INSIGHT on the Issues

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

Claire Noel-Miller, PhD
AARP Public Policy Institute

Medicare beneficiaries spent a median of $3,138 a year of their own money on health care in 2007, the latest year for which comprehensive data are available. Ten percent of beneficiaries—more than 4 million people—spent more than $7,861 a year. The oldest and poorest beneficiaries spent about one-quarter of their incomes on health care.

The Medicare program pays for certain health care services for adults age 65 and older and for younger individuals with certain disabilities. The program pays a portion of costs for the inpatient and outpatient health care services beneficiaries receive, as well as prescription drugs.

While Medicare is a vital program that helps older adults pay for needed health care services, it typically requires significant cost sharing from beneficiaries. This report assesses the out-of-pocket (OOP) spending burden on Medicare beneficiaries, using data from the most recent Medicare Current Beneficiary Survey (MCBS), the 2007 Cost and Use File.

In 2007, beneficiaries paid a $992 deductible for each inpatient spell of illness.[1] After 60 days in a hospital or 20 days in a skilled nursing facility, beneficiaries also paid daily copays, with benefits ending after 90 or 100 days, respectively. Beneficiaries also faced monthly premiums of $93.50 for Part B plus an annual deductible of $131 for outpatient services, and paid 20 percent (or more[2]) of all costs after that. Furthermore, Medicare does not cover services such as hearing aids, eyeglasses, dental care, and most long-term care services.

Many Medicare beneficiaries faced high OOP spending burdens, which varied based on a number of factors (table 1). Demographic characteristics such as age, income, gender, education, health status, and health conditions were linked to OOP spending burden. Most beneficiaries (92 percent) had some sort of supplemental coverage to help defray those costs, but the remaining 8 percent had no supplemental coverage. Even with supplemental coverage, some beneficiaries could face high OOP costs if they got sick.

Overall, in 2007 beneficiaries in the fee-for-service Medicare program spent a median of $3,138 OOP on health care services and premiums for supplemental health insurance.[3] Many beneficiaries had significantly lower OOP spending—one-quarter spent less than $1,615 per year, and 10 percent spent less than $356. Unfortunately, a considerable number spent much more; more than 4 million beneficiaries, or approximately 10 percent of the Medicare population, spent more than $7,861 OOP on health care in 2007.

AARP

About the Methods

The MCBS is an annual panel survey that asks more than 12,000 Medicare beneficiaries about their health care use and spending, health status, and insurance, as well as sociodemographics, income, residence, and other key items. It is representative of the national population of Medicare beneficiaries, and includes people living in long-term care facilities for part or all of the year.

OOP health spending is measured as all personal expenditures for medical services, Medicare premiums (including Medicare Part D premiums), and premiums for supplemental insurance. This includes spending for certain long-term care services as measured in the MCBS. Long-term care spending includes room and board costs as well as spending for ancillary health care services for residents of nursing homes, as reported by facility representatives on behalf of survey participants.

Medical spending is based on 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 (MA) plans (22 percent of the Medicare population) during any part of the year because of the difficulty of attributing spending to these enrollees.

Income is self-reported income for an individual. When respondents reported income for themselves and a spouse, this value was divided by two in order to obtain individual income.

OOP spending is reported at the median and at the 90th percentile. The median represents the "middle" spending value—50 percent of beneficiaries are above the median and 50 percent are below. Unlike the mean, the median is not affected by outliers in the data.

These spending totals often accounted for a large portion of beneficiaries' income, ranging from 8.6 percent to 27.8 percent in 2007 (table 1). Beneficiaries in the middle of that distribution spent 16.6 percent of income on OOP spending (i.e., median OOP spending as a percentage of income was 16.6 percent). Beneficiaries in poor health typically spent a larger fraction of income on health care.

Demographics: Where Does the Burden of OOP Spending Fall?

Beneficiaries spend significantly more OOP for health care as they age. In 2007, beneficiaries age 85 or older spent more than twice as much as beneficiaries under 65 (table 1). Interestingly, beneficiaries under age 65 with disabilities had the lowest median OOP spending, despite the fact that they are in the Medicare program because of serious health care needs. This may be because a higher proportion of beneficiaries with disabilities are on Medicaid, which pays some of their OOP costs.

Women face higher OOP costs than men. Median spending was $3,319 for women compared with $2,948 for men, despite the fact that women were more likely than men to have supplemental insurance (93 percent of women have supplemental insurance, compared with 87 percent of men). The burden on women was even greater when compared with income—median spending as a percentage of income was 18.7 percent for women, compared with 14.2 percent for men.

Table 1
Out-of-Pocket Spending Depends on Several Factors

	Total OOP Spending (Mean)	Total OOP Spending (Median)	Total OOP Spending (90th Percentile)	OOP Spending as a Percentage of Income (Median)
Overall	**$4,559**	**$3,138**	**$7,861**	**16.6%**
Age				
Under 65	3,078	1,762	6,479	13.7
65–69	3,546	2,676	6,335	11.0
70–74	4,042	3,236	7,219	16.8
75–79	4,814	3,572	7,834	19.2
80–84	5,628	3,817	9,437	23.0
85+	7,975	4,237	17,481	27.8
Gender				
Men	3,910	2,948	7,203	14.2
Women	5,091	3,319	8,560	18.7
Race/Ethnicity				
White	4,870	3,340	8,142	17.2
Black	2,837	1,744	6,272	13.7
Hispanic	2,303	1,090	5,003	8.6
Other	2,538	1,531	5,543	9.5
Income Level				
Up to 100% FPL	2,498	1,384	5,595	25.4
101–150% FPL	4,269	2,930	6,878	27.3
151–200% FPL	4,344	3,445	7,475	26.1
201–300% FPL	4,384	3,507	7,172	18.9
Over 300% FPL	4,919	3,887	8,472	11.1

Source: AARP PPI analysis of MCBS 2007 Cost and Use File, fee-for-service beneficiaries only.
Note: FPL = federal poverty level.

Race and ethnicity are also associated with different patterns of OOP spending. Whites had higher median OOP costs than other groups, and paid a higher proportion of total health care costs OOP than other groups. This higher spending was due to both higher premium spending and higher spending on health care services.

Although OOP spending rises with income, the burden of that spending is greatest for poor beneficiaries. Median OOP spending as a percentage of income for individuals with income below 200 percent of the federal poverty level (FPL) was 25 to 27 percent. Individuals with incomes between 100 and 200 percent of FPL shoulder the largest burden. Median OOP spending more than doubles for those at 101–150 percent of FPL compared with those below 100 percent of FPL.

In contrast, median spending as a percentage of income for individuals with income above 300 percent of FPL was only 11.1 percent, though their spending was notably higher in absolute dollars.

Health Status: Showing the Burden of Illness

The burden of OOP spending was also much higher for beneficiaries in poor health than for those in excellent or very good health (table 2). Median OOP spending as a percentage of income for beneficiaries in poor health was 20.5 percent, compared with 13.6 percent

Table 2
Out-of-Pocket Spending: The Burden Falls Most Heavily on the Sickest

	Total OOP Spending (Mean)	Total OOP Spending (Median)	Total OOP Spending (90th Percentile)	OOP Spending as a Percentage of Income (Median)
Overall	**$4,559**	**$3,138**	**$7,861**	**16.6%**
Excellent/Very Good Health	3,853	3,123	6,859	13.6
Good Health	4,717	3,207	7,962	17.6
Fair Health	5,085	3,141	9,260	20.5
Poor Health	5,655	2,825	11,156	20.5
No Supplemental Coverage	6,969	2,134	16,260	17.5
Any Supplemental Coverage	4,268	3,248	7,671	16.5
Type of Supplemental Coverage				
Medicaid	3,062	719	8,266	9.7
Employer-related	4,344	3,254	7,170	14.4
Other Private (Medigap)	4,736	3,952	8,053	19.5
Other Public (Veterans Administration)	4,709	3,211	7,550	26.3

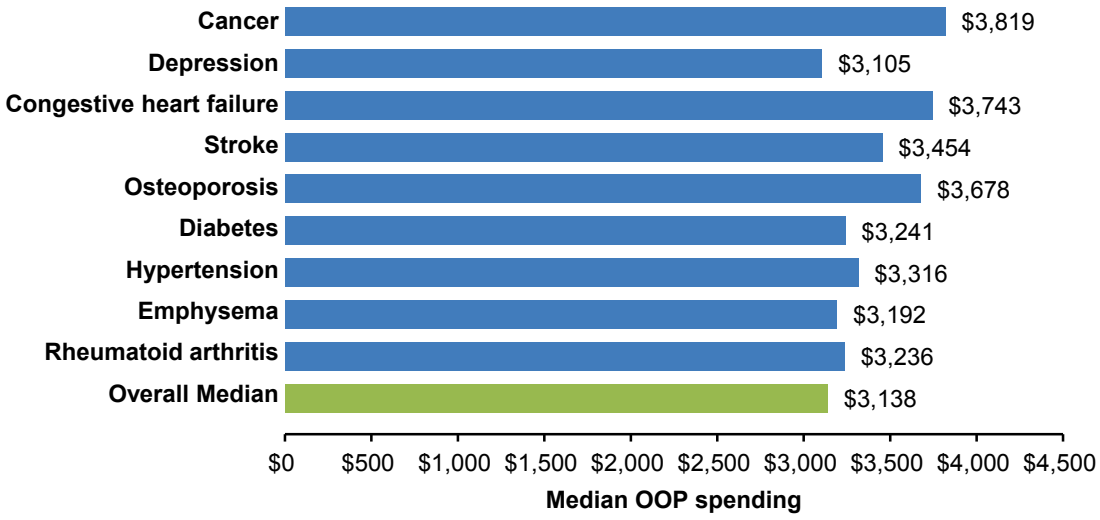
Source: AARP PPI analysis of MCBS 2007 Cost and Use File, beneficiaries in traditional Medicare only.

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 (84.9 percent vs. 91.3 percent), despite having greater need for services.

Some illnesses and health conditions led to higher spending than others (figure 1).

Median OOP spending was $3,819 for patients with cancer and $3,743for patients with congestive heart failure. For patients with a stroke, congestive heart failure, or rheumatoid arthritis, OOP spending as a percentage of income was 22 percent, 24.8 percent, and 20.1 percent, respectively.

Figure 1
Median Out-of-Pocket Spending Varies by Chronic Condition

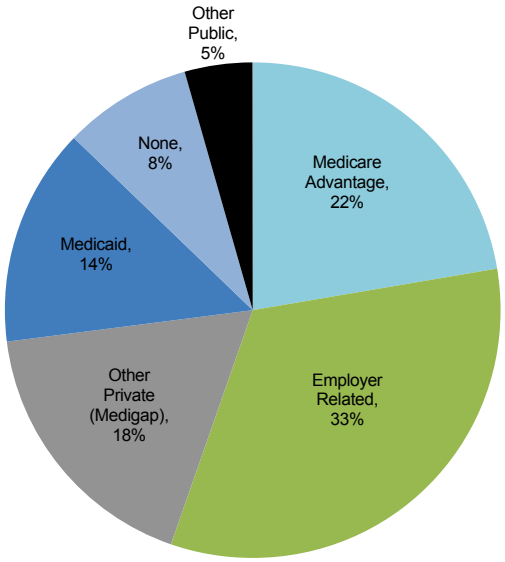


Beneficiaries with Supplemental Insurance Have Higher OOP Spending

Because the Medicare program requires significant cost sharing from beneficiaries, most people have supplemental insurance to help cover those costs. In 2007, roughly nine out of ten beneficiaries had some sort of supplemental coverage, either through a former employer, through Medicaid, through MA, through another public insurance program, or by purchasing a Medigap or other private plan (figure 2). Women were more likely than men to have supplemental insurance, and those in excellent or very good health were more likely to have it than those in poor health. This may be due in part to limitations on open enrollment and guarantee issues. Sicker beneficiaries may be unable to get coverage or unable to afford what is offered if they want to purchase coverage outside of specific enrollment periods.

Median OOP expenditures for beneficiaries with supplemental insurance were higher than median OOP spending for beneficiaries with no supplemental insurance ($3,248 versus $2,134, figure 3).

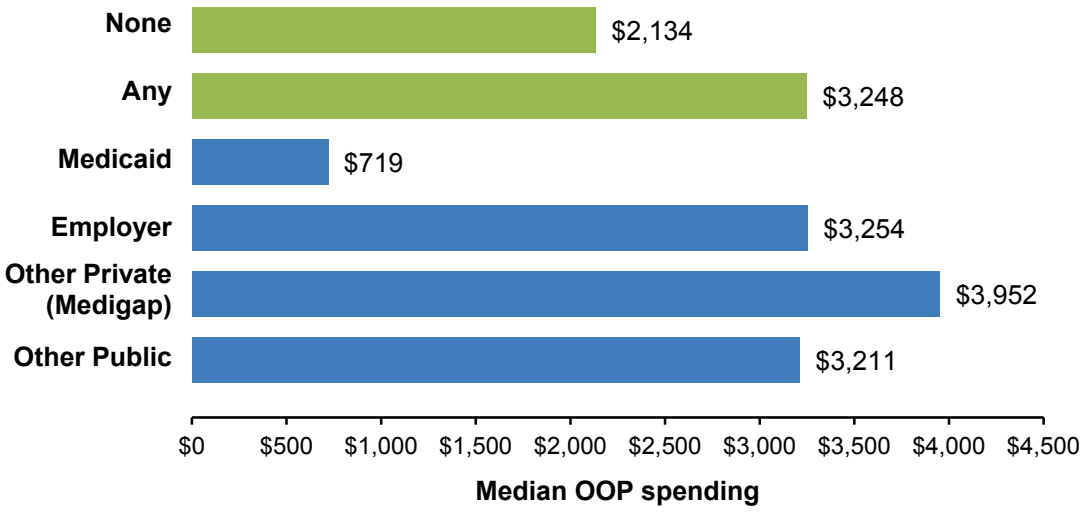
Figure 2
Most People Had Supplemental Coverage in 2007



Among beneficiaries with supplemental insurance, those with Medigap or other private insurance had the highest median OOP spending ($3,952).

Dual eligibles (Medicare beneficiaries who are also eligible for Medicaid because of their low income) present an exception to the pattern of higher OOP expenditures

Figure 3
Out-of-Pocket Spending was Higher for Those with Supplemental Insurance



among Medicare beneficiaries with supplemental insurance. Median OOP health care spending was $719 among dual eligibles (table 2). The top 10 percent of dual-eligible beneficiaries spent at least $8,266. Those with high spending likely spent at least part of the year in long-term care facilities. Medicaid-covered nursing facility residents are required to surrender 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. As explained in the box on page 2, these costs include room and board as well as health care services.

Where Does the Money Go?

Where does the money Medicare beneficiaries spend on health care services go? The largest categories of OOP spending in 2007 were for long-term care facility costs, prescription drugs, and medical providers. Together, these three categories accounted for three-quarters of beneficiary spending.

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

Almost all beneficiaries saw a clinician at least once in 2007, roughly nine in ten used one or more prescription drugs, and almost three-quarters received treatment in a hospital outpatient department. Only about one in five was admitted to a hospital, and far fewer used home health, skilled nursing care, or hospice (table 3).

Use of services that are not covered by Medicare was lower. Approximately 42 percent of Medicare beneficiaries saw a dentist, and about 6 percent spent at least part of 2007 in a long-term care facility.

Among Medicare-covered services, median OOP spending was highest for prescription drugs, at $351. While most beneficiaries had low OOP spending for services, some had high spending. Ten percent of beneficiaries who were admitted to a skilled nursing facility paid at least $5,612 OOP, while 10 percent spent $1,302 or more for prescription drugs. Ten percent of beneficiaries who saw a clinician in 2007 had OOP spending of at least $1,398.

Spending for non-Medicare services was also high. Among users of services, median OOP spending was highest for

Table 3[4]
Beneficiary Out-of-Pocket Spending on Health Care Services

Service	Users of Service (%)	Mean OOP Spending by Users	Median OOP Spending by Users	90th Percentile OOP Spending by Users
Medicare-Covered Services				
Hospital Inpatient	21.3	$506	$0	$992
Hospital Outpatient	74.3	205	0	290
Medical Providers	95.9	647	200	1,398
Prescription Drugs	88.9	578	351	1,302
Home Health	14.4	223	0	0
Skilled Nursing Facility	5.7	1,546	0	5,612
Hospice	2.2	0	0	0
Non-Medicare-Covered Services				
Dental	42.1	624	200	1,495
LTC Facility[5]	6.2	14,383	7,069	43,686

Source: AARP PPI analysis of MCBS 2007 Cost and Use File, beneficiaries in traditional Medicare only.
Note: LTC = long-term care.

long-term care facility services. In fact, the majority of long-term care facility users incurred high OOP costs. Median OOP spending for users of such facilities was $7,069, with 10 percent of users paying at least $43,686 OOP for room and board and health care-related services during 2007. Some of these residents may have been self-financing their nursing facility stay before eventually qualifying for Medicaid.

Conclusions

OOP health care spending presents a significant financial burden for many Medicare beneficiaries. While most have supplemental coverage, a large proportion of many beneficiaries' income still goes toward health care. Between 2007 and 2012, Medicare beneficiaries' OOP spending has continued to increase, with increases in Part B premiums, higher Part A hospital inpatient deductibles and greater hospital and skilled nursing facility co-insurances.

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

While it may not be feasible to extend Medicare coverage to include these services, policymakers should take these costs into account when calculating any potential program changes, including a cap on OOP spending.

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. Changes in benefit design should take these findings into consideration and help to alleviate spending burdens associated with the most expensive chronic illnesses.

Finally, this analysis demonstrates that low-income beneficiaries, including those who are dually eligible for Medicare and Medicaid, still have a very high OOP spending burden.

Policy Options

One option for limiting such high levels of cost exposure is a cap on OOP spending in the Medicare program. The Congressional Budget Office and the Medicare Payment Advisory Commission have both 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 suggested would help fewer than 10 percent of 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 beneficiaries still face high OOP costs relative to income. Raising income limits to help those above 100 percent of FPL, and eliminating asset tests for participation, would reduce the burden these costs impose by allowing more beneficiaries to access the reduced OOP costs these programs offer.

Endnotes

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

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

[3] In 2007, median OOP spending on premiums only was $1,322, and median OOP spending on services only was $992.

[4] The figures shown in this table and discussed in this section include beneficiaries enrolled in Medicare Advantage.

[5] Long-term care facility spending includes basic room and board costs as well as ancillary health spending in nursing homes. Room and board are considered medical expenses when they are a part of the basic charge for nursing homes and similar long-term care institutions, and are counted as such in National Health Expenditures Accounts.

Insight on the Issues 65, May, 2012

AARP Public Policy Institute,
601 E Street, NW, Washington, DC 20049
www.aarp.org/ppi.
202-434-3840, ppi@aarp.org