

Why Premium Support? Restructure Medicare Advantage, Not Medicare

Judy Feder, Stephen Zuckerman, Nicole Cafarella Lallemand, and Brian Biles

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Executive Summary

Premium support proponents argue that restructuring Medicare to replace public insurance with vouchers to purchase private (and, in some versions, public) insurance will harness the power of the marketplace to contain Medicare's costs. But the debate about premium support misses the potential within Medicare's existing structure to promote efficiency through competition. It often ignores not only traditional Medicare's cost advantage in terms of administrative efficiency and purchasing power but also persistent rewards to risk selection that accompany competition among plans.

Rather than restructure all of Medicare, this analysis discusses restructuring payments to Medicare Advantage (MA) plans, which are already offered within the Medicare program. Rewarding efficient MA plans, rather than overpaying the vast majority of MA plans, can reinforce improvements in traditional Medicare to slow growth in program costs, without putting beneficiaries at risk.

Our analysis of recent MA experience shows that despite MA plans' success in competing with traditional Medicare for beneficiary enrollment, they have been markedly unsuccessful in lowering costs. Except in 15 percent of counties, heavily

concentrated in three southern states, average MA costs per beneficiary exceed average costs for traditional Medicare. Even this limited MA cost advantage is likely exaggerated, given continuing evidence of selection into plans of lower cost enrollees. Overpayments, relative to traditional Medicare, not lower costs, have provided MA plans the revenue to support extra benefits to attract enrollees.

Restructuring the terms now governing payment to MA plans can promote efficiency through competition without shifting costs to beneficiaries. Fiscal prudence warrants limiting Medicare's payments to 100 percent of traditional Medicare costs, while keeping payments to MA plans below traditional Medicare in the highest cost counties. These reductions in subsidies, which now supporting extra benefits (and which premium support would totally eliminate), should be offset by updating traditional Medicare benefits to include catastrophic protection (financed by redistributing existing cost-sharing protections or by charging additional premiums). At the same time, government should deal directly with excessive costs in traditional Medicare, by exercising ACA payment reform authority and aggressive control over fraudulent or inappropriate claims for benefits.

Introduction

There's no arguing that containing Medicare cost growth is essential to the nation's fiscal health. But there's plenty of argument and misunderstanding about whether achieving that goal requires a significant Medicare "restructuring"—specifically, the replacement of Medicare's defined health insurance benefit with a defined contribution (or voucher) to purchase health insurance, commonly known as "premium support." The rationale behind premium support is that a defined contribution will harness the power of the marketplace to help solve Medicare's fiscal problems. In general, the proposal is 1) to have private health plans bid to provide Medicare benefits and 2) to provide beneficiaries a fixed dollar voucher

that can be applied toward the premium charged by the plans or, in some proposals, to traditional Medicare. The proposal aims to give beneficiaries the incentive to choose a low-bid plan—since they'd have to pay additional premiums out-of-pocket for higher-premium plans—and to give plans the incentive to compete for beneficiaries by controlling costs. A recent study showed that, in many communities the lowest cost Medicare Advantage (MA) plans have costs at or below traditional Medicare costs.¹

If, as proponents claim, a competitive market simply expanded enrollment in these low cost plans, federal spending could decrease and insurance protection

might be preserved. But if it doesn't, and if the value of vouchers fails to increase with actual health care costs or private plans attract favorable risks, beneficiaries will lose current protections. Most importantly, beneficiaries, rather than the government, will bear the risk of rising health care costs.

The debate around premium support misses the potential within Medicare's existing structure to harness the market to promote efficiency and to do so on terms that do not put beneficiaries at risk for escalating costs. Virtually all Medicare beneficiaries currently have the choice (typically many choices) to enroll in private MA plans, which compete directly with traditional Medicare for enrollees. By design, MA plans have been paid above per capita costs for equivalent beneficiaries in traditional Medicare, and have used these payments to provide extra benefits that have successfully attracted more than a quarter of Medicare beneficiaries into private health plans.

Measures taken by the Affordable Care Act significantly reduce these extra payments. But they do not eliminate the long-standing bias favoring payment policies designed to attract private plans rather than to encourage lower costs. Our analysis of recent MA experience shows that most private plans are more, not less, costly than traditional Medicare. In fact, MA plans with the lowest costs have been found to serve only 10 percent of MA enrollees,² despite their attractiveness in the current market, and they do not reflect the typical MA experience. Only in the highest cost areas for traditional Medicare do typical MA plans deliver care at lower costs than the public program. Even this difference is likely exaggerated, given continuing evidence of favorable risk selection (that is, disproportionate enrollment of low cost enrollees) in private plans. In short, overpayment, not lower costs, drives most of MA plans' success in competing with the public program for enrollees.

The analysis presented here reinforces work done by others³ to demonstrate that Medicare's experience with competition through MA plans provides little evidence of private plan efficiency and little reason to believe that recent proposals for a premium support approach have merit. Instead of premium support, we outline a cost containment path that would change payment policy toward Medicare Advantage plans to replace overpayments aimed at attracting competitors with rewards to efficient competition. Along with aggressive pursuit of payment and delivery reform to enhance efficiency in the traditional Medicare program, MA payment reform can promote competition and efficiency without putting beneficiaries at risk.

Why incorporate private plans in Medicare?

Historically, different rationales have supported policy to encourage private plan participation and market competition in Medicare.⁴ In the 1970s, when Medicare initiated capitation payments to private plans (HMOs), the rationale was that plans like HMOs developing in the private sector would reduce program spending. Hence Medicare agreed to pay plans 95 percent of fee-for-service costs, adjusted for risk, for each enrollee—and expected to reduce program spending for these enrollees by five percent. At the same time, plans were required to share expected savings (beyond the 5 percent that Medicare retained) with beneficiaries by enhancing their benefits, revealing a second rationale for private plan participation—the potential to offer extra benefits at no extra public costs.

In 1997, when Congress revised Medicare policies toward plan payment, the cost containment rationale receded. The more prominent goal became guaranteeing beneficiaries a choice as to how to receive their insurance benefits. In order to attract private plans, Congress committed Medicare to plan payments above traditional Medicare costs in low cost areas. But Congress also reduced the traditional Medicare payment rates to which plan payments were tied. The resulting plan payments led to a reduction, rather than the hoped-for increase, in plan participation in Medicare.

In 2003, Congress “fixed” this problem and commitment to choice took a major leap forward. Congress changed the rules to pay plans a minimum of 100 (rather than 95) percent of traditional Medicare costs per enrollee; and, more importantly, applied a set of geographic payment “floors” and annual updates that ratcheted plan payments upward, independent of spending trends in traditional Medicare. Now called Medicare Advantage or MA plans, private plans not only offered beneficiaries the opportunity for extra benefits at little or no cost (because of the subsidies from generous payment), but also the convenience of obtaining all their health insurance from a single plan. That is not possible within traditional Medicare—which lacks the catastrophic protection, or out-of-pocket spending limits, typical of most private insurance. Most Medicare beneficiaries also have private insurance coverage to supplement limited benefits in Medicare parts A and B and, beginning in 2003, have had to choose a private plan for part D prescription drug coverage. Medicare Advantage plans offer all benefits from a single source.⁵

Promotion of choice and convenience persisted as MA plan payment moved to a bidding system in 2006. Under this system, plans submitted bids indicating their costs (including profits) of providing the traditional Medicare benefit package. Bids were compared to county-level benchmarks that were set at least as high as traditional Medicare's average spending per beneficiary in each county. Plans that bid below the benchmark had to pass along 75 percent of the difference to beneficiaries, through additional benefits, reduced premiums or reduced cost-sharing. The Medicare program kept the remaining 25 percent as savings to the program. Plans that bid above the benchmark were paid the full benchmark, and had to make up the difference through increased premiums from beneficiaries. In 2005, benchmarks varied from 4 percent above traditional Medicare costs in Medicare's high cost areas to 26 percent above traditional Medicare costs in Medicare's low cost areas.⁶ In 2006, once bidding was introduced, the range likely remained similar, since the new policy did not change the methods for calculating benchmarks, other than to update them by the actual rate of growth in per capita spending in traditional Medicare.

In 2010, the Affordable Care Act brought back the cost containment rationale, along with choice, as a guide to payment of MA plans. The reform retained the bidding system, but in response to longstanding criticism of payments promoting choice as wasteful and inefficient,⁷ narrowed the degree to which benchmarks exceeded traditional Medicare costs. By 2017 the ACA transitions to a system that will vary the benchmark, against which plans bid, inversely with the level of traditional Medicare per beneficiary spending—setting benchmarks at 95 percent of traditional Medicare per beneficiary spending in counties in the highest quartile of spending, 100 percent and 107.5 percent in the next two quartiles, and 115 percent above traditional Medicare per beneficiary spending in counties in the lowest quartile of per beneficiary spending in traditional Medicare. The ACA also instituted payment incentives to reward high quality plans with extra resources to enhance benefits or lower premiums.^{8,9} In practice, the result is a policy that, despite reduced benchmarks, continues to promote choice over cost containment in traditional Medicare's low cost counties.

What kind of competition has payment policy produced?

Given the policy priority of choice over cost containment, it is hardly surprising that the inclusion of private plans in Medicare has not been successful in containing Medicare spending. Medicare payments

have intentionally been set above traditional Medicare per capita costs in order to attract private competitors to Medicare and give beneficiaries the opportunity to choose them, rather than to decrease spending.

But little attention has been paid to the nature of the resulting competition for beneficiaries and its relationship to plans' relative efficiency—that is plans' costs per beneficiary relative to per beneficiary costs in traditional Medicare. At the national level, MedPAC estimated 2011 MA average plan costs as equal to traditional Medicare, and 2012 costs as just below (98 percent) traditional Medicare—results dominated by the performance of HMOs.¹⁰

But competition is best analyzed in local markets. Tables 1 and 2 explore the competition/efficiency relationship at the county level for 2009, when MedPAC estimated national average MA plan costs per beneficiary at just above traditional Medicare. Extending a companion comparison of MA plan costs relative to traditional Medicare,¹¹ we rely on the Center for Medicare and Medicaid Services' (CMS) MA plan level enrollment data from June 2009 and the MA State/County Penetration files from May 2009 to divide the nation's counties into three groups, based on whether the county's average per beneficiary plan costs are below, approximately equal to (plus or minus 2 percentage points), or greater than the county's average per beneficiary costs in traditional Medicare.¹² All MA averages shown within county groups are weighted averages across counties that use total MA plan enrollment in each county as the weights. For traditional Medicare averages, we weighted county per beneficiary spending by numbers enrolled in traditional Medicare. We used plan bid data as a measure of MA costs.

Table 1 shows the relationship between MA plans' costs and their success in attracting enrollees, or penetrating the Medicare marketplace. Counties are ranked by whether their average MA plan costs are below (top row), equal to (middle row) or above (third row) traditional Medicare costs. For each group of counties, the table reports the number and share of all counties included, the share of the nation's MA plan enrollees and Medicare eligibles these counties represent, and the county group's average MA penetration rate—or share of Medicare enrollees participating in MA plans.

The top row of table 1 shows that 15 percent of counties, home for about a quarter of all Medicare beneficiaries, had MA plans that were on average relatively more efficient than traditional Medicare; that is, their average costs per beneficiary were below average traditional Medicare costs per beneficiary in 2009. MA penetration across those counties averaged 26 percent. A comparison to the third row of

Table 1. Medicare Advantage (MA) Enrollment in Counties Where MA Costs Are Above, Below, and Equal to Traditional Medicare (TM) Costs

	Percent and Number of Counties	Percent of MA Enrollees	Percent of Total Medicare Beneficiaries	MA Penetration ¹
Counties where per capita MA costs are below per capita TM costs	15% (418)	30%	26%	26%
Counties where per capita MA costs approx. equal ² per capita TM costs	11% (308)	13%	13%	22%
Counties where per capita MA costs are above per capita TM costs	75% (2,152)	57%	62%	21%
Total	100% (2,878 ³)	100.0%	100.0%	

1. MA penetration is the share of Medicare beneficiaries enrolled in MA.

2. MA per capita costs are no more than 2 percentage points higher or lower than TM per capita costs.

3. Due to privacy laws, CMS omits MA plans with fewer than 11 enrollees from plan-level datasets. As a result, counties whose plans have fewer than 11 enrollees are excluded from the analysis.

Source: Centers for Medicare and Medicaid Services, Monthly Medicare Advantage State/County/Contract Data (Baltimore, MD: CMS, June 2009), available at <http://www.cms.hhs.gov/MCRAdvPartDEnrolData/>; Centers for Medicare and Medicaid Services, Monthly Medicare Advantage State/County Penetration Data (Baltimore, MD: CMS, May 2009), available at <http://www.cms.hhs.gov/MCRAdvPartDEnrolData/>; and Centers for Medicare and Medicaid Services, Plan Payment Data (Baltimore, MD: CMS, 2009), available at <http://www.cms.gov/Medicare/Medicare-Advantage/Plan-Payment/Plan-Payment-Data.html>.

table 1 shows that this penetration rate is five percentage points (or 20 percent) greater than penetration in the 75 percent of counties (with 62 percent of Medicare beneficiaries) where MA plans were less efficient (that is, experienced higher average per beneficiary costs) than traditional Medicare.

That a higher penetration rate is associated with plan costs below Medicare's is evidence that, in these counties, plans' efficiency relative to traditional Medicare has indeed facilitated effective competition to enroll beneficiaries. This conclusion is supported by more detailed analysis of how enrollment reflects the relationship between payment rates and costs for these three groups of counties. For each of the county groups, table 2 reports on average costs of traditional Medicare, MA plans' relative efficiency (the average costs, including profit, that MA plans incur relative to average costs in traditional Medicare), MA payment generosity (the average payments MA plans receive relative to average costs in traditional Medicare), and, in the fourth column, the margin MA plans earn, relative to their own costs, to enhance benefits and attract patients (average payments MA plans receive relative to average MA plans' incurred costs).

Moving from counties with MA costs below traditional Medicare to counties with MA costs above traditional Medicare, table 2 shows that traditional Medicare costs fall dramatically; data not shown indicate that MA costs are relatively constant across these county groups. The top row shows that in counties with average per beneficiary MA costs below traditional Medicare, average plan costs per beneficiary were 11

percent below traditional Medicare costs per beneficiary (that is, plan costs were 89 percent of traditional Medicare). At the same time, under the MA payment formula designed to promote choice, plans received payment per beneficiary that was 5 percent above traditional Medicare per beneficiary costs. Together, efficiency and MA payment generosity—but predominantly efficiency—provided plans a margin of 18 percent above their own costs for extra benefits to attract enrollees.

But according to results in table 1, in 2009 over half of MA plan enrollees were in counties with plans that, on average, had higher per beneficiary costs than traditional Medicare. One in five beneficiaries in these counties enrolled in private plans. What's driving competition for beneficiaries here?

Table 2 makes it clear that it is the generosity of MA payments—high enough to more than offset the relative inefficiency of MA plans—that generates the resources plans need to enhance benefits. Although average MA plan per beneficiary costs in these counties are 13 percent higher than traditional Medicare, plans receive average payments 22 percent higher than traditional Medicare. That provides them a margin of 8 percent above their own costs to invest in benefits to attract enrollees.

Overall, MA payment generosity has clearly driven competition between private plans and traditional Medicare for beneficiaries. Indeed, efficiency plays a role in generating net revenues only in a minority of counties and, even in those counties, it is the high costs of traditional Medicare that enables MA plans to attract enrollees.¹³ In fact, 50 of the 100 counties with

Table 2. Comparison of Traditional Medicare (TM) Costs and Medicare Advantage (MA) Payments and Costs

	Average Per Capita TM Costs	MA Costs as a Percent of TM Costs	MA Payments as a Percent of TM Costs	MA Payments as a Percent of MA Costs
Counties where per capita MA costs are below per capita TM costs	\$9,789	89%	105%	118%
Counties where per capita MA costs approx. equal ¹ per capita TM costs	\$9,100	100%	112%	113%
Counties where per capita MA costs are above per capita TM costs	\$8,042	113%	122%	108%

1. MA per capita costs are no more than 2 percentage points higher or lower than TM per capita costs.

Source: Centers for Medicare and Medicaid Services, Monthly Medicare Advantage State/County/Contract Data (Baltimore, MD: CMS, June 2009), available at <http://www.cms.hhs.gov/MCRAdvPartDENrolData/>; Centers for Medicare and Medicaid Services, Monthly Medicare Advantage State/County Penetration Data (Baltimore, MD: CMS, May 2009), available at <http://www.cms.hhs.gov/MCRAdvPartDENrolData/>; and Centers for Medicare and Medicaid Services, Plan Payment Data (Baltimore, MD: CMS, 2009), available at <http://www.cms.gov/Medicare/Medicare-Advantage/Plan-Payment/Plan-Payment-Data.html>.

the lowest MA costs relative to traditional Medicare costs are in three states—Florida, Louisiana and Mississippi—that have some of the highest traditional Medicare costs per beneficiary in the United States.¹⁴

What are the lessons of existing competition for premium support?

Having encouraged competitors to join the market through generous payment, advocates of choice now propose to shift competition to efficiency by changing the payment mechanism. Premium support advocates would eliminate these extra payments and replace guaranteed access to defined benefits with a fixed dollar subsidy to support the premium charged by plans bidding to serve them (in some proposals, including traditional Medicare). The assumption is that private plans not now more efficient than traditional Medicare—the plans now serving the bulk of MA enrollees—would improve efficiency in order to compete. The “gravy” that has historically supported the extra benefits to attract enrollees would be gone.

But a look at Medicare’s own efficiencies and the market’s incentives for risk selection challenges the reasonableness of this assumption. Private insurers nationally pay hospitals about 40 percent more than traditional Medicare and pay physicians about 25 percent more.¹⁵ Further, MA plans incur substantially higher administrative costs than traditional Medicare—an average of 11 percent for MA plans compared to 2 percent for traditional Medicare.¹⁶ Achieving reductions of sufficient magnitude to offset Medicare’s market power and administrative cost advantage would require far more aggressive care management than MA plans have demonstrated to date.

Indeed, it is an open question, given evidence on the inadequacy of risk adjustment, how much of any observed per beneficiary cost differential favoring MA plans over traditional Medicare (for the 15 percent of the nation’s counties identified in table 1) reflects care management rather than disproportionate plan enrollment by low-cost beneficiaries. From the beginning of private plan participation in Medicare, favorable selection has meant risk-adjusted payments in excess of expected costs in traditional Medicare. Selection concerns led to refinements in the methods Medicare uses to adjust for risk—moving beyond adjustments based simply on demographic characteristics to adjustments based on individual beneficiaries’ specific medical conditions (more precisely, Hierarchical Condition Categories or HCCs).

But analyses, based on the internal cost data from a single plan¹⁷ and on administrative data across many plans,¹⁸ show that these risk-adjustment refinements have altered, not eliminated, plans’ financial incentives to favor some beneficiaries over others. Although plans may no longer have incentives to favor beneficiaries with some conditions or in some condition categories over others, they now face incentives to favor lower cost over higher cost patients within condition categories.¹⁹ Analysis shows that plans have effectively responded to changed incentives by changing the enrollees they serve, and as a result, have increased rather than decreased the overpayments they receive, relative to payment for an equivalent beneficiary in traditional Medicare. Resultant extra costs to Medicare were estimated at \$30 billion or nearly 8 percent of total spending in 2006.²⁰

This experience highlights one of several significant risks in transforming traditional Medicare into a fully market-based arrangement.

Segmenting the Market. Proponents of premium support sometimes argue that a shift to a voucher system poses little risk to traditional Medicare, if, in most of the country it remains a low cost option. But this claim ignores the evidence that even after risk-adjustment, MA plans have succeeded in enrolling beneficiaries with lower expected costs. If the sickest, most costly patients end up concentrated in traditional Medicare, it may no longer be a low cost option. These costliest patients will therefore face higher premiums based on their “pre-existing conditions.”

Technical improvements in risk adjustment have not overcome plan incentives to select patients based on risk. Adoption of premium support may well exacerbate rather than improve risk selection, given the antipathy many of its advocates have toward the government oversight and enforcement that effective risk adjustment requires. Ongoing favorable selection by private plans not only generates overpayment of private plans relative to costs in traditional Medicare, but actually redistributes resources away from beneficiaries who need the more costly care to less costly beneficiaries (or to plans serving those beneficiaries). This type of “contracting out” of social insurance and segmentation of the market undermines the very risk-pooling social insurance is designed to achieve.²¹

Loss of Market Power. Having tens of millions of purchasers in a single risk pool gives Medicare another significant advantage over multiple competing plans: market power to limit payments to providers. Health care markets are becoming increasingly concentrated, enabling “must-have” hospitals and physician groups to drive up payments where they can.²² If premium support expands reliance on private plans and traditional Medicare restricts its payments, providers’ ability to demand payment above traditional Medicare rates will likely increase.

Due largely to payment changes in the Affordable Care Act, projected annual growth in Medicare spending per beneficiary for the coming decade has slowed to 3.1 percent per year—almost 2 full percentage points below projected growth in private insurance per-enrollee spending (5 percent), and a point below projected per capita GDP growth (or, with a “fix” in the SGR for physician payment, at or just below the 3.8 percent annual growth in per capita GDP).²³ A unified Medicare, with its enormous buying power, has the capacity to enforce these rates. In the private non-Medicare market, plans either lack the leverage Medicare has, or, where they are big enough to have leverage, they have been unwilling to use it.²⁴ If Medicare beneficiaries are divided among multiple competing plans, providers

can be expected to push back. The result would not only be higher costs, but a new segmentation among Medicare beneficiaries, as beneficiaries with higher incomes choose higher cost, better access health plans.

Shifting Risk to Beneficiaries. Provider pressure will not be the only source of shifted risk under premium support. Hedging their bets on a cost slowdown from competition, premium support proponents typically design their proposals to include a pre-set constraint on increases in the annual support toward plan premiums—that is, the voucher. Indeed, given the current growth in Medicare spending and little or no evidence on the success of competition, this may be the only way CBO would find premium support likely to reduce future spending.

To generate savings below what are now historically low spending projections, however, would require a tight ceiling on voucher growth.²⁵ Projections for total Medicare spending growth—that is, per beneficiary spending growth times growth in the number of beneficiaries—already approximate GDP growth +1 percentage point, or 6 percent. Given that half of Medicare’s projected 6.1 percent annual growth rate reflects annual enrollment increases (as the baby boom generation ages onto Medicare), a meaningful cost-savings target would require slowing spending growth per beneficiary to, say, 2 percent per year (2 points below projected GDP growth per capita and 3 points below projected growth in private insurers’ per capita spending). Analysts are already skeptical about Medicare’s ability to hold per beneficiary growth rates to GDP per capita, let alone cutting them further. Premium supports tied to so low a growth rate would more than likely shift growing costs to beneficiaries, who would have to pay more or get less coverage.

In sum, the lessons from competition within Medicare provide little evidence to support (and considerable evidence to question) whether the best way to enhance efficiency in Medicare is to undermine Medicare’s risk pooling and market-power by replacing it with vouchers.

What are the lessons of existing competition for promoting efficiency without shifting risk?

If the goal is truly to promote efficiency-generating competition and not simply to promote choice among competitors, policymakers can revise the terms that now govern Medicare Advantage payment to reward efficiency in private plans and actively reform payment in traditional Medicare.

Promoting Efficiency in Medicare Advantage.

Despite the reductions in payments to MA plans specified in the ACA, the formula for and implementation of payment rules continues to pay plans as much as 115 percent above traditional Medicare per beneficiary costs, in order to assure choice in low-cost counties. According to MedPAC, transition to the new ACA payment rules reduced 2012 payment benchmarks 3 percent below 2011 levels—consistent with the law’s cost containment objectives. But CMS largely offset these reductions (at least in the initial implementation) by awarding the ACA’s quality bonuses to plans serving over 90 percent of MA plan enrollees, rather than the targeted group MedPAC believes the law intended. As a result, MedPAC estimates that payments to MA plans will exceed by 7 percent what costs would have been had enrollees been in traditional Medicare.²⁶

Arguably, it has never made sense to pay private plans above traditional Medicare costs, simply to provide beneficiaries a choice between public and private insurance. Far more meaningful to beneficiaries is free choice of providers, as in traditional Medicare. And paying MA plans at rates that exceed traditional Medicare costs does not appear to be buying better quality care.²⁷ These excess program payments do, however, support extra benefits—and the means to fill Medicare’s coverage gaps (most importantly, its lack of catastrophic coverage) at little or no extra cost to beneficiaries. In 2009, lowering payments to MA plans with costs above traditional Medicare’s would eliminate subsidies supporting extra benefits in plans serving more than half of MA plan enrollees. (Premium support would, of course, eliminate all subsidies, including those for plans with costs below traditional Medicare’s.)

Subsidizing private plans, however, is an inequitable way to assure the adequacy of Medicare coverage, given the need to alter Medicare’s benefit package to achieve the current norm of coverage adequacy—with limits on out-of-pocket payments relative to income, like those the ACA establishes for qualified health plans. This increased protection could be financed by redistributing existing cost-sharing protections, essentially trading currently low upfront payments (in particular, low deductibles for physicians services) for catastrophic protection; or, as some have proposed,²⁸ by charging an additional premium beneficiaries could pay Medicare, instead of private supplemental plans. These premiums could be income-related as they are in the ACA exchanges so that the burden never exceeds a specified percent of income.²⁹

Fiscal concerns clearly warrant further revision of MA payment policy—keeping rates below traditional

Medicare in the highest cost counties, and limiting Medicare’s payments to 100 percent of traditional Medicare per beneficiary costs.

At the same time, government should deal directly with excessive costs in traditional Medicare. Analysis shows that MA plans best traditional Medicare’s costs where those costs are exceptionally high. Responsibility for addressing these costs appropriately rests with the Medicare program and should not be handed off to plans and beneficiaries. Medicare can live up to its responsibility by exercising the ACA’s new authority to constrain traditional payment rates, re-price overpriced services, and actively test and promote payment and delivery reforms aimed at reducing the rewards providers receive from high volume and increasing the rewards they can earn through efficient delivery. More appropriate use can also be encouraged by management initiatives to reduce fraud and enforce national coverage decisions that use evidence to limit coverage to specific applications of new technologies or procedures.³⁰

The Bottom Line

The assumption that Medicare can only harness the power of the marketplace if restructured as “premium support” ignores the evidence supporting a far less risky opportunity to restructure Medicare Advantage. Private plans have effectively attracted more than a quarter of beneficiaries away from traditional Medicare. But competition for enrollees has had very little to do with private plans’ relative efficiency. On the contrary, it has been driven by extra payments to assure beneficiaries the choice of a private, rather than a public, insurance plan.

If the goal is to promote efficiency, the lesson is not to expand private insurance in Medicare. It is to eliminate any overpayments and focus private plans and traditional Medicare on controlling costs. That does not require replacing Medicare’s defined benefit through public insurance with a defined and limited contribution for insurance through private plans. To do so would segment the market by income and health status, undermine Medicare’s market power and shift costs to beneficiaries. Rather, it requires a modest restructuring of Medicare Advantage payment policy to eliminate overpayments and aggressive cost containment in traditional Medicare. In short, refining Medicare’s existing structure—not replacing it with vouchers for private plans—offers an effective strategy for harnessing the power of the marketplace to achieve not only greater efficiency but also to assure beneficiaries adequate insurance protection.

Notes

1. Song Z, Cutler D and Chernew M. "Potential Consequences of Reforming Medicare Into a Competitive Bidding System." *JAMA*, 308(5):459-60, August 1, 2012.
2. Ibid .
3. Biles B. *Medicare Premium Support: Are Private Plans Cheaper than Traditional Medicare Fee-for-Service*. Presentation at the June 2012 Meeting of Academy Health; Gold M. "Medicare Advantage – Lessons for Medicare's Future." *New England Journal of Medicine*, 366: 1174-7, 2012; McGuire T, Newhouse J and Sinaiko A. "An Economic History of Medicare Part C." *The Milbank Quarterly*, 89(2): 289-332, 2011; and US Government Accountability Office. "Medicare Advantage: Comparison of Plan Bids to Fee-for-Service Spending by Plan and Market Characteristics." Washington DC: GAO, February 4, 2011.
4. For rationale, see: Coulam R, Feldman R and Dowd B. *Bring Market Prices to Medicare: Essential Reform at a Time of Fiscal Crisis*. Washington DC: The AEI Press. 2009; and McGuire et al., 2011. The following description relies heavily on McGuire et al.'s history of the evolution and consequences of private plan payment policy in Medicare.
5. Berenson R. "Medicare Disadvantaged And The Search For The Elusive 'Level Playing Field.'" *Health Affairs*, web exclusive; w4-572-85, 2004.
6. Congressional Budget Office. "Designing a Premium Support System for Medicare." Washington DC: CBO, December 2006.
7. See for example: Medicare Payment Advisory Commission. "The Medicare Advantage Program." In *Report to the Congress: Issues in a Modernized Medicare Program*. Washington DC: MedPAC, June 2005. "The Medicare program needs to offer private options that will help reduce, not increase, overall program spending. In raising MA plans' rates above FFS rates in order to attract plans to new areas of the country, Medicare does not create incentives for the efficient provision of high-quality care. Medicare should set payment rates to encourage plans to achieve high quality with lower resource use. It may be consistent with the Congress's goal of increased availability of MA plans to set MA rates higher than FFS rates in the short term to help plans build infrastructure; however, to continue to do so would be a disservice both to Medicare beneficiaries and—in these times of increasing budget deficits—the taxpayer."
8. Starting in 2012 these benchmarks are adjusted based on plans' performance across certain quality metrics under the nationwide Quality Bonus Payment demonstration. High quality plans have a fixed percentage added to their benchmarks. In 2014 they will also be allowed to retain a larger share than lower quality plans of any savings below the benchmark. The ACA changed the share retained by the Medicare program from 25 percent to a range of 30 to 50 percent—with Medicare's share higher for lower quality plans. See: Medicare Payment Advisory Commission. "The Medicare Advantage Program: A Status Report." In *Report to the Congress: Medicare Payment Policy*. Washington DC: MedPAC, March 2012.
9. Both GAO and MedPAC have found that the application of bonuses to the vast majority, rather than a select set, of plans offsets a significant share of the MA savings generated by the change in benchmarks. The Kaiser Family Foundation has reached a similar conclusion. See: Kaiser Family Foundation, "Medicare Advantage Plan Star Ratings and Bonus Payments in 2012." November 2011; Medicare Payment Advisory Commission, March 2012; and US Government Accountability Office. "Medicare Advantage: Quality Bonus Payment Demonstration Has Design Flaws and Raises Legal Concerns." Washington DC: GAO, July 25, 2012.
10. Medicare Payment Advisory Commission, March 2012.
11. Our analysis relies on the data used in Biles, 2012.
12. Centers for Medicare and Medicaid Services. *Monthly Medicare Advantage State/County/Contract Data*. Baltimore, MD: CMS, June 2009. Available at <http://www.cms.hhs.gov/MCRAdvPartDEnrolData/>; and Centers for Medicare and Medicaid Services. *Monthly Medicare Advantage State/County Penetration Data*. Baltimore, MD: CMS, May 2009. Available at <http://www.cms.hhs.gov/MCRAdvPartDEnrolData/>.
13. This result is consistent not only with the Biles analysis on which it builds (Biles, 2012) but also with the results of GAO's similar analysis of 2010 data (GAO, 2011). GAO reported that only plans (specifically HMOs and regional PPOs) with enrollment concentrated in traditional Medicare's highest cost areas had per beneficiary costs below those of traditional Medicare.
14. Kaiser Family Foundation. *State Health Facts: Medicare Spending Per Enrollee by State of Residence*. Washington DC: KFF, 2009. Available at <http://www.statehealthfacts.org/comparemaptable.jsp?ind=624&cat=6>.
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18. Brown J, Duggan M, Kuziemko I et al. "How Does Risk Selection Respond to Risk Adjustment? Evidence from the Medicare Advantage Program." Working Paper 16977, National Bureau of Economic Research, April 2011; and Medicare Payment Advisory Commission. "Issues for Risk Adjustment in Medicare Advantage." In *Report to the Congress: Medicare and the Health Care Delivery System*. Washington DC: MedPAC, June 2012.

19. MedPAC offers the 2008 variation within the congestive heart failure HCC as an example. The beneficiary in the lowest 5th percentile of costs in that HCC cost traditional Medicare \$115; the beneficiary in the 95th percentile cost traditional Medicare \$37,000. MA plans gets the same payment adjustment (41 percent) for all patients in that HCC. See: Medicare Payment Advisory Commission, June 2012.
20. Brown et al., 2011.
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About the Authors and Acknowledgments

Judy Feder is an Institute Fellow, Stephen Zuckerman is a senior fellow, and Nicole Cafarella Lallemand is a research associate at the Urban Institute's Health Policy Center. Brian Biles is a professor in the Department of Health Policy in the School of Public Health and Health Services at The George Washington University. The authors would like to thank Robert Berenson and John Holahan for their helpful comments and Giselle Casillas for her research assistance.

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