APPENDIX B

Beneficiaries' financial resources and liability for health care costs

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As part of its mandate, MedPAC is charged with monitoring Medicare beneficiaries' access to care. Access to care has many dimensions. The extent of health insurance is an important one. Health insurance enables access to care by reducing cost to patients at the point of service. Medicare beneficiaries all have health insurance, but the Medicare benefit package does not cover all services and, like most forms of insurance, requires cost sharing for most of the services it covers.

Many Medicare beneficiaries obtain supplemental coverage to pay for Medicare cost sharing and services Medicare does not cover. Different forms of supplemental coverage are not equally comprehensive, and some require premiums. Medicaid coverage is the most comprehensive and does not require payment of a premium (see discussion of dual eligibles in Chapter 3). Coverage offered to retirees by previous employers and unions (called employer-sponsored insurance or ESI) and coverage offered by Medicare managed care plans has typically been relatively comprehensive and available at relatively modest premiums—but this varies greatly by ESI plan or Medicare managed care plan. Medigap, a common form of supplemental coverage, provides virtually complete coverage of cost sharing for Medicare-covered services, but very limited coverage of other health services.

This appendix provides an overview of the relationship between Medicare beneficiaries' out-of-pocket spending (defined as the sum of beneficiaries' payments for premiums, cost sharing for covered services, and spending on noncovered services) and their financial resources. If we find that some beneficiaries have very high out-of-pocket spending relative to resources, this might raise some concerns about whether these beneficiaries have sufficient protection from their Medicare coverage and whether access to care may be a problem for them.

MedPAC analysis of access to care has found that beneficiaries with the most comprehensive types of supplemental coverage tend to report the best access to care. Further, those beneficiaries without supplemental coverage are the most likely to report delaying services that they believed they needed due to cost (MedPAC 2004).

The relationships among financial resources, out-of-pocket spending, and supplemental coverage are complex. For example, Medicare beneficiaries' supplemental coverage tends to vary with characteristics such as age and sex (MedPAC 2004), which are in turn related to resources (Aizcorbe et al. 2003). Further, beneficiaries with the most comprehensive coverage tend to use more health care services (Atherly 2001).

Measuring the relationship of out-of-pocket spending to financial resources

The analysis presented in the following pages compares beneficiaries' out-of-pocket spending to their financial resources for different groups and over time. The data are

for 2001 and earlier, so they do not reflect the changes to benefit design under Medicare or supplemental coverage that were required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). These changes, particularly coverage of drugs under a new Part D, should reduce overall out-of-pocket spending among beneficiaries.

Much of our analysis uses the Medicare Current Beneficiary Survey (MCBS). When using the MCBS, we exclude beneficiaries in Medicare managed care plans and those living in institutions. Excluding beneficiaries in managed care plans results in a more accurate portrayal of out-of-pocket spending because their health care expenditures tend to be underreported relative to beneficiaries in traditional Medicare. We exclude institutionalized beneficiaries because the MCBS does not have data on the premiums they paid for supplemental coverage, and data on their prescription drug expenditures are unreliable.

Out-of-pocket spending

Out-of-pocket spending is the sum of beneficiaries' own spending on:

- cost sharing for services covered by Medicare,
- services not covered by Medicare,
- the premium for Part B Medicare, and
- premiums for any insurance that supplements Medicare.

A MedPAC analysis of 2000 data found that among noninstitutionalized beneficiaries in traditional Medicare, 40 percent of out-of-pocket spending was for noncovered services, 31 percent was for supplemental premiums, 17 percent was for Part B premiums, and the remainder—12 percent—was for cost sharing on Medicare services (MedPAC 2003a). Of the out-of-pocket spending on services (covered and noncovered), prescription drugs had the largest share, comprising 18 percent of total out-of-pocket spending.

Resources

For this analysis we generally compare beneficiaries' out-of-pocket spending to their income, although we provide some information on overall assets. We cannot use asset information in our analyses of out-of-pocket spending because available data sources do not permit this comparison.

However, assets are a vital part of beneficiaries' financial circumstances. Therefore, we analyze beneficiaries' assets in the first figure in this appendix, before analyzing financial liability. If we were able to include assets as well as income in our analysis, we would show lower shares of resources going to out-of-pocket spending.

Measuring financial liability

We estimate beneficiaries' financial liability (out-of-pocket spending relative to income) using two related but distinct measures. The first takes out-of-pocket spending as a share of income. The second calculates how much income remains after subtracting out-of-pocket spending (income net of out-of-pocket spending). Making the comparison using the second measure allows us to separate changes over time in the magnitude of growth in the two amounts. It does not always tell the same story as the first measure.

For example, take a person whose income rose from $10,000 to $15,000 over 5 years and whose out-of-pocket spending rose from $1,500 to $2,500 (both in real dollars). Using the first measure, out-of-pocket spending as a share of income, the beneficiary's situation appears to have worsened—it rose from 15 percent to 17 percent. But using the second measure, the beneficiary is better off in the later period, as his income net of out-of-pocket spending has risen from $8,500 to $12,500.

We based both measures of financial liability on beneficiaries' annual income and annual out-of-pocket spending. We used annual data because that is what is available in existing databases. However, for many people, out-of-pocket spending in the year of our analysis is much higher than their out-of-pocket spending in prior and subsequent years. Consequently, data over a much longer period than one year would yield a more accurate picture of a beneficiary's out-of-pocket spending relative to income and less variation in our measures of financial liability.

Data sources

The database we used the most in our analysis is the Cost and Use file of the 2001 MCBS. The MCBS is a beneficiary-level file with data on beneficiaries' income and very detailed information on their expenditures on health care. We are concerned, however, about underreporting of income and beneficiaries' prescription drug expenditures on the MCBS, so we made adjustments to those variables (see text box).

We also used a second database—the Consumer Expenditure Survey (CES)—which includes data on household income, assets, and out-of-pocket spending. However, the assets data are missing for a high proportion of households. Although the CES has poor assets data, it has reliable data on income and out-of-pocket spending over a long time frame. Therefore, we used the CES to analyze the change over time in out-of-pocket spending relative to income among beneficiary households.[1]

Relationship of this to previous work

Several studies analyze beneficiaries' financial liability from out-of-pocket spending on health care services and insurance (Gross et al. 1997, Lee 1998, Maxwell et al. 2001, Maxwell et al. 2000, MedPAC 2000 and 1999, and Moon et al. 1996). The analysis presented here extends the work in those studies along several dimensions, analyzing these issues:

- The variation in financial liability across beneficiaries.
- The change over time in beneficiaries' financial liability from out-of-pocket spending on services and insurance.
- The impact on beneficiaries' financial liability of different supplemental coverage, focusing on reported declines in ESI as a source of supplemental coverage among future retirees.
- The effect of economic and demographic characteristics on beneficiaries' financial liability.

Data and methods

Our analysis uses two databases, the Cost and Use file of the Medicare Current Beneficiary Survey (MCBS) and the Consumer Expenditure Survey (CES). The MCBS includes data on individual beneficiaries, while the CES includes household data. Because of this difference, estimates of the same variable—such as out-of-pocket spending as a share of income—are different between the two databases.

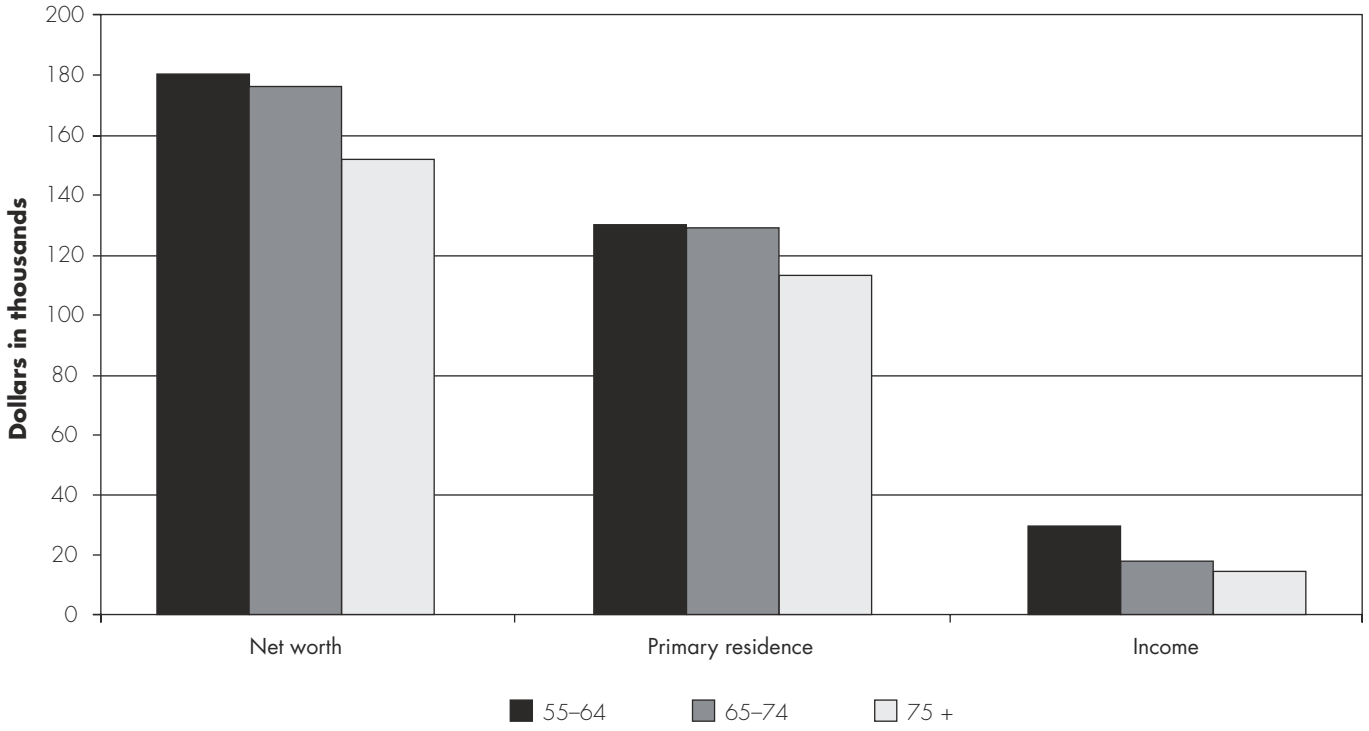
The MCBS also has a general problem of underreporting income and prescription drug expenditures. Working with researchers at the Congressional Budget Office, we adjusted MCBS income amounts on the basis of beneficiaries' age, marital status, and income reported on the MCBS. The intent was to adjust the MCBS income amounts so that in the aggregate they match income amounts on the Current Population Survey (CPS). We caution, however, that the adjusted income amounts still may be too low because the CPS is believed to have underreported income—but to a lesser extent than the MCBS.

We adjusted MCBS prescription drug expenditures using a method developed by a CMS researcher (Poisal 2004). The intent was to adjust MCBS drug expenditures so they match drug expenditures reported by the pharmacies that dispensed the drugs. Adjustments were based on the beneficiaries' reported level of drug expenditures. In general, the adjustment was greater the higher a beneficiary's reported drug expenditures.

An additional issue regarding income is that the MCBS reports income for married beneficiaries as joint income with their spouses. However, health care spending is reported at the individual level. Therefore, when we use MCBS data, we divide each married beneficiary's income by 1.26, the ratio of the poverty line for two-person elderly households to the poverty line for single-person elderly households. ■

FIGURE B-1

Median family net worth, primary residence assets, and income by age of household head, 2001



Note: "Primary residence" includes only families who have equity in a primary residence.

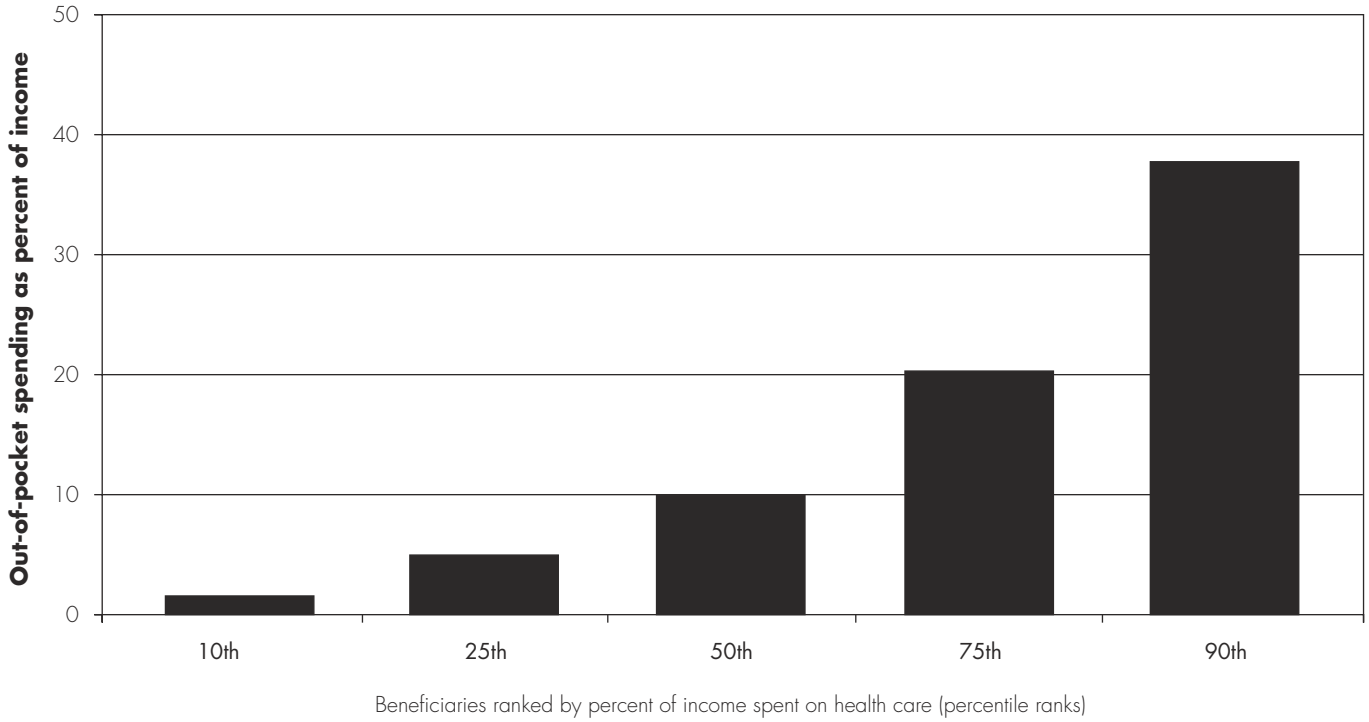
Source: Net worth and primary residence are from the Federal Reserve Board 2001 Survey of Consumer Finances. Income is from the 2001 Consumer Expenditure Survey.

Data from the Survey of Consumer Finances indicate that net worth (assets minus liabilities) tends to be lower among families with older heads of household (Figure B-1). In 2001, the median family with a household head age 65 to 74 had a net worth of $176,000. Median net worth declined to $151,000 for households headed by someone age 75 or older. Much of the wealth held by elderly households is in their primary residence. For example, among households headed by someone age 65 to 74 the median equity in their primary residence was $129,000 in 2001.

We mentioned earlier that shortcomings in the data prevent us from using assets (or net worth) in evaluating beneficiaries' financial liability from health care costs. Instead, we rely strictly on beneficiaries' income. Among families with a household head age 55 or older, income tends to be much lower than net worth. But, a common characteristic of income and net worth is that both tend to be lower among families with older household heads.

FIGURE B-2

Out-of-pocket spending on health care varies widely among beneficiaries, 2001



Note: Sample size is 9,653. Out-of-pocket spending includes out-of-pocket spending on services, the Part B premium, and premiums for supplemental insurance. Analysis is only beneficiaries living in the community who are not enrolled in a Medicare managed care plan.

Source: MedPAC analysis of Cost and Use file, 2001 Medicare Current Beneficiary Survey.

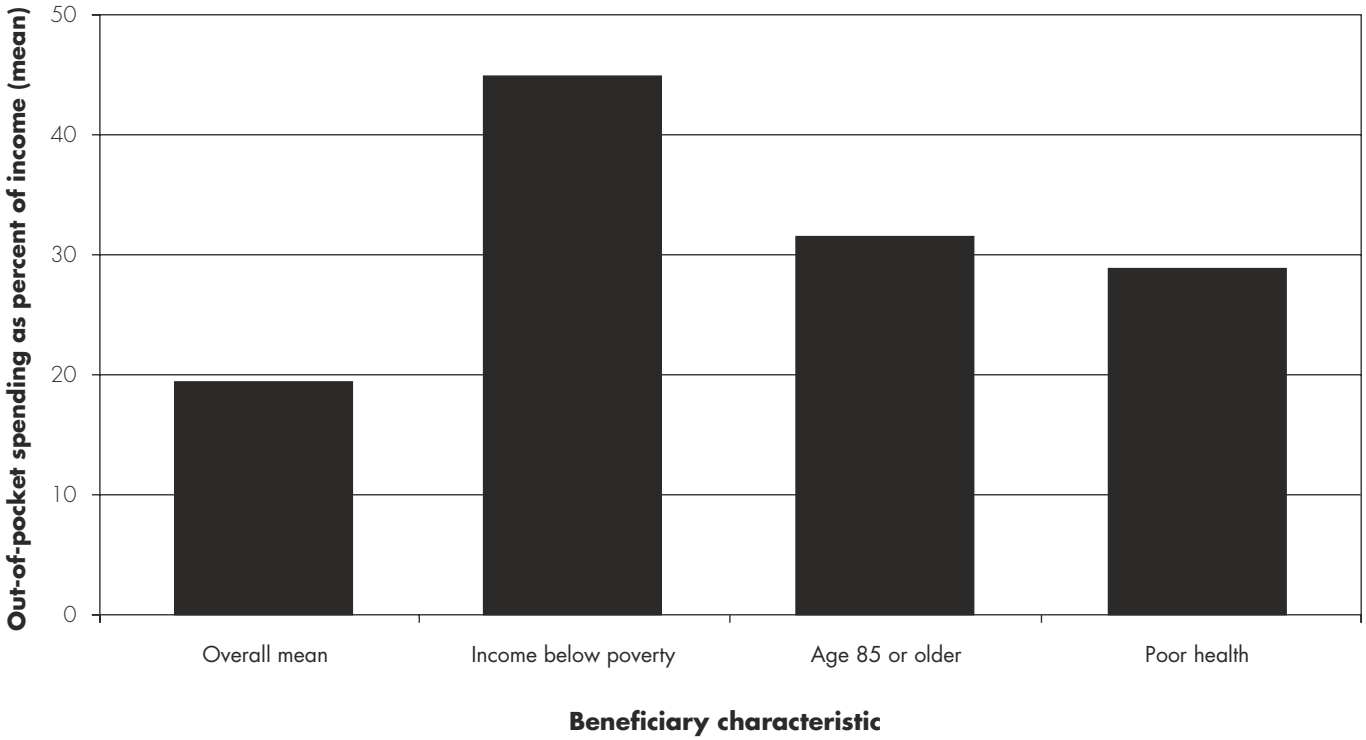
Financial liability from out-of-pocket spending varies widely among beneficiaries (Figure B-2). In 2001, out-of-pocket spending was 10 percent of income for the median (middle) beneficiary. Also, it was 2 percent of income for the beneficiary at the 10th percentile and 37 percent of income for the beneficiary at the 90th percentile.

Financial liability from out-of-pocket spending is also likely to vary widely on a geographic basis. MedPAC analysis indicates wide variation across states and regions in the amount of health care services beneficiaries use (MedPAC 2001, 2003b). It is likely that beneficiaries in the states and regions with the highest service use per beneficiary also tend to have relatively high out-of-pocket spending and financial liability.

Because of the wide variation in financial liability, it is difficult to pinpoint the financial liability faced by the "typical" beneficiary. Many researchers have used the mean of out-of-pocket spending as a share of income. We estimated a mean of 20 percent, but it may not provide a meaningful representation of the typical beneficiary. The mean of 20 percent is twice as large as the median value of 10 percent. Moreover, nearly three-fourths of beneficiaries spend less than 20 percent of their income on health care.

FIGURE B-3

Out-of-pocket spending as a percentage of income is higher for certain beneficiaries, 2001



Note: Sample size is 9,653. Out-of-pocket spending includes out-of-pocket spending on services, the Part B premium, and premiums for supplemental insurance. Analysis is only beneficiaries living in the community who are not enrolled in a Medicare managed care plan.

Source: MedPAC analysis of Cost and Use file, 2001 Medicare Current Beneficiary Survey.

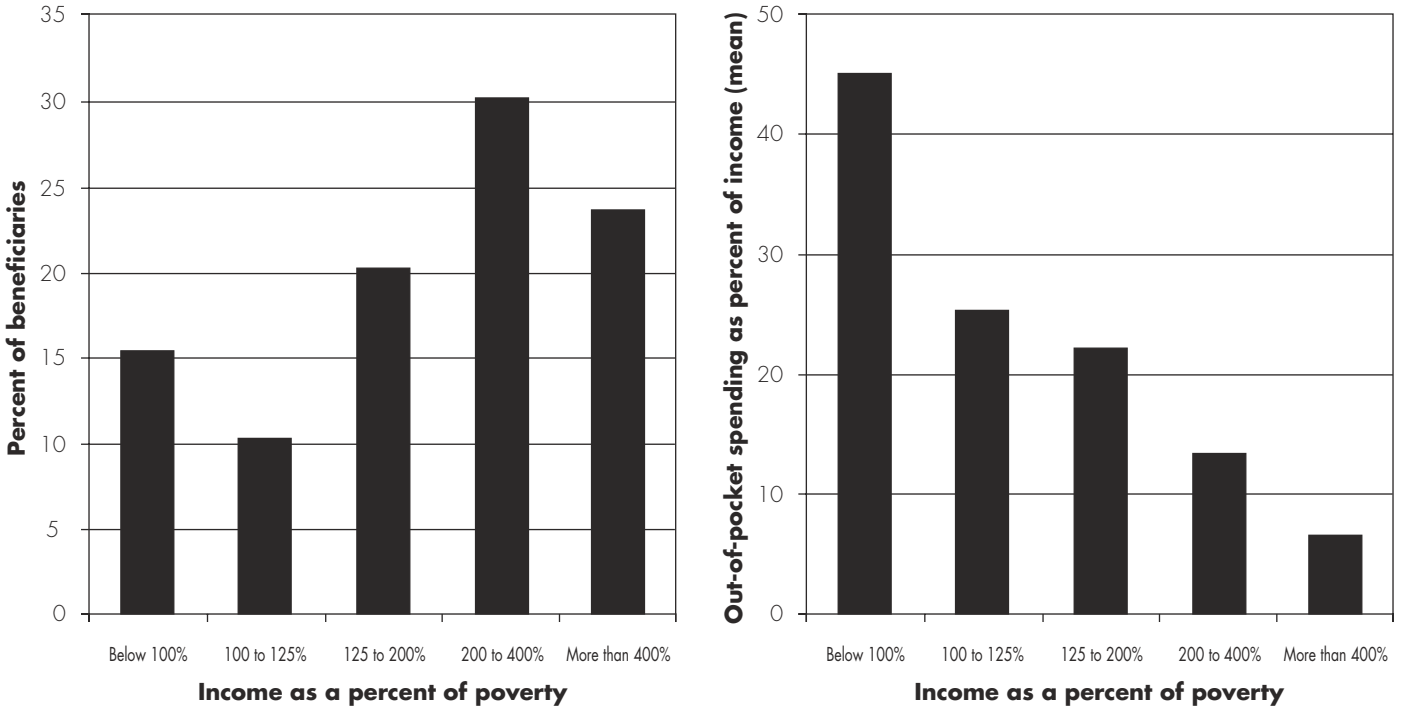
Our analysis of MCBS data indicates higher out-of-pocket spending as a share of income tends to be associated with certain characteristics (Figure B-3). These characteristics include:

- income below poverty
- age 85 or older
- poor health status

In addition, other research shows that rural-dwelling beneficiaries spend a larger share of income on health care than their urban counterparts (Caplan and Brangan 2004).

FIGURE B-4

Out-of-pocket spending as a percentage of income is substantially higher for low-income beneficiaries, 2001



Note: Sample size is 9,653. In 2001, the poverty level for people age 65 or older was $10,715 for married couples and $8,494 for people living alone. Out-of-pocket spending includes out-of-pocket spending on services, the Part B premium, and premiums for supplemental insurance. Analysis is only beneficiaries living in the community who are not enrolled in a Medicare managed care plan.

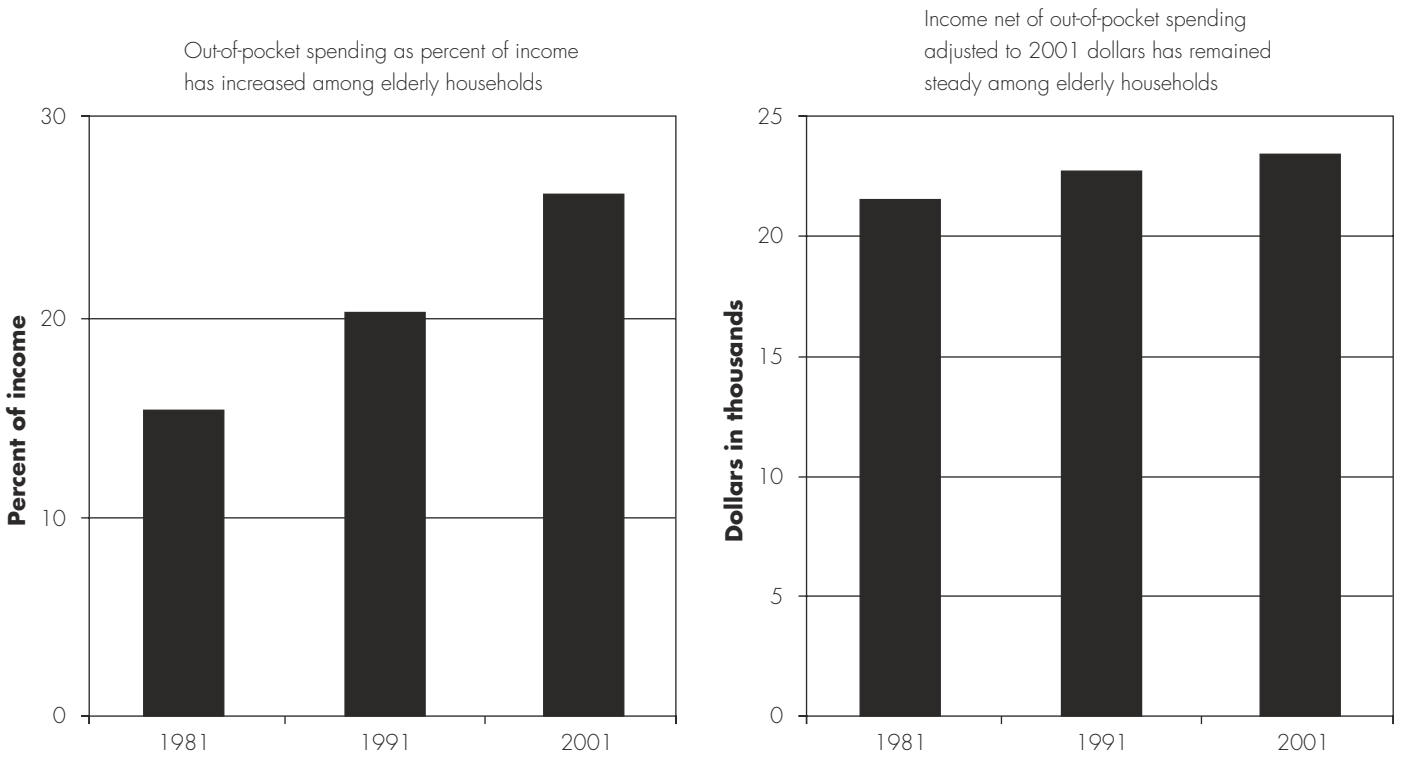
Source: MedPAC analysis of Cost and Use file, 2001 Medicare Current Beneficiary Survey.

Fifteen percent of beneficiaries report income below the poverty line.[2] An additional 10 percent report income between 100 and 125 percent of the poverty line. Among these lower-income beneficiaries, out-of-pocket spending as a share of income is high relative to higher-income beneficiaries (Figure B-4).

Out-of-pocket spending as a share of income averaged 45 percent among beneficiaries with income below the poverty line. In contrast, it averaged only 7 percent among beneficiaries with income greater than 400 percent of the poverty line.

FIGURE B-5

Financial liability due to health care spending among households with elderly members, 1981–2001



Note: Sample size is 3,734 in 1981; 4,543 in 1991; and 6,429 in 2001. Out-of-pocket spending includes out-of-pocket spending on services, the Part B premium, and premiums for supplemental insurance. Analysis is only households with at least one person age 65 or older.

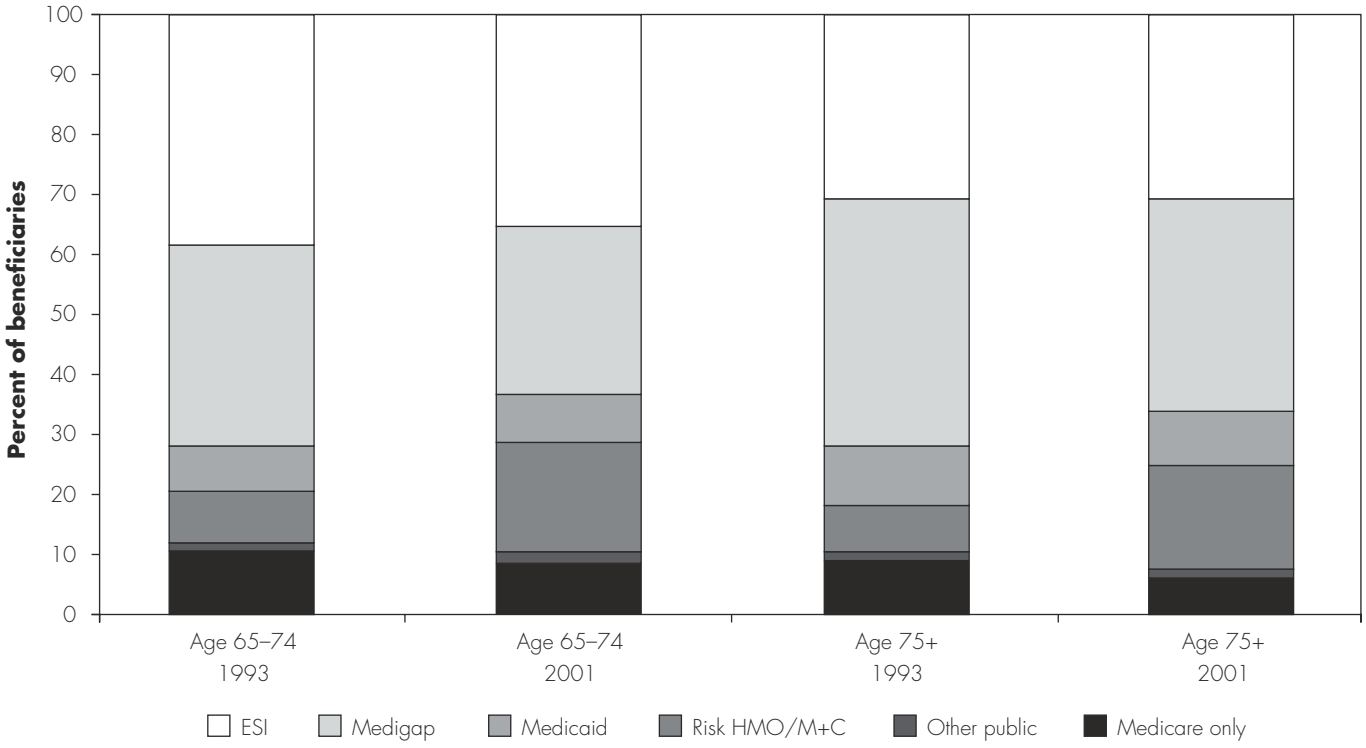
Source: MedPAC analysis of 1981, 1991, and 2001 Consumer Expenditure Survey.

Is beneficiaries' financial liability getting better or worse? Our analysis of the Current Expenditure Survey produced mixed results; the answer depends on the measure (Figure B-5). On the one hand, from 1981 to 2001, out-of-pocket spending as a share of income increased substantially among elderly households (those with at least one member age 65 or older). This result reflects out-of-pocket spending increasing at a faster rate than income. From 1981 to 2001, average income among elderly households increased by 13 percent in real terms, while out-of-pocket spending increased in real terms by 58 percent. We adjusted all dollar amounts to 2001 levels using the consumer price index.

On the other hand, an alternative measure of financial liability—income net of out-of-pocket spending—presents a different picture. After adjusting dollars to 2001 levels, the average income net of out-of-pocket spending among elderly households stayed nearly constant from 1981 to 2001, increasing by 8.8 percent (0.4 percent per year). This reflects the fact that income increased by a larger magnitude than out-of-pocket spending, even though income increased by a smaller percentage.

FIGURE B-6

Employer-sponsored insurance has declined as a source of supplemental coverage among younger beneficiaries



Note: Sample size is 4,223 for age 65–74 in 1993; 4,379 for age 65–74 in 2001; 4,962 for age 75+ in 1993; 5,256 for age 75+ in 2001. ESI (employer-sponsored insurance), M+C (Medicare+Choice). Analysis is of beneficiaries living in the community only.

Source: MedPAC analysis of Cost and Use files, 1993 and 2001 Medicare Current Beneficiary Survey.

Medicare requires beneficiary cost sharing in the form of deductibles, coinsurance, and other mechanisms, and does not cover some services. In addition, Medicare does not have an annual limit on beneficiaries' out-of-pocket spending. In response, most beneficiaries have supplemental insurance. The most common type of supplemental insurance is employer-sponsored insurance (ESI) through previous unions or employers, held by 33 percent of beneficiaries in 2001.

ESI is, in general, the most comprehensive supplemental insurance in the private sector. In addition to providing coverage of Medicare deductibles, coinsurance, and catastrophic costs, many employer-sponsored plans are designed to wrap around Medicare, covering deductibles and coinsurance for covered services and additional services not covered by Medicare, leaving beneficiaries with significantly less out-of-pocket spending than they would otherwise have.

Although it has been the most prevalent source of supplemental coverage, the availability of ESI has started to decline. Among beneficiaries age 65 to 74, the percentage with ESI had a small decline from 1993 to 2001 (Figure B-6). This result, however, hides the magnitude of the downward trend in availability of ESI. Between 1988 and 2003, the number of employers with more than 200 employees offering ESI fell from 66 percent to 38 percent (KFF and HRET 2003). In many instances, these changes affected new hires rather than those already in the workforce, so the impact of the reductions will affect future retirees much more than current beneficiaries.

TABLE B-1

Many large firms have eliminated health benefits for future retirees, and many more plan the same change

	Percent of large firms	
	2001–2002	2003
Eliminated health benefits for future retirees	13%	10%
Somewhat likely to eliminate health benefits for future retirees over next 3 years	22	20

Note: Large firms have at least 1,000 employees.

Source: Kaiser Family Foundation and Hewitt Associates, 2004 and 2002.

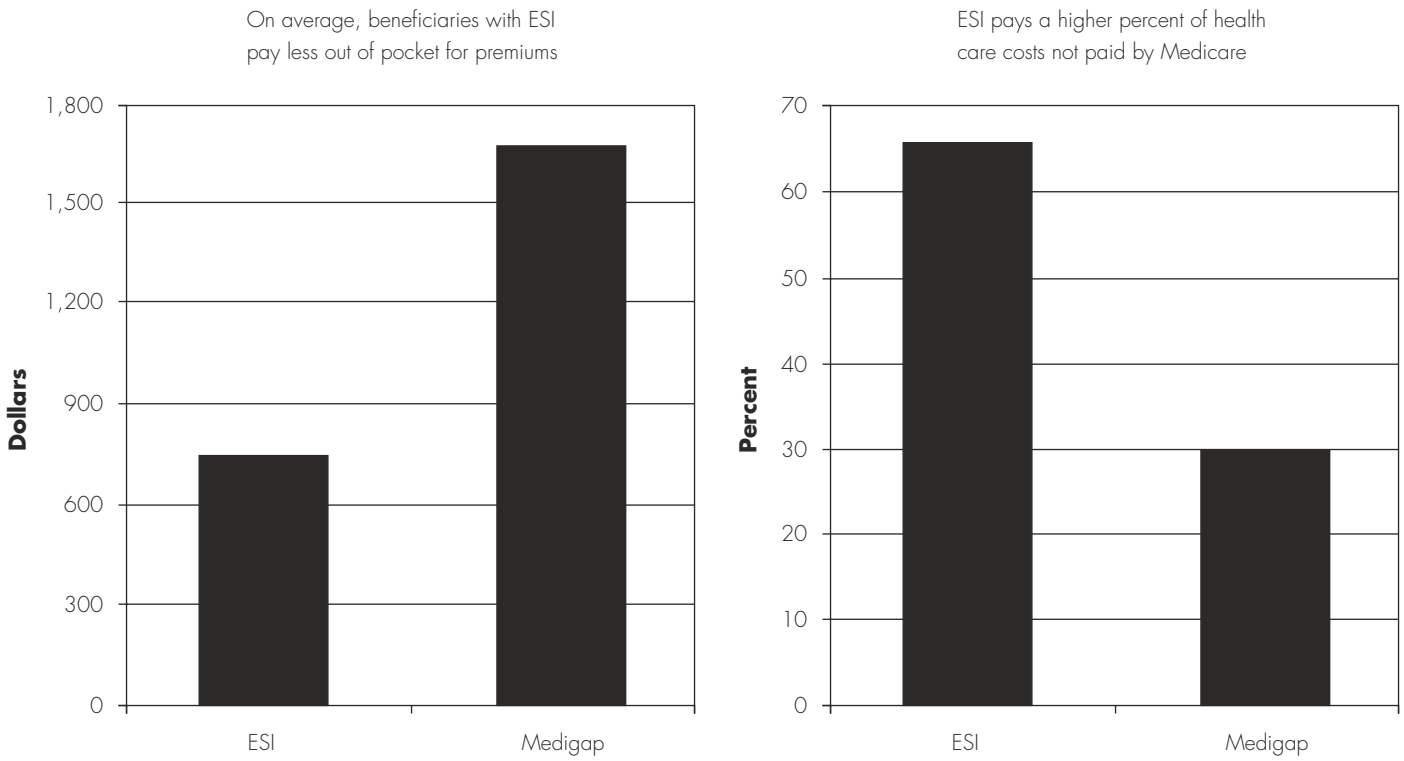
The decline in the availability of ESI coverage for future retirees is evident in recent surveys of large firms (with more than 1,000 employees). Over the 2001–2002 period, 13 percent of large firms eliminated subsidized health benefits for future retirees (Table B-1). In 2003, an additional 10 percent of large firms eliminated such coverage. Moreover, about 20 percent of large firms in recent years said they are at least somewhat likely over the next three years to eliminate subsidized health benefits for future retirees (KFF and Hewitt Associates 2004 and 2002).

In addition to firms terminating health benefits for future retirees, many have recently required retirees to pay 100 percent of the premium for ESI coverage. Over the 2001–2002 period, 14 percent of large firms made this change, and an additional 11 percent made the change in 2003. Also, 26 percent of large firms said they are somewhat likely to implement this policy over the next three years.

Finally, the Equal Employment Opportunity Commission recently voted to allow employers to offer health benefits to retirees under age 65 but reduce or eliminate benefits to retirees age 65 or older. Currently, employers have to offer the same coverage to all retirees. If the vote is allowed to stand, its effect on the prevalence of ESI among beneficiaries is unclear. Some employers may continue to offer ESI to 65 and older retirees that is less generous than the coverage for under-65 retirees. Alternatively, employers may eliminate altogether ESI coverage for 65 and older retirees (Pear 2004).

FIGURE B-7

Employer-sponsored insurance has lower beneficiary premiums and is more generous than Medigap



Note: ESI (employer-sponsored insurance). Sample size is 3,509 for ESI; 3,279 for Medigap. Analysis is only beneficiaries living in the community who are enrolled in ESI or Medigap plans.

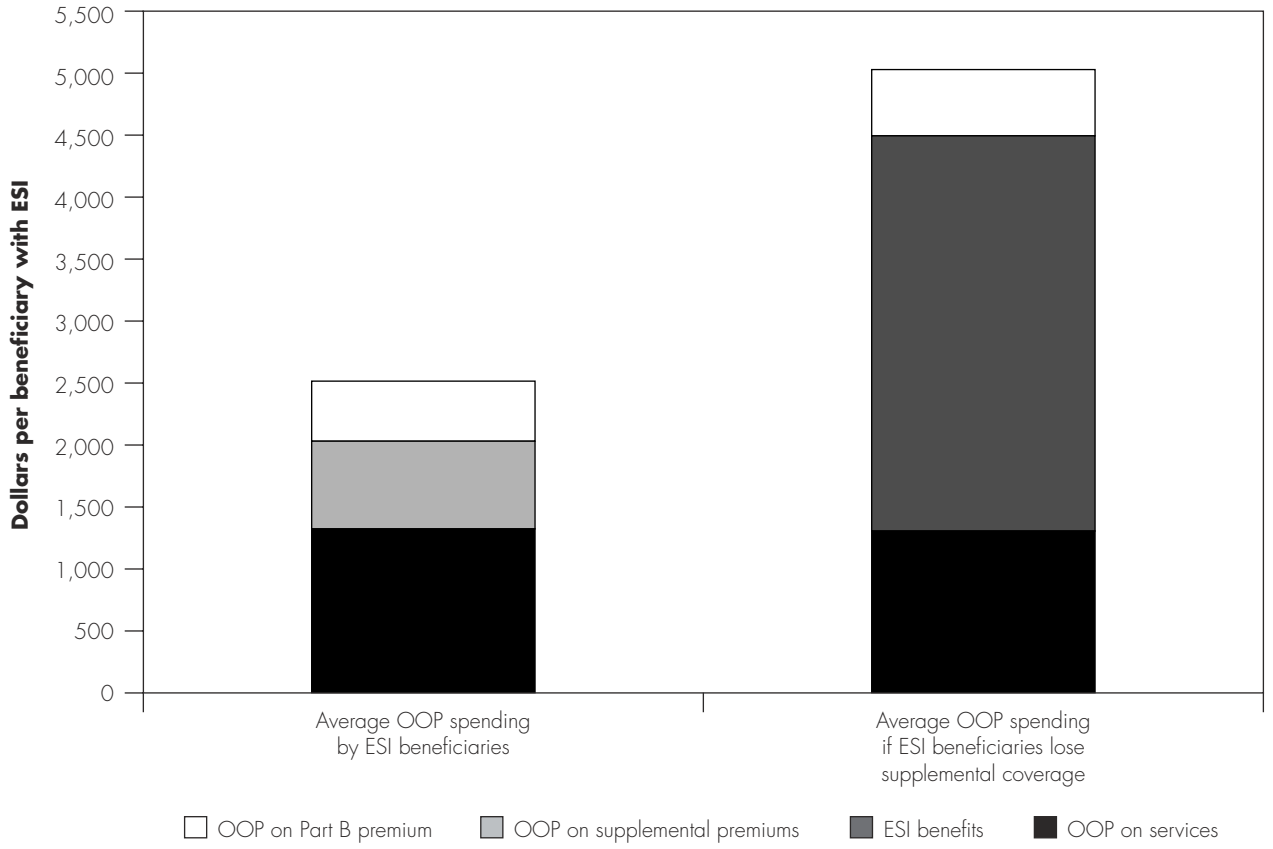
Source: MedPAC analysis of Cost and Use file, 2001 Medicare Current Beneficiary Survey.

To the extent that the prevalence of ESI is declining, beneficiaries' out-of-pocket spending will likely increase, which could adversely affect access to care. One option for the future retirees whose firms have dropped their ESI coverage is to purchase a Medigap plan in the individual market.

On average, beneficiaries with ESI pay less out of pocket for premiums than beneficiaries with Medigap (Figure B-7). Also, ESI tends to be more generous. For beneficiaries with ESI, supplemental insurance pays 65 percent of the costs not paid by Medicare, while Medigap pays 30 percent of costs not paid by Medicare. As a result, the future retirees whose firms have dropped their ESI coverage may pay more out of pocket for services and premiums if they obtain a Medigap plan. A recent study indicates that beneficiaries with Medigap need to save much more than do beneficiaries with ESI to pay for all health care costs in retirement (Fronstin and Salisbury 2003).

FIGURE B-8

Out-of-pocket spending for beneficiaries with ESI would be higher if they had no supplemental insurance and did not change service use



Note: ESI (employer-sponsored insurance), OOP (out-of-pocket). Sample size is 3,509. Analysis is only beneficiaries living in the community who are enrolled in ESI plans.

Source: MedPAC analysis of Cost and Use file, 2001 Medicare Current Beneficiary Survey.

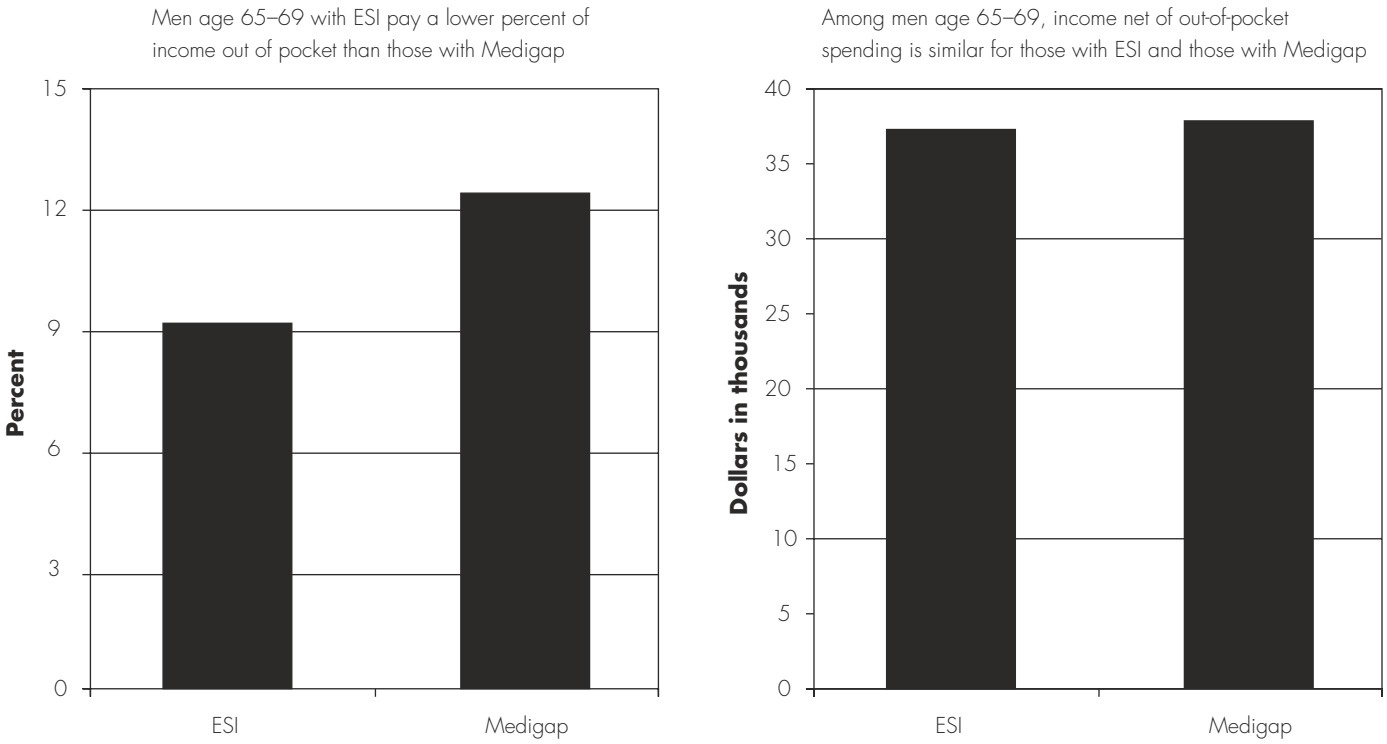
For future retirees whose firms have dropped ESI coverage, another option is to go without any supplemental insurance in traditional Medicare (Medicare only). Their out-of-pocket spending could be much higher under Medicare-only coverage than under ESI. In Figure B-8, the column on the left shows average out-of-pocket spending by ESI beneficiaries, and the column on the right shows average out-of-pocket spending if all ESI beneficiaries became Medicare only and did not change their service use.

In 2001, ESI beneficiaries averaged $2,567 in out-of-pocket spending—$1,319 on services, $734 on supplemental premiums, and $514 on Part B premiums. If these beneficiaries did not have any supplemental insurance, they would not pay any supplemental premiums, but they would still pay out of pocket for services and Part B premiums. In addition, they would have to pay out of pocket for the $3,221 in benefits they currently receive from their ESI.[3] On net, they would face an additional $2,487 in out-of-pocket spending.

Having Medicare-only coverage in lieu of ESI would likely induce beneficiaries to reduce their use of services in response to their exposure to the cost sharing, which would reduce the impact on their out-of-pocket spending. However, in all cases beneficiaries would have a greater likelihood of catastrophic losses from health care expenses. If a beneficiary has out-of-pocket spending that is high relative to their income, they may qualify for Medicaid as "medically needy."

FIGURE B-9

Among male beneficiaries, financial liability varies by supplemental insurance



Note: ESI (employer-sponsored insurance). Sample size is 365 for ESI; 227 for Medigap. Analysis is only beneficiaries living in the community who are enrolled in ESI or Medigap plans.

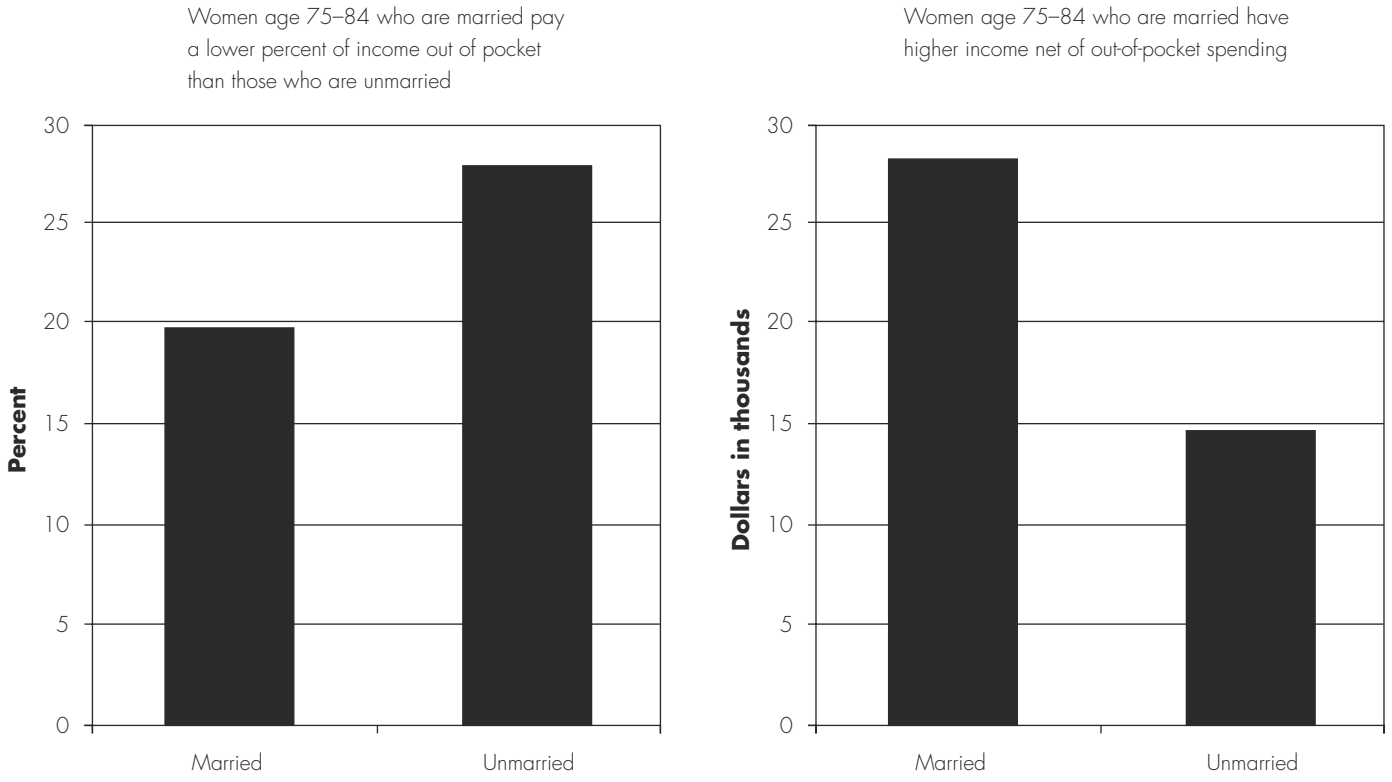
Source: MedPAC analysis of Cost and Use file, 2001 Medicare Current Beneficiary Survey.

Our analysis has focused on the "big picture," examining financial liability of broad Medicare populations. Over the next five pages, we narrow our focus and look at the financial liability of some "typical" beneficiaries. Our purpose is to investigate how demographic characteristics affect beneficiaries' financial liability. Specifically, we examine the significance of age, marital status, gender, and supplemental insurance on financial liability.

Figure B-9 compares financial liability under ESI and Medigap for men age 65 to 69. The diagrams show how financial liability differs in this age cohort between those with ESI and those with Medigap. On average, out-of-pocket spending as a percentage of income is lower among those with ESI. But, because we find that 65- to 69-year-old men with ESI have lower average incomes, income net of out-of-pocket spending is nearly equal for those with ESI and those with Medigap.[4]

FIGURE B-10

Among female beneficiaries, financial liability varies by marital status



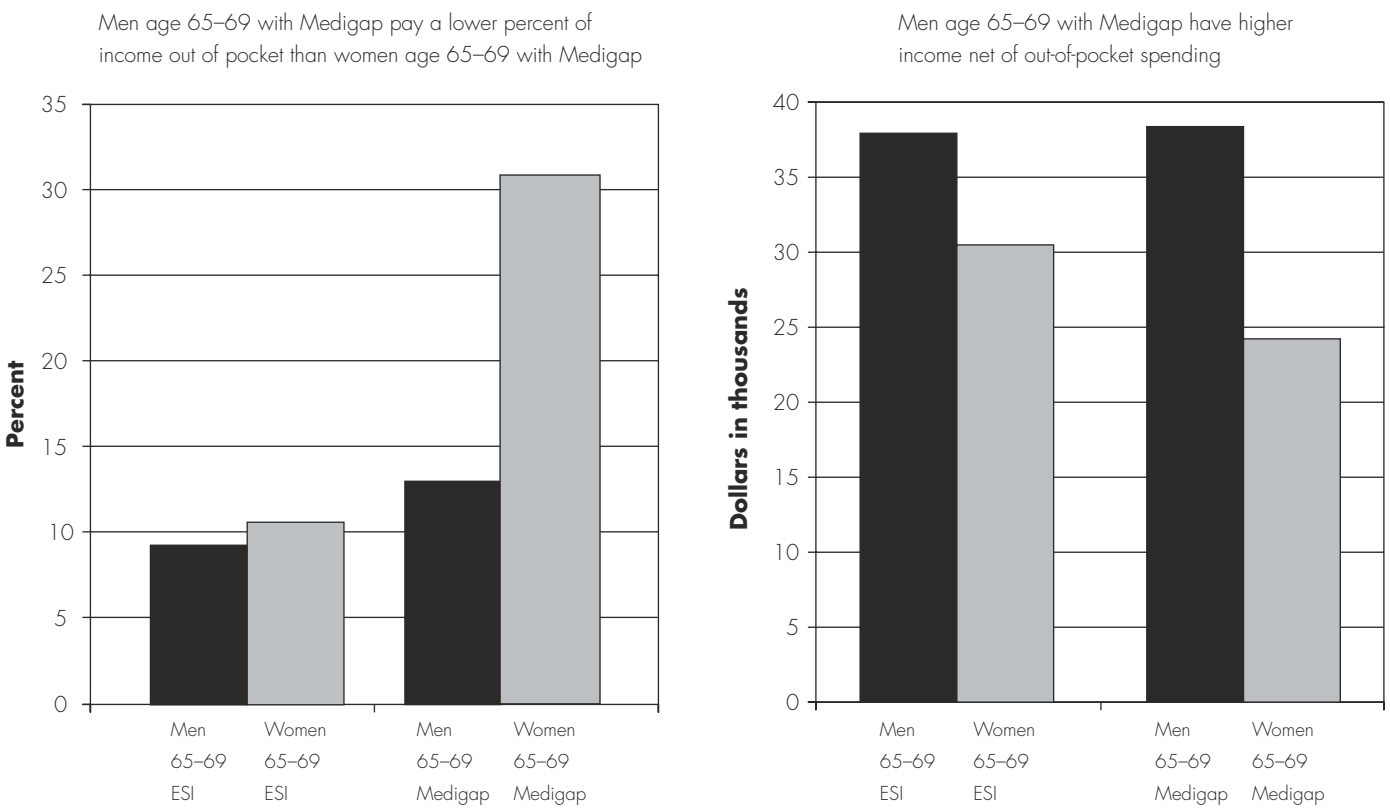
Note: Sample size is 632 for married; 1,173 for unmarried. Analysis is only beneficiaries living in the community who are women age 75–84 and are not enrolled in a Medicare managed care plan.

Source: MedPAC analysis of Cost and Use file, 2001 Medicare Current Beneficiary Survey.

Within the cohort of women age 75 to 84, financial liability is much different for those who are married than for those who are not (Figure B-10). On average, out-of-pocket spending is 20 percent of income among married women age 75 to 84 and 28 percent of income among those who are not married. Also, the average income net of out-of-pocket spending is $28,000 among the married women and just under $15,000 among the unmarried women. The lower liability faced by the married women reflects their substantially higher income, not lower out-of-pocket spending.

FIGURE B-11

Among beneficiaries, financial liability varies by sex



Note: ESI (employer-sponsored insurance). Sample size is 365 for men age 65–69 with ESI; 382 for women age 65–69 with ESI; 227 for men age 65–69 with Medigap; 288 for women age 65–69 with Medigap. Analysis is only beneficiaries living in the community who are age 65–69 and enrolled in either ESI or Medigap plans.

Source: MedPAC analysis of Cost and Use file, 2001 Medicare Current Beneficiary Survey.

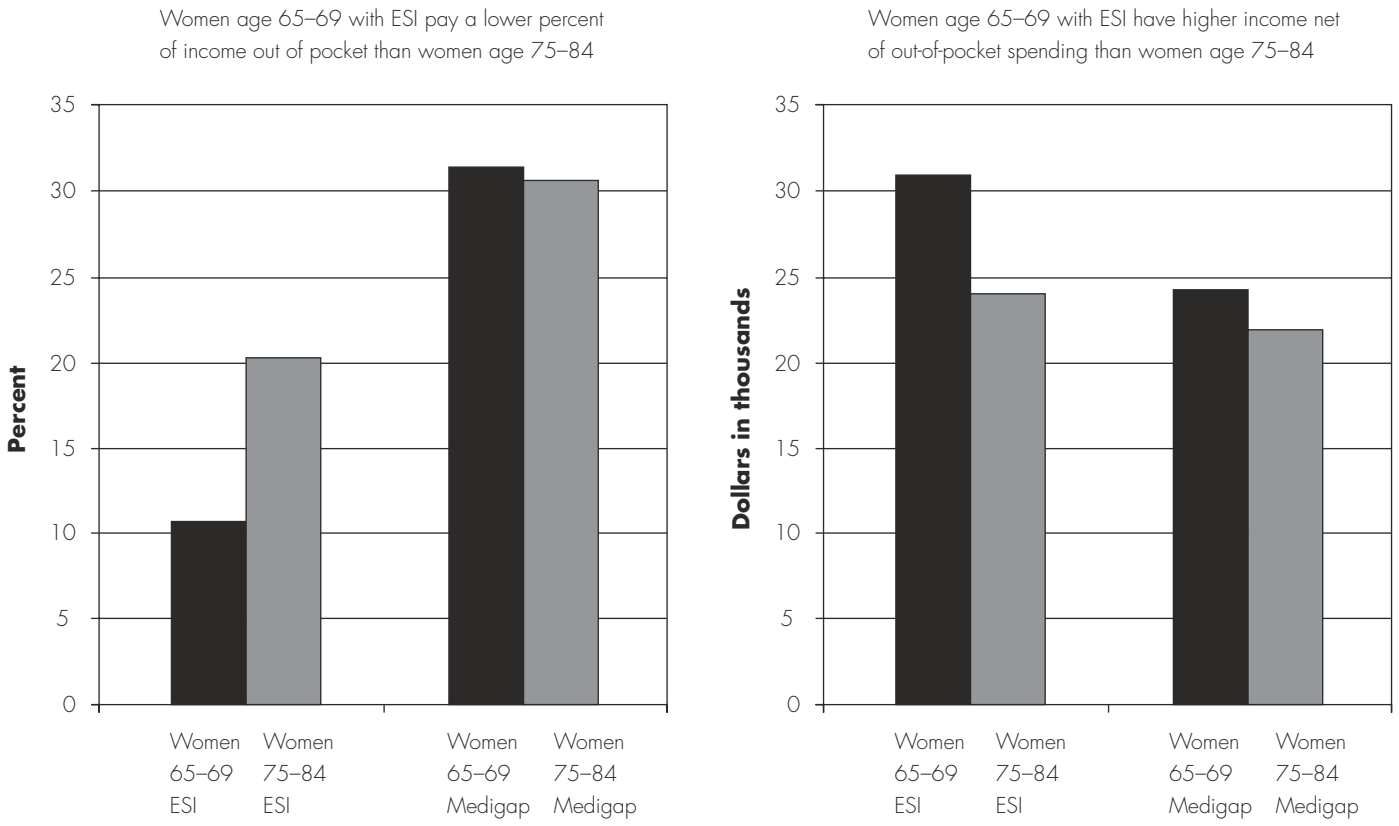
We examined the effects of gender on financial liability by comparing men and women age 65 to 69. The analysis controls for supplemental insurance status because of its strong effect on financial liability.

The data show that for those with ESI, financial liability may be different for women than men (Figure B-11). On the one hand, out-of-pocket spending as a share of income is similar (9 percent for men versus 11 percent for women). On the other hand, income net of out-of-pocket spending appears to be higher among the men ($37,600 versus $31,300), even though the difference is not statistically significant.

The difference in financial liability between men and women age 65 to 69 is quite large for those with Medigap, where exposure to the cost of noncovered services and premiums is greater. Out-of-pocket spending as a share of income is much higher among the women—31 percent versus 13 percent—and income net of out-of-pocket spending is much lower—$23,900 versus $38,200. The greater financial liability faced by the women reflects lower average income relative to the men.

FIGURE B-12

Among female beneficiaries, financial liability varies by age



Note: ESI (employer-sponsored insurance). Sample size is 382 for women age 65–69 with ESI; 607 for women age 75–84 with ESI; 288 for women age 65–69 with Medigap; 829 for women age 75–84 with Medigap. Analysis is only beneficiaries living in the community who are women and enrolled in either ESI or Medigap plans.

Source: MedPAC analysis of Cost and Use file, 2001 Medicare Current Beneficiary Survey.

We examined the effect of age on financial liability by comparing women age 65 to 69 to women age 75 to 84. We again control for supplemental insurance.

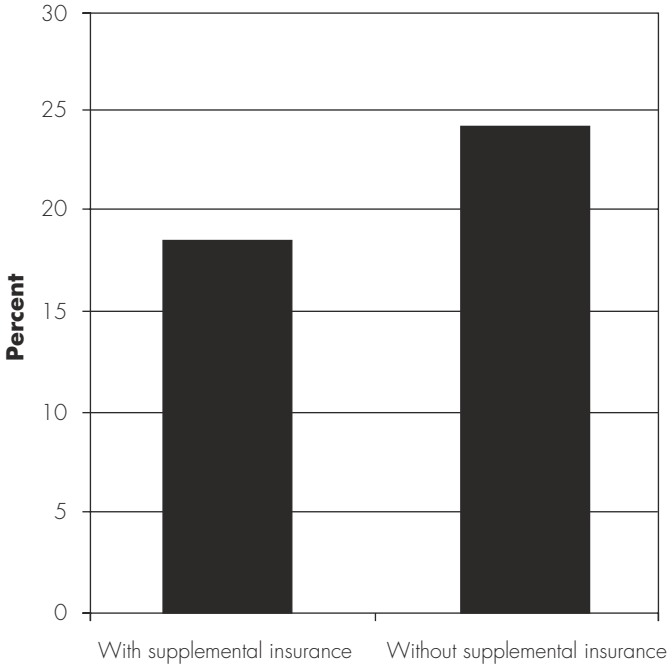
Among beneficiaries with ESI, financial liability increases with age (Figure B-12). Out-of-pocket spending as a share of income is lower among the younger cohort, 11 percent versus 20 percent. In addition, the women age 65 to 69 had higher income net of out-of-pocket spending, $31,300 versus $23,800. These results reflect higher income and lower out-of-pocket spending among the younger women.

Among beneficiaries with Medigap, the impact of age is much smaller. The average of out-of-pocket spending as a share of income is about 31 percent for both age groups, and income net of out-of-pocket spending is similar: $23,900 for the younger women and $21,400 for the older women. We see similar financial liability for these populations because income is only slightly higher among the younger women.

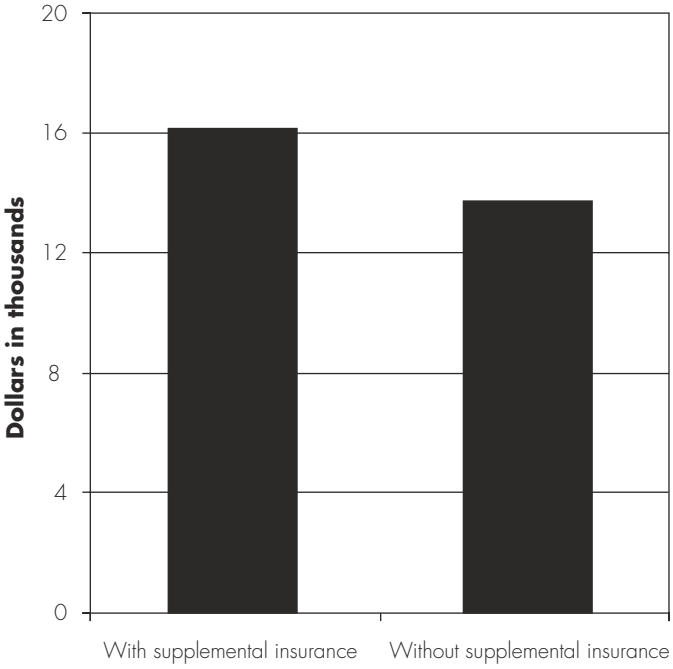
FIGURE B-13

Among disabled beneficiaries, financial liability varies by presence of supplemental insurance

Out-of-pocket spending as percent of income appears to be lower for the disabled with supplemental insurance, but the difference is not statistically significant



Disabled beneficiaries who have supplemental insurance have higher income net of out-of-pocket spending



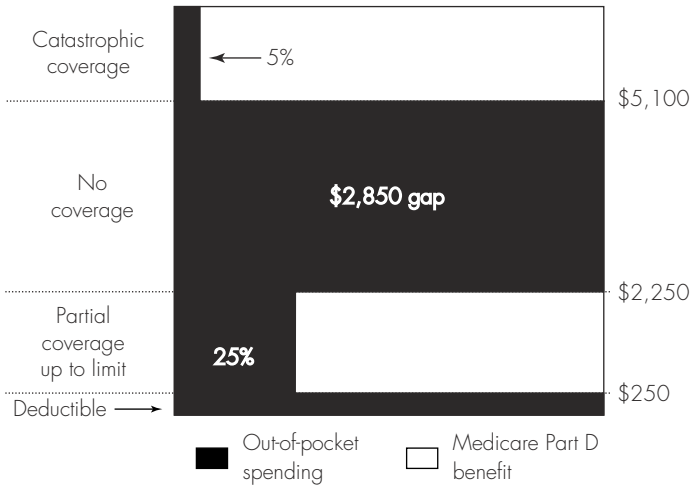
Note: Sample size is 1,461 for disabled with supplemental insurance; 357 for disabled without supplemental insurance. Analysis is only disabled beneficiaries living in the community who are not enrolled in a Medicare managed care plan.

Source: MedPAC analysis of Cost and Use file, 2001 Medicare Current Beneficiary Survey.

A serious issue for beneficiaries eligible for Medicare due to disability (those under age 65) is that a high share, 19 percent, lack supplemental insurance. We compared the disabled beneficiaries with only traditional Medicare coverage to those who have supplemental insurance (Figure B-13).

Those without supplemental coverage appear to have greater financial liability. They have $13,400 of income net of out-of-pocket spending, while those with supplemental insurance have $16,200. About 77 percent of this difference is due to higher income among those with supplemental coverage, and the remaining 23 percent is due to their lower out-of-pocket spending. Out-of-pocket spending as a share of income appears to be higher among the disabled without supplemental insurance, even though the difference is not statistically significant.

FIGURE B-14 **Standard Medicare drug benefit, 2006**



Note: In 2006, the standard drug benefit will have a deductible of $250. For drug expenditures above $250, beneficiaries face a coinsurance rate of 25 percent, until reaching a coverage limit of $2,250. If the program and the beneficiary have combined drug spending over $2,250, the beneficiary is solely responsible for the next $2,850 in drug spending, until reaching the catastrophic limit of $5,100. At $5,100 in total drug spending, beneficiaries will have spent $3,600 out of pocket: $250 for the deductible, $500 for the 25 percent coinsurance on $2,000, and $2,850 for the "gap."

A prominent feature of the MMA is a prescription drug benefit beginning in 2006. Overall, the drug benefit will reduce beneficiaries' out-of-pocket spending. However, the drug benefit has cost sharing for which the beneficiary is responsible (Figure B-14).

The Congressional Budget Office estimates that in 2006 the standard drug benefit for an enrollee with no other form of drug coverage will have an annual premium of $420. The drug benefit also will have a deductible of $250. For drug expenditures above $250, the drug benefit will pay 75 percent of expenditures, and the beneficiary will face a coinsurance of 25 percent until drug expenditures reach a coverage limit of $2,250. If combined drug spending by a beneficiary and the program exceeds $2,250, the beneficiary will be solely responsible for the next $2,850 in drug spending, until reaching a catastrophic limit of $5,100. For drug expenditures beyond the catastrophic limit, the program will pay 95 percent of costs and the beneficiary will pay the remainder.

The cost-sharing parameters will increase each year. Beginning in 2007, the deductible, the coverage limit, and the catastrophic limit will increase by the per capita increase in total spending on covered prescription drugs in the previous year.

The MMA has other provisions that will increase beneficiaries' out-of-pocket spending. These include increasing the Part B deductible from $100 to $110 in 2005, increasing the Part B deductible at the same rate as the Part B premium each year starting after 2005, and linking beneficiaries' share of the Part B premium to their income beginning in 2007.

Endnotes

1 Another database—the Survey of Income and Program Participation (SIPP)—includes data on households' income, assets, and out-of-pocket spending. However, the data on out-of-pocket spending are not reliable, so we did not use the SIPP in our analysis.

2 Our estimate of the poverty rate among Medicare beneficiaries overstates the official poverty rate for this population. Two factors contribute to the overstatement. First, our data reflect income for individuals and married couples, but official poverty measures are based on household income. If an unmarried beneficiary with very low income lives with an adult child with a very high income, the beneficiary is considered low income under our measure but high income under official poverty measures. Second, although we adjusted our income data for underreporting, the database we benchmarked to (Current Population Survey) probably underreports as well, but to a lesser extent than the MCBS.

3 This measure assumes that beneficiaries use the same services under Medicare-only coverage as they use under ESI coverage. In addition, it assumes that beneficiaries pay the same price for each service. In practice, the price for a service often differs by type of insurance coverage. For example, people who have group health coverage often pay lower prices for prescription drugs than people who are uninsured.

4 The lower income among 65- to 69-year-old men with ESI may reflect, in part, employers offering lower cash wages and salaries if they provide health benefits for their retirees.

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