

Buyer Beware: The Fine Print in Medicare Private Health Plan Benefits

In a Nutshell:

1. Private health plan members can encounter barriers to getting the care they need that they would not face with Original Medicare.
2. Private health plan members can face unexpectedly high out-of-pocket costs when they get sick—higher than they would have paid under Original Medicare.
3. The government overpays private health plans to deliver health care to people with Medicare.

Talking Points:

1. **Private health plan members can encounter barriers to getting the care they need that they would not face with Original Medicare.** While the Bush Administration, insurance industry and other private plan supporters say that people can get better benefits from private health plans, plan members regularly call MRC for help appealing plan denials and trying to get out of plans that are not meeting their needs. Common problems experienced by people enrolled in Medicare private health plans include: difficulty getting emergency or urgent care, and care while away from home; broken continuity of care; having to get referrals to see specialists and permission from the plan to get most types of care; and restricted choice of doctor, hospital and other providers.
2. **Private health plan members can face unexpectedly high out-of-pocket costs when they get sick—higher than they would have paid under Original Medicare.** Private plan members often call MRC asking for help because their private plan, which promised to save them money, is charging very high co-payments for life-saving treatment. Two studies corroborate this experience:
 - The Medicare Payment Advisory Commission (MedPAC), a nonpartisan, independent federal body that advises the U.S. Congress on issues affecting the Medicare program, found that some Medicare private health plans have high cost-sharing for “non-discretionary” services such as chemotherapy. For example, the study found that a 70-year-old male with advanced colon cancer, would pay annual out-of-pocket charges of \$7,100 for one plan, \$6,550 for the second plan and \$1,990 for the third plan.
 - A study by The Commonwealth Fund also found that out-of-pocket costs for private health plan members vary widely by health status and plan benefit package. The Fund’s report shows that costs for members in poor health would have been higher than Original Medicare in 19 of the 88 private plans examined.

In Original Medicare people can buy supplemental insurance to cover Medicare deductibles and coinsurance, which makes their out-of-pocket costs fairly predictable regardless of what medical care they may need. People with low incomes may be eligible for assistance programs, like the Qualified Medicare Beneficiary (QMB) or Medicaid, to cover those costs. People in private health plans, on the other hand, cannot get supplemental coverage for the unexpected out-of-pocket costs they may have to face if they become seriously ill with the “wrong” disease for their plan.

3. **The government overpays private health plans to deliver health care to people with Medicare.** Private health plans were brought into the Medicare program with the promise that competition and entrepreneurship would lead to better, more cost-effective care. Yet these middlemen, delivering care to 8.3 million people with Medicare, get paid between 12 and 19 percent more than it would cost Original Medicare to serve the same people, according to MedPAC. The Congressional Budget Office estimates that will amount to \$65 billion over the next five years. Congress should level the playing field by paying private health plans the same amount it costs to insure people in the Original Medicare program.

For more background on this issue and real life examples of the barriers to care commonly faced by people enrolled in Medicare private health plans, see MRC’s report, “Too Good to Be True: The Fine Print in Medicare Private Health Plan Benefits” (www.medicarights.org/MA_care_problems.pdf).