

# MEDICARE

## ISSUE BRIEF

### **How Does the Benefit Value of Medicare Compare to the Benefit Value of Typical Large Employer Plans?**

Prepared by:  
**Dale Yamamoto**  
**Hewitt Associates**

and

**Tricia Neuman and Michelle Kitchman Strollo**  
**Kaiser Family Foundation**

**September 2008**



## How Does the Benefit Value of Medicare Compare to the Benefit Value of Typical Large Employer Plans?

From time to time, researchers and policymakers have asked, how does Medicare stack up against the typical health plan offered by large employers? From a Medicare policy lens, this question is important for providing a benchmark for assessing the relative generosity of the Medicare benefit package compared to large employer-sponsored plans over time. This question is particularly of interest now that Medicare has been updated to provide access to a subsidized prescription drug benefit offered through private plans. The comparison between Medicare and employer plans also comes into play during discussions of health reform, as policymakers and 2008 presidential candidates consider Medicare and other plans as models for establishing a “standard” benefit design for people without health insurance.

To inform future policy discussions about Medicare’s benefit package and health coverage more broadly, this paper compares the value of benefits under Medicare’s fee-for-service program to “typical” employer plans offered by large employers.

### Data and Methods

We commissioned Hewitt Associates<sup>1</sup> to compare the actuarial value of benefits under the original fee-for-service Medicare program to two prototype large employer plans provided to active employees: the Blue Cross/Blue Shield (BCBS) standard nationwide PPO option available to federal employees through the Federal Employees Health Benefits Program (FEHBP) and a typical employer preferred provider organization (PPO) plan, using benefit features based on Hewitt’s 2007 proprietary database of large employer plans.<sup>2</sup> About 50 percent of all FEHBP policyholders are enrolled in this plan.<sup>3</sup> The typical large-employer PPO plan is based on the median 2007 plan design information for 900 major employers in the U.S.<sup>4</sup> A description of benefits offered by the two employer plans and Medicare is included in Appendix A.

We analyze benefits provided under original Medicare because the fee-for-service program covers most people on Medicare; Medicare Advantage plans cover a growing but relatively small share of the total Medicare

---

<sup>1</sup> Dale Yamamoto was principal and national group actuarial practice leader at Hewitt Associates from 1991 through 2007, and is now president of Red Quill Consulting, Inc. He chaired the 2000 Technical Review Panel appointed by the Medicare Board of Trustees.

<sup>2</sup> The analysis based on the Hewitt 2007 SpecBook database as of November 2007 is for benefits provided to salaried employees in companies with at least 1,000 employees.

<sup>3</sup> Personal communication, Ronald Gresch, Office of Personnel Management (OPM), February 11, 2008.

<sup>4</sup> 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 Hewitt database have a deductible equal to or less than \$500 and about half have a deductible equal to or greater than \$500.

population (22 percent), and benefits offered by Medicare Advantage plans vary widely.<sup>5</sup> We focus 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 (see Kaiser Family Foundation Employer Health Benefits Survey, 2007).

This report bases the benefit values on an expected value for participants eligible for Medicare because of age (not disability). It is important to note that this analysis does *not* compare the relative value of Medicare, large employer plans and FEHBP for active workers who would have a different level and mix of utilization. A comparison of plans based on active workers' utilization would be more directly relevant to an examination of options to expand coverage to the uninsured, but is outside the scope of this analysis.

Utilization data are compiled from 2003 health care claims data trended to 2007 based on observed health care trends. This paper compares the value of benefits for the average age 65+ Medicare beneficiary and for beneficiaries with three distinct health care utilization profiles: relatively healthy beneficiaries, beneficiaries who are in moderate health, and those who are in relatively poor health. For this analysis, high-cost users include the top 20 percent of utilizers, moderate-cost users include the average for the next quintile (22 percent), and low-cost users are defined as the average among all others who comprise the bottom 58% of beneficiaries. The findings presented in this paper represent the average benefit value for participants in each of these groups. Appendix B includes a comprehensive set of data tables with the findings.

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., 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. Appendix D provides further details.

---

<sup>5</sup> U.S. Government Accountability Office, "Increased Spending Relative to Medicare Fee-for-Service May Not Always Reduce Beneficiary Out-of-Pocket Costs," Report to Congressional Requesters, February 2008.

## Findings

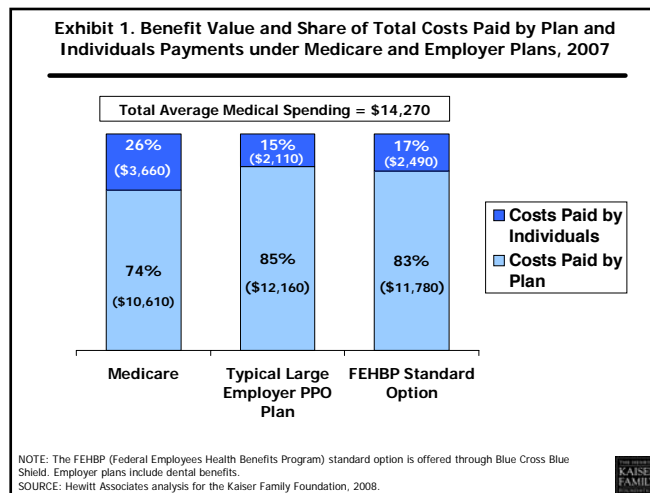
### Medicare vs. Large Employer Plans' Benefit Values

The benefit value of Medicare in 2007, including the prescription drug benefit, is lower than the value of either the typical large employer PPO or the FEHBP standard benefit option (Exhibit 1). This finding is generally consistent with previously published studies that compared Medicare to large employer plans prior to the implementation of the drug benefit (See Appendix C).<sup>6</sup> In 2007, the average benefit value of Medicare (\$10,610) lags behind the benefit value of both the typical large employer PPO (\$12,160) and the FEHBP standard option (\$11,780). The benefit value of the FEHBP standard option is slightly lower than the typical large employer PPO option, principally because it has a higher out-of-pocket maximum and a less generous dental benefit.<sup>7</sup>

Medicare is less generous, on average, than the comparison employer plans because it has higher cost-sharing it has higher cost-sharing for inpatient care under Part A (particularly for relatively short hospital stays), no out-of-pocket limit on services provided under Part B, and less generous drug coverage under the standard Part D benefit. In addition, large employers typically provide some dental coverage while Medicare does not generally cover dental care.<sup>8</sup> Including dental in the total value of the benefit package, as we do in this analysis, further reduces the value of Medicare compared to employer plans. However, a similar picture would emerge even if dental benefits were excluded.

### Share of Costs for Covered Benefits Paid by Plan and Individual

Medicare also pays a smaller share of total costs associated with covered benefits, on average, than the typical large employer PPO or the FEHBP standard option (Exhibit 1). In 2007, Medicare pays 74 percent of costs associated with covered benefits for an individual with average health care costs (\$14,270), while the typical large employer PPO pays 85 percent of total costs and the FEHBP standard plan covers 83 percent



<sup>6</sup> 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.

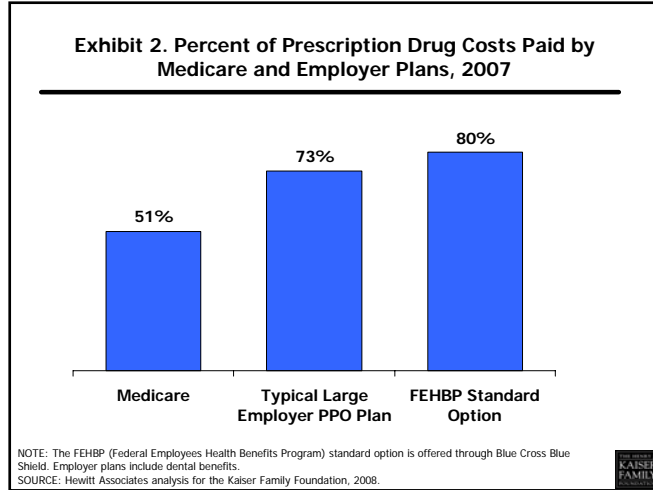
<sup>7</sup> A typical HMO plan design will pay closer to 90 to 95 percent of total charges.

<sup>8</sup> Nearly all (888 of 889) large employers provided a dental plan according to the 2007 Hewitt SpecSummary database.

of the total.

As a result, the average individual covered under Medicare pays a larger share of total costs (26%) than the average individual covered under the typical large employer PPO (15%) or the FEHBP standard option (17%). To help cover expenses that are not covered by Medicare, most people on Medicare have some form of supplemental insurance, such as Medigap, a retiree plan offered by employers, or Medicaid, for those with very modest incomes.<sup>9</sup>

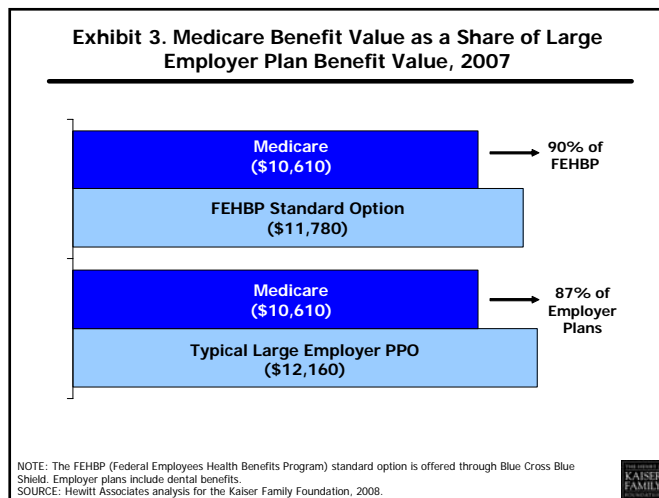
Medicare pays a smaller share of prescription drug costs than either of the comparison employer plans, which is a key factor in



Medicare's lower average value relative to large employer plans (Exhibit 2). The standard Medicare Part D benefit, with a separate deductible and coverage gap (\$3,051 in 2007)<sup>10</sup> covers 51 percent of drug costs, on average, while the typical employer plan and the standard option FEHBP plan pay a substantially larger share of total drug costs (73 percent and 80 percent, respectively). Average prescription drug plan payments in 2007 are lower under Medicare (\$1,590) than under a typical large employer PPO (\$2,270) or the FEHBP standard option (\$2,500).<sup>11</sup>

Medicare as a Share of Employer Plan Benefits

On average, Medicare's benefit value is 87 percent of the benefit value of a typical large employer PPO (\$10,610/\$12,160) and 90 percent of the standard FEHBP option (\$10,610/\$11,780) (Exhibit 3).



<sup>9</sup> Kaiser Family Foundation analysis of Medicare Current Beneficiary Survey 2005 Cost and Use File.

<sup>10</sup> This is the amount of out-of-pocket costs after the initial benefit period before the standard Part D design begins paying the catastrophic benefit. It accounts for the \$265 deductible plus the 25% benefit for the next \$2,135 (\$2,400 coverage limit minus \$265 deductible). The \$3,051 is the remaining amount of the \$3,850 that needs to be paid out of the beneficiaries pocket (\$3,850 - \$265 - 25% x \$2,135).

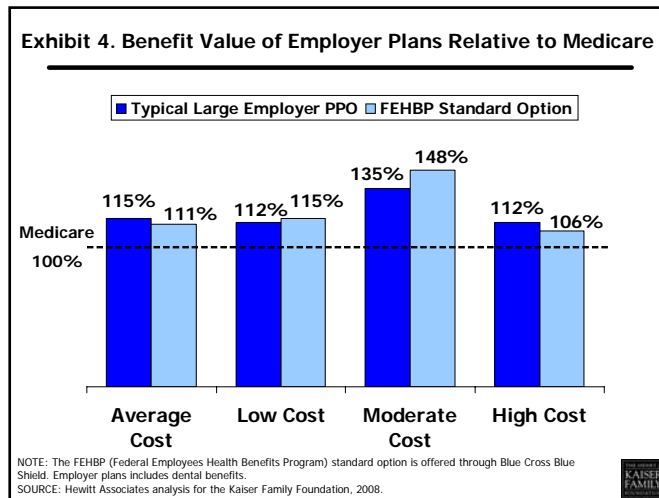
<sup>11</sup> Average per beneficiary costs (plan payments) under Medicare Part D based on 2007 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds.

If employer plans were arrayed based on their benefit value, Medicare would be among plans in the bottom decile. The range in the benefit value offered by large employer plans is fairly narrow. The top 10 percent of large employer plans offer benefits that are at or above 106 percent of the median plan, while the bottom 10 percent of plans have benefit values that are below 93 percent of the median plan.<sup>12</sup> This analysis excludes dental benefits; adding dental to the benefit value of employer plan benefits would further reduce Medicare's benefit value compared to plans offered by large employers.

Conversely, Medicare's ranking would be higher if the analysis were extended to a broader employer base that included small and mid-size employers, or insurance plans in the individual market, which tend to be less generous than plans offered by large employers.

#### Benefit Value of Medicare Relative to Employer Plans for Individuals with Different Health Care Utilization Levels

The benefit value of employer plans relative to Medicare differs for people who are low-cost, moderate cost and relatively high-cost users. That is because plan design features (e.g., deductible level, benefit payment or coinsurance, and out-of-pocket maximums) affect individuals differently. For the relatively healthy beneficiary with low health care utilization, the biggest difference will be the deductible amount. For a high-cost person, the out-of-pocket maximum could be a major factor.



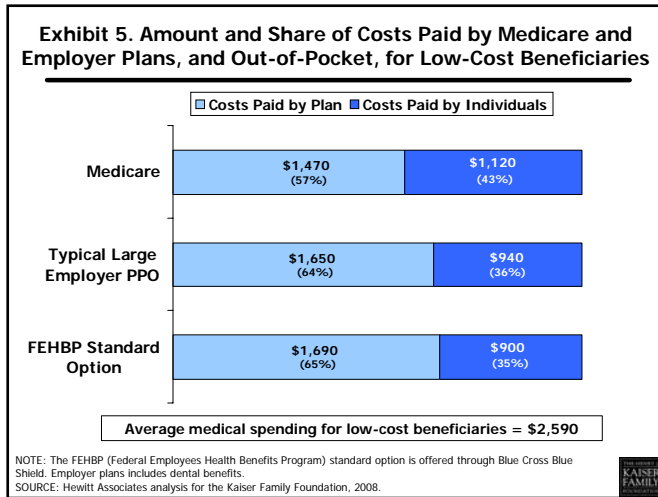
For the average-cost Medicare beneficiary as well as for each of the three profiles (low-, moderate-, and high-cost), Medicare's benefit value is less generous than either a typical large employer PPO or the FEHBP standard option (Exhibit 4 and Appendix B).

*Low Cost.* For an individual with no inpatient hospital care and relatively modest drug use, Medicare lags behind the comparison employer plans, but is not far behind. The benefit value of the typical large employer

<sup>12</sup> Based on Hewitt Associates 2006 analysis of 620 large employers' total plan values for medical, including prescription drugs.

plan is 112% of the benefit value of Medicare, while the FEHBP standard option is 115% of Medicare's benefit value.

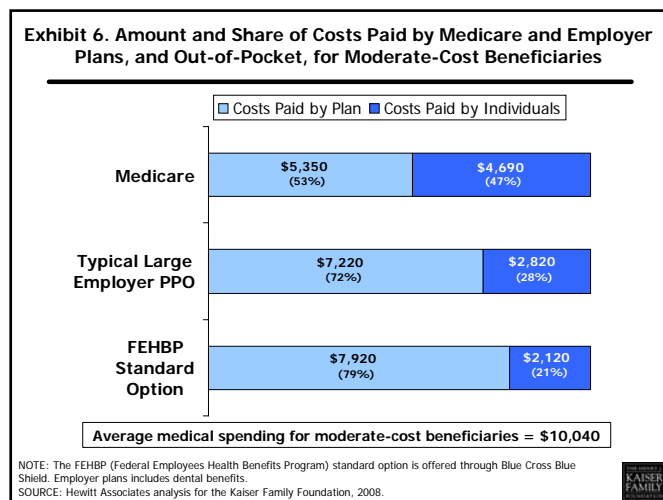
For low-cost beneficiaries, Medicare's benefit value (\$1,470) is lower, on average, than the benefit value of either the prototype large employer plan (\$1,650) or the FEHBP standard option (\$1,690) (Exhibit 5). The value of Medicare benefits is slightly less than the value of the comparison large employer



plans for a relatively low-cost individual mainly because Medicare does not include a dental benefit, and because of the deductible in the standard prescription drug benefit under Medicare, but not under the employer plans. Still, Medicare compares somewhat favorably to the comparison employer plans for a relatively healthy person because of its low Part B deductible. When the value of dental benefits is excluded from employer plans, Medicare is slightly more generous than the typical large employer for a low-cost individual (see Appendix B2).

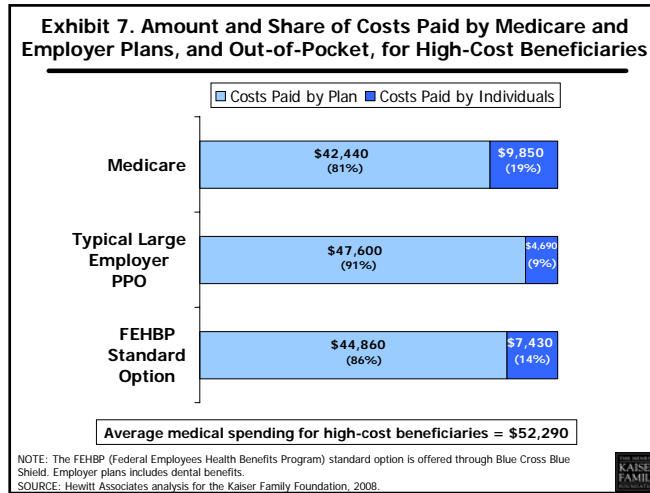
The low-cost user has slightly lower out-of-pocket costs in the FEHBP option than in the typical employer PPO plan because of the FEHBP plan's lower deductible and relatively high benefit payment for in-network (preferred) providers.

*Moderate Cost.* For the moderate-cost user, Medicare lags considerably behind the two employer options (see Exhibits 4 and 6). The benefit value of Medicare (\$5,350) is lower than benefit values under either the prototype large employer plan (\$7,220) or the FEHBP standard option (\$7,920). An individual with moderate use has more than double the out-of-pocket spending in Medicare than in the FEHBP standard option. A person with moderate spending may have a short inpatient hospital stay resulting in a lower benefit



percentage under Part A, and may have gone into the coverage gap under Part D. Our analysis produces the lowest benefit percentage for this individual.

*High Cost.* Medicare is also less generous relative to the comparison employer plans for high-cost users (Exhibits 4 and 7). The benefit value of Medicare is lower for high-cost users than large employer plans or the FEHBP standard option. Out-of-pocket costs are thus higher under Medicare than under a typical employer PPO or the FEHBP standard option for high-cost beneficiaries. Higher



out-of-pocket costs under Medicare are attributable to the absence of an out-of-pocket limit on Part B charges, likely prescription drug spending in the coverage gap, and inpatient hospital care that would require enrollees to pay the Part A deductible.<sup>13</sup>

The FEHBP standard option is less generous than the typical employer plan for the high-cost individual primarily because the FEHBP option has a substantially higher out-of-pocket maximum.

It is worth noting that Medicare and the employer plans pay a larger share of costs for high-cost individuals than for low- and moderate-cost individuals (Appendix B).

## Discussion

Medicare is a critical source of coverage for 44 million beneficiaries, yet even with the new prescription drug benefit, Medicare is less generous than a typical, large employer PPO or the FEHBP standard option plan. Even across different beneficiary prototypes based on varying levels of health status and health care utilization, Medicare is consistently less generous than either a typical large employer PPO or the FEHBP standard option. The difference in generosity is largely attributable to high cost-sharing under Medicare Part A (the relatively high Part A deductible and high coinsurance for extended stays), the absence of an out-of-pocket limit on spending under

<sup>13</sup> For example, a high-cost individual would likely have at least one inpatient hospital visit that would cost \$25,000. Of that amount, the individual would pay the \$992 Part A deductible and Medicare will pay the rest. That is, Medicare pays 96% [ $(\$25,000 - \$992) \div \$25,000$ ] of the bill. A little over half of the high cost individual's charges will be hospital bills so assuming 60 percent of the non-drug bills are hospital and 20 percent of the total will be drugs, we would expect a high-cost participant's Medicare share to be about 82% [ $80\% \times (40\% \times 80\% + 60\% \times 96\%) + 20\% \times 50\%$ ] which is exactly what our analysis produces.

Parts A and B, and the atypically-designed prescription drug benefit with a coverage gap known as the “doughnut hole.”

As policymakers consider Medicare as a model for health reform and a potential means to expand coverage for the uninsured, the findings from this analysis show that Medicare’s benefit package, even with the new drug benefit, is less generous than either the typical large employer plan or the FEHBP standard plan option. Adopting the Medicare benefit package as a model for expanding coverage to the uninsured would clearly provide substantial assistance to those without insurance, as it now does for people on Medicare, but would offer less protection than the typical large employer plan or the FEHBP standard option. This is mainly due to the absence of an out-of-pocket limit for medical spending, lack of dental coverage, and the Part D coverage gap. But, as noted earlier, additional analysis would be needed to compare the relative value of the typical large employer and FEHBP benefit packages for active workers who would have a different level and mix of utilization.

The findings also have important implications for ongoing policy discussions about Medicare’s future, as policymakers consider changes that could either reduce or enhance the value of the benefit package. The results of this analysis suggest that cutting back benefits under Medicare (e.g. by increasing cost-sharing) would further reduce the value of Medicare relative to large employer plans and impose a greater out-of-pocket burden on a group that already assumes a larger share of health care costs than those with more generous employer coverage. Further, while some suggest that Medicare Advantage plans could be used more effectively as a vehicle for delivering additional benefits to people on Medicare, thus far, the evidence suggests that additional benefits offered by these plans are concentrated among a minority of beneficiaries because most (77 percent) are in the original fee-for-service program. Future policy discussions may want to consider the current value of Medicare relative to large employer plans before proposing changes that could erode the value and financial protections offered under the program to elderly and disabled beneficiaries.

## Appendix A

### Comparison of 2007 Benefit Design Features of a Typical Large Employer PPO Plan, the Federal Employees Health Benefits Program Standard Option (BCBS), and Original Medicare

Plan Benefit Provision	Typical Large Employer PPO	Federal Employees Health Benefits Program Standard Option (BCBS)	Original Medicare
Deductible	In-network: \$500 individual/\$1,000 family; Out-of-Network: \$1,000/\$2,000	\$250 per person; \$500 per family	<b>Part B:</b> \$131
Benefit Payment	In-network: 80%; Out-of-Network: 60%	Preferred: 90%; Non-Preferred: 75%	<b>Part B:</b> 80%
Out-of-pocket maximum (including deductible, excluding copays)	In-network: \$2,500; Out-of-Network: \$5,000	\$4,000 for preferred providers only and \$6,000 for combination of preferred and non-preferred providers	None
Physician Office Visits Copays	In-network: \$20; Out-of-Network: NA	Preferred: \$15 per visit; Non-Preferred: 25% <sup>1</sup>	NA
Inpatient Hospital	Same as medical	Preferred: \$100 per admission; Non-Preferred: \$300 per admission	\$992 per admission; \$248 per day of coinsurance for days 61-90; \$496 per lifetime reserve day after 90 days
Skilled Nursing Facility	Same as medical	Not covered	100% benefit first 20 days; \$124 copay for days 21-100; No benefit after 100 days
Plan Benefit Maximum	None	None	<b>Part A:</b> Limit on days per year to 90 plus lifetime reserve days; <b>Part B:</b> None
Employer Account Contribution	None	None	None

<sup>1</sup> Benefit payment after any copayment is 100% unless otherwise noted. Copayments for physician and other services apply toward the out-of-pocket maximum for FEHBP.

<b>Plan Benefit Provision</b>	<b>Typical Large Employer PPO</b>	<b>Federal Employees Health Benefits Program Standard Option (BCBS)</b>	<b>Original Medicare/ Standard Part D Benefit</b>
<b>Outpatient Prescription Drug Benefit Provisions</b>			
Retail Pharmacies	Deductible: None Generic: \$10; Preferred Brand: \$25; Non-Preferred Brand: \$40	Deductible: None Preferred Pharmacy 25%; Non-Preferred Pharmacy: 45%	Deductible: \$265; Coinsurance: 25%; Initial Coverage Limit: \$2,400; Out-of-Pocket Threshold: \$3,850; Copay after OOP threshold met: Greater of \$2.15 generic/\$5.35 brand or 5%
Mail Order	Deductible: None Generic: \$20; Preferred Brand: \$50; Non-Preferred Brand: \$80	Deductible: None \$10 Generic; \$35 Brand	Deductible: \$265; Coinsurance: 25%; Initial Coverage Limit: \$2,400; Out-of-Pocket Threshold: \$3,850; Copay after OOP threshold met: Greater of \$2.15 generic/\$5.35 brand or 5%
<b>Dental Benefit Provisions</b>			
Deductible	\$50	\$0	Not Covered
Preventive Care	100% Not Subject to Deductible	Scheduled (e.g., \$8 periodic, \$9 other evaluation, \$22 complete intraoral x-ray, \$15 palliative treatment)	Not Covered
Minor Restorative	80%	Scheduled (e.g., \$16 one surface amalgam or resin, \$35 four surface)	Not Covered
Major Restorative	50%	Scheduled (e.g., \$16 one surface inlay)	Not Covered
Orthodontia	50% with \$1,500 lifetime maximum	Not Covered	Not Covered
Annual maximum	\$1,500	None	Not Covered

## Appendix B

**Table B1. Benefit Value, including Medical and Dental, of Original Medicare, Typical Large Employer PPO and FEHBP Standard Option, by Type of User**

	LOW COST	MODERATE COST	HIGH COST	AVERAGE COST
<b>Total Average Medical Spending</b>	<b>\$2,590</b>	<b>\$10,040</b>	<b>\$52,290</b>	<b>\$14,270</b>
Percent of Population	58%	22%	20%	100%
<b>Original Medicare</b>				
Total Benefits Paid by Medicare	\$1,470	\$5,350	\$42,440	\$10,610
Percent Paid by Medicare	57%	53%	81%	74%
Out-of-Pocket	\$1,120	\$4,690	\$9,850	\$3,660
<b>Employer PPO Plan</b>				
Total Benefits Paid by Plan	\$1,650	\$7,220	\$47,600	\$12,160
Percent Paid by Plan	64%	72%	91%	85%
Plan Payments as a Percent of Medicare Payments	112%	135%	112%	115%
Out-of-Pocket	\$940	\$2,820	\$4,690	\$2,110
<b>FEHBP Standard Option</b>				
Total Benefits Paid by Plan	\$1,690	\$7,920	\$44,860	\$11,780
Percent Paid by Plan	65%	79%	86%	83%
Plan Payments as a Percent of Medicare Payments	115%	148%	106%	111%
Out-of-Pocket	\$900	\$2,120	\$7,430	\$2,490

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.

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

**Table B2. Benefit Value of Original Medicare, Typical Large Employer PPO and FEHBP Standard Option, Excluding Dental, by Type of User**

	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%
<b>Original Medicare</b>				
Total Benefits Paid by Medicare	\$1,470	\$5,350	\$42,440	\$10,610
Percent Paid by Medicare	68%	56%	82%	77%
Out-of-Pocket	\$690	\$4,260	\$9,420	\$3,230
<b>Employer PPO Plan</b>				
Total Benefits Paid by Plan	\$1,390	\$6,960	\$47,340	\$11,900
Percent Paid by Plan	64%	72%	91%	86%
Plan Payments as a Percent of Medicare Payments	95%	130%	112%	112%
Out-of-Pocket	\$770	\$2,650	\$4,520	\$1,780
<b>FEHBP Standard Option</b>				
Total Benefits Paid by Plan	\$1,630	\$7,860	\$44,800	\$11,720
Percent Paid by Plan	75%	82%	86%	85%
Plan Payments as a Percent of Medicare Payments	111%	147%	106%	110%
Out-of-Pocket	\$530	\$1,750	\$7,060	\$2,120

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

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

## Appendix C

### Comparison of Findings with Previous Studies

The benefit value of Medicare has been compared in two separate reports from the Congressional Research Service in 1996 and 2004<sup>14</sup>. 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 compared to the typical employer plan and compared to the standard FEHBP option as a ratio. A comparable ratio can be derived from this current analysis for comparison purposes.

**Table C1. Relative Values of Medicare to Other Plans**

	1996 CRS Report	2007 Hewitt Analysis
Typical PPO Plan	93%	89%
FEHBP BCBS Plan	96%	91%

SOURCE: Hewitt Analysis for the Kaiser Family Foundation, 2008.

The above comparison is interesting but it is difficult to conclude anything 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 and 2007. However, it does appear that under both analyses, the standard option FEHBP plan slightly trails the typical employer plan design in both years.

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 other medical costs so it would be a more significant factor today than in 1996. This is somewhat borne out by the 2004 CRS memorandum that compared

<sup>14</sup> 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.

the 2003 Medicare program to the 2003 FEHBP design. In this memo, drugs and non-drug medical services are shown separately. This memo shows the benefit value of Medicare to be \$6,570. Compared to the \$9,020 used in this report provides a reasonable 8.25 percent average annual increase between the two years. The following table provides a comparison of some key results.

**Table C2. Relative Values of Medicare to FEHBP**

	2003 CRS Memorandum		2007 Hewitt Analysis	
	Value	% of FEHBP	Value	% of FEHBP
Medicare w/o Rx	\$ 6,570	78%	\$ 9,020	77%
Medicare w/ Rx	-- <sup>15</sup>	--	10,610	90%
FEHBP	8,460	100%	11,780	100%

SOURCE: Hewitt Analysis for the Kaiser Family Foundation, 2008.

The results of the above are consistent because between 2003 and 2007, prescription drug cost trends have been higher than other medical trends. Therefore, the benefit value of plans with drugs should be higher than the plans without. The Medicare benefit value without drugs shows an implicit annual trend of 8.25 percent as noted earlier. The average trend of the FEHBP value is 8.90 percent which demonstrates some consistency between the two actuarial models.

<sup>15</sup> Note that prescription drugs were not covered under Medicare in 2003.

## Appendix D

### Methodology and Assumptions

The analysis included in this paper is based on proprietary health plan design models developed by Hewitt Associates 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. We projected the data to the 2007 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 lend themselves to this split of services. That is, their designs are dependent on expenditures in the service groupings alone and do not 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 average cost of a Medicare beneficiary in calendar year 2007. Table V.B1. from the 2007 Trustees report<sup>16</sup> provides the estimated average per beneficiary cost for the Medicare program for calendar year 2007:

<b>Medicare Program</b>	<b>Average Cost per Beneficiary</b>
Hospital Insurance (Part A)	\$ 4,687
Supplemental Medical Insurance (Part B)	4,328
Prescription Drug Plan (Part D)	1,590
Total Medical (Parts A and B)	\$ 9,015
Prescription Drugs (Part D)	1,590
Total Medicare	\$ 10,605

Dental care is not a Medicare provided benefit and we have utilized the expected 2007 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 choice of plan. 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 analysis to provide a broader picture of total health care spending.

<sup>16</sup> 2007 Annual Report of The Board of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, April 23, 2007.





**The Henry J. Kaiser Family Foundation**

**Headquarters**

2400 Sand Hill Road  
Menlo Park, CA 94025  
(650) 854-9400 Fax: (650) 854-4800

**Washington Offices and  
Barbara Jordan Conference Center**

1330 G Street, NW  
Washington, DC 20005  
(202) 347-5270 Fax: (202) 347-5274

[www.kff.org](http://www.kff.org)

This publication (#7768) is available on the Kaiser Family Foundation's website at [www.kff.org](http://www.kff.org).

The Kaiser Family Foundation is a non-profit private operating foundation, based in Menlo Park, California, dedicated to producing and communicating the best possible information, research and analysis on health issues.