

Are Health Care Costs a Burden for Older Americans?

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Affordable health care is a growing concern for many older Americans. Although Medicare covers nearly all adults age 65 and older, premiums, deductibles, copays, and holes in the benefit package leave many older Americans with substantial out-of-pocket expenses. Fidelity Investments (2009) estimates that a 65-year-old couple retiring in 2009 can expect to pay about \$240,000 out of pocket for health care over the rest of their lives. With health care costs expected to grow further (Sisko et al. 2009), assessments of retirement income adequacy must account for these expenses.

This brief examines the distribution, composition, and financial burden of out-of-pocket health care spending for Americans age 65 and older in 2006 and shows how outcomes have changed since 2001 and 2005. Spending patterns differ in 2006 because Congress introduced Medicare Part D that year, adding drug coverage to the program. The lack of drug coverage was the most glaring hole in the Medicare program, with drug costs accounting for much of seniors' out-of-pocket spending (Crystal et al. 2000). About one-quarter of Medicare beneficiaries age 65 and older who were not in nursing homes lacked supplemental drug coverage in 2003 (Federal Interagency Forum on Aging-Related Statistics 2006). Adding pharmaceutical coverage to Medicare could significantly lower out-of-pocket health care spending, but the benefit's design might limit protections. The standard Part D plan temporarily suspends coverage when beneficiaries' annual spending

exceeds a certain level, and does not resume coverage until their out-of-pocket drug costs become quite high.

The study's data come from the Medical Expenditure Panel Survey (MEPS), a nationally representative household survey sponsored by the Agency for Healthcare Research and Quality, that collects detailed information on health care expenditures. The sample is restricted to non-institutionalized adults.¹

The results show that the majority of older Americans devoted less than one-eighth of their incomes to health care in 2006, with premiums consuming the largest share of their health care dollars. However, nearly half of low-income seniors (with incomes below twice the federal poverty level) spent more than \$1 out of every \$5 of their incomes on health care, even after the introduction of Medicare Part D.² Policymakers considering reforming the retirement income system must keep in mind the difficulties that many low-income older adults face covering their medical expenses. Medical costs for seniors should also figure into the health-reform debate.

Limitations of Medicare Coverage

Depending on their insurance coverage, seniors' out-of-pocket payments include Medicare premiums, deductibles, and cost shares; premiums for supplemental insurance; and spending on uncovered services and devices. Appendix table 1 summarizes older Americans' principal insurance options and their costs.

Medicare consists of four parts: A, B, C, and D. Part A primarily covers hospital stays and is funded mainly by payroll taxes. Very few beneficiaries pay Part A premiums. Part B covers doctor visits and many other outpatient services. The monthly 2009 Part B premium is \$96.40. Part D, added in 2006, provides a voluntary outpatient prescription drug benefit delivered by private insurance plans. These drug plans provide a range of coverage options at different prices, but

they must provide the standard benefits defined in law or benefits at least as generous. Monthly premiums averaged \$30 in 2008 (Hoadley, Thompson, et al. 2008).

Part C provides Medicare benefits through private health plans, known as Medicare Advantage (MA) plans. They generally require smaller deductibles and copays than traditional Medicare and often cover benefits that are excluded from the traditional Medicare package, such as dental care, routine vision care and eyeglasses, and hearing examinations and hearing aids. Most plans also provide drug coverage. However, many restrict enrollees' choice of providers to those affiliated with the plan. In 2006, 19 percent of adults age 65 and older were enrolled in MA plans.³

Older adults with very limited assets and income may qualify for Medicaid, which pays virtually all health care costs for enrollees, including Medicare premiums. Those with too much income or wealth to receive full Medicaid benefits may qualify for more limited public assistance with Medicare premiums, deductibles, and copays through the Medicare Savings Program (MSP), which includes the Qualified Medicare Beneficiary (QMB) program and the Specified Low-Income Medicare Beneficiary (SLMB) program. Additionally, the Medicare Part D Low-Income Subsidy (LIS) fully covers Part D premiums, deductibles, and cost shares for those with incomes at or below 135 percent of the poverty level. It provides more limited help for those with incomes between 135 and 150 percent of the poverty level.

However, enrollment rates are low for these programs, especially for Medicaid and MSP. Medicaid, which covered 8 percent of adults age 65 and older in 2006, enrolls about half of eligible seniors. Only about 33 percent of eligible older adults participate in QMB and only 13 percent participate in SLMB (Congressional Budget Office [CBO] 2004). Limited knowledge of the program, complex application procedures, and the stigma associated with enrolling in a means-tested program appear to reduce participation rates (Medicare Payment Advisory Commission 2008).

Finally, many older Americans obtain private supplemental insurance to fill some of the gaps in Medicare coverage. In 2006, 34 percent of noninstitutionalized adults age 65 and older obtained health benefits from current employers, former employers, or their spouses' current or former employers, and 17 percent purchased private supplemental coverage, known as Medigap, from insurance companies. Most seniors with employer-sponsored health insurance receive subsidized benefits, although they generally have to contribute toward part of the costs. Many firms, however, are cutting back on retiree health benefits, raising retiree premium contributions and copays, or eliminating coverage completely (Buchmueller, Johnson, and Lo Sasso 2006; Kaiser Family Foundation and Hewitt Associates 2006).

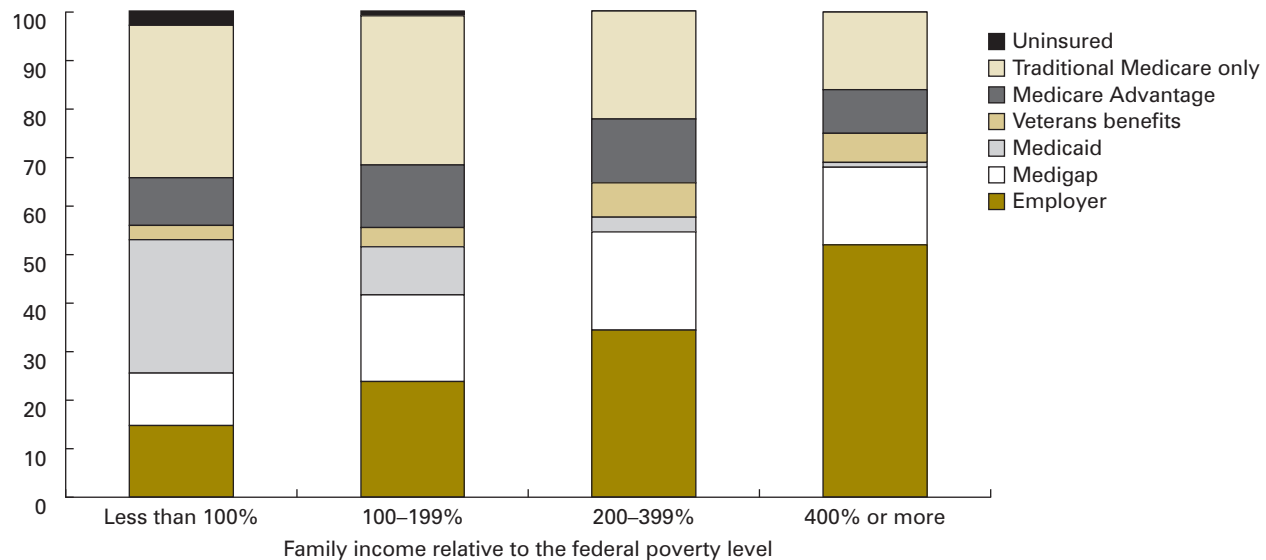
Supplemental-coverage rates vary with income. In 2006, 52 percent of high-income older adults (with incomes at or in excess of four times the poverty level) received employer-sponsored health benefits, compared with 15 percent of those in poverty (figure 1). Medicaid made up some of the shortfall in supplemental coverage for low-income seniors, but it covered only 28 percent of adults age 65 and older living in poverty. As a result, nearly one-third of seniors with incomes below twice the poverty level relied on traditional Medicare alone to cover health care expenses, compared with only about one-sixth of those with incomes in excess of four times the poverty level.

Out-of-Pocket Spending Levels

Americans age 65 and older spent \$2,959, on average, in annual out-of-pocket health care costs in 2006 (table 1). These payments included Medicare deductibles, premiums, and cost shares; premiums for supplemental insurance; and spending on uncovered services and devices.⁴ Costs were relatively modest for many older adults. Half spent less than \$2,463 (the median amount) and one-quarter spent less than \$1,558 (the 25th percentile of the distribution). However, 1 in 10 seniors spent more than \$5,345.

Following the introduction of Medicare Part D, older Americans' real average out-of-pocket

FIGURE 1. Health Insurance Coverage by Income, Age 65 and Older, 2006 (Percent)



Source: Authors' estimates from the Medical Expenditure Panel Survey (MEPS).

Notes: Estimates are based on a sample of 3,312 noninstitutionalized adults age 65 and older. The insurance category is arranged hierarchically, so that the Medigap category excludes any Medigap-covered adults with employer coverage, the Medicaid category excludes any adults with employer coverage or Medigap, and so on. The Medigap category includes respondents with other types of private supplemental coverage and the veterans benefits category includes those with other types of public supplemental coverage. The Medicaid category is restricted to those with full Medicaid coverage.

health care costs fell \$169 between 2005 and 2006, a 5 percent decline. The drop resulted entirely from reduced out-of-pocket drug spending, which fell by \$238 (or 26 percent). Total out-of-pocket costs declined most sharply among the biggest spenders. Real costs at the 90th percentile

of the distribution fell 11 percent, while median costs fell 5 percent and costs at the 25th percentile did not change significantly. Despite the overall decline in out-of-pocket spending in 2006, real average out-of-pocket costs remained 13 percent above their 2001 level.

TABLE 1. Annual Out-of-Pocket Health Care Spending by Adults Age 65 and Older, 2001, 2005, and 2006 (Constant 2006 Dollars)

	Average spending	Percentile of the Spending Distribution			
		25th	50th (median)	75th	90th
2001	2,611 *	1,113 *	2,076 *	3,343 *	5,104
2005	3,128 *	1,510	2,589 *	3,988	5,990 *
2006	2,959	1,558	2,463	3,848	5,345

Source: Authors' estimates from the Medical Expenditure Panel Survey (MEPS).

Notes: Estimates are restricted to noninstitutionalized adults age 65 and older. The sample consists of 3,302 respondents in 2001, 3,137 respondents in 2005, and 3,312 in 2006. Financial amounts are adjusted by the change in the consumer price index.

* $p < .05$ from 2006 level.

Composition of Out-of-Pocket Spending

Premiums now account for the majority of seniors' out-of-pocket health care spending. In 2006, 56 percent of out-of-pocket health care spending went to premiums (figure 2). Another 23 percent went to prescription drugs. Combined, dental, inpatient, and outpatient services consumed 15 percent of seniors' total out-of-pocket costs.

Premium payments grew steadily between 2001 and 2006. Average out-of-pocket premium payments increased by nearly one-third in inflation-adjusted dollars over the period, growing from \$1,259 in 2001 to \$1,639 in 2006 (table 2). By contrast, real average out-of-pocket payments to health care providers did not change significantly over the period. Premiums increased for all insurance coverage groups except for those with Medicaid. Between 2001 and 2006, real aver-

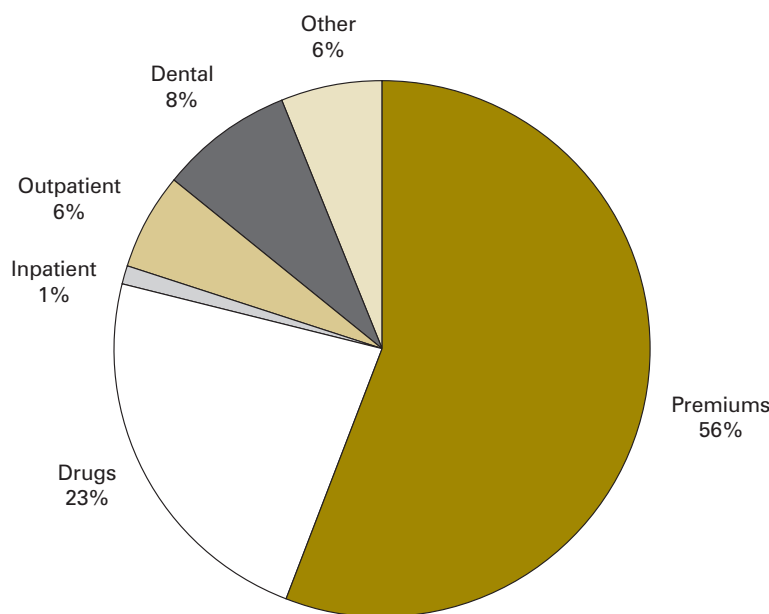
age premiums increased 68 percent for older adults with Medicare only and 40 percent for those with employer-sponsored coverage.

Health Care Spending Relative to Income

In 2006 the median ratio of out-of-pocket health care spending to household income was 12.3 percent for noninstitutionalized adults age 65 and older (table 3). This ratio increased with age and health problems, and was higher among those with limited incomes. For example, the median ratio of costs to income was 19.6 percent for older households with incomes below the poverty level and 19.9 percent for those with incomes between 100 and 199 percent of the poverty level, compared with 6.1 percent for those with incomes at or above 400 percent of the poverty level.

Although low-income seniors devoted a substantial portion of their 2006 incomes to health

FIGURE 2. Composition of Out-of-Pocket Health Care Costs, Age 65 and Older, 2006



Source: Authors' estimates from the Medical Expenditure Panel Survey (MEPS).

Notes: Estimates show the percentage of total out-of-pocket health care costs by older adults spent on premiums, drugs, and other services, and are based on a sample of 3,312 noninstitutionalized adults age 65 and older. The other category includes emergency room visits, home health care, vision aids, and other medical supplies and equipment.

TABLE 2. *Average Out-of-Pocket Premiums and Payments to Health Care Providers, Adults Age 65 and Older, 2001 and 2006 (Constant 2006 Dollars)*

	Population (millions)	Premiums (\$)	Payments to providers (\$)
2001			
All	30.7	1,259 †	1,352
Insurance coverage			
Employer	10.7	1,496 *†	1,169 *†
Medigap	6.0	2,472 *†	1,483
Medicaid	1.9	1 *	558 *
Veterans benefits	0.7	661 †	1,227
Medicare only	11.3	650 †	1,609 †
2006			
All	31.8	1,639	1,320
Insurance coverage			
Employer	10.9	2,096 *	1,450
Medigap	5.3	2,862 *	1,375
Medicaid	2.4	0 *	638 *
Veterans benefits	1.7	1,047 *	1,179
Medicare only	11.2	1,090	1,352

Source: Authors' estimates from the Medical Expenditure Panel Survey (MEPS).

Notes: Estimates are restricted to noninstitutionalized adults age 65 and older. The sample consists of 3,302 respondents in 2001 and 3,312 in 2006. The insurance category is arranged hierarchically, so that the Medigap category excludes any Medigap-covered adults with employer coverage, the Medicaid category excludes any adults with employer coverage or Medigap, and so on. The Medigap category includes respondents with other types of private supplemental coverage, the veterans benefits category includes those with other types of public supplemental coverage, and the Medicare only category includes those in Medicare Advantage plans. The Medicaid category is restricted to those with full Medicaid coverage. Financial amounts are adjusted by the change in the consumer price index.

* differs significantly from adults with Medicare only.

† differs from 2006 ($p < .05$).

care, those living in poverty spent much less than they did in 2005, before the introduction of Medicare Part D. Between 2005 and 2006, the median share of income going to health care fell about 8 percentage points for those with incomes below the poverty level. It also declined for those with Medigap coverage, although they continued to spend much of their 2006 incomes on health care. For the median older adult, however, the share of income devoted to health care increased significantly since 2001 (when the ratio stood at 11.0 percent), and did not change significantly after 2005. For older adults receiving employer

health benefits, the median share of income spent on health care increased between 2005 and 2006.

More than one-quarter of older adults (28.3 percent) spent more than 20 percent of their household incomes on health care in 2006, a common indicator for financially burdensome costs (table 4). High costs relative to income were more common among women and among older, sicker, and lower-income adults. For example, 48.8 percent of adults with incomes below the poverty level and 50.0 percent of those with incomes between 100 and 199 percent of the poverty level devoted more than one-fifth of their incomes to

TABLE 3. Median Percentage of Household Income Spent on Health Care, Adults Age 65 and Older, 2001, 2005, and 2006

	2001	2005	2006
All	11.0 †	12.6	12.3
Gender			
Male	10.3 *	11.0 *	10.4 *
Female	11.8 †	13.8	14.4
Age			
65–74	9.9 *	10.5 *	10.5 *
75–84	12.7	15.0	14.4
85 and older	14.7	15.5	15.9
Health status			
Excellent or very good	9.3 *†	11.0 *	10.5 *
Good	12.6	12.8 *	12.6 *
Fair or poor	13.7	17.2	15.3
Insurance coverage			
Employer	9.5 *†	9.9 *†	11.6
Medigap	19.1 *	22.7 *†	19.2 *
Medicaid	2.9 *	3.5 *	3.3 *
Veterans benefits	10.5	10.2	7.8 *
Medicare only	11.1 †	13.0	12.4
Family income relative to the federal poverty level			
Less than 100%	23.4 *	27.5 *†	19.6 *
100%–199%	18.4 *	22.1 *	19.9 *
200%–399%	11.2 *†	14.3 *	14.1 *
400% or more	5.2 †	6.8	6.1

Source: Authors' estimates from the Medical Expenditure Panel Survey (MEPS).

Notes: Estimates are restricted to noninstitutionalized adults age 65 and older. The sample consists of 3,302 respondents in 2001, 3,137 respondents in 2005, and 3,312 in 2006. Spending includes both out-of-pocket payments to providers and premium payments. Income and spending include those for spouses, regardless of age. The insurance category is arranged hierarchically. See the notes to table 2 for more details.

* differs significantly from last row of the group.

† differs from 2006 ($p < .05$).

health care. Additionally, nearly half of adults with Medigap coverage experienced high health costs relative to income, compared with only about one-tenth of those with Medicaid.

The prevalence of burdensome health care costs for older adults increased between 2001 and 2005, but declined in 2006 following the introduction of Medicare Part D. The share spending more than one-fifth of income on health care fell 10 percentage points between 2005 and 2006 for

older adults in poverty. It also dropped significantly for men, adults ages 75 to 84, those in fair or poor health, those with Medigap, those with veterans health benefits and other types of public supplemental coverage, and those with moderate and higher incomes (200 percent or more of the poverty level).

However, the prevalence of burdensome health care costs significantly increased between 2001 and 2005 for nonpoor low-income older

TABLE 4. *Percentage of Adults Age 65 and Older Spending More than 20 Percent of Their Household Income on Health Care, 2001, 2005, and 2006*

	2001	2005	2006
All	28.5	31.7 †	28.3
Gender			
Male	25.6 *	27.2 *†	22.3 *
Female	30.5	35.1	32.8
Age			
65–74	22.7 *	25.9 *	23.6 *
75–84	35.1	38.1 †	32.3
85 and older	37.0	40.2	38.2
Health status			
Excellent or very good	22.2 *	25.2 *	22.1 *
Good	32.5	32.2 *	31.0 *
Fair or poor	34.5	44.8 †	36.7
Insurance coverage			
Employer	23.0 *	23.3 *	26.4
Medigap	46.0 *	56.9 *†	47.9 *
Medicaid	8.6 *	14.7 *	10.8 *
Veterans benefits	23.9	29.9 †	15.1 *
Medicare only	28.1	30.8	27.0
Family income relative to the federal poverty level			
Less than 100%	55.9 *†	58.7 *†	48.8 *
100%–199%	45.5 *†	53.8 *	50.0 *
200%–399%	22.7 *	31.0 *†	24.4 *
400% or more	3.5	5.9 †	3.7

Source: Authors' estimates from the Medical Expenditure Panel Survey (MEPS).

Notes: Estimates are restricted to noninstitutionalized adults age 65 and older. The sample consists of 3,302 respondents in 2001, 3,137 respondents in 2005, and 3,312 in 2006. Spending includes both out-of-pocket payments to providers and premium payments. Income and spending include those for spouses, regardless of age. The insurance category is arranged hierarchically. See the notes to table 2 for more details.

* differs significantly from last row of the group.

† differs from 2006 ($p < .05$).

adults (those with incomes between 100 and 199 percent of the poverty level) and remained significantly above 2001 levels in 2006. Between 2001 and 2006, the share of these adults devoting more than one-fifth of their incomes to health care increased by about 5 percentage points. This is the only group that experienced a significant increase in burdensome costs over the period.

Policy Implications

Most older Americans do not pay much out of pocket for their health care. Half of adults age 65 and older spent less than 12.3 percent of their income on medical expenses in 2006. On average, seniors spend nearly twice as much on housing as on health care (Butrica, Goldwyn, and Johnson 2005).

However, many low-income older adults continue to struggle with medical expenses. Adding drug coverage to Medicare made a real difference for the most vulnerable seniors, significantly reducing the prevalence of catastrophic health care spending among older adults living in poverty. Nonetheless, nearly half of older Americans in the bottom third of the income distribution, with incomes below twice the poverty level, spent more than one-fifth of their incomes on health care in 2006. By contrast, only 4 percent of seniors in the top third of the income distribution, with incomes exceeding four times the poverty level, devoted more than one-fifth of their incomes to health care.

Boosting enrollment in existing programs that help low-income seniors with medical expenses could lower their out-of-pocket costs. Less than half of eligible older adults enroll in Medicaid (Pezzin and Kasper 2002), and fewer enroll in QMB and SLMB (CBO 2004). For years, advocates and health care experts have urged more outreach to low-income seniors and simplified application procedures to increase participation in these programs (Center for Medicare Education 2001; Ebeler, Van de Water, and Demchak 2006). In 2008 Congress increased federal financial support to community organizations that help older adults apply for MSP and LIS, and these funds could help raise participation rates. The Medicare Payment Advisory Commission (2008) proposed that the Social Security Administration screen applicants for MSP and enroll those who qualify, as it now does successfully for LIS.

The federal government could also encourage state outreach by assuming full responsibility for MSP costs, instead of sharing costs with state governments. Under the current cost-sharing arrangement, some states are reluctant to reach out to potential MSP applicants because higher enrollment further strains already-stretched state budgets (Ebeler, Van de Water, and Demchak 2006).

Additionally, Congress should consider other ways of helping low-income seniors who struggle to cover their medical expenses. One option is to expand MSP eligibility to include those with

incomes up to 150 percent of the poverty level and with personal assets worth as much as \$8,100 for singles and \$12,910 for couples in 2009, as the Medicare Payment Advisory Commission (2008) recommended. The federal asset cutoffs, which have not changed since 1989, especially need to be updated. In addition to increasing the number of vulnerable seniors who qualify for relief from high out-of-pocket expenses, this change would simplify application procedures by equalizing the MSP and LIS eligibility criteria. As Congress debates health reform, the high out-of-pocket cost burden confronting low-income seniors should be part of the discussion.

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Notes

1. The sample is also restricted to respondents who reported at least some household income and who completed all three rounds of interviews in a particular calendar year. We cap total annual out-of-pocket health spending at \$15,000 per respondent, to reduce the influence of a very few cases with extremely high spending. For more information on MEPS, see Cohen (1997).
2. In 2006, the federal poverty level was \$9,669 for single adults age 65 and older and \$12,186 for couples.
3. Coverage estimates in this section are based on the authors' analysis of MEPS data.
4. MEPS asked respondents about their premium payments for private insurance but not for Medicare. We assigned each respondent who had Medicare coverage the Part B premium in effect that year (\$88.50 per month in 2006) and each respondent who had Medicare Part D coverage the average 2006 Part D premium of \$26 per month (Hoadley, Thompson, et al. 2008). However, we set Parts B and D premiums equal to \$0 for those with Medicaid coverage and for those in QMB or SLMB, and we set Part D premiums equal to \$0 for those in LIS. MEPS does not ask about QMB, SLMB, or LIS enrollment. We assumed that only 33 percent of seniors without Medicaid who had incomes below the poverty level enrolled in QMB, and that 13 percent of those with incomes between 100 and 120 percent of the poverty level enrolled in SLMB, consistent with CBO (2004).

assumptions. We also assumed that all QMB and SLMB enrollees participated in LIS and that 36 percent of eligible beneficiaries not enrolled in Medicaid, QMB, or SLMB participated in LIS, a recent estimate of the take-up rate (Hoadley, Hargrave, and Cubanski 2008).

References

- Buchmueller, Thomas C., Richard W. Johnson, and Anthony T. Lo Sasso. 2006. "Trends in Retiree Health Insurance, 1997 to 2003." *Health Affairs* 25(6): 1507–16.
- Butrica, Barbara A., Joshua H. Goldwyn, and Richard W. Johnson. 2005. "Understanding Expenditure Patterns in Retirement." Washington, DC: The Urban Institute. <http://www.urban.org/url.cfm?ID=411130>.
- Center for Medicare Education. 2001. "Increasing Enrollment for Medicare Savings Programs." Issue Brief 2(7). Washington, DC: Center for Medicare Education. <http://ihcrp.georgetown.edu/agingsociety/pdfs/MedicareSavings.pdf>.
- Cohen, Joel. 1997. *Design and Methods of the Medical Expenditure Panel Survey Household Component*. AHCPR Pub. 97-0026. Rockville, MD: Agency for Health Care Policy and Research.
- Congressional Budget Office (CBO). 2004. "A Detailed Description of CBO's Cost Estimate for the Medicare Prescription Drug Benefit." Washington, DC: Congressional Budget Office.
- Crystal, Stephen, Richard W. Johnson, Jeffrey Harman, Usha Sambamoorthi, and Rizie Kumar. 2000. "Out-of-Pocket Health Care Costs among Older Americans." *Journal of Gerontology: Social Sciences* 55B(1): S51–62.
- Ebeler, Jack, Paul N. Van de Water, and Cyanne Demchak, eds. 2006. *Improving the Medicare Savings Programs*. Washington, DC: National Academy of Social Insurance.
- Federal Interagency Forum on Aging-Related Statistics. 2006. *Older Americans Update 2006: Key Indicators of Well Being*. Washington, DC: U.S. Government Printing Office.
- Fidelity Investments. 2009. "Fidelity Investments Estimates \$240,000 Needed to Pay Health Care Costs in Retirement." http://www.emeritihealth.org/pdfs/Fidelity_Retiree_Healthcare_Estimates_2009.pdf.
- Gold, Marsha, Maria Cupples Hudson, and Sarah Davis. 2006. "2006 Medicare Advantage Benefits and Premiums." Report #2006-23. Washington, DC: AARP. http://assets.aarp.org/rgcenter/health/2006_23_medicare.pdf.
- Hoadley, Jack, Elizabeth Hargrave, and Juliette Cubanski. 2008. "Medicare Part D 2008 Data Spotlight: Low-Income Subsidy Plan Availability." Washington, DC: Henry J. Kaiser Family Foundation. <http://www.kff.org/medicare/upload/7763.pdf>.
- Hoadley, Jack, Jennifer Thompson, Elizabeth Hargrave, Juliette Cubanski, and Tricia Neuman. 2008. "Medicare Part D 2009 Data Spotlight: Premiums." Washington, DC: Henry J. Kaiser Family Foundation. <http://www.kff.org/medicare/upload/7835.pdf>.
- Kaiser Family Foundation. 2009. "State Health Facts Online." <http://www.statehealthfacts.kff.org>.
- Kaiser Family Foundation and Hewitt Associates. 2006. "Retiree Health Benefits Examined: Findings from the Kaiser/Hewitt 2006 Survey on Retiree Health Benefits." <http://www.kff.org/medicare/upload/7587.pdf>.
- Medicare Payment Advisory Commission. 2008. "Report to the Congress: Medicare Payment Policy." http://www.medpac.gov/documents/Mar08_EntireReport.pdf.
- Pezzini, Liliana, and Judith D. Kasper. 2002. "Medicaid Enrollment among Elderly Medicare Beneficiaries: Individual Determinants, Effects of State Policy, and Impact on Service Use." *Health Services Research* 37(4): 827–47.
- Sisko, Andrea, Christopher Truffer, Sheila Smith, Sean Keehan, Jonathan Cylus, John A. Poisal, M. Kent Clemens, and Joseph Lizonitz. 2009. "Health Spending Projections through 2018: Recession Effects Add Uncertainty to the Outlook." *Health Affairs* 28(2): w346–57.

APPENDIX TABLE 1. Health Insurance Options for Adults 65 and Older

Insurance	Eligibility in 2009	Benefits	Monthly premiums	Deductible	Copays
Medicare Part A	All	Inpatient hospital stays, home health care, hospice care, and limited stays in skilled-nursing facilities	\$0 (if beneficiary or spouse has 40 quarters of FICA-covered earnings)	Varies by type of service; \$1,068 for hospital stays in 2009	Vary by type of service; for hospital stays in 2009, \$0 for first 60 days, \$267/day for days 61–90, \$534/day for days 91–150; coverage ends after 150 days
Part B	All	Doctor visits and other outpatient services	\$96.40 in 2009 (more for high-income enrollees) ^a	\$135/year in 2009	Vary by type of service; generally 20%
Part C (Medicare Advantage)	All	Traditional Medicare benefits plus supplemental benefits that vary by plan (such as reduced deductibles and copays and coverage for benefits excluded from the traditional Medicare package)	Vary by plan (2006 average = \$26 for plans with drug coverage, in addition to Part B premium) ^b	Varies by plan	Vary by plan
Part D	All	Outpatient prescription drugs	Vary by plan (2008 average = \$30) ^c	Varies by plan (in 2009 standard benefit = \$295)	Vary by plan (in 2009 standard plan = 25% until drug spending reaches \$2,700; then 100% until drug spending reaches \$4,350; then 5% once drug spending exceeds \$4,350)

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Medicaid	Income: varies by state, but may not exceed 100% of federal poverty level (average = 88% of poverty level) ^d Asset limit: generally \$2,000 for individuals and \$3,000 for couples, but states may use higher limits	Covers Medicare premiums, deductibles, and copays and provides some benefits not covered by Medicare	\$0	Generally \$0	Generally \$0
Qualified Medicare Beneficiary (QMB)	Not enrolled in Medicaid; income must not exceed 100% of the federal poverty level; assets must not exceed \$4,000 for individuals or \$6,000 for couples (although some states use higher asset limits)	Covers Medicare premiums, deductibles, and copays	\$0	\$0	\$0
Specified Low-Income Medicare Beneficiary (SLMB) ^e	Not enrolled in Medicaid; income must not exceed 120% of the federal poverty level; assets must not exceed \$4,000 for individuals or \$6,000 for couples (although some states use higher asset limits)	Covers Medicare premiums	\$0	Usual Medicare rules apply	Usual Medicare rules apply
Medicare Part D Low-Income Subsidy (LIS)	Not enrolled in Medicaid; income must not exceed 135% of the federal poverty level for full benefits or 150% for partial benefits; for full benefits assets must not exceed \$8,100 for individuals or \$12,910 for couples	Helps pay for Medicare Part D benefits	\$0	\$0	\$0

(continued)

APPENDIX TABLE 1. *Health Insurance Options for Adults 65 and Older* (continued)

Insurance	Eligibility in 2009	Benefits	Monthly premiums	Deductible	Copays
Medigap	Enrolled in Medicare Parts A and B	Vary by plan; may help cover Medicare premiums, deductibles, and copays and services excluded from the Medicare benefit package	Vary by plan	Varies by plan	Vary by plan
Employer	Must currently work for an employer that offers health benefits, or have previously worked for an employer that offers retiree health benefits, and meet employer's eligibility requirements; some employers offer coverage to spouses of beneficiaries	Vary by plan; may help cover Medicare premiums, deductibles, and copays and services excluded from the Medicare benefit package	Vary by plan; premiums are usually subsidized by employer, so employer plans are typically less expensive than Medigap	Varies by plan	Vary by plan

a. Beginning in 2007, high-income enrollees (single adults with incomes over \$85,000 and couples with incomes over \$170,000 in 2009) pay higher Part B premiums. The highest-income beneficiaries (singles with incomes over \$213,000 and couples with incomes over \$426,000) pay monthly premiums of \$308.30.

b. *Source:* Gold, Hudson, and Davis (2006).

c. *Source:* Hoadley, Thomson, et al. (2008).

d. Based on authors' analysis of Kaiser Family Foundation (2009) data.

e. The Qualified Individual program pays Part B premiums for older adults with incomes up to 135% of the poverty level, but funding for this program is limited. Some state programs provide additional help with medical expenses.

T H E R E T I R E M E N T P O L I C Y P R O G R A M

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THE RETIREMENT POLICY PROGRAM

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