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Medicare Beneficiaries' High Out-of-Pocket Costs: Cost Burdens by Income and Health Status

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ABSTRACT

ISSUE: Fifty-six million people—17 percent of the U.S. population—rely on Medicare. Yet, its benefits exclude dental, vision, hearing, and long-term services, and it contains no ceiling on out-of-pocket costs for covered services, exposing beneficiaries to high costs.

GOAL: To inform discussion of possible changes to Medicare, this issue brief looks at beneficiaries' out-of-pocket costs by income and health status.

METHODS: Spending estimates based on the Medicare Current Beneficiary Survey.

FINDINGS AND CONCLUSION: More than one-fourth of all Medicare beneficiaries—15 million people—spend 20 percent or more of their incomes on premiums plus medical care, including cost-sharing and uncovered services. Beneficiaries with incomes below 200 percent of the poverty level (just under $24,000 for a single person) and those with multiple chronic conditions or functional limitations are at significant financial risk. Overall, beneficiaries spent an average of $3,024 per year on out-of-pocket costs. Financial burdens and access gaps highlight the need to approach reform with caution. Already-high burdens suggest restructuring cost-sharing to ensure affordability and to provide relief for low-income beneficiaries.

KEY TAKEAWAYS

- More than one-fourth of all Medicare beneficiaries spent 20 percent or more of their income on health care, including premiums, cost-sharing, and uncovered services, in 2016.
- Beneficiaries with low incomes or poor health are even more likely to have high cost burdens.
- Because of the program's limited scope of benefits and uncapped cost-sharing, beneficiaries spent an average of $3,024 per year on out-of-pocket costs.

The Commonwealth Fund

INTRODUCTION

For more than 50 years, Medicare has been a stable, trusted source of health insurance that provides basic access and financial protection for elderly and disabled beneficiaries for acute hospital and medical care services.[1] The program has directly contributed to sharp declines in mortality and longer life expectancy for those age 65 and older.[2] It also has succeeded in holding spending per beneficiary nearly flat over the past five years, below private insurance increases.[3]

But Medicare's benefit design also includes high cost-sharing and no limit on out-of-pocket costs. Although prescription drugs were added in 2006, beneficiaries are required to purchase a separate private plan. If they want to buy private Medigap supplemental coverage for cost-sharing, they incur significant additional premiums. Even after they pay for supplemental drug and Medigap plans, beneficiaries face the cost of dental, hearing, vision, and long-term services—all excluded from Medicare. For beneficiaries with multiple illnesses or serious functional limitations, out-of-pocket costs can easily add up to thousands of dollars per year. The resulting out-of-pocket costs for health care and premiums can add up to a substantial share of income, especially for those living on modest or low incomes.

To inform discussions of such potential changes, this brief looks at beneficiaries' financial burdens using 2012 Medicare Current Beneficiary Survey data projected to 2016. The analysis includes spending on premiums and care, including services not covered by Medicare. We profile financial burdens by beneficiary income and also health. (See How This Study Was Conducted.)

To assess the level of financial burden, we use two indicators of beneficiary health care spending relative to income:[4]

- *High total cost burden:* Spending on insurance premiums plus medical care, including copayments, coinsurance, and uncovered expenses, amounts to 20 percent or more of annual income.
- *Underinsurance:* Spending on medical care, excluding insurance premiums, that amounts to 10 percent or more of annual income.

Although someone may have a high total cost burden, he may not be underinsured—if he has purchased robust coverage that does not require large copayments, deductibles, or other cost-sharing to access health care. When someone is underinsured, their coverage does not provide adequate financial protection from health care costs. Our measure of underinsurance captures spending on health services not covered by Medicare or supplemental coverage.

The analysis reveals that millions of beneficiaries spend substantial shares of their income on health care costs. Thus, any proposals to change Medicare must proceed with caution. Already-high financial burdens mean any changes to the program must be assessed to safeguard beneficiaries' access and affordability.

BACKGROUND: MEDICARE BENEFITS AND LOW-INCOME POLICIES

Currently, 56 million people—17 percent of the U.S. population—rely on Medicare. By 2024, Medicare will cover one-fifth of the population.[5] As the population ages and becomes eligible for the program, people will discover they need to supplement their coverage to ensure financial protection, since the program has relatively high cost-sharing and no limit on patient liability for covered benefits.

Medicare Current Benefits

Medicare benefits include substantial cost-sharing as well as no limit on out-of-pocket costs for covered services. For example, beneficiaries pay $1,300 each time they are hospitalized and pay 20 percent of bills for physician care. Beneficiaries also pay a premium for Part B medical services of $1,600 a year. (See Appendix 1 for Medicare benefits and cost-sharing details.) Such costs alone, not counting other health care expenses, represent a large burden for middle- and lower-income beneficiaries.

Supplemental coverage to fill in Medicare's cost-sharing, known as Medigap, is costly. Annual premiums average $2,000 per person, but can be much higher, exceeding $200 a month in areas like New York City.[6] Medigap has notably high overhead costs: administrative costs and profits absorb 20 percent of premiums on average.[7]

Beneficiaries may opt out of traditional Medicare to enroll in a private Medicare Advantage (MA) plan. These plans generally have lower cost-sharing than traditional Medicare. However, in recent years MA plan cost-sharing has increased substantially.[8]

Medicare's Low-Income Provisions

An estimated 25 million Medicare beneficiaries (45%) have incomes below 200 percent of the federal poverty level (just under $24,000 for a single person) and one-third are poor or near-poor with incomes below 150 percent of poverty (below $18,000 for a single person) with, at best, limited assets to last their lifetimes (Appendix 2).

Current policies to help low-income beneficiaries pay for premiums and care are limited and require beneficiaries to navigate complex eligibility rules (Appendix 3). Some with incomes below poverty may qualify for full Medicaid, meaning Medicaid pays Medicare premiums and cost-sharing expenses and provides expanded benefits, including long-term care (although this varies by state of residence).[9] Beneficiaries with incomes up to 135 percent of poverty (about $16,000 for a single person) may be eligible for partial subsidies through the Medicare Savings Programs. Under these programs, Medicaid will pay for Medicare's Part B premium and cost-sharing for people with incomes up to the federal poverty level and will pay for Part B premiums (but not cost-sharing) for beneficiaries with incomes between 100 percent and 135 percent of poverty as long as their assets are no more than $7,290 for a single person or $10,930 for a couple (Appendix 3).

An estimated 11 million Medicare beneficiaries have dual Medicare and Medicaid coverage. But only half of Medicare beneficiaries with incomes below poverty and less than one-fourth of those with incomes between 100 percent and 150 percent of poverty have full protection (Appendix 4).

Low-income beneficiaries apply separately for Medicare Part D subsidies for premiums and cost-sharing. Subsidies are available on a sliding scale up to 150 percent of poverty for those with assets of no more than $13,640 if single and $27,250 if a couple.

BENEFICIARIES' HIGH FINANCIAL BURDENS

Particularly for people living on low or modest incomes, Medicare can leave beneficiaries exposed to substantial out-of-pocket costs. When premiums, cost-sharing, and spending on uncovered services are included, more than one-fourth of all beneficiaries (27%)—an estimated 15 million people—and two of five beneficiaries with incomes below 200 percent of the federal poverty level spent 20 percent or more of their income on health care and premium costs in 2016. As Exhibit 1 illustrates, burdens are high for all low-income groups below twice the federal poverty level. The share of middle-income beneficiaries—those between 200 percent and 399 percent of the federal poverty level, or $24,000 to $36,000 for a single persion—incurring high costs is also notably high (22%).

Medicare's Underinsured

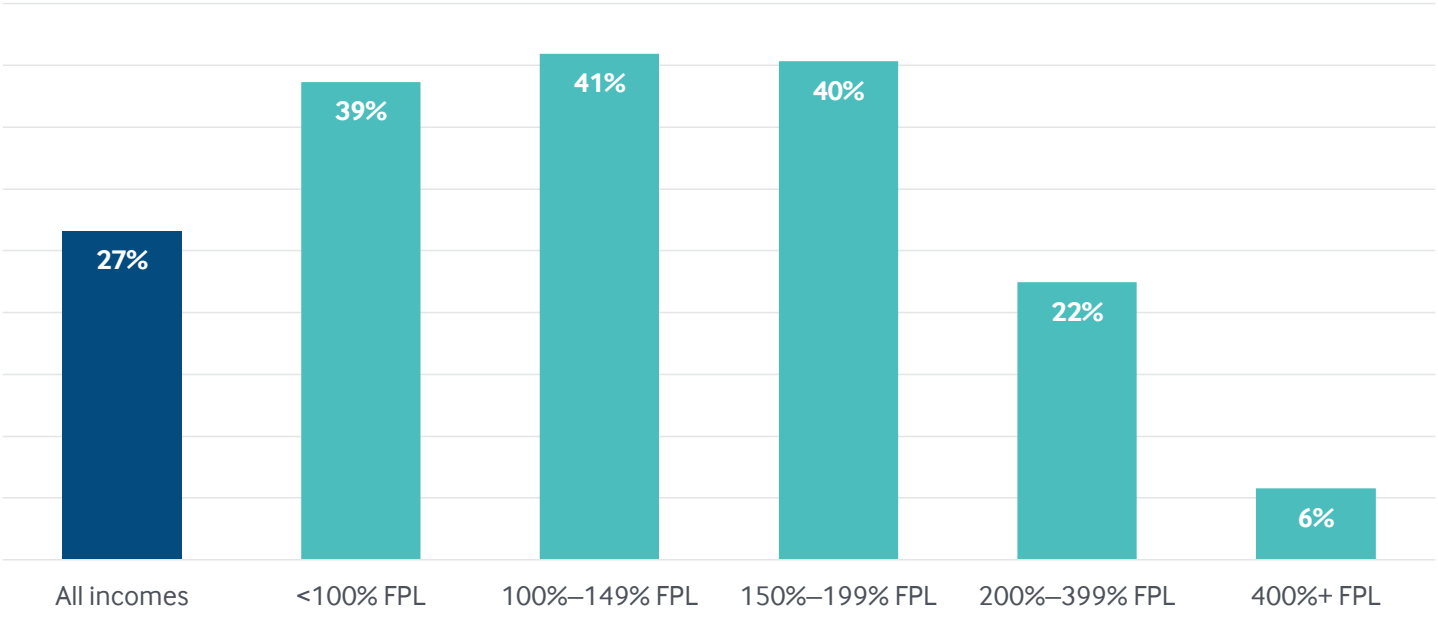
Using our other measure of financial burden, we find that one-fourth of beneficiaries are underinsured—that is, they spend at least 10 percent of their total annual incomes on medical care services, excluding premiums. Of beneficiaries with incomes below the poverty level, one-third spent 10 percent or more (Exhibit 2). Despite having Medicare or supplemental coverage, these people are effectively underinsured.[10] The risks of being underinsured are highest for people with low incomes. Such cost burdens point to gaps in current low-income provisions to cover costs of needed health care, including services not covered by Medicare.

Poor Health as Well as Low Income Intensify Risk of High Cost Burdens

Beneficiaries with high needs—those with multiple chronic conditions or functional limitations that are either physical or cognitive in nature—are at significant financial risk. Nearly one-third (29%) of beneficiaries with three or more chronic conditions and 38 percent of beneficiaries

Exhibit 1. Medicare Beneficiaries Spending 20 Percent or More of Income on Premiums and Care, by Poverty Level

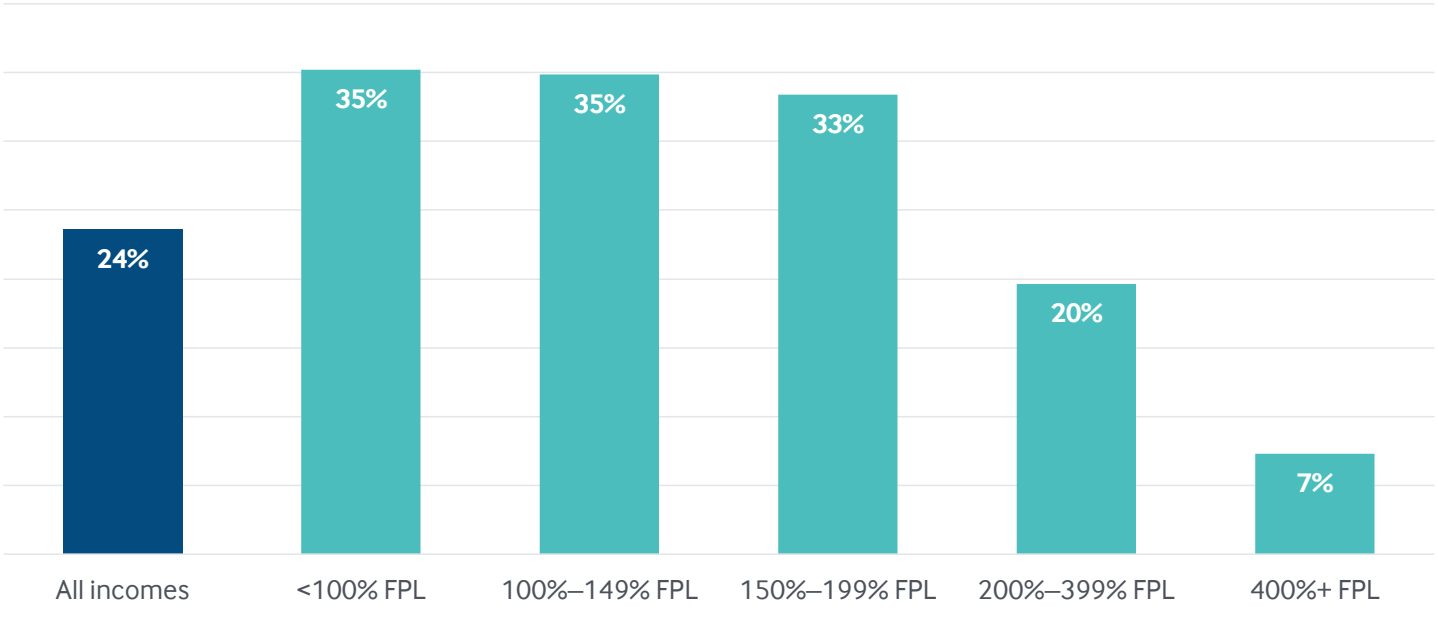
Percent of Medicare beneficiaries



Note: FPL = federal poverty level.
Data: Roger C. Lipitz Center analysis of 2012 Medicare Current Beneficiary Survey projected to 2016.

Exhibit 2. One of Four Medicare Beneficiaries Is Underinsured

Percent of Medicare beneficiaries paying 10 percent or more of income out-of-pocket on medical care alone



Note: FPL = federal poverty level.
Data: Roger C. Lipitz Center analysis of 2012 Medicare Current Beneficiary Survey projected to 2016.

with physical and/or cognitive limitations spent 20 percent or more of their annual incomes on premiums and medical care (Exhibit 3).

Low income and complex health conditions often go together: 68 percent of beneficiaries with incomes below 200 percent of poverty have three or more chronic conditions and/or functional limitations. Among those with low income and poor health, 42 percent spent 20 percent or more of their incomes on premiums and care and 39 percent would be considered underinsured based on medical care costs alone (Exhibit 3).

Out-of-Pocket Spending: Covered and Excluded Services

The medical care cost burdens reflect the limited scope of benefits as well as Medicare's uncapped cost-sharing. Excluding premiums, Medicare beneficiaries spent an average of $3,024 per year on out-of-pocket costs. Of this, more than a third was spent on cost-sharing for medical and hospital care, 25 percent on prescription drugs, and 39 percent on services Medicare does not cover, including dental and long-term care (Exhibit 4). Looking at beneficiaries who live in communities (that is, those not living in long-term care facilities), 45 percent of expenses went toward medical and hospital cost-sharing, 33 percent toward drugs, and 22 percent toward services not covered by Medicare. Notably, beneficiary spending on drugs has increased in absolute dollars and as a share of total out-of-pocket costs.

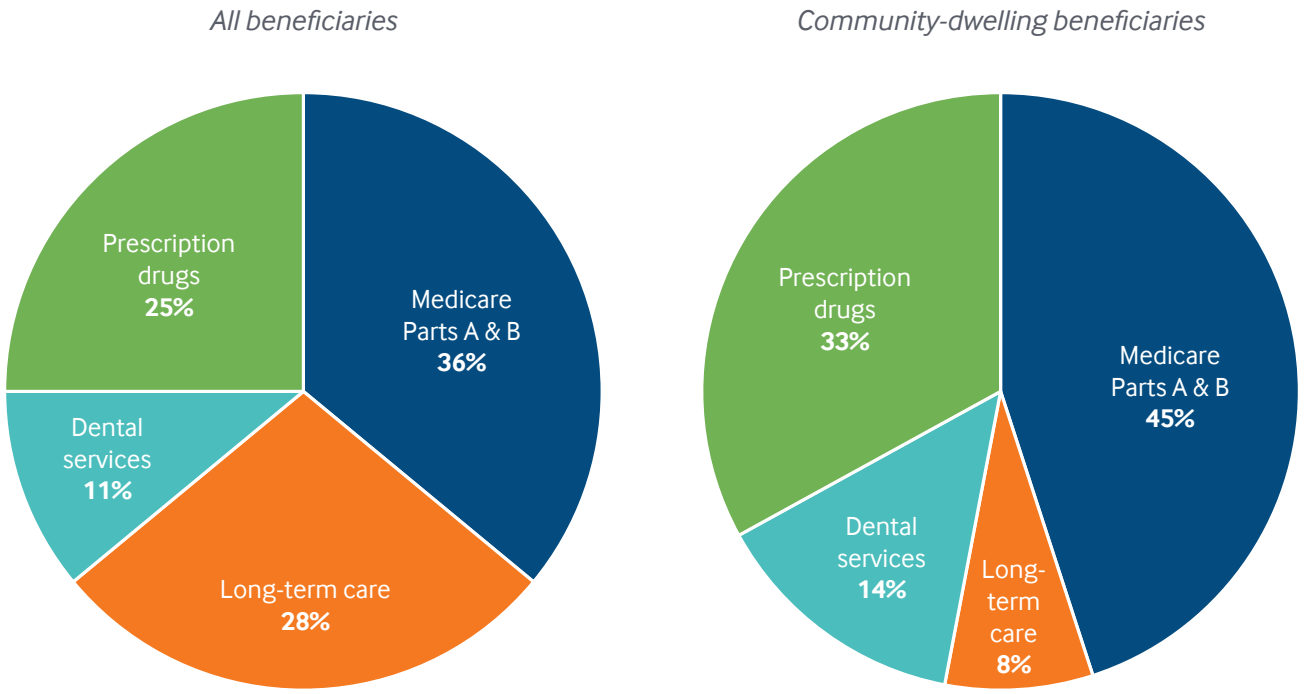
Not surprisingly, the 5.4 million beneficiaries with only Medicare, and no supplemental coverage of any kind, face higher health care costs. These beneficiaries spent an estimated $5,374 on out-of-pocket costs in 2016 compared to $2,587 for beneficiaries who received supplemental coverage from Medicaid (Exhibit 5). With incomes too high to qualify for Medicaid but too low to afford

Exhibit 3. High Cost Burden for High-Need and Low-Income Medicare Beneficiaries

	Number of beneficiaries (in millions)	High total cost burden: Spent 20 percent or more of income on premiums and out-of-pocket medical care	Underinsured: Spent 10 percent or more of income on out-of-pocket medical care alone
All beneficiaries	56.1	27%	24%
Income			
<100% FPL	9.0	38.7%	35.2%
100%–149% FPL	9.2	41.0%	34.9%
150%–199% FPL	7.1	40.4%	33.4%
200%–399% FPL	18.4	22.4%	19.6%
400%+ FPL	12.5	5.8%	7.3%
Health			
Three or more chronic conditions	30.3	29.1%	26.6%
Serious physical and/or cognitive impairment	13.7	38.2%	38.5%
Income and health			
<200% FPL and three or more chronic or functional limitations	17.0	42.4%	38.8%
200%–399% FPL and three or more chronic or functional limitations	11.1	26.5%	24.6%
400%+ FPL and three or more chronic or functional limitations	6.3	8.0%	10.1%

Note: FPL = federal poverty level.
Data: Roger C. Lipitz Center analysis of 2012 Medicare Current Beneficiary Survey projected to 2016.

Exhibit 4. Medicare Beneficiaries' Out-of-Pocket Spending by Type of Health Care Service



Data: Roger C. Lipitz Center analysis of 2012 Medicare Current Beneficiary Survey projected to 2016. Also see Appendix 5.

supplemental coverage, 32 percent of Medicare-only beneficiaries spent 10 percent or more of their income on health care (data not shown).

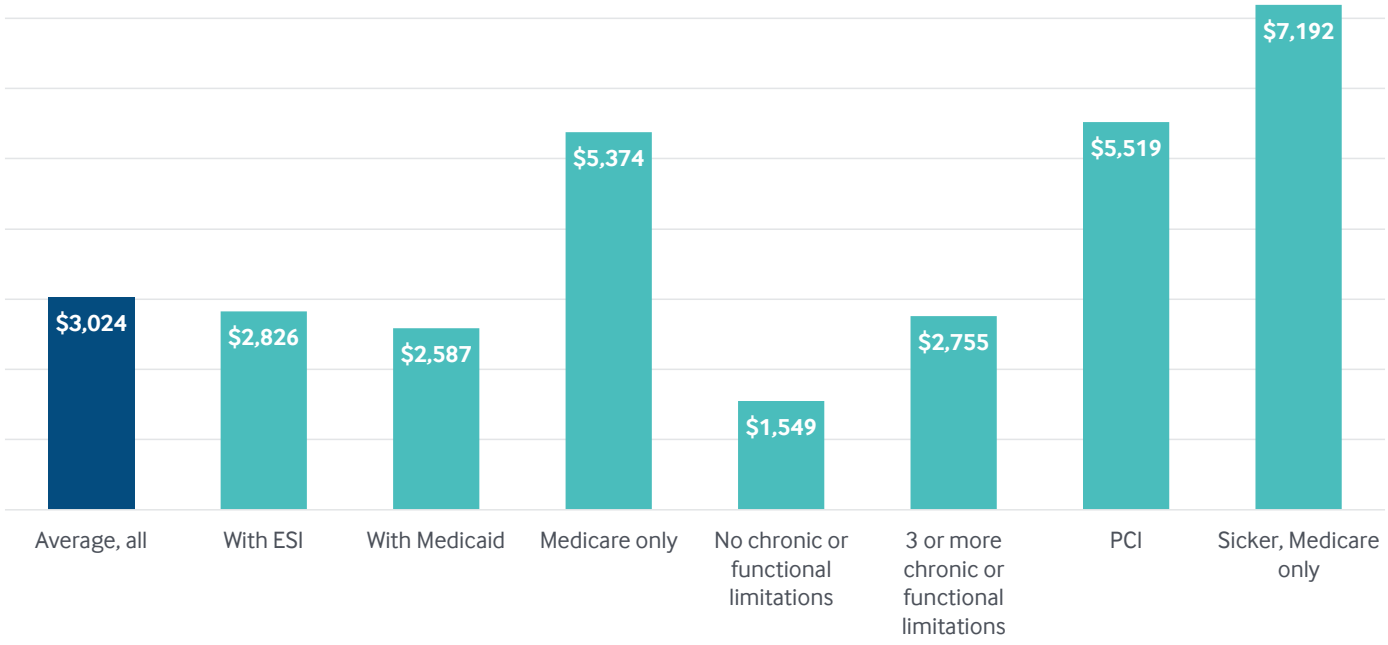
Out-of-pocket spending increases steeply for those with multiple chronic diseases or serious cognitive and/or physical impairments (Exhibit 5). Beneficiaries with serious cognitive and/or physical impairments spend more than three times as much out of pocket, on average, as those without chronic disease or disability ($5,519 vs. $1,549). Without supplemental coverage, high-need, low-income beneficiaries are at particularly high risk: out-of-pocket spending averages more than $7,000 a year for those with only Medicare. This high cost burden is the result of cost-sharing for covered services and out-of-pocket expenses for uncovered care (Appendix 5).

Dental, Vision, and Hearing: Evidence of Unmet Need

Medicare promises to cover all essential medical care but explicitly excludes dental, vision, and hearing. Few beneficiaries have insurance for these services. Medicaid does not always cover such care, with wide state variations. As a result, most beneficiaries face the full costs of such services.

Access and spending follow a steep income gradient; low- and middle-income beneficiaries are far less likely to receive care during the year (Exhibit 6). Compared with their higher-income counterparts, beneficiaries with low incomes were less likely to have vision or dental care during the year and more likely to have problems seeing, hearing, or eating. In fact, 74 percent of Medicare beneficiaries below the poverty level had no dental care during the year and less than half had an eye exam.

Exhibit 5. Medicare Beneficiaries' Average Annual Out-of-Pocket Costs for Medical Care by Coverage and Health



Note: ESI = employer-sponsored insurance; PCI = serious mental or physical functional limitations.
Data: Roger C. Lipitz Center analysis of 2012 Medicare Current Beneficiairy Survey projected to 2016. Also see Appendix 5.

Exhibit 6. Vision, Hearing, and Dental Care and Spending by Medicare Beneficiaries, 2016

		Income				
	All Medicare beneficiaries	<100% FPL	100%–149% FPL	150%–199% FPL	200%–399% FPL	400%+ FPL
Population count in millions	56.1	9.0	9.2	7.1	18.4	12.5
Population distribution	100%	16%	16%	13%	33%	22%
	Column percentages					
Vision						
Can see but a little/a lot of trouble seeing	39%	46%	44%	45%	36%	33%
Had an eye exam in the past year	58%	49%	52%	56%	60%	67%
Total vision OOP costs among those with spending	$426	$222	$297	$445	$502	$471
OOP vision as percentage of total vision costs	60%	43%	60%	54%	62%	63%
Hearing						
Uses a hearing aid	11%	6%	9%	10%	13%	13%
Trouble communicating with doctor because of hearing	21%	38%	28%	22%	16%	11%
Total hearing OOP costs among those with spending	$1,001	$528	$837	$1,114	$1,017	$1,109
OOP hearing as percentage of total hearing costs	75%	58%	74%	75%	73%	80%
Dental						
Had dental visit in past year	46%	26%	29%	36%	51%	72%
Difficulty eating solid foods because of teeth problems	22%	37%	30%	26%	17%	10%
Total dental OOP costs among those with spending	$714	$519	$550	$728	$744	$779
OOP dental as percentage of total dental costs	77%	73%	77%	84%	78%	75%

Note: FPL = federal poverty level; OOP = out-of-pocket.
Data: Roger C. Lipitz Center analysis of 2012 Medicare Current Beneficiary Survey projected to 2016.

SUMMARY AND IMPLICATIONS

Despite the substantial set of benefits that Medicare provides, many beneficiaries are left vulnerable because of financial burdens and unmet needs. As Medicare enters its sixth decade and the baby boom population becomes eligible, the costs of the program will increase, likely placing it on the policy agenda. Despite Medicare's notable recent success in controlling costs per beneficiary, total spending will increase as the program covers more people.[11]

The high financial burdens documented in this brief illustrate the need for caution. Half of Medicare beneficiaries have low incomes; one-third have modest incomes (200% to 399% of poverty). Any potential policy should first consider the impact on beneficiaries.

Access and affordability remain key concerns. In any discussions of potential Medicare reform, it will be important to pay particular attention to consequences for those vulnerable because of poor health or low income. Indeed, the findings point to the need to limit out-of-pocket costs and enhance protection for low-income or sicker beneficiaries.

As the single largest purchaser of health care in the country, Medicare policies directly influence insurance and care systems across the country. With a projected one-fifth of the population on Medicare by 2024, keeping beneficiaries healthy and financially independent is important to beneficiaries, their families, and the nation.

HOW THIS STUDY WAS CONDUCTED

All estimates are based on analysis of the 2012 Medicare Current Beneficiary Survey (MCBS) with population and spending projected to 2016 based on the national health expenditure accounts. The 2012 MCBS includes 11,299 respondents with population weights to be representative of the entire Medicare population, including those disabled and under age 65 and those primarily living in long-term care institutions. By 2016, the projected population was 56.1 million. The data brief displays results for the population-weighted data.

In the survey, beneficiaries report access, care experiences, health status, and spending, including spending on services not covered by Medicare such as dental, hearing, and long-term care services and premiums paid for private plans. In addition to beneficiary reports on costs, the MCBS cost and use files include information about incurred liability for Medicare benefits and spending for Medicare premiums based on administrative data. The MCBS also includes information on Medicaid status regarding whether the beneficiary is eligible for full Medicaid or Medicaid that only covers Medicare cost-sharing and premiums or just Medicare premiums.

The database has a sufficiently robust sample to permit analysis of subgroups by income, coverage, and health. In the analysis, we grouped beneficiaries by income based on their reported annual income relative to the federal poverty level.

NOTES

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2 K. Davis, C. Schoen, and F. Bandeali, *Medicare: 50 Years of Ensuring Coverage and Care* (The Commonwealth Fund, April 2015).

3 C. Schoen, *The Affordable Care Act and the U.S. Economy: A Five-Year Perspective* (The Commonwealth Fund, Feb. 2016).

4 For a state-by state analysis for Medicare using these two indicators based on the U.S. Census Current Population Survey, see C. Schoen, C. Solís-Román, N. Huober et al., *On Medicare But At Risk: A State-Level Analysis of Beneficiaries Who Are Underinsured or Facing High Total Cost Burdens* (The Commonwealth Fund, May 2016).

5 Centers for Medicare and Medicaid Services, NHE Projects, Tables 1 and 17 (CMS, updated June 2015).

6 G. Jacobson, J. Huang, and T. Neuman, *Medigap Reform: Setting the Context for Understanding Recent Proposals* (Henry J. Kaiser Family Foundation, Jan. 2014).

7 Assistant Secretary for Planning and Evaluation, *Variation and Trends in Medigap Premiums* (ASPE, Dec. 16, 2011).

8 G. Jacobson, A. Damico, T. Neuman et al., *Medicare Advantage 2015 Data Spotlight: Overview of Plan Changes* (Henry J. Kaiser Family Foundation, Dec. 2014).

9 M. O'Malley Watts, E. Cornachione, and M. Musumeci, *Medicaid Financial Eligibility for Seniors and People with Disabilities in 2015* (Henry J. Kaiser Family Foundation, March 2016). In 33 states, beneficiaries with higher incomes may be able to spend down into Medicaid when they incur high medical care expenses.

10 C. Schoen, M. M. Doty, R. H. Robertson, and S. R. Collins, "Affordable Care Act Reforms Could Reduce the Number of Underinsured U.S. Adults by 70 Percent," *Health Affairs,* Sept. 2011 30(9):1762–71; and C. Schoen, C. Solís-Román, N. Huober et al., *On Medicare But At Risk: A State-Level Analysis of Beneficiaries Who Are Underinsured or Facing High Total Cost Burdens* (The Commonwealth Fund, May 2016).

11 C. Schoen, *The Affordable Care Act and the U.S. Economy: A Five-Year Perspective* (The Commonwealth Fund, Feb. 2016); M. Buntin, "Spending Growth Trends: Keeping an Eye on Spending per Person," *Health Affairs Blog,* July 28, 2015. For the most recent trend data, see CMS National Health Expenditures, Table 21, Per Capita Historical Trends Comparing Medicare and Private Per Enrollee.

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Vol. 11.

Appendix 1. Medicare Benefits, 2017

	Part A: Hospital	Part B: Medical care
Premium	None if fully eligible	$134 month (for new beneficiaries) $1,608 year/person
Deductible	$1,316 per episode	$183
Cost-sharing	$329/day for days 62–90; $658/day for days 91+	20% of doctors' visits (including in hospital); 20% of outpatient, physical therapy and DME
Cost-sharing for lab tests, home health, hospice		None. Home health medical only
Nursing home	After hospital, up to 100 days; $165/day for days 21–100	
Part D Private Plans: Prescription medications		
Part D costs:	Premiums average $42/month. Cost-sharing and drug formulary lists vary. Multiple cost-sharing tiers. Max deductible $360	

Sources: Parts A and B—Medicare.gov, *Medicare 2017 Costs at a Glance* (Centers for Medicare and Medicaid Services, n.d.); Part D plan offerings in 2017—J. Hoadley, J. Cubanski, and T. Neuman, *Medicare Part D: A First Look at Prescription Drug Plans in 2017* (Henry J. Kaiser Family Foundation, Oct. 17, 2016).

Appendix 2. Medicare Beneficiaries by Income and Supplemental Coverage

	Total	Medicare only	Medicaid	Employer-sponsored insurance	Medicare Advantage	Medigap
Total	56,100,006.61	5,403,600.32	11,006,574.65	18,685,593.98	13,797,728.51	7,206,509.16
Income						
<100% FPL	8,977,862.68	925,974.06	5,894,237.98	468,099.48	1,234,912.19	454,638.97
100%–149% FPL	9,175,934.95	1,235,113.88	3,520,053.82	1,111,478.25	2,463,852.32	845,436.70
150%–199% FPL	7,084,223.98	1,068,008.40	852,209.47	1,484,542.35	2,546,308.84	1,133,154.92
200%–399% FPL	18,404,901.24	1,569,899.43	642,964.18	8,102,573.72	5,303,817.69	2,785,646.22
400%+ FPL	12,457,083.76	604,604.56	97,109.20	7,518,900.18	2,248,837.47	1,987,632.35
	Total	**Medicare only**	**Medicaid**	**Employer-sponsored insurance**	**Medicare Advantage**	**Medigap**
Coverage percent of each row						
Total	100%	10%	20%	33%	25%	13%
Income						
<100% FPL	100%	10%	66%	5%	14%	5%
100%–149% FPL	100%	13%	38%	12%	27%	9%
150%–199% FPL	100%	15%	12%	21%	36%	16%
200%–399% FPL	100%	9%	3%	44%	29%	15%
400%+ FPL	100%	5%	1%	60%	18%	16%

Note: Medicaid includes any Medicaid coverage.
Data: Roger C. Lipitz Center analysis of 2012 Medicare Current Beneficiary Survey projected to 2016.

Appendix 3. Medicare Low-Income Policies, 2016

Full Medicaid 75% to <100% poverty level, varies by state

- Assets limit: $2,000 individual; $3,000 couple (states vary)

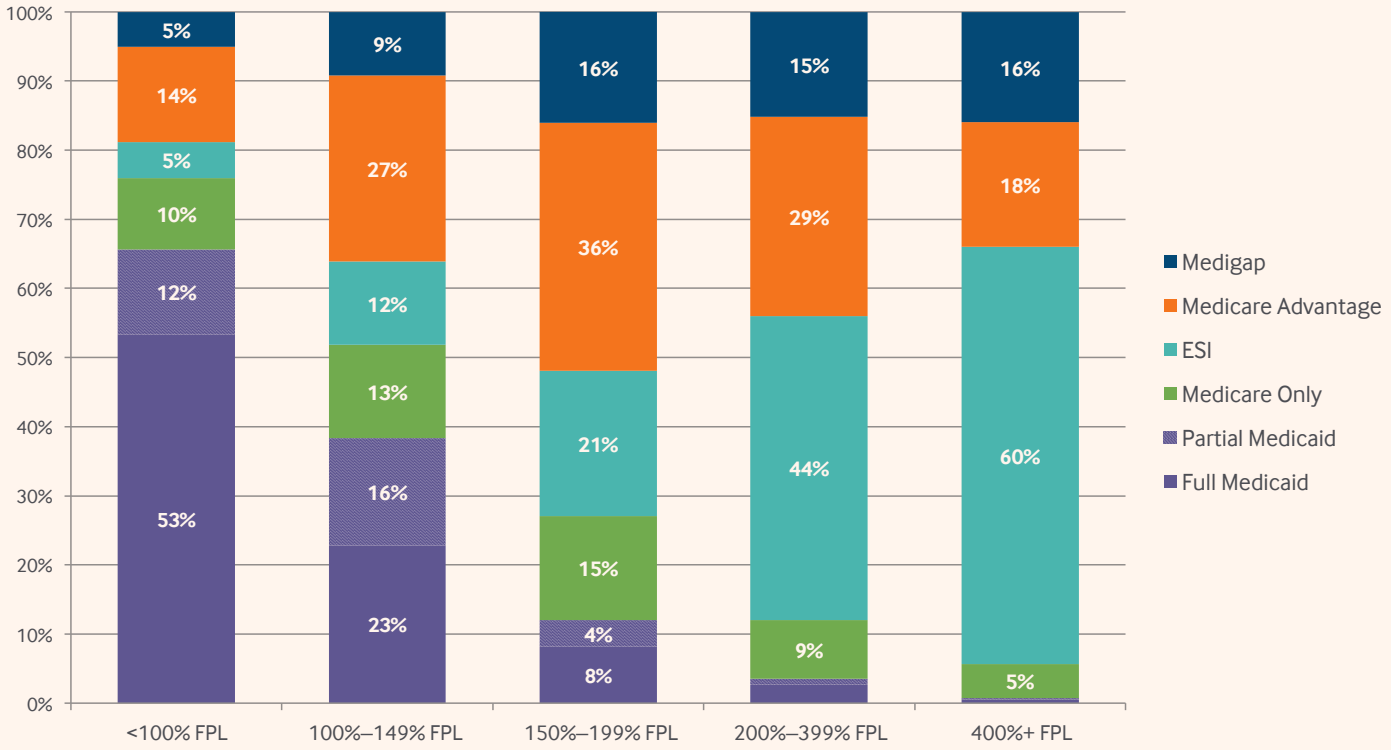
Medicare savings programs for Part A and Part B

- Administered by Medicaid
- Asset limit: $7,280 individual; $10,930 couple
- <100% poverty level: Medicaid pays Medicare premium + cost-sharing
- 100% to 135% poverty level: help with Part B premium only

Medicare Part D sliding scale to 150% poverty level—premium and benefits

- Asset limit: $13,640 individual; $27,250 couple
- Lower assets for full subsidy <135% poverty level ($8,780/$13,930)
- No premium or deductible <135% poverty level; sliding scale to 150% poverty level
- Administered by Medicare

Appendix 4. Medicare Beneficiaries by Income and Supplemental Coverage, Including Full or Partial Medicaid



Note: ESI = employer-sponsored insurance; FPL = federal poverty level.
Data: Roger C. Lipitz Center analysis of 2012 Medicare Current Beneficiary Survey projected to 2016. Retains 2012 coverage distribution.

Appendix 5. Out-of-Pocket Spending by Type of Service and Medicare Beneficiary Income, Coverage, and Health Status

		Average out-of-pocket spending on health care services									
	Number of beneficiaries	Total	Inpatient	ED	Outpatient	Medical providers*	Drugs	SNF	Home health	Facility	Dental
All beneficiaries	56,100,007	$3,024	$90	$14	$123	$684	$760	$71	$92	$861	$329
Income											
<100% FPL	8,977,864	$2,345	$90	$13	$82	$452	$330	$61	$44	$1,138	$135
100%–149% FPL	9,175,936	$2,854	$68	$15	$100	$492	$589	$176	$36	$1,219	$157
150%–199% FPL	7,084,225	$3,271	$147	$15	$119	$835	$926	$72	$66	$832	$260
200%–399% FPL	18,404,903	$3,032	$55	$13	$146	$742	$887	$49	$102	$660	$377
400%+ FPL	12,457,085	$3,486	$125	$13	$136	$820	$913	$35	$167	$714	$564
Medicare only	5,403,598	$5,374	$244	$26	$138	$714	$634	$225	$48	$3,065	$282
Medicaid	11,006,575	$2,587	$89	$17	$77	$446	$265	$166	$21	$1,420	$86
ESI	18,685,594	$2,826	$107	$13	$143	$801	$798	$25	$145	$343	$449
Medicare Advantage	13,797,729	$2,472	$34	$10	$100	$524	$880	$16	$29	$564	$315
Medigap	7,206,512	$3,499	$40	$7	$171	$1,024	$1,282	$38	$215	$270	$453
Top 5% of spending	2,203,159	$19,009	$916	$30	$936	$2,353	$1,169	$1,393	$1,057	$10,902	$253
Health status											
No chronic conditions	25,811,765	$1,549	$23	$6	$41	$337	$313	$21	$233	$148	$427
3+ chronic conditions	30,288,242	$2,755	$124	$16	$150	$839	$974	$35	$121	$165	$331
Serious physical or cognitive impairment	13,702,999	$5,519	$203	$18	$151	$1,001	$857	$243	$362	$2,491	$194
0 ADLs	34,732,782	$2,063	$44	$11	$107	$556	$681	$8	$8	$253	$394
1 ADL	8,719,719	$2,939	$91	$18	$141	$727	$968	$51	$31	$627	$286
2+ ADLs	12,647,505	$5,695	$213	$18	$155	$1,006	$835	$261	$365	$2,660	$183
<200% FPL, all	25,238,019	$3,215	$83	$13	$142	$773	$898	$43	$128	$681	$453
<200% FPL and high need, all**	17,001,477	$3,223	$115	$17	$117	$674	$691	$140	$70	$1,235	$164
<200% FPL and high need, Medicaid**	7,475,973	$2,529	$77	$20	$83	$500	$284	$159	$5	$1,320	$83
<200% FPL and high need, ESI**	1,954,582	$3,759	$61	$18	$184	$964	$906	$90	$107	$1,138	$290
<200% FPL and high need, Medicare only**	1,698,244	$6,737	$513	$36	$176	$900	$816	$400	$31	$3,540	$325

Note: ED = emergency department; SNF = skilled nursing facility; FPL = federal poverty level; ESI = employer-sponsored insurance; ADLs = activities of daily living.
* Medical providers includes hearing and other services not covered by Medicare as well as Medicare cost-sharing.
** High need = Three or more chronic conditions and/or serious physical or cognitive impairment.
Data: Roger C. Lipitz Center analysis of 2012 Medicare Current Beneficiary Survey projected to 2016.

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