DATA DIGEST

OUT-OF-POCKET SPENDING ON HEALTH CARE BY MEDICARE BENEFICIARIES AGE 65 AND OLDER IN 2003

The impacts of out-of-pocket health care costs—and prescription drug costs in particular—on the family budget have been a national concern for many years. In an effort to address these expenses, policymakers have added a prescription drug benefit to Medicare starting in 2006. As prescription drugs make up only one component of out-of-pocket costs, Medicare cost-sharing, premiums, and the costs of other health care goods and services must also be considered to provide a comprehensive picture of beneficiaries' out-of-pocket spending.

This *Data Digest* presents 2003 projections of out-of-pocket health care spending[1] for non-institutionalized Medicare beneficiaries age 65 and older. It highlights the key role that prescription drugs play in beneficiaries' overall health care costs, and illuminates other products and services that contribute—sometimes greatly—to beneficiaries' spending. It also shows how beneficiaries' out-of-pocket spending can vary by demographic characteristics, income, and supplemental insurance status. All data presented are projections for 2003 based on a microsimulation model.[2] Actual data for 2003, or projections based on more recent or other sources may differ from the numbers presented here.

Out-of-Pocket Spending on Health Care

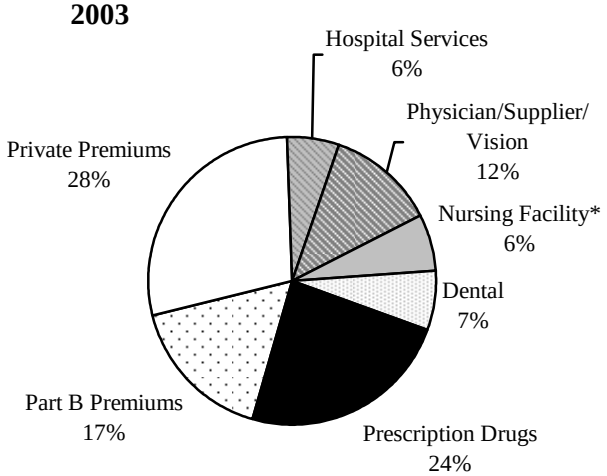
- In 2003, non-institutionalized Medicare beneficiaries age 65 and older spent an average of $3,455,[3] or 22 percent of their income,[4] on health care.
- Almost half (45 percent) of beneficiaries' total out-of-pocket health care expenses were for premiums for Medicare Part B, private Medicare plans (primarily HMOs), and private supplemental insurance (Figure 1).
- Spending on prescription drugs averaged $830 (24 percent of out-of-pocket spending),[5] making it the category of product or service with the largest spending.

Figure 1
Out-of-Pocket Spending on Health Care by Medicare Beneficiaries,[+] by Type of Expenditure, 2003

TOTAL OUT-OF-POCKET SPENDING= $3,455

or

22% of income



[+]Non-institutionalized Medicare beneficiaries age 65 and older.
*Includes costs for short-term nursing facility care only.
Source: AARP Public Policy Institute analysis using the Medicare Benefits Model, v. 5.306.

Out-of-Pocket Spending and Demographic Characteristics

Age

- Just more than half (51 percent) of non-institutionalized beneficiaries age 65 and older in 2003 were between 65 and 74 years old; an additional 12 percent of beneficiaries were age 85 and older.
- Average out-of-pocket spending on health care tends to increase with age. Indeed, beneficiaries age 65-74 spent the least out-of-pocket ($2,920), and beneficiaries age 85 and older spent the most ($4,615) (Table 1).
- Compared to other age groups, the youngest group of beneficiaries (i.e., age 65-74) also had the lowest out-of-pocket expenses as a percent of income (18 percent), while beneficiaries age 85 and older had the highest (30 percent).

Gender

- More than half of beneficiaries age 65 and older in 2003 were women (57 percent).
- Women spent, on average, about $400 more out-of-pocket on health care than men ($3,630 vs. $3,225).
- Women also spent more than men on health care as a percent of their income. Compared with men, who spent an average of 19 percent of their income, women spent 24 percent of their income.

Health Status

- Almost one-quarter of non-institutionalized beneficiaries age 65 and older (23 percent) in 2003 reported their health to be fair or poor, and 44 percent rated their health as very good or excellent.
- Beneficiaries in fair or poor health faced the highest average out-of-pocket health care costs of the health status groups, both in dollars and as a percent of income ($4,000 and 29 percent of income).
- Beneficiaries with excellent health spent $2,845, or 16 percent of their income, on health care in 2003.

Table 1
Out-of-Pocket Spending by Medicare Beneficiaries[+] by Select Characteristics, 2003

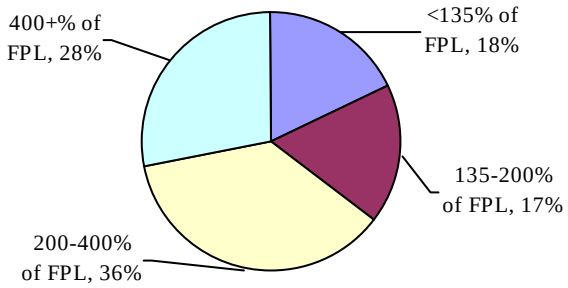
	Percent of Medicare Beneficiaries Age 65+ (N=34.7 million)	Average Out-of-Pocket Spending on Health Care	Out-of-Pocket Spending as a Percent of Income
Total	100%	$3,455	22%
Age			
65-74 years	51%	$2,920	18%
75-84 years	37%	$3,815	24%
85+ years	12%	$4,615	30%
Gender			
Men	43%	$3,225	19%
Women	57%	$3,630	24%
Health Status			
Fair or Poor	23%	$4,000	29%
Good	33%	$3,615	22%
Very Good	28%	$3,165	18%
Excellent	16%	$2,845	16%

[+]Non-institutionalized Medicare beneficiaries age 65 and older.
Source: AARP Public Policy Institute projections using the Medicare Benefits Model, v. 5.306.

Out-of-Pocket Spending and Income

- In 2003, of the 34.6 million non-institutionalized beneficiaries age 65 and older, 18 percent had income below 135 percent of poverty (Figure 2).[6] More than one-quarter had incomes greater than 400 percent of poverty.

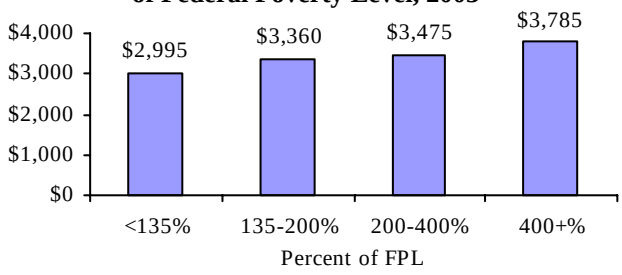
Figure 2
Distribution of Medicare Beneficiaries,[+] by Income as a Percent of Federal Poverty Level, 2003



[+]Non-institutionalized Medicare beneficiaries age 65 and older.
Note: In 2003, the federal poverty thresholds for persons age 65 and older were $8,825 (for individuals) and $11,122 (for couples).
Source: AARP PPI analysis using the Medicare Benefits Model, v. 5.306.

- Out-of-pocket spending on health care tends to rise with income. Those with incomes above 400 percent of poverty spent an average of $3,785, the highest among the income categories presented, while those with incomes below 135 percent of poverty spent the least (Figure 3).

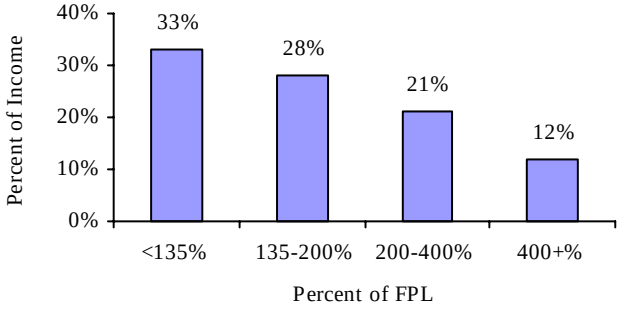
Figure 3
Average Out-of-Pocket Spending on Health Care by Medicare Beneficiaries,[+] by Income as a Percent of Federal Poverty Level, 2003



[+]Non-institutionalized Medicare beneficiaries age 65 and older.
Note: In 2003, the federal poverty thresholds for persons age 65 and older were $8,825 (for individuals) and $11,122 (for couples).
Source: AARP PPI analysis using the Medicare Benefits Model, v. 5.306.

- When examining out-of-pocket spending as a percent of income,[7] the pattern reverses. Spending as a share of income is highest among those with the lowest income and lowest among those with the highest income. Beneficiaries with incomes below 135 percent of poverty spent an average of 33 percent of their income on health care, compared to beneficiaries with incomes above 400 percent of poverty, who spent 12 percent of their income on health care (Figure 4).

Figure 4
Average Out-of-Pocket Spending on Health Care as a Percent of Income by Medicare Beneficiaries,[+] by Income as a Percent of Federal Poverty Level, 2003

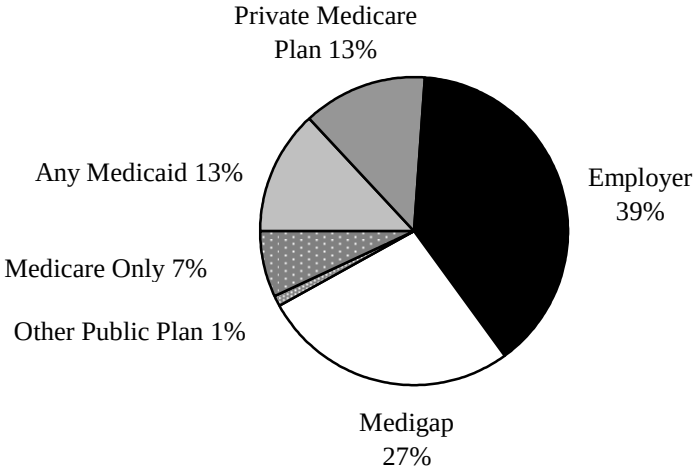


[+]Non-institutionalized Medicare beneficiaries age 65 and older.
Note: In 2003, the federal poverty thresholds for persons age 65 and older were $8,825 (for individuals) and $11,122 (for couples).
Source: AARP PPI analysis using the Medicare Benefits Model, v. 5.306.

Out-of-Pocket Spending and Supplemental Insurance

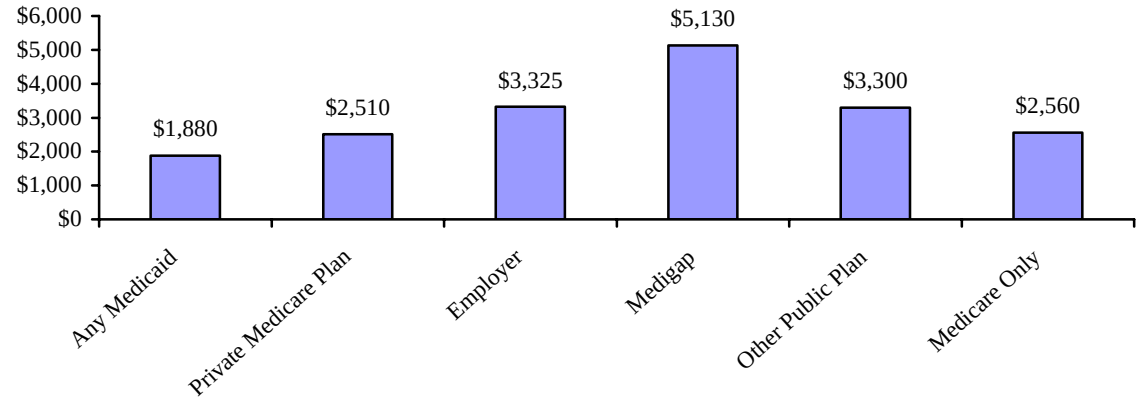
- In 2003, the vast majority of older non-institutionalized Medicare beneficiaries had some type of supplemental insurance[8] to pay for some of the health care costs not covered by Medicare.[9]
- Two-thirds of Medicare beneficiaries had supplemental insurance through either an employer or an individually purchased Medigap policy in 2003, and 13 percent enrolled in a private Medicare plan (Figure 5).[10]
- Thirteen percent of beneficiaries had some level of assistance from a state Medicaid program.[11] Four percent were full-year "dual eligibles" who received full Medicaid benefits, four percent either received full-year assistance with premiums and cost-sharing only, and five percent either received full Medicaid benefits for part of the year or received only assistance with Medicare premiums.
- Beneficiaries with Medigap insurance had the highest out-of-pocket spending, averaging over $5,100 (Figure 6).
- Beneficiaries enrolled in a private Medicare plan had average out-of-pocket health care spending of $2,510. Beneficiaries with "Medicare only" (i.e., traditional Medicare with no supplemental coverage) had average spending of $2,560. Although their total out-of-pocket spending was similar to those in private Medicare plans, beneficiaries with "Medicare only" spent a larger share of their out-of-pocket dollars on goods and services, particularly inpatient and outpatient hospital care and prescription drugs (not shown), and a smaller share on premiums. Those with Medicare only, by definition, did not pay supplemental insurance premiums.
- The $1,880 average out-of-pocket spending for beneficiaries with any Medicaid masks the range of spending levels within this supplemental coverage category. For example, those with full-year, full Medicaid coverage spent an average of $525, whereas those with part-year coverage or assistance with only Medicare premiums averaged $3,245 in 2003.

Figure 5
Distribution of Medicare Beneficiaries,[+] by Type of Supplemental Coverage, 2003



[+]Non-institutionalized Medicare beneficiaries age 65 and older.
Source: AARP PPI analysis using the Medicare Benefits Model, v. 5.306.

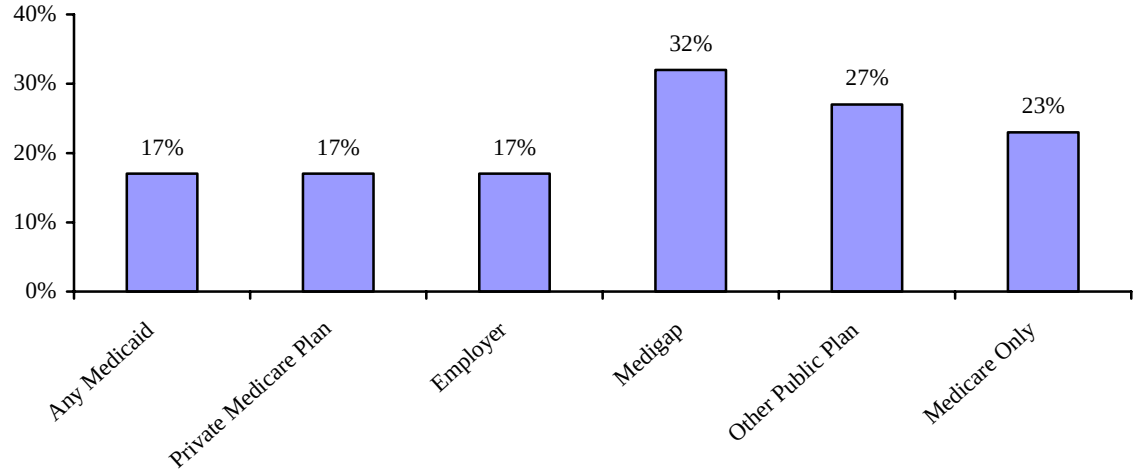
Figure 6
Average Out-of-Pocket Spending on Health Care by Medicare Beneficiaries,[+] by Type of Supplemental Coverage, 2003



[+]Non-institutionalized Medicare beneficiaries age 65 and older.
Source: AARP PPI analysis using the Medicare Benefits Model, v. 5.306.

- Beneficiaries with supplemental coverage through Medigap in 2003 also had by far the highest out-of-pocket health care spending as a share of their income (32 percent) (Figure 7).
- Medicare beneficiaries with any Medicaid spent an average of 17 percent of income out-of-pocket on health care. However, within that category, those with full-year, full Medicaid benefits had the lowest spending as a share of income (6 percent) (not shown).
- Beneficiaries enrolled in a private Medicare plan spent an average of 17 percent of their income out-of-pocket on health care, which was comparable to those with employer-sponsored policies; those with Medicare only spent an average of 23 percent of income.

Figure 7
Average Out-of-Pocket Spending on Health Care as a Percent of Income by Medicare Beneficiaries,[+] by Type of Supplemental Coverage, 2003

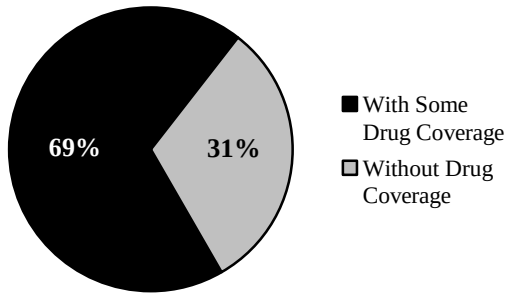


[+]Non-institutionalized Medicare beneficiaries age 65 and older.
Source: AARP PPI analysis using the Medicare Benefits Model, v. 5.306.

Out-of-Pocket Spending and Supplemental Coverage for Prescription Drugs

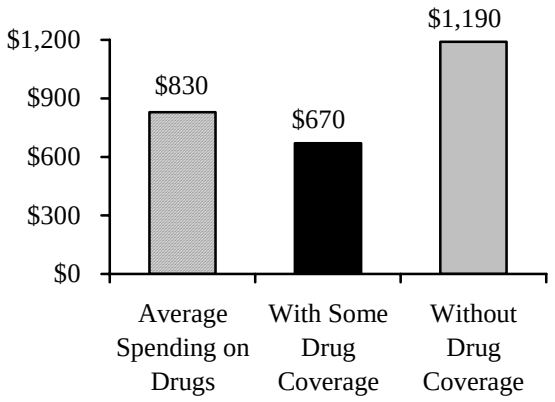
- As shown previously, beneficiaries spent $830, on average, on prescription drugs in 2003.
- The presence of prescription drug coverage greatly affected beneficiaries' out-of-pocket spending on drugs.
- In 2003, about 69 percent of beneficiaries had some level of coverage for drugs during the year (Figure 8).[12]
- Beneficiaries with some prescription drug coverage in 2003 spent an average of $670, compared with $1,190 for those who lacked any coverage (Figure 9).

Figure 8
Distribution of Medicare Beneficiaries,[+] by Presence of Prescription Drug Coverage, 2003



[+]Non-institutionalized Medicare beneficiaries age 65 and older.
Source: AARP Public Policy Institute analysis using the Medicare Benefits Model, v. 5.306.

Figure 9
Out-of-Pocket Spending on Prescription Drugs by Medicare Beneficiaries,[+] by Presence of Prescription Drug Coverage, 2003



[+]Non-institutionalized Medicare beneficiaries age 65 and older.
Source: AARP Public Policy Institute analysis using the Medicare Benefits Model, v. 5.306.

Conclusion

This *Data Digest* has provided an overview of older non-institutionalized Medicare beneficiaries' out-of-pocket spending on health care and describes characteristics by which out-of-pocket spending varies. In 2003, beneficiaries age 65 and older spent an average of $3,455 on health care, or 22 percent of their income. Almost half of those costs were for Medicare and private premiums and almost one-quarter were for prescription drugs. Furthermore, out-of-pocket spending levels can vary greatly by demographic characteristics, income, and supplemental insurance. For example, those with Medigap had the highest out-of-pocket spending of any supplemental coverage category, and those with low income were particularly vulnerable to high out-of-pocket spending as a share of their incomes.

These estimates reflect beneficiaries' burdens under current law and do not reflect program changes—especially the new Medicare drug benefit and associated low-income protections—that were included in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. Regardless of the level of assistance with prescription drug costs that beneficiaries may receive in 2006 (when the Medicare prescription drug benefit is implemented), out-of-pocket spending on health care in general will likely continue to account for a substantial share of many beneficiaries' incomes. The magnitude

of this out-of-pocket spending demonstrates the importance of continually evaluating Medicare's benefit package to assess how well the program meets the needs of all of its beneficiaries.

Endnotes

[1] Total out-of-pocket spending includes Medicare cost-sharing, Part B and private insurance premiums, physician balance billing, and the costs of goods and services not covered by Medicare. Out-of-pocket spending for prescription drugs includes only direct spending on drugs; any premiums for drug coverage through supplemental insurance would be reflected in private premiums. Although the estimate includes costs for short-term nursing facility care, it does not include the costs of home care or long-term nursing home care.

[2] The data are taken from the Medicare Benefits Model, version 5.306. This desktop microsimulation model, developed for AARP's Public Policy Institute by The Lewin Group, projects health care expenditures for Medicare beneficiaries from the 1998 Medicare Current Beneficiary Survey (MCBS) Cost and Use files and other data sources. (At the time work on the model was initiated, the 1998 files were the most current MCBS.) The model trended MCBS statistics forward using actual and projected data from multiple sources, including: (1) the Congressional Budget Office (CBO), (2) the Centers for Medicare and Medicaid Services (CMS) Office of Managed Care, (3) the CMS National Health Accounts, (4) the Bureau of the Census Current Population Survey, and (5) the Social Security Administration. See The Lewin Group. November 2003. *Medicare Benefits Simulation Model, Version 98-5; Model Development and Baseline Assumptions.* The Lewin Group, Fairfax, VA. For a general discussion of the methodology used in making these projections, see David J. Gross, Mary Jo Gibson, Craig F. Caplan, Normandy Brangan, Lisa Alecxih, and John Corea. December 1997. *Out-of-Pocket Spending by Medicare Beneficiaries Age 65 and Older: 1997 Projections*. AARP Public Policy Institute, Issue Paper #9705, Washington, DC.

[3] Out-of-pocket spending estimates throughout this *Data Digest* are rounded to the nearest $5.

[4] The 22 percent figure reflects the average of each beneficiary's share of income spent on health care. To estimate Medicare beneficiaries' average out-of-pocket health care spending as a share of their income, a ratio was computed for each individual, capped at 100 percent, and then averaged across all individuals. This approach is illustrated in the example below. Suppose a population consists of three individuals (#1, 2, 3) whose out-of-pocket health care spending and income are as shown in the second and third columns of the table. Using this information, it is possible to compute each individual's out-of-pocket spending as a share of income, as shown in the fourth column:

Person	Out-of-pocket spending	Income	Out-of-pocket spending, as a share of income
#1	$5,000	$20,000	25%
#2	$2,000	$40,000	5%
#3	$3,000	$10,000	30%

Using the method employed in this report, the average out-of-pocket spending as a share of income for the 3-person group is computed as (25%+5%+30%)/3=20%. (Note: This ratio is *not* computed as the population's average out-of-pocket health care spending divided by its average income, which would have yielded markedly different results.)

[5] This figure is somewhat lower than the $996 in 2003 that was reported in other publications (e.g., Henry J. Kaiser Family Foundation. April 2003. *Medicare and Prescription Drugs.* Henry J. Kaiser Family Foundation, Fact Sheet #1583-06, Washington, DC) and was based on an Actuarial Research Corporation analysis which used CBO's 2003 estimates. The reasons for the disparity include, among others, differences in populations (e.g., the Medicare Benefits Model beneficiary population is only the non-institutionalized, whereas the CBO estimate imputes spending for the institutionalized) and differences in the calculation process (e.g., the Medicare Benefits Model methodology examines out-of-pocket drug spending at the individual beneficiary level whereas the CBO estimate computes total drug spending at the aggregate population level and then applies a predetermined ratio of out-of-pocket spending to total drug spending).

[6] In 2003, the federal poverty thresholds for persons age 65 and older were $8,825 (for individuals) and $11,122 (for couples). See www.census.gov/hhes/poverty/threshld/thresh03.html.

[7] Out-of-pocket health care spending in this report is defined at the individual level. For purposes of computing the ratio of out-of-pocket health care spending to income for a beneficiary, however, single and married individuals are treated differently. For a single individual, the ratio is simply defined as his/her out-of-pocket spending divided by his/her income (as explained in footnote 4). For a married individual, the ratio is defined as his/her out-of-pocket spending

divided by one half of the combined income for both spouses.

[8] Beneficiaries who have more than one type of supplemental insurance (e.g., those in Medicaid who also were in a private Medicare plan) are grouped under only one supplemental insurance category, according to the following hierarchy: Medicaid, private Medicare plan, employer-sponsored plan, Medigap, other public coverage (e.g., Department of Veteran Affairs enrollees), and "Medicare only." For ease of exposition and because of the additional benefits and lower cost sharing that many plans provide, the "private Medicare plan" category is classified as supplemental insurance coverage, although it is actually the beneficiary's primary insurance coverage.

[9] The estimated percentage of beneficiaries with Medicare only are derived from the MCBS Cost and Use files and are lower than the percentage from earlier published estimates that were based on the MCBS Access to Care files. (See, for example, Mary Laschober, et al., "Trends in Medicare Supplemental Insurance and Prescription Drug Coverage, 1996-1999," February 27, 2002. *Health Affairs* (web exclusive, http://130.94.25.113/readeragent.php?ID=/usr/local/apache/sites/healthaffairs.org/htdocs/Library/v21n2/s4.pdf), p. W136.) The Access to Care sample essentially represents a *single point in time*, while the Cost and Use sample includes all individuals with Medicare coverage *at any time during the year*. Because some beneficiaries have supplemental coverage for only part of the year, there are more beneficiaries with some supplemental coverage over the course of the year (as measured in the Cost and Use files) than there are beneficiaries with supplemental coverage at a single point in time (as measured in the Access to Care files).

[10] In 2003, prior to the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), these private Medicare plans were known as Medicare+Choice plans. Once the MMA was enacted, these plans became known as Medicare Advantage plans.

[11] The Medicaid category includes any Medicare beneficiary who was enrolled in a state Medicaid program for the full year ("dual eligible") or part of the year. It also includes beneficiaries with incomes up to 135 percent of the federal poverty level, for whom Medicaid paid Medicare premiums, and, in some cases, cost-sharing of Medicare-covered services.

[12] The estimate of non-institutionalized beneficiaries age 65 and older who lacked drug coverage in 2003 (31 percent) is somewhat higher than estimates based directly on the original 1998 MCBS Cost and Use data used in the model (27 percent). The higher proportion without drug coverage in 2003 reported by the model is driven mainly by a modeled decrease in drug coverage from private Medicare plans (i.e., Medicare Advantage plans, which were formerly known as "Medicare+Choice" plans) between 1998 and 2003. This trend has been documented. For example, Medicare administrative data indicate that the proportion of private Medicare plan enrollees in plans that do not provide drug coverage rose from 16 percent in 1999 to 31 percent in 2003 (Lori Achman and Marsha Gold. December 2003. *Trends in Medicare+Choice Benefits and Premiums, 1999-2003, and Special Topics*. Mathematica Policy Research, Inc., Washington, DC). In addition, the period 1998-2003 also saw an absolute decrease in the number of beneficiaries in private Medicare plans, further reducing the model's estimate of the prevalence of drug coverage.

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