent of beneficiaries with three conditions (diabetes, chronic obstructive pulmonary disease, and congestive heart failure) who had a doctor's visit four weeks after hospitalization, a doctor's visit every six months, annual cholesterol test, annual flu shot, annual eye exam, annual HbA1C test, and annual nephrology test.

Source: G. Anderson and R. Herbert for The Commonwealth Fund, Medicare Standard Analytical File 5% 2001 data.



Two-Thirds of Medicare Spending is for People With Five or More Chronic Conditions

No chronic conditions 1%

1-2 chronic conditions 10%

3 chronic conditions 10%

4 chronic conditions 13%

5+ chronic conditions 66%

Source: G. Anderson and J. Horvath, *Chronic Conditions: Making the Case for Ongoing Care* (Baltimore, MD: Partnership for Solutions, December 2002)

Current Policy Issues

- Prescription Drug Benefit
  - Monitoring implementation
  - Enrollment of low-income beneficiaries
  - Coordinating coverage with States
  - Impact on most vulnerable beneficiaries
  - Ensuring quality and effectiveness

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Current Policy Issues

- Improving Quality and Efficiency
  - Measuring, reporting, and paying for performance
  - Enhancing efficiency
  - Promoting adoption of health information technology
  - Incorporating chronic care management approaches

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Current Policy Issues

- Medicare Advantage
  - Level of payment
  - Risk adjustment
  - Impact on beneficiaries
  - Coordination of care for those with special needs
  - Quality improvement

Policy Options for Medicare's Future

- Expanded coverage for older adults and disabled
- Providing a Medicare Extra alternative to Medigap
- Using Medicare's purchasing power to leverage health system performance
- Improving care coordination and high cost case management

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Conclusion

- Medicare has served beneficiaries well for 40 years
- Medicare is likely to face fiscal strains in the years ahead as the baby boomers retire
- Medicare today is undertaking the most extensive changes in its history
- There are several policy options that could make Medicare more effective in achieving its mission in the future

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