Keohane LM, Grebla RC, Mor V, Trivedi AN. Medicare Advantage members' expected out-of-pocket spending for inpatient and skilled nursing facility services. Health Aff (Millwood). 2015;34(6).

Appendix

Additional detail on study population exclusion criteria

Among 13,172,683 beneficiaries in the HEDIS 2011 data over age 21, we excluded 1,781,444 beneficiaries in employer-sponsored plans, as their benefit information is not publicly available. We also excluded 332,256 members of plans with limited enrollment (cost, medical savings account and state-licensed point-of-service plans), 245,115 who could not be linked to CMS enrollment data, 491,860 living in Puerto Rico or outside the United States. Three hundred ninety-six plans with 1,757,665 members had plan identifiers that could not be merged to plan-level benefits data. Over 60% of these members belonged to two large MA contractors based in California and Pennsylvania. After these exclusions, our final sample included 8,173,985 beneficiaries across 1,841 plans (7,420,245 individuals in 1,508 MA plans, 1,133,042 in 333 SNPs).

To identify whether zero-premium MA plan members had changes in cost-sharing requirements from 2010 to 2011, we examined their 2010 HEDIS enrollment records and Plan Finder benefits data.

Among beneficiaries enrolled in a zero-premium plan in 2011, we excluded 1,003,189 beneficiaries who were enrolled in more than 1 plan in the time period 2010-2011. Another 373,127 were not enrolled in the MA program in 2010 and an additional 70,718 were not enrolled in Medicare in 2010. Another 23,478 were excluded because in 2010 they belonged to an employer plan, lived outside the U.S, belonged to a plan with fewer than 50 members or did not have benefits data for their plan. According to the Medicare Beneficiary Summary File, another 156,922 were enrolled in MA in 2010 but had no HEDIS data so we have no information on whether they were enrolled in the same plan or a different plan in 2010. Finally, 79,355 members were excluded because their plans changed their premiums between 2010 and 2011.

Additional detail on identifying plans' cost-sharing requirements

Using plans' benefit data we calculated the expected cost-sharing amounts for a 7 day inpatient stay, including out-of-pocket costs incurred by day 3. We also estimated costs for a subsequent 7 or 20 day SNF stay. These lengths approximately correspond to average lengths of stay among Medicare beneficiaries who have an inpatient hospital stay and subsequent SNF stay.[7] Most plans charge either a flat copayment per stay or daily copayments, which might vary depending on length of stay. We assumed that all inpatient deductibles would be fully met within three days (largest inpatient deductible was $1,132). We disregarded any plan deductibles that applied to services other than inpatient or SNF care. If a plan had an out-of-pocket limit that applied to inpatient, SNF or all plan services, we capped the expected costs at the relevant limit.

For some plans, the benefit data did not distinguish in-network from out-of-network cost-sharing requirements. If a plan listed multiple forms of cost-sharing for inpatient care or SNF services, we used the lower value of expected costs. For plans that listed both fixed copayments and coinsurance for inpatient or SNF care, we used the copayment amount. We do not report total expected costs for the few plans that only charged coinsurance for inpatient or SNF services.

Many dual SNPs describe their cost-sharing amounts as $0 or greater than $0 depending on a member's level of Medicaid coverage. Because we attempted to estimate costs for members who do not have Medicaid cost-sharing coverage, we report expected costs for dual SNPs two ways. For plans that specified two values, the lower estimate takes $0 as the expected cost-sharing amount. The higher estimate bases costs on the amount that is greater than $0. The higher estimate excludes beneficiaries from dual-SNP plans where the second cost-sharing requirement is in the form of coinsurance (7% of beneficiaries). Plans that only list one cost-sharing amount have that value used in both estimates.

Additional detail on identifying beneficiaries with limited subsides

To assess whether MA out-of-pocket costs differ for individuals with limited resources, we identified low-income beneficiaries based on their participation in Medicare-related needs-based programs. We used Part D and Medicaid participation indicators on the Medicare Beneficiary Summary File to identify beneficiaries with the following benefits: (1) Part D Low-Income-Subsidy benefits without Medicaid (federal income limit 150% FPL) and (2) Specified Low-income Medicare Beneficiaries (SLMB) only (federal income limit 120% FPL) or Qualified Individuals (QI) beneficiaries who have Medicaid subsidies for the Part B premium (federal income limit 135% FPL). In 2011, the asset limits for an individual were $11,140 for the Part D Low-Income-Subsidy program and $6,680 for the SLMB and QI programs. These asset limits excluded the value of individuals' homes.[1,2]

Individuals with higher income can qualify for Medicaid subsidies for the Part B premium in Maine (185% FPL), Connecticut (232% FPL) and the District of Columbia (300% FPL). These states and Arizona, Alabama, Delaware, Mississippi, New York and Vermont waive asset limits for limited Medicaid; Minnesota's asset limits are higher than the federal minimum. Depending on states' Medicaid regulations, individuals with higher income may also qualify for Medicaid in special circumstances, such as in the event of large medical expenses.[3]

We identified beneficiaries' participation in these programs as of January or their first month of Medicare enrollment in 2011. In our analysis of the low-income subgroup, we excluded beneficiaries Qualified Medicare Beneficiaries (QMB only) beneficiaries who have Medicaid coverage of their MA cost-sharing amounts (federal income limit 100% FPL) and beneficiaries with full Medicaid (QMB plus, SLMB plus or Other Medicaid). We excluded these beneficiaries from the low-income subgroup because we wanted to focus on beneficiaries who were liable for expected out-of-pocket costs. In effect,

this subgroup is mainly comprised of MA beneficiaries with incomes slightly over the federal poverty level and relatively few assets.

Notes

(1) Medicaid and CHIP Payment and Access Commission. Report to the Congress on Medicaid and CHIP - Chapter 4: Medicaid coverage of premiums and cost sharing for low-income Medicare beneficiaries [Internet]. Washington, D.C. : MACPAC; 2013 March [cited 2015 Jan 30]. Available from: http://www.macpac.gov/reports/2013-03-15_MACPAC_Report.pdf.

(2) U.S. Social Security Administration. Program operations manual system HI 03030.025: resource limits for subsidy eligibility; 2013 Dec [cited 2015 Jan 30]. Available from: https://secure.ssa.gov/poms.nsf/lnx/0603030025.

(3) Kaiser Commission on Medicaid and the Uninsured. Medicaid financial eligibility: primary pathways for the elderly and people with disabilities [Internet]. Washington (DC): The Commission; 2010 Feb [cited 2015 Jan 30]. Available from: http://www.kff.org/medicaid/upload/8048.pdf

List of Appendix Exhibits

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Appendix Exhibit A2 (Table)
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Appendix Exhibit A1: Characteristics of Medicare Advantage Special Needs Plan (SNP) Members by Type of SNP, 2011

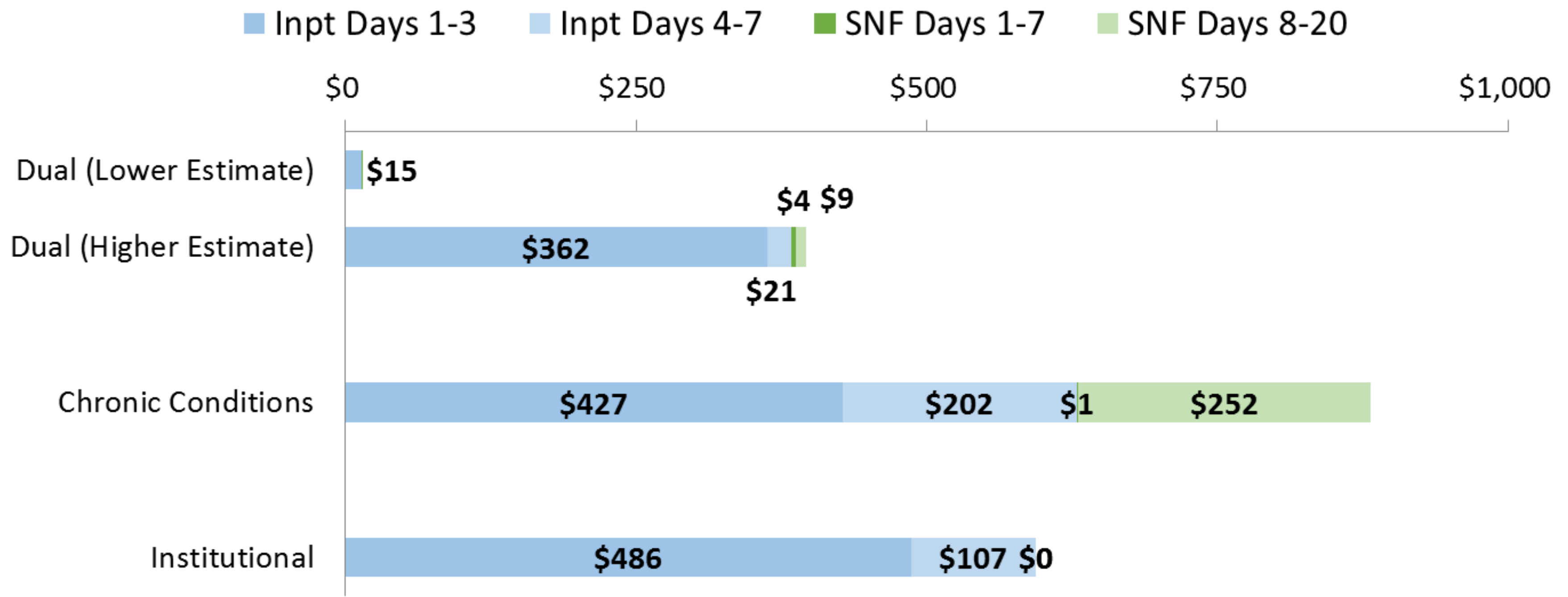
	All SNP Members	Dual-SNP	Chronic Conditions	Institutional
Number of members	1,133,042	881,398	192,612	59,032
Age (%)				
Under age 65	31	34	22	6
Age 65 to 74	34	33	45	13
Age 75 to 84	24	23	26	30
Age 85 and over	12	10	8	51
Female(%)	62	63	56	74
Race (%)				
White	55	52	60	79
Black	26	25	33	15
Other	20	23	7	6
Receipt of financial subsidies (%)				
No financial subsidies	15	5	56	30
Premium/Part D subsidies	13	12	20	4
Full Medicaid/Medicaid Cost-Sharing coverage	73	84	24	66
Region (%)				
New England	3	3	0	9
Middle Atlantic	15	18	4	20
East North Central	3	3	1	10
West North Central	6	6	6	1
South Atlantic	23	17	52	20
East South Central	6	8	1	0
West South Central	13	12	21	0
Mountain	9	10	4	9
Pacific	22	23	11	30

Source: Authors' analysis of Medicare Advantage and Medicare enrollment records
Notes: Dual-SNP plans may enroll Medicare beneficiaries dually eligible for Medicaid.
Chronic condition plans may enroll Medicare beneficiaries with certain chronic conditions. Institutional SNP plans may enroll Medicare beneficiaries who receive long-term-care in an institution for at least 90 days or who qualify to receive home-and-community-based services because they require an institutional level of care.

Appendix Exhibit A2: Coverage Features for Medicare Advantage Special Needs Plan (SNP) Members by Type of SNP, 2011

	All SNP Members	Dual-SNP	Chronic Conditions	Institutional
Mean plan premium ($), interquartile range	118 (115-131)	122 (119-131)	96 (96-127)	117 (96-127)
Out-of-pocket limit meets CMS thresholds (%)				
Meets voluntary threshold (<=$3,400)	45	41	66	28
Between thresholds ($3,401 - $6,999)	4	1	1	44
At maximum threshold ($6,700)	52	57	33	28
Mean out-of-pocket limit ($), interquartile range	5,032 (3,400 - 6,700)	5,179 (3,400-6,700)	4,444 (3,400-6,700)	4,758 (3,400-6,700)
Managed Care Model (%)				
Health Maintenance Organization	82	91	48	54
Health Maintenance Organization - Point of Services	2	2	1	4
Local Preferred Provider Organization	5	3	-	41
Private Fee-For-Service	-	-	-	-
Regional Preferred Provider Organization	12	4	51	-

Source: Authors' analysis of Medicare Advantage and Medicare enrollment records
Notes: Dual-SNP plans may enroll Medicare beneficiaries dually eligible for Medicaid.
Chronic condition plans may enroll Medicare beneficiaries with certain chronic conditions. Institutional SNP plans may enroll Medicare beneficiaries who receive long-term-care in an institution for at least 90 days or who qualify to receive home-and-community-based services because they require an institutional level of care.



Source: Authors' analysis of Medicare Advantage and Medicare enrollment records
Notes: Individuals who have coinsurance as primary form of cost-sharing for inpatient or SNF services are excluded from estimates.
Abbreviations: Inpt, inpatient; SNF, skilled nursing facilities.
Many dual-SNP plans describe their cost-sharing amounts as $0 or a value greater than $0 depending on Medicaid coverage. Two estimates are presented to capture both values. The second estimate excludes dual-SNP members whose secondary form of cost-sharing is coinsurance.

Appendix Exhibit A4: Changes from 2010 to 2011 in Inpatient and Skilled Nursing Facility Costs for Zero-Premium Plan Members by the Addition of an Out-of-Pocket Limit under 2011 Mandate for each Region and Plan Type

	All	By Region				By Plan Type				
		Midwest	Northeast	South	West	HMO	HMO-POS	Local PPO	PFFS	Reg. PPO
Inpatient Costs (7 Days)										
Plan previously offered out-of-pocket limit										
Greater than $250 decrease	18%	3%	3%	30%	10%	11%	19%	0%	84%	50%
Decreased less than $250	19%	16%	55%	16%	16%	21%	23%	10%	0%	10%
No change	31%	47%	15%	29%	25%	38%	20%	22%	0%	28%
Increased by less than $250	16%	21%	3%	18%	7%	21%	4%	26%	0%	5%
Increased by more than $250	16%	14%	24%	7%	43%	10%	34%	42%	16%	7%
Total	1,473,735	342,681	123,949	766,921	240,184	876,110	296,377	79,354	22,346	199,548
Plan added out-of-pocket limit under mandate										
Greater than $250 decrease	8%	0%	0%	1%	19%	9%	0%	0%		
Decreased less than $250	6%	1%	0%	1%	13%	7%	0%	0%		
No change	32%	94%	7%	40%	35%	30%	49%	0%		
Increased by less than $250	7%	0%	14%	6%	4%	7%	1%	10%		
Increased by more than $250	48%	4%	79%	53%	30%	47%	50%	90%		
Total	815,727	22,106	183,254	275,522	334,845	728,658	78,752	8,317	N/A	N/A
SNF Costs (20 Days)										
Plan previously offered out-of-pocket limit										
Greater than $250 decrease	33%	38%	43%	30%	29%	15%	54%	50%	84%	66%
Decreased less than $250	19%	11%	1%	30%	3%	25%	9%	7%	0%	11%
No change	34%	33%	46%	26%	53%	44%	20%	16%	16%	22%
Increased by less than $250	5%	6%	5%	3%	10%	4%	10%	13%	0%	1%
Increased by more than $250	10%	12%	5%	11%	5%	13%	7%	14%	0%	0%
Total	1,473,735	342,681	123,949	766,921	240,184	876,110	296,377	79,354	22,346	199,548
Plan added out-of-pocket limit under mandate										
Greater than $250 decrease	13%	1%	11%	23%	6%	13%	10%	0%		
Decreased less than $250	3%	2%	3%	6%	0%	0%	25%	16%		
No change	39%	95%	26%	33%	46%	41%	23%	0%		
Increased by less than $250	21%	1%	23%	4%	34%	18%	40%	85%		
Increased by more than $250	25%	1%	36%	33%	14%	28%	2%	0%		
Total	815,727	22,106	183,254	275,522	334,845	728,658	78,752	8,317	N/A	N/A

Source: Authors' analysis of Medicare Advantage and Medicare enrollment records; Notes: Abbreviations: SNF, Skilled Nursing Facilities; Analysis limited to members enrolled in the same zero-premium plan for the years 2010 and 2011