

WHAT SHARE OF BENEFICIARIES' TOTAL HEALTH CARE COSTS DOES MEDICARE PAY?

The extent to which Medicare pays for the costs of beneficiaries' health care is a central issue in health policy. Although Medicare provides important coverage for hospital, physician, and other services, its cost-sharing requirements are sometimes substantial. In addition, its benefit package is lacking in several key areas. For example, Medicare does not cover expenses for outpatient prescription drugs, vision, hearing, dental, or long-term care.

This *Data Digest* estimates personal health care expenditures for Medicare beneficiaries in 2000.¹ *Projections* of total personal health care expenditures for the Medicare population in the aggregate and the sources of payment for these expenditures are provided. How sources of payment for elderly beneficiaries differ from those for younger beneficiaries with disabilities is examined. To illustrate how Medicare's share varies across different populations, information is presented on expenditures for selected groups of beneficiaries (i.e., those not in institutions and those not in Medicare+Choice plans).

The data show that, overall, Medicare paid for about half of beneficiaries' total health care costs in 2000. These findings would be even more dramatic if premiums were considered costs of the persons who paid them.

Personal Health Care Expenditures Defined

Personal health care expenditures include the costs of *health care goods and services* purchased directly by beneficiaries or paid by a third party on behalf of beneficiaries.² These include spending on inpatient and outpatient hospital, physician,³ vision, hearing, dental, nursing home, and home health

services,⁴ as well as on outpatient prescription drugs and medical supplies and equipment.⁵

Payments for health care goods and services for Medicare beneficiaries can be made by: (1) Medicare, (2) state Medicaid programs, (3) private insurance plans (employer-sponsored or individually purchased Medigap), (4) beneficiaries (i.e., "out-of-pocket" expenses), or (5) other public health insurance programs such as those administered by the Department of Veterans Affairs (referred to hereafter as "other").

"Out-of-pocket" spending in the context of personal health care expenditures includes payments made directly by beneficiaries. Those payments can be in the form of deductibles, coinsurance, copayments, balance billing amounts, and full payments for goods and services not covered by Medicare or other insurance. Payments of Medicare deductibles and other cost-sharing made by state Medicaid programs, private insurance plans, or "other" public health insurance programs would be reflected as payments by the appropriate program, not as out of pocket.

Because personal health care expenditures reflect only the direct payments for health care goods and services, by definition premium payments (e.g., Medicare Part B, private supplemental insurance, or Medicare+Choice premiums) are not counted as out-of-pocket costs to the individual who pays them. As a result, the definition of out-of-pocket spending in this context differs from that used in most studies on out-of-pocket health care spending, including many published by AARP.⁶ Moreover, these data are for beneficiaries in the aggregate, not at the individual level.

Medicare's Share of Personal Health Care Expenditures

This section examines the expenditures of various categories of beneficiaries.

- **All Medicare Beneficiaries**

Total personal health care expenditures for *all* Medicare beneficiaries are estimated to have been about \$470 billion in 2000. *All* beneficiaries include those age 65 and older and those under age 65 who are eligible for Medicare on the basis of disability; those living in either the community or in an institution for any part of the year; and those enrolled in either fee-for-service Medicare or in a private Medicare+Choice plan. As shown in Table 1, Medicare paid about half (49.1%) of total personal health care expenditures for *all* beneficiaries in 2000.

Medicare paid a much higher share for beneficiaries age 65 and older (51.4%) than for those under age 65 (36.5%). Compared to those age 65 and older, Medicare beneficiaries under age 65 had a higher share of expenditures paid by Medicaid. A greater proportion of beneficiaries under age 65 had low incomes than did beneficiaries age 65 and older and therefore qualified for this low-income assistance program. The Medicaid percentages also reflect differences in the nature of the benefits provided under Medicare and Medicaid, as well as differences in how these benefits are used by older and younger beneficiaries.

- **Residential Status: Community or Institutionalized**

Beneficiaries residing in institutions for the full year⁷ differ greatly from those living in the community, both in terms of income and in the types of health care they use. Table 2 illustrates how Medicare paid a larger share of total personal health care

expenses for beneficiaries living in the community (59.2%) than for all beneficiaries in 2000. This finding holds for beneficiaries age 65 and older (60.6%) and for those under age 65 with disabilities (50.2%).

Overall, compared to those living in the community, beneficiaries who live in institutions for the full year tend to have a smaller share of their total personal health care expenditures paid by Medicare. Since Medicaid covers long-term care services while Medicare does not, Medicaid's share of personal health care expenditures for beneficiaries living in institutions is high for elderly and disabled beneficiaries alike.

- **Type of Medicare Plan: Fee-for-Service Medicare or Medicare+Choice**

The preceding analysis examined all community beneficiaries, including those in either fee-for-service Medicare or Medicare+Choice managed care plans. Medicare makes fixed payments to Medicare+Choice plans for each beneficiary enrolled, rather than payments for individual health care goods and services, as it does for beneficiaries in fee-for-service Medicare.⁸ Focusing on only fee-for-service Medicare beneficiaries living in the community (Table 3) finds that, in 2000, Medicare paid 56.4 percent of their total personal health care expenditures. Consistent with the findings for the broader populations, Medicare's share was higher for fee-for-service beneficiaries age 65 and older (57.7%) than for those under age 65 (48.4%). The lower shares for fee-for-service Medicare beneficiaries living in the community relative to *all* beneficiaries in the community (see "Residential Status" section for numbers) reflects the role of Medicare+Choice as a supplement to Medicare in 2000.⁹

Table 1:
SOURCES OF PAYMENT OF TOTAL PERSONAL HEALTH CARE EXPENDITURES (PHCE)
FOR ALL MEDICARE BENEFICIARIES, * 2000

Beneficiary Population Included	Number of Beneficiaries* (Millions)	Total PHCE (Billions)	SHARE OF TOTAL PHCE BY SOURCE OF PAYMENT				
			Medicare	Medicaid	Private Insurance	Out-of-Pocket	Other
All	41.9	\$470.1	49.1%	14.6%	10.3%	19.5%	6.6%
Age 65 and older only	36.7	\$397.2	51.4%	12.9%	10.6%	20.5%	4.7%
Under age 65 only	5.3	\$72.8	36.5%	23.7%	8.8%	13.9%	17.0%

* Includes beneficiaries living in the community or in institutions, either in fee-for-service Medicare or in Medicare+Choice plans. Also includes beneficiaries enrolled for part of the year, including those who died during the year.

Note: Numbers may not sum to 100 percent due to rounding.

Source: AARP Public Policy Institute *projections* using Medicare Benefits Model, v4.10.

Table 2:
SOURCES OF PAYMENT OF TOTAL PERSONAL HEALTH CARE EXPENDITURES (PHCE)
FOR MEDICARE BENEFICIARIES *LIVING IN THE COMMUNITY*, * 2000

Beneficiary Population Included	Number of Beneficiaries* (Millions)	Total PHCE (Billions)	SHARE OF TOTAL PHCE BY SOURCE OF PAYMENT				
			Medicare	Medicaid	Private Insurance	Out-of-Pocket	Other
All	39.6	\$355.3	59.2%	5.5%	13.3%	16.9%	5.1%
Age 65 and older only	34.8	\$308.0	60.6%	4.4%	13.3%	17.0%	4.7%
Under age 65 only	4.9	\$47.2	50.2%	12.7%	13.0%	16.0%	8.1%

* Includes beneficiaries in fee-for-service Medicare or in Medicare+Choice plans. Also includes beneficiaries enrolled for part of the year, including those who died during the year. Medicare beneficiaries in institutions for less than the full year are counted as community beneficiaries.

Note: Numbers may not sum to 100 percent due to rounding.

Source: AARP Public Policy Institute *projections* using Medicare Benefits Model, v4.10.

Table 3:
SOURCES OF PAYMENT OF TOTAL PERSONAL HEALTH CARE EXPENDITURES (PHCE)
FOR FEE-FOR SERVICE MEDICARE BENEFICIARIES LIVING IN THE COMMUNITY, * 2000

Beneficiary Population Included	Number of Beneficiaries* (Millions)	Total PHCE (Billions)	SHARE OF TOTAL PHCE BY SOURCE OF PAYMENT				
			Medicare	Medicaid	Private Insurance	Out-of-Pocket	Other
All	33.2	\$310.2	56.4%	6.3%	15.1%	17.2%	5.0%
Age 65 and older only	28.9	\$266.5	57.7%	5.0%	15.2%	17.4%	4.6%
Under age 65 only	4.3	\$43.7	48.4%	13.7%	14.0%	15.9%	8.1%

* Includes only beneficiaries in fee-for-service Medicare. Also includes beneficiaries enrolled for part of the year, including those who died during the year. Medicare beneficiaries in an institution for less than the full year are counted as community beneficiaries.

Note: Numbers may not sum to 100 percent due to rounding.

Source: AARP Public Policy Institute *projections* using Medicare Benefits Model, v4.10.

Discussion

Although Medicare's share of total personal health care expenditures is about 50 percent for all beneficiaries of the program, its share for beneficiaries age 65 and older is much larger than that for disabled beneficiaries under age 65. This disparity between older and younger beneficiaries holds for all of those who are enrolled in Medicare (see Table 1 above), are community-dwelling beneficiaries (Table 2), and are community-dwelling fee-for-service Medicare beneficiaries (Table 3). Medicare's share is highest for enrollees living in the community: about 60 percent for those who are elderly and live in the community and 50 percent for those who are disabled. The fact that Medicaid pays a higher share of personal health care expenditures for beneficiaries under age 65 highlights the program's particular importance to this group.

Regardless of which category of beneficiaries is being examined, Medicare fails to cover a sizable portion of their total health care expenditures, requiring enrollees to purchase supplemental coverage and pay a substantial share of their health care expenditures out of pocket. Because the definition of personal health care expenditures consists of only payments for goods and services, premiums for supplemental coverage (and Medicare Part B) are not included in this analysis. These findings re-emphasize the criticality of modernizing Medicare's benefit package to better meet the needs of those who are enrolled in the program.

¹ Data on personal health care expenditures are collected as part of the Medicare Current Beneficiary Survey (MCBS). The personal health care expenditure data were projected forward to 2000 using the Medicare Benefits Model, version 4.10, developed by The Lewin Group. This desktop microsimulation model projected health care expenditures for Medicare beneficiaries from the 1995 MCBS Cost and Use files—the most current source at the time this analysis was initiated—and other data sources. The model trended MCBS statistics

forward using actual and projected data from multiple sources, including: (1) the Congressional Budget Office, (2) Office of Managed Care of the Centers for Medicare and Medicaid Services (CMS), (3) the CMS National Health Accounts, (4) the Bureau of the Census Current Population Survey, and (5) the Social Security Administration. *Actual* data for 2000 or projections based on *more recent* MCBS data may differ from the numbers presented here.

² Personal health care expenditures exclude administrative costs incurred by public programs and private insurance, the costs of research by the government or nonprofit groups, and the value of new construction for hospitals and nursing homes. See G.L. Olin, H. Liu, and B. Merriman (Nov. 1999). *Health & Health Care of the Medicare Population: Data from the 1995 Medicare Current Beneficiary Survey*. Rockville, MD: Westat.

³ Physician services include visits to medical doctors, osteopathic doctors, and health practitioners (i.e., audiologists, optometrists, chiropractors, mental health professionals, therapists, podiatrists, nurses, paramedics, and physician assistants).

⁴ Home health includes only medical home health care.

⁵ Medical supplies and equipment include diagnostic laboratory and radiology services, durable medical equipment, non-durable medical supplies, and medical and surgical services.

⁶ See, for example, D. Gross and N. Brangan, *Out-of-Pocket Spending on Health Care by Medicare Beneficiaries Age 65 and Older: 1999 Projections*, AARP Public Policy Institute Issue Brief #41, Dec. 1999. Out-of-pocket spending in this and other publications includes premium payments. The out-of-pocket estimates in the AARP publications for non-institutionalized beneficiaries also exclude spending for home health and long-term nursing home care.

⁷ Medicare beneficiaries in institutions for less than the full year are counted as community beneficiaries.

⁸ For beneficiaries in Medicare+Choice plans, the fixed payments are included as part of the Medicare payments, and co-payments to plans are part of out-of-pocket expenses. Consistent with the definition of personal health care expenditures and the treatment of premiums, additional premiums paid by beneficiaries to Medicare+Choice plans are not included as out-of-pocket.

⁹ Because the model was developed prior to 2000, the projections for that year did not include certain changes in the Medicare+Choice market that actually occurred in 2000. Among these changes were a significant number of Medicare+Choice plan withdrawals and a decrease in the number of plans offering prescription drug coverage.

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