

CHAPTER

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**Setting a context for  
Medicare spending**

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## Setting a context for Medicare spending

**I**n December 2003, the Congress enacted a major Medicare reform bill, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). The MMA will address a major gap in the benefit package by establishing a prescription drug benefit in 2006.

Medicare spending is growing and was already expected to take up an increasingly large share of the federal budget, requiring policymakers to make difficult trade-offs between Medicare spending, beneficiaries' concerns, and other national priorities. Enactment of the MMA will further increase Medicare spending.

This chapter establishes a financial context for evaluating the payment updates recommended in subsequent chapters. The statistical evidence we offer predates passage of the MMA, but it provides a useful baseline for assessing the financial circumstances of the Medicare program.

In addition to finding that Medicare spending is likely to put increasing fiscal pressure on the federal budget, we find that many beneficiaries are paying larger amounts out of pocket. Moreover, some have few options to obtain comprehensive supplemental insurance coverage for services not covered by Medicare. The absence of supplemental insurance tends to impede access to care. Under the MMA, however, the current design, types, and availability of supplemental insurance may change. We will monitor the extent to which these changes occur.

### In this chapter

- Medicare spending growth
- Beneficiary spending: patterns and implications
- Beneficiaries' perception of their access to care

The Congress has charged MedPAC with assessing the design and implementation of Medicare policy and making recommendations to the Congress to address any problems it identifies. In carrying out these responsibilities, MedPAC examines whether Medicare’s payment policy supports the ultimate goal of the program: ensuring that its beneficiaries have access to medically necessary care of high quality in the most appropriate clinical setting, without imposing undue financial burdens on beneficiaries and taxpayers.

This charge requires that we evaluate not only the technical aspects of Medicare policy, but also the trends in Medicare spending, trends in beneficiaries’ health care spending, and trends in beneficiaries’ access to care.

This chapter finds that growth in Medicare spending continues to outpace economic growth and will likely place significant strain on beneficiaries and the federal budget if it continues unabated. Measured over longer periods of time, Medicare’s growth has been comparable with (albeit somewhat lower than) that of other health care spending because many of the same factors—such as advances in technology and increases in service use—put upward pressure on all payers.

In order to stem growth in spending, many private payers are requiring their enrollees to shoulder a larger share of premiums and pay more cost sharing. To the extent that increases in cost sharing occur in individually purchased or employer-sponsored Medicare supplements, this trend may also affect Medicare beneficiaries.

For certain beneficiaries, we find that fewer comprehensive supplemental insurance options are available. Erosion or elimination of supplemental insurance is a concern because it could adversely affect access to care. However, beneficiary surveys about access to care are reassuring: the majority of beneficiaries report satisfactory access to care. Nevertheless, the Commission remains vigilant about monitoring access for those who report more difficulty.

## Medicare spending growth

Medicare spending has grown rapidly since the Congress established the program. In this section we examine:

- the extent that patients have benefitted from this growth and whether the growth is sustainable;
- how much Medicare spends by type of service and how quickly Medicare is expected to grow in the future; and

- how growth in Medicare spending compares to spending by private insurers and other public-sector entities

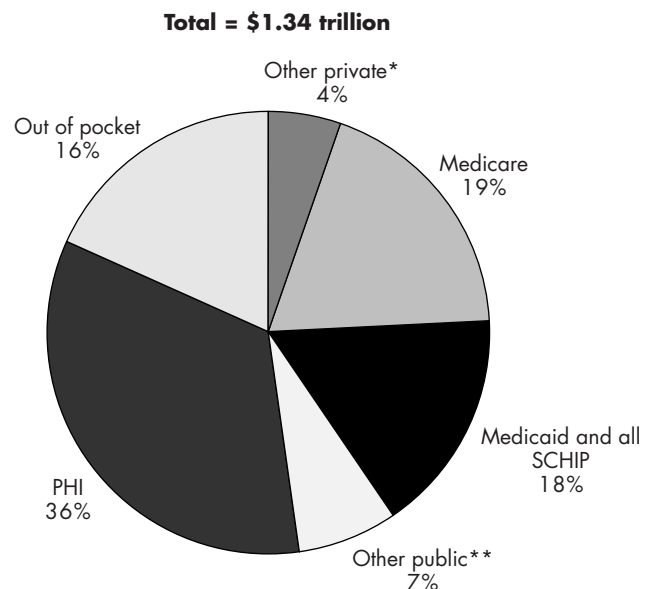
## The sustainability and benefit of future growth in Medicare spending

Medicare spending totaled about \$272 billion in 2003, or \$6,880 per enrollee. In addition, beneficiaries accrued \$43 billion in Medicare coinsurance and deductibles, which they paid out of pocket or through supplemental insurance, which often requires them to pay premiums. In 2002, Medicare made up 19 percent of spending on personal health care, defined as all money spent on clinical and professional services received by patients in the United States, excluding administrative costs and profits of insurers (Figure 1-1).

Over the past several decades, health care spending financed by all payers has grown more rapidly than the

**FIGURE 1-1**

**Medicare was about one-fifth of spending on personal health care in 2002**



Note: PHI (private health insurance), SCHIP (State Children’s Health Insurance Program). Out-of-pocket spending includes cost sharing for both privately and publicly insured individuals. Personal health care spending includes spending for clinical and professional services received by patients. It excludes administrative costs and profits.

\* Includes industrial in-plant, privately funded construction, and nonpatient revenues, including philanthropy.

\*\* Includes programs such as workers’ compensation, public health activity, Department of Defense, Department of Veterans Affairs, Indian Health Service, and state and local government hospital subsidies and school health.

Source: CMS, Office of the Actuary, National Health Accounts, 2004.

overall economy. Medicare program spending per beneficiary reflects that same trend—it outpaced growth in per capita gross domestic product (GDP) between 1970 and 2002 by 3 percentage points. However, the difference in growth between Medicare and GDP was only 1.7 percentage points during 1990–2003 (CBO 2003a).

That march in spending has taken place while beneficiaries have expressed dissatisfaction with aspects of Medicare’s benefit package, notably its lack of coverage for most outpatient prescription drugs. Enactment of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) was intended to address beneficiaries’ most immediate concerns over the benefit package, but did not address their concerns over cost sharing for other services.

Some of Medicare’s cost-sharing requirements, such as a substantial inpatient deductible and high copays on long hospital stays, can lead to a considerable and open-ended financial burden. In order to reduce those risks, over 90 percent of Medicare beneficiaries obtain supplemental coverage. But for many beneficiaries, the premiums or cost-sharing requirements for supplemental policies are growing rapidly, and certain people may have fewer opportunities to obtain that coverage at all. For example, fewer employers are making retiree coverage available.

Thus, policymakers are under pressure to stem growth in program spending, ensure continued access to health care services, and enhance Medicare’s benefit package—all at the same time. The MMA may increase the pressure to stem growth because it requires the President to propose and the Congress to consider legislation to address Medicare spending any time general revenue is projected to fund more than 45 percent of Medicare spending in two consecutive annual reports from Medicare Trustees.

In assessing Medicare spending growth, we explore three questions:

- What forces are leading to rapid growth in Medicare spending over the long term?
- What benefits have we bought with past levels of spending?
- Is Medicare’s growth sustainable?

### **Forces behind the growth in Medicare spending**

Historically, advances in technology (which often increase use of services) have contributed substantially to the

growth in Medicare spending. Analysts also expect future growth in the Medicare population to have a large impact on Medicare spending. This section examines these two factors.

**Advances in technology** Some new technologies can yield savings, by reducing lengths of stay in hospitals, for example. On balance, however, new technologies tend to increase costs because they often mean that more types of services can be performed and more people can benefit from them. As a result, even though the unit cost of services may decline, total spending tends to increase.

New technologies may also replace older, less expensive ones. In some cases, the new technology can improve outcomes to the extent that higher spending on new technology is offset by lower spending on other services. In other cases, however, improvements in outcomes may be marginal or may produce benefits that are real, but do not significantly decrease service use, such as improving pain management and extending patients’ lives. In these cases, increased spending on new technology may not be offset by reduced spending on other services. Finally, when new technology is provided in addition to old technologies, total spending increases.

The diffusion of new technology is enhanced by several factors that increase demand for services:

- Insurance coverage shields many individuals from immediately facing much of the cost of their care, which often induces them to use more care than they might otherwise.
- Physicians, who usually direct beneficiaries’ care, may be insensitive to the costs of care when making treatment decisions.
- Increases in real income, which many people in the United States experienced during the 1990s, tend to increase demand for health care services.
- Beneficiaries’ expectations about their health status as they age are changing. Beneficiaries no longer view illness and debilitation as a necessary part of the aging process. Instead, many expect that medical services should enable them to retain their health and mobility, and even agility, as they age (Alliance for Aging Research 2001).

**Growth in the Medicare population** With the leading edge of the baby boom generation becoming eligible for Medicare in 2011 and life expectancy at age 65 projected

to increase by 20 to 25 percent between now and 2075, the proportion of the nation's population over 65 is expected to nearly double (CBO 2002). That has obvious implications for the size of Medicare's population. But it is also important to consider the implications of that demographic bulge on Medicare financing.

The ratio of the number of workers to the number of beneficiaries is projected to decline from 4.0 today to 2.4 in 2030 to 2.0 in 2077 (Boards of Trustees 2003). The Medicare program relies to a significant degree on payroll and income taxes paid by active workers. A declining ratio of active workers to beneficiaries is one indicator of the economic resources that the Medicare program will require.

### **What have past levels of spending bought us?**

Per capita spending on health care has increased dramatically over time. This section evaluates the benefits of that increased spending and considers whether the additional care could have been furnished more efficiently.

**Average returns on Medicare spending have been positive** Analyses suggest that the benefits of specific advances in health technology, such as treatment of heart attacks and depression, greatly exceed their costs. Indeed, the benefits from advances in treating low-weight infants and heart attacks outweigh all increases in medical spending (Cutler and McClellan 2001). Analysts have also found that since the Medicare program's inception, the average worth of its spending has been high, as measured by improvements in life expectancy and reductions in morbidity, because improvement to health has a value to individuals (Cutler 2000).

If future returns on medical innovation are high, continued spending on technology through the Medicare program could benefit society. If instead returns are lower than those on the alternative uses of financial resources, policymakers might want to restrain future growth in spending.

**Are Medicare's resources used efficiently?** Even if medical innovation financed by Medicare has had a high average return, substantial evidence exists that those resources have not been allocated very efficiently. Previous work by MedPAC points out that Medicare sometimes pays different amounts for the same type of service provided in different settings.

Medicare beneficiaries may receive too little of certain treatments that have high returns, such as preventive services. Other services, particularly certain innovative

technologies, appear to be overused. Research has found significant geographic variation in practice patterns and use of supply-sensitive services; yet people living in higher-use areas do not have better health outcomes or greater satisfaction with their care. In fact, numerous measures of quality, access, and satisfaction are worse (Fisher et al. 2003).<sup>1</sup>

These findings suggest that the benefits of technological change could have been achieved at lower cost. The policy challenge is to promote appropriate use of care. Reducing overuse will generate savings. At the same time, however, there is evidence of underuse of some services (McGlynn et al. 2003, MedPAC 2002, Foote and Hogan 2001, Wagner et al. 2001). Addressing underuse could offset these savings.

Research comparing health care spending of the United States with that of countries in the Organization for Economic Cooperation and Development (OECD) looks at this question from another perspective. It indicates that the U.S. population uses more of certain high-tech services, but most of its other use measures are near the median of other OECD countries. The measures are blunt and do not account for differences in service intensity, but the analysis suggests dramatically higher relative prices as well as higher administrative costs in the United States (Anderson et al. 2003).

### **Is Medicare's spending growth sustainable?**

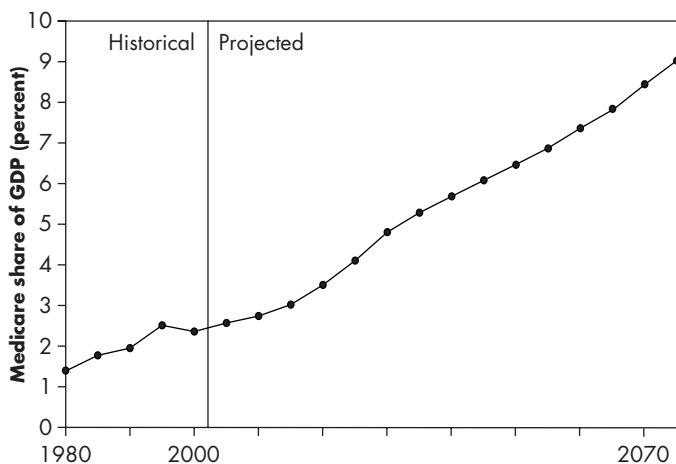
Spending on the Medicare program has grown much faster than the overall economy. It is not clear this growth is sustainable. For example, the Hospital Insurance (HI) trust fund that supports Part A services is projected for insolvency in 2026. This section examines four topics related to the sustainability of Medicare growth:

- the predicted growth of Medicare relative to the overall economy,
- the burden of future Medicare spending,
- the impact of federal budget deficits on the future of Medicare, and
- options for financing future Medicare costs.

**The predicted growth of Medicare relative to the overall economy** Medicare accounted for 2.6 percent of GDP in 2002. The Medicare Trustees project this to increase to 5.3 percent in 2035 and 9.3 percent in 2077 (Boards of Trustees 2003) (Figure 1-2).

**FIGURE 1-2**

**Trustees project Medicare spending to increase as share of GDP**



Note: GDP (gross domestic product). Trustees' data are incurred.

Source: 2003 annual report of the Boards of Trustees of the Medicare trust funds.

However, the Trustees made those projections before the Congress added a prescription drug benefit under the MMA. The prescription drug benefit will drive Medicare's share of GDP higher than the Trustees' projections.

Depending on one's point of view, Medicare's projected growth may signal the nation's collective preferences, a program growing out of control, or something in between. Regardless of one's perspective, however, Medicare's growing share of the economy highlights the opportunity costs: by spending more on Medicare services, less will be available to spend elsewhere.

**The burden of future Medicare spending** Medicare's funding comes from payroll taxes, general revenue, social security taxes, and premiums. As the program is currently structured, receipts from payroll taxes are insufficient to support spending for Part A benefits over the long term. Moreover, a rapidly increasing amount of general revenues and higher premiums will be needed to finance Part B and the new Part D (prescription drug) benefits. Greater general revenue spending could be a problem if policymakers fail to identify other spending priorities for Medicare to replace, or if they postpone steps to balance costs with revenues.

The Medicare program is financed through two trust funds: the Hospital Insurance trust fund for Part A services and the Supplementary Medical Insurance (SMI) trust fund for Part B and Part D (beginning 2006) services.

Unlike the SMI trust fund, the HI trust fund can be exhausted if spending exceeds revenue plus reserves. An accounting mechanism determines Medicare's spending authority; when the HI trust fund is exhausted, the government no longer has authority to pay Part A claims. The pending insolvency date of 2026 therefore exerts pressure on policymakers to balance trust fund revenue and spending to ensure continued operation of Part A (which now accounts for about 55 percent of program spending) (Table 1-1).

For a better understanding of the magnitude of the long-range imbalance, consider that payroll tax revenue (not counting intragovernmental transfers, such as interest on trust fund assets) currently equals 105 percent of expenditures, but is expected to cover only 73 percent of costs in 2026 and just 30 percent 75 years from now.<sup>2</sup> Illustrating what it takes to correct this shortfall, the Trustees estimate that if the Congress immediately enacted an increase, the payroll tax rate would need to rise from its current level of 2.9 percent to 5.3 percent; alternatively, HI expenditures would need to be reduced by 42 percent. If instead, the Congress enacted tax changes to meet spending growth more gradually, it would have to roughly triple the payroll tax by the end of the 75-year period.

Another important benchmark in the HI trust fund is 2013—the year that the Medicare Trustees project expenses to exceed income. This date has no impact on spending authority, but the federal budget would be affected because the HI program would require transfers from the general fund of the Treasury to reflect its draw down of HI trust fund assets. Currently, the excess of income over expenses reduces the amount of borrowing needed to support other government activity.

**TABLE 1-1 Medicare HI trust fund is projected to be insolvent in 2026**

Estimate of growth	Year spending exceeds tax receipts	Year HI trust fund assets exhausted
High	2004	2015
Intermediate	2013	2026
Low	2041	*

Note: HI (hospital insurance). Taxes include payroll and Social Security benefits taxes, Railroad Retirement tax transfer, and income from the fraud and abuse program. Taxes exclude a small amount from general revenues. \*Not exhausted within the 75-year projection period (ending 2077).

Source: 2003 annual report of the Boards of Trustees of the Medicare trust funds. CMS, Office of the Actuary.

In contrast to the HI fund, the SMI fund—financed primarily by federal general revenues and beneficiary premiums—is designed to remain solvent indefinitely by drawing on general revenues. Current law automatically sets annual financing to cover SMI’s expected costs for the upcoming year plus a “contingency reserve.”

However, as the number of beneficiaries grows with the retirement of the baby boom generation, and as health care costs continue to rise, the SMI fund is expected to require increasing amounts of general revenue and substantial increases in beneficiary premiums. For example, the Trustees estimate that for 2002, general revenues devoted to SMI made up 7.8 percent of personal and corporate income taxes. If those taxes remained at the same share of the economy, the SMI program’s general revenue financing would require about 32 percent of total income tax revenue by 2077 (Boards of Trustees 2003). This projection does not include the effects of the drug benefit under the MMA, which will substantially increase the amount of income tax revenue devoted to Medicare.

**The impact of federal budget deficits on the future of Medicare** Near-term growth in Medicare spending would occur at a time when the Congressional Budget Office (CBO) projects federal budget deficits each year through 2013. Currently, CBO estimates a budget deficit of \$477 billion in 2004, \$362 billion in 2005, and a steady decline until reaching a surplus in 2014.<sup>3</sup>

However, these estimates assume all expiring tax provisions will not be extended. CBO estimates that if all current tax provisions are made permanent, the budget outlook for 2014 would change from a surplus of \$13 billion to a deficit of \$455 billion (CBO 2004).

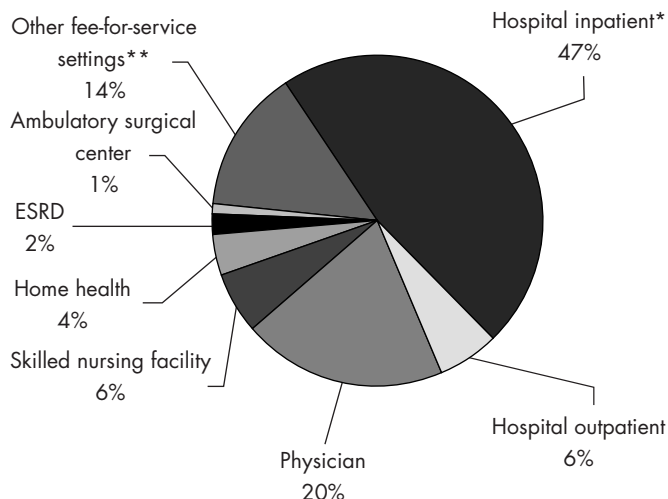
**Options for financing future Medicare costs** Policymakers need to consider whether Medicare’s growing requirement for economic resources matches the nation’s long-term goals. To address the discrepancy between dedicated resources and projected spending, leaders may need to consider a variety of policy changes.

Medicare’s growth could be financed by more borrowing. Under that scenario, the federal government would have to increase spending to cover larger interest payments on the federal debt. Given the magnitude of resources required to finance projected Medicare spending, such an approach could put significant upward pressure on interest rates as the federal government competes with other borrowers for investment capital. Higher interest rates could, in turn, slow economic growth.

**FIGURE 1-3**

**Hospital inpatient was nearly half of all fee-for-service Medicare spending in 2003**

**Total spending in fiscal year 2003 = \$236 billion**



Note: ESRD (end-stage renal disease). Spending numbers are presented as gross outlay, meaning that they include spending financed by beneficiary premiums but do not include spending by beneficiaries (or on their behalf) for cost sharing associated with Medicare-covered services. They are reported on a fiscal year, incurred basis and do not include spending on program administration. Totals may not sum due to rounding.  
 \* Includes all hospitals, both those paid under the prospective payment system (PPS) and PPS-exempt hospitals.  
 \*\*Includes outpatient laboratory; durable medical equipment; hospice; Part B drugs, ambulance services, and supplies; and Rural Health Clinics, Federally Qualified Health Centers, and outpatient rehabilitation facilities.

Source: CMS, Office of the Actuary, 2004 Mid-Session Review.

Other options include raising dedicated taxes to cover Medicare’s growing spending, reducing benefits, slowing growth in provider payments, promoting more efficient provision of care, increasing beneficiaries’ cost sharing, or a combination of approaches. All of those options are difficult, but in general, if policymakers wait longer to realign Medicare spending and financing, the changes they would have to make would be more drastic.<sup>4</sup>

**Medicare spending patterns and growth**

Two factors are essential to assessing the performance and financial sustainability of the program and identifying where changes are needed. First, we need to understand how much Medicare spends for which services and for which beneficiaries; second, we must determine how fast this spending is expected to grow.



## Medicare spending, by type of service

In 2003, inpatient hospital services received the largest portion of the \$236 billion spent in traditional Medicare (47 percent), followed by physician services (20 percent), skilled nursing facilities (6 percent), hospital outpatient services (6 percent), and home health (4 percent) (Figure 1-3). In addition, Medicare spends \$36.4 billion in Medicare+Choice.

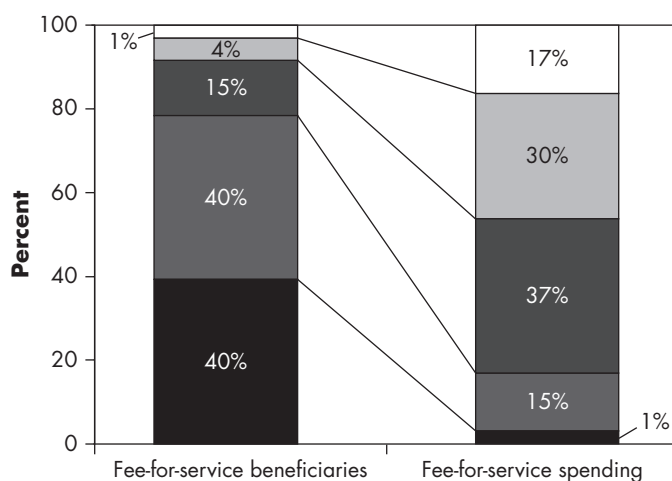
This distribution of resources has changed over time. For example, from 1992 to 2003 inpatient hospital spending shrank as a percentage of spending in traditional Medicare, from 53 percent to 47 percent.

Medicare is the single largest payer for many services. In 2002, the hospital, home health, and durable medical equipment sectors each received about 30 percent of their revenue from Medicare, followed by physicians (20 percent).

Like spending by private insurers, Medicare spending is concentrated among a small percentage of beneficiaries (see text box). Between 1995 and 1999, the costliest 5 percent of beneficiaries accounted for 47 percent of annual spending in traditional Medicare, and the costliest 20 percent accounted for 84 percent. In contrast, the least expensive 40 percent of beneficiaries accounted for only 1 percent of spending (Figure 1-4).

**FIGURE 1-4**

### Medicare spending is concentrated in a small group of beneficiaries



Note: Reflects spending each year from 1995 through 1999. Based on a 5 percent random sample of beneficiaries. Spending is reported in 1999 dollars.

Source: Leiberan et al. 2003

## Who are the costliest beneficiaries?

Some suggest that if we could better manage the care of the most expensive beneficiaries, we could improve quality and lower costs. Others are less convinced that such an approach would be successful. The debate prompts us to review what we know about the most costly beneficiaries.

- Costly beneficiaries in one year are more likely than other beneficiaries to have high costs in the following years. Of the high-cost beneficiaries who were alive at the end of 1993, over half remained in the highest quartile of spending in the next calendar year—a rate twice as high as would be expected by chance (Crippen 2002).
- Costly beneficiaries are likely to have multiple chronic conditions. One analysis found that beneficiaries with three or more conditions (46 percent of beneficiaries) account for almost 90 percent of total spending, while those with no chronic conditions account for less than 1 percent (Anderson 2002).
- Costly beneficiaries often include those in the last year of life. About 25 percent of Medicare outlays are spent on the last year of life for the 4.7 percent of beneficiaries who die each year. It is important to remember, however, that because the year or time of death is not predictable, this figure shows the cost of caring for severely ill individuals with unknown life expectancy, not the cost of care delivered in anticipation of impending death (MedPAC 2000).
- Beneficiaries with end-stage renal disease account for more than 6 percent of Medicare spending, yet comprise less than 1 percent of beneficiaries.
- Spending increases with age, but beyond a certain age, spending begins to decline. ■

Of course, over a longer interval the concentration is less dramatic. For example, over the entire five-year period from 1995 through 1999 the costliest 27 percent of beneficiaries accounted for roughly 75 percent of spending (Lieberman et al. 2003).

In addition, per-beneficiary spending varies geographically. For example, Medicare paid an average of \$3,500 per fee-for-service (FFS) beneficiary in Salem, Oregon, while it paid almost \$9,200 in Miami, Florida, in 2000. Variation in the cost of inputs and health status accounted for about 40 percent of this geographic disparity, while differences in practice patterns and beneficiary behavior accounted for the remainder (MedPAC 2003b).

### Growth in Medicare spending

Over the long term, Medicare spending has grown rapidly—about 9.4 percent annually from 1980 to 2003. In its 2004 Mid Session Review of the President’s Budget, the CMS Office of the Actuary (OACT) projects 2003 baseline spending of \$272.4 billion, an increase of 4.9 percent over 2002.<sup>5</sup> This rate of increase is lower than in 2001 and 2002, 8.8 percent and 9.2 percent respectively.

OACT predicts that spending per beneficiary will increase by 3.7 percent to \$6,880 in 2003, a smaller increase than the 7.8 percent increase in 2001 and the 8.0 percent increase in 2002. The slowdown reflects the so-called “15 percent cut” in the home health base rate, the impact on payments to skilled nursing facilities (SNFs) from expiring provisions of the Balanced Budget Refinement Act of 1999 (BBRA) and the Medicare, Medicaid, and SCHIP Benefits Improvement & Protection Act of 2000 (BIPA), and reduced reimbursement for physicians under the sustainable growth rate.

The projected slowdown in spending growth is evident across the major service areas under traditional Medicare, with spending levels for services provided by home health agencies and SNFs expected to decrease in 2003, before increasing again between 2004 and 2013 (Table 1-2).

Before the Congress enacted the MMA, OACT estimated that future Medicare spending will increase by an average of 6.3 percent annually over the next 10 years (3.9 percent real growth). CBO and the Boards of Trustees’ intermediate estimates for Medicare growth assumed a similar growth rate—6.5 and 6.6 percent (4.2 and 4.3 percent real growth), respectively—over the next 10 years (Figure 1-5).

**TABLE 1-2**

**Changes in annual Medicare spending vary by setting**

Setting	2001–2002	2003	2004–2013
Aggregate Medicare	9.0%	4.9%	6.5%
Hospital inpatient	9.0	5.3	6.3
Hospital outpatient	22.5	7.7	11.8
Physician fee schedule services	10.1	7.9	5.6
Skilled nursing facilities	15.9	–6.6	4.6
Home health agencies	8.8	–2.0	7.2

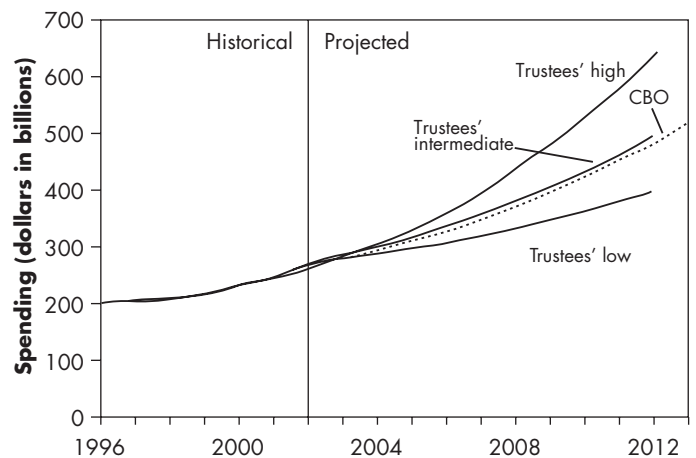
Note: Historical spending calculations based on CMS, Office of the Actuary’s 2004 Mid-Session Review.

Source: Office of the Actuary, CMS 2003.

In making their longer-term projections, both CBO and the Trustees made several assumptions. A key assumption is that Medicare spending per beneficiary will ultimately exceed per capita GDP growth by 1 percentage point through 2077, before accounting for changes in demographics of the Medicare population. Because of uncertainty surrounding these assumptions, these projections may deviate from what actually occurs in the future. In fact, the CBO director noted that this growth assumption may be optimistic, particularly given that between 1970 and 2002 Medicare spending per beneficiary grew at per capita GDP plus 3 percentage

**FIGURE 1-5**

**Trustees and CBO project Medicare growth rate of 6 percent over next 10 years**



Note: CBO (Congressional Budget Office). All data are nominal, gross mandatory program outlays. Trustees’ projections include administrative spending and are presented on a calendar year basis ending in 2012.

Source: CMS, Office of the Actuary, 2004 (historical spending). Trustees Report 2003, CBO 2003 (projections).

points (Holtz-Eakin 2003). Indeed, the number of visits to doctors by those over age 45 grew 26 percent in the last decade, even though this age group grew by only 11 percent over the same period. This reminds policymakers of the potential for increases in the intensity of care over time (Cherry et al. 2003).

These baseline estimates of future growth do not include the impacts of the MMA, which will substantially increase program spending. CBO has estimated that the MMA will increase federal spending by \$394 billion over the 2004–2013 period. Moreover, unofficial CBO estimates indicate it will increase spending by at least \$1 trillion and perhaps as much as \$2 trillion from 2014 to 2023 (Holtz-Eakin and Lemieux 2003).

At the same time, the MMA has several measures that may help moderate future program spending:

- The President must propose and the Congress must consider legislation to address Medicare spending if two consecutive annual reports by the Trustees indicate general revenue will fund more than 45

percent of Medicare spending in at least one year of a seven-year fiscal reporting period.

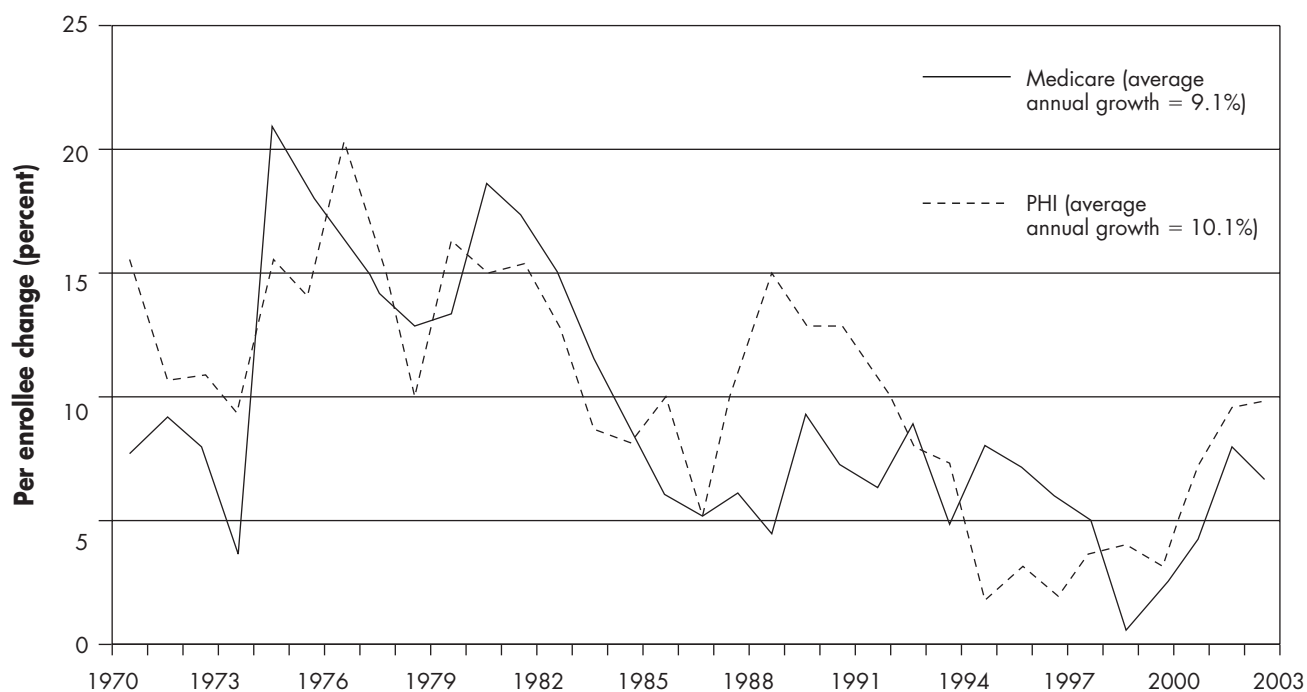
- The standard prescription drug benefit has a deductible (initially \$250) that will increase each year to reflect annual increases in per capita spending on covered outpatient drugs. Also, if combined drug spending by a beneficiary and the program exceed a specified limit (initially \$2,250), the beneficiary must pay all remaining drug costs until reaching a catastrophic limit (initially \$5,100). The size of this so-called “donut hole” will increase annually by the same rate as the deductible. Increasing the deductible and the donut hole will help hold down program spending.
- The Part B deductible increases from \$100 to \$110 in 2005. In subsequent years, it will increase at the same rate as the Part B premium.

### Growth: How does Medicare compare?

Medicare’s annual growth rates have differed from those of private insurance and other sectors of the health care economy (Figure 1-6). Also, Medicare’s average annual

**FIGURE 1-6**

**Changes in spending per enrollee differ between Medicare and private health insurance**



Note: PHI (private health insurance). Chart compares services covered by Medicare and private health insurance, including hospital services, physician and clinical services, other professional services, and durable medical products.

Source: Levit et al. 2004.

growth rate over the long term is lower than the average for private insurance. This may reflect the combined effects of the program's size relative to private insurers and policies that hold down program spending, such as the inpatient prospective payment system (PPS) and provisions in the Balanced Budget Act of 1997 (BBA).

Because of Medicare's size, providers may use Medicare payment rates as a benchmark in negotiations with private insurers. In years where Medicare has relatively low increases in spending per enrollee—such as the mid-1980s, after Medicare began using the inpatient PPS—providers may argue that private insurers must offer higher rates to offset the relatively small increases in Medicare rates.

However, Medicare and private insurers cannot let their rates diverge too much. A payer with rates substantially below other payers may cause access problems for its beneficiaries.

Comparing growth rates in Medicare and private insurance may provide some insight into the effectiveness of different payers' ability to contain costs and the dynamics that underlie variations in growth rates over time.

Any comparison of growth in health care spending must be undertaken with an appreciation for its limits. First, Medicare and other purchasers do not buy the same mix of services. So, for example, the rapid growth in spending for outpatient prescription drugs has had a smaller impact on Medicare than on other purchasers. Conversely, Medicare spending on services provided by home health agencies and SNFs grew rapidly in the 1990s, but these services generally are a small part of the benefits paid by private insurers.<sup>6</sup>

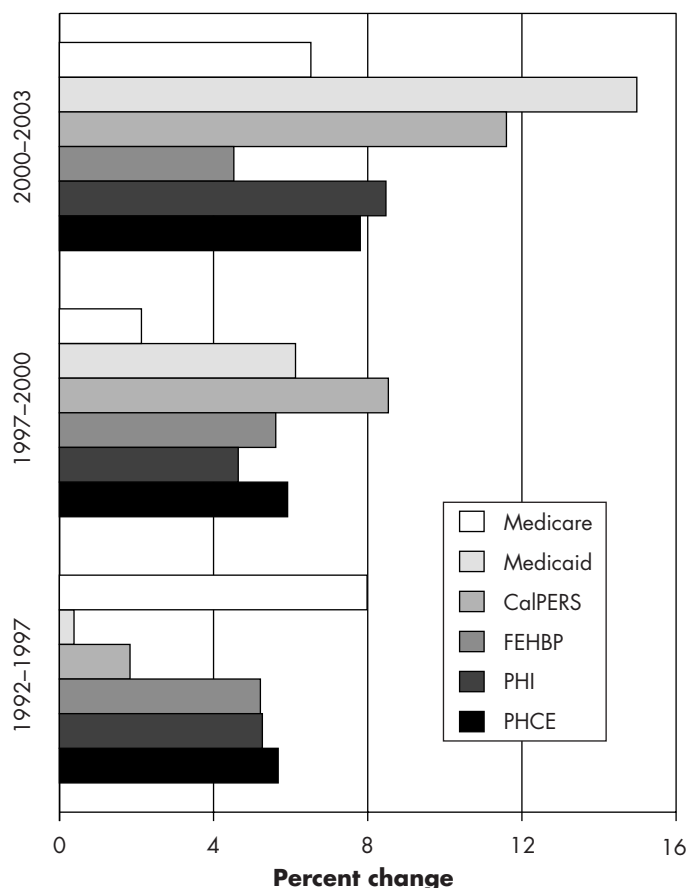
Second, generosity of coverage (e.g., changes in cost-sharing obligations) may change over time. Cost sharing in Medicare has remained largely static because the Congress has rarely changed the cost sharing structure. In contrast, cost sharing in the private sector changes much more frequently in response to market forces, some of which are local in nature.

Finally, conclusions can dramatically differ depending upon the time period analyzed. For this reason, it is best to consider the data over a longer period.

### Spending and premium growth among sectors of the health care economy

With these caveats on the comparability of growth rates in mind, the following discussion highlights growth trends

**FIGURE 1-7** The rate of change in spending per enrollee differs between Medicare and other purchasers



Note: CalPERS (California Public Employees' Retirement System), FEHBP (Federal Employees Health Benefits Program), PHI (private health insurance), PHCE (personal health care expenditures). Changes in spending are nominal. Private health insurance spending excludes spending on administration and profits.

Source: CMS Office of the Actuary, 2004 Mid-Session Review, Medicare and Medicaid (not including SCHIP) spending; FEHBP 2004, FEHBP premium increases; CalPERS 2004, CalPERS premium increases; PHI and PHCE, 2001 National Health Expenditures.

among other subsets of the health care economy, including personal health care expenditures (PHCE), private health insurers, and large government insurers (CalPERS, FEHBP, and Medicaid). In Figure 1-7, we present the recent per enrollee growth rates for each, along with that of Medicare.

Even as insurers are challenged with steep spending increases, both the number and percentage of uninsured individuals have been increasing. According to the U.S. Census Bureau, the number of nonelderly Americans who are uninsured increased by 2.4 million to 43.6 million in 2002—the largest increase in a decade. As a result, 15.2

percent of Americans were uninsured in 2002, compared with 14.6 percent in 2001 (Bureau of the Census 2003a).<sup>7</sup>

**Personal health care expenditures** Personal health care expenditures from all sources of payment is perhaps the best subset of health spending to provide a sense of system-wide spending trends. It includes out-of-pocket spending by consumers as well as spending by a multitude of payers, such as Medicare, insurance companies, and employers. It has recently grown 7 to 8 percent annually (15.9 percent per enrollee between 2000 and 2002), and prior to passage of the MMA, analysts projected it to grow at an average annual rate of 6.4 percent between 2002 and 2012.

Currently, personal health care expenditures account for 12.2 percent of GDP. However, they are projected to constitute 15.5 percent of GDP by 2012 (Figure 1-8).

Growth in hospital spending accounted for the largest share of the increase in PHCE, and hospital price inflation accounted for a larger share of hospital spending growth in 2002 than in 2001 (Heffler et al. 2003). Growth is driven by higher hospital labor costs and increased hospital leverage in negotiations over payment rates, reflecting consolidation of hospitals in many markets and less restrictive networks of providers.

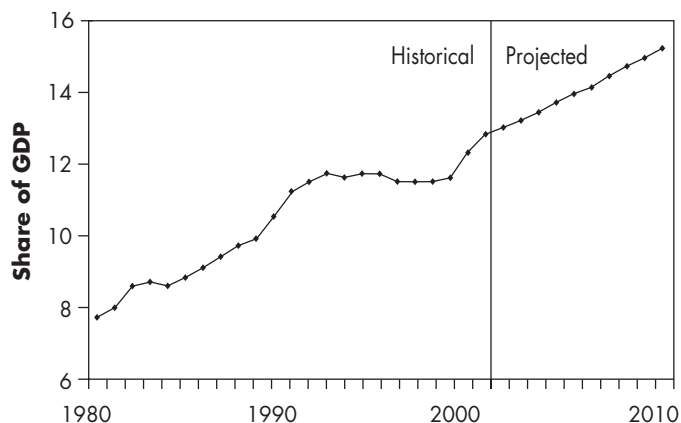
Growth in spending for prescription drugs and physician services are the next two largest contributors to overall growth. Prescription drug spending grew by 13.3 percent in 2002, even though its growth has slowed from its peak in 1999 due to the increasingly broad use of tiered copayments, fewer blockbuster drug introductions, and greater use of generic and over-the-counter drugs (Heffler et al. 2003). Nevertheless, prior to passage of the MMA, analysts projected prescription drugs to account for 14.5 percent of total health spending in 2012, up from 9.9 percent in 2001.

Physician spending is expected to slow somewhat because of negative payments required under the sustainable growth rate.<sup>8</sup> There is some uncertainty about the timing of these negative updates, however. The Congress has already prevented a negative update in 2003 and has legislated positive updates for 2004 and 2005.

**Private health insurance spending** Health care spending by private insurers increased by about 9 percent in 2002. But, for the first time in several years, the rate of increase appears to have slowed. CMS actuaries analyzing the national health account data estimate that per-enrollee

**FIGURE 1-8**

**Personal health care spending is increasing as share of GDP**



Note: GDP (gross domestic product). Personal health care spending includes spending for clinical professional services received by patients. It excludes administrative costs and profits.

Source: CMS, Office of the Actuary. National Health Accounts, 2004.

costs for private health insurance grew about 8.9 percent in 2002—slightly slower than the 2001 growth rate of 10.8 percent. Another study, based on more recent data, suggests that the rate of increase in health care spending per privately insured person is slowing. It grew by just over 10 percent in 2001, by just under 10 percent in 2002, and by 8.5 percent in the first six months of 2003 (Strunk and Ginsberg 2003). Despite this slowdown, private health insurance spending is still rising quite rapidly.

While spending growth appears to have peaked in 2001, growth of private premiums appears to have peaked a little later. The lag in slowdown between spending and premium growth reflects the fact that insurers set premiums before they incur costs. If they overestimate costs, premiums will substantially exceed costs. In subsequent periods, they respond by reducing premiums. Results from recent surveys of employers find premium increases in the range of 14 to 17 percent in 2004, somewhat lower than the 15 to 21 percent growth in 2003. Data from the national health accounts suggest that per enrollee premium growth peaked in 2002 (Heffler et al. 2003).

**Large government purchasers** The Federal Employees Health Benefits Program (FEHBP) and California Public Employees' Retirement System (CalPERS) are two examples of public entities that use market-oriented

approaches to contract with private insurance plans for employee health coverage. Program administrators negotiate premiums with prospective plans. Once the program selects plans, enrollees choose from insurance options. Enrollees' premium contributions depend on the cost of the insurance plan selected.

- CalPERS is a public agency that contracts annually for health benefits coverage on behalf of 1,100 state and local public agencies in California. Many public agencies in lower-cost markets choose not to join CalPERS. Approximately 1.2 million California public employees, retirees, and dependents were in CalPERS plans in 1997 (20 percent of these were retirees). CalPERS raised premiums for its health plans by 16.4 percent on average for 2004.<sup>9</sup>
- FEHBP is the health benefit program run by the federal government for its civilian employees, retirees, and dependents. In 2003, it had 206 health plan options and covered 8.1 million lives (Quayle 2004). In 2004, FEHBP increased premiums by 10.6 percent.

Medicaid is the nation's largest public health insurance program, covering 51 million people, mostly low income. In addition to covering children and their families, it also fills in the gaps in Medicare coverage for low-income seniors, especially for prescription drugs and long-term care.

Because Medicaid's growth rates are influenced by unique eligibility and payment policies, its growth is not expected to be comparable to Medicare's. Nevertheless, as another large public health care program, it provides useful context. Per capita Medicaid spending grew by an average of 5.7 percent between 2001 and 2003, slightly faster than the per capita Medicaid spending over the past 10 years. Because of increased enrollment over the last few years, aggregate growth averaged more than 10 percent per year between 2001 and 2003. Motivated by budget constraints, many states have implemented cost-containment strategies that have succeeded in slowing Medicaid spending growth in 2003.

### **Comparing responses to rapid growth**

Different responses to growth from the private and public sectors explain some of the wide variation in annual growth during certain periods. For example, throughout the 1990s, the private sector (and other public purchasers) turned to managed care as a way of controlling spending growth. In markets characterized by excess capacity

among providers, managed care plans were able to negotiate lower prices per service, and to a lesser extent, reduce the number of services provided.

In contrast, Medicare's payment rates for managed care plans during most of the 1990s were based on the cost of the average beneficiary in traditional Medicare. They were not based on plan costs (nor are they currently based on plan costs). Consequently, Medicare was not able to realize savings through managed care plans during the 1990s. But, beneficiaries typically enjoyed relatively generous benefits for services not covered by traditional Medicare because of the requirement that plans return savings as benefits.

The dynamic in the private sector has since changed, however. A backlash against managed care, provider consolidations, and higher occupancy rates have all contributed to an environment in which providers are able to negotiate higher prices and increase the volume of services delivered. As employers and payers struggle to cope with resulting premium increases, some are changing the portion of the premium enrollees must pay as well as increasing enrollee cost sharing. Many are offering higher deductible plans, higher coinsurance, or tiered networks, which offer beneficiaries lower premiums or cost sharing if they enroll in plans that have provider groups deemed to be more efficient (Lesser and Ginsberg 2003).

In contrast, the Congress has responded to Medicare's growth by changing Medicare's administered prices. After rapid spending growth in the 1990s, the Congress responded with the BBA, which enacted reductions in provider payments in virtually every sector and succeeded in dramatically slowing Medicare's rate of growth. Some of those reductions have been offset in subsequent legislation: the BBRA, the BIPA, and now the MMA.

Another factor that may influence growth rates of Medicare and private insurers and affect the relationship between the two is cost shifting. The theory is that when Medicare rates are low, providers increase pressure on insurers to pay them higher rates; thus, in a sense Medicare's costs are passed on to private insurers. Conversely, when Medicare rates increase, providers put less pressure on insurers to pay higher rates.

Analysts do not agree that cost shifting occurs. Some researchers believe it is plausible (Ginsburg 2003), while others are skeptical (Morrisey 2003, Morrisey 1996, Hadley et al. 1996). Most executives in hospitals, physician organizations, health plans, and businesses

believe that lower rates paid by Medicare and Medicaid lead to higher rates charged to private-sector payers (Ginsburg 2003).

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## **Beneficiary spending: patterns and implications**

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Trends in beneficiaries' health care spending have important implications for beneficiaries' access to care. Does the cost of care adversely affect beneficiaries' ability to obtain needed care? This section examines beneficiaries' out-of-pocket spending and the factors that influence it. It also asks whether the Medicare program and available supplemental insurance options adequately limit beneficiaries' liability. We find the answer varies by beneficiary, and tends to depend on a combination of three beneficiary characteristics:

- income
- health status
- supplemental insurance status

In 2001, Medicare paid just over half (52 percent) of the total cost of beneficiaries' health care services, or \$5,874. Much of the remainder was paid out of pocket by beneficiaries. In addition to out-of-pocket spending on services, beneficiaries typically pay out of pocket for the Part B premium and supplemental insurance. We examine beneficiaries' out-of-pocket spending, which includes four main components: Part B premiums, supplemental premiums, spending on noncovered services, and spending for Medicare coinsurance and deductibles.

For beneficiaries living in the community (not in facilities, such as nursing homes) out-of-pocket spending has grown as a portion of their total health care spending—reflecting, in part, the growth in prescription drug spending and supplemental insurance premiums. The rate of growth in spending (5.9 percent) also outpaced the rate of growth in beneficiaries' income (3.5 percent) from 1993 through 2001.

Out-of-pocket spending is concentrated among a minority of beneficiaries. Five percent of beneficiaries account for 20 percent of out-of-pocket spending. However, out-of-pocket spending is less concentrated than total expenditures from all sources of payment (total spending). Five percent of beneficiaries account for 35 percent of total spending. This indicates that third-party payers (Medicare, Medicaid,

and private insurance) pay a larger share of beneficiaries' health care costs as their total spending increases. This is a positive attribute of insurance and a desirable outcome.

## **Income**

Beneficiaries' ability to pay for their health care varies by their income and resources. Lower-income beneficiaries face a greater burden than their higher-income counterparts.

On average, beneficiaries spend about 20 percent of their incomes on health care services. However, the burden of health care spending is heavier for low-income beneficiaries. Households with incomes less than \$10,000 in 2000 spent 29 percent of their incomes on health care; the corresponding figure for households with incomes greater than \$70,000 was 4 percent (CMS 2002). Nevertheless, wealthier beneficiaries use more care and spend a higher amount out of pocket than low-income beneficiaries.

Most beneficiaries have retired or are unable to work due to disability, so many have relatively modest incomes. Data from CMS show that nearly 65 percent of Medicare beneficiaries had annual income from all sources below \$25,000 in 2000 (CMS 2002). In addition, many beneficiaries—especially those with low incomes—have few financial assets that can be used to pay for health care. Forty percent of beneficiaries have less than \$12,000 in assets, and 85 percent of beneficiaries below poverty have assets below that threshold (Moon et al. 2002).

Disabled beneficiaries are about twice as likely as those age 65 and older to have incomes below the poverty level. Among those 65 and older, the likelihood of being below the poverty level increases with age (Kaiser Family Foundation 2001). Data from the Medicare Current Beneficiary Survey (MCBS) show that in 2001 about 15 percent of noninstitutionalized beneficiaries had incomes below the poverty level, and 48 percent of beneficiaries had incomes below 200 percent of the poverty level.

The Current Population Survey (CPS) provides more recent data on beneficiaries' income compared with the income of the U.S. population as a whole. The CPS uses somewhat different methods than the MCBS for allocating income in family units, producing a lower estimate of the number of people with incomes below the poverty level. But, because the CPS data on income are more complete as well as more recent than the data in the MCBS, they provide important insights.

CPS data indicate that half of households with at least one member age 65 or older had money incomes below \$23,200 in 2002.<sup>10</sup> Between 2001 and 2002, the median of money income declined, in real terms, by 1.4 percent among people age 65 and older. In contrast, the median real income among those age 55 to 64 increased by 1.3 percent from 2001 to 2002, to about \$47,200 (Bureau of the Census 2003b).

People age 65 and older are not, however, more likely to be classified as poor, by standard measures of poverty, than other age cohorts. In fact, the decline in poverty among older Americans is a major success story of the past half century.

The poverty rate for people age 65 and older fell from over 35 percent in 1959 to 10.4 percent in 2002, compared to 10.6 percent among adults age 18 to 64. But, official measures of money income and poverty do not necessarily provide all the information policymakers need to determine whether Medicare beneficiaries have sufficient resources to ensure access to appropriate health care. In particular, the official poverty measure may not adequately account for the population's health care needs (see text box at right).

## Health status

Health status is a key driving factor in beneficiaries' health care spending. Those in poor health tend to spend much more than those in good health. For example, in 1998, beneficiaries reporting good or excellent health status spent about half as much out of pocket as those reporting poor health (Goldman and Zissimopoulos 2003). Moreover, people in poor health are disproportionately low income, and therefore are less able to contribute to their health care costs.

Beneficiaries' health status has improved over time, but the implications for future out-of-pocket spending are mixed. The number of people age 65 or older reporting fair or poor health declined by 8.3 percent from 1991 to 2001 (NCHS 2003). However, with the increase in life expectancy, more are living with chronic conditions. The numbers reporting conditions such as arthritis, heart disease, cancer, and diabetes all increased between 1984 and 1995.

The effect of this increase in chronic conditions on out-of-pocket spending is not clear. On the one hand, we would expect that with increased prevalence of chronic conditions, out-of-pocket spending would increase. These

conditions often progress and for those able to cope, many need assistance later in life with activities of daily living or incur more hospitalizations. The recent dramatic rise in obesity and in the prevalence of diabetes particularly suggests greater spending, as diabetes can be costly to treat.<sup>11</sup>

On the other hand, evidence suggests a decline in the rate of disability associated with chronic disease (Manton et al. 1997, Cutler 2001). To the extent that this lower rate of disability is achieved through medical advances, such as joint replacement and pharmacology therapy, spending can be expected to increase. If instead, improved functioning results from healthier lifestyles, spending may increase less rapidly.

Finally, the reduced rate of disability may have little or no effect on cost over the long term. Recent research indicates that beneficiaries' costliness from age 70 to date of death is similar for the disabled and those with no functional impairments (Lubitz et al. 2003). Beneficiaries without impairments have lower costs per year, but they also tend to live longer. The costs incurred over the additional years they live offset their lower costs each year.

## Supplemental insurance

Medicare requires beneficiary cost sharing in the form of deductibles, coinsurance, and other mechanisms and does not cover some services. Moreover, Medicare does not have an annual limit on beneficiaries' out-of-pocket spending. To offset the risk of high out-of-pocket expenses, most beneficiaries have supplemental insurance (Table 1-3, p. 18).

The drug benefit in the MMA may offset some of beneficiaries' perceived need for supplemental insurance. However, the impact on the number of beneficiaries with supplemental insurance may be small because the drug benefit can still leave beneficiaries with substantial out-of-pocket spending. In addition, the MMA prevents beneficiaries who enroll in Part D from holding a Medigap plan that includes drug coverage.

Beneficiaries who have supplemental coverage use more services and report better access to care. MedPAC analysis indicates that beneficiaries who do not have supplemental coverage are more likely to report having access problems (MedPAC 2003c). This includes not seeing a doctor when necessary, delaying care due to cost, and not having a usual source of care or usual doctor.



However, beneficiaries with supplemental insurance—except those with Medicaid coverage—have out-of-pocket spending at least as high as those without supplemental coverage. This indicates that the additional coverage provided by supplemental insurance is more than offset by beneficiaries' propensity to use care.

Beneficiaries obtain supplemental coverage through a variety of sources, including employer-sponsored retiree health benefits, individually purchased Medigap plans, Medicaid, or a Medicare+Choice (M+C) plan that offers supplemental benefits.

## Measuring poverty in the Medicare population

Whether a poverty measure is useful depends on how accurately the measure reflects the basic needs of a population and the extent to which the different types of resources that are taken into consideration can meet those needs. Whether the official poverty measure reported here adequately depicts the financial well-being of the American population in general, and the well-being of older adults in particular, is a matter of controversy.

The official poverty measure used in policymaking in the United States was put in place at about the same time that the Congress created the Medicare program. The poverty definition was based on a determination of the minimum cost of an adequate diet, multiplied by a factor believed to cover other consumer necessities. That multiplier was derived from a 1955 food consumption survey that showed that families spent, on average, about one-third of their budgets on food. The remaining two-thirds included purchases of medical supplies and services, along with housing and other necessities, reflecting consumption patterns at that time. Except for minor revisions and annual updates to reflect increases in the Consumer Price Index, the official poverty measure is essentially unchanged since it was first implemented.

A panel of the National Academy of Sciences issued a report in 1995 that cited a series of problems with the official poverty measure, including (but not limited to) the fact that it does not reflect direct tax payments and in-kind benefits (such as food stamps or housing assistance), regional differences in the cost of living, differences in health insurance and health care costs, or significant changes in the overall consumption patterns of Americans since 1955.

Expenses for health care and health insurance were among the most difficult conceptual as well as

technical issues addressed in the report. The panel noted that expenditures for health care have become an increasingly larger budget item since the 1960s, but that, because these expenses are not distributed evenly, neither across families nor over time within families, it would not be possible to capture medical costs directly in poverty measures.

Instead, the panel proposed an approach that would incorporate expected medical out-of-pocket (MOOP) spending, derived from survey data, into the poverty measure. Over time, applications of this approach, along with refinements designed to address other weaknesses in the official measure, have been incorporated into “experimental poverty measures.”

The experimental measures employ three different methods for addressing MOOP expenses in six separate measures. Using data from the 2002 Current Population Survey, all these measures result in a small increase in the proportion of the total U.S. population falling below the poverty line, compared to the official poverty measure. The poverty rates under the experimental measures for adults age 18–64 ranged from 10.9 percent to 11.7 percent in 2002, compared to the official rate of 10.6 percent for this age group.

The major effect of the experimental measures occurs in the age group 65 and older. Using the official poverty measure, 10.4 percent of people age 65 and older were below poverty in 2002. Using the experimental measures, the percent of people age 65 and older below poverty was in the 13.4–17.6 range across the six experimental measures. Four of the six experimental measures indicated poverty rates of at least 16 percent for people age 65 and older (Bureau of the Census, 2003c). ■

**TABLE  
1-3**

**Sources of additional coverage, by selected beneficiary characteristics, 2001**

All beneficiaries	Number of beneficiaries	Percent distribution					
		Employer-sponsored insurance	Medigap insurance	Medicaid	Medicare managed care	Other	Medicare only
All beneficiaries	38,508,302	32.6%	28.1%	12.2%	16.2%	2.1%	8.9%
<b>Age</b>							
Under 65	5,303,927	27.9	5.8	35.2	8.2	3.9	19.0
65-69	9,228,111	38.8	24.2	8.6	17.3	1.7	9.5
70-74	8,438,714	32.7	32.0	7.5	18.3	2.0	7.4
75-79	7,182,449	32.6	34.8	8.8	16.8	1.5	5.6
80-84	4,808,139	30.7	36.2	8.4	17.8	1.7	5.2
85+	3,546,961	26.5	38.1	9.9	16.4	2.0	7.2
<b>Income status</b>							
Below poverty	5,933,621	10.2	14.9	51.2	10.4	2.3	11.1
100 to 125% of poverty	3,914,608	19.4	23.6	23.4	15.0	2.9	15.7
125 to 200% of poverty	8,495,685	28.6	31.1	6.1	19.7	2.7	11.8
200 to 400% of poverty	12,838,007	41.9	30.1	1.1	18.5	1.5	7.0
Over 400% of poverty	7,212,890	46.8	34.8	0.3	13.1	1.7	3.3
<b>Eligibility status</b>							
Aged	33,085,573	33.4	31.7	8.4	17.4	1.8	7.3
Disabled	5,111,329	27.2	5.8	35.1	8.5	4.0	19.4
End-stage renal disease	311,400	39.1	10.7	37.2	6.3	1.0	5.8
<b>Residence</b>							
Urban	29,315,365	34.3	24.4	11.6	20.3	1.9	7.5
Rural	9,167,813	27.1	40.1	14.0	3.0	2.6	13.3
<b>Sex</b>							
Women	21,360,302	30.8	30.8	13.5	16.7	1.9	6.4
Men	17,148,000	35.0	24.8	10.5	15.5	2.3	12.0
<b>Health status</b>							
Excellent/very good	15,590,859	35.3	32.1	5.7	17.9	1.5	7.4
Good/fair	19,234,850	31.4	26.8	14.6	15.7	2.3	9.1
Poor	3,521,289	28.0	17.0	27.5	10.6	3.5	13.4

Note: Income status is defined in relationship to the poverty level (\$8,494 if living alone and \$10,715 if living with a spouse). Urban indicates beneficiaries living in metropolitan statistical areas (MSAs). Rural indicates beneficiaries living outside MSAs. Analysis includes beneficiaries living in the community.

Source: MedPAC analysis of 2001 Medicare Current Beneficiary Survey, Cost and Use file.

The availability of supplemental insurance is changing. In addition, the mix of coverage has changed. In general, we see that after a rapid increase in the mid-1990s, M+C enrollment has declined from its peak in late 1999 and early 2000. At the same time, economic pressures led employers to limit their liability for the costs of retiree health benefits, and data are beginning to reflect this among beneficiaries age 65 to 74.

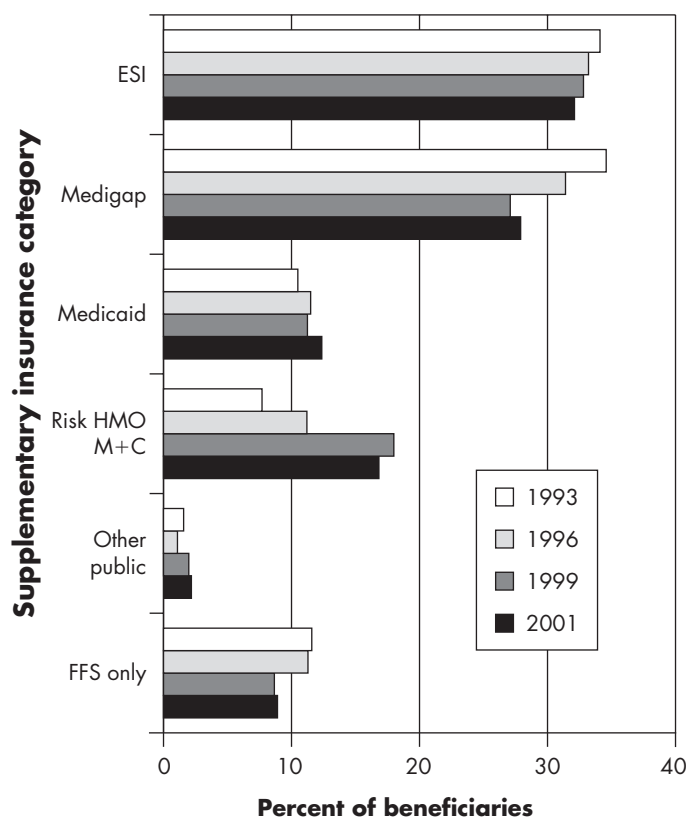
The mix will likely be affected by the MMA as well. For example, some predict employers will drop coverage when their retirees have drug benefits through Medicare. Alternatively, the MMA includes incentives for employers

to provide drug coverage to retirees, which may affect employers' decisions not to offer drug coverage.

In addition, Medigap enrollment seems to have stabilized after losing some of its enrollees to M+C plans in the mid-1990s. Our analysis of data from the National Association of Insurance Commissioners suggests the number of Medigap policies has remained virtually unchanged from 2000 to 2002.<sup>12</sup> Meanwhile, we see that after a decrease through the 1990s, the percentage of beneficiaries without any form of supplementary coverage has leveled off (Figure 1-9).<sup>13</sup>

**FIGURE 1-9**

**Enrollment by type of supplemental insurance, 1993-2001**



Note: ESI (employer-sponsored insurance), FFS (fee-for-service), M+C (Medicare+Choice). Includes community dwelling beneficiaries only. Risk HMOs are precursors of HMOs in Medicare+Choice.

Source: MedPAC analysis of 1993, 1996, 1999, and 2001 Medicare Current Beneficiary Survey, Cost and Use file.

### Sources of supplemental insurance

This section discusses attributes of the five categories of supplemental coverage:

- Employer-sponsored insurance (ESI)
- Medigap
- Medicare+Choice
- Medicaid
- Medicare only

**Employer-sponsored insurance** About one-third of beneficiaries have ESI. These beneficiaries with ESI tend to be younger, more urban, and more affluent than other beneficiaries. In general, it is the most comprehensive

supplemental insurance option available in terms of types of services covered.

However, ESI often requires enrollees to pay coinsurance and deductibles. In addition, some employers are cutting back on the scope of retiree health benefits by increasing qualifying service requirements, or by reducing (or eliminating) the employers' contribution to the premiums, increasing beneficiary cost sharing, or reducing the scope of benefits (KFF and Hewitt Associates 2004).

Health coverage for Medicare-age retirees is concentrated almost entirely among larger (over 200 employees) private sector establishments and government employers.<sup>14</sup> Between 1988 and 2003, the number of large employers offering retiree health benefits fell from 66 percent to 38 percent (KFF and HRET 2003). In many instances, the curtailment of coverage affects new hires rather than those already in the workforce or retired, so the impact of the reductions has not yet fully played out in the Medicare population.

Nevertheless, the percentage of beneficiaries age 65 to 74 with ESI is beginning to decline. In 1993, 39 percent of retirees age 65 to 74 living in the community had ESI coverage, compared to 36 percent of retirees in this age cohort in 2001. Among older cohorts, ESI coverage rates stayed constant (MedPAC analysis of the MCBS).

Part of this decline is attributable to the way that coverage is measured by the MCBS. Beneficiaries enrolled in M+C plans are not counted as having employer-sponsored coverage, even if this coverage is provided through an employer plan. Thus, part of the decline in ESI could be accounted for by the increase in M+C enrollment among younger beneficiaries. However, MedPAC analysis indicates that less than 20 percent of all M+C enrollees are in employer contract plans, so the bulk of the decline in ESI among cohorts is from real declines in coverage.

The decline in ESI coverage is likely to continue. In 2003, ten percent of large firms that have at least 1,000 employees and offer retiree health benefits decided to discontinue coverage for future retirees. Moreover, 20 percent said they are "somewhat likely" to adopt that policy in the next three years (after 2003) (KFF and Hewitt Associates 2004).

**Medigap** In 2001, about 28 percent of beneficiaries had Medigap coverage, a decline from 34 percent in 1993. The percentage of beneficiaries age 65 to 69 who had Medigap

declined from 32 percent in 1993 to 24 percent in 2001; similar declines were also seen among older cohorts.

Medigap insurance is private coverage designed specifically to wrap around the Medicare benefit package. All Medigap plans cover the Part A coinsurance and Part B coinsurance, leaving beneficiaries with little out-of-pocket spending for most covered services. Most beneficiaries have chosen to enroll in plans without drug coverage because of high premiums and limited coverage. Enactment of the MMA will likely cause even fewer beneficiaries to choose Medigap plans with drug coverage.

**Medicare+Choice and other managed care** The number of beneficiaries with M+C and other sources of managed care coverage peaked at the end of 1999 at about 6.8 million beneficiaries.<sup>15</sup> Medicare+Choice experienced a large decline in enrollment at the beginning of 2001 and 2002, so that by the beginning of 2003, only 5.1 million beneficiaries were enrolled in M+C and other managed care plans.

During the mid- to late-1990s, M+C plans tended to offer substantial prescription drug coverage and out-of-pocket spending protection. Since then, this coverage has declined. Fewer plans offer prescription drug coverage. In addition, while the total amount of cost sharing (including Part B premiums, plan premiums, cost sharing for hospital and physician services, and cost sharing for prescription drugs) is lower than that paid by fee-for-service beneficiaries, it doubled between 1999 and 2003 (Gold and Achman 2003).

Provisions in the MMA may spur enrollment in plans. The legislation will increase payments to all plans, and in each area served, plans must offer at least one option that includes the standard drug benefit.

**Medicaid** In 2001, about 12 percent of beneficiaries living in the community were enrolled in the Medicaid program that supplemented their Medicare coverage (Figure 1-9). This percentage has remained relatively constant. A vast majority of these beneficiaries are low income and are more likely to report poor health and be disabled than other beneficiaries.

Medicaid coverage varies by state, but in general, provides comprehensive coverage for both acute and long-term care services. With recent state budget constraints, however, more states are imposing limits on certain benefits and increasing cost sharing.

In addition to Medicaid coverage, more than 30 states have prescription drug assistance programs for low-income elderly or Medicare beneficiaries, but the generosity of this coverage varies. The enacted prescription drug benefit will likely have an effect on these programs.

**Medicare only** The percentage of beneficiaries participating in traditional Medicare without supplemental insurance declined markedly in the mid-1990s, but has leveled off since then. Given the noted declines in the availability of other sources of coverage, we could expect the number of Medicare-only beneficiaries to increase.

Medicare beneficiaries with no supplemental coverage tend to be under age 65, low income (below 125 percent of poverty), eligible due to disability, rural dwelling, and male. They also are more likely to report poor health.

Because these beneficiaries have no supplemental coverage, they are vulnerable to very high levels of out-of-pocket spending. This vulnerability may become an important issue if declines in the availability of supplemental insurance cause an increase in the number of Medicare-only beneficiaries.

Enactment of the MMA creates an interesting situation for Medicare-only beneficiaries. The number of Medicare-only beneficiaries might increase if some employers drop ESI coverage or some beneficiaries with Medigap choose to forgo that coverage. But, Medicare-only beneficiaries who enroll in Part D should be better off because the drug coverage will decrease the likelihood that a Medicare-only beneficiary will experience a very high level of out-of-pocket spending.

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## Beneficiaries' perception of their access to care

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This final section examines recent data concerning beneficiaries' access to care, which is strongly affected by the out-of-pocket spending analyzed in the previous section. The Commission monitors three aspects of access: the capacity of the delivery system to provide care, the ability of beneficiaries to obtain services, and the ability of beneficiaries to obtain appropriate care. In this section, we used beneficiary surveys to evaluate their ability to obtain care. The capacity of the system to deliver care is addressed in each of the payment update chapters, and the appropriateness of care delivered is discussed in the quality chapter.

## Beneficiaries report good access to care, but problems persist for some

Results from several beneficiary surveys are reassuring about beneficiaries' access to care. On a variety of questions pertaining to access discussed in detail below, more than 90 percent of beneficiaries report good access. However, certain beneficiaries are more likely to report problems obtaining care than others. Also, these data show access on a national level. They may hide substantial differences across regions.

Beneficiaries report that their ability to obtain care has remained stable or improved since 1991, the first year of the MCBS (Figure 1-10). In the survey, the ability to obtain care is measured along several dimensions, including whether beneficiaries delayed care due to cost, reported not seeing a doctor when they needed to, or had trouble getting health care.

- When asked whether they delayed health care due to cost, 14 percent of beneficiaries answered yes in 1991, whereas 8 percent answered yes in 2001. The

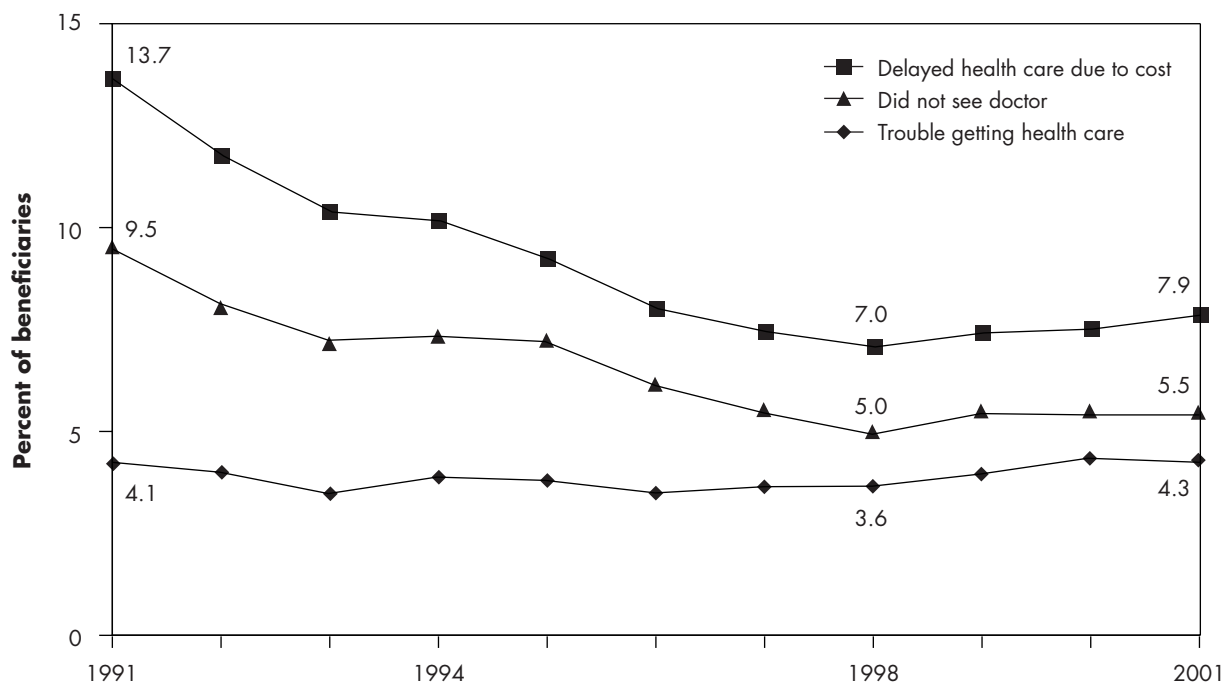
downward trend was fairly steady until 1998, after which it began creeping upward (from 7 percent of beneficiaries to 8 percent).

- Similarly, the percentage reporting that they did not see a doctor (when they needed to) declined from 10 percent of beneficiaries in 1991 to 6 percent in 2001.
- The percentage of beneficiaries reporting trouble getting health care has remained relatively stable at around 4 percent.

Data from the National Health Interview Survey (NHIS) indicate this level of satisfaction with access to care surpasses that of persons under the age of 65. In a recent report summarizing the findings from the 2002 NHIS, only 3 percent of those 65 and older reported in 2002 that they failed to obtain care due to financial barriers, compared with 6 percent of people age 18 to 64 (regardless of insurance status and including disabled Medicare beneficiaries). In the same survey, the elderly were also more likely to report a usual place to go for care than those age 45 to 64.

**FIGURE 1-10**

**Beneficiaries' reports of difficulties obtaining care have declined or remained stable since 1991**



Note: These data reflect the answers given by noninstitutionalized beneficiaries.

Source: CMS analysis of Medicare Current Beneficiary Survey, Access to Care file.

While Medicare beneficiaries as a whole report good access to care, access problems are greater among some minority groups. In the 2000 MCBS, 9 percent of Hispanics and 11 percent of African Americans reported delaying care due to cost compared with 7 percent of Whites.

In addition, while over 90 percent of beneficiaries of all races reported a usual source of care, they appear to be getting care in different settings. Almost 80 percent of Whites said their usual source of care was a doctor's office or clinic, compared with 69 percent of African Americans and 64 percent of Hispanics. African Americans and Hispanics were more likely than Whites to report their usual source of care as an outpatient clinic or emergency room. Interestingly, HMOs are the usual source of care for 14 percent of Hispanics, compared with 8 percent of African Americans and 6 percent of Whites.

The presence of supplemental insurance is also a key determinant of access to care. In 2000, 19 percent of beneficiaries without supplemental insurance reported delaying care due to cost. Beneficiaries without supplemental coverage were also more likely not to have a usual source of care—13 percent reported no usual source of care compared to the overall rate of 6 percent. The majority of beneficiaries with no additional coverage (64 percent) reported their usual source of care as a doctor's office or clinic, but this contrasts with the overall rate of 81 percent.

The type of supplemental coverage also affects access. Even though beneficiaries with additional insurance through the Medicaid program have fairly complete coverage of services, they reported higher-than-average rates of access problems. Twelve percent of beneficiaries with Medicaid as their source of supplementation in 2000 reported delaying care due to cost, compared with the average Medicare rate of 8 percent.

Because these data are not adjusted for factors such as income or patient health status, some of the differences in access may reflect differences in the types of beneficiaries who have each type of coverage. For example, beneficiaries with Medicaid coverage tend to be poorer than the average beneficiary, so they may delay care due to cost even though the cost-sharing requirements under Medicaid are nominal.

## Access to different types of care

The Consumer Assessment of Health Plans Survey (CAHPS), another survey administered by CMS, is an additional source of information on access. CMS uses it to survey beneficiaries on their:

- ability to obtain necessary, urgent, and routine care,
- relationship with their primary provider, and
- ability to obtain different types of services.

### Ability to obtain necessary, urgent, and routine care

The survey found that in each of the three years between 2000 and 2002, at least 97 percent of beneficiaries who required care reported no problem or a small problem receiving necessary care. In 2002, 92 percent of beneficiaries who needed urgent care also reported that they were always or usually able to receive it as soon as they wanted, and 90 percent said the same about getting routine appointments. However, while the latter two percentages were high, they declined slightly from 2000 to 2002 (Table 1-4).

Medicare beneficiaries also report a higher rate of timely access to care compared to the non-Medicare population. Fifty-eight percent of beneficiaries in traditional Medicare and 59 percent of M+C enrollees report getting care without long waits. Only 47 percent of adults with commercial insurance report the same experience.

Although access to different types of care is strong overall, beneficiaries differ in their ability to obtain care (Table 1-5). In addition to highlighting the experiences of different beneficiaries, this table shows how important question

**TABLE 1-4**

**Access continues to be generally good, 2000–2002**

Access to care	2000	2001	2002
Small or no problem getting necessary care	97%	98%	97%
Usually or always get urgent care as soon as wanted	93	92	92
Usually or always get routine appointments as soon as wanted	93	92	90

Source: MedPAC analysis of 2000–2002 Consumer Assessment of Health Plans Survey (CAHPS) data from CMS.

**TABLE  
1-5**

**Beneficiaries differ in their reports of obtaining needed, urgent, or routine care, 2001**

Beneficiary characteristic	No problem getting needed care	Always got care as soon as wanted	
		Urgent	Routine
Overall	90%	73%	67%
Aged Disabled	83	65	62
White	92	74	68
African American	86	70	67
Hispanic	84	64	59
Medicare only	87	68	66
Dually eligible	82	68	62
Additional with Rx coverage	93	75	67
Additional without Rx coverage	92	75	67

Source: MedPAC analysis of data from the Medicare Fee-for-Service National Implementation Subgroup Analysis: Final Report for Year 2, March 2003, submitted to CMS by Research Triangle Institute.

wording is to the findings in a beneficiary survey. The percentage of beneficiaries reporting no problem getting needed care (shown in the first column) is significantly higher than those who report that they can get urgent or routine care as soon as they wanted it (the second two columns). This may seem inconsistent, but the last two questions add the dimension of timing into their responses. It appears that while most beneficiaries are able to get care, they may not be getting it as soon as they want it.<sup>16</sup>

Disabled beneficiaries were more likely than aged beneficiaries to report problems receiving necessary, urgent, or routine care. Eighty-three percent said that they had no problems obtaining necessary care compared with 90 percent of all beneficiaries. Sixty-five percent said that they always got urgent care as soon as they wanted, compared with the overall Medicare rate of 73 percent.

The presence and type of supplemental insurance also affected beneficiaries' ability to obtain care with no problems. Sixty-eight percent of dually eligible beneficiaries reported they always got urgent care as soon as they wanted, compared with 73 percent of all beneficiaries. Those without any supplemental insurance

(Medicare only) report the same experience as dual eligibles in obtaining urgent care as soon as they wanted.

Hispanics had a harder time than other ethnic or racial groups getting all types of care: needed, immediate, and routine. Fifty-nine percent of Hispanics reported always getting routine care as soon as they wanted, compared with 68 percent of Whites and 67 percent of African Americans.

**Beneficiaries report strong relationships with providers**

Responses to the CAHPS survey questions on beneficiaries' relationships with their regular providers were also quite positive. Nearly 90 percent responded that they have a regular doctor or nurse and almost 80 percent have seen their regular practitioner for two or more years. In 2002, 60 percent reported seeing their primary provider (usually a doctor) for over 5 years. Furthermore, 50 percent of beneficiaries have been seeing the same provider since before becoming eligible for Medicare.

**Beneficiaries report good access to special services**

Beneficiaries report that they are satisfied with their ability to obtain all types of services: Almost 90 percent say that they have a small or no problem getting most services (CAHPS reports on prescription medicines, care from a specialist, home health services, durable medical equipment, and special therapies such as physical, occupational, and speech therapy).

Of the services included in CAHPS, in 2002, beneficiaries used prescription medicines and specialists the most. Access to both services was high: 96 percent of beneficiaries report no problem or a small problem getting prescription medicines and 94 percent report the same for specialists. The high level of beneficiary satisfaction with the ability to obtain prescription medicines, although surprising, is consistent with answers to similar questions on other surveys.<sup>17</sup> However, some surveys have found higher rates of reported access problems on differently worded questions, such as whether persons skip doses or delay filling prescriptions.

In addition, different types of beneficiaries report more problems obtaining prescriptions than others. For example, a recent survey by the Center for Studying Health System Change found that 16 percent of elderly African American Medicare beneficiaries reported not purchasing at least

one prescription in 2001 because of cost. This compares with 7 percent of Whites.<sup>18</sup>

Eighty-eight percent of beneficiaries who said that they needed home health services reported a small or no problem obtaining them. However, it appears that although some beneficiaries experienced problems obtaining home health services, they did eventually get the home health care they needed. In 2000, the percentage of beneficiaries who reported on the CAHPS survey the need for home health (7.7 percent) was almost the same as the number of beneficiaries who actually used the services (7.5 percent).

## **M+C beneficiaries' experience obtaining care**

In both the M+C and traditional programs, most beneficiaries report no problem getting needed care. However, more beneficiaries in traditional Medicare (89 percent) report that they get needed care with no problem than beneficiaries in M+C plans (82 percent) (MedPAC 2003a). Many beneficiaries in both programs apparently believe that they have to wait too long for care. Fifty-nine percent of M+C enrollees and 58 percent of FFS beneficiaries said that they always get care without long waits. ■



## Endnotes

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- 1 The link between higher spending and lower satisfaction may reflect regional differences in expectations over health care. In some areas, people may expect more of their health care system than in other areas.
- 2 The Trustees' estimates assume a 4.3 percent annual increase in per capita gross domestic product and a 5.3 percent increase in Medicare expenditures per beneficiary, excluding the effects of changes in demographics.
- 3 The Office of Management and Budget's estimate of the deficit is \$521 billion in 2004 and \$364 billion in 2005.
- 4 A recent study quantifies the cost of delaying changes in the financing of federal programs through a measure called fiscal imbalance (Gokhale and Smetters 2003). This measure is the difference between projected program expenditures and available resources under current policies. The authors calculate that restoring fiscal balance would require one of the following: a 16.6 percentage point increase in payroll taxes, a two-thirds increase in federal income tax revenue, a 45 percent cut in Social Security and Medicare outlays, or elimination of the entire federal discretionary budget. Delaying policy changes until just 2008 makes necessary adjustments much worse: an 18.2 percentage point increase in payroll taxes or a 74 percent increase in income tax revenues.
- 5 These figures are gross mandatory outlays for benefits on a fiscal year, incurred basis, provided by OACT. CBO's estimate for Medicare growth in 2003, adjusted to reflect 12 capitation payments each year, is 7.6 percent. The difference is largely attributed to CBO's estimate being on a cash basis, while OACT's is on an incurred basis.
- 6 Traditional Medicare covers certain outpatient drugs, including those used in cancer treatment, dialysis, organ transplants, and treating hemophilia. Because the use and price of those drugs has increased dramatically, Medicare spending on drugs has increased substantially. Traditional Medicare spent \$8.5 billion in 2002, an increase of 35 percent over 2001.
- 7 The Census results are intended to measure the number of people uninsured throughout a year. Analysts at CBO argue the Census figures are too high and that the number of nonelderly Americans uninsured throughout 1998 was between 21 million and 31 million (CBO 2003b)
- 8 The sustainable growth rate (SGR) system is a payment update formula that adjusts the update for physician services depending on whether spending has been equal to a target. This target is determined partly by growth in the national economy. For more information on the SGR, see Chapter 2 of MedPAC's March 2001 Report to the Congress.
- 9 This figure reflects a weighted average of the premiums of all individual and family policies, calculated at the beginning of the annual open enrollment period for all enrollees except Medicare beneficiaries. CalPERS has a separate benefit design and associated premium for its retirees who are eligible for Medicare.
- 10 This estimate counts pensions and other forms of retirement income, veterans' payments, rents, and other forms of compensation.
- 11 Over the past decade, the percentage of people age 65 to 74 who are obese increased by nearly 50 percent, from about 27 percent to 39 percent. Among those 75 and older, the percentage classified as obese increased from 19 to 25 percent (NCHS 2003). The prevalence of diagnosed diabetes among people age 65 and older increased from 13.2 percent in 1997 to 16.0 percent in 2002. Nationally, direct medical spending for diabetes amounted to \$92 billion in 2002 (Hogan et al. 2003).
- 12 Given that the number of beneficiaries increases over time, the portion of beneficiaries with Medigap likely declined a small amount from 2000 to 2002.
- 13 Data on sources of supplemental insurance can be interpreted differently and show contradictory trends. In particular, our analysis (which relies on MCBS data) counts a beneficiary as Medicare only if the beneficiary has traditional Medicare without supplemental coverage as the most prevalent source (measured by number of months) of coverage throughout a year. Other analysts may rely on data reported only once a year or may assign beneficiaries to categories of coverage using different standards.
- 14 Data from the 2003 Employee Benefits in Private Industry Survey found that 3 percent of all private establishments with 1 to 99 workers provided retiree health benefits to Medicare-age retirees; 15 percent of establishments with 100 or more workers provide these benefits. The 2003 HRET/Kaiser Survey of Employers found that 38 percent of all employers with 200 or more workers provide some retiree health benefits. Among those with 200 or more employees who offer retiree benefits, about three-fourths continue these benefits after retirees reach age 65 and enroll in Medicare. Coverage is far more common among large employers: 54 percent of employers with 5,000 or more employees and 85 percent of state and local government agencies surveyed reported offering retiree health benefits.

- 15 Despite peaking in late 1999, average monthly M+C enrollment was similar throughout 1999 and 2000 at about 6.7 million.
- 16 The responses in Table 1-5 are lower than those in Table 1-4 because Table 1-4 groups beneficiaries who reported “no and small problems” and “usually and always,” instead of only reporting the most positive responses.
- 17 Similar questions were asked on the Medicare Current Beneficiary Survey and the National Health Interview Survey.
- 18 These relatively higher numbers of problems obtaining prescriptions may be due to the manner in which the question was asked.

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