The Costs and Benefits of Medicare Advantage: An Update

Executive Summary

- Out-of-pocket payments for beneficiaries in Medicare Advantage (MA) plans are 34 percent less than out-of-pocket payments for beneficiaries with fee-for-service Medicare. The differences in spending between MA and FFS Medicare are particularly large for beneficiaries with costly chronic illnesses and predictably high medical costs.

- This difference in out-of-pocket payments makes MA plans particularly popular with lower income beneficiaries, minority beneficiaries, and others who are struggling to afford up-to-date medical care. Beneficiaries with incomes between $10,000 and $25,000 – beneficiaries who usually do not qualify for Medicaid, and who are unlikely to have access to inexpensive retiree coverage to supplement their Medicare coverage – are significantly more likely to enroll in MA plans. These beneficiaries comprise about one-third of all Medicare beneficiaries, but make up half of Medicare Advantage enrollees.

- Recent payment increases for MA plans have improved plan benefits and further reduced out-of-pocket costs for beneficiaries. To the extent they encourage more enrollment in MA plans, they may also help control overall health care costs. For example, a recent study by Mathematica showed that total payments (beneficiary plus government) were significantly higher for beneficiaries in fee-for-service Medicare who also purchased the most popular Medigap plan (plan F), compared to beneficiaries in MA plans (formerly Medicare + Choice plans), because of the substantially lower total out-of-pocket costs in MA plans.

- In addition to improving benefits for Medicare enrollees of plans, the recent payment increases have contributed to increased plan participation in the MA program and will enable plans to offer stable and reliable options for Medicare beneficiaries. Since March of 2004, two new MA plans have entered the program, and there are pending applications from 10 more plans. In addition, there are nine pending requests from plans to expand their service areas.

Recent Evidence on Medicare Advantage Plans

Medicare Advantage plans are available to about 75 percent of the Medicare population, with 61 percent of the population having access to Medicare Advantage coordinated care plans and additional beneficiaries having access to Medicare Advantage private fee-for-service plans. Such plans offer enrollees additional benefits beyond those covered by Medicare, and they enable enrollees to reduce their out-of-pocket costs for medical care:

- 64 percent of Medicare beneficiaries live in a county where there is a Medicare Advantage plan offering drug coverage. As noted below, drug coverage offered by Medicare Advantage plans has increased this year.

- Many other benefits are available in particular Medicare Advantage plans that are not part of the defined Medicare benefit package available in FFS Medicare, including: additional preventive benefits and wellness services; disease management and care management services for beneficiaries with chronic illnesses or high medical expenses; and dental, vision, and hearing services.

Beneficiaries choosing Medicare Advantage plans often have lower copayments and deductibles than in FFS Medicare. In addition to expanded benefits and lower beneficiary payments for services, Medicare Advantage enrollees may benefit from lower Medicare premiums as well. Eleven percent of Medicare beneficiaries live in a county in which there is a Medicare Advantage offering rebates on the premiums beneficiaries pay for Medicare Part B. In three counties in Florida (Miami-Dade, Broward, and Hernando) beneficiaries can choose a plan that has no plan premium and which offers a full reduction of the monthly Medicare Part B premium of $66.60.

As a result, research studies have consistently shown that enrollees in Medicare Advantage plans have lower out-of-pocket costs than enrollees in FFS Medicare. The most recent published study on out-of-pocket costs shows that enrollees of Medicare Advantage plans have out-of-pocket costs that are one-third lower than beneficiaries who have only FFS Medicare coverage. While out-of-pocket costs (including the Medicare Part B premium) for beneficiaries with FFS coverage only average about $219, for MA enrollees the comparable average of monthly costs was $164. (Marsha Gold and Lori Achman, "Average Out-of-Pocket Health Care Costs for Medicare + Choice Enrollees Increase 10 Percent in 2003," Commonwealth Fund Issue Brief #667, August 2003. Gold and Achman stated their results as annual figures of $1964 for MA plans and $2631 for individuals with only FFS Medicare, or a 34 percent difference.)

Of course, many beneficiaries in FFS Medicare obtain Medigap coverage to reduce their out-of-pocket costs if they can afford it. While many FFS Medicare beneficiaries today receive Medigap-like supplemental coverage as a retirement health benefit from former employers, the number of employers offering such retiree coverage has been declining. At the same time, the cost of individually-purchased Medigap plans has been rising, leading to a wider gap in out-of-pocket spending between FFS beneficiaries and Medicare Advantage enrollees.

Because they are least able to afford high out-of-pocket costs, beneficiaries with limited means are among those most likely to enroll in Medicare Advantage. A number of studies have shown that individuals who enroll in Medicare Advantage are more likely to be lower income individuals who are not eligible for Medicaid coverage and are unable to afford Medigap supplemental coverage (for example, see Kenneth E. Thorpe and Adam Atherly, "Medicare + Choice: Current Role And Near-Term Prospects," *Health Affairs*, web exclusive W-242, July 17, 2002).

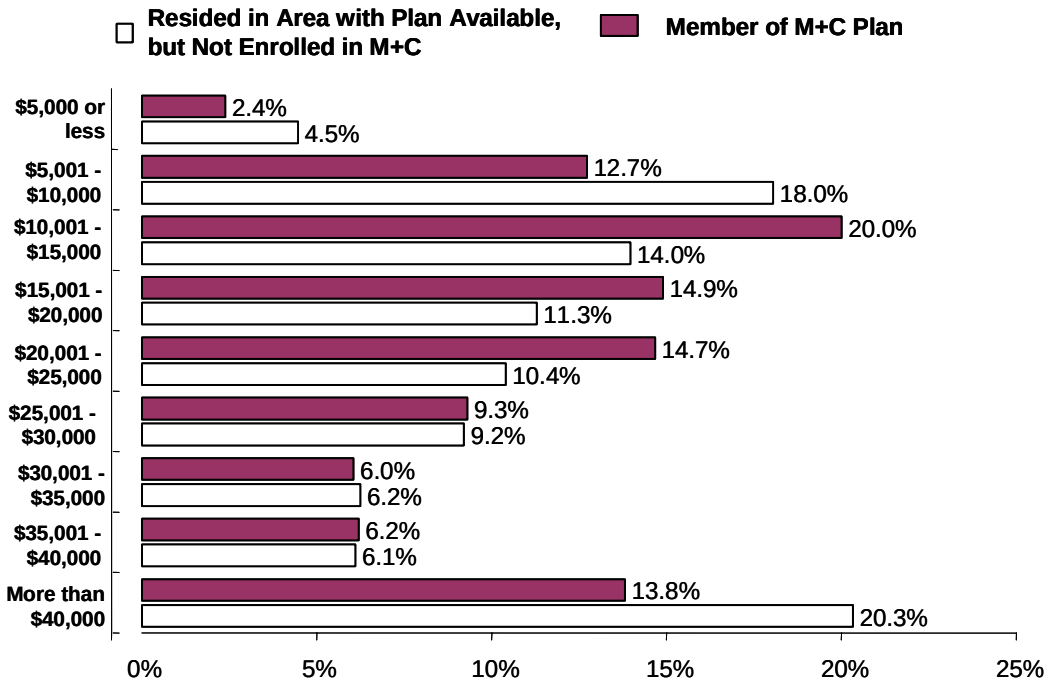
Studies have also found that coordinated-care health plans have important "spillover" effects that help to reduce total health care costs. For example, the plans may help doctors and hospitals deliver care more efficiently (avoiding procedures, admissions, and other treatments and favoring less costly alternatives). See, for example, Laurence Baker, "Association of Managed Care Market Share and Health Expenditures for Fee-For-Service Medicare Patients," *Journal of the American Medical Association*, vol. 281, no. 5, February 1999, pp. 432-7.

This report provides information about out-of-pocket costs in MA plans, and details on the characteristics of beneficiaries who choose to enroll in MA plans.

New Evidence on Performance of Medicare Advantage Plans

Though Medicare beneficiaries in the lowest income categories tend not to enroll in plans because they are dually eligible for Medicaid and Medicare coverage, beneficiaries with slightly higher incomes than the lowest income groups predominantly enroll in Medicare Advantage plans. For example, beneficiaries with annual income over $10,000 an up to $15,000 comprised 20 percent of Medicare + Choice enrollment in 2002 but comprised only 14 percent of the population of non-enrollees in areas where there were M+C plans available. These recent results confirm that Medicare Advantage plans remain

Figure 1: Enrollment Patterns of Medicare Beneficiaries by Income, Medicare+Choice Enrollment and Traditional Fee-for-Service (In Areas Where M+C Plans Are Available)



Source: Unpublished Medicare Current Beneficiary Survey Data, CMS

particularly valuable to lower-income beneficiaries who do not have supplemental employer coverage and thus who are less able to afford the out-of-pocket payments in

FFS Medicare. (Prior to the Medicare Modernization Act, coordinated care plans now referred to as Medicare Advantage plans were known as Medicare + Choice plans.)

With respect to enrollment among minority populations, the 2002 MCBS data indicate that among aged beneficiaries (those age 65 or over), Hispanics were predominately enrollees of M+C plans (constituting 11 percent of plan enrollment, while comprising seven percent of the population in areas with M+C plans), and African-Americans were also more likely to enroll in plans (comprising eight percent of plan enrollment and seven percent of the population in areas with plans).

Mathematica's recent study on cost sharing for Medicare beneficiaries in private plans noted that in previous work Mathematica had determined that the average premium for the most popular Medigap plan, plan F (which has no drug coverage), was $1387 in 2002. Thus, using the numbers that Mathematica shows for average out of pocket costs in M+C plans ($1964) and the numbers they show for the average Medigap premium ($1387), together with the cost sharing that remains a beneficiary responsibility if the person has Medigap plan F coverage (the $704.40 for the Medicare Part B premium, and the $707.76 for outpatient drugs), the rough total of out-of-pocket costs for beneficiaries with Medigap plan F coverage is $2800. This is about 42 percent more than the $1964 that Mathematica determined as the average out-of-pocket costs for M+C plan enrollees. (As Gold and Achman of Mathematica note, Medigap premiums vary greatly across the country. They would tend to be higher in areas of the country in which there were M+C plans in 2003 because those are areas in which, for the most part, Medicare program expenditures have been higher than national average levels.)

Recent Changes in Medicare Advantage Payment Rates Have Improved Benefits, Improved Access to Providers, and Reduced Beneficiary Out-of-Pocket Payments

The Medicare Modernization Act (MMA) provided additional payments to health plans in 2004 by making changes to the method of paying Medicare Advantage (MA) plans. Payment increases were effective in March of 2004, after plans had already determined the benefit packages that were in place prior to the passage of the MMA, and which were in place in January and February of 2004. The MMA required that the additional payments made in March be used for the benefit of Medicare enrollees of MA plans. The majority of the extra funding that went to health plans was passed on to beneficiaries in the form of extra benefits and/or reduced cost sharing, and some of the additional funding went to improving provider networks and "stabilization funds" to provide extra benefits or reduced cost sharing in the year 2005. In dollar terms, 53 percent of the extra funds were used to immediately decrease premiums or cost sharing or to increase the benefit levels for enrollees of MA plans; five percent of the money will be used in 2005 for providing extra benefits through the "stabilization funds"; and 42 percent of the funds were used to strengthen provider networks (for example, by using the extra funds to increase provider payments and ensure their continued participation as network providers).[1] The distribution of extra funds was about the same for plans operating in

[1] The national and State-level information on the distribution of benefits and reduced premiums and cost sharing was based on the adjusted community rate (ACR) proposals (that is, the premium and benefit

rural areas as it was for plans operating in urban areas. (Note that health plans must use all amounts in the "stabilization funds" by the end of 2005. That is, to the extent that there are fund contributions remaining from prior years, including 2004, the funds must be used in 2005 to improve benefits or reduce cost sharing, or the health plans forego the use of the funds and they revert to the Medicare Trust Funds.)

There are numerous examples of the ways in which beneficiaries enrolled in Medicare Advantage saw their benefits increase, and their out-of-pocket costs decrease, because of the increased payments to plans. Before the MMA payment changes, the enrollment-weighted average monthly plan premium for enrollees of MA coordinated care plans and preferred provider organization (PPO) demonstration plans was $42 in 2004. After the MMA payment changes, premiums were reduced to an average of $31 per month. Excluding enrollees that had no plan premium at the beginning of 2004 (that is, considering only those beneficiaries who in January 2004 were paying a plan premium), the weighted average premium declined from $72 a month as of January 2004 to $53 a month as of March 2004—an average decrease of 26 percent.

In many parts of the country and for many enrollees of MA plans, the MMA payment reforms resulted in large reductions in beneficiary costs. In New Jersey, for example, where 88,000 beneficiaries are enrolled in MA coordinated care plans or demonstration PPO plans, the enrollment-weighted average monthly premium for MA plans and PPO demonstration plans declined from $67 to $27 (a 60% decrease). Considering only those New Jersey MA enrollees whose plan charged a premium in January 2004, the weighted average premium declined from $78 to $32 a month (a 59% decrease). The average value of cost sharing for Medicare-covered services in the New Jersey plans declined by $45 a month. Furthermore, plans added extra benefits with an average monthly dollar value of $37 (including the value of reduced cost sharing for extra benefits). In other words, every New Jersey resident enrolled in a Medicare private plan who had been paying a plan premium saw an immediate increase in their monthly income (averaging $46 across all plans). To the extent that they are average users of Medicare-covered services and other benefits offered by their health plans, the average out-of-pocket costs of New Jersey MA enrollees (across all New Jersey plans) are $82 per month less than they would have been in the absence of the MMA payment reforms.

Similarly, in the State of New York, for enrollees of MA plans who were paying a plan premium in January 2004, their premium obligation was cut nearly in half. The enrollment-weighted average premium across all such plans in New York declined from

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package proposals) that health plans submit for CMS approval. All Medicare Advantage and demonstration PPO plans were included, unless they were plans offered exclusively to retirees of unions or employers contracting with Medicare Advantage plans for a different set of benefits not available to individual Medicare beneficiaries (14 percent of enrollees are in such plans). The enrollment figures used were the enrollment figures as projected by the Medicare Advantage organizations for each of the benefit packages they offered (organizations can offer multiple benefit packages in a given county). These enrollment counts, which were used to determine enrollment-weighted numbers, are generally consistent with the actual enrollment counts that plans have been reporting to CMS. For example, the total actual enrollment by benefit package, as reported to CMS by MA organizations as of April 2004, is 97 percent of the projected enrollment from the ACR proposals.

$81 to $43 a month. On average across all New York plans, cost sharing for Medicare-covered services declined by $15 a month, and extra benefits valued at $12 per month were added for the 445,000 enrollees of plans in New York State. In the State of Florida, the weighted average monthly premium for MA enrollees across the State was also nearly cut in half, declining from $40 to $22 per month (among enrollees paying a premium in January 2004). Across all Florida plans, MA enrollees saw an average decrease of $11 per month in cost sharing for Medicare-covered services, and $10 worth of extra benefits added each month for Florida's 535,000 plan enrollees.

These benefit improvements in states around the country are a reflection of improvements in benefits and cost-sharing for Medicare enrollees in specific plans as a result of the MMA. Some of these improvements in benefits between January 2004 and March 2004 included:

- A plan in Alameda County, California (Oakland) reduced its beneficiary premium from $85 to $50 a month, and reduced the copayment for inpatient hospital services from $175 for each of the first eight days of a hospital stay, to $100 per day, applied only to the first four days of a hospital stay. In San Francisco, the same plan reduced the premium from $90 to $59, and changed the hospital copayment from $175 for the first eight days to apply only to the first five days of a stay. The same plan made similar changes to its benefit packages in Southern California, and added coverage of brand-name drugs.

- In Los Angeles, another plan eliminated its copayment for an inpatient hospital stay, which was $300 per stay in January 2004. This plan enhanced its prescription drug coverage by reducing the copayment for non-formulary generic and brand-name drugs from $50 to $20, and by eliminating what had been a monthly maximum coverage for formulary generic drugs of $200 (the plan now has unlimited coverage of formulary generic drugs).

- A plan in Oklahoma reduced its premium to zero from $29, reduced its primary physician copayment to $5 from $15, reduced the inpatient hospital copayment from $550 to $300 per admission, and now provides unlimited generic drug coverage rather than imposing an annual maximum of $500. In addition, as of March the plan now provides brand-name drugs (with a $500 annual limit), whereas in January there was no brand-name drug coverage.

- A plan in Philadelphia reduced beneficiary cost sharing on outpatient surgery from $200 to $50 per service. Inpatient hospital cost sharing was reduced from $100 per day to $50 per day. Coinsurance for durable medical equipment of 10 percent was eliminated. Home health cost sharing, which had been $10 per visit, was eliminated. And the plan changed to unlimited generic drug coverage from the pre-March generic drug benefit that was limited to $1500 per year.

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