Fact Sheet

Medicare Benefits and Cost-sharing: How Does Medicare Compare?

AARP Public Policy Institute

Traditional fee-for-service (FFS) Medicare requires substantial cost-sharing, and health care spending currently consumes a substantial percentage of older people's income. In addition, Medicare is generally less generous than typical large employer health plans, as well as less generous than the federal employee health benefit plan (FEHBP standard option). Here are the facts:

Out-of-pocket Spending Consumes a Large Portion of Beneficiaries' Income

Medicare does not cover many necessary services, such as dental, vision, hearing aids, and long-term services and supports. Beneficiaries have to pay for these out of pocket (OOP).

- **Half of all Medicare beneficiaries spent 17 percent ($3,100) or more of their income on OOP expenses:** Most experts consider spending more than 10 percent to be unaffordable.[1]
- **Ten percent of beneficiaries—about 4 million—spent $7,800 on OOP health care expenses, equivalent to half the average Social Security retired benefit:** Beneficiaries who are sicker or require more services spend a significant share of income on OOP costs.[2]
- **Beneficiaries with no supplemental coverage spent an even greater share of their income on OOP costs:** Approximately 9 percent (about 4 million) of all beneficiaries do not have supplemental coverage and are responsible for all of Medicare's cost-sharing. Half of these beneficiaries have incomes of $12,000 or less. The typical (median) person in this group spent $2,100 OOP, and 10 percent incurred at least $16,200.[3] Relative to their income, health care expenses are simply unaffordable for them.

Traditional Medicare Requires Substantial Cost-sharing (Deductibles, Copays, and Coinsurance)

The traditional FFS Medicare program includes services that are offered under three parts (Parts A, B, and D).[4] Part A services include inpatient hospital care, skilled nursing, home health, and hospice care. Part B services include doctor visits, laboratory tests, durable medical equipment, mental health, and other outpatient services. Part D is Medicare's prescription drug coverage, offered through private plans. Each part requires beneficiaries to be responsible for deductibles, copays, and/or coinsurance, as shown below.

- **Traditional Medicare offers no catastrophic protection:** Traditional Medicare does not limit the total OOP spending that beneficiaries may incur in a year[5]—unlike private health plans, which typically cap OOP expenses.[6] Medicare beneficiaries with a serious illness or who require multiple hospitalizations are at risk of incurring significant OOP costs.

Table 1
Cost-sharing for Traditional Medicare

Traditional Medicare	Deductible	Copays/Coinsurance	Catastrophic Cap
Part A (hospital)	$1,184 per benefit period	Yes (see below)	No
Part B (physician)	$147 per year	Yes (see below)	No
Part D (prescription drugs)	Depends on the plan selected		Yes

- **Beneficiaries are responsible for Part A deductibles, sometimes multiple times a year:** The Part A deductible is $1,184 *for each benefit period*. A benefit period generally refers to a spell of illness associated with an inpatient hospitalization.[7] Beneficiaries who are older or sicker may have multiple spells of illness in a year—so they are responsible for the $1,184 deductible multiple times.[8]
- **Beneficiaries in Part B also are responsible for Part B deductibles:** About 90 percent of all beneficiaries in traditional Medicare enroll in Part B, which covers doctors' services. The Part B deductible is $147 per year, in addition to the Part A deductible.
- **In addition to deductibles, beneficiaries also are responsible for copays and coinsurance in Parts A and B:** Even after meeting the deductibles (for Part A and/or B), beneficiaries still are responsible for copays if they remain in a hospital or mental health facility for more than 60 days, or in a skilled nursing facility for more than 20 days. Additionally, beneficiaries in Part B are responsible for 20 percent of the cost of doctor visits, durable equipment, and other outpatient services.
- **Part B beneficiaries also pay Part B premiums:** Part B premiums in 2013 are $104.90 a month (or $1,258.80 a year) for most beneficiaries, and more for beneficiaries with high income.[9] High-income beneficiaries pay as much as $335.70 a month (or $4,028.40 a year).
- **Beneficiaries incur additional spending for Part D coverage:** Beneficiaries who enroll in a Part D prescription drug plan face additional deductibles, copayments, and premiums that vary from plan to plan. Furthermore, cost-sharing for brand-name drugs in Medicare Part D tends to be higher than in employer plans.[10]

Medicare's Benefit Is Less Generous Than a Typical Large Employer Health Plan

A report published by the Kaiser Family Foundation compared Medicare's traditional FFS program benefit with both the FEHBP standard option and a PPO benefit package offered by a typical large employer.[11] The report concluded:

- **Medicare's benefit would cover a lower share of total costs:** Based on an average estimated spending of $14,890 in 2011 (for individuals aged 65 and older),
  - The Medicare benefit would cover $11,930;[12]
  - The federal employee plan would cover $12,260; and
  - The large private employer PPO plan would cover $12,800.

From the point of view of the beneficiary, traditional Medicare requires beneficiaries to be responsible for $2,960, or 20 percent of the total cost of services. Whereas,

- The FEHBP requires participants to cover 18 percent of total costs, and
- The large PPO plan requires participants to cover 14 percent of total costs.

In summary, Medicare offers good but not luxury coverage. It lacks any protection from catastrophic expenses, unlike most employer health plans, putting older adults at risk of incurring significant OOP costs. Further, it requires significant cost-sharing from beneficiaries, more so than typical large employer plans.

Endnotes

[1] C. Noel-Miller, *Medicare Beneficiaries' Out-of-Pocket Spending for Health Care* (Washington, DC: AARP Public Policy Institute, May 2012). Data are for 2007 spending from the 2008 Medicare Current Beneficiary Survey cost and use file. Out-of-pocket spending includes spending for Medicare and supplemental premiums, and for medical services and some long-term services and supports. Accessed at http://www.aarp.org/content/dam/aarp/research/public_policy_institute/health/medicare-beneficiaries-out-of-pocket-spending-AARP-ppi-health.pdf.

[2] *Ibid*. Data are for 2007 spending from the 2008 Medicare Current Beneficiary Survey cost and use file.

[3] AARP Public Policy Institute calculations using data from the 2008 Medicare Current Beneficiary Survey cost and use file.

[4] Parts B and D are voluntary.

[5] As shown in Table 1, Part A and B services do not have out-of-pocket limits. However, the Part D prescription drug program does have an out-of-pocket limit.

[6] Many Medicare beneficiaries purchase supplemental coverage, through their employer or a Medigap plan, to protect themselves from catastrophic costs.

[7] More specifically, "Under Part A, 60 full days of hospitalization plus 30 coinsurance days represents the maximum benefit period. The benefit period is renewed when the beneficiary has not been in a hospital or Skilled Nursing Facility for 60 days." Guidance available from the Centers for Medicare and Medicaid at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c03.pdf.

[8] Supplemental policies may cover some or all of these deductibles. However, 9 percent of Medicare beneficiaries do not have any supplemental coverage and must pay these deductibles OOP.

[9] Standard and high-income monthly Part B premiums are available at http://www.medicare.gov/your-medicare-costs/costs-at-a-glance/costs-at-glance.html#collapse-4631. About 5 percent of Medicare beneficiaries pay high-income premiums.

[10] A study by the Kaiser Family Foundation [available at http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8357.pdf] noted that Medicare Part D enrollees generally face higher cost-sharing for preferred and nonpreferred brand-name drugs than enrollees in employer plans. Part D plans charge, at the median, $41 per month for preferred drugs and $92 per month for nonpreferred drugs. In comparison, employer plans charge $25 for preferred drugs and significantly less ($51) for nonpreferred drugs. However, Part D cost-sharing for generic drugs is somewhat less than that charged by employer plans.

[11] Available at: http://www.kff.org/medicare/upload/7768-02.pdf.

[12] Without the drug benefit included in the Affordable Care Act (closing the doughnut hole for brand-name drugs), Medicare would have been even less generous compared with these two plans.

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