Standardizing benefits in Medicare Advantage plans: Cost sharing for Part A and Part B services

Eric Rollins

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We use “standardized benefits” to refer to both covered services and enrollee cost sharing

- This presentation focuses on Part A & B services
  - MA plans cover all of these services except hospice
  - Standardization would affect cost sharing only
- Later this fall, we will give a presentation that focuses on non-Medicare supplemental benefits
  - MA plan coverage of these services is optional
  - Standardization would affect both covered services and cost sharing

Selecting a Medicare Advantage (MA) plan can be a challenging process for beneficiaries

- Plans differ on many dimensions
- The average number of plans available doubled between 2017 and 2022 (from 18 to 36)
- Researchers have found that people have more trouble comparing plans when they have a lot of choices
- Requiring plans to have standardized benefits could make it easier to compare plans

Standardized benefits have been used in other health insurance programs

- All Medigap policies have been required to use standard benefit packages since the early 1990s
  - Standardization generally considered a success
- Some states specify the deductibles, cost sharing, and annual out-of-pocket limits for their ACA plans
  - CMS will require insurers to sell standardized ACA plans on the federally-run exchange starting in 2023

Note: ACA (Affordable Care Act of 2010).

MA plans can develop their own cost-sharing rules instead of using fee-for-service (FFS) rules

- Plans can use copayments or coinsurance in most cases
- Plans must charge a single, bundled cost-sharing amount for any facility services
- Most plans use some of their MA rebates to charge lower cost sharing than FFS

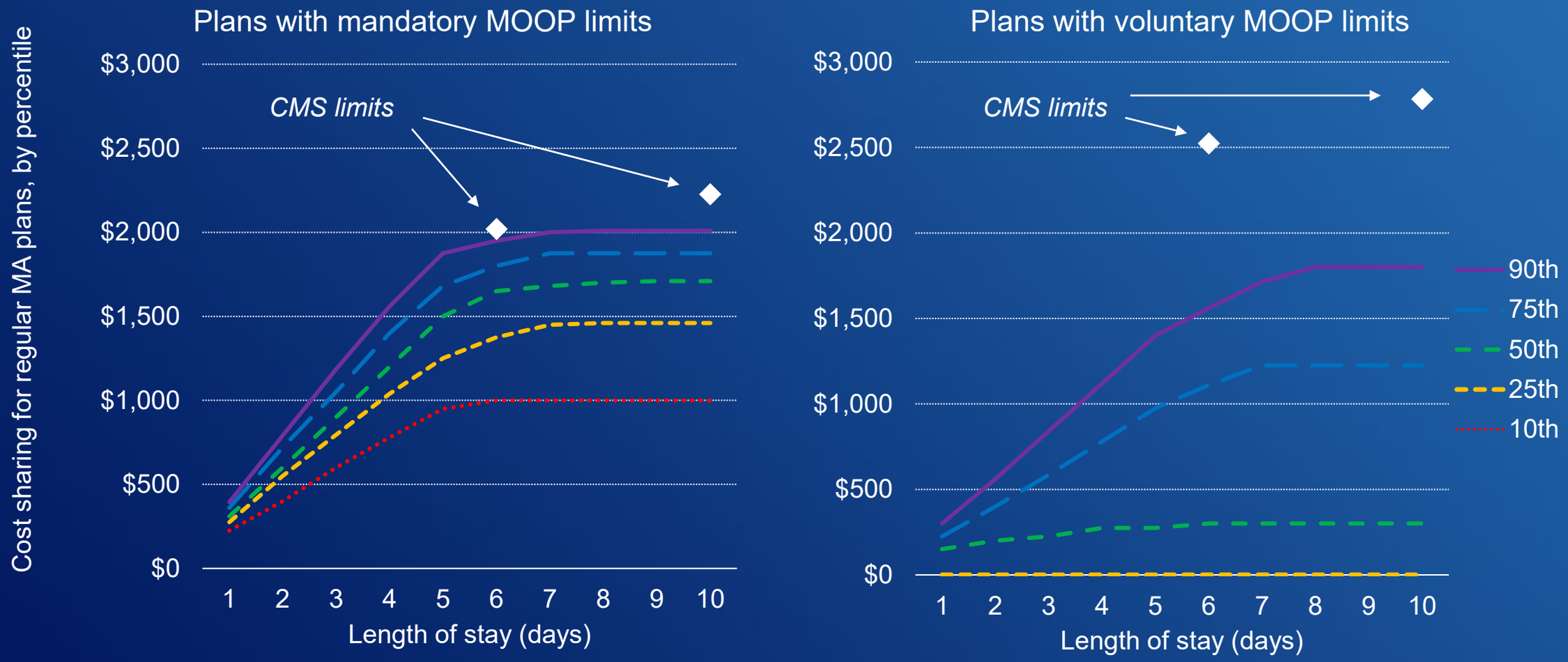
MA cost sharing is subject to limitations aimed at ensuring plan designs are not discriminatory

- Aggregate limits
  - MA cost sharing must be actuarially equivalent to FFS
  - Plans must have an out-of-pocket limit for in-network care
- Service-specific limits
  - Cost sharing for some services (such as inpatient acute care and dialysis) cannot exceed FFS
  - Cost sharing for other services (such as physician services) can exceed FFS but still has some type of specific limit
  - Cost sharing for any services without a specific limit (such as outpatient hospital) cannot exceed 50 percent coinsurance

Most regular MA plans (82 percent) use daily copayments for inpatient acute care

- Copayments usually charged for first 5–7 days of the stay
- Copayment amounts usually range from $200 to $400
  - These amounts are not comparable to the FFS Part A deductible because they also cover related Part B services
- MA cost sharing cannot exceed average FFS cost sharing for certain lengths of stay

MA cost sharing for inpatient acute care is typically lower than FFS cost sharing



Note: MOOP (maximum out-of-pocket). Figures are for 2022 and are preliminary and subject to change. The figure on the right does not have a red line because all plans below the 25th percentile have no cost sharing.

MA and FFS cost sharing for skilled nursing facility care are relatively similar

- MA plans cannot charge more than FFS
- Nearly all plans use the same basic cost-sharing structure as FFS (daily copayments starting on day 21 of the stay)
- About a third of plans effectively use FFS rules
- Some plans have lower copayments or fewer copayment days than FFS, but the differences are often relatively small

Cost sharing for selected Part B services

- Regular MA plans use copayments for many services
  - MA plans usually charge less than FFS for primary care and emergency services
  - MA plans charge roughly the same as FFS for specialist care
  - MA plans often charge more than FFS for dialysis (in dollar terms) and urgent care
- Plans at the 90th percentile may charge 2–3 times more than plans at the 10th percentile

Special needs plans (SNPs) often have different cost-sharing rules than regular MA plans

- Nearly all SNP enrollees (90 percent) are dual eligibles
  - Medicaid covers Part A & B cost sharing for most duals
  - D-SNPs use fewer rebates to lower cost sharing and focus more on offering non-Medicare supplemental benefits
- SNPs are more likely than regular MA plans to use FFS cost-sharing rules or charge no cost sharing

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Note: D-SNP (dual-eligible special needs plan).

Requiring MA plans to use standardized benefits would raise challenging policy issues

- Plans would still cover all Part A & B services but hospice; standardization would focus on enrollee cost sharing
- Plans could use a limited number of benefit packages
  - Larger number of packages would provide more choices but would do less to simplify plan comparison
  - Would insurers be able to offer plans with the same package but different provider networks?
- Standardization could be tied to actuarial value or involve the use of detailed plan designs

Illustrative MA benefit packages with standardized cost sharing for Part A & B services

Service category	Package 1 (Lower generosity)	Package 2 (Medium generosity)	Package 3 (Higher generosity)
Maximum out-of-pocket limit	$6,700	$5,000	$3,400
Deductible	$0	$0	$0
Inpatient acute care (days 1–5)	$335 per day	$300 per day	$225 per day
Skilled nursing care (days 21–100)	$188 per day	$188 per day	$172 per day
Primary care visit	$10	$5	$5
Specialist visit	$40	$35	$25
Outpatient hospital service	$325	$295	$200
Emergency care	$90	$90	$90
Urgent care	$40	$40	$30
Dialysis	20%	20%	20%

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Note: These packages are for illustrative purposes only and do not represent MedPAC policy proposals.

Which types of plans would insurers be able to offer in the MA market?

- Would insurers be required to offer standardized plans?
- Could insurers still offer non-standardized plans?
  - Allowing insurers to offer both types of plans could make plan selection process even more difficult
  - Requiring all plans to use standardized designs would cause some disruption for MA enrollees, but the extent would depend on how closely the standardized plans resemble current plan designs

Some potential payment implications

- Plan bidding behavior would change in ways that are difficult to predict
- Standardization would give plans fewer ways to respond to changes in payment rates
- Plans receive more rebates in some markets than others
  - Some standardized plans may not be offered everywhere

Discussion

- Should MA plans use standardized benefits?
  - Do the illustrative packages seem like the right approach?
  - How should existing plans / enrollees be treated?
- At this point we are looking for initial impressions rather than specific policy judgments
  - Later this fall we will give a presentation that focuses on non-Medicare supplemental benefits
  - What kinds of additional information would be helpful?