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# Medicare at Forty

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*This year marks the 40th anniversary of the Medicare Program. Medicare has achieved its two basic goals of ensuring access to care for elderly and disabled beneficiaries and protecting them from severe financial hardship. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 represents an important improvement by adding prescription drug coverage. Medicare's major future challenge is responding to the retirement of the baby boom generation and rising health care costs. Promising policy options should aim to ensure health and financial security for beneficiaries and proactively use Medicare's purchasing power to achieve greater efficiency and quality in health care for Medicare beneficiaries and all Americans. More policy attention needs to be focused on debating Medicare's future, a more complex issue than even Social Security.*

## INTRODUCTION

This year marks the 40th anniversary of the Medicare Program. When it was enacted 40 years ago, more than one-half of the elderly were uninsured (Merriam, 1964; Rowland, 1991). Many of the elderly lost their health insurance when they retired. Private insurance companies were reluctant to write comprehensive policies for the elderly out of a concern for adverse risk selection; available policies often limited coverage, exempted pre-existing conditions, and offered inadequate protection (Davis and Schoen, 1978).

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Medicare was designed to eliminate financial hardship from medical bills for elderly Americans and ensure access to needed care (Ball, 1995). For 40 years, the program has been essential to the health and economic security of the Nation's sickest and most disabled people. It is one of the most widely supported government programs among voters of all ages and achieves higher levels of satisfaction among beneficiaries than among adults under age 65 with employer or individual private health insurance (Davis et al., 2002). Addition of preventive services and prescription drugs are helping to fill the gaps in Medicare's original benefit package.

Yet, the program faces serious challenges. Expenditures are projected to rise more rapidly than the tax revenues that support the program, necessitating increased tax rates, reduced benefits, and/or a rising share of the Federal budget devoted to financing health care for the elderly and disabled (U.S. Congressional Budget Office, 2003). This fiscal pressure will intensify as the baby boom generation reaches retirement after 2010. Nor are beneficiaries well-prepared to bear health care costs not covered by Medicare.

This article briefly summarizes beneficiaries' satisfaction with Medicare and its track record in ensuring access to care and providing financial protection to beneficiaries. It concludes with the challenges posed by retirement of the baby boom generation and rising health care costs, and presents policy options that would both improve coverage and care for beneficiaries and use Medicare's leverage as

a major purchaser of health services to improve quality and efficiency in the health system for all Americans.

### **Beneficiary Satisfaction**

Medicare beneficiaries are much more likely to report high satisfaction with their health care and their health insurance coverage than non-elderly adults (Table 1). Eighty-seven percent of aged Medicare beneficiaries report being very or somewhat satisfied with the quality of health care received in the past 12 months, compared with 81 percent of those with employer coverage, 79 percent of those with individual coverage, 87 percent of those under age 65 with Medicaid coverage, 80 percent of the Medicare disabled, and less than one-half of the uninsured (48 percent).

Medicare beneficiaries are also more likely to report being very or somewhat confident that they will get the best medical care available when they need it (Table 1). Aged Medicare beneficiaries report more choice in where to go for medical care, compared with non-elderly adults.

Medicare beneficiaries are much more likely to rate their insurance as excellent or very good, than are those covered by employer plans or individual coverage. Two-thirds (68 percent) of elderly Medicare beneficiaries rate their insurance as excellent or very good, compared with 44 percent of those with employer coverage, 41 percent of those with individual coverage, and 54 percent of those with Medicaid coverage.

The high satisfaction of beneficiaries with coverage is also reflected in the importance beneficiaries attach to qualifying for Medicare coverage. The Commonwealth Fund Survey of Older Adults found that almost three-fourths of Medicare beneficiaries (age 50-70) said that it was very important to become eligible for Medicare

(Collins et al., 2005a). This was particularly true of disabled Medicare beneficiaries age 50-64, 84 percent of whom said it was very important to become eligible for Medicare.

### **Access to Care and Financial Burdens**

Compared with health insurance coverage for those under age 65, Medicare beneficiaries report better access to health care services and financial protection from burdensome medical bills. Medicare beneficiaries age 65 or over are less likely to report going without needed care in the past year due to costs (The Commonwealth Fund, 2003; Davis et al., 2002). In particular, Medicare beneficiaries are less likely than non-elderly adults covered by employer plans or individual coverage to report access problems due to cost, such as not going to a doctor when needing medical attention, not filling a prescription, skipping a medical test, treatment, or followup visit recommended by a doctor, or not seeing a specialist when a doctor thought it was needed. Medicare's cost-sharing, however, can be a deterrent to care for lower-income beneficiaries or those without supplemental coverage (Rice and Matsuoka, 2004).

Among aged Medicare beneficiaries failure to fill a prescription has been the most common access problem. In 2003, one-quarter (26 percent) of elderly beneficiaries reported not taking all the drugs prescribed to them by doctors due to cost (Safran et al., 2005). These results are likely to change with implementation of the Medicare prescription drug legislation, particularly for low-income seniors who stand to gain from more extensive subsidies.

Medicare originally did not cover preventive services, but preventive care was gradually added beginning in the 1990s and now covers female preventive services,

**Table 1**  
**Satisfaction With Quality of Care, Confidence in Future Care, and Experiences With Health Insurance: 2003**

Respondent <sup>3</sup>	All Adults Unadjusted	Age Group <sup>1</sup>		Percent	Insurance Status <sup>2</sup> and Age Group					
		19-64	65 or Over		Medicare (65 or Over)	Employer (19-64)	Individual (19-64)	Medicaid (19-64)	Medicare Disabled (19-64)	Uninsured (19-64)
Total in Millions (Estimated)	207.3	171.9	34.1		32.5	11	9.2	10.7	5.6	29.8
Distribution	100	83	16		16	53	4	5	3	14
<b>Overall, how satisfied are you with the quality of health care you have received in the past 12 months?</b>										
Very/Somewhat Satisfied	78	***75	85		87	*81	*79	87	80	***48
Very/Somewhat Dissatisfied	13	***15	7		7	***13	**15	10	*15	***24
Not Received Health Care	7	7	6		5	4	4	2	2	***26
<b>How confident are you that you will get the best medical care available when you need it?</b>										
Very/Somewhat Confident	70	***67	77		80	***70	72	74	74	***48
Not Too/Not At All Confident	27	***30	16		14	***27	***28	*23	*25	***47
<b>Choice in where to go for medical care.</b>										
A Great Deal/Fair Amount	74	***71	84		84	80	***69	***72	*76	***47
Not Too Much/No Choice At All	23	***27	11		11	***19	***27	***24	**22	***50
<b>Rating of current insurance.</b>										
Excellent/Very Good	50	***47	64		68	***44	***41	**54	**52	NA
Good	28	*29	24		23	**30	*34	23	28	NA
Fair/Poor	19	***23	9		8	***24	***23	***22	***20	NA

\*\*\* $p < 0.001$ .\*\* $p < 0.01$ .\* $p < 0.05$ .<sup>1</sup> Model controls for health status and income.<sup>2</sup> Model controls for health status, income, and prescription coverage.<sup>3</sup> Base: all respondents. Adjusted percentages based on logit models.

NOTES: Referent categories are age 19-64 and Medicare 65 or over; health status refers to sicker versus healthier; sicker defined as fair/poor health, any chronic condition (cancer, diabetes, heart attack/disease, and arthritis), or disability. Survey methodology available on request from the author. NA is not available.

SOURCE: The Commonwealth Fund Biennial Health Insurance Survey (2003).

pneumococcal pneumonia and influenza vaccine, and other preventive services. Gaining Medicare coverage greatly improves access to preventive services for those who were uninsured prior to becoming eligible (McWilliams et al., 2003; Leatherman and McCarthy, 2005).

In addition to ensuring access to needed care, Medicare's other major goal was to provide financial protection to beneficiaries. Studies have documented that Medicare beneficiaries are less likely than adults under age 65 to report problems paying medical bills (The Commonwealth Fund, 2003; Davis et al., 2002). Medicare beneficiaries are less likely than those under age 65 to report times when they had difficulty paying or were unable to pay their bills, were contacted by a collection agency concerning outstanding medical bills, or had to change their way of life significantly in order to pay their bills.

Despite these reports from beneficiaries, elderly beneficiaries spend an average of 22 percent of income on premiums and out-of-pocket health care costs, a fraction that is projected to grow to 30 percent by 2025 (Maxwell, Moon, and Segal, 2001). Few older adults have substantial savings going into retirement on which to draw in meeting these expenses (Collins et al., 2005b).

## **Racial and Ethnic Disparities**

Medicare was instrumental in the desegregation of American hospitals. Through vigorous enforcement of Title VI of the Civil Rights Act, hospitals were required to integrate facilities to qualify for participation in the Medicare Program. Within four months of implementation of Medicare in July 1966, the practice of racial segregation in hospitals ended (Eichner and Vladeck, 2005).

Medicare coverage also eliminated disparities in access to hospital services. Prior to enactment of Medicare, elderly Black persons were less likely to be hospitalized. Those differences narrowed with enactment of Medicare (Davis, 1975) and within a decade were largely eliminated (Ruther and Dobson, 1981).

Despite this remarkable accomplishment, racial and ethnic disparities in the quality of care continue to persist. Black and Hispanic elderly people are much less likely than White people to receive influenza and pneumococcal vaccinations (Agency for Healthcare Research and Quality, 2005). Rates of mammography among elderly females over the past 2 years are similar across racial and ethnic groups. Screening for colon cancer, however, remains low for the elderly in general, and particularly low for minority elderly.

New findings also point to disparities in chronic care management (Leatherman and McCarthy, 2005). Black beneficiaries are less likely than White beneficiaries to receive recommended chronic care services and achieve good outcomes, for conditions such as diabetes, beta blocker after heart attack, effective acute-phase antidepressant treatment, and followup in 30 days after hospitalization for mental illness (Virnig et al., 2002; 2004).

## **Medicare Expenditure Trends**

While rising outlays have been a recurring source of concern since the enactment of Medicare, Medicare spending patterns have largely mirrored that of the health care sector. Medicare has had somewhat slower growth than the rise in private health insurance outlays per enrollee for comparable benefits (Boccuti and Moon, 2003). Per enrollee Medicare spending grew at an average of 9.0 percent per year

**Table 2****Annual Growth in Per Enrollee Expenditures for Medicare and Private Health Insurance for Common Benefits<sup>1</sup>: 1969-2003**

Year	Expenditures Per Enrollee	
	Medicare	Private Insurance
	Percent	
1969–2003	9.0	10.1
1970–1993	10.7	12.0
1993–1997	6.5	2.6
1997–1999	1.2	3.5
1999–2003	5.9	8.8

<sup>1</sup> Common benefits are hospital services, physician and clinical services, other professional services, and durable medical products.

SOURCE: Centers for Medicare and Medicaid Services, Office of the Actuary and Office of Personnel Management, National Health Statistics Group.

from 1969-2003—slower than the 10.1 percent average annual growth rate found for private health insurers (Table 2).

Medicare's long-term relative success in holding down spending is partly a result of its structured payment systems and regulatory controls. In fact, Medicare has been a leader in developing prospective methods of payment that have been subsequently adopted by private insurers. Medicare's resource-based relative value fee schedule, implemented in 1992, has provided the basis for private insurance development of managed care payment methods (Ball, 1995).

Despite the evidence that Medicare's strategy for paying hospitals and physicians has had important benefits, the prescription drug legislation explicitly prohibited a government role in setting or negotiating pharmaceutical prices. The failure to take advantage of Medicare's regulatory tools and track record as a purchaser comes at a considerable cost. Anderson et al. (2004) point out that savings from paying prices comparable to those of other industrialized nations would be sufficient to eliminate the doughnut hole (gaps in coverage) in prescription drug coverage.

**FUTURE POLICY OPTIONS**

Medicare has proven its value to beneficiaries and to society over the last 40 years, but the future poses significant challenges. It will be difficult both to eliminate the Federal budget deficit and have sufficient revenues to cover health and financial security requirements of the elderly as the baby boom generation retires.

The most promising options would achieve several objectives:

- Increase the capacity of Medicare beneficiaries to finance out-of-pocket health care costs.
- Achieve economies in insurance administration of Medicare beneficiaries, especially by reducing the fragmentation of coverage between Medicare and supplemental coverage.
- Improve quality of care and preventive care for Medicare beneficiaries, with special attention to effective interventions reducing the prevalence and severity of chronic conditions.
- Leverage Medicare to achieve greater efficiency and improved quality of care for all Americans.

**Beneficiary Financial Responsibility**

As the baby boom generation retires and health care costs continue to rise, Medicare will represent an ever greater share of the Federal budget and gross domestic product (U.S. Congressional Budget Office, 2003). One obvious solution would be to increase the share of expenses paid directly by beneficiaries. The difficulty, however, is that Medicare currently covers only 58 percent of health care expenses of beneficiaries (Maxwell, Storeygard, and Moon, 2002). The Employee Benefits Research Institute estimates that those age 65 or

over will require on average more than \$100,000 to pay their out-of-pocket health care expenses in old age; and those fortunate enough to live to age 95 will require up to \$340,000 (Fronstin and Salisbury, 2004). These estimates are exclusive of long-term care expenses.

Very few older adults have set aside savings of this amount for both living and health care expenses in retirement. Nearly one-half of older adults age 50 to 70 have less than \$50,000 in retirement savings (Collins et al., 2005b).

New strategies are needed to encourage people to save for health care expenses in retirement. In a recent Commonwealth Fund survey of older adults age 50-70, nearly 70 percent of working older adults said they would be willing to have a portion of their wages automatically invested by Medicare in a personal Medicare Health Account that would be available to cover premiums, out-of-pocket medical expenses, and long-term care expenses in old age (Collins et al., 2005b). There was broad-based interest in this option across income, region of the country, and political affiliation.

Creation of Medicare Health Accounts, managed by the Medicare Program and invested in government securities, would give working-age adults the option of setting aside a portion of wages to meet health care expenses in retirement not covered by Medicare. Working age adults could have 1 percent of wages automatically withheld, unless they actively chose not to participate, and those wishing to contribute up to 3 percent of wages could be permitted to do so.

Likely concerns about creation of Medicare Health Accounts include a concern with foregone Federal revenue if such accounts receive tax subsidies, likely greater participation by higher-income individuals, and the low rate of return on

funds invested in the Medicare Trust Fund, essentially government bonds. To address these concerns, contributions to Medicare Health Accounts need not be excluded from taxable income. If tax subsidies are permitted, income limits on those eligible to participate could be established—for example, limited to those with incomes below the Social Security taxable earnings base, approximately \$90,000. These provisions would help ensure that savings are targeted on those with inadequate savings, rather than a tax-break for those who already set aside considerable funds for savings and investment.

To help ensure broad participation, the decision to open an account could be made automatic, and investment could default to the Medicare Trust Fund. Those who want to actively manage their investments could be permitted to invest the funds privately, but automatic withholding is essential for high participation.

## **Medicare Extra**

Medicare beneficiaries wishing to remain in the fee-for-service portion of Medicare and be protected from high out-of-pocket expenses require three sources of coverage: Medicare Parts A and B, Medigap supplemental coverage, and private drug coverage. This creates considerable complexity and confusion for Medicare beneficiaries, as well as unnecessary administrative expenses.

If Medicare were to offer a comprehensive benefits package similar to that offered to Federal employees under the most popular option, the BlueCross<sup>®</sup>/Blue Shield<sup>®</sup> standard plan, a self-financing premium would be considerably lower than that paid by Medicare beneficiaries for supplemental Medigap coverage (Davis et al., 2005). On average such coverage could be expected to add \$92 per month (in 2004 dollars) over

and above the Parts B and D premiums. This is considerably less than the average \$145 to \$230 monthly premium paid by beneficiaries for Plans F and J Medigap coverage, respectively, yet has better prescription drug benefits than Medigap plans and private drug plans. Medicare can offer better benefits for lower premiums because it has lower administrative costs (approximately 2 percent compared with 20 percent for Medigap policies) and because combining benefits in one package eliminates the need to coordinate coverage (Medicare Payment Advisory Commission, 2002). In short, a comprehensive Part E benefit would help beneficiaries get the benefits they want at a lower cost, with less confusion and complexity.

The major concern of a Medicare Extra benefit option is that it could lead to adverse risk selection, with private Medicare Advantage plans attracting relatively healthier beneficiaries. The risk of adverse selection could be minimized by making Medicare Extra the default option for enrollment among those not expressing a preference, and eliminating the differential payment that now rewards Medicare Advantage plans.

Another concern is that premiums for such coverage would not be affordable for lower-income beneficiaries. Part E premiums could be subsidized for low-income beneficiaries, in part, by savings achieved from paying private Medicare Advantage plans on par with fee-for-service Medicare, but additional Federal funds would likely be needed.

### **Improving Care Coordination and Beneficiary Self-Care**

Most Medicare beneficiaries have one or more chronic conditions and require care from multiple providers of care. Errors or failure to follow up often happen in the

“hand-offs” in care provision. The consequences include preventable rehospitalization, repeated diagnostic tests, and failure of information to reach providers or patients in a timely fashion. Investment in modern health information technology could reduce errors and costly duplication of tests.

Medicare outlays are highly concentrated in the sickest patients. Innovations that better manage care for high-cost patients have the greatest potential for savings. For example, transitional care models that assign advanced practice nurses to high-risk hospitalized patients to provide follow-up care at home have been shown to lower costs (Naylor et al., 2004). Promoting their use will require restructuring Medicare benefits and payment to cover transitional care services. This and other models are being tested in Medicare support programs to improve chronic care currently funded by CMS.

Medicare could also be more proactive in engaging beneficiaries as active partners in their care. For example, Medicare could create personal health records from administrative records with a history of all health care utilization over time. Web-based tools may also be useful to beneficiaries (and their adult children) in better managing care.

Medicare policy changes could also help eliminate disparities in quality of care for minority beneficiaries. Eichner and Vladeck (2005) have recommended a number of options that could be pursued including: reducing cost sharing; enhancing benefits; extending Medicare coverage to uninsured older adults to ensure earlier treatment of chronic conditions; promoting evidence-based guidelines in the provision of care, tools that support patient education, self-management, and disease management; rewarding reduction in disparities; reporting of quality data by

race, ethnicity, and income; and stricter enforcement of Title VI, especially with regard to nursing homes, home health agencies, physicians, and other Part B providers. Eichner and Vladeck (2005) urge that CMS prepare a comprehensive plan including improving data collection and analyses on disparities, and systemic and sustained efforts to improve the quality of care provided to racial and ethnic minority beneficiaries.

Medicare could also contribute to improved care for all Americans by accelerating the adoption of modern information technology, making information on provider performance publicly available, and by promoting the diffusion of best practices through its quality improvement organizations and other mechanisms.

Critics are likely to question the savings such innovations would yield in the near future. Demonstrations are testing some of these innovations and will yield a better evidence base. It is important that successful innovations are quickly translated into Medicare policy.

### **Leveraging Medicare's Purchasing Power**

The first section of Medicare states that: "Nothing in this title shall be construed ... to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided." As a result, Medicare accepted the health care system as it was and made no explicit attempt to encourage improvements in the quality or efficiency of health care delivery (Ball, 1995). Not surprisingly, therefore, Medicare outlays have grown as health care outlays have grown, and there are wide variations in the quality and efficiency with which patients are treated across the country (Fisher et al., 2003a,b; Jencks et al., 2003).

Medicare policy has tremendous poten-

tial to change provider behavior, and serve as a model for private insurers as well. There are various ways in which Medicare could reward high performance by providers. Medicare payment could be restructured to provide bonuses to hospitals, physicians, and other health care providers who achieve high levels of quality and efficiency or improve performance on those dimensions. Pay-for-performance has been recommended by the Medicare Prospective Assessment Commission and is the high point of Medicare Value Purchasing legislation introduced by Senators Charles Grassley and Max Baucus (CQ Health Beat, 2005).

Another strategy is to create a virtual value network of high-performing providers in Medicare. Such a network would include hospitals, specialists, and primary care physicians who rank high on quality and low on total cost of care. Incentives could reward beneficiaries agreeing to use services provided by value providers—for example, waiving Medicare's cost-sharing requirements.

Pay-for-performance methods of payment could also reward performance on coordinating care across sites of care and greater efficiency in the provision of care. Pay-for-performance rewards, for example, could be limited to those providers that are in the top quartile in performance on total Medicare outlays for an episode of care. Or providers that are consistently high-cost, low-quality outliers and fail to show improvement could be excluded from Medicare participation.

Major concerns with changing Medicare payment to reward performance are likely to focus on the methods used for adjusting for severity of conditions or measuring efficiency, public reporting of performance at the individual provider level, and the potential for savings as opposed to adding on to payment. Again, considerable experi-

mentation and flexibility to modify new payment methods will be required to fine-tune pay-for-performance methods.

## CONCLUSION

Medicare has served beneficiaries well for 40 years. However, it will come under increasing strain as baby boomers reach retirement. Now is an opportune time to revisit some of the assumptions on which Medicare was predicated. In particular, Medicare needs to move more aggressively to become a leader in promoting high-quality, high-efficiency care for Medicare beneficiaries and for all Americans. It also needs to promote innovative strategies for better management of chronic conditions that account for the bulk of Medicare outlays. It also can make health care more affordable for beneficiaries by encouraging savings before reaching Medicare eligibility, and offering a Medicare Extra benefit option at lower cost than Medigap alternatives available to beneficiaries. These steps could help ensure that Medicare is up to the challenges of the 21st century, and continues to achieve a high level of public support and acclaim from beneficiaries.

## REFERENCES

Agency for Healthcare Research and Quality: *National Healthcare Disparities Report, 2004*. U.S. Department of Health and Human Services. Rockville, Maryland. March 2005. Internet address: <http://www.ahrq.gov/qual/nhdr03/nhdrsum03.htm> (Accessed 2005.)

Anderson, G.F., Shea, D., Hussey P.S., et al.: Doughnut Holes and Price Controls. Web Exclusive. *Health Affairs* W4-396-403. July 21, 2004. Internet address: <http://www.healthaffairs.org>. (Accessed 2005.)

Ball, R.: Perspectives on Medicare: What Medicare's Architects Had in Mind. *Health Affairs* 14(4):62-72, Winter 1995.

Boccuti, C. and Moon, M.: Comparing Medicare and Private Insurers: Growth Rates in Spending Over Three Decades. *Health Affairs* 22(2): 230-237, March/April 2003.

Collins, S.R., Doty, M.M., Davis, K., et al.: *The Affordability Crisis in U.S. Health Care: Findings from the Commonwealth Fund Biennial Health Insurance Survey*. The Commonwealth Fund. New York, NY. March 2004.

Collins, S.R., Davis, K., Schoen, C., et al.: *Will You Still Need Me? The Health and Financial Security of Older Americans: Findings from The Commonwealth Fund Survey of Older Adults*. The Commonwealth Fund. New York, NY. June 2005a.

Collins, S.R., Davis, K., How, S.K.H., et al.: *Medicare Health Accounts: A New Policy Option to Help Adults Save for Health Care Expenses Not Covered by Medicare*. The Commonwealth Fund. New York, NY. June 2005b.

CQ HealthBeat: *Senate Finance, HELP Leaders Unveil Health Bills*. June 29, 2005. Internet address: [http://www.cmwf.org/healthpolicyweek/healthpolicyweek\\_show.htm?doc\\_id=283362](http://www.cmwf.org/healthpolicyweek/healthpolicyweek_show.htm?doc_id=283362) (Accessed 2005.)

Davis, K.: Equal Treatment and Unequal Benefits: The Medicare Program. *Milbank Memorial Fund Quarterly* 53(4):449-488, 1975.

Davis, K., Moon, M., Schoen, C., et al.: Medicare Extra: A Comprehensive Benefits Option for Medicare Beneficiaries. Web Exclusive. *Health Affairs* W5-442-453. October 4, 2005. Internet Address: <http://www.healthaffairs.org> (Accessed 2005.)

Davis, K. and Schoen, C.: *Health and the War on Poverty: A Ten-Year Appraisal*. The Brookings Institution. Washington, DC. 1978.

Davis, K., Schoen, C., Doty, M., et al.: Medicare Versus Private Insurance: Rhetoric and Reality. Web Exclusive. *Health Affairs* W311-324, October 9, 2002. Internet address: <http://www.healthaffairs.org>. (Accessed 2005.)

Eichner, J. and Vladeck, B.C.: Medicare as a Catalyst for Reducing Health Disparities. *Health Affairs* 24(2):365-375, March/April 2005.

Fisher, E.S., Wennberg, D.E., Stukel, T.E., et al.: The Implications of Regional Variations in Medicare Spending. Part 1: The Content Quality and Accessibility of Care. *Annals of Internal Medicine* 138(4):273-287, February 18, 2003a.

Fisher, E. S., Wennberg, D.E., Stukel, T.E., et al.: The Implications of Regional Variations in Medicare Spending. Part 2: Health Outcomes and Satisfaction with Care. *Annals of Internal Medicine* 138(4):288-298, February 18, 2003b.

- Fronstin, P. and Salisbury, D.: *Health Care Expenses in Retirement and the Use of Health Savings Accounts*. Employee Benefit Research Institute. Washington, DC. July 2004.
- Jencks, S.F., Huff, E.D., Cuerdon, T., et al.: Change in the Quality of Care Delivered to Medicare Beneficiaries, 1998-1999 to 2000-2001. *Journal of the American Medical Association* 289(3):305-312, January 15, 2003.
- Leatherman, S. and McCarthy, D.: *Quality of Health Care for Medicare Beneficiaries: A Chartbook*. The Commonwealth Fund. New York, NY. May 2005.
- Maxwell, S., Moon, M., and Segal, M.: *Growth in Medicare and Out-of-Pocket Spending: Impact on Vulnerable Beneficiaries*. The Commonwealth Fund. New York, NY. January 2001.
- Maxwell, S., Storeygard, M., and Moon, M.: *Modernizing Medicare Cost-Sharing: Policy Options and Impacts on Beneficiary and Program Expenditures*. The Commonwealth Fund. New York, NY. November 2002.
- McWilliams, J.M., Zaslavsky, A.M., Meara, E., et al.: Impact of Medicare Coverage on Basic Clinical Services for Previously Uninsured Adults. *Journal of the American Medical Association* 290(6):757-764, August 13, 2003.
- Medicare Payment Advisory Commission: *Report to Congress, Assessing Medicare Benefits*. Washington, DC. June 2002.
- Merriam, I.C.: *Blue Cross and Other Private Health Insurance for the Elderly*. Testimony before the Subcommittee on Health of the Elderly of the Senate Special Committee on Aging 88(2), Pt. 1:3-13. U.S. Government Printing Office. Washington, DC. 1964.
- Naylor, M.D., Brooten, D.A., Campbell, R.L., et al.: Transitional Care of Older Adults Hospitalized with Heart Failure: A Randomized, Controlled Trial. *Journal of the American Geriatrics Society* 52(5):675-684, April 14, 2004.
- Rice, T. and Matsuoka, K.Y.: The Impact of Cost-Sharing on Appropriate Utilization and Health Status: A Review of the Literature on Seniors. *Medical Care Research and Review* 61(4):415-452, December 2004.
- Rowland, D.: Financing Health Care for Elderly Americans. In Ginzberg, E. (ed.): *Health Services Research: Key to Health Policy*. Harvard University Press. Cambridge, MA. 1991.
- Ruther, M. and Dobson, A.: Equal Treatment and Unequal Benefits: A Re-examination of the Use of Medicare Services by Race, 1967-1976. *Health Care Financing Review* 2(3):55-83, Winter 1981.
- Safran, D.G, Neuman, P., Schoen, C., et al.: Prescription Drug Coverage and Seniors: Findings From a 2003 National Survey. Web Exclusive. *Health Affairs* W5-152-165. April 19, 2005. Internet Address: <http://www.healthaffairs.org> (Accessed 2005.)
- The Commonwealth Fund: Unpublished data. Biennial Health Insurance Survey, 2003. Internet address: [http://www.cmwf.org/surveys/surveys\\_show.htm?doc\\_id=228676](http://www.cmwf.org/surveys/surveys_show.htm?doc_id=228676) (Accessed 2005.)
- U.S. Congressional Budget Office: *The Long-Term Budget Outlook (Supplemental Tables)*. December 2003. Internet address: <http://www.cbo.gov/showdoc.cfm?index=4916&sequence=0>. (Accessed 2005.)
- Virnig, B., Lurie, N., Huang, Z., et al.: Racial Variation in Quality of Care Among Medicare+Choice Enrollees. *Health Affairs* 21(6):224-230, November/December 2002.
- Virnig, B., Huang, Z., Lurie, N., et al.: Does Medicare Managed Care Provide Equal Treatment for Mental Illness Across Races? *Archives of General Psychiatry* 61(2):201-205, February 2004.

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