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Why Does Medicare Advantage Work Better Than Marketplaces?

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IN BRIEF

The Medicare program offers an option called Medicare Advantage (MA) in which private insurance plans compete with traditional Medicare. The Affordable Care Act (ACA) set up marketplaces in which insurers compete for enrollees. Both programs provide government-subsidized health insurance coverage in a regulated market that includes guaranteed issue, community rating or modified community rating, benefit standards, and risk adjustment. In both programs, private plans are encouraged to compete for market share based on premiums, quality, provider networks, and differences in cost-sharing and benefits.

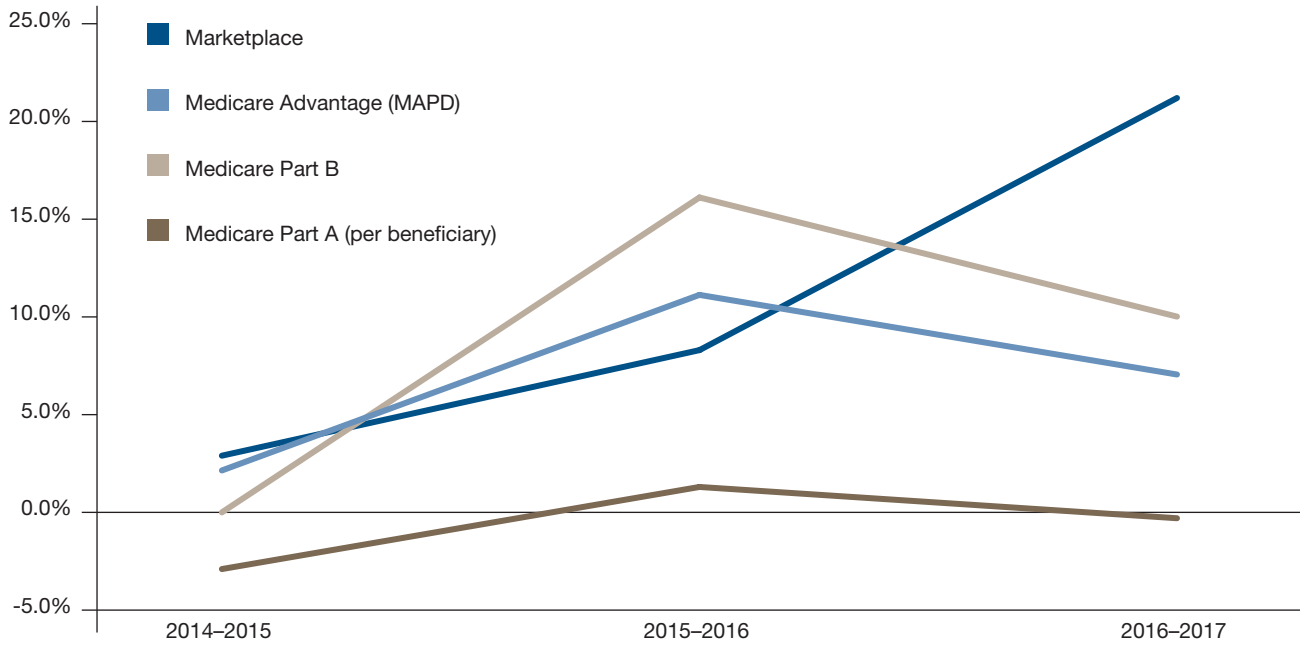
Yet the Medicare Advantage markets are substantially more robust, with higher private insurer participation and lower average premium growth. We assess how structural differences between Medicare Advantage and marketplaces led to these outcomes. We focus on marketplace outcomes through 2017, before the policy changes implemented by the current administration for 2018 and beyond. In this way, our analysis focuses on the implications of different structural components of the two markets, setting aside more recent efforts that may affect the ACA marketplaces and the nongroup nonmarketplace markets.

MEDICARE ADVANTAGE OUTCOMES VERSUS ACA MARKETPLACE OUTCOMES

The Medicare Advantage program seems to be thriving. Premium growth in MA has been far lower on average than in the marketplaces (Figure 1), and enrollment has continued to increase, now accounting for about one-third of Medicare enrollment.[1] Though ACA marketplace enrollment has increased since 2014, that growth slowed appreciably in 2017.[2] Geographic areas with only one or two insurers in the marketplace usually have several insurers participating in Medicare Advantage. Of the 1,036 counties with only one marketplace insurer in 2017, about three-quarters had three or more Medicare Advantage insurers with nonzero enrollment (Table 1). Results for counties with two marketplace insurers were similar. In 2016, large national insurers (e.g., UnitedHealthcare, Aetna, Anthem, Humana, and Cigna) participated in the Medicare Advantage program in most states, though they often did not cover every county within a state (Table 2). These companies participated in the marketplaces in far fewer states, and they often did not offer statewide coverage.

In contrast, many marketplaces struggled through 2017 (2018 is an aberration because of uncertainties surrounding cost-sharing reduction payments, enforcement of the individual mandate, reduction in advertising and navigator funding, and other administrative actions). In many markets, premiums were high or increased substantially, and many insurers exited the marketplaces completely.[3] Large national insurers, such as Aetna and UnitedHealthcare, were particularly likely to exit. In many markets, only national Medicaid chains and local Medicaid plans are doing well, and they tend to offer products with narrow networks and lower provider payment rates.[3] In some markets, Blue Cross insurers have developed very competitive HMO products. But in too many markets, single insurers, such as a Blue Cross affiliate, essentially have monopoly power, with high and rapidly increasing premiums. Many other markets have only two insurers, one of them dominant.[7]

Figure 1: Average Medicare Advantage, Medicare, and Marketplace Premium Growth Rates



Sources: Marketplace premium growth rates are from Holahan et al.[3] Medicare Advantage growth rates are from Jacobson et al.[4] Medicare Part B premiums are from the 2017 Medicare Trustees Report.[5] Medicare Part A (per beneficiary) rates are derived from the CBO Medicare baseline.[6]

Note: MAPD = Medicare Advantage Prescription Drug.

Table 1: Number of Medicare Advantage Parent Companies With More Than 10 Enrollees in Counties With Only One or Two Marketplace Insurers in 2017

Number of Medicare Advantage Parent Companies With More Than 10 Enrollees	Counties With Only One Marketplace Insurer		Counties With Two Marketplace Insurers	
	Number	Share	Number	Share
One	93	9.0%	192	22.6%
Two	165	15.9%	137	16.1%
Three or more	778	75.1%	522	61.3%
Total number of counties in group	1,036		603	

Source: Authors' analysis of marketplace data and CMS monthly enrollment by county and contract. CMS data for Medicare Advantage is available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Monthly-MA-Enrollment-by-State-County-Contract.html.

Table 2: State Participation of National Health Insurance Issuers in Medicare Advantage and Marketplaces

Insurer	Number of States With Medicare Advantage Enrollees in December 2016	Medicare Advantage Market Share in December 2016	Number of States Selling Marketplace Plans in 2016
UnitedHealth Group	51 (31 states partial coverage)	22.5%	34 (12 states partial coverage)
Humana	49 (32 states partial coverage)	18.2%	13 (all states partial coverage)
Aetna	50 (30 states partial coverage)	7.8%	15 (9 states partial coverage)
Anthem	30 (26 states partial coverage)	3.4%	12 (2 states partial coverage)
Cigna	21 (19 states partial coverage)	2.9%	7 (all states partial coverage)

Source: Authors' analysis of marketplace data and CMS state service area and monthly enrollment by contract files for December 2016. CMS data for Medicare Advantage is available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Monthly-MA-Enrollment-by-State-County-Contract.html.

Notes: Participation in both programs has changed since 2016. Several of the insurers listed above now offer Medicare Advantage plans in all areas of all states and the District of Columbia, but national insurers have left the marketplaces in many of the states.

SOURCES OF DIFFERENCES IN OUTCOMES

What explains these differences between Medicare Advantage and marketplace outcomes? First, insurer competition in Medicare Advantage is less cutthroat than that in the ACA's marketplaces, in part because Medicare enrollees are less likely to choose their plan option based solely on price and the benchmark. Medicare Advantage plans compete against each other and traditional Medicare, but enrollees are more highly subsidized and considerably less price-sensitive than those in the marketplaces. Thus, insurers do not have to be one of the two lowest-premium options to gain significant market share. In contrast, ACA marketplace enrollees are mostly low-income and healthier than their older Medicare program counterparts, making them very price-sensitive. As we have shown, marketplace enrollment is highly concentrated in the lower-priced insurance options, which have premiums capped at a percentage of enrollee income.[8]

The benchmark for Medicare Advantage plans is based on per capita spending in traditional Medicare, which has known spending patterns that are mostly consistent from year to year. Medicare Advantage plans know the benchmark before they submit their bids to the program, so these insurers can easily set their premiums low enough to command some market share. The ACA links its premium tax credits to the premium of the second-lowest-cost silver plan available in the area, introducing much more uncertainty about the benchmark premium year over year and forcing insurers to compete aggressively on price in order to earn enough market share to make participation worthwhile.

Second, MA plans enroll many more people than the ACA marketplaces do, and the typical MA enrollee spends considerably more on medical care. This means that insurer risk-taking is more likely to pay off in Medicare Advantage.

Third, the risk-adjustment system, designed to offset adverse selection and make insurer participation less risky, is more favorable to Medicare Advantage plans than to marketplace insurers because risk adjustment does not have to be budget-neutral in the Medicare program. In Medicare Advantage, plan bids are multiplied by enrollees' relative risk scores, with the average risk score set to 1.0 across both Medicare Advantage and traditional Medicare. The Medicare Advantage risk-adjustment system does not require zero net effect on payments to MA plans from risk adjustment of bids, so in theory, all plans could receive additional money under the risk-adjustment system if all plans had an average relative risk score above 1.0. This is not the case in the ACA-compliant nongroup insurance market, where a budget-neutral risk-adjustment system requires that payments from insurers with below-average risks equal payments to insurers with above-average risks at the state level.

Fourth, Medicare Advantage plans can limit their payments to health care providers to no more than traditional Medicare payment rates, but marketplace plans in many markets pay providers at commercial payment rates or lower rates if they can negotiate them. These rates are often considerably higher than traditional Medicare rates, especially in markets with little or no provider competition. Without any regulatory limits on payment rates, premiums usually are higher and increase faster in marketplace plans than in the Medicare Advantage program.

THE MEDICARE ADVANTAGE APPROACH

The Medicare Advantage program has been extremely popular with Medicare beneficiaries, covering 19 million lives in 2017. The Medicare Advantage program was established in 2003 under the Medicare Modernization Act,[9] but private plans have competed with traditional Medicare through various programs since the 1980s.[10]

Competitive Environment: Premium Benchmarks, Bids, and Price Sensitivity

Medicare Advantage plans are paid by the Medicare program under a benchmark and bidding process. The Centers for Medicare & Medicaid Services (CMS) sets a benchmark for each county based largely on the costs of traditional fee-for-service Medicare payers. The benchmark represents the highest amount the Medicare program will pay to a Medicare Advantage plan in that county to cover an average-risk enrollee, and CMS publishes all benchmarks before Medicare Advantage plan bidding begins. Medicare Advantage plans then submit bids to CMS to provide Medicare Part A (hospital) and Part B (physician) benefits to an average-risk enrollee in a county or service area. These bids include the insurer's administrative costs and profits. This bid is compared to the predetermined benchmark, and plans with bids below the benchmark receive part of the difference as a rebate, an extra payment that must be used to provide extra benefits to plan enrollees (less administrative costs and profit). These extra benefits may include lower cost-sharing, prescription

drug benefits for no additional premium, or services not typically covered by traditional Medicare such as eyeglasses and gym memberships.[11] These extra benefits help a plan attract enrollees.[12] Plans with bids above the benchmark must charge enrollees an additional premium that fully covers the difference between their bid and the benchmark.

Medicare Advantage benchmarks are set based on projected traditional Medicare spending in each county, with some adjustments to lower benchmarks in counties with very high traditional Medicare spending and to increase benchmarks in counties with very low traditional Medicare spending. Benchmarks are also adjusted for Medicare Advantage plan quality, with high-quality plans bidding against higher benchmarks and receiving a larger share of the difference between the benchmark and their bid as a rebate. Nationally, Medicare Advantage benchmarks were 106 percent of, and payments were roughly equal to, traditional Medicare spending in 2017.[13]

Evidence suggests that the MA benchmark and bidding system does not yield the lowest possible bids from insurers, which means the system is not promoting the most aggressive price competition.[14] Because benchmarks are made public before the insurer bidding process, they "anchor" bids to some extent; insurers tend to bid below the benchmark but not as low as possible.[15,16] In addition, Medicare Advantage plans tend to offer lower cost-sharing or additional benefits with their rebate dollars, rather than buying down the Medicare Part B premium. Because plans with bids below the benchmark often compete on cost-sharing and extra benefits, not just premiums, the differences between plans may not be as obvious to enrollees. Finally, Medicare Advantage is competing against a disjointed benefit structure that includes separate prescription drug plans and supplemental coverage options, so the simplicity of getting Part A, Part B, Part D, and supplemental coverage all in one insurance plan through Medicare Advantage is attractive to enrollees, even before considering premiums, benefits, and out-of-pocket costs. In short, the competition in Medicare Advantage is not purely premium-based because both plans and enrollees offer other incentives.

Medicare Advantage is designed to be comparable to the traditional Medicare benefit (Parts A and B, and often Part D though it is not required), and both types of coverage are highly subsidized. In 2017, Part B premiums were $134 per month for single beneficiaries making up to $85,000 per year[17] (roughly 700 percent of FPL), and 81 percent of Medicare beneficiaries had access to a Medicare Advantage plan that covered prescription drugs for no more than the standard Part B premium.[4] This difference in subsidy is in part because of the tax structure underlying the Medicare program: Beneficiaries pay into the system throughout their working lives through a dedicated payroll tax for Part A benefits, while Part B and Part D benefits are subsidized by general revenues.

Market Size

The Medicare Advantage market included 19 million enrollees in 2017, 33 percent of the total Medicare population, so the potential market is larger still. This population is highly motivated to enroll in comprehensive coverage with coordinated care because health care risks increase with age. This enrollee population is stable, with little movement between Medicare Advantage plans from year to year. Thus, insurers can see potential returns from managing their enrollees' health care needs. Only about 10 percent of Medicare Advantage enrollees switch plans each year, and very few leave the Medicare Advantage market for traditional Medicare once they enroll.[18]

Risk Adjustment

The Medicare Advantage program includes risk adjustment to discourage plans from seeking only healthy enrollees and to balance the costs of high-risk patients across the system. The risk-adjustment process for Medicare Advantage is similar to that for the marketplaces, but it is not budget-neutral. Medicare Advantage plan bids are adjusted by enrollees' relative risk scores using a formula that is derived from traditional Medicare patterns of diagnoses and spending and is updated annually to set enrollee risk scores equal to 1.0 on average across both traditional Medicare and Medicare Advantage. This means that, in theory, most or all Medicare Advantage plans can have average enrollee risk scores above 1.0, all earning extra payments from the Medicare program. Research has shown that Medicare Advantage plans game the risk-adjustment system by aggressively (and sometimes fraudulently)[19,20] capturing as many enrollee diagnoses as possible,[21] leaving the traditional Medicare system to make risk-adjustment payments for Medicare Advantage beneficiaries who would be considered average-risk or lower-than-average-risk if they were enrolled in the traditional Medicare program.[13]

Protections Against Balance Billing

Medicare Advantage plans benefit from Medicare rules that prevent providers from balance-billing patients, which means hospitals and physicians cannot charge Medicare beneficiaries more than the Medicare fee schedule for covered services.[22,23] This rule applies in Medicare Advantage as well: Out-of-network providers can only charge Medicare rates for care Medicare Advantage enrollees receive out-of-network. This gives Medicare Advantage plans negotiating leverage to secure Medicare rates in-network, and evidence suggests that Medicare Advantage plans do pay at or close to Medicare rates to physicians and hospitals.[24,25] Consequently, all Medicare Advantage plans have access to reasonably low provider payment rates; they do not have to use market share leverage to negotiate reasonable rates to compete in this market.

MARKETPLACES WORK DIFFERENTLY FROM MEDICARE ADVANTAGE

ACA marketplaces are different in several ways. Competition between participating insurers is more intense, enrollees are more price-sensitive, the marketplace benchmark premiums are calculated differently, the nongroup markets enroll many fewer covered lives, risk adjustment is less favorable for insurers, and no regulations limit provider payment rates. The first three of these features are intertwined.

In the ACA-compliant private nongroup insurance markets, insurers can offer plans at four different metal levels: bronze (60 percent actuarial value [AV]), silver (70 percent AV), gold (80 percent AV), and platinum (90 percent AV). Insurers are required to offer plans at the gold and silver levels but may also offer bronze or platinum. Typically, insurers offer several different plans at each metal tier. Within a metal tier, these offerings can vary considerably in deductibles, co-pays, and out-of-pocket limits. For example, in 2017, the Blue Care Network of Michigan offered a silver plan with a $1,650 deductible and a $6,350 out-of-pocket limit for a premium of $286.21 (for a 40-year-old nonsmoker) and another silver plan with a $4,500 deductible and a $5,500 out-of-pocket limit for $287.70 per month. The insurer offered several other silver plans with different premiums, deductibles, and co-pays. The array of choices available to enrollees can be extremely bewildering, reducing effective price competition. Some states regulate the number of plans each insurer can offer on the marketplace, and some construct standardized benefit packages that all participating insurers must offer, but most states do not.[26]

Competition, Price Sensitivity, and Benchmark Premiums

The intensity of marketplace insurer competition depends on how the benchmark premium is determined (the basis for subsidy determination) and how price-sensitive enrollees are. The ACA's premium tax credits are benchmarked to the premiums of the second-lowest-cost silver plan in the enrollee's rating region. If a person chooses a plan with a premium higher than the benchmark, they must pay the full difference. If they choose a plan with a premium lower than the benchmark, they receive the difference in savings. This creates a strong incentive to purchase lower-premium plans.

Evidence shows that enrollees are extremely price-sensitive. Enrollment tends to cluster in the lower-premium silver plans, but enrollment is distributed more broadly across participating Medicare Advantage plans. Marketplace enrollees are, on average, younger and healthier than Medicare Advantage enrollees, so they are more likely to choose lower-cost, narrower-network plans, making it hard for higher-priced, broader-network plans to survive in the marketplaces.

Because insurers usually can offer several plans within an actuarial value tier, it is not uncommon for the second-lowest-cost plan and the lowest-cost plan to be offered by the same insurer.[27] An insurer offering the lowest- and second-lowest-cost plan is likely to command a very high market share. Typically, insurers achieve low premiums by developing narrow provider networks and negotiating favorable contracts with physicians, hospitals, and other providers. An insurer that cannot develop favorable provider contracts—because of low market share, for example—will find it difficult to survive in the market.

Market Size

Currently, only 6 percent of the nonelderly population is enrolled in coverage through the nongroup insurance market nationwide. Roughly half of that enrollment is in marketplace plans, and roughly half is in nonmarketplace plans. With low enrollment in many markets (particularly those in low-population-density areas) and some signs of adverse selection, many insurers have a hard time figuring out how to price their offerings, even without the ongoing uncertainty over federal policy changes. Because many nongroup markets are small, many insurers conclude that they are not worth taking the risk of entering and/or staying in. When setting premiums, insurers have to both protect themselves against losses and compete for market share. This is difficult in a market where they do not know what other insurers will do and there are not many enrollees to go around.

These challenges are exacerbated by the high rate of churn in marketplace and other nongroup insurance coverage year to year. Many enrollees change plans or shift in or out of the market in a year, as people obtain jobs, become eligible for Medicaid, or make other coverage decisions. This makes these markets far less stable than Medicare Advantage markets.[28] If insurers do not see the benefit of managing marketplace enrollees' health care—because longer-term gains are just as likely to accrue to their competitors—they may not invest as much in the marketplaces, leading to higher spending on claims and higher premiums over time.

Risk Adjustment

Private nongroup insurers (including marketplace and nonmarketplace ACA-compliant plans) use a risk adjustor like that used in Medicare Advantage, but with some critical differences. Nongroup risk adjustment is budget-neutral at the state level, so wins and losses must balance out within each state. Medicare risk adjustment is not budget-neutral, so all insurers in Medicare Advantage could, in theory, have risks scores above 1.0 and receive risk-adjustment payments from the Medicare program, an advantage not available to nongroup insurers in states with above-average health care needs. In addition, Medicare Advantage risk-adjustment payments and charges are based on each plan's bid, not on average premiums, as in nongroup market risk adjustment. This means MA plans get additional payments or charges proportional to their underlying costs.

The nongroup market approach to risk adjustment gives a significant advantage to large, established insurers over small, newer insurers, who have much less experience with risk adjustment and coding. If established insurers can increase their risk scores through better diagnostic coding, any additional payments must come from risk-adjustment charges against plans with lower risk scores. In many states, nonprofit co-op plans were required to pay millions of dollars in risk-adjustment payments to the dominant Blue Cross Blue Shield insurer in their state, which some blamed on their lack of experience with diagnostic coding.[29,30] Because risk-adjustment payments are based on state average premiums in the nongroup market, the nongroup market risk-adjustment system also disadvantages plans with low premiums and advantages those with higher premiums. Efficient lower-premium plans make risk-adjustment payments based on average premiums higher than their own; less efficient, higher-premium plans make risk-adjustment payments based on average premiums lower than their own.[31] This discourages aggressive pricing by new plans and limits their ability to gain market share. This problem is particularly acute in states with wide variation in premiums.

No Caps on Provider Payment Rates

Many marketplace plans pay providers at commercial rates, which are typically far higher than Medicare rates (Medicaid plans participating in the marketplace are probably paying rates below Medicare, though data on this is difficult to obtain). If a large, established insurer has negotiated favorable provider contracts in a market, other insurers will have a more difficult time breaking in because they will have no market share to leverage in negotiating competitive rates. Higher provider payment rates translate into higher premiums for consumers. Medicare Advantage plans do not face this scenario because the rule that prohibits balance billing of Medicare enrollees effectively limits provider payment rates to traditional Medicare rates.

POLICY RECOMMENDATIONS

If we want to strengthen the marketplaces for long-term stability and success, making some moves toward the Medicare Advantage approach holds significant promise. Some moves would affect both marketplace and nonmarketplace ACA-compliant nongroup coverage because the ACA treats them as a single risk pool. We recommend the following five steps to improve these markets:[32,33]

1. **Increase enrollment in marketplace plans.** Enrollment in Medicare Advantage is roughly double that in the marketplaces, and average spending per Medicare Advantage enrollee is considerably higher. Many marketplace regions simply have too few enrollees to sustain a market that attracts insurers and promotes their participation. These small regions often have one or two insurers, high premiums, and rapid premium growth. Elsewhere we have proposed several actions to increase enrollment, including (a) increasing premium and cost-sharing subsidies to make marketplace coverage more affordable; (b) fixing the family glitch, which prevents modest-income family members of workers offered affordable employee-only coverage from accessing premium tax credits and cost-sharing subsidies for which they are otherwise eligible; (c) establishing a permanent reinsurance program to lower nongroup insurance premiums, spreading the costs of adverse selection broadly across the taxpaying population; (d) increasing or restoring federal funding for advertising for HealthCare.gov and the marketplaces; and (e) prohibiting short-term non-ACA-compliant policies (not expanding them, as a recent executive order would do).

2. **Cap provider payment rates charged to ACA-compliant nongroup insurers at Medicare rates plus a percentage.** Many marketplaces have few insurers and/or provider monopolies. These conditions lead to higher provider payment rates and higher premiums. One way to address both problems is to establish a public option to compete with private nongroup insurers. This could be a publicly administered insurer that would abide by ACA market rules, offer insurance options on the marketplaces, and pay providers at Medicare rates (or Medicare rates plus

a percentage). But such an organization would take on huge responsibilities and inevitably would draw strong opposition from insurers. An alternative is to follow the example of Medicare Advantage described above. By capping balance billing at the Medicare fee schedule, Medicare Advantage insurers can negotiate paying the Medicare fee schedule in-network as well. Under rate caps, insurers without significant market share could set reasonable premiums, allowing them to enter marketplaces now dominated by one or two insurers with large market share. Rate caps would also break the pricing stranglehold of monopoly provider systems, where upward pricing pressure has been the greatest. With more insurers in the market, competition would slow premium growth. But these policies would have little or no effect in markets with strong competition, where insurers have negotiated rates successfully, in some cases even below Medicare levels.

3. **Standardize cost-sharing within metal tiers, or limit the number of plan designs available.** Only one (or only a few) cost sharing design(s)—meaning deductibles, cost-sharing, and out-of-pocket limits—would be permitted at each metal tier, and each competing insurer would have to use this design. (This approach was implemented in California.)[34] Medicare Advantage requires that each plan design submitted by insurers result in meaningfully different expected out-of-pocket costs, which limits the number of available plans and simplifies consumer choice. Limiting cost-sharing designs in the marketplaces would make comparison shopping considerably easier. It would also make it hard for one insurer to offer both the lowest- and second-lowest-cost plan, which has allowed some insurers to dominate markets and discourage others from participating.

4. **Lift the budget neutrality requirement for risk adjustment in the marketplaces.** In the current marketplace system, low-premium plans with healthy enrollees are disadvantaged in the risk-adjustment payment formula, and new plans may not be as adept as established plans at maximizing return from the risk-adjustment system. Using each plan's actual premium in the risk-adjustment payment calculation could alleviate concerns about disadvantaging efficient plans, but it could mean that risk adjustment would not be zero-sum within a state because contributions from low-premium plans could fall short of obligations to higher-premium plans. Conceptually, risk adjustment in the Medicare Advantage program is not budget-neutral because it is based on plans' individual bids and on relative risk across the entire Medicare program, including traditional Medicare.

5. **Marketplaces should use a higher benchmark than the second-lowest-cost silver plan for computing premium tax credits.** Currently, a single insurer can offer both the lowest- and second-lowest-cost plans in an area, controlling most of the market and discouraging other insurers from staying in. By using, for example, the higher of the median and the second-lowest-cost option, more insurers could remain in or enter markets and offer a plan that would be attractive to the subsidized population making up most of marketplace enrollment—in other words, a plan that would not require consumer contributions beyond the ACA's percent-of-income caps. This differs from the MA approach, in which plans compete against traditional Medicare and each other, but it would open up marketplaces to more insurers.

ENDNOTES

1. Medicare enrollment dashboard. Centers for Medicare & Medicaid Services website. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Dashboard/Medicare-Enrollment/Enrollment%20Dashboard.html. Accessed January 9, 2018.
2. Health insurance marketplaces 2017 open enrollment period final enrollment report: November 1, 2016 – January 31, 2017 [news release]. Baltimore, MD: Centers for Medicare & Medicaid Services Office of Communications; March 15, 2017. https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-03-15.html. Accessed January 9, 2018.
3. Holahan J, Wengle E, Blumberg LJ, Solleveld P. *What Explains the 21 Percent Increase in 2017 Marketplace Premiums, and Why Do Increases Vary Across the Country?* Washington: Urban Institute; 2017. https://www.urban.org/research/publication/what-explains-21-percent-increase-2017-marketplace-premiums-and-why-do-increases-vary-across-country.
4. Jacobson G, Damico A, Neuman T, Gold M. Medicare Advantage 2017 spotlight: enrollment market update. Menlo Park, CA: Kaiser Family Foundation; 2017. https://www.kff.org/medicare/issue-brief/medicare-advantage-2017-spotlight-enrollment-market-update/.
5. Medicare Board of Trustees. *2017 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*. Baltimore, MD: Centers for Medicare & Medicaid Services Office of Communications; 2017. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2017.pdf.
6. Congressional Budget Office. June 2017 Medicare baseline. Washington: Congressional Budget Office; 2017. https://www.cbo.gov/sites/default/files/recurringdata/51302-2017-06-medicare.pdf.
7. Holahan J, Blumberg LJ, Wengle E. *What characterizes the marketplaces with one or two insurers?* Washington: Urban Institute; 2017. https://www.urban.org/research/publication/what-characterizes-marketplaces-one-or-two-insurers.
8. Holahan J, Blumberg LJ, Wengle E. *Marketplace Plan Choice: How Important Is Price? An Analysis of Experiences in Five States*. Washington: Urban Institute; 2016. https://www.urban.org/research/publication/marketplace-plan-choice-how-important-price-analysis-experiences-five-states.
9. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, HR 1, 108th Cong.
10. McGuire TG, Newhouse JP, Sinaiko AD. An economic history of Medicare Part C. *Milbank Q*. 2011;89(2):289–332. https://doi.org/10.1111/j.1468-0009.2011.00629.x.
11. In Medicare Advantage, plans largely compete on extra benefits, such as prescription drug coverage at no additional cost. Thus, premium competition is not as intense as

in the marketplaces, and the primary incentive for plans to bid low is to gain market share by offering a more attractive benefit package.

12. Nicholas LH. Will Medicare Advantage benchmark reforms impact plan rebates and enrollment? *Am J Manag Care*. 2014;20(11):917–924.
13. Medicare Payment Advisory Commission. Status report on the Medicare Advantage program. In: *Report to the Congress: Medicare Payment Policy*. March 2017. Washington: Medicare Payment Advisory Commission; 2017: 345–379. http://medpac.gov/docs/default-source/reports/mar17_medpac_ch13.pdf?sfvrsn=0. Accessed January 9, 2018.
14. In fact, overpaying Medicare Advantage insurers was a policy approach designed to increase insurer participation after insurer exits in the 1990s. Corlette S, Hoadley J. *Strategies to Stabilize the Affordable Care Act Marketplaces*. Washington: Georgetown University Health Policy Institute; 2016. https://www.rwjf.org/en/library/research/2016/08/strategies-to-stabilize-the-affordable-care-act-marketplaces.html.
15. Song Z, Landrum MB, Chernew ME. Competitive bidding in Medicare Advantage: effect of benchmark changes on plan bids. *J Health Econ*. 2013;32(6):1301–1312.
16. Zuckerman S, Skopec L, Guterman S. *Do Medicare Advantage plans minimize costs? Investigating the relationship between Medicare Advantage benchmarks, plan costs, and rebates.* New York: Commonwealth Fund; 2017. https://www.urban.org/research/publication/do-medicare-advantage-plans-minimize-costs-investigating-relationship-between-benchmarks-costs-and-rebates.
17. Part B costs. Medicare website. https://www.medicare.gov/your-medicare-costs/part-b-costs/part-b-costs.html. Accessed January 9, 2018.
18. Jacobson G, Neuman T, Damico A. Medicare Advantage plan switching: exception or norm? Menlo Park, CA: Kaiser Family Foundation; 2016. https://www.kff.org/report-section/medicare-advantage-plan-switching-exception-or-norm-issue-brief.
19. Walsh MW. A whistle-blower tells of health insurers bilking Medicare. DealBook blog. Posted May 15, 2017. https://www.nytimes.com/2017/05/15/business/dealbook/a-whistle-blower-tells-of-health-insurers-bilking-medicare.html. Accessed January 9, 2018.
20. Walsh MW. UnitedHealth overbilled Medicare by billions, U.S. says in suit. DealBook blog. Posted May 19, 2017. https://www.nytimes.com/2017/05/19/business/dealbook/unitedhealth-sued-medicare-overbilling.html. Accessed January 9, 2018.
21. Kronick R. Projected coding intensity in Medicare Advantage could increase Medicare spending by $200 billion over ten years. *Health Aff*. 2017;36(2):320–327.
22. Social Security Act, 42 USC §1395cc (2006).
23. Special rules for services furnished by noncontract providers. *Fed Regist*. 1998;63(123):35002. Codified at 42 CFR §422.214.
24. Berenson RA, Sunshine JH, Helms D, Lawton E. Why Medicare Advantage plans pay hospitals traditional Medicare prices. *Health Aff*. 2015;34(8):1289–1295.
25. Trish E, Ginsburg P, Gascue L, Joyce G. Physician reimbursement in Medicare Advantage compared with traditional Medicare and commercial health insurance. *JAMA Intern Med*. 2017;177(9):1287–1295.
26. Blumberg LJ, Rifkin S, Corlette S, Dash SJ. *Stabilizing Premiums Under the Affordable Care Act: State Efforts to Reduce Adverse Selection*. Washington: Urban Institute; 2013. https://www.urban.org/research/publication/stabilizing-premiums-under-affordable-care-act-state-efforts-reduce-adverse-selection.
27. This is based on our analysis of public use data files from HealthCare.gov and relevant state-based marketplace websites.
28. Office of the Assistant Secretary for Planning and Evaluation. Health insurance marketplace premiums after shopping, switching, and premium tax credits, 2015–2016. Washington: US Dept of Health and Human Services; 2016. https://aspe.hhs.gov/system/files/pdf/198636/MarketplaceRate.pdf.
29. Livingston S. Small insurers rack up large charges while Blues benefit under ACA's risk-adjustment program. *Modern Healthcare*. July 5, 2017. http://www.modernhealthcare.com/article/20170705/NEWS/170709986. Updated July 7, 2017. Accessed January 9, 2018.
30. Liner DM, Siegel J. ACA risk adjustment: special considerations for new health plans. Seattle: Milliman; 2015. http://www.milliman.com/uploadedFiles/insight/2015/2154HDP_20160120.pdf.
31. Payment amounts are set based on the statewide average silver premium, so low-premium plans pay a higher share of their premium revenue into the system if they have a lower risk score than would be expected.
32. Blumberg LJ, Holahan J. Strengthening the ACA for the long term. *N Engl J Med*. 2017;377:2105–2107. http://www.nejm.org/doi/10.1056/NEJMp1713247.
33. Blumberg LJ, Holahan J. *Stabilizing and strengthening ACA nongroup markets.* Washington: Urban Institute; 2017. https://www.urban.org/research/publication/stabilizing-and-strengthening-aca-nongroup-markets.
34. Covered California. *2017 Standard Benefit Designs*. Sacramento, CA: Covered California; 2016. http://hbex.coveredca.com/stakeholders/plan-management/PDFs/2017_Standard_Benefit_Plan_Designs_FINAL_Board-approved_2016-04-07.pdf?v=2.0.

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