INSIGHT on the Issues

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

According to the most recent data available, Medicare beneficiaries spent an average of $4,394 a year of their own money on health care services in 2005. Ten percent of beneficiaries—more than 4 million people—spent more than $8,000 a year. The oldest and poorest beneficiaries spent more than half their incomes on health care services.

The Medicare program pays for certain health care services for adults age 65 and older and eligible individuals with disabilities. The program pays a portion of costs for the inpatient and outpatient health care services beneficiaries receive.

While Medicare is a vital program that helps older adults pay for needed health care services, it typically requires significant cost sharing from beneficiaries. To assess the out-of-pocket (OOP) spending burden for Medicare beneficiaries, researchers from the University of Maryland School of Pharmacy analyzed data on health spending from the most recent Medicare Current Beneficiary Survey (MCBS), the 2005 Cost and Use File. Unless otherwise noted, all data presented in this Insight on the Issues are based on this analysis. An accompanying chart pack can be accessed at www.aarp.org/research/medicare/outofpocket/m8_oop.html.

In 2005, beneficiaries paid a $912 deductible for each inpatient spell of illness.[1] After 60 days in a hospital or 20 days in a skilled nursing facility (SNF), beneficiaries also paid daily co-pays, with benefits ending after 90 or 100 days. Beneficiaries also paid an annual deductible of $110 for outpatient

About the Methods

The MCBS is an annual panel survey that asks more than 12,000 beneficiaries about their health care use and spending, health status, and insurance, as well as socio-demographics, 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 some or all of the year.

We measure OOP health spending as all personal expenditures for medical services, Medicare 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. Unless otherwise noted, our analyses exclude people enrolled in Medicare Advantage (MA) plans during any part of the year because spending may not be accurately attributed for these people.

services, and paid 20 percent of all costs after that. Furthermore, Medicare does not cover certain services such as hearing aids, eyeglasses, dental care, and most long-term care services. Also, as of the time of this survey (2005), Medicare did not offer coverage for most prescription drugs. Therefore, beneficiary spending for drugs in this analysis reflects the higher costs many beneficiaries faced before the introduction of Medicare's Part D prescription drug coverage in 2006.

The research found that 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 (90 percent) had some sort of

In 2005, Medicare's Part D prescription drug coverage program was still a year away. About three-quarters of beneficiaries had at least some coverage for drugs,[2] leaving approximately 11 million beneficiaries without coverage. Beginning in June 2004, all beneficiaries had access to the Medicare discount drug card program, which allowed beneficiaries to join programs that offered reduced rates on many prescription drugs, and many beneficiaries used such cards. The Centers for Medicare & Medicaid Services estimates that some 6.5 million beneficiaries had a discount drug card. Beneficiary spending on drugs in 2005, then, was certainly higher for many than it has been since the introduction of Part D, but lower than it was before 2005, at least for those who used the discount cards.

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

	Total OOP Spending (Mean)	Total OOP Spending (Median)	Total OOP Spending (90th Percentile)	OOP Spending on Services	OOP Spending on Premiums	OOP Spending as a Percentage of Income (range)
Overall	$4,394	$2,912	$8,264	$2,867	$1,527	28 - 37%
Under 65	3,306	1,653	8,173	2,517	789	26 - 34
65–69	3,557	2,536	7,000	1,959	1,598	19 - 30
70–74	3,925	2,965	7,326	2,175	1,750	20 - 29
75–79	4,709	3,258	8,264	2,922	1,787	27 - 37
80–84	5,111	3,504	9,015	3,357	1,754	36 - 46
85+	7,103	3,668	16,342	5,613	1,489	54 - 62
Men	4,105	2,713	7,702	2,580	1,525	23 - 35
Women	4,630	3,072	8,729	3,101	1,529	32 - 40
White	4,662	3,162	8,658	2,979	1,683	28 - 38
Black	3,299	1,753	6,874	2,518	780	30 - 37
Hispanic	3,664	1,609	6,707	2,668	996	29 - 37
Other	3,072	2,059	6,730	1,963	1,110	21 - 29
Up to 100% FPL	2,963	1,192	7,034	2,371	592	66 - 83
101–150% FPL	4,261	2,581	8,291	3,134	1,127	35 - 43
151–200% FPL	4,539	2,901	7,941	3,055	1,484	26 - 34
201–-300% FPL	4,784	3,340	8,513	2,949	1,835	18 - 28
Over 300% FPL	4,978	3,450	8,881	2,875	2,103	10 - 16

Source: University of Maryland analysis of MCBS 2005 Cost and Use File, fee-for-service beneficiaries only.

supplemental coverage to help defray those added costs, but the remaining 10 percent had no supplemental coverage. And having supplemental coverage did not guarantee that beneficiaries would not face high OOP costs if they got sick.

Overall, in 2005 beneficiaries in the fee-for-service Medicare program spent an average of $4,394 OOP on health care services and premiums for supplemental health insurance (figure 1). About two-thirds of that ($2,867) went toward health care services, while one-third ($1,527) went toward premiums. Many beneficiaries had significantly lower OOP spending—one-quarter spent less than $1,500 per year on health care services, and 10 percent spent less than $500. Unfortunately, a considerable number spent much more; more than 4 million beneficiaries, or 10 percent of the Medicare population, spent more than $8,000 OOP on health care in 2005.

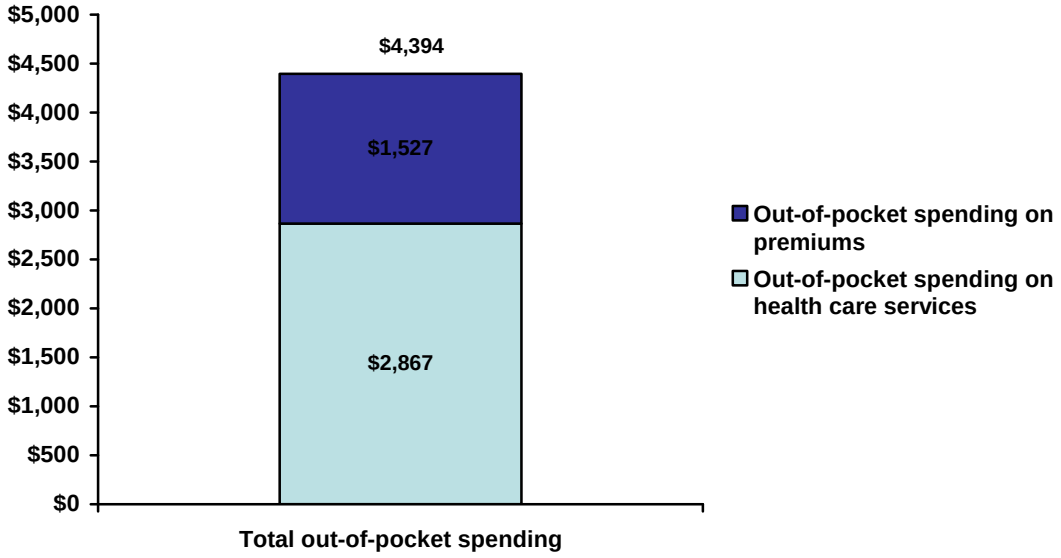
These spending totals often accounted for a large portion of beneficiaries' income. On average, OOP spending accounted for between 28 and 37 percent of income.[3] Median OOP spending as a percentage of income was only between 11 and 16 percent, reflecting the fact that some beneficiaries faced very high OOP spending burdens, while most had lower spending burdens.

Demographics: Where Does the Burden of OOP Spending Fall?

Beneficiaries spend significantly more OOP for health care as they age. In 2005, beneficiaries age 85 or older spent about twice as much as beneficiaries younger than age 69. Interestingly, beneficiaries under age 65 with disabilities had the lowest OOP spending, despite the fact that they are in the Medicare program because of serious health care needs and were significantly less likely than other beneficiaries to have supplemental insurance in 2005.

Figure 1

Average Total Out-of-Pocket Spending for Beneficiaries was $4,394 in 2005…



Source: University of Maryland analysis of Medicare Current Beneficiary Survey 2005 Cost and Use File.

Note: Data reflect beneficiaries in the traditional Medicare program and spending prior to Medicare Part D implementation.

Women face higher OOP costs than men. Women spent an average of $4,630 compared with $4,105 for men, despite the fact that women are 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—women spent between 32 percent and 40 percent of income, on average, for health care, compared with an average between 23 and 35 percent of income for men.

Race and ethnicity also show different patterns of OOP spending. Whites had higher average OOP costs than other groups. This higher spending was due largely to higher premium spending rather than higher spending on health care services. Whites were more likely than other groups to have supplemental insurance and to report being in excellent health.

Although OOP spending rises with income, the burden of that spending is greatest for the poorest beneficiaries. Individuals with income below the federal poverty level (FPL) spent an average of $2,963, or more than two thirds of their income, on health care services. In contrast, individuals with income above 300 percent of the federal poverty level spent an average of $4,978 OOP, or less than one-fifth of income. The difference was largely due to much higher premium spending among high-income beneficiaries than among low-income beneficiaries.

Health Status: Showing the Burden of Illness

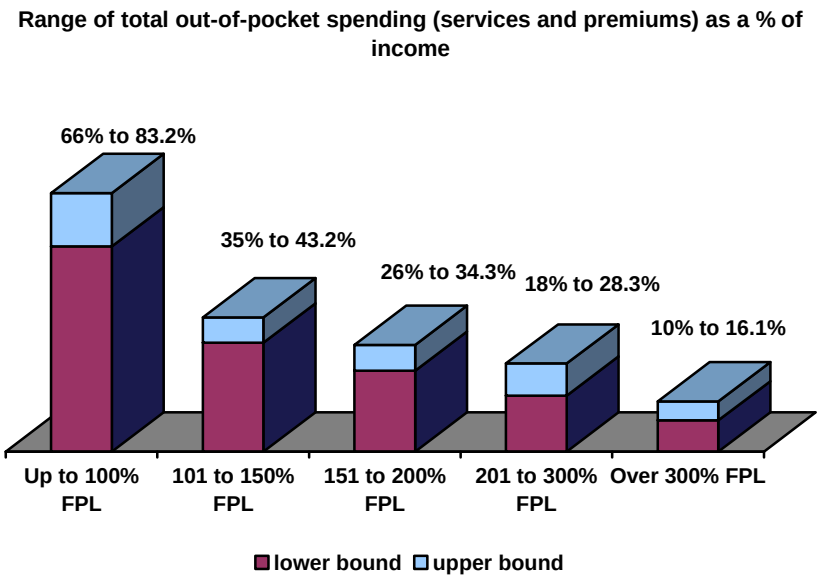
Beneficiaries' need for health care has a

Table 2
Out-of-Pocket Spending: The Sickest Pay the Most

	Total OOP Spending (Mean)	Total OOP Spending (Median)	Total OOP Spending (90th Percentile)	OOP Spending on Services	OOP Spending on Premiums	OOP Spending as a Percentage of Income (range)
Overall	$4,394	$2,912	$8,264	$2,867	$1,527	28 - 37%
Excellent/Very Good Health	3,697	2,849	6,938	1,859	1,838	19 - 27
Good Health	4,546	2,983	8,309	2,975	1,571	30 - 40
Fair Health	4,957	2,885	9,705	3,820	1,137	36 - 47
Poor Health	5,643	3,128	12,084	4,752	891	40 - 54
Alzheimer's Disease	7,384	3,732	16,035	6,190	1,194	61 - 74
Cancer	6,781	4,126	11,437	5,058	1,722	44 - 65
Congestive Heart Failure	5,819	3,668	10,617	4,470	1,349	40 - 51
Coronary Artery Disease	5,385	3,471	9,136	3,645	1,740	30 - 41
No Supplemental Coverage	6,574	2,419	15,571	5,685	889	48 - 59
Any Supplemental Coverage	4,029	2,811	7,746	2,463	1,566	25 - 34
Type of Supplemental Coverage						
Medicaid	2,861	817	7,986	2,621	240	36 - 41
Medicare Advantage	3,630	2,168	6,346	2,304	1,326	22 - 31
Employer-related	4,222	2,894	7,535	2,409	1,812	17 - 26
Other Private (Medigap)	4,896	3,940	8,468	2,430	2,466	26 - 38
Other Public	3,307	2,774	5,918	1,953	1,354	28 - 37

Source: University of Maryland analysis of MCBS 2005 Cost and Use File, fee-for-service beneficiaries only.

Figure 2
But Poorer Beneficiaries Have Higher Out-of-Pocket Burdens



Source: University of Maryland analysis of Medicare Current Beneficiary Survey 2005 Cost and Use File.
Note: Data reflects beneficiaries in the traditional Medicare program and spending prior to Medicare Part D implementation.

direct impact on their OOP spending.

Total OOP spending in 2005 rose as health status declined (table 2). Beneficiaries in poor health were less likely to have supplemental insurance than those in excellent health (85 percent vs. 92 percent) despite having greater need for services.

The burden of OOP spending was also much higher for beneficiaries in poor health than for those in excellent health. Beneficiaries in poor health spent an average of 40 – 54 percent of their income on health care services, compared with less than 30 percent for those in excellent health.

Some illnesses and health conditions led to much higher spending than others (figure 3). Average OOP spending for people with Alzheimer's disease was $7,384, and patients with cancer spent $6,781. For patients with Alzheimer's, OOP spending accounted for 61 to 74 percent of income on average.

Supplemental Insurance Helps

Because the Medicare program requires significant cost sharing from beneficiaries, most people have supplemental insurance to help cover those costs. In 2005, nine out of ten beneficiaries had some sort of supplemental coverage, either through a former employer, through the Medicaid program, through the MA program, or by purchasing a Medigap plan (figure 4). 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.

It is not surprising that beneficiaries who lacked supplemental insurance faced the highest OOP spending (figure 5).[4] Beneficiaries without supplemental coverage spent an average of $6,574 OOP on health care, far more than the second highest group, those with "Other Private" (usually Medigap)

Figure 3
Average Total Out-of-Pocket Spending Varies by Chronic Condition

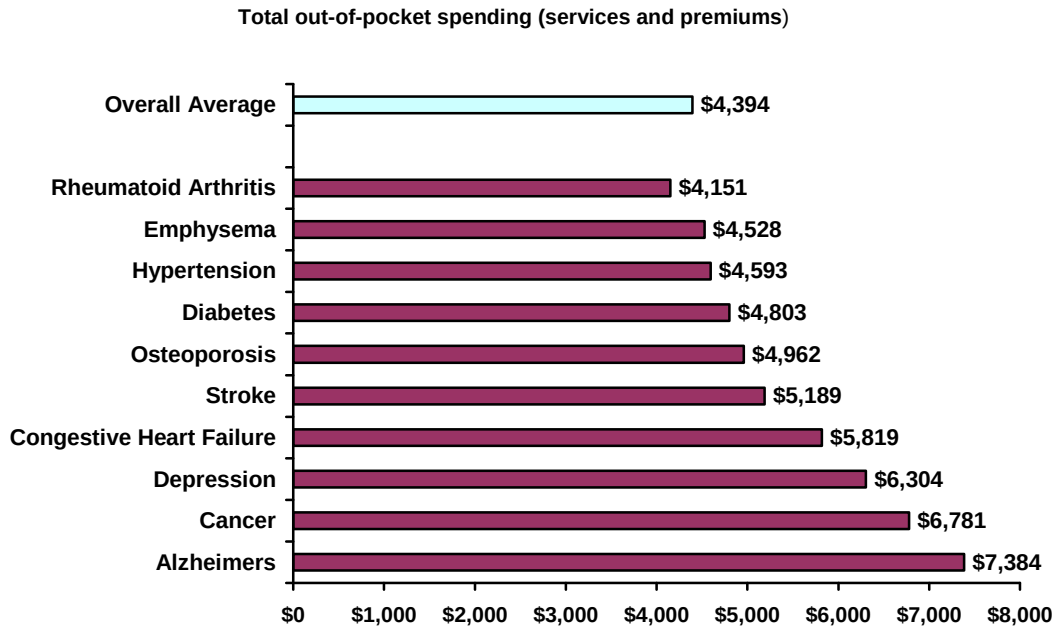
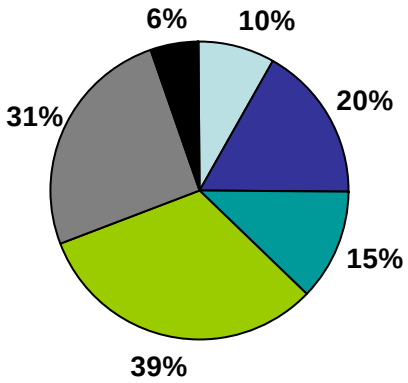
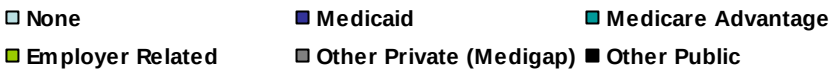


Figure 4
Most People Had Supplemental Coverage in 2005

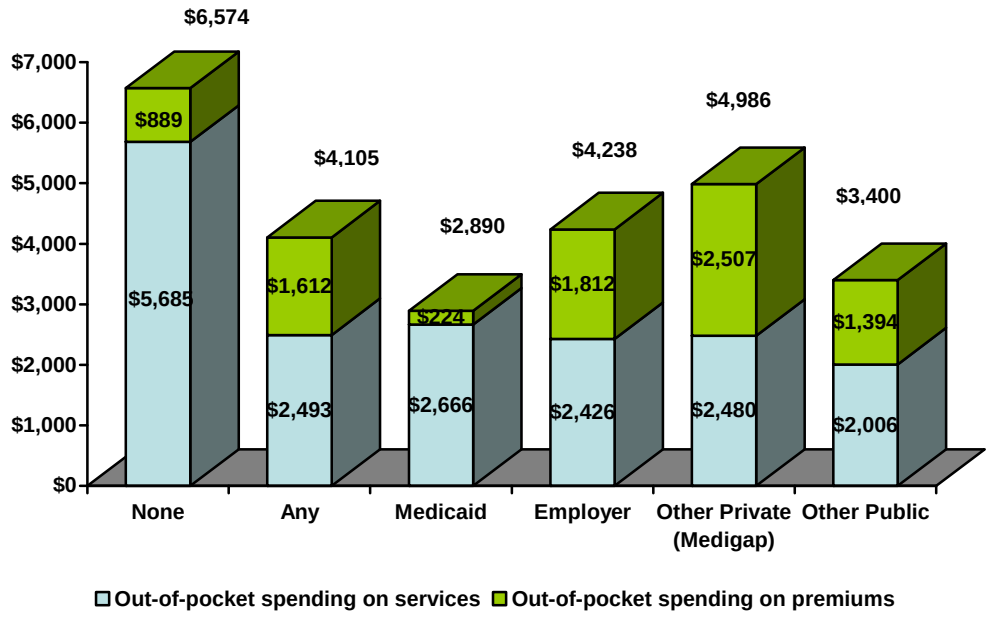




Source: University of Maryland analysis of Medicare Current Beneficiary Survey 2005 Cost and Use File.

Note: Data reflects beneficiaries in the traditional Medicare program and spending prior to Medicare Part D implementation.

Figure 5
Total Out-of-Pocket Spending was Significantly Lower for Those with Supplemental Insurance Compared to Those Without



Source: University of Maryland analysis of Medicare Current Beneficiary Survey 2005 Cost and Use File.
Note: Data reflects beneficiaries in the traditional Medicare program and spending prior to Medicare Part D implementation.

coverage. Ten percent of those without supplemental coverage spent more than $15,000 on care. Those without supplemental insurance spent more than twice as much OOP on direct health care services as any other group.

Interestingly, the second highest average OOP spending amount for services was for low-income dual-eligible beneficiaries covered by Medicaid. Dual-eligibles spent more than one-third of their income on health care, on average. While their spending on premiums was very low, their spending on services was higher than that of other groups, mainly because, even with Medicaid coverage, dual-eligibles faced higher long-term care facility costs. Medicaid-covered nursing facility residents are required to surrender virtually all their income toward the cost of services, retaining only a small "personal needs allowance," generally in the range of $30 to $50 per month. Moreover, as explained in the box on page 1, 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 go? The largest categories of OOP spending in 2005 were for long-term care facility costs, prescription drugs (both of which were noncovered services in 2005), and medical providers. Together, these three categories accounted for almost three-quarters of beneficiary spending. Note that these figures include only spending on health care *services*. As noted earlier, beneficiaries spent about one-third of their health care dollars on premiums.

However, overall spending numbers mask how much the patients who used individual services spent for care. Almost all beneficiaries saw a clinician at least once in 2005, and two-thirds received treatment in a hospital outpatient department. Only about

20 percent were admitted to a hospital, and far fewer used home health, skilled nursing care, or hospice (table 3).

Among services not covered by Medicare, almost nine in ten beneficiaries used prescription drugs (most prescription drugs were not covered by Medicare in 2005). About 40 percent saw a dentist, and one-quarter used vision or hearing services. Six percent spent at least part of 2005 in a long-term care (LTC) facility.

Among Medicare-covered services, OOP spending for SNF services was the highest spending category, at $1,141. While Medicare covers up to 100 days in a SNF, only the first 20 days are covered in full. In 2005, beneficiaries incurred a daily co-payment of $114 for days 21 to 100 in a SNF. Average OOP spending for patients who spent time in a hospital was $654, and 10 percent of patients spent more than $900 for such care. Average OOP spending for clinician services was $606, and 10 percent of patients spent more than $1,100 on these services.

Spending for non-Medicare covered services was also high. Among users of services, OOP spending was highest for LTC facility services. Users of such facilities paid an average of $13,195 OOP for room and board and health care-related services during 2005. It is likely that some portion of these residents began their nursing facility stay paying completely OOP before eventually qualifying for Medicaid.

OOP spending on prescription drugs averaged $825, with 10 percent of beneficiaries spending more than $1,900. Dental services were also expensive, with average OOP costs of $581 and the top 10 percent spending more than $1,300.

As expected, beneficiaries who do not have supplemental insurance faced the greatest OOP spending burden. They spent more than three times more for hospital care and almost twice as much for outpatient care as those with some form of supplemental coverage. Among those with supplemental coverage, individuals with Medicare Advantage spent considerably less on outpatient and clinician services, but spent significantly more than any other group for SNF care.

Table 3
Beneficiary Out-of-Pocket Spending on Health Care Services[5]

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	20.8	$654	$0	$912
Hospital Outpatient	69.9	284	3	373
Medical Providers	94.6	606	141	1,183
Home Health	8.1	236	0	0
Skilled Nursing Facility	4.6	1,141	0	4,104
Hospice	1.9	0	0	0
Non-Medicare Covered Services				
Prescription Drugs	88.4	$825	$484	$1,963
Dental	40.3	581	189	1,367
Vision and Hearing	27.7	315	108	500
LTC Facility[6]	5.7	13,195	7,599	36,754

Source: University of Maryland analysis of MCBS 2005 Cost and Use File, fee-for-service beneficiaries only.

Prescription Drug Spending: Demonstrating the Need for Part D

Despite the fact that many beneficiaries did not have access to drug coverage through Medicare, almost nine in ten beneficiaries used prescription medications during the year. Spending on prescription drugs accounted for 26 percent of OOP spending in 2005. However, at the individual level, prescription drug spending accounted for almost half of the average beneficiary's OOP spending.

On average, beneficiaries spent $870 OOP for prescription drugs. Median drug spending was $428, reflecting the fact that some beneficiaries had very high drug spending. Not surprisingly, those in poor health spent the most ($983), while those in the best health spent the least ($585). Beneficiaries enrolled in MA had the lowest OOP spending for drugs ($317), while those with Medigap coverage had the highest OOP spending ($1,007), reflecting typical benefit designs of these products.

While good information is not yet available on how OOP spending on prescription drugs changed after the introduction of Part D, we do know something about enrollment patterns during the first year of the program. About 64 percent of those who lacked coverage for drugs in 2005 enrolled in a Part D plan during 2006.[7] The higher a beneficiary's OOP spending on drugs in 2005, the more likely the beneficiary was to enroll in a prescription drug plan during 2006.

As part of their analysis, researchers at the University of Maryland School of Pharmacy estimated how OOP spending for prescription drugs was likely to change after the start of Part D. They estimated that for beneficiaries with no drug coverage in 2005, spending for prescription drug coverage would fall from an average of $1,177 without Part D to an average of $492 with Part D. The median estimated change in drug spending as a result of Part D was $208. Part of the drop in OOP spending for prescription drugs would be offset by increased spending for Part D premiums.

For many who lacked drug coverage in 2005, OOP spending would fall substantially after the start of Part D. About two-thirds of beneficiaries, however, had at least some coverage for drugs in 2005.[8] These beneficiaries would experience a less dramatic change in OOP drug spending in 2006.

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. The poor, and those in poor health, face the highest burden, even with programs like Medicaid, which is intended to help these populations.

Another important finding is that a large part of the OOP spending burden comes from services that Medicare does not cover. The Part D benefit should help reduce prescription drug spending. Nevertheless, Medicare still does not cover dental, vision, hearing, and LTC facility 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 mental illnesses, Alzheimer's disease, cancer, or various forms of heart disease 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.

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 an OOP cap of $5,250.

A cap on OOP spending is important, but setting it at $5,250 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 cap would not impact 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. Raising income limits and eliminating asset tests for participation in low-income programs such as the Medicare Savings Program, which helps low-income beneficiaries pay premiums and cost sharing, would reduce the burden that these costs impose.

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[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] D.G. Safran et al. "Prescription Drug Coverage and Seniors: Findings from a 2003 National Survey." *Health Affairs* 24 (2005): W152–W166; J. Rodgers and J. Stell, "The Medicare Prescription Drug Benefit: Potential impact on beneficiaries." Washington, DC: AARP Public Policy Institute, 2004.

[3] Calculating the share of income devoted to health care spending is open to interpretation. Twenty-eight percent of income represents a lower bound, and measures the proportion of household income going toward healthcare. The upper bound – 37 percent – takes only the individual beneficiary's income into account.

[4] The analyses discussed in this section include beneficiaries enrolled in Medicare Advantage.

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

[6] LTC 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.

[7] University of Maryland School of Pharmacy analysis of MCBS 2006 Access to Care file.

[8] Safran, op. cit.

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