

BENEFITS AND COST-SHARING

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More than ten million people – one in four people on Medicare – are enrolled in a Medicare Advantage plan. Medicare Advantage plans, including health maintenance organizations (HMOs), Preferred Provider Organizations (PPOs) and Private Fee-for-Service (PFFS) plans, receive payments from the government to provide all benefits covered under Medicare, but have the flexibility to modify the benefit design as long as the core benefit package is actuarially equivalent to traditional Medicare. Medicare Advantage plans are required to use any extra payments (i.e., rebates) to provide extra benefits to enrollees in the form of lower premiums, reduced cost-sharing, or extra benefits.^{1,2} The Congressional Budget Office estimates the average value of extra benefits for Medicare Advantage enrollees was \$87 per month in 2009, given the current payment system which paid plans 114 percent of Medicare fee-for-service (FFS) costs, on average, in 2009.³

This data spotlight examines benefits and cost-sharing among Medicare Advantage plans that are available for general enrollment in 2010.⁴ The analysis uses publicly available data that supports Medicare Options Compare, a website developed by the Centers for Medicare and Medicaid Services (CMS).⁵ This analysis includes 2,864 Medicare Advantage plans in 2010, 79 percent of which are Medicare Advantage Prescription Drug (MA-PD) plans. Data are unweighted and thus show the choices beneficiaries have available, but not their enrollment decisions; enrollment data for 2010 are unavailable at this time. Estimates of out-of-pocket spending for selected services take into account limits on out-of-pocket spending, when applicable, but do not take into account costs associated with out-of-network care, because the downloadable CMS file does not distinguish well between cost-sharing for in and out-of-network, an analytical limitation for assessing cost-sharing in PPOs.

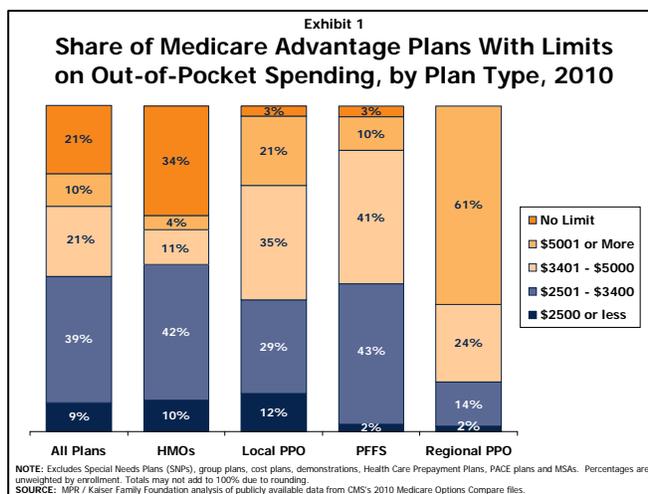
This data spotlight is part of a series of spotlights on Medicare Advantage plans offered in 2010.

Cost-sharing for Medicare-Covered Benefits

Cost-sharing for Medicare-covered services varies widely across plans, but generally differs from the benefit structure in traditional Medicare. For example, Medicare Advantage plans typically use fixed dollar copayments for Medicare-covered services, rather than a coinsurance, and many plans have a limit on enrollees' out-of-pocket spending, unlike traditional Medicare.

Out-of-pocket spending limits. In 2010, most (79 percent) Medicare Advantage plans have a limit on out-of-pocket spending for Part A and Part B services, whereas traditional Medicare does not. Regional PPOs are required to have a limit on out-of-pocket spending, although the level of that limit is not prescribed.⁶ For 2010, CMS encouraged all plans to limit enrollees' out-of-pocket spending for Medicare-covered services to \$3,400 during the calendar year.⁷

- Nearly half (47 percent) of all Medicare Advantage plans have a limit on out-of-pocket spending of \$3,400 or less in 2010, nearly one third (32 percent) have a limit that exceeds the \$3,400 threshold, and 21 percent have no limit. **(Exhibit 1)**



- Most (61 percent) regional PPOs have a limit that exceeds \$5,000. Relatively high out-of-pocket limits are less common among other plan types with limits (4 percent of HMOs, 10 percent of PFFS plans and 21 percent of local PPO plans). Out-of-pocket limits are less common among HMOs (66 percent) than among other plan types; however, HMOs tend to use lower limits than most other plan types when they use them.
- The share of all Medicare Advantage plans with any limit on out-of-pocket spending has increased from 66 percent in 2008 to 79 percent in 2010. However, among plans with limits, the share with limits of \$5,000 or more increased from 2 percent to 10 percent; among regional PPOs, the share increased from 28 percent in 2008 to 61 percent in 2010 (data not shown).

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In the past, at least some of the plans with limits on out-of-pocket spending have excluded selected Medicare-covered benefits from the limit. For 2010, CMS encouraged firms to include all cost-sharing for Medicare-covered benefits in calculating their limits.

- In 2010, 14 percent of plans with limits appear to exclude some Medicare covered benefits from the limit. Twelve percent of the plans with out-of-pocket limits do not count cost-sharing for physician office visits toward the limit; 10 percent do not count cost-sharing for mental health services.

Cost-Sharing for Inpatient Hospital Stays.

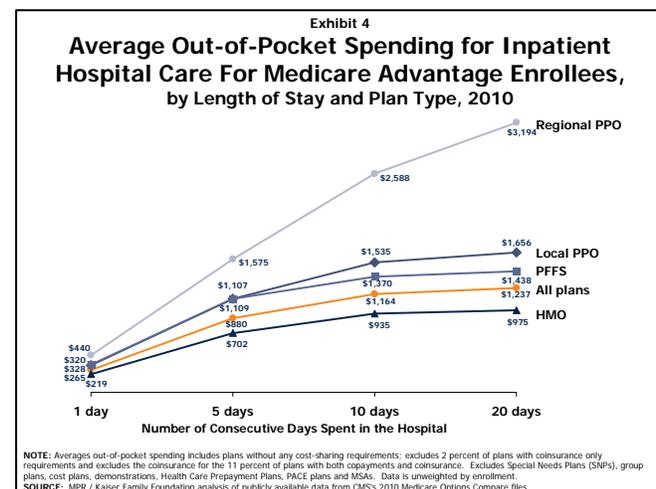
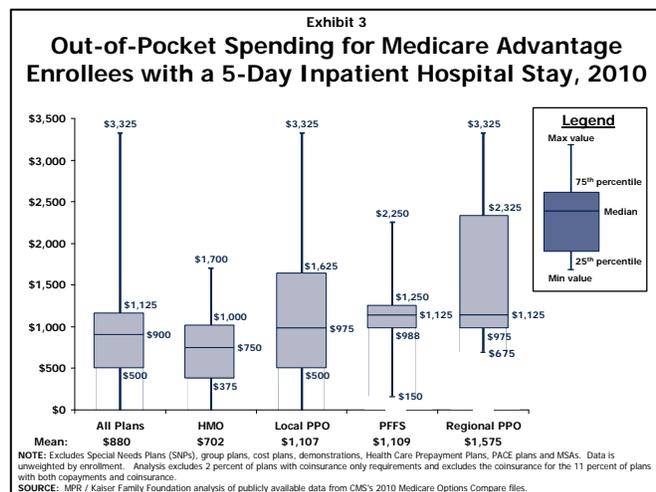
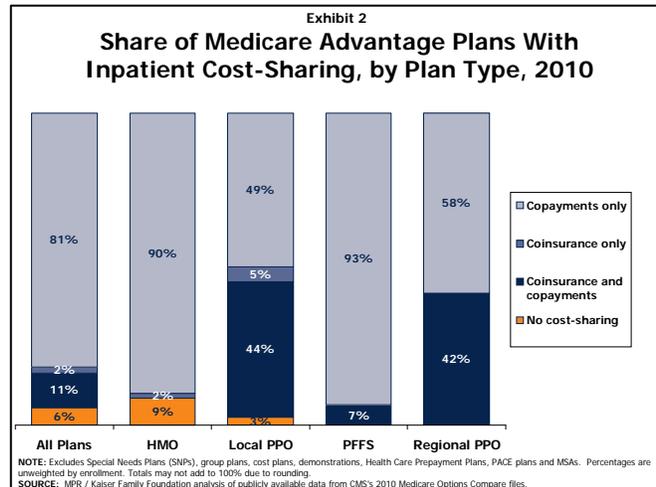
Cost-sharing for inpatient hospital care under Medicare Advantage plans typically differs from the requirements of traditional Medicare, but varies widely across plans. Medicare Advantage plans typically apply fixed dollar copayments for inpatient hospital care, in contrast to traditional Medicare, which has an inpatient deductible (\$1,100 in 2010 per spell of illness spell) and no coinsurance for inpatient hospital stays of up to 60 days. Most Medicare Advantage plans (93 percent) provide unlimited days of hospital care, in contrast to traditional Medicare, which has annual limits and “life-time reserve” days.⁸

- Virtually all Medicare Advantage plans (94 percent) require enrollees to share in the costs of inpatient care: 81 percent impose copayments, 2 percent impose coinsurance, and 11 percent use both (primarily PPOs to distinguish between in-network and out-of-network care).⁹ Six percent of all Medicare Advantage plans have no cost-sharing requirements. Among Medicare Advantage plans charging copayments for inpatient care, 79 percent charge a copayment per day, 16 percent charge a copayment per stay, and 5 percent charge both copayments per day and stay in 2010. **(Exhibit 2)**

For a given beneficiary, out-of-pocket expenses for inpatient hospital care would vary across plans, based on benefit design (e.g., level of copayments and limits on out-of-pocket spending), length of stay, and, for some plans, the number of separate admissions. About one in five Medicare beneficiaries residing in community-based settings have at least one hospital stay a year.¹⁰

- For a 5-day inpatient hospital stay,¹¹ average costs for Medicare Advantage enrollees would be \$880 in daily copayments in 2010. Across all plans, the cost ranges from \$0 to \$3,325. **(Exhibit 3)**

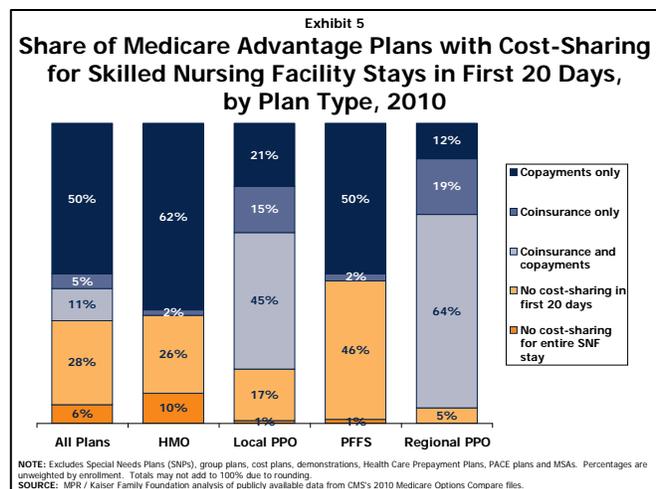
- The average cost for a 5-day hospital stay among regional PPOs is \$1,575, while the average cost for a 5-day stay in HMOs is about \$702. **(Exhibit 4)**
- Even among plans of the same type, there is considerable variation in cost-sharing requirements. For example, among HMOs, mean cost-sharing is \$702, but costs range from \$0 to \$1,700.



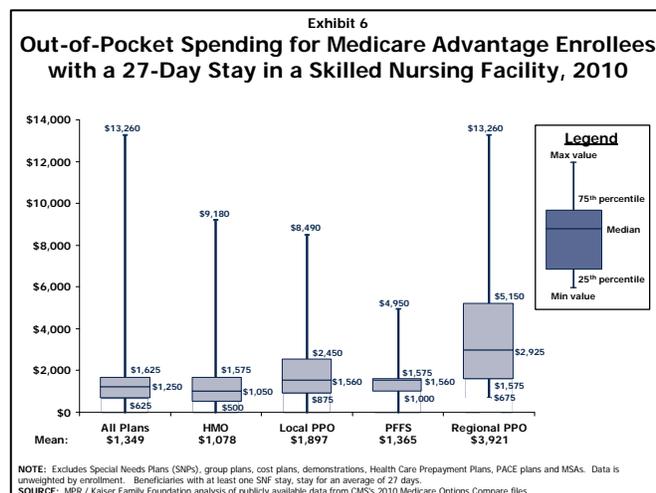
- If we exclude plans that do not charge daily copayments for inpatient stays, the average cost for a 5-day stay is \$944 (versus \$880 when all plans are included). **(See Exhibit 8)**
- Between 2008 and 2010, average cost-sharing among all Medicare Advantage plans for inpatient hospital services for a 5-day stay increased by 36 percent, from \$649 in 2008 to \$880 in 2010 (data not shown).
- For a 10-day hospital stay, average cost-sharing among Medicare Advantage plans is \$1,164, six percent higher than beneficiaries would pay in traditional Medicare, ranging from zero to \$6,600. Costs do not necessarily rise proportionate to length of stay because plans usually limit the number of days that copayments apply, and in some instances, limits on out-of-pocket spending set a ceiling on beneficiary cost-sharing.
 - By plan type, average costs based on copayments range from \$935 (HMOs) to \$2,588 (regional PPOs).
 - Cost-sharing varies widely among plans of the same type. For example, among regional PPOs, the average cost for a 10-day inpatient hospital stay is \$2,588, but ranges from \$675 to \$6,600.
 - For a 10-day stay, average cost-sharing among plans increased by 44 percent, from \$811 in 2008 to \$1,164 in 2010 (data not shown).

Cost-sharing for Skilled Nursing Facility Stays. Traditional Medicare’s skilled nursing facility (SNF) benefit has no cost-sharing requirements for the first 20 days, but imposes a daily copayment for days 21 to 100 (\$137.50 per day in 2010). In contrast, the majority of Medicare Advantage plans begin cost-sharing for SNF benefits from the first day of a stay. As a precondition to coverage of a SNF stay, Medicare requires beneficiaries to have a qualifying hospital stay. All but 8 percent of Medicare Advantage plans waive this requirement, although plans may use other utilization management tools, such as requiring prior authorization, instead. In traditional Medicare, the average length of stay for beneficiaries using the Medicare-covered SNF is 27 days.¹²

- Two-thirds (66 percent) of all Medicare Advantage plans require cost-sharing for at least part of the first 20-days of a SNF stay. Half impose copayments, 5 percent impose coinsurance and 11 percent impose both. Over a quarter (28 percent) of Medicare Advantage plans have no cost sharing for the first 20 days in a SNF, and 6 percent have no cost-sharing at all. **(Exhibit 5)**
- Virtually all regional PPOs (95 percent) require cost-sharing on the front end of a stay, as compared to 64 percent of HMOs and 52 percent of PFFS plans.
- Average cost-sharing for a Medicare Advantage enrollee with a 27-day stay in a SNF is \$1,349 across all plans in 2010. Among the subset of plans that charge copayments for SNF stays, average cumulative cost-sharing for a 27-day stay is \$1,512 in 2010.



- Average cost-sharing for a 27-day SNF stay ranges from \$1,078 among all HMO plans to \$3,921 among all regional PPOs.
- Cost-sharing varies among plans of the same type for a 27-day stay in a SNF; for example, among HMOs, the average cost of a 27-day stay range from \$0 to \$9180. For enrollees of regional PPOs, average costs range from \$675 to \$13,260. **(Exhibit 6)**
- Since 2008, average costs for 27 days in a SNF in all Medicare Advantage plans have increased by 18 percent.



Cost-sharing for Combined Inpatient and Post-Acute Skilled Nursing Facility Care. Medicare beneficiaries receiving inpatient care sometimes require care in a SNF after they are discharged from the hospital. Some will pay less under a Medicare Advantage plan than they would under traditional Medicare, but others could pay more.

- For example, a Medicare beneficiary enrolled in a Medicare Advantage plan would pay \$2,113, on average for a 7-day inpatient hospital stay followed by 22 days in a SNF, the average length of stay for beneficiaries with an inpatient stay followed by a SNF stay.¹³ Average costs for an enrollee with this utilization profile would range from \$1,741 (HMOs) to \$3,823 (regional PPOs).
- Since 2008, average out-of-pocket costs for a Medicare enrollee with this set of services have increased by 41 percent, ranging from 12% among HMOs to 135% among regional PPOs. **(Exhibit 7)**

Exhibit 7
Cost-Sharing for Beneficiaries with an Inpatient Hospital Stay Followed by a Stay in a Skilled Nursing Facility

Year	All	HMO	Local PPO	PFFS	Regional PPO
2008	\$1,494	\$1,552	\$1,156	\$1,572	\$1,624
2009	\$1,462	\$1,440	\$1,251	\$1,575	\$1,521
2010	\$2,113	\$1,741	\$2,384	\$2,481	\$3,823
Percent increase from 2008 to 2010	41%	12%	106%	58%	135%

NOTE: Cost-sharing amounts are for 7.02 days in an inpatient hospital followed by 21.57 days in a skilled nursing facility (SNF), the average length of stay for beneficiaries with an inpatient hospital stay followed by a SNF stay. Excludes Special Needs Plans (SNPs), group plans, cost plans, demonstrations, Health Care Prepayment Plans, PACE plans and MSAs. Data is unweighted by enrollment.
SOURCE: MPR / Kaiser Family Foundation analysis of publicly available data from CMS's 2010 Medicare Options Compare files.

Cost-sharing for Home Health Visits. Most Medicare Advantage plans (88 percent) do not impose cost-sharing for home health visits, like traditional Medicare. Medicare beneficiaries who use the home health benefit have an average of 37 home health visits per year.¹⁴

- Nearly one third of all PFFS plans (30 percent) require a copayment for home health visits in 2010, compared to 10 percent of HMOs, 6 percent of local PPOs, and no regional PPOs.
- Medicare Advantage plans charge \$0.78 per home health visit on average – a very low amount because the average includes the majority of plans that have no copayment requirement for home health visits. When we restrict the analysis to plans that do impose cost-sharing for home health services, average copayments for home health services are \$16.64 per visit, ranging from \$15.21 per visit among PFFS plans to \$18.24 per visit among local PPOs.
- For the average home health user with 37 home health visits in a plan that charges a copayment, average cost-sharing would be \$616 for their home health care. **(Exhibit 8)**

Exhibit 8
Average out-of-pocket spending among Medicare Advantage enrollees enrolled in plans with and without cost-sharing requirements, for selected services, 2010

	Inpatient hospital stay (5 days)	SNF stay (27 days)	Home health (37 visits)
All plans (including plans with no cost-sharing)	\$880	\$1,349	\$28.86
Only plans with copayments	\$944	\$1,512	\$615.68

NOTE: Excludes plans with coinsurance only. Excludes Special Needs Plans (SNPs), group plans, cost plans, demonstrations, Health Care Prepayment Plans, PACE plans and MSAs. Data is unweighted by enrollment.
SOURCE: MPR / Kaiser Family Foundation analysis of publicly available data from CMS's 2010 Medicare Options Compare files.

Since 2008, the share of all plans charging any cost-sharing for home health visits has decreased (from 35 percent in 2008 to 12 percent in 2010) while the average copayment per visit among plans charging copayments has remained relatively stable (\$16.74 in 2008 to \$16.64 in 2010).

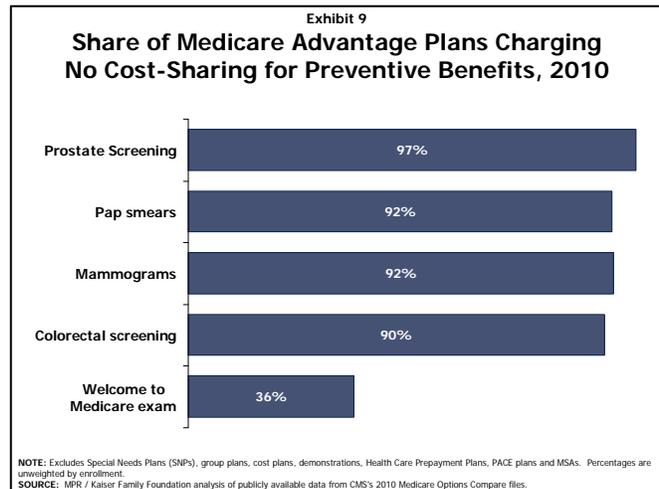
Cost-Sharing for Primary Care and Specialty Care Office Visits. As with other types of services, Medicare Advantage plans favor fixed dollar copayments over coinsurance for office visits. For a primary care visit, 66 percent of plans charge copayments only, 3 percent charge coinsurance only, 11 percent charge both, and 20 percent charge nothing. The distribution is similar for specialist visits except that a much smaller percentage (6 percent) of plans charge nothing (81 percent charge copayments only, 2 percent charge coinsurance only, and 11 percent charge both). Traditional Medicare charges beneficiaries 20 percent coinsurance for each office visit and most other Part B services. Thirteen percent of Medicare Advantage plans charge coinsurance of 20 percent or more for primary care and specialty visits.

- In 2010, 20 percent of Medicare Advantage plans have no cost-sharing for primary care visits, and 5 percent of plans have no cost-sharing for specialty care visits.
- Average copayments for primary care office visits in Medicare Advantage plans are \$10.82, ranging from \$5.56 per visit for HMOs to \$16.26 per visit in PFFS plans.

- Average copayments for specialty office visits are \$26.12 for 2010, and range from \$21.29 per visit for HMOs to \$34.41 per visit for PFFS plans.
- Since 2008, average copayments have remained relatively stable for primary care (from \$10.79 in 2008 to \$10.82 in 2010) and increased for specialty office visits (from \$22.72 in 2008 to \$26.12 in 2010).

Cost-Sharing for Preventive Services. Medicare has covered more preventive services over the years, and traditional Medicare generally requires a 20 percent coinsurance for these services. In 2010, Medicare Advantage plans typically require no cost-sharing for Medicare-covered preventive services, such as mammograms and prostate exams. Medicare Advantage plans also typically cover annual physical exams.

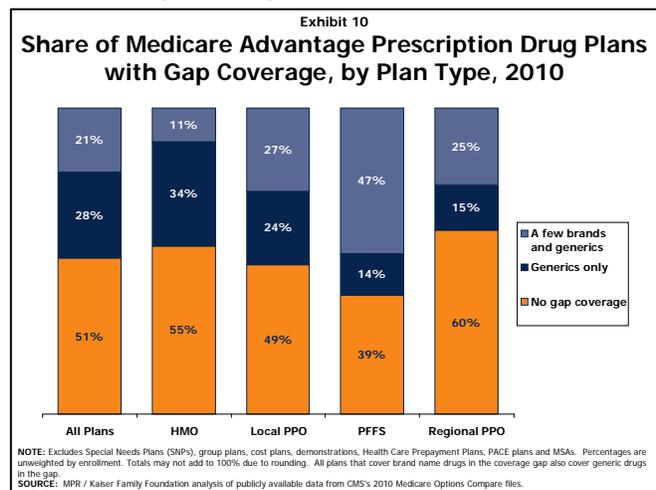
- More than 90 percent of plans have no cost-sharing requirements for preventive benefits (excluding annual physical exams). **(Exhibit 9)**
- Virtually all Medicare Advantage plans say they provide expanded coverage for physical exams beyond the initial “Welcome to Medicare” physical exam. Only 22 percent of all Medicare Advantage plans require cost-sharing for such services, with higher rates among local and regional PPOs (64 percent and 61 percent respectively).
- The share of all plans requiring no cost-sharing for preventive benefits has been relatively constant over time.¹⁵



Part D Benefits and Premiums

Most Medicare Advantage plans (79 percent) offer Part D benefits, including 79 percent of HMOs, 86 percent of local PPOs, 70 percent of PFFS plans, and 68 percent of regional PPOs.

- Eleven percent of all MA-PDs impose a deductible for their Part D benefit. Regional PPOs (40 percent) are far more likely to have a deductible than HMOs (11 percent) or PFFS plans (10 percent; data not shown).
- About half of all MA-PDs (49 percent) provide some coverage in the Part D coverage gap, primarily generics with some brand-name drugs. **(Exhibit 10)**



- Part D premiums average \$18 per month across MA-PDs. Part D premiums are lower in HMOs (\$14 per month) than in regional PPOs (\$21 per month), PFFS plans (\$24 per month), or local PPOs (\$26 per month). This is consistent with previous research showing that HMOs are substantially less likely than other plan types to charge a premium in 2010.¹⁶

Extra Benefits

In the context of the current payment system, many plans offer extra benefits to attract beneficiaries. Medicare Options Compare gives some general information, but offers very little detail, on these extra benefits that are often subject to a dollar or other limit. **(Exhibit 11)**

Preventive Dental. Over half (55 percent) of all Medicare Advantage plans cover some form of preventive dental care. Such benefits typically include a specified number of exams, cleanings or x-rays per year. Virtually all local and regional PPOs provide such coverage (99 percent and 100 percent, respectively). None of the plans provide restorative benefits such as fillings, crowns, or dentures.

Vision. All plans provide some vision benefit, particularly glasses and contacts. Almost all (86 percent) cover exams (typically one per year) and all plans cover eyeglasses generally subject to a dollar limit (\$85 per year, on average) and specified number of pairs.

Hearing. Nearly two thirds (65 percent) of Medicare Advantage plans cover hearing tests; most (89 percent) limit the number of tests allowed and a few (7 percent) have a dollar limit.

- **Hearing Aids.** Thirty-seven percent of plans cover hearing aids, generally subject to a limit. The average value of the hearing test benefit offered by plans is \$299 in 2010. Fifty-one percent of HMOs, 27 percent of local PPOs, 15 percent of regional PPOs, and 7 percent of PFFS plans provide a hearing aid benefit. In a July 2009 study, *Consumer Reports* found that hearing aid prices in New York City varied from \$1,800 to \$6,800 per pair, including fitting and follow-up services — far less than the amount covered by plans.¹⁷

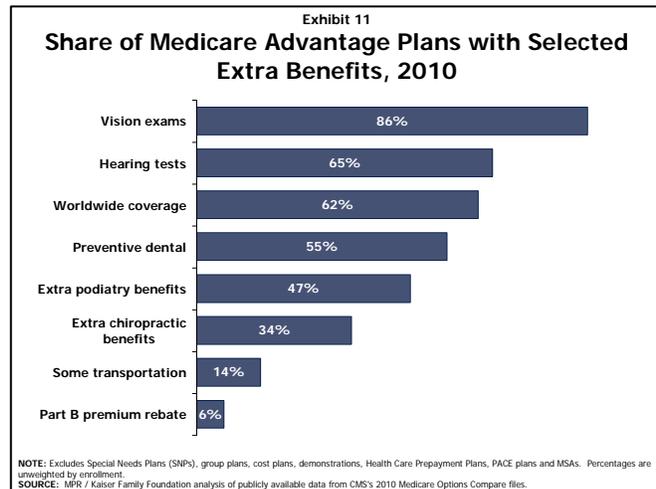
Other supplemental benefits. Forty-seven percent cover more expansive podiatry than Medicare, 34 percent cover more expansive chiropractic services than Medicare, and 62 percent provide a world-wide travel benefit not provided by traditional Medicare. Fourteen percent provide transportation beyond ambulance services, and almost always only to “approved locations.”

Part B rebates. Six percent of Medicare Advantage plans applied funds to reduce enrollees’ monthly Part B premium, with slightly higher rates among HMOs (9 percent) and lower rates among PFFS plans (1 percent). Part B premium reductions have always been relatively rare; in 2006, just 5 percent of Medicare Advantage plans reduced Part B premiums for enrollees.¹⁸

While Medicare Advantage plans often provide some level of extra benefits, it is not always easy to assess the generosity of these benefits, based on the information provided on Medicare Compare. For example, 62 percent of Medicare Advantage plans indicate that they provide some form of worldwide benefit but most describe it in general terms; about half with such coverage state a dollar limit (usually \$10,000 or higher). Similarly, while all plans state they provide some form of health and wellness coverage, the form of coverage, and extent of that coverage, is not always clear. Virtually all plans cover “smoking cessation” in some form. More than half (57 percent) say they offer some form of coverage for a gym or health club membership, and 31 percent provide newsletters or other forms of written information. Beneficiaries could more easily compare the relative value of one plan over another if benefits were described with uniform language, or if benefits were more standardized across plans.

Conclusions

The share of beneficiaries enrolling in Medicare Advantage plans has been on the rise in recent years, in part because plans offer low premiums, extra benefits, and reconfigured cost-sharing with fixed dollar copayments that are attractive to beneficiaries. Most Medicare Advantage plans also provide free preventive services, and limit beneficiaries’ out-of-pocket expenses. However, out-of-pocket costs for a given individual are not necessarily lower in Medicare Advantage plans than traditional Medicare across all plans or for all beneficiaries. Because Medicare Advantage plans can reconfigure the design of Medicare cost-sharing, some beneficiaries, particularly those with significant medical problems could face higher out-of-pocket costs in some Medicare Advantage plans than in traditional Medicare. Also, while limits on out-of-pocket spending have the potential to provide significant protection to enrollees, only about half of Medicare Advantage plans have a limit at or below the level suggested by CMS.



Our analysis shows wide variation in cost-sharing and benefits across plans, underscoring the importance for beneficiaries to look carefully at premiums, benefits and cost-sharing requirements (and provider networks), in addition to premiums, when choosing between traditional Medicare and Medicare Advantage plans, or among various Medicare Advantage plans offered in their area. Lack of transparency about benefits and restrictions, in general, make it difficult for beneficiaries to understand what is and is not covered by their plan. Greater transparency would help beneficiaries understand key differences across plans and critical tradeoffs, rather than just the most visible elements of the plan: monthly premiums.

Trends since 2008 present a mixed picture. On the one hand, the share of plans with limits on out-of-pocket spending has increased, while cost-sharing for primary care and specialist office visits has remained virtually unchanged. On the other hand, average cost-sharing for certain services (inpatient hospital stays and skilled nursing facility stays) has increased since 2008 (36 percent and 18 percent, respectively), appearing to shift greater costs to the subset of beneficiaries with the greatest medical needs.

Against this backdrop, and after a period of expansion, Medicare Advantage benefits may be in transition if Congress reduces the well-documented overpayments to plans. Other changes under discussion could expand prescription drug coverage in the so-called doughnut hole, and enhance benefits (e.g., by prohibiting plans from charging more than traditional Medicare for certain services). These reforms would likely limit the discretion firms have in shaping benefits, but could also make it easier for beneficiaries to choose between Medicare Advantage and traditional Medicare, and choose among Medicare Advantage plans.

¹ For information on Medicare Advantage premiums, see Kaiser Family Foundation, "Medicare Advantage 2010 Data Spotlight: Plan Availability and Premiums," November 2009.

² Rebates are defined under current law as 75 percent of the difference between the amount a plan expects it will cost to provide the Medicare benefit and the county-based (or regional in the case of regional PPOs) benchmark amounts that are set by a formula established in statute.

³ Congressional Budget Office, "Comparison of projected enrollment in Medicare Advantage plans and subsidies for extra benefits not covered by Medicare under current law and under the Patient Protection and Affordable Care Act," November 21, 2009; and Medicare Payment Advisory Committee, "Report to Congress: Medicare Payment Policy," March 2009.

⁴ The analysis excludes group and special needs plans (SNPs) because they are not available for general enrollment. It also excludes separately authorized plans, including 1876 cost plans, Health Care Prepayment Plans, Program for All Inclusive Care for the Elderly (PACE) plans, and demonstrations. The analysis excludes Medicare medical savings accounts (MSAs) because of their unique benefit design and extremely low enrollment.

⁵ For information on what Medicare Options Compare includes, see Marsha Gold, "An Illustrative Analysis of Medicare Options Compare: What's There and What's Not?" AARP Public Policy Institute, Insight on the Issues, April 2009.

⁶ Medical savings account (MSA) plans are also required to have an out-of-pocket limit.

⁷ Centers for Medicare and Medicaid Services, "2010 Call Letter," March 30, 2009.

⁸ Medicare beneficiaries are entitled to coverage of 90 hospital days during any spell of illness. If beneficiaries need more than 90 days, they are entitled to an additional 60 non-renewable days of care, called lifetime reserve days.

⁹ Figures do not sum to 100 percent due to rounding.

¹⁰ Medicare Payment Advisory Committee, "A Data Book: Healthcare Spending and the Medicare Program," June 2009.

¹¹ Beneficiaries with an inpatient hospital stay stayed for an average of 5 days. See Medicare Payment Advisory Committee, "A Data Book: Healthcare Spending and the Medicare Program," June 2009.

¹² Medicare Payment Advisory Committee, "A Data Book: Healthcare Spending and the Medicare Program," June 2009.

¹³ Beneficiaries with an inpatient hospital stay followed by a SNF stay within 30 days spent 7.02 days in the hospital and 21.57 days in a SNF, on average, based on Kaiser Family Foundation analysis of the Medicare Current Beneficiary Survey, Cost and Use Files, 2007.

¹⁴ Medicare Payment Advisory Committee, "A Data Book: Healthcare Spending and the Medicare Program," June 2009.

¹⁵ For comparable data for 2008, see M. Gold and M. Hudson, "Medicare Advantage Benefit Design: What Does It Provide, What Doesn't It Provide, and Should Standards Apply?" Washington DC: AARP Public Policy Institute, March 2009.

¹⁶ For information on Medicare Advantage premiums, see Kaiser Family Foundation, "Medicare Advantage 2010 Data Spotlight: Plan Availability and Premiums," November 2009.

¹⁷ Consumer Reports magazine, "Hear Well in a Noisy World," July 2009.

¹⁸ M. Gold, M. Hudson, and S. Davis, "2006 Medicare Advantage Benefits and Premiums," Washington, D.C.: AARP Public Policy Institute, November 2006.