Plan Competition and Consumer Choice in Medicare: The Case for Premium Support

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Medicare provides health coverage for 50 million seniors and disabled people. The program is projected to spend nearly $600 billion in 2013, making it the third-largest category of federal spending after Social Security and defense. Over the next two decades, 76 million members of the baby boom generation will shift from working and paying the taxes that support Medicare to retiring and receiving benefits. That massive demographic shift, coupled with the continuing trend toward greater use of increasingly expensive medical services, will put unprecedented strain on the US ability to finance the program.

Medicare has faced fiscal challenges almost from the program’s inception. As early as the 1970s, reports from the Medicare trustees warned that the program’s long-term financing was in peril. Growing pressure on the federal budget has led to periodic legislative initiatives intended to slow Medicare spending. Despite such actions, the program continues to grow faster than the economy, both in the aggregate and on a per capita basis.

But the recent recession and anemic economic recovery have put new demands on the federal budget and raised new concerns about the fiscal path of the country. In 2010, the Bowles-Simpson Commission asserted that the country had reached the moment of truth, with projected spending rising much faster than revenues even after the economy recovers. The commission pointed to the need to slow down federal health spending as a key part of the plan to put the nation back on the path to fiscal health, observing that “federal health care spending represents our single largest fiscal challenge over the long-run.”

Congress has adopted policies intended to slow Medicare spending. The Affordable Care Act (ACA) includes substantial reductions in Medicare’s payment rates for health care providers. Previous legislation imposed a 25 percent reduction in Medicare physician fees that is to take effect on January 1, 2014.

Even if those provisions are fully implemented, Medicare spending will continue to grow more rapidly than other elements of the federal budget (including revenue), except for interest on the federal debt. Under this scenario, spending on the major health programs (Medicare, Medicaid, and insurance exchange subsidies) and Social Security will crowd out other policy priorities.

The Congressional Budget Office (CBO) projects that spending for other programs will decline by 40 percent between 2012 and 2037.

Congress is not likely to enforce the large reductions in provider payment rates.
that have already been enacted. It has overridden much smaller cuts in physician fees consistently since 2003, and few doubt that Congress will override the 2014 reduction as well. The Medicare actuary projects that payment reductions under the ACA would result in financial losses for 15 percent of hospitals and other providers by 2019, worsening in later years. Under those circumstances, action to moderate the payment cuts is virtually inevitable. For that reason, the Bowles-Simpson report criticized the "phantom savings from scheduled Medicare reimbursement cuts that will never materialize" as painting an overly optimistic picture of our fiscal future.

This is the crux of the problem with proposals to bend the Medicare cost curve through direct legislative controls. Although policymakers face strong pressure to adopt deficit-reducing measures such as reductions in payment rates, they also have strong pressures to avoid implementing them. The policy challenge is finding a way to reform Medicare that does not require unsustainable political discipline.

Many believe that Medicare reforms based on the principle of defined contribution can provide the framework needed to slow program spending while preserving beneficiaries’ access to high-quality services and promoting continued medical innovation. A number of proposals broadly referred to as “premium support” would replace Medicare’s current defined-benefit system with a defined-contribution one.

Under the defined-benefit approach in use for traditional Medicare, the program pays for all covered services without limiting total spending. That policy has promoted the use of a higher volume and greater complexity of services, a key factor in the growth of Medicare spending. Under premium support, beneficiaries would receive a fixed subsidy to cover the cost of enrolling in one of the health plans competing for their business. Combining market competition and a fixed federal subsidy is intended to reduce unnecessary program spending without restricting beneficiaries’ ability to choose more expensive plans if they would like.

This report focuses on proposals for the market-based reform of Medicare based on premium support, explaining the need to align Medicare’s financial incentives with the policy goals, summarizing the main features of premium support proposals and discussing other reforms necessary to modernize Medicare’s traditional fee-for-service program. The final section assesses recent evidence on competitive bidding and health plan efficiency, the ability of beneficiaries to make sound plan choices, and measures to control risk selection that could otherwise drive up program cost.

INCENTIVES AND MEDICARE SPENDING

Growth in Medicare spending is driven by a variety of demographic, technological, and policy factors. An aging population and the entry of the baby boom generation into Medicare are expected to increase program enrollment by about 70 percent by 2035.
cost of those services are likely to increase. More beneficiaries will use more services that are more effective in treating disease, which will lead to longer lives. But this increasingly older population will likely require even more services.

Although the program’s total spending depends on both the prices paid and the volume and complexity of services used, Medicare has avoided policies that directly affect the use of services or that manage the care of patients. In establishing Medicare, the Social Security Act prohibited federal interference with the practice of medicine. The program has erred on the side of paying for more services and covering greater costs if the physician’s clinical decisions are consistent with the standards of medical practice in the local community. Initiatives focused on improving the quality of care, such as Quality Improvement Organizations and case management for high-cost beneficiaries, appear not to have slowed the growth of program spending.

The design of traditional Medicare, which pays on a fee-for-service basis and offers an essentially uncapped subsidy, has fostered rapid expansion in the use of health care. Providers have an incentive to offer additional services to increase their Medicare payments. Patients are not likely to object to, or even be aware of, the cost because most of their out-of-pocket costs are covered by supplemental coverage through Medigap, retiree plans, or Medicaid. Lack of coordination among providers in traditional Medicare also contributes to duplication and waste that adds to program spending.

Controlling Prices in Traditional Medicare. Medicare has relied primarily on payment policy to slow the growth of program spending. That has meant limiting the amount Medicare pays for services and changing the way payments are made to discourage the unnecessary use of services and promote lower-cost care.

Payment incentives are crucial in determining how health care is delivered and what it will cost. This is demonstrated by Medicare’s shift from cost reimbursement to prospective payment, beginning with the inpatient hospital prospective payment system (PPS) in 1983.

Under cost reimbursement, Medicare paid the cost charged by providers for each specific service used in treating an individual patient. Additional services resulted in additional payment. Under prospective payment, a fee is set in advance that covers the typical cost of caring for patients with a specific medical diagnosis. Providing an additional service directly related to that diagnosis would not generate additional Medicare payments.

Changes in payment incentives can induce dramatic changes in medical practice. For example, inpatient lengths of stay dropped significantly after hospital PPS was implemented. With a fixed payment based on the needs of a typical patient with a particular diagnosis, an additional inpatient day would not produce additional revenue as it did under cost reimbursement. Changes in the management of inpatient care, including shortening lengths of stay, reduced hospital cost and increased hospital margins.
However, the prospective payment incentive to reduce unnecessary hospital cost also provided an incentive to shift patient care to postacute facilities outside the hospital—and, crucially, to facilities that receive their own payment separately from the hospital’s payment. Shorter inpatient hospital stays led to greater spending for skilled nursing and home health care. The efficiency improvements and cost savings by changing the payment incentive for hospitals were offset to some extent by expanded use of services by providers who did not face the same incentives for efficiency.

Broader payment bundles that include more services typically associated with the full course of treatment for a patient would reduce this tendency to shift costs to other providers. Bundled payments can align financial incentives across different providers to promote better coordination in patient care. With a broader bundle of services covered by a single payment, there is a better chance of reducing duplication and providing fewer low-value services.

Although prospective payment systems used in traditional Medicare are a major improvement over cost-based reimbursement, they pay on a fee-for-service basis that rewards the provision of more services (or bundles of services). Moreover, Medicare’s payment depends on the severity of the patient’s illness, which relies in part on which services are used in treatment. Using more complex services is likely to increase the patient’s severity for payment purposes (a process called upcoding), which can lead to unnecessary expense.

One feature common to Medicare prospective payment systems is the annual update factor, which adjusts the payment rate for year-to-year increases in the cost of providing services. Lowering the annual update reduces the prices paid for services, which generates savings for the federal budget but does not lead to system improvements or greater efficiency.

The use of this updating mechanism also does not necessarily yield actual savings, as illustrated by the ongoing controversy over Medicare fees paid to physicians. The sustainable growth rate formula is supposed to limit the growth in those fees, but Congress has overridden the reductions it calls for every year since 2003. The forgone savings are added to future reductions in the update, with the result that the 4.4 percent reduction that was not taken a decade ago has ballooned into a 25 percent cut for 2014. There is virtually no chance that such large fee reductions will be enforced.

**Choice and Competition in Medicare Advantage.** Traditional Medicare depends on the judgment of policymakers to determine the price level for specific services that will balance the availability of care against the program’s cost. The alternative to this regulatory process is competitive bidding, which relies on information from the market to determine prices. A well-designed bidding process offers a strong incentive for health plans to increase their share of the market by undercutting their competitors’ prices.

Competitive bidding is used to set prices for health plans participating in Medicare
Advantage (MA) and for standalone prescription drug plans under Medicare Part D. Beneficiaries may choose to enroll in private MA plans as an alternative to traditional Medicare, and those plans cover at least the basic Medicare Part A and Part B benefits. Beneficiaries who choose traditional Medicare may add prescription drug coverage by enrolling in private Part D plans.

In both cases, the federal subsidy is set at a fixed amount (known as a capitation rate), and the beneficiary is responsible for paying any additional premium charged by the chosen plan. Unlike the fee-for-service system, MA plans that find ways to improve care coordination among providers and reduce unnecessary service use can profit.

Capitation is the ultimate payment bundle in the sense that the amount paid to the health plan for a specific patient does not depend on the volume of services delivered. Limiting the growth of the capitation rate can directly limit the growth of program spending. In contrast, limiting fees in traditional Medicare does not limit spending if the volume and intensity of services used by beneficiaries continue to rise.

However, Medicare Advantage and its predecessor programs that offered private plans have not used that degree of spending control. Instead of holding growth in the federal subsidy to some fiscal target, private plan payments have been tied to growth in the cost of traditional Medicare. Initially, private plans were paid 95 percent of the cost of traditional Medicare. MA plan payments remain tied to benchmarks based on spending levels in the traditional program.

MA plans receive the federal subsidy in the form of a capitation payment, but they remain free to compensate individual providers using any payment system (including fee-for-service, quality-based payment, salary, and other contractual methods). Medicare’s payments to the plans do not depend on those arrangements.

Medicare Advantage offers a variety of competing private health plans, including health maintenance organizations (HMOs), preferred provider organizations, and private fee-for-service plans. MA plans cover the basic Medicare benefit, but they are allowed to restructure that benefit in sensible ways.

For example, instead of charging separate deductibles for hospital and other institutional services (under Part A) and physician and other outpatient services (under Part B), MA plans typically have a single combined deductible. Instead of a complex cost-sharing structure that exposes beneficiaries to potentially high costs, MA plans typically offer a simplified structure for cost-sharing above the deductible and protection against catastrophic costs. MA plans often provide additional benefits, such as coverage for dental and vision services, beyond what Medicare requires. Enrollees in MA plans do not purchase additional Medigap coverage to fill in coverage gaps, unlike beneficiaries in traditional Medicare.

A major criticism of Medicare Advantage is that the plans have been paid more than the cost of traditional Medicare to provide standard program benefits. In 2010, for example, MA plans received payments on average 9 percent higher than the cost of
the traditional fee-for-service program, even though plan bids on average equaled fee-for-service, and HMO plans bid an average of 3 percent less than fee-for-service.\textsuperscript{16}

The high payments are the result of a policy decision to ensure that beneficiaries in sparsely populated areas would have access to a private plan alternative.\textsuperscript{17} The 1997 Balanced Budget Act imposed tight limits on the annual increases in federal subsidies for private plans under what was then known as Medicare+Choice, which caused the number of plans participating in the program to drop sharply. Higher payments succeeded in expanding multiple private plan options to even the most remote counties and gave many beneficiaries access to additional benefits not covered by traditional Medicare but added to the cost of the program.

**Choice and Competition in Part D.**

In contrast to Medicare Advantage, the bidding process in Medicare Part D has been more effective in holding down program costs. Because a comparable benefit did not exist prior to the creation of Part D, all prescription drug plans compete on an equal basis without tying payment to traditional Medicare.

Premiums and subsidies are based on the national average of plan bids, which reflect each plan’s expected benefit payments and administrative costs. No cap limits the allowable growth in federal subsidy amounts from year to year. Instead, the cost of Part D depends solely on the strength of plan competition and the responsiveness of consumers to changes in their costs. The program provides an extra incentive for plans to bid aggressively. “Benchmark” plans offer the drug benefit for a premium no higher than the extra federal subsidy offered to low-income enrollees.\textsuperscript{18} The Centers for Medicare and Medicaid Services automatically assigns low-income beneficiaries who are eligible for full benefits under Medicare and Medicaid to benchmark plans if they have not already selected a specific prescription drug plan.\textsuperscript{19} This auto-enrollment process reduces the drug plan’s administrative costs associated with attracting new members. Because beneficiaries receiving the low-income subsidy account for about 40 percent of Part D enrollees and about 56 percent of Part D spending, a strong incentive exists to bid low.\textsuperscript{20}

Part D’s cost experience has been far better than initially anticipated.\textsuperscript{21} At the start of the program, the CBO estimated that the prescription drug program would cost $509 billion between 2006 and 2011 and $768 billion by 2013.\textsuperscript{22} In contrast, the Medicare trustees report that federal outlays for Part D totaled $336.4 billion through 2011.\textsuperscript{23} By 2013, the program will have spent $485 billion—37 percent less than the CBO estimate.

Part of this difference is undoubtedly the result of faulty assumptions in the original estimate. Enrollment in Part D has been lower than expected, and the slower introduction of new drugs, coupled with the movement of branded drugs to off-patent status, contributed to the slower cost growth.\textsuperscript{24} But we also saw seniors exhibit considerable price sensitivity and pharmaceutical manufacturers discount
aggressively as plans fine-tuned their formularies and steered patients toward lower-cost drugs. The section in this report on Medicare Beneficiaries and Plan Choice points out that seniors participating in Part D have shown that they are active consumers, changing plans once they realize that an alternative offers a benefit that meets their needs at lower cost.25

US spending on prescription drugs slowed relative to other health spending during the late 2000s, with the greatest slowdown occurring in Medicare. Federal cost per Part D enrollee grew 1.0 percent a year between 2006 and 2010, while spending for Medicare Parts A and B grew 3.8 percent. The comparable figures for the country also show a lower drug trend: 2.8 percent growth for prescription drugs versus 3.9 percent for national health spending excluding pharmaceuticals (both on a per capita basis).26

Medicare’s better cost performance did not come at the expense of the consumer. High-cost individuals have ready access to prescription drug coverage rather than being turned away, and consumer satisfaction with Part D is high.27

**MEDICARE PREMIUM SUPPORT**

Proposals to convert Medicare to premium support rely on the concepts of competition, choice, and a defined contribution subsidy. Health plans would compete for enrollees by offering lower prices and better benefits. The federal subsidy would no longer be open-ended, as it is under Medicare’s current defined-benefit approach. Adopting a defined contribution means the subsidy is set at a fixed amount for each beneficiary. Medicare beneficiaries would be able to enroll in any plan but would be responsible for paying the full difference between the government’s subsidy and the plan’s premium.

Premium support reform proposals for Medicare are not new, with roots dating back to Enthoven’s managed competition proposal in the 1970s and proposals by Dowd and colleagues and by Aaron and Reischauer in the 1990s.28 Recent legislative proposals have given the idea new saliency, and that has aroused great controversy. Proponents of premium support argue that the reform will save Medicare for future generations, while opponents argue that premium support will “end Medicare as we know it.”29

Proposals to convert Medicare to premium support rely on the concepts of competition, choice, and a defined contribution subsidy.

PropONENTS believe that premium support offers several advantages for Medicare. First, program spending could be restrained, depending on how the federal subsidy is determined. Second, plans would have a new incentive to engage in price competition while maintaining access and quality of care. Third, beneficiaries could select plans that best meet their needs within a realistic program budget that is affordable for current and future generations of taxpayers.
Opponents say that premium support would eliminate Medicare’s guaranteed benefit and shift health care costs from the government to beneficiaries. Moreover, opponents question whether competition would, in fact, reduce costs of care. That could result in reduced access to care that would most seriously affect poor and frail elderly. Tighter limits on Medicare payments to providers are the best approach, according to these critics.

But that approach is not free of risk. The ACA includes provisions that would lower Medicare payment rates to Medicaid levels or below without changing underlying fee-for-service incentives. The Medicare actuary observes that the ACA’s across-the-board reductions will cause 15 percent of hospitals and other providers of Part A services to lose money on their Medicare patients in 2019, growing to 25 percent in 2030. Implementing those cuts would endanger patient access to care. If they are not, then Medicare becomes an even bigger burden than it is already on the budget and on current and future taxpayers.

A more nuanced approach is needed if we hope to slow Medicare spending and maintain appropriate access to quality care. New ways of paying providers in traditional Medicare can promote higher-value care. However, even with better payment methods, traditional Medicare would remain a fee-for-service system with an open-ended subsidy that continues to promote greater use of services (even if they are better defined).

**Key Design Elements.** As with any proposal to restructure a major federal program, a fully developed plan to convert Medicare to premium support includes numerous provisions that affect how well the reform will work. Most recent proposals do not provide detailed specifications, focusing heavily on slowing the growth of federal expenditures and providing only limited information on other aspects of the reform. Instead of reviewing those proposals, I will focus on several issues in designing a specific reform based on premium support.

The key elements of such a reform include:

- **Competitive bidding.** Health plans would submit bids to the federal government establishing their cost of covering a defined set of services for an average beneficiary in each local market.

- **Comprehensive coverage.** Competing plans would offer at least the basic Medicare benefit, which could be structured like the current Medicare Part A and Part B benefit or modified to better balance health needs and cost. Plans could offer additional benefits as they currently do in Medicare Advantage.

- **Defined contribution.** The federal subsidy would be determined solely based on plan bids, with no additional payments made to plans in particular markets or for other reasons. The subsidy could be set to ensure that all beneficiaries have access to at least two plans that do not charge extra premiums, such as the second lowest bid in an area. The individual’s subsidy would be adjusted to the health risk of the beneficiary, with higher subsidies for
those with greater likely need for care. Additional subsidies would be provided to low-income beneficiaries.

• **Traditional Medicare.** Beneficiaries would have a choice of private plans or traditional Medicare, with further reforms of that program to modernize and simplify the benefit.

• **Spending cap.** The federal subsidy could be capped to increase annually at a rate predetermined by a formula, such as the growth in GDP plus 0.5 percent, or spending growth could be tied to growth in the bids themselves.

• **Regulation.** A restructured Medicare remains a federal program with an obligation to protect the interests of beneficiaries and taxpayers without also stifling competition and appropriate plan initiatives to lower cost.

The following sections discuss the bidding process and whether to impose an explicit limit on growth in program spending, why traditional Medicare should be retained as a plan option, and other changes necessary to implement a comprehensive reform.

**Bidding and the Subsidy.** The current bidding process for Medicare Advantage requires all plans to cover at least the benefits covered by traditional Medicare but allows plans to set their own cost-sharing rules, establish panels of providers, set their own payment rates to those providers, and make other changes intended to reduce plan cost and maintain or improve the quality of care. The bid does not include any additional benefits that may be offered, and the federal subsidy does not cover such benefits. That sensible arrangement could be retained under a reformed Medicare program.

With premium support, the bids provide a basis for determining how much the government will subsidize the average beneficiary. Recent proposals have set the subsidy equal to the second lowest bid in each county as a way of ensuring that beneficiaries would have a choice of at least two plans that would not require an additional premium. Other formulations could be designed, including setting the subsidy at a weighted average of the low bids. Higher subsidies promote greater plan participation (as we have seen with MA’s experience) but reduce the potential for program savings.

Tying the *level* of the subsidy in a predictable way to the plan bids also ties the *rate of growth* of per capita program spending to developments in the market. If the subsidy is set to the cost of the second-lowest bid or some combination of bids, then program spending per beneficiary would grow with year-to-year changes in the bid amounts. In a competitive market, that growth rate would be consistent with the annual change in the cost of providing services in an efficient manner.

However, because of the pressure to advance legislation that the Congressional Budget Office would score as yielding substantial budget savings, recent proposals include a separate cap on the year-to-year growth in program spending. CBO estimates generally do not assume that competitive premium support incentives would yield substantial reductions in health plan costs. They do assume that more direct government
controls over the subsidy would be enforced and would yield savings.

Thus the House budget resolution advanced by Rep. Paul Ryan (R-WI) limits spending growth under premium support to no more than GDP plus 0.5 percent, measured on a per capita basis. That is the same fiscal target President Obama proposed in his fiscal year 2013 budget for the Independent Payment Advisory Board, which would impose fee reductions when necessary to limit Medicare spending.

Although such a provision produces a good CBO budget score, it poses a policy dilemma. The formula-based growth rate might be too tight, in the sense that it may be below the spending growth that would occur in a competitive system without a spending target. That produces budget savings that are ultimately unsustainable without a reduction in access to services for Medicare beneficiaries, but only if the limit is enforced. As we have seen with other attempts to drive down program spending, the threat of a tight limit on spending creates backlash from beneficiary and provider groups that could cause Congress to override the target.

Alternatively, the fiscal target might be too loose. That would allow plans to offer enrollees more benefits rather than keeping bids low, which can be an effective marketing strategy but results in higher program spending.

Nonetheless, having some sort of fiscal target could provide a useful signal to the health sector that Medicare will no longer underwrite unlimited spending increases.

Possibilities include setting the target at per capita growth in the cost of care for the under-65 population or using a blend of the under-65 and over-65 growth rates. Although the level of spending for the Medicare population is substantially higher than that for younger people because of greater incidence of acute and chronic disease in an older population, growth rates may be less subject to this age bias. A blended rate might discourage providers from responding to limits on Medicare spending by shifting more of their practices to private pay patients.

Any fiscal target would have to be evaluated periodically to judge whether it is reasonable given changes in medical technology, disease incidence, and other factors. In addition, Congress should review the appropriateness of Medicare’s fiscal target in the context of the overall federal budget and broader policy priorities.

Setting an external limit on the growth of Medicare spending is an important political message to the health sector that may provide some fiscal discipline, but it is not a way to achieve long-term savings. The fundamental issue is how effective premium support would be in changing the way services are delivered. Better incentives, not fiscal targets, are the source of appropriate reductions in the cost of health care.

A premium support system does not eliminate the need for policymakers to make explicit budget decisions about the overall level of subsidy provided through Medicare compared with subsidies for other domestic and international programs. If spending growth must be slowed below
the rate achieved through plan competition and changed financial incentives, premium support does not make the political decision easier. Premium support does give the health sector greater flexibility than more traditional targeted fee cuts to modify how that reduction in spending is implemented, and it gives beneficiaries greater flexibility in deciding which plan option offers the best value.

**Role of Traditional Medicare.** One of the most difficult questions that premium support proposals must address is how to create vigorous competition among health plans when the government plan—traditional Medicare—dominates the senior market. The concern is that traditional Medicare could use its regulatory power to set below-market payment rates to hospitals, physicians and other providers—lower than private plans could negotiate because they cannot simply dictate to providers what their payments will be.\textsuperscript{39}

The challenge is to ensure a level playing field that does not favor one type of plan over another. Most premium support proposals assume that traditional Medicare would remain an option for all beneficiaries. This is a pragmatic choice that allows beneficiaries to decide for themselves whether they prefer the traditional program or a private plan alternative.

Traditional Medicare currently has 37 million enrollees, and that number is likely to rise over time as the baby boom generation reaches Medicare’s eligibility age, at least until premium support is implemented. The House budget resolution for fiscal year 2012 assumed that traditional Medicare would no longer be a plan option under premium support for people who are newly eligible for benefits.\textsuperscript{40} Even in that case, the number of enrollees in traditional Medicare would initially be in the tens of millions, and a significant number of them likely would choose to remain in the program for decades unless it became unaffordable.

As a result, traditional Medicare will continue to be a major force in the health care market and cannot be ignored. Moreover, traditional Medicare would likely be the low bidder in markets where competition is limited, such as rural markets and small cities dominated by a few health care providers. Lack of competition among providers in such areas gives less room for private plans to negotiate lower costs than traditional Medicare or offer better deals to beneficiaries.

Two studies show that traditional Medicare would remain the low-cost option in many areas under premium support, at least initially. Coulam, Feldman, and Dowd found that setting the federal subsidy equal to the 25th percentile of plan bids would have reduced federal Medicare outlays by 5.6 percent in 2009, assuming that all of the ACA provisions had been in place then.\textsuperscript{41} About half of Medicare beneficiaries would have faced lower premiums in traditional Medicare than in private plans under that scenario.\textsuperscript{42}

Song, Cutler, and Chernew found similar results based on bidding data from MA plans between 2006 and 2009.\textsuperscript{43} Their analysis used the bidding approach proposed in the 2013 House budget
resolution, which tied the federal subsidy to either the second-lowest private plan bid or traditional Medicare cost, whichever is lowest. With that rule, federal subsidies would be reduced from 9 to 13 percent below the cost of traditional Medicare. Traditional Medicare was the low bid for 68 percent of beneficiaries enrolled in that program in 2009.

Retaining traditional Medicare as a plan option also offers beneficiaries a safety valve. Although there is plenty of room to improve efficiency in health care, private plans may fail to find those efficiencies. If that turns out to be the case, then traditional Medicare would be the low-cost plan in most markets, and beneficiaries would shift back to that program when the cost differences became apparent.

Implementing Premium Support. Many discussions of premium support focus on the shift from defined-benefit financing to defined-contribution without considering other aspects of Medicare that must be reformed. Even before premium support can be fully implemented, other policy changes can promote greater efficiency by providers and smarter purchasing by consumers.

The ongoing physician payment crisis caused by the sustainable growth rate formula must be resolved as new payment systems are developed. Better ways to pay for services within a fee-for-service context, such as expanding the payment bundle to cover a broader array of related services, would help reduce inappropriate incentives that result in fragmented care and an increased use of services.

Traditional Medicare’s complex benefit structure should be streamlined to reflect approaches that have long proven effective in private insurance markets. The program’s cost-sharing requirements should be changed to be more understandable to patients, starting with a single deductible for Part A and Part B and a standard copayment requirement for all services. Catastrophic coverage could be offered, and Medigap rules could be changed to make beneficiaries more aware of the cost and value of the services they are offered.

These and other reforms that have been proposed to improve the operation of traditional Medicare are not new ideas. Bundled payment, for example, is the same concept as hospital prospective payment expanded to a larger set of services. Catastrophic coverage was long recognized as a critical gap in insurance protection, yet Medicare still does not offer it to beneficiaries.

Even before premium support can be fully implemented, other policy changes can promote greater efficiency by providers and smarter purchasing by consumers.

The traditional program has adopted new methods, but only sporadically. In a tightening fiscal climate, the program needs greater ability to take advantage of new ways to pay for and deliver care. That calls for Congress to delegate greater authority to modify the program in exchange for
greater accountability by national and regional administrators.

The expanded waiver authority the ACA grants to the Center for Medicare and Medicaid Innovation is a step in that direction. Subdividing the program into regional fee-for-service plans with greater autonomy to respond to local conditions in a timely fashion is another approach that could allow needed midcourse corrections without a lengthy and uncertain political and regulatory process.

The transition to Medicare premium support would span a number of years. Although several proposals would make the reform effective in a decade, a more ambitious timeline should be possible. One option would convert to premium support in five years while implementing other reforms of traditional Medicare on a more expedited basis.

However, even with rapid implementation, the budget impact of such a reform is likely to be modest at first as the health sector adopts new practices that could help reduce costs. Legislation that calls for immediate, large budget savings would create vigorous opposition from provider and patient groups, who would argue with some justification that such reductions in Medicare outlays would be unsustainable. A phased-in approach, allowing time to gauge the success of various initiatives and make necessary midcourse corrections, would be preferable.

**WILL PREMIUM SUPPORT WORK?**

Market-based reform of Medicare based on premium support would change the financial incentives that have been the main drivers of program spending. Under this model, beneficiaries would receive a government contribution enabling them to purchase coverage from any of the plans competing for their business. Beneficiaries could choose more expensive plans, but they would be responsible for any extra premium. Because the subsidy would no longer be open-ended, plans would compete by offering attractive features at affordable prices. That would necessitate finding new ways to deliver care cost-effectively.

The success of such a sweeping reform of Medicare depends on many unpredictable factors. Numerous policy decisions must be made and the resulting policies implemented, and the health sector must respond to those changes. The reform process would begin with legislation, but its impact would be determined by the future actions and reactions of millions of consumers, providers, and health plans.

There is a growing body of evidence on the likely impact of premium support on Medicare beneficiaries, the health sector, and the budget. The following addresses several significant issues, including what the Medicare Advantage experience tells us about the impact of competitive bidding,
whether beneficiaries will be able to make sound choices of health plans, and whether policy measures can control favorable selection (in which private plans attract healthier, lower-cost patients) and reduce unnecessary spending.

**Medicare Advantage and Competition.**

A recent analysis from the Urban Institute compares the bids made by MA plans with the average per capita costs of traditional Medicare and concludes that traditional Medicare is generally more efficient than private plans. Counties where plan bids are below traditional Medicare’s cost also tend to be counties where the cost of traditional Medicare is highest—that is, where traditional Medicare is least efficient, making it easier for private plans to offer low prices. MA bids tend to be higher than traditional Medicare where the cost of traditional Medicare is low.

Given the structure of Medicare’s bidding process, these patterns may not be surprising. Congress set benchmarks higher than the cost of traditional Medicare as a way of promoting plan participation and consumer choice rather than as a way to slow program spending. Setting a benchmark essentially tells the bidders what Medicare is willing to pay. That is not a sensible way to induce the plans to reveal the lowest price that they are willing to take.

Simply lowering the benchmarks does not resolve this inherent defect in the MA bidding process, although it does reduce the amount paid to MA plans. The ACA lowers the average benchmark and reallocates payments, with higher benchmarks in markets that have lower average fee-for-service costs. In counties in the top quartile of fee-for-service costs, such as Dade County (Florida) and Orange County (California), the benchmark will be 95 percent of fee-for-service costs per enrollee. In counties in the lowest quartile, such as Boise (Idaho), the benchmark will be 115 percent of fee-for-service costs per enrollee.

That might reduce federal payments, but it does not change the perverse incentives this bidding system creates. If we expect plan competition to produce lower costs, we cannot tie private plan payments to traditional unmanaged fee-for-service Medicare.

Even with the constraints on effective competition that now exist, private MA plans can provide Medicare benefits at a lower cost than the traditional program. This has long been evident in annual reports from the Medicare Payment Advisory Commission (MedPAC), which consistently show HMOs bidding at or below fee-for-service cost.

HMOs typically offer a limited provider network and some ability to manage the cost of care. That business model is likely to be more efficient than unlimited fee-for-service, but it is also less attractive to beneficiaries. For both reasons, HMO bids are likely to be below those of other plans. The data bear this out. In 2010, HMO bids came in at 100 percent of fee-for-service cost, or 4 percentage points less than the average MA plan bid and 16 percentage points below the payment benchmark.

In contrast, plans that most resemble traditional fee-for-service Medicare tend
to bid the highest amounts. Private fee-for-service plans offer unlimited access to Medicare providers and do not attempt to manage patient care. In 2010, their average bid was 16 percent higher than fee-for-service cost—but 2 percentage points less than the benchmark.48

Comparing MA bids with the cost of traditional Medicare tells us more about the bidding system than about the ability of a better-designed competitive process to promote efficient delivery of health care and reduce cost. Moreover, the single-minded pursuit of lower spending is not a winning strategy for many health plans.

Medicare beneficiaries are well aware that traditional Medicare does not cover services (such as hearing aids, eyeglasses, and dental coverage) that they would like and leaves them exposed to potentially high out-of-pocket costs for services that are covered. Rather than cobbling together more complete coverage by combining traditional Medicare with a Medigap plan costing $1,500 a year or more—and still having to pay for noncovered services out of pocket—a comprehensive MA plan can make financial sense even at a high premium.49

It may not be possible to interpret the bids submitted to the Centers for Medicare and Medicaid Services (CMS) as solely reflecting the cost of providing standard Medicare benefits. A high bid results in the plan having to charge beneficiaries an extra premium. Since money is fungible, beneficiary premiums offset the plan’s general operating cost regardless of how the premium amount is set. Allocating more of the cost (and the premium the beneficiary pays) to the standard benefit may give the plan a marketing advantage, allowing it to claim that additional benefits are low-cost or even “free.” If so, then MA plan bids may not be good indicators of health plan efficiency.

Medicare Beneficiaries and Plan Choice. Can Medicare beneficiaries make economically sound decisions about their choice of health plan? That requires beneficiaries to weigh the premium against other aspects of health insurance—including likely out-of-pocket costs, availability of extra benefits, access to providers, and other factors that are not easy to reduce to a single number. The lowest-premium plan may not be the best choice for an individual, but premium is the one parameter that can easily be compared across health plans.

One indication that many seniors are actively choosing their health plans is current enrollment in MA plans. In 2012, about 27 percent of Medicare beneficiaries were enrolled in MA plans. That figure has held fairly steady over the past five or six years, once plan participation rose following 2003 legislation to increase their payments.50 Those individuals have made a conscious decision not to enroll in traditional Medicare despite the additional effort necessary to become familiar with plan options outside the traditional program.

Because of the many dimensions of plan value that cannot be measured, it is extremely difficult to assess whether beneficiaries’ MA plan choices are economically sound in the sense of...
offering the best benefits for the lowest cost. It is equally difficult to assess whether the decision to enroll in traditional Medicare (or traditional Medicare combined with Medigap) is economically sound for those who select that option.

Attention has focused on plan choice in Part D, which is a less complex decision than the choice of a comprehensive health plan. The main business of prescription drug-only plans is to deliver a product (the prescription drug) to the consumer. Part D plans offer walk-in service at local pharmacies, but the service components of this benefit are minimal compared with plans that cover the services of physicians and hospitals.

Medicare Part D provides a test of whether seniors can successfully select a health plan when faced with a large number of complex choices. The average senior was offered dozens of different plan options characterized by varying combinations of deductibles, coinsurance, drug formularies, and distribution channels (including local retail pharmacies and mail order). Initial studies of Part D indicated that beneficiaries did not select the lowest-cost options. However, those studies did not take into account the learning process necessary to navigate a complicated new system.

A recent analysis published in the *American Economic Review* reports that seniors found ways to reduce their costs over time as they gained experience with Part D. Between 2006 and 2007, overspending—measured as the difference between the beneficiary’s actual out-of-pocket costs (including the insurance premium) and the cost of the cheapest alternative—declined by an average of $298. The primary source of improvement was switching plans. Not surprisingly, those who switched plans or who had overspent the most in 2006 experienced the greatest savings.

The study found that the learning effect improved the plan choices of even the oldest consumers and those taking medications for Alzheimer’s disease, whose cost experience improved by more than the average. That suggests that younger family members, their physicians, and other community institutions assist these individuals in choosing plans and medications. It also confirms the importance of providing decision support that extends beyond websites and 1-800 telephone numbers.

A well-organized market with clear choices and appropriate regulatory safeguards is essential for ensuring that Medicare beneficiaries are able to navigate the system.

This evidence shows that Medicare beneficiaries do respond to differences in the cost of competing prescription drug plans once they have had sufficient experience with their initial plan to recognize that other options might be better. A similar learning process can be expected for beneficiaries choosing among full-service health plans.

A well-organized market with clear choices and appropriate regulatory safeguards
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is essential for ensuring that Medicare beneficiaries are able to navigate the system. Medicare could draw lessons from the Federal Employees Health Benefit Program, which has been operating such a marketplace for more than four decades, and from the work now being done to create health insurance exchanges under the Affordable Care Act. If properly implemented, the effort to change plans after initial enrollment would be reduced, making consumers more likely to reconsider their options periodically to determine whether a new plan would be more suitable.

**Risk Adjustment and Cherry-Picking.**

Any system that offers beneficiaries a choice of health plans could be exposed to risk selection, with some plans attracting a healthier group of enrollees than other plans. Unless the subsidies are adjusted to account for risk selection, that drives up the total cost of coverage.

This has long been an issue with Medicare’s private plan option. Beneficiaries less likely to use health services have been attracted to MA plans, while those with more costs than average have remained in traditional Medicare. Payments did not account for the difference in cost between MA and traditional Medicare. Consequently, favorable selection during the 1990s meant that Medicare spent more per beneficiary who enrolled in MA than if the beneficiary had remained in traditional Medicare.

Risk adjustment systems are used to reduce the extent of under- and overpayment, but much of the variation in health spending across individuals is not predictable. In 2004, Medicare transitioned to the improved Centers for Medicare and Medicaid Services Hierarchical Condition Categories (CMS-HCC) system. CMS-HCC can explain 11 percent of that spending variation compared with 1 percent for the previous system.

To further reduce the extent of risk selection, in 2006 Medicare began to require that enrollees in MA plans remain with their plan for the entire year. Previously, beneficiaries could change plans every month, which made it easier for private plans to attract healthier enrollees and left traditional Medicare with a more expensive group of beneficiaries.

A recent *Health Affairs* study shows that the improved risk adjustment formula and prohibition on monthly disenrollment by beneficiaries have largely succeeded in reducing favorable selection in Medicare Advantage. Between 2004 and 2008, favorable selection had dropped by a factor of three, a marked decline that minimizes its disruptive influence.

Even if favorable selection is largely controlled, MA plans may be geared to a healthier population and thus might not deliver adequate services to all of their enrollees. A companion *Health Affairs* article finds that use rates for major service categories (including emergency departments and ambulatory surgery) were 20 to 30 percent lower in MA health maintenance organizations than in traditional Medicare. The findings suggest that Medicare Advantage HMO enrollees might in general use fewer but more appropriate services than beneficiaries in traditional Medicare.
CONCLUSION

Medicare has fueled the expansion of the American health system, spurring medical innovation and improving lives. However, the program remains wedded to the basic structure that it started with in 1965—a nearly 50-year-old political compromise rather than a modern health plan. Congress has made infrequent changes to the program, more often in response to crisis than to opportunity, without attempting a comprehensive reform that could make Medicare a better value for seniors, taxpayers, and health care providers. As a result, Medicare remains a patchwork that is unprepared for the massive expansion that will occur as the baby boom generation ages into the program.

The single most-discussed challenge facing Medicare is financing. A host of commissions and expert groups, ranging from the President’s National Commission on Fiscal Responsibility and Reform to the Heritage Foundation, have argued that the country is on an unsustainable path. Medicare spending has grown twice as fast as the economy over the past decade, even before millions of baby boomers enter the market as new beneficiaries. There is broad agreement that our future depends on slowing the growth of Medicare spending while ensuring seniors’ access to appropriate care.

Premium support is the core of a market-based reform of Medicare financing. By shifting from defined benefits to defined contributions, premium support dramatically alters the economic incentives that drive program spending rather than program value, and it makes consumers an active part of the solution. The political and technical challenges of instituting market-based reforms cannot be overstated, but the alternative approach of centralized decision making and cost control is less appealing. The power of premium support is in plan competition and consumer choice, not in spending limits that cannot be enforced.

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ENDNOTES


3 Ibid., 36.


5 Author’s calculation of growth between 2015 (after implementation of the Affordable Care Act) and 2057 for major budget categories using CBO’s extended baseline scenario. See CBO, The 2012 Long-Term Budget Outlook, Supplemental Data, www.cbo.gov/publication/43288.


10 See Social Security Act, Public Law 74-271 (1935), Sec. 1801.


19 Benchmark plans are required to offer coverage for prescription drugs commonly used by dual eligibles. The inspector general of Health and Human Services found that Part D plan formularies include 96 percent of the 191 drugs commonly used by this population. See Stuart Wright, “Memorandum Report: Part D Plans Generally Include Drugs Commonly Used by Dual Eligibles,” HHS Office of the Inspector General, OEI-05-12-00060, June 7, 2012, http://oig.hhs.gov/oei/reports/oei-05-12-00060.pdf.


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30 Shatto and Clemens, Projected Medicare Expenditures.

31 Failure to implement previously-legislated reductions in Medicare payment rates would increase spending over current projections, which places additional demands on general tax revenue.


36 Even without a spending target, a well-functioning competitive bidding system only approximates efficient pricing. Medicare’s substantial subsidy can be used only for health services. That drives up demand for those services beyond the level obtained if the same amount of subsidy was provided to beneficiaries as an unrestricted lump-sum cash payment.

37 Limiting growth in the Medicare subsidy to growth in spending for the under-65 population was proposed in Aaron and Reischauer, “The Medicare Debate.”


Personal communication from Roger Feldman, June 25, 2012.


More-complex cost-sharing structures, such as value-based insurance designs, could be developed to give beneficiaries stronger incentives to use appropriate services in an efficient manner. For example, the cost-sharing requirement could be waived for the frequent blood tests needed by diabetic patients.


See, for example, MedPAC, Report to the Congress.

Ibid.


Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, 2012 Annual Report, table V.B3.


Ketcham et al., “Sinking, Swimming, or Learning to Swim in Medicare Part D.”


Ibid.
