

CHAPTER

2

**The next generation of
Medicare beneficiaries**

The next generation of Medicare beneficiaries

Chapter summary

The Medicare population is projected to increase from 54 million beneficiaries today to over 80 million beneficiaries by 2030 as the baby-boom generation ages into Medicare. This expansion will bring changes to the Medicare population. First, the average age of the Medicare population will initially skew younger than in the recent past, but then grow rapidly older as the number and share of beneficiaries ages 85 and older increases. The Medicare population is, and will be for some time, less diverse racially and ethnically than the population as a whole. The health status of future Medicare beneficiaries is not clear. Compared with previous generations, the baby-boom generation has longer life expectancies and much lower rates of smoking, but also has higher rates of obesity and diabetes. Boomers appear to have higher rates of some other diseases and chronic conditions, but they are also much more likely than generations before theirs to have certain health conditions under control.

Baby boomers who have had employer-sponsored insurance likely began their working years having conventional health plans—plans in which health care can be delivered by any provider, with the insurer paying a percentage of the provider’s charges. But over the course of their careers, many experienced the disappearance of conventional plans and the rise and subsequent decline of managed care. Baby boomers likely experienced preferred provider organization plans with broad provider networks. The younger boomers and

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- The health of the future Medicare population
- Supplemental health insurance coverage for Medicare beneficiaries: What to expect in the future
- Income, assets, and wealth
- Challenge for Medicare financing
- Conclusion

the generation that follows them may experience narrow-network plans, high-deductible plans, and the federal and state health insurance exchanges. There are indications that the percentage of firms offering health benefits to Medicare-eligible retirees has declined over the last decade, implying that over time, fewer Medicare beneficiaries will have generous employer-sponsored supplemental health insurance.

The recent recession has taken a toll on the baby-boom generation. Median family income, median family net worth, and the median value of financial assets have not recovered to their prerecession levels. Perceptions of economic well-being are also still low. The oldest baby boomers may have difficulty recouping their losses before entering retirement, which could leave the next generation of Medicare beneficiaries in a more vulnerable economic state than the current Medicare population.

The aging of the baby-boom population could also stress the economic well-being of the working-age population. The number of taxpaying workers per Medicare beneficiary has declined from 4.6 during the early years of the program to 3.1 today; by 2030, this number is projected by the Medicare Trustees to be 2.3. Additionally, Medicare relies heavily on general revenues, and that reliance is projected to increase (from 41 percent of program costs today to 45 percent of program costs in about 15 years); as a result, fewer resources will be available to invest in growing the economic output of the future (e.g., investments in education, transportation, and research and development). Finally, while fee-for-service Medicare covers services delivered by any willing provider, health plans for the working-age population may be narrowing their provider networks and increasing deductibles in an attempt to control health care spending. ■

Introduction

Members of the baby-boom generation (born between mid-1946 and 1964) began aging into Medicare in 2011 at a rate of about 10,000 people per day, a rate that will continue until 2030. Over the next 15 years, Medicare's enrollment is projected to increase almost 50 percent—rising from 54 million beneficiaries today to more than 80 million beneficiaries in 2030. What effect will this large cohort have on the next generation of Medicare beneficiaries and the financial health of the program? This chapter explores that question with particular focus on the following:

- How will the incoming baby boomers affect the age structure of the Medicare population?
- Will the Medicare population be more racially and ethnically diverse given the growing racial and ethnic diversity of the total U.S. population?
- Given the improvements in life expectancies, will the next generation of Medicare beneficiaries live longer and healthier lives than previous generations? Or will the longer life expectancies increase the oldest age groups in Medicare, thereby increasing the rates of disease and chronic conditions?
- What is the projected growth in the share of enrollment in private plans?
- Have baby boomers and especially the oldest of the baby boomers had time to recover from the 2007 to 2009 recession before entering retirement?
- Finally, what is the outlook for the financial health of the Medicare program as the number of taxpaying workers per beneficiary declines?

Looming changes in the size and composition of the Medicare population

Figure 2-1 (p. 38) illustrates in four graphs the aging of the population in the United States that is currently underway. The graph on the top left shows the distribution of the population by age and gender in 1970. At that time, the U.S. population was generally shaped like a pyramid: Starting at the base of the pyramid and moving up, the bars show the population declining in the older age groups. The

dark gray bars depict the baby-boom population, who in 1970 were ages 6 to 24.

In 2010, the oldest boomers were a year away from Medicare eligibility, and the population pyramid was starting to look more like a population rectangle (top-right graph of Figure 2-1). By 2030, the boomers, at that point ages 66 to 84, will have all aged into Medicare and will continue to contribute to rapid population aging (bottom-left graph of Figure 2-1). The sheer numbers of older people will be much higher than in prior years, and there will be a higher proportion of older people represented in the total population. In 2050, the boomers will be ages 86 and over, resulting in a larger population in the oldest old-age groups (bottom-right graph of Figure 2-1). This age structure will be unprecedented in U.S. history. Other economically advanced countries—notably Japan, Germany, Korea, and Italy—are also facing the challenges of aging populations because of low fertility rates and increased life expectancies.

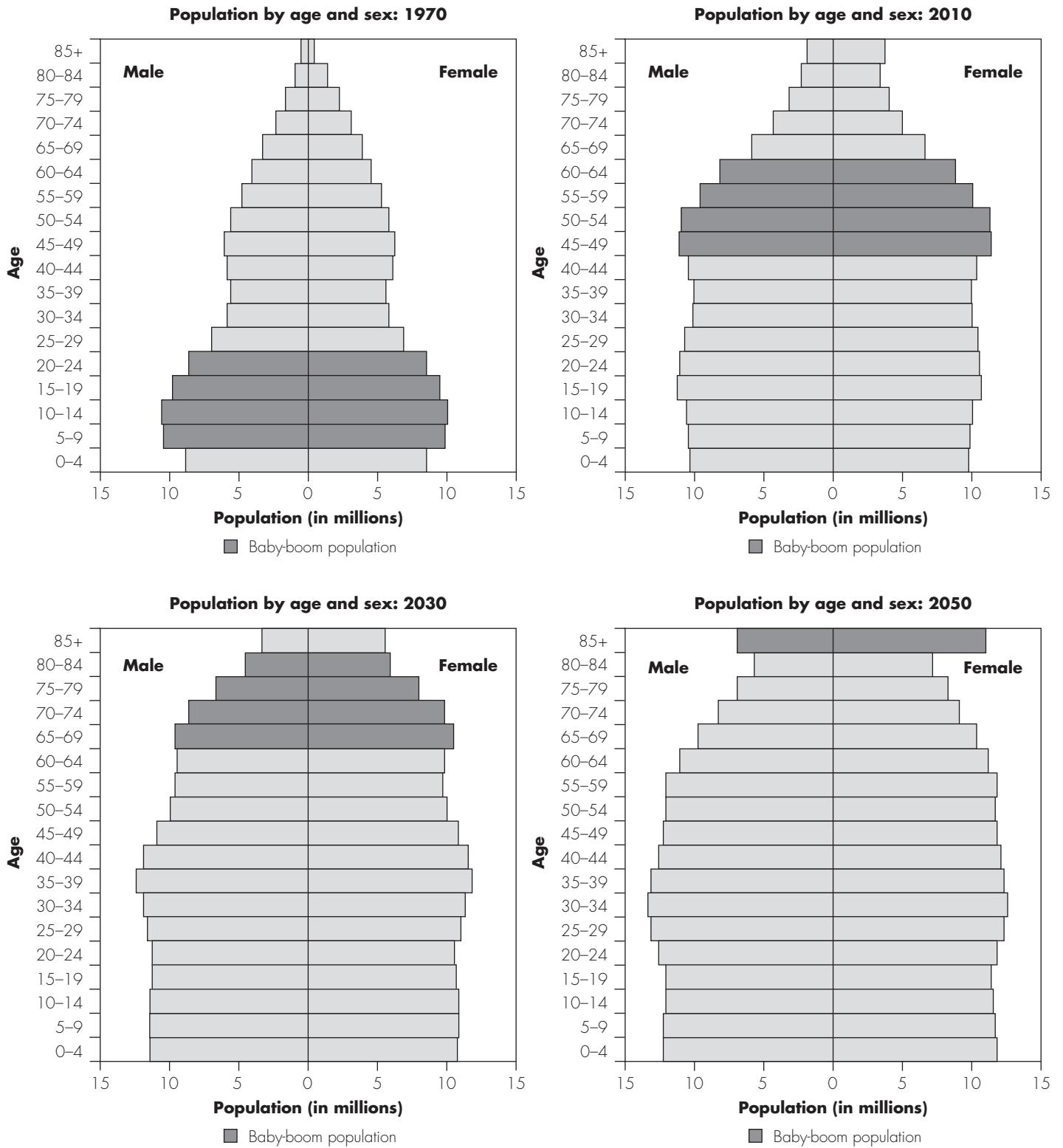
Between 2010 and 2030, the older population (persons ages 65 and over) as a share of the total population is projected to jump from 13 percent to 20 percent, doubling its share from 1970 (Figure 2-2, p. 39). (The demographics of the baby-boom population are relatively similar across the four U.S. census regions, but individual states exhibit more variation. For a description of the demographics of the baby-boom generation by region and by state, see online Appendix 2-A, available at <http://www.medpac.gov>.)

The Medicare population will expand, become younger, and then grow older as the baby-boom generation ages

As the baby-boom generation ages, enrollment in the Medicare program will surge (Figure 2-3a, p. 39). In 15 years, Medicare is projected to have over 80 million beneficiaries—up from 54 million beneficiaries today—almost 90 percent of whom will be of the baby-boom generation. (Medicare enrollment also includes individuals under age 65 who qualify for Medicare based on disability status. See text box, p. 42.) While Medicare enrollment is rising, the number of workers per beneficiary is rapidly declining (Figure 2-3b, p. 39). Workers pay for Medicare spending through payroll taxes and income taxes. However, the number of workers per Medicare beneficiary has declined from 4.6 during the early years of the program to 3.1 today and is projected by the Medicare Trustees to fall to 2.3 by 2030. As discussed at the end of this chapter, these demographics threaten the financial stability of the Medicare program.

FIGURE 2-1

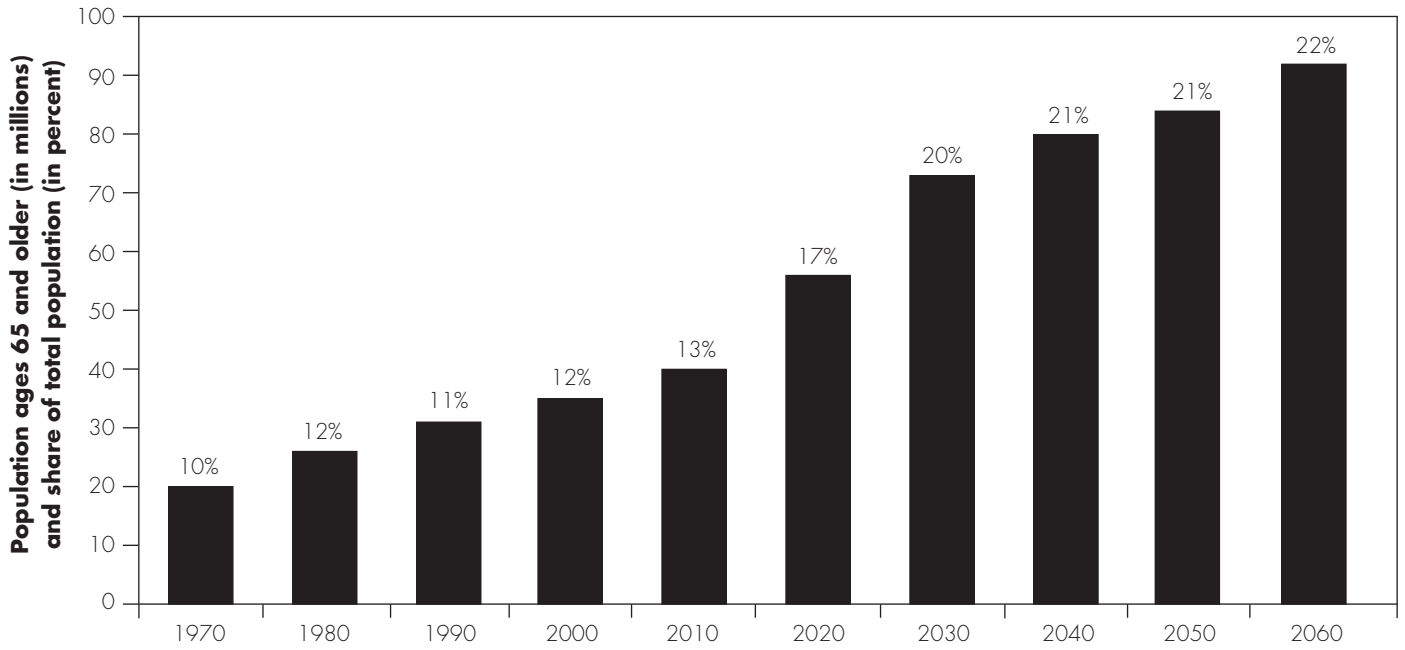
Baby-boom generation's aging causes the U.S. age distribution to shift



Source: Census Bureau 2015a; Census Bureau 2015b.

FIGURE 2-2

The sheer numbers of older people will be much higher than in prior years, as will the older population's share of the total population



Source: Census Bureau 2015a; Census Bureau 2015b.

FIGURE 2-3

Medicare enrollment is rising while workers per HI beneficiary is declining

Figure 2-3a. Medicare enrollment

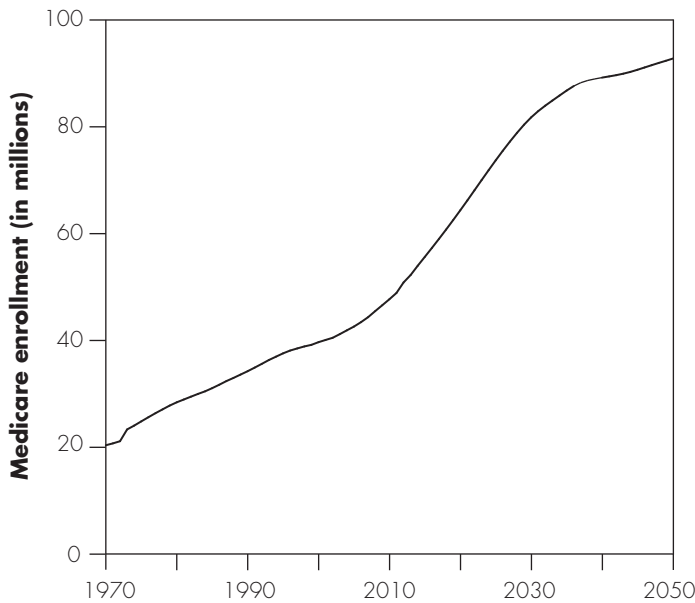
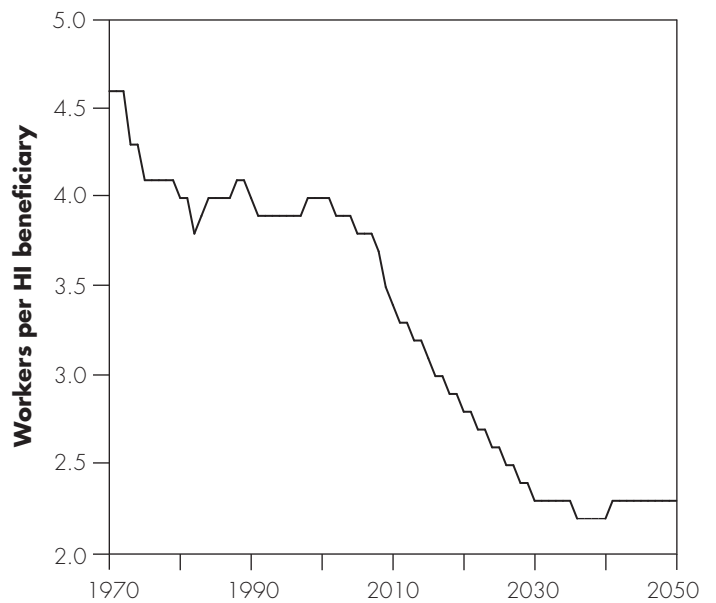


Figure 2-3b. Workers per HI beneficiary

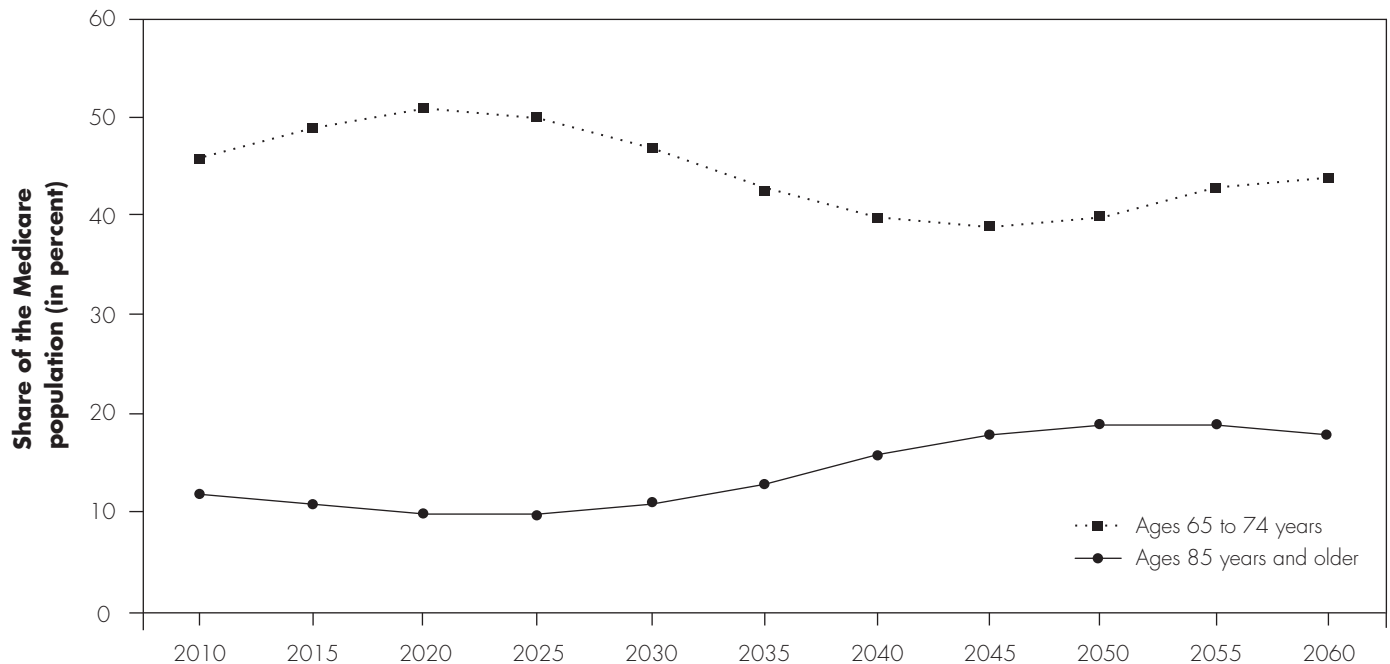


Note: HI (Hospital Insurance). Hospital Insurance is also known as Medicare Part A.

Source: Boards of Trustees 2014.

**FIGURE
2-4**

The Medicare population will become younger and then grow older as the baby-boom generation ages



Source: Boards of Trustees 2014; Census Bureau 2012.

The Medicare population over the next 15 years will be relatively younger as members of the baby-boom generation join its ranks and swell the younger segments (Figure 2-4). The share of the Medicare population ages 85 years and older is projected to decline slightly through 2025 and then grow as baby boomers continue to age (Census Bureau 2012). In 2012, per beneficiary spending for those ages 85 and older was about twice that of those ages 65 to 74. So the changing age structure of the Medicare population will exert somewhat less pressure on spending in the very near term, at least on a per capita basis, and then pressure will increase again over the longer term.¹

Racial and ethnic diversity of the older population will lag behind that of the total population

The older population is, and will be for some time, less diverse racially and ethnically than the total population. Whites will remain a majority of the older population through 2060 (Figure 2-5a), whereas Whites will no longer be a majority of the total population by 2043 (Figure 2-5b). The older population's racial and ethnic

diversity will lag behind that of the total population for several reasons. First, at any given time, the racial and ethnic composition of the Medicare population largely reflects the U.S. population 66 to 100 years ago—when aged Medicare beneficiaries were born. When the baby-boom generation was born—between 1946 and 1964—almost 90 percent of the total U.S. population was White (Ortman et al. 2014). Second, since 1964, the nation's population has become increasingly diverse through increases in immigration and minority births. However, recent immigration does not have much of an effect on the age structure of the older population because most immigrants are under the age of 40 when they arrive in the United States (Ortman et al. 2014). (The racial and ethnic diversity of the baby-boom population varies across U.S. census regions and states. See online Appendix 2-A for a description, available at <http://www.medpac.gov>.)

After 2030, the baby-boom generation's share of the older population will begin to decline, contributing to the increase in the racial and ethnic diversity of the older population. The share of the older population identifying as White is projected to decline modestly from 2012 to 2030, decreasing from 79 percent to 72 percent. By 2060,

**FIGURE
2-5**

The older population (ages 65 and older) is less racially and ethnically diverse than the total population

Figure 2-5a. Percent of the older population, by race and ethnicity

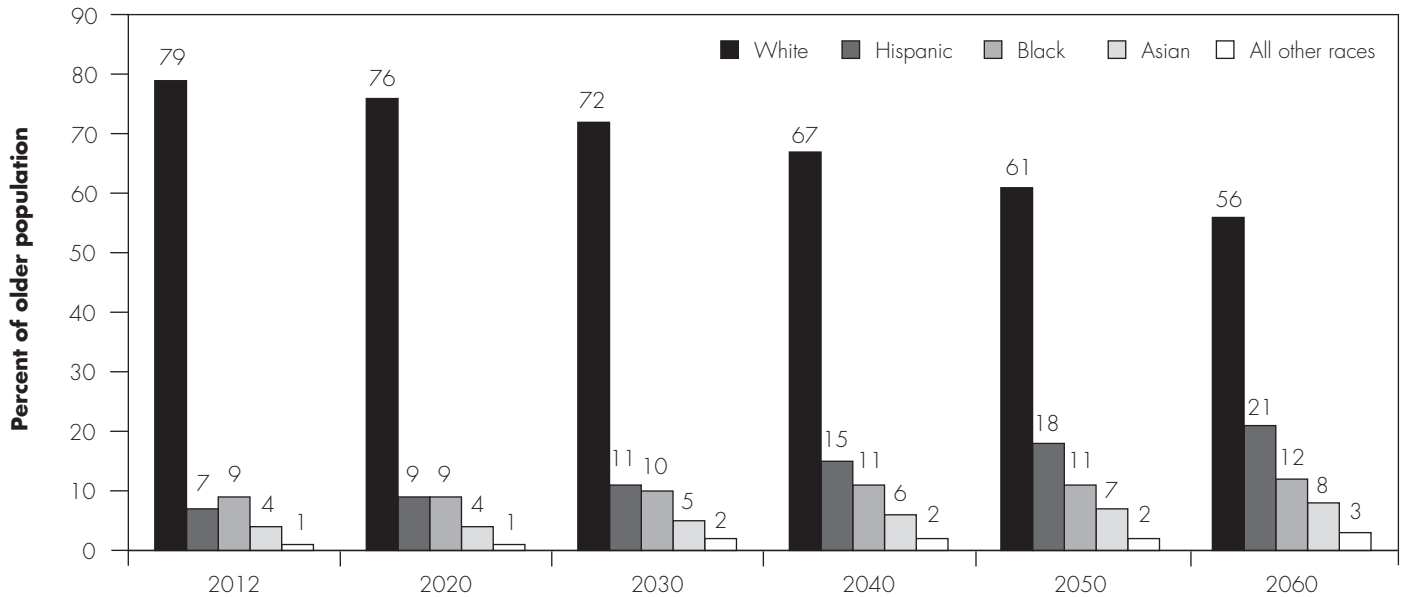
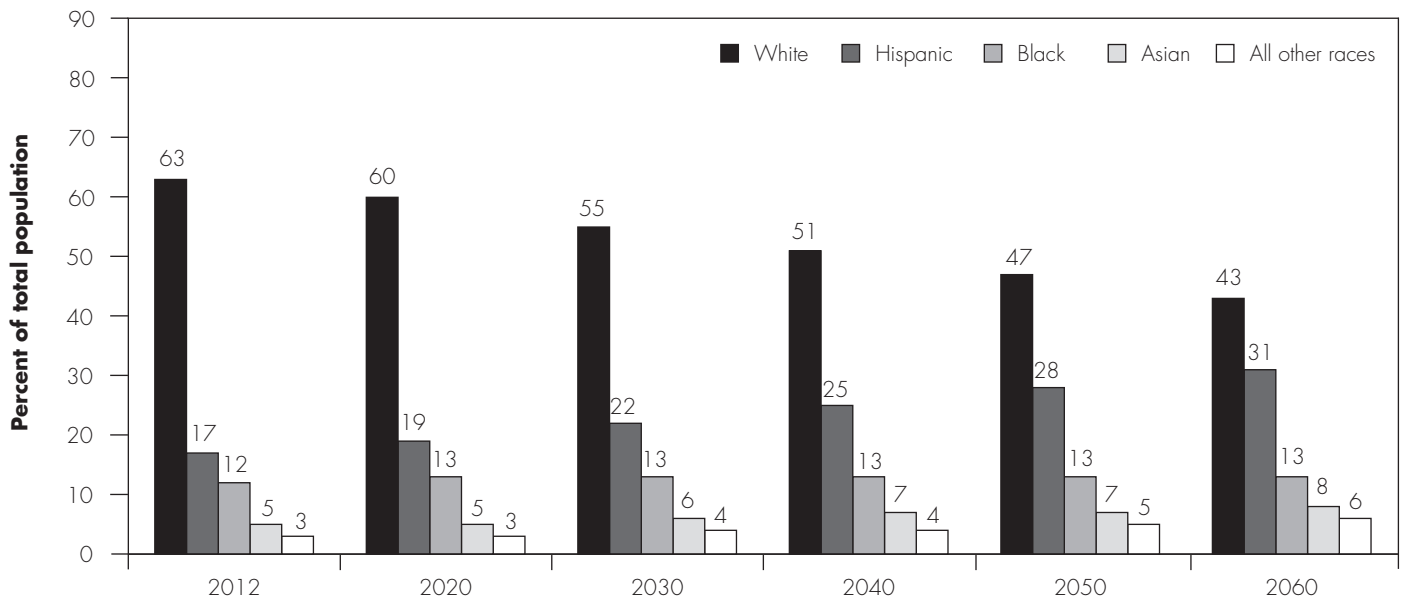


Figure 2-5b. Percent of the total population, by race and ethnicity



Note: "All other" includes American Indian and Alaska Native and multiracial.

Source: Census Bureau 2012.

the share of the older population identifying as White is projected to fall to 56 percent. The share identifying as Hispanic is projected to increase modestly from 2012 to

2030, increasing from 7 percent to 11 percent. By 2060, the share identifying as Hispanic is projected to increase to 21 percent, tripling its 2012 share (Figure 2-5a).

Trends in Disability Insurance enrollment

Demographic and population changes also affect the number of Medicare beneficiaries who are entitled to Medicare on the basis of disability through the Social Security Disability Insurance (SSDI) program. The SSDI program was established in 1956 for workers who are unable to engage in substantial gainful employment as a result of an impairment that would last one year or more or result in death. Currently, individuals under the age of 65 who are entitled to SSDI payments are eligible for Medicare 24 months after their disability begins.

Over the past three decades, the number of SSDI recipients has grown significantly, from 2.9 million in 1980 to 9.0 million in 2013. Part of this growth in SSDI enrollment is due to demographic changes. The rates of disability are highest for individuals ages 55 to 64. As baby boomers moved into these age categories over the past decade, the rate of SSDI enrollment has increased. Many observers expect that the rates of new SSDI recipients will slow as the baby-boom generation moves into retirement age.

Other demographic changes in the workforce have also had an effect on enrollment. Specifically, as labor force participation among women increased, the rates of women becoming entitled to SSDI based on their own work history also rose.

However, these demographic shifts do not explain all of the SSDI enrollment growth. Other changes also appear to have had a significant impact. First, administrative and statutory changes explicitly require the Social Security Administration to consider reported pain and mental impairments. As a result, the largest share of SSDI recipients report musculoskeletal impairments and mental impairments as their disabling condition. These conditions generally occur at ages younger than other disabling conditions and have relatively lower rates of mortality (Autor and Duggan 2006, Dahl and Meyerson 2010, Duggan and Imberman 2009). This demographic change means a significant group of beneficiaries are starting to receive SSDI earlier in their lives and are receiving it for longer (Schwabish 2012).

SSDI has also grown because of changes in the labor force for low-wage workers. The median wage (and

particularly wages for low-income workers) has either remained flat or declined over the past decade. The SSDI benefit amount, in contrast, is indexed to the average wage and so has grown more quickly than the median wage (Autor and Duggan 2006).

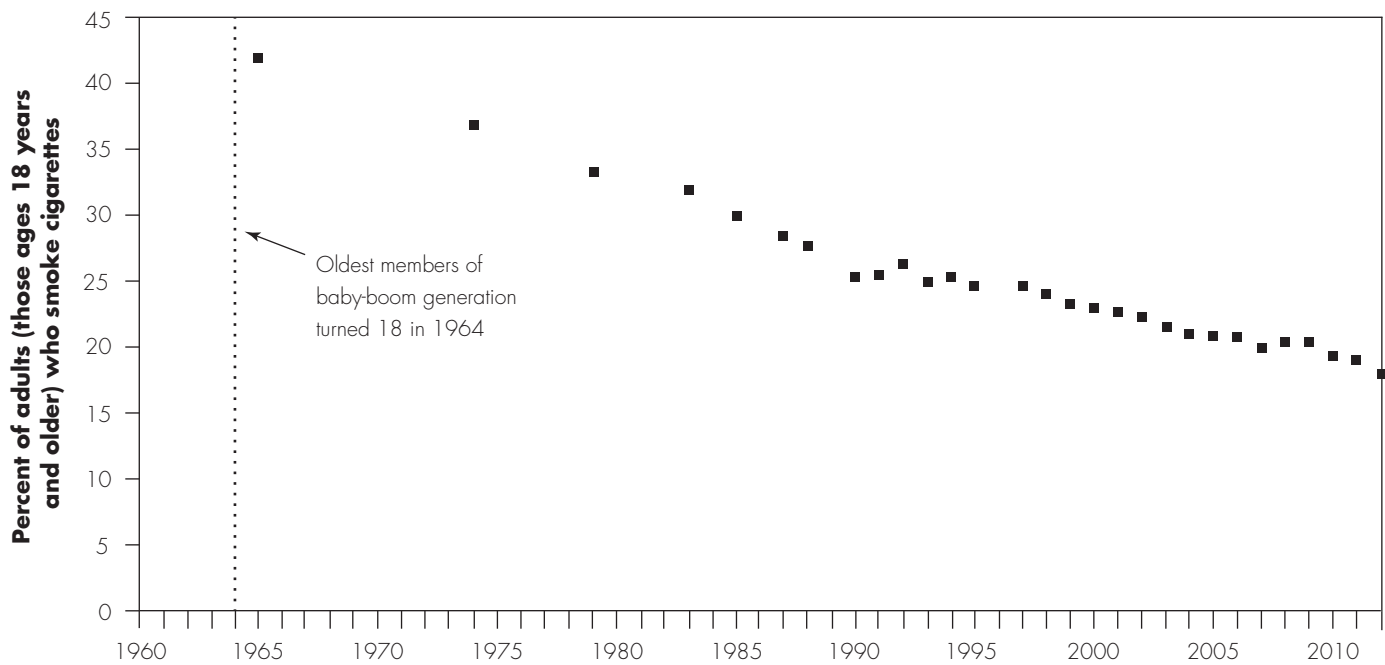
SSDI applications also show a strong countercyclical pattern—as individuals lose their jobs and are unable to find new ones, applications for SSDI increase. The most recent recession has been characterized by very-long-term unemployment and high rates of job loss among older workers, and the number of SSDI applications grew by 50 percent between 2005 and 2010. But fewer than 5 percent of SSDI recipients ever return to work, which means that while SSDI enrollment increases during recessions, the number of beneficiaries does not commensurately fall when the economy recovers (Burkhauser et al. 2013).

Changes in health status and the prevalence of work-limiting disability do not appear to have played a significant role in the growing number of SSDI enrollees. The research on whether the working-age population is becoming more or less disabled over time is mixed, even when researchers use the same data sources and similar methodologies. For one thing, life expectancy has improved for individuals under the age of 65 (Duggan and Imberman 2009, Kaye 2013, King et al. 2013). For another, self-reported rates of limitations in activities of daily living (ADLs) among the total population have remained constant over time or have fallen slightly (National Center for Health Statistics 2014).

However, while the rates of individuals reporting a work-limiting disability have remained constant, reporting a serious work-limiting disability has risen slightly (Social Security Administration 2006). In addition, a few studies have shown higher rates of ADL limitations among younger workers—particularly due to rapidly growing rates of obesity and related conditions (King et al. 2013, Lakdawalla et al. 2004). Overall, however, the significant rise in the number of SSDI enrollees cannot be explained solely by changes in underlying disability among the population. ■

**FIGURE
2-6**

Smoking has been on the decline ever since baby boomers began entering adulthood



Note: Data are not available for all years because surveys were not conducted every year.

Source: National Center for Health Statistics 2014.

The health of the future Medicare population

How will the health of the Medicare population change over the next couple of decades as the baby-boom generation ages into the program? There is a lot of uncertainty surrounding that question. What is known is that members of the baby-boom generation have longer life expectancies and a much lower rate of smoking than earlier generations. However, the baby-boom generation has higher rates of obesity and diabetes than previous generations. Boomers also appear to have higher rates of other diseases and chronic conditions (like hypertension, high cholesterol, and cancer), but those higher rates could be driven by expanded testing and disease definitions. Moreover, boomers are much more likely to have some conditions under control, namely hypertension and high cholesterol.

Positive indicators: Longer life expectancies and lower rates of smoking

The baby-boom generation enjoys much longer life expectancies than earlier generations. Between 1900 and

1960, life expectancy at birth improved by more than 20 years, from 47 years to 70 years. The baby-boom generation compared with earlier generations also enjoys longer life expectancies at older ages (Census Bureau 2014). Individuals born in 1905 who reached age 65 in 1970 had a remaining life expectancy of about 15 years. Individuals born in 1945 who reached age 65 in 2010 had a remaining life expectancy of about 19 years, a 4-year increase over the 1905 birth cohort.

The baby-boom generation's rate of smoking is much lower than it was in previous generations (Cutler and Glaeser 2006). When members of the previous generation were adults in the 1950s and mid-1960s, Americans had one of the highest smoking rates in the developed world—in 1965, over 40 percent of those ages 18 years and older smoked (Census Bureau 2014). But since the mid-1960s and throughout the period that baby boomers entered adulthood, that rate has been on a dramatic decline. By 2012, only 18 percent of those ages 18 years and older smoked (Figure 2-6).

**FIGURE
2-7**

Obesity rates are higher for the baby-boom generation than for previous generations

Figure 2-7a. Female obesity rate, ages 45 to 64

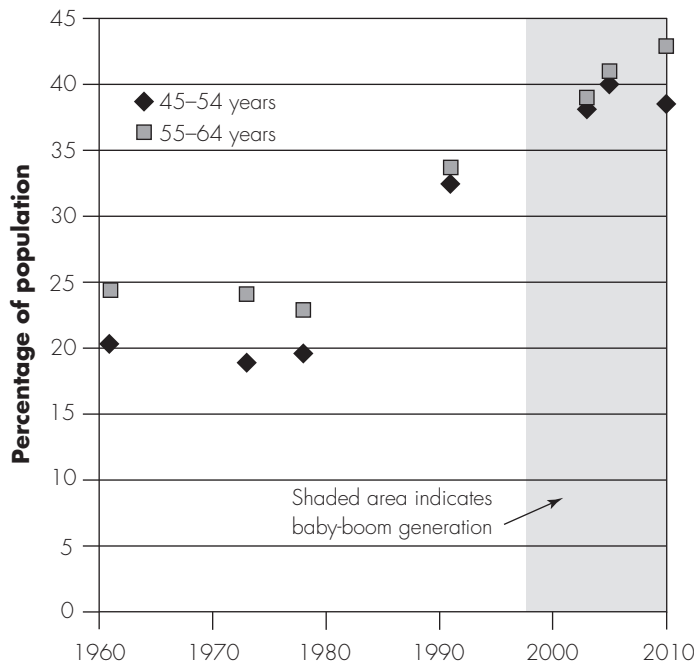
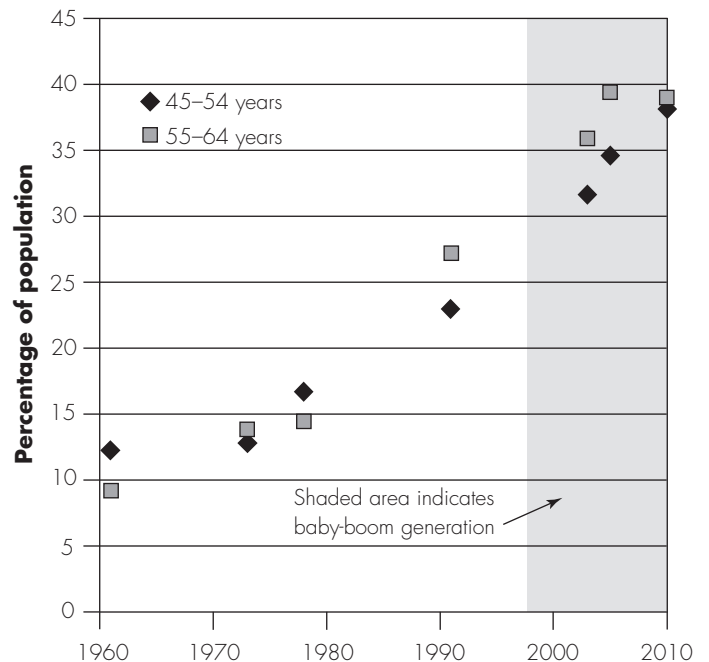


Figure 2-7b. Male obesity rate, ages 45 to 64



Note: Data are not available for all years because surveys were not conducted every year.

Source: National Center for Health Statistics 2014.

Negative indicators: Higher rates of obesity and diabetes

Although smoking rates have declined, the share of adults who are obese has risen dramatically over the last 40 years. In the 1970s, about 15 percent of the adult population ages 20 to 74 years was obese. By 2010, that share more than doubled—reaching 36 percent. The proportion of boomers who were obese in 2010 was even higher, at about 40 percent for both females and males (Figure 2-7). Boomers were ages 46 to 64 years in 2010. For that same age group in the 1960s, 1970s, and 1980s, obesity rates ranged from 19 percent to 24 percent for females and around 9 percent to 17 percent for males.

Related to higher rates of obesity, baby boomers have higher rates of diabetes than the previous generation (15.0 percent versus 13.9 percent, respectively). However, baby boomers diagnosed with diabetes are much more likely to have the disease under control than members of the previous generation.² For the U.S. adult population

overall, researchers found a doubling of the share with diabetes from 1990 to 2008 and a plateauing between 2008 and 2012 (Geiss et al. 2014). Despite the leveling off in recent years, the share of African Americans, Hispanics, and those with a high-school education or less who have diabetes appears to continue to increase.

Mortality from diabetes has declined, leading to more years spent with diabetes but fewer years lost to the disease for the average individual with diabetes (Gregg et al. 2014a, Gregg et al. 2014b). For the population as a whole, however, the number of years lost to diabetes has increased due to the increase in the numbers of people who have the disease.

Mixed indicators: Higher rates of some diseases and chronic conditions, but evidence of better management

When compared with the previous generation, the baby-boom generation has higher rates of hypertension and high cholesterol, but boomers with those conditions are much

more likely to have them under control.³ Perhaps because of better management of those conditions, boomers have shares of heart disease and stroke similar to the previous generation. Some research also indicates that cancer rates have increased among the baby-boom population (National Center for Health Statistics 2014).

However, higher rates of disease and chronic conditions could also be the result of increased use of diagnostic testing and more aggressive or expansive treatment practices (Welch et al. 2011). For example, an extremely slow-growing cancer may now be detectable in a person with no symptoms, but it would never progress to make the person sick, in which case, treatment might not be wise.

Also, not all diseases and chronic conditions have the same impact on per beneficiary spending. For example, high blood pressure and high cholesterol were the two most prevalent chronic conditions among Medicare beneficiaries in 2010, but stroke, chronic kidney disease, asthma, and chronic obstructive pulmonary disease were among the chronic conditions associated with the highest per beneficiary spending (Centers for Medicare & Medicaid Services 2012).

Another factor affecting per beneficiary Medicare spending is whether beneficiaries were continuously insured before age 65. Research has found that Medicare spending is significantly higher for previously uninsured adults than for previously insured adults (McWilliams et al. 2009). Therefore, the increased availability of health insurance under the Patient Protection and Affordable Care Act of 2010 (PPACA) could reduce future Medicare spending for younger baby boomers. Coverage under PPACA through Medicaid expansions (in participating states) and federal and state exchanges began in 2014, when the youngest boomers were 50 years old. So some boomers who otherwise would have been uninsured before aging into the Medicare program now may have up to 15 years of continuous coverage before becoming eligible for Medicare.

Supplemental health insurance coverage for Medicare beneficiaries: What to expect in the future

Medicare does not cover all health care expenses. According to one study, the Medicare fee-for-service (FFS) benefit covered about 80 percent of the cost of Medicare-covered services in 2011, and beneficiaries paid for some of that benefit through premiums (McArdle et al. 2012).

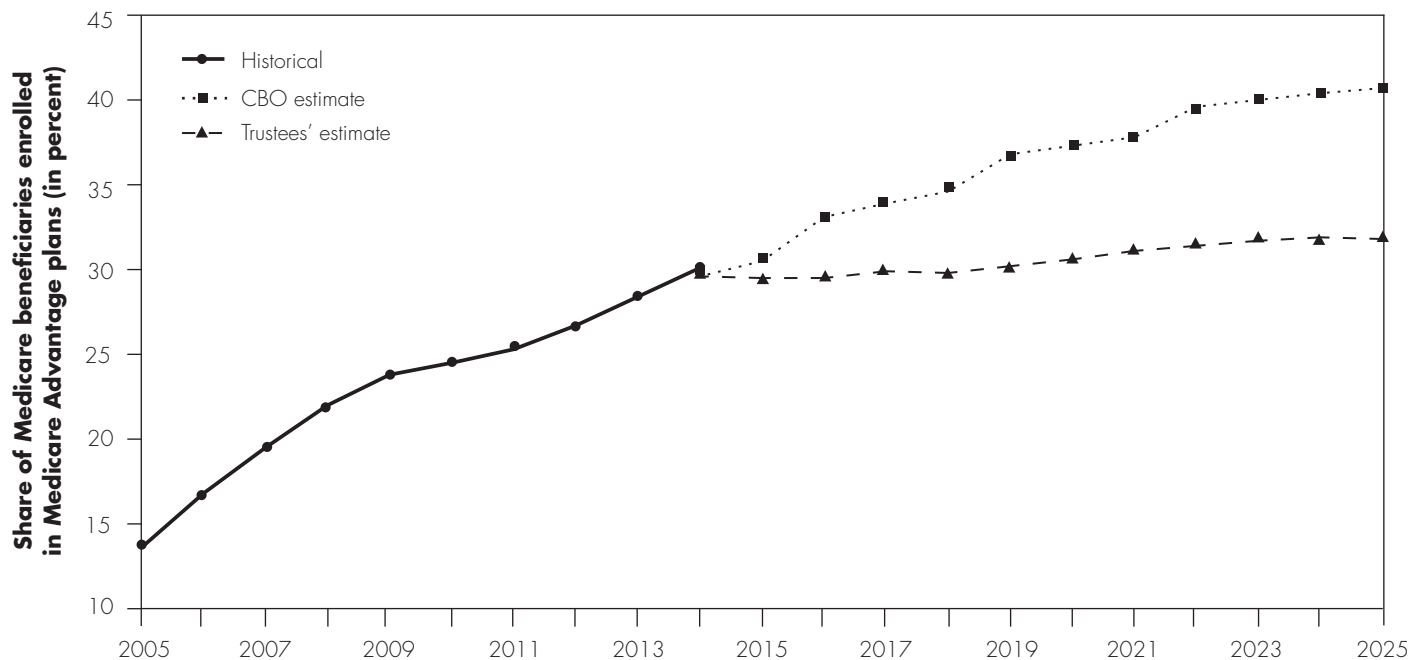
Beneficiaries are also responsible for paying deductibles, coinsurance, and copayments on most covered services, and all the costs of noncovered services, such as dental services. Further, there is no cap on costs for which beneficiaries are responsible. (Medicare does not have a catastrophic limit on how much beneficiaries spend out of pocket for inpatient and outpatient services in its FFS program, although there is a partial limit in Part D, in which cost sharing is significantly reduced after out-of-pocket expenditures for prescription drugs reach a catastrophic threshold.)

To cover some of those additional costs, about 90 percent of beneficiaries have coverage that supplements or replaces the Medicare benefit package. In 2013, about 28 percent of beneficiaries were enrolled in Medicare Advantage (MA) plans—private health plans that replace traditional FFS Medicare in which Medicare pays plans a fixed rate per enrollee rather than a fixed rate per service—and about 21 percent were enrolled in Medicaid—a joint federal–state program that pays for health care services for low-income people (Boards of Trustees 2014). In 2010, 31 percent of beneficiaries had employer-sponsored supplemental retiree coverage (coverage from a former employer that fills in some of Medicare’s gaps in coverage such as coinsurance, copayments, and deductibles), and about 15 percent had Medicare Supplement Insurance (medigap)—coverage purchased by beneficiaries, which also fills in some of Medicare’s gaps in coverage (McArdle et al. 2014). Other types of supplemental coverage include public sector coverage, such as TRICARE and Veterans Health Administration coverage. This section of the chapter examines the outlook for enrollment in MA plans and the share of Medicare beneficiaries with employer-sponsored supplemental retiree coverage.

Medicare Advantage enrollment trends

From 2005 to 2013, the share of Medicare beneficiaries enrolled in MA plans increased from 14 percent to 28 percent—a growth rate of 10 percent per year, on average (Figure 2-8, p. 46). That rapid growth was in large part due to higher per capita payments to MA plans relative to per capita FFS costs. The higher MA payment rates enabled plans to attract beneficiaries with reduced Part B and Part D premiums, lower cost sharing, and additional benefits compared with traditional FFS Medicare.

Changes specified by PPACA were intended to substantially reduce MA payment rates beginning in 2011 to bring rates more in line with FFS costs. There were expectations by some that enrollment in MA plans would

**FIGURE
2-8****Enrollment in Medicare Advantage plans has increased rapidly since 2005; projections assume a slowdown**

Note: CBO (Congressional Budget Office).

Source: Boards of Trustees 2014; Congressional Budget Office 2015b.

decrease. However, the PPACA-mandated payment rate cuts were offset by new quality bonus payments and plans' increased coding of beneficiaries' medical conditions (payments to MA plans are higher when beneficiaries have more medical conditions, all other things being equal); as a result, the share of Medicare beneficiaries enrolled in MA plans continued to grow through 2013.

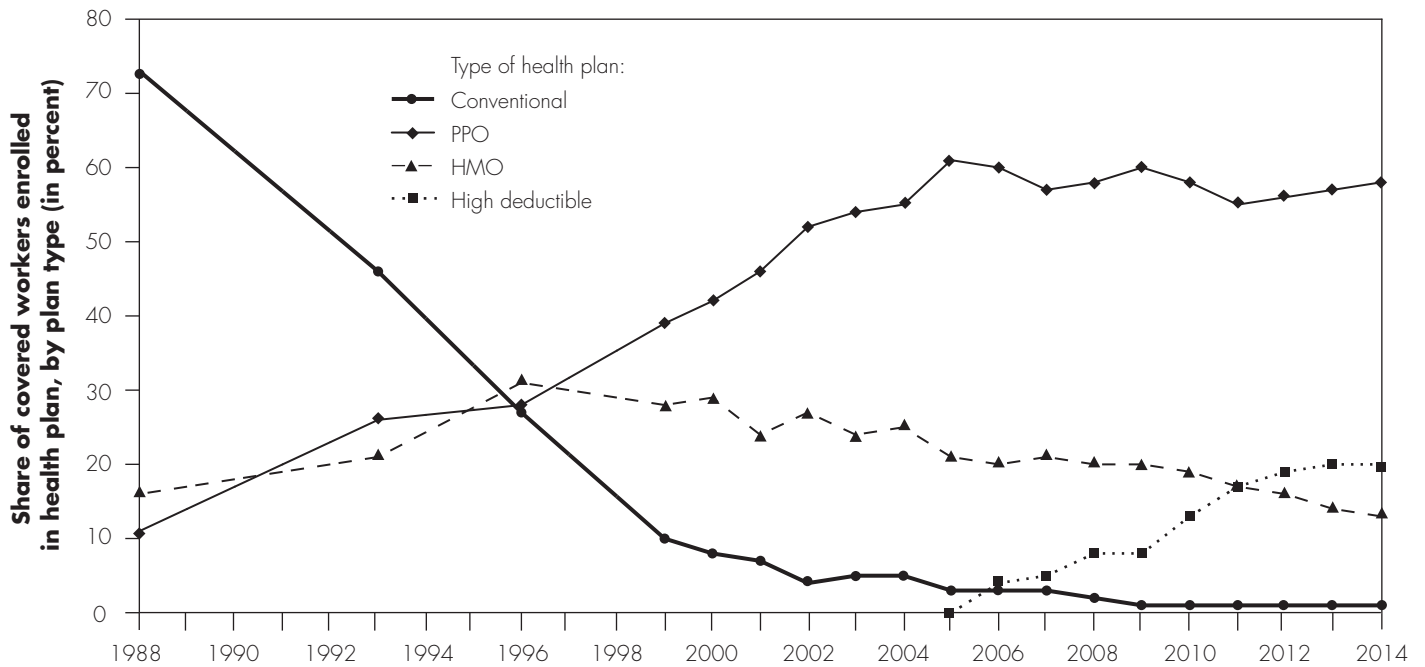
Despite growth in the MA enrollment share of 10 percent per year over the past decade, the Trustees project growth of one-half of 1 percent per year over the next decade, resulting in an MA enrollment share of 32 percent by 2025. As shown in Figure 2-8, that projection would require a marked departure from current trends.

The Congressional Budget Office's (CBO's) projection is higher than the Trustees, but still lower than experienced historically. CBO estimates that the MA enrollment share will grow by about 3 percent per year over the next decade, resulting in a share of 41 percent by 2025.

In addition to MA payments, future enrollment in MA also depends on beneficiaries' experiences with private health

insurance coverage before Medicare enrollment. The under-65 population—accustomed to choosing coverage from a range of plans or receiving care from a limited provider network—may be more likely to consider all their options when they enroll in Medicare, including available MA plans. The baby-boom generation's experience with private health insurance coverage before they become Medicare eligible has been evolving.

In 1988, boomers were between the ages of 24 and 42, many embarking on or in the midst of their working careers. At that time, over 70 percent of workers with employer-sponsored health insurance were enrolled in conventional plans—that is, plans in which health care can be delivered by any provider, with the insurer paying a percentage of the provider's charges (Figure 2-9). Many also experienced the disappearance of conventional plans and the rise and subsequent decline of managed care in the form of HMOs—plans in which health care must be delivered by providers in a network. The share of covered workers enrolled in HMOs reached a high of about 30

**FIGURE
2-9****Many boomers began their working careers in conventional plans and experienced the rise and fall of HMOs**

Note: HMO (health maintenance organization), PPO (preferred provider organization). Data are not available for years 1989 through 1992, 1994 through 1995, and 1997 through 1998.

Source: Kaiser Family Foundation and Health Research & Educational Trust 2014.

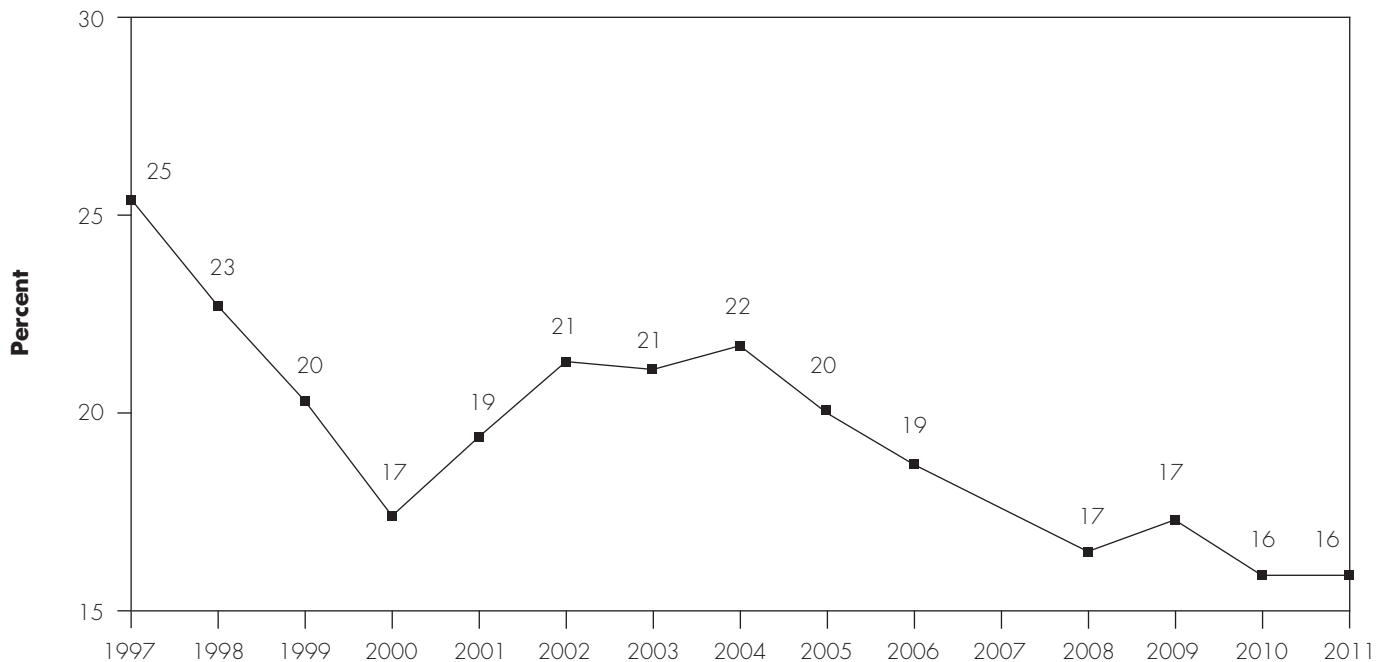
percent in the mid-1990s before steadily falling to its current share of 13 percent.

Throughout that time, the share of covered workers enrolled in preferred provider organizations (PPOs) has grown steadily. PPOs cover only services provided by a network of preferred providers or have lower cost sharing for services delivered by in-network providers versus out-of-network providers. A PPO's provider network is typically not as limited as an HMO's provider network. From 1988 through 2005, the share of covered workers enrolled in PPOs rose from 11 percent of the market to 61 percent and has hovered a little under 61 percent since.

What is harder to quantify is how broad or narrow the access to providers is in PPO plans and how the PPOs' provider networks may have broadened or narrowed over time. The sense from at least some industry observers is that, after the backlash against managed care in the mid-1990s to late 1990s, employees and employers favored the broadest possible access to providers and demanded very large networks, and PPO plans complied. However, since

the 2007 to 2009 recession, employees and employers have been increasingly willing to accept plans with narrower networks in return for lower premiums and cost sharing. According to one survey, 8 percent of employers with 50 or more employees reported offering a narrow-network plan in 2014 (Kaiser Family Foundation and Health Research & Educational Trust 2014). One health policy analyst estimated that, of employers with more than 500 employees, 15 percent included narrow-network plans in their plan offerings in 2013 (Carroll 2014). Narrow-network plans have also been among the offerings on the federal and state health insurance exchanges that commenced in 2014 under PPACA. One research firm estimated that narrow-network plans were available to 92 percent of consumers eligible to purchase health care through the exchanges and that broad-network plans were available to close to 90 percent of these consumers (McKinsey & Company 2014).

High-deductible plans entered the marketplace in the mid-2000s. Those plans typically have lower premiums than

**FIGURE
2-10****Percentage of private sector workers employed by firms offering health insurance to Medicare-eligible retirees declined, 1997-2011**

Note: Data for 2007 are unavailable.

Source: Fronstin and Adams 2012 estimates from Medical Expenditure Panel Survey.

traditional plans but require the enrollee to pay a large deductible amount before receiving insurance benefits. From 2006 through 2013, high-deductible plans rose from just 4 percent of the market to 20 percent and remained at that share in 2014 (Figure 2-9, p. 47) (Kaiser Family Foundation and Health Research & Educational Trust 2014).

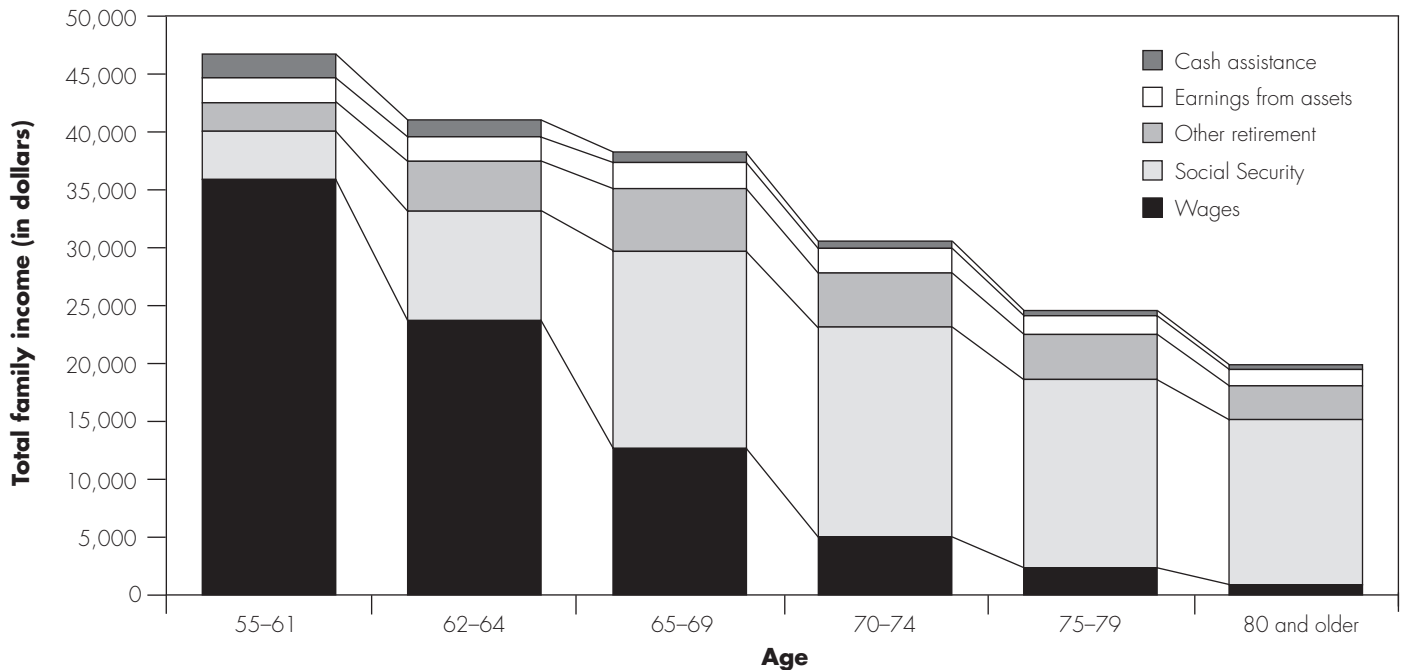
Boomers were 45 to 63 years old at the end of the 2007 to 2009 recession, 49 to 67 years old by the time high-deductible health plans achieved 20 percent of the market, and 50 to 68 years old when the federal and state health insurance exchanges commenced. Thus, the oldest baby boomers may not have had the experience with narrow-network plans, high-deductible plans, and the federal and state health insurance exchanges that younger boomers and the generation that follows them may have.

Employer-sponsored supplemental retiree coverage trends

Some beneficiaries receive from their former employers coverage that supplements the Medicare coverage benefit.

The plans provide benefits that fill in some of Medicare's gaps in coverage, such as coinsurance and deductibles. Plans might also provide "stop loss" coverage, which starts paying enrollees' out-of-pocket costs when they reach a specified maximum amount. Terms of the plans (e.g., benefits, premiums, and cost sharing) are determined by employers and can vary substantially across plans. In 2010, a year before baby boomers began aging into Medicare, 31 percent of Medicare beneficiaries had employer-sponsored supplemental retiree coverage (McArdle et al. 2014).

The share of Medicare beneficiaries with employer-sponsored supplemental retiree coverage will likely decline in the future because an increasing share of employers report that they are not offering retiree health benefits. From 1997 through 2011, the percentage of private sector workers employed by firms offering health insurance to Medicare-eligible retirees declined from 25 percent to 16 percent (Figure 2-10) (Fronstin and Adams 2012). While public sector employees are more likely to receive health benefits upon retirement than private

**FIGURE
2-11****Sources of family income for the population age 55 and over, 2012**

Source: Social Security Administration 2012.

sector employees, the share of state and local governments offering health insurance to Medicare-eligible retirees has also declined over the past decade. From 1997 through 2010, the share of state governments offering health insurance to Medicare-eligible retirees declined from 69 percent to 63 percent, and the share of local governments with 10,000 or more workers offering health insurance to Medicare-eligible retirees declined from 81 percent to 67 percent (data not shown in Figure 2-10) (Fronstin and Adams 2012).

The rising cost of health care coverage, especially for older populations, might have been a reason some employers dropped health benefits for Medicare-eligible retirees. Another reason may have been accounting changes issued in 1990 that required private sector companies to record retiree health-benefit liabilities on their financial statements. Also, public sector accounting changes issued in 2004 required public sector employers to accrue the cost of postretirement health benefits during the years of service as opposed to reporting the cost on a pay-as-you-go basis (Fronstin and Adams 2012).

Income, assets, and wealth

What will be the financial status of persons as they become Medicare eligible? To answer, we examine the financial resources of current beneficiaries, the resources of near-retirees in the context of the recent economic slowdown, and the effects of the recent recession on purchasing patterns and consumer sentiment.

Current picture of beneficiary income

Sources of income and total income change as individuals get older. As individuals leave the workforce, family income shifts from wages to financial assets and retirement supports such as Social Security. By age 80, the average family's income is about half the preretirement level, and the largest share is from Social Security (Social Security Administration 2012) (Figure 2-11).

Median household income is lowest for households headed by individuals ages 24 and under and ages 65 and older (DeNavas-Walt and Proctor 2013) (Table 2-1, p. 50).

**TABLE
2-1**

**Median household income,
by age of householder, 2013**

Age of householder	Median household income
15-24	\$34,311
25-34	52,702
35-44	64,973
45-54	67,141
55-64	57,538
65 and over	35,611

Note: Measure includes cash benefits (e.g., Old Age, Survivors, and Disability Insurance) and excludes noncash benefits (e.g., Medicare).

Source: DeNavas-Walt and Proctor 2013.

Despite their relatively low income level, the share of individuals over age 65 who are below the poverty threshold is lower than it is for individuals under age 65. In 2013, the Census Bureau reported that 9.5 percent of individuals over age 65 were living in poverty, compared with 13.6 percent of individuals between the ages of 18

and 64, and 19.9 percent of children. Those differences result from the nearly universal Social Security coverage of retirees over age 65, providing a minimum level of income. The rate of individuals ages 65 and older in poverty has also fallen over time and has been roughly constant in the past two decades (Figure 2-12).

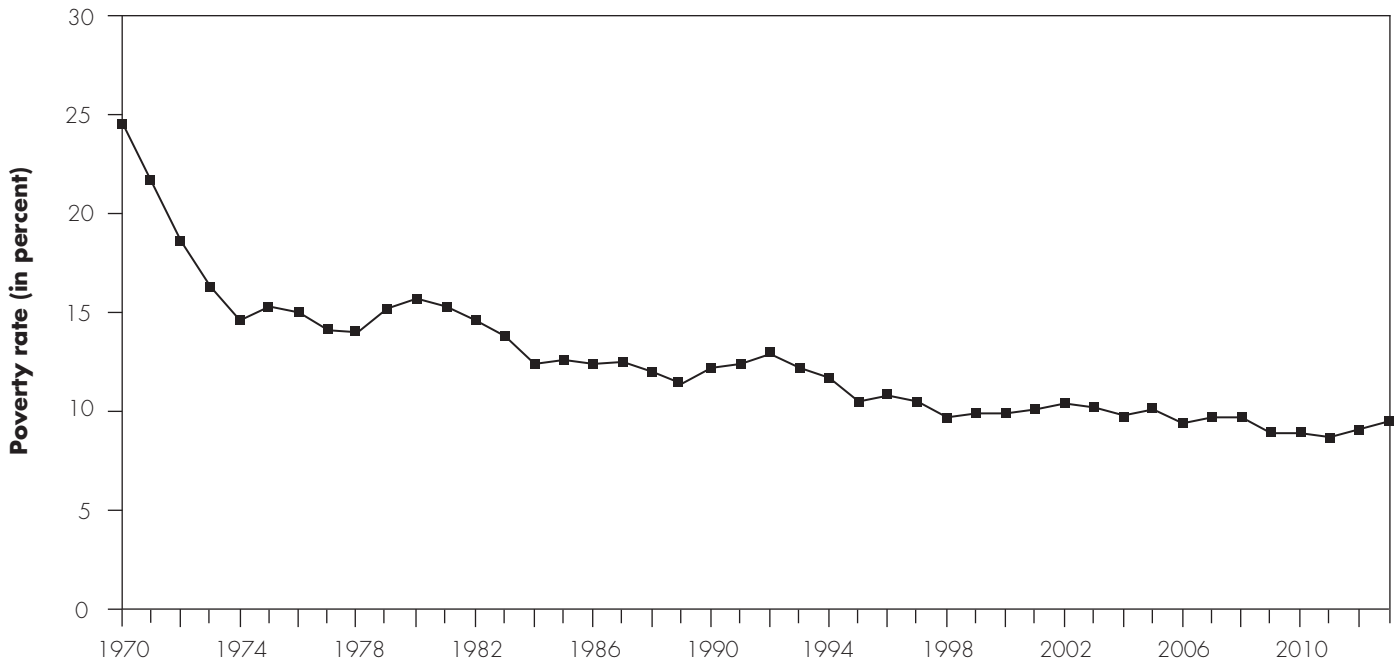
Overall median income remained relatively flat or declined for most age groups over the past decade (Figure 2-13). Income for individuals over age 65 has grown slightly, even during periods of economic contraction, because retirees' income sources (such as distributions from retirement accounts and Social Security) are less likely to be subject to fluctuations in the labor market (DeNavas-Walt et al. 2013, National Bureau of Economic Research 2014).

Effect of the recent recession

The 2007 to 2009 recession had an effect on the income, assets, and wealth of those nearing retirement as well as younger populations. The magnitude of the contraction was the largest since the Great Depression, and employment growth after the recession ended has been slow (Bureau of Labor Statistics 2012).

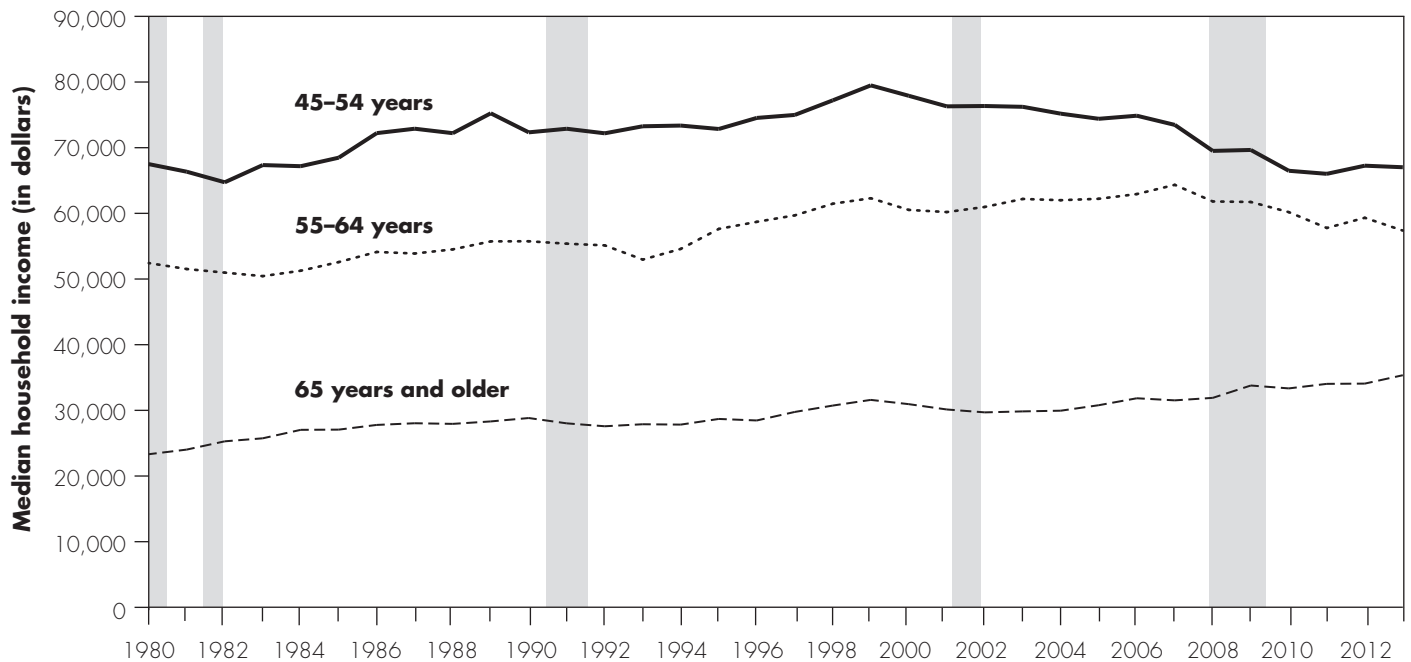
**FIGURE
2-12**

The poverty rate among individuals over age 65 has remained steady since the mid-1990s



Note: The change from 2012 to 2013 is not statistically significant.

Source: DeNavas-Walt and Proctor 2013.

**FIGURE
2-13****Median household income for selected ages, 1980–2013**

Note: Data are in 2013 dollars. Shading shows periods of National Bureau of Economic Research–defined economic contractions.

Source: DeNavas-Walt and Proctor 2013; National Bureau of Economic Research 2014.

However, the recent recession was characterized not only by labor market disruption but also by a decline in the value of housing assets and the stock market. These factors have had varying effects on individuals of different ages, complicating the question of whether individuals near retirement were worse off than younger workers during the recession.

Individuals near retirement may have been disproportionately affected by the most recent recession for three reasons. Individuals near retirement typically have the highest asset values, are less able than younger individuals to be able to modify their consumption and savings behavior to absorb economic shocks, and may be forced into early retirement because of job loss, permanently lowering their income (Hurd and Rohwedder 2010). In addition, older individuals had historically high rates of unemployment during the last recession: Rates more than doubled in a two-year period (Johnson 2012).

For other reasons, however, individuals near retirement may have been relatively shielded from the most recent recession. First, younger individuals were more likely than near-retirees to experience multiple economic shocks such as owing more on their house than the house was worth or losing their job (Gustman et al. 2012, Johnson 2012).

Second, unemployment rates for younger workers—those ages 25 to 49—were higher than for other age groups, and the overall unemployment rate for men exceeded 10 percent, a level not reported since 1940 (Hout and Cumberworth 2012, Johnson 2012).

Despite the end of the economic contraction, median household net worth has not recovered to prerecession levels; for families of varying ages, their net worth remains about a third below their peak in the middle of the last decade (Federal Reserve 2014) (Figure 2-14, p. 52).

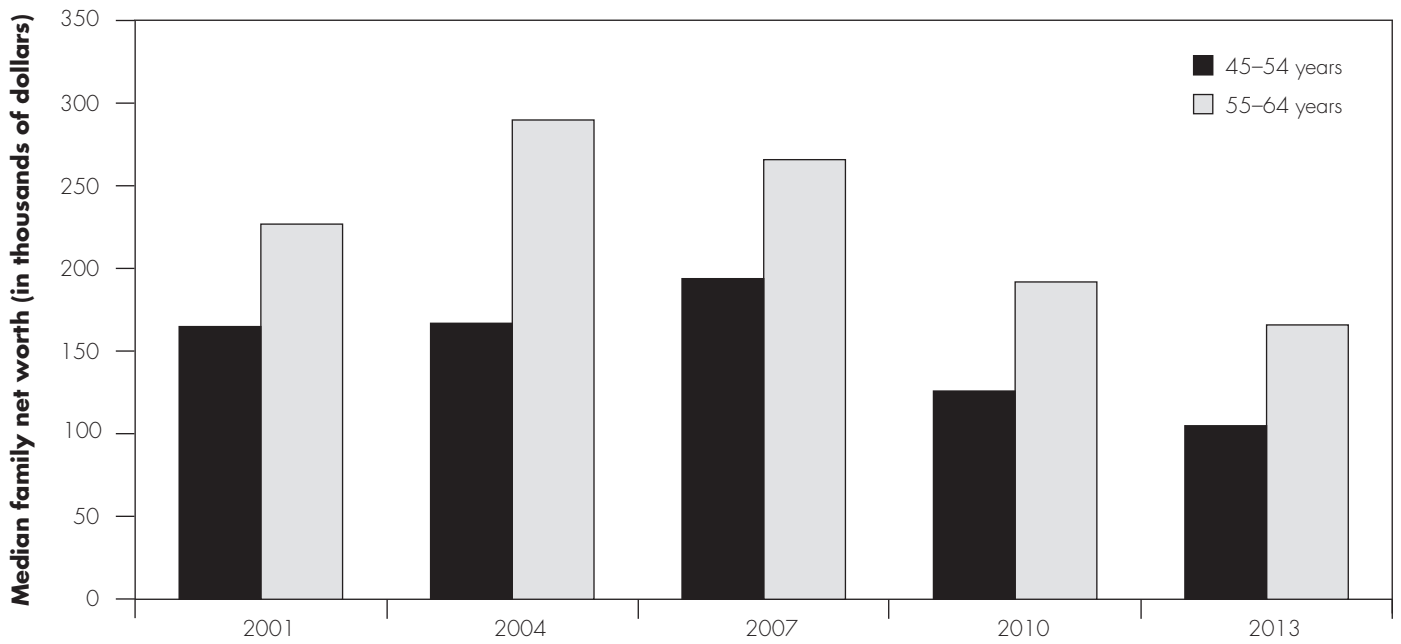
A large share of the decline in net worth is attributable to the continued decline in the value of housing assets and a decreasing share of families who own their own home. The value of families' financial assets (for those who have them) also declined as a result of the recession. But it does appear that individuals who are either in retirement or very close to it (ages 65 to 74) have seen their financial assets recover to some extent (Figure 2-15, p. 52).

Consumer sentiment

These recent patterns in income, employment, and assets for the population as a whole support the perception that the recovery has not been robust. Perception of economic

**FIGURE
2-14**

Median family net worth, by age of primary householder

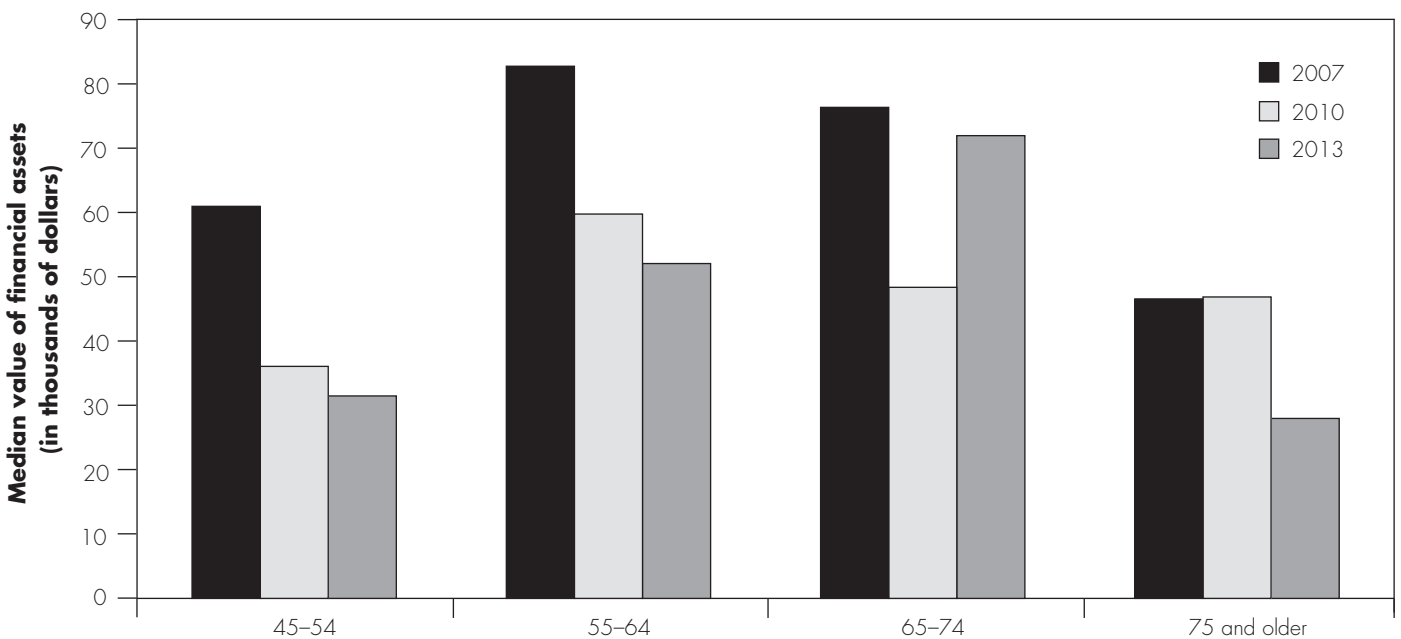


Note: Data are in 2013 dollars.

Source: Federal Reserve 2014.

**FIGURE
2-15**

Median value of financial assets, by age of primary householder

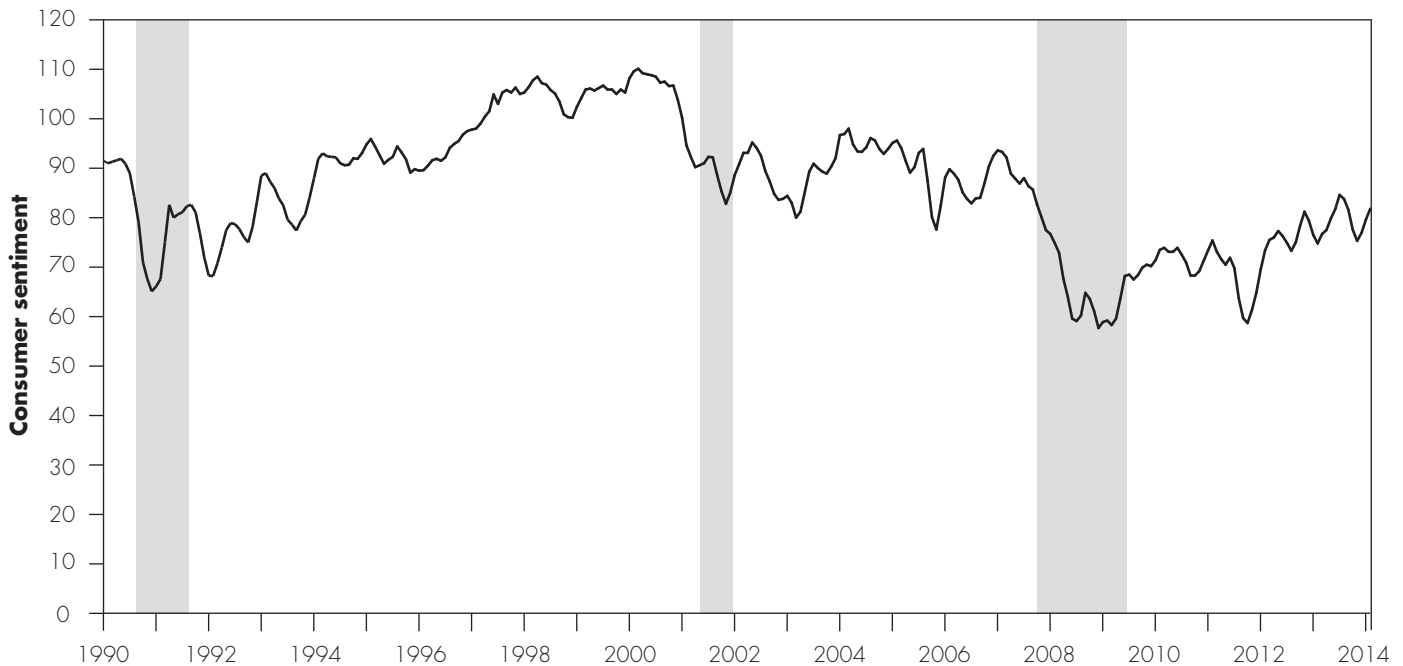


Note: Data are in 2013 dollars. Financial assets include stocks, bonds, certificates of deposit, retirement accounts, and others. Values are only for those respondents who have any financial assets.

Source: Federal Reserve 2014.

**FIGURE
2-16**

Consumer sentiment remains below its prerecession level



Note: Value in 1966 = 100. Shading shows periods of National Bureau of Economic Research–defined economic contractions.

Source: Regents of the University of Michigan 2014.

well-being is still low; specifically, the consumer sentiment index is well below the prerecession level, although it has improved slightly since 2012 (Regents of the University of Michigan 2014) (Figure 2-16). Longer term measures of consumer confidence, such as whether respondents expect income gains in the next five years or whether they expect to lose their job, have improved gradually since 2012, but not to prerecession levels.

It is possible that the combination of unemployment, housing, and stock market shocks characterizing this recession will have a lingering effect on the pattern of savings and consumption, akin to that of the generation who lived through the Great Depression.

Challenge for Medicare financing

The expansion of the Medicare population and its changing profile will have a profound impact on both the program and the taxpayers who support it. Medicare beneficiaries may be less financially secure than in the recent past (because of the 2007 to 2009 recession) and will be

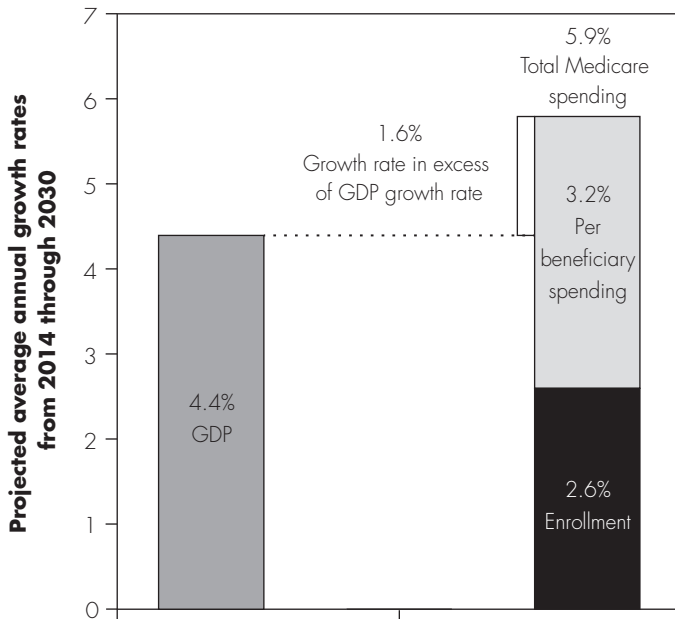
less likely to have employer-sponsored supplemental retiree health coverage, so they may need Medicare more than ever. At the same time, the number of taxpaying workers supporting the program is projected to decline. Additionally, Medicare relies heavily on general revenues, and that reliance is projected to increase (from 41 percent of program costs today to 45 percent of program costs in about 15 years).

The Medicare Trustees project that Medicare’s Hospital Insurance (HI) Trust Fund will be exhausted by 2030 (Boards of Trustees 2014). The HI Trust Fund pays for Medicare Part A services, such as inpatient hospital stays, skilled nursing facilities, and hospice, and is largely funded through a dedicated payroll tax (i.e., a tax on wage earnings). To keep the HI Trust Fund solvent through 2038, the Trustees estimate that the payroll tax would need to be increased immediately and permanently from its current rate of 2.9 percent to 3.3 percent, or Part A spending would need to be reduced immediately and permanently by 10.0 percent (Boards of Trustees 2014).

Furthermore, the HI Trust Fund accounts for only about 45 percent of Medicare spending. The Medicare

**FIGURE
2-17**

Maintaining Medicare spending at 3.0 percent of GDP through 2030 would require a 1.6 percent reduction in its average annual growth rate



Note: GDP (gross domestic product). Numbers do not sum to totals because of rounding.

Source: Congressional Budget Office 2014.

Supplementary Medical Insurance (SMI) Trust Fund covers the rest and is made up of spending on Part B services (physician services and other ambulatory care such as services received in hospital outpatient departments) and Part D services (prescription drug coverage). The SMI Trust Fund is financed by premiums and general revenues, with beneficiaries' annual premiums accounting for about 25 percent of spending and general revenues (funded by taxpayers and federal borrowing) accounting for the rest. Premiums and general revenue transfers are reset each year to match expected SMI spending. With that construct, the SMI fund is guaranteed to remain solvent; however, as SMI spending rises, premiums and transfers from the nation's Treasury to the Medicare program also grow—increasing deficits, the debt, and the strain on the household budgets of both workers and retirees and reducing the resources available to make investments that expand future economic

output (e.g., investments in education, transportation, and research and development).

The different financial structures of the two Medicare trust funds make it difficult to quantify the overall fiscal health of the program. One metric used is Medicare spending as a share of gross domestic product (GDP). Currently Medicare spending accounts for about 3 percent of GDP. From now through 2030 (when boomers will have all aged into Medicare), GDP is projected to grow at 4.4 percent per year on average (Congressional Budget Office 2014). Medicare spending is projected to grow at 5.9 percent per year on average, consisting of enrollment growth (2.6 percent per year) and per beneficiary spending growth (3.2 percent per year). To maintain Medicare spending at about 3 percent of GDP, its average annual growth rate would have to be reduced by 1.6 percent. Assuming no change in the projected growth rate of enrollment, this reduction would have to come from a reduction in the projected growth rate of per beneficiary spending, reducing it from an average annual growth rate of 3.2 percent to 1.7 percent (Figure 2-17).

Conclusion

Over the next 15 years, the aging baby boomers will rapidly increase the size of the Medicare population. As the Medicare population grows, the number of taxpaying workers per beneficiary will decline, straining federal and household budgets. While the nation is becoming more diverse racially and ethnically, diversity in the Medicare population will lag for some years to come. Life expectancies have increased for baby boomers; however, so have obesity rates, leaving much uncertainty about the overall health of the next generation of Medicare beneficiaries and the implications for Medicare per beneficiary spending. Under any outcome, Medicare's spending trends will be affected over the longer term by the growing share of beneficiaries in older age categories. Also, future beneficiaries will have had different experiences with their health insurance coverage because the majority of workers will have been in a PPO. For some groups of baby boomers, the 2007 to 2009 recession weakened their financial well-being, making it difficult for those closest to retirement to recover financially before entering retirement. ■

Endnotes

- 1 For example, the Medicare Trustees estimate hospital inpatient admissions per beneficiary to decline through 2021 and begin increasing thereafter because of the aging of the baby-boom population (Boards of Trustees 2014). The Congressional Budget Office also projects comparatively slow growth in per beneficiary spending for the next decade (2015 to 2025), in part because of the influx of younger beneficiaries, who tend to use fewer health care services and therefore lower Medicare's average spending per beneficiary (Congressional Budget Office 2015a).
- 2 When compared with the previous generation at ages 45 to 64, the baby-boom generation had a larger share of individuals with physician-diagnosed and undiagnosed diabetes (15.0 percent versus 13.9 percent), but a smaller share of individuals with diagnosed diabetes who had poor glycemic control (14.1 percent versus 26.0 percent) (National Center for Health Statistics 2014).
- 3 When compared with the previous generation at ages 45 to 64, the baby-boom generation had larger shares of individuals with hypertension (42.2 percent of male and 39.5 percent of female baby boomers versus 34.2 percent and 32.8 percent of males and females, respectively, in the previous generation), but smaller shares of individuals with hypertension who had uncontrolled high blood pressure (50.2 percent of male and 36.5 percent of female boomers versus 73.1 percent and 62.1 percent of males and females, respectively, in the previous generation).

Similarly, when compared with the previous generation at ages 45 to 64, the baby-boom generation had larger shares of individuals with high cholesterol or taking cholesterol-lowering medication (39.8 percent of male and 42.4 percent of female baby boomers versus 30.1 percent and 36.4 percent of males and females, respectively, in the previous generation) but smaller shares of the population with high serum total cholesterol (16.2 percent of male and 22.4 percent of female baby boomers versus 27.2 percent and 33.4 percent of males and females, respectively, in the previous generation) (National Center for Health Statistics 2014).

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