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2006 Medicare Advantage Benefits and Premiums

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Foreword

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) substantially changed the Medicare program by adding a prescription drug benefit and expanding the role of private health plans. The year 2006 was the first year of full implementation of many of the important changes enacted in the MMA. This issue paper offers an analysis of the benefits and premiums of Medicare Advantage (MA) plans. Although several features of the prescription drug offerings of these plans are presented, it is beyond the scope of the study to assess the prescription drug benefit in detail.

In establishing the MA program, Congress sought to contain growth in Medicare spending, improve the payment approach for private health plans, and provide people on Medicare, particularly those living in rural areas, with more choices as well as enhanced benefits.

Marsha Gold, principal investigator, and her colleagues from Mathematica Policy Research, Inc., have drawn on their extensive expertise in analyzing the public databases available through the Centers for Medicare and Medicaid Services to describe the changes that have occurred in plan offerings by plan type. In addition, they estimate the degree of exposure to out-of-pocket costs Medicare beneficiaries are likely to have by plan type. Finally, the authors give special attention to the offerings of a particular model of MA, the Special Needs Plan, that was authorized to address the unique needs of people with multiple chronic conditions, dual eligibles, and those who live in long-term care facilities.

Private health plans in the Medicare program pose both opportunities and challenges for the program and its beneficiaries. On one hand, having a wide array of private health plan options enhances the likelihood that beneficiaries will find coverage options that meet their needs and preferences. On the other hand, having more choices complicates the selection process and may potentially confuse those facing a wide array of plans. Although multiple components of the MA program (e.g., MA plan payments) must be considered to fully evaluate its value to the Medicare program, this study provides a rich data source on MA premiums and benefits for 2006 that must inform any program assessment.

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PURPOSE

Under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), beneficiaries seeking to take advantage of the new Medicare prescription drug coverage in 2006 can enroll either in a free-standing private prescription drug plan (PDP) or in a private Medicare Advantage (MA) plan that integrates prescription drug coverage with Medicare's historical benefits and supplemental services. Under previous contracts from AARP's Public Policy Institute (2004–2005) and The Commonwealth Fund (1999–2003), Mathematica Policy Research, Inc. (MPR) has analyzed trends in MA benefits and premiums. In this report, we expand on this work by analyzing in more detail how premiums and benefits are structured in MA plans in 2006. This report describes the analysis and documents the findings.

The report addresses four questions:

1. With the introduction of the Medicare drug benefit, how different are MA premiums and benefits in 2006 from what they were before the drug benefit?
2. How do premiums and benefits vary by type of MA plan in 2006, and what range of plans is offered to beneficiaries?
3. How much financial risk or protection are beneficiaries assuming or buying if they enroll in the newer, less managed MA plans—that is, regional and local preferred provider organizations (PPOs) and private fee-for-service (PFFS) plans—and how does that degree of risk or protection compare with traditional Medicare alone or with the most common Medigap supplements?
4. How does coverage in special needs plans (SNPs) compare with generally available coverage for beneficiaries, especially in the same market?

BACKGROUND

Although the number of beneficiaries in Medicare has been relatively stable (albeit with some growth) over time, MA enrollment has fluctuated greatly, as MA's predecessor programs expanded rapidly in the mid- to late 1990s only to be followed by fewer options and less generous benefit packages under Medicare+Choice from 1999 to 2003 (Gold et al. 2004; Gold and Achman 2001; Achman and Gold 2002, 2003). The MMA helped to reverse these trends and prepare the market for 2006 (when both the new drug benefit and additional private plans would be available) by authorizing the Centers for Medicare and Medicaid Services (CMS) to make changes in MA policy that led to more generous payments to plans in 2004 and 2005. The approach was successful—both in stabilizing the market and in prompting an expansion, albeit a modest one, in MA plans and benefits (Gold 2005; Achman and Gold 2004; Achman and Harris 2005).

In 2006, Medicare beneficiaries have an expanded set of MA options. As in the past, beneficiaries can enroll in a health maintenance organization (HMO), PPO, or PFFS plan. Service areas for these plans are based on aggregates of counties and are thus considered "local plans." Starting in 2006, beneficiaries can also enroll in new regional PPO plans, which serve large areas (i.e., a region) defined by CMS to include one or more states. CMS defined 26 regions for this purpose. Regional PPOs must offer the same plan (with the same benefits and premiums) across the entire region. The MMA also authorized SNPs, which can restrict enrollment to subgroups of beneficiaries, including people eligible for Medicare and Medicaid ("dual eligibles"), institutionalized beneficiaries, and beneficiaries with severe or disabling chronic conditions.

To encourage firms to participate in MA, the MMA also modified the methods used to set monthly risk-based payment levels. As of March 2004, the MMA guaranteed that payments to local plans in each county would be at least 100 percent of what the traditional Medicare program pays for beneficiaries residing in that county. The MMA also modified the minimum annual increase so that plans received either a 2 percent increase (the previous policy) or the national growth percentage (6.3 percent in 2004, 6.6 percent in 2005, and 5.5 percent in 2006). The MMA also kept intact prior payment policies that set (and annually update) minimum MA payment levels for urban and rural counties. The MA sector as a whole also is protected from declining rates as risk adjustment is phased in, although such protections will begin to be phased out in 2007. Under the MMA, plan payments defined through these policies serve as benchmarks for assessing firm bids.

According to the Medicare Payment Advisory Commission (MedPAC 2006a), the combined effects of new and existing payment policies mean that in 2006, payments to MA plans are, on average, 111 percent higher than are Medicare payments for Part A and Part B benefits in the traditional Medicare program. The MA benchmarks (used to establish beneficiary premiums) are actually 115 percent higher but, under the MMA, Medicare keeps 25 percent of any savings. In 2006, MA sponsors that can cover Part A and Part B services for less than the CMS benchmark amount must use 75 percent of the difference to enhance benefits or reduce premiums in their MA plan. (The other 25 percent is returned to the government.) In 2006, 95 percent of plan bids were below the benchmark (MedPAC 2006b). Plan savings can be attributed to both overpayments and potential plan efficiency. Of the total premium dollars available, MedPAC estimates that 65 percent was used to reduce cost sharing for Medicare Part A and Part B services, 15 percent was used to lower premiums for Part B (4 percent) or Part D (11 percent), and 19 percent was used to enhance benefits (5 percent for Part D benefits and 14 percent for benefits Medicare does not cover, such as dental or vision care).[1]

METHODS

The analysis described in this report is based on a data file created by MPR from public data in the CMS Medicare Personal Plan Finder and from other sources. For the most part, we analyzed MA plans that include the prescription drug benefit (MA-PDs) because almost all offerors are required to make at least one of these plans available (and many offer more).

[1] Figures don't add to 100 percent because of rounding.

Further, most Medicare beneficiaries enrolled in MA are in MA-PDs. According to CMS, about 7.4 million beneficiaries were enrolled in MA in August 2006, with 6.4 million in MA-PD and about 1.0 million in MA plans without drug coverage ("MA-only" plans).

In previous years, the analysis focused on "basic plans"—the lowest-premium plan offered under a specific Medicare contract in a given geographical area by that firm. Contracts typically are specific to a type of plan (e.g., HMO). In this analysis, we continue to focus on the lowest-premium plan offered under a contract to assess trends and make basic comparisons across types of plans. Because the new drug benefit has encouraged beneficiaries to consider the full range of choices, we also expanded this analysis to provide a more comprehensive profile of all the plans available to beneficiaries, not just the lowest-premium ones of each type offered under contract. For example, the expanded analysis provides information on the share of all plans of each type that provide gap coverage for the Medicare drug benefit; this information is important because such coverage is more likely to be included in higher premium plans than in the lowest-premium plan a sponsor offers.

In contrast to previous years, most statistics in the current analysis are not weighted for MA enrollment because as of the end of June 2006, when this report was being prepared, CMS had not yet released 2006 data on MA enrollment at the individual contract and county level.[2] We prefer statistics that are weighted by plan enrollment because they reflect the coverage that beneficiaries actually have as opposed to the coverage that is available. However, to provide some sense of trends, we used December 2005 enrollment data (the latest that was available) to compare basic characteristics of MA benefits and premiums in 2006 with those in prior years. The trend analysis compares offerings in the lowest-premium MA-PD to basic plans offered in previous years, as the two are defined in relatively the same way. Using the December 2005 enrollment data could overstate the generosity of MA in 2006 if many beneficiaries have enrolled in offerings that are new as of 2006. The overstatement is because many of these new offerings are non-HMO products that, on average, have higher premiums and less extensive benefits (Gold 2006a; 2006c).

FINDINGS

1. With the introduction of the Medicare drug benefit, how different are MA premiums and benefits in 2006 from what they were in the past?

Our analysis of enrollment-weighted lowest-premium MA-PDs in 2006 indicates that average total premiums for MA-PD plans in 2006 are $26 per month, just $4 per month higher than in 2005. The average 2006 premium is substantially higher than it was in the period of rapid growth in 1999 (when it averaged $6 per month), but it is also below its high in 2003 ($37 per month), when MA enrollment was declining. About $9 of the $26 per month premium has gone to supplement federal payments for the new prescription drug benefit. Although some plans

[2] On July 26, 2006, CMS released an Annual Report by Plan that includes enrollment information at the plan level. However, the data are not in the same form as previously provided. We have not updated the analysis with these data because the data were so late in becoming available and involved a different file structure than CMS has historically made available. (Our analysis file was created from the Personal Plan Finder and involved segmented contract data that could take advantage of CMS's historical reports of county-based enrollment.) With limited resources and time, we did not want to delay the publication of this analysis.

covered prescription drugs in the past, the new benefit is substantially better than the average 2005 drug benefit. (In that year, 26 percent of plans provided no drug coverage, 39 percent covered generic drugs only, and 36 percent provided some coverage for brand-name drugs; more than half of those with brand name coverage had a limit of $1,000 per year or more.) We also found a positive relationship between the level of drug coverage a plan provided in 2005 and what it provided in 2006—a fact probably not surprising because both 2005 and 2006 coverage levels are affected by MA payment rates. These rates vary geographically and are correlated over time.

For MA enrollees, the trade-off for low premiums and enhanced drug coverage is higher out-of-pocket costs for hospital and physician cost services in 2006 compared with 2005. Although cost sharing for primary care visits in 2006 is similar to what it was in 2005, copayments for specialty visits have risen modestly in 2006, and substantially more enrollees are required to share at least some of the costs for hospital inpatient and ancillary services.

These changes may not necessarily increase out-of-pocket costs for beneficiaries, at least as analyzed by the methods used here. In 2006, the average enrollee pays an estimated $275 per year out-of-pocket for physician and hospital cost sharing. Enrollees in good health pay less out-of-pocket for physician and hospital cost sharing in 2006 than they did in 2005 ($73 versus $166), as do those in fair health ($726 versus $175). Out-of-pocket costs for those in poor health remain about the same ($1,706 in 2006 versus $1,698 in 2005).

Overall out-of-pocket spending for beneficiaries reflects the amount they pay in premiums and in out-of-pocket spending for all medical services. We were unable to repeat analyses of these costs developed in prior years because estimating out-of-pocket spending for prescription drugs has become more complex as a result of the structure of the Medicare prescription drug benefit under the MMA. Medicare coverage, combined with the catastrophic limit, should reduce average beneficiary out-of-pocket spending both overall and for prescription drugs in 2006 relative to 2005. However, the effect on out-of-pocket costs for particular beneficiaries will vary with their needs and the way in which plans use savings available from Part A and Part B benefits.

2. How Do Premiums and Benefits Vary by Type of Plan in 2006, and What Is the Range of Plans Available?

Premiums. As we have defined them, lowest-premium plans (previously "basic plans") provide a profile of the distribution of types of plans that are offered by diverse sponsors. HMOs have historically been the core of the MA program and they remain so today. Among lowest-premium plans in 2006, 66 percent are HMOs, 20 percent are local PPOs, 11 percent are PFFS plans, and 3 percent are regional PPO plans.[3] Also in 2006, the average total MA-PD premium per month is about two to three times lower in HMOs than in other plan types except for SNPs.

[3] In total there are 935 "contract segments," which are defined as the geographical aggregations of counties in which a firm offers a specific type of contract (e.g., HMO, local PPO) and does so with a consistent set of benefits and premiums. The designation of "lowest-premium plan" is specific to those offering MA-PD only (i.e., it does not consider any MA-only offerings). The terminology used here is specific to this paper; CMS may define these terms differently.

In comparison to the $22 monthly premium for HMOs, the average monthly premium is $44 in PFFS plans, $53 in regional PPOs, and $60 in local PPOs. HMOs also are more likely to offer zero-premium products—64 percent charge nothing for their lowest-premium product, and 9 percent of them also apply some funds to reduce the beneficiary's Part B premium.

Hospital and Physician Cost Sharing. Whereas traditional Medicare makes extensive use of deductibles and coinsurance for Part A and Part B benefits, MA-PDs (regardless of type) rarely use either. (Out-of-network benefits in PPOs are an exception discussed later.) Instead, fixed-dollar copayments are used, possibly because sponsors assume that beneficiaries and providers may prefer this arrangement as the cost-sharing amount is more readily known in advance. A preference for fixed-dollar copayments also is consistent with historical precedents. Under the federal HMO Act (no longer in force), HMOs were not permitted to use deductibles or coinsurance, only fixed copayments.

MA plans of all types require cost sharing for many Part A and Part B services. (As discussed later, SNPs are an exception; most are dominated by dual-eligible enrollees, which influence their benefit design.) Cost sharing is typically lower in HMOs than in other types of plans. For example, though most lowest-premium HMOs (88 percent) now require enrollees to contribute to the costs of hospital care, 29 percent of them charge nothing for primary care visits.

PFFS plans and regional PPOs, in particular, appear to have kept their premiums low, partly by requiring more cost sharing at the point of service. On average, estimated out-of-pocket costs for physician and hospital services among lowest-premium plans is $275 per year in HMOs, $324 in local PPOs, $367 in PFFS plans, and $463 in regional PPOs. The differences in cost sharing within the same type of plans are particularly noticeable for enrollees with chronic needs (previously termed "poor health"). In 2006, we estimate that the average out-of-pocket costs for such enrollees is almost $2,500 per year in a regional PPO or a PFFS plan, $1,900 in a local PPO, and $1,676 in an HMO. These estimates assume that enrollees receive care from in-network providers (costs would be higher if others were used).

The Prescription Drug Benefit. HMOs have kept their overall MA premiums low in part because two-thirds of them do not charge beneficiaries anything for the new prescription drug benefit. In 2006, the average premium for prescription drugs (included in the total premium discussed earlier) is $8.40 in lowest-premium HMOs, compared with $15 in regional PPOs, $16 in PFFS plans, and $22 in local PPOs (SNPs charge $19). Of all plan types, regional PPOs are the most likely to stay with the standard Medicare drug benefit structure: 65 percent have kept the $250 initial deductible, 54 percent use coinsurance rather than tiered copayments, and 92 percent provide no coverage in the gap. Gap coverage is most likely in lowest-premium HMOs (20 percent cover generics and 7 percent cover brand-name drugs). None of the PFFS plans provide any coverage in the gap.

Augmented Benefit Packages. In addition to their lowest-premium MA-PDs, MA sponsors may offer a higher-premium plan of the same type in the same area with more generous benefits. The difference in premium between the lowest-priced MA-PD and other MA-PDs offered is greatest in HMOs and local PPOs. Augmented coverage (e.g., some drug coverage in the gap) is more likely in the higher-priced HMO or local PPO offering of a firm than in its lowest-premium basic offering. Though regional PPOs are more likely than any other plan type to have two or more MA-PDs available, the regional PPO MA-PDs offered by the same firm in the same region

do not appear to differ very dramatically from one another in their benefits. Because sponsors are required to offer the same plans across their entire region, the differences among plans may reflect less an interest in accommodating the diversity of beneficiary preferences than an interest in offering competitive products that will be marketable in different parts of a region where the local competition may differ. Sponsors of PFFS plans are least likely to offer more than one MA-PD in the same geographic area.

MA-Only Plans. In comparison to the 1,349 MA-PDs (including 935 lowest-premium plans) that are the focus of this report, sponsors are also offering 516 MA-only plans. We review the statistics for these plans in the report but find it hard to interpret them without better knowledge of why they are being offered, especially by non-PFFS plans. (PFFS plans are not required to offer prescription drug coverage.) As discussed elsewhere (Gold 2006c), MA-only plans are most likely to target (1) beneficiaries who either do not want the new drug benefit or obtain it elsewhere, or (2) employers who purchase such coverage separately.

3. What financial risk do beneficiaries face if they enroll in MA, especially in the newer, less managed products?

Beneficiaries purchase Medigap coverage because they want predictable costs and, for those needing many or costly services, protection against the potentially high costs associated with the basic Medicare package. Although the standard options vary, Medigap policies generally provide first-dollar coverage for Medicare cost sharing. (The MMA seeks to alter this standard by authorizing new Medigap options that allow more cost sharing.) Because MA has been an alternative source of supplemental coverage for Medicare beneficiaries, we sought to learn more about the potential out-of-pocket costs now associated with MA and examined this issue in several ways.

Increase in Costs for Hospital Stays, 2002–2006. In 2002, when virtually all MA enrollment was in HMOs, the average unweighted facility costs for a three-day hospitalization were $271 and $900 for an enrollee with two six-day stays and one three-day stay. In 2006, the comparable cost, unadjusted for inflation, is $371 and $1,429, respectively, in the lowest-premium HMO MA-PD—or an aggregate increase of 37 percent and 59 percent, respectively, over the period. The rate of increase is substantially higher than the 17 percent increase in the Medicare hospital deductible over the same period. Further, out-of-pocket costs in 2006 are substantially lower in an HMO than in other types of MA plans. For example, enrollees in a regional PPO would pay $543 (for the single three-day stay) and $2,059 (for the mix of three hospital stays) if in-network facilities were used. (All of these estimates exclude professional charges likely to be associated with the stay.)

Increase in Costs for Mental Health Services, 2002–2006. The share of HMOs with cost sharing for inpatient mental health increased from 65 percent to 85 percent between 2002 and 2006. There was also a shift from cost sharing *per stay* to cost sharing *per day*, providing an incentive to beneficiaries for early release. Cost sharing for outpatient mental health visits was common in 2002 and 2006. Although fixed-dollar copayments were typical in all types of plans, PFFS plans made the most use of coinsurance, and the share of enrollees who would pay more than $2,000 for 52 visits a year (one per week) was 25 percent higher in PFFS plans than in any other kind of plan.

Financial Accessibility of PPOs Out-of-Network. PPOs provide some out-of-network coverage and may be attractive to those seeking more choice. Because beneficiaries who use the out-of-network option (offered by both local and regional PPOs) are required to pay more out-of-pocket, we analyzed how cost sharing is structured and found that it is extensive—particularly in regional PPOs in which the cost sharing amounts typically exceed those included in the traditional Medicare program. In lowest-premium regional PPOs, the most common structure of out-of-network benefits includes a deductible for physician services (81 percent of such plans) after which enrollees pay 30 percent for coinsurance (62 percent of such plans). Although there is no deductible for hospital inpatient services, 74 percent of regional PPOs require coinsurance of 30 percent. Local PPOs also have extensive cost sharing, but the amounts are lower than those charged by regional PPOs.

Financial Protection Offered by PFFS Plans. Although PFFS plans have received limited attention, they have been growing rapidly in both number and enrollment in recent years (Gold 2006a). We assessed how cost sharing for physician and hospital services in such plans compares with that in traditional Medicare. The analysis shows that PFFS plans typically impose fixed-dollar copayments rather than deductibles and coinsurance as the traditional Medicare program does. Among lowest-premium PFFS plans (both MA-PD and MA-only), 98 percent require some cost sharing for physician services, though only 4 percent have a deductible and none use coinsurance. Most typically, primary care visits require a copayment of $11 to $15 (49 percent of plans), whereas copayments for specialist visits are higher: 55 percent charge more than $25 for such visits. Inpatient care typically requires a copayment per day (81 percent of plans); this copayment is more than $100 but typically less than $200. Unlike HMOs, which might offer hospital coverage after the Medicare benefit is exhausted, some PFFS plans follow the Medicare model of not offering coverage after lifetime reserve days are exhausted. Annual limits on out-of-pocket spending are common (74 percent of plans use them) but high—almost always over $2,500 but no more than $5,000.

Annual Limit on Out-of-Pocket Spending. In contrast to most group insurance, Medicare does not limit out-of-pocket spending (Gold 2002). Such a limit is required in the new regional PPOs but not in other MA plans. Overall, 56 percent of lowest-premium MA-PDs have no such limit, and another 29 percent have a limit of more than $2,500. The types of plans most likely to use such limits are those in which enrollees face the most extensive cost-sharing charges (e.g., PFFS plans and regional PPOs). Our analysis suggests that a beneficiary with extensive health care needs could generate substantial out-of-pocket expenses in many of the MA plans offered, regardless of type. The structure of most MA plans does not protect beneficiaries in these circumstances either because there is no limit or because the limit is high, particularly for an enrollee with moderate income and/or recurring expenses year after year. CMS's guidance to plans seeks to avoid benefit structures that might discourage enrollment by severely or chronically ill individuals. However, firms have flexibility in structuring benefits subject to CMS review.

4. How Does Coverage in Special Needs Plans Compare with That Generally Available to Beneficiaries?

Our analysis of lowest-premium MA-PDs by type of plan shows that SNP premiums are generally lower than premiums in most other plan types and on par with HMO premiums. Seventy-two percent of lowest-premium SNP MA-PDs do not require a copayment for primary care visits and 53 percent do not require one for specialist visits. Though most require cost

sharing for hospital and other services, we estimate the total out-of-pocket costs are substantially lower in SNPs than in any other type of MA-PD plan.

In this analysis, we sought to learn more about how SNPs structure their benefit package, but we were limited by how CMS structures its Personal Plan Finder, the primary source of analysis for this study. The Plan Finder includes only Medicare benefits despite the fact that most SNPs serve dual-eligible individuals who qualify for Medicare and Medicaid benefits. (CMS will be making changes in the Plan Finder in 2007.) SNPs either are capitated separately by Medicaid for Medicaid's benefits or, more typically in 2006, have Medicaid pay providers directly for the Medicaid benefits for which they qualify. Such benefits usually fill in all or most of Medicare's cost sharing and provide coverage for other services such as dental, vision, expanded mental health, or long-term care. These payments mean that one cannot assume that the SNP's benefits represent all of an enrollee's coverage for medical care costs. Another limitation is that the Personal Plan Finder focuses on general features of benefits but not the special benefits, such as care coordination or personal care services, that SNPs may provide to a targeted population they serve. In addition, the Plan Finder does not include demonstration plans, as do some SNPs in Massachusetts, Minnesota, and Wisconsin that integrate Medicare and Medicaid.

Despite these limitations, our examination of SNPs by type of plan yielded instructive findings. For example, average premiums in the lowest-premium SNPs are substantially higher in plans targeting those with chronic or disabling conditions ($57 per month) than in those targeting dual-eligible ($21 per month) or institutionalized ($22 per month) beneficiaries. In all types of SNPs, almost all the premium is accounted for by the costs of prescription drug coverage, something we would predict because of how CMS structures the low-income subsidy (LIS) for any type of plan. (CMS, not the beneficiary, pays the Part D premium for all full-benefit LIS eligibles and for a large share of the others eligible for the LIS.) Our analysis of SNP premiums versus those for general MA-PDs in the same selected markets shows that SNP premiums exceed those in most, but not all, of the markets we studied. We also profiled the 13 SNPs targeted to those with severe chronic or disabling conditions and found that these plans vary in terms of the group they target. Some target very specific beneficiary subgroups (such as the seriously and persistently mentally ill and those with end-stage renal disease or HIV), whereas others focus more generally on individuals with a specific condition or combination of conditions that are common in the elderly, such as diabetes, chronic heart failure, and chronic obstructive pulmonary disease.

Our review of recent reports on SNPs (MedPAC 2006a; Verdier and Au 2006) as well as our own analysis (Gold 2006a, 2006b) shows that the impetus for SNPs stems partly from an interest in better coordinating care for individuals with complex conditions, many of whom are dual eligible for Medicare and Medicaid and/or institutionalized. The industry's initial response to the SNP authority included in the MMA has been strong, with a show of interest coming from firms already active in MA and from others with a base in Medicaid managed care. Nevertheless, the factors responsible for this interest are likely to vary from firm to firm according to their business base and strategy. The high levels of revenue potentially available in the market probably helped to attract SNP sponsors, although we do not know whether higher payments through risk adjustment are enough or whether a separate frailty adjuster is also required to appropriately pay for care needed by the populations targeted by such plans. MedPAC's site visits indicate that the structure of SNPs is still a work in progress. Also remaining are the significant issues associated with Medicare–Medicaid coordination—both because many SNPs do not have contracts with

states to cover Medicaid benefits and because there are administrative difficulties in integrating Medicare and Medicaid benefits in a single plan.

As Verdier and Au (2006) note, achieving adequate enrollment may be an issue for many SNPs in 2006 because beneficiaries may not be aware of the product and there may be few financial incentives for them to consider it, especially if they are dually eligible. In some cases beneficiaries have been passively enrolled in SNPs, most SNPs have to reach enrollment targets by identifying, locating, and successfully marketing to these dual eligibles in order to build a dual-eligible enrollment of any significance. When well over 90 percent of full dual eligibles have been auto-enrolled into stand-alone PDPs, having them consider a switch is challenging.

It remains to be seen whether SNPs can achieve their goal of better coordinating care. There are models that can be assessed in the short term. The dual-eligible demonstration SNPs in Minnesota, Wisconsin, and Massachusetts have significant experience coordinating Medicare and Medicaid benefits, and SNPs in several other states have substantial dual-eligible enrollment and experience coordinating capitated Medicaid benefits. Nonetheless, there is little time for such assessments, as the statutory authority for SNPs ends in December 2008. Whether or not firms are interested in investing in further development of these plans could depend on whether they are convinced that the plans have a future beyond 2008.

CONCLUSIONS

Operational Concerns

Our findings on the characteristics of benefits and premiums offered by MA plans in 2006 indicate that the structure of such benefits and premiums is complex, presenting beneficiaries with even more MA plan types that vary in how they function and in how benefits and cost sharing are structured. More than ever, beneficiaries will need solid support as they decide on a plan because the challenges in doing so are formidable (Hibbard, Greene, and Tusler, 2006; MedPAC 2006b).

Whereas HMOs continue to provide, on average, the most comprehensive benefits for the lowest premium, their benefit structure now assumes that beneficiaries will share substantially in the costs of such benefits. Newer options such as PFFS plans and regional PPOs require substantially more cost sharing; although they typically have an annual limit on out-of-pocket spending, the limit is also usually high, particularly from the point of view of a beneficiary with limited income and/or recurrent high expenses over the years. In addition, these newer options provide beneficiaries with what appears to be greater access to providers of their choice, but in reality, that access could be far less—either because of the high cost sharing charged by PPOs for out-of-network services or because some providers decide not to treat patients in PFFS plans. The PFFS plans are required to accept all providers willing to take the prices they pay; however, providers are not required to see patients covered under these plans. We are not aware of information suggesting that access problems are prevalent in PFFS plans, but beneficiaries must understand the risks and trade-offs in order to make the best choice for themselves.

Policy Concerns

We do not yet know whether changes in MA present opportunities or risks for Medicare beneficiaries; however, there is some cause for concern. The opportunities stem from the fact that plans integrate benefits from Medicare Part A, Part B, supplemental services, and, if states cooperate, from Medicare and Medicaid as well, particularly through SNPs. Integrated financing under a capitated model has the potential to encourage more coordination, but actually doing so also requires substantial restructuring of care delivery. The fact that most of the recent growth in MA offerings is in relatively unmanaged types of plans seems to conflict directly with this goal. Moreover, the value of PFFS for beneficiaries compared to traditional Medicare is yet to be determined, particularly if the extra benefits offered by these plans are financed by payments that exceed Medicare's own costs for delivering a fee-for-service benefit.

The evolving structure, benefits, and premiums of MA plans also present a risk because of the overall fiscal constraints facing Medicare. The cost of traditional Medicare with Medigap often exceeds the financial capacity of many beneficiaries, but the combination has historically provided beneficiaries with reasonable protection against catastrophic costs, at least for acute care. MA's structure makes the premiums for supplemental coverage more affordable to beneficiaries, but it also leaves beneficiaries, especially those who need care the most, financially vulnerable, particularly if a beneficiary does not qualify for the LIS.

In effect, the structure of MA has put beneficiaries at greater risk than has historically been the case for rising costs. The rationale is that beneficiaries will have a more personal stake in health care costs and therefore an incentive to contain them, an end sought by multiple and competing plans. Sponsors must provide Medicare's benefits, but if the cost of doing so exceeds CMS's payments, they can raise premiums for their plans, including charging more than traditional Medicare does for standard Medicare benefits. Right now, beneficiaries still have some protection because the traditional Medicare program remains intact, giving beneficiaries an option to switch plans.

Whether this protection will continue is not clear. Beneficiaries who drop Medigap coverage when they enroll in an MA plan could find it difficult (because of medical underwriting) or unaffordable (because age rating may be used even in Medigap plans that do not use medical underwriting). Further, if the beneficiaries who remain in traditional Medicare are sicker than those who switch to MA, costs in the traditional program will go up, which may lead Congress to reconsider the promises Medicare has made to beneficiaries.

Even though few analysts expect the MMA's required premium-support demonstration to go forward[4], the design of Medicare Part D, along with associated MA changes, has the potential over time to modify the Medicare program in important substantive ways. In effect, beneficiaries seeking prescription drug coverage now have to choose a private health plan. Choosing a free standing PDP allows them to stay in traditional Medicare. However, there are strong financial incentives for beneficiaries without subsidized support for Medicare

[4] This demonstration calls for head-to-head competition between traditional Medicare (with PDPs) and MA in a number of markets.

supplemental benefits (via former employers, Medicaid or others) to enroll in MA. Further, there are an increasing number of MA choices whose structure provides open access to any provider (assuming they agree to see the patient). MA plan benefits are likely to compare favorably to the Medicare/PDP option because, MA plans typically receive more for providing Part A/B beneficiaries than Medicare now spends in the traditional program; plans must use 75 percent of any savings to expand benefits or reduce beneficiary costs. If sizeable proportions of beneficiaries enroll in these plans, the offsetting protection represented by traditional Medicare's uniform, national package of benefits for a standard premium could weaken.

A. PURPOSE

Two factors are largely responsible for the change in Medicare Advantage (MA) benefits and premiums in 2006: the introduction of Medicare's new drug benefit and the availability of a larger menu of MA plans. Although most beneficiaries have remained in the traditional Medicare program, MA has attracted those who are more sensitive to price and do not have subsidized sources of supplemental coverage (Thorpe and Atherly 2002). In December 2005, 14 percent of Medicare beneficiaries were enrolled in some form of MA plan—mostly health maintenance organizations (HMOs), although enrollment in newer products, such as preferred provider organization (PPO) and private fee-for-service (PFFS) plans, was growing (Gold 2006a).

The number and structure of MA offerings have varied over the years: MA's predecessor programs expanded rapidly in the mid- to late 1990s only to be followed by fewer options and less generous benefits under Medicare+Choice from 1999 to 2003 (Gold et al. 2004; Gold and Achman 2001; Achman and Gold 2002, 2003).[5] To reverse these trends and prepare the market for 2006, when both the new drug benefit and additional private plans would be available, Congress sought through the Medicare Drug, Improvement, and Modernization Act (MMA) of 2003 to stabilize the MA market by authorizing the Centers for Medicare and Medicaid Services (CMS) to make changes in MA policy that led to more generous plan payments in 2004 and 2005. The approach was successful—both in stabilizing the market and in prompting an expansion, albeit a modest one, in MA plans and benefits (Gold 2005; Achman and Gold 2004; Achman and Harris 2005). This report updates our earlier analysis of trends in premiums and benefits in MA for 2006 and presents a more comprehensive analysis of the MA market in 2006.

The analysis described in this brief is based on a data file created by Mathematica Policy Research, Inc. (MPR) from public data in the CMS Medicare Personal Plan Finder and from other sources. For the most part, we analyzed MA plans that include the prescription drug benefit (MA-PDs) because most offerors of any plan must make at least one of these plans available (although they often offer more), and they far outnumber MA plans without drug coverage ("MA-only" plans).[6] In previous years, the analysis focused on "basic" plans—the lowest-premium plan offered in a given geographical area by any firm that has contracted with Medicare. Because the new drug benefit has encouraged beneficiaries to consider the full range of choices, we expanded the prior analysis so that it more systematically compares different types of MA plans and also additional plans offered for a higher premium. And unlike the previous analysis, most statistics in the current analysis are not weighted for MA enrollment because as of June 30, 2006, when this report was being prepared, CMS had not released 2006 data on MA enrollment at the individual contract and county level.[7]

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[5] For this purpose we use MA to describe the program historically. In fact, from 1985 to 1997, Medicare's authority for private plans was authorized through the Medicare risk contracting program. Private plan options were then expanded under Medicare+Choice (M+C), which was enacted as part of the Balanced Budget Act of 1997. The M+C program—which authorized local preferred provider and provider-sponsored plans in MA, as well as a PFFS option and a limited-time medical savings account demonstration—was folded into the MA program, effective March 2004.

[6] The CMS monthly summary report for August 2006 shows a total of 7.4 million beneficiaries were enrolled in MA, including 6.4 million in MA-PDs and 1.0 million in MA-only plans.

[7] On July 26, 2006, CMS released an Annual Report by Plan that includes enrollment information at the plan level. However, the data are not in the same form as those previously provided. We have not updated the analysis with these data because the data were so late in becoming available and involved a different file structure than CMS

The analysis addresses a number of questions relevant in 2006:

1. With the introduction of the Medicare drug benefit, how different are MA premiums and benefits in 2006 from what they were earlier?
2. How do premiums and benefits vary by type of MA plan in 2006, and what range of plans is offered to beneficiaries?
3. How much financial risk or protection are beneficiaries assuming or buying if they enroll in the newer, less managed MA plans—that is, regional and local PPOs and PFFS plans—and how does that amount of risk or protection compare with traditional Medicare alone or with the most common Medigap supplements?
4. How does coverage in special needs plans (SNPs) compare with generally available coverage for beneficiaries, especially in the same market?

We address each question after the following background and methods section (readers seeking additional background on the evolution of MA will find it in Appendix A). Because the answers to these questions draw on overlapping sets of statistics, readers may note some repetition of information in tables used to address each.

B. BACKGROUND

Private plans in Medicare have historically been built around HMOs, which offered both Medicare and supplemental coverage and required beneficiaries to use a certain network of providers to obtain care. When the Medicare managed care program was growing rapidly in the mid- to late 1990s, however, many private plans were offering benefits that went considerably beyond those covered by Medicare for a relatively low, if any, additional premium. For example, in 1999, 80 percent of beneficiaries were enrolled in plans in which there was no additional premium beyond Medicare Part B for the basic offering ("zero-premium plans"); 96 percent did not require cost sharing for hospital admissions; and only 5 percent charged more than a $10 copayment for a primary care physician visit (about twice as many charged more than $10 for specialist visits) (Gold 2005; Gold et al. 2004). By 2003, the share of beneficiaries in zero-premium plans was down by more than half (to 38 percent), 82 percent of plans required some cost sharing for hospital services (versus 4 percent in 1999), and drug coverage often was limited to generics only. Although some PPOs and PFFS plans were offered (they were authorized in the late 1990s under Medicare+Choice), few enrollees were attracted to them.

Under the MMA of 2003, Congress sought to stabilize this situation by establishing MA in anticipation of 2006, when beneficiaries electing the new prescription drug plan would have to choose between (1) staying in traditional Medicare (with or without Medigap) and enrolling in a private prescription drug plan (PDP) or (2) joining an MA plan, through which they would get

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has historically made available. (Our analysis file was created from the Personal Plan Finder and involved segmented contract data that could take advantage of CMS's historical reports of county-based enrollment.) With limited resources and time, we did not want to further delay the publication of this analysis.

integrated Medicare, drug, and supplemental coverage for what might be a competitive price. Under the MMA, MA offered HMOs, PPOs, and PFFS plans on a county-by-county basis—hence the term "local plans." Starting in 2006, MA offered a new, "regional" PPO plan, through which Congress hoped to make private plans offering MA more available to Medicare beneficiaries across the nation (see box) (Gold 2005, 2006a). The MMA also authorized SNPs, which can restrict enrollment to subgroups of beneficiaries including people eligible for Medicare and Medicaid ("dual eligibles"), institutionalized beneficiaries, and beneficiaries with severe or disabling chronic conditions.

To encourage firms to participate in MA, the MMA also modified the methods used to set monthly risk-based payment levels (Berenson 2004; Biles et al 2004). As of March 2004, the MMA guaranteed that payments to local plans in each county would be at least 100 percent of what the traditional Medicare program pays for beneficiaries residing in that county. The MMA also modified the minimum annual increase so that plans received either a 2 percent increase (the previous policy) or the national growth percentage (6.3 percent in 2004, 6.6 percent in 2005, and 5.5 percent in 2006), whichever was higher. In some counties, plans qualified for the existing rural or urban "floor" payments or other enhancements. So though the MMA added an element of competitive bidding in 2006, 2006 payments would still, on average, exceed payments to plans under traditional Medicare (MedPAC 2006a).[8] The MMA provided that firms whose estimated costs for the basic Medicare Part A and B benefits were below the benchmark (formerly the monthly risk-based payment level per capita) would keep 75 percent of the difference, which they are required to return to enrollees in the form of reduced premiums or supplemental services. (If costs exceed the benchmark, firms—for the first time in 2006—have to charge a higher premium for basic Part A and B benefits.) The MMA also included incentives designed to make it more attractive for firms to offer regional PPOs. For example, whereas firms bear the full financial risk in local MA, Medicare shares such risk with regional PPO plans for the first two years (i.e., 2006 and 2007).

As intended, the choices available through MA (and its predecessors) stabilized and then began to increase after the MMA was enacted. Today, almost all Medicare beneficiaries in the United States have at least one kind of MA plan available to them; the exceptions are people who live in many areas of Alaska and parts of New England (Gold 2006a). Although beneficiaries in urban areas have more HMO and PPO choices, PFFS plans and regional PPOs have been particularly important in expanding the choices available in areas where there were none previously. More choice has also stimulated an interest in understanding how MA benefits have changed in 2006 with the addition of Medicare's drug benefit.

[8] These features of MMA policy provide a boost to the competitive position of MA firms because PDP-only plans cover only Part D and do not quality for such additional payments. Firms can use the extra funds as well as any additional funds they generate to offset Part D costs (MedPAC 2006a). MedPAC has argued that the policy does not create a level playing field and should be changed (MedPAC 2004).

Major Types of Medicare Advantage Plans

Local Plans. These define their service area on a county-by-county basis and the plans they offer are called "local plans." Nothing prohibits a local plan from defining its service area to cover an entire region. However, only designated regional plans are subject to the regional plan requirements.

- **Health Maintenance Organizations (HMOs).** These are typically the most tightly managed plans. They have a defined network of providers, which beneficiaries must generally use to receive coverage (with some exceptions, such as emergency care). These plans have the longest history in Medicare and account for most MA enrollment. An HMO plan can have a point-of-service option, which allows individuals to go outside the network if they are willing to pay more. Only a small share of current enrollment is in such products.
- **Preferred Provider Organizations (PPOs).** Like HMOs, these also are network-based plans. In a PPO, enrollees may generally go to any provider they choose. However, using providers outside the network will result in higher out-of-pocket costs. The count of PPOs also includes other authorized plan types, particularly the few provider-sponsored organizations (PSOs) that are offered. We have included PSO plans within the local PPO category because both were newly authorized options in the Balanced Budget Act of 1997 and there are not enough PSOs to warrant complicating the analysis. PSOs are network-based plans offered by provider organizations.
- **Private Fee-For-Service (PFFS).** In contrast to HMOs and PPOs, PFFS plans place no restrictions on the providers that a Medicare beneficiary can use, although providers may limit their willingness to see Medicare beneficiaries in such plans. PFFS plans must pay providers on a fee-for-service basis and accept all those willing to accept their payment. Payment rates do not have to match those of Medicare, as long as CMS concludes that the rates will afford adequate provider access. Plans also have the authority to allow providers to balance-bill beneficiaries up to 15 percent of the difference between payments and charges if they choose. (However, use of Medicare rates and billing practices is common in PFFS.)

Regional PPOs. These are PPOs that serve large areas in the 26 defined regions, which include one or more states. Regional PPOs must offer the same plan (with the same benefits and premiums) across the entire region. Benefits must be restructured to integrate cost sharing across traditional Medicare benefits (Parts A and B) and to include an annual out-of-pocket limit on cost sharing for these benefits, a feature missing in traditional Medicare. (Local plans may, but are not required to, set such a limit.) To encourage regional plans, the MMA allows Medicare to share financial risk with sponsors in 2006 and 2007, provides selected provisions to make it easier to establish networks in rural areas, and establishes a regional stabilization fund starting in 2007 to encourage entry of new plans and retention of existing ones.

Special Needs Plans (SNPs). These may be local or regional plans but they must use a coordinated care model that relies on a provider network (such as HMOs or PPOs). SNPs are designed to serve one or more of three subgroups of individuals with certain special needs: dual eligibles, those who are or are eligible to be institutionalized, and those with serious chronic or disabling conditions. SNPs may be offered through separate contracts but may also be offered as unique plans under existing HMO, PPO, or other contracts. Some have been approved under demonstration authority.

Other Types of Plans. Cost contracts and various demonstrations also may be offered in particular locales. The Medicare Drug, Improvement, and Modernization Act of 2003 provides authority for Medical Savings Account plans but none were offered in 2006. For more information on available types of plans see Gold (2006a).

Source: Gold 2006a (Kaiser Family Foundation)

C. METHODS

The database that underpins this analysis of benefits and premiums was developed by MPR from MA data in the November 2005 release of the 2006 Medicare Personal Plan Finder, a database of benefit packages maintained by CMS. We merged plan information from the Personal Plan Finder with other CMS data, including county-level enrollment data by MA contract in December 2005.

As in our previous analysis, the unit of analysis is the plan, which is a particular package of benefits and premiums offered consistently throughout a set of counties (i.e., by local plans) or in each region (regional PPO) under a single contract known as the "contract segment." Only plans available to individuals (i.e., not those available to employer groups only) are included. We also distinguish between "basic" plans (the plan offering the lowest premium of all plans of that type available to beneficiaries in a given set of counties) and "other" plans, which may offer additional benefits for a higher premium. The analysis includes all HMOs, local or regional PPOs, PFFS plans, and SNPs. Cost contracts, demonstration plans, and other types of plans—such as the Program for All-Inclusive Care of the Elderly (PACE) and health care prepayment plan—are not included as consistent with historical practice.

We have adapted our usual analytic methods to accommodate the changes introduced both in MA and in Medicare more generally in 2006. For the most part, these adaptations still make it possible to do trend analysis while expanding definitions of the measures used in the report in ways likely to be of value in developing new baselines for future trend analysis. Three particular distinctions are addressed: general MA plans versus SNPs, MA-PD versus MA-only plans, and statistics weighted for plan enrollment versus those unweighted for plan enrollment.

General MA Plans versus SNPs. Although MA contracts differ by plan type (HMO, local or regional PPO, PFFS), SNPs are an exception because they are defined not by their form of organization but by the population they serve.[9] SNPs may therefore be authorized under a generic MA contract (e.g., an HMO) or under a contract unique to the SNP offering. In our analysis, we separate SNPs (regardless of the contract under which they are authorized) into a distinct plan category. This classification creates mutually exclusive categories of plans and characteristics of benefits and premiums offered by each type of plan. The MA contract total includes only contracts in which at least one plan is available to all beneficiaries. This distinction prevents double counting contracts that may include both general and SNPs and makes for a clearer summary of the characteristics of plans available to the general Medicare population.

MA-PD versus MA-Only Plans. We distinguish between MA plans that offer prescription drugs and those that do not. HMOs and local PPOs must offer at least one plan that includes prescription drugs; SNPs must offer prescription drug coverage in all their plans. Although PFFS sponsors are not required to offer prescription drugs, the majority do.[10] Thus, almost all contracts

[9] Though many SNPs are offered through HMO-like entities, some SNPs are offered through local or regional PPO contracts as well (PFFS plans are not authorized to offer SNPs).

[10] Cost contracts also are not required to provide prescription drug coverage, but these plans have never previously been included in our analysis because they have unique features and an uncertain future history in MA. We continue that practice here.

include at least one MA-PD plan. Because some statistics that combine MA-PD and MA-only plans are hard to interpret (e.g. average "total plan premium" that include plans that do and do not cover prescription drugs), we focus primarily on MA-PDs. MA-PDs are the dominant plan in the MA program, and most beneficiaries choose them over MA-only plans.

Weighted versus Unweighted Data. Because CMS had not provided detailed enrollment data on MA by the end of June 2006, fewer statistics in this report than in previous reports are weighted by plan enrollment because the data to do so were not available.[11] We prefer statistics that are weighted by plan enrollment because they reflect the coverage that beneficiaries actually have as opposed to that which is available. CMS historically reported MA enrollment at the contract-county level, which does not capture enrollment by plan. However, most enrollment has historically been in basic plans (or at least it was believed to be). In the past, we have therefore used total contract enrollment to weight basic plans for the purpose of trending. But because CMS had not yet released data on 2006 enrollment by county-contract[12], we used the last reported data on enrollment from December 2005 to assess trends in premiums and benefits in MA plans over time.[13] Because a relatively high proportion of plans other than HMOs are new in 2006 (or have new contract numbers), comparisons by type of plan are not weighted, nor are statistics for "all" versus "lowest-premium" or "other" plans. The latter kinds of statistics requires not only 2006 enrollment data by county-contract but also by plan within a contract in that county.

Historically, we have analyzed the MA benefit package by comparing estimates of total out-of-pocket spending, taking into account the Part B premium, the MA premium, hospital and physician cost sharing, and prescription drug costs. We also have compared these components of spending for enrollees in good, fair, and poor health. The approach uses estimates of use for each of these groups that were developed by HealthMetrix Research (see http://www.hmos4seniors.com). Because of the changes in the drug benefit, we focus only on estimates of out-of-pocket costs for hospital and physician cost sharing this year. The ability to use these estimates to trend out-of-pocket spending over time is limited because HealthMetrix modified the hospital-use assumptions in 2005 by assuming that enrollees in fair or poor health used markedly more hospital care than previously (Achman and Harris 2005). For this reason, we report trends separately for 1999 through 2005 (with 2005 data using old assumptions) and for 2005–2006. We also modified the way we captured hospital cost sharing in 2006. Although the algorithm for calculating out-of-pocket costs was not changed, it is possible the programming

[11] On July 26, 2006, CMS released an Annual Report by Plan that includes enrollment information at the plan level. However, the data are not in the same form as previously provided. We have not updated the analysis with these data because the data were so late in becoming available and involved a different file structure than CMS has historically made available. (Our analysis file was file created from the Personal Plan Finder and involved segmented contract data that could take advantage of CMS's historical reports of county-based enrollment.) With limited resources and time, we did not want to delay further the publication of this analysis.

[12] This refers to the availability of a file that shows each county in the nation and the number of enrollees from that county that are enrolled from each contract. Such files, with appropriate codes for counties and contracts, support in depth analysis of how MA enrollment and the particular benefits individuals have vary by county.

[13] The 2006 statistics do not reflect any 2006 switching or enrollment in new contracts. We expect that the magnitude of the short-term shift is relatively small and thus unlikely to result in substantial distortion. For example, though PFFS enrollment grew rapidly between 2005 and 2006, it was still only 7.8 percent of MA-PD enrollment in August 2006 (MPR Analysis of CMS August 2006).

change led to some inconsistency in reporting. The cross-sectional comparisons by type of plan in 2006 are not affected by these limitations.

Note that in 2005 HealthMetrix also modified the terminology used to classify individuals, referring to basically "healthy" beneficiaries versus those with "episodic needs" or "chronic needs." We retain the old language in our trend analysis but update the language for the 2006 comparisons. As previously, we calculate the total figure as a weighted average across the mix of categories, using the Medicare Current Beneficiary Survey (MCBS) to identify the share of MA enrollees in good, fair, and poor health. The 1999 through 2005 time series uses 1999 weights and the revised 2005–2006 estimates use 2003 data (the most recent available on the CMS Website). We have assumed that the mix by good, fair, and poor health is the same as that in the renamed three categories (healthy, episodic needs, chronic needs) reflects the differences across the three renamed categories.

D. FINDINGS

1. Overall Trends in Lowest-Premium Plans, 1999–2006

We compared MA premiums and benefits introduced in 2006 with pre-2006 premiums and benefits. This analysis replicates, as closely as possible, our approach to trending premiums and benefits in MA since 1999.[14] The analysis also complements other analyses in this report, which move beyond traditional trending to provide a more detailed look at MA offerings in 2006. As mentioned, the analysis is based on the lowest-premium MA-PD plan in each contract segment, and plans are weighted by December 2005 enrollment. The estimates for 2006 may therefore be understated to the extent that many enrollees are in new offerings in 2006, many of which are non-HMO products that may have higher premiums.

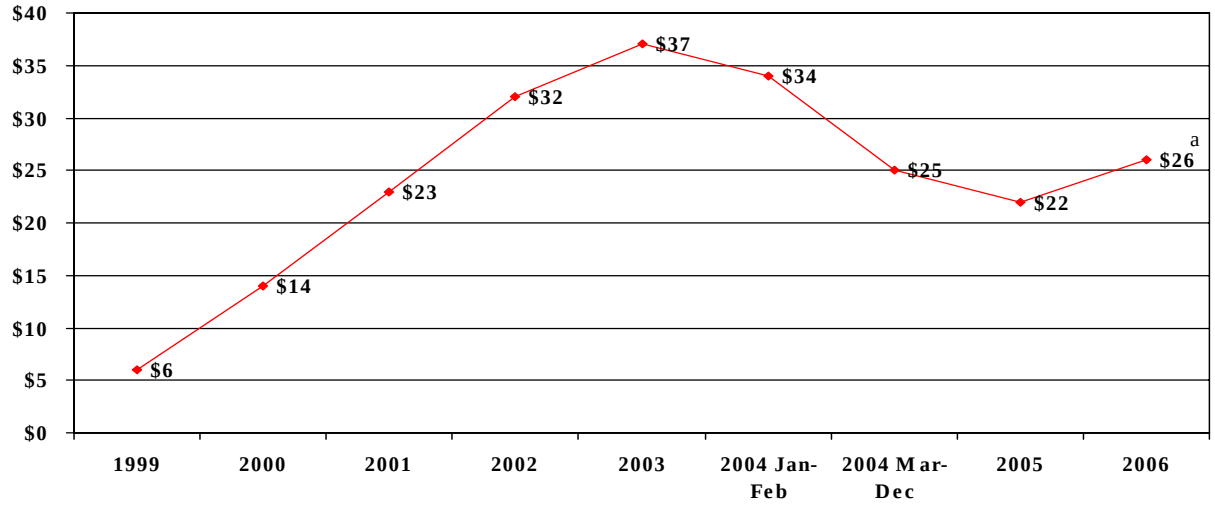
a. Premiums

When the Medicare benefit package was expanded in 2006 to cover prescription drugs (the Part D benefit), the MA capitation rates were modified to include an additional payment for that benefit.[15] MA plans can reduce the beneficiary contribution to the Part D premium with savings they might generate if their costs for Medicare Part A and B benefits are below the Medicare benchmark payment for such benefits. Firms can determine how to spend these savings by

[14] This historically has been referred to as the "basic plan." Though prior-year basic plans did not all cover prescription drugs, such coverage now is required in most contract types. Historically, if there have been two plans with the same "basic" premium, we have developed statistics using the plan that does include prescription drug coverage. Because Medicare pays for prescription drug coverage in 2006 (versus making it available from Part A and B savings or supplemental premiums), it makes sense to us to use only MA-PDs in calculating 2006 trends.

[15] Technically, what the MMA did was to create a separate payment stream for Medicare prescription drug benefits (Part D). However, MA plans can use savings generated in providing Part A and Part B benefits to enhance the Part D benefit or to offset the cost of the prescription drug benefit to beneficiaries.

Figure 1. Average Medicare Advantage Premiums, 1999–2006



Source: Mathematica Policy Research analysis of Medicare Compare data (renamed the Medicare Personal Plan Finder in 2006). Analysis of 1999–2004 data was funded by The Commonwealth Fund; analysis of 2005 and 2006 data is funded by AARP Public Policy Institute. Data from 2006 are weighted by December 2005 enrollment, the latest available. Premiums for beneficiaries for 2006 reflect the introduction of the new Part D benefit (and extra Medicare Advantage payments in 2006).

Note: All data are weighted by enrollment.

[a]The 2006 data are for Medicare Advantage plans with prescription drug benefits only whereas prior-year data include some plans with no prescription drug coverage. Despite the change in definitions, we show these data because they provide insight into how premium costs relevant to considering in Medicare Advantage (versus prescription drug plans with or without Medigap supplement) appear to beneficiaries.

expanding benefits, reducing Part A and B cost sharing, lowering premiums, providing a rebate on the Part B premium, and so on. The Medicare Payment Advisory Commission (MedPAC2006b) analyzed plan bids and found that 95 percent of them were below the benchmark and hence able to take advantage of these provisions. Of the total rebate dollars available, MedPAC found that 65 percent was applied to reduce cost sharing for Medicare Part A and Part B benefits, 15 percent was used to lower the premium for Part B (4 percent) or Part D (11 percent), and 19 percent went to enhance benefits (5 percent for Part D benefits and 14 percent for adding such benefits as dental care or vision care)[16]

These provisions appear to have helped keep the beneficiary premium for the combined MA coverage down in 2006 despite the addition of the prescription drug benefit. Average MA-PD total premiums for beneficiaries in lowest-premium plans were $26 per month in 2006—only $4 per month more than in 2005 (Figure 1).

[16] Statistics don't add to 100 percent because of rounding error.

In 2006, a smaller share of enrollment was in contracts in which the lowest-premium MA-PD offered a reduction in the Part B premiums (3.1 versus 6.5 percent), and there was a small shift upward in the distribution of premiums. Although both weighted and unweighted statistics are highly dominated by HMOs (as discussed later), HMOs account for a higher share of MA enrollment than of lowest-premium plans in 2006; the unweighted averages show higher average premiums ($33 per month) (Table 1).

Table 1. Distribution of Premiums for Lowest-Premium Medicare Advantage Plans with Prescription Drug Benefits (MA-PD) Plans, 2005, 2006

	2006		
	2006 Unweighted	Weighted by December 2005 Contract Enrollment[a]	2005 Weighted
Mean Total Premium	$32.94	$26.24	$22.00
Mean If Premium More Than Zero	$63.90	$62.62	$57.30
Distribution			
Zero	48.4	58.1	55.3
Reduced Part B premium	6.6	3.1	6.5
No reduced Part B premium	41.8	55.0	48.8
$1.00–$19.99	4.6	2.6	2.0
$20.00–$49.99	15.3	14.9	15.0
$50.00 or more	31.6	24.4	21.2
Number of Contract Segments/Enrollees	935	5,298,561	4,619,579

Source: Mathematica Policy Research analysis of Centers of Medicare and Medicaid Services' (CMS) November 2005 Personal Plan Finder; enrollment data from the December 2005 Market Penetration Report; 2005 weighted data from Achman and Harris (2005).

Note: The table excludes contract segments with only Medicare Advantage-only plans (n = 34). Contract segments offering only special needs plans (SNPs) are excluded. Lowest-premium MA-PD plans were defined to include only those available to the general population (no SNPs).

[a]Enrollment reflects the total Medicare Advantage enrollment in that contract segment because CMS does not publicly report enrollment by plan. By definition, contract segments newly offered in 2006 have a zero weight.

b. Offsetting Physician and Hospital Cost Sharing and Other Benefits

Little has changed in some aspects of how MA plans have covered Part A and B cost sharing over the years. Enrollees in the lowest-premium plans have fairly similar copayments for primary care physicians and emergency room visits in 2006 as they did in 2005 (Table 2). Copayments for the emergency room seem to have stabilized, at least for the past few years, at around $50 per visit. (CMS prohibits plans from charging more than $50 for such visits.)

In 2006, copayments for specialty visits rose modestly, returning to pre-MMA levels. Compared with 2005, a lower percentage of MA enrollees are in contracts in which the lowest-premium MA-PD plan charged nothing or $5 or less per visit (8.1 percent versus 11.5 percent in 2005) and a larger share are in plans with charges of $15 or more (66.2 percent versus 59.0 percent). Cost sharing for hospital services also increased in 2006. The share of lowest-premium MA-PD plans requiring some cost sharing for hospital services is 89 percent in 2006, also an increase from 2005 and a return to pre-MMA levels.

Even more striking is the fact that in 2006, there has been a substantial rise in the share of enrollees in contracts in which the lowest-premium plans require cost sharing for hospital outpatient services and ancillary services (such as laboratory and x-ray services). Eighty-seven percent of enrollees are in plans that have some form of copayment for hospital outpatient care, 74 percent are in plans that charge for radiology, and 53 percent are in plans that charge for laboratory services. These percentages are more than double the figures in 2005. We cannot, however, tell whether the increase is real or whether it reflects changes in how CMS captures or reports these data in the Plan Finder.

Consistent with historical trends, the share of beneficiaries in contracts with a lowest-premium plan that covers preventive dental care remains low in 2006 (22 percent) (Table 3). Vision and hearing benefits are typically covered (by 82 percent and 100 percent of plans, respectively), although vision coverage has declined compared with 2005. MA plans are required to offer the expanded preventive services authorized in the MMA (including the "Welcome to Medicare" physician). Thus, they do not all cover physical exams as a supplemental benefit in 2006 though this practice used to be common.[17]

The analysis suggests that many more plans are covering podiatry and chiropractic care, perhaps because we calculated these statistics differently in 2006.[18]

[17] Medicare now covers more preventive services, including a one-time "Welcome to Medicare" physical examination. Also covered are a number of other specific preventive services on a scheduled basis, including cardiovascular screening; various cancer tests (mammograms, pap tests and pelvic exams, colorectal cancer screening, and PSA testing); immunizations (flu, pneumococcal, hepatitis B); bone-mass measurements; diabetes screening, supplies, and self-management; glaucoma tests; and various other items ("Preventive Services," 2006).

[18] Historically, such coverage has been captured by any mention of coverage "for each routine visit." We have modified the approach this year to look more carefully at the description of the benefit (e.g., "you pay 100 percent," "there is no coverage," etc.) Calculations that use what appear to be the historical definitions versus those used in 2006 show that 23 percent have podiatry benefits and 4 percent have chiropractic benefits versus 99 percent and 96 percent using the new definition without weights.

Table 2. Copayments for Medical and Hospital Services in Lowest-Premium Medicare Advantage Plans, 1999–2006

	Percentage of Enrollees					
	1999	2003	Jan–Feb 2004	Mar–Dec 2004	2005	2006
Primary Care Physician						
None	18.0	7.1	9.9	15.1	18.5	15.7
$1.00–$5.00	44.5	5.5	8.1	13.3	18.8	15.4
$5.01–$10.00	32.1	45.6	39.9	43.7	33.3	34.1
$10.01–$15.00	5.1	17.8	20.0	16.5	16.0	21.6
$15.01 or more	0.3	24.0	22.2	11.4	13.3	13.2
Varies[a]	—-	—	—	—	—	12.8
Specialty Physician						
None	15.9	4.1	4.1	6.0	7.2	6.5
$1–$5.00	39.6	1.7	1.0	1.0	4.3	1.6
$5.01–$10.00	26.8	11.8	10.3	22.6	17.7	16.0
$10.01–$15.00	9.9	18.9	13.9	15.4	11.8	9.6
$15.01 or more	1.2	63.5	70.7	55.0	59.0	66.2
Varies[a]	6.6	0.0	0.0	0.0	0.0	2.0
Emergency Room						
None	6.5	3.0	2.3	1.8	2.7	1.3
$1.00–$20.00	24.5	0.4	0.0	0.0	0.0	0.1
$20.01–$40.00	30.5	5.9	3.2	3.3	2.7	4.9
$40.01–$50.00	38.2	91.0	94.5	94.8	94.6	93.6
$50.01 or more	0.2	0.0	0.0	0.0	0.0	0.0
Any Cost Sharing						
Hospital admission	4.3	82.1	85.7	82.1	76.0	89.2
Hospital outpatient	30.7	58.3	58.3	56.8	45.3	86.6
X-ray services	7.5	17.9	36.2	34.3	31.5	73.9
Laboratory services	3.9	13.0	21.1	18.9	19.6	52.7

Source: Mathematica Policy Research Analysis of Medicare Plan Finder Files and Centers of Medicare and Medicaid Services Market Penetration Files, various years.

Note: Enrollment is from March of each year for years 1999–2004; enrollment for 2005 is from January 2005; and 2006 enrollment is weighted by December 2005 data and is based on Medicare Advantage plans with prescription drug benefits in 2006. Contracts new in 2006 have zero weight. For 2002–2005, many plans have provided dollar ranges for the copayment amounts for these services. For instance, a plan may report that enrollees are responsible for a $0–$150 copayment for outpatient hospital services. The percentages reported here use the minimum copayment.

[a] Centers of Medicare and Medicaid Services uses this term to refer to plans that vary the cost-sharing amount for diverse kinds of visits of this type.

Table 3. Supplemental Benefit in Lowest-Premium Medicare Advantage Plans, 1999–2006

Percentage of Enrollees in the Lowest-Premium Plan with Each Benefit	1999	2003	Jan–Feb 2004	Mar–Dec 2004	2006	2006
Preventive Dental	69.9	19.4	16.5	20.5	25.5	22.0
Vision Benefits	97.8	88.2	87.5	92.4	92.2	82.1
Hearing Benefits	91.3	57.1	54.2	62.2	98.6	100.0
Physical Exam	100.0	99.6	98.6	99.7	100.0	74.5
Podiatry Benefits	26.9	26.9	28.0	29.6	29.4	99.3[a]
Chiropractic Benefits	20.9	4.8	2.3	3.5	4.3	95.8[a]

Source: Mathematica Policy Research Analysis of Medicare Plan Finder Files and Centers of Medicare and Medicaid Services Market Penetration Files.

Note: Enrollment is from March of each year for years 1999–2004; enrollment for 2005 is from January 2005; 2006 statistics are weighted by December 2005 enrollment and are for Medicare Advantage plans with prescription drug benefits.

[a] This figure was assessed using a new definition in 2006 that we believe is more accurate. Using historical definitions, the figures are 23 percent for podiatry and 4 percent for chiropractic.

To get a sense of the change both in out-of-pocket costs related to physician and hospital cost sharing and in supplemental benefits over time, we used the same method in the 2006 analysis as in past analyses. As shown in Table 4, from 1999 to 2005, estimated average out-of-pocket costs annually for hospital and physician cost sharing rose from $132 annually to $304 annually. Weighted by December 2005 enrollment, the 2006 estimate is $275 per month, or, using the revised methods beginning in 2006, $304. Historically, beneficiaries in better health have paid less out-of-pocket than did beneficiaries not in good health, and this remains so in 2006. Overall out-of-pocket spending for beneficiaries reflects the amount they pay in premiums and in out-of-pocket spending for all medical services. We are unable to repeat analyses of these costs developed in prior years because estimating out-of-pocket spending for prescription drugs has become more complex because of the structure of the Medicare prescription drug benefit under the MMA. Medicare coverage, combined with the catastrophic limit, should reduce average beneficiary out-of-pocket spending both overall and for prescription drugs in 2006 relative to 2005. However, the effect on out-of-pocket costs for particular beneficiaries will vary with their needs and the way in which plans use savings available from Part A and Part B benefits.

Beneficiaries have traditionally been attracted to MA plans because they cover prescription drugs, a benefit that, for the most part, was not covered by Medicare until 2006. From 1999 through 2005, the share of lowest-premium plans that offered prescription drug coverage dropped from 84 percent to 74 percent.

Table 4. Out-of-Pocket Costs for Medical and Hospital Cost Sharing by Health Status, 1999–2006 (Lowest-Premium Plans)

					2005		2006
	1999	2003	Jan–Feb 2004	Mar–Dec 2004	Original Methodology	Revised Methodology	Revised Methodology
Medical and Hospital Cost Sharing							
All	$132	$301	$355	$317	$304	$415	$275
Good	117	178	192	171	166	166	73
Fair	159	623	787	708	669	1,175	726
Poor	258	1,087	1,380	1,230	1,219	1,698	1,706

Source: Mathematica Policy Research Analysis of Medicare Plan Finder Files and Centers of Medicare and Medicaid Services Market Penetration Files.

Note: This analysis uses methodology from HealthMetrix Research, Inc., to calculate out-of-pocket costs. Results are weighted by plan enrollment in March of each year, except 2005, which is weighted by enrollment in January 2005. Data for 2006 are for Medicare Advantage plans with prescription drug benefits and are weighted by December 2005 enrollment. HealthMetrix revised the utilization assumptions it uses for enrollees in fair and poor health in 2005 by increasing the assumed number of hospital stays and the length of hospital stays. They also modified terminology that year to refer to enrollees as basically "healthy," having "episodic needs," or having "chronic needs." The "all" category for 1999–2001 assumes 79 percent of enrollees are in good health, 15 percent are in fair health, and 6 percent are in poor health. This distribution corresponds to the distribution of self-reported health status among Medicare managed care enrollees in the 1999 Medicare Current Beneficiary Survey (MCBS) (Liu and Sharma 2003). The 2005 (revised) and 2006 estimates for all beneficiaries are from the 2003 MCBS. These estimates assume 78 percent are in good health, 16 percent are in fair health, and 6 percent are in poor health (CMS, Table 2.7 accessed at www.CMS.hhs.gov)

c. Prescription Drug Benefits

Even more striking, the content of prescription drug coverage changed dramatically between 1999 and 2005. In 1999, plans that covered prescription drugs typically covered both brand-name and generic drugs (plans were not asked by CMS to distinguish between the two until 2001). Also in 1999, over half of the enrollees with prescription drug coverage were in contracts whose lowest-premium offering had an annual limit on drug benefits of over $1,000 per year (22 percent had no limit). By 2005, 74 percent of beneficiaries were in plans that covered prescription drugs, but over half of them, or 39 percent of all beneficiaries, were covered only for generic drugs. Among the remaining 36 percent with coverage for brand-name drugs, 54 percent were looking at a coverage limit of $1,000 per year, and 30 percent at a limit of $500 or less.

Under the MMA, the 2006 minimum requirements for standard coverage in Part D include an annual deductible ($250), beneficiary cost sharing of 25 percent up to an initial coverage limit, a coverage gap in which beneficiaries pay all of the costs for prescription drugs, and catastrophic coverage once a beneficiary has incurred $3,600 in annual expenses. Beneficiaries pay 25 percent of the premium for this benefit. Additional help, such as reduced premiums and

cost sharing, is available to those with limited income and assets. Even though the standard benefit leaves beneficiaries (particularly those with extensive use of prescription drugs) with substantial out-of-pocket costs, the standard Medicare drug benefit improves on the coverage that most beneficiaries had from their MA plan before 2006. That standard benefit includes brand-name and generic drugs as well as catastrophic coverage, and the initial coverage exceeds most annual limits in effect in 2005.

The average premium paid by a beneficiary in a lowest-premium MA-PD in 2006 specifically for the drug benefit is $9 per month (Table 5). Almost two-thirds (64 percent) pay no additional premium for prescription drug coverage. Most lowest-premium plans (81 percent) waive the standard initial deductible in standardized Medicare coverage; 21 percent provide some coverage in the gap, almost always for generic-only. Tiered copayments are the norm, as they traditionally have been in MA plans. For an additional premium, about half the plans provide an expanded benefit package, in most cases waiving the deductible or offering generic coverage in the gap.

Regrettably, without further analysis of formularies and other details of the drug benefit package design, it is not possible to fully describe the coverage offered in these plans or what it implies for beneficiary out-of-pocket costs. However, the MedPAC's June 2006 Report to Congress (MedPAC 2006b) addresses this topic. They find that the typical formulary in a MD-PD lists about 1,096 drugs (versus 957 in free-standing PDPs). Larger formularies typically are in plans with more than two tiers of drugs (i.e., at least a generic and preferred and nonpreferred brand-name drug tier). More tiers reduce firms' financial risk because beneficiaries pay more in the higher tiers. Sixty-eight percent of MA-PDs use a three-tier structure, along with a fourth "specialty tier" for select high-priced drugs. On average, MA-PDs list 90 drugs in the specialty tier. Enrollees may not appeal the cost-sharing amounts for these drugs as they may for lower tiers.

Table 6 shows how the characteristics of prescription drug coverage in 2006 vary by the type of coverage offered in 2005 (these data are unweighted). Of the 935 lowest-premium MA-PDs plans in 2006, 337 used the same contract number/segment as in 2005; we used these to compare benefits.[19] The 2006 prescription drug benefits in these 337 plans are much better, on average, than in other plans that either were not offered or had a different contract-segment number in 2005. Both total premiums and premiums for the Part D component of the benefit are much lower, and the plans offered are more likely to cover the deductible.

Plans offering prescription drug coverage pre-MMA were likely to offer a more generous MA-PD benefit in 2006. Sixty-four percent of the 337 plans charged no additional premium for MA in 2005, and most of them (92 percent) did the same in 2006**;** 35 percent also offered some coverage in the gap in 2005. In contrast, plans charging higher premiums ($50 or more) in 2005

[19] The rest (598) include a mix of new entrants later in 2005, plans who experienced a change in contract number from the year before (e.g., in converting PPO demonstration to PPO), and those modifying the way they defined the segments of their service area for which a common benefit package was defined. (CMS requires that prescription benefits be the same across the entire service area within a region but firms may vary other benefits and the amount of savings used to offset the costs of the Part D benefit.)

charged $22 on average for prescription drug coverage in 2006 (and $81 overall for MA). The plans charging higher premiums in 2005 were less, not more, likely to offer expanded drug benefits in 2006, at least according to CMS's data. Plans that offered no drug benefit in 2005 were likely to charge beneficiaries a higher premium for such coverage in 2006, and they were less likely to cover the Part D deductible.

Table 5. Prescription Drug Premiums and Coverage in Medicare Advantage Plans with Prescription Drug Benefits (MA-PDs), Weighted and Unweighted, Lowest-Premium and Other Plans 2006 (Special Needs Plan-Only Contracts Excluded)

	All MA-PD Plans Unweighted	Basic MA-PD Plans Unweighted	Other MA-PD Plans Unweighted	Basic MA-PD Plans Weighted by December 2005 Contract Enrollment
Mean Drug Premium	$18.43	$12.14	$32.63	$8.99
Distribution				
Zero	39.1	52.1	9.9	64.2
Under $20	13.2	15.3	8.5	14.5
$20–$29.99	20.4	17.4	27.1	9.5
$30–$39.99	16.5	12.1	26.3	10.1
$40–$49.99	5.6	2.0	13.5	0.5
$50 or more	5.3	1.1	14.7	1.1
Initial Deductible				
None	80.7	77.0	88.9	81.3
Reduced	2.7	3.3	1.4	2.6
$250	16.6	19.7	9.7	16.2
Tiered Copayments				
Yes	92.2	91.0	94.9	91.1
No	7.8	9.0	5.1	8.9
Benefits in Coverage Gap				
None	72.4	78.9	57.7	78.7
Generic-only	22.6	16.4	36.7	17.0
Generic/brand-name	5.0	4.7	5.6	4.3
Percentage with Mail Order	95.6	94.8	97.3	83.6
Number of Contract Segments	1,349	935	414	5,298,561

Source: Mathematica Policy Research analysis of Centers of Medicare and Medicaid Services' (CMS) November 2005 Personal Plan Finder; enrollment data from the December 2005 Market Penetration Report.

Note: Table excludes contract segments with only Medicare Advantage-only plans (n = 34). Contract segments offering only special needs plans (SNPs) are excluded. Lowest-premium MA-PD plans were defined to include only those available to the general population (no SNPs).

[a]Enrollment reflects the total Medicare Advantage enrollment in that contract segment because CMS does not publicly report enrollment by plan. By definition, contract segments in 2006 are assumed to have a zero premium.

Table 6. Prescription Drug Premiums and Coverage in Lowest-Premium Medicare Advantage Plans with Prescription Drug Benefits (MA-PDs) 2006, Unweighted, by Selected Attributes of 2005 Prescription Drug Coverage

	Identifiable 2005 Segment That Offered Prescription Drug Coverage in 2006[a]		2005 Total Monthly Premium[a]			2005 Prescription Drug Coverage[a]		
Characteristics of 2006 MA-PD	Yes	No	Zero	$1 to $49	$50 or more	No Drugs	Generic-Only	Generic and Brand
Mean Total Premium	$23.23	$38.42	$1.94	$33.11	$81.26	$45.88	$22.97	$18.69
Distribution								
Zero	64%	40%	92%	25%	6%	25%	59%	74%
$1–$49	15	23	7	54	9	33	18	9
$50 or More	22	37	1	21	86	43	22	17
Mean Drug Premium	$7.97	$14.48	$1.49	$15.42	$22.36	$18.09	$9.68	$4.98
Distribution								
Zero	67%	44%	92%	31%	17%	25%	59%	80%
$1–$49	32	56	8.0	67	77	73	39	19
$50 or More	2	1	0.0	2	6	3	2	1
Initial Rx Deductible								
None	89%	70%	96%	75%	79%	55%	89%	96%
Reduced	3	3	1	12	4	10	5	1
$250	7	27	3	14	17	35	6	3
Tiered Copayments								
Yes	98%	87%	99%	100%	94%	88%	100%	100%
No	2	13	1	0	6	13	0	1
Benefits in Coverage Gap								
None	74%	81%	65%	92%	89%	98%	85%	64%
Generic-only	19	15	26	7	9	3	10	28
Generic/brand-name	7	4	9	0.0	3	0	6	8
Number of Contract Segments/Enrollees	337	598	215	52	70	40	103	194

Source: Mathematica Policy Research analysis of Centers of Medicare and Medicaid Services' November 2005 Personal Plan Finder.

Note: Table excludes contract segments with only Medicare Advantage-only plans (n = 34). Contract segments offering only special needs plans (SNPs)s are excluded. Lowest-premium MA-PD plans were defined to include only those available to the general population (no SNPs).

[a]Numbers rounded so totals may not equal 100 percent.

Historically, payments to MA plans have varied markedly across the country because the payments account for variation in traditional Medicare program spending by county. Whereas the differences in part reflect local variation in use and efficiency (Wennberg et al. 1999), variation in MA rates by county also has historically supported differences in the scope of benefits available through MA across the nation. Although the findings reported here do not distinguish between offerings and which plans beneficiaries actually choose, they suggest that geographical variation in the comprehensiveness of MA benefits for prescription drugs continues to exist under MA in 2006.

2. MA Premiums and Benefits by Plan Type, 2006

The following discussion of MA premiums and benefits in 2006 covers variation in lowest-premium plans by type of plan and the role played in the market by higher-premium plans in multiple plan offerings. As discussed previously, this section and the rest of the paper use unweighted data. Additional tabular displays of data on the topics discussed appear in Appendix B.

a. Distribution of Plans by Type and Extent of Multiple Offerings

HMOs have been in MA longer than any other plan type has, and they remain the predominant type of MA plan offered (Table 7).[20] Of the 935 lowest-premium plans, 66 percent are HMOs, 20 percent are local PPOs, 11 percent are PFFS plans, and 3 percent are regional PPOs. The low prevalence of regional PPOs reflects the requirement that they serve one or more of the 26 regions established nationwide (for the purpose of encouraging the availability of regional PPOs nationwide). Thus, though HMOs account for 66 percent of all MA-PDs, they serve smaller, and mostly urban, areas; and despite their numbers, they are available to a smaller percentage of beneficiaries than are regional PPOs (78 percent versus 88 percent). Although PFFS plans account for a small proportion of plans, they are widely available (80 percent of beneficiaries). See Gold (2006a) for additional analysis on this topic.

Firms can offer more than one MA-PD of the same type in the same set of counties.[21] On average, sponsors do this just about a third of the time (Table 7). Multiple offerings are most common in regional PPOs—three of every four regional offerings include both a lowest-premium plan and another plan. Regional PPOs also cover large areas (at least a single state), so sponsors may therefore see several levels of benefits as useful in addressing differences in beneficiaries' needs and preferences. Among plans available to the general population, multiple offerings are least common in PFFS plans (19 percent). Prescription drug coverage is optional in PFFS plans, so sponsors may feel that offering one plan is sufficient.

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[20] Readers seeking additional statistics on trends and availability of plans by type can find them in Gold (2006a).

[21] Because of the way we analyze the data, SNPs are considered separate types of plans though they may be authorized under the same contract. MA-only contracts also are excluded from this analysis. Hence, a contract segment that has only a single MA-PD could potentially also have an MA-only plan and an SNP serving the same area. Our previous analysis presented basic data on the way MA contracts structure their offerings, including the role of MA-only offerings (Gold 2006c, Appendix B).

Table 7. Number of Medicare Advantage Plans with Prescription Drug Benefits (MA-PDs) Plans Offered by Segment, by Contract Type, 2006

	All MA-PD Plans	Lowest Premium	Other	Percentage with 2+ MA-PD Plans
Total Contract Segments[a]	1,349	935	414	33%
Health Maintenance Organization	909	620	289	34%
Local Preferred Provider Organization	267	189	78	32%
Private For-Fee-Service	126	100	26	19%
Regional Preferred Provider Organization	47	26	21	73%
Total Special Needs Plans	242	193	49	24%

Source: Mathematica Policy Research analysis of Centers of Medicare and Medicaid Services' November 2005 Personal Plan Finder.

[a]Total contract segments excludes those that offer only SNPs.

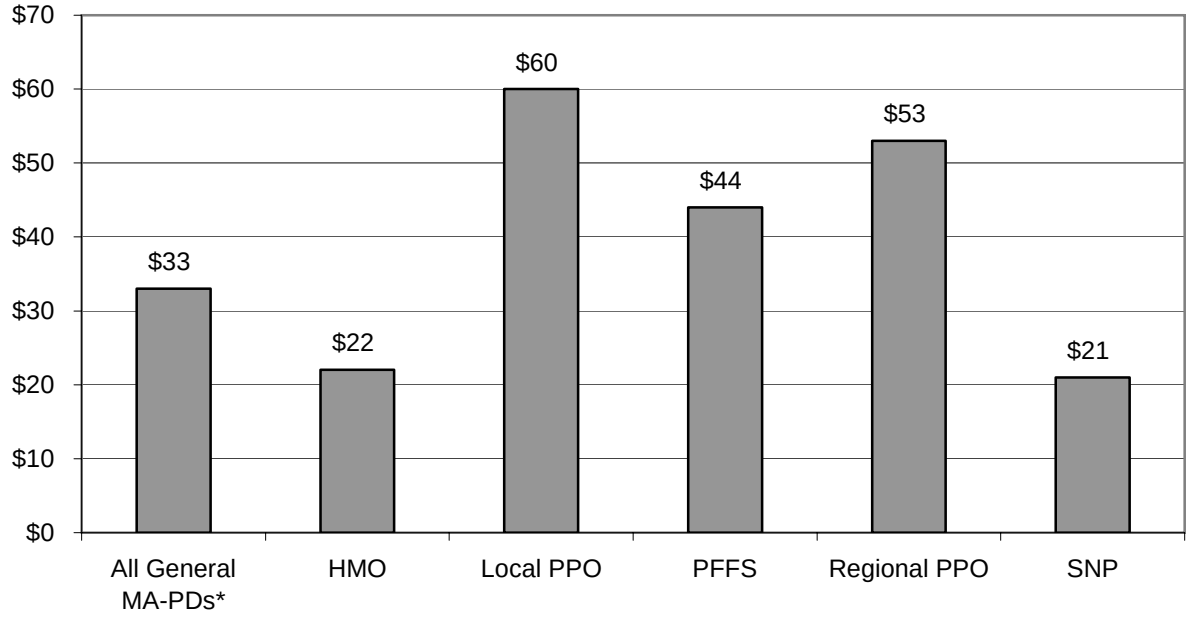
Because SNPs are defined by the population they serve rather than by the form of contract, we analyze them separately and do not include them in the overall MA-PD plan total. Of the 242 SNPs in the November 2005 Personal Plan Finder, 193 are lowest-premium SNPs.[22] Only 24 percent of SNPs offer more than one benefit package. This is not necessarily surprising, as most SNPs target dual eligibles and institutionalized people who qualify for the low-income subsidy (LIS) program that covers most cost sharing.

b. Premiums by MA-PD Plan Type

The total premium charged to Medicare beneficiaries for MA-PD coverage (including traditional Medicare benefits, Part D, and any supplemental coverage) varies substantially by type of MA-PD (Figure 2). Among the lowest-premium plans available to the general population, HMOs have the lowest premium ($22 per month). In other types of plans, premiums are two to three times higher. Local PPOs top the list at $60 per month, followed by regional PPOs ($53 per month) and PFFS plans ($44 per month). SNP premiums average about the same as do HMO premiums, which could reflect not only the fact that many use an HMO model, but also the nature of the target population and the CMS payment rates for such individuals.

[22] The Personal Plan Finder omits demonstration SNPs.

Figure 2. Average Total Monthly Premium Lowest-Premium Medicare Advantage Plans with Prescription Drug Benefits (MA-PD), by Type, 2006



Source: Mathematica Policy Research analysis of Centers of Medicare and Medicaid Services' November 2005 Personal Plan Finder.

*Excludes SNPs

Note: HMO, health maintenance organization; PPO, preferred provider organization; PFFS, private fee-for-service; SNP, special needs plan.

HMOs are also much more likely than other types of plans to offer a zero-premium product (Table 8). Among lowest-premium HMOs, 64 percent have a zero-premium product, including 9 percent that also make a contribution to reduce the Part B premium. Other than in HMOs, MA-PD coverage for no additional premium is most likely to be available in PFFS plans (24 percent). In contrast, 19 percent of local PPOs and 12 percent of regional PPOs charge a premium of $100 or more for their lowest-premium product. One explanation for this difference is that local and regional PPOs are targeting the Medicare supplemental market, which includes individuals who already pay and are used to seeing high premiums. These PPOs may feel less pressure to keep premiums down because the people they seek to reach are less price sensitive and not considering the more tightly managed MA products.

c. Physician and Hospital Cost Sharing by Plan Type

MA-PD plans cover at least some of the cost sharing for Part A and Part B services. Almost all plans charge a fixed-dollar copayment for primary care and physician services, rather than Medicare's standard 20 percent coinsurance.[23]

[23] In this analysis we consider the form of copayments for in-network services only. Later in this paper we examine the amount of cost sharing associated with out-of-network services, which are relevant to the coverage design in local and regional PPOs.

Table 8. Total Premiums for Lowest-Premium Medicare Advantage Plans with Prescription Drug Benefits (MA-PDs) by Type of Plan, Unweighted, 2006

	Lowest-Premium MA-PD Plans					
	All Types[a]	HMO	Local PPO	PFFS	Regional PPO	SNP[a]
Mean Total Premium	$32.94	$22.15	$59.78	$43.90	$52.99	$20.60
Mean If Premium More Than Zero	$63.90	$62.15	$69.32	$57.77	$62.63	$95.71
Distribution						
Zero	48.4%	64.4%	13.8%	24.0%	15.4%	11.9%
Includes reduced Part B premium also	6.6	9.0	3.2	0.0	0.0	4.1
$1–$19.99	4.6	3.7	2.6	14.0	3.8	41.5
$20–$49.99	15.3	10.6	27.0	18.0	30.8	42.5
$50–$99.99	23.5	16.5	38.1	36.0	38.5	3.1
$100 or more	8.1	4.8	18.5	8.0	11.5	1.0
Number of Contract Segments	935	620	189	100	26	193

Source: Mathematica Policy Research analysis of Centers of Medicare and Medicaid Services' November 2005 Personal Plan Finder.

Note: HMO, health maintenance organization; PPO, preferred provider organization; PFFS, private fee-for-service; SNP, special needs plan. [a]Data were segmented separately for SNPs and non-SNPs, with lowest premium assigned separately for each. The "all types" column excludes SNPs to avoid double counting plans within the same contract (where both SNPs and non-SNPs are offered).

Although traditional Medicare makes extensive use of deductibles and coinsurance for Part A and Part B benefits, such elements are rarely used by MA-PDs, regardless of the type of plan. (Out-of-network benefits in PPOs are an exception discussed later.) Instead, fixed-dollar copayments are used, probably because sponsors assume that beneficiaries and providers like the predictability of knowing the cost-sharing amounts in advance.

Among lowest-premium plans, cost sharing is least prevalent in SNPs, 72 percent of which charge no copayments for primary care visits and 53 percent charge no copayments for specialty care visits (Table 9). SNPs also have lower copayments for emergency room services. Although cost sharing for hospital admissions, outpatient care, and ancillary services is the norm, fewer SNPs than other plans charge enrollees for this care or these services. Almost all SNPs serve all or mostly dual eligibles whose cost sharing is covered by Medicaid, which could explain their unique profile. (We examine SNPs in more depth later in the paper.)

Among MA-PDs available to the general population, cost sharing is lowest, on average, in HMOs. Of the lowest-premium HMOs, 29 percent do not charge a copayment for primary care visits, and another 45 percent charge $10 or less. Whereas only about 20 percent of HMOs have a copayment of over $10 per visit for primary care, 65 percent charge this much for specialty care, and most HMOs (88 percent) require some cost sharing for hospital admissions. Moreover, well over half require cost sharing for ancillary care. Local PPOs structure cost sharing for in-network benefits much as HMOs do, but almost all charge some cost sharing for physician visits, and the amount charged is generally a little more than what HMOs charge (see Table 9).

Table 9. Copayments for Medical and Hospital Services in Lowest-Premium Medicare Advantage Plans with Prescription Drug Benefits (MA-PDs), Unweighted, by Type of Plan, 2006

		Lowest-Premium MA-PD Plans, by Plan Type				
	All Types[a]	HMO	Local PPO[b]	PFFS	Regional PPO[b]	SNP[a]
Primary Care Physician						
Mean Copayment	$9.68	$8.32	$11.26	$14.75	$11.12	$0.00
Distribution						
None	21.9%	29.4%	10.1%	2.0%	3.8%	72.3%
Less than $5	9.4	10.9	10.6	0.0	0.0	18.7
$5.01–$10	34.7	34.3	39.9	17.0	73.1	6.6
$10.01–$15	24.4	17.4	27.7	63.0	19.2	2.4
$15.01–$25	9.1	7.2	11.7	18.0	3.8	0.0
$25.01 or more	0.5	0.8	0.0	0.0	0.0	0.0
Varies	5.5	4.2	12.2	0.0	7.7	1.0
Coinsurance	1.0	1.3	0.5	0.0	0.0	14.0
Specialist Visit						
Mean Copayment	$21.67	$20.06	$22.81	$27.05	$30.77	$0.00
Distribution						
None	7.5%	10.2%	2.7%	2.0%	0.0%	52.6%
Less than $5	2.0	2.1	3.2	0.0	0.0	14.7
$5.01–$10	9.1	11.9	5.9	0.0	3.8	14.1
$10.01–$15	10.1	10.4	14.9	2.0	0.0	4.5
$15.01–$25	36.1	36.6	39.9	29.0	23.1	10.9
$25.01 or more	35.1	28.8	33.5	67.0	73.1	3.2
Varies	1.6	1.8	1.1	2.0	0.0	1.6
Coinsurance	1.1	1.5	0.5	0.0	0.0	19.2
Emergency Room						
None	3.5%	4.7%	2.1%	0.0%	0.0%	16.6%
Less than $20	0.1	0.2	0.0	0.0	0.0	0.0
$20.01–$40	3.4	3.7	3.7	2.0	0.0	21.8
$40.01–$50	9.2	91.5	94.2	98.0	100.0	61.7
$50.01–$74.01	0	0	0	0	0	0
$75 or more	0	0	0	0	0	0
Coinsurance	0	0	0	0	0	0
Any Cost Sharing						
Hospital admission	90.3%	87.9%	91.5%	100.0%	100.0%	75.6%
Hospital outpatient	87.9	87.1	83.6	100.0	92.3	55.4
X-ray services	76.1	71.9	74.1	100.0	100.0	61.7
Laboratory services	57.4	54.2	54.0	78.0	80.8	45.1
Number of Contract Segments	935	620	189	100	26	193

Source: Mathematica Policy Research analysis of Centers of Medicare and Medicaid Services' November 2005 Personal Plan Finder.

Note: HMO, health maintenance organization; PPO, preferred provider organization; PFFS, private fee-for-service; SNP, special needs plan.

[a]Data were segmented separately for SNPs and non-SNPs, with lowest premium assigned separately for each. The "all types" column excludes SNPs to avoid double counting plans within the same contract (where both SNPs and non-SNPs are offered).

[b]In PPOs, cost sharing is described for in-network benefits.

Beneficiaries who choose a regional PPO or a PFFS plan pay more out-of-pocket for physician and hospital services. In regional PPOs, the typical copayment for a primary care visit is around $10, but it is $25 or more for a specialty care visit. Eighty-one percent of PFFS plans have a copayment of more than $10 for primary care visits, and 98 percent charge that range for specialty care visits. In both regional PPOs and PFFS plans, copayments of $25 or more for a specialist visit are common (73 percent and 67 percent, respectively). All regional PPOs and PFFS plans have cost sharing for inpatient services (i.e., hospital admissions or days) and radiology; most also require cost sharing for hospital outpatient and laboratory services.

To gain insight into the effect of cost sharing on estimated out-of-pocket costs for enrollees in all types of plans, we used the same methods as in previous analyses to estimate out-of-pocket spending for hospital and physician services in the plans by type (Table 10). Specific estimates are provided for enrollees with different health status. Average estimates assume that enrollee distribution by health status within each type of plan is the same and should, for that reason, be used with caution on some comparisons (e.g., those involving SNPs).

Of plans available to the general MA population, the average estimated annual out-of-pocket spending on physician and hospital cost sharing by an enrollee with average health status is $275 in an HMO, compared with $324, $367, and $463, respectively, in local PPOs, PFFS plans, and regional PPOs. Enrollees with more extensive health care needs pay substantially more. Whereas cost sharing for physician and hospital services for a healthy beneficiary averages $88 per year in all types of plans, people with episodic health care needs pay, on average, $756 per year, and those with chronic-care needs pay $1,823 per year (these terms were previously labeled “good,” “fair,” and “poor” by HealthMetrix as discussed in Chapter 2.

According to the 2003 Medicare Current Beneficiary Survey (see CMS web site reference to Table 2.7), 78 percent of beneficiaries can be categorized as having at least “good” health. For these beneficiaries, the expected out-of-pocket costs in a PFFS plan are essentially the same as those in an HMO ($79 versus $80). For these individuals, enrollment in a regional PPO would cost the most (about $187 per year).

d. Prescription Drug and Supplemental Benefits by Plan Type

As in other areas, HMOs charge less than do other plan types for prescription drug benefits despite having a benefit package that is more comprehensive, on average. The average premium for prescription drug coverage in HMOs is $8.40, with 67 percent charging no premium at all (Table 11). This compares with an average premium of $15 for regional PPOs, $16 for PFFS, $19 for SNPs, and $22 for local PPOs. Among HMOs, 83 percent waive the initial deductible and 93 percent use tiered cost sharing. Though most HMOs (74 percent) retain the standard coverage gap, coverage in the gap is more likely among HMOs than other plans and they also are almost the only type of plan offering gap coverage that includes brand-name drugs. Regional PPOs appear to have the most limited prescription drug coverage—65 percent maintain an initial deductible and 54 percent use standard cost sharing rather than tiered copayments. Only 8 percent of regional PPOs—and no PFFS plans—offer drug coverage in the gap. Mail order benefits are typical in all plans. Free-standing PDPs also tend to offer more comprehensive benefits than Medicare requires but the premiums are higher and the differences aren’t as great (Gold 2006c).

Table 10. Estimated Out-of-Pocket Costs for Hospital and Physician Services in Lowest-Premium Plans, Unweighted, by Type, 2006

Estimated Out-of-Pocket Costs for Hospital and Physician Services, by Health	All (Except SNP)	HMO	Local PPO	PFFS	Regional PPO	SNP[a]
Lowest Premium MA-PDs						
All[b]	$299	$275	$324	$367	$463	N/A
Healthy	$88	$80	$107	$79	$187	$49
Episodic needs	$756	$698	$786	$984	$1,044	$469
Chronic needs	$1,823	$1,676	$1,901	$2,462	$2,498	$1,174
Number of Contract Segments	935	620	189	100	26	193

Source: Mathematica Policy Research analysis of Centers of Medicare and Medicaid Services' November 2005 Personal Plan Finder using HealthMetrix licensed methodology for estimating out-of-pocket costs.

N/A: These individuals are likely to differ in health status from the general population of beneficiaries.

Note: SNP, special needs plan; HMO, health maintenance organization; PPO, preferred provider organization; PFFS, private fee-for-service; MA-PD, Medicare Advantage plans with prescription drug benefits.

[a]Data were segmented separately for SNPs and non-SNPs, with lowest premium assigned separately for each. The "all types" column excludes SNPs to avoid double counting plans within the same contract (where both SNPs and non-SNPs are offered).

[b]Assumes 78 percent are healthy, 16 percent have "episodic needs," and 6 percent have "chronic needs."

Table 11. Prescription Drug Coverage in Lowest-Premium Medicare Advantage Plans with Prescription Drug Benefits , Unweighted, by Type of Plan, 2006

		Lowest Premium MA-PD Plans				
	All Types[a]	HMO	Local PPO	Local PFFS	Regional PPO	SNP
Mean Drug Premium	$12.14	$8.37	$21.88	$16.43	$14.74	$19.04
Distribution						
Zero	52.1%	66.9%	20.6%	27.0%	23.1%	11.9%
Under $20	15.3	11.8	17.5	22.0	57.7	41.5
$20–$29.99	17.4	11.3	28.0	39.0	3.8	29.5
$30–$39.99	12.1	7.3	28.0	12.0	11.5	15.5
$40–$49.99	2.0	1.6	4.2	0.0	3.8	0.0
$50 or more	1.1	1.1	1.6	0.0	0.0	1.6
Initial Deductible						
None	77.0%	83.1%	65.1%	73.0%	34.6%	36.3%
Reduced	3.3	2.3	7.9	2.0	0.0	1.6
$250	19.7	14.7	27.0	25.0	65.4	62.2
Tiered Copayments						
Yes	91.0%	93.2%	91.0%	89.0%	46.2%	59.6%
No	9.0	6.8	9.0	11.0	53.8	40.4
Benefits in Coverage Gap						
None	78.9%	73.7%	83.1%	100.0%	92.3%	0.0%
Generic only	16.4	19.5	15.9	0.0	7.7	0.0
Generic/brand	4.7	6.8	1.1	0.0	0.0	0.0
Percentage with Mail Order	94.8%	92.7%	97.9%	100.0%	100.0%	88.6%
Number of Contract Segments	935	620	189	100	26	193

Source: Mathematica Policy Research analysis of Centers of Medicare and Medicaid Services' November 2005 Personal Plan Finder.

Note: HMO, health maintenance organization; PPO, preferred provider organization; PFFS, private fee-for-service; SNP, special needs plan.

[a]Data were segmented separately for SNPs and non-SNPs, with lowest premium assigned separately for each. The "all types" column excludes SNPs to avoid double counting plans within the same contract (where both SNPs and non-SNPs are offered).

Supplemental benefit coverage does not vary dramatically by type of plan (Table 12). The exception is preventive dental benefits, which are much more common in regional PPOs (58 percent of these plans offer this coverage versus an average of 19 percent for all plans). Though preventive dental, physical exams, and vision benefits are less often covered in SNPs, these benefits are often covered in Medicaid for dual eligibles.

e. Augmented Benefit Packages

To gain further insight into what firms seek to gain by offering more than one MA-PD of the same type in the same geographic area, we compared lowest-premium and other plans on a few common parameters (Table 13): overall premiums, copayments for specialist visits, whether or not hospital cost sharing was used, the average estimated out-of-pocket costs for hospital and physician services, and whether the standard coverage gap for prescription drugs is in place. Because not all sponsors offer more than one MA-PD of each type, we compared not just lowest-premium with other plans but also subdivided the lowest-premium plans into those that did and those that did not offer another MA-PD option. Differences between lowest-premium and other plans among those offering both are particularly relevant in understanding choices available to beneficiaries.

Among HMOs, the most common product, total premiums, and mean specialist copayments are essentially the same in lowest-premium plans whether or not a second plan is offered. Those offering a second plan, however, are more likely to require hospital cost sharing in their lowest-premium offering (96 percent versus 84 percent) and to keep the standard Part D coverage gap (82 percent versus 70 percent). Additional plans cost substantially more per month ($77 versus $23 in the lowest-premium plan among those with two or more). In return they are structured to generate a reduction in expected out-of-pocket costs for hospital and physician services ($177 versus $272 in plans that offer two or more plans of the same type). The higher-premium offerings also are more likely to eliminate the coverage gap, at least for generic drugs.

Among regional PPO plans, where additional offerings are most common, premiums are substantially higher when the lowest-premium plan is one of multiple offerings versus the only offering ($63 versus $27). In the latter case, paying a somewhat higher premium ($85/month), on average, means enrollees face an estimated $405 annual expected out-of-pocket cost for hospital and physician cost sharing, versus the $488 they would face if they chose a lower-premium plan. In some cases (19 percent), individuals also obtain coverage within the gap, at least for generics. Local PPOs charge more than any other plan type in monthly premiums for their expanded plans ($103) but almost two-thirds (64 percent) incorporate some coverage in the gap.

Table 12. Supplemental Benefits in Lowest-Premium Medicare Advantage Plans with Prescription Drug Benefits (MA-PD), Unweighted, by Type of Plan, 2006

Percentage With	All Lowest Premium[a]	Lowest Premium MA-PD Plans by Type				
		HMO	Local PPO	PFFS	Regional PPO	SNP[a]
Preventive dental	18.8	20.6	14.8	5.0	57.7	23.8
Vision benefits	91.0	88.1	94.7	100.0	100.0	80.8
Hearing benefits	100.0	100.0	100.0	100.0	100.0	99.0
Physical exam	71.6	67.6	69.8	96.0	84.6	46.6
Podiatry benefit	98.7	98.2	99.5	100.0	100.0	90.7
Chiropractic benefit	96.4	94.7	99.5	100.0	100.0	83.4
Number of Contract Segments	935	620	189	100	26	193

Source: Mathematica Policy Research analysis of Centers of Medicare and Medicaid Services' November 2005 Personal Plan Finder.

Note: HMO, health maintenance organization; PPO, preferred provider organization; PFFS, private fee-for-service; SNP, special needs plan.

[a]Data were segmented separately for SNPs and non-SNPs, with lowest premium assigned separately each. The "all types" column excludes SNPs to avoid double counting plans within the same contract (where both SNPs and non-SNPs are offered).

Table 13. Selected Characteristics of Medicare Advantage Plans with Prescription Drug Benefits by Type, 2006

Plan Type (number)	Mean Total Premium	Mean Specialist Copay	Percentage with Any Hospital Cost Sharing	Average Out-of-Pocket Cost	Percentage with No Drug Coverage in Gap
HMO					
All lowest premium (620)	$22	$20	88%	$268	74%
Only lowest (408)	22	20	84	266	70
2+ plans (212)	23	21	96	272	82
All others (289)	77	17	82	177	58
Local PPO					
All lowest premium (189)	$60	$23	92%	$316	83%
Only lowest (128)	58	23	92	303	79
2+ (61)	64	23	90	344	92
All others (78)	103	20	85	273	36
PFFS					
All lowest premium	$44	$27	100%	$355	100%
Only lowest (81)	42	28	100	365	100
2+ plans (19)	53	23	100	312	100
All others (26)	64	20	77	268	100
Regional PPO					
All lowest premium (26)	$63	$31	100%	$453	92%
Only lowest (7)	27	26	100	360	86
2+ plans (19)	63	32	100	488	95
All others (21)	85	30	95	405	81

Source: Mathematica Policy Research analysis of Centers of Medicare and Medicaid Services' November 2005 Personal Plan Finder.

Note: HMO, health maintenance organization; PPO, preferred provider organization; PFFS, private fee-for-service.

f. MA-Only Plans

Plans offering MA coverage only are likely to do so for two main reasons: (1) to provide options for beneficiaries who do not want Part D coverage (or have it from another source) and (2) to accommodate employers who purchase such coverage separately. Although the Plan Finder only includes plans available to individuals, some of these plans could be available to all beneficiaries but targeted to beneficiaries with group retiree coverage. PFFS plans are not required to provide prescription drug coverage, so MA-only plans may be the only type of PFFS plan offered by any given firm. (PacifiCare, for example, a major sponsor of PFFS plans, did not include prescription drug coverage in its PFFS plan in 2006, although it did offer a separate nationwide PDP.)

In 2006, MA-only coverage averages $32 per month, ranging from $27 a month in HMOs to $47 per month in local PPOs (Table 14). Like MA-PDs, MA-only plans typically use fixed-dollar copayments (rather than deductibles or coinsurance) for physician visits, at least in-network. Cost sharing for hospital services is also the norm, typically with a fixed-dollar copayment.

3. Extent of Financial Protection in MA, 2006

The following discussion of financial protection offered to beneficiaries in MA-PDs addresses this issue particularly with respect to out-of-pocket spending for hospital and physician services. The discussion addresses (1) the extent of financial protection offered by traditional Medicare alone and as augmented by the two most common standardized Medigap benefits and (2) various ways in which MA's benefit structure would influence out-of-pocket costs for beneficiaries enrolled in MA plans of various types including (a) the extent of out-of-pocket cost limits in MA plans by type; (b) estimates of out-of-pocket costs for individuals either hospitalized or in need of mental health services; (c) out-of-pocket spending associated with the use of out-of-network benefits in local and regional PPOs; and (d) the structure of cost sharing in PFFS, an alternative to traditional Medicare coverage in which enrollment has been rapidly growing.

a. Out-of-Pocket Costs in Traditional Medicare (With and Without Medigap)

Medicare's standard Part A and Part B benefits require cost sharing for hospital and physician services (Table 15). Cumulatively, this requirement can cost a beneficiary a substantial amount of money, particularly if he or she uses a large volume of services.[24] Standard Medicare supplements typically pay all or most of these costs, although the premium tends to be high (over $100 per month)—too high for some beneficiaries, who may ultimately be priced out of the market. Because Medigap is structured to minimize out-of-pocket costs at point of service, the benefit structure also tends to distribute risk across Medicare beneficiaries regardless of how

[24] Standard Medicare coverage places no limit on the amount of out-of-pocket costs, which departs from the practice in employment-based coverage (at least for large employers) (Gold 2002).

Table 14. Overview of Premiums and Benefits, All Medicare Advantage-Only (MA-Only) Plans, by Contract Type, 2006 (Special Needs Plans (SNPs) Excluded)

	All MA-Only	HMO	Local PPO	PFFS	Regional PPO
Average Monthly Premium	$31.74	$27.09	$46.79	$38.28	$28.97
Distribution					
Zero	48.8%	60.8%	27.3%	20.0%	36.4%
$1–$49	24.0	17.0	27.3	49.3	36.4
$50 or more	27.1	22.2	45.5	30.7	27.3
Percentage with Cost Sharing for Hospital Admissions[a]					
None	13.8%	12.3%	20.8%	16.0%	4.5%
Deductible	1.4	2.0	0.0	0.0	0.0
Coinsurance	3.5	2.9	10.4	0.0	0.0
Deductible and coinsurance	1.6	2.3	0.0	0.0	0.0
Copayment	79.8	80.4	68.8	84.0	95.5
Cost Sharing for Primary Care Visits[a]					
None	17.8%	22.5%	3.9%	16.0%	0.0%
Deductible	7.4	2.9	10.4	6.7	68.2
Coinsurance	2.9	2.6	7.8	0.0	0.0
Copayment	82.2	77.5	96.1	84.0	100.0
Cost Sharing for Specialist Visits[a]					
Deductible	7.4%	2.9%	10.4%	6.7%	68.2%
Coinsurance	2.9	2.6	7.8	0.0	0.0
Copayment	89.9	88.6	98.7	84.0	100.0
Percentage That Cover					
Preventive dental	18.6	18.7	20.8	6.7	50.0
Vision benefits	93.4	90.6	98.7	98.7	100.0
Hearing benefits	100.0	100.0	100.0	100.0	100.0
Physical exam	76.0	76.3	67.5	78.7	90.9
Podiatry benefit	98.4	97.7	100.0	100.0	100.0
Chiropractic benefits	96.3	94.4	100.0	100.0	100.0
Number of Contract Segments	516	342	77	75	22

Source: Mathematica Policy Research analysis of Centers of Medicare and Medicaid Services' November 2005 Personal Plan Finder.

Note: HMO, health maintenance organization; PPO, preferred provider organization; PFFS, private fee-for-service.

[a]In-network benefits are described in instances in which out-of-network benefits are offered.

Table 15. Summary of Beneficiary Cost Sharing and Protection in Medicare and Medigap

Selected Coverage Features	Standard Medicare (2006)	Medigap Plan C	Medigap Plan F	New Medigap Plan K/L
Premium	No Part A Premium; $88.50 per month for Part B in 2006	AARP Policy for First-Year New Member (No Age Limit): $112.40 per month (DC)	AARP Policy for First-Year New Member (No Age Limit): $114 per month (DC)	AARP Policy for First-Year New Member (No Age Limit): $55/20/$78.20 (DC)*
Hospital Services	$952 for each hospital stay of 1–60 days (first day's deductible); $230/day for days 61–90; $476 per day for days 91–150 (while using your 60 lifetime reserve days); all costs for a hospital stay over 150	Covers the Part A deductible and hospital coinsurance Allows 365 extra hospital days per lifetime to Medicare's coverage	Same as Plan C	Same as Plan C except beneficiary must pay the initial deductible for each stay (K,L)
Physician Services	$124 Part B deductible; 20 percent of the Medicare-approved amount for most doctor services, outpatient therapy, preventive services, etc.; 50 percent for outpatient mental health	Covers the 20 percent coinsurance	Adds to Plan C coverage for the Part B deductible, and for 100 percent of the excess charges allowed but not paid for by Medicare (nonparticipating providers)	Covers half of the 20 percent coinsurance (K) or 75% (L). Pays all the coinsurance for preventive care. Beneficiary still pays deductible.
Out-of-Pocket Limit	None	None	None	$4,000 (K); $2,000 (L) per year

Source: Medicare.gov Web site; AARP prices are from http://www.aarphealthcare.com/quote/msrates.aspx?planType +MEDSUP (for ZIP Code 20008), accessed June 12, 2006.

*This plan may not yet be available. Medicare.gov shows that there are no Plan K/L plans in the District of Columbia.

much care they use. Medigap premiums are high typically but they provide beneficiaries with predictable health care costs.[25]

In an effort to correct what some view as an overly rich set of standardized Medicare supplemental options that left beneficiaries insensitive to the costs of care, the MMA added two new standardized Medigap plans. Plans K and L cover less of Medicare's front-end cost sharing but add an annual maximum limit ($2,000 and $4,000 respectively) on out-of-pocket spending. Because these plans are new, there is not enough experience for us to judge either their appeal or their premiums.

b. Out-of-Pocket Spending for Select Types of Services

Hospital Inpatient Services. In 2002, we conducted a detailed review of hospital cost sharing in MA (then called Medicare+Choice but we use MA for ease of presentation) (Achman and Gold 2002). At that time, HMOs accounted for almost all MA enrollees. Although HMOs traditionally imposed minimal cost sharing at the point of service (except for a small copayment charged for physician office visits), the use of cost sharing had been increasing and the range of services to which it applied was increasing. Whereas in 1999 only 4 percent of enrollees were in MA plans whose lowest-premium product had cost sharing for inpatient services, by 2002, the share was 78 percent. Deductibles were rare but plans typically charged either a copay per day (28 percent of plans) or a copay per stay (35 percent of plans). Around two-thirds (69 percent and 64 percent, respectively, for unweighted and weighted data) placed no limit on the amount of out-of-pocket spending.[26] Some could have had other forms of financial protection in place.

In 2002, we calculated that the average enrollee would be charged $264 for the facility costs of a three-day stay ($271 unweighted) and $830 ($900 unweighted) if they had two six-day and one three-day stays. When we repeated the same analysis this year for MA plans by type (we were not able to weight the data by enrollment), we found that the costs had increased. The mean estimated out-of-pocket expense for enrollees in the lowest-premium MA-PD HMO was $371 for a three-day stay and $1,429 for the three-stay combination (Table 16). These figures reflect an aggregate increase of 37 percent and 59 percent, respectively, on an unweighted basis over the four-year period. (Over this period, Medicare's Part A deductible increased from $812 in 2002 to $952 in 2006, or 17 percent.)

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[25] In contrast to MA, Medicare in general guarantees Medicare beneficiaries open access to Medicare supplements for only a brief time when they turn 65 and become eligible for Medicare. Disabled enrollees and those already on Medicare can be underwritten or denied coverage. Some states restrict such practices. Thus, beneficiaries may be able to purchase Medigap coverage at points other than their initial Medicare eligibility but, in general, Medicare does not require that insurers make such plans available.

[26] Annual limits were more common—21 percent and 29 percent, respectively, of unweighted and weighted lowest-premium plans. In addition, some plans may have limited total out-of-pocket spending but the amount was not captured in Medicare Compare.

Table 16. Estimated Inpatient Hospital Facility Costs for Enrollees in MA Lowest-Premium Medicare Advantage Plans with Prescription Drug Benefits by Type (In-Network Benefits Where Applicable), 2006

	HMO	Local PPO	PFFS	Regional PPO	SNP[a]
One Three-Day Stay					
Zero	2.9%	4.3%	0.0%	0.0%	1.0%
$1–$200	69.8	58.6	24.0	0.0	88.5
$201–$450	10.6	17.2	10.0	12.0	6.3
$451–$750	8.8	12.4	63.0	84.0	4.2
$751–$1,000	8.0	7.5	2.0	4.0	0.0
Over $1,000	0.2	0.0	1.0	0.0	0.0
Mean	$371	$369	$524[b]	$543	$277
Median	$300	$300	$540[b]	$495	$75
Maximum	$1,050	$900	$1,125	$885	$956[a]
Two Six-Day Stays and One Three-Day Stay					
Zero	16.6%	15.6%	0.0%	0.0%	35.6%
$1–$750	20.2	23.7	8.0	0.0	27.2
$751–$1,250	11.6	8.1	21.0	12.0	7.9
$1,251–$2,000	24.5	21.0	5.0	12.0	7.9
$2,001–$3,000	20.1	24.7	63.0	72.0	21.5
Over $3,000	7.0	7.0	3.0	4.0	0.0
Mean	$1,429	$1,372	$1,967[b]	$2,059	$921
Median	$1,300	$1,325	$2,340[b]	$2,145	$375
Maximum	$4,500	$4,425	$4,400	$3,400	$2,925[a]
Number of Contract Segments	620	189	100	26	192

Source: Mathematica Policy Research analysis of Centers of Medicare and Medicaid Services' November 2005 Personal Plan Finder.

Note: Includes only estimated facility costs (Part A) with any associated physician or other charges that are generated.

Note: HMO, health maintenance organization; PPO, preferred provider organization; PFFS, private fee-for-service; SNP, special needs plan.

[a]SNPs were tabulated separately from other types. Data were segmented separately for SNPs and non-SNPs. Basic flags were assigned separately for SNPs and non-SNPs. The SNP statistics exclude one contract segment with very high and potentially erroneous out-of-pocket costs that distort the coverages. (This SNP's out-of-pocket costs were $2,868 for a three-day stay and $14,340 for two six-day stays and one three-day stay.)

[b]If the lowest-premium PFFS plans are considered when the plans do not cover prescription drugs, the mean cost for a three-day stay is $428 ($450 median) and for the three stays it is $1,666 ($1,800 median); for Medicare Advantage-only plans, the mean costs are $502 ($540 median) and $1,899 ($2,340 median), respectively.

Expected costs for the same hospital use differ across MA types. For both patterns of use examined, costs were lowest in SNPs ($277 and $921, respectively). Out-of-pocket estimates in local PPOs were about on par with HMOs if enrollees stayed in-network ($369 and $1,372, respectively, for the two types of stays). Such costs would be highest for enrollees in PFFS plans ($524 and $1,967, respectively, for each type of stay) and regional PPOs ($543 and $2,059, respectively, for in-network hospitals).

In all probability the full costs of the hospital stay under any of the plans would be substantially greater because these estimates exclude separate physician charges that might be associated with the stay. (The Personal Plan Finder does not describe the features of coverage for inpatient physician care.)

Mental Health Services. In 2002, we also examined patterns of cost sharing for mental health services in Medicare and, as before, the data are based almost entirely on HMOs (Achman and Gold 2002). In 2002, 65 percent of plans (74 percent of enrollees) had some cost-sharing requirement for inpatient mental health services. Only 8 percent of plans imposed a deductible, 30 percent had a copay per day, and 37 percent had a copay per stay.[27] Although deductibles were rare (5.5 percent both weighted and unweighted), copayments per stay or per day were common and some plans (around 8 percent) used both.

Inpatient cost sharing for mental health services was more extensive in 2006 than 2002 and its form has changed (Table 17). In 2006, 85 percent of HMOs (the basis of the 2002 estimates) had some cost-sharing requirement for inpatient mental health services (versus 65 percent in 2002). Deductibles were less common in 2006 than in 2002 (0.3 percent versus 8 percent). However, 6 percent of HMOs in 2006 had cost-sharing requirements for each day of the stay, more than double the share in 2002. The growth in per-day cost sharing was associated with reduced per-stay cost sharing (19 percent in 2006 versus 37 percent in 2002).

Outpatient cost sharing for mental health services was the norm in 2002, which may not be surprising given the fact that the Medicare benefit applies a 50 percent coinsurance charge for such services. All but 3 percent of plans in 2002 had some cost sharing for outpatient mental health services. Although 4 percent of MA plans in 2002 charged coinsurance, most MA plans substituted fixed-dollar copayments for Medicare's cost-sharing requirements. We calculated that a beneficiary making 52 visits in 2002 would spend $1,000 or less in 37 percent of plans, between $1,001 and $2,000 in 52 percent of plans, and over $2,000 in 2 percent of plans.[28]

By 2006, the share of HMOs offering outpatient mental health services without cost sharing (9 percent) increased slightly although so did the share of HMOs making any use of coinsurance (8 percent). On average, beneficiaries in HMOs paid around $25 per mental health visit; some plans charged less for initial visits. There was some improvement in average cost sharing for outpatient visits (see Table 17). The same beneficiary making 52 visits in 2006 would spend

[27] These are unweighted data; some plans used multiple forms of cost sharing—2 percent had both a deductible and a copay per day and 8 percent had both a per-stay and per-day requirement on cost sharing.

[28] These estimates exclude the 4 percent of plans using coinsurance.

Table 17. Mental Health Cost Sharing, Lowest-Premium Medicare Advantage Plans with Prescription Drug Benefits, by Type (In-Network Benefits Where Applicable), 2006

	HMO	Local PPO	PFFS[a]	Regional PPO	SNP[b]
Inpatient Mental Health					
No Cost Sharing	15.2%	13.2%	0.0%	3.8%	22.3%
Deductible Only	0.3	0.0	0.0	0.0	2.1
Copayments:					
Per-stay only	19.4	22.8	29.0	11.5	3.1
Per-day only	61.3	60.3	71.0	69.2	51.3
Both	1.8	3.7	0.0	11.5	4.1
Deductible and Copay Per Day	2.1	0.0	0.0	3.8	17.1
Outpatient Mental Health					
No Cost Sharing	8.5%	1.1%	0.0%	0.0%	36.3%
Other	1.3	0.5	62.0	0.0	0.0
Deductible	0.0	0.0	0.0	0.0	0.0
Coinsurance	7.7	2.6	23.0	3.8	17.1
Copayment:	82.5	95.8	15.0	96.2	46.6
First visit	$25.17	$26.33	$23.33	$33.60	$16.07
Other visits	$25.43	$26.55	$23.33	$33.60	$16.29
Estimated Cost Sharing for 52 Outpatient Mental Health Visits					
Zero	8.5%	1.1%	0.0%	0.0%	36.3%
$1 to $600	7.2	7.9	2.0	3.8	25.9
$601 to $1,000	9.9	11.1	0.0	0.0	9.3
$1,001 to $1,300	34.9	31.7	9.0	11.5	13.5
$1,301 to $2,000	27.6	33.9	62.0	73.1	4.1
Over $2,000	11.9	14.3	27.0	11.5	10.9
Number of Contract Segments/Enrollees	620	189	100	26	193

Source: Mathematica Policy Research analysis of Centers of Medicare and Medicaid Services' November 2005 Personal Plan Finder.

Note: HMO, health maintenance organization; PPO, preferred provider organization; PFFS, private fee-for-service; SNP, special needs plan.

[a]If we also include lowest-premium MA-only plans where no Medicare Advantage plan with prescriptive drug benefits exists (an additional 29 plans), the results are relatively similar in most ways. For the full set of 129 lowest-premium PFFS plans, 27 percent and 73 percent, respectively, are per-stay and per-day copayments for inpatient care. However, 22 percent of the total use coinsurance for outpatient care (versus 48 percent using "other" and 30 percent using copayments for outpatient care). The share of enrollees estimated to spend $1,301–$2000 is 54 percent and over $2,000 is 25 percent (4 percent spend less than $600 and 18 percent spend $1,001–$1,300.)

[b]Data were segmented separately for SNPs and non-SNPs, with lowest premium assigned separately for each.

$1,000 or less in 26 percent of plans, between $1,001 and $2,000 in 63 percent of plans, and over $2,000 in 12 percent of plans.

Although no plan type used deductibles for outpatient mental health services in 2006, coinsurance was very common in PFFS plans (23 percent used it and we estimate that 27percent of beneficiaries would have out-of-pocket costs for 52 visits exceeding $2,000—higher than any other plan type. The mean charge within a regional PPO was substantially higher than in other plan types (around $34 per visit); an estimated 85 percent of beneficiaries would pay $1,300 or more a year if they made 52 visits.

SNPs were more likely to not require any cost sharing (36 percent) and had lower average copayments ($16), but more of them (17 percent) used coinsurance. In SNPs, 36 percent of beneficiaries would have no cost sharing for 52 outpatient visits and another 26 would pay under $600 per month.

c. Financial Risk in Using Out-of-Network Services in PPOs

Conceptually, a major attraction of PPOs rests in the fact that beneficiaries can gain some of the price advantage of negotiated rates in network-based managed care but still have the ability, if they are willing to pay a little more, to seek care from providers who might not be part of the network. However, this option may be mainly psychological if out-of-network cost-sharing charges are very high. For example, if out-of-network care includes a deductible, it could create a financial barrier that would limit enrollees' ability to seek care even for services whose individual costs may not be high.

Table 18 shows the cost-sharing amounts charged enrollees who use out-of-network benefits in a regional or local PPO. Out-of-network deductibles for physician services are common, although more so in regional PPOs than in local PPOs (80 percent versus 45 percent). In about 4 out of 5 plans, cost sharing is structured through coinsurance requirements rather than fixed-dollar copayments. Although Medicare charges 20 percent, higher rates may be charged when a beneficiary in a PPO seeks care out-of-network. Three-fifths of regional PPOs (62 percent) charge 30 percent coinsurance for out-of-network physician services. Local PPOs are more likely than regional ones (38 percent versus 19 percent) to charge beneficiaries the same percentage out-of-network as Medicare charges. However, 13 percent of local PPOs charge 25 percent coinsurance for out-of-network physician services and 19 percent charge 30 percent. These are for primary care visits but there is relatively little difference in the cost-sharing structure between primary care and specialty visits. (MA plans calculate coinsurance based on their own schedule of allowances, and the underlying rates may differ from those Medicare sets.)

Although out-of-network hospital benefits in PPOs are covered, the form of the coverage is likely to make the use of them relatively unattractive to enrollees. Eighty-five percent of regional PPOs and 77 percent of local PPOs require coinsurance for such benefits, which is typically at least as high as Medicare's. None of the regional or local PPOs include a deductible when enrollees obtain hospital inpatient services out-of-network. They all require some cost sharing for these services, most typically in the form of coinsurance. Among lowest-premium regional PPOs, 89 percent require coinsurance, with 74 percent setting this at 30 percent. Among local PPOs, 74 percent use coinsurance but local PPOs tend to have a 20 percent coinsurance requirement (as Medicare does) rather than the 30 percent requirement common in regional PPOs(57 percent of lowest-premium regional PPOs).

Table 18. Out-of-Network Cost-Sharing Requirements in Local and Regional Preferred Provider Organizations (PPOs), 2006 (Lowest-Premium Medicare Advantage Plans With Prescription Drug Benefits)

	Regional PPOs	Local PPOs
Out-of-Network Deductible for Physician Care		
Yes	80.8%	44.7%
No	19.2	55.3
Primary Care Visits		
Copayment	15.4%	22.9%
Coinsurance	84.5	77.1
20 percent	19.2	38.3
25 percent	0.0	12.8
30 percent	61.5	19.1
Other	3.8	6.9
Specialist Visits		
Copayment	15.4%	22.5%
Coinsurance	84.6	77.6
20 percent	15.4	38.0
25 percent	0.0	12.8
30 percent	61.5	19.3
Other	7.7	7.5
Hospital Inpatient Services		
No cost sharing	0.0%	1.1%
Deductible	0.0	0.0
Coinsurance	88.5	73.7
20 percent	17.4	57.1
25 percent	0.0	10.0
30 percent	73.9	27.9
Other	8.7	5.0
Copayment		
Per day	3.8	12.1
Per stay	7.7	12.6
Both	0.0	0.5
Number of Contract Segments	26	190

Source: Mathematica Policy Research analysis of Centers of Medicare and Medicaid Services' Personal Plan Finder (November 2005 Medicare).

d. Extent of Financial Protection in PFFS

We also examined in detail the cost-sharing structure for PFFS plans to see how much financial protection such plans offered beneficiaries. Readers should recall that Medicare itself includes considerable out-of-pocket cost sharing in its benefit structure with no out-of-pocket limits. However, most beneficiaries look to either Medicare supplements or MA to make up this difference. We wanted to see how PFFS compared in protecting beneficiaries choosing such plans.[29] Because PFFS contracts are not required to cover prescription drugs, we looked at all PFFS plans, as well as just PFFS plans that cover prescription drugs (MA-PDs). We also examined all plans versus the lowest-premium plans to get a sense of the range of products in the marketplace.

As shown in Table 19, PFFS plans typically shift Medicare's cost sharing from a model based on deductibles and coinsurance to one based on fixed copayments. For physician services, fewer than 5 percent of all lowest-premium plans have any deductible for physician visits and none use coinsurance. Copayments for primary care visits vary but are often relatively high (over $25/visit) for a specialist visit. For inpatient services, PFFS plans most typically (81 percent of lowest-premium plans) charge a copayment per day that is typically between $101 and $200 per day, is not limited to the first day (as Medicare's deductible is), and changes by day 10. Out-of-pocket costs are limited in all but 23 percent of lowest-premium PFFS plans, with 74 percent having a limit between $2,501 and $5,000 per year. Some augmented plans have less cost sharing though only 8 percent of all plans have an out-of-pocket limit of $2,500 or less per year.

e. Total Annual Limit on Out-of-Pocket Costs

Medicare lacks an out-of-pocket limit on out-of-pocket spending for Part A and Part B services. The MMA requires only regional PPOs to offer such a limit. However, such limits are especially important in contracts that require substantial amounts of cost sharing, or have other features that mean they can result in high costs for those who use substantial service. Table 20 shows the percentage of lowest-cost MA-PDs and other MA-PDs by contract type with such a limit.

Overall, 56 percent of lowest-premium MA-PDs have no limit, and another 29 percent have a limit of more than $2,500. The types of plans that are most likely to carry such limits are ones that have extensive cost sharing. Among lowest-premium MA-PDs, 65 percent of HMOs, 53 percent of local PPOs, and 24 percent of PFFS plans have no limit on annual out-of-pocket spending. Though local HMOs and PPOs are less likely to have such limits, they set them at a lower level, on average, when they do use them. In PFFS and regional PPOs, out-of-pocket

[29] Medicare's regulations specify that benefit packages may not be designed in ways that discourage enrollment or encourage disenrollment of severely or chronically ill beneficiaries. However, Medicare allows firms substantial flexibility in benefit package design (subject to CMS review). For example, in its Call for 2007 MA plans (CMS 2006b), CMS suggests an annual out-of-pocket limit for Part A and Part B services, excluding premium, of $3,100—reflecting the 75th percentile of out-of-pocket costs for beneficiaries in traditional Medicare. However, though CMS recommends sponsors consider such a limit, only regional PPOs are required to do so. To provide some incentive for plans to include such a limit, CMS says it will give more latitude to plans that limit such out-of-pocket expenses to $3,100 or less in establishing cost-sharing amounts for individual services.

Table 19. Cost Sharing in Private Fee-For-Service (PFFS) Plans, 2006

Cost Sharing	All PFFS Plans	Lowest-Premium PFFS Plans	
		All PFFS Plans	MA-PD Only
Primary Care Physician Visit			
None	7.0	1.6	2.0
Deductible	2.5	3.8	0.0
Coinsurance			
Less than 20%	0.0	0.0	0.0
Exactly 20%	0.0	0.0	0.0
20% or more	0.0	0.0	0.0
Copayment			
$10 or Less	31.3	29.5	17.0
$11–$15	33.8	48.8	63.0
$16–$25	24.9	15.5	18.0
More than $25	0.0	0.0	0.0
Varies	0.5	0.8	0.0
Specialist Physician Visit			
None	7.0	1.6	2.0
Deductible	2.5	3.9	0.0
Coinsurance			
Less than 20%	0.0	0.0	0.0
Exactly 20%	0.0	0.0	0.0
20% or more	0.0	0.0	0.0
Copayment			
$10 or less	11.4	2.3	0.0
$11–$15	4.0	3.1	2.0
$16–$25	36.8	33.3	29.0
More than $25	37.8	55.0	67.0
Varies	0.5	0.8	2.0
Hospital Inpatient Stay			
None	9.0	0.0	0.0
Deductible	0.0	0.0	0.0
Coinsurance	0.0	0.0	0.0
Copayment Per Stay	27.9	18.7	15.0
$1–$150	3.0	1.6	2.0
$150 or higher	24.9	17.1	13.0
Copayment Per Day	63.2	81.4	85.0
$100 or less (Day 1)	8.7	7.6	3.5
$101–$200 (Day 1)	85.0	84.8	87.1
$201 or more (Day 1)	6.3	7.6	9.4
Different Copay Day 2	0.0	0.0	0.0
Different Copay Day 10	96.9	96.2	0.0
Limit on Days	10.1	22.9	13.0
Percentage With an Out-of-Pocket Maximum on Total Out-of-Pocket Spending Per Year			
$1,000 or less	6.0	0.0	0.0
$1,001 to $2,500	2.0	3.1	0.0
$2,501 to $5,000	62.2	73.6	76.0
More than $5,000	0.0	0.0	0.0
Percentage with No Out-of- Pocket Maximum	29.9	23.3	24.0
Number of Contract Segments/Enrollees	201	129	100

Source: Mathematica Policy Research analysis of Centers of Medicare and Medicaid Services' November 2005 Personal Plan Finder; enrollment data from the December 2005 Market Penetration Report.

Note: MA-PD, Medicare Advantage plans with prescriptive drug benefits.

Table 20. Percentage of Medicare Advantage Plans with Prescription Drug Benefits (MA-PDs) with an Out-of-Pocket Annual Limit on Spending, by Plan Type, 2006

	All MA-PDs		HMO		Local PPOs		PFFS[a]		Regional PPOs	
	Lowest Premium	Other	Lowest Premium	Other	Lowest Premium	Other	Lowest Premium	Other	Lowest Premium	Other
No Limit	56.1%	58.5%	64.7%	68.2%	52.7%	50.0%	24.0%	23.1%	0.0%	0.0%
$1,000 or less	1.4	3.1	1.5	2.4	2.1	5.1	0.0	0.0	0.0	9.5
$1,001–$2,500	13.6	18.4	14.5	21.1	18.5	16.7	0.0	0.0	0.0	9.5
$2,501–$5,000	28.4	20.0	19.4	8.3	24.3	28.2	76.0	76.9	7.7	9.5
Over $5,000	0.4	0.0	0.0	0.0	2.1	0.0	0.0	0.0	0.0	0.0
Number of Contract Segments	620	414	620	289	189	100	26	26	26	21

Source: Mathematica Policy Research analysis of Centers of Medicare and Medicaid Services' 2006 Personal Plan Finder (November 2005) release.
Note: HMO, health maintenance organization; PPO, preferred provider organization; PFFS, private fee-for-service.

[a]Among lowest-premium Medicare Advantage-only PFFS plans, 21 percent have no limit, 14 percent have a limit between $1,001 and $2,500, and 66 percent have a limit of $2,501–$5,000.

limits almost always are above $2,500 per year annually. When sponsors offer additional MA-PDs of the same type with higher premiums, the higher-priced offerings do not typically add limits if they are not used in the lowest-premium plan and the amount of the limit is not substantially different.

Although the structure of cost sharing in some plans may make such an out-of-pocket limit moot, our analysis suggests that a beneficiary with extensive health care needs could generate substantial out-of-pocket expense. The structure of most MA plans does not protect beneficiaries (particularly for an enrollee with moderate income and/or recurring expenses year after year) in these circumstances because there is either no limit or a limit that is high.

4. Characteristics of SNPs[30]

This section reviews the characteristics of SNPs, their benefits and premiums, the role of these plans in selected markets, and the characteristics of chronic-care SNPs. We conclude with a discussion of the rationale behind SNPs and assess their future viability.

a. Description and Caveats: SNPs' Relationship with Medicaid

Medicare's Personal Plan Finder lists SNPs under 127 contracts, 93 of which are for specific types of MA products. Of the 93, 78 are HMO contracts, 10 are local PPO contracts, 3 are regional PPO contracts, and 2 are regional PPO contracts. United Healthcare is particularly dominant in this market, holding 42 of the 127 MA contracts involving SNPs, but a variety of other organizations also offer SNPs, many of which have been active in the Medicare MA market (Gold 2006b). Nineteen SNPs are offered as demonstrations involving joint Medicare–Medicaid products that were in place before 2006 in Massachusetts, Minnesota, and Wisconsin.

The Plan Finder used for analysis included 242 plans, 81 percent (195) of which are designed for dual-eligible enrollees and 14 percent (34) of which are designed for institutionalized beneficiaries, many of whom are also probably enrolled in Medicaid. Because enrollment in all SNPs includes a very large share of dual eligibles who receive benefits from state Medicaid programs and who have some or all of their Medicare premiums and cost sharing paid by Medicaid, interpreting SNP Medicare premiums and cost sharing presents some special challenges.

SNPs have the option to serve all dual eligibles or only "full" dual eligibles, the latter of whom receive benefits from Medicaid that Medicare may not cover (e.g., vision, dental, mental health, transportation) and pay little or nothing in Medicare premiums and cost sharing. The fact that Medicaid adds to Medicare's benefits and fills in beneficiary cost sharing influences the design of SNP benefit packages for dual-eligible beneficiaries. For example, in thinking about adding benefits in SNPs that may be routine in other MA plans, sponsors have to consider that the benefit already may be covered by Medicaid. If so, little may be gained for beneficiaries by its addition. On the other hand, because the cost of these additional benefits for duals will be paid largely by Medicaid, it may actually cost SNPs little to offer them. In addition, Medicaid's

[30] We are grateful to Jim Verdier for advice on interpreting SNP statistics in policy context.

contribution to Medicare cost sharing and benefits excluded from Medicare may not be as fully available to dual eligibles in practice as they are on paper, given limited beneficiary awareness of the benefits, provider and managed care organization difficulties in collecting cost-sharing payments from states, and wide variability in the generosity of state Medicaid programs.

The analysis of SNP premiums, benefits, and cost sharing is also complicated by the fact that, in some states, such as Arizona, Massachusetts, Minnesota, and Wisconsin, the plans contract directly with the state to cover Medicaid benefits. Although an analysis of SNPs may thus need to be state-specific and even plan-specific to capture the impact of Medicaid on SNP premiums and benefit packages, the Medicare Personal Plan Finder does not incorporate any of these Medicaid cost-sharing or benefit features. It is designed to cover Medicare benefits only. (CMS says that it will be making changes in the Personal Plan Finder in 2007 to provide more information on SNPs.)

Hence, the analysis documented in this section provides an important first cut in understanding SNPs, but it is still just a beginning. We describe SNPs nationwide by type and then, to the extent possible, how offerings vary across markets; we look specifically at a few distinct, large markets in different areas of the country. We conclude this section with a discussion of the rationale for SNPs and some of the factors likely to be relevant in determining their future.

b. SNPs by Type

Table 21 shows the premiums charged and benefits provided in SNPs of each type, a useful distinction given the diversity in focus across plan types. Such diversity mirrors differences in expected need for services and also in expected MA payment levels. For example, the rates CMS pays for MA account for these characteristics for dual eligibles and institutionalized individuals; plans serving those with chronic or disabling conditions receive higher payments through risk adjustment to account for the higher costs of beneficiaries with selected conditions. The latter adjustments are available to any Medicare enrollee with the same health status regardless of whether they are in a regular MA plan or an SNP. As noted above, the tables show only the benefits offered through the Medicare program. Some of the plans may also have contracts with Medicaid that complement the services financed by Medicare. Such Medicaid contracts might include coverage for Medicare premiums and cost sharing for Part A and Part B services as well as benefits for long-term care (especially for institutionalized individuals). Neither CMS nor the Plan Finder provides information on these arrangements, so we cannot describe them here.

Premiums. SNPs are paid just as other local MA plans are paid—with a rate defined on the basis of an enrollee's county of residence, demographic characteristics, and health risk. (Prescription drug payments are the same throughout all counties in a given region.) MA plans are required to cover both traditional Part A and Part B benefits as well as Part D. Plans seeking to enroll dual eligibles (or other individuals eligible for the federal subsidy) must also set premiums below the benchmark for the low-income subsidy for Part D to be judged eligible to have their premiums offset fully by the subsidy. MA plans seeking to serve dual eligibles (as most SNPs do) thus have an incentive to keep the premium below the Part D benchmark but not

Table 21. Special Needs Plans, Unweighted, by Type, 2006

	All SNPs	Dual Eligible	Institutional	Chronic or Disabling Condition
Premium				
Mean Total Premium	$23.04	$20.99	$22.02	$56.57
Mean if Premium More Than Zero	$25.46	$22.48	$26.74	$81.72
Distribution				
Zero	9.5	6.7	17.6	30.8
Includes reduced Part B premium also	3.7	3.6	0.0	15.4
$1–$19.99	36.0	42.1	11.8	7.7
$20–$49.99	49.2	47.2	70.6	23.1
$50–$99.99	3.7	3.6	0.0	15.4
$100 or more	1.7	0.5	0.0	23.1
Mean Drug Premium	$20.43	$19.00	$22.02	$37.70
Drug Distribution				
Zero	9.9	7.2	17.6	30.8
Under $20	36.0	42.1	11.8	7.7
$20–$29.99	36.4	36.9	44.1	7.7
$30–$39.99	16.1	13.3	26.5	30.8
$40–$49.99	0.0	0.0	0.0	0.0
$50 or more	1.7	0.5	0.0	23.1
Hospital and Physician Cost Sharing				
Primary Care Physician				
None	77.1	78.0	80.6	50.0
Less than $5	15.0	17.3	3.2	10.0
$5.01–$10	6.1	3.5	9.7	40.0
$10.01–$15	1.9	1.2	6.5	0.0
$15.01–$25	0.0	0.0	0.0	0.0
$25.01 or more	0.0	0.0	0.0	0.0
Varies	0.8	0.5	2.9	0.0
Coinsurance	11.6	11.3	8.8	23.1
Specialist Visit				
None	59.1	58.3	68.0	50.0
Less than $5	11.8	13.7	0.0	10.0
$5.01–$10	11.3	11.3	4.0	30.0
$10.01–$15	3.4	3.6	4.0	0.0
$15.01–$25	11.8	12.5	8.0	10.0
$25.01 or more	2.5	0.6	16.0	0.0
Varies	1.2	0.5	2.9	7.7
Coinsurance	16.1	13.8	26.5	23.1

Table 21 *(continued)*

	All SNPs	Dual Eligible	Institutional	Chronic or Disabling Condition
Emergency Room				
None	19.0	16.4	29.4	30.8
Less than $20	0.0	0.0	0.0	0.0
$20.01–$40	20.7	23.1	8.8	15.4
$40.01–$50	60.3	60.5	61.8	53.8
$50.01–$74.01	0.0	0.0	0.0	0.0
$75 or more	0.0	0.0	0.0	0.0
Coinsurance	0.0	0.0	0.0	0.0
Any Cost Sharing				
Hospital admission	76.4	74.4	91.2	69.2
Hospital outpatient	57.4	59.0	50.0	53.8
X-ray services	62.4	69.7	29.4	38.5
Laboratory services	48.8	51.8	32.4	46.2
Percentage With				
Preventive dental	22.7	26.7	2.9	15.4
Vision benefits	83.5	81.5	97.1	76.9
Hearing benefits	99.2	99.0	100.0	100.0
Physical exam	50.4	59.5	11.8	15.4
Podiatry benefit	88.8	88.7	97.1	69.2
Chiropractic benefit	82.6	82.6	91.2	61.5
Part D Benefits				
Initial Deductible				
None	33.5	25.1	64.7	76.9
Reduced	1.2	1.5	0.0	0.0
$250	65.3	73.3	35.3	23.1
Tiered Copayments				
Yes	52.1	47.7	67.6	76.9
No	47.9	52.3	32.4	23.1
Percentage with Mail Order	90.5	91.3	85.3	92.3
Number of Contract Segments	242	195	34	13

Source: Mathematica Policy Research analysis of Centers of Medicare and Medicaid Services' November 2005 Personal Plan Finder; enrollment data from the December 2005 Market Penetration Report.

to eliminate it entirely (i.e., no zero-premium plans) because doing so would prevent them from taking advantage of the subsidy. Instead, SNPs—as do other MA plans seeking to serve dual eligibles—have an incentive to keep the premium just low enough to qualify for the subsidy and apply any other available funds to augment benefits or to offset the premium for such services. This incentive assumes, of course, that SNPs can accurately predict where the benchmark would be set in 2006, which would be difficult to determine without prior experience with Part D in 2006.

In 2006, the average SNP charges a $23 premium, most of which ($20) is for Part D. Part D premiums account for a large share of the total premium in both dual-eligible SNPs ($19 of $21) and SNPs for institutionalized beneficiaries ($22 of $22). In contrast, monthly total premiums ($57 on average) and Part D premiums ($38 on average) are higher in SNPs set up to serve beneficiaries with specific severe chronic or disabling conditions. On the other hand, 31 percent of these plans charge no premium at all (including 15 percent—almost all in Puerto Rico—that gave a rebate on the Part B premium). So plans serving beneficiaries with chronic or disabling conditions may be quite variable in terms of premium structure.

Physician and Hospital Cost Sharing. SNPs that focus on dual-eligible or institutionalized individuals feature much less cost sharing than do MA plans focused on the general population. Among SNPs serving dual eligibles, 78 percent do not charge a copayment for primary care visits, and 58 percent do not charge a copayment for specialist visits. Among SNPs geared to institutionalized beneficiaries, the corresponding figures are 81 percent and 68 percent. However, though cost sharing has been low on average, 27 percent of SNPs for institutionalized beneficiaries are structured with coinsurance for specialist care. SNPs created for beneficiaries with severe chronic or disabling conditions are less likely than MA plans available to all beneficiaries to charge a different cost-sharing amount for primary care and specialty care services. But the plans do vary in terms of whether they use cost sharing or not: 23 percent apply coinsurance to both kinds of visits, yet 50 percent charge nothing at all. The rationale for this variation is unclear, though it could reflect the differences in benchmark levels across parts of the country.

SNPs serving institutionalized beneficiaries and those with severe chronic or disabling conditions are also less likely to charge copayments for emergency visits, although, as with other plans, a charge of about $50 is common in the majority of plans. (CMS limits emergency room copayments to no more than this amount.) It could be that sponsors of SNPs serving those with severe chronic or disabling conditions are less concerned about discretionary use of the emergency room by their enrollees than they are in providing easy access to the emergency room in case problems arise regarding other access barriers or problems in coordinating care for severely ill or disabled people.

Cost sharing for hospital services is almost universal among SNPs for institutionalized beneficiaries (91 percent require it), but it is also used by another two-thirds of other SNPs (74 percent of SNPs focused on the dual eligible population use it, as do 69 percent of SNPs serving those with severe, chronic, or disabling conditions). In contrast, those serving dual eligibles are more likely than SNPs serving other populations to have cost sharing for ancillary services (e.g., x-ray and laboratory).

The likelihood that an SNP covers benefits not included in the Medicare package also varies by plan type. For example, 27 percent of SNPs for dual eligibles cover preventive dental services, whereas only 3 percent of SNPs for institutionalized beneficiaries do so (SNPs serving those with severe chronic or disabling conditions fall midway between these extremes). Both institutional and dual-eligible SNPs are also more likely than SNPs for beneficiaries with severe chronic or disabling conditions to cover chiropractic, podiatry, or vision benefits. In contrast, dual-eligible SNPs are more likely than the other two types of SNPs to retain the initial deductible for Part D benefits and standardized Part D cost sharing via coinsurance—designs that may be intended to maximize the value of the LIS benefits received within the SNP so that internal funds can be used elsewhere.

c. SNPs in Local Market Context

Because MA payments (except to regional PPOs) vary by county, it is impossible to really understand how SNPs are positioned with respect to beneficiaries unless one looks at the local market. To provide this perspective, we selected seven counties, listed below, that are (1) well known to those interested in MA, (2) geographically diverse, and (3) known to account for a substantial share of beneficiaries. Each is also home to at least one SNP.

- Dade County, Florida (Miami)
- Hennepin County, Minnesota (Minneapolis)
- Kings County, New York (Brooklyn in New York City)
- Los Angeles County, California
- Maricopa County, Arizona (Phoenix)
- Milwaukee County, Wisconsin
- Pinellas County, Florida (St. Petersburg)

Table 22 summarizes the mix of general MA plans and SNPs in each of the identified counties, along with the total number of beneficiaries. (SNPs in the Minnesota and Wisconsin demonstrations are not included because CMS does not list them in the Plan Finder.) The table shows that both the number of MA contracts and the number and mix of plans vary substantially across markets. Further, though some of the disparity may be due to size, size alone cannot explain why Los Angeles County has 12 contracts and 14 plans, whereas Dade County has 24 and 37, respectively. Dade, which includes Miami, has some of the highest MA payment rates in the nation and a history of many MA offerings in general. Beneficiary premiums for MA-PD plans available to all beneficiaries in the areas we examined vary widely and are very low in such markets as Miami or Los Angeles. Of the markets we examined, premiums are highest in Hennepin (Minneapolis), which has a relatively low payment rate. In SNPs, virtually all the premiums are allocated to Part D services. Drug premiums in SNPs exceed those of general MA-PD plans in the same market, but the relationship between the two kinds of plans in overall premiums varies by market.

d. Chronic-Care SNPs

Table 23 provides information on the 13 SNPs serving beneficiaries with severe chronic or disabling conditions. These plans represent 11 entities (Care Improvement Plus in Maryland has three plans). Only three entities are in the markets mentioned earlier (two in Los Angeles County and one in Maricopa County). The range of beneficiaries targeted by the 11 organizations is very

Table 22. Medicare Advantage (MA) General Plans and Special Needs Plans (SNPs) in Specific Markets, 2006

	Dade	Hennepin	King	LA	Maricopa	Milwaukee	Pinellas
Total Contracts with General MA Plans (not SNP)							
Total	24	7	20	12	18	4	13
Number of plans	37	7	30	14	24	5	24
Number of HMO plans	32	3	23	13	9	2	19
Number of local PPOs	2	0	6	0	4	1	5
Number of regional PPOs	2	1	1	1	2	1	0
Number of PFFS	1	3	0	0	9	1	0
Average Premium (lowest premium MA-PD)							
Total	$3.98	$72.83	$9.28	$0.54	$19.20	$21.40	$12.50
Rx	$1.01	$19.21	$5.09	$0.54	$6.89	$11.43	$4.59
SNPs[a]							
Total	11	1	8	6	9	1	4
Dual eligible	10	1	8	4	6	1	3
Institutionalized	1	0	0	0	2	0	1
Other	0	0	0	2	1	0	0
Mean Premium (lowest-premium SNPs)							
Total	$10.87	$33.11	$22.95	$20.51	$13.78	$10.71	$20.69
Rx	$10.87	$33.11	$22.95	$20.51	$13.87	$10.71	$20.69

Source: Mathematica Policy Research analysis of Centers of Medicare and Medicaid Services' 2006 Medicare Plan Finder (November 2005 release).
Note: HMO, health maintenance organization; PPO, preferred provider organization; PFFS, private fee-for-service; MA-PD, Medicare Advantage plan with prescriptive drug benefits.

[a]These SNPs include SNPs offered under general MA contracts as well as those under SNP-only contracts.

Table 23. Chronic-Care Special Needs Plans

Organization	Location	Population Focus	Total Premium	Hospital Cost-Sharing
Sun Health MediSunONE	Phoenix-Mesa-Scottsdale, AZ	Heart conditions	$0	Max hospital cost sharing per stay $500 No max hospital cost sharing per year
Universal Care Health Advantage	Bakersfield, CA Los Angeles-Long Beach-Santa Ana, CA Oxnard-Thousand Oaks-Ventura, CA Riverside-San Bernardino-Ontario, CA	Seriously and persistently mentally ill	$23.25	Copay of $239.00 per day for days 61 to 90 No max hospital cost sharing per stay No max hospital cost sharing per year
Health Net of California	Riverside-San Bernardino-Ontario, CA	COPD and CHF	$0	No cost sharing
Medicare y Mucho Mas	Puerto Rico	COPD, CHF, renal failure (pre-ESRD), diabetes, and chronic cardiomyopathy plus “some other chronic conditions”	$0	No cost sharing
Dakota Care	Rapid City, SD Sioux City, IA-NE-SD Sioux Falls, SD	Those who have had a stroke or heart problem	$195.71	Copay of $100 per day for days 1 to 2 Copay of $0 per day for days 3 to 90 No max hospital cost sharing per stay No max hospital cost sharing per year
United Healthcare Insurance Company	Atlanta-Sandy Springs-Marietta, GA	ESRD	$30.69	No cost sharing
Aveta CarePartners	Chicago-Naperville-Joliet, IL-IN-WI	COPD, heart disease, CHF, and pre-ESRD	$0	No max hospital cost sharing per stay Max hospital cost sharing per year $675

Table 23 *(continued)*

Organization	Location	Population Focus	Total Premium	Hospital Cost-Sharing
Care Improvement Plus (has three different contract numbers)				
1. Silver plan	Baltimore-Towson, MD Washington-Arlington-Alexandria, DC-VA-MD	ESRD, diabetes, CHF	$33	No copay for 1 to 60 days Deductible per stay: $956 No max hospital cost sharing per stay No max hospital cost sharing per year
2. Gold plan	Baltimore-Towson, MD Washington-Arlington-Alexandria, DC-VA-MD	Diabetes, CHF	$83	Copay of $125 per day for days 1–5 No max hospital cost sharing per stay or year
3. Platinum plan	Baltimore-Towson, MD Washington-Arlington-Alexandria, DC-VA-MD	Diabetes, CHF	$163	No cost sharing
Positive Healthcare Partners	Los Angeles-Long Beach-Santa Ana, CA	HIV/AIDS	$18.37	No cost sharing.
Elder Care Health Plan, Inc.	Madison, WI	Diabetes, heart problems, circulation problems, and chronic lung conditions	$138	No cost sharing
Village Health	Riverside-San Bernardino-Ontario, CA	Dialysis, kidney transplant, and posttransplant patients	$50.20	Deductible per stay $956 No max hospital cost sharing per stay No max hospital cost sharing per year

Notes: COPD, chronic obstructive pulmonary disease; CHF, coronary heart failure;; ESRD, end-stage renal disease; HIV/AIDS, human immunodeficiency virus/acquired immunodeficiency syndrome.

wide; some are geared specifically to seriously and persistently mentally ill individuals, those with end-stage renal disease, and those with HIV, whereas others focus on individuals with one and often several chronic conditions common to the elderly (e.g., coronary heart disease, chronic obstructive pulmonary disease, and diabetes). Actual eligibility criteria may be more detailed than indicated in the Plan Finder.

e. Rationale for the Interest in SNPs and Speculation on Their Future

The number of SNPs has increased dramatically since they were authorized in 2003 by the MMA. Today, 91 entities account for the 164 contracts that include an SNP (CMS 2005; MedPAC 2006b). Some contracts involve sponsors that have been traditionally active in MA. United Healthcare is among the most prominent—its Evercare product for institutionalized beneficiaries was expanded substantially under the MMA. Other SNP sponsors, including firms such as Ameri-Health, Wellcare, Healthspring, AMERIGROUP, and Molina (Gold 2006a), reflect experience in Medicaid programming. A total of 276 SNPs are offered throughout the country, and although the data on these plans are limited, it appears that most SNP enrollees are jointly eligible for Medicare–Medicaid.

MedPAC (2006b) recently analyzed the early experience with SNPs, partly through site visits to three markets (Verdier and Au 2006). The agency sees SNPs as part of a logical progression of efforts to better coordinate care for beneficiaries who are dually eligible for Medicare and Medicaid (see Table 24 for a summary of earlier efforts). Coordination could be particularly valuable now because Medicare and Medicaid have duplicate or sometimes competing requirements that weaken or eliminate incentives to manage the totality of care for dually eligible beneficiaries, particularly if one program benefits and the other pays for services needed for better management of a beneficiaries' care. But MedPAC (2006b) also suggests that the incentives for partnering could diminish in 2006 because the inclusion of a drug benefit under Medicare limits the financial involvement of Medicaid in paying for acute care.

The ultimate potential of SNPs is not clear. They have attracted leading firms in the industry, which obviously see the model as worth exploring. However, in all likelihood, these firms are motivated by different factors depending on their longer-term business strategies and their preexisting portfolio of products. Verdier and Au (2006) point out, for example, that SNP marketing strategies vary. Among SNPs that target dual eligibles, some market extensively whereas others do not and instead seem focused on retaining their current Medicaid managed care enrollees (who are dual eligible) as Medicare absorbs the drug benefit. Institutional SNPs, in contrast, tend to market both to specific facilities known to offer such plans and to the families of residents in those facilities. SNPs that target beneficiaries with chronic and disabling conditions market primarily to physicians, other chronic-care providers, and related advocacy groups. Building enrollment that can support the managed care infrastructure will be a major challenge for SNPs over the next year (Verdier and Au 2006). Verdier and Au also speculate that unless SNPs incorporate long-term care (which is funded by Medicaid), the benefits they offer may not be sufficient to entice enrollees to join.

The future of SNPs may also be influenced by how Medicare addresses select policies. For example, SNP authority expires at the end of 2008 unless Congress acts to extend it. A mandated evaluation of the program is due at the end of 2007, but because of start-up and other issues in

Table 24. Special Managed Care Programs for Dual Eligibles

Program of all Inclusive Care for the Elderly (PACE)	Authorized by the Balanced Budget Act for frail elderly beneficiaries 55 and older who meet state's standards for nursing home placement and reside in areas served by PACE organizations. Most beneficiaries are dually eligible. PACE provides comprehensive medical and social services through interdisciplinary teams in an adult day health care center setting, along with in-home and referral services. Plans are paid separate capitation payments from Medicare and Medicaid. The Medicare rate now includes a frailty adjuster. PACE plans negotiate Medicaid rates with states.
Minnesota Senior Health Options and Disability Health Options	This program, operating under Medicare's demonstration authority, pays separately capitated Medicare and Medicaid rates for program benefits, including home- and community-based care and nursing facility services. It serves enrollees who qualify for nursing home care and others, as a voluntary alternative to Minnesota's mandatory managed care program.
Wisconsin Partnership Program	Under demonstration authority, community-based organizations with a Medicaid managed care contract and Centers for Medicare and Medicaid Services (CMS) contract are capitated for services provided to seniors over 55 and physically disabled dual eligibles. Qualifying beneficiaries must be nursing home certified.
Massachusetts MassHealth Senior Care Options	Under demonstration authority, organizations contract with Medicaid and CMS to provide the full range of Medicare and Medicaid benefits. The organizations serve community-well, community-frail, and institutionalized people ages 65 and over.

Source: Adapted from Medicare Payment Advisory Commission (2006b, p. 216)

2006, it is not clear that this timeline is long enough to amass enough data or experience to assess the program. Unless sponsors feel certain that SNPs will remain an option after 2008, they may be reluctant to invest in their future development, particularly as the deadline approaches.

Another issue involved in the future viability of SNPs is their financial and organizational feasibility. Some suggest that the phase-in of more comprehensive risk adjustment (to be completed in 2007) will provide the incentive necessary to attract sponsors to beneficiaries whose more extensive health care needs qualify them for SNPs (MedPAC 2006b). But MA does not include a frailty adjuster, and SNPs could find such an adjuster valuable, especially if their enrollees incur costs that are not predicted well by the current medically based risk adjuster. These costs of treating frail elders are recognized in plans under PACE; in addition, elected demonstrations receive a frailty adjuster based on member limitations in activities of daily living (the latter will be phased out for demonstrations after 2007). Although CMS is considering applying a frailty adjuster more broadly in MA, the earliest it could take effect would be 2008 (Verdier and Au 2006).

The potential of SNPs to thrive will also depend on how well the federal government and the states can address the many administrative issues that SNPs raise for Medicare and Medicaid (MedPAC 2006b). SNPs that successfully coordinate both Medicare and Medicaid benefits may offer the most promise as a specialized plan. For example, SNPs say that Medicare's Personal Plan Finder now does not distinguish well between the unique features of SNPs, thus obscuring their value to beneficiaries. In addition, SNPs assert that the MA quality monitoring and reporting system is not really applicable to either the SNP target populations or their benefit

package. Finally, conflicting Medicare and Medicaid rules related to such issues as bidding, contracting, enrollment, and marketing also stand in the way of integrating care for dual eligibles under SNPs.

Of course, administrative change to facilitate integration is important only if the SNP design itself is an effective one. Pending further research, the answer to that question will remain unknown. In theory, the concept of specialization and coordination is appealing. Yet MedPAC's site visits reveal that many SNPs, at least in the markets studied, have so far not made major changes in their structure, such as adding new departments, staff, or data systems, which could be valuable in enhancing care management (Verdier and Au 2006). MedPAC (2006b) has indicated its intent to continue monitoring SNPs with a view toward their goal of achieving better integrated and better coordinated care.

E. CONCLUSIONS

The findings from this analysis raise operational and policy concerns, each of which we discuss below.

1. Operational Concerns

The findings from our analysis of the characteristics of benefits and premiums offered by MA plans in 2006 indicate that the structure of such benefits and premiums are particularly complex, presenting beneficiaries with more MA plan types that vary in how they function and in how benefits and cost sharing are structured. More than ever, beneficiaries will need solid support as they decide between one plan and another, as the challenges in doing so are formidable (Hibbard et al., 2006; MedPAC 2006b).

For instance, in the mid- to late 1990s, beneficiaries might have been able to assume that any plan they chose would offer comprehensive benefits at minimal cost at the point of service; however, this is no longer the case. Although HMOs continue to provide, on average, the most comprehensive benefits for the lowest premium, their benefit structure now assumes that beneficiaries will share substantially in the costs of such benefits. Newer options such as PFFS plans and regional PPOs require substantially more cost sharing; and although they generally have an annual limit on out-of-pocket spending, the limit is also typically high, particularly for a beneficiary with limited income or recurrent high expenses. In addition, these newer options provide beneficiaries with what appears to be greater access to providers of their choice, but in reality, that access could be far less—either because of the high cost sharing charged by PPOs for out-of-network services or because some providers decide not to treat patients in PFFS plans. Although the latter are required to accept all providers willing to take plan payment, providers are not required to see PFFS patients. We are not aware of evidence that access problems exist, but beneficiaries must understand the potential risks and trade-offs to make the best choice for themselves.

2. Policy Concerns

We do not know yet whether changes in MA present opportunities or risks for Medicare beneficiaries; however, there is some cause for concern. The opportunities stem from the fact that plans integrate benefits from Medicare Part A, Part B, and supplemental services and, if

states cooperate, from Medicare and Medicaid as well, particularly through SNPs. Integrated financing under a capitated model has the potential to encourage more coordination, but actually doing so also requires substantially restructuring of care delivery. The fact that most of the recent growth in MA offerings is in relatively unmanaged types of plans seems to conflict directly with this goal. Moreover, the value of PFFS for beneficiaries compared to traditional Medicare in particular remains unclear, particularly if the extra benefits offered by these plans are financed by payments that exceed Medicare's own costs for delivering a fee-for-service benefit.

The evolving structure of MA's plans, along with their benefits and premiums, also presents a risk because of what it may mean in light of the overall fiscal constraints facing Medicare. Although the cost of traditional Medicare with Medigap often exceeds the financial capacity of many beneficiaries, the combination has historically provided beneficiaries with reasonable protection against catastrophic costs, at least for acute care. MA's structure makes the premiums for supplemental coverage more affordable to beneficiaries, but it also leaves beneficiaries, especially those who need care the most, financially vulnerable, particularly if a beneficiary does not qualify for the LIS despite his or her limited financial resources.

In effect, the structure of MA has put beneficiaries at more risk than they historically have been for rising costs, the rationale being that this risk will give them a more personal stake in health care costs and therefore an incentive to contain them, an end sought by multiple and competing plans. Sponsors must provide Medicare's benefits, but if the cost of doing so exceeds CMS's payments, they can raise premiums for their plans, including charging more than traditional Medicare does for the program's benefits. Right now, beneficiaries still have some protection because the traditional Medicare program remains intact.

Whether this protection will continue to exist is not clear. Beneficiaries who drop Medigap coverage when they enroll in an MA plan could find it difficult (because of medical underwriting) or unaffordable (because age rating may be used even in plans that don't use medical underwriting) if they decide to switch back to traditional Medicare. Further, if the beneficiaries who remain in traditional Medicare are sicker than those who switch to MA, costs in the traditional program will go up, which may lead Congress to reconsider the promises Medicare has made to beneficiaries.

Even though few analysts expect the MMA's required premium-support demonstration to go forward,[31] the design of Medicare Part D, along with associated MA changes, has the potential over time to modify the Medicare program in important substantive ways. In effect, beneficiaries seeking prescription drug coverage now have to choose a private health plan. Choosing a free standing PDP allows them to stay in traditional Medicare. However, there are strong financial incentives for beneficiaries without subsidized support for Medicare supplemental benefits (via former employers, Medicaid or others) to enroll in MA. Further, there are an increasing number of MA choices whose structure provides open access to any provider (assuming they agree to see the patient). MA plan benefits are likely to compare favorably to the Medicare/PDP option because, MA plans typically receive more for providing Part A/B beneficiaries than Medicare now spends in the traditional program; plans must use 75 percent of

[31] This demonstration calls for head-to-health competition between traditional Medicare (with PDPs) and MA in a number of markets.

any savings to expand benefits or reduce beneficiary costs. If sizeable proportions of beneficiaries enroll in these plans, the offsetting protection represented by traditional Medicare's uniform, national package of benefits for a standard premium could weaken.

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APPENDIX A

MEDICARE'S HISTORY WITH PRIVATE PLANS

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Though an overwhelming majority of Medicare beneficiaries have always been enrolled in the traditional fee-for-service Medicare program, for a number of years Medicare has tried to offer beneficiaries the option of enrolling in a private health plan. This appendix briefly reviews Medicare's history with private plans, including the Medicare risk-contracting program, the Medicare+Choice program, and the current Medicare Advantage program.

EARLY CONTRACTING WITH HMOS

When the Medicare program was created in 1965, it was structured to resemble fee-for-service insurance products that were typical in the health insurance market at the time. However, even in the early days, Medicare made allowances for existing managed care plans. At the time, a few private prepaid health plans served the private employer market. These plans paid their physicians on a salaried basis and were allowed (under Section 1833) to contract with Medicare. Initially, these plans were paid on the same basis as other providers for Part A services and received cost-based reimbursement for Part B services.

In 1972, Congress introduced a voluntary Medicare health maintenance organization (HMO) program under section 1876 of Title 18 of the Social Security Act. (Section 1833 remained an option.) Section 1876 allowed Medicare HMOs to be paid on a cost basis or to receive capitated payments for all Part A and Part B services. This program also established risk sharing with the government. Health plans and the federal government would split up to 20 percent of any savings HMOs could provide in delivering Part A and Part B services, compared with the Adjusted Average Per Capita Costs (AAPCC) that the government would have incurred had the enrollee remained in the fee-for-service system. Any savings greater than 20 percent went wholly to the government. Any losses remained with the health plan, although they could be carried over to future years and applied to subsequent savings. One major difference between plans authorized under Section 1833 and those authorized under Section 1876 was that the latter required open enrollment of Medicare beneficiaries. (Under Section 1833, underwriting standards used in the individual nongroup market could be applied for Medicare.)

Given the option of cost-based contracts or risk-based contracts, most health plans choose cost-based contracts.

THE TEFRA RISK CONTRACTING PROGRAM

Congress authorized the Tax Equity and Fiscal Responsibility Act (TEFRA) in 1982. Under this new risk-sharing program for private plans in Medicare that became active in 1985, HMOs assumed responsibility for providing all Medicare-covered services to beneficiaries, Part A and Part B, in return for a capitated payment. The capitated payment an HMO would receive from the Health Care Financing Administration (HCFA, now the Centers for Medicare and Medicaid Services) for each enrollee in the health plan equaled 95 percent of the cost HCFA estimated it would have spent had the same beneficiary remained in traditional fee-for-service Medicare. Health plans were also required to return any additional savings they achieved in caring for enrollees (beyond the 5 percent) in the form of additional benefits or reduced premiums. Additional benefits could include services not covered by the traditional Medicare program, such as prescription drugs and dental, vision, and hearing services.

The additional benefits and low premiums offered by health plans were the main reason that Medicare beneficiaries enrolled in private health plans in most markets; other factors were more important in markets such as Portland, Oregon (Brown and Gold 1999). In exchange for the lower costs and added benefits, beneficiaries had to give up the choice of provider by agreeing to see the HMO's restricted set of providers.

When the new program began in 1985, fewer than a half million Medicare beneficiaries were enrolled in private health plans (Gold 2001). Enrollment in the program grew steadily, however, and by 1993, 5 percent of all Medicare beneficiaries—about 1.8 million people—were participating in the risk program. An HCFA evaluation of the program found that enrollees in the HMOs received care comparable with that received by those enrolled in fee-for-service Medicare and had substantially lower out-of-pocket costs. However, the evaluation also found that the government wasn't saving any money by having the Medicare beneficiaries in the HMOs because Medicare beneficiaries with better health status were more likely to enroll in the HMOs (to lower their costs) (Brown et al. 1993).

THE MEDICARE+CHOICE PROGRAM

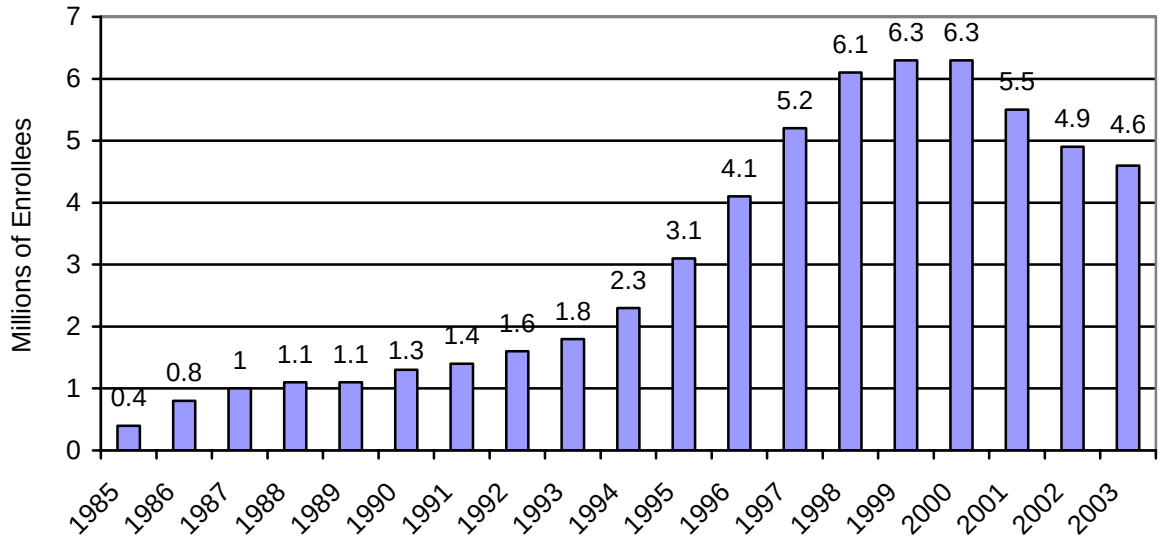
Congress created the Medicare+Choice (M+C) program as part of the Balanced Budget Act of 1997 (BBA) to further expand enrollment in private plans within Medicare. The M+C program was intended to provide more alternatives to traditional fee-for-service Medicare by encouraging newer types of private health plans beyond the traditional HMO to enter the program.

The M+C program incorporated the existing Medicare risk program but also authorized a range of new plan options. In addition to HMOs, the BBA provided for (1) preferred provider organizations (PPOs), which allow beneficiaries to seek out-of-network care at higher cost-sharing levels; (2) provider-sponsored organizations (PSOs), in which the providers sponsor their own managed care organization rather than contracting with an HMO or PPO; and (3) private fee-for-service (PFFS) plans that do not restrict an enrollee's access to providers.[32] As under the Medicare risk program, enrollment in private plans remained voluntary.

Under the Medicare risk program, HCFA paid health plans an administered price based on the county of residence of each enrollee, with rates differing across the country in ways that reflected variation in use in the traditional Medicare program. In creating M+C, Congress modified the payment systems to establish inflation-adjusted minimum payment rates in rural counties (the "rural floor") to encourage health plans to enter areas that were previously underserved by managed care plans. M+C also introduced "blended rates" in an effort to reduce county-by-county variation. Plans were guaranteed that payment rates would increase at least 2 percent a year, however. Because costs in the traditional Medicare program grew slowly after the BBA was enacted, what was envisioned as a 2 percent minimum increase in fact became the overall cap or amount of increase.

[32] Under the M+C program, Congress categorized HMOs, PPOs, and PSOs as coordinated care plans.

Figure A-1. Enrollment in Medicare Risk/Medicare+Choice Plans, 1985–2003



Source: Gold et al. 2004.

Note: Data for 1999–2003 are for enrollees in M+C coordinated care plans. Data for prior years are for enrollees in Medicare risk contracts. All data are for December of the given year based on CMS's *Medicare Managed Care Contract Plans Monthly Summary Report*.

From 1999 forward, significant numbers of health plans withdrew from the M+C program. While there were 309 contracts for coordinated care plans in Medicare+Choice in 1999, that number dropped to just 151 by 2003. In total, approximately 2.4 million M+C enrollees were affected by plan withdrawals from 1999 to 2003 (Gold et al. 2004).

Health plans cited a number of reasons for withdrawing from the program, including inadequate payments from the government, burdensome administrative requirements, and an inability to maintain an adequate provider network. For many national firms, Medicare was not a major line of business (Draper, Gold, and McCoy 2002).

Congress tried to make a number of changes to the program to encourage health plans to remain in the program, or perhaps re-enter. In 1999, the Balanced Budget Refinement Act (BBRA) relaxed barriers to re-entry for exiting plans and authorized new entry bonuses to health plans that entered areas previously not served by health plans. The BBRA also relaxed reporting requirements for PPOs to encourage greater participation in Medicare. Then in 2002, Congress passed the Benefits Improvement and Protection Act, which raised payment rates to M+C plans, particularly in lower-paid areas with urban areas (the "urban floor"). In addition to Congressional fixes, CMS also made attempts to reduce the perceived administrative burden to health plans (Draper, Gold, and McCoy 2002). Despite the Congressional action, enrollment in the M+C program declined substantially (Figure A-1). By 2003, enrollment in the program had dropped to 4.6 million, down from its peak of 6.3 million in 1999.

Those Medicare beneficiaries remaining in the M+C program faced a changed environment as well. The traditional incentives for Medicare beneficiaries to join M+C plans had been low premiums compared with Medigap and the availability of benefits not covered under the fee-for-service benefit package (Gold et al. 2001). Those M+C enrollees still in the program saw the benefit generosity of their health plans decline. Average monthly premiums increased from $6.37 in 1999 to $37.35 in 2003 (Achman and Gold 2003). Pharmacy coverage, one of the most sought-after supplemental benefits, declined from 84 percent of enrollees in 1999 to 69 percent in 2003. Even those with drug coverage saw many of their health plans drop coverage of brand-name prescriptions (Achman and Gold 2003).

THE MEDICARE ADVANTAGE PROGRAM

In late 2003, as part of the Medicare Modernization Act (MMA), Congress renamed the M+C program "Medicare Advantage" (MA). Congress' changes to the private plan component of Medicare were in the larger context of reforming the Medicare program and adding a prescription drug benefit. The MMA envisions a much larger role for private health plans within Medicare.

To provide immediate stability to the MA program, Congress increased payment rates to health plans in 2004 and 2005. Under the new payment rate methodology, no health plan will be paid less than 100 percent of the expected fee-for-service costs in a county. However, many health plans will be paid more than 100 percent of fee-for-service (Achman and Gold 2004; Biles, Nicholas, and Cooper 2004; MedPAC 2004) because floor rates above fee-for-service costs had previously been established in much of the country to try to attract health plans to previously underserved areas.

Beginning in 2006, all Medicare beneficiaries who want the Medicare prescription drug benefit have to join a private, free-standing prescription drug plan. An alternative way to get prescription drug coverage is to enroll in a managed care organization that will provide the drug benefit—either a local MA plan or a new regional PPO plan. Local MA plans continue to choose which areas they serve, but the new regional PPO plans are required to serve one of the 26 newly created regions. The regions span at least one and sometimes multiple states. In 2006, such options exist in 21 of the 26 regions.

Under the restructured Medicare program, Medicare enrollees have a stronger incentive to join either the local or regional MA plans. The MA plans are able to offer enrollees a coordinated set of benefits, including the prescription drug benefit. In comparison, an enrollee who wishes to stay in fee-for-service Medicare and who wants the drug benefit has to enroll in a prescription drug plan, but then may also have a Medigap plan or other supplemental insurance plan to pay for some of the cost sharing charged in the fee-for-service Medicare program.

Since the MMA, health plan participation in the local MA program has increased. In March 2005, there were 212 coordinated care contracts in Medicare Advantage (including the PPO demonstration) and another 8 contracts for PFFS plans (Gold and Peterson 2006). Enrollment also increased, with 4.7 million enrolled in HMOs, PPOs, and similar plans and an additional 199,000 enrollees in PFFS plans.

MOVING FORWARD

As Medicare reform moves forward and the prescription drug benefit is implemented, it will be interesting to see how the role of private plans evolves within Medicare over the years. Until now, private plan enrollment has always been well below a fifth of total Medicare enrollment. However, the MMA provides greater incentive to beneficiaries to join health plans, both through increased payments that can be used by plans to restore benefit generosity and also through the simplification of the Medicare benefit package that MA plans are able to offer.

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APPENDIX B

SUPPLEMENTARY TABLES

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Table B-1. Copayments for Medical and Hospital Services in MA-PD, Lowest-Premium, and Other Plans, Unweighted, 2006 (SNPs Excluded)

	All MA-PD Plans Unweighted	Lowest-Premium MA-PD Unweighted	Other MA-PD Only Unweighted
Primary Care Physician			
None	21.5%	21.9%	20.7%
Less than $5	8.9	9.4	7.8
$5.01–$10	38.6	34.7	47.4
$10.01–$15	22.4	24.4	17.8
$15.01–$25	8.3	9.1	6.3
$25.01 or more	0.4	0.5	0.0
Varies	8.4	5.5	15.0
Coinsurance	0.9	1.0	0.7
Specialist Visit			
None	7.6%	7.5%	7.8%
Less than $5	2.0	2.0	2.0
$5.01–$10	11.3	9.1	16.2
$10.01–$15	11.1	10.1	13.2
$15.01–$25	39.3	36.1	46.6
$25.01 or more	28.7	35.1	14.2
Varies	1.6	1.6	1.7
Coinsurance	1.2	1.1	1.4
Emergency Room			
None	4.1%	3.5%	5.3%
Less than $20	0.1	0.1	0.0
$20.01–$40	4.2	3.4	5.8
$40.01–$50	91.7	92.9	88.9
$50.01–$74.99	0.0	0	0.0
$75 or more	0.0	0	0.0
Coinsurance	0.0	0.0	0.0
Any Cost Sharing			
Hospital admission	88.0%	90.3%	82.9%
Hospital outpatient	85.3%	87.9%	79.5%
X-ray	73.5%	76.1%	67.6%
Lab	54.3%	57.4%	47.3%
Number of Contract Segments/Enrollees	1,349	935	414

Source: MPR analysis of CMS's November 2005 Personal Plan Finder.

Note: Excludes contract segments with only MA-only plans (n = 34). Contract segments that offered only SNPs are excluded. Lowest-premium MA-PD plans were defined to include only those available to the general population (no SNPs).

Table B-2. Supplemental Benefits in MA-PD Plans by Lowest Premium and Other, Unweighted, 2006 (SNPs Excluded)

	All MA-PD Plans	Lowest-Premium MA-PDs	"Other" MA-PD Plans
Percentage With			
Preventive dental	20.9	18.8	25.6
Vision benefits	91.5	91.0	92.8
Hearing benefits	100.0	100.0	100.0
Physical exam	66.4	71.6	54.8
Podiatry benefit	98.1	98.7	96.6
Chiropractic benefit	96.1	96.4	95.7
Number of Contract Segments/Enrollees	1,349	935	414

Source: MPR analysis of CMS's November 2005 Personal Plan Finder.
Note: Excludes contract segments with only MA-only plans (n = 34). Contract segments that offered only SNPs are excluded. Lowest-premium MA-PD plans were defined to include only those available to the general population (no SNPs).

Table B-3. Total Premiums for Lowest-Premium and Other MA-PDs, Unweighted, by Type of Plan, 2006

	Lowest Premium MA-PD Plans						Other MA-PD Plans						All MA-PD Plans					
	All Types[a]	HMO	Local PPO	PFFS	Regional PPO	SNP[a]	All Other MA-PD Plans	HMO	Local PPO	PFFS	Regional PPO	SNP[a]	All MA-PD Plans	HMO	Local PPO	PFFS	Regional PPO	SNP[a]
Mean Total Premium	$32.94	$22.15	$59.78	$43.90	$52.99	$20.60	$81.27	$76.64	$103.21	$64.05	$84.74	$32.67	$47.77	$39.48	$72.47	$48.06	$67.18	$23.04
Mean if Premium More Than Zero	$63.90	$62.15	$69.32	$57.77	$62.63	$95.71	$81.27	$76.64	$103.21	$64.05	$84.74	$102.39	$71.93	$70.36	$80.29	$59.37	$73.43	$98.50
Distribution																		
Zero	48.4%	64.4%	13.8%	24.0%	15.4%	11.9%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	33.6%	43.9%	9.7%	19.0%	8.5%	9.5%
Includes reduced Part B premium	6.6	9.0	3.2	0.0	0.0	4.1	0.5	0.7	0.0	0.0	0.0	2.0	4.7	4.6	2.2	0.0	0.0	3.7
$1–$19.99	4.6	3.7	2.6	14.0	3.8	41.5	2.7	3.7	0.0	7.7	0.0	14.3	4.0	3.5	1.9	12.7	2.1	36.0
$20–$49.99	15.3	10.6	27.0	18.0	30.8	42.5	25.1	29.4	12.8	19.2	19.0	75.5	18.3	16.6	22.8	18.3	25.5	49.2
$50–$99.99	23.5	16.5	38.1	36.0	38.5	3.1	42.5	40.1	42.3	65.4	47.6	6.1	29.4	24.0	39.3	42.1	42.6	3.7
$100 or more	8.1	4.8	18.5	8.0	11.5	1.0	29.7	27.3	44.9	7.7	33.3	4.1	14.8	12.0	26.2	7.9	21.3	1.7
Number of Contract Segments/Enrollees	935	620	189	100	26	193	414	289	78	26	21	49	1,349	909	267	126	47	242

Source: MPR analysis of CMS' November 2005 Personal Plan Finder.

[a]Data were segmented separately for SNPs and non-SNPs, with lowest premium assigned separately for SNPs and non-SNPs. All types exclude SNPs to avoid double counting plans within the same contract (where both SNPs and non-SNPs are offered).

Table B-4. Copayments for Medical and Hospital Services in "Other" MA-PD Plans, Unweighted, by Type of Plan, 2006

		"Other" MA-PD Plans by Type				
	All Types	HMO	Local PPO[a]	PFFS	Regional PPO[a]	SNP[b]
Primary Care Physician						
None	20.7%	25.7%	14.5%	0.0%	0.0%	93.8%
Less than $5	7.8	9.7	3.9	3.8	0.0	2.1
$5.01–$10	47.4	47.9	40.8	23.1	95.2	4.2
$10.01–$15	17.8	13.5	36.8	19.2	4.8	0.0
$15.01–$25	6.3	3.1	3.9	53.8	0.0	0.0
$25.01 or more	0.0	0.0	0.0	0.0	0.0	0.0
Varies	15.0	12.5	30.8	0.0	9.5	0.0
Coinsurance	0.7	0.3	2.6	0.0	0.0	2.0
Specialist Visit						
None	7.6%	10.5%	2.6%	0.0%	0.0%	80.9%
Less than $5	2.0	2.5	1.3	0.0	0.0	2.1
$5.01–$10	11.3	16.1	14.5	23.1	14.3	2.1
$10.01–$15	11.1	13.7	19.7	0.0	0.0	0.0
$15.01–$25	39.3	48.4	44.7	57.7	14.3	14.9
$25.01 or more	28.7	8.8	17.1	19.2	71.4	0.0
Varies	1.6	2.4	0.0	0.0	0.0	0.0
Coinsurance	1.2	1.4	2.6	0.0	0.0	4.1
Emergency Room						
None	4.1%	6.2%	5.1%	0.0%	0.0%	28.6%
Less than $20	0.1	0.0	0.0	0.0	0.0	0.0
$20.01–$40	4.2	6.6	6.4	0.0	0.0	16.3
$40.01–$50	91.7	87.2	88.5	100.0	100.0	55.1
$50.01–$74.99	0	0	0	0	0	0
$75 or more	0	0	0	0	0	0
Coinsurance	0	0	0	0	0	0
Any Cost Sharing						
Hospital admission	82.9%	82.0%	84.6%	76.9%	95.2%	79.6%
Hospital outpatient	85.3	77.2	76.9	100.0	95.2	65.3
X-ray	73.5	61.2	71.8	100.0	100.0	65.3
Lab	54.3	39.4	55.1	76.9	90.5	65.3
Number of Contract Segments/Enrollees	414	289	78	26	21	49

Source: Mathematica Policy Research, Inc., analysis of CMS' November 2005 Personal Plan Finder.
[a]In PPOs, cost sharing is described for in-network benefits.

[b]Data were segmented separately for SNPs and non-SNPs, with lowest premium assigned separately for SNPs and non-SNPs. All types exclude SNPs to avoid double counting plans within the same contract (where both SNPs and non-SNPs are offered).

Table B-5. Copayments for Medical and Hospital Services in All MA-PD Plans, Unweighted, by Type of Plan, 2006

		All MA-PD Plans by Type				
	All Types[a]	HMO	Local PPO[b]	PFFS	Regional PPO[b]	SNP[a]
Primary Care Physician						
None	21.5%	28.2%	11.4%	1.6%	2.1%	77.1%
Less than $5	8.9	10.5	8.7	0.8	0.0	15.0
$5.01–$10	47.5	38.6	40.2	18.3	83.0	6.1
$10.01–$15	38.6	16.2	30.3	54.0	12.8	1.9
$15.01–$25	22.4	5.9	9.5	25.4	2.1	0.0
$25.01 or more	8.3	0.6	0.0	0.0	0.0	0.0
Varies	0.4	6.8	17.6	0.0	8.5	0.8
Coinsurance	0.9	1.0	1.1	0.0	0.0	11.6
Specialist Visit						
None	7.6%	10.3%	2.7%	1.6%	0.0%	59.1%
Less than $5	2.0	2.2	2.7	0.0	0.0	11.8
$5.01–$10	11.3	13.2	8.3	4.8	8.5	11.3
$10.01–$15	11.1	11.4	16.3	1.6	0.0	3.4
$15.01–$25	39.3	40.3	41.3	34.9	19.1	11.8
$25.01 or more	28.7	22.4	28.8	57.1	72.3	2.5
Varies	1.6	2.0	0.7	1.6	0.0	1.2
Coinsurance	1.2	1.4	1.1	0.0	0.0	16.1
Emergency Room						
None	4.1%	5.2%	3.0%	0.0%	0.0%	19.0%
Less than $20	0.1	0.1	0.0	0.0	0.0	0.0
$20.01–$40	4.2	4.6	4.5	1.6	0.0	20.7
$40.01–$50	91.7	90.1	92.5	98.4	100.0	60.3
$50.01–$74.99	0	0	0	0	0	0
$75 or more	0	0	0	0	0	0
Coinsurance	0	0	0	0	0	0
Any Cost Sharing						
Hospital admission	90.3%	86.0%	89.5%	95.2%	97.9%	76.4%
Hospital outpatient	85.3	83.9	81.6	100.0	93.6	57.4
X-ray	73.5	68.5	73.4	100.0	100.0	62.4
Lab	54.3	49.5	54.3	77.8	85.1	48.8
Number of Contract Segments/Enrollees	1,349	909	267	126	47	242

Source: MPR analysis of CMS's November 2005 Personal Plan Finder.

[a]Data were segmented separately for SNPs and non-SNPs, with lowest premium assigned separately for SNPs and non-SNPs. All types exclude SNPs to avoid double counting plans within the same contract (where both SNPs and non-SNPs).

[b]In PPOs, cost sharing is described for in-network benefits.

Table B-6. Estimated Out-of-Pocket Costs for Hospital and Physician Services in Lowest Premium and Other Plans by Type, 2006

Estimated Out-of-Pocket Costs for Hospital and Physician Services by Health	All (except SNP)	HMO	Local PPO	PFFS	Regional PPO	SNP[a]
Lowest-Premium MA-PDs						
All	$292.36	$268.21	$316.19	$355.07	$453.80	$174.86
Healthy	88.12	79.80	106.63	79.10	186.58	49.15
Episodic Needs	755.66	697.52	785.98	83.90	1,043.62	469.13
Chronic Needs	1,823.24	1,675.62	1,900.77	2,461.60	2,497.69	1,173.61
"Other" MA-PDs						
All	$212.51	$177.19	$272.56	$268.90	$405.64	$186.38
Healthy	71.47	55.15	96.64	96.92	170.95	17.35
Episodic Needs	528.98	456.94	695.74	631.15	908.10	547.10
Chronic Needs	1,218.40	1,084.69	1,620.90	1,627.69	2,239.52	1,510.29
All MA-PD						
All	$267.85	$239.27	$303.44	$337.29	$432.28	$180.38
Healthy	83.01	71.96	103.72	82.78	179.60	42.71
Episodic Needs	686.09	621.05	749.10	911.11	983.06	480.93
Chronic Needs	1,656.05	1,487.74	1,819.01	2,253.81	2,382.34	1,241.78
Number of Contract Segments						
Lowest Premium	935	620	189	100	26	193
Other	414	289	78	26	21	49
All	1,349	909	269	126	47	242

Source: MPR analysis of CMS's November 2005 Personal Plan Finder.

[a]Data were segmented separately for SNPs and non-SNPs, with lowest premium assigned separately for SNPs and non-SNPs. All types exclude SNPs to avoid double counting plans within the same contract (where both SNPs and non-SNPs are offered).

Table B-7. Prescription Drug Coverage in All MA-PD Plans, Unweighted, by Type of Plan, 2006

		All MA-PD Plans				
	All Types[a]	HMO	Local PPO	Local PFFS	Regional PPO	SNP
Mean Drug Premium	$18.40	$15.60	$27.50	$18.70	$21.30	$20.40
Distribution						
Zero	39.1%	49.0%	18.4%	21.4%	14.9%	9.9%
Under $20	13.2	11.4	12.7	19.8	31.9	36.0
$20–$29.99	20.4	16.9	21.0	39.7	31.9	36.4
$30–$39.99	16.5	13.8	25.8	19.0	8.5	16.1
$40–$49.99	5.6	4.3	12.0	0.0	8.5	0.0
$50 or more	5.3	4.6	10.1	0.0	4.3	1.7
Initial Deductible						
None	80.7%	84.2%	73.4%	77.8%	61.7%	33.5%
Reduced	2.7	2.2	5.6	1.6	0.0	1.2
$250	16.6	13.6	21.0	20.6	38.3	65.3
Tiered Copayments						
Yes	92.2%	93.3%	93.3%	90.5%	70.2%	52.1%
No	7.8	6.7	6.7	9.5	29.8	47.9
Benefits in Coverage Gap						
None	72.4%	68.8%	69.3%	100.0%	87.2%	0.0%
Generic only	22.6	24.6	28.1	0.0	12.8	0.0
Generic/brand	0.0	6.6	2.6	0.0	0.0	0.0
Percentage with Mail Order	95.6%	93.9%	98.1%	100.0%	100.0%	90.5%
Number of Contract Segments	1,349	909	267	126	47	242

Source: MPR analysis of CMS's November 2005 Personal Plan Finder.

[a]Data were segmented separately for SNPs and non-SNPs, with lowest premium assigned separately for SNPs and non-SNPs. All types exclude SNPs to avoid double counting plans within the same contract (where both SNPs and non-SNPs are offered).

Table B-8. Prescription Drug Coverage in "Other" MA-PD Plans, Unweighted, by Type of Plan, 2006

		"Other" MA-PD Plans				
	All Types[a]	HMO	Local PPO	PFFS	Regional PPO	SNP
Mean Drug Premium	$32.60	$31.00	$41.20	$27.50	$29.40	$25.90
Distribution						
Zero	9.9%	10.4%	12.8%	0.0%	4.8%	2.0%
Under $20	8.5	10.7	1.3	11.5	0.0	14.3
$20–$29.99	27.1	29.1	3.8	42.3	66.7	63.3
$30–$39.99	26.3	27.7	20.5	46.2	6.8	18.4
$40–$49.99	13.5	10.0	30.8	0.0	14.3	0.0
$50 or more	14.7	12.1	30.8	0.0	9.5	2.0
Initial Deductible						
None	88.9%	86.5%	93.6%	96.2%	95.2%	22.4%
Reduced	1.4	2.1	0.0	0.0	0.0	0.0
$250	9.7	11.4	6.4	3.8	4.8	77.6
Tiered Copayments						
Yes	94.9%	93.4%	98.7%	96.2%	100.0%	22.4%
No	5.1	6.6	1.3	3.8	0.0	77.6
Benefits in Coverage Gap						
None	57.7%	58.1%	35.9%	100.0%	81.0%	0.0%
Generic Only	36.7	35.6	57.7	0.0	19.0	0.0
Generic/Brand	5.6	6.2	6.4	0.0	0.0	0.0
Percentage with Mail Order	97.3%	96.5%	98.7%	100.0%	100.0%	98.0%
Number of Contract Segments	414	289	78	26	21	49

Source: MPR analysis of CMS's November 2005 Personal Plan Finder.

[a]Data were segmented separately for SNPs and non-SNPs, with lowest premium assigned separately for SNPs and non-SNPs. All types exclude SNPs to avoid double counting plans within the same contract (where both SNPs and non-SNPs are offered).

Table B-9. Supplemental Benefits In Lowest Premium And "Other" MA-PD Plans, Unweighted, by Type of Plan, 2006

	Lowest-Premium MA-PD Plans						Other MA-PD Plans						All-MA-PD Plans					
	All Basic Plans[a]	HMO	Local PPO	PFFS	Regional PPO	SNP[a]	All Other MA-PD Plans	HMO	Local PPO	PFFS	Regional PPO	SNP[a]	All MA-PD Plans[a]	HMO	Local PPO	PFFS	Regional PPO	SNP[a]
Percentage With																		
Preventive dental	18.8	20.6	14.8	5.0	57.7	23.8	25.6	25.6	23.1	0.0	66.7	18.4	20.9	22.2	17.2	4.0	61.7	22.7
Vision benefits	91.0	88.1	94.7	100.0	100.0	80.8	92.8	89.6	100.0	100.0	100.0	93.9	91.5	88.6	96.3	100.0	100.0	83.5
Hearing benefits	100.0	100.0	100.0	100.0	100.0	99.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	99.2
Physical exam	71.6	67.6	69.8	96.0	84.6	46.6	54.8	52.9	38.5	100.0	85.7	65.3	66.4	62.9	60.7	96.8	85.1	50.4
Podiatry benefit	98.7	98.2	99.5	100.0	100.0	90.7	96.6	95.2	100.0	100.0	100.0	81.6	98.1	97.2	99.6	100.0	100.0	88.8
Chiropractic benefit	96.4	94.7	99.5	100.0	100.0	83.4	95.7	93.8	100.0	100.0	100.0	79.6	96.1	94.4	99.6	100.0	100.0	82.6
Number of Contract Segments	935	620	189	100	26	193	414	289	78	26	21	49	1,349	909	267	126	47	242

Source: MPR analysis of CMS's November 2005 Personal Plan Finder.

[a]Data were segmented separately for SNPs and non-SNPs. Basic flags were assigned separately for SNPs and non-SNPs. SNPs are not included in the "All" column.