April 2008

Issue Brief

Medicare Advantage: Options for Standardizing Benefits and Information to Improve Consumer Choice

Ellen O'Brien and Jack Hoadley
Health Policy Institute, Georgetown University

For more information about this study, please contact:

Jack Hoadley, Ph.D.
Research Professor
Health Policy Institute
Georgetown University
Tel 202.687.0880
E-mail jfh7@georgetown.edu

ABSTRACT: The Medicare Advantage (MA) program offers beneficiaries a choice of private health plans as alternatives to the traditional fee-for-service Medicare program. MA plans potentially provide additional value, but as plan choices have proliferated, consumers contemplating their options have had difficulty understanding how they differ. Through "standardization"—more consistent types of information and a limited number of dimensions along which plans vary—MA plans could reduce complexity and improve beneficiaries' ability to make informed choices. Such standardization steps would offer more meaningful variation in the health coverage options available to beneficiaries, Medicare officials and their community partners would find it far easier to educate beneficiaries about their health plan choices, and beneficiaries would better understand what they were buying. Standardization might also strengthen the ability of the market-based Medicare Advantage program to incorporate beneficiary preferences.

❖ ❖ ❖ ❖ ❖

Overview

The Medicare Advantage (MA) program, offering enrollees the possibility of reduced out-of-pocket costs together with more comprehensive benefits, was designed to provide alternatives to Medicare's traditional fee-for-service program. As a result, MA plans have appealed to some low- and modest-income Medicare beneficiaries who do not have access to employer-sponsored retiree health insurance and may not be able to afford, or wish to purchase, a private supplemental insurance (Medigap) policy.[1] By the end of 2007, 20 percent of Medicare beneficiaries were enrolled in an MA plan.[2]

This and other Commonwealth Fund publications are online at www.commonwealthfund.org. To learn more about new publications when they become available, visit the Fund's Web site and register to receive e-mail alerts.

Commonwealth Fund pub. 1117
Vol. 33

But as the number and types of plan offerings have increased in recent years, the challenges facing beneficiaries in evaluating their options have increased. MA choices have become more varied, including not only Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) but also private fee-for-service (PFFS) plans, regional PPOs, medical savings account (MSA) plans, and special needs plans (SNPs). In theory, the array of alternatives allows each beneficiary to choose a plan with the coverage, cost-sharing, provider network, and quality that best fits his or her individual circumstances. In practice, however, the proliferation of private plans and the dimensions along which they differ has made it increasingly difficult for beneficiaries to become informed about, understand, and compare the available alternatives.

This report describes the variability and complexity of the Medicare Advantage plans and assesses the consequences of that variation for beneficiary decision-making. It then poses three options for easing the situation: 1) stipulating more standardized information and better tools to support individual decision-making; 2) requiring that plans put a cap on out-of-pocket costs; and 3) implementing a few standardized benefit and cost-sharing regimes to limit the numbers of dimensions along which plans may vary.

Making Difficult Choices

In nearly all areas of the country, Medicare beneficiaries can choose between traditional fee-for-service Medicare and an array of private MA plans, as a result of the Medicare Modernization Act of 2003. But with many more plans of different types to choose from, beneficiaries face a major information deficit. Because plans may vary along a great many dimensions, and because critical information is sometimes missing or incomplete, it is practically impossible for beneficiaries to assess accurately the value of competing plans—specifically, to evaluate and compare their out-of-pocket cost risks.

Beneficiaries receive an annual guide to the Medicare program, *Medicare & You,* which provides a general description of the available options. In addition, an online search tool, *Medicare Options Compare* (previously the Medicare Personal Plan Finder), provides detailed information on the plans offered in each area, focusing on the benefits provided and beneficiary cost-sharing responsibility. This tool is relatively new and marks a significant improvement in the availability of standardized information. A decade ago, beneficiaries relied primarily on plan marketing materials and information provided by agents. Agents and brokers, who may be focused on commissions more than the best interests of their clients, still play a large role, but today plans must submit standard information to the Centers for Medicare and Medicaid Services (CMS).

Even with access to the Internet, however, the online tool alone does not solve the problem. Although a great deal of information is available, beneficiaries often have difficulty understanding its significance and using it correctly to make decisions. Research has shown that a majority of beneficiaries have difficulty correctly interpreting even simple displays of Medicare health plan information.[3] One study reported that 40 percent of recent Medicare HMO enrollees did not understand key aspects of Medicare.[4] Medicare beneficiaries' knowledge about characteristics that distinguish health plan types is lower still.[5] Few beneficiaries actively contemplate those choices,[6] and many of those who are aware of their options are bewildered by their complexity.

In 2006, the typical Medicare beneficiary had about 12 MA plan choices; 5 percent of beneficiaries had 40 or more plan choices.[7] In Milwaukee County, Wisconsin, for example, Medicare beneficiaries had 11 health plan choices in 2006—two local HMOs, two local HMOs with a point-of-service (POS) option, one local PPO, three regional PPOs, one PFFS plan, and two SNP options that were not open to all beneficiaries. The options have varying benefit designs and cost-sharing requirements. In 2007, the number of MA plans available in Milwaukee County had risen to 17, and the mix of plan types had changed significantly. In 2008, there are 44 MA plans in total.

Table 1 illustrates some of the information available in 2006, through the Medicare online tool, to

Table 1. Medicare Advantage Plan Choices in Milwaukee County, Wisconsin, 2006

	Plans								
	1 Local PPO H5216-1 Humana	2 HMO-POS H5253-4 UHC WI	3 Local HMO H5253-6 UHC WI	4 Local HMO H5253-7 UHC WI	5 HMO-POS H5253-21 UHC WI	6 PFFS H1804-23 Humana	7 Reg PPO R5826-4 Humana	8 Reg PPO R5826-23 Humana	9 Reg PPO R5826-37 Humana
Premium	$37	$0	$58	$28.15	$28.15	$35	$97	$0	$35
In-Network OOP Max	—	$4,800	$4,200	$775	$4,600	$5,000	$5,000	$5,000	$5,000
Primary Care Office Visit	$10	$20	$15	$0	$20	$15	$10	$10	$10
Specialist Office Visit	$35	$35	$25	20%	$25	$30	$35	$35	$35
Mammography Services	$35–$50	$0	$0	$0	$0	$0	$0	$0	$0
X-ray Services	$10–$50	$0–$10	0%–20%	0%–15%	0%–15%	$15–$30 or 20%	$10–$75	$10–$75	$10–$75
Clinical Lab Services	$0–$50	$0–$10	0%	0%	0%	$15–$30	$0–$75	$0–$75	$0–$75
Radiation Therapy	$35–$50	$0–$10	20%	15%	15%	$15–$30	$15–$30	$15–$30	$15–$30
Outpatient Hospital Services	$50–$100	20%	20%	20%	20%	20%	$75–$125	$75–$125	$75–$125
Ambulatory Surgical Center Services	$100	20%	20%	20%	20%	20%	$100	$100	$100
Home Health Services	$0	$0	$0	$0	$0	$0	$0	$0	$0
Emergency Department Services	$50	$50	$50	$50	$250	20% (to $50)	$50	$50	$50
Inpatient Hospital OOP Max	—	—	—	—	—	—	—	—	—
Inpatient Hospital Copay per Stay	—	—	—	—	—	—	—	—	—
Inpatient Hospital Daily Copays	$175/day, days 1–5	$295/day, days 1–17	$250/day, days 1–17	$75/day, days 1–11	$265/day, days 1–18	$180/day, days 1–5	$165/day, days 1–5	$165/day, days 1–5	$165/day, days 1–5
Skilled Nursing Facility Services OOP Max	—	—	—	—	—	—	—	—	—
SNF Copay per Stay	—	—	—	$0	—	—	—	—	—
SNF Daily Copays	$0/day, days 1–13; $75/day, days 14–100	$150/day days 1–32	$125/day days 1–34	—	$150/day days 1–31	$0/day, days 1–3; $90/day, days 4–100	$0/day, days 1–10; $75/day, days 11–100	$0/day, days 1–10; $75/day, days 11–100	$0/day, days 1–10; $75/day days 11–100
Rx Drugs	Enhanced	Enhanced	None	Enhanced	None	Enhanced	Enhanced	None	Standard

Notes: Two special-needs plans are excluded from this list; premiums cited are the full premiums (including any premium for Part D benefit);
OOP = out-of-pocket; "—" means the plan has no parameter in that category.
Source: Medicare Personal Plan Finder data, downloaded March 9, 2006.

beneficiaries living in Milwaukee County. Although this table provides far less than a comprehensive description of plan benefits—it summarizes cost-sharing for only 12 of the dozens of services that all MA plans must provide—it does illustrate the choice problem that beneficiaries faced. Because cost-sharing varied across all benefits in numerous ways, few beneficiaries could evaluate how their out-of-pocket costs would differ plan by plan; there were simply too many moving parts.

How, for example, might a beneficiary decide between the Plan 1 and Plan 2 of Table 1? Both plans had modest copayments for doctor office visits, clinical lab services, X-rays, and mammography screening, but Plan 2 assessed 20 percent coinsurance for outpatient hospital and ambulatory surgical center services while Plan 1 assessed a flat copayment. The two plans also differed significantly in cost-sharing for hospital and nursing home care. A great deal of pertinent information was made available, but because plans specified cost-sharing in different ways, it was very difficult to make direct comparisons. Most people of any age or health status would have some difficulty making an overarching assessment of plan cost-sharing requirements for even this limited set of benefits. Even trained professionals, such as beneficiary counselors or health policy researchers, find these comparisons challenging.

Beneficiaries in some other locales have faced even bigger challenges. As shown in Table 2, the difficulties in making an informed choice were significantly greater in Pinellas County, Florida, in 2006 because it had far more MA plans (40) than did Milwaukee County. And by 2008, Pinellas County's array had more than doubled, to 91 plans.

Beyond the benefits listed in Tables 1 and 2, a Medicare beneficiary has to consider even more potential differences that could affect his or her choice. These include, for example, the variations in cost-sharing for inpatient and outpatient mental health services, prescription drugs, and ambulance services or different options for supplemental benefits such as hearing, vision, and dental care, disease management, and wellness programs. Differences in plan-network structure (whether one's own or desired physicians are in network and whether certain hospitals, pharmacies, and facilities are included) also matter to the prospective enrollee, as do the conditions for coverage of certain services—such as limits on covered days of inpatient hospital care or what services are counted toward any out-of-pocket cost cap.

Plan utilization-management practices can also vary widely, and they may significantly affect access to services and cost risks. In the case of prescription-drug coverage, even though two plans may both offer an enhanced prescription drug benefit (that is, a drug benefit with a cost-sharing arrangement more generous than Part D's standard coverage), a prospective enrollee needs to consider differences in formularies and cost-sharing as well as in prior-authorization and step-therapy rules that may limit access to the formulary drugs.

When staff of the Medicare Payment Advisory Commission (MedPAC) sought to examine variation across plans in cost-sharing for drugs administered in physicians' offices or outpatient settings (and thus not part of the Part D drug benefit), they also concluded that it was nearly impossible to estimate beneficiaries' relative out-of-pocket cost liabilities. In particular, they had difficulty determining whether out-of-pocket cost caps applied to these drugs, which are an important component of care for patients with cancer and certain other illnesses.[8] Although MedPAC staff determined that a resourceful beneficiary could get some information from the printed explanation of benefits provided by the health plan, even that was unlikely to have charges for specific drugs. "[N]either we nor CMS have data that will tell us answers to questions that we would like to be able to answer," they concluded.[9]

Because there is no easy way, and perhaps no way at all, for beneficiaries to make a straightforward comparison of one plan against another, most of the beneficiary counselors we convened observed that beneficiaries focus on the differences in monthly premiums charged by plans. Premiums are easy for them to understand and compare, but such comparisons may be misleading because of important differences in the

Table 2. Medicare Advantage Plan Choices in Pinellas County, Florida, 2006
(Nine health plans randomly selected from the 40 MA plans available)

	Plans								
	1 Local HMO H1019-16 CarePlus	**2 Local HMO H1032-14 WellCare**	**3 Local HMO H1056-52 Humana**	**4 Local HMO H1056-93 Humana**	**5 Local HMO H1080-36 UHC**	**6 Local HMO H55407-1 CitrusHealth**	**7 Local PPO H5415-48 Humana**	**8 Local PPO H5429-1 Universal**	**9 Local PPO H5532-1 UHC**
Premium	$0	$0	$0	$0	$17.34	$1	$0	$0	$31
Plan OOP Max	—	$3,000	$2,900	—	$1,800	$1,900	—	$3,200	$2,800
Primary Care Office Visit	$0	$0	$0	$0	$0	$0	$10	$0	$10
Specialist Office Visit	$10	$20	$15	$25	$0	$25	$25	$20	$25
Mammography Services	$0	$0	$0–$50	$0–$100	$0	$0	$0–$30 or 10%	$0	$0
X-ray Services	$0–$50	$0–$50	$0	$0–$100	$0–$15 or 0%–25%	$0–$100	$10–$30	$0–$100	$0–$10 or 10%–20%
Clinical Lab Services	$0	$0–$50	$0	$0–$100	$15	$0–$100	$0–$25 or 10%	$0	$10
Radiation Therapy	$25	$0	$0	$0–$100	15%–25%	$0–$100	$25–$30 or 10%	$25	20%
Outpatient Hospital Services	$150	$50	$50	$100–$200	$0	$150	10%	20%	20%
Ambulatory Surgical Center Services	$75	$25	$50	$100	$0	$25–$150	$30	$10	20%
Home Health Services	$20	$10–$20	$0	$20	$0	$0	$10	$40	$0
Emergency Department Services	$50	$50	$50	$50	$40	$0–$50	$50	$50	$50
Inpatient Hospital OOP Max	—	—	—	—	—	—	—	—	—
Inpatient Hospital Copay per Stay	—	—	—	—	—	—	—	—	—
Inpatient Hospital Daily Copays	$200/day, days 1–7	$50/day, days 1–5	$50/day, days 1–5	$200/day, days 1–7	$25/day, days 1–73	$125/day, days 1–5	$100/day, days 1–10	$300/day, days 1–10	$225/day, days 1–13
Skilled Nursing Facility Services OOP Max	—	—	—	—	—	—	—	—	—
SNF Copay per Stay	—	—	—	—	—	—	—	—	—
SNF Daily Copays	$25/day, days 1–9; $100/day, days 10–100	$0/day, days 1–7; $50/day, days 8–100	$0/day, days 1–9; $50/day, days 10–100	$0/day, days 1–9; $100/day, days 10–100	$15/day, days 1–100	$0/day, days 1–16; $100/day, days 7–100	$0/day, days 1–6; $75/day, days 7–100	$0/day, days 1–10; $150/day, days 11–100	$100/day, days 1–28; $0/day, days 29–100
Rx Drugs	None	Enhanced	Enhanced	None	Enhanced	Enhanced	None	Enhanced	Enhanced

Notes: Premiums cited are full premiums (including any premium for the Part D benefit); OOP = out-of-pocket; "—" means the plan has no parameter in that category.
Source: Medicare Personal Plan Finder data, downloaded March 9, 2006.

benefit structures across plans. Beneficiaries focused solely on premiums may not understand that they could face higher cost-sharing at the point of service, as well as greater coverage limitations, in a low-premium MA plan than one with a higher premium.

In fact, beneficiaries are increasingly at risk of high cost-sharing when they are enrolled in some MA plans, even though those plans are typically marketed as offering cost savings relative to traditional Medicare with Medigap supplementation. The authors of one recent study estimated that annual out-of-pocket spending for a Medicare beneficiary in poor health (assuming use of a given set of health care services) varied from a low of $1,359 to a high of $7,522 across 88 MA plans in 2005. In addition, beneficiaries enrolled in almost one-fourth of the plans that the researchers studied paid *more* out of pocket in managed care than they would have in fee-for-service Medicare with supplemental insurance (Medigap Plan F).[10] Another recent study confirms that on average, MA plans provided extra benefits above what traditional Medicare covered in 2006, but that the value of extra benefits was lower for private fee-for-service plans than for other MA plans—meaningful differences few beneficiaries would be able to detect.[11]

The variation in cost-sharing structures results from the flexibility provided to plans. There are only a few specific constraints on plans in law or regulations: MA plans are required to provide all of the services covered under fee-for-service Medicare, and they may not impose cost-sharing for flu and pneumonia vaccines, charge cost-sharing in excess of $50 for hospital emergency-room services, or require a referral for a mammography.[12] However, MA plans are free to impose beneficiary cost-sharing structures that are significantly different from that of fee-for-service Medicare.

Options for Improving Beneficiary Choice

Even the strongest supporters of competition in Medicare acknowledge that the choices facing beneficiaries are increasingly complex and that there is great potential for misinformation and confusion in the current market. But there is substantial disagreement about what, if anything, needs to be done about it. We discuss here three policy options designed to help simplify the process.

The first is for CMS to develop informational formats that are more comparable, more meaningful to beneficiaries, and more complete; in addition, CMS would provide decision-making tools that help beneficiaries understand which plans might best fit their own circumstances. The second option is to require all plans to limit enrollees' out-of-pocket spending liability, thereby providing them with an important piece of information to guide plan selection and a crucial protection against bad choices—or bad circumstances. Regional PPOs are required to cap beneficiary out-of-pocket costs, and this requirement could be extended to all MA plans. The third option is to standardize plan benefits by restricting insurers to a limited set of benefit designs, similar to the way in which the Medigap market was standardized in 1992. With more standardization, the number of dimensions along which plans vary would be reduced, beneficiaries would be better able to make more meaningful comparisons of the available plans, and plans would be encouraged to compete on dimensions of service that matter most to beneficiaries. Benefit packages could be fully standardized—with, say, 10 cost-sharing alternatives—or a more incremental approach could be considered, with standardization of some but not all MA benefits.

Each of these options, which are not mutually exclusive, is considered in turn below.

Option 1: Provide more standardized information and better decision-support tools.

(This option has three parts: 1a, 1b, and 1c.)

1a. Provide more standardized information. One way to help beneficiaries make direct comparisons across plans is to change the way in which information on cost-sharing is reported. For example, beneficiaries now have difficulty comparing the costs that would be incurred for a hospital stay because plans use varying methods to assess cost-sharing—including coinsurance, copayments per day, copayments per stay,

and deductibles combined with daily copayments for stays that extend beyond a certain number of days. Further, even if all of the plans in a market area used the same kind of cost-sharing—say, collecting a copayment per day—the resulting liabilities would be hard to compare unless they also changed their current practice of varying the copayment amount and the number of days over which it is collected.

We examined the variation in out-of-pocket costs for hospital stays in all of the local HMO, PPO, and POS plans listed in the Medicare Personal Plan Finder in 2006 and calculated that costs for a three-day hospital stay ranged from $0 to $1,500 and for a 21-day stay the span was $0 to $4,800 (see Table 3). Similarly, cost-sharing approaches and beneficiaries' out-of-pocket cost risks also varied widely for stays in a skilled nursing facility (SNF): costs for a 7-day SNF stay ranged from $0 to $2,000, and for a 100-day stay from $0 to $15,000 (see Table 4). These differences, though dramatic, might not be apparent to beneficiaries in the current format.

Beneficiaries could sort through such variations more readily if plans provided comparative information on what a beneficiary would pay in any given plan for hospital stays of varying lengths. Cost-sharing for hospital or SNF stays of specified lengths (for

Table 3. Out-of-Pocket Costs for Inpatient Hospital Services, by Length of Stay, All Plans, 2006

	Length of Stay				
	3 days	7 days	14 days	21 days	90 days
Average	$325.31	$556.99	$691.36	$717.42	$947.67
Minimum	$0	$0	$0	$0	$0
Median	$300	$500	$500	$500	$500
Maximum	$1,500	$2,450	$4,130	$4,800	$8,126
Mode	$0	$0	$0	$0	$0
75th Percentile	$525	$875	$956	$956	$1,000
Percent of Plans at the Mode	19%	19%	19%	19%	19%

Source: Authors' estimates based on Medicare Personal Plan Finder data, downloaded March 9, 2006.
Estimates are for local HMO, PPO, and POS plans only.

Table 4. Out-of-Pocket Costs for Skilled Nursing Facility Services, by Length of Stay, All Plans, 2006

	Length of Stay				
	7 days	14 days	21 days	60 days	100 days
Average	$102	$298	$550	$2,141	$3,489
Minimum	$0	$0	$0	$0	$0
Median	$0	$75	$210	$1,700	$2,400
Maximum	$2,000	$2,520	$3,200	$9,000	$15,000
Mode	$0	$0	$0	$0	$0
75th percentile	$75	$400	$850	$3,750	$6,000
Percent of Plans at the Mode	67%	44%	24%	22%	22%

Source: Authors' estimates based on Medicare Personal Plan Finder data, downloaded March 9, 2006.
Estimates are for local HMO, PPO, and POS plans only.

example, 7-day, 21-day, and 90-day stays) could be reported. These figures could be complemented by disaggregations into the kind and level of cost-sharing assessed, which vary across plans and are difficult for beneficiaries to compare.

A further example addresses the overall cap on out-of-pocket costs. In this case, there are fewer definitional issues, although plans sometimes exclude certain costs from their caps, such as cost-sharing for the physician-administered drugs paid under Part B. But even where an overall cap is used, this information is hard to find using Medicare's online tool. When a plan has a cap, that fact is clearly stated under "Premium and Other Important Information." But when a plan has no cap, *Medicare Options Compare* includes no statement. Thus, unless the beneficiary is comparing a plan with a cap to one without, he or she receives no guidance about any caps on out-of-pocket costs.

1b. Require plans to use a standard template when describing benefit design and cost-sharing in their marketing materials. Beneficiary counselors have told us that most beneficiaries make choices on their own, without the assistance of insurance specialists or other independent professionals, and that they typically rely on the brochures sent to them by private plans. For beneficiaries to be able to use these materials effectively, they need to be able to make side-by-side comparisons of plan benefits and cost-sharing. To facilitate that goal, CMS could require insurers to use a standard template so that a beneficiary could readily locate comparable information in the brochures of competing plans.

The U.S. Government Accountability Office (GAO) made such a recommendation when it examined the operation of the Medicare+Choice program (the predecessor to Medicare Advantage) in the late 1990s.[13] The GAO suggested that Medicare standardize the presentation of plans' marketing materials, similar to the approach used in managing the Federal Employees Health Benefits Program (FEHBP). The Office of Personnel Management allows FEHBP plan benefit packages to vary, but it requires that plan materials follow a standard format and terminology.

To set a similar requirement for MA plans, CMS would not have to start from scratch. Its marketing guidance already specifies that plans include particular elements, use standard terminology, and submit marketing materials to CMS regional offices for review. In addition, standardized forms are available, including a model Education and Outreach letter, a model Summary of Benefits form that plans may use to provide information about the plan to prospective enrollees, and a model Evidence of Coverage (EOC) document that summarizes plan benefits for those who have enrolled.[14] In fact, recognizing that these EOCs still vary quite considerably, CMS has strengthened the requirements for standardized documents in its 2009 call letter.[15] However, beneficiary advocates on our expert panel argued that information presented in current plan marketing brochures is not sufficiently standardized.

Therefore CMS could go further. If all plans were required to follow a standard template for their marketing brochures—with standard terminology, standard elements, and standard outline (that is, presented in the same order)—beneficiaries who rely on printed marketing materials would have an easier time finding the information they need and making direct plan comparisons.

1c. Develop better tools to support individual decision-making. Beneficiaries would profit from a tool that guided them through the options and gave them a bottom-line assessment of their out-of-pocket cost risk in any given plan. Ideally, such cost estimates would be highly "individualized"—based, for example, on information about a beneficiary's past health care use.

Medicare has provided an out-of-pocket cost calculator in the past, though none was available in 2006. The *Medicare Options Compare* online tool for 2007 and 2008 includes annual out-of-pocket cost estimates, for beneficiaries in 30 age and health status categories, specific to the plans available in particular market areas.

But because the cost calculator reports averages across beneficiary groups, it is necessarily an imprecise

guide for individuals, whose utilization and costs vary widely. For example, a cancer patient in the same age and health status category as a cardiac patient may have substantially different out-of-pocket costs because of differences in prescription drugs or in the relative use of physician versus inpatient hospital services. Although the 2008 version of *Medicare Options Compare* also includes some information on typical costs for beneficiaries with certain health conditions, that information is still far more general than the situation faced by any individual beneficiary.

Other weaknesses of the cost calculator are that it does not allow a beneficiary to see how the components of out-of-pocket spending vary across specific plans and it doesn't include estimated costs for the full range of services that some patients might use. A more sophisticated tool might calculate costs of services under various scenarios or project an individual's past experience into future spending.[16]

Discussion. It is hard to argue with the assertion that Medicare beneficiaries should receive better information—accurate, meaningful, and presented in standard formats—to help them evaluate their health plan choices. Similarly, proposals to give beneficiaries better tools for processing the information are unlikely to encounter much resistance.

But these steps alone are unlikely to solve the choice problem for most beneficiaries. Advanced decision aids, such as those that factor in past health care use, may be useful for sophisticated consumers of health insurance coverage but perhaps not for the majority of Medicare beneficiaries, who are not prepared to undertake the effort this approach would require.

In order to be effective, requirements for more standardized information and better decision-support tools would also require a substantial increase in the use of one-on-one beneficiary counseling. Medicare provides funds to the states so that they can offer counseling through State Health Insurance Assistance Programs, or SHIPs, but there is widespread agreement that SHIPs are "tremendously under-resourced."[17] In fact, in its 2008 report to Congress, MedPAC recommends that the SHIPs receive more funding.

Option 2: Require all MA plans to limit beneficiaries' out-of-pocket spending.

This proposal addresses one dimension of beneficiaries' information gap by requiring all plans to specify an out-of-pocket spending cap and to adopt a standard method for determining when that cap has been reached. Today, all regional PPOs must have a cap on out-of-pocket spending for in-network services (and a separate cap for services received out of network), but there is no such requirement for local MA plans. As a result, most of them—65 percent of local HMO, POS, and PPO plans in 2006—did not have a cap. Further, as noted earlier, the absence of a limit on out-of-pocket spending is not clearly shown on *Medicare Options Compare*.

Requiring plans to adopt such a cap is a relatively straightforward option that might mitigate some of the financial risk that beneficiaries enrolled in some MA plans now face. Moreover, this upper bound could provide an important piece of information to beneficiaries about differences in cost-sharing across plans.

Discussion. Like the proposal to enhance the accuracy, completeness, and comparability of the information provided to beneficiaries, there may not be much political resistance to a proposal for an out-of-pocket cost cap. In fact, Congress has already indicated its willingness to move in this direction, as evidenced by its requirements on regional PPOs. In addition, CMS has begun recommending that plans limit cost-sharing liability for Medicare Part A and Part B services. In its letter inviting bids for 2007, CMS suggested that plans limit annual out-of-pocket spending for Medicare-covered services, excluding the basic monthly premium, at $3,100 for the 2007 contract year (increased to $3,350 for 2009). Plans that did so were granted "latitude" in establishing cost-sharing amounts for individual services. Plans with out-of-pocket caps in excess of $3,100 were granted "less latitude."[18] Among local Medicare Advantage plans with an out-of-pocket cost cap in 2006, the upper bounds ranged from $200 to $10,000; roughly three-quarters of these plans had a cost cap between $1,500 and $3,500.[19]

If plans were obliged solely to have a cost cap for services received, it is likely that there would be significant variability, as happens today, in how plans define and implement this limit. To make it helpful to beneficiaries, CMS should standardize both the services included under the cap and the method by which spending toward the cap would be counted. The standard approach would also have to include a determination of whether a separate limit on out-of-network services would be allowed or whether and how those costs would be applied to the overall limit.

Option 3: Standardize benefits and cost-sharing.

A third option for improving beneficiary choice is to adopt a number of standardized benefit packages and cost-sharing regimes. Rather than allowing the current degree of flexibility—along with its variation and complexity—policymakers could restrict insurers to a set of standard features, much the way the market for Medigap (supplemental insurance) policies was standardized in 1992, as required by the Omnibus Budget Reconciliation Act of 1990. The Medigap market had been relatively unstructured until then, with no national rules, but the reforms created 10 standardized benefit packages (labeled A through J) that insurance companies could offer. All insurers seeking to sell Medigap in a state were required to offer Plan A; they could offer any or all of the other nine benefit packages as well, but they were not required to do so.[20]

The goal of the Medigap standardization was to improve beneficiaries' ability to make price comparisons across equivalent products, thereby encouraging more price competition among plans, and it is widely agreed that the reforms accomplished that goal. The standardization improved beneficiaries' understanding of their options, and it dramatically reduced consumer complaints about deceptive sales practices.[21] Beneficiaries could easily compare the benefits in the 10 standard insurance policies and choose a package of benefits best suited to their needs at a premium they could afford. In addition, because the benefits do not vary from year to year, consumers have not been faced with new policies (offering marginally different benefits) each year and the consequent need to keep reevaluating their coverage.[22]

Many of the problems that burdened the Medigap market before it was standardized are characteristic of Medicare Advantage today. Thus some experts—in a recent report, for example, by authors from two beneficiary counseling organizations—have called for a similar approach to standardizing Medicare Advantage.[23]

MA cost-sharing could be standardized in a few different ways. The Medigap market offers two variants: a fully standardized model, such as the A–J set of standard plans implemented in 1992; and a core-plus-rider approach, which is used in three states that standardized their Medigap market before 1992. Massachusetts, Minnesota, and Wisconsin received waivers from the federal law that allowed them to preserve their own approaches to standardization. The fully standardized option would necessarily produce fewer cost-sharing regimes. In a core-plus-rider approach, the array of benefit packages would potentially be much larger; even with relatively few core benefit packages and riders, beneficiaries have the flexibility to combine them in unique ways.

A number of the experts in the panels we convened thought that a core-plus-rider approach would make the most sense for the MA program. However, they each had different ideas about how many riders were necessary or desirable. Some panelists envisioned relatively few supplemental riders, all of which would expand on the core benefit package—as described in a research report prepared in 2003 for CMS.[24] Based on an analysis of plan offerings in 2001, this report described three core plans and eight supplemental riders (low- and high-option plans for each of four supplemental benefits—prescription drugs, dental services, vision services, and hearing services). The three core benefit packages included the basic Medicare A and B services, as well as a set of enhanced services that plans typically offered in 2001 (for example, worldwide emergency and urgent care, additional physical exams, and routine chiropractic care).

One of the panelists suggested that there ought to be a far greater number of riders (perhaps as many as 20), which could adjust the core benefit package in various ways. Some riders would add coverage, expanding on the core benefits, while other riders might reduce the core coverage by increasing beneficiary cost-sharing for a specific service. The beneficiary could select from among these many riders and generate an individualized insurance plan.

While some experts on the panel clearly wished to preserve as much flexibility in cost-sharing and benefit design as possible, others favored standardized packages. They are easy to understand, beneficiaries face distinct and meaningful alternatives, and the burden of choice is reduced.

Table 5 illustrates how a fully standardized approach might work, using four standardized plans. The approach, as presented here, is highly simplified, but it illustrates how the plans relate to one another in ways that can be explained to beneficiaries, with Plan 1 providing the lowest cost-sharing across all covered services and each subsequent plan offering equal or progressively higher cost-sharing.

Plan 1 adopts the most common cost-sharing for each MA benefit in 2006: $10 for a primary care office visit, $20 for a specialist visit, $0 for a mammography or for outpatient hospital services, $50 for emergency department services, and so on. Plan 2 and Plan 3 offer modest but somewhat higher cost-sharing and have higher out-of-pocket caps. Plan 4 assesses 20 percent coinsurance for most Part B services (the same as traditional Medicare), imposes higher cost-sharing for inpatient hospital services, and has the highest cap on out-of-pocket costs. (More detailed data on MA cost-sharing in 2006 are provided in Appendix A.)

These plans should be considered a starting point for discussion. Getting to a set of choices that is meaningful to beneficiaries and feasible for the

Table 5. An Option for Standardized Core Benefit Packages

	Plan 1	Plan 2	Plan 3	Plan 4
Plan OOP Max	$1,000	$2,000	$3,000	$4,500
Primary Care Office Visit	$10	$10	$15	$15
Specialist Office Visit	$20	$20	$30	$30
Mammography Services	$0	$0	$0	$0
X-ray Services	$0	$0	$15	20%
Clinical Lab Services	$0	$0	$15	20%
Radiation Therapy	$0	$0	$15	20%
Outpatient Hospital Services	$0	$50	$100	20%
Ambulatory Surgical Center Services	$0	$50	$100	20%
Home Health Services	$0	$0	$0	$0
Emergency Department Services	$50	$50	$50	20% (up to $50)
Inpatient Hospital OOP Max	—	—	—	$1,500
Inpatient Hospital Copay per Stay	$0	$250	$750	—
Inpatient Hospital Daily Copays	—	—	—	$300
Skilled Nursing Facility Services OOP Max	$0	—	—	—
SNF Copay per Stay	—	—	—	—
SNF Daily Copays	— —	$50/day, days 21–100	$75/day, days 21–100	$100/day, days 21–100

Notes: OOP = out of pocket; "—" means the plan has no parameter in that category.
Source: Authors' examples based loosely on 2006 MA plan offerings.

industry would require a more detailed analysis of variation in benefit designs and cost-sharing within and across markets, an actuarial analysis of premiums, and a better understanding of the alternatives that beneficiaries want. In addition, a concrete proposal for a fully standardized model would need to consider how to handle prescription drugs and supplemental benefits (for example, vision, dental, hearing).[25]

Discussion. A strong case can be made that doing something to limit variation and complexity in private plan offerings would help beneficiaries make more meaningful price comparisons of competing plans. Plans will continue to vary across other dimensions that matter to beneficiaries, including whether they will be able to maintain relationships with current providers, and the number, quality, mix, and convenience of providers in a plan's network. But standardized cost-sharing will greatly simplify the task of evaluating the competing plans and could be supplemented with better measures of plan networks and the quality of participating providers—or at least better ways to present these dimensions to beneficiaries.

But proposals to limit plans' flexibility in designing their benefit packages would be opposed by arguments that standardization stifles innovation—that it would prevent plans from adopting new cost-sharing approaches designed to steer beneficiaries toward more cost-effective providers, for example. A second criticism is that standardization might raise costs and thus have the effect of eroding access to private plans for Medicare beneficiaries with modest incomes. Some argue as well that standardization would exacerbate geographic inequities in MA offerings nationwide. The benefit of clearer and better-defined choices, however, would be that competition could be focused on dimensions that matter most to beneficiaries.

One challenge is that the standardized scheme would need to be updated over time. Thus any proposal for standardizing benefits would need to include a mechanism for ensuring that the available benefit packages respond to the needs of current and future enrollees. A proposal would need to specify, for example, how often or under what circumstances the system should be updated and what entity would be responsible for doing that. It may even make sense to avoid locking specific cost-sharing parameters into law or CMS regulations; that way, they could be more easily updated from year to year.

Some members of our panel expressed concern that the biggest problems faced by enrollees stem not from relatively small variations in cost-sharing but rather from the practices that plans adopt to manage service use. Beneficiaries choosing a standardized benefit package may still experience variations in cost and access from other aspects of plan operation—especially plans' approaches to utilization management, prior authorization rules, and other review requirements that must be met before paying for services. What is needed, these experts argued, is not standardized cost-sharing but the increased federal oversight and enforcement of rules that govern plans' day-to-day practices.

Conclusion

The complexity and variability of the benefits offered by Medicare Advantage plans give beneficiaries many options to find plans that best suit their needs, but also create a significant problem. The array of options is bewildering, with a multiplicity of benefit packages and a large number of competing plans. Making a choice may more closely resemble a "roll of the dice" than an informed choice among competing alternatives.[26]

Rather than leaving beneficiaries to grapple with dozens of Medicare Advantage plans that vary widely, the number of cost-sharing regimes could be restricted, thereby providing limited and more meaningful variation that consumers nationwide could more readily understand. By constraining variation in cost-sharing and benefit design, standardization would make it easier for beneficiaries to focus on other important aspects of plans, such as measures of quality of care, differences in plan networks, and customer service. Moreover, better-informed beneficiaries could improve operation of the market principles that are fundamental to the Medicare Advantage vision.

Nevertheless, because there are legitimate concerns about comprehensive regulatory constraints on private plans, a more realistic path might be to pursue incremental improvements—to standardize cost-sharing only for certain benefits that have been problematic. This more modest approach has been suggested before. The authors of a 1999 paper on Medicare standardization argued in favor of it, suggesting that the process might start with the method used by HMOs to calculate when a benefit limit has been reached.[27]

Today, CMS has considerable regulatory authority to push plans toward increased standardization, should it choose to do so. For example, because the agency is empowered to negotiate with plans during the bidding process, many observers have suggested that it impose stricter limits with regard to cost-sharing and benefit design. But although CMS has made insurers aware in recent years of its concerns that some plans have inappropriately imposed high cost-sharing on nondiscretionary services—such as radiation, chemotherapy, and Part B drugs—the agency has so far imposed few specific requirements.

Whether reforms are pursued by CMS's exercising of its regulatory authority or in the legislative arena by Congress, greater standardization of MA plans would help assure that consumers know what they are buying when they enroll. It would allow them to make more meaningful price comparisons across competing insurers—something that is virtually impossible in today's Medicare Advantage marketplace.

Appendix A.

To help assess the feasibility of standardizing Medicare Advantage benefit designs, we analyzed data on how MA plans currently structure cost-sharing for selected Medicare-covered services. Specifically, we obtained data from the Medicare Personal Plan Finder for a subset of core Medicare-covered services, and for most MA plans, in 2006. We examined cost-sharing structures (e.g., copayments, coinsurance) used by plans and the levels of cost-sharing assessed to get a sense of whether plans are standardized across the nation and within selected markets.[28]

We analyzed in-network cost-sharing for all of the local HMOs, PPOs, and HMO plans with point-of-service options, as listed in the Plan Finder on March 9, 2006. These included 1,122 local HMOs, 93 local HMO point-of-service plans, and 337 local PPOs, together representing 82 percent of MA offerings.[29] SNPs were excluded from the analysis, as were PFFS plans, regional PPOs, cost plans, provider-sponsored organizations, and a few other plan types.

Table A-1 shows that plans largely used copayments for most services, though coinsurance was not uncommon for some services. Plans usually charged a fixed amount for all services within a benefit category, but some plans charged differential amounts (a range of copayment or coinsurance amounts, e.g., a copayment for outpatient hospital services of "$0 to $125" or "$25 to $75" or coinsurance of "0% to 20%" or "10% to 20%"). These ranges were based on the specific service received—a lower amount for a standard X-ray, for example, and a higher amount for an MRI—or sometimes the amounts differed as a function of where the beneficiary received the service. That is, some plans used tiered networks, collecting different cost-sharing amounts for different in-network providers.

Table A-2 shows how plans structured cost-sharing for hospital and skilled nursing facility services in 2006. For inpatient hospital services, roughly half of the plans used daily copayments and half used a flat copayment per stay. For SNF services, roughly three-quarters used daily copayments and about a quarter used a flat copayment for a stay of between 1 and 100 days.

Table A-3 consolidates the information and identifies the most common cost-sharing arrangements in Medicare Advantage plans for various one-time services, such as doctor's office visits and mammography services.

Table A-1. Structure of Cost-Sharing, Selected Services, 2006

Benefit	How Plans Structure Cost-Sharing			
	Copayment	Coinsurance	Range of Copayments	Range of Coinsurance
Primary Care Office Visit	90%	2%	7%	0%
Specialist Office Visit	96%	3%	1%	0%
Mammography Services	93%	2%	5%	0%
X-ray Services	44%	7%	38%	11%
Clinical Lab Services	66%	5%	24%	5%
Radiation Therapy	65%	22%	12%	1%
Outpatient Hospital Services	60%	17%	22%	1%
Ambulatory Surgical Center Services	78%	16%	6%	1%
Home Health Services	91%	2%	7%	0%
Emergency Department Services	92%	4%	3%	0%

Note: Data are for 1,552 local HMO, POS, and PPO plans.
Source: Authors' estimates based on 2006 Medicare Personal Plan Finder data, downloaded March 9, 2006.

Table A-2. Cost-Sharing, Inpatient Hospital and Skilled Nursing Facility Services, 2006

Benefit	How Plans Structure Cost-Sharing			
	Copayment per Stay	Copayment per Day of Care	Coinsurance	Deductible*
Inpatient Hospital Services	41%	53%	3%	3%
Skilled Nursing Facility Services	23%	74%**	4%***	0%****

* A deductible of $912 or $956 was assessed, and these plans also collected daily copayments ($228 or $239) for days 61 to 90. Many of these plans covered an unlimited number of days, others used the standard 90-day max, and some covered 150 days.
** Includes seven plans that had upfront copays for the stay plus additional daily copays for later days (e.g., $50 + $50 for days 35 to 100).
*** Includes 49 plans, 42 with fixed coinsurance and 7 that used tiered coinsurance (e.g., 10% coinsurance for days 1 to 10 and 40% coinsurance for days 21 to 100, or 0% for days 1 to 10 and 25% for days 11 to 100).
**** Five plans had a deductible for SNF services.
Source: Authors' estimates based on Medicare Personal Plan Finder data, downloaded March 9, 2006.

Table A-3. Most Common Cost-Sharing in Medicare Advantage Plans, Selected Services, 2006

Benefit	Mode	Percent of Plans	2nd Most Common	Percent of Plans	3rd Most Common	Percent of Plans	4th Most Common	Percent of Plans	5th Most Common	Percent of Plans
Plan OOP Max	None	65%	$3,000	5%	$2,000	4%	$1,500	3%	$2,500	3%
Primary Care Office Visit	$10	31%	$0	26%	$15	15%	$5	10%	Copayment Range	7%
Specialist Office Visit	$20	22%	$0	14%	$30	13%	$25	12%	$15	12%
Mammography Services	$0	90%	Copayment Range	5%	20% Coinsurance	1.6%	$10	0.8%	$20	0.7%
X-ray Services	Copayment Range	38%	$0	32%	$15	5%	20%	3%	$20, 10%	2.6%
Clinical Lab Services	$0	49%	Copayment Range	24%	Coinsurance Range	4.5%	$10	4%	$20	3%
Radiation Therapy	$0	35%	20% Coinsurance	15%	Copayment Range	12%	$25	6%	$20	7%
Outpatient Hospital Services	Copayment Range	22%	$0	21%	$100	13%	$50	10%	20% Coinsurance	10%
Ambulatory Surgical Center Services	$0	23%	$100	16%	$50	13%	20% Coinsurance	8%	$200	5%
Home Health Services	$0	76%	$10	9%	Copayment Range	7%	$20	5%	20% Coinsurance	1.3%
Emergency Department Services	$50	82%	20%	4%	$0	3.5%	$25	3.4%	Copayment Range	3.2%

Note: OOP = out of pocket.
Source: Authors' estimates based on Medicare Personal Plan Finder data, downloaded March 9, 2006.

Appendix B. Expert Panels Members

(with affiliations at the time of the panel meetings)

Expert Panel, December 2005

John Bertko
Vice President and Chief Actuary
Humana

Bonnie Burns
Training and Policy Specialist
California Health Advocates

Bryan Dowd
Professor
University of Minnesota School of Public Health

Joyce Dubow
Senior Policy Advisor
AARP

Jorge Gomez
Insurance Commissioner, Wisconsin

Bob Hurley
Associate Professor
Department of Health Administration
Medical College of Virginia

Marilyn Moon
Vice President and Director of the Health Program
American Institutes for Research

Mary Beth Senkewicz
Senior Counsel for Health Policy
National Association of Insurance Commissioners

George Strumpf
Director, Federal Relations
HIP Health Plans

Expert Panel, September 2006

Bonnie Burns
Training and Policy Specialist
California Health Advocates

Chris DeYoung
Community Outreach Coordinator
Iona Senior Services
Washington, D.C.

Lisa Federico
Coordinator
GeorgiaCares
Atlanta Regional Commission Area Agency on Aging

Ellen Frazier
Elder Information Specialist
East Providence (Rhode Island) Senior Center

Bill Lardy
Director
Senior Health Insurance Counseling
North Dakota Insurance Department

Vicki Mikels
Director
GeorgiaCares
Georgia Division of Aging Services

Beverly Roberts
Director of Mainstreaming Medical Care
The Arc of New Jersey

Stephanie Sue Stein
Director
Milwaukee County Department on Aging

Notes

[1] K. E. Thorpe and A. Atherly, "Medicare+Choice: Current Role and Near-Term Prospects," *Health Affairs* Web Exclusive (July 17, 2002):w242–252, http://content.healthaffairs.org/cgi/content/full/hlthaff.w2.242v1/DC1.

[2] Henry J. Kaiser Family Foundation, "Medicare Advantage Fact Sheet" (Washington, D.C.: Kaiser, June 2007), http://kff.org/medicare/upload/2052-10.pdf.

[3] J. H. Hibbard, P. Slovic, E. Peters et al., *Older Consumers' Skill in Using Comparative Data to Inform Health Plan Choice: A Preliminary Assessment* (Washington, D.C.: AARP Public Policy Institute, 2000).

[4] M. Sing, B. Stevens, A. Cook et al., *Educating New Members of Medicare+Choice Plans About Their Health Insurance Options: Does the National Medicare Education Program Make a Difference?* (Baltimore, Md.: Centers for Medicare and Medicaid Services, July 2001).

[5] J. Hibbard, J. Greene, and M. Tusler, *An Assessment of Beneficiary Knowledge of Medicare Coverage Options and the Prescription Drug Benefit* (Washington, D.C.: AARP Public Policy Institute, May 2006).

[6] M. Gold, L. Achman, and R. Brown, "The Salience of Choice for Medicare Beneficiaries," *Managed Care Quarterly,* Winter 2003 11(1):24–33.

[7] Medicare Payment Advisory Commission, *Report to the Congress: Increasing the Value of Medicare* (Washington, D.C.: MedPAC, June 2006), p. 207.

[8] Medicare Payment Advisory Commission, *Report to the Congress: Benefit Design and Cost-Sharing in Medicare Advantage Plans* (Washington, D.C.: MedPAC, Dec. 2004), p. 19.

[9] Medicare Payment Advisory Commission, Transcript of public meeting, Sept. 9, 2004 (Washington, D.C.: MedPAC), p. 16, http://www.medpac.gov/transcripts/0904_allcombined_transc.pdf.

[10] B. Biles, L. H. Nicholas, and S. Guterman, *Medicare Beneficiary Out-of-Pocket Costs: Are Medicare Advantage Plans a Better Deal?* (New York: The Commonwealth Fund, May 2006). Another report highlighted ways in which plans have used their flexibility to lower out-of-pocket spending for those in good health while raising costs for those with serious or chronic illness: M. Gold, M. C. Hudson, and S. Davis. *2006 Medicare Advantage Benefits and Premiums* (Washington, D.C.: AARP Public Policy Institute, 2006).

[11] M. Merlis, *The Value of Extra Benefits Offered by Medicare Advantage Plans in 2006* (Washington, D.C.: Henry J. Kaiser Family Foundation, Jan. 2008).

[12] CFR Title 42: Public Health PART 422—MEDICARE ADVANTAGE PROGRAM Subpart C—Benefits and Beneficiary Protections §422.113 Special rules for ambulance services, emergency and urgently needed services, and maintenance and post-stabilization care services; and §422.100 (g) Benefits affecting screening mammography, influenza vaccine, and pneumococcal vaccine. 1) Enrollees in MA organizations may directly access (through self-referral) screening mammography and influenza vaccination. 2) MA organizations may not impose cost-sharing for influenza and pneumococcal vaccination on their MA plan enrollees.

[13] U.S. General Accounting Office, *Medicare+Choice: New Standards Could Improve Accuracy and Usefulness of Plan Literature* (Washington, D.C.: GAO, Apr. 1999), http://www.gao.gov/archive/1999/he99092.pdf.

[14] See the Centers for Medicare and Medicaid Services marketing guidelines and model documents on the CMS Web site: http://www.cms.hhs.gov/ManagedCareMarketing/01_Overview.asp#TopOfPage.

[15] See the Draft Standardized Annual Notice of Change and Evidence of Coverage (ANOC/EOC) document included as Attachment J of the 2009 call letter on the CMS Web site at: http://www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/CallLetter.pdf.

[16] MedPAC, *Benefit Design and Cost-Sharing,* Dec. 2004.

[17] Health Assistance Partnership, *State Health Insurance Assistance Programs: A Critical Resource for Medicare Beneficiaries* (Washington, D.C.: Families USA, Health Assistance Partnership, May 2006).

[18] Centers for Medicare and Medicaid Services, "Contract Year 2007 Instructions for Medicare Advantage (MA) and Medicare Advantage Prescription Drug (MA-PDP) Plans," Apr. 4, 2006, p. 35, http://www.cms.hhs.gov/HealthPlansGenInfo/Downloads/REV%20MA-MAPD%20Call%20Letter%20Final.pdf.

[19] Authors' analysis of cost caps in local HMOs, PPOs, and POS plans, based on Medicare Personal Plan Finder data downloaded March 6, 2006.

[20] Some additional standardized plans have since been added to the original set of 10.

[21] P. Fox, R. Snyder, G. Dallek et al., "Should Medicare HMO Benefits Be Standardized?" *Health Affairs,* July/Aug. 1999 18(4):40–52. See p. 42 and footnote 4.

[22] B. Burns, Testimony before the National Association of Insurance Commissioners Medicare Supplement Working Group, Senior Issues Task Force, public hearing on Medigap standardized plans, NAIC Winter National Meeting, Boston, Mass., Dec. 3, 2000.

[23] P. Precht, D. Lipschutz, and B. Burns, *Informed Choice: The Case for Standardizing and Simplifying Medicare Private Health Plans* (Sacramento, Calif.: California Health Advocates and Medicare Rights Center, Sept. 2007.

A similar policy proposal is also raised by Biles, Nicholas, and Guterman, *Are Medicare Advantage Plans a Better Deal?* 2006.

[24] M. Laschober, *Modeling Medicare+Choice Standardized Benefits Packages in Local Markets* (Baltimore, Md.: Centers for Medicare and Medicaid Services, Sept. 2003).

[25] The issues that would arise in standardizing Part D are considered in a companion issue brief. See J. Hoadley, "Medicare Part D: Simplifying the Program and Improving the Value of Information for Beneficiaries" (New York: The Commonwealth Fund, forthcoming).

[26] G. Dallek and C. Edwards, *Restoring Choice to Medicare+Choice: The Importance of Standardizing Health Plan Benefit Packages* (New York: The Commonwealth Fund, Oct. 2001).

[27] Fox, Snyder, Dallek et al., "Should Medicare HMO," 1999.

[28] Although not reported here, we analyzed plan offerings in Milwaukee County, Wisc.; Pinellas County, Fla.; Sacramento County, Calif.; Los Angeles County, Calif.; Providence County, R.I.; and Bronx County, N.Y.

[29] Medicare Advantage enrollment in 2006, as in prior years, was concentrated in local HMOs and PPOs, roughly in proportion to offerings. The large majority of MA enrollees (5.3 million out of 6.8 million) were enrolled in local HMOs (including POS plans); and about 267,000 Medicare beneficiaries were enrolled in local PPOs. Reported in S. Peterson and M. Gold, *Tracking Medicare Health and Prescription Drug Plans, Monthly Report for April 2006, Addendum* (Washington, D.C.: Henry J. Kaiser Family Foundation, 2006), http://www.kff.org/medicare/upload/medicaretrackin0406addendum.pdf.

ABOUT THIS STUDY

This issue brief and the companion Commonwealth Fund brief, "Medicare Part D: Simplifying the Program and Improving the Value of Information for Beneficiaries" (forthcoming), draw on the comments provided by two groups of experts.

The first panel, which we convened in December 2005, included professionals from health plans and beneficiary organizations as well as highly regarded scholars in the health policy field. We convened a second panel, in September 2006, made up of beneficiary counselors from state health insurance assistance programs (SHIPs) and private organizations involved in counseling beneficiaries. Each set of panelists discussed, over the course of a day, broad issues regarding standardization of Medicare Advantage and Medicare Part D benefits, and they were given the opportunity to comment on the draft briefs as well.

This paper has benefited greatly from the input of both groups of panelists. Our discussion here includes many of the observations made by the experts we convened, but it does not reflect a consensus. Although the panel members agreed on some points, they held diverse views on whether standardization was desirable.

About the Authors

Ellen O'Brien, Ph.D., was a research associate professor in the Health Policy Institute at Georgetown University when this paper was written. Currently, she is with the Public Policy Institute at AARP where her research focuses on health care policy and the economic security of the elderly in retirement. Dr. O'Brien received her M.A. in economics at the University of Iowa and her Ph.D. in economics at the University of Notre Dame.

Jack Hoadley, Ph.D., is a research professor in the Health Policy Institute at Georgetown University, where he leads research projects on Medicare, Medicaid, and other health financing topics (with a particular focus on prescription-drug issues). Recent projects have included studies of: the use of formularies by Medicare drug plans; approaches used by Medicare beneficiaries to make choices relating to the Medicare drug benefit; the use of evidence-based medicine to manage pharmacy costs for Medicaid; and the effects of recent changes to Florida's Medicaid program. Dr. Hoadley received his M.A. and Ph.D. in political science from the University of North Carolina at Chapel Hill.

Acknowledgments

The authors appreciate the support of The Commonwealth Fund for this issue brief. They also acknowledge Elizabeth Eaton and Harriet Komisar for their contributions and Carlos Zarabozo for his helpful advice and comments.

The mission of The Commonwealth Fund is to promote a high performance health care system. The Fund carries out this mandate by supporting independent research on health care issues and making grants to improve health care practice and policy. The views presented here are those of the authors and not necessarily those of The Commonwealth Fund or its directors, officers, or staff.