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Making Medicare advantage a middle-class program

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ABSTRACT

This paper studies the role of Medicare's premium policy in sorting beneficiaries between traditional Medicare (TM) and managed care plans in the Medicare advantage (MA) program. Beneficiaries vary in their demand for care. TM fully accommodates demand but creates a moral hazard inefficiency. MA rations care but disregards some elements of the demand. We describe an efficient assignment of beneficiaries to these two options, and argue that efficiency requires an MA program oriented to serve the large middle part of the distribution of demand: the "middle class." Current Medicare policy of a "single premium" for MA plans cannot achieve efficient sorting. We characterize the demand-based premium policy that can implement the efficient assignment of enrollees to plans. If only a single premium is feasible, the second-best policy involves too many of the low-demand individuals in MA and a too low level of services relative to the first best. We identify approaches to using premium policy to revitalize MA and improve the efficiency of Medicare.

1. Introduction

Beneficiaries in Medicare, the federal health insurance program for the elderly and disabled, have for some time chosen between two major options: traditional Medicare (TM) and a set of private health insurance plans, including managed care plans, offered under Medicare Part C. Presently, only about 27% of beneficiaries elect a Part C plan. The objectives of Part C, since 2003 known as Medicare advantage (MA),[1] are to expand health insurance options for beneficiaries while taking advantage of economies of managed care to save money for Medicare. Achieving these dual objectives requires that Medicare pay an MA plan less than what beneficiaries would cost Medicare in TM but more than cost for the beneficiaries in MA, leaving some savings to share with beneficiaries in the form of lower premiums/better coverage in MA to attract them to an MA plan. Research and policy have focused on the "risk adjustment" of Medicare payments to pay more for the sick and less for the healthy joining the MA plans.[2] In spite of improvements in risk adjustment technology and many other policy reforms, Part C has yet, however, to save Medicare money (McGuire et al., 2011). As part of the Affordable Care Act (ACA), Medicare payments to MA plans are being cut, and, based on experience, plan and beneficiary exit will follow;[3] but, based on the same experience, these cuts are unlikely to move the MA program into the black for Medicare.[4]

We argue that a major contributor to the chronically poor performance of Part C is the inefficient sorting of beneficiaries between MA and TM caused by Medicare's premium policy. In this paper, we shift analytic focus away from plan payment and risk adjustment to the premiums and the incentives faced by heterogeneous beneficiaries when they elect MA or TM. To address normative questions around beneficiary choice between MA and TM, we propose a formulation of which beneficiaries *should* be in MA and in TM. Somewhat surprisingly, in light of the policy attention to Medicare and the Part C program, the Medicare policy literature says little about what socially efficient sorting looks like. The fundamental answer to who should be in MA underlies the title of the paper. We argue that MA should, from the standpoint of social welfare,

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[1] The Medicare Modernization and Improvement Act of 2003 renamed Part C plans as Medicare Advantage plans. Previously, plans were called Medicare+Choice plans.

[2] For reviews of the literature on risk adjustment, see Newhouse (2002) or Van de Ven (2000). Broader themes regarding risk and variation are covered in Breyer et al. (2012).

[3] For recent analysis of payment changes from the ACA and plan response showing up in anticipation of these changes, see Afendulis et al. (2011).

[4] In addition to refining risk adjustment, Medicare has raised and lowered the overall level of payment to MA plans a number of times in the past 25 years depending on whether increasing access to MA plans or saving money were the dominant policy concern. McGuire et al. (2011) describe these changes and the plan and beneficiary response.

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draw beneficiaries from the thick central part of the distribution of preferences for health care, and in this sense make MA a "middle class" program.

Our approach is based on the observation that beneficiaries vary in their demand for health care for many reasons. Most attention has been directed to the heterogeneity related to "health status" and the risk adjustment technology designed to deal with it (Pope et al., 2004). Health status-based risk adjustment explains a small share (10% or less) of the individual variation in health care spending, partly because health status is difficult to measure and predict. Another reason, and one that we call attention to here, is that factors other than health status – income, education, "taste" more generally[5] – also influence demand for health care, and therefore choice of plan.

From the standpoint of the beneficiary, anticipated demand for health care, together with the premiums for TM and MA, determine the best plan option. Premiums for TM are described below, and depend on the circumstances of the beneficiary. MA plans choose the premium beneficiaries pay (subject to Medicare regulation), and this premium is the same for all beneficiaries. There is a fundamental problem with this approach. Generally, efficient pricing of health insurance options requires beneficiaries be charged their incremental cost in the various options. Thus, at least some price discrimination according to incremental cost can improve efficiency. Furthermore, any single premium for MA cannot sort beneficiaries between MA and TM. We argue that some form of premium discrimination by non-health status factors affecting demand is necessary to rescue MA from its chronically poor performance. After our analysis, we discuss some ways to change premium policy in TM as well as MA to better achieve Medicare objectives and economic efficiency.

2. Traditional Medicare and Medicare advantage

2.1. Program descriptions

At age 65, most Americans become eligible for Medicare.[6] If beneficiaries do not elect an MA plan, they are automatically enrolled in Part A of Medicare at no cost to them.[7] Part A is financed largely by a payroll tax shared by employees and employers (Kaiser Family Foundation, 2008). Part A covers inpatient hospital services, some post-hospital stays in nursing facilities and home health care, and hospice care, but requires considerable beneficiary cost sharing. The most significant beneficiary cost sharing is the deductible ($1132 for 2011) per hospital episode ("benefit period"). Beneficiaries may also enroll in Part B, which covers doctors' visits, other ambulatory services and some drugs administered in physician offices. The standard Part B premium for 2011, which applies to new enrollees, is $115.40 per month. Many enrollees pay only $96.40 per month because of hold-harmless provisions applying to social security payments from which the Part B premium is deducted (CMS, 2010). Very few (3%) of beneficiaries pay a higher premium because of high individual or family income, and some (17%) have premiums all or partly covered by Medicaid.[8] Part B premiums cover only about 25% of Medicare's cost of Part B, the balance being paid for by general revenues (Kaiser Family Foundation, 2008). The vast majority of beneficiaries in TM enroll in Part B. Beneficiary cost sharing in Part B includes an annual deductible of $162 in 2011 and a 20% coinsurance on Medicare allowed charges. Since 2006, beneficiaries may also join a Part D plan covering prescription drug costs. Part D plans receive about 75% of their federal revenue from general revenues, are offered by private insurers, and vary in coverage. Part D premiums are set by a bidding procedure, the average premium for a stand-alone drug plan (taken as part of TM) was $38/month in 2011 (MedPAC, 2011b, Section 10). Low-income beneficiaries receive a premium subsidy (and lower cost sharing). Beneficiaries with Part A, and the optional Parts B and D, are considered to be in "traditional Medicare."

Most beneficiaries in TM avoid cost sharing in Parts A and B with medigap or some other supplemental coverage. Medicaid pays cost sharing for eligible low-income beneficiaries. Some employers buy wrap-around coverage for retirees. Finally, most beneficiaries in neither of these groups buy medigap policies to cover some or all of the cost sharing. The average monthly premium for the most popular medigap policy (Plan F) was $167 in 2009 (MedPAC, 2011a). Given the pervasiveness of supplemental coverage, we think of TM as traditional health insurance with low cost sharing, with a premium for beneficiaries equal to the Part B premium plus what they pay for Part D and supplemental coverage.

Virtually all hospitals and practicing physicians accept Medicare payment, giving beneficiaries wide choice of providers. Medicare and its regional intermediaries make broad coverage decisions but do not interfere with (a.k.a. "manage") physician and patient choice of treatment. Health care in TM has been criticized as being uncoordinated and costly (Newhouse, 2002). TM contends with cost issues primarily by using its monopsony power to pay physicians and hospitals roughly 20–30% less than private plans on average (MedPAC, 2008).[9]

The Medicare Modernization Act of 2003 (MMA) created MA to replace the short-lived Medicare + Choice version of Part C. MA plans are private, must cover all Part A and B benefits, and may supplement these benefits by reduced cost sharing or coverage for additional services not part of TM, such as vision or dental care (Gold, 2008).[10] MA plans may or may not include drug coverage. Those that do are referred to as MA-PD (i.e., "Prescription Drug") plans. In total, 11 million beneficiaries, or 24% of all, were enrolled in an MA plan in 2010 (KFF, 2010a).

The MMA created new plan types within MA and the higher payments mandated in the legislation awakened dormant plan types established earlier. We distinguish between what we consider to

[5] Income effects, for example, have been studied in health care. Cross-sectional studies generally report a positive income elasticity of demand that is less than one. The Rand Health Insurance Experiment found income elasticities of between 0.1 and 0.2 (Newhouse, 1993). Studies using longitudinal variation in income find much larger elasticities, generally classifying health care as a "luxury good" with income elasticities exceeding 1.0 (see Fogel, 2008). Borger et al. (2008) reviewed over twenty papers and settled on a unit income elasticity to use in their simulation model. In a recent study, Acemoglu et al. (2009) use oil price shocks to estimate the income effect on demand for health care at 0.7. Those with higher income tend to be in better health, so adequate controls for health status are necessary to identify income effects. The same is true for education. The better-educated tend to be healthier, but once health status is controlled for, education increases health care demand.

[6] Medicare also provides health insurance for qualified disabled beneficiaries below age 65. These beneficiaries may also choose to join the same MA plans on the same terms as the elderly beneficiaries.

[7] Beneficiaries with short Medicare work histories and not married to a beneficiary with a long work history may pay a Part A premium but this applies to about 1% of beneficiaries CMS (2011).

[8] In addition, there are penalties for delaying enrollment in Part B in the form of higher premiums (CMS, 2010).

[9] In traditional Medicare, physicians are paid for each procedure according to a fee schedule. Hospitals are paid according to the diagnosis-related group (DRG) in which a patient is classified at discharge. The hospital payment system is partly "prospective," embodies some incentives to the hospital to economize on resources during the hospital stay. For an overview of Medicare payment policies applying to physicians, hospitals and health plans, see Newhouse (2002).

[10] Gold and her colleagues at Mathematica Policy Research have tracked policy, enrollment, plan types and other data on Part C for a number of years in a useful series of publications (Gold, 2009; Gold et al., 2004).