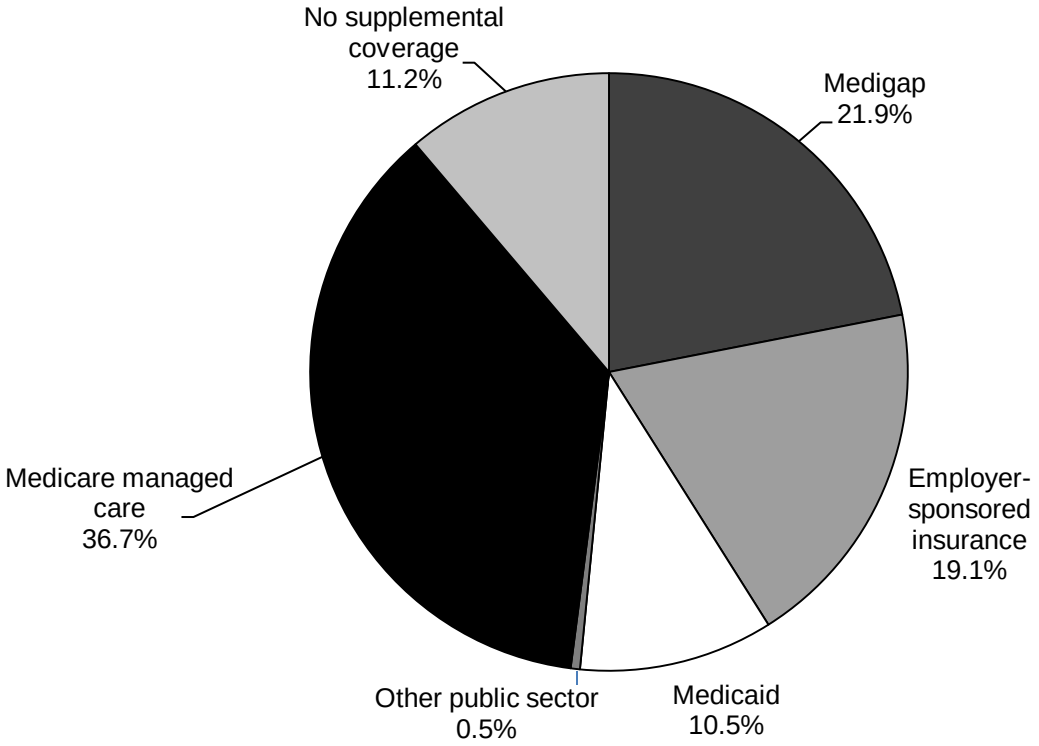
SECTION 3

Medicare beneficiary and other payer financial liability

Chart 3-1. Sources of supplemental coverage among noninstitutionalized Medicare beneficiaries, 2017



Note: We assigned beneficiaries to the supplemental coverage category they were in for the most time in 2017. They could have had coverage in other categories during 2017. "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 2017 or who had Medicare as a secondary payer. Numbers do not total 100 because of rounding. CMS adjusted the beneficiary weights used in the Medicare Current Beneficiary Survey for 2017 so that the estimated number of beneficiaries in the Medicare Advantage program matched a control total. Differences between this chart and those published in previous Data Books may not reflect real change but rather may be due to differences in method.

Source: MedPAC analysis of Medicare Current Beneficiary Survey, Survey file 2017.

- Most beneficiaries living in the community (noninstitutionalized) have coverage that supplements or replaces the Medicare benefit package. In 2017, 89 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 22 percent) or employer-sponsored retiree coverage (about 19 percent).
- About 11 percent of beneficiaries had public sector supplemental coverage, primarily Medicaid.
- About 37 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, 2017

	Number of beneficiaries (thousands)	Employer-sponsored insurance	Medigap insurance	Medicaid	Medicare managed care	Other public sector	Medicare only
All beneficiaries	**47,364**	**19%**	**22%**	**11%**	**37%**	**1%**	**11%**
Age							
<65	7,048	6	4	38	35	1	16
65–69	10,557	19	22	7	38	0	14
70–74	11,239	22	27	5	36	1	9
75–79	8,018	21	26	5	38	0	9
80–84	5,322	23	25	6	38	0	9
85+	5,180	24	24	6	36	0	9
Income-to-poverty ratio							
≤1.00	7,986	4	7	42	35	1	10
1.00 to 1.20	2,842	7	11	24	43	1	14
1.20 to 1.35	2,207	8	16	13	43	1	19
1.35 to 2.00	7,670	14	22	6	42	1	15
>2.00	26,659	29	28	1	34	0	9
Eligibility status							
Aged	40,098	21	25	6	37	0	10
Disabled	6,839	6	4	38	35	1	16
ESRD	372	14	23	24	19	1	20
Residence							
Urban	37,627	19	20	10	40	1	10
Rural	9,736	18	28	14	24	0	16
Sex							
Male	21,312	20	21	10	35	1	14
Female	26,052	18	23	11	38	0	9
Health status							
Excellent/very good	21,771	23	26	4	37	0	10
Good/fair	22,340	17	19	14	37	1	12
Poor	3,045	8	14	28	33	1	15

Note: ESRD (end-stage renal disease). We assigned beneficiaries to the supplemental coverage category they were in for the most time in 2017. They could have had coverage in other categories during 2017. "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 2017 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 2017.

- 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 1.35 times the poverty level, are eligible because of age or ESRD, 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 1.2 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 70, 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										
											High deductible
Benefit	A	B	C*	D	F*	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.
*Beginning in 2020, neither the C plan nor the F plan are allowed to cover the Part B deductible for new policies sold. However, C plans and F plans sold before 2020 can continue to cover the Part B deductible.

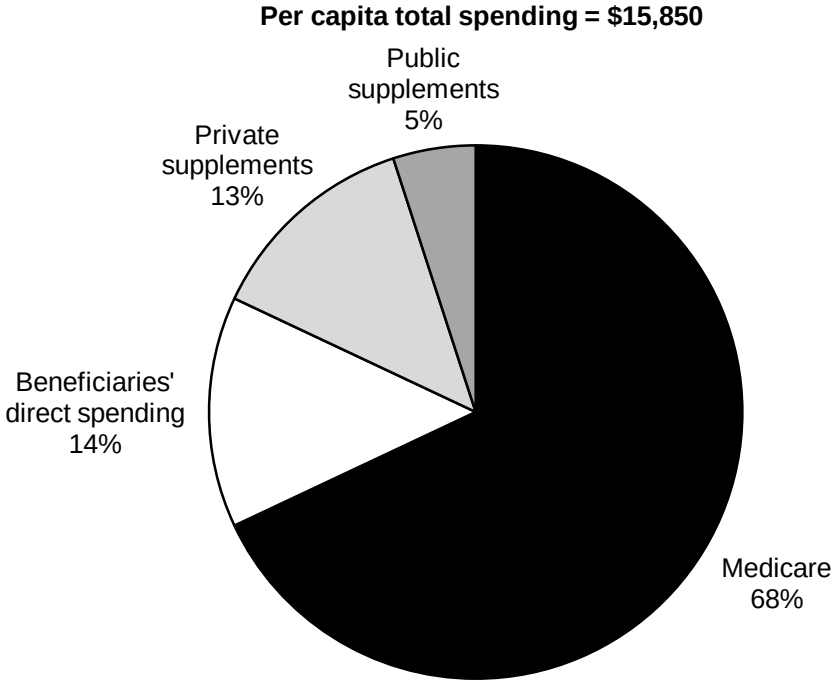
Source: MedPAC analysis of National Association of Insurance Commissioners data, 2019.

- Medicare beneficiaries often 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. 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 the Congress was concerned about the overutilization of Medicare services, legislation prohibits the sale of new Plan F policies as of 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, 2017



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.

Source: MedPAC analysis of Medicare Current Beneficiary Survey, Cost Supplement file, 2017.

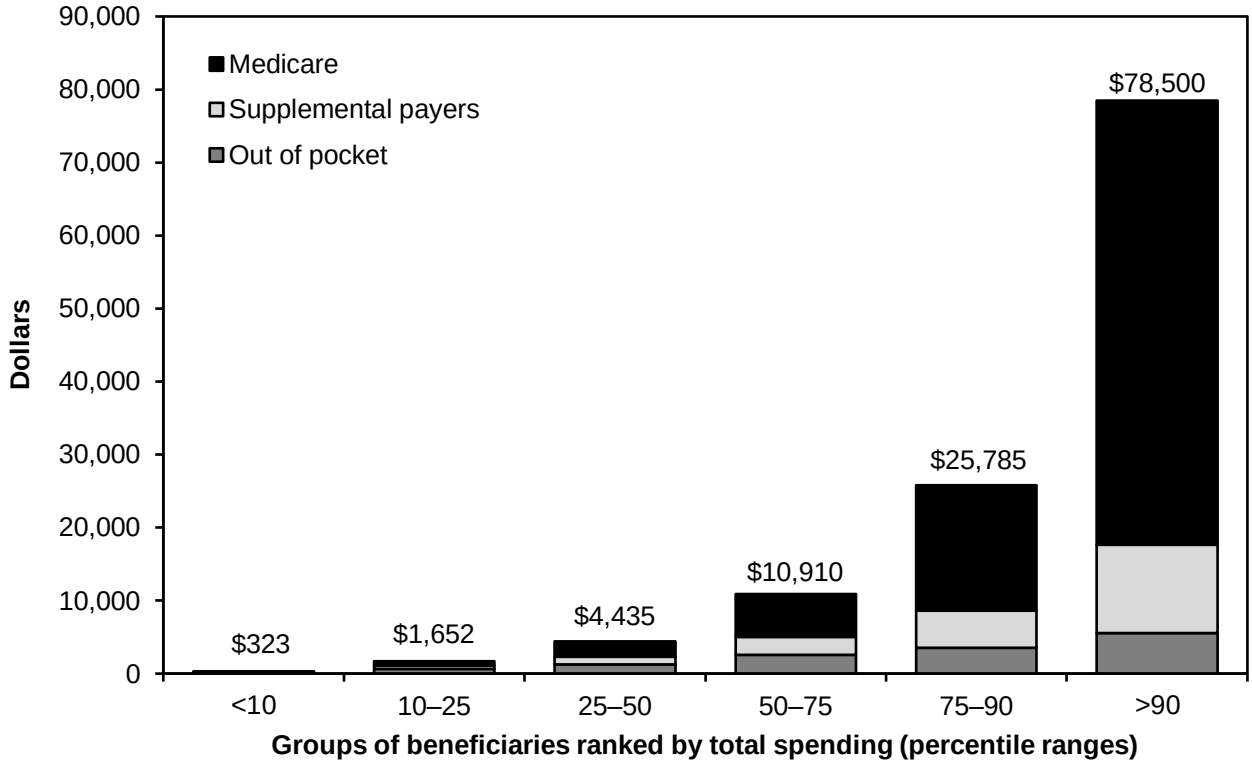
- Among FFS beneficiaries living in the community (noninstitutionalized), the total cost of health care services (beneficiaries' direct spending as well as expenditures by Medicare, other public sector sources, and all private sector sources on all health care goods and services) averaged about $15,800 in 2017. Medicare was the largest source of payment: It paid about 68 percent of the health care costs for FFS beneficiaries living in the community, an average of $10,755 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 $2,087 per beneficiary.

- Beneficiaries paid about 14 percent of their health care costs out of pocket, an average of $2,163 per beneficiary.

- Public sources of supplemental coverage—primarily Medicaid—paid about 5 percent of beneficiaries' health care costs, an average of $846 per beneficiary.

Chart 3-5. Per capita total spending on health care services among noninstitutionalized FFS beneficiaries, by source of payment, 2017



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, 2017.

- Total spending on health care services varied dramatically among FFS beneficiaries living in the community in 2017. Per capita spending for the 10 percent of beneficiaries with the highest total spending averaged $78,500. Per capita spending for the 10 percent of beneficiaries with the lowest total spending averaged $323.

- 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 68 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 7 percent of total spending for the 10 percent of beneficiaries with the highest total spending (data not shown).