BETTER MEDICARE
ALLIANCE

POLICY BRIEF · 2026

Medicare Beneficiary Spending

Average out-of-pocket spending increased for both Medicare Advantage and Fee-for-Service Medicare Enrollees in 2023, and the gap between the two programs continues to grow. In addition to having lower average out-of-pocket costs, Medicare Advantage enrollees reported similar levels of satisfaction with access to and quality of care as Fee-for-Service enrollees and were 15 percent more likely to report having had an annual wellness visit.

Better Medicare Alliance
July 2026

BACKGROUND AND CONTEXT

Out of the 64.1 million individuals enrolled in Medicare Part A and B in February 2026, 56 percent, or 35.8 million beneficiaries, received their healthcare coverage through Medicare Advantage.[1] Beneficiaries could choose from an average of 42 Medicare Advantage plans available in their county in 2026.[2] Medicare Advantage organizations manage cost, service utilization, and quality performance through benefit, premium, cost sharing, and utilization management strategies.[3] Most Medicare Advantage organizations offer additional benefits not included in Fee-for-Service Medicare, such as vision, dental, and hearing, and many do not charge a premium beyond the standard Medicare Part B premium.[4]

The Medicare Advantage program limits annual enrollee out-of-pocket costs with out-of-pocket spending caps required in Medicare Advantage that do not exist in Fee-for-Service. In addition, Medicare Advantage organizations may set deductibles or cost-sharing amounts that differ from Fee-for-Service Medicare. These may be higher or lower for a given service but must be actuarially equivalent in the aggregate.[5] Medicare Advantage organizations can also deploy utilization management strategies that individuals enrolled in Fee-for-Service are not typically subject to, including prior authorization for items and services, and which are designed to help determine medical necessity, manage risk, and deliver high-value care.

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[1] ATI Advisory Analysis of CMS Medicare Monthly Enrollment File for February 2026

[2] ATI Advisory Analysis of data from PY2026 Landscape Files. A plan is the combination of a Contract ID, Plan ID, and Segment ID. Excludes EGWPs, Cost, PACE, and Sanctioned Plans. Analysis includes all 50 states, Washington D.C., and Puerto Rico.

[3] "Compare Original Medicare & Medicare Advantage." *Medicare.gov*. https://www.medicare.gov/basics/get-started-with-medicare/get-more-coverage/your-coverage-options/compare-original-medicare-medicare-advantage

[4] Ochieng, N., Fuglesten Biniek, J., Freed, M., Damico, A., & Neuman, T. (August 9, 2023). "Medicare Advantage in 2023: Premiums, Out-of-Pocket Limits, Cost Sharing, Supplemental Benefits, Prior Authorization, and Star Ratings." *Kaiser Family Foundation*. https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2023-premiums-out-of-pocket-limits-cost-sharing-supplemental-benefits-prior-authorization-and-star-ratings/

[5] "Compare Original Medicare & Medicare Advantage." *Medicare.gov*. https://www.medicare.gov/basics/get-started-with-medicare/get-more-coverage/your-coverage-options/compare-original-medicare-medicare-advantage

Beyond Medicare Advantage, supplemental sources of healthcare coverage for Medicare beneficiaries include employer-sponsored insurance (ESI) plans, Medicaid, and Medigap (only Fee-for-Service beneficiaries are permitted to participate in Medigap). In 2023, 15 percent of Medicare Fee-for-Service enrollees in the community had no supplemental coverage.[6] Thirty-seven percent of Fee-for-Service Medicare enrollees had Medicare and ESI, while 38 percent had Medicare and Medigap.[7] Among Medicare Advantage beneficiaries, around 64 percent were enrolled in Medicare Advantage only in 2023, while the remaining individuals were also enrolled in Medicaid and/or ESI. [8]

The Better Medicare Alliance engaged ATI Advisory to analyze Medicare beneficiary demographics and the total out-of-pocket healthcare spending for beneficiaries (including supplemental coverage premiums), along with their related cost burden and experience with healthcare access and quality. The analysis uses Medicare Current Beneficiary Survey (MCBS) data and compares community-dwelling[9] Medicare Advantage and Fee-for-Service Medicare enrollees' average annual individual out-of-pocket healthcare spending for 2023[10] (inclusive of supplemental plan premiums and cost sharing) by income, race and ethnicity, number of chronic conditions, and geography. The goal is to understand beneficiary characteristics and experiences with financial liability and access to care. This analysis does not examine the specific financial impact of utilization management or other policies that Medicare Advantage organizations leverage to manage service use. This analysis also provides information on beneficiaries' perception of their access to certain types of services, such as annual wellness visits, where possible.

[6] ATI Advisory Analysis of 2023 Master Beneficiary Summary File

[7] ATI Advisory Analysis of 2023 Master Beneficiary Summary File

[8] ATI Advisory Analysis of 2023 Master Beneficiary Summary File

[9] Community-dwelling individuals are defined as individuals who live in community settings, such as a home, rather than an institutional or facility settings, such as a nursing home or assisted living.

[10] This analysis uses the most recent data available at the time of publication.

All comparisons of Medicare Advantage and Fee-for-Service Medicare populations within a given year in this report were tested for statistical significance at the 5 percent level (with a p-value less than 0.05). Data meeting this criterion for statistical significance are marked with an asterisk (*) in the figures. In this brief, ATI expands on previous years' analyses by introducing propensity score weighting for 2021, 2022, and 2023 out-of-pocket spending and cost burden comparisons. Medicare Advantage and Fee-for-Service populations differ significantly on key characteristics that can affect out-of-pocket costs. ATI employed propensity score weighting to create balanced groups of enrollees in Medicare Advantage and Fee-for-Service across demographic, socioeconomic, health, and functional status factors.

Balancing the populations on these key characteristics via propensity score weighting allows the analysis to control for inherent differences (or confounders) that could affect differences in out-of-pocket costs between the two groups. This allows a more rigorous conclusion regarding the impact of Medicare Advantage on out-of-pocket costs than survey-weighted analyses alone. All averages derived from propensity score weighting analysis are model-adjusted averages that account for confounders, reflecting the full Medicare population's predicted average beneficiary spending.

ATI also conducted a survey-weighted regression analysis as a sensitivity check, which confirmed the direction and magnitude of findings under the propensity score weighting. Bivariate analyses were used for variables other than out-of-pocket spending and cost burden, including proportions of beneficiaries in geographic, race/ethnicity, and income categories, as well as self-rated health, access to care, and quality of care measures. See the Methods section for more details.

Summary

In 2023, community-dwelling Medicare Advantage enrollees spent an average of $2,824 (36 percent) less on out-of-pocket healthcare costs than Fee-for-Service Medicare enrollees, a gap that widened by 16 percent from 2022 to 2023. This spending advantage persisted across racial and ethnic groups, rural-urban geographies, dual eligible statuses, and chronic condition burden.

Medicare Advantage and Fee-for-Service Medicare serve beneficiaries with meaningfully different income profiles. Approximately 54 percent of Medicare Advantage enrollees reported incomes below 200 percent of the Federal Poverty Level (FPL)[11], compared to 30 percent of Fee-for-Service enrollees. Despite this, Medicare Advantage enrollees were less likely to experience cost burden (defined as spending more than 20 percent of income on healthcare), with rates of 12 percent in Medicare Advantage versus 24 percent in Fee-for-Service. Among low-income beneficiaries (below 200 percent FPL), cost burden rates were 21 percent in Medicare Advantage versus 40 percent in Fee-for-Service.

Despite having higher out-of-pocket costs, Fee-for-Service Medicare enrollees reported higher levels of self-rated health than the levels reported by Medicare Advantage enrollees. Medicare Advantage enrollees not only spent less out-of-pocket on average but also reported similar levels of satisfaction with care access and quality as Fee-for-Service enrollees and were 15 percent more likely to have had an annual wellness visit.

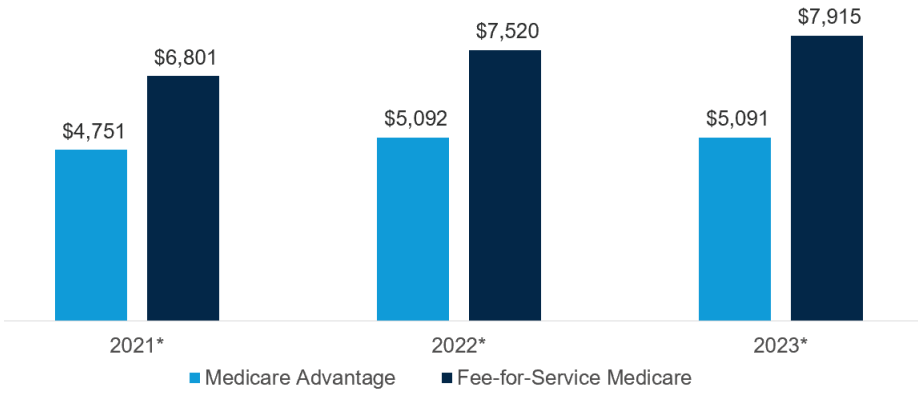
FINDINGS

MEDICARE ADVANTAGE ENROLLEES SPENT LESS ON HEALTHCARE THAN FEE-FOR-SERVICE MEDICARE ENROLLEES

In 2023, Medicare Advantage enrollees spent an average of $2,824 (36 percent) less on out-of-pocket healthcare costs than Fee-for-Service Medicare enrollees, as shown in Figure 1. From 2022 to 2023, the average out-of-pocket healthcare spending for individuals living in the community remained roughly flat for Medicare Advantage enrollees and increased for Fee-for-Service enrollees by 5 percent. The difference in average out-of-pocket healthcare spending in Medicare Advantage and Fee-for-Service Medicare increased by $396, or 16 percent, from 2022 and 2023.

[11] Based on the HHS 2023 Poverty Guidelines, the FPL for 2023 in 48 states and DC (excluding Alaska and Hawaii) was $14,580 for a one-person family/household.

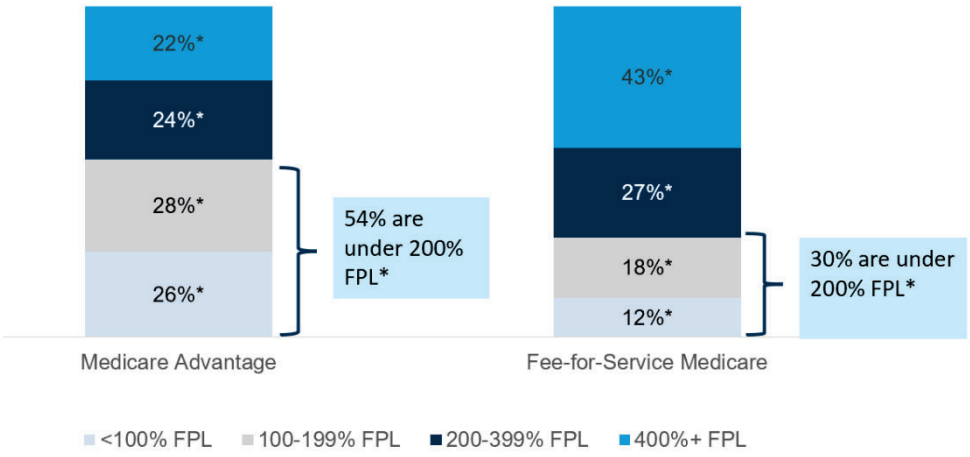
FIGURE 1: AVERAGE OUT-OF-POCKET HEALTHCARE SPENDING AMONG MEDICARE BENEFICIARIES FROM 2021 TO 2023, BY PROGRAM (PROPENSITY SCORE–WEIGHTED)



INDIVIDUALS IN MEDICARE ADVANTAGE WERE MORE LIKELY TO REPORT LOWER INCOMES COMPARED TO THOSE IN FEE-FOR-SERVICE MEDICARE

The distribution of Medicare enrollees by income as a percentage of the FPL varied significantly between the Medicare Advantage and Fee-for-Service Medicare programs in 2023. The portion of Medicare beneficiaries by income in Medicare Advantage is distributed evenly across the four income brackets, compared to Fee-for-Service Medicare in which beneficiaries are distributed more towards the higher income brackets. Medicare Advantage enrollees are 48 percent less likely to report incomes at or above 400 percent FPL compared to Fee-for-Service Medicare enrollees. More than half (54 percent) of Medicare Advantage enrollees reported income under 200 percent FPL, compared to about 30 percent of Fee-for-Service Medicare enrollees, as shown in Figure 2.

FIGURE 2: DISTRIBUTION OF MEDICARE BENEFICIARIES BY INCOME AS A PERCENT OF THE FPL, 2023 (BIVARIATE ANALYSIS)

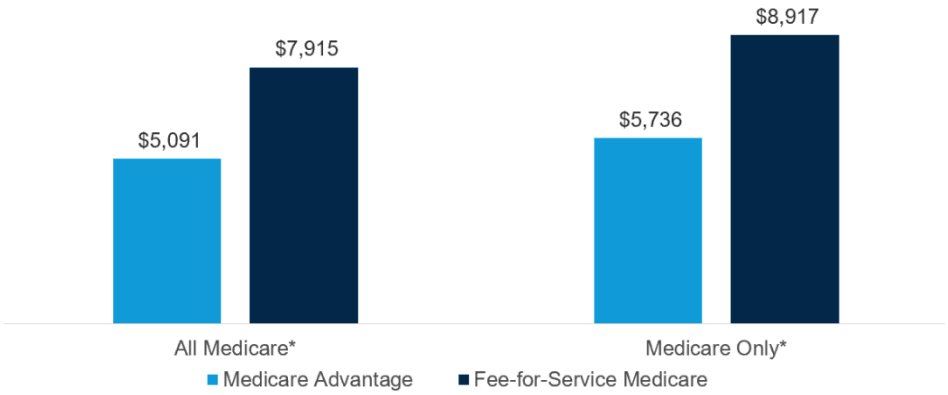


Individuals dually eligible for Medicare and Medicaid are more likely to enroll in Medicare Advantage than Fee-for-Service Medicare compared to individuals who have Medicare only. Sixty-seven percent of full and partial dual eligible beneficiaries chose Medicare Advantage compared to 48 percent of Medicare-only beneficiaries in December 2025.[12] Medicaid covers substantial healthcare costs for dual eligible beneficiaries. ATI adjusted for dual status (Medicare-only, partial dual, and full dual) in both the propensity score weighted and survey-weighted multivariable regression models to account for the potential impact of Medicaid on dual eligible beneficiaries' spending. Out-of-pocket spending among Medicare Advantage enrollees remained lower than Fee-for-Service Medicare enrollees, even in analyses adjusted for dual status. Among Medicare-only individuals, the 2023 average out-of-pocket healthcare spending in Medicare Advantage was $5,736 compared to $8,917 in Fee-for-Service Medicare (Figure 3).

FIGURE 3: AVERAGE OUT-OF-POCKET HEALTHCARE EXPENSES AMONG ALL MEDICARE BENEFICIARIES (INCLUSIVE OF DUAL ELIGIBLE BENEFICIARIES) AND MEDICARE-ONLY

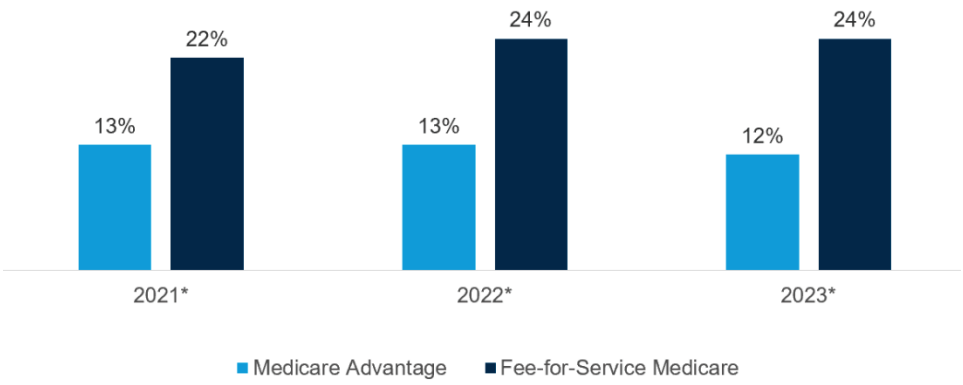
[12] ATI Advisory Analysis of Medicare Master Beneficiary Summary File, December 2025

BENEFICIARIES (NON-DUAL ELIGIBLE BENEFICIARIES ONLY), BY PROGRAM, 2023 (PROPENSITY SCORE–WEIGHTED)



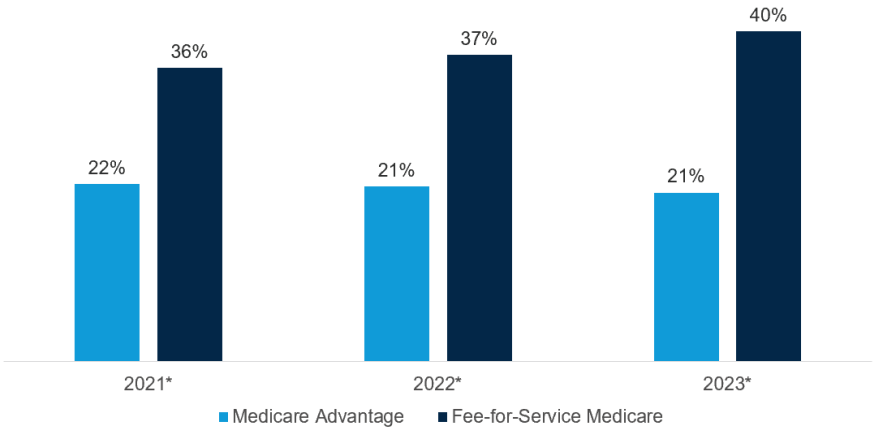
A lower percent of Medicare Advantage enrollees experienced being cost burdened by healthcare expenses than enrollees in Fee-for-Service Medicare. In this report, we define the presence of "cost burden" as spending over 20 percent of one's income on healthcare, such as out-of-pocket costs and premiums (refer to Variable Definitions on page 14 for more details). In 2023, 12 percent of Medicare Advantage enrollees experienced cost burden while 24 percent of Fee-for-Service enrollees experienced cost burden, as shown in Figure 4. This lower cost burden in Medicare Advantage trend holds true across Medicare-only as well as full and partial dual eligible statuses.

FIGURE 4: PERCENTAGE OF MEDICARE BENEFICIARIES WHO EXPERIENCE COST BURDEN FROM HEALTHCARE EXPENSES FROM 2021 TO 2023, BY PROGRAM (PROPENSITY SCORE–WEIGHTED)



As shown in Figure 5, the rate of cost burden by healthcare expenses was also lower among Medicare Advantage enrollees than Fee-for-Service Medicare enrollees when restricted to Medicare beneficiaries who reported incomes less than 200 percent of the FPL. Twenty-one percent of Medicare Advantage enrollees who reported incomes less than 200 percent of the FPL experienced cost burden by their healthcare expenses in 2023 compared to 40 percent of Fee-for-Service Medicare enrollees.

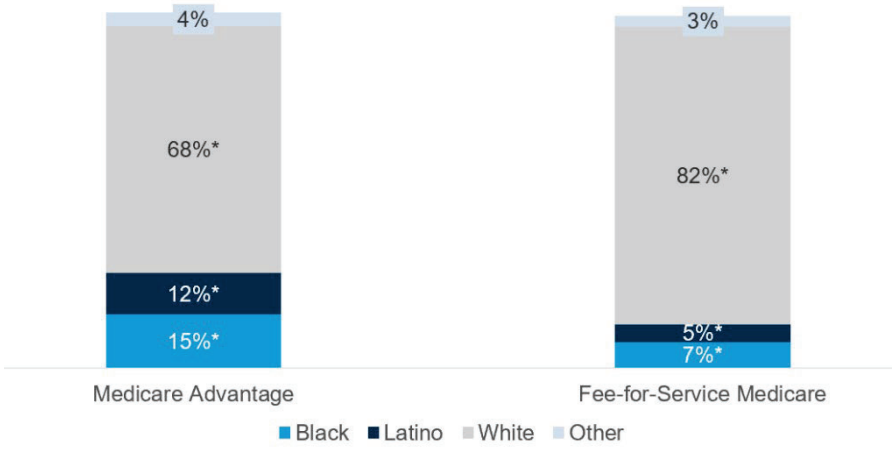
FIGURE 5: PERCENTAGE OF BENEFICIARIES WITH REPORTED INCOMES LESS THAN 200 PERCENT OF THE FPL WHO EXPERIENCE COST BURDEN FROM HEALTHCARE EXPENSES FROM 2021 TO 2023, BY PROGRAM (PROPENSITY SCORE–WEIGHTED)



LOWER OUT-OF-POCKET HEALTHCARE SPENDING IN THE MEDICARE ADVANTAGE PROGRAM HOLDS ACROSS RACIAL AND ETHNIC GROUPS

In 2023, Black and Latino enrollees made up 27 percent of the Medicare Advantage population and 12 percent of the Fee-for-Service population, as shown in Figure 6.

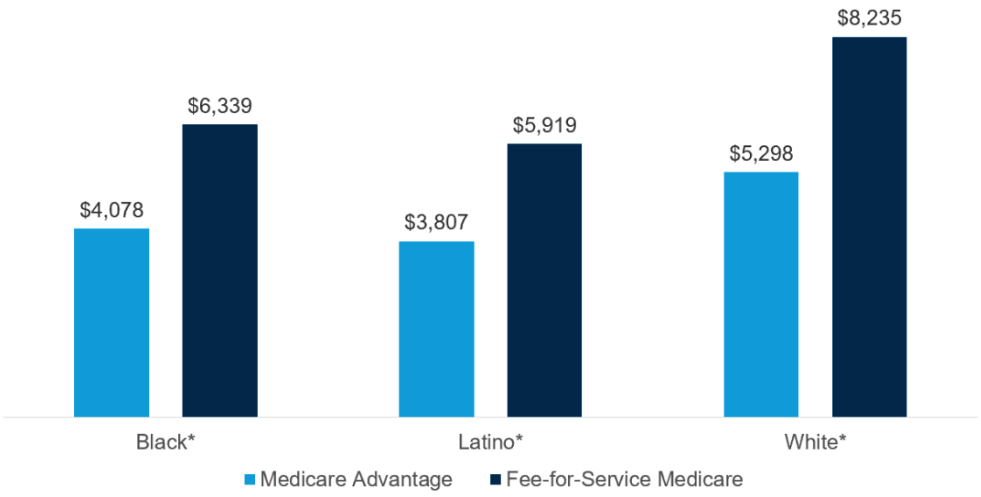
FIGURE 6: RACE/ETHNICITY OF MEDICARE BENEFICIARIES, BY PROGRAM, 2023 (BIVARIATE ANALYSIS)



Due to sample size, spending data on beneficiaries identifying as Asian, North American Native, or Other is not available and not shown.

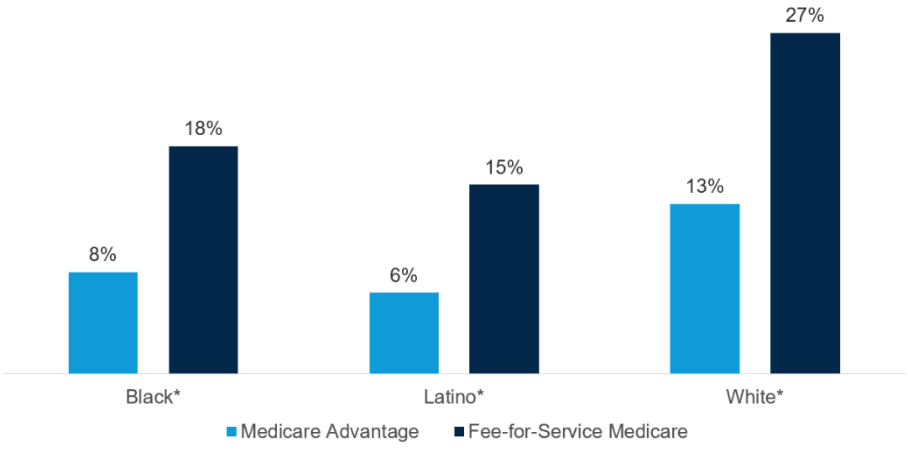
Out-of-pocket healthcare spending varied by race and ethnicity between the two programs in 2023, as shown in Figure 7. Among Black, Latino, and white beneficiaries, white beneficiaries had the highest out-of-pocket spending in both programs, while Latino beneficiaries had the lowest out-of-pocket spending in both programs. Within each race and ethnicity category, out-of-pocket spending for Medicare Advantage enrollees was lower than for Fee-for-Service Medicare enrollees. This aligns with consistently higher average out-of-pocket spending in the Fee-for-Service program compared to Medicare Advantage.

FIGURE 7: AVERAGE OUT-OF-POCKET HEALTHCARE SPENDING AMONG MEDICARE BENEFICIARIES, BY RACE AND ETHNICITY AND PROGRAM, 2023 (PROPENSITY SCORE–WEIGHTED)



Rates of cost burden were lower in Medicare Advantage across Black, Latino, and white beneficiaries. The largest gap was for white beneficiaries, where 13 percent of Medicare Advantage enrollees experienced cost burden compared to 27 percent of Fee-for-Service enrollees. Black and Latino beneficiaries had smaller gaps, as shown in Figure 8.

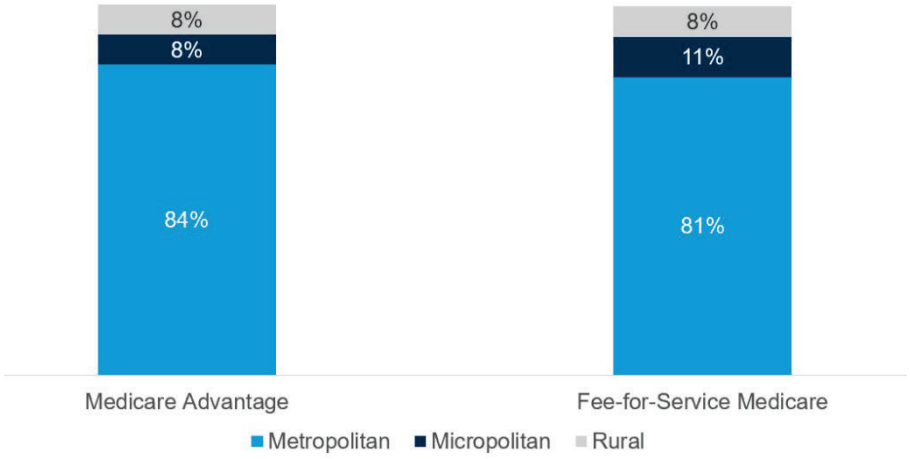
FIGURE 8: PERCENT OF MEDICARE BENEFICIARIES WHO EXPERIENCE COST BURDEN FROM HEALTHCARE EXPENSES, BY RACE AND ETHNICITY AND PROGRAM, 2023 (PROPENSITY SCORE–WEIGHTED)



LOWER OUT-OF-POCKET HEALTHCARE SPENDING IN THE MEDICARE ADVANTAGE PROGRAM HOLDS ACROSS RURAL-URBAN GEOGRAPHIC CATEGORIES

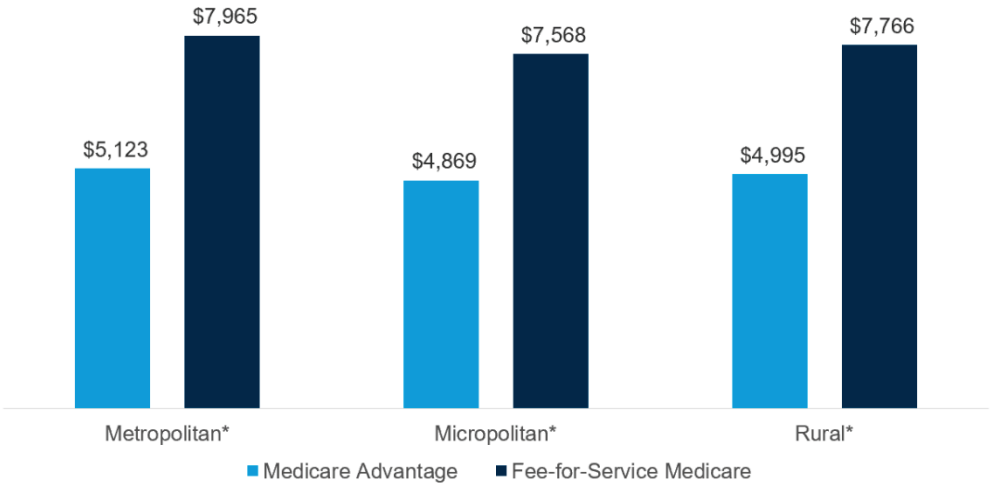
The distribution of beneficiaries living in metropolitan, micropolitan or rural areas did not vary significantly between the Medicare Advantage and Fee-for-Service Medicare programs in 2023, as shown in Figure 9. The majority of enrollees in both Medicare Advantage and Fee-for-Service Medicare (84 percent and 81 percent, respectively) reported living in metropolitan areas compared to micropolitan (8 percent Medicare Advantage versus 11 percent Fee-for-Service) and rural (8 percent in both programs) (refer to Variable Definitions on page 14 for more details on metropolitan, micropolitan, and rural designations).

FIGURE 9: GEOGRAPHY OF MEDICARE BENEFICIARIES, BY PROGRAM, 2023 (BIVARIATE ANALYSIS)



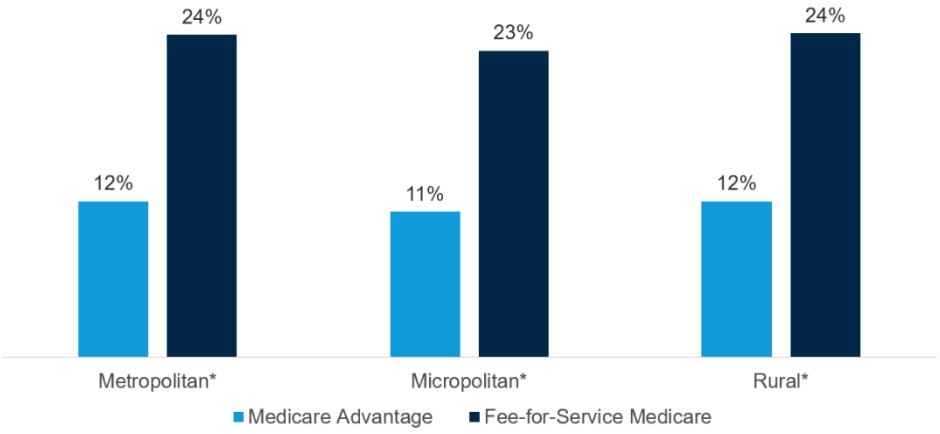
Across geographic categories in 2023, enrollees in Medicare Advantage had lower average out-of-pocket healthcare spending compared to those in Medicare Advantage (Figure 10).

FIGURE 10: AVERAGE OUT-OF-POCKET HEALTHCARE SPENDING AMONG MEDICARE BENEFICIARIES BY GEOGRAPHY, BY PROGRAM, 2023 (PROPENSITY SCORE–WEIGHTED)



In 2023, the difference in the percentage of beneficiaries who experience cost burden between Medicare Advantage and Fee-for-Service Medicare is greater in metropolitan and rural areas than in micropolitan areas, as shown in Figure 11. Fee-for-Service Medicare enrollees are about twice as likely to experience cost burden than Medicare Advantage enrollees regardless of whether they live in a metropolitan, micropolitan, or rural area.

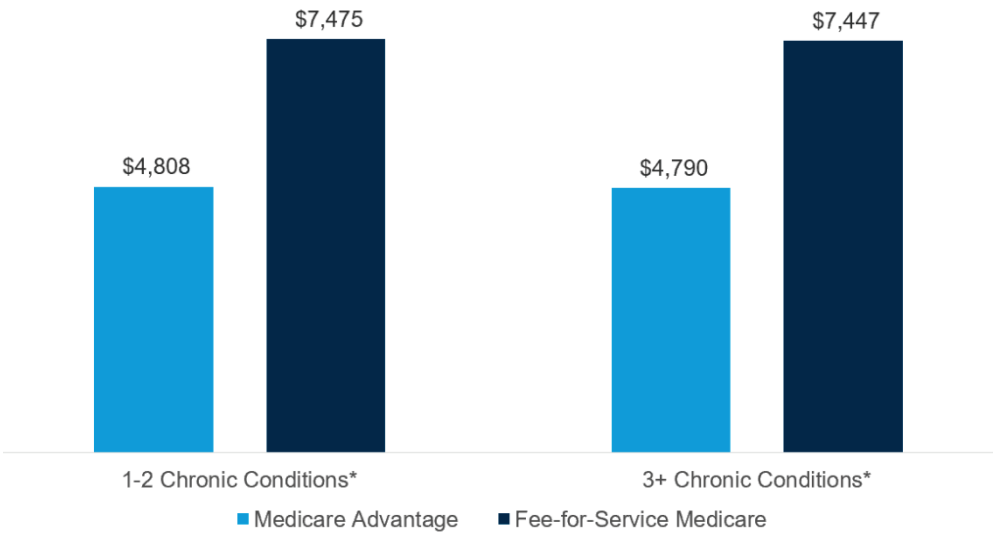
FIGURE 11: PERCENTAGE OF MEDICARE BENEFICIARIES WHO EXPERIENCE COST BURDEN FROM HEALTHCARE EXPENSES, BY GEOGRAPHY AND PROGRAM, 2023 (PROPENSITY SCORE–WEIGHTED)



LOWER OUT-OF-POCKET HEALTHCARE SPENDING IN THE MEDICARE ADVANTAGE PROGRAM HOLDS ACROSS NUMBER OF CHRONIC CONDITIONS

Seventy-five percent of Medicare Advantage enrollees reported 3+ chronic conditions, compared to 70 percent of Fee-for-Service Medicare enrollees in 2023 (data not shown). Among beneficiaries reporting 1-2 chronic conditions, Medicare Advantage enrollees spent an average of $2,666 less on out-of-pocket healthcare expenses annually than Fee-for-Service Medicare enrollees, as shown in Figure 12. Among beneficiaries with 3+ chronic conditions, Medicare Advantage enrollees had $2,656 less in out-of-pocket healthcare spending compared to Fee-for-Service Medicare enrollees.

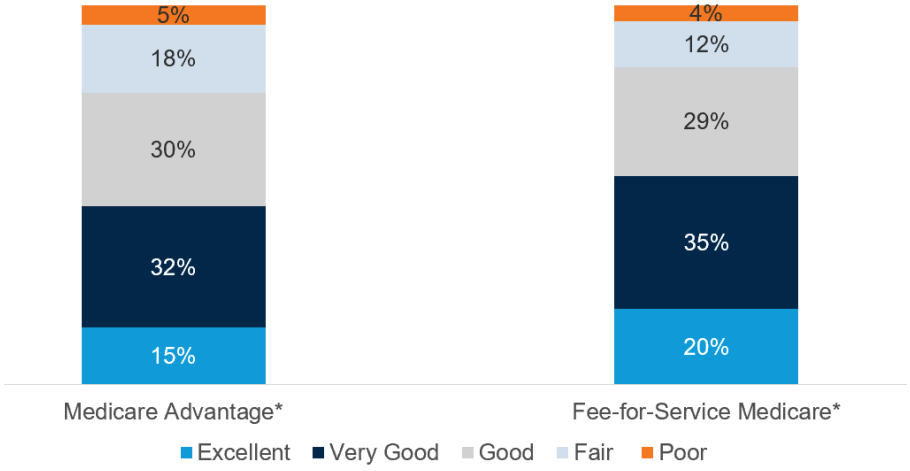
FIGURE 12: AVERAGE OUT-OF-POCKET HEALTHCARE SPENDING AMONG MEDICARE BENEFICIARIES BY NUMBER OF CHRONIC CONDITIONS, BY PROGRAM, 2023 (PROPENSITY SCORE–WEIGHTED)



MEDICARE ADVANTAGE ENROLLEES WERE LESS LIKELY TO REPORT HIGHER RATED HEALTH THAN FEE-FOR-SERVICE MEDICARE ENROLLEES

As shown in Figure 13, a smaller portion of Medicare Advantage enrollees reported very good or excellent health compared to Fee-for-Service Medicare enrollees. Forty-seven percent of Medicare Advantage enrollees reported very good or excellent health in 2023, compared to 55 percent of Fee-for-Service enrollees. Additionally, Medicare Advantage enrollees were 43 percent more likely to report Fair or Poor health compared to Fee-for-Service Medicare enrollees.

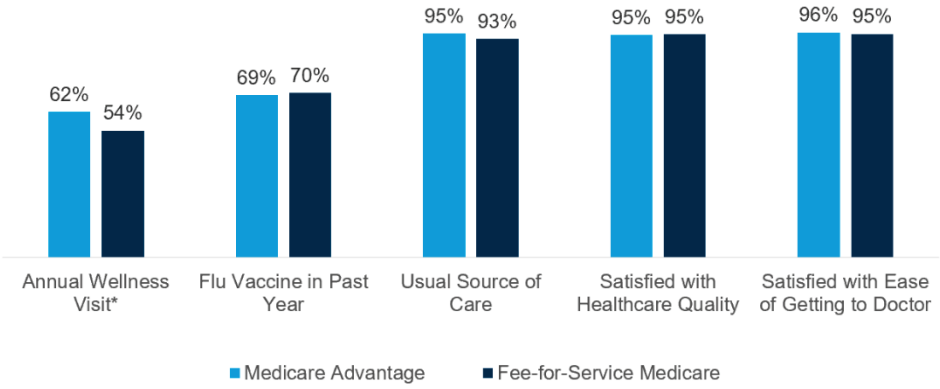
FIGURE 13: SELF-RATED HEALTH OF MEDICARE BENEFICIARIES, BY PROGRAM, 2023 (BIVARIATE ANALYSIS)



ACCESS TO AND QUALITY OF CARE WAS SIMILAR AMONG MEDICARE ADVANTAGE AND FEE-FOR-SERVICE MEDICARE ENROLLEES

Medicare Advantage and Fee-for-Service Medicare enrollees reported similar levels of access to and quality of care in 2023 through a variety of measures, as shown in Figure 14. Similar percentages of enrollees in both programs reported satisfaction with their ability to get to their doctor, having a usual source of care, being satisfied with the quality of healthcare they received, and having received a flu vaccine in 2023. However, rates of annual wellness visits differ between the programs, with Medicare Advantage enrollees being 15 percent more likely to report having an annual wellness visit compared to Fee-for-Service Medicare enrollees. This gap increased slightly in 2023 compared to 2022, when Medicare Advantage enrollees were 14 percent more likely to report an annual wellness visit compared to Fee-for-Service Medicare enrollees.

FIGURE 14: ACCESS TO CARE AND QUALITY OF CARE MEASURES AMONG MEDICARE BENEFICIARIES, BY PROGRAM, 2023 (BIVARIATE ANALYSIS)



CONCLUSION

In 2023, community-dwelling Medicare Advantage enrollees spent, on average, $2,824 less on out-of-pocket healthcare expenses than those in Fee-for-Service Medicare, a pattern consistent with data from 2021 and 2022. The spending differential between enrollees in Medicare Advantage and in Fee-for-Service Medicare continues to widen. These spending differences persist across race, ethnicity, dual eligible status, geography, and number of chronic conditions. Although over half of individuals in the Medicare Advantage program reported incomes under 200 percent of the FPL, among all Medicare enrollees, Medicare Advantage enrollees were 45 percent less likely to report experiencing cost burden from healthcare expenses compared to Fee-for-Service Medicare enrollees. Despite the lower spending in Medicare Advantage compared to Fee-for-Service Medicare, beneficiaries in both programs have similar levels of satisfaction with access to and quality of care received.

METHODS

DATA SOURCE

ATI Advisory conducted this analysis using the 2021 to 2023 MCBS and Cost Supplement files.

INCLUSION AND EXCLUSION CRITERIA

The analysis was filtered to community-dwelling Medicare beneficiaries because individuals residing in institutional facilities have more out-of-pocket spending focused on long-term services and supports, which are only covered under Medicaid if the beneficiary is dually enrolled. This makes isolating programmatic differences in spending between Medicare Advantage and Fee-for-Service more difficult. Additionally, the MCBS includes less cost data for the facility component. In 2023, 97.4 percent of Fee-for-Service Medicare enrollees and 97.9 percent of Medicare Advantage enrollees lived in the community.

In this analysis, Medicare Advantage enrollment is defined as at least one month of coverage under Medicare Advantage and related managed care types (including Medicare Advantage, Medicare-Medicaid Plans, Cost Plans, and Program of All-Inclusive Care for the Elderly [PACE]) during the study year using Centers for Medicare & Medicaid Services (CMS)-derived variables that describe Medicare managed care membership.

STATISTICAL SIGNIFICANCE AND WEIGHTING METHODOLOGY

Statistical significance was performed for figures and calculations of within-year comparisons between Medicare Advantage and Fee-for-Service Medicare at the five percent level (testing for a p-value less than 0.05). Asterisks (*) in figures mark statistically significant differences between individuals in Medicare Advantage and individuals in Fee-for-Service Medicare.

Because out-of-pocket spending is right-skewed and the residuals from an ordinary least squares model are unlikely to be homoscedastic, Fay's method of Balanced Repeated Replication (BRR) was used for variance estimation with a shrinkage factor of 0.30, in line with MCBS complex survey design recommendations.

As in prior years, bivariate analyses were conducted to compare Medicare Advantage and Fee-for-Service Medicare enrollees across various

sociodemographic characteristics. Bivariate analyses included chi-squared tests for categorical variables and t-tests for continuous variables.

Propensity scores were estimated using logistic regression with Medicare Advantage enrollment as the outcome and sex, age, chronic conditions, income, ADLs, dual status, cognitive impairment, and race as co-variates. Stabilized inverse probability weights were used to reduce the influence of extreme weights, and covariate balance after weighting was assessed using standardized mean differences, with a threshold of less than 0.1 indicating acceptable balance. Bivariate analysis (the methodology used in prior years' reports and adjusted through survey-weights only, not propensity scores) found that in 2023 Medicare Advantage enrollees' out of pocket costs were $3,769 (49 percent) less than Fee-for-Service enrollees' costs.

Year-over-year changes within and between programs were not tested for significance and solely reflect observational differences between annual point estimates.

This analysis is observational, and although ATI adjusted for measured confounders in regression and propensity score weighted analyses, results should not be interpreted as causal.

SENSITIVITY ANALYSIS

ATI conducted additional survey-weighted multivariable regression analyses as a sensitivity check to assess the robustness of the propensity score–weighted estimates of out-of-pocket spending differences between Medicare Advantage and Fee-for-Service Medicare. These models adjusted for year, income, sex, race, ethnicity, dual status, rural-urban geography, cognitive impairment, cancer, diabetes, chronic heart disease, chronic lung disease, chronic kidney disease, and stroke or AMI. Results from the sensitivity analyses were consistent with the propensity score–weighted findings, confirming the direction and magnitude of estimated differences in out-of-pocket costs between programs.

VARIABLE DEFINITIONS

Medicare-only Enrollees: Individuals with Medicare who are not enrolled in Medicaid or the Medicare Savings Program.

Out-of-Pocket Spending: Out-of-pocket spending includes beneficiary spending on premiums for Medicare Advantage, Fee-for-Service Medicare, and other health

insurance premiums, like Medigap plans or employer-sponsored insurance. Out-of-pocket spending also includes beneficiary spending toward the deductible and services that may not be covered by Medicare, for example, dental and vision. Out-of-pocket costs also include any beneficiary spending on office visits, inpatient care, outpatient care, prescription medications not fully covered by health insurance, and other healthcare expenses.

In the MCBS, healthcare costs are calculated from healthcare events, using receipts, explanations of benefits, and other resources to assess the full cost of services. For Fee-for-Service Medicare enrollees, the MCBS additionally uses Medicare claims to calculate healthcare costs. Further, the survey adjusts for likely underreporting of healthcare events among Medicare Advantage enrollees. For more details on how the MCBS collects beneficiary spending data, reference the data user guide.[13]

Income: Income is based on self-reported data collected by the MCBS. Data on all income sources including but not limited to income from employment, Social Security Income (SSI), and passive income are collated together into the "income" variable. Missing data may be supplemented/imputed using MCBS methodology.[14]

Cost Burden: ATI leverages income and spending data in the MCBS to calculate cost burden. This report defines the presence of “cost burden” as spending over 20 percent of one’s income on healthcare, such as out-of-pocket costs and premiums based on a commonly used definition.[15]

Chronic conditions: Chronic conditions are calculated as a count of positive responses to the MCBS survey question “Has a doctor ever told you that you have [condition]?” for the following twelve conditions: (1) Hypertension, (2) Hyperlipidemia, (3) CHF, (4) Other heart disease, (5) Stroke, (6) Cancer, (7)

[13] “2023 MCBS Data User’s Guide: Survey File Public Use File.” *CMS*. https://www.cms.gov/data-research/research/medicare-current-beneficiary-survey/data-documentation-codebooks/2023-mcbs-survey-file

[14] “2023 MCBS Methodology Report.” *CMS*. MCBS Methodology Report (year agnostic) | CMS

[15] Ochieng, N., Cubanski, J., and Damico, A. (March 14, 2024). “Medicare Households Spend More on Health Care Than Other Households.” *Kaiser Family Foundation*. https://www.kff.org/medicare/issue-brief/medicare-households-spend-more-on-health-care-than-other-households/

Arthritis, (8) Alzheimer's/Dementia, (9) Depression, (10) Osteoporosis, (11) Emphysema/asthma/COPD, and (12) Diabetes.

Race and Ethnicity: The MCBS codes race and ethnicity using the beneficiary race code historically used by the Social Security Administration and in CMS' enrollment database and applying the Research Triangle Institute (RTI) race code.[16]

Rural-Urban Geographic Categories: Geographic categories reflect ZIP-code level Rural-Urban Commuting Area (RUCA) codes. Metropolitan includes codes 1-3, micropolitan includes codes 4-6, and rural areas include codes 7-10 (including small towns and rural areas).

[16] "Research Triangle Institute (RTI) Race Code." *CMS ResDAC*. https://resdac.org/cms-data/variables/research-triangle-institute-rti-race-code