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Issue Brief

Medicare Beneficiary Out-of-Pocket Costs: Are Medicare Advantage Plans a Better Deal?

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ABSTRACT: The creators of the Medicare Advantage (MA) program envisioned that seniors would opt out of fee-for-service Medicare to take advantage of the lower premiums, lower cost-sharing, and additional benefits available in private plans. Earlier research, however, indicates that out-of-pocket costs for MA enrollees vary widely by health status and plan benefit package. This issue brief examines out-of-pocket costs for beneficiaries in good, fair, and poor health throughout the country. In 2005, annual out-of-pocket costs for plan members ranged from under $100 for beneficiaries in good health to over $6,000 for those in poor health. Costs for beneficiaries in poor health would actually have been higher than fee-for-service in 19 of the 88 MA plans examined. Despite the high payments, relative to fee-for-service costs, that MA plans receive from Medicare to enrich enrollee benefits, these plans may not always be a good deal for sicker beneficiaries who use more health services.

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OVERVIEW

The Medicare Advantage (MA) program established by the Medicare Modernization Act of 2003 is intended to increase the role of private health plans in Medicare. The program's creators envisioned that beneficiaries would opt out of traditional fee-for-service Medicare to take advantage of the lower monthly premiums, lower cost-sharing, and additional benefits available in private plans.

Proponents of private plans have suggested that MA enrollment is financially a good deal for Medicare beneficiaries. In a June 2005 press release, the U.S. Department of Health and Human Services announced:

> Nearly all Medicare beneficiaries have access to Medicare coordinated care plans and other health plan options in 2005, and these plans are providing significant new out-of-pocket savings to Medicare beneficiaries, particularly those with chronic illnesses.[1]

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A specific comparison with Medigap coverage—the private insurance plans that many beneficiaries purchase to supplement their Medicare coverage—claimed particularly large savings:

> Beneficiaries who buy Medigap coverage on their own or who cannot afford Medigap will save just over $100 a month, on average, based on plans approved in March [2005], compared to traditional Medicare with Medigap. Those average savings include $29 in extra benefits, $2 in Part B premium reduction, and $70 in reduced average out-of-pocket expenses for Medicare-covered services compared to the national actuarial value.[2]

Earlier research, however, indicates that broad generalizations about the financial advantages of Medicare private health plan enrollment may be misleading for some beneficiaries.[3] According to an analysis of MA plans in 10 cities across the nation, out-of-pocket costs for enrolled seniors vary widely. These variations correspond with the health status of individual beneficiaries and the benefit package provided by individual plans.

Drawing on 2005 data, this issue brief examines out-of-pocket costs for beneficiaries in good, fair, and poor health throughout the country. The results show that the earlier finding of wide variation in MA plan benefits still holds. Annual out-of-pocket costs for MA plan members now range from under $100 a year for beneficiaries in good health in cities such as Las Vegas, Fort Lauderdale, and San Antonio, to over $6,000 a year for beneficiaries in poor health in Philadelphia, Providence, Portland, Ore., and suburban Westchester County, N.Y.

In a number of these plans, beneficiaries in poor health pay more out-of-pocket than they would have with a combination of traditional fee-for-service Medicare and Medigap—despite the well-documented shortcomings of Medigap coverage.[4]

For individuals in good health, annual out-of-pocket costs in 2005 were lower in all of the 88 MA plans examined than they would have been in the fee-for-service program. It was nearly the same case for beneficiaries in fair health, with lower out-of-pocket costs in 86 of the 88 plans. But the story was different for beneficiaries in poor health: annual out-of-pocket costs in 2005 would actually be higher than fee-for-service in 19 of the 88 MA plans we examined.[5]

Despite the high payments, relative to fee-for-service costs, that MA plans receive from Medicare to enrich enrollee benefits, these plans may not always be a good deal for beneficiaries who, because of their poor health, use more health care services.[6] If a more comprehensive benefit package were made available as part of traditional fee-for-service Medicare, it might well be able to compete with MA plans on an equal footing.[7]

HISTORY OF PRIVATE PLANS IN MEDICARE

From the beginning, private plans have been a part of the Medicare program. The Tax Equity and Fiscal Responsibility Act of 1982 set payments for health maintenance organizations (HMOs) participating in the Medicare risk program at 95 percent of the adjusted average per capita cost for fee-for-service beneficiaries residing in each county. When Medicare payments were projected to exceed a plan's projected cost for providing the standard Medicare benefit package to enrollees, the plan was required to return the surplus to enrollees in the form of extra benefits or reduced cost-sharing.[8]

HMOs were expected to manage their costs more successfully than fee-for-service Medicare. But they also tended to enroll beneficiaries who were healthier, and therefore less costly, on average.[9] As a result of the widening discrepancy between their payments and base costs, Medicare managed care plans were able to offer substantial extra benefits: in 1994, the value of extra benefits offered by the average plan was $43 per member per month; by 1996, that amount had risen to $83.[10] Because of the better benefits the plans were able to provide, their enrollment jumped from 2.3 million (6% of all Medicare beneficiaries) to 4.1 million (11%) over the two-year period.[11]

Medicare+Choice

The role of private plans was expanded when the Balanced Budget Act of 1997 established the Medicare+Choice program, which gave beneficiaries a broader range of private plan choices and changed the way plans were paid. That legislation severed the tie between a plan's adjusted average per capita cost and its payment rates, narrowing the gap in payment rates between the highest-cost areas and other areas, particularly rural communities.

Halting payment rate growth in the highest-cost areas, however, made it less attractive for plans to locate there. Moreover, despite the higher rates now available in rural areas, plans locating to these regions were unable to flourish—for many of the same reasons that had kept them out of those areas before, including difficulty in establishing provider networks and sparse population. As a result, many private plans left the Medicare+Choice program; those that stayed, meanwhile, could not maintain their previous level of benefits. Enrollment in the program peaked in 1999 at 16 percent of Medicare beneficiaries. By 2003, it had fallen to 12 percent.[12]

Medicare Advantage

In the Medicare Modernization Act, Congress attempted to reverse that trend by allowing for substantial additional payments to Medicare Advantage plans in many areas. This change has increased the number of plans willing to participate: the Centers for Medicare and Medicaid Services (CMS) recently announced its approval of 163 new MA plans. It also enabled MA plans to offer more benefits: 70 percent of Medicare beneficiaries have access to a plan that does not require them to pay a premium for their prescription drug coverage.[13] These changes appear to have been successful in attracting more beneficiaries: nearly 7 million beneficiaries were members of MA plans as of April 2006, with enrollment increasing by about 1 million since enrollment in the new prescription drug benefit began (on November 15, 2005).[14]

OUT-OF-POCKET COSTS IN MEDICARE ADVANTAGE

Three factors are responsible for the current variation in out-of-pocket costs for Medicare Advantage plan enrollees, especially those who are in poor health:

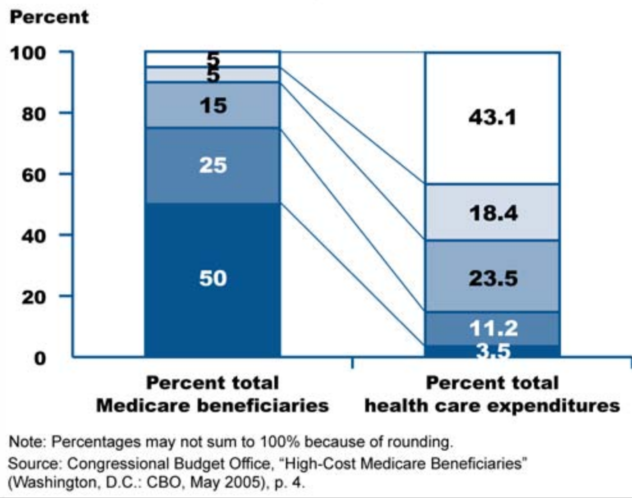
- The high use of health services by Medicare beneficiaries in poor health, as well as the high costs associated with this use.
- Medicare policies that do not: a) sufficiently adjust (raise or lower) MA plan payments based on the costs actually incurred by enrollees, or b) limit MA plans' flexibility in designing their benefit packages.
- The ability of plans to adjust their benefit packages in response to these incentives.

High-Cost Beneficiaries

The most fundamental factor underlying the pattern of out-of-pocket costs by Medicare Advantage enrollees is the great variation in the use of health care services, and the annual cost of services, by individual Medicare beneficiaries. Enrollees in poor health use far more services and have higher costs than enrollees in good health. An analysis of total annual expenditures of Medicare beneficiaries in 2001 (Figure 1) reported:[15]

- The most expensive 5 percent of Medicare beneficiaries, those in the poorest health, were responsible for 43 percent of total Medicare costs, with an average spending of $63,000 per beneficiary during the year;
- The 25 percent of beneficiaries who were most expensive accounted for 85 percent of total costs, with average spending of $35,000;
- The least expensive 50 percent of beneficiaries, those in the best health, accounted for only 4 percent of total costs, with average spending of only $550.

This analysis indicates that it could cost an MA health plan as much to pay for the services for one person in poor health in the most expensive



5 percent group of beneficiaries as it would cost the plan to pay for more than 100 beneficiaries in good health within the least expensive 50 percent.

This pattern provides a substantial incentive for MA plans to avoid the new or continued enrollment of beneficiaries who are in poor health.

Medicare Policies

Currently, Medicare policies only partly counteract the strong incentive for MA plans to avoid enrolling beneficiaries who are in poor health. At the same time, the government allows plans to design their benefit packages in a manner that favors beneficiaries who are in good health.

Risk adjustment. MA plan payments are adjusted to reflect the anticipated costliness of the enrollee, with plans paid more for high-cost enrollees in poor health and less for low-cost members in good health. This risk adjustment is intended to counteract the incentive for plans to avoid sicker beneficiaries while protecting plans that might attract a disproportionate number of these higher-cost individuals. However, the current MA payment system does not completely meet these objectives.

Through 1999, plans' payment rates were adjusted only for demographics and other broad characteristics; they did not reflect the enrollee's specific clinical condition or medical history. Beginning in 2000, CMS began to phase in use of a clinical risk adjuster (referred to as the PIP-DCG, or principal inpatient diagnostic cost groups, model), and since 2004 a new, more sophisticated risk adjuster (referred to as the CMS-HCC, or hierarchical condition categories, model) has been used to adjust payments to MA plans.[16] While a great improvement over the previous system, the current model, however, does not completely remove the incentive to avoid potentially expensive enrollees, because it explains only a small proportion of the variation in costs across individual beneficiaries.

Recent analysis by the Medicare Payment Advisory Commission (MedPAC) found that the CMS-HCC model, even when fully implemented, would systematically underpay plans for enrollees who have the highest costs and overpay for those who have the lowest costs:[17]

- MA payment rates would be only 83 percent of actual costs for the 20 percent of beneficiaries with the highest costs (the highest quintile in Figure 2 below); and
- MA payment rates would be 134 percent of actual costs for the 20 percent of beneficiaries with the lowest costs (the lowest quintile in Figure 2), and 130 percent of actual costs for the second-lowest quintile.[18]

Applying the ratios in Figure 2 to the average costs in each cost quintile indicates that plan payments would be:

- more than $4,200 less than annual costs for enrollees in the highest-cost quintile; and
- approximately $180 per year more than costs for enrollees in the lowest-cost quintile.

The underpayment for one high-cost enrollee thus exceeds the overpayments for more than 20 low-cost enrollees. Clearly, plans still have

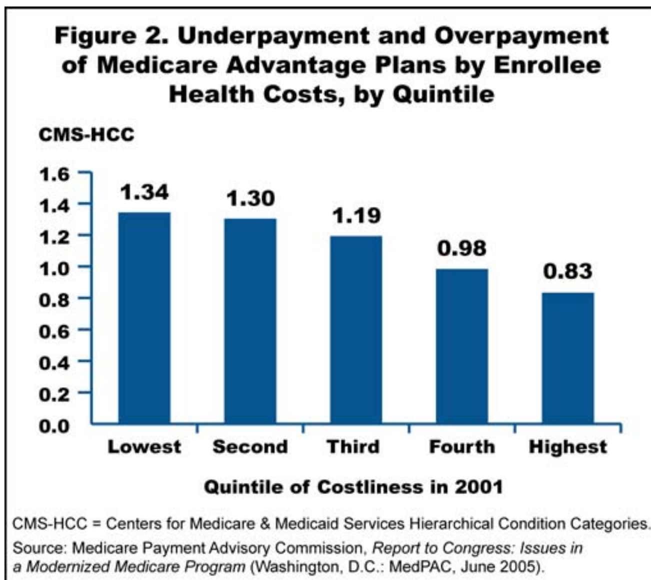


Figure 2. Underpayment and Overpayment of Medicare Advantage Plans by Enrollee Health Costs, by Quintile

CMS-HCC = Centers for Medicare & Medicaid Services Hierarchical Condition Categories.
Source: Medicare Payment Advisory Commission, *Report to Congress: Issues in a Modernized Medicare Program* (Washington, D.C.: MedPAC, June 2005).

strong incentives to enroll low-cost beneficiaries—and particularly strong incentives to avoid beneficiaries with the highest costs.

The application of risk adjustment to MA plan payments, furthermore, is being gradually phased in. In 2005, only 50 percent of MA payment rates were risk-adjusted; in 2006, the share is 75 percent. Rates will not be fully risk-adjusted until 2007.

Flexibility in MA plan benefits. Given the incentives in the MA payment system, private plans can be expected to take steps that would encourage the enrollment of healthy beneficiaries and discourage new or continued enrollment of high-cost members. These steps may involve: the design of the benefit package; the targeting of marketing campaigns; the selection of physicians and other providers for the plan network; and utilization review practices.

Medicare policies generally allow MA plans great latitude in the design of one or more benefit packages. MA plans are prohibited from imposing out-of-pocket costs that, on average, would be expected to exceed the amount in traditional fee-for-service Medicare, which was estimated at $119 per month in 2005.[19] So while the expected average of out-of-pocket costs for all MA plan members is limited, costs for individual plan members, such as those in poor health, are not.[20]

Medicare policy also provides that plans should not discriminate on the basis of health status. Compliance with this broad policy is not carefully defined and enforced by CMS, and many MA plans across the nation have benefit packages with high out-of-pocket costs for hospital, chemotherapy, and other non-discretionary health services.

Medicare policy does not require MA plans to standardize their benefit packages the way that Medigap plans must. Medigap plans can offer one or more of 10 defined benefit packages, which generally cover most out-of-pocket costs for hospital, physician, and other acute care services (see Table 1 for an example of selected packages). Since the benefits are standardized, Medigap plan sponsors compete on the basis of clearly stated monthly premiums. Medigap coverage and costs, meanwhile, are available on the Medigap Compare section of the Medicare Web site.[21]

Medicare Advantage Benefit Packages

Medicare Advantage plans avail themselves of the great discretion they are allowed in the design of monthly premiums and benefits to offer a wide variety of benefit packages. Some examples of this variety and its implications for high-cost beneficiaries are presented in Table 2.

A number of MA plans have designed benefit packages with greater out-of-pocket costs for health services. Some plans, for example, have a copayment of $200 or $300 per hospital day. For individuals in poor health requiring three hospital stays a year, each an average of four days, the out-of-pocket costs can total up to $3,600.[22]

In addition, some plans charge coinsurance of $25 per physician visit. For enrollees in poor health who have 24 physician visits a year, this can amount to over $600 annually. Some MA plans offer benefit packages with out-of-pocket costs of as much as $5,600 for cancer chemotherapy.[23]

Table 1. Benefits Covered by Selected Standard Medigap Benefit Packages

	Medigap plans		
	A	F	J
Part A deductible ($912)		✓	✓
Part B 20% coinsurance	✓	✓	✓
Part B deductible ($110)		✓	✓
Part B excess charges		✓	✓
Rx drug costs up to $3,000			✓

Source: http://www.aarphealthcare.com/prodsvcs/medsup/insurance_basics_sta.aspx. Accessed August 3, 2005.

Table 2. Wide Variation in Medicare Advantage Plan Benefit Packages and Out-of-Pocket Costs for Enrollees in Poor Health, Selected Plans

	Hospital copay[a]	Physician copay[b]	Prescription drug coverage copay[c]	Total OOP costs for enrollee in poor health
Plan 1	$0	$0	$5 for 30-day supply	$1,664
Plan 2	$0	$0	$0 for Tier 1**	$1,610
Plan 3	$50 per stay	$3	$5 for 30-day supply	$2,279
Plan 4	$225/day for days 1–8	$10	No coverage	$7,522
Plan 5	$300/day for days 1–90	$20	$10 for 100-day supply	$5,905
Plan 6	$750 per stay	$20–$25	No coverage	$6,585

[a] Three stays of four days each. [b] 24 primary care visits. [c] 72 prescriptions.
* Based on HealthMetrix utilization profile for enrollees in poor health.
** Many plan formularies place prescription drugs in three or more tiers differentiated by OOP costs. Tier 1 drugs are those with lowest OOP costs for enrollees.

The features of MA plan benefit packages can also vary by geographic region. In several areas, the largest MA plans have hospital copayments of $200 per day or more. In others, there are major plans with no copayments for hospital care.

In addition, MA plans may change their benefit packages from year to year. Under the previous program, Medicare+Choice, out-of-pocket costs for enrollees consistently increased between 1999 and 2003, as payments to private plans were constrained by the provisions of the Balanced Budget Act; out-of-pocket costs began to level off as the extra payments provided by the Medicare Modernization Act took effect in 2004 and 2005 (Figure 3). Analysis by Marsha Gold and colleagues, moreover, finds that out-of-pocket costs for those in poor health were greater and increased much more rapidly than for those in good health in every year through 2004 (Figure 4).

COMPARISON OF OUT-OF-POCKET COSTS

To compare out-of-pocket costs for MA plan enrollees with costs for fee-for-service beneficiaries, the authors focused on 44 areas across the nation for closer study. The selected areas all share the following characteristics: 1) a substantial enrollment in MA plans, with greater than 10 percent of total beneficiaries in plans; (2) at least two competitive MA plans, each with enrollment of more than 2 percent of total beneficiaries; (3) information on out-of-pocket costs of MA enrollees available from HealthMetrix;[24] and (4) coverage under the AARP Medigap Plan F available at a community-rated premium. Estimates of annual out-of-pocket costs for enrollees in MA plans and Medigap Plan F are based on utilization packages for three broad categories of health status: good, fair, and poor (see Appendix 1 on page 11 for the specifics of each utilization package).

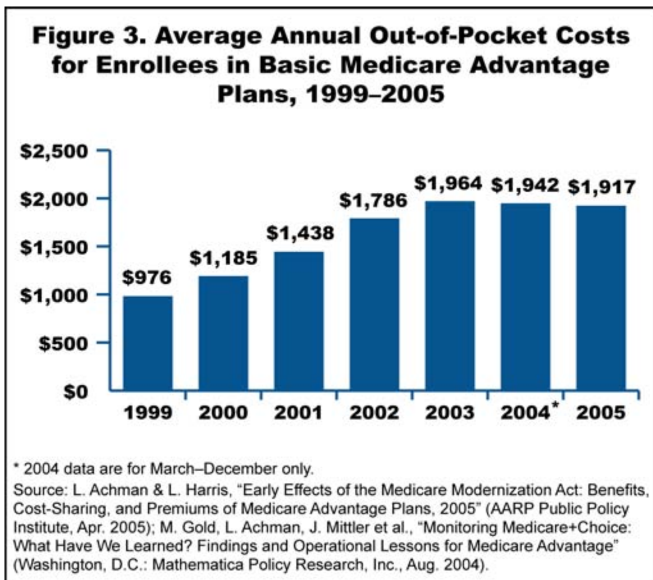


Figure 3. Average Annual Out-of-Pocket Costs for Enrollees in Basic Medicare Advantage Plans, 1999–2005

* 2004 data are for March–December only.
Source: L. Achman & L. Harris, "Early Effects of the Medicare Modernization Act: Benefits, Cost-Sharing, and Premiums of Medicare Advantage Plans, 2005" (AARP Public Policy Institute, Apr. 2005); M. Gold, L. Achman, J. Mittler et al., "Monitoring Medicare+Choice: What Have We Learned? Findings and Operational Lessons for Medicare Advantage" (Washington, D.C.: Mathematica Policy Research, Inc., Aug. 2004).

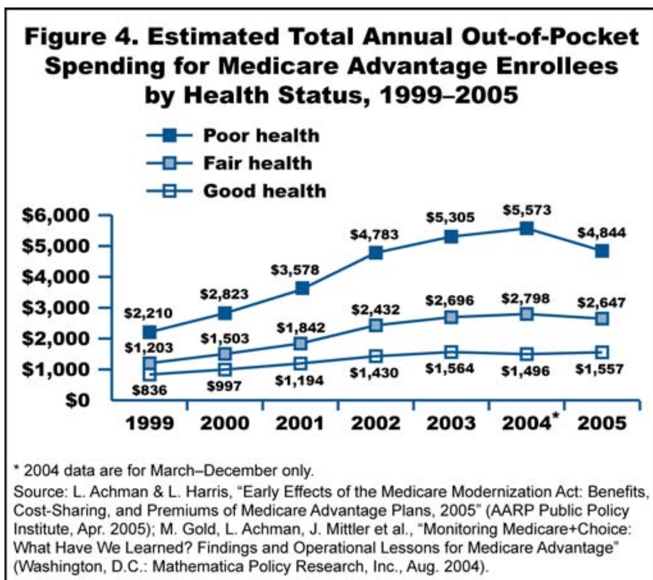


Figure 4. Estimated Total Annual Out-of-Pocket Spending for Medicare Advantage Enrollees by Health Status, 1999–2005

* 2004 data are for March–December only.
Source: L. Achman & L. Harris, "Early Effects of the Medicare Modernization Act: Benefits, Cost-Sharing, and Premiums of Medicare Advantage Plans, 2005" (AARP Public Policy Institute, Apr. 2005); M. Gold, L. Achman, J. Mittler et al., "Monitoring Medicare+Choice: What Have We Learned? Findings and Operational Lessons for Medicare Advantage" (Washington, D.C.: Mathematica Policy Research, Inc., Aug. 2004).

Overall, this analysis found that that total annual out-of-pocket costs for beneficiaries in:

- *good health* are lower for all 88 MA plans than they are in Medigap Plan F.
- *fair health* are lower for all but two of the 88 MA plans than they are in Medigap Plan F.
- *poor health* are higher for 19 of the 88 MA plans than they are in Medigap Plan F.

Therefore, in 22 percent of the plans analyzed, MA enrollees in poor health have higher costs than they would have had with the combination of traditional fee-for-service Medicare and Medigap Plan F. These MA plans are in located in 15 cities across the nation and are in 11 of the 18 states with cities in the study. They had a total of 343,037 Medicare enrollees in 2005. Table 3 shows that estimated out-of-pocket costs for enrollees in poor health varied substantially among MA plans, from less than $1,400 to more than $7,500 among the plans we examined (see Appendix 2 on pages 12–13 for data on all 88 plans in the study). Out-of-pocket costs for the same people under traditional Medicare would have varied much less. As a result, while many MA plans offer much better protection to enrollees in poor health, that protection is not universally available, and the additional costs faced by the sickest beneficiaries in some plans can be substantial.

ACCOUNTING FOR EXTRA PAYMENTS TO MEDICARE ADVANTAGE PLANS

As mentioned earlier, MA plans may be able to provide more benefits than traditional fee-for-service Medicare because the Medicare Modernization Act included provisions that set MA payments greater than per capita fee-for-service costs in every county in the nation. These extra payments to MA plans averaged over 11 percent ($800 per enrollee) in 2005.[25]

Through 2005, MA plans were required to provide additional benefits if their Medicare payment rate exceeds anticipated costs of providing the standard Medicare benefit package. These excess payments could be used to reduce premiums, deductibles, or copayments or to add coverage of services not covered by traditional fee-for-service Medicare.[26,27,28] It follows, therefore, that if plans had not received the extra payments provided under the MMA, their benefit packages would likely have been leaner and their members' out-of-pocket costs greater, and the comparison described above would not have been as favorable to MA plans—not only for enrollees in poor health, but also for some of those in fair and even good health.

Table 3. Comparison of Out-of-Pocket Costs for Individuals in Poor Health, Selected Plans

Medicare Advantage plan	Percent penetration of plan in local area	OOP costs for MA plan	OOP costs for Medicare FFS plus Medigap Plan F	Difference in OOP costs between MA plan and Medicare FFS plus Medigap Plan F
Plan 1	24.3%	$7,522	$5,606	$ 1,916
Plan 2	5.7	7,232	5,677	1,555
Plan 3	12.3	6,720	4,525	2,195
Plan 4	11.3	6,604	5,179	1,425
Plan 5	7.2	6,590	4,525	2,065
Plan 84	8.1	1,664	5,227	–3,563
Plan 85	12.6	1,610	5,984	–4,374
Plan 86	10.1	1,610	6,232	–4,622
Plan 87	19.5	1,560	6,623	–5,063
Plan 88	21.6	1,359	5,984	–4,625

FFS = fee-for-service.
(See Appendix 2 for data on all 88 plans in the study.)

CONCLUSION

The Medicare capitated payment system used for MA plans provides a fixed payment per enrollee per month. This type of arrangement provides a strong incentive for plans to manage the costs of their enrollees so that they stay below the corresponding payment amount.

This may be done by promoting healthier lifestyles and offering more preventive care so that potentially expensive episodes of illness may be avoided, by organizing care so that waste is minimized and effectiveness is maximized, and by coordinating care for chronically ill enrollees so that their conditions can be kept in check and expensive hospitalizations limited. All of these strategies not only make health care more efficient and effective, they help beneficiaries avoid illness when they are healthy and keep conditions under control when they are sick.

However, capitation also provides incentives to stint on health care and to avoid enrollees who are in poor health and represent a greater risk of high costs. Although the application of risk adjustment to the payment rates received by MA plans is intended to eliminate the incentive to avoid enrollees who are in poor health, it is not completely effective in doing so.

The analysis reported here indicates that the benefit packages offered by MA plans often result in substantial out-of-pocket costs for beneficiaries in poor health: in more than 20 percent of the MA plans we examined, located all across the nation in 15 cities in 10 states, enrollees in poor health would have had greater out-of-pocket costs in 2005 than if they had been in traditional fee-for-service Medicare with Medigap Plan F. If not for the extra payments provided to MA plans across-the-board, this pattern could have been even more pronounced.

Even with the completion of the transition to fully risk-adjusted MA payment rates and planned improvements in the risk adjustment methodology, the incentives for plans to avoid enrollees in poor health are unlikely to disappear. Moreover, as increased pressure to control Medicare spending makes continuation of the current level of extra payments to MA plans more difficult to justify, the incentive to shift costs from healthy to sick enrollees will become stronger. To address this situation, several changes in MA policies might be considered.

Suspend the annual MA plan lock-in for beneficiaries. Given the current potential for confusion regarding MA plan benefit packages and

the risk of substantial out-of-pocket costs for sicker enrollees, the policy that locks in Medicare beneficiaries to an MA plan for an entire calendar year—which began in January 2006—could be suspended until new limits on out-of-pocket costs and improved risk adjustment are implemented. Suspension of the new annual lock-in policy would simply reinstate the previous Medicare policy (which gives beneficiaries the right to switch plans or between MA and fee-for-service with 30 days' notice) that was in place for the Medicare+ Choice and Medicare Advantage programs from 1997 through 2005.

Meanwhile, senior counselors, the media, and others who advise the elderly and disabled regarding MA plan enrollment should be especially cautious about the advice they provide, particularly to beneficiaries in poor health. Senior advisors and beneficiaries themselves should carefully review the benefit packages of all MA plans and identify MA plans with benefit package features—such as high copayments for hospital care and chemotherapy—that increase costs for seniors who because of health conditions must use large quantities of health services.

Increase standardization of MA benefit packages. A broader policy that would both protect beneficiaries in poor health and clarify the selection of plans for all Medicare beneficiaries would be for Medicare to require some standardization of benefit packages that MA plans could offer. This type of policy might range from requiring that the definition of terms used to describe benefit packages be consistent across plans, to enumerating the combinations of benefits that could be offered.

Faced with widespread confusion among beneficiaries over premiums and benefits of Medigap polices in 1989, Medicare worked with the state insurance commissioners to develop a set of 10 uniform polices Medigap insurers must offer. These uniform policies have now been in place for over a decade. A similar process could bring order to the Medicare Advantage market, which offers elderly beneficiaries in many areas across the country dozens of Parts A and B acute care and Part D prescription drug benefit packages.

Improve payment accuracy. Improving the ability to risk-adjust payments to MA plans appropriately should be a high priority for CMS over the next five years. In addition, more information is needed on the utilization experience of beneficiaries in MA plans, so that future risk adjustment mechanisms can be appropriately calibrated. Earlier proposals for Medicare private plans to be paid based on partial capitation could be revisited as well; this could diminish the incentive to avoid costly enrollees or shift more costs to them.

Limit the vulnerability of MA plan enrollees to excessive out-of-pocket costs. Current Medicare policy regarding MA plan benefit packages could be strengthened to prohibit out-of-pocket costs that impose a significant financial burden on enrollees in poor health. We found that among the MA plans we studied, the 6 percent of enrollees who were in poor health had annual out-of-pocket costs of $4,844 in 2005, while those in fair and good health had estimated costs of $2,647 and $1,556, respectively.[29] Enrollees in poor health could be helped by prohibiting excessive copayments or by requiring that plans cap out-of-pocket payments at some reasonable amount.

It should also be noted that the analysis described in this paper was conducted in an environment in which the only alternative to Medicare Advantage for most beneficiaries is an increasingly complicated patchwork of coverage requiring some combination of traditional Medicare, Medigap or some other supplemental coverage, and now a third source of prescription drug coverage through a private plan. If Medicare were to offer a true alternative to private coverage—such as a more comprehensive fee-for-service option—market forces could be expected to work more effectively, and beneficiaries choose between comparable alternatives on an equal footing.[30]

NOTES

[1] Centers for Medicare and Medicaid Services, "Medicare Beneficiaries to Have More Health Plan Choices and Greater Savings with Medicare Advantage Plans Than Ever Before" (Washington, D.C.: CMS, 2005). Available at http://www.cms.hhs.gov/media/press/release.asp?Counter=1497.

[2] Ibid.

[3] B. Biles, G. Dallek, and L. H. Nicholas. "Medicare Advantage: Déjà Vu All Over Again?" *Health Affairs* Web Exclusive (Dec. 15, 2004): W4-586–W4-97; G. Dallek, A. Dennington, and B. Biles, *Geographic Inequity in Medicare+Choice Benefits: Findings from Seven Communities* (New York: The Commonwealth Fund, Sept. 2002).

[4] See, for example, U.S. Government Accountability Office, *Medigap Insurance: Plans Are Widely Available But Have Limited Benefits and May Have High Costs* (Washington, D.C.: GAO, July 2001).

[5] In this analysis, out-of-pocket costs for beneficiaries in good, fair, and poor health, respectively, are estimated using profiles developed by HealthMetrix Research; Medigap premiums and coverage are based on Medigap Plan F offered through AARP by United Healthcare in each of the 44 counties we examined. See the discussion in Appendix 1.

[6] See B. Biles, L. H. Nicholas, and B. S. Cooper, *The Cost of Privatization: Extra Payments to Medicare Advantage Plans—2005 Update* (New York: The Commonwealth Fund, Dec. 2004).

[7] See, for example, K. Davis, M. Moon, B. S. Cooper, and C. Schoen, "Medicare Extra: A Comprehensive Benefit Option for Medicare Beneficiaries," *Health Affairs* Web Exclusive (Oct. 4, 2005):W5-442–W5-454.

[8] Plans also had the option of returning the excess payment amount to Medicare, but no plans to our knowledge chose that option. See Prospective Payment Assessment Commission, *Medicare and the American Health Care System: Report to the Congress* (Washington, D.C.: ProPAC, June 1997):44.

[9] R. S. Brown, J. W. Bergeron, D. G. Clement et al., *The Medicare Risk Program for HMOs: Final Summary Report on Findings from the Evaluation* (Princeton, N.J.: Mathematica Policy Research, Feb. 1993).

[10] ProPAC, *Medicare & American Health Care System,* 1997.

[11] Ibid.:36.

[12] M. Gold, "Private Plans in Medicare: Another Look," *Health Affairs,* Sept./Oct. 2005 24(5):1302–10.

[13] Centers for Medicare and Medicaid Services, "Medicare Advantage Plans Provide Lower Costs and Substantial Savings" (Washington, D.C.: CMS, Apr. 3, 2006). Available at http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=1825.

[14] Ibid.

[15] Congressional Budget Office, "High Costs Medicare Beneficiaries" (Washington, D.C.: CBO, May 2005). Available at http://www.cbo.gov/showdoc.cfm?index=6332&sequence=0. Accessed August 2, 2005. It should be noted that other studies have similar findings including A. C. Monheit, "Persistence in Health Expenditures in Short Run: Prevalence and Consequences," *Medical Care,* July 2003 41 (7 suppl.): III53–III64.

[16] G. C. Pope, J. Kautter, R. P. Ellis et al., "Risk Adjustment of Medicare Capitation Payments Using the CMS-HCC Model," *Health Care Financing Review,* Summer 2004 25(4):119–41.

[17] Medicare Payment Advisory Commission, *Report to the Congress: Issues in a Modernized Medicare Program* (Washington, D.C.: MedPAC, June 2005).

[18] Under the policy in effect in 2005, with the risk adjustment applied to only 50 percent of MA plan payment rates, payment rates would be only about 64 percent of actual costs for the beneficiaries in the highest cost quintile and about 194 and 163 percent, respectively, for beneficiaries in the two lowest cost quintiles.

[19] Medicare Payment Advisory Commission, *Report to the Congress: Benefit Design and Cost Sharing in Medicare Advantage Plans* (Washington, D.C.: MedPAC, Dec. 2004).

[20] While CMS suggests MA plans cap individual OOP spending at $2,710 in 2005 this is not a formal requirement and 54 percent of plans do not have a cap. See MedPAC, *Benefit Design,* 2004.

[21] http://www.medicare.gov/MPHCompare/Home.asp.

[22] See Appendix 1 for discussion of HealthMetrix assumptions on use of health services by beneficiaries in good, fair, and poor health.

[23] MedPAC, *Benefit Design,* 2004.

[24] HealthMetrix Research is a Columbus, Ohio-based firm that provides information on Medicare managed care plans, including estimated annual OOP costs for enrollees in plans in over 80 major cities in the U.S., on its Web site: http://www.hmos4seniors.com/.

[25] Commonwealth Fund estimate (unpublished), May 2006.

[26] MedPAC, *Report to the Congress,* 2005.

[27] MedPAC's analysis of the adjusted community rate proposals submitted by MA plans that indicates Medicare payments exceed the ACR in virtually all plans in 2005. Medicare Payment Advisory Commission, *Transcript of Public Meeting: Policy Issues in the Medicare Advantage Program* (Washington, D.C.: MedPAC, Apr. 2005); Congressional Budget Office, "CBO's Analysis of Regional Preferred Provider Organizations Under the Medicare Modernization Act" (Washington, D.C.: CBO, Oct. 2004), available at http://www.cbo.gov/showdoc.cfm?index=5997&sequence=0. Accessed July 25, 2005.

[28] In 2006, plans were required to submit bids that were compared to an area benchmark; if the plan's bid was less than the benchmark amount, the plan could return 25 percent of that difference to beneficiaries in the form of direct rebates.

[29] L. Achman and L. Harris, *Early Effects of the Medicare Modernization Act: Benefits, Cost Sharing, and Premiums of Medicare Advantage Plans, 2005* (Washington, D.C.: AARP Public Policy Institute, Apr. 2005).

[30] See Davis et al., "Medicare Extra," 2005.

Appendix 1. HealthMetrix Care Utilization Packages in 44 Areas of the Country for Medicare Beneficiaries in Good, Fair, and Poor Health

Good Health

- 4 doctor office visits (in-network)
- 0 inpatient admissions
- 1 physical, vision, hearing exam
- 1 urgent care visit (out-of-area)
- 6 prescriptions (30-day supply)
- 1 dental prevention visit

Fair Health with Moderate Annual Utilization

- 12 doctor office visits (in-network)
- 1 inpatient admission (4 days)
- 1 physical, vision, hearing exam
- 1 emergency room visit
- 24 prescriptions (2 per month)
- 1 dental prevention visit

Poor Health with High Annual Utilization

- 24 doctor office visits (in-network)
- 3 inpatient admissions (12 days)
- 1 physical, vision, hearing exam
- 2 emergency room visits
- 72 prescriptions (6 per month)
- 1 dental prevention visit

Expenses for enrollees by health status were calculated and reported by HealthMetrix on its Web site, http://www.hmos4seniors.com/. Medigap Plan F out-of-pocket costs were calculated for this study by adding premium quotes for Medigap Plan F policies obtained from the AARP Web site to supplemental costs based on the HealthMetrix utilization and cost assumptions for utilization of services and costs in each health category.

Appendix 2. Comparison of Out-of-Pocket Costs for Individuals in Poor Health

Medicare Advantage plan	Percent penetration of plan in local area	OOP costs for MA plan	OOP costs for Medicare FFS plus Medigap Plan F	Difference in OOP costs between MA plan and Medicare FFS plus Medigap Plan F
Plan 1	24.3%	$7,522	$5,606	$ 1,916
Plan 2	5.7	7,232	5,677	1,555
Plan 3	12.3	6,720	4,525	2,195
Plan 4	11.3	6,604	5,179	1,425
Plan 5	7.2	6,590	4,525	2,065
Plan 6	2.9	6,585	5,227	1,358
Plan 7	9.5	6,460	5,606	854
Plan 8	7.9	6,267	5,399	868
Plan 9	4.4	6,173	6,232	–59
Plan 10	10.5	6,130	5,525	605
Plan 11	20.8	5,962	5,677	285
Plan 12	26.0	5,905	5,289	616
Plan 13	8.6	5,887	4,786	1,101
Plan 14	8.0	5,875	5,289	586
Plan 15	20.1	5,864	5,435	429
Plan 16	5.9	5,705	5,272	433
Plan 17	18.2	5,495	4,693	802
Plan 18	6.8	5,425	5,525	–100
Plan 19	18.7	5,203	5,408	–205
Plan 20	6.8	5,172	5,272	–100
Plan 21	10.1	5,154	4,786	368
Plan 22	13.9	5,131	4,693	438
Plan 23	15.5	5,045	5,289	–244
Plan 24	11.3	5,045	5,615	–570
Plan 25	11.4	5,015	5,179	–164
Plan 26	7.4	5,010	5,525	–515
Plan 27	3.2	5,010	5,525	–515
Plan 28	4.2	5,010	5,525	–515
Plan 29	7.7	5,005	5,525	–520
Plan 30	4.5	5,005	5,525	–520
Plan 31	13.0	4,995	5,615	–620
Plan 32	33.8	4,942	4,534	408
Plan 33	7.4	4,937	5,525	–588
Plan 34	9.5	4,937	5,525	–588
Plan 35	11.5	4,892	5,503	–611
Plan 36	15.6	4,885	5,289	–404
Plan 37	7.7	4,795	5,289	–494
Plan 38	2.7	4,725	4,786	–61
Plan 39	28.7	4,705	5,289	–584
Plan 40	9.6	4,690	6,623	–1,933
Plan 41	5.9	4,680	5,272	–592
Plan 42	5.0	4,667	4,786	–119
Plan 43	7.9	4,604	5,413	–809
Plan 44	7.0	4,563	5,399	–836
Plan 45	7.4	4,545	5,413	–868

FFS = fee-for-service.

Appendix 2. Comparison of Out-of-Pocket Costs for Individuals in Poor Health (continued)

Medicare Advantage plan	Percent penetration of plan in local area	OOP costs for MA plan	OOP costs for Medicare FFS plus Medigap Plan F	Difference in OOP costs between MA plan and Medicare FFS plus Medigap Plan F
Plan 46	7.4%	$4,525	$4,885	$ –360
Plan 47	4.0	4,520	5,408	–888
Plan 48	7.8	4,429	4,534	–105
Plan 49	12.5	4,341	4,534	–193
Plan 50	5.8	4,325	5,272	–947
Plan 51	9.4	4,325	5,615	–1,290
Plan 52	9.2	4,320	5,503	–1,183
Plan 53	3.6	4,290	5,289	–999
Plan 54	14.2	4,130	5,272	–1,142
Plan 55	7.7	4,115	5,227	–1,112
Plan 56	8.4	4,045	5,525	–1,480
Plan 57	7.6	3,995	5,289	–1,294
Plan 58	15.2	3,915	5,413	–1,498
Plan 59	8.1	3,849	5,386	–1,537
Plan 60	10.7	3,837	4,534	–697
Plan 61	11.4	3,798	5,435	–1,637
Plan 62	27.3	3,790	5,386	–1,596
Plan 63	21.2	3,775	5,210	–1,435
Plan 64	24.3	3,775	5,413	–1,638
Plan 65	11.4	3,770	5,272	–1,502
Plan 66	15.2	3,715	5,615	–1,900
Plan 67	13.3	3,715	5,994	–2,279
Plan 68	16.4	3,693	5,503	–1,810
Plan 69	9.4	3,655	5,994	–2,339
Plan 70	10.9	3,645	5,289	–1,644
Plan 71	14.0	3,645	5,994	–2,349
Plan 72	20.5	3,525	5,615	–2,090
Plan 73	11.7	3,325	5,289	–1,964
Plan 74	8.0	3,212	6,232	–3,020
Plan 75	14.6	3,047	5,210	–2,163
Plan 76	4.6	2,970	5,503	–2,533
Plan 77	8.8	2,845	5,994	–3,149
Plan 78	17.3	2,840	6,232	–3,392
Plan 79	21.3	2,830	6,232	–3,402
Plan 80	11.0	2,505	6,232	–3,727
Plan 81	17.2	2,286	4,885	–2,599
Plan 82	12.8	2,279	5,615	–3,336
Plan 83	5.6	1,945	5,227	–3,282
Plan 84	8.1	1,664	5,227	–3,563
Plan 85	12.6	1,610	5,984	–4,374
Plan 86	10.1	1,610	6,232	–4,622
Plan 87	19.5	1,560	6,623	–5,063
Plan 88	21.6	1,359	5,984	–4,625

FFS = fee-for-service.

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