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Issue Brief

Average Out-of-Pocket Health Care Costs for Medicare+Choice Enrollees Increase Substantially in 2002

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After rapid government payment increases in the mid- to late 1990s, Medicare+Choice plans now face sharply reduced annual increases in government payments for basic Medicare benefits (Gold 2001a). In response, Medicare+Choice plans are cutting back on supplemental benefits and raising premiums (Gold and Achman 2001; Achman and Gold 2002a, 2002c). These changes have increased out-of-pocket spending for health care by Medicare beneficiaries, especially by those who need the most care because of poor health (Achman and Gold 2002b).

This issue brief updates to 2002 an earlier Commonwealth Fund report, *Out-of-Pocket Health Care Expenses for Medicare HMO Beneficiaries: Estimates by Health Status, 1999–2001.* That analysis found that out-of-pocket spending by Medicare+Choice enrollees can be substantial and varies significantly by health status (Achman and Gold 2002b). In 2001, for example, the average enrollee in good health spent $1,195 out-of-pocket on health care while an enrollee in poor health spent $3,578, or about three times as much. Our current analysis shows that out-of-pocket costs for an enrollee in good health will rise by 20 percent in 2002, to $1,429. Costs for an enrollee in poor health will rise by 34 percent, to $4,783.

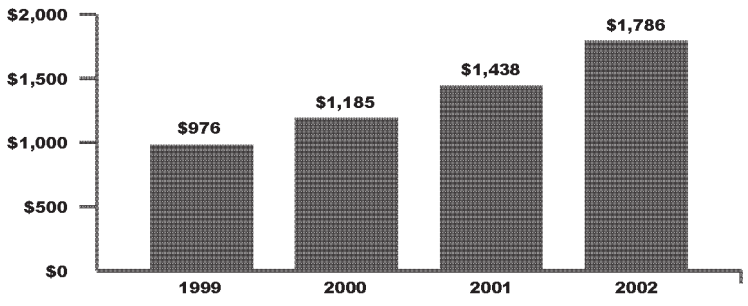
The analysis presented here uses the database Mathematica Policy Research, Inc. (MPR), created from Medicare Compare, a consumer-oriented summary of benefits in Medicare+Choice plans. We licensed the methodology of HealthMetrix Research, Inc., which includes cost and

utilization estimates, to approximate enrollee out-of-pocket costs across Medicare+Choice plans (see Methodology box for further detail). The out-of-pocket cost estimates presented here include four components of cost: (1) Medicare Part B premiums, which cover ambulatory care and related services; (2) supplemental Medicare+Choice premiums; (3) out-of-pocket spending for prescription drugs; and (4) out-of-pocket spending for other acute care services, such as physician services, inpatient hospital visits, emergency room visits, and preventive care. The projections understate total out-of-pocket costs because they exclude cost-sharing for some services and benefits typically not covered by standard medical insurance products (e.g., mental health, rehabilitative, and long-term care).

Average Estimated Out-of-Pocket Costs

In 2002, enrollees in Medicare+Choice plans on average will pay an estimated $1,786 in out-of-pocket expenses for health care, up by 24 percent from $1,438 in 2001 and by 83 percent from $976 in 1999 (Figure 1). The standard Medicare Part B premium is $648 for all Medicare beneficiaries in 2002. The average Medicare+Choice enrollee will also pay an additional $378 for the plan premium, $461 out-of-pocket for outpatient pharmaceutical costs, and $300 in cost-sharing for hospital and physician services (Table 1). Although Medicare's Part B premium increased only modestly from 2001 (8 percent), each of the other three components of out-of-pocket spending increased substantially between 2001 and 2002: Medicare+Choice premiums increased by 37 percent, out-of-pocket drug costs by 34 percent, and other cost-sharing (largely hospital and physician services) by 37 percent.

Figure 1. Estimated Average Annual Out-of-Pocket Health Costs for Medicare+Choice Enrollees, 1999–2002



Note: Results are weighted by Medicare+Choice plan enrollment and include only coordinated care plans. Costs include the Medicare Part B premium, for ambulatory care and related services; the Medicare+Choice plan premium; and estimated out-of-pocket spending for pharmaceuticals and selected acute care services (e.g., hospitalization, physician visits).

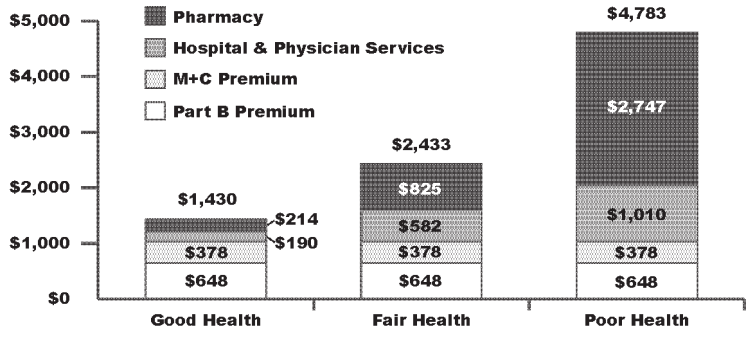
Source: Mathematica Policy Research analysis of Medicare Compare data using HealthMetrix Research's Medicare HMO Cost Share Report Methodology.

Out-of-Pocket Costs by Health Status, 2002

In 2002, as in previous years, out-of-pocket costs will vary substantially among Medicare+Choice enrollees in good, fair, or poor health (Figure 2). Although premiums are the same regardless of a beneficiary's health status, cost-sharing for services varies with the extent and type of services used; not surprisingly, those in poor health are much more likely to use more extensive services than those in better health. In 2002, those with poor health are projected to incur out-of-pocket costs of $4,783—more than three times as much as those in good health ($1,430). According to the 1998 Medicare Current Beneficiary Survey, 79 percent of Medicare managed care enrollees report that they are in good health or better whereas 15 percent report being in fair health and 6 percent report poor health.

The disparity between out-of-pocket health care costs for Medicare+ Choice enrollees in good health and those in poor health will be larger in 2002 than it was in 2001 (Table 1). Specifically, in 2002, estimated out-of-pocket costs are projected to be 20 percent higher for those in good health and 34 percent higher for those in poor health. Since 1999, out-of-pocket costs have increased 116 percent for those in poor health, compared with 71 percent for those in good health. Point-of-service cost-sharing represents a much higher proportion of total out-of-pocket spending for those in fair or poor health than for those in good health (58 and 79 percent for

Figure 2. Estimated Average Annual Out-of-Pocket Health Costs for Medicare+Choice Enrollees by Health Status, 2002



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

those in fair or poor health, respectively, versus 28 percent for those in good health).

In 2001, only 33 percent of Medicare+Choice enrollees had a benefit package that included cost-sharing for an inpatient hospital visit. In 2002, approximately 78 percent of enrollees pay part of the costs of such visits. Cost-sharing for hospital services places a larger burden on enrollees in poor health, who are more likely to use inpatient services (Achman and Gold, 2002d). This increase in inpatient hospital cost-sharing has caused out-of-pocket costs for hospital and physician services to grow substantially in 2002. For enrollees in fair or poor health, out-of-pocket costs for hospital and physician services increased 64 percent and 65 percent respectively, compared with just 18 percent for enrollees in good health.

Growing Differential in Out-of-Pocket Costs

While premiums in Medicare+Choice plans have been rising rapidly (the average enrollee will pay $32 per month in 2002 versus $6 in 1999), the value of coverage for pharmacy benefits and

Table 1. Average Enrollee Out-of-Pocket Costs in Medicare+Choice Plans, 1999–2002

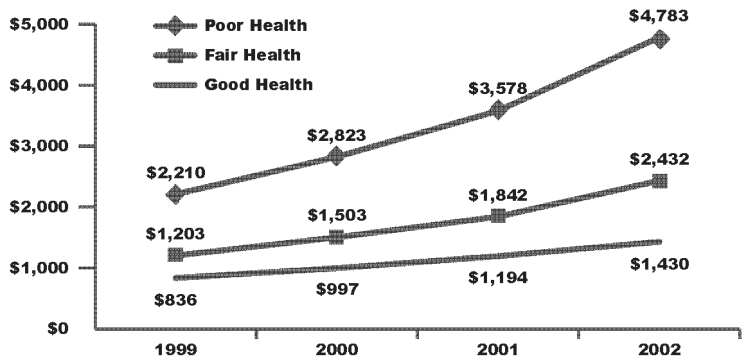
					Absolute Change		Percent Change	
	1999	2000	2001	2002	2001–2002	1999–2002	2001–2002	1999–2002
Annual Part B Premium	$ 546.00	$ 546.00	$ 600.00	$ 648.00	$ 48.00	$ 102.00	8%	19%
Annual Medicare+Choice Premium	63.37	173.16	275.24	377.58	102.34	314.21	37	496
Prescription Drug Out-of-Pocket Costs								
All[2]	234.19	291.75	344.02	460.72	116.70	226.53	34	97
Good Health	109.74	135.09	157.71	213.79	56.08	104.05	36	95
Fair Health	434.61	539.69	610.88	824.69	213.81	390.08	35	90
Poor Health	1,343.62	1,699.25	2,088.98	2,747.28	658.30	1,403.66	32	105
Hospital and Physician Out-of-Pocket Costs								
All[2]	132.08	174.42	218.74	299.89	81.15	167.81	37	127
Good Health	117.08	142.99	161.57	190.19	28.62	73.11	18	62
Fair Health	159.41	244.49	356.02	582.15	226.13	422.74	64	265
Poor Health	257.81	405.23	613.84	1,010.29	396.45	752.48	65	292
Total Annual Out-of-Pocket Costs								
All[2]	975.64	1,185.33	1,438.00	1,786.19	348.19	810.55	24	83
Good Health	836.19	997.24	1,194.52	1,429.56	235.04	593.37	20	71
Fair Health	1,203.39	1,503.34	1,842.14	2,432.42	590.27	1,229.03	32	102
Poor Health	2,210.80	2,823.64	3,578.06	4,783.15	1,205.09	2,572.35	34	116
Total Cost Ratio for Poor to Good Health	2.64	2.83	3.00	3.35				

Note: Results are weighted by plan enrollment.

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

Medicare cost-sharing appears to be shrinking even more rapidly. The result has been a growing differential in expected out-of-pocket costs among Medicare+Choice enrollees, depending on health status (Figure 3). In 2002, enrollees in poor health are projected to pay, on average, 3.3 times more than those in good health, up from 3.0 times more in 2001 and 2.6 times more in 1999.

Figure 3. Estimated Total Annual Out-of-Pocket Spending for Medicare+Choice Enrollees by Health Status, 1999–2002



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

Medicare Managed Care Compared with Other Options in the Individual Market

With out-of-pocket costs for many Medicare+Choice enrollees rising, does the program still hold value for Medicare beneficiaries? This question is particularly relevant to Medicare beneficiaries without access to employer-subsidized retiree coverage or government-subsidized Medicaid coverage. In 2002, for these individuals, the alternatives to Medicare+Choice for supplemental coverage are the private fee-for-service plan (Sterling), Medigap, or going "bare" with only traditional Medicare coverage. Comparisons among supplemental plan alternatives are difficult and potentially misleading, but there is considerable demand for such comparisons nonetheless.[3] To address this demand, we undertook a rough comparison of out-of-pocket costs for alternative options for supplemental coverage by extending the methodology used in the Medicare+Choice out-of-pocket spending projections to other plans (Table 2). The comparisons assume that, in each alternative plan, beneficiaries have the same health status mix and use the same types and volume of services factored into the Medicare+Choice calculations. The projections for each plan alternative therefore represent differences only in plan design and premium cost.

The analysis found that, in 2002, out-of-pocket costs for the average beneficiary would be about $1,787 for Medicare+Choice enrollees and $2,717 to $3,058 for enrollees in the alternative plans (Figure 4). There are differences among the projected total expenses of these alternatives and even greater differences among premiums, prescription drug costs, and other cost-sharing expenses, highlighting the complex trade-offs beneficiaries make when choosing a supplemental coverage plan. None of the options is relatively low in price when compared with the fixed income of most beneficiaries.

To many beneficiaries, Medicare+Choice is more attractive than other supplemental products because the plan premium is lower. For a beneficiary in average health, the expected out-of-pocket costs in the Medicare+Choice managed care plan are lower than for the Sterling private fee-for-service product. Sterling modifies Medicare's cost-sharing requirements. It does not cover prescription drugs and charges a premium substantially higher than that for the average managed care plan.[4] Medicare+Choice also is more attractive than the common Medigap plans, mainly because premiums for Medigap coverage tend to be high and pharmacy coverage in the standard options is limited. Medicare+Choice also provides a better average value than Medicare alone because projected out-

Table 2. Comparison of Projected Average Annual Out-of-Pocket Spending for Selected Supplemental Plans, 2002 [5]

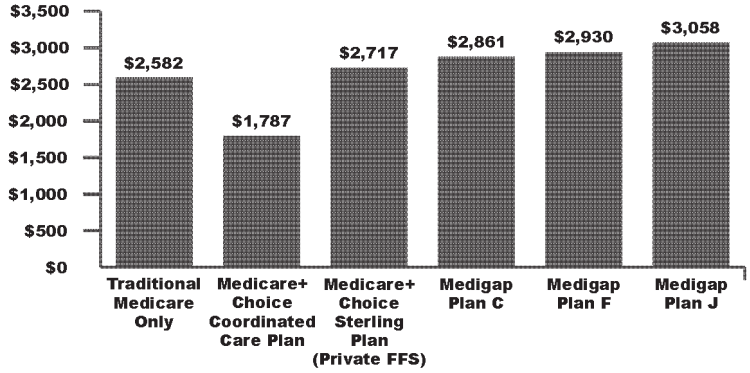
	Traditional Medicare Only	Medicare+Choice Coordinated Care Plan	Medicare+Choice Sterling Plan (Private FFS)	Medigap Plan [6]		
				C	F	J
Total	$2,582	$1,786	$2,717	$2,861	$2,930	$3,058
Part B Premium	648	648	648	648	648	648
Annual Supplemental Premium	0	378	936	1,318 [7,8]	1,387 [7,8]	1,810 [7,8]
Out-of-Pocket Prescription Drugs	670	461	670	670	670	475
Other Cost-Sharing	1,264 [8,9]	300	463	225	225	125

Source: Mathematica Policy Research analysis of Medicare Compare data using HealthMetrix Research's Medicare HMO Cost Share Report Methodology.
Note: FIgures may not add up to total due to rounding.

of-pocket costs for services are higher in traditional Medicare than in the average Medicare+Choice plan.

Yet, although Medicare+Choice appears to provide more value than other supplemental plans, it is not necessarily a good alternative for the average beneficiary because it is relatively expensive and may expose beneficiaries to high out-of-pocket costs. Faced with the current choices, a Medicare beneficiary with limited income might well decide to risk unpredictable out-of-pocket spending at the point of service rather than pay fixed premium costs. Moderate-income beneficiaries may not even consider Medigap because of its high premiums, instead choosing between two options: a Medicare+Choice plan or traditional Medicare. The relatively healthy may choose to forgo supplemental coverage.

Figure 4. Projected Average Enrollee Out-of-Pocket Costs by Type of Medicare Supplemental Plan, 2002



Note: Total costs include Part B premium, supplemental premiums, hospital and physician cost-sharing, and the costs of pharmaceuticals.

Sources: Mathematica Policy Research estimates for Medicare+Choice were developed with HealthMetrix Research's Medicare HMO Cost Share Methodology. Comparisons for supplemental products hold the health status mix constant across options and apply the same assumptions used for M+C coordinated care plans. The methods are adapted to estimate out-of-pocket costs for hospital, physician, and pharmacy in Sterling's private fee-for-service plan and Medigap plans. Traditional Medicare costs for services are based on the Centers for Medicare and Medicaid Services actuarial estimate of benefits. All projections are approximate and do not reflect fully differences in the geographic location or health status of beneficiaries. Medigap premium data are based on Chollet (2001) estimates from National Association of Insurance Commissioners data inflated to 2002.

Choice for Individual Beneficiaries

Broad comparisons among supplemental plans are mainly of interest to policymakers; when choosing supplemental coverage, individual Medicare beneficiaries need to review the plans available in their area, the benefits they provide, and the premiums that will be charged for those products. Medigap premiums in particular vary with age and other factors. A Medicare beneficiary has more choices when he or she first becomes eligible for Medicare than later, when Medigap insurers impose more limits on who is eligible to enroll, how the premium is set, and what amount is charged. Beneficiaries who decide to go bare with only Medicare coverage should carefully consider the trade-offs they make and, in particular, the constraints they may face if their health status changes.

Conclusion

Medicare's basic benefit package is not structured to protect those who are most likely to incur high out-of-pocket costs, which is why supplemental coverage is appealing to many beneficiaries. The analysis presented in this issue

brief suggests that, for beneficiaries in relatively poor health, none of the options available to them in the individual market to supplement Medicare's benefits is particularly effective at filling in the coverage gap at an affordable price. The financial burden is higher for those in poorer health. Rather than increasing premiums, Medicare+Choice plans are raising point-of-service costs to beneficiaries for medical care and pharmacy benefits. This shift necessarily places a greater burden of costs on high users. Thus, policymakers hoping to reduce the financial risk imposed on the sickest Medicare beneficiaries under traditional Medicare can no longer count on Medicare+Choice to provide such protection. The limitations of Medicare's current benefit package need to be addressed.

Notes

[1] Lori Achman, M.P.P., is a research analyst at Mathematica Policy Research, where her work has focused primarily on the Medicare+Choice program. She received a master of public policy degree from the University of California, Los Angeles, School of Public Policy and Social Research. Marsha Gold, Sc.D., has been a senior fellow at Mathematica Policy Research since 1992. Dr. Gold's current work focuses on arrangements between HMOs and providers, Medicare managed care, and Medicaid managed care. Dr. Gold earned her doctorate from the Harvard School of Public Health.

[2] Assumes 79 percent of enrollees are in good health, 15 percent are in fair health, and 6 percent are in poor health, which corresponds to the distribution of self-reported health status among Medicare+Choice enrollees in the 1998 Medicare Current Beneficiary Survey.

[3] Medigap premiums and out-of-pocket costs vary substantially with age, health status, and geographic location, and reliable current national data on the Medigap premiums actually paid by beneficiaries do not exist.

[4] In 2002, Sterling was offered in 25 states, in which 14.8 million Medicare beneficiaries resided. Thirty-eight percent of these beneficiaries had only the Sterling fee-for-service Medicare+Choice option available (e.g., no Medicare+Choice coordinated care plan option). In the Sterling plan, a standard supplemental premium of $78 per month is charged. Beneficiaries pay a $350 copayment per hospital admission and a $20 copayment for an office visit (Gold, 2001b). In April 2002, only 20,211 beneficiaries were enrolled in this product nationwide.

[5] Based on estimates developed with HealthMetrix Research's Medicare HMO Cost Share Methodology. Estimates assume that 79 percent of HMO enrollees are in good health, 15 percent in fair health, and 6 percent in poor health, which corresponds to the distribution of self-reported health status among Medicare+Choice enrollees in the 1998 Medicare Current Beneficiary Survey. Comparisons for supplemental products hold the health status mix constant across options and apply the same assumptions used for Medicare+Choice coordinated care plans.

[6] All three Medigap plans cover the Parts A and B deductibles and cost-sharing. Out-of-pocket costs for "other cost-sharing" are for preventive services not included in Medicare (e.g., eye examination, hearing examination, annual physical examination). Plans C and F do not cover these services or prescription drugs. Plan J covers up to $120 each year in preventive care services, including an annual physical examination and hearing test. Plan J also has a prescription drug benefit that covers 50 percent of prescription drug costs up to $1,500, once a $250 deductible is met.

[7] Premiums are based on Chollet (2001) estimates, which are 1999 averages weighted by plan enrollment. The 1999 averages were then inflated to 2002 estimates using the increases in Consumer Price Index for medical care for 2000–2002 (4.1 percent for 2000, 4.6 percent for 2001, and 4.4 percent for 2002). Actual prices paid vary substantially by location, policy, age, and underwriting factors. In New York City (zip code 10036), for example, a 65-year-old person would pay $1,929 for Plan C and $1,938 for Plan F offered by AARP (Plan J is not available). In Orange County, California (zip code 92646), a 65-year-old person would pay $1,838, $1,862, and $2,621, respectively, for Plans C, F, and J. For all of Washington, D.C., the prices would be $1,145, $1,159, and $1,735, respectively.

[8] The estimates for Medigap premiums and traditional Medicare's "other cost-sharing" are national estimates and are not adjusted to the primarily urban locations of Medicare HMOs

[9] 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 2002 (CMS, 2002). The estimate overstates the differential against Medicare+Choice because it includes some components of out-of-pocket cost (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.

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Methodology

We estimate out-of-pocket spending for Medicare+Choice enrollees using the HealthMetrix methodology, which 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, we 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, how Medicare+Choice plans calculate their drug benefit limits, and the cost of preventive services. For example, in 2002, brand-name prescription drugs are assumed to cost both the health plan and an enrollee without coverage $66 for a month's supply. Similarly, generic drugs are assumed to cost $39 for a one-month supply. Detailed information on the cost assumptions and utilization profiles used in the HealthMetrix HMO CostShare Reports is available on the HealthMetrix Research CostShare Report website at www.hmos4seniors.com or by contacting the authors. The model assumes no change in utilization patterns from 1999–2002. The only prices assumed to have changed during the time 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 out-of-pocket cost estimates for those in good, fair, and poor health according to the reported health status of Medicare beneficiaries enrolled in risk managed care plans in the 1998 Medicare Current Beneficiary Survey (MCBS).

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