



MEDICARE COVERAGE OPTIONS Reforming the Beneficiary Choice Process to Improve Competition

Policymakers considering changes to America’s broken healthcare system should focus on Medicare. The program is a jumble of initiatives added at different times and for different reasons, and it is due for reform.

In “[Medicare Coverage Options: Reforming the Beneficiary Choice Process to Improve Competition](#),” James C. Capretta—a resident fellow at the American Enterprise Institute—reviews Medicare’s structure and the results of a variety of policy experiments to find what has worked, what has failed, and how these lessons can be used to reconfigure the program. He finds that competition, consumer choice, and cost sharing are the keys to effective reform. Using these principles as a basis, his study lays out steps to help Medicare beneficiaries make informed choices about their coverage options—steps that will intensify competition and facilitate affordable coverage while reducing inefficiency and waste.

REVIEW OF MEDICARE

Medicare beneficiaries may choose to receive their benefits in a variety of ways:

- *The traditional fee-for-service (FFS) program and Medigap coverage.* Reflecting standard insurance practice at the time of Medicare’s enactment, FFS simply pays for whatever medical expenses the insured incurs, with some degree of cost sharing to limit consumption. The use of supplemental “Medigap” insurance plans has undermined the effectiveness of this cost sharing.
- *Medicare Advantage (MA) plans.* Medicare beneficiaries may choose to enroll in a private insurance plan through an MA plan, in which case Medicare pays the insurance provider rather than paying for the beneficiaries’ medical expenses directly. Today, more than 30 percent of Medicare beneficiaries are enrolled in MA plans, and MA plans cost (on aggregate) 6 percent less for the same coverage than FFS plans.

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- *Prescription drug benefit (Medicare Part D)*. Part D is a prescription drug plan delivered entirely through private insurance, with government subsidy levels based on insurers' bids. This fixed subsidy encourages seniors to find affordable coverage, which has driven competition that has kept costs low.
- *Accountable care organizations (ACOs)*. ACOs are formed by hospitals and physicians to manage care, much as a traditional HMO would, and they are incentivized to provide care more cheaply than the FFS program does. ACOs have underperformed because of a number of design flaws: beneficiaries cannot choose among ACOs and are instead assigned to one, ACOs cannot incentivize beneficiaries to stay within their network (in fact, beneficiaries are often unaware there is a network), and most ACOs cannot handle payments to members themselves—members are paid through the FFS system.

REFORMS

ACOs were hamstrung by policymakers' failure to consider beneficiaries' role in the reform effort. A better reform would allow physicians and hospitals to form what might be called Medicare provider networks (MPNs) to compete with unmanaged FFS and MA plans. Such networks would be more autonomous than ACOs and could be successful if they include the following features:

- *Explicit beneficiary enrollment*. Enrollment in an MPN should be an annual choice for beneficiaries, driving MPNs to compete with each other and also with regular Medicare.
- *Control over Medicare payments*. Unlike ACOs, MPNs should handle payments to doctors and hospitals instead of relying on the FFS system.
- *In-network benefits*. MPNs should be allowed to implement financial penalties if beneficiaries go outside their networks.
- *Coordination with Medigap policies*. MPN beneficiaries should be allowed to enroll in Medigap policies that provide more expansive coverage than unmanaged FFS plans because the MPNs would take responsibility for managing their patients' care, avoiding the problem of unconstrained consumption.
- *Fair competition with MA plans*. Ideally, MPNs would compete on the basis of price with FFS and MA plans. Because this option may be controversial owing to its implications for high-cost FFS enrollees, an interim step would allow direct competition between MPNs and MA plans by requiring MPNs to participate in today's MA system of bidding to determine baseline prices.

The process by which beneficiaries choose their coverage is also broken—ACO enrollment is involuntary and the process for selecting a Part D insurer is opaque. Beneficiaries should be able to use one platform to make a three-part coverage decision:

- *Basic Medicare*. Beneficiaries would choose among three options: remaining in the traditional unmanaged FFS program, enrolling in an MPN in their region, or enrolling in an MA plan.

- *Drug coverage.* A person enrolling in the FFS program or an MPN would select from the private insurance plans sponsoring drug-only insurance products, while those in MA plans could choose to enroll in added drug coverage sponsored by the same plan.
- *Supplemental coverage.* Beneficiaries who have chosen the FFS program would not be allowed to enroll in a full-coverage Medigap plan, but those who have chosen an MPN could purchase more expansive supplemental coverage, most likely through a private plan that is offered in conjunction with the MPN—possibly as a package.