Spotlight

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

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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 beneficiaries, prescription drug costs. Yet, contrary to popular belief, Medicare does not cover all health care-related costs. Using the 2018 Medicare Current Beneficiary Survey, this Spotlight highlights the high out-of-pocket spending that many Medicare beneficiaries face. This report details actual health care spending by people enrolled in traditional Medicare and shows how large the financial burden of health care is for them, based on costs relative to income (see the appendix for methods). It also highlights the need to consider targeted policies to protect people with 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 traditional Medicare pay significant amounts out of pocket for health care:

- Even though the program offers fairly comprehensive coverage, traditional Medicare does not have a limit on beneficiaries’ annual out-of-pocket spending. Consequently, people with traditional Medicare can face high expenses, especially as they age and need more medical services.

- People with traditional Medicare generally pay a monthly premium for physician (Part B) coverage (in 2018, the standard premium was $134 per month or $1,608 for the year) and for prescription drug (Part D) coverage (the premium varies by plan). A small share of beneficiaries also pay a monthly premium for inpatient hospital (Part A) coverage (in 2018, the full premium was $422 per month or $5,064 for the year). See “At a Glance” for more on Medicare Parts A, B, and D.

- Traditional Medicare requires that beneficiaries contribute to the cost of their care in the form of deductibles, coinsurances, and copayments (see “At a Glance”).

KEY TAKEAWAYS

- Many Medicare beneficiaries face significant out-of-pocket expenses to meet their health care needs.
- In 2018, people with traditional Medicare spent an average of $6,168 on insurance premiums and medical services.
- One in 10 people with traditional Medicare spent at least $10,816 in 2018, and the top quarter of spenders paid an average of $14,123.
- Health care expenses can create a significant financial burden for many Medicare beneficiaries, with half the people with traditional Medicare spending at least 16 percent of their income on health care.
- One in 10 beneficiaries spent at least 52 percent of their income on health care.
**AT A GLANCE**

**Beneficiaries’ Out-of-Pocket Contributions to Their Care under Traditional Medicare**

Traditional Medicare covers an estimated 39 million older adults and younger persons with a disability. The program divides benefits into three parts, each with different requirements for out-of-pocket contributions:

**Part A** covers inpatient hospital visits, skilled nursing facility care, some home health visits, and hospice care. People with traditional Medicare are responsible for the following costs when they use Medicare Part A services:

- a deductible for hospital inpatient or skilled nursing facility care,
- a coinsurance for extended hospital inpatient stays lasting between 61 and 90 days and skilled nursing facility stays lasting between 21 and 100 days, and
- the entire cost of their care after their 90th day in the hospital or 100th day in a skilled nursing facility.

**Part B** helps beneficiaries pay for physician, outpatient, some home health, and preventive services. For Part B services, people with traditional Medicare are responsible for:

- an annual deductible, and
- a coinsurance, which is typically equal to 20 percent of the amount Medicare pays health care providers.

**Part D** is the outpatient prescription drug benefit. It is a voluntary benefit delivered through private plans that contract with Medicare. The deductible, copayment, and coinsurance amounts that people with traditional Medicare are responsible for under Part D vary by plan.

**Glossary**

**Coinsurance:** Share of the cost of a covered health care service a person is responsible for, calculated as a percentage of the allowed amount for the service.

**Copayment:** Fixed dollar amount people owe for a covered health care service, usually when they receive the service.

**Deductible:** Amount people owe during a coverage period (e.g., one year) for covered health care services before health coverage begins to pay.

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2 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. In 2018, the Part A deductible was $1,340.

3 In 2018, the coinsurance was $335 per day for days 61 through 90 of an inpatient hospital stay and $167.50 per day for days 21 through 100 in a skilled nursing facility.

4 In 2018, people with traditional Medicare can choose to use their 60 “lifetime reserve days” after 90 days as hospital inpatients. In this case, they incur a daily coinsurance ($670 in 2018) for days 91 through 150.

5 The Part B deductible was $183 in 2018.

6 In addition to the 20 percent coinsurance for health care providers’ services, people who get care in an outpatient hospital setting usually owe the hospital a copayment for each service they receive. Under Part B, 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.
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. Premiums for such additional insurance can be high.

Beneficiaries pay substantial amounts out of pocket for services and devices not covered by traditional Medicare. Examples include hearing aids, eyeglasses, dental care, and long-term care services. Medicaid, the Medicare Savings Programs, and the Part D Low-Income Subsidy program help offset out-of-pocket expenses for some low-income beneficiaries. For example, the Medicare Savings Programs help people with limited income and resources pay for their Medicare premiums, and, in some cases, Medicare deductibles, copayments, and coinsurance. However, not all low-income people with Medicare qualify for these programs. In addition, for a variety for reasons—including being unaware of eligibility or because of the application process’s complexity—many individuals who do qualify have not enrolled.

Medicare Beneficiaries’ Spending for Health Care

Out-of-pocket costs are significant for many Medicare beneficiaries. People covered by traditional Medicare paid an average of $6,168 for health care in 2018 (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 cover (27 percent).

Beneficiaries in the top 10 percent for out-of-pocket expenses spent at least $10,816 (table 1).

### TABLE 1
Medicare Beneficiaries’ Out-of-Pocket Spending, Overall and by Beneficiaries’ Socioeconomic Characteristics, 2018

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Mean Out-of-Pocket Spending</th>
<th>Out-of-Pocket Spending by Top 10 Percent of Spenders</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>Premiums</td>
</tr>
<tr>
<td>Overall</td>
<td>$6,168</td>
<td>$2,929</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 65</td>
<td>$4,206</td>
<td>$1,918</td>
</tr>
<tr>
<td>65 and Older</td>
<td>$6,509</td>
<td>$3,105</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>$5,659</td>
<td>$2,812</td>
</tr>
<tr>
<td>Female</td>
<td>$6,627</td>
<td>$3,035</td>
</tr>
<tr>
<td>Race/Ethnicity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>$6,546</td>
<td>$3,035</td>
</tr>
<tr>
<td>Black</td>
<td>$4,423</td>
<td>$2,213</td>
</tr>
<tr>
<td>Hispanic</td>
<td>$4,248</td>
<td>$2,359</td>
</tr>
<tr>
<td>Other</td>
<td>$5,317</td>
<td>$3,028</td>
</tr>
<tr>
<td>Income</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Up to 200% of FPL</td>
<td>$5,096</td>
<td>$2,413</td>
</tr>
<tr>
<td>Over 200% of FPL</td>
<td>$6,788</td>
<td>$3,228</td>
</tr>
</tbody>
</table>

Source: AARP Public Policy Institute analysis of the 2018 Medicare Current Beneficiary Survey

FPL = federal poverty level
Considering that half of Medicare beneficiaries live on less than $26,200 a year\(^\text{10}\) and the average annual Social Security retirement benefit is $16,104,\(^\text{11}\) many people in the program face significant out-of-pocket costs for both premiums and non-premium expenses.

Beneficiaries’ total out-of-pocket spending for health care premiums and services varies widely: the bottom quarter of spenders paid $1,606 on average and the top quarter of spenders paid an average of $14,123 (data not shown in tables).

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, White people, and people with higher incomes (table 1). The amount that people with traditional Medicare spend on health care also varies based on their health status and whether they have a chronic condition (table 2). Perhaps unsurprisingly, for example, the data show that in 2018, traditional Medicare beneficiaries in fair or poor health were especially likely to face significant expenses. They paid an average of $2,971 out of pocket for health care services—significantly more than the amount incurred by

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**TABLE 2**

**Medicare Beneficiaries’ Out-of-Pocket Spending by Health Status, 2018**

<table>
<thead>
<tr>
<th>Health Status</th>
<th>Mean Out-of-Pocket Spending</th>
<th>Out-of-Pocket Spending by Top 10 Percent of Spenders</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All services</td>
<td>Medicare covered services</td>
</tr>
<tr>
<td><strong>Self-Reported Health</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Excellent/Very good</td>
<td>$1,956</td>
<td>$1,158</td>
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<tr>
<td>Good</td>
<td>$2,408</td>
<td>$1,591</td>
</tr>
<tr>
<td>Fair/Poor</td>
<td>$2,971</td>
<td>$1,806</td>
</tr>
<tr>
<td><strong>Chronic Condition</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hypertension</td>
<td>$2,421</td>
<td>$1,655</td>
</tr>
<tr>
<td>Congestive heart failure</td>
<td>$3,499</td>
<td>$2,671</td>
</tr>
<tr>
<td>Stroke</td>
<td>$2,983</td>
<td>$2,160</td>
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<tr>
<td>High cholesterol</td>
<td>$2,393</td>
<td>$1,572</td>
</tr>
<tr>
<td>Non-skin cancer</td>
<td>$2,684</td>
<td>$1,824</td>
</tr>
<tr>
<td>Rheumatoid arthritis</td>
<td>$2,582</td>
<td>$1,717</td>
</tr>
<tr>
<td>Alzheimer’s/Dementia</td>
<td>$3,210</td>
<td>$2,548</td>
</tr>
<tr>
<td>Depression</td>
<td>$2,482</td>
<td>$1,676</td>
</tr>
<tr>
<td>Non-depressive mental health disorder</td>
<td>$2,613</td>
<td>$1,676</td>
</tr>
<tr>
<td>Osteoporosis</td>
<td>$2,857</td>
<td>$2,020</td>
</tr>
<tr>
<td>Parkinson’s disease</td>
<td>$3,773</td>
<td>$2,971</td>
</tr>
<tr>
<td>Emphysema/Asthma/COPD</td>
<td>$2,696</td>
<td>$1,906</td>
</tr>
<tr>
<td>Diabetes</td>
<td>$2,742</td>
<td>$1,798</td>
</tr>
</tbody>
</table>

Source: AARP Public Policy Institute analysis of the 2018 Medicare Current Beneficiary Survey

COPD = chronic obstructive pulmonary disease
people in excellent or very good health ($1,956). People with Parkinson’s disease spent more on health care services than those with any other type of illness—an average of $3,773, compared with average spending of $2,482 for those with depression, $2,421 for those with hypertension, and $2,393 for those with high cholesterol.

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 traditional Medicare beneficiary who stayed in such a facility spent $22,953 out of pocket in 2018. Also substantial that year were the out-of-pocket costs for skilled nursing facilities ($2,216), dental care ($924), clinicians’ services ($807), and prescription drugs ($703).

**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 traditional Medicare coverage spent 16 percent or more of their income on premiums and health care services combined in 2018 (table 4).
As is the case with spending totals, the financial burden of health care spending varies by health and other characteristics (table 4). For example, half of those who self-reported being in fair or poor health spent 20 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, traditional 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 2018, 1 in 10 beneficiaries with traditional Medicare spent at least 52 percent of their income on health care (figure 1).

Spending for health care represents a significant burden for many traditional Medicare beneficiaries with modest incomes, even with the financial help available to them through Medicaid (figure 1). For example, among people with incomes up to 200 percent of the federal poverty level (FPL), half spent at least 27 percent of their income on health care. In comparison, half of beneficiaries with higher incomes (over 200 percent of the FPL) spent at least 11 percent of their income on health care. Among people with Traditional Medicare in the top quarter of spenders, 13 percent were individuals who also had Medicaid coverage (data not shown).

As a result of health care’s financial burden, in 2018, 10 percent of traditional Medicare beneficiaries reported delaying care due to cost and 10 percent reported experiencing problems paying their medical bills (figure 2). This was especially true for beneficiaries with lower incomes: 18 percent of those with incomes up to 200 percent of the FPL postponed care because of cost, and 19 percent in that category had difficulties paying medical bills.
Conclusion
The data in this Spotlight highlight the fact that many people with Medicare spend substantial amounts of money on health care. Although 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 traditional 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 any 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.
- Ensure people with Medicare who live on modest incomes and those in poor health are protected from excessively high spending.
- Eliminate enrollment and other barriers to ensure that those who qualify for financial help to afford Medicare premiums and other expenses receive that help.
- Close gaps in insurance coverage (e.g., dental, vision and hearing services) 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 every beneficiary has affordable access to the health care they need.
Appendix: Methods

Data
This study uses the 2018 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. When a respondent lived in a long-term care setting, a facility representative answered questions about how much the beneficiary’s stay costs.

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 2018, 66 percent of all Medicare beneficiaries were enrolled in traditional Medicare. Medicare Current Beneficiary Survey spending data for the remaining 34 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 each year.

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 fluctuations 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 in 2020.


9 The average beneficiary in this high-spenders group spent $22,508 for health care in 2018.


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

13 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.