



Who benefits when the government pays more? Pass-through in the Medicare Advantage program[☆]



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ABSTRACT

Governments contract with private firms to provide a wide range of services. While a large body of previous work has estimated the effects of that contracting, surprisingly little has investigated how those effects vary with the generosity of the contract. In this paper we examine this issue in the Medicare Advantage (MA) program, through which the federal government contracts with private insurers to coordinate and finance health care for 17 million Medicare recipients. To do this, we exploit a substantial policy-induced increase in MA reimbursement in metropolitan areas with a population of 250,000 or more relative to MSAs below this threshold. Our results demonstrate that the additional reimbursement leads more private firms to enter this market and to an increase in the share of Medicare recipients enrolled in MA plans. Our findings also reveal that about one-eighth of the additional reimbursement is passed through to consumers in the form of better coverage. A somewhat larger share accrues to private insurers in the form of higher profits and we find suggestive evidence of a large impact on advertising expenditures. Our results have implications for a key feature of the Affordable Care Act that will reduce reimbursement to MA plans by \$156 billion from 2013 to 2022.

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1. Introduction

Governments often contract with private firms to provide publicly financed goods and services. The size of these contracting arrangements is vast and the breadth is wide, representing 10% of GDP in the U.S. in 2008 and ranging from defense contractors to landscaping companies (OECD, 2011). Private firms are also increasingly involved in social services such as education and health care. “Contracting out” could lead to improved efficiency, as private firms have powerful incentives to control costs. Additionally, if the government contracts with multiple firms, consumers may have access to more

choice. This can improve consumer surplus in two ways: additional competition can lead to quality improvements and private firms may more effectively cater to heterogeneous consumer preferences.

The Medicare program, which currently provides health insurance to 55 million U.S. residents at a cost of over \$600 billion in 2013, offers an important example of “contracting out” (CMS, 2013; CBO, 2013). For most Medicare recipients, the federal government directly reimburses hospitals, physicians, and other health care providers on a fee-for-service basis. However, for 17 million (or 31% of all) Medicare recipients, the federal government contracts with private insurers to coordinate and finance medical care as part of the Medicare Advantage (MA) program. This paper examines the MA market and explores how the quality of private provision changes as the generosity of the contract increases.

Previous research has investigated the effect of Medicare Advantage on Medicare expenditures, health care utilization, and health outcomes (Afendulis et al., 2013, Landon et al., 2012, Lemieux et al., 2012). A related strand of research has explored how MA enrollment is affected by the generosity of plan reimbursement (Cawley et al., 2005, Pope et al. 2006); surprisingly little research has investigated how the characteristics of Medicare Advantage coverage vary with the generosity of plan reimbursement. Plan payment rates

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Fig. 1. Medicare Advantage market share by year. Note: Enrollment data are taken from publicly available CMS files and aggregated to the year level. The X-axis denotes year, while the Y-axis denotes the % of Medicare recipients enrolled in Medicare Advantage plans.

could influence the quality of coverage offered by private insurers as well as the entry decisions of some insurers. Given that a key feature of the recently enacted Affordable Care Act gradually lowers reimbursement to MA plans by an estimated \$156 billion from 2013–22 (CBO, 2012), this gap is unfortunate. While the Congressional Budget Office and others have estimated that these lower payment rates will reduce MA enrollment, there is little evidence on how the quantity and quality of plans will change for those who remain in the program.

We aim to partially fill this gap in the literature by exploiting policy-induced variation in the generosity of MA plan reimbursement. In counties with relatively low Medicare Fee-for-Service (FFS) spending, plan payments are set at a payment floor. This floor is 10.5% higher in counties that belong to metropolitan areas with more than 250,000 residents than it is in counties below this threshold. We leverage cross-sectional variation in payment, focusing in on the 2007–2011 period, which is marked by a substantial expansion in the MA program, as shown in Fig. 1. In doing so, we explore the impact of additional reimbursement on MA enrollment and on the generosity of MA coverage. We compare outcomes in urban counties with a population of 250,000 or more to similar counties below this threshold.¹ The differential payments applying to urban counties are in effect throughout our sample period and affect a substantial percentage of counties, as shown in Fig. 2.

Our first set of empirical results indicate that counties receiving additional reimbursement (by virtue of the urban payment floor) see an average of 1.8 more insurers, as well as an HHI that is 873 lower. These effect sizes are substantial, given that our non-urban control counties have an average of 5.4 insurers and an average HHI of 4308. Our findings imply that increased reimbursement induces more insurers to enter the MA market, which in turn gives Medicare recipients more MA plans from which to choose. We next estimate the effect of the additional reimbursement on the fraction of Medicare

recipients enrolling in MA.² We estimate that the 10.5% increase in plan reimbursement in urban counties leads to a 13.1 percentage point increase in enrollment in MA plans.³ This enrollment increase could arise through a variety of different mechanisms, such as improved quality of coverage, increased advertising, or enhanced plan variety through new plan entry.

One concern is that insurer entry and overall MA enrollment may differ across urban and non-urban counties for reasons apart from MA reimbursement generosity. We conduct a series of falsification tests, using two sets of difference-in-differences specifications. In the first, we restrict to non-floor counties, where FFS expenditures are relatively high and MA reimbursement is set independent of urban status. We find no evidence of higher MA enrollment or greater competition in this set of urban counties relative to their non-urban counterparts. We also estimate a similar set of specifications for the period preceding the introduction of differential urban payments. We find no evidence of a significant relationship between urban status and our outcome variables of interest throughout this earlier period. These results remain unchanged when including a broader set of counties and longer time period, under a triple-difference specification.

Given this evidence of greater competition in counties with higher MA payments, we next explore reimbursement's impact on consumer out-of-pocket costs and premiums. Here, we find much more modest effects. Our estimates suggest that only one-eighth of the additional reimbursement is passed through to consumers and we can rule out pass-through of 49% or more at the 95% level of confidence. These findings suggest that less than half of the additional reimbursement is passed on to consumers, through reductions in premiums, deductibles, or co-payments. Despite evidence of limited pass-through on average, we also find substantial heterogeneity across counties, with greater pass-through in more competitive counties. These results are broadly consistent with recent research by Cabral et al. (2014), which estimates that less than half of incremental reimbursement to Medicare managed care plans in the early 2000s is passed through to consumers and that consumers benefit more in more competitive markets.

Low rates of pass-through could potentially be attributable to compositional differences in insurers across urban and non-urban floor counties. To investigate this possibility, we split the sample into Humana and non-Humana plans, as Humana is the largest provider of MA coverage and operates in virtually all of our markets. If the additional insurers that enter in response to the enhanced reimbursement offer less generous coverage than those already operating, we would expect to find greater pass-through among Humana plans. Consistent with this, our estimates imply significant pass-through of 19% for Humana plans versus (an insignificant) 0.5% for all other plans.

Plans may respond to reimbursement increases through an alternate channel: by improving care quality rather than decreasing their enrollees' financial costs. For example, plans could contract with better providers, cover additional services, or expand the breadth of their provider networks in response to the additional revenues. We use detailed individual-level data from the Consumer Assessment of Healthcare Providers and Systems (CAHPS), which contains information on MA plan satisfaction ratings, utilization, and health outcomes, and find no evidence of increases to patient satisfaction or utilization in urban floor counties. Similarly, we find

¹ Our specifications control flexibly for both the county and the MSA (Metropolitan Statistical Area, as defined by the U.S. Census) population and for county per-capita Medicare FFS expenditures. To obtain a more comparable set of urban and non-urban counties, we focus on counties in metropolitan areas with populations between 100,000 and 600,000 while probing the sensitivity of our results to alternative sample definitions.

² All else equal, a higher level of reimbursement would make the marginal MA enrollee more profitable for health insurers, which would lead insurers to aim for higher enrollment.

³ Our implied elasticity estimates are approximately twice as large as those from studies using data from the late 1990s and early 2000s (Cawley et al., 2005; Cabral et al., 2014) and we outline several plausible explanations for this difference below.

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