Medicare Coverage Options: Reforming the Beneficiary Choice Process to Improve Competition

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ABSTRACT

Medicare is a jumble of choices and regulations. The program's beneficiaries have options for how they get their insurance, but those options are presented to them in ways that lack transparency and clarity. Beneficiaries can choose private insurance (Medicare Advantage, or MA) or the traditional program for their basic Medicare coverage; they can buy supplemental insurance to cover costs that Medicare does not; and they can enroll in one of several competing options for drug coverage. Medicare has recently added a new option, called accountable care organizations (ACOs), for improved management of care in the traditional program, although the beneficiaries are not presented with a clear choice to enroll in ACOs. ACOs should be replaced with Medicare provider networks that compete directly with MA plans and the traditional program. The overall program should be reformed so that the beneficiaries can see more clearly what the various combinations of options would mean for their premiums and overall costs.

JEL codes: I110, I130, I180

Keywords: Medicare, Medicare Advantage, choice, competition

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Medicare beneficiaries have always had options when deciding what kind of insurance arrangements they prefer for paying their medical bills. The default option in Medicare is the traditional, government-run fee-for-service (FFS) insurance program. Although all taxpayers are required to participate in Part A of the program (for hospitalization insurance), enrollment in Part B, which covers physician services and outpatient care, is voluntary. Beneficiaries can also supplement their regular Medicare coverage with a private insurance product—a so-called Medigap plan. (Sometimes these plans are sponsored by former employers.) Medigap coverage is popular because it pays for costs not covered by Medicare.

Since the 1980s, Medicare beneficiaries have also had the option of enrolling in a private insurance plan—such as a health maintenance organization (HMO)—covering regular Medicare benefits. In effect, the Medicare program allows the private insurance plans to compete directly with FFS for beneficiary enrollment. These plans typically provide benefits that go beyond what is covered by traditional Medicare at little or no added cost to their enrollees, thus relieving the beneficiaries of the need to enroll in a Medigap plan.

Since 2006, beneficiaries have had the option of enrolling in one of Medicare's prescription drug benefit offerings. The Medicare drug benefit is delivered entirely through private insurance plans.

More recently, Medicare's administrators have also created an option within the traditional Medicare FFS benefit called accountable care organizations (ACOs). ACOs are the most important of several delivery system reform provisions of the Affordable Care Act (ACA), enacted in 2010. The government is attempting to improve the cost-effectiveness of care delivered to patients by encouraging doctors and hospitals to form ACOs to better manage patient care. Although beneficiaries do not opt to join ACOs (they are assigned to them by the Medicare program), they have the right to opt out of the sharing of their Medicare

claims data with ACOs.[1] Beneficiaries who do opt out make it difficult for ACOs to effectively manage their care.

Some evidence from the drug benefit and the private plans participating in Medicare indicates that competition and choice improve overall program performance. Such evidence is important because Medicare heavily influences how health care is delivered to all patients, not just the elderly. Improving the cost-effectiveness of Medicare could help improve the cost-effectiveness of the entire healthcare system.[2]

A next-stage agenda for Medicare reform should focus, at least initially, on the steps necessary to make the differences among the current options clearer to beneficiaries in an effort to deepen and improve the effects of choice and competition on program performance. Developing such an agenda requires a clear understanding of the options that are presented to beneficiaries today and the implications of the explicit or implicit choices that beneficiaries are making. From there, it is possible to identify a series of changes that can clarify and intensify competition and, thus, also improve the value of the program for beneficiaries and taxpayers alike.

"Over the past half century, most private insurance has evolved away from [the fee-for-service] model, whereas Medicare remains largely as it was originally structured."

MEDICARE'S TRADITIONAL FEE-FOR-SERVICE OPTION AND MEDIGAP COVERAGE

When Medicare was enacted in 1965, its authors wanted to create a program for senior citizens that generally followed the dominant private insurance plans available to working-age Americans. At that time, the most common insurance model was fee-for-service—often provided by Blue Cross Blue Shield plans. Under FFS, the insurance carrier did little more than pay claims. If a plan enrollee was provided

1. Adam J. Hepworth and C. Frederick Geilfuss II, "Final Rule Will Give ACOs Participating in MSSP Access to More Data for More Beneficiaries," *Health Care Law Today*, June 29, 2015.
2. For a discussion of the relationship of Medicare FFS with the broader system of care delivery, see James C. Capretta, "The Role of Medicare Fee-for-Service in Inefficient Health Care Delivery" (RWJF/AEI Working Paper, Robert Wood Johnson Foundation and American Enterprise Institute, Washington, DC, 2013).

services by a licensed medical professional, the claim for reimbursement was paid, presuming compliance with Medicare's regulatory requirements.

In FFS, the primary check on overuse of services is patient cost sharing. The insurance plans are designed with up-front deductibles and coinsurance payable by plan enrollees for each service rendered. The cost-sharing requirements are intended to ensure some cost sensitivity on the part of the insurance plan enrollees when they use services.

Medicare's FFS program was built precisely on this 1965 insurance model. Over the past half century, most private insurance has evolved away from this model, whereas Medicare remains largely as it was originally structured.

Medicare FFS requires rather substantial cost sharing from the beneficiaries. In 2017, Medicare requires a $1,316 deductible for each inpatient hospital stay, a $183 deductible for physician and other outpatient services, and a 20 percent coinsurance payment for each physician office visit and service.[3]

But, historically, these cost-sharing requirements have been ineffective at controlling costs in the Medicare FFS program. The vast majority of FFS beneficiaries—87 percent, according to the Medicare Payment Advisory Commission (MedPAC)—have supplementary insurance in the form of Medigap coverage (Medicare supplemental insurance), retiree wraparound plans, or Medicaid.[4] These secondary insurance plans meet most of the costs not covered by the Medicare FFS program.

Current law allows beneficiaries to select from 10 different standardized Medigap options. All the plans cover the coinsurance requirements for hospital stays under Part A of the program, and most of the plans also cover the Part A deductible. The most popular plans are C and F, which are also the most comprehensive plans, covering all the cost sharing required by both Parts A and B of Medicare for standard benefits (including for hospital stays), the skilled nursing home benefit, and outpatient services under Part B.[5] About 53 percent of seniors enrolled in a Medigap plan choose either plan C or plan F for their coverage.[6]

Medicare's rules also require physicians who agree to participate in Medicare to accept Medicare payment rates as payment in full, effectively precluding

3. Centers for Medicare and Medicaid Services, "Medicare 2017 Costs at a Glance," accessed April 26, 2017.

4. Medicare Payment Advisory Commission, *Health Care Spending and the Medicare Program: A Data Book*, chart 3-1, June 2015.

5. The Medicare Access and CHIP Reauthorization Act of 2015 prohibits the coverage of the Part B deductible in Medigap plans offered to beneficiaries who enroll in the program beginning in 2020. See Pub. Law No. 114-10, § 401, 129 Stat. 159–60 (2015).

6. Jennifer T. Huang et al., *Medigap: Spotlight on Enrollment, Premiums, and Recent Trends* (Menlo Park, CA: Henry J. Kaiser Family Foundation, April 2013).

any additional billing to the patient. Current rules allow nonparticipating physicians to charge up to 109.25 percent of Medicare's rates, with a larger portion of a total bill collected directly from the beneficiary.[7]

Most Medicare FFS enrollees, therefore, pay very little at the point of service even though the Medicare law requires substantial cost sharing. As a consequence, FFS enrollees have little incentive to think twice about the many medical services presented to them as possibly improving their health, and their physicians have strong incentives to favor more tests and procedures over fewer because higher volume generally means higher revenue.

The result of this dynamic is hardly surprising. The volume of services paid for by Medicare FFS has been on a steady and steep upward trajectory for decades. For instance, the real price that Medicare paid for physician services dropped between 1997 and 2005 by nearly 5 percent, but total real spending for physician services rose by 35 percent because of rising use and more intensive treatment per condition.[8] And because physicians are essentially the gatekeepers of the delivery system, as use of their services rises, more lab tests are performed, more prescriptions are written, and more time is spent by patients in hospitals.

The combination of unmanaged FFS Medicare with comprehensive Medigap coverage is an important factor in Medicare's high cost. A recent study estimated that Medicare spending on beneficiaries enrolled in Medigap plans is 22 percent higher than it is for beneficiaries without the added coverage.[9] By driving up the overall costs of Medicare, Medigap increases the premiums that all Medicare beneficiaries—not just those with Medigap coverage—must pay for enrollment in Part B of the program. Medigap also drives up costs for federal taxpayers, who heavily subsidize the Medicare program. Because Medicare covers most of the cost of medical expenses incurred by patients enrolled in the program and Medigap only covers the portion not covered by Medicare, the induced use of medical services caused by enrollment in Medigap plans is not fully covered by the Medigap premiums themselves. There is a cost that spills over into the regular Medicare program and is financed with Medicare premiums, Medicare payroll taxes, and subsidies provided by the general fund of the

7. "Medicare Participation Decision & FAQs," Medical Group Management Association, accessed April 10, 2017, http://www.mgma.com/government-affairs/tools/medicare-participation-decision-faqs.

8. Congressional Budget Office, "Factors Underlying the Growth in Medicare's Spending for Physicians' Services," Background Paper, June 2007.

9. Marika Cabral and Neale Mahoney, "Externalities and Taxation of Supplemental Insurance: A Study of Medicare and Medigap" (NBER Working Paper 19787, National Bureau of Economic Research, Cambridge, MA, January 2014).

Treasury. The premiums Medigap enrollees pay for their coverage, therefore, fall short of the actual cost of Medigap insurance.

The Congressional Budget Office (CBO) agrees that the presence of Medigap plans inflates the overall cost of the Medicare program. The agency has estimated that changing Medicare so that it requires Medigap enrollees to pay a higher deductible before the supplemental coverage kicks in, in combination with a restructuring of Medicare's cost-sharing rules, would lower overall Medicare costs by $111 billion over a decade.[10] The savings would be even higher if these rules applied to employer-sponsored supplemental plans.

US health care is frequently—and rightly—criticized for its fragmentation and lack of coordination. The disconnects that regularly occur among medical providers treating the same patient are a major source of quality problems as well as high costs. Unmanaged Medicare FFS, in combination with expansive supplemental coverage, is a major reason uncoordinated care is still dominant.[11] The program has established separate payment rules for every major provider group. These regulations are written on the assumption that the providers are largely independent operations, disconnected from any other entity providing medical care. Medicare is thus underwriting, to a large extent, today's fragmented system of care delivery.

The political economy of Medicare has proven to be a difficult obstacle to reform. There have been various attempts at using quality and cost data to steer patients toward the most cost-effective providers of services—the start of what might be Medicare's version of a preferred provider network. These efforts have been largely unsuccessful because the providers who would have been left out of the preferred group worked with their representatives in Congress to put up roadblocks preventing their exclusion from the highest level of reimbursement for services.[12]

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10. Congressional Budget Office, "Options for Reducing the Deficit: 2015 to 2024," November 2014, 49. This option specifically assumes the programs' cost sharing would be restructured into a single deductible of $650, plus 20 percent coinsurance on all other services above deductible, up to a maximum out-of-pocket cap of $6,500. The dollar threshold would be adjusted in future years on the basis of per capita FFS cost growth. Medigap plans would not cover the upfront deductible but could cut in half the coinsurance payment required above the deductible. Beneficiaries with Medigap coverage would have a maximum annual out-of-pocket payment of $3,575 in the first year of implementation of the reform.

11. Uncoordinated care remains prevalent in the employer setting, too. One likely reason is the preference of workers for unlimited choices of physicians. Federal tax law also encourages expansive employer coverage by excluding the value of employer-paid premiums from the taxable compensation of workers. See Jonathan Gruber, "The Tax Exclusion for Employer-Sponsored Health Insurance" (NBER Working Paper 15766, National Bureau of Economic Research, Cambridge, MA, February 2010).

12. Kate Steadman and Christopher Weaver, "Medicare Experiments to Curb Costs Seldom Implemented on a Broad Scale," *Kaiser Health News*, November 3, 2009.

Consequently, the FFS model has remained dominant, and cost control efforts have focused, until recently, not on making the delivery system more efficient but on across-the-board payment rate reductions. CBO has estimated that the payment reductions for hospitals and Medicare Advantage (MA) plans in the ACA will produce far greater savings for the federal government than the delivery system reforms aimed at improving the cost-effectiveness of patient care.[13] It is simply much easier, politically and programmatically, to pay all providers less with across-the-board cuts than to steer payments on the basis of quality and value assessments.

MEDICARE ADVANTAGE

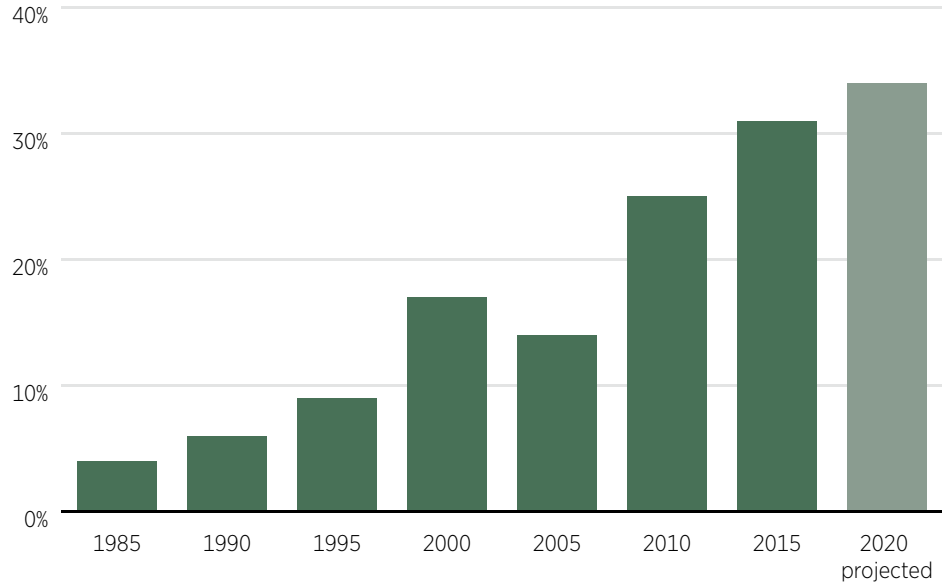
Although FFS remains the dominant form of insurance in Medicare, the program does give beneficiaries the option to take their Medicare entitlement through an alternative arrangement.

Medicare Advantage is the current incarnation of Medicare's capitated payment program, which started in the 1980s as an HMO risk-contracting initiative. The fundamental design of the program remains as it was when the original risk-contracting amendments were enacted in 1982: beneficiaries are given the option to enroll in a private insurance plan instead of the traditional FFS program, and the Medicare program makes a fixed monthly payment to the HMOs and other insurance plans instead of a payment for every service that is provided. It is up to the private insurance plans to manage the care of the beneficiaries to keep overall costs below the aggregate amount of monthly payments received from the government for their enrollees.[14] The managed care plans typically contract with a network of participating physicians and hospitals to cut costs. Beneficiaries who enroll in these plans usually are required to pay a larger share of the costs for services they receive from out-of-network providers.

The managed care plans compete with each other—and with the traditional FFS program—for enrollment by Medicare beneficiaries, who are free to choose to remain in FFS or to enroll in one of the MA plans available in their region. The MA plans distinguish themselves in the marketplace through a combination of the network of physicians and other providers affiliated with their plans, the premiums they charge beyond the Medicare Part B premium, and the

13. Letter from Douglas W. Elmendorf, Director, Congressional Budget Office, to Nancy Pelosi, Speaker of the House, March 20, 2010.
14. Health Care Financing and Organization, "Learning from Medicare: Medicare Advantage," Robert Wood Johnson Foundation, Washington, DC, August 2011.

FIGURE 1. MEDICARE ADVANTAGE ENROLLMENT AS A PERCENTAGE OF TOTAL MEDICARE ENROLLMENT



Note: From 1997 to 2003, Medicare Advantage was called Medicare+Choice. Earlier, it was known as the HMO Risk Contracting program.

Source: Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, *2016 Annual Report*, table V.B4, June 2016.

additional benefits they offer beyond those required in Medicare law. The MA plans have an incentive to control costs so they can offer coverage with competitive premiums and attractive additional benefits.

Enrollment in an MA plan is completely optional for the beneficiaries, and the insurers offering MA plans are free to choose where they would like to offer plans. MA competition is heaviest in more populated areas, where insurers are able to provide some efficiency improvement over FFS by steering patients toward the providers with whom they have a contractual relationship. There are fewer MA plans in less populated counties, where FFS is often able to provide Medicare-covered benefits at a cost that is difficult for the MA plans to match.[15]

Enrollment in MA plans (and their predecessors) has grown steadily as a percentage of overall Medicare enrollment, as shown in figure 1. Today, more than 30 percent of Medicare beneficiaries are enrolled in MA plans, and projections

15. Brian Biles, Giselle Casillas, and Stuart Guterman, "Does Medicare Advantage Cost Less Than Traditional Medicare?" (Issue Brief, Commonwealth Fund, January 2016).

TABLE 1. MEDICARE ADVANTAGE BENCHMARKS, BIDS, AND PAYMENTS AS A PERCENTAGE OF FEE-FOR-SERVICE COSTS

	Benchmarks	Bids	Payments
All MA plans	107	94	102
MA HMOs	106	90	101

Source: Medicare Payment Advisory Commission, *Health Care Spending and the Medicare Program: A Data Book*, chart 9-6, June 2016.

from the trustees overseeing the program indicate that the percentage of beneficiaries opting for MA coverage will continue to grow in the future.

A growing number of studies confirm that MA plans can operate more efficiently than FFS plans in many parts of the country (sometimes much more efficiently), even if the government's payments to MA plans on behalf of the beneficiaries often exceed what would be spent if the beneficiaries had remained enrolled in FFS.

Recent data (see table 1) compiled by MedPAC confirms the relative efficiency of MA plans compared to FFS. In 2016, MA plans of all types submitted premium bids to the Centers for Medicare and Medicaid Services (CMS) that came in at 94 percent of FFS costs. In other words, MA plans are able to provide the Medicare benefit package, as defined in the statute, for 6 percent less than the FFS cost. When only MA HMOs are examined, the cost savings is 10 percent.[16]

Medicare pays the MA plans on the basis of benchmarks, which are set at levels that are generally above the MA bids. Since 2012, if an MA plan bids below the benchmark, it is paid what it bid plus between 50 and 70 percent of the difference between what it bid and the benchmarks (depending on the insurance provider's quality ranking from the government).[17] The plans are also required to return the added payment above their bids to the beneficiaries, either in the form of benefits that go beyond what is required in Medicare law or through lower cost-sharing requirements, such as reduced premiums, deductibles, or copayments. If an MA plan bids above its benchmark amount, it is paid the benchmark

16. Medicare Payment Advisory Commission, *Health Care Spending and the Medicare Program*, chart 9-6.

17. Between 2004 and 2011, all MA plans received 75 percent of the difference between their bids and the benchmark if the bid was below the benchmark. The Affordable Care Act tied the amount returned to the plans to a new quality rating system. The highest-rated plans now receive 70 percent of the difference between their bids and the benchmark returned to them. Plans can also get 65 percent or 50 percent of the difference, depending on their quality ranking.

amount and the beneficiaries are required to pay the additional premium to make up the difference.

MA plans are popular with beneficiaries precisely because enrollees can get coverage that is comparable to FFS plus Medigap without paying the high premiums that full Medigap coverage requires. CBO has confirmed the relative efficiency of MA plans. The agency found that MA plans will be able to offer coverage for Medicare benefits defined in law for a lower cost than FFS in 2020, with average bids from MA plans that are 6 percent lower than average FFS spending. If Medicare were changed to intensify the competition between MA plans and FFS (through the adoption of a reform plan referred to as "premium support"), CBO expects that MA plan bids would fall by an additional 4 percent.[18]

On average, MA plans are able to deliver coverage at a lower cost than unmanaged FFS by putting in place controls to limit unnecessary hospitalizations. One study found that the exit of MA plans from a market area was associated with a 60 percent jump in hospitalizations for beneficiaries who lost their MA plans. This increase in hospitalizations did not lower the mortality rate for the affected patients, nor did it dissipate over time. These results clearly point to the effectiveness of MA plans in lowering the number of unnecessary inpatient hospital admissions.[19]

A major impediment to more intensive price competition among MA plans—and between MA plans and FFS—is the lack of clear information about the premiums beneficiaries must pay for the coverage option they select. Medicare beneficiaries must pay a Part B premium to secure coverage for physician services and outpatient care.[20] MA plans are

"Although the MA program has delivered a product that has proven to be attractive to many Medicare beneficiaries, the clustering of enrollment in zero-premium plans is a clear indication that a more transparent choice structure might lead to even lower premiums for beneficiaries."

18. Congressional Budget Office, "A Premium Support System for Medicare: Analysis of Illustrative Options," September 2013.
19. Mark Duggan, Jonathan Gruber, and Boris Vabson, "The Efficiency Consequences of Health Care Privatization: Evidence from Medicare Advantage Exits" (NBER Working Paper 21650, National Bureau of Economic Research, Cambridge, MA, 2015).
20. The regular Part B premium for 2017 is $134.00 per month. Higher-income beneficiaries pay a higher premium. Centers for Medicare and Medicaid Services, "2017 Medicare Costs" (CMS Product No. 11579, revised November 2016).

allowed to use the rebates they receive for submitting bids below their regional benchmarks to reduce the Part B premium owed by their enrollees, but almost no plans do so. Instead, MA plans tend to use those rebates to enhance the benefits they offer to their enrollees and, if they can, charge no additional premium above what is already collected by the government for Part B (the vast majority of Medicare beneficiaries have their Part B premiums withheld from their monthly Social Security checks). About half of all MA plan enrollees are enrolled in plans that charge no additional premium to what is collected for Part B. (Such plans are known as *zero-premium plans*.) Only 5 percent of MA enrollees are in a plan that allows beneficiaries to pay a reduced monthly Part B premium.[21]

The reason so many MA plans congregate around the zero-premium option is that there is no competitive advantage in offering a lower Part B premium to potential enrollees. Many Medicare beneficiaries use the Medicare Plan Finder website[22] to help them learn about their MA and drug benefit options. That website never provides a direct premium comparison so that beneficiaries can clearly see what they are paying in total premiums. Rather, it separately identifies the additional premium owed for enrollment in an MA plan, including for drug coverage. The focus on the additional premium charged by MA plans is the reason so many of the plans choose not to require an additional premium. (Note that even though these plans are known as zero-premium plans, beneficiaries who enroll will still pay a sizable Part B premium.) A beneficiary must go through additional steps on the website to determine whether there is any Part B premium rebate associated with an MA plan offering.

An additional impediment is the manner in which Part B premium rebates are delivered to enrollees. For the most part, beneficiaries pay their Part B premium through a reduction in their monthly Social Security check. If an MA plan wants to compete with other plans by lowering the Part B premium owed by an enrollee, the beneficiary will see the savings only in the form of a lower amount withheld from his or her Social Security check. That method is too removed from the act of making a choice to join an MA plan to provide an effective competitive advantage.

Although the MA program has delivered a product that has proven to be attractive to many Medicare beneficiaries, the clustering of enrollment in zero-premium plans is a clear indication that a more transparent choice structure

21. Karen Stockley et al., "Premium Transparency in the Medicare Advantage Market: Implications for Premiums, Benefits, and Efficiency" (NBER Working Paper 20208, National Bureau of Economic Research, Cambridge, MA, 2014).
22. Centers for Meicare and Medicaid Services, "Medicare Plan Finder," Medicare.gov, https://www.medicare.gov/find-a-plan/questions/home.aspx.

might lead to even lower premiums for beneficiaries. As matters now stand, many beneficiaries are opting for MA plans that they prefer to FFS, but it is possible that some beneficiaries would prefer to enroll in MA plans that sacrifice some of the added benefits typical in today's offering in return for a transparent and meaningful reduction in their monthly Part B premium.

THE MEDICARE DRUG BENEFIT

Medicare's prescription drug benefit (Part D of the program) has also shown promising results. Congress passed the law creating the benefit in 2003, and it was fully implemented beginning in 2006.

The new drug benefit is designed to be different from the rest of Medicare. It attempts to harness the power of consumer choice to increase value and efficiency in the program. There is no government-sponsored plan or option in Medicare Part D. The benefit is delivered entirely through private plans that submit bids to the federal government based on the premium amounts they will charge for providing drug coverage. The government then calculates what it will pay on a regional basis, using a weighted average of those bids.

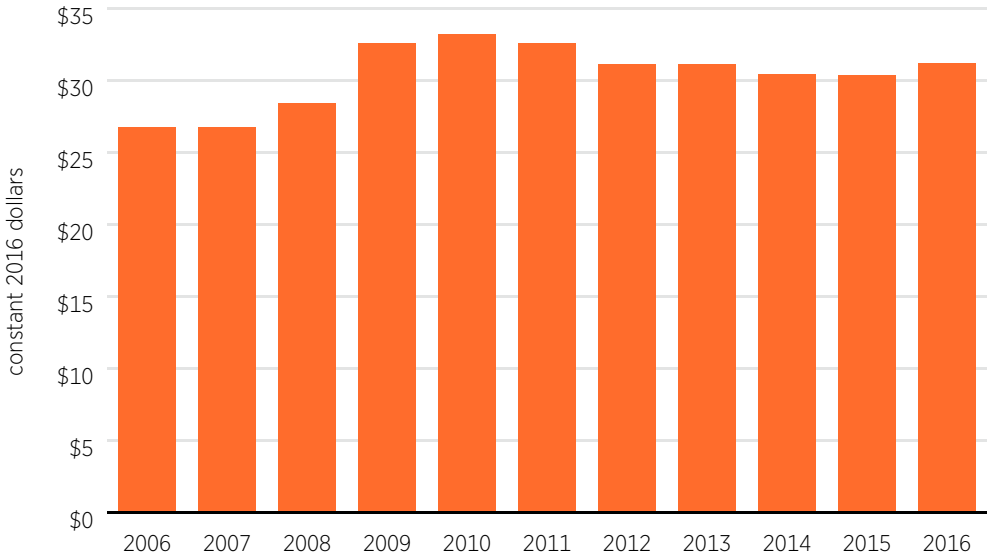
An important feature of the prescription drug benefit is its fixed contribution to financing coverage. The government's payment on behalf of Medicare's beneficiaries is the same for all beneficiaries in a market area, without regard to the plan each beneficiary chooses. If a beneficiary selects a plan that costs more than the contribution by the government, he or she pays the difference out of pocket. Conversely, selection of a relatively less expensive plan would reduce out-of-pocket premium payments from an enrollee.

Now in its 12th year of implementation, the program has performed well and has defied expectations. Some 90 percent of Medicare participants are now in secure drug coverage of some sort.[23] And public opinion surveys show that those who are enrolled in the Medicare drug benefit are satisfied with their insurance.[24]

Moreover, the drug benefit has been successful at holding down cost growth. As shown in figure 2, beneficiaries in 2016 paid an average weighted premium of just over $31 per month—down in real terms from the average premium paid in 2009. Over the period 2006 to 2016, premiums went up at

23. Jack Hoadley, Juliette Cubanski, and Tricia Neuman, *Medicare Part D at Ten Years: The 2015 Marketplace and Key Trends, 2006–2015* (Menlo Park, CA: Henry J. Kaiser Family Foundation October 2015), 7.
24. "Morning Consult National Tracking Poll #150704, July 17–20, 2015," Morning Consult.

FIGURE 2. MEDICARE PART D WEIGHTED AVERAGE PREMIUM



Source: Jack Hoadley, Juliette Cubanski, and Tricia Neuman, *Medicare Part D in 2016 and Trends over Time* (Menlo Park, CA: Henry J. Kaiser Family Foundation, September 2016).

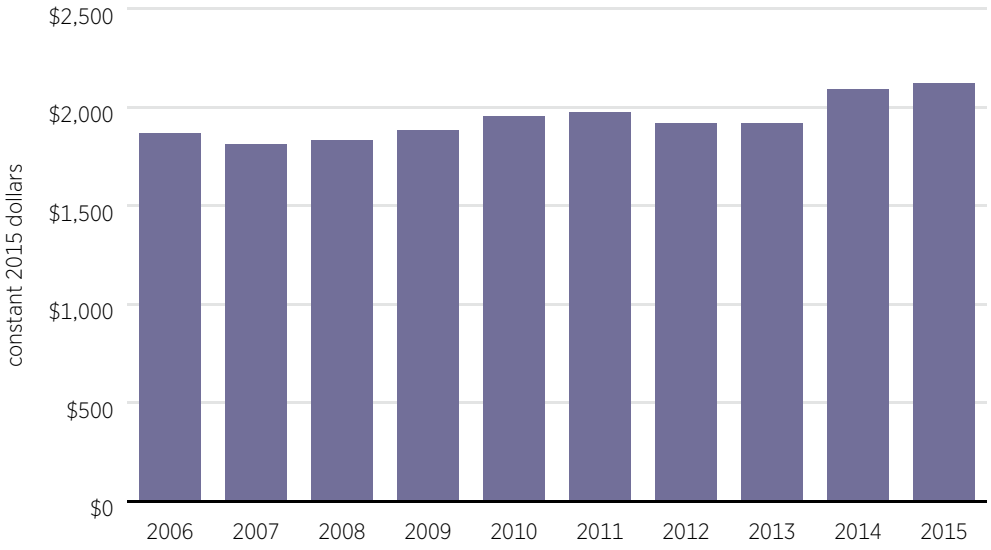
an average annual rate of just 1.5 percent in real terms. It is noteworthy that shortly after the program's enactment, CBO expected the 2006 premium to be $35 per month—well above what beneficiaries paid for the program a decade later.[25]

Premiums for the drug benefit have risen at a relatively moderate pace because overall costs per Part D enrollee have not risen rapidly since the program was enacted. As shown in figure 3, per capita federal spending (in constant 2016 dollars) was $1,870 in 2006 and $2,120 in 2015, for an average annual growth rate of 1.4 percent. The cost to taxpayers for each Medicare beneficiary has grown commensurately to the growth in overall spending per person as well.

The drug benefit has been working because it engages the consumer in cost cutting, although how it does so is somewhat counterintuitive. Before the enactment of the benefit, about one-third of the Medicare population was uninsured for prescription drug purchases, and many other seniors had partial coverage for

25. Congressional Budget Office, "A Detailed Description of CBO's Cost Estimate for the Medicare Prescription Drug Benefit," July 2004.

FIGURE 3. PER CAPITA MEDICARE PART D COSTS



Source: Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, *2016 Annual Report*, table IV.B9 and IV.B10, June 2016.

their purchases.[26] For the most part, the fully uninsured used their own resources to buy the drugs they needed. (Some benefited from charity care and other outside support.) Normally, economists would expect an expansion of insurance coverage to result in a rise in prices of the products consumed in the market because third-party payment makes consumers less sensitive to price changes. But the expansion of insurance coverage from the Part D program has led to a fall in the prices paid for the drugs used by this population. Seniors enrolled in Part D pay premiums for their coverage, and they are price sensitive when making this selection because of the design of the program. The government's contribution toward Part D coverage does not vary on the basis of the plan selected by a beneficiary, which means seniors have an incentive to find cost-effective coverage. In the context of drug coverage, that incentive leads them to select insurance plans that are good at negotiating discounts for branded products and at steering patients to low-cost generic alternatives. Evidence indicates that the pharmaceutical benefit managers who are mainly responsible for negotiating with drug

26. Sebastian Schneeweiss et al., "The Effect of Medicare Part D Coverage on Drug Use and Cost Sharing among Seniors without Prior Drug Benefits," *Health Affairs* 28, no. 2 (2009): w305–15.

companies on the prices paid for various products have succeeded in cutting the prices paid for drugs used by Medicare beneficiaries below what would have been paid had the beneficiaries purchased the drugs directly.[27]

There is an important lesson here for the larger Medicare program. To build an effective model of consumer choice, one must ensure that beneficiaries have an incentive to seek out cost-effective care. But the complexity of health care is such that one should not rely entirely on consumers to navigate the marketplace themselves. Moreover, results will likely be better if consumers are able to come together in larger groups to secure larger discounts. What is needed, then, is competition among those who would serve as agents on behalf of the Medicare beneficiary. That is exactly what Part D has provided.

"To build an effective model of consumer choice, one must ensure that beneficiaries have an incentive to seek out cost-effective care. But the complexity of health care is such that one should not rely entirely on consumers to navigate the marketplace themselves."

Medicare beneficiaries have the option to purchase (a) a stand-alone drug coverage product or (b) drug coverage that is integrated into an MA plan that is also responsible for providing coverage for hospital and physician services. The incentives for plan sponsors are in better alignment when the drug benefit is part a larger, integrated plan. When a drug benefit is part of an MA plan (called an MA-PD plan), the insurer is responsible for the patient's entire cost of care, not just for drug spending. So in those instances when increased use of medications can lessen the need for hospitalization or physician care, the insurer has an incentive to encourage appropriate use of those products by its enrollees. Stand-alone drug plans are responsible only for spending on prescription drugs, which means there is less of an incentive to recognize the possible interaction of the use of drug treatments with the use of other medical services. Not surprisingly, therefore, studies indicate that MA-PD plans are better at encouraging the proper use of prescription drug products and, thus, are also better at controlling

27. Mark Duggan and Fiona Scott Morton, "The Effect of Medicare Part D on Pharmaceutical Prices and Utilization," *American Economic Review* 100, no. 1 (2010): 590–607.

healthcare spending for their enrollees than programs that rely on a combination of unmanaged FFS and stand-alone drug coverage.[28]

ACCOUNTABLE CARE ORGANIZATIONS

ACOs are the most important and prominent of the delivery system reforms of the Affordable Care Act. The theory behind delivery system reform is that Medicare has substantial influence through its size and regulatory power; thus, it can shape how medical care is delivered to all patients through changes in how the program pays for services.

ACOs are formed by hospitals and physicians to manage care, much as a traditional HMO would. The basic idea is to encourage doctors and hospitals to move away from fragmented FFS medicine and toward a model of integrated and high-quality care.

The authority for ACO participation in Medicare has two sources. The first is the provision of the ACA that created the Medicare Shared Savings Program (MSSP). CMS has issued extensive regulations laying out the requirements for ACO participation under the MSSP authority. There are now three different tracks for MSSP ACOs. In Track 1, the ACOs assume no financial risk for missing their financial performance and quality goals but can earn a bonus for meeting or exceeding them (the so-called one-sided model). In Track 2, the ACOs assume financial risk, which means they can be penalized financially for missing their benchmarks for spending or quality of care. They also have the potential to earn somewhat higher bonuses based on their performance. In Track 3, the ACOs also assume financial risk, and there is a new system of designating participating beneficiaries in the ACOs prospectively rather than retrospectively. Track 3 ACOs have the potential to earn higher bonuses than Track 2 ACOs.[29]

In addition to the statutory MSSP, CMS also initiated, through its demonstration authority, a "Pioneer" ACO program to provide experienced integrated care systems with a pathway for managing the care of Medicare beneficiaries quickly and aggressively. CMS designed the MSSP more for provider groups with less experience managing care. CMS officials expected participants in the

28. Amanda Starc and Robert J. Town, "Internalizing Behavioral Externalities: Benefit Integration in Health Insurance" (NBER Working Paper 21783, National Bureau of Economic Research, Cambridge, MA, December 2015).
29. Centers for Medicare and Medicaid Services, "Accountable Care Organizations: What Providers Need to Know," March 2016.

Pioneer ACOs to move rapidly toward some kind of "population-based" or per-enrollee payment.[30]

More recently, as the Pioneer program experienced substantial plan withdrawals, CMS initiated a new demonstration program, dubbed the "Next Generation" ACO (NGACO) model. This model is also intended for more advanced integrated care systems and was designed to address some of the flaws identified by the original Pioneer participants. In particular, NGACOs are allowed to contact beneficiaries to confirm their participation in the ACO, although beneficiaries retain the right to see any qualified provider they choose, including those not aligned with the ACO. Beginning in 2017, NGACOs can also opt to receive payment in a modified capitation arrangement that breaks more cleanly from the fee-for-service payment model.[31]

ACOs have not produced the kind of results the ACA sponsors had hoped they would. When the Pioneer ACO program began in 2012, there were 32 participating ACOs. The program closed at the end of 2016 with just 8 participating plans.[32] Plans dropped out of the program for several reasons, including inadequate risk adjustment, benchmarks that the plans say penalized regions with already low costs, and flaws in the design of the program that hindered the ACOs' ability to adequately manage the use of services by ACO participants.[33]

The number of MSSP ACOs has grown since the program's launch, and there are now a total of 433 participating plans.[34] But the vast majority—411—of these ACOs are in Track 1, where they are eligible for bonus payments and cannot be penalized. Only 22 of the MSSP ACOs are in Tracks 2 or 3. Providers seem willing to participate in ACOs as long as there is no financial risk. Very few providers have been willing, at this point, to take on the responsibility of managing the care of the ACO enrollees within a fixed budget.

In August 2016, CMS announced program results for the MSSP for 2015. Overall, about half of the MSSP ACOs were able to keep spending for the Medicare beneficiaries assigned to them below the benchmarks set by CMS, and the other half spent more than their targets. The net savings was just $429 million

30. Centers for Medicare and Medicaid Services, "Pioneer ACO Model Frequently Asked Questions," May 2016.
31. Centers for Medicare and Medicaid Services, "Next Generation ACO Model: Frequently Asked Questions," March 2016.
32. Centers for Medicare and Medicaid Services, "Pioneer ACO Model," last updated April 17, 2017.
33. Melanie Evans, "Medicare's Pioneer Program Down to 19 ACOs after Three More Exit," *Modern Healthcare*, September 25, 2014; Advisory Board, "From 32 to 19: Three More ACOs Drop Out of Pioneer Program," September 26, 2014.
34. Centers for Medicare and Medicaid Services, "Fast Facts: All Medicare Shared Savings Program ACOs," April 2016.

(less than 0.1 percent of total Medicare spending). Moreover, the ACOs that showed savings were concentrated in regions with high per capita costs in the traditional FFS program. In fact, the ACOs that were eligible for bonuses actually spent more, on average, per beneficiary than those that failed to meet their targets. Finally, when the bonus payments were taken into account, the MSSP ACOs increased overall Medicare spending rather than decreasing it.[35]

Some studies have shown that the savings from ACOs are greater than can be assessed by looking strictly at the cost experience for the beneficiaries assigned to the ACOs. This is because physicians and other providers of services adjust their practice patterns for all their patients, not just for those assigned to an ACO. Still, even when some potential "spillover" savings is included in the calculation, the overall savings from ACOs have been, at best, very modest to date.[36]

ACOs suffer from two flaws in their design. First, the authors of the ACA did not want the dominant form of ACOs to be built around consumer choice.[37] Instead of requiring that beneficiaries be asked explicitly whether they would like to enroll in an ACO, the law provides for beneficiaries to be assigned to ACOs on the basis of their use of physician services. Any beneficiary whose primary doctor has joined an ACO is, de facto, also an assigned member of the ACO.

This approach is the opposite of consumer choice and competition, and it has undermined the effectiveness of the ACO concept. It is not possible to run an effective managed delivery system with an enrolled population that is generally unaware of the network they are in and that also has no obligation or incentive to stay within the ACO for care. Medicare beneficiaries assigned to ACOs are free to get care anywhere they want and will pay no more when they receive care outside of the ACOs they are enrolled in.

The result is that the beneficiaries by and large have no idea they are in an ACO, and even if they do know, they have no incentive to behave any differently than they did before the ACO was initiated. Yet the ACA makes the ACOs accountable for all expenses incurred by the beneficiaries assigned to them, including expenses provided outside the ACO network.

Second, the ACOs are further hamstrung by the continued reliance on FFS payment systems. The hope is that the ACOs will begin to treat the revenue

35. Ashish Jha, "ACO Winners and Losers: A Quick Take," *An Ounce of Evidence*, August 30, 2016.
36. J. Michael McWilliams, "Savings from ACOs—Building on Early Success," *Annals of Internal Medicine* 165, no. 12 (2016).
37. Aaron McKethan and Mark McClellan, "Moving from Volume-Driven Medicine to Accountable Care," *Health Affairs Blog*, August 20, 2009.

associated with caring for Medicare patients like a fixed budget that must be managed to maximize patient health outcomes. But such a culture shift would be far easier to encourage if the providers participating in the ACO program were forced to get their reimbursements for services from the central ACO structure instead of from the Medicare program. However, ACOs have not worked that way to date. Instead, providers in an ACO continue to get paid just as they were before the ACA—directly from the Medicare program—whenever they render services to Medicare patients.

CMS initiated the Next Generation ACO concept to address a number of concerns raised about the ACO model.[38] The benchmarks used to assess NGACO performance will be adjusted to avoid penalizing plans that already have low costs because of a history of using managed care techniques. Moreover, the benchmarks are to be set prospectively to allow greater transparency and planning. In addition, NGACOs are allowed to request payment from Medicare in the form of a capitated monthly payment, which would permit them to take control of the payments made to their affiliated providers. NGACOs would also be allowed to ask beneficiaries, after their assignment to them, whether they would like to remain aligned with the NGACO. This provision would effectively allow beneficiaries to opt out of the NGACO.

These steps may improve the performance of the NGACOs, but they are unlikely to fully solve the problem. Beneficiary enrollment would remain largely a matter of assignment by CMS, and beneficiaries would remain free to seek care, with no financial penalty, from any provider of their choosing. So the beneficiaries would remain very disengaged from the NGACOs and have little stake in their success.

ENHANCING CHOICE AND COMPETITION IN MEDICARE

The next stage of Medicare reform needs to rationalize and improve the process by which beneficiaries enroll in—or are assigned to—the various coverage options available to them. The goal of the reform should be to intensify and clarify the competition and ensure that beneficiaries are cost conscious and, thus, also fully engaged in the process.

A reform agenda focused on improved choice and competition should include a restructured option for integrated care delivery within Medicare

38. Centers for Medicare and Medicaid Services, "Next Generation ACO Model: Frequently Asked Questions," last modified May 2016.

FFS and an improved process for beneficiary choice and enrollment.

MEDICARE PROVIDER NETWORKS AND MEDIGAP REFORM

The ACO concept grew out of an understandable impulse to change the FFS status quo. The dominant model of unmanaged FFS, in combination with expansive supplemental insurance, has fed the fragmented, expensive, and uncoordinated medical care system that has been so prevalent in the United States.

ACOs were intended to provide an answer to this problem, but the authors of the ACA wanted to implement the concept without ever conceding that beneficiaries would need to play a role in the effort, including paying more for less efficient care delivery.

A better and more powerful reform would allow physicians and hospitals to form what might be called Medicare provider networks (MPNs) to truly compete with unmanaged FFS and MA plans. MPNs would be successors to today's ACOs and would serve as alternatives to unmanaged FFS and MA plans.

The ACO concept should be replaced with MPNs instead of being eliminated altogether because there should be a place in the Medicare program for the continued development of integrated care systems that are provider-driven rather than insurance-driven. Many MA plans are long-standing HMOs with deep experience coordinating care for beneficiaries. But most insurers do not own their delivery systems; rather, they purchase care from networks of providers that are in various stages of integration. The relationships of insurers to the delivery systems providing care to their insured populations are often temporary and transactional. After a few years, the insurer may leave the market if it loses an employer contract or may substitute one physician group or hospital system for another to cut costs. To have permanence, effective managed care must involve

"To have permanence, effective managed care must involve a bottom-up reengineering of how care is delivered to patients. That effort takes many years of persistent leadership and a significant investment of time as well as money."

a bottom-up reengineering of how care is delivered to patients. That effort takes many years of persistent leadership and a significant investment of time as well as money. Most importantly, a cultural shift is necessary, and such a shift can occur only if key physicians and hospital leaders are committed to fundamentally changing the way they organize themselves and use data to improve their care protocols.

A permanent MPN option within Medicare would give providers who are not already self-sufficient HMOs the confidence that their efforts at integration will have relevance in the Medicare program, regardless of other developments in the marketplace.

MPNs would be different from the ACOs they would replace because the standards for demonstrating competence in managing care would be higher. ACOs are often loose amalgamations of various provider groups that previously cooperated very little in the care of patients. Moreover, ACOs rely on the Medicare program to provide the data needed to improve the quality of care given to patients.

In contrast, MPNs would be required to have the capacity to collect and use clinical data themselves, which would necessarily mean a level of integration and sophistication that surpasses the capabilities of most existing ACOs. It is not possible to manage something with no information; hence, the first and most important requirement of an MPN would be a demonstrated capacity to acquire the clinical data necessary to continually improve and refine the protocols that the MPN used to care for patients.

Beneficiaries enrolled in MPNs would know that they had chosen an MPN for their care, and they would have strong incentives to stay in-network when seeking services because of the financial consequences of using out-of-network services. Making the MPN concept work would require several deviations from the current ACO concept.

Explicit Beneficiary Enrollment

The assignment of beneficiaries to ACOs would be terminated. Instead, beneficiaries would be given the option to enroll in an MPN at the time of initial eligibility for Medicare and then also once a year at the same time as open enrollment for the drug benefit and for Medicare Advantage plans. It would be entirely up to the MPNs to make themselves attractive to beneficiaries and thus to boost their enrollment numbers. MPNs, in this way, would be competing with Medicare Advantage plans and with unmanaged FFS.

Medicare Payments Directed to the IDNs

With ACOs, Medicare continues to make FFS payments directly to the hospitals, doctors, and other providers (although that has changed for a modest number of systems participating in the NGACO program). With MPNs, FFS payments would go to the MPN itself. The MPN would then make payments to its participating providers in accordance with their contractual arrangements. Moving payments from the providers to the MPNs would substantially increase the power of the MPNs and allow them to adopt any number of innovative payment approaches on the basis of value and performance.

In-Network and Out-of-Network Care and Coordination with Medigap Policies

Today, ACOs are competing against an unmanaged FFS option that can be offered in combination with supplemental insurance that largely insulates the beneficiary from the costs of a poorly managed delivery system. It makes little sense programmatically to allow an unmanaged FFS insurance product to be offered in this manner. Moreover, there is no financial penalty for beneficiaries who get care outside of the ACO network: Medicare provides the same reimbursement for services in and out of an ACO network, and Medigap insurance does not distinguish between the two, either.

Beneficiaries in MPNs should have clear incentives to seek care in the network. To begin with, there should be a higher level of patient cost sharing for services provided outside of the MPN (perhaps 30 percent coinsurance instead of 20 percent). Moreover, MPN beneficiaries should be allowed to enroll in Medigap policies with more expansive coverage (perhaps with just minor copays and smaller deductibles) than enrollees in unmanaged FFS care because the MPNs would take responsibility for managing the care of their patients. Indeed, the best approach would be to have a coordinated MPN-Medigap plan that is sold as a combination product to enrollees. The Medigap plan would fill in most of the cost sharing for providers participating in its affiliated MPN but would pay very little for providers outside of the network.

Beneficiaries would be allowed to enroll in unmanaged FFS, but not with supplemental insurance that covers all their cost sharing. Medigap plans offered in combination with unmanaged FFS should be restricted in what they can cover so that beneficiaries pay a deductible and coinsurance for their use of services up to a maximum out-of-pocket limit. These restrictions on Medigap plans should also apply to retiree wraparound plans sponsored by employers.

The MPN option should be made available to all Medicare beneficiaries, but the changes in the rules for Medigap plans would need to be phased in for new beneficiaries. Current Medicare enrollees should be allowed to stay with their current Medigap plans to avoid disrupting the care arrangements they have established for themselves under today's rules.

Fair Competition with MA Plans and Beneficiary MPN Premiums

The system of benchmarks used to assess ACO performance, including that in the NGACO model, is not directly tied to the payment model for MA plans. Consequently, there is a risk that the payment system could favor ACOs over MA plans, although there is no evidence that ACOs are more cost-effective—and, in fact, history indicates that the opposite is more likely to be the case in many markets.

The most straightforward solution would be to replicate the drug benefit model within the larger Medicare program by establishing direct price competition among the three main competing coverage options: unmanaged FFS, MPNs, and MA plans. Unmanaged FFS and MPNs would submit bids as MA plans do today. For unmanaged FFS, CMS would calculate expected costs in the region for beneficiaries enrolled in that option. MPNs would also need to calculate their expected cost per person and submit bids accordingly. CMS would then calculate a weighted average of all those bids and use it to set the government's benchmark for all plans. Enrollees in plans with bids below the benchmark would pay lower premiums, and enrollees in options with costs above the benchmark would pay higher premiums.

This approach to leveling the playing field for the various coverage options, usually called "premium support," is controversial because of what it might mean for enrollees in unmanaged FFS. In heavily populated parts of the country, unmanaged FFS is often more costly than many MA plans, and thus enrollees in that option would have to pay more for that coverage if it were in direct competition with MA plans.[39]

An interim step would allow direct competition between MPNs and MA plans using today's MA payment system. MPNs, like MA plans today, would submit bids to CMS indicating what they expect their total per-person cost to be in

39. Zirui Song, Mary Beth Landrum, and Michael E. Chernew, "Competitive Bidding in Medicare: Who Benefits From Competition?," *American Journal of Managed Care* 18, no. 9 (2012): 546–52.

a year. They would then be allowed to charge a premium or provide a premium rebate that is commensurate with their expected costs. CMS would then track payments to the MPN over the course of the year and compare those payments to the implied budget of the MPN's per-person bid. If the MPN kept costs below the expected budget, it could share that savings with its providers or use it to help attract beneficiaries in the following year. If the MPN had costs in excess of its budget, it would need to pay CMS back for the overrun.

This approach to MPNs would ensure that they competed on an entirely level playing field with MA plans pending a move toward full competitive bidding with unmanaged FFS as well. Beneficiaries could continue to enroll in unmanaged FFS by paying the regular Part B premium, but the changes in Medigap rules for new program entrants would still make FFS a less attractive option than it is today.

AN IMPROVED PROCESS FOR BENEFICIARY CHOICE AND ENROLLMENT

Medicare today provides beneficiaries with information about their coverage choices, particularly for their MA options and the private plans offering coverage under Part D. There is also a coordinated process of enrollment for MA plans and Part D coverage at the time of initial eligibility and also once a year in the fall.

But this process falls far short of what is necessary to allow beneficiaries to see clearly what their real options are and what the all-in prices are for the various combinations of coverage. Several studies have shown that Medicare beneficiaries are often in plans that cost them more than is necessary.[40]

A major impediment to better choices is the complexity of seeing how the entire package of coverage options fits together. Beneficiaries are choosing among standard Medicare coverage, supplemental coverage, and a drug benefit, each of which involves a different set of comparisons. The existing online Medicare Plan Finder, run by CMS, allows comparisons of the traditional program with MA plans and comparisons among Part D options. But it does not allow beneficiaries to see the financial consequences of a combination of options, such as unmanaged FFS with a Part D plan versus an MA plan with a drug benefit included in the coverage. The website also does not include the effects of Medigap plans on total beneficiary costs, and it can provide comparisons for only three plans at a time. It is thus

40. Florian Heiss et al., "Plan Selection in Medicare Part D: Evidence from Administrative Data" (NBER Working Paper 18166, National Bureau of Economic Research, Cambridge, MA, 2012).

virtually impossible for beneficiaries to see clearly the full financial effects of the choices they are facing.[41]

The process of enrollment in Medicare coverage should be revamped to make it much easier for beneficiaries to use an online portal to research and select the coverage they prefer for all their needs. The following are key features of such an enrollment process.

"The process of enrollment in Medicare coverage should be revamped to make it much easier for beneficiaries to use an online portal to research and select the coverage they prefer for all their needs."

A Three-Part Coverage Decision

Medicare beneficiaries should be able to choose how they want to get their basic Medicare, a plan for prescription drug coverage, and potentially a plan for supplemental coverage of costs not covered by Medicare. Medicare should sponsor an enrollment platform that allows beneficiaries to enroll in all three aspects of their coverage simultaneously and that also allows them to research both the separate and the all-in costs of the many various combinations of options.

Basic Medicare

Beneficiaries should be able to choose whether to remain in the traditional unmanaged FFS program, to enroll in an MPN in their region, or to enroll in an MA plan.

Drug Coverage

The options for drug coverage should depend in part on what kind of basic coverage option is selected. A person enrolling in unmanaged FFS or an MPN could select from the private insurance plans sponsoring drug-only insurance products. A beneficiary who selects an MA plan could choose to enroll in added drug coverage sponsored by the same plan. The combination of an MA plan with drug coverage is often less expensive than FFS with a separate drug-only policy.

41. David Kendall and Garry Lampert, "Give Medicare Beneficiaries Full Information about Their Plans," Third Way, August 19, 2015.

Supplemental Coverage

The options available for supplemental coverage for beneficiaries should also depend on what beneficiaries select for their basic Medicare plan. As previously noted, newly enrolling beneficiaries choosing unmanaged FFS would not be allowed to enroll in full-coverage Medigap plans. Beneficiaries choosing to enroll in an MPN could get more expansive supplemental coverage, most likely through private insurance that was offered in conjunction with the MPN. It would be possible—and even preferable—for MPNs and Medigap insurers explicitly to team up to offer joint products to enrollees. Beneficiaries enrolling in such plans would get the benefits of an integrated care system, including lower premiums and less unnecessary care, and would also benefit from a structure with less cost sharing than unmanaged FFS.

Beneficiaries choosing an MA plan would often be offered supplemental benefits provided through the MA's service delivery structure. The premium for this added benefit from the MA plan would have to be identified separately from the premium needed for basic Medicare or the drug benefit so that the beneficiaries themselves could decide whether the added benefit was worth the added premium (this is not a requirement under current law). Separating the premiums in this way would also allow the beneficiaries to see a fair comparison of the various MA options with unmanaged FFS or any MPN options that might be available to them.

Bringing the choice of supplemental insurance into the enrollment system used for basic Medicare and the drug benefit would make it much easier for beneficiaries and their families to do all-in comparisons of the full spectrum of coverage options. Such comparisons would favor plans that could provide the full spectrum of necessary medical services in a cost-effective manner. According to the evidence, MA plans—and especially well-established HMOs—would very likely look attractive from a price and quality standpoint when compared with the alternatives.

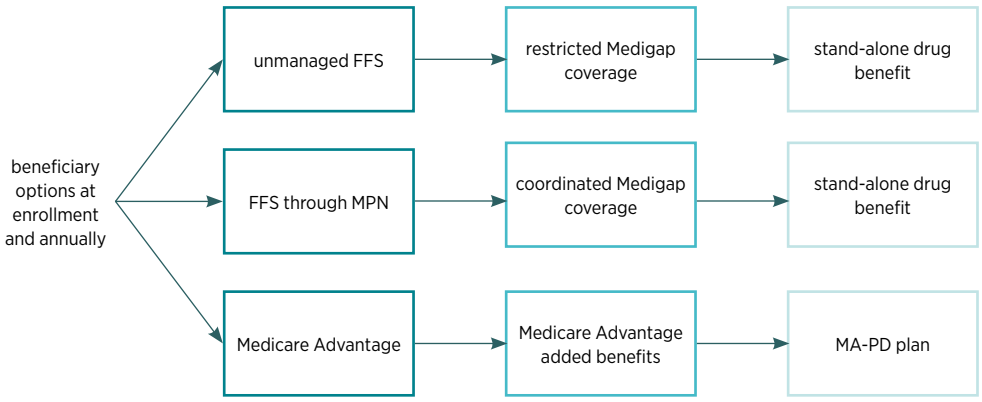
Figure 4 provides a depiction of this reformed choice and enrollment process.

Other Changes

Default options matter because consumers often display what is called *status quo bias*. That is, consumers often stick with their current choice, even if other options might be preferable.

Under current Medicare policy, if beneficiaries make no overt choice for their coverage, such as enrollment in an MA plan, they are presumed to select

FIGURE 4. RESTRUCTURED CHOICES FOR MEDICARE BENEFICIARIES



Note: FFS = fee-for-service, MA-PD = Medicare Advantage Prescription Drug, MPN = Medicare provider network.

unmanaged FFS. There are two options for moving away from making unmanaged FFS the default approach in Medicare:

- One option would be to require newly enrolling beneficiaries to make a choice as outlined in figure 4 before they could start receiving Medicare benefits. In effect, this requirement would force all beneficiaries (or a family member or caretaker) to make a choice, or a series of choices, at initial enrollment.
- A second approach would be to randomly assign new beneficiaries who failed to make a choice on their own to one of the lowest-premium options for basic Medicare coverage. Such default options could be limited to plans with costs (reflected in their MA bids or the MPN's planned spending relative to its benchmark) that are below the expected costs of unmanaged FFS in the region. The Medicare drug benefit currently engages in a similar process for some of the beneficiaries who are eligible for low-income assistance (low-income subsidy, or LIS, beneficiaries). Such beneficiaries are assigned, on a random basis, to drug plans with premiums below the regional benchmark if the beneficiaries did not actively choose a plan themselves in the previous period and were placed in a plan by Medicare's administrators. Placing LIS beneficiaries in low-

cost drug plans ensures that these beneficiaries are not required to pay any premium themselves.[42]

Both of these options would ensure that the program no longer places beneficiaries automatically into unmanaged FFS if they do not choose something else.

Another important change is needed to allow greater price competition among the options for basic Medicare coverage. All beneficiaries, including those in MA plans, must pay the Medicare Part B premium, which is generally withheld from the amount otherwise due to beneficiaries in their Social Security checks. As noted previously, MA plans are permitted to provide premium rebates to the beneficiaries as a way of attracting enrollment, but current policy requires those rebates to come in the form of adjusting the Part B premium withheld from Social Security checks. This practice is a very nontransparent way of encouraging direct price competition between unmanaged FFS and MA because a beneficiary choosing a plan offering a rebate will not see the change in any bill they owe to the MA plan. The result is that very few MA plans compete with FFS in this way; instead, they charge no premium above the Part B premium and then give away whatever else they can in the form of supplemental benefits.[43]

MA plans, as well as MPNs, should be allowed to compete with unmanaged FFS by offering rebates on Part B premiums that go directly to the beneficiaries, separate from their Social Security checks. Ideally, the payments would go directly from the plans to their enrollees. This approach would allow more transparent price competition and would encourage plans to develop and market lower-priced plans than those offered today.

CONCLUSION

Medicare today is a jumble of initiatives added to the existing program at different times and for different reasons. Policymakers added MA and the drug benefit to Medicare to improve coverage for beneficiaries, inject more private-sector initiative into the program, and move away from an entirely regulatory approach to managing costs. The ACO effort is motivated in part by a view that better payment incentives can nudge doctors and hospitals to form more cost-effective organizations for caring for patients.

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42. Jack Hoadley et al., *To Switch or Be Switched: Examining Changes in Drug Plan Enrollment among Medicare Part D Low-Income Subsidy Enrollees* (Menlo Park, CA: Henry J. Kaiser Family Foundation, July 2015).
43. Stockley et al., "Premium Transparency in the Medicare Advantage Market."

What is needed at this point is some rationalization of the choices that beneficiaries face. The governing principle should be transparent and fair competition, such as is the case in the prescription drug benefit. There is room in this approach for provider-driven managed care options in the form of an improved version of ACOs. Beneficiary choice can help steer scarce resources to their best and most cost-effective uses.

Over the long run, it is the dynamic of cost-conscious consumer choice that has the best chance to root out waste and inefficiency in medical care and to reward innovation that produces real breakthroughs. The results would be better both for the beneficiaries who rely on the program and for the taxpayers who support it.

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