



AUGUST 2003

## Issue Brief

# Average Out-of-Pocket Health Care Costs for Medicare+Choice Enrollees Increase 10 Percent in 2003

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**M**edicare reform is one of the top issues on the domestic policy agenda, and the role of private plans in that reform is one of its critical dimensions. The Medicare experience with private plans has been principally through the Medicare+Choice (M+C) program.<sup>1</sup> M+C plans, primarily HMOs, receive capitated payments from Medicare and provide coverage for Medicare-covered services. To the extent that plans have any savings left over, they offer additional benefits as well. Because Medicare requires substantial cost-sharing by its beneficiaries and excludes coverage for important elements of care, such as prescription drugs, the extra benefits provided by M+C plans have played an important role in reducing the out-of-pocket liability of its enrollees. In the past few years, however, that role has been eroding.

The average Medicare enrollee in an M+C plan is spending about \$1,964 out-of-pocket this year, rising 10 percent from last year and doubling from four years ago. An M+C enrollee in relatively poor health spends considerably more—\$5,305—and has experienced an even greater increase over the past four years—140 percent. A new preferred provider organization (PPO) option was introduced this year on a demonstration basis. Out-of-pocket spending is substantially higher, on average, for those in PPO demonstration plans than for those in managed care plans authorized under the regular M+C program (\$2,884 versus \$1,964).

This issue brief provides data for 2003 on out-of-pocket spending by Medicare beneficiaries in M+C and other private plans, including the PPO demonstrations. It is part of an ongoing analysis of the experience of private plans in the M+C program and updates earlier Commonwealth Fund reports on this topic.<sup>2</sup> Those earlier analyses found that out-of-pocket spending by Medicare+Choice enrollees can be substantial and varies significantly by health status and supplemental coverage source.

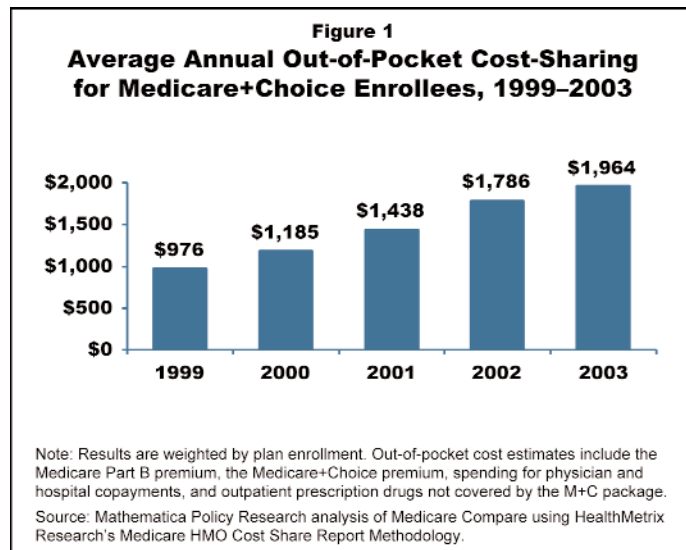
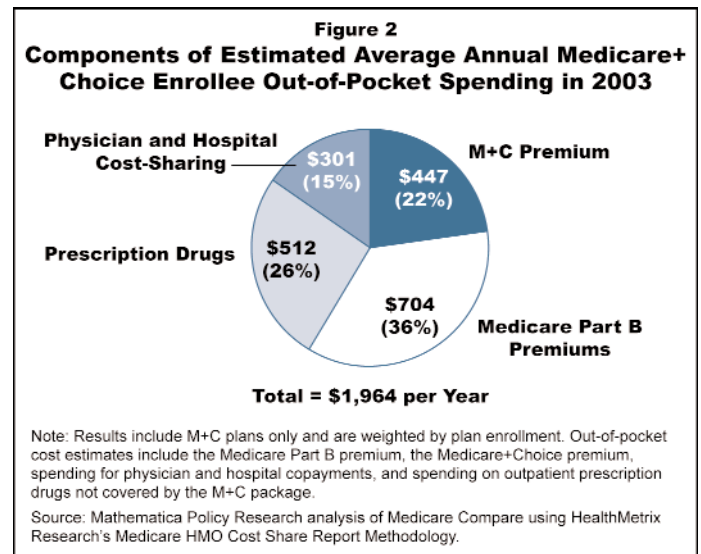
The analysis presented here uses the database that Mathematica Policy Research, Inc. (MPR), created from Medicare Compare, a consumer-oriented summary of benefits in Medicare+Choice plans. We licensed the methodology of HealthMetrix Research, Inc., which includes cost and utilization estimates, to approximate enrollee out-of-pocket costs across Medicare+Choice plans (see Methodology box on back page for further detail). The out-of-pocket cost estimates presented here include four components: (1) Medicare Part B premiums, which cover ambulatory care and related services; (2) supplemental Medicare+Choice premiums; (3) out-of-pocket spending on cost-sharing for physician and hospital services; and (4) out-of-pocket spending for outpatient prescription drugs that Medicare does not cover. The projections understate total out-of-pocket costs because they exclude cost-sharing for some services (e.g., mental health and rehabilitation) and for benefits typically not covered by standard medical insurance products (e.g., long-term care).

**Average Estimated Out-of-Pocket Costs**

In 2003, Medicare+Choice enrollees will pay an estimated \$1,964 in average out-of-pocket expenses for health care, 10 percent more than last year and twice as much as four years ago (Figure 1). By comparison, the average monthly Social Security payment increased just 12 percent over this same four-year period (Social Security Administration 2003 and Social Security Administration 2000).

The standard Medicare Part B premium,

which all beneficiaries pay regardless of the plan in which they are enrolled, is \$704 in 2003. In addition, the average Medicare+Choice enrollee pays \$447 for the M+C premium, \$301 for required physician and hospital cost-sharing, and \$512 for prescription drugs not covered by the M+C plan (Figure 2). Average M+C premiums in 2003 are 18 percent higher than in 2002 (the Medicare Part B premium increased 9 percent over 2003) (Table 1). In contrast, average spending for hospital and physician cost-sharing remained relatively constant from the year before, while out-of-pocket spending for drugs increased 11 percent.



**Out-of-Pocket Spending by Health Status, 2003**

In 2003, as in previous years, costs vary substantially among Medicare+Choice enrollees in good, fair, or poor health (Table 1). While the average Medicare+Choice enrollee in good health pays \$1,564 in 2003, an enrollee in fair health pays about \$2,696 and an enrollee in poor health pays \$5,305. This means that out-of-pocket spending for those in poor health is, on average, about 3.4 times higher than that of someone in good health. According to the 1999 Medicare Current Beneficiary Survey, 79 percent of Medicare M+C enrollees report that they are in at least good health, whereas 15 percent report being in fair health and 6 percent in poor health (Liu and Sharma 2003).

Disparities in out-of-pocket spending by health status are a function of the greater use of health services by those with health problems and of the cost-sharing structure of M+C plans. Medicare and Medicare+Choice

**Table 1. Average Annual Enrollee Out-of-Pocket Costs in M+C Plans, 1999–2003 (weighted by enrollment)**

	1999	2000	2001	2002	2003	Percent Change 2002–03	Percent Change 1999–2003
<b>Annual Part B Premium</b>	\$546.00	\$546.00	\$600.00	\$648.00	\$704.40	8.7%	29.0%
<b>Annual M+C Premium</b>	\$63.37	\$173.16	\$275.24	\$377.58	\$446.79	18.3%	605.0%
<b>Physician and Hospital Cost-Sharing</b>							
All	\$132.08	\$174.42	\$218.74	\$299.89	\$301.04	0.4%	127.9%
Good Health	\$117.08	\$142.99	\$161.57	\$190.19	\$177.81	-6.5%	51.9%
Fair Health	\$159.41	\$244.49	\$356.02	\$582.15	\$622.84	7.0%	290.7%
Poor Health	\$257.81	\$405.23	\$613.84	\$1,010.29	\$1,086.98	7.6%	321.6%
<b>Rx Cost-Sharing</b>							
All	\$234.19	\$291.75	\$344.02	\$460.72	\$511.99	11.1%	118.6%
Good Health	\$109.74	\$135.09	\$157.71	\$213.79	\$235.48	10.1%	114.6%
Fair Health	\$434.61	\$539.69	\$610.88	\$824.69	\$921.67	11.8%	112.1%
Poor Health	\$1,343.62	\$1,699.25	\$2,088.98	\$2,747.28	\$3,067.11	11.6%	128.3%
<b>Total Annual Cost-Sharing</b>							
All	\$975.64	\$1,185.33	\$1,438.00	\$1,786.19	\$1,964.21	10.0%	101.3%
Good Health	\$836.19	\$997.24	\$1,194.52	\$1,429.56	\$1,564.48	9.4%	87.1%
Fair Health	\$1,203.39	\$1,503.34	\$1,842.14	\$2,432.41	\$2,695.70	10.8%	124.0%
Poor Health	\$2,210.80	\$2,823.64	\$3,578.06	\$4,783.15	\$5,305.28	10.9%	140.0%
<b>Total Cost Ratio for Poor to Good Health</b>							
	2.64	2.83	3.00	3.35	3.39		

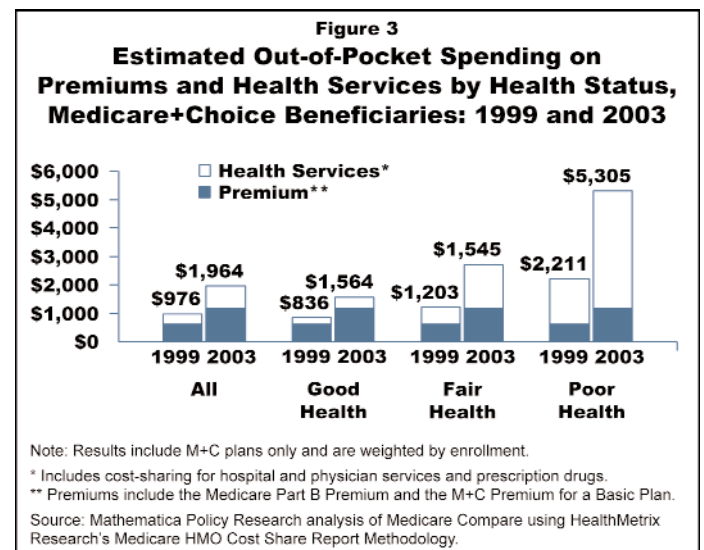
Note: The “all” estimates represent the average beneficiary using the reported health status of Medicare HMO enrollees in the 1999 Medicare Current Beneficiary Survey (MCBS). According to the MCBS, 79 percent of Medicare HMO enrollees report at least good health, 15 percent report fair health, and 6 percent report poor health (Liu and Sharma 2003).

Source: Mathematica Policy Research analysis of Medicare Compare using HealthMetrix Research’s Medicare HMO Cost Share Report Methodology.

premiums are community-rated, so that enrollees all pay the same premiums regardless of health status. The greater the share of out-of-pocket costs accounted for by premiums, the less inequality in out-of-pocket spending by health status there will be. The greater the share of the out-of-pocket costs excluded from the premium and attached to services used primarily by those in poor health, such as hospital care and home health care, the more inequality in out-of-pocket spending by health status there will be.

Premiums (for Medicare Part B and for the M+C plan) averaged \$1,151 per year in 2003, regardless of an enrollee’s health status. This amount constitutes almost three-quarters (74%) of overall out-of-pocket spending for those in good health, but only 43 percent of spending for those in fair health and less than a quarter for those in poor health (Figure 3). A beneficiary enrolled in an M+C plan who is in good health will pay an average of \$178 out-of-pocket for physician and hospital cost-sharing, whereas a beneficiary in poor health will pay \$1,087 on average, or more than five times as much. The disparity

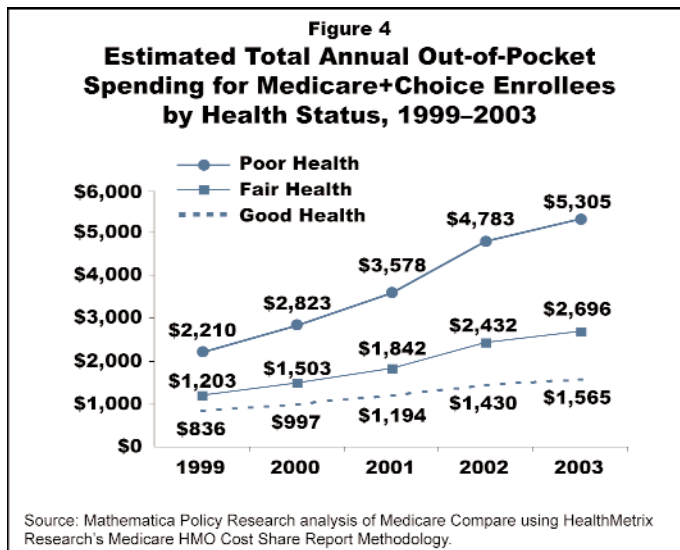
in spending for outpatient prescription drugs is even greater. Since 1999, Medicare+Choice plans have been cutting benefits. The growth in cost-sharing requirements in M+C has required more and more out-of-pocket spending by enrollees with health problems, and these expenditures account for an increased share of these enrollees’ out-of-pocket expenses. As a result,



Medicare beneficiaries, particularly those with health problems, are less protected financially even though they are paying higher premiums than in the past.

### Trends in Out-of-Pocket Costs by Health Status

Since 1999, the disparity in out-of-pocket spending by health status has been growing (Figure 4). While estimated average spending was 2.6 times higher for those in poor health than for those in good health in 1999, it is 3.4 times higher in 2003 (Table 1). The disparity grew rapidly between 2001 and 2002, but remained relatively constant between 2002 and 2003. However, the estimates developed here may lack the sensitivity to detect the effects of subtle changes in benefits.



In 2003, estimated out-of-pocket spending for prescription drugs will grow 10 percent for individuals in good health, compared with 12 percent for those in fair or poor health. Many plans had already imposed tight dollar limits on drug benefits in 2002, so that plans' shifting to cover generic drugs only is the main vehicle for further reductions in coverage in 2003 (Achman and Gold 2002, 2003). Such reductions keep plan premiums down but mean greater out-of-pocket spending on drugs by enrollees. The model may underestimate differentials in cost-sharing by health status because the estimates assume that health status affects the number of prescriptions, but not necessarily the average unit price or mix of drugs.<sup>3</sup> Therefore, the drugs used by individuals in poor health are assumed to be no more expensive than those used by individuals in good health.

Increases in out-of-pocket prescription drug costs from 2002 to 2003 were proportionally similar for all M+C enrollees, regardless of their health status. By comparison, out-of-pocket costs for physician and hospital services increased or decreased from 2002, depending on health status. Average spending for physician and hospital cost-sharing for an enrollee in good health is estimated to decrease from 2002 to 2003 (–6.5 percent), while increasing by nearly the same percentage for an enrollee in fair or poor health (7.0 percent and 7.6 percent, respectively).

### M+C Plans Versus PPO Demonstration Products

Though the Medicare+Choice program authorized a range of managed care products, virtually all offerings are health maintenance organization (HMO) plans. To provide beneficiaries with additional options, the Centers for Medicare and Medicaid Services (CMS) used its demonstration authority in 2003 to sponsor a preferred provider organization (PPO) demonstration (Gold, Achman, and Verdier 2003). Like HMOs, PPOs include a network of providers that cover a geographic area. PPO products typically allow individuals to decide whether to use network providers, with cost-sharing becoming more substantial when they choose to go out of the network.

To attract plan participants, CMS allowed the modification of payment rates in areas that matched certain criteria, offered to share risk with contractors, and eliminated certain administrative requirements. PPO plans are paid the Medicare+Choice rate or 99 percent of the estimated fee-for-service per capita payment per county, whichever is higher. In the private sector, PPOs typically bear little, if any, financial risk, and care management is more limited than in HMOs. Under the Medicare demonstration, PPOs share financial risk with Medicare and must be licensed, risk-bearing entities under state law. Risk-sharing arrangements vary by firm as negotiated by CMS, but in all cases risk-sharing is limited to medical costs and is symmetrical, with CMS and the private plan sharing gains as well as losses. Under all arrangements, plans are at risk for plus or minus 2 percentage points around the target medical loss ratio. The lowest amount of risk carried by a plan beyond the 2 percentage points differential arrangement is 20 percent of gains or losses outside that

range; in practice, greater risk-sharing is common (Gold, Achman, and Verdier 2003). PPOs also have more flexibility than regular M+C plans in structuring their benefit packages.

In February 2003, 31 demonstration PPOs were open for enrollment in 175 counties. Most PPOs operate in counties where M+C plans also are offered. In April, 58,459 enrollees were in PPO demonstration products, about three-quarters of them in the Horizon New Jersey PPO demonstration plan (CMS 2003a).<sup>4</sup> The demonstration ultimately will be available to 10.7 million beneficiaries in 206 counties across the country (when this analysis was conducted, it was available to all but 2 million of these beneficiaries in 20 counties).

Estimated average annual out-of-pocket cost-sharing is substantially higher in the PPO demonstration plans than in regular M+C managed care plans. Enrollees in the PPO plans will spend \$2,884 out-of-pocket in 2003, while those in M+C plans will spend \$1,964.<sup>5</sup> Outside of New Jersey, the totals are \$2,581 and \$1,961, respectively. This disparity is a result of the substantially higher premiums charged by PPO plans compared with M+C plans. PPO plan premiums average \$1,075, while average M+C plan premiums are \$447. The PPO estimates also assume that enrollees use only in-network providers, and thus potentially understate out-of-pocket costs for Medicare PPO enrollees.

### Other Medicare Options

The Medicare+Choice program also authorizes private fee-for-service plans. These plans pay providers on a fee-for-service basis and must take all providers willing to accept the prices. The plans are paid M+C rates but cannot share any risk with providers (Gold 2001b). Less than 25,000 enrollees were in such plans in 2003. While four plans are offered, the first—Sterling, which was first offered in 2000 and covers numerous counties nationwide—has most of the enrollment. Geographic variation in enrollment by plan type makes it hard to compare estimated annual out-of-pocket cost-sharing in managed care plans with that in the private fee-for-service plans.<sup>6</sup> The estimated annual out-of-pocket cost for private fee-for-service plans is \$2,900, which is comparable to the estimates for PPO demonstration plans (Table 2).<sup>7</sup>

A beneficiary in traditional Medicare with no other form of supplemental coverage would incur the Medicare Part B premium, but save the cost of the additional premiums required by private plans. Premiums for the Medicare plan products considered here vary in cost from \$447 to \$1,114 per year (Figure 5). When beneficiaries choose a Medigap product, their premiums will likely be even higher.<sup>8</sup> However, without a private plan's supplemental insurance, beneficiaries are liable for Medicare's required cost-sharing for physician and hospital services and for all prescription

**Table 2. Estimated Average Annual Enrollee Out-of-Pocket Costs by Type of Health Plan, 2003 (weighted by enrollment)**

	M+C	PPO Demonstration <sup>1</sup>	Private Fee-for-Service	Traditional Medicare Only
Part B Premium	\$704.40	\$704.40	\$704.40	\$704.40
Plan Premiums	\$446.79	\$1,075.27	\$1,113.50	—
Physician and Hospital Cost-Sharing	\$301.04	\$419.43	\$374.72	\$1,219.32 <sup>2</sup>
Prescription Drug Cost-Sharing	\$511.99	\$685.10	\$707.61 <sup>3</sup>	\$707.76
<b>Total Out-of-Pocket Spending</b>	<b>\$1,964.21</b>	<b>\$2,884.20</b>	<b>\$2,900.24</b>	<b>\$2,631.48</b>

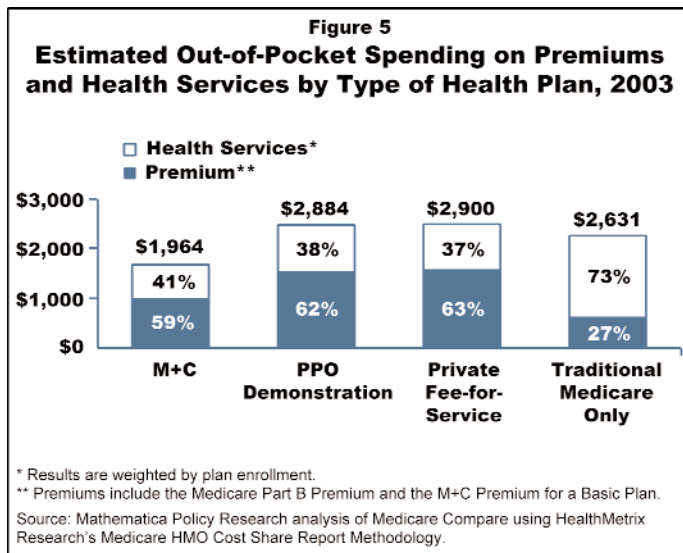
<sup>1</sup> PPO estimates are heavily weighted by New Jersey plans, where about 75% of enrollment is concentrated. Disparities in cost-sharing between M+C plans and PPO demonstration plans are higher outside of New Jersey. The estimated annual average out-of-pocket cost is \$1,961 in M+C compared with \$2,581 in the PPO demonstration when New Jersey plans are taken out of the estimates. (In New Jersey, the comparable statistics are \$2,581 versus \$2,899.)

<sup>2</sup> Annualized projections based on Centers for Medicare and Medicaid Services actuary estimates of the monthly actuarial value of Medicare deductible and coinsurance for Part A and Part B benefits in out-of-pocket costs for 2003 (CMS 2002). The estimate overstates the differential against Medicare+Choice, because it includes some components of out-of-pocket costs (e.g., mental health, rehabilitative care) that are not considered in calculating other options, but understates it to the extent that Medicare+Choice enrollees are located disproportionately in high-cost counties.

<sup>3</sup> Only one private-fee-for service plan, with very low enrollment, offers prescription drug coverage.

Source: Mathematica Policy Research analysis of Medicare Compare using HealthMetrix Research's Medicare HMO Cost Share Report Methodology.

drug costs (Table 2). This liability is extensive for beneficiaries in traditional Medicare without any other supplementary insurance.

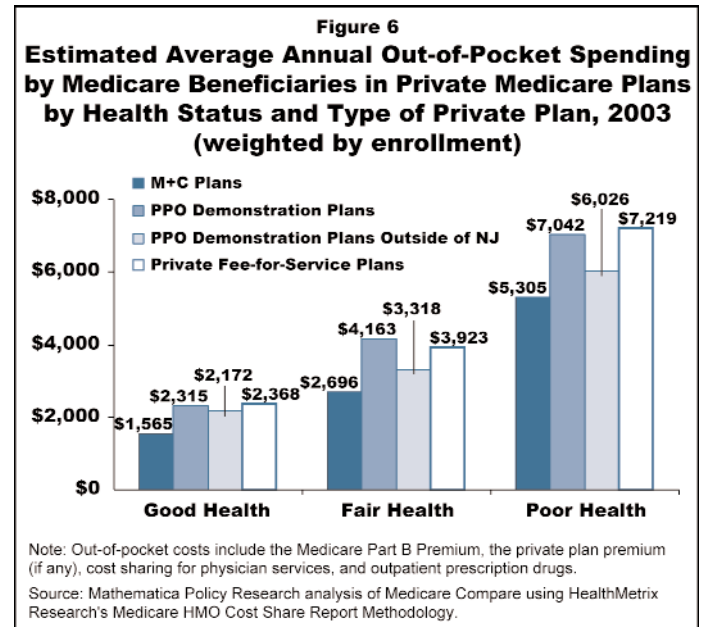


The \$707.76 average estimate for out-of-pocket prescription drug spending in traditional Medicare in 2003 is based on the same assumptions used for the M+C estimates, about pharmacy use by beneficiaries in good, fair, and poor health, and about the average cost of brand and generic drugs. The point of these assumptions is to enable comparison of different health plan options in a standardized way. They do not necessarily reflect the actual costs the government would incur should Congress authorize a Medicare drug benefit.

For the average beneficiary in 2003, estimated out-of-pocket spending is lower, on average, under M+C plans than under traditional Medicare alone. (Individual beneficiaries' costs will differ by the county of enrollment and the plans that are available.) But the potential savings of enrolling in a Medicare PPO demonstration plan or a private fee-for-service plan are less clear. The methods used here to estimate out-of-pocket costs are insufficiently sensitive to account for the effects of county of residence and of including all components of spending (see Maxwell, Storeygard, and Moon 2002 for additional analysis on this topic).

Nevertheless, regardless of their health status, a beneficiary's estimated out-of-pocket costs will, on average, be lower in a M+C managed care plan than

in a Medicare PPO demonstration plan or a private fee-for-service plan (Figure 6). The failure of private fee-for-service plans to limit enrollees' liability for out-of-pocket costs may explain why only 22,344 were enrolled in these plans in April 2003, even though they have been widely available since 2000.



## Conclusion

Out-of-pocket costs under Medicare+Choice continued to increase in 2003. On average, out-of-pocket costs are substantial, regardless of the type of Medicare plan that an enrollee selects and the enrollee's health status. Out-of-pocket spending is especially high for those in fair or poor health. This analysis demonstrates that the M+C experience with HMOs will not be the same in all types of private plans. For options other than traditional managed care plans (typically HMOs), out-of-pocket costs are substantially higher. Current experience suggests that PPO demonstration plans and private fee-for-service plans have less ability to generate savings than do M+C managed care plans (typically HMOs). Based on these findings, the potential for private plans to provide Medicare beneficiaries with cost-savings may be limited. The findings also underscore the importance of addressing limitations in the underlying benefits in the Medicare program to protect the elderly and disabled from high health care costs.

## NOTES

- <sup>1</sup> The Medicare+Choice program was enacted in 1997 and authorized the Centers for Medicare and Medicaid Services (then the Health Care Financing Administration) to contract with a broad variety of private plans. Previously, authority was limited mainly to health maintenance organizations (HMOs) participating under the Medicare risk contracting program established in the early 1980s. Despite the change, HMOs continue to dominate M+C offerings (see Gold 2001a).
- <sup>2</sup> See Gold and Achman 2002; and Achman and Gold 2002c.
- <sup>3</sup> Under the cost model, the number of prescriptions used per month varies by health status; the price does not. A 1:1 ratio of brand to generics is assumed. Quarterly caps are not factored into the model since prescription drug use is considered steady throughout the year. The model is not designed to show behavioral responses to changes in coverage nor the influence of formularies on out-of-pocket spending.
- <sup>4</sup> Horizon offers an M+C product, but dropped its most popular plan in 2003, when it entered the PPO demonstration. In April 2003, 44,745 M+C enrollees were in the Horizon PPO demonstration. Between December 2002 and April 2003, enrollment in Horizon's M+C products declined by 51,023 (CMS 2003a and CMS 2003b).
- <sup>5</sup> The estimates for PPO demonstration products assume enrollees use only in-network care.
- <sup>6</sup> Enrollment in M+C managed care plans and PPO demonstration plans is largely in urban areas; private fee-for-service products reach greater numbers of rural beneficiaries.
- <sup>7</sup> The average private fee-for-service out-of-pocket estimate is higher than the average estimate for PPO demonstration plans outside of New Jersey (\$2,581). New Jersey PPO demonstrations accounted for roughly 75 percent of the demonstration's enrollment in April 2003.
- <sup>8</sup> In 2002, MPR estimated that the premium for a Medigap supplemental plan averaged \$1,318 for Plan C, \$1,387 for Plan F, and \$1,180 for Plan J. However, actual premiums vary widely by location, policy, age, and underwriting factors (Gold and Achman 2002).

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## METHODOLOGY

Estimates of out-of-pocket spending for Medicare+Choice enrollees are based on the methodology developed by HealthMetrix Research for their Medicare HMO Cost Share reports. The methodology is based on utilization profiles for Medicare managed care enrollees in good, fair, and poor health. The estimates are divided into three types of health care expenditures: premiums, out-of-pocket spending for prescription drugs, and other out-of-pocket spending (largely, acute care costs for physician visits, medical care, and some preventive services). In addition to these three categories of costs, Mathematica added a fourth: the Medicare Part B premium, which covers ambulatory care and related services.

To support the estimates for out-of-pocket spending for prescription drugs and other medical services, assumptions are made about the costs of prescription drugs, the way that Medicare+Choice plans calculate their drug benefit limits, and the cost of preventive services. For example, in 2003, brand-name prescription drugs are assumed to cost both the health plan and an enrollee without coverage \$70 for a month's supply. Generic drugs are assumed to cost \$41 for a month's supply. Detailed information on the cost assumptions and utilization profiles used in the HealthMetrix HMO Cost Share Reports is available on the HealthMetrix Research Cost Share Report website at [www.hmos4seniors.com](http://www.hmos4seniors.com) or by contacting the authors. The model assumes no change in utilization patterns from 1999 to 2003. The only prices assumed to have changed during this period are those for prescription drugs.

The issue brief also provides an estimate for "all enrollees." This estimate for the average enrollee was created by weighting the out-of-pocket cost estimates for those in good, fair, and poor health according to the reported health status of Medicare beneficiaries enrolled in Medicare HMOs in the 1999 Medicare Current Beneficiary Survey.

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