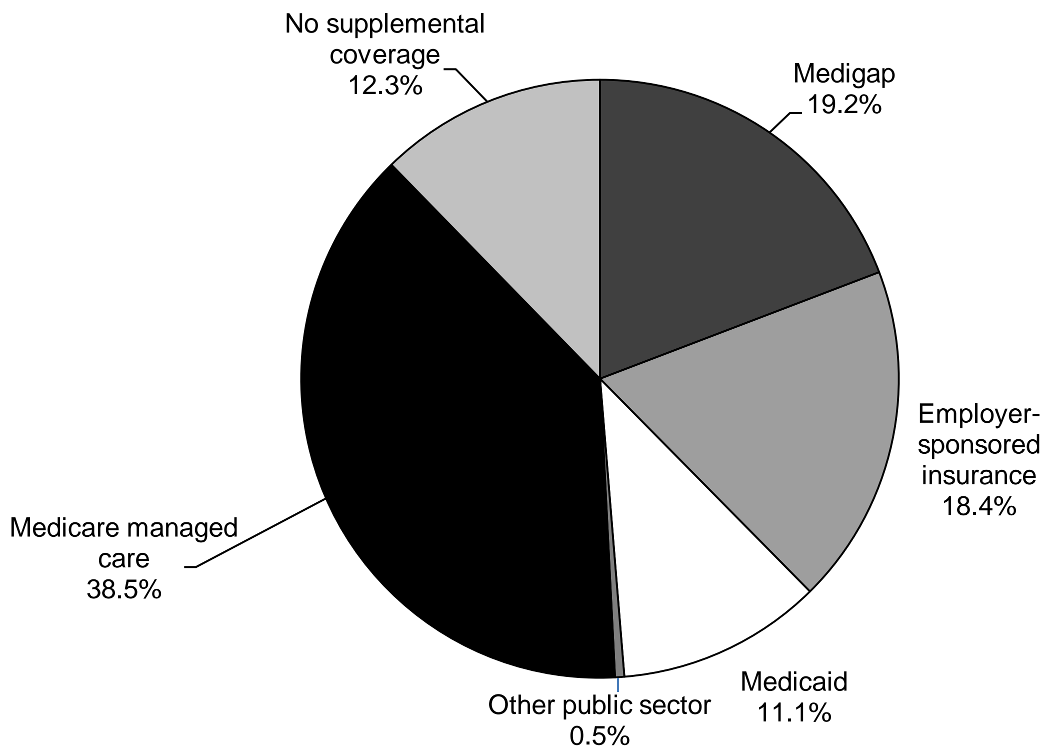
SECTION 3

Medicare beneficiary and other payer financial liability

Chart 3-1. Sources of supplemental coverage among noninstitutionalized Medicare beneficiaries, 2016



Note: Beneficiaries are assigned to the supplemental coverage category they were in for the most time in 2016. They could have had coverage in other categories during 2016. "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 2016 or who had Medicare as a secondary payer.

Source: MedPAC analysis of Medicare Current Beneficiary Survey, Survey file 2016.

- Most beneficiaries living in the community (noninstitutionalized) have coverage that supplements or replaces the Medicare benefit package. In 2016, 88 percent of beneficiaries had supplemental coverage or participated in Medicare managed care.

- About 38 percent of beneficiaries had private sector supplemental coverage such as Medigap (about 19 percent) or employer-sponsored retiree coverage (about 18 percent).

- About 12 percent of beneficiaries had public sector supplemental coverage, primarily Medicaid.

- About 39 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, while 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, 2016

	Number of beneficiaries (thousands)	Employer-sponsored insurance	Medigap insurance	Medicaid	Medicare managed care	Other public sector	Medicare only
All beneficiaries	**47,002**	**18%**	**19%**	**11%**	**39%**	**1%**	**12%**
Age							
<65	7,093	5	4	38	34	1	17
65–69	10,937	18	20	7	41	0	14
70–74	10,823	20	23	6	40	1	10
75–79	7,684	22	22	6	41	0	10
80–84	5,314	25	21	6	37	0	10
85+	5,151	22	23	7	35	1	12
Income-to-poverty ratio							
≤1.00	7,801	4	7	41	36	0	11
1.00 to 1.25	3,687	7	10	28	40	1	14
1.25 to 1.50	3,306	9	17	14	46	1	13
1.50 to 2.00	5,559	13	20	5	44	1	17
>2.00	26,649	26	24	1	37	0	12
Eligibility status							
Aged	39,677	21	22	6	39	0	11
Disabled	6,968	5	4	38	34	1	17
ESRD	357	16	23	16	19	3	22
Residence							
Urban	37,241	18	18	10	42	0	11
Rural	9,755	19	25	14	25	1	16
Sex							
Male	20,950	19	18	10	37	1	15
Female	26,052	18	20	12	40	0	10
Health status							
Excellent/very good	21,341	22	22	5	39	0	11
Good/fair	22,274	16	17	15	38	0	13
Poor	3,167	8	12	28	36	1	15

Note: ESRD (end-stage renal disease). Beneficiaries are assigned to the supplemental coverage category they were in for the most time in 2016. They could have had coverage in other categories during 2016. "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. "Urban" indicates beneficiaries living in metropolitan statistical areas (MSAs) as indicated by core-based statistical areas. "Rural" indicates beneficiaries living outside MSAs, which includes both micropolitan statistical areas and rural areas as indicated by core-based statistical areas. 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 2016 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, Survey file 2016.

- Beneficiaries most likely to have employer-sponsored supplemental coverage are those who are age 65 or older, have income above twice the poverty level, 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 higher than 1.25 times the poverty level, 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 lower than 1.5 times the poverty level, 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, are eligible because of disability or ESRD, are rural dwelling, are male, and report poor health.

Chart 3-3. Covered benefits and enrollment in standardized Medigap plans, 2018

	Medigap standardized plan type										
Benefit	A	B	C	D	F	High deductible F	G	K	L	M	N
Part A hospital costs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Part B cost sharing	✓	✓	✓	✓	✓	✓	✓	50%	75%	✓	$20/$50
Blood (first 3 pints)	✓	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓
Hospice cost sharing	✓	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓
SNF coinsurance			✓	✓	✓	✓	✓	50%	75%	✓	✓
Part A deductible		✓	✓	✓	✓	✓	✓	50%	75%	50%	✓
Part B deductible			✓		✓	✓					
Part B excess charges					✓	✓	✓				
Foreign travel emergency			✓	✓	✓	✓	✓			✓	✓
Lives covered (in thousands)	125	225	700	150	6,750	275	2,300	75	50	5	1,350
Percent change 2016–2018	–20%	–17%	–21%	–18%	1%	18%	82%	8%	0%	–13%	17%

Note: SNF (skilled nursing facility). Three states (Massachusetts, Minnesota, and Wisconsin) have different plan types and are not included in this chart. The ✓ indicates that the plan covers all cost sharing. Percentages indicate that the plan covers that share of the total cost sharing. The $20/$50 indicates that the plan covers all but $20 for physician office visits and all but $50 for emergency room visits.

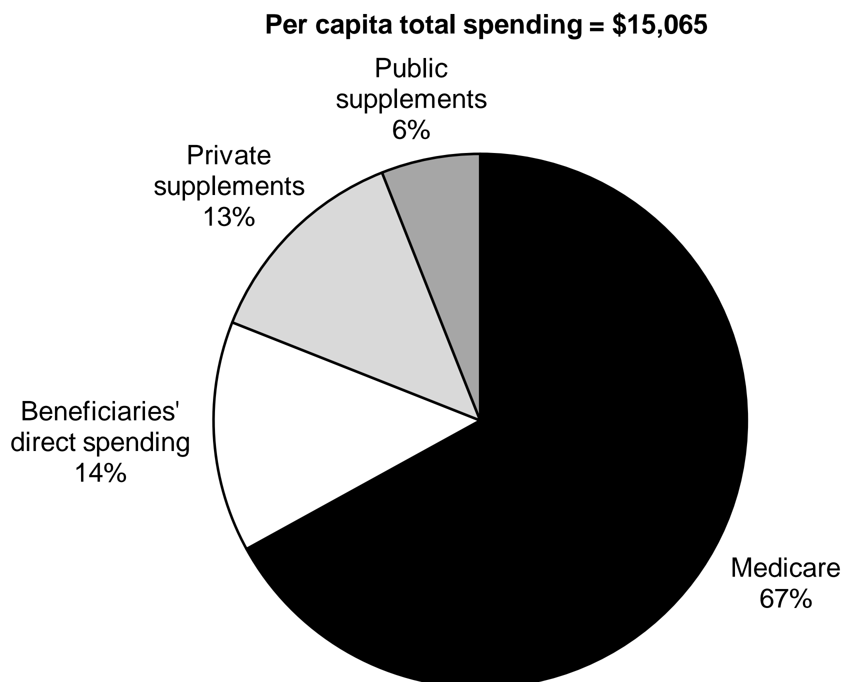
Source: MedPAC analysis of National Association of Insurance Commissioners data, 2019.

- Medicare beneficiaries purchase Medigap plans, also known as Medicare supplementary insurance plans, to cover fee-for-service Medicare cost sharing. Statute specifies 11 standardized plans. States enforce the standards based on model regulations developed by the National Association of Insurance Commissioners (NAIC). Three states (Massachusetts, Minnesota, and Wisconsin) have waivers from these standards and have different standard plan types not included in this chart.

- Plan F, which covers all Medicare cost sharing, is the most popular plan, with 6.8 million enrollees. However, because Congress was concerned about the overutilization of Medicare services, legislation will prohibit the sale of new Plan F policies beginning in 2020. As a result, insurers have begun to direct beneficiaries into other plan types, namely plans G, K, and N, which do not cover the Part B deductible.

- During 2018, almost 14 million beneficiaries enrolled in Medigap plans (including those in Massachusetts, Minnesota, and Wisconsin). Of all Medicare beneficiaries, about one-fifth were enrolled in Medigap plans.

Chart 3-4. Total spending on health care services for noninstitutionalized FFS Medicare beneficiaries, by source of payment, 2016



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. "Beneficiaries' 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 Supplement file, 2016.

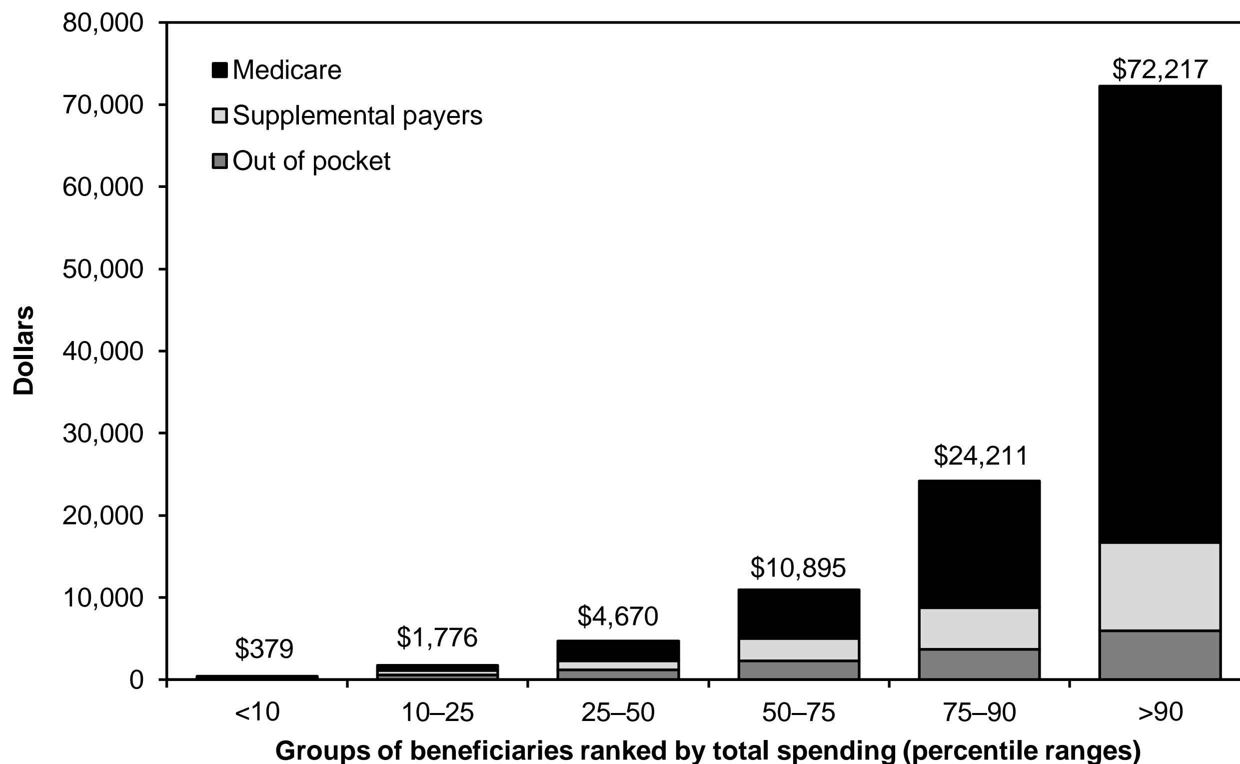
- Among FFS beneficiaries living in the community (noninstitutionalized), the total cost of health care services (beneficiaries' direct spending as well as expenditures by Medicare, other public sector sources, and all private sector sources on all health care goods and services) averaged about $15,000 in 2016. Medicare was the largest source of payment: It paid about 67 percent of the health care costs for FFS beneficiaries living in the community, an average of $10,063 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 about 13 percent of beneficiaries' costs, an average of $1,998 per beneficiary.

- Beneficiaries paid about 14 percent of their health care costs out of pocket, an average of $2,137 per beneficiary.

- Public sources of supplemental coverage—primarily Medicaid—paid about 6 percent of beneficiaries' health care costs, an average of $867 per beneficiary.

Chart 3-5. Per capita total spending on health care services among noninstitutionalized FFS beneficiaries, by source of payment, 2016



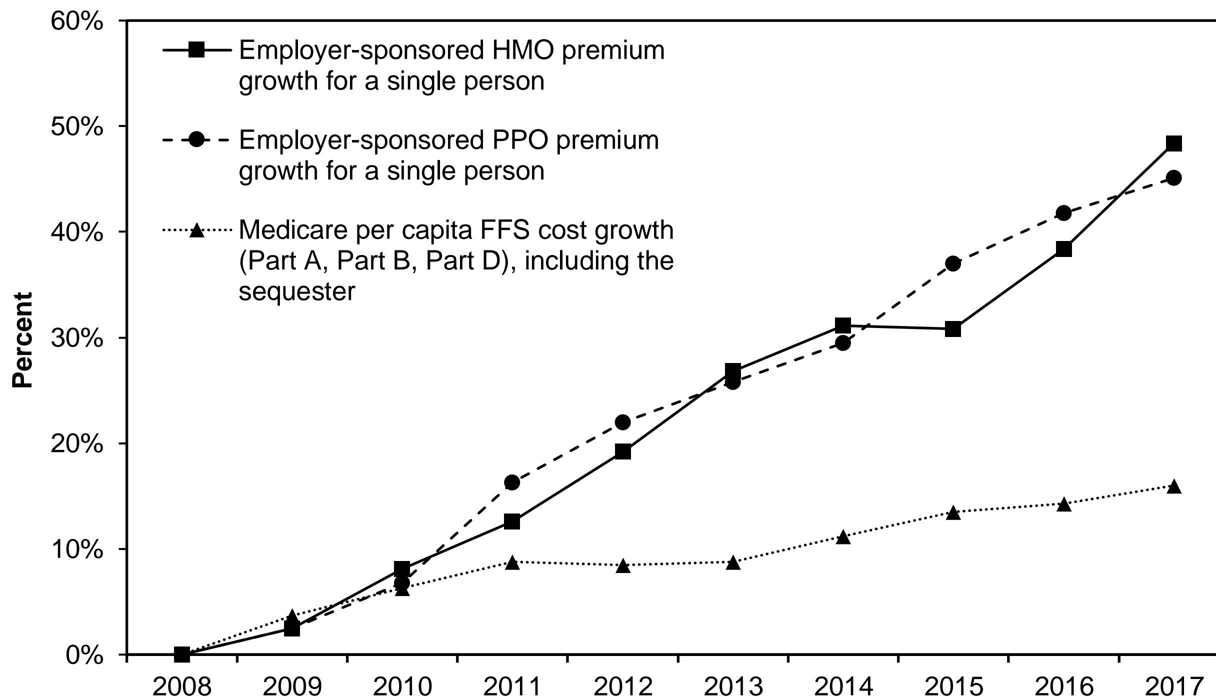
Note: FFS (fee-for-service). Analysis excludes those who are not in FFS Medicare and those living in institutions such as nursing homes. "Out-of-pocket" spending includes Medicare cost sharing and noncovered services, but not supplemental premiums.

Source: MedPAC analysis of the Medicare Current Beneficiary Survey, Cost Supplement file, 2016.

- Total spending on health care services varied dramatically among FFS beneficiaries living in the community in 2016. Per capita spending for the 10 percent of beneficiaries with the highest total spending averaged $72,217. Per capita spending for the 10 percent of beneficiaries with the lowest total spending averaged $379.

- Among FFS beneficiaries living in the community, Medicare paid a larger share as total spending increased, and beneficiaries' out-of-pocket spending was a smaller share as total spending increased. For example, Medicare paid 67 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 14 percent of total spending for all beneficiaries, but only 8 percent of total spending for the 10 percent of beneficiaries with the highest total spending (data not shown).

Chart 3-6. Cost of employer-sponsored commercial insurance has grown more than twice as fast as Medicare costs



Note: HMO (health maintenance organization), PPO (preferred provider organization), FFS (fee-for-service). Medicare spending is reported including the effects of the sequester that began in March 2013, which reduced program spending by 2 percent.

Source: Employer-sponsored premium data are from Kaiser Family Foundation surveys, 2008 through 2017. Medicare spending figures are from Part A and Part B program spending data from CMS actuaries; Part D spending per capita figures through 2016 are from MedPAC analysis of claims and reinsurance data for individuals with Part D coverage. Part D spending for 2017 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 16 percent from 2008 to 2017. This 16 percent growth rate is the cumulative growth in the CMS actuaries' estimated cost of Part A and Part B benefits and the Commission's estimates of the cost of Part D premiums and reinsurance from 2008 to 2017. 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 48 percent and PPO premiums by 45 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.