AARP Public Policy Institute

Medicare Advantage Benefit Design: What Does It Provide, What Doesn't It Provide, and Should Standards Apply?

Marsha Gold, Sc.D., and Maria Cupples Hudson, MS
Mathematica Policy Research, Inc.
Washington, DC 20024

Research Report

AARP

Medicare Advantage Benefit Design: What Does It Provide, What Doesn't It Provide, and Should Standards Apply?

Marsha Gold, Sc.D., and Maria Cupples Hudson, MS
Mathematica Policy Research, Inc.
Washington, DC 20024

AARP's Public Policy Institute informs and stimulates public debate on the issues we face as we age. Through research, analysis and dialogue with the nation's leading experts, PPI promotes development of sound, creative policies to address our common need for economic security, health care, and quality of life.

The views expressed herein are for information, debate, and discussion, and do not necessarily represent official policies of AARP.

2009-03
March 2009

AARP Public Policy Institute
601 E Street, NW, Washington, DC 20049
http://www.aarp.org/ppi

Acknowledgments

Sarah Thomas, who directs the health team at the AARP Public Policy Institute, commissioned this study and provided valuable feedback on an ongoing basis. Joyce Dubow, AARP, who oversaw earlier work on this topic, also offered valuable advice. At Mathematica Policy Research, Erin Fries Taylor provided useful comments on earlier versions of the manuscript. Molly and James Cameron provided editorial support, and Felita Buckner produced the manuscript.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

EXECUTIVE SUMMARY

This Research Report examines Medicare Advantage (MA) as a source of expanded Medicare benefits that integrates Medicare benefits with selected supplemental coverage. MA provides plan sponsors with considerable flexibility in how they structure MA benefits. While MA plans must cover mandated Part A and Part B benefits, they have the flexibility to modify cost sharing and other benefit features if the results are at least actuarially equivalent and nondiscriminatory. The report examines how these plans modify the structure of Medicare Part A and Part B benefits and cost sharing requirements, and what that means for the financial protection provided to plan enrollees. The report also compares MA's benefit structure with those of the standardized Medigap options created in 1990.

Such analysis is important because the traditional Medicare benefit structure leaves beneficiaries financially exposed to an extent that is increasing over time with inflation in health care. With 23 percent of Medicare beneficiaries now enrolled in MA (including one in three persons with Part D coverage), it is increasingly relevant to understand what protection MA does and does not provide.

The analysis of MA benefit design is based on files we created from the downloadable files the Centers for Medicare and Medicaid Services (CMS) provides with data from Medicare Options Compare, a tool used to support beneficiary choice. Data are for 2008 and 2009, with most statistics weighted by plan enrollment in July 2008.

KEY FINDINGS

The findings in this brief show that MA plans have taken advantage of the flexibility afforded them under the Medicare Modernization Act of 2003 (MMA) to modify in important ways the structure of traditional Medicare benefits, the cost sharing that applies to them, and their scope.

Most MA plans simplify Medicare's benefit structure for Part A and Part B benefits, with a shift toward copayments and away from deductibles and coinsurance.

- Most plans eliminate Medicare's inpatient hospital day limits. In 2008, only 7 percent of MA enrollees were in a plan with such a limit, though 17 percent of plans had them in 2008 and 15 percent had them in 2009.

- In MA, most enrollees are in plans with inpatient copayments that vary by length of stay, rather than having a single fixed deductible per stay as in traditional Medicare. While the average amount paid is below that in traditional Medicare, practices vary substantially across plans. For example, the average MA enrollee with a 10-day stay had $823 in hospital cost sharing in 2008 (compared with $1,068 in traditional Medicare and zero under Medigap). However, 12 percent of MA enrollees would pay $2,000 or more.

- MA also alters the structure of cost sharing for skilled nursing facility (SNF) benefits. Ninety percent of MA enrollees in 2008 were in plans that required cost sharing from the beginning of an SNF stay (rather than day 21 as under traditional Medicare). This

means that the average MA enrollee with a 20-day SNF stay had $1,390 of cost sharing in 2008, an amount highest in private fee-for-service (PFFS) plans ($1,807) and lowest in local preferred provider plans (PPOs) ($834). In most MA plans, cost sharing continues for longer stays. Only 8 percent of MA enrollees, however, were in a plan that required a three-day hospital stay before an MA admission.

- MA plans typically require fixed copayments for physician visits rather than using the deductible/coinsurance structure of Medicare. These copayments distinguish between primary care and specialist visits, and are higher for specialist care. Plans vary in whether they charge beneficiaries additionally for specific services that might be provided or ordered during these visits. In 2008, 43 percent of MA enrollees were in plans with no cost sharing for clinical laboratory services, and 23 percent were in plans with no cost sharing for X-ray services. When copayments were required, they were more likely to be fixed than coinsurance (traditional Medicare requires 20 percent coinsurance after the Part B deductible, an amount Medigap plans fill in).

A key concern about Medicare benefits has been the fact that they do not limit the total out-of-pocket amount beneficiaries are obligated to pay for Part A and Part B benefits, a feature common in private insurance but absent in traditional Medicare benefit design. Historically, such a limit was viewed as irrelevant for health maintenance organizations (HMOs), which were the earliest of MA plans and are still the most common form. As cost sharing has increased, more plans are integrating a limit, but many enrollees are in plans that do not have a limit or plans in which the limit is very high. This contrasts with the most popular Medigap plans, which fill in all or almost all of Medicare's cost sharing.

- In 2008, 53 percent of MA enrollees were in a plan with an out-of-pocket limit, including 42 percent of HMO enrollees. More MA enrollees are likely to be in plans that have such a limit in 2009, as the share of plans with a limit is higher than in 2008. But limits tend to be relatively high. Among enrollees with limits, just as many had limits over $4,000 as had limits of $2,500 or less in 2008. The highest limits are in regional PPOs, the only plan type that is required to include them.

- In 2008, some MA plans had cost sharing requirements for Part B drugs (and, to a lesser extent, durable medical equipment) that exceeded those in traditional Medicare, but such arrangements were much less prevalent in 2009. (Concerns that such practices may discriminate against sick enrollees led to increased CMS scrutiny of bids.)

MA plans traditionally have covered some benefits that Medicare excludes. Even though Medicare's preventive benefits have been expanded, this is still the case today.

- MA plans typically eliminate cost sharing requirements for many preventive services that Medicare covers; cover routine physical exams regularly, not just on entry to Medicare as the traditional program does; and incorporate selected health education and wellness benefits, many of which are uncovered in Medicare.

- Thirty-seven percent of MA enrollees in 2008 were in a plan that had a preventive dental benefit. About half of these had a package that included at least one exam and cleaning every six months and at least one X-ray a year. No plan covered restorative services (e.g., fillings).

- Eighty-five percent of MA enrollees had a vision benefit, and 84 percent had some eyeglass coverage in 2008. Most plans limited the amount of this coverage (on average, the limit was $76).
- Seventy percent of MA enrollees were in plans that covered hearing tests, and 36 percent had some benefit for hearing aids in 2008. As with eyeglasses, such benefits typically were limited to a specified amount (on average, $325 in 2008).
- Thirty-two percent of MA enrollees in 2008 were in a plan with an expanded podiatry benefit.
- Seventy-five percent of MA enrollees in 2008 were in plans that appear to have had expanded worldwide travel benefits for emergency care.

CONCLUSIONS AND POLICY IMPLICATIONS

MA plans are selected for a variety of reasons, but often the choice boils down to benefits and premiums, with a perception that MA provides enhanced benefits (or reduced cost sharing) compared with traditional Medicare and lower premiums than standardized Medigap plans. Our analysis provides a profile of MA benefits that illustrates why some beneficiaries may be attracted to MA; it also describes the variation in benefit structures (and reduced cost sharing) across plan types and within plans. On many measures, newer MA options (PFFS plans, regional PPOs) offer less than traditional HMOs, though benefits in HMO plans vary.

Currently, firms that sponsor MA plans have discretion in how they design benefits, in contrast to the standardization in place for Medigap. MA plans differ substantially in structure from most Medigap plans. MA plans are less likely to fill in Medicare cost sharing than to restructure it, resulting in potentially greater financial exposure for beneficiaries in MA compared with Medigap ("insurance risk"). MA also is more likely to offer expanded benefits for common and predictable needs ("prepayment").

In light of the diversity we found, policymakers may want to consider whether greater standardization in MA would be desirable.[1] Our study identifies certain incremental changes that could be very valuable to limit the financial exposure of Medicare beneficiaries who are enrolled in MA (such as an out-of-pocket limit) and make it easier for beneficiaries to anticipate coverage and compare benefits across MA plans (see box).

[1] For an in-depth discussion of this topic, see E. O'Brien and J. Hoadley, *Medicare Advantage: Options for Standardizing Benefits and Information to Improve Consumer Choice*, The Commonwealth Fund, New York, April 2008.

INCREMENTAL CHANGES THAT COULD STRENGTHEN MA BENEFIT DESIGN

Clearer Financial Risk Protection as an Alternative to Medigap

- ***Out-of-pocket limit.*** Strengthen financial risk protection by requiring MA plans to have a combined out-of-pocket limit on enrollee cost sharing for Part A/B benefits.
- ***Standardized limit structures.*** Require limits to mirror two to three standardized choices to simplify choice for beneficiaries.
- ***More comparative analysis of trade-offs.*** Beneficiaries who are deciding whether to elect Medicare alone, Medicare with a Medigap Plan, or an MA plan for their Part A/B benefits would benefit from analysis that clearly lays out the financial risks associated with Part A/B cost sharing and unpredictable health care risks, and the trade-offs inherent in insurance costs that pay for such protections.

Simplified Treatment of Certain Options for Medicare Benefit Design

- ***Mandated changes in Medicare A/B benefit design.*** Require all plans to incorporate certain revisions of Medicare A/B benefits that most plans already have adopted: no limit on inpatient days, elimination of Medicare deductibles, and copayments rather than coinsurance (in-network), other than the standard 20 percent.
- ***Standardized options for expanded coverage.*** Establish standardized designs for commonly offered optional benefits: preventive dental, vision, hearing, and an enhanced preventive services package.
- ***More prominent flags to identify benefit expansions.*** Medicare Options Compare should more clearly indicate when a benefit is identical to that of traditional Medicare, when it is actuarially equivalent, when it is enhanced, and when it is new.

While MA structures have evolved with relatively little guidance, MA is now a major part of the Medicare market. It makes sense to consider how the MA benefit form could be better standardized and simplified to enhance the value of these plans to beneficiaries and increase their ability to make informed choices.

FOCUS OF THIS REPORT

This Research Report examines Medicare Advantage (MA) as a source of expanded Medicare benefits that integrates Medicare benefits with selected supplemental

coverage.[2] The report examines how these plans modify the structure of Medicare Part A and Part B benefits and cost sharing requirements, and what that means for the financial protection provided to plan enrollees. The report also compares MA's benefit structure with those of the standardized Medigap options created in 1990. Such analysis is important because the traditional Medicare benefit structure leaves beneficiaries financially exposed to an extent that is increasing over time as a result of inflation in health care.[3] With 23 percent of Medicare beneficiaries now enrolled in MA (including one in three persons with Part D coverage), it is increasingly relevant to understand what protection MA does and does not provide.

Medicare Advantage provides plan sponsors with considerable flexibility in how they structure MA benefits. While MA plans must cover mandated Part A and Part B benefits, they have the flexibility to modify cost sharing and other benefit features if the results are actuarially equivalent and nondiscriminatory.[4] This flexibility differs considerably from the standardization required of Medigap plans, which must be designed consistent with one of a set of specified benefit packages.[5]

DATA SOURCES AND ANALYSIS

The analysis of benefit design in MA plans was constructed from our analysis of the downloadable file CMS provides with data from Medicare Options Compare—a tool on the Medicare Web site that can be used to support benefit choice. We downloaded files for 2008 and 2009 that showed the characteristics of plans offered to individuals under each contract; we analyzed the county service area in which each plan was offered to identify unique plans available in different contract segments. The analysis focuses on plans open to all beneficiaries; we exclude special needs plans (SNPs) and group plans because of their unique eligibility requirements and because of limitations in available data.[6]

---

[2] MA plans integrate Medicare benefits with supplemental coverage, unlike Medigap options, which are freestanding supplements. Beneficiaries who enroll in such plans on an individual basis do not purchase separate supplemental coverage. (Some exceptions exist for Part D benefits, particularly if a beneficiary enrolls in a private fee-for-service (PFFS) plan without a drug benefit.) The focus of this Research Report, however, is on cost sharing for Medicare Parts A and B coverage, as well as coverage for benefits that are excluded from the Medicare package.

[3] P. Neuman et al. "How Much 'Skin in the Game' Do Medicare Beneficiaries Have? The Increasing Financial Burden of Health Care Spending, 1997–2003," *Health Affairs*, 26(6), November/December 2007; updated to 2005 in February 2009, pp. 1692-1701. Available at www.kff.org. For a more detailed analysis of benefit design, see Medicare Payment Advisory Commission (MedPAC), *Report to Congress: Assessing Medicare Benefits*, Washington, DC, June 2002.

[4] Such modifications have been an issue, with concern expressed by beneficiary groups about some plans designing benefits in ways that discourage sicker persons from enrolling or that make it hard for them to access certain services (e.g., chemotherapy). Our analysis of changes in benefits from 2008 to 2009 suggests that the Centers for Medicare and Medicaid Services (CMS) has recently focused more attention on regulating such practices.

[5] For a more in-depth discussion of this topic, see O'Brien and Hoadley, 2008. "Medicare Advantage: Options for Standardizing Benefits and Information to Improve Consumer Choice," Commonwealth Fund, April 2008.

[6] See M. Gold and M. Hudson, *A First Look at How Medicare Advantage Benefits and Premiums in Individual Enrollment Plans Are Changing from 2008 to 2009*, AARP Public Policy Institute, Washington, DC, February 2009. Medicare Options Compare does not include group plans, and CMS has only limited information on those plans. SNPs are included in the database, but many of these plans are designed to integrate with Medicaid and offer specific services for the people they seek to enroll, so interpretation of benefits is difficult.

For the most part, we show enrollment weighted estimates rather than counts of plan characteristics to reflect enrollee preferences in terms of the features of the plans they have chosen to join. To make these estimates, we used CMS's newly available public data on MA plan enrollment by contract, plan, and county to identify enrollees who selected each plan as of July 2008; weighted estimates for 2009 assume no changes in enrollment for plans offered in both years. In some cases, we also report unweighted data if they are relevant to understanding marketplace practices that may pose issues for beneficiaries who select those plans.

The information on Medicare Options Compare comes from data provided as part of plan bids. The file includes a description of plan benefits for specified types of inpatient, outpatient, preventive, and other services, including cost sharing requirements and limits on coverage. The file is a text file that is designed to support beneficiary choice rather than research. The way benefits are described for different plans is not necessarily standardized or consistent; the same information is not always provided for each plan.[7]

Another limitation is that the file available from Medicare Options Compare does not clearly distinguish which features for preferred provider organizations (PPOs) apply to in-network versus out-of-network providers. For some specialized benefits, this could result in inflated estimates of coverage (if an expanded benefit is available only outside of the network) and cost within the network (coinsurance rather than copayment is most common out of network and sometimes is set at 30 percent).

Our comparison of MA with Medicare alone and with Medigap benefits is based on our knowledge of program history and documents that describe the standardized benefits included in these policies and selected secondary analyses of their enrollment.

FINDINGS

Historical Context

Medicare Benefit Structure. Medicare's structure requires beneficiaries to share in the costs of medical care.[8] Part A includes a deductible for inpatient care per spell of illness ($1,068 in 2009); tiered cost sharing for covered hospital days, beginning with day 61; all costs after days covered for the year and a lifetime reserve of 150 days is depleted; and cost sharing for days 21–100 of skilled nursing facility (SNF) stays and all costs for SNF days thereafter. Under Part B, there is an annual deductible ($135 in 2009) and 20 percent

---

[7] We constructed programs to "recognize" specific language (e.g., amounts, type of cost sharing, type of limit) to support the standardized analysis of benefit features. Because of limitations in the original data source, some degree of error is inevitable. We aimed to minimize these errors with selected logical verification and by reviewing common text phrases against what we were showing in analysis.

[8] Information provided in CMS's 2009 MA capitation rate announcement indicates that the monthly Medicare deductible and coinsurance amounts had an actuarial value of $142.40 in 2008 and $135.91 in 2009, equivalent to $1,709 and $1,622 annually in the corresponding years. Available at www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/Announcement2009.pdf, Accessed on February 6, 2009.

coinsurance on most benefits. There is no limit on the amount of cost sharing, a feature that many policy analysts criticize.

Medigap benefit structure. Beneficiaries who enroll in a Medigap plan can protect themselves from virtually all of these costs. Since 1990, the structure of benefits in these plans has been standardized, although some beneficiaries remain in previously purchased plans and a few states have exemptions from federal requirements to handle standards differently. For the most part, standardized Medigap plans—including those in which the vast majority are enrolled—make up all or virtually all of Medicare's cost sharing for Parts A and B (see appendix table A.1).[9] Concerned that such Medigap standards might induce excess use of services and add to the costs of the Medicare program, Congress authorized two new Medigap options (K and L) as part of the Medicare Modernization Act of 2003 (MMA). Effective in 2006, these cover 50 percent (Plan K) and 75 percent (Plan L) of the out-of-pocket costs associated with common Medicare benefits, combined with annual spending limits ($4,620 under Plan K and $2,310 under Plan L in 2009). As of mid-2006, however, few were enrolled in these or other variants on standardized plans that involve high deductibles.[10]

MA as a Medigap alternative. Medigap has been popular, but premiums are typically higher than some beneficiaries can afford. For whatever reason, 11 percent of Medicare beneficiaries had no supplemental coverage in 2006. Meanwhile, MA has become an increasingly popular source of supplemental coverage for those without access to employment-based retirement benefits or Medicaid supplements; MA's enrollment now exceeds that of Medigap.[11]

Because benefits are integrated with Medicare, MA plans can offset the additional costs of expanding benefits or reducing cost sharing with savings derived from their delivery of Medicare Part A and Part B benefits. Such savings may be regarded as both more equitable (if they finance expansions through savings from delivering Medicare benefits more efficiently than traditional Medicare) and less equitable (if expansion is financed by payments that exceed what traditional Medicare would pay).[12]

Given the way MA payments have been structured in recent years, higher payments and the savings they support have been an important source of funds for benefit expansion.[13]

---

[9] According to the most recent data from America's Health Insurance Plans (AHIP), in July 2006, 51 percent of beneficiaries in standardized plans were in Plan F, 14 percent were in Part C, 9.5 percent were in Plan G, and 8.5 percent were in Plan D. ("A Survey of Medigap Enrollment Trends," July 2006. Available at www.ahip.org.) Plans F and G pay all deductibles and coinsurance, and plans G and D cover everything except the Part B premium.

[10] The AHIP study cited above showed that less than 0.05 percent of those with Medigap are in Plan K or Plan L, and 0.6 percent are in Plan F when it is offered with a high deductible.

[11] This is based on analysis of the Medicare Current Beneficiary Survey, which shows 35 percent with employer-sponsored supplemental coverage, 19 percent with MA, 18 percent with Medigap, 16 percent with Medicaid, and 1 percent with other sources of coverage in 2006. (Kaiser Family Foundation, *Medicare: A Primer 2009*, Washington, DC, January 2009.)

[12] This has been an issue under the MMA. See C. Zarabozo and S. Harrison, "Payment Policy and the Growth of Medicare Advantage," *Health Affairs* Web Exclusive, November 24, 2008 www.healthaffairs.org.

[13] While there is nothing in the law that prohibits an MA plan from offering a rich and expanded benefit package and charging beneficiaries a higher premium to support it, MA sponsors have tended to view no or low premium plans as giving them an

The Medicare Payment Advisory Commission (MedPAC) estimates that, in 2009, 60 percent of the overall savings MA plans realized for benefit enhancement was used to reduce Part A/B cost sharing, 21 percent went to added benefits that Medicare does not cover, 10 percent went to enhanced Part D benefits, and the rest to reducing the premiums for Part D or Part B.[14] This Research Report focuses on the first two features of MA—their cost sharing and expanded benefits beyond those in traditional Medicare.

Out-of-Pocket Spending for Medicare Part A/B Cost Sharing

Reflecting its roots in health maintenance organizations (HMOs), MA's benefit structure is less a way to supplement Medicare than a way to replace it with a prepaid comprehensive plan that emphasizes comprehensive coverage and "nominal" fixed-dollar copayments.[15] Historically, an out-of-pocket limit was viewed as irrelevant to such plans; many still exclude such a limit, even though cost sharing has become more extensive as practices have changed in response to cost increases and other factors. Among MA plans, only regional PPOs are required by statute to limit out-of-pocket spending, but the minimum tends to be reasonably high in practice.[16] In recent years, CMS has encouraged plans to adopt such a limit as an alternative to greater regulatory scrutiny of plan bids. For the 2009 plan year, CMS policy gave greater scrutiny to plans without a limit or with one exceeding $3,350; CMS also said that cost sharing beyond Medicare for certain benefits would be considered discriminatory.[17]

Use of out-of-pocket limits. In 2008, 53 percent of MA enrollees were in a plan with an out-of-pocket limit; this figure is likely to rise in 2009, as the number of plans with such a limit is increasing from 66 percent to 71 percent (see figure 1). Some limits, however, are relatively high. Among enrollees in plans with limits, about the same number were in plans with limits of more than $4,000 per year as in those with limits of $2,500 or less.

Such limits are less likely to be found in HMOs, reflecting their historical roots (see appendix table A.2). In 2008, 58 percent of MA enrollees in an HMO were in a plan with no limit. In 2009, the number is likely lower, since the share of HMO plans with a limit is now at 54 percent, up from 43 percent in 2008. PFFS plans, the most rapidly growing type of MA plan, typically have an out-of-pocket limit, although in 2008, 27 percent of

---

advantage in the marketplace and thus often have been reluctant to expand benefits in ways that drive premiums up, or they have done so only as higher premium alternatives to a basic plan.

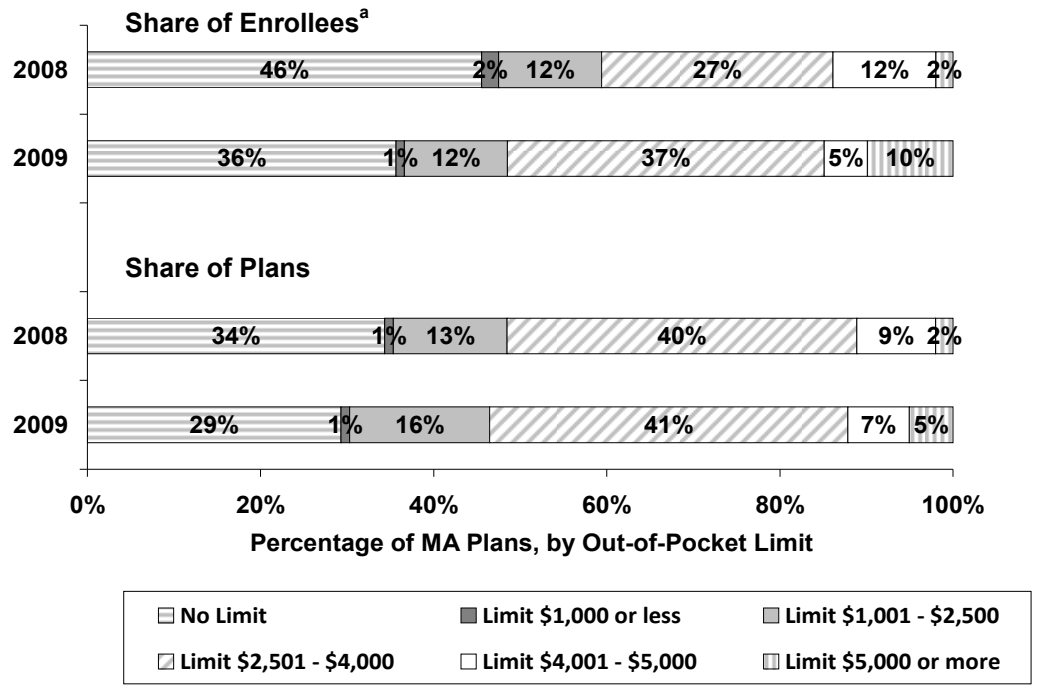
[14] S. Harrison and C. Zarabozo, "The Medicare Advantage Program," December 5, 2008, presentation slides posted on www.medpac.gov.

[15] M. Gold, "Medicare's Private Plans: A Report Card on Medicare Advantage," *Health Affairs* Web Exclusive, November 24, 2008 www.healthaffairs.org.

[16] Regional PPOs were authorized by the MMA and first offered in 2006. In contrast to other MA plans that serve defined aggregations of counties, regional PPOs are required to offer the same benefits at the same premium to a service area that includes one or more of 26 regions defined by CMS and composed of one or more states. Regional PPOs are required to integrate Part A and Part B cost sharing, and to limit total out-of-pocket costs. In 2006, the first year such plans were offered, only 8 percent had a limit of $2,500 or less for in-network benefits (see M. Gold et al., *2006 Medicare Advantage Benefits and Premiums*, AARP #2006-23, Washington, DC, November 2006).

[17] These benefits included renal disease treatment (the same cost sharing required in and out of area), skilled nursing facility benefits, and Part B drugs. (CMS "2009 Call Letter," available at www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/CallLetter.pdf]. Accessed on February 6, 2009.

Figure 1
The Majority of MA Plans Have Out-of-Pocket Limits (Often Relatively High)



[a]Enrollment based on July 2008 figures. 2009 estimates use 2008 enrollment for continuing plans.

Source: MPR analysis of files from CMS Medicare Option Compare. Excludes SNPs and group plans.

PFFS enrollees were in a plan with no limit. A comparison of changes in PFFS plans from 2008 to 2009 suggests that some plans without limits may have added them in 2009 but set them relatively high; more than a third of 2008 PFFS plan enrollees with plans that continued in 2009 had plan limits of more than $5,000 in 2009 (see appendix table A.2). Medicare Options Compare details limits but does nothing special to draw beneficiary attention to the absence of limits in some plans.

Constraints of limits. Out-of-pocket limits in MA do not necessarily mean that beneficiaries pay nothing additional once the limit is reached. The limits apply only to what the insurer determines to be covered by plan benefits. In the traditional Medicare program, decisions on what items and services are covered are continually being made, with some controversy stemming from those decisions and how consistently the policies are applied across CMS regions. Medigap insurers rely on Medicare to make the determinations. In MA, decisions on coverage are shared, in effect, between Medicare and the MA plan. While MA plans are required to cover all Medicare benefits, they have some discretion in determining what "medically necessary services" includes, and they

employ utilization management practices that may affect service access and cost risks.[18] For beneficiaries with very specific needs, these protocols influence which services are subject to the out-of-pocket limit.

The out-of-pocket costs that count against the limit also vary with the MA plan's payment policies. For example, a physician might charge $120 for a visit, but if a plan sets fees based on Medicare's fee schedule, which sets the price it will pay at $100, the beneficiary is liable for 20 percent coinsurance (in this case, $20), and that $20 would count toward the limit. Under traditional Medicare, most beneficiaries are not liable for fees above the established Medicare rate, because a very large percentage of physicians participate in the program and are obligated to accept such fees (and associated coinsurance) as payment in full.[19] The most common Medigap Supplement (Plan F) further protects beneficiaries from such charges (see appendix table A.1). In MA, most beneficiaries are protected similarly but some are not, such as those in some PPOs who seek care out of the network.[20] PFFS plans, at least by statute, have more flexibility to set their payments in ways that can increase out-of-pocket liability for beneficiaries.

Structure of Major Medicare A and B Benefits

Hospital inpatient benefits. Medicare limits hospital days annually (up to a lifetime limit), although most beneficiaries probably would not need more than the amount of care Medicare covers. From the information in Medicare Options Compare, it appears that most, but not all, MA plans have a simplified inpatient benefit structure and eliminate the limits Medicare imposes (see appendix table A.3). In 2008, 17 percent of MA plans had some form of day limit (not shown), although they accounted for only 7 percent of enrollees; a lower percentage of plans have them in 2009. These arrangements are more common in PFFS plans, accounting for about 12 percent of enrollees in 2008.

In 2008, 90 percent of all MA enrollees were in plans that had some cost sharing for hospital services (see appendix table A.3). Deductibles and coinsurance are rarely used, especially outside PPOs, where their use may be restricted to out-of-network services. Instead, fixed-dollar copayments are required, with the amount set on a per-day or per-stay basis, with the former being more common. In 2008, 18 percent of beneficiaries were in a plan in which the copayment for day 1 was more than $200. In most cases, such copayments were required for subsequent days, although 65 percent of the time the amount was different by the time an enrollee had been hospitalized 10 days (data not shown).

---

[18] O'Brien and Hoadley, 2008.

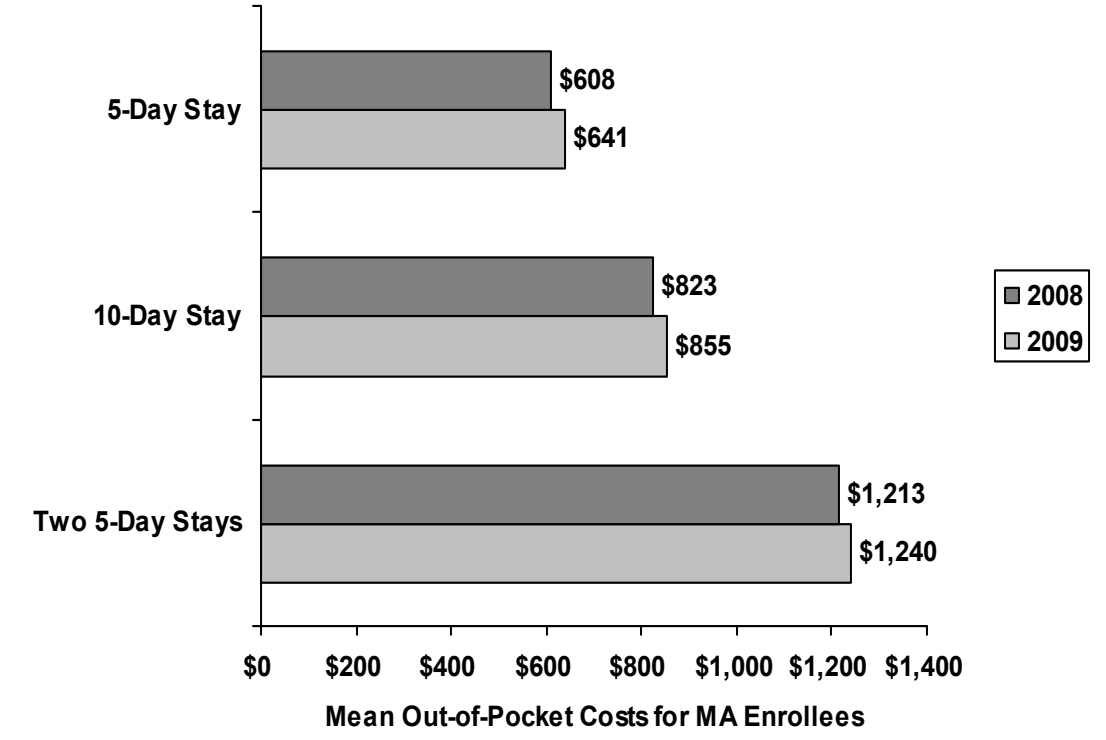
[19] Participation rates may change in the future, because Medicare payment policy limits annual updates to such fees. See MedPAC, *Report to Congress: Medicare Payment Policy*, Washington, DC, March 2008.

[20] The key question is how plans establish the "usual, customary, and reasonable" payment rates they use. In the commercial market, many historically have used the Ingenix vendor software that recently received regulatory scrutiny because it may increase copayments for out-of-network services (see *Health Plan Week*, January 19, 2009).

To better understand the financial exposure beneficiaries face, we calculated the out-of-pocket costs they would experience if they were hospitalized for a 5-day stay, a 10-day stay, or two 5-day stays, applying cost sharing structures and limits derived from the Web site as best we could. In the traditional Medicare program, beneficiaries without supplemental coverage pay a deductible for each admission equal to the first day's cost ($1,068), and that is the full cost to the beneficiary of a 10-day or longer stay (up to 60 days). The cost is double that for two independent stays, even if they total the same 10 days.[21]

With the MA copayment structure, the average out-of-pocket payments for inpatient hospital care for the average MA hospitalization are lower for each type of stay than in traditional Medicare; as in Medicare, costs increase with the number of stays even if the

Figure 2
Mean Hospital Cost Sharing for MA Enrollees Varies with Length and Number of Stays



Source: MPR analysis of files from CMS Medicare Option Compare

days remain the same (figure 2). However, while average costs are lower, the amount of cost sharing required varies substantially across plans, and some enrollees end up paying much more than they would in the traditional program (see appendix table A.3). In 2008,

[21] The deductible technically applies to each "spell of illness." This means that it may not apply to hospitalizations closely related to recent hospitalizations.

for example, 43 percent of MA enrollees with a 10-day stay would have paid less than $500 out of pocket, but 12 percent would have paid $2,000 or more.
Differences exist across plan types as well as within them. Most notably, such costs are substantially higher in regional PPOs. The average regional PPO enrollee would have paid $2,448 out of pocket for a 10-day stay in 2008 (compared with an average of $823 across MA plans and $1,068 in traditional Medicare). Local PPOs also have higher out-of-pocket costs than HMOs or PFFS plans, though differences are less striking. HMOs and PFFS plans had diverging trends between 2008 and 2009, with the average out-of-pocket costs for a 10-day stay declining for the average HMO enrollee (from $803 to $723) but increasing for PFFS enrollees (from $656 to $954). Differences in cost sharing also exist within plan types. For example, 49 percent of HMO enrollees would have paid less than $500 for a 10-day stay in 2008, but 14 percent would have paid $2,000 or more.

Cost sharing for physician visits and related services. In contrast to traditional Medicare, deductibles and coinsurance for physician care are rarely used in MA plans (see table 1); fixed-dollar copayments are commonly used instead. On average, MA plans vary copayments across type of office visit, with lower copayments for primary care and higher copayments much more likely for specialist visits. For example, in 2008, almost a third of MA enrollees were in plans that charged more than $25 for a specialist visit, while only 3 percent were charged that for a primary care visit. Enrollees in PFFS plans were more likely than those in HMOs to have copayments at this level for a specialist (50 percent in PFFS plans versus 29 percent in HMOs; data not presented). Such fixed copayments are more transparent and predictable for enrollees, but for some services they could exceed what a beneficiary would pay with a 20 percent coinsurance limit. MA also may modify cost sharing for related clinical laboratory and X-ray services. In 2008, 43 percent of MA enrollees were in plans with no cost sharing for clinical laboratory services, and 23 percent were in plans with no cost sharing for X-ray services (data not presented). While coinsurance was used by some plans, fixed copayments were more common.[22]

Table 1
MA Typically Uses Fixed-Dollar Copayments for Physician Services, with Higher Rates for Specialty Visits

	Primary Care Visits	Specialist Visits
2008 Enrollees in Plan with:		
No Cost Sharing	19%	7%
Deductible	6%	6%
Coinsurance	8%	1%
20%	8%	1%
Under 20%	0%	0%
Over 20%	0%	0%
Copayment	40%	83%
$10 or less	24	15%

[22] About 18 percent of enrollees were in plans that made some use of coinsurance for clinical laboratory services (sometimes using copayments as well), and 35 percent used coinsurance for X-ray benefits.

$10.01–$15	10	11%
$15.01–$25	2	27%
Over $25	3	31%
Varies with Type of Service	37%	3%

Source: MPR analysis of files from CMS Medicare Options Compare. Enrollment data are from July 2008. Excludes SNPs and group plans.

Structure of SNF benefits. MA plans typically structure skilled nursing facility (SNF) cost sharing differently from traditional Medicare, where cost sharing does not apply until 21 days into a stay (table 2). In 2008, 10 percent of MA enrollees were in plans with no cost sharing for SNF services on any day. All the rest had some form of cost sharing (usually a copayment) from the start of their SNF stay. In some cases (19 percent of enrollees), cost sharing did not apply to later days in the stay. These patterns mean that enrollees will tend to pay more out of pocket in MA than traditional Medicare, particularly for shorter SNF stays. A 20-day stay, for example, would have cost the average MA enrollee $1,390 in 2008, with average costs highest in PFFS plans ($1,807) and lowest in local PPOs ($834) (data not shown).

Table 2
MA Plans Structure SNF Benefits Differently Than Traditional Medicare Does

		MA Enrollees	
	Traditional Medicare	**2008**	**2009**
Prior Hospital Requirement			
Yes	100%	8%	5%
Not noted	0	92	95
Any Cost Sharing Day 1–20			
No	100%	10%	7%
Yes	0	73	74
Coinsurance (%)		7%	7%
Copayment (%)		70%	71%
Any Cost Sharing Days 21+			
No, and not earlier either	100%	10%	7%
No, but earlier	0	19	19
Yes	100	70	75
Mean Cost Sharing			
20-day stay	$0	$1,390	$1,559
10-day stay	$0	$698	$784

Note: Enrollment data are for July 2008. 2009 estimates are based on 2008 enrollees in MA plans that were available both years. Some percentages may add to more than 100, because some plans use more than one technique for cost sharing.

Source: MPR analysis of Medicare Options Compare.

For the most part, MA plans appear to be more flexible than traditional Medicare about requirements that a three-day hospital stay precede any SNF admission. In 2008, only 8 percent of MA enrollees were in a plan that explicitly noted this requirement, which exists in traditional Medicare.

Cost Sharing for Selected Potentially Expensive Services

There has been some concern about the possibility that MA plans may structure their benefit packages to discourage those who are sick from enrolling or may limit the plan's

financial risk if they do enroll. Medicare Options Compare does not allow in-depth assessment of these concerns; for example, it does not show how coverage policy is determined and how easy it is to access the benefits, except to the extent that such practices influence enrollee plan ratings. However, it is possible to examine cost sharing structures for selected benefits. Based on our review of two types of benefits (Part B drugs and durable medical equipment), we find support for concern but less evidence for that concern in 2009 compared with 2008.

Part B drugs. Medicare covers selected drugs under Part B, with a 20 percent coinsurance. These tend to be expensive drugs that are physician-administered on an outpatient basis (e.g., certain chemotherapy drugs); thus, cost sharing results in substantial financial exposure. Table 3 shows that in 2008, 25 percent of MA plans (with 27 percent of MA enrollees) had coinsurance rates for Part B drugs higher than those in the standard Medicare package. Over half of PFFS plan and regional PPO enrollees were in plans with coinsurance rates this high (see appendix table A.4). In 2009, this pattern changed, possibly in response to attention from CMS.[23] With fewer plans using fixed copayments, MA benefits were much more consistent with those of the traditional Medicare program, though coinsurance rates were still higher than if the person had Medigap, which generally covers all or most of these costs. Medicare Options Compare generally lists chemotherapy drugs separately from Part B drugs; however, it shows relatively little difference in cost sharing across the two sets of drugs.

Table 3
High Coinsurance Rates for Part B Drugs Declined from 2008 to 2009

	MA Enrollees[a]			MA Plans	
	2008	2009		2008	2009
Cost Sharing for Part B Drugs					
Coinsurance	78%	71%		86%	75%
20%	42%	64%		50%	68%
Under 20%	9%	7%		10%	7%
Over 20%	27%	0%		25%	0%
Fixed copayment	44%	31%		24%	26%
Cost Sharing for Chemotherapy Drugs					
Coinsurance	78%	80%		86%	86%
20%	41%	70%		57%	76%
Under 20%	10%	10%		12%	10%
Over 20%	26%	0%		17%	0%
Fixed copayment	43%	21%		24%	14%

[a]Enrollment based on July 2008 data. 2009 statistics are for plans continuing in 2009 and assume 2008 enrollment levels.

Source: MPR analysis of files from CMS Medicare Options Compare. Excludes SNPs and group plans.

Durable medical equipment (DME). DME typically is covered in MA with cost sharing similar to or better than that of traditional Medicare, but some plans have higher cost

[23] Less than 0.5 percent of plans (with 775 enrollees) have coinsurance higher than traditional Medicare in 2009. Their rate is 25 percent.

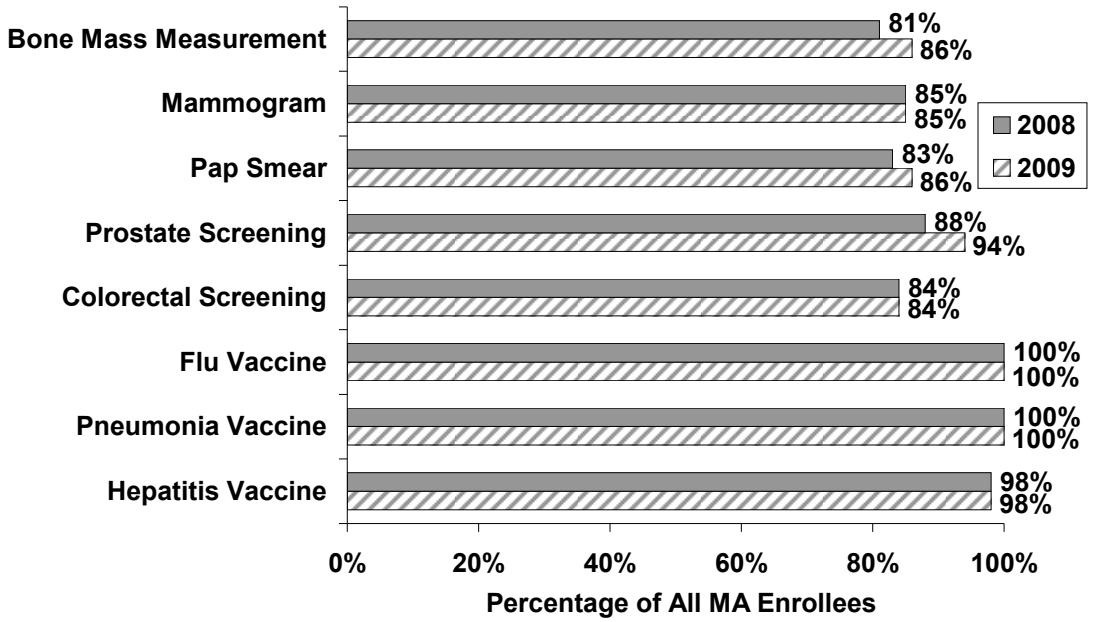
sharing requirements (appendix table A.4). In 2008, 62 percent of enrollees were in plans that used the same coinsurance as Medicare, 20 percent had a lower coinsurance, 10 percent had a higher rate, and 9 percent had a fixed copayment. Enrollees in PFFS plans and regional PPOs were most likely to be in plans with coinsurance above 20 percent (16 percent and 22 percent, respectively). In 2009, coinsurance rates above 20 percent were less likely (only 6 percent of all plans and 4 percent of enrollees). Such features are still more likely in PFFS plans (9 percent of enrollees in plans continuing from 2008 to 2009).

Coverage of Preventive Services

Historically, Medicare's benefits have not covered most preventive services, an area many MA plans have emphasized. In recent years, Medicare coverage of preventive services has improved, making it more complicated to analyze distinctions in coverage between Medicare and MA. From our analysis of Medicare Options Compare, it appears that MA plans still cover some preventive benefits that Medicare does not; their benefits for these Medicare preventive services may be structured with lesser amounts of cost sharing.

Screening tests and specific preventive services. Figure 3 shows the percentage of enrollees in MA plans in 2008 and 2009 that cover selected preventive services with no required cost sharing. All these services are covered by Medicare, but most require 20 percent coinsurance; exceptions apply to certain vaccines or laboratory tests. For example, the colorectal benefit for Medicare includes specified tests at given intervals, with coinsurance for all except fecal blood tests. From Medicare Options Compare data,

Figure 3
Most MA Plans Cover Selected Preventive Services with No Cost Sharing, A Feature Unchanged from 2008 to 2009



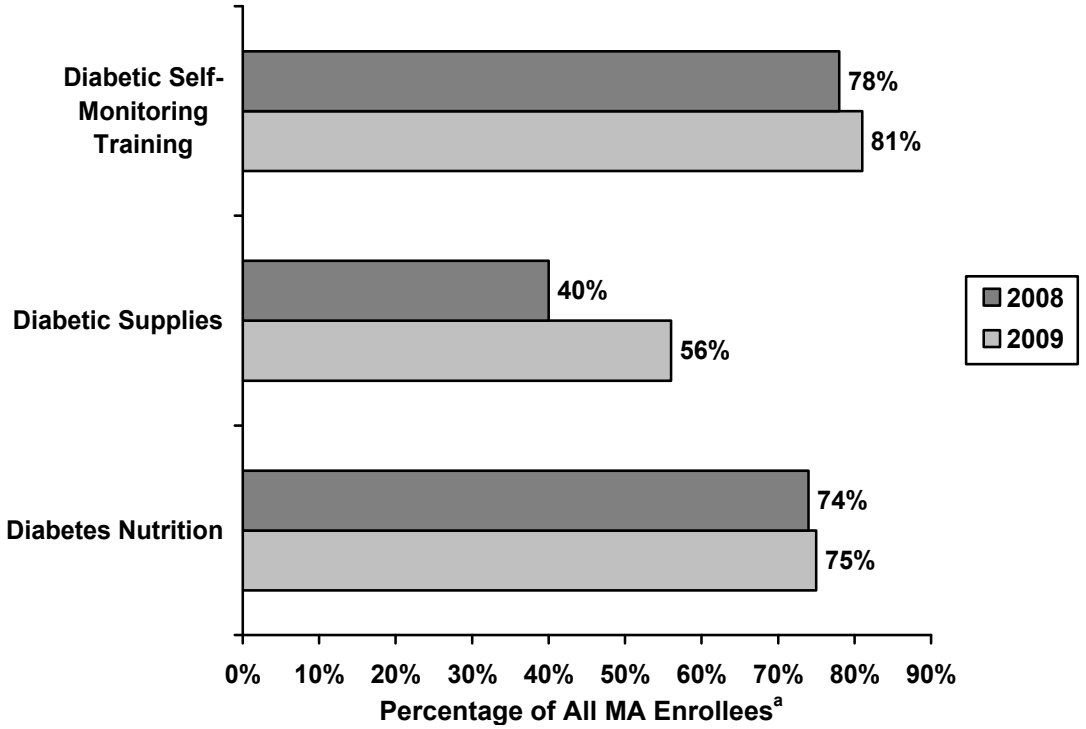
Note: Enrollment based on July 2008 data. 2009 estimates are 2008 data for continuing plans.
Source: MPR analysis of files from CMS Medicare Options Compare. Excludes SNPs and group plans.

it appears that 84 percent of MA enrollees are in a plan that covers this benefit at no cost sharing. This percentage is similar for other preventive services. Compared with other plan types, regional PPOs are less likely to cover such services with no cost sharing, although almost two thirds do (see appendix table A.5).

Routine physical exams. Medicare covers a single Welcome to Medicare physical exam with 20 percent coinsurance; otherwise, it does not cover routine physical exams. MA plans all cover this benefit, as well as the Welcome to Medicare physical. As in traditional Medicare, however, most plans expect enrollees to share in these costs. In 2008, only 17 percent of MA enrollees were in a plan that had no cost sharing for the initial physical, although 39 percent stipulated no cost sharing for routine physicals generally. In 2009, more plans have no cost sharing for routine physicals (74 percent), and a higher share of 2008 enrollees whose plans continued in 2009 were enrolled in them (70 percent). Almost all regional PPO enrollees are in plans that require cost sharing (see appendix table A.5).

Selected diabetes benefits. Certain diabetes benefits may serve a secondary prevention role by helping beneficiaries control their condition, thereby limiting advancing disease and complications. For example, Medicare pays for nutritional therapy (assessment and counseling for those with diabetes or renal disease) and self-management training (10 hours initially and 2 hours of followup per year). While Medicare benefits involve 20 percent coinsurance, about three-quarters of MA enrollees are in plans with no cost

Figure 4
Enrollees in MA Plans Often Are Not Required to Share in the Costs of Preventive Diabetes Services



Note: Enrollment based on July 2008 data. 2009 estimates are based on 2008 data for continuing plans.

Source: MPR analysis of files from CMS Medicare Options Compare. Excludes SNPs and group plans.

sharing for such services (figure 4). Fewer eliminate cost sharing for diabetic supplies (e.g., test strips, monitors), although the proportion is increasing. A smaller percentage of enrollees in PFFS plans and regional PPOs receive diabetic supplies with no cost sharing (see appendix table A.5).

Health education/wellness. Medicare generally does not cover health education and wellness services, with a few exceptions (e.g., eight counseling sessions per year to stop smoking for those diagnosed with certain illnesses). MA plans typically provide more extensive coverage of these services, with 92 percent of enrollees in MA plans that covered them in 2008 (table 4). Services typically are provided without authorization or required copayment. Examples include smoking cessation counseling sessions and gym/health club memberships/fitness classes, both of which appear to be more common in 2009 than in 2008. Forty-one percent of MA enrollees are in plans that have newsletters and other written health education or wellness materials. We cannot determine from these data the scope of the specific services or whether there are charges for services like gym memberships.

Table 4
Most MA Enrollees Are in Plans with Some Health/Wellness Coverage

Percentage of Enrollees[a]	2008	2009
Plan Has Some Coverage	95%	100%
Requires authorization	12%	13%
Requires copay	14%	51%
Plan Provides		
Alternative medicine information	2%	2%
Smoking cessation support	47%	67%
Gym/health club/fitness classes	60%	66%
Newsletter/written material	41%	32%

[a]Enrollment based on July 2008 data. 2009 estimates are based on 2008 enrollment for continuing plans.
Source: MPR analysis of files from CMS Medicare Options Compare. Excludes SNPs and group plans.

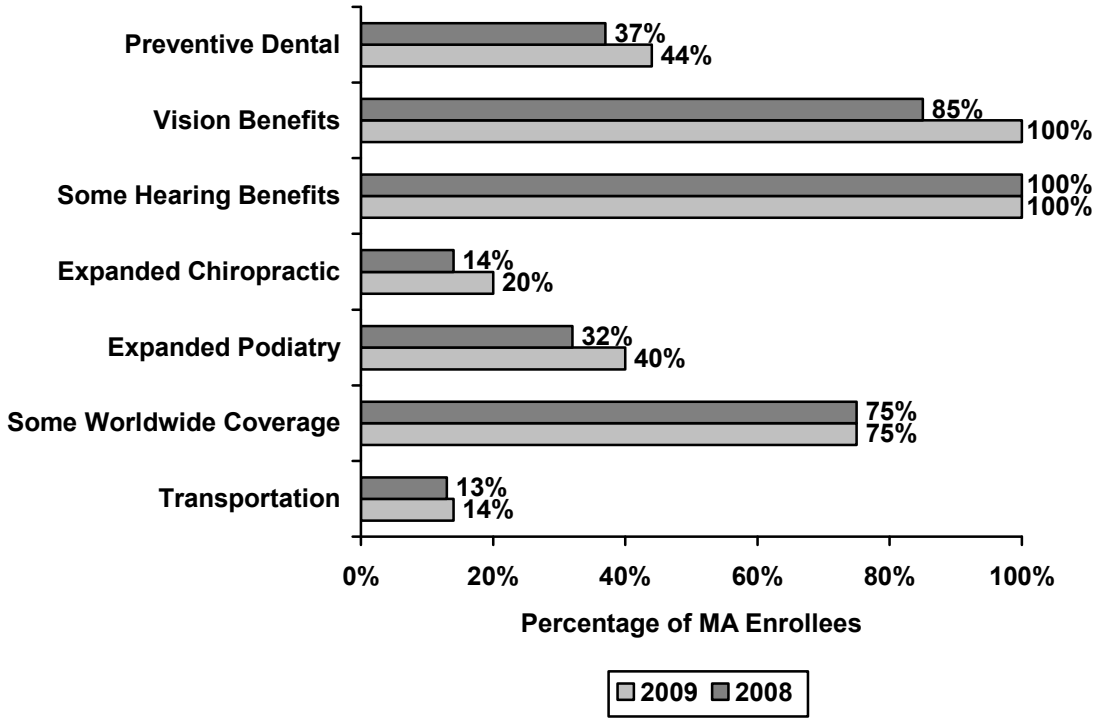
Supplemental Benefits Offered

Although their form varies, most MA plans cover selected services not covered by Medicare (figure 5). These include, for example, preventive dental services (X-rays and cleanings), selected vision benefits (eye exams and glasses), hearing benefits (hearing tests and hearing aids), and more expansive coverage for chiropractic and podiatry services. The form of such coverage varies and often is subject to a limit.[24]

Preventive Dental Services. Medicare generally does not cover dental services. In 2008, 37 percent of MA enrollees were in plans with some form of preventive dental benefit, a figure likely to be higher in 2009, since the percentage of plans with such coverage increased from 36 percent to 57 percent (unweighted for enrollment; data not presented).

[24] Previous analysis appears to overstate supplemental coverage. This is because some statements for these types of services on Medicare Options Compare state that Medicare benefits are covered, although not necessarily with the same cost sharing requirements. Our analysis aims to distinguish between the cost sharing that applies to traditional Medicare benefits and to the supplemental benefits that MA plans may provide.

Figure 5
Enrollees in MA Often Have Some Benefits Medicare Does Not Cover



Note: Enrollment based on July 2008 data. 2009 statistics are based on 2008 enrollment for continuing plans.
Source: MPR analysis of files from CMS Medicare Options Compare. Excludes SNPs and group plans.

Just under half of enrollees were in plans that offered a package including at least one exam and cleaning every six months and at least one X-ray every year; the rest had benefits with different combinations of all or some of these services (see appendix table A.6). Almost all had a visit limit; some plans further limited the benefit in dollar terms.[25] In both 2008 and 2009, no MA plans provided coverage for restorative dental services (e.g., fillings, crowns, bridges). A higher share of PPO enrollees were in plans with a preventive dental benefit, compared with PFFS plan enrollees (see appendix table A.8).

Vision benefits. Medicare does not cover routine eye exams and tests or eyeglasses, but this benefit is very common in MA. In 2008, 85 percent of MA enrollees were in a plan with some form of vision benefit. Almost all were covered for an annual vision examination, and about 84 percent had some coverage for eyeglasses or (most of the time) contact lenses. Such benefits typically were limited by time (e.g., a single pair per year) and a dollar value (the mean limit was $76, and most plans had a limit). PFFS plans were as likely to cover the exam as other plan types, but only about 68 percent of PFFS enrollees in 2008 were in plans that had any coverage for eyeglasses (see appendix table A.7).

[25] Among MA enrollees with such a benefit in 2008, 26 percent were in plans that had a dollar limit; the mean limit was $486 a year.

Hearing benefits. Although Medicare provides some coverage for hearing and balance exams if they are medically indicated, the program generally does not cover hearing exams for most beneficiaries, and hearing aids are not covered. From Medicare Options Compare information, it appears that all MA plans have some hearing benefits, but not all go beyond Medicare coverage (see appendix table A.8). About 70 percent of enrollees in 2008 were in plans that offered a hearing test benefit; 20 percent were in a plan with a noted hearing aid fitting benefit; and 36 percent were in a plan that covered hearing aids. The hearing aid benefit was always limited to a specific dollar amount (on average, $325 in 2008 and $329 in 2009). The percentage of plans covering such benefits appears similar in 2008 to 2009 (data not presented).

Expanded chiropractic benefits. Medicare limits chiropractic benefits to instances of subluxation (when one or more bones of the spine are out of alignment); the standard 20 percent Part B coinsurance applies. In MA, all but 3 percent of plans use fixed copayments rather than coinsurance (data not shown).[26] In 2008, only 14 percent of MA enrollees were in plans that appear to provide expanded chiropractic benefits, with some limiting the number of such visits (the average limit was 10). Although 6 percent of HMO enrollees were in plans with such coverage, the practice appears most common in PPOs; whether it is an in-network benefit or not is unclear (see appendix table A.9).

Expanded podiatry benefits. Medicare does not cover routine foot care, although it may provide coverage in special circumstances (e.g., diabetes-related nerve damage). As with chiropractic care, virtually all MA plans use fixed-dollar copayments rather than coinsurance for such services, with a mean copayment of $20. In 2008, about a third of all MA enrollees (32 percent) were in plans that appeared to offer an expanded podiatry benefit. Two-thirds were in plans that limited the number of visits annually (the mean was four visits among those with a limit). Fixed-dollar copayments were common. Coinsurance is most likely to be used in PPOs (see appendix table A.10).

Worldwide emergency benefits. With very limited exceptions relating to Canada, Medicare does not cover services provided outside the United States, even for emergency care. Beneficiaries who want such coverage can get it as part of the most common Medigap packages (see appendix table A.1), or they can arrange for it separately as part of travel insurance for specific trips. Little analysis exists on how MA plans handle this benefit, but it appears from Medicare Options Compare that some type of such coverage may be included in common MA plans. In 2008, 75 percent of MA enrollees were in plans that had some statement about worldwide benefits in Medicare Options Compare.[27] Twenty percent of enrollees were in plans that had some limit on coverage, most commonly from $10,000 to $24,999.

Transportation. Medicare does not cover transportation except for emergency ambulance services. Beneficiaries who need such services to access health care or return from receiving it must pay for it themselves, since standardized Medigap supplements also do not cover transportation. The same is true for most MA plans offered to the

---

[26] The mean copayment was $23, with 6 percent having no copayment.

[27] An additional 5 percent were in plans with language noting this issue but appearing to exclude such coverage.

general population of beneficiaries.[28] In 2008, 13 percent of MA enrollees were in plans that appeared to provide some additional coverage for this benefit. Such coverage typically is restricted to approved locations. Separate dollar limits or limits on trips do not appear to be used by these plans, nor is cost sharing, so the benefit may be limited to specified circumstances. Very few PFFS plans cover transportation (less than 1 percent in 2008 and 2009). It is most common in HMOs and local PPOs; in 2008, HMOs were much more likely to cover transportation than any other plan type (23 percent of HMOs in 2009; unweighted).

CONCLUSIONS

Beneficiaries who select MA plans probably do so for a variety of reasons. Some may be attracted to particular models of delivery or care management, or may want to continue with the same private plan they had while they were working. Often, however, the choice boils down to benefits and costs, with the perception that MA provides enhanced benefits (or reduced cost sharing) compared with traditional Medicare, with lower premiums than standardized Medigap plans typically require. Price sensitivity is reflected in the large share of MA enrollment in the so-called "zero premium plans," which also offer enhanced Part D benefits.[29]

Much of the new growth has been in PFFS plans; the absence of a network increases the potential appeal of a plan with better benefits and access equal to that of Medicare, at no additional cost.[30] However, this analysis shows that the extent and nature of expanded benefits (and reduced cost sharing) vary substantially by plan within and across contract types. On many measures, newer MA options (e.g., PFFS plans, regional PPOs) offer less than traditional HMOs, though HMOs also vary and have limitations (e.g., frequent absence of out-of-pocket limits).

The findings here show important ways in which MA plans modify Medicare benefits. They also show, however, an MA structure that differs substantially from that of standardized Medigap supplements. In Medigap, the emphasis is almost entirely on filling in Medicare cost sharing so that a beneficiary's financial exposure is eliminated ("insurance risk"). In contrast, MA plans reconfigure but do not eliminate Medicare's cost sharing, while some of them provide expanded benefits ("prepayment") for some part of common predictable expenses (e.g., preventive dental services, eyeglasses). The MA structure potentially reduces, but does not eliminate, the financial risk beneficiaries encounter compared with Medicare on its own.

The question is whether beneficiaries understand the differences in these approaches and the trade-offs associated with them. Currently, it appears easy for a beneficiary to get lost

---

[28] Special needs plans, which are excluded from this analysis, appear more likely to cover such services. See J. Verdier et al. *Do We Know If Medicare Advantage Special Needs Plans Are Special?,* Kaiser Family Foundation, Washington, DC, January 2008.

[29] M. Gold and M. Hudson, *A First Look at How Medicare Advantage Benefits and Premiums in Individual Enrollment Plans Are Changing from 2008 to 2009*, AARP Public Policy Institute, Washington, DC, February 2009.

[30] M. Gold, "Medicare's Private Plans: A Report Card on Medicare Advantage," *Health Affairs* Web Exclusive, November 24, 2008, www.healthaffairs.org.

in the details, which differ across plans and benefits. This may limit consumers' ability to focus on the major choices they need to make. We believe, as O'Brien and Hoadley (2008, see note 1) concluded, that there are some incremental ways of changing MA benefit requirements and the way they are communicated that could strengthen MA as a product and make it much easier for beneficiaries to compare plans (see box).

Financial exposure. By shifting to fixed-dollar cost sharing, MA plans appear to make a beneficiary's out-of-pocket liability more transparent; however, their design could still leave a beneficiary with considerable financial risk. With the use of out-of-pocket limits growing in MA, it is worth considering whether limits should be a standard feature of all MA plans. Limits, regardless of their size, provide some upper boundary on financial exposure. With limits, beneficiaries also may find it easier to compare plans that have different details regarding individual benefits. Requiring plans to incorporate one of a specified set of standardized out-of-pocket limits would allow the plans to respond to what they view as the market while making it easier for beneficiaries to compare plans. Such a structure also should make it easier for CMS to communicate the financial risks associated with different forms of coverage.

INCREMENTAL CHANGES THAT COULD STRENGTHEN MA BENEFIT DESIGN

Clearer financial risk protection as an alternative to Medigap

- ***Out-of-pocket limit.*** Strengthen financial risk protection by requiring MA plans to have a combined out-of-pocket limit on enrollee cost sharing for Part A/B benefits.
- ***Standardized limit structures.*** Require limits to mirror two to three standardized choices to simplify choice for beneficiaries.
- ***More comparative analysis of trade-offs.*** Beneficiaries who are deciding whether to elect Medicare alone, Medicare with a Medigap Plan, or an MA plan for their Part A/B benefits would benefit from more analysis that clearly lays out the financial risks associated with Part A/B cost sharing and unpredictable health care risks, and the trade-offs inherent in insurance costs that pay for such protections.

Simplified treatment of certain options for Medicare benefit design

- ***Mandated changes in Medicare A/B benefit design.*** Require all plans to incorporate certain revisions of Medicare A/B benefits that most plans already have adopted: no limit on inpatient days, elimination of Medicare deductibles, and copayments rather than coinsurance (in-network), other than the standard 20 percent.
- ***Standardized options for expanded coverage.*** Establish standardized designs for commonly offered optional benefits: preventive dental, vision, hearing, and an enhanced preventive services package.
- ***More prominent flags to identify benefit expansions.*** Medicare Options Compare should more clearly indicate when a benefit is identical to the Medicare benefit, when it is actuarially equivalent, when it is enhanced, and when it is new.

Incremental benefit simplification. The benefits in different MA plans differ substantially, sometimes in very subtle ways. Given the current range of practices, it is probably not realistic to gain consensus on a limited number of standardized benefit configurations, equivalent to what currently exists in Medigap. However, some practices appear relatively consistent across plans. It should be possible to take advantage of such consistency to mandate certain standards for benefit design.

For example, with respect to Medicare Parts A and B, most plans already eliminate Medicare's complex day limit; establishing this as a standard would mean that any beneficiary considering enrollment in a plan could rely on this feature. Similarly, since so few plans use deductibles or coinsurance as opposed to copayments (at least for in-network services), MA plans could be restricted from using coinsurance that differs from Medicare's structure, with copayments as the alternative. While such a change would not necessarily reduce out-of-pocket liability for the beneficiary, it would make it easier for potential enrollees to compare plans.

Standardization of supplemental benefits also seems possible, at least individually. For the most part, such benefits are already similar in form across plans. Standards for various supplements (e.g., vision care, preventive dental, a general preventive package) would make it easier for beneficiaries to understand the additional coverage and how the plans compare. Combined with standardized out-of-pocket limits, such standardization might also help beneficiaries understand the trade-offs between financial risk (insurance) and first-dollar coverage (prepayment)

In sum, MA benefit structures have evolved with relatively little guidance. With enrollment in such plans now a substantial share of the Medicare market, it makes sense to think about how the MA benefit form could be standardized and simplified to enhance the beneficiary decision process. This analysis will allow policymakers to identify and consider some relatively incremental changes that build on current marketplace practices and appear to have value for reducing the financial risk faced by beneficiaries, while also making it easier for them to compare plans and decide among the available options.

APPENDIX TABLES

Table A.1
Medigap Standardized Benefits, 2009

	Medigap Plans A through L											
Medigap Benefits	**A**	**B**	**C**	**D**		**E**	**F**	**G**	**H**	**I**	**J**	**K**	**L**
Medicare Part A coinsurance and all costs after hospital benefits are exhausted	√	√	√	√	√	√	√	√	√	√	√	√	√
Medicare Part B coinsurance or copayment for other than preventive services	√	√	√	√	√	√	√	√	√	√	√	50%	75%
Blood (first three pints)	√	√	√	√	√	√	√	√	√	√	√	50%	75%
Hospice care coinsurance or copayment												50%	75%
Skilled nursing facility care coinsurance			√	√	√	√	√	√	√	√	√	50%	75%
Medicare Part A deductible		√	√	√	√	√	√	√	√	√	√	50%	75%
Medicare Part B deductible			√			√					√		
Medicare Part B excess charge						√	80%		√	√			
Foreign travel emergency (up to plan limits)[b]			√	√	√	√	√	√	√	√	√		
At-home recovery (up to plan limits)				√			√		√	√			
Medicare preventive care Part B coinsurance	√	√	√	√	√	√	√	√	√	√	√	√	√
Preventive care not covered by Medicare (up to $120)					√						√		
								2009 out-of-pocket limit			►	$4,620	$2,310

[a]Medigap Plans F and J also offer a high-deductible option. Under this option, enrollees pay for Medicare-covered costs up to the high-deductible amount ($2,000 in 2009) before their Medigap policy pays anything.

[b]Enrollees also must pay a separate deductible for foreign travel emergency ($250 per year).

[c]After meeting out-of-pocket yearly limit and yearly Part B deductibles ($135 in 2009), the plan pays 100 percent of covered services for the rest of the calendar year.

Source: CMS, *Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare, 2009*, Centers for Medicare and Medicaid Services/National Association of Insurance Commissioners, 2009, p. 11.

Table A.2

Profile of Out-of-Pocket Limit Structure in all MA Plans, by Type, 2008 and 2009

(Excludes SNPs and group plans)

	All			HMO			LPPO[a]			PFFS			RPPO[a]	
	2008	2009		2008	2009		2008	2009		2008	2009		2008	2009
Distribution of Enrollees[b]														
$1,000 or less	2%	1%		2%	1%		2%	0%		3%	0%		0%	0%
$1,000–$2,500	12	12		9	8		40	39		12	14		0	1
$2,501–$4,000	27	36		27	37		30	27		24	36		28	40
$4,001–$5,000	12	5		2	2		14	14		34	10		36	12
$5,001 or more	2	10		1	0		4	3		0	36		35	47
None	47	37		58	51		11	17		27	2		0	0
Enrollees (millions)	(6.4)	(6.2)		(4.2)	(4.3)		(0.5)	0.5)		(1.5)	(1.3)		(0.2)	(0.2)
Distribution of Plans														
$1,000 or less	1%	1%		1%	2%		2%	2%		2%	1%		0%	0%
$1,000–$2,500	14	16		13	12		16	28		13	18		0	4
$2,501–$4,000	40	41		24	37		42	37		59	51		5	14
$4,001–$5,000	9	7		3	3		20	11		11	11		59	33
$5,001 or more	2	5		1	0		6	4		0	12		28	49
None	34	29		57	46		15	19		15	8		0	0
Plans	(3,307)	(3,354)		(1,517)	(1,730)		(462)	(548)		(1,271)	(1,016)		(43)	(51)

[a]In-network benefits if there is a difference.

[b]Weighted numbers for both 2008 and 2009 use enrollment from July 2008 at the contract-plans-county level. These numbers in 2009 do not reflect enrollment changes.

NOTE: HMO = health maintenance organization plan; LPPO = local preferred provider organization plan; PFFS = private fee-for-service plan; and RPPO = regional preferred provider organization plan. SNPs are special needs plans targeting subgroups of the Medicare population.

Source: MPR analysis of files from CMS Medicare Options Compare.

Table A.3
Selected Characteristics of Hospital Inpatient Benefits in MA Plans, 2008 and 2009
(Weighted for enrollment, excludes SNPs and group plans)

	All		HMO		LPPO		PFFS		RPPO	
	2008	2009	2008	2009	2008	2009	2008	2009	2008	2009
Day Limit	**7%**	**5%**	**5%**	**3%**	**1%**	**1%**	**12%**	**13%**	**6%**	**0%**
Cost Sharing										
None	10%	9%	10%	12%	3%	3%	10%	1%	0%	0%
Deductible	2%	1%	2%	1%	0%	0%	4%	2%	0%	0%
Coinsurance	2%	4%	0%	1%	38%	44%	0%	0%	31%	43%
Copay Day 1	51%	56%	58%	61%	53%	58%	35%	38%	32%	43%
None	2	2	3	2	0	0	0	5	0	0
$100 or less	30	29	31	31	50	50	21	12	0	0
$101–$200	49	46	46	47	44	43	68	46	35	26
$201 or more	18	23	20	20	6	6	11	36	65	64
Copay Per Stay	36%	33%	30%	24%	36%	36%	51%	60%	50%	43%
$150 or less	7	7	8	8	6	9	4	2	10	0
Over $150	29	26	22	16	30	27	47	58	40	43
Mean Cost Sharing for Selected Hospital Stays										
One 5-day stay	$608	$641	$787	$512	$787	$907	$576	$841	$1,504	$1,702
One 10-day stay	$823	$855	$803	$723	$989	$1,133	$656	$954	$2,448	$2,868
Two 5-day stays	$1,213	$1,240	$1,128	$1,026	$1,433	$1,421	$1,152	$1,681	$2,952	$2,629
Distribution of Cost Sharing for a 10-Day Stay										
Less than $500	43%	41%	49%	49%	42%	37%	31%	23%	16%	3%
$500–$999	32	32	25	26	16	23	56	51	45	58
$1,000–$1,999	18	24	17	24	35	32	16	23	5	3
$2,000 or more	12	8	14	7	8	11	3	6	34	39
Enrollment (millions)	(6.5)	(6.2)	(4.2)	(4.3)	(0.5)	(0.5)	(1.5)	(1.3)	(0.2)	(0.2)

[a]In-network benefits if there is a difference.

[b]Weighted numbers for both 2008 and 2009 use enrollment from July 2008 at the contract-plan-county level. These numbers in 2009 do not reflect enrollment changes.

NOTE: HMO = health maintenance organization plan; LPPO = local preferred provider organization plan; PFFS = private fee-for-service plan; and RPPO = regional preferred provider organization plan. SNPs are special needs plans targeting subgroups of the Medicare population.

Source: MPR analysis of files from CMS Medicare Options Compare.

Table A.4
Cost Sharing of Part B Drugs And Durable Medical Equipment Benefits in All MA Plans, by Type, 2008
(Weighted for enrollment, excludes SNPs and group plans)

	All	HMO	Local PPO	PFFS	Regional PPO
Part B Drugs General					
Any Deductible (%)	0%	0%	0%	0%	0%
Any Coinsurance	78%	70%	69%	99%	93%
Standard Medicare (20%)	42	45	16	48	12
Less than 20%	9	8	32	0	29
More than 20%	27	17	20	50	52
Fixed Copay	44%	43%	47%	47%	37%
Zero	2	0	1	0	0
Other	42	41	46	47	37
Mean Copay	$10	$11	$16	$5	$7
Both Copay and Coinsurance	2%	2%	1%	0%	0%
Part B Chemotherapy Drugs					
Any Coinsurance	78%	70%	68%	98%	93%
Standard Medicare (20%)	41	43	15	50	12
Less than 20%	10	10	33	0	29
More than 20%	26	17	20	48	52
Fixed Copay	43%	42%	47%	47%	37%
Zero	0	0	0	0	0
Other	39	36	42	47	37
Mean Copay	$10	$11	$18	$5	$0
Both Copay and Coinsurance	6%	7%	24%	0%	0%
Durable Medical Equipment					
Any Coinsurance	92%	90%	87%	96%	100%
Standard Medicare (20%)	62%	61%	40%	755	49%
Less than 20%	20%	22%	39%	6%	29%
More than 20%	10%	8%	7%	16%	22%
Fixed Copay	9%	10%	13%	4%	0%
Zero	7	9	7	4	0
Other	2	2	5	0	0

NOTE: HMO = health maintenance organization plan; LPPO = local preferred provider organization plan; PFFS = private fee-for-service plan; and RPPO = regional preferred provider organization plan. SNPs are special needs plans targeting subgroups of the Medicare population.

Source: MPR analysis of files from CMS Medicare Options Compare. Enrollment based on July 2008 CMS data.

Table A.5

Selected Characteristics of Preventive Benefits in All MA Plans, by Type, 2008

(Weighted for enrollment, excludes SNPs and group plans)

Percent of Enrollees with Zero Copay on Medicare Benefits for	All	HMO	Local PPO	PFFS	Regional PPO
Bone mass measurement	81	78	64	100	57
Mammogram	85	83	66	100	64
Pap smear	83	81	57	100	64
Prostate screening	88	86	88	100	64
Colorectal screening	84	78	88	100	63
Welcome to Medicare physical	17	77	8	21	2
Diabetes					
Self-monitoring	78	74	72	98	46
Supplies	40	52	42	12	1
Nutrition therapy	74	67	68	98	45
Vaccines					
Pneumonia	100	100	100	100	100
Flu	100	100	100	100	100
Hepatitis	97	97	95	100	100
Expanded Physical Benefits (Any)	100	100	100	100	100
With no cost sharing	39	42	39	37	1
Enrollment (millions)	(6.4)	(4.2)	(10.5)	(1.5)	(0.2)

NOTE: HMO = health maintenance organization plan; LPPO = local preferred provider organization plan; PFFS = private fee-for-service plan; and RPPO = regional preferred provider organization plan. SNPs are special needs plans targeting subgroups of the Medicare population.

Source: MPR analysis of CMS Medicare Options Compare. Enrollment based on July 2008 data.

Table A.6

Selected Characteristics of Dental Benefits in All MA Plans, 2008

(Weighted for enrollment, excludes SNPs and group plans)

	All	HMO	Local PPO	PFFS	Regional PPO
Medicare Benefits					
Percentage with Any Cost Sharing for	65%	65%	70%	62%	75%
Coinsurance	4%	3%	1%	7%	0%
Standard Medicare (20%)	3	0	0	7	0
Less than 20%	1	2	0	0	0
More than 20%	0	0	0	0	0
Fixed Copay	96%	97%	100%	93%	100%
Zero	34	33	30	38	25
Other	63	64	69	55	75
Mean Copay	$15	$15	$12	$7	$19
Expanded Dental Benefits					
Percentage with Any	37%	38%	66%	22%	55%
Preventive Benefits					
Basic package, six-month cleaning and exam, annual X-ray	49%	40%	76%	66%	48%
Other design	51	60	24	34	52
Subject to Dollar Amount	26%	18%	46%	52%	0%
Mean	$486	$500	$399	$544	--
Limit on Visits	92%	96%	87%	72%	100%
Mean visits	1.6	1.6	2	2	1.6
Any Restorative Benefit	0%	0%	0%	0%	0%
Enrollment (millions)	(6.5)	(4.2)	(0.5)	(1.5)	(0.2)

NOTE: HMO = health maintenance organization plan; LPPO = local preferred provider organization plan; PFFS = private fee-for-service plan; and RPPO = regional preferred provider organization plan. SNPs are special needs plans targeting subgroups of the Medicare population.

Source: MPR analysis of CMS Medicare Options Compare; enrollment data from July 2008.

Table A.7

Selected Characteristics of Vision Benefits in All MA Plans, by Type, 2008

(Weighted for enrollment, excludes SNPs and group plans)

	All	HMO	Local PPO	PFFS	Regional PPO
Percentage with Medicare Benefit Cost Sharing	91%	91%	90%	92%	100%
Coinsurance	2%	0%	0%	6%	0%
Standard Medicare (20%)	2	0	0	6	0
Less than 20%	0	0	0	0	0
More than 20%	0	1	0	0	0
Fixed Copay	98%	100%	100%	94%	100%
Zero	9	9	10	9	0
Other	90	90	90	86	100
Mean Copay	$19	$18	$16	$22	$24
Expanded Vision Benefits	85%	95%	100%	51%	100%
Percentage with Vision Exam	99%	99%	98%	100%	100%
Dollar limit	10%	9%	4%	14%	6%
Mean limit	$124	$134	$55	$110	$50
Visit limit	91%	89%	92%	100%	96%
Mean limit	0.8	0.8	0.8	0.8	1.2
Percentage with Eyeglasses Covered[a]	84%	86%	94%	68%	100%
Dollar limit	87%	87%	82%	100%	61%
Mean limit	$76	$70	$82	$105	$96
Limit on number of pair	77%	86%	45%	64%	18%
Mean number	0.8	0.8	0.8	0.8	0.4
Enrollment (millions)	(6.5)	(4.2)	(0.5)	(1.5)	(0.2)

[a]This benefit usually also covers contact lenses with a combination limit.

NOTE: HMO = health maintenance organization plan; LPPO = local preferred provider organization plan; PFFS = private fee-for-service plan; and RPPO = regional preferred provider organization plan. SNPs are special needs plans targeting subgroups of the Medicare population.

Source: MPR analysis of CMS Medicare Options Compare. 2008 enrollment data are from July.

Table A.8

Selected Characteristics of Hearing Benefits in All MA Plans, by Type, 2008

(Weighted for enrollment, excludes SNPs and group plans)

	All	HMO	Local PPO	PFFS	Regional PPO
Hearing Benefit	100%	100%	100%	100%	100%
Percentage with Hearing Exam Benefits	100%	100%	100%	100%	100%
Coinsurance	6%	0%	49%	6%	31%
Standard Medicare	4	0	22	6	11
Less than 20%	1	0	1	0	18
More than 20%	2	0	26	0	1
Fixed Copay	98%	100%	100%	94%	100%
Zero	11	13	11	8	0
Other	88	87	89	86	100
Mean Copay	$20	$19	$22	$22	$28
Percentage with Hearing Aid Benefit	36%	43%	34%	18%	38%
Dollar limit	100%	100%	100%	100%	100%
Mean limit	$325	$349	$248	$207	$363
Percentage with Hearing Test Benefit	**70%**	**66%**	**48%**	**92%**	**60%**
Percentage with Fixed Copay	100%	100%	100%	100%	100%
Zero	20	27	15	8	1
Other	80	73	84	92	99
Mean	$17	$15	$16	$22	$18
Percentage with Hearing Aid Fitting Benefit	20%	27%	5%	8%	0%
Enrollment (millions)	(6.5)	(4.2)	(0.5)	(1.5)	(0.2)

[a]This benefit usually also covers contact lenses with a combination limit.

NOTE: HMO = health maintenance organization plan; LPPO = local preferred provider organization plan; PFFS = private fee-for-service plan; and RPPO = regional preferred provider organization plan. SNPs are special needs plans targeting subgroups of the Medicare population.

Source: MPR analysis of CMS Medicare Options Compare. 2008 enrollment data are from July.

Table A.9

Selected Characteristics of Chiropractic Benefits in All MA Plans, 2008

(Weighted for enrollment, excludes SNPs and group plans)

	All	HMO	Local PPO	PFFS	Regional PPO
Medicare Benefits					
Percentage with Any Cost Sharing	94%	93%	90%	98%	100%
Coinsurance	2%	0%	0%	4%	30%
Standard Medicare (20%)	1	0	0	0	1
Less than 20%	1	0	0	4	29
More than 20%	0[a]	0	0	0	0
Fixed Copay	98%	100%	100%	96%	70%
Zero	6	7	10	2	0
Other	92	93	90	94	70
Mean Copay	$21	$20	$17	$23	$28
Expanded Chiropractic Benefits					
Percentage of Plans Offering	14%	6%	91%	0%[a]	100%
Nature of Benefits (if offered)					
No stated limit	0%	0%	0%	--	0%
Dollar limit	-	-	-	--	0
Visit limit	30	94	10	--	0
Mean visit limit (if only)	10	10	10	--	0
Percentage with Fixed Copay	68%	100%	52%	--	70
Zero	5	16	2	--	0
Other	63	84	50	--	70
Percentage with Coinsurance	36%	0%	56%	0%	30
20%	14%	0%	26	--	111
Less than 20%	5%	0%	2	--	18
More than 20%	16%	0%	30	--	1
Enrollment (millions)	(6.4)	(4.2)	(0.5)	(1.5)	(0.2)

NOTE: HMO = health maintenance organization plan; LPPO = local preferred provider organization plan; PFFS = private fee-for-service plan; and RPPO = regional preferred provider organization plan. SNPs are special needs plans targeting subgroups of the Medicare population.

-- = not applicable. Number of plans with benefit offered is <0.5 percent of enrollment.

Source: MPR analysis of files created from CMS Health Plan Compare 2008.

Table A.10

Selected Characteristics of Podiatry Benefits in All MA Plans, 2008

(Weighted for enrollment, excludes SNPs and group plans)

	All	HMO	Local PPO	PFFS	Regional PPO
Medicare Benefits					
Percentage with Any Cost Sharing for	94%	94%	90%	96%	100%
Coinsurance	2%	0%	0%	4%	18%
Standard Medicare (20%)	1	0	0	0	0
Less than 20%	1	0	0	0	18
More than 20%	0	0	0	0	0
Fixed Copay	99%	100%	100%	96%	82%
Zero	6	6	10	47	0
Other	93	94	90	92	82
Mean Copay	$20	$18	$17	$24	$25
Expanded Podiatry Benefits					
Percentage of Plans Offering	32%	31%	92%	6%	100%
Percentage with no limit	0%	0%	0%	0%	0%
Visit limit (%)	67%	85%	29%	100%	25%
Mean maximum	4	4	6	6	6
Percentage with Fixed Copay	83%	93%	58%	99%	70%
Zero	11	17	1	4	0
Other	72	76	57	98	70
Percentage with Coinsurance	16%	0%	54%	0%	37%
20%	7	0	1	0	11
Less than 20%	2	0	24	1	18
More than 20%	7	0	30	0	1

NOTE: HMO = health maintenance organization plan; LPPO = local preferred provider organization plan; PFFS = private fee-for-service plan; and RPPO = regional preferred provider organization plan. SNPs are special needs plans targeting subgroups of the Medicare population.

Source: MPR analysis of files created from CMS Health Plan Compare 2008. Enrollment data are from July 2008.