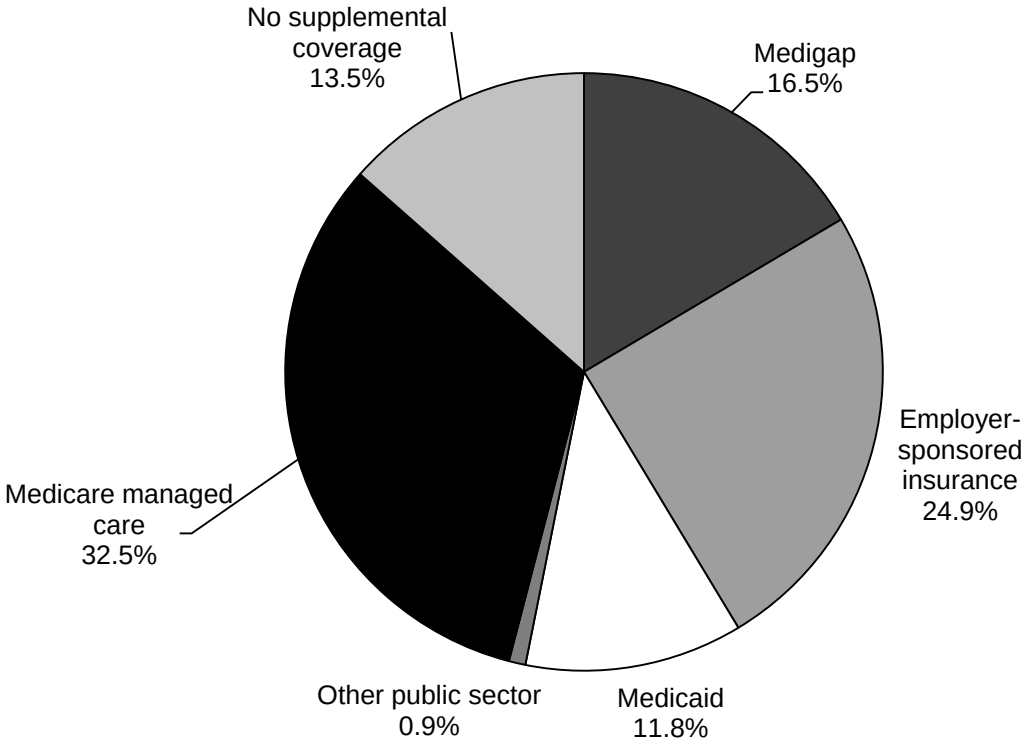
SECTION 3

Medicare beneficiary and other payer financial liability

Chart 3-1. Sources of supplemental coverage among noninstitutionalized Medicare beneficiaries, 2012



Note: Beneficiaries are assigned to the supplemental coverage category they were in for the most time in 2012. They could have had coverage in other categories during 2012. "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 2012 or who had Medicare as a secondary payer. Percentages may not sum to 100 because of rounding.

Source: MedPAC analysis of Medicare Current Beneficiary Survey, Cost and Use file 2012.

- Most beneficiaries living in the community (noninstitutionalized) have coverage that supplements or replaces the Medicare benefit package. In 2012, about 86 percent of beneficiaries had supplemental coverage or participated in Medicare managed care.
- About 41 percent of beneficiaries had private sector supplemental coverage such as medigap (about 17 percent) or employer-sponsored retiree coverage (about 25 percent).
- About 13 percent of beneficiaries had public sector supplemental coverage, primarily Medicaid.
- About 32 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, 2012

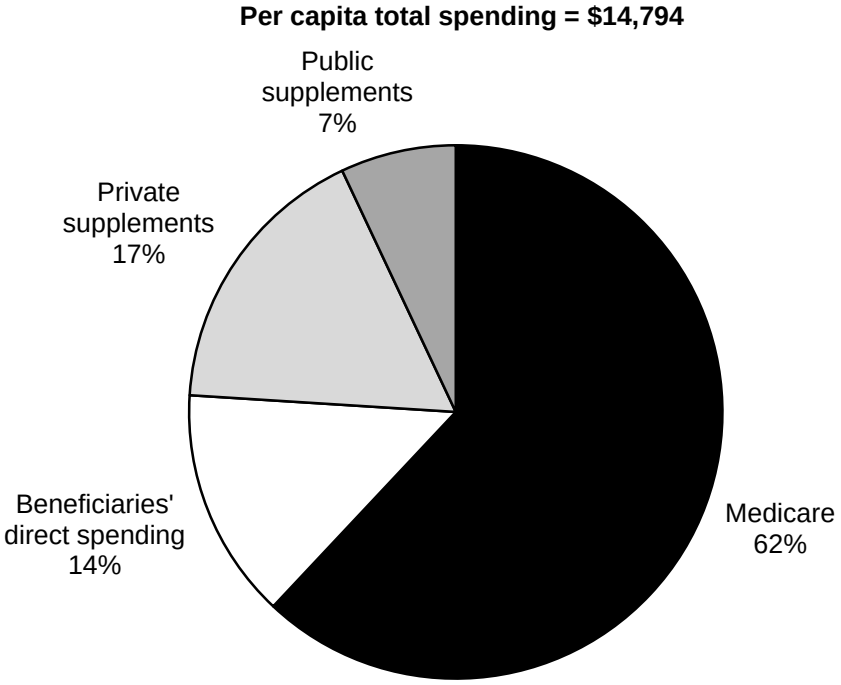
	Number of beneficiaries (thousands)	Employer-sponsored insurance	Medigap insurance	Medicaid	Medicare managed care	Other public sector	Medicare only
All beneficiaries	**44,025**	**25%**	**16%**	**12%**	**32%**	**1%**	**13%**
Age							
<65	7,148	10	3	35	28	1	23
65–69	10,704	25	17	8	32	1	18
70–74	8,894	28	19	6	37	0	10
75–79	6,813	28	20	8	35	1	8
80–84	5,314	31	20	7	32	1	9
85+	5,152	31	22	8	29	1	9
Income category							
<$10,000	5,563	6	8	49	25	1	12
$10,000–$19,999	11,875	12	14	18	37	2	17
$20,000–$29,999	8,535	25	19	3	37	1	15
$30,000–$39,999	5,235	34	16	0	35	1	13
$40,000–$59,999	5,812	35	21	1	31	0	12
$60,000–$79,999	2,898	48	21	0	22	0	9
≥$80,000	4,107	44	23	0	25	0	8
Eligibility status							
Aged	36,650	28	19	7	33	1	12
Disabled	6,987	9	3	36	28	1	23
ESRD	346	22	11	24	28	6	10
Residence							
Urban	33,575	26	14	11	37	1	12
Rural	10,450	23	24	16	19	1	18
Sex							
Male	19,543	26	15	10	32	1	16
Female	24,482	24	18	13	33	1	12
Health status							
Excellent/very good	19,992	28	19	5	34	0	13
Good/fair	20,341	24	15	15	32	1	13
Poor	3,455	12	11	30	25	1	21

Note: ESRD (end-stage renal disease). Beneficiaries are assigned to the supplemental coverage category they were in for the most time in 2012. They could have had coverage in other categories during 2012. "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 includes beneficiaries living in the community. It excludes beneficiaries who were not in both Part A and Part B throughout their enrollment in 2012 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 2012.

- 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 $60,000, are eligible because of disability, 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, 2012



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. Medicare Advantage enrollees are excluded.

Source: MedPAC analysis of Medicare Current Beneficiary Survey, Cost and Use file 2012.

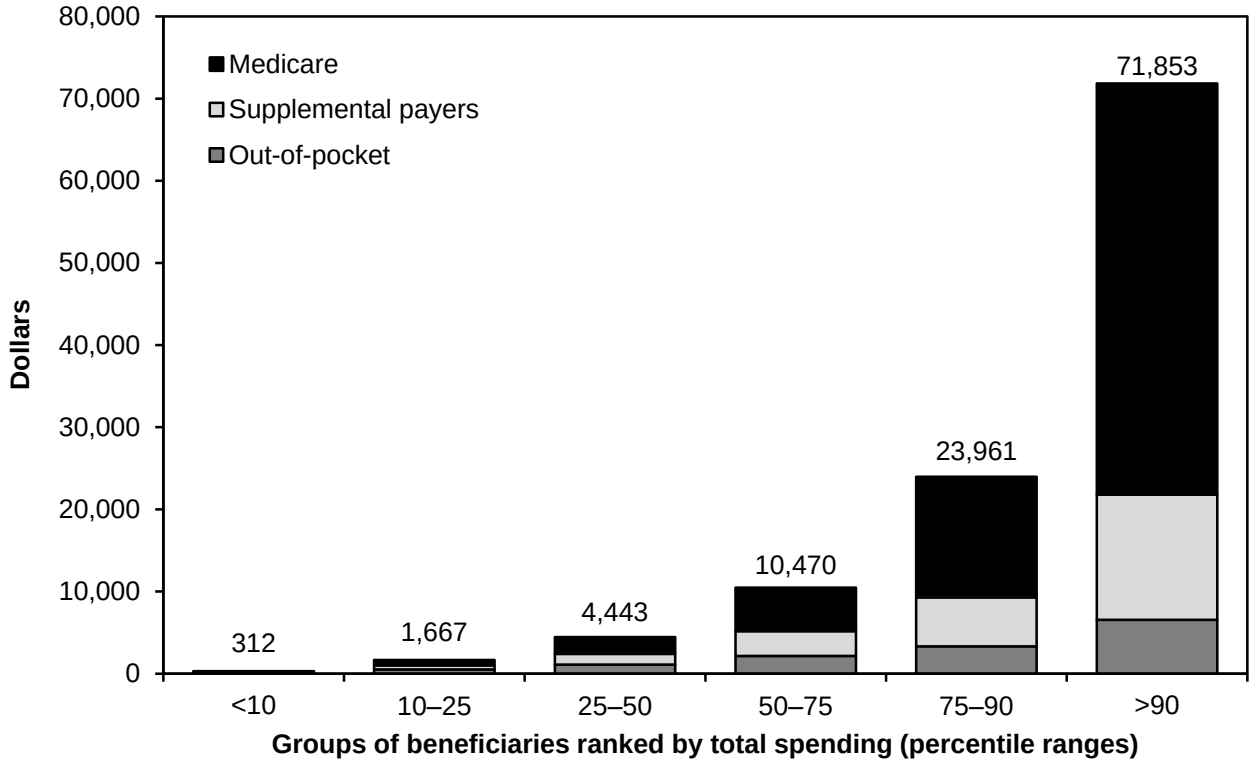
- Among FFS beneficiaries living in the community (noninstitutionalized), the total cost of health care services (defined as beneficiaries' direct spending as well as expenditures by Medicare, other public sector sources, and all private sector sources on all health care goods and services) averaged about $14,800 in 2012. Medicare was the largest source of payment: It paid 62 percent of the health care costs for FFS beneficiaries living in the community, an average of $9,151 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 17 percent of beneficiaries' costs, an average of $2,554 per beneficiary.

- Beneficiaries paid 14 percent of their health care costs out of pocket, an average of $2,058 per beneficiary.

- Public sources of supplemental coverage—primarily Medicaid—paid 7 percent of beneficiaries' health care costs, an average of $1,030 per beneficiary.

Chart 3-4. Per capita total spending on health care services among noninstitutionalized FFS beneficiaries, by source of payment, 2012



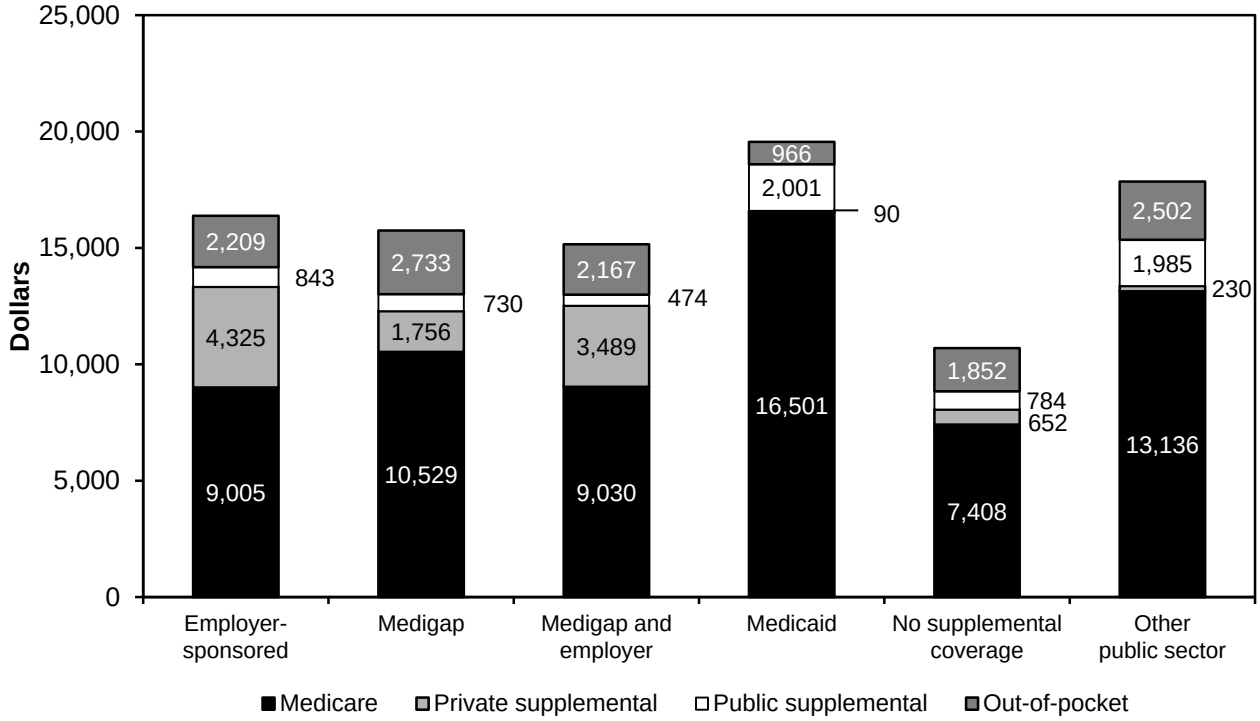
Note: FFS (fee-for-service). Analysis excludes those who are not in FFS Medicare and those living in institutions such as nursing homes. “Out-of-pocket" spending includes Medicare cost sharing and noncovered services.

Source: MedPAC analysis of Medicare Current Beneficiary Survey, Cost and Use file 2012.

- Total spending on health care services varied dramatically among FFS beneficiaries living in the community in 2012. Per capita spending for the 10 percent of beneficiaries with the highest total spending averaged $71,853. Per capita spending for the 10 percent of beneficiaries with the lowest total spending averaged $312.

- 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 62 percent of total spending for all beneficiaries, but paid 70 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 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, 2012



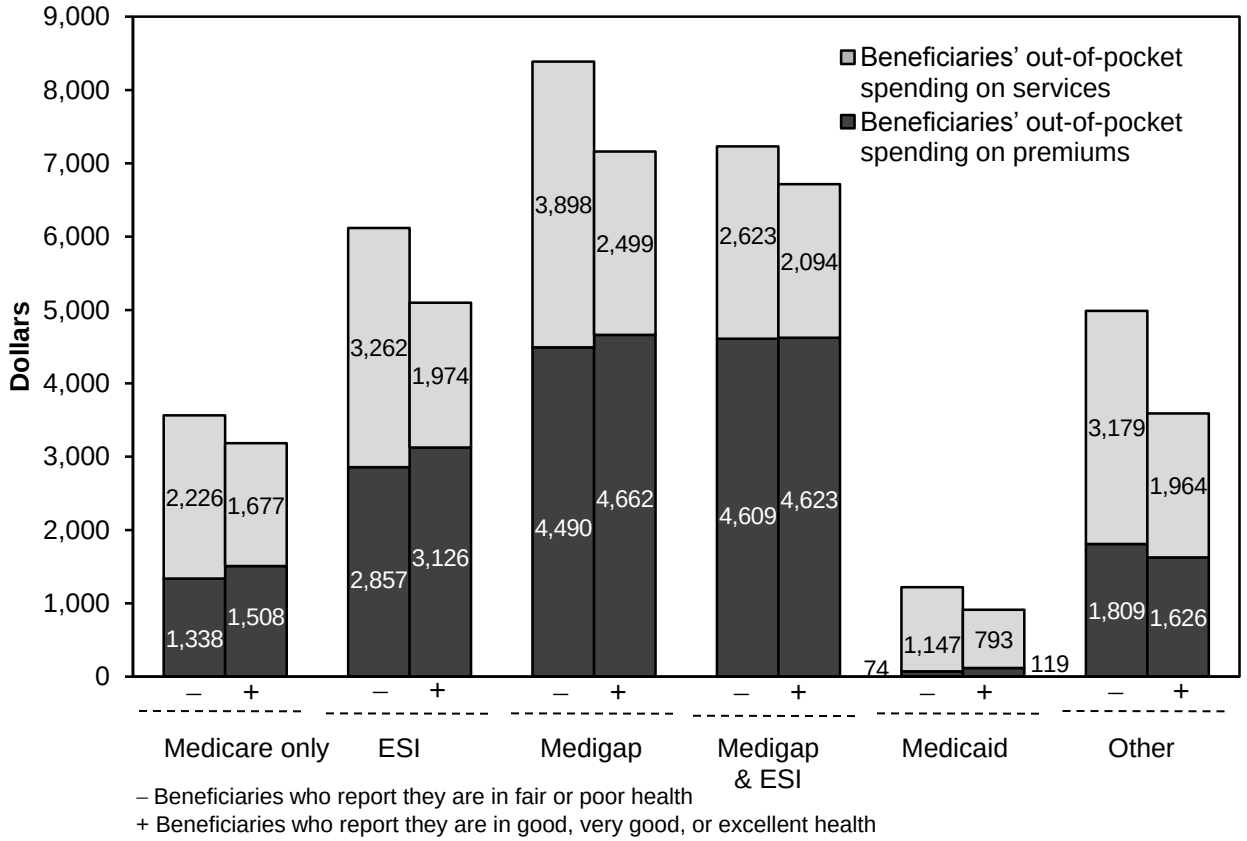
Note: FFS (fee-for-service). Beneficiaries are assigned to the supplemental coverage category they were in for the most time in 2012. They could have had coverage in other categories during 2012. "Other public sector" includes federal and state programs not included in the other categories. "Private supplemental" includes employer-sponsored plans and individually purchased coverage. "Public supplemental" includes Medicaid, Department of Veterans Affairs, and other public coverage. Analysis excludes beneficiaries who are not in FFS Medicare or live in institutions such as nursing homes. It excludes beneficiaries who were not in both Part A and Part B throughout their enrollment in 2012 or had Medicare as a second payer. "Out-of-pocket" spending includes Medicare cost sharing and noncovered services, but not supplemental premiums.

Source: MedPAC analysis of Medicare Current Beneficiary Survey, Cost and Use file 2012.

- 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—83 percent higher than those with no supplemental coverage in 2012.

- 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, medigap 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 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, 2012



Note: ESI (employer-sponsored supplemental insurance).

Source: MedPAC analysis of Medicare Current Beneficiary Survey, Cost and Use file 2012.

- This diagram illustrates out-of-pocket spending on services and premiums by beneficiaries' supplemental insurance and health status in 2012. For example, beneficiaries who had only traditional Medicare coverage ("Medicare only") and reported fair or poor health averaged $1,338 in out-of-pocket spending on premiums and $2,226 on services in 2012. Those who had Medicare-only coverage and reported good, very good, or excellent health averaged $1,508 in out-of-pocket spending on premiums and $1,677 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, regardless of the type of coverage they had to supplement Medicare.
- Despite having supplemental coverage, beneficiaries who had ESI or medigap 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.