THE HENRY J. KAISER FAMILY FOUNDATION

MEDICARE

ISSUE BRIEF

THE VALUE OF EXTRA BENEFITS OFFERED BY MEDICARE ADVANTAGE PLANS IN 2006

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Enrollment in Medicare Advantage plans has increased 63% since 2005, reaching 8.8 million beneficiaries in January 2008.[1] Although most Medicare Advantage enrollees are still in HMOs and other managed care plans, the most rapid enrollment growth has been in private fee-for-service (PFFS) plans, which now account for 22% of Medicare Advantage enrollment.

Much of the appeal of Medicare Advantage plans is their ability to offer broader benefits than original Medicare at little or no cost to enrollees, which is a function of both the current payment system and other factors. This issue brief compares the value of extra benefits offered by PFFS plans and other Medicare Advantage plans in 2006, using an estimation model described at the end of the brief. The model measures only the insurance value of the different types of plans—that is, the out-of-pocket savings for an average enrollee compared to what he or she would pay for services under original Medicare, plus the value of any additional services such as dental or vision care. There are other differences between Medicare Advantage plans and original Medicare and differences among different types of Medicare Advantage plans that are important considerations for beneficiaries, but that are not discussed here. Such considerations may include whether their usual providers are willing to accept payments from the PFFS plan or willing to participate in the networks of other Medicare Advantage plans.

Key findings include:

- The average beneficiary enrolled in a Medicare Advantage PFFS plan was offered less in extra benefits than the average enrollee in other types of Medicare Advantage plans. The average net value of benefits above original Medicare in a PFFS plan was $55.92 a month in 2006, compared to $71.22 in other Medicare Advantage plans.
- The sickest and highest-cost enrollees in PFFS plans would have paid much more for basic Medicare services than those in other Medicare Advantage plans. PFFS enrollees whose total spending would have placed them in the top 5% of all Medicare beneficiaries in 2006 would have paid nearly $1,000 a year more out-of-pocket than comparable enrollees in other Medicare Advantage plans.

[1] The figures omit enrollment in cost and demonstration plans.

- Half of PFFS enrollees lived in a county that was also served by a non-PFFS Medicare Advantage plan offering extra benefits with a greater net value than the PFFS plan they selected.

- PFFS benefit values were about the same in all geographic areas. Enrollees in other types of Medicare Advantage plans were offered less generous extra benefits in rural and other low-cost areas and more generous benefits in areas where costs in the original fee-for-service Medicare program were higher.

THE BASICS OF THE MEDICARE ADVANTAGE PROGRAM

Medicare Advantage enrollees were enrolled in two basic types of plans in 2006:[2]

- Managed care plans including Medicare HMOs, local and regional PPOs, and provider-sponsored organizations. These plans have networks of participating providers. Plans commonly negotiate fees with these providers, and enrollees are required to use network providers or pay higher cost-sharing for out-of-network services.

- Private fee-for-service (PFFS) plans generally do not have provider networks. They typically pay for Medicare-covered services using Medicare's fee schedules, and enrollees may use any provider who is willing to accept the plan's payment.

Of the enrollees whose plan benefits were evaluated for this report, 4.1 million (78%) were enrolled in Medicare HMOs and 430,000 (8%) were in other types of managed care plans; the remaining 730,000 (14%) were in PFFS plans.[3] Among HMO and other managed care plan enrollees, 93% were in plans with prescription drug coverage under Medicare Part D (MA-PD). By contrast, over a third of PFFS enrollees were in plans that did not include Part D coverage. Some of these enrollees may have obtained Part D coverage separately through a stand-alone prescription drug plan (PDP).

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[2] A third type, medical savings account (MSA) plans, were first offered in 2007.

[3] The following types of MA plans have been omitted from the analysis: special plans designed for the frail elderly, other demonstrations, plans available only to members of specific employer groups, plans covering Part B services only, and plans in Puerto Rico. The analysis also excludes plans with which Medicare contracts on a cost-reimbursement, rather than a risk basis. Finally, plans with fewer than 10 enrollees are excluded. A few plans divide their approved market areas into segments and offer different benefit packages (usually different enrollee premiums) in each segment. In this report, each segment is treated as an individual plan. Overall, extra benefit values have been estimated for 1,759 plans or plan segments.

Medicare Advantage plans commonly offer extra benefits to their enrollees. The value of the extra benefits that must be furnished by a plan is established through a bidding process. Each plan submits its expected cost for providing standard Medicare Part A and Part B benefits for its enrollees. This bid is compared to a benchmark amount for the counties where the enrollees live. If the plan's bid for basic benefits is above the benchmark, enrollees must pay the difference. If the plan's bid is below the benchmark, Medicare pays the plan its bid amount plus a *rebate* equal to 75% of the difference between the bid and the benchmark. (All of these calculations include adjustments for enrollee demographics and health risk.)

The rebate must be returned to the enrollee in the form of extra benefits. Plans may use the rebate to reduce cost-sharing for Medicare Part A and Part B services, cover services not covered under Medicare (such as most dental, vision, and hearing care), or offer a reduction in the monthly Part B premium ($96.40 a month in 2008) otherwise paid by all beneficiaries enrolled in Part B. MA-PD plans may also use the rebate to offer Part D coverage at a lower cost than the enrollee would have to pay for comparable coverage from a stand-alone plan.

Many plans furnish all of these extra benefits at no extra cost to the enrollee. Others charge a monthly premium, because the total value of their benefit package is greater than the payment they receive from Medicare. The *net extra benefit value* of a plan is the total estimated value of the plan's extra benefits minus any enrollee premium. Each plan designs its own extra benefits, allocating savings across the different categories and deciding whether to offer richer benefits at the price of a higher enrollee premium.

NET VALUE OF EXTRA BENEFITS IN PFFS AND OTHER MEDICARE ADVANTAGE PLANS

In 2006, the average PFFS enrollee was offered extra benefits worth a net value of $55.92 a month more than the value of original Medicare, compared to $71.22 for enrollees in other Medicare Advantage plans (Exhibit 1). For PFFS enrollees, the net value of extra benefits was about the same in plans with and without Part D drug coverage. For other Medicare Advantage enrollees, the small share (7%) without Part D coverage tended to be in plans with lower net benefit values. This is partly because they are more likely than their counterparts with Part D coverage to be in counties with low benchmarks. The effect of geography on benefits is discussed below.

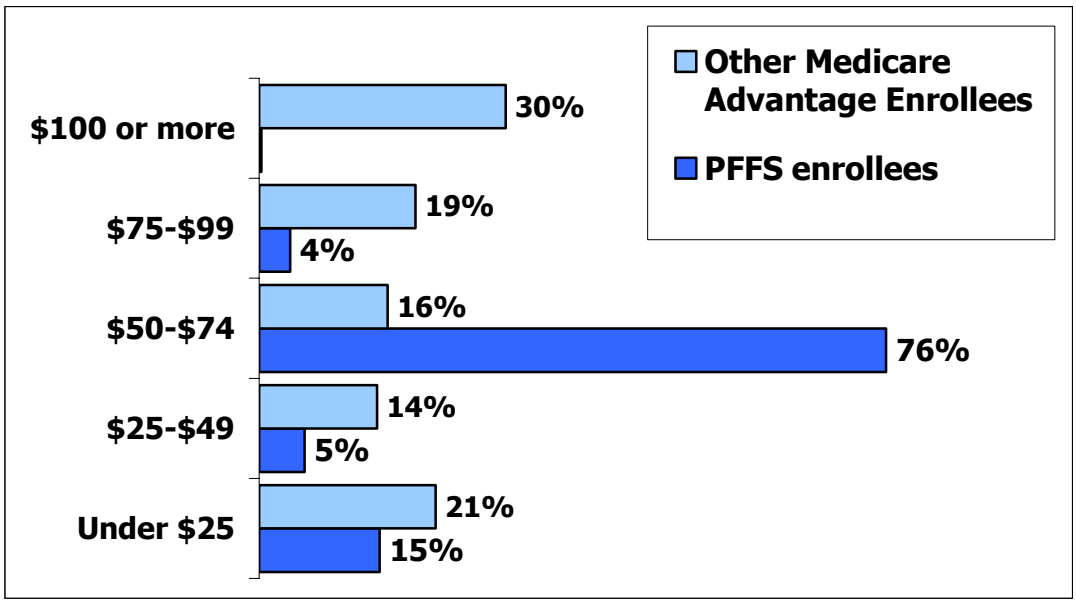
Exhibit 1. Estimated Net Value of Extra Benefits in Medicare Advantage Plans, by Type of Plan, 2006

	Percent of Enrollees within Plan Type	Average Benefit Value
PFFS Plans		
MA-PD	65%	$55.49
MA only	35%	$56.72
Total	**100%**	**$55.92**
Other Medicare Advantage Plans		
MA-PD	93%	$73.46
MA only	7%	$41.52
Total	**100%**	**$71.22**

Source: Author's tabulations, based on 2006 Medicare Compare and Medicare Advantage enrollment data.

There is much wider variation in the estimated value of extra benefits among other types of Medicare Advantage plans than among PFFS plans (Exhibit 2). Three-fourths of PFFS enrollees were in plans with extra benefits valued between $50 and $74 a month. Among Medicare Advantage enrollees in other plans, 35% were in plans with values below this range, while 48% were in plans with higher benefit values.

Exhibit 2. Distribution of Private Fee-for-Service and Other Medicare Advantage Enrollees by Net Benefit Value



Source: Author's tabulations, based on 2006 Medicare Compare and Medicare Advantage enrollment data.

Exhibit 3 shows the components of the average total and net extra benefit values in PFFS plans and other Medicare Advantage plans with drug coverage. The two types of plans offer roughly equal savings on the drug benefit. The most important difference is that enrollees in other Medicare Advantage plans pay much lower cost-sharing than PFFS enrollees for Medicare Part A and Part B services. The difference is partly offset by higher average premiums in the other Medicare Advantage plans.

Exhibit 3. Components of Net Extra Benefit Value, Private Fee-for-Service vs. Other Medicare Advantage Plans with Part D Drug Coverage, 2006

	PFFS Plans	Other MA Plans
Reduced A/B cost-sharing	$33.47	$56.03
Savings on Part D benefit	$16.53	$15.45
Non-Medicare services	$12.80	$19.61
Reduction in Part B premium	—	$1.20
Total, extra benefits	$62.80	$92.29
Less enrollee premium	($7.54)	($20.35)
Net value	$55.49	$73.46

Note: No PFFS plan with drug coverage offers a Part B premium reduction.

Source: Author's tabulations, based on 2006 Medicare Compare and Medicare Advantage enrollment data.

Each plan makes its own decisions about how to allocate the available rebate across different possible extra benefits. For example, PFFS plans could have chosen to set enrollee premiums at levels closer to the average premium for other Medicare Advantage plans; they could then have offered a larger reduction in cost-sharing for basic Medicare services. Instead, they chose to offer a competitive drug benefit and a relatively low premium.

Exhibit 4 compares expected cost-sharing for basic Medicare services in original Medicare, PFFS plans, and other Medicare Advantage plans, using the distribution of 2006 costs for beneficiaries in original Medicare. Low utilizers pay the same, on average, ($47) in private fee-for-service plans and other Medicare Advantage plans.

However, beneficiaries with higher spending levels face much higher cost-sharing in PFFS plans. Among the 5% of beneficiaries with the highest spending, those in PFFS plans could expect to pay nearly $1,000 a year more than those in other Medicare Advantage plans ($3,113 vs. $2,160).

Exhibit 4. Expected Cost-Sharing for Basic Services under Original Medicare, Private Fee-for-Service and other Medicare Advantage Plans, by Beneficiary Spending Range, 2006

		PFFS Plans		Other Medicare Advantage Plans	
	Cost-Sharing, Original Medicare	Cost-Sharing in PFFS	PFFS Cost-Sharing as % of Original Medicare	Cost-Sharing in Other Medicare Advantage Plans	Other Medicare Advantage Cost-Sharing as % of Original Medicare
Low 25% of beneficiaries	$90	$47	53%	$47	52%
Middle 50% of beneficiaries	$557	$341	61%	$310	56%
Top 25% of beneficiaries	$3,256	$1,746	54%	$1,324	41%
Top 5% of beneficiaries	$6,353	$3,113	49%	$2,160	34%
All beneficiaries	$1,114	$637	57%	$567	51%

Source: Author's tabulations, based on 2006 Medicare Compare and Medicare Advantage enrollment data.

GEOGRAPHIC VARIATION IN PLAN BENEFITS

Under the current bidding system, the net value of the extra benefits a Medicare Advantage plan can offer beneficiaries depends on two basic variables: (a) the applicable benchmark for its service area; (b) the plan's relative "efficiency," or ability to bid below the benchmark because of negotiated price discounts, care management, or other factors. In some counties, the benchmark is based on average costs under the Medicare fee-for-service program in the county. In other counties, benchmarks are based on rural and urban "floor" amounts—minimum levels intended to assure that Medicare Advantage plans would be available in areas with lower than average spending under the original fee-for-service Medicare program.[4] In these counties, the benchmarks are often well above spending levels of the fee-for-service Medicare program.

[4] The rural and urban floors were established in 1998 and 2000, respectively. The 2003 Medicare Modernization Act grandfathered in the high benchmarks for "floor counties" by specifying that benchmarks are to be based on either the county's benchmark for the previous year, with a fixed annual update, or its current FFS cost. Temporarily, all county benchmarks are above FFS costs because of a budget neutrality factor meant to offset the effects of payment adjustments based on enrollees' health risk.

Exhibit 5 shows the distribution of PFFS and other Medicare Advantage enrollees by benchmark level and the average net extra benefit values provided by the plans at each level. Nearly all PFFS enrollees in 2006 were in counties where benchmarks were based on the rural or urban floors, while more than half of other Medicare Advantage enrollees were in counties with benchmarks above the urban floor. PFFS extra benefits are roughly the same at all benchmark levels. On the other hand, net extra benefit values in other Medicare Advantage plans rise in direct proportion to the benchmark.

Exhibit 5. Distribution of Enrollees and Net Extra Benefit Value by Area Benchmark Level and Type of Medicare Advantage Plan, 2006

	PFFS Plans		CCP	
Benchmark	**Percent of Enrollees**	**Average Benefit Value**	**Percent of Enrollees**	**Average Benefit Value**
$669.63 (Rural floor)	37%	$57.01	4%	$26.90
$669.64-$740.09	4%	$54.05	1%	$53.03
$740.10 (Urban floor)	51%	$56.20	42%	$57.62
$740.11-$849.99	6%	$49.24	36%	$71.48
$850-$949.99	2%	$53.87	10%	$96.77
$950 and over	1%	$52.85	7%	$145.33
Total	**100%**	**$55.92**	**100%**	**$71.22**

Source: Author's tabulations, based on 2006 Medicare Compare and Medicare Advantage enrollment data.

In higher-cost counties, benchmarks are very close to the average for the original fee-for-service Medicare program, but Medicare Advantage plans (other than PFFS) can offer basic Medicare benefits at lower cost, by managing utilization and negotiating provider discounts. The resulting savings can fund more generous extra benefits in these areas. In lower-cost areas, even though benchmarks may be much higher than the average for the fee-for-service Medicare program, these Medicare Advantage plans are less able to achieve savings, because of problems in negotiating discounts from providers in sparsely populated areas and other factors. The result is that in low-cost areas, PFFS plans were able to offer extra benefits with a net extra benefit value equal to or greater than other Medicare Advantage plans, while in higher-cost areas PFFS extra benefits were much less valuable.

As Exhibit 6 shows, about one-third of Medicare beneficiaries in counties served by a PFFS plan were in a county where no other Medicare Advantage plan was available in 2006 or where the PFFS plan had an extra benefit value greater than that of any available Medicare Advantage plan. About half of PFFS enrollment was drawn from these counties. On the other hand, nearly half of PFFS enrollees had access to at least one other Medicare Advantage plan in the same county with a higher net extra benefit value.

Exhibit 6. Availability of Medicare Advantage Plans in Counties Served by Private Fee-for-Service Plans, for All Medicare Beneficiaries and PFFS Enrollees

	Medicare Beneficiaries in Counties Served by a PFFS Plan	PFFS Enrollees
No Medicare Advantage plan other than PFFS in county	1.6%	1.6%
No Medicare Advantage plan with higher extra benefit value than PFFS	33.8%	49.3%
Available Medicare Advantage plan with higher extra benefit value than PFFS	64.7%	49.1%
Total	**100.0%**	**100.0%**

Source: Author's analysis of 2006 Medicare Compare and Medicare Advantage enrollment data.

DISCUSSION

In most areas, PFFS plans offered less valuable extra benefits to Medicare beneficiaries than those offered by other Medicare Advantage plans. This is because PFFS plans are usually unable to offer basic Medicare benefits at a lower cost than the original Medicare fee-for-service average; they can finance extra benefits only in areas where the Medicare Advantage benchmark is well above costs in the original fee-for-service Medicare program. On the other hand, Medicare Advantage plans other than PFFS can often achieve savings on basic Medicare benefits. They can use these savings, as well as the differential between the benchmark and Medicare's fee-for-service costs to fund extra benefits. The exception is in low-cost rural areas, where most Medicare Advantage plans are less able to operate efficiently. PFFS enrollees are disproportionately drawn from these areas.

Still, close to half of PFFS enrollees in 2006 could have chosen another type of Medicare Advantage plan in their area that offered more valuable extra benefits. Some of these enrollees may have been retirees whose former employers encouraged or required them to take the PFFS option. There is some evidence that employers are showing interest in offering the PFFS option to their Medicare-eligible retirees; because PFFS plans are available everywhere, they can serve groups

whose retirees are geographically dispersed.[5] Some beneficiaries outside employer groups may have been attracted to the extra benefits offered by Medicare Advantage plans but reluctant to enroll in an HMO or other Medicare Advantage plan with a restrictive provider network.

However, there is evidence that beneficiaries have difficulty assessing the relative benefits of the different plans available to them, or in understanding key features of various plans, such as network restrictions. The model developed for this issue brief uses more than sixty different parameters to compare plan benefits, yet this represents only a fraction of the variables Medicare beneficiaries might need to compare and assess in order to identify the best available option in their area. Beginning in 2007, CMS has begun to help beneficiaries by providing estimates of their likely total out-of-pocket costs under different plans available in their area. These estimates are rudimentary and may not be useful for beneficiaries with special health needs. To minimize complexities for people on Medicare, some have suggested limits on variations among plans, perhaps by developing some standard benefit packages comparable to those established for Medigap plans. However, this could defeat one of the goals of the Medicare Advantage program by preventing plans from developing innovative benefits that are attractive to beneficiaries.

Moving forward, it will be important to monitor the value and range of benefits offered by the various types of Medicare Advantage plans and the choices made by enrollees in future years, in order to assess the trade-offs between plan complexity and market competition. In addition to benefits, it may be important for beneficiaries to consider other differences between Medicare Advantage plans and original Medicare, and differences among the various types of Medicare Advantage plans that are not addressed in this paper, such as whether their doctors, specialists and other medical providers are willing to accept payments from the plan or participate in the plan's network. Furthermore, the difference in benefits between original Medicare and Medicare Advantage plans including PFFS are an important consideration in federal budget discussions, given the higher on-budget costs associated with Medicare Advantage plans.

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[5] Jonathan Blum, Ruth Brown, and Miryam Frieder, "An Examination of Medicare Private Fee-for-Service Plans," Medicare Issue Brief, Henry J. Kaiser Family Foundation, March 2007, available at www.kff.org/medicare/upload/7621.pdf

DATA AND METHODS

The model developed for this report provides estimates of the net value of the benefit packages provided by different Medicare Advantage plans in 2006. The value measured is the dollar value of the benefits to the enrollee. It thus differs from figures developed by the Centers for Medicare and Medicaid Services, which include plans' administrative costs and projected profits. These cannot be estimated with publicly available data. The results in this issue brief are quite close to estimates reported by the Blue Cross/Blue Shield Association for 2006, which also omit administrative costs and profit.[6]

Plan benefits. Information on benefits was derived from the Medicare Compare database. This base is continuously updated; the data used here were captured in September 2006. Population data are from two CMS sources: the annual report of total enrollment by plan and the monthly report of county enrollment by contract (which may include several plans). The indexing used in the model requires county-level breakouts of enrollment in each plan. Because these are unavailable, the estimates assume that a plan's share of contract enrollment in each county is proportionate to the plan share of total contract enrollment. For example, if one plan accounted for 60% of enrollees under a given contract, the plan is assumed to have 60% of the contractor's enrollees in each county.

Medicare cost-sharing. Data on Medicare utilization, unit costs, and expected cost-sharing are chiefly derived from the 2004 Medical Expenditure Panel Survey, adjusted to calibrate to CMS estimates for 2006. Average utilization and spending were calculated for eight cohorts of beneficiaries, ranging from the top 1% of spenders (with annual cost-sharing of $9,604 under Medicare rules) to the bottom 8%, who used no covered services. The following plan rules were applied to the utilization and spending estimates derived for the eight cohorts: primary care and specialist physician copayments/coinsurance; outpatient and ER copayments/coinsurance; inpatient-specific deductibles (stay or year), coinsurance or daily copayments, and inpatient out-of-pocket limits; durable medical equipment coinsurance; and overall plan deductibles and out-of-pocket limits (for all services or specific groups of services). Estimated plan cost-sharing for each cohort was then compared to cost-sharing under Medicare rules. Both values were indexed using CMS estimates of 2006 cost-sharing by county and the estimated county distribution of plan enrollees.[7] The estimated value of the plan's cost-sharing reduction (or sometimes increase) is the weighted average of the differences.

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[6] The Blue Cross Blue Shield estimates were limited to HMO plans. They reported that plans had an annual value of $825 in 2006. The estimation model use for this issue brief gives an annual of $851 for HMOs only, excluding other types of non-PFFS plans.

Prescription drug benefits. The model establishes a predicted bid amount for the Part D benefits offered by each MA-PD plan, using a formula based on regression analysis of Part D bids submitted by freestanding prescription drug plans for 2006. (The formula, which includes plan type, type of gap coverage, PDP region, plan deductible and initial coverage limit, and availability of mail-order drugs, accounts for 64% of variation in PDP bids.) The predicted bid, less the standard CMS contribution, gives an expected drug premium for the plan. The estimated benefit value is the difference between this expected premium and the actual drug premium charged by the plan.[8] It should be noted that MA-PD plans quote two beneficiary premium amounts, one for the Part D benefit and one for all other benefits. Some plans quoted a higher general premium than drug premium, while others quoted a higher drug premium. (About half of MA-PD enrollees were in plans that had a zero premium for both components.) As the beneficiary must in any case pay the sum of the drug and general premiums, the plan's decision to label more or less of its total premium as the drug premium affects the estimated value of its drug benefit in this report, but not the estimated total value of the plan.

Non-Medicare services. Dental and vision utilization estimates are based on 2004 MEPS data for people aged 65 or older who reported private insurance coverage for the service at any time during the year. Prices for vision services are from MEPS data; prices for dental services are from the 2006 annual Dental Economics survey. For hearing services, utilization assumptions are derived from a National Council on the Aging study of unmet needs for hearing services. The hearing exam price is the weighted average Medicare fee schedule value for comprehensive audiometry for the area where a plan's enrollees were located. Hearing aids are arbitrarily priced at a very low $1,000; most plans with hearing coverage cap the benefit below this level. For plans that offer non-Medicare covered physical exams, one exam per year is assumed. The price is the weighted average Medicare fee schedule value for a comprehensive exam, new patient, for the area where a plan's enrollees were located.

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[7] Estimates in table 3 are not regionally adjusted, to allow comparison of plan benefits for national average spending levels for the cohorts.

[8] This difference has two components. An MA-PD may bid less than freestanding PDPs for similar benefits, or it may use part of its rebate to reduce the Part D premium. The two factors cannot be separated using publicly available data. CMS has reported that Part D savings for 2007 averaged $20.14, of which $6.62 reflected lower bids for basic coverage and $13.52 reflected use of rebates to buy down the premium.

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