

A First Look at How Medicare Advantage Benefits and Premiums in Individual Enrollment Plans Are Changing from 2008 to 2009

Marsha Gold, Sc.D. and Maria Cupples Hudson, M.S.

Mathematica Policy Research

New analysis of CMS data shows a small increase in the number of regular Medicare Advantage (MA) plans offered for individual enrollment—from 3,307 in 2008 to 3,354 in 2009; 350,000 enrollees, most in private fee-for-service plans, had to switch plans for 2009 because their plans were no longer offered. Medicare Advantage premiums and cost sharing varies substantially across plans. In choosing a plan, MA enrollees appear to have focused heavily on zero premium plans that provide some Part D coverage of the “gap” between regular and catastrophic benefits. As structured, MA plans vary in the protection provided beneficiaries against out-of-pocket costs for Part A and Part B and the costs are highest for those whose needs result in more use of care.

Summary

This report uses newly released public data from the Centers for Medicare and Medicaid Services (CMS) to describe the benefits and premiums that enrollees had from Medicare Advantage (MA) plans in 2008 and how they have changed in 2009. It focuses on plans available to any beneficiary for individual enrollment, including coordinated care plans (such as health maintenance organizations (HMOs) and preferred provider plans (PPOs)), private fee-for-service (PFFS) plans and medical savings account (MSA) plans.¹

The number of MA plans offered for general individual enrollment increased from 3,307 in 2008 to 3,354 in 2009. Around 350,000 enrollees had to switch plans for 2009 because their plans in 2008 were no longer offered. Most of

these enrollees were in PFFS plans; 15.5 percent of those in individual PFFS plans in 2008 had to change plans in 2009. The withdrawal of WellPoint and its Anthem affiliates from the MSA market as of 2009 affected four out of every five of the few beneficiaries in MSAs.

Our findings show wide variability in the premiums charged by MA plans of different types, as well as in the cost sharing enrollees face. The average MA plan with prescription drugs (MA-PD) had a premium of \$63 per month in 2008, but enrollees tended to favor lower premium plans, so the average premium paid by an enrollee was only \$46 per month, and 54 percent were in a plan with no premium.² In choosing a plan, MA enrollees also appear to have focused heavily on enhanced Part D, with interest in enrolling in plans that

provide some coverage of the gap between regular and catastrophic coverage. In both 2009 and 2008, average out-of-pocket spending for hospital and physician services among MA enrollees is lowest for HMOs and highest for regional PPOs; however, it varies substantially with the needs of the beneficiary. In 2009, PFFS plan premiums and benefits, on average, appear less competitive with HMOs than they were in 2008. The change reflects PFFS benefits declining in 2009, while HMOs benefits increased somewhat. In previous studies, HMOs indicated that they were feeling competition from PFFS plans, so they may have responded to that in designing 2009 benefits.³

Data Sources and Analysis

We analyze the characteristics of MA plans available for individual enrollment as reflected in the Medicare Options Compare—a tool CMS uses to support beneficiary choice on the Medicare Web site. We downloaded files for 2008 and 2009 showing the characteristics of plans offered to individuals under each MA contract and analyzed the county service area in which each plan is offered to identify unique plans available in different contract segments. We used CMS's newly available public data on MA plan enrollment by contract, plan, and county to determine the number of enrollees selecting each plan as of July 2008.

The analysis includes both unweighted and weighted estimates. The unweighted data show the characteristics of plans available to beneficiaries. The weighted estimates show the characteristics of MA benefits and premiums experienced by enrollees, which reflects enrollees' preferences for the features of plans they have chosen to join. Because we do not know yet how enrollees are responding to changes in offerings made for 2009, the 2009 weighted estimates show only

how MA benefits and premiums have changed for enrollees in plans that will continue to be available in 2009, assuming no shift in enrollment.

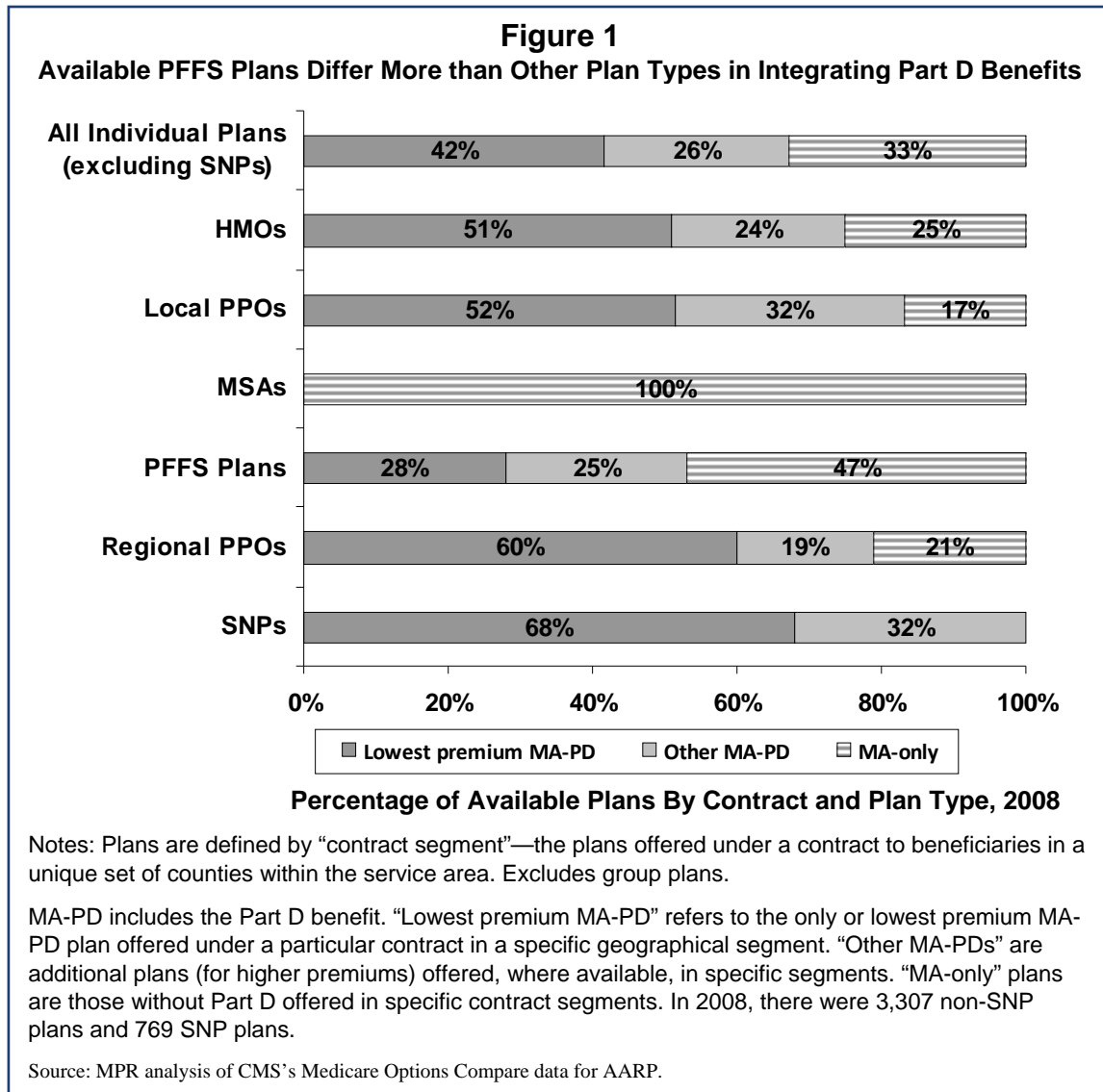
Of the 10.1 million Medicare beneficiaries who received their benefits through MA and similar private plans in November 2008, 9.7 million were in MA plans; 83 percent of these beneficiaries (8.0 million) were in plans available for individual enrollment, and the rest were enrolled through group plans.⁴ Assuming that all enrollees in special needs plans (SNPs) were enrolled individually, 6.8 million were in plans available to any beneficiary in the service area, and 0.9 million were enrolled in SNPs that specialize in services for dually eligible or institutionalized persons, or those with severe chronic or disabling conditions. Our analysis focuses on plans open to all beneficiaries because dual eligibility complicates the interpretation of SNP benefits, which are designed to coordinate with Medicaid benefits to further limit cost sharing for qualified beneficiaries.⁵ The weighted analysis excludes approximately 350,000 enrollees who could not be matched to a specific plan.⁶

Findings

Number of Plans, 2008–2009

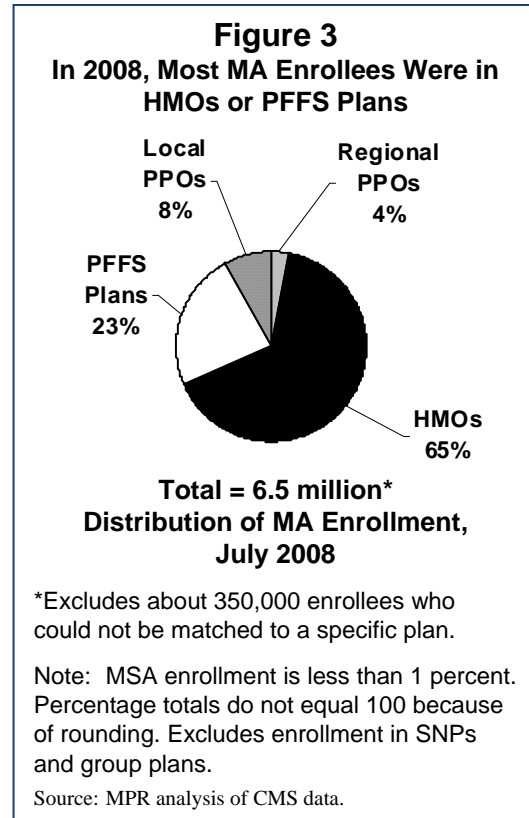
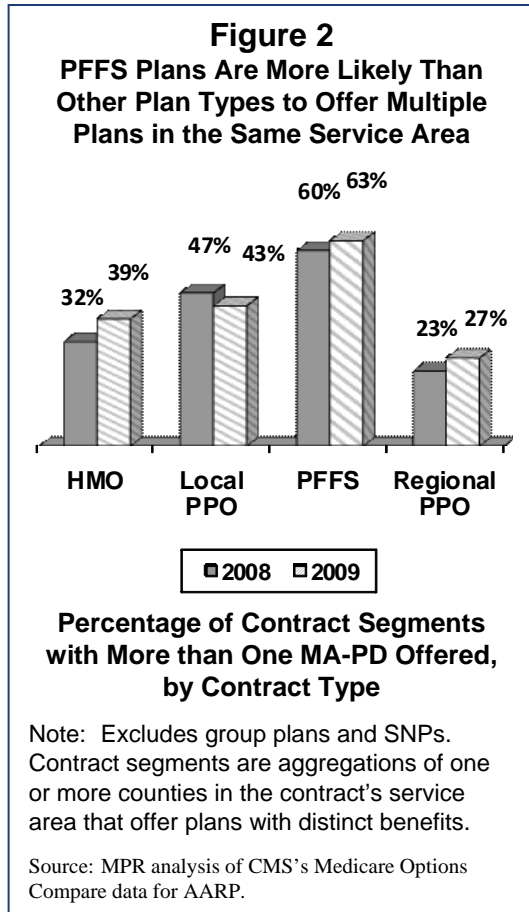
In 2008, 3,307 MA plans were available nationwide for individual enrollment, as well as an additional 769 SNPs for those who qualified. The average beneficiary could choose among 44 plans (other than SNPs), including 28 PFFS plans. At least 15 plans of any type were available in 99 percent of all counties.⁷

About two-thirds of available plans included prescription drugs (Part D benefits) in 2008 (MA-PDs); the rest were MA-only. PFFS plans, for which Part D coverage is optional, were the most diverse (figure 1). Part D coverage is not allowed for MSAs but is required



for SNPs. MA contracts often subdivide their service areas, with benefits varying across contract segments, usually defined by counties. Sometimes a contract offers only one MA-PD in a segment; but often there are more than one, with dual options particularly likely in PFFS plans (figure 2). What we call “lowest premium MA-PD” in this brief combines a single MA-PD plan offered under that contract in a segment and plans with the lowest premium when more than one MA-PD plan is offered under that contract in the same segment.

In mid-2008, 65 percent of individual MA enrollees (excluding those in SNPs) were in an HMO and 23 percent were in a PFFS plan (figure 3). All but 14 percent of enrollees were in an MA-PD; about 23 percent were in an MA-PD that had a higher premium than others offered in the area under that contract by the same sponsor (figure 4). Such enrollment in “other” MA-PD plans was particularly likely among those in local PPOs. The share of enrollment in MA-only plans was larger in PFFS plans than in any other plan type except for MSAs, which may not offer MA-PDs.

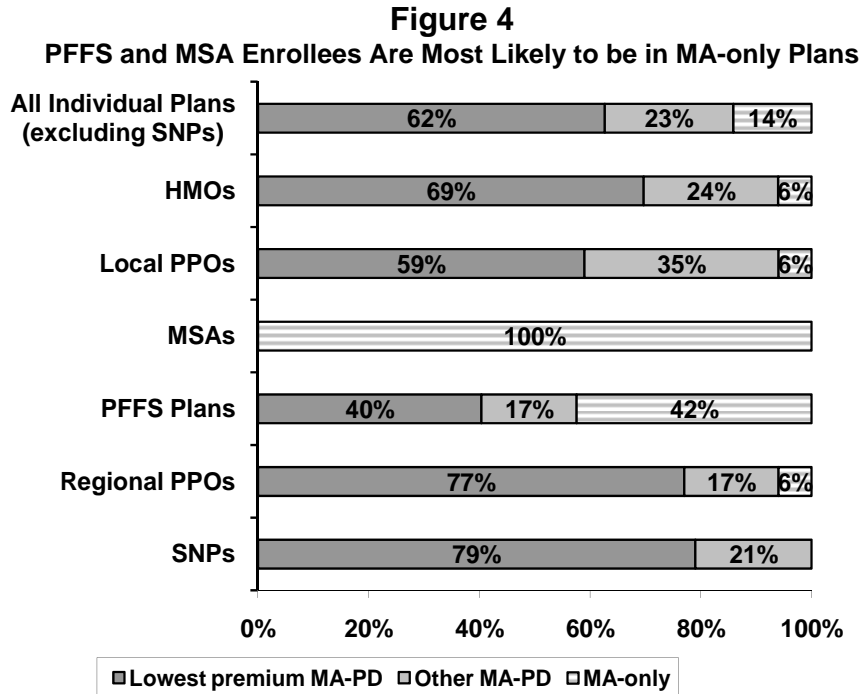


Availability Changes in 2009

In 2009, the number of MA plans available for individual enrollment has risen slightly—from 3,307 to 3,354. (SNPs have increased from 769 to 781 (see appendix table A-1)). However, fewer PFFS plans and MSAs are available for 2009, as more plans are withdrawing than entering. Because these plans tend to have large geographical service areas, plan departures disproportionately affect enrollees in these plan types. Our analysis shows that 353,180 of the 2008 individual MA enrollees were in non-SNP plans no longer available to them in 2009; another 14,003 enrollees in SNPs have been similarly affected (table 1). Withdrawals were concentrated disproportionately in PFFS plans, accounting for 66 percent of all affected

enrollees. Among 2008 PFFS plan enrollees, 15.5 percent had to choose a new plan in 2009. Other PFFS plans were likely available to these enrollees, since these plans are so prevalent. We do not know from these data whether enrollees affected by a withdrawal found another plan (PFFS or other type) with the same sponsor or had to switch companies.

In 2009, 453 PFFS plans (defined here in terms of contract segments) offered in 2008 by 30–40 sponsoring organizations will no longer be offered.⁸ Most of these plans have no or few enrollees: 233 plans have no enrollees, 108 have fewer than 100 enrollees, 80 have 100–999 enrollees, and only 32 have 1,000 enrollees or more. Three firms account for half of the affected PFFS enrollees: Sterling (94,303); Unicare, a WellPoint affiliate (48,971); and Wellcare (35,139). While withdrawals may have a disproportionate geographic impact on certain markets, beneficiaries in many parts of the United States are



Percentage of Enrollees by Contract and Plan Type, July 2008

Notes: Plans are defined by contract segment—the plans offered under a contract to beneficiaries in a unique set of counties within the service area. Excludes group plans.

MA-PD includes the Part D benefit. “Lowest premium MA-PDs” refers to the only or lowest premium MA-PD plan offered under a particular contract in a specific geographical segment. “Other MA-PDs” are additional plans (for higher premiums) offered, where available, in specific segments. “MA-only” plans are those without Part D offered in specific contract segments. In 2008, there were 3,307 non-SNP plans and 769 SNP plans.

Source: MPR analysis of CMS’s Medicare Options Compare data for AARP.

Table 1
PFFS Plans Account for Most of Those Affected by 2009 Withdrawals, But Most MSA Enrollees Had to Choose a New Plan in 2009

Contract Type	2008 MA Enrollment	2008 MA Enrollees in Plans Not Available in 2009	Percentage of MA Enrollees Affected Within Contract Type
All Plans (excluding SNPs)	6,463,601	353,180	5.5%
HMOs	4,230,799	79,413	1.9%
Local PPOs	528,317	22,378	4.2%
PFFS Plans	1,511,607	234,366	15.5%
MSAs	1,723	1,365	79.2%
Regional PPOs	191,155	15,658	8.2%
SNPs	929,888	14,003	1.5%

Note: Excludes group and SNP plans.

Source: MPR analysis of CMS’s Medicare Options Compare data for AARP.

A First Look at How Medicare Advantage Benefits and Premiums in Individual Enrollment Plans Are Changing from 2008 to 2009

likely to feel some effects. While few beneficiaries are in MSAs, Wellpoint and its Anthem affiliates created a national MSA market in 2008; their decision not to offer MSAs in 2009 has affected four out of every five MSA enrollees (table 1).

Under legislation enacted by Congress in 2008 that will be effective in 2010, PFFS plans will be required to have a provider network in most locations in the country and to submit additional information to CMS on quality and performance.⁹ In all likelihood, this will lead to more PFFS plans withdrawing in 2010 and additional disruption for beneficiaries.

Premiums, 2008–2009

In 2008, the average premium charged by MA-PDs was \$63 per month (appendix table A.2). Enrollees were more likely to select lower premium plans, so the average enrollee paid only \$46 per month, and more than half (54%) paid no premium beyond the Part B premium that all Medicare beneficiaries pay (table 2).¹⁰

Average HMO premiums were somewhat lower than those for other plan types, and premiums for enrollees in local PPOs were substantially higher than others (appendix tables A.3 and

A.4, respectively).

The average premium charged for an MA-PD increased to \$70 (up from \$63) in 2009 (appendix table A.2); the average premium in MA-PD plans continuing in 2009 is \$54, \$8 higher than in 2008, assuming no change in enrollment patterns (table 2). While HMO premiums are virtually unchanged in 2009, premiums paid by enrollees in PFFS plans are substantially higher in 2009 (\$81 versus \$46 in 2008), and they are much less likely to have no premium (9 percent versus 51 percent in 2008). Premiums in MA-only PFFS plans are increasing at a less rapid rate (appendix table A.7).

Part D (Prescription Drug) Benefits, 2008–2009

In both 2008 and 2009, almost all MA-PDs offered what CMS defines as an “enhanced Part D” benefit (appendix table A.2); this means that the actuarial value of the benefit is more than the standard Part D benefit. Ninety-four percent of MA-PD enrollees in both years have benefits that involve no Part D deductible; almost two-thirds have some coverage in the gap between regular and catastrophic coverage (appendix table A-2). Beneficiaries

Table 2				
MA-PD Premiums Vary by Plan Type				
Plan Type	Mean Premium		Percentage with Zero Premium	
	2008	2009^a	2008	2009^a
All MA-PDs	\$46	\$54	54%	49%
HMOs	\$42	\$43	58%	61%
Local PPOs	\$86	\$101	29%	18%
PFFS Plans	\$46	\$81	51%	9%
Regional PPOs	\$46	\$46	40%	44%

^a Assumes 2008 enrollment for plans offered in 2009.

Note: Statistics are enrollment weighted and exclude group and SNP plans.

Source: See appendix tables A.2– A.6.

Table 3
Estimated Annual Out-of-Pocket Costs for Hospital and Physician Services Differ by Plan Type and Enrollee Health Status

	All Enrollees ^a		Healthy Enrollees		Enrollees with Episodic Needs		Enrollees with Chronic Needs	
	2008	2009 ^b	2008	2009 ^b	2008	2009 ^b	2008	2009 ^b
All MA-PDs	\$413	\$421	\$100	\$129	\$842	\$815	\$2,010	\$1,927
HMOs	\$350	\$323	\$71	\$72	\$723	\$657	\$1,801	\$1,670
Local PPOs ^c	\$551	\$617	\$267	\$322	\$999	\$1,122	\$1,887	\$1,909
PFFS Plans	\$514	\$684	\$71	\$240	\$1,132	\$1,201	\$2,757	\$3,147
Regional PPOs ^c	\$928	\$945	\$438	\$418	\$1,638	\$1,903	\$3,359	\$3,150

Note: Statistics are enrollment weighted and exclude group and SNP plans.

^aAssumes 72 percent healthy, 19 percent with episodic needs, and 9 percent with chronic needs, which is equal to the distribution of community-residing beneficiaries in good, fair, and poor health.

^bAssumes July 2008 enrollment levels for plans offered in 2009.

^cAssumes use of in-network benefits.

Source: See appendix tables A.1–A.5. Uses assumptions of hospital and physician use based on HealthMetrix.

appear to value gap coverage—only 48 percent of plans offered such coverage in 2008, but 63 percent of MA-PD enrollees were in such a plan. The Medicare Payment Advisory Commission found that MA gap coverage typically is limited to generics rather than brand-name drugs and may only cover a subset of generic drugs.¹¹

Cost Sharing for Physician and Hospital Services, 2008–2009

Beneficiaries in traditional Medicare typically pay 20 percent coinsurance for each Part B service, as well as a deductible for each hospital admission; MA, in contrast, usually structures cost sharing around fixed dollar copayments. These copayments have the advantage of being more transparent and predictable for enrollees; however, the amount charged has increased over time and may be more or less than the amount generated through coinsurance.

The average copayment for a primary care visit in 2008 was \$10; it remains the same in 2009 (appendix table A.2). Specialist copayments are about twice as high: \$21 in 2008 and \$22 in 2009. Ninety percent of all MA-PDs also require cost sharing for hospital services. The majority of MA-PDs incorporate some limit on out-of-pocket expenses associated with such care, although 46 percent of enrollees in 2008 were in plans with no limit. Only 13 percent were in plans with a limit of \$2,500 or less annually. We do not see the sharp distinctions in the characteristics of cost sharing between unweighted estimates and enrollee weighted estimates that we do in premiums and gap coverage. This may mean that beneficiaries are relatively unaware of these plan features, do not value them very highly, or find the differences across plans less important than their similarities.

Cost sharing for Parts A and B services in MA can be relatively high, however,

especially if a person needs considerable care. Using HealthMetrix assumptions on the use of physician and hospital services for MA enrollees in different health status categories, we calculated that the annual cost sharing for these services among enrollees in MA-PD plans was \$413 in 2008 and \$421 in 2009, assuming 2008 enrollment patterns (table 3). Average annual out-of-pocket cost sharing for these services per enrollee was lowest in HMOs (\$350 in 2008), even though only 58 percent of 2008 HMO MA-PD enrollees were in plans with no limit on out-of-pocket costs (51 percent in 2009; appendix table A.3). Average out-of-pocket costs per enrollee were highest in regional PPOs (\$928 in 2008, \$945 in 2009; appendix table A.5).

Across plan types, the average estimated out-of-pocket costs in 2008 for sicker people ranged from \$723 to \$1,638 for those with episodic needs and from \$1,801 to \$3,359 for those with chronic needs (table 3). For healthy enrollees, HMO and PFFS plan enrollees were about equal in likely enrollee cost sharing in 2008, but the difference in cost sharing between relatively healthy and other enrollees was much smaller for HMOs than for all other plan types. With the altered mix of PFFS plans in 2009, out-of-pocket costs for the average enrollee who continues in a plan from 2008 is higher in 2009 and no longer on a par, at least on average, with HMOs.

Conclusion

Our analysis of MA plans in 2008 and 2009 highlights their number and diversity, which make support critical to beneficiaries who are asked to choose among them. While MA provides beneficiaries with many choices, the coverage they receive will vary substantially depending on the plan they choose and their health status. In addition, some enrollees will have to revisit their choices annually because

their current plan is not available for the upcoming year. (In fact, all enrollees may find some benefit in doing so, because the options change.) Such a review can be demanding, however, given the large number of plans. The burden on beneficiaries is increased because the kind of withdrawals experienced in 2009 (which required enrollees to change plans) are inherent in competitive markets; in addition, instability is greater in new plans and associated with pricing that is statutorily determined and unpredictable over time.¹² CMS may want to do more to make beneficiaries aware of these sources of instability, to help them make choices.

Because MA expansion occurred simultaneously with the introduction of Part D, beneficiary support has emphasized encouraging beneficiaries to consider how their choices will affect their premiums and out-of-pocket spending for prescription drugs. Beneficiaries are encouraged, for example, to list all their drugs and use an online calculator to determine which prescription drug coverage is their best buy. However, while such strategies deal with Part D costs, they do not deal with out-of-pocket costs for other Medicare benefits.¹³

Cost sharing in Parts A and B is extensive, so which MA plan a beneficiary chooses can have a significant effect on overall out-of-pocket health spending. Such considerations are especially important if beneficiaries have conditions that require them to use health services extensively. In a companion report also available at aarp.org, we look at variations in the way MA plans supplement Medicare benefits—and fill in Medicare Parts A and Part B cost sharing—to determine how easy it is for beneficiaries to weigh their choices and what they can expect from MA as a supplement to traditional Medicare Part A and Part B benefits.

A First Look at How Medicare Advantage Benefits and Premiums in Individual Enrollment Plans Are Changing from 2008 to 2009

APPENDIX

Table A.1 Number of MA Plans, By Type of Contract, 2008–2009 (Excludes group plans)												
	MA-PD											
	All MA		All		Lowest Premium		Other		MA-Only			
	2008	2009	2008	2009	2008	2009	2008	2009	2008	2009	2008	2009
All Non-SNPs	3,307	3,354	2,232	2,346	1,386	1,464	846	882	1,075	1,008		
HMOs	1,517	1,730	1,138	1,305	768	837	370	468	379	425		
L-PPOs	462	548	384	453	238	287	146	166	78	95		
MSAs	14	9	0	0	0	0	0	0	14	9		
PFFS Plans	1,271	1,016	676	555	354	314	322	241	595	461		
R-PPOs	43	51	34	33	26	26	8	7	9	18		
SNPs	769	781	769	781	526	528	243	253	0	0		

Note: Plans are defined by contract segment and are those offered under a contract to beneficiaries in a unique set of counties within the service area. “Lowest premium” refers to the only or lowest premium plan offered under a particular contract in a specific geographical segment. “Other” MA-PDs are additional plans (for higher premiums) offered, where available, in specific segments. “MA-only” plans are those without Part D offered in specific contract segments.

Source: MPR analysis of CMS Medicare Options Compare data.

A First Look at How Medicare Advantage Benefits and Premiums in Individual Enrollment Plans
Are Changing from 2008 to 2009

Table A.2				
Profile of Benefits and Premiums, All MA-PD Plans, 2008–2009				
(SNPs and group plans excluded)				
Characteristics	Weighted^a		Unweighted	
	2008	2009	2008	2009
Premiums				
Total Premium (Mean for Parts C and D)	\$46	\$54	\$63	\$70
Percentage with Zero Premium	54%	49%	36%	36%
Percentage with Reduced Part B Premium	2%	2%	7%	5%
Part D				
Part D Premium (Mean)	\$12	\$15	\$18	\$20
Enhanced Part D (Percentage)	93%	95%	89%	87%
Has Some Gap Coverage (Percentage)	63%	68%	48%	50%
Has No Rx Deductible (Percentage)	94%	94%	87%	88%
Cost Sharing				
Primary Care Copay (Mean)	\$10	\$10	\$11	\$10
Specialist Copay (Mean)	\$21	\$22	\$23	\$23
Percent with Inpatient Hospital Cost Sharing	90%	90%	90%	90%
Limits on Out-of-Pocket				
Mean Maximum Out-of-Pocket Limit	\$3,624	\$5,428	\$3,487	\$5,382
No Maximum Limit	46%	39%	34%	30%
≤\$1,000	2	1	1	1
\$1,001 – \$2,500	11	9	12	14
\$2,501 – \$4,000	27	35	39	40
\$4,001 – \$5,000	13	5	11	8
More than \$5,000	2	11	2	7
Average Estimated Hospital and Physician Cost Sharing^b				
All Enrollees	\$413	\$421	\$454	\$460
Healthy Enrollees	\$100	\$129	\$149	\$168
Enrollees with Episodic Needs	\$842	\$815	\$878	\$849
Enrollees with Chronic Needs	\$2,010	\$1,927	\$2,000	\$1,982
Enrollment/Contract Segments	5,533,795	5,460,421	2,232	2,346

^a Weighted numbers for both 2008 and 2009 use enrollment from July 2008 at the contract-plan-county level. The 2009 numbers do not reflect 2009 changes in enrollment.

^b Based on HealthMetrix assumptions as to how many hospital and physician services are used by those in the three health status groups, applied to the plan's cost sharing. The "All enrollees" row is a standardized mix of about 72 percent healthy, 19 percent with episodic needs, and 9 percent with chronic needs based on community residents in the Medicare Current Beneficiary Survey (MCBS).

Source: MPR analysis for AARP's Public Policy Institute from files created from CMS's Medicare Options Compare. (Total enrollment excludes 929,806 in MA-only plans and 929,888 in SNPs in 2008, as well as group enrollees and enrollees unable to be matched to a plan in a specific county.)

A First Look at How Medicare Advantage Benefits and Premiums in Individual Enrollment Plans
Are Changing from 2008 to 2009

Table A.3
Profile of Benefits and Premiums, All MA-PD HMO Plans, 2008–2009
(SNPs and group plans excluded)

Characteristics	Weighted ^a		Unweighted	
	2008	2009	2008	2009
Premiums				
Total Premium (Mean for Parts C and D)	\$42	\$43	\$49	\$52
Percentage with Zero Premium	58%	61%	51%	51%
Percentage with Reduced Part B Premium	2%	3%	10%	7%
Part D				
Part D Premium (Mean)	\$10	\$11	\$13	\$15
Enhanced Part D (Percentage)	93%	96%	88%	89%
Has Some Gap Coverage (Percentage)	58%	65%	49%	51%
Has No Rx Deductible (Percentage)	95%	95%	88%	89%
Cost Sharing				
Primary Care Copay (Mean)	\$9	\$8	\$8	\$8
Specialist Copay (Mean)	\$20	\$20	\$21	\$20
Percent with Inpatient Hospital Cost Sharing	90%	87%	85%	85%
Limits on Out-of-Pocket				
Mean Maximum Out-of-Pocket Limit	\$3,163	\$5,966	\$3,057	\$7,264
No Maximum Limit	58%	51%	55%	45%
≤\$1,000	2	1	1	1
\$1,001 – \$2,500	9	8	13	11
\$2,501 – \$4,000	28	38	26	39
\$4,001 – \$5,000	2	2	3	3
More than \$5,000	1	0	1	0
Average Estimated Hospital and Physician Cost Sharing ^b				
All Enrollees	\$350	\$323	\$384	\$334
Healthy Enrollees	\$71	\$72	\$124	\$84
Enrollees with Episodic Needs	\$723	\$657	\$734	\$670
Enrollees with Chronic Needs	\$1,801	\$1,627	\$1,732	\$1,638
Enrollment/Contract Segments	3,988,270	4,017,001	1,138	1,305

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

^b Based on HealthMetrix assumptions regarding how many hospital and physician services are used by those in the three health status groups, applied to the plan's cost sharing. The "All enrollees" row is a standardized mix of about 72 percent healthy, 19 percent with episodic needs, and 9 percent with chronic needs, based on community residents in the MCBS.

Source: analysis for AARP's Public Policy Institute from files created from CMS's Medicare Options Compare e.

A First Look at How Medicare Advantage Benefits and Premiums in Individual Enrollment Plans
Are Changing from 2008 to 2009

Table A.4
Profile of Benefits and Premiums, All MA-PD Local PPO Plans, 2008–2009
(SNPs and group plans excluded)

Characteristics	Weighted ^a		Unweighted	
	2008	2009	2008	2009
Premiums				
Total Premium (Mean for Parts C and D)	\$86	\$101	\$88	\$91
Percentage with Zero Premium	29%	18%	22%	19%
Percentage with Reduced Part B Premium	8%	1%	4%	2%
Part D				
Part D Premium (Mean)	\$23	\$29	\$25	\$28
Enhanced Part D (Percentage)	84%	84%	86%	85%
Has Some Gap Coverage (Percentage)	61%	60%	53%	53%
Has No Rx Deductible (Percentage)	86%	85%	84%	83%
Cost Sharing^b				
Primary Care Copay (Mean)	\$8	\$10	\$11	\$11
Specialist Copay (Mean)	\$18	\$19	\$22	\$22
Percent with Inpatient Hospital Cost Sharing	97%	97%	95%	98%
Limits on Out-of-Pocket				
Mean Maximum Out-of-Pocket Limit	\$3,258	\$3,081	\$3,799	\$3,400
No Maximum Limit	11%	17%	15%	20%
≤\$1,000	1%	0	1%	2%
\$1,001 – \$2,500	39%	37%	15%	24%
\$2,501 – \$4,000	30%	27%	43%	39%
\$4,001 – \$5,000	15%	14%	21%	11%
More than \$5,000	3%	3%	6%	4%
Average Estimated Hospital and Physician Cost Sharing^c				
All Enrollees	\$551	\$617	\$612	\$598
Healthy Enrollees	\$267	\$322	\$332	\$303
Enrollees with Episodic Needs	\$999	\$1,122	\$1,016	\$1,058
Enrollees with Chronic Needs	\$1,887	\$1,909	\$2,000	\$1,999
Enrollment/Contract Segments	496,187	449,793	384	453

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

^b Applies to in-network benefits

^c Based on HealthMetrix assumptions regarding how many hospital and physician services are used by those in the three health status groups, applied to the plan's cost sharing. The "All enrollees" row is a standardized mix of about 72 percent healthy, 19 percent with episodic needs, and 9 percent with chronic needs, based on community residents in the MCBS.

Source: analysis for AARP's Public Policy Institute from files created from CMS's Medicare Options Compare .

A First Look at How Medicare Advantage Benefits and Premiums in Individual Enrollment Plans
Are Changing from 2008 to 2009

Table A.5
Profile of Benefits and Premiums, MA-PD Regional PPO Plans, 2008–2009
(SNPs and group plans excluded)

Characteristics	Weighted ^a		Unweighted	
	2008	2009	2008	2009
Premiums				
Total Premium (Mean for Parts C and D)	\$46	\$46	\$84	\$83
Percentage with Zero Parts C and D Premium	40%	44%	15%	18%
Percentage with Reduced Part B Premium	0%	0%	0%	0%
Part D				
Part D Premium (Mean)	\$11	\$17	\$21	\$27
Enhanced Part D (Percentage)	90%	89%	88%	82%
Has Some Gap Coverage (Percentage)	60%	59%	68%	64%
Has No Rx Deductible (Percentage)	90%	89%	88%	82%
Cost Sharing ^b				
Primary Care Copay (Mean)	\$10	\$14	\$11	\$14
Specialist Copay (Mean)	\$22	\$29	\$25	\$32
Percent with Inpatient Hospital Cost Sharing	100%	100%	100%	100%
Limits on Out-of-Pocket				
Mean Maximum Out-of-Pocket Limit	\$5,311	\$5,831	\$5,385	\$6,811
No Maximum Limit ≤\$1,000	0%	0%	0%	0%
\$1,001 – \$2,500	0%	0%	3%	0%
\$2,501 – \$4,000	30%	43%	21%	18%
\$4,001 – \$5,000	33%	7%	47%	9%
More than \$5,000	37%	51%	29%	73%
Average Estimated Hospital and Physician Cost Sharing ^c				
All Enrollees	\$928	\$945	\$823	\$935
Healthy Enrollees	\$438	\$418	\$410	\$400
Enrollees with Episodic Needs	\$1,638	\$1,903	\$1,447	\$1,769
Enrollees with Chronic Needs	\$3,359	\$3,150	\$2,825	\$3,458
Enrollment/Contract Segments	179,509	163,851	34	33

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

^b Applies to in-network benefits.

^c Based on HealthMetrix assumptions regarding how many hospital and physician services are used by those in the three health status groups, applied to the plan's cost sharing. The "All enrollees" row is a standardized mix of about 72 percent healthy, 19 percent with episodic needs, and 9 percent with chronic needs, based on community residents in the MCBS.

Source: analysis for AARP's Public Policy Institute from files created from CMS's Medicare Options Compare .

A First Look at How Medicare Advantage Benefits and Premiums in Individual Enrollment Plans
Are Changing from 2008 to 2009

Table A.6
Profile of Benefits and Premiums, MA-PD PFFs Plans, 2008–2009
(SNPs and group plans excluded)

Characteristics	Weighted ^a		Unweighted	
	2008	2009	2008	2009
Premiums				
Total Premium (Mean for Parts C and D)	\$46	\$81	\$71	\$95
Percentage with Zero Parts C and D Premium	51%	9%	19%	14%
Percentage with Reduced Part B Premium	0%	2%	5%	1%
Part D				
Part D Premium (Mean)	\$15	\$27	\$21	\$26
Enhanced Part D (Percentage)	98%	98%	93%	85%
Has Some Gap Coverage (Percentage)	84%	85%	43%	45%
Has No Rx Deductible (Percentage)	97%	99%	85%	92%
Cost Sharing				
Primary Care Copay (Mean)	\$14	\$15	\$15	\$15
Specialist Copay (Mean)	\$27	\$29	\$27	\$28
Percent with Inpatient Hospital Cost Sharing	88%	99%	94%	97%
Limits on Out-of-Pocket				
Mean Maximum Out-of-Pocket Limit	\$4,527	\$5,119	\$3,577	\$4,088
No Maximum Limit	20%	0%	11%	5%
≤\$1,000	0%	0%	1%	1%
\$1,001 – \$2,500	5%	4%	10%	12%
\$2,501 – \$4,000	18%	23%	60%	45%
\$4,001 – \$5,000	57%	17%	18%	16%
More than \$5,000	0%	57%	0%	21%
Average Estimated Hospital and Physician Cost Sharing ^b				
All Enrollees	\$514	\$684	\$462	\$614
Healthy Enrollees	\$71	\$240	\$74	\$241
Enrollees with Episodic Needs	\$1,132	\$1,201	\$1,012	\$1045
Enrollees with Chronic Needs	\$2,757	\$3,147	\$2,410	\$2,689
Enrollment/Contract Segments	869,829	829,776	676	555

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

^b Based on HealthMetrix assumptions regarding how many hospital and physician services are used by those in the three health status groups, applied to the plan's cost sharing. The "All enrollees" row is a standardized mix of about 72 percent healthy, 19 percent with episodic needs, and 9 percent with chronic needs, based on community residents in the MCBS.

Source: analysis for AARP's Public Policy Institute from files created from CMS's Medicare Options Compare .

A First Look at How Medicare Advantage Benefits and Premiums in Individual Enrollment Plans
Are Changing from 2008 to 2009

Table A.7				
Profile of benefits and premiums, MA-only PFFs plans, 2008–2009				
(SNPs and group plans excluded)				
Characteristics	Weighted^a		Unweighted	
	2008	2009	2008	2009
Premiums				
Total Premium (Mean for Parts C and D)	\$16	\$18	\$22	\$37
Percentage with Zero Premium	60%	72%	58%	40%
Percentage with Reduced Part B Premium	1%	1%	16%	3%
Cost Sharing				
Primary Care Copay (Mean)	\$11	\$12	\$13	\$13
Specialist Copay (Mean)	\$21	\$23	\$25	\$24
Percent with Inpatient Hospital Cost Sharing	92%	99%	91%	96%
Limits on Out-of-Pocket				
Mean Maximum Out-of-Pocket Limit	\$2,670	\$3,087	\$3,116	\$3,146
No Maximum Limit	38%	5%	20%	12%
≤\$1,000	7%	1%	2%	1%
\$1,001 – \$2,500	21%	34%	16%	24%
\$2,501 – \$4,000	33%	60%	58%	59%
\$4,001 – \$5,000	1%	0%	3%	4%
More than \$5,000	0%	0%	0%	0%
Average Estimated Hospital and Physician Cost Sharing ^b				
All Enrollees	\$329	\$531	\$418	\$541
Healthy Enrollees	\$76	\$236	\$93	\$246
Enrollees with Episodic Needs	\$699	\$904	\$884	\$881
Enrollees with Chronic Needs	\$1,574	\$2,105	\$2,033	\$2,187
Enrollment/Contract Segments	641,778	475,184	595	461

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

^b Based on HealthMetrix assumptions regarding how many hospital and physician services are used by those in the three health status groups, applied to the plan's cost sharing. The "All enrollees" row is a standardized mix of about 72 percent healthy, 19 percent with episodic needs, and 9 percent with chronic needs, based on community residents in the MCBS.

Source: analysis for AARP's Public Policy Institute from files created from CMS's Medicare Options Compare .

Endnotes

¹ Enrollment in MSAs was very low in 2008 (see figure 3), and their benefits are unique; therefore, we exclude them from most analyses in this brief.

² Such premiums are in addition to the standard Part B premium paid by all beneficiaries. The low level of MA premiums reflects, in part, Medicare payment levels that exceed those in the traditional program. (See C. Zarabozo and S. Harrison, "Payment Policy and the Growth of Medicare Advantage," *Health Affairs*, Web Exclusive, November 24, 2008) Available at www.healthaffairs.org.

³ Marsha Gold, "Medicare's Private Plans: A Report Card on Medicare Advantage," *Health Affairs*, Web Exclusive, November 24, 2008 Available at www.healthaffairs.org.

⁴ CMS's monthly summary report on Medicare Advantage cost, Program for All Inclusive Care for Elderly (PACE), demonstration, and prescription drug plan contracts, July 2008. MA plans are specifically authorized by the Medicare Modernization Act of 2003 (MMA) and include local coordinated care plans (primarily HMOs and PPOs), PFFS plans, regional PPOs, and MSAs, along with SNPs that coordinated care contracts may offer. The total enrollment figure also includes a small number of enrollees in other plans that beneficiaries may find indistinguishable from MA plans. These plans include cost, Health Care Prepayment Plan (HCPP), PACE, and various demonstration plans.

⁵ For additional details on SNPs, see James Verdier, Marsha Gold, and Sarah Davis, *Do We Know If Medicare Advantage Special Needs Plans Are Special?* Kaiser Family Foundation, Washington, DC, January 2008; and Marsha Gold, Maria Cupples Hudson, and Sarah Davis, *2006 Medicare Advantage Benefits and Premiums*, Report # 2006-23, AARP Public Policy Institute, Washington, DC, November 2006.

⁶ To support our analysis, we matched plan IDs and county codes to link county-based plan enrollment and the service areas of specific plans. Some of these codes could not be matched to data in the Medicare Options Compare. The total enrollment in the data set we developed is less than that reported for individual enrollment in CMS's monthly aggregate report. We assume that these discrepancies occur because of privacy concerns, CMS does not report enrollment at the plan-county level if a plan has fewer than 10 enrollees.

⁷ Marsha Gold, "Medicare's Private Plans: A Report Card on Medicare Advantage," *Health Affairs*, Web Exclusive, November 24, 2008 Available at www.healthaffairs.org.

⁸ The Medicare Options Compare lists 38 organizational names; a few have joint ownership (e.g., Unicare, Blue Cross of California, and Empire Blue Cross-Blue Shield).

⁹ These provisions are in the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008.

¹⁰ This is the combined premium charged for Parts C and D after rebates, and is in addition to the regular premium all Medicare beneficiaries pay for Part B coverage.

¹¹ Medicare Payment Advisory Commission, "Chapter 4: Part D Enrollment, Benefit Offerings and Plan Payments," in *Report to Congress: Medicare Payment Policy*, Washington, DC, March 2008, pp. 277–304.

¹² For previous analysis of Medicare+Choice, see, for example, Marsha Gold, Beth Stevens, Lori Achman and Jessica Mittler. *Monitoring Medicare+Choice: What Have We Learned: Findings and Operational Lessons for Medicare Advantage*, Mathematica Policy Research, Washington, DC, August 2004.

¹³ Using estimates from the 2003–2004 Medicare Current Beneficiary Survey, the Medicare Options Compare provides estimates of the aggregate of these costs for a person in his or her age and health status group, but these estimates have important limitations. The way data are reported also makes it hard to compare out-of-pocket spending for MA with the traditional Medicare that beneficiaries are likely to purchase with a PDP or Medigap plan. (The estimates of out-of-pocket costs do not reflect prescription drug coverage unless it is integrated with the Medicare A/B plan, according to notes embedded in the Medicare Options Compare.)

Insight on the Issues 25, March 2009

AARP Public Policy Institute, 601 E Street, NW, Washington, DC 20049.

www.aarp.org/ppi.

202-434-3890, ppi@aarp.org

© 2009, AARP.

Reprinting with permission only.