INSIGHT on the Issues

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

According to the most recent data available, Medicare beneficiaries spent a median of $3,103 a year of their own money on health care in 2006. Ten percent of beneficiaries—more than 4 million people—spent more than $8,300 a year. The oldest and poorest beneficiaries spent about one-quarter of their incomes on health care.

The Medicare program pays for certain health care services for adults age 65 and older and younger individuals with certain 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 on 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 2006 Cost and Use File. Unless otherwise noted, all data presented in this Insight on the Issues are based on this analysis.

In 2006, beneficiaries paid a $952 deductible for each inpatient spell of illness.[1] After 60 days in a hospital or 20 days in a skilled nursing facility, beneficiaries also paid daily copays, with benefits ending after 90 or 100 days. Beneficiaries also faced an annual deductible of $124 for outpatient services, and paid 20 percent (or more[2]) of all costs after that. Furthermore, Medicare does not cover services such as hearing aids, eyeglasses, dental care, and most long-term care services.

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 supplemental coverage to help defray those added costs, but the remaining 10 percent had no supplemental coverage. Even with supplemental coverage, some beneficiaries could face high OOP costs if they got sick.

Overall, in 2006 beneficiaries in the fee-for-service Medicare program spent a median of $3,103 OOP on health care services and premiums for supplemental health insurance. Many beneficiaries had significantly lower OOP spending—one-quarter spent less than $1,600 per year, and 10 percent spent less than $400. Unfortunately, a considerable number spent much more; more than 4 million beneficiaries, or 10 percent of the Medicare population, spent more than $8,300 OOP on health care in 2006.

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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 sociodemographics, income, residence, and other key items. It is representative of the national population of Medicare beneficiaries, and includes people living in long-term care facilities for 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. Our analyses exclude people enrolled in Medicare Advantage (MA) plans (19 percent of the Medicare population) during any part of the year because of the difficult of attributing spending to these enrollees.

Income is self-reported income for an individual. When respondents report income for themselves and a spouse, we divide it by two to estimate individual income.

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

Medicare's Part D optional prescription drug benefit began in 2006. Prior to 2006, about three-quarters of beneficiaries had at least some coverage for drugs,[3] leaving approximately 11 million beneficiaries without coverage. Enrollment for Part D was open from January through May 2006. About 20 million beneficiaries joined Part D during that time.[4] Because of the extended enrollment period, average beneficiary OOP spending for prescription drugs was lower in 2006 than previous years, but may have been higher than when the program became fully functional.

These spending totals often accounted for a large portion of beneficiaries' income, ranging from 11 percent to 25 percent in 2006 (table 1). Beneficiaries in the middle of that distribution spent 17 percent of income on OOP spending (i.e., median OOP spending as a percentage of income was 17 percent). Beneficiaries in poor health typically spent a larger fraction of income on health care. Median spending as a percentage of income for people with cancer, congestive heart failure, or Alzheimer's was roughly 25 percent in 2006 (table 2).

Demographics: Where Does the Burden of OOP Spending Fall?

Beneficiaries spend significantly more OOP for health care as they age. In 2006, beneficiaries age 85 or older spent more than twice as much as beneficiaries under 65 (table 1). Interestingly, beneficiaries under age 65 with disabilities had the lowest median

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

	Total OOP Spending (Mean)	Total OOP Spending (Median)	Total OOP Spending (90th Percentile)	OOP Spending as a Percentage of Income (Median)
Overall	$4,586	$3,103	$8,383	17%
Under 65	3,379	1,779	8,203	13
65–69	3,575	2,754	6,766	13
70–74	4,066	3,253	7,467	17
75–79	4,698	3,517	8,108	18
80–84	5,603	3,849	9,760	22
85+	7,710	3,932	16,487	24
Men	4,282	2,979	7,899	15
Women	4,832	3,236	8,778	19
White	4,967	3,372	8,825	18
Black	3,066	1,958	6,580	14
Hispanic	3,085	1,792	6,189	15
Other	3,017	2,006	7,151	11
Up to 100% FPL	2,993	1,299	7,268	22
101–150% FPL	4,336	2,665	8,297	25
151–200% FPL	4,717	3,291	8,026	25
201–300% FPL	5,106	3,352	8,640	19
Over 300% FPL	5,236	3,861	8,934	11

Source: University of Maryland analysis of MCBS 2006 Cost and Use File, fee-for-service beneficiaries only.
Note: FPL = federal poverty level.

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

	Total OOP Spending (Mean)	Total OOP Spending (Median)	Total OOP Spending (90th Percentile)	OOP Spending as a Percentage of Income (Median)
Overall	$4,586	$3,103	$8,383	17%
Excellent/Very Good Health	3,905	3,106	7,134	15
Good Health	4,707	3,223	8,647	18
Fair Health	5,324	2,952	9,706	19
Poor Health	5,468	3,015	10,741	22
Alzheimer's Disease	7,670	4,060	15,239	26
Cancer	6,371	4,315	13,110	23
Congestive Heart Failure	5,352	3,705	10,323	25
Coronary Artery Disease	4,933	3,596	9,043	21
No Supplemental Coverage	4,461	2,342	8,521	17
Any Supplemental Coverage	4,605	3,237	8,378	17
Type of Supplemental Coverage				
Medicaid	3,013	833	8,203	10
Employer-related	4,360	3,237	7,687	15
Other Private (Medigap)	5,650	3,970	9,162	21
Other Public (VA)	4,622	3,355	7,670	27

Source: University of Maryland analysis of MCBS 2006 Cost and Use File, beneficiaries in traditional Medicare only.

OOP spending, despite the fact that they are in the Medicare program because of serious health care needs. This may be because a higher proportion of beneficiaries with disabilities are on Medicaid, which pays some of their OOP costs.

Women face higher OOP costs than men. Median spending was $3,236 for women compared with $2,979 for men, despite the fact that women were more likely than men to have supplemental insurance (83 percent of women have supplemental insurance, compared with 78 percent of men). The burden on women was even greater when compared with income—median spending as a percentage of income was 19 percent for women, compared with 15 percent for men.

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

Although OOP spending rises with income, the burden of that spending is greatest for poor beneficiaries. Median OOP spending as a percentage of income for individuals with income below 200 percent of the federal poverty level (FPL) was 22 to 25 percent. Individuals with incomes between 100 and 200 percent of FPL shoulder the highest burden. Median OOP spending doubles for those at 101–150 percent of FPL compared with those below 100 percent of FPL.

In contrast, median spending as a percentage of income for individuals with income above 300 percent of FPL was only 11 percent, though their spending was much higher in absolute dollars.

Health Status: Showing the Burden of Illness

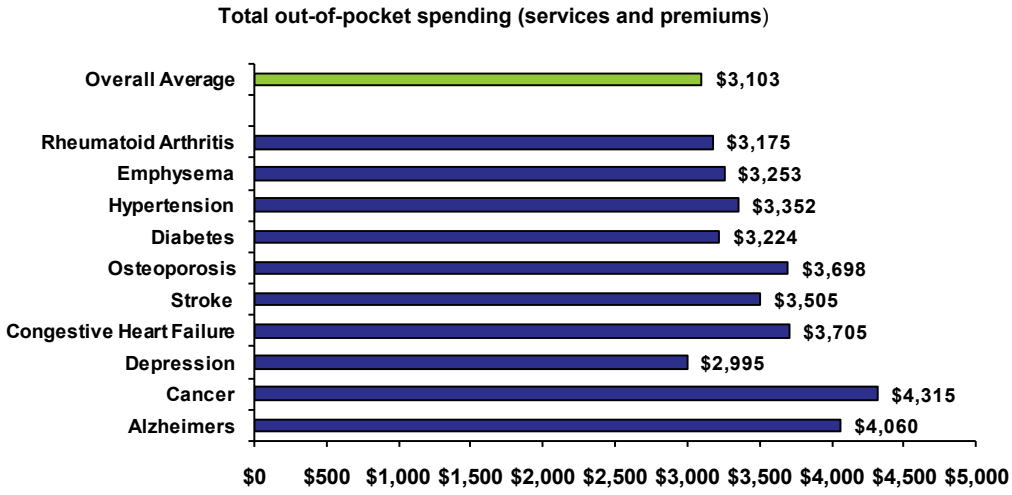
The burden of OOP spending was also much higher for beneficiaries in poor health than for those in excellent health (table 2). Median OOP spending as a percentage of income for beneficiaries in poor health was 22 percent, compared with less than 15 percent for those in excellent health. Beneficiaries in poor health were less likely to have supplemental insurance than those in excellent health (76 percent vs. 82 percent), despite having greater need for services.

Some illnesses and health conditions led to much higher spending than others (figure 2). Median OOP spending for people with cancer was $4,315, and for patients with Alzheimer's disease, median OOP spending was $4,060. For patients with Alzheimer's, congestive heart failure, or cancer, median OOP spending as a percentage of income was about 25 percent.

Supplemental Insurance Helps

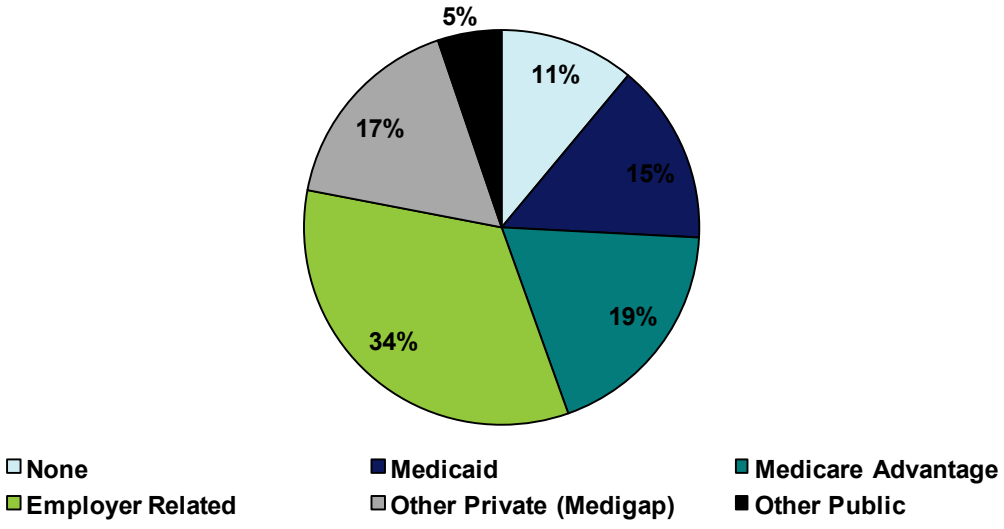
Because the Medicare program requires significant cost sharing from beneficiaries, most people have supplemental insurance to help cover those costs. In 2006, almost nine out of ten beneficiaries had some sort of supplemental coverage, either through a former employer, through Medicaid, through MA, or by purchasing a Medigap plan (figure 3). Women were more likely than men to have supplemental insurance, and those in excellent or very good health were more likely to have it than those in poor health. This may be due in part to underwriting or lack of guaranteed issue for Medigap plans under certain circumstances, with sicker beneficiaries

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



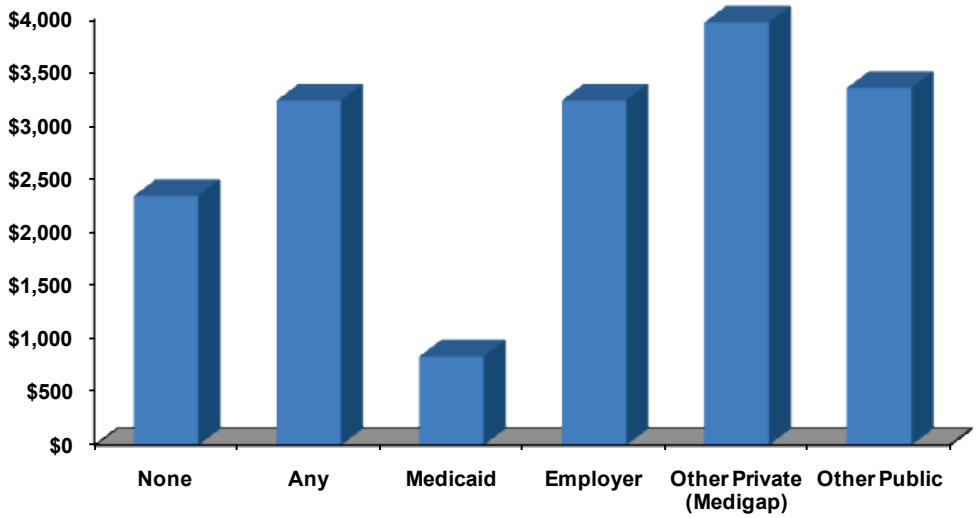
Source: University of Maryland analysis of Medicare Current Beneficiary Survey 2006 Cost and Use File.
Note: Data reflect beneficiaries in the traditional Medicare program only.

Figure 2
Most People Had Supplemental Coverage in 2006



Source: University of Maryland analysis of Medicare Current Beneficiary Survey 2006 Cost and Use File.

Figure 3
Out-of-Pocket Spending in 2006 was Higher for Those with Supplemental Insurance Compared to Those Without



Source: University of Maryland analysis of Medicare Current Beneficiary Survey 2006 Cost and Use File.
Note: Data reflect beneficiaries in the traditional Medicare program only.

unable to get coverage or unable to afford what is offered.

Median OOP health care spending for dual-eligibles (Medicare beneficiaries who are also eligible for Medicaid because of their low income) was $833. The top 10 percent of dual-eligible beneficiaries spent at least $8,200. Those with high spending likely spent at least part of the year in long-term care facilities. Medicaid-covered nursing facility residents are required to surrender virtually all their income toward the cost of services, retaining only a small "personal needs allowance," generally in the range of $30 to $50 per month. As explained in the box on page 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 2006 were for long-term care facility costs, prescription drugs, and medical providers. Together, these three categories accounted for three-quarters of beneficiary spending. Note that these figures include only spending on health care *services*, and do not include the cost of supplemental or Part D premiums.

However, overall spending numbers mask what services patients used and what they spent for care. Almost all beneficiaries saw a clinician at least once in 2006, nine in ten used one or more prescription drugs, and almost three-quarters 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).

Use of services that are not covered by Medicare was lower. About 40 percent saw a dentist, and about 30 percent used vision or hearing services. Six percent spent at least part of 2006 in a long-term care (LTC) facility.

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	21.6	$766	$0	$951
Hospital Outpatient	72.7	208	4	380
Medical Providers	95.4	684	158	1,434
Prescription Drugs	87.9	711	403	1,513
Home Health	9.1	247	0	1
Skilled Nursing Facility	5.4	949	0	3,939
Hospice	2.0	0	0	0
Non-Medicare-Covered Services				
Dental	40.1	$617	$213	$1,630
Vision and Hearing	28.7	373	131	564
LTC Facility[6]	6.2	14,352	7,611	41,937

Source: University of Maryland analysis of MCBS 2006 Cost and Use File, beneficiaries in traditional Medicare only.

Among Medicare-covered services, median OOP spending was highest for prescription drugs, at $403. While most users had low OOP spending for services, some had high spending. Ten percent of beneficiaries who were admitted to a skilled nursing facility paid at least $3,939 OOP, while 10 percent spent $1,513 or more for prescription drugs. Ten percent of beneficiaries who saw a clinician in 2006 had OOP spending of at least $1,434.

Spending for non-Medicare-covered services was also high. Among users of services, median OOP spending was highest for LTC facility services. In fact, the majority of LTC facility users incurred high OOP costs. Median OOP spending for users of such facilities was $7,611, with 10 percent of users paying at least $41,937 OOP for room and board and health care-related services during 2006. It is likely that these residents were self-financing their nursing facility stay before eventually qualifying for Medicaid.

Prescription Drug Spending: Early Effects of Part D

An optional outpatient prescription drug benefit, Medicare Part D, began in 2006. Beneficiaries had until May to enroll, meaning that some beneficiaries had coverage for only part of the year. Prior to 2004, about one-quarter of beneficiaries had no prescription drug coverage.[7]

About 64 percent of those who lacked coverage for drugs in 2005 enrolled in a Part D plan during 2006.[8] 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. Part D enrollees are more likely than non-enrollees to be institutionalized, minorities, or to have disabilities; to be in poor health; and to die during the year.[9] About one-third of enrollees receive extra help with part D costs via the low-income subsidy , which greatly minimizes their out-of-pocket costs for both plan premiums and prescriptions.[10]

Median OOP prescription drug spending for all beneficiaries enrolled in traditional Medicare in 2006 was $338 (median OOP spending for the subset of beneficiaries who used prescription drugs was $403). Median OOP spending on prescription drugs was higher for beneficiaries who had Part D coverage in 2006 than for those without coverage ($355 vs. $240), but those with Part D coverage paid a smaller share of total drug costs OOP than those without coverage (25 percent vs. 30 percent).

While the introduction of Part D has increased access to prescription drugs, it still leaves some with very high out-of-pocket burdens, particularly those who reach the coverage gap and those who require drugs or biologics in specialty tiers.[11]

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. Medicare does not cover dental, vision, hearing, LTC facility costs, or most home-based care costs.

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

It is also notable that specific illnesses can lead to very high spending. Beneficiaries who suffer from 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.

Policy Options

One option for limiting such high levels of cost exposure is a cap on OOP spending in the Medicare program. The Congressional Budget Office and the Medicare Payment Advisory Commission have both explored the budget impact and other issues associated with a Medicare OOP cap of $5,250.

A cap on OOP spending for Medicare services 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 Medicare 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. Despite programs such as the Medicare Savings Program, which helps low-income beneficiaries pay premiums and cost sharing, low-income beneficiaries still face high OOP costs relative to income. Raising income limits to help those above 100 percent of FPL, and eliminating asset tests for participation, would reduce the burden these costs impose by allowing more

beneficiaries to access the reduced OOP costs these programs offer.

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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] For services received in hospital outpatient departments, beneficiaries pay a copayment rather than a coinsurance amount. In 2006, beneficiary coinsurance payments accounted for more than 28 percent of total payments for services delivered in hospital outpatient department settings.

[3] 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).

[4] Board of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, *2010 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds* (Washington, DC: Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds).

[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] Safran et al., "Prescription Drug Coverage and Seniors"; Rodgers and Stell, *The Medicare Prescription Drug Benefit*.

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

[9] "CMS Guide to Request for Medicare Part D Prescription Drug Event Data," Version 3.0 (March 2008), http://www.cms.gov/PrescriptionDrug CovGenin/Downloads/GuidePartDv3%203-17-09%202.pdf.

[10] CMS enrollment information, February 2010, http://www.cms.gov/PrescriptionDrugCovGenIn/

[11] For a more detailed discussion of these issues, please see N. Lee Rucker, *What Prescription Drugs Are Medicare Part D Enrollees Using, as What Cost, and Why Does it Matter?* (Washington, DC: AARP Public Policy Institute, forthcoming 2011).

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