

D E C E M B E R 2 0 0 4

REPORT TO THE CONGRESS

Benefit Design and
Cost Sharing in
Medicare Advantage Plans

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Medicare Advantage Plans

MEDPAC Medicare
Payment Advisory
Commission

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RECOMMENDATIONS

1 To provide critically important information about the implications of coverage and benefit options, CMS should use an array of approaches for beneficiaries and those who help them. In the short term, CMS should:

- continue to provide estimates of out-of-pocket costs on the Medicare Personal Plan Finder, and
- begin to make available more tools that reflect out-of-pocket costs under various scenarios for use of services and their likelihood.

As soon as feasible, CMS should develop advanced consumer decision tools that use individuals' actual experience to project future out-of-pocket spending.

COMMISSIONER VOTES: YES: 17 • NO: 0 • NOT VOTING: 0 • ABSENT: 0

2 CMS should interpret its authority granted in the MMA to negotiate with MA plans broadly on their benefit design and cost sharing. Specifically, MedPAC believes the agency should use this authority to ensure that plans do not discriminate on the basis of health status.

The Congress may need to provide CMS with additional staff resources and administrative flexibility to carry out this function effectively.

COMMISSIONER VOTES: YES: 17 • NO: 0 • NOT VOTING: 0 • ABSENT: 0

3 To prevent discriminatory benefit designs, CMS should develop guidelines for plans on benefit design and cost sharing that, if adopted, would provide safe harbor from extensive negotiations with the agency. Guidelines should include:

- an out-of-pocket cap on cost sharing for Medicare-covered services, and
- limitations on disproportionate cost sharing for services that are less discretionary in nature.

COMMISSIONER VOTES: YES: 17 • NO: 0 • NOT VOTING: 0 • ABSENT: 0

Under the Medicare Advantage (MA) program (formerly Medicare+Choice), private plans compete for enrollees on the basis of the benefits they offer, their networks, the quality of their providers, and the premiums they charge. The Centers for Medicare and Medicaid Services gives plans flexibility in designing their benefits and cost sharing. But there are inherent tradeoffs between giving plans flexibility and protecting beneficiaries from discriminatory behavior. A plan's cost sharing can be an important tool for managing care when applied to services that are discretionary in nature—in other words, when enrollees play more of a role in initiating care and determining how much to use. Cost sharing can be one mechanism for steering plan members toward appropriate types and levels of care, and it can help to constrain growth in premiums. Although patients have some element of discretion whenever they use health care services, plan members are less likely to have discretion over services such as inpatient stays, drugs covered under Part B of Medicare, renal dialysis, and radiation therapy. Requiring relatively higher cost sharing of persons who clinically have less discretion about their use of care could seem aimed more at discouraging sicker members from continuing in the plan than encouraging appropriate levels of care. Such behavior may, in turn, affect access to care for sicker beneficiaries who are enrolled in those plans, and could affect beneficiaries' decisions about enrolling in plans. If CMS's risk adjusters do not capture differences in individuals' use of services well, such behavior could also lead the Medicare program to overpay certain plans.

In recent years, beneficiary advocates and CMS have expressed concern that some MA plans were increasing cost sharing markedly for services such as chemotherapy and dialysis. At the same time, plans were concerned that their Medicare payment rates were growing more slowly than the cost of providing services. Although the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) raised payment rates for 2004, the topic is of continued interest because program changes such as the move toward competitive bidding and the introduction of an outpatient drug benefit could influence how plans design their benefits and cost sharing.

To address these concerns, the MMA mandated that MedPAC examine the extent to which cost-sharing requirements under MA plans affect access to services covered by Medicare or result in risk selection of enrollees. The mandate requests recommendations for legislation and administrative actions if the Commission considers it appropriate. (See Appendix A for the mandate language.)

This report approaches the policy question from the perspectives of both enrollees and plans. We look at the types of information that are available to help beneficiaries choose a plan, and we show examples of how the same individual's out-of-pocket (OOP) spending varies among plans in his or her county. We provide an example of the financial implications of cost-sharing requirements if a beneficiary were to experience one very serious type of illness—colon cancer. We also look for evidence of risk selection by analyzing the benefit structures and cost-sharing requirements of MA plans operating in 2004, the relative health of their enrollees, and information about why people leave plans.

Based on the discussions of an expert panel convened by MedPAC staff and available data on plan benefits and rates of disenrollment, this analysis finds that benefit designs that affect selection or lead to access problems are not widespread. Under current law, a plan may require cost sharing for individual services that is more than that under fee-for-service (FFS) Medicare, so long as average cost sharing for all services is no higher than the \$113 per month that FFS beneficiaries are projected

to pay, on average, in 2004. Our analysis suggests that for most types of services, very few MA plans require cost sharing higher than that charged in FFS Medicare. In most cases, enrollees receive more benefits from their plans than they would if they were in FFS Medicare without supplemental coverage, and they often pay no or low premiums. Data suggest that MA members have, on average, lower OOP spending than other Medicare beneficiaries.

Our analysis finds mixed evidence of the degree to which plan cost sharing is commensurate across services. Only a small number of plans charge more than FFS's cost-sharing requirements for any single type of service, and very few charge more than FFS for services in which beneficiaries have little discretion about their use of care. However, we find evidence that some plans charge relatively more for certain services that are less discretionary in nature than they charge for discretionary services. For the past several years, CMS has raised similar concerns about relative increases in plan cost sharing for dialysis, chemotherapy, inpatient, and other services in its annual guidance to MA plans. Although evidence differs across types of services, our analysis points to the provision of Part B-covered drugs (including chemotherapy) as one in which a number of plans use cost sharing like that in FFS Medicare while requiring relatively lower cost sharing for physician visits. The incidences of advanced cancer and other serious illnesses that require treatments with Part B drugs are relatively rare, but for these beneficiaries, OOP costs can be large. As CMS has recommended, some plans cap the OOP spending of their enrollees, which mitigates the effects of uneven cost sharing. In addition, incommensurate cost sharing across services could lead to unfair competition among plans. Some plan officials with whom we spoke noted that a few of their competitors have raised cost sharing for services such as inpatient stays more than for other services, leaving their plan at a disadvantage because they attract sicker beneficiaries. Based on this analysis, the Commission encourages CMS to monitor the issue, and this report includes recommendations for strengthening the agency's role in preventing discriminatory benefit designs.

Additionally, while the Commission believes that Medicare's web-based tool, the Personal Plan Finder, is useful for helping beneficiaries choose among plans and coverage options, CMS should strive to improve it. In particular, the Plan Finder's projections of average OOP costs may be less informative than the more tailored estimates that some commercial plans make available to their members. Some beneficiaries will not find tailored projections of OOP costs as useful as others. Nevertheless, the Commission believes it is incumbent upon CMS to continue to make detailed information available for those beneficiaries who choose to use it, especially during the next few years as the agency implements the MMA's policy changes.

To help focus this research, MedPAC staff convened a panel of 15 experts on March 31, 2004. That panel included representatives of private plans, beneficiary advocates, academic researchers, and consulting actuaries to major employers. (A summary of the panel meeting deliberations is included as Appendix B of this report.) Our discussion with these experts explored their perceptions about the amount of variation in plan benefit designs, the degree to which plans use benefit design as a means of selection, and CMS's role in approving proposals for plan benefit packages. In general, panelists noted that there is considerable variation in cost-sharing requirements and premiums charged across MA plans, but most did not think that this variation was affecting access to care in a widespread manner. However, the panel recognized that certain plans appear to require higher cost sharing for some services such as chemotherapy. They agreed that a continuing challenge for the Medicare

program is to help beneficiaries understand the personal and financial implications of choosing among their coverage options.

With the insights of the expert panel and discussions with CMS staff as context, we used information from the Plan Benefit Package file compiled by CMS to examine benefit structures. Those data cover benefits for 2004 and reflect changes that plans made to their packages after increased payment rates. We also evaluated projections of OOP cost sharing that CMS provides to beneficiaries in the Medicare Personal Plan Finder. In addition, we used other data from CMS such as scores that reflect the average health status of enrollees and data from the Consumer Assessment of Health Plans Survey (CAHPS) Disenrollment Reasons survey to look for evidence of risk selection.

We would like to thank the National Cancer Institute for providing information about the costs of cancer care. Those data, along with details about current forms of cancer therapy that we obtained from cancer researchers and practicing clinicians, allowed us to construct an example of the amount of cost sharing a patient would be required to pay for a year of care following initial diagnosis of stage III colon cancer. Although relatively few Medicare beneficiaries experience this serious health condition, the example illustrates how cost-sharing requirements for illnesses could lead to surprising OOP liabilities and might lead to access problems.

Issues in the Medicare Advantage program

This section describes how the MA program operates, as well as CMS's process for reviewing and approving plan proposals. It also describes the role that the agency plays in balancing measures to protect beneficiaries with flexibility for plans to design their own distinct package of benefits and cost-sharing requirements.

Approaches toward competition among plans

Some health programs and employers have private plans compete for enrollees while delivering one or a few types of standardized benefit packages. The California Public Employees' Retirement System (CalPERS) and General Motors are two such examples. With standardized benefits, plans compete on the basis of their premiums, the desirability of their networks, and the quality of their providers. This approach can simplify choices for beneficiaries because there are fewer plan characteristics to compare. Standardized benefits may also enhance price (premium) competition, thereby providing incentives to deliver care more efficiently.

Terminology and payment method for Medicare Advantage plans

In the Medicare Advantage (MA) program, Medicare beneficiaries may choose to receive Medicare-covered services from a private plan rather than from the traditional fee-for-service (FFS) program. There are several types of plans: coordinated care plans (CCPs), which are primarily health maintenance organizations and have the vast majority of MA enrollees, while other categories include private fee-for-service, preferred provider organization demonstration plans, Medicare cost plans, others designed specifically for frail beneficiaries, and medical savings accounts (MedPAC 2003). The Medicare program pays MA plans a county-based capitated rate for the 13 percent of beneficiaries who are currently enrolled (including enrollees in plans that are a part of demonstration programs). Those payments will amount to about \$40 billion in 2004.

CCPs receive a capitated payment from Medicare for providing all Medicare-covered services, and generally their enrollees must use plan providers. Through 2006, CCPs are allowed to provide additional benefits and to charge members an additional premium for them. However, if a plan's projected costs for Medicare benefits are lower than its Medicare payments, it is required to either return the difference to enrollees in the form of additional benefits or lower Part B premiums. In practice, enrollees in these plans often have lower cost sharing than under FFS Medicare and may receive extra benefits at no or low additional premiums.

In many cases, payment rates are tied to average levels of FFS spending in the counties in which MA plans operate. Since there is a sizable amount of geographic variation in average FFS spending around the country, there is also considerable geographic variation in the premiums charged and the amount of extra benefits that MA plans offer.

Medicare is phasing in changes to its payment methodology that could affect the way that plans structure their benefits and cost sharing for expensive forms of care. In 2000, the Secretary began phasing in a risk adjustment system that includes diagnoses from administrative claims data in addition to demographic information. CMS has developed "standard" risk adjusters as well as separate ones for beneficiaries with long-term stays in institutions, those with end-stage renal disease, and those who are enrolled in special managed care programs for the frail. Current law requires that CMS phase in new risk adjusters by 2007. For 2004, 70 percent of plan payments are adjusted using demographic factors, and 30 percent using the new risk adjusters that reflect diagnoses.

The MA program gives managed care organizations flexibility in designing benefit packages so long as they provide all Medicare-covered services, use cost-sharing requirements that are actuarially equivalent to those under FFS Medicare, and do not discriminate on the basis of enrollee health status. One reason for allowing flexibility is that Medicare beneficiaries can choose among a broader variety of benefit packages, potentially finding one that best suits their individual needs. Medicare's

payment rates have varied over time and, given their pool of current enrollees and increases in the cost of providing care, plans may need to adjust their benefit structures and cost sharing in response to those changes and to competitive pressures. Flexibility also allows plans to adapt innovative benefit designs that they offer for other populations to the MA program.

Another reason for giving plans flexibility is that plans use cost sharing to discourage inappropriate care. In general, supplemental coverage that shields beneficiaries from FFS cost-sharing requirements leads to greater use of services and higher Medicare spending—17 to 28 percent higher, by some estimates (Christensen and Shinogle 1997). Most managed care plans use cost-sharing requirements as one mechanism to control the use of services by making enrollees more sensitive to the costs of their care—an approach widely adopted by employer-sponsored insurance plans for active workers. Enrollees in some MA plans can purchase additional coverage of non-Medicare services or lower cost sharing on Medicare services from the plan, but typically they cannot also buy individually purchased medigap policies. Once enrolled, beneficiaries must abide by the plan's benefits design and cost-sharing requirements.

One possible consequence of offering different benefit designs is that it could lead to biased selection among plan risk pools. For example, healthier beneficiaries might tend to enroll in plans with less generous benefits and lower premiums, while sicker beneficiaries opt for more coverage. And since a very small proportion of members tend to account for a large share of health care spending, some plans may try to encourage their sicker members to leave.

In the case of the MA program, it may be important to consider differences in business models that could affect the approaches that plans use in designing their benefits and cost-sharing structures. For example, a staff model HMO is likely to collect beneficiary cost-sharing requirements itself at the point of service. Providers in network-style HMOs may collect cost sharing directly from the patient; the plan itself would not receive those revenues and might not even know whether the beneficiary actually paid, but its payments to providers would take cost-sharing requirements into account.

Evaluating benefits and cost sharing in Medicare Advantage

CMS uses a formal process to review and approve MA plans, which is intended to both document that payments above plan costs are returned to beneficiaries and help prevent discriminatory benefit design. Through 2005, CMS will continue to use the Adjusted Community Rate Proposal (ACRP) process for reviewing the MA plans' benefits. That process requires MA organizations to submit data on their proposed benefits, cost sharing, and expected costs and revenues to CMS for review.

For 2006 and beyond, the MMA calls on CMS to use a bid process instead of the ACRP. It also broadened CMS's oversight role by giving it authority to negotiate with plans over their bids in a similar manner as the Office of Personnel Management (OPM) uses for Federal Employees Health Benefits Program (FEHBP). Although OPM's authority is quite broad, CMS's proposed rules suggest that it interprets its new authority somewhat more narrowly: specifically, that it can negotiate over the actuarial assumptions that plans use in their bid and cost-sharing requirements for supplemental benefits financed with some of the difference between CMS's payment rate and the plans bid. We discuss this issue further later in this report. (Although CMS must continue to

approve private FFS and medical savings account (MSA) plan contracts, the agency does not negotiate specific details about benefits and cost sharing with those plans.)

CMS issues a call letter each spring that includes guidance for submitting plan proposals, as well as statutory and administrative changes in how the program will operate for the upcoming calendar year. As part of the ACRP process, each MA organization must submit a Plan Benefit Package (PBP)—its proposal for covered health benefits, cost sharing, premiums, and any supplemental coverage—along with an adjusted community rate (ACR) that reflects proposed pricing for the PBP. The term ACR refers to an MA organization’s estimate of plan costs for the upcoming contract year, which are based on the costs in the current year adjusted for projected changes in benefit structure, utilization, technology, and demographics. CMS reviews proposals to evaluate each plan’s pricing and to ensure that any excess amount between CMS’s average payment rate to the plan and its ACR is returned to enrollees in the form of additional benefits or lowered Part B premiums or (prior to 2005) is distributed to the plan’s stabilization fund.

The agency also reviews benefit proposals in order to meet statutory and regulatory requirements for protecting beneficiaries. Specifically, current law states that managed care organizations may not deny, limit, or condition plan coverage or provision of benefits based on any factor related to health status. CMS interprets this to mean that plans may not discriminate, discourage enrollment, or hasten disenrollment of sicker beneficiaries through the design of their benefit packages. MA plans also face a statutory limit on enrollee premiums for basic and additional benefits, as well as on the actuarial value of their plan’s deductibles, coinsurance, and copayments, which may not exceed the actuarial value of cost sharing that is applicable, on average, under FFS Medicare. For 2004, CMS actuaries estimated that amount to average \$113 per month nationwide for enrollees in Parts A and B of Medicare (and about \$119 per month for 2005). CMS has authority to disapprove a plan’s proposal on either grounds—discriminatory benefit design or excess average cost sharing.

Balancing flexibility of plan design and beneficiary protection

There are inherent tradeoffs between protecting beneficiaries and allowing plans’ flexibility. Since 2003, CMS has noted in its call letter that some plans have raised cost sharing significantly for dialysis services and chemotherapy drugs, which could appear discriminatory. For 2005, it has also pointed to deductibles and cost sharing for Medicare-covered drugs, inpatient and skilled nursing facility stays, services in outpatient departments and ambulatory surgical centers, and ambulance services as other areas of concern (CMS 2004). Yet, on average, the amount of cost sharing by enrollees in those plans is no higher than the average amount for FFS.

Observers differ in their opinions about how effectively CMS uses its authority to disapprove a plan’s benefit structure. Some participants in MedPAC’s expert panel noted that CMS could prevent a managed care organization from offering a plan with relatively high cost sharing for nondiscretionary services if it chose to exercise its full authority. Plan representatives and CMS pointed out that the agency has, in fact, made some plans revise their ACRPs in order to reduce certain cost-sharing requirements or to add a catastrophic cap on their enrollees’ OOP cost sharing. Beneficiary advocates on our expert panel noted, however, that certain plans charge 20 percent

coinsurance for services such as dialysis and chemotherapy, which they consider overly burdensome for some of the sickest patients.

CMS has begun recommending that plans cap cost-sharing liability for Medicare-covered Part A and Part B services at certain levels using three benchmarks:

- nationwide average premiums for standard F-type medigap policies,
- distributions of total OOP costs that beneficiaries face under FFS Medicare, and
- requirements imposed under the federally-qualified HMO program.¹

For 2004, CMS recommended an annual cap of \$2,560, excluding enrollee premiums (\$2,710 for 2005).² Although such caps are voluntary, if a plan uses one, CMS said it will allow more latitude in the individual components of a plan's cost-sharing requirements than it would otherwise. It will also allow plans to use different variations on the recommended cap if the plan offers an appropriate rationale.

In some cases, plan representatives told us that they have included OOP caps because they believe they are in the best interests of enrollees, and consistent with the tenets of managed care. Excessive OOP costs could undermine patient compliance with recommended care, coordination of services, or the use of preventive services. Expert panel members noted that other plans have introduced caps to comply with CMS cost-sharing guidelines. We provide data later in the report on how widely OOP caps are used among MA plans.

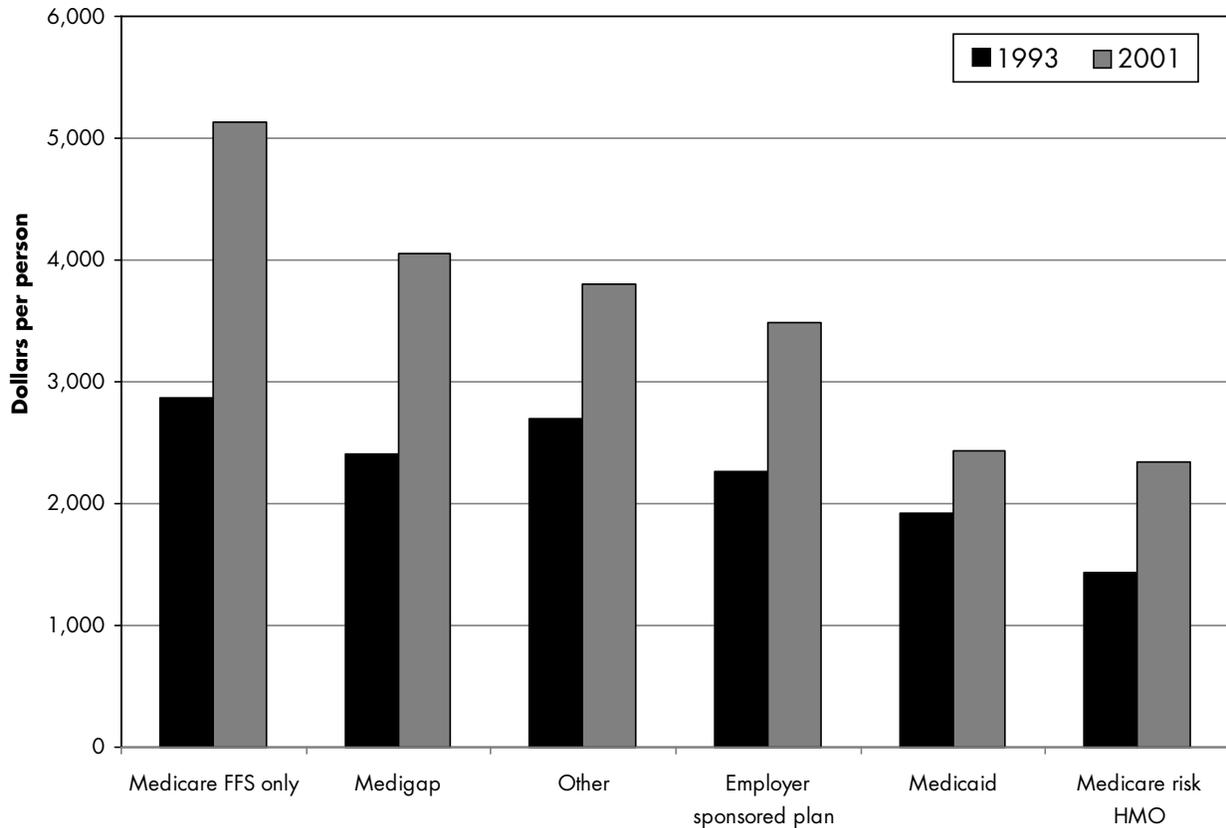
Comparing Medicare Advantage plans and enrollees to FFS Medicare

Historically, Medicare managed care plans kept cost-sharing requirements for most or all Medicare-covered services to levels substantially lower than the levels required by Medicare Parts A and B. Because beneficiary cost sharing for hospital care and physician visits was typically low, MA enrollees have had, on average, lower OOP spending (including premiums) than FFS beneficiaries with medigap coverage (CMS 2002). Plans generally had little reason to include provisions limiting total cost sharing for Medicare-covered services. In the years following the Balanced Budget Act of 1997, however, many plans increased beneficiary cost sharing, raised premiums, and reduced or eliminated supplemental benefits not covered by Medicare such as outpatient prescription drug coverage (Gold and Achman 2003, Achman and Gold 2002). For 2004, increased payment rates in the MMA have led many plans to reverse some of those changes, and our data analysis presented later in this report reflects those higher payment levels.

According to data from the 2001 Medicare Current Beneficiary Survey (MCBS), enrollees in Medicare risk HMOs continue to have lower OOP spending, on average, than do other Medicare beneficiaries (Figure 1, p. 8). Note that these statistics do not adjust for health status. To the extent that

Figure 1

Per capita out-of-pocket spending for Medicare beneficiaries, by type of insurance coverage, 1993 and 2001



Note: FFS (fee-for-service). Premium payments and spending on services not covered by Medicare (such as outpatient prescriptions drugs) are included.

Source: CMS, Office of Research, Development, and Information: Data from the Medicare Current Beneficiary Survey 1993 and 2001 Cost and Use files.

enrollees in MA plans are healthier than beneficiaries in FFS Medicare, one might expect cost sharing to be lower (MedPAC 2004). The issue addressed in this mandated report is whether the cost-sharing requirements of some MA plans discriminate against beneficiaries who need specific high-cost services, which may not be evident in data on average cost sharing. Nevertheless, it is important to note that the average MA enrollee faces lower OOP spending than they would under FFS alone, or even with some types of supplemental coverage.

Who enrolls in MA plans? According to data from the 2000 MCBS, enrollees in MA health maintenance organizations are more likely to be near poor and lower-middle income than are FFS beneficiaries who live in areas where MA plans are available (Murgolo 2002). The poorest beneficiaries who also qualify for premium and cost-sharing assistance through Medicaid tend to

remain in FFS Medicare, as do those who can afford medigap policies. Sizable numbers of enrollees are in MA plans sponsored by their former employers. Nevertheless, most retirees with employer-sponsored supplemental coverage remain in FFS Medicare. MA plans include a disproportionate share of Hispanic enrollees. Enrollees in MA plans also tend, on average, to be younger and report that they have better health status than FFS beneficiaries.

Most beneficiaries who remain in FFS and hold supplemental coverage are cushioned from some or all cost sharing. Certain FFS cost-sharing requirements, such as a substantial inpatient deductible (\$876 in 2004) and high copays on long hospital stays, can lead to a considerable and open-ended financial burden. In order to reduce those risks, many FFS enrollees obtain supplemental coverage—primarily through their former employers or medigap policies, with others qualifying for Medicaid. In 2001, fewer than 10 percent of beneficiaries had only FFS Medicare (MedPAC 2004). About a third of FFS enrollees purchase medigap policies, which provide first-dollar coverage and effectively eliminate FFS cost-sharing liability for services covered by Medicare in return for monthly premiums. However, few of those policies cover outpatient prescription drugs. Although the price of some medigap policies sometimes surpasses the actuarial value of coverage, a market for such coverage persists because of the strong preference for the certainty of monthly premiums over the uncertainty of FFS cost sharing.

What information is available to help beneficiaries choose among plans?

Beneficiaries make decisions about health plans based on their preferences, understanding of options, and financial resources. Decisions to disenroll are usually based on a member's actual experience, but initial decisions about joining a plan rely more heavily on marketing information—in print or electronic forms or from direct sales mailings—and information provided by private and government organizations, including CMS. The most detailed information CMS offers is its web-based tool to help consumers evaluate their coverage options, the Medicare Personal Plan Finder, at <http://www.medicare.gov>.

The information from the Plan Finder provides some generally useful points of comparison for consumers. It is also used by individuals and organizations that assist Medicare beneficiaries in choosing among coverage options, such as their adult children and counselors with State Health Insurance Assistance Programs. After going to the Plan Finder web site, the beneficiary enters his or her ZIP code or county and state, indicates his or her age group (65–69, 70–74, 75–79, 80–84, and 85 or older), and estimates his or her health status (excellent, very good, good, fair, or poor) using pull-down menus. The Plan Finder then provides basic information about coverage under FFS Medicare, medigap policies, or MA plans that offer services in the area. The web tool projects what a beneficiary's OOP costs would be under each coverage option and, for MA plans, it also provides quality measures and disenrollment rates.

Projections of out-of-pocket spending

Plans submit detailed data across many types of categories of health spending. The Plan Finder displays it in three groups:

- inpatient care (Medicare covered, plus some noncovered psychiatric hospital or facility care and skilled nursing care).
- “other medical” care (other Medicare-covered services such as physician visits, lab tests, outpatient procedures, durable medical equipment, etc.).
- outpatient prescription drugs.

Projections of OOP costs are based on average use of services reported for FFS enrollees in combined claims and survey data from the 1999 and 2000 versions of the Medicare Current Beneficiary Survey, for people within the same age group and with similar self-reported health status (Fu Associates 2003). CMS’s Plan Finder takes that projected use of services and applies the benefit design and cost-sharing structures for plans from the latest available Plan Benefit Package data to estimate OOP spending.

How much higher might OOP costs be for beneficiaries with chronic conditions? The Plan Finder provides projections of OOP spending for beneficiaries who have one of three high-cost conditions: diabetes, congestive heart failure, and heart attack. (See text box for an illustration of how cost-sharing obligations can vary among competing MA plans for one other high-cost illness, advanced colon cancer.) Table 1 shows an example of Plan Finder’s OOP projections for three competing plans from one market. This particular market has county-level payment rates that are above national averages, but not among the highest rates. The CMS data include cost sharing for Medicare-covered services, outpatient prescription drugs, and dental care, as well as the cost of Medicare Part B and plan premiums. Plan 2 appears to have significantly lower cost sharing across all three high-cost conditions. Expressed as annual costs, these data indicate average OOP spending in the range of \$2,400 to \$6,000 per year.

Table 1

Estimates of out-of-pocket costs among competing Medicare Advantage plans from the Medicare Personal Plan Finder, 2004

	Average monthly out-of-pocket costs for a typical person with:		
	Diabetes	Congestive heart failure	Heart attack
Plan 1	\$351–400	\$401–450	\$451–500
Plan 2	201–250	201–250	201–250
Plan 3	351–400	401–450	451–500

Note: Costs are for the same beneficiary if he or she were enrolled in one of three plans in the same market.

Source: Medicare Personal Plan Finder. <http://www.Medicare.gov>.

Benefit design and variation in cost sharing for colorectal cancer

In recent years, CMS has noted concerns about increases in cost sharing for chemotherapy in its annual guidance to Medicare Advantage (MA) plans. MedPAC staff heard similar concerns when they convened an expert panel as an initial step of this research. Our analysis of the data on Medicare's web-based Personal Plan Finder showed that it can be very difficult for beneficiaries to learn what their out-of-pocket (OOP) costs would be if they required chemotherapy. To shed light on the topic, we include here a case study of cost-sharing requirements that a beneficiary could face if he or she were diagnosed with one high-cost condition: colorectal cancer.

Colorectal cancer is one of the most common forms of cancer in the Medicare-age population: The probability of developing it is about 1 in 25 among men age 60 to 79. We focus on colorectal cancer because clinical studies suggest that adjuvant chemotherapy can extend a patient's survival, and it is as effective and no more toxic in otherwise healthy older patients than in younger ones (American Cancer Society 2004).³ Thus, ensuring access to treatment may be especially important for this illness.

Colorectal cancer is very expensive to treat. Analyses conducted by researchers at the Applied Research Program of the National Cancer Institute (NCI) used data from the Surveillance, Epidemiology, and End Results (SEER) cancer registry merged with Medicare fee-for-service (FFS) claims to profile the use of Medicare services for patients with colorectal cancer. The analysis included cases diagnosed between 1983 and 1999, and followed them through 2001. Medicare paid, on average, \$38,500 (in 2001 dollars) for the initial treatment phase of stage III cancer with lymph node involvement. NCI estimates that about 90 percent of the value of that care was related to cancer. About \$27,000 of this reimbursement was for Part A services, and \$11,500 for Part B. For beneficiaries, OOP costs would be about \$792 for the Part A deductible for one hospitalization in 2001, plus \$2,975 for Part B services⁴, for a combined total of \$3,767.

However, that estimate does not reflect more recent changes in the standard chemotherapy regimen for colon cancer used today (Schrag 2004). New drugs integrated into a regimen called FOLFOX are being used for colon cancer with lymph node involvement. Treatment regimens are beginning to include even newer drugs as well, and their costs are two to three times higher than those described here (Schrag 2004). Clinical studies indicate that the FOLFOX regimen extends median survival of patients with metastatic colorectal cancer from 12 to 21 months. Medicare paid, as of 2004, about \$10,000 for the specific drugs needed for each FOLFOX regimen (Schrag 2004). In FFS Medicare, the beneficiary (or his or her supplemental insurer) is responsible for 20 percent coinsurance for these drugs.

To get a sense of what a plan enrollee might pay for care after diagnosis, we started with NCI data for colon cancer patients to construct a profile on their use of Medicare services. With the help of national experts on colorectal cancer, we updated that profile to reflect more recent treatment protocols. That profile describes the number and types of services that a male, age 70, of average size and weight, and in otherwise average health would use following a diagnosis of stage III

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Benefit design and variation in cost sharing for colorectal cancer (cont.)

colon cancer. We then estimated what this same patient would pay OOP for his cancer care if he were enrolled in each of three competing MA plans available in his county. We selected three plans with the largest enrollment in a large county that has a history of active competition. Note that OOP costs could be quite different in other markets.

The table below shows that in 2004, the patient's cancer-related cost sharing would range between \$1,990 and \$7,100. The estimates do not include OOP spending for Medicare-covered drugs other than FOLFOX, such as anti-nausea medications. Nor do they reflect spending for prescription drugs not covered by Part B, nor for any other health care services not directly related to the cancer diagnosis. Using data provided to us by a managed care plan that directly acquires chemotherapy drugs, we estimate that the combined annual cost of all drugs included in the FOLFOX regimen would total \$28,000. In plans that require 20 percent coinsurance, beneficiaries would be responsible for \$5,600 for chemotherapy drugs in the first year following diagnosis. We do not include cost sharing for physician administration expenses for chemotherapy that are separately billable in FFS Medicare, because MA plans typically charge no additional cost sharing for drug administration beyond that for the physician visit. In FFS Medicare, drug administration can be on the order of more than half of the cost of the chemotherapy drugs (Hoverman 2004).

None of the plans in the market used in this illustration charge an additional premium in 2004. (Plan 2 gives beneficiaries a rebate toward the Part B premium.) All three of the plans require cost sharing for inpatient hospital stays and, in all three plans, a beneficiary diagnosed with colon cancer would incur several thousand dollars in OOP costs for treatment following diagnosis. In this market, the major difference in potential OOP liability stems from the coinsurance charges for chemotherapy required by two of the three plans we analyzed.

Estimated cost sharing for colon cancer care in three Medicare Advantage plans, 2004

Components of cost sharing	Annual cost sharing in dollars		
	Plan 1	Plan 2	Plan 3
Surgery	\$1,050	\$1,400	\$ 700
Outpatient surgery, physician visits, and emergency room visit	450	350	250
Lab costs	0	0	0
Chemotherapy	5,600	0	5,600
Patient's total cost sharing	7,100	1,990	6,550

Source: MedPAC.

The Commission believes that the Plan Finder is a useful tool for Medicare beneficiaries. Nevertheless, there are some important limitations about its projections of OOP spending:

- The Plan Finder's estimates reflect FFS prices and utilization rates, and do not make any adjustments for management of care by MA plans. For example, lower prices or discounts that MA plans might negotiate are not reflected in the estimated costs for MA enrollees, nor are any differences in utilization, such as fewer hospitalizations or reduced lengths of stay that might be associated with care management.
- The Plan Finder's projections for high-cost conditions do not allow beneficiaries to see how the components of OOP spending vary across plans. That is, they cannot tell whether higher costs in Plans 1 and 3 are due to cost sharing for inpatient care, for prescription drugs, or some other plan feature. The Plan Finder estimates are also based on average costs for all beneficiaries with these conditions, regardless of age or other health care problems, making it hard to determine what changes in cost sharing an individual with these conditions might face as they age or become more seriously ill. For example, OOP spending for beneficiaries with stable diabetes is averaged with those who are sicker.
- Projections of OOP costs are averaged across the population in the age-health status category, including costs for those who use services as well as for those who do not. For example, not all beneficiaries in poor health have a hospital admission in a year. If 20 percent have hospital stays in a year, and patient cost sharing for these stays is \$1,500 per person (e.g., \$250 per day for six days), the Plan Finder would calculate a figure of \$300 per year in hospital costs per beneficiary (averaging zero spending for 80 percent of the people with \$1,500 spending for those with hospital stays). When divided into 12 monthly amounts, this would be reported as an estimated \$25 per month for inpatient cost sharing. But if a plan enrollee were hospitalized, the OOP cost for an average stay would be about \$1,500 per year rather than \$300, or \$125 per month. We discuss alternative ways that CMS could present OOP projections to Medicare beneficiaries later in this report.

CMS considered other approaches when it developed OOP projections for the Plan Finder, but ultimately decided to use actuarial values because officials believed it would be burdensome to make beneficiaries enter data on their expected use of services. Some analysts have also suggested that if more interactive tools were available for just a few components of each plan's benefit, such as for hospital stays or prescription drugs, plans might use their benefits design to make OOP spending for those categories of services look relatively low, with higher cost sharing on other categories that would not be scrutinized as closely.

CMS could address other limitations of the Plan Finder's OOP projections if resources were available for quality control and for technical assistance to plans. For example, some of the data on the Plan Finder appear to be incorrect. We have not conducted a systematic review of the accuracy of all OOP data in the Plan Finder, but there were multiple cases where cost-sharing projections did not agree with plan benefit designs, largely because the values submitted by plans to the data file used to generate estimates were miscoded, or because the ways in which categories of spending were combined led to incongruous results.

Providing useful projections of OOP costs to beneficiaries will become even more difficult when the Part D benefit is in place. CMS is considering a range of options, but it has not yet decided what sort of estimates of OOP costs it will be able to provide in the Plan Finder for 2006. One near-term concern is how well the agency could project OOP spending for the new Medicare drug benefit as that program gets up and running.

Reasons why individuals leave plans

Another piece of information that CMS reports on the Plan Finder is the rate of voluntary disenrollment for the MA plans that operate in a beneficiary's county, along with the reasons members left (Harris-Kojetin et al. 2002). Although plan benefits may have changed in important ways over the two years between the time the survey was conducted and today, the data may give a sense of issues that beneficiaries might want to investigate further before choosing a plan, and point to the magnitude of problems that disenrollees experienced.

As one example, consider the same three plans that we presented earlier in Table 1. In this case, as shown on Table 2, cost issues appear to have been a factor in disenrollment from the two plans with higher cost sharing. For both plans 1 and 3, issues relating to premiums, copayments, and coverage were cited most often as the main reason for leaving, and the disenrollment rates from these plans were higher than the average rate for the state where the plans operate. Thus, while there is no detailed information on the specific reasons that people left plans (for example, whether the concern was cost sharing versus coverage of particular types of care), there is enough information to lead beneficiaries to probe more deeply into benefit design.

Table 2

Reasons why individuals leave Medicare Advantage plans, from the Medicare Personal Plan Finder, 2004

	Percent of plan enrollees who left voluntarily for the following reasons:				
	Getting the doctors wanted	Getting information from the plan	Getting care	Premiums, copayments, or coverage	Getting or paying for prescription medicines
Plan 1	3%	1%	2%	8%	2%
Plan 2	0	0	1	2	0
Plan 3	2	1	2	6	1
U.S. average	2	1	2	4	1
State average	2	1	1	4	1

Note: Data are from the 2002 Consumer Assessment of Health Plans Survey (CAHPS) Disenrollment Reasons survey.

Source: Medicare Personal Plan Finder. <http://www.medicare.gov>.

Plan cost-sharing requirements and benefit designs

In this section, we look more closely at the distribution of cost-sharing requirements among MA plans, as well as the premiums and benefit designs they use to attract enrollees. Cost sharing differs considerably among MA plans. Although cost sharing for most beneficiaries is lower than it would be in FFS Medicare without supplemental insurance, some plans require as much, or in a small number of cases, more beneficiary cost sharing for specific services.

For this analysis, we used CMS data from its PBP file for 2004. CMS compiles PBP data from information submitted by plans as part of the ACRP process, including details about their proposed benefits and cost sharing. Managed care organizations typically operate several plans—unique combinations of benefit packages and cost-sharing requirements offered for a given premium—under a single contract with CMS. Here we analyze 2004 PBP data at the plan level. In other words, plans included under one contract are treated as separate observations.⁵ We omitted plans that were not enrolling beneficiaries from the broader Medicare population: employer-sponsored plans, those for frail elderly, and a variety of demonstration plans, including CMS’s preferred provider organization (PPO) demonstration plans.

Altogether, we examined the beneficiary cost-sharing provisions of 505 of the 630 plans included in CMS’s PBP file. Among those plans, 484 were HMOs or HMO point-of-service plans, 9 were PPOs, 5 were provider-sponsored organizations, and 7 were private FFS plans. We used the values for projected enrollment included in each plan’s ACRP submission to estimate the number of beneficiaries subject to its cost-sharing provisions. Projected enrollment for these 505 plans totaled 4,229,407, accounting for about 90 percent of actual plan enrollment in 2004.

Inpatient cost sharing and out-of-pocket spending limits

Cost-sharing requirements vary by plan, and within a plan they usually vary across different types of services. Cost sharing is typically lower for care provided within the plan’s network, and can vary depending on whether services are subject to prior authorization.

Cost sharing for certain types of services—especially inpatient hospital stays—can reach high dollar amounts. Some plans have introduced caps that limit beneficiaries’ annual OOP costs. Those caps vary in whether they provide catastrophic coverage for Medicare-covered services or for all services provided by the plan, including supplemental benefits.

Consumer advocates and CMS have raised particular concerns about cost sharing for inpatient hospital care. Some plans require no cost sharing for inpatient care (at least for care at hospitals within their network), but other plans use deductibles or copayments for each day of the patient’s stay, sometimes up to a maximum amount per stay. Only a small number of plans have an inpatient deductible (5 percent), with values ranging from \$100 to \$880. Copayments per day range from \$0 to \$400; they might apply, for example, to one day, to the first three days of a stay, or for up to nine days. Among the plans we analyzed, multiplying the cost-sharing charge per day by the maximum

number of days for which the cost sharing would be applied results in potential OOP liability for inpatient care ranging from \$0 to \$27,000.

Out-of-pocket caps limit potentially catastrophic levels of cost sharing that can result from hospitalizations in 46 percent of plans, applying to half of the enrollees in the plans we studied (Table 3). Twenty-nine percent of plans and about the same share of enrollees have OOP caps on some or all Medicare-covered services, including inpatient hospital care. Most also cover services at skilled nursing facilities and inpatient psychiatric care. Many of the caps that cover inpatient and outpatient services also cover other Medicare-covered services such as radiation therapy, durable medical equipment (DME), and emergency care. But PBP data on catastrophic caps are not coded consistently across plans, so it is difficult to discern precisely from those data which services are under an OOP cap. Another 18 percent of all the plans we analyzed do not have annual OOP caps for some or all Medicare-covered services, but instead set specific limits on beneficiary OOP spending for inpatient hospital care. Those inpatient caps apply to about 20 percent of plan enrollees.

Table 3
Distribution of plans and enrollees by type of out-of-pocket cap, 2004

	Number of plans	Percent of plans	Number of enrollees*	Percent of enrollees*
All plans	505	100%	4,184,348	100%
Plans with OOP caps that apply to some Medicare-covered services, including inpatient hospital care	144	29	1,258,502	30
Plans with OOP caps that only apply to inpatient hospital care	89	18	841,273	20
Plans with no cap on inpatient hospital care**	272	54	2,084,573	50

Note: OOP (out of pocket). The numbers above exclude demonstrations (including preferred provider organization demonstrations) and plans that are only open to employer groups. Separate plans listed under a single contract (H-number) are each treated as different observations.

* Enrollee projections from plan Adjusted Community Rate Proposal submissions.

** Ten plans reported that they had an OOP cap, but those caps did not cover inpatient hospital care.

Source: MedPAC analysis of 2004 Plan Benefit Package data from CMS.

In its guidance to plans for 2004, CMS notes that plans which adopt a \$2,560 cap on cost sharing for all types of Medicare-covered services would receive greater latitude in their design of specific cost-sharing requirements. Our analysis suggests that among the 29 percent of plans with catastrophic limits that apply to some or all Medicare-covered services, just over half use cap values of \$1 to \$2,560, covering about 14 percent of plan enrollees. Comprehensive caps range in value from \$300

Table 4**Distribution of plans and enrollees, by out-of-pocket cap amount, 2004**

Value of catastrophic cap	Caps that apply to some Medicare-covered services, including inpatient hospital care		Caps that only apply to inpatient hospital care	
	Percent of all plans	Percent of enrollees in all plans	Percent of all plans	Percent of enrollees in all plans
\$ 1– 500	1%	2%	5%	6%
501–1,000	2	2	6	7
1,000–1,500	1	1	3	3
1,501–2,000	4	2	2	2
2,001–2,500	4	2	1	3
2,501–3,000	9	17	0	0
3,001–3,500	1	1	0	0
3,501–4,000	2	0	0	0
4,001–4,500	0	0	0	0
4,501–5,000	4	3	0	0
Sum	29	30	18	20

Note: Plans without an out-of-pocket cap are not shown. Sums may not add to totals due to rounding.

Source: MedPAC analysis of 2004 Plan Benefit Package data from CMS.

to \$5,000. About 20 percent of plans have caps with values between \$1 and \$3,000, and many of the caps are clustered around CMS's suggested value (Table 4). Those caps apply to about one-quarter of plan members. About 7 percent of all plans and 4 percent of enrollees have overall catastrophic caps that are \$3,000 or higher in 2004.

In addition to comprehensive caps, another 18 percent of plans have caps that only cover inpatient care, with values ranging from \$200 to \$2,250. It would be misleading to compare these caps with CMS's suggested catastrophic limit because they do not limit OOP liability on all types of Medicare-covered services. Some plans apply inpatient caps on a per-stay basis, with others applied on a per-year basis and a small number applied per spell of illness. Table 4 shows that most plans with inpatient caps use values of \$1,000 or less, and members of those plans account for 13 percent of total enrollment in all the plans we analyzed.

Cost sharing for other services covered by Medicare

For some beneficiaries, cost sharing for medical care provided in outpatient or ambulatory care settings may be as significant a concern as for inpatient care. Here we examine four types: Medicare-covered drugs, renal dialysis, radiation therapy, and durable medical equipment.

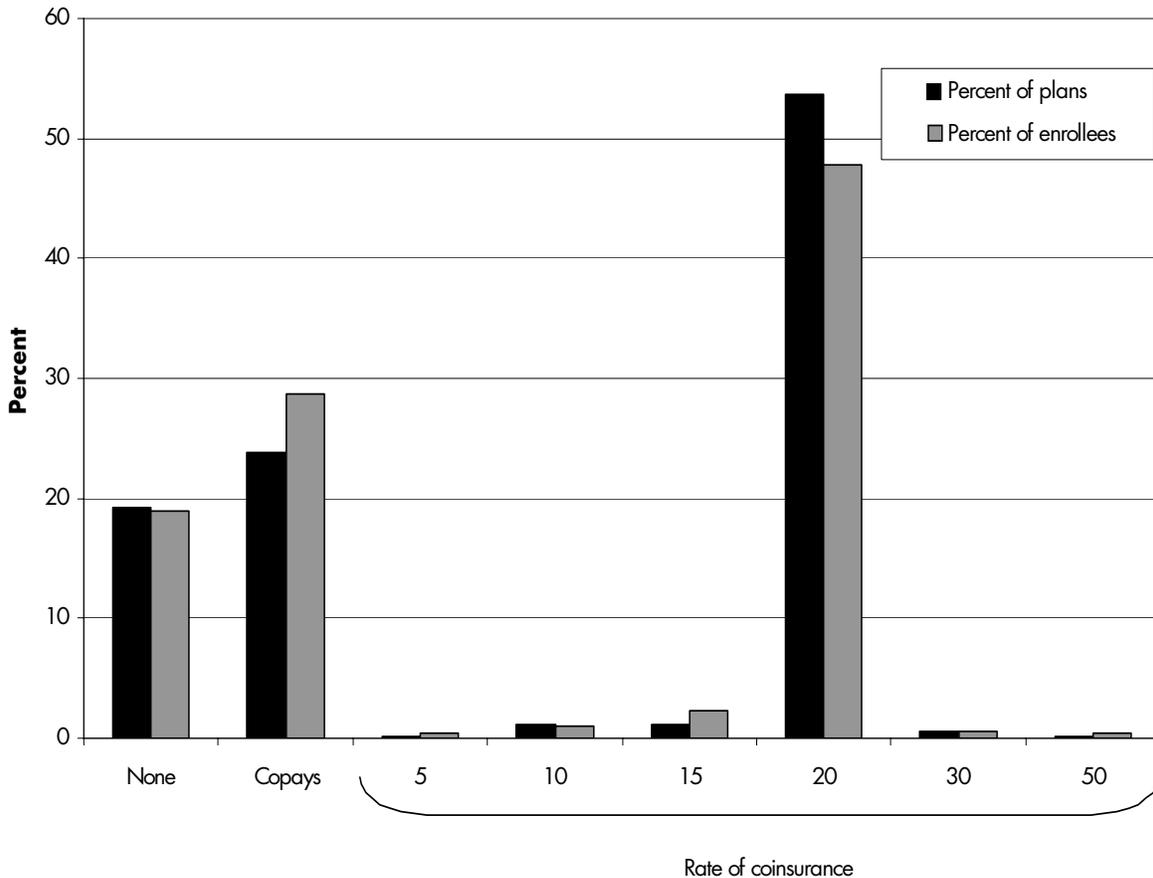
Drugs covered under Part B

For the past several years, CMS has indicated concern in its annual call letter to MA plans about increases in cost sharing for drugs covered under Part B. Oncology drugs are of particular concern because of their very high costs. In San Diego, for example, one oncology group reported that in 2004, an 8-week course of five drugs for a patient with lymphoma would lead to OOP costs of between \$5,205 and \$6,940. Patients with other serious conditions may also face very high costs for physician-administered drugs covered by Medicare. A payment of 20 percent coinsurance for myelodysplastic refractory anemia, for example, can amount to \$20,000 per year (Clark 2004).

Nearly 20 percent of MA plans (with a similar percentage of enrollees) do not require cost sharing for Part B-covered drugs (Figure 2, opposite). About a quarter of plans require only copayments, applying to just under 30 percent of enrollees. Most copayments are in the range of \$10 to \$100 per administration, but a small number of plans charge over \$500 per treatment. About 57 percent of plans require beneficiaries to pay a percentage of the cost of some Part B drugs (the sum of those bars that reflect coinsurance in Figure 2). This applies to just over half of all enrollees in the plans we analyzed. Fewer than 10 percent of plans using a combination of coinsurance and copayments, depending upon the drug prescribed. (In Figure 2, those are only shown in the bars for plans that charge coinsurance.)

Figure 2

Medicare Advantage plan cost sharing for drugs covered under Medicare Part B, 2004



Note: Less than 10 percent of the plans we analyzed require a combination of copayments and coinsurance, depending upon the type of drug administered. Those plans are shown in the bars that reflect percent coinsurance.

Source: MedPAC analysis of 2004 Plan Benefit Package data from CMS.

The PBP data suggest that among the plans that require coinsurance for Part B-covered drugs, most charge 20 percent. That is the same amount that beneficiaries pay if they are in FFS Medicare and have no supplemental coverage. But some plans use lower rates of coinsurance, and a small number charge more. Among the 54 percent of plans requiring coinsurance of 20 percent or higher, about one-third have some form of cap on beneficiary OOP liability. However, we could not determine clearly from the PBP data whether those caps apply to some or all Part B drugs.⁶ The remaining two-thirds have no cap.

Dialysis and radiation therapy

Some dialysis services are associated with short-term treatment of acute illness, others are related to end-stage renal disease (ESRD). Although MA plans are not currently allowed to enroll beneficiaries with ESRD, members who develop ESRD after having enrolled in a plan can remain in that plan if they choose to do so. CMS uses a separate formula to pay plans for ESRD patients, which is designed to account for the severity of their illness and the high cost of their care. Currently, most plans (more than 60 percent, with about three quarters of all plan enrollees) do not require copayments or coinsurance for dialysis services (Figure 3, opposite). Among plans that use copayments, the amounts range from \$10 to \$50 per treatment. About 18 percent of all the plans we analyzed charge 20 percent coinsurance for dialysis services—the same cost sharing that a beneficiary would face in FFS Medicare without supplemental coverage.

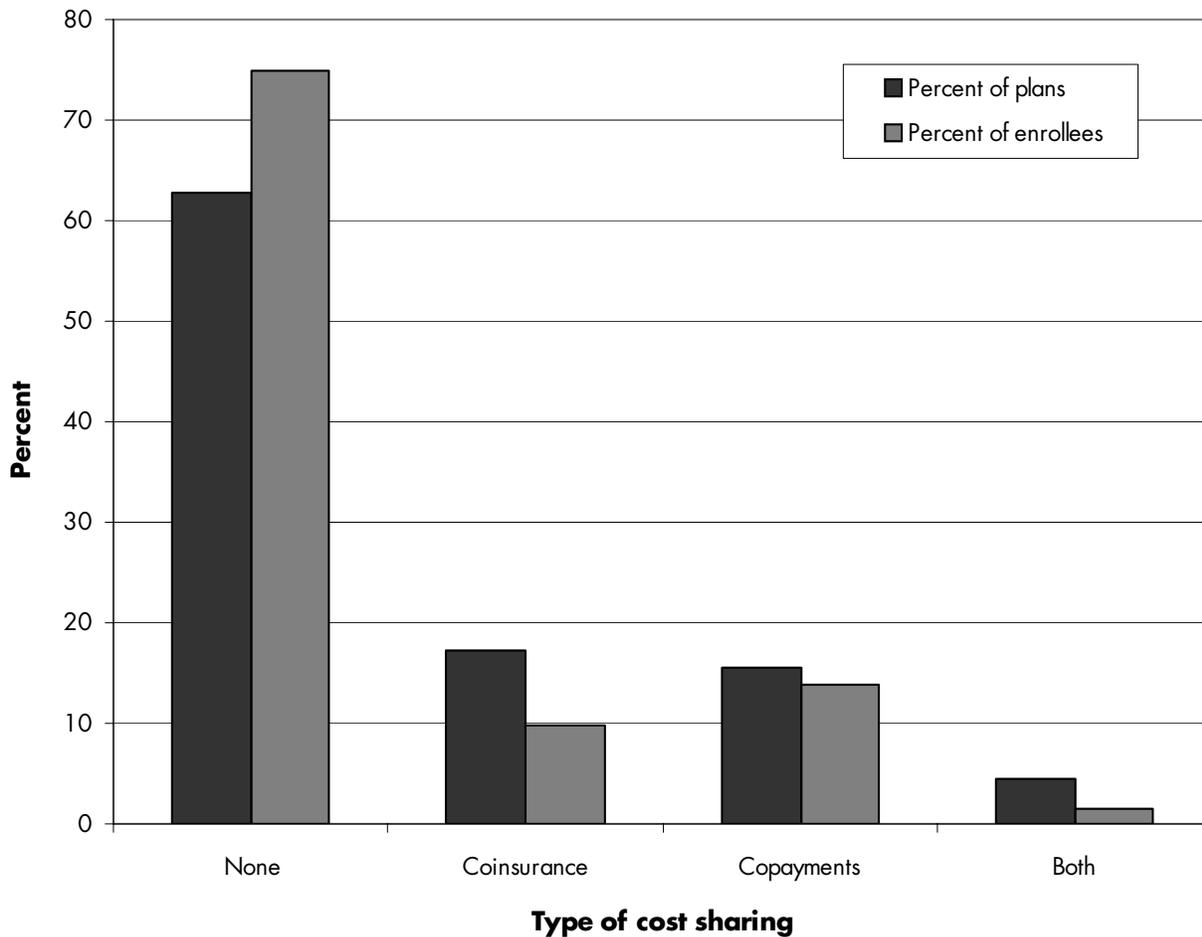
About 44 percent of MA plans—accounting for half of all plan enrollment—do not require any cost sharing for radiation therapy services. Nearly one-third of plans charge copayments that range from \$5 to \$200 per treatment. Twenty-five percent of plans require coinsurance, and three-quarters of those plans (or 19 percentage points) charge 20 percent for these services (again, equal to cost sharing in FFS Medicare without supplemental coverage). Most plans that limit beneficiary OOP spending apply the limits to radiation therapy and similar services. Of the 19 percent of plans with 20 percent or higher coinsurance for radiation therapy services, about one third cap beneficiaries' OOP spending.

Durable medical equipment

DME encompasses a wide variety of equipment and supplies, some of which is quite expensive. Some plans have instituted cost-sharing provisions designed to help control the use of DME services, including requiring higher cost sharing for services obtained without prior authorization. Plans increased DME cost-sharing requirements in response to widespread overuse of services. However, some beneficiaries need DME services over a long term for managing serious conditions such as chronic obstructive pulmonary disease or emphysema. Patients who require round-the-clock oxygen could, for example, be exposed to high OOP costs for these services.

Figure 3

Medicare Advantage plan cost sharing for renal dialysis, 2004

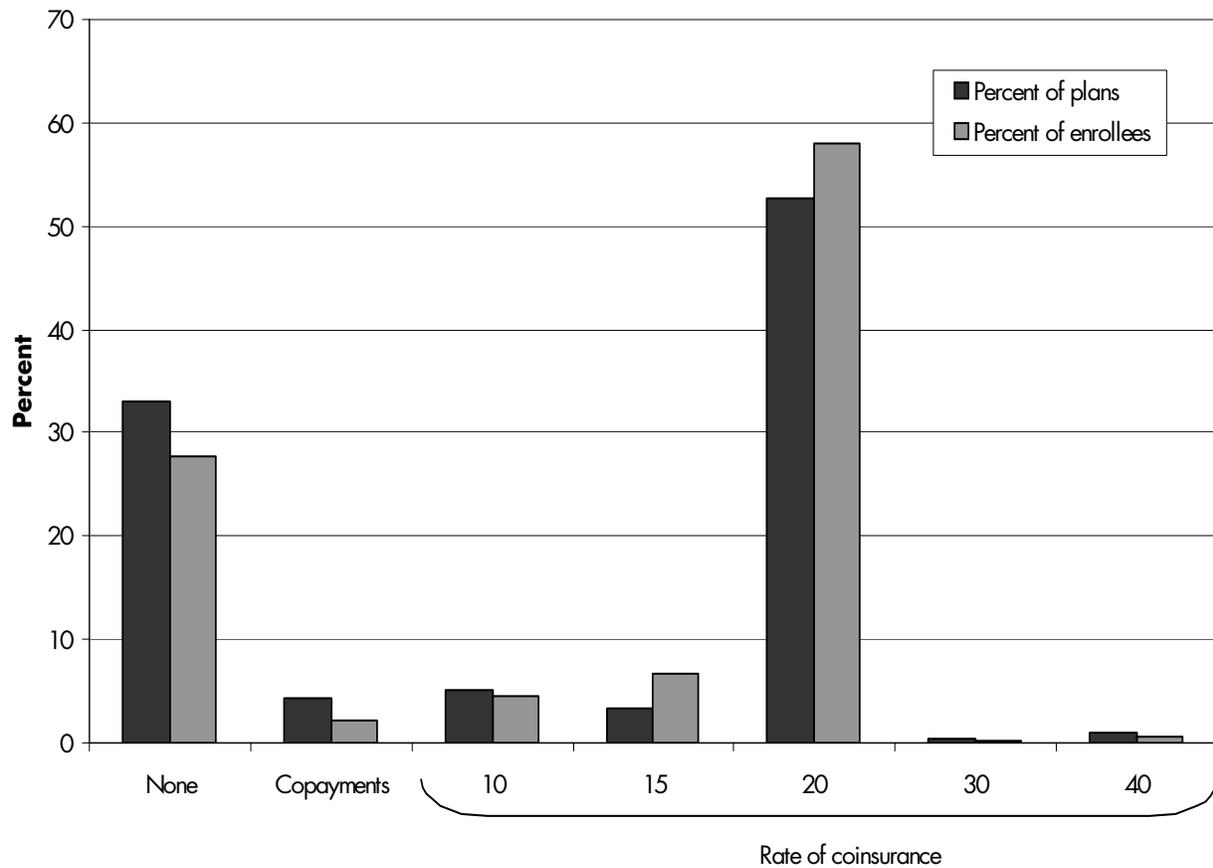


Source: MedPAC analysis of 2004 Plan Benefit Package data from CMS.

Thirty-seven percent of all the plans we analyzed require no cost sharing for Medicare-covered DME (Figure 4, p. 22). More than half of all plans charge rates of coinsurance of 20 percent or higher, with the vast majority charging 20 percent—the same cost-sharing requirement as in FFS Medicare. A small number of plans (1 percent) require 40 percent coinsurance for DME; none of these plans cap beneficiaries' OOP spending for these services.

Figure 4

Medicare Advantage plan cost sharing for durable medical equipment, 2004



Source: MedPAC analysis of 2004 Plan Benefit Package data from CMS.

Uneven cost sharing

Charging 20 percent coinsurance does not necessarily indicate that a plan is trying to dissuade sicker beneficiaries from enrolling, or encouraging sicker individuals who are already members to disenroll. A plan that routinely charges 20 percent coinsurance for all types of services may have a benefit structure that is no more generous than FFS Medicare, but it is not being discriminatory.

To shed more light on this issue, we compared plan cost-sharing requirements for visits to primary care physicians with certain services where enrollees probably have less discretion about using care—specifically, for inpatient hospital care, drugs covered under Medicare Part B, and dialysis and

radiation therapy services. We omitted analysis of durable medical equipment on the grounds that beneficiaries are likely to have more discretion over its use. Since this analysis examines a limited number of services, our results are suggestive rather than exhaustive.

One should note that FFS Medicare itself has different cost-sharing requirements among services. For example, a beneficiary without supplemental coverage would pay 50 percent coinsurance for outpatient mental health services, 20 percent for physician visits, and no cost sharing for home health visits. For this reason, we examined how plan cost-sharing requirements compared with those under FFS Medicare, rather than whether plans required commensurate cost sharing across all types of services.

In general, we found mixed results across services. Among the 505 plans we analyzed, the vast majority appear to charge lower cost sharing for primary care visits than does FFS Medicare; only 8 percent of plans charged 20 percent or higher coinsurance or copayments of \$20 or more (Table 5, p. 24). Yet some of the plans that required relatively lower cost sharing for primary care visits had relatively higher cost sharing (though usually equal to the FFS amount) for some services that are less discretionary. When plans also include a catastrophic limit on OOP spending, that benefit structure mitigates the effects of uneven cost sharing.

Results varied across inpatient care, drugs covered under Medicare Part B, renal dialysis, and radiation therapy services. For example, in 2004, 22 percent of all plans use a combination of lower cost sharing for primary care visits with cost sharing for inpatient hospital care that is comparable to or greater than that charged in FFS Medicare. However, more than two-thirds of those plans also provide their members with catastrophic protection on OOP spending, which FFS Medicare does not provide. Fifty-two percent of all plans charge lower cost sharing for primary care than FFS Medicare yet require cost sharing that is the same as FFS Medicare for drugs covered under Part B. Of those plans, more than two-thirds do not include an OOP cap. Eighteen percent of plans charge relatively higher cost sharing for primary care visits than for renal dialysis, with nearly two-thirds capping OOP liability for their enrollees. Thirty-three percent of all plans charge relatively higher cost sharing for radiation therapy services; of those, two-thirds have no cap.

Table 5**Medicare Advantage plans by categories of coinsurance or copayment requirements, 2004**

Category of cost sharing	For a primary care office visit	
	Less than 20% coinsurance, or less than \$20 copay	Coinsurance of 20% or more, or \$20 copay or higher
For hospital inpatient care:		
Less than \$876 per stay	70	5
Greater than or equal to \$876 per stay	<u>22</u>	<u>3</u>
Subtotal	92	8
For drugs covered by Medicare Part B:		
Less than 20% coinsurance	40	6
Coinsurance of 20% or more	<u>52</u>	<u>2</u>
Subtotal	92	8
For renal dialysis services:		
Less than 20 % coinsurance, or less than \$30 copay	74	5
Coinsurance of 20% or higher, or \$30 copay higher	<u>18</u>	<u>3</u>
Subtotal	92	8
For radiation therapy:		
Less than 20% coinsurance	59	4
Coinsurance of 20% or more	<u>33</u>	<u>4</u>
Subtotal	92	8

Source: MedPAC analysis of 2004 Plan Benefit Package data from CMS.

There are several caveats to consider about this approach. Some plans charge relatively low cost sharing for primary care visits as a means of attracting potential enrollees. Since beneficiaries of both good and poor health status use physician services, cost-sharing requirements for this specific service may reflect more about plans' approaches to marketing than any attempt at selection. Sicker beneficiaries would benefit from relatively lower cost-sharing requirements on physician visits since they tend to use more care. Plans may also use lower cost sharing for primary care visits in order to encourage preventive care that could ultimately reduce the need for costlier services. As a check on the sensitivity of our results, we repeated the analysis substituting cost-sharing requirements for visits to specialists rather than for primary care. The results were generally similar.

Another caveat to bear in mind is that categorizing benefits as discretionary or nondiscretionary is not always clear cut. For example, even hospitalizations have some degree of variation. Although few beneficiaries would choose to be hospitalized unless it were needed, both patient and provider have some discretion over the intensity of care and the length of stay. Nevertheless, comparing cost-sharing requirements for primary care or specialist visits to those for services such as inpatient care, Part B drugs, and radiation therapy may be one strategy that CMS could use to monitor plan cost-sharing requirements.

Our analysis suggests that CMS may want to look more closely at cost-sharing requirements for certain services such as the provision of Part B drugs. Only a small number of plans charge cost sharing that is higher than the cost-sharing requirements of FFS Medicare. Yet a somewhat larger number may be charging relatively more cost sharing for services in which enrollees have less clinical discretion about the care they receive, without limiting OOP spending. Relatively few beneficiaries use these types of services, and thus they may not affect the overall average dollar amount of cost sharing that all of a plan's members pay. But for these beneficiaries, OOP costs could be large. Such a benefit design could seem aimed more at discouraging sicker individuals from continuing in a plan than encouraging members toward appropriate care. However, it could also reflect other factors, such as a plan's strategy for reducing its expenses for the types of services whose costs are growing rapidly.

Premiums and benefit designs

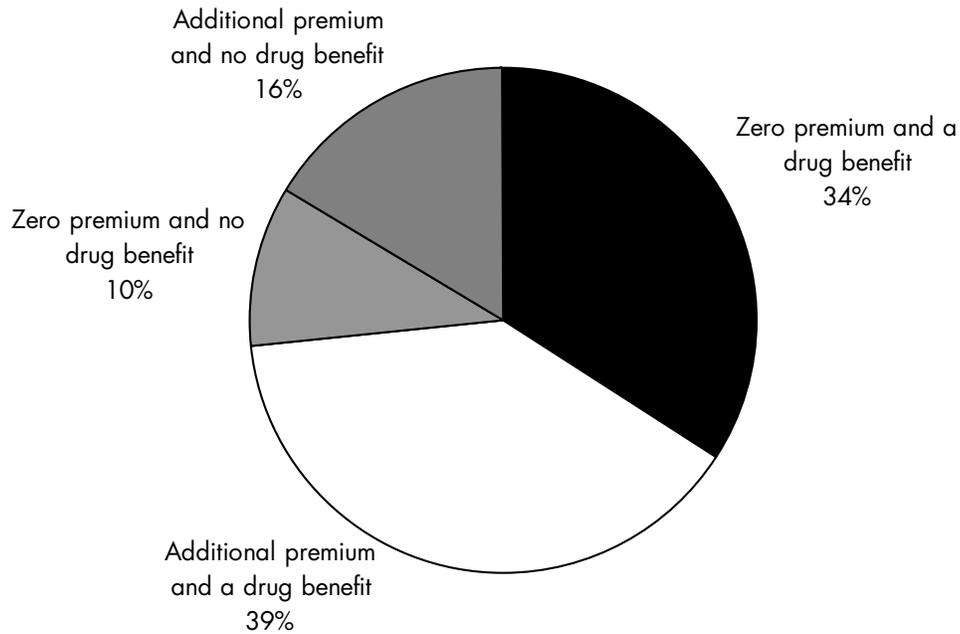
MA plans try to balance a mixture of beneficiary preferences for low premiums, help with prescription drug costs, access to the doctors they want to see, and protection against unexpected high-cost services. But they must also operate within the constraints of the payment rates that CMS provides in the counties they serve. In areas where payment rates are relatively high, plans may be able to offer extra benefits beyond those covered by Parts A and B of Medicare, or they may offer the same services with lower cost-sharing requirements or more extensive coverage. Other areas with lower payment rates may have comparatively fewer additional benefits, require cost sharing that is closer to that under FFS Medicare, or charge enrollees premiums for extra benefits.

Which types of benefits do enrollees want most from plans? Some prior research suggests that when deciding to enroll, beneficiaries look most closely at premiums and whether an MA plan provides prescription drug benefits (Atherly et al. 2004). Beneficiaries have a strong interest in drug coverage since drugs account for the bulk of OOP medical expenses after premiums. However, ready access to primary care doctors is also a major factor influencing beneficiaries' choice of health plans (Gold et al. 2004).

We analyzed PBP data to get a snapshot of plan benefit offerings and beneficiary preferences in 2004. Among all the plans we analyzed, nearly three-fourths offer a drug benefit: 39 percent charge an additional premium and 34 percent do not (Figure 5, p. 26). Forty-four percent of plans offer a benefit design with no additional premiums beyond the basic Part B premium of \$66.60, and some are able to provide a partial rebate of the Part B premium. Thirty-four percent of plans have no premium yet provide a drug benefit, while 10 percent had no premium and no drug benefit.

Figure 5

Distribution of Medicare Advantage plans by whether they include an outpatient drug benefit and whether they charge an additional premium, 2004



Source: MedPAC analysis of 2004 Plan Benefit Package data from CMS.

Plans that offer a drug benefit attracted 82 percent of enrollees in 2004. Forty-five percent enrolled in plans with a drug benefit and no premium, while 37 percent paid an additional premium for a benefit package that included outpatient drugs.

Since some beneficiaries prefer the certainty of premiums to the uncertainty of OOP cost sharing, one might expect some plans to offer lower cost sharing for an additional premium. To get a sense of how important lower cost sharing is to consumers, we examined plan cost-sharing requirements for inpatient hospital care, the provision of Part B drugs, radiation therapy services, and visits to primary care doctors.

For plans that offer a drug benefit, enrollees may receive more generous drug coverage or wider networks of providers when they pay a premium, but most of their cost-sharing requirements are not lower. However, when a plan does not include an outpatient drug benefit, more generous coverage

of cost sharing for Medicare-covered services may take on greater importance in a beneficiary's enrollment decision. For example, 96 percent of additional premium plans without a drug benefit offer lower cost sharing for inpatient services. Likewise, a greater proportion of plans offer lower cost sharing for the other services we analyzed when they charge an additional premium but do not include an outpatient drug benefit.

From the perspective of marketing a plan to potential enrollees, low premiums, outpatient prescription drug benefits, and greater access to providers may be stronger drivers of plan design than protection against OOP spending for Medicare-covered services. Enrollment data suggest that outpatient drug benefits are particularly attractive to enrollees; for others, wider networks of providers are important. For example, in several markets we analyzed, managed care organizations offer a "high-option" plan that includes more physicians or hospitals in their network (or access to a specific group of providers). These plans do not offer lower cost sharing for Medicare-covered services, and in some cases actually require higher cost sharing as part of the package that includes significantly higher premiums, in exchange for choice of more providers.

For the future, the introduction of the new Medicare Part D benefit could result in significant changes to the dynamics that shape benefit design in MA plans. However, it is impossible to predict whether the introduction of Part D will affect plan or beneficiary preferences regarding cost-sharing provisions for Medicare-covered services.

Does benefit design affect risk selection?

In this section, we examine whether data on the average risk scores of managed care organizations show any clear relationship between benefit design and risk selection. We also analyze data from CMS's survey of disenrollees to see whether many members have left plans because of concerns about cost sharing.

Benefits and risk scores

A direct way to address the question of whether benefit design leads to risk selection would be to compare the health status of beneficiaries in plans with different benefit designs. However, data limitations prevent us from using that approach. We were able to obtain information on average health status (in the form of risk scores) for each contract between a managed care organization and CMS, but often those contracts include more than one plan: several distinct offerings of a premium, benefits, and cost-sharing requirements. If a managed care organization offers two plans in the same market, one "low" option at a lower premium and another with more generous coverage for a higher premium, we are only able to observe the average health status of their members in both plans, not each plan's average score.

Given limitations of the data, we focused on markets that are likely to have wide variation in plan risk scores, and then compared each plan's cost-sharing requirements. This tells us whether it is possible to identify differences in plan benefit design that could be associated with differences in the health status of enrollees. Looking at variation within specific markets allowed us to control for

differences in payment rates, differences in demographics, and delivery system characteristics. We selected four markets for analysis: three MSAs that had large measures of variation among the contract-level risk scores of competing plans, and a fourth that had less variation among competitors but a mean risk score of plans that was considerably lower than the mean for the MSA's FFS population. For each market, we examined plan premiums and then evaluated OOP costs for hospital inpatient care, other Medicare-covered services, and outpatient prescription drugs using the estimates developed for CMS that appear on the Medicare Personal Plan Finder at <http://www.medicare.gov>. We collected projections of OOP spending from the Plan Finder for people between 70 and 74 years of age, comparing those with different health status.

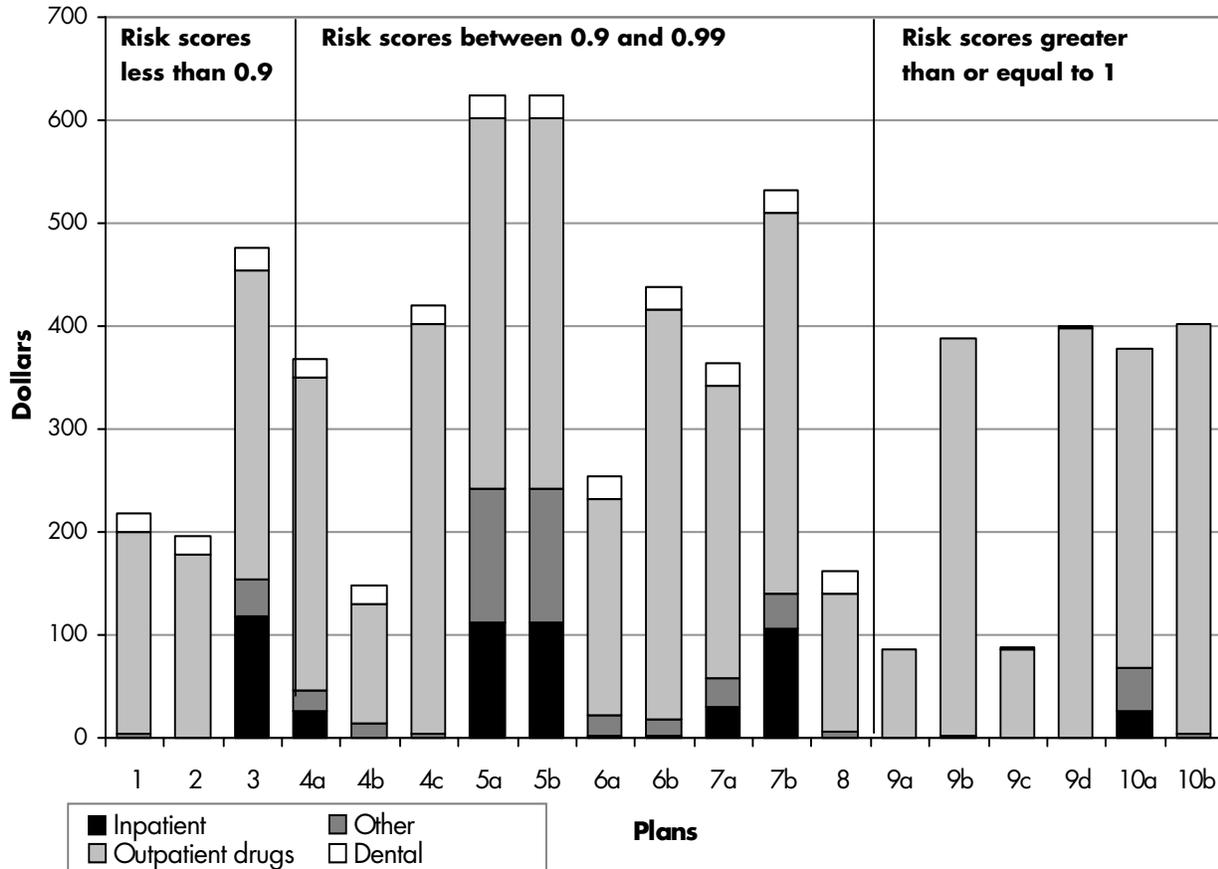
Not surprisingly, there is less variation in what beneficiaries in excellent health might pay out of pocket relative to those in poor health, since they use fewer health care services. But the data also show some variation in expected beneficiary OOP costs across plans within each of the markets.

The same 70- to 74-year-old beneficiary in poor health in one county of one of the MSAs we analyzed could face very different cost sharing, depending on the plan in which he or she was enrolled (Figure 6). In this particular county, there were 9 MA contracts covering about 20 separate plans. Since some of the individual plans had very similar benefit designs (for example, differing only by whether they offer a Medicare drug card), we omitted several plans from the chart. Contract-level risk scores are not shown in the figures, but we ordered plans from lowest to highest (left to right), with values ranging from around 0.8 to about 1.0. Only one plan in this market charges a premium above the basic Part B premium.

Looking across all four market areas, we did not observe a consistent relationship between the contract-level risk scores and OOP costs for inpatient care or other Medicare-covered services. For example, in the market illustrated in Figure 6, some of the plans under contracts with the highest risk scores have higher cost sharing for inpatient care (for example, Plan 7b), while others have no cost sharing at all for inpatient care (for example, Plan 9a). However, without plan-level risk information, we cannot determine if there is any clear association between benefit design and risk selection based on health risk. CMS is currently developing methods to compile risk scores at the plan level. Accurate plan-level scores could provide the most direct means of determining whether benefit design is related to risk selection, and could be useful in reviewing plan proposals.

Figure 6

Monthly out-of-pocket costs for a 70- to 74-year-old in poor health, who lives in a large county with a large variety of health plans, 2004



Source: MedPAC analysis of 2004 Plan Benefit Package data from CMS.

Evidence from disenrollment reasons

Earlier, we noted that CMS provides beneficiaries who are interested in joining MA plans with information about why other individuals chose to leave the plans in their area. The source of this information is the CAHPS Disenrollment Reasons (DR) survey. The DR is a separate instrument from other CAHPS Medicare Managed Care surveys.⁷ First fielded in 2000, it asks questions about why respondents chose to leave their plans. The DR instrument includes a list of preprinted reasons to help respondents with recall, as well as an open-ended question about the most important reason that captures intensity of the response. CMS uses responses to the open-ended question in the Personal Plan Finder and in reports to plans to reflect the primary reason for leaving.⁸

Note that the DR survey's sample frame was designed around contracts with managed care organizations, even though that contract may cover several separate MA plans. As was the case with risk scores, this contract-level sampling approach limits our ability to examine directly whether high rates of disenrollment are associated with particular plans that have high cost-sharing. Nevertheless, these contract-level rates could be useful as an indicator to CMS to look closer at plans under contracts with high disenrollment.

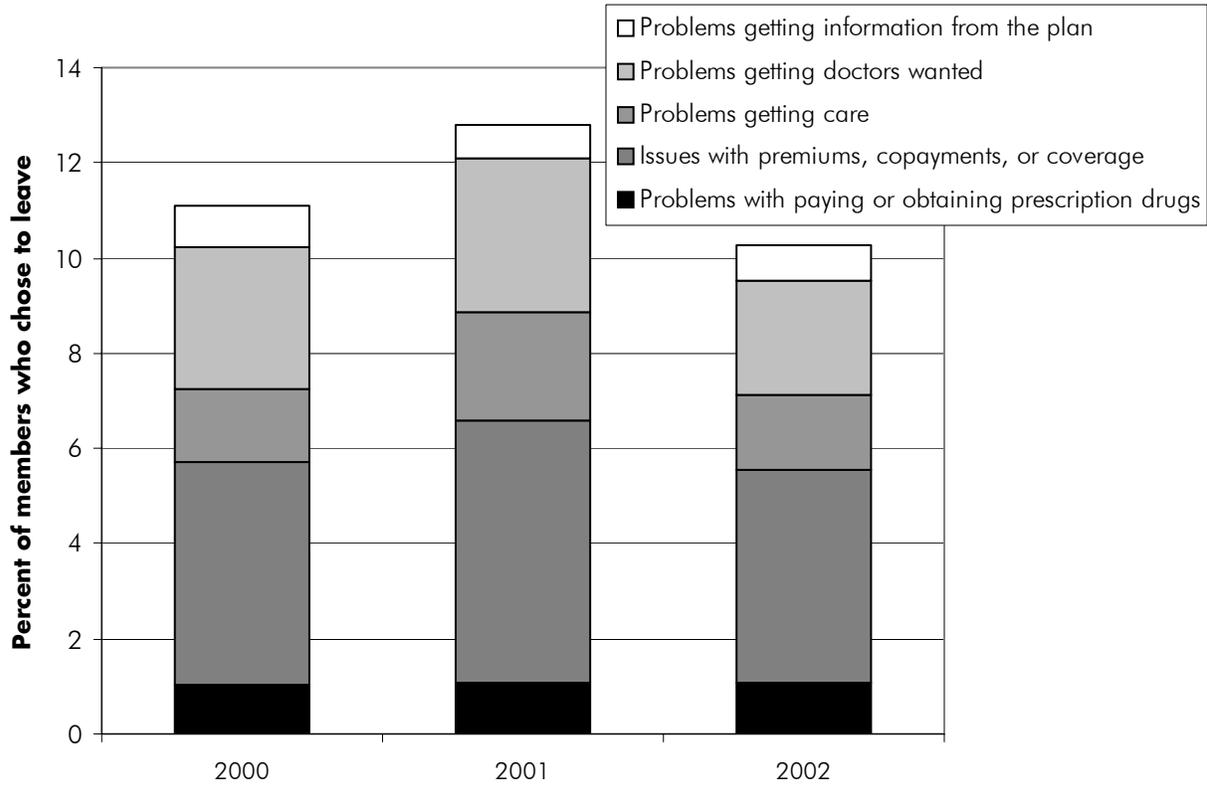
The nationwide average rate of voluntary disenrollment across all contracts has varied from 11 percent in 2000, to nearly 13 percent in 2001, and just over 10 percent in 2002 (Figure 7).⁹ Although it is not clear that previous statistics were calculated in exactly the same way, one publication noted that the annual disenrollment rate in 1994 was 14 percent (Riley et al. 1997), and another estimated the mean rate of voluntary disenrollment in 1998 at less than 12 percent (Lied et al. 2003).

Across MA contracts, rates of voluntary disenrollment in 2002 ranged from 1 percent to 76 percent, with a median of about 7 percent. In 2002, half of survey respondents subsequently enrolled in another MA plan, while the remainder went to FFS Medicare. Previous research has shown that relative to members who remain enrolled in MA plans, disenrollees are more likely to have lower self-reported health status and more visits to doctors, and they include a disproportionate share of non-Hispanic blacks and disabled beneficiaries under age 65, and are more likely to have some college education (Laschober 2003).

CMS groups reasons for disenrolling into five categories. Most disenrollees cite cost concerns as their primary reason for leaving (Figure 7). In 2002, 44 percent reported that their most important concern was premiums, copayments, or coverage. In addition, about 10 percent of respondents said that getting or paying for prescription drugs was their most important reason for disenrolling. The second most common group of reasons (24 percent of respondents) related to problems in seeing the doctors that the beneficiary wanted to see. Problems in getting care—such as not being able to get an appointment as soon as they wanted or having to wait too long past the time of their appointment—accounted for 15 percent of disenrollee responses. Another 7 percent named difficulties in getting information from the plan, such as problems with billings by the plan or dissatisfaction with customer service.

Figure 7

Average voluntary disenrollment rates and groupings of the most important reasons enrollees left Medicare Advantage plans, 2000–2002



Note: Problems getting information from the plan includes reasons such as “after I joined, plan was not what I expected” and “information from the plan was hard to get or not helpful.” Problems getting doctors wanted includes reasons like “the doctor I wanted to see was dropped from the plan.” Problems getting care includes reasons such as “difficult to get referrals to specialists” and “had to wait too long to get an appointment.” Issues with premiums, copayments, or coverage includes reasons such as “another plan would cost me less,” “plan started charging a premium,” or “plan increased copay for office visit.” Problems with paying or obtaining prescription drugs includes reasons like “maximum dollar amount for medicine not enough.”

Source: MedPAC analysis of Medicare Consumer Assessment Health Plan Survey (CAHPS) disenrollment reasons data from CMS.

Disenrollment rates associated with cost concerns

In our analysis of 2002 DR survey data we focused on responses associated with cost concerns—specifically issues with premiums, copayments, or coverage—as the main reason for leaving. Other categories of responses reflect a plan’s management techniques—the relative tightness of its network, prior authorization rules, or other gatekeeping policies—rather than its cost-sharing structure. For example, a plan may not have included the member’s preferred physician within its network, or the enrollee may have had to leave the hospital before they or their doctor thought they should. While these reasons may suggest some access problems, they are not directly attributable to a plan’s cost-sharing structure, which is the focus of this study.

Relatively few plans had high disenrollment due to cost concerns. In 2002, 107 MA contracts had 5 percent or fewer enrollees leave the plan because of concerns about premiums, copayments, or coverage. Another 31 contracts had related disenrollment rates of 10 percent or less, bringing the cumulative share to nearly 90 percent of all the plans we analyzed.

How many beneficiaries are enrolled in plans that had higher rates of disenrollment associated with cost concerns? In 2002, approximately 3.1 million members were enrolled in plans that had cost-related disenrollment rates of 5 percent or less. Another 1.5 million were in plans with rates between 5 and 10 percent. Combined, 7 percent—about 300,000 beneficiaries—were in plans with rates higher than 10 percent.

These rates and enrollment levels overstate the degree to which cost sharing motivates beneficiaries to disenroll, because the category “cost concerns” also includes issues related to premiums and some responses about coverage. We turn now to look at all of the responses that fall under “cost concerns” in greater detail.

Specific concerns about costs

When combined, specific responses related to cost concerns account for 56 percent of all disenrollees in 2002. Table 6 provides more detail about individual responses that are related to premiums, copayments, or coverage. Here we include all responses from two of the Plan Finder categories shown in Figure 7 (“issues with premiums, copayments, or coverage” and “problems with paying for or obtaining prescription drugs”) as well as a handful of other responses from other categories that seem similar. Those include: “deductible for hospital care too expensive,” “plan would not pay for some needed care,” and “plan refused to pay for emergency care.”

One limitation of this analysis is that for several of the responses we analyzed, it is unclear whether they refer to enrollee premiums, plan cost sharing, both, or neither. For example, some respondents said that the most important reason they left a plan in 2002 was that “my former plan was or became too expensive” or “another plan would cost me less.” Such answers are obviously ambiguous and make it difficult to disentangle the importance disenrollees place on premiums relative to cost sharing. Those responses comprised 22 percent of all disenrollees in 2002.

Table 6**Most important cost or coverage reasons for voluntarily disenrolling from Medicare Advantage plans, 2002**

Subcategory of reasons	Percent of all responses
Plan became too expensive or another plan cost less	22.2%
Problems paying for or getting prescription drugs	12.8
Plan started charging a monthly premium	9.4
Another plan offered better benefits	4.2
No longer needed coverage or qualified for other benefits (Medicaid, VA, etc.)	2.5
Hospital deductible too high	2.2
Plan increased copays for office visits	1.3
Plan would not pay for care	<u>1.2</u>
Total	55.8

Note: VA (Department of Veterans Affairs).

Source: MedPAC analysis of Medicare Consumer Assessment Health Plan Survey (CAHPS) disenrollment reasons data from CMS.

Problems with paying for or getting prescription drugs were the second most commonly cited concern among the individual responses we examined, followed by dissatisfaction because the plan began charging a member premium. These results are consistent with our conversations with plan representatives who told us that beneficiaries seem to look first at premiums and prescription drug benefits when choosing among plans.

Only two responses were very clearly and unambiguously associated with plan cost sharing: “hospital deductible was too high” and “plan increased copay for office visits.” About 3 percent of all disenrollees (2 percent and 1 percent, respectively) unambiguously cited cost sharing as their reason for leaving their plan.

Implementing changes in the program

Several changes to the MA program will likely affect how private plans design their benefit packages, and the Commission reviewed these factors as it considered making recommendations. Some, but not all of the changes, may reduce incentives to try to enroll healthier beneficiaries. Many of these changes were initiated by the MMA. Others were already underway, such as the phasing in of new risk adjusters by 2007.

Beginning in 2006, the MA program will include PPOs and other plans that deliver the same benefit structure and charge the same premium across multicounty regions (known as regional MA plans). The MMA provides for payment incentives to encourage private PPOs to offer services in markets

where county-level MA plans have been unwilling to enter (primarily in certain rural areas). In addition, the new regional PPOs are to offer a benefit that includes a combined deductible for services covered under Parts A and B of Medicare, as well as an OOP catastrophic cap. However, the MMA does not define the amounts of those benefit parameters. It is also unclear how the new benefit structures of regional PPOs may affect the benefits that competing local MA plans decide to offer.

Historically, some Medicare beneficiaries have been drawn to private MA plans because many offered outpatient prescription drug benefits. Beginning in 2006, however, MA plans will compete with stand-alone plans that offer Medicare's new Part D prescription drug coverage. Under Part D, most types of private plans (both local and regional) must provide at least one MA plan within their service area that includes an outpatient drug benefit that is at least actuarially equivalent to the standard Part D benefit.¹⁰ As with stand-alone drug plans, CMS will pay MA plans a new capitated payment to cover Part D services, as well as individual reinsurance payments for enrollees with particularly high levels of drug spending and risk corridor payments if plans' aggregate costs are much higher than expected. If plans enroll beneficiaries who are eligible for Part D's low-income subsidies, CMS will also compensate the plan for some or all of those enrollees' premiums and cost sharing.

Another key change is that in 2006, MA plans will move from the ACRP process to a system of bidding. Under that approach, plans are to submit bids for the expected price of delivering basic services covered by Parts A, B, and D (if included) for a Medicare beneficiary with a national-average risk profile. That bid is to be based on cost sharing that is equal or actuarially equivalent to the cost-sharing requirements of FFS Medicare. Plans may also include bids for supplemental coverage (mandatory and/or optional). If a plan's basic bid is lower than CMS's benchmark payment rate, then 75 percent of the difference must be rebated to enrollees—in the form of premium-free mandatory supplemental benefits (which could include lower cost sharing for services under Parts A and B), or lower Part B or Part D premiums. The remaining 25 percent remains in the Trust Funds, except in the case of regional plans where a portion is used for the regional stabilization fund. Plans with basic bids that are higher than their benchmark must charge enrollees a premium to make up the difference. The introduction of this 75/25 split of the savings for lower-priced bids may constrain the resources with which plans can offer cost sharing that is more generous than FFS Medicare.

One final change relates to the length of open-enrollment periods for MA plans. Beginning in 2006, CMS will phase in a policy whereby, ultimately, Medicare beneficiaries who choose to enroll in MA plans must generally stay in those plans until the next annual open-enrollment period. Currently, individuals may disenroll from MA plans as frequently as once per month. For beneficiaries who are unhappy with a plan for any reason, this provides a "safety valve." However, the practice may accentuate biased selection if plans encourage certain beneficiaries to disenroll, or if beneficiaries change from one plan to another as they reach coverage limits on their benefits or want greater choice of providers. Thus, carrying out this so-called "lock-in" provision could help to constrain risk selection in MA plans. Moreover, if higher-cost enrollees remain in a given plan for an entire year, in the subsequent year, the plan's risk-adjusted payments for those individuals will reflect their higher use of services.

Conclusions and recommendations

The Commission makes several recommendations for helping beneficiaries make more informed choices and strengthening CMS's role in preventing discriminatory benefit designs.

Help beneficiaries make informed decisions

Currently CMS provides the Medicare Personal Plan Finder to help consumers evaluate their coverage options. The data on the Plan Finder are extracted from data submitted to CMS by individual plans. Because the specific details of benefits are complicated, reporting the data accurately and completely is difficult, as is organizing the data so that it can be reported in usable ways. Information on Medicare-covered drugs, and in particular, chemotherapy drugs that are administered by a physician, is not reported or coded in a way that allows CMS and, consequently beneficiaries, to understand or compare MA plans' cost-sharing requirements for these drugs. In addition, some of the problems reporting and coding the data result in erroneous or misleading information. Improving the quality of the data will likely require additional technical assistance to plans and better systems for editing and correcting problems. Accurate information will become even more important as the MA program evolves, and as plan options and benefits expand under the provisions of the MMA.

The Plan Finder is not the only means by which CMS provides information about Medicare benefits and plans' options. Other channels include 1-800-Medicare and the State Health Insurance Assistance Programs.¹¹ These typically involve one-on-one conversations with beneficiaries, which may be a more effective means of communication for some people. Providing counselors with training and information about benefits design and potential OOP costs—from the Medicare Personal Plan Finder or other interactive data bases that CMS might make available to beneficiaries or advocates—is another avenue for helping beneficiaries make informed choices, but it would also require greater resources.

CMS has not determined whether it will continue to include projections of OOP spending on the Plan Finder for 2006. The Commission's view is that projections of cost sharing for the components of plan packages other than Part D benefits would still be very important information for beneficiaries.

The ways in which information on benefits and cost sharing are made available to beneficiaries should also be improved. Currently, for example, the Plan Finder provides an actuarial value—that is, an average—of OOP spending across groups of enrollees rather than the range of circumstances an individual might expect to see with the probability of those events occurring. Thus, while the Plan Finder's projections of OOP spending for 70- to 74-year-olds in poor health reflect a much higher chance of being hospitalized than do comparable projections for a 70- to 74-year-old in excellent health, the projections are an average for the entire group, including people who were not hospitalized at all. An alternative way to present information would be to show the OOP costs for a hospitalization and report that most beneficiaries have only a one-in-five chance of such an event in a given year.

In the short term, CMS could incorporate a relatively simple approach that is used in the *Guide to Health Plans for Federal Employees and Annuitants* (Consumers' Checkbook 2004). It provides different scenarios of use of services during a year, along with the amount of OOP spending a member would incur under each available plan for each scenario and the overall probability of those events occurring. Consumers can then pick the scenarios that seem closest to their projected use of services to help them compare plan coverage and cost-sharing requirements.

CMS should also begin work on a more technically difficult approach that is currently being refined by private sector insurers. This approach uses web-based tools that allow members to access their past use of services or provide input about their expected use and plug it into a given plan's benefit design to project their OOP spending (Rubenstein 2004).

RECOMMENDATION 1

To provide critically important information about the implications of coverage and benefit options, CMS should use an array of approaches for beneficiaries and those who help them. In the short term, CMS should:

- **continue to provide estimates of out-of-pocket costs on the Medicare Personal Plan Finder, and**
- **begin to make available more tools that reflect out-of-pocket costs under various scenarios for use of services and their likelihood.**

As soon as feasible, CMS should develop advanced consumer decision tools that use individuals' actual experience to project future out-of-pocket spending.

Rationale

The Commission found that the data CMS provides to help beneficiaries choose among plans and coverage options may not be adequate to thoroughly evaluate the implications of their choices. Not every beneficiary wants detailed information on cost sharing. However, some do and it is particularly important to make information available to beneficiaries who might expect to use a lot of health care services.

Implications

Spending. This recommendation should not affect Medicare benefit spending. However, it could require a small amount of new funding or challenge CMS to reallocate some of its existing resources toward additional administrative spending.

Beneficiary and provider. This recommendation should improve the amount and quality of information available to beneficiaries. Providers might benefit as well from clearer understanding by beneficiaries of the OOP cost implications of treatment options.

Strengthen CMS's negotiation authority with plans

The MMA explicitly gives CMS authority to negotiate with most types of plans (other than private FFS and MSAs) over their bids, similar to the authority that OPM uses to administer FEHBP. According to its proposed rules, CMS interprets this to mean that it can negotiate with plans over the actuarial assumptions that they use in their bid, as well as over cost-sharing requirements for supplemental benefits financed with some of the difference between CMS's payment rate and the plan's bid.

How does OPM use its authority? OPM reviews bids to ensure that proposed benefits meet certain minimum standards, suggests cost containment strategies, and may remove certain plans (for low enrollment, for example, although this happens very rarely). Currently OPM has the equivalent of around 17 full-time positions to perform these tasks for the 8 million-member FEHBP program. However, the vast majority of the more than 200 plan options offered nationally under FEHBP are HMOs that are subject to less review than are the 15 or so nationwide FFS plans. HMOs that offer an FEHBP plan base their premiums on rates paid by other employer groups in the same community with similarly sized enrollment.

CMS may need greater resources to perform its negotiation and oversight role adequately than it now devotes to the MA program. The agency anticipates that its workload will increase with its new negotiation authority, but it does not yet know the magnitude of that increase. One key factor affecting this will be the number of plans with which it must negotiate. There is also considerable uncertainty about what level of staff resources CMS will have for reviews of proposals and negotiations with plans. Currently, the Center for Beneficiary Choices (the agency within CMS that has primary responsibility for administering the 5 million-member MA program) has a relatively small number of dedicated personnel. However, staff from CMS's Office of the Actuary will also participate in the process of bid reviews and negotiations, and both offices plan to use contractors to expand their capacity as needed.

Nevertheless, CMS's role in negotiating with MA plans is likely to be more time intensive than OPM's role in administering the FEHBP, since the commercial plans offered by managed care organizations are significantly different from their MA products. Rather than simply adding full-time positions, policymakers might also consider giving CMS greater flexibility in managing its personnel, introducing more merit-based compensation, and reallocating positions within the agency. Similar steps have been introduced in recent years at other federal agencies, such as the Departments of Defense and Homeland Security. Such an approach could help CMS to make better use of the resources it already has, rather than merely increasing demand for new resources.

RECOMMENDATION 2

CMS should interpret its authority granted in the MMA to negotiate with MA plans broadly on their benefit design and cost sharing. Specifically, MedPAC believes that the agency should use this authority to ensure that plans do not discriminate on the basis of health status.

The Congress may need to provide CMS with additional staff resources and administrative flexibility to carry out this function effectively.

Rationale

The Commission believes that CMS should use the authority it was granted by the MMA aggressively in cases where cost-sharing requirements are relatively high for services where enrollees have little discretion. Our analysis found that while plans, on average, have cost sharing that is no higher than that under FFS, some have relatively high cost sharing for services such as the provision of Medicare-covered drugs.

Implications

Spending. This recommendation should not affect Medicare benefit spending. However, it could require additional CMS administrative spending.

Beneficiary and provider. This recommendation should better protect beneficiaries from relatively higher cost sharing where beneficiaries have less discretion over the services they need.

Increase oversight to limit discriminatory benefit designs among plans

The Commission reviewed a variety of options for reducing the potential for selection and access to become widespread problems within the MA program.

The Commission considered a model in which CMS or a designated entity would design a relatively small number of standard benefits packages that would be the only allowable types of coverage that MA plans could offer. The main advantage of using standard benefit designs is that Medicare enrollees would find it easier to compare available plans in their market and assess their value. Standardization could lead to a greater degree of competition on the basis of enrollee premiums rather than on benefits or selection. Researchers found evidence of greater price competition after medigap standardization (McCormack et al. 1996). From a provider's perspective, standardization could reduce the administrative burden of sorting out different payments and coinsurance that, in many MA plans, are dealt with at the point of service. In addition, standard cost-sharing arrangements would make it easier for providers to understand and to explain to patients the cost implications of treatment options.

However, moving to standard benefit packages has problems. With the large amount of variation that exists in MA payment rates, beneficiaries in some parts of the country might find standard packages attractive, but others might not. In other words, the design of a few nationwide standard benefits might not fully capture the range of what consumers want to purchase in local marketplaces. Standardization could also stifle creativity in the introduction of new benefit designs that better serve the preferences of Medicare beneficiaries. Nor do standardized benefits guarantee that selection will be avoided. For example, evidence suggests that insurers have set medigap premiums for policies that include outpatient prescription drug coverage to account for adverse selection (McCormack et al. 1996). Some insurers withdrew such policies from certain market areas in recent years as their premiums became unaffordable. Indeed, the combination of minimum standards in benefits design and adverse selection can lead to the unintended consequence of less insurance coverage (Finkelstein 2002).

Based on these considerations, the Commission does not believe that the weight of the evidence supports a move to standardized cost sharing in MA plans.

“Safe harbor” benefit structures

Although few plans use cost sharing that is higher than that for FFS Medicare, the practices of some plans could lead to high levels of cost sharing for certain services that are less discretionary and affect few individuals, such as chemotherapy. There may be several reasons behind such benefit designs, but to the extent that a few plans use an explicit strategy of selection, the Commission finds this unacceptable. To address this issue, and to prevent a potential problem from undermining the MA program over time, the Commission supports a less regulatory approach that retains plan flexibility but would increase the rigor of CMS oversight of MA plan cost sharing requirements.

The Commission recommends a policy option that would help CMS review for discriminatory benefit designs while retaining the flexibility that managed care organizations now enjoy by encouraging the use of certain prototypical benefits designs. This approach builds on CMS’s current position with respect to catastrophic protection in coordinated care plans. Currently, if an MA plan uses the OOP spending limit suggested in the annual call letter, CMS grants the plan “safe harbor” and does not scrutinize the plan’s cost-sharing structure as closely as it would otherwise.

The option recommended by the Commission would use this approach more broadly to include cost-sharing requirements for specific Medicare-covered services as well as a voluntary cap on total OOP liability for Medicare Part A and B services.

This approach would lead to less confusion for beneficiaries without directly regulating plan benefit designs. Managed care organizations could individually decide whether CMS’s suggested benefit design would be appropriate within their market, or whether they were willing to deviate from the safe harbor design and negotiate with CMS. CMS could then focus its resources on plans that are different from the proposed design.

The degree to which plans adopt CMS’s proposed benefit design would depend, in part, on how burdensome plans find CMS’s oversight and negotiation process. If, for example, CMS has few or misallocated resources for administering the MA program, this option may not provide sufficient

incentive for plans to use the proposed benefit design. On the other hand, if CMS’s negotiation process were to take a significant amount of time, plans might find it advantageous to adopt the proposed benefit structure and thereby avoid delay in preparing their product. At the extreme, if CMS were too heavy handed, managed care organizations might choose not to enter a market at all.

CMS should identify the benefits that would be included under the safe harbor. First priority should be given to less discretionary services needed to treat serious medical conditions. For example, CMS might set an appropriate rate of coinsurance (or its actuarially equivalent copay) for dialysis, therapeutic radiation, or chemotherapy treatments. Plans could propose alternative structures, but would need to be prepared to discuss the rationale for them with CMS. At the same time, a plan would be free to develop its own cost-sharing requirements to discourage overuse of services that are more discretionary in nature (for example, imaging).

RECOMMENDATION 3

To prevent discriminatory benefit designs, CMS should develop guidelines for plans on benefit design and cost sharing that, if adopted, would provide safe harbor from extensive negotiations with the agency. Guidelines should include:

- **an out-of-pocket cap on cost sharing for Medicare-covered services, and**
- **limitations on disproportionate cost sharing for services that are less discretionary in nature.**

Rationale

The available data do not provide convincing evidence that current cost-sharing practices of MA plans lead to widespread discrimination against beneficiaries based on health status. Nevertheless, the Commission remains concerned that CMS needs to work more actively to limit uneven cost sharing across services. The Commission considered a range of approaches and chose a less regulatory route to addressing potential problems with cost sharing in MA plans. To an extent, CMS already uses a “safe harbor” approach by recommending that plans adopt caps on OOP spending. The agency should expand the concept of a safe harbor to encourage plans to avoid uneven cost sharing or cap enrollee OOP liability for services covered by Parts A and B of Medicare.

Implications

Spending. This recommendation should not affect Medicare benefit spending.

Beneficiary and provider. This recommendation should better protect beneficiaries from relatively high cost sharing where they have less discretion over the services they need.

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Endnotes

1. Under regulations for federally qualified HMOs, the cumulative amount of enrollee cost sharing can be no more than 200 percent of a hypothetical annual premium if the plan had no cost sharing.
2. On its website, CMS notes that the cost-sharing guidance “is intended to apply to in-network benefits offered in MA plans. To the extent that cost sharing related to receipt of out-of-network Medicare-covered benefits does exceed FFS levels (and to the extent that cost sharing related to in-network receipt of Medicare-covered benefits does not exceed FFS levels), reviewers generally will not question a plan’s cost-sharing structure.” (See <http://www.cms.hhs.gov/healthplans/letters/callletter2faq.pdf>.)
3. Colorectal cancers are among the most common cancers in both male and female adults, and the primary risk factor for colorectal cancers is age. About 106,000 new cases of colon cancer were expected to occur in 2004. Only 38 percent of all colorectal cancers are detected at the earliest stage; the majority have spread to other direct extensions of the tumor site or to lymph nodes, (stage II or III tumors). After the cancer has spread to adjacent organs or lymph nodes, the five-year survival rate is 66 percent. When the cancer has metastasized further, the five-year survival rate is 9 percent.
4. This estimate of part B cost sharing assumes the patient pays a \$100 deductible plus 20 percent of the remaining \$14,375 in allowable charges (\$11,500 divided by 80 percent). Cost sharing for outpatient surgeries could be higher than 20 percent, so this estimate may be understated for beneficiaries who need outpatient surgery to insert a catheter port.
5. The data on premiums and benefits for this analysis came from the plan benefits file we obtained from CMS in spring 2004. Some plans adjusted premiums and/or benefits later in the year. Those changes were incorporated into Medicare Plan Finder data, but they were made after the analysis of plan benefits conducted by CMS during the contract review process, and are not included in the analysis reported here. We also deleted information for a small number of plans in the file that included data that we determined to be incorrect, due to coding or data transfer errors made by the plans when their data was submitted to CMS. Some of these errors were not corrected on the Plan Finder information available on the Internet.
6. In some MA plans, Part B-covered drugs that do not have to be administered in an office or clinic setting, such as certain antiemetic drugs and nebulizers, are treated like other drugs covered under the plan’s outpatient prescription drug plan—that is, under the plan’s formulary rules. In these cases the plan sometimes states specifically in its PBP that Part B drugs do not count toward a dollar limit that might apply to other drugs. Drugs that are administered by physicians (such as drugs that are infused) may be subject to different cost-sharing requirements, such as a standard coinsurance rate, or may not have any cost-sharing. PBP data fields and codes do not provide the level of detail needed to identify these different cost sharing features within a plan.

7. As part of its effort to measure quality of and access to care, CMS conducts three annual nationwide surveys of Medicare beneficiaries in MA plans: the Medicare managed care (MMC) CAHPS survey of people who continue their enrollment in a private plan, the CAHPS Disenrollment Assessment survey, and the CAHPS Disenrollment Reasons survey. The first two surveys include core CAHPS questions like those in the fee-for-service CAHPS instrument, which are designed to provide reliable satisfaction ratings of the Medicare beneficiary's overall health care experience and of experiences with their providers. The MA-specific instruments also include questions that reflect the respondent's overall perceptions about their health plan, as well as others that help managed care organizations fulfill HEDIS reporting requirements (Goldstein et al. 2001). CMS initiated the disenrollment assessment survey in the late 1990s out of concern that ratings from the MMC survey did not include responses of beneficiaries dissatisfied enough to disenroll from a plan (Bender et al. 2003).
8. The DR sample is drawn randomly from noninstitutionalized beneficiaries who voluntarily left a Medicare managed care plan in 2002. Involuntary disenrollees—such as those whose plan pulled out of the member's service area—were excluded. Survey administrators mailed questionnaires to sufficient numbers of disenrollees in each continuing MA contract so that, on average, results would be accurate within plus or minus 7 percentage points. The data set for 2002 was made up of 25,305 observations from 178 contracts, but we excluded 3,791 people from the data set who left plans because they joined Tricare, moved out of their plan's service area, or their employer stopped offering the plan. The average response rate for the 2002 DR survey was 66 percent. Sample weights were adjusted to take into account the greater likelihood of responses by certain types of beneficiaries (CMS 2003).
9. Disenrollment rates are calculated as total voluntary disenrollments during the year divided by the sum of enrollment at the start of the year and the number enrolled during the year.
10. Medical savings account plans are not permitted to offer a Part D benefit, and private FFS plans may, but are not required to, offer Part D coverage.
11. The State Health Insurance Assistance Program (SHIP) is a national program that provides free counseling via telephone and face-to-face sessions, along with public education presentations, programs, and media campaigns. The program operates in all 50 states, the District of Columbia, Puerto Rico, and Guam. Federal funding was approximately \$21.1 million in 2004, but many states and local communities provide additional funding and in-kind support. Most SHIP counselors are volunteers. The number of SHIP offices and counselors across the states reflects wide variations in funding and resources. About one-third of state SHIPs have fewer than 100 volunteer counselors, and the majority of state organizations have one or two full-time paid staff. With the support of local organizations, the national SHIP coordinating organization reports that in 2003 they were able to serve over 2 million Medicare beneficiaries, about 1.2 million of these over the telephone or in one-on-one in-person sessions. (State Health Insurance Assistance Program. 2004. <http://www.shiptalk.org/login-default.asp>.)

A P P E N D I X A

Mandate for report

Mandate for report

Medicare Prescription Drug, Improvement, and Modernization Act, Title II, Sec. 211(h)

(h) MedPAC study and report on clarification of authority regarding disapproval of unreasonable beneficiary cost sharing.

(1) Study. The Medicare Payment Advisory Commission, in consultation with beneficiaries, consumer groups, employers, and organizations offering plans under part C of title XVIII of the Social Security Act, shall conduct a study to determine the extent to which the cost-sharing structures under such plans affect access to covered services or select enrollees based on the health status of eligible individuals described in section 1851(a)(3) of the Social Security Act (42 U.S.C. 1395w-21(a)(3)).

(2) Report. Not later than December 31, 2004, the Commission shall submit a report to Congress on the study conducted under paragraph (1) together with recommendations for such legislation and administrative actions as the Commission considers appropriate.

A P P E N D I X B

Findings of MedPAC's expert panel

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MedPAC staff convened a panel of 15 experts at its offices on March 31, 2004. That panel included representatives of private plans, beneficiary advocates, academic researchers, and consulting actuaries to major employers (see the list of organizations represented at the end of this appendix). A contractor facilitated the discussion using a series of questions drafted by MedPAC staff. Those questions, provided in advance to panel members, aimed to uncover their perceptions about the amount of variation in plan benefit designs, the degree to which plans use benefit design as a means of selection, and CMS's role in approving proposals for plan benefit packages.

In general, panelists recognized that there is considerable variation in cost-sharing requirements and premiums charged across MA plans, but most did not think that problems were affecting access to care in a widespread manner. However, the panel recognized that certain plans appear to have observable biases in cost sharing, such as for chemotherapy and dialysis services. Panel members noted that Medicare faces the continuing challenge of helping beneficiaries understand personal and financial implications when choosing among their coverage options.

Perceptions about variations in benefit designs of MA plans

Panel members focused most of their comments on variation in plan benefits within the same geographic area, attributing broader variation across markets largely to differences in payment rates. Even competing plans within the same market area exhibit a large amount of variation, although not as exaggerated as variation across markets. Many markets experienced an erosion of prescription drug coverage as payment rates grew more slowly than program costs after the Balanced Budget Act. One panelist suggested that as payment levels grew slowly, the amount of variation among plans within the same market area decreased—in other words, competing plans began to offer packages that were more similar.

Representatives of private plans who participated in MedPAC's expert panel thought that discriminatory behavior was unusual among plans: most want to provide quality care to sicker beneficiaries in order to maintain their reputation with enrollees and because they believe it is the right thing to do. One expert pointed out that even plans that do not have a catastrophic cap on OOP spending sometimes overlook cost-sharing requirements for enrollees who are very ill and cannot afford it.

On the other hand, not all plans use those approaches, and CMS may not enforce its rules against discrimination to the degree that beneficiary advocates might like. One panelist described plans that charge the same cost sharing as FFS Medicare for chemotherapy drugs and services (20 percent coinsurance), with lower cost sharing for more routine services and no catastrophic cap. Although a beneficiary enrolled in the FFS program with no supplemental coverage would face the same amount of cost sharing, in that expert's opinion, private plans must protect sick beneficiaries from such high liabilities, much as supplemental coverage would.

Are beneficiaries making informed choices?

The panel voiced many different perceptions about the knowledge, interest, and sophistication of Medicare beneficiaries and their ability to make informed choices among their Medicare options. They generally agreed, however, that the number and complexity of offerings in many markets can make it difficult for beneficiaries to understand differences among plans. A key challenge lies in finding ways to effectively highlight differences across options in ways that do not confuse or overwhelm beneficiaries.

Several panel members argued that the sheer number of plans available to some can be bewildering, and certain beneficiaries do not have a good understanding of the full financial implications of their choices. One panelist referred to a study of two communities (Cleveland and Tampa) in which the Medicare population had seven or eight choices of plans in 2001, each with different cost-sharing requirements for specific services such as doctor visits, inpatient care, radiation therapy, prescription drug coverage, etc. (Dallek and Edwards 2001). The analysis revealed that for a beneficiary with the same profile of service use, annual OOP spending could differ by about \$3,000. Yet, the panel member thought that such differences could not have been identified easily by comparing cost-sharing requirements across plans in a chart.

A plan representative countered that his plan is distributing web-based tools to help people make choices. When people renew their enrollment, they can view their claims from the previous year and estimate what their cost sharing would look like for the upcoming year for the same pattern of service use under the plan's alternatives. The same participant noted that CMS has added more information to its web-based plan-finding tool to help beneficiaries understand the financial implications of their options.

Several times during the discussion, a few panelists raised the idea of allowing only a limited number of plan choices with some degree of benefit standardization. One panelist noted that such an approach might help beneficiaries make clearer choices among plans, possibly leading to a greater degree of competition based on prices (premiums) than on benefit designs. For example, CalPERS uses a standard benefit package, and beneficiaries choose among plans offering that package based on their premiums, the desirability of their networks, and quality of services.

Although panelists generally agreed on the importance of giving beneficiaries clear and understandable information, they did not reach a consensus on the issue of standardization of benefits. One plan representative noted that an important overarching factor contributing to beneficiary confusion has been annual variations in funding for the MA program. As funding became more constrained in recent years, plans had to make decisions about whether to stay in certain markets and, if they did, how to adjust benefits and cost sharing in the face of increases in the cost of providing services. Plans might be less likely to remain in markets without the flexibility to adjust benefits and cost sharing in response to payment levels.

One expert took the position that since different plans suit different individuals, having a wider variety of choices was a good outcome. At least one other participant believed that the problem facing beneficiaries was not too many options, but too few. Given that many private plans had left

the MA program in recent years as payment rates grew more slowly than costs, beneficiaries were left with fewer options.

Another plan representative noted that standardization of benefits has not prevented risk selection among medigap plans: Selection problems have been found among the three standard types of medigaps that include some coverage for outpatient prescription drugs (H, I, and J policies). Purchasers of such policies tend to use more prescription drugs, on average. Some medigap insurers discontinued offering such policies because premiums grew to high levels.

Does competition among plans lead to innovations in benefit designs?

One plan representative suggested that competition promotes innovation in benefit design, citing as an example his firm's efforts to examine beneficiary interest in raising the hospital deductible in return for better prescription drug coverage. The plan is pursuing this approach on the grounds that better outpatient drug coverage may keep some people out of the hospital. The panelist asked if this might be considered a fair trade-off. Another responded that it would be, so long as beneficiaries truly understand the benefit options and their implications. However, that panel member thought that with so many plans and design variations, the new option would likely get lost in the confusion.

Another participant reiterated the point that constrained payment rates may force plans to modify their benefits and cost sharing from year to year. However, plans often enhance their benefit offering after they learn what benefits their competitors are offering within the same market. If they identify a benefit change in their competitor's package that they believe may attract their enrollees, plans often try very hard to make a mid-year adjustment and add this same enhancement. Given the high cost of attracting and enrolling new members, plans find it particularly important to reduce the risk of losing members to their competitors.

Perceptions about CMS's oversight role

Participants in the expert panel who represented plans described the ACRP process in the past as being one of limited communication: A plan would submit its proposal and CMS would send it back if it did not like some aspect of it. Several panel members noted past problems in retaining MA plans, and thus more recently CMS has moved toward negotiating with plans and communicating back and forth more frequently. CMS has also described more specifically what types of cost-sharing requirements are likely to trigger closer scrutiny.

One panelist said that when CMS flags certain cost-sharing requirements in a benefit proposal, plans take that process quite seriously, given that CMS could ultimately keep the firm from offering a plan in certain markets or at all. Another person emphasized the negative impact of delays in the ACRP approval process as being more important than the threat of disapproval. They noted that plans need to move very quickly to get their mailings to beneficiaries out in time, and thus they cannot afford to lose 60 days arguing a point with CMS.

Several panel members were aware of at least one case in which CMS had to use a heavier hand against a plan that was proposing inappropriately high copayments for oncology services. One

person characterized CMS’s role as being more inclined to keep a plan from imposing certain cost-sharing requirements rather than prompting plans to add coverage or OOP limits.

Although CMS has made recent changes to its procedures for reviewing plan marketing materials, several participants commented that in the past, the agency was too inflexible. One noted that some of the required formats for explaining plan benefits were confusing and unlike the formats that beneficiaries with employer-sponsored coverage typically see. A specific example was that cost-sharing requirements for in-network and out-of-network services were displayed on different pages rather than side-by-side. Another plan representative expressed concern about inconsistent reviews of marketing materials across CMS regional offices.

Expectations about the effects of risk adjustment and CMS’s negotiating authority

A number of participants were hopeful that CMS’s new risk adjustment methodology will reduce plan incentives to attract healthier enrollees. Representatives of some plans believe that their delivery model has always focused on providing coordinated care for beneficiaries with complex medical needs (rather than avoiding such beneficiaries), and better risk adjustment will help them promote this capability.

Others suggested that the success of risk adjustment will depend on the quality of data that CMS receives from providers. Right now there are significant problems with these data, they noted, and it will take considerable time and effort to ensure accuracy. One participant thought that their plan would not have a sense of whether they were fairly compensated under the new risk adjustment model for another 18 months.

Several participants stated that risk adjustment models or even standardization of benefits cannot completely address the issue of selection bias across competing plans. Citing the experiences of CalPERS, FEHBP, and other employer-based programs, they noted that plan characteristics other than benefit design—such as the tightness or broadness of provider networks—influence choice.

Organizations represented at MedPAC staff’s expert panel on benefits design

Actuarial Research Corporation	Prescription Solutions
Hewitt Associates	Reden & Anders
Horizon Blue Cross Blue Shield	University of California, Irvine, Graduate School of Management
Humana	University of California, Los Angeles, School of Public Health
Independent consultant on beneficiary protection issues	University of Minnesota, School of Public Health
Kaiser Foundation Health Plans	Wellpoint Health Networks
Medicare Rights Center	
Ovations Insurance Solutions	

A P P E N D I X C

Commissioners' voting on recommendations

Commissioners' voting on recommendations

In the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000, the Congress required MedPAC to call for individual Commissioner votes on each recommendation, and to document the voting record in its report. The information below satisfies that mandate.

Recommendation 1

To provide critically important information about the implications of coverage and benefit options, CMS should use an array of approaches for beneficiaries and those who help them. In the short term, CMS should:

- continue to provide estimates of out-of-pocket costs on the Medicare Personal Plan Finder, and
- begin to make available more tools that reflect out-of-pocket costs under various scenarios for use of services and their likelihood.

As soon as feasible, CMS should develop advanced consumer decision tools that use individuals' actual experience to project future out-of-pocket spending.

Yes: Bertko, Burke, Crosson, DeBusk, DeParle, Durenberger, Hackbarth, Milstein, Muller, Nelson, Raphael, Reischauer, Scanlon, Smith, Stowers, Wakefield, Wolter

Recommendation 2

CMS should interpret its authority granted in the MMA to negotiate with MA plans broadly on their benefit design and cost sharing. Specifically, MedPAC believes the agency should use this authority to ensure that plans do not discriminate on the basis of health status.

The Congress may need to provide CMS with additional staff resources and administrative flexibility to carry out this function effectively.

Yes: Bertko, Burke, Crosson, DeBusk, DeParle, Durenberger, Hackbarth, Milstein, Muller, Nelson, Raphael, Reischauer, Scanlon, Smith, Stowers, Wakefield, Wolter

Recommendation 3

To prevent discriminatory benefit designs, CMS should develop guidelines for plans on benefit design and cost sharing that, if adopted, would provide safe harbor from extensive negotiations with the agency. Guidelines should include:

- an out-of-pocket cap on cost sharing for Medicare-covered services, and
- limitations on disproportionate cost sharing for services that are less discretionary in nature.

Yes: Bertko, Burke, Crosson, DeBusk, DeParle, Durenberger, Hackbarth, Milstein, Muller, Nelson, Raphael, Reischauer, Scanlon, Smith, Stowers, Wakefield, Wolter

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