AGENDA ITEM NO. V.

PRESENTATION ON HEALTH MAINTENANCE ORGANIZATIONS AS THEY RELATE TO THE FEDERAL MEDICARE PLAN

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PAYING FOR CHOICE: THE COST IMPLICATION OF HEALTH PLAN OPTIONS FOR PEOPLE ON MEDICARE

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Report Highlights

Medicare coverage alone does not provide sufficient financial protection for many program beneficiaries. Thus, the vast majority obtains supplemental coverage from four main sources: former employers, individual "Medigap" insurance policies, Medicaid, and Medicare+Choice plans. Those who are eligible for coverage from a former employer, or from Medicaid, usually take advantage of this subsidized coverage. Other beneficiaries—approximately 56%—can choose between purchasing a Medigap policy, joining a Medicare+Choice (M+C) plan, or forgoing Medicare supplementation altogether.

This report examines the financial implications associated with these different choices by calculating how much people on Medicare would spend annually out-of-pocket on costs including—premiums, cost-sharing requirements, and spending for uncovered services—under different supplemental insurance arrangements. To assess cost implications of choosing among different Medigap and M+C options, we estimated the range in health care spending for three prototype beneficiaries in eight national markets. Cost estimates were made for four Medigap plans (types A, F, H, or J) and up to five M+C plans, all compared with not purchasing supplemental coverage in each geographic market. Of particular interest is the range in out-of-pocket costs that results from the various alternatives, which highlights the importance of these choices. Costs were calculated for the following prototypical beneficiaries: a 50 year-old man with disabilities, a relatively healthy 65 year-old woman, and a frail 80 year-old woman. Findings include:

- Medicare beneficiaries face wide variations in costs associated with supplemental insurance choices. In the starkest example, the potential out-of-pocket costs for the 50 year-old with disabilities ranges from $6,010 (M+C plan, Miami, FL) to $21,857 (Medigap Plan J, Oakland, CA), depending on where he lives and the plan he chooses. Similarly, the frail 80 year-old may face high expenses ranging from $1,342 to $12,482. Perhaps most surprising are the variations in costs for the healthy 65 year-old with far fewer health care needs, who would face up to a $9,000 difference in total spending depending on the plan she chooses and where she lives. This cost difference alone reflects over half the mean annual income of women ages 65 and older (~ $16,000).

- The types of plan beneficiaries choose often affect out-of-pocket spending. In general, M+C plans are less costly (when available) than Medigap plans. In Miami, FL for example, total costs for the healthy 65 year-old beneficiary vary from $58 to $1,013 when choosing an HMO, and from $3,465 for the lowest cost Medigap Plan A to $5,163 for the highest cost Medigap plan J. The healthy 65 year-old may spend less out-of-pocket without supplemental coverage, since insurance is designed to reduce risk and not save money. However, this is not advisable

because her health status could deteriorate at any time, and because she would lose Medigap open enrollment privileges if she did not purchase coverage within six months of becoming eligible for Medicare.

- Even within a particular insurance type within a given market, the specific plan chosen affects costs as well. For example, in Minneapolis, costs for even the healthy 65 year-old who chooses Medigap Plan F vary by over $1,300 annually, depending on the insurance company. Similarly, if she chooses an M+C plan, her spending would vary by over $750, depending on the plan selected.

- Geographic location can also make a big difference in cost. The 80 year-old who chooses the least expensive Medigap Plan J would spend $6,376 in Manchester, NH but $9,520 if she lived in Miami, FL. In contrast, she could spend as little as $1,342 for the cheapest M+C plan in Miami, but as much as $7,082 for the lowest-cost M+C option in Seattle, WA.

- Premiums are a poor barometer for gauging total out-of-pocket spending. While premiums play a major role in determining overall costs, prescription drugs and other non-Medicare covered services are important "hidden" factors affecting total out-of-pocket spending. These items are important considerations because they are fully paid for by the beneficiary unless he has supplemental coverage, and even then, costs associated with supplemental plans can pose major financial burdens. In Baltimore, MD, for example, the 50 year-old man with disabilities would spend about $2,200 annually on premiums for Medigap Plan J, but still incur relatively high total out-of-pocket expenditures (over $9,650) as a result of "hidden" costs such as prescription drugs and other health services.

The supplemental insurance market presents opportunities for Medicare beneficiaries to insure themselves against future health care costs, but the choice is neither easy nor risk-free—particularly for those living on fixed incomes. Depending on beneficiaries' individual circumstances, mainly their health needs and where they live, this decision could result in expenditures that represent a sizeable share of their income. In the area of Medicare supplementation, there are no obvious "right" choices for Medicare beneficiaries. Spending is often lower in M+C plans, but this is not always the case. Forgoing supplemental coverage could save money—but only if a beneficiary remains healthy. Scope of coverage provided by supplemental insurance is often a more important determinant of total out-of-pocket costs than are premiums, but often difficult for consumers to assess and compare. Even those with chronic illnesses and predictable service and equipment needs would be challenged to project costs under alternative supplemental insurance options, due to formularies and coverage limits that are often difficult to decipher prior to enrollment. This study confirms the substantial financial stakes involved for beneficiaries choosing among supplemental coverage options.

The Medicare+Choice Program Is a Safety Net for Many Low-Income and Minority Beneficiaries

Many Financially Vulnerable Beneficiaries Rely on Medicare+Choice As Their Only Option for Comprehensive, Affordable Health Care

Medicare+Choice plans play an important role in providing health coverage to many low-income and minority beneficiaries who cannot afford the high out-of-pocket costs they would incur under the Medicare fee-for-service program. For many beneficiaries who do not receive supplemental coverage through Medicaid or a prior employer, the Medicare+Choice program serves as a crucial health care safety net by providing comprehensive, affordable coverage that is not available under the Medicare fee-for-service program.

The American Association of Health Plans (AAHP) and the BlueCross BlueShield Association (BCBSA) have released studies showing that financially vulnerable beneficiaries are more likely to enroll in Medicare+Choice plans than other beneficiaries. These financially vulnerable beneficiaries rely on the Medicare+Choice program as their only option for comprehensive, affordable health coverage.

Key Findings of AAHP Study:

- **Medicare+Choice plans serve many beneficiaries who have modest incomes, but do not qualify for Medicaid assistance.** Among unsubsidized Medicare beneficiaries in the urban West who had supplemental coverage and who had annual incomes below the federal poverty level, 76 percent had selected Medicare HMOs.

- **Medicare+Choice plans serve many beneficiaries who do not receive supplemental health coverage that is paid for by Medicaid or prior employers.** Among beneficiaries in the urban Northeast, 41 percent of beneficiaries who had *unsubsidized* supplemental coverage were enrolled in Medicare HMOs while only 5 percent of beneficiaries who had *subsidized* supplemental coverage were enrolled in Medicare HMOs.

- **Medicare+Choice plans play an important role in providing prescription drug coverage to beneficiaries who do not receive such coverage through Medicaid or a prior employer.** Among Medicare beneficiaries who receive unsubsidized supplemental coverage for prescription drugs, 54 percent obtained such coverage through Medicare HMOs.

"Supplemental Coverage" refers to coverage for services not covered by the Medicare fee-for-service program

"Unsubsidized Coverage" refers to coverage that is not paid for by Medicaid or a prior employer

Key Findings of BCBSA Study:

> **"Active Choosers"** are the 13 million Medicare beneficiaries who live in areas where Medicare+Choice plans are available and who do not receive Medicaid coverage or employer-sponsored coverage

- **A large percentage of minorities are enrolled in Medicare+Choice plans.** Nationwide, 56.1 percent of Hispanic "active choosers" and 40.3 percent of African-American "active choosers" are enrolled in Medicare+Choice plans.

- **A large percentage of low-income beneficiaries are enrolled in Medicare+Choice plans.**
  - In southern California, 78 percent of "active choosers" with incomes between $10,000 and $20,000 are enrolled in Medicare+Choice plans.
  - In Philadelphia, 67 percent of "active choosers" with incomes between $10,000 and $20,000 are enrolled in Medicare+Choice plans.
  - In southern Florida, 51 percent of "active choosers" with incomes between $10,000 and $20,000 are enrolled in Medicare+Choice plans.
  - Nationwide, 40 percent of "active choosers" with incomes between $10,000 and $20,000 are enrolled in Medicare+Choice plans.

- **If the Medicare+Choice program was no longer available, a total of 1.5 million current Medicare+Choice enrollees would choose to go without supplemental coverage.** The BCBSA study concludes that 30 percent of current Medicare+Choice enrollees would go without supplemental coverage, 18 percent would obtain Medicaid assistance, and 52 percent would purchase Medigap coverage. Among those who would choose to go without supplemental coverage, more than half earn less than $20,000 a year.

- **If the Medicare+Choice program was no longer available, 42 percent of African-Americans currently enrolled in Medicare+Choice plans would rely on the Medicare fee-for-service program only (with no supplemental coverage).** The BCBSA study cautions that "ending access to Medicare+Choice would have a disproportionate effect on African-American beneficiaries."