CHAPTER 1

Medicare in the 21st century: Changing beneficiary profile

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Chapter summary

The profile of Medicare beneficiaries is expected to change in ways that could have strong implications for the Medicare program. Some of these profile changes could include:

- A greater proportion of beneficiaries being treated for multiple chronic conditions, which puts upward pressure on Medicare costs (Thorpe and Howard 2006). This increase reflects growth in the prevalence of obese beneficiaries, advances in technology for diagnosing and treating conditions, and changes in disease definitions.
- Fewer beneficiaries with disabilities, who tend to be more costly than those without disabilities. This decrease suggests downward pressure on Medicare costs. However, the costliness of beneficiaries without disabilities has been increasing much faster than the costliness of the disabled (Chernew et al. 2005).

In this chapter

- Fewer beneficiaries with employer-sponsored insurance (ESI) to supplement Medicare (KFF/Hewitt Associates 2005, 2004). ESI is relatively comprehensive supplemental coverage, so a decline in its prevalence could reduce beneficiaries' service use and expose them to greater financial liability.
- Key changes in family structure including people having fewer children, more women having children after age 35, and adult children living greater distances from their parents. These changes may affect the availability of adult children to provide long-term care for their parents. As beneficiaries are less able to rely on their children for unpaid care in the home, they may turn to institutions such as assisted living facilities and nursing homes or to paid custodial care in the home. Medicare generally does not cover the care provided by these sources, so increased reliance on them can substantially increase a beneficiary's financial liabilities.
- Demographic changes based on census data suggest:
  - The race/ethnicity mix of Medicare beneficiaries will change, with a higher percentage of beneficiaries being Hispanic or Asian. This could affect the Medicare program if Hispanic or Asian beneficiaries have different health care profiles than other beneficiaries.
  - The percentage of beneficiaries age 85 or older is likely to first decline as the baby-boom generation enters Medicare, and then increase as that group ages. Older beneficiaries cost the Medicare program 40 percent more than the average beneficiary, are more likely to have a living arrangement that includes formal assistance, and are more likely to have comorbidities, particularly Alzheimer's disease.

- Years of formal education will increase among Medicare beneficiaries. More educated beneficiaries may be more involved in the clinical decisions regarding their health. In addition, higher levels of education have been shown to be correlated with later onset of Alzheimer's disease.
- Per capita income typically grows more slowly than health care costs, especially in recent years. If growth in health care costs continues to outpace growth in per capita income, access to care could be adversely affected. Also, the distribution of income among the elderly may become more uneven, which may increase disparities in access to care between wealthy and poor beneficiaries.

Changes in the characteristics of Medicare beneficiaries will affect program spending and the types of services beneficiaries will want and need in the future. We convened a panel of experts who shared their thoughts on which changes in beneficiary characteristics will be most important and how the Medicare program could be changed to better serve beneficiaries. Combining the panel's thoughts with previous MedPAC work on program changes, we developed the following list of possible ways to change Medicare to address the needs of future beneficiaries:

- Facilitate care coordination in traditional Medicare. This would especially help improve the care of those with chronic conditions.
- Expand the use of health information technology (IT), which may improve efficiency and quality of care for all beneficiaries and facilitate care coordination. Moreover, as beneficiaries' level of formal education rises, their use and understanding of IT may expand as well. Therefore, increased use of health IT may help beneficiaries make more informed decisions about their health care.
- Increase the use of comparative-effectiveness analyses as a source of information and guidance for providers and beneficiaries.

- Implement public health efforts that promote healthy lifestyles, such as programs that help reduce the prevalence of obesity through better diet and exercise. In addition to Medicare beneficiaries, such a program could also target younger populations so that they have already made beneficial lifestyle changes before becoming eligible for Medicare.
- Modify the benefits and cost sharing of traditional Medicare in the following ways:
  - A single deductible for Part A and Part B. Currently, they have separate (and very different) deductibles.
  - No cost sharing beyond the deductible for hospital inpatient care, but cost sharing beyond the deductible for most other services. The structure of this cost sharing should be carefully considered so that beneficiaries do not have incentives to forgo services that are highly beneficial.
  - A stop loss that limits beneficiaries' financial liabilities, which reduces their risk of becoming impoverished from a costly illness. Reducing this risk will have greater importance if ESI becomes less prevalent as a source of supplemental insurance or if beneficiaries' incomes grow more slowly than their financial liabilities from health care.

The analysis presented in this chapter is the first in a two-step process. In the second step, we will develop estimates of the effects of changes in the profile of Medicare beneficiaries and modifications to the Medicare program that address those changes, with a focus on the design of the benefit package. We emphasize that the purpose of this work is not to address the long-run sustainability of the Medicare program. Other changes will be needed to address that issue. ■

The Medicare program is facing important changes in the coming decades. Well-known changes include substantial growth in the beneficiary population—as the baby-boom generation becomes eligible for Medicare—and technological advancements in health care that extend lives. The impact of the baby-boom generation on the size of the beneficiary population will put strong upward pressure on Medicare spending and considerable strain on the federal budget. Advances in technology can take many forms but are frequently associated with upward pressure on health care use and spending because they are often costly and usually add to, rather than replace, existing technology.

A change that has not been as widely studied is the likely change in the profile of beneficiaries' characteristics in the coming decades. We convened a panel of experts and reviewed the literature to identify the changes that are likely to be important to the Medicare program. The list of changing characteristics that we developed includes:

- Greater prevalence of being treated for chronic conditions, especially for multiple chronic conditions, which increases beneficiaries' health care use (Thorpe and Howard 2006);
- Fewer beneficiaries with disabilities, which suggests downward pressure on health care use. But the difference in spending between disabled and nondisabled beneficiaries has declined, which will reduce or could even eliminate the downward pressure from fewer disabled beneficiaries (Chernew et al. 2005);
- Fewer beneficiaries with employer-sponsored insurance (ESI) to supplement Medicare, which may reduce beneficiaries' access to care and increase their risk of catastrophic loss from health care expenses (KFF/Hewitt Associates 2005, 2004);
- People having fewer children, more women having children after age 35, and adult children living greater distances from their parents, which may reduce the availability of adult children of beneficiaries to provide long-term care in the home; and
- Demographic changes suggest:
  - The racial/ethnic mix may change, with an increase in the percentage of beneficiaries of Hispanic origin and, to a lesser extent, Asian origin, who may have different health care needs than other beneficiaries.
  - The proportion of beneficiaries who are age 85 or older may decrease and then increase. These beneficiaries are likely to have different health care needs than younger beneficiaries.
  - Beneficiaries may have more formal education, which may increase their participation in clinical decisions and is correlated with later onset of Alzheimer's disease.
  - Income may grow more slowly than health care costs or may become less evenly distributed. These income issues may lead to access problems for at least some beneficiaries or may exacerbate differences in access to care between high-income and low-income beneficiaries.

In this chapter, we discuss the potential effects of these changing characteristics and how they may affect beneficiaries' health care use and their interaction with the health care system. In addition, our expert panel discussed some of the ways the Medicare program could be changed to better serve future beneficiaries. We synthesized their views with previous MedPAC studies on how to improve Medicare to address the changing characteristics of Medicare beneficiaries.

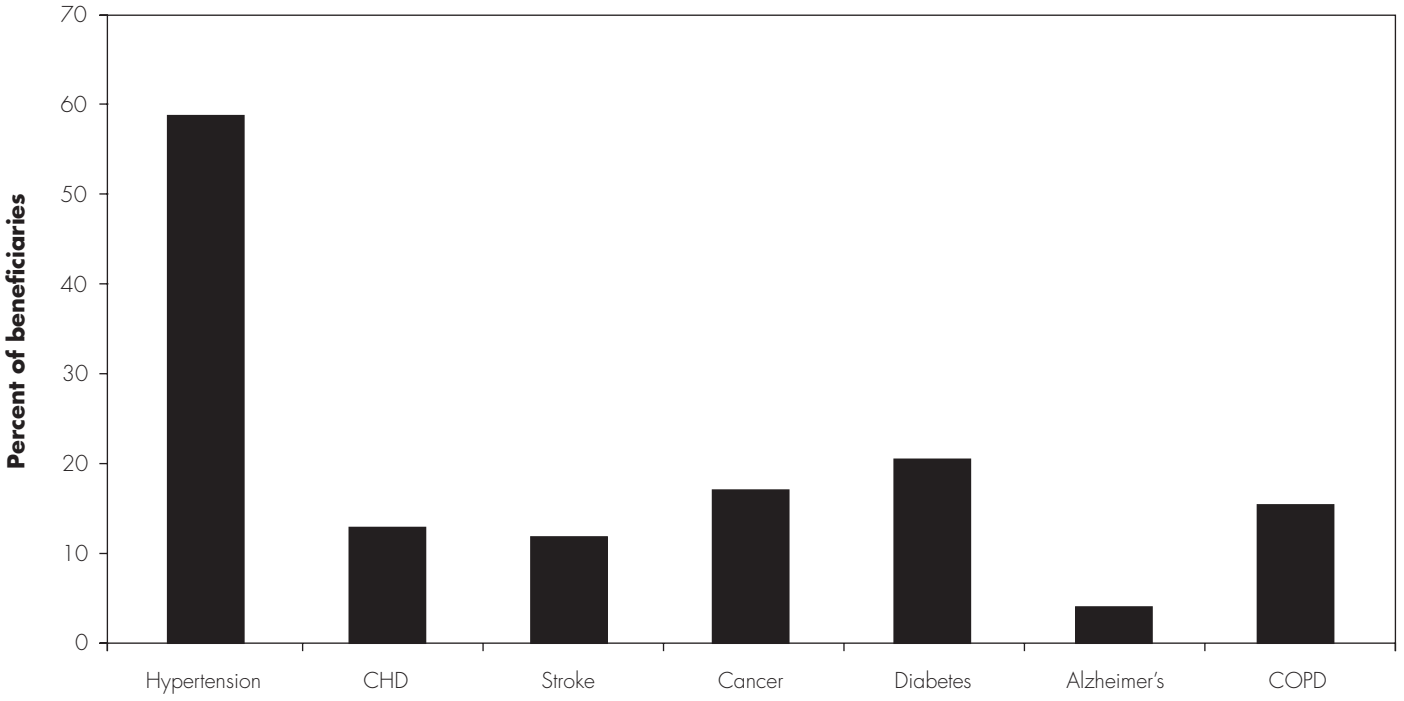
Changes in the characteristics of Medicare beneficiaries

This section discusses the potential qualitative effects of the changes to the profile of beneficiary characteristics, with some supporting empirical results.

Increase in treatment of chronic conditions puts upward pressure on Medicare spending

Chronic conditions are widespread among Medicare beneficiaries (Figure 1-1, p. 8). Research indicates that an increase in the treated prevalence (the percentage of the population receiving treatment) of many chronic conditions has fueled much of the increase in Medicare spending over the last two decades.[1] Also, the proportion of beneficiaries treated for multiple chronic conditions has increased. In 1987, 31 percent of Medicare beneficiaries received treatment for five or more chronic conditions, accounting for about half of total health care spending on Medicare beneficiaries. Fifteen years later, more than half of all Medicare beneficiaries were treated for five or more chronic conditions, accounting for 76 percent of

FIGURE 1–1 **Chronic diseases are prevalent among Medicare beneficiaries, 2003**



Note: CHD (coronary heart disease), COPD (chronic obstructive pulmonary disease). Analytic sample consists of beneficiaries in traditional Medicare.

Source: MedPAC analysis of 2003 Medicare Current Beneficiary Survey Cost and Use file.

health care spending on beneficiaries. Nearly all spending growth for Medicare beneficiaries from 1987 to 2002 can be attributed to those treated for three or more chronic conditions (Thorpe and Howard 2006).

The reasons underlying the increased treated prevalence of chronic conditions include:

- Higher rates of obesity—defined as a body mass index (BMI) of 30 or higher—likely have increased the prevalence of conditions such as diabetes, hyperlipidemia, and hypertension.[2] Recent data suggest that the obesity rate among the elderly is at a historically high level (Figure 1-2). The impact of obesity on the prevalence of chronic conditions may become even stronger in the coming decades because the prevalence of obesity is higher among the population age 40 to 59 than among those age 60 or older (Ogden et al. 2006).
- Technology for identifying the presence of conditions has advanced, such as the dual-energy X-ray absorptiometry (DXA) scan for osteoporosis. These advances have resulted in patients being diagnosed for conditions that could not have been detected several years ago.
- Technology for treating conditions has advanced, such as the development of selective serotonin reuptake inhibitors (SSRIs) for treating depression, discussed on p. 10. Looking forward, personalized medicine, which uses genetic information to tailor treatments to a patient, may become an important technological advance in the coming years.
- Clinical definitions of some diseases have changed. For example, the definition for metabolic syndrome—which increases the risk of cardiovascular disease, stroke, and diabetes—includes abnormal fasting glucose levels.[3] In 2004, the American Diabetes Association lowered the definition of abnormal fasting glucose levels from 110 milligrams per deciliter (mg/dL) to 100 mg/dL. This change increased the prevalence of metabolic syndrome among adults age 20 or older by 20 percent (Ford et al. 2004).

Obesity has increased prevalence of chronic conditions and Medicare spending

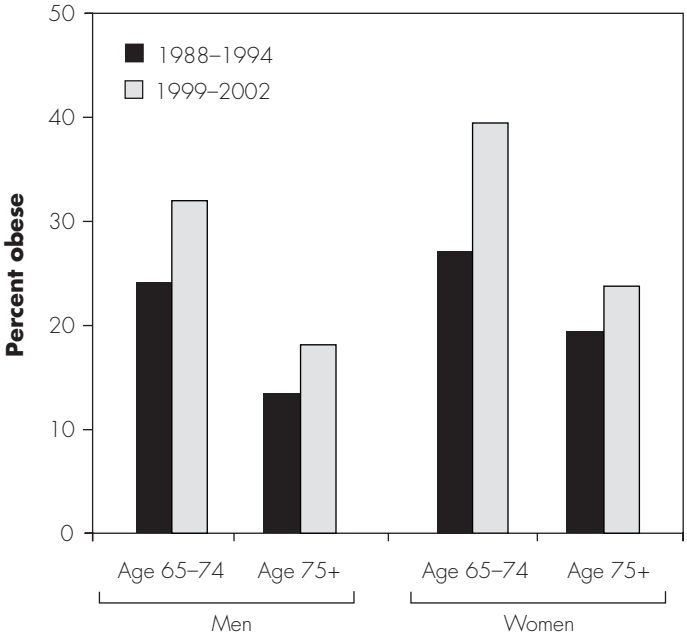
Increased obesity rates among the Medicare population have not only increased the treated prevalence of chronic conditions, they have likely played a role in the spending increase over the last two decades because many obese people have multiple conditions such as hyperlipidemia, diabetes, and hypertension.[4] Data from the Agency for Healthcare Research and Quality (AHRQ) indicate that the share of Medicare spending attributable to obese beneficiaries nearly tripled from 9.4 percent in 1987 to 24.8 percent in 2002.[5]

Obesity is a particularly important risk factor because it has spread across all age groups and segments of society, and research indicates that it tends to reduce life expectancy. Over the last three decades, improvements in risk factors such as smoking, high blood pressure, and drinking have increased life expectancy. However, increased obesity rates have offset part of these gains. Moreover, continued increases in obesity rates would further erode the gains from improvements in other risk factors (Cutler et al. 2007).

However, research also suggests that the effect of obesity on life expectancy may decline with age and even may have no effect once people reach age 70 (Lakdawalla et al. 2005, Olshanky et al. 2005, Fontaine et al. 2003, Stevens et al. 1998). This finding may reflect a complicated relationship in which obesity can have very different effects on longevity depending on an individual's medical circumstances. For example, it is plausible that the age at which an individual becomes obese may affect life expectancy. More research on this issue may help clarify the effect of age on the association between obesity and longevity.

Irrespective of its effect on longevity, obesity increases disability rates. Obese beneficiaries spend a greater amount of their lifetimes with a limitation in one or more activities of daily living (ADLs) than beneficiaries who are the recommended weight (the list of ADLs includes eating, bathing, dressing, transferring from bed to chair, walking, and using a toilet). Obese 70-year-olds can expect to spend 40 percent more of their remaining years with a limitation in one or more ADLs than 70-year-olds of recommended weight (Lakdawalla et al. 2005). Moreover, obesity increases the likelihood of having several chronic conditions including diabetes, gallbladder disease, hypertension, and osteoarthritis; it also increases the likelihood of needing dialysis (Must et al. 1999).

FIGURE 1–2 **Obesity rates have been increasing among older Americans**



Source: Table 73 in *Health, United States, 2005* from the National Center for Health Statistics.

The increased limitations in ADLs, presence of chronic conditions, and need for dialysis among the obese translate to higher annual spending on health care. To the extent that the effect of obesity on life expectancy declines as people age, research suggests that lifetime Medicare spending is much higher (34 percent) among the obese than among those of recommended weight (Lakdawalla et al. 2005).

Technology has increased treatment of chronic conditions

Although obesity likely played a role in the growth of the proportion of beneficiaries treated for chronic conditions, increases in the share of nonobese beneficiaries treated for five or more chronic conditions indicate that other factors also matter. From 1987 to 2002, the share of beneficiaries who had the recommended weight and were treated for five or more chronic conditions increased from 11.5 percent to 16.0 percent, and the percentage of total Medicare spending these beneficiaries accounted for increased from 19.6 percent to 24.1 percent (Thorpe and Howard 2006).[6]

One explanation for the increase in the proportion of beneficiaries of recommended weight being treated for five or more chronic conditions is that physicians are more aggressively diagnosing and treating healthier beneficiaries. In 1987, 33 percent of beneficiaries treated for five or more chronic conditions reported good or excellent health. This proportion increased to 60 percent in 2002.

Another reason for this increase in the proportion of relatively healthy beneficiaries being treated for five or more chronic conditions may be the introduction of technologies for either treating or detecting chronic conditions at earlier or less severe stages. An example of a relatively new technology that treats a chronic condition is SSRIs for depression. Prior to SSRIs, the most common method for treating depression was psychotherapy, which often entailed large costs to patients, in both time and money (Howard et al. 2006). A technology that detects a chronic condition is the DXA scan for osteoporosis.

Reconciliation and summary of literature on chronic conditions

In contrast to the results from the research we have cited thus far, other research suggests that chronic conditions only modestly affect Medicare spending. One team of researchers examined seven chronic conditions and found that cumulative Medicare spending beginning at age 65 is only moderately higher among beneficiaries with a particular condition than among those without it. For example, a beneficiary with diabetes at age 65 has about $17,000 more in cumulative health care spending than a beneficiary without diabetes at age 65 (Joyce et al. 2005).

It appears that two bodies of research found very different effects of chronic conditions on Medicare spending. However, these seemingly inconsistent results can be reconciled. The research by Joyce and colleagues indicates that lifetime costs of beneficiaries who do not have a chronic condition at age 65 are only moderately lower than for those who do have a chronic condition at age 65. However, this research does not account for the fact that many beneficiaries without a chronic condition at age 65 develop one at a later age, so it does not fully reflect the effect of chronic conditions on beneficiaries' lifetime costs. Also, the research by Joyce and colleagues does not reflect the increase in the proportion of beneficiaries treated for chronic conditions. In contrast, Thorpe and Howard show that much of the increase in Medicare spending has been due to an increase in the prevalence of beneficiaries being treated for chronic conditions.

In summary, it appears that an increase in the proportion of beneficiaries being treated for several chronic conditions is increasing Medicare spending. It is plausible that high obesity rates, technological advances, and changing clinical definitions will continue to expand the treated prevalence of chronic conditions, which will raise Medicare spending in the future.

These trends in the prevalence of treatment for chronic conditions and the prevalence of obesity suggest that it could be beneficial for Medicare to encourage systems of care coordination. However, most beneficiaries are in traditional Medicare, which complicates effective use of care coordination. Encouraging systems of care coordination would require changes in traditional Medicare that we discuss later in this chapter.

Disability rates have declined, but cost pressures have not

Research indicates that the rate of disability among Medicare beneficiaries, usually measured by limitations in ADLs, has been decreasing. The average number of ADL limitations per noninstitutionalized beneficiary decreased from 0.68 in 1992 to 0.61 in 2000, and the percentage of beneficiaries with at least one ADL limitation fell from 30.4 percent to 27.8 percent over the same period. In general, a beneficiary's annual cost to the Medicare program tends to increase as the number of ADL limitations increases (Chernew et al. 2005). Therefore, it would be reasonable to expect a decline in the prevalence of disability to result in lower Medicare expenditures.

However, downward pressure on Medicare spending from lower disability rates has been at least partially offset and possibly eliminated by nondisabled beneficiaries becoming more costly in relation to disabled beneficiaries. Spending for the beneficiaries with no ADL limitations increased more than 20 percent in inflation-adjusted terms from 1992 to 2000. In contrast, it increased 10 percent for those with one or two ADLs, increased 0.6 percent for those with three or four ADLs, and decreased 10 percent for the most disabled (five or more ADLs).

Because of the faster rate of cost growth among the least disabled, lower disability rates among beneficiaries may not slow total Medicare spending. This is especially true if the treated prevalence of chronic conditions among healthy beneficiaries continues to increase. Moreover, it is not clear whether the decline in disability rates will continue when the baby-boom generation begins to enter Medicare.

In a recent study, researchers used results from a survey that interviewed a cohort of current Medicare beneficiaries when they were age 51 to 56 and later interviewed a cohort of baby boomers when they were age 51 to 56. The baby boomers reported more difficulty than the Medicare beneficiaries in activities such as walking, climbing stairs, getting up from chairs, and kneeling or crouching (Soldo et al. 2006).

Percentage of beneficiaries with ESI has declined and is likely to decline further

The percentage of Medicare beneficiaries who have ESI—retiree health coverage through a former employer—declined from 28.1 percent in 1997 to 25.5 percent in 2002 (Fronstin 2005). This decline is likely to accelerate in the future. Large employers are much more likely to offer coverage than smaller employers, but the proportion of large employers that offer health benefits to future retirees has been declining.

Among the large firms offering subsidized retiree health benefits, 8 percent decided in 2004 to drop these benefits for future retirees, and 12 percent decided to do so in 2005 (KFF/Hewitt Associates 2005, 2004). Some of the firms that terminated coverage for future retirees will offer affected employees "access only" coverage that requires the employee to pay the full premium. However, it is plausible that many employees will decide paying the full premium is "not worth it" and decline that coverage. Because employers are dropping coverage for future retirees rather than current retirees, these changes may not have a noticeable effect on trends in insurance coverage until at least a few years after the baby-boom generation starts to retire (Fronstin 2005).

Another factor that could reduce the prevalence of ESI is the accounting rules the Governmental Accounting Standards Board (GASB) has recently issued. These rules are similar to those the Financial Accounting Standards Board established in the early 1990s, which observers have credited with leading fewer businesses to provide health benefits to future retirees. The new rules from the GASB require public agencies such as state and local governments to fully disclose the future cost of health insurance benefits, something many had not been doing. When the new accounting rules begin in 2008, the full cost of future health benefits will become clear, and the magnitude of the liability will be large for many state and local governments. For example, the California Legislative Analyst's Office estimates a liability of $40 billion to $70 billion for retiree health care and related liabilities. As the magnitude of the liability becomes clear, state and local governments may reduce the generosity or availability of health benefits for future retirees (Porterfield 2006).

The decline in ESI coverage is likely to increase the use of three alternatives: medigap supplemental insurance, Medicare Advantage (MA) plans, and traditional Medicare without supplemental coverage (Medicare only). Two of these alternatives—medigap and Medicare only—are typically less comprehensive than traditional Medicare with ESI coverage, so they may make beneficiaries more aware of the costs of services. Therefore, the decline in ESI coverage can reduce beneficiaries' service use and, consequently, Medicare spending.

However, all three alternatives have features that make them generally less attractive to beneficiaries than most forms of ESI coverage. Not only is medigap generally less comprehensive than ESI, but beneficiaries with medigap typically pay more in premiums because employers often subsidize their employees' ESI premiums. MA plans often have small or no premiums and often supplement standard Medicare coverage. However, most MA enrollees are in managed care plans that generally are more restrictive regarding provider choice than traditional Medicare combined with an ESI plan.[7] Finally, going without supplemental coverage requires no additional premiums, but it exposes beneficiaries to full Medicare cost sharing, which increases their risk of becoming impoverished because of a costly illness. To the extent that more beneficiaries become impoverished, more will incur enough medical expenses to "spend down" their income so that they qualify for Medicaid.

In the absence of any changes to traditional Medicare and MA, the decline in the prevalence of ESI will likely result in increased medigap and MA enrollment. However, the members of our expert panel believe that the benefits and cost sharing in traditional Medicare could be restructured so that beneficiaries may be more satisfied with Medicare only. Also, employer coverage among the working population is becoming less comprehensive. Therefore, future beneficiaries may be more willing to accept a restructuring of traditional Medicare, because they may view a restructured Medicare program as better coverage than they had during their working years. We discuss potential changes to the benefits and cost sharing in traditional Medicare in more detail later in this chapter.

TABLE 1–1

Hispanic and non-Hispanic beneficiaries have different disease profiles

	Percent of beneficiaries	
Condition	**Hispanic**	**Non-Hispanic**
Hypertension	57.6%	59.1%
CHD	13.1	12.8
Stroke	10.7	12.3
Cancer	10.9	17.4
Diabetes	31.5	19.8
Alzheimer's disease	4.4	3.8
COPD	15.3	15.6
Limitations in three or more ADLs	19.1	12.6

Note: CHD (coronary heart disease), COPD (chronic obstructive pulmonary disease), ADL (activity of daily living). ADLs include bathing, dressing, eating, transferring from bed or chair, walking, and using a toilet. Population includes only beneficiaries in traditional Medicare.

Source: MedPAC analysis of 2003 Medicare Current Beneficiary Survey Cost and Use file.

Adult children may be less available to provide long-term care

The discussion with our expert panel revealed concerns about sources of long-term care provided in the home for Medicare beneficiaries. Historically, family members, primarily women, provided much of this care (CDC/Merck Institute of Aging and Health 2004). However, demographic changes are occurring that could diminish the extent to which adult children will be available to provide long-term care in the future:

- Baby boomers who are nearing Medicare eligibility had fewer children than their parents.
- More adult children live long distances from their parents, making it impractical for them to be sources of care.
- The prevalence of women having children after age 35 has increased. Having children at older ages makes women less available to provide care for their aged parents.
- Increased life expectancy is making it more common for the children of beneficiaries to be Medicare beneficiaries themselves. Providing care to a very old Medicare beneficiary may be physically demanding for someone who is age 65 or older.

It is not clear whether these demographic changes will decrease the availability of adult children to provide long-term care. But, to the extent their availability decreases, more beneficiaries may have to rely on sources outside the home such as assisted living facilities and nursing homes.

Increased use of these other sources to provide long-term care could present both a problem and an opportunity for Medicare. It could be a problem because Medicare does not cover long-term care provided by these other sources, so use of these other sources can be quite costly to beneficiaries to the point they become impoverished. It could present an opportunity because providers could deliver some types of care more efficiently because the typical assisted living facility has many beneficiaries living near each other. For example, house calls and programs that encourage preventive services and care management in the home can be done more efficiently in assisted living facilities. Medicare does not cover those types of services, but the panel suggested that it could change its policies to encourage their use.

Racial/ethnic composition of Medicare beneficiaries will change

The Medicare program will likely see a change in the racial and ethnic composition of its beneficiaries. Current and projected demographics suggest growth in the percentage of beneficiaries of Hispanic origin and, to a lesser extent, the percentage that are of Asian origin. Data from the Census Bureau indicate that in 2005 about 6 percent of the population age 65 or older was Hispanic and 3 percent was Asian. At the same time, 9 percent of the population age 50 to 54 was Hispanic and 4 percent was Asian. In the extended future, the Census Bureau projects that the percentage of the U.S. population that is Hispanic will increase from 14 percent in 2005 to 20 percent in 2030, and the percentage that is Asian will increase from 4.3 percent in 2005 to 6.2 percent in 2030.

Changes in the racial and ethnic profiles of beneficiaries may present issues for Medicare because of differences in language and health profiles. Language barriers can make it difficult for beneficiaries to find providers of care with whom they are comfortable, can make it difficult for beneficiaries to understand the Medicare system (especially the complicated benefits and cost-sharing systems), and can result in medical errors when the patient and provider have a difficult time understanding each other.

Also, Hispanic beneficiaries are a particular minority group that has some important differences from other beneficiaries in terms of their health profiles. Relative to other beneficiaries, Hispanics are more likely to have diabetes, less likely to have cancer, and more likely to have limitations in three or more ADLs (Table 1-1). In addition, data from the National Health and Nutrition Examination Survey indicate that 37 percent of Hispanics age 60 or older are obese, compared with 31 percent of all Americans age 60 or older (Ogden et al. 2006).

Whether we will continue to see these differences in health profiles between Hispanic and other beneficiaries may depend on why the differences exist in the first place. If they are due to underlying physical attributes, the differences are likely to persist. But, if they are due to cultural factors, they may dissipate with assimilation. Also, research indicates that racial and ethnic minorities—especially Hispanics—are more likely to lack health insurance than non-Hispanic whites (NCHS 2006), and lack of health insurance can affect an individual's health profile (Fowler-Brown et al. 2007). Therefore, if differences in health insurance coverage between non-Hispanic whites and minorities continue, differences in health profiles may continue as well.

Proportion of beneficiaries who are age 85 or older will fluctuate

The Census Bureau projects that the percentage of beneficiaries that is age 85 or older will initially increase from current levels, then decrease as the baby-boom generation becomes eligible for Medicare, and then increase at a fast rate as the baby boomers age. In 2005, 13.9 percent of the U.S. population age 65 or older was also age 85 or older. The Census Bureau projects that the proportion will increase to 15.2 percent in 2010, decrease to 13.4 percent in 2030, and then increase to 19.2 percent in 2040.

Changes in the proportion of beneficiaries age 85 or older may be important because these very elderly beneficiaries are relatively costly. In 2003, per capita Medicare expenditures for beneficiaries age 85 or older were 40 percent higher than for those of all beneficiaries (MedPAC 2006a). In addition, these beneficiaries are more likely to have a living arrangement that involves formal assistance such as a nursing home or assisted living facility. Care in these facilities can be quite costly to beneficiaries or their families because it is often not covered by Medicare (Stone 2007).[8] Finally, these beneficiaries have important differences in their health profiles compared with the overall Medicare population, including a higher probability of having Alzheimer's disease, ever having a stroke, or having limitations in three or more ADLs (Table 1-2). As the population age 85 or older makes up a larger share of the Medicare population, the conditions that are relatively prevalent in that population—particularly Alzheimer's disease and dementia—are issues that Medicare may need to address to better serve future beneficiaries.

TABLE 1–2

Beneficiaries age 85 or older are more likely to have Alzheimer's disease, a stroke, or functional limitations, 2003

	Percent of beneficiaries	
Condition	**Age 85 or older**	**All**
Hypertension	61.9%	59.0%
CHD	11.9	12.8
Stroke	17.8	12.2
Cancer	16.6	16.9
Diabetes	16.1	20.6
Alzheimer's disease	12.3	3.9
COPD	10.9	15.6
Limitations in three or more ADLs	30.9	13.1

Note: CHD (coronary heart disease), COPD (chronic obstructive pulmonary disease), ADL (activity of daily living). ADLs include bathing, dressing, eating, transferring from bed or chair, walking, and using a toilet. Population includes only beneficiaries in traditional Medicare.

Source: MedPAC analysis of 2003 Medicare Current Beneficiary Survey Cost and Use file.

Increase in formal education may affect how beneficiaries interact with providers

The amount of formal education among Medicare beneficiaries will increase in the coming decades, and our expert panel indicated this could be an important development. The proportion of beneficiaries who did not complete high school will decrease, and the proportion with an undergraduate degree or higher will increase. Data from the Census Bureau indicate that, in 2004, 27 percent of the U.S. population age 65 or older did not complete high school compared with only 14 percent of the population age 55 to 64. Also, 19 percent of the population age 65 or older has a bachelor's degree or higher compared with 28 percent of the population age 55 to 64.

More educated beneficiaries can affect the Medicare program by taking a more active role in the clinical decisions that affect their health. Some members of our expert panel suggested that more educated beneficiaries come to their encounters with providers more prepared in terms of understanding their medical options. Consequently, they may ask their providers more questions about treatment options and have a better understanding of the alternatives for treating a particular condition.

Also, more educated beneficiaries may be more willing to use—and more adept at using—information technology to improve their health care. This may include using personal health records so that they can easily share their medical history with their providers or using the Internet to become more informed consumers by accessing information on providers and health plans.

Finally, a more educated population may result in a different health care profile among Medicare beneficiaries. For example, research indicates that higher levels of education are correlated with later onset of Alzheimer's disease and with later onset of chronic conditions (Gatz et al. 2006, Smith 2005).

Patterns of income growth could affect access to care

Per capita income usually increases each year among Medicare beneficiaries, as it does among the rest of the U.S. population. Per capita income (adjusted for inflation) increased by an average of 1.3 percent per year from 1993 to 2003 among Americans age 65 or older (Census Bureau 2005). The future rate of income growth and the distribution of income can have important implications for beneficiaries' access to care. This will become an even more pressing issue if ESI continues to decline as a source of supplemental insurance, because more beneficiaries may to turn to medigap—which typically is less comprehensive than ESI and usually requires larger premium contributions from beneficiaries—or to traditional Medicare with no supplemental insurance.

Recent data on growth in beneficiaries' incomes and health care costs suggest beneficiaries may have greater difficulty paying their health care expenses in the future. For example, from 1993 to 2003, the Part B premium increased at an inflation-adjusted rate of 2.5 percent per year, which is nearly twice the annual rate of increase in per capita income among the population age 65 or older, 1.3 percent.[9] Moreover, the monthly Part B premium has increased substantially in recent years, rising from $78.50 in 2005 to $93.50 in 2007.

Another issue regarding beneficiaries' incomes is that changes in income equality could lead to increasing differences in access to care between wealthy and poor beneficiaries. Data from the Census Bureau are ambiguous about the trend in income equality. From 1993 to 1999, there was little change in income equality as indicated by the Gini coefficient, a measure of the difference between perfect income equality and the actual distribution of income. However, income became slightly less evenly distributed in 2000 and 2001 (the most recent years of available data). Among low-income beneficiaries, this has implications for participation in Part B and supplemental insurance plans. For example, research indicates that participation in health plans declines as premiums become larger in proportion to income (Hudman and O'Malley 2003).

A final issue related to beneficiaries' future income is whether members of the baby-boom generation have saved enough to help pay their future health care costs and other retirement expenses. If they are not adequately funding their retirement, there may be a large future increase in the percentage of beneficiaries who qualify for Medicaid. However, there is not consensus in the literature on this issue. Some studies argue that baby boomers are not well positioned to fund their retirement because of low retirement savings (Gist 2006, DeVaney and Chiremba 2005, Goodman and Orszag 2005). In contrast, others argue that these studies do not accurately represent the ability of members of the baby-boom generation to fund their retirements because they exclude important sources of wealth such as capital gains. If one considers total wealth accumulation, it can be argued that the financial behavior of baby boomers is similar to that of previous generations (CBO 2003).

Modifying traditional Medicare to better serve future beneficiaries

We drew heavily on ideas discussed by our expert panel and from previous MedPAC work to identify some policy changes that would allow the Medicare program to better serve future beneficiaries. The possible policy changes discussed by our expert panel or previously analyzed by MedPAC include:

- facilitate care coordination in traditional Medicare for beneficiaries who have chronic conditions or who are complex cases;
- improve incentives to use health information technology (IT) such as electronic health records;
- expand use of comparative-effectiveness analyses and make results available to help guide providers' and beneficiaries' decisions about care;
- develop public health initiatives that promote healthy lifestyles; and
- change the structure of benefits and cost sharing in traditional Medicare, such as putting a catastrophic limit on beneficiaries' cost sharing.

In the next several sections, we discuss how these changes can be implemented and how they are related to the changing profile of Medicare beneficiaries. Some of the changes are interconnected—such as facilitating care coordination and increasing use of IT—and we include this interconnectedness in our discussion. These changes are not intended to address the long-run sustainability of the Medicare program. Other changes are needed to address that issue. We discuss them in Chapter 1 of our March 2007 report to the Congress (MedPAC 2007).

Facilitating care coordination

In previous work, the Commission explored ways to expand care coordination by creating incentives for a patient's providers to share clinical information among each other, monitor the patient's status between visits, and fully communicate with the patient about how to care for his or her condition(s) (MedPAC 2006b). Patients who can benefit the most from care coordination have several chronic conditions and other complex needs. Therefore, the increase in the proportion of beneficiaries being treated for several chronic conditions indicates that facilitating care coordination could be quite beneficial to future beneficiaries.

Policymakers have shown an interest in advancing the role of care coordination in traditional Medicare. For example, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) authorized the Medicare Health Support (MHS) program, a pilot program designed to develop and test coordinated care initiatives. In addition, the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 authorized a physician group practice demonstration intended to encourage care coordination among large physician groups. These programs are still in the early stages, so results on how well they reduce costs and improve quality are not yet available.

Why would care coordination be beneficial?

Earlier in this chapter we discussed the substantial increase over the last two decades in the proportion of beneficiaries that are treated for chronic conditions. This proportion may continue to increase. In response, our expert panel suggested that greater use of care coordination in the Medicare program could improve the quality of care for beneficiaries with chronic conditions and has the potential to lower program costs.

In a previous analysis of care coordination, MedPAC interviewed experts and reviewed the literature. Our research indicated that care coordination can improve beneficiaries' care by reducing hospitalizations—including readmissions—and use of emergency departments by improving adherence to evidence-based guidelines. Moreover, self-management programs for older adults have been found to improve care for hypertension and diabetes, and other interventions have been effective for coronary artery disease, diabetes, heart failure, and asthma (MedPAC 2006b).

Because there is some evidence that care coordination reduces hospitalizations, it is plausible that it could reduce upward pressure on Medicare spending and beneficiaries' financial liability. However, care coordination also has the potential to increase Medicare costs unless the programs target the patients who would benefit the most and avoid those who would benefit little. Technological advancements have made it possible to identify conditions at very early stages of the disease. In some of these cases, the patient may be healthy enough that care coordination may provide little benefit. Using care coordination in those cases would do little more than increase program spending and, potentially, the patient's cost sharing.

Obstacles to care coordination in traditional Medicare

Our expert panel said that the structure of the fee-for-service payment system in traditional Medicare is an obstacle to effective care coordination. Traditional Medicare pays individual providers based on what they do in a visit or during an inpatient stay. Payment does not depend on how well a provider coordinates the care

provided in a visit or inpatient stay with the care the patient receives from other providers or in other settings. Moreover, many of the services required by individuals with chronic conditions or other complex needs, such as ongoing monitoring and education for self-management, are not performed within the typical face-to-face visit.

Early results from the MHS program suggest that successfully implementing care coordination into traditional Medicare may not be easy. Eight organizations contracted to participate in the MHS. After the first year, one dropped out of the program and another announced that it had missed its targets for cost reductions (Enrado 2006).

Keys to facilitating effective coordinated care in traditional Medicare

Fundamental changes to the structure of traditional Medicare are necessary to facilitate care coordination. These changes should include changes to the system of care delivery, the benefit system, and the systems for reimbursing providers.

In MedPAC's previous work on care coordination, we discussed two models of care coordination that are currently being used in pilot or demonstration projects. We called one the provider group and the other the care management organization plus physician office. The two models are quite similar, with one key difference: the entity accountable for coordinating a patient's care. In the provider group model, the accountable entity is a large provider group. In the other model, the accountable entity is a care management organization that works with a beneficiary's providers. Our work on this issue revealed five factors that should be present for either of these models to be effective in traditional Medicare (MedPAC 2006a):

- Care managers, usually nurses who act as the point person and oversee a patient's care, must be available and have incentives to serve Medicare beneficiaries. The care manager develops a plan for tracking the patient's status, helps the patient understand how to manage his or her condition, teaches the patient how to effectively navigate the health care system, and communicates the patient's needs to his or her providers.
- Information systems should be available that allow care coordination programs to identify patients who would benefit most. This would hold down Medicare spending by avoiding care coordination for patients who would receive little benefit. In addition, providers could use information systems to track patients' health status over time.
- The patient's physician should be a part of the care coordination team. To encourage physicians' participation, they should receive fees or a share of cost savings for the time they spend interacting with the care coordination team.
- Beneficiaries should be engaged in their care management, especially in regard to adhering to their care plan and properly monitoring their condition.
- The responsible organizations and the physicians interacting with the programs should be held accountable. The organizations responsible for a patient's care should be accountable for cost savings and quality, which can be promoted through a payment system that ties payment to performance. Quality measures must be developed to indicate whether an organization is using the appropriate treatment methods for specific conditions, such as annual eye and foot exams for diabetics. Quality measures can also be used to hold physicians accountable through pay-for-performance programs.

Improving incentives to use health information technology

IT in the health care sector does not have a precise definition. It is perhaps best identified by how it is used: Providers use electronic mechanisms to collect, store, retrieve, and disseminate information. Health IT can be in many forms, but they can all be grouped into two broad categories, financial and clinical. In this section, we focus on clinical IT, which includes:

- ***electronic health records (EHRs)***, which typically have a record of a patient's medical history that providers can access to help guide clinical decisions;
- ***computerized provider order entry (CPOE)***, which allows physicians and other providers to electronically order medications, lab tests, procedures, radiology studies, discharges, transfers, and referrals; and
- ***picture archiving and communications systems***, which collect and store patients' diagnostic and radiologic images in electronic files and allow for dissemination to health care sites when needed.

Benefits of health information technology

MedPAC has previously reported on IT in the Medicare program, citing the potential to improve quality and efficiency as the primary benefits (MedPAC 2005, 2004). For example, IT could improve quality through reduced medication errors and adverse drug events in hospitals. In addition, IT could be used to efficiently collect quality data on providers. Providers could use these quality data to evaluate their performance, and payers and consumers could use the data to evaluate the quality of the care they receive and purchase. IT could improve efficiency by bringing cohesion to the fragmented delivery system of traditional Medicare. When treating a patient, providers often have to gather and evaluate data from a number of sources. These data are usually obtained via paper documents, telephone conversations, or fax machines. IT, especially EHRs, can streamline this process by putting all of a patient's information in a single electronic file.

The improved efficiency and quality would be important to all beneficiaries, but IT can be especially helpful to those with chronic conditions. These beneficiaries often have several providers and many encounters with the health care system, which can make care coordination difficult. IT could facilitate coordination of their care by collecting their health care history in a single file that all their providers could access.

The Congress has shown interest in expanding the role of IT in the Medicare program. The MMA established the Medicare Care Management Performance Demonstration. The purpose of this three-year demonstration is to promote the adoption and use of health IT to improve the quality of care for chronically ill beneficiaries. Participating physicians who meet or exceed performance standards established by CMS in clinical delivery systems and patient outcomes receive bonus payments.

Although use of IT is usually discussed from the perspective of providers, greater use of IT among beneficiaries also may be advantageous. The amount of formal education among beneficiaries is expected to increase, which may result in future beneficiaries being more comfortable using IT. This could present an opportunity for greater use of personal health records (PHRs) among beneficiaries. As a concept, PHRs are files individuals maintain that contain information about their medical histories such as allergies, adverse drug reactions, illnesses, hospitalizations, surgeries, lab results, and family history.

PHRs allow patients to create a complete list of their medical history that they can easily reference and make it easier for them to share their medical history with their providers. This may reduce errors and eliminate duplicate procedures and processes. Because of these potential benefits of PHRs and because beneficiaries are becoming more comfortable with information technology, it may be advantageous for Medicare to encourage wider use of PHRs.

Obstacles to adopting health information technology

Use of IT by health care providers has been growing but remains low. A recent study estimates that in 2005, 5 percent of hospitals were using CPOEs and 24 percent of physicians were using EHRs (Jha et al. 2006). Many factors appear to contribute to the slow uptake of IT. Providers, particularly physicians, cite the cost of IT and the lack of a clear return on investment. Another barrier may be the difficulty of successful implementation. Many providers may not know enough about IT to effectively navigate the market, implement choices they make, and maintain the system. In addition, introducing IT into the workplace may require changes to workplace procedures that clinicians and office staff could resist.

Also, the structure of health care payment systems may result in the purchasers of IT sometimes not receiving the full financial reward of their investments. For example, use of EHRs may result in fewer medical errors, which may lead to the need for fewer services. Payers would benefit because they would have to reimburse physicians for fewer services, but the physicians who invest in the EHRs may end up with lower revenues.

A final barrier may be the lack of a standard system for transmitting data and describing the content of the data. This limits providers' ability to share and use information across systems. For example, a physician's office may find that information from an outside source, such as a laboratory, may not be compatible with its system. Because a patient can receive care in a number of settings, providers may be hesitant to invest in systems that cannot be linked to other parts of the health care system.

Increasing the presence of health information technology in Medicare

The Commission considered three methods for advancing the use of IT in the Medicare program: providing grants

and loans, requiring use, and establishing quality measures that are linked to IT (MedPAC 2005).

The Commission argued against using grants and loans because:

- Providers may need to commit to changes and be willing to revise work processes to successfully implement IT. Effectively targeting grants and loans to providers who are willing to make the necessary changes could be difficult.
- Grants and loans should be funneled to providers most in need of assistance. But it may be difficult to identify those most in need.

In regard to requiring providers to implement and use IT, the Commission determined that this approach could be overly burdensome to providers.

The Commission determined that the best way to increase use of IT would be to incorporate into pay-for-performance initiatives the use of quality measures that require the use of IT, are facilitated by IT, or are likely to improve if providers use IT. The Commission made this decision for these reasons:

- Under pay-for-performance initiatives, providers would need to collect and report information on performance measures, and IT systems may make this easier.
- Use of IT can be directly measured, and these IT measures could be part of a larger set of quality measures.
- Tying payments to quality could increase the financial benefit of investing in IT and sustaining its use vis-à-vis other investment options.
- Medicare should pay providers for using IT, not just for purchasing it.

Expanding use of comparative-effectiveness analyses

Comparative effectiveness is the process of comparing the relative contribution of services to improvements in the health of patients. It can help providers and patients make well-informed decisions about alternatives for diagnosing and treating a condition. A complete discussion of the benefits of comparative effectiveness and how it can be produced so that public payers, private payers, providers, and patients can use it appears in Chapter 2 of this report.

Promoting healthy lifestyles

Our expert panel discussed the importance of promoting healthy lifestyles. An example of how healthy lifestyles could be promoted is through public health campaigns—not necessarily operated through Medicare—aimed at lowering obesity rates by improving diet and exercise. To the extent that such a campaign is successful, lower obesity rates could reduce the prevalence of costly chronic conditions such as diabetes and hypertension.

Some panelists emphasized that it would be important to reach beyond the Medicare program and promote healthy lifestyles among the population that is nearing Medicare eligibility. Their rationale for including future beneficiaries in lifestyle promotions is that more beneficiaries would have healthy lifestyles when they become eligible for Medicare. However, the beneficial effects of promoting healthy lifestyles may be limited. For example, the success of promotions depends on the willingness of people to make behavioral changes. Moreover, some people may have genetic predispositions to being overweight that lifestyle changes cannot overcome.

Changing benefits and cost sharing

Medicare has long been credited with improving beneficiaries' access to care (MedPAC 2006a). However, traditional Medicare—the choice of more than 80 percent of beneficiaries—is based on a model of health insurance design from the 1960s. Health insurance in the private sector has changed since then, so Medicare has a system of benefits and cost sharing that is somewhat different from most private-sector health plans. The structure of the benefits and cost sharing creates incentives that could dissuade providers and beneficiaries from choosing the most clinically effective options. Moreover, the benefit structure of traditional Medicare does not limit beneficiaries' exposure to financial loss, and, because of its coverage limitations, beneficiaries often rely on other sources to supplement Medicare, which adds inefficiency to the health care system by encouraging excessive and inappropriate use of services.

In this section, we review the current structure of benefits and cost sharing in the Medicare program and then review changes discussed by our expert panel or by MedPAC in a previous report so that Medicare can better serve beneficiaries (MedPAC 2002). In the future, we intend to

estimate the potential effects of changing the benefits and cost sharing on program spending as well as beneficiaries' cost-sharing liabilities and service use.

The benefits and cost sharing in traditional Medicare have limitations

The benefit package in traditional Medicare has three parts:

- Part A primarily covers acute care services provided in hospital inpatient units (including drugs), skilled nursing facilities, and hospices. It also covers some home health services. Most beneficiaries are entitled to Part A and do not pay a premium to participate.
- Part B covers acute care services provided by physicians, hospital outpatient departments, and ambulatory surgical centers. It also covers home health services not covered under Part A, diagnostic laboratory tests, outpatient mental health services, durable medical equipment, and some preventive services. In general, drugs furnished as part of Part B services are covered under Part B. Beneficiaries pay a subsidized premium to participate in Part B, although low-income beneficiaries can have their premium paid through their state's Medicaid program.
- Part D covers outpatient prescription drugs that are not covered under Part B. Beneficiaries pay a subsidized premium to participate in Part D, but low-income beneficiaries can have some or all of the premium subsidized further.

The benefit package in traditional Medicare has been credited with helping elderly Americans access needed care. However, traditional Medicare, which accounts for most Medicare enrollment, has some important limitations including:

- The structure of the cost sharing may add inefficiencies to the health care system.
- The program does not limit beneficiaries' liability for cost sharing on covered services, putting beneficiaries at risk for catastrophic losses.

Traditional Medicare may not promote efficient health care choices The benefits and cost sharing in traditional Medicare are a patchwork system (Table 1-3, p. 20). The cost-sharing design affects the costs beneficiaries face when they use health care services, which may affect their decisions—or those of their providers—about whether to seek care and what mix of services to use. Furthermore, some features of Medicare's cost sharing may lead providers and beneficiaries to make inefficient choices.

For example, hospital inpatient care typically depends on random events that are beyond beneficiaries' control. By contrast, some—but not all—of the ambulatory care covered in Part B is more discretionary. Insurance theory suggests that nondiscretionary care should be covered more fully than care that is within the insured person's control. The logic behind this theory is to avoid financial penalties for events that are beyond beneficiaries' control, and need for inpatient care is typically beyond their control. In other words, individuals have no choice but to receive inpatient care, so do not punish them for getting sick.

In contrast, greater cost sharing in many instances is appropriate for ambulatory care because beneficiaries' use of it is often discretionary. In these cases, cost sharing gives patients an incentive to consider the benefit of the care relative to the cost. When faced with cost sharing, beneficiaries will not use care that has little benefit to them. This implies that inpatient care in most instances should have less cost sharing than ambulatory care. But, in one respect, the opposite is true in traditional Medicare: The inpatient deductible, $992, is much higher than the Part B deductible, $131. However, the structure of cost sharing for ambulatory care must be considered carefully so that it does not give beneficiaries incentive to forgo beneficial services.

Traditional Medicare does not limit financial risk A limitation in the benefit structure of traditional Medicare cited by our expert panel is that it does not limit beneficiaries' financial losses if they experience a costly illness. Private health insurance plans typically become more generous as a beneficiary's costs increase. For example, insurance in the private sector typically has a deductible and coinsurance or copayments at relatively low cost levels and a stop loss that limits beneficiaries' liability if they have high costs. Stop-loss provisions are typically present even in the high-deductible plans associated with health savings accounts.

In contrast to most private-sector plans, traditional Medicare lacks a stop loss. Consequently, beneficiaries who are in traditional Medicare and lack supplemental coverage have no limit on the financial liability they can incur from covered medical expenses. The high total costs that some beneficiaries incur illustrate the potential risk

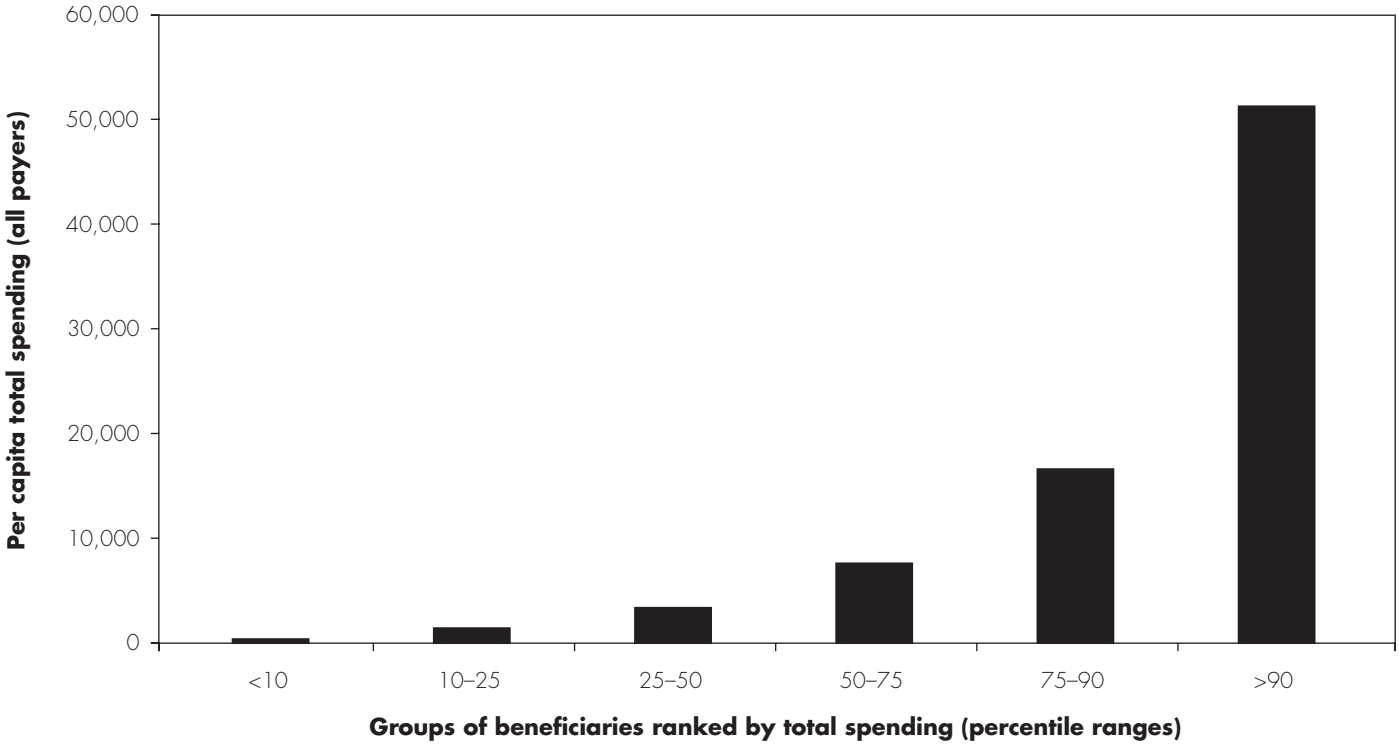
TABLE 1–3

Medicare benefits and cost-sharing requirements, 2007

Services	Beneficiary cost sharing
Part A	
Inpatient hospital (up to 90 days per benefit period plus 60 lifetime reserve days)	$992 for the first stay in a benefit period Days 1–60: Fully covered Days 61–90: $248 per day 60 lifetime reserve days: $496 per day
Skilled nursing facility (up to 100 days per benefit period)	Days 1–20: Fully covered Days 21–100: $124 per day
Hospice care for terminally ill beneficiaries	Nominal coinsurance for drugs and respite care
Part B	
Premium	$93.50–$161.40, per month, depending on income
Deductible	$131 annually
Physician and other medical services (including supplies, durable medical equipment, and physical and speech therapy)	20 percent of Medicare-approved amount
Outpatient hospital care	Greater of 20 percent of Medicare-approved amount or 20 percent of 1996 national median charge updated to 2000
Ambulatory surgical services	20 percent of Medicare-approved amount
Laboratory services	None
Outpatient mental health services	50 percent of Medicare-approved amount
Both Part A and Part B	
Home health care for homebound beneficiaries needing skilled care	None
Part D	
Premium	Depends on plan choice
Deductible	$265*
Coinsurance	20 percent on costs from $265 to $2,400, 100 percent from $2,400 to $3,850, and nominal cost sharing above $3,850*

Note: The Part B premium increases from $93.50 to $161.40 per month based on a sliding scale for individuals with incomes above $80,000 and below $200,000 and for couples with incomes above $160,000 and below $400,000.
*Standard benefit plans may offer actuarially equivalent or enhanced benefits.

FIGURE 1–3 **Ten percent of beneficiaries have more than $50,000 of annual health care spending**



Note: Analysis includes fee-for-service beneficiaries living in the community.

Source: MedPAC analysis of 2003 Medicare Current Beneficiary Survey Cost and Use file.

of catastrophic loss (Figure 1-3). Moreover, MedPAC has shown that the lack of a stop loss can limit beneficiaries' options for where they can receive care. For example, MedPAC found that beneficiaries' cost sharing for cancer drugs has been rising. For those who lack supplemental coverage, the cost-sharing liabilities for these drugs can be large. When beneficiaries cannot pay the cost sharing, providers respond by changing their delivery of care. For example, oncology practices in some areas of the country have stopped treating patients without supplemental insurance in their offices and send them to hospital outpatient departments or safety-net facilities (MedPAC 2006c).

In response partly to the risk of large financial losses in traditional Medicare, nearly 90 percent of beneficiaries in traditional Medicare have supplemental coverage beyond the standard Medicare benefits.[10] Some of the changes in the profile of beneficiaries' characteristics discussed above may increase their vulnerability to being impoverished from health care expenses. This is especially true if the decline in the proportion of beneficiaries with ESI continues or if beneficiaries' incomes continue to increase more slowly than the cost of health care services and premiums. To the extent that beneficiaries' risk of catastrophic loss increases, the lack of a stop loss becomes a more pressing issue.

Possible changes to Medicare benefits and cost sharing

From the discussion with our expert panel and review of previous MedPAC analyses, we have identified some possible changes to the benefits and cost sharing in traditional Medicare so that the program would better serve beneficiaries in the future. These changes include:

- Create a single deductible for Part A and Part B. Beyond the deductible, it may be reasonable to have no additional cost sharing for hospital inpatient care and require some cost sharing for most other services. In addition:
  - Most beneficiaries in traditional Medicare have supplemental coverage, which can largely reduce the effectiveness of cost sharing in deterring excessive spending. Limiting the extent to which supplemental insurance is allowed to cover cost sharing could reduce program spending. However, the limitations should not be so severe that beneficiaries face excessive risk of catastrophic loss.
  - Careful thought should be given to the structure of the cost sharing because even a small amount can have a strong effect on beneficiaries' use of some services and runs the risk of discouraging use of beneficial services. For example, research suggests that use of physician office visits and adherence to drug regimens can be very sensitive to cost sharing (Chandra et al. 2007, Goldman et al. 2006). In addition, cost sharing can have an especially strong effect on low-income beneficiaries, who may forgo beneficial services if they view cost sharing as too great a financial burden (Hudman and O'Malley 2003).
  - Cost sharing in Part B should encourage preventive care and discourage services of marginal value.
- Include a limit (stop loss) on beneficiaries' liability for cost sharing on covered services.
  - A stop loss would reduce beneficiaries' risk of incurring health care liabilities that could impoverish them. This would improve their financial circumstances, especially if their incomes continue to rise slowly relative to health care costs and if ESI continues to wane as a source of supplemental insurance.
  - Also, a stop loss may convince some beneficiaries to discontinue their supplemental coverage because they may begin to view the restructured Medicare benefit design as adequate. Fewer beneficiaries with supplemental coverage would make the health care system more efficient because many supplemental plans cover most or all of a beneficiary's cost sharing, which gives them an incentive to use services that have little or no benefit. In addition, it would reduce the administrative expenses providers and insurers incur in processing claims and managing multiple sources of coverage.

Summary and next steps

The general profile of characteristics among Medicare beneficiaries is likely to change in important ways in the coming decades. These changes include:

- a greater proportion with several chronic conditions,
- a smaller proportion with disabilities,
- fewer with ESI,
- adult children being less available to provide long-term care in the home,
- a different racial and ethnic mix,
- a changing proportion age 85 or older,
- more years of formal education, and
- changes in per capita income and the distribution of income.

To the extent these changes occur, they will affect beneficiaries' needs and preferences for health care as well as costs to the Medicare program.

In this chapter, we discussed details of the changing characteristics and offered some possible changes to Medicare so that the program could better serve future beneficiaries. The changes we presented include:

- Facilitate care coordination, which can be especially beneficial to those who have several chronic conditions.
- Encourage greater use of IT, which can improve quality, efficiency, and care coordination.
- Expand use of comparative-effectiveness analyses, which can help beneficiaries and providers make informed decisions about health care choices.

- Develop and use public health initiatives that promote healthy lifestyles, which could help reduce cost pressures on Medicare.
- Change the structure of benefits and cost sharing in traditional Medicare, which can help improve efficiency in the health care sector and reduce beneficiaries' risk of catastrophic loss.

The analysis we presented in this chapter is intended to be the first part of a longer term analysis. In the coming year, the Commission plans to revisit ideas for restructuring Medicare benefits and what we have learned about the changing characteristics of future Medicare beneficiaries. We also will be looking in greater depth at how Medicare can promote changes to the health care delivery system to provide the care coordination that will address the changing needs of Medicare beneficiaries. ■

Endnotes

1 A chronic condition is a disease that cannot be cured or is infrequently cured. Examples of chronic conditions include diabetes, hypertension, and coronary heart disease.

2 BMI is calculated as weight in kilograms divided by height in meters squared.

3 The complete definition of metabolic syndrome is having three or more of the following conditions: abdominal obesity, defined as waist circumference of more than 102 centimeters (cm) in men and 88 cm in women; high triglyceride levels (more than 150 milligrams per deciliter (mg/dL)); low high-density lipoprotein (below 40 mg/dL in men and below 50 mg/dL in women); high blood pressure (above 130/85 millimeters); and high fasting glucose (above 100 mg/dL) (Ford et al. 2002).

4 Hyperlipidemia is the presence of elevated or abnormal levels of lipids or lipoproteins in the blood.

5 The data sources from AHRQ are the 1987 National Medical Expenditure Survey and the 2002 Medical Expenditure Panel Survey.

6 A person of recommended weight has a BMI of 20 to 24.9.

7 Private fee-for-service plans are a type of MA plan that has little or no restriction on which providers beneficiaries can see. See Chapter 3 of this report for a description of the enrollment trends in the MA program.

8 Beneficiaries can receive coverage for care in facilities through Medicaid. However, they must meet income and asset criteria to be eligible for Medicaid coverage. Often, beneficiaries have to incur enough medical expenses to "spend down" their income and assets to levels that make them eligible for Medicaid.

9 The Part B premium increased from $36.60 in 1993 to $58.70 in 2003 in nominal terms and from $36.60 in 1993 to $46.82 in 2003 in inflation-adjusted terms. Mean household income among Americans age 65 or older increased from $25,965 in 1993 to $36,893 in 2003 in nominal terms and from $25,965 in 1993 to $29,429 in inflation-adjusted terms.

10 Another motivation for obtaining supplemental insurance is a preference for predictable spending.

References

Census Bureau. 2005. Historical income tables—households, table H-10. http://www.census.gov/hhes/www/income/histinc/h10ar.html.

Centers for Disease Control and Prevention and Merck Institute of Aging and Health. 2004. *The state of aging and health in America 2004*. Atlanta, GA: CDC.

Chandra, A., J. Gruber, and R. McKnight. 2007. *Patient cost-sharing, hospitalization offsets, and the design of optimal health insurance for the elderly*. NBER working paper no. 12972. Cambridge, MA: NBER.

Chernew, M. E., D. P. Goldman, F. Pan, and B. Shang. 2005. Disability and health care spending among Medicare beneficiaries. *Health Affairs Web Exclusives* (September 26). http://www.healthaffairs.org/.

Congressional Budget Office. 2003. *Baby boomers' retirement prospects: An overview*, Chapter 3. Washington, DC: CBO. http://www.cbo.gov/showdoc.cfm?index=4863&sequence=3&from=0.

Cutler, D. M., E. L. Glaeser, and A. B. Rosen. 2007. *Is the U.S. population behaving healthier?* NBER working paper no. 13013. Cambridge, MA: NBER.

DeVaney, S. A., and S. T. Chiremba. 2005. *Comparing the retirement savings of the baby boomers and other cohorts.* http://www.bls.gov/opub/cwc/cm20050114ar01p1.htm.

Enrado, P. 2006. Medicare pilot off to a rocky start. *Healthcare IT News*. December 1.

Fontaine, K. R., D. T. Redden, C. Wang, et al. 2003. Years of life lost due to obesity. *Journal of the American Medical Association* 289, no. 2: 187–193.

Ford, E. S., W. H. Giles, and W. H. Dietz. 2002. Prevalence of the metabolic syndrome among U.S. adults. *Journal of the American Medical Association* 287, no. 3: 356–359.

Ford, E. S., W. H. Giles, and A. H. Mokdad. 2004. Increasing prevalence of the metabolic syndrome among U.S. adults. *Diabetes Care* 27, no. 10: 2444–2449.

Fowler-Brown, A., G. Corbie-Smith, J. Garrett, and N. Lurie. 2007. Risk of cardiovascular events and death—Does insurance matter? *Journal of General Internal Medicine* 22, no. 4: 502–507.

Fronstin, P. 2005. *The impact of the erosion of retiree health benefits on workers and retirees*. Issue brief no. 279. Washington, DC: EBRI.

Gatz, M. J., A. Mortimer, L. Fratiglioni, et al. 2006. Potentially modifiable risk factors for dementia in identical twins. *Alzheimer's and Dementia: The Journal of the Alzheimer's Association* 2, no. 2: 110–117.

Gist, J. 2006. *Boomer wealth–Beware of the median*. AARP data digest no. 143. Washington, DC: AARP.

Goldman, D. P., G. F. Joyce, and P. Karaca-Mandic. 2006. Varying pharmacy benefits with clinical status: The case of cholesterol-lowering therapy. *American Journal of Managed Care* 12, no. 1: 21–28.

Goodman, J. C., and P. R. Orszag. 2005. *Common sense reforms to promote retirement security*. Washington, DC: Retirement Security Project.

Henry J. Kaiser Family Foundation and Hewitt Associates. 2005. *Prospects for retiree health benefits as Medicare prescription drug coverage begins*. Publication no. 7439. Washington, DC: KFF/Hewitt.

Henry J. Kaiser Family Foundation and Hewitt Associates. 2004. *Current trends and future outlook for retiree health benefits*. Publication no. 7194. Washington, DC: KFF/Hewitt.

Howard, D. H., S. Busch, and K. E. Thorpe. 2006. Understanding recent increases in chronic disease treatment rates: Are we getting sicker or getting screened? Unpublished manuscript. October 5.

Hudman, J., and M. O'Malley. 2003. *Health insurance premiums and cost-sharing: Findings from the research on low-income populations*. Publication no. 4071. Washington, DC: Kaiser Family Foundation.

Jha, A. K., T. G. Ferris, K. Donelan, et al. 2006. How common are electronic health records in the United States? A summary of the evidence. *Health Affairs Web Exclusives* (October 11). http://www.healthaffairs.org/.

Joyce, G. F., E. B. Keeler, B. Shang, and D. P. Goldman. 2005. The lifetime burden of chronic disease among the elderly. *Health Affairs Web Exclusives* (September 26). http://www.healthaffairs.org/.

Lakdawalla, D. N., D. P. Goldman, and B. Shang. 2005. The health and cost consequences of obesity among the future elderly. *Health Affairs Web Exclusives* (September 26). http://www.healthaffairs.org/.

Medicare Payment Advisory Commission. 2007. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

Medicare Payment Advisory Commission. 2006a. *A data book: Healthcare spending and the Medicare program*. Washington, DC: MedPAC.

Medicare Payment Advisory Commission. 2006b. *Report to the Congress: Increasing the value of Medicare*. Washington, DC: MedPAC.

Medicare Payment Advisory Commission. 2006c. *Report to the Congress: Effects of Medicare payment changes on oncology services*. Washington, DC: MedPAC.

Medicare Payment Advisory Commission. 2005. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

Medicare Payment Advisory Commission. 2004. *Report to the Congress: New approaches in Medicare*. Washington, DC: MedPAC.

Medicare Payment Advisory Commission. 2002. *Report to the Congress: Assessing Medicare benefits*. Washington, DC: MedPAC.

Must, A., J. Spadano, E. H. Coakley, et al. 1999. The disease burden associated with overweight and obesity. *Journal of the American Medical Association* 282, no. 16: 1523−1529.

National Center for Health Statistics. 2006. *Health, United States 2006*. Hyattsville, MD: NCHS.

Ogden, C. L., M. D. Carroll, L. R. Curtin, et al. 2006. Prevalence of overweight and obesity in the United States, 1999−2004. *Journal of the American Medical Association* 295, no. 13: 1549−1555.

Olshansky, S. J., D. J. Passaro, R. C. Hershow, et al. 2005. A potential decline in life expectancy in the United States in the 21st century. *New England Journal of Medicine* 352, no. 11: 1138−1145.

Porterfield, B. 2006. Retiree health care could bankrupt governments. *USA Today*. September 25. http://www.usatoday.com/news/health/2006-09-24-retiree-benefits_x.htm.

Smith, J. P. 2005. *The impact of SES on health over the life-course*. RAND working report no. WR–318. Santa Monica, CA: RAND.

Soldo, B. J., O. S. Mitchell, R. Tfaily, and J. F. McCabe. 2006. *Cross-cohort differences in health on the verge of retirement*. NBER working paper no. 12762. Cambridge, MA: NBER.

Stevens, J., J. Cai, E. R. Pamuk, et al. 1998. The effect of age on the association between body-mass index and mortality. *New England Journal of Medicine* 338, no. 1: 1−8.

Stone, R. I. 2007. The demand for long-term care: Implications for workforce development. Presented to Committee on the Future Health Care Workforce for Older Americans, March 27, at the Institute of Medicine, Washington, DC.

Thorpe, K. E., and D. H. Howard. 2006. The rise in spending among Medicare beneficiaries: The role of chronic disease prevalence and changes in treatment intensity. *Health Affairs Web Exclusives* (August 22). http://www.healthaffairs.org/.