



**Medicare at 40:
Past Accomplishments and Future Challenges**

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I. Introduction

Before the enactment of the Medicare program (Title XVIII of the Social Security Act) in 1965, older persons had either inadequate or no health insurance:¹ slightly more than half of older Americans had hospital insurance compared to about 75 percent of those under age 65,² and employer-provided retiree health coverage was the exception. Older persons trying to buy health insurance privately were often denied coverage on the basis of age or pre-existing conditions; still others simply could not afford the cost of such coverage. Without health insurance, the choices for older adults needing health care were bleak; they could deplete their savings, seek assistance from their children, look for charity care, do without other life essentials, or forgo care altogether.³

The value of Medicare as a source of health care coverage was apparent from the outset of the program. Within 11 months of its implementation, 19.1 million persons age 65 and older were enrolled in the hospital and other inpatient services component of Medicare (Part A). Nearly 18 million (approximately 92 percent of persons age 65 and older) voluntarily signed up the first year for the physician and other outpatient services component of Medicare (Part B);⁴ by 1970, 97 percent of older adults were enrolled.⁵ Medicare virtually eliminated uninsurance among older persons.

As we commemorate Medicare's 40th anniversary, the program's accomplishments are clear and significant. For its beneficiaries, it represents a stable source of health insurance protection that provides a vital component of retirement security. The program has achieved its initial goals of increasing access to health care services and reducing the financial burden of the high cost of medical care among the older population. Medicare's essential protections to older individuals and those with disabilities have favorably affected millions of lives and have contributed, in substantial measure, to a better quality of life for older persons, the lengthened life expectancy of the U.S. population, and the drastic reduction in the proportion of poor adults.

Medicare also has demonstrated impressive resilience and innovation in response to a rapidly changing health care environment. Over the years, Medicare has been strengthened with the addition of new benefits (most notably, a wide array of preventive services and the prescription drug benefit), innovative payment approaches, and enhanced consumer choices. In addition, Medicare has extended explicit protections to beneficiaries – such as grievance and appeal rights, and privacy of personal health information – that preceded, and set the standard for, stronger consumer protections in private health plans. Medicare has begun to emerge as a leader in the effort to improve health care quality.

Notwithstanding the considerable accomplishments that have been achieved since 1965, several significant challenges remain if Medicare is to keep pace with the changing needs of the growing beneficiary population. In reflecting on its accomplishments and the many challenges it faces, it is important to bear in mind that the Medicare program is a part, albeit a large one, of the nation's health care system. As such, it faces the same problems and challenges that confront and

confound other large purchasers: escalating health care costs, an aging population, quality of care deficiencies, and the rapid proliferation of technological advancements. However, because of Medicare's size, the program has the opportunity to positively influence the overall health care system as it establishes and refines its own policy direction. It is within this context that Medicare's accomplishments and future challenges must be considered.

Below, we review the major achievements of the Medicare program over the past 40 years and identify improvements that would ensure that Medicare remains a viable, affordable, beneficiary-focused program covering comprehensive, high quality services, while at the same time carefully stewarding program resources. Section II discusses Medicare's accomplishments, including improving access to health coverage and services, providing greater financial security to beneficiaries, controlling program spending, and emerging as a leader in quality improvement activities. In Section III, we consider future challenges, including ensuring Medicare affordability for program beneficiaries, addressing the chronic care needs of an aging population, improving the quality of care in Medicare, ensuring the financial strength of the program, and ensuring fair competition among all Medicare coverage options. Section IV concludes with a brief summary.

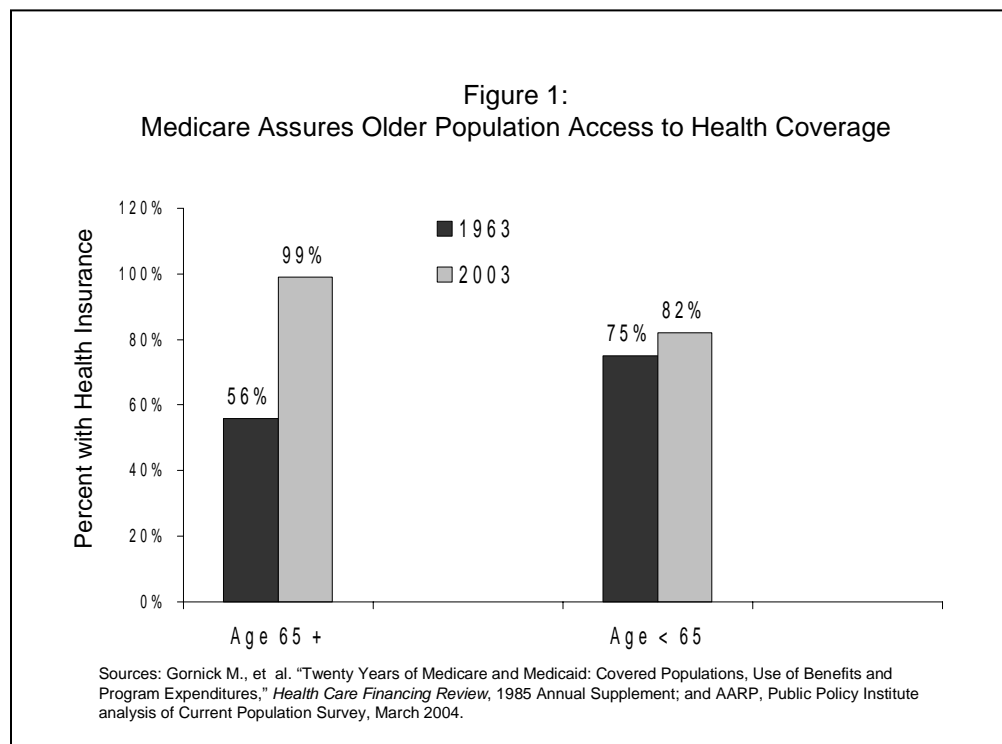
II. Looking Back: Medicare's Accomplishments

Improved Access to Health Coverage and Services

The passage of Medicare in 1965 marked the culmination of over a decade-long debate about universal health coverage for all. Although such coverage was then only extended to older adults, the universal nature of the Medicare program for the older population remains one of its hallmarks. In 1963, 44 percent of those age 65 and older were uninsured.⁶ It is a testament to Medicare's success that, in 2003, less than one percent of those aged 65 and older lacked health coverage (see Figure 1). The security that Medicare offers its beneficiaries, regardless of their health status, is immeasurable.

Expansion of the Medicare entitlement to persons with disabilities was another significant milestone in the history of the program. The 1972 amendments to Title XVIII of the Social Security Act extended Medicare eligibility to those with End State Renal Disease (ESRD), as well as to individuals with disabilities who receive Social Security Disability Income (SSDI) benefits and have satisfied Medicare's 24-month waiting period. In 1973, two million people enrolled in Medicare on the basis of their disabilities; by 2004, 6.4 million such individuals were enrolled. Medicare coverage for persons with disabilities has significantly improved access for those without a connection to the workforce and who cannot obtain adequate or any coverage in the private market. Persons with disabilities who do not qualify for Medicare or Medicaid and who also lack access to other kinds of insurance coverage face daunting problems getting health care.

This link between coverage and improved health status and quality of life is widely accepted. Medicare coverage for hospital and medical services offers beneficiaries access to medical and scientific advances that have transformed health care. For instance, access to implantable cardiac defibrillators has saved many beneficiaries from sudden death due to heart arrhythmias. Cataract surgery and hip and knee replacements have reduced limitations in vision and mobility that previously compromised the quality of life and mobility of many adults with cataracts and



osteoarthritis. Medicare coverage for organ transplants, including heart, lung, liver, and kidneys, has given recipients a new lease on life. By ensuring access to these important advances in modern science, Medicare has both improved the quality of life of beneficiaries and likely contributed to increased life expectancy.

In addition to keeping pace with advances of modern medical care, Medicare has evolved to reflect changes in health care delivery and the composition and needs of the Medicare population. Notably, the program has added benefits for some preventive services intended to detect and treat medical problems early. In addition, the hospice benefit, added to the program in 1982, improved options for terminally ill patients who desire palliative care. Other critical benefits added include speech and physical therapy. The home health care benefit was also improved, and modest steps were taken toward greater mental health parity with Medicare's other health benefits. Most recently, prescription drug coverage was added as a voluntary benefit—a long-overdue enhancement that was essential in order for Medicare benefits to keep pace with contemporary medical practice. In addition, the shift of many services from inpatient to outpatient hospital settings is reflected in Medicare's spending. In 1980, two-thirds of Medicare's dollars (67.4%) went toward inpatient hospital care.⁷ In contrast, in 2004, inpatient hospital services accounted for only 38 percent of Medicare's total expenditures.⁸

Additionally, although Medicare offered some beneficiaries access to private health plans (i.e., pre-paid group practice plans) almost from its inception, with the enactment of the Balanced Budget Act of 1997 (BBA) and the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), Medicare beneficiaries are offered a much larger array of coverage options than ever before.

Medicare has also played a leadership role in improving access to care for minority populations. Coming on the heels of the Civil Rights Act of 1964, the Medicare program helped African Americans gain access to health care providers and facilities which were previously unavailable to them. In 1963, nonwhite individuals age 75 and older visited a doctor an average of 4.8 times; by 1971, these nonwhite persons averaged 7.3 visits to a doctor, a rate comparable to that of their white counterparts.⁹ Nevertheless, Medicare has undeniably helped to improve access to health care services for racial and ethnic minorities, health disparities related to race and ethnicity are still pervasive.

An array of evidence demonstrates the value of Medicare to its beneficiaries. Nine in ten Medicare beneficiaries say that, if they have a health problem, they see a doctor.¹⁰ Compared to adults under age 65, the population age 65 and older expresses higher levels of satisfaction with care they have received in the last two years and with their current health insurance. They are also more likely than their younger counterparts to express confidence about getting the treatments they need.¹¹ In 2004, Americans with annual incomes below \$35,000 and minorities are particularly likely to express confidence in various aspects of the health care system when they consider their future entitlement to Medicare.¹²

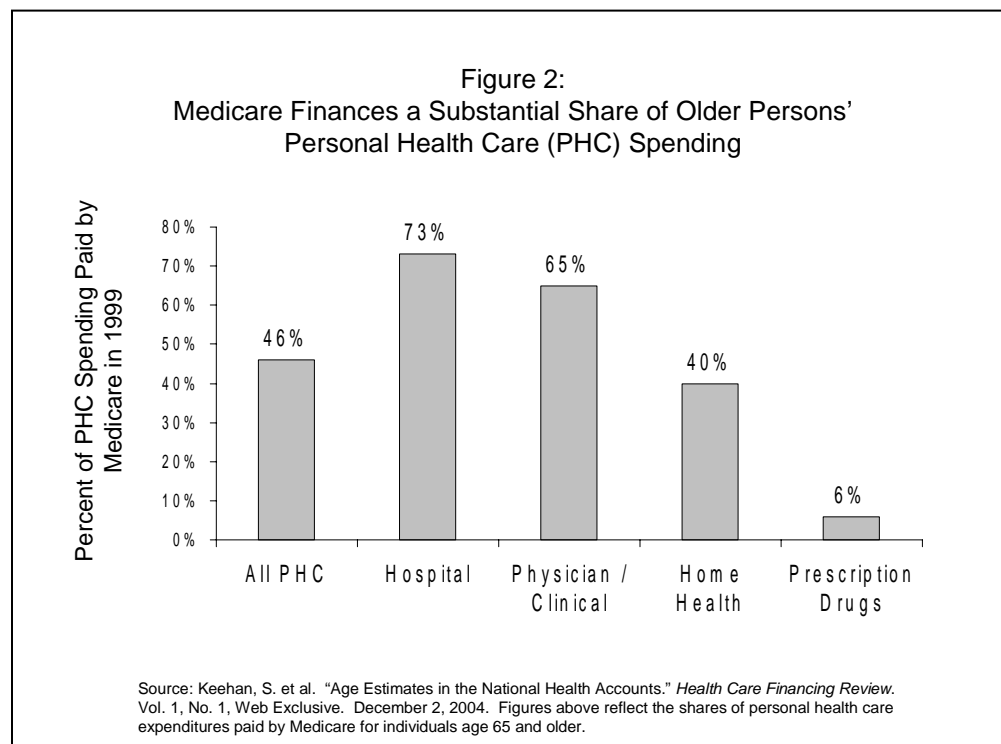
Greater Financial Security for Medicare Beneficiaries

As a result of Medicare's passage, millions of older Americans gained important financial protection against the threat of potentially large acute health care expenses. Older persons are particularly at risk of incurring substantial financial liabilities because, compared with persons under age 65, older persons require more health care resources. In 1999, individuals age 65 and older made up 13 percent of the U.S. population but consumed 36 percent of all personal health care spending. At the individual level, total personal health care spending for persons age 65 and older in 1999 was, on average, roughly four times that for individuals under age 65.¹³ While employer-sponsored and other insurance covers many of the costs of persons younger than age 65, Medicare coverage ensures that many of these health care costs are covered for older Americans (and younger Americans with disabilities).

The Medicare program lessened the financial burdens of health care costs that older Americans would have faced otherwise. The typical person age 65 and older spent about 19 percent of his or her income on health care in 1965. In 1968, following Medicare's implementation, out-of-pocket health care spending as a share of income fell to 11 percent.¹⁴ Not surprisingly, as health care inflation continues to outpace general inflation, the portion of income spent on health care by older Americans has increased in recent years. According to the latest projections by the AARP Public Policy Institute, in 2003, non-institutionalized Medicare beneficiaries age 65 and older spent 22 percent of their income (or \$3,455), on average, for health care, including Medicare cost-sharing, Part B and private insurance premiums, and the costs of goods and services not covered by Medicare.¹⁵ (This estimate excludes the cost of long-term nursing home care and the costs of home care.) Although spending 22 percent of income on health care still represents a substantial outlay, the figure would be even higher for most people in the absence of Medicare, and many beneficiaries would likely forgo necessary care if the program did not exist.¹⁶

Furthermore, as a result of major Medicare legislation passed in the late 1980s, Medicare beneficiaries with limited income and assets are entitled to additional financial protections. This assistance takes the form of Medicaid payment of Medicare premiums and, sometimes, deductibles and other cost-sharing amounts for Medicare beneficiaries known as Qualified Medicare Beneficiaries (QMBs), Specified Low-Income Medicare Beneficiaries (SLMBs), and Qualifying Individuals (QIs). Currently, about 1 million Medicare beneficiaries who are not entitled to full Medicaid benefits receive this assistance with their out-of-pocket Medicare liabilities. In addition, many of the over 6 million Medicare beneficiaries who are also eligible for Medicaid benefits are helped in the same way.

Today, Medicare provides a relatively high degree of financial protection for certain types of health care services (see Figure 2). For example, Medicare financed 73 percent of older persons' hospital care spending and 65 percent of their physician spending in 1999. Overall, Medicare financed 46 percent of older persons' total personal health care expenditures.¹⁷



Controlling Medicare Spending

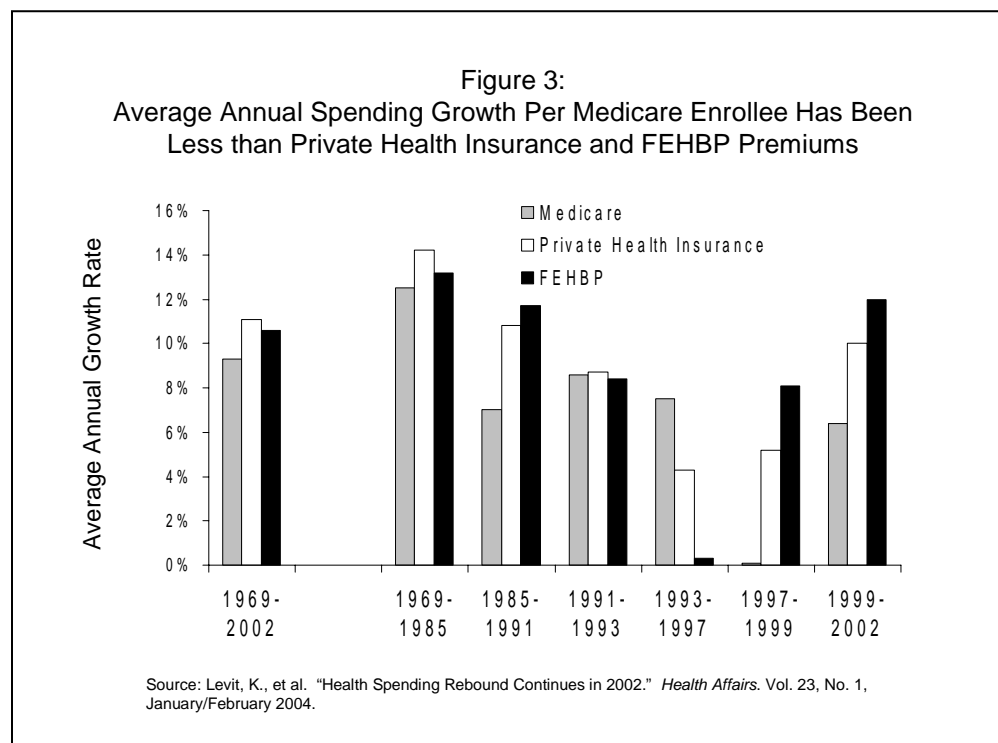
Even as Medicare spending has grown from \$7.7 billion in 1970 to \$283.1 billion in 2003¹⁸, the program has been relatively successful in controlling costs compared to the rest of the health care sector. It is noteworthy that, in general, Medicare has performed as well or better than the private health insurance sector and the Federal Employees Health Benefits Program (FEHBP) in controlling per capita costs (see Figure 3). Of course, Medicare's spending has grown at a faster rate than private health insurance and the FEHBP during some time periods and at a slower rate in other periods; the differences have sometimes been dramatic. On average, however,

Medicare's spending grew at an annual rate of 9.3 percent between 1969 and 2002, while private health insurance and the FEHBP grew by 11.1 percent and 10.6 percent, respectively, during this same period. When comparing across benefits that are common to Medicare, private insurance, and FEHBP, the difference among growth rates narrows, but average annual Medicare spending growth remains slower than the other two sources of coverage.¹⁹

In addition, Medicare has developed innovative cost-control measures that have been borrowed (with some adaptations) by the private sector. When Medicare was first implemented, it reimbursed hospitals and other health care providers based on the reasonable costs of services as reported by providers. Since providers were paid based on *their* reported costs for providing services, providers had incentives to provide more services. These incentives, along with increases in the costs of technology, led hospital expenditures to grow rapidly.²⁰ The 1983 introduction of a prospective payment system (PPS), under which hospitals are paid a prospectively determined amount per discharge based upon diagnosis related groups (DRGs), has resulted in less rapid growth in Medicare's inpatient hospital costs. According to the Medicare Payment Advisory Commission (MedPAC), beneficiaries continue to experience appropriate access to hospital services under this payment policy.²¹

To control the costs of other types of services, Medicare has introduced prospective payment systems or fee schedules in other settings, as well. For example, starting in 1992, physician service payments were set using a fee schedule (rather than through a reasonable cost basis). Since 1992, new prospective payment systems for outpatient hospital services, skilled nursing facilities, home health care, and other services have been implemented. Many private health insurers, that had also reimbursed most providers on a reasonable cost basis in the past, have adopted Medicare's innovative methods of reimbursing providers.

Finally, through the years, Medicare's administrative costs have been low, particularly in comparison to private health insurance plans. In 2002, Medicare's administrative costs



accounted for 1.8 percent of total benefit payments.²³ In comparison, average administrative costs as a percentage of private health insurance premiums were 11.6 percent in 2002.²⁴ Medicare's administrative costs have been lauded on the one hand and, on the other hand, viewed as evidence of under-funding for key Medicare administrative functions.

An Emerging Leader in the Effort to Improve Health Care Quality

From its inception, Medicare recognized its responsibility to assure the effective use of program resources through the provision of high quality care. The program's efforts reflected the state of quality assurance throughout the health care industry.²⁵ They began with a focus on reducing unnecessary utilization of physician and hospital services and an emphasis on utilization and case-level reviews. However, Medicare's approach to quality improvement has evolved into a multi-pronged strategy that includes certification of providers and health plans to ensure that they meet specified conditions of participation; technical assistance to providers and practitioners offered by the Quality Improvement Organizations (QIOs); public reporting; development and testing of quality measures; and consumer protections (e.g., grievance and appeals procedures) to ensure beneficiaries' appropriate access to needed services.

The centrality of quality improvement and related activities on the Centers for Medicare and Medicaid Services (CMS) agenda reflects the imperative to address quality deficiencies in the Medicare program. To advance the premise that substantial improvement is not likely without health information technology (HIT) and process redesign, CMS has implemented a number of physician-focused pilots. These include the use of clinical performance measures to assess how well physicians care for their patients; the application of physician office standards that help to assess physicians' use of various registries to track patients with chronic illness, referrals, and test results; the assessment of workflow efficiencies, continuity of care, and care management; and the administration of a survey to measure patient experience of care. In addition, HIT deployment is promoted by assisting physician offices in adopting and using HIT to improve quality and safety, and by working with the vendor community to promote the development of appropriate and affordable technology.

MedPAC has also recommended that Medicare implement financial incentives to improve quality by linking payment to higher performance (i.e., "pay for performance"). Medicare has already initiated demonstration programs to reward hospitals for better performance. In addition, Congress is currently considering several proposals that would initially reward providers, practitioners, and health plans for collecting and reporting information; ultimately, they would receive higher payments for improving or attaining designated levels of care.

Medicare has played a leading role in publishing and disseminating information about the performance of health plans, hospitals, nursing homes, home health agencies, and dialysis centers. Through its web site and toll-free telephone number, people on Medicare, their families, and advocates are able to compare the performance of competing organizations. With the MMA's reliance on consumer choice to reduce costs and drive improvement, all Medicare health plans, including the traditional fee-for-service program, will compete for enrollees on the basis of the cost and quality of the care they provide. Therefore, information about cost, benefits, and

health care quality to facilitate comparison among coverage options and aid beneficiary decision making will become even more important.

III. Looking Ahead: Challenges for the Future

Ensuring Affordability for Medicare Beneficiaries

The ability of beneficiaries to afford health care services is a function of both Medicare spending trends and the nature of Medicare coverage itself. As noted above, Medicare spending growth has been similar to the health care sector in general, and this trend is expected to continue in the near future. According to the most recent projections of national health expenditures, Medicare spending is projected to grow by 7.3 percent annually between 2006 and 2014.²⁶

As Medicare spending increases over time, the program's premium amounts will continue to rise as well. For example, between 2003 and 2005, the monthly Part B premium increased from \$58.70 per month to \$78.20 per month, an increase of 33 percent. This means that, for a typical worker who retired in 2000 and receives the average Social Security benefit, the annual Part B premium increases consumed over 40 percent of his/her annual cost-of-living adjustments (COLAs) in both 2004 and 2005.²⁷ Such unusually high Part B premium increases are expected to continue in 2006. The premium increases have been especially high in recent years, due in part to provider payment increases and the growth of Part B drug spending. In 2007, the Part B premium increases will be even higher for certain individuals because the premium then will be income related.

The experience of the physician payment update formula illustrates the challenge of simultaneously controlling costs – to beneficiaries and the program – while maintaining access to care. To help control Part B spending, the physician payment formula includes budget targets that were to have resulted in negative physician payment updates for 2002 through 2005 (the update formula can yield either positive or negative payment updates). Yet due to intense political pressure against such decreases and concerns about disrupting access to physician services, Congress has generally chosen to revise physician payments by overriding the formula when the end result is payment reductions. These changes have contributed to both higher Part B premiums and cost-sharing for physician services.

Even if the physician payment update formula is not further modified by Congress, beneficiaries' out-of-pocket costs can be expected to continue growing. As noted earlier, Medicare coverage is sometimes accompanied by substantial cost-sharing requirements and, unlike most private health insurance policies, Medicare does not have a dollar limit on beneficiary cost-sharing liability.

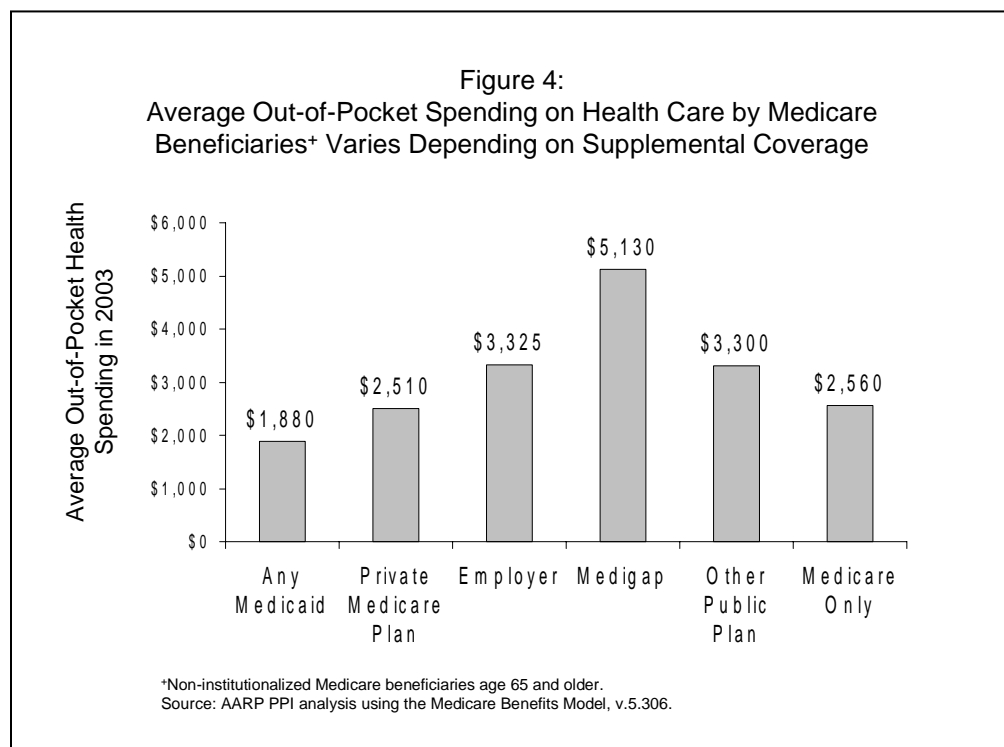
In addition, beneficiaries without supplemental coverage face cost-sharing levels for certain Medicare benefits that resemble those found in high-deductible insurance products in the commercial insurance market. For example, in 2005, the Part A hospital deductible was \$912; the benefit also carries a very substantial coinsurance for long hospital stays. Since hospital care is typically not discretionary, vulnerable patients who cannot afford supplemental coverage are likely to struggle with the required high cost-sharing requirements as well. However, in the current commercial market, high-deductible coverage that is coupled with a "consumer-driven" health plan usually incorporates information and decision support to help individuals who select these products. In contrast, Medicare does not offer the necessary tools to facilitate this type of

decision making, nor are all Medicare beneficiaries likely to be able to use such tools unless they are customized to address health literacy and other issues.

Furthermore, significant coverage gaps remain: Medicare provides limited coverage of certain health care services, including mental health, long-term care, vision, hearing, and dental care. In addition, while the Medicare prescription drug benefit is a strong first step toward affordable drug coverage for people on Medicare, the benefit leaves a significant coverage gap that must be filled. As technology and other health care costs continue to rise, it could become increasingly difficult for beneficiaries to afford the costs of Medicare's premiums and cost-sharing, as well as the costs of services that Medicare does not cover. Under current law, by 2010, the Part B and Part D premiums and cost-sharing are expected to consume 13 percent and 22 percent, respectively, of the average Social Security benefit.²⁸

Given limitations in Medicare's benefit structure, most beneficiaries today have private or public supplemental coverage to pay for some of the health care costs not covered by Medicare. However, the premiums for both Medicare and additional coverage can account for a substantial portion of beneficiary out-of-pocket health care spending (see Figure 4). Even in Medicare Advantage plans that typically feature lower out-of-pocket costs than the fee-for-service Medicare plan, enrollees in fair or poor health faced average out-of-pocket costs of \$2696 and \$5305, respectively in 2003, a significant burden for low-income individuals.²⁹

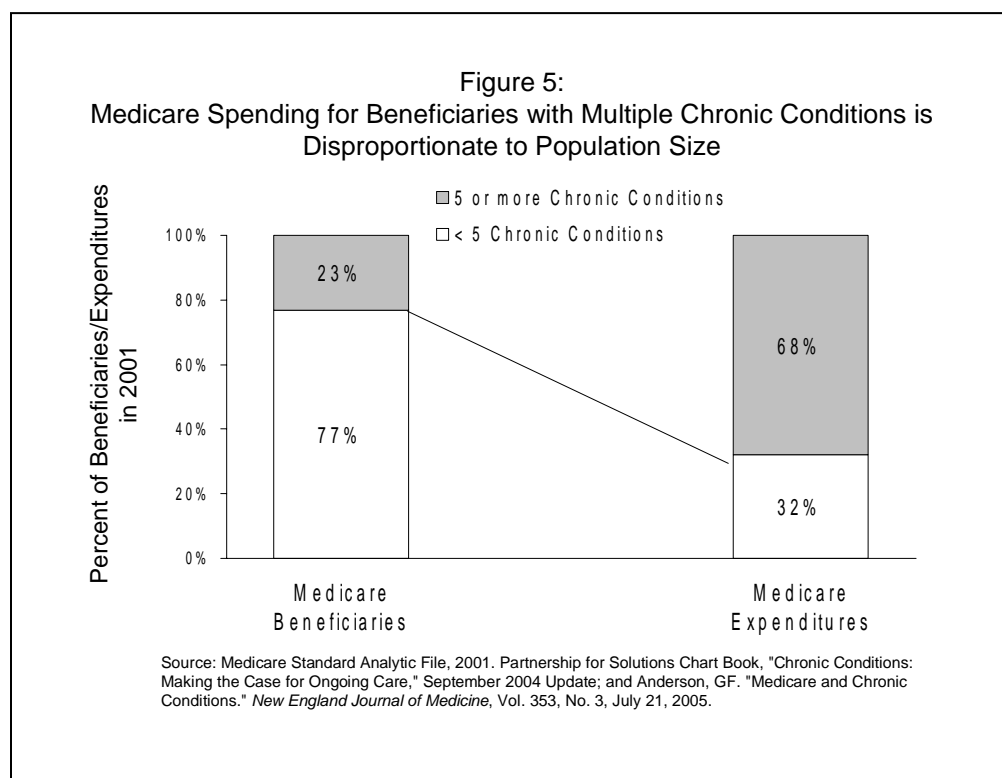
The fact that the Medicare benefit package is in need of supplementation is also of concern because persons with disabilities under age 65 often are not able to purchase private individual supplemental coverage. In 1997, only 14 states required Medigap insurers to offer Medicare beneficiaries under age 65 the opportunity to buy such coverage.³⁰ (In some states, these beneficiaries were able to purchase supplemental coverage through high risk pools—an important but expensive source of coverage.) Individuals with disabilities who have no other source of coverage (e.g., state disability programs, Veterans' benefits, workers' compensation) may find that the cost of needed care is unaffordable.



Addressing the Chronic Care Needs of an Aging Population

Chronic conditions are pervasive among Medicare beneficiaries: 82 percent of beneficiaries over age 65 have at least one chronic condition, while about 12 percent have at least 5 chronic conditions. The prevalence of multiple chronic conditions increases with age.³¹ In addition, Medicare beneficiaries with chronic conditions are more likely to require multiple services from different providers. Medicare beneficiaries with one chronic condition visit an average of four different physicians per year, while those with five chronic conditions visit 13.8 physicians, annually.³² As the number of chronic conditions increases, so does the number of prescriptions written for beneficiaries. Medicare beneficiaries with two chronic conditions fill an average of 18 prescriptions per year, while those with five or more chronic conditions fill an average of 40 prescriptions per year.³³

The high and increasing prevalence of chronic conditions, particularly multiple chronic conditions, among Medicare beneficiaries has significant financial implications for both beneficiaries and the program (see Figure 5). Medicare program spending is highly concentrated in beneficiaries with chronic conditions: about one-quarter (23%) of Medicare beneficiaries have at least 5 chronic conditions and account for about two-thirds (68%) of Medicare fee-for-service expenditures.³⁴ One study found that 12% of beneficiaries with five chronic conditions were hospitalized with a condition that might have been avoidable with appropriate ambulatory care, and the percentage rose to almost 30% for those with 9 chronic conditions. The avoidable hospitalizations were estimated to have cost \$24.6 billion in 2001.³⁵



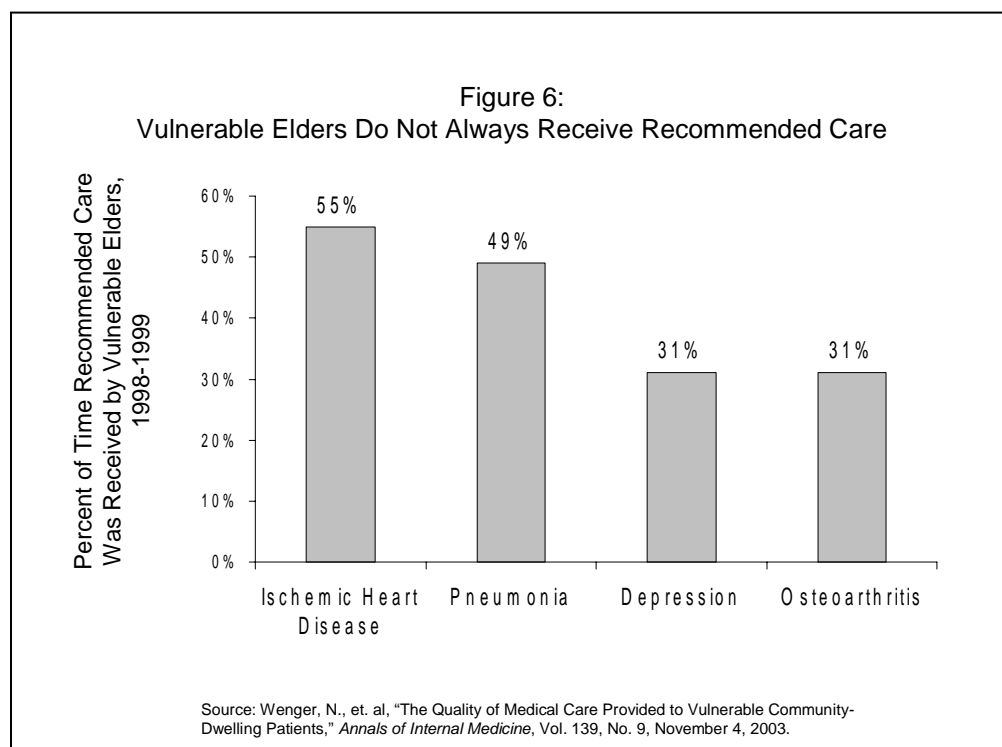
With its emphasis on acute, episodic care, the Medicare program often has difficulty meeting the needs of beneficiaries with chronic conditions. Fragmented payment systems encourage fragmented care. Medicare's fee-for-service payment methods emphasize the importance of individual providers and discrete services, even though a team approach is often a key ingredient of care coordination for chronic conditions. Medicare fee-for-service payments are not adequately adjusted for complex care associated with chronic conditions. It is difficult to track and compare the status of patients' health, functional ability, and quality of life across settings of care. Lack of clinical practice guidelines for care coordination discourages effective chronic care management. In addition, by law, Medicare is not permitted to exercise control over the practice of medicine or the manner in which medical services are provided. Congressional approval is required for certain Medicare changes that could substantially improve care coordination. This rigidity discourages experimentation with benefits design and beneficiary incentives. For instance, the Medicare program is not allowed to single out coordinated care providers with different financial incentives or distinguish them as "preferred" providers.

Chronic care coordination appears to offer the Medicare program an opportunity to both improve the quality of care and reduce its cost. Medicare is pursuing a wide range of research and other initiatives to improve fee-for-service care for beneficiaries with chronic conditions including, among others, voluntary participation in care coordination programs for beneficiaries with selected chronic conditions, such as diabetes, congestive heart failure and emphysema; separate reimbursement to physicians who provide care coordination for chronic conditions; and payment vouchers to beneficiaries with chronic conditions so they can better control delivery of their personal care services in the home through the use of family and friends. Capitation payment under the Medicare Advantage Program already offers managed care plans incentives and flexibility to improve approaches to care delivery for beneficiaries with chronic care conditions.

Medicare's willingness to experiment with promising and innovative approaches to care coordination for beneficiaries with chronic conditions represents critical movement in the right direction. However, it is too early to tell which of the approaches being tested might be successful in improving care coordination or whether any of them can slow projected increases in Medicare spending. Nevertheless, it is essential that the results of these demonstrations be translated into improvements in chronic care within the broader Medicare program without being overshadowed by a search for savings. The investment in approaches that increase the value of care for chronic conditions will play an important part in transforming Medicare into a well-coordinated program serving the needs of the growing number of beneficiaries with chronic conditions.

Improving Health Care Quality

The shortcomings of the American health care system are well documented. Many individuals do not receive recommended care and too often, patients suffer needlessly as a result of medical mistakes. In addition, many patients receive care for which the risks exceed the benefit of the treatment provided. Moreover, disparities linked to race, ethnicity, and socioeconomic characteristics are pervasive. These problems of overuse, underuse, and misuse of services are found throughout the health care system, regardless of the health care setting (physician offices, hospitals, health plans) or payer, including Medicare (see Figure 6).



Current payment policies discourage quality improvement by paying the same amount for good care or poor care. In addition, Medicare spending varies dramatically across the nation. Yet beneficiaries in higher-spending areas do not experience better health outcomes or report greater satisfaction with their care.³⁷ Moreover, HIT is so limited that its absence seriously handicaps clinicians and health care workers who would benefit from the implementation of electronic medical records, decision support, and other technological advancements. A majority of outpatient visits in the traditional Medicare program in 2001 were to physicians who lacked “significant IT support” for patient care.³⁸

Even in Medicare, where there has been a concerted effort to provide beneficiaries with comparative information, the type and extent of information varies considerably by setting. Thus, there is substantial information on clinical quality and patient experiences to permit comparison of health maintenance organizations; however very little similar information is available to allow beneficiaries to make head-to-head comparisons with care in the traditional Medicare program, or, for that matter, with other types of private health plans, such as preferred provider organizations. Although much progress is being made in the direction of individual and medical group assessment, people on Medicare do not yet have the information they would like about the quality of care provided at this level. Thus, beneficiary decision making is hampered by the lack of sufficient information to facilitate truly informed choices.

Both decision making and quality improvement require valid and reliable performance measures. Measures development remains a slow and costly process; therefore, Medicare’s role in supporting this activity is essential. In addition to the need for measures of physician and medical group performance, additional measures are also needed at the hospital level. Finally, the addition of the new Medicare drug benefit presents a new challenge: how to compare the quality

of competing prescription drug plans. Continued research by Medicare and the Agency for Healthcare Research and Quality is needed to better understand the type of measures that will be most meaningful to consumers and that will also advance efforts to improve quality.

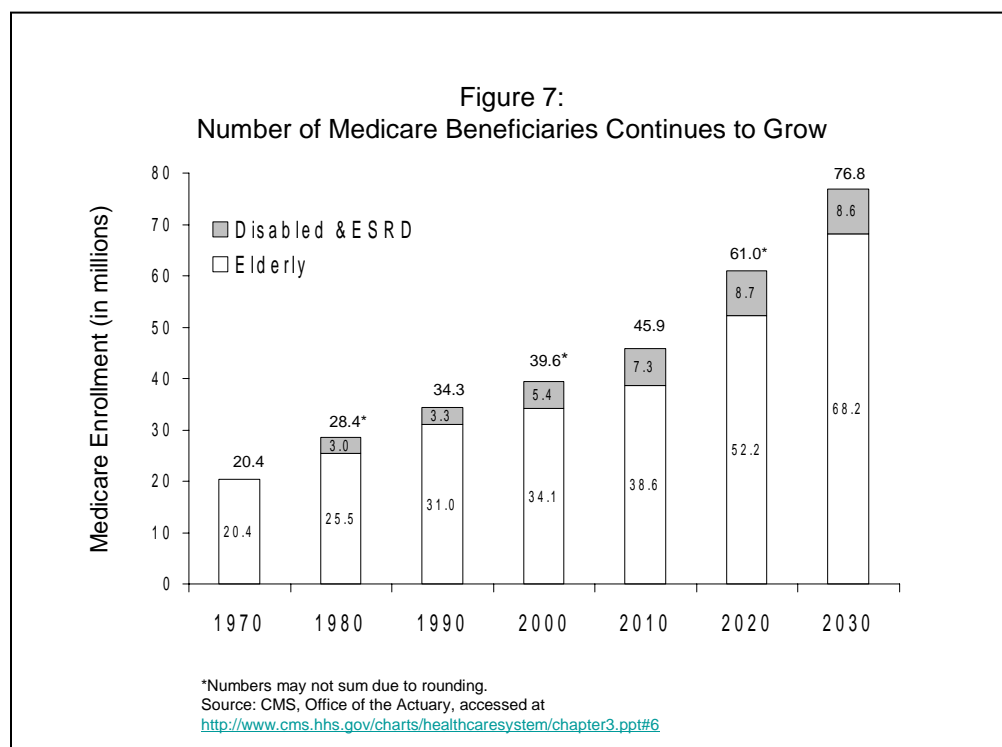
The promise of improved quality would significantly enhance the future of the Medicare program, and greater reliance on HIT would necessarily be a major factor in that effort. Eliminating unnecessary care and making appropriate use of resources by ensuring that patients get the right care when they need it would lead to greater efficiency and, potentially, lower costs. Better decision support could help to ensure more consistent use of evidence-based clinical guidelines. HIT would facilitate performance assessment by making clinical information easily retrievable (in contrast to time-consuming and costly manual chart abstraction). Finally, it would integrate the fragmented components of the health care system by permitting information sharing through interoperable systems, thus fostering improved coordination, reduced duplication of services, and fewer medical errors.

Ensuring Financial Strength of the Medicare Program

According to the 2005 report of the Medicare Trustees, because Medicare's Hospital Insurance (HI or Part A) Trust Fund is projected to be solvent until some time during the year 2020, the Medicare Part A program is not considered to be in immediate financial "crisis." In practical terms, however, the continuing rise of health care and Medicare costs, the forthcoming entry of the boomers, and the increased longevity of the population mean that the financial health of Medicare needs to be fortified if the program is to continue protecting beneficiaries from the cost of health care³⁹ (see Figure 7).

In theory, potential policies for strengthening Medicare's financial condition include reducing provider payments, reducing Medicare benefits by increasing cost-sharing, increasing the age of eligibility, reducing the scope of Medicare benefits, increasing payroll taxes or other taxes used for Medicare, or increasing beneficiary premiums (or combinations of these approaches). Medicare is financed through a combination of taxes (primarily *payroll taxes*, which finance most of Part A costs, and *personal and corporate income taxes*, which finance about 75 percent of Part B costs and, starting in 2006, Part D costs) and beneficiary contributions (premiums).

The challenge in ensuring the future financial strength of Medicare is that policymakers may not view all of these policy tools as viable. For example, previous efforts to contain costs by reducing payments to providers – such as through the BBA – were significantly weakened by subsequent legislation that increased payments to the affected providers and others. More recently, as part of a market-based approach to containing costs in the Medicare program, legislators chose to allow payments to private health plans to exceed fee-for-service payments in the traditional Medicare program for similar patients. Also as part of the MMA, the "Medicare funding warning" measure was created to help policymakers assess the funding of the Medicare Supplementary Medical Insurance (SMI) Trust Fund, consisting of accounts for Part B and Part D. This measure calls attention to the percentage of Medicare costs that are financed by general revenues, implying that percentages above an arbitrarily-determined level are undesirable. The policy tools that remain to address Medicare's financial condition rely disproportionately on beneficiaries shouldering the cost. In light of Medicare's growing cost-sharing and premium requirements, it is unrealistic to expect that beneficiaries can shoulder much more of the financing burden without impoverishing many of them.



Although policymakers have expressed reluctance to raise revenues so that Medicare can continue meeting the needs of its beneficiaries, recent public opinion polls indicate that adequately financing Medicare for future generations is a high priority and additional revenues should be considered. In November 2004, 58 percent of adults surveyed indicated that making Medicare more financially sound for the future should be the top health care priority for the President and Congress.⁴⁰ Furthermore, in a 2003 public opinion survey on taxes, when interviewees were asked whether having the government provide needed services or cutting taxes was more important, 66 percent of adults surveyed responded that they would prefer that the government provide the needed services, with only 31 percent preferring tax cuts.⁴¹

Ensuring Fair Competition

With the enactment of the MMA, Congress expanded competition and other market-oriented features that previously had been confined largely to a small portion of the program—the Medicare Advantage component—that currently covers only about 5 million, or 13 percent of, beneficiaries. In spite of the MedPAC recommendation that Congress adopt “payment neutral” policies, the MMA included provisions that made payments to Medicare Advantage plans in 2005 that are, on average, 8 percent higher than fee-for-service payments for similar beneficiaries; in some counties, such payments exceeded fee-for-service payments by as much as 20 percent.⁴² In addition to creating the new payment policies, Congress also bestowed several attractive attributes, most notably a cap on beneficiary out-of-pocket spending for in-network care, upon a new type of private plan, the “regional preferred provider organization.”

These policies, and others that provide incentives to encourage private plan participation in Medicare and financial incentives to beneficiaries to select plans with lower costs, introduce an

“unelevel” playing field among Medicare coverage options that could potentially disadvantage the traditional program. While it is clear that one coverage option does not meet the needs of all beneficiaries, the traditional program remains a highly popular option that addresses the preference for choice of doctors by many beneficiaries.

In the end, competition may serve both the traditional program and private plans well by forcing them to compete in areas that matter most to beneficiaries—cost and quality. However, to permit healthy competition among alternative coverage options, the basis of competition must be fair. Thus, the traditional Medicare program must be strengthened and further improved by ensuring that it has the flexibility to adopt attributes and features available to private health plans and that the inclusion of sicker enrollees will not unfairly disadvantage traditional Medicare.

IV. Conclusion

In assessing the achievements of the Medicare program, it is important to keep in mind the people it was designed to serve. Medicare beneficiaries are, on average, persons of modest means. Medicare beneficiaries rely on the program to provide high quality, affordable coverage. The coverage gaps in Medicare and the resulting out-of-pocket spending beneficiaries face continue to create barriers to access to needed care for too many people on Medicare. The average annual median income of householders age 65 and over in 2003 was \$23,787 compared to \$44,857 for householders of all ages.⁴³ Although entitlement programs such as Social Security and Medicare have played a critical role in eliminating poverty for older persons, slightly more than 10 percent still are poor, with an additional 6.7 percent having incomes between 100 and 125 percent of the poverty threshold.⁴⁴ (In 2003, the poverty threshold was \$8,825 for a single person age 65 and over and \$11,122 for couples age 65 and over.) Social Security remains the principal source of income for two-thirds of older persons and virtually the *only* source for one-third.⁴⁵

By virtue of its size and importance, the Medicare program occupies a unique and prominent place in the entire health care system. As a mark of its success during the past four decades, one need only consider the leadership role Medicare has played in virtually every aspect of health care financing and delivery. In the face of dynamic and rapid progress in the health care sector, Medicare has kept pace with new technologies, and has frequently introduced innovative and trend-setting practices. In addition, it has focused national attention on the unique needs of persons with chronic illness through program design and payment policies. Further, it has been a leader in supporting informed decision making and quality assurance programs. However, perhaps Medicare’s most significant contribution has been the achievement of virtually universal health insurance coverage for older Americans—an achievement that can be well appreciated as the nation faces the daunting reality of 45 million individuals under age 65 who are without any health coverage. Universal coverage has provided the platform upon which all the other of Medicare’s achievements have been built. In this regard, as with many of its other lasting contributions, Medicare offers an invaluable example for the rest of the health care system. The program has made a critical and dramatic difference in the lives of its beneficiaries and their families.

In 2005, the Medicare program is grappling with the many challenges of an aging and increasingly diverse population. Major issues such as the program’s solvency and affordability remain. However, as part of the larger health insurance environment, many of the challenges

Medicare faces must be addressed system-wide. Without the concerted attention of all sectors of the health care system, it will not be possible to address the formidable challenges of cost-containment, quality improvement, and transforming health care delivery to meet the needs of a population with chronic illness.

In the future, Medicare will continue in its effort to realize its original goals of access to care and economic security. With the necessary resources, leadership, continued innovation, and political support, Medicare will meet the challenges of the future, just as it has demonstrated its ability to meet the challenges of the past 40 years. As the program works toward the achievement of its original goals, it can and should lead by example. It must forge collaborative relationships with the private sector, as well as foster and implement new and innovative strategies, while serving as a model for the entire health care system.

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