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ISSUE BRIEF

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HOW DOES THE BENEFIT VALUE OF MEDICARE COMPARE TO THE BENEFIT VALUE OF TYPICAL LARGE EMPLOYER PLANS? A 2012 UPDATE

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INTRODUCTION

Medicare has been a major focus of several recent proposals to reduce federal spending and the federal budget deficit. As part of these discussions, some have suggested scaling back benefits by increasing deductibles and cost-sharing requirements for certain Medicare-covered services, such as home health and skilled nursing facility, to reduce spending or increase beneficiaries' "skin in the game". More broadly, some have proposed to cap federal payments by transforming Medicare from a defined benefits program to a defined contribution system (also known as "premium support"), some versions of which are expected to shift costs onto beneficiaries, according to the Congressional Budget Office.[1]

To inform policy discussions, this paper compares the expected value of benefits for individuals ages 65 and older under Medicare's fee-for-service program to two "typical" plans offered by large employers: a typical large employer preferred provider organization (PPO) plan and the Blue Cross/Blue Shield Standard Option for enrollees in the Federal Employees Health Benefits Program (FEHBP), also a PPO plan. This report refers to the latter as the "FEHBP Standard Option" (although other insurers in FEHBP also have a "standard option"). This analysis updates a 2008 Kaiser Family Foundation report that found Medicare's benefit package to be less generous than the comparison employer plans, largely due to a higher deductible for inpatient care, the absence of a limit on out-of-pocket spending, a less generous prescription drug benefit, and a lack of dental coverage.[2] This report revisits those findings in light of changes to Medicare enacted in the health reform law and changes in employer-sponsored coverage.

Key findings from this report include:

- For individuals ages 65 and older, Medicare is less generous on average than the comparison large employer plans. The average benefit value of Medicare for a person age 65 or older in 2011 is 97 percent of the FEHBP Standard Option benefit value and 93 percent of the typical large employer PPO benefit value.
- Relative to the typical large employer PPO plan, Medicare provides somewhat more generous benefits for low-cost individuals ages 65 and older because of the relatively low Part B deductible for individuals who do not use inpatient care; however, Medicare is less generous than the typical large employer PPO plan for seniors with moderate and high costs. Similarly, relative to the FEHBP Standard Option, Medicare is slightly better for low-cost individuals ages 65 or older, but is notably less generous for moderate-cost individuals and somewhat less generous for high-cost individuals.
- Medicare's average benefit value relative to the comparison employer plans has improved since we last conducted this analysis in 2007, largely because of the 50 percent discount on brand-name drugs in the Part D "doughnut hole" included in the 2010 health reform law, and also because the actuarial value of the FEHBP Standard Option has contracted over the past few years due to changes in its benefit design (mainly, the increase in the limit on out-of-pocket spending).

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METHODS AND BACKGROUND

We commissioned Aon Hewitt to update a 2008 report that assesses and compares the actuarial value of benefits under the fee-for-service (FFS) Medicare program to two prototype large employer plans provided to active employees: the Blue Cross/Blue Shield (BCBS) standard nationwide preferred provider organization (PPO) option – which covers about 44 percent of all federal employees in the Federal Employees Health Benefits Program (FEHBP)[3] – and a typical large employer PPO plan.[4] In 2011, there were about 1,258 plans in the Aon Hewitt database (SpecBook);[5] some of these plans may provide more or less generous coverage than is offered by the "typical" large employer PPO plan. This analysis focuses on large employer plans, rather than benefits offered by small and mid-size employers, to be consistent with previous analyses which also looked at the FEHBP Standard Option (see Appendix C). Medicare would likely compare more favorably to small and mid-sized firms, which tend to have less generous benefits than large employer plans.[6]

Medicare's benefit design differs from that of the typical large employer PPO and the FEHBP Standard Option in several ways:

- **Deductibles/Coinsurance.** Medicare has multiple deductibles depending on the service type. In 2011, these were: $1,132 per inpatient hospital admission (Part A), $162 for outpatient services (Part B), and a standard $310 deductible for FFS beneficiaries enrolled in Part D.[7] The typical large employer PPO plan has a single deductible of $500 for inpatient and outpatient services and the FEHBP Standard Option has a deductible of $350 for outpatient services (with no deductible for inpatient hospital care, but a $250 copayment for each admission). In both comparison large employer plans, there is no deductible for prescription drug expenses. Coinsurance or copayments above the deductible also differ between Medicare and the two comparison plans, with Medicare requiring more cost-sharing in some instances and less cost-sharing in others. For instance, after the $1,132 deductible for inpatient hospital care, Medicare has no daily coinsurance for the first 60 days. In contrast, the typical large employer PPO imposes a 20 percent coinsurance beginning on the first day of an inpatient stay.
- **Out-of-pocket spending limit.** Medicare does not have a limit on how much beneficiaries are required to spend out-of-pocket for inpatient and outpatient services in its fee-for-service program, although the standard Part D benefit includes a limit on out-of-pocket pharmaceutical spending after $4,550 (in 2011). In contrast, the typical large employer PPO plan *does* have limits on out-of-pocket spending for inpatient and outpatient services,[8] but not for pharmaceutical spending. The FEHBP Standard Option differs from the typical large employer PPO because its out-of-pocket spending limit applies to inpatient and outpatient services and pharmaceuticals.[9]
- **"Doughnut hole".** Unlike the two comparison plans, Medicare has a gap in pharmaceutical coverage between an initial coverage limit and the out-of-pocket spending limit. The health reform law has begun to phase in coverage of generic and brand-name drugs in this "doughnut hole", starting in part with a 50 percent discount on brand-name drugs provided by pharmaceutical companies and 7 percent coverage of generic drugs in 2011, the year used for this analysis.[10] (Note: this report does not include the new coverage for generics, but we expect that the impact of excluding this is probably small).
- **Dental coverage.** Unlike the two comparison plans, Medicare does not provide dental coverage. *It is important to note that our analysis does not take into account dental expenses*, which thereby understates the value of the comparison large employer plans relative to Medicare to a modest extent.
- **Separate network copayments.** Medicare requires beneficiaries to pay the same cost-sharing regardless of provider, while the comparison large employer plans require smaller payments for in-network providers.

A more detailed description of benefits offered by the two large employer plans and the Medicare FFS program is included in Appendix A.

This report uses claims data to calculate the expected value of each plan for people age 65 and older. We consider the average value of each benefit design for individuals ages 65 and older, and for low-, moderate-, and high-cost seniors.[11] (Note: this analysis does *not* compare the relative value of plans for active workers, who would have a different level and mix of utilization than individuals ages 65 or older.) The benefit values shown in this report are based on a static set of utilization rates and are not adjusted for potential changes in utilization that may result when an individual has more generous coverage (e.g., when covered by a plan that pays 80 percent of costs instead of 50 percent of costs). In reality, individuals do change their behavior when their financial obligations change, as has been demonstrated in numerous studies. However, the purpose of this study is to compare the pure benefit value of Medicare and employer plans, assuming no change in enrollees' behavior and utilization of health care services based on coverage.

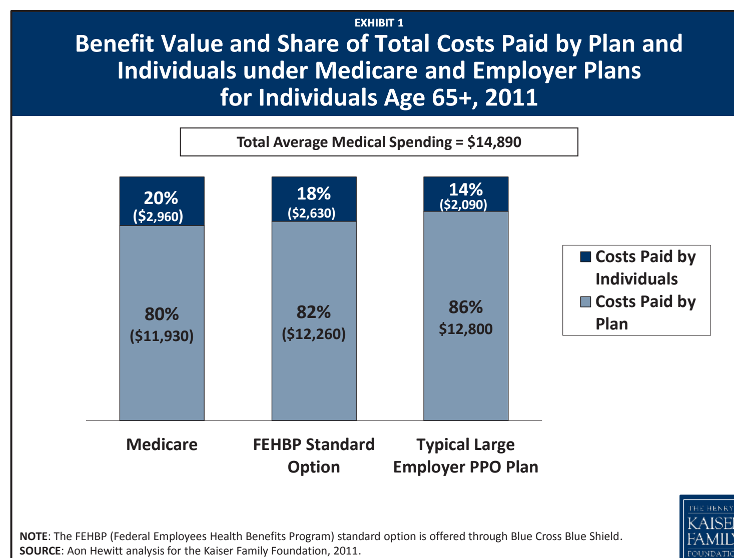
Our trend analysis is based on changes in benefit design (e.g., deductibles and cost-sharing), but does *not* account for some other ways in which employer coverage has eroded over the past few years. First, it does not account for workers shifting into other types of plans, such as high deductible health plans. Since 2007, the proportion of covered workers in large firms (with at least 200 employees[12]) who were enrolled in PPOs decreased somewhat, as did the proportion in HMOs and conventional or point-of-service plans, while the percentage in high deductible health plans increased substantially (from 4 to 15 percent).[13] Second, this analysis does not factor in the average increase in premium contributions for workers that has occurred in large employer plans: employee premium contributions increased by about 50 percent in large employer PPO plans from 2007 to 2011 (from $717 to $1077) and in the FEHBP Standard Option (from $1,489.80 to $2,246.16).[14] Similarly, the analysis does not take into account changes in Medicare premiums during this period.[15]

Appendix D describes the data used for this report and provides further details on this report's methodology.

FINDINGS

For individuals ages 65 and older, Medicare is less generous on average than the comparison large employer plans.

The average value of benefits provided by Medicare for an individual age 65 or older is lower than the value of benefits provided by the FEHBP Standard Option and the typical large employer PPO plan (see Exhibit 1):



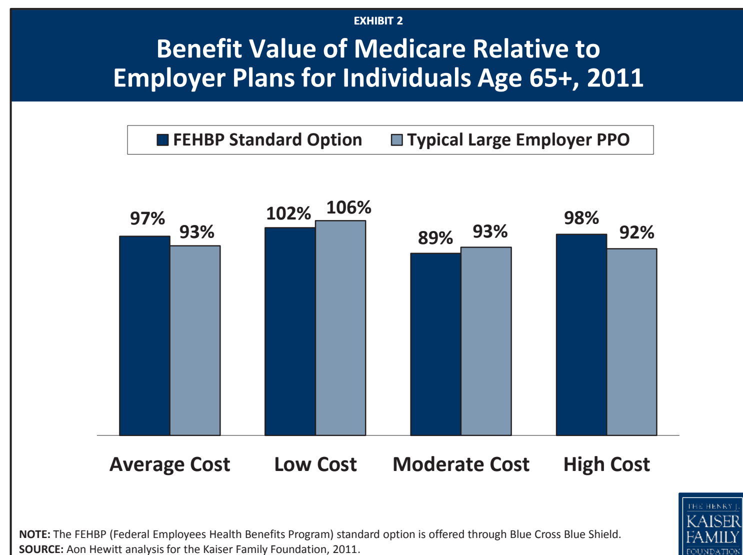
- In 2011, the estimated average spending on Medicare-covered services for an individual age 65 or older is $14,890. Of this amount, the Medicare FFS benefit design would cover $11,930 (80 percent) on average, the FEHBP Standard Option design would cover $12,260 (82 percent), and the typical large employer PPO plan would cover $12,800 (86 percent). Put another way, Medicare's average benefit value is 97 percent of the FEHBP Standard Option benefit value and 93 percent of the typical large employer PPO plan benefit value (see Exhibit 2).

- Individuals are responsible for any remaining expenses, though Medicare beneficiaries may have some of these expenses covered by supplemental insurance plans like Medigap. For individuals ages 65 and older, the average cost-sharing liability for Medicare-covered services is $2,960, $330 (12%) more than it would be under the FEHBP Standard Option benefit design ($2,630) and $870 (41%) more than it would be under the typical large employer PPO plan design ($2,090).

Medicare is less generous, on average, than the comparison large employer PPO plans because Medicare has higher cost-sharing for inpatient care under Part A for short hospital stays (given the relatively high deductible of $1,132 per admission in 2011), no out-of-pocket limit on services provided under Parts A and B, and less generous drug coverage under Part D.

This analysis may understate the difference between Medicare and the comparison employer plans by excluding dental expenses, which are not covered under Medicare but *are* covered under the FEHBP Standard Option and by most large employer plans. However, because the coverage offered by the two large employer plans is relatively limited, the exclusion of dental services does not substantially change our results.[16] When the value of dental coverage is included, Medicare's benefit value falls from 93 percent to 91 percent of the value of the typical large employer plan, but remains at about the same share, 97 percent, of the value of the FEHBP Standard Option.

Relative to the typical large employer PPO, Medicare has a higher benefit value for low-cost individuals ages 65 or older, but a lower benefit value for moderate-cost and high-cost individuals. Similarly, relative to the FEHBP Standard Option, Medicare provides somewhat more generous benefits for low-cost individuals ages 65 and older, but a significantly lower benefit value for moderate-cost individuals and a slightly lower benefit value for high-cost individuals.



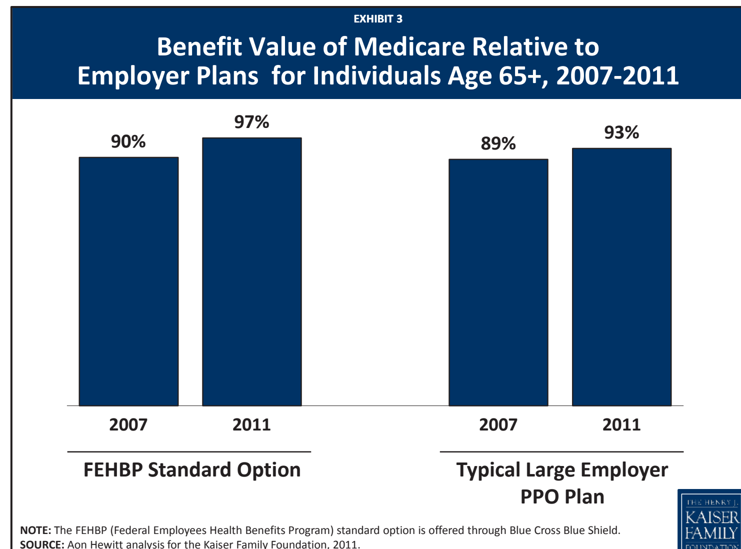
Relative to the two large employer plans, Medicare provides less generous coverage for moderate- and high-cost individuals (those in the top two quintiles of spending, i.e., the top 40%). For a person age 65 or older with moderate costs, the Medicare benefit package covers 89 percent of the benefit value on average of the FEHBP Standard Option and 93 percent of the benefit value of the typical large employer PPO plan (see Exhibit 2). For an elderly individual with relatively high costs, the average value of Medicare is 92 percent of the value of the typical large employer PPO. Medicare falls behind the typical large employer PPO and/or the FEHBP Standard Option on average for moderate- and high-cost individuals because it has a relatively high Part A deductible, less drug coverage for costs between $2,840 and $4,550, and no out-of-pocket spending limit for outpatient and inpatient services. Nonetheless, the difference between the average value of Medicare and the FEHBP Standard Option is relatively small for high-cost elderly individuals ages 65 and older (i.e., 98 percent of the value of the FEHBP plan), in part because the FEHBP Standard Option also includes some gaps in coverage for this group, such as the lack of skilled nursing facility coverage.[17]

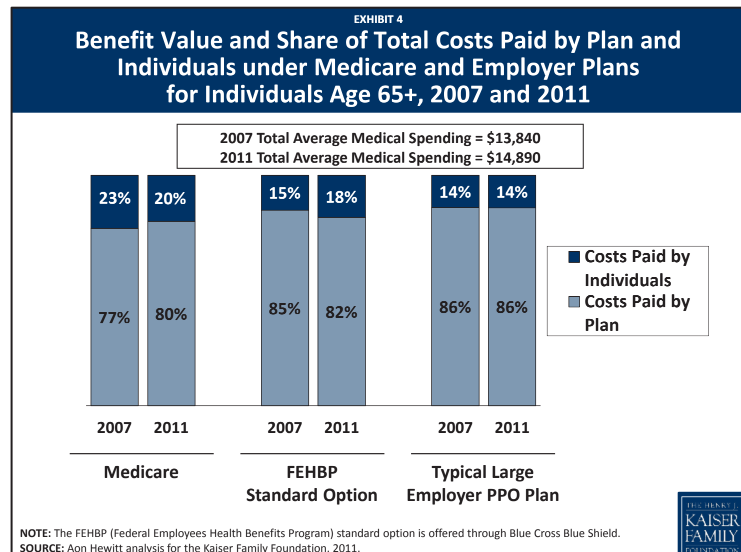
It is important to note that some high-cost elderly Medicare beneficiaries would benefit substantially from the out-of-pocket limit on inpatient and outpatient services provided under the comparison employer plans. The lack of an out of pocket spending limit can lead to substantial costs for the relatively small share of individuals ages 65 or older with inpatient stays longer than 60 days, skilled nursing facility stays longer than 20 days, or high outpatient costs (such as from biologic drugs administered in a doctor's office).

Although Medicare provides less generous coverage on average for moderate- and high-cost individuals, it provides better coverage (or slightly better coverage) for low-cost individuals ages 65 and older (those in the bottom three quintiles of spending, i.e., the bottom 60%). For this group, Medicare has an average benefit value that is 102 percent of the value of the FEHBP Standard Option and 106 percent of the value of the typical large employer PPO respectively (Exhibit 2), providing better coverage on average because of the relatively low Part B deductible for individuals who use physician care but no inpatient care.

Between 2007-2011, Medicare's average benefit value relative to the two employer plans has improved, largely because of the 50 percent discount on brand-name drugs for enrollees in Part D plans with spending in the so-called "doughnut hole" that was provided under the health reform law. This provision increases the value of Medicare generally and particularly for those with relatively high drug spending.

Between 2007 and 2011, Medicare's average benefit value increased from 90 percent to 97 percent of the value of the FEHBP Standard Option, and from 89 percent to 93 percent of the value of the typical large employer plan for individuals ages 65 and older (see Exhibit 3).[18] This improvement is largely due to changes enacted by the health reform law, which provided a 50 percent discount on brand-name drugs in the Part D coverage gap and eliminated coinsurance for many preventive services. As a result, the share of total costs covered by Medicare increased from 77 percent in 2007 to 80 percent in 2011 (see Exhibit 4). Without the 50 percent discount in particular, the benefit value of Medicare would have actually fallen from 2007 to 2011 and would have stayed relatively constant as a share of the value of the two large employer plans.





Medicare's improvement relative to the FEHBP Standard Option is also partially due to the decline in value of the latter. Since 2007, the FEHBP Standard Option benefit design has become less generous, as the out-of-pocket spending limit has increased from $4,000 to $5,000 (for enrollees who only use preferred providers) and the copayment for an

inpatient hospital admission has risen from $100 to $250, amongst other changes. In 2007, the FEHBP Standard Option covered 85 percent of medical expenses on average for individuals ages 65 and older, whereas it now covers 82 percent. Even with the erosion of coverage under the plan, the benefit value of the FEHBP Standard Option is greater than the benefit value of the Medicare FFS program on average, although the erosion in the FEHBP plan's generosity has helped narrow the gap. The coverage offered by the typical large employer PPO has also contracted somewhat, although to a much smaller extent (e.g., a $15 increase in office visit copayments in certain cases). More typically, large employers are raising premiums and/or transitioning employees to high deductible plans with lower premiums, rather than adjusting the benefit design of their PPOs.

The future direction of large employer health plans is uncertain. Should they continue to become less generous or eventually less prevalent in the future, they may no longer serve as a useful benchmark for Medicare's benefit design.

Discussion

The Medicare FFS program continues to offer a less generous benefit package for individuals ages 65 and older than is typically offered by the typical large employer PPO plan or under the FEHBP Standard Option. Relative to the typical large employer PPO plan, Medicare provides somewhat more generous benefits for low-cost individuals ages 65 and older because of the relatively low Part B deductible for people who do not use inpatient care; however, Medicare is less generous than the typical large employer PPO plan for seniors with moderate and high costs. Similarly, relative to the FEHBP Standard Option, Medicare is slightly better for low-cost individuals ages 65 or older, but is notably less generous for moderate-cost individuals and somewhat less generous for high-cost individuals.

Medicare's benefit value has nonetheless begun to approach the value of the comparison large employer plans, due in large part to the 50 percent discount on brand name drugs in Medicare brought about by health reform, as well as the contraction of the comparison employer plans' benefit designs. The gap between Medicare and large employer plans could continue to narrow in the future as the health reform law phases in coverage in the "doughnut hole" or if employer coverage continues to erode.

Adding a limit on out-of-pocket spending for inpatient and outpatient services and reducing deductibles would help to bring the Medicare benefit design in line with private large employer plans. The reverse is also true: increasing Medicare beneficiaries' out-of-pocket costs – an idea floated during recent discussions about the national debt as a way achieve federal savings – could further widen the gap between Medicare and large employer plans and contribute to beneficiaries' out-of-pocket spending burden. [19]

Appendix A

Benefit Design Features of a Typical Large Employer PPO Plan, the Federal Employees Health Benefits Program Standard Option (BCBS), and the Medicare FFS Program, 2011

Plan Benefit Provision	Typical Large Employer PPO	Federal Employees Health Benefits Program Standard Option PPO (BCBS)	Medicare FFS Program, 2011
Inpatient and Outpatient Services			
Deductible	In-network: $500 individual/$1,000 family; Out-of-Network: $1,000/$2,000	$350 per person; $700 per family	**Part A:** $1,132 (per admission) **Part B**: $162
Coinsurance	In-network: 20%; Out-of-Network: 40%	Preferred: 15%; Non-Preferred: 35%	**Part B**: 20%
Physician Office Visits Copays	In-network: $20 PCP/$35 specialist per visit; Out-of-Network: 40%	Preferred: $20 PCP/$30 specialist per visit; Non-Preferred: 35%	**Part B:** 20% coinsurance
Inpatient Hospital	In-network: 20%; Out-of-Network: 40% (begins on first day of admission, following deductible).	Preferred: $250 per admission; Non-Preferred: $350 per admission + 35%	No cost-sharing for the first 60 days; $283 per day for days 61-90; $566 per lifetime reserve day after 90 days
Skilled Nursing Facility	In-network: 20%; Out-of-Network: 40% (begins on first day of admission, following deductible).	Not covered	No cost-sharing for the first 20 days; $141.50 copay for days 21-100; No benefit after 100 days
Plan Benefit Maximum	None	None	**Part A**: Limit of 90 inpatient hospital days per year plus lifetime reserve days; **Part B**: None
Out-of-pocket spending limit	Applies to inpatient and outpatient services (excludes copayments, drug spending, and dental services). In-network: $2,000; Out-of-Network: $4,000	Applies to inpatient, outpatient, and drug spending (excludes deductible and dental services). $5,000 for preferred providers only and $7,000 for combination of preferred and non-preferred providers[1]	None (see Part D out-of-pocket spending limit below)

[1] The FEHBP Standard Option also excludes the following expenses from its out-of-pocket maximum: 1) The difference between the Plan allowance and the billed amount, and 2) Expenses for services, drugs, and supplies in excess of the maximum benefit limitations; See page 22 at http://www.fepblue.org/benefitplans/2011-sbp/bcbs-2011-RI71-005.pdf These exceptions are not valued for lack of data, so the result may very slightly overstate the overall value of the FEHBP Standard Option.

Plan Benefit Provision	Typical Large Employer PPO	Federal Employees Health Benefits Program Standard Option (BCBS)	Medicare FFS Program/Standard Part D Benefit,[2] 2011
Outpatient Prescription Drugs			
Deductible	None	None	$310
Retail Pharmacies	Generic: $10; Preferred Brand: $25; Non-Preferred Brand: $45	Preferred retail pharmacy: 20% for generic and 30% for brand-name or specialty Non-preferred retail pharmacy: 45%	Coinsurance: 25%; Initial Coverage Limit: $2,840; “Doughnut hole”: Enrollees receive 50% discount on brand name drugs (and pay 93% coinsurance for generic drugs, although that coverage was not included in our model)
Mail Order	Generic: $20; Preferred Brand: $60; Non-Preferred Brand: $100	$10 Generic; $70 Brand	
Out-of-pocket spending limit	None	Drug spending is included under the same out-of-pocket maximum that applies to inpatient and outpatient services (see details above)	$4,550; Payments after OOP threshold met: minimum of $2.50/generic, $6.30/brand; or 5% coinsurance
Dental Care			
Deductible	$50	$0	Not Covered
Preventive Care	No cost-sharing	Scheduled (e.g., plan pays $8 of periodic, $9 of other evaluation, $22 of complete intraoral x-ray, $15 of palliative treatment)	Not Covered
Minor Restorative	20%	Scheduled (e.g., plan pays $16 of one surface amalgam or resin, $35 of four surface)	Not Covered
Major Restorative	50%	Scheduled (e.g., plan pays $16 of one surface inlay)	Not Covered
Orthodontia	50% with $1,500 lifetime maximum	Not Covered	Not Covered
Plan Benefit Maximum	$1,500	None	Not Applicable
Out-of-pocket spending limit	None	None	Not Applicable

[2] This report calculates the actuarial value of the standard Part D drug benefit. In reality, benefits and cost-sharing requirements typically vary across Part D plans. Plan benefit designs are required to be at least actuarially equivalent to the standard Part D design.

Appendix B

Table B1. Benefit Value of FFS Medicare, Typical Large Employer PPO and FEHBP Standard Option, Excluding Dental, by Type of User, 2011

	LOW COST	MODERATE COST	HIGH COST	AVERAGE COST
Total Average Medical Spending	**$2,595**	**$11,222**	**$54,083**	**$14,892**
Percent of Population	58%	22%	20%	100%
FFS Medicare				
Total Benefits Paid by Medicare	$1,851	$7,704	$45,244	$11,931
Percent Paid by Medicare	71%	69%	84%	80%
Medicare Payments as a Percent of Employer PPO Plan Payments	106%	93%	92%	93%
Medicare Payments as a Percent of FEHBP Standard Option Plan Payments	102%	89%	98%	97%
Out-of-Pocket	$743	$3,518	$8,839	$2,960
Employer PPO Plan				
Total Benefits Paid by Plan	$1,752	$8,327	$49,265	$12,797
Percent Paid by Plan	68%	74%	91%	86%
Out-of-Pocket	$843	$2,895	$4,819	$2,094
FEHBP Standard Option				
Total Benefits Paid by Plan	$1,823	$8,638	$46,057	$12,257
Percent Paid by Plan	70%	77%	85%	82%
Out-of-Pocket*	$771	$2,584	$8,027	$2,634

NOTE: The FEHBP (Federal Employees Health Benefits Program) standard option is offered through Blue Cross Blue Shield. All include prescription drugs.
* Note that the out-of-pocket (OOP) cost shown above reflects full OOP payment by the member for skilled nursing facility (SNF) care, which is not covered under the Standard Option for members who do not have Medicare Part A. This fact helps explain why our estimates show that high-cost individuals have expenses above the FEHBP Standard Option out-of-pocket spending limit of $5,000. Nonetheless, members with complex and/or chronic health issues who require SNF care may be eligible through one of the FEHBP Standard Option's coordinated care programs, the case management program, to have those costs mitigated through the program's "flexible benefits option", which includes the possible provision of alternative benefits for medically necessary treatment (e.g., coverage of SNF care in some circumstances). More detail is available through the plan brochure (http://www.opm.gov/insure/health/planinfo/2011/brochures/71-005.pdf).
SOURCE: Aon Hewitt analysis for the Kaiser Family Foundation, 2011.

Table B2. Benefit Value, including Medical and Dental, of FFS Medicare, Typical Large Employer PPO and FEHBP Standard Option, by Type of User, 2011

	LOW COST	MODERATE COST	HIGH COST	AVERAGE COST
Total Average Medical Spending	**$3,075**	**$11,702**	**$54,563**	**$15,372**
Percent of Population	58%	22%	20%	100%
FFS Medicare				
Total Benefits Paid by Medicare	$1,851	$7,704	$45,244	$11,931
Percent Paid by Medicare	60%	66%	83%	78%
Medicare Payments as a Percent of Employer PPO Plan Payments	91%	90%	91%	91%
Medicare Payments as a Percent of FEHBP Standard Option Plan Payments	98%	89%	98%	97%
Out-of-Pocket	$1,223	$3,998	$9,319	$3,440
Employer PPO Plan				
Total Benefits Paid by Plan	$2,032	$8,607	$49,545	$13,077
Percent Paid by Plan	66%	74%	91%	85%
Out-of-Pocket	$1,043	$3,095	$5,019	$2,294
FEHBP Standard Option				
Total Benefits Paid by Plan	$1,883	$8,698	$46,117	$12,317
Percent Paid by Plan	61%	74%	85%	80%
Out-of-Pocket*	$1,192	$3,004	$8,446	$3,055

NOTE: The FEHBP (Federal Employees Health Benefits Program) standard option is offered through Blue Cross Blue Shield. All include prescription drugs; Employer plans include dental benefits.

* Note that the out-of-pocket (OOP) cost shown above reflects full OOP payment by the member for skilled nursing facility (SNF) care, which is not covered under the Standard Option for members who do not have Medicare Part A. This fact helps explain why our estimates show that high-cost individuals have expenses above the FEHBP Standard Option out-of-pocket spending limit of $5,000. Nonetheless, members with complex and/or chronic health issues who require SNF care may be eligible through one of the FEHBP Standard Option's coordinated care programs, the case management program, to have those costs mitigated through the program's "flexible benefits option", which includes the possible provision of alternative benefits for medically necessary treatment (e.g., coverage of SNF care in some circumstances). More detail is available through the plan brochure (http://www.opm.gov/insure/health/planinfo/2011/brochures/71-005.pdf).

SOURCE: Aon Hewitt analysis for the Kaiser Family Foundation, 2011.

Table B3. Benefit Value of FFS Medicare, Typical Large Employer PPO and FEHBP Standard Option, Excluding Dental, by Type of User, 2007

	LOW COST	MODERATE COST	HIGH COST	AVERAGE COST
Total Average Medical Spending	**$2,160**	**$9,610**	**$51,860**	**$13,840**
Percent of Population	58%	22%	20%	100%
FFS Medicare				
Total Benefits Paid by Medicare	$1,470	$5,350	$42,440	$10,610
Percent Paid by Medicare	68%	56%	82%	77%
Medicare Payments as a Percent of Employer PPO Plan Payments	106%	77%	90%	89%
Medicare Payments as a Percent of FEHBP Standard Option Plan Payments	90%	68%	94%	90%
Out-of-Pocket	$690	$4,260	$9,420	$3,230
Employer PPO Plan				
Total Benefits Paid by Plan	$1,390	$6,960	$47,340	$11,900
Percent Paid by Plan	64%	72%	91%	86%
Out-of-Pocket	$770	$2,650	$4,520	$1,780
FEHBP Standard Option				
Total Benefits Paid by Plan	$1,640	$7,890	$45,210	$11,810
Percent Paid by Plan	76%	82%	87%	85%
Out-of-Pocket*	$520	$1,720	$6,650	$2,030

NOTE: The FEHBP (Federal Employees Health Benefits Program) standard option is offered through Blue Cross Blue Shield. All include prescription drugs.
* Note that the out-of-pocket (OOP) cost shown above reflects full OOP payment by the member for skilled nursing facility (SNF) care, which is not covered under the Standard Option for members who do not have Medicare Part A. This fact helps explain why our estimates show that high-cost individuals have expenses above the FEHBP Standard Option out-of-pocket spending limit of $5,000. Nonetheless, members with complex and/or chronic health issues who require SNF care may be eligible through one of the FEHBP Standard Option's coordinated care programs, the case management program, to have those costs mitigated through the program's "flexible benefits option", which includes the possible provision of alternative benefits for medically necessary treatment (e.g., coverage of SNF care in some circumstances). More detail is available through the plan brochure (http://www.opm.gov/insure/health/planinfo/2011/brochures/71-005.pdf).
SOURCE: Hewitt Associates and Aon Hewitt analysis for the Kaiser Family Foundation, 2008 and 2011.

Table B4. Benefit Value, including Medical and Dental, of FFS Medicare, Typical Large Employer PPO and FEHBP Standard Option, by Type of User, 2007

	LOW COST	MODERATE COST	HIGH COST	AVERAGE COST
Total Average Medical Spending	**$2,590**	**$10,040**	**$52,290**	**$14,270**
Percent of Population	58%	22%	20%	100%
FFS Medicare				
Total Benefits Paid by Medicare	$1,470	$5,350	$42,440	$10,610
Percent Paid by Medicare	57%	53%	81%	74%
Medicare Payments as a Percent of Employer PPO Plan Payments	89%	74%	89%	87%
Medicare Payments as a Percent of FEHBP Standard Option Plan Payments	86%	67%	94%	89%
Out-of-Pocket	$1,120	$4,690	$9,850	$3,660
Employer PPO Plan				
Total Benefits Paid by Plan	$1,650	$7,220	$47,600	$12,160
Percent Paid by Plan	64%	72%	91%	85%
Out-of-Pocket	$940	$2,820	$4,690	$2,110
FEHBP Standard Option				
Total Benefits Paid by Plan	$1,700	$7,950	$45,270	$11,870
Percent Paid by Plan	66%	79%	87%	83%
Out-of-Pocket*	$890	$2,090	$7,020	$2,400

NOTE: The FEHBP (Federal Employees Health Benefits Program) standard option is offered through Blue Cross Blue Shield. All include prescription drugs; Employer plans include dental benefits.

* Note that the out-of-pocket (OOP) cost shown above reflects full OOP payment by the member for skilled nursing facility (SNF) care, which is not covered under the Standard Option for members who do not have Medicare Part A. This fact helps explain why our estimates show that high-cost individuals have expenses above the FEHBP Standard Option out-of-pocket spending limit of $5,000. Nonetheless, members with complex and/or chronic health issues who require SNF care may be eligible through one of the FEHBP Standard Option's coordinated care programs, the case management program, to have those costs mitigated through the program's "flexible benefits option", which includes the possible provision of alternative benefits for medically necessary treatment (e.g., coverage of SNF care in some circumstances). More detail is available through the plan brochure (http://www.opm.gov/insure/health/planinfo/2011/brochures/71-005.pdf).

SOURCE: Hewitt Associates and Aon Hewitt analysis for the Kaiser Family Foundation, 2008 and 2011.

Appendix C

COMPARISON OF FINDINGS WITH PREVIOUS STUDIES

The benefit value of Medicare has been compared to large employer plans in two separate reports from the Congressional Research Service in 1996 and 2004[20]. The 1996 report compared the Medicare program to typical employment based plans as compiled by Bureau of Labor Statistics surveys of medium and large firms as well as the standard option under the FEHBP. The comparison of the Medicare program was done similarly as this report by comparing against a typical set of design features that are intended to represent the typical employer plan. They utilized the CRS Health Care Benefit Valuation Comparison model (version 7.6) that determines benefit values similar to the model used in this report.

The 1996 report reported the value of Medicare in 1996 and compared it the value of the typical employer plan and the standard FEHBP option. A comparable ratio can be derived from our analyses for comparison purposes.

Table C1. Relative Values of Medicare to Other Plans

	1996 (CRS Report)	2007 (Hewitt and Aon Hewitt Analysis)	2011 (Aon Hewitt Analysis)
Typical PPO Plan	93%	89%	93%
FEHBP BCBS Standard Plan	96%	90%	97%

SOURCE: Hewitt Associates analysis for the Kaiser Family Foundation, 2008 and Aon Hewitt analysis for Kaiser Family Foundation, 2011.

Table C1 shows the relative value of Medicare compared to the typical large employer PPO plan and the FEHBP Standard Plan Option at three points in time. The above comparison is interesting but it is difficult to conclude too much from the two sets of numbers because the underlying models are different, starting points for costs may be different and the plan designs have definitely changed between 1996, 2007, and 2011. However, it does appear in Table C1 that under both the CRS and Hewitt/Aon Hewitt analyses, the FEHBP Standard Plan option plan slightly trails the typical employer plan design in all three periods. The fact that FEHBP is higher percentage means that it is closer in value to Medicare and thus lower in value than the typical large employer PPO plan.

It is interesting to note that the 1996 analysis is comparing a Medicare program without a prescription drug benefit to two plans with a drug benefit. Anecdotally, prescription drug costs have increased much faster than medical costs so it has become an ever larger portion of retiree health expenses. This is somewhat borne out by the 2004 CRS memorandum that compared the 2003 Medicare program to the 2003 FEHBP design. In the table below, the value of Medicare including and excluding pharmaceuticals is shown over time.

Table C2. Relative Values of Medicare to FEHBP Standard Plan Option

	2003 (CRS Memorandum)		2007 (Hewitt and Aon Hewitt Analysis)		2011 (Aon Hewitt Analysis)	
	Value	**% of FEHBP**	**Value**	**% of FEHBP**	**Value**	**% of FEHBP**
Medicare w/o Rx	$ 6,570	78%	$ 9,020	76%	$ 9,243	75%
Medicare w/ Rx	□ [21]	□	10,610	90%	$ 11,931	97%
FEHBP w/o Dental	8,460	100%	11,810	100%	$ 12,257	100%

SOURCE: Hewitt Associates analysis for the Kaiser Family Foundation, 2008 and Aon Hewitt analysis for Kaiser Family Foundation, 2011.

This table highlights the earlier finding that the major reason for the improvement in Medicare's relative position between 2007 and 2011 was the improvement in the prescription drug benefits via the 50% brand discount. The relative value of the non-drug portion of the Medicare benefit has remained very consistent across the three analyses.

Appendix D

Methodology and Assumptions

The analysis included in this paper is based on proprietary health plan design models developed by Aon Hewitt in its work with large private employers. The main source of the data is a compilation of health care claims experience from 2003 from a number of national employers scaled to a sample average large employer population. We projected the data to the 2011 plan year based on observed health care trends between the two years.

The model includes claims distributions for three distinct groups of participants in an employer-sponsored plan—active employees, pre-Medicare retirees and post-Medicare retirees. This analysis utilized the post-Medicare claims distribution for comparison purposes. We could have used the other distributions in this analysis and they would have produced larger disparities in the plan values due to the nature of the three distributions. However, we chose the post-Medicare distribution as the baseline data for the group to illustrate the differences in the value of the Medicare program and its primary beneficiaries compared to plans available to the working population.

The database utilized for this analysis is split into three distinct service groupings—medical, outpatient prescription drugs and dental. The plan designs analyzed typically lend themselves to this split of services. That is, their designs are often dependent on expenditures in the service groupings alone and do not tend to share provisions between each other.

We group the medical data included in the model by total eligible charges and in the following service categories:

- Inpatient room and board
- Inpatient ancillary
- Inpatient surgical (professional)
- Other inpatient professional
- Emergency room
- Pathology and radiology
- Other outpatient facility
- Outpatient surgical (professional)
- Other outpatient professional
- Inpatient behavioral health and chemical dependency
- Outpatient behavioral health and chemical dependency
- Outpatient prescription drugs

In addition, other detailed tables show utilization experience such as inpatient admissions and lengths of stay.

For purposes of this analysis, we normalized the data to the projected average cost of a Medicare beneficiary in calendar year 2011. We obtained the projected average cost of a Medicare beneficiary age 65 or older in 2011 by using the estimate for calendar year 2009 from the 2009 Trustees report) and projecting forward to 2011 based on historical trends. [22]

Medicare Program	Average Cost per Beneficiary
Hospital Insurance (Part A)	$ 5,291
Supplemental Medical Insurance (Part B)	$ 4,713
Prescription Drug Plan (Part D)	$ 2,015
Total Medical (Parts A and B)	$ 10,004
Prescription Drugs (Part D)	$ 2,015
Total Medicare	$ 12,019

Dental care is not a Medicare provided benefit and we have utilized the expected 2011 costs directly from our pricing model for the dental values. The only adjustment to our model is to use the utilization of services for a Medicare population.

In order to compare the value of the different benefit programs offered, it is typical actuarial practice to anticipate behavior change due to the level of benefits. Some sources refer to this as benefit induction, that is, individuals are *induced* to behave in a certain fashion depending on the financial impact that results from their choices. For this analysis, we have not included any effect of benefit induction in the calculations. Our primary purpose in this financial comparison is to understand the pure difference in value each program has on an individual without changing their utilization of health care services.

For medical services, the report shows both an average value as well as a representative distribution of the actual total distribution used to determine the average. We have taken the 50 rows of claim groupings and condensed them into three groups. One view of the three groups is the healthy, typical and high cost individuals. The distribution of these three broad groups is representative of our employer population and not necessarily Medicare's, although we would expect the percentages to be similar.

We did not split up the dental distribution in a similar fashion because the values are relatively low compared to medical and are included in the Appendix B to provide a broader picture of total health care spending.

References

[1] Congressional Budget Office, "Long-Term Analysis of a Budget Proposal by Chairman Ryan", April 5, 2011, available at: http://www.cbo.gov/ftpdocs/121xx/doc12128/04-05-ryan_letter.pdf.
[2] NOTE: The results in this report cannot be directly compared to those in the 2008 report for two reasons. First, the 2008 report *included* dental expenses for the most part in the body of the report while this report mostly *excludes* dental expenses from consideration. Second, the 2007 figures in this report also differ slightly from those reported in 2008 due to a minor adjustment to AonHewitt's model.
[3] Personal communication, Ronald Gresch, Office of Personnel Management (OPM), November 25, 2011.
[4] The analysis based on the Aon Hewitt 2011 SpecBook database of benefits provided to salaried employees in companies with at least 1,000 employees. The typical large-employer PPO plan is based on the median 2011 plan design information for 967 major employers in the U.S. For example, the $500 deductible chosen for the in-network deductible of the PPO plan means that about half of the plan designs in the Aon Hewitt database have a deductible equal to or less than $500 and about half have a deductible equal to or greater than $500.
[5] Aon Hewitt SpecSummary Database, October 12, 2011 and Office of Personnel Management, "FEHB Fact Sheet", available at: http://www.opm.gov/insure/openseason/FEHBP_FactSheet.pdf.
[6] Kaiser Family Foundation and Health Research and Educational Trust, "Employer Health Benefits: 2011 Annual Survey", September 27, 2011.
[7] This report calculates the actuarial value of the standard Part D drug benefit. In reality, benefits and cost-sharing requirements typically vary across Part D plans. Plan benefit designs are required to be at least actuarially equivalent to the standard Part D design
[8] The typical large employer PPO does not count copayments towards the out-of-pocket spending limit (although it does count coinsurance and deductible payments).
[9] The FEHBP Standard Option deductible does not count towards the out-of-pocket maximum (which the plan calls "catastrophic protection"). The FEHBP Standard Option also excludes the following expenses from its out-of-pocket maximum: 1) The difference between the Plan allowance and the billed amount, and 2) Expenses for services, drugs, and supplies in excess of the maximum benefit limitations; See page 22 at http://www.fepblue.org/benefitplans/2011-sbp/bcbs-2011-RI71-005.pdf
[10] See Kaiser Family Foundation, "Summary of Key Changes to Medicare in 2010 Health Reform Law," May 5, 2010. The health reform law phases in coverage of drugs in the doughnut hole. By 2020, enrollees will be responsible for 25 percent of the cost of both brands and generics in the doughnut hole, down from 100 percent in 2010.
[11] For this analysis, high-cost users include the top 20 percent of utilizers, moderate-cost utilizers include the average for the next quintile (22 percent) and low-cost utilizers are defined as the average among all others who comprise the bottom 58 percent of utilizers
[12] The figures for large employer plans in this paragraph come from the Kaiser Family Foundation and Health Research and Educational Trust survey of employer health benefits. That survey groups employers with at least 200 workers. However, our typical large employer PPO plan is based on employers with at least 1,000 workers.
[13] Kaiser Family Foundation and Health Research and Educational Trust, "Employer Health Benefits: 2011 Annual Survey", September 27, 2011 and Kaiser Family Foundation and Health Research and Educational Trust, "Employer Health Benefits: 2007 Annual Survey", September 11, 2007.
[14] Kaiser Family Foundation and Health Research and Educational Trust, "Employer Health Benefits: 2011 Annual Survey", September 27, 2011; United States Office of Personnel Management, "Non-Postal Premium Rates for the Federal Employees Health Benefits Program", available at: http://www.opm.gov/insure/health/rates/nonpostalffs2011.pdf; Kaiser Family Foundation and Health Research and Educational Trust, "Employer Health Benefits: 2007 Annual Survey", September 11, 2007; and United States Office of Personnel Management, "Non-Postal Premium Rates for the Federal Employees Health Benefits Program", available at: http://www.opm.gov/insure/archive/health/07rates/2007non_postal.pdf;
[15] Medicare does not have a directly comparable premium, given that most beneficiaries are exempt from the Part A premium and that Part D is optional. The Part B premium increased by 23 percent from 2007 to 2011 (from $93.50 to $115.40)

[16] The two comparison employer plans do not cover all dental services (such as dentures for the FEHBP Standard Option) and still require enrollees to pay a large portion of their expenses (e.g., any expenses above $1,500 for the typical large employer PPO)
[17] Note that members with complex and/or chronic health issues who require skilled nursing facility (SNF) care may be eligible through one of the FEHBP Standard Option's coordinated care programs, the case management program, to have those costs mitigated through the program's "flexible benefits option", which includes the possible provision of alternative benefits for medically necessary treatment (e.g., coverage of SNF care in some circumstances). More detail is available through the plan brochure (http://www.opm.gov/insure/health/planinfo/2011/brochures/71-005.pdf).
[18] The 2007 figures reported here are different from those discussed in our 2008 report, for reasons discussed in footnote 2.
[19] Kaiser Family Foundation, "How Much 'Skin in the Game' is Enough?: The Financial Burden of Health Spending for People on Medicare", June 2011.
[20] Madeleine Smith, "Medicare: Comparison to Typical Employment-Based Health Insurance," CRS Report to Congress, December 18, 1996 and Chris Peterson, "Comparison of Actuarial Values: Current Medicare Benefit to a "Typical" Health Plan Available to Federal Employees," *CRS Memorandum*, March 31, 2004.
[21] Note that prescription drugs were not covered under Medicare in 2003.
[22] 2009 Annual Report of The Board of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, May 12, 2009.

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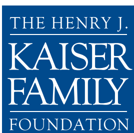

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