AARP Public Policy Institute

INSIGHT on the Issues

# An Illustrative Analysis of *Medicare Options Compare:* What's There and What's Not?

**Marsha Gold, ScD**

**Mathematica Policy Research**

**This Insight on the Issues assesses *Medicare Options Compare,* a Web site maintained by the Centers for Medicare & Medicaid Services (CMS) to help beneficiaries choose among available Medicare Advantage (MA) plans. The findings show that the site helps beneficiaries identify the health plan choices specifically available in their zip code, and provides them with an extensive amount of information on these choices. But beneficiaries also could likely have trouble interpreting or be misled by some of the information. Though the site limitations partly reflect the complexity of the program, CMS could enhance the usefulness of the site by restructuring some of the information to better support beneficiary choice.**

## SUMMARY

This issue brief presents findings from an assessment of *Medicare Options Compare*, a Web site maintained by the Centers for Medicare & Medicaid Services (CMS) to help beneficiaries choose among the Medicare Advantage (MA) plans available to them. The brief identifies both the site's contributions and the ways in which it might be improved.

The findings on *Medicare Options Compare* are mixed. On the one hand, the site helps beneficiaries identify the health plan choices specifically available in their zip code, and provides them with an extensive amount of information on these choices. On the other hand, it is likely that beneficiaries could have trouble interpreting or be misled by some of the information. In particular, beneficiaries who have not been able to narrow down the choices before consulting *Medicare Options Compare* may find it difficult to do so via the Web site.

To a great extent, the site's limitations reflect both the complexity of the Medicare Modernization Act of 2003 (MMA) and the large number of companies that offered plans in response to that legislation. Medicare is designed so that the basic choice facing beneficiaries who have no other subsidized sources of medical insurance supplements is comparing a single MA plan to a combination of traditional fee-for-service Medicare, a freestanding private prescription drug plan (PDP), and potentially a Medigap plan.[1] In contrast to Medigap plans, the benefit designs of MA plans are not standardized, and numerous different types of plans are available (e.g., health maintenance organization or HMO, local

AARP

or regional preferred provider organization or PPO, private fee-for-service or PFFS). However, within that context, CMS could enhance the site's value by restructuring the information on plan features, such as benefits, and the potential financial risks of each type of plan, such as out-of-pocket costs and other financial risks beneficiaries assume by enrolling. Information on new drug coverage also could be better integrated into the site. This would help beneficiaries to choose between traditional Medicare (with or without Medigap and a private, freestanding PDP) and the MA plans available to them.

## DATA SOURCES AND ANALYSIS

Our data source for this brief consisted essentially of our personal experience with *Medicare Options Compare.* We went to www.medicare.gov just as a beneficiary (or someone helping them) might do. For a point of departure, we assumed that we were a beneficiary living in President Obama's former neighborhood—the Hyde Park section of Chicago, zip code 60637—seeking to understand the MA (called "health plan" on the site and here henceforth) choices available in 2009.[2] Plans in this zip code generally are offered at least throughout all of Cook County, Illinois. To simplify the task, we assumed that our beneficiary neither qualified for the low-income subsidy nor had preexisting or employment-based supplemental coverage.[3]

The site prompts the beneficiary for age and health status so that it can provide estimates of out-of-pocket costs based on average service use for an average beneficiary with those characteristics. We assumed our beneficiary was 65 to 69 years old—a common age for someone choosing an MA plan for the first time. Although we assumed that our beneficiary was in "good" health, we also looked at the different information a beneficiary might learn from the site if he or she reported being in "excellent" or "poor" health. The site allows beneficiaries to limit the choices shown to them according to various criteria (maximum premium, an ability to use any doctor, inclusion of Part D, plans designed as a Medicare medical savings account, specific chronic conditions or disabilities, and so on). However, we asked to see all choices for the purpose of the analysis. We used the site's "default" setting for ordering choices by estimated out-of-pocket costs (within the chosen age/health status group) versus alternatives for ordering based on plan names, premium amounts, coverage of drugs, vision or dental coverage, and scores on quality ratings.[4]

Appendix A summarizes what the site offered our hypothetical beneficiary at three levels of analysis:

1. An overview of what the site shows about the MA plans available in 2009 (table A.1).

2. A more detailed look at what the site shows beneficiaries about how their top three choices compare. We did this once for coordinated care plans (table A.2) and again for PFFS plans (table A.3).

3. An assessment of what beneficiaries might learn about choosing MA versus traditional Medicare (with or without Medigap) (table A.4).

We did not examine how the site supports a comparison of specific coverage offered in Part D because to do so would entail another level of potentially complex review. Because our analysis is based on a single locale, readers also should not assume the specific plan details we show apply nationwide.[5]

## FINDINGS

*Medicare Options Compare* lists 37 health plan options in 2009 for the Hyde Park zip code, one of which is Original Medicare.[6] Only 30 of the MA plans (along with Original Medicare) would be relevant to our beneficiary, because four are special needs plans (SNPs), and two are offered by the Mennonite Mutual Aide Association (see table A.1) (the remaining choice is original Medicare).[7,8] The latter six plans have specific eligibility requirements that we assumed our beneficiary would not meet. Though the Web site shows these choices, it does not allow beneficiaries to choose them online, instead indicating that interested beneficiaries should contact these plans by phone to determine whether they would be eligible. We do not know if the typical beneficiary would find the inclusion, particularly of the Mennonite plans, confusing.[9]

### Narrowing Down the Choices

*Medicare Options Compare* is structured such that beneficiaries get certain types of information on each plan. Additional information for a specific plan or to compare up to three plans at a time is available on request via a mouse click. The general information provided by the site is described below, along with an explanation of what beneficiaries would learn from the site to help them choose a plan.

**Plan Type and Provider Access.** As beneficiaries begin the selection process, they can use *Medicare Options Compare* to make relatively gross distinctions between types of plans available based on the way the plan is structured and authorizes access to providers. For example, our Hyde Park beneficiary has 14 HMO choices, 6 of which limit coverage to "plan doctors" and 8 of which make "some exceptions" to those requirements. (This is called a point-of-service [POS] option with an HMO.)[10] Six PPO plans and 10 PFFS plans are offered as well. The Web site shows each PPO as providing access to "any doctor," presumably because out-of-network benefits are available. But beneficiaries are not warned here that their costs will be higher for using an out-of-network doctor than if they stay within the network. Most PFFS plans are shown as having access to "any willing doctor." Two plans (Today's Options Value and Today's Options Premier) indicate that there is access to "any doctor," and the distinction between "any willing doctor" and "any doctor" is not apparent. It takes a more targeted search for beneficiaries to access information on the number of physicians affiliated with a plan or on out-of-pocket costs for out-of-network care. Even then, the information has its limitations, as discussed later.

**Firm Affiliation.** Beneficiaries who prefer certain firms that sponsor health plans can substantially narrow down their choices, a feature that probably gives sponsors an incentive to "brand" their offerings. Though there are 30 health plans available to our beneficiary in Hyde Park, six firms account for all of them because it is common for a company to offer more than one type of plan and several plans of each type with differing benefits. The six companies are Humana (traditional HMO, local and regional PPO, and PFFS); Aetna (traditional HMO, PPO, PFFS); WellCare (HMO with a POS option); HealthSpring (traditional HMO as well as an HMO with a POS option); AARP/Secure Horizons (HMO with a POS option); and Today's Options/Universal American (PFFS).

**Plan Names.** The plan names show the sponsor but do not necessarily help beneficiaries narrow their choices based on the type of plan or scope of benefits.

For example, among HMOs, HealthSpring's Healthy Advantage is an HMO with neither a POS option nor drug coverage, but its Healthy Advantage Basic Rx and Premier Rx are HMOs with both features. Its Healthy Living Premier Rx appears identical (see table A.1) to the Healthy Advantage Premier Rx, but the Healthy Living product has a higher monthly premium ($37 versus $0) and higher estimated out-of-pocket costs ($2,800 versus $2,600). Today's Options Value from Universal American is a PFFS plan without a drug benefit, but WellCare Value is an HMO with a POS option and a drug benefit.

**Monthly Plan Premium.** The Web site clearly shows the differences in monthly premiums from one plan to the next, perhaps making this portion of the site more transparent than the rest. As discussed later, however, premiums account for a variable share of out-of-pocket costs, so beneficiaries could be misled if they rely too heavily on premiums in selecting a plan. The fact that premiums are expressed on a monthly basis while total estimated out-of-pocket spending is expressed in annual terms could also be confusing.

**Part D Coverage.** Beneficiaries who know they want Part D can eliminate 8 of the 30 plans and still have a substantial number of choices, including 11 HMOs, 5 PPOs, and 6 PFFS plans. Many beneficiaries know whether or not they want Part D when they look at MA options, so having readily accessible information on whether Part D is included in the plan is important.

**Dental and Vision Coverage.** The Web site indicates whether dental and vision services are covered, not covered, or, in a few cases, covered for an additional cost. However, our nationwide analysis of MA coverage of these benefits in 2009 suggests that this simplified presentation is misleading.[11] All MA plans include the very limited benefits Medicare provides for these services, often substituting a fixed copay for the 20 percent Medicare cost sharing. Fifty-seven percent of MA plans provide some preventive benefit in 2009 (up from 36 percent in 2008), but none provide additional coverage for restorative services (e.g., fillings, crowns). Virtually all plans provide coverage for eye exams and eyeglasses in 2009, but they typically limit the frequency for exams or new glasses and the amount they will pay for the glasses.

**Summary Rating of Quality.** *Medicare Options Compare* uses a five-star rating system to summarize the quality of care and other features of the performance delivered by the health plans and drug plans. The ratings are based on aggregate measures constructed by CMS from individual measures of care developed from survey, claims, and administrative data. The stars represent summary measures that combine, in an unspecified way, ratings of staying healthy, getting timely care, managing chronic (long-lasting) conditions, health plan responsiveness, and handling appeals well and quickly. Ratings for the drug plans are based on customer service, member complaints and turnover, member experience, and drug pricing and safety. Plans can get from one to five stars, with five being the highest. The site does not show the weights used to generate star ratings from individual ratings (whether some ratings are more important than others) nor the specific data elements used to compile the individual ratings (what the individual rating is based on).

Health plan ratings are not available for 16 of the 30 plans in the site, including all but 2 of the PFFS plans. Of the plans that are rated, almost all received 2.5 stars, and the rest got only 2, making it difficult for a beneficiary to differentiate

between the quality of one plan versus another. The drug plan ratings are more complete, but even so, they vary only a bit more than the health plans (from 2.5 to 3.5 stars). Those findings could mean plans have similar performance that the ratings are not sufficient to detect real differences.

Plans that are not rated have missing data because (1) survey and other data are not available for new plans or for those with only a year or two of experience, and (2) reporting of quality-based measures is voluntary for PFFS plans (until 2010). In addition, because the ratings are developed at the contract level, all plans offered by that contract serving that zip code will have the same rating, a fact that limits variation in ratings across plans.[12,13]

**Estimated Out-of-Pocket Cost.** These estimates, based on 2003–2004 Medicare claims data, are the main vehicle through which beneficiaries can see how their total spending could vary from one plan to another.[14] The estimates combine premiums (for Part B and MA) with expected average out-of-pocket costs for inpatient care, outpatient prescription drugs, dental, and other services.

Beneficiaries are given an idea of their potential out-of-pocket cost by estimates that show what the average cost would be for someone in their age group with the same perceived health status. In this specific zip code, for example, the site tells a beneficiary that HMOs will tend, on average, to have lower out-of-pocket costs, that PFFS plans will have higher out-of-pocket costs, and that their costs could vary by as much as $1,000 within each plan type—more if they are in poorer health and less if they are in excellent health. Some differences, however, are much smaller. For example, Aetna's Golden Medicare HMO plans include a basic option without Part D benefits and three plans with Part D—a Value, Standard, and Premier plan; the premiums differ from one to the next, but CMS's out-of-pocket cost estimates for a beneficiary differ by only $200 annually from low to high.

Regrettably, the documentation on the site is not clear on how overall costs are defined and what they include. In particular, the user note does not indicate clearly that estimates include Part B and plan premiums as well as estimated out-of-pocket costs for services. As we discuss later, CMS could make better use of the available data to help beneficiaries understand both predictable costs (premiums) and more uncertain costs (costs related to their use of health services). The distinction could be important because all these health plans have an insurance component to provide some degree of financial protection to beneficiaries. Each plan must provide at least actuarially equivalent coverage to that offered by traditional Medicare, but almost all change Medicare's cost-sharing structure in ways that could increase or decrease the financial protection beneficiaries would experience compared to each other or to traditional Medicare.

### Digging Deeper

Beneficiaries can dig deeper for information on specific plans they are interested in or to compare plans. Tables A.2 and A.3, respectively, provide our summary of this information for three lower-cost coordinated care plans and for three PFFS plans in zip code 60637, excluding, for simplicity, the detailed description of Part D benefits and some others.

**Estimated Out-of-Pocket Costs.** The plan profile repeats information on the summary sheet about total estimated annual out-of-pocket costs, but beneficiaries are given the option to ask for more information. When they do, the

Web site breaks down the estimate by category of expense on a monthly basis: Part B premium, plan premium, inpatient care, outpatient prescription drugs, dental services, and all other services. Premiums are the same regardless of a beneficiary's health status, but the other costs differ with plan design. In table A.2 we examined these figures for one of the plans and found that, for someone in excellent health, out-of-pocket costs beyond the premium account for only 40 percent of the estimated total out-of-pocket spending, but these costs are much higher for those whose health is poor (or becomes so after enrollment) (see box 1). Out-of-pocket spending for those in poor health was more than double that for those in excellent health.

In our chosen plan in box 1, 73 percent of out-of-pocket costs for an enrollee in good health occur when the enrollee uses services rather than through payment of monthly premiums for Medicare or MA.[15] Drug costs account for only 26 percent of these costs; the remainder reflect spending for hospital, physician, and other health services. Yet by design of the included PDP tool, the Web site steers beneficiaries toward considering likely drug costs rather than toward these other costs. By combining dental costs with cost sharing associated with Parts A and B benefits, the site may also mute differences in health plans for beneficiaries whose health status varies, because estimated spending on dental services, unlike other services, is lower for those in worse health (see box 1).

**Provider Networks.** Though research shows that beneficiaries care a great deal about which providers are in their plan, the Web site does not have information on this topic. This is not surprising and reflects a lack of uniformity in data collection and tracking of provider networks across the industry and the potential speed with which this kind information changes. For coordinated care plans, the site shows the number of providers affiliated with the plan within categories (e.g., 501–1000, 2,001–2,500) (see table A.2). Counts are for the service area of the plan, which may differ from one plan to another in the counties it includes. Thus, plans with larger service areas may appear to have more provider choice even if some of these providers are relatively distant from the beneficiary. In addition, provider counts do not show anything about the characteristics of the network (e.g., criteria for selection; inclusion of certain large, dominant practices). For this information, beneficiaries would have to consult individual plans, for which the site provides links and contact information. Beneficiaries thus cannot find out from *Medicare Options Compare* which providers are affiliated

**Box 1**
**Illustration: Point-of-Service Cost Sharing Accounts for a Higher Share of Out-of-Pocket Costs for Sicker Beneficiaries**

| Out-of-Pocket Components | Excellent Health | Good Health | Poor Health |
|---|---|---|---|
| **Total (Monthly)** | $161.40 | $206.40 | $363.40 |
| **Part B Premium** | 96.40 | 96.40 | 96.40 |
| **Monthly Plan Premium** | 0.00 | 0.00 | 0.00 |
| **Inpatient Care** | 2.00 | 19.00 | 85.00 |
| **Outpatient Prescription Drugs** | 19.00 | 40.00 | 94.00 |
| **Dental Services** | 30.00 | 24.00 | 16.00 |
| **All Other Services** | 14.00 | 27.00 | 72.00 |

Source: *Medicare Options Compare* 2009 estimates for WellCare Value Plan (HMO-POS) in zip code 60637; beneficiaries ages 65–69 by self-reported health status.

with the plan.

**Benefit Specifications.** The Web site provides details on how each plan handles limits and cost sharing for Medicare Parts A and B services. Such features may differ substantially across plans. Among coordinated care plans, for example, WellCare Value charges a $50 copay for hospital days one through five, Humana Gold Plus charges $550 per stay with a $3,500 limit, and Aetna's Golden Choice Standard PPO charges $500 per stay in network and 30 percent of charges out of network. It may be challenging for beneficiaries to compare plans that differ on so many dimensions for each benefit. Beneficiaries also may not fully appreciate the financial risk to them of different benefit features (e.g., the high cost of hospital care and difference between hospital charges and MA payment rates) and how that might add to their costs in using out-of-network providers.

In some instances, the descriptions of the benefits also are not specific enough to give beneficiaries a clear sense of what is and is not covered, and at what price. For example, the site shows that Humana Gold Plus HMO pays anywhere from $0 to $50 for many ancillary services (e.g., clinical laboratory tests), and coordinated care plans may require authorization to pay for durable medical equipment (see table A.2). It could also be challenging to compare coinsurance (e.g., 20 percent, as in traditional Medicare) with what most plans, using fixed dollar copayments, would charge unless beneficiaries are familiar with Medicare payment rules. (Most probably are not.) The Web site also makes standard distinctions between in- and out-of-network cost sharing for PFFS plans, though such distinctions are not relevant to PFFS plans. Including this kind of information could confuse beneficiaries. (For simplicity, we do not show this level of detail in the appendix tables.)

**Detailed Performance Ratings.** Beneficiaries delving deeper into the Web site can find five-star ratings for each of the components used to construct the previously discussed summary performance scores for health plans and for PDPs. A plan that has no summary rating may have sufficient data to provide a star rating for a specific component of the summary rating. In this zip code, there is more differentiation across plans in component ratings than in the summary ratings. Separate ratings for health plans and the drug plan they offer are consistent with the split in traditional Medicare between Parts A, B, and D. However, separate ratings are not as applicable to MA plans, in which all Medicare benefits are integrated into a single package.

**Why Enrollees Leave the Plan.** This information may be of considerable interest to beneficiaries, but it is not easily identifiable or retrievable on the site, and the information is very dated (2004–2005). Users see reference to this information only if they request detailed information on the out-of-pocket costs in a plan and notice (and click on) a separate tab for "Why People Leave." This tab contains information on the percentage of members who leave, how the reasons for leaving break down between "health care or services" or "benefits and costs," and additional detail on some specific reasons. But users who want that information must first read a lengthy text of explanation and proactively request that data be shown. (The default appears to leave it hidden.) They then get national and state averages and, if available, information for that contract (which may include multiple plans). Because the data are so old, they are often missing. Thus, it is not clear how valuable the information

provided on this topic would be to a beneficiary.

### Deciding between Traditional Medicare and Medicare Advantage

The Web site appears to be most limited in its ability to help beneficiaries choose between traditional Medicare (with or without a PDP or Medigap plan) and MA plans. The site preceded Part D. After the MMA, CMS appears to have built on the site to emphasize helping beneficiaries decide which freestanding PDPs or MA plans provide the best coverage for the particular drugs they take. However, that may not be the most important information to beneficiaries concerned about how their health plan choice could influence total out-of-pocket spending. As shown in box 2, CMS's estimates of out-of-pocket spending show that hospital, physician, and other services account for a majority of out-of-pocket costs under traditional Medicare—not prescription drugs, even without Part D. Further, the way *Medicare Options Compare* is structured, a beneficiary could be misled about the relative out-of-pocket costs for MA health plans and traditional Medicare, with or without a Medigap option. This is because the out-of-pocket cost estimates for the traditional Medicare program on the site *exclude* any PDP or Medigap coverage. By going to a different part of the site that allows Medigap policies to be compared, beneficiaries can get information on benefits and expected out-of-pocket costs for traditional Medicare and each of the standardized Medigap options (see table A.4). These, too, *exclude* drug benefits, while such benefits do influence estimates provided for MA.

This structure has some problems. First, it implicitly steers beneficiaries away from traditional Medicare because the out-of-pocket spending estimates do not account for PDP enrollment, even though PDPs are popular with beneficiaries who have no other source of drug coverage. Second, the patchwork of information could be confusing to beneficiaries, because if they choose the traditional Medicare program, their expected out-of-pocket costs are not what the site shows for Medicare alone, but for a combined total reflecting the decisions they make about Medigap and

**Box 2**

**Illustration: Common Medigap Plans in Hyde Park have Lower Expected Cost Sharing Than Medicare Alone and May Compare Favorably to PFFs MA-PDs**

| Out-of-Pocket Components | Traditional Medicare A/B Only | Medicare + Medigap C | Medicare + Medigap F | Today's Option Value With Rx PFFS | Aetna Medicare Open Basic With RX |
|---|---|---|---|---|---|
| **Total (Monthly)** | $331.40 | $ 349.00 | $ 349.65 | $346.10 | $375.00 |
| **Part B Premium** | 96.40 | 96.40 | 96.40 | 96.40 | 96.40 |
| **Monthly Plan Premium** | 0.00 | 118.60 | 119.25 | 86.70 | 112.00 |
| **Inpatient Care** | 42.00 | 0.00 | 0.00 | 31.00 | 34.00 |
| **Outpatient Prescription Drugs** | 95.00 | 95.00 | 95.00 | 44.00 | 59.00 |
| **Dental Services** | 39.00 | 39.00 | 39.00 | 39.00 | 39.00 |
| **All Other Services** | 59.00 | 0.00 | 0.00 | 49.00 | 35.00 |

Source: *Medicare Options Compare* 2009 estimates for traditional Medicare and Medicare/Medigap Plans C and F in zip code 60637; beneficiaries ages 65–69 by self-reported good health (assumes no PDP coverage). The PDPs shown are the least expensive ones listed with Part D coverage.

also Part D.

Perhaps even more critical, the focus on aggregate estimates of out-of-pocket costs may discourage beneficiaries from giving due consideration to their tolerance for risk and to the potential trade-offs they wish to make (or can afford to make) between fixed and predictable premiums and less predictable cost sharing at the point of service. As box 2 shows, the most popular Medigap options (C and F) typically eliminate out-of-pocket costs for hospital and physician services. The estimated total of a beneficiary's out-of-pocket costs for these plans in Hyde Park actually are lower and more predictable than the same costs for those in the least expensive PFFS plans offered in that locale, even though the latter include prescription drugs. While the specific facts are likely to vary across markets, it is important that beneficiaries have access to information that can help them make these kinds of assessments.

## CONCLUSIONS

Though CMS has made a considerable investment in *Medicare Options Compare* to help beneficiaries (and their advisors) make a choice of Part D plans and navigate the overall Medicare environment, our analysis suggests that substantially more can be done to make *Medicare Options Compare* valuable to beneficiaries choosing a health plan under the MMA. The site covers a lot of ground, but it could be challenging for beneficiaries to use. While our analysis reflects only our own experience on the site and does not provide feedback on what beneficiaries actually experience, the results have three implications.

First, CMS's efforts to help beneficiaries choose among the plans authorized by the MMA drive home the magnitude of the task posed by the legislation. Both the range of options allowed in MA and Congress's decision to operate Part D apart from traditional Medicare Parts A and B make for some very complex choices. It is not clear that any one tool can adequately simplify the decision between one plan and another for beneficiaries or their advisors. If MA health plan benefits were standardized (as they are for Medigap), it could be simpler for beneficiaries to compare health plans. Standardization of plan names also could make it easier for the site to display, and beneficiaries to compare, their health plan choices.[16]

Second, the Web site could be modified to offer beneficiaries a better understanding of how the choice of one plan over another translates into their probable out-of-pocket spending and financial risk. The basis for this improvement already exists within the site itself, as it already contains data that can be used to look separately at the different types of out-of-pocket spending. Beneficiaries might be able to compare plans more easily if such costs were clearly broken down into four categories: (1) premiums that are fixed and predictable; (2) inpatient and other medical services, whose costs vary with health status and are less predictable over time; (3) outpatient prescription drugs, whose costs vary with Part D decisions and coverage; and (4) dental and other services not included in the traditional Medicare package. With a bit more work and the same data, CMS also should be able to provide beneficiaries with potentially useful information to assess the uncertainty of the estimates. The raw data, for example, could support analysis for each health status and age group to show beneficiaries not just average out-of-pocket costs, but also how common it might be for a beneficiary like them to encounter substantially higher out-of-pocket costs. Dental benefits could also be labeled more accurately so that beneficiaries know that the extra dental benefits they

might receive relate solely to preventive services.

Third, CMS should probably review the site's focus on Part D relative to the information on the overall choice facing beneficiaries. The current structure of the Web site makes it too easy for beneficiaries to base decisions on the monthly premium and prescription drug coverage. The fundamental choice is whether to go with traditional Medicare (with or without Part D and/or Medigap) or with an integrated MA plan. The utility of the site as it now stands has been adversely affected by CMS's need to revise it quickly to support the new Part D option launched in 2006. A reexamination of its form is now overdue.

## Table A.1
**Medicare Advantage Plans Available for General Enrollment, 2009**
Zip Code 60637 (Hyde Park, IL)

| Plans (by type, as sorted by *Medicare Options Compare* on estimated out-of-pocket cost for beneficiaries in good health) | Monthly Premium (excluding Part B) | Part D | Any Vision | Any Dental | Star Rating (of 5) | | Estimated Out-of-Pocket Cost Ages 65–69[a] | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | Health Plan | Rx | Excellent Health | Good Health | Poor Health |
| **HMO (no POS option)** | | | | | | | | | |
| Humana Gold Plus | $0 | Yes | Yes | No | 2.5 | 3.5 | $2,150 | $2,550 | $4,500 |
| Health Spring Healthy Advantage | $0 | No | Yes | Yes | 2 | -- | $1,600 | $2,600 | $5,700 |
| Aetna Golden – Medicare Standard | $38 | Yes | Yes | (for Extra) | NA | 3.5 | $2,650 | $3,250 | $5,200 |
| Aetna Golden – Medicare Value Plan | $0 | Yes | Yes | (for Extra) | NA | 3.5 | $2,400 | $3,300 | $6,100 |
| Aetna Golden – Medicare Premier | $73 | Yes | Yes | (for Extra) | NA | 3.5 | $2,950 | $3,450 | $4,950 |
| Aetna Golden – Medicare Basic | $0 | No | Yes | (for Extra) | NA | -- | $2,500 | $3,550 | $7,000 |
| **HMO (POS option)** | | | | | | | | | |
| WellCare Value | $0 | Yes | Yes | Yes | 2.5 | 3 | $1,950 | $2,500 | $4,350 |
| WellCare Choice | $0 | Yes | Yes | Yes | 2.5 | 3 | $1,950 | $2,550 | $4,700 |
| Health Spring Healthy Advantage Premier Rx POS | $0 | Yes | Yes | Yes | 2 | 3 | $2,000 | $2,600 | $4,550 |
| WellCare Rx | $24 | Yes | Yes | Yes | 2.5 | 3 | $2,550 | $2,750 | $4,700 |
| Health Spring Healthy Advantage Basic Rx POS | $13 | Yes | Yes | Yes | 2 | 3 | $2,200 | $2,800 | $4,950 |
| Health Spring Healthy Living, Premier Rx POS | $37 | Yes | Yes | Yes | 2 | 3 | $2,250 | $2,800 | $4,600 |
| AARP Medicare Complete Plus Plan 1 | $0 | Yes | Yes | (for Extra) | NA | 3 | $2,250 | $2,950 | $5,450 |
| AARP Medicare Complete Plus Plan 2 | $0 | No | Yes | (for Extra) | NA | -- | $2,450 | $3,550 | $7,000 |
| **PPO** | | | | | | | | | |
| Humana Choice PPO | $0 | No | No | Yes | 2.5 | -- | $2,100 | $3,200 | $6,700 |
| Aetna Golden Choice Standard | $53 | Yes | Yes | (for Extra) | NA | NA | $3,550 | $3,450 | $5,600 |
| Humana Choice PPO (regional) | $91 | Yes | No | Yes | 2.5 | 2.5 | $2,950 | $3,950 | $6,600 |
| Humana Choice PPO (local) | $78 | Yes | No | Yes | 2.5 | 3.5 | $2,950 | $3,600 | $5,950 |
| Humana Choice PPO (regional) | $97 | Yes | No | Yes | 2.5 | 2.5 | $3,200 | $3,900 | $6,300 |
| Aetna Golden Choice Premier | $134 | Yes | Yes | (for Extra) | NA | NA | $3,700 | $4,200 | $5,700 |

**Table A.1 (continued)**

| Plans (by type, as sorted by *Medicare Options Compare* on estimated out-of-pocket cost for beneficiaries in good health) | Monthly Premium (excluding Part B) | Part D | Any Vision | Any Dental | Star Rating (of 5) | | Estimated Out-of-Pocket Cost Ages 65–69[a] | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | Health Plan | Rx | Excellent Health | Good Health | Poor Health |
| **PFFS** | | | | | | | | | |
| Today's Options Value Powered by CCRx | $87 | Yes | Yes | No | NA | 2.5 | $3,350 | $4,150 | $7,000 |
| Aetna Medicare Open Basic Plan with Rx | $112 | Yes | Yes | No | NA | 3.5 | $3,700 | $4,500 | $4,150 |
| Today's Option Value | $65 | No | Yes | No | NA | -- | $3,400 | $4,500 | $7,850 |
| Today's Option Premier | $99 | No | Yes | No | NA | -- | $3,600 | $4,600 | $7,850 |
| Today's Option Premier Powered by CCRx | $154 | Yes | Yes | No | NA | 2.5 | $4,050 | $4,600 | $6,600 |
| Aetna Medicare Open Basic Plan | $90 | No | Yes | No | NA | -- | $3,550 | $4,650 | $7,200 |
| Humana Gold Choice PFFS | $148 | Yes | No | No | 2.5 | 3 | $4,050 | $4,700 | $7,250 |
| Humana Gold Choice PFFS | $134 | Yes | No | No | 2.5 | 3 | $4,100 | $4,750 | $7,750 |
| Aetna Medicare Open Standard with Rx | $199 | Yes | Yes | No | NA | 3.5 | $4,300 | $4,950 | $6,400 |
| Aetna Open Standard Plan | $167 | No | Yes | No | NA | -- | $4,500 | $5,200 | $7,850 |

Source: Author's construction from information on www.Medicare.gov, January 7, 2009.

NA = Not available, usually because the plan is of a type not required to submit it or is too new to have such data.

Note: Excludes four SNPs from Health Spring (Chronic Care, Institutional), Evercare (Chronic Care, Institutional), two PFFS plans offered by the Mennonite Mutual Aide Association (not available for online enrollees), and Original Medicare.

[a]Based on CMS analysis applied to benefits design in 2009 bids. Includes out-of-pocket costs associated with Part B premium, health plan premium, inpatient care, prescription drugs, dental, and skilled nursing care, whether or not they are Medicare covered, as well as a variety of Medicare-covered benefits. For MA-PDs, prescription drug costs are based on the Part D plan. (This differs from traditional Medicare and Medigap, which assumes no such coverage.) From www.Medicare.gov/MPPF/Include/DataSection/OOPC/OOPCCalculations.asp.

-- = Does not offer Rx.

## Table A.2

**Comparison of Lowest-Premium Coordinated Care Plans (with Part D coverage) of Each type, Selected Information Abstracted from *Medicare Options Compare,* 2009**

| | WellCare Value (HMO with POS) | Humana Gold Plus HMO | Aetna Golden Choice Standard (PPO) |
|---|---|---|---|
| **Estimated Out-of-Pocket Costs for Ages 65–69 in Good Health** | $2,500 | $2,550 | $3,450 |
| **Service Area** | Cook and Will Co. | Cook and Will Co. | Cook Co. |
| **Provider Network** | 2,001–2,500 | 501–1,000 | 1,001–1,500 |
| **Ratings** | | | |
| Staying healthy | 2* | 2* | Not enough data |
| Timely care | 2* | 2* | Not enough data |
| Managed home care | 3* | 3* | Not enough data |
| Health plan response | 2* | 3* | Not enough data |
| Appeal speed | 5* | 5* | Not enough data |
| Drug plan services | 4* | 3* | 5* |
| Member complaints Rx plan | 2* | 4* | Not enough data |
| Member experience Rx plan | 2* | 3* | Not enough data |
| Drug pricing/safety | 4* | 4* | 5* |
| **Premium (Monthly)** | $0 | $0 | $53 |
| **Out-of-Pocket Limit** | $1,500 (in network) | None | $5,000 (in network)<br>Some services (Same out-of-pocket network, but $500 deductible.) |
| **Inpatient Care** | $50/day (1–5)<br>$0 after/No day limit<br>Prior notification (except emergency) | $550/stay<br>$3,500 out-of-pocket limit annually<br>No day limit | $500/stay<br>No day limit<br>(30% out-of network) |
| **Doctor's Visit** | No copay for primary care visits<br>$25 urgent care<br>$30 specialist | No copay for primary care visits<br>$30 for specialist visits | 20% in network/<br>30% out of network |
| **Durable Medicare Equipment** | 20% (authorization may be required) | 20% (authorization may be required) | 20% in network/<br>30% out of network<br>authorization |
| **Ancillary Services (in network)** | | | |
| Lab | $0 | $0–$50 | $0 |
| Diagnostic procedures | $30–$50 | $0–$50 | $0 |
| X-ray | $0 | $0–$50 | $3 |
| Diagnostic radiology | $50 | $0–$110 | $175 |
| Therapeutic radiology | $30 | $0–$50 | $30<br>(30% non-network) |
| **Part B Drugs** | | | |
| General | 20% | 20% | $45 |
| Chemotherapy | 20% | 20% | $45 |

Source: Author's construction from information on *Medicare Options Compare*, January 7, 2009, zip code 60637.

* = Star rating.

## Table A.3
### Comparison of Lowest-Premium PFFS Plans (with Rx), Selected Characteristics Abstracted from *Medicare Options Compare,* 2009

| | Universal American Today's Options with CCRx | Aetna Medicare Open Basic Plan with Rx | Universal American Today's Option Premier with CCRx |
|---|---|---|---|
| **Estimated Out-of-Pocket Costs for Those Age 65–69 in Good Health** | $4,150 | $4,500 | $4,600 |
| **Service Area** | NE/Midwest/South 6 | Selected counties in 5 states | West/Midwest/South 6 |
| **Provider Network** | Not available | Not available | Not available |
| **Ratings** | | | |
| Staying healthy | 2* | 4* | 2* |
| Timely care | 4* | 4* | 2* |
| Managed chronic care | Not enough data | Not enough data | Not enough data |
| Health plan response | 3* | 3* | 3* |
| Appeal speed | Not enough data | 5* | Not enough data |
| Drug plan services | 3* | 4* | 3* |
| Member complaints Rx plan | 1* | 2* | 1* |
| Member experience Rx plan | 1* | 3* | 1* |
| Drug pricing/safety | 3* | 4* | 3* |
| **Premium (Monthly)** | $86.70 | $112 | $153.50 |
| **Out-of-Pocket Limit** | $3,000 (in and out of network combination) | $4,000 | $2,500 (in and out of network) |
| **Inpatient Care** | $195/day (1–5)<br>$0 copay other days<br>No limit days | $400/day (1–7)<br>$0 copay other days<br>No limit days | $350/stay<br>$0 copay other days<br>$875 annual out-of-pocket limit |
| **Doctor's Visit** | $20–$25 for primary care, $35 for specialists | $20 for primary care and for specialists | $10–$35 for primary care<br>$25 for specialists |
| **Durable Medicare Equipment** | 20% | 20% | 20% |
| **Ancillary Services (in network)** | | | |
| Lab | $0 | $20 | $0 |
| Diagnostic procedures | $0 | $20 | $0 |
| X-ray | 20% | $20 | 10% |
| Diagnostic radiology | 20% | $150 | 10% |
| Therapeutic radiology | 20% | $20 | 10% |
| **Part B Drugs** | | | |
| General | 20% | $45 | 20% |
| Chemotherapy | 20% | $45 | 20% |

Source: Author's construction from information on *Medicare Options Compare*, January 7, 2009, zip code 60637.

* = Star rating.

**Table A.4**
**CMS's Estimates of Out-of-Pocket Costs for Alternatives to Medicare Advantage, by Health Status, 2009**
(Zip Code 60637)

| | Monthly Premium Range[a] | Estimated Annual Costs Ages 65–69 by Self-Reported Health Status[b] | | |
|---|---|---|---|---|
| | | Excellent | Good | Poor |
| **Medicare Only** | $0 | $2,700 | $4,000 | $8,250 |
| **Medicare + Medigap C** | $109–$318 | $3,600 | $4,200 | $5,900 |
| **Medicare + Medigap F** | $102–$294 | $3,600 | $4,200 | $5,900 |
| **Medicare + Medigap K** | $53–$94 | $3,450 | $4,550 | $8,200 |

Source: CMS's *Medicare Options Compare*, accessed January 8, 2009, on www.Medicare.gov.

[a]Excludes the regular Part B premium all beneficiaries pay.

[b]Based on CMS-provided analysis applied to standardized benefit design. Includes out-of-pocket costs associated with inpatient care, prescription drugs, dental, and skilled nursing care, whether or not Medicare covers them, as well as a variety of Medicare-covered services (assumes no Part D coverage purchased separately). From www.Medicare.gov/MPPF/Include/DataSection/OOPC/OOPCCalculations.asp, accessed January 7, 2009.

[1] Beneficiaries who are eligible for Medicaid and related public coverage or group-based retiree benefits are exceptions because their eligibility for these subsidies modifies the choices they are likely to consider. In 2006, 35 percent of beneficiaries had employer-sponsored coverage, and 16 percent had Medicaid as a source of supplemental coverage. Of the remainder, 19 percent were enrolled in MA, 18 percent in Medigap plans, and 11 percent in traditional Medicare only (Kaiser Family Foundation, *Medicare: A Primer 2009*, Washington, DC: January 2009).

[2] This portion of the site preexisted the MMA and the Part D expansion and focuses on helping beneficiaries choose an MA plan or Medigap plan, depending on which they want. The site was modified after Part D was enacted to reflect changes in Medicare drug benefits. A separate channel on the site, added after the MMA, focuses on Medicare PDPs and assists beneficiaries seeking to learn how coverage of specific drugs they use varies across the formularies and benefit designs of available freestanding PDPs and MA options that incorporate drug coverage.

[3] Choices for beneficiaries eligible for the low-income subsidy are influenced by the fact that their Part D coverage is subsidized. Beneficiaries with group-based coverage may find that enrolling in an MA plan voids their group-based coverage; thus, *Medicare Options Compare* encourages them to talk to their former employer before making an MA choice.

[4] While the ability to customize is useful, it also could result in frustration for beneficiaries because if a user leaves the site and begins again later, the site may display different plans, plans ordered in different ways, or other differences.

[5] The plans we show typically have service areas that include Cook County (Chicago) and perhaps proximate counties, though service areas for regional PPOs and many PFFS plans will be broader. Readers seeking information on MA benefits and premiums nationwide can find them in companion issue briefs available from AARP (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* and M. Gold and M. Hudson, *Medicare Advantage Benefit Design: What Does It Provide, What Doesn't It, and Should Standards Apply?* Washington DC: AARP Public Policy Institute, March 2009]).

[6] This number of choices is somewhat below the average nationally. In 2008, the average beneficiary had 44 plan choices (excluding special needs plans), with 35 choices available in the average county. See Marsha Gold, "Medicare's Private Plans: A Report Card on Medicare Advantage," *Health Affairs Web Exclusive*, November 24, 2008 (www.healthaffairs.org)

[7] SNPs are coordinated care plans designed to serve enrollees with certain special needs: dual eligible (Medicare-Medicaid), those who are institutionalized or eligible for institutionalization,

and those with serious chronic or disabling conditions.

[8] Table 1 lists the choices and the information shown for each plan as ordered by the sort (for those in good health). The one exception is that we sort plans into four categories of provider choice (HMO with and without point-of-service option, PPO, and PFFS). (The Web site names the plan model (e.g., HMO) and describes doctor choice separately and doesn't sort by this under the default option.)

[9] Because of the way the MMA is structured, SNP choices exist in most markets and seem necessary to include, although only a subset of beneficiaries may be eligible.

[10] Also referred to as "open-ended HMOs" in the past, such options provide some coverage when selected out-of-network services are used (often with higher cost sharing).

[11] See M. Gold and M. Hudson, *Medicare Advantage Benefit Design: What Does It Provide, What Doesn't It, and What Standards Should Apply?* (Washington DC: AARP Public Policy Institute, March 2009).

[12] CMS makes certain exceptions for contracts with a wide geographical scope (e.g., some PFFS plans are offered under contracts that cover much of the United States).

[13] A contract is for a particular type of plan (e.g., an HMO) from a sponsor and typically is for a defined service area. However, multiple plans with different benefits may be offered under the same contract, and other distinctions also are allowed across plans under a single contract (e.g., HMOs with and without a POS option).

[14] Additional detail on how costs are calculated are provided directly on the site at www.medicare.gov/MPPF/Include/DataSection?OOPC/OOPCCalculations.asp (accessed January 7, 2009) and through a link provided from that site to a document on the CMS Web site ("CY 2009 Medicare Options Compare Cohort Selection and Out-of-Pocket Cost Estimates Methodology," by Fu Associates, October 17, 2008).

[15] Though these figures are for a single plan within the zip code, CMS's estimates of out-of-pocket costs reflect national estimates of use based on the Medicare Current Beneficiary Survey for individuals in a given age and health status group, applied to the specific plan's benefits. Thus, while plan and location choice will influence the benefit package, it should not influence the use assumptions. This fact means that there is likely to be a reasonable consistency to the patterns reflected in estimates for different plans and locales. CMS does not make public the data behind the estimates in an analytical file, so we cannot provide market or national estimates on these topics.

[16] Additional analysis of this issue is included in a companion AARP report by M. Gold and M. Hudson, *Medicare Advantage Benefit Design: What Does It Provide, What Doesn't It, and What Standards Should Apply?* (Washington DC: AARP Public Policy Institute, March 2009); and also in E. O'Brien and J. Hoadley, *Medicare Advantage: Options for Standardizing Benefits and Information to Improve Consumer Choice* (New York: The Commonwealth Fund, April 2008).

Insight on the Issues I 27, April, 2009

Written by Marsha Gold, Mathematica Policy Research, for the
AARP Public Policy Institute,
601 E Street, NW, Washington, DC 20049
www.aarp.org/ppi
202-434-3890, ppi@aarp.org