Although Medicare provides important health insurance for older Americans, its coverage is not comprehensive. Medicare requires substantial cost-sharing for many covered services, and it does not cover some other health care services, such as outpatient prescription drugs, vision and dental care, and some preventive services. Most Medicare beneficiaries obtain some type of private or public supplemental coverage to fill these gaps in Medicare’s benefit package, often at additional cost. Despite the prevalence of supplemental coverage, many beneficiaries still incur substantial expenses for their health care. This Issue Brief provides 1999 projections of average out-of-pocket health care costs for non-institutionalized Medicare beneficiaries age 65 and older.

The estimates presented in this Issue Brief cannot be compared to our previous analysis of out-of-pocket health spending\(^1\) for three reasons. First, they include the costs of short-term nursing facility care, which had previously been excluded.\(^2\) Second, they differentiate between spending patterns of beneficiaries who qualify for full Medicaid benefits and those enrolled in Qualified Medicare Beneficiary (QMB) and Specified Low-Income Medicare Beneficiary (SLMB) programs, which provide assistance with some Medicare-related costs to lower income beneficiaries who are not eligible for full Medicaid benefits. Past estimates could not differentiate among these groups of Medicaid recipients. Finally, the current estimates were derived from a revised benefits simulation model that incorporates more recent data, reflects more representative estimates of spending by HMO enrollees, and incorporates Medicare spending trends resulting from legislative changes in the Balanced Budget Act of 1997.\(^3\)

### Average Out-of-Pocket Spending on Health Care

Medicare beneficiaries age 65 and older are projected to spend about $2,430, or 19 percent of income,\(^4\) out-of-pocket for health care in 1999 (Figure 1). Payments for health care goods and services—Medicare deductibles and coinsurance, and payments for goods and services not covered by Medicare, such as prescription drugs and dental care—account for over half of this amount (54 percent). The remaining 46 percent is spent on premium payments for Medicare Part B, private insurance, and Medicare+Choice plans.\(^5\) The estimates do not include the costs of home care or long-term nursing home care.\(^6\)

Prescription drugs account for the single largest component of out-of-pocket spending on health care, after premium payments. On average, beneficiaries are expected to spend as much out-of-pocket for prescription drugs (17 percent of total out-of-pocket health spending) as for physician care, vision services, and medical supplies combined. By contrast, inpatient and outpatient hospital care each account for about 3 percent of older beneficiaries’ total out-of-pocket health spending.
Average Out-of-Pocket Spending on Health Care by Medicare Beneficiaries,*  
by Type of Service, 1999

TOTAL = $2,430

Nursing Home Care* 8%  
Prescription Drugs 17%  
Part B Premium 19%  
Dental 8%  
Physician; Supplier; Vision ** 17%  
Outpatient Hospital 3%  
Inpatient Hospital 3%  
Private Insurance Premiums  (including Medicare+Choice) 27%  

*Non-institutionalized Medicare beneficiaries age 65 and older.  
*Includes costs for short-term nursing facility care only.  
**The Medicare Benefits Model does not separate spending on physician services, supplier, and vision items. Prior studies suggest that out-of-pocket spending for physician services account for about 85 percent of the combined physician/supplier/vision spending. See Gross, et al., 1997.  
Note: Figures may not sum to 100% due to rounding.  
Source: AARP PPI analysis using the Medicare Benefits Model, Version 2.0.

Distribution of Out-of-Pocket Spending on Health Care

While average out-of-pocket health spending is projected to be $2,430 in 1999, the distribution of out-of-pocket health spending is skewed (Figure 2). More than half of beneficiaries—55 percent—are projected to spend less than $2,000 out-of-pocket for health care in 1999. Another 20 percent are projected to spend between $2,000 and $3,000, and the remainder (25 percent) will spend over $3,000 for their health care.

Distribution of Out-of-Pocket Spending on Health Care by Medicare Beneficiaries,* 1999

$2,430

<$1,000 $1,000-$2,000 $2,000-$3,000 $3,000-$4,000 $4,000-$5,000 >$5,000

28% 27% 20% 11% 6% 8%

* Non-institutionalized Medicare beneficiaries age 65 and older.  
Source: AARP PPI analysis using the Medicare Benefits Model, Version 2.0.
Supplemental Coverage Among Medicare Beneficiaries

Over 9 in 10 non-institutionalized beneficiaries age 65 and older are projected to have some type of supplemental coverage to help pay for health care costs not covered by Medicare in 1999 (Figure 3). Most of these beneficiaries obtain private or public supplemental coverage while remaining in original fee-for-service Medicare. Many others enroll in Medicare+Choice plans, which typically offer supplemental benefits not covered by original Medicare.

<table>
<thead>
<tr>
<th>Percent of Beneficiaries</th>
<th>0%</th>
<th>5%</th>
<th>10%</th>
<th>15%</th>
<th>20%</th>
<th>25%</th>
<th>30%</th>
<th>35%</th>
<th>40%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medigap</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employer</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicare Only</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>4%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicare+Choice</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full year Medicaid</td>
<td></td>
<td></td>
<td></td>
<td>4%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full year QMB</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full year SLMB/Part year Medicaid</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Non-institutionalized Medicare beneficiaries age 65 and older. Numbers may not add to 100% because of rounding. These figures do not include the one percent of beneficiaries who have non-Medicaid public insurance (for example, CHAMPUS or VA coverage).

Source: AARP PPI analysis using the Medicare Benefits Model, Version 2.0.

Almost two-thirds (64 percent) of beneficiaries remain in original fee-for-service Medicare and obtain some type of private supplemental coverage—either through an employer or through an individually purchased Medigap policy. The benefits offered by employer-sponsored plans vary greatly, and employers may require the beneficiary to pay a portion of the premium. The benefits offered by Medigap plans also vary; since 1992, benefit packages have been limited to 10 standardized plans. Each plan covers Medicare’s coinsurance requirements, and many also include coverage for Medicare’s deductibles and some other additional benefits. Three plans cover a portion of prescription drug costs. The cost of Medigap insurance varies by plan, the geographic market in which the plan is being offered, and the company from which it is purchased. 
Eight percent of beneficiaries are projected to have original (fee-for-service) Medicare only and no supplemental coverage. For the most part, these beneficiaries are financially responsible for all cost-sharing requirements and all payments for the cost of non-covered health care goods and services they receive.\(^9\)

Some beneficiaries opt out of original Medicare by enrolling in a Medicare+Choice plan.\(^10\) About 16 percent of beneficiaries are projected to enroll in a Medicare+Choice plan in 1999. These plans typically have lower cost-sharing than original Medicare and often provide additional benefits such as prescription drugs and physical exams. Some of these plans require payment of supplemental premiums.

Eleven percent of beneficiaries receive some type of assistance from their state Medicaid program. They may receive these benefits through original Medicare or through a Medicare+Choice plan. Some beneficiaries qualify for full Medicaid benefits for the entire year, thereby receiving coverage for Medicare cost-sharing as well as many benefits not covered by Medicare, such as prescription drugs, physical exams, and vision care. Beneficiaries who are not eligible for full Medicaid benefits, but who have incomes below the federal poverty level,\(^12\) can receive assistance through the Qualified Medicare Beneficiary (QMB) program, which covers the Part B premium and all Medicare cost-sharing.\(^13\) Beneficiaries with incomes between 100 and 120 percent of the federal poverty level can enroll in the Specified Low-Income Medicare Beneficiary (SLMB) program, which covers Part B premiums only. Because their coverage is limited, beneficiaries in the QMB and SLMB programs may still face substantial out-of-pocket costs not incurred by beneficiaries with full Medicaid coverage.

**Supplemental Coverage and Out-of-Pocket Health Spending**

Average out-of-pocket spending varies greatly depending on the type of supplemental coverage (Figure 4). Beneficiaries with Medigap policies are projected to spend the most out-of-pocket for health care, on average—$3,250 vs. $2,430 for all beneficiaries. By contrast, enrollees in Medicare+Choice plans are projected to have the lowest out-of-pocket health spending among non-Medicaid beneficiaries—$1,630. On average, Medicare-only beneficiaries and beneficiaries who have employer-sponsored coverage each are projected to spend slightly above the average for all beneficiaries.

Beneficiaries who receive full Medicaid coverage or who receive QMB benefits are projected to spend substantially less out-of-pocket for health care than do other Medicare beneficiaries. Those with full Medicaid benefits for the full year are projected to spend an average of $280 out-of-pocket for health care, while those in the QMB program for the full year will average $840 in out-of-pocket spending.\(^14\) By contrast, beneficiaries who are enrolled in the SLMB program or who receive Medicaid assistance for only part of the year are projected to incur higher than average out-of-pocket health costs, spending an estimated $2,630 out-of-pocket for health care.\(^15\)
Figure 4 shows the average share of income spent out-of-pocket on health care by type of insurance coverage. Beneficiaries with Medigap coverage are projected to spend just over one-quarter of their incomes out-of-pocket for health care. This figure reflects two patterns within this population: (1) higher average out-of-pocket spending than other beneficiaries, and (2) lower than average incomes.

Medicare-only beneficiaries are projected to spend a much higher share of their income out-of-pocket on health care (22 percent) than those with employer-sponsored coverage (16 percent), even though the dollar value of average out-of-pocket health spending for the two groups is similar. This result is largely attributable to (1) lower-than-average incomes among Medicare-only beneficiaries, and (2) higher-than-average incomes among beneficiaries who have employer-sponsored coverage.

Medicare+Choice enrollees’ health care costs are estimated to take 12 percent of their income, on average. This relatively low figure is attributable to a combination of lower-than-average out-of-pocket spending and slightly higher-than-average incomes.

Beneficiaries with full Medicaid coverage, who receive substantial protection from out-of-pocket costs, are projected to spend about five percent of their income for health care. Those Medicaid enrollees enrolled in the QMB program for the full year are expected to pay substantially more—13 percent of their income. Full-year SLMB enrollees and part-year Medicaid enrollees are projected to have the largest financial burden, with average out-of-pocket health spending consuming 30 percent of their income.
**Figure 5**

Average Out-of-Pocket Spending on Health as a Percent of Income by Medicare Beneficiaries*, by Type of Insurance, 1999

<table>
<thead>
<tr>
<th>Type of Insurance</th>
<th>0%</th>
<th>5%</th>
<th>10%</th>
<th>15%</th>
<th>20%</th>
<th>25%</th>
<th>30%</th>
<th>35%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>19%</td>
<td>22%</td>
<td>16%</td>
<td>12%</td>
<td>26%</td>
<td>5%</td>
<td>13%</td>
<td>30%</td>
</tr>
<tr>
<td>Medicare Only</td>
<td>19%</td>
<td>22%</td>
<td>16%</td>
<td>12%</td>
<td>26%</td>
<td>5%</td>
<td>13%</td>
<td>30%</td>
</tr>
<tr>
<td>Employer</td>
<td>19%</td>
<td>22%</td>
<td>16%</td>
<td>12%</td>
<td>26%</td>
<td>5%</td>
<td>13%</td>
<td>30%</td>
</tr>
<tr>
<td>Medigap</td>
<td>19%</td>
<td>22%</td>
<td>16%</td>
<td>12%</td>
<td>26%</td>
<td>5%</td>
<td>13%</td>
<td>30%</td>
</tr>
<tr>
<td>Medicare+Choice</td>
<td>19%</td>
<td>22%</td>
<td>16%</td>
<td>12%</td>
<td>26%</td>
<td>5%</td>
<td>13%</td>
<td>30%</td>
</tr>
<tr>
<td>Full year Medicaid</td>
<td>19%</td>
<td>22%</td>
<td>16%</td>
<td>12%</td>
<td>26%</td>
<td>5%</td>
<td>13%</td>
<td>30%</td>
</tr>
<tr>
<td>Full year QMB</td>
<td>19%</td>
<td>22%</td>
<td>16%</td>
<td>12%</td>
<td>26%</td>
<td>5%</td>
<td>13%</td>
<td>30%</td>
</tr>
<tr>
<td>Full year SLMB/Part year</td>
<td>19%</td>
<td>22%</td>
<td>16%</td>
<td>12%</td>
<td>26%</td>
<td>5%</td>
<td>13%</td>
<td>30%</td>
</tr>
</tbody>
</table>

*Non-institutionalized beneficiaries age 65 and older.
Source: AARP PPI analysis using the Medicare Benefits Model, Version 2.0.

**Out-Of-Pocket Spending by Type of Insurance Coverage and Type of Spending**

Figure 6 shows the distribution of payments, by coverage status, both for insurance premiums and for health care goods and services. *Part B and private insurance premiums* includes payment for the Medicare Part B premium, Medigap and employer premiums, and Medicare+ Choice premiums. *Goods and services* includes payments for inpatient and outpatient hospital care, short-term nursing facility care, physician/supplier/vision services, dental care, and outpatient prescription drugs. The costs for home care and long-term nursing home care are not included.

Examination of these data reveals several interesting patterns:

1. **Medicare-only beneficiaries incur high out-of-pocket spending on health care goods and services.** While Medicare-only beneficiaries and those with employer-sponsored coverage pay similar amounts for health care in the aggregate, Medicare-only beneficiaries tend to spend much more on health care *goods and services*—$2,040 vs. $1,415. They also tend to spend more on health care goods and services than do beneficiaries with Medigap coverage or those enrolled in Medicare+Choice plans.

2. **Medicare-only beneficiaries spend a relatively small share of their health care goods and services expenses on prescription drugs and dental care.** As shown in Table 1, about 28 percent of goods and services payments by Medicare-only beneficiaries ($570) is for prescription drugs and dental care. Most of their out-of-pocket spending for health care goods and services is for expenses that, for the most part, are otherwise covered by supplemental or Medicare+Choice plans. By contrast, beneficiaries who have employer-sponsored coverage are projected to spend an average of 41 percent ($575) of their out-of-pocket spending on health care goods and services on drugs and dental care; Medicare+Choice enrollees are projected to spend 55 percent ($505); and beneficiaries with Medigap coverage are projected to spend 62 percent ($845).
3. **Compared to those with employer-based coverage, beneficiaries with Medigap policies spend similar amounts out-of-pocket for health care goods and services but much more for premiums.** While beneficiaries with Medigap coverage are projected to spend substantially more out-of-pocket, on average, than beneficiaries with employer-sponsored coverage, both groups’ projected average out-of-pocket spending on health care goods and services is similar—about $1,400. However, Medigap enrollees, who must pay the entire cost of their supplemental coverage, are projected to spend an average of about $1,360 (or almost $115 per month) on private insurance premiums, compared to $630 (or about $50 per month) for beneficiaries with employer-sponsored coverage (Table 1).

4. **Medicare+Choice enrollees incur relatively low out-of-pocket costs for both premiums and payments for health care goods and services.** On average, Medicare+Choice enrollees are projected to pay less out-of-pocket for most health care goods and services than either beneficiaries with employer-sponsored coverage or beneficiaries with private Medigap policies. In addition, the average supplemental premium paid by Medicare+Choice enrollees—$195, or about $16 per month—is substantially lower than the average for employer-provided or Medigap coverage (Table 1).
5. QMBs, SLMBs, and part-year Medicaid beneficiaries can incur substantial out-of-pocket costs for health care goods and services. The financial assistance that Medicaid provides is evident in the much lower out-of-pocket payments for goods and services made by full-year Medicaid enrollees ($250, on average). However, QMB enrollees, who receive Medicaid coverage for Medicare cost-sharing but not for uncovered services (such as prescription drugs) face a much greater financial responsibility for those services ($775, on average). Moreover, average out-of-pocket health spending by full-year SLMB and part-year Medicaid enrollees ($2,200) is similar to that of Medicare-only beneficiaries ($2,040), who have no supplemental benefits. However, much of the cost for this population comes from high out-of-pocket spending on short-term nursing facility care (over $1,000, on average).

### Table 1

*Out-of-Pocket Health Care Spending for Non-Institutionalized Medicare Beneficiaries Age 65 and Older, by Type of Spending and Insurance Coverage, 1999*

<table>
<thead>
<tr>
<th></th>
<th>TOTAL</th>
<th>Medicare Only</th>
<th>Employer</th>
<th>Medigap</th>
<th>Medicare + Choice</th>
<th>Full Year Medicaid</th>
<th>Full Year QMB</th>
<th>Full Year SLMB/Part Year Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>AVERAGE OUT-OF-POCKET SPENDING</strong></td>
<td>$2,430</td>
<td>$2,505</td>
<td>$2,545</td>
<td>$3,250</td>
<td>$1,630</td>
<td>$280</td>
<td>$840</td>
<td>$2,630</td>
</tr>
<tr>
<td><strong>Subtotal of Part B and Private Insurance Premiums</strong></td>
<td>$1,100</td>
<td>$465</td>
<td>$1,130</td>
<td>$1,885</td>
<td>$720</td>
<td>$30</td>
<td>$65</td>
<td>$430</td>
</tr>
<tr>
<td>Medicare Part B Premium Contributions*</td>
<td>$455</td>
<td>$465</td>
<td>$500</td>
<td>$525</td>
<td>$525</td>
<td>$0</td>
<td>$0</td>
<td>$160</td>
</tr>
<tr>
<td>Private Insurance/HMO Premium Contributions</td>
<td>$645</td>
<td>$0</td>
<td>$630</td>
<td>$1,360</td>
<td>$195</td>
<td>$30</td>
<td>$65</td>
<td>$270</td>
</tr>
<tr>
<td><strong>Subtotal for Health Care Goods and Services</strong></td>
<td>$1,330</td>
<td>$2,040</td>
<td>$1,415</td>
<td>$1,365</td>
<td>$910</td>
<td>$250</td>
<td>$775</td>
<td>$2,200</td>
</tr>
<tr>
<td>Inpatient Hospital</td>
<td>$65</td>
<td>$355</td>
<td>$35</td>
<td>$30</td>
<td>$35</td>
<td>$45</td>
<td>$25</td>
<td>$90</td>
</tr>
<tr>
<td>Outpatient Hospital</td>
<td>$60</td>
<td>$175</td>
<td>$60</td>
<td>$45</td>
<td>$25</td>
<td>$5</td>
<td>$20</td>
<td>$210</td>
</tr>
<tr>
<td>Physician/Supplier/Vision</td>
<td>$400</td>
<td>$655</td>
<td>$465</td>
<td>$415</td>
<td>$200</td>
<td>$65</td>
<td>$275</td>
<td>$400</td>
</tr>
<tr>
<td>Nursing Facility</td>
<td>$200</td>
<td>$285</td>
<td>$280</td>
<td>$30</td>
<td>$145</td>
<td>$50</td>
<td>$125</td>
<td>$1,030</td>
</tr>
<tr>
<td>Dental</td>
<td>$195</td>
<td>$140</td>
<td>$230</td>
<td>$200</td>
<td>$250</td>
<td>$5</td>
<td>$110</td>
<td>$30</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>$410</td>
<td>$430</td>
<td>$345</td>
<td>$645</td>
<td>$255</td>
<td>$80</td>
<td>$220</td>
<td>$440</td>
</tr>
</tbody>
</table>

**SOURCE:** AARP PPI analysis using the Medicare Benefits Model, Version 2.0.

**NOTE:** Out-of-pocket health care spending excludes home care services and long-term nursing facility care. Numbers are rounded to the nearest $5. Numbers may not sum to total because of rounding.

*The average Part B premium contribution represents an average premium cost over the entire year. The average contribution differs between each group because of differences in the number of months that each group’s average enrollee was enrolled in Medicare.*
Out-of-Pocket Spending by Beneficiaries in Different Income Groups

In general, average out-of-pocket spending on health care tends to rise with income. For example, the 9 percent of beneficiaries with family incomes below the federal poverty level are projected to face annual out-of-pocket costs of $1,770, on average, while the 11 percent of beneficiaries with incomes over 600% of the poverty level are projected to pay an average of over $2,600 out-of-pocket for their health care (Figures 7 and 8).\textsuperscript{18}

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{Figure7.png}
\caption{Distribution of Medicare Beneficiaries$^+$ by Income as a Percent of Federal Poverty Level, 1999}
\end{figure}

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{Figure8.png}
\caption{Average Out-of-Pocket Spending on Health Care by Medicare Beneficiaries$^+$ by Income Level, 1999}
\end{figure}

$^+$Non-institutionalized Medicare beneficiaries age 65 and over.

\begin{flushleft}
The federal poverty level for persons age 65 and older in 1999 is projected to be $8,075 for individuals and $10,185 for couples. Source: AARP PPI analysis using the Medicare Benefits Model, Version 2.0.
\end{flushleft}
By contrast, the share of income spent out-of-pocket on health care falls as income rises. Beneficiaries with incomes below the poverty level are projected to spend, on average, one-third of their income on health care, and beneficiaries with incomes between 100% and 200% of poverty will spend, on average, about one-quarter of their income (Figure 9). Beneficiaries with incomes between 200% and 400% of poverty are projected to spend 17 percent of their income on health care, while those with incomes above 600% of the poverty level are projected to spend an average of 8 percent of their income.

Figure 9
Average Out-of-Pocket Spending on Health Care as a Percent of Income by Medicare Beneficiaries, by Income Level, 1999

<table>
<thead>
<tr>
<th>Income as a Percent of the Federal Poverty Level</th>
<th>0%</th>
<th>5%</th>
<th>10%</th>
<th>15%</th>
<th>20%</th>
<th>25%</th>
<th>30%</th>
<th>35%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>19%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;100%</td>
<td>33%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>100-125%</td>
<td>25%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>125-200%</td>
<td>24%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>200-400%</td>
<td>17%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>400-600%</td>
<td>13%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>600%+</td>
<td>8%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Non-institutionalized Medicare beneficiaries age 65 and over.
Note: The federal poverty level for persons age 65 and older in 1999 is projected to be $8,075 for individuals and $10,185 for couples. Source: AARP PPI analysis using the Medicare Benefits Model, Version 2.0.

The estimates of out-of-pocket spending for beneficiaries with incomes below the poverty level (denoted henceforth as “poor” beneficiaries) presented in Figures 8 and 9 do not distinguish between poor beneficiaries who receive Medicaid assistance and those who do not. Indeed, about half of poor beneficiaries, or more than 1.5 million poor Medicare beneficiaries, do not receive any assistance from Medicaid.

Out-of-pocket health spending for these beneficiaries is substantially higher than for other poor beneficiaries. Poor beneficiaries who do not receive Medicaid assistance are projected to spend about half their annual income out-of-pocket for health care (Figure 10), on average. Among this population, beneficiaries with individually-purchased Medigap policies (566,000 beneficiaries) are projected to pay an even greater share of annual income—59 percent—while those with employer-based coverage (315,000 beneficiaries) spend about half of their income on health care, on average. Those enrolled in Medicare+Choice plans (317,000 beneficiaries) or who are Medicare-only beneficiaries (also 317,000 beneficiaries) are projected to spend somewhat less—close to 40 percent of their incomes, on average.
Conclusions

These data show that out-of-pocket health care spending continues to pose a substantial financial burden for many Medicare beneficiaries age 65 and older. On average, these beneficiaries are projected to pay $2,430, or 19 percent of income, out-of-pocket for health care in 1999. Furthermore, 25 percent of beneficiaries are projected to spend over $3,000 out-of-pocket for health care. As noted earlier, this analysis excludes home care and long-term nursing home care costs. Inclusion of these costs would, naturally, increase our estimates of out-of-pocket health care spending.

This analysis also shows that out-of-pocket health care spending is particularly burdensome for poor beneficiaries who do not receive Medicaid assistance. Furthermore, while Medicaid often provides substantial financial relief for beneficiaries who receive full Medicaid benefits, those who receive only partial Medicaid assistance—QMBs, SLMBs, and part-year Medicaid enrollees, also can incur high out-of-pocket health costs.

Some Medicare beneficiaries obtain private insurance coverage to reduce their out-of-pocket payments for health care goods and services. On average, beneficiaries who have employer-sponsored or individual Medigap coverage spend about 30 percent less (about $600) on health care goods and services than do beneficiaries in original (fee-for-service) Medicare who have no supplemental coverage. In addition, beneficiaries with private supplemental coverage devote a greater share of health care goods and services spending to prescription drugs and dental care, which are not covered by Medicare, than do Medicare-only beneficiaries.
However, the costs of private insurance coverage can be substantial. For example, Medigap premiums—$1,360, on average—account for over 40 percent of these beneficiaries’ total out-of-pocket costs. Premiums for beneficiaries with employer-sponsored coverage consume an average of about one-fourth of their total out-of-pocket health spending, or $630.

Out-of-pocket spending for health care is also lower for Medicare+Choice enrollees than for those in original (fee-for-service) Medicare or those who have private supplemental insurance. On average, Medicare+Choice enrollees are projected to spend about half as much as Medicare-only beneficiaries, and about two-thirds of what beneficiaries with employer-sponsored or Medigap coverage are projected to spend, on health care goods and services. In addition, average annual premiums for Medicare+Choice plans are projected to be about two-thirds of the average premium costs for employer-sponsored plans, and about 40 percent of the cost of the average Medigap premium. The data used for this analysis do not reveal the extent to which lower out-of-pocket spending is due to lower cost-sharing in Medicare+Choice plans, greater efficiencies in Medicare+Choice plan operations, or better health status among Medicare+Choice enrollees.

It is difficult to predict future impact of private supplemental coverage and Medicare+Choice plans on beneficiary out-of-pocket health spending. Retiree health coverage through an employer may cease to be an option for many beneficiaries: the share of employers offering supplemental health coverage to Medicare-eligible retirees fell from 35 percent in 1995 to 30 percent in 1998.19 Others who have Medigap coverage may drop it because they cannot afford annual premium increases. Finally, Medicare+Choice enrollees may face higher premium and out-of-pocket costs if plans cut back their benefits because of rising health care costs and uncertainty about federal payment levels.
Because this projection is based on data from beneficiaries living in the community at some point during the year, the out-of-pocket expenses are predominately for short stays in nursing homes—that is, care in a nursing home that does not last for the entirety of 1999.

The out-of-pocket spending estimates were derived from a microsimulation model developed for AARP by The Lewin Group, Inc. This model projects 1999 out-of-pocket health care spending from the 1995 Medicare Current Beneficiary Survey (MCBS) Cost and Use Files. For a discussion of the methodology used in making these projections, see Gross et al., 1997.

Average out-of-pocket spending as a percent of income is calculated as the average of each beneficiary’s share of income spent out-of-pocket for health care. It is not calculated by dividing average income into average out-of-pocket health spending. Therefore, multiplying average out-of-pocket health spending by 0.19 (average out-of-pocket spending as a percent of income) will not yield average income for Medicare beneficiaries.

Medicaid beneficiaries who enroll in a Medicare+Choice plan are not included in the 16 percent figure presented for Medicare+Choice enrollees. As in our prior study, we excluded home health care services because the definition of home health care services used in the MCBS differs from that used in previous studies of out-of-pocket health care costs. Specifically, the MCBS reports out-of-pocket expenditures only for home health services that were medical in nature. Some previous studies included spending not only on medical services but also for non-medical visits that might be considered necessary for the chronically ill (for example, personal assistance services), and services that were not performed by a health professional. Because we were not able to obtain comparable home health spending data, we excluded these costs from our analysis. We excluded the costs of long-term nursing home care in order to be consistent with previous studies of out-of-pocket health spending. For examples of previous studies of out-of-pocket health spending by older Americans, see M. Moon et al., Protecting Low-Income Medicare Beneficiaries, The Commonwealth Fund, December 1996; AARP Public Policy Institute and the Urban Institute, Coming Up Short: Increasing Out-of-Pocket Health Spending by Older Americans, Public Policy Institute, AARP, Report #9507, April 1995.

About one percent of beneficiaries has supplemental coverage through a public program other than Medicaid, such as CHAMPUS or Department of Veterans’ Affairs (VA) programs. Data for these beneficiaries are not presented here because the low sample size for this group makes projections statistically unreliable.


Some of these beneficiaries may receive limited assistance from state pharmacy assistance programs or charitable organizations.

The Medicare+Choice program was created as part of the Balanced Budget Act (BBA) of 1997. As a result of the BBA, Medicare beneficiaries may have the option of enrolling in a wider range of health plans than was previously available, including Medicare-certified Health Maintenance Organizations (HMOs), Preferred Provider Organization (PPOs), Provider Sponsored Organization (PSOs), and private fee-for-service plans. However, our model assumes that all Medicare+Choice beneficiaries are enrolled in HMOs, since HMOs account for virtually all health plans participating in Medicare+Choice in 1999.

Medicaid beneficiaries who enroll in a Medicare+Choice plan are not included in the 16 percent figure presented for Medicare+Choice enrollees.

The federal poverty level for persons age 65 and older in 1999 is projected to be $8,075 for individuals and $10,185 for couples. Census Bureau estimates of the poverty level for 1999 were not available at the time of analysis.

Because of inconsistencies in the way that states report QMB enrollment to the Health Care Financing Administration, some beneficiaries classified here as QMBs with prescription drug coverage may be receiving full Medicaid benefits.

Eligibility for full Medicaid benefits varies by state. In general, states set income thresholds for full Medicaid coverage for persons age 65 and older at a level well below the federal poverty level. As of 1999, only twelve states allowed persons age 65 and older with incomes between 90% and 100% of the poverty level to qualify for full Medicaid benefits.
Full year SLMB and part year Medicaid enrollees were put into the same category because they have similar characteristics with respect to out-of-pocket spending and because the sample size for each group was so small that the results would not be statistically significant if reported individually.

Beneficiaries with employer-sponsored coverage likely used more prescription drugs and dental services than did Medicare-only beneficiaries, even though the average out-of-pocket spending for these two groups was virtually identical. This is because out-of-pocket spending represents only cost-sharing amounts for beneficiaries who have supplemental coverage, but total spending for those without coverage.

The relatively low level of drug coverage among Medigap enrollees may partly explain this figure. About two-thirds of beneficiaries with Medigap policies lack any prescription drug coverage. Beneficiaries who have Medigap drug coverage may still incur high out-of-pocket costs, because Medigap policies with drug benefits have a $250 deductible, 50 percent coinsurance, and a benefit cap of either $1,250 or $3,000. As a result of these limits, beneficiaries with Medigap coverage who have prescription drug coverage are projected to spend an average of $570 out-of-pocket for prescription drugs in 1999, compared to an average of $320 for all Medicare beneficiaries who have drug coverage. Beneficiaries with Medigap policies who lack prescription drug coverage are projected to spend an average of $690 on prescription drugs in 1999, compared to an average of $590 for all beneficiaries who lack drug coverage. See D. Gross and N. Brangan, Medicare Beneficiaries and Prescription Drug Coverage: Gaps and Barriers, Issue Brief IB39, AARP Public Policy Institute, June 1999.

In 1999, income for persons age 65 and older that is 600% of the federal poverty level is projected to correspond to $48,450 for individuals and $61,110 for couples.


Written by David Gross and Normandy Brangan, Public Policy Institute, Research Group, December 1999
©1999, AARP
AARP, 601 E Street, NW, Washington, DC 20049
http://research.aarp.org
Reprinting with permission only.