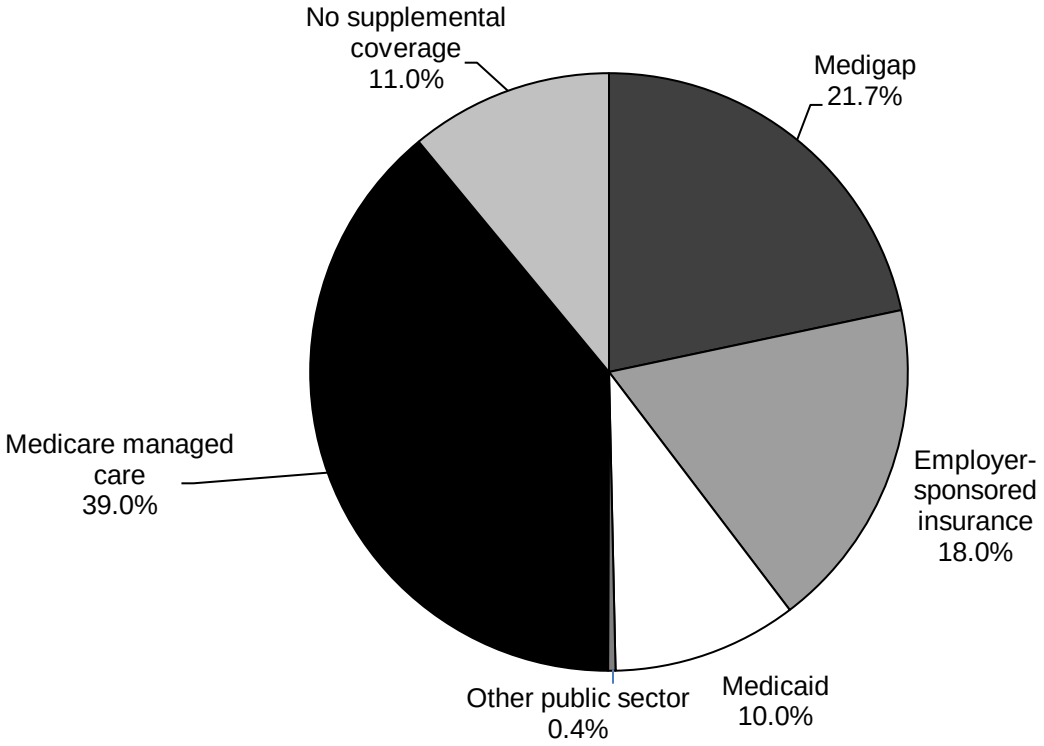
SECTION 3

Medicare beneficiary and other payer financial liability

Chart 3-1. Sources of supplemental coverage among noninstitutionalized Medicare beneficiaries, 2018



Note: We assigned beneficiaries to the supplemental coverage category they were in for the most time in 2018. They could have had coverage in other categories during 2018. "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 2018 or who had Medicare as a secondary payer. Numbers do not total 100 because of rounding.

Source: MedPAC analysis of Medicare Current Beneficiary Survey, Survey file 2018.

- Most beneficiaries living in the community (i.e., noninstitutionalized) have coverage that supplements or replaces the Medicare benefit package. In 2018, 89 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 22 percent) or employer-sponsored retiree coverage (18 percent).
- About 10 percent of beneficiaries had public sector supplemental coverage, primarily Medicaid.
- Thirty-nine percent of beneficiaries participated in Medicare managed care. This coverage includes Medicare Advantage, health care prepayment, and cost plans. These types of arrangements generally replace Medicare's fee-for-service coverage and often provide 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, 2018

	Number of beneficiaries (thousands)	Employer-sponsored insurance	Medigap insurance	Medicaid	Medicare managed care	Other public sector	Medicare only
All beneficiaries	**48,821**	**18%**	**22%**	**10%**	**39%**	**0%**	**11%**
Age							
<65	6,947	6	3	36	37	1	17
65–69	10,850	16	24	7	40	0	13
70–74	11,950	21	25	5	38	1	11
75–79	8,578	20	25	5	42	0	8
80–84	5,436	24	24	6	38	0	8
85+	5,060	21	26	6	38	0	9
Income-to-poverty ratio							
≤1.00	8,038	3	6	42	39	0	10
1.00 to 1.20	2,765	4	11	23	48	0	14
1.20 to 1.35	1,908	4	18	13	42	1	22
1.35 to 2.00	8,182	11	20	5	48	1	15
>2.00	27,927	27	28	1	35	0	9
Eligibility status							
Aged	41,630	20	25	6	39	0	10
Disabled	6,783	6	3	36	37	1	17
ESRD	408	11	21	29	21	2	15
Residence							
Urban	38,986	18	20	9	42	0	10
Rural	9,835	18	27	14	26	0	15
Sex							
Male	21,964	19	20	9	38	1	13
Female	26,857	17	23	11	40	0	10
Health status							
Excellent/very good	22,409	22	26	4	39	0	9
Good/fair	23,410	16	19	13	40	1	12
Poor	2,787	9	12	29	34	1	15

Note: ESRD (end-stage renal disease). We assigned beneficiaries to the supplemental coverage category they were in for the most time in 2018. They could have had coverage in other categories during 2018. "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. Analysis also excludes beneficiaries who were not in both Part A and Part B throughout their enrollment in 2018 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 2018.

- 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, have income between 1.00 and 2.00 times the poverty level, 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, 2019

	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)	108	207	628	129	6,804	306	3,067	81	43	4	1,360

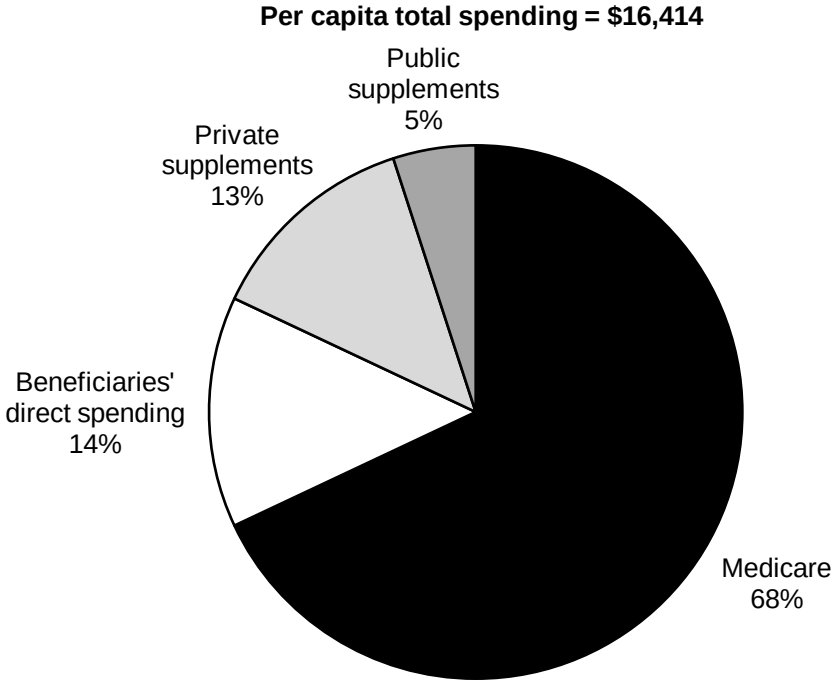
Note: SNF (skilled nursing facility). Three states (Massachusetts, Minnesota, and Wisconsin) have different plan types and are not included in this chart. The ✓ indicates that the plan covers all cost sharing. Percentages indicate that the plan covers that share of the total cost sharing. The $20/$50 indicates that the plan covers all but $20 for physician office visits and all but $50 for emergency room visits.
*Beginning in 2020, new policies for Plans C or F are not allowed to be sold. However, beneficiaries who purchased C plans or F plans before 2020 will be able to continue to purchase those plans.

Source: MedPAC analysis of National Association of Insurance Commissioners data, 2020.

- 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 2019, 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, 2018



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, 2018.

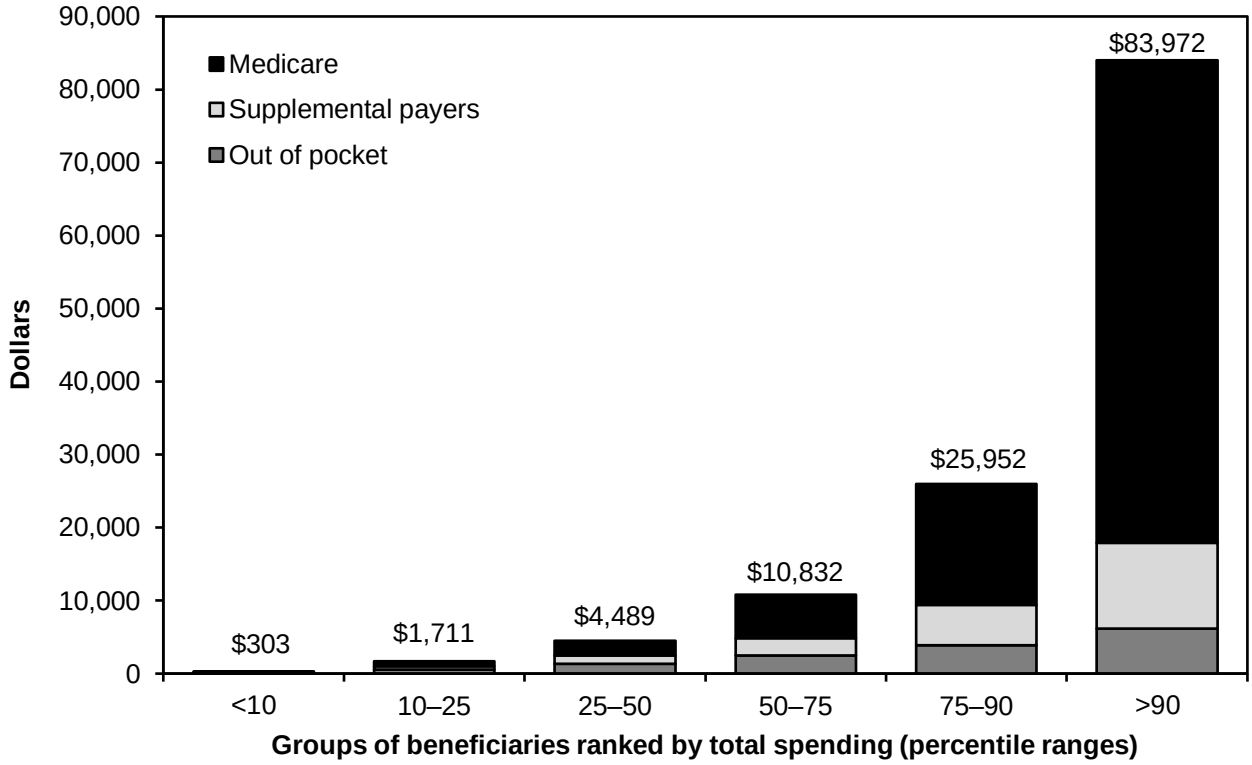
- Among FFS beneficiaries living in the community (that is, they are not institutionalized), the total cost of health care services (beneficiaries' direct spending as well as expenditures by Medicare, other public sector sources, and all private sector sources on all health care goods and services) averaged about $16,400 in 2018. 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 $11,195 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 $2,172 per beneficiary.

- Beneficiaries paid about 14 percent of their health care costs out of pocket, an average of $2,249 per beneficiary.

- Public sources of supplemental coverage—primarily Medicaid—paid about 5 percent of beneficiaries' health care costs, an average of $798 per beneficiary.

Chart 3-5. Per capita total spending on health care services among noninstitutionalized FFS beneficiaries, by source of payment, 2018



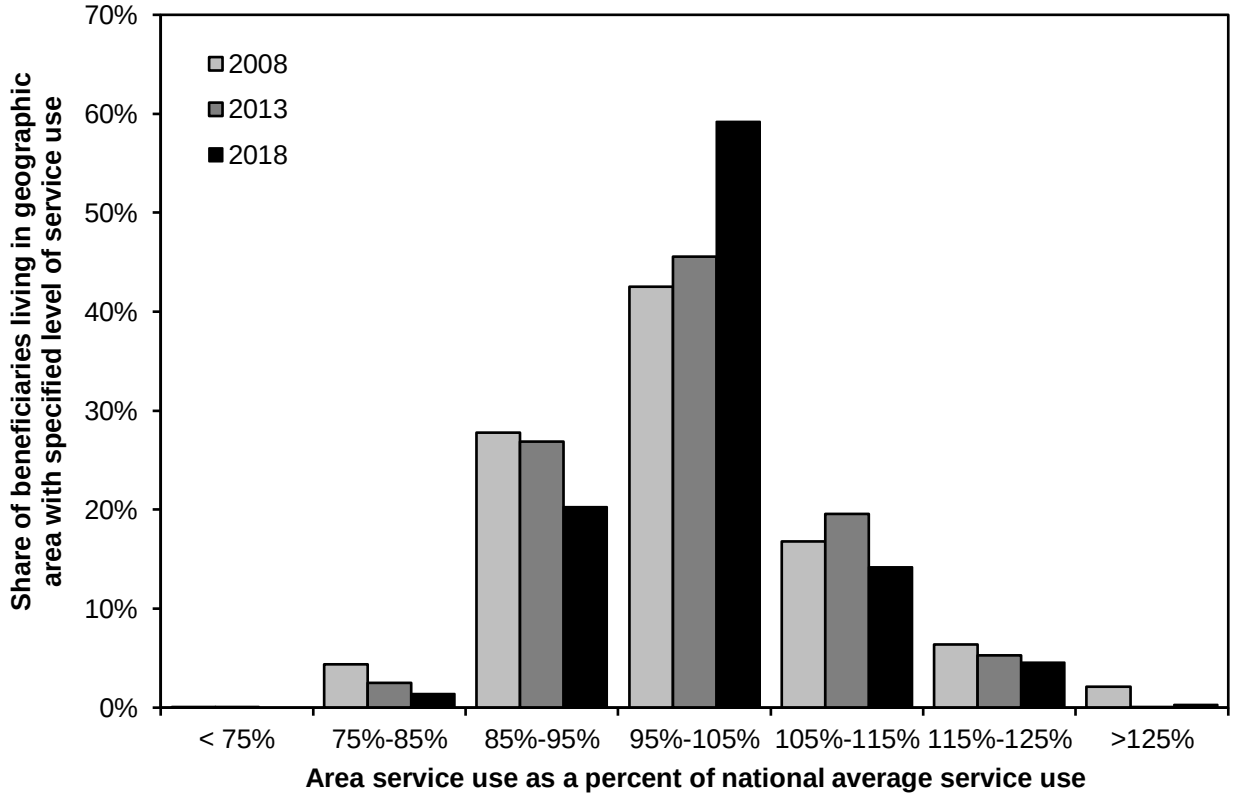
Note: FFS (fee-for-service). Analysis excludes those who are not in FFS Medicare and those living in institutions such as nursing homes. “Out-of-pocket" spending includes Medicare cost sharing and noncovered services, but not supplemental premiums.

Source: MedPAC analysis of the Medicare Current Beneficiary Survey, Cost Supplement file, 2018.

- Total spending on health care services varied dramatically among FFS beneficiaries living in the community in 2018. Per capita spending for the 10 percent of beneficiaries with the highest total spending averaged nearly $84,000. Per capita spending for the 10 percent of beneficiaries with the lowest total spending averaged $303.

- Among FFS beneficiaries living in the community, Medicare paid a larger share 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 79 percent of total spending for the 10 percent of beneficiaries with the highest total spending. Across FFS beneficiaries living in the community, out-of-pocket spending amounted to 14 percent of total spending, but only 7 percent of total spending for the 10 percent of beneficiaries with the highest total spending (data not shown).

Chart 3-6. Geographic variation in use of services has decreased among FFS Medicare beneficiaries, 2008–2018



Note: FFS (fee-for-service). "Service use" is per capita monthly Part A and Part B service use among FFS beneficiaries in each area. We defined areas as metropolitan statistical areas within each state for urban counties and rest-of-state nonmetropolitan areas for nonurban counties.

Source: MedPAC analysis of 2008, 2013, and 2018 beneficiary-level spending from the Medicare Beneficiary Summary Files and Medicare inpatient claims.

- FFS beneficiaries' use of Medicare-covered services varies by geographic area, but that variation decreased from 2008 to 2018. The share of FFS beneficiaries living in geographic areas that had service use within 5 percent of the national average (95 percent to 105 percent) increased from 43 percent in 2008 to 59 percent in 2018. Also, the share of FFS beneficiaries living in geographic areas that had service use more than 25 percent higher than the national average (>125 percent) decreased from 2 percent in 2008 to almost 0 percent in 2018.

- The service sector that had the largest decrease in variation from 2008 to 2018 was post-acute care, especially home health care (data not shown). From 2008 to 2018, the variation in use of home health services across geographic areas declined by 24 percent.