

HOW MUCH DOES HEALTH SPENDING EAT AWAY AT RETIREMENT INCOME?

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Introduction

The 14.5-percent increase in Medicare's Part B premium for 2022 was a shock for many, raising a broader concern about the burden of out-of-pocket (OOP) health care spending on retirees. One way to gauge this burden is to look at how much OOP costs eat into retirees' Social Security benefits and other income. OOP costs include Medicare premiums for Parts B and D and any supplemental coverage; cost sharing for Medicare-covered services; and the full cost of services not covered by Medicare, such as dental and vision.

This *brief*, which updates an earlier study, looks at the extent to which OOP medical expenses affect retirees' finances.¹ Specifically, it uses the 2018 *Health and Retirement Study* to calculate the share of Social Security benefits and total income available for non-medical spending and explores how this measure differs by gender, age, health status, income, and supplemental insurance coverage.

The discussion proceeds as follows. The first section provides background on OOP spending. The second section discusses the data and methodology. The third section presents the results, showing that – for the median retiree – only 75 percent of Social Security benefits and 88 percent of total income are

available for non-medical spending. The final section concludes that, with such a substantial portion of their income going to medical costs, retirees' finances are more precarious than Social Security benefit levels alone might suggest.

Background

The general public and policy analysts tend to evaluate the adequacy of retirement income, and Social Security benefits in particular, based on the level of retirees' total income. More relevant to their purchasing power, though, is their income net of OOP medical costs, which are often considered nondiscretionary.²

Even though nearly all retirees over age 65 are covered by Medicare, they still face considerable costs. In the case of Medicare Part A, which covers inpatient hospital care and is financed primarily by payroll taxes, beneficiaries face cost sharing. Medicare Part B, which covers physician and outpatient hospital services, and Part D, which covers prescription drugs, are both partly financed by premiums and also include further cost sharing. Because Medicare's OOP costs

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are often significant, many enrollees buy supplemental insurance coverage – including Medicare Advantage, which can involve additional premiums. Finally, retirees without supplemental plans face the full cost of the many services not covered by Medicare, such as dental, vision, and hearing. Expenditures on long-term care, which can be substantial, are excluded from this analysis in order to characterize the impact of OOP spending in a typical year.³

The primary question is how OOP spending affects the share of Social Security benefits or total income available for non-medical expenditures. It is also interesting to see how this pattern varies across subgroups. Prior work has shown that women, older retirees, those in the worst health, and the near poor who do not qualify for Medicaid have the lowest post-OOP incomes.⁴

The relationship between supplemental coverage and the share of income remaining is a particularly interesting issue. The three main types of supplemental insurance are:⁵

- Medicaid, the public insurance program for low-income individuals that covers Medicare cost sharing and premiums as well as services not covered by Medicare;
- Medicare Advantage (also called Medicare Part C), which is private insurance that covers enrollees' standard Medicare benefits, while also covering other services and reducing the amount they have to pay in cost sharing; and
- Retiree health insurance (RHI), a form of private group health coverage that some employers offer to former employees after retirement.

When both premiums and other OOP costs are considered, prior work consistently finds that Medicaid enrollees have the highest share of post-OOP income, in most cases followed by Medicare Advantage enrollees, with enrollees with no supplemental insurance or private supplemental insurance having the lowest shares.⁶

Accounting for OOP cost burdens is important, because it is crucial to know how much the large share of retirees who rely exclusively on Social Security have remaining for non-medical spending. In addition, understanding benefit adequacy across different types of people helps identify those who may be particularly at risk. Finally, with the growing importance of supplemental insurance, participants

need to understand what types are likely to leave them in the best position. The following analysis addresses all these issues.

Data and Methodology

The analysis uses the *Health and Retirement Study* (HRS), which collects information every two years on the financial security, work histories, medical expenditures, insurance coverage, and self-reported Social Security benefits of respondents, who are over age 50. The original analysis includes trends from 2002-2014, while this *brief* focuses on 2018, the most recent year (notably, pre-pandemic) for which full information is available.

The sample is limited to respondents who are at least 65 years old and are receiving both Social Security and Medicare benefits, and it excludes those who are working or report receiving health insurance from a current employer or spouse's employer. In other words, the sample is limited to retirees fully detached from the labor force and reliant on Medicare.

The three key components of the study – Social Security benefits, total personal income, and OOP medical expenditures (excluding long-term care) – are derived from self-reported information in the HRS. Since Social Security benefits do not capture the total resources available to retirees, the analysis also examines the percentage of total income – including pensions, government transfers, capital income, and income from 401(k)s and IRAs – that remains after spending on health care.

In terms of OOP expenditure, the HRS includes an aggregate cost measure that captures home health care, prescription drugs, nursing home care, special facilities, surgery, and medical visits to doctors, hospitals and dentists. It also includes self-reported measures for premiums paid for Medicare Part D, Medicare Advantage (Part C), and private supplemental plans. Medicare Part B premiums are imputed from reported income. These components, excluding long-term care costs, are combined to calculate the share of income remaining after OOP spending for each beneficiary in each year.

The analysis examines the extent to which outcomes differ by gender, age, health status, and household income. Health status in the survey year is measured with two separate indicators: 1) whether the respondent reported difficulty with at least two activities of daily living (ADLs);⁷ and 2) whether the respondent ever had a chronic health condition.⁸

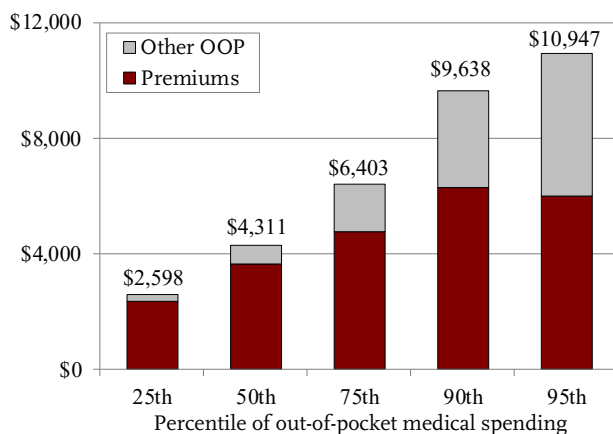
Results

This section presents the results first for the entire sample, then by population subgroups, and finally by type of supplemental health insurance coverage.

Full Sample

Figure 1 demonstrates the breadth of OOP spending among retirees in the HRS sample. The median retiree spent \$4,311 on medical costs in 2018 (in nominal dollars). Spending at the 95th percentile is more than twice as large. Figure 1 also illustrates that while premiums comprise the bulk of OOP costs, the differences between high spenders and others are mostly due to outlays for cost-sharing and uncovered services.

FIGURE 1. MEDICAL OUT-OF-POCKET SPENDING IN 2018, BY SPENDING TYPE AND PERCENTILE

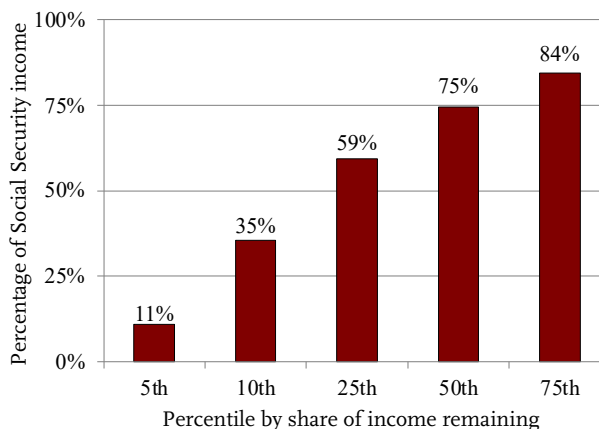


Source: Authors' calculations from University of Michigan, Health and Retirement Study (HRS) (2018).

Figure 2 shows the share of Social Security income remaining after OOP spending.⁹ For the median retiree in this distribution, only 75 percent of the Social Security benefit remains after paying premiums and other OOP costs. OOP spending is much more burdensome for those with the least remaining income. For example, the highest-spending 5 percent of retirees have only 11 percent of their benefit left after OOP costs. Even at the 10th percentile, retirees spend all but a third of their

benefit on OOP costs. These results demonstrate that, for a large number of retirees, OOP costs comprise a sizable share of Social Security income.

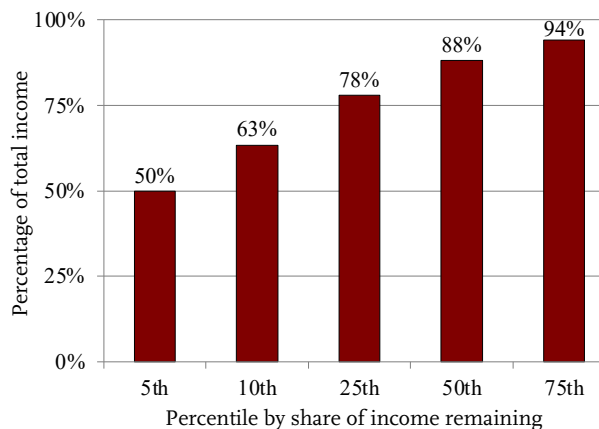
FIGURE 2. SHARE OF SOCIAL SECURITY INCOME REMAINING AFTER MEDICAL OOP SPENDING IN 2018, BY PERCENTILE



Source: Authors' calculations from HRS (2018).

When looking at total income, the share remaining is higher, as expected, but still varies considerably (see Figure 3). The median retiree has 88 percent of his total income left over, but 5 percent of the sample is left with no more than half of total retirement income after medical spending.

FIGURE 3. SHARE OF TOTAL INCOME REMAINING AFTER MEDICAL OOP SPENDING IN 2018, BY PERCENTILE



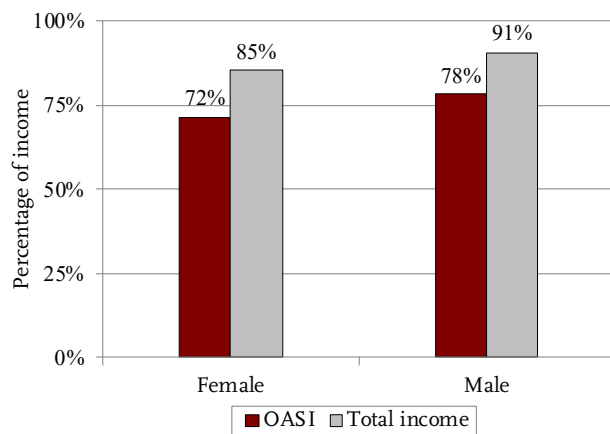
Source: Authors' calculations from HRS (2018).

Differences by Various Factors

The portion of retirement income left over after OOP costs varies across different groups of people identified by gender, age, health status and income.

Figure 4 shows that, for women, the median share remaining is 72 percent of Social Security benefits compared with 78 percent for men. Interestingly, the issue is not that women pay substantially higher health costs than men – their premiums are slightly lower and their other OOP costs are slightly higher – but rather that they have substantially lower Social Security benefits. Because their total incomes are also lower, women have 85 percent of total income remaining after OOP whereas men have 91 percent.

FIGURE 4. MEDIAN SHARE OF SOCIAL SECURITY AND TOTAL INCOME REMAINING AFTER MEDICAL OOP SPENDING IN 2018, BY GENDER

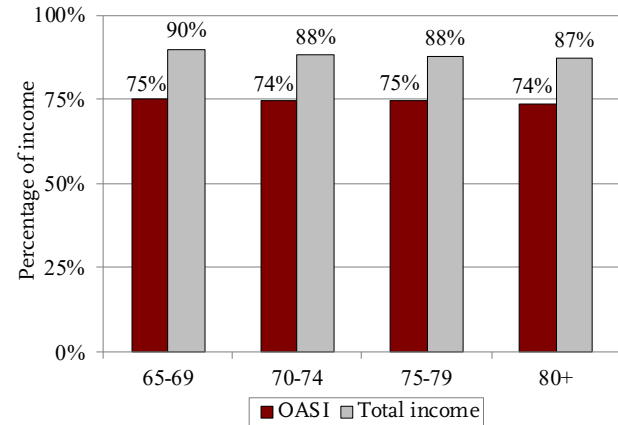


Source: Authors' calculations from HRS (2018).

Turning to the effects by age, Figure 5 shows that the share of both Social Security benefits and total income remaining after OOP spending change very little as people grow older.

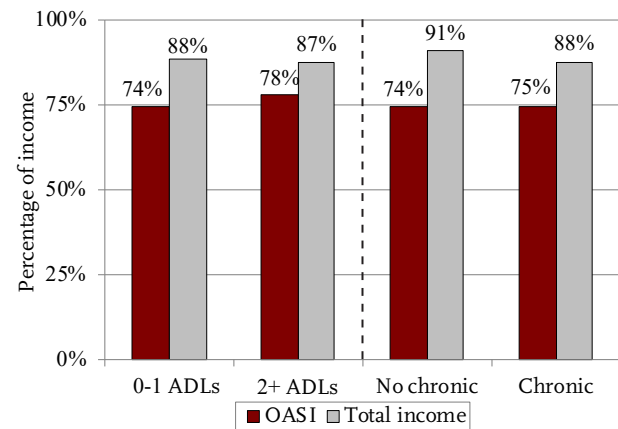
With respect to health status, the share of Social Security benefits or total income available for non-medical spending is surprisingly similar for retirees with and without health concerns (see Figure 6). The exception arises in the case of those never reporting a chronic condition, who have 91 percent of their total income remaining after OOP costs. This outcome occurs because their total retirement income is much higher than for those with any chronic conditions.

FIGURE 5. MEDIAN SHARE OF SOCIAL SECURITY AND TOTAL INCOME REMAINING AFTER MEDICAL OOP SPENDING IN 2018, BY AGE



Source: Authors' calculations from HRS (2018).

FIGURE 6. MEDIAN SHARE OF SOCIAL SECURITY AND TOTAL INCOME REMAINING AFTER MEDICAL OOP SPENDING IN 2018, BY HEALTH STATUS

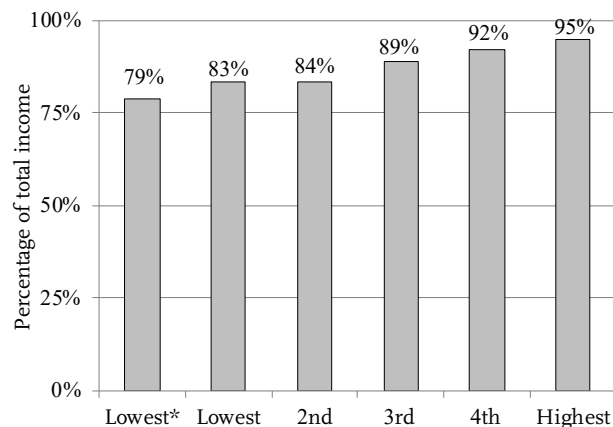


Note: "Chronic" means whether the respondent ever had a chronic condition.

Source: Authors' calculations from HRS (2018).

In terms of differences across the income distribution, the pattern is predictable – the share of income remaining after accounting for OOP costs rises with income (see Figure 7 on the next page). (The focus here is total income because of the relatively little variation in Social Security benefits.) The highest quintile has 95 percent of total income remaining,

FIGURE 7. MEDIAN SHARE OF TOTAL INCOME REMAINING AFTER MEDICAL OOP SPENDING IN 2018, BY HOUSEHOLD INCOME QUINTILE



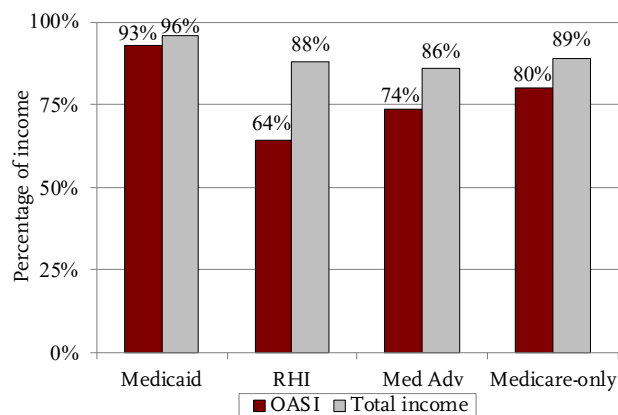
* Excludes Medicaid.

Source: Authors' calculations from HRS (2018).

even after accounting for income-related premium surcharges for Part B. The lowest quintile has 83 percent, in large part due to Medicaid. Excluding those who report Medicaid coverage (about half of the lowest quintile's sample), the share of income remaining after OOP spending is only 79 percent.

One final distinction with respect to OOP spending is the type of supplemental insurance retirees have (see Figure 8).¹⁰ Medicaid enrollees have

FIGURE 8. MEDIAN SHARE OF SOCIAL SECURITY AND TOTAL INCOME REMAINING AFTER MEDICAL OOP SPENDING IN 2018, BY SUPPLEMENTAL INSURANCE



Source: Authors' calculations from HRS (2018).

the highest share of income – both Social Security and total – remaining after OOP spending, which is to be expected given that Medicaid often has no premiums and minimal cost sharing. Among the other groups, it is helpful to look by source of income separately. With respect to Social Security, surprisingly, those with only Medicare appear to do the best, at least for the median retiree, followed by those with Medicare Advantage and those with RHI. These differences are due entirely to premiums. All three groups have similar Social Security income and spend a similar amount on cost sharing and uncovered services, but those with Medicare only pay no premiums for supplemental insurance.¹¹ As a share of total income, all four groups have much more similar post-OOP income available. Respondents with RHI have much higher total incomes in retirement, and only about half of the average RHI enrollee's income comes from Social Security; as a result, the share remaining after OOP increases to 88 percent.

Conclusion

This study shows that, at the median, OOP medical costs – including premiums, cost-sharing, and uncovered services (excluding long-term care) – leave only 75 percent of Social Security benefits available for spending on other items. Premiums for Medicare Parts B and D, Medicare Advantage, and supplemental plans (including retiree health insurance) make up the lion's share of medical spending for most retirees, except those with the highest spending. The share of income remaining after OOP spending is lower for women and those in low-income households. With OOP health expenditures eating away at retirement income, and Part B premiums on the rise, it is understandable why many retirees likely feel that making ends meet is difficult.¹²

Endnotes

1 McInerney, Rutledge, and King (2017). This original study also includes an analysis of trends in the burden of OOP spending.

2 For example, the U.S. Census Bureau's Supplemental Poverty Measure examines family income net of medical spending, because OOP medical costs are assumed to be non-discretionary (Renwick and Fox 2016).

3 Belbase, Chen, and Munnell (2021) explore the burden of long-term care costs. McInerney, Rutledge, and King (2017) feature supplemental analysis that includes long-term care, and the results are qualitatively similar.

4 Cubanski et al. (2014a); Neuman et al. (2007); Noel-Miller (2015); and Akincigil and Zurlo (2015).

5 About 21 percent of Medicare beneficiaries buy private supplemental coverage through Medigap (Koma, Cubanski, and Neuman 2021), but recent waves of the HRS (including 2018) do not ask explicitly about Medigap coverage, so it is not included in the analysis by supplemental insurance category.

6 Akincigil and Zurlo (2015); Cubanski et al. (2014a); Neuman et al. (2007); and Noel-Miller (2015).

7 Specifically, the HRS asks whether the respondent currently has difficulty with six ADLs: walking across a room, getting dressed, eating, bathing oneself, using the bathroom, and getting into/out of bed.

8 Possible chronic health conditions include cancer, lung disease, stroke, heart problem, diabetes, and high blood pressure.

9 Because this measure subtracts OOP spending from Social Security benefits, someone spending at the 95th percentile in Figure 1 will end up with very little net income, putting them around the 5th percentile of the distribution of retirees by post-OOP income in Figure 2. Similarly, the 90th percentile from Figure 1 roughly corresponds to the 10th percentile in Figure 2, as long as the distribution of Social Security income is not too skewed.

10 The 31 percent of the sample who report supplemental coverage other than Medicaid, RHI, or Medicare Advantage are not included as a separate group in this figure because they are heterogeneous. They range from individuals with low-cost TRICARE plans to those with self-purchased Medigap plans that carry high premiums.

11 This premium burden is in line with Cubanski et al. (2014b), who found that respondents in the *Medicare Current Beneficiary Survey* with RHI supplementing their Medicare coverage spent half of their OOP spending on premiums in 2010. Retirees with no supplemental coverage still face the cost of Medicare Part B and D premiums.

12 On top of medical spending, retirees face a substantial amount of other non-discretionary costs. Farrell and Greig (2017) find that housing expenses, taxes, and non-housing debt consume about 30 percent of retirees' household income, leaving even less for surprise expenses and any other desired spending.

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