Insight on the Issues

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

Claire Noel-Miller
AARP Public Policy Institute

Many Medicare beneficiaries face significant out-of-pocket expenses to meet their health care needs. In 2017, people with traditional Medicare spent an average of $5,801 on insurance premiums and medical services. One in 10 people on Medicare spent at least $10,268. Health care expenses can create a significant financial burden for many Medicare beneficiaries, with half the people in traditional Medicare spending at least 16 percent of their income on health care.

Medicare provides vital health care coverage to millions of adults ages 65 and older and to some younger persons with a disability or end-stage renal disease. 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. Using the 2017 Medicare Current Beneficiary Survey—the most recent available data—this *Insight on the Issues* highlights the fact that many Medicare beneficiaries have high out-of-pocket spending. The report details actual health care spending by people enrolled in traditional Medicare[2] (hereafter referred to simply as "Medicare") and shows how large the financial burden of health care is, based on costs relative to income (see the appendix for methods). It also highlights the need to consider targeted policies to protect people on Medicare from burdensome health care spending, especially as enrollment continues to grow, and outlines some guiding principles for any related Medicare policies.

WHAT'S BEHIND MEDICARE BENEFICIARIES' HEALTH CARE SPENDING FIGURES

Several 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 with traditional Medicare generally pay a monthly premium for physician (Part B) coverage (the standard premium was $134 in 2017) and for prescription drug (Part D) coverage (the premium varies by plan).[4] A small share of beneficiaries also pay a monthly premium for inpatient hospital (Part A) coverage ($413 in 2017).[5] See the box, "Traditional Medicare at a Glance" for more explanation of Medicare Parts A, B, and D.

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

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

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

Out-of-pocket costs are significant for many Medicare beneficiaries. People covered by Medicare paid an average of $5,801 for health care in 2017 (table 1). They spent almost half of that money (47 percent) on Medicare or supplemental insurance premiums. The remainder was out-of-pocket spending for health care services that Medicare covers (26 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 $10,268 (table 1).[8]

The fact that half of Medicare beneficiaries live on less than $26,200 a year,[9] and the average annual Social Security retirement benefit is ($16,104),[10] underscores the reality that many people covered by the program face significant out-of-pocket costs for both premiums and non-premium expenses.

TRADITIONAL MEDICARE AT A GLANCE

Traditional Medicare covers an estimated 38 million[11] 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[12] for care in a hospital or skilled nursing facility ($1,316 in 2017) before Medicare coverage begins. Beneficiaries generally pay coinsurance for extended hospital inpatient stays ($329 per day for days 61–90 and $658 per day for days 91–150 in 2017[13]) or skilled nursing facility stays ($164.50 per day for days 21–100 in 2017). After their 90th day in the hospital[14] or 100th day in a skilled nursing facility,[15] 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 coverage, beneficiaries pay an annual deductible ($183 in 2017) before Medicare coverage starts. They are responsible for a coinsurance after meeting the deductible–typically equal to 20 percent of the amount Medicare pays.[16,17]
- **Part D is the outpatient prescription drug benefit.** It is a voluntary benefit delivered through private plans that contract with Medicare.

TABLE 1

Medicare Beneficiaries' Out-of-Pocket Spending, Overall and by Beneficiaries' Socioeconomic Characteristics, 2017

Characteristic	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	$5,801	$2,728	$1,522	$1,551	$10,268	$5,218	$3,740	$2,537
Age								
Under 65	$4,183	$1,810	$1,441	$932	$9,329	$2,262	$3,697	$2,155
65 and Older	$6,089	$2,891	$1,536	$1,662	$10,551	$5,413	$3,744	$2,612
Gender								
Male	$5,375	$2,668	$1,452	$1,254	$9,764	$5,280	$3,405	$2,450
Female	$6,175	$2,780	$1,583	$1,813	$10,742	$5,199	$4,023	$2,633
Race/Ethnicity								
White	$6,128	$2,849	$1,613	$1,665	$10,687	$5,344	$3,932	$2,681
Black	$4,054	$2,000	$1,264	$789	$7,926	$3,756	$3,407	$1,470
Hispanic	$4,275	$2,205	$1,056	$1,014	$8,748	$4,841	$2,491	$2,328
Other	$5,276	$2,608	$1,035	$1,632	$9,097	$5,682	$2,288	$1,640
Income								
Up to 200% of FPL	$5,019	$2,287	$1,376	$1,356	$9,254	$4,440	$3,387	$1,800
Over 200% of FPL	$6,306	$3,012	$1,616	$1,678	$10,789	$5,664	$3,932	$2,780

Source: AARP Public Policy Institute analysis of the 2017 Medicare Current Beneficiary Survey.

FPL = federal poverty line

Beneficiaries' total out-of-pocket spending for health care premiums and services varies widely: the bottom quarter of spenders pay $1,557 on average and the top quarter of spenders pay an average of $13,296.

Out-of-pocket spending for health care varies with beneficiaries' socioeconomic characteristics, such as age, gender, race/ethnicity, and income level. Total spending on 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 whether they have a chronic condition (table 2). The data show that, in 2017, Medicare beneficiaries in fair or poor health were especially likely to face significant expenses. They paid an average of $2,755 out of pocket for health care services—significantly more than the amount incurred by people in excellent or very good health ($1,894). People with Parkinson's disease spent more on health care services than those with any other type of illness—an average of $3,768, compared with average spending of $3,397 for cancer, $2,950 for congestive heart failure, and $2,923 for non-skin cancer.

TABLE 2

Medicare Beneficiaries' Out-of-Pocket Spending by Health Status, 2017

Health Status	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	$1,894	$1,153	$741	$4,725	$2,791	$1,925
Good	$2,182	$1,471	$711	$5,599	$3,759	$1,777
Fair/Poor	$2,755	$1,700	$1,055	$5,968	$4,240	$2,226
Chronic Condition						
Hypertension	$2,353	$1,602	$751	$5,590	$4,104	$1,908
Congestive heart failure	$2,950	$2,254	$696	$6,864	$5,923	$1,784
Stroke	$2,531	$1,815	$716	$6,174	$4,934	$1,671
High cholesterol	$2,293	$1,523	$770	$5,481	$3,886	$2,019
Non-skin cancer	$2,923	$2,004	$919	$6,800	$4,739	$2,716
Rheumatoid arthritis	$2,379	$1,645	$734	$5,551	$4,026	$1,787
Alzheimer's/Dementia	$3,397	$2,756	$641	$5,554	$4,162	$1,592
Depression	$2,417	$1,687	$731	$5,757	$4,102	$1,934
Non-depressive mental health disorder	$2,152	$1,447	$705	$5,816	$3,715	$1,777
Osteoporosis	$2,623	$1,838	$786	$5,845	$4,035	$2,086
Parkinson's disease	$3,768	$3,124	$643	$5,795	$5,285	$2,034
Emphysema/Asthma/COPD	$2,369	$1,660	$709	$5,568	$4,037	$1,675
Diabetes	$2,536	$1,727	$809	$5,984	$4,823	$2,049

Source: AARP Public Policy Institute analysis of the 2017 Medicare Current Beneficiary Survey.

COPD = Chronic obstructive pulmonary disease

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 $20,664 out of pocket in 2017. Out-of-pocket costs for skilled nursing facilities ($2,162), dental care ($857), clinicians' services ($776), and prescription drugs ($709) are also substantial.

TABLE 3
Where Does the Money Go?

Type of Service	Percentage of Beneficiaries Using	Average Amount Spent
Services Covered by Medicare		
Hospital inpatient	17%	$396
Hospital outpatient	77%	$189
Medical providers	96%	$776
Prescription drugs	89%	$709
Home health	16%	$387
Skilled nursing facility	5%	$2,162
Hospice	2%	$0
Services Not Covered by Medicare		
Dental care	52%	$857
Long-term care facility	4%	$20,664

Source: AARP Public Policy Institute analysis of the 2017 Medicare Current Beneficiary Survey.

FINANCIAL BURDEN BY SHARE OF INCOME

The significant financial burden of health care expenses for many Medicare beneficiaries is perhaps most evident when considering not just the total costs as described above but those costs relative to beneficiaries' resources. Half of the people with Medicare coverage spent 16 percent or more of their income on premiums and health care services combined in 2017 (table 4). This level of spending burden has remained about the same over the past several years.

As is the case with spending totals, 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 18 percent or more of their income on premiums and health care services; in comparison, those who were in excellent or very good health spent 12 percent or more of their income on premiums and health care. Likewise, Medicare beneficiaries who are under age 65, are women, or identify as Black or Hispanic typically spent a larger share of their income on health care.

In 2017, 1 in 10 beneficiaries[18] spent at least 53 percent of their income on health care (figure 1).

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 1). Half of those with incomes up to 200 percent of the federal

TABLE 4
The Financial Burden of Health Care Spending, Overall and by Medicare Beneficiaries' Socioeconomic and Health Characteristics, 2017

Characteristic	Median Share of Income Spent on Health Care
Overall	16%
Age	
Under 65	21%
65 and older	15%
Gender	
Male	14%
Female	17%
Race/Ethnicity	
White	15%
Black	19%
Hispanic	19%
Other	15%
Self-Reported Health	
Excellent/Very good	12%
Good	17%
Fair/Poor	18%

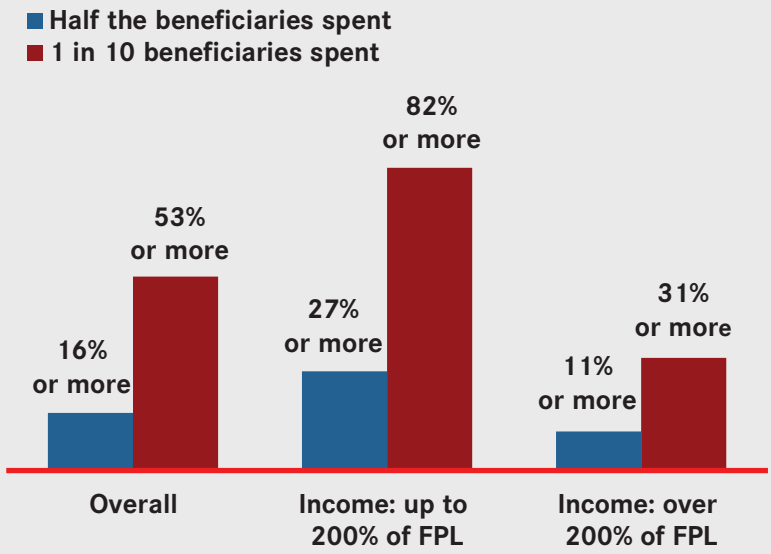
Source: AARP Public Policy Institute analysis of the 2017 Medicare Current Beneficiary Survey.

poverty line spent 27 percent 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 11 percent or more of their income. In addition, 1 in 10 beneficiaries with lower incomes spent 82 percent or more of their income on health care and long-term care expenses.

As a result of health care's financial burden, 10 percent of beneficiaries delay care due to cost and 10 percent experience problems paying for their medical bills (figure 2). This is especially true for beneficiaries with lower incomes: 17 percent postponed care because of cost and 18 percent had difficulties paying medical bills.

FIGURE 1

Out-of-Pocket Spending as a Percentage of Income, Overall and by Income Level, 2017



Source: AARP Public Policy Institute analysis of the 2017 Medicare Current Beneficiary Survey.

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

CONCLUSION

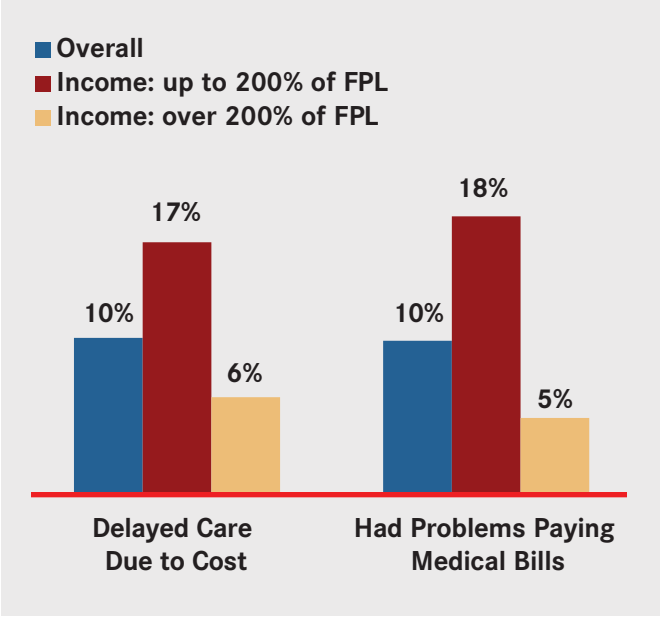
Many people who rely on Medicare spend substantial amounts of money on health care. While the program provides critical coverage to millions of beneficiaries, traditional Medicare does not limit people's out-of-pocket spending and has relatively high cost-sharing requirements. Many Medicare beneficiaries also buy often-costly private insurance in addition to paying for Medicare's premiums and pay substantial amounts for services that Medicare does not cover. Consequently, spending for health care consumes a significant share of many Medicare beneficiaries' incomes. Beneficiaries who live on modest incomes or who are in poor health face especially heavy financial burdens.

To make Medicare more affordable and to protect people on Medicare from burdensome health care spending, 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.

FIGURE 2

Delayed Care Due to Cost and Problems Paying Medical Bills, Overall and by Income Level, 2017



- Ensure people with Medicare who live on modest incomes and those in poor health are protected from excessively high spending.
- Ensure those who qualify for financial help to afford Medicare premiums and other expenses receive that help.
- Close gaps in insurance coverage that lead to substantial expenses for some people with traditional Medicare.

Ultimately, a key guiding principle for all policy proposals affecting Medicare should be to ensure that all beneficiaries have affordable access to the health care they need.

APPENDIX: METHODS

Data

This study uses the 2017 Survey File and Cost Supplement of the Medicare Current Beneficiary Survey (MCBS), an annual panel survey of approximately 15,000 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 the following:

- 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 traditional 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 Traditional Medicare is also known as Original Medicare or Fee-for-Service Medicare. In 2017, 67 percent of all Medicare beneficiaries were enrolled in traditional Medicare. Medicare Current Beneficiary Survey spending data for the remaining 33 percent who had a Medicare Advantage plan were not reliable. See Kaiser Family Foundation, "Medicare Advantage," Kaiser Family Foundation Fact Sheet, June 2019, https://bit.ly/2u0n8ab.

3 Unlike traditional Medicare, Medicare Advantage plans limit the total amount that 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 of 2015 prohibits the sale of Medigap policies that cover Part B deductibles to people who become eligible for Medicare starting in 2020.

8 The average beneficiary in this high-spenders group spent $21,068 for health care in 2017.

9 G. Jacobson et al., "Income and Assets of Medicare Beneficiaries, 2016–2035," Kaiser Family Foundation Issue Brief, April 2017, https://www.kff.org/medicare/issue-brief/income-and-assets-of-medicare-beneficiaries-2016-2035/.

10 The average Social Security retirement benefit in 2018 was $1,342 per month. Social Security Administration, "Annual Statistical Supplement to the Social Security Bulletin," Table 5.A1, 2019, https://www.ssa.gov/policy/docs/statcomps/supplement/2019/5a.pdf.

11 Centers for Medicare and Medicaid Services (CMS)/Office of Enterprise Data and Analytics/Office of the Actuary, "CMS Fast Facts," November 2019, https://go.cms.gov/2T7fYf0.

12 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.

13 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.

14 Unless people use their 60 "lifetime reserve days" after 90 days in the hospital. In this case, they incur a daily coinsurance ($658 in 2017) for days 91–150.

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

16 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.

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

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

Insight on the Issues 151, June 2020

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https://doi.org/10.26419/ppi.00105.001