Insight on the Issues

Medicare Beneficiaries' Out-of-Pocket Spending for Health Care

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Half of all Medicare beneficiaries in the fee-for-service program spent at least $3,595 of their own money on health care in 2011. That represents 18 percent or more of their income spent for health care premiums and services. One in 10 beneficiaries—over 3.5 million people—spent more than $10,436. The burden of health care costs was particularly heavy for the sickest, oldest, and near-poor beneficiaries.

The Medicare program pays for certain health care services provided to adults ages 65 and older and to younger individuals with a disability. The program pays a portion of the costs for covered inpatient and outpatient health care services, as well as for some prescription drug costs for beneficiaries who elect Part D coverage.[1]

Medicare is a vital program that helps older adults and people with a disability pay for needed health care services. However, the traditional fee-for-service (FFS) program that provides health insurance coverage for most Medicare beneficiaries[2] does not cover all health care–related costs. It typically requires significant cost sharing from beneficiaries for covered services. In addition, beneficiaries are liable for the cost of health care services that are not covered by Medicare FFS, and most also pay premiums for Medicare and other supplemental health care coverage. This report assesses the out-of-pocket (OOP) spending burden on Medicare beneficiaries enrolled in the traditional FFS program, using data from the most recent Medicare Current Beneficiary Survey (MCBS), the 2011 Cost and Use File.

In 2011, beneficiaries were responsible for a $1,132 deductible for each inpatient spell of illness.[3] After 60 days in a hospital or 20 days in a skilled nursing facility (SNF), they also faced daily copays until they reached 90[4] and 100[5] days, respectively. Beyond that, beneficiaries paid the full cost of their care in a hospital or in a SNF. Beneficiaries with Part B coverage also faced monthly premiums of, typically, $115.40.[6] In addition, they faced an annual Part B deductible of $162 for outpatient services, and were responsible for 20 percent (or more)[7] of all Part B costs beyond the deductible. Furthermore, beneficiaries paid out of pocket for services that Medicare does not cover, such as hearing aids, eyeglasses, dental care, and most long-term care (LTC) services.

As a result, many Medicare beneficiaries had high OOP spending. For many, this spending represented

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an important share of their income. Such financial burden varied with sociodemographic characteristics such as age, income, gender, health status, and health conditions. Most (88 percent) beneficiaries in Medicare FFS had some form of supplemental coverage to help defray those costs. The remaining 12 percent had none. Supplemental plans vary in coverage of deductibles, coinsurances, and copays. Some plans cover all Medicare cost sharing;[8] others cover only a portion and

METHODS

The MCBS is an annual panel survey that asks approximately 11,000 Medicare beneficiaries about their health care use and spending, health status, insurance, sociodemographic characteristics, income, residence, and other key items. It is representative of the national population of Medicare beneficiaries, and includes people living in LTC facilities for part or all of the year.

Medical spending figures come from self-reported data verified by invoices, receipts, explanation-of-benefits forms, and empty prescription containers, supplemented by Medicare claims data. The analyses presented here exclude people enrolled in Medicare Advantage plans (26 percent of the Medicare population in 2011) because of the difficulty of attributing spending to these enrollees.

This report presents data on OOP spending toward (1) total health care costs, (2) Medicare covered services, and (3) non-Medicare covered services. Total health care OOP spending includes Medicare premiums (including Medicare Part D premiums), premiums for supplemental insurance, and all personal expenditures for Medicare covered and non-Medicare covered services. Payments toward health care services refer to copayments, deductibles, balance billing payments to physicians, personal payments, and payments made directly by third parties for the respondent. The following Medicare covered service categories are included in this analysis: inpatient hospital, outpatient hospital, medical providers, home health care, hospice and SNF. Non-Medicare covered services captured in the MCBS are: dental services and LTC facilities (licensed/skilled nursing homes, assisted living and other residential facilities, other LTC facilities). LTC spending includes spending for health care services as well as room and board costs for residents of nursing homes and other LTC facilities, as reported by facility representatives on behalf of survey participants. The MCBS does not measure expenditures toward some non-Medicare covered categories of health care services such as vision, hearing, and home-based care. Therefore, the data likely underestimate actual total expenditures toward non-Medicare covered services. OOP spending for prescription drugs was included in spending toward Medicare covered services for respondents with Part D coverage and in spending toward non-Medicare covered services for respondents without Part D coverage.

Income is self-reported. Individual income is half of a couple's income when respondents reported income for themselves and a spouse.

This report shows OOP spending at the mean, the median, and the 90th percentile. The median represents the "middle" spending value–50 percent of beneficiaries are above the median and 50 percent are below.

beneficiaries make up the rest by paying out of pocket. Consequently, even with supplemental coverage, some Medicare beneficiaries could face high OOP costs for health care services, particularly if they become ill.

Overall, in 2011, beneficiaries in the FFS Medicare program spent a median of $3,595 out of pocket on health care (table 1), which includes Medicare premiums, premiums for supplemental health insurance coverage, and spending on Medicare and non-Medicare covered services.[9] Many beneficiaries had significantly lower total OOP spending—one quarter spent less than $1,775 per year, and 10 percent spent less than $563. Unfortunately, a considerable number spent much more; approximately 10 percent of the FFS Medicare population, or over 3.5 million beneficiaries, spent more than $10,436 out of pocket on health care in 2011.

OOP health care spending often accounted for a large portion of beneficiaries' income, ranging from 11 percent to 29 percent in 2011 (tables 2 and 4). Half of all FFS beneficiaries spent at least 18 percent of their income on OOP health care expenses (i.e., median OOP spending as a percentage of income was 18 percent). The burden of health care costs was particularly heavy for the sickest and oldest beneficiaries as well as for near-poor beneficiaries (tables 2 and 4).

SOCIODEMOGRAPHIC CHARACTERISTICS: WHERE DOES THE BURDEN OF OOP SPENDING FALL?

Beneficiaries in FFS Medicare spent significantly more out of pocket for health care as they aged. In 2011, total spending for the average beneficiary age 85 and older was almost three times greater than for the average beneficiary under 65 (table 1). On average, older beneficiaries spent more on both Medicare and non-Medicare covered

TABLE 1

Out-of-Pocket Spending Varies by Beneficiaries' Socioeconomic Characteristics

		Mean Spending			Median Spending			90th Percentile of Spending		
		Total	Medicare covered services	Non-Medicare covered services	Total	Medicare covered services	Non-Medicare covered services	Total	Medicare covered services	Non-Medicare covered services
	Overall	**$5,357**	**$1,370**	**$1,401**	**$3,595**	**$454**	**$196**	**$10,436**	**$3,156**	**$2,002**
Age	Under 65	3,358	1,326	786	1,951	407	0	7,696	3,005	1,866
	65–69	4,137	904	728	3,082	316	188	8,662	2,240	1,499
	70–74	5,335	1,360	875	4,219	504	250	10,514	3,320	1,788
	75–79	5,403	1,466	964	4,175	558	247	10,552	3,550	1,885
	80–84	6,407	1,601	1,646	4,556	552	257	11,487	3,482	2,141
	85+	9,469	2,029	4,478	5,041	575	332	19,180	4,121	11,352
Gender	Men	5,011	1,291	1,275	3,421	398	206	9,848	3,014	1,884
	Women	5,651	1,437	1,507	3,783	510	186	10,879	3,255	2,162
Race/ Ethnicity	White	5,736	1,424	1,527	3,942	504	236	10,794	3,236	2,139
	Black	3,530	1,266	682	1,959	274	25	8,272	2,784	1,256
	Hispanic	2,270	715	502	1,076	201	0	6,250	1,845	650
	Other	3,299	775	949	1,740	233	0	8,699	2,260	1,578
Income Level	Up to 100% FPL	2,680	1,123	296	1,332	300	0	6,343	2,502	639
	101–150% FPL	4,445	1,506	500	2,995	532	6	9,467	3,587	978
	151–200% FPL	5,474	1,694	818	4,175	702	180	10,099	4,056	1,463
	201–300% FPL	5,107	1,294	739	4,165	521	269	9,766	3,061	1,642
	Over 300% FPL	5,595	1,314	895	4,469	465	413	10,376	3,051	2,116

services than younger beneficiaries. Interestingly, beneficiaries under age 65 had the lowest levels of total OOP spending, despite the fact that they are in the Medicare program because of a serious health condition or functional limitation. This is likely because a significantly higher proportion of beneficiaries with disabilities are on Medicaid, which pays for some of their OOP costs.[10]

Women in FFS Medicare incurred higher total OOP spending than men. Median total spending was $3,783 for women compared with $3,421 for men (table 1). The higher OOP spending is, in part, because women spent more on premiums than men did:[11] a higher proportion of women than men had supplemental coverage (90 percent of women v. 85 percent of men). Another reason for the higher spending is that, on average, women were older than men in the sample. Consequently, women spent more on Medicare-covered services ($1,437) than men ($1,291).[12] Table 2 shows a significantly higher burden of health care spending on women than men (median spending as a percentage of income was 20 percent for women compared with 16.6 percent for men). This is because, in addition to higher spending, female beneficiaries in Medicare's

TABLE 2
The Burden of Out-of-Pocket Spending by Beneficiaries' Socioeconomic Characteristics

		Median Total OOP Spending as a Percentage of Income
	Overall	**18.1%**
Age	Under 65	16.6
	65–69	12.8
	70–74	17.5
	75–79	20.8
	80–84	23.6
	85+	29.2
Gender	Men	16.6
	Women	20.0
Race/ Ethnicity	White	18.6
	Black	16.3
	Hispanic	14.7
	Other	15.2
Income Level	Up to 100% FPL	22.7
	101–150% FPL	25.9
	151–200% FPL	26.8
	201–300% FPL	19.8
	Over 300% FPL	11.2

TABLE 4
The Burden of Out-of-Pocket Spending by Beneficiaries' Health Status

		Median Total OOP Spending as a Percentage of Income
	Overall	**18.1%**
Health Status	Excellent/very good health	15.7
	Good health	19.5
	Fair health	23.4
	Poor health	22.5

TABLE 3
Out-of-Pocket Spending Varies by Beneficiaries' Health Status

		Mean Spending			Median Spending			90th Percentile of Spending		
		Total	Medicare covered services	Non-Medicare covered services	Total	Medicare covered services	Non-Medicare covered services	Total	Medicare covered services	Non-Medicare covered services
	Overall	**$5,357**	**$1,370**	**$1,401**	**$3,595**	**$454**	**$196**	**$10,436**	**$3,156**	**$2,002**
Health Status	Excellent/very good health	4,823	940	888	3,654	350	240	9,590	2,212	1,701
	Good health	5,512	1,434	1,414	3,764	516	203	10,455	3,406	1,806
	Fair health	6,228	1,991	2,237	3,535	607	98	12,049	4,598	3,039
	Poor health	5,589	1,969	1,967	2,727	677	31	12,050	4,840	3,083

FFS program also had lower income levels than their male counterparts ($22,833 v. $26,178 on average).

Race and ethnicity were also associated with different patterns of total OOP spending. Whites had higher median total OOP spending than other groups and paid a higher proportion of their income on OOP health care costs than other groups (tables 1 and 2). Compared with other racial/ethnic groups, whites in FFS Medicare spent more out of pocket on premiums ($2,786 v. $1,509 for nonwhites on average). This is because whites were more likely to purchase one of the more expensive types of supplemental coverage policies, such as Medigap (25 percent of whites had Medigap v. 7 percent for nonwhites. Whites also spent more on Medicare covered services ($1,424 v. $1,080 for nonwhites on average). For example whites were slightly more likely to see a clinician than nonwhites (96 percent v. 94 percent for nonwhites). Half of all white beneficiaries who saw a medical provider paid at least $258—much more than the corresponding $146 for nonwhites. There were also similar racial/ethnic differences in OOP spending for non-Medicare covered services, particularly for spending toward LTC services. The average white beneficiary who used an LTC facility paid $15,543 out of pocket as compared with $7,580 for the average nonwhite beneficiary. This is largely because white beneficiaries generally had higher incomes ($26,085 vs. $15,127 for nonwhites on average) and were therefore less likely to qualify for Medicaid (14.6 percent duals among white beneficiaries vs. 45.6 percent among nonwhites).

Although OOP spending generally rises with income, table 2 shows that the burden of spending was greatest for near-poor beneficiaries with incomes between 101 and 200 percent of the federal poverty line (FPL). Median OOP spending as a percentage of income was about 26 percent for individuals with income between 101 and 150 percent of the FPL and about 27 percent for individuals with incomes between 151 and 200 percent of the FPL. The burden of OOP spending on health care was also very high for the poorest beneficiaries with incomes up to 100 percent of FPL. Among this group of beneficiaries, median total health care OOP spending represented about 23 percent of their income.

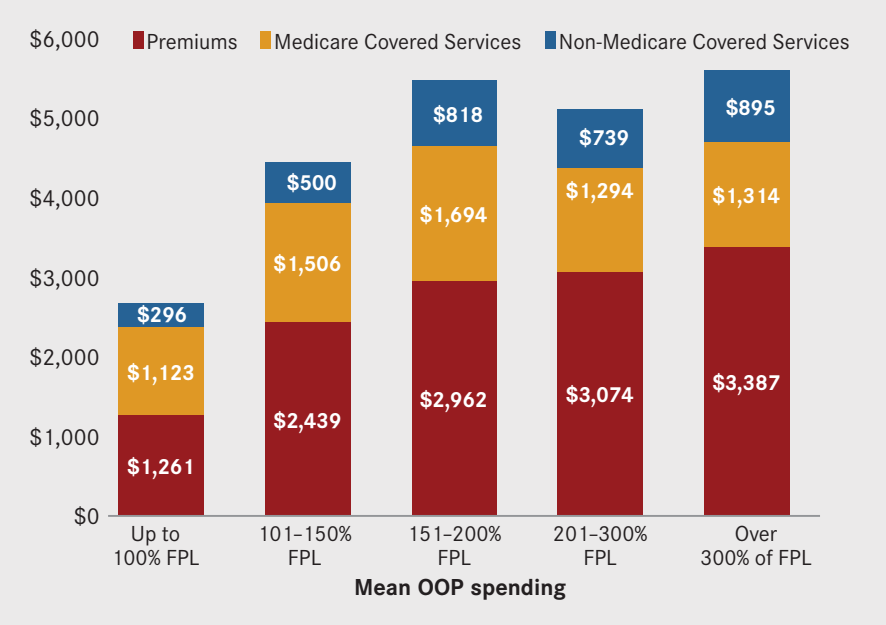
These high burden levels reflect the low-income status of people in these groups. Even though poor and near-poor beneficiaries qualify for financial assistance with cost sharing and Medicare premiums (in full or in part) through the Medicaid program, not all receive this assistance. For those who do not, the amount they pay for premiums and cost sharing represents a significant portion of their income.

In contrast, median spending as a percentage of income for individuals with income above 300 percent of FPL was 11.2 percent. OOP spending was notably higher in absolute dollars for this group, however.

Looking further at components of OOP spending, premiums were the largest component for all FFS Medicare beneficiaries (figure 1).

FIGURE 1

Out-of-Pocket Spending on Services and Premiums by Income Level



For example, near-poor beneficiaries with incomes between 151 and 200 percent of FPL spent more on premiums ($2,962 on average) than on Medicare covered services ($1,649 on average) and on non-Medicare covered services ($818 on average).

HEALTH STATUS: SHOWING THE BURDEN OF ILLNESS

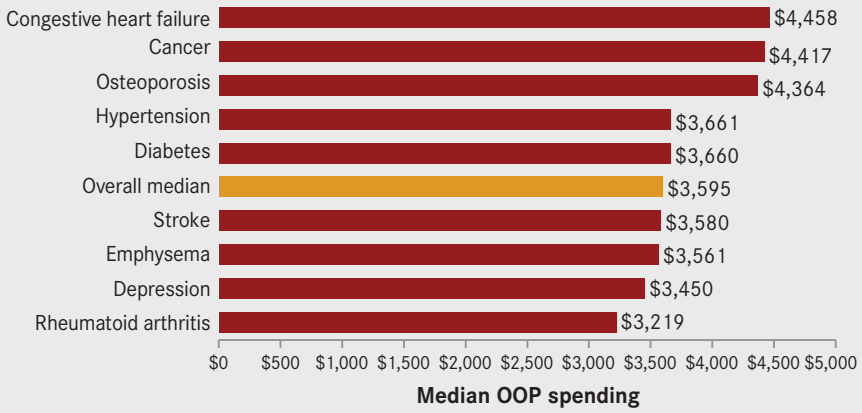
The burden of OOP spending was much higher for beneficiaries in poor or fair health than for those in excellent or very good health (table 4).

Median OOP spending as a percentage of income for beneficiaries in poor or fair health was about 22–23 percent compared with about 16 percent for those in excellent or very good health. Beneficiaries in poor health were less likely to have supplemental insurance than those in excellent or very good health (84 percent v. 89 percent), despite having greater need for health care services.[13]

Some illnesses and health conditions were associated with higher spending than others (figure 2). Median OOP spending was $4,458 for patients with congestive heart failure and $4,417 for patients with cancer. At the lower end of spending, patients with rheumatoid arthritis and patients suffering from depression spent $3,219 and $3,450, respectively.

FIGURE 2

Median Total Out-of-Pocket Spending Varies by Chronic Condition



BENEFICIARIES WITH SUPPLEMENTAL INSURANCE HAVE HIGHER TOTAL OOP SPENDING

Because the traditional FFS Medicare program requires significant cost sharing from beneficiaries, most people have supplemental insurance to help cover those costs. In 2011, roughly 88 percent of all FFS beneficiaries had some form of supplemental coverage, either through a former employer, by purchasing a Medigap or other private plan,

TABLE 5

Out-of-Pocket Spending Varies by Beneficiaries' Supplemental Insurance Status

		Mean Spending			Median Spending		
		Total	Medicare covered services	Non-Medicare covered services	Total	Medicare covered services	Non-Medicare covered services
	Overall	**$5,357**	**$1,370**	**$1,401**	**$3,595**	**$454**	**$196**
Supplemental Insurance Status	None	3,327	1,597	355	2,428	604	55
	Any	4,938	1,284	661	3,897	462	208
Type of Supplemental Coverage	Employer sponsored	4,902	1,191	885	3,690	375	410
	Medigap	7,202	1,706	606	6,193	844	126
	Employer sponsored and Medigap	7,252	1,461	856	6,110	726	437
	Medicaid	1,409	899	91	711	250	0
	Other public/private insurance	3,409	1,735	154	2,803	998	0

or through another public insurance program. In addition, the Medicaid program paid covered OOP costs for some Medicare beneficiaries (figure 3).

Women were more likely than men to have supplemental insurance, and those in poor health were less likely to have it than those in excellent or very good health.

A relatively large share (85 percent) of poor Medicare beneficiaries—those with income up to 100 percent of the FPL—had supplemental insurance, primarily through Medicaid. The near poor with incomes between 101 percent and 200 percent of the FPL had the lowest levels of supplemental insurance coverage, although the vast majority of this group had supplemental coverage. Approximately 78 percent of beneficiaries in this group had any form of supplemental coverage compared with 91 percent among beneficiaries making at least 200 percent of the FPL.

Generally, median total OOP expenditure for beneficiaries with supplemental insurance was higher than median total OOP spending for beneficiaries with no supplemental insurance ($3,897 v. $2,428; table 5). The difference was largely because of differences in spending on premiums.

On average, beneficiaries with and without supplemental coverage had comparable OOP spending on health care services ($1,945 and $1,952, respectively; figure 4). In contrast, beneficiaries

FIGURE 3

Most Medicare Beneficiaries Have Supplemental Coverage

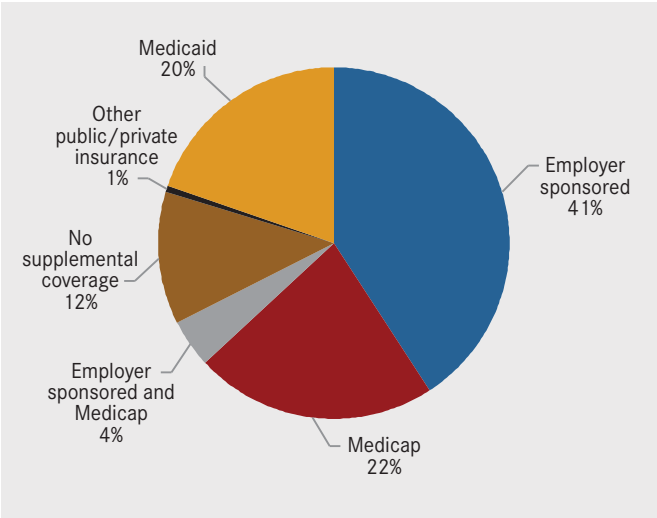
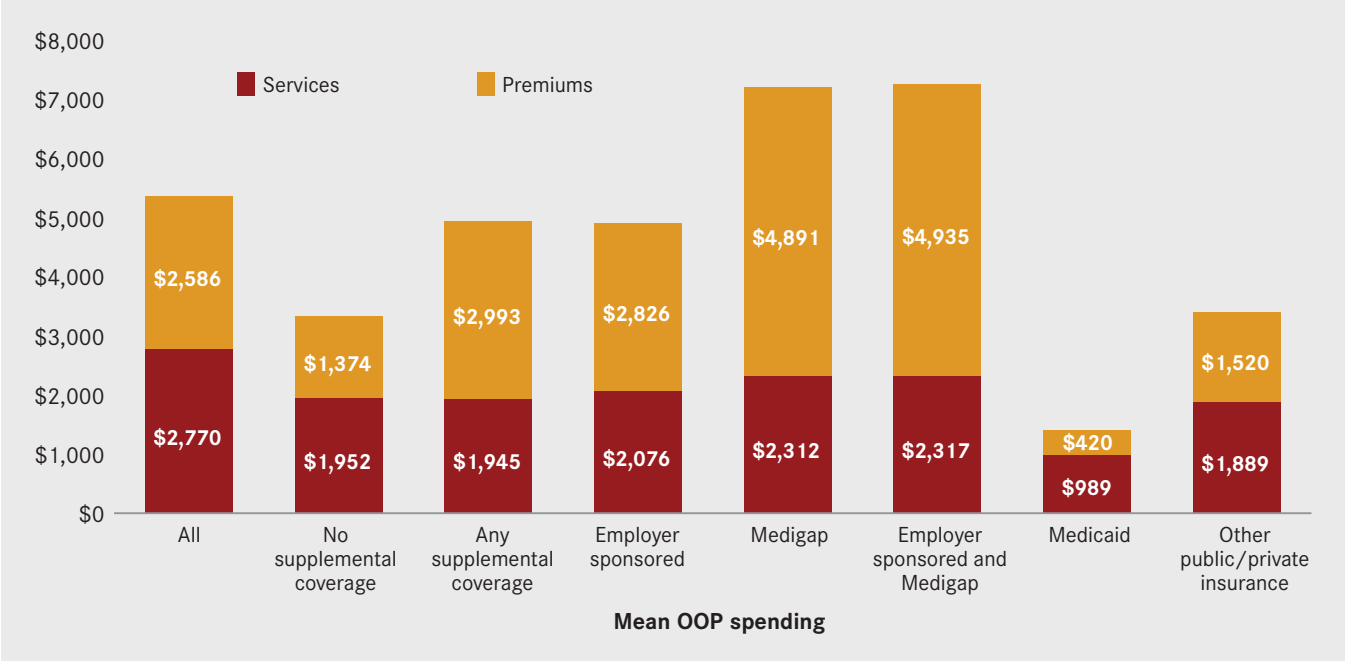


FIGURE 4

Out-of-Pocket Spending on Services and on Premiums by Supplemental Coverage



with supplemental coverage spent more than twice as much on premiums as beneficiaries without supplemental coverage ($2,993 v. $1,374; figure 4).

Differences in spending on premiums also explained differences in total OOP sending across the different types of supplemental coverage. Among beneficiaries with supplemental insurance, those with Medigap had the highest median total OOP spending (approximately $6,100; table 5). Looking at the components of spending, beneficiaries with Medigap supplemental insurance spent much more on premiums (about $4,900; figure 4) than beneficiaries with other public/private supplemental coverage and those who were also eligible for Medicaid ($1,520 and $420, respectively; figure 4).

As a group, dual eligibles had the lowest total OOP spending (table 5) as well as the lowest burden of total OOP health care expenditures (table 6). However, a nontrivial portion of dually eligible beneficiaries had significant OOP spending. Median OOP health care spending was $711 among all dual eligibles (table 5), but the top 10 percent of dual eligibles spent at least $2,863. Those with high spending likely resided at least part of the year in an LTC facility, such as a nursing home. Medicaid covered nursing facility residents are required to contribute toward their LTC costs by surrendering virtually all their income toward the costs of services, retaining only a small "personal needs allowance," generally in the range of $30 to $50 per month. Dual eligibles' OOP spending includes their contributions toward LTC spending.[14]

WHERE DOES THE MONEY GO?

Where does the money Medicare beneficiaries spend on health care go? On average, 52 percent of Medicare beneficiaries' OOP expenses went toward health care services, with the remainder corresponding to spending on insurance premiums (figure 4). Average spending on premiums was lowest for Medicare beneficiaries with Medicaid ($420), for beneficiaries with no supplemental coverage ($1,374), and for beneficiaries with other public/private supplemental coverage ($1,520).

The largest categories of OOP spending for health care services in 2011 were for LTC facility

TABLE 6

Burden of Out-of-Pocket Spending by Beneficiaries' Supplemental Insurance Status

		Median Total OOP Spending as a Percentage of Income
	Overall	**18.0%**
Supplemental Insurance Status	None	19.4
	Any	17.7
Type of Supplemental Coverage	Employer sponsored	14.6
	Medigap	32.1
	Employer sponsored and Medigap	23.0
	Medicaid	11.3
	Other public/ private insurance	24.5

costs, prescription drugs, and physician services (medical providers). Together, these three categories accounted for three-quarters of beneficiary spending on health care services.

However, overall spending numbers mask the types of services that beneficiaries used and what they spent for care.

Almost all beneficiaries saw a physician at least once in 2011. Roughly 9 in 10 used one or more prescription drugs. About 7 in 10 received treatment in a hospital outpatient department. Only about 1 in 5 went to a hospital, and fewer used home health, skilled nursing care, or hospice (table 7).

Use of non-Medicare covered services was low. Approximately 43 percent of Medicare beneficiaries saw a dentist, and about 6 percent spent at least part of 2011 in an LTC facility.

Most beneficiaries had relatively moderate OOP spending for Medicare-covered services. However, a small group of beneficiaries had high spending. For example, 10 percent of beneficiaries admitted to a SNF paid at least $3,938 out of pocket for their stay, while 10 percent of prescription drug users spent $1,358 or more for their drugs. Ten percent of beneficiaries who saw a clinician in 2011 had OOP spending of at least $1,461 toward their physician fees.

TABLE 7
Beneficiary Out-of-Pocket Spending on Health Care Services

	Service	Users of Service %	OOP Spending by Users		
			Mean spending	Median spending	90th percentile of spending
Medicare Covered Services	Hospital inpatient	19.7	560	0	1,132
	Hospital outpatient	74.3	217	0	402
	Medical providers	96.0	660	242	1,461
	Prescription drugs	89.5	578	301	1,358
	Home health	17.1	425	0	0
	Skilled nursing facility	5.8	1,712	0	3,938
	Hospice	2.7	0	0	0
Non-Medicare Covered Services	Dental	42.8	687	230	1,825
	LTC facility	6.1	14,500	7,320	43,301

Similarly, a small group of beneficiaries spent a significant amount for some non-Medicare covered services. Although only 6 percent used an LTC facility, when they did, they generally incurred high OOP costs. Median OOP spending for users of such facilities was $7,320, with 10 percent of users paying at least $43,301 out of pocket for room and board and health care-related services during 2011.[15] Some of these residents may have been self-financing their nursing facility stay before eventually qualifying for Medicaid.

DISCUSSION

OOP health care spending presents a significant financial burden for many Medicare beneficiaries. Premiums make up a sizable—in some instances the largest—component of that spending.

The near poor, those in fair or poor health, and the oldest beneficiaries faced the highest burden of OOP health care costs. Even with programs like Medicaid aimed at helping the low-income population, on average, the poorest Medicare beneficiaries spent 23 percent of their income on health care. This analysis demonstrates that some low-income beneficiaries can still have a high OOP spending burden either because they did not enroll in Medicaid or because the program does not cover all of their costs.

Another important finding is that a large part of OOP spending burden comes from services that Medicare does not cover—dental, vision, hearing, LTC facility costs, and most home-based care costs.

Finally, it is also notable that specific illnesses can lead to very high spending. Beneficiaries who suffer from cancer, congestive heart failure, or osteoporosis face unusually high spending.

Policy makers should be cognizant of these high OOP burdens when considering changes to improve the Medicare program.

One option for limiting such high levels of cost exposure is to set a cap on OOP spending in the Medicare program. Both the Congressional Budget Office and the Medicare Payment Advisory Commission have explored the budget impact and other issues associated with a Medicare OOP cap.

Providing a budget-neutral OOP cap on spending would reduce the financial risk for beneficiaries with high spending and may mitigate the need to purchase supplemental insurance, a significant expense for many beneficiaries. Although a cap on OOP spending for Medicare services is important, setting it at $5,250 as has been previously suggested would help a little over one-quarter of all beneficiaries, and would still expose many beneficiaries to a large spending burden relative to their typically modest incomes. Further, a Medicare cap would not affect the large share of OOP spending on services that Medicare does not cover.

A better option for limiting costs would be to combine a cap on beneficiary spending with an expansion of programs intended to help low-income beneficiaries.

Despite programs such as the Medicare Savings Program, which helps low-income beneficiaries pay Medicare premiums and cost sharing, low-income and near-poor beneficiaries still face high OOP spending relative to income. Raising income limits to help those above 100 percent of the federal poverty level, and eliminating asset tests for participation in the Medicare Savings Program, would reduce the burden these costs impose by allowing more beneficiaries to access the reduced OOP spending these programs offer.

1 There are two types of plans for Medicare drug coverage: (1) Stand-Alone Prescription Drug Plans that offer only prescription drug coverage, paired with original Medicare; and (2) Medicare Advantage with Prescription Drug plans that cover all Medicare benefits, including prescription drugs.

2 In 2011, 74 percent of all Medicare beneficiaries were in the FFS program and the remaining 26 percent had a Medicare Advantage (MA) plan. The analysis excludes beneficiaries in MA because MCBS OOP spending data are not reliable for this population. See http://kff.org/medicare/state-indicator/enrollees-as-a-of-total-medicare-population/.

3 A spell of illness begins the day a beneficiary goes to a hospital or skilled nursing facility (SNF). The spell ends when the beneficiary has not received any inpatient hospital or SNF care for 60 days in a row. If the beneficiary goes into a hospital or a SNF after one spell of illness period ends, a new one begins and the beneficiary must pay the deductible again.

4 Beneficiaries may elect to use part or all of their 60 "lifetime reserve days" after 90 days in the hospital in each benefit period. Beneficiaries are responsible for a coinsurance amount for each "lifetime reserve day."

5 In practice, Medicare has occasionally denied coverage of SNF care before 100 days. This happened when Medicare considered that the facility was providing "custodial" rather than "skilled nursing" care since the beneficiary's health was no longer improving.

6 Since 2007, high-income Medicare-eligible individuals who enroll in the Part B program have been required to pay a monthly Part B premium that is higher than the standard premium.

7 For services received in hospital outpatient departments, beneficiaries pay a copayment rather than a coinsurance amount.

8 Recent legislation—aimed at fixing the way Medicare reimburses doctors—limits "first-dollar" coverage on certain Medigap plans by prohibiting coverage of the Part B deductible starting in 2020.

9 In 2011, median OOP spending for Medicare covered services was $454 and median OOP spending for non-Medicare covered services was $196 (table 1).

10 In 2011, 56 percent of Medicare beneficiaries under age 65 in the FFS program also enrolled in Medicaid. In contrast, only 11 percent of those 65 and older were also Medicaid recipients.

11 In 2011, yearly average expenditures toward premiums were $2,707 for women compared with $2,445 for men.

12 An examination of gender differences in mean OOP expenditures on Medicare covered services within age categories revealed generally smaller differences than those presented in table 1 for the full sample of men and women. This provides suggestive evidence that gender differences in the Medicare populations' age structure at least partially explain gender differences in OOP spending for Medicare covered services.

13 Whether supplemental coverage leads to better-reported health or healthier individuals are more likely to purchase supplemental coverage is beyond the scope of this paper.

14 As explained in the Methods box on page 2, LTC facility spending includes basic room-and-board costs as well as ancillary health spending in nursing homes and other LTC facilities. Room and board are considered medical expenses when they are a part of the basic charge for nursing homes and similar LTC institutions, and are counted as such in National Health Expenditures Accounts.

15 About two-thirds of Medicare beneficiaries who were in LTC at least part of the year were also in Medicaid, which partly covers their facility costs.

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