BRG

INTELLIGENCE THAT WORKS

Sticker Shock: Personal Financial Factors Leading New Medicare Beneficiaries to Choose Medicare Advantage over Traditional Medicare

April 2025

AUTHORS

John Barkett, Mickey Kennedy

Introduction

New Medicare beneficiaries who think Medicare offers free, generous coverage are often shocked to learn Traditional Medicare (TM) is neither free nor generous. To enroll in TM, most beneficiaries must pay the Medicare Part B premium of $185 per month in 2025. Once a beneficiary has paid their premium, TM in 2025 requires a deductible payment of over $1,676 per benefit period for inpatient care. It requires a 20 percent co-insurance for doctor visits and other expensive outpatient care such as drugs administered in a physician's office. TM does not cover prescription drugs or dental, vision, and hearing care; that coverage must be purchased separately. And perhaps most shocking, TM has no out-of-pocket maximum. Even after enrolling in TM, beneficiaries are exposed to uncapped medical costs each year.

For these reasons, nearly 90 percent of beneficiaries enroll in additional coverage.[1] Those who do not qualify for Medicaid or supplemental coverage from a former employer have two primary options for obtaining more comprehensive coverage: supplement TM by purchasing Medigap coverage to pay for their medical out-of-pocket costs (OOP) and a standalone Part D (PDP) plan for prescription drug coverage; or forego TM and enroll in a Medicare Advantage (MA) plan that includes Part D (an MA-PD plan) to get their Medicare benefit, often for zero additional premium.

Much has been made of the share of Medicare beneficiaries enrolled in TM versus MA. The most recent Medicare Trustees Report projected 52.2 percent of Medicare beneficiaries would be enrolled in an MA plan in 2025, up from 31.5 percent in 2015.[2] With MA beneficiaries now making up more than half of Medicare, policymakers are asking whether policy changes are needed to ensure Medicare's twin programs—TM and MA—remain solvent and operationally sound for current and future Medicare beneficiaries. With half of Medicare beneficiaries living on less than $36,000 per year in income, changes to the program that shift costs to beneficiaries likely would add financial strain to many American households.[3]

In this paper, we consider one dynamic that can get lost in in the TM-versus-MA debate: the financial decision new Medicare beneficiaries face when choosing between supplementing TM with Medigap and PDP plans and replacing TM altogether with an MA-PD plan.

1 Ochieng, N., J. Cubanski, & T. Neuman, *A Snapshot of Sources of Coverage Among Medicare Beneficiaries*, KFF (September 23, 2024).
2 Medicare Trustees, *2024 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, Table IV.C1., "Private Health Plan Enrollment," p. 157 (link)
3 Cottrill, A., et al., *Income and Assets of Medicare Beneficiaries in 2023*, KFF (February 5, 2024).

Approach

BRG created scenarios to illuminate consumers' decisions between Medigap/PDP and MA-PD coverage options. We examined the coverage options in five markets—Tampa, Florida, Dallas, Texas, Reno, Nevada, Brooklyn, New York, and New Orleans, Louisiana—and selected the Medigap, PDP, and MA-PD plans with the largest enrollment in each market as the options our new Medicare beneficiaries would choose between.[4] Table 1 describes the availability of Medigap, PDP, and MA-PD plans in each market.

Table 1. Medigap, PDP, and MA-PD Carrier and Plan Availability and Most Popular Plan in Five Markets, 2025

Market	Medigap Plans	PDP Plans	MA-PD Plans
Tampa, FL (Hillsborough County, 33614)	- 28 carriers - 30 plans - United Healthcare/AARP Plan G	- 6 carriers - 14 plans - Wellcare Value Script	- 17 carriers - 48 plans - Humana Gold Plus
Dallas, TX (Dallas County, 75201)	- 33 carriers - 47 plans - United Healthcare/AARP Plan G	- 6 carriers - 15 plans - Wellcare Value Script	- 8 carriers - 43 plans - AARP Medicare Advantage from UHC
Reno, NV (Washoe County, 89501)	- 24 carriers - 29 plans - United Healthcare/AARP Plan G	- 6 carriers - 14 plans - Wellcare Value Script	- 9 carriers - 22 plans - Renown Preferred Plan by Senior Care Plus
Brooklyn, NY (Kings County, 11226)	- 7 carriers - 7 plans - United Healthcare/AARP Plan G	- 5 carriers - 12 plans - Wellcare Classic	- 13 carriers - 34 plans - Healthfirst Signature
New Orleans, LA (Orleans Parrish, 70119)	- 29 carriers - 39 plans - United Healthcare/AARP Plan G	- 5 carriers - 12 plans - Wellcare Value Script	- 6 carriers - 29 plans - Peoples Health Choices 65

Source: Medicare.gov plan finder for plan year 2025.

We developed three patient personae to simulate how patients with different demographics and health needs face financial implications when choosing between Medigap/PDP and MA-PD options:

- Persona 1 ("Healthy") is a 75-year-old female nonsmoker with two or fewer chronic conditions who takes two generic maintenance medications and believes she will remain healthy during the upcoming plan year.
- Persona 2 ("Episodic") is a 70-year-old male nonsmoker with three to five chronic conditions who takes four generic maintenance medications and believes he could experience a short episode of care involving a hospitalization during the upcoming plan year.
- Persona 3 ("Chronic") is a 65-year-old female nonsmoker with six or more chronic conditions who takes four generic maintenance medications and one brand maintenance medication; and has one expensive brand drug administer in a physician's office setting. Persona 3 believes she may experience multiple episodes of care involving hospitalizations in the coming plan year.

4 For Medigap plans, we selected a Medigap Plan G plan offered by the carrier with the highest market share in each state according to the *2023 Medicare Supplement Loss Ratios* report (National Association of Insurance Commissioners, 2024). Plan G is the most popular Medigap plan selected by newly enrolling beneficiaries.

We then simulated how each persona might evaluate the choice between Medigap/PDP and MA-PD. For simplicity's sake we limited their options to the most popular Medigap and PDP plans and the most popular MA-PD plan in our five selected markets. We calculated and compared the premiums, medical OOP costs, and prescription drug OOP costs for each option. For our medical and drug OOP cost calculations, we used our three personae to demonstrate expected OOP costs for patients who, when shopping for insurance coverage, may think of themselves as healthy, potentially in need of an episode of acute care, or chronically ill. We also calculated the maximum OOP costs to model a scenario where each persona experienced a significant decline in health and required a "catastrophic" amount of care in a year. We examined the supplemental benefits available through MA-PD plans and compared them to comparable dental, vision, and hearing plans available for individual purchase. Finally, we considered the nonfinancial differences (e.g. prior authorization and out-of-network providers in MA-PD; lack of care coordination and other supplemental benefits in Medigap) between the Medigap/PDP and MA-PD options, as well as other factors including the likelihood of premium and OOP cost increases over time.

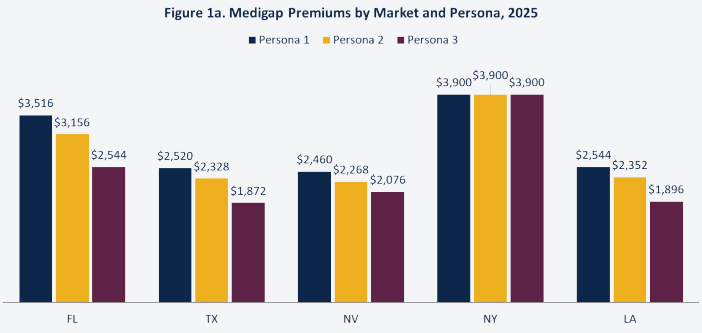
Premium Comparison

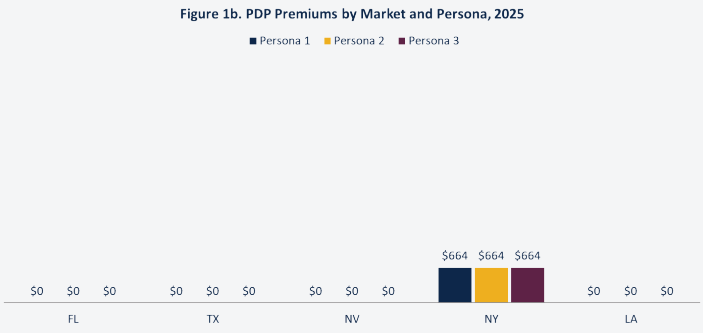
BRG used Medicare.gov's plan finder to calculate and quote Medigap, PDP, and MA-PD plan premiums in each market. Demographic information for each persona was input to quote Medigap plans. Medigap premiums were validated by running quotes on each carrier's website. Quotes were run assuming each persona was ineligible for Medicaid, Supplemental Security Income, Medicare Savings Programs, or Extra Help.

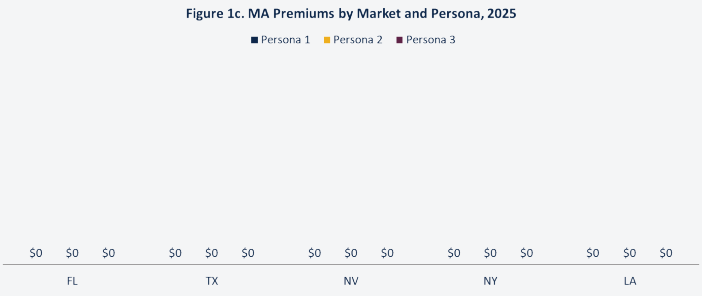
Medigap, PDP, and MA-PD premiums for Personae 1, 2, and 3 for the most popular plan across the five markets in 2025 are displayed in Figures 1a–c.

- Medigap premiums vary by market and persona, from a low of $1,872 to a high of $3,900 per year.
- PDP premiums are $0 per year in all markets except Brooklyn, where the premium is $664 per year.
- MA-PD premiums are $0 per year in all markets.

Figures 1a–c. Premiums by Market and Persona, 2025







The Medigap premiums reported in Figure 1a assume the Medicare beneficiary is enrolling in Medicare for the first time. In most states, beneficiaries applying for Medigap plans may be forced to go through underwriting unless they are applying during a special enrollment period (SEP), such as the seven months surrounding one's initial Medicare eligibility date. Without SEP eligibility, Medigap carriers may charge a higher premium or refrain from offering coverage based on the results of underwriting. Changing from one Medigap plan to another, or from an MA-PD to a Medigap plan, does not qualify an enrollee for an SEP. As a result, enrollees in most states who choose Medigap coverage when they first enroll are effectively locked in, though they can choose to switch to an MA-PD plan each year during the annual enrollment period.

PDP and MA-PD insurers must offer plans on a guaranteed-issue basis during the fall annual enrollment period. They cannot underwrite or deny coverage due to preexisting conditions. Premiums can vary by county but cannot vary by age, sex, or smoking status. As a result, Figures 1b and 1c show no premium variation for PDP or MA-PD by persona.

On the other hand, Medigap premiums can vary by age, sex, smoking status, and residential location.[5] In New York, Medigap premiums are "community rated"; they may vary only by geography. In Florida, Medigap premiums are "issue-age rated"; they are set according to the applicants' age at the time the policy is issued. Texas, Nevada, and Louisiana allow any type of Medigap plan rating. In those states, the most popular plans, including the ones we selected, are "attained-age rated"; these plans offer lower premiums to new enrollees, but premiums increase due to the enrollees age as they grow older. While all three rating types allow for annual price increases due to increases in the underlying cost of care, only attained-age rating allows price increases due to age after the initial enrollment period. Attained-age rating plans typically offer the lowest premiums when first enrolling but experience the highest rate increases over time. Community-rated plans tend to be the most expensive plans for new enrollees, but their rates typically do not increase as much over time.

Medigap Plan G is the most generous of the ten standardized Medigap plan types, covering 100 percent of Medicare Parts A and B cost-sharing except the Part B deductible ($257 in 2025), as well as emergency care in a foreign country. As a result, it is typically the most expensive Medigap plan offered by Medigap insurers. Nevertheless, Medigap Plan G is the most popular Medigap plan, suggesting beneficiaries who choose Medigap prefer to trade high premiums for low- to no cost-sharing when they seek medical care.

Medical Out-of-Pocket Comparison

To estimate medical OOP costs, BRG mapped each persona's expected utilization to the cost-sharing required by the selected plans in each market. Personae 1, 2, and 3 were designed to represent patients with healthy (Persona 1), episodic (Persona 2), and chronic (Persona 3) patterns of care. Those patterns of care were validated through analysis of average utilization in each market for patients with the same age, sex, and number of chronic conditions as each persona, using the Master Beneficiary Summary File's (MBSF) Cost and Use Segment.[6] We also calculated the maximum medical OOP cost for each plan type to simulate the utilization and resulting cost-sharing for a patient experiencing a significant decline in health and thus needing a "catastrophic" amount of care in a year.

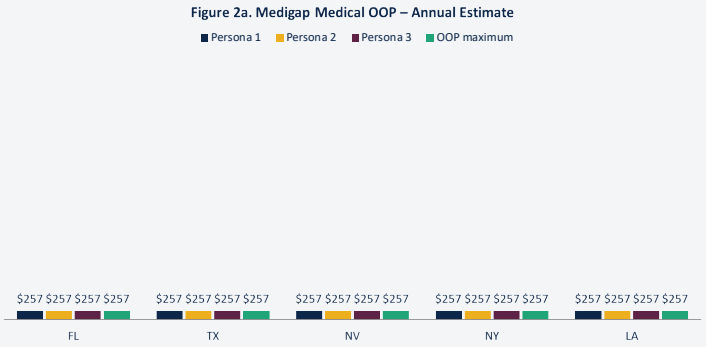
We present medical OOP cost estimates for Personae 1, 2, and 3 for the Medigap and MA-PD options in each market in Figures 2a–b.

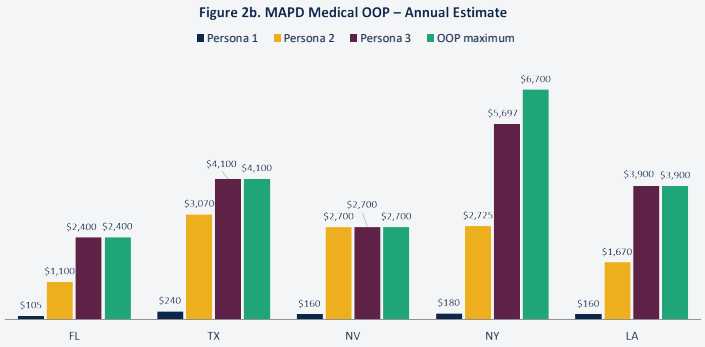
- We estimate Personae 1, 2, and 3 will pay $257 in OOP costs for medical care under their Medigap Plan G in each market. Medigap Plan G requires cost-sharing only for the Part B Deductible ($257 in 2025), and we assume all three patient personae will utilize enough care to reach that deductible.
- We estimate Personae 1, 2, and 3 will pay between $105 and $6,700 in OOP costs for medical care under their MA-PD plans across the five markets. The variation in cost-sharing is driven by the utilization patterns for each patient persona and the medical OOP maximum for each MA plan.

5 Though not reflected in this analysis, modest premium discounts may be offered for Medigap enrollees from the same household or for paying premiums through direct deposit.

6 ResDAC, MBSF Cost and Use files. https://resdac.org/cms-data/files/mbsf-cost-and-use

Figures 2a–b. Medical OOP Cost Annual Estimates by Market and Persona





As noted above, Medigap Plan G covers all medical OOP costs except the Part B deductible ($257 in 2025). As a result, Medigap Plan G effectively caps medical OOP expenditures at the Part B deductible each year. All of our personae hit this effective cap—even "healthy" Persona 1, whose few trips to the doctor resulted in at least $257 of medical costs.

Our MA-PD medical cost estimates vary by persona. Persona 1 would pay less in medical OOP costs if they enrolled in an MA-PD plan instead of a Medigap Plan G in any of the five markets we studied, due to the MA-PD plans' $0 deductibles and low copayments for physician office visits, lab tests, and other outpatient services. Persona 2's hospital visit and outpatient services amounted to significantly higher medical OOP costs in an MA-PD plan. Persona 3's multiple hospitalizations and expensive physician-administered drug utilization pushed their OOP costs up to their MA-PD plan's OOP maximum.

Prescription Drug Out-of-Pocket Comparison

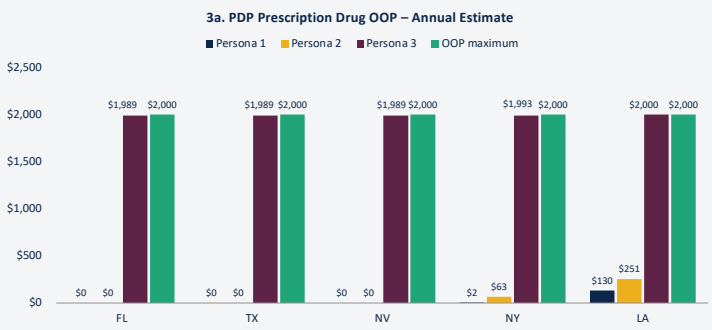
To estimate prescription drug OOP costs, BRG used the Medicare.gov plan finder's OOP cost estimator tool to estimate the total OOP cost for Personae 1, 2, and 3 had they enrolled in our selected plans. Prescriptions for each persona were input into the OOP cost estimator, and two retail pharmacies were selected. Persona 1 fills prescriptions for lisinopril and atorvastatin (both generic); Persona 2 fills those two prescriptions plus clopidogrel and metoprolol (also both generic). Persona 3 fills those four prescriptions plus apixaban (brand).[7] We also calculated the maximum medical OOP cost for each plan type to simulate the utilization and resulting cost-sharing for a patient needing a "catastrophic" amount of care in a year.

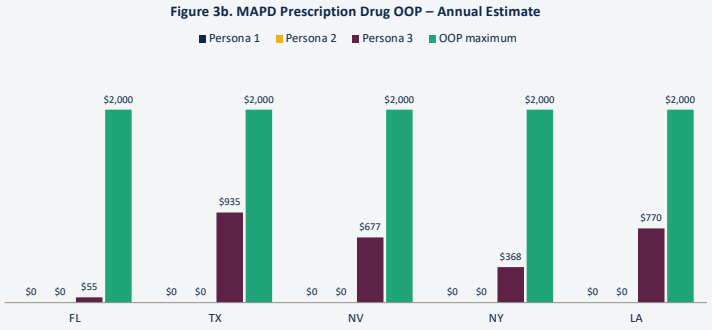
We present prescription drug OOP cost estimates for Personae 1, 2, and 3 for the PDP and MA-PD options in each market in Figures 3a–b.

- We estimate Personae 1, 2, and 3 will pay between $0 and $2,000 in OOP costs for prescription drug care under their standalone PDP plan in each market. In all markets, Persona 3 nearly reaches or does reach the OOP maximum due to the cost of their brand drug prescription.
- We estimate Personae 1, 2, and 3 will pay between $0 and $935 in OOP costs for prescription drugs under their MA-PD plans across the five markets. The MA-PD plans required less cost-sharing than the PDP plans for Persona 3's brand drug prescription, leading to lower estimated annual OOP costs.

7 See the appendix for a full description of the prescriptions used in our simulation.

Figures 3a–b. Prescription Drug OOP Cost Annual Estimates by Market and Persona





Both standalone PDP and MA-PD plans offered generous coverage of each persona's generic drugs. The difference between the plans across all five markets was their coverage of a brand drug; the MA-PD plans were more likely to cover the drug on a preferred brand tier that required lower cost-sharing.

Starting in 2025, both PDP and MA-PD plans come with an OOP maximum of $2,000 for prescription drugs. Patients with significant drug needs will find no OOP cost advantage between PDP and MA-PD plans, leading them to prioritize other factors (such as premiums) when determining the cost.

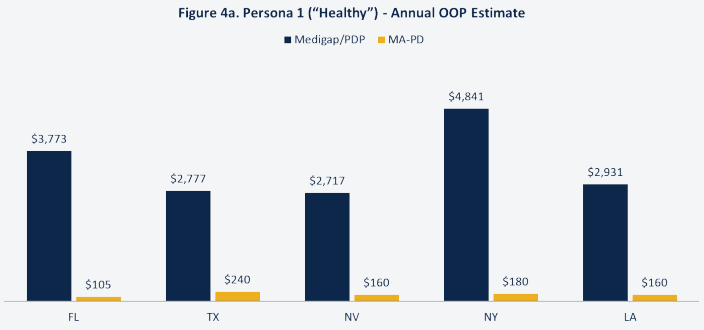
To keep focus on the choice between Medigap/PDP and MA-PD plans, this modeling exercise intentionally compared the drug benefits of the most popular PDP and MA-PD plans in each market. We did find other PDP and MA-PD plans that covered our personae's drugs at a lower cost share, though the differences were minor and the gap in Persona 3's example remained.

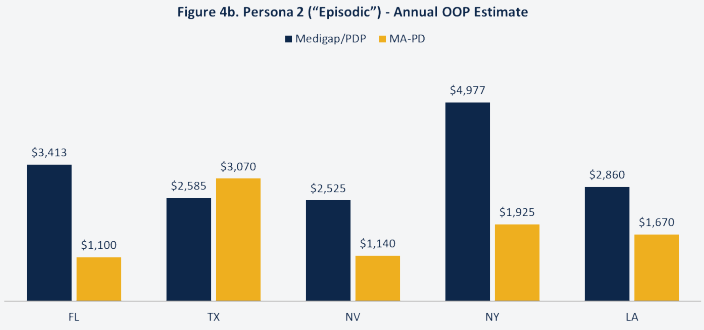
Total Annual Estimated and Maximum Out-of-Pocket Cost Comparison

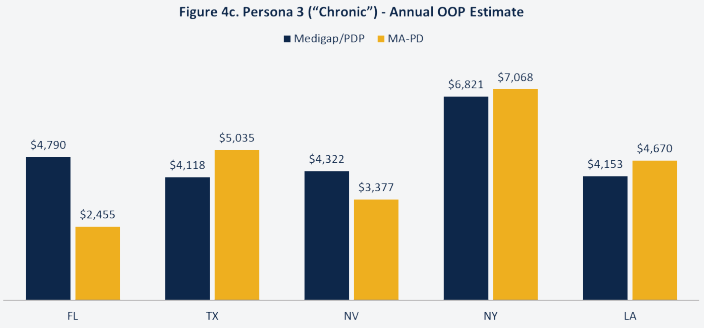
We added up our premium, medical OOP, and prescription drug OOP cost estimates to obtain a total annual OOP cost estimate for each persona in each selected market. The results are presented in Figures 4a–c.

- "Healthy" Persona 1 fared better in MA-PD plans across all five markets. On average, Persona 1 would have saved $3,239 annually by choosing the most popular MA-PD plan over the most popular Medigap/PDP plan.
- "Episodic" Persona 2 fared better in MA-PD plans in four of five markets. In those four markets, Persona 2 would have saved $1,985 on average by choosing the most popular MA-PD plan over the most popular Medigap/PDP plan. In Dallas, Persona 2 would have saved $485 by selecting the Medigap/PDP plan.
- "Chronic" Persona 3 fared better in Medigap/PDP plans in three of five markets. In those three markets, Persona 3 would have saved $560 on average by choosing the Medigap/PDP plan. In the other two markets, Persona 3 would have saved $1,640 on average by choosing the MA-PD plan.

Figures 4a–c. Total Annual Premium and OOP Cost Estimates by Market and Persona







We also added up each plans' premiums and medical and drug maximum OOP costs to demonstrate the experience of an enrollee with a "catastrophic" amount of care in their plan year. Doing so allowed us to simulate a new enrollee asking the question, "What's the worst-case financial scenario for either option?" We present the results in Figures 5a–c.

- "Catastrophic" Persona 1 fared better in Medigap/PDP plans in three of five markets. On average, Persona 1 would have saved $1,334 on average by choosing the most popular Medigap and PDP plans over the most popular MA-PD plan. In the other two markets, Persona 1 would have saved $695 on average by choosing the MA-PD plan.
- "Catastrophic" Persona 2 fared better in Medigap/PDP plans in four of five markets. In those four markets, Persona 2 would have saved $1,140 on average by choosing the most popular Medigap and PDP plans over the most popular MA-PD plan. In Tampa, Persona 2 would have saved $1,013 by selecting the MA-PD plan.
- "Catastrophic" Persona 3 fared better in Medigap/PDP plans in four of five markets. In those four markets, Persona 3 would have saved $1,416 on average by choosing the most popular Medigap and PDP plans over the most popular MA-PD plan. In Tampa, Persona 3 would have saved $401 by selecting the MA-PD plan.

Figures 5a-c. Maximum Annual Premium and OOP Costs by Market and Persona

Figure 5a. "Catastrophic" Year – Persona 1 Reaching Medical and Drug Maximum OOP

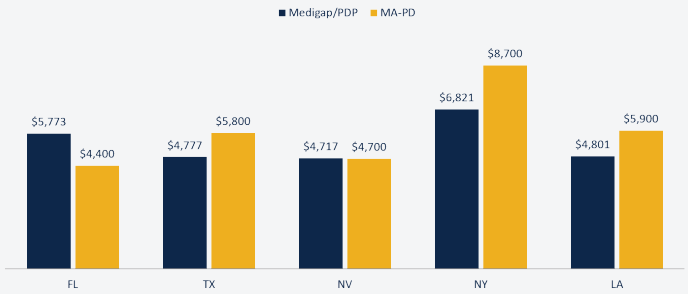


Figure 5b. "Catastrophic" Year – Persona 2 Reaching Medical and Drug Maximum OOP

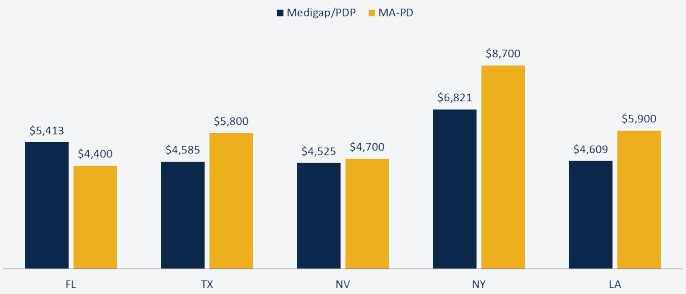
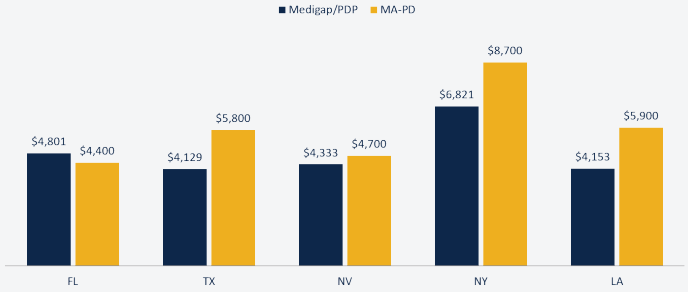


Figure 5c. "Catastrophic" Year – Persona 3 Reaching Medical and Drug Maximum OOP



In eleven of fifteen cases, our estimate of total annual spending would lead our personae to the conclusion that an MA-PD plan would benefit them more financially than Medigap and PDP plans in the following plan year. Performing a "worst-case scenario" exercise would lead our personae in eleven of fifteen cases to conclude the Medigap/PDP option would be better for them financially than an MA-PD for a single plan year. Several factors contribute to these outcomes:

- In general, Medigap Plan G's high premiums compared to MA-PD plans' $0 premiums cause OOP cost estimates for patients with few care needs to be lower by enrolling in an MA-PD.
- In general, comparing Medigap Plan G's 2025 Part B deductible requirement of $257 to MA-PD plans' higher medical OOP maximum will lead patients with significant medical needs to estimate lower total medical costs in a Medigap plan. Exceptions can be found in certain markets where MA-PD plans offer particularly generous medical coverage.
- In general, $0 premium PDP and MA-PD plans were available across markets. An exception was Brooklyn, where our selected PDP plan's annual premium was $664.
- In general, MA-PD plans offered more generous coverage of our personae's brand drug prescription than the PDP coverage in the same market. Both types of plans offer a $2,000 prescription drug OOP maximum, suggesting only those patients taking a small number of expensive medications may see the benefit of the MA-PD plan's drug coverage over the PDP plan's coverage.

To understand how each persona might factor in cost differences between a typical year and a "catastrophic" year, BRG examined the MA-PD savings (in a typical year) and extra spending (in a catastrophic year) averaged across all markets by persona in both scenarios. Tables 2 and 3 demonstrate how shoppers may find enrolling in MA-PD is a better option because of the savings they can "bank" each year as a healthy, episodic, or chronic patient.

Table 2. Total Annual OOP Costs by Persona, Averaged across Five Markets, 2025

Persona	Average Total Annual Costs (Premiums + OOP)		
	TM (Medigap + PDP)	MA-PD	MA-PD Savings
"Healthy" Persona 1	$3,408	$169	$3,239
"Episodic" Persona 2	$3,272	$1,781	$1,491
"Chronic" Persona 3	$4,841	$4,521	$320

Table 3. Total Annual OOP Costs by Persona in a "Catastrophic" Year, Averaged across Five Markets, 2025

Persona	Average Total Annual OOP Costs – Catastrophic		
	TM (Medigap + PDP)	MA-PD	MA-PD Extra Spending
"Healthy"	$5,378	$5,900	$522
"Episodic"	$5,191*	$5,900	$709
"Chronic"	$4,847*	$5,900	$1,053

* The Episodic and Chronic shoppers spend less than the Healthy shoppers because they pay lower Medigap premiums due to their ages (70 and 65, versus 75).

Table 4 compares differences in MA-PD savings in typical years to extra spending in catastrophic years. For each healthy year, an enrollee would save enough to cover 6.2 years of extra spending in a catastrophic year. The "banked savings ratio" was 2.1 for episodic shoppers and 0.3 years for chronic shoppers, respectively.

Table 4. Comparison of Savings and Extra Spending in Regular and Catastrophic Years, 2025

Persona	Average Savings: Typical MA-PD Year	Average Extra Spending: Catastrophic MA-PD Year	Banked Savings Ratio*
"Healthy"	$3,239	$522	6.2 years
"Episodic"	$1,491	$709	2.1 years
"Chronic"	$320	$1,053	0.3 years

* The banked savings ratio compares the average savings in a typical MA-PD year to the average extra spending in a catastrophic MA-PD year. For example, a Healthy beneficiary will save enough money in one year by choosing MA-PD to cover 6.2 years of extra spending in a catastrophic year.

Because the typical Medicare beneficiary is unlikely to experience such a catastrophic plan year in any given year (see Box 1), new Medicare beneficiaries concerned about costs in a catastrophic year may still find enrolling in MA-PD plan lowers expected OOP costs more often than TM over time.

Box 1. Medicare beneficiaries must make enrollment decisions that fit their preferences for multiple years.

Given constraints on switching, Medicare beneficiaries must enroll in the plan options that fit their care needs and preferences for multiple years, not just the next year. As they enter Medicare and decide which insurance to buy, new beneficiaries must consider their current health status and utilization patterns *and* evaluate the risk of a significant health event or deterioration in their health status resulting in a "catastrophic" year.

Given Part D plans are now required to have a $2,000 maximum OOP cap, our modeling suggests high Part A costs (e.g., multiple multiday hospital visits) or high Part B costs (e.g., receiving expensive physician-administered drugs) will likely determine whether one's total OOP spending will be lower under Medigap + PDP or MA-PD. The following research suggests the typical Medicare beneficiary would not expect to have a catastrophic year at the start of the year:

- The Congressional Budget Office reports only 20 percent of Medicare beneficiaries incur Part A Costs in a given year.[8] About 15 percent of Medicare beneficiaries incur no Part A or B costs, and 65 percent incur Part B costs only.
- Hyland et al. report around 11 percent of Medicare beneficiaries had a Part B drug administered in 2023.[9]
- MedPAC reports the least costly 75 percent of TM beneficiaries accounted for only 16 percent of total TM spending in 2021.[10]

This does not mean Medicare beneficiaries should ignore the prospect of an eventual catastrophic spending year. Rather, it suggests choosing coverage when one first enrolls in Medicare is a long-term financial planning exercise that must account for growth in premiums and OOP costs over one's lifetime.

Other Factors Driving Consumer Decisions

The analysis above considers only the premium and OOP cost implications of our personae's initial plan year in evaluating the difference between Medigap/PDP and MA-PD. Below we consider options that come into play for consumers deciding between the two types of coverage options.

Premium Rate Increases

While $0 premium MA-PD plans tend to maintain $0 premiums from year to year, Medigap premiums rise for multiple reasons. All Medigap premiums tend to rise to keep up with medical trends. Attained-age rated plans like the Texas, Nevada, and Louisiana plans included in our analysis will additionally rise as enrollees age. Males, smokers, and enrollees in higher-cost residential areas pay more than females, nonsmokers, and those who reside in lower-cost areas.

There is little recently published evidence on Medigap premium increases over time, but anecdotal evidence suggests attained-age rated Medigap policies may go up 5 to 8 percent per year, meaning these Medigap premiums could double every ten years or so. Understanding how one's Medigap premiums can rise is an important component of the longer-term financial planning exercise new Medicare beneficiaries go through when choosing coverage. Just as a healthy 65-year-old might want to consider a future year in which they need more care, so might a risk-averse 65-year-old consider their Medigap premiums in ten years before deciding to opt for a Medigap plan that limits their OOP exposure.

8 Duchovny, N., et al., *CBO's Medicare Beneficiary Cost-Sharing Model: A Technical Description*, Congressional Budget Office working paper (October 2019).

9 Hyland, M.F., et al., "Spending on and Use of Clinician-Administered Drugs in Medicare," *JAMA Health Forum* 4(9) (2023). doi: 10.1001/jamahealthforum.2023.2941. PMID: 37682554; PMCID: PMC10492179.

10 Medicare Payment Advisory Commission (MedPAC), *A Data Book: Health Care Spending and the Medicare Program* (July 2024), Chart 1-9, "FFS program spending was highly concentrated on a small share of beneficiaries, 2021."

Supplemental Benefits

Most MA plans offer supplemental benefits that go beyond what TM covers and are designed to enhance the overall health and well-being of beneficiaries. Common benefits include dental care (e.g., routine dental exams, cleanings, fillings, and more extensive procedures like crowns and dentures); vision care (e.g., eye exams, eyeglasses, and contact lenses); hearing care (e.g., hearing exams and hearing aids); fitness programs (e.g., access to gym memberships, fitness classes, and wellness programs to promote physical activity); and transportation services (e.g., coverage for transportation to and from medical appointments.

Our research and others found MA plans that offer supplemental benefits save money for Medicare beneficiaries. Using eHealth's dental coverage shopping tool, BRG examined the price of standalone dental coverage in our five selected markets that would match the annual maximum benefit of the dental benefits offered by our selected MA-PD plan in those markets (Table 5).

Table 5. Premiums of Standalone Dental Plans Offering Similar Maximum Benefit as Selected MA-PD Plans, 2025

Market	Selected MA-PD Plan's Maximum Annual Benefit	Lowest-Cost Health Plan with Closest Maximum Annual Benefit	Annual Premium
Tampa, FL (Hillsborough County, 33614)	$3,000	Manhattan Life Dental, Vision and Hearing Select - $3,000 maximum	$603
Dallas, TX (Dallas County, 75201)	$3,000	Manhattan Life Dental, Vision and Hearing Select - $3,000 maximum	$629
Reno, NV (Washoe County, 89501)	$500	Ameritas Prime Star Lite- $750 maximum	$283
Brooklyn, NY (Kings County, 11226)	$3,000	Manhattan Life Dental, Vision and Hearing Select - $3,000 maximum	$629
New Orleans, LA (Orleans Parrish, 70119)	$2,500	NCD Essentials by MetLife - $2,000 maximum	$864

Our analysis found MA beneficiaries would have had to spend between $283 and $864 on standalone dental premiums to find a plan with the same or similar annual maximum benefit as their MA-PD plan.

A Kaiser Family Foundation analysis found enrolling in an MA plan allowed enrollees requiring dental and vision care to save $226 and $48, respectively, in 2018.[11] The same study found enrollees who required hearing care saved $222, though the findings were not significant.

These analyses suggest suggests Medicare beneficiaries could achieve significant savings by obtaining coverage for hearing, dental, vision, and other supplement benefits offered through MA-PD plans over trying to buy such care on their own.

Care Management, Prior Authorization, and Network Restrictions

MA plans coordinate patient care, develop personalized care plans, improve medication adherence, and aim to reduce unnecessary hospital readmissions to improve patient experience and care quality while lowering costs.

Most MA plans use prior authorization and other utilization management tools to limit low-value and unnecessary care. Prior authorization rules require healthcare providers to gain approval from the MA plan before a patient can receive certain treatments, tests, or procedures. Prior authorization is much less common in Traditional Medicare. TM does not typically require prior authorization for most services, meaning patients can receive medical tests, surgeries, and other treatments without needing approval from Medicare beforehand. Medicare enrollees who would prefer to avoid dealing with prior authorization may favor a Medigap/PDP option at the risk of receiving uncoordinated care.

Many MA-PD plans are health maintenance organizations (HMOs) that may not cover care provided outside the plans' contracted physician network. HMOs also may require a referral to obtain specialist care. In the analysis above, all MA-PD selected plans were HMOs, and our OOP cost estimates assumed patients only sought in-network care. Medicare enrollees who may wish to see any doctor they like may prefer the Medigap/PDP option at the risk of receiving more fragmented care.

11 Freed, M., J. Cubanski, N. Sroczynski, N. Ochieng, & T. Neuman, *Dental, Hearing, and Vision Costs and Coverage Among Medicare Beneficiaries in Traditional Medicare and Medicare Advantage*, KFF (September 21, 2021).

Conclusions

This paper demonstrates the financial dynamics surrounding a new Medicare beneficiary's choice between Traditional Medicare (including Medigap and PDP coverage) on the one hand and MA-PD plans on the other. Our analysis suggests consumers will tend to prefer MA-PD plans over TM in a majority of scenarios, with demographics, geography, health status, and risk tolerance all factoring into the decision. Driving this conclusion is the fact that TM on its own is not comprehensive coverage, and Medigap plans charge high premiums that rise each year, potentially pushing them out of reach for lower-income Medicare beneficiaries. This could explain why Medigap enrollees are more likely to be White, have higher incomes, and report better health than other TM enrollees.[12]

We note this paper describes the typical Medigap/PDP versus MA-PD choice of an enrollee ineligible for financial support. Low-income beneficiaries may qualify for Medicaid, Medicare Savings Programs, and the Extra Help program to provide additional coverage at low or no cost. As policymakers consider structural reforms to Medicare, they should account for the fact that Medicare enrollees who are ineligible for financial support likely will find Medicare Advantage to offer a better deal than Traditional Medicare.

12 Freed, M., et al., *Key Facts About Medigap Enrollment and Premiums for Medicare Beneficiaries*, KFF (October 18, 2024).

Appendix: Assumptions and Methodology

Personae Assumptions

- Persona 1: 75-year-old female, nonsmoker, 0 to 2 chronic conditions
- Persona 2: 70-year-old male, nonsmoker, 3 to 5 chronic conditions
- Persona 3: 65-year-old female, nonsmoker, 6+ chronic conditions

Medigap Premiums

- Selected Medigap Plan G plan with highest market share in the state, according to NAIC *2023 Medicare Supplement Loss Ratios* report (2024).
- Premiums collected from medicare.gov plan finder tool.

Medigap OOP Costs

- The statutory maximum out-of-pocket (OOP) cost for Plan G in 2025 is $257.

Part D Premiums

- Selected Part D plans with highest market share from the Centers for Medicare and Medicaid Services (CMS) CMS.gov Medicare Advantage/Part D Contract and Enrollment Data "Monthly Enrollment by Contract/Plan/State/County" file (November 2024).
- Premiums collected from medicare.gov plan finder tool; no household or roommate discounts were selected.

Prescription Drug OOP Estimates

- BRG performed an analysis using Medicare's Cost and Use file available through CMS's Virtual Resource Data Center (VRDC) to identify the average number of prescriptions for persons similar to Personae 1, 2, and 3.
- BRG then consulted published research validated with a primary care physician who treats geriatric populations to identify common chronic diseases in the Medicare patient populations.
- BRG then selected the most prescribed medications to treat those chronic diseases.
- Part D OOP estimates were calculated using Medicare.gov's plan finder Rx cost estimation tool, selecting the closest CVS and Walmart pharmacies and then choosing the lowest-cost pharmacy to obtain the prescriptions cost to the patient:
  - > Persona 1: lisinopril, 10MG once daily; atorvastatin calcium, 10MG once daily
  - > Persona 2: lisinopril, 10MG once daily; atorvastatin calcium, 10MG once daily; clopidogrel bisulfate, 75MG once daily; metoprolol, 100MG per day
  - > Persona 3: lisinopril, 10MG once daily; atorvastatin calcium, 10MG once daily; clopidogrel bisulfate, 75MG once daily; metoprolol, 100MG per day; Eliquis, 5MG twice daily

MA-PD Medical OOP Calculation Methodology

- Utilization patterns modeled off average, national, 65–69, 70–74, and 75–79-year-old utilization patterns collected using Medicare's Cost and Use file through CMS's VRDC.
  - > We considered county-specific and female-only patterns but chose national and all-sex due to data robustness.
- Assign three distinct utilization patterns to different "patient personae":
  - > Persona 1 modeled off averages for patients with 0 to 2 chronic conditions, but in relatively good health.
    - Regular check-ups, no hospital use, two prescriptions (all generic)
  - > Persona 2 modeled off averages for patients with 3 to 5 chronic conditions, with one hospitalization.
    - Regular check-ups plus follow-up visits, 3-day hospital stay, 4 prescriptions (all generic)
  - > Persona 3 modeled off averages for patients with 6+ chronic conditions, frail with hospitalizations.
    - Dozens of physician visits, 2 five-day hospital stays, 5 prescriptions (1 branded drug), 1 Part B drug
- Utilization multiplied by cost-sharing in each plan benefit design.
  - > Where there were cost-sharing ranges, we assumed the highest cost-sharing.