CHASP Center for Health and Social Policy

Policy Brief

MEDICARE:

Present Challenges and Persistent Disparities

Introduction

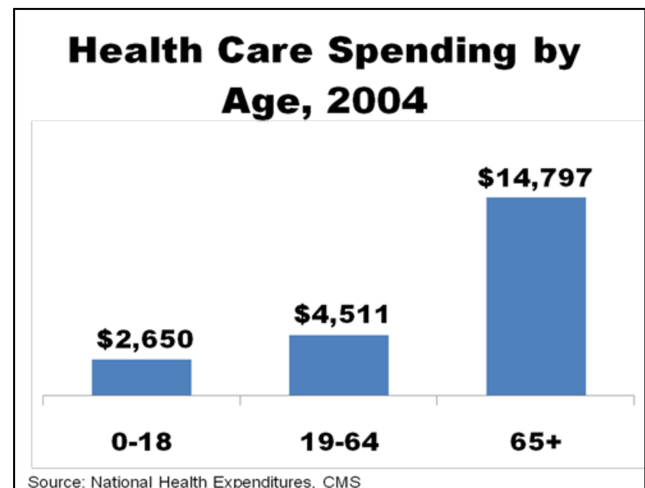
Medicare provides health insurance to nearly 45 million elderly and people with disabilities nationwide. Since its inception in 1965, Medicare has successfully improved the health status, financial stability, and general quality of life of its beneficiaries. In addition, Medicare has served to greatly improve the quality of the health care system as a whole through the encouragement of innovation in both medical practices and the delivery system.

Despite Medicare's accomplishments and high approval rating, important challenges remain. The overall success of the Medicare program is dependent on effective cost containment and the ability to ensure appropriate access to and quality of health care services to all beneficiaries. The presence of persistent disparities among beneficiaries highlights the need for improvement in Medicare structure, policies, and financing. Current challenges stand to become more pronounced given growing health care costs and the ever-rising number of people relying on Medicare.

Present Challenges

Costs. In 2006, Medicare spending comprised 14 percent of the federal budget and 19 percent of national health care expenditures.[1] Medicare spending growth rate is in line with the rate of private insurance spending growth. Medicare fares far better than private insurance when it comes to administrative costs. However, Medicare's spending growth rate outpaces economic growth rate and sustained rapid growth is projected to continue without mitigating action.[2]

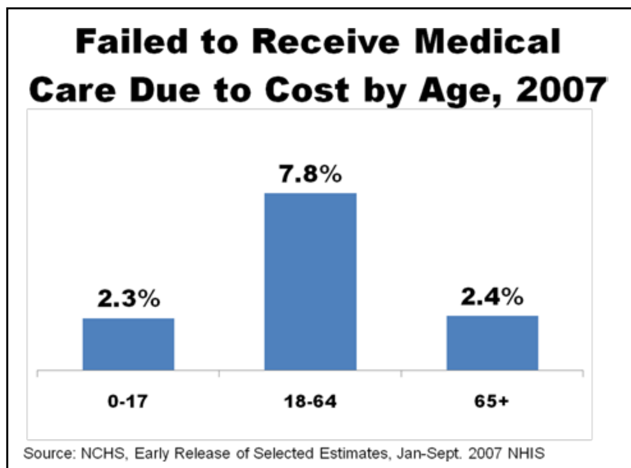
Cost containment proves difficult due to the characteristics of the beneficiary population. Health care spending per capita for people age 65 and over averaged $14,797, compared to $4,511 for working-age adults, in 2004.[3] Representative of the highly variable and distinct health care needs within the population, spending is largely concentrated, with 10 percent of beneficiaries accounting for more than two-thirds of expenditures while a full 22 percent of beneficiaries account for 0 percent of expenditures. In addition, spending per beneficiary in the last year of life is roughly four times greater ($22,107) than the average of all other beneficiaries ($5,694).[4]



Medicare tends to cover a smaller share of health spending than do other health insurance programs. As such, Medicare beneficiaries spend a larger percentage of their income on out-of-pocket health costs: 12.5 percent compared to 2.2 percent, than the under-65 population.[5] While cost sharing strategies are often used to contain insurance costs, the already-high burden of health care costs on the beneficiary population limits its use – as does the fact that beneficiaries over age 65 are more likely to be poor or near poor .

Quality. The quality of health care in the United States varies widely and is universally low in relation to what people pay for it. Medicare is no different. Medicare attempts to provide the best care available to all beneficiaries. However, given the pervasive geographic disparities in quality of care, the vastness of the program, and the limited tools Medicare has to address it, quality control and assurance is a difficult goal.

Research suggests a low or decreasing quality of care received by beneficiaries. The Medicare Payment Advisory Commission documented an increase in adverse events experienced by Medicare patients in six of twelve measurement categories between 2003 and 2005.[6] A recent study found that in Medicare alone, nearly a quarter-million deaths over three years may be attributable to low quality care.[7]



Access. Ensuring access, both financially and physically, to all beneficiaries is an essential function of Medicare. Current satisfaction with overall access is high, with fewer than 10 percent of beneficiaries reporting access problems.[8] Only 4 percent of beneficiaries report that they were dissatisfied with the availability of health care and ease of access to doctors.[9] Because most medical providers accept Medicare patients and incentives are given to rural and low density areas, Medicare is able to provide high physical access to care.

While perceived satisfaction with access is high, benefit limitations of Medicare's coverage prevent access to important services. Medicare does not cover most long-term care services or comprehensive mental health services. Medicare also does not cover periodic health exams after initial enrollment or routine dental, vision, or hearing care. Some but not all of highly-recommended preventive services are covered by the program.

In addition to uncovered services, many of Medicare's deductibles for commonly used services, such as the hospital deductible, are higher than under most private plans. Finally, Medicare does not include a limit on out-of-pocket spending; a policy that leaves beneficiaries at risk of catastrophic liabilities that can arise from serious illness or chronic conditions.

Supplemental Insurance. Cost-sharing policies and service gaps often create unmanageable levels of out-of-pocket costs. To ameliorate these problems of access, beneficiaries obtain supplemental insurance. In fact, 91 percent of Medicare beneficiaries have supplemental coverage. Beneficiaries obtain supplemental insurance through a variety of sources including former employees (33 percent), Medigap policies (26 percent), Medicaid (17 percent), Medicare Advantage (13 percent), and other (2 percent).[10]

The largest current source of supplemental insurance is former employers. This retiree coverage tends to be the most comprehensive coverage of all supplemental insurance. However, mandatory premium contributions have more than tripled in inflation-adjusted dollars between 1998 and 2002 and the rate of employer-sponsored supplemental insurance is declining.[11] Both the increase in premiums and the decrease in offer rate could degrade access to employer supplemental insurance.

A large percentage of beneficiaries also rely on Medigap policies for supplemental coverage. Medigap is wrap-around private health insurance that covers cost-sharing and certain coverage gaps in Medicare. While most Medigap policies comprehensively supplement Medicare's benefit package, the cost is relatively high and beneficiaries are subject to many of the same problems in the private insurance market that non-elderly Americans face. For many of the most health-care needy beneficiaries, Medigap policies are unaffordable. In 2005, women aged 65 spent an average premium of $1,750 for Medigap policies without the inclusion of drug coverage.[12]

Low-income beneficiaries may qualify for supplemental insurance from Medicaid or the new Medicare Low-Income Subsidy Program. These programs offer a range of additional coverage, from full Medicaid benefits for "dual eligibles" to premium assistance for near-poor seniors. However, participation rates are low and near-poor beneficiaries who do not qualify for low income assistance are often unable to bear the costs of purchasing supplemental insurance.

Still other beneficiaries choose to supplement their Medicare benefits by enrolling in private plans through Medicare Advantage. Offering many of the services not covered by traditional Medicare, Medicare's private plan options often limit the beneficiaries' choice of hospitals and doctors.

Problems result from both the presence and absence of supplemental coverage. A lack of such coverage is associated with reduced access to care. [13] Yet, while supplemental insurance may alleviate problems of access, it creates cost ones. Individuals with supplemental coverage use services, irrespective of need, more than those with the same health status and no supplemental coverage.[14] In addition, the necessity of purchasing a second – and sometimes third – insurance policy adds to administrative costs and increases the cost burden on low-income beneficiaries.

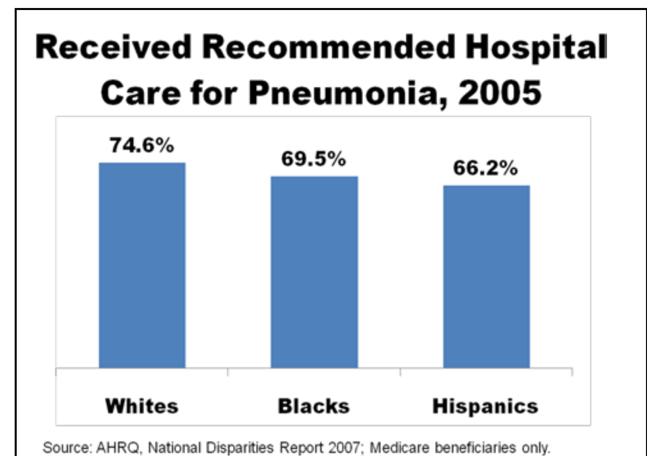
Persistent Disparities

Despite the overall success of Medicare, persistent disparities in health care cost, quality, and access are evident within the beneficiary population.

Disability and Age. A full 15 percent of Medicare beneficiaries are under the age of 65 and permanently disabled, a population characterized with lower-than-average incomes and higher rates of health problems than other beneficiaries.[15] Because of these higher-than-average health care needs, people with disabilities account for a disproportionate share of costs. Two-thirds live on income below 200 percent federal poverty level and 40 percent qualify for dual enrollment with Medicaid.[16] While Medicaid coverage is able to provide many of the services not provided through Medicare to those with the lowest levels of income, many beneficiaries with disabilities face large out-of-pocket costs.

Similar to the permanently disabled Medicare population, much of the aged population (60 percent) lives on income below 200 percent poverty level, at a time when out of pocket costs can be expected to be the highest.[17] Both poverty rates and the need for greater, more expensive medical care rise with age. People age 85 and older have average health spending that is 2.5 times higher than that of people ages 65 to 74 and 5 times higher than the national average.[18]

Racial Disparities. One of Medicare's greatest accomplishments is the reduction of racial disparities through the provision of health insurance coverage to all those aged 65 and older regardless of race. However, while less than they were, disparities by race in health access and quality still exist. Life expectancy is higher across the board than it was in 1960 at age 65, yet disparities in life expectancy are higher, with a difference at age 65 between white and black males of 1.6 years in 2004 compared to 0.5 years in 1960.[19]

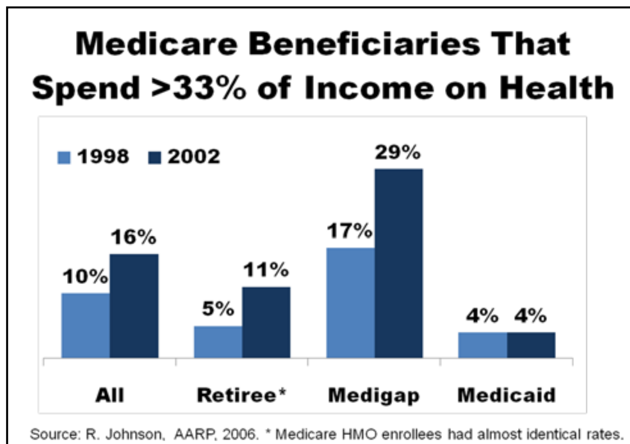


Medicare reduced inequities in health care caused by lack of insurance, but as the Institute of Medicine reports, disparities in the quality of care persist.[20] One study reports that black Medicare fee-for-service beneficiaries experienced a much lower rate of high-cost surgical procedures than white beneficiaries and that the rate difference increased between 1992 and 2001 for five of the nine procedures.[21] The National Healthcare Disparities report, which draws many of its conclusions from studies of Medicare, documents disparities in most health care settings, disease areas, and clinical services.

Medicare beneficiaries who are racial minorities also tend have less financial protection than do white beneficiaries. More than 70 percent of African Americans and Hispanic beneficiaries have income below 200 percent poverty level, compared to 28 percent of white beneficiaries.[22] As such, minority beneficiaries are less able to afford supplemental insurance for uncovered services. [23] A full 27 percent of African Americans and 20 percent of Hispanics over age 65 lack supplemental benefits.[24]

Income Disparities. Some of the greatest disparities within the Medicare population persist due to differential income. While programs exist for low-income beneficiaries to help cover cost sharing, participation rates are low, with only 50 percent of those eligible for Medicaid enrolled.[25]

Existing programs are also not adequately inclusive. Complicated rules and policy limits mean that beneficiaries with income below 150 percent of the poverty level experience financial difficulties in meeting out-of-pocket health care costs, leaving many of the near-poor without adequate access to services.[26] About 25 percent of beneficiaries with income below the poverty level lack supplemental coverage, compared with 8 percent of those with incomes above 400 percent of poverty level.[27]



Highlighting inequality in the quality of care received by low-income beneficiaries is the presence of a growing disparity in life expectancy between high- and low-income individuals. Life expectancy differences at age 65 between high- and low-income groups was 0.3 years in 1980 compared to a difference of 1.6 years in 2000.[28]

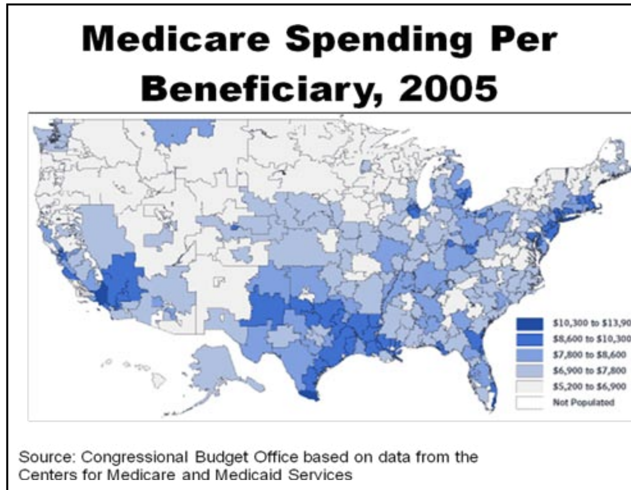
Differences also exist in the percentage of income beneficiaries spend on out-of-pocket costs. Up from 10 percent in 1998, 16 percent of beneficiaries aged 65 and older spent more than one-third of their income on health care in 2002.[29] In 2003, beneficiaries with incomes under 135 percent of poverty level spent 33 percent of their income on uncovered care on average compared with 12 percent of those with income above 200 percent poverty. [30] The projections of increased per capita health care costs only add to the concern over these disproportionate costs.

Geographic Disparities. Medicare spending, quality, and access also vary by region. Per capita health care spending is highly variable across the United States. In fact, among groups of Medicare beneficiaries with similar health, those living in high-spending areas receive roughly 60 percent more in services than those in low-spending areas.[31] In the last two years of life, Medicare spending at U.C.L.A. Medical center was an average of $93,842 compared to $53,432 at the Mayo Clinic in Rochester, Minnesota.[32] These spending differences can be attributed to differences in practices and care delivery rather than differences in demographic or underlying health status of the region. One estimate reports that Medicare spending would decrease by 29 percent if spending in high and medium spending regions equaled those in the low spending regions.[33]

Coupled with spending disparities, there are also quality differences in the care beneficiaries receive regionally that are independent and, in many cases, negatively related to the spending on such care.[34] One study found that when spending per Medicare beneficiary increased by $1,000 in a given state, there was a decrease in most measures of "good" medical practices including the percentage of heart attack patients given aspirin and percentage of pneumonia patients receiving antibiotics within 8 hours of hospital arrival.[35]

Access also varies by region. While Medicare provides incentives to providers in rural and underserved areas, access to care in rural areas is limited when compared to more populated, urban areas. One study found that patients in rural areas had to travel on average 2 to 3 times farther to see a medical or surgical specialist than patients in urban areas. In addition, it was found that the more rural

the area, the greater the beneficiaries' reliance on generalists as opposed to specialists.[36] Another study found that less than 1 percent of urban beneficiaries compared with over 17 percent of rural beneficiaries live in areas with no or little home health care use.[37]



Source: Congressional Budget Office based on data from the Centers for Medicare and Medicaid Services

Medicare Variation Relative to Other Programs

While disparities are clearly present across income, race, and geography among Medicare beneficiaries, Medicare generally equals or outperforms other health programs. Geographic variation in Medicare health care spending per capita is lower than the variation in total health care spending per capita.[38] In comparing growth rates of annual spending per beneficiary, Medicare has been roughly one percentage point lower than private health insurance spending growth rate since its inception.[39] However, this success is hard to quantify given the higher than average health care needs of Medicare beneficiaries than individuals in the private insurance market.[40]

Satisfaction with Medicare is consistently high, with satisfaction rates exceeding those covered by private insurers.[41] In addition, 26 percent of low-income, poor health Medicare beneficiaries rated their insurance as excellent compared to only 12 percent of those with similar income and health status under employer-sponsored insurance.[42] Beneficiaries also enjoy a greater choice of providers than most private health plans since most doctors accept Medicare.

Perceived access is high, despite Medicare's benefit limitations. Seniors were only three-fifths as likely as people aged forty-five to sixty-four to report they had delayed or failed to obtain health care because of cost.[43]

Conclusion

Policy and financing changes are inevitable as Medicare must deal with escalating health care spending, a growing elderly population, and emerging chronic diseases. Given the financial limitations of the beneficiary population and the persistent disparities already inherent in the system, policymakers must aim for reform that not only improves cost containment, access, and quality to all beneficiaries, but also policy that improves the equality of health outcomes and financial protections within the beneficiary population itself.

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