Insight on the Issues

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

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Many Medicare beneficiaries face significant out-of-pocket expenses to meet their health care needs. In 2013, people with traditional Medicare spent an average of $5,680 on insurance premiums and medical services. One in 10 people on Medicare spent at least $10,852. Health care expenses can create a significant financial burden for many Medicare beneficiaries, with half the people in fee-for-service Medicare spending at least 17 percent of their income on health care.

Medicare provides vital health care coverage to millions of adults 65 and older and to younger persons with disabilities. The program pays for a portion of the costs for certain inpatient and outpatient health care services and for some prescription drug costs.[1]

Contrary to a common belief, Medicare does not cover all health care–related costs. Based on the 2013 Medicare Current Beneficiary Survey (see "Box 2"), the following analysis of health care spending by people enrolled in traditional (also known as Original or fee-for-service) Medicare[2] (hereafter also referred to simply as "Medicare") shows that many Medicare beneficiaries have high out-of-pocket spending. As a result, many people in the program spend a significant share of their income to pay for their health care needs.

WHAT'S BEHIND MEDICARE BENEFICIARIES' HEALTH CARE SPENDING FIGURES?

A number of factors explain why many people with Medicare pay significant amounts out of pocket for health care.

First, even though the program offers fairly comprehensive coverage, traditional Medicare does not have a limit on beneficiaries' annual out-of-pocket spending.[3] Consequently, people on Medicare can face high expenses, especially as they become frail and need more medical services.

Second, people on traditional Medicare generally pay a monthly premium for physician (Part B) services ($104.90 in 2013) and for prescription drug (Part D) coverage (premium varies by plan).[4] A small share of beneficiaries also pays a monthly premium for inpatient hospital (Part A) services ($441 in 2013).[5] See "Box 1" for more explanation of Medicare Parts A, B, and D.

Third, Medicare requires that beneficiaries contribute to the cost of their care in the form of deductibles, coinsurances, and copayments[6] (See "Box 1").

Fourth, many people covered under traditional Medicare buy private supplemental insurance—such as Medigap or employer-sponsored retiree coverage—to help pay for their out-of-pocket costs for Medicare-covered services.[7] Premiums for such additional insurance can be high.

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BOX 1

Traditional Medicare at a Glance

Traditional Medicare covers an estimated 38 million[8] older adults and younger persons with a disability.

The program divides benefits into three parts:

PART A covers inpatient hospital visits, skilled nursing facility care, some home health visits, and hospice care. Under Medicare Part A, beneficiaries pay an initial deductible[9] for care in a hospital or in a skilled nursing facility ($1,184 in 2013) before Medicare coverage begins. Beneficiaries generally pay coinsurance for extended hospital inpatient stays ($296 per day for days 61–90 and $592 per day for days 91–150 in 2013[10]) or skilled nursing facility stays ($148 per day for days 21–100 in 2013). After their 90th day in the hospital[11] or 100th day in a skilled nursing facility,[12] beneficiaries pay the entire cost of their care. Beneficiaries do not pay a coinsurance for days 1–60 of an inpatient hospital stay or days 1–20 of a skilled nursing facility stay, and there is no cost sharing for home health visits.

PART B helps beneficiaries pay for physician, outpatient, some home health, and preventive services. For Part B services, beneficiaries pay an annual deductible ($147 in 2013) before Medicare coverage starts. They are responsible for a coinsurance after meeting the deductible –typically equal to 20 percent of the amount Medicare pays.[13,14]

PART D is the outpatient prescription drug benefit. It is a voluntary benefit delivered through private plans that contract with Medicare.

Last, beneficiaries pay substantial amounts out of pocket for services and devices—such as hearing aids, eyeglasses, dental care, and long-term care services—that are not covered by Medicare.

Medicaid, the Medicare Savings Programs, and the Part D Low-Income Subsidy programs help some low-income beneficiaries afford Medicare premiums and other expenses. However, not all low-income people on Medicare qualify for these programs and many who do are not enrolled.

MEDICARE BENEFICIARIES' SPENDING FOR HEALTH CARE

For the majority of Medicare beneficiaries, out-of-pocket costs are significant relative to their income. People covered by Medicare paid an average of $5,680 for health care in 2013 (table 1). They spent almost half of that money (46 percent) on Medicare or supplemental insurance premiums. The remainder was out-of-pocket spending for health care services that Medicare covers (27 percent) and for those that the program does not offer (27 percent).

The top 10 percent of beneficiaries facing the largest out-of-pocket expenses spent at least $10,852 (table 1), with the average beneficiary in this high-spenders group paying $23,301 for health care.

Because half of Medicare beneficiaries live on less than $26,200 a year[15] and the average annual Social Security retirement benefit is $16,101,[16] those numbers underscore that many people covered by the program face significant out-of-pocket costs for both premiums and non-premium expenses.

Beneficiaries' spending for health care varies widely, with the bottom quarter of spenders paying $860 on average and the top quarter of spenders paying an average of $14,312.

Out-of-pocket spending for health care varies with beneficiaries' socioeconomic characteristics—such as age, gender, race/ethnicity, and income levels. Spending on both premiums and health care services rises with age and is generally higher for women, Whites, and people with higher incomes (table 1).

The amount that people on Medicare spend on health care also varies with their health status and

TABLE 1
Medicare Beneficiaries' Out-of-Pocket Spending, Overall and by Beneficiaries' Socioeconomic Characteristics, 2013

		Mean Spending				90th Percentile of Spending			
		Total	Premiums	Medicare Covered Services	Non-Medicare Covered Services	Total	Premiums	Medicare Covered Services	Non-Medicare Covered Services
Overall		$5,680	$2,594	$1,567	$1,520	$10,852	$5,874	$3,341	$2,128
Age	Under 65	$3,570	$1,268	$1,444	$858	$8,615	$2,759	$3,237	$1,522
	65 and Older	$5,680	$2,594	$1,567	$1,520	$10,852	$5,874	$3,341	$2,128
Gender	Men	$5,129	$2,490	$1,397	$1,243	$10,406	$5,651	$3,290	$1,957
	Women	$6,164	$2,685	$1,716	$1,763	$11,318	$6,060	$3,397	$2,305
Race/ Ethnicity	White	$6,080	$2,788	$1,623	$1,669	$11,217	$6,186	$3,481	$2,241
	Black	$3,778	$1,607	$1,400	$771	$8,541	$3,611	$2,802	$1,439
	Hispanic	$3,682	$1,031	$1,801	$850	$5,289	$1,799	$1,382	$845
	Other	$3,467	$1,894	$833	$740	$8,547	$4,604	$2,157	$1,101
Income	Up to 200% of FPL	$3,960	$2,021	$1,408	$531	$8,502	$4,847	$3,006	$935
	Over 200% of FPL	$5,850	$3,330	$1,615	$905	$10,963	$7,001	$3,564	$1,988

Source: *AARP Public Policy Institute analysis of data from the Medicare Current Beneficiary Survey, 2013 Cost and Use File.*
FPL=federal poverty line

whether they have a chronic condition (table 2). The most recent available data show that, in 2013, Medicare beneficiaries in fair or poor health were especially likely to face significant expenses. They paid an average of $4,496 out of pocket for health care services—more than twice the amount incurred by people in excellent or very good health ($2,216). People with congestive heart failure spent more on health care services than those with any other type of illness—an average of $5,550, compared with average spending of $4,586 for cancer, $4,338 for stroke, and $3,832 for osteoporosis.

TABLE 2
Medicare Beneficiaries' Out-of-pocket Spending by Health Status, 2013

		Mean Spending			90th Percentile of Spending		
		All Services	Medicare Covered Services	Non-Medicare Covered Services	All Services	Medicare Covered Services	Non-Medicare Covered Services
Self-Reported Health	Excellent/Very Good	$2,116	$1,054	$1,062	$4,165	$2,368	$1,836
	Good	$3,164	$1,740	$1,423	$5,796	$3,564	$2,041
	Fair/Poor	$4,496	$2,221	$2,275	$9,443	$4,915	$2,825
Chronic Condition	Cancer	$4,586	$3,532	$1,054	$7,928	$5,886	$1,362
	Depression	$2,921	$1,723	$1,198	$5,589	$3,608	$1,688
	Congestive Heart Failure	$5,550	$3,284	$2,266	$10,137	$5,796	$3,027
	Stroke	$4,338	$2,767	$1,571	$8,891	$5,360	$2,581
	Osteoporosis	$3,832	$2,209	$1,623	$7,092	$4,297	$2,285
	Diabetes	$2,465	$1,834	$631	$5,097	$3,945	$1,481
	Hypertension	$3,179	$1,740	$1,439	$6,229	$3,629	$2,000
	Emphysema	$3,214	$2,083	$1,131	$6,612	$4,285	$2,074
	Rheumatoid Arthritis	$3,364	$1,871	$1,493	$6,784	$4,042	$2,161

Source: *AARP Public Policy Institute analysis of data from the Medicare Current Beneficiary Survey, 2013 Cost and Use File.*

Long-term care facilities—which Medicare does not cover—are, by far, the most expensive category of out-of-pocket spending (table 3). The average Medicare beneficiary who stayed in such a facility spent $16,737 out of pocket in 2013. Out-of-pocket costs for skilled nursing facilities ($2,118), clinicians' services ($744), and dental care ($665) are also substantial.

THE FINANCIAL BURDEN OF OUT-OF-POCKET SPENDING FOR HEALTH CARE

Health care expenses can create a significant financial burden for many Medicare beneficiaries. Half of the people with Medicare coverage spent 17 percent or more of their income on premiums and health care services combined in 2013. The percentage of their income that Medicare beneficiaries spend on health care has remained nearly unchanged since 2006 (figure 1).

The financial burden of health care spending varies with health and other characteristics of people with Medicare (table 4). For example, half of those in fair or poor health spent 21 percent or more of their income on premiums and health care services; in comparison, those who were in excellent or very good health spent 14 percent or more of their income on premiums and health care. Likewise, Medicare beneficiaries who are 65 and older, are women, or identify as White typically spent a larger share of their income on health care.

In 2013, one in 10 beneficiaries[17] spent at least 75 percent of their income on health care (figure 2).

Spending for health care represents a significant burden for many Medicare recipients with modest incomes, even with the financial help available to them through Medicaid (figure 2).

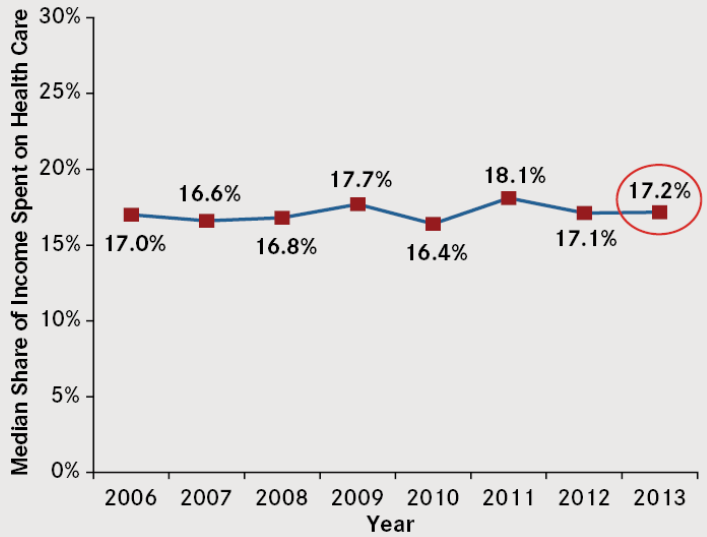
TABLE 3
Where Does the Money Go?

		Percentage of Beneficiaries Using	Average Amount Spent
Services Covered by Medicare	Hospital Inpatient	17.8%	$533
	Hospital Outpatient	75.7%	$196
	Medical Providers	96.7%	$744
	Prescription Drugs	91.3%	$618
	Home Health	19.1%	$626
	Skilled Nursing Facility	5.8%	$2,118
	Hospice	2.2%	$0
Services Not Covered by Medicare	Dental Care	47.0%	$665
	Long-Term Care Facility	6.0%	$16,737

Source: *AARP Public Policy Institute analysis of data from the Medicare Current Beneficiary Survey, 2013 Cost and Use File.*

Half of those with incomes up to 200 percent of the federal poverty line spent about a quarter or more of their income on insurance and health care services. In comparison, half of beneficiaries with incomes over 200 percent of the federal poverty line spent 13 percent or more of their income. In addition, 10 percent of lower-income beneficiaries spent almost the entirety of their income on health care and long-term care expenses.

FIGURE 1
Out-of-Pocket Health Care Spending as a Percentage of Income, 2006–13



Source: *AARP Public Policy Institute analysis of data from the Medicare Current Beneficiary Survey, 2013 Cost and Use File.*

TABLE 4

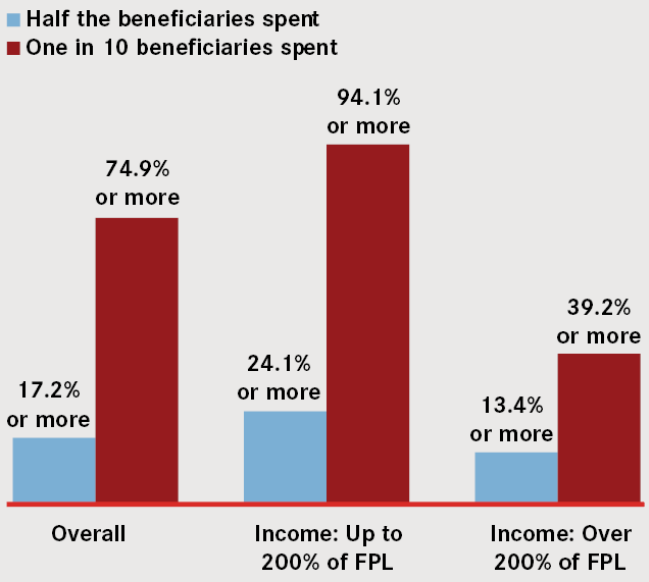
The Financial Burden of Health Care Spending, Overall and by Medicare Beneficiaries' Socioeconomic and Health Characteristics, 2013

		Median Share of Income Spent on Health Care
Overall		17.2%
Age	Under 65	15.5%
	65 and Older	17.5%
Gender	Men	15.2%
	Women	19.0%
Race/ Ethnicity	White	17.8%
	Black	15.5%
	Hispanic	12.2%
	Other	13.1%
Self-Reported Health	Excellent/Very Good	14.1%
	Good	19.4%
	Fair/Poor	21.1%

Source: *AARP Public Policy Institute analysis of data from the Medicare Current Beneficiary Survey, 2013 Cost and Use File.*

FIGURE 2

Out-of-Pocket Spending as a Percentage of Income, Overall and by Income Level, 2013



Source: *AARP Public Policy Institute analysis of data from the Medicare Current Beneficiary Survey, 2013 Cost and Use File.*

Note: *Out-of-pocket spending includes health and long-term care expenses. FPL=federal poverty line.*

CONCLUSION.

Some policy makers and researchers have proposed increasing the amounts that people on Medicare pay for their health care benefits as a way to control federal spending. These proposals usually assume that Medicare beneficiaries currently pay very little out of pocket. In fact, many people who rely on the federal program already spend substantial amounts of money on health care. While the program provides critical coverage to millions of beneficiaries, traditional Medicare does not limit people's out-of-pocket spending and has relatively high cost-sharing requirements. Many Medicare beneficiaries also buy private insurance in addition to paying for Medicare's premiums and pay substantial amounts for services that are not covered by Medicare. Consequently, spending for health care consumes a significant share of many Medicare beneficiaries' incomes. Many beneficiaries who live on modest incomes or who are in poor health face especially heavy financial burdens.

This *Insight on the Issues* highlights the need to consider targeted policies to protect people on Medicare from burdensome personal spending—especially as baby boomers age into the program and Medicare's rolls continue to swell.

To make Medicare more affordable, Congress should

- Evaluate how proposals to redesign Medicare will directly and indirectly affect beneficiaries' out-of-pocket spending, while being fully informed of the level of burden beneficiaries already incur;
- Limit increases in the amounts that Medicare recipients pay for insurance premiums and health care services;
- Ensure that people with Medicare who live on modest incomes and those in poor health are protected from excessively high spending; and
- Close gaps in insurance coverage that lead to substantial expenses for some people with traditional Medicare.

The bottom line is that, ultimately, such policies should ensure that all Medicare beneficiaries have affordable access to the health care they need.

BOX 2

Methods

Data

This study uses the 2013 Cost and Use Files of the Medicare Current Beneficiary Survey (MCBS)—an annual panel survey of approximately 11,000 respondents. The MCBS sample is representative of Medicare's population of older adults, persons with a disability, and persons with end-stage renal disease—including those who live in long-term care facilities. The analysis excludes people enrolled in Medicare Advantage plans because their personal spending data were not reliable.

In most cases, respondents reported how much they paid for premiums and health care services. Interviewers verified respondents' answers with invoices, receipts, explanation-of-benefits forms, and empty prescription containers. In some instances, the information on personal spending came from Medicare claims—for example, when there was strong evidence that a respondent reported an incorrect number or when a respondent could not remember or show evidence of how much he or she spent. When a respondent lived in a long-term care setting, a facility representative answered questions about how much the beneficiary's stay cost.

Measuring How Much People on Medicare Pay Out of Pocket for Health Care

Medicare beneficiaries' total spending is the sum of the yearly amounts they (or a third party on their behalf) paid for:

- Premiums for Medicare Parts A, B, and D as well as premiums for supplemental coverage.
- Services covered by Medicare: deductibles, copayments, coinsurance amounts, and balance billing payments for inpatient and outpatient hospital stays, medical providers, home health care, hospice, and skilled nursing facilities.
- Services not covered by Medicare: spending for dental care and long-term care facilities (licensed/skilled nursing homes, assisted living, and other residential facilities)—including spending for health care services and for room and board.
- Prescription drugs

Measuring What Share of Their Income Beneficiaries Spend on Health Care

The share of income spent on health care is the total amount spent out of pocket divided by the respondent's self-reported individual income. When respondents reported incomes for both themselves and their spouse, the analysis assumed that individual income was equal to half the reported figure.

Exclusions

The MCBS does not have information on how much people on Medicare spend for some health care services that Medicare does not cover, such as vision, hearing, and home-based care. Because these represent additional personal spending, this analysis underestimates how much people with Medicare spend on health care.

1 For beneficiaries who elect Part D coverage.

2 In 2013, 72 percent of all Medicare beneficiaries were enrolled in traditional Medicare. Spending data for the remaining 28 percent who had a Medicare Advantage plan were not reliable. See Kaiser Family Foundation, "Medicare Advantage," Kaiser Family Foundation Fact Sheet, October 2017, https://www.kff.org/medicare/fact-sheet/medicare-advantage/.

3 Unlike traditional Medicare, Medicare Advantage plans limit the total amount beneficiaries can owe.

4 People with incomes above a certain amount pay higher, income-related, Part B and D premiums.

5 Most people get premium-free Part A coverage based on their (or their spouse's) work history.

6 Deductibles, copayments, and coinsurance amounts can change annually to reflect changes in the program's costs.

7 The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 prohibits the sale of Medigap policies that cover Part B deductibles to people who become eligible for Medicare starting in 2020.

8 Centers for Medicare and Medicaid Services (CMS)/Office of Enterprise Data and Analytics/Office of the Actuary, "CMS Fast Facts," August 2017, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMS-Fast-Facts/index.html.

9 The deductible covers all inpatient services and related outpatient services for 72 hours before admission obtained during the first 60 days of each benefit period (a benefit period begins on the day of hospital inpatient or skilled nursing facility admission and ends when the beneficiary has not received any inpatient hospital or skilled nursing facility care for 60 consecutive days). Beneficiaries must pay an inpatient deductible for each benefit period and there's no limit to the number of benefit periods.

10 Coinsurance amount is for people who use their 60 "lifetime reserve days" after 90 days in the hospital. Otherwise, beneficiaries incur the entire cost of their care after their 90th day as a hospital inpatient.

11 Unless people use their 60 "lifetime reserve days" after 90 days in the hospital. In this case, they incur a daily coinsurance ($592 in 2013) for days 91–150.

12 Medicare has sometimes refused to cover skilled nursing facility care before the 100 days mark on the grounds that the patient was no longer improving—and therefore getting "custodial" rather than "skilled nursing" care.

13 Under Part B, people on Medicare generally owe a set amount (rather than a percentage of the cost) for each hospital outpatient service other than the doctor or other health care provider's services.

14 There is no coinsurance or deductible for the annual wellness visit or for preventive services that are rated "A" or "B" by the US Preventive Services Task Force.

15 G. Jacobson, S. Griffin, T. Neuman, and K. Smith, "Income and Assets of Medicare Beneficiaries, 2016–2035," Kaiser Family Foundation Issue Brief, https://www.kff.org/medicare/issue-brief/income-and-assets-of-medicare-beneficiaries-2016-2035/ April 2017.

16 The average monthly Social Security retirement benefit in 2015 was approximately $1,342 per month. Social Security Administration, Annual Statistical Supplement to the Social Security Bulletin, 2016, (Washington, DC, Social Security Administration, 2016), https://www.socialsecurity.gov/policy/docs/statcomps/supplement/2015/5b.html#table5.b8.

17 The top decile of out-of-pocket spending.

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