
# ARE THE 2004 PAYMENT INCREASES HELPING TO STEM MEDICARE ADVANTAGE'S BENEFIT EROSION?

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**ABSTRACT:** To expand the role of private managed care plans in Medicare, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) provided Medicare Advantage plans with significant increases in monthly payment rates, beginning March 2004. About one-half of the payment increases were used by plans to reduce enrollee premiums and cost-sharing and enhance benefits; providers received most of the rest. Premiums had already begun to decrease in the Medicare Advantage program in early 2004 for the first time in several years, but the payment increases led to further declines—average monthly premiums dropped from $34 to $25 after the increases. The payment rate increases also slowed the trend toward generic-only drug coverage. Overall, average out-of-pocket costs declined to 2003 levels, although managed care enrollees in good health experienced a higher percentage reduction in out-of-pocket spending than those in poor health.

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## ABOUT THE AUTHORS

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# ARE THE 2004 PAYMENT INCREASES HELPING TO STEM MEDICARE ADVANTAGE'S BENEFIT EROSION?

## OVERVIEW

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) made significant changes to expand the role of private managed care plans in Medicare. MMA increased payments to these plans—formerly known as Medicare+Choice, now called Medicare Advantage (MA)—substantially, as of March 2004. In 2006, other changes will include the addition of regional preferred provider organizations (PPOs) and a new method of paying plans to include a component based on competitive bidding. This issue brief examines trends in MA benefits and premiums in 2004, paying particular attention to the impact of the payment increases. On average, these payments rose 10.9 percent (weighted by plan enrollment) over 2003 levels and 7.4 percent over the originally slated 2004 payment schedule.[1] Highlights of the findings include:

- Overall, about one-half of the 2004 MMA increase was used by plans to reduce enrollee premiums and other cost sharing or to enhance benefits.[2] Most of those benefit changes were used to reduce plan premiums, which dropped an average of $9 per month.
- Average out-of-pocket costs declined to the 2003 level. Although all managed care enrollees received the same dollar benefit, healthier managed care enrollees experienced a higher percentage reduction in out-of-pocket spending than did those in poor health.
- The portion of plans offering prescription drug coverage remained about the same. However, among those plans that offer drug coverage, a higher proportion now cover brand name drugs, as opposed to only generics.
- Coinsurance for physician services was reduced slightly; the share of plans with any cost-sharing for hospital services remained about the same.
- The availability of coverage for services not covered by Medicare—dental, vision, hearing—increased slightly.

## BACKGROUND

With support from The Commonwealth Fund, Mathematica Policy Research (MPR) has been tracking trends in Medicare Advantage's benefits and premiums since the program's inception in 1998.[3] During this period, MPR has documented a downslide—a steady increase in enrollees' premiums and decline in benefits, particularly for enrollees in poor health. Many health plans increased cost-sharing for Medicare services and offered fewer

additional benefits for uncovered items, such as prescription drugs. These and other cost-saving actions were made in response to changes in the Balanced Budget Act of 1997 and resulted in lower payment increases and greater pressure by providers to raise their payments.[4]

In 2003, MMA aimed to increase the role of private plans and to stabilize the market by providing additional payments to plans in the two years between its enactment and the implementation of other changes slated for 2006, like the drug benefit and addition of regional plans.[5] Prior to MMA, plans received the highest of the following four monthly county rates for enrollees served by the plan:

- a floor, or minimum level payment, of $535 per enrollee for rural counties
- a floor of $592 per enrollee for urban counties
- a minimum update of 2 percent over the county's previous year rate
- a blend rate combining increases in spending for the county and nation as a whole, to be considered only if it were budget neutral, which applied in 2000 alone, and not 2001 to 2004.

These older rates were used in January and February 2004, before the MMA changes went into effect.

Effective March 2004, MMA authorized a fifth method of payment: 100 percent of the average county costs in traditional fee-for-service (FFS) Medicare. It changed the method for calculating the minimum update, effectively increasing it from 2 percent to the national Medicare growth rate percentage of 6.3 percent in 2004. This update applied to all counties (including floor counties) and meant that plans were guaranteed at least a 6.3 percent increase relative to 2003, regardless of category. Finally, the MMA eliminated the budget neutrality requirement on the blended rate update. On average, the largest percentage increases went to plans serving enrollees in the newly established category of 100 percent of FFS rate (Table 1). Forty-one percent of enrollees fell in this category, with an average increase of 15.3 percent over 2003 rates. All counties, regardless of type, benefited from the MMA payment increases.[6]

The Congressional Budget Office estimated the total cost of the additional payments at $0.5 billion in 2004.[7] The Medicare Payment Advisory Commission estimated that the increases raised average plan payments from 103 percent to 107 percent of estimated costs for similar beneficiaries in traditional FFS Medicare.[8] The amount of the

additional payments varied by county and the rate category into which the county fell. For this reason, we also evaluate how enrollees in different types of counties fared.

By statute, MA plans were required to use the additional payments to: 1) reduce enrollee premiums or cost-sharing; 2) enhance benefits; 3) stabilize provider networks; or 4) maintain a stabilization fund to offset future premium increases or benefit cuts, though such funds had to be used by 2005. According to the Centers for Medicare and Medicaid Services (CMS), about one-half the funds made available to plans went directly to beneficiaries as reduced premiums, lowered cost-sharing, or enhanced benefits (Figure 1). The remaining money was used largely to enhance provider payments (42%).[9]

This analysis of plan benefits and premiums relies on a database developed by MPR using information from Medicare Health Care Compare, a database of plan benefit packages maintained by CMS.[10] (See appendix for more information.)

## OVERALL TRENDS IN MEDICARE ADVANTAGE PREMIUMS AND BENEFITS

### Premiums

From 1999 to 2003, the average monthly premium for enrollees in Medicare managed care plans increased almost fivefold, from $6 in 1999 to over $37 in 2003 (Figure 2). However, in early 2004, prior to implementation of the MMA, the trend in premiums began to reverse itself. Monthly premiums in January to February of 2004 averaged $34. Although this is considerably higher than historic levels, it marked the first ever decline in average MA premiums. When the payment increases mandated by MMA went into effect in March 2004, monthly premiums declined by an additional $9. As a result, more enrollees were in zero-premium plans—packages that require no premium beyond the Part B premium (Table 2). In January and February 2004, 46 percent of enrollees were in packages with a zero premium. This represents an increase over 2003 but is still far below the program's 1999 peak, when nearly 80 percent of enrollees were in zero-premium plans. After the March 2004 payment rate increases, the percentage of enrollees in zero-premium plans increased to 56 percent. The share of enrollees with a monthly premium greater than $50 decreased.

### Prescription Drug Coverage

In 2002, Medicare managed plans began cutting drug benefits by shifting toward generic-only prescription drug coverage (Figure 3). This trend continued through the beginning of 2004. In January 2004, overall levels of drug coverage remained stable relative to 2003, with about 69 percent of MA enrollees provided with some drug coverage in their basic

plans. However, in terms of brand-name drugs, coverage declined over the same period. In 2003, 41 percent of MA enrollees had some brand-name coverage; by January 2004, the number had fallen to 25 percent.

The MMA payment increases reversed the trend toward generic-only coverage to some extent. While very few enrollees who lacked drug coverage before March 2004 gained it after the payment increases, there was a significant shift toward covering brand-name drugs. Brand-name drug coverage increased from 25 percent to 33 percent, but coverage remains limited. In March 2004, more than one-half of enrollees with brand-name drug coverage (57%) had an annual limit of $1,000 or less (Table 3). The percentage of enrollees with more than $2,000 in annual brand-name drug coverage increased from 14 percent in January 2004 to 25 percent in March. There was little change in prescription drug copayments among plans that cover only generic drugs. Among plans that cover brand-name drugs and generics, there was a small reduction in copayments.

**Copayments for Medical and Hospital Services**

Prior to the payment increases in 2004, private Medicare plans attempted to constrain monthly premium increases by raising cost-sharing requirements on medical and hospital services. Many plans used the MMA payment increases to reverse this trend by reducing the physician visit copayments. The percentage of enrollees with a primary care physician copayment of more than $15 was cut in half from 22 percent in January–February 2004 to 11 percent in March 2004 (Table 4). There was a similar trend in specialist visit copayments. By March 2004, average copayments for primary care and specialist visits were below those in 2003.

Very few plans, however, used their additional funding to eliminate cost-sharing requirements for more intensive services, such as hospital, X-ray, or laboratory services.

**Supplemental Benefits**

One attractive aspect of MA plans has been the inclusion of benefits not covered under traditional FFS Medicare, such as prescription drugs and dental, vision, and hearing care. However, coverage of these supplemental benefits has declined over time as health plans tightened their packages. The increased payments from the MMA reversed this trend. By March 2004, more enrollees had coverage of dental, vision, hearing, and podiatry services compared with 2003 (Table 5). The only exception to the this trend of supplemental benefits is chiropractic services: slightly fewer enrollees had chiropractic benefits in 2004 than did in 2003. Hearing benefits received the largest coverage increase, rising from 54 percent of enrollees in January 2004 to 62 percent in March 2004.

### Overall Impact of Changes on Out-of-Pocket Spending

On average, the changes made in response to MMA reduced overall enrollee out-of-pocket spending to about the same level as 2003 (Figure 4). Compared with estimated levels in January–February 2004, average annual out-of-pocket costs declined 8 percent in March 2004, from $2,119 to $1,942. The reduction puts out-of-pocket costs levels roughly on par with 2003 levels ($1,964), but still much higher than the 1999 level of $976.

Reduction in premiums created the biggest change in beneficiaries' out-of-pocket costs. Annual out-of-pocket spending for MA premiums declined 33 percent from January 2004 to March 2004 (Table 6). Healthier managed care enrollees—who are less likely to use services and incur associated point-of-service charges than are sicker enrollees—benefited the most in terms of cost reduction. These beneficiaries experienced a nearly 10 percent drop in out-of-pocket spending. While enrollees in poor health received a similar reduction in terms of absolute dollars, they only saw a 5 percent reduction in out-of-pocket costs. As of March 2004, estimated out-of-pocket spending for enrollees in poor health was 3.7 times that of their healthier counterparts.

## VARIATION IN EFFECTS BY RATE CATEGORY

Health plans in counties receiving the new 100-percent-of-average-FFS-costs rate received the largest payment increases from the MMA, followed by the few health plans that were in blended-rate counties. Not surprisingly, these high-payment update counties also experienced the largest premium reductions. Monthly premiums in health plans in the 100-percent-of-FFS counties declined by nearly $15, to $19 in March 2004 (Table 7). Even prior to MMA, premiums in these counties had started to fall, declining $7 from 2003 levels to $33 per month in January 2004. Blended-rate counties experienced similar trends, with average monthly premiums declining from $81 in 2003 to $78 in January 2004, and to $64 in March 2004. While all types of counties saw declines in average premiums, the other three rate categories experienced smaller decreases, generally around $4 to $5 after the payment increases became effective.

MA enrollees in 100-percent-FFS counties also benefited the most from enhancements in prescription drug coverage (Table 8). In 2004, the percentage of enrollees in 100-percent-of-FFS counties with no drug coverage declined from 34 percent in January–February 2004 to 29 percent by March. During the same period, brand-name prescription drug coverage nearly doubled. However, benefit levels in counties paid at 100 percent of FFS remain below levels in counties where payment rates are above FFS spending levels.

## CONCLUSION

By authorizing the payment increases to MA plans, Congress intended to stabilize, and potentially reinvigorate, the Medicare managed care program before the full implementation of the prescription drug benefit and regional PPO system in 2006. Plans were required to use the additional funds to enhance benefits, to enhance access through higher provider payments, or to put into a fund for later use.

There is insufficient information to determine the impact that the additional payments made on providers—a group that received 42 percent of the increased payments. But Congress and CMS hoped that increases in provider payments would help plans stabilize their networks and improve access for beneficiaries.

The impact on plans and beneficiaries is more clear. This analysis shows that many plans reduced premiums and physician office copayments, and, to a limited extent, improved drug and other supplemental benefit coverage. These changes—particularly premium reductions—provide gains for all enrollees, as opposed to targeted changes that benefit enrollees in poorer health who use more health care services. Because plans had to act quickly, it is possible that organizations made the changes that were easiest to execute.[11]

MA enrollees in the newly established, 100-percent-of-FFS-costs counties comprise the largest contingent of current program enrollment (41%). Enrollees in these counties benefited the most from the MMA changes, with slightly less than 900,000 enrollees seeing a reduction in monthly premiums, nearly 625,000 getting some enhancement to their prescription drug coverage, and about 400,000 experiencing a reduction in primary care physician copayments (Table 9).

It is too early to gauge whether the payment changes are enough to reverse the downslide in private plans' participation in the MA program and beneficiaries' enrollment in these plans in the long term. CMS reports of enrollment and pending applications do show some impact. MA beneficiary enrollment increased by 90,000 from January to October 2004, and the agency reports 31 pending applications for new MA plans and an additional 21 pending applications for service area expansions.[12] However, despite these recent events, the share of Medicare beneficiaries in private plans still remains relatively low (12.7 percent as of October 2004), when compared with the entire Medicare population.

## TABLES AND FIGURES

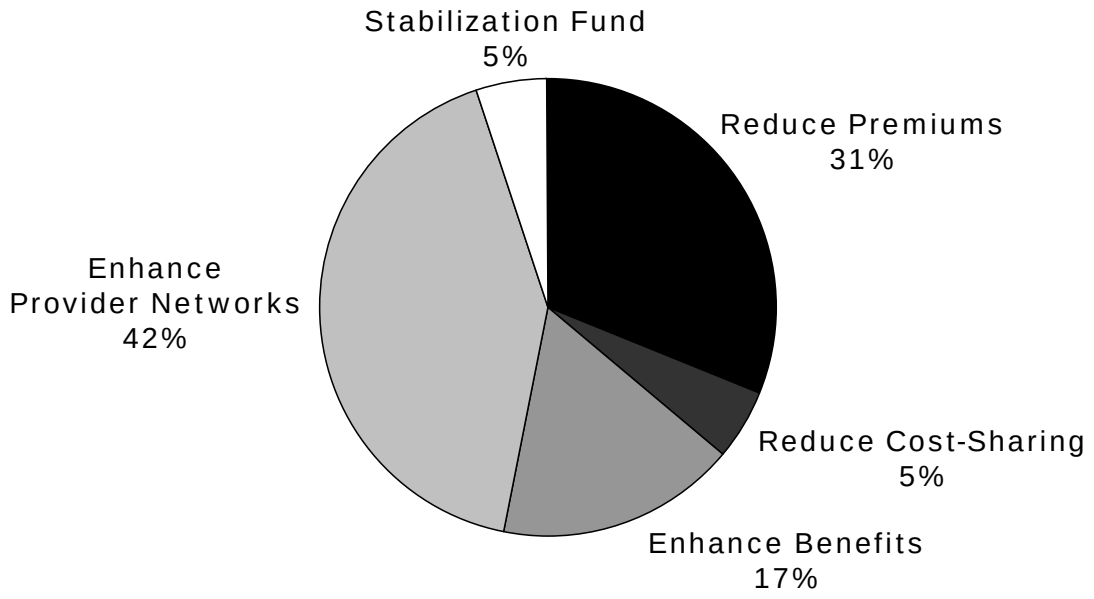
Table 1. MMA Payment Rate Increases by Payment Rate Category

| Rate Category | Percent of MA Enrollees | Average 2003 Payment | Average Jan–Feb 2004 Payment | Average Mar–Dec 2004 Payment | Total Payment Increase (%) 2003 to Mar–Dec 2004 |
|---|---|---|---|---|---|
| Overall | 100.0% | $620 | $640 | $689 | 10.9% |
| Rural Floor | 4.1% | $500 | $525 | $544 | 8.8% |
| Urban Floor | 26.0% | $564 | $592 | $614 | 8.9% |
| Minimum Update | 21.8% | $717 | $733 | $763 | 6.3% |
| 100% FFS | 40.7% | $619 | $636 | $713 | 15.3% |
| Blended Update | 7.3% | $608 | $624 | $667 | 9.8% |

Notes: Information excludes counties in Guam and the Virgin Islands, but includes Puerto Rico. All data were weighted by the number of MA enrollees in a county in September 2003. Data presented includes only demographic payment rates, which account for 70 percent of total plan payments in 2004.

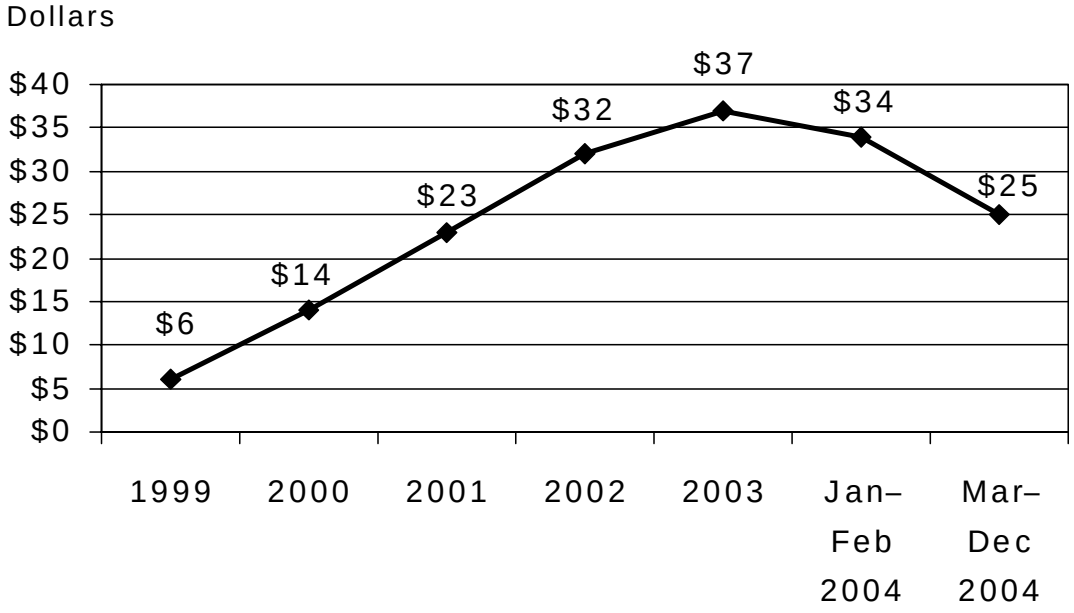
Source: Achman and Gold, February 2004.

Figure 1. MA Health Plans Use of Increased Payments from the MMA




Source: "Review Shows Beneficiaries in Medicare Advantage Plans Will See Better Benefits, Lower Costs," Centers for Medicare & Medicaid Services, February 27, 2004.

## Figure 2. Average Medicare Advantage Premiums, 1999–2004



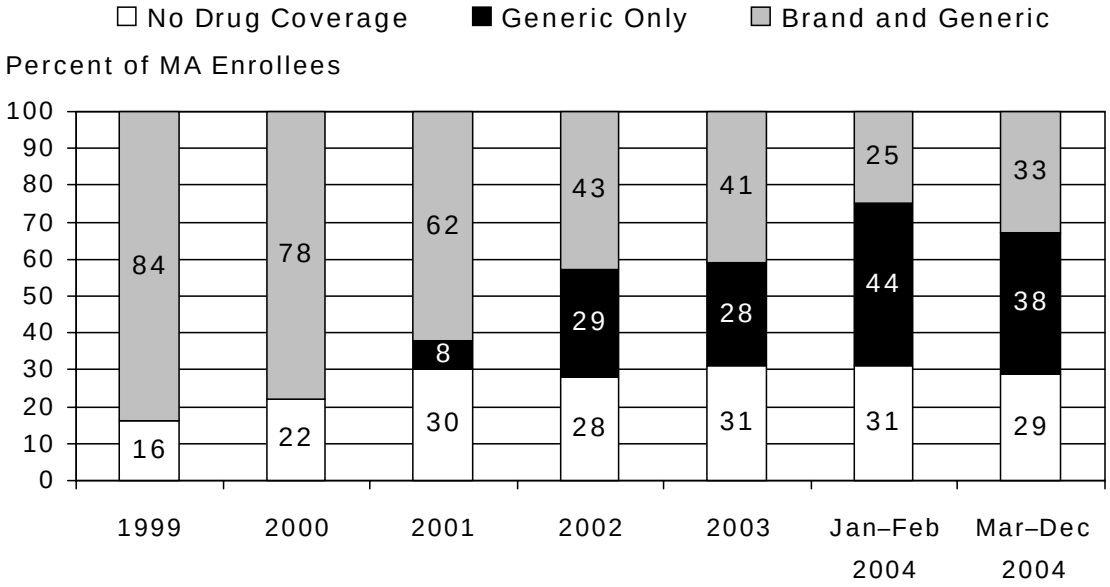

Note: With the exception of the January–February 2004 data, all other data is weighted by March enrollment of each year. January–February 2004 data is weighted by February 2004 enrollment.
Source: MPR Analysis of Medicare Compare for The Commonwealth Fund.

## Table 2. Monthly Premiums in Medicare Advantage Plans, 1999 and 2003–2004

| | Percentage of Enrollees | | | |
|---|---|---|---|---|
| | 1999 | 2003 | Jan–Feb 2004 | Mar–Dec 2004 |
| Reduced Premium/$0 | 79.6 | 38.5 | 46.3 | 55.7 |
| Less than $20.00 | 3.1 | 1.3 | 2.0 | 3.0 |
| $20.00–$49.99 | 13.5 | 25.3 | 19.3 | 17.5 |
| $50.00 or more | 3.2 | 34.9 | 32.4 | 23.9 |
| Unknown | 0.6 | 0.0 | 0.0 | 0.0 |
| Mean | $6.37 | $37.29 | $34.29 | $25.31 |
| Mean if premium does not equal $0 | $32.11 | $60.45 | $62.01 | $52.64 |
| Number of Contract Segments/Enrollees | 6,254,616 | 4,546,635 | 4,500,990 | 4,503,282 |

Note: With the exception of the January–February 2004 data, all other data is weighted by March enrollment of each year. January–February 2004 data is weighted by February 2004 enrollment.
Source: MPR analysis of Medicare Compare for The Commonwealth Fund.

## Figure 3. Changes in Type of Drug Coverage in Medicare Advantage Plans, 1999–2004




Note: With the exception of the January–February 2004 data, all other data is weighted by March enrollment of each year. January–February 2004 data is weighted by February 2004 enrollment. Information on generic-only prescription drug coverage was not tracked in 1999 and 2000. The number of enrollees with generic-only coverage during those two years is assumed to be negligible.
Source: MPR Analysis of Medicare Compare for The Commonwealth Fund.

## Table 3. Prescription Drug Coverage in Medicare Advantage Plans, by Type of Coverage Offered

| | Percentage of Enrollees | | | |
|---|---|---|---|---|
| **Prescription Drug Coverage by Type** | **2001** | **2003** | **Jan–Feb 2004** | **Mar–Dec 2004** |
| No Drug Coverage | 29.9 | 31.2 | 31.1 | 28.7 |
| Percent Covering Generics Only | 8.0 | 28.2 | 44.4 | 38.4 |
| Percent Covering Generics and Brand | 62.1 | 40.6 | 24.8 | 32.9 |
| Generic Only Coverage | | | | |
| $500 or less | 4.6 | 19.1 | 6.5 | 3.0 |
| $501–$750 | 1.8 | 1.5 | 2.2 | 0.7 |
| $751–$1,000 | 8.2 | 0.0 | 1.4 | 0.3 |
| $1,001–$1,500 | 0.0 | 1.5 | 0.1 | 0.0 |
| $1,501–$2,000 | 0.0 | 0.0 | 2.5 | 0.9 |
| $2,001 or more | 0.0 | 4.3 | 0.0 | 0.0 |
| No Cap | 85.4 | 73.7 | 87.2 | 95.1 |
| Generic Copays | | | | |
| None | 0.0 | 0.0 | 2.8 | 1.1 |
| $10.00 or less | 81.6 | 56.5 | 71.9 | 72.3 |
| $10.01 or more | 18.4 | 43.5 | 25.4 | 26.6 |
| Brand and Generic Coverage | | | | |
| $500 or less | 19.7 | 20.5 | 33.8 | 34.6 |
| $501–$750 | 12.1 | 12.9 | 13.9 | 13.0 |
| $751–$1,000 | 11.9 | 29.9 | 19.7 | 8.9 |
| $1,001–$1,500 | 14.3 | 10.0 | 5.9 | 10.7 |
| $1,501–$2,000 | 24.6 | 18.6 | 12.1 | 7.3 |
| $2,001 or more | 5.8 | 5.8 | 8.3 | 20.4 |
| No Cap | 11.6 | 2.4 | 5.4 | 4.6 |
| Generic Copays | | | | |
| None | 8.8 | 9.7 | 11.9 | 17.0 |
| $10.00 or less | 83.6 | 82.4 | 64.7 | 65.0 |
| $10.01 or more | 7.6 | 8.0 | 23.4 | 18.0 |
| Brand Copays | | | | |
| None | 2.4 | 0.8 | 1.8 | 3.7 |
| $10.00 or less | 21.7 | 5.9 | 8.8 | 8.9 |
| $10.01–$20.00 | 43.6 | 18.6 | 22.9 | 23.8 |
| $20.01 or more | 32.3 | 74.7 | 66.5 | 63.8 |

Note: With the exception of the January–February 2004 data, all other data is weighted by March enrollment of each year. January–February 2004 data is weighted by February 2004 enrollment.

Source: MPR analysis of Medicare Compare for The Commonwealth Fund.

## Table 4. Copayments for Medical and Hospital Services in MA Plans

| | Percentage of Enrollees | | | |
|---|---|---|---|---|
| | 1999 | 2003 | Jan–Feb 2004 | Mar–Dec 2004 |
| Primary Care Physician | | | | |
| None | 18.0 | 7.1 | 9.9 | 15.1 |
| $5.00 or less | 44.5 | 5.5 | 8.1 | 13.3 |
| $5.01–$10.00 | 32.1 | 45.6 | 39.9 | 43.7 |
| $10.01–$15.00 | 5.1 | 17.8 | 20.0 | 16.5 |
| $15.01 or more | 0.3 | 24.0 | 22.2 | 11.4 |
| Specialty Physician | | | | |
| None | 15.9 | 4.1 | 4.1 | 6.0 |
| $5.00 or less | 39.6 | 1.7 | 1.0 | 1.0 |
| $5.01–$10.00 | 26.8 | 11.8 | 10.3 | 22.6 |
| $10.01–$15.00 | 9.9 | 18.9 | 13.9 | 15.4 |
| $15.01 or more | 1.2 | 63.5 | 70.7 | 55.0 |
| Varies | 6.6 | 0.0 | 0.0 | 0.0 |
| Emergency Room | | | | |
| None | 6.5 | 3.0 | 2.3 | 1.8 |
| $20.00 or less | 24.5 | 0.4 | 0.0 | 0.0 |
| $20.01–$40.00 | 30.5 | 5.9 | 3.2 | 3.3 |
| $40.01–$50.00 | 38.2 | 91.0 | 94.5 | 94.8 |
| $50.01 or more | 0.2 | 0.0 | 0.0 | 0.0 |
| Any Cost Sharing | | | | |
| Hospital Admission | 4.3 | 82.1 | 85.7 | 82.1 |
| Hospital Outpatient | 30.7 | 58.3 | 58.3 | 56.8 |
| X-Ray | 7.5 | 17.9 | 36.2 | 34.3 |
| Lab | 3.9 | 13.0 | 21.1 | 18.9 |

Notes: With the exception of the January–February 2004 data, all other data is weighted by March enrollment of each year. January–February 2004 data is weighted by February 2004 enrollment. Many of the benefit descriptions for hospital outpatient, x-ray, and laboratory services provide a range of copayments. For instance, a plan could indicate that copayments for laboratory services range from $0 to $150. If zero was part of the range of copayments, the plan is characterized here as not requiring a copayment.

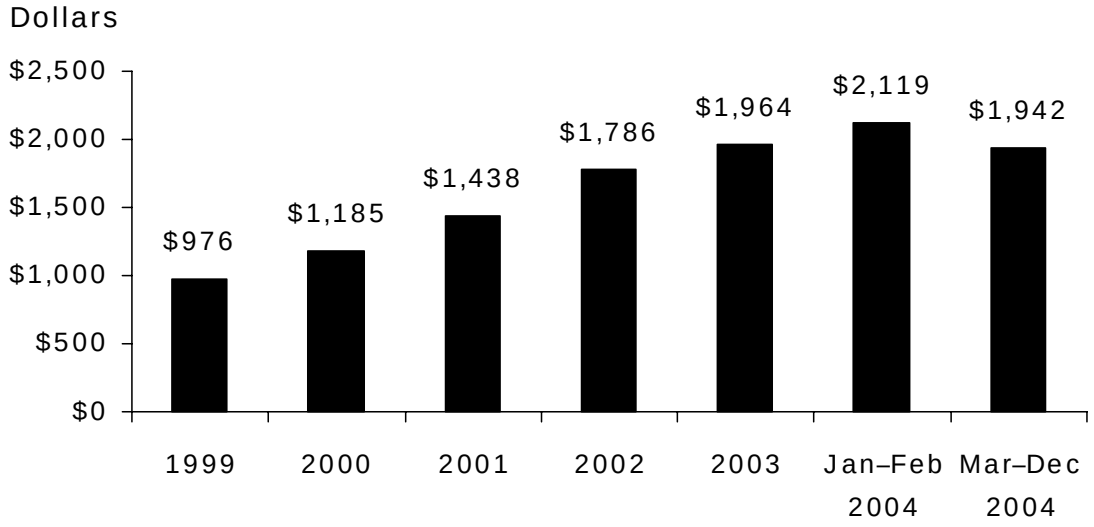
Source: MPR Analysis of Medicare Compare for The Commonwealth Fund.

Table 5. Supplemental Benefits in MA Plans

| | Percentage of Enrollees | | | |
|---|---|---|---|---|
| | 1999 | 2003 | Jan–Feb 2004 | Mar–Dec 2004 |
| Preventive Dental | 69.9 | 19.4 | 16.5 | 20.5 |
| Vision Benefits | 97.8 | 88.2 | 87.5 | 92.4 |
| Hearing Benefits | 91.3 | 57.1 | 54.2 | 62.2 |
| Physical Exam | 100.0 | 99.6 | 98.6 | 99.7 |
| Podiatry Benefits | 26.9 | 26.9 | 28.0 | 29.6 |
| Chiropractic Benefits | 20.9 | 4.8 | 2.3 | 3.5 |

Note: With the exception of the January–February 2004 data, all other data is weighted by March enrollment of each year. January–February 2004 data is weighted by February 2004 enrollment.
Source: MPR analysis of Medicare Compare for The Commonwealth Fund.

Figure 4. Average Enrollee Out-of-Pocket Costs in MA Plans, 1999–2004




Notes: With the exception of the January–February 2004 data, results are weighted by March enrollment of each year. January–February 2004 data is weighted by February 2004 enrollment. Average costs assume 79 percent of enrollees are in good health, 15 percent in fair health, and 6 percent in poor health. This distribution corresponds to the distribution of self-reported health status among Medicare managed care enrollees in the 1999 Medicare Current Beneficiary Survey (Liu and Sharma 2003).
Source: MPR analysis of Medicare Compare data using HealthMetrix Research's Medicare HMO Cost Share Report Methodology.

## Table 6. Enrollee Out-of-Pocket Costs in Health Plans

| | 1999 | 2003 | Jan–Feb 2004 | Mar–Dec 2004 | Percent Change from Jan–Feb 2004 to Mar–Dec 2004 |
|---|---|---|---|---|---|
| Total Cost Sharing | | | | | |
| All | $975.64 | $1,964.21 | $2,119.35 | $1,942.10 | –8.4% |
| Good | $836.19 | $1,564.48 | $1,651.90 | $1,495.71 | –9.5% |
| Fair | $1,203.39 | $2,695.70 | $3,031.05 | $2,798.32 | –7.7% |
| Poor | $2,210.80 | $5,305.28 | $5,883.73 | $5,573.42 | –5.3% |
| Premiums | | | | | |
| Annual Part B Premium | $546.00 | $704.40 | $799.20 | $799.20 | 0.0% |
| Annual Plan Premium | $63.37 | $446.79 | $394.76 | $266.13 | –32.6% |
| Physician-Hospital Cost Sharing | | | | | |
| All | $132.08 | $301.04 | $354.96 | $317.27 | –10.6% |
| Good | $117.08 | $177.81 | $191.95 | $170.96 | –10.9% |
| Fair | $159.41 | $622.84 | $786.62 | $707.60 | –10.0% |
| Poor | $257.81 | $1,086.98 | $1,379.52 | $1,229.55 | –10.9% |
| Rx Cost Sharing | | | | | |
| All | $234.19 | $511.99 | $570.43 | $559.50 | –1.9% |
| Good | $109.74 | $235.48 | $265.99 | $259.42 | –2.5% |
| Fair | $434.61 | $921.67 | $1,050.47 | $1,025.39 | –2.3% |
| Poor | $1,343.62 | $3,067.11 | $3,310.25 | $3,278.54 | –1.0% |

Notes: Results are weighted by plan enrollment in March of each year, with the exception of January–February 2004, which is weighted by February 2004 plan enrollment. The "all" category assumes 79 percent of enrollees are in good health, 15 percent in fair health, and 6 percent in poor health. This distribution corresponds to the distribution of self-reported health status among Medicare managed care enrollees in the 1999 Medicare Current Beneficiary Survey (Liu and Sharma 2003).

Source: MPR analysis of Medicare Compare data using HealthMetrix Research's Medicare HMO Cost Share Report Methodology.

## Table 7. Changes in Average Monthly Premiums by Payment Rate Category

| | Overall | Rural Floor | Urban Floor | Minimum Increase | Blended Increase | 100% FFS Rate |
|---|---|---|---|---|---|---|
| 2003 | | | | | | |
| Percent with Zero Premium | 38.5 | 22.9 | 28.7 | 65.2 | 0.0 | 36.9 |
| Percent with Premium $50 or more | 34.9 | 51.7 | 40.2 | 8.4 | 98.8 | 33.2 |
| Average Premium | $37.40 | $47.44 | $40.26 | $13.34 | $81.44 | $40.06 |
| Number of county enrollees | 4,546,635 | 111,599 | 1,191,481 | 1,074,337 | 369,885 | 1,799,333 |
| Jan–Feb 2004 | | | | | | |
| Percent with Zero Premium | 46.3 | 33.6 | 31.5 | 78.8 | 0.0 | 47.9 |
| Percent with Premium $50 or more | 32.4 | 47.2 | 34.8 | 4.4 | 98.7 | 32.2 |
| Average Premium | $34.29 | $44.52 | $41.12 | $9.00 | $78.02 | $33.35 |
| Number of county combinations/enrollees | 4,500,990 | 140,450 | 1,190,284 | 1,042,457 | 369,179 | 1,757,783 |
| Mar–Dec 2004 | | | | | | |
| Percent with Zero Premium | 55.7 | 35.3 | 36.8 | 85.6 | 0.0 | 64.1 |
| Percent with Premium $50 or more | 23.9 | 44.9 | 32.0 | 3.8 | 96.5 | 13.4 |
| Average Premium | $25.31 | $40.77 | $35.81 | $5.96 | $63.53 | $18.63 |
| Number of county combinations/enrollees | 4,503,282 | 144,430 | 1,190,875 | 1,040,868 | 369,326 | 1,757,783 |

Notes: Results are weighted by plan enrollment in March, with the exception of January–February 2004, which is weighted by February 2004 plan enrollment.

Source: MPR analysis of Medicare Compare for The Commonwealth Fund.

Table 8. Changes in Drug Coverage by Payment Rate Category, 2003–2004

| | Overall | Rural Floor | Urban Floor | Minimum Update | Blended Increase | 100% FFS Rate |
|---|---|---|---|---|---|---|
| 2003 | | | | | | |
| No Coverage | 31.2 | 85.7 | 47.4 | 21.6 | 1.4 | 28.9 |
| Generic Only | 28.2 | 6.8 | 24.2 | 17.9 | 28.3 | 38.4 |
| Brand+Generic | 40.6 | 7.5 | 28.5 | 60.5 | 70.3 | 32.7 |
| Jan–Feb 2004 | | | | | | |
| No Coverage | 31.1 | 83.6 | 43.9 | 15.3 | 0.5 | 33.9 |
| Generic Only | 44.3 | 7.7 | 31.1 | 47.6 | 98.3 | 42.9 |
| Brand+Generic | 24.6 | 8.7 | 24.9 | 37.1 | 1.3 | 23.2 |
| Mar–Dec 2004 | | | | | | |
| No Coverage | 28.7 | 83.6 | 42.1 | 14.8 | 0.5 | 29.3 |
| Generic Only | 38.4 | 8.5 | 26.5 | 54.0 | 98.3 | 27.0 |
| Brand+Generic | 32.9 | 7.9 | 31.4 | 31.2 | 1.3 | 43.7 |

Notes: Results are weighted by plan enrollment in March of each year, with the exception of January–February 2004, which is weighted by February 2004 plan enrollment.

Source: MPR analysis of Medicare Compare for The Commonwealth Fund.

## Table 9. Number of MA Enrollees Who Saw Selected Changes in Benefits or Premiums as a Result of MMA Payment Increases

| | Overall | Rural Floor | Urban Floor | Minimum Increase | Blended Increase | 100% FFS Rate |
|---|---|---|---|---|---|---|
| Total Enrollees | 4,0936,614 | 141,554 | 1,166,679 | 794,706 | 369,194 | 1,621,481 |
| Reduced Premium | | | | | | |
| Yes | 1,858,501 | 35,904 | 472,178 | 103,227 | 351,206 | 895,986 |
| No | 2,235,113 | 105,650 | 694,501 | 691,479 | 17,988 | 725,495 |
| Enhanced Drug Coverage | | | | | | |
| No Coverage to Brand and Generic Coverage | 63,807 | 84 | 4,061 | 2,062 | 0 | 57,600 |
| No Coverage to Generic Only Coverage | 43,851 | 328 | 18,846 | 5,842 | 0 | 18,835 |
| Increased Brand Limit | 356,475 | 4,112 | 29,945 | 97,087 | 15 | 225,316 |
| Added Brand Coverage to Generic-Only Coverage | 396,166 | 237 | 88,323 | 26,144 | 0 | 281,462 |
| Increased Generic Limit | 100,259 | 177 | 57,123 | 0 | 1,567 | 41,392 |
| No Change | 3,133,056 | 136,616 | 968,381 | 663,571 | 367,612 | 996,876 |
| Reduced Primary Care Physician Copay | | | | | | |
| Yes | 1,059,804 | 9,359 | 251,181 | 380,591 | 14,857 | 403,816 |
| No | 3,033,810 | 132,195 | 915,498 | 414,115 | 354,337 | 1,217,665 |
| Eliminated Inpatient Hospital Cost Sharing | | | | | | |
| Yes | 91,095 | 0 | 0 | 59,395 | 15 | 31,685 |
| No | 4,002,519 | 141,554 | 1,166,679 | 735,311 | 369,179 | 1,589,796 |

Notes: Assumes enrollment in the basic plan. Numbers in this chart do not add up to the total number of enrollees in February 2004 because individuals whose basic plan changed from February 2004 to March 2004 were excluded from the analysis. The total number of enrollees excluded for this reason was 498,471.

Source: MPR analysis of Medicare Compare for The Commonwealth Fund.

## APPENDIX. DATA SOURCES AND METHODS

This analysis of plan benefits and premiums relies on a database developed by Mathematica Policy Research (MPR) using information from Medicare Health Care Compare, a database of plan benefit packages maintained by the Centers for Medicare and Medicaid Services (CMS). Plans may offer more than one benefit package to enrollees; MPR defines the "basic package" as one with the lowest monthly premium or—if several have the same low premiums—the one with the best pharmacy benefits. The basic package is designed to offer insight on enrollees' minimum coverage.

Analyses presented in this report assign enrollment to the basic plan in each contract segment, using data from the Geographic Service Area File. (The data do not distinguish enrollees' benefit package if a plan offers more than one package in an area.*) All results presented are weighted by enrollment. We included health maintenance organizations, non-demonstration preferred provider organizations and point-of-service plans, and provider service organizations in our analysis.

* The effect of assigning all enrollees to the basic plan is to understate coverage and premium levels, but doing so provides a consistent trend line for the most affordable option enrollees have to choose.

## NOTES

[1] L. Achman and M. Gold, *Medicare Advantage 2004 Payment Increases Resulting from the Medicare Modernization Act* (Washington, D.C.: Mathematica Policy Research, February 2004).

[2] Centers for Medicare and Medicaid Services, *Review Shows Beneficiaries in Medicare Advantage Plans Will See Better Benefits, Lower Costs* (Baltimore, Md.: CMS, February 27, 2004).

[3] M. Gold and L. Achman, *Trends in Premiums, Cost-Sharing, and Benefits in Medicare+Choice Health Plans, 1999–2001* (New York: The Commonwealth Fund, April 2001); L. Achman and M. Gold, *Medicare+Choice: Beneficiaries Will Face Higher Cost-Sharing in 2002* (New York: The Commonwealth Fund, March 2002); L. Achman and M. Gold, *Trends in Medicare+Choice Benefits and Premiums, 1999–2003, and Special Topics* (Washington, D.C.: Mathematica Policy Research, December 2003).

[4] M. Gold, "Can Managed Care and Competition Control Medicare Costs?" *Health Affairs* Web Exclusive (April 2, 2003): W3-176–W3-188.

[5] Health Policy Alternatives, Inc., *Prescription Drug Coverage for Medicare Beneficiaries: An Overview of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003* (Washington, D.C.: Henry J. Kaiser Family Foundation, January 14, 2004).

[6] L. Achman and M. Gold, *Medicare Advantage 2004 Payment Increases Resulting from the Medicare Modernization Act* (Washington, D.C.: Mathematica Policy Research, February 2004); B. Biles, L. H. Nicholas, and B. S. Cooper, *The Cost of Privatization: Extra Payments to Medicare Advantage Plans—2005 Update* (New York: The Commonwealth Fund, December 2004).

[7] Congressional Budget Office, *CBO Estimate of Effect on Direct Spending and Revenues of Conference Agreement on H.R. 1* (Washington, D.C.: Congressional Budget Office, November 20, 2003).

[8] Medicare Payment Advisory Commission, *Report to Congress: Medicare Payment Policy* (Washington D.C.: MedPAC, March 2004).

[9] Centers for Medicare and Medicaid Services, *Review Shows Beneficiaries in Medicare Advantage Plans Will See Better Benefits, Lower Costs* (Baltimore, Md.: CMS, February 27, 2004).

[10] Benefits for January–February 2004 are based on the November 2003 version of Medicare Compare and are weighted by February 2004 enrollment. Benefits for March 2004 are based on the March 2004 Medicare Compare and enrollment files.

[11] The revised 2004 payment rates were announced by CMS on January 16, 2004. Plans were required to submit their revised benefit packages by January 30, 2004.

[12] Centers for Medicare and Medicaid Services, *Medicare Managed Care Contracts (MMCC) Plans Monthly Summary Report, January 2004* (Baltimore, Md.: CMS, January 2004); Centers for Medicare and Medicaid Services, *Medicare Managed Care Contracts (MMCC) Plans Monthly Summary Report, October 2004* (Baltimore, Md.: CMS, October 2004).