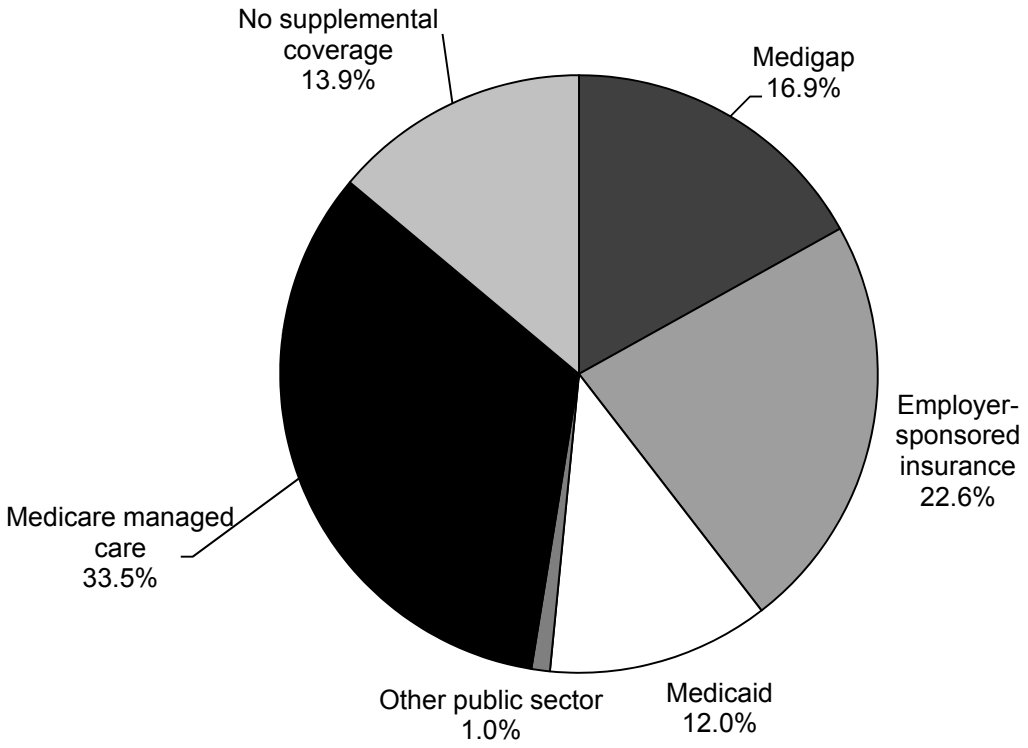
SECTION 3

Medicare beneficiary and other payer financial liability

Chart 3-1. Sources of supplemental coverage among noninstitutionalized Medicare beneficiaries, 2013



Note: Beneficiaries are assigned to the supplemental coverage category they were in for the most time in 2013. They could have had coverage in other categories during 2013. "Other public sector" includes federal and state programs not included in other categories. Analysis includes only beneficiaries not living in institutions such as nursing homes. It excludes beneficiaries who were not in both Part A and Part B throughout their enrollment in 2013 or who had Medicare as a secondary payer. Percentages do not sum to 100 because of rounding.

Source: MedPAC analysis of Medicare Current Beneficiary Survey, Cost and Use file 2013.

- Most beneficiaries living in the community (noninstitutionalized) have coverage that supplements or replaces the Medicare benefit package. In 2013, about 86 percent of beneficiaries had supplemental coverage or participated in Medicare managed care.
- About 40 percent of beneficiaries had private sector supplemental coverage such as medigap (about 17 percent) or employer-sponsored retiree coverage (about 23 percent).
- About 13 percent of beneficiaries had public sector supplemental coverage, primarily Medicaid.
- About 33 percent of beneficiaries participated in Medicare managed care. This care includes Medicare Advantage, health care prepayment, and cost plans. These types of arrangements generally replace Medicare's fee-for-service coverage and often add more coverage.
- The numbers in this chart differ from those in Chart 2-5, Chart 4-1, and Chart 4-4 because of differences in the populations represented in the charts. This chart excludes beneficiaries in long-term care institutions, Chart 2-5 and Chart 4-4 include all Medicare beneficiaries, and Chart 4-1 excludes beneficiaries in Medicare Advantage.

Chart 3-2. Sources of supplemental coverage among noninstitutionalized Medicare beneficiaries, by beneficiaries' characteristics, 2013

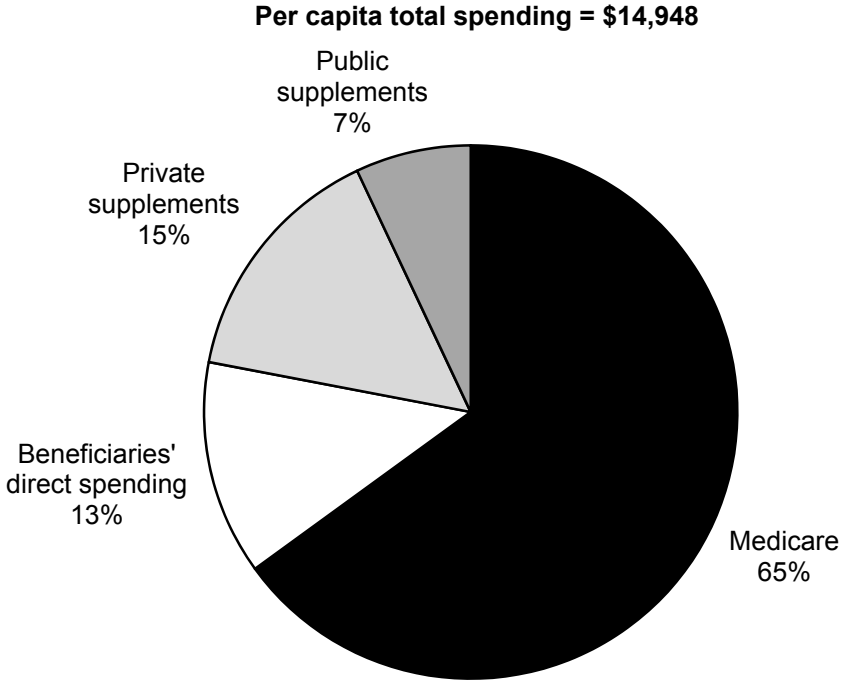
	Number of beneficiaries (thousands)	Employer-sponsored insurance	Medigap insurance	Medicaid	Medicare managed care	Other public sector	Medicare only
All beneficiaries	**45,483**	**23%**	**17%**	**12%**	**33%**	**1%**	**14%**
Age							
<65	7,484	7	4	36	28	2	23
65–69	11,050	20	19	8	33	1	19
70–74	9,480	27	19	6	37	1	10
75–79	7,181	28	19	7	36	1	9
80–84	5,059	28	21	7	34	1	9
85+	5,289	30	21	8	32	1	9
Income category							
<$10,000	5,773	6	6	44	30	1	13
$10,000–$19,999	12,359	10	13	21	37	2	16
$20,000–$29,999	8,343	25	17	3	37	1	17
$30,000–$39,999	5,938	28	21	1	34	0	15
$40,000–$59,999	5,738	33	22	0	34	0	11
$60,000–$89,999	4,012	43	18	0	28	0	11
≥$90,000	3,320	41	29	0	22	0	8
Eligibility status							
Aged	37,854	26	19	7	35	1	12
Disabled	7,229	7	4	37	28	2	22
ESRD	345	16	13	22	24	2	22
Residence							
Urban	34,988	23	15	11	37	1	12
Rural	10,495	22	23	14	21	1	19
Sex							
Male	20,341	23	16	11	33	1	17
Female	25,142	23	18	13	34	1	12
Health status							
Excellent/very good	20,668	26	20	6	35	1	12
Good/fair	21,098	21	15	15	33	1	15
Poor	3,526	12	10	29	29	2	19

Note: ESRD (end-stage renal disease). Beneficiaries are assigned to the supplemental coverage category they were in for the most time in 2013. They could have had coverage in other categories during 2013. "Medicare managed care" includes Medicare Advantage, cost, and health care prepayment plans. "Other public sector" includes federal and state programs not included in other categories. Married people have joint income reported on the data file. We divided their income by 1.26 to create an equal measure with unmarried people. "Urban" indicates beneficiaries living in metropolitan statistical areas (MSAs). "Rural" indicates beneficiaries living outside MSAs. Analysis excludes beneficiaries living in institutions such as nursing homes. It excludes beneficiaries who were not in both Part A and Part B throughout their enrollment in 2013 or who had Medicare as a secondary payer. The number of beneficiaries differs among boldface categories because we excluded beneficiaries with missing values. Numbers in some rows do not sum to 100 percent because of rounding.

Source: MedPAC analysis of Medicare Current Beneficiary Survey, Cost and Use file 2013.

- Beneficiaries most likely to have employer-sponsored supplemental coverage are those who are age 65 or older, have income over $20,000, are eligible because of age, and report better than poor health.
- Medigap is most common among those who are age 65 or older, have income of $20,000 or more, are eligible because of age, are rural dwelling, and report better than poor health.
- Medicaid coverage is most common among those who are under age 65, have income below $20,000, are eligible because of disability or ESRD, are rural dwelling, and report poor health.
- Lack of supplemental coverage (Medicare coverage only) is most common among beneficiaries who are under age 65, have income below $40,000, are eligible because of disability or ESRD, are rural dwelling, are male, and report poor health.

Chart 3-3. Total spending on health care services for noninstitutionalized FFS Medicare beneficiaries, by source of payment, 2013



Note: FFS (fee-for-service). "Private supplements" includes employer-sponsored plans and individually purchased coverage. "Public supplements" includes Medicaid, Department of Veterans Affairs, and other public coverage. "Direct spending" is on Medicare cost sharing and noncovered services, but not supplemental premiums. Analysis includes only FFS beneficiaries not living in institutions such as nursing homes. We excluded Medicare Advantage enrollees.

Source: MedPAC analysis of Medicare Current Beneficiary Survey, Cost and Use file 2013.

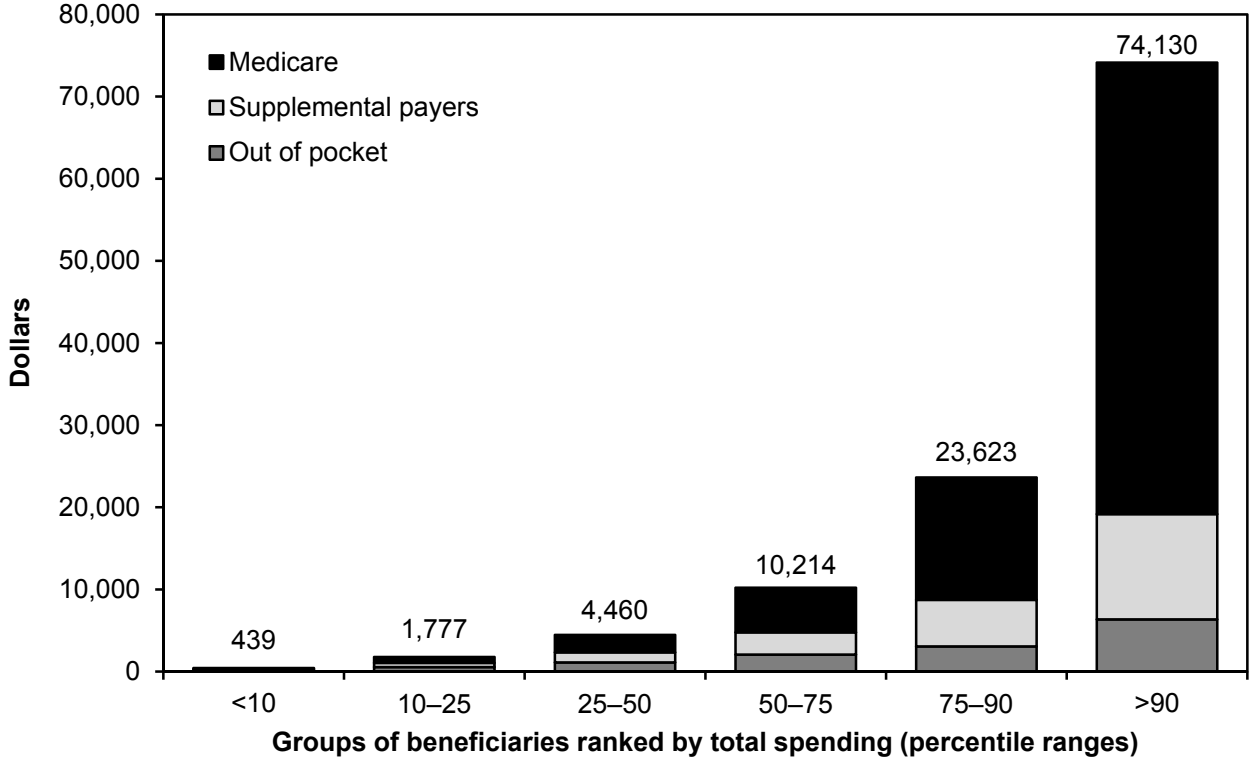
- Among FFS beneficiaries living in the community (noninstitutionalized), the total cost of health care services (defined as beneficiaries' direct spending as well as expenditures by Medicare, other public sector sources, and all private sector sources on all health care goods and services) averaged about $15,000 in 2013. Medicare was the largest source of payment: It paid 65 percent of the health care costs for FFS beneficiaries living in the community, an average of $9,748 per beneficiary. The level of Medicare spending in this chart differs from the level in Chart 2-1 because this chart excludes beneficiaries in Medicare Advantage and those living in institutions, while Chart 2-1 represents all Medicare beneficiaries.

- Private sources of supplemental coverage—primarily employer-sponsored retiree coverage and medigap—paid 15 percent of beneficiaries' costs, an average of $2,198 per beneficiary.

- Beneficiaries paid 13 percent of their health care costs out of pocket, an average of $1,993 per beneficiary.

- Public sources of supplemental coverage—primarily Medicaid—paid 7 percent of beneficiaries' health care costs, an average of $1,009 per beneficiary.

Chart 3-4. Per capita total spending on health care services among noninstitutionalized FFS beneficiaries, by source of payment, 2013



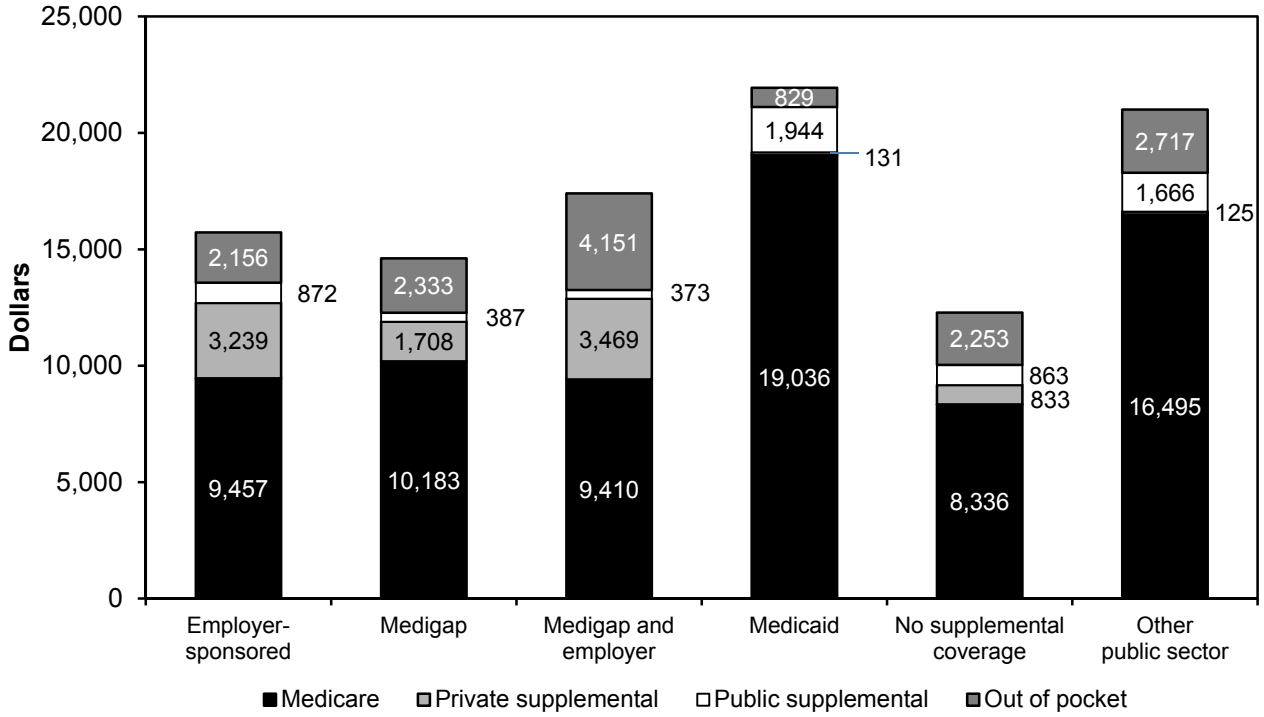
Note: FFS (fee-for-service). Analysis excludes those who are not in FFS Medicare and those living in institutions such as nursing homes. “Out-of-pocket" spending includes Medicare cost sharing and noncovered services.

Source: MedPAC analysis of Medicare Current Beneficiary Survey, Cost and Use file 2013.

- Total spending on health care services varied dramatically among FFS beneficiaries living in the community in 2013. Per capita spending for the 10 percent of beneficiaries with the highest total spending averaged $74,130. Per capita spending for the 10 percent of beneficiaries with the lowest total spending averaged $439.

- Among FFS beneficiaries living in the community, Medicare paid a larger percentage as total spending increased, and beneficiaries’ out-of-pocket spending was a smaller percentage as total spending increased. For example, Medicare paid 65 percent of total spending for all beneficiaries, but paid 77 percent of total spending for the 10 percent of beneficiaries with the highest total spending. Beneficiaries’ out-of-pocket spending covered 13 percent of total spending for all beneficiaries, but only 9 percent of total spending for the 10 percent of beneficiaries with the highest total spending.

Chart 3-5. Variation in and composition of total spending among noninstitutionalized FFS beneficiaries, by type of supplemental coverage, 2013



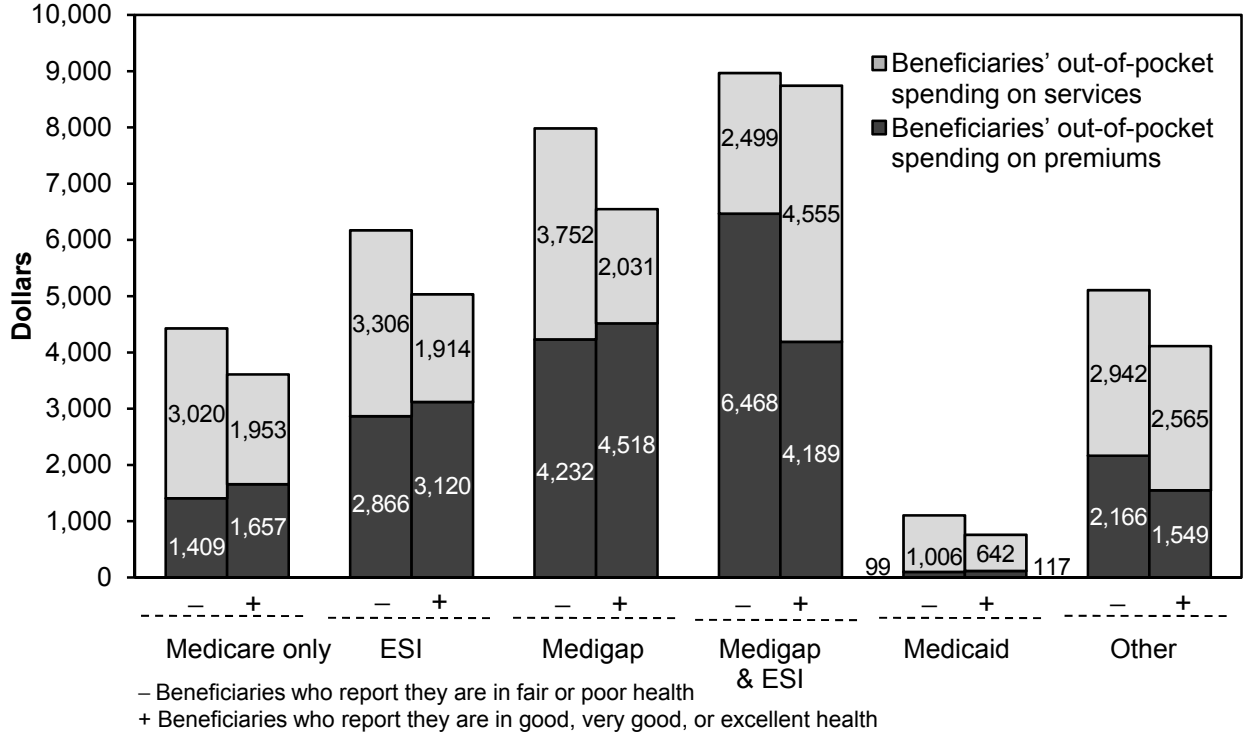
Note: FFS (fee-for-service). Beneficiaries are assigned to the supplemental coverage category they were in for the most time in 2013. They could have had coverage in other categories during 2013. "Other public sector" includes federal and state programs not included in the other categories. "Private supplemental" includes employer-sponsored plans and individually purchased coverage. "Public supplemental" includes Medicaid, Department of Veterans Affairs, and other public coverage. "Out-of-pocket" spending includes Medicare cost sharing and noncovered services, but not supplemental premiums. Analysis excludes beneficiaries who were not in FFS Medicare or lived in institutions such as nursing homes. It excludes beneficiaries who were not in both Part A and Part B throughout their enrollment in 2013 or had Medicare as a second payer.

Source: MedPAC analysis of Medicare Current Beneficiary Survey, Cost and Use file 2013.

- The level of total spending (defined as beneficiaries' out-of-pocket spending as well as expenditures by Medicare, other public sector sources, and all private sector sources on all health care goods and services) among FFS beneficiaries living in the community varied by the type of supplemental coverage they had. Total spending was lower for those beneficiaries with no supplemental coverage than for those beneficiaries who had supplemental coverage. Beneficiaries with Medicaid coverage had the highest level of total spending—79 percent higher than those with no supplemental coverage in 2013.

- Medicare was the largest source of payment for beneficiaries in each supplemental insurance category, but the second largest source of payment differed. Among those with employer-sponsored or Medicaid supplemental coverage, combined public and private supplemental coverage was the second largest source of payment. Among those who were covered by medigap, medigap with employer-sponsored insurance, or only by Medicare, beneficiaries' out-of-pocket spending was the second largest source of payment.

Chart 3-6. Out-of-pocket spending for premiums and health services per beneficiary, by insurance and health status, 2013

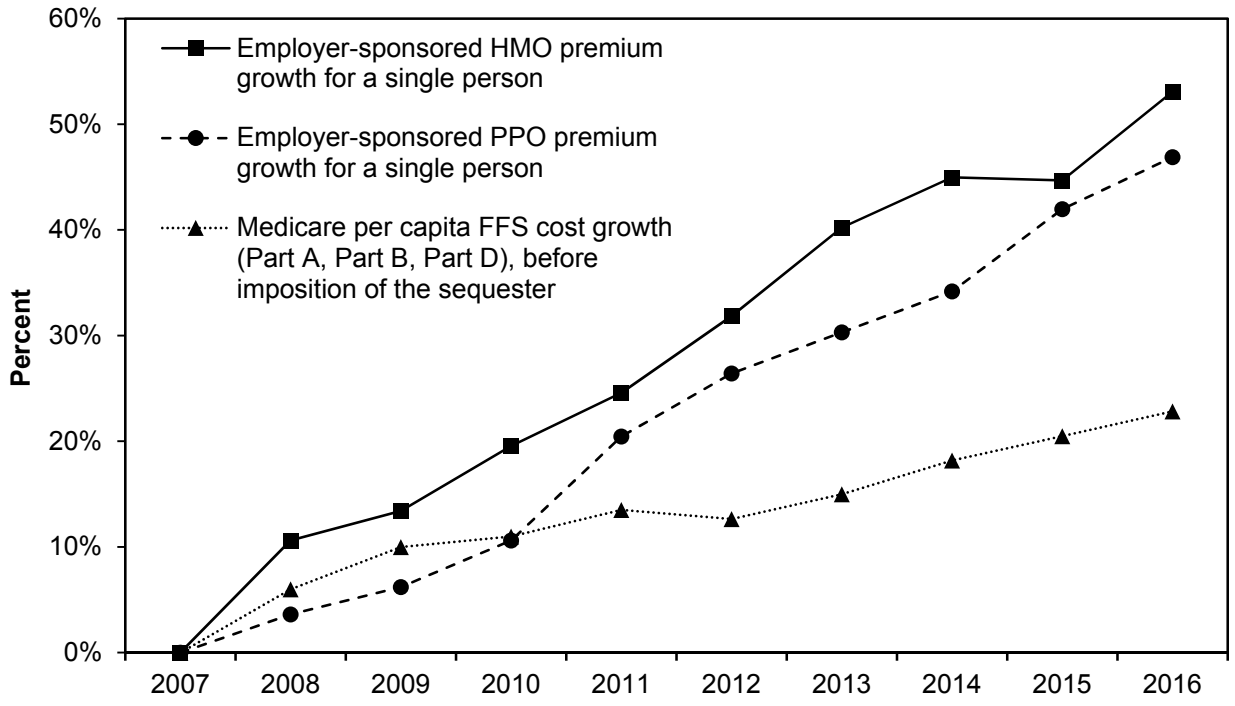


Note: ESI (employer-sponsored supplemental insurance). The amount of out-of-pocket spending on services for Medicare-only beneficiaries who have fair or poor health increased substantially over the amount on the analogous chart from our June 2016 data book. The reason for this increase was that the data sample we used in this chart had fewer beneficiaries reporting zero out-of-pocket spending than the sample we used for the June 2016 data book. Likewise, the amount of out-of-pocket spending on services for beneficiaries who have both medigap and ESI coverage and report good, very good, or excellent health in this chart is substantially higher than in the analogous chart from our June 2016 data book. The reason for this increase is that the sample we used in this chart had one observation with an extremely high level of out-of-pocket spending.

Source: MedPAC analysis of Medicare Current Beneficiary Survey, Cost and Use file 2013.

- This diagram illustrates out-of-pocket spending on services and premiums by beneficiaries' supplemental insurance and health status in 2013. For example, beneficiaries who had only traditional Medicare coverage ("Medicare only") and reported fair or poor health averaged $1,409 in out-of-pocket spending on premiums and $3,020 on services in 2013. Those who had Medicare-only coverage and reported good, very good, or excellent health averaged $1,657 in out-of-pocket spending on premiums and $1,953 on services.
- Insurance that supplements Medicare does not shield beneficiaries from all out-of-pocket costs. Beneficiaries who reported being in fair or poor health spent more out of pocket for health services than those reporting good, very good, or excellent health, except for those who had medigap and employer-sponsored supplemental coverage. This result for those who had medigap and employer-sponsored coverage is likely an artifact of a small sample size.
- Despite having supplemental coverage, beneficiaries who had ESI or medigap often had out-of-pocket spending that was more than those who had only coverage under traditional Medicare ("Medicare only"). This result likely reflects the fact that beneficiaries who had ESI or medigap had higher incomes and were likely to have stronger preferences for health care.
- What beneficiaries actually pay out of pocket varies by type of supplemental coverage. For those with medigap, out-of-pocket spending generally reflects the premiums and costs of services not covered by Medicare. Beneficiaries with ESI usually pay less out of pocket for Medicare noncovered services than those with medigap but may pay more in Medicare deductibles and cost sharing.

Chart 3-7. Cost of employer-sponsored commercial insurance has grown twice as fast as Medicare costs per capita



Note: HMO (health maintenance organization), PPO (preferred provider organization), FFS (fee-for-service).

Source: Employer-sponsored premium data are from Kaiser Family Foundation surveys, 2007 through 2016. Medicare spending figures are from Part A and Part B program spending data from the CMS Actuary; Part D spending per capita figures through 2015 are from MedPAC analysis of claims and reinsurance data for individuals with Part D coverage. Part D spending for 2016 is a projection.

- Medicare costs have risen more slowly than commercial insurance premiums in part due to slower price growth for Medicare services.
- Per capita costs in FFS Medicare grew by 23 percent from 2007 to 2016. This 23 percent growth rate is the cumulative growth in the CMS Actuary's estimated cost of Part A and Part B benefits and the Commission's estimates of the cost of Part D premiums and reinsurance from 2007 to 2016. The Medicare FFS growth rate also was not adjusted for enhancements of the Part D benefit that included a shrinking of the coverage gap.
- In the commercial sector, employer-sponsored HMO premiums grew by 53 percent and PPO premiums by 47 percent over the same period, despite the rapidly increasing deductibles reported in the Kaiser Family Foundation survey. While deductibles grew rapidly for both employer-sponsored HMOs and PPOs, they tended to grow fastest for PPOs, possibly explaining why PPO premiums grew at a slightly slower rate than HMO premiums.
- None of the growth rates that we discuss have been adjusted for changes in demographics. We note that the average age of Medicare FFS beneficiaries declined by 0.3 years over this period.