ISSUE BRIEF
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How the Erosion of Employer-Sponsored Insurance Is Contributing to Medicare Beneficiaries' Financial Burden

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ABSTRACT

ISSUE: More Medicare beneficiaries are facing the costs of health care and supplemental coverage in retirement without assistance from their former employers. As a result, more Medicare beneficiaries, especially those with low to middle incomes, face financially burdensome premiums.

GOAL: With employers shouldering less of the cost of health care in old age, public policies will need to be developed to ensure an adequate safety net of health insurance coverage for Medicare beneficiaries. This issue brief examines trends in supplemental health insurance coverage and implications for beneficiaries at different income levels.

METHODS: Profile trends in supplemental insurance coverage and premiums of Medicare beneficiaries by income groups using the 2010 and 2016 Medicare Current Beneficiary Survey.

KEY FINDINGS: The proportion of Medicare beneficiaries with supplemental employer-sponsored insurance (ESI) dropped between 2010 and 2016. The erosion of ESI was particularly marked for those with low and middle incomes. Beneficiaries not eligible for Medicaid face average annual premiums of more than $500 for Medicare Advantage coverage and four times that for Medigap coverage, on top of standard Medicare Part B annual premiums.

CONCLUSION: Improving Medicare's benefits would reduce the need for supplemental coverage and protect aging beneficiaries against the unpredictable cost of health care.

TOPLINES

- **The proportion of Medicare beneficiaries with supplemental employer-sponsored insurance dropped from 38% to less than 28% between 2010 and 2016, a decline that was particularly marked for those with low and middle incomes.**
- **Medicare Advantage and Medicaid have expanded as sources of coverage, but many beneficiaries are still exposed to high cost-sharing.**

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INTRODUCTION

Medicare provides essential health insurance coverage for elderly and disabled beneficiaries, but the program's benefit design can leave beneficiaries exposed to high out-of-pocket costs. For 2019, the Part A deductible is $1,364 per hospital episode; Part B has a $185 deductible with 20 percent coinsurance on covered services. There is no ceiling on out-of-pocket costs. As a result, 90 percent of Medicare beneficiaries obtain supplemental coverage to help pay Medicare's high cost-sharing.

In the past, large employers often provided supplemental coverage for their retirees. However, because of economic pressure on employers, fewer are now offering such benefits. Particularly for adults with limited incomes, the erosion of employer-sponsored retiree health insurance means that more Medicare beneficiaries are on their own to obtain supplemental coverage to protect against high out-of-pocket costs.

Approximately 18 million Medicare beneficiaries live on annual incomes below 150 percent of the federal poverty level — less than $18,000 a year for a single person (see Appendix 1). Of those with incomes below the poverty level (i.e., less than $12,000, if single), two-thirds receive assistance with premiums and cost-sharing from Medicaid; one-third of those with incomes between poverty and 149 percent of poverty receive assistance paying Medicare premiums. Nearly 40 percent of the near poor with incomes between poverty and 199 percent of poverty spend 20 percent or more of their income on premiums and health care each year. Prior research has shown broad evidence of unmet care needs as well as financial hardship.[1]

Beneficiaries with high incomes (i.e., four times the poverty level or higher, or $48,000, if single) are the most likely to have coverage through retiree health plans from former employers, or, if they are still in the workforce, through current employer plans. Modest-income beneficiaries with incomes between 150 percent and 399 percent of poverty ($18,000 to just under $48,000, if single) are caught in between. They typically purchase Medicare Advantage or Medigap private supplemental health insurance to fill in for Medicare's cost-sharing.

In this issue brief, we profile coverage trends for Medicare beneficiaries between 2010 and 2016, looking at rates of employer-sponsored insurance (ESI), Medigap health insurance, and Medicare Advantage. Beneficiaries sometimes report multiple sources of coverage during the year, either because they have more than one type of plan in addition to Medicare or because they change plans during the year.

FINDINGS

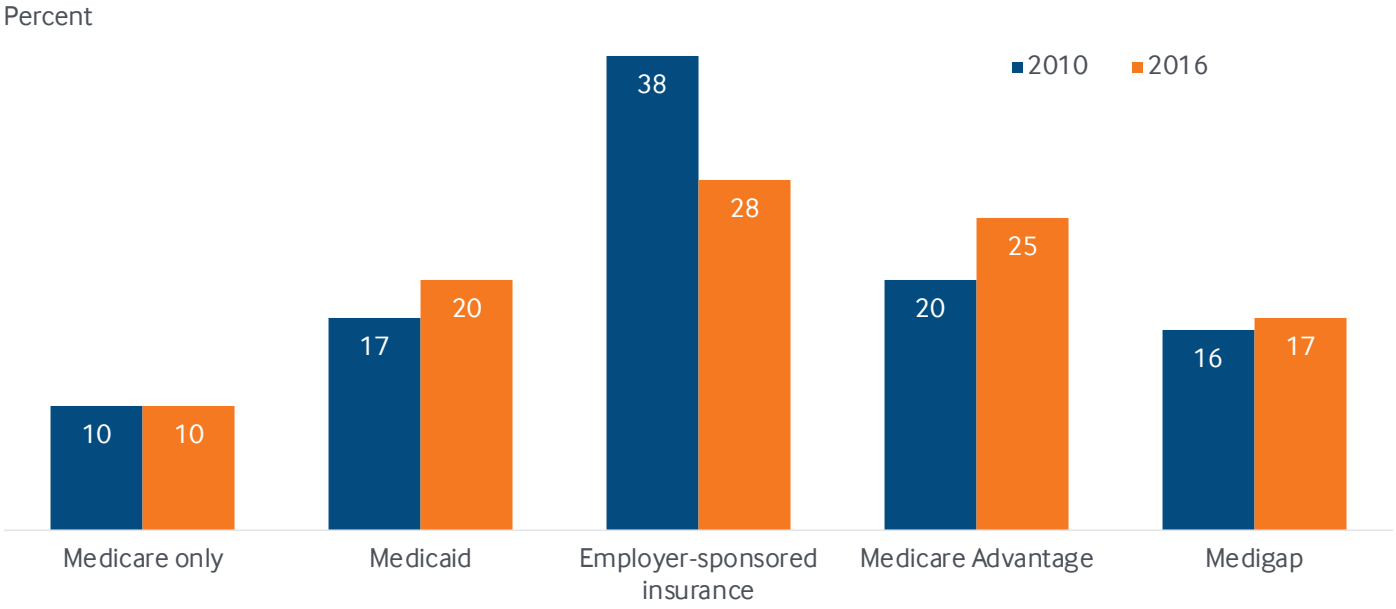
Erosion in Employer-Sponsored Insurance for Medicare Beneficiaries

Between 2010 and 2016, the proportion of Medicare beneficiaries with ESI declined from 38 percent to 28 percent (Exhibit 1). Some beneficiaries are still working and receive this coverage from their current employers, while others receive it as retiree health benefits from a former employer. As this coverage has eroded, risk-averse beneficiaries have sought to obtain other sources of coverage to protect against unpredictable out-of-pocket costs. Medicaid provided supplemental coverage for 20 percent of beneficiaries in 2016, up from 17 percent in 2010. Enrollment in Medicare Advantage plans increased from 20 percent to 25 percent, while Medigap coverage grew from 16 percent to 17 percent.

The type of supplemental coverage varies markedly by income level. In the highest-income group of beneficiaries — incomes four times the poverty level or greater ($48,000 or higher for a single adult) — slightly less than half (47%) had ESI as well as Medicare in 2016. This was down from 63 percent in 2010 — a 25-percent drop in just six years (Exhibit 2).

ESI is much less common among modest-income beneficiaries, and erosion of these benefits in this group between 2010 and 2016 was more rapid. For beneficiaries with incomes between 150 percent and 199 percent of poverty, the proportion with ESI dropped from 31 percent to 19 percent — a decline of 39 percent. A small proportion of poor and near-poor beneficiaries have ESI, which declined between 2010 and 2016. For those beneficiaries with incomes below poverty, the proportion with ESI fell from 7 percent to 6 percent (Exhibit 2).

Exhibit 1. Distribution of Insurance Coverage Among Medicare Beneficiaries, 2010 and 2016



Data: Authors' analysis of Medicare Current Beneficiary Survey, 2010 and 2016.

Exhibit 2. Trends in Supplemental Coverage by Income, 2010–2016

	Total	Medicare only	Medicaid	Employer-sponsored insurance	Medicare Advantage	Medigap
2010						
Coverage percent of each row						
Total	100%	9.83%	16.85%	38.00%	19.66%	15.66%
Poverty group						
<100% FPL	14.33%	11.21%	65.22%	7.10%	10.95%	5.49%
100%–149% FPL	16.69%	15.07%	34.08%	14.90%	21.81%	14.14%
150%–199% FPL	13.72%	14.23%	8.04%	30.96%	26.58%	20.19%
200%–399% FPL	34.38%	7.83%	1.71%	49.46%	23.21%	17.79%
400%+ FPL	20.88%	5.09%	0.58%	63.43%	13.55%	17.36%
2016						
Coverage percent of each row						
Total	100%	10.28%	19.93%	27.71%	25.09%	17.00%
Poverty group						
<100% FPL	16.29%	9.92%	64.99%	5.76%	13.01%	6.32%
100%–149% FPL	14.73%	11.51%	41.86%	10.61%	23.98%	12.04%
150%–199% FPL	12.11%	15.67%	14.46%	18.76%	34.10%	17.01%
200%–399% FPL	27.25%	10.00%	4.44%	32.71%	30.98%	21.87%
400%+ FPL	29.62%	7.91%	0.73%	47.35%	23.17%	20.85%

Note: FPL = federal poverty level.

Data: Authors' analysis of Medicare Current Beneficiary Survey, 2010 and 2016.

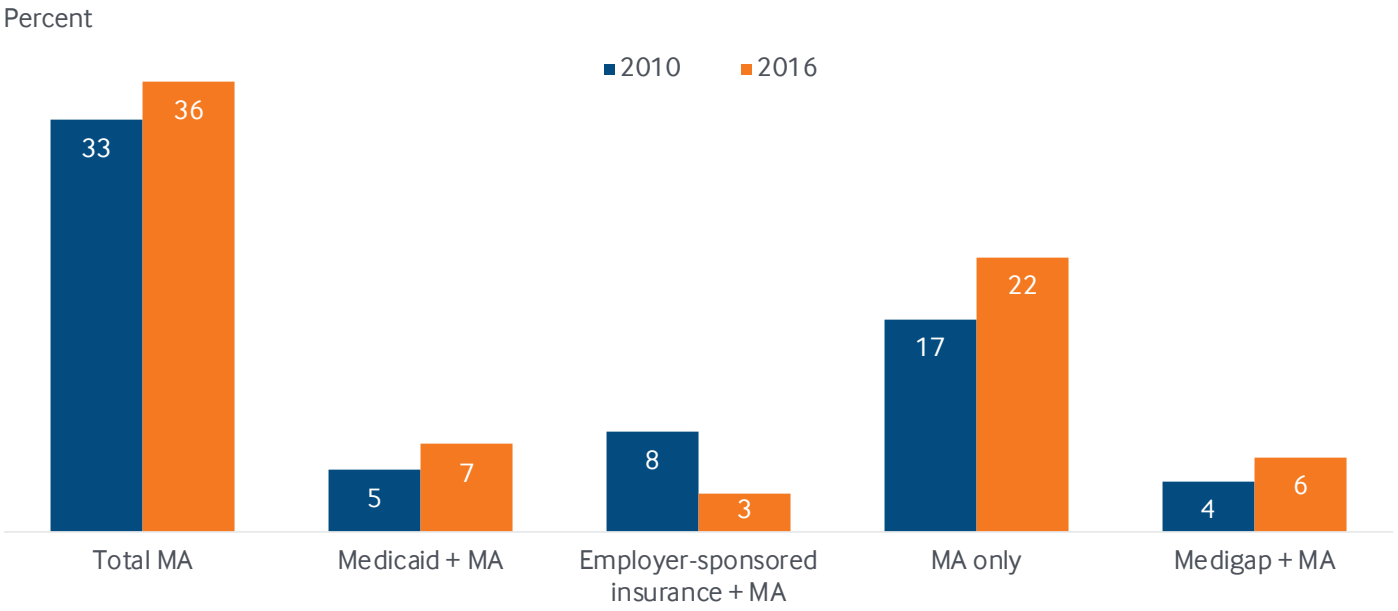
Medicare Advantage Enrollment Is Higher Among Modest-Income Beneficiaries

The second-most-common form of protection against Medicare cost-sharing is enrolling in Medicare Advantage (MA) plans. These are private managed care plans that use restrictive provider networks or techniques like prior authorization to control health care costs. MA is particularly attractive to beneficiaries with limited incomes. Twenty-five percent of Medicare beneficiaries enroll directly in MA plans (Appendix 1). In low- and middle-income groups, MA is more common than Medigap. One-third (34%) of those with incomes between 150 percent and 199 percent of poverty ($18,000 to just under $24,000) are enrolled in MA, as are 31 percent of those with incomes between 200 percent and 399 percent of poverty. Those with the highest incomes ($48,000 or more) are now, compared with six years ago, more likely to enroll in Medicare Advantage (23%) than to supplement Medicare with Medigap coverage (21%). Over time we have seen beneficiaries with modest incomes (i.e., between 150% and 399% of poverty) increasingly enrolling in MA plans as employer coverage has eroded.

MA enrollment is even more marked when we include people with multiple sources of coverage. ESI may enroll retirees in MA plans or provide financial assistance with MA premiums. Unduplicated counts of beneficiaries in Exhibits 1 and 2 show such beneficiaries as covered by ESI. Those with both Medicaid and MA — including, for example, those who switch coverage from MA to Medicaid or the reverse in a given year — are counted as Medicaid beneficiaries.

Medicare beneficiaries enrolled in MA increased between 2010 and 2016, including those in MA only, plus those with both MA and ESI (Exhibit 3). In addition, a few Medicare beneficiaries report both MA and Medigap coverage. This is presumably people who switch from one to the other over the course of the year.

Exhibit 3. Medicare Advantage and Multiple Sources of Coverage, 2010 and 2016



Note: MA = Medicare Advantage.

Data: Authors' analysis of Medicare Current Beneficiary Survey, 2010 and 2016.

MEDICAID SAFETY NET HAS EXPANDED TO HELP OFFSET THE LOSS OF EMPLOYER-SPONSORED INSURANCE

In 2016, 58 million people were covered by Medicare (Appendix 1).[2] One-third (18 million people) had incomes below 150 percent of the federal poverty with, at best, limited assets to last their lifetimes.[3] For many, the Medicare Part B premium, Part A hospital deductible, or a 20 percent share of physician bills are simply unaffordable. These people often go without care or accumulate debt. For those with incomes near the poverty level (less than $12,000, if single), the sum of the standard Part B annual premium ($1,626), hospital deductible ($1,364), and medical deductible ($185) is more than 25 percent of their income.

Low-income provisions called Medicare Savings Programs (MSPs) and Extra Help that pay for Medicare premiums, cost-sharing, or Part D prescription drugs are limited, fragmented, and complex. Beneficiaries with incomes below poverty may qualify for full Medicaid to supplement Medicare but only if they have meager savings. In 25 states, they must have incomes levels lower than 75 percent of poverty.[4]

Medicaid coverage of Medicare beneficiaries increased from 17 percent to 20 percent between 2010 and 2016. However, these existing provisions leave substantial gaps in protection for Medicare's low-income beneficiaries. One-third of people with incomes below poverty and more than half of those with incomes between 100 percent and 149 percent of poverty did not have Medicaid in 2016.

Beneficiaries with incomes below 135 percent of poverty who are not eligible for full Medicaid may qualify for help with Medicare premiums and cost-sharing through MSPs. All states are required to provide MSPs through Medicaid, with the federal government setting minimum income and asset standards. Beneficiaries with incomes up to poverty receive help paying for Medicare premiums and cost-sharing. Those with incomes between 100 percent and 135 percent of poverty receive help with premiums only. In 2016, the federal asset standard for MSPs was $7,280 if single and $10,930 for a couple, not including allowance for burial. Four states have higher income limits and 11 have higher asset limits than the federal minimums.[5] Similarly, Medicare Part D's Extra Help program helps pay for prescription drugs and premiums for people with incomes up to 150 percent of poverty.

PREMIUMS FOR SUPPLEMENTAL COVERAGE ARE EXPENSIVE

Not everyone can afford to protect themselves against high potential medical bills, particularly as ESI continues to shrink. Private coverage typically has 20 percent or higher administrative loading built into the premium. The average annual premium for MA plans was $508 in 2016 (Exhibit 4). Private Medigap coverage was even more costly, with average annual premiums of $2,161 in 2016 — four times those of MA plans. These premiums come on top of standard Part B annual premiums of $1,626 in 2019. For modest-income beneficiaries, premiums alone could make it difficult to pay bills for housing, food, utilities, and transportation, as well as uncovered medical services.

Exhibit 4. Annual Premiums for Supplemental Coverage by Beneficiary Income and Type of Coverage, Not Including Medicare Part B Premiums, 2010 and 2016

	2010	2016
Total average premiums	$963	$955
<100% FPL	$294	$422
100%–149% FPL	$636	$673
150%–199% FPL	$973	$809
200%–399% FPL	$1,156	$1,042
400%+ FPL	$1,361	$1,367
Medicare only	$13	$252
Medicaid	$144	$362
Employer-sponsored insurance	$1,268	$1,306
Medicare Advantage	$651	$508
Medigap	$2,095	$2,161

Notes: Total premium minus Medicare Part B. Many Medicare only beneficiaries report additional premium costs because of enrollment in Part D.
FPL = federal poverty level.

Data: Authors' analysis of Medicare Current Beneficiary Survey, 2010 and 2016.

POLICY IMPLICATIONS

Several policy options would help ensure financial security for Medicare beneficiaries. A ceiling on out-of-pocket expenses, which are common to private insurance plans including Medicare Advantage, would help ensure beneficiaries are not wiped out financially by a serious illness.[6] Replacing the Part A deductible — $1,364 in 2019 — with a modest copayment of $100 to $300 per hospital admission would remove the most burdensome of Medicare's cost-sharing.[7] Expanding benefits to cover essential uncovered services such as dental, vision, and hearing services (including hearing aids), would both improve access to such services, which are central to quality of life and health outcomes, and ease financial burdens.[8] Adding a home- and community-based benefit to Medicare would help those with physical or cognitive impairment continue to function independently.[9] Providing premium and cost-sharing assistance on a sliding scale to all poor and near-poor beneficiaries with incomes up to 150 percent of poverty would target assistance on those most severely strained by premiums and medical bills.[10]

Medicare has served its 59 million beneficiaries well for more than 50 years, meeting its goal of ensuring access to care and essential financial protection.[11] Now Medicare will serve a generation that has experienced little or no growth in real wages, a reduction of assets and savings through economic crises, and loss of employer-provided pensions and retiree health benefits. It is an urgent priority that policymakers reexamine the program's benefits and financing to meet the needs of older adults.

HOW WE CONDUCTED THIS STUDY

All estimates in this brief are based on analysis of the 2010 and 2016 Medicare Current Beneficiary Survey (MCBS). The 2010 MCBS includes 10,741 respondents with population weights representative of the entire Medicare population, including the disabled under-65 population and those primarily living in long-term-care institutions. The 2016 MCBS similarly includes 14,778 respondents. The issue brief displays results for the population-weighted data.

In addition to beneficiary reports, the MCBS cost-and-use files include information about incurred liability for Medicare benefits and spending on Medicare premiums based on administrative data. The MCBS also includes information on Medicaid status: whether the beneficiary is eligible for full Medicaid, Medicaid only for Medicare cost-sharing and premiums, or Medicaid for Medicare premiums.

The database has a sufficiently robust sample to permit analysis of subgroups by income and type of coverage. In the analysis, we grouped beneficiaries by income based on their reported annual income relative to the federal poverty level. We also grouped beneficiaries into one of five mutually exclusive insurance categories: Medicare only, Medicaid, ESI, Medicare Advantage, and Medigap. If beneficiaries had more than one source of supplemental coverage, we used the following hierarchy to assign them to a group: Medicaid, ESI if any ESI (and not Medicaid), Medicare Advantage (if not Medicaid or ESI), and Medigap.

NOTES

1. Cathy Schoen, Amber Willink, and Karen Davis, *Medicare Beneficiaries' High Out-of-Pocket Costs: Cost Burdens by Income and Health Status* (Commonwealth Fund, May 2017); and Amber Willink, Karen Davis, and Cathy Schoen, *Risks for Nursing Home Placement and Medicaid Entry Among Older Medicare Beneficiaries with Physical or Cognitive Impairment* (Commonwealth Fund, Oct. 2016).

2. Centers for Medicare and Medicaid Services, National Health Expenditure Projects, Table 1 and 17, updated June 2015.

3. Analysis of the Federal Reserve Board's ongoing survey (every three years) finds the bottom half of retirees less likely to have any pension income than earlier decades or than high-income retirees, and as a group, the bottom half of the income distribution have median private financial assets of under $7,000. Sebastian Devlin-Foltz, Alice M. Henriques, and John E. Sabelhaus, "The Role of Social Security in Overall Retirement Resources: A Distributional Perspective," *FEDS Notes* (blog), Board of Governors of the Federal Reserve System, July 29, 2016. Only 25 percent of the bottom quintile income receive any income from assets. Half of this low-income group received less than $150. Ke Bin Wu, *Sources of Income for Older Americans, 2012* (AARP Public Policy Institute, Dec. 2013).

4. Molly O'Malley Watts, Elizabeth Cornachione, and MaryBeth Musumeci, *Medicaid Financial Eligibility for Seniors and People with Disabilities in 2015* (Henry J. Kaiser Family Foundation, Mar. 2016).

5. National Council on Aging, "Medicare Savings Programs: A Profile of State Options," NCOA, May 2016, and updated table, Mar. 2018.

6. Cathy Schoen et al., *Medicare Benefit Redesign: Enhancing Affordability for Beneficiaries While Promoting Choice and Competition* (Commonwealth Fund, Oct. 2018).

7. Schoen et al., *Medicare Benefit Redesign,* 2018.

8. Amber Willink, Cathy Schoen, and Karen Davis, "Consideration of Dental, Vision, and Hearing Services to Be Covered Under Medicare," *Journal of the American Medical Association* 318, no. 7 (Aug. 15, 2017): 605–6; and Amber Willink et al., *How Medicare Could Provide Dental, Vision, and Hearing Care for Beneficiaries* (Commonwealth Fund, Jan. 2018).

9. Karen Davis, Amber Willink, and Cathy Schoen, "Medicare Help at Home," *Health Affairs Blog,* Apr. 13, 2016; and Karen Davis, Amber Willink, and Cathy Schoen, "Integrated Care Organizations: Medicare Financing for Care at Home," *American Journal of Managed Care* 22, no. 11 (Nov. 2016): 764–68.

10. Cathy Schoen et al., *A Policy Option to Enhance Access and Affordability for Medicare's Low-Income Beneficiaries* (Commonwealth Fund, Sept. 2018).

11. David Blumenthal, Karen Davis, and Stuart Guterman, "Medicare at 50 — Origins and Evolution," *New England Journal of Medicine* 372, no. 5 (Jan. 29, 2015): 479–86.

Appendix 1. Medicare Beneficiaries by Income Level and Supplemental Coverage, 2010 and 2016

	Total	Medicare only	Medicaid	Employer-sponsored insurance	Medicare Advantage	Medigap
2010						
Total	48,420,576	4,759,743	8,158,867	18,399,819	9,519,485	7,582,662
Poverty group						
<100% FPL	6,938,669	777,825	4,525,400	492,645	759,784	380,933
100%–149% FPL	8,081,394	1,217,866	2,754,139	1,204,128	1,762,552	1,142,709
150%–199% FPL	6,643,303	945,342	534,122	2,056,767	1,765,790	1,341,283
200%–399% FPL	16,646,994	1,303,460	284,664	8,233,603	3,863,767	2,961,500
400%+ FPL	10,110,216	514,610	58,639	6,412,910	1,369,934	1,755,134
Coverage percent of each row						
Total	100%	9.83%	16.85%	38.00%	19.66%	15.66%
Poverty group						
<100% FPL	14.33%	11.21%	65.22%	7.10%	10.95%	5.49%
100%–149% FPL	16.69%	15.07%	34.08%	14.90%	21.81%	14.14%
150%–199% FPL	13.72%	14.23%	8.04%	30.96%	26.58%	20.19%
200%–399% FPL	34.38%	7.83%	1.71%	49.46%	23.21%	17.79%
400%+ FPL	20.88%	5.09%	0.58%	63.43%	13.55%	17.36%
2016						
Total	58,641,440	6,028,340	11,687,239	16,249,543	14,713,137	9,969,045
Poverty group						
<100% FPL	9,552,691	947,627	6,208,294	550,235	1,242,805	603,730
100%–149% FPL	8,637,884	994,220	3,615,818	916,480	2,071,365	1,040,001
150%–199% FPL	7,101,478	1,112,802	1,026,874	1,332,237	2,421,604	1,207,961
200%–399% FPL	15,979,792	1,597,979	709,503	5,226,990	4,950,540	3,494,781
400%+ FPL	17,369,595	1,373,935	126,798	8,224,503	4,024,535	3,621,560
Coverage percent of each row						
Total	100%	10.28%	19.93%	27.71%	25.09%	17.00%
Poverty group						
<100% FPL	16.29%	9.92%	64.99%	5.76%	13.01%	6.32%
100%–149% FPL	14.73%	11.51%	41.86%	10.61%	23.98%	12.04%
150%–199% FPL	12.11%	15.67%	14.46%	18.76%	34.10%	17.01%
200%–399% FPL	27.25%	10.00%	4.44%	32.71%	30.98%	21.87%
400%+ FPL	29.62%	7.91%	0.73%	47.35%	23.17%	20.85%

Note: FPL = federal poverty level.

Data: Authors' analysis of Medicare Current Beneficiary Survey, 2010 and 2016.

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Affordable, quality health care. For everyone.

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