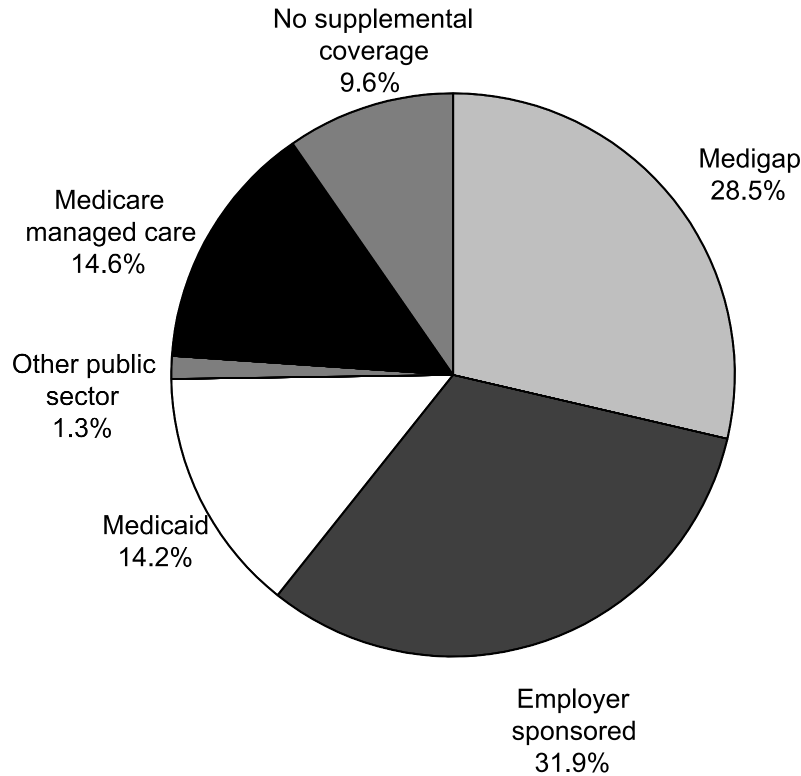
SECTION 6

Medicare beneficiary and other payer financial liability

Chart 6-1. Sources of supplemental coverage among noninstitutionalized Medicare beneficiaries, 2005



Note: Beneficiaries are assigned to the supplemental coverage category that applied for the most time in 2005. They could have had coverage in other categories throughout 2005. 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 2005 or who had Medicare as a second payer.

Source: MedPAC analysis of Medicare Current Beneficiary Survey, Cost and Use file, 2005.

- Most beneficiaries living in the community have coverage that supplements or replaces the Medicare benefit package. About 90 percent of beneficiaries have supplemental coverage or participate in Medicare managed care.
- About 60 percent have private-sector supplemental coverage such as medigap (about 28 percent) or employer-sponsored retiree coverage (about 32 percent).
- About 16 percent have public-sector supplemental coverage, primarily Medicaid.
- Fifteen percent participate in Medicare managed care. This includes Medicare Advantage, cost, and health care prepayment plans. These types of arrangements generally replace Medicare coverage and often add to it.
- The proportion of beneficiaries who have managed care enrollment on this diagram (about 15 percent) is much smaller than the proportion listed in Chapter 10 (22 percent). The difference is due the fact that the results in this chart reflect 2005 data, and the results in Chapter 10 reflect 2008 data. Managed care enrollment grew substantially in the intervening years.

Chart 6-2. Sources of supplemental coverage among noninstitutionalized Medicare beneficiaries, by beneficiaries' characteristics, 2005

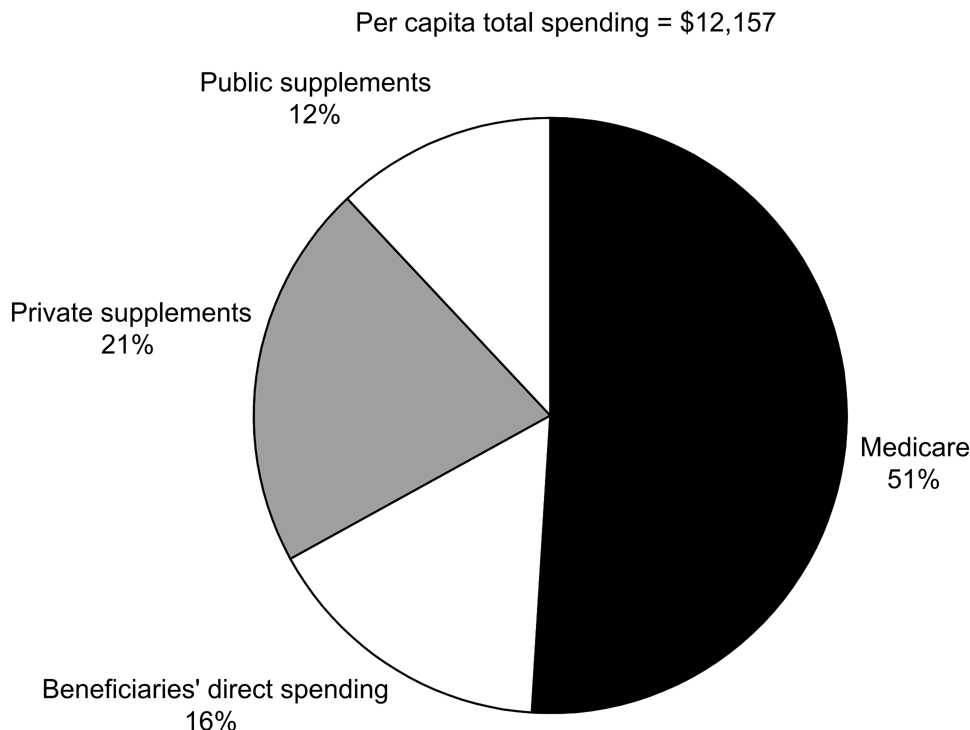
	Number of beneficiaries (thousands)	Employer-sponsored insurance	Medigap insurance	Medicaid	Medicare managed care	Other public sector	Medicare only
All beneficiaries	**36,978**	**32%**	**28%**	**14%**	**15%**	**1%**	**10%**
Age							
Under 65	5,323	19	5	44	7	2	22
65–69	8,012	38	29	10	12	1	10
70–74	7,631	33	31	9	19	1	7
75–79	6,815	33	34	9	16	1	6
80–84	5,261	32	35	9	17	1	6
85+	3,936	32	36	9	16	1	6
Income status							
Below poverty	6,092	11	14	50	10	2	13
100 to 125% of poverty	3,712	16	25	28	15	3	13
125 to 200% of poverty	7,426	27	28	12	18	2	14
200 to 400% of poverty	10,803	40	31	2	17	1	9
Over 400% of poverty	8,880	47	38	0	12	0	3
Eligibility status							
Aged	31,511	34	32	9	16	1	7
Disabled	5,090	18	5	44	8	2	23
ESRD	314	43	16	23	8	0	9
Residence							
Urban	28,078	32	27	13	19	1	8
Rural	8,889	32	34	17	2	2	14
Sex							
Male	16,244	34	26	13	13	1	13
Female	20,733	30	30	15	16	1	7
Health status							
Excellent/very good	15,628	35	34	6	16	1	8
Good/fair	18,327	30	26	18	15	1	10
Poor	2,871	25	14	34	8	3	16

Note: ESRD (end-stage renal disease). Beneficiaries are assigned to the supplemental coverage where they spent the most time in 2005. They could have had coverage in other categories throughout 2005. 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. In 2005, poverty was defined as $9,367 for people living alone and $11,815 for married couples. Urban indicates beneficiaries living in metropolitan statistical areas (MSAs). Rural indicates beneficiaries living outside MSAs. Analysis includes beneficiaries living in the community. Number of beneficiaries will differ between boldface categories because we exclude beneficiaries with missing values.

Source: MedPAC analysis of 2005 Medicare Current Beneficiary Survey, Cost and Use file.

- Beneficiaries most likely to have employer-sponsored supplemental coverage are those who are above age 64, higher income (above 200 percent of poverty), eligible due to age or end-stage renal disease (ESRD), and male, and who report better than poor health.
- Medigap is most common among those who are "older" aged (age 75 or older), middle or high income (above 125 percent of poverty), eligible due to age, rural dwelling, female, and who report excellent or very good health.
- Medicaid coverage is most common among those who are under 65, low income (below 125 percent of poverty), eligible due to disability or ESRD, rural dwelling, female, and who report poor health.
- Medicare managed care is most common among those who are age 65 or older, with income between 125 and 400 percent of poverty, eligible due to age, urban dwelling, female, and who report better than poor health.
- Lack of supplemental coverage (Medicare coverage only) is most common among beneficiaries who are under age 65, with income below 200 percent of poverty, eligible due to disability, rural dwelling, male, and who report poor health.

Chart 6-3. Total spending on health care services for noninstitutionalized FFS Medicare beneficiaries, by source of payment, 2005



Note: FFS (fee-for-service). Private supplements include employer-sponsored plans and individually purchased coverage. Public supplements include 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.

Source: MedPAC analysis of Medicare Current Beneficiary Survey, Cost and Use file, 2005.

- Among fee-for-service (FFS) beneficiaries living in the community, 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) averages $12,157. Medicare is the largest source of payment; it pays 51 percent of the health care costs for FFS beneficiaries living in the community, or an average of $6,180 per beneficiary.

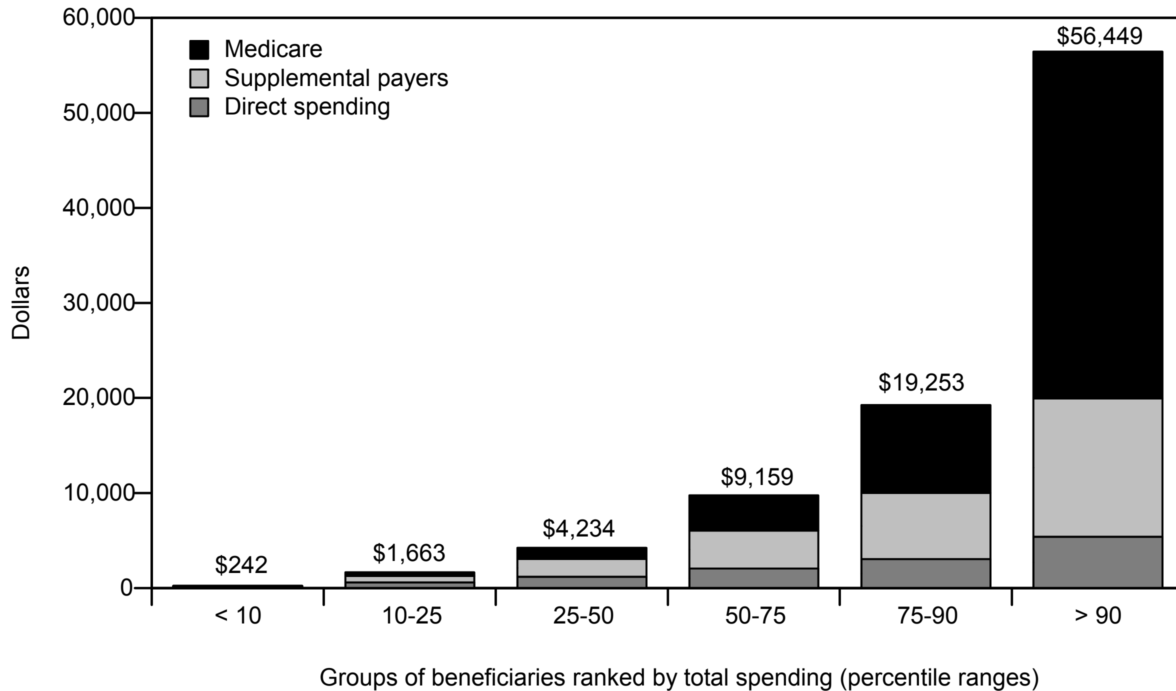
- Private sources of supplemental coverage—primarily employer-sponsored retiree coverage and medigap—paid 21 percent of beneficiaries' costs, or an average of $2,603 per beneficiary.

- Beneficiaries paid 16 percent of their health care costs out of pocket, or an average of $1,910 of spending per beneficiary.

- Public sources of supplemental coverage—primarily Medicaid—paid 12 percent of beneficiaries' health care costs, or an average of $1,463 per beneficiary.

- The effects of the prescription drug benefit established under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 are not reflected in these results or in Charts 6-4, 6-5, and 6-6.

Chart 6-4. Per capita total spending on health care services among noninstitutionalized FFS beneficiaries, by source of payment, 2005



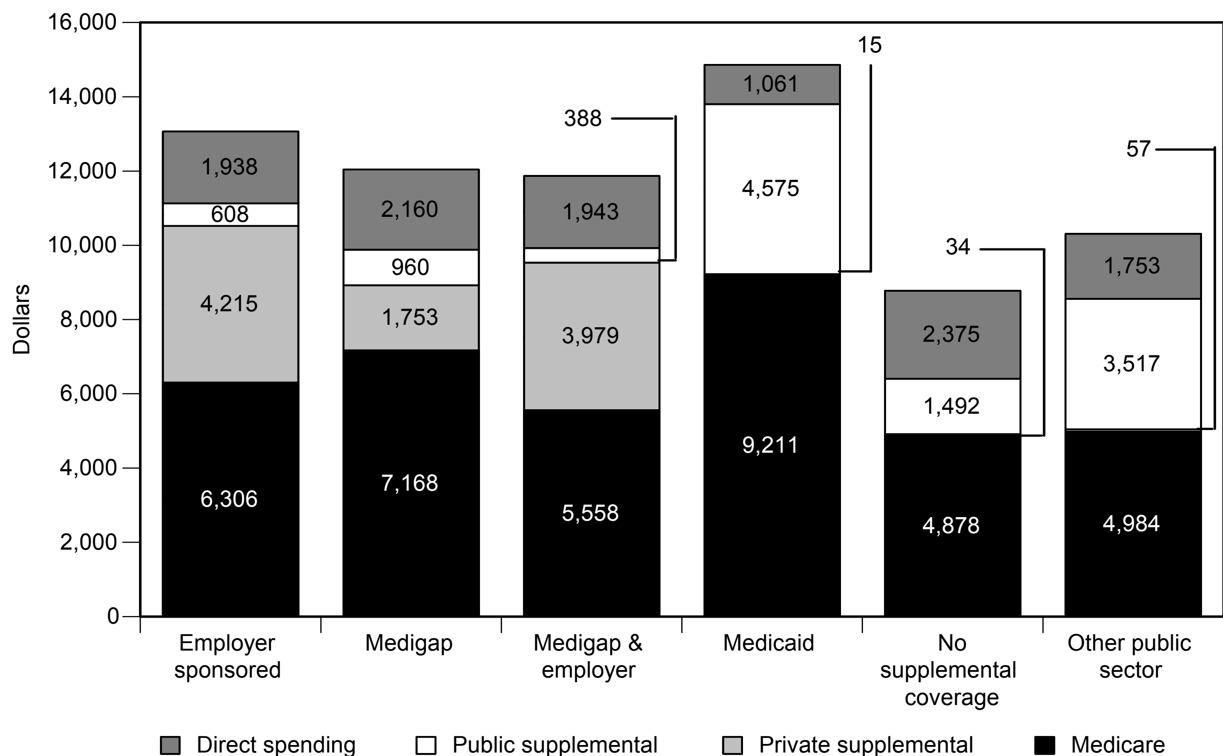
Note: FFS (fee-for-service). Analysis includes FFS beneficiaries not living in institutions such as nursing homes. Direct spending is on Medicare cost sharing and noncovered services.

Source: MedPAC analysis of Medicare Current Beneficiary Survey, Cost and Use file, 2005.

- Total spending on health care services varies dramatically among fee-for-service (FFS) beneficiaries living in the community. Per capita spending for the 10 percent of beneficiaries with the highest total spending averages $56,449. Per capita spending for the 10 percent of beneficiaries with the lowest total spending averages $242.

- Among FFS beneficiaries living in the community, Medicare pays a larger percentage as total spending increases, and beneficiaries' direct spending is a smaller percentage as total spending increases. For example, Medicare pays 51 percent of total spending for all beneficiaries but pays 65 percent of total spending for the 10 percent of beneficiaries with the highest total spending. Beneficiaries' direct spending covers 16 percent of total spending for all beneficiaries but only 10 percent of total spending for the 10 percent of beneficiaries with the highest total spending.

Chart 6-5. Variation in and composition of total spending among noninstitutionalized FFS beneficiaries, by type of supplemental coverage, 2005



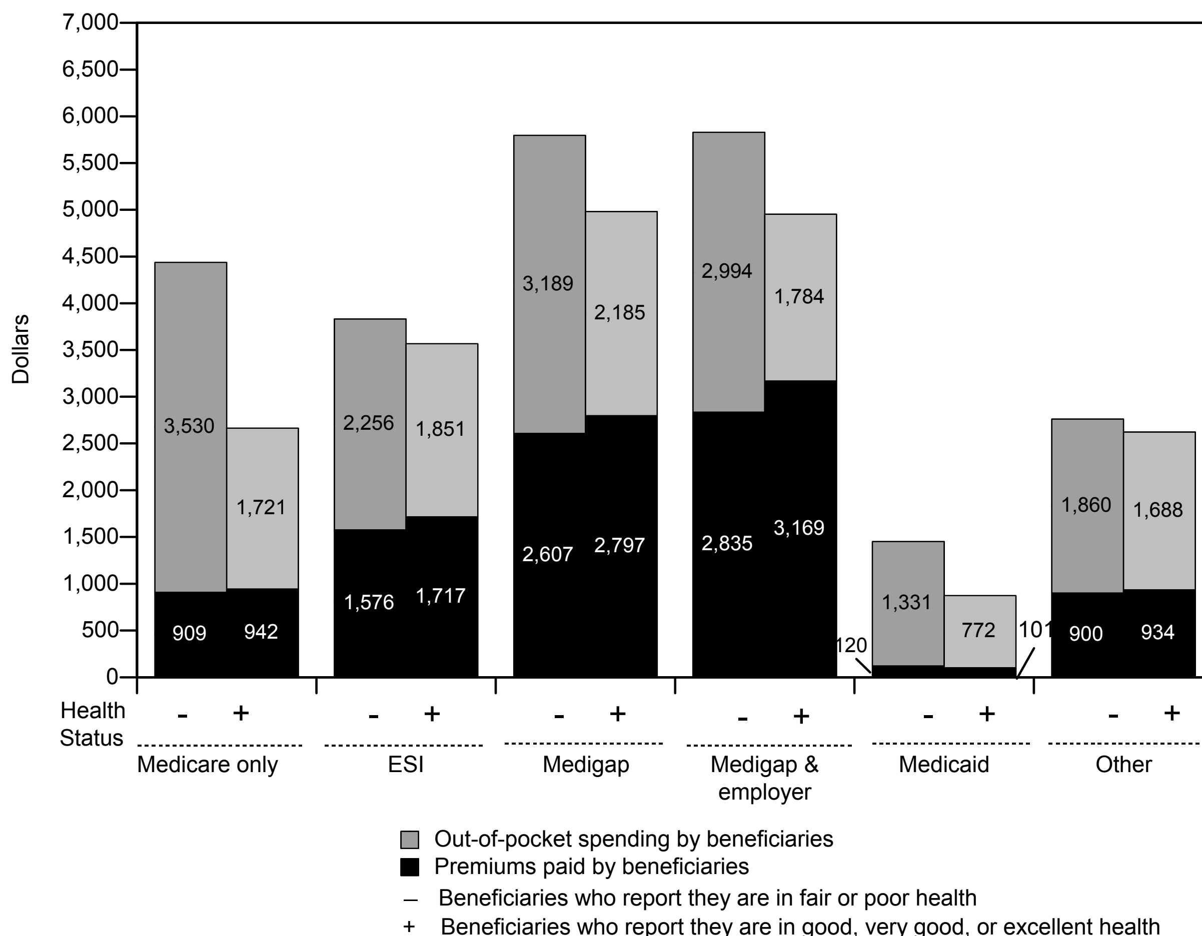
Note: FFS (fee-for-service). Beneficiaries are assigned to the supplemental coverage category that applied for the most time in 2005. They could have had coverage in other categories throughout 2005. Other public sector includes federal and state programs not included in the other categories. Private supplements include employer-sponsored plans and individually purchased coverage. Public supplements include Medicaid, Department of Veterans Affairs, and other public coverage. Analysis includes only FFS 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 2005 or had Medicare as a second payer. Direct spending is on Medicare cost sharing and noncovered services but not supplemental premiums.

Source: MedPAC analysis of Medicare Current Beneficiary Survey, Cost and Use file, 2005.

- 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 fee-for-service beneficiaries living in the community varies by the type of supplemental coverage they have. Total spending is much lower for those beneficiaries with no supplemental coverage than for those beneficiaries who have supplemental coverage. Beneficiaries with Medicaid coverage have the highest level of total spending, 69 percent higher than those with no supplemental coverage.

- Medicare is the largest source of payment for beneficiaries in each supplemental insurance category, but the second largest source of payment differs. Among those with supplemental coverage, that coverage—public and private combined—is the second largest source of payment. However, among those with Medicare only, beneficiaries' direct spending is the second largest source of payment.

Chart 6-6. Out-of-pocket spending for premiums and health services per beneficiary, by insurance and health status, 2005



Note: ESI (employer-sponsored supplemental insurance).

Source: MedPAC analysis of Medicare Current Beneficiary Survey, Cost and Use file, 2005.

- This diagram illustrates out-of-pocket spending on services and premiums, by beneficiaries' supplemental insurance and health status. For example, beneficiaries who have only traditional Medicare coverage (Medicare only) and report fair or poor health had an average of $909 in out-of-pocket spending on premiums and $3,530 on services. Those who have Medicare-only coverage and report good, very good, or excellent health had an average of $942 in out-of-pocket spending on premiums and $1,721 on services.
- Insurance that supplements Medicare does not shield beneficiaries from all out-of-pocket costs. Beneficiaries who report being in fair or poor health spend more out of pocket for health services than those reporting good, very good, or excellent health, regardless of the type of coverage they have to supplement Medicare.
- Despite having supplemental coverage, beneficiaries who have employer-sponsored insurance (ESI) or medigap have out-of-pocket spending that is comparable to or larger than those who have only coverage under traditional Medicare (Medicare only). This likely reflects the fact that beneficiaries who have ESI or medigap have higher incomes and are 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 prescription drugs and other services not covered by Medicare. Beneficiaries with ESI usually pay less out of pocket for prescription drugs than those with medigap, but may pay more in Medicare deductibles and cost sharing.

Web links. Medicare beneficiary and other payer financial liability

- Chapter 1 of the MedPAC 2008 Report to the Congress provides more information on Medicare program spending.

  http://www.medpac.gov/chapters/Mar08_ch01.pdf

- Chapter 1 of the MedPAC March 2007 Report to the Congress provides more information on Medicare program spending.

  http://www.medpac.gov/chapters/Mar07_ch01.pdf

- Chapter 1 of the MedPAC March 2006 Report to the Congress provides more information on Medicare program spending.

  http://www.medpac.gov/publications/congressional_reports/Mar06_Ch01.pdf

- Chapter 1 of the MedPAC March 2005 Report to the Congress provides more information on Medicare program spending.

  http://www.medpac.gov/publications/congressional_reports/Mar05_Ch01.pdf

- Appendix B of the MedPAC June 2004 Report to the Congress and Chapter 1 of the MedPAC June 2002 Report to the Congress provide more information on Medicare beneficiary and other payer financial liability.

  http://www.medpac.gov/publications/congressional_reports/June04_AppB.pdf

  http://www.medpac.gov/publications/congressional_reports/Jun2_Ch1.pdf

- Chapter 1 of the MedPAC March 2004 Report to the Congress provides more information on beneficiary and Medicare program spending as well as information about supplemental insurance.

  http://www.medpac.gov/publications/congressional_reports/Mar04_Ch1.pdf

- Chapter 1 of the MedPAC March 2003 Report to the Congress provides more information on beneficiary and program spending.

  http://www.medpac.gov/publications/congressional_reports/Mar03_Ch1.pdf