By Juliette Cubanski and Cristina Boccuti

Medicare **Coverage**, **Affordability**, and **Access**

Gaps remain in Medicare's coverage and accessibility for low- to moderate-income older adults.

For fifty years, Medicare has been a bedrock of economic and health security for older Americans, providing access to essential medical benefits that address many acute, chronic, and preventive health service needs. Prior to its enactment in 1965, only slightly more than half of all older adults had insurance to help pay for hospital care (Gornick et al., 1996). Many were unable to obtain health insurance either because they could not afford the premiums or because they were denied coverage based on age or pre-existing health conditions. Because of Medicare, millions of older Americans and people with disabilities no longer have to worry about being uninsured for their medical care needs.

In important ways, however, Medicare coverage is not comprehensive, and, due in part to Medicare's premiums, deductibles, and cost-sharing requirements, paying for Medicare and Medicare-covered services can represent a financial challenge, particularly for people with low and moderate incomes. The combination of coverage gaps and affordability concerns can lead to access problems that some on Medicare struggle to overcome.

This article will review the state of Medicare coverage, affordability, and access, examine ways in which Medicare falls short, and discuss the implications. Findings are based upon previously published research and new analysis of the Medicare Current Beneficiary Survey 2012 Access to Care file, a nationally representative survey of Medicare beneficiaries conducted by the Centers for Medicare & Medicaid Services (CMS) (Centers for Medicare & Medicaid Services, n.d.).

Overview of Medicare Coverage

Medicare benefits are covered under three parts—Part A, Part B, and Part D—and beneficiaries can access Medicare benefits through two programs—traditional Medicare and Medicare Advantage. Part A benefits include inpatient care provided in hospitals, short-term stays in skilled nursing facilities, hospice care, and post-acute home healthcare. Part B benefits include outpatient services, including outpatient hospital care, physician visits, and preventive services (such as mammography and colorectal screening). Other Part B outpatient benefits include laboratory services and diagnostic tests, durable medical equipment (such as wheelchairs and oxygen), outpatient mental health care, and some home health visits. Part D covers a voluntary outpatient prescription drug benefit delivered through private plans that contract with Medicare, including stand-alone prescription drug plans (PDP) or Medicare Advantage drug plans.

Beneficiaries can access parts A and B benefits through the traditional Medicare

Copyright © 2015 American Society on Aging; all rights reserved. This article may not be duplicated, reprinted or distributed in any form without written permission from the publisher: American Society on Aging, 575 Market St., Suite 2100, San Francisco, CA 94105-2869; e-mail: *info@asaging.org*. For information about ASA's publications visit *www.asaging.org/publications*. For information about ASA membership visit *www.asaging.org/join*.

program, which pays for care delivered by medical providers such as doctors and hospitals on a fee-for-service basis, and can enroll in a standalone Part D plan for drug coverage. As an alternative to traditional Medicare, beneficiaries can enroll in a private Medicare Advantage plan, such as a health maintenance organization (HMO) or preferred provider organization (PPO), for all Medicare-covered Part A and Part B benefits, and, typically, Part D benefits. Enrollment in Medicare Advantage plans has grown over time, with nearly 16 million beneficiaries (30 percent of all beneficiaries) in a Medicare Advantage plan in 2014 (Jacobson et al., 2014).

While benefits covered by Medicare are the same for enrollees in traditional Medicare and Medicare Advantage plans, issues related to gaps in coverage, affordability, and provider access are different for these populations, and are discussed separately below.

Gaps in Medicare Coverage

Traditional Medicare does not cover some services that could greatly benefit many older adults and people with permanent disabilities, including long-term services and supports (LTSS), dental services, eyeglasses, and hearing aids. Beneficiaries in Medicare who need these services must pay the full cost out of their own pockets unless they have other sources of coverage. Those with low incomes may qualify for Medicaid coverage of these services.

Because traditional Medicare does not cover dental services, eyeglasses, and hearing aids, some beneficiaries may not be able to afford them, which may adversely affect their overall health. Oral health care is closely correlated with health and well-being, and lacking adequate or appropriate oral health care can exacerbate health problems or create new ones (Kaiser Family Foundation, 2012). While age-related changes in hearing and vision may be a normal part of aging, sensory impairments can compromise social functioning and hinder quality of life (Crews and Campbell, 2004).

Research suggests that seven in ten older adults will require LTSS at some point in their lives (Stevenson et al., 2010). Averaging more than $90,000 for a year of nursing home care in a private room and more than $20,000 for annual home health care (MetLife Mature Market Institute, 2012), few people on Medicare have the financial resources to afford either the high cost of custodial LTSS or the lower cost of receiving skilled care at home. Beneficiaries with very low incomes, or who spend down their savings to pay for medical and long-term care, may qualify for LTSS coverage through their state Medicaid program. Medicaid is not available to everyone on Medicare who needs long-term care, however, depending upon state policy choices with regard to Medicaid coverage of older adults and people with disabilities (Young et al., 2013). Consequently, most people living in the community who need LTSS rely on informal, unpaid caregivers, including family and friends (The SCAN Foundation, 2013), but providing this care can have negative health and financial effects on caregivers themselves (Feinberg et al., 2011).

There were nearly 16 million beneficiaries (30 percent of all beneficiaries) in a Medicare Advantage Plan in 2014.

Medicare's Affordability

In addition to Medicare's other sources of financing (primarily general revenues and payroll taxes), beneficiaries pay for Medicare coverage in the form of premiums and cost-sharing requirements. Part A benefits are subject to a deductible ($1,260 per benefit period in 2015) and a daily copayment for hospital and skilled nursing facility stays. Beneficiaries pay a monthly premium for Part B benefits ($104.90 in 2015), which are subject to a deductible ($147 in 2015)

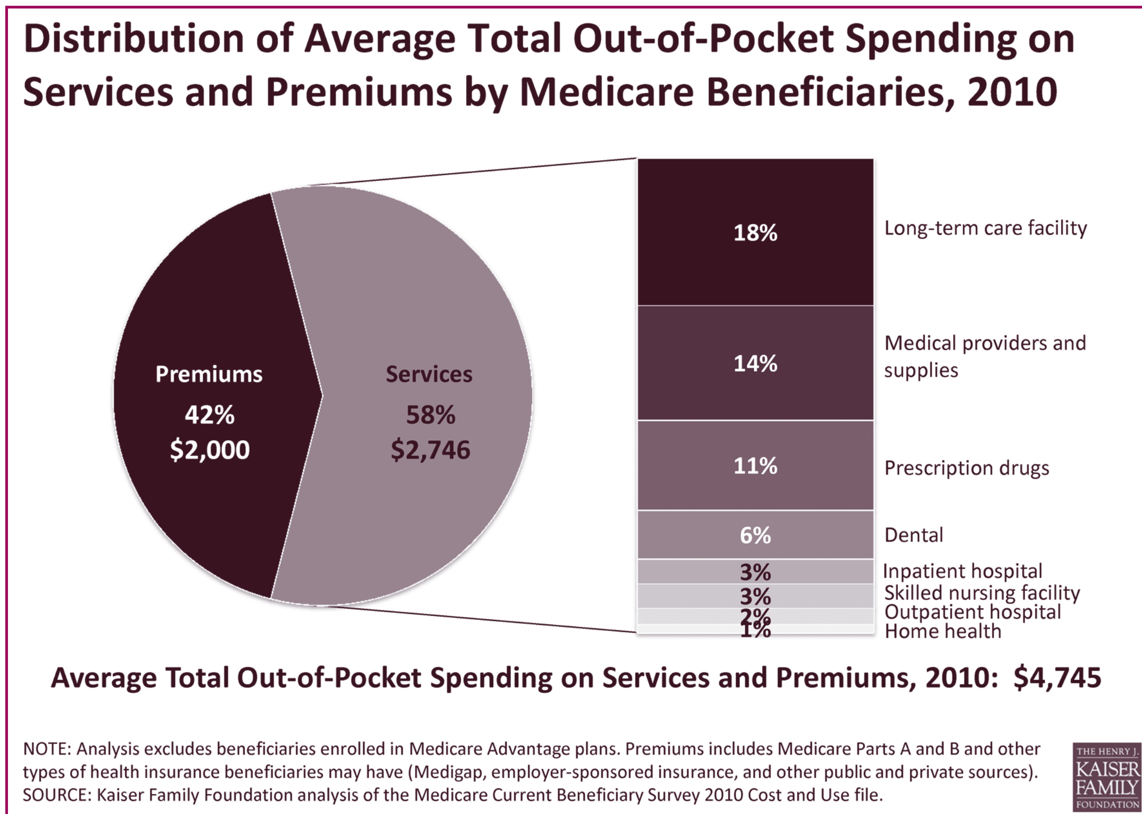
Copyright © 2015 American Society on Aging; all rights reserved. This article may not be duplicated, reprinted or distributed in any form without written permission from the publisher: American Society on Aging, 575 Market St., Suite 2100, San Francisco, CA 94105-2869; e-mail: *info@asaging.org*. For information about ASA's publications visit *www.asaging.org/publications*. For information about ASA membership visit *www.asaging.org/join*.

and 20 percent co-insurance (most preventive services are covered at no charge). Beneficiaries with annual incomes that are more than $85,000 per individual or $170,000 per couple pay a higher, income-related premium reflecting a larger share of total Part B spending. Part D plan enrollees pay monthly premiums (averaging $38.83 for PDPs in 2015 [Hoadley, 2014]) and cost-sharing for prescriptions (varying widely by plan), with additional financial assistance for beneficiaries with low incomes and modest assets. Similar to Part B, higher income enrollees pay a larger share of the cost of Part D coverage.

Part D enrollees also may be subject to higher costs in the drug benefit's coverage gap (the so-called donut hole). In 2015, beneficiaries with prescription drug spending exceeding $2,960 pay 45 percent of the cost for brand-name drugs and 65 percent of the cost of generics until they reach the catastrophic coverage limit ($4,700 in out-of-pocket costs in 2015). As a result of a provision in the Affordable Care Act, the coverage gap is gradually closing by 2020, when beneficiaries will pay no more than 25 percent of their drug costs in the gap.

While traditional Medicare limits the amount that physicians and other providers may charge beneficiaries, it lacks the key financial protection of a limit on beneficiaries' annual out-of-pocket spending. Catastrophic coverage for very high medical bills is a common feature of private commercial plans and is required for plans offered in the Health Insurance Marketplace and in Medicare Advantage. Research shows that adding a $5,000 out-of-pocket limit to Medicare would protect a small share (6.5 percent) of beneficiaries against catastrophic expenses in any given year, but nearly one-third of beneficia-

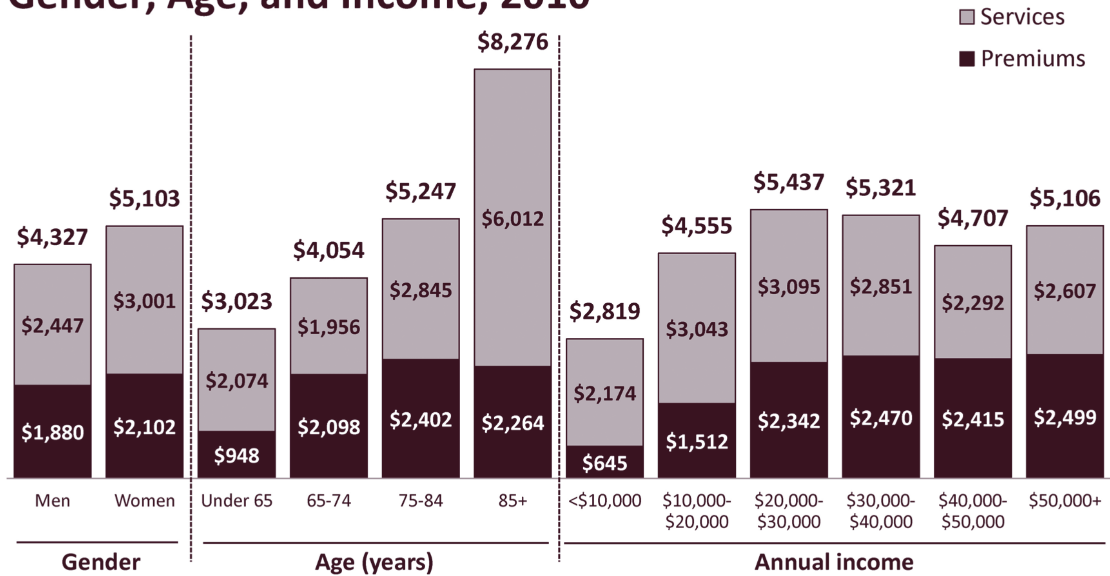
Figure 1.



Copyright © 2015 American Society on Aging; all rights reserved. This article may not be duplicated, reprinted or distributed in any form without written permission from the publisher: American Society on Aging, 575 Market St., Suite 2100, San Francisco, CA 94105-2869; e-mail: *info@asaging.org*. For information about ASA's publications visit *www.asaging.org/publications*. For information about ASA membership visit *www.asaging.org/join*.

Figure 2.

Variation in Average Total Out-of-Pocket Spending on Services and Premiums by Medicare Beneficiaries, by Gender, Age, and Income, 2010



NOTE: Analysis excludes beneficiaries enrolled in Medicare Advantage plans. Premiums includes Medicare Parts A and B and other types of health insurance beneficiaries may have (Medigap, employer-sponsored insurance, and other public and private sources).
SOURCE: Kaiser Family Foundation analysis of the Medicare Current Beneficiary Survey 2010 Cost & Use file.

ries would reach the limit in one or more years over a ten-year period (Kaiser Family Foundation/MedPAC, 2013).

In response to traditional Medicare's benefit gaps, cost-sharing requirements, and lack of an out-of-pocket limit that can leave beneficiaries at financial risk for costly medical and long-term-care bills, many beneficiaries in traditional Medicare have supplemental insurance to help pay expenses for Medicare-covered services. Those with low incomes may qualify for Medicaid coverage, which provides some benefits that Medicare does not and helps with the cost of Medicare premiums and cost-sharing. Beneficiaries with incomes or assets above Medicaid eligibility limits may be able to obtain private supplemental coverage, such as Medigap or employer-sponsored retiree health benefits, but premiums for these policies can add hundreds or thousands of dollars to annual out-of-pocket costs.

Taking these premium and non-premium expenses into account, many beneficiaries face significant out-of-pocket costs to meet their medical and long-term-care needs. Health expenses accounted for 14 percent of Medicare household budgets in 2012, nearly three times the share of spending on healthcare in non-Medicare households (Cubanski et al., 2014a). In 2010, Medicare beneficiaries spent $4,745 out-of-pocket for healthcare, on average, including $2,000 in premiums and $2,746 for medical and long-term-care services (Cubanski et al., 2014b) (see Figure 1, page 28).

As might be expected, beneficiaries in poorer health, who typically need and use more medical and long-term-care services, have higher than average out-of-pocket costs. Out-of-pocket spend-

Copyright © 2015 American Society on Aging; all rights reserved. This article may not be duplicated, reprinted or distributed in any form without written permission from the publisher: American Society on Aging, 575 Market St., Suite 2100, San Francisco, CA 94105-2869; e-mail: *info@asaging.org*. For information about ASA's publications visit *www.asaging.org/publications*. For information about ASA membership visit *www.asaging.org/join*.

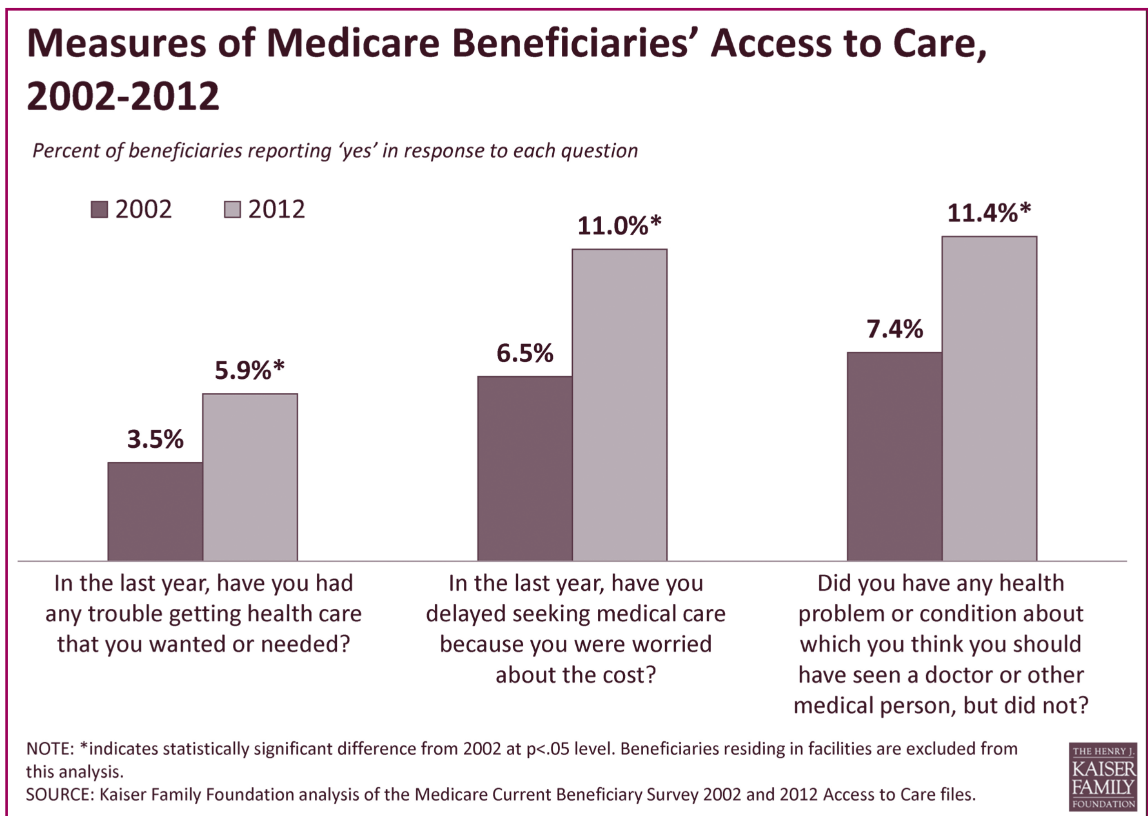
ing on services by beneficiaries in poor self-reported health averaged nearly two and a half times more than among beneficiaries who said they were in excellent health ($4,246 vs. $1,797, respectively, in 2010). Out-of-pocket spending on services is as large among those with low and modest incomes as it is among those with higher incomes, suggesting a greater burden among beneficiaries with the fewest resources (see Figure 2, page 29). Out-of-pocket spending also rises with age among beneficiaries ages 65 and older, and is higher for women than for men, especially among those ages 85 and older.

Access to Care

Medicare beneficiaries generally enjoy broad access to physicians, hospitals, and other providers, and report relatively low rates of problems across a number of access measures, including having a usual source of care, obtaining medical care when needed, ability to schedule timely appointments, and finding new physicians when needed. Yet there is some evidence of access problems among certain demographic subgroups.

One key indicator of access to care is the share of people reporting they have a usual source of care for when they are sick or seeking medical advice, such as a doctor's office or clinic. In 2012, the vast majority of Medicare beneficiaries (95 percent) reported having a usual source of care, a rate higher than younger adults with private insurance (90 percent), as reported in the National Health Interview Survey (CDC, n.d.). When scheduling doctor appointments or looking for new physicians, most older adults in Medicare report easy access and are as likely as privately insured adults ages 50 to 64 to report problems

Figure 3.



Copyright © 2015 American Society on Aging; all rights reserved. This article may not be duplicated, reprinted or distributed in any form without written permission from the publisher: American Society on Aging, 575 Market St., Suite 2100, San Francisco, CA 94105-2869; e-mail: info@asaging.org. For information about ASA's publications visit www.asaging.org/publications. For information about ASA membership visit www.asaging.org/join.

(Medicare Payment Advisory Commission, 2013). For both these populations, however, access to primary care doctors is generally somewhat worse than access to specialists. Among the small share of adults ages 65 and older on Medicare (7 percent) who said that they looked for a new primary care physician in 2013, 28 percent reported a problem finding one—equating to about 2 percent of all older adults in Medicare.

Premiums for private supplemental coverage can add hundreds or thousands of dollars to annual out-of-pocket costs.

While a relatively small share of Medicare beneficiaries report experiencing problems obtaining needed medical care, the share reporting such problems has increased modestly in the past ten years. About 6 percent of beneficiaries reported trouble getting healthcare in 2012 (up from 3.5 percent in 2002), 11 percent of beneficiaries said they delayed seeking medical care because of cost (up from 6.5 percent), and 11.4 percent reported not seeing a doctor about an existing health problem (up from 7.4 percent) (see Figure 3, page 30).

Certain beneficiary subgroups report access problems more frequently than others, particularly those who typically need more healthcare services because of medical problems. For instance, 17 percent of Medicare beneficiaries with disabilities who are younger than age 65 experienced trouble accessing needed care, compared to just 4 percent of beneficiaries ages 65 and older. Beneficiaries who are in fair or poor health, are non-white, or have lower incomes are also at higher risk for having problems accessing healthcare, or delaying care because of cost. Other survey research finds that 19 percent of Americans ages 65 and older report experiencing at least one cost-related problem accessing healthcare during the year—not seeing a doctor, not seeking recommended medical tests, or not filling prescriptions or skipping doses of pills (Osborn et al., 2014). This finding suggests that while Medicare coverage is nearly universal among older adults, out-of-pocket expenses are troublesome for one in five—either because of Medicare's benefit gaps or difficulties meeting Medicare's cost-sharing requirements.

Access indicators generally look positive when viewed from the perspective of Medicare providers. The majority of office-based physicians (91 percent) report accepting new Medicare patients (Boccuti et al., 2013). As for other types of insurance, the same proportion of physicians (91 percent) report accepting new patients with private non-capitated insurance (such as PPOs), but a smaller share says they accept new patients with private capitated insurance (such as HMOs) (72 percent), with Medicaid (71 percent), or without insurance (47 percent). Nearly all physicians and other health professionals (96 percent) who bill Medicare are "participating providers," meaning that for their Medicare patients, they agree to accept Medicare's fee-schedule rate as full payment and will not charge higher fees for Medicare-covered services. As a result, most beneficiaries encounter predictable expenses when seeing their physician. A small share of physicians (less than 4 percent) who bill Medicare do not have these agreements and may charge higher fees ("balance bill") up to a specified maximum for Medicare-covered services. Less than 1 percent has elected to "opt out" of Medicare, instead contracting privately with all of their Medicare patients (Boccuti, 2014).

Coverage under Medicare Advantage

Beneficiaries enrolled in Medicare Advantage plans face a different set of coverage, affordability, and access issues compared to their counterparts in traditional Medicare. Medicare Advantage plans are required to provide all Medicare-covered benefits, but are allowed to vary benefit design and cost-sharing charged for services, as long as the core benefit package

Copyright © 2015 American Society on Aging; all rights reserved. This article may not be duplicated, reprinted or distributed in any form without written permission from the publisher: American Society on Aging, 575 Market St., Suite 2100, San Francisco, CA 94105-2869; e-mail: *info@asaging.org*. For information about ASA's publications visit *www.asaging.org/publications*. For information about ASA membership visit *www.asaging.org/join*.

(excluding the value of supplemental benefits) is equal in value to traditional Medicare. Medicare Advantage plans also may offer extra benefits not covered under traditional Medicare, such as dental services, eyeglasses, or hearing exams. For this reason, some benefit gaps in traditional Medicare may not apply to all Medicare Advantage enrollees. Medicare Advantage plans also charge varied amounts for Medicare-covered services—typically flat cost-sharing amounts rather than co-insurance—and all Medicare Advantage plans are required to have an out-of-pocket limit (no more than $6,700 in 2015). For these reasons, people with Medicare Advantage do not equally share the potential financial liability traditional Medicare beneficiaries experience with catastrophic medical expenses.

Less than 1 percent of physicians has elected to "opt out" of Medicare, instead contracting privately with all of their Medicare patients.

Cost burdens may still be a concern for Medicare Advantage enrollees, however. Beneficiaries enrolled in Medicare Advantage typically pay monthly premiums for additional benefits covered by their plan in addition to the Part B premium. In 2015, enrollees will pay, on average, $41 per month in Medicare Advantage premiums (Jacobson et al., 2014). While recent data on out-of-pocket spending for Medicare Advantage enrollees are not available, evidence from 2015 shows that plans are increasing costs in the form of higher deductibles and out-of-pocket limits (Jacobson et al., 2014), which will translate to higher costs for enrollees.

In terms of access and quality of care, a recent review shows that evidence on the performance of Medicare Advantage plans compared to traditional Medicare is lacking, limited, or outdated (Gold and Casillas, 2014). Older evidence shows Medicare HMOs have provided better access to preventive services and have lower rates of potentially avoidable hospital admissions. Beneficiary ratings of quality and access, however, are more favorable for traditional Medicare than for Medicare Advantage.

Medicare Advantage enrollees may face more limited choices of providers than traditional Medicare beneficiaries. Most Medicare Advantage plans contract with providers to participate in their networks; enrollees generally are required to seek care from network providers or pay higher costs to see non-network providers. On a national level, beneficiaries in Medicare Advantage and traditional Medicare report that they are able to schedule timely appointments at similar rates (Boccuti et al., 2013). Recently, however, there has been concern about some Medicare Advantage plans curtailing provider networks and terminating providers during the year, which could affect beneficiaries' access to their preferred physicians (Jaffe, 2014). Current rules allow plans to make such changes mid-year, but beneficiaries who lose access to their providers as a result are unable to change plans until the next open enrollment period.

Conclusion

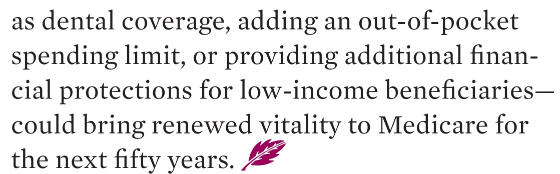
While Medicare offers access to a wide array of medical benefits, Medicare's benefit gaps and cost-sharing requirements leave beneficiaries at risk of not getting or not being able to afford needed care. Gaps in the traditional Medicare benefit package include no coverage of LTSS, dental services, eyeglasses, and hearing aids—benefits that could be especially valuable for an older population. Medicare's out-of-pocket spending burden is greater for some groups than others, depending upon socioeconomic factors, health status, and medical needs. At the same time, while access problems have not been widely documented, small shares of beneficiaries encounter difficulty affording needed care and finding a new physician.

In light of Medicare's benefit gaps and cost-sharing requirements, most beneficiaries in tra-

Copyright © 2015 American Society on Aging; all rights reserved. This article may not be duplicated, reprinted or distributed in any form without written permission from the publisher: American Society on Aging, 575 Market St., Suite 2100, San Francisco, CA 94105-2869; e-mail: *info@asaging.org*. For information about ASA's publications visit *www.asaging.org/publications*. For information about ASA membership visit *www.asaging.org/join*.

ditional Medicare have supplemental coverage to help cover their costs for Medicare-covered services. Alternatively, beneficiaries can enroll in Medicare Advantage plans. The prevalence of supplemental coverage, however, suggests that Medicare coverage alone is not sufficient to protect beneficiaries from the high cost of care and unpredictable medical expenses.

Overall, beneficiaries report high levels of satisfaction with Medicare, the quality of care they receive, and various features of their Medicare coverage, such as the availability of specialty care. Nonetheless, it is important not to overlook the existence of Medicare's gaps, cost burdens, and access barriers, particularly as those beneficiaries who may be hardest hit are among those with the greatest needs. Improving coverage and enhancing financial protections—whether by adding benefits such as dental coverage, adding an out-of-pocket spending limit, or providing additional financial protections for low-income beneficiaries—could bring renewed vitality to Medicare for the next fifty years.



Acknowledgment

The authors thank Giselle Casillas and Anthony Damico for data programming assistance in the preparation of this article.

Juliette Cubanski, Ph.D., M.P.P., M.P.H., is associate director of the Program on Medicare Policy at the Kaiser Family Foundation in Menlo Park, California. She can be contacted at jcubanski@kff.org. *Cristina Boccuti, M.P.P., is senior associate in the Program on Medicare Policy at the Kaiser Family Foundation in Washington, D.C. She can be contacted at* cboccuti@kff.org.

References

Boccuti, C. 2014. "Paying a Visit to the Doctor: Current Financial Protections for Medicare Patients When Receiving Physician Services." Kaiser Family Foundation. http://kff.org/medicare/issue-brief/paying-a-visit-to-the-doctor-current-financial-protections-for-medicare-patients-when-receiving-physician-services/. Retrieved December 15, 2014.

Boccuti, C., et al. 2013. "Medicare Patients' Access to Physicians: A Synthesis of the Evidence." Kaiser Family Foundation. http://kff.org/medicare/issue-brief/medicare-patients-access-to-physicians-a-synthesis-of-the-evidence/. Retrieved December 15, 2014.

Centers for Disease Control and Prevention (CDC). n.d. "National Health Interview Survey." www.cdc.gov/nchs/nhis.htm. Retrieved March 25, 2015.

Centers for Medicare & Medicaid Services. n.d. "Medicare Current Beneficiary Survey." www.cms.gov/Research-Statistics-Data-and-Systems/Research/MCBS/index.html. Retrieved December 15, 2014.

Crews, J. E., and Campbell, V. A. 2004. "Vision Impairment and Hearing Loss Among Community-dwelling Older Americans: Implications for Health and Functioning." *American Journal of Public Health* 94(5): 823–9.

Cubanski, J., et al. 2014a. "Health Care on a Budget: The Financial Burden of Health Spending by Medicare Households." Kaiser Family Foundation. http://kff.org/medicare/issue-brief/health-care-on-a-budget-the-financial-burden-of-health-spending-by-medicare-households/. Retrieved December 15, 2014.

Cubanski, J., et al. 2014b. *How Much Is Enough? Out-of-Pocket Spending Among Medicare Beneficiaries: A Chartbook*. Kaiser Family Foundation. http://kff.org/health-costs/report/how-much-is-enough-out-of-pocket-spending-among-medicare-beneficiaries-a-chartbook/. Retrieved December 15, 2014.

Feinberg, L., et al. 2011. "Valuing the Invaluable: 2011 Update: The Growing Contributions and Costs of Family Caregiving." AARP Public Policy Institute. http://assets.aarp.org/rgcenter/ppi/ltc/i51-caregiving.pdf. Retrieved January 22, 2015.

Copyright © 2015 American Society on Aging; all rights reserved. This article may not be duplicated, reprinted or distributed in any form without written permission from the publisher: American Society on Aging, 575 Market St., Suite 2100, San Francisco, CA 94105-2869; e-mail: *info@asaging.org*. For information about ASA's publications visit *www.asaging.org/publications*. For information about ASA membership visit *www.asaging.org/join*.

Gold, M., and Casillas, G. 2014. "What Do We Know About Health Care Access and Quality in Medicare Advantage Versus the Traditional Medicare Program?" Kaiser Family Foundation. http://kff.org/medicare/report/what-do-we-know-about-health-care-access-and-quality-in-medicare-advantage-versus-the-traditional-medicare-program/. Retrieved January 22, 2015.

Gornick, M. E., et al. 1996. "Thirty Years of Medicare: Impact on the Covered Population." *Health Care Financing Review* 18(2): 179–237.

Hoadley, J., et al. 2014. "Medicare Part D: A First Look at Plan Offerings in 2015." Kaiser Family Foundation. http://kff.org/medicare/issue-brief/medicare-part-d-a-first-look-at-plan-offerings-in-2015/. Retrieved December 16, 2014.

Jacobson, G., et al. 2014. "Medicare Advantage 2015 Data Spotlight: Overview of Plan Changes." Kaiser Family Foundation. http://kff.org/medicare/issue-brief/medicare-advantage-2015-data-spotlight-overview-of-plan-changes/. Retrieved December 16, 2014.

Jaffe, S. 2014. "Draft Rules Would Protect Seniors When Medicare Advantage Plans Drop Doctors." *Kaiser Health News*. http://kaiserhealthnews.org/news/proposed-medicare-advantage-rules-on-dropping-doctors/. Retrieved December 16, 2014.

Kaiser Family Foundation. 2012. "Oral Health and Medicare Beneficiaries: Coverage, Out-of-Pocket Spending, and Unmet Need." http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8325.pdf. Retrieved December 15, 2014.

Kaiser Family Foundation/MedPAC. 2013. "An Analysis of the Share of Medicare Beneficiaries Who Would Benefit from an Annual Out-of-Pocket Maximum Under Traditional Medicare Over Multiple Years." http://kff.org/medicare/issue-brief/analysis-of-share-of-medicare-beneficiaries-who-would-benefit-from-out-of-pocket-maximum-over-multiple-years/. Retrieved January 22, 2015.

Medicare Payment Advisory Commission. 2013. "Report to the Congress: Medicare Payment Policy." www.medpac.gov/documents/reports/mar13_entirereport.pdf?sfvrsn=0. Retrieved December 16, 2014.

MetLife Mature Market Institute. 2012. *The 2012 MetLife Market Survey of Long-Term Care Costs*. www.metlife.com/assets/cao/mmi/publications/studies/2012/studies/mmi-2012-market-survey-long-term-care-costs.pdf. Retrieved December 15, 2014.

Osborn, R., et al. 2014. "International Survey of Older Adults Finds Shortcomings in Access, Coordination, and Patient-Centered Care." *Health Affairs* 33(12): 2247–55.

The SCAN Foundation. 2013. "Who Provides Long-Term Care in the U.S.?" www.thescanfoundation.org/sites/thescanfoundation.org/files/us_who_provides_ltc_us_oct_12_fsrevised-10-10-13.pdf. Retrieved December 16, 2014.

Stevenson, D., et al. 2010. "The Complementarity of Public and Private Long-term-care Coverage." *Health Affairs* 29(1): 35–43.

Young, K., et al. 2013. "Medicaid's Role for Dual Eligible Beneficiaries." Kaiser Family Foundation. http://kaiserfamilyfoundation.files.wordpress.com/2013/08/7846-04-medicaids-role-for-dual-eligible-beneficiaries.pdf. Retrieved December 15, 2014.

Copyright © 2015 American Society on Aging; all rights reserved. This article may not be duplicated, reprinted or distributed in any form without written permission from the publisher: American Society on Aging, 575 Market St., Suite 2100, San Francisco, CA 94105-2869; e-mail: *info@asaging.org*. For information about ASA's publications visit *www.asaging.org/publications*. For information about ASA membership visit *www.asaging.org/join*.