



Paying more for less? Insurer competition and health plan generosity in the Medicare Advantage program[☆]



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ABSTRACT

This paper explores the relationship between insurer competition and health plan benefit generosity by examining the impact of a regulatory change that caused the cancellation of 40% of the private plans in Medicare. I isolate cancellation's causal effect by using variation induced by insurers canceling all plans nationally. Results show that insurers in markets affected by cancellation reduced the benefit generosity of the plans remaining in the market. In the average market, out-of-pocket costs for a representative beneficiary enrolled in plans not directly affected by the policy increased by \$91 annually. In the least competitive markets, out-of-pocket costs increased by roughly \$64–\$127 a year for enrollees in those plans. Meanwhile in the most competitive markets, benefit generosity barely changed. These findings have crucial implications for markets such as health insurance exchanges, as they suggest that plan generosity is degraded when competition declines.

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Many health insurance markets, such as those formed under the Affordable Care Act (ACA) and Medicare Part D, are structured to foster insurer competition. Regulators set parameters on the number and characteristics of plans insurers can offer, and insurers offer plans based on those parameters. Enrollees choose from a menu of plans, and, in theory, competition between insurers for enrollees encourages insurers to offer affordable, high-quality plans.

A large literature has shown that competition between insurers generally reduces premiums, but research on the effect of competition on plan quality is more limited (Dafny et al., 2015, 2012; Guardado et al., 2013; Lustig, 2011; Dafny, 2010; Starc, 2014; Town and Liu, 2003; Town, 2001; Wholey et al., 1995). Moreover, in the-

ory, competition between insurers need not increase plan quality.¹ In a market where consumers value higher plan quality and lower premiums, insurers must balance the gains from increasing plan quality with the additional costs (and therefore higher premiums) of improving quality. If consumers value low premiums more than plan quality – or, alternately, if premiums are more salient to consumers than plan quality – then insurers may cut quality to reduce premiums. Competition may increase the pressure to reduce premiums – with the side effect that competition could reduce quality.

This paper examines the effects of changes in health insurance market competition on one particular dimension of plan quality – plan benefit generosity. Benefit generosity is defined here as the proportion of medical spending covered by the insurer and is determined by plan financial characteristics such as copays, deductibles, and covered benefits. Though other plan characteristics such as the size of a plan's networks or the quality of its customer service are also important aspects of plan quality, plan benefit generosity has a large impact on consumers. Specifically, although less generous benefits can encourage plan enrollees to consume care prudently, limited benefit generosity also increases financial liability and may decrease access to care in the privately insured population (Hamel et al., 2016).

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¹ Gaynor (2006) provides an excellent framework and literature review on competition and quality in healthcare (Gaynor, 2006).

In the policy experiment analyzed here, Congress passed legislation intended to reduce over-payment to a particular type of private health insurance plan in Medicare – private-fee-for-service (PFFS) plans. PFFS plans are offered through the Medicare Advantage (MA) program, in which Medicare beneficiaries purchase health plans to cover their Medicare benefits. Most Medicare Advantage plans provide benefits that are more generous than fee-for-service (FFS) Medicare, but also have more limited networks. However, prior to the policy change, PFFS plans were not required to create provider networks or contract with providers. Rather, beneficiaries could visit any Medicare provider at no extra cost. If a provider agreed to treat PFFS plans' enrollees, then PFFS plans could pay providers administratively-set Medicare FFS rates. Medicare FFS payment rates are often thought to be lower than the payment rates commercial insurers negotiate with providers (Clemens and Gottlieb, 2017; White et al., 2013), and, at this time, Medicare paid most Medicare Advantage plans a per-enrollee price for accepting beneficiaries that was higher than the cost of providing care for a similar beneficiary in FFS. Those two factors – combined with a pattern of selective entry into counties where Medicare Advantage payment rates were particularly high, relative to Medicare FFS – potentially led to PFFS plans having substantially higher margins than other types of Medicare Advantage plans.

Congress responded to reports suggesting PFFS plans were over-paid (Medicare Payment Advisory Commission, 2007; Neuman, 2007; Gold, 2007) by passing a law requiring insurers to establish provider networks for PFFS plans in the majority of counties. The law also stipulated that insurers must negotiate payment rates for providers in those networks, rather than paying administratively-set Medicare FFS rates (Medicare Improvements for Patients and Providers Act of 2008, 2008). Those requirements removed PFFS plans' cost advantage and eliminated the characteristic that differentiated them. Insurers responded by canceling roughly two-thirds of their PFFS plans, forming networks for the remainder.

I explore how remaining plans' characteristics changed in response to PFFS cancellation using cross-county variation in cancelled plans' market shares. To address the fact that PFFS plans were not randomly distributed at baseline, I use a difference-in-differences specification with county and year fixed effects, where cancelled plans' market shares are used as a continuous treatment variable. To avoid endogeneity due to selective cancellation, I estimate cancellation's impact using baseline PFFS market shares for those insurers who cancelled all their PFFS plans nationally. National cancellations are plausibly unrelated to unobserved confounding variables, because an insurer's decision to cancel all plans is unlikely to be driven by unobserved changes in profitability in local markets.²

I relate nationally cancelled plans' market shares to two measures of plan generosity: expected out-of-pocket costs for a representative enrollee and plan premiums. I find clear evidence that generosity decreased (out-of-pocket costs increased) in markets with more cancellation. In the average county, expected out-of-pocket costs for an MA beneficiary rose by about \$132 annually due to plan cancellation. Additionally, changes were not limited to plan types directly affected by the policy. Among PFFS plans – which were directly affected by the policy – cancellation caused annual expected out-of-pocket costs to increase by \$205 in the

average county, while among Health Maintenance Organization plans (HMOs) and Preferred Provider Organization (PPO) plans – which were not directly affected by the policy – cancellation caused annual expected out-of-pocket costs in the average county to increase by around \$91. These estimates suggest that cancellation reduced MA HMO and PPO plans' generosity advantage over FFS Medicare by about 15–22%.³

In contrast, cancellation's effect on premiums was much smaller and was limited to plans directly affected by the policy. Premiums increased by about \$36 annually due to cancellation, and increases were only significant among PFFS plans, which might plausibly be passing on the increased costs of the policy by raising premiums. Cancellation potentially had a larger effect on benefit generosity than premiums because most plans are subsidized by the Medicare benchmark and, thus, do not charge more than the standard Part B premium. Consistent with this, I find that plans that charged a premium at or below the standard premium in the prior period modify their benefits by more than plans that charged an additional premium.

To further explore if changes in benefit generosity were driven by changes in competition, I test whether insurers changed benefits by more in counties that had less competition between PFFS plans' substitutes (HMOs and PPOs) at baseline. Specifically, I divide counties into groups by their baseline levels of competition among insurers offering HMOs and PPOs. Consistent with theory and past empirical work, I find that benefits decreased the most in markets with the least competition between PFFS plans' substitutes – the markets where insurers likely gained the most market power. In those markets, out-of-pocket cost for a representative beneficiary in an average county enrolled in an HMO or PPO rose by roughly \$64 to \$127 annually.

This analysis focuses on a particular policy change, but the results are relevant to a broader literature on health insurance competition and plan characteristics. Chiefly, although many studies have investigated the impact of plan competition on premiums, relatively few have examined the effects of competition on plan characteristics such as benefit generosity (Pizer and Frakt, 2002; Town and Liu, 2003; Chorniy et al., 2013; Cabral et al., 2014; Duggan et al., 2016).⁴ Moreover, their conclusions conflict. Town and Liu (2003), Pizer and Frakt (2002), and Cabral et al. (2014) find that reducing competition in Medicare Advantage decreases benefits (drug coverage and cost sharing), while Chorniy, et al. find that consolidation in Part D leads to better benefits (more generous formularies) (Chorniy et al., 2013). Finally, Duggan et al. find that greater competition in Medicare Advantage only affects beneficiary out-of-pocket costs in the most competitive quintile of markets (Duggan et al., 2016).

There are several challenges in assessing competition's effect on plan characteristics. First, data on health insurance plan characteristics (beyond premiums) are not widely available, and insurance plans are complicated multidimensional products. Second, exogenous variation in competition is rare and omitted variables may cause both high premiums (or stingy benefits) and concentrated insurance markets. This paper contributes to the literature by showing, in a well-identified setting, that competition can have a major impact on insurance plan generosity. Additionally, few studies explore the relationship between competition and plan benefits

² This strategy is similar to those used in Dafny et al. (2015) and Dafny et al. (2012). Dafny et al. (2012) examine the effect of a change in competition on premiums in the employer-sponsored health insurance market, using local variation in insurance market structure caused by the merger of two national firms. This approach avoids many potential sources of endogeneity, as the two merging firms operated in all markets prior to the merger. Thus, insurers' decision to merge nationally is unlikely to be related to omitted variables that affected premiums at the local level.

³ On average across all years in the study period, expected out-of-pocket costs are about \$50 a month lower in Medicare Advantage than in FFS Medicare.

⁴ Most studies find that premiums are higher in less competitive markets (Dafny et al., 2015; Guardado et al., 2013; Lustig, 2011; Dafny, 2010; Starc, 2014; Town and Liu, 2003; Wholey et al., 1995) and that consolidation increases premiums (Dafny et al., 2012; Town, 2001). However, there are exceptions; for instance, Feldman et al. (1996) find that HMO mergers only increase premiums in the most competitive markets and that mergers' effects dissipate quickly (Feldman et al., 1996).

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