Restructuring Medicare
The False Promise of Premium Support

Robert A. Berenson    Laura Skopec    Stephen Zuckerman
October 2017
ABOUT THE URBAN INSTITUTE
The nonprofit Urban Institute is dedicated to elevating the debate on social and economic policy. For nearly five decades, Urban scholars have conducted research and offered evidence-based solutions that improve lives and strengthen communities across a rapidly urbanizing world. Their objective research helps expand opportunities for all, reduce hardship among the most vulnerable, and strengthen the effectiveness of the public sector.
Contents

Acknowledgments iv

Restructuring Medicare: The False Promise of Premium Support 1
The Problem of Medicare Spending Is Greatly Exaggerated 3
Premium Support Would Work Differently than Medicare Advantage 5
Premium Support Wrongly Imposes Responsibility for Restraining Medicare Spending on Beneficiaries 8
Premium Support Would Reduce Beneficiary Choices 9
Risk Adjustment Can't Support Premium Support 13
Government-Administered Prices Are Crucial to Medicare's Success 15
Conclusion 17

Notes 18

References 21

About the Authors 24

Statement of Independence 25
Acknowledgments

This report was funded by the AARP Public Policy Institute. We are grateful to them and to all our funders, who make it possible for Urban to advance its mission.

The views expressed are those of the authors and should not be attributed to the Urban Institute, its trustees, or its funders. Funders do not determine research findings or the insights and recommendations of Urban experts. Further information on the Urban Institute’s funding principles is available at www.urban.org/support.
Restructuring Medicare: The False Promise of Premium Support

Prominent Republicans including Speaker Paul Ryan and former secretary of health and human services Tom Price have advocated for a premium support program in Medicare, an approach that would fundamentally restructure the Medicare program (House Budget Committee 2016; Office of the Speaker of the House 2016). This restructuring would change Medicare from a program that offers defined benefits with specified cost-sharing to one in which beneficiaries would be entitled to a fixed-dollar defined contribution—what some call a voucher—to shop for health insurance in a Marketplace.

Under the premium support approach, the federal government would contribute the same risk-adjusted amount toward coverage for each beneficiary in a region. People who choose a plan (or traditional Medicare) that costs more than the federal contribution would generally have to pay higher premiums, and those who choose less costly options could pay lower premiums or receive cash rebates or extra benefits. Premium support proponents argue that the heightened competition created by requiring beneficiaries to use their own funds, dollar for dollar, to pay for plans more costly than the fixed contribution would reduce costs and produce savings for the government. Presumably, more intense plan competition under the defined-contribution approach would lower health plans' bids to provide Medicare benefits and increase pressure on beneficiaries to choose lower-cost options, resulting in reduced federal contributions and program savings (CBO 2013; CBO 2017b; Coulam, Feldman, and Dowd 2009; House Budget Committee 2016; Office of the Speaker of the House 2016).

For most of its 52-year history, Medicare has allowed beneficiaries to choose private health plans as an alternative to receiving care through traditional Medicare; this option is now called Medicare Advantage. About two-thirds of beneficiaries now remain in traditional Medicare, but an increasing number—approaching one-third of the nearly 60 million beneficiaries—have opted for private Medicare Advantage plans to provide their basic Part A and Part B benefits (usually with integrated Part D prescription drug benefits as well; Jacobson et al. 2016).

The premium support concept has arisen many times over the past decade as a proposed solution to increasing Medicare spending and deficits, and it was recently included in the 2018 budget passed by the House. The Senate’s competing budget resolution does not explicitly transform Medicare into a premium support system, but it would cut $473 billion in Medicare spending (Senate Budget Committee Minority Staff 2017), which would be difficult to achieve without significant restructuring of the program. In addition, the Center for Medicare & Medicaid Innovation recently issued a request for
information seeking new options to pay for Medicare beneficiaries’ care beyond traditional Medicare and Medicare Advantage; some observers have interpreted this as a reference to premium support. Proponents of Medicare restructuring claim that the program—even with Medicare Advantage—is inefficient, unable to control spending growth, and “going broke” (Coulam, Feldman, and Dowd 2009; Office of the Speaker of the House 2016). This issue brief challenges those characterizations of the current Medicare program and focuses on the shortcomings of the premium support approach.

First, we demonstrate that the supposedly dire financial situation of Medicare has been greatly exaggerated. Medicare’s finances are sound, and its share of the federal budget is not inordinate, given the aging of the population. Then, we describe how premium support would work and how it differs from the current Medicare Advantage program that provides choice and competition in Medicare. We explore key differences in the approaches to argue that fundamentally altering Medicare from a defined-benefit program to a defined-contribution program would make unreasonable demands on vulnerable people with limited financial resources.

Next, we show that premium support could reduce beneficiary choice of health plans because traditional Medicare spending varies so greatly across the country. In some regions, beneficiaries would have to pay high premiums to remain in traditional Medicare; in other regions, private plans would be priced too high to successfully compete, limiting choice. We explain that the deficiencies in current methods of risk-adjusting the government contribution to plans and traditional Medicare based on the health status of enrollees would create unfair competition favoring the plans. Under premium support, the failure of risk adjustment to adequately compensate for high-risk enrollees in traditional Medicare would become a disabling problem, systematically underpaying traditional Medicare and creating an insurmountable financial burden for beneficiaries who prefer traditional Medicare. In some areas, this unfair advantage could drive the traditional Medicare program into a "death spiral."

We show that Medicare Advantage works well because plans can pay hospitals and providers at or near Medicare payment rates, rather than the much higher rates that commercial insurers pay. The Medicare statute’s protection of beneficiaries from provider balance billing leads virtually all providers to accept Medicare’s administered prices. Without such an active role for government—one that proponents of Medicare premium support typically oppose and that some seek to overturn—private plans would not be able to successfully compete with traditional Medicare.

Finally, we examine how premium support proposals have evolved through successive Congressional Budget Office (CBO) projections. Once a premium support structure is firmly in place, design features softened to protect beneficiaries could easily revert to earlier, harsher iterations.
The Problem of Medicare Spending Is Greatly Exaggerated

Proponents of restructuring Medicare through premium support, including Speaker Paul Ryan, assert that Medicare is “going broke.” In fact, the 2017 Medicare Trustees Report projected that Part A, the hospital insurance trust fund covering about 43 percent of Medicare costs, will not be depleted until 2029 (Boards 2017). Some advocates of premium support also claim that the Affordable Care Act (ACA) “rewrote” Medicare and shortened the trust fund solvency period to help fund Obamacare, but the law accomplished just the opposite, extending the duration of solvency by 12 years.

The problem policymakers face is not an inefficient program that permits out-of-control spending, but the challenge of caring for a rapidly growing Medicare beneficiary population.

Dire predictions of Part A insolvency have been a fixture in political posturing over the Medicare program since 1970—just five years after the program began—when actuaries projected that the Part A trust fund would be exhausted in 1972. The trust fund has been projected to reach insolvency within 12 years or less in 22 of the annual trustee reports issued since 1970, six of which predicted the trust fund would be “broke” within five years or less (Davis 2016). Policy changes were implemented to address the prospective shortfall, and nothing remotely resembling insolvency has ever occurred.

Still, Medicare constitutes a large and growing part of the federal budget. CBO projects that between 2017 and 2047, Medicare spending will grow from 3.1 percent to 6.7 percent of GDP (CBO 2017a). But, partly because of the ACA, Medicare spending growth has been rising more slowly than ever. Though in 2009 CBO predicted that Medicare spending net of receipts would be $689 billion in 2016, spending was actually $588 billion, or nearly 15 percent below projections.

Premium support proposals are based on two main assumptions: (1) the traditional, government-administered Medicare program is inefficient; and (2) private plans competing in a consumer-directed market would cost much less (Antos 2012; Roy 2011). Yet for much of the past decade, Medicare per-beneficiary spending increases have been modest, lower than in any decade since Medicare’s inception in 1965 (Boards 2017, appendix D), in no small part because of measures adopted in the ACA and
subsequent legislation. Moreover, recent reports by the Congressional Budget Office and the Medicare Payment Advisory Commission (MedPAC) have identified numerous opportunities for substantial spending reductions that do not require fundamental restructuring of the Medicare program (CBO 2016; KFF 2013; MedPAC 2016).

The problem policymakers face is not an inefficient program that permits out-of-control spending, but the challenge of caring for a rapidly growing Medicare beneficiary population. As of 2011, about 10,000 people aged into the Medicare program every day, and Medicare enrollment is expected to grow by 50 percent by 2030, almost entirely because of the aging-in of the baby boom generation (MedPAC 2017a). As shown in figure 1, per capita growth in Medicare spending was 1.3 percent per year between 2010 and 2015, well below the 6.8 percent growth rate between 2000 and 2010 and less than half the 3.2 percent growth rate of commercial plans over the same period. Figure 1 also illustrates the impact of baby boom age-in on Medicare, with average annual enrollment growth increasing from 1.8 percent in the last decade to 3.1 percent between 2010 and 2015.

Proponents of premium support want it to further reduce modest per-beneficiary spending increases to fix a problem caused mostly by the growth of the beneficiary population. Put another way, the misguided policy rationale for premium support is that beneficiaries themselves—in what some proponents call a “consumer-directed” solution—should solve the spending problem associated with the aging of the population by facing increased out-of-pocket spending to maintain their preferred health plan.
Premium Support Would Work Differently than Medicare Advantage

Traditional Medicare promises to pay for all covered services rendered by participating providers according to administratively preset payment schedules. The premium support approach would instead give each beneficiary a subsidy—the "premium support"—to purchase coverage for a defined set of Medicare covered benefits, but without any guarantees about premiums from one of the competing plans available in his or her geographic area. Many design decisions would determine the impact on Medicare beneficiaries and Medicare program spending. Premium support has evolved since Speaker Ryan's first proposal in 2010, when Ryan was a member of the House Budget Committee. More recent versions would include traditional Medicare as one of the competing plans, and those who wish to maintain traditional Medicare could use the premium support subsidy to purchase it. However, beneficiaries would no longer be able to obtain traditional Medicare coverage, with their financial obligations limited to the current, statutorily specified premium. If the premium for the competing traditional Medicare program exceeds the benchmark government contribution in the region, beneficiaries selecting traditional Medicare would have to pay the full difference.
The nation would be divided into regions where interested plans would submit their bids to provide the standard Medicare Part A and Part B benefits to a beneficiary of average health (MedPAC 2017a). The government contribution would be determined by private health plan bids and the traditional Medicare “bid,” reflecting actuarial projections of its cost based on historical spending in the region where it would be competing. The government contribution would be set as a function of the bids of all the plans including traditional Medicare, for example, at the enrollment-weighted average of all the bids including traditional Medicare’s passive bid (see box 1 for other variations).

The annual update to the premium support contribution affects federal savings. Early versions of premium support set a path for Medicare spending over time by annually updating the premium support amount according to an external index such as the increase in per capita GDP. This approach could yield significant government savings because health care costs generally increase faster than GDP, but it would also increase beneficiary out-of-pocket costs (Van de Water 2012). To reduce the negative and cumulative impact on beneficiaries of the likely growing differential between health care spending growth and per capita GDP growth, more recent premium support proposals have softened the impact of the government contribution by basing it on annual bids without a cap, thereby reducing savings substantially and reducing the negative effect on beneficiaries’ out-of-pocket costs (CBO 2013; CBO 2017b).

A risk-adjustment mechanism would take into account the illness burden of a plan’s enrollees by adjusting payments to plans using enrollee diagnoses. Though the government contribution would be risk adjusted, paying more or less depending on each enrollee’s health status, the beneficiary’s premium would not vary based on health status (Office of the Speaker of the House 2016).

Health plan bidding also takes place in the Medicare Advantage program, but plans bid against benchmarks that are used to determine the government contribution and are administratively set by the Centers for Medicare & Medicaid Services (CMS) based on spending in the traditional Medicare program. Traditional Medicare costs vary much more by geography than Medicare Advantage plan bids do. Under the ACA, benchmarks are based on spending in traditional Medicare but adjusted to be closer to Medicare Advantage plan costs in individual counties to promote competition, choice, and equity in the availability of additional benefits across the country. Medicare Advantage benchmarks vary from 95 percent to 115 percent of spending in traditional Medicare, which comes closer to representing variation in plan costs nationwide.
A camel nose under the tent, a wolf in sheep’s clothing, a Trojan horse—pick your favorite metaphor for the implications of ever softer versions of premium support. From 2010, when Speaker Ryan first introduced a premium support proposal,\(^a\) to 2016 (Office of the Speaker of the House 2016), when he presented his most recent vision, design provisions have become gentler with each iteration. Proposals were revised in response to CBO analysis of flaws in earlier versions or in response to political blowback. After the initial proposal, premium support has included the traditional Medicare program as a competing plan option, largely because CBO stated that traditional Medicare was necessary to make private plans cost-competitive.

Two provisions in House budget proposals from 2014 to 2016 deserve mention. To generate greater program savings, earlier premium support versions would have set the government contribution to the second lowest bid within a region or to traditional Medicare costs, whichever is lower (House Budget Committee 2013). This would have imposed a major financial burden on beneficiaries who wished to stay in traditional Medicare in many parts of the country. In the most recent version of premium support, the government contribution would be set by the weighted average of all bids. CBO recently estimated that this change would cut savings two years after implementation by about one-half, from 15 percent of net federal Medicare spending for Parts A and B to just 8 percent, or from $84 billion to $41 billion (CBO 2017b).

The second deviation from "pure" premium support concerns how bids and the government contribution would rise over time. In earlier versions, the government contribution would have been set to achieve a specific path for Medicare spending by setting an initial amount per person based on initial bids and increasing it annually based on the growth of an economic or budgetary measure external to the health care system, such as per capita GDP. Setting the federal contribution in this way would give the government greater control over spending, but beneficiaries would face higher premiums if the insurers’ costs grew faster than the contribution—as they usually do. For example, average annual nominal GDP growth between 2003 and 2013 was 3.9 percent, compared with 5.4 percent annual nominal growth in national health expenditures (Catlin and Cowan 2015).\(^b\) This once fundamental premium support element has been softened to update the government contribution based on annual bids without an external cap on increases, thereby reducing both savings and the negative effect on beneficiaries.

Subsequent versions of premium support have been more benign than earlier versions. But even in an attenuated form, premium support would constitute a fundamental and likely irreversible restructuring of Medicare. Once in place, the more aggressive forms of premium support could easily be reconstituted to increase budgetary savings by shifting costs to beneficiaries.

\(^b\) This was one of the smallest gaps between national health expenditure growth and GDP growth since the Medicare program began.
A Medicare Advantage plan that bids below the administratively set benchmark payment amount receives a federal payment in the amount of the bid plus a “rebate” that is a percentage of the difference between the bid and the benchmark and that ranges from 50 to 70 percent, depending on the Medicare Advantage plan’s performance on quality measures. Medicare Advantage plans are required to return much of the difference to the plan’s beneficiaries in the form of supplemental benefits, including reduced cost-sharing. The amount that CMS keeps—the difference between the bid and the total payment including rebate—is the source of savings for the program.22 Research suggests that these extra benefits have helped attract enrollees to the Medicare Advantage program (Nicholas 2014). Under a premium support program, such extra benefits would likely disappear, replaced by cash rebates for choosing plans with premiums below the premium support amount.23

Premium Support Wrongly Imposes Responsibility for Restraining Medicare Spending on Beneficiaries

Though the premium support model of competition could theoretically reduce bids and thus the government contribution, it would place the primary responsibility for exercising cost control on beneficiaries. Most Medicare beneficiaries live on modest incomes and could not pay much more for their health care if the results of competitive bidding caused the premiums required to remain in traditional Medicare (or their preferred private plan) to rise significantly. The median annual income of individual Medicare beneficiaries was about $25,000 in 2014, and only about 15 percent of Medicare beneficiaries had incomes over $50,000. Moreover, 8 percent of beneficiaries had no savings or were in debt, and 25 percent had savings of less than $12,000. Median savings for black and Hispanic beneficiaries were particularly low, at about $12,000 and $10,000 respectively (Jacobson et al. 2015); premium support could be particularly detrimental for these racial/ethnic minorities.

In 2012, Medicare households spent nearly three times as much of their household budgets on out-of-pocket spending as non-Medicare households did—14 percent versus 5 percent (Cubanski et al. 2014). By 2030, per capita income is expected to increase among the Medicare population, but those increases will largely accrue to the top 5 percent (Jacobson et al. 2015). Thus, premium support could force lower-income beneficiaries into plans that they would not otherwise choose, while those with higher incomes could afford the plan that best meets their needs.
Faced with the current array of insurance choices in Medicare, beneficiaries often do not choose the plan that would reduce their costs. Placing more financial pressure on the outcome of this choice through premium support would probably not result in better decisionmaking among this particularly vulnerable population.

A large body of research shows that seniors do not make the best choices for their circumstances in the Medicare Part D prescription drug program (Abaluck and Gruber 2011; Heiss et al. 2013; Zhou and Zhang 2012). Older adults are more likely to make suboptimal financial decisions than middle-aged adults, and cognitive function, including important decisionmaking capacities such as practical numeracy, decline with age (Agarwal et al. 2009). Over one-quarter of adults ages 65 and older have cognitive impairment or dementia and may not be able to make informed choices, even with family support (Langa et al. 2017).

The enhanced competition of the premium support model, featuring dollar-for-dollar savings or additional premiums resulting from competitive bids, puts unreasonable financial pressure on a vulnerable population to make important decisions about their health insurance. Evidence suggests that, faced with the current array of insurance choices in Medicare, beneficiaries often do not choose the plan that would reduce their costs (Abaluck and Gruber 2011; Heiss et al. 2013; Zhou and Zhang 2012). Placing more financial pressure on the outcome of this choice through premium support would probably not result in better decisionmaking among this vulnerable population.

Premium Support Would Reduce Beneficiary Choices

Premium support would likely cause private plans to dominate in some regions and leave traditional Medicare as the only viable option in other regions. Few geographic areas would have a level playing field for plan competition, in which beneficiaries faced comparably priced premiums for private plans and traditional Medicare. Now, Medicare Advantage offers a wide array of private plans alongside traditional Medicare in almost all parts of the country, precisely because the Medicare Advantage benchmarks reflect the greater geographic variation of spending in traditional Medicare, compared with spending in Medicare Advantage plans. Premium support, on the other hand, relies on competitive plan bids and traditional Medicare costs in each region, which could dramatically reduce health plan
choice for beneficiaries—an outcome policymakers were explicitly trying to avoid by adopting varying benchmarks in Medicare Advantage.

Before the Balanced Budget Act of 1997, so-called Medicare risk plans were spread unevenly throughout the country because the plans were paid based on traditional Medicare spending at the county level. The Balanced Budget Act and subsequent legislation24 aimed to provide broader choice for beneficiaries throughout the country initially by establishing payment “floors” for paying private plans and later, in the ACA, by varying the benchmarks from 95 to 115 percent of traditional Medicare spending to more closely approximate private plan costs.25

This approach has been successful: in 2017, an average of 10 Medicare Advantage plans are offered in each county (MedPAC 2017b). This method of promoting choice between Medicare Advantage plans and traditional Medicare would be undone by premium support. Some premium support proponents argue that there is no policy justification for paying more than the lowest amount a plan is willing to accept for ensuring beneficiary choice (Domenici and Rivlin 2011). Consistent with this viewpoint, a premium support approach would reduce beneficiary choice of health plans.

The Medicare Advantage approach offers choice to beneficiaries and does so on a budget-neutral basis by varying benchmarks by 20 percent across geographic areas. Medicare beneficiaries tend to stick with either Medicare Advantage plans or traditional Medicare, an important finding that was cited by a federal district court in disapproving the proposed Aetna-Humana merger that would have limited choice within the Medicare Advantage market.26 Less than 5 percent of beneficiaries in traditional Medicare switch to a Medicare Advantage plan each year, and vice versa.27 Of the 2 to 3 percent who do switch from a Medicare Advantage plan to traditional Medicare (Jacobson, Neuman, and Damico 2015), more than half reenroll in a Medicare Advantage plan within 12 months (Newhouse et al. 2012). This suggests that beneficiaries switch back to traditional Medicare for broader provider choice to address a particular condition and then move back to Medicare Advantage when that health issue is resolved.

Premium support advocates point to evidence that a known external benchmark “anchors” health plan bids to some extent, and the higher the benchmark, the higher the bid.28 Premium support assumes that increased competition, not only with other plans but also with traditional Medicare, and the enhanced incentive to bid low by heavily incentivizing beneficiaries to choose a low-cost plan would lead insurers to reduce their administrative and medical care costs or decrease their expected profit margins to attract market share.

However, a MedPAC analysis showed that using competitive bidding to set Medicare Advantage benchmarks may not always produce the desired results (MedPAC 2009). Bidding could drive all but
one plan from the market, and that plan’s bids may be so low that it no longer can provide extra benefits, making it less attractive as an alternative to traditional Medicare. This could eliminate expected program savings from private plan competition, especially in high-cost areas. Thus, even competitive bidding may need an administrative pricing fallback and other safeguards to ensure that low bidders can serve the population they enroll.

Figure 2 demonstrates that premium support as commonly proposed would likely replicate the experience of pre–Balanced Budget Act risk plans and traditional Medicare, making private plans prohibitively costly for many beneficiaries in some geographic regions and traditional Medicare too costly in others. In 27 percent of counties (accounting for 43 percent of Medicare beneficiaries), traditional Medicare currently spends more than $50 more per month than the average Medicare Advantage plan selected by beneficiaries and would likely be unaffordable for many beneficiaries under premium support. In 20 percent of counties (accounting for 11 percent of beneficiaries), the average Medicare Advantage plan selected by beneficiaries costs more than $50 more per month than traditional Medicare, and private plans would likely be unaffordable under premium support.
Assuring substantial coverage of Medicare Advantage plans and traditional Medicare across the country is a rational and defensible goal. First, traditional Medicare and private plans have different strengths and weaknesses that appeal to different beneficiaries (Dowd et al. 2005). For example, some beneficiaries may prefer traditional Medicare’s broad access to virtually all licensed providers, but those selecting Medicare Advantage plans may accept narrower provider networks and more use management in exchange for extra benefits and an out-of-pocket spending cap. In addition, a traditional Medicare beneficiary seeking low cost-sharing and prescription drug coverage must deal with three separate policies with separate premiums: traditional Medicare, a Medigap or other supplemental

Note: Areas in white do not have payment data available for Medicare Advantage plans because of low enrollment; these areas also generally have few Medicare beneficiaries.
insurance plan, and a stand-alone Part D prescription drug plan. Medicare Advantage offers one-stop shopping for beneficiaries: a single point of entry to provide the standard Part A and Part B benefits, supplemental coverage including a cap on out-of-pocket expenses, and Part D prescription drugs. Given these distinctions, beneficiaries tend to have “durable preferences” for private plans or traditional Medicare. Second, though traditional Medicare has low administrative overhead and considerable market purchasing power, it also produces more cost variation than Medicare Advantage (Fisher et al. 2003a, 2003b), along with pockets of wasteful and sometimes overtly fraudulent spending. Medicare Advantage plans, in contrast, have more freedom and flexibility to promote narrow networks to improve quality and efficiency; provide active disease and utilization management programs; and alter benefit design to encourage better approaches to care delivery and greater emphasis on preventive care.

Mounting evidence suggests that the coexistence of traditional Medicare and Medicare Advantage programs creates positive spillover effects in both directions. The most prominent spillover is Medicare Advantage plans’ use of traditional Medicare provider prices, discussed in the next section. Medicare Advantage plans also reduce the costs associated with care in traditional Medicare, but the mechanisms for these spillover cost savings are not well understood (Baicker, Chernew, and Robbins 2013; Callison 2015; Chernew, DeCicca, and Town 2008).

Risk Adjustment Can’t Support Premium Support

Premium support requires an effective risk-adjustment mechanism to ensure that competing plans and the de facto competing traditional Medicare program are paid fairly for the patient populations that select them. As a defined-contribution program, premium support is dependent on effective risk adjustment. Unfortunately, the current risk-adjustment system is not up to this task. Medicare Advantage plans continue to attract healthier-than-average beneficiaries compared with traditional Medicare, either because of the program’s efforts or because of beneficiary preferences. And given the inherent limitations of risk adjustment, Medicare Advantage plans are overpaid. Only the amount of overpayment is in dispute; estimates range from 3 percent to 15 percent (Brown et al. 2014; MedPAC 2012; Newhouse et al. 2015). Though such overpayment does not directly harm traditional Medicare enrollees because of the program’s defined-benefit structure, risk adjustment under a premium support scenario could eventually lead to a traditional Medicare “death spiral” because of the systematic underpayment of traditional Medicare relative to enrollee risk. The traditional Medicare “premium” would increase each year to compensate for this underpayment because traditional Medicare’s “bid"
would reflect poorly risk-adjusted actual costs. This would make the program less competitive and drive healthier enrollees willing to accept narrower provider networks toward private plans, exacerbating the problem of risk-adjustment underpayment.

Some experts assert that Medicare Advantage risk adjustment works well enough to keep overpayment attributable to favorable selection in check. But even they concede that this result is achieved through CMS’s use of administrative tools to mitigate plans’ incentives to select healthier-than-average beneficiaries (Newhouse et al. 2015). CMS manages the flaws in risk adjustment by limiting plan marketing practices and plans’ selection of their service areas; requiring that plans meet provider network adequacy requirements; and ensuring that benefit packages offered to beneficiaries do not preferentially attract healthy beneficiaries, with a focus on how cost-sharing is constructed.

*Underpayment relative to enrollee population risk could force traditional Medicare into a death spiral in many parts of the country, not because of poor performance but simply because of its inability to risk-adjust payment fairly.*

CMS actively manages the weaknesses in the risk-adjustment system to mitigate incentives to risk-select enrollees. MedPAC recently suggested even more administrative measures to rein in incentives for plans to engage in risk selection, such as financial penalties for excessive disenrollment of high-cost beneficiaries (MedPAC 2014).

MedPAC has emphasized the problem of Medicare Advantage plans’ aggressive diagnosis coding practices, which raise the diagnosis-based “risk score” in the risk-adjustment model. The commission found that Medicare Advantage risk score growth through 2015 was about 4 percent higher than CMS’s administrative adjustment for coding intensity (which was already over 5 percent in 2015; MedPAC 2016). Medicare Advantage plans increased their risk scores by “finding” additional diagnoses or by reporting increased severity of diagnoses by nearly 10 percent, producing comparable increases in Medicare payments. These analyses are supported by recent revelations that allege fraudulent inflation of risk scores by some Medicare Advantage insurers.32

The additional payments related to risk-adjustment flaws benefit Medicare Advantage plans and their enrollees but cost taxpayers more. These additional program costs marginally increase the Part B
premium, but because traditional Medicare remains a defined-benefit program for the most part, beneficiaries who choose to remain in traditional Medicare are not seriously disadvantaged. In a premium support system that would move traditional Medicare from a defined-benefit to a defined-contribution structure, the deficiencies of risk adjustment would have much greater impact, systematically underpaying traditional Medicare.

This will occur for two reasons. First, the nearly unlimited provider choice in traditional Medicare tends to attract sicker enrollees. Second, because traditional Medicare does not have staff to manage the diagnostic coding process to ensure all diagnoses are captured, as Medicare Advantage plans routinely do, the program will be underpaid for those sicker enrollees in the risk-adjustment system, just as it is today. To cover risk-adjustment losses, traditional Medicare would have to raise its “premium” over time, pricing it out of many markets and further ensuring that only the sickest with the most need for wide provider choice would join the program. Over time, underpayment relative to enrollee population risk could force traditional Medicare into a death spiral in many parts of the country, not because of poor performance but simply because of its inability to risk-adjust payment fairly. Premium support could build in an active role for CMS to manage the competition, as Medicare Advantage does. However, the political philosophy animating premium support aims to minimize the role of government, which in Medicare Advantage involves providing administrative cures for the failings of the risk adjuster.

In a 2017 analysis, CBO recognized how significant this problem could become in premium support. However, CBO assumed that differences in risk coding between traditional Medicare and private plans would be held to no more than 5 percent, roughly the current level of excess payment to Medicare Advantage plans resulting from plans’ coding of risk scores (CBO 2017b; MedPAC 2016). Would such an “arbitrary” cap (as CBO labeled it) be adopted in a premium support system predicated on market competition and a reduced role for government as payer and regulator? CBO provided no mechanism to enforce this cap, even though coding differences between traditional Medicare and Medicare Advantage have grown over time, despite CMS efforts to curtail them (MedPAC 2016).

Government-Administered Prices Are Crucial to Medicare’s Success

Many premium support proponents fail to appreciate that Medicare Advantage works precisely because of traditional Medicare’s functioning as a public option alternative for beneficiaries. Neither do
they acknowledge that Medicare Advantage plans are competing well in Medicare only because they can pay hospitals and physicians at traditional Medicare rates, which are much lower than the rates commercial insurance plans pay.

The Medicare statute does not allow providers to bill patients more than would be allowed for payment in traditional Medicare; that is, balance billing in excess of Medicare rates is not permitted in Medicare Advantage. Though legislated as a protection for beneficiaries, the limitation of payment to traditional Medicare rates directly affects negotiating leverage between Medicare Advantage plans and providers. In the Medicare Advantage program, hospitals essentially choose to be “in-network” at Medicare rates or “out-of-network” at the same rates (Berenson et al. 2015); they lack leverage to demand the higher commercial rates that most hospitals negotiate (Maeda and Nelson 2017).

The gap between traditional Medicare payments and commercial health plan payments to hospitals has consistently increased, with commercial plans paying about 10 percent more than traditional Medicare in the late 1990s and 75 percent more in 2012 (Selden et al. 2015). A recent analysis by CBO finds an even larger differential. Reviewing 2013 claims from three large national insurers, CBO found that commercial insurance rates for inpatient hospital services were 89 percent higher than traditional Medicare rates, but Medicare Advantage plan rates for inpatient services were roughly equal to traditional Medicare’s rates (Maeda and Nelson 2017). If Medicare Advantage plans had to pay at or near their negotiated commercial rates, they would not be competitive with traditional Medicare virtually anywhere in the country. No amount of care management to reduce service use would overcome the pricing differential for hospital care, nor that for physician care (Berenson 2015).

By placing strict limits on balance billing of Medicare beneficiaries and thereby tying Medicare Advantage rates to the administered prices set by traditional Medicare, the Medicare statute effectively promotes competition among Medicare Advantage plans on overall costs, quality, access, and service. Unless such pricing limitations are included, premium support would not produce useful competition, and only traditional Medicare would be viable in most markets.

CBO modeling of premium support proposals now assumes that premium support would retain this design feature central to the success of Medicare Advantage (Maeda and Nelson 2017). Yet no premium support proposal acknowledges the essential need for this provision, even though it allows Medicare Advantage plans to be price-competitive with traditional Medicare. Instead, it seems premium support proponents do not want to retain it. Prominent conservative policy experts have criticized traditional Medicare’s administered pricing, calling it ineffective and distorting. As a member of Congress, former secretary of health and human services Tom Price introduced legislation that
would allow physicians to bill beneficiaries for charges that exceed Medicare-approved amounts. A recent CMS request for information included a similar proposal, which would undermine the direct link between traditional Medicare rates and the negotiated Medicare Advantage rates that allow Medicare Advantage plans to compete with traditional Medicare.

Conclusion

Premium support has an undeserved reputation among market-oriented policymakers as the right “fix” for Medicare’s rapidly growing share of the federal budget. But without an active role for government—as an alternative plan, price setter, and administrative overseer of the competition—the market is not likely to become more competitive than it already is. The role of government in premium support must be larger than its proponents envision, and it must be comparable to the role of government in the already successful Medicare Advantage program.

Even with a strong government role, premium support would place a great burden on the vulnerable Medicare population, forcing people to select their preferred plan based primarily on financial considerations. As a result, traditional Medicare’s wide provider choice may only be accessible to affluent beneficiaries in some areas, and private plans may cease to exist as an option in others.

Medicare Advantage is accepted by beneficiaries and can remain the source of competition and choice within the Medicare program. We do not mean to imply that either traditional Medicare or Medicare Advantage are performing perfectly today. The ACA made an overdue correction to inflated benchmarks that produced excessive payments to Medicare Advantage plans. In addition, MedPAC continues to monitor Medicare Advantage performance and has proposed other course corrections to increase downward pressure on Medicare Advantage benchmarks and reduce overpayments to Medicare Advantage plans, based on quality measures and flawed risk adjustment. These improvements include, for example, eliminating doubling of quality bonuses in certain counties and applying a coding adjustment in the risk-adjustment system that fully accounts for differences in coding between traditional Medicare and Medicare Advantage (MedPAC 2016). Traditional Medicare spending can be contained using methods less drastic than an overhaul of the program from a defined-benefit to a defined-contribution approach (CBO 2016; KFF 2013).
Notes


2. It would be a limited form of a defined contribution because the subsidy could only be used for purchase of approved health plans providing a defined benefit.

3. Some proponents argue that the premium support subsidy is not a voucher because it is paid directly to the health plan rather than to the beneficiary.

4. Most premium support proposals have excluded dual-eligible people. See, for example, premium support approaches evaluated by the Congressional Budget Office (2013).

5. The sizes of these regions are not clear in the premium support proposals. Current Medicare Advantage benchmarks are set at the county level. Transitioning to a regional system would have multiple countervailing effects; spreading the very high costs of some counties over a larger area and population may bring traditional Medicare and Medicare Advantage premiums closer together than shown in figure 1, but it could also discourage the entry of smaller local plans, including those organized by health care systems.


15. CBO’s 2009 projection assumed that sustainable growth rate cuts would go into effect. Without this assumption, the 2009 projection for 2016 would have been even higher. See CBO’s January 2017 and January 2009 10-year budget projections at https://www.cbo.gov/about/products/budget-economic-data#3.

16. In its analysis of premium support, the Congressional Budget Office assumed that insurers would submit a separate bid for providing prescription drug benefits through Part D, and that Part D enrollment would remain voluntary for beneficiaries.

17. For various premium support options, see KFF (2012).


19. All Medicare premium support proposals prohibit medical underwriting and require guaranteed issue and community rating, with government contributions to plans risk adjusted for underlying health risks, including the effect of age and gender on spending.

20. In its June 2009 report to Congress, MedPAC analyzed approaches to setting Medicare Advantage benchmarks and found that an approach set to expected variation in Medicare Advantage plan costs was least likely to reduce competition in the Medicare Advantage program (MedPAC 2009).

21. In its June 2009 report to Congress, MedPAC noted that a system varying benchmarks in a similar manner would more closely reflect the variation in Medicare Advantage plan bids (MedPAC 2009).

22. Where plans are paid up to 115 percent of traditional Medicare costs, the difference between the bid and the rebate is still likely above the cost to the program if the beneficiary had chosen traditional Medicare.

23. The 2011 Wyden-Ryan premium support plan, “Guaranteed Choices to Strengthen Medicare and Health Security for All,” stated that providing extra benefits rather than cash rebates to beneficiaries selecting lower-cost plans in the Medicare Advantage program prevented Medicare Advantage plans from directly competing with traditional Medicare and sometimes led to increased use and costs. See Wyden and Ryan (2011).

24. For a legislative history, see McGuire, Newhouse, and Sinaiko (2011).

25. Counties with benchmarks set at 115 percent of traditional Medicare spending still have lower benchmarks than counties with benchmarks set at 95 percent of traditional Medicare spending, in absolute dollars.


27. One factor that likely contributes to this “stickiness” is that beneficiaries who initially select Medicare Advantage cannot move easily back to Medigap, which does not provide guaranteed issue if beneficiaries do not choose it when they first select to receive their Part B benefits.

28. For every $1.00 increase in the benchmark, the bid increases by approximately $0.50 (Song, Landrum, and Chernew 2013; Zuckerman, Skopec, and Guterman, forthcoming).

29. This analysis excludes current Medicare Advantage plans that are not available to all enrollees, such as special needs plans, employer group health plans, and plans that serve only beneficiaries eligible for both Medicare and Medicaid.
30. This estimate is likely conservative because our dataset does not include the additional premiums beneficiaries already pay to Medicare Advantage plans that bid above the benchmark. In addition, this analysis does not account for the areas that currently have no significant Medicare Advantage penetration, shown in white in figure 2.


35. See note 10.
References


About the Authors

Robert A. Berenson joined Urban as an Institute fellow in 2003. He conducts research and provides policy analysis primarily on health care delivery issues, particularly related to Medicare payment policy, pricing power in commercial insurance markets, and new forms of health delivery based on reinvigorated primary care practices. In 2012, Berenson completed a three-year term on the Medicare Payment Advisory Commission, the last two years as vice chair. From 1998 to 2000, he was in charge of Medicare payment policy and private health plan contracting in the Centers for Medicare & Medicaid Services.

Laura Skopec is a research associate in the Urban Institute’s Health Policy Center, where her research focuses on health insurance coverage, health care access, and health care affordability, with a focus on the effects of the Affordable Care Act. Before joining Urban, she worked on Affordable Care Act implementation at the Office of the Assistant Secretary for Planning and Evaluation in the US Department of Health and Human Services, and on transparency in health insurance and health care at the American Cancer Society Cancer Action Network.

Stephen Zuckerman is a senior fellow and codirector of the Health Policy Center. He has studied health economics and health policy for almost 30 years and is a national expert on Medicare and Medicaid physician payment, including how payments affect enrollee access to care and the volume of services they receive. He is currently examining how payment and delivery system reforms can affect the availability of primary care services, and studying the implementation and impact of the Affordable Care Act.
Statement of Independence

The Urban Institute strives to meet the highest standards of integrity and quality in its research and analyses and in the evidence-based policy recommendations offered by its researchers and experts. We believe that operating consistent with the values of independence, rigor, and transparency is essential to maintaining those standards. As an organization, the Urban Institute does not take positions on issues, but it does empower and support its experts in sharing their own evidence-based views and policy recommendations that have been shaped by scholarship. Funders do not determine our research findings or the insights and recommendations of our experts. Urban scholars and experts are expected to be objective and follow the evidence wherever it may lead.